Responsiveness and Accountability in the Health Sector, Pakistan

A report for DFID and AusAID

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LIST OF ABBREVIATIONS

ADB	Asian Development Bank
BHU	Basic Health Unit
CCB	Citizens Community Board
CSG	Community Support Groups
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
EDO(H)	Executive District Officer (Health)
FIA	Federal Investigation Agency
HMIS	Health Management Information System
HSSPU	Health Systems Strengthening Policy Unit
LGO	Local Government Ordinance
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
NHP	National Health Policy
NHRIC	National Health Resource Information Centre
NAB	National Accountability Bureau
NACS	National Anti-Corruption Strategy
NHIRC	National Health Information Resource Centre
NSP	Non State Provider
PCMC	Primary Care Management Committee
PNC	Pakistan Nursing Council
PRSP	Punjab Rural Support Programme
RAF	Research and Advocacy Fund
RHC	Rural Health Center;
THQ	Tehsil Headquarters Hospital
TRF	Technical Resource Facility

EXECUTIVE SUMMARY

A complex, changing landscape

1. The complex, changing landscape of the health sector in Pakistan requires a strategy that promotes responsiveness and accountability. The 18th Amendment of the Constitution and the suspension of the Local Government Ordinance triggered a shifting of power from the federal to the various provincial governments but have left considerable uncertainty about the context in which health services will be delivered.

The challenges facing the health sector

2. Amidst such uncertainty, Pakistan faces tremendous challenges in meeting the MDG health targets. The public health system is perceived as failing and corruption is seen to be endemic to the sector. Health service provision is fragmented; in the provinces a public health system operates alongside non-state providers of primary health care services and several centrally-managed federal health programmes. Different health service providers are responsible to different federal ministries. In response to the low quality of public health service provision, a largely unregulated private sector is meeting a growing proportion of need.

Accountability as value for money

3. More effective mechanisms of accountability have become increasingly important in such a changing, challenging scenario. With aid transfers to sector set to increase, the strategy highlights how improved health outcomes and greater 'value for money' might be achieved through increased public scrutiny of health expenditures, more effective planning, monitoring and reporting of health commitments, and improved parliamentary oversight.

Building the strategy on key lessons

4. Initial steps involve learning from international and regional research and then, drafting some guiding principles. This attempts to base the strategy on 'political realism' (i.e. what might be done rather than what might be ideal), to work within existing governance arrangements wherever possible and avoiding parallel structures, and to balance supply and demand options. Options have been linked to commitments in the National Health Policy 2010 to reflect national health priorities and commitments.

Four 'pillars of accountability

5. The strategy is based on four main 'pillars':
    - *Civil society and the media*: to cater to growing public demand for responsive, accountable health services.
    - *The public health system*: to establish planning, reporting and monitoring systems that provide a pubic framework for measuring and managing performance.
    - *Public and state accountability fora*: to provide effective oversight of the performance of the public health sector.
    - *Legal and regulatory mechanisms*: to regulate a growing private and alternative health sector.

Public communications and advocacy on health

6. A media sector, growing in size and diversity, is widely recognised as a positive driver for change in Pakistani society. It is increasingly assuming a watchdog role in response to public expectations and has an important role to play in heightening public awareness on health issues and in generating political will for change. The strategy identifies ways in which the media can be encouraged to give more profile to health issues, and conversely, for the civil society, to generate compelling and evidence-based narratives on health for the media. Specific emphasis is given to poor and marginalised communities as a target audience and to the importance of non-print media in local languages at provincial and district levels.

Building the case for partnership with the community

7. Community-based organisations can play an important role in voicing local demands and in working with local service providers to produce more responsive health services. There have been a number of donor-supported initiatives in Pakistan to mobilise communities in partnership with local health service providers. These have had some positive results and sound methodologies have been developed. Further pilot initiatives would have comparatively little impact and add little to established learning methodologies. The challenge, particularly in light of resistance from many health professionals, is to demonstrate how a community-based approach can be a (cost) effective way of improving local health outcomes for the poor and marginalised, and to further, make such approaches an integral part of

the public health system. The strategy suggests how a case might be made to do this by building on the experience of existing programmes and avoiding the start-up costs of a new initiative.

Public scrutiny of health services and expenditures

8. Access to information - in particular, increased financial transparency - can be a cornerstone of accountability in the provision of services. While a lot of work has been done to support the civil society to monitor budget allocations and expenditures in the education sector in Pakistan, the health sector has less experience in this area. The strategy suggests that increased public scrutiny of local health services including budget tracking of health allocations and expenditures would usefully supplement all community monitoring media.

Accountability of non-state service providers

9. The introduction of accountability mechanisms, as close as possible to the point of service delivery, is likely to bring immediate benefits to the poor and marginalised end-users. There are two ways of doing this. The first is to introduce performance-linked contracts for the non-state providers (NSPs) who provide a significant proportion of primary health care services in Pakistan. There is evidence that the operational flexibility and organisational culture of the NSPs have contributed to the improved outputs of local health units. The strategy suggests that a refocusing of the contribution of Community Support Groups (CSGs) in NSP contracts and operations would enhance local accountability at little additional cost. The second is to grant EDO (H)s delegated powers of the same level as those enjoyed by NSP managers. Public health employees frequently assert that the public health system could outperform NSPs if they enjoyed equivalent operational flexibility and level of resourcing. Since this hypothesis is critical to the development of a more responsive public health sector, the strategy suggests that by piloting the enhanced powers of the EDO(H) in human resource and financial management in selected districts

Weakness of formal accountability mechanisms

10. The strategy views the variety of state and public accountability mechanisms in Pakistan - such as the Auditor General's Office and Public Accounts Committee - as peripheral to the responsiveness and accountability strategy with a focus on poor and marginalised. There is little public confidence in

these bodies and they are widely perceived as ineffectual. Institutions such as the Pakistan Medical and Dental Council (PMDC) and the National Council for Tibb should have an important role to play in, for example, regulating standards in a growing private and alternative health care sector. Currently, support for these institutions would likely represent high investment and low return in terms of benefits for the poor and marginalised, though they might provide a focus for media and civil society advocacy.

Role of provincial regulatory authorities

11. Anticipating public accountability mechanisms may follow the devolutionary trend to the provinces. The strategy suggests that the proposed Heath Care Commission in the Punjab, along with existing regulatory authorities in Khyber Pakhtunkwa and Balochistan provinces, be supported to regulate private and alternative health care practices.

Putting health on the political agenda

12. Although Pakistan's MDG health indicators are among the worst in the region, the state of the nation's health is not yet a political priority and focus for public and political debate. There is widespread ignorance of the realities of the nation's health among parliamentarians and political parties. The strategy suggests how support might be given to sensitise political parties to the urgency and importance of health issues and to seek to translate this into political commitments.

Strengthening parliamentary oversight

13. The strategy recognises that the National Assembly Standing Committee on Health has shown positive signs of willingness to exercise its role of parliamentary oversight over the health sector and identifies how it might be supported to become more effective in this role. The strategy also recognises that, following the 18th Amendment, it can be anticipated that the standing committees of the provincial assemblies might play a more active role in this regard, although this would require reforms to and strengthening of their procedural rules.

Three 'building blocks' of accountability in public health system

14. The capability of the public health system to respond to the needs and demands of citizens must be the lynchpin of a responsiveness and

accountability strategy for the sector. The systemic, internal weaknesses of the health sector are well documented but largely beyond the scope of this strategy. Rather, it focuses on the key internal 'building blocks' namely, greater transparency and accountability, within the public health system that is:

- A planning framework with clear targets and budgets that provides a framework of transparency and accountability;
- An open system of review of progress to objectives that enables remedial action when necessary;
- A functional system of information gathering and monitoring relevant to performance management and public accountability.

The lack of 'fit-for-purpose' systems of planning, reporting and monitoring within the public health system, unless addressed, will continue to act as a break on progress towards increased transparency and accountability.

Strategic plans for health in the provinces

15. The first 'block' is a planning framework with clear policy objectives, strategies and budgets. The National Health Policy sets out policy objectives at a national level but provincial governments have the responsibility for health service delivery. The strategy highlights the importance of strategic plans for health at provincial level as potential public accountability frameworks in a devolved system of health service delivery. The strategic plan being developed in Khyber Pakhtunkwa province, for example, provides an opportunity to monitor progress of health priorities by tracking the activities and expenditures aligned to them. Provincial strategic plans also provide a suitable vehicle for donor funding of health priorities in a federal system, in line with international commitments on aid effectiveness.

Public monitoring of progress to National Health Policy

16. The capability to publicly review and report progress on health commitments is also of key significance for an accountable health system. There is, as yet, no clear mechanism to do this at a provincial level. At a national level, it is proposed to reconstitute the National Health Policy Council (NHPC) with a broader mandate and wider representation, including civil society, to oversee the implementation of national heath policy. The strategy suggests support for this representative public body engaging the public, media and political parties in monitoring progress to health policy commitments.

A functional system of monitoring and reporting

17. A meaningful review of health sector performance at any level is dependent on a functional system of monitoring and reporting. There are a variety of standards and information systems in place in the public health sector but the newly developed DHIS system offers a viable platform for a system of monitoring and reporting. The challenge is to incorporate DHIS into a system of performance management that provides incentives to ensure that monitoring data is used effectively by health managers. The strategy suggests strengthening the capacity of HSRU units in the provinces and HSSPU at a national level to develop an effective model of generating data and measuring results to makes health programmes and policies more responsive to the needs of end-users.

Combining approaches at provincial level

18. The provinces provide a critical focus for the strategy in light of the ongoing devolution of responsibility for health service delivery. While the security and developmental conditions are not yet present in Balochistan province, Khyber Paktunkwha and Punjab provinces offer sufficient political conditions to invest in a responsive, accountable health sector. There is a case for implementing a combination of options in specific districts since the effectiveness of the strategy will be increased by seeking synergy between its component elements i.e. support for demand-led initiatives, such as support for local media, community mobilisation groups and budget tracking, being combined with support for the supply side i.e. non-state providers and/or EDO(H)s.

1. INTRODUCTION

1.1. Background

This strategy on 'responsiveness and accountability' is a part of DFID's support to the Government of Pakistan in strengthening the health sector. This includes direct sectoral budgetary support; a Technical Resource Facility (TRF) to provide technical assistance to the Ministry of Health; and a Research and Advocacy Fund (RAF) to support research and advocacy. All these elements work to support the objectives of the Maternal, Newborn and Child Health (MNCH) programme of the Ministry of Health.

The overall purpose of DFID's support to the health sector is to implement the National Health Policy. One output of this support was identified as *"enhanced responsiveness and accountability of federal, provincial and district governments (in the health sector)"*. A background paper was prepared in July 2009 which reviewed some of the principal institutions and mechanisms that relate to the accountability in the health sector and made a number of initial recommendations. However, it was not until May 2010 that a team of consultants was identified to develop a "responsiveness and accountability" strategy in support of the National Health Policy which was close to being finalised. The team consisted of Cowan Coventry (International Team Leader), Maliha Hussein (National Team Leader), Dr. Sulemain Qazi (Public Health Expert) and Akmal Wasim (Legal Expert). Shazreh Hussain joined the team in the preliminary consultation phase.

1.2. Methodology

The team developed a number of data collection tools, methodologies and documents in May/June 2010 as part of the inception stage of the consultancy i.e.

- A SWOT analysis of stakeholders (see Annex 7);
- A commentary on the earlier background paper;
- A review of international and regional research on 'voice and accountability' initiatives in service delivery (see Annex 5);
- A situation analysis of the public health sector in Pakistan (see Annex 6);
- A review of civil society in Pakistan in relation to responsiveness and accountability;

From these preparatory documents, the team identified key learning points from research and drafted some principles to guide the development of the strategy in a semi-structured format for the first round of consultations with key stakeholders. The

team was asked to focus the strategy on Punjab, Khyber Paktunkwha and Balochistan provinces. During June 2010, a series of consultations with key stakeholders (see Annex 1) took place in Punjab and Khyber Paktunkwha provinces with stakeholders from Balochistan in Karachi, due to security considerations and with key respondents, the media and civil society representatives in Islamabad. A review of the legal and regulatory frameworks as they pertain to responsiveness and accountability in the health sector was also commissioned.

Following these consultations, the team drafted a number of initial options to strengthen the responsiveness and accountability of the health sector. Each one of these options was assessed using various criteria, one of which was the options' alignment with the National Health Policy. These formed the basis of a second round of consultations with provincial stakeholders from Khyber Paktunkwha province on 6th July and Punjab province on 8th July (see Annex 2). During these consultations, every effort was made to liaise closely with the Ministry of Health through the Health Systems Strengthening Policy Unit (HSSPU).

Following the consultations on the first set of options, an early 'pre-draft' was discussed with DFID and AusAID prior to the delivery of a complete first draft strategy to HSSPU and DFID/AusAID on 28th July 2010. A final version of the strategy, incorporating suggestions and comments on the draft report, was submitted on 16th August 2010.

In the following sections we will:

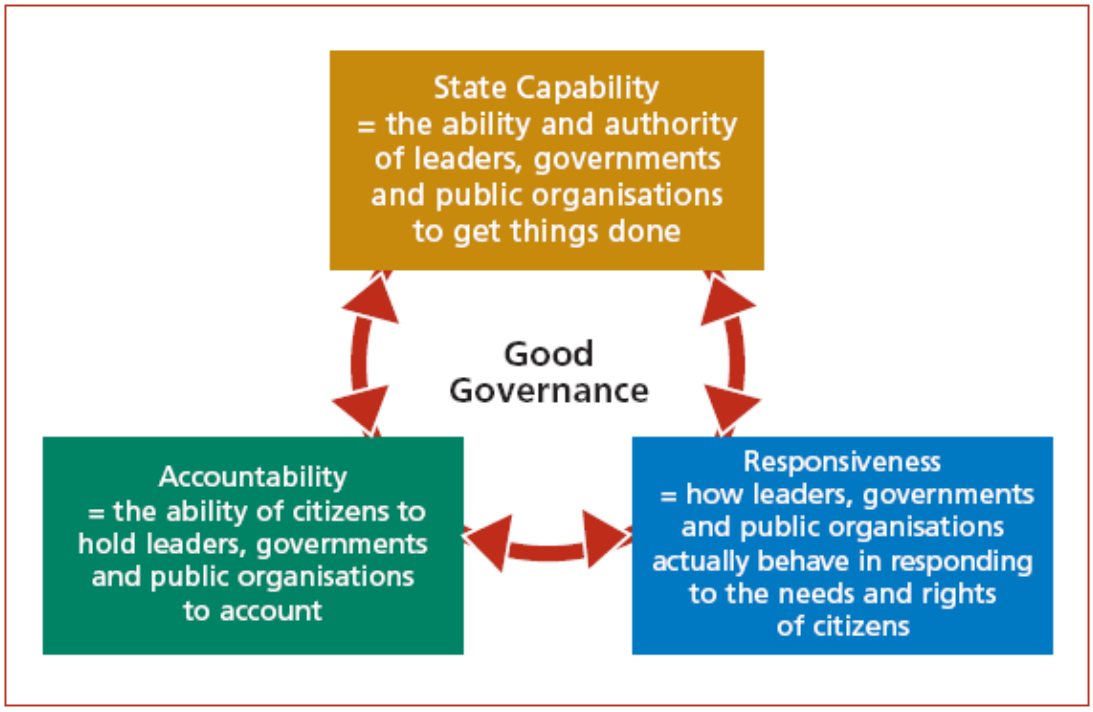
- Clarify our understanding of the concepts of responsiveness and accountability and summarise the key lessons to emerge from international research and their application to health service delivery (Section 2);
- Review the National Health Policy vision for a responsive, accountable health service, the principle challenges facing its achievement and assess the roles and capabilities of the four 'pillars' of an accountability framework i.e. public health system, state and public accountability forums, legal and regulatory mechanisms and civil society and the media, in delivering that vision (Section 3);
- Identify and assess ten options to support a responsive, accountable health service along with indicative budgets and implementation arrangements, and draw some general conclusions (Section 4);
- Suggest a monitoring and evaluation framework for the strategy (Section 5).

2. RESPONSIVENESS AND ACCOUNTABILITY: KEY CONCEPTS AND LEARNING.

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[1] and DFID, more generally, in relation to good governance[2] . 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[3]. In this section we will clarify and explore the key concepts before summarising some of the key learning to date to their applicability to health service delivery.

2.1. Key Concepts.

Although there are a number of donor approaches to promoting accountability as part of good governance, the DFID 'CAR' framework[4] has widespread currency. The CAR framework centres on the concepts of capability, accountability and responsiveness. These three, sometimes overlapping but reinforcing, concepts are seen as forming a virtuous cycle of good governance, as illustrated in the following diagram.



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 that are held accountable to their performance by their citizens.

More specifically, in relation to the health sector:

- *Capability* would include the existence of well-staffed, independent oversight institutions for the sector that are impervious to political interference;
- *Accountability* would refer to the ability of end-users to hold public health system to account through, for example, community or district committees for the quality of services provided;
- *Responsiveness* would refer 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[5].

The concept of accountability is pivotal in the CAR framework but the concept is open to interpretation. A weak interpretation would be, for example, 'answerability' i.e. the right to receive a response and the obligation to provide one. In contrast, a stronger element of accountability is 'enforceability' i.e. the capacity to enforce action and seek redress when accountability fails.

A distinction is also often made between vertical and horizontal systems of accountability. Vertical accountability refers to citizens holding institutions to account through formal processes e.g. elections, through lobbying or through mass mobilisation. Horizontal accountability refers to state institutions engaging in mutual scrutiny to correct 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.

It is important to distinguish formal and informal accountability. Systems of formal accountability e.g. laws, (written) rules and regulations, can bear little relationship to actual accountability relationships. Informal accountability, for example, refers to unwritten rules, norms, and processes - such as 'clientelism' or corruption - that can fundamentally shape how formal institutions operate. Formal mechanisms of accountability can be undermined by informal systems of accountability. 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.

'Voice' and accountability are frequently paired as levers for good governance. Voice refers to the ways in which citizens - individually or collectively - place pressure on policy makers to demand and advocate for better governance - or service providers to advocate for better services'[6]. 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.

2.2. Key Lessons for Health Service Delivery.

There is a growing body of literature on 'voice and accountability' initiatives and specifically in relation to provision of services. Research evidence on 'vertical' accountability, in particular, on the role of communities in holding service providers to account, predominates over research on the regulatory and oversight mechanisms associated with a 'horizontal' system of accountability, most likely as a reflection of donor patterns of funding. Some researchers[7] are of the 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.

For example, 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. 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[8].

Community mobilisation or monitoring initiatives share the premise 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 create a stronger basis for holding service-providers accountable. There is little evidence that individual citizens in poor communities are able to hold providers to account through the assertion of individual consumer rights[9].

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.

More generally the literature supports the view that civil society has an important role to play in responsive and accountable service provision, both as a health service provider and as an advocate for improved services. In relation to the former, for example, the state can regulate and/or enter into contractual agreements with non-state providers (NSPs) to deliver health services. This can offer a cost-effective method of delivering health services, for example, in difficult or conflict-affected environments. Recent research[10] indicates that NSPs tend to be able to deliver services more efficiently and cost-effectively than governments, to the poorest in difficult environments, highlighting that 'performance-based contracting' can increase service utilisation and quality.

Civil society organisations (CSOs) can also undertake advocacy at local or national level in support of improved service provision. However, CSO capacity for policy formulation and influence is often overestimated. 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[11]. Some researchers[12] have suggested 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"* rather than protesting against policy commitments or advocating new policies.

However, there is a growing body of evidence that supports the idea that demand-led initiatives are more likely to generate more responsive services if they are combined with initiatives to build capacity on the supply side[13]. These might include systems reforms such as decentralisation of decision-making authority over facilities and budgets, good information and monitoring systems, and availability of mechanism of redress.

There have been a number of attempts to synthesise some of the learning that has emerged from the growing body of research on responsiveness and accountability in service provision[14][15][16]. While there are no universal prescriptions for every context, there is considerable overlap in key learning to date. We have summarised four key lessons for this strategy namely:

- *Build a strategy on political realism.All responsiveness and accountability* strategies have to be sensitive to local context and adjust to political realities. Interventions should be conditioned b*y* an understanding of the interaction between formal and informal institutions and of the incentives framework within which different actors operate. The strategy will need to work with institutions as they are, not as they would ideally be. It should engage with, rather than ignore, the informal institutions and practices that predominate. It will need to be opportunistic and responsive; build on existing impetus for change; and provide 'quick wins' that governments want in the short term.
- *Building ownership through existing frameworks.*
  A strategy should be aligned with existing governance arrangements. It should encourage ownership and commitment by key stakeholders and avoid creating new entities, parallel structures or transplanting institutional frameworks from the outside. It should aim to increase formal accountability through existing institutional arrangements, for example, by strengthening legislation, improving systems and investing in capacity building.
- *Strengthen both supply and demand capacity.*
  The well-informed 'voice' of poor and marginal end-users - either directly or indirectly through CSOs - can help to drive improvements in service delivery. However, support for demand-side initiatives must be balanced by a parallel effort to build the effectiveness and capacity of state institutions to respond to end-user demands, if they are not to result in a mutually frustrating impasse.
- *Deploy a mix of funding instruments and approaches*
  Finally, the literature identifies a number of lessons for donors themselves. Donors should employ a mix of aid instruments to build citizen and state capacity. Responsiveness and accountability initiatives can take a long time to bring about, since they aim to change entrenched attitudes and alter power dynamics. Donors, therefore, should be prepared to provide long term, flexible support. They should also be prepared to 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.

In developing the strategy, we have sought to build on learning from the available research and we will return to these four key lessons (see pp36-7) when introducing options to be included in the strategy.

3. HEALTH SERVICE DELIVERY IN PAKISTAN: VISION, CHALLENGES AND CAPABILITIES

In this section, we review the National Health Policy vision for a responsive, accountable health service, identify the principle challenges facing its achievement, and assess the roles and capabilities of the four 'pillars' of an accountability framework.

3.1. The Vision

This responsiveness and accountability strategy has been developed to assist the Ministry of Health in taking its commitments in the National Health Policy 2010 further. The new National Health Policy sets out a vision to *'promote national development via the improved health and well-being of all Pakistanis, particularly women and children, though access to essential health services.'* [17] This vision is guided by five key principles that is, a commitment to:

- The responsibility of the state to ensure universal access to preventive and curative health services;
- Overcome social and economic inequities that might impede improved outcomes;
- Ensure the health system responds to the needs of the people, especially the poor, marginalised and vulnerable;
- Ensure good governance, meritocracy and transparency at all levels of health care management;
- Promote a results-based culture and evidence-based policy making.

The National Health policy also recognises primary health care as the most effective approach to improve the population's health and *emphasises 'preventive, promotive and rehabilitative aspects with community participation and effective referral linkages'.*[18]

Taken together, these underlying principles form a commitment to a responsive and accountable health system. The vision refers to a health system that is responsive to the needs of the poor and marginalised, characterised by good governance and transparency, driven by a results-base culture and guided by evidence-based policy making. It also recognises the role of the community in primary health care. These

principles are, at last, partially reflected in the policy objective on 'Governance and Accountability' in the National Health Policy.

To achieve this incipient vision of a responsive, accountable health service, a number of key challenges will need to be faced the most important of which is, Pakistan's public health system's inability to respond effectively to the state of the nation's health.

3.2. The Challenge

The state of Pakistan's health

Pakistan's health indicators, as acknowledged in the National Health Policy 2010, remain amongst the worst in South Asia and, indeed, the world. Communicable diseases, reproductive health problems and malnutrition constitute about half the national burden of disease. Respiratory infections and diarrhoeal diseases remain the major killer diseases in Pakistan despite the fact that they could be prevented at relatively low costs. Pakistan is one of the four remaining countries where polio remains endemic and has the seventh highest tuberculosis burden in the world. Hepatitis is endemic in the general population with 12 million people being infected with the hepatitis B or C virus.

Poor and vulnerable sections of the population - in particular, poor women and children - are particularly badly affected. Pakistan's under-five mortality is the highest in South Asia except for Afghanistan. Nearly 11,000 women die annually while giving birth – among the highest, in the region. Malnutrition remains widespread and its rates have not changed significantly over the last two decades. There are nine million malnourished children in Pakistan which constitutes as the second highest prevalence of underweight children in South Asia.

Pakistan is committed to the Millennium Development Goals (MDG) and has committed itself to a series of targets in maternal, infant and under-five mortality rates to control the spread of communicable diseases, increase the proportion of one-year old children immunised against measles, and increase the proportion of births attended by skilled health personnel. The 2008 report of the MDG Gap Task Force recognised that some progress has been made in the last decade. For example, the maternal mortality rate has fallen by half in the last decade and skilled birth attendance has improved from 18% in the late 1990s to 38% in 2006. Nonetheless,

the Task Force highlighted that key commitments regarding child mortality and maternal health are lagging behind schedule.

Challenges facing the public health system

The National Health Policy acknowledges that the national health system is currently failing to deliver the necessary health outcomes and to meet the pressing health needs of the population. Pakistan faces many challenges in improving health outcomes - particularly for the poor and marginalised who bear the major burden of diseases - and meeting the MDGs. There are a number of external factors that contribute to poor health outcomes including illiteracy, poverty, unemployment, gender inequality, social exclusion, lack of access to safe drinking water and inadequate sanitation. However, there are a number of critical challenges that will need to be met by the health system itself if it is to provide a responsive, accountable health service that meets the needs of the population of which the most important ones are:

- Systemic weaknesses in the management and governance of the public health system. An endemic culture of political interference and patronage at all levels undermines effective health service management and delivery. In particular, it undermines the ability of health managers to manage human resources effectively i.e. recruit, motivate, remunerate and performance manage health professionals appropriately.
- An inadequate level of public sector expenditure, insufficiently targeted to tackle health inequities and meet the needs of the poor, vulnerable and marginalised sections of the population. According to WHO, government expenditure on health in 2006 amounted to only 1.4% of total government expenditure.
- A complex set of arrangements for health service delivery with multiple service providers, delivery models and systems of accountability straining the capacity of the system to exercise effective management and oversight. The increased deployment of NSPs and vertical programs in the past decade have eroded the stewardship of federal and provincial health authorities and resulted in fragmented health services delivery and potential duplication of resources.
- A health information system which, despite reforms, remains fragmented and partially implemented, undermining the ability of health managers to monitor and manage performance on the basis relevant, accurate information.

- Limited capacity and resources for health research, in particular, health policy and systems research to guide evidence-based policy and planning.
- An expansive infrastructure that is nonetheless poorly located, inadequately equipped and maintained, and which provides inadequate coverage and access to essential basic services.
- A private health sector, particularly in urban areas, which continues to expand in an unregulated manner without a system for accreditation; standards or enforcement mechanisms.
- An inadequately regulated pharmaceutical sector which is failing to ensure that that the population has access to essential medicines of acceptable quality and at affordable price.

In the next section, we will review the strengths and weaknesses of the complex of institutions, mechanisms and actors with a stake in the delivery of public services to meet these challenges and contribute to a responsive, accountable health sector.

3.3. The Capability

Our analysis is based on four 'pillars' that, taken together, would constitute a framework for a responsive and accountability strategy for the health sector i.e.

1. *The public health system* i.e. the capability of the public health system to become more accountable for end users;
2. *Public and state accountability fora* i.e. whether the multiple public and state oversight bodies provide effective oversight of the health sector, and offer recourse and response to the public demand for responsive services;
3. *Legal and regulatory mechanisms* i.e. what legal, regulatory and supervisory bodies exist in relation to the sector, including a growing private and alternative health sector;
4. *Civil society and the media* i.e. what role civil society and the media plays or might play in articulating public demand for improved services and in holding service providers to account.

This analysis is undertaken against a backdrop of transition and uncertainty in Pakistan governance arrangements. Three developments, in particular, deserve attention. As a Federal State, the Pakistan constitution provides two lists for legislative purposes, a federal list and a concurrent legislative list, which describes

the distribution of legislative powers between national and provincial assemblies. Under the proposed 18th Amendment to the Constitution, the power of legislation on the 47 subjects on the concurrent legislative list will be devolved exclusively to the provinces. This would transfer a number of key health responsibilities to the provinces exclusively - for example, the regulation of drugs on the market. The National Finance Commission Award of 2009 also gives greater fiscal autonomy to the provinces and is likely to change the availability of funds available for health expenditures at both the federal and provincial levels.[19] Finally, the Local Government Ordinance is in abeyance which leaves provincial government considerable scope, within constitutional boundaries, to determine the shape of local government within the provinces.

The full implications of these transformational changes for the public health system and local governance are not yet discernible although they certainly reflect a further shift of power and responsibility for health service delivery to provincial governments. The following analysis may need to be reviewed once the impact of these changes on the roles and responsibilities within the health sector becomes more evident.

3.3.1. The Public Health System

The Pakistan health system operates at federal, provincial and district level. We will review the role of all three levels and focus on the potential contribution of monitoring and information systems to increased transparency and accountability with regard to the performance of the public health system.

- **Federal Level**

The federal Ministry of Health (MOH) is primarily responsible for national health policy, health legislation, quality of health care and health planning and educational standards in the medical and nursing, dental, pharmaceutical, and paramedical professions. However, the MOH has also managed a number of major 'vertical' preventive programmes, heavily supported by international donors. It is frequently observed that federal responsibility for these programmes has undermined accountability at provincial and local government levels and diminished its stewardship roles of policy making, regulation, monitoring and evaluation.

A donor-supported Health Systems Strengthening Unit (HSSPU) supports the MOH in its policy mandate. HSSPU has contributed to the health sector reform agenda and has played a significant role in the formulation of the new National Health Policy

(NHP). However, it's role and mandate within the MOH needs to institutionalised; its human and financial capacity strengthened; and its relationship strengthened with provincial Departments of Health (DOH) and Health Planning and Reform Units (HSRU), if it is to effectively fulfil its contribution to a responsiveness and accountability agenda.

The MOH is not solely responsible for all health services in Pakistan. The Cabinet Division, which forms part of the Prime Minister's Secretariat, has also initiated country-wide initiatives in the social sectors on several occasions. In the health sector, it is responsible for the People' Primary Health Care Initiative (PPHI) in 69 districts in the three provinces of Sindh, Baluchistan, NWFP/FATA and Gilgit-Baltistan**.** This has created a 'parallel' system of health service delivery and accountability in the provinces which has drawn criticism from many in the public health sector.

- **Provincial Level**

The provincial Departments of Health (DOH) are the cornerstone of the health service in Pakistan, working autonomously under the guidance of the MOH. The DOH has regulatory, standard setting, technical support and resource mobilisation functions. It frames laws, rules and regulations to enforce federal government policies with regard, for example, to foodstuffs, blood safety, drugs, smoking etc. It lays down standards for quality control of drugs, electro-medical equipment and quality of health care services and prescribes standards for medical education and training of doctors, nurses and paramedics. The DOH is responsible for personnel and performance management in the public health system at provincial level and is expected to provide capacity building support at district level in key areas.

The Provincial Health Secretary has overall responsibility for the Department while the Director General, Health Services, as the technical head, reports to the Secretary. The Provincial Health Secretary translates the provincial health policy and has direct control over the budget. The DOH, through the provincial Secretary of Health, exerts direct control over teaching hospitals, tertiary care hospitals and other special institutions. The provincial Director General Health Services (DGHS) is the chief executing officer responsible for the delivery of policies and plans related to primary and secondary health care delivery. A team of Directors supports the DGHS at the provincial level, including Director MCH or Reproductive Health. The DGHS

supervises the work of Divisional Director Health Services (DDHS) who are posted at the divisional level.

Donor-supported Health Sector Reform Units (HSRU) have been established in some provinces to spearhead health sector reform along the lines of the HSSPU at federal level. The relationship between HSRUs and the provincial health administration varies across the provinces, as does the relationship between the HSRUs and the HSSPU.

- **District Level**

Districts have direct responsible for implementing routine health services and federally funded national programs through a network of Basic Health Units (BHUs), Rural Health Centres (RHCs), maternal and child health centres, and secondary and tertiary hospitals. Managers of all Tehsil Hospitals, RHCs and BHUs report to the Executive District Officer Health (EDO-H) who is responsible for delivering preventive and curative services through the outreach workers and primary care facilities in the district. The EDO-(H) and Medical Superintendent, who is responsible for the district headquarter hospital, both report to the Director General of Health.

While the EDO-(H) has responsibility for nearly all health services in the district, s/he typically faces a number of challenges and her/his ability to provide responsive services is constrained by a number of factors. Staff absenteeism is a major problem especially at the BHU level. Most health facilities lack proper medical equipment and funds to maintain the equipment they do have. Health facilities often suffer from basic shortages e.g. broken X-ray units; shortage of X-ray film or laboratory chemicals, out of order ambulances; out of date medicines etc.

An EDO-(H) lacks the resources and financial and management flexibility to resolve these problems. He is constrained by eexcessive bureaucracy. There is no system or culture of performance management. His ability to appoint, transfer or performance manage staff is likely to be undermined by political pressure from senior staff or elected political leaders. While the EDO(H) is responsible for ensuring the implementation of national 'vertical' programmes, federal programme managers retain control over resources and decision making leading to management tensions and lack of ownership of these programmes at local level.

Aware of its importance to improved health service delivery, the Government of Pakistan and development partners have explored ways of strengthening monitoring and managing capacity at district level. The *District Health Management Team (DHMT)* was introduced in 1999, funded by the Asian Development Bank (ADB), as a district health system strengthening initiative. DHMTs were intended to play a role in bringing together representatives from the district to monitor and manage local health services. Various donor-funded projects have since then tried to revive the DHMT idea. For example, PAIMAN and SOHIP have promoted the functioning of DHMTs as forum for civil society, public health officials and elected representatives to plan, monitor and review the delivery of health services within the district. A PAIMAN evaluation found that DHMTs had achieved a broad-based membership and had been able to influence some positive changes such as increase in health budgets. An evaluation of the Save the Children health programme in Battagram District also indicated the potential for a DHMT to play a useful oversight role. Other projects seeking to experiment with DHMTs have highlighted that a high level of support is required to make the model work.

The Local Government Ordinance of 2001 was intended to create a system of local government to better represent citizen preferences and provide improved services For example, *Monitoring Committees* at the Union Council, Tehsil and District level were formalised. However, these have never been resourced and operationalised on any scale and it is unlikely that they will survive the continuing uncertainty about the shape of local government in the provinces.

More recently, the Punjab Health Sector Reforms Programme, financed by the Asian Development Bank, has adapted a district monitoring system, developed previously to assess progress in the Punjab Education Sector Reform Programme, to monitor progress in the health sector. The system is based on a District Monitoring Office with a District Monitoring Officer (DMO) and Monitoring and Evaluation Assistants (MEA) who undertake surprise inspection visits to the health care centres. MEAs monitor some key indicators through a checklist system e.g. 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. Districts are ranked on the basis of these assessments and the data is also posted on a special website developed by the PHSRP. The system can be seen to lead to more responsive services when corrective action is taken following these assessments. For example, an EDO(H) can use these reports to highlight some of the key problems and

constraints that afflict a particular facility and leverage resources. However, it is a top-down inspection model that can also be seen to undermine the authority of the EDO(H) who acts as a post office forwarding reports 'up the line' without having the authority or resources to take the corrective action.

- **Monitoring and Information Systems**

An open culture of monitoring and reporting in the public health sector at district level should form the basis of public accountability and performance management. However, there is no such culture or practice in Pakistan. The diversity and limitations of health information systems is a contributory factor. A Health Management Information System (HMIS) was established in the early 1990s for the public health system but has generally failed to develop its credibility and become a key tool in decision-making. The public hospital system also lacks a standardized information system and most public hospitals maintain their own information system. Each federal 'vertical' programme has more or less its own information system. None of these health information systems cover the private health sector and all have experienced problems with data gathering and reporting.

A District Health Information System (DHIS) is expected to take the place of the HMIS system and work is in progress to begin its implementation across Pakistan. DHIS offers the potential for a fit for purpose system of data gathering for the purposes of accountability and management. It is a district-centred information system that integrates primary and secondary care level information; information from various vertical programmes; and information on public health sector human resources, logistics and finance.

3.3.2. State and Public Accountability fora

Although Pakistan has several formal public and state accountability mechanisms and arrangements to ensure transparency and good governance, the pursuit of 'accountability' by the government has always been looked upon with suspicion. There has been a tendency for the governments to pursue a politically motivated accountability agenda and create new accountability mechanisms to identify cases of corruption in the previous Government. There is, therefore, a proliferation of accountability mechanisms in the country some of which have had a very short-lived history such as the National Accountability Bureau and the National Reconciliation Ordinance.

- **State Institutions of Accountability**

The *Auditor General's (AG) Office*, as the Supreme Audit Institution of the country, is expected to hold the public sector accountable for corruption and misuse of public funds. The Auditor General has a dual responsibility for both the accounting and auditing function of the Federation and the Provinces. This gives rise to a conflict of interest and has been the subject of critical comment. There have been several donor funded efforts in the last few years to introduce international best practice in auditing and reporting into the AG's office. As a result the AG's office has reorganised itself and initiated a capacity building program 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.

The *Federal Ombudsman's Office* remains one of the few ostensibly independent organs of government where citizens can seek redress, free of charge, for a variety of complaints. The Federal Ombudsman can carry out independent investigations into complaints of 'maladministration' in any Federal Government agency. Recommendations for redress are sent back to the Government; the Ombudsman himself does not have the means for redress. *Provincial Ombudsman's Offices* can hear complaints against any provincial government department. The independent complaints handling service is free and open to everyone. There is limited awareness in the public about the role of these forums and very few complaints related to the health sector are brought before the Ombudsman. Most offices of the Ombudsman publish annual progress reports. Some, like the Punjab Ombudsman's 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, to strengthen its systems and build its capacity for improved service delivery, for example in strengthening public grievance redress mechanisms.

Provincial Governments have set-up *Anti Corruption Establishments (ACE)* with a mandate to detect and report corruption cases within the government departments, and *Anti Corruption Departments (ACD)* with 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 is working to expand the authority of its officers. These departments have not worked well and suffered from the same issues that affect all Government departments - a lack of resourcing and a lack of political will to exercise their mandate due to political influence.

Federal and Provincial Service Tribunals exist to hold civil servants responsible for any lack of discipline and to provide fair adjudication on matters regarding their terms and conditions. The mandate of these tribunals is limited to matters pertaining to administrative and disciplinary aspects and is not related to job performance. No specific opportunities have been identified of engaging these tribunals in the R&A strategy.

The Federal Investigation Agency (FIA) is the premier Federal Law Enforcement Agency created under an Act of Parliament and deals with corruption-related investigative work involving public servants and the private sector. The capacity and efficiency of FIA as an independent and impartial agency is often under question in light, for example, of its failure during its history to prosecute anyone above grade 19. The FIA is also under-resourced and lacks capacity for modern investigation techniques.

Pakistan's *judicial system* stems from the British tradition of an independent judiciary but is subject to pressure from the executive 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. However, 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 helped to demonstrate the strength of 'peoples' power' in this regard. The Supreme Court has also by its recent actions demonstrated the capacity of the judiciary to hold the executive accountable. However, there are no specific opportunities of engaging with the judiciary in the formulation of the responsiveness and accountability strategy for the health sector.

The government of Punjab has set up eleven courts and *Consumer Councils* to implement the Punjab Consumer Protection Act 2005 which provides a specialised forum for protecting the consumer. About 10% of the cases presented concern health issues and, in a few cases, the system has been fairly effective in delivering judgements. No specific opportunity has been identified at this stage for the engaging Consumer Councils, which have a fairly broad mandate, in the strategy.

- **Public Accountability fora**

Standing Public Accounts Committees (PAC) are established by Federal and Provincial Governments to hold the public sector accountable for the use of public funds. The function of the Federal Committee is to examine government accounts and report of the Auditor General. It may deal with other matters referred to it by the Minister for Finance. In recent years the Federal Committee has enhanced its stature by dealing with high profile cases of misuse of public funds and by highlighting corruption in the public sector. The appointment of the leader of the opposition as Chairman of the federal Committee has given it a higher profile. The provincial Committees are mostly dormant and have met on very few occasions. The Federal Committee has devoted just 45 hours per year to oversee the performance of state institutions. Expectations of the PAC must be tempered by the fact that dissolution of the National Assembly or change in the current political leadership is likely to change the composition of the Committee.

The *Parliamentary Standing Committee on Health (PSC)* was formed in November 2008 and currently includes representatives from six political parties. The PSC at the federal level has *suo moto* powers and can summon whoever it likes to appear before it. The Committee has been very active and has met several times, including a special session on budgetary proposals for health in 2009-10 as well as a special hearing on a proposed bill for organ transplant. Several sub-committees have been constituted and Committee Chair is thinking of developing several permanent thematic committees to encourage a more sustained effort in the identified areas of health care. The current Chair 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 Committee has also been active in critically reviewing the approval of a large number of drugs in a short period of time by the Federal Government.

The Committee's willingness to move forward on accountability issues offers an opportunity to support it in exercising greater oversight of the public and private health sectors. Its multi-partisan approach also provides an opportunity to strengthen its role in identifying, drafting and helping to enact key legislation for the health sector. In particular increased policy and research capacity would enable it to play a more strategic role. However, a major risk is that a dissolution of the National Assembly or change in the current political system and leadership would likely result in a change in the composition of the PSC.

The Provincial Committees, in light of the change in the 18th Amendment, should potentially play a greater role in holding the public health system accountable on specific high issues. However, this would require their statutory powers and rules of procedure to be changed as they currently have no *suo moto* powers and are restricted to considering issues raised on the floor of the assembly and referred to them by the Speaker.

- **National Accountability Bureau and Commission**

In 1999 the Musharraf government launched an anti-corruption and accountability agenda to justify its seizure of power. The *National Accountability Bureau (NAB)* was established in 2002 to implement a National Anti-Corruption Strategy (NACS) and subsequently pursued a number of high profile cases. However, in the search for political reconciliation which paved the way for Musharraf stepping down, a National Reconciliation Ordinance (NRO) was passed in 2007 which granted indemnity to politicians and holders of public offices accused of corruption. However, the Supreme Court of Pakistan subsequently ruled the Ordinance unconstitutional and all cases disposed off by the controversial Ordinance were revived.

In keeping with past traditions, the current Government has initiated its own accountability agenda. It has drafted a Holders of Public Offices Bill (HPOA) 2009 to legislate for an alternative accountability mechanism to replace the National Accountability Bureau with an *Independent Accountability Commission*. The Bill has yet to be introduced or approved by the National Assembly and it is not yet clear what role the new Accountability Commission might play in the health sector. Although the expectation was that the scope of the new Accountability Commission would be broader than that of the NAB, there are growing concerns that the jurisdiction of the new Commission will be more limited and that a higher percentage of policy and decision makers and other offenders will be excluded from the ambit of accountability.

3.3.3. Legal and Regulatory Frameworks

- **Federal authorities**

There are a number of specialised regulatory bodies in the health sector such as the Pakistan Medical and Dental Council (PMDC), the Pakistan Nursing Council (PNC), the National Council for Homeopathy and the National Council for Tibb. The focus of

these bodies is on the quality of education and training and the registration of individual practitioners. Some, like PMDC, are empowered to take disciplinary action against its members in cases of misconduct although there is little awareness among the general public of this complaint redress mechanism. However, there is little evidence that any of these bodies are oriented towards enhancing accountability and responsiveness and it is difficult to envisage how they could be involved in the strategy.

The *Pakistan Medical and Dental Council (PMDC)* is the statutory regulatory authority with the responsibility to oversee the quality of medical education and individual practitioners. It includes representatives from the political, judiciary, teaching and health sectors and is charged with protecting the public interest in the realm of medical and dental care. PMDC has a Code of Ethics to govern the conduct of all medical practitioners and institutions; keeps a register of qualified doctors and dentists; a detailed complaint mechanism with a clear timeline; and is empowered to take disciplinary action against its members in cases of misconduct. In response to a complaint, PMDC's disciplinary committee may recommend *"an admonition, a temporary suspension for a specified period or life-long expulsion from . . . PMDC."* The committee has occasionally taken up case of gross medical negligence but there is little awareness among the general public of PMDC's complaint redress mechanism. There is little evidence to date that PMDC has worked in favour of consumers though heightened public scrutiny by the media and civil society might contribute to a more diligent approach to fulfilling its mandate..

Similar to the PMDC there are Councils for the registration of other health practitioners. *The Pakistan Nursing Council (PNC)* is empowered to register (license) Nurses, Lady Health Visitor, Midwives and graduates of public health schools. The PNC inspects and approves schools of nursing, midwifery and public health; and maintains standards of education and practice, education and nursing services. Although the PNC can de-register nurses for professional misconduct there is little evidence that it takes action against the nurses in case of complaints. There is little awareness among the general public of PNCs role and, as with the PMDC, no specific opportunity has been identified to involve it in the strategy. With regard to 'alternative' health services about 40,000 homeopathic physicians are registered with the *National Council for Homeopathy* and the Ministry of Health, through the *National Council for Tibb,* oversees the qualifications of ayurvedic practitioners.

The *Central Licensing Board, Drug Regulatory Board* and the *Drug Appellate Board,* at the federal level, and *Quality Control Boards* at provincial level exist to ensure the quality of drugs available on the market. Federal inspectors of manufacturing facilities can revoke manufacturing licenses and provincial drug inspectors are mandated to ensure the quality of drugs at retail outlets and in the distribution chain. However, these institutions are largely dysfunctional and the implementation of the laws is for most part mechanical or discretionary. There is also a conflict of interest as the agency responsible for policymaking is also responsible for regulatory and implementing arrangements. The creation of the Drug Regulatory Authority in 2005 was intended to mitigate against this by separating functions and entrusting regulation to an independent agency. However, work on the Authority has not been forthcoming. With the 18th Amendment some responsibilities regarding drug regulation and supervision may be transferred to the provinces but this is yet to be confirmed.

The presence of a large volume of spurious drugs in Pakistan highlights the weaknesses of the regulatory institutions. The *Drugs Control Organisation (DCO)* is responsible for implementing the Drugs (Research) Rules (1978) and for registering and quality controlling drugs, as well as participating in the regulation of drug research. However, the due diligence of the DCO is open to question; drugs banned elsewhere are easily available over the counter in Pakistan.

- **Provincial Authorities**

Some of the provincial governments have also taken measures to improve the regulation of the health sector. The NWFP Government established a Health Regulatory Authority (HRA) in 2003. Key among its responsibilities is set standards across the health sector including preventive, curative and traditional health practices; issue licenses/permits to health professionals for private practice; register and monitor private health institutions, and deal with cases of malpractice or violation of standards in the private sector. The efficiency of the HRA was reported to be undermined by deficiencies in the original ordinance and an Amendment Act was notified in 2006. The HRA has subsequently received ongoing technical assistance from GTZ in quality management and health regulation. Quality standards for primary and secondary care have been developed and a baseline study for assessing quality of standards. The Provincial Government is aware of the importance of the HRA and has included HRA strengthening as an agreed reform agenda with the World Bank. However, few tangible results with regard to the performance of the health sector have emerged to date.

The Government of Punjab has recently presented a Bill to form a *Punjab Health Care Commission* for the *"improvement of healthcare services and ban quackery in all its forms and manifestations".* The Act is designed to include both public, private, non-profit, charitable hospitals, trust hospitals, semi-government and autonomous health care organisation. The Commission would have wide ranging powers to monitor and regulate the quality and standards of health care services developed by the Government. Health care service providers will be required to register with and be licensed by the Commission. It will have the power to enquire and investigate into maladministration, malpractices and failures in service provision; issue consequent "advice and orders"; and collect penalties on violation. The Commission will also be able to take action on the complaint of any aggrieved person, Government agency, provincial assembly or the Supreme Court or Lahore High Court.

3.3.4. Civil Society and Media

Pakistan civil society is becoming increasingly diverse, ranging from NGOs and professional associations to faith-based organisations and less formal traditional institutions such as *jirgas* or tribal councils of elders. Civil society organisations have are involved in a wide range of activities including service delivery, research and advocacy.

- **NGOs and Service Delivery in the Health Sector**

NGOs track record in Pakistan in helping to improve the health status of poor rural households contributed to convincing government that some of the basic public health facilities in villages should be transferred to non-state providers (NSPs). Two programmes in particular that tested changes to hospital management practices to increase access of low income patients to public health units and hospitals - the Rahim Yar Khan pilot project managed by the Punjab Rural Support Programme (PRSP) and the Gujrat Pilot Projects of NCHD - were key to this policy decision. .

The PRSP model enjoys strong political support and has been replicated at a rapid pace in other provinces through the President's Primary Health Care Initiative (PPHI). Key to the model is the fact that district level managers have relative autonomy in financial, human and logistics management and a system of monitoring of health outputs through periodic inspection. Greater operational flexibility has enabled the PPHI to demonstrate improved health outputs such as outpatient attendance but the

model tends to face resistance from public health professionals at district level as it is seen to by-pass the health system and erode the authority and credibility of the public health system.

The NCHD model works at the BHU level but, unlike the PPHI, does not get involved in facility management. It places greater emphasis on outreach preventive services; on community participation in PHC service delivery and management; and on strengthening the referral system from the community to secondary-level hospitals. The NCHD model has been scaled up in selected districts of Punjab. It does not receive a budget from the District Government; rather its operational costs are covered through a Planning Commission Proforma-1 (PC-1). The NCHD model has a number of strengths. It has a performance-based M&E system with baseline surveys: provision for financial incentives for staff; a focus on both curative and preventive services; a focus on community participation; and it seeks to link closely with school health services. However, the model has not had time to fully consolidate itself and its future is uncertain as the NCHD seems to lack political, administrative and financial support.

- **NGOs and Advocacy**

There has been a shift in the focus of much civil society activism in the last few years - from poverty alleviation and rural development to issues of good governance, accountability and political and human rights. NGOs participate in the accountability agenda at various levels. SAP-PK and SPO, for example, have organised grass roots communities to advocate on a range of issues including the environment and social sector service delivery. Other NGOs such as the Sustainable Development Policy Institute and the Mahbub-ul Haq Human Development Centre have sough to influence policy through research-based evidence. Some e.g. the Governance Institutions Network International (GINI), focus on corruption and issues of governance in general; others e.g. Heartfile, focus on governance and corruption in the health sector specifically. All these efforts have been supported by bilateral donor agencies. Shirkat-Gah, Aurat Foundation and other NGOs such as Sahil have worked on the rights of women and children.

These organisations have adopted several approaches to enhancing the accountability agenda. Organisations like SAP-PK, SPO and the Network for Consumer Protection have adopted a community based approach to enhancing awareness about a range of health issues e.g. the promotion of breastfeeding. The

Network and Bedrai have also experimented with a complaint redress mechanism and there is some evidence that consumer's complaints' mechanisms can lead o access to the justice system. Shirkat Gah, Heartfile, SDPI, MHDC have used a more research oriented approach while Aurat Foundation tries a range of activities to enhance awareness about women's political and social rights and has helped increase women's participation in the political sphere. GINI has focused on broadening education curriculum to introduce governance issues.

Several donors have supported consumer bodies to raise awareness about consumer rights and voice their demand for a better legal regime for consumer protection. The Network for Consumer Protection was the first organisation of its kind working exclusively on consumer protection issues in Pakistan. Later the Consumer Rights Commission of Pakistan (CRCP) linked consumer protection with governance issues and broadened the scope of its work by focusing not only on consumers but also on citizens.

- **The Media**

In the last decade the media has become one of the most influential sections of civil society. Today there are over 1,500 newspapers and journals in the country, including publications in Urdu, English, and in regional languages. Sound broadcasting reaches 95 per cent of the population and is an effective method of communication since the literacy rate is low and other methods of communication are sometimes not available. Television arguably holds more sway over public opinion, with coverage in the mid-1990s reaching more than 80 percent of the population, cutting across the social strata. There has been a rapid increase in the number of television channels and there are now approximately a 100 TV channels in the country.

Pakistan is experiencing a quiet revolution in which the media has proved to be a strong force for change and accountability. The media's watchdog role has been heightened in a context where parliament appears unable to act as the custodian of peoples' rights and when the judiciary faces constraints in safeguarding its independence. At the same time, the media has become less dependent on government advertising blunting the weapon that governments have traditionally used against the privately-owned media. It is anticipated 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.

The Lawyers Movement, which captured the public imagination and led to country-wide protests for restoring the Chief Justice, is symptomatic of the combined power of media and its relationship with civil society actors. It brought into sharp focus the role that the media and professional associations can play in enhancing the accountability of government, and has changed the dynamic of the relationship between the state and civil society in a way that is nothing short of revolutionary.

3.3.5. Conclusions

Over the course of the last decade there has been a lot of experimentation on how to introduce greater accountability within the public health sector and beyond in Pakistan. Despite a high level of donor support for community-based initiatives, health system reforms, legislative strengthening and public oversight mechanisms the public perception is that there has been little progress in achieving a responsive, accountable health service. Many of the formal entities in the accountability landscape are moribund or ineffectual and have had little impact on the responsiveness of health service delivery. Many of the institutions that should be contributing to heightened transparency and accountability in the health sector Pakistani are themselves victims of the systemic deficiencies they seek to address such as political patronage and corruption.

With this in mind, investing in the reform of most formal state and public accountability mechanisms in our view represents a high investment/low return option that would be unlikely to result in significant direct, measurable benefits for poor women and men. An exception to this is the role of the National Assembly Standing Committee on Health which we have noted has demonstrated willingness and capacity to exercise its oversight function.

In addition the role of several of these institutions may be affected by a continuing process of devolution of responsibilities within a federal state. In particular, the 18th Amendment to the Constitution continues to consolidate the responsibility of provincial governments for health service delivery. This raises a number of unresolved issues including the role of the national health policy vis-à-vis provincial health plans, and future role of provincial entities such as provincial regulatory

authorities for the health sector and the standing committees on health in the provincial assemblies. It also raises issues for development partners on how they can most effectively channel development assistance to the health sector in a federal state where responsibility for service provision is increasingly devolved to the provinces.

The future of local governance within the province is also uncertain with the suspension of the Local Governance Ordinance 2001. Despite its intentions, local government reform nearly a decade ago failed to result in a widespread, effective partnership between local communities and service providers to deliver the quality, essential services. It is not yet clear what pattern of local governance will emerge in the provinces though it is likely this will vary from province to province. This presents challenges for a responsiveness and accountability strategy that seeks to connect local mechanisms of health service accountability with local government bodies.

From the perspective or poor women and men, particularly in rural communities, a primary focus for this strategy has to be the public health system itself, where reforms might produce more immediate and tangible benefits in terms of service delivery. Both those who work in it and those who use it, however, concur that the public health system in Pakistan is 'broken' and that there is little incentive for health managers to 'fix' it. For poor women and men this is particularly relevant at district level. Local health services remain unduly influenced by political patronage and influence. EDO(H)s lack the flexibility and autonomy to respond to local health needs, and the means to respond to poor performance or to reward good performance.

Despite the state of its MDG health indicators there is little public outcry in Pakistan about the state of the nations' health. Health issues feature low on the national political agenda and health expenditures are only 1.4% of total government expenditure. Heightened public awareness of the state of the nation's health will not be a sufficient condition of achieving a more responsive health service in Pakistan but it will be a necessary condition. A growing public demand, adopted by politicians and parliamentarians, translates itself into political will for change. There is evidence that the media, in consort with other civil society actors, can build a forward momentum for change, as in the Lawyers Movement. The nexus of relationships between civil society, the media and political parties represents the most likely impetus for change towards a responsive, accountable health service in Pakistan.

Civil society engagement with the health sector must take place at all levels of Pakistani society, including the involvement of communities in monitoring local health services. We have seen that a wide rage of approaches to community participation in local health services have been experimented with in Pakistan with donor support. There is little justification for continuing to pilot such initiatives as they are unlikely to have widespread impact or result in significant new learning. However, the closer the point of delivery of accountability reforms is, the greater the benefits that might be accrued from these for poor and marginalised communities. The unresolved challenge is how - in face of resistance amongst many health professionals - to incorporate a cost-effective model of partnership with local communities in the public health system to increase the responsiveness and accountability of health service delivery.

The central challenge remains - how the public health system can overcome its systemic deficiencies to respond to the pressing health needs of the nation and, in particular, the poor and marginalised. It is not the province of this strategy to address many of these system weaknesses directly e.g. the lack of adequate systems of performance management, reward and remuneration etc. However, there are a number of possible entry points from the point of view of responsiveness and accountability. For example, a simple, fit for purpose system of planning, monitoring and reporting at all three levels of the public health system that clearly set out health commitments and targets and how progress would be monitored could provide a framework of transparency and accountability, if open to public review.

However, there are no simple solutions to developing a more responsive, accountable health system in Pakistan. In order to demonstrate results in the short term it will be important to support those areas where there some impetus for change e.g. the media, civil society and, in some cases, political parties. However, longer-term impact will be dependent on reforms to a public health system that has deeply-rooted, intransigent problems.

4. A RESPONSIVE, ACCOUNTABLE HEALTH SERVICE: OPTIONS.

4.1. Introduction

In identifying the following options we have sought to build on an international body of evidence to date; to learn from experiences in the health sector in Pakistan the region; and to draw upon our analysis of the capabilities of the relevant institutions and actors in the national 'accountability landscape'. From the key lessons on responsiveness and accountability in Section 2 we have identified a number of evidence-based principles to guide our identification of options, three of which are highlighted here:

- *Build a strategy on political realism.*

We have sought to identify options where there may be some support to take change forward in the health services in Pakistan. DFID's analysis of the potential drivers for change in Pakistan recognises that these are limited in scope and number; suggests that there is little prospect of sustained pro-poor change from structural or institutional factors in the short to medium term; and highlights civil society, the media and political parties as principal change agents[20].This analysis is reflected in public attitudes. In contrast, formal, state and public accountability mechanisms are perceived as ineffectual and peripheral to overseeing or enforcing citizens' or consumers' rights vis-à-vis service providers.

- *Build ownership through existing frameworks.*

The strategy seeks to reinforce the implementation of national policy frameworks such as the National Health Policy 2010 (NHP) - in particular its commitments to establish a culture of results-based monitoring and sound managerial practices; to enhance national and provincial capacity to generate evidence, measure results and guide policy; and to pilot locally appropriate models of health care so as to recommend sustainable systems. Wherever possible we sought to avoid suggesting the creation of new initiatives or systems parallel to the public health system though we recognise a case for supporting existing non-state providers to delivering a stronger accountability agenda.

- *Deploy a mix of funding instruments and approaches*

The options represent a mixed portfolio of funding instruments and approaches. The aim has been to identify modalities of funding, appropriate to different kinds of aid

interventions and target groups, ranging from short-term grant funding to long-term support.

The following table summarises the options we present under four main 'pillars':

Civil Society and the Media

- Strengthen public communications and advocacy on health
- Scale up and embed community approaches
- Increase local scrutiny of health allocations and expenditures

Public Health System

- Support provincial government strategic frameworks for health
- Support a reconstituted National Health Policy Council
- Strengthen the capacity of HSSPU/HSRUs to develop a monitoring model
- Introduce performance-based contracts and accountability focus to NSPs
- Pilot test an autonomous district model of healthy management

Public and State Accountability Fora

- Strengthen national and provincial Parliamentary Standing Committees (Health)
- Strengthening Political Parties Heath Manifestos

Legal and Regulatory Mechanisms

- Strengthen Provincial Regulatory Authorities oversight of private & alternative health sectors

We will offer a summary rationale and appraisal for each option. Each option will be appraised according to a number of principles/criteria drawn from the learning points above i.e.

- *Alignment* i.e. how aligned is the option with national institutional and policy frameworks e.g. the NHP? How likely is it that it would be welcomed and 'owned' by stakeholders who are in a position to influence its success?
- *Sustainability* i.e. how likely is it that the option would continue to have an impact after the period of funding?

- *Partnership* i.e. what potential is there for coordination between development partners on this option?
- *Cost effectiveness* i.e. how proportionate is the likely impact of the option in relation to the cost of supporting it? How viable will it be to measure results i.e. outcomes, and attribute them to DFID support?
- *Risk* i.e. what are the risks to the successful implementation of the project?

The strategy was asked to consider options for the Punjab, Khyber Paktunkwha and Balochistan provinces. Most options recommend implementation in the first two provinces as the security and developmental conditions for many of the options are not currently present in Balochistan province.

4.2. Civil Society and the Media

Under this pillar we consider how to take advantage of the symbiotic relationship the media and civil society to build political momentum for a more responsive, accountable health service; how to scale up and incorporate community approaches to accountability within the public health system; and how to support increased scrutiny by the communities and local NGOs of health sector allocations and expenditures.

4.2.1. Build momentum on health issues through the media

Rationale

The media, along with the judiciary, is recognised as a positive driver of change in Pakistan, having grown in diversity and confidence in recent years. The number of print, radio and TV outlets in English, Urdu and provincial languages has grown exponentially. Radio and TV channels are particularly important for the poor and marginal in a country where adult illiteracy is 62%, rising to 77% for adult women. Other forms of electronic media e.g. mobile telephony and the internet, also have growing coverage.

The media, particularly the private media, is increasing assuming a 'watchdog' role and there are growing public expectations regarding its role in identifying problems in society, suggesting solutions and holding the powerful to account. A National Association of Health Journalists has also recently been formed with a view to raising the profile of health issues in the media. Representatives from print and tele-visual media expressed enthusiasm and willingness to profile health issues during the consultation process. However, the capacity of the media to promote a health

agenda is largely dependent on the availability of compelling 'stories' that they can readily use.

However, health 'stories' and 'narratives' are more likely to result in policy or practice change if they are the product of good quality research. DFID and AusAID have already funded a Research and Advocacy Fund (RAF) to promote policy-relevant research and advocacy in relation to Maternal and Newborn Health. Civil society organisations have an important role to play in producing and publicising informed narratives that illustrate key health issues. Some sophisticated NGOs already have the capacity to provide the media with research-based stories on the health sector e.g. SDPI, Network, Heartfile. These already have recourse to RAF for research or advocacy funding and all proposals have to include a communications element.

More generally, however, it recognised that many NGOs do not have communications competencies, especially at provincial and district level. It is here the priority should be. It is important to ensure that the media outlets most popular with the poor and marginalised sections of the population e.g. local and provincial media in Urdu and other provincial languages, are supported in promoting 'health literacy', awareness of rights and entitlements, and transparency in reference to performance of health services. There have been some interesting experiments in this regard - for example, PAIMAN and the Network for Consumer Protection experiments with talk-show formats in both TV and radio. These can be produced at low-cost; the average cost of the PAIMAN TV talk show in 2007, for example, was U$1,800 per episode. Local radio has also been shown to be effective in the social marketing of health initiatives such as family planning, vaccination campaigns and iodised salts.

This option seeks to build an ongoing campaign, at national, provincial and district level, through TV, radio and newspapers to raise public awareness of the state of the nation's health; the need to reform and strengthen the capacity of the public health system to meet the needs of poor and vulnerable people; the need for greater regulation of the private and alternative health sectors; and for systems of accountability to local people.

Option

Strengthen public communications and advocacy for responsive, accountable health services through:

A) Support to the media to increase and improve coverage of health issues e.g.

- Sensitisation workshops 'gatekeepers' of the media to enable mainstreaming of public health issues in the media.
- Build the capacities of journalists to report proactively on public health issues, through media fellowships, national and international information networks, seminars etc. (Reuters Institute, Panos Institute etc)
- Specially commissioned TV and radio programmes, and media packages.
- Dialogues between citizens groups and policy makers and politicians.
- Support to the Association of Health Journalists Pakistan.

B) Strengthening the communications capacity of NGOs, CSOs to provide stories to the media through:

- Communications training for NGOs/CSOs or NSPs involved in health sector.
- Media briefings, news features, radio and television features, books and reports to policy planners, programme managers, decision makers, NGOs, media and communities.
- Media packages e.g. for TV or local radio in reference to entitlements
- Support for innovative approaches to use of ICTs to promote awareness of health issues.

C) Continuing support to the Research and Advocacy Fund to encourage policy-literate research and advocacy to promote a more responsive, accountable health service by:

- Focusing on the responsiveness and accountability of local health facilities as a priority area in the third or fourth Call for Proposals.

Outcomes, Outputs, Indicators

The expected outcome of this option would be increased public awareness of and demand for the improved, accountable health services that respond to the needs of the poor and marginalised. While this applies to all levels of Pakistani society the target population will the poor and marginalised, particularly in rural areas. Outputs would include:

- Increased incidence of health-related media coverage in print, radio and TV, particularly in local media and local languages, and
- Increased number of advocacy-related public communications in health-related issues.

The key outcome indicators would be changes in awareness, understanding and concern regarding health issues in target populations as measured by surveys.

Output indicators would include frequency of health-related communications and advocacy products.

Implementation

Project management for Options A and B would be the responsibility of a management agency with demonstrated local capacity contracted by DFID to manage its proposed project 'Raising Voices and Building Accountability' which will also have a small advisory committee. Options A and B would contribute to the Output 1 of the project to 'increase citizen participation in strengthened democratic processes' and Output 4 to 'strengthen the capacity of civil society for evidence-based advocacy'. Funding for options A and B could be through the either of the two funding mechanisms envisaged that the new 'Raising Voices' project i.e. through a strategic partnership arrangement with an established NGO or through a proposed Challenge Fund. Option C requires no new management arrangements since it refers to the Research and Advocacy Fund which is already established and functioning. RAF's operating procedures allow for a Call for Proposals to focus on a specific priority area for research and advocacy. This option would also contribute to output 4 of the proposed 'Raising Voices' project.

Budget (£ sterling)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Support to media	150,000	150,000				300,000
Media products	150,000	150,000				300,00
Support to NGOs	200,000	200,000				400,000
RAF commitments	(1,500,000)					(1,500,000)
Total (£)	500,000	500,000				1,000,000

Appraisal

Alignment: The NHP 2010 makes no reference to increasing public awareness and understanding of health issues but it does emphasise the value of evidence-based policy formulation.

Sustainability: Support would be welcomed by the media and civil society. The aim would be to build a lasting motivation and capacity in the media and civil society to communicate and advocate on health issues.

Partnership: Opportunities for partnership with other development partners and non-governmental actors such as PILDAT, Panos Institute, Pakistan and the Association of Health Journalists Pakistan.

Cost-effectiveness: The potential benefits in relation to the costs are considerable given the influence of the media on public attitudes and political processes. No new funds are required to support evidence-based advocacy through RAF.

Risk: The option is based on the premise that heightened public awareness will lead to great public demand for improved health services which in turn will lead to more responsive health services. However, multiple factors can impede these causal links.

4.2.2. Scale up and embed a community approach to accountability

Rationale

International research studies have shown that community monitoring initiatives, albeit under special conditions, can be effective in stimulating more responsive, accountable local health services. Although there have been comparatively few research studies in Pakistan, there is a growing body of experience of projects that have sought to involve local communities in supporting or monitoring the quality of local health services. While some approaches have mobilised communities through local autonomous organisations e.g. RSPN, SAP-PK, others have sought to revive and/or work through notified bodies that were otherwise largely dormant throughout the country - for example, Citizens Community Boards (CCB)s or Primary Care Management Committees (PCMC)s.

These community-based initiatives have most often sought to work collaboratively with local health managers such as MOs of BHUs and at district level with the EDO(H). In a number of cases they have revitalised District Health Management Teams (DHMT) and used these as a forum for stakeholders to openly review the performance of health services within the sector. A number of these initiatives have been able to demonstrate increased responsiveness by health service providers as a result community involvement. A number of sound methodological tools and approaches have been developed and documented in the process. SOHIP, for example, has worked with provincial and district governments in the Punjab to develop and install new protocols and mechanisms that address management and accountability issues. These have taken the form of bye-laws for example for District Health Management Teams, model of Three Years Rolling Plans for districts, course curricula on management and leadership, standards and protocols, operations manual for DHQ Hospitals etc.

However, these achievements have been dependent on the capacity building support offered by an implementing agency and local NGO partners, who in turn have been funded by external donors. Given this level of external support, it is difficult to justify an option that involves another 'start up' pilot project involving local communities in seeking to hold local health service providers to account. It would involve considerable 'start up' costs, have limited impact, and would be unlikely to result in better methodological tools than those that already exist. The challenge is to demonstrate how community accountability mechanisms can be assimilated within the public health service over time. In addition to level of support required, a major obstacle to this is the cynicism expressed by many medical professionals within the public health system towards a constructive role for local people, especially the poor and marginalised, in promoting responsive, accountable health services.

It is not an easy task to identify an option to support local communities in Pakistan in holding service providers to account that respects our guiding principles of political realism and working within existing frameworks. One way forward would be to support the work of partners with established programmes, demonstrable expertise and proven methodologies in working with local communities in such a way that might enable them to scale up and embed their approach in the public health system. This would keep investment costs - such as initial research and organisational start up costs - to a minimum and build on and extend established relationships. The emphasis would be on developing a body of evidence to demonstrate that local communities working in partnership with local service providers represent a (cost) effective approach to ensuring that local health services meet local needs, and to gain ownership of such an approach within the public health system.

Option

Support existing programme/s with effective community mobilisation approach to scale up their impact through broader-based policy and practice reform by e.g.

- Developing policy prescriptions for broader application based on documented evidence of cost-effectiveness of a community-based approach.
- Supporting a programme to raise awareness within the public health system of the value of a partnership approach to accountability with the community.

Outcomes, Outputs, Indicators

The outcome of this option would be the broader assimilation of community mobilisation/support approaches within the public health system. Outputs would

include case study and research materials on the (cost) effectiveness of community approaches; communications materials and media packages; training and 'sensitisation' workshops for medical professionals within the public health service (and medical schools?). The principal outcome indicator would be the number of community accountability initiatives established within the public health sector in the catchment area that require no external funding. Output indicators would to the number of case study and communications material distributed, workshops conducted etc.

Implementation

There are two options with regard to implementation of this option. The first is to project fund existing implementing agencies such as the CESSD project in Khyber Pakhtunkhwa or Save the Children USA to develop a body of evidence and set of policy prescriptions to research the contribution that local communities can make to more responsive health services and to take forward a programme of awareness raising with health professionals on the value of a partnership approach e.g. by involving local people themselves. This might be funded through the proposed Challenge Fund anticipated under the DFID 'Raising Voices' project. The second is to focus a Call for Proposals of the Research and Advocacy Fund on the role of local communities in improving health services and enhancing health outcomes, as indicated by Option 4.5.1.A.

Budget (£ sterling)

The costs will reflect the number of Districts involved. The figures below refer to two Districts.

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Research	100,000	100,000				200,000
Communications/advocacy	100,000	100,000				200,000
Administration	25,000	25,000				50,000
Total	225,000	225,000				450,000

Appraisal

- *Alignment:* NHP makes no reference to working in partnership with local communities but there is ongoing interest from donors, NGOs and MOH senior management.
- *Sustainability:* Dependent on donor funding but aim is to establish case for the sustainability of the approach.
- *Partnership:* Opportunities for partnership with donors and NGOs

- *Cost-effectiveness:* Aim is to test and promote the case for the cost-effectiveness of community approach.
- *Risk:* Resistance within the public health system and medical profession.

4.2.3. Support public scrutiny of health service performance

Rationale

Public access to information is frequently cited as an important pre-condition to responsive and accountable public institutions. In particular, financial transparency in health-related allocations and expenditures is a keystone of accountability and a disincentive to corruption. A variety of stakeholders have an investment in understanding how funds are allocated to health service delivery at all levels of the system. Clients of basic health services need to be reassured that local budgets are being well-spent and not misappropriated; health service managers need to know how funds are being spent in order to assess value for money and allocate resources effectively; development partners need to be able to track their funding to health outputs or outcomes in order to meet their commitments to 'manage for development results'. The focus of this option is to support the capacity of local communities and NGOs to track financial allocations and expenditures in the health sector.

There has been comparatively little support for this kind of work in the health sector in Pakistan but there has been considerable experience of budget tracking initiatives with the community in the education sector in Pakistan. The Commonwealth Education Fund (CEF) supported a major programme, in which the Pakistan Human Rights Committee was a partner, to bring education budgets under the scrutiny of civil society organisations by enabling them to engage in budget analysis; track disbursement flows through the education system; monitor expenditure and lobby to influence budget allocations. The programme is extremely well documented and developed a Guide for civil society organisations (CSOs) to enable them to analyse budgets and use this to hold governments and non-state actors accountable for their policy commitments, budget allocations and expenditure. The Centre for Peace and Development Initiatives (CPDI) also has a 'budget watch' programme to build budget tracking capacities in civil society e.g. to track the use of budget allocations, identify anomalies or inefficiencies if any, and implement advocacy activities to address the problems identified.

Other NGOs such as the Network for Consumer Protection and SDPI have experimented in testing the Freedom of Information Law to require the release from government of information previously withheld from the public.

This option focuses on the public's right to information on the performance of essential services. It seeks to build the capacity of local communities and NGOs to access information relevant to their holding local service provides to account; and to understand and use this information to improve local health services. It aims to introduce increased financial transparency into the health sector, particularly at district and local level, by enabling communities to monitor the funding and cost-effectiveness of health service providers, identify delivery or resourcing gaps; and take remedial action when appropriate.

Option

Support public scrutiny of local health service performance through open access to relevant information, by supporting:

- Capacity building of community groups and local NGOs to engage in budget analysis; track disbursement flows; monitor expenditure and influence budget allocations and expenditures.
- Support to community groups and local NGOs in accessing information relevant to local health service performance through, for example, the Freedom of Information Act, where appropriate
- Dissemination of findings in accessible formats to the public health system; in local media; to local citizens groups and to politicians as part of a campaign in support of more accountable, responsive services.

Outcomes, Outputs and Indicators

The outcome would be increased transparency and public understanding of local health service performance including financial allocations and expenditures. Outputs would include financial analyses of local health expenditures; public communications documents and media coverage; public discussions etc. The principal outcome indicator would be increased local awareness of local health performance and finances as measured through perception surveys and other methods. Output indicators would include the number financial reports, communication materials, public meetings etc.

Implementation

It is suggested that an implementing agency be appointed through open tender to provide capacity building support in budget analysis and advocacy to community groups and NGOs in two districts, one in KP province, and the other in Punjab. If possible the choice of districts should coincide with other options included in the strategy - for example, those relating to the role of non-state providers and the EDO(H) - to benefit from potential synergies. In addition to building capacity in budgetary analysis the implementing agency would support local community groups in developing an influencing strategy targeted at local decision-makers and in making representation to, for example, the EDO(H) on health expenditures on the basis of informed analysis.

Budget (£ sterling)

The figures below refer to two Districts.

Activity	Yr1	Yr2	Yr3	Yr4	Yr5	Total
Capacity building	100,000	100,000				200,000
Research/communications	75,000	75,000				150,000
Administration	25,000	25,000				50,000
Total	200,000	200,000				400,000

Appraisal

Alignment: NHP 2010 makes no reference to access to information or external monitoring of budgets but does refer to monitoring ODA and government-funded interventions to 'minimise waste and pilferage'.

Sustainability: Dependent on grant funding but aims to build a sustainable capacity to monitor budgets within the local area.

Partnership: Opportunities for partnership with other donors and coordination with education sector budget tracking. Possibilities of linkages with other projects e.g. media.

Cost-effectiveness: Cost-effective if increased financial transparency results in better use of existing allocations.

Risk: Budget tracking activities incur opposition from public health sector which undermines relationships with the community.

4.3. The Public Health System

The capability of the public health system to respond to the needs and demands of citizens must be the lynchpin of a responsiveness and accountability strategy for the

sector. In particular, its ability to monitor, report and manage the performance of health services at all levels is key. This is acknowledged in the NHP2010 in which the need to monitor results and performance, and strengthen national and provincial capacity for M&E features prominently. A functional planning, monitoring and reporting system within the public health system is vital for all stakeholders - end-users, managers, development partners etc. - who have an interest in responsive, accountable health services.

A framework to build a responsive, accountable public health service in Pakistan will consist of a number of 'building blocks' internal to the public health system. These are:

1. A planning framework with clear targets and budgets that provides a framework of transparency and accountability;
2. An open system of review of progress to objectives that enables remedial action when necessary;
3. A functional system of information gathering and monitoring relevant to performance management and public accountability;
4. Clear systems of accountability to the public and the public health system of non-state providers of public health services;
5. Capability and flexibility of health managers at the 'front line' of delivery to respond to the needs of local communities.

The following options seek to address these five key elements.

4.3.1. A Planning Framework for Transparency and Accountability

Rationale

Put very simply, systems of accountability for service providers are greatly assisted by planning frameworks that set out clear policy objectives and/or targets; strategies and budgets to achieve these; and how progress will be monitored and reviewed. This provides a framework for transparency and accountability for internal and external stakeholders. In the case of the public health system in Pakistan achieving such a framework is by no means straightforward.

The NHP 2010 sets out policy objectives and priority actions for the sector at national level. Since health service delivery is the responsibility of provincial governments

there is no intention to 'operationalise' the NHP 2010 in the form of national level strategic plan. The Medium Term Budgetary Framework (MTBF) - 3 year rolling plan currently from July 2010 to June 2013 - serves as the strategic plan at federal level, although this does not link sectoral policy objectives to targets, strategies and budgets.

Provincial governments have responsibility for the bulk of health service provision and the MTBFs being developed in Punjab and KP provinces, for example, will serve as provincial strategic plans. To date, only KP province is developing a strategic 'plan' for the health sector policy that links policy objectives (some of which are drawn from the NHP2010) to outputs, strategies and budgets. Significantly 'real life' budgets are being drawn up on the basis of district, provincial and federal (i.e. vertical programme) expenditures in addition to 'off budget' expenditures i.e. from direct donor funding. This will have a seven year horizon in line with the Comprehensive Development Plan.

Many, if not most districts in Pakistan, do not have specific plans for health service delivery. However, we have seen (Section 4.2.2.) that revitalised District Health Management Teams (DHMT) can have a role to play in approving and monitoring district health plans and that methodologies have been developed in this regard e.g. by SOHIP. The DHMT could also play a role in monitoring of heath services and facilities on the basis of a system of monitoring information and in developing a system of incentives for high-performing facilities and staff.

The relationship between the National Health Policy, provincial and district health plans is not well defined and it is difficult at this stage to see how performance to objectives or targets might be effectively managed or monitored from the district to the federal level. However, some kind of strategic framework with policy objectives linked to outputs, strategies and budgets is a desirable if not a necessary condition of an accountability framework. The KP strategic framework for the health sector is currently the only example of its kind that offers this level of alignment and detail and provides an opportunity for a provincial government to 'lead from the top' in publicising its health policy commitments and holding itself publicly accountable for their achievement.

It also offers an opportunity for the provincial government to negotiate donor funding in line with provincial health priorities and within a framework of transparency and

accountability. DFID and AusAID currently support the health sector in Pakistan through a combination of 'on' and 'off' budget support; of sectoral budgetary support and project funding of specific initiatives such as TRF and RAF. The Paris (2005) and Accra (2008) High Level Forums on Aid Effectiveness have committed development partners coordinating and aligning development support to national priorities and demonstrating results. There is a good case for development partners paying closer attention to the aid modalities best suited to federal systems; to directly support provincial and district reforms and service delivery; and reinforce systems of accountability at lower levels of government[21].

Option

Support provincial governments to develop, publicise and implement strategic plans for the health sector by:

- Supporting the KP provincial government to produce the health sector strategic plan as a public communications document, and to distribute, launch and communicate the plan with civil society as well as within the provincial health department;
- Identifying specific arrangements for publicly reviewing progress to the framework (see section 4.3.2);
- Negotiating with development partners to align funding for the sector more explicitly with the policy objectives and strategies of duration and targets of the framework;
- Supporting the development, publication and implementation of a strategic plan for the health sector in Punjab.

Implementation

It is suggested that when the KP strategic framework is presented to the provincial government in late 2010, its potential as a framework for public accountability and aid coordination emphasised. A public review body should be identified; a *modus operandi* agreed and a three year budget prepared. Funding should be made available to disseminate the framework and establish a public review body in partnership with the provincial government. Support for the development of a Punjab strategic framework should include the active participation of HSRU/HSSPU to ensure that the strategic planning capability is embedded in public health system. It is suggested DFID/AusAID reviews its funding modalities for the health sector in Pakistan, in light of the further impact of the 18th Amendment on provincial

governments and international commitments on aid effectiveness, with a view to direct funding of health priorities within provincial strategic frameworks.

Outcome, Outputs, Indicators

The outcome would be public scrutiny and accountability of provincial health strategic plans. Outputs would be the publication and communication of provincial strategic frameworks; the identification and implementation of a public mechanism to monitor progress; and the alignment of development partner funding to provincial priorities in the framework. Outcome indicators would include indicators for the responsiveness of the provincial government to public scrutiny. Output indicators would include the number of policy/practice changes in provincial health services in response to public scrutiny of the health plans and quantity of development assistance aligned to the framework.

Budget (£ sterling)

Working directly with the KP provincial government to fund provincial health priorities in line with the strategic framework in itself would involve no additional funding. However, provision should be made to launch and publicise the framework with he general public, local NGOs, other donors etc. The cost of technical assistance to the Punjab government to develop a similar framework is based on the budget for the KP technical assistance.

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Communication of KP SP	25,000					25,000
Support to review body	100,000	100,000	100,000			300,000
TA to develop Punjab SP	120,000					120,000
Communication of Punjab SP	25,000					25,000
Total	170,000	100,000	100,000			370,000

Appraisal

Alignment: In line with Paris and Accra declarations on Aid Effectiveness. NHP2010 makes reference to federal and provincial governments developing joint strategies to enhance ODA (para70).

Sustainability: Sustainable for the duration of the frameworks i.e. seven years, and capability is embedded in public health system (see Option 4.2.3.)

Partnership: There should be possibilities of coordination with other development partners in the health sector as it is in line with the Aid Effectiveness agenda.
Cost effectiveness: Likely to enhance the effectiveness and accountability of aid at little additional cost. It would result in increased transparency in reference to cost effectiveness since budgets policy objectives should be more accurate reflections of funding and expenditure.
Risk: Lack of political will to implement a tighter framework of mutual accountability.

4.3.2. An open process of review to progress on health commitments

Rationale

Once a planning framework is in place, the ability to monitor the implementation of health policy commitments, and respond effectively, is key to an accountable health service. The degree to which such a monitoring and reporting process is transparent and open to a range of primary stakeholders, the more substantive the accountability of service providers.

At a federal level, there has been some discussion with regard to reviving the National Health Policy Council (NHPC) in order to oversee and energise the implementation of the National Health Policy 2010. The NHPC was notified in August 2005 but has since become dormant. It is proposed that the NHPC be reconstituted as an independent, non-partisan body with a broader mandate and wider representation, including representatives from civil society; made a statutory body through parliament; and report annually to the Social Sector Committee of the Cabinet

A number of options have been proposed with regard to the strength of powers available to the revived Council, ranging from a policy forum to a monitoring or indeed a regulatory body. The majority of those consulted favoured a monitoring and advisory/regulatory body working under the Ministry of Health.

A reconstituted, reinvigorated NHPC, working in partnership with the Ministry of Health, could contribute to increased responsiveness and accountability of the health service at a national level by providing a process of open and public review of the performance of the sector - for example, by engaging the public, media and political parties - and supporting senior management to drive forward well-evidenced, thought-through reforms.

However, as responsibility for health service delivery is consolidated at provincial level there is a pressing case for effective review and oversight of health sector performance at that level. Provincial Parliamentary Committees are limited in their powers (see Section 4.4.1) and there is currently no provision nor proposal along the lines of the NHPC as how progress to provincial health commitments might be reviewed. As we have highlighted in the previous Section, the development of the KP provincial strategic plan offers an opportunity for the provincial government to identify and constitute a public review body.

Option

Support a reconstituted NHPC, with a broader mandate and wider representation, to monitor and oversee the implementation of national health policy. The revived NHPC would:

- Review critical issues related to the health sector and contribute to health policy formulation;
- Monitor the implementation of health policy e.g. through an annual health sector performance report, and suggest solutions to resolve obstacles in policy implementation;
- Recommend new legislation, review proposed legislation, identify policy research needs and endorse and monitor standards of health care;
- Engaging the public, media and political parties in monitoring health legislation.

Implementation

DFID/AusAID would support an additional staff member in HSSPU, as the nominated Secretariat to the Council, to take the necessary steps to reconstitute the NHPC, draft its rules of business, present a three year budget; prepare a Call for Nominations from civil society; and provide ongoing support. This would preferably be in association with the approval and launch of the NHP2010 and a commitment to a process of public review of national health sector performance. The MOH should take steps to confirm the status of HSSPU within the Ministry as a properly notified body so as to establish its legitimacy and authority in its internal and external communications. The MOH would assume the operational costs of the NHPC during the budget period as an indication of its commitment to such a body while DFID/AusAID would provide additional funds e.g. for commissioning policy analysis or development.

Outcomes, Outputs, Indicators

The outcome would be government and MOH that is responsive to an open process of review of progress to national health priorities. The outputs would be a fully functioning NHPC, annual health sector assessments and policy and practice recommendations for the sector. Output indicators would include the number of recommendations re policy or operations adopted by MOH; number of legislative initiatives that reference or can be attributed to NHPC influence; and the number of media references to NHPC and associated health issues.

Budget (£sterling)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Support to HSSPU	50,000	50,000	50,000			150,000
Support to NHPC	100,000	100,000	100,000			300,000
Total	150,000	150,000	150,000			450,000

Appraisal

Alignment: No current reference to the NHPC in the NHP2010. It's non-inclusion in the NHP2010 as approved by Cabinet would reflect a lack of ownership within the Ministry of Health.

Sustainability: Unlikely to be sustainable without donor support. A test of the likely sustainability of the option would be a commitment by the MOH to fund or partially fund the NHPC.

Partnership: Opportunity of partnership with other donors working in the health sector.

Cost effectiveness: Costs would be reduced if shared with government and/or other development partners. The potential impact on the health system of a high status, high profile body with civil society and government representation monitoring the nations' health outcomes could be significant in putting health issues on a public and political agenda.

Risk: Lack of MOH support for the NHPC might undermine its re-establishment or its effectiveness by sidelining or ignoring its policy and practice recommendations.

4.3.3. Monitoring and reporting for performance management and public accountability.

Rationale

A system of monitoring and reporting on health service delivery through a series of key indicators is key to public accountability e.g. to the NHPC; policy formulation e.g.

to the HSSPU; and internal accountability and performance management e.g. to health managers at all levels.

At a federal level, the performance of the NHPC would depend on the monitoring data generated at district by information cells and provincial level by the HSRUs, and channelled through the NHIRC in Islamabad, although the NHIRC currently has little visibility at federal level. One proposal is that the provincial HSRUs would put together a quarterly monitoring report from the districts which would be aggregated by HSSPU into a quarterly report to the NHPC with a summary of findings. This would require a degree of consistency with regard to planning, monitoring and information systems at all three levels of the public health system.

In fact, there no consistent approach to how national health priorities 'cascade' down to provincial and district health plans and link with vertical programmes. Neither is there a consistent approach to how local health service performance is monitored. There exists a number of initiatives with regard to management information systems for the health sector e.g. Minimum Service Delivery Standards (MSDS) and Key Performance Indicators (KPIs) in Punjab and some stand-alone, donor supported systems e.g. MEAs in Punjab. The Punjab Health Sector Reforms Programme (PHSRP) offers free online access to external, non-clinical monitoring reports which are updated on monthly basis. Districts are also ranked based on monthly aggregated indicators such as presence of staff; availability of medicine and equipment; overall cleanliness of utilities; and public satisfaction.

However, the cornerstone of a national system of monitoring and reporting on the health sector should be the district-based health information system (DHIS) - a decentralised system of data collection which is replacing the current health information system (HMIS). Opinion is divided on the new system. There have been some initial software problems - for example, it has been criticised with regard to its ability to absorb large amounts of data. Some positive features are that it includes fewer, more relevant indicators including data on vertical programmes, human resources, logistics, finance and, importantly, some quality of service indicators. However, the new system is being implemented patchily and many questions remain with regard to its implementation.

The central challenge remains - how to establish a simple, effective system of information gathering and reporting in the public health sector that provides the basis

for performance management at all levels of the health system, and internal and external accountability. However, the public health system lacks a culture and tradition of gathering and using information as an integral part of performance management and policy development. While a one-system-fits-all approach is unlikely to be appropriate under a federal system there needs to be a degree of consistency and compatibility between provincial and district approaches, and vertical programmes, that enables monitoring information to be aggregated up to form, for example, health sector assessments as referred to in the NHP 2010.

There are a number of potential entry points to strengthen public health information systems. For example, the role of NHIRC could also be expanded beyond the management of DHIS system to become a national health information 'clearing house' collating health information, research studies and surveillance-related data to assist policy and decision-makers. This option focuses on developing a functional model of monitoring and reporting that enables the public health system to manage and be held accountable for its performance.

Option

Strengthen the capacity of HSRU and HSSPU to develop a monitoring model for generating data, measuring results, managing performance by:

- Identifying key information needs for health managers at all levels;
- Agreeing key indicators drawing on DHIS and other information systems
- Reviewing roles and responsibilities in health system;
- Providing capacity building support e.g. on data analysis;
- Reviewing incentive schemes to generate and use information as part of performance appraisal system;
- Involving the community in monitoring information at health facility level and in discussing e.g. issues such as accessibility;
- Including DHIS, surveillance and research data in NHIRC for policy purposes.

Outcome, Outputs, Indicators

The outcome would be the effective use of regular, accurate, and useful monitoring of information and reports for managing performance and public accountability. The outputs would be a simplified, fit for purpose, system of gathering and reviewing data within the public health system; clarification of staff roles and responsibilities and training and support to fulfil them; production of regular monitoring information for managers at district, provincial and federal levels. Outcome indicators would include

evidence of the frequency of use of monitoring information by managers and monitoring committees and public stakeholders at all levels of the health system. Indicators would be identified regarding the quality, frequency and usefulness of the outputs.

Implementation

TRF would provide technical assistance to HSSPU and HSRUs on M&E systems, human resource development and data management to support key activities above.

Budget (£sterling)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
M&E TA	100,000	100,000	100,000			300,000
HRD TA	100,000	100,000	100,000			300,000
Data management TA	100,000	100,000	100,000			300,000
Total	300,000	300,000	300,000			900,000

Appraisal

Alignment: Closely aligned to NHP2010 commitments to "standardise the collection, collation and analysis of routine health information" and to strengthen national and provincial health policy units to generate evidence and measure results.

Sustainability: Enhanced capacity requires additional funding but a functional model should be self-sustaining.

Partnership: Opportunities for coordination with current funders e.g. ADB.

Cost effectiveness: The application of sound systems of monitoring and reporting of health performance at all levels would be a cornerstone of an R&A strategy and have great impact if acted on by health managers.

Risk: Ownership may vary at different levels. Evidence of low importance assigned to health information and few incentives assigned to data collection and reporting and resistance to policy and methodological advice by health service managers 'down the line'. Continuing disparity between policy guidance and what happens in practice.

4.3.4. Accountability of non-state providers (NSPs) to the public health system

Rationale

Non-state providers (NSP)s provide a substantial proportion of the nation's primary care services i.e. health services most pertinent to the poor and marginalised. In addition to being free to define their own methodologies, NSPs are not constrained

by public sector employment and HR polices and practices. This gives them more flexibility over how they manage their labour force e.g. re hiring and firing, salaries and remuneration, and allows them to develop their own organisational culture. Recent research has concluded that there is some evidence that NSPs can deliver services more cost-effectively to the poorest than the public health system in difficult environments[22] and has highlighted that 'performance-based contracting' can increase the take up and quality of services. An earlier study[23] in the region confirmed that NSPs have worked well in Afghanistan, Nepal and Bangladesh. This is supported by the experience of NSPs in Pakistan who, with the flexibility allowed them, have been able to improve some key indicators with regard to local health service delivery e.g. reducing staff absenteeism, increasing the number of patients visiting primary health care facilities, and improving the availability of medicines and medical supplies.

A more open process of contracting NSPs and a more robust approach to managing their performance could maximise their relative autonomy to deliver more responsive, accountable health services. Contracts are currently awarded without competition; no quantifiable targets are set to form the basis of performance management; and disbursements are not conditional upon performance. A refocusing of the model towards an increased role for Community Support Groups (CSG)s at local level and their network of social organisers in monitoring the quality of health services could have a significant impact on local systems of accountability. Making NSPs more accountable to the public health system and to the communities they serve could significantly benefit the poor and marginalised and be easier to achieve than, for example, widespread reform within the public sector.

Option

Introduce or re-negotiate performance-based contracts for NSPs with special emphasis on the role of local communities in enhancing the accountability and responsiveness of local health services i.e.

- Open up renewal of contracts to competitive tender;
- Set measurable performance targets and measures in contracts consistent with provincial and national health policy objectives;
- 'Cascade' plans and targets down to district level;
- Refocus the role of community support groups(CSGs) and social organisers in the provincial health system to a monitoring/accountability role;
- Notify CSGs and include them in district monitoring systems and structures;

- Pilot and review different community monitoring approaches and systems e.g. surveys, appraisals, report cards, in different districts;
- Report openly on progress to targets at all levels;
- Link funding to performance - from programme to district level.

Outcomes, Outputs, Indicators

The outcome would be the increased accountability of primary health care facilities managed by NSPs to poor and marginalised communities. Outputs would include performance-oriented contracts with targets; CSGs refocused and functioning and community monitoring groups; experiments with community monitoring and reporting methodologies. The outcome indicator would the percentage of take up of CSG suggestions by local health resource and NSP managers. Output indicators would refer to measurable frequency and quantities of process and outputs.

Implementation

In the medium term DFID/AusAID could support the introduction of performance contracting by providing technical assistance on procurement through TRF. TRF or a local NGO could also provide social development advice on how to incorporate social accountability more extensively in NSP operations and on the refocusing of CSGs. A supplementary approach in the shorter term might be to support a pilot NSP 'performance contract' in one district in KP and Punjab provinces to pilot and demonstrate a strengthened accountability approach.

Budget (£ sterling)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement TA	25,000					25,000
Social development TA	100,000	100,000				200,000
Support to CSG	50,000	50,000				100,000
Total	175,000	150,000				325,000

Appraisal

Alignment: The NHP 2010 commits federal and provincial governments to consider models to 'insulate health service provision and delivery from undue influences' - such as publicly monitored contracting - that might be implemented on a national

scale. There are questions of ownership as the PPHI is managed by the Cabinet Division rather than provincial health departments.

Sustainability: While the PPHI is an established feature of the health system in Pakistan, NSP contracts are time-bound raising issues of long-term sustainability.

Partnership: Opportunities for coordination/collaboration with other development partners working on health service delivery at provincial level - such as ADB, GTZ, CIDA and USAID - is considerable.

Cost effectiveness: The potential cost-effectiveness of this option is likely to be relatively high. Routine NSP operations are currently financed by public health budgets so funding support for this option might be targeted at a refocused effort, for example, on involving the community in enhancing the responsiveness and accountability of primary health care services. The operational flexibility of NSPs should allow for improved performance in these key areas, although some degree of cultural change will be necessary.

Risk: The perception of PPHI being a parallel system that is not accountable directly to the public health system might continue to undermine the active collaboration of federal or provincial health authorities.

4.3.5. Capability of EDO(H)s to Respond to Needs of Local Communities

Rationale

EDO(H)s maintain that they do not have the capability to respond to the health needs of the public because they do not have the flexibility to manage their staff or funds. Furthermore, that their limited powers to manage, for example, poor performing health professionals within the district is a major obstacle to increased accountability within the system. Greater flexibility would enable them to check staff absenteeism, stock basic health facilities with essential medicines and equipment and provide staff incentives for good performance. The hypothesis is the public health system at district level would outperform NSPs were EDO(H)s to have equivalent flexibility to manage personnel, finances and facilities and that this would represent a more cost-effective and sustainable option than current NSP arrangements. DFID's own research[24] on health workers' role in responding to the needs of the poor confirms that empowering them to change their environment is a proven incentive.

This option is designed to test this hypothesis. A local accountability mechanism would be introduced through the District Health Management Team (DHMT) which would incorporate political leaders and civil society in monitoring the experiment, and

in helping to protect the EDO(H) from political and other pressures. There is some evidence e.g. from the PAIMAN programme, that DHMTs can play such a role if activated and supported. SOHIP has also developed a number of tools and methodologies to support DHMTs in playing an effective role in monitoring local health service delivery.

Option

Pilot test an autonomous district model of management by:

- Providing EDO (H) same powers over financial and human resources as under PPHI.
- Building political ownership and support through a DHMT.
- Providing operational budgets for proper monitoring and supervision of performance of local health facilities.
- Evaluating the success of the pilot to use as the basis for policy recommendations.

Outcomes, Outputs, Indicators

The expected outcome is strengthened capacity of the public health system to respond to the health needs of rural households especially women and children. The expected outputs are:

- training of 20 staff members in two districts in Punjab;
- 140 Basic Health Units with allocated staff, equipment and medicine;
- improved system of record keeping in 140 Basic Health Units;
- improved system of monitoring and reporting in two districts;
- decentralised system of financial allocation and personnel management and assignment in 2 districts;
- evaluation report on the model and policy implications for replication.

Baseline information would be recorded before the start of the pilot to record information on all key indicators with respect to the BHU such as current levels of utilisation by gender, staffing, staff absenteeism rates, availability of medicines, type and status of equipment, client satisfaction levels, etc. At the outcome level, key indicators would include the utilisation rates by women and children, level of satisfaction, assessment of quality of care through client satisfaction surveys and independent evaluation. At output level indicators would include the number of trainees, number of BHUs provided with staff, equipment, medicines and other

supplies, the system of record keeping and monitoring and the evaluation report on the model and policy implications for replication.

Implementation

This option is dependent on the MOH seeking or granting approval for the EDO(H)s in the selected districts to be granted increased operational flexibility on the same basis as the PPHI and PRSP models. It would be implemented by the Department of Health of the Government of Punjab in the short-term, and in KP and Balochistan if its effectiveness is demonstrated. At the provincial level, the Department will take overall responsibility for ensuring that all the financial and personnel management decisions are transferred to the EDO (Health) in the two selected districts. This would be agreed in a grant agreement between DFID and the Provincial Government. The Executive District Officer (Health) would be given the lead responsibility for implementing this option.

Technical assistance will be provided through the HSSPU in areas agreed jointly with the EDO(H) in the selected districts. The type of support provided to the BHUs will be jointly agreed with the Medical Officers and other BHU staff. The systems to be put in place will be closely coordinated with other initiatives in the province such as the DHIS etc.

Budget (£ Sterling)

The Government will provide the core funds for the BHUs from its annual budget for the payment of salaries, medicines and equipment. The support from DFID will provide additional funding to meet part of the capital and operational costs for the EDO(H) for monitoring and supervision, upgrading equipment and technical assistance to develop systems.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Training of District Staff	20,000	20,000				40,000
Operational Budgets for Districts	48,000	48,000	48,000	48,000	48,000	240,000
Improved System of Record Keeping etc.	45,000	45,000	55,000			145,000
Monitoring and Reporting System	24,000	24000	24,000	24,000	24,000	120,000
Technical Assistance	12,000	20000	30,000	20,000	20,000	102,000
Base line Evaluation and	30,000		30,000		30,000	90,000

Policy Reports						
Capital Costs at District Level	82,000					82,000
TOTAL	262,000	157,000	187,000	92,000	122,000	819,000

Appraisal

Alignment: The NHP 2010 explicitly mentions the *"piloting of locally appropriate and effective models of care and healthcare management"* on the basis of which *"Federal and Provincial health authorities will recommend sustainable systems to ensure the effective provision and delivery of health care services to all Pakistanis."* Discussions with stakeholders indicates that within the public health system there has been a long standing demand to test such a model and there is likely to be a high level of ownership of this option.

Sustainability: The pilot, if successful, could be highly sustainable if it led to reforms in district-level health management. Although the option anticipates an increase in the operational funds available to the EDO(H), the amount of financial outlay will not be more than the funds the Government is currently spending in outsourcing the management of the BHUs e.g. under the PPHI.

Cost effectiveness: Core costs would be covered by the public health system and additional costs associated with the pilot will be initially funded by development partners and eventually by the Government of Pakistan. A successful pilot could have a high impact in terms of strengthening the public health system and enabling it to use the given resources to reduce staff absenteeism, increase supply of medicine and equipment at the BHU level, increase utilisation and quality of care especially for women and children.

Partnership Potential: There is potential for partnership with ADB in Punjab and GTZ in KP both of which have been trying various options for reform of the health systems. This option could build on the experience of ADB's work in Punjab in developing minimum standards at the Basic Health Unit and JICA's investment in the DHIS system.

Risk: Public health officials such as EDO(H)s may be less able than NSPs to withstand pressure and interference from political elites in postings, transfer and any attempt at disciplinary action.

4.4. Public and State Accountability Mechanisms

As we have seen in the Section 3, there are several public and state accountability institutions and fora some of which relate directly to the health sector while others deal with accountability at a more general level.

Specialised regulatory bodies are tasked with registering individual practitioners and overseeing the quality of the education or training provided. Some, like the PMDC, are empowered to take disciplinary action against its members in cases of misconduct but there is little public awareness of the redress mechanisms available in cases of medical malpractice or negligence. They have not performed an accountability role in the sector and are perceived as membership networks that rarely act against member interests rather than accountability fora.

The inclusion of more generalised accountability institutions such as the Auditor-General's Office and the Ombudsman's would not directly address the issues which are key to the responsiveness and accountability agenda in the health sector. Other institutions such as the Federal Investigation Agency and the Anti-Corruption establishments deal with criminal cases and would be peripheral to a sectoral strategy. It has been difficult to identify an option to strengthen these institutions that would be likely to have a significant impact on the responsiveness and accountability of health services. However, there is scope to support more effective parliamentary oversight of the sector through provincial and national parliamentary processes and the political parties themselves.

4.4.1. Effective Parliamentary Oversight of the Health Sector.

Rationale

National and provincial standing committees on health should have an important role to play in the public oversight of health sector polices and performance - for example, by exercising oversight of health budgets and identifying and crafting a legislative agenda for the sector. Standing committees exist within the provincial and national parliaments. At the federal level there is a National Assembly Committee and a Senate Committee. Provincial committees have been largely dormant to date. However, since the provinces have responsibility for the delivery of health services in line with the NHP2010 it would follow that, with the continuing delegation of health service responsibilities to the provinces in accordance with the 18th amendment, they should technically play a more significant role in the future

Standing committees have yet to achieve their full potential in exercising parliamentary oversight in Pakistan. Committee members are often inexperienced in parliamentary procedures and have limited understanding of the policy issues under consideration. There is a limited vision of the potential role of the Committees in parliamentary oversight and the committees lack a strong capacity for policy analysis or research. Their performance is usually dependent upon the capacity and willingness of the Chair and there is a tendency for members to use committees to pursue an individual agenda or to provide services to their constituents.

However, the National Assembly Standing Committee - which has a high representation of doctors and women - is one of the few to have been proactive in exercising its mandate. It has recently been active on a broad range of issues including negligence in public and private hospitals and drug regulation. The committee has demonstrated a strong multi-partisan approach but has tended to be issue-led rather than strategy-led and to follow rather than lead the communications agenda.

Parliamentary standing committees on health at both national and provincial level could play an increasingly important role in the oversight of the sector. In particular, increased access to research and policy support would enable them to have a more pro-active, informed agenda for the sector, although it would be prudent for this support to be independently sourced to avoid the risk of political bias. The USAID has invested more than U$16 million in its 'Legislative Strengthening Project' in the last five years and provided technical assistance to the National Assembly, Senate and provincial assemblies on drafting legislation, parliamentary procedures, budgeting and oversight. It has also provided U$10 million to construct a facility for the Pakistan Institute for Parliamentary Services (PIPS). PIPS is an independent entity, funded by Parliament, which will provide training, research, analyses, legislative drafting and support to parliamentarians.

Option

Strengthen the capacity of national and provincial parliamentary committees of health by supporting:

- Access policy and research capacity through a 'call-down' arrangement with independent research/policy agencies to support its capacity to draft legislation; review health sector performance e.g. through parliamentary

hearings; suggest mechanisms for strengthened accountability; and develop policy recommendations.

- Opportunities for international exchange visits to provide exposure to other international parliamentary committee experiences, such as the UK select committee system, and styles of work - for example, use of inquiries; oral evidence sessions; budget scrutiny; use of media, etc.

Outcomes, Outputs, Indicators

The expected outcome of this option is strengthened capacity for legislative oversight and reform to enhance responsiveness and accountability in the health sector. The expected outputs from this option would be

- Research reports on key areas of health reform;
- Exposure visits for 15 members of the parliamentary health committee;
- Broad range of tools to strengthen the system of accountability and oversight;
- 3 key bills regarding health legislation approved as law;
- Parliamentary hearings on health issues;
- Annual reports presented to the Parliamentary Committees on the state of health in Pakistan by the Ministry of Health.

At the outcome level, this option will monitor the strengthened capacity of the Parliamentary committees for legislative oversight and reform in enhancing the responsiveness and accountability of the health sector. A set of indicators at the outcome level will be agreed between the implementing partner, HSSP and the Parliamentary Committees. These are likely to include the activism of the Parliamentary Committees as measured by number of meetings, level of participation in meetings, numbers of questions in Parliament etc. Baseline information on all these indicators will be recorded at the start of the project.

Outputs indicators would include the number of research reports produced on the health sector, the number of members sent on exposure visits, the number of tools introduced into the system for strengthening the system of accountability and oversight and the number of bills introduced regarding health legislation and the number approved as law, the number of annual reports presented to the Parliamentary Committees on the state of health in Pakistan by the Ministry of Health.

Implementation

In the short-term this option should be implemented at the Federal level which has an active Parliamentary Standing Committee on Health. Once lessons start emerging from the Federal level, Standing Committees on Health in the Punjab and KP provinces, which are weak, might be included.

Several organisations in Pakistan have been working closely with strengthening the parliamentary committees at the federal and provincial levels, including the recently established Pakistan Institute for Parliamentary Services (PIPS), the Pakistan Institute of Legislative Development (PILDAT) and the National Democratic Institute. PILDAT has received funding from both DFID and has a track record of working closely with parliamentarians on a range of issues. One of these organisations could be contracted on a competitive basis to implement the activities envisaged under this option. Alternatively, support could be provided to the Pakistan Institute for Parliamentary Services (PIPS).

Budget (£ sterling)

	Year1	Year 2	Year 3	Year 4	Year 5	Total
Research support	50,000	50,000	50,000			150,000
Accountability instruments	90,000	90,000	90,000			
Legislative support	90,000	90,000	90,000			
Health system reports	90,000	90,000	90,000			
Exposure visits	80,000	80,000				160,000
Total (£)	400,000	400,000	320,000			1,120,000

Appraisal

Alignment: There is no specific mention of Parliamentary Committees in the current version of the NHP although earlier versions placed strong emphasis on the Parliamentary Committees as a mechanism for enhancing responsiveness and accountability of the health sector. The NHP places considerable emphasis on the use of legislation to improve governance in the health sector and the National Assembly Standing Committee on Health has indicated its strong support for the activities proposed under this option.

Sustainability: Public funding has not been available to strengthen the role of the committees. However, it is anticipated/hoped that support to the committees will strengthen their capacity, influence their *modus operandi* in exercising parliamentary

oversight; and lead to new legislation - all of which will lead to changes that can be sustained over time.

Cost effectiveness: Both exposure visits and a research facility could be reasonably expensive but the option could be cost-effective as greater parliamentary scrutiny of health service policy and performance, however, could potentially yield considerable benefits.

Partnership Potential: this option will build on previous support have provided support to Parliamentary Committees by USAID, DFID and the British High Commission. Additional resources for research and strengthening the support mechanisms have been provided to the committees. There is the potential to collaborate with the Pakistan Institute for Legislative Development and Transparency (PILDAT) and the recently established Pakistan Institute of Parliamentary Services (PIPS).

Risk: Changes in the leadership and composition of the committees might undermine their effectiveness since the activism of the committees tends to depend upon individuals. A reorientation towards a more strategic role will require considerable effort. Research support to the Committees may lead to research and data manipulation if not independently generated.

4.4.2. Increased political commitment to improving health outcomes

Rationale

Increased parliamentary oversight of the health sector will, to some degree, be dependent on the state of the nation's health becoming more prominent on the political agenda. Currently health issues do not feature prominently in political manifestos or debate. Many parties do not have health manifestos and political leaders when they are elected lack a health sector agenda. When health issues have political prominence it has tended to be reactive to events rather than pro-active debate in improving the quality of health services.

Although there are more than 120 parties registered with the Election Commission, only a handful of political parties command popular support. The major political parties, include the Pakistan Peoples' Party (PPP) and the Pakistan Muslim League-Nawaz (PML-N) and the PML-Q. In the smaller provinces, strong regional-based parties generally tend to dominate. These include the Muttahida Qaumi Movement

(MQM), a party which is strong in the urban centres of Karachi and Hyderabad. In the North West Frontier Province, the National Awami Party (NAP) exercises a strong influence over Frontier politics. In Balochistan the leading national parties have always struggled and nationalist and regionalist parties such as Pukhtoon Khwa Milli Awami Party (PKMAP) Jamhoori Watan Party (JWP) and the Balochistan National Party (BNP) tend to hold sway.

Raising the awareness of politicians of the importance of health-related issues to their constituents is a necessary condition to these issues being debated in parliament and in the media. Similarly having clear commitments to health-related issues in political manifestos is a first step to greater political accountability on health issues.

Promoting greater awareness and understanding among politicians of health-related issues as they affect the poor and marginalised, could also be combined with briefing on the limitations of current legislation, regulatory frameworks and their implementation and discussion of appropriate reforms.

Option

Strengthen the Health Manifestos of main political parties by supporting:

- Briefing/orientation sessions on health issues;
- International exchange visits;
- All party caucuses on health issues.

Outcomes, Outputs, Indicators

The expected outcome of the option is a strong political commitment to the health sector. Expected outputs would include;

- orientation sessions with the political leaders in health sector issues;
- exchange visits to learn from the political parties in the UK and other countries;
- health manifestos of the political parties.

Progress towards the outcome level would be monitored through the types of changes that different political parties undertake when they are in positions of power such as policy reform, allocation of resources, special programmes and projects in the health sector. At the output level the progress will be measured through the number of participants in the orientation sessions and exchange visits and the changes in the manifestos of the political parties with regard to the health sector.

Implementation

It is envisaged that at the outset that only the main political parties will be included in this option. Several not-for-profit organisations working could be potential partners including the National Democratic Institute (NDI), PILDAT and the Centre for Civic Education. The NDI has worked closely with political parties in democratic development in Pakistan since 2002 and has been funded by the British High Commission to work with political parties on reform strategies for FATA, and, recently, from the Canadian Government to develop effective parliamentary caucuses in Pakistan. The Centre for Civic Education (CCE) has also been working closely with political parties to enhance the capacity of Pakistan's political parties to undertake internal party reform. The Pakistan Institute of Legislative Development (PILDAT) has a track record of briefings for parliamentarians (most recently on the federal budget) and in forming cross-party party caucuses in the health sector e.g. on promotion of immunisation.

Budget (£ sterling)

	Year 1	Year 2	Year 3	Year4	Year 5	Total
Orientation sessions	50,000	50,000				100,000
Exchange visits	120,000	130,000				250,000
Health manifestos	25,000	25,000				50,000
Total (£)	195,000	205,000				400,000

Appraisal

Alignment: The NHP 2010 does not mention political parties explicitly in relation to governance and accountability. However, they are likely to welcome this opportunity to strengthen their capacity and political agendas in the health sector which is a key issue for their constituencies.

Sustainability: Highly sustainable if health manifestos are developed and retained by the parties as political commitments.

C*ost effectiveness*: Highly cost-effective as an initial investment of two years will help to put health sector issues firmly on the political agendas. The initial DFID investment will be leveraged and pursued by the elected representatives.

Partnership Potential: Potential partnership opportunities to build on other donor initiatives in this area e.g. with the British High Commission, Canadian Government,

the Government of the Netherlands, and USAID. The U.S. Department of State, Bureau of Democracy, Human Rights and Labour is "Supporting Women Political Leaders in Muslim South Asia," which sought to promote women as political candidates and elected representatives.

Risk: A major risk associated with this option is that some of the prominent political leaders may not always be able to give time to the activities envisaged under this initiative. Also some of the different political parties may not be willing to participate in the same forum. However, the risk is low as there is a coalition Government in power.

4.5. Legal/Regulatory Fora

4.5.1. Regulation of private and alternative health services.

Rationale

A responsiveness and accountability strategy for the health sector in Pakistan must address the need to regulate the standards and performance of private and alternative health service providers. The private health sector is growing rapidly and accounts for approximately 75% of health care in the country including a large number of practitioners of alternate medicine such as homeopaths, Tibb and ayurvedic practices. There is no effective regulation of the private health sector, nor of alternative health care providers and no standardisation of their products, sales and practice.

Provincial regulatory authorities should have an important role to play, in a decentralised system of health provision, in setting and monitoring standards for the sector. There is a provincial Health Regulatory Authority (HRA) in KP and the Punjab Government has recently passed an Act which envisages the formation of a permanent a Punjab Health Care Commission with wide ranging powers. Three regulatory authorities were established in 2005 in Balochistan with regard to clinical laboratories; private hospital regulation and safe blood transfusion, which have mandate to quality assure and license, for example, private health practices and laboratories. However, the impact of these authorities has been very limited. There are currently efforts to revive the HRA in KP province which, to date, has lacked the resources, expertise and rule and regulations - and possibly the political will - necessary to properly execute its mandate.

The Government of Punjab has recently presented an Act to the provincial parliament to create a Health Care Commission with wide ranging powers, including the *"improvement of healthcare services and ban quackery in all its forms and manifestations"*[25] The Act covers public, private and charitable hospitals; trust hospitals; and semi-government and autonomous health care organisations. The Commission would monitor and regulate the quality and standards of the health care services developed by the government and grant accreditation to health care service providers who meet its prescribed standards. It will also have the power to enquire and investigate into maladministration, malpractices and failures in the provision of health care services. The Commission also plans to commission independent Performance Audit of Health Care Establishments with Tertiary Care Hospitals in the private sector, and to take measures to stop over the counter sale of drugs without prescription. While the Act has faced some political opposition, the Punjab Government feels it has enough support to drive forward the agenda for regulation of the public and private health care facilities. There is, therefore, an opportunity to support the PHCC at a formative stage.

his option suggests that the most effective 'entry point' to improve the quality of regulation of private and alternative health practices is to support and strengthen the terms of reference, internal organisation, human resources and operations of provincial regulatory authorities.

Option

Strengthen the regulation and accountability of private and alternative health services by supporting the establishment of the Punjab Health Care Commission (PHCC); strengthening the HRA in KP and establishing one inclusive, regulatory authority in Balochistan. Support to the PHCC would include technical assistance to develop:

- Terms of reference and organisational structure;
- Monitoring criteria and quality standards; and
- A system of accreditation.

Outcomes, Outputs, Indicators

The expected outcome is a well regulated system of private and public hospitals. The expected outputs are:

- A well structured Commission with clearly defined roles and responsibilities;
- A policy and an operations manual with well specified criteria for monitoring, regulation, accreditation and system of penalties;

- Development of the Board members through exchange visits;
- Well trained staff at different tiers of the Commission;
- A well-established system of complaints and mechanisms for redress;
- A system of reporting with well defined indicators against which reports will be produced, performance assessed and communicated to the public;
- A data base of private health care providers.

The key outcome indicator of a regulatory authority will be the proportion of providers within its ambit and the difference in the quality of care. Outputs will be monitored to provide information on the organisational development of the regulatory authority as well as the development of its policies, procedures, operations, data base, monitoring and reporting system.

Implementation

Technical assistance would be provided to the Punjab Department of Health - potentially by TRF - to help develop the PHCC and work closely with the Chairman of the Board and the staff of the Commission in the first two years of its existence. Ongoing technical support would be offered to the HRA in KP, which has already received support from GTZ, and, when the security situation permits, to establish a similar Commission in Balochistan. Working across the provinces would enable shared learning and capacity building to take place – for example, in relation to the development of policies, procedures, data base development, staff development etc.

Budget (£ sterling)

This budget refers to support to the Punjab Health Care Commission only.

	Year 1	Year 2	Year 2	Year 2	Total
TA for Organisational Development	60,000				60,000
Development of Policy and Operations Manual	60,000				60,000
Strengthening of Board Members	30,000	30,000			60,000
Staff Training	12,500	50,000			62,500
TA for Complaint Redress System	60,000	60,000			12,0000
TA for Reporting System	60,000	60,000			120,000
Data Base Development	278,000	60,000			338,000
Total	560,500	260,000			820,500

Appraisal

Alignment: The NHP2010 gives considerable focus to the regulation of healthcare delivery and recognises the importance of a growing, largely unregulated private health care sector, including clinical laboratories. The policy outlines plans to *"develop a better insight into the functioning, composition and reach of the private sector",* in collaboration with provincial health departments and to *"create a model for regulation in the federal jurisdiction which could then be replicated by the provincial authorities."* The policy also outlines plans for the *"development of a system for monitoring the quality of services and accreditation, in collaboration with institutions like Pakistan National Accreditation Council (PNAC), Pakistan Medical and Dental Council (PMDC) and the Pakistan Nursing Council (PNC), in order to demonstrate a workable a model which could then be adopted by provinces*." While the policy outlines its aim to "*mainstream alternative systems of care being practiced in the country, such as the Unani, Ayruvedic and Homeopathic systems while improving regulation and oversight",* it does not specifically outline how this will be done.

Sustainability: The Punjab Government appears to be committed to the establishment and resourcing of the Punjab Health Care Commission although the level of support has not yet been indicated. The HRA in KP has not been able to establish itself as a strong regulatory body in the province although it has recently been allocated Rs20 million by the KP Government. It is unclear whether funding alone will solve its problems in the absence of strong political will and a mechanism to improve the quality of health care facilities.

Cost-Effectiveness: Potentially very cost effective since the effective regulation of a large private and alternative health sector would help to improve and make more accountable the quality of health care which large numbers of poor and marginalised people seek.

Partnership Potential: GTZ has been working with the HRA in KP. Coordination with GTZ will help to identify key lessons that can further refine the activities under this option.

Risk: The effective functioning of provincial HRAs is likely to be resisted by vested interests within the sector. The KP HRA has not functioned well in the past, although it is currently being revived. The PHCC Bill is facing strong opposition from the Assembly in Punjab but currently there appears to be strong political will.

4.6. Conclusions

In identifying the options included in the strategy we have been guided by the principles derived from the lessons to emerge from international research and by our analysis of the capabilities of the relevant institutions and actors in the national 'accountability landscape'. We have sought to be politically realistic and to build on existing drivers for change; to identify options that are aligned with existing governance arrangements and policy frameworks and to avoid creating parallel systems; to balance support for public demand for accountable health services with support to the public health system to deliver more responsive services; and to include a variety of funding modalities as appropriate to each option.

The relationship between the media, civil society and political parties represents the strongest 'impetus' for change in contemporary Pakistan. Representatives from the media, civil society and the National Assembly consulted indicated a willingness to embrace the accountability agenda as it affects the health sector. One aim of the strategy is to increase pubic demand for improved essential health services, in particular for the more vulnerable sections of the population, and create the political will to make the necessary reforms to the public health system to deliver these. Without effective citizen demand there is currently little incentive for public health service providers to improve their performance. The intention is to create a synergy between politicians, media and civil society to raise public understanding and concern about the state of the nation's health; to increase public scrutiny of the performance of the health sector; and to incorporate firm commitments to address the health needs of the poor and marginalised in the manifestos of the main political parties. The Standing Committees on Health of the national and provincial assemblies have an important role to play in this regard. In particular the strategy recognises and seeks to build on the seriousness of intent of the National Assembly Standing Committee to exercise effective parliamentary oversight.

We have sought to anticipate a 'post-18th Amendment' Pakistan in crafting the options but a degree of uncertainty remains with regard to the devolved responsibilities of provincial governments for health service delivery and the local governance arrangements to which they will be accountable. Nonetheless it is clear that a strategic focus for the strategy must be at provincial level - in particular, the Khyber Paktunkwha and Punjab provinces where the political conditions exist to support more responsive and accountable health services. The Khyber Paktunkwha strategic plan for the health sector offers a good opportunity for public scrutiny of the

delivery of provincial health priorities and a framework for public accountability. It also provides an opportunity for donors to lead by example by aligning their support to national health priorities in a more transparent, accountable way.

Although the full implications of the continuing process of devolution are not yet clear, the strategy anticipates the growing importance of provincial accountability institutions such as the Standing Committees of Health of the Provincial Assemblies and provincial health regulatory authorities. Both sets of institutions will need support to exercise effective parliamentary oversight and regulate the growing private and alternative health sectors respectively.

The most cost-effective options are more likely to be at provincial level where the operational responsibility for health services lies. A guiding assumption is that the closer accountability reforms are to the point of service delivery, the more immediate and tangible the benefits to the poor and marginalised. Managing non-state provision of primary health services, such as PPHI and PRSP, through competitively-tendered performance contracts linked to the involvement of local communities in accountability systems would potentially bring the most immediate benefits for the poor and marginalised at comparatively little cost since this is already state-funded. The operational flexibility and stronger management and service-oriented organisational culture of non-state providers make it more likely that they could successfully adapt to an accountability agenda. Alternatively, the option to pilot test a model of district health management that gives enhanced powers to EDO(H)s, similar to those available to PPHI district health managers, to deliver improved health outputs would be very cost-effective if proved successful.

Those options that seek to introduce greater transparency and accountability into the public health system itself are, at once, the most strategic i.e. likely to bring lasting benefits for the poor and marginalised, and most complex and difficult to achieve. Throughout the development of this strategy we have resisted the temptation to address directly the deeply-rooted, systemic problems facing the public health system such as resourcing, staffing, organisational culture, political interference and corruption. Rather we have sought to identify reforms to the health system that provide the preconditions to greater transparency, accountability and thus its responsiveness. In summary, these refer to ‘fit for purpose’ systems of planning, monitoring and reporting at district, provincial and federal levels that provide a

framework for performance management within the public health system and its accountability to the general public and public bodies.

A responsive, accountable in Pakistan will be the product of a combination of the different components or 'building blocks' identified in this strategy - articulate public demand; strengthened capacity and increased transparency in the public health system; and more effective oversight and regulation of the health sector by public and regulatory bodies. To bring these complementary elements together - demand, responsiveness, accountability - it is recommended that options be implemented wherever possible in coordination with current or proposed funding arrangements or projects that have the potential to enhance responsiveness and accountability in the service sector or, more generally, governance. The primary focus for the strategy in the short term is the Punjab and Khyber Paktunkwha provinces but consideration should be given to focusing on a small number of specific districts within each province so as to combine the different approaches embodied in the options and achieve some 'critical mass' and maximum impact.

5. A FRAMEWORK FOR MONITORING AND EVALUATION

1. The Challenge of Measuring Results

DFID and AusAID are committed to measuring the results of their development assistance and its impact on their broader developmental goals such as the Millennium Development Goal (MDG) indicators. However, it is generally recognised that measuring the results of responsiveness and accountability programmes presents a number of challenges. For example:

- How to measure change and results in a policy area that is complex, intangible and highly contextual. In particular, how to identify a set of indicators that simplify and capture complex processes and relationships that are transformed through R&A interventions.
- How to use a logframe approach appropriately by making space and time to diagnose and measure these complex changes so as to 'change course' if necessary and implemented more flexibly and with better results. Inappropriate use of a logframe *"can encourage linear, reductionist and technocratic thinking in interventions that are non-linear, unpredictable and highly politicised"*[26].
- How to encourage a shared conceptual understanding of R&A among donor and government partners and integrate R&A data generation with local monitoring and evaluation instruments and institutions in order to reduce transaction costs and ensure that the benefits can be shared with the wider development community, in line with Paris Declaration commitments on donor harmonisation and national ownership.

This M&E framework works off the premise that a 'results-based' approach to responsiveness and accountability can be achieved if these challenges are addressed by using a logframe approach sensitively and flexibly as a means of monitoring and reviewing assumptions and activities; carefully considering how quantative and qualitative indicators, associated with R&A work can be identified and progress measured; and linking, wherever possible, with development partner initiatives and government information systems.

2. Objective and Guiding Principles

The objective of this M&E framework is to support the effective implementation of the strategy by providing a clear framework of mutual accountability for DFID/AusAID and partners.

A responsive and accountability strategy must itself be responsive and accountable. It must model, and reinforce with partner agencies, the principles upon which it is based. In response to the challenges above, therefore, this monitoring and evaluation framework is based on the following guiding principles:

- *Responsiveness*. It allows for ongoing monitoring to ensure that assumptions are reviewed and updated so that programme activities can be adapted in the light of changing circumstances. It places special emphasis on learning from experience so that programme strategies are subject to continuous improvement.
- *Accountability.* By identifying a clear purpose, set of outputs, activities and targets, and by linking in at every opportunity with existing monitoring and reporting systems it offers a framework of transparency and mutual accountability with partner agencies.
- *Partnership.* It seeks to build a sense of partnership and shared ownership to increase the responsiveness and accountability of the public health system by working in a participatory and consultative fashion with partners to develop a shared purpose and set of activities and to monitor and review progress towards agreed targets.

3. Implementation Arrangements and M&E Frameworks

The options presented in this strategy are aligned wherever possible with National Health Policy commitments and other donor initiatives. They offer a range of interventions targeted at different stakeholders, with different outputs that would require different kinds of indicators and data collection. It is unlikely that they will be taken forward by DFID and AusAID as a 'stand alone' programme. This raises the issue of what kind of monitoring and evaluation framework would be most appropriate to monitor progress to the options identified. Two ways forward are possible which are not necessarily mutually incompatible:

- Develop a comprehensive logframe that includes all options to be taken forward.
- 'Embed' options within other relevant M&E frameworks.

- **A responsiveness and Accountability Log Frame for the Options**

A draft logframe has been developed (Annex ?) that illustrates how the options might be monitored as a coherent body of work. The *goal* for the logframe is derived directly from the vision of the NHP 2010. The logframe *purpose* is compatible with Policy Objective 6 of the NHP 2010 on 'Governance and Accountability', although this section does not contain a stated objective. The logframe converts the four 'pillars' referred to in the strategy into *outputs* to deliver this purpose. The options themselves form the basis of the *indicators* associated with each output.

The logframe is an incomplete draft for the purposes of illustration. Key stakeholders should be involved in developing the logframe to ensure that it reflects local realities and has, for example, government approval and ownership. Multi-stakeholder design workshops should be held to ensure integration with the DFID country programme and other donor and government programmes. For example, it is important that assumptions and risks are commonly identified and understood. A volatile environment such as Pakistan requires a more frequent review of progress so that programme assumptions and activities can be reviewed and, if needs be, revised.

- **Embedding Options in Other M&E Frameworks**

Alternatively options selected could 'nest' within other donor or government logframes. The preferred approach would be to align options wherever possible with National Health Policy commitments on Governance and Accountability and monitor their implementation under the M&E framework to monitor progress to the plan. This is in line with donor commitments on Aid Effectiveness and to a partnership approach between development partners and government to implement and review joint commitments. In line with options 4.3.2 and 4.3.3., progress to options would form part of HSSPU reporting to the NHPC and, for example, might form part of regular health sector assessments. Monitoring activities and methods would be aligned to national monitoring and reporting efforts to reduce the transaction costs of reporting to and monitoring progress to the options.

4. Appropriate Methodologies

Responsiveness and accountability initiatives present some methodological challenges and, as development interventions, are comparatively innovative. The following are some important considerations that would need to be taken into account, whatever the final M&E framework chosen.

- *Identify relevant indicators*

Special effort will need to be taken in identifying appropriate indicators that, wherever possible, should be drawn from what is already in use by governments or donors so as to avoid duplicate data-gathering. A responsiveness and accountability strategy will require both quantative and qualitative indicators. In order to meet expectations of key stakeholders, some qualitative or process-related indicators in relation to demand-oriented activities e.g. increased awareness or demand, will need to be measured quantatively. The next section describes how such data might be gathered and measured.

- *Agree data collection methods*

The new DFID logframe requires baseline data and seeks to measure change according to a set of milestones leading to an identified target. Once indicators for each of the outputs have been identified, therefore, it will be important to gather relevant baseline data. In many cases baseline data might not be readily available and would need to be gathered independently. Different indicators will typically require different kinds of data and data collection methods to measure them.

As mentioned above, many indicators of responsiveness and accountability are process indicators that measure changes in behaviour and relationships. Behavioural change can be measured by quantitative data generated by observation or recall or by quantification of qualitative changes using perception scores. Both types of data can be standardised, aggregated and subjected to statistical procedures although it is important that it is socially disaggregated, for example by sex, age, or by ethnic, religious background.

The challenge will be to gather as much data as possible from current systems of monitoring and reporting within the health system. Parallel M&E processes should be established only if absolutely essential. Data collection that is harmonised with existing systems reduces transaction costs and ensures that the benefits are not for DFID/AusAID alone. For example, a first port of call as a data source should be the

DHIS to identify suitable indicators for logframe outputs. It might be appropriate also to review other possible sources of monitoring data such as the KPIs and Minimum Service Delivery Standards (MSDS) in the Punjab.

5. A Focus on Learning

A recent review of the literature[27] highlighted the need to incorporate lesson learning in all R&A programmes to generate a body of good practice. An M&E framework, therefore, should not only plan and budget for routine monitoring but also for:

- Methodological development e.g. with regard to baseline and monitoring data gathering,
- Lesson learning and knowledge sharing e.g. through the production of case study material in association with M&E activity.

FOOTNOTES[28]

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