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Shirkat Gah
Women's Resource Centre

POLICY BRIEF # 5:

PROGRESS & CHALLENGES HEALTH SYSTEMS BUILDING BLOCKS IN SIX DISTRICTS OF PAKISTAN

WHO Building Block 2: Health Workforce

A well-performing **health workforce** is one that works in ways that are **responsive, fair** and **efficient** to achieve the **best health outcomes** possible, given available resources and circumstances (i.e. there are **sufficient staff, fairly distributed; they are competent, responsive and productive**).

- WHO, 2010, Monitoring the Building Blocks of Health Systems: A handbook of Indicators and their Measurement Strategies, Geneva.

Generally, staffing has increased and fewer posts remain vacant in 2017 than in 2014. There are sharp disparities across provinces and districts, however: some districts remain severely constrained by limited budgets; for others, retention remains a challenge. Balochistan and Sindh face the greatest problems. Some limited staff training is taking place, but regular training is largely confined to mother and child health under the Maternal Newborn and Child Health (MNCH) programme. No other in-service training was reported; there is no prior needs assessment to ensure trainings cater to the specific requirements of different facilities. Staff behaviour has improved in many places, but sexual harassment of girls was reported in 2016. This is of serious concern, suggesting that training must include gender sensitisation as well as encourage better behaviour with patients and their attendants.

District Jaffarabad (Balochistan)

- The district faces serious **staff retention** problems. Recently, eleven doctors had themselves transferred to bigger cities. This was attributed to the poor standards of the district's facilities and the inability to meet the expectations of doctors from bigger cities in terms of, for example, residential facilities and educational opportunities for their children. Limited resources make it difficult to recruit the required technical staff. There is no anaesthetist, and if someone were to be hired from the adjacent district of Jacobabad, the cost would be Rs. 5,000/case – putting services out of the reach for most of the community. A separate staff-related issue is the high level of patronage dynamics across healthcare facilities, enabling staff appointed through such influence to flout the rules. **Political interference** in the recruitment process is so prevalent that ensuring accountability of even janitorial staff is a challenge, as indicated by the irregularity of staff at the BHU Cattle Farm.

- No in-service **staff training** was reported except at the BHU level. Under the public-privae partnership, the People's Primary Health Initiative (PPHI) provides training for those joining as well as in-service BHU staff. There is no other regular or systematic training of the health workforce by either the government or private institutions.

- The dismissive **attitude of doctors and other healthcare staff** at public facilities is one factor that pushes women to seek private health facilities. Community women believe that staff does not pay attention to their needs or treat them well as they are seen to be accessing free healthcare facilities and therefore have no right to complain. Private hospitals, on the other hand, were reported to treat them better as they were paying clients.

- Of great concern is the reported **misbehaviour of male staff with girls**, illustrated by the two testimonies below:

"When the compounder was giving me an injection, he started putting his hands here and there... and said 'I'm giving you an injection, why are you so terrified?' I told him to administer the injection in a respectable manner otherwise 'I'll kick up a real fuss. What do you think you're you doing? Giving injections or fulfilling your lust?' This shamed him and administered the injection in silence and went away."

"I used to faint so my father was worried about why this happened [and], took me to the hospital himself, and the boy who was there... put the band around my arm for extracting blood and deliberately touched my breast. When I pushed him away in anger he [had the gall to tell] my father 'Your daughter has no shame'".[2]

[1] Focus Group Discussion with married women, Gandakha, Balochistan, 2016.

[2] Focus Group Discussion with unmarried girls, Cattle farm, 2016

District Sukkur (Sindh)

- Following recruitments in 2016, the acute shortage of human resources, including specialist doctors noted in 2014 at the **THQ Pano Aqil**, has been largely overcome. There is sufficient staff to ensure round-the-clock emergency services; an anaesthetist enables Caesarean-section operations at the facility. However, the orthopaedic and surgeon posts are unfilled, affecting effective delivery of comprehensive Emergency Obstetric and Neonatal Care (EmONC) services. The lack of technical staff at the **THQs** in Rohri and Bagarji and absence of a Lady Health Visitor (LHV) and Woman Medical Officer (WMO) at **BHU Haji Khan Chachar** also impede services despite new equipment, for as the chair of the Local Council Health Committee[3] pointed out in 2017, all equipment is worthless if there aren't enough technicians to operate these.
- **Need-based trainings and refreshers** for new and old staff are now being conducted by the PPHI. The positive outcome is that *"there are a lot of new things to learn and we are mobilising the community better. **People** [are poor and] **prefer government facilities now because the health system has improved".*** [4] No other training was reported to be taking place.
- Here too, **political interference** hinders service delivery. For example the **BHU Haji Khan Chachar** only provides ultrasound facilities once a week instead of daily as should be the case because the WMO only comes once a week. Absenteeism was attributed by the District Health Officer (DHO) due to her political connections.
- The community had considerable complaints about the **attitude of the doctors** at public facilities in 2014; women would access private facilities for abortions because, *"In government (hospitals) the doctor scolds us."* [5] It was recommended that supervisory and complaint mechanisms be put in place to keep a check on doctors and other healthcare related staff.

> *"If we go to the hospitals the doctors shut the door. Doctors are very arrogant at the public facilities and do not talk to the patients. If we ask about anything [or complain], they say 'stop pestering us' (demagh nahin khao). We go to private [facilities where] there are quality services."* [6]

- The situation had not improved much in 2016 and one woman reported that she is reluctant to visit public facilities after a nurse forcefully pushed her husband and spoke to him rudely.[7]

District Shahdadkot (Pr Sindh)

- In 2014, the district faced a **shortage of human resources** and, for example, only seven women doctors were working in the district against 30 sanctioned posts. As in Jaffarabad, doctors with specialised degrees prefer to work in bigger cities such as Larkana, where their residence, children's education, and promotion prospects are comparatively better. Despite several requests submitted by facilities to enhance staff, the situation is not much improved in 2017. The paucity of staff severely impacts the **RHC** services. The facility cannot provide laboratory services as there is no lab technician. Similarly, there is **no technical staff** to operate the ECG machine at night at the **THQ Shahdadkot**. Community women feel the RHC needs *"at least 4-5 lady doctors in 3 shifts"* to meet their needs that are not being met by the single woman doctor appointed.[8]
- **Staff training** on mother and child healthcare was being carried out even in 2014, but officials stressed the need for trainings to enhance managerial skills.[9] Discussions with health officials in 2017 revealed that while the World Health Organisation (WHO) occasionally runs trainings, there are no systematic staff trainings.
- **Political patronage** was reported as the major obstacle to monitoring and accountability in 2014. Most LHWs were recruited from Qubo or Shahdadkot cities and not the villages falling within the BHU's catchment area. These LHWs were said to *"have been chosen – based on nominations by MPA and MNA, (who) just appear on Polio days."* [10]

[3] Chair, Local Council Health Committee, Multistakeholder Forum, Pano Aqil, 2017
[4] WMO, BHU Haji Khan Chachar Sukkur Checklist responses 2016
[5] Rapid Situational Analysis, Focus Group Discussion with married women, village Kauro Khan Panhyar, Sukkur, 2014
[6] Rapid Situational Analysis, Focus Group Discussion with married women, village Kauro Khan Panhyar, Sukkur, 2014
[7] Focus Group Discussion with married women, village Kauro Khan Panhyar, Sukkur, 2016
[8] Focus Group Discussion with married women, Qubo Saeed Khan, 2016
[9] Rapid Situational Analysis, In-depth Interview with District Health Officer, Qubo Saeed Khan, 2014
[10] Rapid Situational Analysis, Focus Group Discussion with CSOs, Qubo Saeed Khan, 2014

District Muzaffargarh (Punjab)

- In 2014, staff shortage was attributed to intra-departmental disparity in salary packages between the MNCH staff and other Department of Health (DoH) employees. In 2016, **staff shortage had been overcome at Mehmoodkot BHU,** which now has sufficient human resources to ensure that someone is always on duty to cope with emergencies. In 2017 there were **no unfilled posts in Muzaffargarh.** It was reported that there has been up to 98% increase in the number of Women Medical Officers across Punjab and a substantial increase in the number of Paramedics and Grade 4 staff, including LHVs, dispensers, and midwives.
- The DoH does conduct **regular staff trainings,** but officials believe there is a need to focus on technical and practical skills that graduates of private sector academic institutions are lacking.
- **Staff attitudes** in public health facilities have been reported as off-putting by women. One said that she decided she would never to go to a government hospital for her deliveries after witnessing a woman in labour helplessly crying out in pain being ignored by all staff.[11]

District Vehari (Punjab)

- The district's workforce challenges relate to **posts for specialist doctors and WMOs lying vacant** in the district. Lady Health Workers (LHWs) have been regularised and disbursements from the district accounts office have overcome the previous lags in salary payments. Lady Health Supervisors (LHS) have been placed in basic payscale 7, but the low salary package despite holding a Masters' degree, undercuts motivation. **The Population Welfare Department** (PWD) too, faces **a shortage of female doctors** for their Mobile Service Units, mainly due to a lack of incentives for a field intensive job. To ensure **staff retention**, local officials suggest that the DoH and PWD incentivise employees with better salary packages and facilities.
- Facilities are said to be operative on a 24/7 basis, and monitoring has been strengthened, but some problems persist. At the project's 2017 Multi-stakeholder Forum, a journalist reported he was unable to find a doctor after 2 pm at the **RHC** Gaggo Mandi (not a project site) stressing that Gaggo Mandi, too, deserves a doctor available on a 24-hour basis instead of allowing the chowkidar (watchman) to handle emergencies.
- As elsewhere, **staff training** on Mother and Child health is regular and is reported as having improved. There is consensus amongst diverse stakeholders that **staff needs to be sensitised** to improve behavior towards patients.

District Mardan (Khyber Pakhtunkhwa)

- In 2014, Mardan district too, suffered from an **unavailability of specialist staff, especially female staff**, as only three out of 18 available posts for medical officers were filled across D-type hospitals. **Staffing has improved** at the **DHQ.** Still, while posts have been filled, a member of the District Complaint Cell feels staffing remains problematic as most of the doctors are busy in private practice; hence, patients are referred to the Mardan Medical Complex and onwards to Peshawar.
- Of **deep concern,** in 2016, women reported being **sexual harassed by male doctors** *"if we go to male doctors for a check-up, they touch you here and there that is why we don't go there alone."*[12]
- While some **staff capacity building** issues identified in 2014 across the district's health facilities have been addressed, here too, staff training is not systemised. Data from 2016 and discussions in 2017 indicate that the staff requires training to overcome **gender biases** and improve **behaviour towards patients.**

[11] Focus Group Discussion with married women, Qubo Saeed Khan, 2016
[12] Focus Group Discussion with unmarried girls, Khazana Dheri, 2016

About the Project

The "Strengthening Governance in Health Systems for Reproductive Health and Rights (RHR) in Pakistan: An Intervention Case Study" was implemented by Shirkat Gah in six districts across four provinces of Pakistan, including Districts Shahdadkot and Suk ur (Sindh), District Mardan (Khyber Pakhtunkhwa); Districts Vehari and Muzaffargarh (Punjab), and District Jaffarabad (Balochistan), from 2014 to 2017.

This pilot study aims to propose a model or pathway for a larger intervention on participatory governance and policy implementation for reproductive health and rights (RHR) in Pakistan. It is grounded in the key principles of equity, non-discrimination, participation and accountability, with particular attention to the promotion of gender equality and the realisation of the vision for the highest attainable standards of sexual and reproductive health and rights for all, particularly women and girls.

About Shirkat Gah

Shirkat Gah - Women's Resource Centre (SG) was initiated as a small voluntary women's collective in Pakistan in 1975, and has evolved into a leading women's rights organisation that operates out of offices in Karachi, Peshawar, Lahore, and four field stations across all four provinces.

SG's core strategies in its work with grassroots organisations in more than 20 districts, include research to generate evidence for capacity building and advocacy in the areas of sexual and reproductive health and rights (SRHR); personal status rights and laws; promoting a gendered perspective in sustainable development, and promotion of peace, with violence against women traversing the four focus areas.

Nationally, SG has contributed significantly to the overall policy and legal framework and works with elected representatives and government functionaries to bolster an environment conducive for women to claim rights and to facilitate accountability. SG also engages regularly with international development organisations, agencies and UN processes both for setting norms and standards as well as ensuring accountability on Pakistan's international obligations.

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