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POLICY BRIEF # 2:

Health Systems Frameworks for Advancing Reproductive Health & Rights in Pakistan

Shirkat Gah
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Reproductive health was recognised as a fundamental right by the 1994 United Nations International Conference on Population and Development (ICPD). Sadly, more than twenty years later, **comprehensive reproductive health services remain beyond the reach of most women and girls in Pakistan.** The essential question to be asked is why. Answering this question is all the more important as Pakistan seeks to meet its obligations under the Sustainable Development Goals, 2015-2030 (SDGs) which include reproductive health and rights for all.

In order to better understand the key levers for health systems governance strengthening in Pakistan, Shirkat Gah - Women's Resource Centre (SG) embarked on an ambitious intervention research from 2014 to 2017, titled, ***Strengthening Governance in Health Systems for Reproductive Health and Rights in Pakistan: An Intervention Case Study.*** The project was implemented in six districts across Pakistan.[1] engaged 1,282 community women, girls and men, 335 duty-bearers/service providers, 188 civil society members and 40 media personnel. Its aim was to assess the viability of a 3-pronged intervention for strengthening the governance of health systems across Pakistan's four provinces. (For further details see About the Project) The project used the following key frameworks:

- Building blocks framework (WHO, 2007);
- Health systems governance assessment framework (Siddiqi M., et al, 2009);
- Committee on Economic Social & Cultural Rights (CESCR) General comment No. 2 (2014) on accessibility;[2]
- Making services work for the poor (World Bank, 2004 further adapted by RTI International);
- Benchmarks of fairness for health care reform (Daniels N., et al., 2000).

INSIGHTS ON THE BEST USE OF EXISTING FRAMEWORKS

One crucial set of determinants relates to health governance systems themselves; a second set relates to upstream community-based impediments to women, and especially adolescent girls, in accessing health services. Despite systemic improvements and more robust health delivery services, field data suggests that gross inequities persist across districts and provinces.

For diagnostic purposes, there has been a proliferation of health systems frameworks over the past three decades that converge and digress in terms of focus, goals, scope, taxonomy, linguistics, utility, and other features (See Table 1 and 2 below). Taking forward the principles of the 1978 Alma Ata Declaration of the World Health Organisation (WHO), most frameworks aim to guide actions towards optimising health systems delivery for all, and carry the weight of empirical evidence gathered across the globe. Each has been advanced to fill a perceived or real gap in preceding frameworks and the particular constellation of assessment indicators offered by these frameworks is excellent for advancing conceptual understanding.

Framework	Author	Framework	Author
Actors framework	Evans R.,1981	**Capacity framework**	Mills A, el al, , 2006
Fund-flows and payment framework	Hurst J., 2001	**Public management framework**	Khaleghian D.G., 2004
Demand-supply framework	Cassels, 1995	**Building blocks framework**	WHO, 2007
Performance framework	WHO, 2000	**Essential public health functions framework**	PAHO, 2008
Benchmarks of fairness for healthcare reform	Daniels, N., et al., 2000	**Systems framework**	Atun, R., 2008
Control knobs framework	Hsiao, 2003	**Health systems governance assessment framework**	Siddiqi, M., et al, 2009
Reforms framework	Roberts, M., et al., 2004		
Health Rights of Women Assessment Instrument (HeRWAI)	HoM, 2006	**Universal Health Coverage: Moving Towards Better Health**	WHO, 2016

Table 1: Health Systems Governance Frameworks

[1] **Muzaffargarh** and **Vehari** in Punjab; **Sukkur** and **Shahdadkot** in Sindh; **Mardan** in Khyber Pakhtunkhwa; **Jaffarabad** in Balochistan.

[2] **CRPD/C/GC/2** Available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/033/13/PDF/G1403313.pdf?OpenElement

A major challenge was agreeing on the framework against which health systems governance could be studied with respect to women's reproductive health and rights. Attracted by the principles of equity and inclusion, participation, transparency, accountability, and ethics, the Project set out with Siddiqi's **Health Governance Principles** (Figure 1). Facility-level data from the field, however, fit more comfortably within the **WHO's Building Blocks** (Figure 2), that had the added advantage of being widely used by the government.

Health Governance Principles
1. Strategic vision
2. Participation & consensus orientation
3. Rule of law
4. Transparency
5. Responsiveness
6. Equity & inclusion
7. Effectiveness & efficiency
8. Accountability
9. Information and intelligence
10. Ethics

Figure 1: *Health systems governance assessment framework*, Siddiqi M., et al, 2009

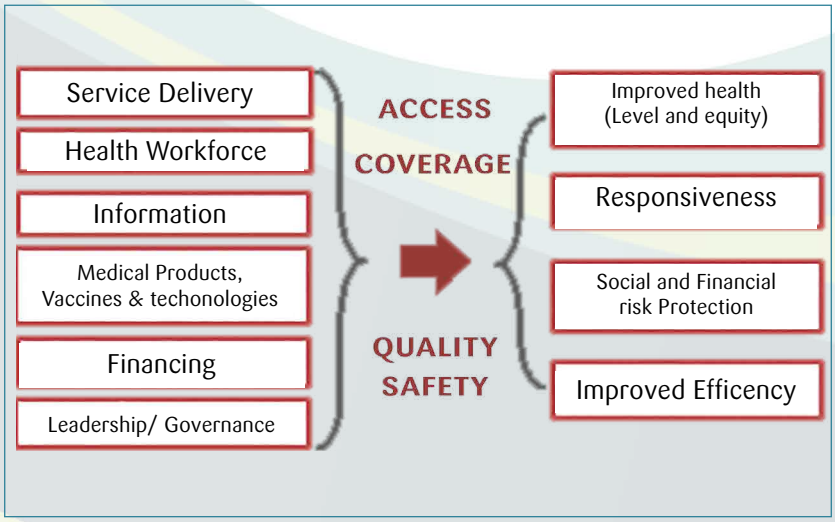

Figure 2: *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action*, WHO, 2007

However, the project revealed the limitations imposed by the single-use of any of the frameworks (see Table 2 for governance dimension of major institutes and related indices). Many health systems frameworks do not account sufficiently for issues rooted in the community. While some frameworks call for looking at determinants lying beyond the health sector (such as WHO's Social Determinants of Health and Atun's Systems Framework), most:

- Reflect poorly on socio-cultural dynamics ***amongst*** members of any given community - not least in terms of how these dynamics can be measured and addressed effectively from within health systems;
- Presume some degree of democratic relationship between citizens and the state (in terms of both officials in the health sector and elected representatives); and
- Do not account for people's expectations of a good health system, which may be entirely misplaced against what the government is currently providing

Institution	Dimensions of governance	
World Bank Institute (Worldwide Governance Indicators, WGIs)	• Voice and accountability • Political stability and absence of violence • Government effectiveness	• Regulatory quality • Rule of law • Control of corruption
United Nations	• Participation • Rule of law • Transparency • Responsiveness • Consensus orientation	• Effectiveness and equity • Accountability • Transparency • Efficiency
Overseas Development Institute/ World Governance Assessment	• Participation • Fairness • Decency	• Accountability • Transparency • Efficiency
Mo Ibrahim Foundation, Ibrahim Index of African Governance	• Safety and rule of law • Participation and Human rights	• Sustainable economic opportunity • Human development

Table 2: Governance dimensions according to different institutes. Source: World Bank, in Shakarishvili, G. 2009 pp 8

MATCHING FIELD EVIDENCE AND FRAMEWORKS

The data is replete with evidence indicating that women and girls are prevented from accessing services. Unfortunately, available frameworks preclude any means to measure such denial within the home (whether in the form of refusal to transport women to existing services or dismissing reproductive health ailments as an unfortunate but inevitable condition of being female). This is further exacerbated by the precarious absence of citizens, especially women, across the myriad district-level health committees set up by provincial governments across Pakistan to promote multi-sectorial participation. Siddiqi's **Health Governance Principles** on consensus-orientation becomes all the more problematic in spaces where women's presence is close to negligible.

The power nexus between poor citizens as end-users, (service) providers, and the state was succinctly captured originally by the World Bank's **Health Governance and Power Inequalities** framework, and later adapted by other agencies (for RTI International's adaptation, see Figure 3). Seen against this framework, research findings suggest that while considerable work has been done in Pakistan post-devolution to address the two-way relationship between the state (policy-makers in particular) and providers, as well as the one-way flow from service providers to citizens, less efforts have been put into strengthening the relationship between citizens and policy-makers (dubbed the 'long route of accountability') in terms of an upward flow of voice; and between citizens and providers (the 'short route'), in terms of immediate accountability

With respect to the World Bank's framework, the project's interventions confirm that **greater dividends can be reaped by strengthening the shorter route of accountability** as well as the relationship between users and providers, provided that this is supported by a strong presence of advocacy groups, well-informed of the health governance systems at the local level.

This framework is useful for understanding power relationships between the three main actors in health governance, but it does not provide related indicators against which the strength of relationships can be gauged. It also provides few clues into ground-level sustainable solutions, particularly where relationships break down, or when there is a shift in power dynamics. For example, while the relationship between providers and citizens may be the easiest focus of interventions, government notifications that curtail civil society activities can change the terms of relationship-building overnight. The same can be said of the fallout of the devolution of authority relating to health to the provinces in 2010, following the 18th Constitutional Amendment.

Factors contributing to the unequal relationship between health systems and people have been captured as non-financial barriers to access in the **Benchmarks of Fairness for Health Care Reform (Figure 4),** which include 'gender'

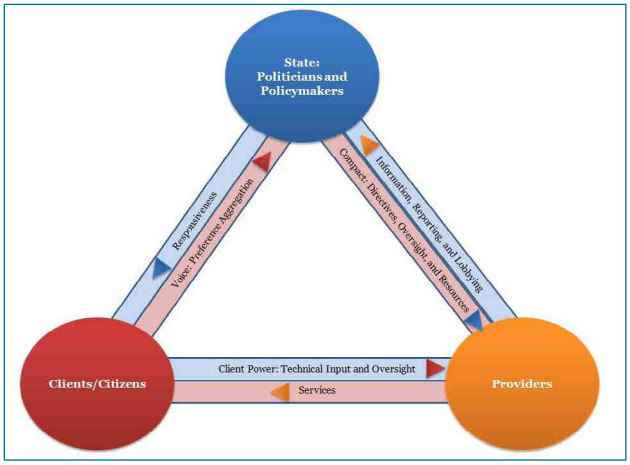

Figure 3: *Health governance and power inequalities,* RTI International, adapted from World Bank *Framework of Accountability Relationships, 2004*

as a non-financial barrier. Gender-based barriers are further divided into 'status in family regarding decision-making; mobility; access to resources; reproductive autonomy; gender sensitive provision of services

Benchmarks of fairness for healthcare reform

- **B1: Intersectoral public health**
- **B2: Financial barriers to equitable access**
- **B3: Non-financial barriers to equitable access**
- **B4: Comprehensiveness of benefits and tiering**
- **B5: Equitable financing**
- **B6: Efficacy, efficiency & quality improvement**
- **B7: Administrative efficiency**
- **B8: Democratic accountability & empowerment**
- **B9: Patient & provider autonomy**

Figure 4: *Benchmarks of fairness for health care reform,* Daniels, N., et al., 2000

and involvement of community political groups to address gender barriers'. The Benchmarks highlight the need to address Democratic **Accountability and Empowerment principles (Benchmark 8**), of which two aspects are an **enabling environment for advocacy groups, and stimulation of public debate**, including participation of vulnerable groups. These are either downplayed or missing from other frameworks.

These Benchmarks are unquestionably relevant for understanding issues particular to women's reproductive health in Pakistan, as they acknowledge "upstream" factors (such as social disadvantage, risk exposure, and social inequities). The Benchmarks themselves do not however offer any specific tool for measuring upstream impediments and their relationship with the more quantifiable determinants (such as income disparities, access to and control over productive resource, etc.).

With regards to **community participation** in health programmes, evidence clearly shows that community members lack knowledge on what is available and where. This missing knowledge falls outside the ambit of existing frameworks under **Information** (WHO, 2017) **and Information and Intelligence** (Siddiqi et al, 2009) that focus on information flow largely within health systems, visible in the form of the District Health Information Systems (DHIS) in Pakistan. These are essentially monitoring and evaluation tools for the health sector that generate information on systems' performances against targets and indicators across different health programmes in quantitative values. **They do not generate information on how communities may appraise services**, except in terms of the telephonic complaint systems that are distinct and disconnected from the DHIS. Evidence also indicates that even within these information systems, the officers filling in the pro-forma or punching in the numbers are often unaware of how decisions are made on the basis of information transmitted. This compromises the core objective of DHIS, which aims for evidence-based decision-making. Further, the information dimension of both the WHO Building Blocks and Siddiqi's Health Governance Principles do not address health education, outreach and/or sharing information with people outside the system in any clear terms. A quandary for health information systems is posed when the community's lack of information about existing services combines with unreasonable expectations to over-deliver (a critical finding in this study). The system's collective "intelligence" is thus not able to match expectations with reality, or provide insights on how to enable citizens to make use of health information to optimise engagement with health systems.

RECOMMENDATIONS IN THE LIGHT OF SHIRKAT GAH'S RESEARCH

To benefit from the multiple frameworks that complement one another, the **federal ministry and provincial health departments** together **with key stakeholders and experts should develop a synthesised framework relevant for Pakistan** that enables a more diagnostic approach to health inequalities, particularly for women and girls. For this:

- The government should **draw upon the principles of good governance that apply equally to health and merge the major dimensions of good governance,** for example, put forth by the World Bank, United Nations Development Programme, Overseas Development Institutes, and Ibrahim Index of African Governance.
- The integrated framework must keep Health Governance Principles proposed by Siddiqi and others at the centre of inputs, outputs and outcomes.
- The **framework** should factor in the interactions between the different elements and principles in existing frameworks to maximise the results from the whole, with particular regards to women and girls.
- The development of such a framework is **contingent on establishing indicators and a better understanding of "upstream" obstacles and how to both measure and act to change these.** This may require further research.

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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 Sukkur (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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