

## POLICY BRIEF # 1:

# STRENGTHENING GOVERNANCE IN HEALTH SYSTEMS FOR REPRODUCTIVE HEALTH AND RIGHTS (RHR) IN PAKISTAN: AN INTERVENTION CASE STUDY

## Key Project Insights & Recommendations

In 1994 the United Nations International Conference on Population and Development recognised reproductive health as a fundamental right. Yet, more two decades later, **comprehensive reproductive health services remain beyond the reach of most women and girls in Pakistan.** For Pakistan to meet its obligations under the Sustainable Development Goals, 2015-2030 (SDGs) that include reproductive health and rights for all, requires improving the access of women and girls to quality health services. 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*. Implemented in six districts across Pakistan,<sup>1</sup> the project engaged 1,282 community women, girls and men, 335 duty-bearers/service providers, 188 civil society members and 40 media personnel. The aim: **assessing 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)

Since the Health Systems Governance Strengthening project started in 2014, a host of actions taken by provincial governments have led to progress against most of the WHO Building Blocks for health governance. (See Policy Brief # 2, and progress against each in Policy Briefs # 4-9) While the progress is sometimes remarkable in the areas in the study, it is also uneven, underlining the need for further actions to strengthen health systems governance in Pakistan. This brief provides some key insights and recommended actions based on Shirkat Gah's four-year long interventional and participatory action research.

## 1. ACCESS OF WOMEN AND GIRLS TO HEALTH SERVICES

### Insights: Up-stream Community Issues

**Significant resources are being invested to make public sector health services available for all, but crucial family and community driven obstacles to women and girls seeking health services remains largely unaddressed, especially when it comes to reproductive health matters, in particular for unmarried girls. Interventions to overcome these critical "upstream" hurdles are almost exclusively run by civil society organisations. An effective nation-wide communication strategy to drive demand and uptake is not visible.**

**Women's lack of economic resources undermines autonomous decision-making over their own health and that of their daughters. Men, who hold the purse strings, make the decisions; societal norms dictating chaperones for women and girls visiting health facilities, multiply the economic burden in terms of transport costs and loss of income for daily wage earners.**

Reproductive health (RH) is not taken seriously and socio-cultural taboos keep women, and especially girls silent on RH issues. When girls have the temerity to express a problem, this is often dismissed as insignificant and a condition of being female, or treated with over-the-counter painkillers. Mothers are embarrassed to discuss RH with their daughters; parents fear that a visit to a health professional, especially gynecologists, will damage the girl's reputation and bring shame to the family. It is not uncommon to take a girl suffering from menstrual pain to see a spiritual healer rather than a doctor, or resort to homemade concoctions to alleviate pain. (Similar solutions may be adopted for terminating unwanted pregnancies, often with mortifying results.<sup>2</sup>) Should it become imperative for a girl to be taken to see a doctor, facilities near their residence are eschewed, and a distant facility selected to avoid prying eyes increasing the economic burden of seeking treatment. Taboos are so entrenched that some girls are not allowed to

explain their ailments to the doctors, and must rely on mothers to be intermediaries with healthcare providers. Finally, community women commented that religious leaders play an important role in preventing women from accessing RH services in particular contraception, by preaching that it is a sin.

## What works: Recommended Action for Addressing Upstream Community-based Issues

Consistent work by civil society in communities catalyses important changes in attitudes as well as practices regarding health matters for both girls and married women.

**“Changes in our village started since the Shirkat Gah people started working here. Now we try and ensure that women's health problems are addressed.”<sup>3</sup>**

**Having recognised the importance of pre-natal check, women seek such services and are saving money for eventual deliveries: “Now we set aside money. Women now have more sense and knowledge as to when and where to go. Previously women used to lose their babies...Now we get Ultrasound tests done which tells us if the child should be delivered at home or the hospital. Now women get their [ante-natal] injections and ultrasound [done]. For injections we go to the Cattle Farm BHU [Basic Health Unit] and for ultrasound we go to Usta Mohammad city.”<sup>4</sup>**

**Taboos and negative traditional practices around the health needs of girls are starting to change and more attention is being paid to their needs. Breaking the taboo about girls speaking about menstrual pain or irregularities, “now we tell [our] mothers...previously, we were told not to eat [various foods]. Now, thanks to Shirkat Gah's work, we're told to eat everything.”<sup>5</sup>**

## Insights: Facility-based Issues

### Public vs. Private Facilities:

An important insight is that women prefer public health facilities, providing services are of adequate standards.

### Staff Attitudes:

Opinions and experiences regarding staff attitudes vary tremendously within as well as across districts. In Vehari, for example, community women report a clear positive shift in the attitudes of staff at public facilities since 2014: more attention to patients' needs and no rudeness. Still, a District Councilor while lauding the efforts of the District Health Officer (DHO) stressed that doctors' behaviour towards patients needed improvement.<sup>6</sup> In several locations, complaints about attitudes persist, however, with reports of staff being rude, scolding, pushing and shoving patients and/or their families.<sup>7</sup> District Council Members confirm poor attitudes and behaviour.

More **alarmingly, testimonies of sexual harassment** by male staff, especially of girls and young unmarried women were recorded in several places.

<sup>1</sup> Muzaffargarh and Vehari in Punjab; Sukkur and Shahdadkot in Sindh; Mardan in Khyber Pakhtunkhwa; Jaffarabad in Balochistan.

<sup>2</sup> Shirkat Gah research under the Safe Abortion Action Fund, 2014-2015. Available from [http://shirkatgah.org/shirkat/wp-content/uploads/2017/02/SAAF-booklet\\_LowRes.pdf](http://shirkatgah.org/shirkat/wp-content/uploads/2017/02/SAAF-booklet_LowRes.pdf).

<sup>3</sup> Jafarabad, UC Cattle farm, Focus Group Discussion with married women, 2016.

<sup>4</sup> Jafarabad, UC Cattle farm, Focus Group Discussion with married women, 2016.

<sup>5</sup> Jafarabad, UC Cattle farm, Focus Group Discussion with unmarried girls, 2016

<sup>6</sup> Vehari, village 569 EB, focus Group Discussion with married women, 2016.

<sup>7</sup> Sukkur, village Kauro Khan Panhyar, focus Group Discussion with married women, 2016; Muzaffargarh, Focus Group Discussion with married women,, 2016.

## What Works: Recommended Actions for Increasing Access to Health Services of Women and Girls

- The **government and CSOs** need to **demystify prevalent misconceptions and myths** surrounding RH in communities, especially for women and girls and expand the outreach of awareness programmes;
- The **state narrative around family planning** needs to be strengthened and a clear, well-resourced and well thought out communication strategy promoting the vitality of the health of women and girls, especially RH, as a societal need, deployed;
- The **government and CSOs** need to expand the **outreach of community sensitization** programmes to strengthen uptake and create a demand for services;
- **Trainings** of all public health service providers must incorporate a special focus **gender sensitization and ethical treatment** of patients and their attendants;
- All government facilities **must comply with the Sexual Harrassment Act 2010 protocols**; prominently display the principles, constitute an Inquiry Committee, details of which should be prominently displayed, and institutionalise effective complaint mechanisms to ensure practical implementation of the Act and elimination of impunity.

## 2. GOVERNMENT RESPONSIVENESS: SERVICES, STAFF AND COMPLAINT MECHANISMS

### Insights: Services & Staffing

A host of steps have been taken to overcome perennial problems of access and services identified by women in 2014. Free ambulance services are being, or have been, introduced especially for women and medical emergencies, helping to overcome home-to-facility and inter-facility transfer transport, though the number of such vehicles is insufficient. New equipment has been purchased (most crucially for women, ultrasound machines) and dysfunctional equipment repaired; infrastructure has been upgraded including toilets and drinking water for patients; arrangements made for electricity outages/ load-shedding, enhancing cold chain management; the supply of medicines has improved; an increasing number of BHUs now provide 24/7 services. New staff has been recruited and far fewer posts remain vacant than in 2014. (For details, see Briefs #4-9, *Progress & Challenges Health Systems Building Blocks in Six Districts of Pakistan*.)

Supporting better responsiveness are: the recognition of health in the purview of local government functions in the provinces of Khyber Pakhtunkhwa and Punjab that enable new budgetary allocations for Basic Health Units (BHU); integration and enhanced coordination between programmes (Maternal, Neonatal & Child Health [MNCH] and Lady Health Workers [LHWs]) and the departments of Health and Population Welfare (DoH and PWD respectively); a host of district level coordination and oversight bodies, some including elected representatives; an added emphasis on communication and outreach strategy in Sindh's Costed Implementation Plan (CIP).

**Results**, as well as actions, **are uneven** however, and there are sharp disparities across provinces, districts and

#### Staff Issues:

facilities.

- Some facilities **lack budgets** for adding staff; **retention** remains a challenge in others; in yet others, the requisite number of **female staff** is missing;
- Staff **retention** in more remote/less well serviced regions is impacted by no or poor residential facilities, children's schools, and career advancement;
- There is some pre-service **training**, but regular in-service training is largely confined to mother and child health under the MNCH. No other institutionalised in-service training was reported. Although some training is provided by the WHO or civil society organisations (CSOs), there is **no prior needs assessment** to ensure training caters to the specific requirements of different facilities. (See Policy Brief # 5)

#### Budgets:

- Some districts confront severe budget constraints, especially Balochistan and Sindh where allocations are skewed and district budgets do not provide for health as the Local Government Acts do not recognise health as a primary subject of the local government;
- Some facilities still confront crucial delays in the processing of repair and maintenance requests;
- Allocated on the basis of an administrative unit, budgets do not take into account the differentiated need of facilities, such as catering to an in-flow of patients from adjoining areas as in those in Jaffarabad and Shahdadkot; (See Policy Brief # 6)

#### Equipment & Medicines:

- Investments in expensive equipment are wasted when there is no facility to house sensitive machinery or technical staff to operate these;

- Despite improved stock-in of medicines and vaccines, the absence of electricity backup compromises cold storage, and hence the quality of goods. (See Policy Brief # 7)

## What works: Recommended Actions to Further Improve Services:

- **Systemised need-assessments determining district and facility-specific requirements** must be carried out prior to posting staff or purchasing equipment, and expensive and sensitive equipment should only be sent to facilities after ensuring that the appropriate technical staff and physical space are available;
- Some **discretionary funds should be allocated to all health facilities** to cover repair and maintenance costs so as to overcome time-lags in the release of funds, as now available in some districts;
- Redoubled efforts are needed to guarantee an adequate number of **female professionals**;
- **Incentives** should also be introduced to retain female professionals and male staff in areas considered to be hardship posts. This could include adequate staff residences, and a sliding salary scale with the highest salary for the most remote locations such as recently introduced in Khyber Pukhtunkhwa;
- Appropriate **technical trainings and refresher courses** should be instituted for all pre- and in-service medical professionals to continuously improve the quality of the workforce, **based on a prior needs assessment** to respond to the dissimilar requirements of different facilities and work conditions;
- The government, in collaboration with civil society and experts, should develop structured capacity building programmes on **gender sensitisation, adolescent RH** and the **social determinants** of health.
- **Health** should be **recognised as a primary subject of local government** in Sindh and Balochistan to help overcome budgetary constraints.

## Insights: Complaint Mechanisms

A **variety of complaint mechanisms** to receive and address grievances have been established across facilities and provinces. **Effective upward communication within departments** is also helping to resolve complaints and, for example, PWD field offices forward serious complaints to the District offices and Secretary PWD, as well as to the (CM) Minister's office, Chief Justice, and Ombudsman.

Complaint mechanisms **must afford anonymity**; stories of **bad experiences spread rapidly** through the community grapevine reinforcing a general reluctance to complain. An extreme case shared in the research was of a man who "Imran went to the BHU (Basic Health Unit) and had a fight with doctor [the MO] and the doctor got him jailed and an FIR was lodged against him. Now he has become a psycho patient that is why no one complains. And even if they do, no change happens."<sup>8</sup>

## Complaint boxes:

These confront numerous **issues that obstruct usage**: locked boxes with keys in the custody of senior-most facility in-charge; inability of community to write; lack of standardised forms (or even paper/pen to use for writing); inappropriate placement of the box; reluctance of population to give a complaint in writing for fear of negative consequences; culture of oral complaint; and general reluctance "to get involved". In Punjab, for example, although complaint boxes exist at all PWD Tehsil and District offices, few complaints are received through these.

Alternatives to complaint boxes deployed in facilities include (i) placing a complaint register at the facility reviewed and responded to by the Executive District Officer (EDO) himself,<sup>9</sup> and an open-door policy of key senior management.<sup>10</sup> However, it is unclear why the use of a register should differ significantly from a complaint box, and while an open-door policy is always welcome, the effectiveness of such a policy is highly dependent on the particular officer in charge, and precludes complaints against the officer maintaining the open-door policy.

## Telephonic and Electronic-based Complaint Mechanisms:

- In some places **Complaint Cells** have been instituted, but neither the names of the members nor their telephone numbers have been publicised. In any case, mobile telephone numbers are deemed to get better responses than landlines. Where these are available, they are used more frequently.
- **Electronic web-based complaint mechanisms** are less effective/useful in rural areas with poor network coverage; they also tend to **exclude the poor and women to a larger extent** as their access to smart phones is limited. The Citizens' **Portal** in Khyber Pakhtunkhwa requires complainants to have an email account, which further limits its usage by women.
- **Punjab** has the **greatest number of mechanisms** that include the CM Complaint Cell and DCO Office Complaint Cells. Telephone numbers for complaints are posted outside offices and publicised on banners at seminars, etc. Monthly reports are sent to the CM Secretariat, and meetings held with DCOs to ascertain actions taken and number of cases resolved.

## What works: Recommended Actions for Further Strengthening Complaint Mechanisms:

- All existing mechanisms must be **widely publicised**:
  - **Brochures and mass media campaigns** should inform citizens about complaint cells and other mechanisms, providing the names of officials, mobile telephone numbers as well as landlines and street addresses;
  - Information should include a **step-by-step “how to”** guide for filing a complaint, what the procedure will be and expected time lapse in terms of response.
- **Complaint boxes** should be **discontinued** unless specific facilities report high usage.
- **Electronic complaint mechanisms** should not require setting up an email address; efforts must be made to expand Internet coverage to ensure rural accessibility, and special arrangements made for women to access these, such as Internet stations.
  - The procedure for the **Citizens' portal** should be simplified and mechanisms explored for expanding usage by those who have no android and places where connectivity is poor.

<sup>8</sup> Muzaffargarh, Rapid Situational Analysis, Focus Group Discussion with males – village Poli Wala, 2014.

<sup>9</sup> Vehari, Rapid Situational Analysis, In-depth Interview with Senior Medical Officer, RHC, 2014.

<sup>10</sup> Vehari, In-depth Interview with District Population Officer, District Coordination Officer and Executive District Officer, 2014.

### 3. PEOPLE'S PARTICIPATION IN HEALTH SYSTEMS GOVERNANCE

#### Insights: Community Involvement

Provincial governments have instituted new, as well as strengthened and/or reactivated existing systems of internal and external accountability and participation. These include Union Council (UC) and District-level Health Committees. At the local level, the People's Primary Health Initiative (PPHI) has instituted Community Support Groups. District Health Committees are complemented by entities such as the District Health Management Teams (DHMT), District Technical Committees (DTC), local government health committees in Khyber Pakhtunkhwa, and in Punjab, the District Health Authorities (DHA) include elected representatives in keeping with the Local Government Act.

A **remarkable change** since 2014 is the **emphasis district health officials now place on citizens' participation** and the importance of understanding the diverse range of problems that differently situated people confront in accessing healthcare facilities.<sup>11</sup> Previously, community members and health officials across cadres were ill informed of the government-instituted platforms and participation was largely limited to the LHW monthly meetings. Community (and civil society) participation, to close the loop of internal and external participation for greater accountability within systems, was either non-existent or a mere formality in the areas of study.<sup>12</sup>

The effectiveness of such participation in terms of guiding policy and facilitating decision-making for better health governance remains uneven, with Districts officials in some facilities confirming the lack (or insufficient level) of community participation in monitoring and accountability processes.

The **benefits of community participation** were underscored in **Vehari**, where a citizens' Community Support Group participates in monitoring and accountability of BHUs to ensure effective healthcare service delivery in close collaboration with the DoH.

CBOs strengthened through the HSGS project have become members of UC health committees.

There is a virtual absence of non-service-delivery Civil Society Organisations (CSOs) in the decision-making District Health Committees. The exclusion of organisations working to change community attitudes and practices in district health committees is unfortunate as **it deprives the health system of vital information and insights on how to overcome community-based upstream obstacles that are major obstacles to women and girls accessing health services especially for reproductive health care.**

#### What works: Recommended Action for Strengthening People's Participation in Health Systems Governance

**A major success of the HSGS project is that a local CBO partner secured membership in the Jaffarabad District Health Management Team in 2017. (See Policy Brief # 3)**

**The role of district councilors can be pivotal.** It is therefore unfortunate that the **Sindh and Balochistan** local government acts do not incorporate health as a key subject. **District Health Authorities** instituted in Punjab are a **welcome development**, but the required members from the district council have not yet been appointed. Councilors with strengthened understanding of local government mandate, rules and budgets as well as health issues can effectuate long-term institutional change, as evident in this intervention study. See the box below and Policy Brief # 3 for further details.

<sup>11</sup> Jaffarabad, Multistakeholder Forum, 2017

<sup>12</sup> Shahdadkot, RSA, In-Depth Interview with District Health Officer, 2014.

### PROJECT-STRENGTHENED COUNCILOR HAVING A BUDGET ALLOCATED FOR BHUS FROM THE COUNCIL FUNDS IN MARDAN

After attending Community Accountability training and having increased his knowledge base around local government functions and budgetary processes, Naresh Kumar, a member of the district council/assembly in Mardan, was able to mobilize 9.4 million rupees for infrastructural up-gradation across 47 BHUs in the district. The District Assembly has also decided to allocate PKR 200,000 for each BHU in the annual budgets as a result of a resolution moved by Kumar in collaboration with other members.

## Insights: Role of Civil Society Organisations

Concerted efforts by CSOs have increased people's health literacy and enhanced access to health services of women and girls by catalysing a shift away from traditional practices to seeking professional help. **Provided they have opportunities to participate, CSOs can play a crucial role in terms of:**

- **Spreading awareness**, complementing and reinforcing the communication and outreach capacity of government departments, which emerged as one of the weakest element in health systems governance;
- Navigating complex cultural dynamics to **effectively negotiate the overturning of community based hurdles** women and girls confront in seeking healthcare,
- Operating as an effective watchdog helping to **gather vital feedback** for better health systems governance.

## What Works: Recommended Actions for Further Strengthening Community and CSO Participation

The HSGS Project intervention indicates that real change can take place in terms of community participation for more effective governance when citizens are informed of available services, have a better understanding of State-citizen relationships and health systems governance frameworks. This enables them to engage with health systems and contribute from a strengthened knowledge base.

Knowledge and capacity to generate their own evidence for advocacy purposes builds self-confidence and shifts the power dynamics allowing for a greater uptake of their suggestions. (See Policy Brief #3)



## Governments Should:

- Appoint Council members on District Technical Committees and District Health Authorities as a matter of priority;
- Ensure all councillors are oriented to the roles of the different facilities and their own mandates to enable them to effectively participate in relevant Committees and take up health in the local councils;
- Reactivate defunct health committees and institutionalise their input for improved service delivery;
- Acknowledge the pivotal role CSOs can play not just by providing services but by raising awareness and addressing upstream obstacles to accessing healthcare, especially for women and girls in terms of reproductive health matters, and:
  - **Expand the spaces for CSO engagement**, and contribution in accountability processes;
  - **Encourage CSOs** to engage with communities by removing obstacles, such as No-Objection Certificates (NOCs) and prior permission, and simplify the process for signing Memoranda of Understanding (MoU) for specific activities;
  - **Ensure that District and UC Health Committees include district-based CSOs** with proven records of improving community health awareness, and successfully negotiating cultural barriers to effectuate attitudinal change and modified practices, especially those working with women and girls;
    - For this, undertake a mapping of CSOs working on health and women in each district and an assessment of their community based achievements;
  - **Include CSOs** in the District Health Management Committees and Monthly Coordination meetings.
- **Sindh and Balochistan** should incorporate health as a primary function of local government to enhance ownership and effective health governance at the local level.

## CSOs Should:

- **Become familiar** with post-devolution changes in the health system and Local Government systems, and **share this knowledge** with community actors and build the capacity of CBOs, councillors and media;
- **Support the government in the formulation of an effective communication strategy** with a clear set of indicators for measuring message clarity and impact;
- **Empower the community** for evidence-based advocacy and accountability to improve health service delivery; and
- **Establish multi-stakeholder platforms** and channel the community's felt-needs to decision-making forums.

## 4. GOVERNANCE & SYSTEMS MANAGEMENT

### Insights: Information Systems, Public-private partnerships & the Policy Framework

The **District Health Information System (DHIS)** is a significant improvement over the previous Health Management Information System (HMIS) that collected basic statistical information and “*was not comprehensive information to facilitate analysis.*”<sup>13</sup> . Still, compromising the core objective of DHIS, i.e., evidence-based decision-making:

- The DHIS remains a monitoring and evaluation tool, essentially generating quantitative information on systems' performances against targets and indicators across different health programmes; it lacks qualitative data collection tools that would help to assess the quality of services being provided and the experiences of end-users;
- Telephonic complaint systems remain disconnected from the DHIS; and
- 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.

**Public-private partnerships** have become a preferred model for improving governance for more effective quality health services. These have **enhanced efficiency and service delivery** in many places, however:

There is **little transparency with regards** the terms of such partnerships. It is unclear whether and how partnerships **improve the government's health sector governance systems** without which partnerships can only provide temporary relief and not long-term solutions to endemic issues of governance. There is the risk of a **loss of investment on trained staff** that may not be retained when partnerships expire. The fear of job insecurity is underscored by writ petitions: in Muzaffargarh and Vehari the Employees' Association has gone to court and been granted a stay order. In Khyber Pakhtunkhwa, the partnership was discontinued and management returned to the health department after a court decision in a writ petition filed by public sector employees; officials noted the difficulty of retrieving medicines from the private partner.

Numerous health systems frameworks outline actions to optimise health systems delivery for all, most carrying the weight of empirical evidence gathered across the globe. Each has been advanced to fill a perceived gap in preceding frameworks and the constellation of assessment indicators offered by diverse frameworks advances conceptual understanding. (For details please see Policy Brief # 2 *Health Systems Frameworks for Advancing Reproductive Health & Rights in Pakistan*) However, there are limitations in the single-use of any particular framework for a number of reasons. No framework accounts for people's expectations of a good health system, which may be entirely misplaced against what the government is currently providing. Few take into account major “upstream” community based socio-cultural barriers obstructing the access of women and girls to health services; those that do (e.g., the WHO social determinants of health and Benchmarks of Fairness), do not elaborate on how to measure (or address) socio-cultural power dynamics *within* communities.

<sup>13</sup> Muzaffargarh, Stakeholder meeting, 2017.