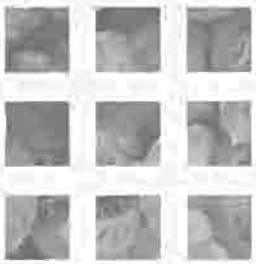

The Role of NGOs in Community Health in Pakistan

A NGO Pulse Report

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Gulzar H Shah
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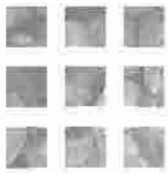

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The Role of NGOs in Community Health in Pakistan

NGOs Pulse Report

LUMS-McGill Social Enterprise Development Centre

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Preface

Dawood N Ghaznavi
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Preface

This report on *The Role of NGOs in Community Health in Pakistan* is the second in a series of reports aimed at improving understanding of the role of NGOs in the selected thematic area. The first report on *The Role of NGOs in Basic and Primary Education in Pakistan* yielded positive feedback. These reports are based on primary research conducted by the NGO Pulse, one of the eight key components of the Social Enterprise Development Centre (SEDC).

The SEDC is a CIDA funded project that came into being through a collaborative initiative between Lahore University of Management Sciences (LUMS) and McGill University. SEDC's mission is to improve the understanding of the role of the NGO sector, and to strengthen the capacity of the civil society organizations through training, research, and consultancy services.

Health is more than an absence of illness and infirmity. It is rather a state of complete physical, mental, and social well-being. Access to health care is a basic human right, which may not be available to, or affordable by, a considerable proportion of our population. Although the Pakistani health care system is primarily regulated by the government, NGOs have an important role to play in providing health care education and services, particularly to the underprivileged, including women, the elderly, children, the poor, and those located remotely from urban centres and road and rail network.

This research report uses multiple methods of data collection, including a survey, in-depth interviews, and a stakeholders' workshop, to provide insights into the structure and functions of NGOs involved in health care in Pakistan, and the role they are playing or need to be playing regarding health and health care in Pakistan.

The NGO Pulse team would like to acknowledge CIDA's financial support of the Programme and McGill's role as an active partner in the entire SEDC initiative. The cooperation of NGOs during the various data collection carried out for this study, is gratefully acknowledged.

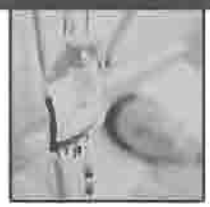
We hope that this study will generate a valuable insight and debate leading to more ideas regarding the role of civil society organizations in health through advocacy, service, research, innovation and partnerships with the public sector and other organizations.

Executive Summary

Nadia Ejaz

Executive Summary





There is limited research on the role of health-related NGOs in Pakistan. This report is an attempt to address this gap. More specifically, this study aims to assess the extent and the nature of NGOs' involvement in Pakistan's health sector, in order to gain understanding of their role, responsibility and the potential to provide or facilitate access to this basic social need. Issues faced by health NGOs are also part of the investigation. It is hoped that this report will not only provide information to the various stakeholders on what is happening in this sector, but will also trigger relevant debates in the various areas to be focused on. In addition, it will help build a network by providing research, training and management consultation to NGOs. This would include information about NGOs involved in the health sector, such as:

i. The basic profile of the NGO, including length of involvement in the sector, contact information and legal basis of existence and operation;

ii. Key activities and intervention projects/programmes related to geographic coverage in the provision of health care;

iii. Information concerning the support base, including staff, budget and potential for expansion;

iv. The NGO's understanding of challenges facing the health sector in Pakistan and the NGOs' role in taking on some of these challenges and their perception about the need for, potential of, and barriers against public-private collaboration in addressing the issue.

The report, based on literature review, a survey of 71 representative NGOs, a consultative workshop held with thirty participants and twenty five in-depth interviews, analyses the broader context in which these NGOs are located and then goes on to focus more specifically on the role and scale of these organizations. It concludes that:

The status of health amongst the Pakistani populace is low. Health indicators compare unfavorably with other developing countries in South Asia and the Middle East. The government continues to spend less than 1% of the GNP on health and the public sector accounts for only one-third of all health expenditures in the country; the private sector accounts for two thirds of it. Both sectors show significant biases towards gender, urban areas, and tertiary and curative care.

NGOs form an important part of the private sector. More than 500 NGOs of various institutional forms operate in this field. Most were established in the 1990s and are registered under a variety of legal acts. About 57% of the NGOs surveyed operate in the Punjab. Their scale of operations is also small: over 50% work in fewer than five districts. Preventive health education is the most common activity amongst these NGOs, while those involved in direct service delivery tend to use community based clinics or special camps.

Grassroots mobilization and close links to the community are particular strengths of NGOs when compared with either other private actors or the public sector. Key concerns include inadequate funding, knowledge management, capacity building, monitoring and evaluation, and regulation.

Most NGOs are receptive to the idea of partnerships. Of the surveyed NGOs, 38% were involved in partnerships with the public sector, 52% with other NGOs, and 40% directly with the community. Public-private partnerships, in particular, offer the opportunity to create new synergies; however, there is a need to further investigate the modalities of such partnerships.

There are a range of cross cutting issues that require more attention from policy makers in both the private and public sectors. More specifically, health care in Pakistan will benefit from more consistent policies that include all stakeholders. There is a need to collect more baseline and disaggregated data on health. There is scope for better utilizing indigenous medical knowledge and to inculcate a spirit of volunteerism with regard to health issues.

Overview

Overview of the State of Health care Services in Pakistan

Nadia Ejaz



Overview of the State of Health Care Services in Pakistan

1. Introduction

This chapter provides an overview of the state of health care services in Pakistan, particularly with respect to the public health system and the non-governmental sector. The chapter describes the key features in each case; delineates key trends within each sector and contextualizes them with respect to relevant international and regional developments.

1.1 Definition of health

The definition of health varies depending on different philosophical viewpoints, medical traditions and context of usage. In a negative sense, health may be defined as the absence of illness and disease.[1] Using a functional perspective, health is the ability of the organism to cope with everyday activities. Using a minimalist, biological approach, health is a form of homeostasis whereby the organism is in a state of balance, with inputs and outputs of energy and matter in equilibrium (allowing for growth). More generally, health can also imply good prospects for continued survival. For the purposes of this report, we employ the broad definition used by the World Health Organization (1994) as:

'a state of complete physical, mental and social well-being, [which] does not consist only of the absence of disease or infirmity.'[2]

1.1 Use of indicators to assess national health

In order to assess national health, policy makers have used different indicators and frameworks, ranging from specific indicators such as child mortality, nutritional status of the population, life span, maternal mortality rate, incidence of chronic and communicable diseases and access to health facilities. In addition, several composite indicators have been developed which combine indicators for mortality, morbidity and disability and allow for comparative assessments of disease burden at the global level[3].

For example, in 1993, the World Bank developed the concept of Burden of Disease[4] (BoD) which attempts to come up with an aggregate indicator for health and which serves as a basis of comparison between countries. BoD is measured by combining losses from premature death, (defined as the difference between actual age of death and life expectancy at that age in a low mortality population) and loss of healthy life resulting from disability. More recently still, the Millennium Development Goals (2000) of the United Nations Development Programme have been used as a broad benchmark to assess the status and progress of health care in different countries. In this report we will be relying on these and other indicators to provide an overview of the health care system in Pakistan.

2. The Status of Health Care: National and Comparative Perspectives

Given Pakistan's low ranking on the Human Development Index (HDI)[5], where it was ranked 135 in 2005, and the low levels of expenditure reserved for health care (the Pakistan government has, to date never spent more than 1% of the GNP on public health) it is perhaps no surprise that Pakistan does not fare all too well when compared with other South Asian countries. Table 1, on the next page shows the health expenditure of Pakistan from 1995 to 2002.

For example, in 2003, its infant mortality rate was 16% higher than the average for other South Asian countries (Lashari and Karim 2004 ix). Life expectancy at birth was similarly one of the lowest in the region as shown in Table 2, also on the next page.

Similarly, according to the World Bank, the BoD in Pakistan in the early 1990s was assessed at 350 Disability-Adjusted Life

[1]http://en.wikipedia.org/wiki/Health

[2]Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[3]See Hyder AA, Rotllant G, Morrow RH. Measuring the burden of disease: healthy life years. *American Journal of Public Health*. 1998;88:196-202. Williams A. Calculating the global burden of disease: time for a strategic reappraisal? *Health Economics* 1999;8:1-8.
Hyder AA, Applying Burden of Disease Methods in Developing Countries: A Case Study From Pakistan *American Journal of Public Health*.2000;90:1235-1240

[4]The most commonly used measure of the burden of disease is the disability-adjusted life year (DALY). The advantages of employing DALYs are: 1. they combine mortality, morbidity, and disability in a single measure; 2. they reflect explicit choices about discounting future benefits, age weighing (morbidity and mortality are given maximum weight at age 22 and lesser weights at younger and older ages), and weights given to different types of disabilities; and 3. they attempt to develop estimates of disease burden that are independent of advocacy efforts by groups interested in specific diseases. The major issues in using DALYs include: 1. they are heavily dependent on assumptions about disease incidence in developing countries, about which data are scarce and inaccurate; 2. they incorporate many assumptions and the overall sensitivity of the results to these assumptions is significant; and 3. caution must be used in interpreting changes over long periods because technological advances and some epidemiological changes are difficult to predict. In spite of the difficulties in their use, DALYs can provide a broad picture of the changing burden of disease. World Development Report: 1993.

[5]The HDI is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development:
- A long and healthy life, as measured by life expectancy at birth
- Knowledge, as measured by the adult literacy rate (with two-thirds weight) and the combined primary, secondary and tertiary gross enrolment ratio (with one-third weight)
- A decent standard of living, as measured by GDP per capita (PPP US$).

http://www.undp.org/hdr2001/

Table 1: Health expenditure (Rs in billion)

Baseline Year 1990 as % GDP	Fiscal Year	Total Budget	Development	Recurrent	As % of GDP
0.76	1995-96	16.35	5.741	10.44	0.8
	1996-97	18.34	6.485	11.857	0.8
	1997-98	19.66	6.077	13.587	0.7
	1998-99	20. 81	5.492	15.316	0.7
	1999-00	22.08	5.887	16.190	0.7
	2000-01	24.28	5.944	18.337	0.7
	2001-02	25.05	6.688	18.717	0.7

Source: Health Sector Study: Key Concerns and Solutions, *World Bank's Pakistan Population Assessment, 2003*, UNFPA, Gov. of Pakistan

In a comparison with Latin America, Hyder and Morrow (2000:1236) claim that:

"lost healthy life years due to premature mortality and disability was 456 years per 1000 people in Pakistan, whereas the indicator ranged from 150-300 years per 1000 people for Latin American nations"

Table 2: Health and social indicators, Pakistan, SAARC and neighboring countries, 2003

Country	HDI	Life expentancy at birth	Adult Literacy 15&above)	PopLiving Below Poverty line	IMR ★	MMR ★★	Mortality under 5 ★★★	Pop Growth Rate	Health Exp % GDP
Pakistan	144	60.4	44	32.6	84		709	2.8	0.9
Bangla-desh	139	60.5	40.6	33.7	51	400	77	2.4	1.5
Bhutan	136	62.5	47		74	380	95	2.3	3.7
China	104	70.6	85.8	4.6	31	55	39	1.3	2.0
India	127	63.3	58	28.6	67	540	93	2.0	0.9
Iran	106	69.8	77.1		35	37	42	2.7	2.7
Nepal	143	59.1	42.9		66	540	91	2.3	1.6
Sri Lanka	99	72.3	91.9	25.0	17	90	19	1.7	1.8

Source: *Human Development Report, 2003* UNDP *IMR: Infant Mortality Rate/1000 live births
**MMR: Maternal Mortality Ratio/100,000 live births
***Mortality under 5: Mortality of children under five years of age per 1000 live births

Years (DALYs) per 1000 population per year which was about 16% higher than the average for other countries in the Middle Eastern region[6]. In terms of other trends in the overall health status of Pakistan's population, recent decades have seen a noticeable change in the epidemiological burden which has changed from communicable diseases such as diarrhea, pneumonia, and tuberculosis (TB) to chronic diseases such as heart attacks, strokes, depression and cancer eventhough the communicable diseases are still responsible for 58% of the BoD in Pakistan (ADB).

[6]The Global Burden of Disease in 1990: http://www.hsph.harvard.edu/organizations/bdu/GBDseries_files/gbdsum4.pdf

Table 3: Pakistan's ranking on the human development index

Region	HDI rank 2003 (177 countries)	GDP per capita rank 2003 (177 countries)	GDP per capita (PPP US$) rank minus HDI rank (higher means better on HDI)	GDP per capita value (PPP US$) 2003	HDI value 2003
Pakistan	135	130	-5	2,097	0.527
South Asia Countries	-	-	-	2,897	0.628
Best performer in South Asia (Sri Lanka)	93	110	17	3,778	0.751
Worst performer in South Asia (Bangladesh)	139	138	-1	1,770	0.520

Source: *Human Development Report, 2005* UNDP

This is in keeping with the trend for the Asia/Pacific region where by 2020, the proportion accounted for by non-communicable diseases will nearly double to about 67 percent. For details on other changes in the Asia-Pacific region see Appendix 1.

In keeping with other trends in the Asia/Pacific region, experts from the Asian Development Bank predict that with growing urbanization, differential access to health care facilities in Pakistan is likely to rise in the coming years. In addition, international aid for health in the form of overseas development assistance to Pakistan is likely to decrease in the future:

"the available data suggest that ODA for health in the Developing Member Countries is lower in real terms than it was 10 years ago and is unlikely to rise appreciably in the next few years."
(ADB 2005)

Critics have also pointed out that despite a universal awareness of the importance of health information systems for sound health planning, Pakistan remains backward in this regard. According to Hyder and Morrow (2000) and Lashari and Karim (2004), population-based, nationally representative and disease-specific data are less common than data from hospital-based, small-sample studies:

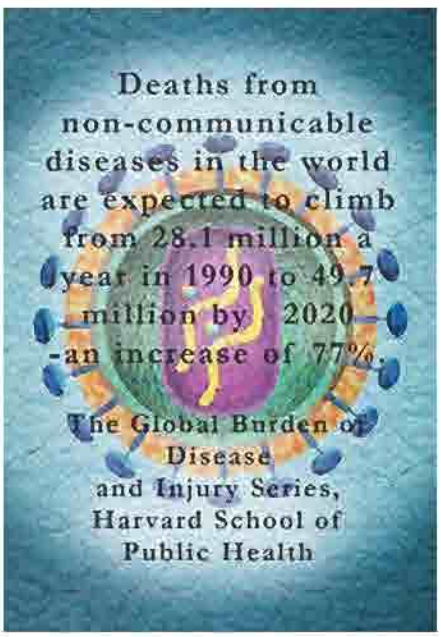
"Policymakers in Pakistan need to know the number of people dying each year from major diseases such as tuberculosis and malaria. This information cannot be obtained unless systems are implemented that capture deaths and their causes. The need for such a system goes beyond the importance of counting numbers for national statistics to helping rational allocation of resources for preventing deaths in the country"

(Hyder and Morrow 2000: 1238).

Pakistan's national health achievements can also be assessed by using the broad benchmark of the Millennium Development Goals (MDG). As elaborated in Table 4, on the next page, Pakistan has made some progress in terms of the health-related MDG targets, but even according to the Ministry of Health's own statistics, it is struggling to meet the projected figures for 2015.

Moreover, critics point out that even though the MDG targets have become prominent in terms of the rhetoric of public policy, campaigns and health programmes run at different government tiers and often fail to establish the link to these targets.

"There is thus, a dissonance between the official rhetoric about MDGs and the practical reality of health projects and programmes"[7]



[7]Interview Marie Stopes, 18 April, 2005, Lahore, Insha Hamdani, Senior External Relations Manager, Marie Stopes, Karachi

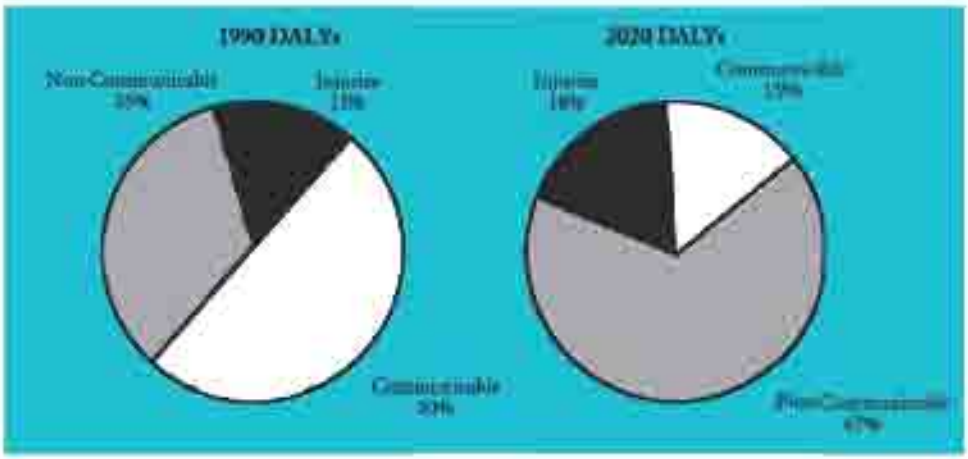


Figure 1: Burden of disease in Asia and the Pacific, 1990 and 2020

Source: Murray and Lopez. 1996. *The Global Burden of Disease*. Geneva: World Health Organization

Indicators	1990	MDG* Targets up to 2015	Current Position
Reduced Child Mortality			
Under five mortality Rate (/1000 live births)	140	47	105
Infant Mortality Rate (/1000 live births)	120	40	82
Proportion of fully immunized children (12-23 months)(%)	25	>90	53
Improve Maternal Health			
Maternal Mortality Ratio (/100,000 live births)	550	140	350
Births attended by skilled birth attendant (%)	N/A	90	24
Contraceptive Prevalence (%)	12	55	30

Table 4: Millennium Development Goals (MDG) Targets for Pakistan

Source: *Progress on Agenda for Health Sector Reform, May 2003*, Ministry of Health.

	ADB 2005 Proportion of Population Below Minimum Level of Dietary Energy Consumption (%)		
	1990-1992	1995-1997	2000-2002
Afghanistan	..	..	..
Bangladesh	35	40	30
Bhutan	..	..	..
India	25	21	21
Maldives	..	..	..
Nepal	20	26	17
Pakistan	24	19	20
SriLanka	28	26	22

Table 5: Population below energy consumption

Source: ADB 2005

Table 6: Comparison of Pakistan with other South Asian countries: Mortality rates

South Asia	Under Five Mortality Rate (per 1,000 live births)			Infant Mortality Rate (per 1,000 live births)			Proportion of 1-Year Old Children Immunized Against Measles (%)		
	1990	2000	2003	1990	2000	2003	1990	2000	2003
Afghanistan	260	257	257	168	165	165	20	35	50
Bangladesh	144	82	69	96	54	46	65	76	77
Bhutan	166	100	85	107	77	70	93	76	88
India	123	94	87	84	68	63	56	56	67
Maldives	115	80	72	80	59	55	96	99	96
Nepal	145	95	82	100	69	61	57	71	75
Pakistan	130	108	103	100	85	81	50	56	61
Sri Lanka	32	20	15	26	16	13	80	99	99

Source: World Bank 2005

Table 7: Health expenditures

Commitment to health: resources, access and services	
Public health expenditure (% of GDP), 2002	1.1
Private health expenditure (% of GDP), 2002	2.1
Health expenditure per capita (PPP US$), 2002	62
One-year-olds fully immunized against tuberculosis (%), 2003	82
One-year-olds fully immunized against measles (%), 2003	61
Children with diarrhoea receiving oral rehydration and continued feeding (% under age 5) 1, 1994-2003	33
Contraceptive prevalence rate (%), 1995-2003	28
Births attended by skilled health personnel (%), 1995-2003	23
Physicians (per 100,000 people), 1990-2004	66

Source: UN (United Nations). 2005. Millennium Indicators Database. Department of Economic and Social Affairs, Statistics Division, New York. [http://millenniumindicators.un.org]. Accessed March 2005, based on a joint effort by the United Nations Children's Fund (UNICEF) and the World Health Organization

Table 8: Population access to water, sanitation and nutrition

Source: UN (United Nations). 2005. Millenium Indicators Database. Department of Economic and Social Affairs, Statistics Division, New York. [http://millenniumindicators.un.org]. Accessed March 2005; based on a joint effort by the United Nations Children's Fund (UNICEF) and the World Health Organization.

Water, sanitation and nutritional status	
Population with sustainable access to improved sanitation (%), 1990	38
Population with sustainable access to improved sanitation (%), 2002	54
Population with sustainable access to an improved water source (%), 1990	83
Population with sustainable access to an improved water source (%), 2002	90
Population undernourished (% total), 1990-1992	24
Population undernourished (% total), 2000-2002	20
Children underweight for age (% under age 5), 1995-2003	38
Children under height for age (% under age 5), 1995-2003	37
Infants with low birthweight (%), 1998-2003	19

3. Health Systems and Policies: History and Overview

Health policy in Pakistan has evolved through several stages. Table 9 tabulates some of the most significant events in the history of health planning in Pakistan. Before the creation of Pakistan, the most important event vis-à-vis health policy was the 1943 Health Survey and Development Committee, also known as the Bhore Commission. This Commission was one of the first endeavors undertaken to provide comprehensive health care for all at the time of the British Raj.

According to Ilyas[1], the Bhore Commission itself was preceded by several important milestones. These included the appointment of a royal commission to enquire into the health of the Army in India in 1859; the introduction of an act to delegate powers to vaccinate in 1880; a report on the Plague Commission (1904) following the outbreak of plague in 1896; and health reforms introduced by the Government of India Acts 1919 and 1935.

Nevertheless, the Bhore Commission was the first step towards organized health planning and was at the forefront by establishing a strong link between development and health. For example, it linked good health to the elimination of poverty, low unemployment, improvement in agriculture and industrialization, the development of village roads, communications etc.

"The Bhore Commission examined a socialised system of health services that would more effectively meet people's needs and in which public health predominated, and eventually replaced medical practice. The Bhore report was radical in its recognition that nutrition and general living standards were major determinants of health [...]. The report therefore recommended, among other things, the establishment of a health system in the country that emphasised preventative measures and was based on salaried workers in a public health service that linked villages to district health centres."[2]

The story of public health policy after Partition in 1947, has been dominated by Pakistan's Five Year Plans, which has also been the core of economic planning in Pakistan. According to Lashari and Karim (2004:14) between 1947 and the introduction of the First Five Year Plan in 1955 there was no significant improvement in the health status of the population. For instance, in 1947, about 3 million people in cities had protected water supply and this only rose to 5 million by 1951. Similarly, there was only one medical college at the time of Partition and this increased to 6 in 1955.

3.1 The First Five Year Plan

The First Five Year Plan (1955-60) contained a detailed programme for the health sector, but its implementation was unsatisfactory due to lack of human resources and delays in disbursement of funds. It is estimated that only about 50% of the total planned allocation of Rs 287 million was utilized during this time period.

3.2 The Second Five Year Plan

During the Second Five Year Plan (1960-65) there was a more marked improvement in health performance. Three new medical colleges were established in East Pakistan (now Bangladesh) and nearly 200 Rural Health Centres (RHCs) were planned. Moreover, a major programme for the eradication of malaria was launched and there was significant success in the

[1]Ilyas M. *Community Medicine and Public Health* 5th ed. Time Publisher, Karachi, 2001
[2]Jeffery, R. (1988) *The Politics of Health in India*. University of California Press, Berkeley.

Table 9: Significant events in health planning in Pakistan

Event	Year
All Pakistan Health Conference	1947
All Pakistan Health Conference	1951
All Pakistan Health Conference	1956
Medical Reform Commission	1959 (report published in 1960)
Medical Reform Commission	1969 (report published in 1970)
Health Study Group	1969
System of Local Health Services in rural area	1965-66(report in 1970)
Nutrition Survey of West Pakistan	1961
Rural Health Center Scheme	1972
Peoples Health scheme	1973
Eradication of Smallpox	1976
1st National Conference on Medical Education	1976
Concept of Primary Health Care	1976
School Health Service Program	1980
Decentralization of Health services in Punjab	1990
National Health Policy	1990
Social Action Programme	1993-1996
National Health policy	1997
National Health policy	2001

Source: Fazli Hakim Khattak Economics of Health Sector Reforms in Pakistan 1st ed. Ad Rays Publishers, Islamabad 2001

government's campaign against smallpox. The entire population of East Pakistan was vaccinated against small pox resulting in a decrease in the cases from 79,000 in 1958 to about only 50 cases in 1964.

3.3 The Third Five Year Plan

During the Third Five Year Plan (1965-70) health indicators began to improve. The ratio of nurses was 1 for 32,000 people; one lady health visitor was available for 115,000 people; IMR was 155/1000. Still, the government was only able to attain 50% of its targets in terms of increasing the ratio of Lady Health Visitors (LHVs) and RHCs per 1000 persons.

3.4 The Fourth Five Year Plan

The period of the Fourth Five Year Plan (1970-75) was marked by some progress in Pakistan's public health system, particularly during the latter half of this time period. From 1972 to 1978, health expenditure rose to almost Rs 684 million and significant progress was made in the expansion of health facilities. The programme to control malaria was revived and Pakistan was declared free from smallpox in December 1976. The number of RHCs almost tripled and community health workers were introduced in the Northern Areas of Pakistan for the first time.

3.5 The Fifth Five Year Plan

The Fifth Five Year plan was presented in 1978. This period also saw the government underachieving in terms of planned targets. During the plan period, 625 RHCs and 4,596 Basic Health Units (BHUs) were planned, but 206 RHCs and only 1,617 BHUs were actually built. The target for IMR was set to be reduced from 105/1,000 people to 79, but it could only achieve the figure of 100.

3.6 The Sixth Five Year Plan

The Sixth Five Year Plan (1983-88) made progress in terms of the coverage of BHUs in Pakistan as most of the Union Councils in the country were provided with BHUs. However, increased defense expenditures and a flood of refugees to Pakistan after the Soviet invasion of Afghanistan in December 1979, as well as the sharp increase in international oil prices in 1979-80, drew resources away from planned investments[10]. In relation to health targets, the government was not able to create a cadre of credible health managers, nor was it able to expand the private health sector.

[10]Pakistan: Development Planning http://www.country-data.com/cgi-bin/query/r-9822.html

Table 10: Sector achievements during three decades (1950-70)

Items	1949-50	1959-60	1969-70
Doctors	3,000	12,000	21,000
Nurses	100	3,000	5,000
Hospitals Beds	17,000	27,000	39,000

Source: Five Year Plans (Lashari and Karim 2004: 14)

Table 11: Health personnel

Indicators	Baseline Year 1990	Outcome Indicators 1996-97	2001	2002
Doctors	55,572	78,470	91,832	96,248
Nurses	18,150	28,661	40,019	40,019
Lady Health workers	-	43,000	55,127	70,000
TBAs	-	57935	58,259	-
Paramedics	-	115,000	-	-

Source: Statistical Bulletin, July 2003, Federal Bureau of Statistics
Annual Report of Director-General, 2000-1
Progress on Agenda for Health Sector Reforms, 2003

Table 12: Social services indicators

Indicators	Baseline Year 1990	Outcome Indicators 1996-97	2001	2002
Water Supply population coverage (%)	52		63	65
• Urban	80		85	85
• Rural	45	43	53	55
Sanitation population coverage (%)	22		38	40
• Urban	55		59	58
• Rural	10	20.5	25	28

Source: Annual Report Plan 2003-04
Fazli Hakim Khattak, Economics of Health Sector Reforms in Pakistan 2001
S Akbar Zaidi, Issues in Pakistan's Economy 1999

3.7 The Seventh Five Year Plan

The Seventh Five Year Plan was presented in 1988. The major achievement during this time was the expansion of the Immunization Programme. However, the overall thrust of the public system remained focused on the building of infrastructure and on curative care while neglecting the preventive side of health care.

3.8 The Eighth Five Year Plan

The Eighth Five Year Plan (1993-98) coincided with the launch of the Social Action Programme (SAP) by the government in 1993-4. This programme, carried out with the assistance of the World Bank was a response to the continuing dismal performance of the social sector in Pakistan as reflected in the poor health status of its populace. For the next several years, SAP became the paradigm for the government's development policy in the country, including that of the health sector. The first phase was completed at the cost of Rs 106 billion, whereas the second phase (1997-2002) was launched with an estimated cost of Rs 498 billion. Analysis consider SAP to have provided a major jolt to Pakistan's health planning and hold it responsible for diverting attention towards primary health care for the first time in concrete terms.

SAP was followed by another major policy framework in the shape of the Millennium Development Goals (MDGs), set by the UN and other international agencies in the year 2000. As discussed earlier, Pakistan became a signatory to the MDGs and this remains the broad benchmark for assessing its progress in terms of development goals including those relating to health. Of the eight broadly stated goals and 18 specific targets to be achieved by the year 2015, six are directly related to health.

Table 13: Health facilities

Indicators	Baseline Year 1990	Outcome Indicators 1996-97	2001	2002
Hospitals	756	865	879(1999)	906
Dispensaries	3.795	4,523	4,583	4590
MCH Centers	1.050	853	855	862
RHCs	456	513	541	550
BHUs	4,213	5,121	4,507	5,308
TB Clinics	220	262	272	285
Total Beds	72,997	89,929	97,945	98,64
Population per Bed	1,505	1,504	1,443	-

Source: Annual Report of Director General Health 2000-01

4. Key Issues

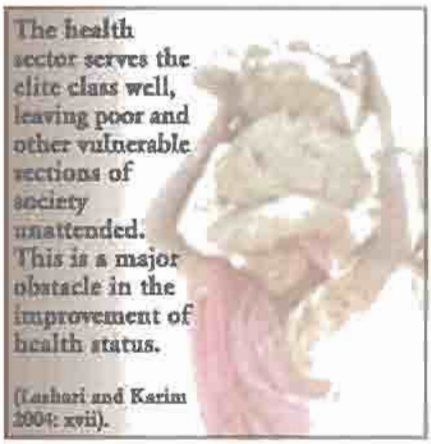
Critics[11] maintain that health planning in Pakistan has been poor since it has not received sustained and focused attention from successive governments. Most policy initiatives have been ad-hoc and short-sighted; there has been a reluctance to accept that national health care standards can only be raised if there is a concerted effort across a range of relevant sectors (including private, NGO, pharmaceutical, education, sanitation etc). Health, as a fundamental human right and as an important aspect of modern citizenship remains an unfulfilled dream[12]. The following discussion attempts to provide a summary overview of some of the key issues that have hindered the formation of a strong public health sector in Pakistan.

4.1 Health policies have lacked consistency and have seemed contingent on the whims of particular governmental regimes. The general pattern of policies display short-sightedness and there have been frequent changes in overall health paradigms (see Appendix 2 for overview of the health policy process at the Ministry of Health).

4.2 The association of health with development, though well-established in literature, has been largely ignored. With few exceptions, health has been seen as a largely medical issue and not necessarily an issue fundamentally linked to development. Or, even if the link to development has been acknowledged in theory, in practice this link has not been maintained.

4.3 The role of international agencies is critical but a significant portion of this international aid has been spent on vertical preventive campaigns, marginalizing holistic and integrated approaches to health.

4.4 Historically, more attention has been given to curative care at the expense of preventive care, despite the fact that communicable diseases have constituted a large portion of Pakistan's burden of disease and the country has limited resources to dedicate to health. As a result, the root causes of morbidity and mortality have often not been addressed with negative consequences for national development. According to Bjorkman (1988), the total impact of the government's health expenditure has been small because so much of it has been spent on curative action rather than preventive strategies. A recent study conducted in the NWFP, shows for example,[13] that 88% of all health expenditures were related to curative care and only 12% was spent on preventive measures.



4.5 Budgetary allocations have been consumed by salaries and primary health care has been marginalized at the expense of secondary and tertiary health care. It is reported that about 60 percent of the recurrent budget is consumed for salaries while the remaining 40 percent is spent on primary, secondary, and tertiary care (Khattak 1996). Of this 40 percent, primary care receives the smallest share of the budget, which is, in any case, dominated by salaries for health care workers. The budget for primary health care facilities in 1999 in the Punjab reveals that 30%, was spent on electricity bills, 24% on medicine and 4.2% on maintenance. Since maintenance and repair is critical for the optimum functioning of health facilities, these inadequate funds lead to further deterioration of the primary health care system (Karim and Lashari 2004: 4).

[11]See Lashari and Karim 2004 "Pakistan's Health Policy: Quest for a Vision Hyder AA, Applying Burden of Disease Methods in Developing Countries: A Case Study From Pakistan *American Journal of Public Health*.2000;90:1235–1240

[12]SPDC. Social Development in Pakistan, Annual Review 2001 Zaidi SA. The Political Economy of Health Care in Pakistan. Vanguard Publishers 1988

[13]NWFP: Working for Health – Strategy for Health Sector Reform: Oxford Policy Management, UK, 2003

4.6 Non-governmental stakeholders, such as the private sector, direct beneficiaries, traditional health care providers and NGOs have not been allowed to play an important or significant role in policy making. This, despite the fact that in Pakistan the private sector is a major contributor to health care services in Pakistan[14]. In 2004, it was estimated that the private sector provided six big hospitals, 520 small hospitals, 20,000 general practitioners, 300 maternal homes, 340 dispensaries, and 420 laboratories. In addition, it is estimated that 254 NGOs impart some form of health care under the allopathic system[15]. In terms of more traditional or non-conventional health care providers, including Homeopathy[16], *Unani*[17] and *Ayurvedic*[18] medicine systems, there are 73,878 homeopaths, 45,799 *hakims*[19] and *tabibs*[20] and 537 *vaids*[21] respectively[22].

4.7 A very low percentage of Pakistan's GDP is spent on health; an amount lower than most other comparable low-income countries. In fact, the government's health expenditures on health declined between 1991-2 and 1997-8 from 0.76 to 0.71 % of GDP respectively and remains less than 1% to date.

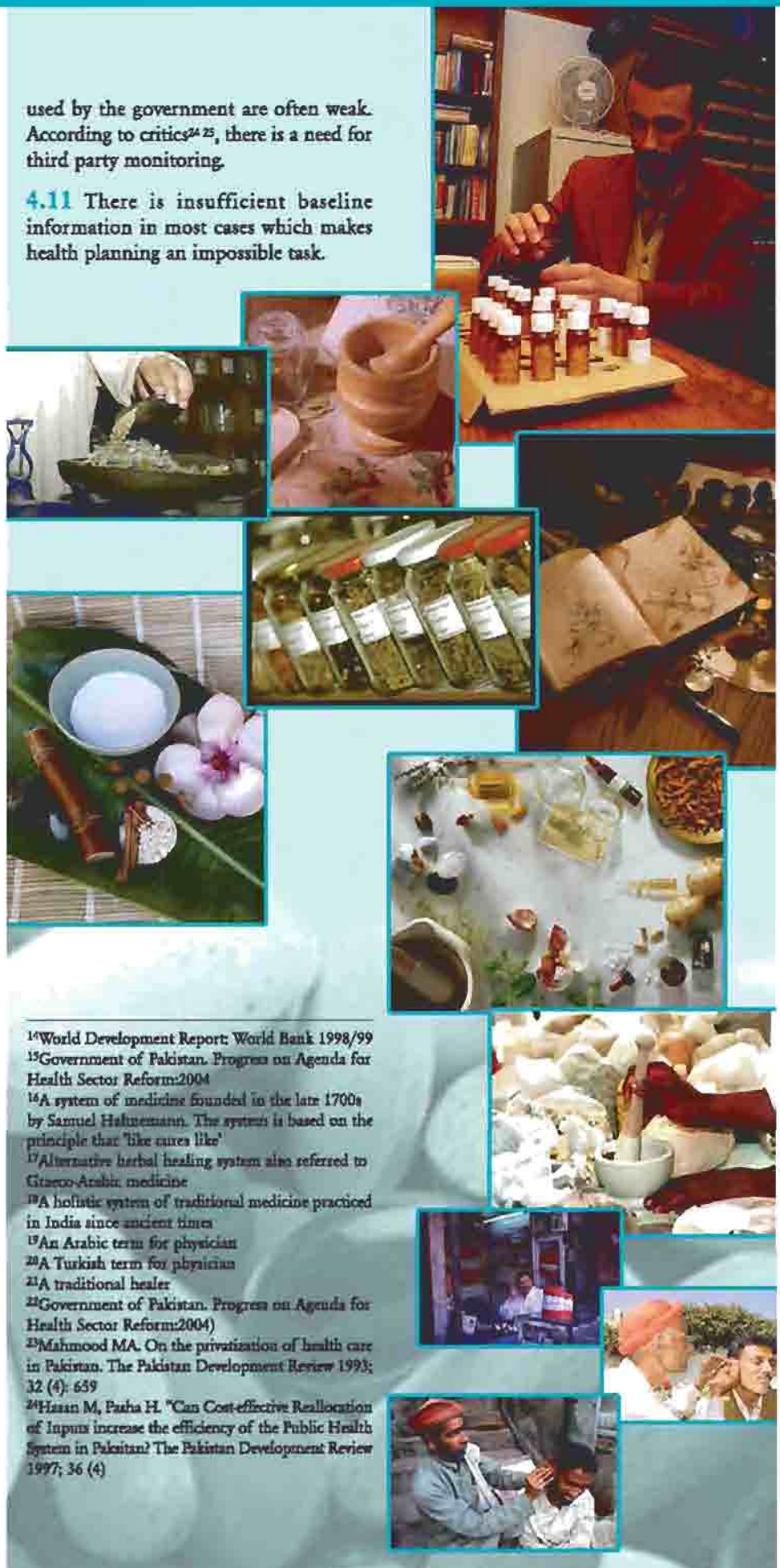
4.8 The issue of governance and its impact on health delivery has not been sufficiently analysed. Health planning has often faltered due to poor governance structures and lack of coordination between different government departments and tiers. Most recently, the Devolution Plan (2000) has given new life to district governments. However, the division of labour between federal, provincial and district levels of government still remains vague resulting in mismanagement, time delays and dissonance between responsibility and decision-making functions of governance. According to Karim and Lashari (2004: xvii) the policy process,

'does not determine the tiers of federal, provincial and district governments and neither are their roles defined'.

4.9 Since communities are not made an integral part of the planning process, there is a subsequent lack of ownership.

4.10 Monitoring and evaluation methods used by the government are often weak. According to critics[24,25], there is a need for third party monitoring.

4.11 There is insufficient baseline information in most cases which makes health planning an impossible task.



[14]World Development Report: World Bank 1998/99
[15]Government of Pakistan. Progress on Agenda for Health Sector Reform:2004
[16]A system of medicine founded in the late 1700s by Samuel Hahnemann. The system is based on the principle that 'like cures like'
[17]Alternative herbal healing system also referred to Graeco-Arabic medicine
[18]A holistic system of traditional medicine practiced in India since ancient times
[19]An Arabic term for physician
[20]A Turkish term for physician
[21]A traditional healer
[22]Government of Pakistan. Progress on Agenda for Health Sector Reform:2004)
[23]Mahmood MA. On the privatization of health care in Pakistan. The Pakistan Development Review 1993; 32 (4): 659
[24]Hasan M, Pasha H. "Can Cost-effective Reallocation of Inputs increase the efficiency of the Public Health System in Pakistan? The Pakistan Development Review 1997; 36 (4)

The Pakistan Devolution Plan 2000

Pakistan's Devolution Plan 2000 was designed with three broad objectives in mind:

- To bring in new spirit to a political system which is considered to be the domain of historically entrenched interests;
- To provide measures to enable marginalized citizens - women, peasants, workers - to access formal politics;
- To introduce stability into a turbulent political scene by creating a stronger accountability between new politicians and local electorates.

Other technical objectives were:

- Improved delivery of social services;
- Enforcement of property and labor rights and regulation of economic activities;
- Access to justice in the form of improved performance by local administrations, courts and police, with greater awareness of basic human rights[1].

(Devolution in Pakistan: The World Bank)

[1]http://web.worldbank.org/wbsite/external/countries/southasiaext/extsouthasiatop/extsouthasiadec/extsouthasiadevolution/

Public-Private Partnership in the Post-Devolution Context:

The Case of the Punjab Rural Support Programme (PRSP) and Basic Health Units in Punjab Province

Conference Proceedings on Devolution, 1st June 2005

Lahore University of Management Sciences, LUMS

Introduction

In an attempt to provide more effective management of Basic Health Units (BHUs) throughout the province of Punjab in a post-devolution context, the provincial government took the initiative to utilise the expertise of the Punjab Rural Support Programme (PSRP) to ensure a minimal standard of service delivery in the health sector. Consequently, an agreement was reached between the PRSP and the Punjab Government in 2002 whereby the PRSP, working in tandem with, and not parallel to, the provincial government, attempted to overhaul the health care structure at the union level.

Background

BHUs were initially established in the late 1970s with 2456 BHUs being provided to 2497 union councils within Punjab. BHUs form the lowest tier of the health care system within Pakistan, and, therefore, can only provide for basic health care, although the aim is to provide for comprehensive medical care, both curative and preventive, as well as facilities for maternal and child health. BHUs however, remain important tools for policy implementation, with programmes such as the National Welfare Programme, the National Programme for Family Planning and Primary Health care, the extended programme on Immunisation, the Communicable Disease Control Programme, the TB DOTS Campaign, the Women Health Project, and the Sanitation Programme, all finding a focal point of application within the BHUs at the Union Level.

At the present, BHUs throughout the Punjab suffer from a considerable amount of neglect. With a single BHU costing eight million rupees, little effort has been made to upgrade existing facilities, or to maintain a minimum level of efficiency. This can be attributed primarily to a lack of ownership on the part of the communities, the government, and any other political authorities that may exist. The management of BHUs remains poor, and an inadequate amount of financial discipline also hinders their ability to function at optimal levels. Inflexible operating procedures, coupled with insufficient supplies, bad infrastructure and understaffing, all contribute to hampering the effectiveness of BHUs.

The Rahim Yar Khan Pilot Project

In view of the deteriorating situation of the BHUs, the Rahim Yar Khan Pilot Project was launched. Having already met with some success in District Ludhran, the use of non-governmental actors, such as the PRSP, to contribute to the working of the BHUs, was taken up by District Rahim Yar Khan in 2003 to act as a possible template which could then be applied throughout the province. With the Rahim Yar Khan experience subsequently providing positive results, the Chief Minister's 'Initiative for Primary Health care' was launched, with the PRSP being given the mandate to improve the situation of the BHUs throughout the province, complete with support for their endeavours by the Provincial government. At present, the PRPSP is operating in twelve districts.

The agreement between the PRSP and the Government of Pakistan was based on several major points. Firstly, the PRSP was given assurance that any staff employed in the project would be protected in that, their status would not be changed. The major points of the agreement were:

The PRSP would ensure the maintenance of the infrastructure of the BHUs.

- The PRSP would operate the BHUs with the fullest transparency, discipline and efficiency with regards to the use of public resources.
- The PRSP would stay within the

budgetary limitations of the district governments, transfer no liabilities to the government.

- The PRSP would be subject to an evaluation after the first year. After this, the potential for broader provincial and national projects would be considered.

The PRSP Strategy

The strategy adopted by the PRSP to manage the BHUs was to first group three BHUs together under one Medical Officer to increase efficiency. This grouping was done on a need basis, and ensured the provision of quality staff by providing for the ability to provide higher salaries to workers within these clusters. To a very large extent, in addition to this, the PRSP has also succeeded in providing an adequate supply of medicines to the BHUs. Furthermore, additional services (with a nominal one rupee fee, as with all the services of the BHU) are also supplied by BHUs under the management of the PRSP, including Community Health Sessions, School Health Sessions, Female Health Services, Support Groups, routine testing for diseases, and a Resource Group of top doctors at the provincial level. In particular, the Support Groups provide for an interesting insight into how the PRSP attempts to include the citizens within the service provision process, with 20-25 people acting as a bridge between the community and the BHU. From data gathered from the pilot project in District Rahim Yar Khan, it can be seen that the utilisation of the local BHUs has gone up since 2002.

Decentralization of the Project

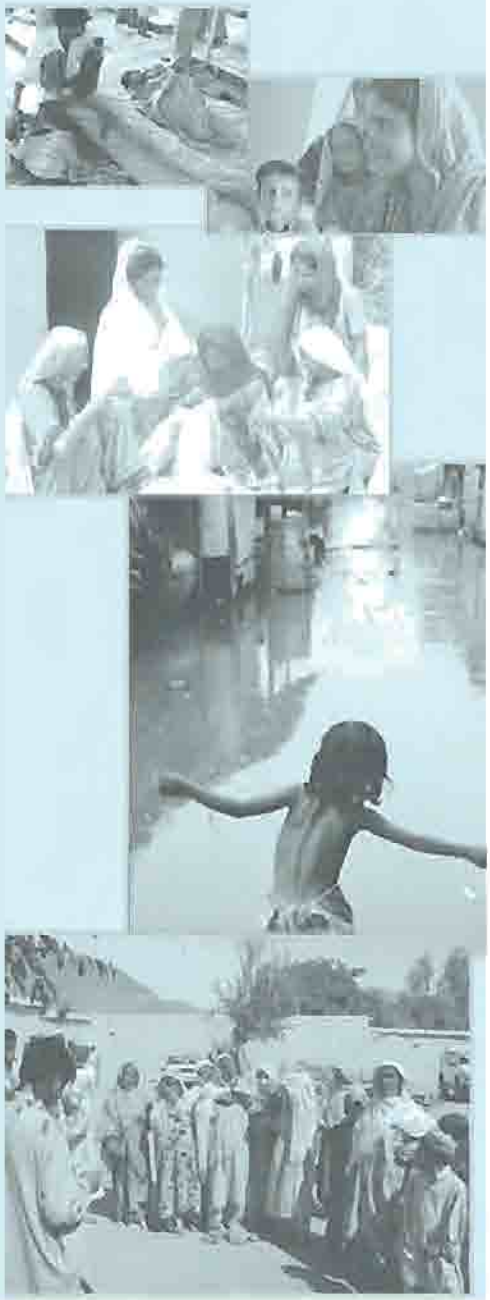
Essentially, the PRSP has been able to achieve all these targets by incorporating a considerable amount of flexibility in their operating procedures, by decentralising the project itself, and by ensuring strict monitoring. Flexibility can be seen, for example, in the way in which the PRSP ensures relatively high salaries for those working at BHUs, providing an incentive for quality staff to be present in the BHUs. Similarly, in the procurement of medicines, traditional supply lines have been replaced by more flexible, cost effective ones, with UNICEF and the WHO also being contacted for help in devising new systems of medicine procurement. High levels of monitoring are put in place by the PRSP by employing District Support Managers who, with their staff, always remain on the move, checking on individual BHUs. The provision of telephone lines to the BHUs has also made monitoring easier. All in all, the management of BHUs, under the PRSP, comes to a cost of about 11.95% of the budget of the District Management, a figure obtained from District Rahim Yar Khan, and one that is significantly lower than the cost prior to the intervention of the PRSP.

Conclusion

Having said all this, however, questions do remain about the viability of the approach taken by the PRSP. First and foremost is the question of how this approach, by outsourcing health to non-governmental organisations, removes the onus of providing quality health care from the shoulders of the state. This is made particularly relevant by the fact that the PRSP cannot work indefinitely, and will have to withdraw at some point due to its limited capacity. While it is argued that the model could be replicated by the government itself, and that support groups could provide citizens with the space through which they could articulate demands, there is, nonetheless, a feeling that the PRSP could potentially create a system running parallel to that of the state.

The potential however, does remain for further development of the PRSP model. Family planning, and female and community health programmes, for example, are seen as areas in which the PRSP could enhance the role of the BHUs. Also, increased synergies with national and provincial health programmes to better integrate the local level are also envisaged. Considerable work still needs to be done with regard to improving the infrastructure of the BHUs and hence, more efficient supply chains, better communications networks, more competitive staff salary packages, and strengthening the input from resource and support groups, are all seen as measures that could potentially add to the efforts of the PRSP. Indeed, an evaluation of the work of the PRSP in Rahim Yar Khan was carried out by the State Bank of Pakistan in 2003, and findings showed that the PRSP approach could definitely form the basis for an excellent model for providing health care in rural Punjab.

Contributed by Hassan Iqbal



5. The Role of the Private Sector[16] in Pakistan's Health Care

It is easy to surmise from the above discussion that the public health care system in Pakistan faces a number of challenges which hinder its ability to adequately address the health needs of the Pakistani population. This, despite constitutional commitments to the provision of health care for citizens, and a well-established link between the development of a country and its health status[17]. The remaining gap between the demand and supply of health services is bridged in part by the private sector.

However, Pakistan is not an exception in this regard. The trend towards privatization of health care is almost a global phenomenon. According to the Asian Development Bank, the largest source of health care financing in the Bank's Developing Member Countries comes from private expenditures, most of which are out-of-pocket (The Bank reaches this conclusion using data from national health accounts as an indication of the shares of private and public expenditures and claims that government budgetary allocations account for much less than half of total expenditures for all its developing member countries). In the Philippines, for example, they account for 44 percent of total expenditures and, in India, 22 per cent (See Appendix 3 for more details on privatization of health care in India). Typically, 70 percent or more of the public subsidies support public hospitals, leaving less than 15 percent of total health expenditures to cover primary health care[18]

The increasing privatization of health care affects the way in which health care is delivered and the pay and working conditions of health workers. In addition, there are many dimensions of privatisation, which may be adopted simultaneously or at different times. These dimensions include: the corporatisation of public sector health care institutions, the establishment of public-private partnerships, the changing role of the public sector as a provider of health care, the expansion of health insurance, and the development of medical tourism.

Despite it being a pervasive global and regional trend, there is little consensus on the effects and benefits of such health sector reforms. Traditionally, proponents have argued that increased privatization enhances the efficiency of public service delivery, tends to be more participatory and responsive to customer needs, and less susceptible to political patronage[19]. Skeptics and critics disagree. According to Hall and Lobina (2005), it is widely assumed that the private sector is 'obviously' more efficient than the public sector. However,

"the empirical evidence and the theoretical debates do not support this assumption. There is a consistent stream of empirical evidence consistently and repeatedly showing that there is no systematic significant difference between public and private operators in terms of efficiency or other performance measures. The theory behind the assumption of private sector superiority is also being shown to have serious flaws"[20].

Based on a comprehensive survey of health sector reforms in different countries over the last two decades, Jane Lethbridge, concludes that leaving health care to the interplay of market forces with minimum government intervention has led to "rapid cost escalation, widening inequities, and poorer-than-expected health outcomes". In particular, she argues that the unrestrained provision of high-technology services, such as magnetic resonance imaging, combined with fee-for-service re-reimbursement schemes, has resulted in substantial cost escalation.

The ADB concurs that a unilateral reform towards privatization may not be advisable[21]. According to the Bank there are a number of good reasons for public intervention in the health sector, including the fact that many health interventions, such as immunization or TB control, display substantial positive externalities; the occurrence of unexpected epidemics and catastrophic illnesses which impel governments to ensure that there is risk pooling; the possibility of serious insurance market failures; the existence of economies of scale, for example in the purchase of vaccines and essential drugs; and equity considerations where marginalized groups such as women and rural populations may not be targeted by the private sector due to low profitability[22].

While the debate about relative merits and demerits of privatization versus public provision of health care services is an ongoing one, it is nevertheless beyond doubt that the private sector is a crucial component of health care in most countries around the world.

5.1 The scale of the private health sector in Pakistan

In Pakistan, the private sector is a major contributor with a 77% share in the country's health expenditures[23]. The private sector has relied on traditional as well as modern allopathic health care delivery. Results from the Pakistan Integrated Household Survey (PIHS) reveal that while

[16]The private sector consists of a range of non-public institutions/organizations which may be profit-oriented enterprises or non-profit ones. To keep the analysis simple, both types of enterprises will be collectively referred to as 'private sector' institutions in this report. However, distinctions have been drawn wherever required. Specifically, non-profit private institutions will encompass peoples' organizations, community-based organizations, private voluntary organizations and non-governmental organizations. For-profit institutions will encompass the profit oriented private sector.

[17]ADB 2005 "The Bank's Health Policy", http://www.adb.org/documents/policies/health/health303.asp?p=policies

[18]Ibid.

[19]Mahmood MA. On the Privatization of Health Care in Pakistan. The Pakistan Development Review 1993; 32 (4): 659

[20]The relative efficiency of public and private sector water, David Hall and Emanuele Lobina, PSIRU, Business School, University of Greenwich, September 2005 Public Services International

[21]According to the ADB 2005, even in the most market-oriented countries, the public sector is expected to play a large role. In these countries, which are the world's most market-oriented economies, public sector financing (including publicly mandated finance) ranges from 80 to 97 percent of health expenditures. This experience suggests that mandating universal coverage is a practical long-term policy objective. Developed countries currently spend an average of 8 percent of their GDP on health services.

[22]Ibid

[23]World Development Report. World Bank. 1998/99

Table 14: Proportion of health expenditures and population served by type of services, 1994

Services	Share of Public Sector health Expenditure (%)	Share of Private Sector Health Expenditure (%)
Primary Health Care	15	85
Secondary Health Care	45	55
Tertiary care	40	60

Source: Health Section: Planning and Development Division 1994

the government has been relatively successful in providing preventive health care to the population, yet, more than 80% of curative health services are being provided by the private sector[56]. The Survey also claims that private practitioners handle 63% of the cases of diarrhea among children in urban areas, and 60% in rural areas. Moreover, with regard to childbirth, private facilities are used for over half of all cases of non-home deliveries[57].

Not only is the private health sector in Pakistan substantial in size, it also exhibits a great deal of variation in institutional form, organizational structure, and complementarity with the public sector. In the section below we highlight some key features of this burgeoning sector in Pakistan.

5.1.1 Hospitals

The private sector in Pakistan is heavily skewed in favour of tertiary care in urban areas. This has resulted in a proliferation of private and/or profit-oriented hospitals in urban areas (See Table 15 for list of prominent private hospitals).

In addition, a range of privatized services have been introduced in the existing governmental hospitals. According to Iqndar, following legal reforms such as the Punjab Health Ordinance (2002), government hospitals have downsized a range of hitherto subsidized services. The latter have been substituted by user-fees. In the case of Punjab's teaching hospitals, x-rays and blood tests that used to be free now cost on average Rs 50-60 each. Registration fees have risen from Rs 2 to Rs 10-20[58].

5.1.2 Health insurance

Insurance is a relatively new concept in the context of Pakistan's domestic market[59]. The government allowed private companies to offer insurance about less than 10 years ago. Previously there was only one government-run life insurance company called the State Life Insurance (SLI). In less than 10 years more than 40 life insurance companies have emerged.

Health insurance is an even more recent innovation. There are less than half a dozen health insurers and the four largest agencies - Adamjee Insurance, EFU Insurance, Commercial Union Insurance and New Jubilee Insurance - introduced health insurance less than four years ago. All four companies have started insurance on the insistence of their corporate clients and follow a customized approach fulfilling the particular demands of each corporate client. In addition, there are plans for these insurance companies to forge alliances with international insurance agencies such as Allianz. Typically, the health services offered are divided into four categories that service out-patients, maternity, hospitalization, and critical illnesses.

5.1.3 Non-governmental organizations (NGOs)[60]

NGOs constitute an important part of the private health care sector. There is a wide variety of NGOs working in Pakistan today - according to one estimate, more than 500 NGOs work in health and health-related thematic areas[61] (See Appendix 4 for complete list).

Most of these organizations have cropped up in recent times. Many are registered under government acts such as the Societies Registration Act (1860), the Charitable Endowments Act (1890), the Voluntary Social Welfare Agencies (Registration and Control) Act (1961), and the Companies Ordinance (1984). A substantial number of health NGOs are also non-registered entities.[62]

Health NGOs in Pakistan have been traditionally associated with ethnic or religious communities (e.g., the Aga Khan Foundation), philanthropic associations (e.g., the Marie Adelaide Leprosy Centre) and foundations (e.g., the Edhi Foundation). Moreover, their area of focus has been largely restricted to urban areas whereas rural populations have been relatively marginalized. according to a survey carried out in 1988, 97 out of 106 hospitals run by NGOs were located in urban areas[63]. This geographical bias is maintained to this day. Not only are the majority of health NGOs located in urban areas, but they also tend to be more organizations based in the more developed provinces of Punjab and Sindh as opposed to Balochistan and NWFP[64].

"In 1990, a survey revealed that out of all the NGOs working in the health sector, 123 were located in Punjab, 111 in Sind, 16 in Balochistan and 4 in NWFP[65]".

Today, even though the absolute number of health NGOs have increased in all provinces, this provincial bias is maintained. (See note on prominent NGOs in Balochistan on the next page.) With regard to institutional forms and variations, health NGOs again demonstrate a wide variety. According to the World Bank they may be

[56]Social Policy and Development Centre. (1999)
[57]Social Policy and Development Centre. (2000)
[58]Humera Iqndar, Feb 07, 2003 Health Care Privatization in Pakistan in Zeus
[59]Haya Al-Mani 2000 "Health insurance for Kashf clients: A framework for Project Analysis"
[60]Non-governmental organizations and their partnerships with the government is the main focus of Chpts 2-3.
[61]Guide to NGOs in Pakistan (2004)
[62]Ibid
[63]Ibid
[64]Ibid
[65]Ibid

Table 15: List of private hospitals in Pakistan

Islamabad (Capital Territory)	Punjab	Sindh	
- Islamabad International Medical Complex - Shifa International Hospital	- Al-Shifa Trust Eye Hospital, Rawalpindi - Aziz Bhatti Hospital, Gujrat - Bahawal Victoria Hospital, Bahawalpur - The Children's Hospital, Lahore - Fatima Medical Centre, Multan - Faisal Hospital, Jhelum - Fauji Foundation Hospital, Rawalpindi - Hameed Latif Hospital, Lahore - Healers Centre (Pvt.) Ltd., Rawalpindi - Maryam Memorial Hospital, Rawalpindi - Medicare Hospital, Multan - Mian Muhammad Trust Hospital, Faisalabad - National Hospital, Faisalabad - Rasheed Hospital, Lahore - Razzaq Hospital, Lahore - Saahil Hospital, Faisalabad - Sadiq Hospital, Sargodha - Salamat Hospital, Gujranwala - Sharif Medical City Hospital, Lahore - Valley Clinic (Pvt) Limited, Rawalpindi - WAPDA Hospital, Lahore	- Abbasi Shaheed Hospital, Karachi - ABM Hospital, Hyderabad - Aga Khan Hospital, Hyderabad - Aga Khan University Hospital, Karachi[5] - Bantwa Memon Hospital, Karachi - City Care Hospital, Hyderabad - Civil Hospital, Karachi - Dar-ul-Sehat Hospital, Karachi - Hamdard University Hospital, Karachi - Health Care Hospital, Karachi - Hilal-e-Ahmar Hospital, Hyderabad - Ibne-Sina (Avicenna) Hospital, Karachi - Imam Clinic and General Hospital, Karachi - Isra University Hospital, Hyderabad - Jinnah PMC, Karachi - Karachi Adventist Hospital, Karachi - Kharadar General Hospital, Karachi	- Kiran Hospital for Nuclear Medicine, Karachi - Kusiana Memon Hospital, Karachi - Liaquat National Hospital, Karachi - Liaqat University of Health Sciences, Hyderabad - Liari General Hospital, Karachi - Majee Hospital, Hyderabad - OMI Hospital, Karachi - Patel Hospital, Karachi - PIMS Hospital, Rawalpindi - Safee Hospital, Karachi - Shilokh Mission Hospital, Jalapur Jattan, Gujrat - SIUT, Karachi - South City Hospital, Karachi - TABBA Heart Institute, Karachi - Wapda Hospital, Hyderabad
NWFP			Balochistan
- Al-Khidmat Hospital, Peshawar - Al Ishaq Hospital, Abbottabad - Gulshanara Maternity Clinic, Kohat - Health Care Centre, Peshawar - Hira General Hospital, Abbottabad - Khattak Medical Centre & Hospital, Peshawar - Mardan Surgical Hospital, Mardan - Medicare Hospital & Maternity Home, Kohat - Orthopedics & Surgical Hospital, Peshawar - Rehman Medical Institute, Peshawar			Data not available

Source: Wikipedia. (2005)

Balochistan

Balochistan ranks the lowest in terms of human development among all regions of Pakistan[3]. The province still has the lowest life expectancy (57 for men; 56 for women in 2000). Nutritional status of infants and the infant mortality rate have not improved over time. Most women do not use any method of fertility regulation, while access to family planning services, particularly in rural areas, is difficult[4].
According to the IUCN, the NGO sector could contribute usefully towards Balochistan's social development, given its vast geographical area and limited accessibility.

Prominent NGOs working on health/ health-related themes in Balochistan:

- Balochistan Rural Support Program
- Development Association of Youth
- Environment Foundation Balochistan
- Family Planning Association of Pakistan
- Oxfam
- Pak Public Development Society
- Strengthening Participatory Organization
- Tanzeem Idara Bahali-e-Mustehqeen
- Trust for Voluntary Organizations

Work by Balochistan NGOs according to health-related thematic areas

Health and Nutrition	7%
Family Planning/Population Welfare	5%
General Social Welfare	5%
Rehabilitation of Drug Addicts	4%

Source: Balochistan Conservation Strategy 2000. (IUCN)

[3]IUCN (2000)
[4]Ibid

categorized as:

- Umbrella organizations, which offer other NGOs funding for investments in the health sector (e.g., the Pakistan Voluntary Health and Nutrition Association [PAVHNA])
- Broad-based multi-sectoral organizations having primary health care as one of their areas of operation along with a host of other areas (e.g., the National Rural Support Program [NRSP])
- Organizations initiated by health practitioners dealing specifically in health care (e.g., the Health and Nutrition Development Society [HANDS], the Aga Khan Health Services [AKHSP]).
- Organizations established for a specific purpose within the health sector (e.g., societies set up for the welfare of the disabled, such as) Dar-ul-Rehmat Development Association for Promotion of Health and Disabled)
- Organizations established with a principal aim of setting up specialized hospitals for treatment of the poor (e.g., the Shaukat Khanum Memorial Hospital).[44]

5.1.4 Public Private partnerships

The private sector is also being drawn into operating within the public health sector through a series of mechanisms. One of the most influential, in terms of redefining public and private sector relationships, are public-private partnerships (PPPs). The latter cover a wide range of possible relationships, from contracting the private sector to supply goods (e.g. drugs) or services (e.g. cleaning), to arrangements where a private company may manage a public hospital or finance a new hospital *in return for a long-term concession to* provide services. PPPs may also include private universities collaborating with the government.

In Pakistan, there is an emerging consensus among policy-makers that NGOs in particular can play a critical role in the delivery of social sector services by forging closer links with the public sector. The skepticism which was typical of the government's attitude towards partnerships with NGOs is considerably mitigated in this new policy environment, except where the government is wary of the political connections of these organizations[45]. This moderation of outlook is partly due to the government's recognition of its own failure to meet the health requirements of the entire population.

According to the World Bank[46], the pre-requisites for a successful public-private partnership are the presence of synergy between the partners, strong leadership, shared objectives, successful coalition building, appropriate changes in the structure of governance, a proper legal framework and built-in safeguards.

5.2 Key issues in the private sector:

i. The biggest policy issue relating to the private health sector in Pakistan relates to a lack of regulation. Private sector pharmacies often tend to be poorly regulated and inadequately staffed with unskilled personnel. Private health institutions often lack well-defined legal frameworks or self-regulatory networks. There is also no obligation on private hospitals to obtain licenses or certification before operating.
There is thus a dire need to ensure that at least a certain minimum quality of medical care is being provided by the private sector, especially where the clientele consists chiefly of underprivileged households.

ii. Despite trends to the contrary, the private sector is not sufficiently integrated into public health planning. As noted above, the private sector is crucial and health policy cannot be limited to the public sector alone.

iii. The increasing commercialisation of health care leads to health care being seen as a service that can be bought and sold; not as an essential right for the population. This philosophical shift, may have adverse effects on the most marginalized sections of Pakistani society, who frequently cannot afford to 'buy' health services.

In some developing countries, one woman in ten dies from a pregnancy-related cause over the course of her child-bearing years.
In industrialized countries, the chances average around one in 4000.

Source: Joint Statement by WHO, UNFPA, UNICEF and World Bank

[44]World Bank (1994)
[45]'Pakistan: Improving Social Sector Delivery Systems for the Poor: Review of the Primary Health Sector' (Background paper for the Pakistan Poverty Assessment) Prepared by the World Bank. 1994
[46]Ibid

Pakistan: Scaling Up Rural Support Programmes (2004)*

Pakistan's Rural Support Programme (RSP) movement pioneered bottom-up, community-driven development using a flexible, autonomous, politically neutral approach, which has been replicated successfully. RSPs mobilize and organize communities to stimulate more effective demand for better public goods and services, foster important linkages between the communities and service providers, and at times directly supply services. The establishment of core capital funds provides RSPs with a basis for sustainability and helps them retain autonomy. Over the long run, these programmes show a substantial, direct impact on poverty reduction and per capita income growth with indirect improvement in education and health. RSPs have also had significant influence on approaches to local governance, and the adoption of microfinance and community-owned infrastructure as mainstream development strategies.

The movement began in 1982 in remote, poor, and sparsely populated rural districts and gradually expanded to include larger districts and even some work in poor urban communities. Today the RSPs work with more than 43,000 community organizations that have more than one million member households. Expansion happened not by scaling up the work of a single organization but through setting up autonomous RSPs, working in different geographical areas, that replicated the RSP approach but had the advantages of being smaller and more adaptable to local needs and conditions.

Faced with high poverty levels and inadequate service delivery, especially for the poor, stakeholders in government and civil society began to seek development solutions outside the public domain. In 1982 the Aga Khan Rural Support Programme (AKRSP) was established in the Northern Areas of Pakistan. It acted as a catalyst for rural development by organizing communities, working with them to identify development opportunities and promoting the provision of services needed to tackle the specific problems of high mountain regions. Through the combination of direct service delivery and indirect influence on the policies and working of public and private sector players, AKRSP showed remarkable results in a short period of time.

AKRSP focused on building up the long-term asset base (physical, human, social, and financial) of rural households on an equitable basis, both directly through its own interventions and indirectly through improving the efforts of government and the private sector. It was through the rapid accumulation and better distribution of such resources that economic growth in the Northern Areas directly translated into reductions in poverty levels and improved the share of the lowest income groups. The demonstrated effectiveness of the approach attracted local and international attention and other rural support programmes were established, beginning in 1989. In 1992 the government of Pakistan showed an interest to support the countrywide replication of the RSP model. This culminated in the creation of the National Rural Support Programme (NRSP).

The economic impact of the work of RSPs is best captured from the work of the oldest RSP. Data from the districts in which the AKRSP works show that incomes were less than one-third of the national average in 1991, rising to more than half of the national average in 2001. While national economic growth slowed considerably in the 1990s, the Northern Areas economy experienced an impressive growth in per capita income of 84 percent from 1991 to 2001. The incomes of village organization member households were found to be 15-20 percent higher than those of non-members. There is also evidence of significant improvements in health and education outcomes. What the RSPs have been able to do better than any other large-scale development effort has been to organize poor people and enable them to be included in mainstream development opportunities.

The RSP movement has also had an impact on development policies and practices in the country. Today's widespread acceptance of the importance of community-driven development, the growth of community infrastructure as an important means of poverty reduction, and the growth of the microfinance sector were influenced by the RSP model. Much of what the RSPs have tried to do over the past twenty years is reflected in the commitments made by the government in the recently approved Punjab Rural Support Programme, Sind Rural Support Organization, and a planned RSP for Azad Jammu and Kashmir.

Several factors have driven the scaling up process. First, the existence of an effective model, developed in the field, that clearly demonstrated effectiveness at a grassroots' level made it possible to sell the model to government, donors and-importantly-to other poor communities.

Second, the RSPs consciously maintained a non-confrontational approach with government and other stakeholders. Advocacy for change was important, but it was done through demonstrating practical, useful results at the community level. Third, during the 1990s several key opportunities to expand the RSP movement were seized where government provided funding directly to begin a new RSP. The alignment of interests required to do this did not materialize often, but each opportunity was crucial to the growth of the movement. Fourth, although the government was instrumental in supporting the growth of the movement, it did not try to control the RSPs it established and instead set them up as independent, self-governing organizations with control over their own decisions and financial resources. Lastly, while the government initially expected the work of these RSPs to largely complement and help improve the delivery of social sector services, the government did not interfere when RSPs took on roles that went well beyond those initial expectations.

Factors related to institutional innovation and learning also affected the scaling up of the RSP movement. The key to expansion was the social mobilization

approach, the antithesis of the top down blueprint approach to development that was widely practiced until recently. The RSP approach fosters community organizations able to deal with a wide range of issues, not just one specific problem or sector. Reducing poverty requires the flexibility to adopt a holistic approach using multiple interventions. The main lessons that emerge from the RSP movement are:

- It was essential to have organizations to support communities in the process of community-driven development, and it works best if these support organizations are autonomous of government and have some independent means of sustaining themselves.
- Complementing and supporting government, private sector, and civil society initiatives to reduce poverty and improving service delivery can leverage limited resources for greater effect.
- Scaling up through a process of replication, rather than expansion, provides advantages in terms of local ownership and support as well as adaptation to local needs and opportunities.
- Impact requires consistent effort over time. In the case of the RSPs this meant at least ten years of concerted effort at the grassroots level before results began to be visible.
- People count. A few people have played key leadership roles in sustaining and spreading the core values of the movement, but it was important from the beginning to allow many opportunities for leadership to emerge, rather than remain dependent on very few people.

*This is an excerpt taken from a case study from 'Reducing Poverty, Sustaining Growth – What Works, What Doesn't, and Why - A Global Exchange for Scaling-up Processes'. Shanghai, May 25-27 2004

iv. There are three major problems that can arise with public-private partnerships and private finance initiatives. It may affect the quality of the services delivered; pay, terms and conditions for workers; and it may neutralise any "incentive" for the private sector to be efficient"[3].

5.3 Conclusion

The national health care system of Pakistan is in a period of change. The public health sector faces a plethora of challenges which does not allow it to fulfill the demand for health care in the country. In line with global trends, the Pakistani government is increasingly cognizant of the importance and relevance of the private sector. This means that the role of the government is not merely to be a 'provider' but also to be an 'enabler' for the private sector, often relinquishing direct control over providing health care services and taking on a coordinating and in some cases, regulatory role.

The private health sector is burgeoning in Pakistan in the form of a variety of institutional and financial arrangements including public-private partnerships. NGOs constitute an important part of this landscape. We will go on to investigate the role of NGOs in more detail in the subsequent chapters.

[3]Changing health care systems in Asia, Jane Lethbridge, Senior Research Fellow Public Services International Research Unit (PSIRU), University of Greenwich, 10 December 2004

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Appendix 1
Asia/Pacific Trends-ADB 2005

1. The demographic transition:

Improvements in health (with consequent increases in life expectancy) and declining fertility in all the DMCs mean that the proportion of elderly will rapidly increase in the coming years. The proportion of the population that is over 60 years old will increase from 7.5 percent in 1990 to almost 12 percent in 2020, and the absolute number will increase from 200 million to 455 million. This rapid increase has important implications for the health policies of the Bank and its DMCs. Much of the disease burden among the elderly results from chronic, noncommunicable diseases that are difficult and expensive to treat. Indeed, almost all the shift toward noncommunicable diseases that will occur between 1990 and 2020 will be due to demographic changes.

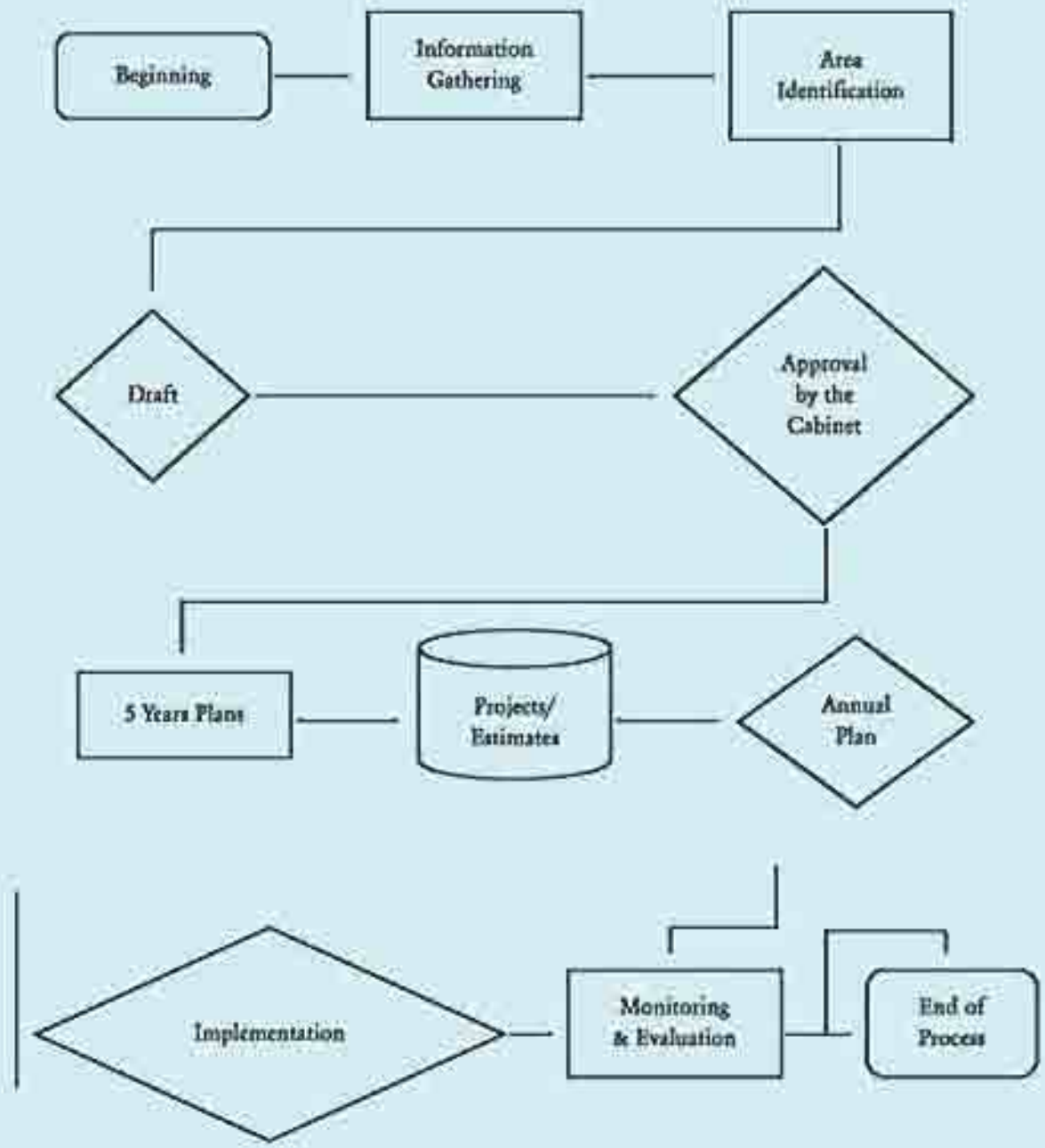
2. Urbanization:

Over the next three decades, the urban population of the region is expected to increase dramatically from 1.2 billion in 1995 to 2.5 billion in 2025 and more than 400 million will reside in cities of 10 million or more. Available data from household surveys indicate that, on average, urban populations enjoy better health status than those in rural areas. For example, in Papua New Guinea, the IMR is 34 per 1,000 live births in the cities but 87 in the countryside, a pattern that is observed in all the countries in the region. However, this simple type of analysis hides the large disparities that exist between income classes. A study in Manila showed that the IMR was 2.8 times higher in a slum area than for non-squatter areas. Hence, the urban poor suffer from health conditions that are significantly worse than simple rural/urban comparisons suggest.

Appendix 2
The Government's Planning Process

Health policy is formulated in the Federal Ministry of Health and at the Planning Commission, whereas planning and implementation rests with the provinces. Responsibilities are now further delegated under the current political set-up of decentralization. The policy process is centered around the Ministry of Health. Initial information is collected by the Ministry of Health from the government's Biostatics Unit and Health Management Information System (HMIS). After this, preparatory meetings are held where all the provinces are represented. Key areas are identified, on which consensus is developed and the first draft is prepared. This draft is sent to the Planning Commission and the Ministry of Finance where consultations take place and the draft is then finalized. The final draft is sent to the Cabinet which gives its approval after discussion. A five-year plan is formulated based on this policy document. Subsequently, projects are designed and Public Sector Development Programmes (PSDP) are developed. The provincial governments bear the responsibility for implementation as well as monitoring and evaluation. (Lashari and Karim 2004).

Flow Diagram : Health policy process



Source: Ministry of Health, Government of Pakistan

Appendix 3
India

There have been extensive changes in the Indian healthcare system in the past twenty years, which have resulted in a greater involvement of the corporate sector in healthcare provision. In the 1990s several state level governments restructured their secondary level hospitals with support from World Bank loans. The funds have been used to renovate buildings, and purchase equipment and drugs. Part of the restructuring introduced user fees, to provide a source of revenue for the secondary level hospitals[i].

The corporate sector experienced growth during the 1980s but this was unevenly distributed among the states. In 1973, 22.3% of total hospitals' beds were in the private sector but by the early 1990s, this had increased to 37%[ii]. About 65% of private sector beds are now in urban areas. The largest part of the private sector consists of individual private practitioners both trained and untrained, who are based in both urban and rural areas. Nursing homes and hospitals are generally in the urban areas and owned by one owner or a partnership.

There has also been an increase in imports of medical technology. By 1998 several multinational companies had set up units to manufacture medical equipment, for example, ultrasounds and scanners. Multinational companies either operated alone or set up joint ventures with Indian companies. There was no public sector provision of equipment. Few limits were placed on the import of equipment and the only government requirement was that private hospitals importing equipment should provide some services free of cost to low income patients[iii].

The Apollo Group set up the first corporate hospital in 1987 in Chennai. Large business groups, for example, the Tata Group, involved in hospital provision before then had set up trusts which could benefit from charitable status rather than establish corporate entities. The Apollo Group first involved non-resident Indian doctors into medical care investments. Governments provided subsidised land and duty free import of medical equipment.

The costs of healthcare in the corporate owned hospitals have increased and the costs of specific surgical procedures are often twice that of a smaller hospital or nursing home. The increased costs are partly due to the costs of imported equipment. The rising costs of corporate care have led middle and upper income groups to demand access to health insurance schemes that will cover the cost of health care[iv].

The development of the insurance sector has also been an important step in the continued privatisation of healthcare. In 1999, an insurance bill was approved which has encouraged some foreign companies to enter into joint ventures with domestic companies. However, there has still been a requirement for companies to invest a certain amount of capital, which has acted as a barrier to entry into the Indian market for many foreign insurance companies. There is still no effective system of regulation for either hospitals or health insurance companies.

[i] Baru R. (2000) Privatisation and Corporatisation
[ii] ibid
[iii] ibid
[iv] ibid

Appendix 4

The following is a list of main NGOs working in Health and Health-related thematic areas in Pakistan. The list has been compiled from the websites, www.sedc.org.pk and www.net-ngo.com. It is important to note that the list does not constitute a totally exhaustive database on the number of NGOs participating in the health sector in Pakistan: certain active NGOs might have been excluded on grounds of being non-registered, while several other social sector NGOs (such as some educational NGOs which also have health agendas) have been left out because their main target area is not health.

1. Association of Business, Professional & Agricultural Women Pakistan
2. Aagahi
3. Aaghosh
4. Aahung
5. Aas
6. Aashayana Welfare Society - AWS
7. Aashiana Welfare Organization - AWO
8. Aashiana Women Development - AWD
9. Ababeel

10. Abbasia Education and Welfare Society
11. Abbottonians Medical Association - AMA
12. Adara-e-Tehqeeq-ul-Advia
13. Afzaal Foundation
14. Afzal Jahan Memorial Social Welfare Trust International
15. Aga Khan Health Services, Pakistan - AKHSP
16. Aghaz-e-Zindagi
17. Ahsas Welfare Organization
18. Ahsas Welfare Trust - AWT
19. AIDS Prevention Association of Pakistan - AIDSPAP
20. Akhuwat
21. Al-Raheem Welfare Foundation
22. Al-Asif Foundation
23. Al-Asr Development Organization - ADO
24. Al-Faisal Welfare Society
25. Al-Falah Health Organization - AHO
26. Alfallah Welfare Organization - AWO
27. Al-Hayat Welfare Centre
28. Ali Organization for Development, Multan - AOFD
29. Ali Zaib Foundation
30. Al-Khair Development Organization, Gujrat
31. All Pakistan Women Association - APWA
32. All Pakistan Women Association NWFP - APWA (NWFP)
33. AL-Madad Falahi Tanzeem
34. Al-Meharan Rural Development & Welfare Organization - AMRDWO
35. Al-Nisa
36. Al-Noor Foundation - ANF
37. Al-Noor Welfare Council
38. Alpha Foundation - Alpha Family
39. Al-Qadir Foundation
40. Al-Qasim Foundation - AQF
41. Al-Sahara Welfare
42. AL-Shaoor Welfare Association
43. Al-Zain Trust - ZCCS
44. Aman Foundation Peshawar - AFP
45. Angela Lewis Human Development and Child Care Foundation - ALHDCCF
46. Anjman-e-Falah-e-Kawateen - AFK
47. Anjuman Falah-e- Niswan - AFN
48. Anjuman Falah-o-Behbood Shaikhani Bazaar
49. Anjuman Islah-e-Moashra - AIM
50. Anjuman Ittehad Nojowanan - AIN
51. Anjuman Nawjawanan, Charsadda - ANC
52. Anjuman Nowjwanan-e-Khidmat-e-Insaniat - ANKI
53. Anjuman Taraqi-e-Nuswaa - ATN
54. Anjuman-e-Khawateen - AKBFB
55. Asian Network for Social Utilization
56. Association for Development and Rehabilitation of Socially Handicapped - ADARSH
57. Association for Alleviation of Poverty & Illiteracy - AAPI
58. Association for Community Transformation - ACT
59. Association For Education, Environment And Training - AFEEAT
60. Association for Network for Community Empowerment - ACNE
61. Association for Rational Use of Medication in Pakistan
62. Association for Services of Humanity
63. Attock Sahara Foundation - ASF
64. Awami Committee for Development - ACD
65. Awaz-e-Khalaq
66. Awaz Welfare Organization - AWO
67. Azad Foundation - AZ
68. Azad Welfare Trust - AWT
69. Baanhn Beli
70. Badin Rural Development Society
71. Bahawalpur Social Development Program - BSDP
72. Baidarie
73. Bakhat Development Foundation
74. Bakht Social Welfare Association
75. Balkhi Memorial Foundation - BMF
76. Balochistan Institute for Future Development - BIFD
77. Balouch Flah-e-Marizan Society – BFM
78. Baltistan Health & Education Foundation - BHEF
79. Bannu Development Program - BDP
80. Basic Urban Services for Katchi Abadis - BUSTI
81. Basic Urban Rural Services & Training - BURST
82. Be Empowered Through Awareness & Knowledge - BETHAK
83. Beeas Foundation
84. Behari Welfare Trust
85. Behbud Association
86. Bhagh Bharee Society
87. Bismillah Welfare Society
88. Brilliant Welfare Society
89. Brisk Assistance for Rural Areas of the Nation - BARAN
90. Balochistan Social Development Program

91. Candle Welfare Society - CWS
92. Cooperation for Advancement, Rehabilitation and Education - CARE
93. Care and Kindness Society - CKS
94. Caritas
95. Center for Research and Equitable Development - CRED
96. Center for Sustainable Development Actions - CSDA
97. Centre for Health and Population Studies - CHPS
98. Chaudhry Ahmad Khan Bakhar Shaheed Memorail Welfare Trust International
99. Chenab Welfare Society - CWS
100. Chenab Welfare Trust - CWT
101. Child Care Foundation - CCF
102. Child Development Organization - CDO
103. Child Health, Education and Nutrition - CHEN
104. Children Cancer Foundation - CCF
105. Children's Education & Social Welfare Society - (CEWS)
106. Chinar Multipurpose Cooperative Society Ltd
107. Christ Changes the World Ministries
108. Citizen Welfare Council
109. Citizens' Commission for Human Development - CCHD
110. Citizens Welfare Association - CWA
111. City Welfare Society - CWS
112. Civil Society Human and Institutional Development - CHIP
113. Coalition on Rights and Responsibilities of Youth - CRY
114. Community Healer - CH
115. Community Appraisal and Motivation Program - CAMP
116. Community Care Concern - CCC
117. Community Development Concern - CDC
118. Community Development Foundation - CDF
119. Community Development Network Forum - CDNF
120. Community Development Network Organization - CDNO
121. Community Development Organization - CDO
122. Community Development Program - CDP
123. Community for Human and Nature Development - CHAND
124. Community Relief Organization - CRO
125. Community Support Concern - CSC
126. Community Uplift Program - CUP
127. Concern for Children Trust - CFC
128. Cornerstone Ministries Trust - CMT
129. Council of Human Shelter
130. Creative Rural Development Organization - CRDO
131. Creative Spirit
132. Credit and Welfare Association - CAWA
133. Cured Cancer Patients' society
134. Dad Foundation Pakistan - DFP
135. Daman Environment Protection Society - DEPS
136. Dar-ul-Rehmat Development Association for Promotion of Health and Disabled
137. DAUST Foundation
138. Dawn Welfare Society
139. Decent Human Rights Services - DHRS
140. Decent Welfare Society - DWS
141. DEEDS International
142. Development Association of Youth Balochistan - DAY
143. Development for Education, Environment, Population Welfare and Poverty Alleviation - DEEPP
144. Development for Education, Environment, Health and Training - DEEHAT
145. Development of Lasting Primary Health care in National Setup - DOLPHINS
146. Developmental Organization, Chuher Khel - DOC
147. Dhoraji Association
148. Dhoraji Memon Association
149. Disabled Rehabilitation & Independence Program - DRIP
150. Disciplines Aid Foundation
151. District Development Association, Tharparkar - DDAT
152. Dosti for All Welfare Foundation
153. Dua Health Project
154. Eagle Volunteer Social Welfare Association - EVSWA
155. Ecumenical Commission for Human Development - ECHD
156. Edhi Foundation
157. Fatima Jinnah Women, Educational, and Vocational Welfare Organization
158. Fatimid Foundation
159. Forehead Foundation Pakistan
160. Forum for Development Association - FFDA
161. Friends of Environment and Development - FOED
162. Friends Welfare Organization - FWO
163. Friends Without Borders - FWB
164. Frontier Development Organization
165. Frontier Primary Health Care - FPHC
166. Frontier Welfare Association - NGO
167. Gidroshai Institute for Social Development and Public Health - GISDAPH
168. Global Council of Pakistan - GCP
169. Global Development Program - GDP
170. Global Environmental Protection Organization
171. Global Foundation - GLOUN

172. Global Islamic Welfare Organization
173. Global Youth Organization - GYO
174. Global Organization for Human Empowerment and Rights - GOHER
175. Good Thinkers Organization for Human Development
176. Gorakh Development Welfare Organization
177. Green Circle Organization - GCO
178. Green Pak Welfare Society
179. Haq-ul-Mustaqeem Welfare Society
180. Haquqe-e-Insani Welfare Association
181. Hawa Welfare Society - HAWA
182. Hayat Memorial Hospitals Pakistan
183. Hayat Memorial Trust International Pakistan
184. Health and Nutrition Development Society - HANDS
185. Health Education and Literacy (HEAL) Trust
186. Health, Education, Livestock and Population Welfare Society
187. Health Oriented Preventive Education - HOPE
188. Health Welfare Association - HWA
189. Heartfile
190. Help Trust - HT
191. HELP Welfare Society
192. The Helpline Trust - THT
193. Hope Today
194. Hope Worldwide
195. Hospital Waste Management - HWM
196. House of Friends
197. Hujra Foundation
198. Human and Natural Resources Development Society - HNRDS
199. Human Development & Research Organization - HDRO
200. Human Development Council - HDC
201. Human Development Organization, Doaba - HDOD
202. Human Friends Welfare Association - HFWA
203. Human Guides - HG
204. Human Resource Development Network - HRDN
205. Human Rights Campaign International - HRCI
206. Human Rights Council
207. Human Rights Group of Pakistan - HRGP
208. Human Rights International Foundation
209. Human Rights, Orientation of Democracy, Poverty/Pollution, Education & Environment - HOPE International
210. Human Welfare Organization, Hangu - HWO
211. Humanitarian Movement International - HMI
212. Humanity International - HI
213. Humanity Welfare Organization - HWO
214. Hunch Welfare Foundation - HWF
215. Hygeia Foundation
216. Idara-e-Aaghosh
217. Idara-e-Taleem-o-Aagahi (Centre for Education and Consciousness) - (ITA)
218. Institute for Development Studies and Practices - IDSP
219. Imams Trust
220. Indus Development Action Research Organization, Mirpurkhas - IDARO
221. Indus Development Association, Balhreji - IDA
222. Indus Organization
223. Indus Resource Centre - IRC
224. Initiator Human Development Foundation - IHDF
225. Institute of Allied Medical Professions - IAMP
226. Institute of Social Research and Development - ISRD
227. Integrated Development, Empowerment and Advocacy for Livelihood Support - IDEALS
228. International Development Trust - IDT
229. International Human Rights Observer - IHRO
230. Islamic Relief
231. Islamic Relief Agency - Pakistan - ISRA
232. Jaago Development Society - JDS
233. Jesus Christ Trust Ministries
234. Jinnah Welfare Organization - JWO
235. Kalam Cultural Society
236. Karachi Administration Women Welfare Society - KAWWS
237. Karachi Primary and Reproductive Health Society - KPRHS
238. Karwan-e-Zindagi
239. Kashmir Welfare Society - KWS
240. Khadima Welfare Organization - KWO
241. Khairpur Development Society - KDS
242. Khalid Jaleel Welfare Trust (International) - KJWT
243. Khawra Development Organization, Muzaffarabad, Pakistan
244. Khidmat-e-Insaniat
245. Khwendo Kor Women and Children Development Program
246. Kinza Welfare Trust - KWT
247. Kohistan International Social Welfare Association - KISWA
248. Kot Radha Kishen Development Trust - KDT
249. Kurram Valley Rural Development Organization - KVRDO
250. Laar Development Association, Badin - LDA
251. Legal Assistance for Medical & Humanitarian Aid - LAMHA
252. Lasani Welfare Foundation - LWF

253. Lasoona - Society for Human & Natural Resource Development
254. Latif Social Circle - LSC
255. Leads International Organization
256. Legal Aid and Welfare Society - LAWS
257. Learn Implementation Fertility Environment - LIFE
258. Life Orthopedics
259. Light of Awareness for Fair Advancement of Mankind - LAFAM
260. Lotus Social Welfare Trust International
261. Lower Sind Rural Development Association - LSRDA
262. Makran Educational and Development Organization - MEDO
263. Makran Resource Center - MRC
264. Marie Stopes Society
265. Mashal-e-Rah
266. Maternal and Child Health Support Group
267. Maternity & Child Welfare Association of Pakistan - MCWAP
268. MediHelp
269. Mehran Social Welfare Association - MSWA
270. Meirman Women's Development Centre, Kohat - MWDC
271. Mera Ghar Welfare Association - MGWA
272. Mera Pakistan
273. Minhaj Welfare Foundation
274. Model Welfare Association - MWA
275. Mothers Trust
276. Movement and Action for Social Services - MASS
277. Movement of Awareness of Drugs and Diseases - MADAD
278. Mubashar Shaheed Foundation
279. Mughal Welfare Society - MWS
280. Mujahid-e-Awal Sardar Muhammad Abdul Qayyum Khan Educational and Developmental Foundation
281. Muslim Welfare Society
282. Nai Subha Organization - NSO
283. Najjat Trust
284. Narowal Rural Development Program - NRDP
285. National Rural Support Program - NRSP
286. National Services Trust - NST
287. National Social Organization - NSO
288. National Welfare Foundation - NWF
289. Natural Resource Protection Program
290. Naya Savera Welfare Organization - NSWO
291. New Hope
292. Nida-e-Asr Medical Welfare Association
293. Nindo Shaher Welfare Association - NSWA
294. Noken Sohb Social Development Society - NSSDS
295. Oasis Foundation Dadu
296. Omeed Development Organization - OMEED
297. Orangi Pilot Project - Research and Training Institute - OPP-RTI
298. Orangi Welfare Project (Trust) - OWP
299. Organization for the Development, Rehabilitation of Environment and Movement for Sustainable Development - DREAMS
300. Organization for Community Development - OCD
301. Organization for Participatory Development - OPD
302. Oxford Social and Educational Development Society Balochistan - OSAEDSB
303. Pak Chandni
304. Pak Community Development Program - PAK-CDP
305. Pak Development Organization - PDO
306. Pak Eagles Development Organization - PEDO
307. Pak Social Welfare Society - PSWS
308. Pak Welfare Society - PWS
309. Pakban Welfare Trust
310. Pak Hope
311. Pakistan Academy of Social Sciences - PASS
312. Pakistan AIDS Prevention Society - PAPS
313. Pakistan Blood Bank - PBB
314. Pakistan Christian Peace Foundation - PCPF
315. Pakistan Crescent Youth Organization
316. Pakistan Federation of Business and Professional Women - PFBPWO
317. Pakistan Health and Education Foundation - PHAEF
318. Pakistan Human Rights promoters - PHRP
319. Pakistan International Peace & human Rights Organization - PIPHRO
320. Pakistan National Circle Trust
321. Pakistan Rural Workers Social Welfare Organization - PRWSWO
322. Pakistan Society for Psychotherapy - PSP
323. Pakistan Society for the Welfare of Youth & Patients
324. Pakistan Voluntary Health & Nutrition Association - PAVHNA
325. Pakistan Welfare Council - PWC
326. Pakistan Women Network - PWN
327. Pakistan Young Facilitators Association - PYFA
328. Pakistan Young Help Movement - PYHM
329. Pakistan Youth Organization - PYO
330. Pakistan Youth Progressive Association - PYPA
331. Paragon Citizen Community Board, Pakpattan
332. Participatory Rural Development Program - PRDP
333. Participatory Village Development Program - PVDP

334. Patients' Welfare Association - PWA
335. Patients Welfare Society
336. Pattan Development Organization
337. Pehchan Foundation
338. Pehl Foundation
339. Peoples Development Organization - PDO
340. Phool Club, Multan
341. Phyze Welfare Society - PWS
342. Potwar Social Welfare Association
343. Pravalli Welfare Trust
344. Progressive Social Welfare - PSW
345. Progressive Efforts to Reform the Locality - PERL
346. Public Development Society - PDS
347. Public Welfare Society - PWS
348. Punjab Rural Support Program - PRSP
349. Qadir Foundation
350. Qandeel Social Welfare Society
351. Quaid-e-Azam Foundation - QAF
352. Raahein Welfare Trust - R W T
353. Rabia Khuzdari Educational & Social Society, Khuzdar - RESS
354. Rahnuma Foundation - RF
355. Raja Mubashar Shaheed Foundation
356. Raja Mubashar Shaheed Welfare Trust, Gujar Khan
357. Rajput Social Welfare Society
358. Rakshan Development Organization
359. Ramzan Aziz Memorial Trust - RAMT
360. Rannah Welfare Development Program
361. Rastah Foundation
362. Rawalpindi Eye Donors Organization - REDO
363. Regional Organization for Serving Humanity and Nature - ROSHAN
364. Rehber Foundation - RF
365. Rehman Foundation
366. Research Society of Human Genetics - RSHG
367. Rise Up - RU
368. Roshni Foundation - RF
369. Roshni Organization
370. Rural & Agricultural Development Foundation - RADF
371. Rural Development & Human Rights for Women, Bagra Haripur
372. Rural Development Foundation of Pakistan - RDF
373. Rural Development Organization - RDO
374. Rural Women Development Organization - RWDO
375. Sabra Khanum Foundation
376. Society for Awareness, Facilitation & Education - SAFE
377. Safe Hands
378. Sahar Foundation for Human Development
379. Sahkar Dost Welfare Association - SDWA
380. Saibaan Development Organization
381. Saifullah Foundation for Sustainable Development - SFSD
382. Samaaj Sudhaar
383. Sarhad Rural Support Corporation - SRSC
384. Sassi Foundation
385. Sutlej Development Organization - SDO
386. Save and Serve
387. Save Our World International - SOW
388. Sayah Welfare Organization - SWO
389. Scientific Education and Religious Communication House - SEARCH
390. Sewa organization
391. Shah Abdul Latif Bhittai Social Welfare Association - SALBSWA
392. Shahbaz Development Foundation Sakrand - SDF
393. Shahbaz Welfare Association - SWA
394. Shaheen Welfare Society
395. Shaheen Youth Society Pakistan - SYSP
396. Shahen Qabile Parmakh Thag
397. Shama Development Organization - SDO
398. Shehri Ijtamai Tarqiati Council - SHATAC
399. Shelter for Ailing Human Beings Welfare Organization - SAHBWO
400. Shelter Welfare Trust
401. Sind Agricultural and Forestry Workers Coordinating Organization - SAFWCO
402. Sind Cultural Development Association
403. Sind Development Society - SDS
404. Sind Graduates Association - SGA
405. Sind Human Welfare Organization, Sanghar
406. Sind Journalists' Network
407. Sind Rural Development Program - SRDP
408. Sind Society for Research and Development
409. Sind Successful Partners Organization
410. Sind Welfare Development Organization, Sanghar
411. Skyian Welfare Organization
412. Sharifa Bibi Memorial Hospital - SMH
413. Social Advocacy Development and Awareness Foundation
414. Social Awareness Development Active Forum - SADAF

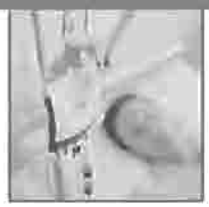
415. Social Development Forum
416. Social Development Services
417. Social Mobilization Society - SMS
418. Social Organization for Health and Education, Bolida - SOHEB
419. Social Organization for the Advancement of Community Health - SOACH
420. Social Relief & Development Services, Chitral - SRDSC
421. Social Welfare & Community Development Society - SWCDS
422. Social Welfare & Health Society - SWHS
423. Social Welfare Organization for Rural Development - SWORD
424. Social Welfare Society
425. Social Youth Council of Patriots - SYCOP
426. Society for the Advancement of Community, Health, Education & Training - SACHET
427. Society for Advancement of Education, Welfare and Agro-ecological Knowledge - SAEWAK
428. Society for Education & Development - SED
429. Society for Integrated Development - SIRD
430. Society for Public Awareness & Development Economy - SPADE
431. Society for the Protection of the Rights of the Child - SPARC
432. Society for the Service of Humanity - SFSH
433. Society of Surveillance - SOS
434. Socio-Cultural &Educational Welfare Association - SCEWA
435. Sustainable Poor Integrated Development Association - SPIDA
436. Sultana Foundation - SF
437. Sunehrey Din - SD
438. Sungi Development Foundation
439. Sunshine Welfare Center
440. Sustainable Development Concern - SDC
441. Sustainable Development Policy Institute - SDPI
442. Swat Youth Front - SYF
443. Tuberculosis Association, Charsadda - TBA
444. Takmil-e-Aas Welfare Association
445. Tameer-e-Millat Society
446. Tamir Welfare Organization
447. Tanzeem-Al-Fallah
448. Taraqee Foundation - TF
449. Taraqee Trust
450. Tash Development Organization
451. Taxalian
452. Thardeep Rural Development Program - TRDP
453. The Friends
454. The Knights Inspirational The Legends Society
455. The Prudents
456. The Reformers (Women)
457. The Solver
458. Tobian Development Council
459. Town Foundation
460. Trodden's Clarion Receptors Development Organization - TCRDO
461. Trust for Village Development
462. Tulip Organization
463. Ujala Foundation - UF
464. Ujala Social Welfare Organization
465. Unar Social Welfare Association
466. United Christians Organization - UCO
467. United Global Organization of Development - UGOOD
468. United Welfare Organization
469. United Welfare Society, Latamber Karak - UWSLK
470. Universal Community Development Organization - UCDO
471. Village Youth Social Welfare Organization
472. Village Development Association
473. Village Welfare Association - VWA
474. Villager's Association for Rural Integral Services - VARIS
475. Voice Human Rights Foundation
476. Wali Welfare society - WWS
477. Well Wisher foundation
478. Welfare Society, Mashkel
479. Welfare Society, Nowshera - WSN
480. Woman Welfare Society - WWS
481. Women Assistance Association - WAA
482. Women Education & Development Association - WEDA
483. Women Empowerment, Literacy and Development Organization - WELDO
484. Women Entreprenuership & Development Organization - WE&DO
485. Women's Awareness for Networking and Development - WAND
486. Young Chinar
487. Young Men's Christian Association
488. Young Welfare Association, Deh Sohu - YWADS
489. Young Women Christian Association - YWCA
490. Youth Anti Narcotics - YAN
491. Youth Commission for Human Rights - YCHR
492. Zainab Sharif Trust
493. Zarar Shaheed Trust - ZST
494. Zohra Foundation

Findings

The Survey Findings: Nature of NGOs Involvement in Health Care in Pakistan

Gulzar Shah





The Survey Findings: Nature of NGOs' Involvement in Health Care in Pakistan

1. Introduction

The purpose of this chapter is to provide insights into the nature of the involvement of NGOs in the health care system of Pakistan, using primary data collected from 71 health NGOs from the four provinces of Pakistan.

In Pakistan the public sector has been the chief supplier of physical infrastructure and manpower while the private sector is the main supplier of medicines and other health care supplies (Hussein, 1994). NGOs are acknowledged to be among the major political players influencing the functioning of health care services. Other players include:

> 'the international donor agencies, recently elected central, provincial and local governments, professional wings of political parties, professional bodies, ... and philanthropists' (Karim et al., 2004:83-84).

This report hopes to further the understanding of the nature of NGOs involved in the health sector in Pakistan. There are no readily available data sets on NGOs in Pakistan and this has meant that where there are some detailed case studies of individual health NGOs and sometimes of smaller focused sectors, there is no in-depth analysis of such NGOs at the macro level. The aim of this chapter is to fill this gap and to assess the extent and the nature of NGOs' involvement in Pakistan's health sector, in order to gain understanding of their role, responsibility and the potential to provide or facilitate access to this basic social need.

2. The Research Design and Methodology

The data for this research was collected through postal-mail survey of 71 health NGOs in all four provinces of Pakistan. Surveys are a widely used method of data collection and are appropriate for determining characteristics of massive populations and groups. These attributes may include attitudes, opinions, behaviour, characteristics, expectations, and self classification, many of which are subjects of this particular study. A variety of survey techniques are used in social sciences, including mail, personal meetings, telephone, e-mail, and internet surveys or a combination of one or more of the above.

Our preference for the mail survey over other survey designs rests on the notion that, as opposed to the general public, NGOs have a better capacity to handle and respond to mail inquiries. However, it is typical of NGOs that they are generally under-resourced and any additional work such as completing surveys are relegated to the bottom of their priority list, which was likely to seriously hamper the response rate in our study.

Obtaining the sampling frame for the study was a daunting task. This is particularly so as there is no single, unified registering authority for NGOs in Pakistan. They can be registered as/under a variety of authorities and regulations including the Societies Act; Companies Act; trusts, social welfares and foundations. A unified list was created through all registering authorities. The target population for the study were all NGOs known to be involved in the provision of some health care service. Only those NGOs were included in the study that claimed to have health related activities as one of their primary concerns/activities. Using the sampling frame compiled for the study, 200 NGOs were sampled using purposive sampling, with preference given to NGOs with broader coverage and relevant activities. The primary instrument for the survey was a structured questionnaire with mostly closed ended pre-coded response categories. This is so because closed ended

questions not only standardise response categories for analytical comparisons but they also improve the item response rate. The questions focus on capturing basic information on NGOs' budget and personnel, their key programme components, their perceived accomplishments, and a perceived sense of future direction concerning health sector activities in Pakistan.

Along with the survey questionnaire a cover letter was attached highlighting the benefits of the study for the NGOs in order to attract the respondents' interest, and instilling a sense of relevance to the project to boost the response rate. An aggressive follow up via telephone and email was conducted for over a three month period. A total of 71 completed questionnaires were received, yielding a response rate of 35.5%. See Appendix 1 for a complete list of NGOs who completed and returned the questionnaire for this study. The collected survey data was transferred from the coded questionnaires to an electronic database form, using the Statistical Package for Social Sciences (SPSS). In the way of data cleaning, exploratory data analysis was performed in order to correct data entry errors.

NGOs not only provide services, but they are perhaps more effective in providing health education
(Khoja et al, 2000)

3. Findings

3.1 Basic Profile of NGOs

Involvement of NGOs in community health care is a recent phenomenon. Of the NGOs covered in the study, the first was established in 1953, the second in 1959, and the third in 1965. During the 1970s, three more NGOs in our sample were established. The growth of NGOs then started picking up in the 1980s.

A province-wise distribution of NGOs selected in the study appears in the table below.

Table 1: Frequency and percentage distribution of NGOs completing the questionnaires

Location of NGOs' head offices	Number	Frequency
Punjab	38	54.3
Sindh	16	22.9
NWFP	12	17.1
Balochistan	4	5.7
Total	70	100.0

In the 1980s and 1990s there was a massive growth of NGOs in Pakistan, and the same trend is reflected in the sample of NGOs involved in health. Over 62% of all NGOs in our sample were established in the 1990s as presented in Table 2.

Table 2: Frequency and percentage distribution of NGOs according to year of registration

Year established	Frequency	Percent	Cumulative Percent
1959 or before	2	2.9	2.9
1960-69	1	1.4	4.3
1970-79	3	4.3	8.7
1980-89	10	14.5	23.2
1990-99	43	62.3	85.5
2000-05	10	14.5	100.0
Total	69	100.0	

3.1.1 The legal structure

Most health care NGOs register under the Social Welfare Act and Societies Act; accounting for 56.3%, and 24% of the NGOs in our sample respectively. Other legal bases for the NGOs are shown in Table 3.

Table 3: Frequency and percentage distribution of sampled NGOs by legal status

Legal Structure	Frequency	Percent
Unregistered	2	2.8
Registered under Companies Act	2	2.8
Registered under Social Welfare Act	40	56.3
Guarantee Ltd. Company	1	1.4
Registered under Societies Act	17	23.9
Registered under Trust	1	1.4
Registered under Foundation	1	1.4
Voluntary Social Welfare Agencies Ordinance	1	1.4
Others/unknown	6	8.4
Total	71	100.0

3.2 Organisational Outreach/Partnerships

3.2.1 Area of Operation

The province-wise distribution of NGOs' operations is represented in Table 4. Of the NGOs surveyed, 57% had operations in Punjab, 36% in Sindh, 34% in North Western Frontier Province (NWFP), and 27% in Balochistan. One of the criticisms of the NGO sector is the urban bias and the roadside bias. Our sample, being a representative sample hints at the presence of development bias, meaning that NGOS are more likely to operate in the provinces that are more developed.

Table 4: Distribution of NGOs by area of operation

Province where NGO operates (multiple responses)	Frequency		Percent	
	Yes	No	Yes	No
Punjab	40	30	57.1	42.9
Sindh	25	45	35.7	64.3
NWFP	24	46	34.3	65.7
Balochistan	19	51	27.1	72.9
Total				

Figure 1: Percent distribution of NGOs' head offices province-wise

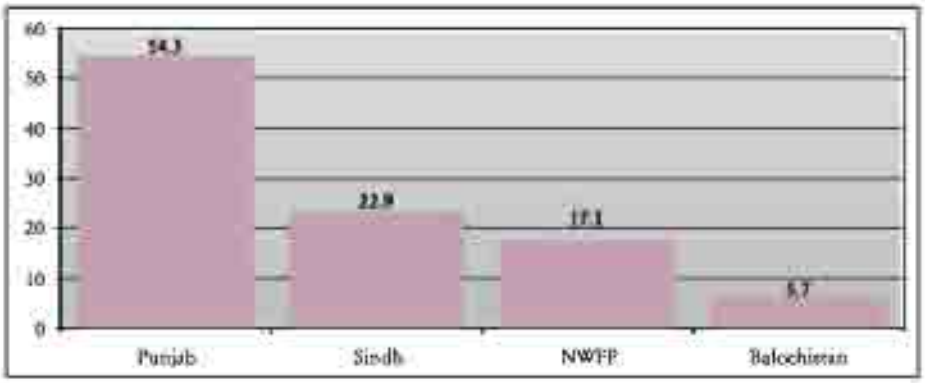


Table 5: Percentage distribution of NGOs by number of districts covered

Number of districts covered	Number of NGOs	Percent
4 or less	34	50.0
5 - 9	11	16.1
10-14	4	5.9
15-19	3	4.4
20-24	8	11.8
25-112	8	11.8
✓ 26	(1)	
✓ 34	(3)	
✓ 54	(1)	
✓ 101	(1)	
✓ 108	(1)	
✓ 112	(1)	
Total	68	100.0

As seen in figure 1, over half of the NGOs had their head offices located in Punjab, 23 percent in Sindh, 17 percent in NWFP, and 5.7 percent in Balochistan.

3.2.2 Scale of operation

One indicator of the scale of NGOs' operation is the number of districts covered. Exactly half of the NGOs covered were in five districts or less. About 16 percent were in 10 to 14 districts and only 3 NGOs were in 100 districts. Hence, the scale of most of the NGOs' operation is fairly small, limited to a few districts only. This is an important dimension of the profile of NGOs since they do not have the capacity or the desire to replace the government as the primary provider of the health care in Pakistan. See Table 5.

There was significant positive correlation between the time of establishment and number of districts covered. In other words, the older NGOs are more likely to cover more districts than the newer NGOs. This is evident from the correlation coefficient ($r = 0.279$; significant at alpha = 0.05) between the year of establishment and the total number of districts covered. See Table 6.

3.2.3 Public-Civil Society Partnerships

Public-private/civil society partnerships have acquired increasing importance in community development programmes and the health sector is no exception.

The popularity of the public-civil society partnership is evident from the prevalence of such partnerships among the NGOs involved in community health care. The results of our survey show in Figure 2, that nearly 8 out of 10 NGOs had some formal partnership with other NGOs or

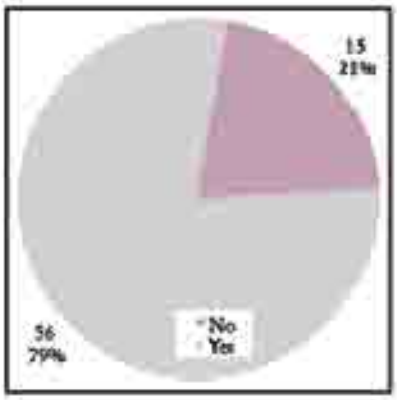
Table 6: Average number of districts covered by the year of establishment

Year of establishment	Average number of districts covered
1959 or before	58.00
1960-69	6.00
1970-79	8.00
1980-89	12.33
1990-99	14.21
2000-05	7.00
Total	13.89

with the government. The nature of such partnerships, however, varies across NGOs.

In the survey it was seen that NGOs (52%) are most likely to form partnerships with other NGOs. The least frequent partnerships were between NGOs and the government; only 38%, see Figure 4. Working with the government was not popular among health NGOs because of a myriad of barriers to such partnerships. The concept of partnership implies that partners have shared goals and responsibility, and mutual accountability. It is also seen that government agencies show the least interest in partnerships, and are rarely accountable to partnering NGOs, which defy the true essence of partnerships.

Figure 2: Distribution of health NGOs according to formal partnerships with other organizations



3.2.4 Nature of focus regarding area of intervention: single or multiple

Another defining characteristic of NGOs is their multiple theme focus regarding their areas of intervention. Since ability to accomplish grassroot mobilization is one of the NGOs' strengths, they rarely restrict themselves and their activities to a single type of community service. Our survey indicates that among the NGOs involved in health, only 30% focused exclusively on health as an area of intervention. The majority of the health NGOs, about 59% had more than two areas of focus. A small proportion, 11% had a dual focus, with health being one of them. This is represented in Figure 3.

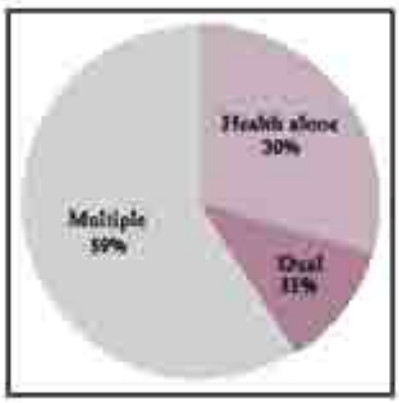


Figure 3: The percent distribution of NGOs involved in health by number of areas of intervention

3.2.5 Types of services provided

An important aspect of NGOs' role in community health is the nature of their interventions. They provide a wide array of services and the most frequently provided services are education and awareness to communities at household

Figure 4: Percent distribution of NGOs by the type of partnership with other organizations

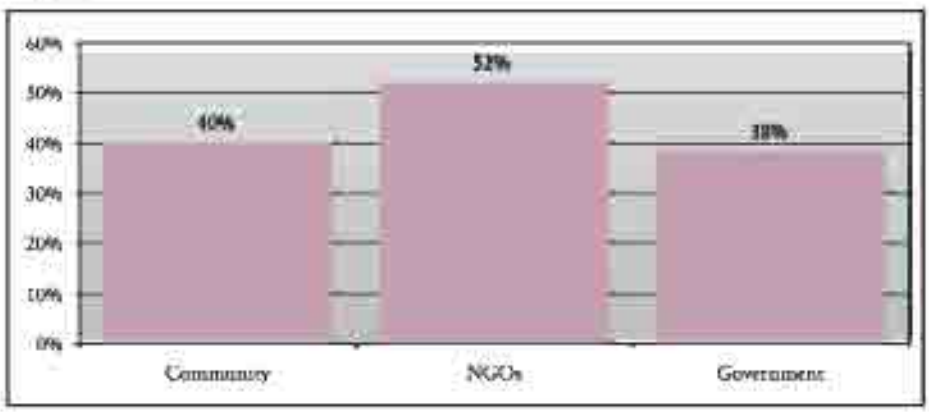
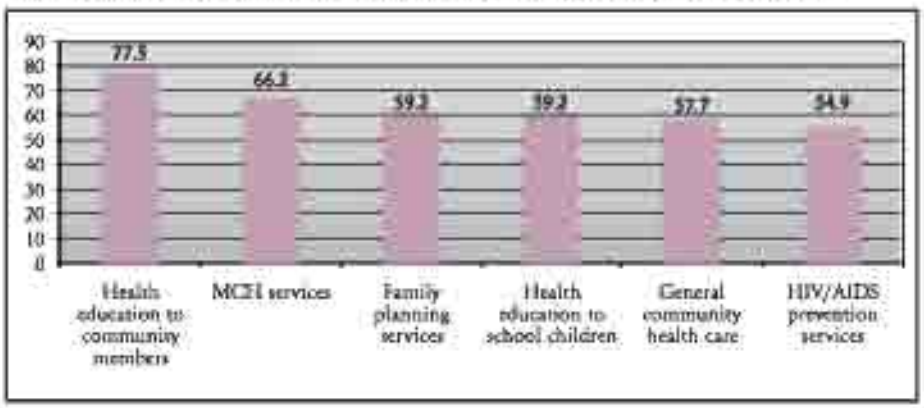


Table 7: Frequency and percentage distribution of NGOs by type of services provided

Type of Services Delivered	Response	Frequency	Percent
Maternal and Child Health (MCH)	No	24	33.8
services	Yes	47	66.2
Obstetric and Gynecology (OBGYN	No	44	62.0
services	Yes	27	38.0
Family planning services	No	29	40.8
	Yes	42	59.2
Sexual health services	No	36	50.7
	Yes	35	49.3
HIV/AIDS prevention services	No	33	45.1
	Yes	39	54.9
General community Health care	No	30	42.3
	Yes	41	57.7
Health education to school children	No	29	40.8
	Yes	42	59.2
Health education to community	No	16	22.5
members	Yes	55	77.5
Dental care services	No	61	85.9
	Yes	10	14.1
Eye care services	No	46	64.8
	Yes	25	35.2
Psychiatric services	No	60	84.5
	Yes	11	15.5
Minor surgeries/wound management	No	48	67.6
	Yes	23	32.4
Other preventative health services	No	35	49.3
	Yes	36	50.7
Check/monitor sale of spurious drugs	No	67	94.4
	Yes	4	5.6
Any other services	No	45	63.4
	Yes	26	36.6

Figure 5-A: Percent distribution of NGOs by the type of services provided

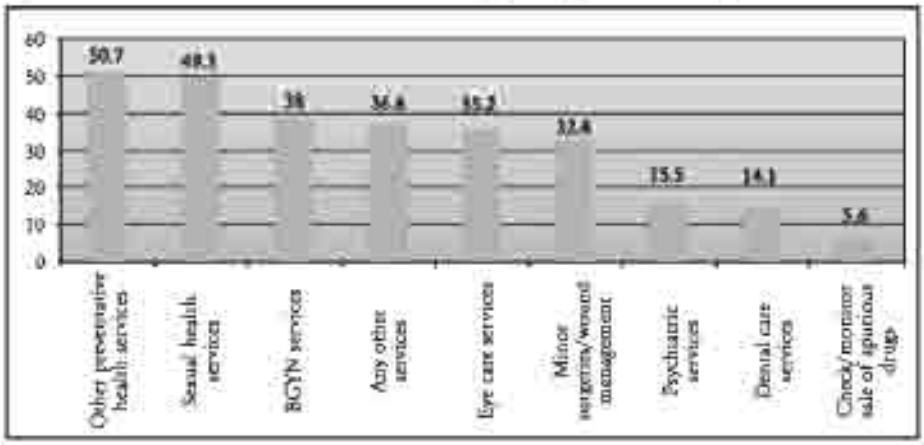


levels as well as in schools. This implies that health NGOs attach higher priority to prevention. The leading category was health education to the community (creating an awareness about preventative health, health rights, services etc.) with 77.5% NGOs providing this service. Over 59% of health NGOs reported providing health education to school children. This is shown in Table 7.

The other most frequently provided set of services was family planning services (59.2%), sexual health services (49.3%), obstetrics and gynaecology (OBGYN) services (38%) and general community health services (57.7%) as shown in Figure 5-A. Another significantly visible service area is HIV/AIDS preventive services with over 57.7% reporting to provide this.

Dental health is an area that has been given little attention by both NGOs and the government in Pakistan. Consequently, it is a common phenomenon for most Pakistanis to lose most of their teeth by the time they reach their late fifties. Dental cleaning and preventive check up services are neither available nor considered important. Barefooted doctors, quacks, and *hakims* have monopolized dental surgeries, constituting mostly of teeth removal procedures. Our survey shows that only 14.1% of NGOs have dental care services as their area of intervention, and is of the second lowest importance as reflected in Figure 5-B.

Figure 5-B: Percent distribution of NGOs by the type of services provided



The least frequent area of intervention was checking or monitoring the sale of spurious drugs with only 6.5% of NGOs involved in this activity. Quality and prices of pharmaceutical products do not undergo any kind of regulation in Pakistan and NGOs' involvement can help improve this situation.

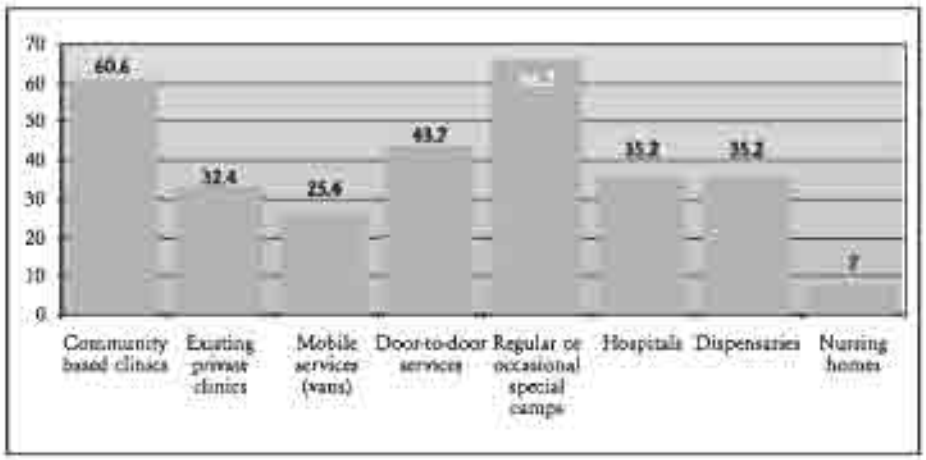
Psychological health and wellbeing of a population is just as important and vital to physical health. With rising consumerism, materialism and costs of living and sociological transformation due to increasing western and regional influences, Pakistanis are at a risk of greater psychological problems. Only 15.5% of NGOs are involved in this area of intervention. With a few exceptions of well-established NGOs, the nature of NGOs' activity focus is often funded driven.

3.2.6. Mode of services delivery

NGOs use a variety of service delivery modes. Regular or occasional camps were the most frequently used mode for delivering health care services. Over 66.2% of the NGOs reported conducting special camps. In line with NGOs' grass root level interest, community-based clinics were the next most frequently (60.6%) used means of providing health care services and providing services through door-to-door visits was approximately 44%.

Nursing home services, while more prevalent in developed countries, have the lowest priority in Pakistani health care systems, both public, as well as NGOs. Only 7% NGOs provided these services and the figure is likely to be exaggerated for lack of understanding of the term 'nursing homes'. In the developed world, nursing homes are used as formal,

Figure 6: Percent distribution of NGOs by the mode of services delivery



institutionalized living arrangements for the elderly where food, accommodation and health care are provided. Ironically, in Pakistan the family support for the elderly is gradually eroding away due to structural changes within the Pakistani family system which is shifting from a predominantly joint and extended family system to a more nuclear one. With the changing family structure, nursing homes would need to be essential for elderly care, and yet such facilities are neither available nor encouraged by Pakistani cultural and societal values.

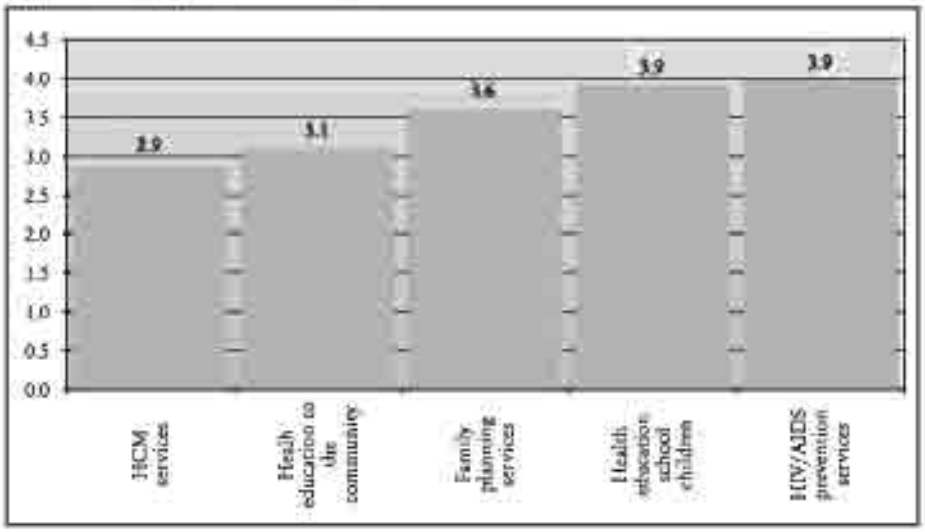
The clash of values, such as the conventional respect for the elderly versus the right to privacy, independence, consumerism etc., are all factors in unspoken neglect of the elderly and of possible abuse. Health NGOs need to plan ahead and realise future societal needs; they should build more nursing homes and promote an awareness regarding their existence and acceptability.

Interestingly, over 35% of the health NGOs sampled provided health care services through hospitals as well and the same proportion of NGOs used dispensaries as means of service provision. The distribution of NGOs by mode of services delivery is depicted in Figure 6 and highlights an important aspect of the nature of NGOs involvement in the Pakistani health care system.

3.2.7. Services that need attention

In order to capitalize on the NGOs' experience in recognising gaps in health care provision, respondents were asked to identify which services needed the most attention by ranking them from 1 to 5, with 1 being the services needing the most attention and 5 being the services needing the least attention. See Figure 7.

Figure 7: Average rank of services



Although over 66 percent of NGOs were involved in the provision of Maternal and Child Health (MCH) services, NGOs rightfully ranked MCH as one that needs the greatest attention in Pakistan. MCH is an important area of health care that has traditionally been known to comprise of an array of reproductive health preventative and curative services including services for and counselling on family planning and nutrition, contraceptive use, prenatal care, intrapartum (labour and delivery) care, delivery, and neonatal, postnatal, and family health care (Burke, 1977). More recently, comprehensive framework of services and indicators has been developed to guide and monitor MCH services (Dievler, Grason and Guyer, 1997).

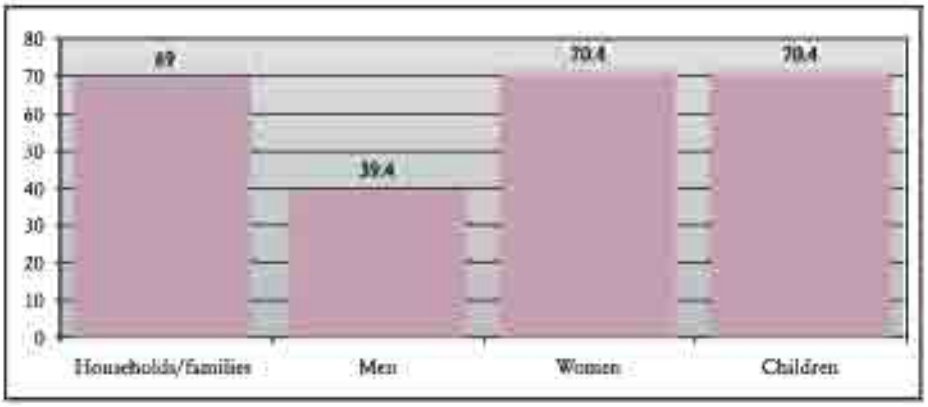
Unfortunately, in Pakistan, MCH services consist of a narrowly defined set of services, mostly curative in nature. For instance, studies have shown that prenatal care, an essential component of MCH is not a norm in Pakistan (Shah and Zaidi, 2005). A comprehensive study in all 34 districts of Punjab, based on a large sample of 30,932 households, noted that less than 43% of women with a live birth obtained prenatal care from a skilled health worker (Kogan et al, 1998 as cited in Shah and Zaidi, 2005). This leads to low birth weight births, complications of birth, and higher maternal mortality (Midhet, Becker and Berendese, 1998). Hence, the NGOs are right in identifying MCH as one of the areas needing greater attention.

Other services needing attention, in the order of importance, are health education to community, family planning services, health education to school children, and HIV/AIDS prevention services. Other studies have shown that providing family planning services, improving maternal health, and reducing morbidity throughout the life cycle are the main priorities identified in an accompanying study titled, Improving Women's Health in Pakistan (Tinker, 1998).

3.2.8. Target Beneficiaries

The type of beneficiaries targeted for interventions also reveal an important dimension of the NGOs' involvement in health care. Approximately 70% of NGOs considered women and children and entire families to be their targeted beneficiaries for intervention and less than 40% of the NGOs had only men as their beneficiaries. See Figure 8.

Figure 8: Percent distribution of NGOs by primary beneficiaries



3.3 NGO's support base, personnel, and direction of change

3.3.1. Size of NGOs' budget

The budget of NGOs reveal the organization's financial support base and stability and conveys the sense of the scales of their operations. The average size of the budget of the health NGOs sampled was Rs 40 million. Also seen was a striking variation in the size of the various NGOs' budget. Ironically, there was a considerable proportion (17.5%) of the NGOs which had an annual budget of less than Rs 20,000 and nearly 16% had an annual budget of over Rs 100 million. See Figure 9.

3.3.2 Sources of NGOs budget

The financial source of NGOs is an important factor in guiding their interventions. Their priorities primarily depend on financial support from international donors and are set by the donors, which sometimes creates a disparity and even a conflict between international priorities and local needs. The survey revealed that the major source of funding for health NGOs was foreign and local donor support on average constituted nearly half of their funding. Earnings from personal membership and consultancy averaged to over 17 % of their funding. Slightly below 17% of their funding came from public support and community support. Funding from the government, on average, remained a non-significant source of their financial support, accounting for less than 6 % of their funding, as shown in Figure 10.

Figure 9: Percent distribution of NGOs by size of annual budget

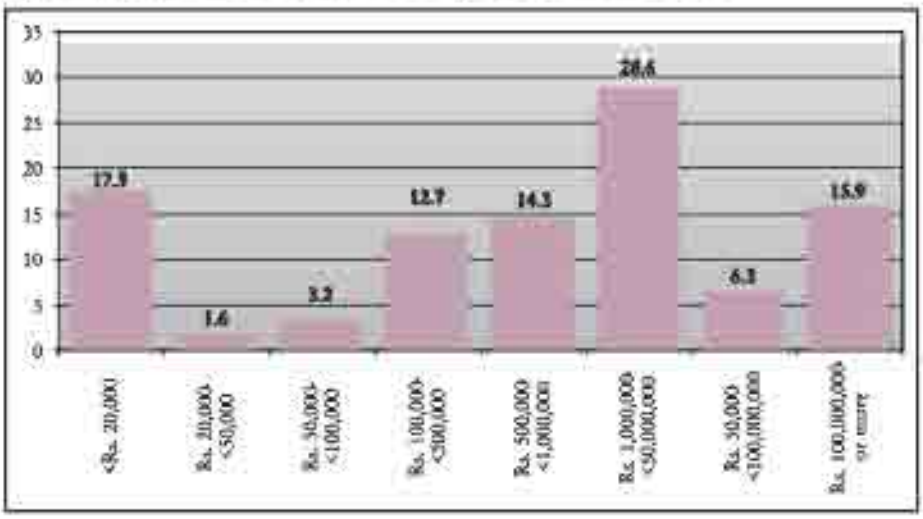
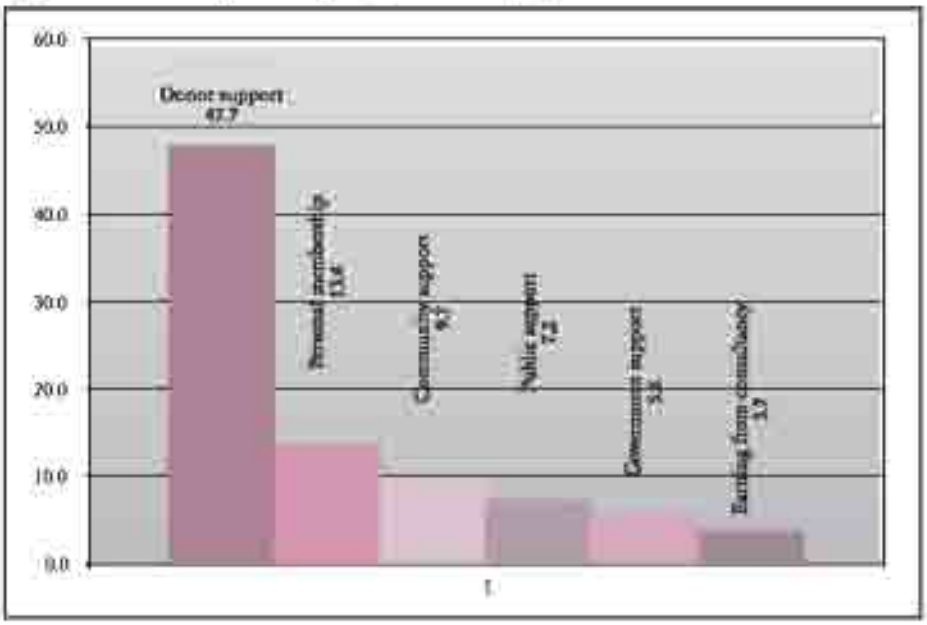


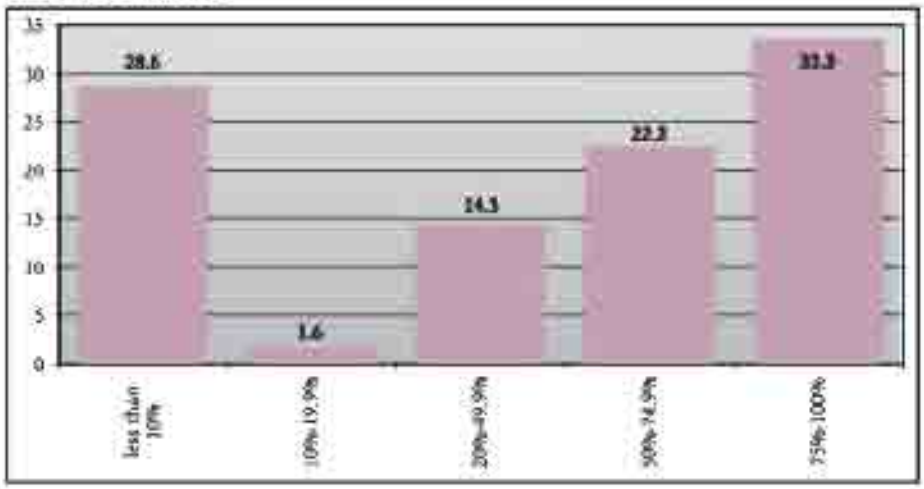
Figure 10: Percentage of budget by source category



3.3.3. Proportion of budget allocated for health activities

As shown earlier, NGOs rarely have a single area of intervention as their primary focus. Accordingly, their budget is allocated to various areas of intervention. It is of interest to observe the percentage of budget allocated for health by health care NGOs. Results of the survey show that on the average, NGOs spend 49% of their budget on health. The majority (55.5%) of NGOs involved in health spend over 50% of their budget on health care, 1 in every 3 NGOs spends over 75% and nearly 29% of the NGOs spend less than 10% of their budget on health care. See Figure 11.

Figure 11: Percent distribution of NGOs by proportion of their budget allocated for health activities



3.3.4. Size and Composition of Staff

On average the NGOs sampled had a total of over 94 employees/volunteers, of which 43 were full time, 10 were on contract and 41 were volunteers. Given that there is a significant bias against women in the public or private sector job market in Pakistan (Shah and Zaman, 2005; Muzaffar, Pervez and Shah, 2005), NGOs tend to play the role of an 'equalizer', in that they tend to be sensitive to such bias. They are more likely to avoid such prejudice against women in hiring and promotion practices, as reflected in Figure 12-A. There were, on average, 42 male and 53 female employees in an NGO, with a gender ratio of 78 males per 100 females. NGOs had more females (24) than males (19) as their full time employees. This is perhaps the healthiest of the latent functions of NGOs involvement in health and other areas of public good.

The size and composition of NGOs staff is an important indicator of the nature of their involvement in health care. For instance, the presence of Lady Health Visitors (LHVs) on NGOs staff indicates the nature, quality and level of services provided.

The LHV as a health care provider has existed in Pakistan since 1951; they are the 'underdogs' of the health care provider community in Pakistan and are underpaid and underprivileged, and yet provide a variety of vital services such as basic nursing care, maternal child health services, and training of community workers. LHVs are registered with the Pakistan Nursing Council and undergo one year midwifery training. While it is typical for nurses to work at a hospital, an LHV is often a community level service provider (Upvall,

Figure 12-A: Average number of NGOs' employees by gender and nature of their employment

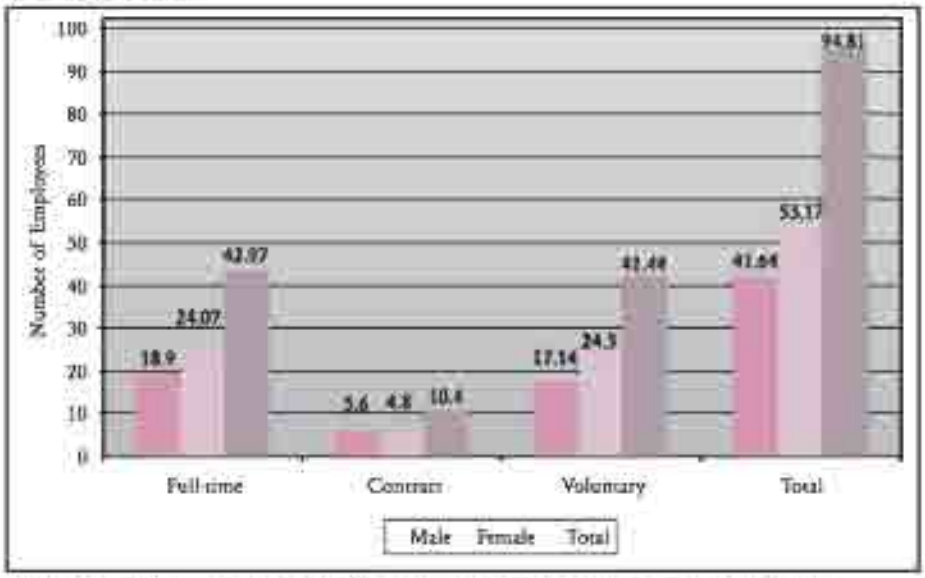


Figure 12-B: Average number of employees by category of their profession

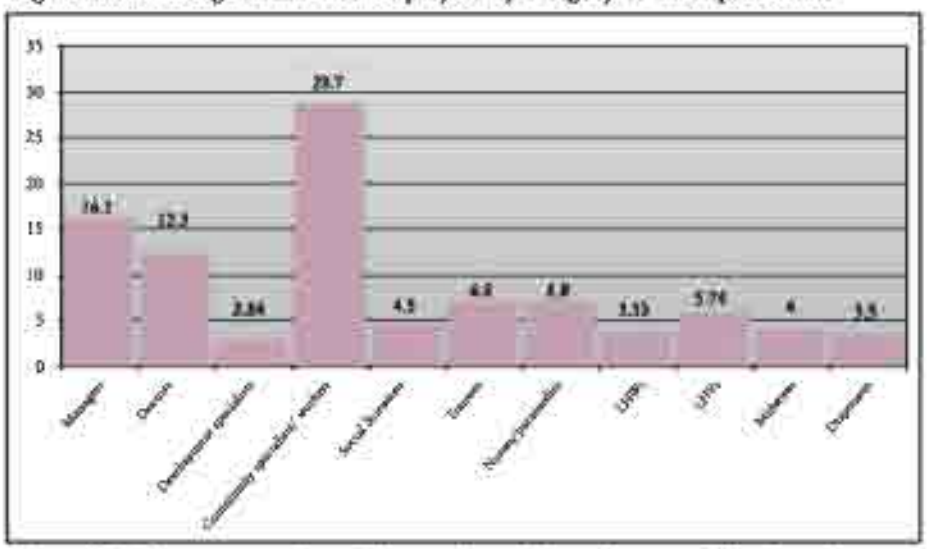


Figure 12-C: Average number of doctors by gender and nature of their employment

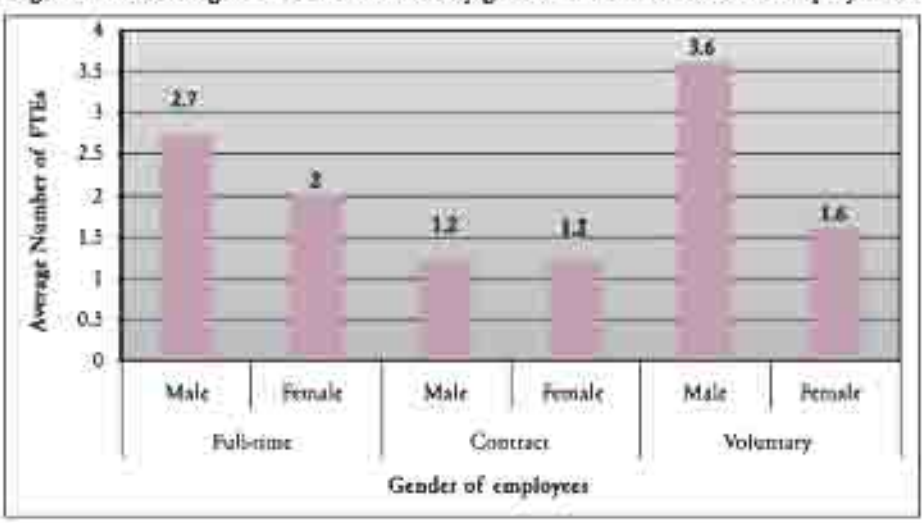


Figure 12-D: Average number of nurses/paramedics by gender and nature of their employment

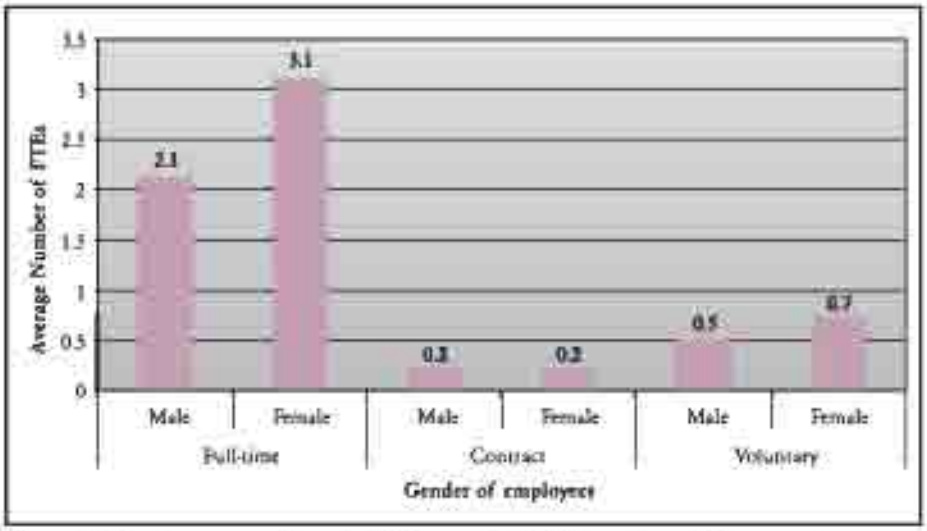


Figure 12-E: Average number of LHVs and LHWs by nature of their employment

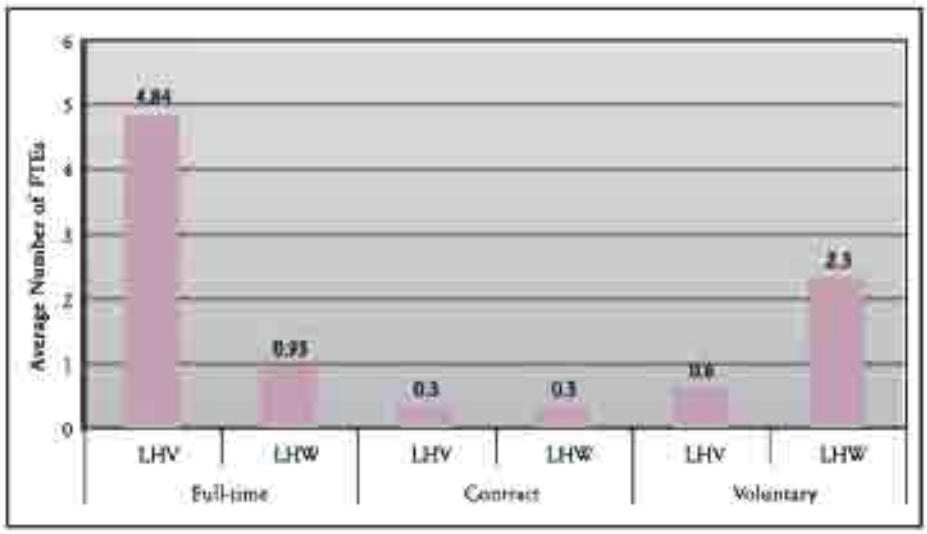
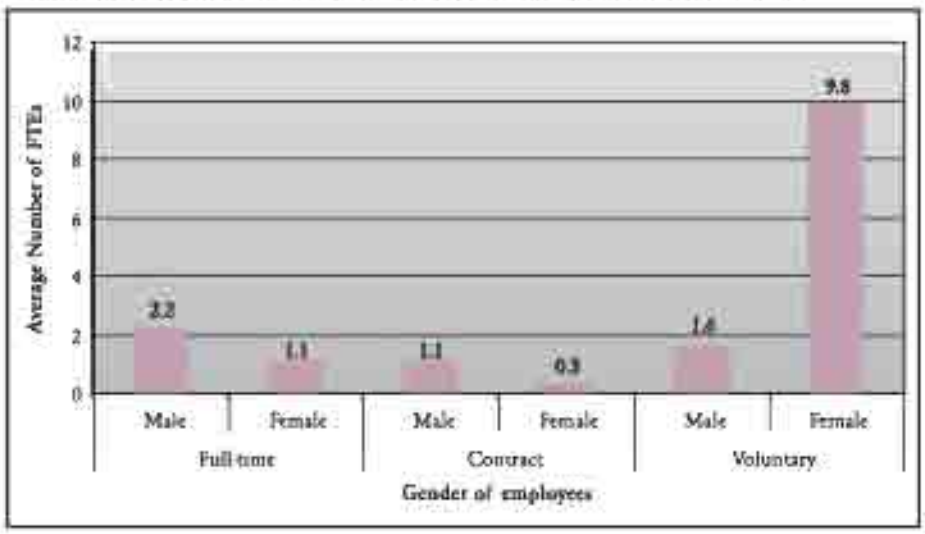


Figure 12-F: Average number of managers by gender and nature of work



Sochael, and Gonsalves, 2002). The presence of doctors is indicative of the capacity of health NGOs to provide clinical services often not offered by nurses, LHVs and Lady Health Workers (LHWs).

As seen in Figure 12-E, NGOs on average had 16 employees categorized as managers and the largest number of employees were community specialists or workers, averaging to 29 per NGO. Overall, the number of doctors per NGO averaged out to be over 12. However, only less than five were full time, non-contract employees. In addition, NGOs averaged at 6.8 nurses, 9 LHVs / LHWs, 4 midwives and 3.5 dispensers.

Of the average 12.3 doctors, 2.7 were males and 2 were female full time employees. The remaining doctors were either contract employees or volunteers.

Nursing has traditionally been considered a pink collar job[1] and there are several negative stereotypes against it. Although trends are changing and men are joining the nursing profession, there are still more women in this profession than men. The sample showed that on average there were 3 female and 2 male nurses per NGO.

On average there was a total of 5 LHVs and one LHW working full time in a typical health NGO sampled. This not only speaks of the nature of services provided by the NGOs but also the scale of their operations. Generally in the manager category, there are more males than females, and that bias is prevalent even in the developed world. The same was the case for health NGOs in this survey. There were on average twice as m any male managers as female managers.See Figures 12-C, D, E, F

[1]The term is given to traditionally "female" jobs like beautician, waitress, sales clerk, secretary and nurse. Pink collar jobs are usually low paying, monotonous, and offer few or no benefits and no chance of advancement; commonly, they are part-time, seasonal, or temporary.

The categories of employees working in the health NGOs are given in Table 8.

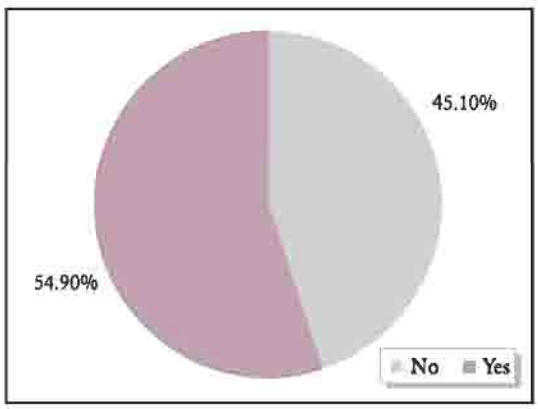
Table 8: Average number of employees by category of employment and gender

Type of Staff	Full - time		Contract		Voluntary	
	Male	Female	Male	Female	Male	Female
Managers	2.2	1.1	1.1	0.3	1.6	9.8
Doctors	2.7	2.0	1.2	1.2	3.6	1.6
Development specialists	0.8	0.5	0.7	0.3	.34	.2
Community specialists/ workers	5.9	5.1	1.4	1.1	8.3	6.9
Social scientists	1.6	0.5	.4	0.4	1.1	.5
Trainers	2.7	2.3	0.3	0.4	.7	.4
Nurses/paramedics	2.1	3.1	0.2	0.2	.5	.7
LHWs	-	0.93	-	0.3	-	2.3
LHVs	-	4.84	-	0.3	-	.6
Midwives	-	3.0	-	0.2	-	.8
Dispensers	0.9	0.7	0.3	0.1	1.0	.5
Total	18.9	24.07	5.6	4.8	17.14	24.3

3.3.5. Change in focus of intervention

In response to the question, 'In the last 5 years, has there been a change in the organizational focus with respect to the area of intervention?' most NGOs mentioned that there had been a change. NGOs are often criticized for being funding driven and for changing their focus with change in the donors' focus. The figure below shows this.

Figure 13: Percentage of NGOs having a change in the organizational focus in the last five years.



3.3.6. Resources required to expand the capacity of NGOs

Funds were reported by 94.4% of NGOs to be the most important resource if NGOs were to expand their capacity. More equipment (73%), more staff training (63.4%), and more outreach workers (35%) were the other resources identified. See Figure 14.

Figure 14: Percent distribution of NGOs by stated requirements for expanding their capacity

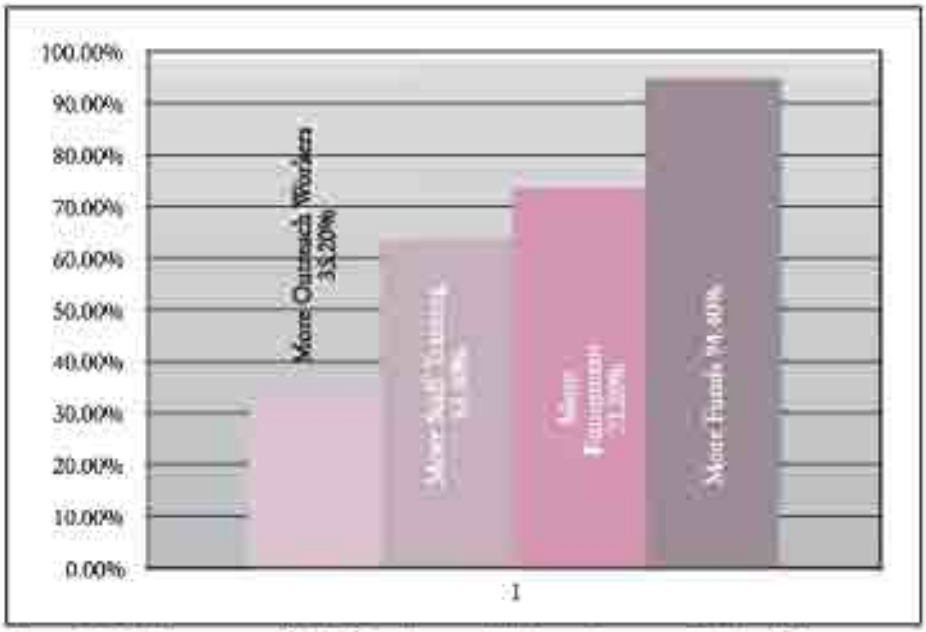


Figure 15-A: Frequency of NGOs where medical and paramedical staff has not undergone any training

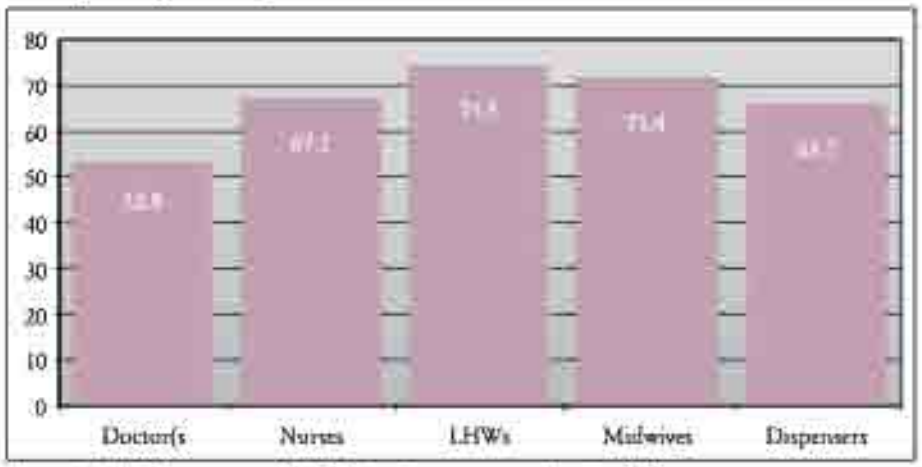
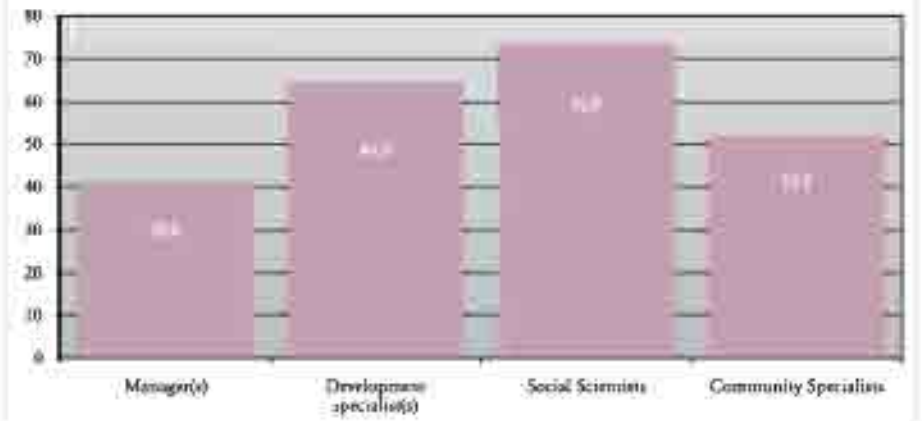


Figure 15-B: Frequency of NGOs where non-medical staff has not undergone any training



3.4 Training and other needs

3.4.1 Training

Health NGOs were asked to report the frequency of training that their staff had undergone in addition to their basic professional education/training. The results are shown in Figures 15-A, and 15-B.

As doctors are trained professionals they may not require frequent training as other members in the medical field. Nearly 53% of the NGOs sampled claimed that their doctors did not go for any training beyond their basic professional degree. The rest had some training ranging from twice a year to once every two years.

On the contrary, midwives require extensive training and refresher courses to keep their practice safe, and skills honed and modernized. Over 71 % of the NGOs mentioned that their midwives did not have any further training in addition to the training they had before joining the NGO. Over 74 % NGOs mentioned that their LHWs did not have any additional training, 67 % mentioned no training for nurses and approximately the same proportion reported no training for dispensers.

Frequency of NGOs with no training for managers and other non-medical staff is shown in Figure 15-B. Over 40% of the NGOs mentioned that their managers did not have any training.

Nearly 73% of the NGOs mentioned that their social scientists did not consider any additional training necessary. Over 36% of the NGOs reported to have managers' training twice a year or more frequent; over 20% reported to be annual.

The frequency of staff's training is shown in Figures 16-A and 16-B.

There is considerable variation in the frequency of training by the type of staff. For instance, doctors are more likely to be sent for training (47%) while nurses are less likely to have post-employment training, of those who do go for training; frequency of their training is greater. Doctors are likely to be sent for training once every two years or once a year; nurses are more likely to have training twice a year or more often. The frequency of training by NGOs' managerial and other non-medical staff is given in Figure 16-B.

3.5 Strengths and weaknesses of NGOs

Figure 17 portrays NGOs' perception of their own strengths and weaknesses. The lower score on the rank means that that particular strength is more important. On a rank of 1 to 5, sustainability was considered amongst the greatest strengths of the health NGOs. Ironically, NGO projects are often criticized for lack of sustainability because they are often time-bound and so face threats to their sustainability after the close of the funded project period.

Project approach, programme approach, expertise and training, and collaboration with other NGOs were other strengths in order of importance.

Health NGOs in the survey were also asked to express their perceptions of their weaknesses. The ranks assigned to each of the structured response categories were averaged. The results are reported in Figure 18. A struggle with funds was reported to be the highest ranking and hence the most important of the NGOs' weaknesses. While some larger NGOs have a stable stream of funds coming in, this is an important issue for the smaller NGOs. The sampled NGOs also mentioned that their salary levels were not very favourable and was, therefore reported as a weakness.

Another important weakness is the inability to establish collaborations with the government. Our earlier findings show that only 38% of the health NGOs had partnerships with the government and that this was the least frequent form of

Figure 16-A: Frequency of NGOs by frequency of training of medical and paramedical staff

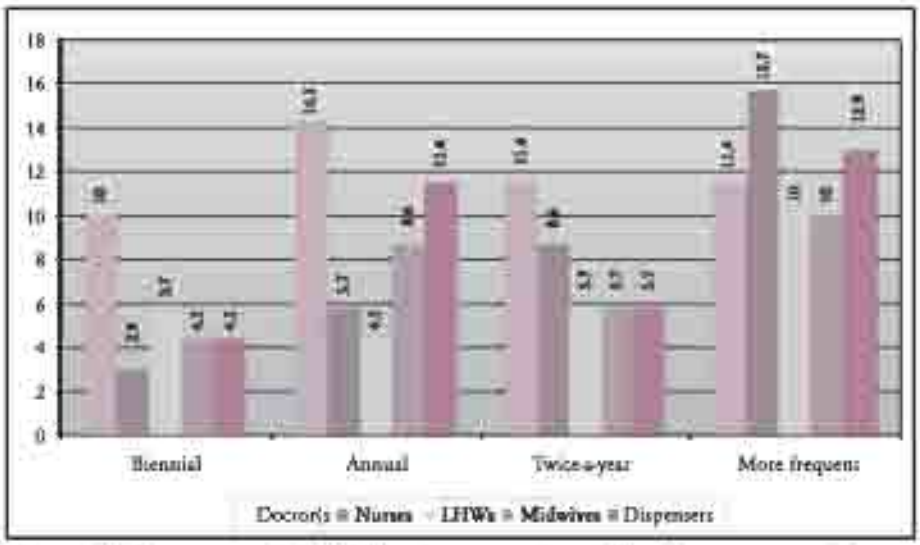


Figure 16-B: Frequency of NGOs by frequency of training of managers and other non-medical staff

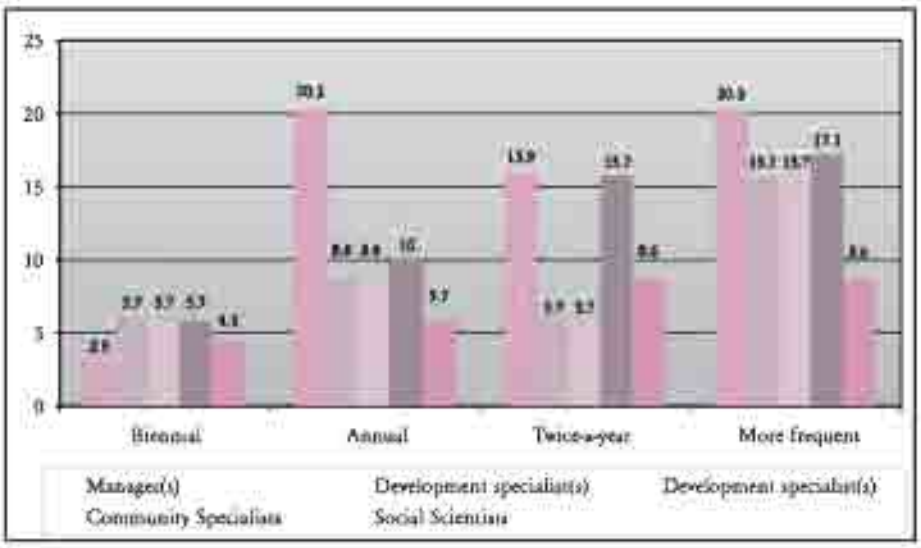


Figure 17: NGOs rank (1 being the highest and 5 the lowest) of the strengths

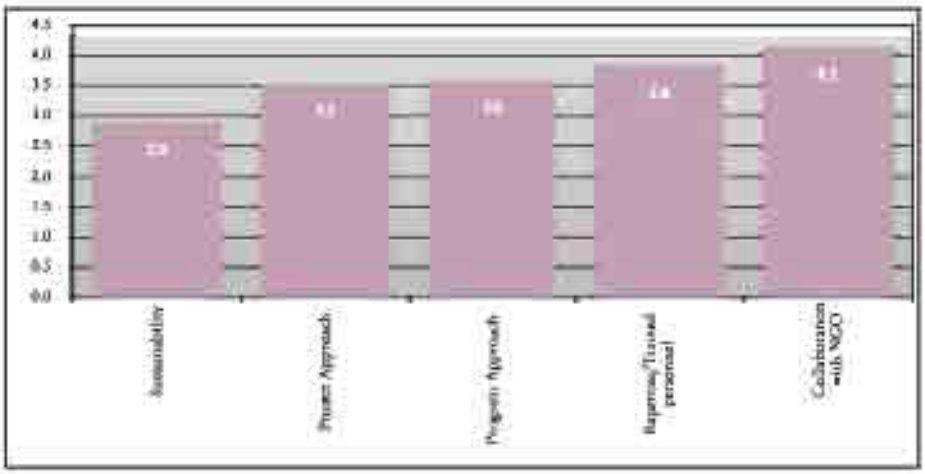
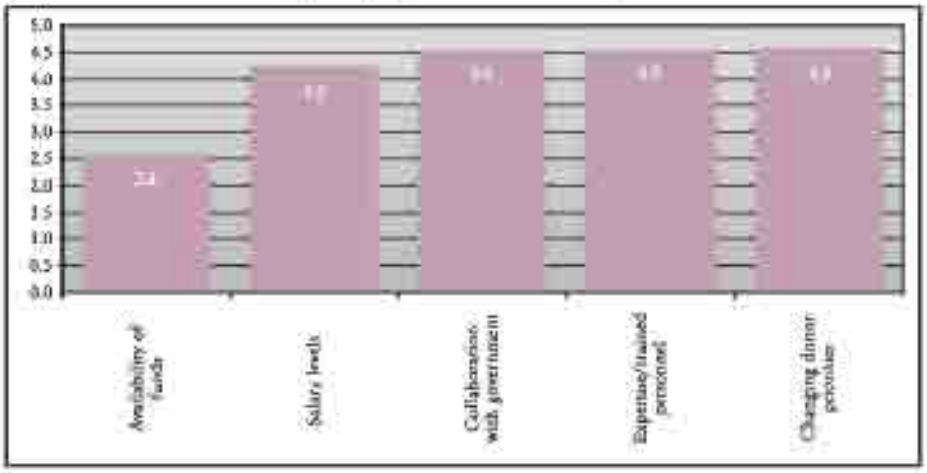


Figure 18: NGOs ranking (1 being highest and 5 lowest) of their weaknesses



partnership, corroborates this result. The changing priorities and focus of donors was fifth in rank among the weaknesses listed.

3.6 NGOs training needs

The NGOs in the survey were asked an open ended question, 'What are your training needs?' Their responses for training needs from the qualitative data were grouped into the following categories:

3.6.1 Training in management

Most of the health NGOs surveyed stressed the need for training in management. An array of management areas were mentioned by various NGOs, including time management, organizational development and management strategies, office management, office record maintenance, programme management, human resource management, financial management, and other management skills. Long term trainings in good governance, capacity building, financial management, risk management, disaster management and project implementation skills were among the other management related training areas.

3.6.2 Research, analysis and writing skills

A need for research, analysis and writing skills was mentioned as the second most important training need. Specific sub-themes included proposal writing, project and document development, research design, data collection, data management, data analysis and report writing. Other areas identified, were assessment of community based programmes, TOT participatory planning, monitoring and evaluation. Need for monitoring and evaluation was stressed by the NGOs surveyed as:

...training in effective communication skills to accomplish behavioural change will be helpful. We also want our staff to be trained in communication and facilitation skills, modern techniques of health education, monitoring and evaluation, health management information system (HMIS), monitoring and evaluation system of health projects, fundraising for and sustainability of health projects...

...we need training in research, project proposal development, database management and analyses, writing skills, budget and finance management, community outreach, research, marketing and other state of the art tools for monitoring and supervision of on-going projects...

3.6.3 Communication, negotiation, facilitation and conflict management /resolution skills

The next important category of training needs was communication, negotiation, facilitation, conflict management/ resolution skills, and promotion strategy. Other related training subjects were motivation and community mobilization skills and relationship skills with donors and other stakeholders.

3.6.4 Healthcare skills for doctors and paramedics

Various health care skills including primary health care, first aid, treatment of the physically challenged, family planning methods, child care, women's health education, wounds' care, and reproductive health were some areas of health care in which need for training was recognized. The health NGOs surveyed also wanted training of trainers and identified this as an effective way of training existing staff.

"...training for a qualified lady health visitor as master trainer for the training of Traditional Birth Attendants (TBAs)..."

In addition, the need for training manuals for health care education in primary classes, material on HIV/STDs for awareness and training, and comprehensive training in health and hygiene was suggested. Training of specific staff members on Obstetric Care and New-born Care was also identified. NGOs also mentioned that LHVs, midwives, dispensaries, internal training, and community specialist workers needed to be trained on a regular basis.

...training of LHVs, LHWs, TBAs on STDs and HIV/AIDS, and on preventive medicine would be of great help. Refreshing courses and workshops for doctors and paramedical staff to get them acquainted with new technologies in the medical field are also a necessity. Mid level ophthalmology technicians need training as well...

...the staff needs to be adequately trained in screening of blood collected from various sources against HIV, Hepatitis B and C, malaria and syphilis. In addition, all staff should be trained in attending to emergencies during routine blood transfusions. Improvements in technical skills, ultra-sonography, dealing with emergencies etc. are other areas where training is required...

3.6.5 Training in other miscellaneous areas

The NGOs sampled identified other training needs in gender, sexuality and related issues, growth monitoring, psycho-socio counselling and quality assurance. Interest in fundraising skills for community project and resource and social mobilization skills was another important training topic. Life skills approach, crisis management, and technical training such as projectors, multimedia facilities were also among areas of important training needs.

3.7 NGOs assessment and their role

3.7.1 Parameters against which health careNGOs should be assessed:

Several parameters were identified against which health and performance of NGOs should be measured.

A. Quality and scope of services

1. Quality, affordability and timeliness of services delivered in health care were one of the basic yardsticks. Examples of quantifiable measures include number of community visits by doctors, health educationists and other paramedics; quantity of health care services provided vis-à-vis unmet need.
2. Geographic coverage/outreach of the NGO in delivering core services; number of projects and service areas, and quality of community outreach programme are among important indicators.
3. The length of time since health care services have been provided: The number of years an NGO has been active in an area of intervention indicates the experience in a particular field as well as the ability to make the least minimum progress to maintain credibility and generate funds.
4. Impact: The changes that have been brought about at the grassroot level in terms of health status of the community before and after the intervention; actual change in ground realities rather than paper-based performance, and level of awareness in the community about health and prevention of disease.

B. Capacity and scale of operations

1. Profile of NGO staff: Number of service providers including health workers, LHWs, LHVs and doctors; level of staff commitment to bring about the required outcomes are important indicators of the capacity of health NGOs. Other qualitative markers of capacity are experience, level of skill, expertise of staff implementing health programmes, the quality of their previous and ongoing training, level of education and professionalism of staff, particularly of volunteers. Another aspect of quality of staff is the availability/flexibility of staff working in different cultural and class settings.
2. Number of beneficiaries: Number of direct and indirect beneficiaries of preventive, curative and counselling services indicates the outcome of interventions. Level of community involvement, and cost effectiveness of the services delivered, indicate the degree of NGOs' effectiveness.
3. Satisfaction of the beneficiaries with the quality of services, affordability and attitude of the NGOs' staff are important measures of quality of services, which can be determined by various methods, including exit-client interviews (exit from service outlet); knowledge, attitude, and practice (KAP) assessment of beneficiaries and so forth.
4. Credibility of NGOs among beneficiaries and general public is among the most sought after strengths of NGOs as opposed to public or for-profit sector. Credibility and social acceptability of the NGO should be used to measure the success of NGOs.
5. Competency in implementation of the ongoing project.
6. Revenue: Amount of funds utilized, e.g., in the previous year's budget; the ability to attract funds.
7. Sustainability of the projects concluded in the past.

C. Organizational structure, development and maturity

Various indicators of organizational maturity were considered as important measures of health NGOs including:

1. Prior experience of working in community context, regardless of specific interventions.
2. Number and quality of medical equipments, buildings/service outlets etc. at the present time.
3. The quality and quantity of partnerships with other stakeholders.
4. The ability to develop and maintain health management information systems.

D. Evaluation and assessment procedures in place and future capacity for monitoring and evaluation

For effective project implementation, the ability to monitor projects on an ongoing basis, the evidence of staff and the infrastructure in place to do so, the existence of feedback loops and summarised evaluation were considered an important aspect of health NGOs. Specific sub-themes included:

1. Data collection and management for assessment and feedback purposes.
2. Media and evaluation reports; outcomes of NGOs' self evaluation and third party evaluation report, any media coverage of NGO's progress, photographs, and video evidence of the projects' functioning and their success.
3. Number of baseline surveys combined with summarised evaluation in the past and capacity to conduct such surveys in the future.

4. Regular impact assessment efforts for various phases of the ongoing projects.
5. Achievements of stated outcomes and their objectives.

3.7.2 Requirements in order to improve NGOs' performance

NGOs were asked about their perception about, "What is needed to improve NGOs' performance and make them more effective?" Responses to this question were fairly consistent with their perception of what indicators NGOs should be measured against and what ought to be the role of NGOs in health care. A summary of qualitative answers lead to the following factors:

1. Improved capacity for research, monitoring and evaluation: Good research capacity building for documentation of various aspects of the interventions/projects leading to a clear policy feedback is necessary for NGOs' success. This is an essential requirement for advocating a vigorous integrated approach to primary health care and referrals using schools as an entry point.
2. More funds, particularly from international donors were constantly mentioned by the NGOs, as a step in the way of improvement in the NGOs' performance. Long term commitment of funds is needed for comprehensive long term programmes and proper utilization of funds is necessary. More funds and resources can be used to recruit more health care staff in schools/communities to provide basic services. Greater availability of resources is needed for timely provision of medical equipments. It is obvious that for better performance, NGOs should be equipped with necessary health parameters, tools, qualified staff and proper delivery of services. Having access to sufficient vehicles for transportation is essential to pick and drop beneficiaries who cannot afford transport, and for referral services for patients.
3. Credibility: NGOs should work together to improve their credibility, which in theory is one of the major strengths of the NGO sector over the public and corporate sector. NGOs agreed that the level of trust NGOs ought to have in the community has not evolved, particularly because of selfish ulterior motives by a few NGOs. In other words, while most NGOs strive for making a social impact without any gains for their organization, there are some who use NGOs funding to advance their personal economic gains.
4. Partnerships: Having the ability to forage linkages with the local public health care sector for primary health and referrals will improve effectiveness of both NGOs and the public health care sector. In addition to linkages with other stakeholders, developing a national platform for all NGOs will improve overall communication, helping them boost synergies and prevent duplications and omissions of services.
5. Mass Media Involvement: Greater involvement of and linkages with mass media, both electronic and print is essential. The media can be an effective means of awareness-raising, particularly when NGOs' physical presence is not possible.
6. Provision of life skills should be an integral part of NGOs intervention.
7. Better and more frequent training: Proper training and orientation of staff in various skills as mentioned earlier was required by many NGOs.
8. Community involvement: Better awareness-raising throughout communities by using immobilizers and Information Education and Communication (IEC) materials is an absolute essential. Finding and filling gaps with respect to this will be extremely beneficial. NGOs should launch meetings with the community to involve them in the feedback loop and evaluation process.

3.7.3 The essential role of NGOs

• Holistic approach to health care:

Facilitating sustainable development is a general goal for NGOs and healthy individuals and communities are at the core of sustainable development. Health is a vital component of human rights; one questionnaire stated:

"...complete physical, mental and social well-being is the goal that we believe every society should embrace..."

Many NGOs mentioned that promoting a holistic approach to health is one of the most important roles that health NGOs should adopt. This is particularly important as health care-seeking behaviour in Pakistan is misinformed and passive in that people only seek health care after getting sick. The value of holistic and preventive health is undermined.

NGOs are aware that poverty, underdevelopment, illiteracy and lack of gender in-equity are all unhealthy trends and contribute to the spread of disease, which has reversed health and development gains of the past decade. Improvements to health should be regarded on the basis of their potential contribution to human capital, the building block of the future.

• Grassroot mobilization, advocacy and awareness raising:

Awareness-raising of health related issues was among the most emphasized role by the health NGOs. NGOs should:

"...develop model communities wherein awareness should be raised about health education, primary health care and life skills, targeting children, youth, men, and women. Do all necessary education and awareness for lessening the burden of disease on poor households..."

• Community mobilization for promotion of health care services:

NGOs should provide grassroot level door-to-door mobilization and awareness raising to women on health issues that are generally ignored, including female sexual health, knowledge about prevention of HIV/AIDS, family planning, spacing of children, and preventive health care measures. NGOs should assess the community's health care needs and need to play an important role in conveying ground level realities to the policy makers, generally not

captured in macro level surveys. They should also assess women's health care needs and help play a role in women's empowerment.

• **Using a participatory approach:**

NGOs should adopt a participatory approach as an important feature of their role is to understand community needs through needs assessment, participation and empowering communities, particularly the underprivileged. The underprivileged should be acknowledged as one of the most important stakeholders in the process of development and health care services delivery. NGOs need to build partnerships with local authorities, private institutions and local community.

• **Non-profit services**

NGOs should work with zeal to provide services without having selfish ulterior motives. NGOs ought to provide high quality services with a likeable attitude in order to live up to their image of being trustworthy, non-profitable, and service-oriented partner in development.

• **Working in Partnership with the State**

Health NGOs need to develop strong linkages with other stake holders, and to seek community participation at all stages of the project. Rebuilding health systems today is not just the state's responsibility. Rather, NGOs have an increasingly important role to play in partnership with the state. The principal role of NGOs in the area of community health should be to deliver measurable joint collaborative action plans that also contribute to poverty eradication and gender equity.

Strengthening the health system and its capacity to reach the poor will entail strong state involvement. Rebuilding health systems today is not just the state's responsibility and NGOs have an increasingly important role to play in partnership with the government. NGOs cannot replace state funded and state backed public health systems. However, NGOs can show the way in building experimental health systems starting with people's needs, no matter how poor. States can then cooperate and assimilate NGO's health systems. Health is an integrated state of wellbeing and requires the fulfillment of basic needs - such as water and nutrition - and therefore, the ideal set up of a health system should be funded and staffed by the State and be linked to a large array of community based organized groups and NGOs. This situation will mean having a democratic participation in the elaboration and functioning of health care systems for the poor.

4. Discussion

Health as a theme was selected for this report because the state of the quality of health care provided and access to it is quite bleak in Pakistan despite government efforts to improve it. With poverty as widespread with over 23% living below the poverty line[1] an awareness about and affordability of quality basic health care is not possible for many. Those who have resources to procure health care may not live healthy life styles either, primarily because the awareness about the risk factors and methods for living a healthy life style is simply non-existent. Consequently, the social structure is not supportive of preventive health care. The norm is to seek health care only for curative purposes and only after the sickness or disease has worsened, to the extent that care becomes absolutely necessary. In this situation, NGOs can and should play a crucial role as they have a distinct advantage of reaching poor communities passionately, effectively and efficiently[2].

Three major problems facing the Pakistani health care system are the non-availability of health care facilitates in rural areas, low utilization of medical facilities and a wide gap in the national health services. Traditionally, women's health has not been a national priority. Cultural bias, stereotypical beliefs against women and their low status in society discourages them from seeking health care unless absolutely necessary. As men are often the breadwinners of the family, health care is immediately sought when a male member of the household falls ill. Women, on the other hand are expected to survive the sickness till it goes away naturally. While health is defined by WHO as, 'the state of complete physical, mental, and social well-being and not just the absence of disease or infirmity', most women only ask for health care when the sickness worsens to the extent that not seeking medical treatment becomes life threatening.

On the provision side, the health care system of Pakistan has not been designed with women's health needs in mind. For instance, in the public health care system, there is no norm for women to seek prenatal care or postnatal preventive checkups. In developed countries, use of both prenatal care and postnatal care is common and widespread. Such care helps prevent maternal mortality, foetal death, miscarriages, and complications of delivery to mother and newborn. In Pakistan, NGOs is general recognise the importance of women's health care. In the survey, 66 percent of NGOs were involved in the provision of Maternal and Child Health (MCH) services. NGOs also ranked MCH as one of the areas of care that needed the greatest attention in Pakistan.

NGOs can play a vital role in correcting the traditional bias against females by providing health care services to them. The traditional public health care system has neglected women's sexual and reproductive health (SRH) rights as a central area of intervention. NGOs recognize this service, and the findings reveal that as many as 49% provide sexual health rights, services and education.

NGOs also vary dramatically in their budget ranges varying from Rs 20,000 to a few hundred millions annually. The major source of funding for NGOs involved in health was from foreign and local donor

[1]Ministry of Finance, 2005
[2]Green and Matthias, 1997; Zaidi, 1999

support, on the average constituting nearly half of their funding. Slightly below 17 percent of their funding came from public support and community support and government funding, on average, remained a non-significant source of their financial support, accounting for less than six percent of their funding.

NGOs tend to play an important role in empowering women in the job market. The survey showed that there were more female than male employees in the NGOs surveyed. On the average, there were 24 female employees and 19 male employees per NGO. Also a typical gender grouping is found in the public and private employment sectors, wherein men tend to occupy prestigious jobs such as doctors, managers, engineers and women are only or mostly, hired as nurses and primary schools teachers. Such gender stereotyping is not significantly present in the NGO sector where women are hired in all categories. However, in some job categories such as doctors, the male-to-female ratio of employees was in favour of men.

What is needed to improve NGOs' performance and make them more effective? Some factors suggested by the health NGOs include: improved capacity for research, monitoring and evaluation, funds, having access to sufficient vehicles for transportation, credibility, partnerships, mass media involvement, provision of life skills should be an integral part of NGOs intervention, better and more frequent training, community involvement.

NGOs perceive they have many roles that are appropriate for them to take on. Taking a holistic approach to health care is important in that mental and physical health are interconnected. NGOs ought to carry out grassroot mobilization, advocacy and create an awareness of preventive community health and the health of the under-privileged, including women. NGOs need to use a participatory approach to effectively assess and address the community's health care needs; they should work as not-for profit entities; conduct research and be advocates of the health care needs and appropriate interventions, working in partnership with the government and other agencies.

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Appendix 1: List of NGOs included in the Survey

S.No.	Name of the NGO
1	Aahung
2	Ahsas Welfare Organization
3	Aids Awareness Society
4	AIDS Prevention Association of Pakistan
5	Al-Falah Health Organization
6	Al Asar Development Organization
7	Al Shabaz Social Welfare Association
8	Amal Human Development Network
9	Bunyad Literacy Community Council
10	Caritas Pakistan Faisalabad
11	Child Health Foundation
12	Children Education & Social Welfare Society
13	DARES Society for Health Care
14	Daws
15	De Laas Gul Welfare Program
16	Development Association for Women in Neglect (DAWN)
17	Dost Welfare Foundation
18	Family Planning Association of Pakistan (FPAP)
19	Frontier Primary Health Care (FPHC)
20	HEAL Trust (Health, Education and Literacy)
21	Health Education Promoting Organization of Pakistan
22	Health Oriented Preventive Education (HOPE)
23	Health Promotion Welfare Society
24	Heart File
25	Human Friends Welfare Association
26	Idara-e-Taleem-o-Aagahi
27	Karsaz Eye Welfare Foundation
28	Khawra Development Organization (KDO)
29	Khyber Welfare Association
30	Layton Rahmatulla Benevolent Trust (LRBT)
31	Life Welfare Society
32	Marie Stopes Society
33	Movement for Sustainable Social Autonomy & Gender Equity
34	Nai Zindagi
35	Narowal Rural Development Program (NRDP)
36	National Commission for Human Development
37	New Hope
38	OPP - Karachi Health and Social Development Association
39	Pakistan Family Welfare Council
40	Pakistan Thalassaemia Welfare Society
41	Pakistan Voluntary Health & Nutrition Association (PVHNA)
42	Public Welfare Society
43	Publishing Extension Network (PEN)
44	Qarshi Foundation
45	Rehber Foundation
46	Rural Development Organization
47	Sabawoon Welfare Society (SWSS)
48	Satluj Welfare Foundation
49	Save the Children Federation Inc.
50	SEPP - Qiadat International

S.No.	Name of the NGO
51	Seva Social Welfare Organization
52	Shaheed Shah Nawaz Khan Memorial Social Welfare Association
53	Shajar Environmental Org (Youth Club)
54	Shehri Ijtamai Taraqiati Council
55	Sindh Health and Education Development Society (SHEDS)
56	Sindh Qaumi Welfare Association (SQWA)
57	Social Marketing Pakistan (Guarantee) Limited - Greenstar
58	Social Relief & Development Services Chitral
59	Society for Education, Environmental & Population Welfare
60	SOS Children's Villages of Pakistan
61	Sukkur Blood and Drugs Donating Society (SBDDS)
62	Swat Youth Front
63	Thardeep Rural Development Program
64	The Prudents
65	Ugala Foundation
66	UKS Research, Resource & Publication Centre on Women & Media
67	United Rural Development Organization (URDO)
68	United Welfare Society Latamber - Karak
69	Welfare Hand Organization (WHO)
70	Zainabia Welfare Society
71	Zarar Shaheed Trust

Key Informants' Workshop: The Role of NGOs in the Health Sector of Pakistan

Nadia Ejaz



Key Informants' Workshop: The Role of NGOs in the Health Sector of Pakistan

1. Background, purpose and design of the workshop:

The NGO Pulse workshop was held on April 18th, 2005 as part of a consultative dialogue between the different stakeholders within the health sector. More specifically, the workshop investigated the role of NGOs working within the health sector in Pakistan and, as such, served as an additional source of data collection for the current NGO Pulse project. The agenda for the workshop was loosely formulated given the rather broad theme of health and the rather limited time period allotted to the workshop. Amongst the key questions raised were:

- What are the main challenges facing the health sector?
- What are some of the best practices?
- What are the innovations being experimented with by individual NGOs?
- Can one develop linkages across different sectors (NGOs, government, donors) or within each sector and, if so, what would be the best way to proceed?

In terms of the selection of participants, there was a heavy emphasis on NGO representation. However, there was an acute awareness of the fact that NGOs do not work in a vacuum and that their relation with the government and donors is of critical importance. Bearing this in mind, government officials and donors working within the field of health services were also invited. In addition, we had two further criteria for the selection of participants: geographical diversity and representation of personnel at different levels of managerial positions. Thus, invitations were sent to organizations in all the different provinces as well as to a range of personnel, from fieldworkers to upper management. Yet, despite this attempt to have a broad, representative participant list, rtain significant actors/stakeholders were missing. For instance, the private or corporate sector (pharmaceutical companies, as well as corporations that contribute significantly to private philanthropy) was missing[1], as were direct beneficiaries such as patients. See Appendix 1 for list of workshop participants.

As mentioned earlier, the theme of the workshop – the role of NGOs in the health sector – was quite broad and inclusive. Ideally, one would have chosen a much more nuanced discussion on specific issues/topics. However, this was the mandate set by our donors and hence we had to retain focus on sectoral analysis rather than specific aspects of the health theme. Nevertheless, despite conforming to this broad mandate, we were able to deepen discussion through the design of the workshop.

In designing the logic of the workshop, we shifted back and forth between macro and micro perspectives. To begin with, under topic 1, we had a host of presentations from the government, NGO and donor representatives on the current situation vis-à-vis health. Next, under topic 2, we shifted to a more micro perspective by investigating the major challenges faced by NGOs corresponding with different areas of intervention and management styles.

We concluded the workshop on a macro note, once again, by focusing on avenues for collaboration within each sector and across the different sectors. This included discussion about public-private partnerships as well as the role that LUMS could play in terms of carrying out further research.

The remaining sections of the chapter will elaborate on some of the salient points brought up during this workshop.

2. Snapshots of Different Sectors

This session was designed to give participants an overview of what is currently happening in each sector.

A. Snapshot by the government

Dr Darakshan Badr, Director Health Services, Government of Punjab, presented on the government's role with regard to health services in Punjab. During her presentation, she highlighted some general information about health services in the Punjab, as well as reproductive health and how it has been tackled in the province.

In terms of general information about health services in the Punjab, Dr Badr pointed out that there are eight Millennium Development Goals (MDGs) that are relevant for Pakistan in terms of health services. These are:

1. Eradication of extreme poverty and hunger
2. Achievement of universal primary education
3. Promotion of gender equality and women's empowerment
4. Reduction of child mortality
5. Improvement in maternal health
6. Combating HIV/AIDS, malaria, Tuberculosis and other diseases
7. Ensuring environmental sustainability
8. Developing a global partnership

Reflecting on the general state of health services in the country, Dr Badr commented that the MDGs have stayed largely unattainable due to weak governance structures within the different branches of the government and due to a lack of coordination between the government and the NGO sector. According to her,

[1]Increasingly corporations are investing a great deal in NGOs in Pakistan. According to PCP (Pakistan Centre for Philanthropy) there is a large amount of donor money being generated in Pakistan through corporations.

key reform areas include:

- implementation of all health reforms at the district level;
- training of providers of services;
- logistic support to ease management of service delivery;
- monitoring and evaluation of the various health systems in the country.

In terms of reproductive health, Dr Badr pointed out that Pakistan has very high infant and maternal mortality rates[2]. Due to a number of different factors, which include socio-economic constraints of households; the low status of women in society; and most importantly, the fragmented rural health package at the district level. Dr Badr highlighted that 80% of all reproductive health packages are provided by the private sector and that the government's share of these is a mere 20%. Moreover, a majority of the births in the country are carried out by unskilled workers. In Punjab, this figure is estimated to be at 80% of all births. Reflecting on some solutions to these problems, she stated that Pakistan needs vital registration at the time of birth as well as clear medical certificates that specify the cause of the mother's death in maternal mortality cases. In addition, the figures for maternal and infant mortality can be reduced if the number of overall births is decreased through an extensive implementation of family planning on an effective scale or by providing sufficient and skilled health support to deal with complications at the time of birth.

B. Snapshot by NGOs

The second snapshot was presented by Dr Mian Iftikhar Hussein from the Health Promotion Welfare Society. According to Dr Hussein, NGOs' role consist of affecting public health policy, providing quality care to the poor and vulnerable, and stimulating behavioural change in the field (since NGOs usually enjoy good relations with the community). He elaborated:

'NGOs can bring about major changes in social behaviour and social practices. They tend to have very good social mobilization skills and can really create an attitudinal change in the communities. For example, in terms of health, we can try to change the numerous harmful stereotypes ranging from myths about who should carry the blame for the repeated birth of daughters, to the idea that more medication is the solution to good health. NGOs can play an effective role in (the) development, promotion, and modification (of) misperceptions about physical and mental diseases.'

Dr Hussein was of the opinion that the major issues faced by NGOs include dependency on donors, low levels of finances, lack of managerial capability, low levels of human resource development and a lack of collaboration with other sectors (government as well as private).

3. Major Challenges faced by the Government, Donor and NGO sectors

The first topic for group discussions focused on the major challenges within the government, donor and NGO sectors in terms of health services. The participants were divided into five groups and this was followed by a report-back session. The following section elaborates on some of the key points presented by the different groups.

3.1 Challenges faced by the government:

- There is a lack of role definition in terms of the different tiers of the government. There is very rarely any synchronization between these different tiers, since there is very little communication between them, and very few formally instituted communication channels. There is also a lack of collaboration between the Ministries of Health and Population Welfare.
- Monitoring and evaluation systems are weak. There should be a properly defined surveillance system and the main findings at the district and provincial levels should be synthesized in one national-level report.
- The finances of the various health departments are maintained haphazardly, leading to poor human resource development. Many government health workers do not get paid on time and salary packages are not reviewed regularly for appraisals. Moreover, most salary packages are un-competitive when compared to the private sector and hence there are inadequate incentives for the retention of quality government employees.
- There is poor logistical support in most government departments. In the words of one participant:

'One only needs simple apparatus at the grassroots level especially for basic or primary health services. But even these are lacking. In fact logistical support for basic health is most inadequate especially in rural areas. Compared to this, there is better logistical support at the tertiary level in the cities. Or if we do have the proper apparatus, there are no proper maintenance contracts for them. Clearly, no health system can work under these circumstances'.

- There are strong cultural constraints that prohibit female employees from utilizing their full potential at work. A participant elaborated on this point:

'In the rural areas especially, Lady Health Workers or even doctors are not that mobile. They cannot service an area in the same way as a male doctor because of the cultural belief that women should not travel far without a chaperon. Also, Lady Health Workers are reluctant to be involved in severe or critical cases, because in case of a patient's death, they would be required to testify and deal with the police and courts. Once again, women often shy away from this, given their upbringing and socialization'.

3.2 Challenges faced by donors:

- The biggest issue for donors was the lack of NGO credibility. According to one participant:

'Lack of credibility creates all kind of problems for the donor as well as for the development scenario in the country, broadly speaking. It is not that donors do

[2]The WHO puts the infant mortality rate at 98 out of every 1000 male children, and 108 out of every 1000 female children under 5.

not want to dispense funds. Often we cannot find an NGO that is credible enough in our eyes to receive our financial support. Because of this scarcity, donors tend to stick to the few credible NGOs that they have worked with earlier and with whom they have established good working relations. This obviously means that many well-deserving NGOs get left out simply because they do not have sufficient evidence to prove their credibility. Also, this means that sometimes donors will stick to a particular NGO even if it is not the best match for the given mandate'.

• A number of NGOs suffer from a lack of quality control. Either guidelines for quality control are weak or else they are not well-followed. As a result, donors are hesitant about providing funds to these NGOs.

• There is a lack of consistency in government policymaking with regard to donors. As the political climate in Pakistan tends to change, so do the priorities of the government. This means that previous commitments with donors may be bypassed.

• Most NGOs have inadequate accountability systems. Few publish comprehensive annual reports and, or credible audit reports. For donors, these shortcomings hamper funding activities as they indicate a general lack of professionalism in the NGO sector in Pakistan.

• Donors may sometimes concentrate too much on one area of intervention at the expense of other areas. This usually happens due to lack of coordination with other donors and the absence of a comprehensive overview of any particular development issue.

• The lack of a democratic culture in organizations can lead to nepotism within donor agencies.

• There should be some mechanism through which the direct beneficiaries of donor interventions are able to give feedback to the donors about the effectiveness of their projects.

3.3 Challenges faced by NGOs

• NGOs tend to be dependent on donors for funding. Because of this dependency, these NGOs frequently have to cater to donor-driven agendas.

• Some NGOs never become sustainable and remain dependent on donors for the continuation of their projects. A sudden discontinuity in terms of donor funds can therefore adversely affect the core-business of an NGO.

• A weak knowledge system in an NGO means that knowledge accumulation is neither well documented nor well directed. In such cases, the organization cannot create a strong repository of knowledge for future reference.

• NGOs are often poorly skilled at organizing fundraising activities.

• NGOs often suffer from inadequate and unskilled human resources - a number of NGOs working in the health sector have staff with very little health and hygiene knowledge. There is also a need for more management expertise.

• The quality of service delivery and health care equipment in NGOs needs to be scrutinized and its shortcomings rectified.

• There is frequently a lack of collaboration and networking among NGOs. There is extensive overlapping in terms of interventions and there is little sharing of knowledge or experiences.

• The new trend of 'government-driven NGOs', such as those run by the wives of high ranking government officials is often problematic. Such NGOs tend to face conflicts of interest due to their strong ties with the government as well as allegations of mismanagement of funds.

• Acceptance from, and coordination with, the government needs to improve. PPP needs to be undertaken so that NGOs may complement the government in implementing an effective strategy for development in the country.

4. Cross-cutting Concerns

4.1 Alternative medicine

Indigenous and alternative medicine should be developed and encouraged. A basic knowledge of alternative medicine should be part of every medical student's course requirements. The government has already moved towards this goal by allocating seats in health care administration to hakims, though there are no clear standards against which, one could evaluate the practices of hakims. Since alternative medicine enjoys widespread acceptance in major parts of the country, it was recommended, that its practice be streamlined and standardized.

4.2 Demand-side problems

Discussions about the shortcomings of the national health care system tend to revolve around the gaps in supply of health care services and products. The demand side of health care – that is the consumers and their attitudes – are frequently neglected. According to one participant, research in Balochistan and NWFP shows that on average, a doctor prescribed antibiotics to 30% of the patients regardless of whether they needed these or not. This has been attributed, in part, to a patient-driven approach to treatment which leads doctors to prescribe only what a patient thinks he or she wants without conducting a thorough medical examination.

4.3 Regulation

There is a need for regulation, certification and accountability with regard to both NGOs and government health care practices. There is an immediate need for assigning a reliable agency with this responsibility.

5. Challenges and Solutions with Respect to NGOs' Specific Area of Focus and Management Practices

5.1 Thalassaemia

Service delivery for thalassaemia patients is extremely marginalized in Pakistan. There is a scarcity of NGOs working on this health hazard and donor funding is also

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attended by key informants
and stakeholders

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relatively low. The prevention or treatment of this blood disorder is also low on the priority list of the government's health policy. Further research on the disorder is required urgently. In the box on the right is more information on this disease and some of the key points brought up by workshop participants in relation to this disorder is mention below.

5.1.1 Blood screening and transfusion-related issues:

• Collection of blood is a major challenge in the treatment of thalassaemia. While this remains a challenge even in urban areas, it is a particularly pressing problem in rural areas. In order to overcome these challenges, the media has to be engaged to create greater awareness about the disease and to encourage a spirit of volunteerism in the population to donate blood. In particular, the relatives of thalassaemia patients need to be targeted as they are potential blood donors and can ensure that patients get fresh blood on short notice.

• There is a lack of proper screening facilities, which results in unsafe blood transfusions. This is one of the major factors why people hesitate in donating blood. According to one participant:

"Almost 70% of the total population of Pakistan lives in rural areas, which are poorly equipped to carry out blood transfusions or to store blood. This lack of safe transfusion facilities results in the spread of Hepatitis and HIV/AIDS."

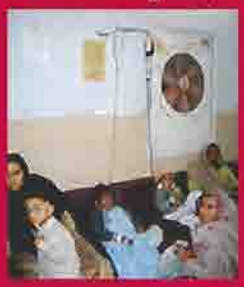
• Not only is the storage of blood problematic but even the transportation of blood poses several issues. The establishment of blood banks at close proximity to target communities may partly resolve the problem of transporting blood to geographically remote areas.

• Blood collection centres are not registered, despite the government having made their registration mandatory.

• 'Professional donors', who might make up for the lack of blood transfusion centres in Pakistan have been disallowed by the government. While it is true that the

Thalassaemia in Pakistan

• Thalassaemia is a blood related genetic disorder which involves the absence of or errors in genes responsible for production of haemoglobin, a protein present in the red blood cells. The severity of the disease depends on the mutations involved in the genes, and their interplay.



• A haemoglobin molecule has sub-units commonly referred to as alpha and beta. Both sub-units are necessary to bind oxygen in the lungs properly and deliver it to tissues in other parts of the body. Genes on chromosome 16 are responsible for alpha subunits, while genes on chromosome 11 control the production of beta subunits. A lack of a particular subunit determines the type of thalassaemia (eg. a lack of alpha subunits results in alpha-thalassemia). The lack of sub units thus corresponds to errors in the genes on the appropriate chromosomes.

• There can be various gradations of the disease depending on the gene and the type of mutations. It is estimated that there are 80-90 million carriers of Thalassaemia worldwide and 60-70000 births of affected children every year. Most of these die in early life, often without a diagnosis or because of inadequate treatment.

Prevalence:

• The alpha and beta thalassaemias are the most common inherited single-gene disorders in the world with the highest prevalence in areas where malaria was or still is endemic. The burden of this disorder in many regions is of such a magnitude that it represents a major public health concern.

• In Pakistan, around 10 million children are affected. Some 500 to 700 children are diagnosed with the disease every month. Every year more than 5,000 babies who are born with Thalassaemia major die before reaching their fifteenth birthday due to the unavailability of properly screened and matched blood.

• Transfusions are expensive and bone marrow treatment costs up to US$100,000 per patient. Thalassaemia major necessitates a blood transfusion every 15 to 20 days.

• Most remote districts in Pakistan lack awareness of the disease, as well as proper medical facilities, for its prevention and treatment[3].

• The map below shows regions that are affected by Thalassaemia.

[3]"Pakistan: Marching on World Thalassaemia Day," World Vision International, 11 May 2005.

concept of professional blood donation is problematic, it nevertheless means that an additional source of blood donation has been forfeited.

5.1.2 Prevention measures required:

• The prevention of Thalassaemia must be a key priority for policymakers. In this regard, one area that requires attention is pre-marital or genetic counselling to make sure that this hereditary disease is not passed down to another generation. A simple blood test could be made mandatory for all couples intending to marry. In addition, marriages within families should be discouraged. According to one participant:

"Cousin marriages are a major reason for the spread of Thalassaemia. In order to remedy this, all the stakeholders in cousin marriages should be involved and pre-marital counselling should be prescribed for cousins intending to marry."

5.2 Reproductive Health:

Reproductive health is defined as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of, and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant[4].

5.2.1 Maternal Mortality

• Most participants were very critical about the role of the government in addressing Pakistan's high maternal mortality rate. According to one government official,

'there is no protocol, no policies, and no coordination in government hospitals with respect to maternal care'.

• It was commonly believed that the government has neglected this issue because in the cultural context of Pakistan, maternal care and reproductive health more generally speaking, is connected to sensitive topics such as women's sexuality and reproductive rights. In the words of one participant

'The government is well aware of the issues concerning maternal mortality but tends to conveniently brush them aside instead of addressing them. There is also the political pressure from theologians and conservative Islamic groups, which makes the government take a conservative stance on this problem. From the distribution of condoms to spreading awareness about the reproductive rights of women, the government has carried out these campaigns half-heartedly and defensively'.

5.2.2 Funding:

• A major portion of the funding for family planning campaigns comes from international donors. This has made such campaigns very vulnerable to the shifting trends in donor circles and changing political conditions. Most recently, for example, the US government has cut down its funding for family-planning in Pakistan. Some critics believe that this is connected to the conservative political views of the current Republican regime in the US.

5.2.3 Service Delivery:

Devolution Reforms (2000) in Pakistan have had an impact on a range of services, including the government's public health programmes. These devolved government structures have further complicated the roles and responsibilities of different tiers of government in terms of health services delivery. According to one participant,

'There is a need to have a holistic plan of action with a demarcation of clear roles for all the stakeholders in reproductive health services'.

• Comparable baseline statistics on key reproductive health indicators is missing. This poses a problem for policy making and discourages need-based resource allocation.

5.2.4 Gender

• Access to reproductive health services is compromised not only because of inadequate resources but also due to cultural constraints such as women's low empowerment. As a marginalized group in society, women are not able to exercise great control over their own sexuality and reproductive health. This has a direct impact on their ability to access these services:

'Women are often controlled by their husbands or their in-laws. Frequently, they are just not in a position to make decisions about family planning and have to seek permission before taking any step in this direction'.

• In addition to lady health workers, the government should also use male health workers in its interventions. Men are often in positions of power, and male health workers can establish dialogue with them in their target communities to raise their awareness about these issues and to encourage male participation in family planning strategies.

• Reproductive health needs to be analyzed from a woman's perspective – a woman's satisfaction with suggested family planning techniques should be taken into account.

5.2.5 Adolescence

• Even though there are social taboos that discourage adolescents to discuss sexuality and reproductive health issues, the government must target this group and raise awareness among them at a young age. One way of doing this would be to incorporate reproductive health in school and college curricula.

5.3 HIV/AIDS

Pakistan has a narrow window of opportunity to act immediately and

[4]ICPD Programme of Action, A/CONF.171/13, paragraph 7.2

decisively to prevent a widespread HIV/AIDS epidemic. Although the estimated HIV/AIDS burden is still low - around 0.1 percent of the adult population (suffers from AIDS) - the threat due to risk factors is significant. Without vigorous and sustained action, Pakistan runs the risk of experiencing the overwhelming social and economic impact of a full-blown HIV/AIDS epidemic. In recognition of this threat, the government of Pakistan has decided to scale up and strengthen its National AIDS Control Programme. The Government of Pakistan has developed and endorsed a national HIV/AIDS strategic framework, which needs to be prioritized and operationalised for a significant expansion and scaling up of the programme in selected areas.[5]

5.3.1 Awareness/taboo issues:

- The primary obstacle to the success of the AIDS prevention programmes is the criticism that the programmes face from religious clerics. A resolution to this issue is the involvement of these theologians and religious leaders so that they can assist in creating public awareness. However, at present there is a lack of political and religious commitment to prevent the spread of the HIV/AIDS virus.
- There is great shame and stigma attached to the virus which hinders those affected from seeking medical help. Patients require counseling as well as confidentiality in pre- and post-testing procedures.
- Different myths about AIDS (such as the idea that AIDS is only spread through sexual practices) need to be dispelled.

5.3.2 High-risk population:

- Drug addicts, prisoners, and sex-workers constitute a high-risk population. Drug addicts, for example, often share the needles and syringes used to inject drugs and this frequently leads to the further spread of the infection. Research also shows that prisoners are highly susceptible to infection since they live in a closed environmentand often use drugs and sex to vent their frustrations. Sex-workers are another

[5] *AIDS Threat to Pakistan Can Reverse Progress*, by Mieko Nishimizu, Vice President, South Asia Region, Published in Business Recorder, October 9, 2002, World Bank.

AIDS in Pakistan

The first case of AIDS in a Pakistani citizen was reported in 1987 in Lahore. During the late 1980s and 1990s, it became evident that an increasing number of Pakistanis, mostly men, were becoming infected with HIV while living or traveling abroad. Upon their return to Pakistan, some of these men subsequently infected their wives who, in some cases, passed along the infection to their children. In 1993, the first recognised transmission of HIV infection through breastfeeding in Pakistan was reported in the city of Rawalpindi. During the 1990s, cases of HIV and AIDS began to appear among groups such as commercial sex workers (CSWs), drug abusers and jail inmates. The increased rates of infection among these groups are assumed to have facilitated, at least to some extent, a further dissemination of HIV into the general population. Like in most of the region, the estimated HIV prevalence remains low at about 0.06 per cent of the population. Cases have been reported from all provinces, but they appear to have been confined mainly to people engaged in high-risk behaviour. Most of the infected persons belong to the 20 to 49 years age group. Until 1993, most infections were detected among foreigners and in Pakistani citizens returning from abroad. Though heterosexual route is the most common, infection through contaminated blood and blood products and through IDU is also prevalent.

Since the official recognition of the first case in 1987, the number of officially reported HIV infections and AIDS cases has grown to 1699 (as of September 2000). Heterosexual transmission accounts for the majority (37%) of reported HIV cases, with the next most frequent mode of transmission (18%) being related to infection through contaminated blood or blood products. The remainder of the reported HIV cases are linked with infection through injecting drug use (4%), homosexual or bisexual sex (6%), and mother to child transmission (1.3%). Transmission modes for 35% of the reported HIV cases are unknown. Unfortunately, most observers believe that the number of reported cases represents only the "tip of the iceberg", and that the number of actual cases may be far greater than official reports suggest.

While HIV prevalence appears to be low in Pakistan at present, the presence of a number of vulnerabilities and risky behavioural patterns suggest the need for urgent, prioritized, and coordinated action to curtail the emergence of a widespread epidemic. Poverty, genders inequalities and low levels of education and literacy all contribute to HIV vulnerability in Pakistan. Other, related factors that can increase vulnerability at the individual level include unemployment, social exclusion or marginalisation, physical and/or mental abuse, and gender-based discrimination.

Figures	Value	Year
Estimated Number of HIV cases (Adults and children)	74,000	2003
Adults (15-49 years)	73,000	2003
Women (15-49)	8,900	2003
Children	–	–
Esimated number of deaths due to AIDS	4,900	2003
Estimated Number of AIDS orphans	–	–

Source: UNAIDS Global HIV/AIDS Report 2004

vulnerable group and a special effort needs to be made to raise awareness amongst them.

5.3.3 Prevention:

The government health care system with regard to AIDS is cure-oriented. There is a need to shift the focus to preventive measures and strategies. Furthermore, the issue of non-detection/non-reported cases of AIDS must be dealt with by creating greater public awareness.

6. Possible Avenues for Collaboration Within and Across NGO, Government, and Donor Sectors

- Government policies concerning health care systems are fragmented, poorly linked, and poorly prioritized. There is a need for the creation of better, reliable and more consistent knowledge, through baseline surveys and research that can be carried out through formal as well as informal networks.
- Different models for public-private partnerships need to be analysed and discussed. According to one participant, public-private partnerships need to be implemented at multiple levels: at the level of policymaking as well as service delivery.
- There is a research bias among the older generation of researchers, and therefore new researchers should be encouraged and supported in their research initiatives in order to eliminate this bias.

7. Future Role for LUMS

- LUMS needs to expand its image from that of being a mere business-school to an institution which also engages with the key development challenges facing the country. It needs to streamline its development research projects and to create better linkages with other institutions working within the development sector.
- LUMS should encourage increased student participation in development research projects, which could perhaps be incorporated as a mandatory course requirement at both the undergraduate as well as graduate levels.

Frontiers of Hope: The Pak District Comprehensive Eye Care Programme Story

1. Introduction

Globally, it is estimated that there are about 40 million people who are blind. The majority of these are needlessly blind due to conditions such as cataract, refractive error and low vision, trachoma, River blindness and childhood blindness. See boxes for more information on these diseases. Blindness is a major public health problem in Pakistan. It is estimated from recent nationwide surveys carried out by the World Health Organization (WHO) and the Government of Pakistan that the prevalence of blindness in the country is about 1% - i.e. one out of every hundred is blind in both eyes – according to the criteria established by the WHO.

The WHO, together with the International Agency for the Prevention of Blindness (IAPB) and several international NGOs developed a global strategy for Vision 2020: The Right to Sight – that aims to eliminate avoidable blindness by the year 2020. In May 2003, the World Health Assembly passed a resolution urging member countries to implement Vision 2020 at the country level. With an aim to test the strategy of Vision 2020, the Pakistan Institute of Community Ophthalmology in Peshawar, in cooperation with Sight Savers International and the European Commission came up with a proposal to develop comprehensive eye care in seven agencies of the Federally Administered Tribal Areas (FATA) and three districts of the North West Frontier Province (NWFP).

2. The Groundwork for Vision 2020

Professor M. Dawood Khan, the chairman of the Pakistan National Steering Committee for Prevention of Blindness, rector of the Khyber Institute of Ophthalmic Medical Sciences in Peshawar and a visionary behind the District Comprehensive Eye Care Programme in Pakistan, states:

> The districts that were chosen (for Vision 2020) were according to their economic indicators, hence those districts with the worst social economic indicators were chosen for intervention.

The Pakistan Institute of Community Ophthalmology (PICO) is the public branch of the Public Institute of Ophthalmic Medical Sciences. Dr M. Aman, the executive director of PICO elaborated on the elementary research that was carried out to pave the way for Vision 2020:

> We started a primary research to observe the barriers and obstacles at the district level to see why ophthalmologists were doing badly. To our utter surprise we found that they did not have any trained paramedics to help them in outpatient operations and in the wards. Human resource development in training ophthalmologists at the district level is extremely important and without such development, rural districts would not have been able to deliver the services that they were supposed to deliver.

The district as an administrative unit with a defined population and health services structure lends itself as an appropriate geographical area where an eye care programme could be implemented, effectively monitored, detection and referral network established and the overall impact determined. Within the district, there is usually a district headquarters hospital, which may or may not have an eye unit. The plan of the Pak District Comprehensive Eye Care Programme (DCEC) was to upgrade existing facilities and to establish new ones where none existed. Each district eye unit was given a separate

operation theatre, an independent outpatient clinic with a waiting area and a separate ward for patients with eye problems.

The district eye unit is staffed by a district ophthalmologist and assisted by ophthalmic assistants called ophthalmic technicians who have received a one year training at PICO. The district headquarters hospital is usually located within an urban centre, while most of the population of that district resides in rural areas. Awareness about eye health diseases in villages is often poor – many community members do not have confidence in existing health facilities.

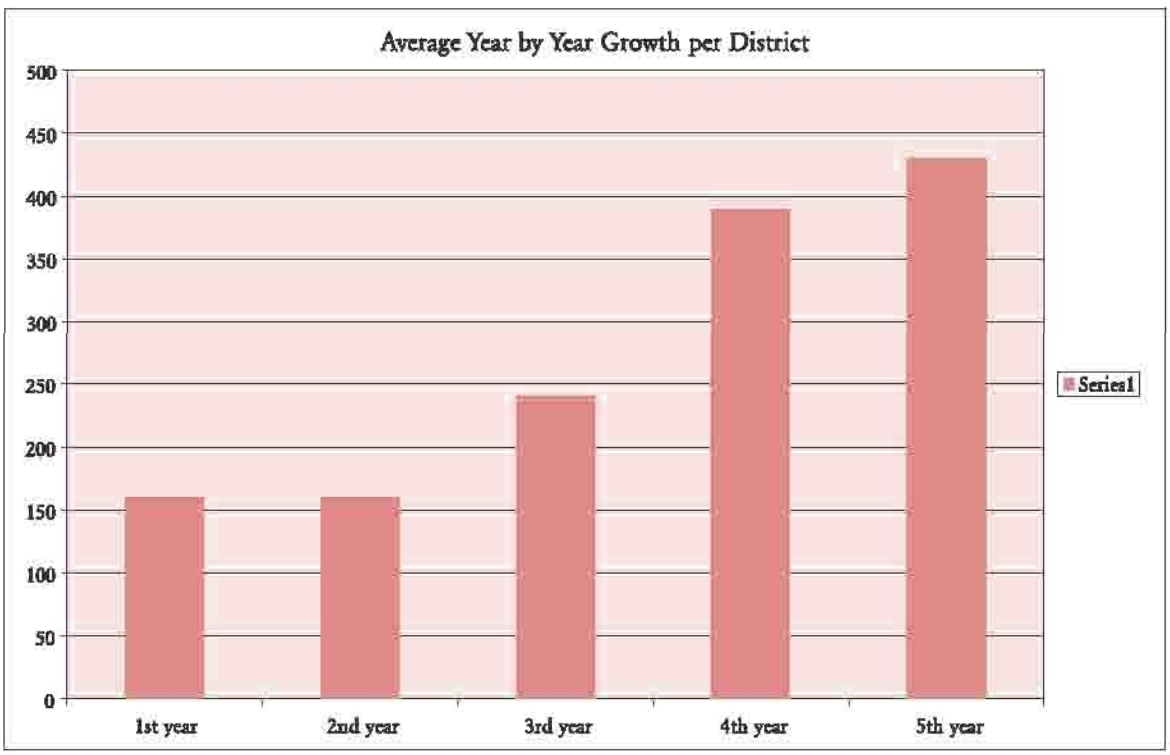
3. Important Stakeholders

For District Comprehensive Eye Care Programme to function effectively, it is important to recognize the other stakeholders within the district. These include, among others, community groups like the *jirga* which is a rural assembly that takes decisions by consensus. These comprise of influential members of the community, who discuss and solve issues related to the welfare of the community. They are also important in mobilizing resources and adopting cost sharing practices for meeting with the cost of surgery for poor people. Other key actors in the district include district administration and health officials. It is vital that they are sensitized early in the Programme and their cooperation is ensured.

4. Monitoring and Program Management

However, no programme can be expected to propel itself on its own without a system of monitoring and programme management in place. A comprehensive eye care training or CECT is composed of a programme manager, an administrator and biomedical technicians providing logistic support to maintain the momentum of the programme and ensure that the objectives are achieved. Dr Nadeem, the Programme Manager states:

To highlight a few success stories of the Pak District Comprehensive Eye Care Programme: the infrastructure development in the hard-to-reach FATA and remote regions of NWFP, and the materialization of the process of reaching the unreachable. The second success is the supply and provision of logistic technological support to those units where the programme has been implemented. The third achievement is the development of human resources for implementing this programme. Another big achievement is the linkages that it has developed among the district's health staff, the provincial leaders of the health system, the local community builders, the NGOs and the political and social elites of the communities in these areas.



Advocacy is an imperative factor for Vision 2020. One of the major problems confronting the very poor in this region was the cost of an intraocular lens used during cataract surgery. In many cases, the cost of the lens was more than a month's earnings. PICO pursued the issue of cataract surgery for the poor with the provincial government and was successful in obtaining government grants to purchase intraocular lenses and other consumables for the poorest of the poor in seven agencies of the tribal areas.

5. Evaluation of the Impact of Vision 2020

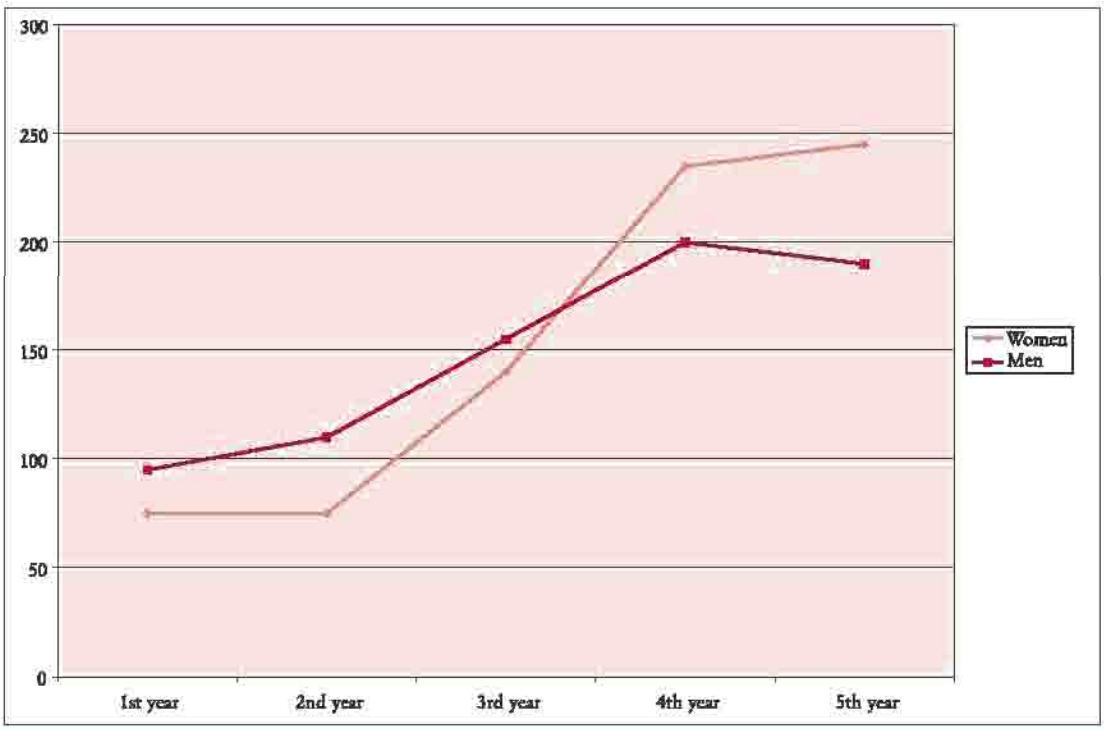
A programme is only as good as the impact it makes. The figure on the previous page illustrates an incremental increase in the uptake of services and is an indicator of the community's confidence in the eye units.

The other major impact that this programme had was on gender and development, as seen in the graph below.

Initially, the access to services for women was lower than those for men. However, by the fourth year of the Programme, the uptake of services by women exceeded that of men. This was made possible by bringing the eye care services closer within the district and by creating an effective detection and referral pathway through primary eye care as part of primary health care.

To recapitulate, the main components of the District Comprehensive Eye Care Programme include:

- Strengthening of infrastructure
- Supply of essential equipments
- Human resource development for primary and secondary eye care
- Developing cataract surgical services as part of disease control
- Increasing access to eye care services for marginalized groups
- Increasing equity in terms of quality of eye care for all
- Enhancing coverage through outreach screening and community eye care
- Community Mobilization in cost sharing and increased uptake of services
- Advocacy for government ownership
- Sustaining development through institutionalization within the existing government health structure
- Partnership with other organizations



Dr Haroon Awan, the country representative of Sight Savers International has been closely associated with this Programme, commends the success of Vision 2020:

This Programme depicts a unique partnership in eye care that has led to the development of the District level Eye Care Programme as a demonstration model for the government. Its wider impact is clearly evident in terms of its replication in over fifty districts of the country. The DCEC Programme provides a platform on which additional layers of capacity can be added for other elements of Vision 2020, such as childhood blindness etc.

Professor Khan adds that:

The concept of comprehensive degree - that is taking care of the preventive needs, operational needs, curative needs and rehabilitative needs has become very popular and is the basis now for eye health care delivery in almost all the developing countries of the world.

Some of the main challenges that future Pak District Comprehensive Eye Care Programmes will have to address include: reaching the unreachable and how to develop effective networking and better coordination between eye care services, rehabilitation for the incurably blind and education services for children who are blind or visually impaired.

Acknowledgements: This report was based on the documentary 'Frontiers of Hope', produced by The Pakistan Institute of Community Opthamology (PICO), in 2004, in association with Sight Savers International, and presented at the Consultative Workshop: The Role of NGOs in the Health Sector of Pakistan, LUMS-McGill Social Enterprise Development Programme.

Onchocerciasis (River Blindness)

What is Onchocerciasis?

Adult worms
(onchocerca volvulus)

Onchocerciasis is an eye and skin disease caused by a worm (filaria) known scientifically as onchocerca volvulus. It is transmitted to humans through the bite of a blackfly (simulium species). These flies breed in fast-flowing streams and rivers, increasing the risk of blindness to individuals living nearby, hence the commonly known name of 'river blindness'. Within the human body, the adult female worm produces thousands of baby or larval worms which migrate in the skin and the eye.

What are the consequences of the disease?

The death of larval worms is very toxic to the skin and the eye, producing terrible itching and various eye manifestations (lesions). After repeated years of exposure, these lesions may lead to irreversible blindness and disfigurative skin diseases sometimes named 'leopard' skin and 'lizard'" skin.

In some West African communities, about 50% of men over the age of 40 years had been blinded by the disease. Finally, people fled the fertile river valleys to settle in less productive upland country. Hence the annual economic losses were estimated, in the 1970s, at US$ 30 million.

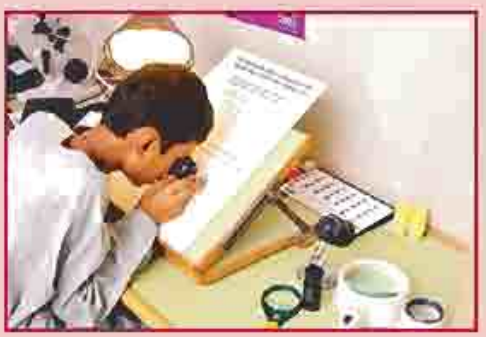
Where is onchocerciasis distributed?

The distribution of onchocerciasis is linked to the location of blackflies which are naturally found close to the fast-running streams and rivers in the inter-tropical zones. Therefore, about 90% of the disease occurs in Africa. Onchocerciasis is also found in six countries in Latin America and in Yemen in the Arabian Peninsula, where the disease is believed to be exported by the slave trade.

An adult blackfly (Simulium damnosum) taking a bloodmeal on human skin

Source: World Health Organization, 2005

Trachoma



The Disease and how it Affects People

Trachoma is an infection of the eyes that may result in blindness after repeated re-infections. It is the world's leading cause of preventable blindness and occurs where people live in overcrowded conditions with limited access to water and health care.

Trachoma spreads easily from person to person and is frequently passed from child to child and from child to mother within the family. Infection usually first occurs in childhood but people do not became blind until adulthood. The disease progresses over years as repeated infections cause scarring on the inside of the eyelid, earning it the name of the 'quiet disease'. The eyelashes eventually turn in. This causes rubbing on the cornea at the front of the eye. The cornea becomes scarred leading to severe vision loss and eventually blindness.

The Cause

Trachoma is caused by an organism called Chlamydia trachomatis. Through the discharge from an infected child's eyes, trachoma is passed on by hands, on clothing, or by flies that land on the face of the infected child.

Distribution

Trachoma occurs worldwide and most often in poor rural communities in developing countries. Blinding trachoma is widespread in the Middle East, North and Sub-Sahara Africa, parts of the Indian subcontinent, Southern Asia and China. Pockets of blinding trachoma occur in Latin America, Australia (among native Australians) and the Pacific Islands.

Scope of the Problem

The World Health Organization (WHO) estimates that six million worldwide are blind due to trachoma and more than 150 million people are in need of treatment.

Interventions

Primary interventions advocated for preventing trachoma infection include improved sanitation, reduction of fly breeding sites and increased facial cleanliness (with clean water) among children at risk of disease. The scaring and visual change for trachoma can be reversed by a simple surgical procedure performed at village level which reverses the inturned eyelashes.

Good personal and environmental hygiene has been proven to be successful in combating trachoma. Encouraging the washing of children's faces, improved access to water, and proper disposal of human and animal waste has been shown to decrease the number of trachoma infections in communities.

Trachoma has blinded an estimated six million people, and a further 146 million people are infected with the disease.

Source: World Health Organization (WHO).

Appendix 1

List of participants attending the stakeholders' workshop.

Government:

1. Dr. Sarshar Ahmad
Chief Chemical Examiner,
Government of Punjab

2. Dr. Darakshan Badr
Director MCH,
Government of Punjab

3. Dr. M. Safdar
Government of Punjab

Donor:

4. Mr. Nawazish Ali Khan Asim
National Trust for Population Welfare-
NATPOW, Islamabad

5. Mr. Rafiq Jaffer
Chief Pakistani Consultant
GeoSpatial/SALASAN
Program Monitor and Technical Advisor
CIDA Democratic Governance Program
Lahore

6. Mr. Niazullah Khan
Programme Officer
Sight Savers International (UK)
Pakistan Country Office
Islamabad

7. Amer Hilal
TVO - Trust for Voluntary Organizations
Islamabad

NGOs:

8. Mr. Aijaz Ahmed
Joint Secretary
Human Friends Welfare Association
District Jacobabad, Sindh

9. Dr. Shahzad Rashid Awan
Chairman
Ahsas Welfare Association
Peshawar City

10. Mr. Abdul Hameed Blund
President
Shehri Ijtamai Taraqiati Council
SHATAC Complex Street,
Mandi Baha Ud Din, Punjab

11. Mr. M. Anwar Choudhry
MPH

12. Ms. Kaniz Fatima
Program Manager
De Laas Gul Welfare Program
Peshawar

13. Ms. Insha Hamdani
Senior External Relations Manager
Marie Stopes Society
Karachi.

14. Dr. Mian Iftikhar Hussain
Executive Director
Health Promotion Welfare Society
Peshawar.

15. Mr. Malik Jamil
Convener/President
Children Education & Welfare Society
CEWS-Renaissance of the Nation
Lahore

16. Mr. Shujjat Ali Khan
Health Programme Officer
Swath Youth Front
Mingora Swat,
NWFP

17. Dr. Parveen Azam Khan
President/Director
DOST Welfare Foundation,Peshawar.

18. Ms. Bushra Khanum
Regional Operations Manager-Punjab
Marie Stopes Society
Karachi.

19. Mr. Zaheer Khattak
CEO
United Rural Development Organization
Peshawar Cantt.

20. Mr. M. Rizwan Lateef
President
Rehber Foundation
Distt: Khushab, Punjab 41100

21. Dr. Akhtar Malik
Chairman
Health&Education Relief Association
Lahore

22. Dr. Ashfaq A. Malik
President
Karsaz Eye Welfare Association
Lahore

23. Dr. Andreas Matt
SOS Children's Villages
Lahore

24. Ms. Tasnim Mian
Executive Member
Lahore Hospital Welfare Society

25. Dr. Mohammed Naeem
President
Sukkur Blood And Drugs Donating Society (SBDDS)
Sukkur, Sindh

26. Mr. Syed Qamaruddin
President
DARES Society for Health Care
Quetta

27. Mr. Mohammed Qazi
Senior Administrator
ShamsShahabuddin Convalescent Home
Mayo Hospital, Lahore

28. Ms. Rehana Rashdi
Director Programs
Pakistan Voluntary Health and Nutrition Association-PAVHNA
Karachi

29. Mr. Allah Nawaz Samoo
Thardeep Rural Development Program
Siran Mithi, Sindh

30. Brigadier Dr. M. Sarwar
Pakistan Thalassaemia Welfare Society
Rawalpindi

31. Mr. Khalid Shafee
Chairman
Sindh Health & Education Development Society, SHEDS,
Hyderabad, Sindh

32. Mr. Wafadar Khan Sundrani
President
Shaheed Shah Nawaz Khan Memorial Social Welfare Association
Jacobabad

33. Ms. Ayesha Wasim
Executive Member
Lahore Hospital Welfare Society

34. Mr. Imran Zafar
CEO
Greenstar Social Marketing
Karachi.

35. Bilal Aziz
Coordinator Trainings
BLCC -Bunyad Literacy Community Council
Lahore

36. Emmanuel Rafail
Sindh Qauwmi Welfare Association

Interviews

In-depth Interviews with Key Informants

Nadia Ejaz



In-depth Interviews with Key Informants

1. Introduction

In order to further strengthen its data gathering process, the NGO Pulse team conducted in-depth interviews with health NGOs in Lahore, Karachi, Quetta, Peshawar and Islamabad. The team employed a semi-structured format for these interviews and most lasted for an hour. Though specific questions were planned for each interviewee, yet the team was open to discussing new insights and directions pertaining to health issues. In total, 25 interviews were carried out.

This chapter looks at the role of NGOs in providing health care in Pakistan through the lens of these interviews. This chapter has been divided according to the salient themes that emerged during this process of data collection: the role of NGOs and the government; reflections on public-private partnership; the challenges facing the health sector; and important lessons learnt. Here, it should be noted that although all the interviews were transcribed, all of them could not be represented equally in this chapter due to the limited scope of this report. Hence, for example, some interview extracts were excluded to avoid repetition in terms of content. Other extracts have also been excluded which were specific to an NGO's own experience that their valence for a wider audience was lost. Thus, a balance had to be maintained between generalization and specificity.

There are essentially four kinds of NGOs:

1. Political NGOs: Their distinguishing features are advocacy, political resources and political linkages.
2. Bureaucratic NGOs: They follow a rigid, non-flexible structure.
3. Humanistic NGOs: They are flexible, non-bureaucratic and participatory. There is a focus on consensus team-building.
4. Symbolic NGOs: They work to serve a noble cause e.g. in churches, mosques etc. Examples include the Edhi Foundation and the Aga Khan Foundation.

Finally, though the chapter is organized around the four key themes mentioned above, each time a new interviewee is introduced, a profile of his or her NGO is provided for the reader in order to offer a better context for the interview. A summary of key points is presented at the end of the chapter.

2. Theme One: The Role of NGOs and the Government

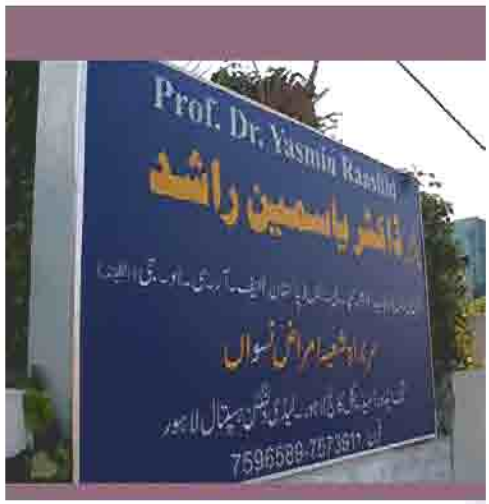
- What constitutes the separate role of NGOs, and where does their responsibility end?
- How do we demarcate the boundary between the role of NGOs and that of the Government?
- What constitutes a feasible division of labour between the two in achieving key development goals in Pakistan?
- How can NGOs better facilitate the government?
- Can they really fill severe gaps in service delivery of health?

In this section, some of these concerns will be analysed.

Dr Yasmin Rashid

Managing Director - Jehandad Society
General Secretary – Thalassaemia Society of Pakistan
Patron – Alzheimer's Pakistan

Dr Yasmin Rashid is a gynaecologist, a medical professor and a prominent member of three NGOs: Jehandad Society, Thalassaemia Society of Pakistan, and Alzheimer's Pakistan. These NGOs raise both, awareness about thalassaemia and deliver health services. The Thalassaemia Society, of which Dr Rashid is general secretary, is a purely medical centre, as opposed to the Jehandad Society, which has a much larger mandate and is actively engaged in providing aid to thalalassaemia patients. Dr Rashid is also the patron for Alzheimer's Pakistan and has recently started a day care centre at the Mayo Hospital, Lahore for the old and needy.



According to Dr Rashid, NGOs in Pakistan have an extremely important role to play in the country's development but to this date this sector has not fully realized its potential.

> "Of course NGOs have a very important role to play in Pakistan. If you look at the role of government in health care it has not been satisfactory. Even the government's primary health care system is not entirely in place and they have had a tough time grappling with some basic issues such as reproductive health, family planning and infant mortality. So by the time you talk about special diseases like Thalassaemia you really see the importance of NGOs. However, the NGO sector is also not coherent. And I think this is a major problem".

Elaborating on this lack of coherence in the NGO sector she explained:

> "Sometimes I feel that while we are quick to criticize the government, we need to also see the gaps and shortfalls in the NGO sector. And if we say that the government's health policies often lack coherence, that there is duplication, and lack of an integrated policy, then how do NGOs compare? There is also vertical duplication amongst NGOs. I think they could really benefit from more collaboration and linkages between themselves so we can spend our limited resources in the best way possible".

Faisal Shafique

Project Manager – AMAL Human Development Network

AMAL has been working for the past ten years in Pakistan, tackling the causes and treatment of HIV/AIDS. Its health education programme focuses on HIV/AIDS and gender.

AMAL focuses on capacity building in the development and social sectors through training workshops and the development of training manuals. The NGO also runs several community outreach and health education outreach programmes. AMAL's Youth Empowerment Services (YES) programme has been recognized by UNICEF as a 'best practice' project. Recently, AMAL has been assigned a project to help commercial sex workers under the National AIDS Programme.

When asked about the role of NGOs in the health sector, Mr Shafique felt that NGOs could certainly prove useful where gaps in the government's capacity could be identified. For example, if the government is only covering government schools to raise awareness about HIV, NGOs could cover private schools. According to Mr Shafique,

> "NGOs can plan at a smaller scale and hence be more effective as opposed to the government that tends to have a mega approach. Often our social mobilization skills are better and we have strong linkages with the community".

"Motherhood cannot be safe until women are allowed to be more than mothers and properly valued and respected by their families and by society. Discrimination against women and girls in terms of nutrition, health care, education, and employment opportunities must be eliminated, and access to reproductive health, including family planning information and services, must be guaranteed."

Dr. Nafis Sadik, Executive Director of UNFPA.

Each year close to 600,000 women - more than one woman every minute - die from complications related to pregnancy and childbirth. In addition, these complications contribute to more than three million infant deaths within their first week of life and another three million stillbirths.

Source: WHO, UNFPA, UNICEF, The World Bank

He also suggested the possibility of forming partnerships with the government and the integration of public-private programmes – a theme which will be covered later on.

Dr Zia
Advisor: Marie Adelaide Leprosy Centre (MALC)

The Marie Adelaide Leprosy Centre initiated work for leprosy patients in Pakistan in 1960. By 1990s, the incidence of leprosy in the country was reduced considerably. MALC has played a central role in this transition under the dynamic leadership of Dr Ruth Pfau.

Today, MALC's main areas of intervention in the health sector include leprosy and tuberculosis and provides nationwide, free-of-cost treatment to underprivileged patients. 98% of the 50,000 tuberculosis patients that MALC treats every year receive free treatment. The MALC also provides training to paramedical staff for tuberculosis and leprosy.

Dr Zia feels that there is certainly a 'gap' between the supply and demand of health services:

> "If we look at our own work, there is virtually no presence of the government in the field of leprosy in Baluchistan and Sindh. But NGOs can go in and target even the most remote areas. Once again, we can frequently provide special expertise for specific diseases. This is not to say that the government should be left out. Certainly not. In 1968, MALC invited the government of Pakistan to undertake a National Leprosy Control Programme in partnership with MALC. And that was a success. So much so that in 1996 the World Health Organisation declared that the disease had been controlled in Pakistan."

Dr Zia maintained that NGOs had an important role to play in facilitating the government and to sometimes pave the way for the treatment of particular diseases and special campaigns.

Fauzia Matloob
Manager Operations – PAVHNA (Pakistan Voluntary Health and Nutrition Association)

PAVHNA is a consortium of nearly 30 NGOs and CBOs (small community based organizations) as its members, working in the development field in Pakistan. In 1979 it started as a mother-child nutrition programme. Today, it has evolved into an organization that deals with family planning, reproductive health, ante and post natal care, STIs and STDs (including HIV/AIDS).

PAVHNA is working in the 'poorest of poor' areas in both urban and rural centres like Korangi in Karachi, and Larkana. Recently, PAVHNA's main focus has been on HIV/AIDS in children in Karachi. PAVHNA works with 17 partners and each NGO covers approximately 140,000 people in specifically demarcated areas. Staff includes Lady Health Visitors (LHVs), helpers, and sessional doctors. PAVHNA also lays importance on health education for males, as a result of which, male talking groups are held.

According to Ms Matloob, NGOs should take some of the pressure of providing health services off the government. She sees the NGO sector as a system that can support the government and its health initiatives:

> "I don't think that NGOs need to necessarily restrict themselves to spreading awareness only. We know that the government cannot cater to all the demand in the country."

According to Ms Matloob, the role of health NGOs should be twofold:

"We have to continue with advocacy work. And we have to continue to lobby with the government. I agree that the problem in the public health care system is not just one of inadequate funding. Even if the allocated budget was well-spent we would see remarkable improvements in the public health system. So obviously there are also endemic problems of corruption and mismanagement. As civil society actors, we must form a pressure group and raise our voices against this. At the same time, we cannot just sit and wait. If we can intervene directly by providing health care facilities we must do this".

PAVHNA currently caters to the health needs of 2.5 million people in Pakistan:

"We currently have 34 community-based clinics and 3 surgical centres and at the same time we provide the government with data that can help them in their own work".

Rumi Dossal
Chief Operating Officer – Fatimid Foundation

The Fatimid Foundation was established as an NGO in Karachi in 1979. It deals with Thalassaemia, Haemophilia and other blood related disorders through therapeutic management. It also handles blood management, which is the processing of blood components for patients. Fatimid Foundation has a strong presence in Karachi, Lahore, Multan and Peshawar and intends to expand to Quetta, while their blood-banking network is nationwide with an emphasis on urban areas.

The Fatimid Foundation handles 70% of all Thalassaemia patients under treatment by Pakistani NGOs. The Foundation has 8,000 Thalassaemia patients and 3,000 haemophilia patients under treatment.

According to Mr Dossal the role of NGOs in health is more important than that of the government or the for-profit sector:

"Currently, I feel that NGOs are more transparent than either the government or the private company set-ups. They tend to have better management practices. Our role is critical in catering to the health needs of communities in Pakistan."

Mr Dossal, used the example of Edhi Foundation to elaborate his point:

"This particular organization's outreach and effectiveness is so great that hospitals are extremely dependent on Edhi ambulances and the entire health system would collapse if Edhi shut down."

According to Mr Dossal, the Fatimid Foundation also provides a similarly critical role in the health system in Pakistan:

"It is estimated that Pakistan requires more than 4000 units of blood everyday. We transfuse around 10,000 bags of healthy screened blood and blood products every month to registered patients. As you can imagine, blood transfusion is one of the basic needs of any medical and health system. But the government lacks such a network. And commercial blood banks are susceptible to all kinds of unethical practices. Under these circumstances, NGOs and Foundations like ours are really providing some of the basic support to the public health system".

3. Theme Two: Reflections on Public-Private Partnerships

Having looked at the views regarding the individual roles of the government and NGOs, informants were urged to reflect on the possibility of collaboration between the public and private sectors in terms of health service provision. The questions asked drew forth a myriad of responses, noted here:

Some 80% of all maternal deaths world-wide are the direct result of complications arising during pregnancy, delivery, or the first six weeks after birth. The five main causes of maternal mortality are haemorrhage - responsible for about a quarter of all maternal deaths-infections, high blood pressure, obstructed labour and unsafe abortion. The last condition, unsafe abortion, accounts for more than a third of maternal deaths in some parts of the world.

The remaining 20% of maternal deaths are the result of pre-existing health conditions that are exacerbated by pregnancy or its management. One of the most significant of these indirect causes of death is anaemia. Other important indirect causes of death include malaria, hepatitis, heart disease and, increasingly in some setting, HIV/AIDS.

Source: WHO, UNFPA, UNICEF, The World Bank

The Fatimid Foundation

Mr Iman-ullah
Concern Pakistan

Concern Pakistan is an Irish NGO that started working in Pakistan in the1960s in response to the Afghan refugee crisis. Gradually, they have also initiated programmes in the areas of HIV/AIDS, advocacy, micro-financing, health and livelihood.

Their interventions in health include hygiene issues on a community level, providing Traditional Birth Attendance service (TBA), helping the government and other NGOs with the National Immunization Programme, and growth monitoring in children.

Regarding public-private partnerships, Mr Imanullah felt that this was of great potential importance:

> "Yes, I do think that looking to the future, this is of critical importance and we need to start thinking systematically of good models for public-private partnership. Currently we see that the government is working closely with many education NGOs. Why cant we take the initiative in terms of health?"

Mr Imanuallah pointed out that there are several reasons why public-private partnerships have not become a trend in the health sector:

> "I think there is great hesitancy on the part of the government. A partnership means both parties have to share information, dialogue over management styles, budgets and so on. And perhaps this does not suit some government departments. Having said that, I think many NGOs also feel that this may complicate their work and that they would be better off carrying on with their mandate without what they perceive as 'interference' of the government. But I think these perceptions need to change. We need to create that change".

When asked whether particular governmental regimes create more enabling environments for public-private partnerships than others, Dr Rashid replied that the issue of which regime was in power was insignificant:

> "I have been working for decades in this field and I really did not feel that one governmental regime was more favourable than another for either NGOs or partnerships. The real problem with the government is that they have the funds but do not know how to allocate them properly. Let me give you an example - I received a grant from the government for one of my reproductive health projects. But they put so many excessive stipulations that spending this money became a nuisance. I would rather not get such funding. This is when collaboration with the government can become troublesome."

Nevertheless, Dr Rashid maintains that public-private partnerships can be immensely productive if implemented efficiently. One such partnership is in operation at the Sir Ganga Ram Hospital in Lahore under the guidance of Dr Rashid. The Thalassaemia Society of Pakistan (TSP) has set up a Thalassaemia Centre at the hospital. TSP contributes a doctor and medicines for thalassaemia, whereas the hospital provides electricity, a rent-free place and shares other municipal facilities such as water and telephone lines. In addition, some of the more critical patients at the Centre have access to specialized care at the hospital.

> "So if a patient of ours goes into cardiac arrest, we can actually send them to the ICU at Ganga Ram. This is one of the many advantages of such partnerships."

Dr Rashid also shared some of her other experiences with collaboration and partnership. Since the 1980s, the Ganga Ram Hospital had stopped serving food to patients. Under her guidance, the Jehandad Society has been serving lunch to all patients at the hospital and has recently begun a programme for the provision of breakfast as well.

Similarly, the Nigh-e-baan Centre is a government-owned centre run for runaway children. According to Dr Rashid, it was in a shambles before the Jehandad Society renovated it. Today, they provide toiletries such as toothpaste and extra nutrition in the form of milk and eggs and toothpaste to each child. They also arrange checkups of the children by doctors on a monthly basis.

At the Kot Lakhpat Jail, the Jehandad Society has arranged for the provision of two lawyers, and offers free legal facilities to all those women who do not have a lawyer. The Jehandad Society also looks after the medical and nutritional needs of the prison inmates.

Rehman Khan
Chief Executive - Gidroshia

A health and development NGO based in Quetta.

Experiences with partnerships are not always positive however as the next informant noted. According to Mr Khan,

> "It is important to have meaningful partnerships. In my experience, I have observed that the government has given subsidies to some district health units in Baluchistan, but there are no checks and balances. In my view, such partnerships are worse because it leads to more potential corruption and wastage of funds".

Mr Operandi of Plan Pakistan had similar views.

Anibal Operandi
Country Head - Plan Pakistan

Plan International has carried out work in the health sector since its inception in 1967. The NGO commenced work in Pakistan in 1997. The four major components that make up the NGO's task mission are health, education, water and sanitation and income generation.

The NGO's main focus area is rural regions of the network. Most houses in rural Pakistan lack proper sewage and villages do not have access to basic education and health services. To carry out its multilateral agenda at the grassroots level, Plan Pakistan has set up the ECCD (Early Child Care and Development Centre).

According to him, public and private actors frequently have very different ideas as to what such partnerships should entail.

> "Often the government looks to forge contracts, rather than partnerships. Partnerships entail a shared vision, an attempt to combine strengths and gain from the created synergy, and the sharing of common principles, such as gender sensitivity. Contracts, on the other hand, are mere economic obligations, and therefore lack the values that drive a successful partnership. This is perhaps the reason why many public partnerships have not been sustainable".

At the Marie Adelaide Leprosy Centre, despite some very successful cases of partnership with the government, (MALC is a major forerunner in the National Leprosy Control Programme in coordination with the government's Provincial Health Departments) there were nevertheless some concerns. It was noted for example that,

> "Co-operation with the public sector has not always been a fruitful experience. Collaboration with the government on a project involving district hospitals outside Karachi turned out to be inefficient as expectations of the government staff were too high and the burden of managerial responsibility and supervision was in the hands of the NGO."

On a similar note, Dr Zia felt that it would be easier if NGOs worked independently.

Various institutions providing health care services.

He felt that there would be a fundamental clash of management philosophies in the two sectors:

> "The government spends many resources on appeasing its staff through promotions and transfers. Nepotism frequently overlooks merit, and the government staff depends on seniority in the system for promotions rather than on good performance. The private sector, by and large, runs differently. There tend to be more checks and balances and I think this enhances its ability to carry out objective planning. But when you talk about partnerships, I fear, these management philosophies may not be compatible".

4. Theme three: NGO problems

Like other NGOs, health NGOs in Pakistan also face a range of challenges. One overriding concern, for instance, is related to inadequate finances. Another problem relates to a lack of coordination with other NGOs and the government, resulting in duplication of programmes and hence a waste of limited resources. The section below examines some of the concerns shared with the research team in the interviews.

Mr Imanullah of Concern Pakistan, talked about the need for coordination between NGOs and the government:

> "The health sector is so big. A lot of NGOs are working on one or two issues. It is difficult to grasp the overall picture. In addition, the public health policy is not that clear. There are different tiers of government with overlapping and sometimes confusing delegation of power. This makes coordination even more difficult".

Another problem identified in the interview was related to rural areas. According to him, human resources are a particularly big problem in the rural areas.

> "It is very difficult to find doctors and other skilled personnel in the rural areas. In addition, even the limited human resources that we do have in these areas, tend to migrate out because of the low pay scales. At the same time, there are virtually no incentives for urban-based doctors or nurses to come to the villages. Not only do they risk lower salaries and fees but they may also be worried about security issues."

He explained further that there is a gender dimension to these problems since they are all the more acute in relation to lady health workers. Community participation and ownership of health projects was another area of concern:

> "When we work in the field, we realize that communities often think that health is the prime responsibility of the government. There is very little community ownership of either government or NGO health projects. In order to rectify this we have to ensure that we do not use bottom-down approaches. Community participation is essential. And in order to achieve this, we have to involve communities from the beginning, during the planning and conceptualization phase and not just during its implementation. Otherwise, we will continue to see an apathetic attitude where some people in the community continue to abuse the system for their own personal or familial benefits."

According to Mr Operandi, of Plan Pakistan, many small-sized local NGOs may be contributing to the development of their localities but due to low administrative and management standards they are not able to realize their full potential. He added that human resource management is a particularly weak area for many of these organizations, where there is lack of open dialogue between different levels of management and hence little consensus-building. In addition, human resources are not always utilized very well:

"For example, certain staff members may be skilled in specific areas such as social mobilization but the organization may recruit them for training. One often sees such a mismatch between skills and job descriptions and there is little attempt to build the capacity of these employees. As a result, the staff under-performs and this affects the impact of the NGO."

Fatima Haider
AAHUNG - Programme Manager

AAHUNG commenced operations in 1997. The NGO provides 'life skills education' to adult and primary school students. A multi-level approach was adopted to develop a curriculum including content and courses on sexual health. AAHUNG aims to change the medical curriculum taught in institutions to include sexual health.

It also provides capacity building training to other organizations that provide medical services. It aims to develop skills to deal with clients and their sexual health problems and to improve the doctor-client relationship. Source:www.aahung.org

According to Ms Haider of AAHUNG, consensus-building in organizations is definitely to be encouraged but it needs to be balanced with systemized processes and procedures:

"At AAHUNG, we have always taken great pride in having a very open and consultative environment and we value the opinions of all employees. But sometimes, we have found this to be problematic as well. When every one wants to be a part of everything else, and roles are not well defined this can lead to internal inefficiency".

Ms Matloob of PAHVNA felt that fund-raising was one of the biggest challenges faced by most NGOs:

"Even if an NGO is currently in good financial shape with a lot of donor money coming in, sooner or later the donor will expect the programme to become sustainable. Thus, NGOs must come with creative methods of fund-raising and this should be an on-going activity. In this regard, I find that proposal-writing skills are imperative and this is definitely an area on which capacity needs to be built. I find so many good development projects that could be scaled up, if only the organization could put together a good proposal and develop expertise in fund-raising strategies".

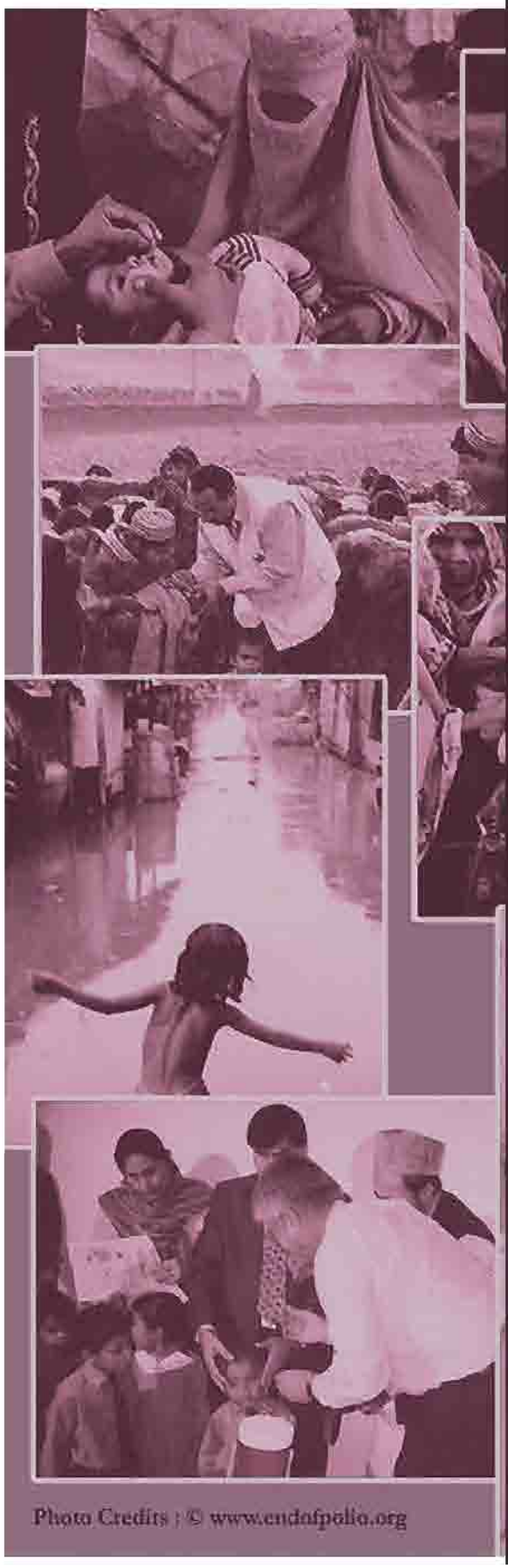
Dr Tanveer Ahmed and Dr Sarwat Mirza
HANDS (Health and Nutrition Development Society)

HANDS was created in 1979 and formally registered in 1993. The organization has been working since then with a strong commitment to develop underprivileged communities through institutionalization functions on an integrated rural development approach. The methodology is to identify, train, develop leadership, facilitate and empower the community to bring about meaningful change.

HANDS' main thematic areas are health, education and poverty alleviation. In health, its main focus areas are maternal and neonatal health and their primary operating areas are in five districts of Sindh including Lower Sindh, Thatta, Hyderabad and Sangarh.

According to Dr Ahmed, the private sector, including NGOs and the for-profit organizations, need better governmental regulation:

"I know that this is not a fashionable thing to say and there has been a lot of criticism of the government in terms of its attempt to regulate the NGO sector. But I think we must strike a balance here. In a country like Pakistan, with weak judicial systems, we cannot allow consumers to be at the mercy of



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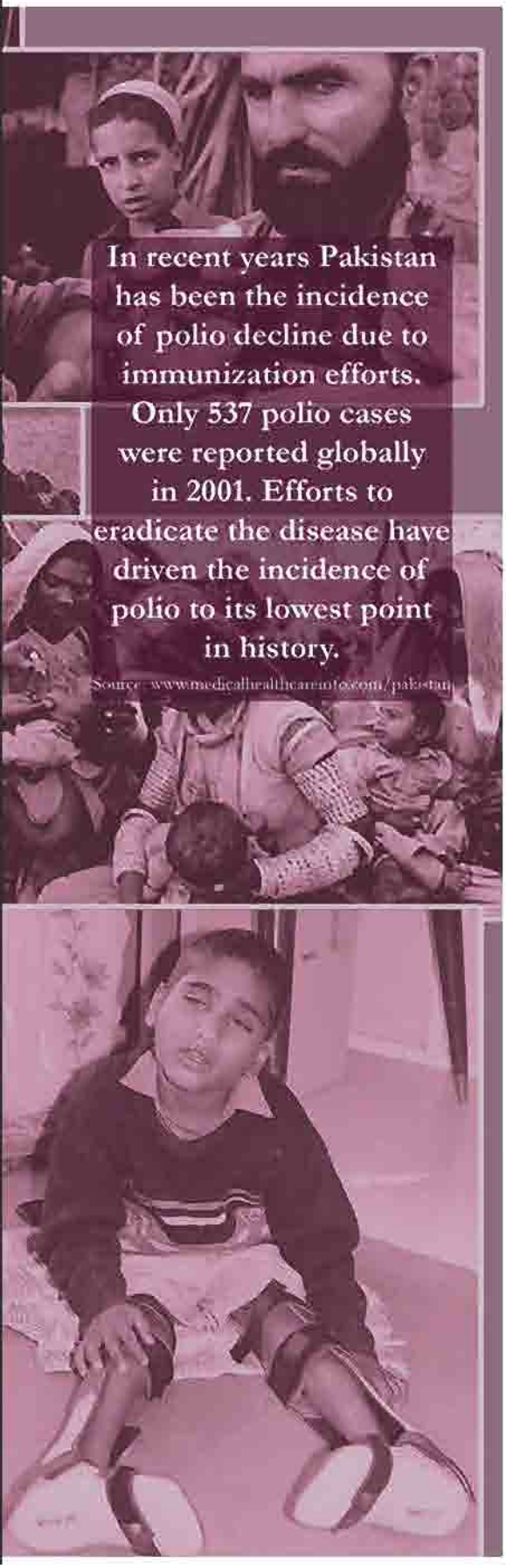

the private sector especially with potentially life-threatening services such as health care. The government must step in and introduce its own regulations and not leave the private sector to create its own standards since the latter will always be vulnerable to the profit motive".

Another area of concern for Dr Ahmed was the relatively little attention given to the training of paramedic staff:

> "Currently the ratio of paramedics to clinicians is 1 to 10. In general the medical universities and the health care system has been geared to training doctors – to enhance their level of specialization. Nurses, paramedics, lady health workers and lady health visitors are all seen as less important in the hierarchy of the medical world. But this is a huge mistake. Paramedics are the foundation of a good national health system. In most countries, we see that this is recognized. But in Pakistan, these professionals are both under-paid and under-appreciated. We need to reverse this trend".

5. Theme Four: Innovative models

A. Jehandad Society: Innovative fund raising, volunteering and awareness

Dr Yasmin Rashid of the Jehandad Society suggests a two-pronged approach to alleviate the problems faced by the health sector of Pakistan. First, she suggests, a spirit of awareness needs to be inculcated among the general populace of the country. In order to do this, NGO personnel need to deliver informative talks and lectures. Another way to do this could be enhanced participation of NGOs in social events, such as organizing 'walks' and festivals.

She consents that it is hard to come up with output indicators for these measures, but there certainly are ways in which their effectiveness can be gauged. For instance, NGOs receive a lot of feedback from society in the form of 'fan mail'. Moreover, there is also the effect of dissemination through the media, particularly radio.

She gives the example of a woman she met who grabbed her hand and said,

> "I had heard you on radio and you had said that the moment a pregnant women starts bleeding, she must rush to the hospital to save her life and that of the infant..."

In another incident, a Pathan man called her and said that after listening to her radio show, he realized that he should not blame his wife for his three successive daughters because the Y chromosome actually comes from the father, rather than the mother.

Secondly, she stresses the need for innovative models of fundraising. According to Dr Rashid, Pakistan has internationally attracted the attention of donor agencies interested in assisting the country in curbing its high maternal fatality rates. However, she is not particularly enthusiastic about the idea of foreign donors. Rather, she believes that the key to development lies in the ownership of the community and indigenous sources of philanthropy. As a result, she is keen to tap into private channels of philanthropy within Pakistan.

Interestingly, Dr Rashid largely relies on informal and private contacts for fundraising. For example, she claims that the Jehandad Society is funded entirely by private individuals who pay in both cash and kind. She maintains that fundraising is not a problem for NGOs in Pakistan, provided that the NGO has a credible name. She agrees that ideally, the NGO should have a system whereby the societies should be able to run even without her 'brand image', but it is true that there is a brand name emerging and people are contributing to the societies on their own.

B. Integrated Health Services (HIS) as a model for school health

The objective of the IHS is to provide health services that are not commonly available or are neglected. Its main thematic areas are disaster management and health. The IHS provides services at peoples' homes and receives its funding by asking for payments for services but at a subsidized rate. IHS does not gain any funding from outside sources. IHS provides emergency relief services through a 'Rescue 15' programme where medical coverage may be given to rescue patients that have been victims of car accidents, natural disasters and so on.

IHS is also seen as the pioneer of 'school health', which was almost non-existent in Pakistan earlier. This entails health education in schools, vaccination/immunization and monitoring child health and growth. On the curative side, in-house school health clinics have been opened to cater to school emergencies. This is the largest in-house school health clinics in school health provision but due to the requirement of funds, services are provided at a cost.

Training is also given in first aid and disaster management by IHS. Master trainers also train school staff and their training is charged from high profile clients. IHS also covers occupational health issues for workers working in hazardous industries.

C. HANDS

Public-Private Partnership (PPP)

Coordination with other NGOs, and different committees and partnerships should be established in order to divide roles. For example, HANDS helps the Aga Khan University Hospital (AKUH) screen patients for Hepatitis B and C. They also have a John Hopkins Water Project aiming towards the reduction of cholera. 45% of HANDS' funds are from local sources by way of donations from the business community and other concerned citizens. HANDS' main international donors are the United States Agency for International Development (USAID), Department for International Development – UK (DFID), European Community (EC), World Population Fund (WPF) and the Aga Khan Foundation (AKF).

HANDS functions in accordance with a public-private partnership. The organization has invented, tried and tested useful models of grassroots and secondary level training programmes. When asked about the successes of HANDS, Dr Tanveer mentioned that the most notable so far is the 'Sustainable Health Services Project'.

HANDS has also established a mid-wifery school. It offers a one year training diploma for men and women. The trainees then return to their local communities and establish their own centres and financial and technical support is provided by HANDS for the local centres. Dr Tanveer also informed the team that the curriculum used at the training schools is uniform through out the whole country. In conjunction with PPP the facilities used are public and the expertise (capital investment, technical skills) and training provided are private.

In accordance with HANDS' integrated rural development approach, adolescent and reproductive health are linked with micro-enterprise (micro-credit income generation) units. HANDS is also behind many nutrition programmes for 40,000 girls at the primary school level.

HANDS has submitted a proposal to the World Population Fund (WPF) so that it may continue to replicate the 'sustainable health services project' model. Another project near completion is the HANDS Institute of Community Development. This provides trainings to other partners. Training programmes are directed to doctors and Lady Health Visitors (LHVs).

"Better health and education, and freedom to plan their family's future, will widen women's economic choices; but it will also liberate their minds and spirits."
Dr. Nafis Sadik

The Department of Community Health Services at the Aga Khan University

In view of Pakistan's low performance in the social sector, the Aga Khan University (AKU), which is the country's premier medical education institution, stepped forward to address the long neglected health issues of the nation. These core values are echoed in the University's mission statement, which reiterates:

[The AKU strives to address] the health problems of the people of Pakistan, especially the more deprived populations, through the primary care approach, and to contribute to improvements in health services, particularly through human resource development.

The AKU's Community Health Services (CHS) programme aims to accomplish this mission through a people-oriented approach. The CHS syllabus is an essential part of the five-year undergraduate medical training programme at AKU. CHS was started by the AKU in the mid 1980s with capacity building in health systems development. The Department progressed through the 1990s with various advances in the application of epidemiology, family medicine and public health practice. Reorganization in 1999 has renewed CHS with an efficient structure for delegation of authority involving experienced and qualified leaders in all core areas. Presently, CHS has a faculty of approximately 33 full-time equivalent posts, plus several honourary faculty members, and in addition, about 120 staff members.

The University has incorporated CHS within its educational setup through the help of two key principles:

i. All students are required to participate in community-based teaching, during which they visit less privileged areas,

ii. Primary health care (PHC) is part of the syllabus, allowing students to experience and acquire first-hand knowledge of all pertinent issues.

In order for the community-based teaching initiative to work at AKU, the CHS staff required training, so that they could teach and mentor undergraduate students. As a result, in-house training programmes were designed and offered to all fresh faculty members. The AKU's Urban Health Programme (UHP), which has intervened successfully in antenatal care, water quality and immunization in five slum areas, was utilized to establish modest PHC systems for the primary health component of CHS, from which both students and the community could benefit. This, in turn, necessitated women to be educated as community health workers and traditional birth attendants (TBAs). Consequentially, the CHS Department devised training materials for both types of health workers.

By initiating these processes, CHS has essentially pioneered community-based learning in Pakistan. Today, the Pakistan Medical and Dental Council (PMDC) has officially adopted the CHS model as a recommendation to all local medical colleges. CHS rural and urban community ventures have been commended for their relevance and quality of programming at both the national and international levels. The Department's education activities have catered to some 450 candidates over the past five years, of whom about one in four have come from foreign countries.

Important Issues/Programmes

The CHS has traditionally relied on a conventional PHC approach, wherein the social development of a region is initially assessed with the assistance of indigenous groups, and then a particular health intervention is proposed.

Following its initial success, CHS facilitated training for community-based organizations in various aspects, including PHC technologies, financial management and proposal writing (see Table 1). Consequently sponsored by the World Bank, the Health Systems Research Project (HSRP) was launched in Thatta (Sind) in collaboration with the provincial government. In this project, too, training inputs were required at various levels to enhance the capacity of a diverse group of individuals. In yet another undertaking, the Rural Community Development Project (RCDP) in Khairpur (Sind), CHS was sponsored by the business sector to provide PHC training. This project represents a noteworthy example of an alliance between a university, a local CBO, an NGO, the local government and the community.

The experience of training from the UHP, RCDP and HRSP led CHS to develop two large-scale schemes: the Family Health Project, a province-wide programme implemented in collaboration with the provincial health department, and the School Nutrition Project, a pilot project undertaken in partnership with the provincial education department and local NGOs. In both cases, training focused on imparting knowledge and skills to a diverse group of learners.

The field experience of the CHS was also consolidated into short courses offered to NGO staff and government officials. These include:

• Continuing Education Programme

Managers and mid-level professionals in the social sector in Pakistan are confronted with complex organizational and programmatic issues. Launched in response to this problem, the CEP provides training in core public health topics, such as reproductive health, quantitative methods and health systems research and management. Under the CEP umbrella, tailor-made courses are offered in fields such as:

- Epidemiology, surveillance and biostatistics
- Health systems research and management
- Community-based social development
- Nutrition
- PHC and reproductive health

The programme has drawn on candidates from throughout Pakistan and abroad over the past five years. It has been taken on the road several times, in Kenya and in the Northern Areas of Pakistan. The success of this programme can be gauged from its financial self-sustainability through fees and external scholarships.

Table 1: Various types of community - based courses included in particular projects.

Family Health Project	School Nutrition Project	Rural Community Development Project
Project Management training for senior government officials – District Health Officers; Divisional Directors	Nutrition and growth monitoring	MCH training for the staff of the MCH centre
Training for the formation of District Health Management Committees	Project Management and implementation training	Volunteers, outreach teams & TBAs trained in PHC, safe obstetrics, family planning and referral of complicated cases
Training of Women Health Visitors: Safe motherhood components	Training in community mobilization, team building, conflict resolution, proposal writing, record keeping, etc	Training in formation of Village Health Committees (VHCs) and CBOs
Training for the formation of Village Health Committees	Using participatory approaches such as 'theatre for development'	For VHC and CBO members, training courses on issues such as decision making, leadership, proposal writing, computer skills, communication skills, organizational management, planning and monitoring

• Community Medicine Residency

CHS has taken a leadership role in Pakistan in developing a four-year residency programme to train physicians in public health skills. The programme combines teaching methods such as classroom teaching, research, field assignments, placements, and on-the- job training in service provision and programme development.

• Research officers training

This programme operates at the entry level and combines course work with a maximum three year attachment with various projects. Besides these short courses, CHS also has other educational programmes:

• Undergraduate and Postgraduate Education

CHS currently delivers about 18% of classroom teaching and coordinates 90% of off-campus education involving students in urban primary health care sites. CHS commenced AKU's first postgraduate degree in 1996, a two-year MSc programme in Epidemiology. This programme was the first of its kind in Pakistan. In 2000, CHS launched a second two-year MSc programme in Health Policy and Management. CHS graduate programmes to date have built a certain potential to develop a PhD in Community Health Services in the future and graduates have been selected for challenging job opportunities in the public and private sector both nationally and internationally. CHS also supplies substantial course content to the AKU's PhD degree programme in Health Sciences, launched in 1999.

• Specialty Education

CHS developed Pakistan's first specialty programme in Family Medicine and Community Medicine. Both programmes are recognized by the College of Physicians & Surgeons of Pakistan and make extensive use of PHC, as well as relevant external attachments under supervision.

• Other Education and Training Initiatives

In order to support the development of research officers attached to projects, CHS for many years has run a Research Officers Programme. This has recently been upgraded (1999) into a Research Officers Training Programme to incorporate formal structured training in research methods. In support of the School of Nursing, CHS has also contributed substantially to the development of Community Health Nursing as a distinct disciple, as well as to the BSc Nursing programme.

Characteristics of the CHS model of training and education:

• Training focus on communities at the

grassroots level or CBOs

- Community participants identifying the training needs themselves
- Use of the participatory approach in training
- Use of transformative learning: change in the perspective of trainees over time
- Approaches such as problem-based decision making through case studies
- Training provided through a diverse work force: public health professionals, community development workers, social scientists, lawyers, epidemiologists, economists, biostatisticians, demographers, and theatre and film specialists
- Research skills in scientific inquiry emphasized
- Training manuals and protocols of priority health issues developed, including a Health Management Information System (HMIS)
- Outcome-oriented training with specific measurable objectives
- Experiences of training shared with the stakeholders
- Wide dissemination of training materials, courses and manuals.

Conclusion

Medical education and training has been a central part of all programmes of the CHS over several years (see Table 1 and characteristics of the CHS model). Through a holistic approach to community development and empowerment, CHS pioneered the idea of community-based medical education in Pakistan at a time when this model was being introduced and adapted internationally. A key aspect of the CHS model is training the health workforce, as well as empowering communities to take development initiatives themselves. Across Asia and in many developing countries, this model has been replicated with similar objectives.

Pakistan's position within South Asia with respect to formal training in public health has been dismal so far, and there is a dire need for more institutes in this field. However, the recognition of research in academic as well as development settings is even more demanding than establishing schools of public health training in the country. It is essential, then, to incorporate a research orientation within the curriculum. Developing research capacity in a country that began with a complete lack in this area is a painstaking process, and involves investing a great deal of time and other resources. Being part of a university that values research, CHS takes pride in leading the country in this valuable and coveted direction.

After having emerged as a centre of excellence for public health in South Asia, CHS is now charging ahead with new and improved educational initiatives and a diversified portfolio of development and research projects in response to the vision and mission of the Aga Khan University.

Over the years, training at the CHS has evolved to accommodate a variety of situations and a wide range of target audiences. This experience has enabled CHS to recognize the processes and methods that help make training more effective. The most important lesson learned is that the method of training should be designed according to the overall objectives of the programme as well as the needs of clients and their specific context.

Source credits: Israr et al, 2003, 2005. Department of Community Health Sciences, 2001

A view of the Aga Khan University Hospital Campus, Karachi

Conclusions

Summary and Conclusions

Nadia Ejaz



Summary and Conclusions

1. Situational Analysis of Health Care in Pakistan

Article 25 of the Universal Declaration of Human Rights (1948)[1] claims adequate health care to be a basic human right. Since then, a succession of international and national constitutions has reiterated this sentiment. Moreover, a substantial portion of development literature establishes a clear link between healthy populations and the development status of a country. Using a sample of seventy countries, the World Bank estimates that a decrease in under-five mortality of 1 percent is associated with a 1.24 percent increase in per capita income growth[2]. Another study showed that improvements in male adult survival rates from 1965 to 1990 accounted for a large proportion of GDP growth and that the effect was particularly strong in poorer countries.

In Pakistan, as well, access to health care is given constitutional legitimacy. The country is also a signatory to the United Nations' Millennium Declaration (2000), which directly relates health to four of its eight major goals[3]. Despite this, however, the status of health care in Pakistan is in dire need of improvement. Most composite and specific health indicators for the country compare favourably with regional trends – a fact that is reflected in the country's low ranking (135) in the Human Development Index (2005)[4]. In particular, infant and maternal mortality rates are high. The health care system also shows gender and urban biases. Furthermore preventive and primary health care is neglected at the expense of curative and tertiary health care.

Together with low levels of public spending on health (less than 1% of GNP), inconsistent policies, weak governance, and inadequate monitoring and evaluation, the public sector is not able to meet the demand for health care in the country. It is estimated that public expenditure on health only amounts for 33% of the total health expenditure.

The private sector - which includes a range of profit-oriented enterprises and non-profit institutions - has a crucial role to play in meeting this unmet demand. Collectively, the private sector accounts for more than 70% of all health expenditures in Pakistan. This resonates with a regional and global trend towards privatization of health care. However, though fulfilling important health needs, the private sector is also heavily skewed towards urban areas and, the more profitable, tertiary health care services. In addition, this sector requires careful regulation, both in terms of cost-escalation and quality of services.

The increasing privatization of health care in Pakistan also elicits a change in the role of the government, from being merely a 'provider' of health care to being an 'enabler' for a range of private actors. At the same time, this trend may lead to the increasing commodification of health care, rather than it being seen as a human right. The debates about the ramifications of these changes are yet to be resolved.

NGOs form an important part of the growing private health sector in the country -according to NGORC, more than 500 NGOs work on health or health-related themes. In addition, the role of NGOs is further enhanced as they enter fruitful partnerships with both the government as well as other actors in the private sector. The remaining report focuses exclusively on the role of these NGOs and their partnerships with other stakeholders.

2. The Role of Health-related NGOs

Based on a questionnaire survey of 200 representative NGOs (with a response rate of approximately 35%); a consultative workshop held with key stakeholders, and in-depth interviews with prominent NGO practitioners, the study reaches a number of conclusions:

- The NGO sector as a whole rose to prominence in the 1990s. Health-related NGOs are similarly a recent phenomenon: 62% of NGOs surveyed for this report were also established in the 1990s.

- There is little centralized and synthesised information about the role of health-related NGOs in Pakistan. This maybe partly attributed to the fact that there is no single regulatory body for NGOs. Moreover, the latter are not always registered. Those registered, fall under a wide array of Acts, which makes it even more difficult to document their role in delivering heath care. According to our survey, 56% of the sampled NGOs are registered under the Social Welfare Act; 24 % under the Societies Act.

- There is a strong geographical bias in favour of urban areas and developed provinces amongst NGOs. 57% of those surveyed reported to have their headquarters in Punjab.

- The scale of operations for most NGOs is small. 50% of those surveyed cover less than 5 districts whereas only 3 NGOs covered more than 100 districts.

- Most NGOs see their role as complementing that of the government and not substituting it. While many are involved in direct service delivery and curative care, most approach it with caution and feel that comprehensive outreach atthe national level is currently beyond the

[1]http://www.un.org/Overview/rights.html
[2]ADB 2005
[3]http://www.un.org/millenniumgoals/
[4]http://hdr.undp.org/reports/global/2005/pdf/presskit/HDR05_PKE_HDI.pdf.

scope of the sector. Most NGOs, therefore, emphasize preventive health care and awareness building. Providing health education to community members also emerged as the most common type of service provided by NGOs sampled for this report.

• Many NGOs are not involved in direct service delivery of health products. However, for those that do undertake this activity the primary modes of service delivery include community based clinics and regular or special camps. The figures for the surveyed NGOs were 60% and 66% respectively.

3. Strengths of NGOs

• Grassroot mobilization, advocacy and raising awareness are considered to be key strengths of NGOs. 59% of NGOs surveyed for this study reported providing preventive health education to communities.

• Many NGO practitioners felt that due to their small scale of operations, they tend to recognize the health needs of their communities much better than those who make policies at a macro-level. This also enables NGOs to use more participatory approaches for their projects as compared with either public or other private actors (e.g. pharmaceutical or health insurance companies).

4. Challenges faced by NGOs

• The unavailability of funds poses a big challenge. Most NGOs reported this to be their primary concern. In addition, they tend to be dependent on donors for funding. Because of this dependency, they have to frequently cater to donor-driven agendas. A sudden discontinuity in terms of donor funds can therefore adversely affect the core-business of an NGO.

• Weak knowledge management in an NGO means that knowledge accumulation is neither well documented nor well directed. In such cases, the organization cannot create a strong repository of knowledge for future reference.

• NGOs are often poorly skilled at organizing fund raising activities.

• NGOs often suffer from inadequate and unskilled human resources - a number of NGOs working in the health sector have staff with very little health and hygiene knowledge. There is also a need for more management expertise.

• The quality of service delivery and health care equipment in NGOs needs to be scrutinized and its shortcomings rectified.

• There is frequently a lack of collaboration and networking among NGOs. There is extensive overlapping in terms of interventions and there is little sharing of knowledge or experiences.

• The new trend of 'government-driven NGOs', such as those run by the wives of high ranking government officials is often problematic. Such NGOs tend to face conflicts of interest due to their strong ties with the government as well as allegations of mismanagement of funds.

• Weak accountability systems have led to low credibility for many NGOs. This constraint needs to be removed if these organizations are to generate funds for their projects and/or win support from the government.

3 Public-Private Partnerships

Most NGOs are receptive to the idea of partnerships. Of those included in our survey, 38% were involved in partnerships with the public sector, 52% with other NGOS, and 40% directly with the community. This also emerged as a key theme in the consultative workshop and interviews. The following points were particularly salient in these discussions:

• Acceptance from, and coordination with, the government needs to improve. Public-private partnership needs to be undertaken so that NGOs may complement the government in implementing an effective strategy for development in the country. Moreover, these partnerships need to be implemented at multiple levels: at the level of policymaking as well as service delivery.

• Different models for public-private partnerships need to be analysed and discussed. There is currently a dearth of research on this topic.

• There is a sense developing that options which include public sector financing of such services for implementation and management by the private sector need to be explored, and perhaps even pilot-tested.

4. Other Cross-Cutting Concerns for Health Care in Pakistan:

• Alternative medicine

Different forms of alternative medicine, including indigenous systems of medical knowledge need to be studied, documented and revived. In particular, there is great scope for utilizing indigenous forms of medicine as low-cost alternatives to allopathic medicine. There is a need to study, revive and form linkages with traditional systems of medicine.

• Regulation

Lack of regulation emerged as a key concern for both the private and public sector. In view of the burgeoning role of the private sector and lack of regulatory bodies, the government needs to take a more pro-active role in this regard. Our survey also revealed that regulation of drugs and health care standards is the least frequent area of intervention for NGOs.

• Statistics

There is a dire need to develop databases for baseline information for all sectors. Furthermore, there is a need for disaggregated data as there are substantial geographical and gender biases in the health care system.

• Demand Side problems

There is a frequent tendency for policy makers to focus on the supply-side of health care. There is an urgent need to study the demand side, particularly the cultural context of targeted communities and their particular concepts of health and health needs. Related to this is the issue of lack of community ownership. Both public and private sectors need to develop more participatory approaches to their projects to ensure maximum cooperation from communities.

• **Concepts of health**

While there is a diversity of perspectives on health and medical treatment, there is a need to encourage debate about holistic perspectives that can address the many different dimensions of what it means to be a healthy individual. There should also be dialogue about the different ramifications of conceptualizing health as a commodity as opposed to an inalienable right.

• **Gender**

Gender disparities in health care systems exist both in terms of demand and supply. More specifically, not only are women less able to access health care, but they are also under-represented in health policymaking and the medical profession.

• **Paramedics**

There is an urgent need to develop paramedics as they form a crucial support system between doctors and patients.

• **Stakeholders**

Policies with regard to health must include all actors from the public and private sectors as well as direct beneficiaries.

• Medical Colleges and Universities Education

Medical curricula need to put greater emphasis on community health and health policy.

• **Volunteerism**

The potential for the use of volunteers has been under-utilised.

• **Vertical Campaigns**

Both the public and private sectors display a tendency to work on vertical campaigns. There is a dire need to form horizontal synergies in view of an integrated vision for health in the country.