Devolution in Health Sector
Challenges & Opportunities for Evidence Based Policies

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Authorship & Copyrights

Dr. Babar Tasneem Shaikh is one of the leading public health experts in the country with areas of interest in Health Systems, Health Policy and Health Systems Reforms. He has worked on themes such as quality of care, access to health care especially for women and children, health systems strengthening through decentralization, and public private partnership in primary health care revitalization in the country. His flagship work on health seeking behaviours and health services utilization has become a cutting edge in the field. His research work is extensively disseminated through more than 70 peer reviewed publications in both national and international indexed journals. Besides his articles, he has published training manuals, research reports, position papers and a chapter in the book titled Health System of Pakistan.

The work is commissioned by Lead Pakistan, a non-governmental organization which has a mission to create and nurture networks of people and institutions promoting change towards the sustainable development – the development that is economically sound, environmentally responsible and socially equitable.
## Abbreviations and Acronyms

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency Syndrome</td>
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<td>AJK</td>
<td>Azad Jammu &amp; Kashmir</td>
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<td>BHU</td>
<td>Basic Health Unit</td>
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<td>BISP</td>
<td>Benazir Income Support Program</td>
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<td>CCI</td>
<td>Council of Common Interests</td>
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<td>CMW</td>
<td>Community Midwife</td>
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<td>DEWS</td>
<td>Disease Early Warning System</td>
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<td>DGHS</td>
<td>Director General Health Services</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DoH</td>
<td>Department of Health (Provincial)</td>
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<td>DTL</td>
<td>Drug Testing Laboratory</td>
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<td>EDL</td>
<td>Essential Drug List</td>
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<td>EHSP</td>
<td>Essential Health Service Package</td>
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<td>EPI</td>
<td>Expanded Program of Immunization</td>
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<td>FLL</td>
<td>Federal Legislative List</td>
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<td>GB</td>
<td>Gilgit-Baltistan</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, TB &amp; Malaria</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>HRIS</td>
<td>Human Resource Information System</td>
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<tr>
<td>IHMNCI</td>
<td>Integrated Management of Neonatal &amp; Child Illnesses</td>
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<td>IPAP</td>
<td>Information, Planning and Policy</td>
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<td>LHW</td>
<td>Lady Health Worker</td>
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<td>LMIS</td>
<td>Logistics Management Information System</td>
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<td>MHSI</td>
<td>Minimum Health Services Package</td>
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<td>MNCH</td>
<td>Maternal, Neonatal &amp; Child Health</td>
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<td>MoH</td>
<td>Ministry of Health (Federal)</td>
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<td>MSDP</td>
<td>Minimum Service Delivery Package</td>
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<td>MSDS</td>
<td>Minimum Service Delivery Standards</td>
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<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<td>NFC</td>
<td>National Finance Commission</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NNS</td>
<td>National Nutrition Survey</td>
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<td>OOP</td>
<td>Out of Pocket (expense)</td>
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<td>PDHS</td>
<td>Pakistan Demographic &amp; Health Survey</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHSA</td>
<td>Provincial Health Services Academy</td>
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<td>PPRA</td>
<td>Pakistan Procurement Regulatory Authority</td>
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<td>PSLSM</td>
<td>Pakistan Survey of Living Standards Measurement</td>
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<td>PWD</td>
<td>Population Welfare Department (Provincial)</td>
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<td>RHC</td>
<td>Rural Health Center</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UN</td>
<td>United Nations</td>
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Foreword

LEAD Pakistan in partnership with David & Lucile Packard Foundation has launched “Our World: Women Leadership in Reproductive Health & Development”, a project that aims to sensitize a cross-sectoral network of leaders and motivate them to raise the profile of reproductive health in the social development sector through public policy engagement and media. The goal of the project is to generate debate and dialogue with multi-sectoral experts, academics, intellectuals and policy makers on pertinent issues in the field of health, climate change and human development to enable informed policy making.

With the deadline of Millennium Development Goals approaching near, Pakistan needs to assess its position on the health status of its nation. The health of its citizens is amongst the poorest in the world. The state’s healthcare system has suffered a lot, owing to structural fragmentation, resource scarcity, inefficiency and lack of functional specificity, gender insensitivity and inaccessibility. Given the eighth highest newborn death rate in the world, between 2001 to 2007 one in every ten children born in Pakistan died before reaching the age of five. Similarly for women, there is a one in eighty chance of dying of maternal causes during reproductive life. Compared to other South Asian countries, Pakistan currently lags behind in immunization coverage, contraceptive usage and infant and child mortality rates.

This called for innovative and sweeping changes, the basis for which, it seems, has been laid by the 18th amendment, albeit without the intention of its authors. However, the 18th amendment has indeed ushered in new opportunities and challenges of governance, legislation, management, leadership, financing, resource allocation, human resource, monitoring, coordination, compliance and service delivery. It has brought a new shift of power and responsibilities between the federation and provinces. With decentralization, there are opportunities for streamlined processes, more accountability, increased autonomy for decision making, evidence based estimation and management of human and financial resources, increased capacity building of health workforce and an overall pragmatic, practical and realistic approach of health care management. This offers a chance to rebuild the ailing health system, but these opportunities come with innumerable challenges as well.

This paper explores pre- and post-devolution status of health related subjects following abolition of the Federal Ministry of Health. It highlights the implication of devolution on governance, service delivery, health information, medical and drug regulations, human resource and healthcare financing based on the six pillars of the WHO framework. It also presents outlines of proposed strategies that the provinces have developed in the wake of devolution. Listing and briefly discussing all key issues of the health sector before and after devolution, the goal of this comprehensive study is to encourage debate and discussion on policy implications, providing insight on future roadmap for the provinces. Through this paper, LEAD has attempted to demystify the devolution process and understand the impact of 18th amendment on health reforms. We hope it will adequately serve the purpose for which it was conceived and actualized.

Ali T. Sheikh
CEO, LEAD Pakistan
Executive Summary

Health system in Pakistan has been lagging behind in terms of key health indicators of maternal and child health as well as of Tuberculosis, Malaria and HIV/AIDS. To accelerate the pace toward achieving or at least nearing the Millennium Development Goals and targets concerned, it would be imperative to take some radical and rational steps for improving the performance of our health system. There is growing evidence that decentralized sharing of powers can bring decision-makers and service providers closer, better informed and more accountable to populations they serve. Pakistan has undergone organizational reforms through a constitutional amendment in June 2011 (famous as 18th amendment). Health as a result becomes solely a provincial subject. Since provinces are autonomous and constitutionally more powerful to decide for their health systems roadmaps, it is very opportune time for all of them to consider and employ best practices and opt advocated strategies for health system strengthening worldwide. Issues of governance, financing, human resource and service delivery ought to be taken on priority for the sake of serving the poverty struck people of Pakistan. These are some of the imperatives for ensuring the equity, efficiency, quality and financial soundness in the new devolved system. The commitment to achieve the health related Millennium Development Goals becomes even more challenging.

This paper has endeavored to analyze the WHO framework on building blocks of health system to catalogue challenges and constraints in wake of recent health reforms. These are, governance, service delivery, health information, financing, human resource and medical products/technologies. Salient features of all the provincial health sectors and their respective strategies (Punjab, Khyber Pakhtunkhwa, Sindh, Balochistan, AJK, & Gilgit-Baltistan) are presented so that readers can appraise whether these 5 years plans made by the provinces, will suffice to meet the requirements, demands and challenges of provincial health systems.

Last part of the paper deliberates on the health systems and policy implications of the devolution, presenting both positive and negative sides of the phenomenon. Key strategies for health system strengthening are proposed with an aim to assist the provincial governments to benefit from these guidelines. For non-government outfits, this paper will be an effective advocacy tool for lobbying with the government entities and providing technical assistance wherever the need is felt.
Introduction

Globally, 115 countries in the world unambiguously recognize right to health, but not the constitution of Pakistan. With recent promulgation of 18th amendment in Pakistan, education is included as fundamental human right, whereas right to health has yet not accorded any attention. Health for all is not treated as a legislative subject, though some of the subjects related to health are included in the legislative list of the Constitution of Pakistan.

Ratification of this famous amendment decentralized decision-making on health related subjects to the four provincial health departments of Pakistan. Decentralization mostly driven through political pressures as the case in Pakistan may have various forms such as de-concentration, delegation, devolution and privatization. The over overall purpose is to share powers and take decisions at decentralized level (district or provincial) of health system. There is growing evidence that decentralized sharing of powers can bring decision-makers and service providers closer, better informed and more accountable to populations, they serve. Decentralization tends to simplify management and enhance the efficient use of resources, ensuring equity in terms of improved access to and delivery of health services for the under-served, marginalized, vulnerable and remotely located population groups. Decentralization as a national agenda involves other sectors, thus promoting an inter-sectoral collaboration, which is a cornerstone for revitalization of Primary Health Care (PHC) services in developing countries like Pakistan. As a result, responsiveness of health system can be improved as well as the quality of health services.

Objectives of Devolution in Health Sector

Mixed results have been yielded as a result of decentralization or devolution of power in health and social sectors in various countries across the continents. Absence of a national policy and stance, the inequities in the distribution of finances, human resources and structures can even deteriorate. There is a likelihood of an increased inefficiency due to gaps in the managerial capacity of sub-national tiers of the government. Moreover, the political pressures can escalate on local managers, and corruption may become more rampant with the availability of increased resources and weakened monitoring and evaluation of health system performance. At times, the decentralization makes it more difficult pursuing coherence of local plans with national goals and policies. This scenario is even worse where the sub-national capacity and an overall environment are weak. The overarching objectives, however, behind any devolution focus the empowerment of the people at grass roots level and ensuring a bottom up decision making process. It is also envisaged that quality health care will be provided with an integrated approach and resource pooling. Sub national units will be able to develop their own human resource and therefore will address the issue of programmatic sustainability. Lastly, devolution is considered to bear fruits of governance in the shape of prompt, equitable & professional services.

Guiding principles and pre-requisites

Lately, WHO presented the guiding principles as pre-requisites for a successful decentralization of health services such as, political context, organizational change, forecasting realistic goals, compliance with legal and regulatory framework, evidence based estimation and management of human and financial resources, capacity building of health workforce and monitoring and evaluation to practice equity, efficiency, quality and financial soundness of the new system.
Devolution in Pakistan: the 18th amendment

The health system of Pakistan has experienced a slow evolution of reforms since its establishment. Decentralization in Pakistan predominantly resulted as a consequence of democratic political decisions; nonetheless, there were economic, legal, and organizational reasons behind these reforms. One of the hallmarks was devolution of powers in 2001 which led to decentralization of health services and hence creation of district health system. Yet again, two momentous reforms related to constitution and fiscal relationship among provinces and federation have undergone a drastic change.

These organizational and fiscal reforms are 18th Constitutional amendment (2010-2011) and 7th National Finance Commission Award (NFC) of 2010-11. Under NFC Award, remarkable share of finances and other resources have been transferred to provinces. The 18th amendment has shifted administrative and financial powers to provinces due to abolition of concurrent legislative list. As a result, 18 ministries including health, population welfare and other social sectors have been removed from the federal list in the of the constitution of 1973. New constitutional provisions pertaining to health related subjects have been added to federal legislative list as a result of recent overdue reform phase. Ironically, health is still not mentioned as a fundamental right in constitution of Pakistan which may have serious repercussions on policy and management of health sector in wake of recent reforms particularly when unplanned transfer of resources are taken into account. The 18th amendment brings a major change in structures, service delivery and resource generation between federal and provincial governments.

Despite having significant health reforms with new administrative and financial control of provinces over health related subjects, the country’s health indicators have progressed slowly towards attainment of Millennium Development Goals 4, 5 & 6. Maternal, neonatal, and child health indicators are below par, and are associated with health system constraints. World Health Report prioritizes focus equities in health, access to care and quality of health care and it identifies primary health care as a key to strengthen health system. Recent reforms in Pakistan bring an opportunity to align by and large vision for health and development as well as make a difference in rural population of four provinces that is in dire need for essential health packages.

This paper will present pre- and post-devolution status of health related subjects following abolition of federal Ministry of Health. The implications of devolution on governance, service delivery, health information, medical and drug regulations, human resource and healthcare financing will also be discussed. Finally this paper will catalogue threats and opportunities for healthcare provision by provinces in post-devolution scenario.

Pre-18th amendment scenario

During pre-18th amendment scenario, two health related subjects have been added to legislative lists (federal and concurrent), were part of the constitution to set sharing of legislative powers between federal and provincial assemblies on various portfolios. The Ministry of Health (MoH) was operating through concurrent legislative list and was managing provincial health departments, eleven vertical programs and seven tertiary care centers.

With a few exceptions, the MoH performed number of functions such as role of stewardship including policy-making, standardization of guidelines, formulation of academic policies for all cadres of health workforce, dealing with foreign governments and agencies, international commitments and agreements. The standardization, registration
and pricing of medicines were a federal responsibility, with the provinces involved only in quality control issues. All the financing mechanisms such as collecting, pooling and purchasing for health were federal prerogatives. Furthermore, Federal Ministry of Health was implementing eleven vertical priority preventive programs notably those for the lady health workers, maternal, neonatal and child health, tuberculosis control, malaria control, national AIDS control program, EPI, control of hepatitis, and prevention of blindness program. While all these programs received funding from bilateral/multilateral donors and/or UN agencies, they were also co-funded by the provincial exchequer, with some federal support both in financial and technical terms. Although some of these vertical programs were financed exclusively by the federal ministry, National Health Management Information System and other parallel information systems of specific programs on family planning and primary health care, EPI, tuberculosis, AIDS, malaria etc were being operated at the federal level.

Post-18th amendment scenario

By virtue of exclusion of concurrent list and shifting of some health related subjects to federal list, the provinces will be more empowered to operate their respective health systems, financially and administratively. The second part of the Federal Legislative List (FLL) is influenced by the Council of Common Interests (CCI). The CCI has even representations from the parliament and the provinces and has attained a significant role in formulation and regulation of policies for all the subjects including health after the abolition of the Ministry of Health. The federal government can only legislate on the subjects in second part of federal list after consultations with the provincial representatives of CCI. Subsequently, many of the functions of the abolished MoH are now delegated to eight institutional settings in the capital and service delivery entirely to the provinces. The entities taking on MoH functions at the capital level are Economic Affairs Division, Cabinet Division, Planning & Development, Ministry of Inter-Provincial Coordination, Ministry of National Regulation and Services, Capital Administration & Development and Federal Bureau of Statistics.

The stewardship functions such as policy formulation and use of evidence in health planning has been devolved to provinces. The provinces have now have control over to plan their own health needs and evidence based policies. Service delivery programs which focus on vulnerable segments of the Pakistan population can help provincial governments to meet health needs through decentralized decision making. Yet under contractual arrangements, some programs such as TB, Malaria and AIDS have been retained with Federal Ministry Of Inter-Provincial Coordination. Following organizational reforms, provinces will get enhanced financial share under 7th NFC awards. However, service delivery programs are facing financial constraints from the federation and respective provincial health departments during this interim phase of organizational reforms.

Pakistan has history of allocating more of its health budget on secondary and tertiary care as compared to primary health care. At present, provinces have leverage to spend more in primary health care system to improve efficiency and utilization of health services. National Health Management Information System has been replaced with District Health Information System where information flow mechanism is from first level care facilities to provincial health departments. Drug Regulatory Authority for standardization, legislation and administration of drugs has been retained with the federation in the post 18th amendment scenario.

Manifestly, recent wave of organizational reforms has devolved other social sectors including health to provinces. While envisaging six building blocks of health system, many functions and coordination mechanisms of the abolished MoH are fragmented and distributed to various institutional settings in the central ministries.
Challenges

The commitment to achieve the health related Millennium Development Goals becomes even more challenging with the abolition of the federal MoH, leaving many areas vacant, where federal role is still very crucial. Nonetheless, devolution of health sector poses many questions in terms of the capacity of provinces for health planning and regulation of policies, strategic directions and leadership, health information generation, human resource development and international agreements. Current institutional arrangements pose health system challenges and constraints, as various functions and departments related to health have been devolved, merged or retained.

The WHO framework on building blocks of health system would be analyzed to catalogue challenges and constraints in wake of recent health reforms. These are notably the governance, service delivery, health information, financing, human resources and medical products/technologies.

A successful reform brings transition of health programs in such a way that healthcare delivery should not suffer. The financial backlash of transferring the federal vertical program was not worked out for each province. The transfer of additional programs and activities to provinces was sudden, with nominal interim technical guidance from federation. As a result vertical programs are facing issues of fiscal support from their respective health department in each province. Lack of ownership by the provincial governments to support vertical programs can have serious implications on availability, affordability and accessibility of health commodities and services.

b) Service delivery

Adequate health policy framework, which set norms and standards, has been the missing link in health system of Pakistan. At present, government has no national health policy. A draft version of National Health Policy 2009 was prepared but could not be approved due to very recent organizational reforms. These reforms now put added responsibility on four provinces of Pakistan to seek policy guidance in order to develop their own health strategies. Only two province, Khyber Pakhtunkhwa and Punjab has approved health strategy as opposed to other provinces which are currently developing respective strategies. Inter provincial harmonization on national health policy development is missing and can be advocated through the forum of CCI.

Post 18th amendment, there is absence of federal regulatory authority for the regulation and coordination of health related subjects such as international relationship, national health information and reporting mechanisms, financial forecasting and donor coordination. The fragmented functions and distributed coordination activities assigned to various institutions and provincial departments is challenge for the provinces, where minimal coordination among institutional settings shall be overseen. Another challenge for the provinces is creation of good administration and fair governance in their health systems. Local Government Ordinance 2001 aimed at improving health system responsiveness according to local needs through participatory decision making and more accountability to public. However, weak political support and fragile capacity of the local governments could not institutionalize and govern health systems. The weaknesses such as stewardship role and leadership at the provincial level should not be overlooked in this interim transitional phase.
provincial harmonization, contractual agreements, resource mobilization and donor preferences in order to practice one window operation with donor organizations. An example to cope with this challenge is Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) which is retained in federation to support three vertical programs under contractual agreements.17

c) Health Information

Institutional capacity to address public health emergencies and disease security is strongly dependent on collated information system, where prime purpose is to collect, collate, analyze and disseminate information for evidence based policy and practice. Most important challenge for Pakistan in the post devolution scenario is lack of integrated disease surveillance system and lack of inter-provincial information sharing mechanisms. There is likelihood that tools and indicators to measure and monitor health may vary across provinces.

In such situation, there is limited utilization of the information and evidence for planning in national programs, assessment of health services and surveillance in cases of disease security. Absence of collated provincial information system and irregular reporting mechanisms from health facilities are key constraints in informed decision making by provincial stakeholders and coherent resource allocation for priority interventions.

d) Human Resource

Lack of trained staff is a chronic issue for under-utilization of primary health care services in Pakistan. So, far provinces have failed to address inadequacies and mal-distribution of human resource that is unevenly deployed in urban and rural settings. At this point in time provinces have to develop human resource information system for the purpose of future human resource (HR) requirements.

The abolished MoH strength was 450 employees and other functionaries serving in federal institutions. With the effect of devolution, provinces have to absorb this additional human resource which puts extra burden on fiscal capacity of provinces. In addition, concerns regarding service structure and protection of medical and paramedical staff are immediate repercussions of 18th amendment. Very recently, frequent strikes by the young doctors of Pakistan on their service structure issues have become a serious affair for the provincial health departments.

e) Health Financing

NFC will remain responsibility of federal government after 18th amendment. However, there is increase financial share of provinces in the 7th NFC award. The total health allocations of provinces have been increased up to 40% during last two years.17 Due to weakly planned process of recent reforms, swift transfer of financial resources to provincial vertical programs has not occurred. As a result, vertical health programs are facing issues regarding fiscal support.

It is noteworthy that no performance parameter due to lack of collated information system was used to augment financial share for provinces. Similarly, resource tracking through national health accounts is crucial for any health system to monitor flow of financial resources. Better performance and responsiveness of health system could not be achieved due to lack of information on health spending in Pakistan. Compilation of provincial health accounts is key challenge in wake of recent reforms to prioritize expenditures and increase own revenues.

The contribution of GDP to health in Pakistan is 0.25%, which is insufficient to meet non-development expenditures of vertical health program. To promote essential healthcare packages through universal coverage, countries have to allocate WHO target of 5%
GDP expenditure on health. Provincial governments with elevated financial shares need to strategize reallocation of respective health expenditures. In the absence of national health accounts, it would be a test for the provinces to reset priorities for primary, secondary and tertiary care services. Mix of public-private health system in Pakistan has promoted out of pocket payments which put financial risk on households. Insurance mechanisms such as social health insurance for the formal sector and social protection strategies for the informal sector are direly needed to attain universal coverage. Provincial governments are facing challenge of outlining pro poor strategies in this transitional phase of reforms to protect poor from catastrophic expenditures.

f) Medical Products/Technologies
The functions retained at Federal level Regulatory Authority are standardization and manufacture of pharmaceutical products, regulation of drugs and administrative control of respective institutes. Centralized authority is very crucial to maintain quality, price and administration of drugs and medical supplies. There is growing evidence that corruption is more rampant in public sector of developing countries with regards to overpayments for medicines and technologies. A central control for drug regulation is a significant implication of the 18th amendment.

One of the key factors for under-utilization of public healthcare systems is unavailability of drugs. Lack of Logistic Management Information Systems (LMIS) is another strong contributor for lack of drugs at public health facilities. Very recently, planning and development department has effectively coordinated between donor organization and provincial health departments to ensure availability of contraceptive commodities to the end mile. Such interim arrangements for availability of other essential health care packages and development of LMIS are critical challenges for provincial health departments for uninterrupted supply of health commodities to primary health care facilities.

Salient features of provincial health sector strategies

1. Punjab
The Department of Health Punjab is strategizing to:

- Institute Essential Health Services Package (EHSP) for primary (including facility-based and outreach services), secondary and tertiary level healthcare facilities.
- Establish district health complexes which will provide oversight to rural as well as urban primary health care.
- Ensure free of cost, level-specific, 24/7, quality emergency services at all levels of care.
- Focus and strengthen MNCH, family planning and nutrition services at all levels as part of EPHS.
- Strengthen prevention and management of communicable and non-communicable diseases.
- Integrate preventive healthcare (vertical) program which have common objectives.
- Implement Minimum Service Delivery Standards (MSDS) and standardize services in the hospitals.
- Restructure the entire department for a robust stewardship and monitoring role.
Optimize decentralization to districts and autonomy to health facilities.

Fully operationalize the Punjab Health Commission and Health Sector Reforms Program.

Establish a Human Resource Planning and Development Unit.

Fill all vacant posts of healthcare providers at primary and secondary healthcare facilities, especially in rural and hard-to-reach areas.

Develop a Provincial Health Services Academy (PHSA) on the lines of Civil Services Academy for trainings of different categories of health workers.

Strengthen community based information system and its integration with facility-based health information system.

Link tertiary care and the private sector health facilities with district and provincial level information systems.

Establish a comprehensive integrated Disease Surveillance System at provincial and district level.

Organize, analyze and publish pertinent health information on health sector performance for a wider dissemination.

Strengthen health research in both public and private sector.

Enhance existing logistics and supply chain management system and regular review of EDL.

Increase overall government expenditure on health care especially for the primary level.

Introduce mechanisms of social safety nets such as health voucher schemes for protecting poor from health shocks.

Increase budget utilization rate at the provincial and district governments.

Implement a MHSP to be provided by all primary health care units and outreach services e.g. BHUs, RHCs, LHWs, CMWs, EPI technicians.

Implement necessary training e.g. Integrated Management of Neonatal and Childhood Illnesses (IMNCHI) training at all levels of the public health care system, and support the training of private providers.

Upgrade health facilities on the basis of need and according to criteria established by the DoH.

Allocate resources according to incidence and prevalence of diseases, cost effectiveness of a programme/policy, and poverty levels.

Improve estimates on incidence and prevalence of diseases with analysis based on surveillance systems, surveys and from the DHIS and on poverty levels.

Revitalize the delivery of family planning services in the public sector health facilities with a mechanism for forecasting the contraceptive requirements.

Pilot tele-health to support provision of specialized care to the poor in remote areas of the province.

Analyse existing services in terms of safety nets or free services to the poor community and develop a feasible proposal with the primary objective of reducing out of pocket expenditures.

Develop an emergency response mechanism with close inter-sectoral linkages and implemented to cover emergencies, epidemics and disasters at the provincial and district levels.

Establish trauma care and burn units at divisional level hospitals and develop linkages with 1122 for the provision of pre-hospital care services.

Develop a comprehensive Mental Health Strategy and ensure establishment of institutions for rehabilitation of mental patients.

2. Khyber Pakhtunkhwa

The Department of Health Khyber Pakhtunkhwa is strategizing to:

Revitalize the delivery of family planning services in the public sector health facilities with a mechanism for forecasting the contraceptive requirements.

Pilot tele-health to support provision of specialized care to the poor in remote areas of the province.

Analyse existing services in terms of safety nets or free services to the poor community and develop a feasible proposal with the primary objective of reducing out of pocket expenditures.
Strengthen the Personnel section at DoH to build in evidence based interventions.

Re-define links with PWD with shift of contraceptive services through district and urban PHC systems and aimed at birth spacing in younger couples.

Enhance sector-wide access to essential drugs through improvement in quality assurance, affordability, supply management and rational prescriptions.

Regulate the health sector in particular the extensive private sector towards licensed practice, standardization of care, minimal reporting requirements and address of medical negligence.

Increase investment in health sector and shift towards innovative financing systems to reduce OOP expenditure in the poor.

Pilot inter-sectoral district based projects on nutrition and social development through collaboration with BISP, water & sanitation, education and other sectors.

Develop a trained administrative cadre to improve efficiency of health administration.

Develop a hospital pharmacy cadre to ensure rational use of drugs and quality management of inventory.

Establish hospital autonomy pilots for major tertiary hospitals while building in social accountability and transparency and pro-poor protection measures.

3. Sindh

The Department of Health Sindh is strategizing to

Strengthen district health systems starting with most under-developed districts of Sindh.

Implement an Urban PHC system built on public private partnerships and addressing contextual needs of low income urban population.

Establish Comprehensive Health Centers offering EPHS in each district.

Contract out facilities in remote talukas of disadvantaged districts to qualified private sector entities for publically financed provision of MSDP.

Streamline human resource production, retention and capacity to support priority health needs.

Functionlalyze MNCH services at ESDP, MSDP and community based level and enhancement of community based services building in evidence based interventions.

4. Balochistan

The Department of Health Balochistan is unfortunately lagging behind in terms of embarking upon the exercise of developing a 5 years strategy for its health sector. Donor’s assistance is there and the team of consultants is about to be finalized.

Nonetheless, DoH Balochistan is well cognizant of the issues and challenges
confronted in the wake of law and order and political instability in the province. Looking at the PDHS 2006-07, NNS 2011, PSLSM 2011, it is quite evident that Balochistan as a province has grossly under performed in terms of all health indicators, nutrition status, and socio-economic parameters. Maternal mortality ratio is one of the highest not only in the country but in the region (785/100,000 live births). More than 56% women do not get any supplementation during the pregnancy. Contraceptive prevalence rate is the lowest in the whole country (14%). Only 41% women seek antenatal care, out of which barely 23% deliver at a health facility. Children with full vaccination coverage are 35% which is again lowest in terms of program coverage. One third of the children do not receive any vaccination at all. For half of the children in Balochistan, no treatment is sought for ARI and diarrhea. Around 32% children are stunted or severely malnourished.

Moreover, being an under-developed province with scarcity of financial, technical and human resources, it is quite logical to predict that Balochistan will be able to map out more or less same system’s related issues, perhaps with more gravity. Thus the need would be to have the most workable health sector strategy for the province, which would be owned by the DoH and would assist the provincial decision makers to re-orient the health system in the best interest of the marginalized people of Balochistan.

5. Azad Jammu & Kashmir

The Department of Health AJK is strategizing to:

- Implement a costed essential service package both at primary and secondary healthcare level.
- Implement MSDS both at primary and secondary healthcare levels of public sector as well as in the private sector.
- Institutionalize an operational referral system from primary to secondary and from secondary to tertiary healthcare level.
- To improve the immunization coverage among the women and children population across the state of AJK.
- To increase the proportion of deliveries attended by the skilled birth attendants.
- To reduce the unmet need for family planning by introducing integrated and sector wide approaches to address the issue.
- To reduce the number of miscarriages by instituting operational research across the state of AJK and re-orienting the maternal health services accordingly.
- To re-align the MNCH strategies and activities in the light of findings of AJK-DHS 2010.
- To ascertain the burden of disease due to NCDs by instituting hospital-based and participatory research with communities across the state of AJK and re-orienting the services accordingly.
- Streamline the collaboration of DoH with PPHI enlisting clear roles & responsibilities with mutually agreed deliverables & performance targets.
- To formulate and implement a comprehensive SRH policy for production, management, retention and motivation of health personnel to serve the population of AJK.
- To revisit HRIS and implement as a decision making tool for addressing the HR issues.
- To implement, operationalize and strengthen the DHIS in all the 10 districts of AJK.
- To establish a DHIS unit at the level of DGHS office for consolidation of the information and reports generation.
- To revisit the scope and content of the DHIS so as to integrate data from LHW, MNCH and DEWS etc.
- To improve logistic and supply chain management system for regular, uninterrupted and adequate availability of
essential drugs at all levels of health care

- To establish a procurement and logistic cell at the state level and to implement PPRA rules and regulation for public sector drugs procurement.
- To implement and revisit EDL for all levels of health care according to the burden of diseases of the population served.
- To operationalize the DTL for enforcing and improving the manufacturing standards for drug companies.
- To implement an integrated budgetary planning process whereby DoH has the main role in consultation with Finance and Planning Departments.
- To align the donor funding with DoH strategy and priority areas for investment.
- To introduce social health insurance and other safety nets protecting the disadvantaged and vulnerable from catastrophic health expenditures.
- To enhance the efficiency of public spending by re-orienting certain budget heads and re-costing of certain entities, thus improving budgetary utilization.
- To explore private sector participation in provision of publically provided health services by outsourcing through transparent competitive process.
- To establish an autonomous health regulatory authority for ensuring standards in service delivery, drugs regulation, human resource production and accreditation etc.
- To decentralize the management in DoH to divisional and district level for improved efficiency and responsiveness in the service delivery.
- To integrate or merge health and population departments for resource saving and streamlining the activities pertaining to reproductive health.
- To revitalize IPAP to take up the role of HSRU for overseeing the proposed and future reforms across the health sector.
- To establish a Provincial Health Services Academy for instituting in-service training of all cadres of health personnel in the DoH.
- To foster a meaningful collaboration with NGOs, private sector and development partners for taking initiatives towards health system strengthening.

6. Gilgit-Baltistan

The Department of Health GB is strategizing to:

- Strengthen the stewardship role of the department in the context of new roles and challenges faced by the department.
- Establish a Policy Planning unit at provincial level and staff it with competent professionals after competitive selection.
- Ensure the representation of the community in the Policy & Planning processes by ensuring their membership in the relevant bodies.
- Develop the Human Resource policy framework to enhance the quality and productivity of work force.
- Develop and implement HRIS optimally to ensure transparency of the processes and timely decision making, based on evidence.
- Develop a costed MHSP to ensure the uniform implementation of health services.
- Increase coverage and utilization of quality services at primary & secondary health care levels by implementing MHSP.
- Introduce quality assurance mechanism to ensure safety of patient / client.
- Develop regulatory framework both for public and private sector to ensure good quality /optimal services.
- Ensure implementation of District Health Information System and allocate adequate resources for DHIS through regular budget.
- Integrate different information systems and produce consolidated annual report for evidence based decision making.
- Improve availability of quality essential
medicines in health facilities based on standardized services at each level.

► Review and formulate essential drug list based on population need and standardized services for each level of services

► Strengthen the existing revenue generation system to raise sufficient and sustainable funds through efficient means to provide essential health services to the public.

► Establish a disease surveillance system by integrating information from both public and private health facilities.

► Develop a risk pool system based on a mix of general revenue/social insurance/out-of-pocket payments.

► Introduce Voucher Scheme and SHI in collaboration with private health sector to assist identified beneficiaries.

► Ensure functional parliamentary health committees conducting regular performance review and facilitate the Health department in implementation.

Health Systems & Policy Implications after Devolution

The optimistic view

Some of the important positive sides of devolution are worth discussing at this juncture. The provinces have been constitutionally granted the autonomy which they had always envied in the light of original constitution of 1973 of Islamic Republic of Pakistan. Having this level of autonomy, the provinces are now free to strategize, plan and act for the improvement of their respective health sectors; and that also in their own local context.

a) Provinces are now the stewards of their health systems to provide vision, roadmap and framework for steering the health affairs of their respective populations.

b) The health sector strategies which are being developed with the donors’ assistance in each of the provinces are more relevant and context based on a fresh, sound and thorough situation analysis conducted in each of the area; 4 provinces, AJK and GB.

c) Since these strategies and roadmaps are being developed in a process of exhaustive consultations with the provincial departments of health, other line departments, P&D, and other stakeholders in non-government arena, it is envisaged that this will eventually culmination into a higher level of ownership by the respective provincial stakeholders.

d) Having participated, approved and owned the strategies for health sector in the provinces, now a great deal of responsibility lies with the provincial health authorities to roll out these strategies in the best possible and viable manner. Only a realistic and timely operationalization of the strategies will bear fruits i.e. improved health outcomes of the most vulnerable populations who have been devoid of essential and basic healthcare at their doorsteps for years.

e) All the strategies have been asked to follow the WHO’s health systems strengthening building blocks which provide a uniform framework for benchmarking as well as carrying out a comparative analysis at some point in time.

The down side

Looking at the down side and a bit of pessimistic view point, the whole process of devolution suffered from a knee jerk reaction of the provincial governments who claimed unprepared, incapacitated and perhaps also unaware of the actual implications of the devolution. Other schools of thought outside
the health departments also worried about the future of this reform and to some extent these concerns have got the substance.

a) An integrated and unified vision for health for all was the prime responsibility of the central government which is now questioned as to who will ensure that the entire nation has a common vision and a cohesive mission. Would every province and area be having a different vision, strategy and goals for the health of their people? Is there still a role of the federation in this regard?

b) Regulation & standardization was yet another responsibility of the federation which ideally lies with the provinces now. Medical education, service delivery, skills and qualifications, quality of drugs, licensing and accreditation were some of the matters which would need attention of the provincial DOHs and of course they would not have the required level of capacity and expertise.

c) Inter-provincial harmony is often needed. Federal government was in a position to moderate such conducive relationship

d) Donors and development partners are still in the state of ambiguity. Their preference is to deal with one window. However, after devolution, this may not be the case and they will have to interact with multiple windows across the country. Donors will be more strategic and choosy in terms of investing and that will be primarily based on their convenience to work with certain provinces and not to work with others. Federal government or a central authority was in a position to redirect donors’ money where there was a felt need and priority investment was required.

Key strategies for health systems strengthening

Come what may, there is a global consensus on some key strategies which the developing countries must adopt in order to strengthen their health systems. These strategies or actions seem very pertinent to the current scenario of health system of Pakistan and therefore must be considered very thoughtfully for the sake of making our system responsive to needs of the people of Pakistan.

a) Building capacity of health system to deliver

By and large, the health care delivery was with the provinces (the sub-national units) except the vertical programs which were financed and managed by the Federal Ministry of Health before the devolution. These included National Program for Family Planning & Primary Health Care (LHW program), Maternal, Newborn and Child Health, Hepatitis Control, Expanded Program for Immunization, Tuberculosis control, Roll Back Malaria, HIV/AIDS Control etc. These programs have delivered reasonable results. Therefore, the provinces will have to strategize how to integrate and wisely manage the vertical programs (financing, human resources) in order to reach out to the people without any interruptions or decline in the performance. For this challenge, it would be essential to build capacity of the human resource, revitalize the primary health care and
adequately finance all the services: preventive, curative and promotive at the district level. Perhaps, a meaningful partnership with NGOs, who have a sound track record of technical work in this regard, can also be considered. NGOs can also be instrumental in filling in the gaps in service delivery where government feels incapacitated to reach out and deliver.

b) Balancing cost and sustainability
Traditionally, split of non-development budget has been bigger than the development budget. Furthermore, in the post 18th amendment scenario, additional human resource transferred to the provinces will have to be catered for their salaries and benefits. Provincial health departments have to be vigilant enough to allocate a justified amount to the development side of the health too. Role of donors, development partners, NGOs, philanthropists and private sector must be reviewed rationally and considered for ensuring the sustainability in the health sector operations. Before launching new projects and new interventions, it would be imperative to carry out value-for-money analyses. As a matter of fact, this means formulating right methodologies for estimating costs at the level of service delivery and designing instinctive ways to look at these costs and use them to improve the efficiency of service delivery system.

c) Improving health governance
Good governance aims to improve the quality of essential health services. Health system in Pakistan has been confronted with all levels and types of corruption impeding the quality service delivery and severely affecting the health outcomes. These reforms are a critical step and needed to bring rapid improvements in health services at the point of delivery. At the same time, there is a need to review and reform the organization and functioning of the provincial department of health and district health offices to address some of the core governance issues that are responsible for the poor health services not only in the public domain but also in the private sector.

Institutional mechanisms for strategic health planning, regulation and standard setting, fair financing and credible audit, health information and its use, human resource development and distribution, and disease surveillance need to be strengthened at the provincial level now. Engagement of the civil society organizations at the provincial level and the communities' representatives at the district level can bring in an element of transparency in the functioning of the health system.

d) Protecting people from financial risks
Out-of-pocket health spending by households accounts for more than half of total health financing in most developing countries in Asia; and more than 65% in Pakistan. While seeking health care in the private sector (utilized by 80% people for first level care), almost 92% goes out of pocket. Reducing OOP payments and developing appropriate financial risk protection systems is crucial to increasing access to health care by the poor and working towards the goal of universal coverage. Provincial governments may not be ready at this point in time to embark upon the venture of social health insurance. However, other mechanisms of social protection and safety nets must be tried out. These include conditional cash transfers, prepaid vouchers and community based health insurance and financing. Provinces will have to increase the health sector allocation by 50% every year for the next 10 years to attain a respectable set of health indicators. This can only happen if the provinces consolidate the expenditure information and develop the coordinating mechanisms that can oversee progress on planning strategic and long-term investments, introducing pro-poor health reforms and making the basic analyses on strategic choices and financing options. Rising poverty and uncontrolled inflation in the country necessitate steps to protect the poor from
incurring catastrophic expenditures on health, which is a basic human right.

e) Measuring and monitoring health system's performance

Conventionally, provinces have never been awarded the share of resources from the federal government based on any performance parameters. As a consequence, the districts too were funded based on incremental budgets. For determining the performance of a health system, be it the provincial or at district level, there has to be a robust information system which would furnish data on expenditures, allocative efficiency, human resource, disease burden etc. In the post devolution times, all the provinces must strategize to develop and organize a Health Systems Database which would allow users to easily compile and analyze provincial and district level data to quickly assess the performance of a district health system, benchmark district's performance against others and monitor progress toward system strengthening goals. Simultaneously, it would be worthwhile that provinces develop mechanisms to keep an eye on the responsiveness of the health services that is a reflection of direct satisfaction of its users.

f) Paying for results to improve health system's performance

Pay for performance is a strategy to link payments and incentive to a set of targets to be achieved. This approach has shown to improve the use of health services, and improve the quality and availability of those services. For the provinces, who would want to be more strategic in terms of spending their money, pay for performance approach can be adopted for the districts against the results delivered as well as with the hospitals by giving them specific targets. In Pakistan, pay for performance has been experimented through supply-side payments to the health providers and demand-side vouchers that subsidize the costs of a package of reproductive health care services and transportation for the poor women. It has shown to reduce maternal and infant mortality by increasing utilization of antenatal care, skilled delivery, and postnatal care, as well as family planning services. In recent years, the primary health care facilities have been contracted to non-state entities. No doubt this endeavor has shown tremendous improvement in various aspects of service delivery at a level and in circumstances where government has struggled for years. Since provincial governments would be the forefront financier of health, scaling up of this contracting initiative should also be linked with pre-determined set of indicators and targets to achieve the best results and maximum benefit for the population to be served.

g) Tracking expenditures through health systems

Resource tracking monitors the flow of financial resources within the health sector. Governments as well as the development partners depend on health expenditure data to appraise past performance of health programs and thereafter guide the decision-making. Pakistan government has not been able to compute National Health Accounts (NHA) on regular basis. Nevertheless, two reports were compiled for year 2005-06 and then 2007-08. To what extent the information was used for decision making, remains questionable. Pakistan represents a health sector where government's share in health spending is barely US$ 4-6 per capita, out of pocket expense is heavy, donors' contribution is unpredictable and private sector's expenditure is growing day by day, owing to escalating cost of quality health care. A costed health sector strategy could be the only solution to ascertain the essential health service package at primary and secondary health care levels which are under provincial control now. This is crucial to achieve the WHO target of 5% GDP expenditure on health and of Commission on
Macroeconomics and Health to secure universal coverage to an essential package of health services. In the post-devolution times, the provinces will require a comprehensive health spending information, perhaps by establishing their respective NHAs, which will inform the policy making processes for resource mobilization, pooling and allocation in the years to come.

h) Allocating human resources to health system
Primary health care has been grossly under-utilized in Pakistan. Besides numerous other issues, lack of trained human resource is a chronic issue. One, there are not enough personnel trained; second, those who are trained do not want to serve the rural areas and PHC centers because they do not find the enabling environment and conducive working conditions. In search of better civic amenities, majority of the health care workers settle down for an employment or establish their practices in urban centers of Pakistan. At one point in time, there were only 25% of PHC facilities with a female health care provider. After contracting PHC services, situation is improving slowly. Doctor-patient ratio and doctor-nurse ratio is far below the international standards. In this regard, it is critical for the provinces to develop a human resource information system and use it for future HR requirements. Medical, dental, nursing and paramedics schools should be established according to the need of the health departments.

Opportunities & Way forward
First and the foremost step in the current scenario of transition would be to educate ourselves, educate the partners, educate the communities and all other stakeholders. Keeping oneself well informed of the constitutional amendment and new provisions would be worthwhile. It is quite evident now that in the new arrangement, it is imperative to interact closely with provinces, and least with the federal tier of government, except in few cases and instances where certain domains still lie with the center. This will be a very pragmatic approach to embark upon an action oriented advocacy for plugging the gaps in the health system, previous as well as existing. This is a high time for lobbying for instituting appropriate checks and balances to curb the corruption across the health sector and to ensure a fair degree of transparency. In these times of gradual transition, there is a clearly felt need for institutional strengthening and capacity building at the provincial level, mainly for ensuring a responsive service delivery with continuity and quality. Lastly, all criticism apart, the matter of the fact is that this devolution is a window of opportunity to re-orient the entire health system of the country bringing in the most crucial yet overarching element of good governance.

Acknowledgements
The author thanks LEAD Pakistan for sponsoring this strategic paper for the sake of assisting all the provincial governments to make use of it while rolling out their respective health sector strategic plans.
References


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Introduction: In 1991 the Philippines Government introduced a major devolution of national government services, which included the first wave of health sector reform, through the introduction of the Local Government Code of 1991. The Code devolved basic services for agriculture extension, forest management, health services, barangay (township) roads and social welfare to Local Government Units. In 1992, the Philippines Government devolved the management and delivery of health services from the National Department of Health to locally elected provincial, city and municipal governments. Various Health Sector Reforms. Devolved Acts. The Kenya 2010 Constitution guarantees health for all Kenyans. In SA Department of Health officials came up with a policy for devolution in the health sector. Local government health officials were critical that they were not formally represented on the team that developed the document arguing that those that were responsible for the document did not understand local government and how it operates. Although policy is a constitutional function of national government, top-down approach runs counter to the objects of devolution. Blotted governance-The Kenya Health Services Commission. Part 4 of the Bill: This is an unnecessary Devolution presents unprecedented opportunities and challenges to the health sector that determine the effectiveness of overall service delivery. Devolution of healthcare services allows county governments to do among other things; design innovative models. The objectives behind the formation of devolution in Kenya included recognizing the right of communities to manage their own affairs and to further their development, Protecting and promote the interests and rights of minorities and marginalized communities, promoting social and economic development and the provision of proximate, easily accessible services throughout Kenya, Ensuring equitable sharing of national and local resources throughout Kenya, Facilitating Devolution of Public health care Services in Kenya and its Implication on Universal Health Coverage. Timothy C. Okech, PhD. Associate Professor of Economics, United States International University-Africa. Worldwide, there has been a trend in the devolution of authority in healthcare whereby the authority that was often sitting with one central Ministry or Department of Health devolved over time (KPMG, 2015; Okech, 2016). When governments devolve functions, they transfer authority for decision-making, finance, and management to quasi-autonomous units with corporate status (World Bank, 2014).