Health policy analysis

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The Impact of Political Context upon Health Policy Process in Pakistan

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Public Health, accepted pending revisions

Abstract

Analysis of the political context is important to understand health policy and its success because contextual factors may significantly influence health policy process and health. This article describes how the political structure and the policy context in Pakistan influences the health policy process. The article used content analysis based upon documents on policy in Pakistan and data from research reports. Interviews of one hundred and forty-four relevant actors were used to analyze the impact of the political context on the health policy in practice. The country experienced unbalanced power structure and frequent change in governments which caused disruption in health policy formulation, planning and implementation. The political system was centralized which hindered wider participation of citizens. Health care needs were not recognized adequately. It is concluded that the political context has had a negative influence on the health policy process in Pakistan.

Key words: Health Policy Analysis: political context, impact, health policy process

Introduction

Context analysis is important to understand health policy and to explain its success since contextual factors significantly influence health policy process (Navarro, 2000, Phillips, et al., 1998; Walt & Gilson, 1994). Health policy context includes political, socio-cultural, economic and demographic domains. Contextual factors such as violent political conflicts, civil war, the distribution of wealth and income, housing, employment, literacy level, corruption, industrialization, aging of the population and rural urban migration may significantly influence the health policy process and health itself. It is therefore also important to pay attention to all such contextual factors in realizing an effective health policy. This article focuses upon the political context (for other contextual factors such as economic, and socio-cultural) see other (Khan et al., 2006) because of the complex contextual analysis.

The political context reflects power relationships between various sectors, actors and stakeholders. It influences agenda building, policy formulation, implementation, and evaluation, and deals with the allocation of resources. Factors such as violent political conflicts and civil wars are direct causes of high mortality and morbidity particularly in developing countries (Horton, 1999; Lanjouw et al., 1999; Navarro, 2000; Zwi & Ugalde, 1989). Several studies state that political instability resulting in frequent change of governments, tends to stimulate centralization and threatens accountability, while low priority is given to the welfare sector, allocating minimum resources for the health sector (Khan et al., 2006; Lanjouw et al., 1999; Phillips, et al., 1998; Walt & Gilson, 1994). Even more important, a review of 139 studies found that the complex relationships that occur between individual and contextual variables were largely neglected in studies focusing upon health in developing countries (Navarro, 2000; Phillips, et al., 1998). In many developing countries, the impact of the political context upon the health system and the health of the people is ignored when health policies are analyzed (Phillips, et al., 1998). This article attempts to fill the gap for Pakistan. The article presents an analysis of the political context in which health policy is embedded. The article will first shortly describe the political structure of Pakistan , followed by an analysis on how the political context affects the health policy process. The discussion will comment on these effects and offer some solutions/recommendations.

Methods

The most important stakeholders involved in the health policy process were identified by document analysis. The document analysis was based upon policy documents, official reports of health ministries, health related departments and international agencies published during 1970-2005. The reviewed policy documents include: reports of the medical reform commissions and health study groups, Peoples Health Schemes 1972 and three national health policies. The governmental reports and documents include evaluation reports of health programs including nutrition programs, immunization programs, Primary Health Care (PHC) and Health For All (HFA) prepared by the Ministry of Health, annual plans, economic surveys manuals for development projects, and reports of the social action program prepared by the Planning and Development Division, Islamabad. International reports include Human Development Report 2004 of the UNDP, World Health Report 2003 and 2004 of the World Health Organization and World Bank's Development Report of 2004 and 2005. The impact of governance crisis and of the political context upon health policy making, planning and implementation was derived from these documents and from health policy documents particularly the National Health Policy 1990, National Health Policy 1997 and National Health Policy 2001 of the country. Besides the document analysis, open-ended interviews of one hundred and fifty-two actors involved in the health policy process at the district (local), provincial, federal and international level were conducted in Islamabad, Lahore, Karachi, Peshawar, Quetta, Rawalpindi, Abbottabad and Geneva in 2004. Of the interviewees one hundred forty four were asked about the impact of political context upon health policy process. Excluded were representatives of international agencies. These interviewees included elected representatives (including current and former health related ministers of the Ministry of Health, The Environment, Local Government & Rural Development), policy makers and civil servants from the Ministry of Health, physicians, public heath professionals, health managers and representatives of health-related NGOs as well as associations including Pakistan Medical Association, Pakistan Medical and Dental Council and Public Health Association of Pakistan. The interviewees were visited in their offices, homes and public places. They were asked about their opinions and experiences concerning the impact of the political context on the health policy process and were invited to speak as open as possible by assuring anonymity of their whereabouts particularly to those who work within ministries and other governmental departments. The content of the interviewees were analyzed by categorizing their experiences, opinions and statements. The used categories are change in governments, financial resources, centralization and accountability, based on the reviewed literature concerning the role of the political context. These four categories were also used in analyzing reports, studies and documents.

The political structure in Pakistan

The total population of Pakistan is 153. 96 million with a population growth rate of 2 percent. The population is denser in the industrialized and agriculturally fertile regions than in the uncultivated areas (Pakistan, 2004). The population is a complex mixture of indigenous people. Pakistan is in general linguistically heterogeneous, and no single language can be said to be common to the whole population. Each province has its own language. However, Urdu is used as a common language for communication in every part of the country. Almost the entire population in Pakistan is Muslim. Hindus, Sikhs, and Christians constitute only 3 percent of

the population. The current literacy rate is 53 percent; males 66.25 percent, females 41.75 (Pakistan, 2005).

After its independence from British in 1947, Pakistan experienced a delay in framing a constitution. The first constitution was promulgated in 1956, which was federal in form and parliamentary in composition. The second constitution was promulgated in 1962; this emphasized a presidential over a parliamentary form of government, referred the entire executive powers to the President, and made him solely responsible for the country's administration (Mahmood, 2000). In 1973, the first elected National Assembly approved the new constitution. Given the parliamentary democratic system, the Parliament is the most important institution in Pakistan. The Constitution provides two lists for the legislation. One list is called the Federal List and the other is known as the Concurrent Legislative List. These constitutional lists describe the distribution of legislative powers between the national and provincial assemblies.

According to Article 90 of the Constitution, the Federal Government of Pakistan is composed of the Prime Minister and the members of his cabinet. The Prime Minister and his Cabinet are collectively responsible to the National Assembly. In order to be elected as Prime Minister, the Constitution requires the candidate to poll the votes of the majority of the total number of members of the National Assembly. The Prime Minister forms his Cabinet from amongst the Members of Parliament. The Prime Minister has the power to remove any Minister from the Cabinet. The President is elected in a joint sitting of the two Houses (the Senate and the National Assembly) of Parliament by a majority vote. The term of the President is five years from the day he assumes office. A person cannot hold the office of President more than two consecutive terms. According to Article 48 of the Constitution as it originally stood, the President was bound by the advice of the Prime Minister in the performance of his duties. However, military regimes amended the constitution and presently the President, who is also the chief of Army, is more powerful than the Prime Minister and the Parliament. The President appoints the Governors, Attorney General, Chief Election Commissioner, Chief Justice, and Chief of Staff of the Army, the Navy, and the Air Force.

The Constitution of Pakistan specifies a bicameral legislature: the Senate as upper and the National Assembly as lower house. However, the National Assembly enjoys more powers than the Senate. The National Assembly consists of 332 members who are directly elected by the people. The seats have been allocated in the National Assembly for each province, the Federal Capital and Federally Administered Tribal Areas. These seats have been allocated on the basis of the population of each province. The term of the National Assembly is fixed for five years unless it is dissolved earlier. All the decisions in the National Assembly are taken by the majority vote of the members. The National Assembly elects from amongst its members a Speaker and a Deputy Speaker. The Senate comprises 100 members representing the four provinces, Tribal Areas, and the Federal Capital. Provincial assemblies conduct the election for the Senate in accordance with the system of proportional representation by means of single transferable vote. The term of office of the members of the Senate is four years. The members of the Senate elect from among themselves a Chairman and a Deputy Chairman. The term of the office of Chairman and Deputy Chairman is two years.

Pakistan is divided into four provinces, North West Frontier Province (NWFP), Punjab, Sind and Baluchistan. Each province is headed by a Governor who is appointed by the President on the advice of the Prime Minister. Constitutionally, the Governor is the representative of the President and is responsible to him. The Governor's political and executive position in the province is similar of that of the President at the federal level. The Provincial Government is

composed of the Chief Minister and his Cabinet. It performs its functions and duties through the Chief Minister. Although executive actions and decisions are taken in the name of the Governor, the actual source of these decisions is the Provincial Government, that is, the Chief Minister. The provincial assemblies legislate for their provinces within the limits laid down in the Constitution. The tribal belt adjoining NWFP is managed by the Federal Government and is named Federally Administered Tribal Areas (FATA). Azad Kashmir and Northern Areas have their own respective political and administrative machinery, although certain matters are managed by the Federal Government through the Ministry of Kashmir Affairs and Northern Areas. The Provinces are divided into Divisions. Every division is administratively controlled by a Commissioner who is a civil servant and appointed by the provincial government. There are no elected bodies at division level. Divisions are further divided into Districts. Every district body is consisted upon the Nazims (councilors) who are democratically elected by the people for four years. Nazims democratically elect a Nazim-e-Ala (head of the district) for four years. Districts are divided into Tehsils (municipalities). Every Tehsil level body is also consisted upon the councilors who are democratically elected by the people for four years. They democratically elect a Tehsil Nazim (head of the Tehsil) for four years. The district is the organizational basis for the health care system. There are 118 districts in the country and every district is engaged in the delivery of health care services (Pakistan, 2005).

There is a Supreme Court in Pakistan and a High Court in each province, and other courts exercising civil and criminal jurisdiction. The Supreme Court is the highest in the judicial system of Pakistan. It consists of a Chief Justice and thirteen other judges that are appointed by the President. To deal with specific types of cases Special Courts and Tribunals are constituted. The Constitution (1973) of Pakistan protects fundamental rights, but several amendments enacted by the military governments have administratively limited the judicial authority of the courts to protect basic human rights. Military regimes in 1977 and 1999 amended the constitution. These amendments caused an unbalanced power structure and turned the Presidency into a dominant authority with the power to dismiss the Prime Minister, government and the National Assembly. In practice, a ruling establishment referred to as the “troika”, consisting of the President, the Prime Minister, and the Chief of the Army Staff (COAS), rules the country (Hussain & Hussain, 1993; Jalal, 1995; Mahmood, 2000). It means that ministries with a specific content like health and education are considered less influential and less powerful in formulating policy and setting priorities on their field. The governor-generals, presidents and chiefs of the army have dissolved elected governments and parliaments. No elected civilian government has ever transferred power to another civilian government; all have been replaced through non-electoral instruments and imposition of military rule. The Governor Generals abolished the governments and 1953 and 1955. The military dissolved governments and assemblies in 1958, 1969, 1977, and 1999. Furthermore, Presidents dissolved governments and assemblies in 1988, 1990, 1993, and 1996.

The influence of the political context on health policy

Of the 144 interviewees 98 (68%) gave their opinions and comments about the influence of the political context on health policy (see table 1). All respondents on federal level expressed opinions. On district level about two third of the interviewees gave their opinions. Remarkable is the low number of civil servants and managers on provincial level, who answered on this issue. The role of the political context is clearly recognized by most respondents. According to an expert working in a health related international organization “health strategies and

programs that successfully work in other countries may not work in Pakistan primarily due to unfavorable political context".

Table: 1. Number of Interviewees (Actors) who believe that political context, i.e. change in government, lack of financial resources, centralization and lack of accountability, affects the health policy process

	Federal level				Provincial level			District level			Total
	International	Politicians	Managers	Professionals	Politicians	Managers	Professionals	Politicians	Managers	Professionals	
Total Interviewees	6	4	8	8	8	24	12	15	32	27	144
Interviewees Responded	6	4	8	8	8	4	12	13	17	18	98
Change in Government	5	3	2	3	8	4	6	1		1	
Lack of Financial Resources	6	2	2	4	6	4	8	10	16	18	
Lack of Decentralization	5	2	1	4	5	3	6	13	17	16	
Lack of Accountability	5	3	3	5	6	4	7	7	8	15	

Change of government

As described Pakistan experienced frequent change of government that affected health policies accordingly 33 interviewees as shown in the Table1. Mostly this was seen by the interviewees at federal and provincial level, exclusively civil servants. The 33 actors believed that due to changes of government every new government changed the health policy formulated by the previous government. It meant that not enough time was available to any health policy for its effective implementation, which resulted into wastage of resources. This issue is not recognized as much by the actors at local level. In 1997, the government introduced its new National Health Policy by replacing the National Health Policy of 1990. The present government introduced a new health policy in 2001 by replacing the previous one. According to the interviewees at federal level particularly representatives from the international organizations and health professionals at the federal and provincial level the content of these health policies do not vary much in essence as considerable attention is still given to the delivery of health care service rather than disease prevention and health promotion. Frequent changes of governments have also removed the political energy that is needed for the effective implementation of health policies and programs. As expressed by a professional at federal level "it is impossible to work and plan under uncertain political situation particularly when health ministers are changed and every new minister asks for changes in health plans". During the military regime of General Zia, the population-planning program was seriously affected (Lee et al., 1998; Khan, 1996). Zia froze the population program when he assumed power in 1977 due to his antagonism to former Prime Minister Z. A. Bhutto and Pakistan People's Party (PPP). Mr. Bhutto used his party (PPP) workers as field motivators to make the population program accessible and popular (Khan, 1996).

The Army has directly ruled the country longer than the elected regimes. On average, military regimes have tended to last for a decade, while civilian regimes had tenure of three years or less (Noman, 1997). Military regimes tend to propagate topics that concern national enemies, or perceived threats to security in order to increase defense expenditures at the cost of good health. During interviews 74 interviewees at all levels expressed that military regimes consider defense and industry as high profile ministries and allocate these sectors maximum financial resources as compared to health. According to the interviewed political leaders and health professionals at national level, health-related issues, environmental protection, and the promotion of a healthy lifestyle do not attract the attention of the military regimes in agenda building and health policy making due to low priority given to health. According to a representative of a professional organization "a constant increase in health-damaging industries including tobacco is acceptable to ruling elite due to their large share in governmental revenue". Military regimes consider defense, industry and interior as high profile sectors and allocate these sectors maximum financial resources as well as better staff (Jalal, 1995; Noman, 1997).

Lack of resources

The country has maintained an average growth rate of GDP of 6% during the past three decades (Pakistan 2005). However, there is a persistent contrast between reasonable economic growth and governmental expenditures upon health. The average share of the health sector in the national budgets during elected regimes (1990-1998) was 0.8 percent of the total GDP (Pakistan, 2003). The current military regime during 1999-2002 dropped the share of health sector in the national budgets to 0.7 percent and from 2003-2005 it fell further to 0.6 percent of the total GDP (Pakistan, 2004; 2005). A governmental document stated that the government has committed itself to increase governmental health expenditures in the national budgets to 2 percent of the GDP by 2010 (Pakistan, 2004). In practice in June 2006, the government dropped it further and allocated 0.5 percent of the GDP to the health sector in the national budget for 2006-2007 (Mahmood, 2000). According to a representative of a professional organization "Pakistan has attained the status of a nuclear power but its health indicators and overall health conditions are still lower than many other developing countries in the Asian region due to low priority given to health and minimum governmental health expenditures".

According to governmental documents the health authorities intend to reduce child mortality, improve maternal health and combat disease including HIV/AIDS, TB and malaria in accordance with the MDGs (Pakistan, 2005; 2006). In practice, infant mortality is still 74 per 1000 and the under-fives mortality rate is 98 per 1000. Eighty percent of all births take place at homes and 16,500 maternal deaths occur annually in the country (Pakistan, 2004; Pakistan, 2005). There are about 80,000 HIV/AIDS infected persons in Pakistan and level of infection is increasing (Baqi et al., 1999; UNAIDS, 2004; USAIDS, 2005). The percentage of TB cases detected and cured increased to 40 percent in 2005 (Pakistan, 2006). According to many studies Pakistan needs to pay attention to health good health in its political agenda by increasing governmental health expenditures, protecting environment and promote healthy lifestyle in order to address health problems such as higher child and infant mortality, malaria. cancer, TB., HIV/AIDS and Diabetes (Baqi et al., 1999; Haque et al, 2004; Siddiqi, 2004; USAIDS, 2005).

Low governmental expenditures for health sector in the national budgets lead to resource constraints for the health sector as indicated by interviewees at all the levels. However this problem was more frequently mentioned at district level as compared to respondents at federal level, exclusively representatives of international organizations. The later recognized this problem evidently (see Table 1). As a consequence of the lack of financial resources, health policy implementation is difficult and health projects suffer from delays in their preparation and successful implementation as disclosed by the interviewees. For example, interviewees working at federal and provincial level indicated that government planned to open 50 new basic health units (BHUs) and 13 new rural health centers (RHCs) in 2003. In practice government could open 25 BHUs and 6 RHCs due to lack of financial resources. Similarly, in 2000 government planned to introduce school nutrition package for schoolgirls in 5300 girls-schools in rural areas of the country till 2005. However, government introduced the said nutritional program in 3679 schools and stopped further implementation of the program due to lack of financial resources (Pakistan, 2005; 2006). The resource constraints also increase the dependency of the Ministry of Health on donors (Abbasi, 1999; Bhutta, 2001). Health professionals working at the federal and provincial level disclosed during the interviews that Pakistan has been highly dependent on donors for the implementation of health programs including Health for All (HFA) and Primary Health Programs (PHC). According to said interviewees, donor dependence for these programs creates uncertainties regarding the amount and flow of financial resources and disturbs implementation. Many studies have also expressed the similar view regarding the said donor dependence of the Ministry of Health and its negative impact upon the health policy implementation (Abbasi, 1999; Bhutta, 2001; UNAIDS, 2004).

Decentralization

Pakistan has a centralized health system. According to a governmental document Pakistan is fully committed to the Millennium Development Goals (MDGs) and acknowledges access to essential health as a basic human right (Pakistan, 2006). The Government takes responsibility to provide free medical treatment to all citizens in need for health care services. The public health sector in the country comprised 916 hospitals, 552 Rural Health Centers, 5,301 Basic Health Units and 4,582 dispensaries. There were 99,908 hospital beds and population per bed ratio was 1,540 in the country (Pakistan, 2005). There are also number of hospitals, nursing homes, maternity homes and pediatric hospitals offering health care services in the private sector but it is very expensive and the majority of people, particularly the poor, cannot afford private services as learnt from the interviewees working at all levels.

The Federal Ministry of Health in collaboration with the Ministry of Planning formulate and approve health programs and projects. A concern about the lack of decentralization is expressed by 72 actors. The issue of centralization/decentralization is most often mentioned by respondents at district level (62%) as compared to federal level (46%). In every province there is a provincial ministry that controls health care system and implement the health policies, programs and recommendations of the Federal Health Ministry. Due to centralization provincial health ministries implement health policies and plans without playing any role in health agenda building, policy making and planning as described by the politicians and professionals at provincial level. These interviewees have also expressed that there is a need to decentralize the health system in order to assure participation from important stakeholders, individuals, groups, and communities in the health policy process. According to a health professional

working in an international organization "generally, people are less willing to place confidence in centralized health institutions and not willing to extend their participation and cooperation in making health policies and programs effective".

Below the provincial level the district (local) level is also responsible only for the implementation of plans and recommendations of the provincial health ministry. According to a representative of a professional organization "the existing health systems at the federal and provincial levels are not enough decentralized and participative in responding adequately to health problems and finding their practical solutions at lower levels". According to the interviewees at local level, there is a general absence of delegation of authority for operational decision-making to the local level and decision making on matters such as program budgeting and finance are restricted to the top level of the provincial and federal hierarchy. The interviewees working locally were rather explicit on the many health care needs in the population, but stated these needs were not recognized at the provincial and national level. The interviewees, involved in health care practice at local level, felt they were not heard even if they tried to catch the attention of politicians and administrators on the provincial and national level. Interviewees at the provincial and local level disclosed that centralization also hinders wider participation from professional groups, NGOs and communities in the health policy process and so often results in the implementation failures. Lack of participation decreases the chances of effective implementation and leads to the issues related to access, inclusion, equity and collaboration (Khan, 1996; Siddiqi, 2004; UNAIDS, 2004). A representative from an international health related organization expressed during his interview "in a centralized and non-participative health system, effective democratic control by the beneficiaries of health services cannot be established".

Accountability

Many governments have maintained their supremacy over the judiciary and tried with varying degrees of success to appoint judges of their own choice in the superior courts by violating the rules and principles of merit (Hussain & Hussain, 1993; Memon, 1997; Newberg, 1997). In popular perception, there is also criticism of the judiciary and its role in certain situations as disclosed by interviewees, especially by health professionals (see Table 1). It is viewed as a status quo institution that does not act on issues that are unfavorable to the government (Newberg, 1997). For example, the Supreme Court upheld the unconstitutional acts of the dissolution of the governments and legislative assemblies in 1954, 1959, 1977, and 1999. It declared General Yaya Khan and General Zia "usurpers" and their military coups illegal only at the time when they were already out of their offices (Hussain & Hussain, 1993; Newberg, 1997). Consequently the systems of accountability has been handicapped and civil servants as well as health professionals working in the governmental health sector do not feel themselves accountable for their performance, eventually bribery and misuse of resources (Hussain & Hussain, 1993; Newberg, 1997; Noman, 1997). Such a view has been expressed by the 63 interviewees in total (see Table. 1).

The health sector is among the top six key sectors in Pakistan that are seriously affected by the corruption (Waxman, 2003). There are numerous charges of corruption, repeated complaints of bribery, misuse of resources and sale of public equipment in government hospitals (Khan et al, 2006; Rehman et al, 2004; Waxman, 2003). As a result the health sector loses its scarce resources and health policy implementation is distorted as disclosed by the interview-

ees at all levels. They have recognized that there is high level of corruption in the health sector that disturbs trust of people in health sector and hinders wider participation in the implementation of health care polices, programs and innovations in health care. According to a politician at provincial level "corruption has undermined the health system consequently health services suffer from quality and people do not trust governmental health services". Such eroded institutions could not develop cooperation, integration and collaboration in promoting health and improving life conditions. Interviewees at provincial and local level have disclosed that corruption demotivates many workers in the field, creates problems of accessibility, and hinders wider participation from the people in implementing health programs such as immunization, nutrition, maternal and child health care and family planning.

Free media is an important prerequisite for good governance. However, Pakistan has no free, independent and pluralistic media as a source of information and knowledge (Baqi et al, 1999; Jalal, 1995; Shafqat, 1997). The position of the media is weak and its influence on public opinion is limited (Hussain & Hussain, 1993; Jalal, 1995; Shafqat, 1997). The electronic media, comprising radio and television, are entirely owned and controlled by the government. So electronic media only reflects the governmental view and officially certified health needs of the people. The official print media falls in the same category. However, independent journalists work hard to promote general awareness, the protection of human rights and democratic values in the society (Hussain & Hussain, 1993; Shafqat, 1997). According to interviewees, generally, public health-related issues, issues of equity, availability and accessibility of health services, environmental protection, and the promotion of healthy lifestyles do not attract the attention of the media. Mostly the media feel comfortable in propagating topics that concern national enemies, or perceived threats to security rather than better health conditions and quality of life as stated by the interviewees. So, the impact of the media on the health policy process is limited as expressed by most of the interviewees.

Discussion

Health policy process does not take place in a political vacuum but is embedded in a political and administrative context (Navarro, 2000; Walt & Gilson, 1994; Walt, 1994). According to international organizations, governments should be "stewards" of their national resources, maintaining and improving them for the benefit of their populations (W HO, 2000; 2005). In health this means government's continuous and permanent responsibility for the careful management of the citizens' health and well being (WHO, 2000; 2005). By acknowledging the importance of political context the National Health Policy of Pakistan (2001) states that good governance is one of the basic key features of the policy and government considers good governance as the basis of health sector reform to achieve quality of health care (Pakistan, 2001). However, as the analysis showed, in practice governments could neither offer a good governance nor a favorable policy context that can assure an effective health policy process. Consequently health policies and programs lack sustainability, the health sector suffers from the resource constraints and the health system does not offer any wider participation in the health policy process.

Modern health paradigms including Health For All (HFA) approach argue for a wider participation from people their representatives, groups and communities in order to develop networks of trust, respect, and cooperation to mediate between differing interests of the governmental sectors and society at large for the pursuit of good health (WHO, 1997; 2005). A

continuous democratic political context is important in developing a wider participation and ensuring that health systems, policies and programs are aligned to health and well being of the people (WHO, 1998; 2000; World Bank, 1994). In Pakistan, the basic administrative, legal and health care structure is centralized that neither offers a place for wider participation nor a favorable health policy context assuring the availability of health and welfare services to the people. Consequently a large part of the population feels alienated from the political process generally and in health care especially (Mahmood, 2000; Memon, 1997; Shaikh, 2000).

Pakistan needs to develop a democratic and participative health policy context so that people and their representatives can participate in a democratic process as well as health policy process. It is important to create mass public awareness among people, their representatives, professional groups, technocrats and NGOs in order to avoid the undue influence of political instability and frequent change in health policies. Involving media in the health policy process can effectively create awareness about health-related issues, the importance of environmental protection and the development of healthy lifestyle. The Ministry of Health and the Ministry of Environment need to collaborate with media particularly with journalists who write about health related issues, environmental protection and healthy lifestyles at national, provincial and local level. Such collaboration may lead to the participation from journalists and representatives of media in the health policy process. It can also stimulate journalists to increase their knowledge about health related issues and to create massive awareness through media campaigns including documentary films, group discussions, lectures and TV talks.

A democratic and participative context can also develop a strong feeling among the people to own health and welfare projects, avoid the wastage of their resources and to build a pressure upon authorities and NGOs for the sustainability of health policies and programs. According to a study wider participation and collaboration by local governments, NGOs, and community groups helped health authorities in Indian state of Kerala in implementing primary health program and improving health condition of the people (Varatharajan et al, 2004). In Bangladesh participation and collaboration with stakeholders, communities and NGOs in a decentralized health system showed positive results in controlling tuberculosis (WHO, 2003). Siddiqi et al (2004) believes that maternal and child health (MCH) and family planning programs can be implemented more effectively by involving communities and their representatives, relevant interest groups, stakeholders and district governments in Pakistan (Siddiqi et al, 2004).

Health ministries need to stimulate wider participation from individuals, professional groups, political parties stakeholders, NGOs and communities to play their role in the implementation of health policies, programs and projects. As mentioned collaboration with media, professional groups and community representatives can help in providing health related information and finding feasible as well as desirable ways to reach the people and initiate the process of creating mass awareness. For example, in controlling smoking various ways can be found and different health promoting roles can be assigned to various stakeholders and groups. In this regard, media can highlight smoking risks and present ways that can help in quitting smoking through talks, discussions, movies, and documentaries as recommended by the interviewees at all the levels. Interviewees particularly at local level have recommended that provincial health ministries in collaboration with the local governments need to provide free TV sets to community centers and youth centers in the rural areas where people can watch healthy TV programs and films. Furthermore, collaboration and wider participation can help to control smoking in public places and in controlling selling cigarettes to the teenagers. Involving people is more important in the rural areas because health professionals particularly at local level be-

lieve that a large part of the population in the rural areas feels alienated from the health system and services.

According to international organizations Pakistan falls in that category of countries where economic advances are being made but low governmental health expenditures have blocked progress towards achieving several health and welfare goals (UNDP, 2005; WHO, 2003; World Bank, 2005). Pakistan needs to increase its governmental health expenditures from 0.5 percent up to 2 percent in the next national budget 2007-08 and 3 percent till 2009 as recommended by the international agencies including WHO, UNDP and World Bank (UNDP, 2005; WHO, 2000; 2005; World Bank, 2005). Increasing governmental expenditures for health sector not only can solve the problem of resource constraints but can also decrease the dependency of the Ministry of Health on donors for the implementation of health programs as disclosed by the representatives from the international organizations and health professionals at federal and provincial level. Furthermore, increasing governmental health resources can avoid uncertainties regarding the amount and flow of financial resources and risks of implementation failures.

The government needs to decentralize the health system by delegating powers and functions to lower levels (provinces and districts) enhance the institutional capacity of these levels and ensure their participation not only in implementation but all the stages of health policy process. Interviewees at local level have recommended that studies based upon the experience of the field officers and professionals involved in the health policy process need to be considered by the planners at provincial and federal level because such studies can provide useful feedback for the policy formulation, planning and implementation. It should be emphasized that interviewees working at local level believe that a regular bottom up communication and its careful consideration at provincial and federal level can make the health policy process flexible, participative, collaborative and effective.

It is also important to develop an effective system of accountability in the health sector through democratization and wider participation from the people and their representatives. Wider participation can also help in building trust of population health policies, programs, and services. In controlling low quality medicines and medical equipment the ministry of health needs to increase the number of drug inspectors, ensure their regular visits of the drug market and pharmaceutical industry by offering them financial and career incentives for good performance and penalties for poor performance. Collaboration among provincial health ministries, health departments and local governments in the district, consumer organizations, media and health boards should be developed to control low quality medicines and medical equipment. Such collaboration may supervise the performance of drug inspectors and other health professionals. It can also control the low quality drugs and medical equipment, bribes and kickbacks in the health sectors. An effective collaboration and wider participation can develop communication between the users of health services and health authorities in improving the health system and services. In this regard provision of special telephone numbers and telephone facilities to the beneficiaries in order to make their complaints can be a positive step.

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