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Health Policy Process and Health Outcome: The Case of Pakistan

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Abstract

The health policy process is the process by which a government or society sets its goals, activities and allocates resources to develop and maintain health services for the population. In developing health policy it is important to pay attention to the health policy process because it helps in understanding how (far) health policies and programs achieve their targets. This article presents an analysis of the important stages of the health policy process such as agenda building and policymaking, planning, implementation, monitoring and evaluation in Pakistan. Various problems existing in these stages of the health policy process are identified. The main problems, which affect the health policy process, are centralization, the influence of narrowly focused biomedical model of health, shortage of trained public health professionals, unfavorable health policy context and lack of financial resources. The suggested directions in order to improve health policy process include: decentralization, participation, knowledge and awareness of modern health paradigms, training of public health professionals and a reasonable increase in financial resources.

Keywords: Health Policy Process: effectively, planning, implementation

Introduction

A government or society, which has formulated a health policy and defined its goals as well as its activities to combat health problems and improve life conditions, has to plan actions, allocate resources and build awareness. This so-called health policy process consists of different phases or stages such as agenda building and policymaking, planning, implementation, monitoring and evaluation (Barker, 1996; Falcone, 1980; Walt, 1994). In developing health policy it is important to pay attention to the health policy process because it helps in understanding why many health problems are not solved, why policies are not implemented effectively and why health policies as well as programs could not achieve their targets (Brewer & Leon, 1983; Walt & Gilson, 1994).

In developing countries, health policies and programs scarcely achieve their targets because the health policy process is often characterized by many weaknesses and failures (Falcone, 1980; Theobald, et al, 2005; Walt & Gilson, 1994). Firstly, within a health policy process the causes of important health problems may not be recognized, and secondly these causes are not effectively reached with the planned actions (Brewer & Leon, 1983; Kingdon, 1984; Laterveer, et al, 2003; Theobald, et al, 2005). In some countries policymakers seem to deny factors explaining the major health problems (Bracht, 1999; Khan & Van den Heuvel, 2005a). In many developing countries, there is seldom attention for an effective policy process focusing upon all major determinants of health. There are also huge gaps between declared goals on the one hand and the resources and implementation instruments needed to achieve those goals on the other (Green & Kreuter, 1999, Siddiqi et al, 2004). As a consequence, health policymaking often consists of a cascade of policy plans that are not or only partly implemented (Abel-Smith, 1994; Green, 1995; Theobald, et al, 2005). Socio-cultural, political and economic conditions and as a consequence insufficient resources also frustrate and delay the implementation process in the developing world (Lush et al, 2003; Siddiqi et al, 2004; Walt & Gilson, 1994; Walt 1994).

This article describes briefly the health system in Pakistan and important stages of the health policy process such as agenda building and policymaking, planning, implementation, monitoring and evaluation. It also identifies different problems in the said stages of the process and how these problems affect the health policy outcome in the country. In the discussion strategies are suggested to overcome the described problems.

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. 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 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 problems in agenda building and policymaking were derived from policy documents particularly the National Health Policy 1990, National Health Policy 1997 and National Health Policy 2001 of the country. The problems in planning and implementation were derived from evaluation reports of the Ministry of Health, surveys, plans, and manuals of the Planning and Development Division and reports of international organizations. Besides the document analysis, open-ended interviews of one hundred and fifty-two important actors involved in the health policy process at the district (local), provincial, federal and international level were conducted in Islamabad, Rawalpindi, Lahore, Karachi, Peshawar, Abbottabad and Quetta. These interviewees (actors) included elected representatives (including current and former health ministers), policy makers, civil servants, physicians, public health professionals, health managers and representatives of health-related NGOs as well as associations including Pakistan Medical Association, Pakistan Medical and Dental Council and Pakistan Public Health Association. The interviewees were visited in their offices, homes and public places.

The Health System in Pakistan

Pakistan has a centralized health care system. The Government takes responsibility to provide free medical treatment to all citizens in need for health care services. National health care services provide medical care, including hospital care free of charge and immunization program exist in almost all cities and towns. The governmental institutions involved in the health policy process include the Federal Ministry of Health and several planning and approval institutions. The Federal Ministry of Health handles all health matters. The Ministry has to plan its activities according to the goals expressed on in the national health policy.

The Federal Ministry of Health is responsible for health legislation, quality of health care, health planning and coordination of health related activities. The Ministry is also responsible for educational standards in the field of medicine and nursing, dental, pharmaceutical, and paramedical professions. In addition, the Ministry takes care of the provision of educational facilities for backward areas, and admissions in all the state-owned medical colleges. The

Ministry is involved in the collection of health statistics. It elaborates the provision of health care in accordance with the guidelines approved by the government. Although the Federal Ministry of health is formally responsible for all these tasks realization is strongly dependent from other governmental bodies such as Planning and Development Division (P&D Division), the National Economic Council (NEC), the Executive Committee of the National Economic Council (ECNEC), the Economic Coordination Committee of the Cabinet (ECC), and Provincial Developmental Working Party (PDWP). These institutions are engaged not only with health affairs, but with other sectors of public policy as well. The P&D Division plays an important role in health planning in collaboration with the Ministry of Health. The NEC, being the supreme policymaking body, has an overall control over planning and approves all plans and policies in the country including health. The ECNEC sanctions health projects and schemes costing more than 100 million Pakistani Rupees (US\$ 1 = Pak Rupees 60). It also supervises the implementation of health care policy. The ECC coordinates the health and other public policies, oversees the monetary situation, and extends approval to the health projects in private sector such as hospitals, health institutes and medical colleges. Each province has a PDWP that scrutinizes various health projects and approves provincial health projects costing up to 100 million Pakistani Rupees.

The Federal Ministry of Health consists of one division: the Health Division and eighteen departments. These departments are situated in different cities, however, working under the supervision of the Health Division in Islamabad. The important functions performed by these federal health departments include, hospital services, drug control, stimulation of medical research, child health care and care for the handicapped. Civil servants working in the Federal Ministry of Health deal with all stages of the health policy process such as agenda building, policy formulation, planning, implementation, monitoring and evaluation. These top-level civil servants make health policy statements and introduce laws as well regulations in a centralized way (Bjorkamn, 1986; Khan, 1996). There are about 462 employees working in the Federal Ministry of Health in Islamabad. Among these employees 78 are mid- and top level civil servants (Grade 17 and above) and 384 administrators as well as clerical staff (Grade 16 and below).

In all the four provinces (Baluchistan, NWFP, Punjab and Sind) of Pakistan there is a provincial ministry of health having an exclusive directorate of health care services. Several directors and deputy directors deal with administration, preventive health, and curative care in the provincial directorates. The number of directors and deputy directors in the provincial health ministries vary due to different size of population and number of health facilities in every province. There are teaching hospitals providing specialized care and medical training for both medical students and newly graduated physicians in every province. The provincial health ministries exert direct control over these teaching hospitals. Below the provincial level the district (local) level is responsible for the implementation of plans, policies and recommendations of the federal and provincial government. There are 118 districts in the country and in every district several agencies and departments are engaged in the delivery of health care services (Pakistan, 2005c). These agencies include: teaching and district headquarter hospital headed by a medical superintendent, state-owned health care services under the administrative control of the district health officer, and municipal health services exclusively for urban areas under the administrative control of the municipal health officer.

At June 2005, the public health sector in the country comprised 916 hospitals (teaching, district and municipal hospitals), 552 Rural Health Centers (RHCs), 5,301 Basic Health Units (BHUs) and 4,582 dispensaries. There were 99,908 hospital beds and population per bed ratio

was 1,540 in the country (Pakistan, 2005a). The majority of health care facilities are in urban areas so the rural population has much lower access to health care facilities. Mostly, the rural population gets health care from traditional healers (Hakims and Homoeopaths) operating in the private health sector (Pakistan, 2005a). In urban areas the private sector also offers health care but it is very expensive and the majority of people, particularly the poor, cannot afford private services. There are number of hospitals, nursing homes, maternity homes and pediatric hospitals offering health care services in the private sector in all the cities of Pakistan. However, the reliable figures showing the number of these health facilities in the private sector are not available.

Health Policy Process and Health Outcome in Pakistan

This section describes the important stages of the health policy process (i.e. agenda building and policymaking, planning, implementation, monitoring and evaluation), which influence health outcome in Pakistan. The description is followed by an explanation, why problems exist in the process.

Agenda Building and Policymaking

Formally, the health agenda is set and the Federal Ministry of Health makes policy decisions. Civil servants and medical professionals play a major role in setting health agenda and making policy. Within the ministry of health physicians among the civil servants play a dominant role due to their health-related knowledge and skills. Physicians are trained to find the solution to a health problem mostly in clinical diagnosis and treatments. They tend to find solutions to every health problem in accordance with the biomedical model of health. The content of National Health Policy 1990, 1997 and 2001 clearly show that the main focus in formulating the health policies was on clinical health care (Khan & Van den Heuvel, 2005). Such approach may hinder the understanding of more behavior-related health problems and may pay less attention to other determinants of health and disease lying outside the biomedical model of health. The biomedical model of health particularly ignores comprehensive socio-cultural and environmental factors of health and therefore is not able to provide solutions for new health problems (Ali, 2000; Green, et al, 1997). The consequence is that health care facilities are high on the health agenda.

The influence of biomedical model of health results in strong investment in the delivery of clinical health care services. For example, NHP 2001 identified ten keys areas to address health problems and improve health conditions in the country. Most of these key areas aim to increase health care services by increasing the number of hospitals, basic health units and the number of nurses as well as physicians (Pakistan, 2001). The intention of another key area of the policy document is to increase the provision of equipment and medical technologies, emergency care, surgical services, anesthesia and laboratory facilities in hospitals (Pakistan, 2001). The aim is also to increase the number of specialists in areas such as Medicine, Surgery, Pediatrics, Gynecology, ENT and Ophthalmology in the hospitals. Moreover, the seventh key area stipulates the intention to introduce the required regulation for quality assurance of health care services in the private hospitals, clinics laboratories and medical colleges in the private sector (Pakistan, 2001). It is positive that these key areas of the NHP 2001 intend to increase and improve the quality of health care services, however, it is also important to pay

attention to other determinants of health particularly environment and lifestyle. NHP 2001 has neither offered any policy intervention to protect the environment nor to stimulate healthy lifestyles in order to prevent disease and promote health in accordance with the principles of new public health (Khan and Van den Heuvel, 2005; Khan et al., 2005).

Planning

The important institutions engaged in health planning include the Federal Ministry of Health, P&D Division, NEC, ECNEC and ECC at the federal level. However, the Ministry of Health plays an important role in health planning in collaboration with the P&D Division. At provincial level, provincial ministries of health in collaboration with the PDWP are engaged in health planning. Below the provincial at district (local) level no planning activity takes place. Districts are responsible only for the implementation of plans, policies and recommendations of the federal and provincial government. Health planning is hardly flexible, participative and integrated with other decision-making processes in Pakistan (Bjorkman, 1986; Green et al 1997). As a consequence of the narrowly focused agenda building, planning is mostly directed to the delivery of health care services and increasing the number of clinics, clinical laboratories and physicians. For example, the Annual Plan 2004-05 of Pakistan stated that the government planned to open 40 new Basic Health Units (BHUs), to upgrade 35 existing BHUs, to open 8 new Rural Health Centers (RHCs), to upgrade 15 existing RHCs, to increase the number of hospital beds by 1800, to train 3700 physicians, 250 dentists and 2300 nurses (Pakistan, 2004c). These are positive steps in increasing and improving health care services by following the biomedical model of health, however, the said plan did not pay attention to disease prevention and health promotion by investing in healthy lifestyles and protecting environment in accordance with modern health paradigms. It also ignored the shortage of public health professionals and did not include any plan to increase training opportunities in the area of public health and health promotion. Similarly, the Annual Plans 2002-2003 and 2003-2004 also focused on increasing the number of BHUs, RHCs, hospital beds, physicians and nurses and without any attention to increase the number of public health professionals in the country (Pakistan, 2002; Pakistan 2003b; Siddiqi et al, 2004).

Many studies have stated that health planning in Pakistan has largely consisted of the production of planning documents, and the preparation of formal documentation for short-term measures (Alam et al., 2003; Ali, 2000; Bjorkman, 1986; Green et al., 1997). Many observe that health policies and planning documents in Pakistan set ambitious targets in the absence of a concern about distributional aspects of health status, services and providing enough details about how objectives will be translated into practice or how realistic they are (Ali, 2000; Green et al., 1997; Siddiqi et al, 2004). It is positive that the Annual Plan 2005-06 aims to immunize 4.5 million infants against preventable diseases, 2 million children against polio, and 5.6 million childbearing women against tetanus through Extended Program of Immunization (EPI) in collaboration with Global Alliance for Vaccine Initiative (Pakistan, 2005b). However, as learnt by the interviews of the actors at provincial and district level, it is not clear that without increasing the financial and human resources how 4.5 million infants against preventable diseases and 2 million children against polio will be immunized. It is also not clear that how 5.6 million childbearing women will be immunized against tetanus. Furthermore, it is not clear that how a collaboration will be developed between the EPI program of the Ministry of Health and Global Alliance for Vaccine Initiative. Governmental analysis has pointed out that the health planning process in the country suffers from problems of inade-

quacy of data, unrealistic cost estimates, over-estimation of benefits, lack of coordination, incorrect assumption of the availability of inputs, lack of proper implementation schedules and lack of appropriate human resources (Pakistan, 2003a).

Implementation

The implementation process in the country is influenced by the political, economic and socio-cultural context. Governments change frequently and every new government tends to change or decrease its support for health policies and programs initiated by the former government. Such a trend in governments neither provides specific time for the implementation nor for the intended goals to be achieved. It also results in a lack of government support for health programs and a waste of resources. For example, the military government, after assuming power in 1977, froze the family planning program due to its antagonism to the former elected government. The former Prime Minister and his party Pakistan People Party (PPP) were motivated to make the population program accessible and popular on priority basis. The then military government suppressed the family planning program while suppressing the PPP (Khan, 1996).

In implementing health policies and programs health professionals, civil servants and administrators working at the federal, provincial and district levels play various roles according to their qualifications and professional capabilities. During interviews these actors working at federal, provincial and district level acknowledged that the implementation process suffers from communication gaps between health professionals, civil servants and administrators. They also disclosed that these communication gaps hinder the flow of information from upper to lower level actors particularly in understanding specific objectives of the planned health projects before implementation. As disclosed by the interviewees, during implementation of comprehensive public health projects, field officers and health professionals at grass roots level are neither provided sufficient information nor proper guidance to attain control over the implementation process. The interviews also added that health professionals working at district level were trained only for the delivery of health care services but have to implement comprehensive disease prevention programs. Health professionals and field officers working at district level acknowledged during interviews that they were neither trained in public health nor had they been properly informed about how to implement multi-sectoral disease prevention programs in a collaborative way. As a result, such health professionals could not take appropriate actions to keep the implementation of multi-sectoral health programs upon the desired track in order to avoid implementation failures (Casterline et al., 2001; Khan, 2005; Lee et al., 1998).

Implementation schedules for women's health programs and nutrition programs are not based on a systematic approach such as Bar Charts, Critical Path Methods (CPM), Project Evaluation and Review Techniques (PERT) (Ali, 2000; Pakistan, 2003a). As indicated by the interviewees, the Ministry of health intends to follow implementation schedules, however, in practice several times implementing agencies and private contractors do not follow implementation schedules in accordance with specified time frame, resulting in delays in the completion of projects and wastage of resources. For example, so often, the ministry of rural development and private contractors delay in constructing and handing over the buildings of BHUs and RHCs to the Ministry of Health. Consequently, the Ministry cannot employ the necessary staff and arrange the equipment in order to provide health care services through BHUs and

RHCs according to its time frame. Public health projects and programs aiming to promote health by protecting environment, restraining industry that is causing pollution, and promoting tobacco cessation are resisted by tobacco manufacturers and owners of the polluting industrial units (Khan et al., 2005). These industrialists and manufacturers feel threatened because effective implementation of health promotion programs may restrict the growth of the polluting industry and reduce the sale of tobacco, and ultimately can lead to a loss of profits.

Monitoring and Evaluation

Health authorities in the country have not developed an efficient system of monitoring particularly to monitor multi-sectoral public health projects (Bhutta et al, 2003; Lee et al., 1998; Luby et al., 2004; Green et al., 1997). The interviewees working at the provincial and district level state that there are no institutionalized arrangements for monitoring, especially a set-up with forward and backward linkages. Furthermore, collected data and information from the districts are not properly processed, trained personnel are not available, and site visits of the health projects are often lacking (ADB, 2005; Green et al., 1997; Pakistan 2003a). During interviews health professionals and field officers working at district level have disclosed that the Ministry of health has developed particular forms for monitoring and evaluation of health projects, however, in practice this system comprises only paper monitoring, depending solely on the completion of the specified forms. They also disclosed that there is no mechanism to ensure that the monitoring forms are completed and returned in time to the appropriate authorities. Monitoring of health projects and programs particularly in the rural areas is not regularly conducted, as has already reported for many years (Al-Jalaly, 1991; Lee et al., 1998; Pakistan, 2003a). As a result the process of collecting important information does not work properly.

Modern monitoring and evaluation techniques as well as methods such as CPM, PERT, BAR Chart, etc are not regularly used, particularly in observing the delivery of multi-dimensional services according to plan, ways of resource extension, and utilization of resources according to the various public health activities in Pakistan. Experimental methods and quasi-experimental methods are not used regularly in evaluating health projects in the country (ADB, 2005; Al-Jalaly, 1991; Ali, 2000; PHMIS, 2005). Field officers pointed out during the interviews that regular site visits at the pre-evaluation stage and post-evaluation stage are not conducted systematically. Furthermore, in evaluating health projects it is uncommon to compare the situation after program implementation with the situation before the program (ADB, 2005; Al-Jalaly, 1991; Ali, 2000; Bhutta et al., 2003).

Discussion

The health policy process is centralized and lacks wider participation from other important stakeholders such as NGOs, professional groups, people representatives and communities (Khan and Van den Heuvel, 2005; Siddiqi et al., 2004). New public health is a comprehensive approach that argues to increase institutional capacities of health ministries and institutions, enhance competences of human resource for health, ensure participation and collaboration in order to prevent disease and promote health (Green & Kreuter, 1999; Laterveer, et al, 2003; Lush et al, 2003). It is positive that Pakistan, became a signatory of the Health for All (HFA) in 1978, however, could not increase institutional capacity of the ministry of health, enhance

competences of human resource for health, ensure participation and develop collaboration between health and other social welfare sectors, NGOs, professionals groups and communities.

Pakistan needs to decentralize its health system by delegating powers as well as functions to lower levels in order to involve provinces and districts not only in implementation but also in other stages of the policy process. Decentralization can help in ensuring wider participation and developing collaboration between the Ministry of health and other social welfare sectors, NGOs, professionals groups and communities in order to improve health policy process, make the health programs more effective and services more accessible. In a decentralization structure collaboration and participation by local governments, NGOs, and community groups helped health authorities in Indian state of Kerala in implementing PHC 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 (Zafar Ullah, et al., 2006). Siddiqi et al., (2004) believes that maternal and child health (MCH) and family planning (FP) policies and programs can be implemented more effectively by involving communities and their representatives, relevant interest groups, stakeholders and district governments. Participation can also help in protecting the environment, targeting specific groups, addressing the issues of implementation and developing health lifestyles.

It is positive that training facilities and the number of health care professionals has been increased in the country. There are 113,206 physicians, 6,127 dentists, and 48,446 nurses (Pakistan, 2005a). However, as mentioned earlier that the training facilities in the area of public health and number of public health professionals is low. The Health Services Academy, Islamabad, is the only governmental institute that offers a “Master of Public Health (MPH)” degree to its students. The academy awarded MPH degrees to 118 public health professionals during 1997-2004 (Pakistan, 2004a). A private university “Baqai Medical University, Karachi” has also been providing public health training and awarding MPH degrees to 15 health professionals annually since 1999. It indicates that Pakistan experiences an imbalance among health care professionals and public health professionals having knowledge and experience in accordance with HFA. There is a general lack of knowledge and awareness regarding modern health paradigms among human resource involved in the policy process at federal, provincial and local level as demonstrated before. Consequently, the causes of many health problems are neither recognized nor properly addressed in the health policy process.

Interviewees have indicated that the lack of knowledge and awareness regarding modern health paradigms disturbs coordination between planners (at top levels) and implementers (at grass roots levels). Although implementers are close to the problem in the local situation, they cannot translate policy objectives of the national health policy and international programs (including HFA) to their local situation. Furthermore, they cannot give any input into policy making, and change plans for the purpose of effective implementation. Interviewees also pointed out that the knowledge deficiencies disturb collaboration between health and other welfare sectors such as education, water and sanitation, environment, local government and rural development.

Pakistan seriously needs to increase training opportunities in order to train its health professionals, increase knowledge and create awareness in the comprehensive areas of new public health and health promotion (Khan and Van den Heuvel, 2005; Siddiqi et al, 2004). It is also important to launch awareness campaigns through media, NGOs, religious leaders and com-

munity representatives. Comprehensive knowledge and awareness of public health can help in making health system participative, developing collaboration and improving the health policy process paying attention not only upon the clinical health services but also upon other determinants of health. Furthermore, trained public health professionals can strengthen links between planning, implementation, monitoring and evaluation, develop a smooth as well as effective flow of information from federal to provincial and local levels.

According to the evaluation of the Government of Pakistan and the World Bank, the National Health Policy (NHP) 2001 has been achieving its targets however, progress is slow and achievement record is still low (Pakistan, 2004a; Pakistan, 2004b; World Bank, 2005). It is positive that second key area of the NHP intended to recruit, train and deploy 100,000 Lady Health Workers (LHWs) in the field by the year 2005. At June 2005, health authorities recruited, trained and deployed 80,000 LHWs in the field. It is also positive that the fifth key area of the NHP intended to reduce low birth weight babies from 25% to 12% by 2010. In practice, the country did not experience a reasonable improvement in the number of low birth weight babies. The number of low birth weight babies was 25% during 2000-2001. During 2002-2003 the rate fell to 23%, and in 2004 to 21% (Pakistan, 2004). At the present in 2006, the number of low birth weight babies is 20%.

It is positive that the country is reducing infant and child mortality rate however, the progress is still slow. For example, the infant mortality rate was 82 per 1000 and mortality among the under-fives was 105 per 1000 in 2004 (Pakistan, 2004). At the present in 2006, infant mortality is 74 per 1000 and the under-fives mortality rate is 98 per 1000 in the country (Pakistan, 2005a). An estimated 400,000 infant deaths and 16,500 maternal deaths occur annually in Pakistan. Eighty percent of all births take place at homes either unsupervised or supervised by inadequately trained personnel (Pakistan, 2004a). The data shows that Pakistan experienced progress in increasing the number of physicians and health care facilities, in improving the health of mothers, newborn babies, infants and children under-five. Pakistan needs to improve the institutional capacity of the Ministry of Health, provide appropriate training to its human resource for health and improve its health policy process (Khan et al 2005; Pakistan, 1990, 1997, 2004a; Siddiqi, et al., 2004).

As disclosed by the interviewees, health authorities do not consider political desirability, cultural sensitivities, socio-cultural blockades and early warning signals on expected implementation failures. For example, religious groups opposed population-planning programs by mobilizing the people. They persuaded the people not to use birth control methods by labeling such methods as anti-religion and immoral. The professionals working at grass roots level informed their higher authorities of the influence of religious groups on the implementation of population programs (Khan, 1996; Lee et al., 1998). However, the authorities ignored these warnings and kept on increasing the supplies of contraceptives rather than creating awareness among the people and religious groups. As a result population-planning programs suffered from implementation. In India family planning program particularly forced sterilization campaigns also suffered by ignoring political desirability (Kambo et al., 1994; Rajaretnam & Deshpande, 1994). Whereas, Bangladesh experienced effective implementation of its family planning program with a better outcome by creating mass awareness, increasing community participation and involving religious leaders into family planning campaigns (Barkat et al., 2000; Rahman et al., 2001). Health authorities in Pakistan need to consider political desirability, possible socio-cultural blockades and technical feasibilities in implementing health programs particularly family planning programs and control of HIV/AIDS.

According to interviewees and scientific data implementation failures and a slow progress in improving the health conditions in the country can also be attributed to unfavorable policy context and lack of resources for health sector (Khan et al., 2005; Siddiqi et al, 2004). The average economic growth rate of Pakistan during the past three decades was 6 percent and in 2004-05 it was 8.4 percent (IMF, 2005; Pakistan, 2005a). However, the country allocated minimal resources for health sector as compared to other developing countries in Asian region as mentioned earlier.

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