# Governance and health sector development: a case study of Pakistan

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**Citation**

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**Abstract**

BackgroundThe volatile political history of Pakistan has led to problems with governance overall and in the health sector. MethodsGovernance is defined by six domains of concern: voice and accountability; political stability and absence of violence; government effectiveness; regulatory quality; rule of law; and control of corruption. A review of the literature concerning health sector in Pakistan is interpreted using this conceptual framework. Results and DiscussionThe domains of governance are illustrated with examples from Pakistan's health sector. Two case studies, the President's Primary Health Care Initiative and the Tawana Pakistan Program are used to help understand how poor governance undermines important and positive political initiatives. Globalization effects governance through an evolving relationship between donors, multilateral agencies, and client states.ConclusionsGovernance issues are major barriers to improving health in Pakistan. This study contributes to our understanding of governance and the role of donors and multilateral agencies.

## BACKGROUND

Failing states and the failure of aid have been associated with stagnation or deteriorations of health status in populations ( , ). Problems with governance, the poor performance of governments, have been used as part of the explanation of continued poor health in less developed countries ( ). This case study of governance in the health sector in Pakistan connects the troubled history of Pakistan with health and social indicators that have lagged behind those of other South Asian countries whose economic conditions are poorer than Pakistan ( , ). Political life in Pakistan since its creation in 1947 has been dominated by three factions: the military, the civil service, and politicians, with the military retaining the upper hand in the power struggles. The government has changed hands twenty three times over this period, alternating between military governments and fragile democratically elected civilian governments.

Donors have been the other set of crucial players in Pakistan with a substantial but inconsistent role ( ). The strategic importance of Pakistan to donor countries has gone through important shifts, first with the Pakistan-India conflict, again with the Cold War's denouement, and now with the current "war on terror." External resources for health have recently reached 3% of overall health expenditures in the country. (Table 1)

**Figure 1**

Table 1 Health Expenditure in Pakistan (Rs. Million)

| Year | Total | % of GDP | External resources for health (% of total expenditure on health) |
|---|---|---|---|
| 2000-01 | 24,281 | 0.58 | 0.90 |
| 2001-02 | 25,405 | 0.57 | 1.40 |
| 2002-03 | 28,814 | 0.59 | 1.80 |
| 2003-04 | 32,805 | 0.58 | 2.20 |
| 2004-05 | 38,000 | 0.57 | 2.50 |
| 2005-06 | 40,000 | 0.51 | 1.1 |
| 2006-07 | 50,000 | 0.57 | 3.0 |

Data from World Development Indicators World Bank, & Economic Survey of Pakistan 2006-7, PSDP 2006-8

While scarce resources in the social sector have been a problem in Pakistan, the issue of governance raises questions about how those resources have been spent. In this paper, we do not consider forms of government (dictatorship versus democracy) or state formations (welfare state versus laissez affair) which set important parameters on health and governance ( , ). Instead we will focus on the how effectively the government of Pakistan has managed the health system and the health of the population. The influence donor agencies have over issues of governance is raised. We explore the assumption that developing countries like Pakistan can improve health outcomes within existing levels of funding through better governance. This paper discusses

the role of donor nations and multilateral agencies in the governance of their clients, relationships that have been effected by globalization ( ).

## METHODS

The article is based on a review of published literature and the extensive experience of the authors most of whom have worked in the health sector of Pakistan for many years.

Governance of the health sector is discussed in six domains or aspects ( ). A review of the published and grey literature from Pakistan provides example of issues raised by each of these domains. Two case studies are provided as examples of how these domains of governance work together. These are cases in which the authors have had considerable first hand experience.

## GOVERNANCE AND DEVELOPMENT

Governance as a concept in the development literature has evolved to include a number of well defined domains (see box 1). These domains have been operationalized into a measurable indicator which has been used to compare nations ( ). Weaver analyzed the evolution of the governance literature revealing the contentious nature of the concept within multilateral donor agencies ( ). The impetus of the literature on governance supports government action, which moves in a direction against the dominant neo-liberalism of many multilateral donor agencies. While the governance literature was initially associated with the World Bank, later contributions came from other multilateral organizations (WHO and UNDP) and from academia. This evolution of the concept of governance encompasses the changing role for governments where new policies and mechanisms -- contracting out, the creation of self-regulatory bodies, and empowerment of consumer groups -- have been developed to compliment with traditional health sector activities -- standard setting, enforcement activities, and care delivery by governments ( ).

**Figure 2**

Box 1 Six Aggregate Indicators of Quality Governance

- **Voice and Accountability:** the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.
- **Political Stability and Absence of Violence:** the likelihood that the government will be destabilized by unconstitutional or violent means, including terrorism.
- **Government Effectiveness:** the quality of public services, the capacity of the civil service and its independence from political pressures; the quality of policy formulation
- **Regulatory Quality:** the ability of the government to provide sound policies and regulations that enable and promote private sector development
- **Rule of Law:** the extent to which agents have confidence in and abide by the rules of society, including the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.
- **Control of Corruption:** the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as "capture" of the state by elites and private interests

http://info.worldbank.org/governance/wgi/index.asp

While recognition of the importance of good governance has grown, the role of donors and multilateral agencies in governance of client countries has not been well addressed. Donor and multilateral agencies speak of themselves as guests in countries but they are also major stakeholders playing an important role in the governance of client nations. This role ranges from passive acceptance of bad governance, to a narrow focus on donor priorities, or complicity with existing relations ( ). By identifying the role of donor and multilateral agencies in governance this issue is understood as part of globalization with its own consequences on health.

## WHY GOVERNANCE MATTERS TO HEALTH?

Governance matters to health first because market forces alone can not ensure equitable distribution health care and health in populations. The governance in the health sector is closely related to the issue of equity because health care is guaranteed by constitutions of many nations and international treaties. Moreover, prevention measures including road traffic injury control, provision of clean water and sanitation, or draining malaria swamps are public goods with externalities that require social coordination to ensure action. Assuring conditions for health and well being in populations can be fulfilled only by the assurance of adequate regulatory, legislative and social measures.

Poor governance in the health sector has led to misdirected spending of funds intended to improve the health status of the population. Corruption, inefficiency, poor regulatory authority undermine health care delivery in much the same way they do for police services, courts and customs.

The relevance of governance to health must also be considered within the specific context of Pakistan. For many years over seventy-five percent of health care in Pakistan has

been delivered through the private sector health care delivery system which has serious problems of access and quality of care ( , ). The role of government to assure provision of health must be expanded to include assurance of quality service provision both in the public and private sector and issues of access.

## RESULTS AND DISCUSSION: GOVERNANCE ISSUES IN PAKISTAN

In this section six domains of governance are discussed and examples of problems with governance that have consequence for health in Pakistan are provided.

## A. VOICE AND ACCOUNTABILITY

Problems with voice and accountability can be identified in the inequities in access to health care and in the lack of a process by which stakeholders participate in decision making related to health in the government. The constitution of Pakistan guarantees health care for all and the country is a signatory to most international treaties that ensure equity; notwithstanding, there are conspicuous health inequalities and the distribution of health expenditures tend to benefit the privileged in the country. The government spent US$ 1.06 million for health care for eleven members of the Pakistani elite, received outside the country. That amount exceeds the amount to run a tertiary care hospital for a whole year, and is thirteen times more than total amount the government spends on prevention and control of non-communicable diseases ( ).

### Figure 3

Box 2 Problems with voice and accountability lead to inequitable distribution of health care.

- Two tertiary care hospitals under the MOH in Islamabad (Pakistan institute of Medical Sciences and Federal Government Health Services Hospital) have a larger budget than total health budget of the province of Baluchistan.
- There are 3 MRIs in the public sector hospitals of Islamabad/Rawalpindi to treat the elite bureaucracy compared to only one MRI to care for the entire population of the Baluchistan province (approximately eight million).

The Central Development Working Party, the premier development body of the country which is responsible for approval of all development projects approved a MOH request for the construction of two “medical towers” - high tech tertiary centers catering to medical tourism for transplants- in Islamabad and Karachi -- at a cost of about Rs. 6.5 billion in October 2006. These plans were proposed without any feasibility study or business plan as to how these towers might function.

Problems with voice and accountability are also reflected in lack of a process by which stakeholders participate in decision making and policy formulation, particularly the poor who depend on the Ministry of Health (MoH) for their care. The Government of Pakistan has developed three National Health Policies (NHP) in1990, 1997 and 2001. NHP have been were conceived, directed, and implemented by a small group of professionals at the Ministry of Health without involvement of civil society, development community, professional bodies, consumer organizations, or members of parliament, with the exception of some minor consultation conducted around the 1990 NHP.

Minimal consultation for development of these plans has led to poor quality and lack of support outside of narrow policy circles in Islamabad. The NHP 1997, set the target of “reduction in IMR from 86 in 1998 to 40 in 2003 and 20 in 2010” without any feasibility study. Both the NHP 1997 and the 2001 failed to mention chronic diseases, despite their contribution to 40% of the national burden of disease in the country ( ). The development of the National Health Policy Forum (Box 3) provides a positive example of what can be done through a public private partnership to increase participation of stake holders.

### Figure 4

Box 3 Improving voice and accountability

An example of a positive development supporting improvement of voice and accountability in the health sector has been the creation of the National Health Policy Forum. The forum has created a public private partnership to promote good government policy in the health sector. Over 160 private sector members (including universities, the pharmaceutical industry, and NGOs have contributed to a series of policy documents that have contributed to support the formation of government policy. (see www.nhps.org). The limitation of this important initiative is lack of public participation, lack of feedback mechanisms for the common Pakistani, dependency on foreign donors and a modest budget.

Devolution of the health sector, which was intended to increase accountability and voice, has paradoxically damaged the implementation of some public health programs ( ). Districts do not have incentives to take up the low visibility preventive programs and have opted for high visibility projects like construction new hospitals, some of which sit empty due to lack of staff and equipment ( ) .

## B. POLITICAL INSTABILITY AND VIOLENCE

Political instability and violence have had a detrimental effect on the development of health programs and policies. When leaders are continually addressing security issues, health issues are given low priority and programs are delayed or ignored ( ). Political instability directly affects health bureaucracies. Johkio and Pappas have documented the extremely high levels of turn over in top positions in the Department of Health in Sindh province associated with the

highly politicized and unstable provincial bureaucracy( ). Administration and management positions in the bureaucracy are frequently based on political favoritism, without regard to credentials or experience.

International instability in the region and violent military action in neighboring countries also affect governance inside Pakistan. Efforts to eradicate Polio in Pakistan have been slowed by a political backlash in conservative communities, particularly in Swat and Malakand in NWFP, where regional conflicts are interpreted as foreign aggression against Muslims. Some political leaders in these areas opposed polio vaccination because it is seen as connected with foreign support ( ). The consequences on the health sector of these between global political events should not be dismissed.

Finally political violence itself is a public health issue for the over loaded and weak health care systems of Pakistan. Inadequate systems of emergency management of all forms of injury lead to avoidable death and long term consequences ( ).

## C. GOVERNMENT EFFECTIVENESS

Effective government is reflected in the quality and appropriateness of public services as established in evidence, the degree of its independence from political pressure, the quality of policy formulation and the implementation, and the credibility of the government's commitment to such policies as demonstrated in an outcomes approach to program.

Poor quality and inappropriate government health services continue to be major problems for Pakistan. The quality of hospital care in the country is very poor ( ). The rapid growth the private sector in health care in Pakistan is in part a response to the perceived poor quality of care provided by public facilities. Less than 30% of users of public facilities are satisfied; reasons for dissatisfaction given include non availability of medicines, distance to the facility, and attitude of the staff ( ). More about the weaknesses of the primary care system is presented in the first case study presented below. An epidemic of Hepatitis C in Pakistan is due to iatrogenesis, a fatal and expensive disease spread by the unhygienic practices of doctors and dentists ( ).

There are also serious weaknesses in the processes around planning, policy, and program implementation in the health sector ( ). These three critical functions operate independently instead of being link, interdependent. Project planning is the domain of the Planning Commission which need not follow priorities set in the health policy formulated by the Ministry of Health. On the other hand implementation of health policies and service delivery is the responsibility of the district governments which need not take direction from Provincial or Federal level.

Duplication in the bureaucracy is another sign of inefficiency. The Ministry of Population was established in 1965 to promote family planning and operates its own health/population facilities which in many cases these are separate from the health outlets. Weak coordination between the two ministries has further lead to poor implementation of these interventions.

## D. REGULATORY ISSUES

Lack of appropriate regulatory activity in Pakistan has created additional health problems for the population. Substandard and fraudulent pharmaceuticals are common ( ). Counterfeit medicines constitute between 40 and 50 per cent of total supply in Pakistan ( ). Total duties and taxes on pharmaceuticals in Pakistan come to 33% ( ). Poor quality medical practice by quacks and doctors are major problems in the country( , , ). Government bodies have weak authority and poor procedures for regulation of the quality of pharmaceuticals and quality of medicine.

## E. RULE OF LAW

Pakistan suffers from low levels of confidence in, and poor obedience to rules of society. This problem has been created by many years of poor contract enforcement, an overwhelmed judicial system, and poorly trained and ill-equipped enforcement agents. In the health sector patient and consumer safety have suffered. Medical negligence is well documented and the legal system is poorly prepared to address abuses ( , ). Pakistan has a very weak system to monitor medical negligence, to discipline those found in error, and to provide restitution to victims. There are no specific policies at the federal level nor are there any programs to protect patients.

Years of neglect and inaction has led to very low levels of trust towards health sector institutions. Pakistan, like many developing countries, tolerates non-adherence to rules barring public sector physicians from maintaining private practice. Despite these systemic failings village level empowerment programs have demonstrated that communities can operate with a set of rules when provided with adequate support ( ).

## F. CONTROL OF CORRUPTION

Surveys in Pakistan document that there is a perception that corruption is very common in the health sector making corruption perhaps the greatest challenge to good governance ( ). In Pakistan the most conspicuous example of corruption in the health care system is absenteeism of health care personnel, better termed "ghost workers". It is very common for health care workers given assignments to particular posts and receive salaries but fail to attend their clinics, especially in rural centers. Very often they do not even live in the community or near by. Portions of salaries allotted for "ghost" physicians are shared with officials that manage the clinical system ( , , , ). Another form of corruption is illegal user fees which are routinely charged and represent a major burden on the poor, out of pocket cost which are a high proportion of monthly incomes in Pakistan. These forms of corruption are endemic and highly organized.

Corruption in the pharmaceutical sector is pervasive ( ). Procurement process includes collusion among bidders to reduce competition and to influence the selection process. Kickback and bribes to public officials monitoring the contracting process are tolerated. In clinical facilities drugs and medical supplies are stolen from central stores for resale in private practices or on the black market resulting in chronic shortage of medication in public facilities. Institutionalized corruption take the form of dispensing drugs to "ghost patients", graft and padding of bills, over payment, over invoicing, or simply pocketing the patient's payment. Corrupt management and monitoring capacity lead to poor quality of medication on the shelves including expired, counterfeit and harmful drugs. The process of licensing pharmacies or chemists' shops is corrupted by bribes. Physician practices are adversely affected by aggressive drug marketing strategies and unethical promotion of medicines.

## TWO CASE STUDIES

In this section two case studies are developed which provide examples of the way in which the domains of governance work together and are reinforced in the health sector in Pakistan. The Primary Health Care System (PHCS) has tolerated high levels of absenteeism for years and a Presidential initiative was created to address the problem. The second case also describes a Presidential initiative to address the long standing problems of child malnutrition and low school attendance for girls, the Tawana Pakistan Program.

## THE PRESIDENT'S PRIMARY HEALTH CARE INITIATIVE: A LOST OPPORTUNITY FOR REFORM

The failure of the primary health care (PHC) system has been recognized by the government at the highest level land and led to the creation of the President's Primary Health Care Initiative (PPHI). The PPHI was launched with the view that PHC centers could be better managed by contracting out services. The failure of the old PHC system can be summarized by low utilization rates caused by doctor absenteeism and poor management. The reform program was piloted in District Rahim Yar Khan involving thirty Basic Health Units (BHU) which took away authority and funds from the Punjab Health Department (PHD) and endorsing a new approach administered by the Ministry of Industry and Special Initiatives (MOISI). MOISI contracted with the Punjab Rural Support Program (PRSP) to manage the BHU service delivery. The PRSP is a parastatal organization that has successful managed many rural development programs through community mobilization.

The results were striking; utilization rates in the PRSP run PHC facilities increased by over 200 percent in a few matter of months ( ). The simple explanation for the success is that absenteeism was not tolerated by the PRSP management and that patients responded to the availability of a doctor and medicines in the PHC facilities. Patients come to clinics if doctors are available. PRSP also increased the salaries of the doctors three fold by allowing one doctor to work in as many as three PHC facilities. The most remarkable aspect of the pilot was that utilization increased at half the cost of the old system.

Unfortunately, despite the success of the pilot, the key policy lessons were lost in a complex scenario involving several dimensions of governance failure. The reports of the results of the PRSP experience were distorted by the federal health ministry (MOH) and Punjab health department (PHD). The MOH and PHD used the report of the PRSP experience to justify tripling the salaries of the doctors working at PHC facilities. The employees in the failed PHC system were thus rewarded without any change in the management and without addressing absenteeism or other problems. Political rivalries between MOH and MOISI and federal and province levels created further obstacles. The federal strategists who created the pilot in the MOISI did not show sufficient ownership in the initiative, failing to properly disseminate the lessons learned by the PRSP experiment which led to distortions. Leadership at MOISI did not create a transition

strategy for the initiative out of the MOISI as health care in that Ministry was not be seen as a long term solution. Constructive criticism to create additional mechanisms of contracting out services (other than PRSP) was never acted upon.

The multilateral and donor communities also failed by largely ignoring the results of the RRSP experience. Finally there was insufficient public accountability in the process -- missing were voices of the people, the constituents of the program. Communities were were neither consulted nor were they focus of the policy process. An evaluation component which should have been built into the RSSP experience was an afterthought and represents poor management of the initiative.

## TAWANA PAKISTAN PROGRAM: A PROGRAMMATIC SUCCESS AND A POLITICAL FAILURE

The Tawana Pakistan Project (TPP) was a mega pilot of the Government of Pakistan addressing the long standing poor nutrition and low educational attainment of primary school age girls, also a Presidential initiative ( ). TPP worked in twenty-nine of the poorest districts in the country, serving cooked lunches to over 400,000 girls in 4019 schools. The core strategy of TPP was to provide freshly cooked, balanced lunches in schools and was implemented by local NGOs. Meal planning, shopping, cooking, and serving of the meals were done by School Tawana Committees (STC) made up of volunteer women from the villages.

The results of the program were striking. Wasting decreased by almost half (45%) over the course of the project. ( ). School attendance improved by over 40%. In addition, the number of teachers in TPP schools increased, school discipline improved, and more schools operated on time. Improvements infrastructures in schools were also documented. And finally, empowerment of community women was both a strategy of the project and a positive outcome itself. Perhaps the most important lessoned learned was that Pakistan has the capacity to make a difference in the lives of school age girls – a critical resource for the country's future.

Funds were made available through the Government, and a sufficient numbers of NGOs existed to work in thousands of communities all over the country. These micro public-private partnerships allowed for 75 percent of the TPP funds to be spent at the local level – an astonishingly high figure for Pakistan, especially for centrally managed health projects.

Despite the documented programmatic success, the program was cancelled by Government of Pakistan. This health and education program was administered by the Ministry of Social Welfare and never receive support from Ministry of Health or Education which had no ownership in the program( ). Poor contractual arrangements and administrative structure over the program caused a lack of clarity on roles, and created a hostile climate between the government and the contractor. The final report of TPP was ignored. A well designed outside evalution with controls was commissioned and conducted but the report never reviewed. A "third party" evaluation was commissioned by the Ministry of Social Welfare done by former bureaucrats who have no expertise in education or nutrition, Their report cited the positive outcome of the program but supported cancellation of the project, clearly what the government wanted to hear.

After the original project was canceled the Ministry of Social Welfare re-design Tawana, creating a second phase. The second phase was "commodity push" program that replaced the cooked meals with a nutritionally inferior "milk and cookies" program. The locally produced, culturally appropriate, lower cost, better quality food items, and were replaced with a program that was more costly, nutritionally harmful, in a program that undermined the empowerment of community. Moreover, the commodities of the redesigned program never reached the girls or they were served with spoiled commodities. The second phase of Tawana was also later cancelled.

Lack of involvement or interest of the multilateral and donor community in a huge program (over 1.6 billion rupees) targeted on girl children's health and education is a failure. This lack of engagement with this major government program by the donor community demonstrates an unwilling to take on governance problems. International milk producers opposed the program from the outset and were present at may government meetings that concerned TPP. The role of international milk producers raises points to possible influence that led to cancelation of the original model and replacement by the "milk and cookies" program. It also raises questions about foreign embassy trade representatives whose jobs are to promote foreign products in Pakistan.

## CONCLUSION AND POLICY OPTIONS

There are examples of well governed programs in Pakistan

have worked to improve health of the population. The Lady Health Worker program is an indigenous program that was developed on local and international evidence with little direct financial contribution from donors ( ). Strong management, appropriate incentives, supervisory mechanisms, and planned and successive evaluations have lead to program integrity and success. This success gives indication that improvements in governance of health are possible in the country. Reform recommended here can improve performance of the health system within a context of continued political uncertainty.

1. Create checks and balances in the health care delivery system by giving voice and accountability

Governance in the rural primary care setting can be improved by giving voice to communities through the creation of community health committees and consumer protection organizations. Successful models already exist in the country. Accountability of the contracted out services can also be ensured by re-inventing the Federal Ministry as a quality assurance agency with the charge of supporting and promoting professional standards. Models for government led quality assurance are well developed. Models for community participation should be added to contracting out schemes and funded.

2. Improve government efficiency through creation of a formal link between policy, planning, and program

Formal links between policy, planning, and program will help overcome some of the well know inefficiency in the health sector in Pakistan. Personnel at the Ministry of Health should be brought together in a process that will allow shared knowledge, noted historical trends, and use of intuitive thinking that work to determine policy focus and budgetary allocations for different public programs.

3. Introduce transparency and voice by involving concerned stakeholders

A sustained dialogue between government and civil society from many sectors will lead to better policy, and a flow of support. The currently fragmented health sector can be replaced with continuity based on the creation of a community of expanded stake holders that meets often and provides leadership for reform through the policy, planning, and program process. Public dialogues attended or convened by government supporting the health sector could be sustained and expanded.

4. Improve the evidence base of the health sector by funding policy research and monitoring and evaluation

Sustained improvement of management in the health sector in Pakistan requires adequate investment in monitoring and evaluation and policy research. Monitoring and evaluation must become an integral part of program instead of an after thought, and be routinely included with at the initial planning. Monitoring and evaluation are typically started when the program faces difficulties and are often a political instead of a management tool. Management guidelines for the health sector suggest that ten percent of a program budget should be devoted to monitoring and evaluation. Building monitoring and evaluation into the early implementation stages of all programs and projects is essential. Modification of the contracting process (PC-1) to require monitoring and evaluation plans for all projects is a way this issue can be concretely addressed.

5. Enhancing public sector capacity for governance in health by create structures and rules for human resource management for health

Expectations for good governance cannot be met unless the requisite skill set is present in those who govern. Capacity development of policy makers, appointed officials and program managers must be addressed. Creation of appropriate incentives and working conditions are also needed to recruit and retain competent, trained professionals. It is equally important that capacities and competencies within MOH should be strengthened in policy research, policy analyses and utilization of available evidence for improved decision making.

Well developed policy and support mechanism for human resources are needed to address problems such as absenteeism and frequent transfers. Human resource rules and polices will help shelter the bureaucracy from the vagaries of political changes that dominate parliamentary politics. Tenure postings, merit based criteria for employment, including trainings and experience should be essential criteria for postings. These sorts of policies would stabilize the bureaucracy in the face of political uncertainties. Serious investment in training of managers of the many aspects of the health system is essential for efficiency to improve. Models for this sort of administrative reform exist and could easily adapt to the Pakistani context.

6. Development of legal frameworks for promoting health

The lack of a strong legal framework for health governance

in Pakistan is an issue and needs to be corrected. For example, legal reforms to protect patient safety and the creation of a legal framework for malpractice, and mechanisms to enforce existing controls on pharmaceuticals must be enacted. The use of regulatory and oversight means is key to good governance and without these tools health sector governance will continue to escape major reform. Regional models may provide Pakistan with a direction.

7. Government engagement with the private sector in health care.

Public private partnerships in health care Pakistan are still poorly developed. Private sector has moved forward in spite of government instability and related problems now providing over three quarters of health care in the country but not without its own problems. Donors and government should develop strong programs to encourage the role of civil society in health and the government health sector through a quality assurance program. A more aggressive and confident civil society can play a strong watch dog that may improve governance in the country and work against corruption. Government should encourage such a role.

8. Donor and multilateral agencies

Donor and multilateral agencies should recognize the role they play in governance in theory and is practice. While many of these agencies have special programs to encourage good governance, these efforts should be mainstreams and integrated into the health sector programs.

Health indicators in Pakistan have stagnated, in part due to poor governance in the country. The literature on governance provides a useful way to organize the complex experience in Pakistan over the past decades and illustrates the ways the domains or aspects of governance reinforce one another. This paper draws the role of donor and multilateral agencies into an understanding of governance, focusing on globalized relations between these agencies and their clients. Donor and multilateral agencies can not be seen as external operators on client countries but are part of the governance structure of countries. Despite major barriers to improving governance in the health sector recommendations are offered that are feasible in the short term, which take into account the difficult conditions in the country.

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