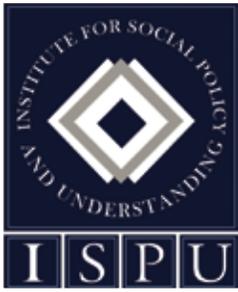


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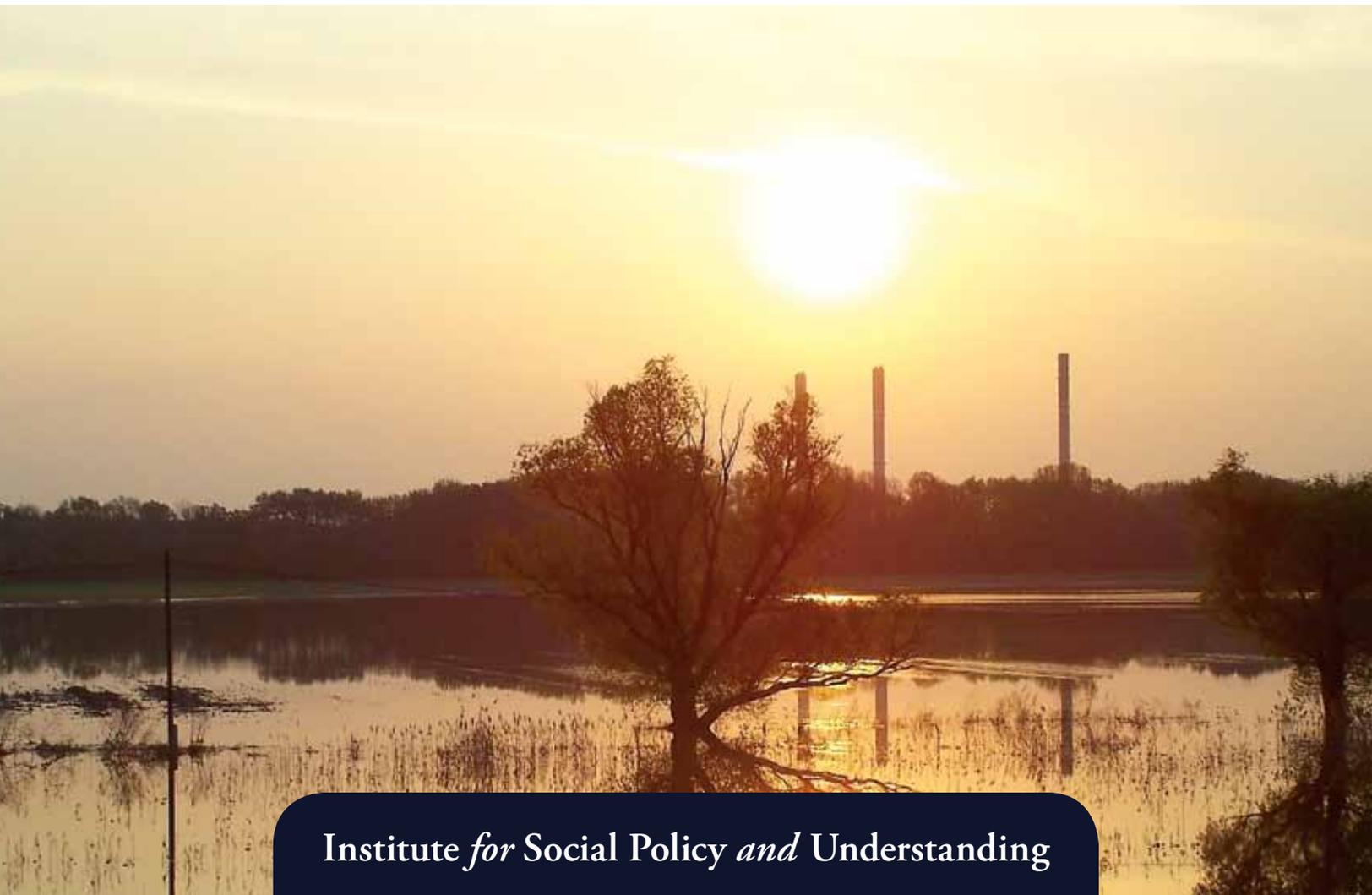


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THROUGH THE HEALTH LENS: *The Aftermath of the 2010 Pakistan Flood*

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Heartfile

Heartfile is a non-profit health sector NGO think tank, which focuses on catalyzing change within the health system and broader systems of governance in order to improve health and social outcomes; the organization is recognized as a powerful and respected health policy voice within Pakistan and a unique model for replication in other developing countries.

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Introduction

The devastation evident in the aftermath of the 2010 flood in Pakistan, the worst humanitarian disaster on the face of this planet in recent history, drives home the importance of several health norms: the definition of health with reference to the inclusion of “well-being” alongside “absence of disease and infirmity,”¹ the growing importance of the interplay of the social determinants of health enshrined in a landmark report,² the recent emphasis on the “Health in All Policies” statement,³ the notion that a health system is broader than a healthcare system,⁴ and the importance of the holistic vision for human security.⁵

With 20 million people affected and a majority of them homeless without access to adequate clean water, sanitation, food, and healthcare, the importance of factors outside of the health sector and the inter-sectoral scope of health have been brutally brought to public notice. The floods are also a reality check, reminding us that climate change can alter the equation of human existence with devastating impact for vulnerable populations and serious implications for health and well-being.

Over 1.6 million houses have been damaged, many razed to the ground, and 3.2 million hectares of standing crops inundated. Twenty percent of the country’s land mass— more than the entire landmass of Italy — has been affected. In some of these areas access has become a major issue, with roads and bridges washed away and colossal damage done to communication and irrigation infrastructure in other badly hit areas. Millions of poor people in the riverside communities of the Indus have been pushed further into poverty.

Unfortunately, the flood hit while the country is grappling with many issues on several fronts. The huge need to allocate resources for relief, rehabilitation, and rebuilding has arisen at a time when grinding economic challenges are competing for resource allocation priorities vis-à-vis internal security, the ongoing war, the energy crisis, etc. As a result, there is a widespread reliance on humanitarian and development assistance for the relief and rebuilding phases. Such expectations might not be fully realized, however, as donors themselves are recovering from the impact of a global recession. Donor fatigue among bilateral and multilateral donors has already set in, as well as a lack of trust regarding the weaknesses in governance and transparency.⁶ In fact, many donors recently stated that Pakistan should step up its indigenous capacity to mobilize resources rather than relying on external aid.

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A further compounding factor is the ongoing reshaping of the state's institutional arrangements. The Eighteenth Amendment to the Constitution of Pakistan has altered the equation of responsibility in the federating system by envisaging the empowerment of provinces as subnational units with greater autonomy. As this is being implemented now, many processes are in flux. The local system of government is being reshaped, and the ensuing lack of clarity in responsibilities and prerogatives has been one of the most critical impediments in the relief phase. This constraint has undermined the government's ability to implement plans effectively. Additionally, non-state actors are not sure who they are to engage with at the local government level in many districts. The flood and its handling by the government and non-state actors have made visible a host of critical institutional challenges within Pakistan's governance system. It is not possible to analyze each constraint here. The objective of the paper is to provide a snapshot view of the flood's impact on Pakistan's health system and the health of its population, as well as the limitations that systemic constraints have posed in this regard. The analysis has largely been based on a qualitative assessment, inclusive of reviews of published and grey literature. Information has been supplemented with informants' views where necessary.

Health Governance

Beyond health governance, the flood has highlighted many weaknesses in Pakistan's overarching governance systems. It has been acknowledged that the disaster management institutional arrangements created in the aftermath of the October 2005 earthquake do not have the functional capacity to be fully responsive and that there are critical issues with the existing Flood Relief Commission. There is little justification for creating parallel structures—many ideas are being mooted—while the prevailing impediments in existing institutions remain pervasive and unaddressed.

The flood has also revealed the limited capacity within the system to cope with climate change. While it is correct that the disaster's true scale could not have been predicted, the calamity itself was not a surprise. Analyses by multilateral agencies and Pakistan's Task Force on Climate Change had predicted the country's vulnerability many years ago. The meteorological office's warning on June 26, 2010, a few weeks before the floods commenced, did not translate into appropriate action, which indicates weaknesses in the institutional capacity to respond. Unfortunately, Pakistan does not have an institutional arrangement focused on the holistic vision of security in place to forecast disasters. Previous efforts to create such a structure have been thwarted.⁷

In addition, the disaster reflects issues inherent to governing the Indus river and the politics that plague it—ill-planned settlements around the river and the politics of canal and flood embankment breaches show how influence is wielded and power is abused. Furthermore, the entire nation is being reminded that the existence of strategic dams would have greatly lessened the scale of the devastation. This drives home the point that politicizing a key national issue such as water reservoirs, one result of the lack of accountability within the decision-making process, has taken a huge toll. Moreover, the involvement of grass-roots religious organizations, some of them with fundamentalist ideologies, indicates their level of entrenchment in communities. These grass-roots dynamics create an imperative for the government to act as a stronger steward at this stage.

In terms of health more specifically, the crisis is a reminder of many governance constraints, which have been summarized under the domains of setting strategic directions, implementation, and oversight and regulation.⁸ Issues of public finance management, procurement, and

The flood has also revealed the limited capacity within the system to cope with climate change.

organizational functioning have impacted health-related relief options and will continue to constrain the government's ability during the rehabilitation phase. There are reports of graft in the procurement of medicines and supplies from various provinces.

This section will focus on two aspects of governance related to the flood: coordination and the local government system. The ability to coordinate is the key to effective governance and planning in disaster situations, for only effective coordination can harness the potential unleashed by civil society and volunteer contributions after they have been mobilized to respond. The importance of volunteers' contributions at such times has been recognized in Resolution 56/38 of the UN General Assembly.

The Government of Pakistan's coordination capacity is known to be weak. The overall responsibility for coordination rests with the National Disaster Management Authority (NDMA), which is supported by the UN's Office for the Coordination of Humanitarian Affairs (UNOCHA). Provincial disaster management authorities (PDMA) and district coordination officers are responsible at the provincial and district levels, respectively, and their capacity is being enhanced through the UNOCHA's satellite offices. There are a number of clusters organized under the rubric of UNOCHA.

Health sector coordination is achieved through a variety of arrangements, but principally through the UNOCHA-supported health cluster. The health cluster's lead agency is the World Health Organization, and its primary Government of Pakistan counterpart is the Ministry of Health. Cluster partners include a range of state and non-state entities. The cluster's stated objective for the relief phase was to *"reduce the burden of avoidable death and illness through lifesaving interventions among flood-affected populations of Pakistan, ensuring that women and men can access health services equally,"* while the objective for early recovery is *"to address the factors that contribute to the main mortality risks..."* Numerous task forces and working groups operate under the rubric of the health cluster. These institutional mechanisms provide a point of contact for several stakeholders, including civil society agencies, individual philanthropists, and the private sector, all of which bring diverse skills and contributions to the table. A member of the National Steering Committee on Health Emergency Preparedness and Response, a government established set-up, is also represented in the health cluster. This

cluster's six regional clusters (Islamabad, Peshawar, Multan, Sukker, Hyderabad, and Quetta) enable it to coordinate regionally. Its proceedings are published periodically.

The cluster's work is closely related to the nutrition, (social) protection, and WASH clusters; the latter deals with the availability of clean water and sanitation. UNICEF is the cluster lead agency for WASH; the Ministry of Environment and the Provincial Public Health Engineering Departments are the government counterparts. Cluster lead agencies for nutrition and protection are UNICEF and the International Organization for Migration/UNHCR, respectively; the government counterparts are the Ministry of Health and Social Welfare, respectively.

The present set-up has drawn on lessons from experiences with the 2005 earthquake and how the development and humanitarian community engaged with the government and local civil society in its aftermath. This arrangement is heavily dependent on external resources, which means that as time progresses and interest wanes it will become very difficult to sustain. Ideally, there should be a minimally functioning, coordinating arrangement already in place that can be put in place as the need arises.

Most references to coordination in the given context refer to a supra-organizational structure or mechanism. Many difficulties stand in the way of creating such a structure. Agencies have varying mandates, missions, and objectives as well as diverse administrative and reporting relationships. When asked to synchronize, share information, and come under the control of another structure, they fiercely guard their own turf and independence. Coordination cannot be aligned on vertical principles when agencies do not have reporting hierarchical relationships. Any supra-organizational coordination structure, therefore, has to offer two things to be successful: incentives for agencies to participate and the ability to add value to what the existing arrangements have to offer. Taking these into account, the idea of a Flood and Disaster Observatory has been mooted.⁹ This is envisaged as a dynamic user-friendly Web-based graphical interface that can drill down to the *tehsil* (a third-tier subnational unit) level to enable real-time information updating about the needs of various geographic regions and the agency commitments and actions in response.

The strength of this approach lies in the fact that state agencies are already working with something that can be a stepping stone to developing an observatory. NDMA's flood relief pages and PDMA's websites have many useful features; for example, they post regular weather forecasts, flood warnings, and information about relief camps and urgent needs. Punjab's provincial disaster management authority has information for registering NGOs and volunteers in addition to many active features related to flood relief. Real-time updating, interaction, and visibility would incentivize agencies to participate; moreover, since the mechanism would be non-coercive, it would be acceptable to most stakeholders and would make perfect sense given Pakistan's excellent telecommunications infrastructure. It is this system of information and authentication that can enable coordination.

The sheer simplicity of the Flood and Disaster Observatory concept should not undermine its relevance. Far more complicated technological solutions are being planned and presented as part of a package of projects for funding at the Pakistan Development Forum, scheduled to be held shortly. The potential advantage of this appears to outweigh the others.

The second aspect of governance that merits attention relates to Pakistan's confusing local government system. The Eighteenth Amendment to the Constitution of Pakistan states that provincial governments are responsible for deciding the fate of the local government system, which was installed in 2001 under a military regime. Thus the scuffle between the proponents of the local government system and those that want to scrap it and revert to the old post-colonial system of local management is ongoing. The ensuing impasse and lack of clarity has impacted the government's implementation capacity at the grass-roots level, where good governance matters to the poor and marginalized people. This disconnect was sorely felt in the flood's aftermath, when relief had to be coordinated from various sources.

Service Delivery

By inundating an area equal to the size of Britain, the flood created a three-fold health challenge with respect to service delivery: it destroyed and damaged health facilities and thus left vast populations without access to health services, created emergency health situations for displaced and vulnerable communities, and posed the challenge of long-term rebuilding of damaged facilities in a fiscally constrained environment.

Official records state that of the 9,721 health facilities in the flood-affected areas, 329 have been partially damaged and 186 have been totally destroyed. Officially, 10,500 Lady Health Workers—Pakistan’s field force of grass-roots level workers responsible for door-to-door delivery of a defined package of services—have been misplaced from their areas of operation. The quantum of damage and the loss in capability to deliver services in one hospital alone in the garrison city of Nowshera, located on the banks of the Kabul River, was so significant that a large population was forced to seek tertiary healthcare located one hundred kilometers away.

The actual quantum of impact on the nation’s health infrastructure appears to be much larger than what has officially been stated and will largely remain unknown. Official estimates take into account public infrastructure, whereas Pakistan’s extensive market system, characterized by a diverse range of non-state actors, plays a dominant role in providing healthcare.

The health needs of the flood-stricken internally displaced communities compounded the sudden reduction in the capacity to deliver services. The officially reported death toll, as of early November 2010 was 1,514 with 2,605 people confirmed as injured.¹⁰ The biggest problem in the immediate aftermath stemmed from water-borne diseases due to contamination, such as rampant diarrheal diseases, pneumonic-type illnesses, and skin diseases. This was evidenced by the pattern of health consultations: more than 7.3 million were reported through the Disease Early Warning System (DEWS) as of November 5, 2010. Thirteen percent of these were for acute watery diarrhea, 16% for acute respiratory infection, and 17% for skin diseases.¹¹ A rise was also observed in vector borne diseases due to stagnant pools of water; 5% of the consultations reported through DEWS were for malaria. The worst outbreak of dengue was reported in Pakistan in the early recovery phase—4,363 cases of suspected dengue fever, with 2,062 confirmed cases and 15 deaths as of October 22, 2010. The early recovery assessment findings have reconfirmed impressions related to environmental problems arising as a result of stagnant water, animal carcasses, and rubble from damaged buildings.

The actual quantum of impact on the nation’s health infrastructure appears to be much larger than what has officially been stated and will largely remain unknown.

It is difficult to generically describe the local and international community's response in relation to stepping up health service delivery for the affected population. A number of solutions were provided by a plethora of stakeholders in the flood's aftermath. Medical camps were located in schools, tents, and makeshift arrangements; mobile teams were established; efforts were made to ensure the availability of health professionals around the clock at various points; several health facilities were made operational 24/7; and many existing facilities were strengthened to cater to the increased workload. The response from the local and international community, provincial departments of health and population, the Peoples Primary Health Care Initiative (PPHI), local NGOs, the armed forces, international donors, international NGOs (INGOs), and bilateral country missions was unprecedented. It is not possible to map and summarize the diversity of healthcare delivery response. However, information related to external contributions is relatively more systematically reported. Table 1 summarizes details about field hospitals set up through bilateral international support, and table 2 sums up the contributions of INGOs. Although the contributions of some local agencies are also well-archived, such as those of the PPHI,¹² those of many other efforts remain undocumented. It also has not been possible to note the contributions of the hundreds of thousands of mobilized individual volunteers and local NGOs.

In addition to the new/emergency infrastructure, there were many reports of undamaged, functioning health facilities in the immediate vicinity of the affected sites that stretched their services to capacity. There are no analyses in the public domain that indicate, in a consolidated fashion, where these locations were, the kinds of needs emerging, and how gaps were being bridged. It is not clear if hospitals such as the one referred to in the footnote, which took the major brunt of the service delivery burden as a result of damage to other hospitals in neighboring flood-afflicted areas, were part of the needs-assessment discussions at health cluster meetings that drove the planning agenda.¹³

The health cluster targeted its services to an area with a total catchment of 8 million potential beneficiaries in the relief phase (300,000 children under-five; 1,760,000 women of child-bearing age, of which 193,200 were estimated to be pregnant in any given month with nearly 29,000 requiring some type of intervention at delivery). This cluster recently reported that it has reached out to 4 million people with medical supplies and treatments; delivered emergency reproductive health services to 59,664 patients; conducted 1,222 deliveries as well as 7,395 antenatal and 1,636 post-natal consultations; vaccinated 445,000 children against polio and

Table 1: Field Hospitals Set Up by Bilateral Missions

Country	No. of Team Members	Geographic Locality
PUNJAB		
Italian Field Hospital	42 Bedded	Muzaffargarh (Jatoi)
Italian Field Hospital	42 Bedded	Muzaffargarh (Gujrat)
Italian Field Hospital	42 Bedded	Layyah
Australian Field Hospital	40 Bedded/70 members	Kot Addu
Saudi Field Hospital	100 Bedded/71 Members	Rajanpur (to be deployed)
SINDH		
Turkish Field Hospital	30 Bedded/21 Members	Khairpur
Saudi Field Hospital	100 Bedded/71 Members	Thatta
Chinese Field Hospital	6 Bedded detention facility/65 Members	Thatta
EU Field Hospital	24 Bedded/16 Members	Jacobabad
EU Field Hospital	24 Bedded/16 Members	Larkana
EU Field Hospital	24 Bedded/16 Members	Dadu
KPK		
Italian Field Hospital	42 Bedded	Dasu-Kohistan; Madyan-Swat
Balochistan		
Turkish Field Hospital	30 Bedded/21 Members	Dera Murad Jamali
Italian Field Hospital	42 Bedded	Dera Allah Yar
GB		
Italian Field Hospital	42 Bedded	Chhashi

Source: From a presentation on health updates by the Ministry of Health; mid-October 2010

428,000 against measles; and administered vitamin A supplements to over 338,000 children. The health cluster stated that in the early recovery phase, interventions will be directed toward a total catchment of 11 million people.

The response in terms of delivering health services in the emergency situation has been remarkable. Unfortunately, it was also paralleled with reports of abuse at the field level, particularly in relation to pilfering supplies and exploiting procedures laid out for procurement in emergency situations. In Pakistan's mixed health system, the triad of insufficient funding for

Table 2: Contributions of Multilateral and International Development Agencies

* = Mobile Teams # = Fixed Primary Healthcare Units, BHU's and support to government health facilities

Agency	Punjab	KPK	Sindh	Balochistan	GB	AJK
UNFPA	* &	*#&	*#&			
WHO	*#	*#	*#	*#	*#	*#
UNICEF	*			*#		
UNHCR				*		
American refugee committee international (ARC)		*				
Care International	*	*	* &			
Church World Services		*				
International Catholic Migration Commission		*				
International Medical Corps (IMC)		*#&				
Mercy Malaysia		*#				
Medical Emergency Relief International (MERLIN)	&	*#&				
Pakistan Red Crescent Society/German Red Crescent		&				
Relief International		*		*		
Savera Development		*				
Cordaid	*#	*				
Integrated Health Services (IHS Pakistan)	*					
Helping Hand for Relief and Development (HHRD)			*			
Mercy Corps			*			
American Rescue Committee international				#		

165 static health units and almost 1,200 mobile health units are currently operating (early November 2010). Source: WHO, Epidemiological Bulletin (weekly)

the public sector, a poorly regulated private sector, and a lack of transparency in governance act together to compromise the quality of public services and defeat the equity objective through a number of pathways.¹⁴ These constraints have an important bearing on emergency service delivery. Most importantly, these systemic constraints will have to be dealt with while rebuilding damaged and destroyed health facilities as the flood waters recede and the rehabilitation phase begins.

Health continues to be a priority area in all strategic plans and strategies, which were developed after the flood. Given that some funds will probably be made available for rebuilding damaged health facilities, this opportunity should be seized to create institutional arrangements based upon lessons learned from past failures. For example, the location of first-level care facilities should be one consideration. One reason for the suboptimal utilization of these facilities to date relates to their unsuitable location; this problem can be addressed if facilities are rebuilt from scratch. Forecasts of future floods must be analyzed when planning their locations. Other constraints to be factored in are the paucity of funds for these facilities and the lack of mechanisms to harness the ownership of non-state entities functioning in the market system in the same catchment area. It would be critical to use this rebuilding opportunity to test the feasibility, acceptability, and effectiveness of out-of-the-box service delivery options, which would also mitigate against current weaknesses in public delivery at the grass-roots level.

Health Information Systems

Several problems plague Pakistan's health information architecture. Three of them are of critical significance to the health information-related need that arose after the flood. First is the fragmentation of the country's existing disease surveillance system. Currently, more than fourteen surveillance systems are operational with varying frequencies of reporting; some are vertical whereas others are decentralized (table 3). Many of them are discrete, horizontal, fragmented, and dependent upon external donor support. While significant investments have been made in some of them, as in the case of the Acute Flaccid Paralysis (AFP)/polio surveillance system, Pakistan does not have an integrated disease surveillance system. The lack thereof was considered an impediment during successive outbreaks in Asia of Avian Influenza, in particular, Pandemic Influenza A H1N1 in 2009. The considerable under-reporting of H1N1 was due to the absence of a well-functioning surveillance system and the undetected cases, evidence of Pakistan's failure to fulfill its commitments as part of the International Health Regulations (IHR) 2005, which requires all member states to improve their detection, identification, characterization, and reporting capabilities.

In any emergency situation, the capacity to gather information from the field, detect outbreaks, monitor emergency health responses, and guide scale up of the latter is critical. The characteristics of DEWS, a WHO-developed surveillance system suitable for use in emergencies, enable just that. These include field investigation of outbreak alerts, analysis of surveillance data, identification of public health threats, and use of epidemic intelligence data.

DEWS was deployed in the districts affected by the October 2005 earthquake. But when the flood hit, it was operational only in a few districts of one province. A month later, it was made operational again. The system has been incrementally deployed, and its use has steadily increased. According to the latest issue of the *Weekly Epidemiological Bulletin*, posted on the World Health Organization's website, 48 out of 64 flood-affected districts were reporting surveillance data to DEWS as of November 4, 2010. The bulletin reports that 7,877,634 patient consultations have been reported through DEWS since its deployment. Currently, the system has many weaknesses despite the injection of substantial financial resources: limited coverage and quality assurance and the paucity of experienced human resources, in particular. DEWS, which is an expensive operation, is only suitable in emergency situations; while it has an important place among disease surveillance systems, it and other disease-specific or situation-specific surveillance systems cannot function optimally in the absence of an integrated disease surveillance system.

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Table 3: Disease Surveillance Systems Operating in Pakistan

Disease Early Warning System (DEWS)
Lady Health Worker (LHW) Surveillance System
Surveillance for EPI Targeted Diseases
Second Generation HIV/AIDS Surveillance
Acute Hepatitis Surveillance
Bacterial Meningitis Surveillance System
Pneumonia Surveillance
Islamabad Motorway Police Surveillance System for Road Traffic Injuries
TB Surveillance
Malaria Surveillance
AFP surveillance
Lab-based Seasonal Influenza Surveillance System
Rota virus Surveillance
District Health Information System (DHIS)

Pakistan should invest in an integrated disease surveillance system to improve its capacity to undertake infectious disease surveillance. The initiative is also critical for complying with IHR 2005. It is important to build upon past initiatives in this regard: the 2004-2005 joint evaluation of the surveillance system by the Centers for Disease Control (Atlanta), the WHO, the World Bank, and the Ministry of Health (MOH); the establishment of the Field Epidemiological and Laboratory Training program as a result thereof; the existing framework of Public Health Laboratories network; and the recent commitment by the Pakistani prime minister to invest in an integrated disease and response system.

Second, in addition to being fragmented, some surveillance systems are antiquated and thus have not benefited adequately from technology. For example, the Health Management and Information System (HMIS), a nationwide system that collects data from public sector first-level care facilities, and many others have not been fully automated. Therefore, the potential that exists to leverage Pakistan's telecommunications boom and create a central computing facility to which both the public and the private sectors can report remains untapped. Work is currently underway to replace HMIS with the District Health Information System, but the pace is slow and the process plagued by many institutional challenges.

Third, the absence of an institutional agency responsible for collecting, collating and consolidating, and relaying information and data has been felt for a long time. Such an agency can analyze evidence from infectious disease surveillance and other systems and then relay it in a timely manner for decision making. Several agencies created in the past could have played such a role, namely, the National Health Policy Unit and the National Health Information Resource Center, but their mandate was not clearly expanded to serve this objective. These bottlenecks in Pakistan's existing health information architecture have posed an impediment during health emergency operations.

Health Financing

Pakistan's health spending is meager to begin with, given that the public sector spends only 1.16% of the gross domestic product (GDP) on health, or US\$ 8.86 per-capita. This is staggeringly short of the US\$ 64 per-capita stipulated by the Report of the High Level Task force on Innovative International Financing for Health Systems as being the minimum level adequate for delivering basic health needs to populations by nation states. Low spending leads to a systemic distortion, characterized as the Mixed Health Systems syndrome, which plays a role in undermining the performance of public facilities and the equity objective of healthcare, helps graft become pervasive, and causes out-of-pocket spending for healthcare to escalate.¹⁵ The dire need to channel funds for maintaining existing health infrastructure and overcoming these constraints has always been recognized as a critical imperative by advocates for change. But financial constraints, a contractionary fiscal policy, and the failure to give due priority to efficiency and effectiveness-enhancing measures in general and health in particular have stood in the way of achieving that objective. The flood has brought an additional and unprecedented need to finance and support health infrastructure strengthening and rebuilding.

External and internal contributions played a major role in financing the emergency rescue and relief phase. The former included humanitarian contributions from bilateral and multilateral development agencies, country missions, INGOs, and the Pakistani diaspora; the latter included Pakistan's civil society, private sector, citizens and communities, and various parts of the government's machinery. The total value of external humanitarian support is difficult to quantify, as the majority was channeled in kind.

In a recent UN report, the health cluster outlined a requirement of US\$ 200,771,963 to meet the health sector requirements in the early recovery phase. The World Bank/Asian Development Bank damage assessment report was not in the public domain as yet, and therefore their needs assessment of the health sector was not known at the time of completing this paper.

External support does not seem to be forthcoming in a major way. Even before the flood, plans were underway to mobilize additional resources to ease the present fiscal crunch in line with the country's agreements with the IMF. Plans to impose a Value Added Tax have intensified after the second IMF tranche of US\$ 3 billion was delayed because Pakistan did not fulfill a conditionality related to resource mobilization. After the flood, the unprecedented need for financing to rebuild

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and rehabilitate prompted the government to announce that the Public Sector Development Program (PSDP) would be radically reshaped with priorities for the reallocation of development resources redefined; plans are also underway to impose a “wealth levy.” These plans, however, are not yet in the public domain. The extent to which these additional resources will be made available to meet the health sector’s needs remains to be seen.

The need to mobilize indigenous resources is all the more imperative since donors, who have until now been contributing heavily toward PDSP allocations for the social sector, have clearly indicated that such options need to be explored. A recent paper suggested several ideas, citing examples from the policy sphere of health to underscore the relevance of out-of-the-box solutions.¹⁶ For example, international experience shows that a very small earmarked indirect tax imposed on specific products or transactions can raise significant revenue. Although it is accepted that in Pakistan, which already has a very high indirect taxation ratio, an adverse ratio of indirect to direct taxes, and plans to levy the reformed GST underway, the idea of an “earmarked flood tax” could be met with resistance. But the key element in the kind of indirect tax being referred to herein is its very low charge. Such taxes are imposed on specific products or transactions, collected by the retailer, and forwarded to the taxation authority.

Such taxes have been considered as humanitarian contributions and have provided significant resources in other countries. For example, Brazil’s tax on bank account transactions set at 0.38% and levied on paying bills online and major withdrawals, raised an estimated US\$ 20 billion per year, which provided funding for 87% of the government’s social protection program (Bolsa Familia) before it was voted down. Similarly, a solidarity contribution or “tax” on airline tickets represents 72% of UNITAID’s financial base—UNITAID is an international facility for the purchase of drugs against HIV/AIDS, Malaria and Tuberculosis. This was initially introduced in France. As of today, thirteen countries have implemented the tax and others are in the process of joining. UNITAID attests to the fact that an international solidarity micro-levy is well accepted by the public and causes no economic distortion. Countries have also been exploring the feasibility of a “digital” or a “bit” tax, which involves a charge on Internet traffic.

Voluntary business and consumer contributions are another innovative means of mobilizing resources and can be a source of financing. These donations, made by individual consumers,

operate in various ways. One model features a voluntary linking of the donation with paying for a particular service (e.g., mobile phone bills or income tax); in other arrangements these can be automatic. Voluntary contributions have less certain funding streams than a tax; however, once established they are reasonably predictable.

Financing innovations can also be relevant to debt relief efforts. The latter is increasingly becoming a rallying cry, especially for organizations and individuals associated with the Campaign for the Cancellation of Foreign Debt. Such ideas, however, should ideally center on an appropriate instrument. For example, debt relief had been allowed in Pakistan through the Poverty Reduction Strategy Paper instrument on the condition that the freed-up resources be used for poverty reduction. Similarly, Pakistan has been part of Debt2Health, an initiative of the Geneva-based Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), under which the German government relinquished its right to receive partial loan repayments on the condition that Pakistan invest the freed-up resources in GFATM-approved programs.

Insight can also be gained from the financing arrangements within the health sector's global product development partnerships (PDPs). PDPs, which operate on a not-for-profit basis and as "quasi venture capital funds" to improve health outcomes, raise funds from a wide range of public and philanthropic sources, select the projects that offer the likely highest health return for investment, and closely monitor and manage their investment portfolio's progress. As a result, they act as a major consolidator of public funding, investment risk, and global coordination in their specific field. Given the need to tap into private sector resources, some useful lessons can be gained from such undertakings, particularly with reference to constructing the multi-donor trust fund toward which donors appear to be working. A "partnership fund" can enable the harmonization, coordination, and pooling of aid in support of a particular strategy. In fact, this is the fundamental premise enshrined within the Paris Declaration on Aid Effectiveness. It could also harness the potential of indigenous Pakistani philanthropy.

Financing instruments that can enable and enhance the government's capacity to deliver services through purchasing services from and contracting the private sector are important. Purchasing is an important policy tool for Pakistan, as a majority of services are provided by non-state entities in any case. These private sector entities can be an important stakeholder in

the process of rebuilding, particularly in the areas of health and education, as the infrastructure in these two areas has been destroyed in the flood-hit areas.

During the rebuilding phase, one can also explore infrastructure financing through the public-private partnership (PPP) route. Even before the flood, the need to tap into private financing for infrastructure building had become essential, due to the gap between the need for infrastructure investment and the fiscal space within PSDP that had allowed this. After the flood, the huge need to rebuild infrastructure at a time of great fiscal crunch makes this approach one of the few viable options. But not all projects will be commercially viable. The government's PPP institutional machinery, the Infrastructure Project Development Facility, can help ascertain viable options that will serve the goal of achieving equity.

However, there are substantial costs associated with tendering for and negotiating public-private contracts, for these raise issues of economic efficiency. In addition, the asserted claim of commercial confidentiality for financial information and performance data, both of which are necessary to determining whether value-for-money objectives are being achieved, as well as issues of accountability, raise the question of how and when paying any additional costs can be justified. When governments cannot afford to fund public hospitals, it appears logical to privatize infrastructure and finance operating leases rather than spending capital. There is a need to bring clarity to safeguards in this connection.

The deep social pain caused by this crisis can only be eased with an unprecedented response, for which resources are critical. Innovative solutions offer an option to mobilize additional resources. While these options do exist, their application in Pakistan will depend on the government's capacity to plan in the local context and implement the agreed-upon projects in an environment characterized by many systemic constraints. There are many challenges to implementing the taxes being referred to herein, as they may not necessarily appeal to politicians and consumers and may require complex legal changes and ongoing regulation to ensure compliance. Similarly, the success of infrastructure PPP's depends upon the government's fiscal and legal prudence and its ability to build safeguards and share risk in a manner that benefits both the public and the private sectors. Likewise, any contracting out necessitates a whole new set of institutional norms and regulatory frameworks. Although these challenges appear daunting, they can be overcome with careful evidence-informed planning and the right institutional competencies. The need to think outside the box has become imperative in the post-flood situation; the gap is just too large for conventional sources to bridge.

Lessons Learned and Policy Reflections

Lessons learned from this assessment can be synthesized in four key areas. First, weaknesses in Pakistan's indigenous capacity to cope with disasters, the absence of an operationally functional disaster coordinating framework, a limited capacity to harness the potential within stakeholders' contributions in disasters, the lack of clarity in the local government system, and systemic issues with respect to transparency in public finance management and procurement have all been overarching impediments in the relief and early recovery phases and are likely to pose a challenge in the reconstruction phase. The flood is a reminder of the value of good governance in shaping the state's response in disasters. Within this context and more specifically in relation to the social sectors and health, Pakistan must invest in a disaster coordinating framework that incentivizes agencies to participate and adds value to what the existing arrangements have to offer, thereby leveraging the strength of stakeholders and the country's telecommunication infrastructure.

Second, external support has enabled a ramping-up of service delivery coverage in the flood's aftermath. However, it is important to rebuild damaged health infrastructure before external support is withdrawn and field hospitals and mobile teams wrap up. In this respect, a careful needs assessment should guide the rebuilding of public infrastructure and innovative means of delivering services should be explored to optimize resources and harness the potential within non-state actors.

Third, the imperative for Pakistan to improve its capacity to mobilize indigenous resources has been made all the more compelling by the unprecedented need for post-flood financing. Pakistan should explore innovative means of revenue mobilization in addition to the current modes of revenue generation that are being pursued. Alongside these efforts, allocations should be made to improve returns on spending by seeking to address the central systemic constraints that compromise investments in a highly constrained environment.

Finally, the need to invest in an integrated disease surveillance system is now beyond dispute. Therefore, the existing momentum in this direction should be maintained by building further on the government's recent commitments. Additionally, an institutional entity should be mandated and made responsible for collecting, collating, and analyzing information and data, and then forwarding it for timely decision making in the health sector.

The flood is a reminder of the value of good governance in shaping the state's response in disasters.

Pakistan has been hit by a crisis of unprecedented magnitude at a time when it is grappling with many competing priorities and is faced with a grinding fiscal crunch. The social and economic well-being of millions of impoverished people in the riverside communities of the Indus river is at stake if the country and the international community fails to accord it due attention. Although ongoing international commitment to the cause is critical, any progress will ultimately depend on the quality of governance and the commitment of the country's leadership.

Key Areas for Action

- Establishing a national supra-organizational structure with responsibility for responding to health-related issues and the capacity to harness the potential within stakeholders' contributions in disasters
- Setting up a Flood and Disaster Observatory, a dynamic user-friendly Web-based graphical interface, that can create incentives for stakeholders' participation and act as an implicit coordination mechanism
- Devising an innovative means of resource mobilization to help rebuild social sector infrastructure
- Rebuilding damaged health infrastructure before external support is withdrawn, albeit through measures that revitalize state infrastructure and harnesses the outreach of private providers
- Investing in an integrated disease surveillance system and an apex coordinating arrangement for health information
- Making strategic investments in technology to secure the medicines and supplies distribution chain and procurement process, and creating a mechanism to stockpile for emergency situations
- Garnering the political will to address the central systemic constraints in overall governance and lack of clarity in the local government system.

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