The Right to Reproductive Healthcare in Pakistan:

The Voice of Women

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Executive Summary

Pakistan's slow progress in achieving the Millennium Development Goals 4 and 5 is reflected in its high burden of maternal and child mortality, third highest on the international platform. The role that reproductive health and wellbeing plays in achieving these goals is crucial. The right for everyone women to have access to affordable user-friendly health services that address their reproductive health needs is set in the United Nations Human Rights Declaration of 1948.

Women from lower socio-economic status are amongst the most vulnerable without the safety net of universal health coverage. In lieu of this there are two government-based social systems but still almost 8 in 10 people pay out of pocket for health services in Pakistan. For many this results in catastrophic expenditure further trapping them in the poverty loop. Heartfile's Healthcare Financing (HHF) innovation has provided a third option for many impoverished people, especially women seeking treatment for reproductive problems and related payment. The aim of this study was to assess how women pay for reproductive treatment and what financial barriers they faced in the process.

A comparative case study approach was utilised to assess the perceptions of women who had received financial support from HHF (Case Study 1) with the perceptions of those women who had not received any financial support from Heartfile (Case Study 2). Qualitative methods were utilised whereby semi-structured interviews were conducted with both case studies (telephone and face-to-face interviews). A purposive sample of fourteen (n=14) women was obtained from the HHF for Case Study 1 and a random sample of seventeen (n = 17) women from a reproductive health clinic in Islamabad for Case Study 2. The interviews were recorded, transcribed and coded to provide thematic data.

Most of the women from this study were suffering from the impact of reproductive healthcare cost in the form of physical illness as well as depression or stress. There were three main coping strategies i.e. borrowing money, selling items to pay for treatment and delaying treatment. The majority of study participants were married during their adolescent years and the majority were not using contraceptives.

The main findings from this research suggest that a combination of interventions is required to tackle specific access barriers and affordability of healthcare. The HHF data base is capturing parameters related to some of these factors which can be utilised to develop contextual interventions. Women at the centre of all health policies are the ultimate goal with political support to make reproductive healthcare affordable and accessible. Reproductive wellbeing is a woman's right.

1. Introduction

This report is the culmination of research that was undertaken during 2012 and 2013 at *Heartfile* [1]. The research focused on listening to the voices of women, their reproductive health (e.g. starting a family, the use of contraceptives, the number of pregnancies etc.) and how they paid for the cost of interventions related to these conditions.

What follows is a brief introduction to the topic of women and their reproductive health with a particular focus on those women living in the Punjab Province of Pakistan. Existing knowledge and research related to the topic has been reviewed and presented in the second section. How the research was undertaken is covered in the third section followed by the main findings (section four). The report finishes with a discussion and conclusion and some insights as to the way forward from a policy perspective.

1.1. Women and their Right to Health

It is the right of every woman to have access to health care and health information to promote reproductive health and wellbeing. The Human Rights Declaration of 1948 [2] in Article 25 states that:

(1) **Everyone has the right** to a standard of living adequate for the **health and well-being** of himself (and herself) and of his (and her) family, including food, clothing, housing and **medical care** and necessary social services, and the right to security in the event of unemployment, **sickness**, disability, widowhood, old age or other lack of livelihood in circumstances beyond his (her) control.
(2) **Motherhood** and childhood are entitled to **special care and assistance**. All children, whether born in or out of wedlock, shall enjoy the same social protection.

In 2000, the world decided to launch a collaborative attack on poverty and the problems of illiteracy, hunger, and discrimination against women, unsafe drinking water and a degraded environment. Most of the targets set for progress on the Millennium

Development Goals (MDGs) were benchmarked for the period 1990 to 2015 – promising clear and measurable improvement on standards prevailing in 1990 by the end of 2015 [3]. All eight goals impact on the lives of women and their right to live a healthy fulfilling life. Specifically, MDG Goal 5 aims to improve maternal health which is underpinned by Goal 3 to empower women through gender equality which in turn is nurtured by Goal 2 achieve universal primary education [3].

At an international level, in 2004, a "March for Women's Lives" supported the concept of "reproductive rights" in United States, however this has since been changed to "reproductive justice", which some academics argue is a positive change for the rights of all women especially with respect to their reproductive health [4].

1.2. Women's Reproductive Health

Unfortunately the vital registration system in Pakistan does not provide significant information about mortality statistics and therefore those related specifically to the wide spectrum of women's reproductive health issues [5]. What is generically recorded is the Maternal Mortality Ratio (MMR) which is 276 per 100,000 live births in Pakistan which is high by international standards [6]. Collectively though, Pakistan has the third highest burden of maternal, foetal and child mortality at an international level[7].

Self-rated health (SRH) is a robust predictor of mortality however it has not been widely utilised at a population level in Asian countries[8]. In the latest National Health Survey of Pakistan just over 7 in 10 women (77.2%) rated their health as poor/fair. Whereas for men this was just over 5 in 10 (51.3%) [9].

Morbidity data related to such conditions as postnatal depression, childbirth complications, delayed treatment (e.g. for hysterectomies) *etc*. are also not comprehensively collated from various sources.

Data that is available is the total fertility rate or the number of children per women is 3.5[1] and the contraceptive prevalence rate is 29.6 % [6]. According to Sathar, family planning is the most overlooked and neglected component of women's health in Pakistan[10]. By focusing on family planning from a policy and program perspective, inroads can be made with the improvement of maternal and child health. Evidence suggest that the unmet need for family planning can be reduced and that contraceptive use in the rural setting can be increased [10], however, Pakistan's health system and service delivery in this public health domain needs considerable strengthening and an injection of adequate funding. Evidence suggests that with the up-scaling of community-based strategies that address women's reproductive health and child health, their collective morbidity could be reduced by as much as 57% [7].

1.3. Payment for Reproductive Healthcare

In Pakistan, there are two government-owned social protection systems related to health, Bait-ul-mal and Zakat. However, despite these two government-owned social protection systems, almost 79% of the population of Pakistan has to spend out-of-pocket to access treatment [11], [12]. Since the country has a mixed health system where both public sector and private sector are engaged in provision of health services to people, those who are protected through insurance or other means are enjoying better accessibility to health care. Examples are of the armed forces personnel and their dependents, retired army personnel through Fauji Foundation, and industrial/commercial establishments with more than ten employees under a stipulated salary scale protected through a vertically-integrated health insurance system of Employees Social Security Institution (ESSI)[5].

Broadly speaking, easy access to health facilities and affordability are the most important reasons which determine the utilization pattern of health care[13]. In the present scenario, to achieve the above objective of easy accessibility and reducing out of pocket

[1] Pakistan Social Indicators (Federal Bureau of Statistics Pakistan 2011).

expenditure on health care, a proper insurance system for the masses is a pre-requisite. However, the underlying foundation required is a strengthened and robust health system. With a greater financial investment in health and a concerted effort at remedying governance issues, Pakistan's health system can perform. According to Nishtar et al "…with appropriate policy, institutional and legislative action within and outside the health system, the existing challenges could be overcome"[11].

In terms of the current social protection systems, Bait-ul-mal is an autonomous body set up through a 1991Act and works under the Prime Minister's Office. This system contributes toward poverty alleviation through its various focused services and assistance to destitute, widow, orphan, invalid, infirm & other needy persons, as per eligibly criteria approved by Bait-ul-Mal Board [14]. Assistance through Bait-ul-mal is provided to 192 hospitals in the country with almost one third of the total assistance channelled to a tertiary care facility in Islamabad [15].

The other social protection system is that of Zakat which is the practice of charitable giving by Muslims based on accumulated wealth, and is obligatory for all who are able to do so. It is considered to be a personal responsibility for Muslims to ease economic hardship for others and eliminate inequality [16]. Individuals and their families from lower socioeconomic status can utilise this to obtain free healthcare services in the public sector hospitals. The local government co-ordinates this support to the needy however, Zakat accounts for less than one *per cent* of the total health expenditure [5].

Statistics show that health care costs are the most common cause of monetary stress for many households in Pakistan [5].The sector of the population from lower socioeconomic status have a limited capacity to pay for expensive medical interventions whether in a community or hospital setting. This results in "catastrophic expenditure" which for many women this expenditure if born is from male members of the family who are the main wage earners.

In view of the evidence, and the high MMR in Pakistan [17], *Heartfile* [1] developed a third option to support high medical cost called 'Heartfile's Healthcare Financing' (HHF) (Appendix 1). HHF was initially supported by bilateral and multilateral donors, Pakistan's Poverty Alleviation Fund[2] (PPAF), private foundations and other donors to address the issue of "out-of-pocket" payments. In Pakistan more than half of the population pay out-of-pocket for healthcare [5].

HHF[3] system is simple [15], [18] with three main elements: a technology platform a health equity fund and a system of validating and prioritising clients. A summary of the process involved is presented in Appendix 2.

In short, when a client has been assessed by a doctor (in one of the pre-registered hospitals[4]), the doctor sends a request for financial assistance to HHF (*e.g.* via SMS-on template and web interface, through fax, telephone, or letter). HHF assesses the eligibility of the client by cross referencing the information from the doctors, the HHF volunteers' assessment and an online validation of poverty status by Pakistan's National Database Registration Authority (NADRA). After the validation eligible clients are financially supported through a donor-fed-fund, to pay for their medical treatment (reducing the catastrophic expenditure experience) of the client and family.

The World Health Organisation's Alma Ata Declaration [19] supported the primary health care approach and several parameters that were essential for population health and health for all by the year 2000 [20]. The current HHF model supports the primary health care approach by focusing on the most vulnerable population group and allows

[2] Pakistan's Poverty Alleviation Fund is government owned and supported by the World Bank.
[3] http://www.heartfilefinancing.org

[4] The pre-registered hospitals are located primarily within Punjab but more recently have included hospitals in Khyber Pakhtunkhwa and Sindh

support for one time catastrophic treatment costs. Its scope has been expanded to facilitate women with reproductive problems that require treatment [21].

At a WHO level, the HHF intervention has been incorporated in the World Health Report of 2010 [22], to highlight the need for a pathway to universal health coverage. Additionally, the international community has supported the low operational cost of HHF and its targeted focus on the women's reproductive health.

2. Complexities of Women's Reproductive Wellbeing and Payment for Services

This section provides a snapshot of literature which exposes the complexities of women's reproductive health and provides insights into issues related to the access and payment of medical treatment in a low-resource country such as Pakistan.

Based on the main research question *what are the financial barriers to accessing reproductive health services at a tertiary care level in Islamabad?* The following literature review questions were identified:

- What factors support the payment and accessibility of women's reproductive healthcare?
- What factors hinder the payment and accessibility of women's reproductive healthcare?

The literature review identified several key words from the review questions (women's reproductive health, barriers to accessing, barriers to financing). Finding all relevant studies are not possible in practice, therefore the key words facilitated and focused the review [23]. Major search engines were utilised (e.g. Google Scholar) and electronic databases (e.g. Pub Med) to access relevant literature related to the keywords.

2.1 Factors that support Reproductive Healthcare

There are various barriers to accessing health care e.g. geographical access, availability, affordability and acceptability. Jacobs et al have suggested an **analytical framework** (see Appendix 3) of all identified access barriers to healthcare and interventions to address them in low-income Asian countries. This framework enables policy makers and health professionals identify certain barriers and devise appropriate interventions [24]. Findings from this study suggest that a combination of interventions is required to tackle specific access barriers but that their effectiveness can be influenced by contextual factors. There is demand and supply-side barriers that affect access to health services, (especially for the poor) however their individual effectiveness may be enhanced when applied in combination.

Access to adolescent reproductive health services was researched in United States and compared with the United Kingdom and other western European countries and the findings indicated that in the latter two countries the greater accessibility of services improved reproductive health outcomes for adolescents [25]. Access can depend upon the extent to which the consumer (client) has health insurance coverage whether that be public or private; the ability to pay directly for services. Adolescents who are eligible for benefits through health insurance systems (sponsored or mandated by the government) face fewer financial barriers to services and access to contraceptives (the UK and other western European countries support this process) [25].

2.2 Factors that hinder Reproductive Healthcare

It is a women's right to have access to life-saving services of skilled health care providers especially in the case of childbirth. However, in Pakistan there are many factors that restrict women's access to reproductive health services. Geographical obstacles to timely access exist; poor infrastructure of health facilities is an impediment, which is compounded by high staff absenteeism and health facility working hours inconsistent with the need for a 24/7 essential provision of services. The cultural norm in Pakistan generally dictates that women should be seen by **female doctors whose dearth** makes reproductive health services inaccessible. There is a need to increase skilled female health workers to enhance the capacity of reproductive health care at all levels [26].

The **limited independence** of women in developing countries is seen by some academics as a key barrier to improvements in their reproductive health [27]. Rarely though is the concept of being independent or autonomous being used to gain a greater insight into the determinants of women's reproductive health [27]. Academics call for a greater understanding of women's reproductive wellbeing in Pakistan within the contextual reality of social, cultural, economic and political factors especially at a rural level (8).

Women's reproductive self-rule and barriers to the use of contraceptives in Pakistan is significantly associated with the **husband-wife education attainment** when the issue of using contraceptives was investigated [28]. Aiming for an improved husband-wife education level can result in greater reproductive autonomy of women and an increased use of contraception. The other barriers to the use of contraceptives include the husband's desire for more children, a preference for the sex of the next child, and the woman's poor education level [28].

The patterns of women's mobility and their relationship with contraceptive use was examined in Pakistan and found there was **no direct relationship between a women's unaccompanied mobility and her use of contraception** [29].The research cautioned

against the use of western notions of "freedom of movement" and associated quantitative indicators.

2.3 Vouchers and Reproductive Healthcare

Reducing maternal mortality is one of the Millennium Development Goals [3] and is of major concern for policy makers, health professionals, donor organisations and non-government organisations in Pakistan. **Low utilisation** of maternal health services has been identified as one of the barriers to reducing maternal mortality [30]. Demand side financing is being proposed as an option to increase access to reproductive health services. [30]

Social protection strategies and health financing to **safeguard reproductive health** for the poor is the need of the hour. Millions of people globally are not covered by any social protection or health insurance system. Pakistan with its high maternal mortality rate needs a mechanism to focus on women's reproductive health. All health related stakeholders need to build upon successful interventions (e.g. vouchers, cash transfers, micro-credits and community based insurance etc.) that focus on reproductive health and not just general health issues. Public private partnerships would facilitate the process and achievement of meaningful interventions [31].

Voucher systems do exist globally. However, the evaluation of the impact of the voucher and accreditation approach on improving reproductive behaviours and status is a growing area for research related to health care financing [32]. Demand-side financing or output-based aid channel government or donor support to the **user** rather than the service provider (the traditional route). Research suggests that voucher programs can increase access, reduce inequities and enhance program efficiency and service quality [32]. In Cambodia, the voucher transfers purchasing power to the poor who choose which facility they want to visit and then the providers are reimbursed for their services [32].

Similarly in Kenya and Uganda the vouchers have demonstrated that **they can deliver quality reproductive healthcare**. The output based financing offers incentives for the service providers to serve and attract clients [33]. In this setting vouchers are meant to serve as a catalyst for developing long term health financing strategies. However, ownership of these programs is imperative for their long-term success.

A review of voucher programmes in developing countries revealed that **they appear to be successful** [34]. This success was related to goals of targeting specific population groups, increasing the utilisation of services and improving the quality of services. However further research is needed to assess the impact on the health of populations [34].

3. Research Design

The main aim of this research was to ascertain factors that influenced the ability of women from lower socioeconomic status being able to pay for their reproductive health. A comparative approach [35] was utilised whereby one group of women who had received financial support from HHF were compared with another group of women who had not received any financial support from HHF.

Two main research objectives were identified for both groups:

1. To ascertain factors that support access and payment of reproductive healthcare.
2. To ascertain factors that hinder access and payment of reproductive healthcare.

The scope of work that underpinned this research was provided by Heartfile. The following sections cover the research process employed to undertake this research.

3.1 Research Approach

A constructive theoretical approach [36] was utilised to compare the perceptions of women who had received financial support from Heartfile (Case Study 1) with the perceptions of women who had not received any financial support from Heartfile (Case Study 2). A case can be an individual, institution or a community, and in this research it represents the two groups of women just described [37].

A qualitative research method [35] was adopted for the data collection to facilitate a deeper meaning to the secondary quantitative data available from the HHF database. Table 1 presents an overview of the research methods.

Table 1: Research Methods

Case Study Unit	Research Questions	Research Method/s
Case Study 1: HHF supported	1. What factors supported the payment of reproductive healthcare within this case? 2. What factors hindered the payment of reproductive healthcare within this case?	Semi-structured interviews with women who had received financial assistance from HHF. Primary data collection. Summary of statistics from the HHF database. Secondary data collection.
Case Study 2: Not supported by HHF	1. What factors supported the payment of reproductive healthcare within this case? 2. What factors hindered the payment of reproductive healthcare within this case?	Semi-structured interviews with women who had not received financial assistance from HHF. Primary data collection.

Document review and analysis was utilised to explore the development of HHF (as this process had been documented extensively) and to explore other relevant literature.

3.2 Selection of the Case Studies & Participants

Case Study 1: Women who had received financial assistance from HHF for reproductive health care and attended the Pakistan Institute for Medicine (PIMS).

Case Study 1 participants: A **purposive** sample [35] of fourteen (n=14) women was obtained from the HHF database. These women had received payment for treatment related to their reproductive health.

Case Study 2: women who had not received financial assistance from HHF but attended the reproductive health clinic (Obstetrics and Gynaecology O & G) at the Shifa Foundation Hospital, Islamabad. This is part of the Shifa International Hospital and provides a service for individuals and families from lower socioeconomic status.

Case Study 2 participants: A **random** sample [35] of seventeen (n=17) women were asked to participate in the research. They were attending the O & G inpatient service at Shifa Foundation Hospital. Seven (n=7) declined the interviewee saying they had no difficulties paying for their healthcare. The remaining eleven interviews proceeded.

3.3 Data Collection

Data collection occurred in two phases with phase one focusing on the first case study and the second phase focusing on the second case study.

Phase 1 of Data Collection = Case Study 1 (Women financially supported by HHF)

All **fourteen** women from the HHF database were **telephoned** by the researcher to obtain consent to participate in the interview. For the majority of phone calls the husband of the study participant answered the call. If the husband consented to the interview and it was convenient to proceed with the interview then this proceeded. Otherwise a mutually convenient time was arranged to call back for the interview.

Accessing women for a telephonic interview was a challenge as majority of the contact numbers were of mobile phones owned by male members of the family. Many of them worked in cities for wages whereas the women were living in the village. For this reason all of the fourteen study participants could not be interviewed. Some of the men did not like the idea of "their women" being interviewed. For this reason only nine women had received permission to be interviewed.

Phase 2 of Data Collection = Case Study 2 (Women who did not receive HHF support)

A **face-to-face** interview was undertaken with **eleven** women from the O & G inpatient service at the Shifa Foundation Hospital (therefore diagnosed with similar reproductive health problems as the study participants from Case Study 1). Verbal consent was obtained before the interview commenced.

3.4 Study Instruments

A semi-structured interview instrument was developed based on three sections with eighteen questions:

Section 1: You and starting a family

Section 2: You and your reproductive health

Section 3: You and the cost of reproductive health

See Appendix 4 for Case Study 1 (HHF financed).

Part 3 of the instrument for Case Study 2 was modified to account for the fact that the study participants had not received any financial support from HHF.
See Appendix 5 for Case Study 2 (Not financed by HHF).

The instruments were piloted and modified according to the feedback from the pilot participants. The instrument was translated into the two main languages Urdu and Pashto.

3.5 Interviewing the Participants

Case Study 1: Study participants were telephoned in the afternoon or early evening on the weekends to accommodate those women whose husbands worked in cities (most of the mobile telephone numbers were those of the study participant's husbands or male member of the family and not their own personal phones). If the husband consented and their wife was available the interview commenced immediately, however there were some study participants that had to be telephoned at a more convenient time.

The study participant's response was noted as the interview proceeded.
There was one patient assisted by Heartfile whose brother wanted to provide the answers to the interview. Since this could have created bias in the study, the interview was not commenced.

Case Study 2: Women attending the O & G outpatient clinic at Shifa Foundation Hospital and admitted as inpatients were **randomly** approached to seek their approval to be interviewed. Once the consent was received the interview commenced taking into account the confidentiality of the topic. The privacy of the study participant being interviewed was of primary concern given the nature of this research. The study participant's response was noted as the interview proceeded.

One of the researchers spoke fluent Urdu and Pashto and the other researcher spoke Urdu so the interviewees were able to speak in their local language (Appendix 6).

3.6 Data Analysis

Primary Data Analysis for Case Study 1 and Case Study 2: The interview transcripts were translated into English, read and re-read to collate main themes [23].

Secondary Data Analysis: Quantitative data from the HHF database was collated to investigate parameters related to the research objectives.

For **Case Study 1**, relevant data was collated from the HHF data base maintained by Heartfile. Data regarding the type of reproductive health issues and treatment provided were obtained and collated.

For **Case Study 2**, these parameters were obtained during the face-to-face interview.

3.7 Research rigour & Ethics

There are a number of techniques used to ensure rigor[5] in qualitative research e.g. the appropriate selection of research strategy (theoretical rigor), documentation of the research method (methodological rigor) and combining different methods of data sources and consent of the participants (ethical rigor) [38].

According to Liamputtong and Ezzy [38] rigorous qualitative research is trustworthy and provides information related to the real world (validity) and it can be repeated by following the same research method (reliability).

In this research theoretical rigor was gained by using document review and semi-structured interviews with the study participants and a two phase data collection

[5] Rigor is used instead of "reliability and validity" which are derived from quantitative research.

strategy. To ensure research method rigor, the process was documented to enable another researcher to undertake a similar study. Ethical implications were discussed amongst the researchers and focused on confidentiality and the consent of all participants to willingly participate in the study.

4. The Voice of Women

The main findings are presented in three sections as per the interview structure under the headings of starting a family, reproductive health and payment of reproductive health care.

4.1. Starting a family

The age range for the total study participants (n=20) was 19 to 64 years of age. The Case Study 1 participants had a slightly older average age of 37 years whereas Case Study 2 had an average age of 30 years. Table 2 presents the age ranges of financed and non-financed study participants.

Table 2: Age Profile and Percentages

Age Range in Years	Case Study 1 (HHF-Financed)	Case Study 2 (Not financed by HHF)
18 to 20 years	0	1 (9.0%)
21 to 30 years	4 **(44.4%)**	4 (36.4%)
31 to 40 years	2 (22.2%)	6 **(54.6%)**
41 to 50 years	2 (22.2%)	0
51 to 60 years	0	0
61 plus years	1 (11.1%)	0

The majority of Case Study 1 participants were married (n=7) with two unmarried. The age range for getting married was 16 to 21 years of age. The average age was 18 years and 6 months.

With respect to **Case Study 2**, the majority were also married (n=10) and one participant was divorced. The age range for getting married was 13 to 29 years of age. The average age was 20 years.

Case Study 1 participants had a range of two to four children whereas the Case Study 2 participants had one to eight children. However, the total number of pregnancies for the Case Study 1 participants was nil to five whereas with Case Study 2 this was one to eight.

Only one of the **Case Study 1** participants was using contraceptives for the spacing of her children. The majority were not using any contraceptives (n=8)
However of these, two were unmarried and one participant had infertility problems. One interviewee was considering family planning and in her words:

> "…I never used any contraceptives but given the problems I have during the birth of the children and financial constraints associated with it, I am now thinking of using family planning methods to keep my family limited…" (interviewee Shazia).

Similarly, the majority of **Case Study 2** participants were not using contraceptives (n=9). The few who were using contraceptives used them for the spacing of births. One of the interviewee's commented that her husband was against the use of contraceptives (she had eight children):

> "…I was always against having so many children as I felt weak with every birth and we are also not strong financially…my husband was against using family planning methods and when I decided to go for a surgery after the birth of eighth child my

husband refused to finance it…I had to take money from my brother and had a surgery not to conceive again…against the wish of my family…" (interviewee Sakina).

4.2 Reproductive Health

Interviewees who were provided financial assistance by HHF (Case Study 1) and the interviewees who sourced their own financial payment (Case Study 2) for the payment of reproductive conditions are presented in Table 3.

Table 3: Reproductive Health Conditions and Percentages

Reproductive Health Conditions	**Case Study 1** (HHF-Financed)	**Case Study 2 (**Not financed by HHF)
D & C	1 (11%)	2 (18%)
C-Section	0	5 **(45%)**
Hysterectomy	3 (33%)	1 (9%)
Surgical procedure (Reproductive)	5 **(56%)**	3 (27%)

Just over half of the Case Study 1 participants had a surgical procedure related to their reproductive health with just over a third undergoing a hysterectomy.

In comparison nearly half of the Case Study 2 participants had a C-section delivery and nearly a third had other surgical procedures related to their reproductive health.

4.3. Payment of Reproductive Healthcare

This section provides an overview of monthly household income, borrowing to pay for healthcare, who makes the financial decisions in the household, items sold to pay for healthcare, other issues such as the cost of transport and medicines.

4.3.1 Monthly income

Table 4 provides a summary of household monthly income for both case studies.

Table 4: Monthly Income Profile and Percentages

Monthly Income in Rupees	Case Study 1 (HHF-Financed)	Case Study 2 (Not financed by HHF)
Less than 3, 900	5 **(56%)**	
3,900 to 10, 400	4 (44%)	2 (18.2%)
10, 400 to 15, 600		5 **(45.6%)**
Husband Unemployed		1 (9%)
Did not reveal		2 (18.2%)
Other (Supported by family)		1 (9%)

Just over half of the **Case Study 1** participants lived in a household with a monthly income that was less 3,900 rupees.

In comparison, nearly half of the **Case Study 2** participants lived in a household with a monthly income that ranged from 10,400 to 15,600 rupees.

4.3.2 Women and Financial Decisions

For Case Study 1 there was a **range of responses** regarding who made the financial decisions in their household. A third took the financial decisions (one consulted her parents and the other was employed), a few participants said their husbands, a few participants did not allude to this role and a few participants said their husbands were unemployed but did not specify who then undertook the financial decisions.

Most of the participants from Case Study 2 said their **husbands made the financial decisions** (including one mother-in-law and husband combination), one participant said her brother made the financial decisions, one participant said her mother-in-law and one participant did not reply to this question.

4.3.3 Borrowing to Pay for Healthcare

The high financial burden born by most of the study participants in the absence of safety nets was evident from the data set as more than 70% had to borrow money from various means (mostly from family or friends) in order to pay for reproductive health treatment. Case Study 1 had a slightly higher percentage or borrowing at 78% when compared with Case Study 2 where 64% had borrowed money (Table 5).

Table 5: Source of Borrowed Money

Source of money	Case Study 1 (HHF financed)	Case Study 2 (Not financed by HHF)
Family & Friends	5 (78% including others)	7 (64%)
Other	2	0
No borrowing	2 (22%)	4 (36%)

One interviewee from Case Study 2 stated:

> "…It would not have been possible without my father's help and I am thankful because otherwise it would have meant delaying the treatment or cutting down on essential expenditure or even selling something…" (interviewee Farhat).

Another interviewee from Case Study 2 alluded to using a "Dai":

> "…my husband was previously a labourer and it was difficult to meet expenses for a hospital delivery…so they opted for deliveries by a dai which was more affordable…in this way we did not have to cut back on too much of expenses, sell anything, borrow a large amount of money from someone or take any other drastic measures…" (interviewee Zabiha).

The majority of study participants (Case Study 1 and Case Study 2) did not refer to Bait-ul-mal or Zakat as a source of financial assistance. One of the interviewees from Case Study 1 stated that the Bait-ul-mal was too complicated to apply for financial assistance.

4.3.4 Items sold to pay for healthcare

When the study participants were asked if they had ever sold any personal belongings to pay for their reproductive health treatment there were a range of answers.

With Case Study 1, **a third** of the participants had **sold a personal belonging** (e.g. a sewing machine, cattle and jewellery for a C-section), one participant said they might have to sell something to pay for medicines. One interviewee said she reduces her daily expenditure to put money towards healthcare cost.

One interviewee said they had nothing to sell as they had lost all their possessions during the 2005 earthquake:

> "…it was very difficult for us to arrange for all the direct and indirect costs associated with my treatment…we lost our home and all household assets during the earthquake therefore we had no savings and nothing to sell…for people like us how are living in far off areas… going to big hospitals in cities is also a costly option…we even had to borrow for arranging transport and staying in Islamabad…" (interviewee Khadija).

The interviewee who had to sell her sewing machine stated that:

> "…I had a sewing machine and I used to do sewing for the ladies in the village…but since I could not sew anymore given my health condition and I needed money for the medicines I had to sell the machine…it was the only earning source for me…" (interviewee Razia).

Selling cattle was the only option for one of the interviewees:

> "…the only asset we have is our cattle which I had to sell for visits to the doctors and buying the medicines…this situation made me very depressed as I needed the surgery...I was very relieved when I came to know that Heartfile would be financing my treatment…" (interviewee Naheed).

With Case Study 2, **most** of the participants **did not have to sell** anything but the two who did, sold jewellery (one for a C-section). Some of their responses are presented below:

One interviewee said:

> "…my husband is a clerk…I took a teaching job in order to meet the expenses…at the time of (financial) crisis I had to sell my jewellery to pay for the C-section)…" (interviewee Rabiya)

There was one interviewee who resorted to budgeting:

> "…I try to reduce my spending to the lowest in order to get through the month…" (interviewee Bano).

One interviewee from Case Study 2 borrowed from a Women's Savings Group:

> "…my C-section cost 20,000…my husband earns 10,000…arranging for this type of money is extremely difficult and through all these years this has been possible only because I am a member of a Women's Savings Group of the neighbourhood…I hardly shop for clothes and I hold back on all things that are not essential…" (interviewee Rakheela).

4.3.4 Other issues (transport and medicines)

A few participants from **Case Study 1** mentioned the **cost of medicines** as being a problem and one of these participants also mentioned that she could not even afford the transport to receive healthcare.

The rising cost of living was referred to:

> "…now due to rising inflation the healthcare costs have increased tremendously and it is very difficult to even buy medicines…" (interviewee Razia).

Over half of the **Case Study 2** participants' alluded to the **cost of medicines** by way of borrowing to pay for medicines or trying cheaper alternatives e.g. homeopathic treatment.

One interviewee from Case Study 2 stated that:

> "…I am thinking of changing to homeopathic medicine for the management of my condition because allopathic medicine is costly and I am not satisfied with its results…" (interviewee Masooma).

Two participants mentioned **transport** (unaffordable and needed to borrow to visit their doctor). One participant said that she wished there was some way out for poor and vulnerable women.

4.3.5 Other health and wellbeing issues

Most of the **Case Study 1** participants **delayed their treatment** due to the cost. The time span was a few months up to years. One participant delayed her treatment for 10 years.

In contrast **most** of the **Case Study 2** participants **did not delay their treatment**. The reason for this was they had accessed finances from their family or friends, their own savings or the health insurance from a husband's employee scheme.

However, one interviewee from Case Study 2 stated that:

> "…since I kept on delaying the surgery for such a long time I might never be in good health again…I wish I was better …I might have found some work to earn so that I don't have to borrow all the time for buying medicines…" (interviewee Sakina).

Most of the participants in **both Case Study groups** suffered from some form of **mental illness** such as depression or stress associated with their health and the cost of treatment.

One interviewee from Case Study 1 stated that:

> "…I had to worry since I have three daughters and I thought if anything happened to me who will look after them…the helplessness I felt due to the health issues and our financial problems I felt depressed quite often…" (interviewee Razia).

One interviewee from Case Study 2 stated that:

> "…I had to delay the treatment many times because I did not have enough money for surgery and due to this I have been very stressed…" (interviewee Gul).

Over half of the participants in **Case Study 1** said that their **physical health** had been compromised by their reproductive health issues whereas in Case Study 2 this was not a strong theme.

Table 6 presents a summary of the findings that were similar between Case Study 1 and Case Study 2 participants.

Table 6: Similar Findings between Case Study 1 (CS1) & Case Study 2 (CS2)

Topic	Data
Married	**Majority**
Average Age Married	**CS 1 = 18 & half years** **CS2 = 20 years**
Not using contraceptives	**Majority (85%)**
Stressed, Depressed or Anxious	**Most**
Did not mention Bait-ul-mal or Zakat	**Majority**

Table 7 presents the findings that were different between the two Case Study groups.

Table 7: Different Findings between Case Study 1 (CS1) & Case Study 2 (CS2)

Topic	Data
Treatment Received	CS1 over half surgical procedure (other than hysterectomy) CS2 nearly half had a C-section
Monthly Earnings	CS1 Less than 10,400 Rupees CS2 10,400 to 15,600 Rupees
Financial Decisions	CS1 range of responses CS2 most said husbands
Sold belongings to pay for health	CS1 A third did sell before receiving assistance from HHF CS2 most did not sell
Delayed Treatment due to cost	CS1 most did CS2 most did not
Physical Health affected	CS1 over half said yes CS2 not a strong theme

5. Discussion & Conclusion

Before discussing the main findings of this research, it is important to share some of the challenges faced during the data collection phase and differences in methodology. Given the difficulty in physically accessing the Case Study 1 participants, their interviews were conducted via mobile phones. However, with the Case Study 2 participants, the interviews were face-to-face due to their availability in Islamabad. Some academics would argue that the researcher gains a better insight into the topic through face-to-face interviews with study participant [35]. The depth of information gained through both interview sets was similar despite the different interviewing techniques. An important difference between the two case studies was that with Case Study 1 the study participants were accessed via a male member of the family i.e. their husband or brother whereas with Case Study 2 the participants were directly approached. With the former approach there were less women who were given consent to participate in the research reducing the sample size.

In terms of settings, the participants from Case Study 1 attended a public hospital whereas Case Study 2 participants had attended a service within a private hospital. Within the private hospital (Shifa International Hospital) there is the Shifa Foundation Hospital or "Falahi Clinic" which provides service for clients who are less able to afford the cost of medical interventions. The different settings from which the study participants were selected could be seen as a limitation. However, the latter setting was the most accessible and convenient for this comparative analysis.

This qualitative research on HHF project has primarily exposed many determinants of women's reproductive wellbeing and their inability to pay for the cost of healthcare. In addition what these two groups of women shared was the majority were married at an early as an adolescent and in terms of their reproductive health the majority were not using contraceptives. In the literature review, husbands who wanted more children and had a child preference were negatively associated with a woman's reproductive wellbeing [28]. What the literature review highlighted was that a better level of education for both the husband and wife was positively associated with better reproductive health and the use of contraceptives for women [28].

In many cases, the preference for a male child and social pressures also results in having large families. The data from this study also revealed large family sizes. In the absence of financial barriers in buying contraceptives, only 2% of women in this study were using them. This figure is considerably lower than the national average of 29% [39] despite the fact that in Pakistan contraceptives are available free of cost through government or non-government organizations.

Another common thread both groups shared was the feeling of being depressed or stressed due to their health and the cost of treatment. In addition to a poor mental health status, over half of the Case Study 1 participants also said their physical health had been affected which may have been related to their life in a household where the monthly income was minimal and where they had to endure a much harsher lifestyle. The household monthly income for Case Study 2 ranged from 10,400 rupees to 15, 600 rupees whereas for Case Study 1 participants this was less than 10,400 rupees.

One of the coping strategies utilised to help with the payment of healthcare was the selling of possessions with over a third of Case Study 1 participants selling jewellery, a sewing machine or cattle. The selling of personal possessions happened before the HHF safety net became available to these women. Most of the Case Study 2 participants were

not pushed to such a limit because of the fact that they belonged to a slightly higher income bracket. However, the selling of items in the absence of a safety net by both groups shows that health risks can become one of the greatest causes of poverty.

Before the HHF safety net was available, most of Case Study 1 participants had to delay treatment (ranging from one month up to ten years) whereas most of the Case Study 2 participants did not have to delay their treatment. With the former group this delay may have compounded their physical wellbeing which most stated was not very good.

Family and friends were the main coping strategy for both groups when it came to borrowing money to pay for healthcare. Another interesting coping strategy was from a Women's Savings Group and several of the participants referred to budgeting to accrue some savings. Not having enough savings or a limited monthly income was a barrier to Case Study 1 more than for Case Study 2.

The literature referred to better **access** to healthcare [25] and for some of the study participants paying for transport to see their health professionals was a barrier. Many of the participants referred to extra financial support for the payment of medicines. The role that vouchers can play needs to be further researched as an adjunct to the HHF primary financial assistance [32]. Voucher programs in other developing countries have proved to be successful [34] however additional research is needed to ascertain their impact on reproductive health outcomes.

In conclusion, most of the women from this study were suffering from the impact of reproductive healthcare cost in the form of depression or stress. There were three main coping strategies i.e. borrowing money, selling items to pay for treatment and delaying treatment.

In the absence of universal health coverage in Pakistan, overcoming access barriers to reproductive health care can be addressed by utilizing Jacobs *et al* framework to identify

interventions that effectively address particular access barriers [21]. For example in the context of this research, from the demand side, community-based interventions could focus on strategies that deal with affordability (savings and budgeting skills) and from the supply side the use of vouchers can be further explored as an alternative to direct payment for service. The findings from this research suggest that a combination of interventions is required to tackle specific access barriers but local contextual factors play an important role. There are both demand and supply-side barriers that affect access to reproductive healthcare however their individual effectiveness may be enhanced when applied in combination.

The HHF data base is capturing parameters related to some of these factors by providing evidence-based data. With such data at hand relevant interventions can be developed and recommendations put forward for **women-friendly health policies** including **"gender proofing"** of all policies that impact on women's health especially their reproductive health. A greater focus on the promotion of **positive mental health** for women and coping strategies is also required.

With this backdrop, public health professionals need to advocate for a multi-sectoral approach [31] to address women's health in a holistic way, the dissemination of research findings to promote the right to reproductive wellbeing is crucial with further research into innovative ways to finance interventions that focus on **promoting** reproductive health and wellbeing. The ultimate goal is health in all policies with a special focus on women's reproductive wellbeing. It is imperative that financial assistance and subsidies are planned as a cornerstone for this population group so timely services and ease of payment can be achieved with dignity. Reproductive wellbeing is a woman's right and a healthy mother is a healthy nation.

Appendix 1: IT Platform for HHF

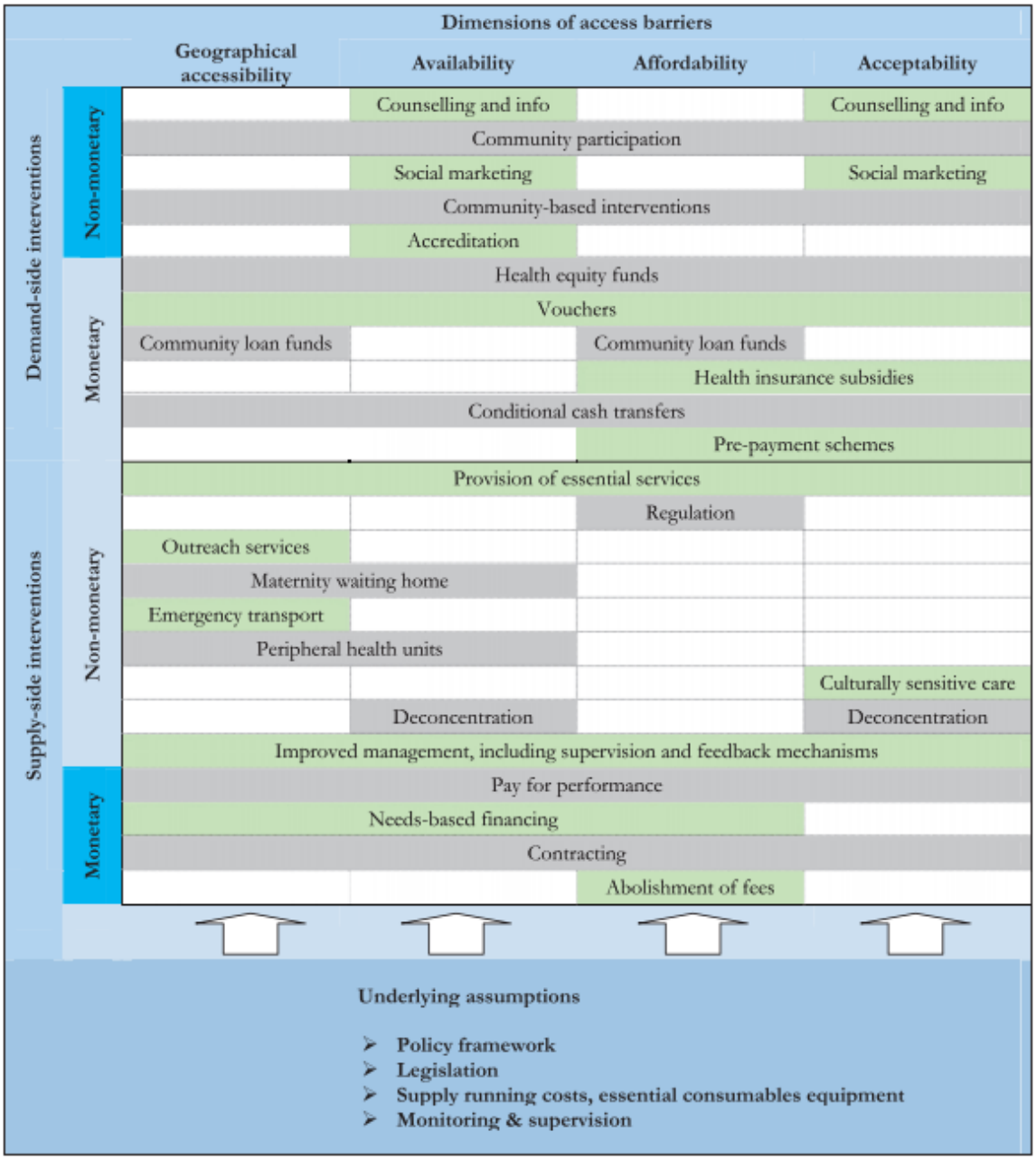
The Heartfile Health Financing innovation is a comprehensive real-time donor health financing system. The information management platform has been developed by 'Valentia Technologies <www.valentiatech.com> and includes the following features:

- Provider/donor management
- Financing management
- Patient needs evaluation
- Patient referral for treatment
- Patient funding evaluation
- Patient verification
- Verification of clinical treatment & outcomes
- Outcomes management & follow up
- Community follow up
- Community nursing interventions
- Detailed reporting to aid funders
- Comprehensive business intelligence & reporting

Appendix 2: HHF Procedure for Financial Assistance

Main Steps to Acquiring Financial Assistance from HHF
1. Doctors report the patient in need on bed- side, through SMS or web interface; the patient does not have to follow up.
2. HHF team visits the patient to verify his/her status.
3. Vendors are contacted by the HHF team when the patient has been approved for financial support.
4. There is no application process. Once identified as eligible, the doctor simply sends a text message on behalf of patients. Once approved, vendors supply the essential equipment for treatment on the same day and to the patient.
5. This is automatically generated from the system.
6. Vendors' invoices are signed by doctors and are paid within a week.
7. Patients are followed up. Further assistance is provided if the illness is prolonged.
NB: There are no offices visited by the patient and no cost incurred in the process.

Appendix 3: Jacobs et al Analytical Framework (2012)



Appendix 4: Case Study 1 Interview Instrument

Interview with women who **have received** financial assistance (Thurs 31st Jan 2013 KA)

A.A. My name is Gulrukh. I work at Health Services Academy Islamabad as a Researcher. I would like to ask you a few questions related to your health, having children, family planning and the cost of healthcare. Everything you tell me will remain confidential.

[If interviewee married go to part 1 and if single go straight to part 2.]

Part 1: You and starting a family

1. How long have you been married? _____
2. How old were you when you were married? _____
3. How old were you when you had your first child? _____
4. How many children do you have and what are their ages?

_____

5. Have you ever used any methods for family planning?

   If yes what did you try? _____And were you satisfied?

   If no, was there a reason? _____

NB: Use this table to probe and fill in responses.

Children	Age	Any **major** problems during this pregnancy that needed medical intervention?	Any **major** problems during the delivery that required medical intervention? (probe for delivery location)	Did any of your pregnancies or deliveries incur costs that were beyond your means?	What did you do regarding the cost implication? (e.g. no treatment, borrowed etc)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Part 2: You and women's health (especially reproductive health)

6. Have you ever had any major women's health conditions? No_____
If yes (probe) _____

7. Have you ever been asked to pay for advice or treatment for these conditions?
No_____
If yes (which provider) _____: And did you ever experience difficulty paying the fee? _____

8. Have you ever delayed treatment due to the cost? No_____
If yes, how many times? _____: And how did the delay affect your health?
_____
(Probe for mental health & emotional wellbeing)_____
(Probe for physical health)_____

9. Have you ever used your savings to pay the fee? No_____
If yes, did you go without certain items?
(Probe)_____

10. Have you ever borrowed from other people to pay the fee? No_____
If yes, who did you borrow from? _____

11. Have you had to sell something to pay for the fee? No_____
If yes, what did you sell? _____

12. Do you make decisions about how to pay the fee? Yes_____
If no who (e.g. Husband, Mother-in-law, Others: _____)

Part 3: You and health care cost

13. For your most recent women's health condition (and treatment) how did you feel when financial help was provided by Heartfile Health Financing?

_____

14. Did you receive financial support for follow-up? No_____
If yes, where was the money spent? (e.g. Transport, medicines, doctor's fees etc.)

_____
___

15. What were your options if you had not received financial help from Heartfile Health Financing?

_____
____

16. How could HHF be improved to help women with their reproductive health?

_____
____

17. Do you have any comments or suggestions regarding women's health (especially to do with reproductive health and the cost faced by women in seeking health advice and treatment?

_____
_____
_____

Thank you for the time to interview you, all the information will remain confidential and yet help those organisations who are looking at women's health (especially reproductive health).

Appendix 5: Case Study 2 Interview Instrument

Interview with women who **have not received** financial assistance (Thurs 31st Jan 2013 KA**)**

A.A. My name is Mariumn. I work at Health Services Academy Islamabad as a Researcher. I would like to ask you a few questions related to your health, having children, family planning and the cost of healthcare. Everything you tell me will remain confidential.

[If interviewee married go to part 1 and if single go straight to part 2.]

Part 1: You and starting a family

1. How long have you been married? _____
2. How old were you when you were married? _____
3. How old were you when you had your first child? _____
4. How many children do you have and what are their ages?

_____

5. Have you ever used any methods for family planning?
   If yes what did you try? _____And were you satisfied?
   If no, was there a reason? _____

NB: Use this table to probe and fill in responses.

Children	Age	Any **major** problems during this pregnancy that needed medical intervention?	Any **major** problems during the delivery that required medical intervention? (probe for delivery location)	Did any of your pregnancies or deliveries incur costs that were beyond your means?	What did you do regarding the cost implication? (e.g. no treatment, borrowed etc)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Part 2: You and women's health (reproductive health)

6. Have you ever had any major women's health conditions? No_____
   If yes (probe) _____
7. Have you ever been asked to pay for advice or treatment for these conditions?
No_____
   If yes (which provider) _____: And did you ever experience difficulty paying the fee? _____
8. Have you ever delayed treatment due to the cost? No_____
   If yes, how many times? _____: And how did the delay affect your health?
_____
(Probe for mental health & emotional wellbeing)_____
(Probe for physical health)_____
9. Have you ever used your savings to pay the fee? No_____
   If yes, did you go without certain items?
(Probe)_____
10. Have you ever borrowed from other people to pay the fee? No_____
   If yes, who did you borrow from? _____
11. Have you had to sell something to pay for the fee? No_____
   If yes, what did you sell? _____
12. Do you make decisions about how to pay the fee? Yes_____
   If no who (e.g. Husband, Mother-in-law, Others: _____)

Part 3: You and health care cost

13. Were you aware of the cost for treatment of you reproductive health?
Yes_____ No_____
If yes, with whom did you discuss it?
Husband_____ Mother-in-law_____ Doctor_____ Others (specify)_____
If No- Probe e.g. was this kept from you? Or were you not interested in the cost etc.
14. What options did you contemplate when you found out about the costs for treatment (related to reproductive health)?
   a. Delaying treatment-_____
   b. Utilization of savings_____
   c. Borrowing-If Yes, from whom?
_____
   d. Cutting down on essential expenditures: Probe: what were they?_____
   e. Not getting any treatment or procedure at all: Probe: why?
_____

f. Any other-(please specify)
_____
15. What did you eventually decide to do? Probe: which option did you eventually go for?
_____
16. Did you have a say on the decision making process? Yes_____if No (probe e.g. Husband_____ Mother-in-law_____ Doctor_____ Others (specify)_____
17. Did you get the treatment you needed for your reproductive health? If yes probe with the following:
a) Level of satisfaction with the treatment: _____
_____
b) Quality of life after your treatment:_____
_____
___
If there was no treatment probe related to quality of life and effect on capacity to earn (if applicable)
18. Were there any follow-up costs associated with your reproductive health? If yes: how did you arrange this?
_____
___
Or No cost involved_____
19. Any additional comments?

Thank you for the time to interview you, all the information will remain confidential and yet help those organisations who are looking at women's health (especially reproductive health).

Appendix 6: Profile of Researchers

Researcher: Katrina Aminah-Ronis

Education:

- Doctorate in Public Health (Flinders University, South Australia)
- Masters in Primary Health Care (Flinders University, South Australia)
- Graduate Diploma in Human Nutrition (Flinders University, South Australia)
- Bachelor of Science (Adelaide University, South Australia).

Service and Research Background:

Katrina has worked in the health sector (public and private) in Australia, Saudi Arabia, Ireland and Pakistan in the settings of primary care, community and hospital. She has contributed to the development of public health nutrition with marginalised population groups and the establishment of community-based nutrition services in rural areas. From a policy perspective she supported the implementation and evaluation of the *Health Services Nutrition Policy* in the north west of Ireland. At a national level she co-ordinated the research and development of the Irish *National Health Promotion Strategy for 2000-2005*. Within Pakistan, she has been involved with the research and development of policy outputs from the local health think tank Heartfile. Her doctorate through qualitative **research** examined the influence of Pakistan's Health Policy Forum (a participatory stakeholder think tank) and the local policymaking process. Katrina is currently working at the Health Services Academy as an Assistant Professor within the Health Systems and Policy Department and supporting the doctorate and masters programs offered at the Academy.

Main Positions Held:

- Assistant Professor: Health Services Academy, Pakistan (Current position)
- Senior Public Health Officer: Heartfile, Pakistan.
- Director of Health Promotion: ECAHB, Ireland.
- Health Promotion Advisor: Ministry of Health, Ireland.
- Project Manager for the development of the Irish National Health Promotion Strategy: Ministry of Health, Ireland.

Researcher: Gulrukh Mehboob

Education:

- Doctorate Candidate in Health Economics (Commencing October 2013)
- Masters in Philosophy (FUUAST Islamabad), submitted
- Masters in Business Administration (Virtual University; in process)
- Masters in Science and Economics (University of Peshawar)
- Bachelor of Science (University of Peshawar)

Service and Research Background:

Gulrukh has extensive experience in the field of health and economics and lectures in macroeconomics for health, research methods, health planning, and health care financing. Her research fields include development economics, macroeconomics for health, international economics and micro-financing. She has been a coordinator at the Department of Economics, Shaheed Benazir Bhutto University Peshawar (SBBUP) and is a member of the Examination Discipline Committee and Board of Studies at the (SBBUP).

Main Positions Held:

- Assistant Professor (Health Services Academy, Islamabad): Current position
- Faculty Member, Shaheed Benazir Bhutto University Peshawar (BPS-18)
- Lecturer in Economics at Sarhad University of Science & Information Technology Peshawar
- Small & Medium Enterprise Development Authority (SMEDA).

Assistant Researcher: Mariumn Masood

Education:

Bachelors in Medicine and Bachelors in Surgery Shifa College of Medicine, Islamabad- in final year.

Work experience:

In 2010 Mariumn worked as a Research Elective Student in Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore where she participated in the field work, laboratory work and research focused on breast cancer in Pakistan.

In 2012 she completed a research elective at Health Services Academy (HSA), Islamabad where she also participated in the 3rd Annual Public Health Conference and helped formulate policy briefs for various sessions. During her tenure in HSA she also helped with the transcription and development of research questionnaires for several projects. Marium has also co-authored an article that has been published in the Pakistan Journal of Public Health.

Researcher: Saba Amjad

Education:

- Bachelors in Medicine and Bachelors
- Masters in community Health and Nutrition

Work experience:

Dr. Saba Amjad is a medical doctor with a Master's degree in community health and nutrition and has several years of experience in public health. She has been associated with Heartfile since 2002 and is currently working as Senior Manager.

She has been involved in World Health Organization protocols validation for Risk Management Package for cardiovascular diseases. She has been the project manager of the surveillance component of the National Action Plan for Non Communicable Diseases and conducted several training workshops for it. She also co-authored a report 'Synergizing Health and Population in Pakistan' and is involved in a project which analysed and focused on outlining modalities of the game change in health and population introduced by the 18th constitutional Amendment and their implications at the systems level, both Packard funded research projects. She is also involved in the research for publications of her organization and has represented her organization at national and international forums.

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