REVIEW ARTICLE

Legislative Gaps in Implementation of Health-related Millennium Development Goals: a case study from Pakistan

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Abstract

Numerous health legislations concerning child mortality, maternal health and life-threatening diseases such as polio and tuberculosis are crafted in the health sector of Pakistan. A critical assessment of health legislations points to their in-effective or sub-optimal implementation. By engaging with the concept of public law, there is a strong relationship of public health and health legislations. While the basic purpose of health legislations is to craft and enforce essential health legislations for improving public health, an examination of health legislations across Pakistan indicate an extensive health engagement which is facing certain challenges indicating traditional health practices, enforcement constraints arising due to political compulsions and complexities, and systematic problems in the health sector, reflecting issue of governance. Through focus group discussions and in-depth interviews held with policy-makers, senior health officials private health entities and parliamentarian tasks forces on millennium development goals, this study engages with health-sector legislations. In so doing, it focuses on the problematic health sector and interventions. It is observed that unless an overarching legislative framework and a shift from programmatic approach to a human rights approach is adopted, the targets of millennium development goals 4, 5 and 6 would remain off-track in Pakistan.

Keywords: Health legislations, Child mortality, Maternal health, Life-threating disease, Legislative gaps and challenges.

Introduction

To alleviate poverty and to promote sustainable development across developing countries, in September 2000, the United Nation General Assembly adopted a number of resolutions. One of the resolutions transpired in eight Millennium Development goals (MDGs). Out of eight MDGs, three specifically relate to health — goal 4 relates to child mortality; goal 5 to maternal health; and goal 6 concerns combating human immunodeficiency virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS), malaria and other life-threatening diseases such as tuberculosis (TB) and polio. All 189 member states, including Pakistan, ratified the resolution. It was also agreed by member states to reduce child mortality by two-thirds, maternal mortality rates by three-quarters and the reversal of HIV/AIDS and other major diseases by the year 2015 (taking 1999 as the base year).[1] A cursory glance at the state of health in Pakistan presents a bleak picture. Pakistan has 8th highest newborn death rate all over the world.[2] During 2001-07, one out of 10 children died before reaching the age of five. Women have a 1-in-80 chance of dying during reproductive life because of maternal health causes such as lack of skilled birth attendant, unsafe abortion, lack of adequate services and lack of education.[3] Pakistan is highly vulnerable to waterborne infectious diseases such as dengue, hepatitis B and C and TB.[4] A recent report by the Pakistan Institute of Parliamentary Services (PIPS) underscores slow and unsatisfactory progress towards achieving MDGs 4, 5 and 6.[5] Now MDGs are transformed into sustainable development goals (SDGs) which are more holistic and globally collaborative than MDGs. At first glance it could appear that health has a less central role in the SDGs than the MDGs; just 1 out of 17 goals sets specific targets for health. However, this single health goal, "Ensure healthy lives and promote wellbeing for all at all ages", is broad, underpinned by several targets that cover a wide area of health. Ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development. Significant steps have been made in increasing life expectancy and reducing some of the common killers associated with child and maternal mortality. Major progress has been made on increasing access to clean water and sanitation, reducing malaria, TB, polio and HIV/AIDS. However, many more efforts are needed to fully eradicate a wide range of diseases and address many different persistent and emerging health issues.

This study engages with the aforesaid discussion from a legislative perspective and underscores a strong relationship between health legislations, public law and the underlying systemic problems impacting the health system

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and programmes. These include family planning and family healthcare through Lady Health Worker (LHW) programme; Expanded programme of immunisation (EPI); Malaria control programme; TB control programme; HIV/AIDS control programme; Maternal and child health programme (MNCH); and prevention and control of hepatitis.

On the basis of primary data, the study further identifies constraints faced by health providers, and highlights the areas which create institutional and operational difficulties in achieving the targets of health. While some of these difficulties are related to capacity (skills, health coverage and resource constraints), the central issue pertains to lacunas in the implementation of health legislations which falls under three particular areas. The first relates to how social and political practices influence or undermine implementation of legislations. The second suggests policy and institutional measures of establishing a central legislative and legal framework for tracking progress on health. The third outlines new legislations, their ambit and need. The study encompasses three broad objectives: to provide the task forces with knowledge about the existing legislative provisions covering areas related to goals 4, 5 and 6 of MDGs; to analyse the implications of weak laws or absence of them; and to provide task forces an insight into new legislative requirements at federal and provincial levels necessary for the progress towards MDGs.

The study is divided into four sections. The first section briefly engages with the status of health-related MDGs and provides key statistics on health. The second section deals with the methods of undertaking the study. The third section engages with the analyses of the main findings, and the final section outlines specific policy recommendations.

Status of Health Related MDGs in Pakistan

MDG-4: Reduced Child Mortality

Progress on MDG-4 is measured against six indicators: i) under-five mortality rate, ii) infant mortality rate, iii) proportion of children 12-23 months fully immunised, iv) proportion of children under 1 year of age immunised against measles, v) proportion of children under 5 years of age suffering from diarrhoea in previous 30 days, and vi) LHW coverage. The current status of these indicators are self-explanatory (Figure-1).

MDG-5: Improve Maternal Health

Progress on MDG-5 is measured against 5 indicators: i) proportion of women aged 15-49 years who had given birth during the last 3 years and made at least one antenatal care consultation, ii) contraceptive prevalence rate, iii) proportion of birth attendant to skilled birth attendants, iv) maternal mortality ratio (MMR), and v) total

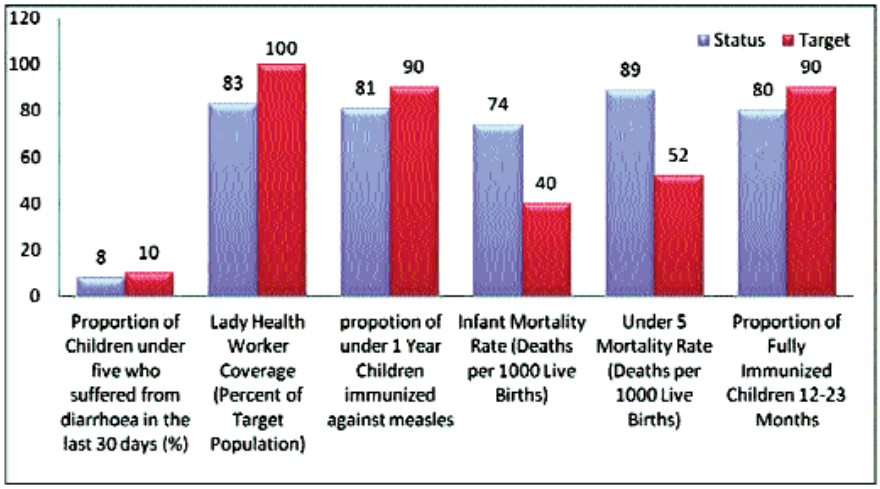

Figure-1: Reduce Child Mortality.
Source: Pakistan Millennium Development Goal Report 2013, Planning Commission, Government of Pakistan.

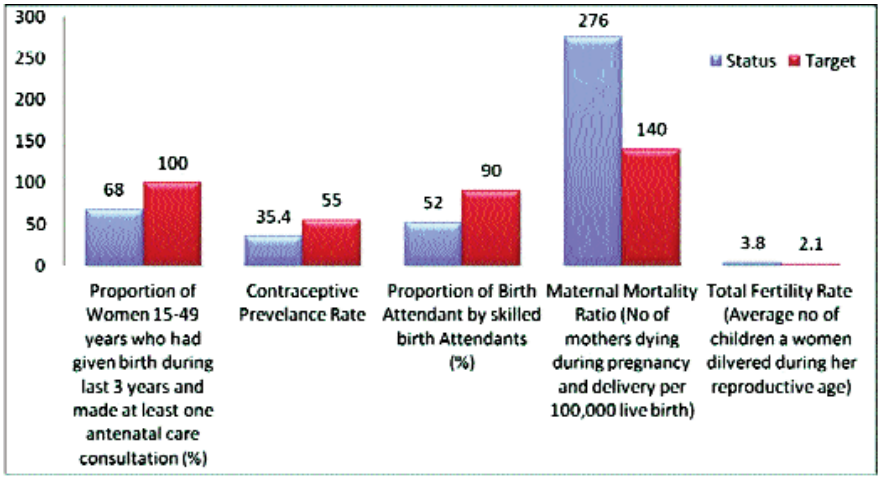

Figure-2: Improve Maternal Health.
Source: Pakistan Millennium Development Goal Report 2013, Planning Commission, Government of Pakistan.

fertility rate. The current status of these indicators are also known (Figure-2).

MDG-6: Combat HIV/AIDS, Malaria and other diseases

Progress on MDG-6 is measured against 5 indicators: i) HIV prevalence among pregnant women aged 15-49 years, ii) among vulnerable groups, iii) proportion of population in malaria-risk areas using effective prevention and treatment measures, iv) incidents of TB, and v) TB cases detected and cured under directly-observed treatment-short-course(DOTS). Pakistan is off track on three out of five indicators and therefore unlikely to achieve the MDG-6 as can be seen through the current status of these indicators (Figure-3).

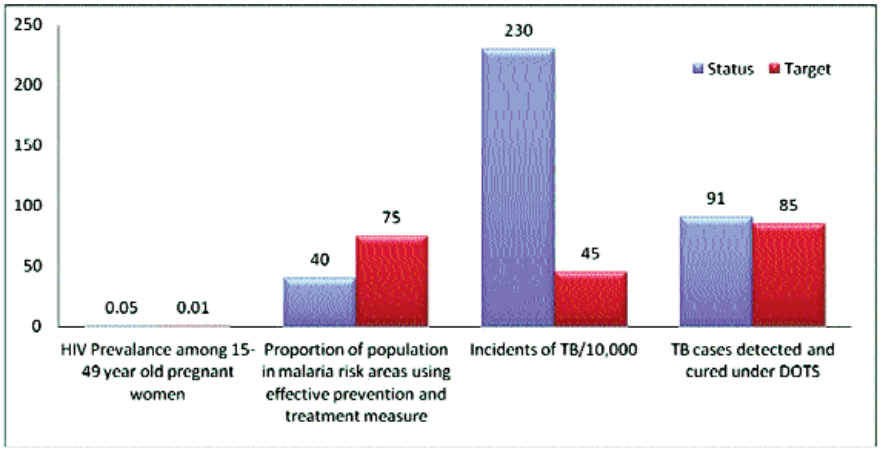

Figure-3: Combat HIV/AIDS, Malaria and other Disease.
Source: Pakistan Millennium Development Goal Report 2013, Planning Commission, Government of Pakistan.
HIV: Human immunodeficiency virus.
AIDS: Acquired immunodeficiency syndrome.

Study Design and Approach

Before embarking upon field work, an extensive literature review was carried out concerning the weaknesses and gaps in the health sector. Since the primary focus of the study was related to health legislation, the preliminary step was to compile all the existing health legislations. Through the examination of legislations, "awareness" and "lacunas" were identified as broad guiding strands. The strands aided in the development of a semi-structured questionnaire. The study adopted qualitative research methods such as, informal interviews and focus group discussions (FGDs). The sampling universe of the study consisted of parliamentarians, public officials and private-sector entities. The category of parliamentarians included standing committee members on MDGs at the federal level. The category of public officials constituted retired and in-service senior and mid-carrier officials such as, director-general (DG) Health and medical officers at federal and provincial levels. The private-sector entities consisted of non-governmental organisations (NGOs) working in the domain of health as well as private health practitioners. Prior to data collection, key informants were identified from the sampling frame through a combination of purposive and snowball sampling techniques. The study was initially implemented at the federal level and then across the provinces. The FDGs generated an interactive discussion on topics such as governance issues in the implementation of legislations, weak inter-sectoral linkages between health programmes and issues of access to health facilities. The interactive process added depth to data collected through interviews of key informants. The interviews were held to gain a deeper understanding of interviewer's perceptions and the context of responses in relation to implementation or non-existence of health legislations. All interviews and FDGs were tape-recorded and transcribed. Data analysis was guided by content analysis, a qualitative technique used to determine the presence of certain concepts in texts. The text was read line by line to determine recurring themes and checking them against the data collected from the interviews and FDGs. The qualitative data revealed conceptual categories public law, enforcement and governance issues impeding or discouraging the implementation of legislations.

2. Public Health and Legislations

The concept of public health law forms the core foundation of public health legislation. Public health law is about the study of powers, rights and duties of the state to prevent, ameliorate and limit risks of health hazards to individuals.[6] In collaboration with the private sector, community, media and academia, the state ensures the conditions for the people to be healthy. The primary goal of public health law is the endeavour to ensure the "highest possible level of physical and mental health in the population, consistent with the values of social justice".[6] What emerges from this definition is that in a democratic and politically elected setup, it is the prime responsibility of the state and the legislature to act on behalf of the people to protect their health. The people electing the government thus have a legitimate authority

Table: An inventory of Legislations pertaining to MDGs-4,5,6 in Pakistan.

MDGs-4,5: Child Mortality and Maternal Health
The Protection of Breast Feeding and Child Nutrition ordinance 2002
The Pakistan Nursing Council Act
The West Pakistan Vaccination Ordinance 1958
The Khyber Pakhtunkhwa Maternity benefits Act
The Khyber Pakhtunkhwa Protection of Breastfeeding and Child Nutrition Bill 2014
The Newborn Screening Ordinance in Sindh 2013
The Sindh Reproductive Maternal, Neo-Natal and Child Health Authority Ordinance 2014
The Sindh Nurses, Midwives and Health Visitors Registration (Amendment) Act 1943
The Sindh Promotion and Protection of Breast Feeding and Child Nutrition Act 2013
The Sindh Newborn Screening Bill 2013
The Sindh Child Marriages Restraint Bill, 2014
The Sindh Nurses, Midwives and Health Visitors Registration Act 1939
The Punjab Reproductive, Maternal, Neo Natal and Child Health Authority Act 2014
The Punjab Vaccination Ordinance 1958
MDGs-6: Life threating Disease
The Drug Regulatory Agency of Pakistan Ordinance 2012
The Drug Regulatory Authority of Pakistan Act 2012
The Islamabad Transfusion of Safe blood Ordinance 2002 (MDG 6)
The Sindh HIV and Aids Control and Treatment and Protection Bill 2013
The Sindh HIV and Aids Control, Treatment and Protection Ordinance 2013
The Drug Labeling and Packaging Rules 1986
The Sindh Prevention and Control of Thalassemia Act, 2014
The Sindh Regulation and Control of Disposable Syringes Act 2011
The Sindh Transfusion of Safe Blood Act 1997
The Tuberculosis Notification Ordinance 2013
The Balochistan Control on Possession and Consumption of Drugs Act 1973
The Balochistan Drug Rules 1983

MDG: Millennium development goal.

to hold the state accountable for a meaningful health protection. Furthermore, public health is an integrated concept which encompasses community and civic participation, private sector, social justice, public health system, and it has population focus and prevention orientation. In line with the essence of public health, public health legislations relate to devising specific health standards and regulations in order to protect the health of individuals against epidemics, injury and other diseases emerging from waste disposal and water and sanitation.[7] The legislations require a framework which enables the state to implement, monitor, sets the rights and duties of implementers as well as to fix accountability on various arms and institutions of the state. Numerous health legislations are framed in Pakistan, but it is interesting to note that there is no overarching legislative framework of health. Currently and after the 18th Constitutional Amendment, health sector faces a host of challenges originating from the implementation of health legislations.

The 1973 Constitution of Pakistan considers health a provincial subject and mandates provincial and federal governments to legislate on various health areas such as drugs, opium, environmental pollution, mental illness and medicine etc.[6] The existing legislations (Table) relate to some of these areas. The real problem in the implementation of legislations consists of structural and procedural difficulties. For instance, Breastfeeding and Child Nutrition Ordinance (2002) concerns service delivery which currently does not take into account a binding public health framework conceived on the basis of public law.[8] The effectiveness of the aforesaid ordinance not only depends on state institutions, but there is also a need of developing an overarching public health policy and framework consisting of rights and responsibilities and mechanisms to ensure that state guarantees health provision to all citizens without discrimination. In addition, health is not explicitly regarded as a fundamental human right in the Constitution of Pakistan. In the absence of explicit reference to a rights-based approach to health, it undermines the universal recognition of health on the one hand, and ignoring the health needs of the poor and disadvantaged, on the other.

Gaps in Existing Legislations

Besides, there are lacunae in the existing health-related legislations. The assessment of lacunas engages with the reasons which contribute to ineffective implementation of legislations; and; the social and political reasons behind weak enforcement of legislations.

2.1 Legislations for Child Mortality in Pakistan (MDG-4)

Legislations dealing with MDG 4 consist of the "Protection of Breastfeeding and Child Nutrition Ordinance (2002)", "Vaccination Ordinance (1958)" and the "Reproductive Maternal Neonatal and Child Health Authority Ordinance (2014)".

One of the major sources of killer disease amongst children in Pakistan is the lack of breastfeeding and use of unhygienic bottles and formula milks.[2] To improve children's health across Pakistan, "Protection of Breast-Feeding and Child Nutrition Ordinance"was promulgated by the federal government in 2002. After a decade, the Punjab government enacted the ordinance into law in 2012, followed by Sindh in 2013, and Khyber Pukhtunkhwa (KPK) and Balochistan in 2014. Despite breastfeeding legislations, only 38% infants (under six months) were exclusively breastfed.[9] According to our respondents, doctors mostly recommend specific brands of formula milk. The alternative milk provision underscores ignoring promotion and supporting

breastfeeding as a public health priority. An insufficient attention to breastfeeding practices and care also highlight potential problems associated with those mothers who do not breastfeed. Moreover, legal steps should be taken to prevent regulation of the unethical promotion of baby formula milk. In this case, Balochistan has taken a positive initiative of not only adopting this law but establishing a provincial infant feeding board for its enforcement. The lack of coordination between the provinces has resulted in unchecked marketing of baby formula milk. It is pertinent to note that nutritional status of children under 2 years of age is directly related to breastfeeding practices.

The existing ordinances on children's health protection necessitate responding to the aforesaid challenges and entail developing a well coordinated response by policy-makers, health providers at service delivery levels and private sector working on early childhood development and care.[10] In order to fully materialise breastfeeding and nutritional ordinances, there is also a need of reviewing provincial health strategies, plans and budgets in order to determine their consistency with children health ordinances. In this regard, the provincial legislative bodies should ensure coordination and planning between the federal and provincial health ministries for an effective enforcement mechanism of breastfeeding legislation.

Concerning the prevention of public health in cases of waterborne or communicable diseases, the "West Pakistan Vaccination Ordinance of 1958" served as the basis of the enactment of mandatory children vaccination act (XII-1880). At a later stage, the vaccination act was repealed by Punjab province and as a consequence, an expanded immunisation programme, which still continues, was initiated in Pakistan in 1978. The immunisation programme provides health protection against six major diseases: TB, diphtheria, pertussis, tetanus, polio and measles. The average routine immunisation coverage in 2010 was 68%, which was increased to 75% in 2011.[4] While immunisationis considered to be an important public health intervention, it is reported that Pakistan is one of the five countries where 10 million children did not receive vaccination against measles in 2011.[11] The legislative gaps in vaccination ordinance strongly indicate problems associated with mandatory immunisation regime and ethical issues in administering vaccination, particularly in rural communities. Vaccinations are also not administered to every eligible child. This means that vaccination requirements across different provinces and communities are important means of achieving high vaccination coverage. An act on public health data therefore becomes extremely important for maintaining public health record. Another gap in administering vaccination pertains to the absence of legislation in the cases of vaccination refusals among parents arising due to personal beliefs/religion, suspicion of government vaccine programme and insufficient knowledge amongst rural societies about risk exposure to diseases. This important observation means that unvaccinated children are vulnerable to outbreaks of diseases. Immunisation programme should administer vaccination in the context of ethical issues mentioned above and develop policies and strategies of dealing with the challenge of implementing mandatory immunisation.

Moving on, globally, Pakistan has "the third highest burden of maternal, foetal, and child mortality".[12] The country has also made slow progress on MDGs 4 and 5.[13] The situation becomes even more worrisome after the disbandment of the federal Ministry of Health in 2011 and the devolution of health to provinces, entrusting a huge responsibility on provinces related to health planning and decisions concerning reproductive, new-born, maternal and child health (RMNCH). The determinants of RMNCH, poverty and malnutrition, have received greater attention at different forums and in policy circles in Pakistan. However, skilled and adequate human resource across health programmes has not received much attention at policy and legislative forums.[14] In the aftermath of devolution, the province of Punjab and Sindh have constituted provincial authorities entrusted with the mandate of managing health-related human resources on national programmes such as primary healthcare and family planning.[15] Based on interactions with policy practitioners and health programme managers, RMNCH faces critical challenges related to the availability of human resources at service delivery units such as Basic Health Units (BHUs)which provide the maternal, child health, family planning services and curative care for gynaecological problems.

Human resource challenges indicate structural/governance problems, lack of incentives to performance and issues of "access" to basic health services. For instance, LHWs are mandated to provide reproductive health services to citizens. But LHWs are largely involved in obstetric care and a few are involved in birth deliveries.[12] We also learnt that many remote and inaccessible areas in Sindh and Balochistan are still without LHWs because of low incentives. The gaps in legislation on RMNCH points to the lack of political ownership of maternal and child health in Pakistan and structural barriers faced by women when accessing family planning services. The devolution of health services to provinces also require casting focus on examining

existing health inventions such as the MNCH programme, launched in 2005, in relation to poor health facilities and healthcare in rural areas.

2.2 Legislations for Maternal Mortality in Pakistan (MDG-5)

The prevalence of high MMR of 276 per 100,000 live births in Pakistan has received much attention nationally as well as internationally. Maternal health relates to women health, particularly during child-bearing age. According to a recent research, women aged between 15 and 39 years in Pakistan face health complications due to pregnancy and childbirth, leading to deaths.[16] Besides systematic problems in health sector, the major cause of maternal mortality is the weak "implementation" of existing laws. The Early Child Marriages Restraint Act 1929 clearly mentions imposition of penalties and imprisonment in case of early child marriage and solominisation of child marriage. The punishment of child marriages is simple imprisonment which may extend to one month or with a fine of Rs 1,000, or both. The law further prescribes punishment for the male guardian involved in the act of child marriage. The lacunae in implementing aforesaid acts relate to "enforcement" of laws and social, political and religious factors. The "enforcement" of acts are problematic because early child marriages are seldom reported either by the union council where forced or marriages of young children takes place, or by the provincial government.[9] Unless cases of child marriages are reported, the courts cannot take cognisance of those offences which are committed under the ambit of existing laws.

2.3 Legislations for Life-Threating Diseases in Pakistan (MDG-6)

Pakistan has comprehensive legislative protection for life-threating diseases such as Hepatitis, HIV/AIDS, TB and Thalassemia.

Prevention of HIV in adolescents and providing care to persons living with HIV/AIDS is the most important public health priority of the state. In 2007, the federal legislature in Pakistan enacted HIV Prevention and Treatment Act to "prevent HIV from becoming established in general population, particularly in vulnerable populations; to provide for the care, support and treatment of persons living with HIV and AIDS".[8] In the context of HIV/AIDs, all provinces have implemented HIV control and treatment programme aimed at reducing discriminatory practices, screening of HIV cases and providing counselling to people affected by HIV. In terms of addressing HIV across Pakistan, the existing law must recognise multiple causes of HIV in Pakistan. In addition, there must be a greater recognition of spreading awareness on sexually transmitted diseases (STDs) by adopting educational measures which emphasise human rights as a strategy of preventing HIV.

The overriding aim of the Tuberculosis Notification Act 2012 is to prevent and control the transmission of TB infection. In Pakistan, TB is responsible for 5.1% of the total burden of diseases. Inequalities, inadequate nutrition and poor environmental conditions are largely responsible for the occurrence of tuberculosis.[17] The National TB Control Programme in Pakistan was conceived to achieve countrywide coverage by the end of 2005. The programme has been able to achieve progress in the implementation of DOTS strategy across 120 districts. The real challenge is to implement the TB Control Programme beyond the public sector.

3 Systematic Bottlenecks in Health Sector

The lacunae in health legislations must also recongise systematic issues in the health sector, which directly or indirectly contribute to the ineffective implementation of health legislations across the country. There is a dire need to address all the bottlenecks otherwise we'll not be able to achieve the SDGs.

3.1 Federal provincial linkages

One of the main constraints in realising health targets concerns linkages in federal and provincial health departments. After devolution of health to provinces, the federal health ministry faces a real dilemma concerning its mandate and jurisdiction.[18] What is the role of the federal ministry after the 18th amendment requires immediate political attention.[19] Moreover, coordination between federal and provincial governments takes the focus away from health targets, especially when complying with international health agreements such as International Health Regulations 2005 (IHR). The inter-provincial health ministry at federal level lacks a robust health information system for providing information on access to health across the country. Unclear duties and responsibilities in the health sector also undermine the capability of federal and provincial government to provide effective health coverage to citizens. This means that there is a dire need of restructuring existing health system for the implementation of SDGs.

3.2 Multi-sectoral approach to health

The prevalence of infectious diseases such as malaria and hepatitis is directly related to safe drinking water and sanitation. In Pakistan, inadequate water supply and sanitation services contribute to poor health, resulting in high incidences of waterborne infections. Legislations related to MDG 6 have to be interpreted in terms of a public

health intervention which has a multi-stranded realm.

Currently, life-threatening diseases like as HIV/AIDS, malaria, TB and hepatitis underpin adopting a multi-sectoral approach. This requires revisiting health delivery strategy which conceives and delivers health sectorally i.e. education, water and sanitation. The transformation must take into account active citizen participation in health delivery and developing partnerships between the state and the private health-sector organisations for achieving the SDG targets.

3.3 Health-related Human Resource

This study noted inadequate health-related human resource impacting health in areas such as birth delivery, basic health facilities and affordability of medicines. According to senior officials of the Health Department, human resource constraints are more acute in rural areas. Numeric inadequacies in health sector were hard to obtain because of lack of consolidated data on health staff. The study observed that the province of Punjab has adequate skilled human resource followed by KPK, Sindh and Balochistan.[20] The province of Punjab outperforms because it allocates substantially higher development budget[21] on human resources. Concerning the availability of skilled birth attendants, we learnt that in Pakistan, more than half (51%) deliveries take place at home under the care of traditional midwives. Human resource is critical when there are only 5,000 paediatricians catering to 90 million children in Pakistan. Regarding quality of care, minimum service delivery standards have been set by WHO but there is need for mentoring health facilities towards achievement of these standards.[22] Finally, the absence of health-related human resource is a serious deficiency in health service delivery in Pakistan. So, there is a dire need to strengthen health-related human resource capacities for the promotion of SDGs.

3.4 Accountability and Transparency

One of the core problems in the health sector is the lack of accountability and qualitative data of tracking progress on health indicators. In areas such as child mortality, maternal health and life-threatening diseases, the provincial ministries/divisions/departments face constraints in knowing community preferences and the lack of trust on the formal provision of health inventions. Improved monitoring and evaluation is also necessary not only to improve the performance of the health sector but also to enhance existing programmes and reforms. Some instruments, such as the Health Monitoring Information System (HIMS) developed by the government in 1992 with the help of United States Agency for International Development (USAID), are in place, but public health surveillance system in Pakistan is still fragmented and has been unable to generate the data required to make informed public health decisions. Callen, Gulzar, Hasanain, and Khan[23] drew on the admirable example of an intervention conducted at the BHU level to monitor public worker absenteeism. They used smartphone technology designed to increase inspections at rural clinics. Such studies can be useful in developing effective means of monitoring and evaluating the health system. Weak management, non-transparent performance evaluation and weak incentives to performance lead to suboptimal performance, with absenteeism and vacant positions still widespread in the system. Improved monitoring and evaluation is also necessary not only to improve the performance of the economy but also to enhance the SDGs.

4 Framework for Legislative Implementations

In the light of above-mentioned gaps and our consultations with both stakeholders and health-sector practitioners, we propose a framework for timely and

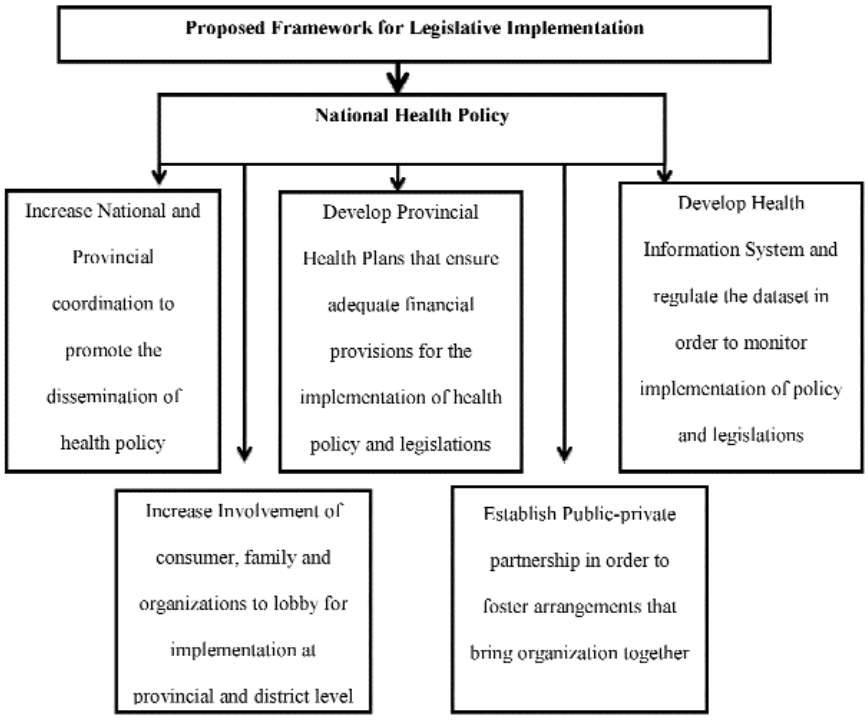

Figure-4: Proposed Framework for Legislative Implementation.

efficient legislative implementation (Figure-4).

After reviewing existing health legislations on MDGs 4, 5 and 6, the key findings are that the lacunae in health legislations consist of structural, social and political barriers which hamper their implementation; there seems to be very little political commitment to health-related MDGs primarily due to lack of ownership and ineffective engagement of the policy-makers in the delivery of health services; after devolution of health, the federal ministry of health faces the challenge of what should be its role in health policy, financing and monitoring; in the absence of an overarching legislative framework, provincial and federal linkages would remain unclear; legislative bodies have not paid adequate attention to service delivery problems in health. Financing of already passed initiatives by the parliament are also confronted with shrinking fiscal space[24] Moreover, the enforcement of legislations and enacting new legislations must be the utmost priority of the legislature. The enactment of new health legislations must also address systematic bottlenecks in health system; and to track progress on health indicators, the private sector must have adequate representation on health advisory boards and monitoring forums.[25]

In view of the above findings, the study recommends an alternative framework for legislative implementation. Our key policy suggestions: establish an inter-sectoral committee for legislative assessments that represent all the sectors; assessment of existing legislations for implementation and potential follow-up as appropriate, such as further assessments, revision of existing legislations or adoption of new legislations; build the capacity and effectively deploy human resource to improve career structure of all healthcare professionals; establish public-private partnership in order to foster arrangements that bring organisations together; establish social health insurance as part of a comprehensive social protection; and effective management and monitoring of healthcare system should be owned by district governments to maintain standards.

Finally, there are a few areas where legislative cover is not available for health-related MDGs. We, therefore, propose a province-level enactment of legislation against vaccination refusal; legislation for regularising the private health sector; legislation for ban on over-the-counter sale of TB drugs; and legislation for eliminating the quacks. Besides, legislation is also needed to achieve self-sufficiency and self-reliance in vaccine because chickenpox, typhoid, measles vaccines generally remain out of stock in the country. In case such self-reliance is not possible in the short term, import of select vaccines may be allowed.[26]

Conclusion

The study was done against the backdrop of devolved health services and fiscal decentralisation in Pakistan. It observed that devolution of administrative and financial powers in the health sector also requires some legislative changes. Some of these changes have been proposed in this paper. Legislation will be more effective if complimentary reforms towards health policy, financing and monitoring in health sector are vigorously pursued.

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