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MAKING DECISIONS, USING INFORMATION ABOUT POPULATION AND HEALTH IN PAKISTAN

Introduction

Despite considerable investments, most MNCH and FP indicators languished or worsened during the past decade in Pakistan. A variety of personal and institutional motives determine not only what decisions policy makers make but also the processes by which these decisions are made, including which information sources they seek and trust and to what extent and means new information is sought and incorporated in the decision making process. In a developing country such as Pakistan, institutional mandates are not fully established and public good often runs in conflict with personal motivations. This complicates the overall process of decision making. We conducted a preliminary study of how decision makers gather information and arrive at decisions in order to better understand why health outcomes were not improving in Pakistan.

Methods

Study tool was developed based on international experience but adapted to local context in light of the following questions: 1) How and which decisions are made in health and population and at which level of organizational hierarchy do they originate; 2) How are needs for information recognized and/or Identified; 3) What are the main sources of Information, and how is information processed; 4) How is information used for making decisions.

In discussion with stakeholders 5 types of interviewees were identified: Politicians (who are interested in health and population), senior and mid-level Bureaucrats, Donors, Public Health experts and Media personnel. Each interview was conducted one on one and transcribed and subjected to Content Analysis. The results are reported as "positive analysis".

Results

Most new ideas originate from top political leadership, based on personal agendas, donors, or political expediency. Politicians mainly see health as a means to garner votes via either investment projects or by providing jobs. Senior bureaucrats follow politicians' agenda and mid-level officials maintain status quo and follow "authority". Since officials' performance and therefore recruitments, promotions, transfers and (rare) dismissals are based on arbitrary standards, individuals and institutions are reluctant to take initiative without "consensus" among their colleagues often leading to inaction, obviating initiatives or reforms. Formal systems of information gathering and processing are absent.

Institutional memory or mechanisms to promote learning from experiences and avoiding prior mistakes are lacking in the public sector, in part due to the absence of engagement with academic institutions. Media mostly caters to their audience and reports only "hot issues" in health (i.e. Dengue, Hepatitis etc.). Their sources were a combination of public opinion, experts and printed reports with little verification of the reliability and accuracy of their sources. Donors were the most likely to follow evidence for decisions making. However country level personnel follow their institutional priorities and sometimes in the "urgency to move resources" ignored evidence that ran contrary to these priorities.

Conclusions

Top political leadership initiates decisions based on personal agendas, political expediency or donors (i.e. what brings in funding) and is often a means to promote their political positions by either "headline projects" i.e. constructing hospitals/clinics or by providing private goods i.e. individual jobs to potential voters. Senior bureaucrats who have unpredictable and short tenures (average: 4-7 months) appease politicians for job security by following politicians' agenda and their middle officials maintain status quo and simply follow orders. These compounded by uncertainty from arbitrary performance standards for promotion, recruitment and transfers means that there is seldom innovation or reform. People simply go along to get along. Political expediency at all levels also means no one is penalized or dismissed for poor performance and eventually the systems do not even measure outcomes as a performance indicator (means of verifying outcomes are seldom present in government documents). Other measures such means to institutionalize 'lessons learnt', interfacing with academia and an educated media that sustains focus on key issues (as opposed to one-time sensational news of calamities) have yet to develop.

Our study showed that much of the decision making was individual driven and ad hoc. Formal avenues for feedback or even gathering and using new information have yet to develop. In part this is due to the key focus of the system on personal or political gains rather than on delivering services. Thus the system seeks to perpetuate itself and does not allow room for reform or innovation.

SALIENT RECOMMENDATIONS

- Decision making is often ad hoc and person based
- Key policy decisions are often initiated by politicians while government officials often make management decisions
- There are no institutions to support evidence use in policy making and academia are not connected with decision makers
- There are few incentives to make evidence based policy decisions as there are no rewards for good decisions
- Media interest is transient and driven by "hot issues"
- Donors often follow the evidence the most but usually also follow their institutional policies

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