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on

Development of Curricula on Human Rights and Health Equity in Public Health Response

Submitted to

World Health Organization

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Executive Summary

Introduction

Health as a human right concern appears to be inadequately addressed at various levels of medical education in Pakistan (HRCP, 2014; Akhtar, 2010; Moazzam et.al. 2008). Generally, the medical curriculum and in-service training programs pay a little attention to introducing the notions of human rights including social determinants of health (SDH), health equity and gender based violence (GBV) at various tiers of medical education. As a result, medical professionals are relatively less sensitive and aware of the human rights aspects while treating their patients (Moazzam et.al. 2008). By training and by the prevalent professional traditions, they tend to focus on biomedical and biotechnical processes, thereby the welfare and well-being of the patients gets low priority. In such a system, patients in general and marginalized sections of society in particular become highly vulnerable to myriad types of human rights violations (Nishter, 2013; Sarah, 2010)..

Given this back drop, the present study aimed i) to assess country context and needs of public health professionals, care providers, and health institutions (pre-service and in-services) for curricula on health equity and human rights taking into account gender equality and GBV treatment dimensions, ii) to develop issue specific model curricula to be utilized for pre-service and in-service capacity building of health professionals, service providers and health institutions at federal and provincial level, and iii) to develop an action plan, in consultation with stakeholders, for the adaptation of the developed curricula on the subject issue.

Methodology

The study used triangulation of methods including review of literature, curricula review, In-depth Interviews (IDIs), Focus Group Discussions (FGDs), Curriculum-Strengths Weaknesses Opportunities and Threat (C-SWOT) analysis, and Training Needs Assessment (TNA) of in-service health professionals.

For assessing the country context, review of literature was done on six technical areas exploring the human rights issues and their integration in Pakistani medical system. For identifying the gaps, review of contents of curricula from various medical programs with regard to health equity

and human rights lens taking in account SDH and GBV was done. Curricular review was carried out as per the standard set forth by WHO (2005) and WHO (2014) guidelines. The needs of healthcare professionals for curricula were obtained through 54 IDIs with course designers, implementers, and deliverers/users from various categories of healthcare providers. Additionally, two FGDs, one each with health managers and public health practitioners were arranged to solicit their views. TNA was conducted with in-service health managers and public health practitioners by using TNA self-administrated questionnaire in four provinces and Capital Islamabad. Finally, by using C-SWOT analysis tool, data were collected from principals and students of medical colleges and public health institutions.

For developing model curriculum, a framework steered by the WHO tools and guidelines on human rights, health equity, GBV and SDH was used. The existing context was assessed mainly by using qualitative methods, and the gaps were identified with the help of primary and secondary data. The gaps in the existing curricula and organizational capacity informed and guided the development and adaptation of the curricula for both the pre-service and in-service health professionals. Additionally, for generating a consensus on the issue and to define institutional mechanism for putting research results into policy and practice, consultative meetings were organized with relevant stakeholders.

Findings

The review of literature highlighted the fact that human rights-based approach and equity principles in treating patients were highly deficient at all levels of healthcare service delivery. Similarly medical professionals were not sensitized about the concept of health equity and its implications on health of the patient and his/her treatment. Findings of the curricula review of different pre-service medical program revealed that the concepts of human rights, health equity, SDH and GBV were not adequately addressed in their syllabi. Nevertheless, some aspects of human rights and GBV were partially and superficially covered in the course of ‘Behavioral Science’ under the heading of ‘Medical Ethics’ and ‘Forensic Medicine’ under heading of ‘crime against the newborn, infants and child,’ respectively, in MBBS/BDS program. Similarly, some dimensions of human rights and GBV in the course of ‘Sociology and Health’ under the headings of ‘basic human rights’, ‘right based approach to health’, and ‘socio-cultural

determinants of GBV'. In case of pharmacy, the curricula did not cover any of these concepts. However, the concepts of health equity and SDH were totally missing in all the curricula.

Review of curriculum of various public health institutions found that some aspects of human rights including 'gender and health, gender specific determinants of health, gender and mental health, gender inequality, gender related policies and gender responsive budgeting' were covered under the subject of "reproductive health." The coverage of the concept of health equity was limited to topics such as ethical issues in healthcare. GBV related topics were insufficiently addressed in the curricula of almost all of the institutions, except one, where GBV was taught under the course of "Reproductive health" Overall the coverage of cross-cutting notions of human rights (e.g. health rights, health equity, SDH, GBV) were inadequate, sketchy and superficial.

Qualitative data generated through IDIs and FGDs revealed that each category of health professionals claimed to have in-adequate knowledge about human rights related issues. The participants from all professional categories wanted to get education and training in human rights with special reference to health equity, SDH, and GBV. They specifically wanted integration of these specialized concepts in curriculum in the context of their day-to-day professional life. In the TNA, the participants underlined the need to learn the art of practicing and applying human rights perspective in encountering the patients in various clinical and non-clinical settings.

In the wake of the 18th Constitutional amendment in Pakistan, healthcare services and health education have largely been devolved from the federal to the provincial governments(UNDP, 2015). Nonetheless, provincial governments lack institutional capacity to meet the international commitments with regards to implementation of human rights in medical settings, including medical education. At institutional level, the findings of the C-SWOT revealed that medical institutions had very limited powers and opportunities to incorporate human rights perspective in their course curriculum. However, there was high degree of willingness on the part of all stakeholders to incorporate human rights, health equity, SDH and GBV in their curriculum. During C-SWOT, many heads of the institutions viewed that incorporating human rights was not just adding few topics or courses in the curriculum. It needed high degree of commitment both at

policy and implementation levels. To achieve this objective, the institutions required resources, trained human resource and political commitment and efforts. Additionally, medical students must understand the importance of human rights education as an integral part of their degree requirements and professional practice.

The data revealed that there was a growing realization about the significance of dovetailing the health and human rights issues. Though, at present, there were many gaps and inadequacies in country's medical education, yet a strong concern about this deficiency was visible. Many medical academics wanted a comprehensive human rights education as a part of their research and class room operations.

Almost all the stakeholders stressed the need to develop culturally relevant human rights curriculum which could empower medical professionals to address such issues at grass root level. It was also noted that, each category of professionals and sections of society have different needs, therefore the training programs be tailored to address and meet the specific challenges accordingly. The respondents were of the view that there was no "one-size-fit-for-all" formula. To have a successful and practically relevant human rights education needs integration of the concepts with ground realities and the real challenges faced by health professionals at primary, secondary and tertiary levels.

Based on the review of the existing curricula in different settings of medical education as well as on the findings of the primary data generated by the field study, the issue specific model curriculum was prepared for each category of pre-service and in-service health professionals. During development of model curricula, "objective model approach" was adopted. The whole process of model curricula development was spearheaded by a steering committee – under which there was a curriculum design committee comprising of the technical experts in four disciplines including human rights, health equity, GBV, and SDH. The modal curriculum comprised of four modules including human rights, health equity, GBV, and SDH. Each module covered various sessions followed by different units. For each category of healthcare providers, each session contained different units, which were included according to their job description.

For the adaptation of the developed curricula on the subject issue, an action plan, outlining various strategies, has been proposed. In this regard, first, University of Health Sciences (UHS) conference is going to be held in October, 2015 where almost 30 institutes will participate. WHO may coordinate with the UHS and a comprehensive presentation be given at that conference. It would result in a better understanding of the all stakeholders about the issue and it would serve as a way forward for adaptation of the developed curricula. Second, WHO may send the relevant part of the developed curricula to the concerned regulatory authority (e.g. PMDC, HEC, PPC, PNC etc.) for taking them on board for integration of that curriculum. Third, the developed curriculum could be pilot tested with the in-service medical professionals for identifying the strength and weaknesses of the curriculum. Furthermore, this pilot testing would be followed by formative and summative evaluation of the in-service medical professionals to check the workability of that curriculum. Fourth, some key individuals' from medical setting could be trained on the given subjects so that they could serve as resource persons for the rest of medical professionals.

In essence, human rights perspective is essential in making Pakistan's healthcare system responsive, egalitarian and equitable. It is also necessary to mitigate commercial and market driven tendencies in health care system. With a strong human right component in the teaching curriculum, health system is expected to be capable of addressing health care needs of majority of the population including women, children, disabled, ethnic minorities and stigmatized sections of society. Based on the findings of the study, some recommendations have been given to advance the operational and policy interventions in healthcare system of Pakistan.

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List of Acronyms and Terms

AIDS	Acquired Immunodeficiency Syndrome
BDS	Bachelor of Dental Surgery
BHU	Basic Health Unit
BSN	Bachelor of Sciences in Nursing
CDC	Curricula Design Committee
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CHW	Community Health Workers
CRC	Convention on the Rights of the Child
C-SWOT	Curriculum- Strengths, weaknesses, Opportunities and Threats
ESCR	Economic, Social and Cultural Rights
FGDs	Focus Group Discussions
GAP	Gender and Policies
GBV	Gender Based Violence
GDP	Gross Domestic Product
GPP	Gross Primary Production
HCHR	Health Commission on Human Rights
HCP	Health Care Professionals
HEC	Higher Education Commission
HiAP	Health in all Policies
HIV	Human Immunodeficiency Virus
HRBA	Human Rights Based Approach
HRCP	Human Rights Commission of Pakistan
ICESCR	International Covenant on Economic Social & Cultural Rights

IDIs	In-Depth Interviews
IGWG	Interagency Gender Working Group
IPH	Institute of Public Health
KPK	Khyber Pakhtoonkhaw
LHWs	Lady Health Workers
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDGs	Millennium Development Goals
MHUs	Mobile Health Units
MMR	Maternal Mortality Rate
MPH	Masters in Public Health
NAP	National Action Plan
NCD	Non-Communicable Disease
NGOs	Non-governmental Organizations
NHS	National Health Survey
PDHS	Pakistan Demographic and Health Survey
PHD	Programs for Human Development
PMDC	Pakistan Medical & Dental Council
PNC	Pakistan Nursing Council
PPC	Pakistan Pharmacy Council
PPHI	People's Primary Healthcare Initiative
RHC	Rural Health Centre
SDH	Social Determinants of Health
SDPI	Sustainable Development Policy Institute
TNA	Training Needs Assessment
UDHR	Universal Declaration of Human Rights

UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNPF	United Nations Peace Forces
USAID	United States Agency for International Development
WHO	World Health Organization

Chapter 1: Introduction

The complacency of the health professionals may primarily be couched in the lack of grooming in the formative years of their medical training. It may be taken as a truism that medical programs so far do not lay much attention throughout the curriculum on the concepts of social determinants of health, human rights, health equity and Gender Based Violence (GBV). The premise of the study in hand is that the pre-service and in-service training to health professionals appear to provide little grooming in basic human rights in general, and health equity and gender based violence in particular. This assertion is based on the general observations experienced with respect to the way health personnel handle their "powerless" and "marginalized" patients. Therefore, the need for human rights education in the health professions stems from its intrinsic value in alleviating human suffering, promoting health and well-being in general, and those of the marginalized in particular. Given the significance of the issue, an effort is being made to take stock of the situation and suggest appropriate interventions in view of the WHO (2004 & 2014) guidelines.

1.1 Background

Health as a human right concern has garnered much attention during the last couple of decades across the world, including Pakistan (WHO, 2013). This is because every country has become a state party to at least one of the human rights treaties addressing human rights directly or indirectly (WHO, 2013). By and large, Universal Declaration of Human Rights (UDHR) serves as an umbrella for determining human rights that enshrine the notion of human dignity as well as provide legal and moral ground for improving standards of human living (UDHR, 1948). Thereby, everyone is entitled, to a standard of living, adequate for the health and well-being of oneself and of one's family, including medical care and necessary social services with security in the event of unemployment, sickness, disability, widowhood, old age or other reasons for lack of livelihood in circumstances beyond one's control UDHR [Article 25(1)]. Despite such entitlements there are stark disparities in health realities of different nations, and more so in the developing countries.

Health disparities refer to the differences between groups regarding the prevalence of health conditions and health status (Braveman, 2006). The systemic bottlenecks and uneven distribution

of resources give rise to such imbalances (Brennan, Baker, & Metzler, 2008; Braveman & Gruskin,2003). Both health equity and human rights principles, dictate striving for equal health opportunity for the groups who have historically suffered discrimination and the resultant marginalization (Braveman & Gruskin, 2003). It is argued that elimination of systemic health disparities could mitigate the damaging effects of inequity and poor health outcomes among general public (Brennan, Baker, & Metzler, 2008). In case of Pakistan, the health sector initiatives aimed to address equity are mainly focused on horizontal lines (the equal treatment of equals) thus the issues pertaining to vertical equity (the fair treatment of un-equals) are mainly ignored (Akhtar, 2010). This is how, as per Global Gender Report, Pakistan is ranked at 119 of 142 countries in terms of health disparities (The Global Gender GAP Report, 2014). Moreover, the same report shows that Pakistan is at 141 of 142 countries in terms of gender based disparities – which, probably, is the root cause of GBV. The constitution of Pakistan under article 38(a) stipulates that state shall secure the well-being of the people, irrespective of sex, caste, creed, and race, whereas the clause (d) section 38 envisages the provision of basic necessities of life, including medical relief for all such citizens, who are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment.

Pakistan enshrines the right to health to its citizens through various international commitments including the International Convention on the Elimination of All Forms of Racial Discrimination (Article 5 e), The International Covenant on Economic, Social and Cultural Rights (Article 12), The Convention on the Elimination of All Forms of Discrimination against Women (Articles 11, 12, 14), The Convention on the Rights of the Child (Article 24), and The Convention on the Rights of Persons with Disabilities (Article 25). Pakistan reflects a wide range of commitment towards right to health in Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs). Additionally, as an all-encompassing agenda, Pakistan needs to adhere and comply with 27 United Nations conventions of human rights and development committed under the Generalized System of Preferences (GSP) plus awarded in December 2013. The GSP plus would be reviewed after two years. In case of noncompliance to 27 conventions, the membership of Pakistan could be under threat.

Despite all the national and international measures, Pakistan has to traverse a bumpy road for the full realization of human rights including the right to health. Such a challenging situation

demands the implementation of the enunciated measures (constitutional and international commitments) in letter and spirit to reduce the human rights violations including health disparities and gender based violence (GBV) in the country. Gender based violence refers to "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" (UN, 1993).

A big proportion of women (70-90 percent) in Pakistan experience violence in one or the other form (HRCP, 2014). One of the potential root causes of high prevalence of GBV in Pakistan is that it is socially accepted, whereby, it often goes unreported and people are left with little choice but to suffer in silence (IGWG, 2010). This brings in the issue of normative definitions of behaviors.

Notwithstanding the contextual refinements, the GBV has not only been considered as a violation of human rights but it has also been recognized as a grave public health concern (Rico, 1997). Depending upon the seriousness of the outcome of violence, health professionals are often the earliest point of contact for treatment (IGWG, 2010). Given the sensitivity of the situation, the health personnel appear to be in a unique position to act as catalysts to change the societal attitudes by, reframing violence as a public health concern (Aleksandra& Mikanovic, 2014). They are in a key position for the screening and documentation of GBV, which could be the basis for legal action against the perpetrators (IGWG, 2010). Nonetheless, most of them are not adequately trained how to respond to GBV cases, whereby they merely focus on medical treatment (UNFPA, 2013). Subsequently, the patients experiencing GBV miss the opportunity to get a comprehensive care including medico-social support. (Sarah Bott, 2010).

Healthcare professionals, by and large, are not even well aware of the laws related to gender based discriminations and violence and health equity. Additionally, they are not familiar with Pakistan's national and international commitments to address these issues (Paula, Sofia, 2003). Most often, considering the GBV case as medico-legal issue, health care providers remain reluctant in getting involved in such cases. Resultantly, the persons experiencing violence are neither fully owned nor treated adequately which puts them at a disadvantageous position, even in a medical setting(UNFPA, 2013). Therefore, *prima facie* healthcare as an institution is not

fully prepared to play its proactive role in mitigating human rights violations and being instrumental in reducing health disparities (Limentani, 1999).

The adoption of human rights based approach in the national health policy, provincial health strategies, public health and health care curricula, health care delivery mechanisms, and even overall health system performance has yet not become a practical reality in the country (Onathan et al, 1994). Lack of political will for health policies, inadequate guidelines, health curriculum devoid of human rights approaches, and the lack of capacities of healthcare professionals appear to be the key barriers in realization of health equity and human rights. The issue is of extreme importance, given the gender inequality, the prevalence of GBV in the country and the corresponding lukewarm response by the public health personnel.

Integration of human rights perspective, particularly health equity principles and GBV response in health sector, will not only provide a unifying framework to undertake the catalytic role of health practitioners in society, but will also serve as a basis for the making of an effective health policy. As a primary interface between patients and health care systems, the role of health professionals including doctors, nurses, and paramedics, is critical in protecting and promoting human rights in their daily practices. Concomitantly, the realization of human rights by medical professionals and their proactive role as duty bearer in upholding the mission could result in promoting gender equity and human rights in medical setting.

Given this background, the present study is a step to identify the entry points for the integration of human right based approaches in the existing curricula of health professionals by highlighting the existing situation. This whole process has been undertaken as part of public health response of Pakistan in the adaptation of WHO guidelines and tools (2005 & 2014). The integration of human right based approach in medical curricula would help in sensitizing and informing graduate students, public health practitioners, health managers, service delivery experts, healthcare providers and policy makers about the protection and promotion of human rights of patients.

1.2 Objectives

The objectives are:

- To assess country context and needs of public health professionals, care providers and health institutions (pre-service and in-service) for curricula on health equity and human rights taking account of gender equality and GBV treatment dimensions in Public Health Response of Pakistan
- To develop evidence based curricula on Health Equity and Human Rights to be utilized for pre-service and in-service capacity building of health professionals, service providers and health institutions at federal and provincial level.
- To develop an action plan, in consultation with stakeholders, for the adaptation of the developed curricula on integrating Health Equity and Human Rights in Public Health Response of Pakistan

Chapter 2: Methodology and Literature Review

2.1. Literature Review

The literature review involve an extensive search of various library sources, official gazettes, economic and legal documents, public releases and statements, and online material from national and international agencies like Planning Commission of Pakistan, Economic Affairs Division (EAD) of Pakistan, HRCP, PDHS, WHO, ILO, UNDP, UNICEF, etc. As a result, the context of Pakistan with reference to right to health has been ascertained. Details of each technical area are given as under:

2.1.1 Human rights based approach and health equity in public health response

Public health sector in Pakistan is divided into primary, secondary, and tertiary health care institutions. The said technical area aims to appraise that to what extent human rights based principles, values and health equity dimensions, in public health response at various levels are being addressed and practiced. Review of literature on this issue would enable us to identify the health equity and human rights gaps at different levels of health care provision. Resultantly, this information would help us to draw conclusions and recommendations in the present study on this area.

The public health service delivery infrastructure in Pakistan consists of 5000Basic Health Units (BHUs), 600 Rural Health Centers (RHCs), 7500 other first-level care facilities and over 100000 lady health worker providing primary health care services across the country. Additionally, there are 989 secondary care hospitals, at tehsil and district levels responsible for referrals (WHO, 2015). Even with such a fairly good public infrastructure, only 27 percent of population benefits from public health care coverage, whereas, 73 percent of the population depends on out of pocket payments (Settle, 2010).The primary care outlets including BHUs and RHCs are designed to provide a comprehensive array of health care services targeting at protection, treatment and promotion services (Technical Resource Facility, 2013).

It has been envisaged in the national health policy, 2009 and other official proclamations (Economic Survey of Pakistan, 2015) that the major burden of healthcare would be borne by primary care centers. This thinking is based on the assumption that primary health care centers have a geographical coverage across the country including the rural and distanced areas, and they

can provide health services to the public in general and to the disadvantaged in particular. However, the prevailing situation of health care system deviates from the said envisaged policy. In this regard, it is estimated that Pakistan spends almost 85 percent of health budget on tertiary health care that is used by only 15 percent of population. Whereas, the remaining 15 percent of the health sector budget is utilized for 85 percent of the population– resulting in widening the gap between health services utilization by the general public (Ahmed & Shaikh, 2008; WHO, 2008).

The Constitution of Pakistan reflects its commitment to access to health services as a policy principle without any discrimination on the basis of age gender, class, religion, ethnicity or social status for achieving good health outcomes (WHO, 2015). Right to health principles, values and elements focus on availability, accessibility and affordability, acceptability of quality health care for all particularly to vulnerable and marginalized populations ensuring equity, dignity, respect and non-discrimination (WHO, 2015). Pakistan's political and economic crises, natural disasters and the increasing security situation hinders people's accessibility and affordability of basic needs particularly health, safe water and sanitation (WATSAN) and nutrition services (WHO, 2015). It can be reflected from the fact that Pakistan is still lagging behind in achieving MDGs. Despite many efforts, maternal healthcare utilization is not improved even according to the level of other neighboring countries. In Pakistan around 75.5% women received some form of ANC during their pregnancy, 59% received skilled health providers' assistance during delivery, and 55.3% delivered in a healthcare facility (PDHS, 2013). And most of these services were not utilized by poor and uneducated mothers which resultantly lead to high maternal mortality among this group (PDHS, 2013).

In the backdrop of inequitable health sector response to health equity, the utilization and service delivery of all three tiers of public health sector has largely remained unchanged during the last three decades (Mehmood & Bashir, 2012). Pakistan with one of the most widely spread district health system networks in the region, has not delivered at the expected capacity. A series of health system reform agendas are stipulated but the state's healthcare system in Pakistan has suffered a lot, owing to the bad governance, inadequate funding in health sector, shortage of adroit medical professionals, and the lack of training of health professionals (WHO, 2011).

These limitations together become an obstacle towards achieving the goal of health equity in Pakistan.

In order to achieve an equitable health system, devolution could be the best opportunity for the provinces to launch their need based health policies taking into account health equity as well as human rights (Nishtar et.al, 2013). Nonetheless, even after almost four years of devolution, not a single provincial government has come up with such an integrated health policy. This section concludes that, in Pakistan, there are many shortcomings in public health system both at policy and at operational level. These shortcomings result in widening the gap between service demand and public healthcare delivery in Pakistan. . Concomitantly, human rights and health equity are overwhelmingly ignored in public health sector.

2.1.2 Position of right to health as a priority in National Legal and Policy level mechanisms and International human rights obligations and commitments of Pakistan

National legal and policy level mechanism

Health as a right has not been overtly recognized in the constitution of Pakistan; however, there are several places where the right to health elements has been indirectly enshrined. In this regard, article 38 (a) stipulates that state shall secure the well-being of the people, irrespective of sex, caste, creed and race, whereas the clause (d) Section 38 envisages the provision of basic necessities of life, including medical relief for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment.

In Pakistan both, federal government and the provincial governments have the powers to promulgate legislation on health issues. In wake of the 18th Constitutional amendment, the powers of federal government have been devolved to the provinces; hence health has become primarily a provincial subject (Sania Nishtar, 2010). By the same token, provinces are independent in making their health policy as well as in their financial matters. Nonetheless, in order to regulate the diverse and cross cutting health issues, the federal government established National Health Services Regulations and Coordination Division (NHSRCD) to regulate the diverse health activities (Federal Ministry of Health, 2013)

The history of making health policy dates back to 1988, when the government of Pakistan started working on it. Subsequently, the first health policy of Pakistan was launched in 1990. This policy was based on a public health and health promotion perspective, mainly focusing on school health services, family planning, nutrition programs, malaria control programs, control of communicable diseases (e.g. tuberculosis and infective hepatitis), sanitation and safe drinking water (Lashari, 2004). It is pertinent to mention here that the first health policy of Pakistan did not contain anything about health as human right in general, and anything about health equity and GBV in particular.

The first health policy continued for seven years, and in 1997 the second National Health Policy was launched by the Ministry of Health, Government of Pakistan (National Health Policy, 2009). In this policy, the health promotion and health education received a prominent place but again health rights were not mentioned in it. Additionally, a major focus was laid upon the prevention and control of non-communicable diseases, such as, cardiovascular disease, cancer and diabetes. Although the focus of this policy was health education and health promotion, but the five principles of the Ottawa Charter for Health Promotion (WHO, 1986) as a guiding framework per se were not alluded to.

Almost after four years of the second health policy, the third health policy was launched in 2001. Interestingly, this policy pretermitted the major focus of antecedent health policy and also omitted the prevention and control of non-communicable diseases. In this backdrop, *Heartfile*, a non-government organization, intervened and lobbied for implementation and evaluation of third health policy. Subsequently, a tripartite partnership was formed between the Ministry of Health, The World Health Organization, and *Heartfile* (Nishtar et al., 2005). On the basis of their findings, the National Action Plan for Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan (NAP-NCD) was launched in 2004. The NAP-NCD appeared to be the both a policy tool as well as an implementation document. That is how, it is considered as a milestone in health promotion and public health policy development.

In wake of devolution of health to provinces in 2011, Provincial governments came up with their health sector strategies to improve health outcomes. In contrast to the old national health policies, the provincial health strategies appeared to be better because these have been tailored

on need basis and situation analysis. Although, the notion of health as a human right is not overtly outlined, but somehow these strategies address covertly the concepts including human rights and health equity as well as provide some space for integration of these concepts at provincial health system. For instance, one of the key actions of KPK health sector strategy is to improve quality of in-service and pre-service training through curriculum review and assessment (Technical Resource Facility, 2013).

Likewise, Health Strategy of Punjab clearly speaks about 'Equity in Public Expenditure Efficiency in Public Expenditure' in the chapter of 'health financing and expenditure' (Technical Resource Facility, 2013). The Sindh health sector strategy claims congruence with existing international commitments and MDGs. It also builds upon the key parameters of access, equity and universal coverage of health in the province (Technical Resource Facility, 2013). However, in case of Baluchistan, the health sector strategies are being aligned with the Medium Term Budgetary Framework (MTBF) (Technical Resource Facility, 2014).

There are a number of health related laws in Pakistan. These include The Public Health (Emergency Provisions) Ordinance, 1944, Medical & Health Institutions and Regulation Amendment Act, 2006, Pharmacy Act, 1967, The Pakistan Nursing Council Act, 1973, The Mental Health Ordinance 2001, The Punjab Medical and Health Institutions Act, 2003, Health (Management) Service Rules 2008The University of Health Sciences, Lahore Ordinance 2002 etc. A critical review of all such laws revealed that the notions of human rights and health equity were missing in these laws. This state of affairs invites the attention of legislators and policy makers for integrating the concepts of human rights and health equity into national and provincial legislature.

Review of literature suggests that the right to health taking into account human rights and health equity perspectives did not remain a priority in national legal and policy mechanisms. Ironically, not a single health policy in Pakistan has addressed the health equity and Gender based violence in particular.

International Commitments

In 1978, Pakistan became one of the initial signatories to the World Health Organization's (WHO) Alma-Ata Declaration, which laid the foundation and target for Health for All by the Year 2000 (WHO, 1978). One of the five principles to emerge from Alma-Ata focuses on disease prevention, health promotion, and curative and rehabilitative services. Alma-Ata was the first health related international declaration binding on Pakistan since its Independence, and also on other member states, which created a new thought process for policy formulation.

Pakistan has ratified a number of international treaties and covenants in which health is recognized as a fundamental right of the citizens. Universal Declaration of Human Rights (UDHR) 1948 serves as an umbrella for determining and guiding the human rights across the world. In this regard, along with many other countries, Pakistan has ratified a number of International conventions/treaties in which the right to health is directly or indirectly addressed. Among such international obligations, the International Covenant on Economic Social & Cultural Rights (ICESCR 1966), which Pakistan ratified in 2008, is most important because Article 12 exclusively pertains to "Right to Health", which again could not be satisfactorily realized yet.

Along with this, Pakistan is the signatory to a number of human rights instruments like the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, the Convention on the Elimination of All Forms of Discrimination against Women of 1979, the Convention on the Rights of the Child of 1989 (CRC), the Convention on the Rights of Persons with Disabilities (2006), The Ottawa Charter for Health Promotion (1986), Cairo Declaration on Human Rights in Islam (1990), Program of Action of the International Conference on Population and Development (1994), Beijing Declaration of Indigenous Women (1995), Jakarta Declaration on Leading Health Promotion into the 21st Century (1997), Rio Declaration on Environment and Development (1992) and Rio +20 (2012) etc. In presence of all these conventions, the realization of the right to health has been still a pending issue and not realized in true spirit of these commitments.

Pakistan has adopted Millennium Development Goals (MDGs) in 2000. Pakistan is off track in 24 of 34 indicators of eight MDGs with the deadline set by United Nations completing in

2015(Planning Commission of Pakistan, 2013). Three (4, 5, and 5) of the eight MDGs are directly related to health. Under MDG 4, Pakistan intends to reduce the under-five child mortality by two-thirds. It has six indicators, of which Pakistan is off-track on five (United Nations, 2014). The MDG 5 is related to reduce the maternal mortality rate (MMR). Despite efforts to reduce MMR by three-quarters, Pakistan is off-track on all its indicators (United Nations, 2015). In this connection, the infant mortality rate in 2013 was 69.0 against the target of 40, under 5 mortality rate was 85.5 against the target of 52, whereas, maternal mortality ratio was 170 against 140 (Economic Survey of Pakistan 2014-15).

The prevailing position of right to health as a priority in national legal and policy level mechanisms and international human rights obligations shows that Pakistan so far has not been able to come up with robust health care reforms. The legal structure and various polices could neither restructure the in-efficient system nor these gave priority to the preventive aspect of various diseases (Lewis, 2006).

2.1.3 Province specific progress on core health indicators with human rights and health equity lens in perspective of devolution of Ministry of Health

Along with many other social sectors, the 18th Amendment also posed many implications in the health sector in provinces. Nonetheless, "the devolution and development of health sector in Pakistan could not involve strategic, policy and long term planning" (Dodani, 2012). Before devolution, the provincial health departments had centralized control over the health sector allocations, human resource management and supplies. This situation outlined several pre-requisites for the efficient management of health services – which is now the sole responsibility of provincial bodies. In this backdrop, although, provinces did not adopt any policy which overtly outlines the health equity or human right concern, yet there are certain programs and health sector strategies of various provinces which directly or indirectly address the issue to the some extent.

Punjab

Punjab has performed better than other provinces in terms of core health indicators concerning health equity and human rights. This is probably because government of the Punjab has taken a number of health initiative including Punjab Health Sector Reform Project (PHSRP) and Policy

& Strategic Planning Unit (PSPU), Health Education Program, Extended Program on Immunization (EPI), Nutrition Program etc. Furthermore, an emphasis has been laid upon the provision of Mobile Health Units (MHUs) and Lady Health Workers (LHWs) program to reach children and child bearing women in hard to reach areas and in areas lacking the facilities.

Nonetheless, taking into account the MDGs, Punjab is still far from achieving its targets of reducing child mortality and improving maternal health, whereas, for measuring progress against HIV/AIDS, malaria and other diseases prevention, no authentic data is available (United Nations, 2015). The progress towards achieving MDGs shows that there is a discrepancy among the envisaged and achieved goals/indicators. For instance, in MDG 4, under 5 mortality rate stood at 111 against the target of 52, infant mortality rate was at 77 against the target of 40, and immunization against measles was 36.4 percent against the target of more than 90 percent. In MDG 5, maternal mortality ratio remained at 227 against the target of 140, proportion of births attended by skilled birth attendants was 46 percent against the target of more than 90 percent, and total fertility rate could come down to 3.6 against the target of 2.1 (Technical Resource Facility, 2013).This state of affairs affirms that in Punjab health related human rights could not be ensured yet.

Sindh

The progress of Sindh on core health indicators mentioned in MDGs has been very slow and uneven and thereby much below to be called satisfactory. For instance, in MDG 4, infant mortality rate was at 81 against the target of 40, and immunization against measles was 77 percent against the target of more than 90 percent. In MDG 5, maternal mortality ratio remained at 314 against the target of 140, proportion of births attended by skilled birth attendants was 42 percent against the target of more than 90 percent. The Government of Sindh has primarily been focusing on primary health care facilities at the community level through its People's Primary Healthcare Initiative (PPHI) and Lady Health Workers Programs. As a policy framework, these initiatives denote stark rural/urban disparities across the province (UNDP and Government of Sindh, 2012). The devolution of health ministry could not result in any substantial progress on health indicators in Sindh. This is probably because of floods of in 2011 and the worse economic

and law and order and security situation in Sindh (UNDP, 2013). As a result of the given situation, the human rights in health do not show an encouraging picture.

Khyber Pakhtunkhwa

After devolution, the government of Khyber Pakhtunkhwa (KPK) has been working steadily to improve the core health indicators in the province. The government of KPK has adopted a set of policy priorities for improving the overall health indicators of the province. Nonetheless, the KPK progress is off track on the three health related MDGs (United Nations, 2014). The Health Sector Strategy of Khyber Pakhtunkhwa (2013) showed that maternal mortality could not be brought down to MDG target of 140 and it remained at 275. Likewise, the infant mortality rate of 63 and under 5 mortality rate of 75 appeared to be higher than the MDGs targets (Technical Resource Facility, 2013). It is pertinent to mention here that among other factors, low economic growth, worsened law and order situation, presence of Internally Displaced Persons (IDPs) were the major issues whereby the government of KPK remained off track to the MDGs particularly health related MDGS (UNDP, 2013). In this backdrop, the government of KPK, as like other provinces, also needs to work much more in health sector for ensuring the right to health in this province.

Baluchistan

As Baluchistan is the largest province of Pakistan in terms of geographical area with a highly scattered rural population, the provision of health services becomes a challenging task. It has been reported that Baluchistan is the worst performing province in most if not all areas of the MDGs. Baluchistan is completely off track and even below national average for almost all indicators in the aftermath of the floods, and the declining national economic and security situation post 2007 (UNDP, 2013). The performance of Baluchistan while completely off track and below the national average for almost all indicators, is especially of grave concern in health related indicators. In this province, 43 percent of children are underweight against a target of 20 percent, reflecting a severe lag in performance. Baluchistan is also underperforming in 5 indicators of child mortality with a staggeringly high infant mortality rate by national standards. In MDG 5, progress is especially lagging for all indicators with 785 deaths per hundred thousand live births; the maternal mortality ratio deserves immediate attention (UNDP, 2013).

The devolution could not result in a substantial progress in all social sectors including the health sector across provinces. Despite the provincial autonomy, all four provinces are off track on health related MDGs including MDG 4, 5, and 6. By and large, the situation is same across provinces where there is an inadequate access to health care services for public at large. There are certain limitations in achieving health equity vis-à-vis human right concern in health sector. These include lack of political will as well as insufficient competent human resource (Health Sector Strategy-Punjab, 2013) , fragile service delivery system (Shaikh, Rabbani, Safi, & Dawar, 2010)., and most of all low spending on health (Ahmed & Sheikh, 2008). These factors have resulted in leaving large segments of population with inadequate access to health care which is mostly characterized with human rights violations.

2.1.4 Importance, required skills and approach to address gender based violence as public health issue and serious violation of health related human rights in health sector response

Gender based violence is a global phenomenon prevalent across classes, ethnicity, religions, and other social divisions. Various national and international studies indicate high prevalence of GBV in Pakistan (HRCP, 2012). It has been found that GBV endangers the physical integrity and overall well-being of victims, particularly women and girls. Therefore, it has emerged as a grave public health concern across the globe. Although GBV is recognized as a public health issue globally (Western, 2013; Ellsberg, & Emmelin, 2014)., but the health sector response in Pakistan towards addressing this issue is scant. This limited response is mainly characterized with the lack of public recognition of the problem, inadequate institutional and individual capacities of health service providers, and the patriarchal mindset widely prevailing in Pakistani society (WHO, 2011).

GBV is overwhelmingly under-reported, because it is considered as a private family matter (Babur 2007; Garg, 2008; Zakar, 2012). The reporting and screening of GBV cases can help in reducing GBV. Literature suggests that public health facility could be recognized as a potential place to identify and report GBV because survivors are more likely to seek health services. Nonetheless, the survivors do not spontaneously disclose violence against them to the healthcare professionals. Research indicates that the chances of disclosure of GBV can be increased when

health professionals are trained to sensitively enquire about GBV from survivors (Feder et al., 2011; Zakar et al., 2011).

Women, who have been subjected to violence, often seek health care, including for their injuries, even if they do not disclose the associated abuse or violence. A health-care provider is likely to be the first professional contact for survivors of GBV (WHO, 2013). By the same token, healthcare professionals are reckoned to be in a better position to screen GBV and document such cases as they are the first point of contact for the patient. It is therefore extremely important for health care professionals to have a thorough understanding of the concept of GBV, violence and its types and how violence is linked with health, human rights and equity issues. Moreover, in-adequate training of health professionals to deal with the case of GBV results in the limited provision of care to survivors and eventually the violation of health related human rights (Zakar & Kraemer , 2011).

In view of the above, the WHO (2013) Clinical and Policy Guidelines in responding to intimate partner violence and sexual violence against women can serve as a road map for the training of health care professionals. The target audience of these guidelines is health care providers because they can address the health and psychological needs of women who have experienced violence. These guidelines offer evidence-based guidance to healthcare providers on appropriate care, including clinical interventions and emotional support to the survivors (WHO, 2013).

2.1.5 Guidelines to address health equity and human rights taking in account gender inequality and gender based violence issues during facility based clinical management in Pakistan

In Pakistan, National Health Policy (2010) does not explicitly speak about facility-based clinical management system in a particular context to address health equity and human rights taking into account the gender inequalities and GBV. Moreover, there are no specific guidelines for addressing these issues in health sector. By and large, the clinical management in Pakistan works on the principle of symptomatic treatment instead of taking into account the social and demographic perspective of the patients. As a result, special needs of GBV patients are ignored vis-à-vis no standardized tools are adopted in health sector for screening of such cases in Pakistan.

The response of medical system towards medico-legal cases is different as compared to general cases. In particular reference to medico-legal cases of GBV, the medical, legal, and other support systems do not play their envisaged role (World Health Organization, 2003). For instance, if a case of GBV is not reported in police station, the doctor does not own that and likewise the referral mechanism does not come into play to support the victim of violence

Review of literature suggests that, in Pakistan, health has not be included as a cross cutting agenda in all polices. It is argued that government objectives can be best achieved when all sectors include health and well-being as a key component of policy development (WHO, 2010). This is how most of the time, causes of health and well-being are socially and economically determined. In order to integrate considerations of health, well-being and equity during the development, implementation and evaluation of polices and services, an integrated approach is required. In this regard, the WHO and Government of South Australia document 'Adelaide Statement on Health in All Policies' (WHO, 2010) can serve a road map for leader and policy makers to make health as a cross cutting agenda in all polices including health policy, economic policy, environment policy, population policy, etc.

In case of Pakistan, there are no specific guidelines or tools which could address health equity by taking into account the social determinants of health. In this backdrop, WHO's (2010) Urban Health Equity Assessment and Response Tool (Urban HEART) could be helpful towards achieving health equity by taking into account the social determinants of health. The said tool is a user-friendly guide for policy and decision makers at national and local levels. By using this tool, inequalities in health can be determined among people belonging to different socio-economic characteristics. Furthermore, this tool could facilitate decision making process towards making viable and effective strategies, interventions and actions that could reduce health inequalities. The cyclical nature of the planning and implementation of the said tool ensures consistency with local governance processes, and facilitates linkages with other sectors. Furthermore, Urban HEART can complement existing social and health initiatives by providing an equity lens (WHO, 2010).

Similarly, some guidelines (Ministry of Health and Social Welfare, 2011; UNFPA, 2001; WHO, 2013) are used globally for integration of GBV in health sector. These guidelines can provide a

step by step roadmap for integration of GBV in health and for improving public health response to GBV in Pakistan. For example, National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (2011) provides standards for the provision of high-quality and comprehensive medical services and procedures to GBV survivors, and encourage providers to identify and quickly mobilize the required resources, materials and essential medication for GBV at health facilities. Another guideline 'A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers by UNFPA (2001) suggests a step-by-step guidance for developing healthcare facility based projects for screening and preventing GBV. It includes awareness among the clients visiting the facility through displaying material about GBV and referring identified cases of GBV to necessary care and support. WHO Clinical and Policy Guideline for Responding to Intimate Partner Violence and Sexual Violence against Women (2013) offer evidence-based guidance to health-care providers on providing appropriate care including clinical interventions and emotional support for women suffering violence through improved capacity-building of health-care providers.

2.1. 6 Integration of health equity and human rights principles, values and elements to strengthen health systems, financing, governance and accountability.

The health equity and human rights perspective explore the root causes of human rights violations, its impact, and the efforts made to redress the discrepancies in health sector (Nishtar et.al, 2011). Equity and human rights are closely linked with health both conceptually and operationally. This relationship provides unique and valuable guidance for the functioning of health institutions (Whitehead, 2000). Public health research suggests that both equity and human rights principles emphasize the necessity to strive for equal opportunity for disadvantaged and marginalized groups. Health institutions can deal with health inequality within a framework encompassing the human rights and equity in five ways including i) institutionalizing the human rights and equity perspective in all public health operations, ii) strengthening and expansion of health care services, iii) equitable healthcare financing, iv) responding effectively to the major cause of illness among disadvantaged, and v) monitoring, advocating, and taking action to address health inequity and human rights implications of policies in sectors affecting health (Braveman & Gruskin, 2003; Maeseneer et.al, 2007).

As a signatory to human rights treaties, the government of Pakistan is accountable for setting targets and showing good faith towards progressive realization of human rights, including the right to health. The adoption of equitable approaches and integration of human rights can not only narrow down the service delivery gaps in health sector but it can also help in achieving health equity. Data show that 77 percent of total health expenditure comes from out-of-pocket whereas the remaining 23 percent is provided by public health sector (Settle, 2010). The disparity owes to the low spending of government in health sector. This is how, Pakistan just spent 0.46 percent of its GDP on health in year 2014-15 (Economic Survey of Pakistan, 2014-15).

Likewise, the health expenditure in total public sector expenditure is, the most significant variable affecting the health status of people (Kea, Saksenaa, &Hollyb, 2011). It has been found that infant and child mortality become lowest in the countries where there is high spending on health in Public Sector Development Program (PSDP). Nevertheless, in case of Pakistan, health did not remain a priority in PSDP 2014-15, where only 12 percent (21 billion rupees) of the total PSDP was allocated for health. This is one of the major reasons that Pakistan's progress towards ensuring the right to health remained slow thus off track on a majority of MDGs' health indicators (United Nations, 2015). In this scenario, it becomes evident that the meager allocations as well as expenditures patterns in health sector exacerbate the situation and widens the disparities in health care provision – which directly links to the human rights violations.

In a human right-based approach, importance is not only given to the outcomes, instead processes are also important (Gruskin, Bogecho, & Ferguson, 2010). In this regard, international human rights mechanisms for legal accountability could be integrated in health sector to reduce health inequity (Hunt & Backman, 2008). It is argued that equity in health is not just restricted to improve health outcomes but it can also contribute to good governance (WHO, 2013; Hunt & Backman, 2008). Concomitantly, this is a means of achieving mutual benefits in multiple sectors leading towards the public good. But this is only possible when "health in all policies (HiAP)" approach is adopted (Leppoet.al., 2013).

2.2. Methodology

The human rights based approach, assuring health equity, taking in account gender inequality and particularly, in case of Pakistan, gender based violence (GBV) issues rarely figure out in public health response. It is imperative therefore to build the capacity of healthcare professionals through providing them an understanding and lens to address health equity and human rights taking in account gender equality and in particular GBV issues in their day-to-day practice. This objective can be achieved by integrating these issues into the curricula of public health professionals and healthcare providers at both pre-service and in-service level. This study was a step in this direction. According to the objectives, the present assignment was comprised of the following elements:

1. Assessment of country context and needs of health sector for curricula and organizational capacity; and
2. Designing a model curriculum for the integration of health equity and human rights taking in account gender equality, GBV and SDH into health sector response.

2.1 Assessment of country context and needs of health sector for curricula and organizational capacity

The assessment of country context and existing situation were analyzed by focusing on the following:

1. Review of existing curricula of pre and in-service health institutions with regard to health equity and human rights lens taking in account SDH and GBV dimensions; and
2. The status of health sector realization, readiness, challenges and response to issues like health equity, human rights, GBV and SDH.

Study population and sampling

In order to assess the country context, we reviewed the existing curricula of different degree programs. To identify the needs of healthcare professionals for curricula qualitative interviews were conducted with different healthcare professionals. Table 1 identifies the categories of health professions or targets of curricula. Within each category, three levels of curricula discourse were identified: designer, implementers and deliverers. For assessing the needs of healthcare professionals, respondents were selected purposively from these categories representing all three levels of the curricula discourse. In order to assess the status of health sector realization, readiness, challenges and response to health equity, human rights, GBV and SDH issues,

respondents were selected purposively from managers and practitioners related to the same categories of health professionals, selected for curricular review.

Table 1: Categories of Health Professions at levels of curricular discourse

Categories of health profession or curricular targets	Curricular designing/ Regulatory Body	Curricular implementers	Curricular deliverers/ users
Doctors/ Dentist	PMDC/HEC	Principals/deans of medical and dental colleges	Teachers
MPH candidates	University /HEC	Dean of Public Health Institute	Teachers
Pharmacists	PPC/HEC	Principals/deans of Pharmacy training institutes	Teachers
Nurse practitioners	PNC/HEC	Principals/deans of nursing colleges/ schools	Instructors
Paramedical Staff	Medical Faculty (provincial)	Principals/deans of schools of paramedics	Instructors
LHW/CHW	Director General Health Services and Provincial Programme Director	LHW programme Coordinators (in districts)	Master trainers

Data collection

For data collection from course designers, implementers, providers/users, C-SWOT and TNA information was collected from participants from following institutions:

1. Pakistan Nursing Council (PNC, Islamabad
2. Pakistan Pharmacy Council (PPC), Islamabad
3. Higher Education Commission, Islamabad
4. Health Services Academy, Islamabad
5. AllamaIqbal Medical College, Lahore
6. Institute of Public Health, Lahore
7. Punjab Medical Faculty, Lahore

8. College of Nursing, Jinnah Hospital, Lahore
9. Program Coordinator LHW Program in Lahore, Karachi, Quetta
10. Ziauddin Medical College, Karachi
11. Jinnah Post Graduate Medical Center, Karachi
12. Sindh Medical Faculty, Karachi
13. Nursing College, Jinnah Post Graduate Medical Center, Karachi
14. Khyber Medical University, Peshawar
15. College of Pharmacy, University of Peshawar, Karachi, Lahore, and Quetta
16. Institute of Public Health and Social Sciences, Khyber Medical University, Peshawar
17. School of Nursing, Hiatabad Medical and Teaching Hospital, Peshawar
18. Khyber Pakhtunkhwa Medical Faculty Peshawar
19. Baluchistan Medical Faculty, Quetta
20. Fatima Jinnah Medical College and Hospital, Quetta
21. Bolan Medical College, Quetta
22. Institute of Public Health Quetta
23. College of Nursing, Baluchistan

Curricula review

In order to assess the current curricula context and organizational capacity, the curricula of pre-service and in-service medical and public health institutions were assessed against standards, as set forth by WHO (2005[1], 2014[2]) for health as human right, health equity and gender (see Table-3.1 in Annexure II). A panel of experts had assessed different curricula on a five-point scale adapted from the aforementioned guides. The scale is given below:

1. Overt, explicit or written curriculum
2. Hidden or covert curriculum
3. Null curriculum
4. Curriculum-in-use
5. Not applicable

[1]WHO Module on Curricular Integration (2005)
[2]WHO Handbook (2014) for "integrating equity, human rights and gender into WHO guideline"

The current curricular context was assessed in terms of whether the curriculum taught in medical and public health teaching and training institutes covered these issues. The curricula were reviewed and assessed for presence and/or absence of the following topics:

1. Topics/contents related to human rights
    a. Definition and types of human rights
    b. International human rights standards
    c. Key human rights principles of service provision
    d. Women and children's rights and health
    e. Human rights concerns in Pakistan
2. Topics/contents related to health equity
    a. Understanding health inequalities
    b. Poverty and health
    c. Gender disparities and health system
    d. Equity and equality
    e. Equity and healthcare delivery in relation to health care needs
    f. Equity and financing in relation to ability to pay
    g. Equity and efficiency
3. Topics/contents related to gender based violence
    a. Defining of GBV and cultural issues pertaining to it
    b. Diagnosis of GBV cases
    c. Documentation of GBV
    d. Legal and ethical issues related to GBV
    e. Treatment and rehabilitation of GBV cases
    f. Referral of GBV victims
    g. Support to the victims of GBV
4. Topics/contents related to Social Determinants of Health
    a. Role of SDH in healthcare service delivery
    b. Individual, biological, and environmental factors
    c. SDH approaches
    d. Link between SDH and health

Review of Job Description. We also conducted a review of job description of healthcare providers including medical professionals, public health experts, nurses, allied health professional, pharmacists, and community health workers. It helped us in identifying the needs for incorporation of guidelines and tools for applying health equity and human rights approaches and addressing GBV cases during their practical experiences.

Qualitative Interviews

In-depth interviews. In addition, semi-structured interviews were conducted with respondents selected purposively from the public health (including policy) and service delivery experts in public health institutions representing all three levels of the curricula design, implementation and delivery. Qualitative interviews were continued till the saturation point was achieved. Nevertheless, this point was different for each category of respondents (see Table 2). In-depth interviews with each category of health professionals representing different levels of curricular discourse enabled us in capturing information about written as well as unwritten aspects of the curricula taught in health institutions. Interview guide for different levels of curricular discourse is attached in Annexure V.

Table 2. Number of in-depth interviews conducted with each healthcare professionals

Health professional categories	Designers	Implementers	Users	Total
Doctors/ Dentist	2	4	4	10
Public Health	1	4	4	9
Pharmacy	1	4	4	9
Nursing	1	4	4	9
Paramedic	1	2	4	8
Field profession (LHW/CHW)	1	4	4	9
Total	7	22	24	54

Focus Group Discussions. In order to substantiate the information, we also conducted two Focus Group Discussions (FGDs) with health managers and health practitioners to assess the views of relevant stakeholders about the curricula contents pertaining to human rights, health equity, SDH and GBV. The main objectives of the FGDs were to determine:

(i) whether they were exposed during studies to the concepts;

(ii) to what extent they faced these issues in their workplace and practice;

(iii) what is the importance of including/substantiating (if already included) these concepts in the undergraduate and postgraduate curricula; and

(iv) whether health managers and practitioners, while in service, required training and exposure to these concepts.

The FGD guide was used as tool of data collection (see Annexure VI). For FGDs, participants were invited from the list of MPhil and PhD candidates enrolled in the Department of Public Health, University of the Punjab as they were working as health managers and health practitioners in different parts of Punjab. In two FGDs, in total, 8 health managers and 10 practitioners participated.

Training need assessment

Training needs assessment (TNA) was conducted for in-service health professions categories, working as health managers and healthcare practitioners in four provinces and Capital Islamabad. For this purpose, healthcare professionals' job description with regard to health as human rights and health equity taking into account GBV and SDH was designed. In the next step, vis-à-vis the said based job description, the available capacities amongst incumbents in the health system was determined. This exercise was conducted with participants selected purposively from health managers and healthcare practitioners. For this purpose, Likert scale 1 to 5 was used, where 1 = don't know; 2 = heard about; 3 = heard about and understand the concept; 4 = practice the concept in workplace; 5 = advocates and tends to inculcate amongst colleagues – seniors, peers and juniors. Finally, in the third step the training need was determined by looking into the difference between required and the available capacities. The process for TNA is presented in Table 3. The results from TNA sessions were used to define comprehensive training need assuring the human right and health equity lens used by incumbents in their day-to-day practice. TNA guide is attached at Annexure VII.

Table 3. Training needs assessment for in-service health professions

Health profession categories	Job description in relation to health equity, human rights, GBV and SDH in health sector response	Competencies required to do job related to health equity, human rights, GBV and SDH	Competencies possessed by the incumbents	Training needs
		A	B	C= A-B
Health managers and healthcare practitioners				

C-SWOT Analysis

We used C-SWOT (curriculum – strengths, weaknesses, opportunities and threats) management tool to assess the organizational capacity of medical institutions (i.e., medical colleges and public health training institutions). For C-SWOT analysis, one medical college and one public health training institution was selected purposively at each provincial and federal level. Respondents for SWOT were academicians (Principals and teachers of medical and dental colleges and public health institutes) and students. C-SWOT Analysis matrix is attached at annexure VIII.

The findings of C-SWOT were used to define a comprehensive set of strategies in the wake of existing strengths, weaknesses, opportunities and threats in the educational environment and used in preparation of plan for the adaption of the developed curricula on health equity, human rights taking into account gender equality and GBV in public health sector.

A brainstorming session was organized and a matrix was developed, which in turn wasfed into preparing a plan for the adoption of the curricula. The exercise was conducted with a group of academicians and students in each province and capital Islamabad by addressing the following steps:

1. Defined the goal and measurable outcomes, that is, the health professions education institutions conducting the model curricula;
2. Completed a SWOT matrix, identifying current strengths and weaknesses;
3. Identified opportunities that were there or could be created for the institutes;
4. Identified threats that existed in the environment, which could hinder in achieving the institutional goal.
5. Defined strategies in the wake of existing strengths, weaknesses, opportunities and threats in the educational environment and prepared a plan.

Tools of data collection

In light of the objectives of the present study, a team of experts conducted an extensive review of the state of the art literature for developing the tools of data collection. This process was followed by detailed deliberations wherein the researchers and technical experts identified four major dimensions (themes) reflecting the views of the target population about the integration of health equity and human rights perspectives into the curricula of health professionals. These four dimension included human rights, health equity, GBV, and SDH. Accordingly, four separate tools i.e. an In-depth guide (Annex-I), discussion guide (Annex-II), TNA questionnaire (Annex-III), and questionnaire for C-SWOT (Annex-IV) were developed. For the review of curricula, the

entry points for human rights and health equity taking in account gender based violence were adapted using the WHO (2014) Handbook for Guideline Development. The questions for interview guide and FGD guide were adapted from the different guidelines such as Urban Health Equity Assessment and Response Tool (WHO, 2010). The questions on GBV were adapted from Guidelines for medico-legal care for victims of sexual violence (WHO, 2003), Rapid Assessment: Health Sector Capacity and Response to Gender-based Violence in Pakistan (WHO, 2011), Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (WHO, 2013), Human Rights and Gender Equality in Health Sector Strategies (WHO, 2011) and HCHR. A Human Rights-Based Approach to Health guidelines were consulted for adapting questions on human rights. The Hennessy-hicks Training Needs Analysis Questionnaire and Manual (Hennessy & Hicks, 2011) was used to assess TNA of healthcare professional.

Ethical consideration

The research objectives and methodology of the present study were reviewed and approved by the Institutional Review Board (IRB) of University of the Punjab, Lahore. Accordingly, the ethical and safety considerations were fully observed during the present study. Informed consent was taken from institutional heads and all participating respondents.

Field operations

Five teams comprising of 21 highly qualified (M-Phil and Masters in Social Sciences) field researchers were recruited for primary data collection in four provinces and federal capital. In each province, each team consisted of four team members (gender balanced), except Punjab where the field team was comprised of five members including 3 females and 2 males. For field orientation, a team of senior researchers and technical experts held two days training sessions to the selected field researchers from four provinces and federal capital. These training sessions were held at the Institute of Social & Cultural Studies, University of the Punjab, Lahore. All selected field researchers were fully informed about different theoretical and practical aspects of human rights, health equity and GBV. Moreover, the study objectives, tools of data collection were shared with the team members and an extensive briefing on these tools was given. During

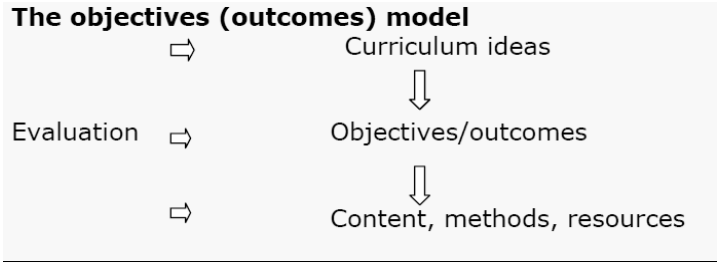
field research audio recording and photographs were taken where possible with the permission of the participants of the study.

Designing a Model Curriculum

The framework for curriculum development

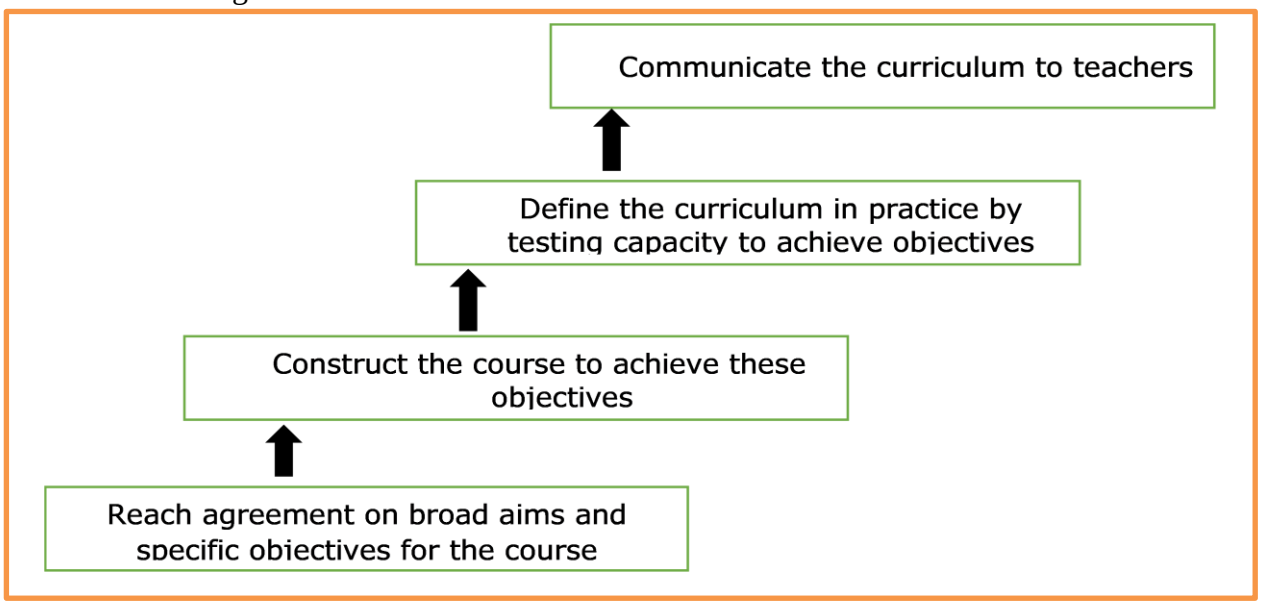
The curriculum was designed using "objective model approach" (Figure 1). The objective model is a systematic approach to course planning that "takes as its major premise the idea that all learning should be defined in terms of what students should be able to do after studying/being on the programmes, in terms of the learning outcomes or learning objectives."

Figure 1: The Objective Model



The objective model approach forms part of the outcomes based education which states that the "educators should think about the desirable outcomes of their programmes and state them in clear and precise terms". The curriculum design using the objective model had four steps.

Figure 2: Curriculum design steps using object model approach

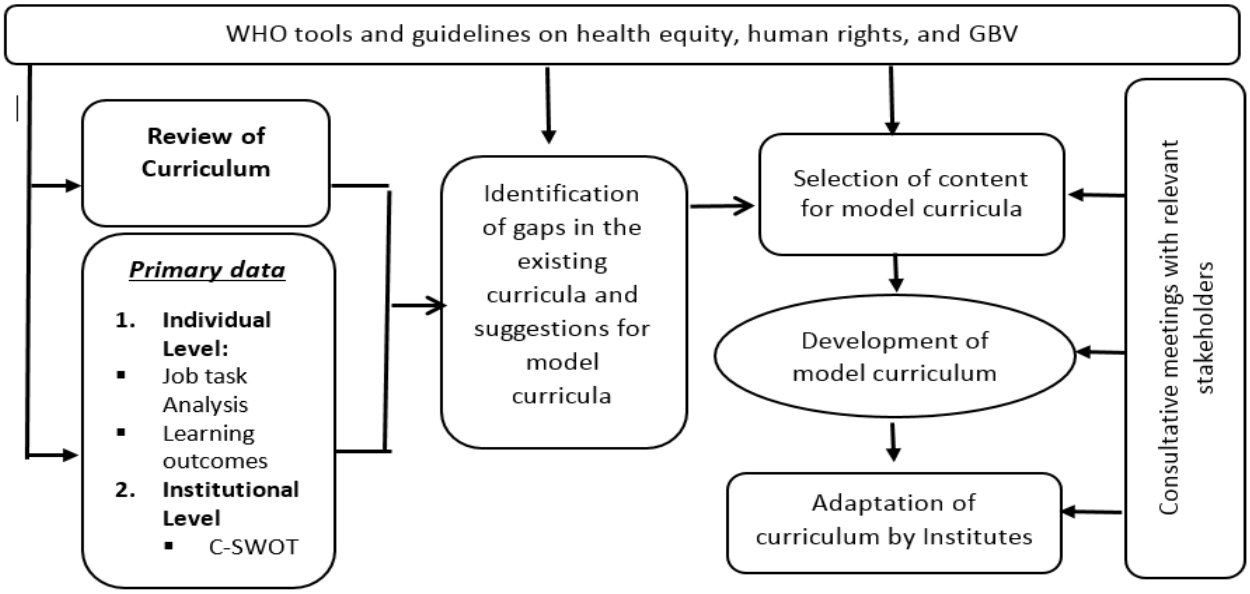


Given the dimensions and terms of references of the assignment, a framework steered by the WHO tools and guidelines on human rights, health equity, GBV and SDH was used. The existing

context was assessed mainly by using qualitative methods, and the gaps were identified thereof with the help of primary and secondary data. The gaps in the existing curricula and organizational capacity informed and guided the development and adaptation of the curricula for both the pre-service and in-service health professionals. Additionally, for generating a consensus on the issue and to define institutional mechanism for putting research results into policy and practice, consultative meetings were organized. The schematic presentation of the framework used in this study can be seen in Figure 3.

The envisaged output of the exercise was to enable public health experts, including policy makers that might have the capacity of applying health equity and human rights lens in their day to day practice. Driven by the above framework, a team of key persons/researchers (see section on key persons) managed this process in different phases.

Figure 3: Project Model for Developing Curricula for integration of Health Equity, Human Rights, Gender-Based Violence into Public Health Response



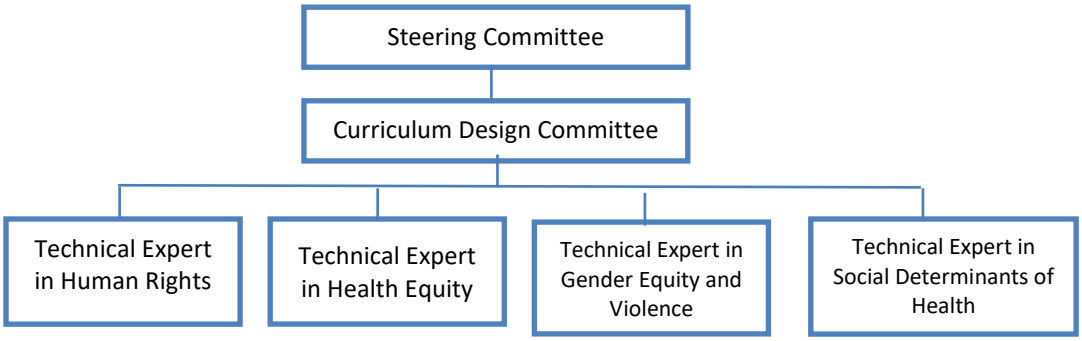
Curricular development process

A set of curriculum for each category of healthcare providers was developed by a specialized working group, comprising of experts on (i) human rights, (ii) health equity, (iii) gender based violence, and (iv) social determinants of health. The working group followed different steps for curriculum development. Firstly, they reviewed the relevant literature to complement and enrich

the curriculum development process. Secondly, findings of the assessment (assessing the context; assessing the needs, and C-SWOT analysis) were reviewed. Thirdly, based on the analysis of the findings they drafted the curriculum covering concepts like human rights, health equity taking in account gender based violence, and SDH.

For assuring participatory approach, a curricular development committee (CDC), working under the overall guidance of the steering committee was organized to oversee the curricular development process and to ensure quality, adequacy and relevance of the contents (Figure 4). The working group presented draft curriculum (see section on framework for guiding curriculum development) to CDC for review.

Figure 4: Organization for curriculum development



Contents of curricula

The model curriculum is consisted of four modules covering health equity, human rights, GBV and SDH (see details in Chapter 4). Each module is explained by topics, readings, sample class exercises, and case histories.

Adaptation of the model curricula

After CDC had reviewed the draft curriculum, a consultative workshop was held in which all the relevant stakeholders participated. The draft curriculum was presented to the participant with the aim to finalize the draft. Then the participants deliberated in groups, each led by the relevant specialist, on draft curriculum for different areas. Consequently; the feedback of each group, findings of the assessment and relevant literature, and the comments so generated in the meetings were incorporated by specialized working group and submitted to the CDC for final peer review. The CDC reviewed the curriculum and proposed some technical amendments – which were incorporated and the draft of curriculum was finalized.

In the follow up to consultative workshop, another workshop was held with stakeholders to disseminate the model curriculum. This workshop served as a session of policy dialogue to sensitize and generate consensus on a roadmap or plan of action for the adoption and integration of model curricula into the existing curriculum of pre-service degree programs (in medical, dental, and public health programmes) and in-service training curricula of heath professional, as part of their continuing medical education (CME).

Chapter 3: Findings of Assessment and Curricula Review

The findings in this section are based on review of curricula of both pre-service and in-service medical institutions and in-depth interviews (IDIs) with various categories of healthcare providers including MBBS/BDS, MPH, Nursing, Pharmacy, Paramedics, and LHWs at course designing, implementation and delivery levels. Additionally two focus group discussions (FGDs) were conducted in Punjab with health managers and public health practitioners. For assessing the organizational capacity of medical and public health institutions regarding integration of contents related to human rights, health equity, GBV and SDH in curricula, C-SWOT was conducted. Furthermore, TNA was conducted with the in-service healthcare practitioners to assess their needs for addressing the human rights approaches in their practice. The findings have been presented below under pre and in-service medical programs:

3.1. Per-Service Medical Program

Curricula review

The curricula was reviewed by using the standards set forth by WHO (2005) and WHO (2014) for health as human right, health equity and gender equity as given in Table 3.1 in Annex IV. The curriculum review of different pre-service medical programs revealed that the concepts of human rights, health equity, GBV, and SDH were not adequately addressed in their syllabi. Nevertheless, some aspects of human rights were partially and superficially covered in the course of 'Behavioral Science' under the heading of 'Medical Ethics' in MBBS/BDS program. Similarly, some general aspects of GBV were partly included in the course of 'Forensic Medicine' under heading of 'crime against the newborn, infants and child'. However, the concepts of health equity and SDH were totally missing in the curricula.

The curriculum of nursing and paramedics covered some dimensions of human rights and GBV in the course of 'Sociology and Health' under the headings of 'basic human rights', 'right based approach to health', and 'socio-cultural determinants of GBV'. Nevertheless, contents related to SDH and health equity were completely missing in their curricula. In case of pharmacy, the curricula did not cover any of the concepts including human rights, health equity, GBV and SDH (see Table 3.2 in Annex IV).

In-depth Interviews (IDIs)

In-depth interviews were conducted with course designers (Registrars of regulatory bodies), course implementers (that is, principals of medical institutions), and course users (teachers/facilitators who deliver the relevant courses for pre and in service medical programs). The focus of IDIs was to understand their perspectives about the coverage of concepts related to human rights, health equity, GBV, and SDH.

> *"Medical students must learn human rights. However, some mechanism should also be in place to evaluate the behaviour of doctors in terms of empathetic introspection with patients during their practice," said one Principal of Medical College from Lahore*

Data revealed that not a single pre-service medical program offered any specialized topics related to human rights. Nonetheless, almost all of the medical programs partly or superficially covered some general topics. Data found that MBBS/BDS program covered some topics related to definition of human rights, state of human rights and types of human rights in the course of 'Behavioral Science'. Nevertheless, GBV was covered only under the heading of "injuries" in the course of 'forensic medicine'. It shows that MBBS/BDS students were taught GBV within the bio-medical context by completely ignoring the socio-cultural circumstances leading to GBV in their communities. Resultantly, our in-service healthcare providers cannot provide comprehensive care to GBV victims. A majority of the participants viewed that in the absence of proper understanding of human rights and GBV, the medical student could not develop a good relationship with patients and treat them empathetically. The coverage of the concept of health equity in all of the pre-service medical programs was non-existent. Almost all of the participants of different categories highlighted that the concept of health equity was rarely discussed in the classes. In particular, the MBBS/BDS students were taught only about 'need based approach' and not beyond that. A majority of the participants viewed that proper understanding of specialized concepts of health equity could result in better performance of

> *"Doctor do not have enough time to listen the stories of GBV cases", stated one Principal of Medical College from Peshawar*
>
> *One Dean of Dentistry College from Karachi opined: "It is the job of a doctor to cure patients and not to get involved in their interpersonal conflicts."*

> *"Health equity should be integrated in health policy as well. Resultantly, Health policy directs the teaching and training of healthcare professional. So for true application of health equity it could be integrated in health policy", Said one Medical Superintendent from Quetta.*

doctors by equitable treatment of marginalized sections. In addition to lack of integration of health equity in the curriculum, SDH was only superficially discussed in MBBS/BDS curricula. It was highlighted by almost all of the participants that knowledge about SDH was critically important to properly understand the socio-cultural causes of diseases.

> *"Doctors are trained to detect and kill pathogens. They are not trained to understand the social causes of disease. This is how our medical education system is designed", shared Dean of a Dentistry College from Sindh.*

The participants belong to nursing and allied professions reported that human right dimension covered in their curricula was only 'rights of women and children' under the course of 'Ethics in Nursing' and 'Pediatrics Nursing'. Data revealed that nursing and paramedics programs did not directly cover topics related to human rights. Nevertheless, these topics were informally discussed in the class and covertly covered in their curricula. But because of lack of recognition, students did not consider it useful to learn. It consequently results in a gap between nurses' expected and actual behavior. Some of the participants linked this gap with the absence of courses/training on specialized concepts of human rights.

> *"Nurses should focus on sterilization, proper dispensation of drugs and implementation of doctors' instructions. They should be given training in these technical areas. Nurses should not waste time in discussing topics like human rights", said one Nursing Instructor from Baluchistan.*

> *"In the nursing training institutions, things are different. Student nurses and instructors are focused on technical things. There is no tendency of discussing abstract intellectual things like 'health equity'," said one senior Nursing Instructor from KPK.*

A significant number of participants suggested that education on human right issues and its application in the field would ultimately improve patient care. Contrary to this understanding, a small number of participants considered human right notion as 'western agenda' and slogan of NGOs or foreign organizations having no application in their cultural settings. A majority of the participants from all provinces except Punjab reported that GBV was discussed as a passing reference in classes and never given importance as a grave public health concern. However, in Punjab, nursing curriculum at least included introductory information related to GBV. The

> *Vice Principal of a Nursing College from Punjab shared: "Nurses are only taught how to take history of a patient but purely in a medical perspective."*

participants from Punjab opined that in the absence of proper training about handing GBV cases, nurses could not contextualize the cases of GBV and deal them judicially.

During IDIs with nursing professionals, the participants reported that the concepts related to health equity such as 'equity and healthcare delivery', 'healthcare needs' and 'basic care facilities' were considerably taught in their curricula. There was a growing concern that inadequate understanding of health equity could result in widening the gap between the patients and healthcare delivery. The participants from Punjab and Sindh reported that in certain rural areas healthcare professionals work under feudal system where affluent people have been given importance and vulnerable people were ignored. It is pertinent to mention that almost all of the participants from all categories of health professions stressed upon the inclusion of specialized concepts of health equity such as horizontal and vertical equity, health financing, and equity and efficacy of healthcare system.

> *"Training about dispensing and distributing the quality drugs is not enough, pharmacists should be trained about human rights and 'pharmaceutical care' too," said one Professor of Pharmacy from KPK.*

> *"GBV survivor may not visit to the doctor but must visit the pharmacy. A pharmacist can help to identify GBV cases, if they are properly trained in it", opined one Dean of Pharmacy from Sindh*

> *"Pharmacists are not trained to reduce inequities by modifying their communication strategies. They are not trained to meet the needs of marginalized group," said Chairman Department of Pharmacy from Baluchistan.*

IDIs with pharmacist revealed that pharmacy curriculum also covered only some introductory topics related to human rights and GBV under the course of 'Community Pharmacy' and 'Clinical Counseling Pharmacy' respectively. Consequently they had lack of knowledge of the link between human rights and GBV issues with their job description. A majority of the participants suggested the inclusion of specialized concepts of human rights and GBV in pharmacy curriculum, but some of the participants also opposed the idea and did not consider relevant to their profession. Similarly, the participants were aware about the significance of health equity for their profession. Although, they were not very clear about the

> *"It is not the responsibility of the pharmacist to provide public health information to people or patient, his/her task is just to provide the right," commented Professor of Pharmacy from KPK*

concept but were familiar pharmacists could enhance their scope of work by providing equitable access to medicines and information when needed by the patients. The pharmacy curricula just covered definition of GBV under the course of 'Clinical Counseling Pharmacy'.

Overall the data showed that a majority of the participants from six categories of healthcare professions were in favor of inclusion of human right, GBV, health equity and SDH in their curricula. Nevertheless, they had the fear that it would increase the stress for their students who were already overburdened because of many other subjects. With some exceptions, almost all of the participants emphasized that specialized topics such as definition of the concepts, their linkages with health, effect of socio-cultural factors, diagnosis, related legal and ethical issues, treatment and rehabilitation should be included in the curricula of pre-service medical programs.

> *"Our medical students are too occupied to memorize bio-medical facts. They don't have time and incentive to learn about notions like "health equity", said one Registrar of medical college from KPK.*

C-SWOT analysis with MBBS /BDS degree program institutions

C-SWOT analysis with principals and students of pre-service medical institutions revealed that at institutional level, there is general acceptance and relevance of the concepts such as human rights, health equity, GBV and SDH in their curricula. Currently, students are learning these concepts as hidden curricula during the class discussion. The acceptability and recognition of these concepts are the strengths for integration of such concepts in the curricula. The medical college can use these strengths to take advantage of the available opportunities including the collaboration with other institutions for sensitizing and training medical professionals on these issues. The strengths of medical institutions could also be used to overcome the threats which are in the form scarcity of human and financial resources, cultural limitation in addressing the GBV cases in medical setting.

Since no practical examination of the human rights concepts was given to students, therefore, they did not take interest in discussing these concepts during lectures. Additionally, students did not get any experience during the house job practices. In backdrop of these weaknesses, the medical institutions could take advantage of given opportunities which could help medical

institution to integrate human right based approaches in MBBS/BDS programs. Additionally, the administration of medical colleges could overcome the weaknesses by reducing the external threats appearing as structural, cultural, and organizational limitations (Details has been presented in Table 4).

Training Need Assessment (TNA)

TNA was conducted with medical students and doctors who were doing house job. It was done on a five point Likert scale (1 to 5) where 1 = don't know; 2 = heard about; 3 = heard about and understand the concept; 4 = practice the concept in workplace; 5 = advocates and tends to inculcate amongst colleagues – seniors, peers and juniors. TNA with medical students and house job residents found that a majority of them had only heard about some concepts of human rights, SDH and GBV but they did not know their applications. They identified following weaknesses in applications of these concepts:

- Ability to communicate with patients appropriately
- Considering confidentiality, self-esteem and anonymity of patients information
- Knowledge about patients' rights
- Known measures including legal and assuring patients respect and dignity

With respect to GBV, they identified the following points where they considered themselves ill-informed and lacked the capacity to help the patients:

- Ability to communicate with at risk families of GBV victims
- Ability to diagnose case of GBV at an early stage
- Ability to cope with patients stress while dealing with family
- Understanding of legal responsibilities for protecting at risk women

Regarding health equity, they were very clear about the concept. They lacked the understanding about the following:

- Attend patients with any discrimination of class, income and gender
- Equal treatment of equals
- More health care for those in need of more
- Practicing health equity while providing services

Similarly, they were not very clear how to apply the concept of SDH in their professional work. They highlighted the following weaknesses:

- Ability to address poverty related issues of poor families
- Ability to ask about social issues from patients
- Ability to identify community resources and legal services to vulnerable
- Able to identify patients with social needs.

Overall, the findings suggest that medical students, on average, were not very much acquainted with these topics. They were also not familiar with guidelines to ensure right-based approach in their daily practice.

Table 4. C-SWOT analysis of Pre-service Medical Institutions

Internal or External Attribute	Factors likely to lead to positive change and future improvement in the quality of the program	Factors which may compromise further improvement in the quality of the program
Inside the Institution (Internal Attributes)	**Strength** 1. Doctors themselves understand the importance and relevance of the curricula in advancement of their professional career; 2. the contents of courses are designed keeping in view the local realties, so the class room debate will both be interesting and rich learning experience for the participants; and 3. by participating in these courses, the doctors may feel more skilled to handle clinical encounters, they may be better skilled to handle patients with marginalized sections whose rights are more frequently violated.	**Weakness** 1.Doctors are overworked to learn new techniques of biomedicine, they may not have time or motivation to invest time on learning human rights related issues; 2. in the local cultural context, human rights debate is considered a part of 'foreign agenda', and some element may oppose it or consider it unnecessary; 3.in medical institutions, more prestige and resources go to curative techniques and approaches, human rights related matters are considered less important and peripheral; 4.medical intuitions may not have teachers having specialized knowledge about human rights issues. In the absence of such teachers, students may not develop interest in the subject; 5.for the last half a century, medical education in Pakistan has developed a culture of focusing on learning curative techniques and that culture has the power to reproduce itself. In such an environment, the new subject may not find space to grow.
Outside the Program (External Attributes)	**Opportunities** 1. Doctors may be able to relate the course contents with their every-day clinical life and considered themselves better equipped to deal with patients; and 2. there is chance of collaboration with other institutions who can provide resource person for teaching such concepts to students	**Challenges** 1.Qualified faculty may not be available especially who have the competence to teach human rights in medical settings; 2.one time introduction of curricula may not guarantee its continuity, it needs to be continuously updated. 3.The policy makers and curriculum designers need strong commitment for the continuity.

Table 5. Summary of Findings of Pre-Service Medical Institutions

Technique	Relevant courses related to Human Rights	Relevant courses related to Health Equity	Relevant courses related to GBV	Relevant courses related to SDH
Curricular Review	• The concepts of human rights were not adequately addressed in the curriculum of all of the pre-service medical programs • In MBBS/BDS curriculum, some aspects of human rights were partially and superficially covered in the course of 'Behavioral Science' under the heading of 'Medical Ethics' • The curriculum of nursing and paramedics covered some dimensions of human rights in the course of 'Sociology and Health' under the headings of 'basic human rights', 'right based approach to health'. • In case of pharmacy, the curricula did not cover any of the concepts of human rights.	• In all programs, the concepts of health equity were totally missing in the curricula	• In MBBS, some general aspects of GBV were partly included in the course of 'Forensic Medicine' under heading of 'crime against the newborn, infants and child'. • The curriculum of nursing and paramedics covered some dimensions of GBV in the course of 'Sociology and Health' under the headings of 'basic human rights', 'right based approach to health', and 'socio-cultural determinants of GBV'.	• In all the programs, SDH was completely missing in the curricula
IDIs	• Not a single institution offered any human rights related specialized topics related to human rights. Nonetheless, almost all of the medical programs partly or superficially covered some general topics. • MBBS program covered 'definition of	• The coverage of the concept of health equity in all of the pre-service medical programs was non-existent. • In Nursing, 'equity and healthcare delivery', 'healthcare needs' and 'basic care	• In MBBS program, GBV was covered only under the heading of "injuries" in the course of 'forensic medicine'. • In Nursing, GBV was discussed as a passing reference in classes and never given importance as a public health concern • In Pharmacy, only some introductory topics related to GBV under	• SDH was only superficially discussed in all of the curricula.

	human rights, state of human rights and types of human rights' in the course of 'Behavioral Science'. • In Nursing program, human right dimension was only 'rights of women and children' under the course of 'Ethics in Nursing' and 'Pediatrics Nursing'. • In Pharmacy program, only some introductory topics were covered under the course of 'Community Pharmacy' and 'Clinical Counseling Pharmacy'	facilities' were considerably taught.	the course of 'Community Pharmacy' and 'Clinical Counseling Pharmacy'	
C-SWOT	**Strengths** • Healthcare providers acceptability and understanding of the importance and relevance of the curricula **Weaknesses** • More importance to bio-medicine. Doctors are overworked to learn new techniques of biomedicine • Lack of time or motivation to invest time on learning human rights related issues • Local cultural mindset that considers 'human rights and related issues' as 'western agenda' • Lack of teachers having specialized knowledge about human rights issues at medical institutions **Opportunities** • Strong relevance of the concepts with healthcare providers professional practice • Opportunity of collaboration with other institutions who can provide resource persons **Challenges:** • The continuity and sustainability of the course • Lack of political will and commitment of curriculum designers			

3.2 Findings Related to In-Service Healthcare Programs

Review of curricula

After reviewing the contents of curriculum of various public health institutions of Pakistan, it was noted that some aspects of human rights were covered under the subject of "reproductive health." The topics included gender and health, gender specific determinants of health, gender and mental health, gender inequality, gender related policies and gender responsive budgeting. The coverage of the concept of health equity was limited to topics such as ethical issues in healthcare. GBV related topics were insufficiently addressed in the curricula of almost all of the institutions, except one, where GBV was taught under the course of "Reproductive health" Overall the coverage of cross-cutting notions of human rights (e.g. health rights, health equity, SDH, GBV) were inadequate, sketchy and superficial.

In LHW training program, health equity was partially and indirectly covered under the topics of "interpersonal communication skills" and "community organization." Similarly, human right issues were partly and indirectly covered under the topics of "care of sick" and "maternal health" and SDH was partially covered under the topics of "Hygiene, water and sanitation". Nevertheless, there was not even a single topic included related to GBV and gender issues.

IDIs and FGDs

A majority of public health practitioners from Punjab during FGDs viewed that public health discipline covered some of the topics related to human rights, health equity and SDH in its curricula. However, these topics were tiny part of some courses rather than being an independent course. Contrarily, in-service physicians and doctors reported that these topics were not at all included in the course outline of their training programs. Some of the health managers argued that human dignity and health equity need an independent course and not just indirect reference. "We must take these issues seriously

> *"It is important to include topics such as 'patient rights' and 'cultural barriers to human rights' in the CME sessions for doctors", opined Registrar of JPMC from Karachi*

> *"Knowledge about SDH will enable the public health professionals to understand the non-medical factors of epidemics which may reduce the burden of disease," said Associate Professor of Community Medicine from Lahore*

otherwise health inequality will further worsen" said assistant director, PSPU from Lahore. "Indirect and passing references in the curriculum on human rights and health equity related issues are not sufficient", said one Head of Department of Community Medicine from Lahore. There was a broader consensus and deeper consciousness among the participants that the curriculum should illuminate human right issues in such a way that the practitioners could be capable of providing some relief to the deprived and marginalized.

> *"There should be mandatory training sessions on social issues related to health for health professionals, so they can address such issues in their day to day practice", said Director of Maternal and Child Health Program from Punjab*

The issue of GBV was ideologically contested and culturally sensitive. Most of the participants were aware about the international debate on GBV as public health issue. However, their opinion and perspective were largely shaped by media rather than the result of specialized training. This may be the reason that almost all of the participants reported that they did not learn about GBV comprehensively in their curricula. A majority of in-service doctors and health practitioners were not clear about the link between GBV and health nor do they consider violence as public health problem. "We only treat GBV within bio-medical perspective, we never crossed our minds to think it as a human right issue" said one family physician from Lahore.

> *"To reduce health inequities, it is essential to understand health equity and health disparities at first. Thus, health equity should be included in public health curriculum," said one Professor of Community Medicine form Lahore*

> *"GBV survivors need not only medical treatment but also require social rehabilitation, and this could not be achieved until the medical and public healthcare professionals are not trained to provide comprehensive care including medical and social support," said one Head of Community Medicine from Punjab.*

Unlike GBV, health equity was an abstract concept for the participants. Almost all the participants had heard the term "health equity", though lacked its in-depth understanding**.** They reported that health equity as a subject was not introduced though the topic of health finance partly dealt it. Some of the participants suggested that health equity should be taught by citing real life examples. Some of

> *"Once I asked a survivor about her experience of violence, her husband warned me not talk to my wife about 'irrelevant things [referring to their domestic issues]. He threatened me that in this case you will be fired from my job", said one Family Physician from Lahore.*

them viewed that health information, empowering women and minorities will help to attain health equity. “just talking about health equity without making doctors aware of the ground realities will not be helpful”, said Director of provincial MNCH program in Lahore. The concept of SDH was also not very easily understood by the participants. All the health practitioners and health managers reported that they were not trained to comprehend SDH. However, the knowledge of public health practitioners was better as they had studies social causes of disease in their training. By having realization of the importance of SDH, most of the participants emphasized the inclusion of health equity and SDH in their in-service training program.

IDIs with LHWs found that topics related to human rights and GBV were superficially discussed during their training sessions. A majority of LHWs were in favor of integration of such concepts in their training contents by using locally understandable language. Nevertheless, a facilitator of LHW training program from Punjab perceived that it was very difficult to discuss such abstract concepts like human rights, SDH and related topics because of LHWs’ poor educational background. “If we raise the educational qualification for LHWs, then it is possible that they understand these concepts”, suggested another facilitator from Sindh. However, a majority of the participants from Punjab and KPK argued that LHWs are fairly capable of understanding human right and health equity related topics provided the curriculum is designed according to their level of education and job description.

> *“Being community worker, LHWs are the main stakeholder in identifying and screening cases of GBV. Nevertheless, LHWs are not trained and utilized to provide help and support to victims,” opined a LHW Training Program Instructor from Sindh.*

> *“Being ‘health educator’ LHWs are in dire need of understating SDH, so they can deliver appropriate preventive messages and care to community”, said LHW Program Coordinator, Punjab.*

C-SWOT Analysis

C-SWOT analysis with head of public health institutions and students from four provinces and Islamabad found that almost all of the participants were in favor of recognition of the concepts of human right, health equity and GBV in the curricula. This acceptability and recognition of the concepts were considered as the strengths of public health institutions. The participants also highlighted some of the concerns or weaknesses of their institutional capacity for incorporating these concepts in public health curricula. Insufficient number of teachers having both health and social sciences background/qualification were the main weakness. Nevertheless, they suggested that this can be overcome by academic collaboration with other universities having social science departments. Moreover, the public health institutions can also overcome the weaknesses by reducing the external threats appearing as structural and cultural limitations. (see Table 6).

> *"A deeper and proper understanding of the concept of health equity can contribute in reducing the huge gaps of health inequities at grass-root level", opined Dean of Institute of Public Health from Lahore*

Table 6. C-SWOT Analysis with In-service Institutions

Inside the program (Internal Attributes)	**Strengths** 1. Increasing coverage of health rights related issues in mass media and in professional forums, the public health professional have high awareness about the importance of these issues in their career. 2. It will be easy to integrate the two credit hours courses on human rights in the main curricula 3. Conceptually the course is designed to strengthen the existing courses on humanities and social science (e.g. Medical sociology, Medical ethics, etc.). The public health students are not entirely unfamiliar with such topics. So the strength of this course to build on the existing courses. 4. There is high acceptability and understanding of relevance of the concepts	**Weaknesses** 1. Strict regime of recognition/accreditation of courses might create bottlenecks in the introduction of human rights subjects 2. If credit points are not given to these courses, students might not take interest. 3. At initial stage, lack of coordination with other institution/organization could undermine the success of the courses 4. Though lot of scientific literature on human right exists, yet literature illuminating the local health right issues is still lacking. Absence of comprehensive knowledge base could be one weakness/threat for the success of the course.
Outside the program (External Attributes)	**Opportunities** 1. Leading publishing houses and recognized journals always go for article having perspective on human rights so the doctors may have incentives to learn about health rights 2. For the last ten years, government has established many new universities at the district level with strong departments of social science and humanities. The medical institutions, which do not have teachers of social science, may request the neighboring university for visiting faculty to teach the curriculum on human rights. 3. Science of public health has becoming increasingly interdisciplinary. Introducing courses on human rights at this stage would be well received both by the students and teachers. 4. Role of Provincial Health Departments, Health Ministry local NGOs, and civil society organization is also very important. By making them onboard and sensitizing them about the significance, the program can be initiated at pre and in-service level.	**Challenges** 1. Success of a particular program depends on the qualified and dedicated teaching staff. The public health institutions need to invest to develop their faculty in this particular area of specialty. 2. Just introducing new courses is not enough. For the success of these courses, it is important to create awareness among all the stakeholders about the importance of human rights and health right education at all levels of medical education. 3. Just introducing the courses at one level (e.g. at undergraduate level) or at one cadre of health force is not enough. These course need to be introduce at all levels and all medical professionals (e.g. doctors, paramedics, allied health professionals). An isolated action will not be helpful. 4. At policy making level, political commitment is essential for sustainability of the initiatives. All the stakeholders must realize that without formal training of the health professionals, human rights and health rights of the population cannot be guaranteed.

Training Need Assessment (TNA)

TNA was conducted with in-service doctors, nurses, public health practitioners and LHWs from four provinces. It was done on a five point Likert scale (1 to 5) where 1 = don't know; 2 = heard about; 3 = heard about and understand the concept; 4 = practice the concept in workplace; 5 = advocates and tends to inculcate amongst colleagues – seniors, peers and juniors. TNA with public health practitioners found that a majority of them had heard about the concept of human rights and SDH and their average score was 4 of 5 on Likert scale, whereas, the average score was 2 of 5 on Likert scale in health equity and GBV. The findings suggest that in-service public health practitioners were well conversant with some of the concepts but lacked the application of the notion of health equity and GBV in their work.

TNA with doctors revealed that a majority of doctors had only heard about and understood the concepts of human right, GBV and SDH and their average score was 3 of 5 on Likert scale. However, their knowledge and practice about health equity was below average (2 of 5). Many doctors confused health equity with health inequality. This analysis suggests that doctors, on average, were not well conversant with these concepts which ultimately affect the application of these concepts in their professional practice. Overall, doctors felt the need for training in the following areas:

- Knowledge about patients' rights and known measures including legal for assuring respect of human being
- Practical aspect of health equity while providing services
- Ability to communicate with at risk families of GBV
- Knowledge about guidelines and protocols in diagnosing GBV cases at an early stage
- Understanding legal responsibilities for protecting at risk women
- Ability to address poverty related issues of poor families
- Ability to identify community resources and legal services to vulnerable

TNA with LHWs found that a majority of LHWs had only heard about the concept of human rights and SDH and their average score was 2 of 5 on Likert scale. Overall, the findings suggest that LHWs, on average, were not very much acquainted with these topics. They were also not familiar with guidelines to ensure right-based approach in their daily practice. Overall, the

findings of TNA with LHW suggest a need for training in almost all of the topics of these concepts for an effective integration of human right approaches in their daily practices.

TNA was conducted with nurses from each of four provinces. The results of TNA demonstrated that nurses possessed low competencies to practice human rights approaches in their practice. Owning to this inadequacy of competencies, a majority of nurses had only heard about the concept of human rights as the average score was 2 of 5 on Likert scale, whereas, the average score was 3 of 5 on Likert scale in health equity, GBV and SDH. On average, the findings suggest that nurses were not highly accustomed to these topics and they did not know how to incorporate these concepts in their professional practice. This analysis of TNA suggests need for training in the following areas:

- Awareness of human rights concepts
- Ability to communicate with patients appropriately
- Considering confidentiality, self-esteem and anonymity of patients information
- Knowledge about patients' rights
- Known measures including legal and assuring patients respect and dignity
- Ability to communicate with at risk families of GBV victims
- Ability to diagnose case of GBV at an early stage
- Ability to cope with patients stress while dealing with family
- Understanding of legal responsibilities for protecting at risk women
- Knowledge of health equity
- Equal treatment of equals
- More health care for those in need of more
- Practicing health equity while providing services
- Ability to ask about social issues from patients
- Ability to identify community resources and legal services to vulnerable
- Ability to identify risky health behaviors
- Ability to identify patients with social needs.

Data showed that, among all the medical professional cadres right from doctors to health practitioners to LHWs, there was inadequate awareness and understanding about various dimensions of human rights. Health practitioners including doctors' level of awareness and understanding were higher than the paramedics; but overall, comprehensive understanding of the concepts were lacking. Their commitment to implement these concepts to their professional practice was almost non-existent. This state of affairs underline the urgency of introducing human rights related courses at levels of medical education. Understandably, without imparting proper training and professional socialization about the importance of human rights, Pakistani healthcare system cannot achieve health equity nor its professionals can understand social determinants of health and provide appropriate care to the victim of GBV.

Table 7. Summary of Findings of In-Service Medical Institutions

Technique	Relevant courses related to Human Rights	Relevant courses related to Health Equity	Relevant courses related to GBV	Relevant courses related to SDH
Curricular Review	• In public health program, some aspects of human rights including 'gender and health, gender specific determinants of health, gender and mental health, gender inequality, gender related policies and gender responsive budgeting' were covered under the subject of "reproductive health." Overall, the coverage of cross-cutting notions of human rights was inadequate, sketchy and superficial. • In LHW program, human right issues were partly and indirectly covered under the topics of "care of sick" and "maternal health".	• The coverage of the concept of health equity was limited to topics such as ethical issues in healthcare. • In LHW training program, health equity was partially and indirectly covered under the topics of "interpersonal communication skills" and "community organization."	• GBV related topics were insufficiently addressed in the curricula of almost all of the institutions, except one, where GBV was taught under the course of "Reproductive health"	Nevertheless, there was not even a single topic included related to GBV. In LHW program, SDH was partially covered under the topics of "Hygiene, water and sanitation".
FGDs/IDIs	• Not a single institution offered any human rights related specialized topics related to human rights. Nonetheless, almost all of the medical programs partly or superficially covered some general topics. • MBBS program covered 'definition of human rights, state of human rights and types of human rights' in the course of 'Behavioral Science'. • In Nursing program, human right dimension was only 'rights of women and children'	• The coverage of the concept of health equity in all of the pre-service medical programs was non-existent. • In Nursing, 'equity and healthcare delivery', 'healthcare needs' and 'basic care facilities' were considerably taught.	• In MBBS program, GBV was covered only under the heading of "injuries" in the course of 'forensic medicine'. • In Nursing, GBV was discussed as a passing reference in classes and never given importance as a public health concern • In Pharmacy, only some introductory topics related to GBV under the course of 'Community Pharmacy' and 'Clinical Counseling Pharmacy'	• SDH was only superficially discussed in all of the curricula.

	under the course of 'Ethics in Nursing' and 'Pediatrics Nursing'. • In Pharmacy program, only some introductory topics were covered under the course of 'Community Pharmacy' and 'Clinical Counseling Pharmacy'			
TNA	• In-service public health practitioners were well conversant with some of the concepts of human rights and SDH but lacked the application of the notion of health equity and GBV in their professional practice • A majority of doctors had only heard about and little bit understood the concepts of human right, GBV and SDH. However, their knowledge and practice about health equity was poor. Many doctors confused health equity with health inequality. Doctors, on average, were not well conversant with these concepts which ultimately affect the application of these concepts in their professional practice. • TNA with LHWs found that a majority of LHWs had only heard about the concept of human rights and SDH. LHWs, on average, were not very much acquainted with these topics. They were also not familiar with guidelines to ensure right-based approach in their daily practice.			
C-SWOT	**Strengths** • High acceptability and understanding of the importance and relevance of the concepts **Weaknesses** • Strict regime of recognition/accreditation of courses • Lack of students interest if credit points are not given to these courses • Lack of coordination with other institution/organization • Lack of relevant literature illuminating the local health right issues is still lacking. **Opportunities** • Strong relevance of the concepts with public health practice • Opportunity of collaboration with other institutions who can provide resource persons • Interdisciplinary nature of public health discipline **Challenges:** • The continuity and sustainability of the course • Lack of political will and commitment of curriculum designers • Lack of qualified resource person having both health and social science background			

Summary of findings, conclusion and recommendations for curricula contents and structure

The findings of the present assignment revealed that human rights-based approach and equity principles were highly deficient at all levels of healthcare service delivery. Public health practitioners, health mangers and other medical professionals were not well familiarized with the concept of human rights, GBV, health equity and SDH and their linkages with health of patients. Findings of the curricula review of different pre and in-service medical program showed that the concepts of human rights, health equity, SDH and GBV were not adequately addressed in their syllabi. Nevertheless, some aspects of human rights and GBV were partially and superficially covered. Overall the coverage of cross-cutting notions of human rights (e.g. health rights, health equity, SDH, GBV) was inadequate, sketchy and superficial.

The IDIs and FGDs data found that each category of health professionals except public health practitioners reported their in-adequate knowledge about human rights related issues. Almost all of the participants were in favor of integration of these specialized concepts in curriculum in the context of their day-to-day professional life and refresher training in human rights with special reference to health equity, SDH, and GBV. In the TNA, the in-service healthcare professionals underlined the need to learn the art of practicing and applying human rights perspective in encountering the patients in various clinical and non-clinical settings.

At institutional level, the findings of the C-SWOT revealed that medical institutions had some strengths and opportunities, including acceptability and recognition of the concepts in their profession, to incorporate human rights perspective in their curriculum. Though they shared some weaknesses and challenges including recognition of the course from regulatory bodies, lack of resource persons, and overburdened nature of job of healthcare professionals, yet there was high degree of willingness on the part of all stakeholders to incorporate human rights, health equity, SDH and GBV in their curriculum. During C-SWOT, many heads of the institutions viewed that incorporating human rights was not just adding few topics or courses in the curriculum. They viewed that it needed high degree of commitment both at policy and implementation levels. To achieve this objective, the institutions required financial resources, trained human resource and political commitment and synergistic efforts.

Given this backdrop, there is a need of practically relevant human rights based education for all categories of healthcare providers. Application of human right based approach in healthcare is intrinsic in alleviating human suffering, promoting health and well-being in general, and those of the marginalized in particular. Based on the review of the existing curricula in different settings of medical education as well as on the findings of the primary data generated by the field study, a model curriculum was developed for each category of pre-service (MBBS/BDS, nursing, pharmacy, paramedics) and in-service health professionals (public health practitioners and community health workers including LHWs). Each category of healthcare professionals have different job descriptions and different needs, therefore the contents of the curriculum or training programs have been tailored accordingly.

During development of model curricula, "objective model approach" was adopted. The whole process of model curricula development was spearheaded by a steering committee – under which there was a curriculum design committee comprising of the technical experts in four disciplines including human rights, health equity, GBV, and SDH. The modal curriculum comprised of four modules including human rights, health equity, GBV, and SDH. Each module covered various sessions followed by different units. For each category of healthcare providers, each session contained different units, which were included according to their job description. The last section of the assignment deals with strategic recommendations and implementation plan for model curricula.

Chapter 4: Model Curricula

Health as a human right concern appears to be inadequately addressed at various levels of medical education in Pakistan. Generally, the medical curriculum and in-service training programs pay a little attention to introducing the notions of human rights including SDH, health equity and GBV at various tiers of medical education. The findings of this assignment also provide the evidence that all categories of healthcare providers have inadequate, superficial and imprecise knowledge about these concepts. As a result, they are relatively less sensitive and incompletely aware of the human rights aspects while treating their patients. Given this backdrop, there is an urgent need of integration of human rights based approaches in medical education at both in and pre-service level. This modal curriculum is a step in this direction.

4.1 Structure of Curricula

The curriculum for each category of healthcare professional contains four modules, that is, human rights, gender based violence (GBV), health equity, and social determinants of health (SDH). Each module consists of various sessions. As each category of healthcare providers have different job description and different learning and training needs, so each session contains different units according to their job description. For example, for doctors, dentist and public health professionals, five modules have been included which cover most of the dimensions of these concepts. As health practitioners and health mangers are also involved in policy making and program development at broader level, so their curriculum is more detailed on human right, GBV, health equity and SDH than other healthcare providers. Nevertheless, for LHWs, the focus of curricular contents is on the basic concepts and understanding of protocols for screening and referring the patients to the required services. The table 12 below shows a glimpse of this difference in units under each session

4.2 Contents of Curricula

4.2.1 Contents and distribution of credit hours of curriculum for MBBS/BDS/MPH

Following is a suggested format, which the regulatory body, PMDC and HEC in this case, can adjust. It is a flexible arrangement in order to give room to the facilitator in using teaching and training techniques appropriate for the curricular contents.

Table 8. Detail about credit hours and teaching methods for MBBS/BDS/MPH Program

S.#	Type of programme	Subject/ module title	Credits	Contact hours	Teaching methods
1.	Pre-service for undergraduate medical and dental students	Human rights	2	10	Lectures Library/ self-reading Assignments
2.		Gender based violence	2	10	
3.		Health equity	2	10	
4.		SDH	2	10	
5.	Master in Public Health Program	Human rights	2	10	Lectures Library/ self-reading Assignments
		Gender based violence	2	10	
		Health equity	2	10	
		SDH	2	10	
Total pre-service (undergraduate medical and dentistry education)			**8**	**40**	
6.	In-service training for public health professionals and health care practitioners	Human rights and gender based violence	3	24	Workshop to use: Lecture Group work Project/ case study Library/ self-reading
7.		Health equity and social determinants of health	3	24	
Total in-service (public health professionals and health care practitioners)			**6**	**48**	

4.2.2 Contents and distribution of credit hours of curriculum for nursing program

Following is a suggested format for pre-service and in-service education and training of nurses, which the respective regulatory body, i.e. PNC and HEC, can adjust. A flexible arrangement is however suggested in order to give room to the facilitators to design the curricular contents and accordingly use appropriate teaching and training techniques.

The required qualification for entry into Baccalaureate of Science in Nursing (BSN) like medical and dental colleges is intermediate premedical (biology, chemistry and physics). It is assumed that both categories of students are likely to possess equal level of understanding and comprehension. Therefore, it is suggested that the pre-service curriculum on Human Rights, Health Equity and Gender Based Violence in Public Health Response of Pakistan, as proposed for the undergraduate medical and dental colleges may be taught in Nursing Colleges/Institutes with adjustments keeping in view the nursing processes and their role in public health response.

Table 9. Detail about credit hours and teaching methods for nursing program

S.#	Type of Programme	Subject/ module title	Credits	Contact hours	Teaching methods
1.	Pre-service for Baccalaureate of Science in Nursing	Human rights	2	10	▪ Lectures ▪ Library/ self-reading ▪ Assignments
2.		Gender based violence	2	10	
3.		Health equity	2	10	
4.		Social determinants of health	2	10	
Total pre-service (Baccalaureate of Science in Nursing)			8	40	
5.	In-service training for registered nurses	Human rights and gender based violence	3	24	Workshop to use: ▪ Lecture ▪ Group work ▪ Project/ case study ▪ Library/ self-reading
6.		Health equity and social determinants of health	3	24	
Total in-service (registered nurses)			**6**	**48**	

Currently, most of the nurse workforce in Pakistan hold diploma in general nursing, which has metric degree with science as entry qualification. But, Pakistan Nursing Council (PNC), which is a regulatory body for nursing and midwifery, has now set a deadline that no new entrant to diploma in general nursing shall be taken beyond 2018. And the schools of nursing should be upgraded as college of nursing to conduct BSN. In addition, the existing nurse workforce should undergo BSN Post-RN, BSN. It is therefore suggested that workshops designed for the in-service training of health professionals and healthcare practitioners be adapted for administering to the in-service registered nurses.

4.2.3 Contents and distribution of credit hours of curriculum of pharmacy program

Following is a suggested format, which the regulatory body, PPC and HEC in this case, can adjust. It is a flexible arrangement in order to give room to the facilitator in using teaching and training techniques appropriate for the curricular contents.

Table 10. Detail about credit hours and teaching methods for Pharmacy program

S.#	Type of Programme	Subject/ module title	Credits	Contact hours	Teaching methods
1.	Pre-service for undergraduate Pharmacists	Human rights	2	10	Lectures Library/ self-reading Assignments
2.		Gender based violence	2	10	
3.		Health equity	2	10	
4.		Social determinants of health	2	10	
Total pre-service (undergraduate Pharmacists)			8	40	
5.	In-service training for Pharmacists	Human rights and gender based violence	3	24	Workshop to use: Lecture Group work Project/ case study Library/ self-reading
6.		Health equity and social determinants of health	3	24	
Total in-service (Pharmacists)			6	48	

4.2.4 Contents and distribution of credit hours of curriculum for LHWs

Following is a suggested format, which the regulatory body, Director General Health Services and Provincial Programme Director in this case, can adjust. It is a flexible arrangement in order to give room to the facilitator in using teaching and training techniques appropriate for the curricular contents.

Table 11. Detail about credit hours and teaching methods for Lady Health Workers Program

S.#	Type of Programme	Subject/ module title	Credits	Contact hours	Teaching methods
1.	Pre-service for LHWs	Human rights	2	10	Lectures Library/ self-reading Assignments
2.		Gender based violence	2	10	
3.		Health equity	2	10	
4.		Social determinants of health	2	10	
Total pre-service LHWs			8	40	
5.	In-service training for LHWs	Human rights and gender based violence	3	24	Workshop to use: Lecture Group work Project/ case study Library/ self-reading
6.		Health equity and social determinants of health	3	24	
Total in-service (LHWs)			**6**	**48**	

4.3 Integration of Curricula in each Degree Program

4.3.1 Integration with existing curriculum of MBBS/BDS/MPH

An assessment of the curricula in vogue in undergraduate medical and dentistry education was reviewed to determine the coverage of topics: human rights, gender based violence, health equity and social determinants of health.

Table 12. Integration of developed module into exiting curriculum of MBBS/BDS/MPH

Category	Level of education/ training	Subject/ module title	Integration with current curricula
Undergraduate medical and dentistry students	Pre-service	Human rights	"Behavioural Sciences"
		GBV	"Forensic Medicine"
		Health equity	"Community Medicine"
		SDH	"Community Medicine"
Public health professionals and health care practitioners	In-service	Human rights and gender based violence	This is a new initiative and it is proposed that 3-days workshop should be organized to impart knowledge about Human rights and gender based violence.
		Health equity and social determinants of health	This is a new initiative: 3-days workshop on "Health equity and social determinants of health"

Drawing on the results of the curricular review, above scheme for integrating the proposed topics into the existing curriculum taught in the undergraduate medical and dental institutions is suggested. The concerned regulatory bodies, i.e. PMDC and HEC may review and adjust as per the requirements of the profession. Likewise, a scheme for in-service training of public health professionals and health care practitioners is proposed.

4.3.2 Integration in existing curriculum of nursing program

An assessment of the curricula in vogue for Baccalaureate of Science in Nursing was reviewed to determine the coverage of topics: human rights, gender based violence, health equity and social determinants of health. It revealed that apart from 'human rights[3]', other modules are not covered.

Table 13. Integration of developed module into exiting curriculum of Nursing

Sub-category	Level of education/ training	Subject/ module title	Integration with current curricula
Bachelor of Science in Nursing	Pre-service	Human rights	Currently taught as Unit X of the BSN curriculum. It will not be repeated. However, the module is kept for facilitator's use.
		Gender based violence	This module, since not covered, may be integrated into the current curriculum.
		Health equity	Both modules, since not covered, may be integrated into the current curriculum.
		Social determinants of health	
Registered nurse	In-service	Human rights and gender based violence	This is a new initiative: 3-days workshop on "Human rights and gender based violence". The facilitator may use unit X of the curriculum of BSN to substantiate contents.
		Health equity and social determinants of health	This is a new initiative: 3-days workshop on "Health equity and social determinants of health"

[3]Nursing – BSN curriculum in Unit X: Human Rights, covers topics that at the end of the unit, the learners will be able to: 1. Recognize basic human rights; 2. Define human rights; 3. Appreciate the importance of human rights; 4. Conceptualize a rights based approach to health; 5. Identify nurses' role in client centered health care approach; 6. Discuss the concept of poverty; 7. Describe poverty and related theories; 8. Discuss poverty distribution; 9. Identify the impact of poverty in Pakistani society; 10. Explore the relationship between poverty and health.

Drawing on the results of the curricular review, above scheme for integrating the proposed topics into the existing curriculum taught in the colleges of nursing (as mentioned above, the current schools of nursing will be upgraded to colleges of nursing and the hitherto run diploma in general nursing will be replaced with BSN) is suggested. The concerned regulatory bodies, i.e. PNC and HEC may review and adjust as per the requirements of the profession. Likewise, a scheme for in-service training of registered nurses is proposed.

4.3.3 Integration in existing curriculum of pharmacy program

An assessment of the curricula in vogue in undergraduate Pharmacy education was reviewed to determine the coverage of topics: human rights, gender based violence, health equity and social determinants of health. Drawing on the results of the curricular review, following scheme for integrating the proposed topics into the existing curriculum taught in the undergraduate Pharmacy institutions is suggested. The concerned regulatory bodies, i.e. PPC and HEC may review and adjust as per the requirements of the profession.

Table 14. Integration of developed module into exiting curriculum of Pharmacy

Sub-category	Level of education/ training	Subject/ module title	Integration with current curricula
Undergraduate Pharmacy Institutions	Pre-service	Human rights	"Islamic Studies" and "Community Pharmacy"
		Gender based violence	"Forensic Pharmacy"
		Health equity	"Community Pharmacy"
		Social determinants of health	
Registered pharmacists	In-service	Human rights and gender based violence	This is a new initiative: 3-days workshop on "Human rights and gender based violence".
		Health equity and social determinants of health	This is a new initiative: 3-days workshop on "Health equity and social determinants of health"

4.3.4 Integration in existing training program of LHW

An assessment of the curricula in vogue in Lady Health Workers Training education was reviewed to determine the coverage of topics: human rights, gender based violence, health equity and social determinants of health. Drawing on the results of the curricular review, following scheme for integrating the proposed topics into the existing curriculum taught in the undergraduate medical and dental institutions is suggested. The concerned regulatory bodies may review and adjust as per the requirements of the profession and translation of the curricula into local languages.

Table 15. Integration of developed module into exiting curriculum of Lady Health Workers

Sub-category	Level of education/ training	Subject/ module title	Integration with current curricula
Pre-service LHWs	Pre-service	Human rights	These Modules can be integrated in the first three months of their initial training
		Gender based violence	
		Health equity	
		Social determinants of health	
In-service LHW	In-service	Human rights and gender based violence	This is a new initiative: 3-days workshop on "Human rights and gender based violence" can be integrated in their refresher training program
		Health equity and social determinants of health	This is a new initiative: 3-days workshop on "Health equity and social determinants of health" can be integrated in their refresher training program

4.4 Overview of difference in units for each session according to job description of health professionals

Table 16 presents the overview of difference in units for each session according to job description of health professionals.

Table 16. Overview of difference in units for each session according to job description of health professionals

Name of Session	Units			
	MBBS/BDS	**Pharmacy**	**Nursing**	**LHW/ Paramedics**
Human Rights (HR)	1. Definition, types, and evolution of human rights 2. Principles of human rights 3. International, national commitments, and instruments of human rights in Pakistan 4. Human rights and healthcare services integration and linkages 5. Guidelines and tools to apply human rights based approaches in public health response	1. Definition, types, and evolution of human rights 2. Principles of human rights 3. International, national commitments, and instruments of human rights in Pakistan 4. Guidelines and tools to apply human rights based approaches in public health response	1. Definition, types, and evolution of human rights 2. Principles of human rights 3. Guidelines and tools to apply human rights based approaches in public health	1. Definition, types, principles and evolution of human rights 2. Guidelines and tools to apply human rights based approaches in public health response
Health Equity (HE)	1. Introduction to Equality and Health Equity 2. Equity, accountability and healthcare delivery in relation to healthcare needs 3. Equity and health financing in relation to ability to pay 4. Guidelines and tools for applying health equity approach and analysis	1. Introduction to Equality and Health Equity 2. Equity and health financing in relation to ability to pay 3. Guidelines and tools for applying health equity approach and analysis	1. Introduction to Equality and Health Equity 2. Equity, accountability and healthcare delivery in relation to healthcare needs 3. Guidelines and tools for applying health equity approach and analysis	1. Introduction to Equality and Health Equity 2. Guidelines and tools for applying health equity approach and analysis

Name of Session	Units			
	MBBS/BDS	**Pharmacy**	**Nursing**	**LHW/ Paramedics**
Gender Based Violence (GBV)	1. Understanding GBV 2. Factors pertaining to GBV in Pakistan 3. International and national commitments related to GBV 4. Role of health sector to address GBV as a public health problem 5. Guidelines for treatment of GBV cases and health sector response	1. Understanding GBV (definition, types, and factors pertaining to GBV in Pakistan) 2. International and national commitments related to GBV 3. Guidelines for treatment of GBV cases and health sector response	1. Understanding GBV 2. Factors pertaining to GBV in Pakistan 3. Role of health sector to address GBV as a public health problem 4. Guidelines for treatment of GBV cases and health sector response	1. Understanding GBV 2. Factors pertaining to GBV in Pakistan 3. Guidelines for treatment of GBV cases and health sector response
Social Determinants of Health (SDH)	1. SDH Approaches to Public Health 2. Importance of addressing SDH to achieve universal health coverage and health equity 3. Guidelines for addressing and integrating SDH at policy and program level	1. SDH Approaches to Public Health and its significance 2. Guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action.	1. SDH Approaches to Public Health 2. Importance of addressing SDH to achieve universal health coverage and health equity	1. SDH Approaches to Community Health Sector 2. Guidelines for addressing and integrating SDH at community level through inter-sectoral action.

Model Curriculum for MBBS/BDS/MPH Programs

Introduction

Human rights seek to create respect for human dignity and promote human well-being. Human well-being and the protection of health is intrinsically linked to the universality of human rights (Gruskin, Mills, & Tarantola, 2007). In this context, the right to health stipulates that every human being has the right to the highest attainable standards of health including access to all medical services, quality healthcare, safety as well as adequate food at health care facility, healthy working conditions, and quality loving environment (Grover, 2010; Backman et.al., 2008). The existing healthcare system in Pakistan falls short of the required standards (Nishtar, 2010; Shaikh, & Hatcher, 2004). From another angle medical practitioners appear to have inadequate knowledge about human rights standards, protocols and obligations. Resultantly, it undermines quality healthcare delivery, specifically to marginalized population, particularly women and survivors of Gender Based Violence (GBV).

GBV is not only a social and public health issue but also a problem with grave implication for women's physical, sexual, mental and reproductive health (Western, 2013; Ellsberg, & Emmelin, 2014). In case of Pakistan, the pervasive patriarchal mindset, couched in the cultural milieu, has generated high rate of GBV. Studies suggest that healthcare providers/professionals are the first resort for most of the survivors of violence (Ashford & Feldman, 2010). Nevertheless, most of the healthcare professionals including doctors, dentists, and public health experts are not adequately trained on how to respond to GBV cases (UNFPA, 2013). Due to lack of appropriate training healthcare professionals are not playing proactive role in mitigating human rights violation and being instrumental in reducing health disparities.

Medical and health professionals need to be aware of health inequities as an important public health problem and also be familiar with concepts of health equity and Social Determinants of Health (SDH) (WHO, 2013; Friel & Marmot, 2011). Therefore, to provide a holistic and evidence-based care to patients, the nurses need to be aware about such concepts and obligations enshrined in the maxim "right to health". In this backdrop, this module is designed to equip health professionals including doctors, dentist, and public health practitioners with understanding about human rights, SDH, health equity, and GBV.

Learning objectives

This module consists of four sessions. The learning objectives are mentioned under each session.

Human Rights:

By the end of this session, the participants will be able to:

- understand the concepts of human rights and right to health;
- recognize the significance of the execution of the relevant national and international policies, treaties and commitments; and
- explore and apply guidelines of human rights based approaches in public health response of Pakistan.

Gender Based Violence:

By the end of this session, the participants will be able to:

- understand the concept of GBV and the significance of public health response;
- deal with the cases of GBV in the light of WHO guidelines;
- strengthen the capacity of health professionals to meet the practical and strategic needs of victims/survivors of GBV within the human rights framework; and
- ameliorating the trauma of victims.

Health Equity:

By the end of this session, the participants will be able to:

- understand reasons of health inequities
- identify barriers to health faced by population and communities with poor health outcomes; and
- comprehend the reasons for health disparities and their link to the human rights and social determinants of health; and
- develop approaches to improve health outcomes particularly for the vulnerable and marginalized populations.

Social Determinants of Health:

By the end of this session, the participants will be able to:

- understand the concept of social determinants of health;
- analyse the various levels at which health determinants operate and the interrelation between these determinants;

- acquire the skills to apply the SDH approaches to understand the structural factors underlying the impact of health policies and interventions; and

Methods and assessment

Teaching-learning strategy shall be interactive consisting of class discussions, studying the textbook material, participation in the class discussions, and doing the class assignments. The grade of the module will be based on an assignment (25%), presentation (25%), and a final paper (50%).

Session: Human Rights

Session structure

This session is divided into six units covering the various topics that have direct relevancy with the public health functioning.

Unit 1. Definition, types, and evolution of human rights

Unit 2. Principles of human rights

Unit 3. International, national commitments and instruments of human rights in Pakistan

Unit 4. Human rights and healthcare services integration and linkages

Unit 5. Guidelines and tools to apply human rights based approaches in public health response

Unit 1. Definition and evolution of human rights

In the last two decades, there has been a growing concern to promote human rights perspective in healthcare setting. The healthcare professionals' (HCP) knowledge about human rights can promote human dignity in medical practices. This unit is designed to enhance HCPs' understanding of the significance of human rights, right to health, and history of human rights in health sector.

Learning objectives

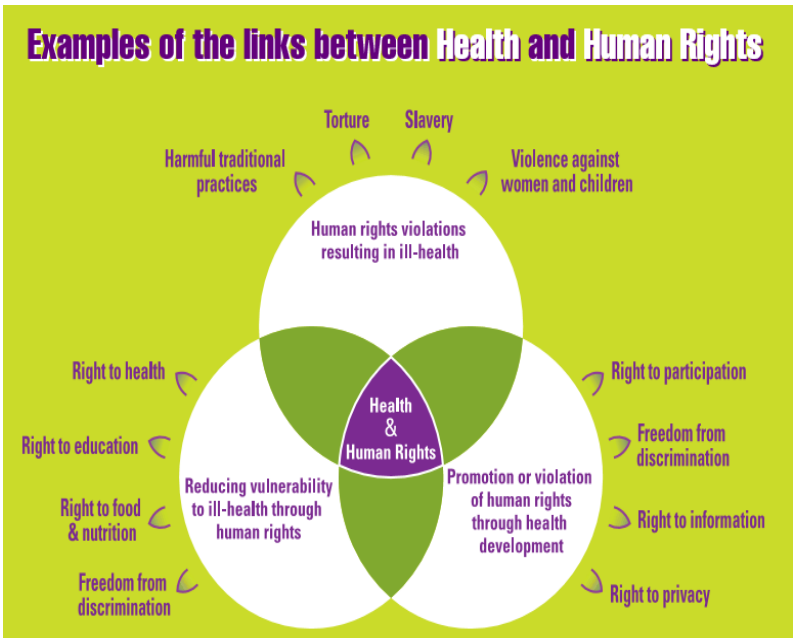
By the end of the training unit the participants will be able to:

- understand the concept of human rights and human rights to health
- learn evolution of its application to health; and
- explore different types of human rights and recognize the interrelationship among these rights;

Contents

Following are the contents to be covered under this unit:

1. Definition of terms:
    a. Human rights
    b. Right to health
    c. Right based approach to health
2. Evolution of the Human Rights concept
    a. Natural law doctrine
    b. Appearance and evolution of the first legal instruments for human rights protection
        i. Magna Carta Libertatum
        ii. Declaration of Rights from the state of Virginia
        iii. Universal Declaration of Human Rights (UDHR)
3. Categories of human rights
    a. Social rights
    b. Cultural rights
    c. Economic rights
    d. Civil rights
    e. Political rights



Source: WHO. Linkages between health and Human rights

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights. Health & Human Rights Publication Series Issue No.1, July 2002. Geneva, Switzerland.
2. UN. (2006). Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation. Office Of The United Nations High Commissioner For Human Rights. New York, Geneva.
3. Eugen,Ciobota.. Evolution of the Human Rights Concept. Territorial Office of the People's Advocate Institution from Târgu-Mureş.

Unit 2. Principles of Human Rights

The principles of human rights such as universality, indivisibility, participation, accountability transparency, equity, and non-discrimination are fundamental to achieve the right to health.

Having an adequate knowledge about these principles, the HCPs would be able to maintain patients' dignity and treat them without any discrimination.

Learning objectives

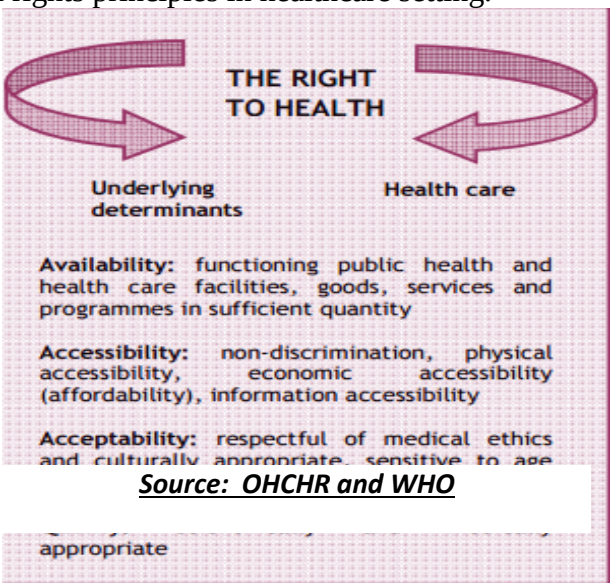
By the end of the unit the participants will be able to:

- understand the principles and elements of human rights to health; and
- recognize the implications of violations of human rights principles in healthcare setting.

Contents

Following are the content to be covered under this session:

1. Principles of human rights to health
    a. Universality
    b. Indivisibility
    c. Participation
    d. Accountability
    e. Transparency
    f. Equity
    g. Non-Discrimination
2. Elements of human rights to health
    a. Availability, Accessibility, Acceptability, and Quality (AAAQ)
    b. Integration of human rights principles in medical setting



Source: OHCHR and WHO

Suggested readings

1. OHCHR and WHO. A Human Rights-Based Approach to Health. Available at: http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf
2. WHO. (2002). 25 Questions & Answers on Health and Human Rights. Health & Human Rights Publication Series Issue No.1, July 2002. Geneva, Switzerland. .

Unit 3. International, national commitments, and instruments of human rights in Pakistan

Pakistan is the signatory of a number of human rights treaties and commitments which directly or indirectly address the right to health. However, the implementation of these commitments has to be fully ensured in the country. Among others, the HCPs are also in a dire need to be educated and trained about the national and international legal framework of human rights with a particular focus on right to health. In this backdrop, this unit aims to enhance the HCP's knowledge about national and international legal frameworks and its implication on health.

Learning objectives

By the end of the unit the participants will be able to:

- understand the significance and implications of national and international commitments on health priorities; and
- increase their knowledge about relevant international treaties ensuring right to health (such as UDHR, ICESCR, CRC, CERD, and CEDAW).

Contents

Following are the content to be covered under this unit:

1. Significance of international treaties and commitments
2. Importance of charter of Universal Declaration on Human Rights (UDHR)
3. Health to rights enshrined in:
    a. International Covenant on Economic, Social and Cultural Rights (ICESCR),
    b. Convention on the Rights of the Child (CRC),
    c. Convention on the Elimination of All Forms of Racial Discrimination (CERD),
    d. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
4. Human rights to health and Constitution of Pakistan

Suggested readings

1. WHO. (2008). The Right to Health. Office of the United Nations High Commissioner for Human Rights. Geneva, Switzerland.
2. IP3. (2013). Handbook on Human Rights for Parliamentarians, Committees and Secretariat Staff in Pakistan.
3. WHO. Country Cooperation Strategy for Pakistan 2011-17. Geneva, Switzerland.

Unit 4. Human rights and Healthcare Services Integration and Linkages

Health sector in Pakistan operates through horizontal and vertical programs. There is a lack of coordination among different programs which ultimately results in either the absence or duplication of services. Moreover, the linkages between different sectors is devoid of human rights perspective. In the given context, there is a need that all health sectors should be linked with each other through human rights perspective as a cross cutting agenda. Accordingly, this unit aims to enhance the understanding of HCPs about relationship between health rights and human rights.

Learning objectives

By the end of the unit the participants will be to:

- learn how the linkages between various stakeholders are important for improving service delivery;
- use human right as a cross cutting agenda among different sectors of health; and
- integrate human rights perspective in horizontal and vertical programs.

Contents

Following are the content to be covered under this unit:

1. Link between human rights and health
2. Significance of health linkages
3. Three levels of healthcare integration
    a. Macro-level – integrated care delivered across the full spectrum of services to the whole population.
    b. Meso-level – integrated care for a particular group of people with the same disease or condition.
    c. Micro-level – integrated care for individual service users through means such as care co-ordination, care planning or case management.

Source 3: Pike and Mongan. 2014

4. Integrative processes
    a. Organizational – health and social care team areas align with other departments.
    b. Clinical – care coordination with single point of contact
    c. Informational – patient records are accessible to the whole team.
    d. Financial – pooled health and social care budget.
    e. Normative – there are regular management-staff seminars.

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights.
2. Pike and Mongan. (2014). The integration of health and social care services. Health Research Board. Available at: http://www.hrb.ie/uploads/tx_hrbpublications/The_integration_of_health_and_social_care_services_2014.pdf

Unit 5. Guidelines and Tools to Apply Human Rights Based Approaches in Health Response

The application of human right based approaches at healthcare setting calls for a range of measures to eliminate human rights violations. In this regard, WHO has developed a number of guidelines which can be applied to protect human rights of patients for improved delivery of services.

Learning objectives

By the end of the unit the participants will be to:

- understand the institutional processes and healthcare responsibilities;
- learn the ethics and guidelines to provide equitable healthcare services; and
- knowledge about guidelines on human rights in patient care.

Contents (lecture)

Following are the content to be covered under this unit:

1. Institutional processes and healthcare responsibilities
2. Core ethical values and standard of good health practice
3. Promotion of supportive and enabling environment through availability, accessibility, and acceptability, and quality services (AAAQ)
4. Human rights of the Patients
    a. Respect of patient dignity
    b. Ensures access to care
    c. Protects safety of patients

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights. Health & Human Rights Publication Series Issue No.1, July 2002. Geneva, Switzerland. .
2. United Nations, Protect, Respect and Remedy Framework and Guiding Principles. Available at: http://business-humanrights.org/en/un-secretary-generals-special-representative-on-business-human-rights/un-protect-respect-and-remedy-framework-and-guiding-principles

3. PRETORIA. (2008). Guidelines for good practice in the health care professions general ethical guidelines for the health care professions. Available at: http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf

Session: Gender Based Violence

Session structure

This session is divided into six units covering the topics that are directly relevant with the public health functioning.

Unit 1. Understanding GBV

Unit 2. Factors pertaining to GBV in Pakistan

Unit 3. International and national commitments related to GBV

Unit 4. Role of health sector to address GBV as a public health problem

Unit 5. Guidelines for treatment of GBV cases and health sector response

Unit 1. Understanding GBV

GBV is a general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two, within the context of specific society. GBV is directed towards women and it disproportionately affects them across the globe.

Learning objectives

At the end of the unit participants will be able to:

- define GBV and understand its forms;
- understand the magnitude of the problem of GBV; and
- understand various explanations of GBV.

Contents

1. Definition of terms:
    a. Difference between sex and gender
    b. Gender Based Violence (GBV)
    c. Childhood sexual abuse
    d. Domestic violence
    e. Rape or Sexual assault
    f. Intimate partner violence
    g. Non-intimate partner violence

2. Types/forms of GBV
    a. Physical violence
    b. Psychological/Emotional violence
    c. Sexual violence
    d. Gender based discriminatory cultural practices (e.g child marriage, vani, karo kari etc.)
3. Prevalence of violence worldwide and in Pakistan

Suggested Readings

1. UNFPA. (2001). A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers. New York. United States.
2. WHO. (2014). Global Status Report on Violence Prevention 2014. Geneva. Switzerland.
3. WHO. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva. Switzerland.

Unit 2. Factors pertaining to GBV in Pakistan

GBV is a structural phenomenon embedded in the context of socioeconomic, cultural and political power relations. Like other developing countries, Pakistan also has a patriarchal society where men consider themselves superior to women and think violence against women as their moral legal right. Such erroneous perceptions result in the continuation of violence against women. In this context, it is necessary to understand the socio-cultural factors associated with GBV and its health consequences.

Learning objectives

At the end of the unit participants will be able to:

- understand social, cultural, economic and political factors that underpin the gender based violence; and
- Comprehend the health consequences of gender based violence

Contents

1. Social and Cultural Factors
    a. Patriarchal structure
    b. Violence as private family matter
    c. Discriminatory customs and practices
    d. Acceptability of violence as a means to resolve conflict

2. Economic Factors
    a. Women's economic dependence on men
    b. Limited access to employment
    c. Limited access to education
3. Political Factors
    a. Under-representation of women in different fields
    b. Domestic violence not taken seriously, as consider it family matter
4. Health consequences of violence
    c. Physical
    d. Psychological
    e. Sexual and reproductive

Suggested Readings

1. International Planned Parenthood Federation. (2000). A Good Practice Training Module for Health Care Professionals. South Asia Regional Office, New Delhi, India
2. USAID. (2010). Gender-Based Violence: Impediment to Reproductive Health.

Unit 3. International and national commitments related to GBV

Pakistan has adopted a series of national and international commitments pertaining to various issues of GBV. However, due to inadequate knowledge of legal structures and ethical guidelines, healthcare professionals are not fully prepared to play their proactive role in mitigating human rights violations including GBV. Given this situation, it is important to educate health professionals about national and international laws pertaining to GBV.

Learning objectives

At the end of the unit participants will be able to:

- understand the important role of national laws, institutional structures, international commitments, and ethical considerations in protecting and upholding rights of women against GBV;
- identify their role as service providers in supporting survivors to uphold their legal rights; and
- play their role in the interest of survivors of GBV.

Contents

1. International commitments
    a. Universal Declaration of Human Rights
    b. International Covenant on Civil and Political Rights
    c. International Covenant on Economic, Social and Cultural Rights
    d. Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

e. Convention on the Rights of the Child
f. Convention on the Elimination of Discrimination against Women
g. Vienna Declaration and Programme of Action
h. Beijing Declaration and Platform for Action
i. Millennium Development Goals

2. National laws and commitments

a. Constitution of the Islamic Republic of Pakistan.
b. National Plan of Action (NPA)
c. National Policy on Development and Empowerment of Women
d. National Strategic Framework for Family Protection
e. Protection of Women (Criminal Laws Amendment) Act, 2006
f. Acid Throwing Act, 2006
g. Domestic Violence (Prevention and Protection) Act, 2012

Suggested Readings

1. UN. (2014). Women's Rights are Human Rights. New York and Geneva.
2. Zaheer & Shamreeza (2013) Legal Protections Provided Under Pakistani Law against Anti-Women Practices: Implementation Gaps between Theory and Practice.
3. Anita M. Weiss (2010) Moving Forward with the Legal Empowerment of Women in Pakistan; United States Institute of Peace.

Unit 4. Role of Health Sector to Address GBV as Public Health Problem

GBV is a major public health problem that urgently needs to be addressed by the government and health organizations. Since health sector/professionals are usually the earliest point of contact for survivors of violence, their role becomes critical in addressing the GBV as a major public health problem. They can contribute in reducing violence by changing social attitudes towards GBV and projecting it as a public health problem. Additionally, by strengthening their linkages with other professionals, they can screen the cases of violence and refer them to need based services.

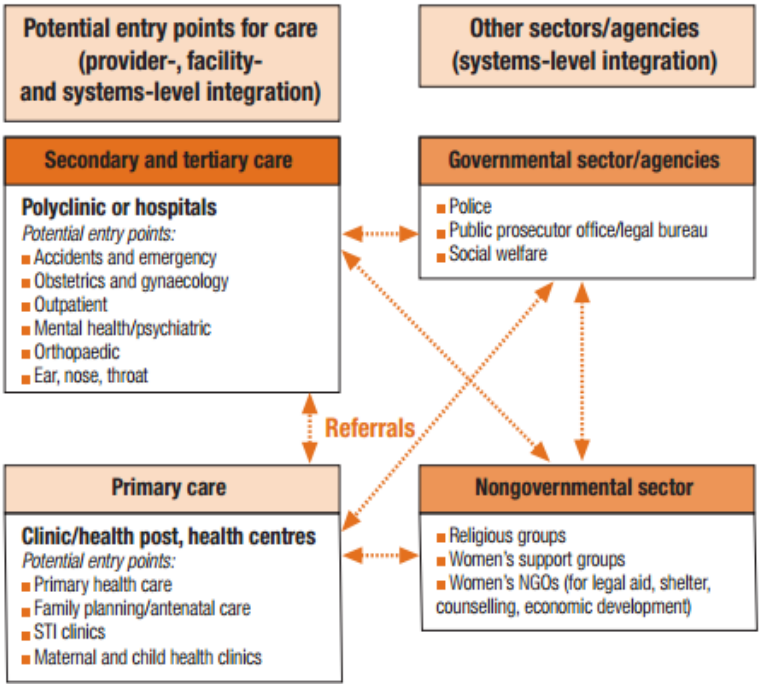
Learning objectives

At the end of the unit participants will be able to:

- understand their roles and responsibilities in supporting survivors of GBV;
- identify impediments that survivors face in assessing support services in a medical setting; and
- develop synergy with the other stakeholders including psychologists, lawyers, and welfare officers.

Contents

1. Significance and need for health sector response for GBV
2. Impediments medical setting for GBV survivors
   a. Lack of multi-sectoral referral network at the provincial, district and community level
   b. Lack of capacity of healthcare providers to address GBV
   c. Lack of integrated Management Information System for documenting GBV cases
   d. Lack of surveillance system, protocols for detection and quality of care
   e. Lack of forensic infrastructure and skills
3. Levels of service integration to address GBV
   a. selective provider and/or facility level integration
   b. comprehensive provider and/ or facility-level integration
   c. systems-level integration



Source: Colombini, Manuela et. Al 200.

Suggested Readings

1. Colombini, Manuela et. al. (2008). Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities, Bulletin of the World Health Organization, Vol. 86, Number 8, pp. 635-642.

Unit 5. Guidelines for treatment of GBV cases and health sector response

WHO has given a number of guidelines for dealing with the victims of GBV These guidelines cover almost every aspect of GBV in medical setting and ensure an improved health sector's response towards the overall wellbeing of the survivors of violence. Nonetheless, public health sector in Pakistan mostly operates without adopting any standardized guidelines for dealing the cases of GBV. As a result, health sector response towards treatment of survivors of violence remains poor.

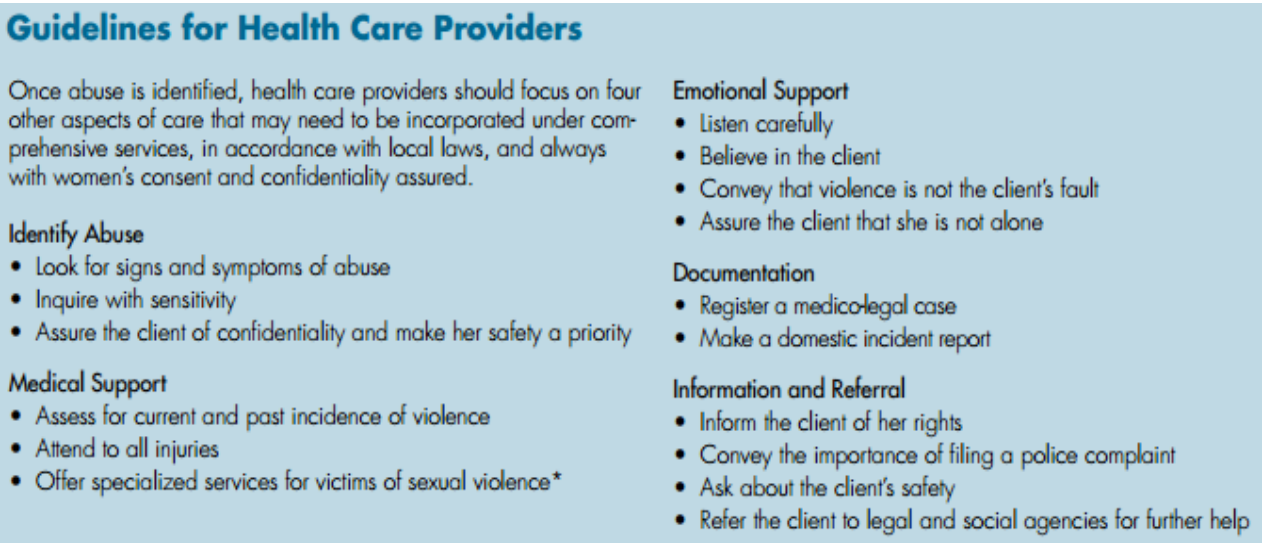
Learning objectives

At the end of the unit participants will be able to:

- understand the significance of using guidelines in healthcare sector to deal with GBV cases
- understand the ethical considerations in protecting rights of women
- learn the steps to support to the survivors of GBV including identification, documentation, counseling of survivors and their family members;

Contents

1. Basic guidelines for healthcare providers/managers
    a. Identify GBV cases
    b. Medical Support
    c. Emotional Support
    d. Documentation
    e. Information and Referral
2. Ethical concern in addressing GBV
    a. Confidentiality
    b. Privacy
    c. Safety
    d. Nondiscrimination
    e. Respect



Guidelines for Health Care Providers

Once abuse is identified, health care providers should focus on four other aspects of care that may need to be incorporated under comprehensive services, in accordance with local laws, and always with women's consent and confidentiality assured.

Identify Abuse
- Look for signs and symptoms of abuse
- Inquire with sensitivity
- Assure the client of confidentiality and make her safety a priority

Medical Support
- Assess for current and past incidence of violence
- Attend to all injuries
- Offer specialized services for victims of sexual violence*

Emotional Support
- Listen carefully
- Believe in the client
- Convey that violence is not the client's fault
- Assure the client that she is not alone

Documentation
- Register a medico-legal case
- Make a domestic incident report

Information and Referral
- Inform the client of her rights
- Convey the importance of filing a police complaint
- Ask about the client's safety
- Refer the client to legal and social agencies for further help

Source: Ashford & Feldman-Jacobs, 2010

Suggested Readings

1. Ashford, L., & Feldman-Jacobs, C. (2010). The crucial role of health services in responding to gender-based violence., available at. http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdf

2. WHO. (2003). Guidelines for medico-legal care for victims of sexual violence, Geneva: World Health Organization.
3. UNFPA. (2013). Health Sector Response to GBV National Guideline on providing care and prevention for Health Care Providers. Health Protection Agency UNFPA, Available online http://www.health.gov.mv/publications/25_GBV_Guideline-Maldives.pdf

Session: Health Equity

Session structure

The session on health equity will comprise the following units:

Unit 1. Introduction to Equality and Health Equity

Unit 2. Equity, accountability and healthcare delivery in relation to healthcare needs

Unit 3. Equity and health financing in relation to ability to pay

Unit 4. Guidelines and tools for applying health equity approach and analysis

Unit 1. Introduction to Equality and Health Equity

Health equity means to provide health services according to the needs of people. On the other hand, equality means having an equal right to health for everyone. Pakistan's health care system follows a 90/10 approach in allocating and rendering health care services. Owing to the financial constraints the country cannot provide dynamic services to all particularly to marginalized groups. Health sector follows various equity approaches such as vertical (from federal level to basic unit level) and horizontal (at the same level). Such types of approach are also known as community oriented health services. This unit will build up the healthcare professionals' understanding regarding the need of vertical and horizontal equity.

Learning Objectives

At the end of the unit, the participants will be able to:

- differentiate between equity and equality; and
- expand their acumen in relation to social justice and health inequities; and
- understand the significance and need for deployment of horizontal and vertical equity.

Contents

Following are the content to be covered under this unit:

1. Introduction to health equity
    a. Definition of health equity
    b. Differentiate between equity and equality
    c. Differentiate Health Disparity and Health Equity
2. Types of Health equity
    a. Horizontal equity
    b. Vertical equity
    c. Significance of deployment of horizontal and vertical equity
3. Social justice and health inequities
    a. moral importance of health care
    b. identify unjust health inequalities
    c. limits of fair health care

Suggested readings

1. Public Health Reports. (2014). What Are Health Disparities and Health Equity? We Need to Be Clear Supplement 2 / Vol129; Available at http://www.publichealthreports.org/issueopen.cfm?articleID=3074
2. Kawach I and Kennedy BP. (1997). Health and social cohesion: Why care about income inequality? British medical journal. Available at http://www.hsph.harvard.edu//benchmark/ndaniels/pdf/justice_health.pdf

Unit 2. Equity and Health Financing in relation to ability to pay

The healthcare cost in Pakistan is increasing day by day, especially for the marginalized groups. In order to achieve health equity, it is imperative to understand where and how to deploy health financing. Through this unit, the participants will be able to comprehend the need for equitable allocation of resources in health sector.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the current situation and need for equitable health financing in Pakistan; and
- demonstrate the skills required to monitor, evaluate and deploy various modes of health financing in-order to achieve health equity.

Contents

Following are the content to be covered under this unit:

1. Current situation in Pakistan
    a. non-prioritization of poor disease
    b. financial barriers for poor man and inability to pay
    c. inequitable distribution of power and money
    d. lack of equitable health financing in Pakistan
2. Required skills to achieve health equity
    A. Monitoring
        a. Cycle of health monitoring
    B. Evaluate
        a. assessment of the equitable resources
        b. complaint and response mechanism
        c. Financial barriers to equitable access
3. Various modes of health financing to achieve health equity
    A. Initial steps to achieve
        a. Advocate for and mobilize increased public funding for health care
        b. Reduce out-of-pocket payments,
        c. allocate government resources between geographical areas, taking account of population health needs
    B. Middle income strategies to achieve health equity
        a. Reduce fragmentation and segmentation within the health-care system
        b. Explore the use of risk-equalization mechanisms, where appropriate, to ensure equitable resource allocation between financing schemes
        c. Strengthen purchasing strategies,
        d. Regulate private insurance to prevent distortions in the overall system

Suggested readings

1. Consumer Protection Healthcare Financing in Pakistan. (2005). Health Policy Unit of the Network for Consumer Protection. Available at;http://www.thenetwork.org.pk/Resources/Reports/PDF/15-8-2011-3-17-26-931-Health%20Care%20Financing.pdf
2. World Health Organization. (2013). Health inequality Monitoring; Available at http://www.who.int/social_determinants/final_report/csdh_finalreport_2008_part5.pdf
3. WHO. (2013). Closing the Health Equity Gap Policy Options and Opportunities for Action, available at: http://www.cdc.gov/nchhstp/socialdeterminants/docs/who-closing-health-equity-gap-policy-opportunities-.pdf

Unit 3. Equity, accountability and health care delivery in relation to health care needs

To achieve health equity, accountability of healthcare delivery system is critically important. The health care professionals need to understand root causes of inequalities at cross government and inter-sectoral levels. Furthermore, they require understanding about accountability procedures and guidelines for ensuring equitable healthcare.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand health care delivery approach in national context; and
- Comprehend an evidence-based approach to monitor health equity including regular assessment, prioritization, planning, action and evaluation of health care delivery in relation to health care needs

Contents

Following are the content to be covered under this unit:

1. Autonomy of Health care Institutions
2. Structure of Health care Institutions
3. Levels of healthcare facilities
4. Management structure of healthcare institutions
5. Monitoring progress on health equity
6. Methodology review of equity assessment
7. Measurement and evidence and process of health monitoring and evaluation

Suggested Readings

1 WHO. (n.d). Evidence on social determinants of health. Geneva.

2. Cochrane. Health Equity Field: contribution to an evidence-based approach to equity, available at: http://www.eventos.bvsalud.org/agendas/BVS-COR/public/documents/vivian_equity-182604.pdf

3. Equity-Oriented Monitoring in the Context of Universal Health Coverage, Published online 2014 Sep 22 available at; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4171107/

4. Sania Nishtar. Health System in Pakistan. available at: http://www.heartfile.org/pdf/phpf-GWP.pdf

Unit 5. Guidelines and tools for applying health equity approach and analysis

To achieve health equity, there is a need to integrate equity goals, approaches, and indicators into policies, plans and development agendas. This unit will address the international guidelines and framework as a model for providing health equity in country context.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the equity framework and approaches to equitable resources; and
- analyse WHO guidelines and tools for applying health equity; and
- assess health care facilities and health equity in country context.

Contents

Following are the contents to be covered under this unit:

1. Approaches to Reduce Health Inequities
    a. targeting disadvantage population groups/social classes
    b. narrowing the health gaps
    c. reducing inequities throughout the whole population
2. Guidelines and Tools for Applying Health Equity
    a. defining the tools and setting the agenda
    b. developing the policies to meet the guidelines for health equity
    c. implementing strategies to eradicate the health inequities
    d. monitoring and evaluation of policies on health equity
3. Assessment of Health facilities and Health Equity in Pakistan
    a. national and provincial policies and commitment to health equity
    b. governance and accountability
    c. health care financing and mobilization of resources
4. The Role of Health Care Providers to reduce Health Inequities
    a. gathering information regarding the socio-economic conditions of the patients
    b. finding supportive linkages
    c. adopting equitable treatment strategies

Suggested Readings

1. Canadian Medical Association. (2013). Physicians and Health Equity: Opportunities in Practice, available at;
   http://healthcaretransformation.ca/wp-content/uploads/2013/03/Health-Equity-Opportunities-in-Practice-Final-E.pdf
2. Government of Pakistan. (2001). National Health Policy 2001, The Way forward: Agenda for Health Sector Reform, Islamabad: Ministry of Health.

3. WHO. (2010). Urban Health Equity Assessment and Response Tools, Kobe: World Health Organization.
4. WHO. (n.d). Country Cooperation Strategy for Pakistan 2011-2017, Islamabad: World Health Organization

Session: Social Determinants of Health

Session Structure

The session on social determinants of health will comprise the following units:

Unit 1	SDH Approaches to Public Health
Unit 2	Importance of addressing SDH to achieve universal health coverage and health equity
Unit 3	Guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action.

Unit 1. SDH Approaches to Public Health

The SDH approach to public health is guided by the view that health is not simply a medical issue based on natural, biological factors and medical interventions. Health is a social issue and a product of the interaction between biology and the physical, socio-cultural and political environment in which individuals live and act. The healthcare professionals should have a comprehensive understanding of SDH approaches and the ways to implement these in promoting health status of individuals.

Learning Objectives

At the end of the unit, the participants will be able to:

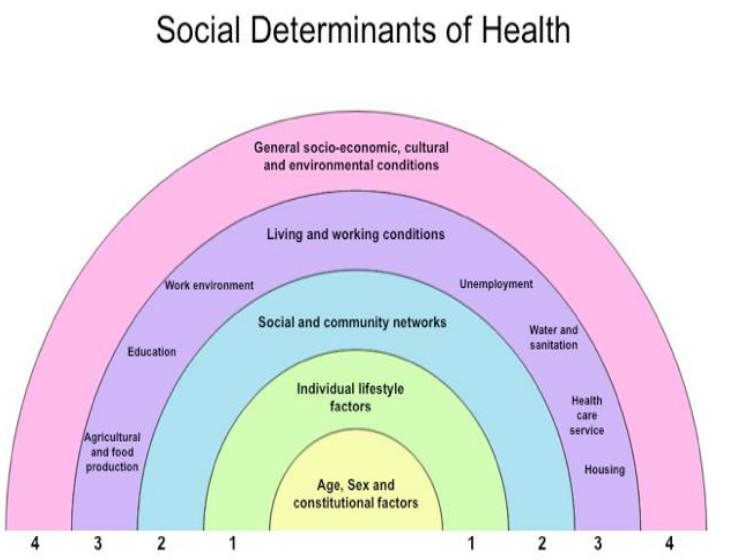
- understand social determinants of health; and
- learn Key areas and components of SDH

Contents

Following are the content to be covered under this Unit:

1. Definition of Terms:
    a. Social determinants
    b. Social determinants of health

2. Key areas of SDH and its components
    a. Economic Stability
        i. Poverty
        ii. Employment
        iii. Food Security
        iv. Housing Stability
    b. Neighbourhood and built Environment
        i. Access to Healthy Foods
        ii. Quality of Housing
        iii. Crime and Violence
        iv. Environmental Conditions
    c. Health and Health care
        i. Access to Primary Care
        ii. Health Literacy
    d. Social and Community Text
        i. Social Cohesion
        ii. Civic Participation
        iii. Perceptions of Discrimination and Equity
        iv. Incarceration/Institutionalization
    e. Education
        i. High School Graduation
        ii. Enrolment in Higher Education
        iii. Language and Literacy
        iv. Early Childhood Education and Development



Dahlgren & Whitehead 1991 Policies and strategies to promote social equity in health. Stockholm: Institute of Future Studies.

Suggested Readings:

1. World Health Organization (WHO). (2008). Commission on Social Determinants of Health . Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.
2. Office of Disease Prevention and Health Promotion. (2015). Healthy People 2020: Social Determinants of Health.
3. Community Tool Box. Addressing Social Determinants of Health and Development: Chapter 17. http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main

Unit 2. Importance of addressing SDH to achieve Universal Health Coverage and Health Equity

The availability of efficient and effective health coverage is the basic human right of every individual. It is essential to have an understanding of the significance of addressing SDH in order to achieve universal health coverage and health equity.

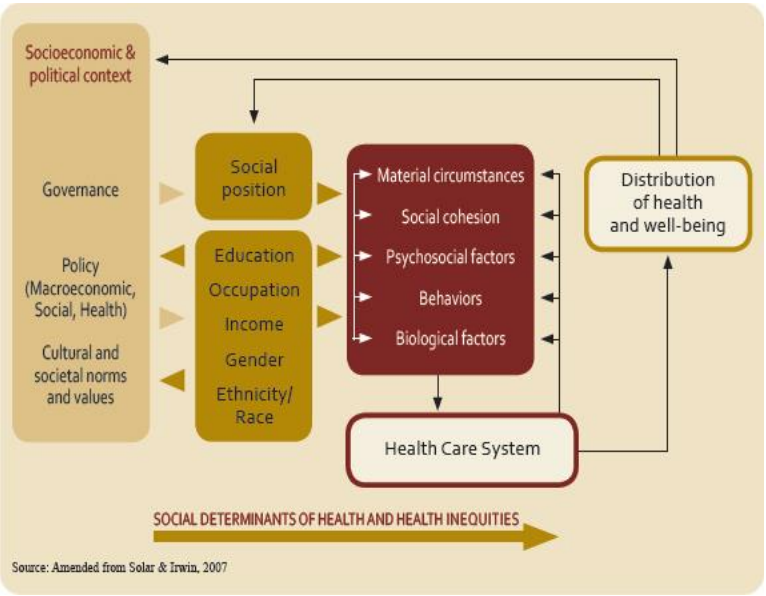
Learning Objectives

At the end of the unit participants will be able to:

- understand what are the various options for measuring health issues;
- understand the link between SDH and health equity; and
- learn how SDH approaches can contribute to improve universal health coverage

Contents

The contents of this Unit will be:



1. Measuring Health issues
    a. Building reference point
    b. Identifying the measuring indicators
    c. Developing a consistency in measuring these issues
    d. Assessing the community to measure such issues
2. SDH and Health Equity
    a. Social class and health inequities
    b. Displaced persons Culture, and health inequities
    c. Social and economic barriers to achieve health equity
    d. Distribution of resources to achieve health equity
    e. Monitoring health inequities
3. Role of SDH in achieving universal health coverage
    a. Social connectedness
    b. Achieving economic stability
    c. Improving environmental and policy conditions
        i. Knowledge and skills
        ii. Support within and between groups
        iii. Barriers to, access to, and opportunities for resources and services
        iv. Exposure to or protection from hazards
        v. policies

Suggested Readings:

1. CDC. (2005). Methodological Issues in Measuring Health Disparities
2. WHO. (2005). Closing the gap in a generation: Health equity through action on the social determinants of health.

Unit 3. Guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action

For integrating SDH at policy and program level, government needs to coordinate and align different sectors and different types of organizations in the pursuit of health and development. Building governance, whereby all sectors take responsibility for reducing health inequities, is essential to achieve this goal. In addition to government participation in integrating SDH at policy level, the participation of individuals, community and civil society is also mandatory for reducing health inequities. The application of WHO guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action can contribute to improve health equity.

Learning objectives

At the end of the Unit participants will be able to:

- understand the guidelines for integrating SDH into policy and programs;
- understand the role of different sectors in integrating SDH into policy and programs; and
- understand the significance and applications of "health in all policies" strategy to improve health equity.

Contents:

The contents of this unit will be:

1. Guidelines for integrating SDH into policy and programs
    a. Theoretical models of program evaluation
    b. Structural factors affecting policy and programs
    c. Multilevel framework for understanding SDH
        i. International level
        ii. National level
        iii. Community level
        iv. Household level
        v. Individual level
2. Inter sectorial approach in integrating SDH into policy and programs
    a. Social participation and ownership
    b. Health Governance
    c. Development of institutional framework

d. Advocacy for inter sectorial action
e. Health Public Policy

3.Health in all policies

a. Need of "Health in all policies"
b. Five key elements/principles of "Health in all policies"
    i. Promote health, equity, and sustainability
    ii. Support inter sectoral collaboration
    iii. Benefit multiple partners
    iv. Engage stakeholders
    v. Create structural or procedural change
c. "Health in all policies" approaches
d. "Health in all policies" outcomes
    i. Development of health public policy
    ii. Creation of supportive environments
    iii. Strengthening of community action
    iv. Reorientation of health services

Suggested Readings:

1. WHO. (2012). Social Determinants of Health Discussion Paper 9: Integration of social determinants of health and equity into health strategies, programes and activities; health equity training process in Spain.
2. American Public Health Institution. (2013). A Guide for State and Local Governments.
3. Commission on the Social Determinants of Health (2008). Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health -- Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization. Available at http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

Examples of Class Exercises for Facilitator

Session: Human Rights

1. Class exercise for *Unit 3.*

It is argued, "International commitments do not offer set 'prescriptions, but only directs the states that the full realization of the rights contained in the treaty must be achieved through all appropriate means, including particularly the adoption of legislative measures."

Keeping this in view, discuss how does international commitments about human rights instigated Pakistan to include some articles/clauses in constitution or health policy to ensure human rights related to health?

2. Class exercise for Unit 4.

"Health linkages are essential to improve the quality and cost-effectiveness of care for people, by ensuring that services are well coordinated around their needs."

Discuss possible ways to have linkages with other social and health departments and also discuss how different sectors can work together to provide comprehensive care.

3. **Class Exercise for *Unit 5.***

Discuss the violation of human rights in hospitals and possible ways to ensure dignity of the patients particularly women experiencing sexual violence or victims of acid throwing.

Session: Gender Based Violence

1. Class Exercise for *Unit 1:*

Case Study: Safia is a young Pakistani woman who lives with her husband and fivechildren ina small village of Southern Punjab. Her husband is unemployed and drinks alcohol excessively. Whenever things get out of hand, Safia leaves her home and takes refuge at her parents' house. In these situations, her husband did not allow her to meet with the children. Every time she reconciles with him. He forces her to have sex without protection, often resulting in a new pregnancy. She always remained worried about her children and she did not want more pregnancies in this non-conducive environment. The family needs money but her husband forbids her from working. Because of continues stress, poor financial condition of the family and pressure from her husband, she did not able to communicate or work independently for the survival of her children during the previous years which often resulted into shouting, beating and torturing. Due to certain socio-cultural restraints, she was not able to expose her plight.

Identify the types of violence, Safia is facing? Also that how the types of violence being experienced by Safia can be identified in our socio-medical scenario?

2. Class Exercise for *Unit 2:*

Case Study: A poor and physically weak rural woman Razia 45 year's age lives in remote village of Pakistan. She is married and has seven children. She lives with her family and in-laws. She has been experiencing domestic violence from her husband and in-laws for many years. One day, Razia receives severe injuries on her face and body. One of her (female) neighbour took her to the nearest Basic Health Unit for medical treatment. She bleeds from her head, nose and has several bruises on her back and legs. When asked by the lady doctor about the cause of the injuries, she simply replied that she fell down the stairs. Razia's previous medical record showed

that she visited the BHU many times, with the same type of injuries. She also sought emergency contraception thrice because of her unwanted pregnancies. The doctor is anxious about the health of her patient, and believes that her symptoms could be caused by domestic violence. She is hesitant what to do, as she realizes that Razia is not willing to talk about the nature of her injuries.

Instructions for the students; Read the above case study and discuss the following questions in your class:

1. *What is the role of BHU health care providers to confront a patient like Razia? What are the steps, a health care provider should take to handle such patients. List some of the important steps.*

2. *Divide the class into five different groups. Each group should discuss the causes of domestic violence and then write the possible steps on their note books and then each group should nominate a group leader to present these steps in front of their class mates.*

3. Class Exercise for *Unit 4:*

*"*Women and Children are disproportionately targets" and constitute the "majority of all victims in the contemporary circumstances of domestic violence".

Keeping in view this statement, discuss the possible causes as well consequences of the domestic violence. Furthermore, adopt the suggestions that how the contemporary state health care system can respond this issue.

5. Class Assignment for *Unit 5:*

Select one of the following guidelines available online, and then suggest suitable protocols/guidelines for responding GBV in Pakistan.

a. WHO, Guidelines for medico-legal care for victims of sexual violence (2003)

b. IPPF, Improving the health sector response to GBV: A resource manual for health care professionals in developing countries (2010)

c. WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013)

Session: Health Equity

1. Class Exercise for Unit 1:

"Canada's publicly-funded health care system is based on the concept of equality. It is designed to ensure that everyone has the same access to health care providers and services regardless of their ability to pay for care. This seems fair, but it only goes so far in promoting justice because it ignores other factors such as language, place of residence, sexual orientation and gender that can also act as barriers to care. In order to address these issues, there is a need of equity based health care system, that is, provision of services according to needs."

Discuss this issue in Pakistani context with the students.

2. Class Exercise for *Unit 2:*

Case study: Siraj Ahmed, a poor old man 60 years of age, was suffering with lung cancer. His financial condition was very poor and he could not afford expensive treatment of this disease. He went to a public hospital for treatment. During the treatment examining process the Siraj tried to negotiate with the doctor and said, 'I heard that cancer can be cured through freely available treatment facilities." The doctor abruptly said that the hospital has limited resources and cannot afford his treatment. Furthermore, the doctor explained that cancer treatment is expensive, you cannot afford it. It is better to stay at home and pray from Allah for health." He further said that I cannot explain more than this to you, and he called his assistant for the next patient. Siraj Ahmed deeply heart due to his poor economic conditions. But later on, his son took him to another hospital, where doctor examined him politely "Baba G' (old man) do not as your disease is at initial stage. The hospital not only will facilitate in his treatment but also accommodate him financially through aligned social welfare department. After a short span of treatment cycle, the health of old man is now started to improve.

Discuss with class that how the role of the health care providers is important in giving equal health treatment facilities to the patients in hospital setting by aligning different welfare channels present in the society?

3. Class Exercise for *Unit 3:*

Explain the structure of health department and health institutions at all levels. Explain the departmental hierarchy, monitoring channel and process.

4.* Class Activity 1 for *Unit 5:

The demonstrator will ask the students to find approaches inside the health sector as well as outside the scope of health to achieve health equity.

6. Class Activity 2 for *Unit 5:*

The teacher will ask the student to identify the most suitable tools of health equity in Pakistani context.

Session: Social Determinants of Health

1. **Class Exercise for *Unit 1*:**

In developing and even middle-income countries, the rural villages may get all their water for drinking, washing, waste disposal, and other uses from a single above-ground source, such as a lake or stream. In that case, the villagers are far more apt to be exposed to water-borne diseases and pollutants than wealthier neighbours who can afford to buy bottled water or drill a well

Keeping the situation of inhabitant of rural areas, discuss with the class how the medical professionals can help in overcoming this issue.

2. Class Exercise for *Unit 2:*

Case Study: To eliminate cholera, one of the most important steps is to provide people with clean drinking water. During the London cholera epidemic of 1854, John Snow, a physician, mapped the houses where the disease struck. He learned that many of the stricken were drawing water from a pump that tapped a filthy part of the Thames River, because conventional wisdom said it was better than the piped water also available to them – which actually came from a cleaner area. He was able to close the pump and substitute piped for pumped water, almost immediately ending the outbreak. Snow's insights about the social determinants of cholera, along with the later work of others, eventually helped to eliminate the disease as a threat in most of the developed world. But they also served to stop the 1854 epidemic.

Discuss with the class that how we can work together with the community keeping in mind social determinants of health to prevent the occurrence of epidemics.

3. Class Exercise for *Unit 3:*

"With literacy, people gain skills that allow them to continue and expand the community development activities, or to get jobs that will better serve them and their families. Literacy also gives people (who've typically been powerless) a means of power over their lives by helping them understand the forces working on them and take action on their own behalf."

Discuss with class that how level of education and awareness effects health.

Model Curriculum for Pharmacy Program

Introduction

Pharmacists work in regulatory control and drug management, hospitals, communities, pharmaceutical industries, academic and research institutions (Fernandes, & Samaga, 2015; Rahim & Usmani, 2012; Pasquier, 2012). Pharmacists working in hospital and communities are more accessible to the public (Davies, 2013). Their role is more than a supplier of medicine as their professional activities also cover counseling of patients at the time of dispensing of prescription and non-prescription drugs; drug information to health professionals, patients and the general public; and participation in health-promotion programs (Fernandes, & Samaga, 2015; Mark, 2001). They also maintain links with other health professionals in primary health care. Hence, being the primary interface between patients and health systems, pharmacists have an important role in protecting and promoting human rights in their daily practice (Pasquier, 2012). It has been widely acknowledged that pharmacists should be trained on human right based approaches. A better understanding and awareness of human rights to health may motivate pharmacists to deliver and advocate for patient care that reflects a "broader health promotion model rather than only biomedical model" (Mark, 2001).

In addition, pharmacists should be taught about social aspects of ill-health, as the major proportion of the global burden of disease arises from the conditions in which people are born, grow, live, work, and age. These conditions are also referred to as Social Determinants of Health (SDH). Literature on SDH highlighted that health inequities or health disparities in healthcare settings is one of the main cause of ill-health health (Western, 2013; Ellsberg, & Emmelin, 2014). Nonetheless, healthcare providers including pharmacists can help to reduce the health inequities by ensuring health equity and provision of equitable healthcare services to patients including the survivors of Gender Based Violence (GBV). However, the equitable healthcare services to patients cannot be ensured until the healthcare providers including pharmacists are equipped with theoretical and practical knowledge about human right based approaches (WHO, 2013; Friel & Marmot, 2011). Nevertheless, pharmacists in Pakistan appear to have inadequate knowledge about human rights, SDH, health equity, and GBV. Resultantly, it undermines quality of healthcare service delivery, specifically to marginalized population including survivors of GBV (Ashford & Feldman, 2010). To provide a holistic and evidence-based care to patients, the

pharmacists need to be aware about such concepts and obligations enshrined in the maxim "right to health". In this backdrop, this module is designed to equip the pharmacists with understanding about human rights, SDH, health equity, and GBV.

Learning objectives

This module consists of four sessions and each session is divided into several units. It is expected that by the end of this session, the participants will be able to:

- understand the concepts of human rights, GBV, SDH, and health equity;
- comprehend the reasons for health disparities and their links to the human rights, GBV, and SDH;
- strengthen the capacity of pharmacists to meet the practical and strategic needs of patients including marginalized patients and survivors of GBV; and
- explore and apply guidelines of human rights based approaches in public health response of Pakistan.

Methods and assessment

Teaching-learning strategy shall be interactive consisting of class discussions, studying the textbook material, participation in the class discussions, and doing the class assignments. The grade of the module will be based on an assignment (25%), presentation (25%), and a final paper (50%).

Session: Human Rights

Session structure

This session is divided into six units covering the various topics that have direct relevancy with the public health functioning.

Unit 1. Definition, types, and evolution of human rights

Unit 2. Principles of human rights

Unit 3. International, national commitments, and instruments of human rights in Pakistan

Unit 4. Guidelines and tools to apply human rights based approaches in public health response

Unit 1. Definition and evolution of human rights

In the last two decades, there has been a growing concern to promote human rights perspective in healthcare setting. The knowledge of pharmacist about human rights can promote human dignity in pharmacy practices. This unit is designed to enhance understanding of students of pharmacy about the significance of human rights, right to health, and history of human rights in health sector.

Learning objectives

By the end of the training unit the participants will be able to:

- understand the concept of human rights and human rights to health
- learn evolution of its application to health; and
- explore different types of human rights and recognize the interrelationship among these rights;

Contents

Following are the contents to be covered under this unit:

1. Definition of terms:
    a. Human rights
    b. Right to health
    c. Right based approach to essential medicine
2. Link between human rights and health
3. Evolution of the Human Rights concept
    a. Natural law doctrine
    b. Appearance and evolution of the first legal instruments for human rights protection
        i. Magna Carta Libertatum
        ii. Declaration of Rights from the state of Virginia
        iii. Universal Declaration of Human Rights (UDHR)
4. Categories of human rights
    a. Social rights
    b. Cultural rights
    c. Economic rights
    d. Civil rights
    e. Political rights

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights.
2. UN. (2006). Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation.

3. Eugen,Ciobota.. Evolution of the Human Rights Concept. Territorial Office of the People's Advocate Institution from Târgu-Mureş.
4. Elvira Beracochea and David Lee. Rights-Based Approach to Essential Medicines. In Rights-Based Approaches to Public Health. Dr. Elvira Beracochea, Corey Weinstein, and Dabney Evans.

Unit 2. Principles of Human Rights

The principles of human rights such as universality, indivisibility, participation, accountability transparency, equity, and non-discrimination are fundamental to achieve the right to health. Having an adequate knowledge about these principles, the students of pharmacy would be able to maintain patients' dignity and treat them without any discrimination.

Learning objectives

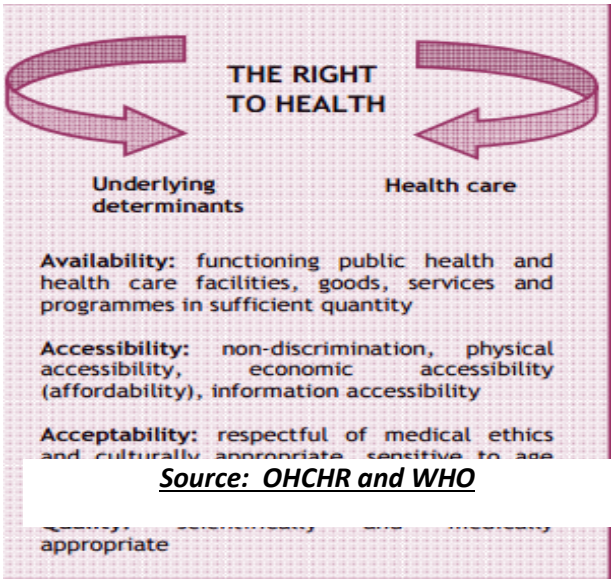
By the end of the unit the participants will be able to:

- understand the principles and elements of human rights to health; and
- recognize the implications of violations of human rights principles in healthcare setting.

Contents

Following are the content to be covered under this session:

1. Principles of human rights to health
    a. Universality
    b. Indivisibility
    c. Participation
    d. Accountability
    e. Transparency
    f. Equity
    g. Non-Discrimination
2. Elements of human rights to health
    a. Availability, Accessibility, Acceptability, and Quality (AAAQ)
3. Integration of human rights principals in pharmaceutical setting



Source: OHCHR and WHO

Suggested readings

1. OHCHR and WHO. A Human Rights-Based Approach to Health. Available at: http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf

2. WHO. (2002). 25 Questions & Answers on Health and Human Rights.
3. WH0. (2012). Good Pharmacy Practice: Joint FIP/WHO Guidelines on GPP, Standards for quality of Pharmacy Services.

Unit 3. International, national commitments, and instruments of human rights in Pakistan

Pakistan is the signatory of a number of human rights treaties and commitments which directly or indirectly address the right to health. However, the implementation of these commitments has to be fully ensured in the country. Among others, the HCPs are also in a dire need to be educated and trained about the national and international legal framework of human rights with a particular focus on right to health. In this backdrop, this unit aims to enhance the HCP's knowledge about national and international legal frameworks and its implication on health.

Learning objectives

By the end of the unit the participants will be able to:

- understand the significance and implications of national and international commitments on health priorities; and
- increase their knowledge about relevant international treaties ensuring right to health (such as UDHR, ICESCR, CRC, CERD, and CEDAW).

Contents

Following are the content to be covered under this unit:

1. Significance of international treaties and commitments
2. Importance of charter of Universal Declaration on Human Rights (UDHR)
3. Health to rights enshrined in:
    a. International Covenant on Economic, Social and Cultural Rights (ICESCR),
    b. Convention on the Rights of the Child (CRC),
    c. Convention on the Elimination of All Forms of Racial Discrimination (CERD),
    d. Convention on the Elimination of AllForms of Discrimination Against Women (CEDAW)
4. Human rights to health and Constitution of Pakistan

Suggested readings

1. WHO. (2008). The Right to Health.
2. IP3. (2013). Handbook on Human Rights for Parliamentarians, Committees and Secretariat Staff in Pakistan
3. WHO. Country Cooperation Strategy for Pakistan 2011-17

Unit 4. Guidelines and Tools to Apply Human Rights Based Approaches in pharmacy practice

The application of human right based approaches at healthcare setting calls for a range of measures to eliminate human rights violations. In this regard, WHO has developed a number of guidelines which can be applied to protect human rights of patients for improved delivery of services.

Learning objectives

By the end of the unit the participants will be to:

- understand the institutional processes and healthcare responsibilities;
- learn the ethics and guidelines to provide equitable healthcare services; and
- knowledge about guidelines on human rights in patient care.

Contents (lecture)

Following are the content to be covered under this unit:

1. The Right to Health and Access to Medicines - State Obligations and Pharmaceutical Industry Responsibilities
2. Public-Private Partnerships: Opportunities for Promoting Human Rights
3. Essential Medicines Under the Right to Health: Entry Points for Supporting State Obligations.
4. Guidance on patient's confidentiality to protect human rights in pharmacy practice
5. Promotion of supportive and enabling environment through availability, accessibility, and acceptability, and quality services (AAAQ)

Suggested readings

1. WHO. (2002), 25 Questions & Answers on Health and Human Rights.
2. Current Debates on Realizing Health and Human Rights: An Annotated Bibliography on the Human Rights Roles and Responsibilities of the Pharmaceutical Industry. Program on International Health and Human Rights. Harvard School of Public Health, Boston, USA. Available at: file:///C:/Users/Haier-p/Downloads/humanrights_pharma_annotatedbibliography%20(2).pdf
3. General Pharmaceutical Council. Guidance on patient confidentiality. London, UK. Available at: http://www.pharmacyregulation.org/sites/default/files/Guidance%20on%20Confidentiality_April%202012.pdf

Session: Gender Based Violence

Session structure

This session is divided into six units covering the topics that are directly relevant with the public health functioning.

Unit 1. Understanding GBV (definition, types, and factors pertaining to GBV in Pakistan)

Unit 2. International and national commitments related to GBV

Unit3. Guidelines for treatment of GBV cases and health sector response

Unit 1. Understanding GBV

GBV is a general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two, within the context of specific society. GBV is directed towards women and it disproportionately affects them across the globe. GBV is a structural phenomenon embedded in the context of socioeconomic, cultural and political power relations. Like other developing countries, Pakistan also has a patriarchal society where men consider themselves superior to women and think violence against women as their moral and legal right. Such erroneous perceptions result in the continuation of violence against women. In this context, it is necessary to understand the socio-cultural factors associated with GBV and its health consequences.

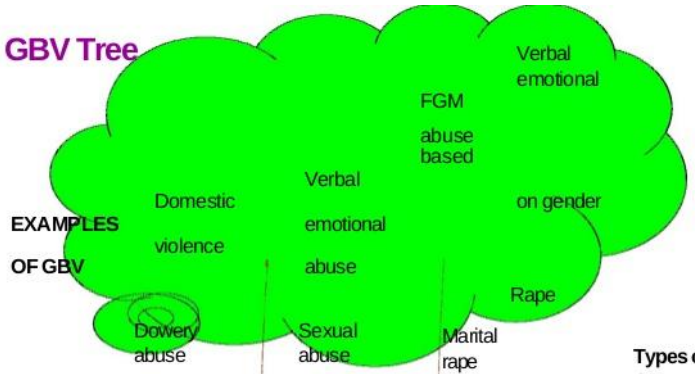
Learning objectives

At the end of the unit participants will be able to:

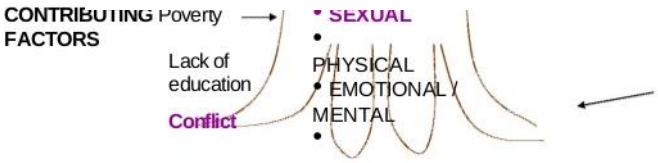
- define GBV and understand its forms;
- understand the magnitude of the problem of GBV;
- understand social, cultural, economic and political factors that underpin the gender based violence; and
- understand various explanations of GBV.

Contents

1. Definition of terms:
    a. Difference between sex and gender
    b. Gender Based Violence (GBV)
    c. Childhood sexual abuse
    d. Domestic violence
    e. Rape or Sexual assault
    f. Intimate partner violence
    g. Non-intimate partner violence
2. Types/forms of GBV
    a. Physical violence
    b. Psychological/Emotional violence
    c. Sexual violence
3. Prevalence of violence worldwide and in Pakistan
4. Factors pertaining to GBV in Pakistan
    a. Social and Cultural Factors
    b. Economic Factors
    c. Political Factors
    d. Health consequences of violence



Source .Mehmood, Malik Khalid. Guidelines for Gender Based Violence Interventions in Humanitarian Settings.



Suggested Readings

1. UNFPA. (2001). A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers. New York. United States.
2. WHO. (2014). Global Status Report on Violence Prevention 2014. Geneva. Switzerland.
3. WHO. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva. Switzerland.
4. WHO. (2005). Sexual Gender-Based Violence and health Facility Needs Assessment: Lofa, Nimba, Grand Gedeh And Grand Bassa Counties Liberia.

Unit 2. International and national commitments related to GBV

Pakistan has adopted a series of national and international commitments pertaining to various issues of GBV. However, due to inadequate knowledge of legal structures and ethical guidelines, healthcare professionals are not fully prepared to play their proactive role in mitigating human rights violations including GBV. Given this situation, it is important to educate health professionals about national and international laws pertaining to GBV.

Learning objectives

At the end of the unit participants will be able to:

- understand the important role of national laws, institutional structures, international commitments, and ethical considerations in protecting and upholding rights of women against GBV;
- identify their role as service providers in supporting survivors to uphold their legal rights; and
- play their role in the interest of survivors of GBV.

Contents

1. International commitments
    a. Universal Declaration of Human Rights
    b. International Covenant on Civil and Political Rights
    c. International Covenant on Economic, Social and Cultural Rights
    d. Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
    e. Convention on the Rights of the Child
    f. Convention on the Elimination of Discrimination against Women
    g. Vienna Declaration and Programme of Action
    h. Beijing Declaration and Platform for Action
    i. Millennium Development Goals
2. National laws and commitments
    a. Constitution of the Islamic Republic of Pakistan.
    b. National Plan of Action (NPA)
    c. National Policy on Development and Empowerment of Women
    d. National Strategic Framework for Family Protection
    e. Protection of Women (Criminal Laws Amendment) Act, 2006
    f. Acid Throwing Act, 2006
    g. Domestic Violence (Prevention and Protection) Act, 2012

Suggested Readings

1. UN. (2014). Women's Rights are Human Rights. New York and Geneva.
2. Zaheer & Shamreeza. (2013). Legal Protections Provided Under Pakistani Law against Anti-Women Practices: Implementation Gaps between Theory and Practice.

3. Anita M. Weiss. (2010). Moving Forward with the Legal Empowerment of Women in Pakistan; United States Institute of Peace.

Unit 3. Guidelines for treatment of GBV cases and health sector response

World Health Organization has given a number of guidelines for dealing with the victims of GBV. These guidelines cover almost every aspect of GBV in medical setting and ensure an improved health sector's response towards the overall wellbeing of survivors of violence. Nonetheless, public health sector in Pakistan mostly operates without adopting any standardized guidelines for dealing the cases of GBV. As a result, health sector response towards treatment of survivors of violence remains poor.

Learning objectives

At the end of the unit participants will be able to:

- understand the significance of using guidelines in healthcare sector to deal with GBV cases
- understand the ethical considerations in protecting rights of women
- learn the steps to support to the survivors of GBV including identification, documentation, counseling of survivors and their family members;

Contents

1. Role of Pharmacist in addressing GBV
2. Basic guidelines for healthcare providers/managers
    a. Identify GBV cases
    b. Medical Support
    c. Emotional Support
    d. Documentation
    e. Information and Referral
3. Ethical concern in addressing GBV
    a. Confidentiality
    b. Privacy
    c. Safety
    d. Nondiscrimination
    e. Respect

Suggested Readings

1. Ashford, L., & Feldman-Jacobs, C. (2010). The crucial role of health services in responding to gender-based violence., available at. http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdf

2. WHO. (2003). Guidelines for medico-legal care for victims of sexual violence, Geneva: World Health Organization
3. Health Sector Response to GBV National Guideline on providing care and prevention for Health Care Providers (2013) Health Protection Agency UNFPA, Available online http://www.health.gov.mv/publications/25_GBV_Guideline-Maldives.pdf
4. Cerulli, C., Cerulli, J., Santos, E. J., Lu, N., He, H., Kaukeinen, K., ... & Tu, X. (2010). Does the health status of intimate partner violence victims warrant pharmacies as portals for public health promotion?. Journal of the American Pharmacists Association: JAPhA, 50(2), 200.

Session: Health Equity

Session structure

The session on health equity will comprise the following units:

Unit 1. Introduction to Equality and Health Equity

Unit 2. Equity and health financing in relation to ability to pay

Unit 3 Guidelines and tools for applying health equity approach and analysis

Unit 1. Introduction to Equality and Health Equity

Health equity means to provide health services according to the needs of people. On the other hand, equality means having an equal right to health for everyone. Pakistan's health care system follows a 90/10 approach in allocating and rendering health care services. Owing to the financial constraints the country cannot provide dynamic services to all particularly to marginalized groups. Health sector follows various equity approaches such as vertical (from federal level to basic unit level) and horizontal (at the same level). Such types of approach are also known as community oriented health services. This unit will build up the healthcare professionals' understanding regarding the need of vertical and horizontal equity.

Learning Objectives

At the end of the unit, the participants will be able to:

- differentiate between equity and equality; and
- expand their acumen in relation to social justice and health inequities; and
- understand the significance and need for deployment of horizontal and vertical equity.

Contents

Following are the content to be covered under this unit:

1. Introduction to health equity
    a. Definition of health equity
    b. Differentiate between equity and equality
    c. Differentiate Health Disparity and Health Equity
2. Types of Health equity
    a. Horizontal equity
    b. Vertical equity
    c. Significance of deployment of horizontal and vertical equity
3. Social justice and health inequities
    a. moral importance of health care
    b. identify unjust health inequalities
    c. limits of fair health care

Suggested readings

1. Public Health Reports (2014) What Are Health Disparities and Health Equity? We Need to Be Clear Supplement 2 / Vol129; Available at http://www.publichealthreports.org/issueopen.cfm?articleID=3074
2. Kawach I and Kennedy BP,(1997), Health and social cohesion: Why care about income inequality? British medical journal. Available at http://www.hsph.harvard.edu//benchmark/ndaniels/pdf/justice_health.pdf

Unit 2. Equity and Health Financing in relation to ability to pay

The healthcare cost in Pakistan is increasing day by day, especially for the marginalized groups. In order to achieve health equity, it is imperative to understand where and how to deploy health financing. Through this unit, the participants will be able to comprehend the need for equitable allocation of resources in health sector.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the current situation and need for equitable health financing in Pakistan; and
- demonstrate the skills required to monitor, evaluate and deploy various modes of health financing in-order to achieve health equity.

Contents

Following are the content to be covered under this unit:

1. Current situation in Pakistan
    a. non-prioritization of poor disease
    b. financial barriers for poor man and inability to pay
    c. inequitable distribution of power and money
    d. lack of equitable health financing in Pakistan
2. Required skills to achieve health equity
    A. Monitoring
        a. Cycle of health monitoring
    B. Evaluate
        a. assessment of the equitable resources
        b. complaint and response mechanism
        c. Financial barriers to equitable access
3. Various modes of health financing to achieve health equity
    A. Initial steps to achieve
        a. Advocate for and mobilize increased public funding for health care
        b. Reduce out-of-pocket payments,
        c. allocate government resources between geographical areas, taking account of population health needs
    B. Middle income strategies to achieve health equity
        a. Reduce fragmentation and segmentation within the health-care system
        b. Explore the use of risk-equalization mechanisms, where appropriate, to ensure equitable resource allocation between financing schemes
        c. Strengthen purchasing strategies,
        d. Regulate private insurance to prevent distortions in the overall system

Suggested readings

1. Consumer Protection Healthcare Financing in Pakistan (2005). Health Policy Unit of the Network for Consumer Protection. Available

at;http://www.thenetwork.org.pk/Resources/Reports/PDF/15-8-2011-3-17-26-931-Health%20Care%20Financing.pdf

2. World Health Organization (2013) Health inequality Monitoring; Available at http://www.who.int/social_determinants/final_report/csdh_finalreport_2008_part5.pdf
3. WHO (2013) Closing the Health Equity Gap Policy Options and Opportunities for Action, available at: http://www.cdc.gov/nchhstp/socialdeterminants/docs/who-closing-health-equity-gap-policy-opportunities-.pdf

Unit 3. Guidelines and tools for applying health equity approach and analysis

To achieve health equity, there is a need to integrate equity goals, approaches, and indicators into policies, plans and development agendas. This unit will address the international guidelines and framework as a model for providing health equity in country context.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the equity framework and approaches to equitable resources; and
- analyse WHO guidelines and tools for applying health equity; and
- assess health care facilities and health equity in country context.

Contents

Following are the contents to be covered under this unit:

1. Approaches to reduce health inequities
    a. targeting disadvantage population groups/social classes
    b. narrowing the health gaps
    c. reducing inequities throughout the whole population
2. Guidelines and tools for applying health equity
    a. defining the tools and setting the agenda
    b. developing the policies to meet the guidelines for health equity
    c. implementing strategies to eradicate the health inequities
    d. monitoring and evaluation of policies on health equity
3. Assessment of health facilities and health equity in Pakistan
    a. national and provincial policies and commitment to health equity
    b. governance and accountability
    c. health care financing and mobilization of resources
4. The role of pharmacist to reduce health inequities
    a. gathering information regarding the socio-economic conditions of the patients
    b. finding supportive linkages
    c. adopting equitable treatment strategies

Suggested Readings

1. Canadian Medical Association. (2013). Physicians and Health Equity: Opportunities in Practice, available at; http://healthcaretransformation.ca/wp-content/uploads/2013/03/Health-Equity-Opportunities-in-Practice-Final-E.pdf
2. Government of Pakistan. (2001). National Health Policy 2001, The Way forward: Agenda for Health Sector Reform, Islamabad: Ministry of Health.
3. WHO. (2010). Urban Health Equity Assessment and Response Tools, Kobe: World Health Organization.
4. WHO. (n.d). Country Cooperation Strategy for Pakistan 2011-2017, Islamabad: World Health Organization

Session: Social Determinants of Health

Session Structure

The session on social determinants of health will comprise the following units:

Unit 1	SDH Approaches to Public Health and its significance
Unit 2.	Guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action.

Unit 1. SDH Approaches to Public Health

The SDH approach to public health is guided by the view that health is not simply a medical issue based on natural, biological factors and medical interventions. Health is a social issue and a product of the interaction between biology and the physical, socio-cultural and political environment in which individuals live and act. The healthcare professionals should have a comprehensive understanding of SDH approaches and the ways to implement these in promoting health status of individuals.

Learning Objectives

At the end of the unit, the participants will be able to:

- understand social determinants of health; and
- learn Key areas and components of SDH

Contents

Following are the content to be covered under this Unit:

1. Definition of Terms:
    a. Social determinants
    b. Social determinants of health
2. Significance of SDH
3. Key areas of SDH and its components
    a. Economic Stability
        i. Poverty
        ii. Employment
        iii. Food Security
        iv. Housing Stability
    b. Neighbourhood and built Environment
        i. Access to Healthy Foods
        ii. Quality of Housing
        iii. Crime and Violence
        iv. Environmental Conditions
    c. Health and Health care
        i. Access to Primary Care
        ii. Health Literacy
    d. Social and Community Text
        i. Social Cohesion
        ii. Civic Participation
        iii. Perceptions of Discrimination and Equity
        iv. Incarceration/Institutionalization
    e. Education
        i. High School Graduation
        ii. Enrolment in Higher Education
        iii. Language and Literacy
        iv. Early Childhood Education and Development

Suggested Readings:

1. World Health Organization (WHO). (2008). Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.
2. Office of Disease Prevention and Health Promotion. (2015). Healthy People 2020: Social Determinants of Health.

3. Community Tool Box. Addressing Social Determinants of Health and Development: Chapter 17. http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main

Unit 2. Guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action

For integrating SDH at policy and program level, government needs to coordinate and align different sectors and different types of organizations in the pursuit of health and development. Building governance, whereby all sectors take responsibility for reducing health inequities, is essential to achieve this goal. In addition to government participation in integrating SDH at policy level, the participation of individuals, community and civil society is also mandatory for reducing health inequities. The application of WHO guidelines for addressing and integrating SDH at policy and program level through inter-sectoral action can contribute to improve health equity.

Learning objectives

At the end of the Unit participants will be able to:

- understand the guidelines for integrating SDH into policy and programs;
- understand the role of different sectors in integrating SDH into policy and programs; and
- understand the significance and applications of "health in all policies" strategy to improve health equity.

Contents:

The contents of this unit will be:

1. Guidelines for integrating SDH into policy and programs
    a. Theoretical models of program evaluation
    b. Structural factors affecting policy and programs
    c. Multilevel framework for understanding SDH
        i. International level
        ii. National level
        iii. Community level
        iv. Household level
        v. Individual level
2. Inter sectorial approach in integrating SDH into policy and programs
    a. Social participation and ownership
    b. Health Governance
    c. Development of institutional framework
    d. Advocacy for inter sectorial action
    e. Health Public Policy

2. Health in all policies
    a. Need of "Health in all policies"
    b. Five key elements/principles of "Health in all policies"
        i. Promote health, equity, and sustainability
        ii. Support inter sectoral collaboration
        iii. Benefit multiple partners
        iv. Engage stakeholders
        v. Create structural or procedural change
    c. "Health in all policies" approaches
    d. "Health in all policies" outcomes
        i. Development of health public policy
        ii. Creation of supportive environments
        iii. Strengthening of community action
        iv. Reorientation of health services

Suggested Readings:

1. WHO. (2012). Social Determinants of Health Discussion Paper 9: Integration of social determinants of health and equity into health strategies, programes and activities; health equity training process in Spain
2. American Public Health Institution. (2013). A Guide for State and Local Governments

Examples of Class Exercises for Facilitator

Session: Human Rights

1. Class Exercise for *Unit 2:*

Case study: Mohammad Rahim, a poor old man 55 years of age, was suffering from malaria. He went to a public hospital for the treatment. He reached hospital early in the morning, paid for a slip of an appointment, and got his check up done after waiting for two to three hours. The doctor gave him a medical prescription and told him that he can get these medicines at the pharmacy counter free of cost. Then, he further said that i cannot explain more than this to you, and he called his assistant for the next patient. The old man, shivering with fever headed towards the counter. There was a long queue of patients there, he tried to request the pharmacist to give him the medicines first as he cannot stand for a long time due to ill-health. The pharmacist replied him harshly, "Baba G, Apni Bari Per Ana". He took the prescription and went to a private pharmacy shop where the pharmacist on duty treated him in a polite manner and gave him his

prescribed medicines on urgent medicines. *Discuss with class whether they agree that the behavior of pharmacists can have an impact on health of the patients.*

2. Class Exercise for *Unit 2:*

It is argued, "If human rights are to become a reality for everyone, parliaments must fully play their role and use powers they have, to implement these rights in the health sector of Pakistan."

Keeping this in view, discuss how does international commitments about human rights instigated Pakistan to include some articles/clauses in constitution or health policy to ensure human rights related to health?

3. Class Exercise for Unit 4:

"Linking health and human rights can deliver a more robust and cost effective response, and increase progress on achieving Millennium Development Goals by 2015 and beyond."

Discuss possible ways to improve these linkages in order to achieve a robust response.

Session: Gender Based Violence

1. Class Exercise for *Unit 1:*

Case Study: Shahida, a young woman of 30 years, married with three daughters living in a small town in Sahiwal. She used to visit her local pharmacy store on regular basis in order to buy Bandages, Iodex and ointments. Whenever, she visits there the Pharmacist of that store noticed that she has some physical injuries like someone has beaten her very badly. One day he enquired her about her injuries and she told him that her husband physically and verbally abuse her because she cannot give him a son. The Pharmacist didn't know what he could do for her to alleviate her miserable condition except showing her a gesture of sympathy. *Discuss with the class, what responsibilities of a pharmacist can be in such circumstances, and where they need to refer such cases.*

2. Class Activity for *Unit 2:*

"Interventions against gender-based violence in development strategies, though not necessarily absent, are too vaguely defined, except in disaster situations. This shows a lack of understanding of the problem in the local context of Pakistani society". *Discuss with the class that by keeping this statement in their minds, how the interventions for reducing GBV in the context of Pakistan can be redefined in the Health Policies.*

3. Class Assignment *for Unit 3:*

Ask the class to write down some possible treatment options for physical and sexual abuse of women keeping in mind the cultural context of Pakistan under the headings of:

- *Screening of victims*
- *Referral for victims*
- *Legal safety for the survivors*

Session: Health Equity

1. **Example for *Unit 1:***

Male babies are generally born at a heavier birth weight than female babies. This is a health disparity. While there may be a difference in the birth weight between male babies and female babies, the difference is unavoidable and rooted in genetics. On the other hand, babies born to rural women are more likely to die in their first year of life than babies born to urban women. Some of this difference is due to poverty – a higher percentage of rural mothers are poor and face hardships associated with poverty that can affect their health. But we find differences in the health of urban and rural mothers and babies even if we compare urban and rural with the same income. Many Researchers believe that it is lack of resources experienced by rural women that explains this extra difference. This is a health inequity because the difference between the groups is unfair, avoidable and rooted in social injustice.

2. **Class Exercise for *Unit 2:***

"Following the principle that payments for healthcare should correspond to capacity to pay, the equity concern nevertheless is perceived differently in societies with different social, economic, political and cultural background."

Discuss with the class that how these factors can affect the ability of paying for health in Pakistani Cultural Context.

3. **Class Activity for *Unit 3:***

Ask the class to answer the following questions in the context of Pakistan according to their understanding:

1. *Who is experiencing health inequities in our society?*
2. *How does different socio-economic factors impact health of the people?*
3. *How do these health inequities impact health outcomes?*
4. *What can pharmacists do in reducing these inequities?*

Session: Social Determinants of Health

1. **Class Exercise for *Unit 1:***

In Bolivia, babies born to women with no education have infant mortality greater than 100 per 1000 live births, while the infant mortality rate of babies born to mothers with at least secondary education is under 40 per 100. These digits suggest that education, that is, important key area of SDH, has a pivotal role in achieving good health.

Model Curriculum for Bachelor of Science in Nursing Program

Introduction

Nurses as frontline healthcare providers play a pivotal role in all areas of health service delivery including treatment, promotion, prevention, and rehabilitation (Needleman & Hassmiller, 2009; Drach-Zahavy, 2009). Concomitantly, as the primary interface between patients and health systems, nurses have also an important role in promoting and protecting human rights in their daily practice. It has been widely acknowledged that "there is perhaps no better place to begin to impart an awareness of human rights and human dignity than in the small world of the nurses-patient relationship" (Cook et al, 2003). A better understanding and awareness of human rights to health may motivate nurses to deliver and advocate for patient care that reflects a "broader health promotion model rather than only biomedical model" (Mark SP, 2001).

In addition, nurses should be taught about social aspects of ill-health as the major proportion of the global burden of disease arise from the conditions in which people are born, grow, live, work, and age. These conditions are also referred to as Social Determinants of Health (SDH). Literature on SDH highlighted that 'health inequities' or health disparities in healthcare settings is one of the main cause of ill-health (WHO, 2013; Friel & Marmot, 2011). Nonetheless, healthcare providers including nurses can help to reduce the health inequities by ensuring health equity and provision of equitable healthcare services to patients including the survivors of Gender Based Violence (GBV). However, the equitable healthcare services to patients cannot be ensured until the healthcare providers including nurses are equipped with theoretical and practical knowledge about human right based approaches (Ashford & Feldman, 2010). Nevertheless, nurses in Pakistan appear to have inadequate knowledge about human rights, SDH, health equity, and GBV. Resultantly, it undermines quality of healthcare service delivery, specifically to marginalized population including survivors of GBV (UNFPA, 2013). To provide a holistic and evidence-based care to patients, the nurses need to be aware about such concepts and obligations enshrined in the maxim "right to health". In this backdrop, this module is designed to equip the nurses with understanding about human rights, SDH, health equity, and GBV.

Learning objectives

This module consists of four sessions. It is expected that by the end of this session, the participants will be able to:

- understand the concepts of human rights, GBV, SDH, and health equity;
- comprehend the reasons for health disparities and their link to the human rights and social determinants of health;
- strengthen the capacity of nurses to meet the practical and strategic needs of patients including marginalized patients and survivors of GBV; and
- explore and apply guidelines of human rights based approaches in public health response of Pakistan.

Methods and assessment

Teaching-learning strategy shall be interactive consisting of class discussions, studying the textbook material, participation in the class discussions, and doing the class assignments. The grade of the module will be based on an assignment (25%), presentation (25%), and a final paper (50%).

Session: Human Rights

Session structure

This session is divided into six units covering the various topics that have direct relevancy with the public health functioning.

Unit 1. Definition, types, and evolution of human rights

Unit 2. Principles of human rights

Unit 3. Guidelines and tools to apply human rights based approaches in public health

Unit 1. Definition and evolution of human rights

In the last two decades, there has been a growing concern to promote human rights perspective in healthcare setting. The nurses' knowledge about human rights can promote human dignity in medical practices. This unit is designed to enhance nurses' understanding of the significance of human rights, right to health, and history of human rights in health sector.

Learning objectives

By the end of the training unit the participants will be able to:

- understand the concept of human rights and human rights to health
- learn evolution of its application to health; and
- explore different types of human rights and recognize the interrelationship among these rights;

Contents

Following are the contents to be covered under this unit:

1. Definition of terms:
    a. Human rights
    b. Right to health
    c. Right based approach to health
2. Evolution of the Human Rights concept
    a. Natural law doctrine
    b. Appearance and evolution of the first legal instruments for human rights protection
        i. Magna Carta Libertatum
        ii. Declaration of Rights from the state of Virginia
        iii. Universal Declaration of Human Rights (UDHR)
3. Significance of international treaties and commitments
4. Categories of human rights
    a. Social rights
    b. Cultural rights
    c. Economic rights
    d. Civil rights
    e. Political rights

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights.
2. UN. (2006). Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation.
3. Eugen,Ciobota.. Evolution of the Human Rights Concept. Territorial Office of the People's Advocate Institution from Târgu-Mureş.

Unit 2. Principles of Human Rights

The principles of human rights such as universality, indivisibility, participation, accountability transparency, equity, and non-discrimination are fundamental to achieve the right to health. Having an adequate knowledge about these principles, the nurses would be able to maintain patients' dignity and treat them without any discrimination.

Learning objectives

By the end of the unit the participants will be able to:

- understand the principles and elements of human rights to health; and
- recognize the implications of violations of human rights principles in healthcare setting.

Contents

Following are the content to be covered under this session:

4. Principles of human rights to health
    a. Universality
    b. Indivisibility
    c. Participation
    d. Accountability
    e. Transparency
    f. Equity
    g. Non-Discrimination
5. Elements of human rights to health
    a. Availability, Accessibility, Acceptability, and Quality (AAAQ)
6. Integration of human rights principals in medical setting

Suggested readings

1. OHCHR and WHO. A Human Rights-Based Approach to Health. Available at: http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf
2. WHO. (2002). 25 Questions & Answers on Health and Human Rights.

Unit 3. Guidelines and Tools to Apply Human Rights Based Approaches in Health Response

The application of human right based approaches at healthcare setting calls for a range of measures to eliminate human rights violations. In this regard, WHO has developed a number of guidelines which can be applied to protect human rights of patients for improved delivery of services.

Learning objectives

By the end of the unit the participants will be to:

- understand the institutional processes and healthcare responsibilities;
- able to able to identify a human rights issue influencing patient' health within the healthcare setting;
- learn the guidelines and ethics of nursing which is grounded in a human rights approach; and
- knowledge about guidelines on human rights in patient care.

Contents (lecture)

Following are the content to be covered under this unit:

1.Nursing and the Ethic of Just Care

2. Core ethical values and standard of good health practice

3. Guide to good nursing practice health promotion

a. Advocacy -to create essential conditions for health
b. Enabling -to enable all people to achieve their full health potentials
c. Mediating -to mediate between the different interests in the society in the pursuit of health

4. Promotion of supportive and enabling environment through availability, accessibility, and acceptability, and quality services (AAAQ)

5. Human rights of the Patients

a. Respect of patient dignity
b. Ensures access to care
c. Protects safety of patients

Suggested readings

1. WHO. (2002), 25 Questions & Answers on Health and Human Rights.
2. Nursing Council Hong Cong. (2006). Guide to Good Nursing Practice Health Promotion. Professional Development Committee of the Nursing Council, of Hong Kong. Available at: http://www.nchk.org.hk/filemanager/en/pdf/health_promotion_e.pdf
3. ANA Position Statement. (2010). The nurse's role in ethics and human rights: protecting and promoting individual worth, dignity, and human rights in practice settings. Center for Ethics and Human Rights Advisory Board. Available at: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Ethics-Position-Statements/-Nursess-Role-in-Ethics-and-Human-Rights.pdf

Session: Gender Based Violence

Session structure

This session is divided into six units covering the topics that are directly relevant with the public health functioning.

Unit 1.	Understanding GBV
Unit 2.	Factors pertaining to GBV in Pakistan
Unit 3.	Role of health sector to address GBV as a public health problem
Unit 4.	Guidelines for treatment of GBV cases and health sector response

Unit 1. Understanding GBV

GBV is a general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two, within the context of specific society. GBV is directed towards women and it disproportionately affects them across the globe.

Learning objectives

At the end of the unit participants will be able to:

- define GBV and understand its forms;
- understand the magnitude of the problem of GBV; and
- understand various explanations of GBV.

Contents

1. Definition of terms:
    a. Difference between sex and gender
    b. Gender Based Violence (GBV)
    c. Childhood sexual abuse
    d. Domestic violence
    e. Rape or Sexual assault
    f. Intimate partner violence
    g. Non-intimate partner violence
2. Types/forms of GBV
    a. Physical violence
    b. Psychological/Emotional violence
    c. Sexual violence
3. Prevalence of violence worldwide and in Pakistan

Suggested Readings

1. UNFPA. (2001). A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers. New York. United States.
2. WHO. (2014). Global Status Report on Violence Prevention 2014. Geneva. Switzerland.
3. WHO. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva. Switzerland.

Unit 2. Factors pertaining to GBV in Pakistan

GBV is a structural phenomenon embedded in the context of socioeconomic, cultural and political power relations. Like other developing countries, Pakistan also has a patriarchal society where men consider themselves superior to women and think violence against women as their moral and legal right. Such erroneous perceptions result in the continuation of violence against women. In this context, it is necessary to understand the socio-cultural factors associated with GBV and its health consequences.

Learning objectives

At the end of the unit participants will be able to:

- understand social, cultural, economic and political factors that underpin the gender based violence; and
- Comprehend the health consequences of gender based violence

Contents

1. Social and Cultural Factors
    a. Patriarchal structure
    b. Violence as private family matter
    c. Discriminatory customs and practices
    d. Acceptability of violence as a means to resolve conflict
2. Economic Factors
    a. Women's economic dependence on men
    b. Limited access to employment
    c. Limited access to education
3. Political Factors
    a. Under-representation of women in different fields
    b. Domestic violence not taken seriously, as consider it family matter

4. Health consequences of violence
    a. Physical
    b. Psychological
    c. Sexual and reproductive

Suggested Readings

1. A Good Practice Training Module for Health Care Professionals (2000), *International Planned Parenthood Federation.* South Asia Regional Office, New Delhi, India
2. USAID. (2010). Gender-Based Violence: Impediment to Reproductive Health.

Unit 3. Role of Health Sector to Address GBV as Public Health Problem

GBV is a major public health problem that urgently needs to be addressed by the government and health organizations. The nurses are usually the earliest point of contact for survivors of violence, their role becomes critical in addressing the GBV as a major public health problem. They can contribute in reducing violence by changing social attitudes towards GBV and projecting it as a public health problem. Additionally, by strengthening their linkages with other professionals, they can screen the cases of violence and refer them to need based services.

Learning objectives

At the end of the unit participants will be able to:

- understand their roles and responsibilities in supporting survivors of GBV;
- identify impediments that survivors face in assessing support services in a medical setting; and
- develop synergy with the other stakeholders including psychologists, lawyers, and welfare officers.

Contents

1. Significance and need for health sector response for GBV
2. Impediments medical setting for GBV survivors
    a. Lack of multi-sectoral referral network at the provincial, district and community level
    b. Lack of capacity of healthcare providers to address GBV
    c. Lack of integrated Management Information System for documenting GBV cases
    d. Lack of surveillance system, protocols for detection and quality of care
    e. Lack of forensic infrastructure and skills
3. Levels of service integration to address GBV
    a. selective provider and/or facility level integration
    b. comprehensive provider and/ or facility-level integration
    c. systems-level integration

Suggested Readings

1. Colombini, Manuela et. al. (2008). Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities, Bulletin of the World Health Organization, Vol. 86, Number 8, pp. 635-642.

Unit 4. Guidelines for treatment of GBV cases and health sector response

WHO has given a number of guidelines for dealing with the victims of GBV. These guidelines cover almost every aspect of GBV in medical setting and ensure an improved health sector's response towards the overall wellbeing of survivors of violence. Nonetheless, public health sector in Pakistan mostly operates without adopting any standardized guidelines for dealing the cases of GBV. As a result, health sector response towards treatment of survivors of violence remains poor.

Learning objectives

At the end of the unit participants will be able to:

- understand the significance of using guidelines in healthcare sector to deal with GBV cases
- understand the ethical considerations in protecting rights of women
- learn the steps to support to the survivors of GBV including identification, documentation, counseling of survivors and their family members;

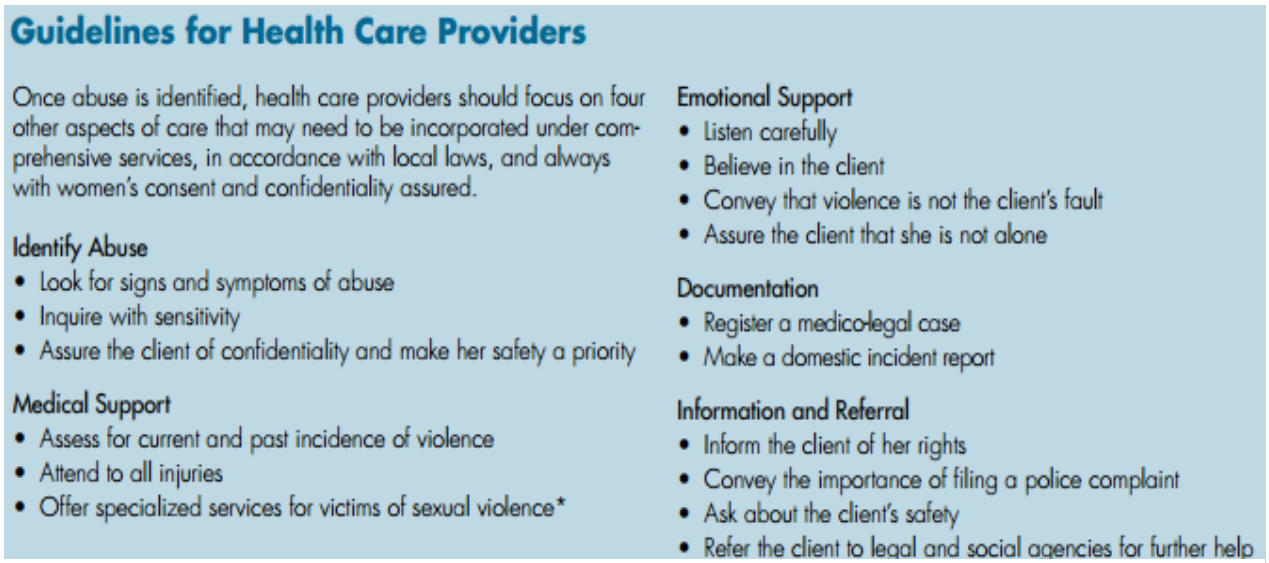
Contents

1. Basic guidelines for healthcare providers/managers

   a. Identify GBV cases
   b. Medical Support
   c. Emotional Support
   d. Documentation
   e. Information and Referral

2. Ethical concern in addressing GBV

   a. Confidentiality
   b. Privacy
   c. Safety
   d. Nondiscrimination
   e. Respect



Guidelines for Health Care Providers

Once abuse is identified, health care providers should focus on four other aspects of care that may need to be incorporated under comprehensive services, in accordance with local laws, and always with women's consent and confidentiality assured.

Identify Abuse
- Look for signs and symptoms of abuse
- Inquire with sensitivity
- Assure the client of confidentiality and make her safety a priority

Medical Support
- Assess for current and past incidence of violence
- Attend to all injuries
- Offer specialized services for victims of sexual violence*

Emotional Support
- Listen carefully
- Believe in the client
- Convey that violence is not the client's fault
- Assure the client that she is not alone

Documentation
- Register a medico-legal case
- Make a domestic incident report

Information and Referral
- Inform the client of her rights
- Convey the importance of filing a police complaint
- Ask about the client's safety
- Refer the client to legal and social agencies for further help

Source: Ashford & Feldman-Jacobs, 2010

Suggested Readings

1. Ashford, L., & Feldman-Jacobs, C. (2010). The crucial role of health services in responding to gender-based violence., available at. http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdfWHO. (2003). Guidelines for medico-legal care for victims of sexual violence, Geneva: World Health Organization
2. Health Sector Response to GBV National Guideline on providing care and prevention for Health Care Providers (2013) Health Protection Agency UNFPA, Available online http://www.health.gov.mv/publications/25_GBV_Guideline-Maldives.pdf

Session: Health Equity

Session structure

The session on health equity comprise the following units:

Unit 1. Introduction to Equality and Health Equity

Unit 2. Equity, accountability and healthcare delivery in relation to healthcare needs

Unit 3. Guidelines and tools for applying health equity approach and analysis

Unit 1. Introduction to Equality and Health Equity

Health equity means to provide health services according to the needs of people. On the other hand, equality means having an equal right to health for everyone. Pakistan's health care system follows a 90/10 approach in allocating and rendering health care services. Owing to the financial constraints the country cannot provide dynamic services to all particularly to marginalized groups. Health sector follows various equity approaches such as vertical (from federal level to basic unit level) and horizontal (at the same level). Such types of approach are also known as community oriented health services. The profession of nursing is involved in health promotion, counselling, education and collaboration with other health care professionals. Therefore, this unit will build up their understanding regarding the need of vertical and horizontal equity.

Learning Objectives

At the end of the unit, the participants will be able to:

- differentiate between equity and equality; and
- expand their acumen in relation to social justice and health inequities; and
- understand the significance and need for deployment of horizontal and vertical equity.

Contents

Following are the content to be covered under this unit:

1. Introduction to health equity
    a. Definition of health equity
    b. Differentiate between equity and equality
    c. Differentiate Health Disparity and Health Equity
    d. Barriers to Health Equity
        i. Racism
        ii. Ethnocentrism
        iii. Segregation
        iv. Stereotyping
        v. Classism
        vi. Lack of money, resources and education
2. Types of Health equity
    a. Horizontal equity
    b. Vertical equity
    c. Significance of deployment of horizontal and vertical equity
3. Social justice and health inequities
    a. moral importance of health care
    b. identify unjust health inequalities
    c. limits of fair health care
    d. Factors affecting health outcomes and Health equity

i. Interpersonal factors
ii. Institutional factors
iii. Social factors
iv. Political factors

Suggested readings

1. Public Health Reports (2014) What Are Health Disparities and Health Equity? We Need to Be Clear Supplement 2 / Vol129; Available at http://www.publichealthreports.org/issueopen.cfm?articleID=3074
2. Kawach I and Kennedy BP,(1997), Health and social cohesion: Why care about income inequality? British medical journal. Available at http://www.hsph.harvard.edu//benchmark/ndaniels/pdf/justice_health.pdf
3. Deatrick, J. A., Lipman, T. H., Gennaro, S., Sommers, M., de Leon Siantz, M. L., Mooney-Doyle, K., ... & Jemmott, L. S. (2009). Fostering health equity: clinical and research training strategies from nursing education. The Kaohsiung journal of medical sciences, 25(9), 479-485.

Unit 2. Equity, accountability and health care delivery in relation to health care needs

To achieve health equity, accountability of healthcare delivery system is critically important. The nurses need to understand root causes of inequalities at cross government and inter-sectoral levels. Furthermore, they require understanding about accountability procedures and guidelines for ensuring equitable healthcare. This unit will enable them to better serve citizens/patients in the face of opportunities and constraints of evolving healthcare systems.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand health care delivery approach in national context; and
- Comprehend an evidence-based approach to monitor health equity including regular assessment, prioritization, planning, action and evaluation of health care delivery in relation to health care needs

Contents

Following are the contents to be covered under this unit:

1. Autonomy of Health care Institutions
2. Structure of Health care Institutions

- Structural causes of health disparities

3. Levels of healthcare facilities
4. Monitoring progress on health equity
5. Intersection of health and social justice

Suggested Readings

1. WHO. (n.d). Evidence on social determinants of health. Geneva.
2. Cochrane. Health Equity Field: contribution to an evidence-based approach to equity, available at
3. http://www.eventos.bvsalud.org/agendas/BVS-COR/public/documents/vivian_equity-182604.pdf
4. Equity-Oriented Monitoring in the Context of Universal Health Coverage, Published online 2014 Sep 22 available at; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4171107/
5. Sania Nishtar. Health System in Pakistan available at: http://www.heartfile.org/pdf/phpf-GWP.pdf

Unit 3. Guidelines and tools for applying health equity approach and analysis

To achieve health equity, there is a need to integrate equity goals, approaches, and indicators into policies, plans and development agendas. The nurses can support in identifying priority populations through surveillance and assessment, and address the program/service needs of specific populations negatively affected by determinants of health. This unit will address the international guidelines and framework as a model for providing health equity in country context.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the equity framework and approaches to equitable resources; and
- analyse WHO guidelines and tools for applying health equity; and
- assess health care facilities and health equity in country context.

Contents

Following are the contents to be covered under this unit:

1. Approaches to Reduce Health Inequities
    a. targeting disadvantage population groups/social classes

b. narrowing the health gaps
c. reducing inequities throughout the whole population

2. Guidelines and Tools for Applying Health Equity
    a. defining the tools and setting the agenda
    b. globalization and health equity
    c. developing the policies to meet the guidelines for health equity
    d. implementing strategies to eradicate the health inequities
    e. monitoring and evaluation of policies on health equity
3. Assessment of Health facilities and Health Equity in Pakistan
    a. national and provincial policies and commitment to health equity
    b. governance and accountability
    c. health care financing and mobilization of resources
4. The Role of Health Care Providers to reduce Health Inequities
    a. gathering information regarding the socio-economic conditions of the patients
    b. finding supportive linkages
    c. adopting equitable treatment strategies
    d. avoidable patterns of inequalities

Suggested Readings

1. Public Health agency of Canada. (2014). Toward health equity: Canadian approaches to the health sector role
2. Government of Pakistan. (2001). National Health Policy 2001, The Way forward: Agenda for Health Sector Reform, Islamabad: Ministry of Health.
3. WHO. (2010). Urban Health Equity Assessment and Response Tools, Kobe: World Health Organization.
4. WHO. (n.d). Country Cooperation Strategy for Pakistan 2011-2017, Islamabad: World Health Organization

Session: Social Determinants of Health

Session Structure

The session on social determinants of health will comprise the following units:

Unit 1 SDH Approaches to Public Health

Unit 2 Importance of addressing SDH to achieve universal health coverage and health equity

Unit 1. SDH Approaches to Public Health

The SDH approach to public health is guided by the view that health is not simply a medical issue based on natural, biological factors and medical interventions. Health is a social issue and a

product of the interaction between biology and the physical, socio-cultural and political environment in which individuals live and act. The healthcare professionals especially nurses should have a comprehensive understanding of SDH approaches and the ways to implement these in promoting health status of individuals. .Drawing on their historical legacy as patient advocates, patient care expertise, and community focused education, nurses are ideally positioned to lead the nation in strategies to promote health equity and identify social determinants. Nurses can work on their individual practices to reorient the healthcare system and become able to understand the impact of SDH on the health of their patients.

Learning Objectives

At the end of the unit, the participants will be able to:

- understand social determinants of health; and
- learn Key areas and components of SDH

Contents

Following are the content to be covered under this Unit:

1. Definition of Terms
    a. Social determinants
    b. Social determinants of health
2. Key areas of SDH and its components
    a. Economic Stability
        i. Poverty
        ii. Employment
        iii. Food Security
        iv. Housing Stability
    b. Neighbourhood and built Environment
        i. Access to Healthy Foods
        ii. Quality of Housing
        iii. Crime and Violence
        iv. Environmental Conditions
    c. Health and Health care
        i. Access to Primary Care
        ii. Health Literacy
    d. Social and Community Text
        i. Social Cohesion
        ii. Civic Participation
        iii. Perceptions of Discrimination and Equity
        iv. Incarceration/Institutionalization

e. Education

i. High School Graduation
ii. Enrolment in Higher Education
iii. Language and Literacy
iv. Early Childhood Education and Development

3. Conceptual framework of SDH

i. Levels of analysis

- Socioeconomic context and position
- Differential exposure
- Differential vulnerability
- Differential health outcomes
- Differential consequences

Suggested Readings:

1. World Health Organization (WHO). (2008).Commission on Social Determinants of Health . Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.
2. Office of Disease Prevention and Health Promotion. (2015). Healthy People 2020: Social Determinants of Health.
3. Canadian Nursing Association. (2012). Social Determinants of Health and Nursing: A summary of issues.

Unit 2. Importance of addressing SDH to achieve Universal Health Coverage and Health Equity

The availability of efficient and effective health coverage is the basic human right of every individual. It is essential to have an understanding of the significance of addressing SDH in order to achieve universal health coverage and health equity.

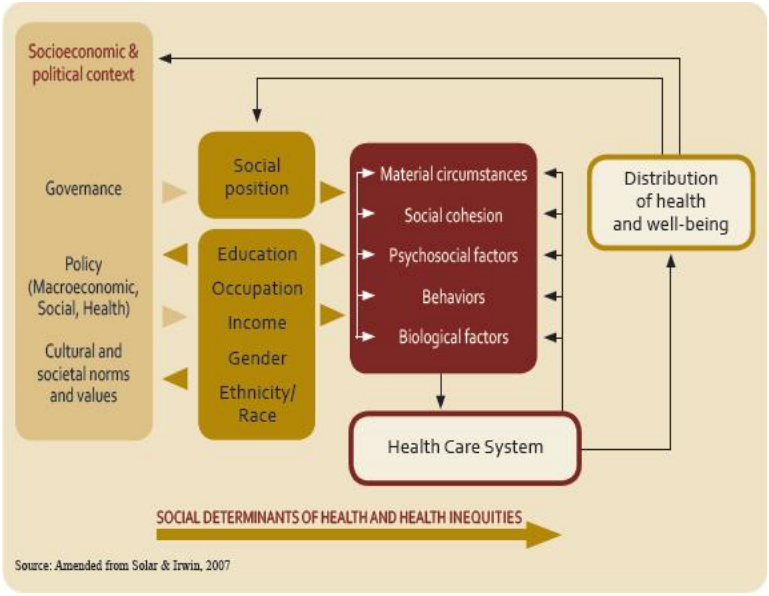
Learning Objectives

At the end of the unit participants will be able to:

- understand the link between SDH and health equity; and
- learn how SDH approaches can contribute to improve universal health coverage

Contents

The contents of this Unit will be:



1. SDH and Health Equity
    a. Social class and health inequities
    b. Displaced persons Culture, and health inequities
    c. Social and economic barriers to achieve health equity
    d. Distribution of resources to achieve health equity
    e. Monitoring health inequities
2. Role of SDH in achieving universal health coverage
    a. Social connectedness
    b. Achieving economic stability
    c. Improving environmental and policy conditions
        i. Knowledge and skills
        ii. Support within and between groups
        iii. Barriers to, access to, and opportunities for resources and services
        iv. Exposure to or protection from hazards
        v. Policies
3. Translating knowledge of SDH into actions
        i. Nursing actions: challenges
        ii. Individual barriers
        iii. Professional barriers
        iv. Institutional barriers
        v. Societal barriers

Suggested Readings:

1. CDC. (2005). Methodological Issues in Measuring Health Disparities
2. WHO. (2005). Closing the gap in a generation: Health equity through action onthe social determinants of health.
3. Lathrop, B. (2013). Nursing leadership in addressing the social determinants of health. Policy, politics, & nursing practice, 1527154413489887. Chicago

Examples of Class Exercises for Facilitator

Session: Human Rights

a. Class Exercise for *Unit 1:*

Case Study: Safia is a young Pakistani woman who lives with her husband and five children in a small village of Southern Punjab. Her husband is unemployed and drinks alcohol excessively. Whenever things get out of hand, Safia leaves her home and takes refuge at her parents' house. In these situations, her husband did not allow her to meet with the children. Every time she reconciles with him. He forces her to have sex without protection, often resulting in a new pregnancy. She always remained worried about her children and she did not want more pregnancies in this non-conducive environment. The family needs money but her husband forbids her from working. Because of continues stress, poor financial condition of the family and pressure from her husband, she did not able to communicate or work independently for the survival of her children during the previous years which often resulted into shouting, beating and torturing. Due to certain socio-cultural restraints, she was not able to expose her plight.

Identify the types of violence, Safia is facing? How the types of violence being experienced by Safia can be identified in our socio-medical scenario?

b. Class Exercise for *Unit 2:*

Case study: Javed, a poor old man 50 years of age, was suffering with Hepatitis C. He went to a public hospital for the treatment. He reached hospital early in the morning to ensure that hemight got check-up on the same day after getting a slip of an appointment. However, even with getting slip of appointment early in the morning, waited for four to five hours for check-up as he was not an influential man. His cloths were very dirty and odour of sweating was filling the room. He saw a nurse nearby reception who was writing something on a register. He moved towards reception desk and asked about his turn. The nurse asked to wait. The old man tried to enquire about treatment of diseases from nurse and asked, 'I heard that hepatitis can be cured through freely available medicine." The nurse abruptly said, 'I don't know. Hepatitis medicine is expensive, you cannot afford. It is better to stay at home and pray from Allah for health." He

further said that i do not have time to explain more than this to you, go and wait for your turn. The old went back and sit silently.

Discuss with class whether they agree that the behavior of nurses can influence provision of healthcare services to people or not by keeping the principles of health in view.

Class Exercise for *Unit 3:*

Discuss the violation of human rights in hospitals and possible ways to ensure dignity of the patients particularly women experiencing sexual violence or victims of acid throwing.

Session: Gender Based Violence

1. **Class Exercise for *Unit 3:***

"Women and Children are disproportionately targets" and constitute the "majority of all victims in the contemporary circumstances of domestic violence".

Keeping in view this statement, discuss the possible causes as well consequences of the domestic violence. Furthermore, adopt the suggestions that how the contemporary state health care system can respond this issue.

2. **Class Assignment for *Unit 4:***

Select one of the following guidelines available online, and then suggest suitable protocols/guidelines for responding GBV in Pakistan.

a. WHO, Guidelines for medico-legal care for victims of sexual violence (2003)

b. IPPF, Improving the health sector response to GBV: A resource manual for health care professionals in developing countries (2010)

c. WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013)

Session: Health Equity

1. **Class Exercise for *Unit 1:***

Case Study: Ahsan, a 34 years old male, got admitted to oncology ward with terminal stage colon cancer. His family was in highly panic state. The nursing attendant, who has been taught

health equity in their curriculum, found increased comfort in communicating with patients and families across illness continuum. She also learned to modify interventions to reflect patient responses, elicit health beliefs, and engage in difficult conversations.

Discuss with the class the other outcomes of teaching health equity to them

Session: Social Determinants of Health

2. Class Exercise for *Unit 1:*

Case Study: A patient, 48 years of age, with the muscular dysfunction came to the Outdoor Patients Department (OPD) and the doctor referred him for the physiotherapy. Now, this is the responsibility of nurse to assess his financial status and to guide him for the financial assistance to seek the recommended therapy.

Discuss with the class more of their responsibilities for such circumstances.

3. Class Activity 1 for *Unit 2:*

Do you know how you might further incorporate knowledge of the social determinants of health into your everyday practice?

4. Class Activity 2 for *Unit 2:*

How has your practice approach been framed thus far? Do you need to shift your approach on the basis of what you have learned about the social determinants of health? Will reframing questions in your practice approach radically change your practice? (if, for example, you began asking "What broader social, economic, political conditions are making it more or less likely for this person (or group) to smoke or live a sedentary lifestyle?" instead of "Why is this person (or group) engaging in unhealthy behaviours such as smoking or living a sedentary lifestyle?").

Model Curriculum for Lady Health Workers and Paramedics Programs

Introduction

Lady Health Workers (LHWs) are educated and usually belong to their own communities, reducing the unfamiliarity differences (Haines et.al., 2007; Hafeez. et.al. 2011). This criterion enables them to interact more openly and bridge the gaps between healthcare facilities and communities. People in many ways rely on information in relation to healthcare from these professionals (Haines et.al., 2007). LHWs are paid, trained, supervised by a predefined criterion. A trained LHW is educated to the level where they can provide all basic health care facilities to the community in which they are appointed. LHWs can provide family planning methods, MCH services, preventive, curative and rehabilitative services to the community (Mumtaz, 2013). Hence, communities seek for guidance and support from them. It is essential for these professionals to be educated regarding human rights, human equity, gender based violence and social determinants of health so that, they can support, refer and treat the communities especially any gender based victims appropriately and effectively (Nishtar et.al., 2013).

On the other side, in hospital setting, the paramedic staff has direct contact with patients and families. Their interaction with patients and families make their role equally important as that of doctors and nurses. Sandam & Nordmark (2006) reported that the paramedic practice and human rights are inextricably linked as it guides patient-practitioner relationship. They further emphasize that it is duty of paramedic staff to respect patient autonomy and protect their human rights.

Despite having a significant roles and duties of both LHWs and paramedical staff, they could not due perform their duty adequately due to lack of training and guidelines on human right based approaches, health equity, gender based violence, and social determinants of health. This curriculum has been designed primarily keeping in Pakistan's needs and the ways to support the knowledge of LHWs and paramedical staff to improve the health of the communities.

Learning objectives

This module consists of four sessions and each session is divided into several units. It is expected that by the end of this session, the participants will be able to:

- understand the concepts of human rights, GBV, SDH, and health equity;
- comprehend the reasons for health disparities and their link to the human rights, GBV, and SDH;
- strengthen the capacity of pharmacists to meet the practical and strategic needs of patients including marginalized patients and survivors of GBV; and
- explore and apply guidelines of human rights based approaches in public health response of Pakistan.

Methods and assessment

Teaching-learning strategy shall be interactive consisting of class discussions, studying the textbook material, participation in the class discussions, and doing the class assignments. The grade of the module will be based on an assignment (25%), presentation (25%), and a final paper (50%).

Session: Human Rights

Session structure

This session is divided into six units covering the various topics that have direct relevancy with the public health functioning.

Unit 1. Definition, types, principles and evolution of human rights

Unit 2. Guidelines and tools to apply human rights based approaches in public health response

Unit 1. Definition, Types and Principles of human rights

In the last two decades, there has been a growing concern to promote human right perspective in healthcare setting. The knowledge about human rights among LHWs and allied health professionals can promote human dignity in healthcare practices. This unit is designed to enhance understanding of LHWs and allied health professionals about the significance of human rights and right to health. Having an adequate knowledge about the principles, the LHWs and allied health professionals would be able to maintain patients' dignity and treat them without any discrimination.

Learning objectives

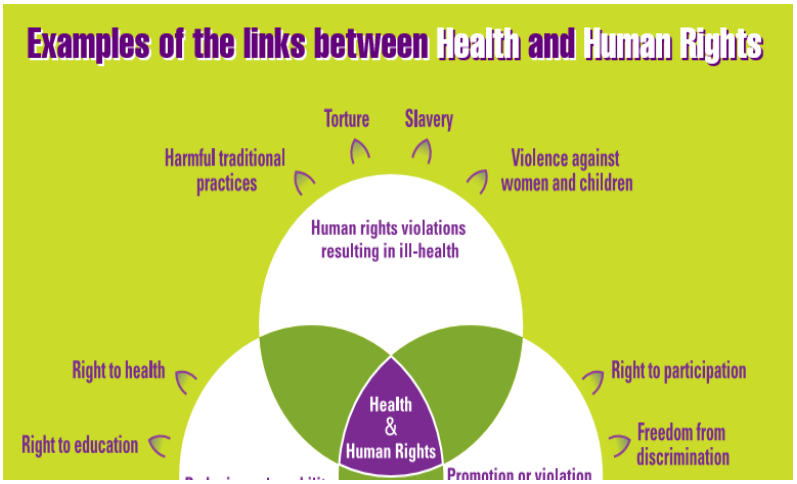
By the end of the training unit the participants will be able to:

- understand the concept of human rights and rights to health
- explore different types of human rights and recognize the interrelationship among these rights; and
- understand the principles and elements of human rights to health

Contents

Following are the contents to be covered under this unit:

1. Definition of terms:
    a. Human rights
    b. Right to health
    c. Right based approach to health
2. Categories of human rights
    a. Social rights
    b. Cultural rights
    c. Economic rights
    d. Civil rights
    e. Political rights
3. Principles of human rights to health
    a. Universality
    b. Indivisibility
    c. Participation
    d. Accountability
    e. Transparency
    f. Equity
    g. Non-Discrimination



Source: WHO. Linkages between health and Human rights

Suggested readings

1. WHO. (2002). 25 Questions & Answers on Health and Human Rights.
2. UN. (2006). Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation.
3. Eugen,Ciobota.. Evolution of the Human Rights Concept. Territorial Office of the People's Advocate Institution from Târgu-Mureş.
4. OHCHR and WHO. A Human Rights-Based Approach to Health. Available at: http://www.ohchr.org/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf
5. WHO. (2002). 25 Questions & Answers on Health and Human Rights.

Unit 2. Guidelines and Tools to Apply Human Rights Based Approaches in Health Response

The application of human right based approaches at healthcare setting calls for a range of measures to eliminate human rights violations. In this regard, WHO has developed a number of guidelines which can be applied to protect human rights of patients for improved delivery of services.

Learning objectives

By the end of the unit the participants will be to:

- understand the institutional processes and healthcare responsibilities;
- learn the ethics and guidelines to provide equitable healthcare services; and
- Gain knowledge about guidelines on human rights in patient care.

Contents (lecture)

Following are the content to be covered under this unit:

1. Institutional processes and healthcare responsibilities
2. Core ethical values and standard of good health practice
3. Promotion of supportive and enabling environment through availability, accessibility, and acceptability, and quality services (AAAQ)
4. Human rights of the Patients
    a. Respect of patient dignity
    b. Ensures access to care
    c. Protects safety of patients

Suggested readings

1. WHO. (2002), 25 Questions & Answers on Health and Human Rights.
2. United Nations, Protect, Respect and Remedy Framework and Guiding Principles. Available at: http://business-humanrights.org/en/un-secretary-generals-special-representative-on-business-human-rights/un-protect-respect-and-remedy-framework-and-guiding-principles
3. PRETORIA. (2008). Guidelines for good practice in the health care professions general ethical guidelines for the health care professions. Available at: http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf

Session: Gender Based Violence

Session structure

This session is divided into six units covering the topics that are directly relevant with the public health functioning.

Unit 1. Understanding GBV

Unit 2. Factors pertaining to GBV in Pakistan

Unit 3. Guidelines for treatment of GBV cases and health sector response

Unit 1. Understanding GBV

GBV is a general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two, within the context of specific society. GBV is directed towards women and it disproportionately affects them across the globe.

Learning objectives

At the end of the unit participants will be able to:

- define GBV and understand its forms;
- understand the magnitude of the problem of GBV; and
- understand various explanations of GBV.

Contents

1. Definition of terms:
    a. Difference between sex and gender
    b. Gender Based Violence (GBV)
    c. Childhood sexual abuse
    d. Domestic violence
    e. Rape or Sexual assault
    f. Intimate partner violence
    g. Non-intimate partner violence
2. Types/forms of GBV
    a. Physical violence
    b. Psychological/Emotional violence
    c. Sexual violence
3. Prevalence of violence worldwide and in Pakistan

Suggested Readings

1. UNFPA. (2001). A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers. New York. United States.
2. WHO. (2014). Global Status Report on Violence Prevention 2014. Geneva. Switzerland.
3. WHO. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva. Switzerland.
4. NHS Scotland (2009). What health workers need to know about gender-based violence: an overview.

Unit 2. Factors pertaining to GBV in Pakistan

GBV is a structural phenomenon embedded in the context of socioeconomic, cultural and political power relations. Like other developing countries, Pakistan also has a patriarchal society where men consider themselves superior to women and think violence against women as their moral and legal right. Such erroneous perceptions result in the continuation of violence against women. In this context, it is necessary to understand the socio-cultural factors associated with GBV and its health consequences.

Learning objectives

At the end of the unit participants will be able to:

- understand social, cultural, economic and political factors that underpin the gender based violence; and
- Comprehend the health consequences of gender based violence

Contents

1. Social and Cultural Factors
    a. Patriarchal structure
    b. Violence as private family matter
    c. Discriminatory customs and practices
    d. Acceptability of violence as a means to resolve conflict
2. Economic Factors
    a. Women's economic dependence on men
    b. Limited access to employment
    c. Limited access to education

3. Political Factors
    a. Under-representation of women in different fields
    b. Domestic violence not taken seriously, as consider it family matter
4. Health consequences of violence
    a. Physical
    b. Psychological
    c. Sexual and reproductive

Suggested Readings

1. A Good Practice Training Module for Health Care Professionals (2000), *International Planned Parenthood Federation.* South Asia Regional Office, New Delhi, India
2. USAID. (2010). Gender-Based Violence: Impediment to Reproductive Health.
3. USAID. (2012). The Crucial Role of Health Services in Responding to Gender-Based Violence

Unit 3. Guidelines for treatment of GBV cases and health sector response

WHO has given a number of guidelines for dealing with the victims of GBV. These guidelines cover almost every aspect of GBV in medical setting and ensure an improved health sector's response towards the overall wellbeing of survivors of violence. Nonetheless, public health sector in Pakistan mostly operates without adopting any standardized guidelines for dealing the cases of GBV. As a result, health sector response towards treatment of survivors of violence remains poor.

Learning objectives

At the end of the unit participants will be able to:

- understand the significance of using guidelines in healthcare sector to deal with GBV cases
- understand the ethical considerations in protecting rights of women
- learn the steps to support to the survivors of GBV including identification, documentation, counseling of survivors and their family members;

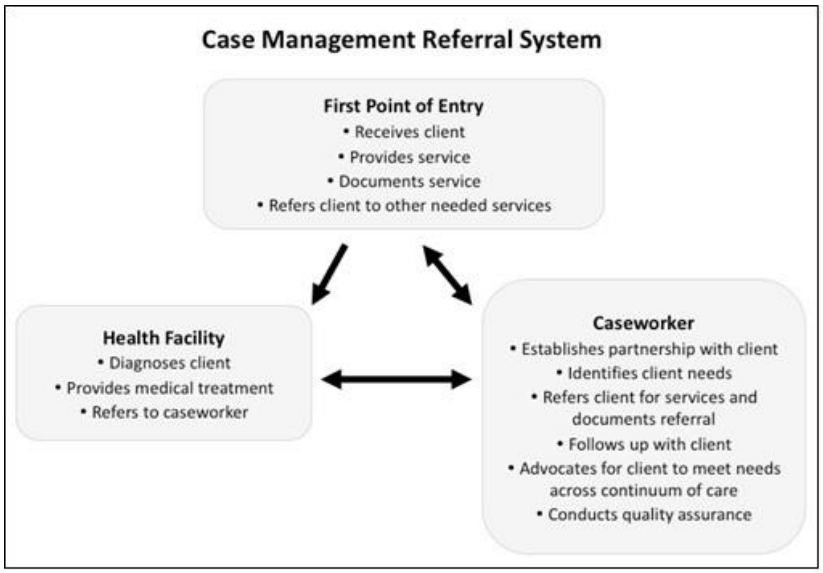
Contents

1. Basic guidelines for healthcare providers/managers

    a. Identify GBV cases
    b. Medical Support
    c. Emotional Support
    d. Documentation
    e. Information and Referral

2. Ethical concern in addressing GBV

    a. Confidentiality
    b. Privacy
    c. Safety
    d. Nondiscrimination
    e. Respect



Source: GBV Resource Tool. (2008): Establishing GBV Standard Operating Procedures (SOP Guide) May 2008 IASC Sub-Working Group on Gender & Humanitarian Action

Suggested Readings

1. Ashford, L., & Feldman-Jacobs, C. (2010). The crucial role of health services in responding to gender-based violence., available at. http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdfWHO. (2003). Guidelines for medico-legal care for victims of sexual violence, Geneva: World Health Organization
2. Health Sector Response to GBV National Guideline on providing care and prevention for Health Care Providers (2013) Health Protection Agency UNFPA, Available online http://www.health.gov.mv/publications/25_GBV_Guideline-Maldives.pdf
3. WHO. (2005). Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies

Session: Health Equity

Session structure

The session on health equity will comprise the following units:

Unit 1. Introduction to Equality and Health Equity

Unit 2. Guidelines and tools for applying health equity approach and analysis

Unit 1. Introduction to Equality and Health Equity

Health equity means to provide health services according to the needs of people. On the other hand, equality means having an equal right to health for everyone. Pakistan's health care system follows a 90/10 approach in allocating and rendering health care services. Owing to the financial constraints the country cannot provide dynamic services to all particularly to marginalized groups. Health sector follows various equity approaches such as vertical (from federal level to basic unit level) and horizontal (at the same level). Such types of approach are also known as community oriented health services. This unit will build up the healthcare professionals' understanding regarding the need of vertical and horizontal equity.

Learning Objectives

At the end of the unit, the participants will be able to:

- differentiate between equity and equality; and
- expand their acumen in relation to social justice and health inequities; and
- understand the significance and need for deployment of horizontal and vertical equity.

Contents

Following are the content to be covered under this unit:

1. Introduction to health equity
    a. Definition of health equity
    b. Differentiate between equity and equality
    c. Differentiate Health Disparity and Health Equity
2. Types of Health equity
    a. Horizontal equity
    b. Vertical equity
    c. Significance of deployment of horizontal and vertical equity
3. Social justice and health inequities
    a. moral importance of health care
    b. identify unjust health inequalities
    c. limits of fair health care

Suggested readings

1. Public Health Reports (2014) What Are Health Disparities and Health Equity? We Need to Be Clear Supplement 2 / Vol129; Available at http://www.publichealthreports.org/issueopen.cfm?articleID=3074

2. Kawach I and Kennedy BP,(1997), Health and social cohesion: Why care about income inequality? British medical journal. Available at http://www.hsph.harvard.edu//benchmark/ndaniels/pdf/justice_health.pdf
3. Health Care Aotearoa and the University of Auckland Aotearoa / New Zealand. (2011). The role of the Community Health Worker in a Māori person's health journey

Unit 2. Guidelines and tools for applying health equity approach and analysis in Community

To achieve health equity, there is a need to integrate equity goals, approaches, and indicators into policies, plans and development agendas. This unit will address the international guidelines and framework as a model for providing health equity in country context.

Learning Objectives

At the end of this unit, the participants will be able to:

- understand the equity framework and approaches to equitable resources; and
- analyse WHO guidelines and tools for applying health equity; and
- assess health care facilities and health equity in country context.

Contents

Following are the contents to be covered under this unit:

1. Approaches to Reduce Health Inequities
    a. targeting disadvantage population groups/social classes
    b. narrowing the health gaps
    c. reducing inequities throughout the whole population
2. The Role of Health Care Providers to reduce Health Inequities
    a. gathering information regarding the socio-economic conditions of the patients
    b. finding supportive linkages
    c. adopting equitable treatment strategies

Suggested Readings

1. Canadian Medical Association. (2013). Physicians and Health Equity: Opportunities in Practice, available at;http://healthcaretransformation.ca/wp-content/uploads/2013/03/Health-Equity-Opportunities-in-Practice-Final-E.pdf
2. Government of Pakistan. (2001). National Health Policy 2001, The Way forward: Agenda for Health Sector Reform, Islamabad: Ministry of Health.

3. WHO. (2010). Urban Health Equity Assessment and Response Tools, Kobe: World Health Organization.
4. WHO. (n.d). Country Cooperation Strategy for Pakistan 2011-2017, Islamabad: World Health Organization
5. Braveman, P. (2014). What are health disparities and health equity? We need to be clear. Public Health Reports, 129(Suppl 2), 5.

Session: Social Determinants of Health

Session Structure

The session on social determinants of health will comprise the following units:

Unit 1 SDH Approaches to Community Health Sector

Unit 2 Guidelines for addressing and integrating SDH at community level through inter-sectoral action.

Unit 1. SDH Approaches to Community Health

The SDH approach to public health is guided by the view that health is not simply a medical issue based on natural, biological factors and medical interventions. Health is a social issue and a product of the interaction between biology and the physical, socio-cultural and political environment in which individuals live and act. The healthcare professionals should have a comprehensive understanding of SDH approaches and the ways to implement these in promoting health status of individuals.

Learning Objectives

At the end of the unit, the participants will be able to:

- understand social determinants of health; and
- learn Key areas and components of SDH

Contents

Following are the content to be covered under this Unit:

1. Definition of Terms:
    a. Social determinants
    b. Social determinants of health
2. Key areas of SDH and its components
    a. Economic Stability
        i. Poverty
        ii. Employment

iii. Food Security
iv. Housing Stability

b. Neighbourhood and built Environment

i. Access to Healthy Foods
ii. Quality of Housing
iii. Crime and Violence
iv. Environmental Conditions

c. Health and Health care

i. Access to Primary Care
ii. Health Literacy

d. Social and Community Text

i. Social Cohesion
ii. Civic Participation
iii. Perceptions of Discrimination and Equity
iv. Incarceration/Institutionalization

e. Education

i. High School Graduation
ii. Enrolment in Higher Education
iii. Language and Literacy
iv. Early Childhood Education and Development

Suggested Readings:

1. World Health Organization (WHO). (2008). Commission on Social Determinants of Health . Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.
2. Office of Disease Prevention and Health Promotion. (2015). Healthy People 2020: Social Determinants of Health.
3. Community Tool Box. Addressing Social Determinants of Health and Development: Chapter 17. http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main
4. WHO. (2009).Action on the Social Determinants of Health: Learning From Previous Experiences

Unit 2. Guidelines for addressing and integrating SDH at Community level through inter-sectoral action

For integrating SDH at community level, government needs to coordinate and align different sectors and different types of organizations in the pursuit of health and development. Building governance, whereby all sectors take responsibility for reducing health inequities, is essential to achieve this goal. In addition to government participation in integrating SDH at policy level, the participation of individuals, community and civil society is also mandatory for reducing health inequities.

Learning objectives

At the end of the Unit participants will be able to:

- understand the guidelines for integrating SDH at community level;
- understand the role of different sectors in integrating SDH at community level ; and
- understand the significance and applications of "health in all policies" strategy to improve health equity.

Contents:

The contents of this unit will be:

1. Ways to Address SDH issues
2. Guidelines for incorporating inter sectoral means to resolve problems related to SDH

Suggested Readings:

1. WHO. (2012). Social Determinants of Health Discussion Paper 9: Integration of social determinants of health and equity into health strategies, programes and activities; health equity training process in Spain
2. American Public Health Institution. (2013). A Guide for State and Local Governments.

Examples of Class Exercises for Facilitator

Session: Human Rights

1. Class Exercise for *Unit 1:*

Case study: Shakeel Ahmed, a poor old man 60 years of age, was suffering from Tuberculosis. He went to a public hospital for the treatment. He got his appointment early in the morning. His cloths were very dirty and bad odor of sweating was coming from him. After his examination, the doctor asked him to get some infusions. He went to the paramedical staff and asked them to inject him the medicines. No one was paying attention to him as he was not an influential man.

One of the staff said to him, " Baba G please come later as we have other patients to attend to". Shakeel got very upset with the attitude of the Dispensers. His dignity was badly affected. He went to a private clinic and asked the same question. The medical Attendant made him seat properly, and inject him the prescribed medications. The old man felt very happy and his health started to improve. *Discuss with class whether they agree that the behaviour of paramedical staff can influence the health of people or not by keeping the principles of health in view.*

2. Class Exercise for *Unit 2:*

Discuss the violation of human rights in hospitals and possible ways to ensure dignity of the patients particularly patients from rural and low middle class families.

Session: Gender Based Violence

1. Class Exercise for *Unit 1:*

Case Study: A poor and physically weak rural woman Naseema 45 year's age lives in remote village of Pakistan. She is married and has seven children. She lives with her family and in-laws. She was experiencing domestic violence from her husband and in-laws for many years. One day, Naseema receives severe injuries on her face and body. One of her (female) neighbour took her to the nearest Basic Health Unit for medical treatment. She bleeds from her head, nose and has several bruises on her back and legs. When asked by the paramedical staff about the cause of the injuries, she simply replied that she fell down the stairs. Naseema's previous medical record showed that she visited the BHU many times, with the same type of injuries. She also sought emergency contraception thrice because of unwanted pregnancies. The staff is anxious about the health of this patient, and believes that her symptoms could be caused by domestic violence. They were hesitant what to do, as they realize that Naseema is not willing to talk about the nature of her injuries.

Instructions for the students; Read the above case study and discuss the following questions in your class:

1. What is the role of BHU Paramedical to confront a patient like Naseema?

2. What are the steps, a Dispenser should take to handle such patients. List some of the important steps.

3. Divide the class into five different groups. Each group should discuss the causes of domestic violence and then write the possible steps on their note books and then each group should nominate a group leader to present these steps in front of their class mates.

2. Class Exercise for *Unit 2:*

Case Study: Bushra is a young woman who lives with her husband and seven children in a small rural area of Punjab. The lady Health Worker (LHW) of that area visits regularly for the provision of medical services. During her visits, she notices that Bushra often seems very depressed and sometimes there are prominent marks on her body that shows that someone has beaten her badly. On enquiry, Bushra tells her that her husband is unemployed and drinks alcohol excessively. Whenever things get out of hand, he abuses her physically and sexually. He forces her to have sex without protection, often resulting in a new pregnancy. She always remain worried about her children and do not want more pregnancies in this non-conducive environment. The family needs money but her husband forbids her from working. Because of continues stress, poor financial condition of the family and pressure from her husband, she did not able to communicate or work independently for the survival of her children during the previous years which often resulted into shouting, beating and torturing. Due to certain socio-cultural restraints, she was not able to expose her plight.

Identify the types of violence, Bushra is facing? And what can be the responsibilities of LHW can be in such circumstances.

Session: Health Equity

1. Example for *Unit 1:*

Research (evidence) shows that people living in poverty receive less than a proportional share of public funding for health, relative to the better off. Gender, socio-cultural and financial discrimination contribute significantly to inequities in health and in access to health care services. For example Australia's Health Report (AIHW 2008b) states that, "compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives, higher levels of disease risk factors and lower use of preventive health service". *Discuss this issue in Pakistani context with the students.*

2. Class Activity 1 for *Unit 2:*

What roles paramedical staff and Lady Health Workers (LHW) can play within their own health facility and Community in the advancement of achieving Health Equity.

3. Class Activity 2 for Unit 3:

The teacher will ask the student to identify the most suitable tools of health equity in Pakistani context

Session: Social Determinants of Health

1. Example for *Unit 1*:

In the past some years, there is in increased incidence of Dengue and malaria cases. It was observed that the rate of these cases were high in the areas where there is a poor sanitation and waste Disposal System. The socio cultural factors of inhabitants are somehow linked to these diseases. Moreover, lack of awareness and education also make them vulnerable to these diseases.

Keeping the situation of inhabitant of such areas, discuss with the class how the lady health workers and paramedical staff can help in overcoming this issue.

2. Class Exercise for *Unit 2:*

"With literacy, people gain skills that allow them to continue and expand the community development activities, or to get jobs that will better serve them and their families. Literacy also gives people (who've typically been powerless) a means of power over their lives by helping them understand the forces working on them and take action on their own behalf."

Discuss with class that how level of education and awareness effects health.

Format of Training Workshop for in-Service Health Practitioners On Human Rights and Gender Based Violence

Background

It is imperative that health managers and practitioners in health care delivery system are cognizant of the human rights and gender based violence (GBV). In the current scenario, however both these concepts are inadequately, if at all, addressed in their professional

education and training. Consequently, these issues are not explicit in the public health response. It is now intended that the health managers and practitioners are exposed to these concepts.

The aim and learning objectives

The aim or outcome of the training workshop is that the participants at the end of the exercise may acquire demonstrable learning or skill development and a tangible improvement in practice, in terms of assuring health as a human right and screening and treating the cases of GBV.

Within the remits of the above aim, the objectives of this workshop are to build the participants' understanding regarding health as a human right and how they deal and manage the issues related to GBV are well addressed in their day-to-day actions and decisions. The discourse will encompass the concepts *per se* and the related aspects, knowledge about the national and international policies, treaties and commitments; the guidelines, including framed by WHO, and their applications in public health response; and the needs of women victims of violence within the framework of human rights.

Training material

Training material for the workshop shall be developed by the facilitator. It will mainly be the power point. slides drawn on the material designed for the pre-service training modules in 'health as human right' and 'gender based violence'. This approach is advised essentially to ensure that the outline of the material is uniform as well as allowing enough flexibility for the facilitators to use their innovation and adjustment according to the training needs of the participants.

Training evaluation

This is an important aspect of in-service training. It will cover two levels of **Kirkpatrick model**[4] for training evaluation. The **level 1** will measure the participants' reaction to training in terms of their feeling about the instructor, the topic, the material, its presentation, and the venue. This level of evaluation helps in understanding how well the training was received and to improve for future trainees and to identify areas or topics that are missing from training.

[4] http://www.mindtools.com/pages/article/kirkpatrick.htm accessed on 29 July, 2015

The **level 2** measures what the trainees have learned in the workshop. That is, how much has their knowledge increased as a result of the training? A pre-test and post-test exercise essentially drawing on the workshop objectives and training material contents will be conducted. The facilitator will be responsible for analyzing and reporting the evaluation results. **Level 3** evaluation is about how far trainees have changed their behavior, specifically, how trainees apply the information they received in training. This level can be judged after adequate time, say about six months after training.

Workshop programme

Individual and group exercises that are essential learning tools to reflect the experiences and their integration to the new knowledge and skills development usually take more time than scheduled. Therefore, while it is important that by the end of workshop objectives are achieved, programme should be kept flexible to accommodate and harness the opportunity of reflective learning.

In addition, adequate time should be allowed for an appropriate introduction and pre-test at the outset and a post-test and summary at the end to facilitate learning. Likewise, it might be a good idea to start the day with a recap of the previous day's proceedings. In certain districts, there might also be a formal ceremony for closing the workshop and agreeing with participants a way forward.

NB: the column for 'time' in the programme is not filled, primarily to allow the facilitator to adjust according to the situation.

Day 1		
Opening Session		
Time	Activity	Presenter/facilitator
	Registration	Insert name and designation of responsible person
	Welcome address	Insert name and designation
	Address by guest of honour	Insert name and designation
	Workshop objectives and programme	Insert name and designation
	Introduction of participants and workshop logistics	Insert name and designation
	Coffee Break	
Session 1		
	Pre-test[5]	Insert name and designation
	Health as human right: definitions and concepts	Insert name and designation
	Group work – human rights' status in workplace[6] as adjudged by the participants	
	Plenary – presentation of group work	
	Lunch and prayers	
Session 2		
	Human rights in the context of equity: concepts and definition of linkages	Insert name and designation
	Group work[7]	
	Plenary – presentation of group work	
	Allocation of assignment[8]	
Day 2		
Session 3		
	Re-cap of day-1 and plenary for submission of assignment	
	National and international policies, strategies and treaties: concepts	
	Group work[9]	
	Plenary – presentation of group work and discussion	
	Coffee Break	
Session 4		
	Human rights: introduction to guidelines[10] for application in day-to-day work in health	

[5] The facilitator is encouraged to design multiple choice questionnaire (comprising about ten questions).
[6] The group can be asked: "in the light of definition and the broader concept of health as human right, to what extent is this respected and applied in the workplace setting the participants/group members come from".
[7] The group will be given an article: http://www.who.int/bulletin/volumes/81/7/en/Braveman0703.pdf and asked to comment in the wake of situation in the district the group members' come from.
[8] All participants will be asked to review the article in their own time, and comment (written not exceeding half page) on the plenary presentations made during group work in session 2.
[9] The group will be provided a copy of the national commitment towards human rights and asked to discuss and comment on the level of implementation at the national level.
[10] Guidelines available at: http://www.ohchr.org/Documents/Publications/Traffickingen.pdf

	Group work – develop a plan for using guidelines at the workplace	
	Plenary – presentation of group work and discussion	
	Lunch and prayers	
Session 5		
	GBV: concept and the public health response	
	Group work[11] – develop a plan for assuring public health response to GBV	
	Plenary – presentation of group work and discussion	
	Assignment for individual participants[12]	
	Day 3	
Session 6		
	Re-cap of day-2 and plenary for submission of assignment	
	WHO guidelines on gender based violence[13]: an introduction	
	Group work – develop a plan for using guidelines at the workplace	
	Plenary – presentation of group work and discussion	
	Coffee Break	
Session 7		
	Building capacity of health professionals for assuring public health response to GBV: concepts	
	Group work – what are capacity needs for public health response to GBV	
	Plenary – presentation of group work and discussion	
	Lunch and prayers	
Session 8		
	Post – test and evaluation	
	Summary of workshop	
	Handing in the attendance certificates	
	Closing and way forward	

[11] The group will discuss and write 100 words on, to what extent public health response to GBV is adequate and allied to human rights?

[12] The individual participants will reflect on what was discussed during the group work (session 5) and refine the plan of action of their specific workplace.

[13] http://www.who.int/hac/network/interagency/news/iasc_gender_guidelines/en/

Format of Training Workshop Training of Health Practitioners in Social Determinants of Health and Equity

Background

In order the public health managers and clinical practitioners in health care delivery system are aware of the social determinants of health and use equity as the basis for their day-to-day actions and decisions, it is imperative they are exposed to such concept and practices. That is, inter-alia, they within the domain of social determinants of health need to be aware of the importance of equity in the financing and provision of health services and that health inequity is a public health problem, essentially adversary to social justice and that the health managers and clinical practitioners can in their work contribute to its exacerbation or amelioration?

The aim and learning objectives

The aim of the training workshop is that the participants at the end of the exercise will have acquired demonstrable learning, skill development and a tangible change or improvement in practice. They will have understanding that inequality in the distribution of social determinants of health is a problem, which they should address in their day-to-day actions and decisions, marking public health response.

Within the remits of the above aim, the objective of this workshop is to build the participants' understanding regarding the importance of assuring equity in the distribution of social determinants of health. The discourse will encompass different aspects and related concepts, e.g. equity and equality; equity in health services provision and financing, vertical and horizontal equity, equity as a principle of health for all by 2000 (WHO, Alma Ata, 1978) and will address questions like how the quest for efficiency is likely to affect equity.

Training material

Training material for the workshop shall be developed by the facilitator. It will mainly be ppt. slides drawn on the material designed for the pre-service training module on 'social determinates of health' and 'health equity'. This approach is advised essentially to assure that outline of the training material is uniform as well as allowing the flexibility for the facilitators to use their innovation and adjustment according to the training needs of the participants.

Training evaluation

This is an important aspect of in-service training. It will cover two levels of Kirkpatrick model[14] for training evaluation. The level 1 will measure the participants' reaction to training in terms of their feeling about the facilitator, the topics, the material, its presentation, and the venue. This level of evaluation helps in understanding how well the training was received and to improve its delivery for future trainees and to identify areas or topics that are missing from training.

The level 2 measures what the trainees have learned. That is, how much has they gained and their knowledge increased as a result of the training? A pre and post-test exercise essentially drawing on the workshop objectives and training material contents will be conducted. The facilitator will be responsible for analysing and reporting the evaluation results.

NB: Level 3 evaluation is about, consequent to attending training how far the trainees have changed their behaviour, specifically, how they apply the information received in training in day-to-day work. This level can be judged after adequate time, say about six months after training. The authors of this curriculum will be willing to design and undertake this exercise should WHO was willing to support.

Workshop programme

Individual and group exercises that are essential learning tools to reflect the experiences and their integration to new knowledge and skills development usually take more time than scheduled. Therefore, while it is important that by the end of workshop objectives are achieved, programme should be kept flexible to accommodate and harness the opportunity of reflective learning.

In addition, adequate time should be allowed for an appropriate introduction and pre-test at the outset and a post-test and summary at the end to facilitate learning. Likewise, it might be a good idea to start the day with a recap of previous day's proceedings. In certain districts, there might be a formal ceremony for closing the workshop and agreeing with participants a way forward.

NB: the column for 'time' in the programme is not filled, primarily to allow the facilitator to adjust according to the situation.

[14] http://www.mindtools.com/pages/article/kirkpatrick.htm accessed on 29 July, 2015

Day 1		
Opening Session		
Time	Activity	Presenter/facilitator
	Registration	Insert name and designation of responsible person
	Welcome address	Insert name and designation
	Address by guest of honour	Insert name and designation
	Workshop objectives and programme	Insert name and designation
	Introduction of participants and workshop logistics	Insert name and designation
	Coffee Break	
Session 1		
	Pre-test	Insert name and designation
	Health equity: concepts (horizontal & vertical equity)	Insert name and designation
	Equity in healthcare delivery – group work[15]	
	Plenary – presentation of group work	
	Lunch and prayers	
Session 2		
	Health equity, human rights and SDH linkages	Insert name and designation
	Group work – status of Health equity and human rights in a sample district	
	Plenary – presentation of group work	
	Allocation of assignment[16]	
Day 2		
Session 3		
	Re-cap of day-1 and plenary for submission of assignment	
	Equity and equality: concepts	
	Group work – inequality and inequities and social justice[17]	

[15]**Group work**: The group will be provided with two sets of data and asked to: (i) complete the data set; (ii) interpret data; and (iii) analyze data and draw inference whether healthcare is equitable? (see tables at the end of workshop module under heading 'Group Work 1')

[16]**Assignment**: Given the two data sets as a health manager, what actions would you recommend to assure equitable provision of health services? You are required to work individually and come back with response that should not exceed 300 words. **NB**: the participants will be provided a copy of the '***manual of urban heart***' for reading overnight in order to be ready for exercise on day-2.

[17]**Group work** – group will be provided with two slides and asked to: (i) review the slides and explain the two scenarios; and (ii) define interventions for assuring equity amongst population groups. (see tables at the end of workshop module under heading 'Group Work 2')

	Plenary – presentation of group work and discussion	
	Coffee Break	
Session 4		
	Equity in financing health: concept	
	Group work – how equitable is health financing[18]	
	Plenary – presentation of group work and discussion	
	Lunch and prayers	
Session 5		
	Urban heart: introduction to the tool for measuring equity	
	Group work – develop a plan for equity assessment[19]	
	Plenary – presentation of group work and discussion	
	SDH – an introduction and allocating group work[20]	
Day 3		
Session 6		
	Re-cap of day-2 and plenary for submission of assignment	
	Equitable distribution of SDH for universal health coverage: concepts	
	Group work – finalise plan for implementing the recommendations of commission on SDH	
	Plenary – presentation of group work and discussion	
	Coffee Break	
Session 7		
	Intersectoral action for health: the basis for addressing SDH	
	Group work – how to assure intersectoral collaboration for health	
	Plenary – presentation of group work and discussion	
	Lunch and prayers	
Session 8		
	Post – test and evaluation	
	Summary of workshop	
	Handing in the attendance certificates	
	Closing and way forward	

[18]**Group work** – The group will use allocation of budget to different regions (with varying demographic and epidemiology) as example and deliberate to comment on the level of equity in financial allocation; and suggest measures how to bring equity in resource allocation.

[19]**Group work** – the group will select a district and plan for conducting equity assessment.

[20]**Assignment** –participants will be provided a copy of recommendations made by WHO Commission on Social Determinants of Health. The recommendations will be divided amongst groups who will be asked to deliberate and develop plan of action for implementation in their setting.

GROUP WORK 1

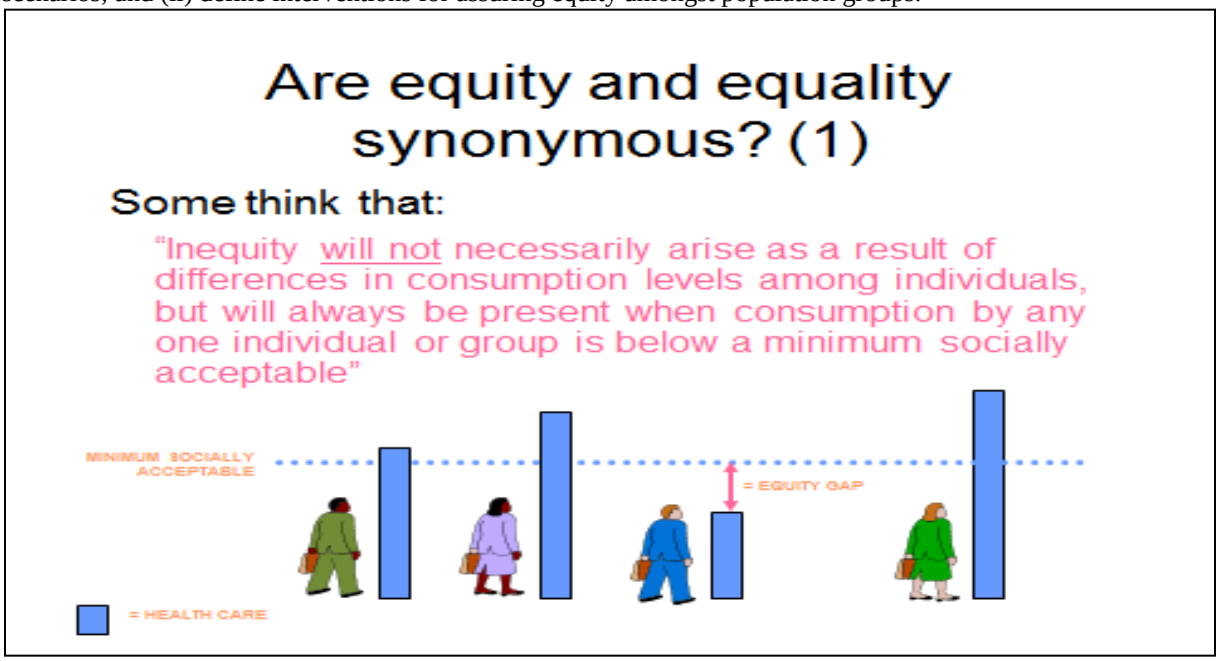
Group work: The group will be provided with two sets of data and asked to: (i) complete the data set; (ii) interpret data; and (iii) analyze data and draw inference whether healthcare is equitable?

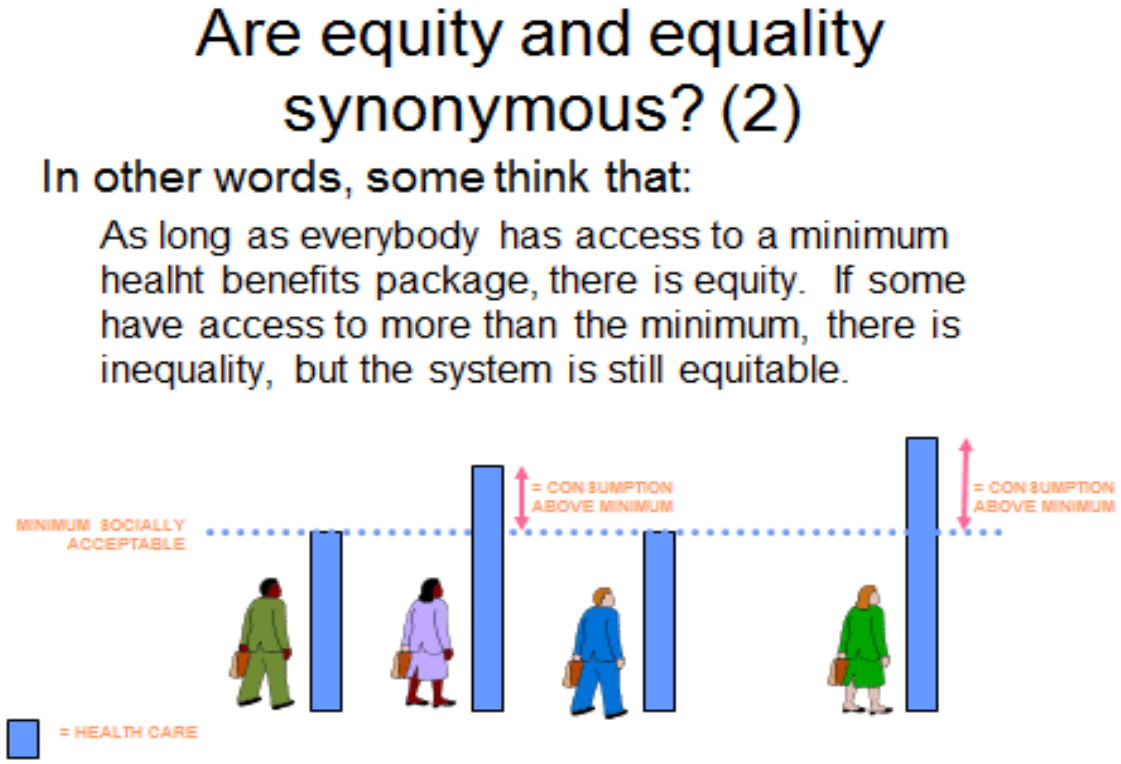
Equity in delivery: example 1					
Quintile	Population	People with health problem	% of people with health problem	People getting health care	% of those with health problem got health care
1	4000	400		200	
2	4000	320		200	
3	4000	300		180	
4	4000	250		180	
5	4000	250		200	
Total	20000	1520		960	

Equity in delivery: example 2				
Illness	People with health problem	% of people with health problem	People getting health care	% of those with health problem got health care
Common cold	1000		700	
Flu	250		200	
Tuberculosis	150		40	
AIDS	120		20	
Total	1520		960	

GROUP WORK 2

Group work: group will be provided with two slides and asked to: (i) review the slides and explain the two scenarios; and (ii) define interventions for assuring equity amongst population groups.





Chapter 5: Strategic recommendations and implementation plan for model curricula

Findings of the study and feedback from the consultative meetings enabled us to give some recommendations for integration of the concepts such as human rights, health equity, SDH, and GBV in the course curricula of medical professionals of various categories. In the context of Pakistan, socially acceptable and culturally appropriate actions are required for taking interventions in health sector at any levels. Based on the findings of the present study, following recommendations have been drawn to advance policy and intervention development in public health sector.

1. ***Introducing human perspective at levels of health care delivery system.*** Findings of this study have shown that, in Pakistan, human rights perspective is missing at various levels and dimensions of health care delivery system. As a first step, it is recommended that all the existing healthcare policies, programs, and projects should be scanned with a human rights lens and the subject concepts should be incorporated in the legal documents.
2. ***Fulfilling international human rights' commitments in the domain of health care system***. Pakistan is the signatory to a number of international conventions and commitments for realizations of health rights but the same commitments are not reflected in the indigenous health care policies and programs. There is a need to align domestic healthcare initiatives with the international human rights commitments.
3. ***Teaching human rights issues through learning based approaches***. Once the subject concepts are incorporated in the mainstream curricula of health professions, the focus should be on learning based approaches (discussions, case studies, consultative sessions) instead of mainly relying on lectures.
4. ***Debating human rights issues through Continuous Medical Education (CME) program.*** For in-service professionals, workshops, seminars, symposiums should organize periodically and these events should be mandatory for in-service healthcare professionals of all levels. It is recommended that such events should be part of the Continuous Medical Education (CME) program required for the PMDC registration.
5. ***Devising monitoring and evaluation mechanism to check the quality and progress of the human rights education and training in medical institutions.*** The Health Care Commission in every province in consultation with various provincial regulatory

authorities may devise a monitoring and evaluation mechanism to check that whether or not quality human rights education and training being imparted to the pre-service and in-service health professionals.

6. ***Human right education may be a part of the health care system***. Awareness about human rights and health rights cannot be created merely by delivering lectures, the concept need to be practically integrated with the structure and functioning of health care system. It is recommended that appropriate SOPs should be developed for ensuring the practice of human rights based approaches during health professionals' day-to-day practice.
7. ***The notions of human rights and health equity need to be incorporated in mainstream degree programs***. These concepts need to be incorporated in mainstream degree programs including Masters in Medical Education Program. Of late such programs are being offered in reputed Pakistani universities such as Agha Khan University, and Health Sciences University.
8. ***Introduction of short courses or diplomas on human rights for various medical professionals.*** In addition to the regular courses, short courses or diplomas may be introduced for various medical professionals. These courses may be optional and could offer a window of opportunity for those who want to learn more about health rights and allied disciplines.
9. ***Health Rights education as an instrument of institutional checks and accountability.*** Given the unequal power relations between doctor and patient, there is hardly any checks and accountability mechanism in place to inhibit doctor from making decision for his/her own commercial interest rather than patient's welfare. In order to protect the relatively powerless patients, human rights education could be used as institutional arrangements to protect interests of patient.
10. Although the present study has come up with different modules for pre-service and in-service healthcare professionals, yet there is a need to take up the issue with the ministry of health and relevant regulatory authorities to incorporate the said modules as credit hour courses in medical education.
11. ***Sensitization of all the relevant stakeholders about the importance of human right education through comprehensive presentations and policy Briefs:*** Sustained and

continuous support of all the stakeholders (e.g. health policy makers, senior officials of Health Ministry, Deans and Directors of Health Institutions and Principals of Medical Colleges, etc.) is essential for the continuation of these courses. In this connection, it is recommended that all the relevant stakeholders should be sensitized and taken on board through a comprehensive presentation about the issue in question.

Implementation plan for model curricula

During consultative meeting and dissemination seminar, a discussion was raised for the adaptation of the developed curricula on the subject issue. Following strategic steps were recommended by the participants.

1. ***Disseminate the modal curriculum to health education regulatory bodies along with federal and provincial departments of health***. Both at federal and provincial levels senior officials need to be aware about the modal curriculum, its underlying philosophy. For this a dissemination meeting may be arranged at national level where the selected functionaries (representative of Health Ministry, provincial health department, health regulatory bodies, principals of medical colleges) from provincial and federal level may be invited to participate in the meeting.
2. ***Disseminating curricula in higher educational institutions and medical universities/colleges.*** Curricula may be disseminated to these institutions so that they also understand the relevance and importance of human rights in medical sciences
3. ***Consultation with Ministry of Health and Provincial Health Departments***. Introduction of the curriculum at broader level also need the positive role of Ministry of Health and provincial health departments. So it is important to make them onboard about the need of this curriculum. Ministry of Health can direct the regulatory bodies for the integration of these concepts in their existing curricula.
4. ***Country's regulatory authorities (e.g. PMDC, HEC, PPC, PNC etc.) may be kept on board for integration of human right curricula in medical education***. WHO may be in touch with and send the relevant part of the developed curricula to the concerned regulatory authorities (e.g. PMDC, HEC, PPC, PNC etc.) for taking them on board for integration of human rights curricula as one of the core courses of medical education. For this it suggested that:
    a. Copies of the final curricula be sent to these bodies/institutions

b. Statutory changes (if required) may be suggested for making the curricula an integral part of the medical education.
c. Procedural, technical and substantive bottle necks may be removed once identified by the above stated bodies/institutions

5. ***Consultation with non-medical public sector organizations regarding the implementation of the curricula.*** There are many non-medical departments such as social welfare, labor welfare, Zakar and Ushar, and Baitul Mal departments and non-governmental and civil society organizations. These departments and organizations indirectly deal with social determinants of health and health equity as they are supposed to provide resources or assists to the marginalized sections of society. The policy makers and managers of these departments may be interested to learn more about the human rights perspective of their work/responsibilities.
6. ***Reach out Local bodies responsible for the provision of sanitation and potable water***. Provincial government has been increasingly concerned about the provision of sanitation and potable water to the masses and the local bodies are responsible for the service delivery. Admittedly these amenities are the fundamental social determinants of health. Local bodies may therefore be kept on board and the curricula may be shared with them. They may use this curriculum as a whole or as a part to educate their relevant functionaries in various training programs.
7. ***Consultation with provincial departments of Human Rights and Minorities Affairs and at federal level Ministry of Law, Justice and Human Rights.*** Of late, at provincial level, department of Human Rights and Minority Affairs have been established. This department is responsible to look after the legislation regarding human rights. At federal level, Ministry of Law, Justice and Human Rights is responsible for the promotion and protection of human rights including health rights. Senior official of these ministries/departments may be kept on board for the implementation of the human right curricula not only in medical institutions but also in non-medical training institutions. It may be noted here that there are countless number of autonomous bodies and attached departments who are relevant with SDH and GBV. The curricula may be of interest for all these institutions.

8. ***Consultation with NGOs, media outlets and other civil society organizations about the curricula.*** In Pakistan, there are many activities organizations which actively pursue human rights matters at different levels. For instance, Bar Councils, Pakistan Human Rights Commission, Population Council, and many other organizations are working to protect the rights of women and minorities
9. ***Human right discourse be made a part of on-going medical discourse.*** At various conferences and professional events, where medical fraternity gathers for professional interests, University of Health Sciences (UHS) conference where almost 30 institutes will participate. WHO may coordinate with the UHS and a comprehensive presentation be given at that conference. It would result in a better understanding of the all stakeholders about the issue and it would serve as a way forward for adaptation of the developed curricula.
10. ***In-built and continuous evaluation of the developed curriculum through testing and updating.*** No curriculum could be perfect; it needs to be updated to address the changing needs of the society as well as the learners. It is recommended that the courses could be pilot tested with the in-service medical professionals for identifying the strength and weaknesses of the curriculum periodically and feedback from the professionals should be incorporated to insert appropriate changes.. Furthermore, this pilot testing would be followed by formative and summative evaluation of the in-service medical professionals to check the workability of that curriculum.
11. ***Faculty development for teaching courses and conducting research on human rights in medical settings.*** , Just developing a course and making it a part of the curricula does not guarantee the success of the initiative, unless there are competent and professionally committed teachers to execute the curricula. For this it is recommended that each training institute should launch a capacity building programs for the development of faculty to teach human rights by offering them scholarship and project grants to conduct research on health right.

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Annexure II. Inventory of Technical Documents Reviewed for the Assignment

For Pre- Service Curricula

Sr. No	Title of the Document	Organization	Year
1.	Curriculum of MBBS/BDS	PMDC & HEC	2011
2.	Doctor of Pharmacy Degree Course	Pharmacy Council of Pakistan	2005
3.	License Practical Nursing Curriculum	Pakistan Nursing Council	2012
4.	Curriculum for the core course of two years' post matric diplomas in Allied health sciences	Punjab Medical Faculty	2013
5.	National Programme for Family Planning and Primary Health Care "The Lady Health Workers Programme"	Ministry of Health, Government of Pakistan	2010
6.	The Right to health (Fact Sheet No.31)	World Health Organization	2002
7.	Encyclopaedia of Human Rights	World Health Organization	2009
8.	The evolution of human rights in World Health Organization policy and the future of human rights through global health governance	World Health Organization	2014
9.	Health Disparities and Health Equity: Concepts and Measurement	Paula Braveman, Centre on Social Disparities in Health, University of California, San Francisco, San Francisco, California	2005
10.	Promoting Health Equity A	Centre for Disease Prevention	

	Resource to Help Communities Address Social Determinants of Health		
11.	UNPF Annual report	United Nations	1998
12.	State of Human Rights in 2014	Human Rights Commission of Pakistan	2014
13.	Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia	United Nations	2015
14.	International Review of the Red Cross: Humanitarian debate: Law, policy, action	ICRC	2014
15.	The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism	American Journal of Public Health	2003
16.	Improving the Health Sector Response to Gender Based Violence A Resource Manual for Health Care Professionals in Developing Countries	International Planned Parenthood Federation	2010
17.	Introduction to Health and Human Rights	Yale School of Medicine	1999
18.	Applying an Equity Lens to Maternal Health Care Practices in Pakistan	Pakistan Institute of Development Economics	2012
19.	Health equity, quality of care and community based approaches are key to maternal and child survival in	Journal of Pakistan Medical Association	2011

	Pakistan		
20.	Health Systems in Pakistan: A way Forward	Pakistan's Health Policy Forum	2010
21.	Constitution of Pakistan	Government of Pakistan	1973
22.	National Health Policy, 2009 Stepping towards better health	Ministry of Health Government of Pakistan	2009
23.	Community health promotion in Pakistan: a policy development perspective	IUHPE-Promotion and Education	2005
24.	Health and Human Rights	International Covenant on Economic, Social and Cultural Rights	1966
25.	Reforms of 2001 in Pakistan: opportunities lost in strengthening health service delivery	Pakistan Journal of Public Health	2012
26.	Report on the Status of Millennium Development Goals Sindh	UNDP	2012
27.	Health promotion, human rights and equity	World Health Organization	2003
28.	Violence Against Women in Pakistan : Current realities and strategies for change	European University Centre for Peace Studies	2007
29.	National Guidelines for GBV SOPs for Prevention of and Response to GBV in Humanitarian Settings	SOPs working group - GBV sub cluster Islamabad	2011

30.	Concepts and principles for tackling social inequities in health	World Health Organization	1990
31.	Helsinki Statement Framework for Country Action	World Health Organization	2014
32.	Social Determinants of Health Discussion Paper 9	World Health Organization	2010
33.	A conceptual framework for action on the social determinants of health	World Health Organization	2010

For in service Curricula

Sr. No	Title of the Document	Organization	Year
1.	Course Syllabus for MPH	Institute of Public Health, Lahore	2014
2.	Student's Prospectus for MSPH/EMSPH/PhD Public Health	Health Services Academy, Islamabad	2015
3.	Course Syllabi for MSc in Health Policy & Biostatistics, MSc in Health Policy & Management & PhD in Health Sciences	Department of Community Health Sciences, Agha Khan University	2014
4.	Health and Human Rights in a Changing World	World Health Organization	2013
5.	A Framework for Advancing Equity in Health for Pakistan	Jamshed Akhtar	2010
6.	The Global Gender Gap Report	World Economic Forum	2014
7.	Pakistan Demographic and Health Survey	National Institute of Population Studies, Pakistan	2012-13
8.	The Crucial Role of Health Services in	USAID	2010

	Responding to Gender-Based Violence		
9.	Addressing Gender Based Violence	UNFPA	2013
10.	Human Rights, Equity and Health	The Nuffield Research: For Research and Policy Studies in Health Services	2003
11.	The role of ethical principles in health care and the implications for ethical codes	Journal of Medical Ethics	1999
12.	Primary Health Care	World Health Organization	2008
13.	WHO reform for a healthy future: an overview	World Health Organization	2011
14.	Constitution of Pakistan	Government of Pakistan	1973
15.	Stewardship in Health Policy and its relevance to Pakistan	Journal of Pakistan Medical Association	2013
16.	The Ottawa Charter for Health Promotion	World Health Organization	1986
17.	Declaration of Alma-Ata	World Health Organization	1978
18.	Governance and Corruption in Public Health Care Systems	Centre for Global Development	2006
19.	Taking Equality Seriously: Applying Human Rights Frameworks to Priority Settings in Health	Harvard University	2014
20.	Contracting of primary health care services in Pakistan: is up-scaling a pragmatic thinking	Department of Community Health Sciences: The Agha Khan University	2010
21.	Pakistan: Country Gender Profile	Sustainable Development Policy Institute (SDPI)	2008

22.	Gender-based violence in the world of work	International Labour Office	2011
23.	Gender-based violence and reproductive health in five Indian states	London School of Economics	2008
24.	Challenging Inequity Through Health Systems	WHO Commission on the Social Determinants of Health	2007
25.	Action on the social determinants of health: learning from previous experiences	World Health Organization	2010
26.	Evaluating intersect oral processes for action on the social determinants of health: learning from key informants	World Health Organization	2013

Annexure III. Inventory of stakeholders and participants with complete profile

Category: Course Designers

Sr.	Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Name of council
1	Prof. Dr. Shamoon	042-99260298	Member of Pharmacy Council	Course Designer	25 years	M	Pakistan Pharmacy Council
2	Mrs. ZubaidaMusarat	042-99200964	Member of Nursing Council	Course Designer/Assistant Controller	20 years	F	Pakistan Nursing Council
3	Dr. AhsanGondal	042-99231352	Registrar PMF Lahore	Management/ course Designer	26 years	M	Punjab Medical Faculty
4	Dr. AmeerUd Din	042-99205328	Program coordinator LHW IRMNCH	Management/course Designer	25 years	M	LHW program

Category: PMDC Course Implementers

Sr.	Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
1	Dr. Shaukat Mehmood	Nil	Principal AIMDC	Dean/Principal	30 years	M	Punjab
2	Prof.Dr. Khakim Khan Afridi	0331-3216218	Principal Khyber medical University Peshawar	Administration	20 years	M	KPK

3	Dr.Saddique Aftab	081-9213188	Medical Superintendent Fatima Jinnah General Chest Hospital	Management	26 years	F	Baluchistan
4	Prof.Dr. Mervn M Hosein	021-35862937	Dean Ziauddin College of Dentistry	Dean /Management	20 years	M	Sindh

Category: Pharmacists Course Implementers

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Mubashar Butt	Nil	Dean University college of Pharmacy, University of the Punjab, Lahore	Administration /pharmacist	31 years	M	Punjab
Prof.Muhammad Saeed	092-91-9216750	Chairman/Director Institute of Pharmacy University of the Peshawar	Administration	Nil	M	KPK
Prof.Ghulam Razzaq	081-9211547	Chairman Department of Pharmacy University of the Baluchistan	Management & teaching	15 years	M	Baluchistan
Dr.Ali Akbar Sial	0300-9214505	Dean of Pharmacy Ziauddin University	Management	25 years	M	Sindh

Category: Public Health Course Implementers

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Maaz Ahmad	0300-9451159	Dean Institute of public health Lahore	Administration	25 years	M	Punjab
Prof.Dr.Hussain-Ud-Din	091-5700799	Director community medicine and public health Khyber Medical University Peshawar	Administration	Nil	M	KPK
There is no public health institute in the Baluchistan	Nil	Nil	Nil	Nil	Nil	Baluchistan
Dr.Javeena	0300-5165637	Registrar JPMC	Administration Public health	10 Years	F	Sindh

Category: Nursing Course Implementers

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Afshan Parveen	0301-4973140	Vice Principal Allama Iqbal Nursing College	Administration	25 years	F	Punjab

Miss Tasleem Akhar	091-92-9216830	Principal Nursing School khyatatbad medical and teaching hospital Peshawar	Administration	Nil	F	KPK
Mabil Iqbal	081-9213063	Principal Nursing School	Administration & teaching	29 years	M	Balochistan
Ms.Alishbah	0342-2997592	In charge Nursing school JPMC	Management & nursing	10 years	M	Sindh

Category: Para Medical Staff Course Implementers

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Ahsan Mehmood Gondal	Nil	Registrar Punjab Implementer medical Faculty	Administration in Public Health	30 years	M	Punjab
Dr.Zareen	Nil	General senior Management officer & consultant DHA Hospital	Management	Nil	M	KPK
Bilal Masood	0300-8386351	Demonstrator MBC	Medical Education	5 years	M	Baluchistan
Mr.Haroon	0314-2351973	Registration Clerk	Nursing attendant	11 years	M	Sindh

Category: LHWs Course implementers

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr.Amir-Ud-Din	042-99205328	Program coordinator LHW IRMNCH	Deputy program director	28 years	M	Punjab
Dr,Basit Saleem	0337-9230029	District Program coordinator LHW program district Mardan	Administration	Nil	F	KPK
Ms.Tahira		Superintendent LHW program	Management and teaching	26 years	F	Baluchistan
Mr.Haroon	0314-2351973	Registration Clerk	Nursing attendant	11 years	M	Sindh

Inventory of Course user's participants with complete profile

Category: PMDC Course Users

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Muhammad Bin Yamin	0341-7555505	Associate Professor, Physiology AIMC Lahore	Teaching	20 years	M	Punjab
Dr. Mrs Khan	081-9211547	Assistant Professor University of Baluchistan	Teaching	30 years	F	Baluchistan

Dr. Shameen Siddique	021-35340281	Medical Officer DHA Medical Centre	Teaching and clinical work	10 years	F	Sindh
Dr. Mohammad Peshawar	091-9216218	Associate Professor Forensic Medicine, Khyber Medical University	Teaching	20 years	M	KPK

Category: Pharmacists Course Users

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Nasir Abbas	0331-7724909	Assistant Professor, University College of Pharmacy, PU Lahore	Teaching	13years	M	Punjab
Prof. Nisar Ahmed	0301-3920955	Assistant Professor, Pharmacy, University of Baluchistan	Teaching	15 years	M	Baluchistan
Syed Sajjad Hussain	0301-2832090	Lecturer Pharmacy, Karachi University	Teaching	10 years	M	Sindh
Dr. Fazal Sub Khan	091-9216750	Professor Pharmacy Department	Teaching and Curriculum Development	33 years	M	KPK

Category: Public Health Course Users

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr.Humaira	0300-4013358	Assistant Professor, IPH Lahore	Teaching, Training & Clinical activities	23 years	F	Punjab
Sakina Butt	Nil	Trainer Public Health School, Quetta	Teaching and Training	20 years	F	Baluchistan
Miss.Daisey Nasreen	0302-2581688	Trainer Public Health, JPMC Karachi	Teaching and Training	30 Years	F	Sindh
Dr. Rubeena Gul	091-9218515	Associate Professor	Teaching	16 Years	F	KPK

Category: Course Users Nursing

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Sidra Shafique	Nil	Nursing Instructor, College of nursing, Jinnah Hospital Lahore	Teaching	05 years	F	Punjab
Kausar Butt	Nil	Teacher Nursing	Teaching	20 Years	F	Baluchistan
Mrs. Afshan Nazly	021-99201300	Principal College of Nursing JPMC	Administration and Teaching	25 years	F	Sindh

		Karachi				
Miss Basmeen Akhtar	091-9216830	Senior Instructor Nursing School Peshawar	Teaching	16 years	F	KPK

Category: Course Users Paramedical staff

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr.Ishfaque Ahmed	0321-9409690	Senior Lecturer PMF Lahore	Teaching	21 years	M	Punjab
Rubeena Hameed	Nil	Instructor Paramedics	Teaching	22 years	F	Baluchistan
Muraad Zamir	0315-2125646	Instructor Paramedics	Teaching	08 years	M	Sindh
NIL	NIL	NIL	NIL	NIL	NIL	NIL

Category: LHWs course Users

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Noreen Sajjad	Nil	Master Trainer LHW Program Lahore	Teaching and Training	12 years	F	Punjab
Shahida Dost	081-9203494	Trainer, LHW Program Quetta	Teaching	32 years	F	Baluchistan
Munira Abdul Ali	0333-2370720	LHW Instructor	Teaching and Training	22 years	F	Sindh
Ms. Tayyaba Ghazal	0937-9230029	Trainer LHW Program	Training	10 years	F	KPK

Inventory of SWOT participants with complete profile

Category: SWOT demographic inventory of Course implementers MBBS/BDS

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Mehmood Shaukat	042-99231441	Principal AIMDC	Dean/Principal	30 years	M	Punjab
Prof. Dr. Hakim Khan Afridi	0331-3216218	Principal Khyber medical University Peshawar	Administration	20 years	M	KPK
Prof. Shabbir Ahmad Lehri	081-9213070	Principal Bolan Medical College Quetta	Principal	22 years	M	Baluchistan
Prof. Kamran Hameed	021-35823517	Dean, Faculty of Medicine, Ziauddin College of Dentistry	Dean /Management	17 years	M	Sindh

SWOT demographic inventory of Course users MBBS/BDS

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Dr. Bin Yameen		Associate Professor AIMDC	Teaching Staff	27 years	M	Punjab
Ms. Sajida	091-9216830	Instructor Khyber medical and Teaching Hospital Peshawar	Teaching Staff	16 years	F	KPK

Dr. Muhammad Yousaf	091-9216218	Associate Professor Khyber Medical University Peshawar	Teaching Staff	22 years	M	KPK
Dr. Saddam Khan	0342-94527904	Instructor	Teaching staff	4 years	M	KPK
Annonymous	Nill	Instructor Bolan Medical College Quetta	Teaching Staff	10 years	F	Baluchistan
Dr. Javaria	0300-5165637	Senior Registrar Jinnah Post Graduate Medical College Karachi	Teaching Staff /Management	19 years	F	Sindh

Demographic inventory of Course Designers MBBS/BDS

Name of Participant	Contact details	Designation and institution	Nature of job & specialty	Years of experience	Gender M/F	Province
Muhammad Usman Khan	0334-5333318	Head of the Department, Health Services Academy Islamabad	Management/ Teaching Staff	25 years	M	Federal Islamabad
Shehzad Alam Khan	0308-8568668	Instructor Health services Academy Islamabad	Teaching Staff	20 years	M	Federal Islamabad

Annexure IV: Findings of Curricula Review

Table 3.1: Curriculum assessment standards as adapted from WHO (2005) and WHO (2014)	
Entry Points	**Brief Description**
Analysis of evidence on inequities and their determinants	Evidence in terms of topics related to health equity and human rights taking in account GBV and SDH issues into health sector response
Analysis of laws, policies, standards, protocols and guidelines	Curriculum includes topics on laws, policies, standards, protocols, guidelines and tools for applying human rights, health equity, GBV and SDH approaches in public health response.
Analysis of the social determinants at play	Curriculum addresses social determinants of health (SDH) like: • gender expectations and repression, • social norms that can undermine health, • SDH approaches to public health • poverty and unemployment, • family and community dysfunction, poor knowledge, • low levels of health literacy and care-seeking, • poor quality health services, biased • referral system and discriminatory treatment and care • Guidelines for addressing and integrating SDH at policy and program level

Table 3.2. Curricula Review of Different Pre-Service Medical Degree Programs				
Levels	**Relevant courses related to Human Rights**	**Relevant courses related to Health Equity**	**Relevant courses related to GBV**	**Relevant courses related to SDH**
	Entry point: Analysis of laws, policies, standards, protocols and guidelines for applying human right approaches in health	**Entry point:** Analysis of evidence on inequities and their determinants	**Entry point:** Analysis of laws, policies, standards, protocols and guidelines	**Entry point:** Analysis of the social determinants at play
MBBS	Included in **Behavioral Science course,** taught in 2nd Prof under the heading of **Medical Ethics**	No relevant courses are included	• Violence in general: Course of **Forensic Medicine** under the heading **of Crime against New Born Infants and Child.** • Topic of GBV is not included.	No relevant courses are included
BDS	Included in **Behavioral Science course, taught in** 2nd Prof under the heading of **Medical Ethics**.	No relevant courses are included	Topic of GBV or any type of violence is not included.	No relevant courses are included
Nursing and Paramedics	Course- **Sociology and Health Unit X** (this unit covers in detail the topic of Human Rights) Areas covered • Recognition of basic human rights • Appreciation of the importance of human rights • Conceptualize a right base approach to health • Poverty and health	No relevant courses are included	Course- **Sociology and Health Unit IX (Societal Perception towards Gender/Domestic Violence)** Areas covered • Gender as a sociological construct • Analysis of personal, societal and cultural perception towards gender • Role and status of women in Pakistan society. • Societal attitudes towards factors enhancing women status.	No relevant courses are included
Pharm D	No relevant or related courses are included	No relevant courses are included	No relevant or related courses are included	No relevant courses are included

Table 3.3 Curricula Review of Different In-Service Health Programs				
Institutes/degree	**Relevant courses related to Health Equity (HE)**	**Relevant courses related to Human Rights (HR)**	**Relevant courses related to GBV**	**Relevant courses related to SDH**
Institute of Public Health/MPH	Subject: **Essentials of Public Health** *Topics covered*: Ethical issues in health care	No relevant courses are being taught	No relevant courses are being taught	Taught under the topic of "Social causes of disease and illness"
Department of Public Health. University of the Punjab, Lahore/MPhil & PhD.	Course/subject: **Introduction to Principles of Public Health** *Topics covered:* • Medical ethics • Health equity	Course/subject: **Reproductive Health** *Topics covered:* • Reproductive health rights	Course/subject: **Reproductive Health** *Topics covered:* • Reproductive health rights • Gender Based Violence	Course/subject: **Sociology of health and illness** *Topics covered:* • Social detriments of health • Gender differentials in health
Department of Community Health Sciences, Agha Khan University/ MSc in Epidemiology & Biostatistics,MSc in Health Policy & Management & PhD in Health Sciences	No relevant courses are being taught, nevertheless health equity related topics have been covered in course outline of MSc in Health Policy & Management	No relevant courses are being taught	No relevant courses are being taught	No relevant courses are being taught at MSc level. Nevertheless, seminars have been given on social determinants of health to PhD students
Health Services Academy/MSPH & PhD	No relevant courses are being taught	Subject: **Gender and Health**. *Topics covered:* • Gender & health • Gender specific determinants of health • Gender inequality • Gender responsive budgeting • Gender related policies	No relevant courses are being taught	Course/subject: **Gender and health** *Topics covered:* • Gender specific detriments of health health
National Program for Family Planning & Primary Health Care, Pakistan/Lady Health Workers Training Program	HE is indirectly covered under the topics of "interpersonal communication skills" and "community organization"	HR issues are indirectly covered under the topics of "care of sick" and "mental health"	No relevant topics are being taught	SDH is covered under the topics of "Hygiene, water and sanitation"

Annexure V: Tools of Data Collection

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab

Qualitative interview guide for Curricula Designer

Project: Development of curricula for health professionals on health equity, human rights, gender based violence and social determinates of health in public health response

Introduction: After introducing yourself and seeking consent of the respondent for a short interview, the enumerator will introduce the initiative. For example, "it is intended to develop/ substantiate curricula currently in vogue in health professions institutes with a focus on health equity, human rights, gender based violence and social detriments of health in public health response".

Question guide (Curricular design/ Regulatory Body)

Name of participant	Contact details	Designation and Institution	Nature of job & specialty	Years of Experience	Gender (M/F)

Guidance for enumerator: this question guide has four sections, human rights, health equity, gender based violence and social determinants of health. The response to all questions in each section should be recorded.

Human Rights

1. Whether human right as an issue is included in the curricula?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are covered in the curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   i. Definition of human rights
   ii. Types of human rights
   iii. Principles of human rights
   iv. Human rights and health equity
   v. Human rights concerns in Pakistan

vi. Any other (please specify)
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3. If no, do you consider human rights important to be included in curricula?

i. Yes - go to Q 4 and 5
ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including health equity in the curricula, please comment
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5. If yes, what topics under human rights you think be included in the curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

i. Definition of human rights
ii. Types of human rights
iii. Principles of human rights
iv. Human rights and health equity
v. Human rights concerns in Pakistan
vi. Any other (please specify)
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6. If no, why do you think so, i.e. human right is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Health Equity

1. Whether health equity as an issue is included in the curricula?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   i. Equity and equality
   ii. Horizontal and vertical equity
   iii. Equity and health care delivery in relation to health care needs
   iv. Equity and financing in relation to ability to pay
   v. Equity and efficiency

vi. Any other (please specify)

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3. If no, do you consider health equity important to be included in curricula?

i. Yes - go to Q 4 and 5
ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including health equity in the curricula, please comment

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5. If yes, what topics under health equity you think be included in the curricula? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

i. Equity and equality
ii. Horizontal and vertical equity
iii. Equity and health care delivery in relation to health care needs
iv. Equity and financing in relation to ability to pay
v. Equity and efficiency

vi. Any other (please specify)
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6. If no, why do you think so, i.e. health equity is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Gender Based Violence

1. Whether gender based violence (GBV) as an issue is included in the curricula?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   i. Definition of GBV
   ii. Prevalence and cultural issues pertaining to GBV
   iii. Diagnosis of a case of GBV
   iv. Legal and ethical issues related to GBV
   v. Treatment and rehabilitation of GBV cases
   vi. Referral of GBV victim
   vii. Support to the victims of GBV
   viii. Any other (please specify)
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3. If no, do you consider GBV important to be included in curricula?

   i. Yes - go to Q 4 and 5
   ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including GBV in the curricula, please comment

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5. If yes, what topics under GBV you think be included in the curricula? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

   i. Definition of GBV
   ii. Prevalence and cultural issues pertaining to GBV
   iii. Diagnosis of a case of GBV
   iv. Legal and ethical issues related to GBV
   v. Treatment and rehabilitation of GBV cases
   vi. Referral of GBV victim
   vii. Support to the victims of GBV
   viii. Any other (please specify)
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6. If no, why do you think so, i.e. GBV is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on the response.
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Social Determinants of Health

1. Whether social determinants of health related topics are included in the curricula?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   i. Individual factors
   ii. Biological factors
   iii. Environmental factors
   iv. SDH approaches
   v. Link between SDH and health
   vi. Any other (please specify)
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3. If no, do you consider SDH important to be included in curricula?

   i. Yes - go to Q 4 and 5
   ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including SDH in the curricula, please comment

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5. If yes, what topics under SDH you think be included in the curricula?

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6. Do you think that SDH is important to address for achieving health equity and universal health coverage? If yes, how

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Project: Development of curricula for health professionals on health equity, human rights, gender based violence and social determinants of health in public health response

Introduction: After introducing yourself and seeking consent of the respondent for a short interview, the enumerator will introduce the initiative. For example, "it is intended to develop/ substantiate curricula currently in vogue in health professions institutes with a focus on health equity, human rights, gender based violence and social determinants of health in public health response".

Methodology: Semi-structured interviews will be conducted with respondents selected purposively from public health (including policymakers) and service delivery experts in public health institutions representing three levels of curricular discourse (table above).

Question guide (Implementers)

Name of participant	Contact details	Designation and Institution	Nature of job & specialty	Years of Experience	Gender (M/F)

Guidance for enumerator: this question guide has four sections, human rights, health equity, gender based violence and social determinants of health. The response to all questions in each section should be recorded.

Human Rights

1. Whether human right as an issue is taught in the institution?
   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are taught? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.
   i. Definition of human rights
   ii. Types of human rights
   iii. Principles of human rights
   iv. Human rights and health equity

v. Human rights concerns in Pakistan

i. Any other (please specify) ……..
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3. If no, do you consider human rights important to be taught?

i. Yes - go to Q 4 and 5
ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including health equity in the teaching schedule, please comment
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5. If yes, what topics under human rights you think be included in the teaching schedule? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

i. Definition of human rights
ii. Types of human rights
iii. Principles of human rights
iv. Human rights and health equity
v. Human rights concerns in Pakistan
vi. Any other (please specify) ……..
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6. If no, why do you think so, i.e. human right is not important to be included in the teaching schedule? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Health Equity

1. Whether health equity as an issue is taught in the institution?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are taught in the institution? Enumerator – don't read out. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

   i. Equity and equality
   ii. Horizontal and vertical equity
   iii. Equity and health care delivery in relation to health care needs
   iv. Equity and financing in relation to ability to pay
   v. Equity and efficiency
   vi. Any other (please specify)
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3. If no, do you consider health equity important to be included in teaching schedule?

   i. Yes - go to Q 4 and 5
   ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including health equity in the teaching schedule, please comment

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5. If yes, what topics under health equity you think be included in teaching schedule? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.
   i. Equity and equality
   ii. Horizontal and vertical equity
   iii. Equity and health care delivery in relation to health care needs
   iv. Equity and financing in relation to ability to pay
   v. Equity and efficiency
   vi. Any other (please specify)

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6. If no, why do you think so, i.e. health equity is not important to be included in teaching schedule? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Gender Based Violence

1. Whether gender based violence (GBV) as an issue is taught in the institution?

   i. Yes - go to Q 2
   ii. No - go to Q 3

2. If yes, what topics under this issue are taught in the institution? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   i. Definition of GBV
   ii. Prevalence and cultural issues pertaining to GBV
   iii. Diagnosis of a case of GBV
   iv. Legal and ethical issues related to GBV
   v. Treatment and rehabilitation of GBV cases
   vi. Referral of GBV victim
   vii. Support to the victims of GBV
   viii. Any other (please specify)
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3. If no, do you consider GBV important to be included in teaching schedule?

   i. Yes - go to Q 4 and 5
   ii. No - go to Q 6

4. If yes, in your opinion what can be achieved by including GBV in teaching schedule, please comment ……
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5. If yes, what topics under GBV you think be included in teaching schedule? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

   i. Definition of GBV
   ii. Prevalence and cultural issues pertaining to GBV
   iii. Diagnosis of a case of GBV
   iv. Legal and ethical issues related to GBV
   v. Treatment and rehabilitation of GBV cases
   vi. Referral of GBV victim
   vii. Support to the victims of GBV
   viii. Any other (please specify)
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6. If no, why do you think so, i.e. GBV is not important to be included in teaching schedule? Enumerator - record verbatim and probe to clarify and seek explanation on the response.
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Social Determinants of Health

7. Whether social determinants of health related topics are taught in the curricula?

   ii. Yes - go to Q 2
   iii. No - go to Q 3

8. If yes, what topics under this issue are taught in your institute? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   vii. Individual factors
   viii. Biological factors
   ix. Environmental factors
   x. SDH approaches
   xi. Link between SDH and health
   xii. Any other (please specify)
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9. If no, do you consider SDH important to be included in teaching schedule?

   iii. Yes - go to Q 4 and 5

iv. No - go to Q 6

10. If yes, in your opinion what can be achieved by including SDH in the teaching schedule, please comment

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11. If yes, what topics under SDH you think be included in the curricula?

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12. Do you think that SDH is important to address for achieving health equity and universal health coverage? If yes, how

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INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab

Qualitative interview guide for Curricula Designer

Project: Development of curricula for health professionals on health equity, human rights, gender based violence and social determinates of health in public health response

Introduction: After introducing yourself and seeking consent of the respondent for a short interview, the enumerator will introduce the initiative. For example, "it is intended to develop/ substantiate curricula currently in vogue in health professions institutes with a focus on health equity, human rights, gender based violence and social detriments of health in public health response".

Question guide (Curricular design/ Regulatory Body)

Name of participant	Contact details	Designation and Institution	Nature of job & specialty	Years of Experience	Gender (M/F)

Guidance for enumerator: this question guide has four sections, human rights, health equity, gender based violence and social determinants of health. The response to all questions in each section should be recorded.

Human Rights

7. Whether human right as an issue is included in the curricula?

   iii. Yes - go to Q 2
   iv. No - go to Q 3

8. If yes, what topics under this issue are covered in the curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

   vii. Definition of human rights
   viii. Types of human rights
   ix. Principles of human rights
   x. Human rights and health equity
   xi. Human rights concerns in Pakistan
   xii. Any other (please specify)

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9. If no, do you consider human rights important to be included in curricula?

iii. Yes - go to Q 4 and 5
iv. No - go to Q 6

10. If yes, in your opinion what can be achieved by including health equity in the curricula, please comment

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11. If yes, what topics under human rights you think be included in the curricula?
Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

vii. Definition of human rights
viii. Types of human rights
ix. Principles of human rights
x. Human rights and health equity
xi. Human rights concerns in Pakistan
xii. Any other (please specify)

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12. If no, why do you think so, i.e. human right is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Health Equity

7. Whether health equity as an issue is included in the curricula?

iii. Yes - go to Q 2
iv. No - go to Q 3

8. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

vii. Equity and equality
viii. Horizontal and vertical equity
ix. Equity and health care delivery in relation to health care needs
x. Equity and financing in relation to ability to pay
xi. Equity and efficiency
xii. Any other (please specify)
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9. If no, do you consider health equity important to be included in curricula?

iii. Yes - go to Q 4 and 5
iv. No - go to Q 6

10. If yes, in your opinion what can be achieved by including health equity in the curricula, please comment
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11. If yes, what topics under health equity you think be included in the curricula? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

vii. Equity and equality
viii. Horizontal and vertical equity
ix. Equity and health care delivery in relation to health care needs
x. Equity and financing in relation to ability to pay
xi. Equity and efficiency
xii. Any other (please specify)
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12. If no, why do you think so, i.e. health equity is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on response.
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Gender Based Violence

7. Whether gender based violence (GBV) as an issue is included in the curricula?

iii. Yes - go to Q 2
iv. No - go to Q 3

8. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

ix. Definition of GBV
x. Prevalence and cultural issues pertaining to GBV
xi. Diagnosis of a case of GBV
xii. Legal and ethical issues related to GBV
xiii. Treatment and rehabilitation of GBV cases
xiv. Referral of GBV victim
xv. Support to the victims of GBV
xvi. Any other (please specify)
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9. If no, do you consider GBV important to be included in curricula?

iii. Yes - go to Q 4 and 5
iv. No - go to Q 6

10. If yes, in your opinion what can be achieved by including GBV in the curricula, please comment

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11. If yes, what topics under GBV you think be included in the curricula? Enumerator – don't read out from the list. Instead let the respondent identify and speak out. Probe and encourage response if necessary.

    ix. Definition of GBV
    x. Prevalence and cultural issues pertaining to GBV
    xi. Diagnosis of a case of GBV
    xii. Legal and ethical issues related to GBV
    xiii. Treatment and rehabilitation of GBV cases
    xiv. Referral of GBV victim
    xv. Support to the victims of GBV
    xvi. Any other (please specify)

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12. If no, why do you think so, i.e. GBV is not important to be included in the curricula? Enumerator - record verbatim and probe to clarify and seek explanation on the response.

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Social Determinants of Health

13. Whether social determinants of health related topics are included in the curricula?

iii. Yes - go to Q 2
iv. No - go to Q 3

14. If yes, what topics under this issue are covered in curricula? Enumerator – don't read out. Instead let the respondent identify. Probe and encourage response if necessary.

xiii. Individual factors
xiv. Biological factors
xv. Environmental factors
xvi. SDH approaches
xvii. Link between SDH and health
xviii. Any other (please specify)
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15. If no, do you consider SDH important to be included in curricula?

v. Yes - go to Q 4 and 5
vi. No - go to Q 6

16. If yes, in your opinion what can be achieved by including SDH in the curricula, please comment
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17. If yes, what topics under SDH you think be included in the curricula?

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18. Do you think that SDH is important to address for achieving health equity and universal health coverage? If yes, how

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Focus Group Discussion

Project: Development of curricula for health professionals on health equity, human rights, gender based violence and social determinants of health in public health response

Respondents: health managers and the other with practitioners; NB: respondents for the two FGDs will be drawn from the students of MPhil and PhD, who are serving health managers or practitioners, at Department of Public Health, University of the Punjab.

Introduction: We are from Institute of Social and Cultural Studies, University of the Punjab and are working on a project. It aims at designing a model curricula related to human rights, health equity, gender based violence and social determinants of health in health sector response. The developed curricula will be integrated into the in vogue curriculum for health professionals taught in the under and postgraduate institutes.

Methodology: Two focus group discussions (FGDs), one with health managers and the other with practitioners, will be conducted. On average 6-8 persons will participate in each FGD.

The facilitator, after seeking and noting participants details will brief on the project and objective of the FGD session. The facilitator, who will steer the discussion, shall not indulge in discussion and divulge him/herself opinion.

The questions from the guide will be posed to a participant. Focus group discussion is not a series of individual interviews. Instead, it is an opportunity for the participants to present their own views and listen to the views of others, reflect on what has been said, and in the light of this reflection consider their own standpoint further and express accordingly. The conversation goes backwards and forward around the group. Individual responses in this discourse become sharper and refined and move to a deeper level.

Participants' details

Name of the incumbent	Designation and Institution	Nature of job & specialty	Years of Experience	Gender (M/F)

Question guide

Objective: to discern the opinion of health managers and practitioners on the inclusion/ substantiating the in-vogue curricula for health professionals with concepts of human rights, health equity, gender based violence and social determinants of health in public health response. With this pretext, following is the question guide:

1. What are the important elements of: (facilitator – don't read out. Instead probe and encourage response. This question is meant primarily to prompt and prepare foundation for the ensuing discussion in the group.

Issues	Elements
1. Human rights	a. Definition of human rights b. Types of human rights c. Principles and values of human rights d. Human rights and health linkages e. Information about guidelines and tools to apply human right approaches in public health
2. Health equity	a. Equality and health equity b. Horizontal and vertical equity c. Health equity, human right and SDH linkages d. Equality, accountability and healthcare delivery e. Equity and health financing in relation to ability to pay f. Information about guidelines and tools for applying health equity approaches
3. Gender based violence	a. Definition of GBV b. Prevalence and socio-cultural issues pertaining to GBV in Pakistan c. Legal, institutional and ethical issues related to GBV d. Health sector role and response to address GBV cases e. Psycho-social support to the GBV survivors
4. Social determinants of health	a. What are social determinants of health b. SDH approaches to health c. Importance of addressing SDH to achieve universal health coverage and health equality d. Information about guidelines for addressing SDH at policy and program level

2. whether they (participants) were exposed during studies to the concepts;
3. to what extent they (participants) face these issues in their workplace and practice;
4. what is the importance of including/substantiating (if already included) these concepts in the undergraduate curricula;

5. what is the importance of including/substantiating (if already included) these concepts in the postgraduate curricula;
6. whether health managers while in service require training and exposure to these concepts; and
7. whether health practitioners while in service require training and exposure to these concepts.

INSTITUTE OF SOCIAL & CULTURAL STUDIES
University of the Punjab

Training needs assessment

Project: Development of curricula for health professionals on health equity, human rights, gender based violence in public health response

Respondents: In-service healthcare professionals and it is preferred that persons with same job and specialty work in group to conduct TNA exercise.

Participants' matrix

Name of the incumbent	Designation and Institution	Nature of job & specialty	Years of Experience	Gender (M/F)

Introduction: We are from Institute of Social and Cultural Studies, University of the Punjab. We are working on project that aims at designing curricula related to human rights, health equity, gender based violence and social determinants of health in public health response. This curriculum is for pre-service as well as in-service health professionals.

Methodology: In order to determine what elements should be included in the curriculum for in-service training of health professional a training needs assessment is conducted. Attributes (knowledge, attitude and practice) that should depict in job are assumed.

Based on these attributes, which are given in column-A of table, incumbents are asked to rate their competence on a scale of 1 to 5, considering that: 1 = don't know; 2 = heard about; 3 = heard about and understand the concept; 4 = practice the concept in workplace; 5 = advocates and tends to inculcate amongst colleagues – seniors, peers and juniors.

NB: should the incumbent think there is another job attribute they practice, may be added under "other". If there are more job attributes, more lines be added or written below matrix.

Training Need Assessment Matrix

Skills/thematic areas in job description	**Competencies possessed (on a scale of 1 to 5)**	**Competencies (optimal) required (on a scale of 1 to 5)**	**Training needs**
Human Right	**A**	**B**	**C = B - A**
1. Awareness of human rights concept			
2. Ability to communicate with patients appropriately?			
3. Considers confidentiality, self-esteem and anonymity while dealing with patients and victims of violence?			
4. Have knowledge of patients' rights			
5. Knows measures, including legal for assuring respect of human rights			
6. Other --- (specify)------			
Health Equity			
7. Attends to patients regardless of caste, income class and gender			
8. Understands and differentiates between: a. Equity and equality b. Equal treatment of equals c. More healthcare for those in need of more			
9. Have knowledge of health equity: a. In terms of health needs b. In terms of ability to pay			
10. Practices health equity while providing services: a. Attends to who needs more b. Charges to who can pay			
11. Other --- (specify)------			

Gender Based Violence			
12. Aware of GBV concept and its types			
13. Knows about guidelines on referral procedures for GBV victims			
14. Ability to communicate with at-risk families of GBV victims			
15. Ability to diagnose victim of violence at early stage			
16. Ability to cope with patient's stress while dealing with family of victim			
17. Understands legal responsibilities for protecting at-risk women			
18. Other --- (specify)------			
Social Determinants of Health (SDH)			
19. Aware about SDH			
20. Have the skill to assess patients for social and environmental risks			
21. Ability to identify high risk health behaviors			
22. Able to address poverty related issues of poor families			
23. Able to ask about social issues from patients			
24. Ability to identify community resources and legal services to vulnerable families			
25. Able to identify patients with social needs			

INSTITUTE OF SOCIAL & CULTURAL STUDIES
University of the Punjab

C-SWOT (Curriculum-Strengths, Weaknesses, Opportunities, and Threats) Analysis

Project: Development of curricula for health professionals on health equity, human rights, gender based violence and social determinants of health in public health response

Respondents: Academicians (Principals and teachers of medical and dental colleges and public health institutes) and students.

Introduction: It is intended to develop/substantiate curricula currently in vogue in health professions institutes with a focus on health equity, human rights, gender based violence and social determinants of health in public health response. In this regard, C-SWOT, which is a management tool, will be used to assess the capacity of these institutions.

Methodology: A brainstorming session will be organized with a group of academicians and students in the following manner.

6. Define the goal and measurable outcomes, i.e. to have the health professions education institutions conducting the model curricula;
7. Complete a SWOT matrix, identifying current strengths and weaknesses;
8. Identify opportunities that are there or could be created for the institutes;
9. Identify threats that exist in the environment, which could hinder in achieving the institutional goal.
10. Define strategies in the wake of existing strengths, weaknesses, opportunities and threats in the educational environment and prepare a plan.

C-SWOT matrix

Objective: prepare plan for the adoption of the developed curricula on health equity and human rights taking in account gender equality and GBV dimensions in public sector response.	
Strengths What are the strengths in programmes (MBBS/BDS/MPH) that facilitate in equipping students with knowledge and positive attitude towards: • Health Equity • Human Rights • Gender Based Violence • Social Determinants of Health 1. - 2. - 3. - 4. –	**Weaknesses** What are the weaknesses in programmes (MBBS/BDS/MPH) that hinder in equipping students with knowledge and positive attitude towards: • Health equity • Human Rights • Gender Based Violence • Social Determinants of Health 1. - 2. - 3. - 4. -

Opportunities What are opportunities for programmes (MBBS/BDS/MPH) available to harness strengths and overcome weaknesses that students are equipped with knowledge and positive attitude towards: • Health Equity • Human Rights • Gender Based Violence • Social Determinates of Health 1. - 2. - 3. - 4. –	**Threats** What are threats for programmes (MBBS/BDS/MPH) hindering harnessing strengths and adding to weaknesses that students are equipped with knowledge and positive attitude towards: • Health Equity • Human Rights • Gender Based Violence • Social Determinants of Health 1. - 2. - 3. - 4. -
Strategies: **S-O – use strengths to take advantage of opportunities** **S-T – use strengths to avoid threats** **W-O – Overcome weaknesses by taking advantage of opportunities** **W-T – Minimize weaknesses and avoid threats**	

Annexure VI: Pictures of Data Collection

Punjab:

Dr Afshan Nursing College AIMC Lahore

Public Health Dr Humaira (IPH, Lahore)

Sidra Shafique, Nursing College Jinnah Hospital

Dr Mahmood Shaukat Dean AIMC Lahore

Dr Kamran Dean, Sheikh Zayed Medical College Lahore

Dr Ahsan Gondal registrar Punjab Medical Faculty Lahore

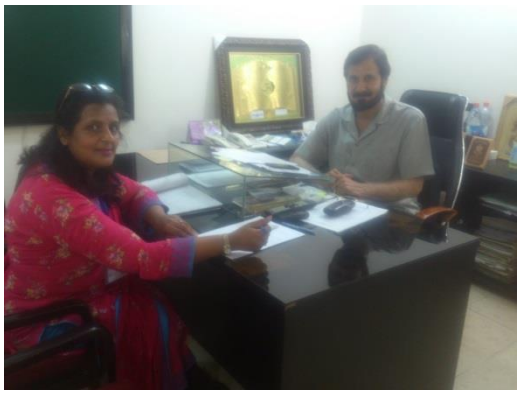
Dr Bin Yameen Associate Professor Physiology AIMC Lahore

Dr Nasir Abbas, Assistant Professor Pharmacy, UCP PU Lahore

Dr. Ishfaque Ahmed Senior Lecturer PMF Lahore

Dr Maaz Ahmed Dean IPH Lahore

Dr Mubasher Ahmed Butt, Dean UCP PU, Lahore



Dr Shamoon Course Designer Pakistan Pharmacy Council

FGD with Medical Students SIMS Lahore

FGD with Public Health Experts Lahore

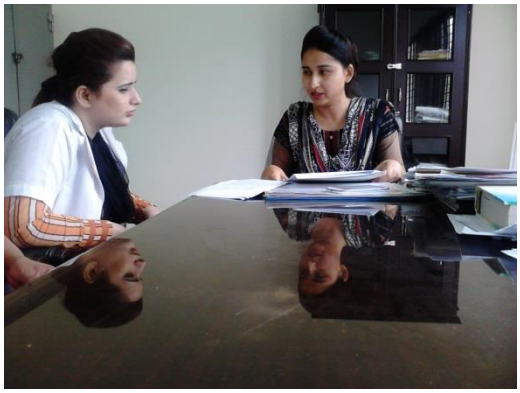
FGD with Public Health Students ISCS PU Lahore

LHW Coordinator Lahore

LHW Master Trainer Dr Noreen

TNA with MBBS Doctor

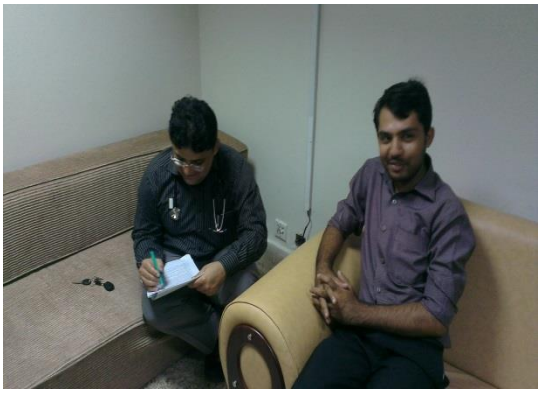
TNA with nurses



TNA with Nurses

TNA LHW

TNA Public Heath Physicians



TNA with In service MBBS Doctor

Baluchistan Pictures:

Dr. Ajab In service doctor Civil Hospital Quetta TNA

Prof. Nisar Ahmed Shawani

MSJ In Service Nurse Civil Hospital Quetta

Prof. Ghulam Razaq , Chairman Pharmacy Department University of Baluchistan

Dr. Nadra Khan, Principal, Public Health School

Shaida But Superintendent PHS Quetta

Dr. Bilal Ahmed BMC

Dr. Abad Student MBBS Final year

Dr. Muhammad Sadiq Aftab M.S. FJC Quetta

Principal Nursing School Quetta

Principle BMC Quetta

KPK Pictures:

Doctor

LHW Director Operation

Pharmacy Director and Teacher

Public Health And Community Medicine Department Peshawar

Public Health Expert Supervisor

Sindh Pictures:

Afshan Nazlay JPMC Principal College of Nursing

Alishba Albert, Nursing Instructor JPMC

Daisey Nasreen Head Nurse JPMC

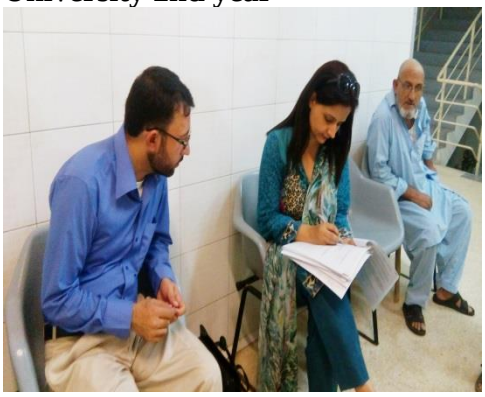
Dr Shameen DHA Medical centre

Dr Uzma CMO JPMC

Dr Zarmeen DHA Medical Centre

Female students at Ziauddin Medical University 2nd year

Mr. Gul Muhammad Paramedics JPMC



Muhammad Zamir OT Technician JPMC

Prof. Kamran Hameed Dean of Pharmacy Ziauddin University