HEALTH SECTOR **REFORM** FRAMEWORK

Jointly Developed by

Punjab Resource Management Program
Planning and Development Department
Government of the Punjab

Health Department
Government of the Punjab

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Planning & Development Department, Government of the Punjab
Lahore, Pakistan

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Punjab Resource Management Program, Planning & Development Board,
Government of the Punjab.

Published by Media & Publication Cell, PRMP
Format, Graphics & Design by
Nauman Ellahi, Network Administrator, PRMP.

Foreword

Government attaches the highest priority to improvements in health sector in Punjab. The linkages of the health sector with poverty are well documented. The primary and secondary health sectors are essentially pro poor. The commitment to improving the health, with consequent poverty alleviation, is reflected in our urge to achieve the Millennium Development Goals and poverty reduction strategy paper. We have embarked upon holistic and innovative interventions to rehabilitate and improve the standards of health care in Punjab.

In the past however, despite a significant increase in resource availability and a good level of allocative efficiency, the development in the health sector could not be based on holistic approach resulting in imbalances. Utilization of primary health care remains limited due to various constraints. The preventive programs have a significant role in the sector but integration with mainstream health services has worried policy makers. The decentralization initiative has immense potential despite many irritants that need to be settled. The equity issues relating to poor and the vulnerable sections of society are a challenge as well.

Indeed health sector is a complex paradigm. The process of change in the sector must deal with a large number of competing forces operating in a multifaceted and multi-sectoral environment. Therefore, a holistic and innovative health care reform initiative has been considered an absolute necessity to harness the health sector to deliver services in line with the highest quality standards.

Health Sector Reform Framework is a step in the direction of developing a comprehensive health sector reform agenda. While clearly defining the strategy and milestones for enhancing service delivery systems in health sector, it identifies the major themes and issues confronting the health sector in the Punjab. Government is committed to provide all the required technical and financial resources to enhance coverage and quality of health services to the people of Punjab. I hope implementation on this Framework will lead to quality health service delivery that is equitable, accessible and sustainable.

I must commend Mr. Asad Sumbal, Program Director, PRMP and Mr. Shoeb I. Syed, Deputy Director, PDSSP who have tirelessly worked on developing first the Reform Matrix and now this comprehensive reform framework for the health sector. Special mention is due to Mr. Adnan Qadir Khan who initiated this work. I must also make a notable mention of the Health Department who have supported and owned this initiative fully and are now set to plan and launch the second generation of under the Health Sector Reforms Program.

Suleman Ghani
Chairman, P & D Board
Government of the Punjab

List of Abbreviations

ASPs	Annual Sectoral Plans
BHUs	Basic Health Units
CBOs	Community Based Organizations
CCBs	Citizen Community Boards
CME	Continual Medical education
CMIPHC	Minister's Initiative for Primary Health Care
DGs	District Governments
DHQs	District Headquarters
ECCD	Early Child Care Development
EMIS	Education Management Information System
HMIS	Health Management Information System
HSRP	Punjab Health Sector Reforms Programme
HSRF	Punjab Health Sector Reforms Framework
LHWs	Lady Health Workers
LMSF	Licentiate in Medicine and Surgery Faculty
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding
MSDP	Minimum Service Delivery Package
MTBF	Medium Term Budget Framework
MTSP	Medium Term Strategic Plan
NCHD	National Commission for Health Development
PDSSP	Punjab Devolved Social Services Programme
PEAS	Punjab Emergency Ambulance Service
PESRP	Punjab Education Reforms Programme
PFIS	Poverty Focused Investment Strategy
PHC	Primary Health Care
PHF	Punjab Health Foundation
PITB	Punjab Information Technology Board
PLGO	Punjab Local Government Ordinance
PMDC	Pakistan Medical and Dental Council
PRMP	Punjab Resource Management Programme
RHCs	Rural Health Centres
RPHP	Reproductive Health Project
RYK	Rahim Yar Khan
SBAs	Skilled Birth Attendants
SEMS	Strengthening Emergency Medical Services
TA	Technical Assistance
THQs	Tehsil Headquarters
ToP	Terms of Partnership
VHCs	Village Health Committees
WHP	Women Health Project
WSS	Water Supply & Sanitation

TABLE OF CONTENTS

ABBREVIATIONS

FOREWORD

EXECUTIVE SUMMARY

1. INTRODUCTION

2. OUTCOMES OF REFORM

3. INGREDIENTS OF REFORM

4. PUNJAB HEALTH SECTOR REFORM PROGRAM – AN OVERVIEW

5. PUNJAB DEVOLVED SOCIAL SERVICES PROGRAM – AN OVERVIEW

6. HEALTH SECTOR REFORM FRAMEWORK

6.1 PRIMARY HEALTH CARE

6.1.1 Staff Absenteeism
6.1.2 Low Utilization
6.1.3 Low Quality Care
6.1.4 Limited Planning and Ownership
6.1.5 Lack of Strong referral links between PHC and SHC institutes

6.2 INCREASED FOCUS ON PREVENTIVE [PRO POOR] HEALTH AND ACTIVELY TARGET MDGS

6.3 HEALTH PROFESSIONALS – NURSES, PARAMEDICS ETC.

6.4 CAPACITY FOR PLANNING, COSTING AND BUDGETING

6.5 EFFECTIVE HUMAN RESOURCE MANAGEMENT SYSTEMS

6.6 IMPROVED DATA ANALYSIS AND RESEARCH FOR EVIDENCE AND OUTCOME BASED PLANNING

6.7 EMPHASIS ON COMMUNITY PARTICIPATION AND PUBLIC-PRIVATE PARTNERSHIPS

6.8 EFFECTIVE ROLE OF REFORM OF HEALTH FOUNDATION

6.9 AUTONOMY FOR HOSPITALS

6.10 COMPREHENSIVE REVIEW OF MEDICAL COLLEGES EDUCATION SYSTEM

6.11 NEED TO FOCUS ON HEALTH EDUCATION – SCHOOL HEALTH PROGRAM AND ISSUES OF GERIATRICS

6.12 LITTLE UNDERSTANDING OR EMPHASIS ON CROSS-SECTORAL LINKAGES

6.13 PRIVATE PRACTICE

6.14 REVIEW OF DRUGS POLICY

6.15 SOCIAL PROTECTION / INSURANCE OF VULNERABLE POPULATION GROUPS

6.16 IMPROVEMENT IN GOVERNANCE IN HEALTH CARE

7. CONCLUSION

ANNEXURES

ANNEX 1 - PDSSP Policy Paper
ANNEX 2 – Presentation by AQK

ANNEX 3 -Mapping of Health Sector Reforms
ANNEX 4 - Presentation by PRMP

REFERENCES

EXECUTIVE SUMMARY

There has been a broad consensus in Punjab that the health sector is in need of fundamental reform in order to achieve the Millennium Development Goals and a better impact on the health status of the population, particularly the poor and vulnerable segments in the society. A holistic and innovative health care reform initiative has been considered an absolute imperative to realize the legitimacy and stability of the devolution process.

Punjab, therefore, embarked upon evolving a strategy to clearly define the priorities for the use of public revenues, identify the weaknesses in the management of health services and pave the way for reforms besides improving the utilization of available services. It also had to keep in view the concern about ensuring support for the devolution process by enhancing the capacity of the devolved health sector.

The Punjab Government finalized the Poverty Focused Investment Strategy (PFIS) in July 2005 that consists of in-depth analysis of the issues confronting the health sector and recommendations to effectively address them with in the broader framework of the devolution program. The PFIS provided the groundwork for the development of the Punjab Health Sector Reform Framework (HSRF) under the aegis of the Punjab Resource Management Program (PRMP). The HSRF aims to set the tone and direction for health sector reforms by emphasizing the need to clearly define the strategy and milestones for enhancing service delivery systems in health sector.

The present document is an attempt to present, in a succinct fashion, the major themes and issues confronting the public health sector in the Punjab, as identified in the PFIS and the HSRF. The nature and magnitude of these issues present a stupendous challenge to the provincial government for bringing about a positive change. The existing institutional capacity and resources of the public health sector, however, are not adequate to realize such an ambitious reform agenda. It would require massive technical and financial resources and capacity. The Punjab Government has, therefore, instituted a number of reform programs with the active assistance of its domestic and international partners.

This document also endeavors to briefly map out the initiatives currently in offing. The two salient initiatives that it heavily borrows from are the HSRP, and the Punjab Devolved Social Sectors Program (PDSSP). The instant document also discusses the Chief Minister's Initiative for Primary Health Care (CMIPHC), the Women Health Program (WHP), and the Reproductive Health Project (RHP), besides consulting the Punjab Health Department's Medium Term Strategy Plan (MTSP).

The first phase of the Punjab Health Sector Reform Program was launched in 2005. Its scope broadly includes provision of missing human and physical facilities at the Basic Health Units (BHUs) and Rural Health Centres (RHCs), improvement in health service delivery, human resource development, timely supply of essential medicines, and creation of health awareness through health education.

The Punjab Devolved Social Sectors Program (PDSSP) aims to strengthen the devolved social services in order to achieve progress on Millennium Development Goals concerned with poverty, gender, education, health, and Water Supply & Sanitation (WSS). The program's objective is to support more equitable, efficient, and sustainable social services in accordance with provisions of the Punjab Local

Government Ordinance (PLGO). With 65% of the program resources going into health sector, the program mainly focuses on improving health services at the district level.

In short, the HSRP is an implementation and monitoring arm of the Health Department's effort to institutionalize health sector reforms, whereas the PDSSP with its sizeable Technical Assistance (TA) component envisages building and sustaining capacity of District Governments (DGs), and to plan, implement, and evaluate health sector programs.

Analysis of primary health care systems in the Punjab reveals staff absenteeism, low utilization of services, low quality of care, limited planning, lack of ownership, and absence of any meaningful referral links between primary, secondary, and tertiary health service outlets as some of the major ills affecting primary health care. In order to address these issues effectively, the Government of the Punjab has taken a holistic view of the challenges confronting the health sector. It is now adopting measures both in the short to medium terms to effectively address these issues.

The provincial government's reform initiatives are focused on a comprehensive needs assessment to identify the missing physical and human infrastructure. The Punjab Government is committed to provide such missing facilities under the Terms of Partnership (ToPs) signed between it and the District Governments (DGs). Government has already approved a policy based on financial and other incentives to attract highly qualified health care professionals, particularly Women Medical Officers, to work at primary health care level. Such a system will introduce a combination of performance-based, market-driven, incentivized pay and benefits package, with additional allowance for the remote and 'hard' areas.

The District Governments (DGs) and Tehsil Municipal Administrations (TMAs), under the guidance of the PDSSP, are in the process of preparing essential drugs list on the basis of districts-specific 'burden-of-disease'. The provincial government will ensure supply of these essential medicines in accordance with the instruments of ToPs. The Health Sector Reform Framework also proposes innovative strategies to check the problem of absenteeism and under-utilization of primary health care facilities. These, among other things, include a proposal to make it compulsory for all fresh medical graduates to undergo part of the house-job training at the PHC level, and mandating consultant-specialists to periodically visit Rural Health Centres (RHCs), and Tehsil and District level hospitals.

In addition to considering institution of all these innovative measures to address absenteeism, and enhance the utilization of primary health services, the provincial government is also seeking development of a comprehensive monitoring and evaluation (M&E) framework to assess the impact of these reforms and plan corrective measures where necessary, besides vouching for systematic and disciplined planning, costing and budgeting.

While the PDSSP provides for capacity building measures, developing skills and training of the human resource at all levels of the health care system, the HSRF seeks creation of new job descriptions, clearly defined career paths, and performance indicators to motivate the health service providers and to hold them accountable when they fall short of their explicitly assigned responsibilities. The emphasis on compilation of Operations Manual, development of manual of standard medical practices and SOPs, and urgent establishment of Minimum Service Delivery Package

(MSDP) are steps in the direction of bringing the quality of health care in the public sector at par with internationally recognized standards.

'One size fit all' approach has always limited the planning horizons in Punjab's health sector, whereas vertical programs with narrow and limited provincial and district roles have led to lack of ownership and ineffective targeting of high poverty areas. Under the PDSSP-sponsored Annual Sectoral Plans, the District Governments are now adopting development plans characterized by sectoral interventions, which will help target the poor and vulnerable segments of the population. The PDSSP, besides having prepared software for the Health Management Information System (HMIS), is also concentrating on improving the planning, costing and budgeting skills of health service managers.

The HSRF has recommended collection of district-specific desegregated databases to develop nuanced budgets for rehabilitation of health services in the districts, which will, among other things, help achieve pro-poor, Millennium Development Goals (MDGs)-related interventions. It also suggests delimitation of catchment areas for the BHUs to secure easier access of rural population to one-stop, fully integrated promotive, preventive and curative primary healthcare facilities. The provincial government is also contemplating a variety of innovative options to radically improve the referral system by integrating all the health care tiers in the Punjab.

The Punjab Government accords top priority to fulfilling pro-poor MDGs. In this regard, budget allocations for MDGs-related interventions are being made in the Medium Term Budget Framework (MTBF) in order to protect such pro-poor allocations. Efforts are in the offing for extensive re-training of Lady Health Visitors, Paramedics and Village Health Workers, who can facilitate preventive interventions, and impart health education. Revival of School Health Programs, Strengthening Emergency Medical Services (SEMS) Initiative, and free of cost provision of MCH kits are some of the examples of such pro-poor initiatives. Public-private partnerships are also being encouraged to offer preventive health services to the poor, besides generating awareness about emerging disease.

The provincial government is cognizant of the immense importance of community participation in the planning and implementation of reform initiatives, besides creating a sense of ownership in the health sector. The HSRF strongly supports the involvement of non-state actors in delivery of health services. It emphasizes social mobilization for creation of user committees and village committees to monitor service delivery, and eventually manage health care services. Such committees can liaise between the community, village health workers and BHUs in preventive, curative, nutrition, and health awareness programs. The framework also proposes the creation of elaborate linkages between community organizations and such social sector interventions as the District Monitoring Office (DMO). These arrangements will bring the accountability of health services within the purview of end-users, besides ensuring greater community participation in health care planning.

Reliable data and quality research serve as the backbone of a progressive health sector, and is deemed critical for evidence-based planning. Unfortunately, the health sector in Punjab suffers from absence of "research culture". There is no mechanism to collect and collate valuable data from official records. Now, a number of initiatives have been launched at the PDSSP-level, including the development of HMIS, to collect data for purposes of monitoring and evaluation. The Punjab Government is also planning to reorient the Punjab Health Foundation (PHF) into a

public health sector research organization. In addition to creating an environment conducive to health research, the PHF will also manage an Endowment Fund to finance research initiatives, and also arrange for the wide dissemination of research findings on issues of public health.

The provincial government also recognizes the importance of the private sector for modernizing the health sector. Where it has reiterated the commitment to facilitate and encourage public-private partnerships in delivery of health care services and in imparting state-of-the art medical education, there it also finds it necessary to create awareness among the people about their rights and duties in the health sector, particularly in the private health sector. It is why the Punjab Government has expressed its intention to regulate private sector research and practice, in a non-intrusive fashion through a peer-based mechanism aimed at developing a clearly defined code of ethics and Minimum Service Delivery Standards.

Although the initiative of granting autonomy to tertiary hospitals and health institutions is a step in the right direction, this measure, however, could not by itself lead to systemic improvements. The government is, therefore, considering measures to take the autonomy forward by linking it to external monitoring mechanism to eliminate issues such as "elite capture" in such institutions. It will also encourage these institutions to enter into public-private partnerships with domestic and international centres of excellence to improve systems development capacity, which is fundamental to the success of autonomy in these entities.

The Punjab Government is alive to the overwhelming importance of quality medical education for the sustainability of the public health sector. It, therefore, envisages revamping of medical education in the province with a view to bringing an increased focus on community and public health. Such an initiative will involve partnerships with renowned domestic and internationals medical education institutions in addition to a comprehensive review and revision of medical curriculum with the assistance of the Pakistan Medical and Dental Council (PMDC). The government will also regulate the private medical colleges to ensure the same academic and professional standards as it contemplates to achieve in the public health sector. Lastly, efforts will be made to adopt Continued Medical Education (CME) as one of the measures for evaluating the performance of health professionals.

Limited inter-sectoral coordination has resulted in wastage and ineffective use of resources. While the PDSSP has developed sectoral guidelines for health with a view to creating strong linkages with education, water supply & sanitation, poverty elimination, and gender development, the HSRF suggests that the PDSSP will make identification of cross-sectoral linkages an integral component of the capacity building measures being considered for health managers and planners. It also proposes that the PDSSP may employ its conditional grant mechanism to compel District Governments to clearly workout cross-sectoral linkages in order to ensure more holistic development planning and avoid wastage of limited resources.

Absence of a social safety net has made it prohibitively expensive for the poor and vulnerable segments of the society to meet the ever-rising costs of health care even through public sector health facilities. There exists no provision of insurance of the poor against critical illness. Social protection for the ageing population and fixed-income groups is almost non-existent. The provincial government is aware of this harsh reality and has recognized, through the HSRF, the urgent need to create social safety nets for ageing population and to arrange some form of health insurance cover for

government servants. It strongly endorses the plans to provide critical disease cover or minimal health insurance for the poor and vulnerable groups. The government also plans to examine, through in-depth study, the feasibility of using Zakat funds for health insurance purposes.

Dichotomous relationships, which came to fore in the wake of devolution of powers, lack of accountability, limited data and research, skewed human resource profile, chronic staff absenteeism, critical shortage of female healthcare professionals, and locational disadvantages (like poor access, physical condition of buildings, accommodation and other services) are manifest of a 'governance deficit' in the public health sector in the Punjab. The existence of such gap in the governance of public health sector can render all government initiatives for reform fruitless. Therefore, the government is according top priority to delineate roles and responsibilities of provincial and local governments in line with Punjab Local Government Ordinance (PLGO). It is also aims to establish a Policy Planning and Strategy Cell in the Health Department, which will act as a think-tank to monitor and measure results, ensure evidence-based planning, and spearhead the reform initiatives in the offing.

The Punjab Health Sector Reform Framework also proposes that the security of tenure of health care professionals needs to be linked with realistic and measurable performance indicators under a contractual employment mechanism. It endorses early adoption of performance budgeting, comprehensive framework for performance appraisals, and results-based accountability for all. It also calls for strengthening and empowering the district health offices [EDO Health] and facilities to implement the Minimum Service Delivery Standards.

The Health Sector Reform Agenda of the Punjab Government is, undoubtedly, holistic and ambitious, yet with the support of the present political leadership and the guidance of its domestic and international partners, it is hoped that in the months and years ahead, Punjab will witness phenomenal improvements in the coverage of health service delivery, which will not only be equitable and pro-poor, but would also meet the most stringent measures of quality, and comprehensiveness. Characterized by public-private partnerships, redesigned and reoriented public sector agencies, innovative financial arrangements, market-driven employment mechanisms, and institutionalized monitoring, evaluation and accountability frameworks, the reformed public health system will set the tone and direction for realizing the overarching objective of a prosperous, and poverty free Punjab.

1. INTRODUCTION

Comprehensive reforms in the Health Sector are in the vanguard of the provincial reform agenda. This document briefly outlines the broad contours of the health sector reforms agenda of the Government of the Punjab. Drawing heavily upon Poverty Focused Investment Strategy (PFIS) prepared under the Punjab Resource Management Program (PRMP), it aims at present the outlines of the health sector reform program predicated on a holistic vision and framework. The first phase of the Punjab Health Sector Reform Program [HSRP] is underway. The Health Sector Reform Framework [HSRF] seeks also to set the tone and direction for comprehensive health sector reforms by clearly defining the strategy and milestones for enhancing service delivery systems in health sector.

HSRF incorporates almost all the major themes and issues of the health sector in Punjab, and offers an all encompassing reform framework. Based on work done by the PRMP with the Health Department over the last two years, the papers identifies gaps that critically affect the health sector and proposes short to medium term interventions to address policy and service delivery issues. Some of the interventions proposed—especially those that are more long term-- are indicative in nature and are subject to further research and study.

The HSRF has been developed after a careful mapping of the reform initiatives being implemented in the Punjab under various programs and projects. As such innovative programs as the Punjab Health Sector Reform Program (HSRP), the Punjab Devolved Social Services Program (PDSSP), and the Chief Minister's Initiative for Primary Health Care (CMIPHC) in addition to other vertical interventions have been factored into the recommendations. Most of the reform options presented are predicated on the existing programs while many would require new initiatives or changes in the business processes of the existing ones. It also refers to the recommendations contained in the Poverty Focused Investment Strategy (PFIS) for the improvement of health sector.

The broad areas and issues, listed in the Health Sector Reform Framework, requiring attention and action present a significant challenge to the provincial government for bringing about a positive change. Needless to say, the provincial health sector needs to take major strides to enhance the quality of health services during the years ahead; however, the existing institutional capacity and resources are not adequate to realize such an ambitious reform agenda. Working on this sweeping agenda would require massive technical and financial resources and capacity. The Punjab Health Sector Reform Program (HSRP) and the (PDSSP) Punjab Health Sector Reform Program have been launched to offer the Health Department the financial and technical support it needs to undertake the challenging task of introducing comprehensive health sector reforms in the Punjab.

The HSRP is more of an implementation and monitoring arm of the Health Department's effort to institutionalize health sector reforms, whereas the PDSSP has a substantial Technical Assistance (TA) component that the Health Department will utilize mostly for building and sustaining capacity of District Governments (DGs) to plan, implement, and evaluate health sector programs.

Before presenting the framework of reforms being proposed, the paper presents the salient features of the PDSSP and HSRP, two major programs that are going to impact the health sector in the medium term.

2. EXPECTED OUTCOMES OF THE HEALTH SECTOR REFORMS

The major reform initiative being proposed in this framework would have far reaching outcomes for Punjab and Pakistan. Briefly some of these are listed below.

- Measurable impact on MDGs
- Improvement in health delivery services
- Significantly reduced incidence of disease
- Better Health Management Systems

- Reduction in poverty
- Social protection for vulnerable population groups
- Improved Primary / Secondary and Tertiary Health Care
- Enhanced utilization of BHU/RHC
- Optimal utilization of Facilities
- Effective and Quality Referral System
- Enhanced Capacity for Planning, Costing and Budgeting
- Improved Capacity for Data Analysis and Research
- Evidence and outcome based planning
- Better patient management
- Community Participation and Public Private Partnership
- Giving Private Sector its due share in Public Policy

3. BROAD INGREDIENTS OF REFORM

The reform program being envisaged would cover many areas. There however would be basic common areas and convergences of actions some of which are listed below.

- Improve Performance of Health Management System
- Improve Access & Quality of Trained Manpower, Drugs and Technology in Health Service System
- Review Existing Policy Framework for Health Service Delivery
- Improve Health Service Delivery Infrastructure
- Health Mass Awareness
- Introduce Public Private Partnerships
- Broaden Health Financing Mechanisms

4. PUNJAB HEALTH SECTOR REFORMS PROGRAM – AN OVERVIEW

The Government of the Punjab is committed to undertaking policy and governance reforms for economic emancipation of the masses and improved public services in the province. The Chief Minister of Punjab reiterated this commitment in his Vision 2020 that enunciates a strategic direction for the province and provides a framework for continuation of reforms over the medium to long term. In line with the commitments contained in Vision 2020, the Punjab Government launched the Punjab Health Sector Reforms Program

(HSRP) to improve the coverage and quality of primary health services, and to achieve the Millennium Development Goals through provision of missing health facilities.

The Punjab Health Sector Reforms Program (HSRP) was launched in with block allocations of Rs. 700 million and Rs. 500 million during ADP 2004-05 and ADP 2005-06, respectively. The scope of the first phase of PHSRP broadly includes provision of missing human and physical facilities at the Basic Health Units (BHUs) and Rural Health Centres (RHCs), improvement in health service delivery, human resource development, timely supply of essential medicines, and health awareness/health education. Civil works constitute about 70% of the program, while the remaining 30% of it is concerned with provision of equipment.

The program envisaged the signing of terms of partnership between the district governments (DGs) and the provincial government, whereby the provincial government has committed to provide the DGs with the missing infrastructure to strengthen the existing medical facilities at the BHU and RHC levels. The HSRP provides for a comprehensive needs analysis of the missing facilities (physical and manpower) at the BHU and RHC level with the assistance of DGs.

Under the program, the Health Department is expected to standardize the staff, medicines and equipments at the public health care (PHC) level by clearly defining the yardsticks for recruitment and procurement. In the beginning, recruitment would be carried out against vacant posts, subsequently, new positions of health care providers will be created according to the new yardsticks. Staff capacity will be enhanced through training and refresher courses. The HSRP also provides for the development of mechanisms to improve the supply of drugs.

Improvement of female health is a primary concern under the HSRP. The program will offer special incentives-based salary package to female doctors in

order to retain their services at the BHU and RHC levels for the health welfare of the female population.

Child and maternal health is another area receiving Government's special attention, Under the HSRP, lady health workers (LHWs) would be encouraged to provide pre-natal and post-natal services to pregnant mothers to achieve dual objectives of lowering infant mortality and reducing pregnant mothers' morbidity rates. The program envisages offering market-driven cash incentives to LHWs and LHVs to encourage PHC facilities-based deliveries.

Absenteeism and lack of qualified health care service providers has always undermined the PHC level. In order to improve the availability of health care providers at the BHUs and RHCs, the program proposes incentivized pay packages for employees. Besides, it advocates accord of preference to those candidates for admission to postgraduate courses that have at least one to two years' experience of rural health service. Also, the Provincial Public Service Commission will be approached to award additional marks to candidates with rural service experience during recruitment and selection for positions at PHC level.

To attract and retain the staff at the BHU level, the HSRP plans to provide transport and/or offer adequate compensation for the schooling of health care providers' children. In addition, the provincial government will devise a comprehensive policy to permit private practice at the BHU and RHC levels in the evening/off-office hours, besides allowing the medical practitioners to use the medical equipment available at the BHUs and RHCs. The program also provides for developing incentivized pay package to attract Women Medical Officers (WMOs). Such a pay package will be linked to clearly defined performance indicators. It is expected that such initiatives will improve the availability of necessary medical staff at the PHC outlets.

Punjab's medico legal system has long suffered from lack of adequately trained manpower and physical resources. The Health Sector Reform Program

provides for a package of initiatives that are expected to bolster the existing over-burdened and archaic system. This includes the creation of a separate cadre of Medical Legal Officers under the Prosecution Department, along the lines of the Coroner's Department. Such an initiative apart from bringing in specialization, would also free up more doctors, presently deputed for medico legal work, to concentrate on their regular duties. The plan envisages offering special incentives to medico legal experts in the new cadre for postmortem work at Tehsil Headquarter (THQ) and District Headquarter (DHQ) Hospitals.

A Program Management Unit (PMU) has also been set up to manage the overall implementation of the program. Skeleton staff has been recruited for this purpose. Activities of the HSRP would be monitored through baseline surveys, regular reporting on the status and performance of human and physical resources, service delivery standards, and HMIS indicators. The program also provides for the establishment of Regional Monitoring Units (RMUs). Employees at the RMUs will be offered 30% more salary as an incentive to ensure their retention and transparency in monitoring.

Under its promotional activities, the HSRP provides for establishment of Village Health Committees (VHCs), School Health Programs, and Early Child Care Development (ECCD) Programs. The monitoring and evaluation (M&E) of HSRP shall follow the model being pursued in the Punjab Education Sector Reform Program (PESRP). In addition, the services of the Punjab Information Technology Board (PITB) have been engaged to help HSRP devise appropriate software for effective monitoring and evaluation of its program activities. The Chief Minister is to chair the monthly progress review meetings of the HSRP. Provincial Steering Committee headed by the Chief Secretary, Punjab would oversee the program activities. Almost all the foreign funded interventions will also be brought under the umbrella of the program in due course of time. Such a linkage will improve coordination and enhance overall monitoring of the program activities by ensuring effective and efficient use of program resources.

The personal interest and support of the Chief Minister is facilitating the achievement of multifarious objectives and goals of the HSRP. In this regard, the Health Department's incentives-based salary package for the staff of BHUs and RHCs through out the province is worthy of mention. It is hoped that this innovation will attract qualified health service providers and help reduce the attrition rates at the PHC level. The details of the incentivized salary package are as follows:

Health Facility	Staff	PHRSP Allowance (in Rs.)
RHC	SMO*	8,000
	WMO*	10,000
	MO*	8,000
BHU	WMO	10,000
	MO	10,000

*SMO = Senior Medical Officer, *WMO = Woman Medical Officer, *MO = Medical Officer

5. PUNJAB DEVOLVED SOCIAL SERVICES PROGRAM – AN OVERVIEW

The Punjab Devolved Social Services Program (PDSSP) is another initiative of the Government of the Punjab that aims at improving service delivery in select social sectors, including health by injecting technical and financial resources. The PDSSP is designed for province-wide support, covering all 35 districts of the Punjab for 3 years. The program is built around five principal policy outcomes: firstly, realignment of inter-governmental relationship to support the delivery of devolved social services; secondly, rationalizing social services and setting minimum standards to support pro-poor policies and strategies; thirdly, strengthening public accountability mechanisms and community participation at the province and district levels; fourthly, promoting public-private partnership and innovations in alternative service delivery; and finally, enhancing social sector financing and allocative efficiency.

A fine balance between institutional reform and addressing of governance issues characterizes the PDSSP's design. Its program activities are supported by a generous Technical Assistance (TA) package. The overall goal of the PDSSP is to strengthen the devolved social services in order to achieve progress on Millennium Development Goals concerned with poverty, gender, education, health, and Water Supply & Sanitation (WSS). The program's objective is to support more equitable, efficient, effective, and sustainable social services in accordance with provisions of the Punjab Local Government Ordinance (PLGO). With 65% of the program resources going into health sector, the program mainly focuses on improving health services at the district level.

The PDSSP is committed to flexible financing of social sectors with a view to address gaps in service delivery. It particularly targets services meant for the poor and vulnerable, including children and women. The program will fund activities aimed at capacity building, and monitoring and evaluation of the reform measures. A huge technical assistance package is available under the PDSSP, bulk of which will be available under this program for the health sector reform at the district level. The TA component of PDSSP will also be utilized for technical studies and analyses envisaged in the PHSRF.

The program has already launched several innovative initiatives aimed at capacity building and improving M&E in the health sector. These include the Compendium of Existing Service Delivery Standards, a 5-Year Strategic Plan, and a Monitoring and Evaluation Framework. The PDSSP resources will play a major role in realizing the ambitious plans outlined in the PHSRF.

6. HEALTH SECTOR – KEY CHALLENGES AND ISSUES

6.1 Primary Health Care (PHC) - Issues

Analysis of primary health care systems in the Punjab reveals staff absenteeism, low utilization of services, low quality of care, limited planning, lack of ownership and absence of strong referral links between Primary Health

Care and Rural Health Centers as some of the major ills affecting primary health care.

The following section examines the causes of these problems. It briefly maps out the initiatives in offing under various development programs inspired by the Poverty Focused Investment Strategy (PFIS). Finally, it lists suggestions incorporated in the Punjab Health Sector Reforms Framework for improvement and strengthening of healthcare facilities in the medium to the long term.

6.1.1 Staff Absenteeism - Causes

The primary health care facilities suffer from severe staff absenteeism. Abysmally low salaries, and non-existence of residences and transport for health service providers, among other things, are attributed as its main causes. In addition, weak internal management, characterized by lack of monitoring and evaluation mechanisms; and absence of effective external checks and controls, which is the result of failure to involve the community; contribute to chronic absenteeism at the PHC level. Lack of medical equipment and essential drugs have been identified as other major disincentives for the staff the BHU and RHC levels.

Mapping of Existing Initiatives

Provincial government is undertaking a number of initiatives to address these gaps. The Punjab Devolved Social Services Program (PDSSP), a prominent reform initiative of the provincial government is working to improve the quality, effectiveness, access, and cost-effectiveness of services in the devolved social sectors, particularly health by contributing high quality technical assistance and offering financial support through novel mechanisms.

Under the PDSSP, all the 35 district governments have been required to prepare their respective Annual Sectoral Plans (ASPs), including one for health sector. These ASPs will comprise of sectoral and future need analysis regarding missing, and/or needed physical and human resources along with annual development targets in the health sector. The ASPs for health will specifically

include situation analysis of absenteeism and propose concrete action plans to address the stupendous challenge of rehabilitating the BHUs and RHCs in the initial phase, and later the Tehsil and District Headquarters Hospitals. In order to improve availability of staff, the ASPs will include proposals to introduce performance-based incentives for officials working in the health sector. Efforts are afoot to make such ASPs more realistic and dynamic.

A monitoring and evaluation (M&E) framework, along with related by-laws, has also been developed for the health sector under the PDSSP. It is expected that such a framework would significantly improve the M&E procedures in practice in the health sector, thereby ensuring better health service delivery. Such a framework will also facilitate the PDSSP to effectively implement the conditional grant mechanism for extending financial support to District Governments (DGs).

The Punjab Health Sector Reforms Program (HSRP) has mainly targeted the provision of missing facilities at the BHU and RHC levels based on a comprehensive need analysis of the missing facilities (physical and staffing). Under the terms of partnership agreed between the DGs and the provincial government, the latter will provide the missing infrastructure to the DGs to improve the health care service at the PHC level. The PHRSP needs substantial improvements and motivation in order to perform its envisaged role.

Lack of adequate transportation facilities for their school-going children makes the BHUs and RHCs unattractive places for the health service providers. In order to attract and retain the staff at these levels, the HSRP plans to provide transport or rent for the schooling of health service providers' children as a part of the incentivized pay package that is under consideration of the Health Department. The provincial government also plans to develop a policy that will encourage medical practitioners to conduct private practice at the RHC/BHU premises in the evening hours as an added incentive. Such a policy will also permit the doctors to use the medical equipment, which the HSRP will

provide at all PHC outlets. It is expected that these initiatives will considerably improve staff availability at the BHUs and RHCs.

Attrition of female doctors at the PHC level has been a long-standing issue. Rapid turnover of female medical practitioners adversely affects primary health care services for women. The PDSSP, with the active participation of the Punjab Health Department, is working on developing a performance-based incentivized salary package for Women Medical Officers (WMOs) with a view to encourage them in seeking employment at BHUs and RHCs, and to vouch for their retention in the long term.

The Chief Minister's Initiative for Primary Health Care (CMIPHC) – another aggressive intervention of the Punjab Government to reform the PHC sector - is targeting primary health care issues in twelve districts of the province. It has constituted local Resource Groups to help monitor and review government's initiatives to address chronic PHC issues. An incentives-based salary package has been offered to the staff working under this initiative. The program has assigned WMOs to clusters of five BHUs each in the target districts under competitive pay packages. The CMIPHC has also formed Support Groups to oversee and facilitate working of the BHUs. These groups consist of elected councilors, teachers, female students, professional and representatives of minorities.

A number of other reforms projects and programs such as the Women Health Project (WHP) and the Reproductive Health Project (RPHP) are also contributing to the reform agenda at the PHC level. Such programs are proving quite helpful in lending support to the already existing vertical preventive programs.

Proposed Interventions

The Health Sector Reforms Framework, prepared under the aegis of the Punjab Resource Management Program (PRMP) proposes to offer differential incentive packages [salaries, allowances/bonuses] for health service in hard

and inaccessible areas with a view to attract and retain highly qualified health care providers at the BHU and RHC level. Incentives-based career planning, such as contracts with pensions and CPF in a manner that does not burden the provincial exchequer is imperative to maintain an optimal level of motivation among the employees at the PHC level. The framework also proposes to carry out a more comprehensive study to better understand the causes and impacts of staff absenteeism, for which sufficient funds are available with the PDSSP.

The framework recommends more innovative planning at the Provincial Health Department to address staff absenteeism at the PHC level. In this regard, it suggests that the Health Department may consider increasing the duration of mandatory period from one to 2 years, where every fresh medical graduate could be required to work at the PHC level for at least one year.

Community oversight of PHC facilities is essential to quality and transparency of service delivery. The Rahim Yar Khan (RYK) Model though successful, has little by way of community oversight. Establishing, encouraging, and empowering Health User Committees can play a significant role in this regard. The Gujrat Model of partnership with National Commission for Human Development [NCHD] however provides a solid model of involving communities through social mobilization. RYK model must also incorporate this element into its program and eventually prepare an exit strategy. The PDSSP has already initiated an exercise for creation of such committees. All out efforts must be made for an early completion of this initiative.

The HSRF proposes exploring innovative ideas to address the staffing challenges. It proposes that the Punjab Health Department may examine the possibility of utilizing, at the PHC level, the services and skills of non-serving medical graduates (particularly, female doctors), who leave the medical profession due to personal exigencies. Engaging such health professionals to work on flex-time/part-time basis either at the PHC outlets or, in select cases, from their residences through soft compensation packages may prove quite

helpful in addressing staff shortages. This can more easily be achieved in urban areas.

Attaching every district to the nearest teaching and/or tertiary health care centre may ultimately help achieve the much-desired objective of providing advanced heath care services at primary health care (BHU/RHC) and secondary health care (THQ/DHQ Hospitals) levels. Such an arrangement would vouch for mandatory visits of specialists from teaching and tertiary health care institutions to the RHCs and secondary health care tier. This will also go a long way in helping streamline the referral of critical patients from the primary and secondary health care centres to tertiary health institutions.

6.1.2 Low Utilization – Causes

Low utilization of health care facilities is another area of critical concern at the PHC level. Site suitability, dilapidated and/or missing infrastructure, staff absenteeism, shortage of essential drugs, and lack of medical equipment are described as the major factors inhibiting the optimal utilization of PHC facilities.

Mapping of Existing Initiatives

Government is trying to address this issue through different initiatives. The PDSSP is to provide for conditional grants to the DGs to enhance spending on areas outlined and prioritized in their respective Annual Sectoral Plans on health care. It requires that the ASPs include future needs assessment of medicines and medical equipments at the district level, thereby affording the DGs an opportunity to secure sufficient budgetary support from the government to effectively plug the most crucial gaps. Though not very sophisticated, the Annual Health Plans are serving well as the basic documents for devising drugs and medical equipment procurement plans at the district level.

Under the terms of partnership, the provincial government is committed to finalize guidelines for better utilization of health facilities at the BHUs and RHCs. The scope of HSRP includes the provision of missing physical facilities,

foolproof and consistent supply of essential medicines, and improved human resources management to strengthen the service delivery. It also envisages creation of health awareness.

Under the lead of HSRP, inventory of all BHUs and RHCs will be prepared to identify both functional and non-functional units in terms of availability of physical and human infrastructure. It will also ensure improved supply of medicines and medical equipment on the basis of need assessment in every district.

The HSRP is committed to improving the standards of health service delivery. It will develop performance measures/indicators for monitoring and evaluation in order to improve the utilization of health facilities at the PHC level.

The CMIPHC is, currently, operational in 12 district of Punjab. Due to its operational flexibility and customized business processes, it has met with significant success at the PHC level. Since long, cumbersome procurement procedures have been a source of delay in provision of medicines and medical equipment at the PHC level. The CMIPHC is planning to develop a shorter, but "better" list of drugs, and a new, swifter process of procurement that will ensure quality with affordability at the local level.

Lastly, the Punjab Health Department has also developed a Medium Term Strategic Plan (MTSP) for the health sector, which provides for rehabilitation of existing infrastructure and provisions of missing physical and human facilities. Both Women Health Project [WHP] and Reproductive Health Project [RPHP] are also rendering valuable services in their respective areas of activities.

Proposed Interventions

HSRF has developed models of Basic Health Unit and Rural Health Centre, which identify the optimal levels of infrastructure, staffing, equipment, drugs supply and vertical linkages with other health care tiers that

are prerequisite to ensure service delivery in accordance with existing modern standards. These models also provide for computerized maintenance of health records.

The framework also emphasizes the need for development of annual health plans for procurement of medicines and equipment, based on the burden-of-disease for each BHU and RHC. However, District Governments have weak procurement capacities. The framework recommends involvement of the PDSSP and/or the Decentralization Support Program (DSP) to arrange training and capacity building of the district health officials in this regard.

The framework suggests that the government should review and update the Essential Drugs List (EDL) for the PHC facilities in order to ensure the availability of essential drugs. It also draws attention towards the urgent need for technical assessment of the locations of BHUs in the province to identify the non-serviceable units in order to ensure optimal utilization of functional and operable units, and relocation or permanent closure of those that are either not functional and/or cannot be made operational at all.

6.1.3 Low Quality of Care - Causes

Low quality of care is a major cause of low utilization of PHC services. Staff absenteeism and part-time service coupled with poorly trained staff are identified as the main factors affecting the quality of health care at the BHUs and RHCs. Weak pre-service and in-service training and lack of refresher programs contribute to low quality of PHC providers. Absence of Standing Operating Procedures (SOPs) and medical manuals, and low non-salary component in health budgets is equally responsible for low quality PHC.

Mapping of Existing Initiatives

The PDSSP has recently compiled a Compendium of Existing Technical Delivery Standards for the health sector in the Punjab. This useful document will prove to be a step further towards developing minimum package of health service delivery standards. Under its technical assistance (TA) component, the

PDSSP is committed to funding the capacity building of health sector staff in all the districts with a view to improve the quality of health care.

Government is committed to securing the rights health system's beneficiaries. Efforts are afoot under the HSRP to require all the RHCs to explicitly define and prominently display all medical procedures and essential medicines that are supposed to be offered to end users irrespective of their financial, political or social status. Such an initiative will help protect the patients' right to know the level of service they can claim at PHC outlets.

Under the terms of HSRP, the provincial government is to develop new job descriptions, clearly re-define career paths and devise performance measures based on modern service standards for health service providers. These will be communicated to the DGs for implementation. The DGs will also recruit medics, para-medics and ancillary support staff, besides providing other missing human resource at the BHUs and RHCs. The HSRP also includes provisions for training of all PHC staff and health professionals through the Provincial and District Health Development Centres.

The CMIPHC has developed a Manual of Operations that comprehensively covers all forms and levels of operations at the PHC level in the project districts. The manual has helped considerably improve the performance of the staff and service delivery. The Chief Minister's Initiative is also sponsoring capacity building of Lady Health Visitors (LHVs) and midwives in the 12 districts of the Punjab. It is also leading the effort to enhance the capacity of Medical Officers during its Monthly Review Meetings (MRM) through interactive sessions with the Resource Group that consists of health care experts and stakeholders.

The Health Department's Medium Term Strategic Plan (MTSP) requires assessment of current and future needs in terms of physical and human infrastructure and resources at the PHC level. It also envisages development of operational policies, SOPs and standardized packages of service delivery for each level of health care with explicitly defined boundaries, and clearly laid out vertical and horizontal linkages that are clearly ensured to the public.

Finally, other vertical interventions and provincial initiatives, such as the Reproductive Health Project (RPHP) and the Women Health Project (WHP) are also striving to improve the quality of health care through capacity building and training of LHVs, midwives, and family welfare workers and by offering free medicines and missing facilities at the PHC level.

Proposed Interventions

The HSRF proposes preparation and implementation of Minimum Service Delivery Standard/Package [MSDP] that will conform to the recognized best and evidence-based health practices under the aegis of the PDSSP. Since correct sequencing of reform initiatives is critical to the success of such measure, the HSRF has proposed continued engagement of the PDSSP in order to develop more realistic and dynamic MSDP, which would be adopted at the primary, secondary and tertiary levels of health care in a phased and rationally sequenced fashion. The HSRF also recommends that the PDSSP develop a manual of standard medical practices, state-of-the-art job descriptions, standardized medical protocols and SOPs to further support the effective implementation of MSDP.

The framework regards a total integration of all PHC preventive and promotive services, including vertical programs like the National Program for Primary Health Care, Family Planning (PHC & FP) and Nutrition, and other pro-poor MDG-related preventive interventions, such as the School Health Program, at the BHU level as an absolute imperative to radically improve the quality of health care at this level.

In order to address the capacity issues, extensive re-training and capacity building of staff needs to be undertaken on emergent basis. There is an urgent need to design attractive incentives-based salary packages for health service providers serving in “hard” areas to stem the attrition trend. Incentive-based career planning should be adopted at the earliest to prevent brain drain. In addition, the Health Department ought to recognize the immense significance of childhood nutrition to immediately introduce comprehensive

interventions similar to the Early Child Care Development (ECCD) program by integrating nutrition, mother-child health care (MCH) and other similar programs at the PHC level.

6.1.4 Limited planning and ownership - Causes

Limited and "one size fit all" type of planning, and lack of ownership has adversely affected PHC service delivery. While uniform and project-based approach has limited the planning horizon, vertical programs with narrow and limited provincial and district role have led to lack of ownership and ineffective targeting of high poverty areas, bringing the need for sectoral planning into a sharp focus.

Mapping of Existing Initiatives

The Annual Sectoral Plans required under the TORs of the PDSSP will pave the way for the redesigning of health services in accordance with the needs of each district. Since the PDSSP focuses on sectoral interventions, therefore it has a much broader scope, which will lead to better and integrated planning. The program's design provides for a conditional grants mechanism, which will help ensure more effective pro-poor targeting of vulnerable sub-sectors. The PDSSP's monitoring framework and by-laws will also vouch for more effective M&E through District Health Monitoring Teams, which, in turn, will lead to frequent corrections and improvements in the planning process. Finally, community participation will ensure more ownership of health care facilities at the PHC level.

The design of HSRP provides for a well-defined mechanism to monitor and evaluate the inputs in the health sector and their outcomes. It is hoped that these innovations will help strengthen and modernize the planning process in the health sector.

The CMIPHC targets PHC at the BHUs level. It has placed a lot of emphasis on integration of vertical interventions in to the preventive health care facilities at PHC level. However, evidence exists, which suggests that such

an arrangement virtually de-links the vertical interventions from the Executive District Officer (Health) who is the focal point in the district for al vertical programs. This aspect needs to be examined in order to ensure flawless planning and ownership of all the integrated initiatives at the PHC level, including the vertical interventions in preventive health.

The Health Department's Medium Term Sectoral Plan (MTSP) also focuses on designing and implementation of organizational and system changes. It has recommended the development of horizontal linkages between the vertical programs and their ultimate integration into the mainline service delivery at the PHC level with a view to improve the quality of health care services through enhanced planning and ownership of health facilities.

Proposed Interventions

HSRF goes a step further and proposes integration of all PHC facilities, promotive, preventive and curative, with pro-poor, MDG-related preventive interventions at the BHU and RHC level. It suggests that the PDSSP may study and develop comprehensive mechanisms in this regard. More specifically, the HSRF recommends a detailed study to establish the "burden of disease" at the districts and provincial level. Such an exercise, which could be carried out under the auspices of the PDSSP, will provide impeccable segregated databases to build nuanced budget plans for rehabilitation and equipping of health care units, thereby helping the health sector managers to step away from the "one size fit all" approach for budget plans.

The existing system of Union Councils-wise allocation of populations to the BHUs is not only archaic; it is also highly inefficient and cost-ineffective. The HSRF, drawing inspiration from the highly successful NCHD Gujrat Model, strongly advocates innovative de-limitation of "catchment areas" for the BHUs. In this regard, surveys could be conducted to identify the nearest PHC facilities for different catchment populations; followed by the registration of local population with the nearest possible BHU for provision of integrated PHC services, irrespective of the Union Council limits within which such catchment

populations reside. It is expected that such an innovative approach will secure totally integrated PHC facilities to the target populations, besides conserving time and energy, and ensuring optimal utilization of resources.

The HSRF further proposes that in due course all the families residing in such catchment areas can be provided with registered health cards, which could be used by the members of the household to gain easy access to one-stop, integrated, promotive, preventive and curative facilities at the BHU and RHC. Such health cards would also help create awareness among the rural population as regards maintenance of personal health records, which, in turn, will prove helpful in ultimately developing a more effective referral system.

The HSRF is of the view that a broader approach to health sector reform needs to be adopted through instituting new organizational and financing arrangements for health care. Health care planning needs to be reinvented by implementing sector-based rather than project-based funding, changing public and private roles and responsibilities, and promoting accountability of health care system. In this regard, it calls upon the PDSSP to arrange for extensive re-training and capacity building of the health staff.

6.1.5 Lack of Strong Referral Links between PHC and SHC Facilities - Causes

Absence of effective and strong referral links between Primary Health Care (PHC), Secondary Health Care (SHC) and Tertiary care have tremendously undermined the quality of service delivery at all levels. Absence of proper guidance and health education for the less literate and poor rural population, lack of information among the rural population about the existing services at PHC outlets, cumbersome patient enrolment process, and lack of transportation facilities, such efficient ambulance service, only serve to compound this disconnect and absence of referral linkages between the primary and secondary health care tiers.

Mapping of Existing Initiatives

Health education plays an important role in offering guidance and awareness on health issues. The Technical Assistance (TA) component of the PDSSP plans to allocate funds for health education and creating health awareness campaigns. Similarly, provisions for promoting health education and running health awareness campaigns figure prominently in the policy objectives of the HSRP.

The Punjab Health Department's Medium Term Strategic Plan (MTSP), similarly, contains provision for the development and implementation of a comprehensive referral system that would link different levels of health care facilities. The Women Health Project (WHP) is also looking into social mobilization for creating health awareness and to facilitate community-based health care with special focus on improving women's health. It is also proactively pursuing health education in the context of women health.

Proposed Interventions

HSRF has proposed a comprehensive referral system that treats the BHUs, RHCs, THQ and DHQ Hospitals along with the tertiary health care complexes as a single network of health care facilities, and not as stand-alone posts. It recommends testing this innovative measure in a few pilot districts before adopting it province-wise.

The framework further emphasizes the need for a policy that requires consultant specialists at the District Headquarters (DHQ) Hospitals and tertiary health care centres to conduct mandatory periodic visits of the RHCs and Tehsil Headquarters (THQ) Hospitals, and other remote areas. Such arrangements will offer advanced health care facilities at the poor and remote beneficiaries' doorstep.

The HSRF recommends introduction of a health card system, which will not only enable the rural households to receive one-stop PHC coverage at the

BHUs, it will also facilitate the introduction of an innovative and comprehensive referral system on the lines suggested above. In addition, such a measure will also encourage the rural households to maintain updated personal health records, which will lend further support to the proposed referral system.

The framework also calls for a detailed feasibility assessment of the Gujrat Model in order to determine its cost-effectiveness from a point of view furthering its scope and area of operation. It also recommends that the CMIPHC immediately institute a comprehensive referral system along the lines suggested above.

6.2 Need to increase focus on preventive [pro-poor] Health and to actively target MDGs – Causes

Millennium Development Goals (MDGs) are commonly accepted as a framework for measuring development progress and encompass several pressing health needs, such as reducing childhood mortality, improving maternal health, and combating HIV/AIDS, malaria, tuberculosis (TB), and other infectious diseases; and the crucial importance of gender equality in achieving these goals. Poor targeting of the Millennium Development Goals at the PHC level, existence of strong urban elite bias (evident in greater focus of resources at the tertiary level), and highly diffused control in preventive health are some of the daunting challenges that severely undermine the health sector's efforts and initiatives to achieve the MDGs.

Mapping of Existing Initiatives

In order to improve the targeting of MDGs and to adopt pro-poor initiatives, the PDSSP is providing conditional grants to the District Governments (DGs) to facilitate the implementation of their Annual Sectoral Plans (ASPs). About 65% of the conditional grants are to be spent on the health sector. These conditional grants are required to be spent on pro-poor and gender sensitive schemes, improvement of the PHC component, and measures to significantly reduce child and maternal mortality, which are a mandatory

and integral part of all ASPs. The PDSSP also requires of the DGs to incorporate schemes for the revamping of midwifery schools, intensive and modern training of midwives, and recruitment of paramedic staff for the PHC level to qualify for its conditional grants.

The HSRP, which has been mandated to provide all the missing facilities at the PHC outlets, also plans to create linkages between community midwives and RHCs through incentive-based mechanisms. The program also intends to offer free-of-charge MCH service packages and medicines for antenatal, natal and postnatal care.

The CMIPHC is engaged in capacity building of LHVs and midwives in the 12 project districts to achieve the pro-poor MDGs. Under the "Strengthening Emergency Medical Services" (SEMS) initiative, the Punjab Health Department is revamping emergency departments. The CMIPHC is also committed to offering free-of-cost round the clock emergency services through the Punjab Emergency Ambulance Service (PEAS) – Rescue 1122.

Training of LHWs, midwives, family welfare workers, and LHVs is an important component of the Reproductive Health Project (RPHP). It also offers basic emergency obstetrics care at the BHU level. Capacity Building of doctors at PHC level is also an integral part of the RPHP. Training of LHVs, midwives, and LHWs also figures prominently on the Women Health Project's agenda. In addition, Health Department's MTSP provides for schemes to strengthen the emergency care services at THQ and DHQ Hospitals, including the development of a rapid rescue service.

Proposed Interventions

The HSRF proposes to integrate all PHC services at the BHU level with broad focus to include more pro-poor, MDGs-related preventive interventions, including vertical programs like the National Primary Health Care, Family Planning (PHC & FP) and Nutrition program. In this regard, the PDSSP can be asked to conduct an in-depth study and develop mechanisms for this purpose.

Extensive re-training and capacity building of PHC staff, including LHWs, LHVs, and Village Health Workers (VHWs) is an absolute imperative to improve service delivery at the BHU and RHC levels. The PDSSP and DSP could be engaged for this purpose. It also recommends that the PDSSP immediately prepare and ensure introduction of a minimum service delivery standard/package (MSDP) that conforms to best practices.

The framework suggests that the Punjab Health Department should make clear budget allocations for implementing the preventive, pro-poor, MDGs-related interventions in the Medium Term Budgetary Framework (MTBF) and Medium Term Development Framework (MTDF) so that such pro-poor allocations could be secured and protected for exclusive use to achieve the MDGs-related objectives.

The framework also recommends adoption of alternate delivery of preventive health services. It proposes that the Health Department develop incentives-based service delivery standards to attract and regulate private health facilities in the rural areas.

Creation of special School Health and Pre-school Children Nutrition programs are envisaged under the framework, wherein specially trained nursing and paramedic cadres could be engaged for health education and creating awareness about preventive health among students through Public-Private Partnerships (PPP). Existing precedents, such as the NCHD model, are worth examining for the purpose. In this regard, the framework also proposes creation of a mobile health service to offer preventive health care to students across the province. It is also suggested that arrangements be made for training of teachers in preventive health. Such efforts will pave the way for attracting children to education.

The HSRF suggests that the Health Department adopt innovative strategies to achieve the MDGs. Immunization coverage plays a critical role in preventive health. It, therefore, recommends innovative strategies for immunization coverage for all age groups.

There is a major disconnect between vertical preventive programs and the district level health offices. The framework proposes strengthening these linkages.

Paramedics and local health workers can play an important role in pro-poor service delivery. It is, therefore, necessary to introduce innovative incentives to ensure retention of LHWs and LHVs at the PHC level. The framework further recommends emergency investment for prevention of such diseases as TB, Malaria and Diarrhea.

While the HSRF encourages the involvement of private sector in providing health care facilities, it believes that the Punjab Health Department must evolve a mechanism to bring the ever-growing private health care facilities within the ambit of clearly defined standards and a code of ethical conduct to protect the rights of the poor and their claim to quality health care.

6.3 Lack of Health Professionals / Nurses / Paramedics etc. - Causes

The health sector in the Punjab has long suffered from shortage of qualified and highly motivated health professionals, nurses and paramedics. Pro-doctor bias in the health culture, low nurse-patients and doctor-patients ratios, and lack of sufficient skilled health technicians and paramedics are attributed as some of the major causes for poor performance of the health sector. Poor training, low social esteem attached with nursing and paramedical professions, absence of clearly defined career paths, and lack of emphasis on training of Medical Assistants are some of the key factors behind the discouraging shortage of such critically important health service providers.

Mapping of Existing Initiatives

While the HSRP is focusing its attention on providing missing human resource in the health sector, the PDSSP will rationalize staff and arrange for capacity building at all levels of the health sector under its TA component. The PDSSP's mandate includes behavioral change as one of the top priorities with a

view to enhancing the social esteem of health care providers, thereby raising their motivation level.

Similarly, the CMIPHC is also undertaking capacity building of LHVs and mid-wives in the 12 districts of Punjab. The Health Department is exploring the viability of strengthening paramedic services by replacing the existing cadre of medics with new cadres of specially trained paramedics and community midwives/Skilled Birth Attendants (SBAs).

The RPHP's attention is concentrated upon up-gradation of training institutes and public health schools. It is also establishing LHW Training Centers at the THQ Hospital level. RPHP has successfully trained around 600 midwives. Similarly, the Women Health Program (WHP) has also trained about 2200 midwives according to the modern standards. The project is also involved in capacity building of training institutes concerned with improvement of women's health.

Proposed Interventions

The HSRF places great emphasis on proactively addressing the existing problem of low self-esteem among the health staff in order to arrest their attrition at the PHC level. It proposes to review and improve job descriptions and career paths for nurses and paramedics and offer them better salary and incentives. The framework recognizes the urgent need for expeditious recruitment of nurses and doctors to bring the nurse-patient and doctor-nurse ratios at par with international standards.

The framework also recommends that the Health Department strengthen the training capacity of such institutions as the Institute of Public Health (IPH) and Post-Graduate College of Nursing. Foreign trainers and innovative partnerships with the local centres of excellence, such as the Agha Khan University Hospital (AKUH) can help build the training capacity of these institutions. The Health Department may also explore the possibility of sending high-performing nurses and paramedics for training abroad.

The HSRF recommends that the government may conduct a comprehensive study into the viability of creating a new cadre of paramedics and nurses for rural areas along the lines similar to the LSMF of the past. Such a cadre of public health professionals will have same entry requirements as regular doctors and will undergo a rigorous education of about two to three years focused on public health issues including community medicine and preventive health, basic procedures and some curative aspects. These professionals then need to be incentivized to serve in rural areas, urban un-serviced areas and to serve under regular doctors in mainstream health institutions. These public health professionals would also have the option, after they have served for some years in the field, of being able to join medical colleges in order to become regular doctors by studying for some more years. While such a cadre of public health professionals may not solve all the HRM problems facing the health sector, but it would be more inclined to serve in areas where doctors at times find it hard to serve.

6.4 Weak capacity for Planning, Costing and Budgeting – Causes

Limited and "one size fit all" type of planning, complete absence of results-oriented culture, chronically low share of development schemes in the budget, lack of clarity on rules and regulations, low budget utilization and traditionally low priority accorded to the health sector are all reflective of the weak planning, costing and budgeting capacity in the Punjab health sector.

Mapping of Existing Initiatives

The serious political commitment of the Punjab Government to the reform of the health sector is evident in the multifarious development and reform initiatives underway in the province. The design and TORs of the PDSSP will considerably transform the planning, costing and budgeting practices in the health sector. The MTBF and MTDF modes will also play a significant role in ensuring optimal budget utilization. The PDSSP-required Annual Sectoral Plans (ASPs), for the first time, provide explicit guidelines to the line departments

for budget and expenditure management. These ASPs, subsequently, will develop into three-year rolling plans.

The conditional grant mechanism built in to the PDSSP's mandate would also ensure proper utilization of funds at the districts level. In addition, the PDSSP will invest TA resources to build capacity of the line departments as regards planning, M&E, and human resources management. The PDSSP has also prepared a comprehensive compendium of existing laws, rules, and regulations related to the devolution of administrative and financial powers in the health sector for the facility of DGs and TMAs. This exercise will also help identify the gaps in the existing legal framework for necessary corrective actions.

76. On the other hand, the HSRP has developed a Health Management Information System (HMIS) to enhance the planning and budgeting capacities of health managers. The medical procedures manual and SOPs to be provided and displayed at the RHC level under the HSRP will also ensure better utilization of health budgets in the rural areas. The CMIPHC-developed manual of operations, encompassing all aspects of health operations from the beginning to the end, will similarly benefit the health sector. In addition, the Medium Term Strategic Plan (MTSP) of the Health Department has proposed a wide range of measures to strengthen the planning, budgeting and costing capacity of health officials. In order to improve the planning and budgeting skills of the district health officials, the District Health Monitoring Teams (DHMTs) are preparing one-year operational and five-year strategic plans in eight districts of the Punjab under the auspices of the Women Health Project (WHP). The Decentralization Support Program is also catering to the budget and planning needs of the districts. Health department has also attempted at developing a Medium Term Budget Framework (MTBF), thereby facilitating the health managers in obtaining accurate information about targets set for various health schemes and their corresponding protected allocations.

Proposed Interventions

The framework emphasizes the need for outcome-linked program mapping in order to identify gaps in planning and execution, and to evolve improved development strategies. The HSRF identifies the absence of a policy-planning unit in the Health Department as a critical hurdle in this regard. Such a unit could act as a think-tank to create the required policies, indicators and M&E framework. It, therefore, recommends immediate operationalization of a policy planning and strategy cell in the Health Department. A policy cell will facilitate evidence-based planning and spearhead the reform process.

The framework notes that the office of the Executive District Officer (EDO), Health is currently operating below its required capacity. It suggests that the PDSSP may formulate a restructuring plan to strengthen this vital link between the provincial government and the DGs along functional lines of budgeting, planning, and statistical support.

The HSRF also recommends independent district based surveys to update the HMIS and MICS. It strongly supports district level planning focused on district-specific health needs. The framework recommends that the districts should assess district-specific burden of disease to set district-specific health targets. It is expected that these measures would eliminate the "no results culture", increase the development component of health budget and significantly improve its utilization. Lastly, the framework is of the view that adoption of conditional grants mechanism, similar to the one that exists in the PDSSP, through the Terms of Partnership (ToPs), and the Provincial Finance Commission (PFC) will pave the way for the results-oriented planning and budgeting in the health sector.

6.5 Lack of effective Human Resource Management Systems - Causes

Improper staff and skills mix, overstaffing of health facilities in the urban areas, lack of re-training and absence of performance-based incentives

have consistently undermined the efforts to build an efficient, highly skilled and motivated human resource in the health sector. Low capacity of training institutions and dearth of management capacity in the districts has further contributed to the prevailing situation.

Mapping of Existing Initiatives

The TA component of PDSSP will assist in the rationalization of staff at DGs level and support their capacity building in planning, M&E, PPP and managing minimum service delivery package.

The ASPs, developed under the PDSSP guidelines, require the DGs and the TMAs to indicate attractive incentive plans to attract qualified individuals for management positions, and to retain skilled and trained employees. Comprehensive M&E frameworks as well as by-laws to implement this framework have already been prepared by the DHMTs.

In order to improve the quality of human resources, the Health Department along with the PDSSP has evolved a market-driven incentive package for MOs and WMOs. On the other hand, the HSRP has prepared software for creating a Human Resource Management Information System (HMIS) with the active assistance of PESRP. In addition, it will develop new job descriptions for paramedics that will be communicated to the DGs for implementation. The HSRP has linked the performance based incentivized pay package for the WMOs with performance indicators prescribed for the Mother Child Health (MCH). Similarly, the CMIPHC has devised a system for performance evaluation of health service providers in the project districts on quarterly basis, where good performance is handsomely rewarded.

The Women Health Project (WHP) is involved in skills development of WMOs at teaching hospitals. It is also offering postgraduate training to WMOs, health managers and nurses. The WHP has also conducted training of various District Health Monitoring Teams (DHMTs).

The MTSP also incorporates a scheme to develop a 15-20 years perspective plan for human resource development in the health sector with

special focus on greater HRD. In addition, the MTSP has proposed a comprehensive study to rationalize the number and types of cadres in the health sector with a focus on improving vertical and horizontal mobility. The Plan also includes a study to examine the viability of creating a cadre of trained paramedics for strengthening PHC at BHU/RHC level. The MTSP also provides for a review and update of the job descriptions of health service providers in order to enhance their skills levels in the light of the Minimum Health Service Delivery Standards. It also strongly emphasizes the importance of Continued Medical Education (CME) for skills development of health providers and managers.

Proposed Interventions

The HSRF proposes the creation of an effective, computerized, Human Resource Management Wing at the provincial and district levels to manage matters related to transfers, appointments, promotions, salary and benefits, and discipline of health professionals.

The framework strongly recommends a comprehensive review and development of job descriptions, performance evaluation measures, career paths and incentivized pay packages in line with the modern management standards for all cadres and tiers in the provincial health sector.

It also proposes a complete review of the existing contract policy in order to make "hard areas" more attractive to health service providers and to ensure their long-term retention. It emphasizes the importance of appropriate sequencing of these reform initiatives in order to derive best possible outcomes.

The HSRF finds it imperative to redefine the objectives of training programs at all levels with a view to bringing the archaic training system at par with internationally recognized standards, and to move in the direction of institutionalizing a system of CME for skills development and specialized training in management.

The framework realizes the urgent need to revamp the existing medico-legal system in the Punjab. It endorses the creation of an independent, modern and dynamic Coroner's Service, adequately staffed and equipped to conduct medico-legal work in the province. This, in turn, will free up a large number of health care staff at the primary, secondary and tertiary levels.

6.6 Need for Improved Data Analysis and Research for Evidence and Outcome Based Planning - Causes

Limited availability of organized data and reliable data and evidence-based planning capacity, coupled with sheer absence of government-sponsored incentives to encourage research activities have resulted in neglect of important public health issues that have long awaited well-researched and accurately planned solutions. The existing research in the health sector, which leaves a lot to be desired in terms of methodology and quality of content, is either conducted for the large pharmaceutical companies or with a view to fulfilling the procedural formalities required, under the rules, to be completed for securing promotion/vertical mobility within the health cadres. It is evident that all such research is conducted in a tight hierarchical order with little opportunities of dissemination, thereby negating the very essence and spirit of research. Absence of research culture is manifest in the non-use of HMIS for health management and/or resource allocation decisions. There is no system in place to extract, collate and organize the wealth of data that exists in the public health system's records.

Mapping of Existing Initiatives

The PDSSP is designed to encourage research-based initiatives in the health sector. Under its tranche conditionality, the DGs & TMAs are required to develop an M&E framework to create linkages among various sub-systems, and identify operational deficiencies, besides advising on collection, reporting and use of gender-disaggregated data for performance-based monitoring and planning. The PDSSP also contains provisions for developing Mini MICS. The

research data so collected will be used for benchmarking and evidence-based planning. It also plans to develop Mini MICS/second MICS.

The HSRP has completed the software for HMIS with the help of PERSP. The CMIPHC is also engaged in preparing a databank of health indicators that will prove invaluable for monitoring, evaluation and planning purposes. The Health department's MTSP provides for a review and redesigning of the HMIS to ensure availability of up-to-date information in a user-friendly format for informed decision making and to support operational research. The Health Department has also posted the District Monitoring Officers (DMOs) to collect data about the needs of the health system and to report on the performance of reform initiatives.

Proposed Interventions

The HSRF places a lot of emphasis on the need to encourage and promote a quality research culture in the health sector. It envisages creation of an endowment for research whereby the research agenda is determined by the government and research is grants based competitive system open both to the public and private sectors. Such an arrangement can possibly be housed in the Punjab Health Foundation (PHF). It will be responsible for creating an environment conducive to quality research on critical public health issues. The framework also requires the PHF to develop strategies and mechanisms for extensive dissemination of research findings. It suggests that the PHF publishes best research in its journals to encourage quality research.

The HSRF also strongly supports upgrading of the existing HMIS in order to bring at par with the widely acclaimed Education Management Information System (EMIS). It also recommends a complete institutionalization of the existing MICS to facilitate better budgeting and planning.

The framework also suggests adoption of measures for non-intrusive regulation of the private sector research (particularly, in the major

pharmaceutical companies) with a view to creating linkages with research interests of the state programs.

6.7 Lack of emphasis on Community Participation and Public-Private Partnership - Causes

Lack of health education, limited public awareness, social exclusion and absence of environment conducive to public-private partnership (PPP) has led to a situation where community participation and ownership, and public-private collaboration are almost non-existent at all levels of provincial health sector.

Mapping of Existing Initiatives

Recognizing the overwhelming importance of private sector's collaboration in the delivery of public health services, the PDSSP has prepared comprehensive guidelines, in the form of a White Paper, to encourage and facilitate PPP at the district level. According to a Memorandum of Understanding (MOU), the Provincial Government is committed to notify operational guidelines for facilitating PPP initiatives. Under the conditional grant mechanism of the PDSSP, the DGs are required to allocate at least 10% of their share of conditional grants for promoting PPP initiatives. The PDSSP also envisages co-opting regional umbrella NGOs to enhance community participation in health service delivery.

The HSRP is already planning activities to promote health education and creating health awareness campaigns. Similarly, the CMIPHC-established Support Groups are overseeing and facilitating the functioning of the BHUs in the project districts.

The Women Health Project (WHP) is working on imparting gender-sensitive health education to female population. The government has approved free of cost distribution of safe delivery kits to the target beneficiaries.

The Health Department's MTSP supports development of sectoral policy for promoting PPP in the health sector. Alternate systems of health care in the private sector, such as 'Tibb' and Homeopathy have long been serving a sizable section of population. The MTSP is expected to prepare a plan for regulation, accreditation, and standardization.

Proposed Interventions

The HSRF recognizes the importance of community participation as essential to promoting quality health care on sustainable basis. It, therefore, proposes strengthening of productive community involvement in health (CIH).

While strongly supporting the involvement of non-state actors in health sector delivery, the framework encourages social mobilization to set up health users committees and village committees in select pilot districts. It suggests that these committees may be adequately empowered to monitor service delivery, and eventually manage health care services. Such committees can liaise between the community, village health workers and BHUs in preventive, curative, nutrition, and health awareness programs. The HSRF further proposes the creation of elaborate linkages between community organizations and such social sector interventions as the District Monitoring Office (DMO). Such thoughtful arrangements can bring the accountability of health services within the purview of end-users, besides ensuring greater community participation in health care planning.

The framework believes that corrective actions are needed to reform the private health sector. As a first step, people ought to be made aware of their rights and responsibilities in the private health system. The government should endeavor to mainstream private health sector facilities by encouraging them to conform to clearly defined service delivery standards. Furthermore, the private sector PHC facilities can be encouraged to support public sector programs and interventions. The private sector can also be engaged in the management services of public sector hospitals and other health institutions through contracting-in and contracting-out arrangements. The HSRF identifies

the Rahim Yar Khan and NCHD model in Gujrat as experiments in public-private partnership that can be evaluated for replication elsewhere in the Punjab.

The HSRF contends that governments can co-opt the private sector in the modernization and management of projects, while remaining responsible for preserving public interest and ensuring optimum level of service delivery standards. Public-Private Partnerships facilitate governments to modernize services and provide value for taxpayers by enhancing efficiency in service delivery. The framework, therefore, proposes that the Punjab Health Foundation, after restructuring, may also be mandated, among other things, with facilitating public-private partnership as a PPP clearing house.

6.8 Reform of Health Foundation - Causes

The Punjab Health Foundation (PHF) has been providing useful service in helping doctors set up clinics. However it suffers from an outdated mandate and an obsolete structure. Government's interest in its operations has been marginal of late. As a result, the PHF has been reduced to the status of a mere lending agency of the provincial government, responsible for offering loans to the doctors, who wish to establish private health care facilities.

Mapping of Existing Initiatives

The Health Department with the assistance of the Punjab Resource Management Program (PRMP) is presently conducting a technical study of the PHF in order to redefine its role and introduce structural changes, which will facilitate the achievement of its reoriented organizational goals and development objectives.

Proposed Interventions

The Health Sector Reforms Framework recommends complete overhaul of the PHF. This involves radical restructuring and reorientation in order to prepare the Foundation to effectively face the challenges of growing PPP trend and to achieve high standards of modern research. The framework envisages the PHF to act as a clearing-house for public-private partnerships, besides

housing an Endowment Fund for supporting research on important public health issues. In addition, the PHF may conduct innovative pilot projects, such as the Health Vouchers Scheme; test new institutional models, and produce impact-outcome studies.

The framework expects the reinvented PHF to design innovative projects for strengthening the health sector. These include PPP involving public health institutions and private centres of excellence; soft loans mechanism binding doctors receiving PHF loans to provide PHC services in under-served rural areas according to the government guidelines; and incentives for doctors in the private sector to initiate home visits in low-service urban and rural areas.

6.9 Autonomy for Hospitals – Causes

Although the initiative of granting autonomy to tertiary hospitals and health institutions is a step in the right direction, this measure, however, cannot by itself lead to systemic improvements. Today, autonomous health institutions face 'Elite capture', and suffer from lack of capacity building of systems development, because of which these entities have not been able to show any visible gains to the public health sector.

Mapping of Existing Initiatives

The Health Department's MTSP requires a comprehensive evaluation of the issue of autonomous health institutions, and subsequent recommendations for improvement. It also provides for developing an action plan to strengthen the autonomous status of tertiary health care institutions, enabling them to offer better pro-poor health services.

Proposed Interventions

The HSRF identifies an urgent need for creation of a specialized wing in the Health Department to address the issues concerning autonomous hospitals. At present, no such centralized/specialized unit exists in the parent department. While it advocates greater autonomy to these institutions, the framework stresses that it has to be linked with external monitoring of outcomes through third party evaluations and annual performance surveys. The

Health Department with the assistance of the PDSSP can develop such external M&E framework.

Autonomous health institutions suffer from lack of systems development capacity. Health Department may engage outside expertise, such as consultants, and partnerships with advanced health institutions in the private sector like the Agha Khan University Hospital, to help these autonomous institutions build their capacity in developing quality patient management, inventory control, management information, and equipment management systems.

In compliance of the overarching objectives of the PFIS, the Health Department needs to proactively protect the interests of the poor. It may, therefore, develop well-defined protocols for social protection of the poor beneficiaries in these autonomous institutions. The PDSSP may, therefore, be called upon to fund a comprehensive technical study, under its TA component, to develop models for incentive-based, institutionalized, and regulated private practice on the premises of these intuitions.

6.10 Comprehensive review of Medical Colleges Education System - Causes

The medical education system in the province suffers from academic and professional stagnation because of outdated curriculum, skewed focus towards curative rather than preventive medical education, low priority to research, and absolute absence of academic quality standards. Mushrooming of unregulated private medical colleges, non-existing CME, and limited professional training opportunities have only served to further aggravate the quality of medical education.

Mapping of Existing Initiatives

The University of Health Sciences is endeavoring to enhance the standards of medical education, promote research culture, and enhance the number of PhDs/Post-Graduates in health sciences. However, substantial

improvements would not be possible without involving the Pakistan Medical and Dental Council (PMDC) in revision and updating of the curriculum. The Health Department has also granted autonomous character to various medical education institutions in order to enable them to swiftly adopt modern academic and professional practices. However, this initiative also suffers from "elite capture", and has not been able to generate the desired objectives due to lack of management capacity.

Proposed Interventions

The Health Sector Reform Framework has recommended that the Punjab Government engage the PMDC to review the existing medical curriculum in order to make it community health intensive. Such a change, coupled with modernization of the medical curriculum will tremendously facilitate the achievement of pro-poor, MDGs-based preventive health targets. The HSRF also supports creation of partnerships and linkages with domestic and international centres of medical excellence.

It is also proposed that the Health Department, with the assistance of the PDSSP, develop an action plan for phased attachment of select DHQ and THQ Hospitals as well as PHC units with teaching hospitals in order to open avenues for house-job training of fresh medical graduates at primary and secondary health care levels. Such an innovative measure will help train the medical graduates in community medicine, besides addressing the health professionals' shortage at the grassroots.

The framework strongly supports complete revamping of the curricula and academic programs at the Institute of Public Health and the Post-Graduate College of Nursing to make them community medicine-oriented. It also suggests immediate development of a regulatory framework, including clearly defined medical education standards, for growing number of medical colleges in the private sector.

6.11 Need to focus on Health Education – School Health Program and Issues of Geriatrics - Causes

Low literacy rate among rural and semi-urban populations (particularly among women), coupled with almost non-existent health education initiatives have contributed to the poor health status in the Punjab. High infant mortality rates, lack of childhood immunization and rampant malnutrition are manifestations of these issues. There is hardly any awareness about the seniors' rights or their needs either in the public or the government. As a result, the seniors are faced with challenges in terms of quality of life and old age-related health issues.

Mapping of Existing Initiatives

Health education, revival of School Health Programs, and designing of Child Nutrition Program are prominently included in the PDSSP's mandate. These initiatives will help identify common diseases and impairment among children. Various vertical preventive interventions, such as the Expanded Program of Immunization (EPI), and National Program for Primary Health Care & Family Planning and Nutrition, have also been introduced to support the health education measures. The PDSSP will utilize its TA component to launch a community based behaviour change campaign. Its Sectoral Guidelines for health and education also focus on creating strong linkages with other social sectors as regards this issue.

Under the CMIPHC, Medical Officers at the BHU level attend Community Health Sessions at local schools to create health awareness among students. Similarly, the HSRP requires these MOs to participate in interactive sessions with the local communities to raise awareness about public health issues. The Women Health Project is focusing its resources on imparting health education and creating health awareness among female rural population.

Proposed Interventions

The HSRF strongly supports the revival of School Health Programs and creation of Child Nutrition Program, through PPP or based on NCHD model, to

create public health awareness among school going children. Such program can initially focus on screening children for eyesight, speech and hearing impairments as well as dental hygiene, and their scope can be expanded later on. These programs should also focus on educating the target groups about preventable diseases, need for sanitation and hygiene, and importance of nutrition particularly in the early childhood years. The framework suggests recruitment of a new PHC-level cadre of public health professionals, comprising nurses, paramedics, and health technicians, along the lines of the LSMF cadre of the past, to create awareness about public health issues at the rural level.

The framework calls upon the government to carry out a comprehensive needs assessment of senior citizens in order to develop a Senior Citizens' Package, including a Geriatric Health Program. Such a program will create awareness regarding senior citizens' needs, besides creating geriatric health care units at district and tertiary health care outlets.

6.12 Little understanding or emphasis on Cross-Sectoral Linkages - Causes

Limited inter-sectoral coordination has resulted in wastage and ineffective use of resources. Recognizing potential linkages of safe and clean water supply and sanitation with health can remarkably improve public health at a much lesser cost. However, such understanding of cross-sectoral linkages is absent in the provincial government, in general, and at the District Governments level, in specific. The consequent disconnect between various sub-sectors often results in policy failures or skewed of public policies.

Mapping of Existing Initiatives

PDSSP includes developing better understanding of cross-sectoral linkages between different social sectors. The PDSSP has developed sectoral guidelines for health with a view to creating strong linkages with education, water supply & sanitation, poverty elimination, and gender development. Similar initiatives are underway in the CMIPHC where District Welfare Departments are being asked to ensure benefits of cross-sectoral linkages.

Proposed Interventions

The HSRF proposes that identification of cross-sectoral linkages may be made an integral component of capacity building measures being considered at the PDSSP for health managers and planners. It also suggests that the role of the District Monitoring Office may be expanded in order to act as a hub for cross-sectoral coordination. The PDSSP may look into the possibility of creating awareness at the PHC/community level regarding the immense importance of inter-sectoral linkages. Lastly, the PDSSP may employ its conditional grant mechanism to compel District Governments to clearly workout cross-sectoral linkages in order to ensure more holistic development planning and avoid wastage of limited resources.

6.13 Complete lack of Regulation of Private Practice - Causes

Non-regulated private practice of government doctors and other functionaries is ascribed as one of the main reasons behind non-functioning of the public health system. The private health sector is generally devoid of a "diagnosis culture". Excessive prescription of prohibitively expensive medicines is common. There is a proliferation of quackery in the private health sector, which also supports such nefarious activities as the sale of fake and spurious drugs. The situation warrants adoption of immediate regulatory measures for private health sector.

Mapping of Existing Initiatives

The District Governments' Annual Sectoral Plans (ASPs), required under the PDSSP's conditional grant mechanism, now include concrete analysis and well-considered action plan to root out quackery. The Punjab Health Department's MTSP contains provisions for enacting a legal framework to regulate private health sector activities, and development of legal mechanisms to eradicate quackery and check sale of spurious medicines.

Proposed Interventions

In the Punjab, the private health sector offers 70% of the total health care services, and that too, in the absence of a proper regulatory framework. The Poverty Focused Investment Strategy (PFIS) highlights the need for regulation of the private health sector to protect the poor against rising costs of medical treatment and to discourage quackery and manufacturing and sale of spurious drugs.

As a first step, it recommends that people should be made aware of their rights and duties in the private health system. In accordance with the guidelines contained in PFIS, the HSRF provides options to regulate private practice through a code of conduct without creating harassment. It calls for development of a regulatory model that is non-intrusive and encourages self-regulation.

In order to encourage the doctors employed in the public sector to abstain from private practice, the HSRF recommends two possible courses of action. Firstly, it suggests a review of the existing Non-Practice Allowance (NPA) in order to enhance it to a level where private practice becomes unattractive for government doctors. The alternate course involves institution-based private practice.

The framework recommends an in-depth study to examine the viability of registration of doctors with the provincial government for private practice licensing. Such an arrangement will not only help control quackery; it will also help the government link its private practice licensing system with candidates' continued medical education (CME), and compliance of diagnosis and record-keeping standards, which will be subject to regular medical and prescription audits. In addition, it will provide the government with a tool to prevent over-concentration of private doctors in a particular area.

6.14 Review of Drugs Policy - Causes

The public health sector in Punjab faces critical shortage of essential drugs at all levels of health care. Lack of procurement capacity is attributed as the main cause for such shortages. The scenario, however, turns grave given the people's lack of economic capacity to afford ever-rising cost of medicines, the quality of which also leaves a lot to be desired.

Mapping of Existing Initiatives

The District Governments have been required to reassess the need for essential medicines at the PHC level. The Annual Sectoral Plans (ASPs), prepared under the PDSSP's guidelines, accord due importance to supply and procurement of essential medicines. The HSRP is committed to standardization of essential medicines provided at the PHC level. It is also planning to offer free service packages and medicines. The CMIPHC plans to develop a shorter, yet "better" list of essential drugs in the twelve target districts. It is also expected to devise a new procurement procedure, which will ensure quality with affordability. Under this initiative, specialized pharmacies will be opened with all the FMOs. The Health Department's Provincial and District Quality Control Boards (PQCB/DQCBs) are endeavoring to eliminate spurious drugs from the market and also ensure sale of quality medicines.

Proposed Interventions

The HSRF emphasizes the need for complete review of the Essential Drugs List (EDL) for PHC outlets, and recommends availability of essential drugs at all times in accordance with the minimum services delivery standards (MSDP). It calls upon the PDSSP to review and update the EDL for all health care tiers and to develop comprehensive pharmacopoeias.

The framework also proposes that the Health Department, with the help of the PDSSP, inject financial and technical resources to strengthen the scope,

mandate and role of the Provincial and District Quality Control Boards (PQCB/DQCBs). It also suggests that the Provincial Government negotiate rationalization of the EDL with the Federal Government.

In order to assure social protection to the poor, the framework vehemently endorses the creation of Pharmacy Banks where essential medicines would be available to poor beneficiaries either free of cost or at minimal prices.

6.15 Absence of Social Protection/Insurance - Causes

Absence of social safety nets has left the poor and marginalized segments of society in complete uncertainty, as they are unable to meet the costs of health care even through public sector health facilities. These health care costs generally include the corollary expenses of transportation of critically ill patients and their attendant(s), the costs of specialized medicines and services not available at PHC outlets, and other ancillary costs such as living expenses for the attendant(s) for the duration of the treatment. There is no provision of insurance of the poor against critical illness. No social protection exists for the ageing population and fixed-income groups; including the government servants, adding to their economic hardships.

Mapping Existing Initiatives

The Health department is endeavoring to engage the services of an international consultant, who will help formulate options and recommendation on this issue. In addition, the MTSP envisages introduction of alternative health delivery of health financing at the district and institutional levels.

Proposed Interventions

The HSRF recognizes the urgent need to create social safety nets for ageing population and to arrange some form of health Insurance cover for government servants. It strongly endorses the plans to provide state provision of critical disease cover or minimal health insurance for the poor and vulnerable groups. It also supports the proposal regarding an in-depth study

about the feasibility of using Zakat funds for health insurance purpose. It recommends that the government should make serious efforts to create a health insurance market for the facility of other segments of population, as well.

6.16 Improvement in Governance in Health Sector - Causes

Dichotomous relationships, which came to the fore in the wake of devolution of service delivery to the DGs while resources remained a provincial domain, inability of the system to hold health service providers accountable for their failures, lack of organized and correct data and research, skewed human resource profile, chronic staff absenteeism, critical shortage of female healthcare professionals, and locational disadvantages (like poor access, physical condition of buildings, accommodation and other services) are manifest of a 'governance deficit' in the public health sector in the Punjab.

Mapping Existing Initiatives

The PDSSP's TA resources will be used to conduct a comprehensive review and delineation of roles and responsibilities of provincial and local governments in line with PLGO. In addition, the Health Department is contemplating the creation of a Policy and Strategy Support Unit to provide support to decision makers in policy development; organize, manage, monitor and coordinate technical support in the health sector, and build local capacity for these purposes; develop a culture of participatory and information-based decision making and needs-based data collection; and, finally, to facilitate HRD to implement new initiatives.

Efforts are underway to bring the provincial health financing within the MTBF, which will go a long way in protecting allocations for pro-poor, MDGs-related interventions, besides facilitating better utilization of non-salary and development budgets.

Proposed Interventions

There is an urgent need to operationalize the Policy Planning and Strategy Cell in the Health Department to act as policy think-tank within the public health sector. Such a Cell will also monitor and measure results, ensure evidence-based planning, and spearhead the reform initiatives in the offing. It may have the assistance of outside experts from time to time. The HSRF proposes that the security of tenure needs to be linked with realistic and measurable performance indicators under a contractual employment mechanism. It endorses early adoption of performance budgeting, comprehensive framework for performance appraisals of employees, departmental units and field offices, and results-based accountability for all. The framework also calls for strengthening and empowering the district health offices to discipline and hold health professionals accountable in accordance with Minimum Service Delivery Standards. Finally, it stresses the need for integration of service delivery with increased diversity of providers to ensure transparency and competition.

7. CONCLUSION

The Health Sector Reform Agenda of the Punjab Government is, undoubtedly, holistic and ambitious, yet with the support of the present political leadership and the guidance of its domestic and international partners, it is hoped that in the months and years ahead, Punjab will witness phenomenal improvements in the coverage of health service delivery, which will not be equitable and pro-poor, but would also meet the most stringent measures of quality, and comprehensiveness. Characterized by public-private partnerships, redesigned and reoriented public sector agencies, innovative financial arrangements, market-driven employment mechanisms, and institutionalized monitoring, evaluation and accountability frameworks, the reformed public health system will set the tone and direction for realizing the overarching objective of a prosperous, and poverty free Punjab.

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Annexures

ANNEX 1 - PDSSP Policy Paper
ANNEX 2 – Presentation on Issues and Reform Options
ANNEX 3 - Mappiing of Health Sector Reforms
ANNEX 4 - Presentation by PRMP

Annexure 1

Development Policy Letter
(From Chairman, Planning Board, Punjab to the Secretary Economic Affairs Division)

Asian Development Bank:
Loan for Devolved Social Services Program, Government of the Punjab

The Government of Pakistan has been pursuing reforms agenda over the last 4 years and putting the economy on a stronger and more stable footing. With the rescheduling of external debt and a more proactive debt management strategy in place, record levels of exports, lowering of interest rates, a buoyant stock market and a continued policy of privatization, the GDP growth has shown a persistent upward trend, estimated at about 6.4% in FY2004, and projected to rise at 6.6% during FY2005. The experience in the past shows that the benefits of economic growth do not reach the poor unless targeted interventions specially relating to delivery of essential social services are not implemented.

At the core of the governance reform agenda is the devolution program, which has created a new structure and opportunities to increase local ownership, participation, responsiveness to local needs, and accountability to the public. These reforms are expected to enhance the efficiency, equity, effectiveness and sustainability of social services delivery.

The Government of Pakistan has also prepared a Poverty Reduction Strategy Paper (PRSP) with the Province of Punjab having developed a similar province level PRSP, which sets out a comprehensive policy reform agenda to break the vicious cycle of poverty. Prepared after extensive consultations with all stakeholders, the PRSP revolves around four basic strategies: (i) achieving high and broad-based economic growth, (ii) improving governance and consolidating devolution, (iii) developing human capital and efficient delivery of social services, and (iv) reducing inequalities and bringing the poor, vulnerable and the backward regions in the mainstream of development.

The Government of Punjab is fully committed to the reforms program initiated by the Federal government. The broad based governance and devolution support programs of the Government of the Punjab include the Punjab Resource Management Program (PRMP), Punjab-Poverty Reduction Strategy, Devolution Support Program (DSP) and Punjab Education Sector Reforms Program (PESRP). These programs aim at better management of finances in the province and strengthening of institutional and systems capacity for improved services delivery. As delivery of social services is the basic function of the Local Government institutions, these programs will ultimately improve delivery of social services in the province.

The social development indicators of the Punjab province are reflection of overall situation of the country. These indicators have lagged behind neighboring and many other low-income countries in terms of health, fertility and social sector outcomes. Child mortality is very high — nearly 11% of the children do not sec their fifth birthday because of limited access to adequate childhood healthcare services. Women face burden of childbearing in addition to gender discrimination. Every year, about 200,000 women suffer complications of pregnancy, only about 15% are able to reach a hospital, and nearly 10,000 die because of lack of access to obstetric emergency care. Although the mean age at marriage (22.5 years) and contraceptive prevalence rate (30%) have increased overtime, the average household size is still 6.54 persons. While literacy rates in Punjab have shown gradual increase over the years, enrollments in primary and middle education have generally declined or at best stagnated from 1996 to 2001.The

The poor social indicators in Punjab are due to a variety of reasons. The most important challenges in the past constraining the quality of, and access to social services have been the result of frequent recruitment bans, insufficient funding, lack of allocative efficiency, poor utilization and sometimes misuse of allocated funds, delayed release of funds for operations and maintenance, high turnover of personnel in leadership positions, poor governance practices and limited stakeholders involvement in the design and management of service delivery, and weak public accountability at all levels.

Realizing the need for human capital development to accelerate economic growth and reduce poverty, the Government of Punjab in the recent years has been giving high priority to improving the quality of and access to social services. To meet the challenge, it has realigned expenditures both at the provincial and the district levels in favour of social services, particularly for education, health, and water and sanitation sectors. The authority to manage general health and education services has been devolved to District Governments, while water and sanitation to the Tehsil Municipal Administration (TMAs). The local governments' institutional system though nascent has shown some improvements in the last three years in terms of better staff attendance, improved availability of supplies and drugs, and considerable expansion of municipal services. Although local governments provide great opportunities in the coming years for improving governance and effectiveness of public services, the system needs continued support to achieve the stated objectives.

The social sector priorities set by the Government of Punjab are an integral part of its poverty alleviation strategy reflected in the Poverty Reduction Strategy Paper, and the overall reforms agenda of PRMP and DSP. The Poverty Reduction Strategy aims to achieve progress on the targets set under the Millennium Development Goals (MDGs) and to improve the social indicators through governance reforms, qualitative and quantitative improvements in delivery of social sector services, improved fiscal and financial management, and promotion of private sector development including fostering community involvement in the delivery of social services.

The Government of Punjab has already initiated Education Sector Reform Program since the beginning of 2004. It has targeted at increasing enrollment rates especially for girls and improving the quality of education. The main reforms include: (i) public finance reforms to increase the level and share of education expenditures and reduce uncertainty in resource allocation; (ii) devolution and public sector reforms comprising support for devolution and strengthening governance and fiduciary environments; and (iii) education sector reforms comprising strengthening teachers management, revitalization of school councils, strengthening monitoring and evaluation, improving education quality and access, and strengthening public-private partnerships. Education has been made free up to grade 10 including free text-books up to class VIII and stipends for girls in grade VII - VIII. Furthermore, accountability mechanisms have been strengthened by the introduction of facility-based recruitment of teachers. As a result of these interventions, there have been improvements in retention and enrolment rates. The Government of the Punjab is in the process of extending monitoring capacity developed under PESRP to other sub-sectors of the social sector.

The Government of Punjab is currently assessing the quality and utility of health infrastructure through a mapping exercise. The health sector budgets have been substantially increased in last three years raising allocations from Rs9.796 billion in FY 2002 to Rs 17.805 in FY2004. The district governments have been allocated about 40% of the provincial health budget to finance salary and operation and maintenance (O&M) expenditures of health facilities ranging from basic health units to district hospitals. However, health sector still remains under-funded and understaffed for providing essential package of health services. These are the major factors constraining delivery of basic health services.

The Government of Punjab under P-PRSP, 2003 envisages implementing a policy framework in line with National Health Policy 2001 and National Population Policy 2002. The P-PRSP pledges to achieve targets

set under MDGs to reduce infant and child mortalities, improve immunization of children, increase proportion of births attended by health professionals, improve contraceptive prevalence rate and reduce total fertility. The P-PRSP, 2003 has highlighted the following strategies for accelerating health status: (i) strengthening PI-IC services with a focus on the population residing in rural areas and slums, the women, and the poorer segments of society; (ii) provision of adequate referral backup services including emergency care; (iii) training and retaining of medical staff to improve quality of services; (iv) addressing gender imbalance, both in provision and delivery of services; (v) encouraging public-private partnerships; and (vi) granting administrative autonomy to the hospitals.

The major source of drinking water in Punjab is groundwater. However, in 26 districts, there are significant pockets of water scarcity or brackish sub-soil water where about l0,000 villages are located. About 94 % households have water source inside the house. The remaining 6% households use unsafe water from shallow wells, rivers or canals that are often located at a considerable distance, with the burden of fetching water largely falling on women. Treatment of public water supplies is undertaken only at few places and even that is on a limited scale. The infrastructure for water supply and sanitation (WSS) was developed in the past without analyzing the feasibility of operation and maintenance costs. As a result several hundred poorly designed rural water supply schemes have been abandoned. Access to sanitation facilities is extremely limited with only 32% of the rural population having household latrine facility. The Government of Punjab expects Public Health Engineering Department (PEIED) to support quality assurance and capacity building, with a focus on improving sanitation and gradually devolving authority for technical sanctions to TMAs.

Following devolution, PHED has been merged with the Local Government and Rural Development Department and continues to carry out; the major development schemes. TMAs have been made responsible for the provision of municipal services including water and sanitation, but they lack capacity in participatory planning and implementation and in managing these services adequately through community infrastructure. However, the Government of Punjab has substantially increased expenditures on WSS schemes, growing from Rs 601 million in FY2002 to Rs 5,536 million in FY2004.

The Government of Punjab is committed to improve the efficiency of public schools by strengthening school councils. Under the ESRP, Government of Punjab is piloting support to school councils. More models of school councils have to be explored to recognize the differences across districts. The Punjab Devolved Social Services Program (DSSP) will pilot other forms of school councils to increase enrollment particularly of girls, to improve quality by providing more resources and support to schools as well as by improving attendance of students and teachers. As part of Government of Punjab's commitment to provide equal opportunities to all children to attend schools, DSSP will explore different options to support special education to enroll children with special needs.

The Government of Punjab is committed to its poverty reduction and governance reforms program. There is strong political commitment to address challenges faced by the social sectors by pursuing a policy agenda that could lead to tangible improvements in the quality, efficiency, access and effectiveness of the social sector services, especially for the poor and vulnerable populations. The DSSP has been developed with support from ADB, after extensive dialogue with and incorporating the views of the local governments, NGOs, service providers and beneficiaries. The design of DSSP is based on essential policy reforms, which will create an enabling environment for the local governments to finance the identified institutional, social, planning, managerial, financial and capacity needs of social sector services that are not financed from other sources.

The DSSP will provide flexible support to the district governments, TMAs and NGOs/CBO based on perceived local needs and priorities. Only a "short negative list" will restrict the utilization of funds by specifying activities on which the funds made available to the local governments would

not be spent, combined with a broad positive list would allow sectoral in the investments in the priority areas in line with policies and strategies to achieve MDGs. This approach is expected to incentivize the districts and participating TMAs to prioritize and implement their programs to meet the MDGs. In this process, it is anticipated that the much needed capacity at the provincial and local government level would improve to strengthen devolved social services in line with the PLGO.

The reforms proposed under the DSSP form an integral part of the wide-ranging economic and social sector reforms launched by the Government of Punjab with the support of multilateral and bilateral donors, such as the World Bank through the Punjab Education Sector Reform program; the Asian Development Bank (ADB) through the DSP that strengthens capacity of local governments; the ADB with the PRMP to operationalize provincial goals and priorities of PRSP with focus on social sectors; the ADB with the Access to Justice Program to bring about judicial reforms; the four ADB projects in health and water and sanitation sectors for improving reproductive health and municipal services respectively; and other UN assisted projects in the social sectors.

The local governments will enter in terms of partnership (TOP) with the Government of Punjab to deliver basic package of essential services within each social sector using funds from all sources. The TOP will indicate eligibility criteria for funding the districts and define broadly the scope of areas to be supported. The funds will be channeled through Account IV under PFC, based on a transparent and predictable formula through a conditional grants system.

The Government of Punjab will develop a five-year strategic plan for improvement of delivery of social services in the province. The district governments will develop three year rolling plans based on the policy guidance available through provincial five-year strategic plan. The District governments will be able to access funding for the social sectors on the basis of rolling plans identifying the overall strategy of the district government for the sector. A baseline for all key outcomes, performance indicators and expenditure benchmarks will be established that would facilitate the monitoring of reform interventions.

The Government of Punjab with the involvement of the district governments will decide mode of recruitment for each category of staff for the social sector departments. In order to enhance accountability and address governance issues, a transparent recruitment process will be developed and implemented for all recruitments in the districts and the province. The proposed mechanism may involve third party for either carrying out recruitment process or monitoring this process. However, adequate weightage will be given to local and female candidates.

There are major programmatic and financing gaps in the public health sector. The focus of DSSP will be to: improve reproductive health services through trained midwives; transforming the current service package into essential pro-poor package of services; improving staff mix and skill mix backed by skill development; expanding public private partnerships; and improving internal and external monitoring systems. The rural health centers (RHCs) and tehsil hospital would provide 24-hour emergency services at least for women and children to improve survival rate of children and pregnant women. To ensure high quality and reliable services, all essential vacant positions will be filled besides trying facility specific contractual appointment of the health staff, with incentives built-in for remote areas. In remote areas, innovative models like contracting out of primary health care services to reputed NGOs will also be expanded.

To ensure participation of the local communities in running the health facilities, health committees at district and tehsil hospitals will be established, and given the authority to generate additional resources and use for improving the quality of health services. The proposed committees will provide safety net for protection of poor in a way that services are not refused to any one just for financial reasons. These improvements will be backed by consolidation and up-gradation of existing health infrastructure.

The Government of Punjab has identified WSS as a major means of improving preventive health services. The priority future interventions under DSSP, besides expansion of water and sanitation coverage in program TMAs that do not receive support from any other projects or programs, include preparation of sector strategic plan, development of integrated master plan and prioritized annual plan for each TMA. The community motivation will be an integral part of the program to organize NGOs, CCBs, CBOs and water user committees to guide sustainability of future investments. The TMA will be encouraged and supported to develop special promotional campaigns for rapidly increasing availability of minimum basic sanitation facilities in the rural areas. The capacity of the TMAs will be developed for monitoring the quality of drinking water.

To enhance the effectiveness of the proposed DSSP interventions, a set of policy guidelines, an institutional framework and terms of engagement clearly delineating the roles and responsibilities of different collaborating agencies will be developed and rigorously implemented. These operating procedures, coupled with support to local governments to rationalize services, would produce the kind of fiscal and planning discipline that is needed to improve the performance and efficiency of the social sectors.

The Government of Punjab also recognizes the need to improve the capability of local governments, as they are increasingly assuming greater responsibilities, through a combination of specific and overarching capacity building efforts, to develop and implement sector specific plans, and to ensure service and technical standards through community participation and innovative alternatives. For the first 30 months of the DSSP, the local governments will be assisted in the preparation of these plans, with varying degree of support, through the office of the Program Support Unit and Local Support Groups.

A Program Support Unit, managed by highly skilled and dedicated staff from three line departments, attached to the Department of Health, will be established as the secretariat of the Planning and Development Department. The office of each District Coordination Officer will be strengthened by providing a number of resource persons to provide technical assistance to the district governments in managing the policy reforms and implementation of program innovations under a flexible arrangement. A high-powered Steering Committee chaired by the Chairman, Planning Board, with representation of all the concerned departments, will oversee the overall program execution. In order to ensure coordination with DSP and PRMP, the respective program directors will be represented on the steering committee. In addition to this, the Planning and Development Department will share the reviews of other relevant programs and projects with the steering committee to provide regular feedback to DSSP implementation.

The Government of Punjab is confident of the sustainability of the DSSP reforms because: (i) policies of similar nature are pursued at the federal level; (ii) the fiscal situation will improve substantially and there will be adequate fiscal space for continuing program interventions in the future from the savings on debt servicing arising from improved debt management and accelerated repayments of debt under the PESRP, PRMP and DSSP; and (c) that the counterpart funds generated from ADF portion of the loan for the proposed social sector interventions will be channeled through the district Account number IV.

You will agree that these initiatives require substantial financial and technical support backed by political commitment, which already exists at all levels of government. We are confident that the DSSP will make a substantial contribution to the achievement of this objective and with the support of the Asian Development Bank and Department for International Development (DFID), U.K. Government of Punjab will be able to provide better quality of social services to its citizens, especially the poor and vulnerable population groups.

Annexure 2

Health Sector Reforms Issues and Reform Options

Planning and Development Department, Punjab

1. Capacity for Capacity-Building

- Issue: Need for a Planning and Thinking Cell for Health Sector
  - HSRP- missing facilities
  - DSSP- TAs
- Objectives:
  - Measure and track results
  - Conduct holistic evidence-based planning
  - Encourage innovations and pilot test
  - Suggest systemic reforms and micro improvements

2. Primary Health Care – BHUs/RHCs

- **Issue: Low Utilization**
  - **Evidence: very low bed occupancy rates – 19% for RHC, 35% for THQ, 34% for DHQ) vs 80% generally considered necessary for efficiency**
  - **Doctors: 9-16 outpatients/day (30-40 OECD)**
  - **BHUs: 22 patients/day**
- **Causes:**
  - **Locational disadvantages**
    - **Not suitably sited**
    - **Infrastructure rehabilitation**
  - **Staff absenteeism**
    - **Low incentives (salaries, residences, transport)**
    - **Weak internal management, M&E**
    - **Little external check (community inv. – VHC)**
  - **Shortage of drugs etc.**

Primary Health Care – BHUs/RHCs

- **Issue: Low Quality**
- **Causes:**
  - **Staff absenteeism**
  - **Part time service**
  - **Poorly trained staff**
    - **Weak pre-service training**
    - **Little in-service training/refresher courses**
  - **No SOPs**
  - **Low non-salary component**

Primary Health Care

- **Issue: Limited planning and ownership**
- **Causes:**
  - **Uniform and standard approach**
    - **No nuanced planning based on segregated data**
  - **Project approach**
  - **Federally driven vertical programs with narrow provincial and district role**
  - **No targeting**

MDGs and Pro-Poor Interventions

- **Issues:**
  - Urban, elite bias (tertiary care bias)
  - Poor targeting of MDG indicators - Diverging trend in some indicators (CMR- 112 to 75; TB incidence – 181/100,000^{+})
  - Diffused control in Preventive Health - Who is responsible?
- **Options**:
  - Protecting pro-poor budget/PHC
  - Separate budgets?
  - Package of minimum services with minimum standards guaranteed by the public sector

Primary Health Care

- **Strong referral links between PHC and SHC institutes**
  - **Enrolment process at PHC**
  - **Guidance / Health education**
  - **Provision of transport**
- **Multipurpose and more skilled VHWs**

Rahim Yar Khan Model

- **Contributory factors to success:**
  - Effective Management (capable, incentivized managers)
  - Rationalized Clustering
  - Autonomy and Accountability
    - Flexibility
    - Hiring and firing powers
    - Performance measurement
  - Third Party Validation
- **Options for Expansion:**
  - Participation: community oversight by activating and capacity-building of Health Committees
  - Spatial: districts with low indicators; strong NGO presence or history of community involvement; strong commitment by district government
  - Program: inclusion of higher tiers
  - Linkages: education interventions, health education

3. Lack of Health Professionals - Nurses

- **Issues**:
  - Pro-doctor bias?
  - Low no. of nurses (6,136, doctor-nurse ratio of 1:2, 19% with LGs)
  - Low motivation (social esteem, career paths)
  - Poor training
- **Options**:
  - Incentives: hiring in higher scale, career paths, BCC
  - Higher paid facility specific contractual appointments
  - Improved training (AKUH), refresher courses
  - Capacity building of training institutes

3. Lack of Health Professionals - Paramedics

- Issues:
  - Lack of sufficient number of health technicians, paramedics skilled in preventive, public health issues
  - Low emphasis on training of Medical Assistants, MTs/HTs
- Possible Options:
  - New cadre of public health professionals with option/incentive of up-gradation
  - Retraining/CB of existing cadres
    - Better incentives (pay, differential salaries in hard areas, career paths)
    - CB of training institutes (Outsourcing?)

4. Planning, Costing and Budgeting

- **Issues**:
  - Limited and separate planning
  - ‘One size fits all’ approach
  - No results culture!
- **Options**:
  - Strong provincial planning (interventions) and monitoring of outcomes (coverage, gaps)
  - District planning focused on district specific health needs
    - Wide disparity in Immunization Measles Coverage from 19.2% (Rajanpur) to 90.2% (Jhelum) – EPI Survey 2002
    - Outcome-linked program mapping with identification of gaps and focused strategies
      - IMR: 40% due to ARI & diarrhea (immunization, malnutrition etc) and 50% due to neo-natal deaths (neo-natal tetanus, SBA)
      - MMR: SBAs, Training of TBAs, Incentivize delivery in institutes etc)
  - Restructuring and capacity-building of district EDO(H) office (strengthening planning function)

Planning Specimen - Strategic Plan for Mpumalanga Provincial Health Department

- Medium Term Strategic Plan (MTEF) for province and districts
- Contents:
  - Sector Analysis based on burden of disease and expenditure review and audit (province + district)
  - Trends in expenditure and planned budgets
  - For each program and sub-program:
    - Situation Analysis
    - Policies and Priorities
    - Key constraints, objectives and performance indicators
    - Financial outlays

4. Planning, Costing and Budgeting

- Issues:
  - Low non-salary share
  - Clarity of rules, regulations
  - Low utilization of budget
  - Low priority to health sector in many districts (concern?)
    - Conditional grants, ToPs

5. Human Resource Management

- **Issues:**
  - **Improper staff and skill mix**
    - **Overstaffing in urban areas**
    - **Improper skill mix (41% in BS 1-4)**
  - **Career paths with growth prospects**
  - **Little retraining**
  - **Low incentives to perform**
  - **Little management capacity, especially at district levels**
- **Possible Focus Areas:**
  - **Performance based incentives**
    - **Individual level**
    - **Organizational level**
  - **Facility-specific and contractual but differential pay packages for hard, inaccessible areas**
  - **Courses/ specialization in health management**
  - **Staff rationalization with well defined job descriptions**

6. Data Analysis and Research

- Issues:
  - Little reliable, comprehensive data
  - Low evidence-based planning
- Opportunity:
  - Reliable, segregated, comprehensive data on health indicators (intermediate, outcome) now available
  - Low capacity to utilize this data in planning
- Updation of HMIS on the pattern of EMIS, to be monitored by DMOs

6. Data Analysis and Research

- **Issue**: negligible research
  - Neglect of high-priority public health issues
  - Dominated by pharma companies
  - Hierarchical model of research
  - Little dissemination of research
- **Options**:
  - Encouraging, incentivizing public health research at teaching, training institutions
  - Endowment Fund for Research
    - Autonomous: managed by professionals
    - Focus on public health issues and other neglected areas
    - Challenge fund
    - Strong peer review

7. Community Participation, Public-Private Partnerships and Alternate Delivery Systems

- Options for community involvement:
  - Village Health Committees
  - THQ/DHQ Boards
  - Allowing and facilitating involvement of CCBs in health care delivery
- Options for private sector involvement:
  - Contracting-in management
  - Contracting out management of some hospitals (DHQs, THQs)
  - Contracting out services
  - Capacity building of GPs
  - PPP of public and private health institutions
    - White Paper on PPPs with focus on health
  - Social marketing – e.g. Safe Kit!

7. Community Participation, Public-Private Partnerships and Alternate Delivery Systems

- **Other possible interventions:**
  - Reform of Health Foundation – pro poor focus, pilot test innovations like Health Vouchers
  - Demand side interventions
  - Encouraging trusts/charities a role in management of health institutions and on preventive side
  - Encouraging, recognizing and supporting innovations
    - Mobile BHUs

8. Autonomy for Hospitals

- **Issue:**
  - **No visible gain of Autonomy so far**
  - **‘Elite Capture’?**
  - **Little model building or systemic improvements**
- **Different approaches**
  - **Grant of more autonomy (financial, personnel, functional) along with external monitoring of outcomes through Performance Surveys**
  - **Contracting in management**
- **Possible Focus Areas:**
  - **Capacity building – systems development**
    - **Indoor/Outpatient Patient Management Protocols/Systems**
    - **Inventory Control Systems**
    - **Financial systems development (budgeting, revenue gen, sustainability)**
    - **Protocols for protection of poor**
  - **Quality of care assessment surveys**
  - **Generation and utilization of data on in-patient and out-patient care (MIS)**
  - **Formulation of rules, regulations**
  - **Regulated private practice?**

9. Medical Colleges

- Revision of curricula for emphasis on community health
- Adoption of some non-teaching hospitals and outlets (BHUs and RHCs) for more realistic training and for model-building
- Catering for female underemployment after graduation
  - Mandating and enforcing some service in rural areas for all graduates
  - Creating a market in higher education

10. Health Education – School Health Program

- School Health Program
  - Education on preventable diseases, hygiene, nutrition etc
  - Linkages with education interventions
- Health Education through
  - Resource centers/ Help line
  - Media
  - Community leaders

11. Cross-Sectoral Linkages

- Issue: limited inter sectoral coordination
- Potential Linkages:
  - Water supply – emphasizing and educating use of safe water
  - Sanitation – health awareness campaign to be linked to expansion of sanitation coverage
  - Slums and kachi abadis – emphasis on sanitation
  - Conditional cash transfers

12. Regulation

- Issue: regulating private sector without harassment
  - No culture of diagnosis
  - Over dosage of unnecessarily expensive medicines
  - Proliferation of quackery, fake medicines
- Options:
  - Developing a self-enforcing code of conduct with state action in extreme circumstances
  - Capacity Building of GPs (refresher courses, etc)
  - Involvement of private sector in CDC and in TB and their capacity building

13. Drugs

- **Issues:**
  - **Procurement**
  - **Affordability**
  - **Quality**

- **Options:**
  - **Negotiating with Federal govt for reduction of EDL**
  - **Pharmacy banks for poor patients**
  - **Quality Control**

14. Insurance

- **Critical illness cover for infectious diseases**
- **Insurance cover for government servants**
  - **Contributory health insurance**
  - **Creating a health insurance market to be expanded later to other segments of population**

Annexure 3

Mapping of Health Sector Reforms Agenda

# [1]	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
A **A.1**	**Primary Health Care** ***Low Utilization*** *CAUSES:* - Locational disadvantages [site suitability, infrastructure rehabilitation] **[5,7]** - Shortage of drugs etc **[4,5,6,7]** - Lack of equipment **[4,5,6,7]** - Staff absenteeism **[on next page]**	- Replicate RYM **[6]** - Development of local system of procurement **[6]** - Capacity Building of staff in standard procurement procedures **[8]** -Provide missing facilities to bring BHU / RHC up to modern design standards **[4,5]** *- Relocate/close BHU that are declared totally unserviceable*	- Under the policy matrix, the 34 DGs / 32 out of 34 Program TMAs have prepared health sector plans that include future need analysis of medicines at district level. **[Working]** *[These are not very sophisticated and need to be improved. However, these can serve as basic documents for making procurement plan for a district]*	- Under ToP signed with 34 DGs, the PG is committed to finalize guidelines for better utilization of health facilities at BHU and RHC. **[Planning]** -PG to prepare performance indicators/yardsticks for monitoring/ enhancing utilization of health facilities **[Planning]** -Improved supply of medicines and related supplies **[Planning]** -DGs to prepare inventory of all BHUs / RHCs and operationalize non-functional units. **[Planning]** -Program scope includes provision of missing facilities to improve service delivery, HRM, supply of medicines and health awareness at RCH/BHU. **[Planning]**	**-** RYK model adopted in 12 districts**. [Done]** - CMIPHC is planning to develop a shorter but a 'better' list of drugs and a new process of procurement that ensures quality with affordability. **[Planning]**	- Rehabilitation of existing infrastructure and provisions of lacking facility form part of the Medium Term Strategic Plan for Health Sector. **[Planning]** - Both Women Health Project [WHP] and Reproductive Health Project [RPHP] are also providing medicines in their areas of activities. **[Working]**	**1. Provide missing facilities and equipment upto modern design standards [HSRP]** **2. Prepare annual health plan [procurement plan for medicines/ drugs] for each BHU / RHC [DSSP]** **3. Training and Cap Building generally and esp. in procurement for district health officials [DSP/ DSSP]** **4. Review EDL for BHU / RHC and ensure availability of drugs in line with minimum packages. [see 'N'/Page 18]** **5. Assessment of locations of BHU to identify non serviceable units. Closure / re-location?**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
A.2	**Staff absenteeism** **CAUSES:** - Low incentives [salaries, residences, transport]**- [4,5,6,7]** - Weak internal management [M&E] **[4,6,7]** - Little external check [community involvement, VHC] **[4,6,7]** - Lack of equipment **[4,5,6,7]**	- Offer differential packages [salaries, allowances /bonuses] in hard and inaccessible areas **[4,5,6,]** - Performance based incentives **[4,5,6]** - Work at BHU compulsory for post graduation - Attach every district with a teaching institution within the regions. - Two years house job, one year to be spent at rural level	- Annual Sectoral Plan [ASP] also seeks planned incentives for officials working in Health sector **[Working]** -M&E framework developed for health sector **[Working]** - Model bye-laws developed for M&E by District Council **[Working]** - ASP includes future needs assessment of medical equipments at district level. **[Planning]** - ASP seeks information about absenteeism and consequent action plan to confront this challenge **[Planning]**	- 30% of the allocation has to go to missing medical equipments. **[Planning]** - DoH will standardize the medical equipment to be provided to RHC/BHUs. **[Planning]** - Provision of transport or rent for the schooling of the children of the health providers will be the part of the package **[Planning]** - DoH would devise policy to allow private practice at the RHC/BHU level in the evening. The doctors would also be allowed to use the medical equipments **[Planning]** - Incentivized pay package for WMOs linked to MCH performance indicators **[Planning]**	- CMIPHC targets primary health care. **[Working]** - A specialized pharmacy is provided with all the FMOs. **[Working]** - Resource Group is formed to review the PHC issues **[Working]** - Under competitive packages Female MO are assigned clusters of five BHU. Visit schedule are widely publicized. [18 FMO/90BHUs] **[Working]** - Support Groups are formed to overview and facilitate the working of BHUs. The group consists of elected councilors, teachers, women students, professionals and minorities. **[Working]** - Some civil work is also being done **[Working]**	- DGs to implement new HMIS [JICA & UNFPA] for better monitoring and evaluation **[Working]** -MTSP to review and redesign HMIS to ensure availability of required information support for decision making process **[Working]**	**1. Better salaries in hard areas; [CM has already approved this?]** **2. Incentive based career planning; e.g. contracts with pensions and CPF** **3. Detailed analysis of absenteeism [PDSSP]** **4. Establishing, encouraging, and empowering Health User Committees [PDSSP]** **5. RYK model in 12 Districts to involve communities through social mobilization and prepare an exit strategy.** **6. Provide missing facilities and equipment upto modern design standards [HSRP] [Also in Issue A.1]**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	COMMENTS/PROPOSED INTERVENTIONS [8]
A.3	**Low Quality of Care** *CAUSES:* - Staff absenteeism **[see A.2/ Page 2]** - Part time service - Poorly trained staff • Weak pre service training • Little in service training/ refresher courses - No SOPs - Low non-salary component	- Develop a medical manual including job descriptions, Protocols and SOPs at PHC. **[7]** - Incentive based salaries **[4,5,6]** - Capacity building of staff **[4,5,6,7]** - Package of minimum service standards **[4,7]**	- Under tranche conditionality PDSSP has prepared existing technical delivery standards **[Working]** - TA component also provides for capacity building of staff in health sector **[Planning]**	- Procedures and medicines to be provided, defined and displayed at RHC level **[Planning]** - PG to communicate new job descriptions of paramedics to the DGs for implementation **[Planning]** - DGs to undertake recruitment of Medics, Para-medics and support staff at for BHU/RHC **[Planning]** - Providing missing human resource **[Planning]** - Training of all PHC staff and health professionals through Provincial and District Health Development Centres. **[Planning]**	- A manual of operation extending to all aspects of operations from conclusion of agreement has been prepared. **[Done]** - Capacity Building of LHVs & midwives is also being taken care off in these 12 districts **[Working]** - Capacity building of MOs during the Monthly Review Meeting [MRM] through interactive sessions with the Resource Group that consists of relevant experts and stakeholders **[Working]**	- Medium term strategic plan [MTSP] for health sector provides for a. preparation of operational policies and SOPs for different constituent units **[Planning]** b. development of standard packages of service delivery for each level of health care with defined boundaries and linkages to be legally ensured to the public **[Planning]** c. assessment of current and future requirements in terms of infrastructure, human resource, equipments etc **[Planning]** -Under **Reproductive Health Project [RPHP]** training of LHWs, midwives, family welfare workers, LHVs etc. is an important component. **[Working]** - Under **Women Health Project [WHP]** training of LHVs, midwives etc figures prominently **[Working]**	**1. Prepare and ensure implementation of a minimum service delivery standard /package [MSDP] that conforms to best practices. [PDSSP]** **2. Develop medical manual and job- descriptions, protocols and SOPs to support MSDP. [PDSSP]** **3. Integration of total PHC at the BHU level with broad focus to include more pro-poor, MDG related preventive interventions e.g. vertical programs** **4. Extensive re-training and capacity building of staff.** **5. Better salaries in hard areas; [CM has already approved this?]** **6. Incentive based career planning; e.g. contracts with pensions and CPF**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
A.4	**Limited planning and ownership** *CAUSES:* - Uniform and standard approach / Project approach **[4,5**] - Vertical programs with narrow provincial and district role **[7]** - No targeting **[4,5,6,7]**	- Redesigning of health services / programs **[4,7]** - Broader approach of health sector reform through • *instituting new organizational and financing arrangements for health care,* ***[4,5,6,7]*** • *implementing sector- based rather than project-based donor funding,* ***[4,5]*** • *changing public and private roles and responsibilities, and* • *promoting accountability in* health system **[4,5,6,7]** - Creating linkages of PHC facilities with vertical national health programs. **[5,7]** - Develop mechanism for proper provincial input in vertical programs. **[7]**	- ASP will ensure redesigning of health services as per district needs. **[Planning]** - PDSSP is a sector based program. - Conditional grants would ensure proper targeting **[Planning]** - Monitoring framework developed for health sector **[Working]** - Bye-laws drafted for M&E by DHMTs **[Planning]**	- Monitoring & evaluation of inputs and outcomes **[Planning** - HMIS developed. **[Planning** - Recruitment of Statistical Officer **[Planning**]	- Targets PHC at BHU level - Emphasizes the need for integrating the vertical interventions in preventive health. [How since it de-links the system from the EDO Health who is the focal point in the district for all/or most of the vertical programs?]	- MTSP also focuses on a. Designing & implementation of organizational & system modifications b. development of horizontal linkages amongst the vertical programs and their integration into the mainline service delivery also form part of MTSP -	**1. Integration of total PHC at the BHU level with broad focus to include more pro-poor, MDG related preventive interventions e.g. vertical programs - [PDSSP can conduct study and develop mechanisms for this] [Also in A.3]** **2. Detailed study to establish burden of disease [PDSSP]** **3. Extensive re-training and capacity building of staff. [PDSSP-DSP] [Also in A.3]** **4. Catchement areas for BHUs to be determined through surveys followed by registration of locals with respective BHU for all integrated services e.g. family card etc. [NCHD model]**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
A.5	**Lack of Strong referral links between PHC and SHC institutes** *CAUSES:* - Enrolment process at PHC - Guidance / Health Education **[4,6,7]** - Provision of transport **[5,6]**	- Specialists working in tertiary care institutions to have periodical visits to the remote areas with well publicized schedule **[7]** - Introduce family card/physician system at PHC **[7]** - PHC physicians to decide referral to secondary care **[7]**	- TA component provides for health education and awareness campaign **[Planning]**	- Provision of transport and educational facilities for the health providers is being looked into under HSRP **[Planning]** - Health education and awareness campaign [**Planning]**	- Every MO at BHU goes to local schools for Community Health Session. Students are also screened for common diseases **[Working]** - Every MO at BHU goes out for interactive sessions with local community on public health care issue **[Working]**	- MTSP provides for development and implementation of a comprehensive referral system linking different levels of health facilities **[Planning]** - Social mobilization and community based health care is being looked into under Women Health Project. **[Working]** - WHP is also working on health education in the context of women health care **[Working]**	**1. Prepare, pilot test and implement a compreh'sive referral system that views BHU, RHC, THQ, DHQ and tertiary care hospitals as a network and not as stand alone posts** **2. Implement policy for periodic visits [posting] specialist doctors to THQs and RHCs and other remote areas [either from DHQ or nearest tertiary care set up].** **3. Asses the feasibility and cost effectiveness of furthering the Gujrat Model.** **4. Districts in CMIPHC to institute referral system immediately.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	COMMENTS/PROPOSED INTERVENTIONS [8]
B	**Need to increase focus on preventive [pro poor] Health and actively target MDGs** *CAUSES:* - Poor targeting of MDGs at PHC level for MCH **[4,5,6,7]** - Urban elite bias [tertiary care bias] **[4,5,6,7]** - Diffused Control in Preventive Health - Who is responsible? **[4,5,6,7]**	- Innovative strategies for immunization coverage for all age groups. - "Malaria Free Punjab" could be got declared by the WHO. - Strengthen coordinating role of DGHS **[4,5,7]** - Fresh training, esp. in midwifery **[4,5,6,7]** - Incentive for good LHWs - to be regularized as LHVs after 1 year training - Emergency Aid, TB, Malaria, Diarrhea **[7]** - Protecting pro-poor budget/PHC **[4,5,6,7]** - Separate Budgets? **[4,5,6,7]** - Package of minimum services with minimum standards **[4,7]** - Capacity building of VHWs **[4,5,6,7]** - Protocols for diseases and injuries **[5,7]** - Focus on emerging diseases Diabetes, Hypertension, STDs etc. **[5,7]** - Private health facilities to conform with defined standards - Mobile health service to provide preventive health care to students [an incentive for attracting children to education]	- Compendium of existing technical minimum service delivery standards has been prepared. **[Working]** - ASP would be implemented through conditional grants **[65% of conditional grant to health sector] [Working]** - Conditional grants have to be spent on **[Planning]** a. Pro poor and gender sensitive schemes b. Improvement of PHC c. Reducing less than five year child mortality and maternal mortality. d. Midwifery schools, training of midwives, recruitment of paramedics	Provision of missing facilities at BHU/RHC **[Planning** - Create linkages with community midwives with RHC through incentivized mechanisms **[Planning** - Free packages of MCH service and medicines for pre-natal, natal and post natal cases **[Planning**	Capacity Building of LHVs & midwives is also being taken care off in these 12 districts **[Working]**	- Under the Strengthening Emergency Medical Services (SEMS) initiative, the emergency departments are being revamped with a goal of provision of free of cost emergency services 24 hours a day. - Provincial and District Health Development Centres for capacity building -Under **Reproductive Health Project** [RPHP] training of LHWs, midwives, family welfare workers, LHVs etc. is an important component. - RPHP also provides for basic emergency obstetric care at BHU. - Capacity Building of doctors at PHC level is an integral part of RPHP. - Training of LHVs, midwives etc figures prominently under **Women Health Project [WHP]** - MTSP also provides for strengthening of emergency services at THQ/DHQ including rapid rescue service	**1. Integration of total PHC at the BHU level with broad focus to include more pro-poor, MDG related preventive interventions e.g. vertical programs - [PDSSP can conduct study and develop mechanisms for this] [Also in A.3 & A.4]** **2. Extensive re-training and capacity building of staff, LHWs, LHVs, VHWs. [PDSSP-DSP] [Also in A.3 & A.4]** **3. Incentive based career planning; good LHWs to be regularized as LHVs after 1 year training etc.** 4. **Prepare and ensure implementation of a minimum service delivery standard /package [MSDP] that conforms to best practices. [PDSSP]** **5. Clearly delineated budget for preventive, pro poor, MDG related interventions in MTBF/MTDF mode i.e. protected** **6. Develop and implement incentive based service delivery standards for private health facilities in rural areas**. **7. School health program through PPP or NCHD model. [Teacher training and local referrals to public / private sector facilities]**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
C	**Lack of Health Professionals – Nurses, Paramedics etc.** **CAUSES:** - Pro doctor bias **[4,5,7]** - Low no. of nurses [6,136, doctor-nurse ratio of 1:2, 19% with LGs] **[4,5,6,7]** - Lack of sufficient number of skilled health technicians, paramedics **[4,5,6,7]** - Poor training **[4,5,6,7]** - Low motivation (social esteem, career paths) **[4,5,6]** - Low emphasis on training of Medical Assistants [MTs/HTs] **[4,5,6,7]**	- Address the pro-doctor bias **[4,5,6,7]** - Incentives [hiring in higher scale, salaries, career paths] **[4,5,6,7]** - Higher paid contractual appointments, in hard areas **[4,5,6,7]** - Capacity building of training institutes [outsourcing] **[7]** - Improved training, refresher courses in Family Medicine **[7]** - Introduction of foreign trainers/trainings especially nurses - New cadre of public health professionals with option/incentive of up-gradation [7] - Retraining / capacity building of existing cadres **[4,5,6,7]** - Incentive linked attitudinal change. [individual and group incentives to health staff] **[4,5,6,7]** - Multipurpose and more skilled VHWs **[4,5,6,7]**	- Staff rationalization is being looked into under TA component. - Family medicine / CMH is being looked after under the TA component **-** Attitudinal change is a priority with PDSSP.	- Free packages of MCH service and medicines for pre-natal, natal and post natal cases **[Planning** - Provision of missing human resource **[also see page 3]**	- Capacity Building of LHVs & midwives is also being taken care off in these 12 districts **[Working]**	- DoH is exploring the options of replacing/ augmenting medics at th a cadre of specially trained paramedics and launching of new cadres, including community midwives (Skilled Birth Attendants – SBAs). **RPHP** - Up gradation of training institutes - Establishment of LHW Training Centres at THQ - Up-gradation of public health schools - Training of 600 midwives **WHP** - Training of 2200 midwives - Capacity building of training institute	**1. Review and improve career paths for nurses and paramedics along lines similar to doctors to address self esteem issues and arrest staff attrition** **2. Better salaries in hard areas and Incentive based career planning; e.g. contracts with pensions and CPF** **3. Comprehensive program to enhance capacity of training institutes [Postgraduate College of Nursing and others] through innovative means including employing of foreign trainers and partnerships with local centers of excellence [AKUH]** **4. Detailed study to analyze the viability of the new cadre of public health professionals for rural areas similar to LSMF with basic initial training and option to complete MBBS later on** **5. Extensive re-training and capacity building of existing staff, LHWs, LHVs, VHWs. [PDSSP-DSP] [Also in A.3, A.4, B]** **6. Selective foreign training with performance bonds?** **7. Recruit more nurses to correct the doctor: nurse ratio**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
D	**Weak capacity for Planning, Costing and Budgeting** *CAUSES:* - Limited and uniform planning **[4,5,7]** - No results culture! - Low non-salary share [**4,5,6]** - Clarity of rules, regulations [**4,7**] - Low utilization of budget **[4,5,7]** - Low priority to health sector in many districts ,**[4,5,6,7**]	- Develop standard procedures [4,5,6,7] - DHMT to prepare district health plans initially on annual basis and subsequently three-year rolling plans [**4,7**] - Strong provincial planning (interventions) and monitoring of outcomes (coverage, gaps) **[4,7]** -Conditional Grants through ToPs, PFC [**4,5,6,7**] - Demand side interventions [**4,5,7**] - District planning focused on district specific health needs [**4,5,6,7**] - Independent surveys on health outcomes to update HMIS for evidence based planning [**4,5,7**] - Province to facilitate process of district-based planning. [**4,5,6,7**] - Restructuring and capacity-building of district EDO(H) office (planning & budgeting functions) [**4,5,6,7**]	- ASP includes guidelines for budget and expenditure management **[Working]** - ASP will subsequently be three year rolling plans **[Planning]** - Guidelines for five year strategic plan for health sector [**Done**] - Conditional grant system would ensure proper utilization of funds [**Planning**] - Health service delivery standards for DHQ, THQ, RHC and BHU and etc. [**Working**] - TA resources will be utilized at the provincial level to build capacity of line departments in planning, M&E, HRM etc. **[Planning]** - As tranche condition compendium of existing laws, rules, regulations etc relating to devolved administrative and financial powers prepared. **[Working]** - Under the conditional grants, the 70% of the allocation is based upon the population size and 30% of the conditional grant is done on need basis [poverty of the area] **[Planning]**	-HMIS developed **[Planning** - Creation of post of statistical officer **[Planning** **-** Procedures to be provided, defined and displayed at RHC level **[Planning]** - Budgeting of Free packages of MCH service and medicines **[Planning]**	- A manual of operation extending to all aspects of operations from conclusion of agreement has been prepared. **[Done]** **Women Health Project** -DHMTs are preparing their 1 year operational and 5 years strategic plans in the 8 districts -DSP is catering to the budget and planning needs of the districts - Gujrat Model - MTBF developed by Finance Department	- **MTSP proposes** **[Planning** a. needs assessment, scope finalization and estimation of budget requirements b. preparation of operational policies and SOPs for different constituent units **]** c. development of a prototype hospital management system to be implemented at DHQs and all teaching hospitals d. development of a compendium of existing laws, rules, regulations etc in health sector. e. drafting, legislating and updating laws relating to health services f. Review / design HMIS - Training of DHMTs **Women Health Project [WHP]**	**1. Need to operationalize policy planning and strategy cell in HD to act as the thinking cell; measure and track results; evidenced based planning; spear head reforms etc.** **2. Reform and restructure office of EDO Health, strengthen planning and budgeting functions [PDSSP?]** **3. MICS and other independent district based surveys to update HMIS and for evidence based planning** **4. Determining district specific burden of disease and district specific health needs to set targets.** **5. Prepare and ensure implementation of a minimum service delivery standard /package [MSDP] that conforms to best practices. [PDSSP] [Also in B]**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
E	**Lack of effective Human Resource Management Systems** ***CAUSES:*** -Improper staff and skill mix a]. Overstaffing in urban areas b]. Improper skill mix (41% in BS 1-4)] **[4,5,6,7]** -Little re-training **[4,5,6,7]** - Low incentives to perform **[4,5,6,7]** - Low capacity of proper training institute **[7]** -Little management capacity, especially at district levels **[7]**	- Career paths with growth prospects - Job delineation. **[5,7]** - Re-defining objectives of training at all levels, - Core competencies focused management training **[7]** - Establish a system of Continued Medical Education (CME). **[7]** - Performance based incentives **[4,5,6,7]** - Reward with parallel accountability through DHMT **[4,7]** - Recruitment through PPSC - Pilot testing for adoption of market wages **[4,5,6,7]** - HMIS to be refined and regularly updated and used for sector planning and monitoring of results **[4,5,7]** - Courses/ specialization in health management - Staff rationalization with well defined job descriptions **[4,5,7]** - Coronary service to provide specialized medico-legal services for freeing up the time of regular health staff. **[7]**	- Rationalization of staff at DGs level is being looked into under the TA component **[Planning**] **-** TA component will support capacity building in planning, M&E, PPP and managing minimum service delivery processes **[Planning]** - ASP also seeks TMAs & DGs to indicate incentive plans for the employees working in the DGs. **[Working**] - Further bye-laws have been prepared for M&E by the DHMTs **[Done]** - M&E framework prepared for health sector **[Done]**	- PG to communicate new job descriptions of paramedics to the DGs for implementation - Software for HMIS has been prepared by PESRP. - Incentivized pay package for WMOs linked to MCH performance indicators **[Planning]**	- A system of quarterly evaluation of performance has been developed. Good performance is rewarded. - Performance based incentives	**Women Health Project [WHP]** - Skill Development Training of WMOs in teaching hospitals - Postgraduate training of WMOs, health managers and nurses is also being taken care off - Training of DHMTs **- MTSP provides for** a. A review of medico-legal work in the health sector including medico-legal work by female doctors, court attendance, medico-legal by private sector and designing improvements in this sphere b. Development of 15-20 years perspective plan for health HRD with special focus on gender HRD. c. A study to rationalize number and types of cadres with a focus on provisions for vertical and horizontal mobility d. option of replacing / augmenting medics at BHU with a cadre of trained paramedics e. review / development of job descriptions of staff in the light of health service delivery packages for all level of health facilities f. Introduction and enactment of continued medical education	**1. Effective, computerized, HR Wing to handle matters of transfers, postings, promotions, E&D etc at the DG's office level. Similar set ups in the EDO Health offices for DG level issues** **2. Develop job descriptions and performance evaluation systems for health professionals at various levels.** **3. Review and improve career paths for doctors, nurses and paramedics along** **4. Better salaries in hard areas and Incentive based career planning; e.g. contracts with pensions and CPF [Also in C]** **3. Comprehensive review to redefine the objectives of training at all levels moving to a system of continued medical education and selective specialized trainings in management** **[program to enhance capacity of training institutes [Postgraduate College of Nursing and others] through innovative means including employing of foreign trainers and partnerships with local centers of excellence [AKUH] [Also in C]** **4. Detailed study to analyze the viability of the new cadre of public health professionals for rural areas similar to LSMF with basic initial training and option to complete MBBS later on [Also in C]** **5. Extensive re-training and capacity building of existing staff, LHWs, LHVs, VHWs. [PDSSP-DSP] [Also in A.3, A.4, B, C]** **6. Set up coroner's service for medico legal work and free up time for regular health staff at RHC and THQ etc.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
F	**Need for improved Data Analysis and Research for evidence and outcome based planning** *CAUSES:* -Little reliable, comprehensive data **[4,5,7]** - Low evidence-based planning **[4,5,7]** - Low capacity to utilize this data in planning **[7]** - Negligible research - Neglect of high-priority public health issues - Dominated by pharma-companies - Hierarchical model of research - Little dissemination of research **[4]**	- Reliable, comprehensive data on health indicators now available [MICS] - Updating of HMIS on the pattern of EMIS, to be monitored by DMOs **[4,5,7]** - Encouraging public health research at teaching, training institutions - ***Endowment Fund for Research*** a Autonomous: managed by professionals b. Focus on public health issues and other neglected areas c. Challenge fund d. Strong peer review - Research on following may be given priority. o *Adolescent Immunization o Adult Immunization o Assessment Barriers to Vaccination* *o Community and Partnerships* *o Childhood Immunization* *o Cultural Diversity o Health Communications o Health Education* *o Policy and Legislation o New Vaccines and Vaccine Development* *o Vaccine-Preventable Diseases* *o Vaccine Safety o Immunization Registries*	- As tranche conditionality DGs TMAs to develop an M&E framework proposing **[Working]** a. linkages among various sub-systems, b. identifying operational deficiencies, c. advising on collection, reporting and d. use of gender disaggregated data for performance based monitoring and planning. **-** Mini MICS/ second MICS planned **[Planning]** [Information collected may be used for benchmarking and evidence based planning]	- Software for HMIS has been prepared by PESRP. - Creation of post of statistical officer **[Planning]**		**-** MTSP provides for **[Planning]** a. Review / design HMIS to ensure availability of information for informed decision making b. provide support to operational research - District Monitoring Officer posted **[Working]**	**1. Restructure and redefine the role of Punjab Health Foundation enabling it to make innovative pilot projects with PPP and set up an endowment fund for research on important public health issues and agenda to be determined by the government each year [or in a medium term mode]** **2. Develop methodology for dissemination of research findings through various means including publication of best research in PHF journals.** **3. As a pre requisite for research and planning, HMIS to be upgraded to the level of EMIS in a sustainable manner.** **4. MICS to be institutionalized as a regular feature.** **5. Non intrusive regulation of private sector research through additional incentives.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
G	**Lack of emphasis on Community Participation and Public-Private Partnerships**	- Further RYM: - Program: inclusion of higher tiers - Linkages: education interventions, health education **[6]** - Greater Community Involvement **[4,5,6,7]** - Establish Health Councils at village level **[4,5,6,7]** - *Allowing and facilitating involvement of CCBs in Health Care Delivery* *- THQ/DHQ Boards* *- Role of trusts/charities in health management and on preventive side* - Recognize and encourage Private Sector Involvement in health care **[4,5,6,7]** - Contracting-in management - Contracting out management of some hospitals (DHQs, THQs) - Contracting out services - Capacity building of GPs - Bring private sector into the modernization and management of projects with public sector regulation -Establish a clearing house for PPP - PPP of public and private health institutions - White Paper on PPPs with focus on health **[4]** - Social marketing [safe kit] **[7]** - Creating linkages of private sector PHC facilities with vertical national health programs	- White paper prepared with guidelines for PPP at district level. **[Done]** - Under MoU, PG is to notify operational guidelines to facilitate PPP initiatives. **[Planning]** - DG is bound to allocate at least 10% of its share of conditional grants for PPP initiatives **[Planning]** - Regional umbrella NGOs will be taken on board to enhance community participation in health sector service delivery **[Planning]**	- Health education and awareness campaign **[Planning]** - Community participation **[Planning]**	- Support Groups to overview and facilitate working of BHUs. The group consists of elected councilors, teachers, women students, professionals and minorities. **[Working]** - Every MO at BHU goes to local schools for Community Health Session. Students are also screened for common diseases **[Working]** - Every MO at BHU goes out for interactive sessions with local community on public health care issue **[Working]**	- WHP is also working on health education in the context of women health care - Under Women Health Project social marketing of Safe delivery kits has not been allowed as the government has approved free of cost distribution of safe delivery kits to the end users. - MTSP provides for a. development of sectoral policy for promoting PPP in the health sector. b. preparation of a plan for promotion, accreditation, and standardization of alternate systems of care including TIBB & Homeopathy c. development of mechanism for involvement of local representatives in managing health facilities	**1. Integration of total PHC at the BHU level with broad focus to include more pro-poor, MDG related preventive interventions e.g. vertical programs - [PDSSP can conduct study and develop mechanisms for this] [Also in A.3 & A.4, B]** **2. CMIPHC / RYK model in 12 Districts to involve communities through social mobilization and prepare an exit strategy** **3. Training and capacity building of staff, LHWs, LHVs, VHWs in social mobilization. [Also in A.3 & A.4, B]** **4. Establishing, encouraging, and empowering Health User Committees [PDSSP] to liaise between the community, village health workers and BHUs in preventive, curative, nutrition and health awareness programs like School Health Programme. PHC Extension** **5. Restructure and redefine the role of Punjab Health Foundation enabling it to make innovative pilot projects with PPP and to act as a swift clearing house for PPP.** **6. Asses the feasibility and cost effectiveness of replicating the Gujrat Model** **7. Involve other non state players in health service delivery** **8. School health program through PPP or NCHD model. [Teacher training and local referrals to public / private sector facilities [Also in B]** **9. Create strong linkages with other social sector interventions. [PDSSP]**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	COMMENTS/PROPOSED INTERVENTIONS [8]
H	**Ineffective role of Reform of Health Foundation**	- PHF to be reconstituted on the pattern of PEF - Pro poor focus, pilot test innovations like Health Vouchers - Public financing of private sector. - Encourage PPP for carrying out innovative pilot projects, new institutional models and impact studies. - Recipients of loans should be bound to provide PHC services as per guidelines of the Government.				- Punjab Health Foundation [PHF] being restructured [Working] - PHF offer loan to doctors in the private sector [Could be refined through addition of incentives and conditions]	**1. . A detailed study of PHF to restructure and reorient its role to innovate pilot projects with PPP and set up an endowment fund for research on important public health issues and agenda to be determined by the government each year [or in a medium term mode]** **2. PPP involving public and private health institutions under PHF** **3. Pro poor focus, pilot test innovations like Health Vouchers** **4. Public financing of private sector. Recipients of loans should be bound to provide PHC services as per guidelines of the Government.** **5. Encourage PPP for carrying out innovative pilot projects, new institutional models and impact studies.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	COMMENTS/PROPOSED INTERVENTIONS [8]
I	**Autonomy for Hospitals** **CAUSES:** - No visible gain of autonomy so far - 'Elite Capture'? - Little model building or systemic improvements - Different approaches - Grant of more autonomy with external monitoring of outcomes through Performance Surveys - Contracting in management	- Greater autonomy to be linked with external monitoring of outcomes through annual Performance Surveys by third parties. - Capacity building – systems development - Indoor/Outpatient Patient Management Protocols - Inventory Control Systems - Financial systems development - Protocols for protection of poor - Quality of care assessment surveys **[7]** - Generation and utilization of data on in-patient and out-patient care (MIS) **[5,7]** - Formulation of rules, regulations **[7]** - Regulated private practice **[7]**		HMIS developed		- MTSP for health sector provides for a comprehensive evaluation of autonomy issue and subsequent recommendations for improvement - Further it envisages for an action plan to strengthen autonomy and provision of pro poor service delivery in tertiary care institutions	**1. Specialized wing of the HD to look into the issues of Ahs.** **2. Policy issue. Greater autonomy to be linked with external monitoring of outcomes through annual Performance Surveys by third parties.** **3. Systems required for patient management, inventory control, financial systems, pro-poor protocols and social safety nets etc.** **4. Databases and medical records etc.** **5. Initiate study into developing options for incentive based institutionalized and regulated private practice??**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	COMMENTS/PROPOSED INTERVENTIONS [8]
J	**Comprehensive review of Medical Colleges Education System** ***CAUSES:*** - Outdated curricula - Private Medical Colleges - Medical Education skewed towards cardiac-vascular diseases - Least focus on community medicine	- Revision of curricula for emphasis on community health - Adoption of some non-teaching hospitals and outlets (BHUs and RHCs) for more realistic training and for model-building - Catering for female underemployment after graduation - Some service in rural areas compulsory for all graduates - Creating a market in higher education -Regulation/ standardization of private medical education				University of Health Sciences	**1. Revision and updating of curricula is a Federal subject {PMDC]. A Curricula Committee exists that reviews the curricula.** **2. GoPb can engage PMDC to make curricula more focused on community health.** **3. Medical colleges can adopt some non-teaching hospitals and outlets (BHUs and RHCs) for more realistic training and for model-building** **4. Detailed study to assess the viability of the new cadre of public health professionals for rural areas similar to LSMF with basic initial training and option to complete MBBS later on** **5. Policy for compulsory utilization of services of public sector medical college graduates, especially females??** **6. Standards and regulation of private medical education??**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
K	**Need to focus on Health Education – School Health Program and Issues of Geriatrics**	- School Health Program needs to be revived. **[4,5,6,7]** - Education on preventable diseases, hygiene, nutrition etc **[4,5,6,7]** - Linkages with education interventions **[4,7]** - Health Education through: **[4,5,6,7]** a. Resource centers/ Help line b. Media c. Community leaders - Senior citizen package including old age home to deal with the old age people problems.	- A priority with PDSSP **-** TA funds will also be utilized to launch a community participation and a behavior change campaign - Sectoral Guidelines for health and education also focus on creating strong linkages with other social sectors	- Under ToP with DGs, PG is committed to execute an awareness campaign	- Every MO at BHU goes to local schools for Community Health Session Students are also screened for common diseases - Every MO at BHU goes out for interactive sessions with local community on public health care issue	- Health education/ awareness campaign through electronic media under Women Health Project in the context of women health care	**1. School health program through PPP or NCHD model. [Teacher training and local referrals to public / private sector facilities** **2. Initial focus can be on screening for** • **eyesight, hearing** • **Hygiene** • **Dental hygiene** **Can be expanded later on after the backlog has been cleared** **3. Referral system and school based medical camps initially** **4. Prepare / announce Senior citizen package including geriatrics' departments, specialties and old age home to deal with the old age people problems.** **5. BHU based integrated community mobilization to raise awareness on child health and ageing / geriatric care issues.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	/PROPOSED INTERVENTIONS [8]
L	**Little understanding or emphasis on Cross-Sectoral Linkages** ***CAUSES:*** - limited inter sectoral coordination	- Potential Linkages: [4,6] • Water supply – emphasizing and educating use of safe water • Sanitation – health awareness campaign to be linked to expansion of sanitation coverage • Slums and kachi abadis – emphasis on sanitation • Conditional cash transfers	- Sectoral Guidelines for health and education also focus on creating strong linkages with other social sectors		**-** District Welfare Department is being involved.	**MTSP**	**1. PDSSP is ideally placed to ensure that linkages between schools/ education, water supply and sanitation and public health are brought in sync** **2. Awareness raising through BHU based community mobilization initiatives.** **3. Program for awareness raising in urban and slum areas can be prepared through PHF under new mandate.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
M	**Complete lack of Regulation of Private Practice** ***CAUSES:*** - No culture of diagnosis - Over dosage of unnecessarily expensive medicines - Proliferation of quackery, fake medicines **[4,5,7]**	- Regulating private sector without harassment - Enhance NPA - Option of getting NPA or doing institutional practice after office hours on practice sharing basis. - Only properly qualified persons practice. - Charges and fees to be standardized and displayed properly - Renewal of license and registration linked to satisfactory medical and prescription audits - Regional distribution of practitioners and hospitals to prevent over-concentration in certain areas. - Develop a self-enforcing code of conduct with state action in extreme circumstances - Capacity Building of GPs (refresher courses, etc) - Involvement of private sector in CDC and in TB and their capacity building - Minimum standards and requirement for various types and kinds of hospitals and nursing homes - Renewal of registration linked to continuing medical education	- ASP seeks for information and an action plan quackery			**-** MTSP provides for a. enactment for regulating private sector activities b. development of stringent mechanisms for quackery control c. enactment to confront quackery.	**1. Initiate study into developing options for incentive based institutionalized and regulated private practice?? [also in I]** **2. Regional distribution of practitioners and hospitals to prevent over-concentration in certain areas.** **3. Setting up hospital specific private practive clinics of evening based practice** **4. Enhance NPA and give option for either institution based practice or NPA** **5. Renewal of registration and license linked to satisfactory medical and prescription audits and continuing medical education.** **6. Develop code of conduct for private sector practice to be enforced through peers and with state's role in extreme cases or neglect etc.**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
N	**Review of Drugs Policy** **CAUSES:** - Procurement **[4,5,6,7]** - Affordability **[4,5,6,7]** - Quality **[5,6,7]**	- Negotiate with Federal govt for reduction of EDL - Pharmacy banks for poor patients - Quality Control	ASP	- Standardize the medicines to be provided at the RCH/BHU **-** Provision of free service package and medicines	**-** Planning to develop a shorter but a 'better' list of drugs and a new process of procurement that ensures quality with affordability. - A specialized pharmacy is provided with all the FMOs.	- Provincial Quality Control Board works under the DoH	**1. Review Essential Drugs List** **2. Review EDL for BHU / RHC and ensure availability of drugs in line with minimum packages.** **3. Strengthen role of PQCB**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
O	**Absence of Social Protection / Insurance**	- Govt to pay premium for the total health coverage insurance on sharing basis. - The feasibility of using Zakat funds for this purpose - Critical illness cover for infectious diseases - Insurance cover for government servants - Contributory health insurance - Creating a health insurance market to be expanded later to other segments of population				**-** Engagement of an international consultant is in the pipeline. The consultants will formulate recommendations on this issue. - MTSP envisages introduction of alternative health delivery systems of health financing at the district and institutional level	**1. Need to provide Insurance cover for government servants.** **2. Need to create social safety nets for ageing population** **3. Critical illness cover for infectious diseases** **4. Other social protection mechanisms ??**

#	ISSUES [2]	OPTIONS [3]	PDSSP [4]	HSRP [5]	CMIPHC [6]	HEALTH DEPTT [7]	PROPOSED INTERVENTIONS [8]
P	**Improvement in Governance in health care** **CAUSES:** - Dichotomous relationships - Accountability - Human resources **[see E/ Page 9]** - Absenteeism **[see A.2/ Page 2]** - Shortage of female doctors/staff: - Location **[see A.1/Page 1]**	- Planning and Thinking Cell for Health Sector [Utilization of outside expertise] - Results-based accountability [Performance Budgeting , Performance Appraisal] - Security of tenure linked with Performance Contracts and incentives - Recruitment through PPSC	- TA resources will be used to conduct a comprehensive review and delineation of roles and responsibilities of provincial and local governments in line with PLGO.			- Establishment of a Policy and Strategy Support Unit is in the pipeline. The main objective of the unit would be to: a. provide support to decision makers to develop policies. b. organize, manage, monitor and coordinate technical support in health sector and build local capacity for that c. develop culture of participatory and information based decision making and needs based data collection in the health sector d. HRD to implement new initiatives	**1. Need to operationalize policy planning and strategy cell in HD to act as the thinking cell; measure and track results; evidenced based planning; spear head reforms etc. [Utilization of outside expertise]** **2. Performance budgeting, performance appraisal and results' based accountability.** **3. Security of tenures linked with realistic and measurable performance targets through contracts.** **4. Integration of service delivery with increased diversity of providers.**

Annexure 4

Health Sector Reforms Framework and Action Plan

Punjab Resource Management Program
P&D Department

Expected Outcomes of Reforms 1/2

1) Measurable impact on MDGs
2) Improvement in health delivery services
3) Significantly reduced incidence of disease
4) Better Health Management Systems
5) Reduction in poverty
6) Social protection for vulnerable population groups
7) Improved Primary / Secondary and Tertiary Health Care
8) Enhanced utilization of BHU/RHC
9) Optimal utilization of Facilities
10) Effective and Quality Referral System

Expected Outcomes of Reforms 2/2

11) Enhanced Capacity for Planning, Costing and Budgeting
12) Improved Capacity for Data Analysis and Research
13) Evidence and outcome based planning
14) Better patient management
15) Community Participation and Public Private Partnership
16) Giving Private Sector its due share in Public Policy

Broad Ingredients of Reform

1. Improve Performance of Health Management System
2. Improve Access & Quality of Trained Manpower, Drugs and Technology in Health Service System
3. Review Existing Policy Framework for Health Service Delivery
4. Improve Health Service Delivery Infrastructure
5. Health Mass Awareness
6. Introduce Public Private Partnerships
7. Broaden Health Financing Mechanisms

Improve Primary Health Care

Provide Missing Facilities (Human & Physical)

Conduct Needs Assessment for rehabilitation at BHU, RHC, THQ & DHQ levels upto modern standards

Prepare Plan for Provision of Missing Facilities (Human/ Physical)

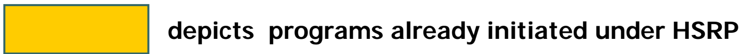
Prepare & implement District Annual Health Plans including medicines etc.

Prepare & implement Staffing Plan in a phased manner inline with needs assessment

Provide funds through TOPs initially for BHU & RHC and later for THQ & DHQ (Conditional financing mechanism/ databases/ indicators-process & outcome)

Months

1 6 12 18 24



depicts programs already initiated under HSRP

Improvements

◆ Access ◆ Drugs & Equipment ◆ Staff Attendance ◆ Planning & Budget

HD/PDSSP

Improve Primary Health Care

Integration of Services/Programs at BHU/RHC level

Study to integrate PHC facilities with vertical programs

Develop mechanism to integrate all preventive programs at BHU and RHC levels

Improvement of Quality of health care through Integration of total PHC at BHU/RHC (MDG, ECCD, School health programs, vertical programs, etc.)

Study Gujrat Model for nutrition & school health programs

Introduce integrated Nutrition & School Health programs in a phased manner in selected districts

Survey to revise catchment areas & register local house holds to develop health card system in selected districts

Revise catchment areas and register local with BHUs/ RHCs in selected districts

Improvements

◆ Access ◆ Utilization ◆ MDGs & Health Indicators◆ Health Care

Health Department & PDSSP in selected Districts

Model
Basic Health Unit

Integrated Services Model

Main Building

- Hospital Block
- Residential Block
- Boundary Wall
- Approach Road
- Water Supply
- Electricity/Sui Gas
- Telephone
- Furniture Complete Provision
- Adequate Repair Allocations

Equipment

- All relevant/ Functional Equipment e.g. Nebulizar, Glucometer, Safe delivery Kits
- Delivery Room operational through LHV / Midwife
- Ambulance cover either from RHC or at focal BHU
- Computer for recs/ repts
- Facilities (allowance) for doctor to act as HO

Infrastructure

Staff

IC/ MO/SMO
Paramedics
Dispenser [1 or 2],
Health Tech [1]
HT for SH& NP [1]
Midwife [1+1]
LHV [1+1]
LHW [1 or 2]
LHS [as reqd]
Vaccinator
CDC Supervisor
Comp Oprt [1]
Sanitary Inspector
NQ/CK/SW

Visiting Staff

WMO
for OBGYN once a week from RHC

Services

Curative

- Minor Ailments
- Referral

RHC/ THQ/ DHQ

Preventive

Vertical Programs:
IC\MO to be focal point

- National Program for FP & PHC
- EPI/Polio/TB Dots
- Malaria/HIV/AIDS
- Hepatitis Control
- Health Education
- Food and Nutrition
- National MCH [fut]

Promotive

Village Health Committees
School Health [Prop]
ECCD/Nutrition Prog [Prop]
LHW Program
FHP / MCH Services

Model RHC

Main Building

- Hospital Block
  - Wards [12 - 20 beds]
  - OT
- Residential Block
  - Res/ Mess for BHU MOs
- Boundary Wall, App Road
- Elec/ Gas/ Tele/ WSS
- Furniture Complete Provision
- Adequate Repair Allocations

Equipment

- All relevant/ Functional Equipment e.g. US Machine, FHD OT AC plus existing
- Delivery Room operational for 24 hrs through WMO
- Ambulance to cover BHUs and referrals
- Computer for recs and repts
- School veh for children of staff

Infrastructure

Rural Hospital: Preventive Curative, Diagnostic and Referral

Services

Staff

IC/SMO/SWMO
Paramedics
Dispenser [4], Medical Tech [2]
Midwife [4+2]
LHV [1+1]
Charge Nurse [6]
OTA/LA [1+1]
LHW [as reqd]
LHS [as reqd]
Vaccinator
CDC Supervisor
Data Analyst [1]
Sanitary Inspector
NQ/CK/Mali
SW [2+2]
Dying cadres [Homeo/Hakeem Dai/TBA & WC etc]

Visiting Staff

Specialists

From THQ/DHQ & Tertiary Hosp

Services

- All Curative
- Routine Surgery
- Medico Legal
- Diagnostic
- Emergency
- Referral

THQ/ DHQ/ Tertiary

BHU

Preventive

Vertical Programs:

IC\SMO to be focal point

- National Program for FP & PHC
- EPI/Polio/TB Dots
- Malaria/HIV/AIDS
- Hepatitis Control
- Health Education
- Food and Nutrition
- National MCH [fut]

Promotive

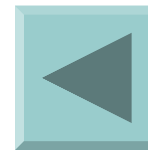
Health Users' Committees
School Health [Prop]
ECCD/Nutrition Prog [Prop]
House Job Prog [Prop]
LHW Program
FHP / MCH Services

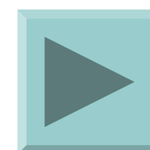
Medico Legal System

Reform Options

Examine options for reform of Medico Legal system along the following lines:

- Establish Specialized Agency e.g. Provincial Coroner Service, or
- Authorize private sector doctors & create regulatory mechanism, or
- Create appropriate incentives for public sector, or
- Any other innovative plan aimed at relieving pressure on PHC & SHC doctors





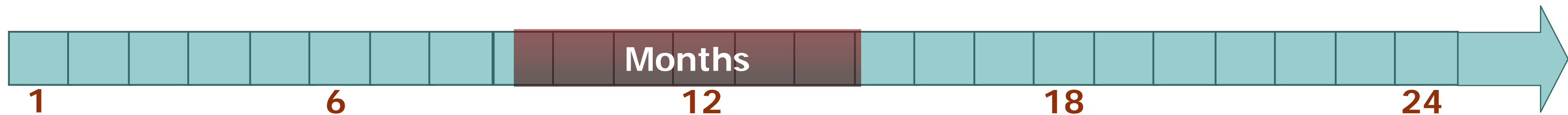
Improve Primary Health Care
Minimum Service Delivery Package

Study to develop Minimum Service Delivery Standards/ Package

Implement Minimum Service Delivery Packages & Standards in a phased manner at BHU, RHC level initially and later on at THQ & DHQ level

Develop medical manual, job descriptions, protocols, SOPs, incentive based salaries etc.

Implement in the field



Improvements

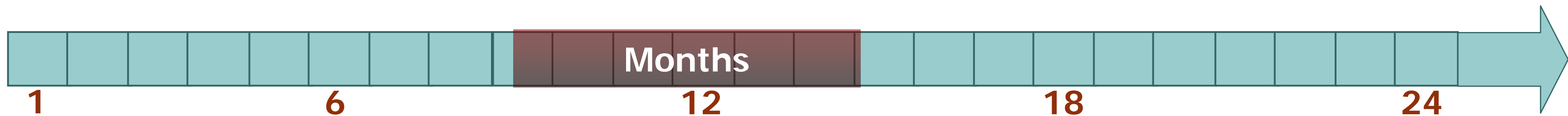
◆ Quality of PHC ◆ Performance ◆ Accountability ◆ M&E

Responsibility

PDSSP in Pilot Districts

Improve Primary Health Care
Referral System

Prepare a comprehensive referral system between PHC,SHC & Tertiary Care	Pilot Test Referral system	Evaluate & Implement Province wide
Formulate policy for periodic visits of specialists doctors to RHCs & THQs	Pilot Test Policy	Evaluate & Implement Province wide



Improvements

◆ Patient Management ◆ Optimal utilization ◆ Medical Records

Responsibility: HD/PDSSP

Human Resource Management 1/2
Nurses & Paramedics

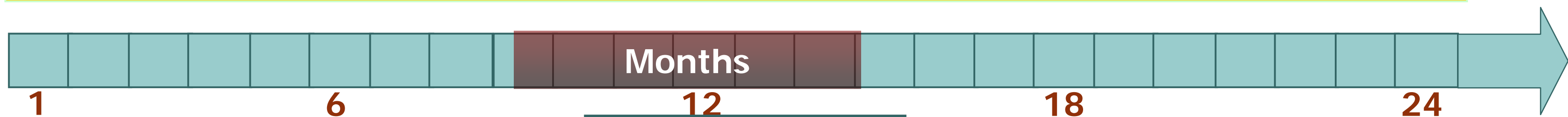
Analyze absenteeism & review career structure along lines similar to doctors (self esteem & attrition issues)

Identify & implement specialization for nursing/ paramedic cadres

Correct doctor: nurse ratio by recruiting more nurses & paramedics & improve career structure. Prepare 10 year supply plans for the sector

Prepare & implement program to enhance capacity of training institutes through innovative means including foreign trainers & partnerships

Analyze viability of new cadre of public health professionals for rural areas with initial training in community medicine and option to complete MBBS



Improvements

◆Training & skills ◆ Patient Management ◆ Attitudinal Change ◆Pro doctor bias ◆ Attendance

Responsibility: HD/PDSSP

Human Resource Management 2/2
Doctors

Design & develop integrated computerized HRM system in the province & districts

Pilot & replicate

Review & develop job descriptions, performance evaluation, career paths & incentivised pay packages (for hard areas)-Review of contract policy

Implement hard area incentives and Performance Eva Sys.

Finalize restructuring plan for EDO (H) Office along functional lines (budgeting, planning, statistical support etc.)

Implement restructuring plan in a phased manner

Study alternate approaches to utilize services of non-serving medical graduates (esp. female doctors) through flex time/ part time work etc.

Develop & Implement Policy

Improvements

◆ Management ◆ Access ◆ PM&E ◆ Utilization of health resources

Responsibility: HD/PDSSP

Training & Capacity Building

Conduct training needs assessment for extensive re-training of existing staff (technical and managerial)

Review structures / curricula & conduct TNA of Institute of Public Health

Review structures / curricula and conduct TNA of training institutes [Postgraduate College of Nursing and others]

Prepare and implement Capacity Building Plan [partnerships with local centres of excellence-AKUH, employ foreign trainers, etc]

Improvements

◆ Performance ◆ Patient Management ◆Utilization of Resources

Responsibility

HD

Governance in Health Care

Operationalize Policy Planning & Strategy Cell.	PP&S Cell to act as the thinking cell; measure & track results; evidence & outcome based planning & spear head reforms. Work on reviewing rules /regulations, developing min. service delivery packages, capacity building etc.

Bring provincial health financing within MTBF	Study & implement in phased manner performance budgeting, output based appraisal & accountability mechanisms

Study to develop options for improved Medico-Legal System through involving private sector or creation of a specialized service (Coroner Service)	Develop legal framework & implement

Delegation of authority for posting & transfers & E&D under the PLGO to districts

Improvements

◆ Governance ◆ HRM ◆ Planning & Budgeting
◆ Access, Coverage & Service Delivery

Responsibility: HD/PDSSP/ PRMP

Research & Evidence Based Planning

Update HMIS on lines with EMIS / Institutionalize MICS
Carry out first annual survey to establish benchmarks

Standardize routines for data generation, management & reporting

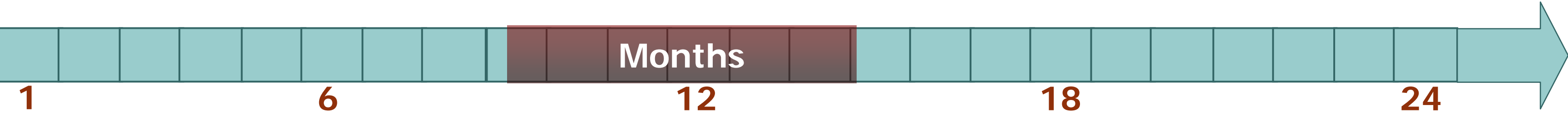
Survey to determine district specific Burden of Disease

Allocation of resources as per district annual health plan based on BoD: on pilot basis

Study to create endowment fund for medical research and its dissemination

Formulate operational modalities

Operationalize Fund



Improvements

◆PM&E Capacity ◆ Databases ◆ Relevant research ◆ Optimal utilization ◆ Service delivery

HD / Punjab Health Foundation /PDSSP

Community Participation & Public Private Partnership

Study of PHF for redefining its mandate, involving non-state players in health sector delivery etc.	Revise rules and regulations to expand role of PHF	PHF to initiate innovative projects, GP home visits, soft loans, esp. in rural areas
Set up health users committees & village health committees for BHU and RHC in pilot districts	Conduct social mobilization & empower committees to monitor service delivery and eventually manage the facility [RSP exit strategy]	Evaluate results & replicate in more districts
Create linkages with other social sector interventions (DMO)		

Improvements

◆Community participation ◆ Accountability◆ Coordination
◆ Access & coverage ◆ PPP

Responsibility: HD/PHF/PDSSP

New Programs & Facilities

Design school health program & child nutrition program

Implement on pilot basis through dedicated paramedics at BHU/RHC

Evaluate, improve & expand to more districts

Carry out needs assessment & prepare senior citizens' package & Geriatric Health Program

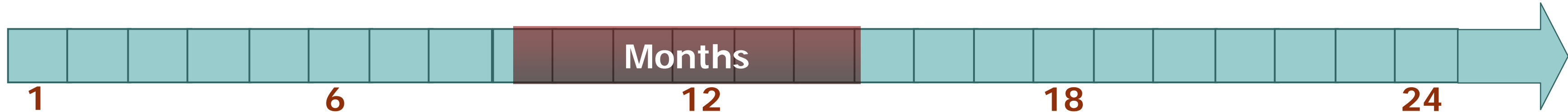
Implement the program in pilot districts and tertiary care centres

Feasibility study for establishing Stroke centres & Trauma centres

Based on recommendations, approve setting up of Stroke & Trauma centres

Design & initiate mental health care system with strong referral links at primary level on a pilot basis

Evaluate, improve & expand to more districts



Improvements

◆ MDGs & Health indicators ◆ Planning & Coverage ◆ Critical specialties

Responsibility

HD/ PDSSP/ PHSRP

Review Drugs Policy

Review and update Essential Drugs list for all tiers & develop pharmacopeias

Study to strengthen scope/mandate and role of DQCBs/PQCB	Build capacity of PQCB	Build capacity of DQCBs in a phased manner

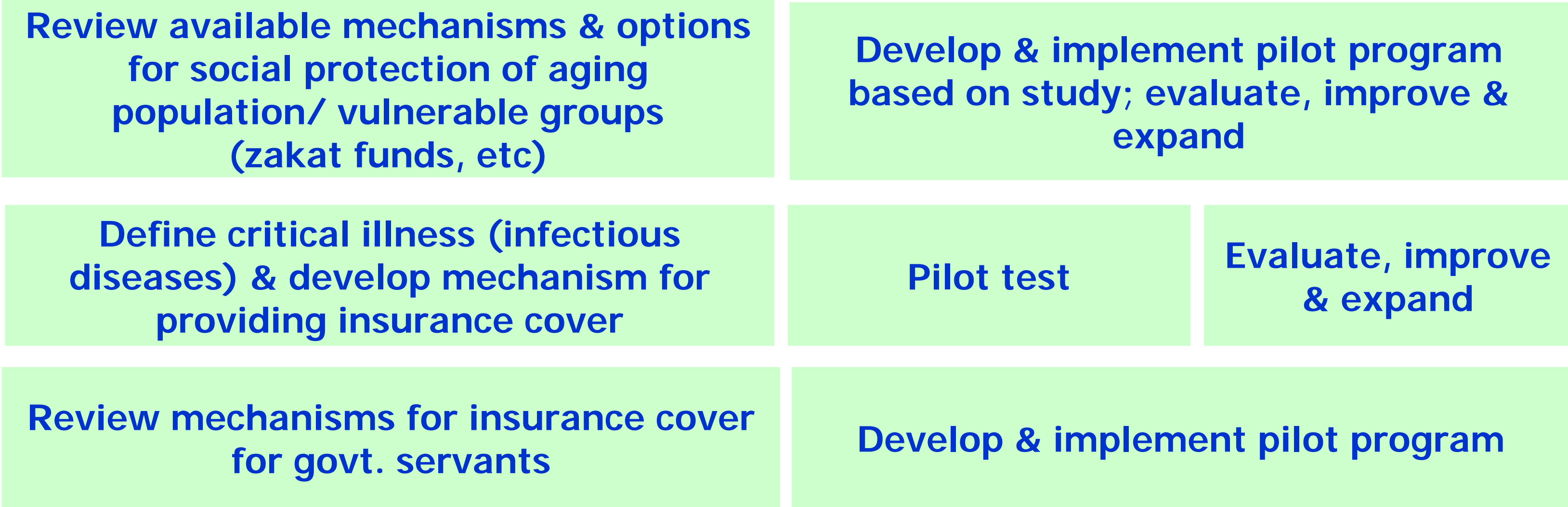
Improvements

◆ Quality & availability of drugs ◆ Planning

Responsibility

HD/PDSSP

Social Protection / Insurance



Improvements

◆ Social protection ◆ Access & Coverage ◆ Health insurance

Responsibility

HD/ PDSSP

Autonomy of Hospitals

Create Specialized wing to handle issues of AHs

Review autonomy of hospitals to link greater autonomy with external monitoring of outcomes & annual performance surveys

Implement

Review health management systems and protocols in AHs including those for social protection

Develop & implement health management systems and protocols in AHs

Improvements

◆ Management Sys ◆Med Recs ◆ Pro Poor ◆ Utilization

Responsibility

HD/ PDSSP

Review of Medical Education

Engage PMDC to update MBBS curricula with adequate focus on community health

Develop & Implement Action Plan for medical graduate house job program with non-teaching hospitals & DHQ/THQ/RHC/ BHU in a phased manner

Engage PMDC to standardize and regulate private medical education

Improvements

◆ Med. Education ◆ Utilization ◆ Community Health Edu. ◆Curricula

Responsibility

HD/ PDSSP

Regulation of Private Practice

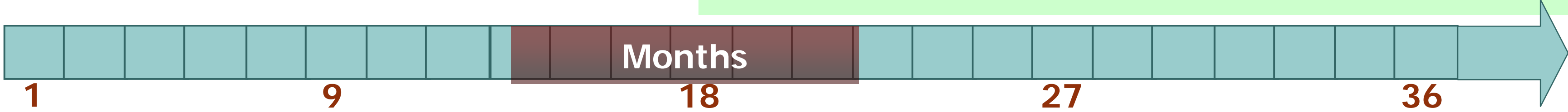
Study to examine options for regulation of private practice without harassment through a code of conduct including hospital based practice

Review and enhance non-practice allowance (NPA)

Prepare Plan

Implement

Review options for provincial registration of doctors & linking renewal of the same with Continuing Medical Education and maintenance of prescribed standards to be regulated through medical & prescription audits



Improvements

◆ Coverage ◆ Regulation of health service ◆ Health service delivery

Responsibility

HD / PDSSP

PRMP

Program Management Unit
Punjab Resource Management Program
Planning & Development Department
Govt. of the Punjab

URL: www.punjab-prmp.gov.pk
Email: info@punjab-prmp.gov.pk