Departmental Sector Review to work on MTBF related technical sector review of Health Department Punjab

Contech International
Health Consultants
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>ADP</td>
<td>Annual Development Programs</td>
</tr>
<tr>
<td>AMIs</td>
<td>Autonomous Medical Institutions</td>
</tr>
<tr>
<td>DSR</td>
<td>The Departmental sector review</td>
</tr>
<tr>
<td>ECCD</td>
<td>Early Childhood Care &amp; Development</td>
</tr>
<tr>
<td>FMC</td>
<td>Financial Management Cell</td>
</tr>
<tr>
<td>GoPB</td>
<td>Government of the Punjab</td>
</tr>
<tr>
<td>GRAP</td>
<td>Gender Reform Action Plan</td>
</tr>
<tr>
<td>JDs</td>
<td>Job Descriptions</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MTBF</td>
<td>Medium Term Budgetary Framework</td>
</tr>
<tr>
<td>MTDF</td>
<td>Medium Term Development Framework</td>
</tr>
<tr>
<td>PDSSP</td>
<td>Punjab Devolved Social Services</td>
</tr>
<tr>
<td>PGEIP</td>
<td>Punjab Government Efficiency Improvement Program</td>
</tr>
<tr>
<td>PHDC</td>
<td>Provincial Health Development Centre</td>
</tr>
<tr>
<td>PHF</td>
<td>Punjab Health Foundation</td>
</tr>
<tr>
<td>PHSRP</td>
<td>Punjab Health Sector Reform Program</td>
</tr>
<tr>
<td>PMDGP</td>
<td>Punjab Millennium Development Goal Program</td>
</tr>
<tr>
<td>PRMP</td>
<td>Punjab Resource Management Program</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
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DEPARTMENTAL SECTOR REVIEW TO WORK ON MTBF RELATED TECHNICAL
SECTOR REVIEW OF HEALTH DEPARTMENT PUNJAB

1. **Introduction and background**
   In view of important role of the health sector in the overall development of socio-economic status of the society, the health sector has been enjoying a high priority in the investment programs of the province. However, despite substantial investment in the sector, significant improvement in the health indicators has not been achieved. The analysis of the situation indicates that in the past, either there was no clear health policy or its guiding principles were not followed for the investment in the sector. Major emphasis was placed on enhancing health coverage to the population through expansion of health care facilities (mostly physical infrastructure) with specific attention to curative aspects of health. The major portion of resources invested thus went to the curative sector or that to in bricks & mortar. The more critical part of manpower development, management systems development and use of cost effective interventions could not be adequately addressed. Resultantly, the health care system which was in place could not be able to bring a visible improvement.

1.1. **MTBF Initiative**
The existing situation suggests that any further investment in the health sector, without changing the system, is likely to go waste. The circumstances forced the decision makers to re-evaluate current strategies and reorient the financing mechanism, with a view to overcome the existing imbalances, disparities and inefficiencies for improvement of health services delivery and health status of the population in real terms.

In order to achieve the objectives a number of initiatives have been taken by the Punjab government with the assistance of different donors including Asian Development Bank (ADB). Most significant initiative taken by the government is introduction of new budget mode in shape of Medium Terms Budgetary Framework (MTBF) & Medium Term Development Framework (MTDF). This mode of budgeting is being implemented in a phased manner. In the initial phase it would be implemented in 5 line departments of the Punjab. Medium Term Budgeting was initiated in 2009-10 (as the first year) in Irrigation & Power and Health Departments. MTBF will be rolled out in 3 more line departments i.e. Excise and Taxation, Livestock & Dairy Development and Higher Education Departments in 2010-2013.

1.2 **Departmental Sector Review**
The Departmental Sector Review (DSR) is a step in the budget preparation under the Medium Term Budgetary Framework (MTBF). It would assess extent to which the budgets and expenditures are in line with policies in the health sectors so as to form the basis for effective targeting of resources in the budget formulation process. For the purpose of this review, information available from the Health Department is to be analyzed in terms of allocations, expenditures and achievements. The expenditures incurred by district governments on health are not a part of this review.
2. **Objectives of the assignment**

According to the TORs of the assignment, the specific objective of DSR is to review the link between department’s policy objectives and its budgets and expenditures. DSR is undertaken in the context of MTBF preparation as part of the annual budget cycle and involves an assessment of how policy objectives are defined and monitored with clear indicators of improved performance.

The core of DSR is an assessment of whether the department’s programs/projects and expenditures are supporting achievement of its policies. It covers both recurrent and development expenditures, looking at the composition of each and assessing the relationships between them. The process provides strategic direction to the overall budget allocation process in the department. On completion it should be used by the department to inform the inter-departmental allocation of resources.

3. **Scope of work**

The consultants will perform the following in collaboration with the line department:

3.1 **Departmental Overview**
- Description of sector objectives (provincial) e.g. policies and objectives, mission statement;
- Overview of key issues and challenges being faced by the sector (including projects/programs) in the medium and long term;
- Overview of the departmental priority programs and activities;
- Description and analysis of present functions and budgets within the provincial sector policy.
- Assess appropriateness of the activities of the provincial department in the sector;
- Monitoring: description of responsibilities for setting and monitoring output indicators and the mechanisms that exist or are being developed for reporting this information; and
- Drawing on above, summaries provincial budgets and expenditures for FYs 2006/07 to 2008/09, disaggregated according to: current and development; and within major program, functional and economic classifications.

3.2 **Department’s Performance and Monitoring Framework**

For each key policy area:

i. Policy objective: a description of the policy area to be addressed and the specific policy objectives that are intended to be achieved over the MTBF period;

ii. Outcomes/outputs: a description of how progress is monitored against policy objectives. Assessment of monitoring indicators where they exist; and suggestion, time permitting, of indicators based on international experience where they do not.

3.3 **Analysis of recent performance and budget/expenditure trends:**

Analysis of recent performance and budget/expenditure trends for each key policy area including:

i. Describe current performance: summaries the current provision of services in the policy area including:
recent and present output levels (progress in achieving targets by indicators); and,
Assessment of the extent to which required service levels are being met including the quality of service delivery.

ii. Past expenditures: analysis of expenditure trends for 2005/06 to 2007/08 including comparisons of current to development expenditures, wages and salaries to non wage and salaries, the relation of expenditures to outputs (to the extent possible);

iii. Analysis of budget implementation constraints by assessing the budget, release, expenditure process;

iv. If possible as part of the pilot, projection of future trends of recurrent and development budgets based on existing policies, i.e. already approved projects, the transfer of recurrent costs of projects on completion to the recurrent budget;

3.4 Recommendations
i. Based on the analysis, comment on the strategic orientation of expenditures and their fit with policy objectives; and

ii. Propose as an input to strategic budget discussions, options for high level reallocations / re-adjustments which would be expected to increase the allocative efficiency of expenditure and align expenditures more closely with policies over the period 2010/11 to 2012/13.

3.5 Outputs / Deliverables
The expected deliverable will be the Department Sector Review. The consultant will work with the departmental focal persons, core teams and MTBF consultants and would prepare the deliverables.

4. Methodology
A comprehensive strategy has been followed in conducting the assignment which includes extensive review of relevant documents and interviews of the stakeholders involved in preparation and spending the budget under MTBF format. The review of documents provided overall situation of health department Punjab with specific focus on policy objectives, priority programs, financial and budgetary allocations and expenditures. The interviews of the stakeholders helped in getting the first hand information and perspective of the developers and users of the MTBF and MTDF as well as of policy makers. In order to conduct interviews of the stakeholders a questionnaire has been designed and used which is placed at Annexure-1.

4.1 Documents Review:
Besides others, following documents have been consulted during conducting this consultancy assignment:

1. National Health Policy 2001
2. Draft National Health Policy 2009
4. Estimates of Charged Expenditure and Demands ( Current Expenditure) for the years 2006-07, 2007-08, 2008-09, 2009-10
5. MTBF 2010-13 (Health Sector)
6. Annual Development Programs (ADP) ,allocations and expenditure in the Health Sector for the years 2006-07, 2007-08, 2008-09, 2009-10
7. MTDF 2010-13 (Health Sector)
9. Vertical Programs Reports for the years 2006-07, 2007-08, 2008-09, 2009-10
10. Material and presentations used by the PRMP consultants for training of staff on MTBF
11. Training workshop report organized on 26th April 2010 under SP-09 of Punjab Devolved Social Services (PDSSP)
12. Gender Reform Action Plan (GRAP) Punjab

4.2 Interviews of Stakeholders:
Interviews of different stakeholders involved at policy level, officials responsible for planning/ budgeting in health secretariat and Director General Health Services (DGHS) office along with operational levels were conducted using the questionnaire referred above. Some of the interviewees are mentioned as under:

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mr. Abdullah Khan Sumbal</td>
<td>Special Secretary, Health Dept.</td>
</tr>
<tr>
<td>3.</td>
<td>Mr. Abdul Haq Bhatti</td>
<td>Chief Planning Officer, Health Dept.</td>
</tr>
<tr>
<td>4.</td>
<td>Mr. Sarfraz Ahmad</td>
<td>Dy. Secy. Budget, Health Dept.</td>
</tr>
<tr>
<td>5.</td>
<td>Dr. Muhammad Anwar Janjua</td>
<td>Director Development, DGHS Punjab</td>
</tr>
<tr>
<td>6.</td>
<td>Mr. Shahid Javed</td>
<td>Director Budget, DGHS Punjab</td>
</tr>
<tr>
<td>7.</td>
<td>Mr. Ghulam Muhammed</td>
<td>Budget Officer, DGHS Punjab</td>
</tr>
<tr>
<td>8.</td>
<td>Dr. Darkshan Badar</td>
<td>Project Director, TB Control Program, DGHS Punjab</td>
</tr>
<tr>
<td>9.</td>
<td>Dr. Arshad Iqbal Dar</td>
<td>Director EPI, DGHS Punjab</td>
</tr>
<tr>
<td>10.</td>
<td>Mr. Shahid Pervez</td>
<td>Project Director, Hepatitis Control Program, DGHS Punjab</td>
</tr>
<tr>
<td>11.</td>
<td>Mr. Dawood Ahmad</td>
<td>Dy. Team Leader, MTBF Consultant, PRMP</td>
</tr>
<tr>
<td>12.</td>
<td>Dr. Amjad Shehzad</td>
<td>Deputy Program Director, Punjab Health Sector Reform Program (PHSRP)</td>
</tr>
<tr>
<td>13.</td>
<td>Ms. Shazia Siraj</td>
<td>Gender Specialist, Health Department</td>
</tr>
</tbody>
</table>

5. Proceedings of the assignment

5.1 Observations of the Department:
The assignment was accomplished in accordance with the TORs and draft report was submitted to the government. The report was discussed in a meeting held on 15-07-2010 under the Chairmanship of Special Secretary Health. Following observations were raised in the meeting:

1. The report is more in the form of a situational analysis of the budget of the Health Department.
2. The organogram of the Health Department provided in the report is not up to date.

3. In the report, Secretary Health has been reflected as Chief Executive of Accounts whereas the Secretary Health is the Principal Accounting Officer of the Health Department.

4. Various programmers like TB Control Program, Malaria Control Program etc have been mentioned without any reference to the subject matter, thereby being irrelevant or inconsistent.

5. The consultant has not given accurate figures of allocation of funds for various schemes. There is a need to incorporate accurate figures in respect of the allocation of funds to various program/ projects etc.

6. The report is silent altogether about the past trends of the budgetary allocations and even no recommendations whatsoever are given to improve the budgetary allocation among various sub-sectors of the health sector on the basis of past experience.

7. The report is a collection of bits and pieces of information which lacks cohesion and continuity of ideas. Therefore, it is difficult to draw any lesson from the report.

5.2 Steps for addressing observations:
In the light of above mentioned observations, the report has been revisited and revised by taken the following steps.

1. Conducted interviews of different stakeholders as mentioned above. The purpose of these interviews was to obtain up to date situation of health policy objective and preparation of MTBF & MTDF accordingly along with implementations of new budgeting module at functional levels.

2. Obtain accurate and up to date information about the structure of health department, allocations and expenditures under development and non-development budgets to analyze the budgeted trends in the Health Sector.

3. Visited program managers of various vertical programs like TB, EPI Malaria and Hepatitis to know their scope allocations, expenditures and visible impact, if any.

4. Accuracy of data has been ensured by verifying it from the relevant officials.

5. Analysis / findings of study recorded along with clear cut recommendations as per observations of above mentioned meeting under the Chairmanship of Special Secretary Health.

6. **Health Department Punjab: An Overview**
Pakistan’s Health System has three tiers; Federal, Provincial and District level. The federal Ministry of Health is mainly responsible for policy, planning and coordination. Provinces take care of macro planning and technical guidance of the districts. Since devolution the districts are responsible for providing primary and secondary health care services.
There are also a number of vertical public health programs funded by federal government like MNCH, EPI, TB, Malaria, Hepatitis and LHW programs. These programs, although funded by the Federal Government, are implemented in the provinces and districts. The federal government mostly provides assistance under these programs in shape of commodities and technical assistance to augment the activities already under way in the province.

Health is second largest sector in Punjab in terms of physical infrastructure and human resources. The number of people employed in the public sector (Health) in Punjab exceeds 175,000 including about 52,000 Lady Health Workers. After devolution, one line budget is transferred to the district government and decision making for planning and implementation of primary and secondary health service is a function of the districts.

6.1 Role and Functions of Provincial Health Department:

Nevertheless, role of the province is still important and post-devolution functions of provincial health department are as under:

Policy development, legislation and monitoring the implementation;
Planning and Development for all provincially managed institutions and macro level planning for the districts;
- Policy dialogue/coordination with Federal/district Government and Donors;
- Development of minimum standards of service delivery;
- Budget allocation and control for provincial institutions only;
- Undertake Health System Research;
- Supervision and monitoring of provincial institutions and district performance and provide technical guidance;
- Provision of technical support to the Districts in all respect;
- Coordination and regulation of Medical, Dental, Nursing & and Paramedical Education;
- Constitution of Medical Boards for provincial employees, Standing & Special Medical Board (SBM) for all employees;
- Data analysis & feedback to Ministry of Health (MoH) and Districts;
- Health and Nutrition Education activities;
- Resolve inter- and intra-district conflicts;
- Annual monitoring of district performance against agreed indicators;
- Recruitment, transfer, posting, promotion & disciplinary action of all cadres /grades for provincial institutions;
- Recruitment, transfer, posting, promotion & disciplinary action from BPS 18 & above for doctors and BPS 17 & above for other cadres of district;
- Procurement of goods /services for provincially managed institutions, vehicles, electro - medical equipment, technical assistance and rate contract for medicines for districts.

6.2 Administrative Structure:

The Health Department is headed by the Secretary who is the over-all administrative and management in-charge. He/she is also the Principal Accounting Officer for the Department with the over-all responsibility of financial management and control. He/she provides
direction to the Department and plays lead role in setting and implementing provincial health policy objectives.

The Secretary Health is assisted by Director General Health Services (DGHS), Director General Nursing, Additional Secretaries (Admin, Development, Technical and General), Executive Director Special Projects, Chief Executives of teaching hospitals, Principals of Medical Colleges and Deans of Post Graduate Institutes in running the affairs of Health Department.

DGHS is head of attached department supervising health services in the periphery. He/she is supported by different directors.

Administrative structure of the Health Department Punjab is briefly described in the following diagram whereas detailed organizational hierarchy is exhibited at Annexure-2.

6.3 **Service Delivery Structure:**
The public sector health delivery system comprises of four tiers: (i) Outreach and Community based activities, which focus on immunization, sanitation, malaria control, maternal and child health and family planning; (ii) Primary care facilities including Basic Health Units (BHUs) and Rural Health centers (RHCs) for preventive and curative care; (iii) Tehsil Headquarters Hospitals (THQH) and District Headquarters Hospitals (DHQHs) for inpatient and outpatient care; and (iv) Tertiary care hospitals located in the major cities for more specialized care. After devolution, primary health care facilities fall under the jurisdiction of district governments. Provincial government manages the specialized / teaching hospitals as mentioned below:
<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Services Hospital, Lahore</td>
</tr>
<tr>
<td>2.</td>
<td>Lahore General Hospital</td>
</tr>
<tr>
<td>3.</td>
<td>Mayo Hospital, Lahore</td>
</tr>
<tr>
<td>4.</td>
<td>Ganga Ram Hospital, Lahore</td>
</tr>
<tr>
<td>5.</td>
<td>Dental Hospital, Lahore</td>
</tr>
<tr>
<td>6.</td>
<td>Pediatric Hospital / Institute of Lahore Nursing School cum Hostel (Children Hospital Lahore)</td>
</tr>
<tr>
<td>7.</td>
<td>Jinnah Hospital, Lahore</td>
</tr>
<tr>
<td>8.</td>
<td>Punjab Institute of Cardiology, Lahore</td>
</tr>
<tr>
<td>9.</td>
<td>Fatima Jinnah Medical College, Lahore</td>
</tr>
<tr>
<td>10.</td>
<td>Allama Iqbal Medical College, Lahore</td>
</tr>
<tr>
<td>11.</td>
<td>Services Institute of Medical Sciences, Lahore</td>
</tr>
<tr>
<td>12.</td>
<td>King Edward Medical University, Lahore</td>
</tr>
<tr>
<td>13.</td>
<td>Nishtar Medical College, Multan</td>
</tr>
<tr>
<td>14.</td>
<td>Rawalpindi Medical College, Rawalpindi</td>
</tr>
<tr>
<td>15.</td>
<td>Quaid-e-Azam Medical College, Bahawalpur</td>
</tr>
<tr>
<td>16.</td>
<td>Punjab Medical College, Faisalabad</td>
</tr>
<tr>
<td>17.</td>
<td>Lady Wellinngdon Hospital, Lahore</td>
</tr>
<tr>
<td>18.</td>
<td>Lady Aitchison Hospital, Lahore</td>
</tr>
<tr>
<td>19.</td>
<td>Nishtar Hospital, Multan</td>
</tr>
<tr>
<td>20.</td>
<td>Punjab Institute of Cardiology, Multan</td>
</tr>
<tr>
<td>21.</td>
<td>Children Complex Multan</td>
</tr>
<tr>
<td>22.</td>
<td>DHQ Hospital, Rawalpindi</td>
</tr>
<tr>
<td>23.</td>
<td>Rawalpindi General Hospital, Rawal Pindi</td>
</tr>
<tr>
<td>24.</td>
<td>Holy Family Hospital, Rawalpindi</td>
</tr>
<tr>
<td>25.</td>
<td>Sheikh Zayed Hospital, Rahim Yar Khan</td>
</tr>
<tr>
<td>26.</td>
<td>BV Hospital, Bahawalpur</td>
</tr>
<tr>
<td>27.</td>
<td>DHQ / Allied Hospital, Faisalabad</td>
</tr>
<tr>
<td>28.</td>
<td>Faisalabad Institute of Cardiology, Faisalabad</td>
</tr>
<tr>
<td>29.</td>
<td>Mental Health Services, Lahore</td>
</tr>
</tbody>
</table>

### 6.4 Budget outlay:

There has been a sharp rise in health budget allocations in comparison with total provincial budget outlay. Health budget in comparison to total provincial outlay has doubled from 2006-07 (3.46%) to 2010-11 (8.20%). A further split of similar analysis into current and development budget also reveals consistent steep increasing trends from 2006-11 in both current and development budgets of the department as tabulated below:

<table>
<thead>
<tr>
<th>Descriptions</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Budget</td>
<td>10,691</td>
<td>15,288</td>
<td>22,947</td>
<td>34,572</td>
<td>47,581</td>
</tr>
<tr>
<td>Current Budget</td>
<td>6,047</td>
<td>8,854</td>
<td>13,415</td>
<td>22,547</td>
<td>22,801</td>
</tr>
<tr>
<td>Development Budget</td>
<td>4,644</td>
<td>6,435</td>
<td>9,533</td>
<td>12,025</td>
<td>24,780</td>
</tr>
<tr>
<td>Provincial Budget</td>
<td>338,194</td>
<td>393,487</td>
<td>417,000</td>
<td>489,873</td>
<td>580,287</td>
</tr>
<tr>
<td>Current Budget</td>
<td>191,378</td>
<td>243,487</td>
<td>257,000</td>
<td>314,873</td>
<td>386,787</td>
</tr>
</tbody>
</table>
6.5 Vision

Health Population with a sound health care system practicing health lifestyle, in partnership with private sector including civil society, which is effective, efficient and responsive to the needs of low socio-economic groups especially women in the reproduction age.

6.6 Health Indicators

The Millennium Development Goals (MDGs) provide an overall framework for improvement of health status of the population with more focus on reproductive health and communicable diseases responsible for major part of morbidity and mortality in the developing countries. The (MDGs) are a set of quantifiable and time-bound goals for improving the human condition by 2015. Health Department Punjab has adopted MDGs based health indicators:

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Targets</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>MDGs 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infant Mortality Rate per 1,000 live births</td>
<td>73</td>
<td>70</td>
<td>67</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>Maternal Mortality Ratio per 100,000 live births</td>
<td>232</td>
<td>225</td>
<td>218</td>
<td>140</td>
</tr>
<tr>
<td>3</td>
<td>Children fully immunized 12-23 months (%)</td>
<td>84</td>
<td>88</td>
<td>92</td>
<td>&gt;90</td>
</tr>
<tr>
<td>4</td>
<td>Delivery by Trained Birth Attendants (%)</td>
<td>52</td>
<td>57</td>
<td>62</td>
<td>&gt;90</td>
</tr>
</tbody>
</table>

Source: MTDF 2010-2013
### 6.7 Policy Objectives

<table>
<thead>
<tr>
<th>Policy Objective Number</th>
<th>Policy Objective Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reducing widespread prevalence of communicable diseases and strengthening preventive health care</td>
</tr>
<tr>
<td>2</td>
<td>Addressing inadequacies in primary and secondary health care and increased pro-poor health expenditure</td>
</tr>
<tr>
<td>3</td>
<td>Creation of Health Care Commission quality management, standardization and accreditation</td>
</tr>
<tr>
<td>4</td>
<td>Improving patient care facilities at tertiary care level</td>
</tr>
<tr>
<td>5</td>
<td>Provision of quality medical education</td>
</tr>
<tr>
<td>6</td>
<td>Providing and strengthening of allied health services</td>
</tr>
<tr>
<td>7</td>
<td>Strengthening of restructured Director General Health Services</td>
</tr>
<tr>
<td>8</td>
<td>Private sector involvement and mainstreaming</td>
</tr>
<tr>
<td>9</td>
<td>Improving governance at all levels and addressing systemic issues at macro level</td>
</tr>
</tbody>
</table>

Source: MTBF 2010-13

### 6.8 Punjab Health Policy Framework (Vision of the Chief Minister Punjab)

In order to ensure provision of quality health services with a pro-poor focus aimed at achieving the three health related MDGS; the Chief Minister (CM) has approved Punjab Health Policy Framework in January, 2009 which covers various health sector core areas as mentioned below:

**Governance & Larger Systemic Issues**

1. Capacity constraints & Systemic Weaknesses
2. Restructuring of the DGHS Office
3. Punjab Health Foundation (PHF) Restructuring
4. Ownership & Implementation of Reform
5. Private Sector Mainstreaming & Public-Private Partnerships
6. Creation of Punjab Health Care Commission
7. Medical Research
8. Standardization of Health Care adherence to Standard Operating Procedures (SOPs)
9. Upgradation of THQ & DHQ Hospitals
10. Job Descriptions (JDs) of Medics & Paramedics / Allied Health Sciences Professionals
11. Robust M&E System
12. Sub-Optimal Utilization of Equipment
13. Lack of adequate focus on Preventive Health Care
14. Integration of Vertical Programs
15. Planning & Development of Human Resource
16. Dissatisfaction among Doctors & Paramedics
17. Non-availability of Female Doctors
18. Emergency Services
19. Health Education & Awareness Campaigns
20. Erratic Supply of Drugs
21. Spurious Drugs
22. Mobile Health Units  
23. Referral System  
24. Sehat Sahulat Cards  
25. Early Childhood Care & Development (ECCD)

Tertiary Health Care Level  
1. Third Party performance Audits of Autonomous Medical Institutions (AMIs)  
2. Development of MSDS for Tertiary level Hospitals  
3. Quality Issues in Tertiary Care Service Delivery  
4. Pro-poor interventions at the Tertiary level (all levels to benefit essentially)  
5. Questionable quality of Medical Education  
6. Disruption of referral Chain  
7. Creation of Centers of Excellence within AMIs  
8. Social Health Insurance  
9. Healthcare of marginalized sections of society

Details of Punjab Health Policy Framework may be perused at Annexure -3 (Source: Special Secretary Health)

6.9 Preventive Programs  
Reducing wide spread prevalence of communicable diseases and strengthening preventive health care is Policy Objective -1 of the Health Department. For this purpose a number of preventive programs are under implementation in the province. Although federal government also give some financial and commodity assistance for these programs but it insufficient and interrupted. Health Department Punjab provides funds under recurrent and development budgets.

6.9.1 Expended Program of immunization (EPI)  
Over all vision of the program is that “all children and women are fully protected against vaccine preventable diseases and a polio free Punjab.”

The program was started in 1978 as pilot project which was further expended in 1983. It was integrated into regular health services in 1985. Its initial scope was vaccination against 6 preventable diseases of children. Later on 7th and 8th Vaccine of Hepatitis B & HIB were included in the program. Regular human resource as mentioned below is available for implementation of the Program.

<table>
<thead>
<tr>
<th>Posts</th>
<th>Health Department</th>
<th>Local Government</th>
<th>GAVI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSVs</td>
<td>29</td>
<td>10</td>
<td>0</td>
<td>39</td>
</tr>
<tr>
<td>CSVs</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>ASVs / ISVs</td>
<td>90</td>
<td>49</td>
<td>0</td>
<td>139</td>
</tr>
<tr>
<td>IVs</td>
<td>86</td>
<td>81</td>
<td>6</td>
<td>173</td>
</tr>
<tr>
<td>Vaccinators</td>
<td>3,121</td>
<td>541</td>
<td>200</td>
<td>3,862</td>
</tr>
<tr>
<td>CDC supervisor</td>
<td>900</td>
<td>0</td>
<td>0</td>
<td>900</td>
</tr>
<tr>
<td>Sanitary Inspector</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
<td>1,418</td>
</tr>
<tr>
<td>LHWs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>46,536</td>
</tr>
</tbody>
</table>

Source: DGHS office
This program is financed from following sources:

- Federal Government & development partners mostly provide commodity & technical assistance like Cold Chain equipment, Vaccines, Syringes, Training of Staff, funds for social mobilization and training of the staff. As mentioned in the above table LHWs are funded from the Federal Govt. out of National Program for PHC & FP.

- The Provincial Government provides assistance out of its development funds through EPI projects. In the past GAVI has also been providing assistance to the program through provincial government funds. The detail of allocations & expenditures under the ADP Punjab is as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation Rs. Million</th>
<th>Increase/(Decrease) %</th>
<th>Expenditure Rs. Million</th>
<th>Increase/(Decrease) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>70</td>
<td>-</td>
<td>69.288</td>
<td>-</td>
</tr>
<tr>
<td>2007-08</td>
<td>233</td>
<td>233 %</td>
<td>172.5</td>
<td>149 %</td>
</tr>
<tr>
<td>2008-09</td>
<td>146.53</td>
<td>(37)%</td>
<td>39.621</td>
<td>(77)%</td>
</tr>
</tbody>
</table>

Trend showing yearly percentage increase/(decrease) in the allocation and expenditure is as under:

![Year-wise Allocation & Expenditure EPI Program](image-url)
District Government provides funds for human resource as mentioned above except LHWs.

6.9.2 Prevention and Control of Hepatitis Program

Hepatitis B & C have emerged as major public health problem in the country. It has been estimated that every 13th Pakistani is potentially infected with either Hepatitis B or C. According to estimates, overall prevalence of hepatitis B & C is 3-4 percent and 6-8 percent respectively in Pakistan. It is presumed that more or less similar situation prevails in the Punjab.

Keeping in view the federal government started a Hepatitis Control program which continued for about 5 years. This project was not sufficient to address the magnitude of problem therefore government of the Punjab started its own program with the name of Comprehensive Hepatitis Control program which remained under implementation form 2006-07 to 2009-10. After expiry of project period the government of Punjab started another project namely Prevention and Control of Hepatitis in 2009-10. The objectives of the program as under:

1. Control the transmission of Hepatitis B and C
2. Reduce the mortality caused by the diseases
3. Provide free treatment to the poor and deserving patients.
4. Educate and create awareness about the mode of transmission of disease.
5. Capacity building through orientation and training of health professionals.
6. Consolidate the Hospital Waste Management Systems in all Sentinel Sites / District Headquarter Hospitals in the Punjab.
7. Strengthen laboratory and screening facilities in the Punjab.
8. Provide free Hepatitis B Vaccination to the high risk group in the Punjab.

- Activities
  1. Hepatitis B Vaccination to infants and high risk groups (ongoing).
  2. Increase awareness among the public by using all channels of communication.
  3. Develop, produce and disseminate Health Education Material.
  4. Arrange Training Workshops for physicians, pathologists and medical superintendents.
  6. Provide medicine, vaccine, lab consumables, regents, safety boxes and syringe cutters etc.

- Components
  1. Hepatitis B Vaccination
  2. Provision of Immunoglobulin
3. Treatment and management.
4. Screening & Improved Diagnosis
5. Hospital Waste Management
6. Training & Capacity Building
7. Printing and Publication
8. Mass awareness
9. Project Management

This program is financed from the following sources:

- Federal government mostly provides commodity assistance like Vaccines, Syringes and small management unit for implementation of its project in the Punjab. This source is now becoming dry as the project is at its end. However, the federal government is providing vaccine for 20,000 persons against prevention of Hepatitis B and medicine for treatment of 2000 hepatitis C patients this year.

- The Provincial government provides funds for the components mentioned above through ADP. Allocations and expenditure of fund during the last years for this program is as under:

![Year-wise Allocation & Expenditure Hepatitis Control Program](image)

**Figure 2**
Trend showing yearly percentage increase/(decrease) in the allocation and expenditure is as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation Rs. Million</th>
<th>Increase/Decrease %</th>
<th>Expenditure Rs. Million</th>
<th>Increase/Decrease %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>20</td>
<td>-</td>
<td>19.683</td>
<td>-</td>
</tr>
<tr>
<td>2007-08</td>
<td>25.575</td>
<td>28 %</td>
<td>23.167</td>
<td>18 %</td>
</tr>
<tr>
<td>2008-09</td>
<td>140</td>
<td>447 %</td>
<td>126.94</td>
<td>448 %</td>
</tr>
<tr>
<td>2009-10</td>
<td>276.23</td>
<td>97 %</td>
<td>132.222</td>
<td>4 %</td>
</tr>
<tr>
<td>2010-11</td>
<td>300</td>
<td>9 %</td>
<td>----</td>
<td>-</td>
</tr>
</tbody>
</table>

- District governments implement the program through their secondary care facilities (THQ & DHQ hospitals). The expenditure on the part of district government is on human resource and services of health facilities.

6.9.3 Provincial Tuberculosis Control Program Punjab

Pakistan ranks 8th amongst the 22 high disease burden countries in the world. It has 44% of total caseload of Eastern Mediterranean Region (EMR). According to estimates about 300,000 new cases are added each year. In Punjab it is estimated that all type of TB cases are 167,799(@181 per 100000) and NSS (+ve) 75,092(@81 per 100000). ¼ of total disease burden of EMRO region is borne by Punjab.

- Diagnostic and treatment arrangements

<table>
<thead>
<tr>
<th>No of Districts</th>
<th>Total Population</th>
<th>No. of Diagnostic Centers</th>
<th>No. of Treatment Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>94.6 Million</td>
<td>543</td>
<td>2889</td>
</tr>
</tbody>
</table>

- DOTS Strategy:

Following are the 5 components of DOTS

- Political commitment
- Diagnosis by microscopy
- Adequate supply of the right drugs
- Directly observed treatment
- Accountability

- Targets & Achievements

<table>
<thead>
<tr>
<th>Case Detection Rate New Smear Positive Case</th>
<th>Targets</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Success Rate at least Default Rate</td>
<td>70%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>&lt;5%</td>
<td>4%</td>
</tr>
</tbody>
</table>
• **Resource allocation**
  - National T B Control program (NTP)
    Like other programs the federal government provides resources in shape of commodities and technical assistance. The program also receives resources from various development partners like WHO, Global Fund for TB, Malaria and AIDS (GFTMA).
  - Provincial TB Control Program (PTP)
    The Punjab government is committed to eradicate TB in the province. It provides substantial funds through its development program. Allocation and expenditure during last years are as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation Rs. Million</th>
<th>Increase/Decrease</th>
<th>Expenditure Rs. Million</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>65</td>
<td>-</td>
<td>55.142</td>
<td>-</td>
</tr>
<tr>
<td>2007-08</td>
<td>200</td>
<td>208 %</td>
<td>177.949</td>
<td>223 %</td>
</tr>
<tr>
<td>2008-09</td>
<td>189.21</td>
<td>(5)%</td>
<td>134.32</td>
<td>(25)%</td>
</tr>
<tr>
<td>2009-10</td>
<td>50</td>
<td>(74)%</td>
<td>45.984</td>
<td>(66)%</td>
</tr>
<tr>
<td>2010-11</td>
<td>100</td>
<td>100 %</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>
6.9.4 Malaria Control Program in the Punjab

Overall objective of the Program is to reduce malaria morbidity and eliminate malaria mortality by keeping malaria under effective control so that it does not become a major public health/socio-economic problem. There is a long history of Malaria Programs in the Punjab. It was started during sixties and still under implementation with different designs and components. Brief description of these programs is as under:

- Malaria Eradication Program – 1960-1971
- Malaria Control Program – 1971-2002
- Roll Back Malaria Program – 2002 to date

Available data for reveal that Malaria endemicity in the province fluctuated during 1961 to 2007 between hypo- to meso-endemicity levels during “normal” years and was subjected to “regional” malaria epidemics with periodicity of 5-8 years. The highest malaria incidence was reported in 1974 (API 9.44%), reducing to very low level in 1977-1980. Next increase in malaria incidence occurred in 1984 (API 1.35%) and in 1992 (API 0.99%), thereafter and up to now the incidence was demonstrating steady declining trend, reaching API 0.02% in 2006.

Slide Positive Rate (SPR) was following the similar pattern, being 21.0% in 1972, declining to 0.5% in 1979, increasing to 2.5% in 1984 and to 3.6% in 1992, and thereafter showing ever declining trend to 0.07% in 2006.

(Source: Situation Analysis Of Malaria Situation in the province of Punjab by Dr. Anatoly Kondracshine, WHO Consultant)

Malaria is now rapidly emerging as a big public problem in flood affected area of the Punjab.

Strategies of Malaria Control Program in the Punjab are in line with the principles of the Global Malaria Control Strategy i-e within the framework of the Roll Back Malaria:

- Early detection and prompt treatment at the health facilities and in the community
- In keeping with the reduced reliance on the use of insecticide, to restrict selective deployment of the IRS in well defined malaria endemic areas
- Strengthening disease surveillance and malaria outbreaks response

Major anti malaria activities include the following:
- Case detection (ACD, PCD and MBS)
- Treatment of cases
- Availability of malaria diagnosis facilities at various levels of health system, with in-built system of reference laboratories at district and provincial level
- Surveillance activities including monitoring and evaluation
- Vector control activities, including the IRS, fogging, larval control, limited use of mosquito nets
- Malaria information system
• Social mobilization and health education

Following indicators are used to evaluate the success of malaria control program in the province:
• Annual Parasite Incidence (API)
• Slide Positive Rate (SPR)
• Annual and Monthly Blood Examination Rates (ABER, MBER)
• % of *P.falciparum* cases to total malaria cases
• Vector density per room, animal shade in sentinel sites and in areas under IRS

This program is financed from following sources:
• Federal Government & Development Partners provide mostly commodity assistance and training outs of its development budget and assistance received from different donor agencies.
• The districts contribute substantially in shape of outreach workers (CDC Supervisors) and districts supervisory staff

The detail of allocations & expenditures under the annual development budget in Punjab during last financial years is as under:

![Year-wise Allocation & Expenditure Malaria Control Program](image-url)

*Figure 4*
Trend showing yearly percentage increase/(decrease) in the allocation and expenditure is as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation Rs. Million</th>
<th>Increase/Decrease</th>
<th>Expenditures Rs. Million</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>20</td>
<td>-</td>
<td>6.067</td>
<td>-</td>
</tr>
<tr>
<td>2007-08</td>
<td>10.868</td>
<td>(46)%</td>
<td>7.724</td>
<td>27%</td>
</tr>
<tr>
<td>2008-09</td>
<td>16.5</td>
<td>52%</td>
<td>11.851</td>
<td>53%</td>
</tr>
<tr>
<td>2009-10</td>
<td>30</td>
<td>82%</td>
<td>2.844</td>
<td>(76)%</td>
</tr>
</tbody>
</table>

7. Analytical Framework

The Medium Term Budgetary Framework (MTBF) is an approach to budgeting that integrates policy making, planning and budgeting within a medium term framework. According to decision taken by the federal cabinet on 21st January 2009, the Ministry of Finance is implementing MTBF to strengthen the budget process and make it more responsive to achieve the strategic objectives of the government. Hence, MTBF is now a countrywide budgetary format.

It was observed that there was a substantial gap between the goals/objectives of Punjab government and budgetary practices in the province. Annual incremental budgeting was unable to deliver the desired results. In order to address this gap, Medium Term Budgetary Framework (MTBF) has been adopted. MTBF is briefly describes as under:

- MTBF is a multi-year approach to budgeting
- It introduces a three year perspective in the Punjab towards planning and budget preparation
- Assists in relating spending to policies and objectives

Government of the Punjab (GoPb) is committed to bring meaningful reforms in public sector financial management. For this purpose “Punjab Government Efficiency Improvement Programs” has been introduced with the assistance of Asian Development Bank (ADB). Punjab Resource Management Program (PRMP) includes Medium Term Budgetary Framework (MTBF).

Medium Terms Budgetary Framework (MTBF) & Medium Term Development Framework (MTDF) is under implementation is in 5 line departments of Government of the Punjab. Initially, Medium Term Budgeting was started in 2009-10 (as the first year) in irrigation & Power and Health Departments. MTBF has now been rolled out in 3 more line departments i.e. Excise and Taxation, Livestock & Dairy Development and Higher Education Departments in 2010-2013.

It may be pertinent to mention that Punjab is the first province in the country to adopt MTBF approach even before introduction of this concept in the federal government.
Mandate of this study is to review the links between Health Department policy objectives and its budgets and expenditures. Analytical Framework and review is based on:

1. Clarity in provincial health policy and policy objectives.
2. Challenges and issues confronting the health department.
3. Prioritization of policy objectives for allocation of funds in the budget under some defined criteria instead of subjective and discriminatory judgment.
5. Effect of MTBF/MTDF.

8. Analysis

8.1 Policy and Policy objectives

Formulation of health policy is mandate of federal government. The existing Health policy was approved by the federal ministry of health in 2001 which is in practice in the country. A draft of revised health policy was prepared in 2009 which still requires approval of competent authority. Health department Punjab has derived its policy objectives from the National Health Policy with some context specific amendments. Health Department Punjab has adopted 9 policy objectives for making allocations in the current and development budgets.

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Policy Objective</th>
<th>Budget Estimates</th>
<th>Budget Estimates</th>
<th>Budget Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2009-10</td>
<td>2010-11</td>
<td>2011-12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current</td>
<td>Develop</td>
<td>Current</td>
</tr>
<tr>
<td>1</td>
<td>Reducing widespread prevalence of communicable diseases and strengthening preventive healthcare</td>
<td>0.0%</td>
<td>8.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2</td>
<td>Addressing inadequacies in primary and secondary health care and increased pro-poor health expenditure</td>
<td>2.6%</td>
<td>68.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>3</td>
<td>Creation of Health Care Commission quality management, standardization and accreditation</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>4</td>
<td>Improving patient care facilities at tertiary care level</td>
<td>75.0%</td>
<td>13.4%</td>
<td>77.3%</td>
</tr>
<tr>
<td>5</td>
<td>Provision of quality medical education</td>
<td>16.2%</td>
<td>5.1%</td>
<td>16.5%</td>
</tr>
<tr>
<td>6</td>
<td>Providing and strengthening of allied health services</td>
<td>0.5%</td>
<td>1.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>7</td>
<td>Strengthening of restructured Director General Health Services</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
1. Reducing prevalence of communicable diseases and strengthening preventive care is policy objective-1. This is also MDG-6. Allocation under policy objective is too small as compared to other policy objectives. The allocation varies from 9% to 15% in the development budget whereas nothing has been provided in the current budget. The preventive programs have been discussed in detail in the preceding paragraphs (Overview of Health department) which include background, program areas, targets, allocations and expenditures.

2. The primary and secondary health care facilities fall under the jurisdiction of district governments. These facilities were not in very good conditions. The district governments were not able to make adequate improvement due to financial constraints. The Punjab government provided substantial amount of funds for addressing inadequacies in primary and secondary health care and increase pro-poor expenditures. This funding is being made under Chief Minister’s Accelerated Program for health care. The allocation for this program varies from 0.2% to 2.6% of current budget and 17.9% to 68.1% in development budget during the period 2009 to 2011. The Punjab government has prepared MSDS for up- grading the facilities in a uniform patron. The MSDS is not fully implemented despite huge investment has been done for MSDS in shape of technical assistance.

3. Private health sector is rapidly expanding in terms of coverage, quality and use of high technology. In order to ensure quality, standards and regulate the health sector a “Health Care Commission” has been constituted through legislation. This will help in improvement of quality of care at bear minimum levels. For implementation of this intervention 0.2% to 0.6% of development budget has been allocated. No allocation has been made in Current budget. Progress on implementation of Health Care Commission initiative is considerably slow.

4. All the patients from primary and secondary levels are referred to the tertiary care level. The patients visiting tertiary care facilities need highly skilled professionals, high tech equipment and procedures. Prime emphasize of government is on this policy objective which is evident from the huge allocations in this area. As mentioned in the above table 75% to 77% of current budget while 13% to 46% of development budget is allocated to this policy objective.

5. Medical education in the Punjab includes training of doctors, nurses, paramedics and allied services staff. Private sector is also started contributing in this area. The Punjab government is spending a lot of amount, The allocation of current budget ranges from 16.2% to 16.5% and 5.1% to 27% percent of development budget. Despite huge investment, no human resource plan has been prepared.
6. Providing and strengthening of allied services is policy objective-6 for MTBF/MTDF. Allied services include medical equipment workshop, govt. transport repairing workshop, drug testing laboratory and Govt. Public analyst laboratory etc. This area remained neglected in the past. The allocation in MTBF/MTDF 2010-2012 appears to be meager. Allocation in the current budget is 0.5% and in the development budget it ranges from 0.4% to 1.9%.

7. The Directorate General of Health Services (DGHS) is an attached functional unit of the provincial Health Department, which used to be responsible for field operations in the districts using its vertical administrative hierarchy. After introduction of Devolution in 2001, there has been a major shift in the role of DGHS. It was observed that corresponding changes in its organizational setup were required. The GoPb approved proposal for restructuring of DGHS office in 2008. It was further decided that restructured setup of DGHS office would be strengthened. For this purpose following Steering Committee was notified by Secretary Health on 24-11-2008.

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Designation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Special Secretary, Health</td>
<td>Chairman</td>
</tr>
<tr>
<td>2.</td>
<td>Director General Health Services, Punjab</td>
<td>Member</td>
</tr>
<tr>
<td>3.</td>
<td>Program Director, HSRP, Health Department</td>
<td>Member</td>
</tr>
<tr>
<td>4.</td>
<td>Additional Secretary (Development), Health Department</td>
<td>Member</td>
</tr>
<tr>
<td>5.</td>
<td>Additional Secretary (Technical), Health Department</td>
<td>Member</td>
</tr>
<tr>
<td>6.</td>
<td>Director, B&amp;A, O/o DGHS Punjab</td>
<td>Member</td>
</tr>
</tbody>
</table>

The progress on this policy objective is negligible as the above mentioned committee has not completed its task. As far as budget provision is concerned it is about 0.65% in the current budget whereas it ranges from 0.3% to 0.6% in the development budget.

8. Private sector involvement and mainstreaming is policy objective 8. Public health sector cannot meet with the demand for health care services. There is a need to also join hands with the private sector. According to a safe estimate about 80% of curative health is managed by the private sector. Health Department, Punjab is emphasizing on this issue and provision has been made in the budget. The budget provision varies between 4.4% to 5.3% in the current budget and 2.3% to 6.0% in the current budget.

9. Improving governance at all levels and addressing systematic issues at macro level is policy objective-9 of health sector. This is most difficult area because a number of reforms and initiatives are needed. No budget provision neither in current nor in development budget has been made in this policy objective.

The following diagrams show policy objective wise MTBF / MTDF budgetary outlay for the years 2009-10 to 2011-12. The budget provisions reveal that major share goes to policy objective-4 (Improving patient care facilities at tertiary care level), policy objective-2 (Addressing inadequacies in primary and secondary health care and increased pro-poor health expenditure) and policy objective-5 (Provision of quality medical education). The remaining policy objectives receive minimum share of allocation.
Figure 5

Policy Objective Wise Allocation (2009-2010)

Figure 6

Policy Objective Wise Allocation (2010-2011)
Prima facie, it appears that there is no change in the structure of MTBF/MTDF because same budget lines and allocation have been maintained as they were followed prior to the introduction of new budget format.

Policy issues have further been considered in the health department and an extensive list has been prepared as a vision of “Chief Minister Punjab”. The issues are quite relevant and fall within overall National Health Policy Framework but there is no time bound plan for addressing these issues. There is no documentary evidence for tracking progress of these issues or policy objectives. Awareness about policy objectives is quite limited in the health department even in higher hierarchical level (Secretariat and DGHS office). Gender related issues particularly gender main streaming is not part of 9 policy objective, however, it has slightly been touched in the “Chief Minister Vision”. One gender specialist is working in the health department. She is not employee of Health Department. Social Welfare Department, along with some departments, has deputed her under GRAP project. She was previously working in the Civil Secretariat, Health Department. She has now been directed to sit in the PHSRP. She has developed a “Gender Action Plan” which is placed as Annexure-4. There is little probability of implementation of this plan in the present situation.

There is no institutionalized arrangement in the health department to review and revised the policy objectives in the light of emerging challenges, epidemiology, governance, financial constraints, prioritization in funding process, human resource issues and gender mainstreaming.
8.2 Challenges and Problems;
Health Department Punjab is facing enormous challenges and problems. During the interviews with the stakeholders these challenges were discussed in detail. Main challenges being faced by the health department are as under:

8.2.1 Planning Capacity
Planning capacity in the department is limited despite a full fledge Planning Cell or Development Wing is in place. The Planning Cell or Development Wing is underutilized in the present shape. Major projects either are prepared by the consultants or by the end users (Districts or institutions). Health Department has now introduced a new initiative i.e. to outsource the project for their completion on turnkey basis. It is an innovative idea but it is not an easy task. Tremendous multi skill capacity (Health Planners, Architects, Engineers, Health Managers and Medical Equipment Experts) is required to scrutinize the proposals and monitoring of the projects implementation/ completion.

Districts are most important tier of management with regard to the implementation of programs and delivery of health services. Planning capacity in the districts is also very weak. One thing is, however, encouraging that one post of Statistical Officer has been created in each district. The statistical officers have also been designated as Planning Officers.

8.2.2 Financial Constraints:
Financial constraints have been perceived as a major challenge for implementation of priority programs. The recent flood has further deepened the problem as the funds are being diverted from ADP to the flood affected areas.

8.2.3 Human Resource:
Health is a highly complex sector as compared to others. Variety of staff is needed for managing the health services. A number of training institutions are working in public and private health sector. These are producing manpower such as medics, Paramedics, nurses and allied services staff for managing the health services. Consistency in human resource policy is lacking about required numbers in the future, quality of professionals and skill mix. There is no human resource plan to exactly know the current and future requirement of various trained staff for health services in public and private sector. Private sector is now much vibrant in production of human resource for health sector. Quality of training in the private sector is a big question mark.

Over production may be as serious as deficiency of human resource because it creates frustration in the society when educated people are in search of jobs and they are not getting. Furthermore, there is no clear policy and plan for in-service training. Some of the persons are getting the similar trainings time and again where as others are deprived of it. Resultantly, when the staff is transferred either they are over trained in some particular area or they have a little concept about their new assignment.
Government of Punjab has developed job descriptions for the staff with the assistance of PDSSP but no serious effort has done for implementation of the JDs. There is no mechanism to judge the performance of staff against the defined JDs. Substantial incentives have been given to primary health care (PHC) staff under PHSRP and Punjab Rural Support Program (PRSP). The staff is not fully satisfied with their job conditions and environments resultantly department is facing continuous brain-drain. There are serious concerns over personal and career development.

8.2.4 Health System:
The health system is neither need-base nor demand oriented to respond the emerging challenges in the service delivery. It has a number of weaknesses in terms of administrative/ financial management, supervision, monitoring & evaluation. Health managers are taken from the pool of general cadre of the doctors. They are not professionally trained in management. There is no training plan for required training of health managers to enable them to perform their assigned managerial tasks.

It is a fact that most of the MTBF work for the financial years 2009-10 and 2010-11 has been done by the consultants. During the interviews with the stakeholders, it has been observed that understanding about MTBF and MTDF is quite high among the concerned functionaries of the department. They are confident that they would be able to prepare and implement the MTBF and MTDF in the incoming years. Nevertheless, they are of the view that it is a new concept and continuous refresher trainings are required. Health Department has planned to establish a Financial Management Cell (FMC). Major functions of this cell would to manage all the budgetary and financial matters within the framework of MTBF and MTDF. The staff for purpose has not so far been created and posted. The delay is perhaps on the part of Finance Department.

8.3 Program prioritization;
The program prioritization should base on challenges / problems, policy objectives and expected future resources. There should be some criteria for program or intervention prioritization keeping in view the magnitude, severity, cost effectiveness and viability of interventions. Although priority programs have been designed and funded in line with the policy objectives, and priority area. This exercise appears to be based on subjective judgment and under the influence of the more powerful stakeholders in the department. Allocations to the tertiary care is a good example in this regard.
8.4 **Budgetary and Expenditure Trends**

The analyses of budgetary trends have been divided into Development budget (MTDF) and Current budget (MTBF). In case of development budget actual figures of revised allocations, releases and expenditures have been obtained from the Planning Cell/ Development Wing of Health Department. The Development budget is provided under different sub-sectors. Details of sub-sector wise allocation, releases and expenditures for last years from 2005-06 to 2010-11 is mentioned as under:

<table>
<thead>
<tr>
<th>Sub-Sectors/ Ongoing Programs</th>
<th>Year 2005-06</th>
<th>Year 2006-07</th>
<th>Year 2007-08</th>
<th>Year 2008-09</th>
<th>Year 2009-10</th>
<th>Year 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Program</td>
<td>501</td>
<td>469</td>
<td>458</td>
<td>800</td>
<td>678</td>
<td>660</td>
</tr>
<tr>
<td>Health Sector Reforms Program</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>484</td>
<td>484</td>
<td>467</td>
</tr>
<tr>
<td>Tertiary Care Hospitals</td>
<td>1598</td>
<td>1598</td>
<td>1589</td>
<td>2032</td>
<td>2032</td>
<td>1902</td>
</tr>
<tr>
<td>Medical Education</td>
<td>172</td>
<td>172</td>
<td>166</td>
<td>431</td>
<td>431</td>
<td>420</td>
</tr>
<tr>
<td>Research &amp; Development</td>
<td>20</td>
<td>20</td>
<td>9</td>
<td>0.29</td>
<td>0.29</td>
<td>0.00</td>
</tr>
<tr>
<td>Chf Minister's Accelerated Program</td>
<td>510</td>
<td>510</td>
<td>245</td>
<td>622</td>
<td>622</td>
<td>600</td>
</tr>
<tr>
<td>Supplemenary</td>
<td>199</td>
<td>199</td>
<td>185</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3499</td>
<td>3467</td>
<td>3152</td>
<td>4369</td>
<td>4247</td>
<td>4049</td>
</tr>
</tbody>
</table>
The following diagrams show budgetary trends under different sub-sectors wise allocations.
Figure 10

Year-wise Allocation
(2005-2011)

Figure 11

Year-wise Releases
(2005-2010)
8.5 **Current Budget / Non Development Budget**

The data for non-development budget has been taken from Estimates of Charged Expenditure and Demands for Grants (2005-06 to 2009-10). In this regard revised estimates have been followed. Despite best efforts the consultants could not get expenditure of current budget from the health department. The current budget has been divided into five main functions. Allocation against each function during the years 2005-10 has been given as under. The following table provides function wise five years details.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gen Hospital Services</td>
<td>4937</td>
<td>8286</td>
<td>7704</td>
<td>15629</td>
<td>17943</td>
</tr>
<tr>
<td>2</td>
<td>Mental Hospital</td>
<td>136</td>
<td>160</td>
<td>183</td>
<td>264</td>
<td>321</td>
</tr>
<tr>
<td>3</td>
<td>Chemical Labs</td>
<td>45</td>
<td>55</td>
<td>53</td>
<td>62</td>
<td>48</td>
</tr>
<tr>
<td>4</td>
<td>Administration</td>
<td>293</td>
<td>559</td>
<td>435</td>
<td>915</td>
<td>3794</td>
</tr>
<tr>
<td>5</td>
<td>Universities/Colleges</td>
<td>112</td>
<td>433</td>
<td>479</td>
<td>608</td>
<td>905</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>5522</td>
<td>9494</td>
<td>8854</td>
<td>17479</td>
<td>23010</td>
</tr>
</tbody>
</table>

Source: Estimates of Charged Expenditure and Demands for Grants (2005-06 to 2009-10)
The allocations show that major portion of the budget goes to General Hospital Services. This function is mainly consist of tertiary care hospitals except a few secondary care services facilities. The trend is constant and there is no change even introduction of MTBF budget format which is mainly based allocation against policy objectives. The following diagrams figures demonstrate year-wise trend based on percentage.
Function-wise Allocation of Recurrent Budget Year 2006-07

- Gen Hospital Services: 87%
- Administration: 6%
- Chemical Labs: 1%
- Mental Hospital: 2%
- Universities/College: 4%

Figure 14

Function-wise Allocation of Recurrent Budget Year 2007-08

- Gen Hospital Services: 87%
- Administration: 5%
- Chemical Labs: 1%
- Mental Hospital: 2%
- Universities/College: 5%

Figure 15
Function-wise Allocation of Recurrent Budget Year 2008-09

- Gen Hospital Services: 89%
- Administration: 5%
- Chemical Labs: 0%
- Mental Hospital: 2%
- Universities/College: 4%

Figure 16

Function-wise Allocation of Recurrent Budget Year 2009-10

- Gen Hospital Services: 78%
- Administration: 17%
- Chemical Labs: 0%
- Mental Hospital: 1%
- Universities/College: 4%

Figure 17
The following figures demonstrate the trend of budget allocation for General Hospital Services from the year 2005-06 to 2009-10. The trend is constantly increasing.

**Figure 18**

The following figures demonstrate the trend of budget allocation for Special Hospital Services (Mental Hospital) from the year 2005-06 to 2009-10. The trend is constantly increasing.
The following figures demonstrate the trend of budget allocation for Chemical Examiner and Laboratories from the year 2005-06 to 2009-10. The trend is variable.

![Year wise Allocation for Chemical Examiner and Laboratories](image)

**Figure 20**

The following figures demonstrate the trend of budget allocation for Administration from the year 2005-06 to 2009-10. The figure shows that the trend is variable, particularly in the year 2009-10 there is sharp jump.

![Year wise Allocation for Administration](image)

**Figure 21**
The following figures demonstrate the trend of budget allocation for Professional/Technical/Universities/Colleges from the year 2005-06 to 2009-10. The trend is constantly increasing.

![Year wise Allocation for Professional/Technical/Universities/Colleges](image)

### Figure 22

#### 8.6 Effect of MTBF/MTDF

The MTBF/MTDF was started from last financial year 2009-10 and current year is its second year. The effect of the program can ideally be measured with input indicators, process indicators, output indicators, outcome indicators and lastly impact indicators. Due to short time of implementation period input, process and output indicators can be used to judged the effect of MTBF/MTDF, if data is available. The budgetary trend analysis shows that there is no difference of budget allocations in different areas, functions and policy objectives before and after introduction of MTBF, MTDF concept. The details of output indicators during for last two years are not available. District Health Information System (DHIS) could be good source for providing health service delivery indicators. In the present situation DHIS cannot be used for this purpose. The DHIS was started in September 2009 and its performance report upto December 2009 is available which falls the first year of MTBF/MTDF. The performance cannot be compared with the previous years as the DHIS was not in place. The report of DHIS beyond 01-01-2010 has not so far been finalized as such comparison is not possible with regard to service delivery situation or output indicators. Indicators with regard to implementation of MTBF/MTDF are not also available. However, during the interviews with the stakeholders it was informed that the MTBF/MTDF would definitely be helpful in better financial discipline, control and transparency. The new system is successfully implemented in the health department. In the proceeding paragraphs, the monitoring mechanism to judge the performance has been indicated.
8.7 Performance and Monitoring Framework

Performance is assessed through monitoring. The monitoring involves collecting, analyzing, and reporting data on inputs, activities, outputs, outcomes and impacts as well as external factors, in a way that supports effective management. It provides managers, decision makers and other stakeholders with regular feedback on progress in implementation and results; as well as early indicators of problems that need to be corrected. It usually reports on actual performance against what was planned or expected. There is no built-in monitoring mechanism for assessing the performance of MTBF and MTDF.

During the interviews with the stakeholders monitoring of programs particularly MTBF/MTDF was discussed in detail. It was overall agreement that it is a weak area and needs attention. There is no organization which could monitor MTBF/MTDF as whole. Following components could be essentially part of monitoring mechanism:

- Financial reporting including current and development budgets to assess the expenditure against the allocations and effective financial discipline
- Outputs of spending in quantitative and qualitative terms
- Process review to rectify the operational shortcomings
- Impact on service delivery. For this purpose DHIS and Key Performance Indicators (KPIs) may be useful.

9. Recommendations

1. Policy and policy objectives are not something static. They should be amended and reset with the changing situation. The objectives should not only be clearly defined but also be widely disseminated among the stakeholders. It would create ownership and help in better implementation of these objectives. Presently, there is no institutionalized arrangement to deal with policy and policy objectives. A small nucleus may be created at secretariat level (Preferably in planning cell) or at PHSRP. Existing staff may be used for this purpose and hiring of additional staff is not required. This unit may periodically review the existing policy objectives and their implementation status. However the staff designated for this purpose may be given necessary training on policy formation, policy objectives, its linkages with budget allocation and impact of funding on the overall health service delivery.

2. Planning capacity in the department is limited. A planning cell or development wing is working at secretariat level. This wing is heavily staffed. The staff consists of one Additional Secretary (Development), one Chief Planning Officer, three Senior Planning Officers, five planning officers along with support staff member. This cell needs to be restructured with clearly defined functions and Jobs description of each staff. Their performance should be judged against the job description. Except one or two, in-service training has not been given to the staff which is also a reason for ineffective planning cell. A training plan may be developed including nature of training, duration of
training, place of training for each staff member to make them a useful part of health department.

3. The office of Director General Punjab is an important part of provincial tear. Its function is to provide guidance, technical support and supervision on health care activities being delivered in the districts. This office has been restructured and new designations have been created replacing the old one. After restructuring of this office one post of Director Development and another post of Additional Director (Monitoring) have been created. This unit needs capacity building. It is important to mention that capacity development of DGHS office should be viewed as a whole with specific focus on providing support in health planning, budgeting implementation and monitoring of health services.

4. One post of statistical officer has been created at each district who has also been nominated as planning officer. In order to strengthen the planning capacity at district level, adequate training may be given to the statistical officers/planning officers along with their statistical assistant.

5. Provincial Health Development Centre (PHDC) and District Health Development Centers were established to meet the training requirements of Health Department. The efficiency of these institutions is not up to the mark. An extensive review with regard to their staffing structure organizational mandate is required to increase their efficiency.

6. Technical Assistance Management (TA Management) is one of the important area. During nineties and onwards, a huge amount of TA was provided by different donors. The fundings and recommendations were hardly considered for implementation. The reports/studies have either been put in the shelves or disappeared. TA management unit may be created to develop TORs of the assignments, over see the work of consultants and prepare recommendations on implementation of TA funding/recommendations.

7. Prevention of disease is one of the most important policy objective of in the health sector. The program is confined to the control of communicable diseases. Epidemiological trends show that magnitude of communicable and non-communicable diseases is almost same in Pakistan. Moreover, magnitude of non-communicable diseases is gradually increasing due to multiple reasons including changes in the lifestyle. There should be a comprehensive disease prevention program with due allocation of funds. For this purpose scope and extent of policy objective one may be revisited and reviewed.

8. Under the 18th amendment in Constitution of Pakistan, the functions included in the concurrent list are now under transfer to the provinces. Health is one of area to be transferred to the Punjab province. This is a good opportunity for making preparation. MTBF/MTDF are 3 years budgetary program. The functions/activities to be transferred to the Punjab should be placed under MTBF/MTDF umbrella and policy objectives may be review if necessary.
9. Another change is taking place. Punjab government is promulgating new local government laws. Resultantly, there will be shifting of some powers/functions to the divisional and provincial tier. While preparing the MTBF / MTDF for next year, this aspect should be taken into account.

10. Private health sector is vibrant and rapidly growing in the province. Health department should consider to change its role from service provider to regulator so that quality of care is ensured and interests of consumers are protected. For this purpose “Health Care Commission” may be fully activated and made operational.

11. Financial Management Cell (FMC) would be established in the Secretariat. The cell should deal with the financial and budgetary matters. FMC staff, whenever, is deployed should be given an extensive induction training.

12. All the budget provisions should be part of the MTBF/MTDF. For example, huge amount have been released as tranche one ($50 Million) and tranche two ($75 Million) under ADB funded Punjab Millennium Development Goal Program (PMDGP) for onward transfer to the districts as tied grant for upgradation of MNCH services. This amount should also be reflected in MTBF or MTDF under the existing policy objective or a new policy objective regarding upgradation of MNCH services may be added.

13. Most of the work on MTBF/MTDF has been done through the external support (consultants). It is now second year of the program. If the external support is withdrawn, it may be difficult for the department to continue it. A capacity building plan may be developed which should include refresher trainings and hands on support.

14. The policy objectives have been funded on last year’s trends. Significance of each policy objective needs to be defined. Some criteria should be evolved for program prioritization and allocation of funds to each policy objective according to their significance. This will lead to adoption of MTBF/MTDF strategy in real term.
## Annexure-1

### STAKEHOLDERS INTERVIEWS

Name of interviewee  :  

Designation  :  

Date of interview  :  

<table>
<thead>
<tr>
<th>SNO</th>
<th>Questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Has the Health Department Punjab defined provincial health policy or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Health Policy is being followed?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>When the provincial health policy was finalized?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>What are provincial policy objectives?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Does the health department have some institutionalized arrangements for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>policy formation and implementation?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>What arrangements do you suggest to ensure health policy implementation?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Does the health policy implementation is properly addressed in budget</td>
<td></td>
</tr>
<tr>
<td></td>
<td>formation process under MTDF mode?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Is gender mainstreaming a part of health policy?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Was the health policy properly disseminated?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>What are the main issues / challenges confronting the health sector Punjab?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Have the priority program selected according to the issues?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Whether the activities have appropriately been designed in the priority programs?</td>
<td></td>
</tr>
</tbody>
</table>

### Issues and Challenges

<table>
<thead>
<tr>
<th>SNO</th>
<th>Questions</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Do you think MTBF provide solution for addressing the issues / challenges faced by the health sector in the Punjab?</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Whether the priority programs budgeted in the MTBF mode?</td>
<td></td>
</tr>
<tr>
<td>SNO</td>
<td>Questions</td>
<td>Response</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>14</td>
<td>What challenges are faced by the department in preparing and implanting the budget in MTBF format?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you think department has adequate capacity for MTBF?</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you think would it make some difference in maintaining good financial governance and better delivery of health services?</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Do the people are comfortable with MTBF at functions / implementation level?</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>What further actions are required to strengthen and streamline the MTBF process in the department?</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Monitoring</strong></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Is monitoring mechanism available for setting and monitoring the output indicators?</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Does the existing monitoring mechanism is working and providing information to evaluate the outputs?</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Are the newly developed key performance indicators sufficient to monitor the outcome of MTBF?</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>If not, what for step are required?</td>
<td></td>
</tr>
</tbody>
</table>
DGHS is at the apex of supervising health services in the periphery. He is supported by the Directors of Communicable Disease Control, Expanded Program of Immunization, Basic Health Services/Headquarters, Reproductive Health / Maternity and Child Health and Planning & Evaluation and a number of Additional and Assistant Directors Health Services at the provincial Directorate and by Directors Health Services at Divisional headquarters.

In addition to the offices under line control of the Secretary, there are also autonomous entities like the Punjab Health Foundation and autonomous teaching hospitals/medical colleges set up under the acts of the Provincial Assembly. Hospitals/Teaching Institutions falling under the jurisdiction of Health Department are as follows.
This departmental review is a step in the budget preparation under the Medium Term Budgetary Framework (MTBF). The objective of this review is to assess the extent to information available from the Health Department is to be reviewed / which the expenditure is in line with policies in the health sectors so as to form the basis for effective targeting of resources in the budget formulation process. For the purpose analyzed with specific focus on allocations, expenditures and achievements under development and non-development budgets. Focus of this review is provincial budget and the expenditure incurred by district governments on health is not a part of this assignment.

The Medium Term Budgetary Framework (MTBF) is an approach to budgeting that integrates policy making, planning and budgeting within a medium term framework. According to decision taken by the federal cabinet on 21st January 2009, the Ministry of Finance is implementing MTBF to strengthen the budget process and make it more responsive to achieve the strategic objectives of the government.

It is pertinent to mention that Punjab is the first province in the country to adopt MTBF approach even before introduction of this concept in the federal government. It was observed that there was a substantial gap between the goals/objectives of Punjab government and budgetary practices in the province. Annual incremental budgeting was unable to deliver the desired results. In order to address this gap, Medium Term Budgetary Framework (MTBF) has been adopted. MTBF is briefly describes as under:

- MTBF is a multi-year approach to budgeting
- It introduces a three year perspective in the Punjab towards planning and budget preparation
- Assists in relating spending to policies and objectives

Government of the Punjab (GoPb) is committed to bring meaningful reforms in public sector financial management. For this purpose Punjab Government Efficiency Improvement Program has been introduced with the assistance of Asian Development Bank (ADB). Punjab Resource Management Program (PRMP) is managing this program. Public Financial Management (PFM) includes Medium Term Budgetary framework (MTBF), Tax Policy and Administration Reforms and better Contingent Liability Management. The principal objectives of the PFM reforms are:

- To improve expenditure management to strengthen fiscal discipline,
- To improve tax policy and administration/ structure to increase provincial own source revenue, and
- To improve financing, investment, and sustainability of pension and GP Fund liabilities.

Medium Terms Budgetary Framework (MTBF) & Medium Term Development Framework (MTDF) mode of budgeting is going to be implemented in 5 line departments of Government of the Punjab, to deepen the expenditure management system in Punjab. Medium Term Budgeting was initiated in 2009-10 (as the first year) in Irrigation & Power and Health Departments. MTBF will be rolled out in 3 more line departments i.e. Excise and Taxation, Livestock & Dairy Development and Higher Education Departments in 2010-2013.
# HEALTH POLICY OF THE PUNJAB: THE POLICY FRAMEWORK

Vision of the Chief Minister Punjab:
“Provision of quality health services with a pro-poor focus aimed at achieving the three Healths related MDGs.”

<table>
<thead>
<tr>
<th>No.</th>
<th>Issues</th>
<th>Action</th>
<th>Implementation Strategy</th>
<th>Responsibility &amp; Time Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Capacity Constraints &amp; Systemic Weaknesses</td>
<td>Systemic improvements through well-formulated and designed TA</td>
<td>TA-Based soft reform to be undertaken/continued methodically; Strengthening of in-service training</td>
<td>• PDSSP, PMDGAP, SPU, PHDC, AS(D) &amp; AS(T)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medium to Long term</td>
</tr>
<tr>
<td>2</td>
<td>Restructuring of the DGHS Office</td>
<td>Report developed by the PDSSP to be implemented in its entirety</td>
<td>Restructuring being undertaken under the PMDGAP; DGHS Office to be revamped and resurrected for greater efficiency gains</td>
<td>• PMDGAP, PDSSP, DGHS, AS(D), AS(T), AS(E) &amp; Divisional Directors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Short-term</td>
</tr>
<tr>
<td>3</td>
<td>PHF Restructuring</td>
<td>Restructuring Report by PDSSP to be implemented</td>
<td>PHF to move away from its traditional role; Pro-poor financing mechanism to be put in place through revamped role of the PHF; Private sector mainstreaming by franchising primary level outlets</td>
<td>• PHF, AS (D), AS(T), PDSSP &amp; PMDGAP</td>
</tr>
<tr>
<td></td>
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<td>• Medium-term</td>
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<td>4</td>
<td>Ownership &amp; Implementation of Reform</td>
<td>Soft reform to be mainstreamed and taken to its logical conclusion</td>
<td>Chief Minister’s keenness to accept the vitality of soft, TA-based reform; Implementation of soft reform to be meticulous</td>
<td>• AS(D), PMDGAP, PDSSP, HSRP, AS(T), SPU</td>
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<td>• Medium to Long term</td>
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<td>5</td>
<td>Private Sector Mainstreaming &amp; Public-Private Partnerships</td>
<td>PPP Strategy for Social Sectors to be implemented</td>
<td>Development of regulations for private sector; PPP Models to be developed under the PPP Strategy; for instance the PPP Model for Eyesight Screening of School Children in the partnership with Sight Savers International, UK; Implementation Guidelines (bi-lingual) have also been provided</td>
<td>• PDSSP, AS (D), AS (T) SPU; Commissioners, DCOs, EDOs (F&amp;P), Incharge/MS Health facilities</td>
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<td>• Medium-term</td>
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</table>
| 6   | Creation of Punjab Health Care Commission                                | Creation of Commission to help in standardization, quality assurance & accreditation of health facilities | PDSSP working on it under the directions of the chief Minister; Creation to be done through international expertise | • PDSSP, AS(D), AS(T), SPU in Health Dept.  
• Short to Medium term |
| 7   | Medical Research                                                        | Institutionalization of Research                                       | Revamped PHF can play a role and identify as well as facilitate financing options for researchers; UHS to have a significant role | • UHS, PHF, SPU in Health Dept, AS (D) & AS (T)  
• Long-term |
| 8   | Standardization of Health Care & adherence to SOPs                      | Implementation of the Minimum Service Delivery Standards (MSDS), SOPs and Standardized Medical Protocols (SMPs) developed by the PDSSP | Punjab committed under the PMDGAP to complete the implementation process in three & a half years; Conditional Grants mechanism put in place through PMDGAP & PDSSP; MSDS backed up by SOPs & SMPs; Negative-Positive List being employed for encouraging MSDS related spending; Implementation Guidelines (bi-lingual) have also been provided to the District Governments for effective MSDS implementation | • PMDGAP, PDSSP, DGHS, AS (D), DS (B&A), Commissioner, DCO, EDO (H), MS THQ & DHQ Hospitals I/C RHC & BHU  
• Medium-term |
| 9   | Upgradation of THQ & DHQ Hospitals                                       | Implementation of MSDS in a phased manner; Result-oriented interventions; | Free Renal dialysis, MRI & CT Scan (effort at both procuring equipment and training manpower to operate efficiently); Installation of Power Generators etc. | • AS (D), AS (T), AS (E), HSRP, PMDGAP, PDSSP & DGHS  
• Commissioner, DCO, EDO (H), EDO (F&P)  
• Medium-term |
| 10  | Job Descriptions (JDS) of Medics & Paramedics/Allied Health Sciences      | Approval of JDS developed by the PDSSP                                | Implementation under the PMDGAP; Effective Monitoring of JD implementation              | • AS (T), AS(D), AS (E), PMDGAP, PDSSP, DGHS  
• Commissioner, DCOs, EDOs (H), |
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<tr>
<td></td>
<td>Professionals</td>
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<td>MS/Incharge Health Facilities • Short-term</td>
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<td>11</td>
<td>Robust M&amp;E System</td>
<td>Integration &amp; Strengthening of M&amp;E System</td>
<td>System devised by HSRP to be continued &amp; strengthened; DHIS to be mainstreamed and made result –oriented; Patient/Client Satisfaction to be factored in M&amp;E systems Check Lists developed; important role for immediate supervisor; M&amp;E seen as an accountability mechanism; Possibility of going for Third Party Audits</td>
<td>• DGHS, HSRP, PMDGAP, AS (D), AS (T) • Commissioners, DCOs, EDOs (H), DMOs • Short-term</td>
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<td>12</td>
<td>Sub-optimal Utilization of Equipment</td>
<td>Maintenance &amp; upkeep of equipment; HSRP efforts to be strengthened</td>
<td>Protocols being developed; existing SOPs to be strengthened as well</td>
<td>• HSRP, DGHS, AS (T), AS (D), AS (E) • DCOs, EDOs (H), EDOs (F&amp;P), Incharge/MS Health Facilities • Medium-term</td>
</tr>
<tr>
<td>13</td>
<td>Lack of adequate focus on Preventive Health Care</td>
<td>Preventive Health Care interventions to be strategized</td>
<td>Working Group on Health also mandated to work on this; Performance of EDOs (H) to be assessed against clearly identified targets aimed at preventive health care; Community Medicine’s importance to be raised in curriculum</td>
<td>• Working Group on Health, UHS, DGHS, AS (T)&amp; AS(D) • EDOs (H) • Short-term</td>
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<tr>
<td>14</td>
<td>Integration of Vertical Programs</td>
<td>Implementation of the Framework developed by the HSRP</td>
<td>PMDGAP to lead the process of integrating the 11 Vertical Programs at the BHU level</td>
<td>• PMDGAP, HSRP, DGHS, AS (D) &amp; AS (T) • EDOs (H), Incharge BHU • Short-term</td>
</tr>
<tr>
<td>15</td>
<td>Planning &amp; Development of Human Resource</td>
<td>Train relevant staff in HRM</td>
<td>Establish a Human Resource Planning &amp; Development (HRPD) Cell within the Strategic Planning Unit being</td>
<td>• PMDGAP, SPU in Health Department, Health Care Commission,</td>
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<td>16</td>
<td>Dissatisfaction among Doctors &amp; Paramedics</td>
<td>Incentivized Salary packages; Career Progression of Paramedics</td>
<td>Regularization of Contractual employees; Walk-in Interviews; Further rationalization of incentivized salary packages being contemplated; Incentives for serving at more challenging areas/health facilities; Career Progression for Allied Health Sciences personnel being ensured (PDSSP &amp; HSRP collaborated)</td>
<td>AS(D), AS (E) • HSRP, DGHS, AS(E), AS (T), AS (D) • Medium-term</td>
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<tr>
<td>17</td>
<td>Non-availability of Female Doctors</td>
<td>A workable and sustainable WMO positioning plan with innovative thinking to be put in place</td>
<td>Stakeholder Consultation; International &amp; Regional Best Practices to be studied; Flexi-time approach to be considered; Transportation plans &amp; Mobile Female Clinics; Involvement of private sector lady doctors</td>
<td>DGHS, HSRP, SPU in Health Dept, AS (E) &amp; AS (T) &amp; AS (D) • DCOs, EDOs (H), EDOs (F&amp;P) • Medium-term</td>
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<tr>
<td>18</td>
<td>Emergency Services</td>
<td>Comprehensive 24/7 Emergency Services; To go beyond Rescue 1122</td>
<td>Protocols &amp; SOPs for Emergency Services to be developed &amp; implemented</td>
<td>DG Rescue 1122, DGHS, AS (T), AS (D) • EDOs (H), EDOs (F&amp;P), Incharge of Medical Facilities • Medium-term</td>
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<td>19</td>
<td>Health Education &amp; Awareness Campaigns</td>
<td>Strategizing the various awareness campaigns</td>
<td>Vigorous &amp; consistent awareness &amp; behavior change campaigns aimed at preventive health care issues; their hitherto sporadic nature to be ended</td>
<td>HSRP, DGHS, AS (T), PDSSP &amp; SRP, DGHS, AS (T), PDSSP &amp; SPU • DCOs, EDOs (H), Incharge/MS Health facilities</td>
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<tr>
<td>20</td>
<td>Erratic Supply of Drugs</td>
<td>Assessment of annual drug requirement for each facility; Review Essential</td>
<td>Comprehensive work at the Provincial level; Districts to have consolidated EDL; Facility-wise cost of</td>
<td>DGHS, PMDGAP, HSRP, SPU, AS (T), AS (A) • DCOs, EDOs (H), EDOs (F&amp;P)</td>
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<tr>
<td>21</td>
<td>Spurious Drugs</td>
<td>Elimination of Spurious Drugs without loss of time</td>
<td>3 Task Forces constituted; Drug Inspectors given targets; Close monitoring; Health Department can ask for information at any time</td>
<td>• Task Forces, DGHS, AS(T), PQCB, Drug Courts &lt;br&gt; • Commissioners, DCOs, EDOs(H), District Drug Inspectors, DQCB &lt;br&gt; • Short-term</td>
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<td>22</td>
<td>Mobile Health Units</td>
<td>To be piloted soon in 3 Tehsils</td>
<td>Tehsils to be of the Districts where static coverage is low; Specs developed; Advertisement is being developed</td>
<td>• HSRP, DGHS, AS (D), AS (T) &lt;br&gt; • EDOs (H), Incharge BHUs/RHCs, MS-THQ Hospitals &lt;br&gt; • Short-term</td>
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<tr>
<td>23</td>
<td>Referral System</td>
<td>Implementation of Referral System developed by the PDSSP</td>
<td>A PMDGAP Policy Action; Clearly defined plan for action for this would be designed</td>
<td>• PMDGAP, PDSSP, DGHS, AS (D) &lt;br&gt; • Incharge/MS Health Facilities &lt;br&gt; • Medium-term</td>
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<td>24</td>
<td>Sehat Sahulat Cards</td>
<td>A health Voucher for extending MCH coverage</td>
<td>Implementation through PDSSP; To be replicated in other Districts after assessment</td>
<td>• PDSSP, PMDGAP, AS (T), AS (D0 &lt;br&gt; • Commissioners, DCOs, EDOs(H), Incharge of BHUs &lt;br&gt; • Medium-term</td>
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<td>25</td>
<td>Early Childhood Care &amp; Development (ECCD)</td>
<td>Another MDG related area; Focus on Child Nutrition</td>
<td>Adoption &amp; subsequent implementation of ECCD-Nutrition Model developed by the PDSSP</td>
<td>• PDSSP, HSRP, DGHS &lt;br&gt; • EDOs (H), Incharge Health Facilities; Health &amp; Nutrition Supervisor at the BHU &lt;br&gt; • Medium-term</td>
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<td></td>
<td><strong>Tertiary Health Care Level</strong></td>
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<td>26</td>
<td>Third Party Performance Audits of Autonomous Medical Institutions (AMIS)</td>
<td>Third Party Audits through the PDSSP T.A</td>
<td>Dissemination of results; Corrective actions; Systemic and service delivery improvements based on these results</td>
<td>• PDSSP, Health Care Commission, AS (D), AS (A), AS (T) &lt;br&gt; • Short-term</td>
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<td>27</td>
<td>Development of PDSSP mandated</td>
<td>Consultant input;</td>
<td></td>
<td>• PDSSP, Health Care Commission, AS (D), AS (A), AS (T) &lt;br&gt; • Short-term</td>
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<td>28</td>
<td>Quality Issues in Tertiary Care Service Delivery</td>
<td>Extension in coverage to be complemented by quality considerations</td>
<td>MSDS to help; Quality issues to be taken care of through a well-designed system; Pro-poor focus to stay intact</td>
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<td>• AS (D), AS (A), AS (T), SPU</td>
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<td></td>
<td>• Boards of Management Principal of Medical Colleges, Heads of Departments, MS of Tertiary Hospitals</td>
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<td>• Medium-term</td>
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<td>29</td>
<td>Pro-poor interventions at the Tertiary level (all levels to benefit essentially)</td>
<td>Systematic &amp; well thought out interventions that are not cosmetic; Analysis of Out of Pocket Expenses and User Charges (for User Charges exemption)</td>
<td>Free Medicines; Installation of Air Conditioners etc; Studies on Out of Pocket Expenses and User Charges being conducted under the PMDGAP through the PDSSP TA</td>
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<td>• PMDGAP, PDSSP, AS (D), AS (A) &amp; SPU</td>
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<td></td>
<td>• Boards of Management Principal Medical College, MS Tertiary HospitalMedium-term</td>
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<td>30</td>
<td>Questionable quality of Medical Education</td>
<td>Standardization under the umbrella of UHS; Uniform Curriculum; Internationally acceptable standards of syllabi; Emphasis on Allied Health Sciences Education too; Continued Medical Education not to be overlooked</td>
<td>Uniform entry test; Meritocracy to prevail; Upgradation of curriculum; Health Care Commission to have a role too; Each Tertiary Hospital to have a School of Paramedic Education as well; Punjab Medical Faculty to improve coordination with the UHS; Community &amp; Preventive Medicine to be given its due status in syllabi</td>
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<td>• All AMIS, Health Care Commission, UHS, Punjab Medical Faculty, IPH, PHDC, AS (T), AS (A)</td>
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<td>• Medium-term</td>
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<td>31</td>
<td>Disruption of Referral Chain</td>
<td>Implementation of Referral System and Linking</td>
<td>Linking AMIs with DHQ Hospitals initially; Gradually replication it at</td>
<td>• SPU in Health Dept, AS (D), AS (A), Principals of</td>
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| 32  | Creation of Centres of Excellence within AMIs                         | Concerted efforts at creating Centres of Excellence; Focused investments backed up by effective monitoring | Good examples like Jinnah Burn Centre, Lahore to be replicated elsewhere; Efficient project management and skills | Medical Colleges, MS of Tertiary Care Hospital  
• Long-term |
| 33  | Social Health Insurance                                                | Part of the Pro-poor Interventions (Financing)                                                    | Study under the PMDGAP being conducted through the PDSSP TA; A few models to be piloted | Task Force, PMDGAP, PDSSP, AS (D), AS (T) & HSRP  
• Medium-term |
| 34  | Healthcare of marginalized sections of society                        | Gender Mainstreaming, Geriatrics and Prison Health Reforms                                      | Gender Sensitive policies, Gender Disaggregated data, Targeted interventions in Jails/Prisons | SSH, AS (D), AS (T), DGHS, PD-PACP, PD-TB Control Programme, Gender Mainstreaming Unit, ICRC and Home Department |

- The implementation of this detailed Policy Framework shall be supervised and monitored by the Secretary Health & Special Secretary Health.

- Short Term signifies a period of upto 6 months, Medium Term a period of 1 to 2 years and Long Term a period of upto 3 years.
# GENDER ACTION PLAN
(Pakistan: Subprogram 2 of the Punjab Millennium Development Goals Program)

<table>
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<tr>
<th>Rational / Objectives</th>
<th>Activity/ ies</th>
<th>Performance Target Indicators</th>
<th>Responsibility</th>
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<tr>
<td>Component 1: Improve availability and quality of primary and secondary health care</td>
<td>1.1.1 Conduct a gender assessment of information/ behavior change campaigns that were undertaken within the Province of Punjab</td>
<td>a) A gender assessment report on information/ behavior change campaigns done in the district is completed.</td>
<td>Ministry of Health of Punjab</td>
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<tr>
<td>1.1. To integrated preventive promotive and curative. Maternal and Neo-child Health (MNCH) services within the broader perspective of comprehensive reproductive health care</td>
<td>Implementation of KAP needs additional resources, DoH can allocate funds, gender desk can coordinate for this survey done with additional assistance by the technical person/ consultant</td>
<td>b) A KAP survey report with an assessment of the factors that facilitate women living in poor communities is completed.</td>
<td>Ministry of Welfare Development and women through gender specialist/s placed in all line ministries of the provincial government of Punjab.</td>
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<td>1.1.2 Conduct knowledge Attitudes and Practices (KAP) survey on health-seeking behavior of women and men based on the assessment of conducted change behavior campaigns.</td>
<td>c) A plan for sustaining and expanding information is developed using the results of the gender assessment report and the KAP survey on health seeking behavior of women and men</td>
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<td>d) The plan for sustaining and expanding information/ behavior change campaigns is adopted and implemented by the Ministry of Health of Punjab in at least on pilot area.</td>
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| **1.1.3** Conduct a survey on the knowledge Attitudes and Practices (KAP) of community health workers, especially Lady Health Workers (LHW) and the Cadre of Midwives | e) A KAP survey report with an assessment of gender-sensitivity and responsiveness of LHWs and the Cadre of Midwives is completed.  

f) A capacity building plan for community health workers which addresses gender issues identified in the KAP survey is developed, and implemented by the Ministry of Health of Punjab. | Ministry of Health of Punjab  
Ministry of Welfare Development and women through gender specialist/s placed in all line ministries of the provincial government of Punjab. |
| **1.1.4** Mainstream gender in mandatory staff training seminars. | g) Development and inclusion of a gender-sensitivity orientation module in the training curriculum for continuing education of MNCH staff and medical professionals | Ministry of Health Training institution for paramedics, lady health workers, nurses, doctors |
| **1.1.5** Review the congruence of MNCH plans and policy instruments generated by the Program to laws and the Pakistan government’s commitments to gender equality | i) SMPs4, SOPs and referral protocols6 on MNCH and the 3-year rolling plans of districts on MSDS are complaint to the GRAP (Gender Reform Action Plan) and other legal/ policy instruments on gender equality...  

j) MSDS implementation, | |
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<th>Performance Target Indicators</th>
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<td>1.1.6 To address the lack of female MNCH staff in health facilities, especially in rural areas.</td>
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<td>guidelines include mechanisms for immediate detection inappropriate interventions on hidden gender issues in relation to reproductive health care concerns. PHSR framework missing Gender review of MSDS is present in the gender audit report of PHSRP</td>
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<td>k) A plan for recruitment, retention of female health workers that includes incentives as well as protection for female staff assigned in rural areas, is prepared and implemented within the 1st year of the project...</td>
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<td>l) Majority of government health facilities in the Province of Punjab, especially at the village level, have at least on (1) female medical staff.</td>
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<td>Activity/ ies</td>
<td>Performance Target Indicators</td>
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| **Component 2: Better management of health service delivery**<sup>8</sup> | 2.1. To improve district health management and monitoring | 2.1.1 Mechanisms to systematically capture and analyze data on maternal and child health are instituted. | a) Feedback system and instruments (i.e. citizens report card) that measure health workers gender sensitivity are developed, implemented, and result are inputted into the annual planning process.  
b) Comprehensive district health information (DHIS) systems obtain, analyses, and disseminates sex-disaggregated data. | Ministry of Health Public hospitals and BHUs  
Ministry of Welfare Development and women through gender specialist/s placed in all line ministries of the provincial government of Punjab |
|  |  |  | |
| **Component 3: sustainable pro-poor health financing**<sup>10</sup> | 3.1. To provide targeted assistance to very poor women in especially difficult circumstances. | 3.1.1 Evaluate the Sehat Sahulat Card System | a) Action Plan for institutionalizing the Sehat Sahulat card system is developed.  
b) Increased rate of maternal and child, survival among very poor women Criteria of assessment, poverty indicators, management | Ministry of Health  
ADB |
|  |  |  | |
| **Component 4: Plan implementation and Monitoring** | 4.1. To establish a working structure and process that will ensure implementation of this gender action plan. | 4.1.1 Strengthening gender expertise in the project | a) A gender specialist is hired on an intermittent basis.  
b) Selection criteria for other project staff members include qualities that demonstrate openness, to and | Ministry of Health |
|  |  |  | |
### Rationale / Objectives

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<td>familiarity with gender mainstreaming principles.</td>
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<td>c) A gender sensitivity training program is designed and implemented for the project staff.</td>
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#### 4.1.2 A project Gender Focal Point Committee is created to oversee implementation of this Gender Action Plan

d) TOR, official appointment, and approved work plan of project Gender Focal Point committee. Members.
e) MOU with the Ministry on Women Development

#### 4.1.3 Incorporation of the indicators in this gender plan to the regular project monitoring tools/formats.

f) GAP Monitoring and reporting tool developed and implemented

**Responsibility**

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<th>EA: Ministry of health, Ministry of Women Development</th>
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**1. Basis:** RRP-DMF- Output# 1, dated November 2008  
2. Basis: RRP-DMF- Activities with Milestones, Sub-Program2, No. 6  
3. Basis RRP-DMF- Activities with Milestones, Sub-Program2, No. 9  
4. SMP- Standard Medical Protocol  
5. SOP- Standard Operating Procedures  
6. Basis: RRP- Policy Matrix, Output 1.3 in Subprogram 2  
7. Basis: RRP- Policy Matrix, Output 1.1 in Subprogram 2  
9. Basis: RRP- Policy Matrix, Output 2.1 in Subprogram 2  