Primary Healthcare Services in the Rural Punjab

A Public-Private Partnership

Chief Minister's Initiative for Primary Healthcare
(CMIPHC)
2008

Acknowledgment

The Primary Healthcare services that we are able to deliver are used predominantly by the rural poor. They are resource-less and friend-less. They have to be so – they are poor. The same happens to be an important explanation of why our own work has so few friends. This is what makes our debt of gratitude, to the few friends that we can count, even greater. Some of these friends now belong to the past. There are others whose support has never ceased.

For us, there was always only one reason why we thought that our work deserved to be supported. That reason may have seemed all too naive to those who are responsible for higher matters in life. After all, the poor have survived – if not grown in numbers and poverty – without even the minimal primary healthcare. Why suddenly go overboard and get excited about it, therefore?

The reasons for not supporting our work have been numerous and not terribly complex to understand. If one looks closely, these may appear even primitive. It is no surprise, therefore, that even the high and mighty found supporting our work a tiresome business. Our frustrations have been many but we have much to thank the Almighty for the gift of those few hearts that beat in the right place.

These few and inadequate words are intended for those rare men who chose to help the cause of the poor. Each one of them supported – or continues to support – our work in ways relevant to their station in life. We respect and hail the spirit that moved them. Where would we be if Allah had not chosen to give us friends like:

1. Mr. Sohail Ahmad, formerly Secretary, Health Department and now Secretary, Finance Department, GoPb.
2. Mr. Javaid Akhtar, formerly DCO, Rahim Yar Khan.
3. Dr. Shujaat Ali, Chief Economist, P&D Department, GoPb
4. Ch. Mohammad Farooq, formerly DCO, Pakpattan.
5. Dr. Inaam ul Haq, Senior Health Sector Specialist, WB, Islamabad.

6. Sardar Mumtaz Khan Kichhi, formerly Zila Nazim of Vehari.
7. Mr. Nawazish Ali Khan, DCO, TTS.
8. Dr. Benjamin Lovinshon, Senior Health Specialist at the World Bank in Washington.
9. Mr. Khushnood Akhtar Lashari, formerly Additional Chief Secretary, GoPb.
10. Mian Amir Mahmood, the Zila Nazim of Lahore.
11. Mian Mohammad Ijaz, DCO, Lahore.
12. Mr. Naguibullah Malik, Additional Chief Secretary, GoPb.
13. Mian Mohammad Mushtaq Ahmad, formerly Additional Secretary in Health and Finance Departments.
14. Mr. Mohammad Ayub Qazi, formerly DCO, Vehari & currently DCO, Sahiwal.
15. Rai Hassan Nawaz Khan, the Zila Nazim of Sahiwal.
16. Rana Imtiaz Ahmad Khan, formerly the Zila Nazim of Kasur.
17. Sardar Ghulam Abbas Khan, the Zila Nazim of Chakwal.
18. Capt. (R) Khalid Sultan, formerly DCO, Lahore.
19. Dr. Mohammad Azam Saleem, formerly DCO, Chakwal.
20. Mr. Salman Siddique, formerly Secretary / Principal Secretary Finance Department and now Chief Secretary, GoPb.
21. Syed Sajid Mehdi Naseem, formerly Naib Zila Nazim of Vehari.
22. Mr. Mohammad Imtiaz Tajwar, formerly DCO Vehari.
23. Mr. Mohammad Hashim Tareen, formerly DCO, Kasur.
24. Mr. Saeed Iqbal Wahlah, DCO, Pakpattan.

God Bless them for their caring hearts.

PRSP
Lahore
January 2008

Farooq Haroon

A Public-Private Partnership
Delivering Primary Healthcare Services in Rural Punjab

Background:

It may have started from Lodhran District, back in August 1999, from a mere three Basic Health Units (BHUs).* These BHUs were taken over from the Punjab Government (GOPb) by the National Rural Support Program (NRSP). The three BHUs were run by one Medical Officer (MO), engaged by the NRSP at an enhanced salary. A "Revolving Fund" of Rs. 100,000 was created, with private resources, for maintaining a store of high-quality medicines. Patients had the option of purchasing medicines from this store or of receiving free medicines that are supplied by the Government at all BHUs. The Fund revolved as many as twenty two times during 36 months showing a strong public preference for quality medicines. The turn-out of patients at the three BHUs registered a quantum increase during the NRSP management.

It is difficult to say in what way the Lodhran experience inspired the Rahim Yar Khan (RYK) Pilot. Both are conceived around BHUs and both clustered three BHUs in the care of one Medical Officer. While the similarity may not go beyond these two features, the Lodhran experience admittedly encouraged more ambitious plans. For the Punjab Rural Support Program (PRSP), the Initiative was important for one predominant reason – the acknowledged importance of Primary Healthcare (PHC) to Poverty. This is why the delivery of primary healthcare services to the rural poor has always been seen as being eminently in line with the PRSP Charter.

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* The man behind the Lodhran experiment was Mr. Jahangir Khan Tareen, at that time Chairman of the Task Force for Agriculture in the Punjab Government. Later, he was an MNA from Rahim Yar Khan District and an Advisor to the Chief Minister Punjab on "New Initiatives in the Social Sectors". It was Mr. Tareen who, in 2003, prevailed upon the PRSP to be the engine for the RYK Pilot. Until recently, he was Federal Minister for Industries, Production and Special Initiatives in the Government of Pakistan.

It was Mr. Tareen who steered the evolution of the "CMIPHC" and, later, of its national version – "the President's Primary Healthcare Initiative" (PPHI). At every stage, the contribution from him was as immense as it was sincere. More is owed to Mr. Jahangir Khan Tareen than can be adequately recorded here.

Why the PRSP ???

This is one of the first questions raised – especially from those who wonder about the wisdom behind Public-Private Partnerships. PRSP is, in a sense, a special non-government organization in the Punjab. Both the GoPb and the PRSP can press special claims upon each other. PRSP's unique standing with the GoPb assures the PRSP many advantages in its operations. It also provides the GoPb the rare ability to launch some of its initiatives in a non-government mode where such a mode is considered necessary.

The Initiative is not as novel as some are apt to think. There are at least 8 similar experiences elsewhere in the world which the World Bank has studied and documented. What the PRSP is trying to do in the Punjab is, therefore, the ninth such experience in the world. The Initiative is indeed the first of its kind in many ways in Pakistan. The scale of it is truly without a parallel in the social sectors in the country.

BHUs:

BHUs were established as the "First Level Healthcare Facilities" (FLHFs) in the rural areas under the Health Policy of the 1970s and early 1980s. A BHU was designated to be the FLHF for the area of a Union Council which, in the Punjab, means an average of 11 "revenue estates", commonly referred to as "villages". The functions of a BHU, as listed by the Department of Health (DOH) of the GOPb, are at ***Annex-A*** to this Introduction.

In the 35 Districts of the Punjab, there are 2456 BHUs. (Please see map at ***Annex B***) Each BHU is established upon approximately 2 to 3 acres of land and comprises the Healthcare block, an MO's residence and, ordinarily, 5 other residences for the staff. The total constructed area of a BHU exceeds 9,000 sft with its own water supply and drainage facilities. Almost all the BHU buildings in the Punjab are in advanced stages of disrepair and decay. Residences, which are rarely lived in, are by far the worst part of a BHU. FLHFs in the rural areas are perceived to be notoriously dysfunctional. However, their non-performance is not meant to be discussed here. This Introduction briefly records some early experiences of an Initiative to start up the delivery of primary healthcare services in the rural Punjab. It does not mean to deal with any of the larger issues plaguing the sector except in so far as it is necessary to refer to these while describing our own work.

Rural Dispensaries:

The Rural Dispensaries (RDs) or the Mother and Child Health Centers (MCHCs) are in an even sorrier state than the BHUs. These are often more poorly provisioned than a BHU. The RDs are commonly housed in inadequate and ancient buildings with few essential amenities. But RDs can be more centrally located than many BHUs. Given just a little attention, therefore, many RDs come alive with very large numbers turning up at these for medical assistance.

The RYK Pilot:

A proposal was made to the Chief Minister, Punjab, in January 2003. In it, he was apprised of: (i) the proposition developed by the Zila Nazim of RYK for the PRSP to take over the management of all the 104 BHUs in that District: and of (ii) the broad features of how these health facilities (HFs) were proposed to be managed by the PRSP using the "Lodhran experience".

No tall claims were made on this occasion. In fact, it was plainly acknowledged that much would have to be learnt as one went along. It was conceded that few aspects of the proposed operation could be precisely anticipated. However, there was an abundance of good intentions and enthusiasm which made up for a lot that was conspicuously absent from the proposition. A faithful account of the occasion must, therefore, mention the understandable skepticism about the entire idea. What finally weighed with the Chief Minister was the acknowledged failure of the services over many years and the resolve to remedy the situation. There were no arguments against either of these. The Chief Minister approved the Pilot for immediate launch. He must be applauded for a courageous decision; for throwing his weight behind an enterprise that was bitterly opposed by those who essentially recommended status quo; for supporting an operation which was backed by few convincing arguments but was opposed by weighty ones.

There had been a major devolution of governance in the country since the Lodhran experiment. The newly established District Governments (DG) had, since August 2001, inherited authority from the Provincial Government in many sectors of which the Primary Healthcare sector was one. In March 2003, two months after the approval of the Chief Minister, an Agreement was signed between the District Government of RYK (DGRYK) and the PRSP. The essential framework of the Agreement was crafted with much care in the absence of precedents that could serve as models. It was thoroughly vetted by the Health, Finance, Local Government and the Law Departments of the Provincial

Government for the comfort of the nascent District Government. And finally, it was the un-flinching support of the then Zila Nazim, RYK * that over-rode the reservations persisting within the DGRYK.

The plans for the management of the Initiative had to suffer a fundamental review soon after the Agreement was concluded. Contrary to expectations, PRSP could not be provided the services of key management personnel by the Government. As a result, the "Project Management Unit" (PMU) had to be created within the DOH of the GoPb and not in the PRSP. As an administrative arrangement, this was seriously flawed, to say the least. But this is how the work had to commence. PRSP's association with the operation, though intimate from the start, remained indirect in some ways until the end of June 2004.

Given the number of medical professionals in RYK in March 2003, assigning one MO to a cluster of 3 BHUs, along the Lodhran lines, seemed to be the most recommended course. Accordingly, the 104 BHUs in the District, were clustered and assigned by the first week of July 2003. The similarity in clustering between Lodhran and RYK was, however, only coincidental. Had the number of medical professionals been different in RYK, clustering may also have been otherwise. The next two changes that the PMU was able to initiate were (i) the staff presence and (ii) the availability of medicines at the BHUs. Credit for these achievements must go to the small PMU, led by the first Project Director, all of them driven by an exemplary crusading spirit.

It is strongly realized now how fortunate it was to have made the beginning from RYK. All the higher elements were strongly supportive in this District. A beginning anywhere else could have caused serious, perhaps fatal, frustrations to the Initiative. Even with all this support, it took the Initiative from March to July 2003 to become a reality on ground. Establishing credibility and acceptability with the large work-force and the numerous relevant elements in the DG was also critically important and it took time.

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* Note: Makhdoom Syed Ahmad Mahmood, then Zila Nazim of RYK, an ardent supporter of the idea, was the first to demonstrate courage in taking the initiative. He believed in the strength of Public-Private Partnerships and never flinched from extending help in removing hurdles. Every honest account of the operation will record his massive support to an undertaking of which the beneficiaries were predominantly the rural poor.

It required skill, discretion and perseverance. It also demanded a lot of physical endurance. We have learnt over the years that initiation is a painful phase and it can take many frustrating months. Let this not create the

impression, however, that thereafter the frustrations come to an end. They do not!

The Next Steps:

In October of 2003, the Chief Minister, Punjab, who had remained in touch throughout, reviewed the work that had been possible to do in RYK. It was admittedly too soon to make any major claims. But even at that early stage, the incontrovertible promise of the Initiative had become obvious. The beginnings of Doctor, staff and medicines becoming available at the BHU was no small achievement. Three major decisions were taken by the Chief Minister at the review. First, that the Initiative, henceforth to be called "the Chief Minister's Initiative for Primary Healthcare" (CMIPHC), would be extended to such other Districts as were adjudged truly keen about it. Secondly, the cost of a Project Support Unit (PSU) at Lahore and a District Support Unit (DSU) in every intervened District shall be borne by the GOPb. And finally, that the GOPb shall provide the services of hand-picked Government personnel to the PRSP for leadership roles in the management of the Initiative. Happily, all these decisions were implemented, in letter and spirit, and have very greatly helped in taking the CMIPHC forward*.

Agreements with District Governments:

After the RYK (Agreement dated 11/03/2003), PRSP has extended the CMIPHC to eleven other Districts namely; (ii) Chakwal (Agreement dated 17/12/2003); (iii) Vehari (Agreement dated 19/12/2003); (iv) Lahore (Agreement dated 01/04/2004); (v) Faisalabad (Agreement dated 05/08/2004); (vi) Sahiwal (Agreement dated 25/09/2004); (vii) Kasur (Agreement dated 01/01/2005); (viii) Mianwali (Agreement dated 14/01/2005); (ix) Toba Tek Singh (Agreement dated 24/03/2005); (x) Hafizabad (Agreement dated 05/05/2005); (xi) Lodhran (Agreement dated 06/05/2005) and (xii) Pakpattan (Agreement dated 30/06/2005).

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* All credit is due to the Chief Minister, Chaudhary Pervaiz Elahi, for demonstrating decisiveness at a most critical time during 2003. He placed confidence in the concept long before the Initiative had much to show for itself. His support to the Initiative remained complete until the middle of 2005. Thereafter, tragically for the CMI, this support was effectively withdrawn. The fact that the withdrawal of support had nothing to do with the performance of the operation, only nominally diminishes our grief.

The CMIPHC now extends to **845** BHUs, **184** Rural Dispensaries, **14** MCHCs and **6** "Tibbi" Dispensaries. Our experience thus relates to as many as **1049** Health facilities. A typical Agreement with a DG is at ***Annex-C***.

It can take from 6 to 9 months to come effectively on ground following the conclusion of an Agreement depending on the state of local opposition and support. Both vary from District to District. Both can also vary from time to time. The CMIPHC has suffered some strange and unforeseen forms of opposition. It has also received heartwarming support in generous measures. Regrettably, the former has been more frequent than the latter. Without a single exception, the Initiative has been launched in a District in response to extreme keenness demonstrated by its DG – invariably led by the Zila Nazim. Yet the history of the Initiative is a sad story of an important work of great potential often being discouraged, opposed and obstructed.

Going Forward - too fast, too soon???

One clause in all the Agreements concluded with the DGs requires an evaluation of performance upon the completion of the first year of the Initiative. The evaluation of the work in RYK was undertaken by the World Bank during 2005. Its Report came later during the same year. The World Bank recognized some achievements. It also, quite rightly, raised some concerns. A summary of findings is at ***Annex-D***.

It is sometimes commented that the Initiative has been taken too soon to other Districts – that the scaling up has been too fast and without an adequate appraisal of the experiences. That one should have waited for reviews, evaluations and studies before taking the decision to expand.

This approach perhaps does not reflect a sense of urgency that deserves to be attached to the delivery of the Primary Healthcare services to the poor. It seems to show, inter alia, a certain lack of understanding of how the poor survive without the FLHFs. The CMIPHC is now launched in twelve Districts, taken up from time to time in response to the keen-ness of the concerned District Governments. Those who consider our expansion too fast would have wanted us to decline the assignments? We should have informed the DGs that we cannot help them with their keen desire to deliver PHC services – because we were still learning? We did not feel like taking this line then nor do we think along these lines now.

We accept that the present might be an appropriate stage for a pause – and for consolidation. But it should be remembered that operation research is not a primary object of the CMIPHC. Our primary object is to deliver the best primary healthcare services that we can to the rural poor. The Initiative

enthusiastically welcomes all evaluations, every assessment and survey because the findings can only help in delivering better services. But for the PRSP, the CMIPHC was never a research undertaking. For the PRSP, the CMIPHC is only a service for the poor – to be delivered as well as it is possible to in our circumstances.

The expansion is the result of long and hard reflection. PRSP believes that many tasks are possible to perform on a small and a limited scale. Achievements at a small scale cannot necessarily be accomplished on a significantly larger scale. It is important, therefore, that options are demonstrated at a large enough scale to deserve serious consideration at the decision-making levels. Whatever is put forward as a solution will be relevant only if the scale of it is appropriate to the context. Neither poverty, nor poor access to Healthcare services, are small problems. Neither are these confined to a specific area. Only if the CMIPHC can show another way to deliver Primary Healthcare services in a number of districts, through a few hundred FLHFs, will it deserve notice. Pilots are, therefore, important and relevant only when these have the single most important potential – that of being taken to the required scale.

Community Support:

PRSP envisions that the most effective way to ensure that a service delivers the desired volume and quality is to assign an appropriate role to the beneficiaries. There can be no greater assurance of the desired volume and quality, on a continuing basis, than this linkage. The CMIPHC has, therefore, organized a "Support Group" attached to every BHU. Each Group comprises carefully selected individuals who represent important interests like elected Councillors, teachers, women, students, professions, minorities, etc, etc. The Group meets at least once a month and integrates the BHU with the community that has a stake in the services delivered through the BHU. It is a responsibility of the Group to see that the BHU is enabled, at all times and on a sustained basis, to provide larger and better range of services. A member of the DSU staff arranges, attends and minutes all meetings.

We are witnessing numerous new possibilities as the "Support Groups" gradually acquire maturity. This is the first experience of linking stakeholders to HFs in the Punjab. Hitherto, such linking has been mostly confined to educational facilities. It is most reassuring to see the enthusiasm of the community and the support it is providing. The Groups provide bonding between the FLHF and the population it is meant to serve. The variety of

heart-warming instances is pleasantly surprising and shows the many possibilities that can emerge for the BHUs and the communities. A list of functions that Support Groups are encouraged to perform is attached at ***Annex-E*** to this Introduction.

Community Health Sessions:

This is a new activity at the BHUs. Every MO (and Paramedic) is now going out into the villages and getting the community together for interactive sessions on Healthcare issues. These sessions are expected to create and enhance public awareness on hygiene, sanitation, nutrition, family health, disease prevention, family planning, immunization, inocculations, child health, etc, etc. Just to give an idea of how this effort is proceeding, here are some numbers which show the participants in the Community Health Sessions. At ***Annex-F*** is an illustrative list of topics around which interactive sessions are organized.

Community Health Sessions: Participants

Year	RYK	CKL	VRI	LHR	FSD	SWL	KSR	MI	TTS	HZD	LD	PK
2005	31241	89883	71761	38890	29126	33803	35351	11338	14267	2688	10726	5479
2006	105039	100135	65087	56039	60011	39687	64045	17697	104177	9578	35824	20765
2007	144333	95924	73298	70529	77113	44664	67584	12207	191388	14783	35192	21272
Total	**280613**	**285942**	**210146**	**165458**	**166250**	**118154**	**166980**	**41242**	**309832**	**27049**	**81742**	**47516**

School Health Sessions:

This too is a new activity. Every MO (and Paramedic) is now going into the schools in the area of the BHU and holding interactive sessions with the students/teachers in the relevant fields. School children are also brought to the BHUs for such sessions if the BHU in not far. Children are screened for some of the common medical problems that they could be suffering from. Health Cards, which record important data on the child, are now being provided to students who have been screened. We are in the process of arranging vision testing facilities and planning the provision of reading glasses where required. Here are some numbers to show how far we have come in this field.

School Health Sessions:

District	Students	2005	2006	2007	Total

RYK	**Screened**	9285	22695	33299	**65279**
	Treated	7705	11256	14977	**33938**
CKL	**Screened**	65981	52161	42139	**160281**
	Treated	41573	34294	29370	**105237**
VRI	**Screened**	102482	56656	61598	**220736**
	Treated	67195	28739	34005	**129939**
LHR	**Screened**	71351	51126	44223	**166700**
	Treated	44180	35385	24284	**103849**
FSD	**Screened**	37144	66061	60874	**164079**
	Treated	19651	37087	41152	**97890**
SWL	**Screened**	30462	40708	53357	**124527**
	Treated	16496	20360	33505	**70361**
KSR	**Screened**	43797	57429	57752	**158978**
	Treated	18883	27356	26380	**72619**
MI	**Screened**	11972	14037	14886	**40895**
	Treated	7464	7856	7199	**22519**
TTS	**Screened**	34747	45429	52061	**132237**
	Treated	7053	20240	30017	**57310**
HZD	**Screened**	3015	8023	6518	**17556**
	Treated	1169	4073	3431	**8673**
LD	**Screened**	17712	42736	43862	**104310**
	Treated	7697	21667	22379	**51743**
PK	**Screened**	4684	10303	15534	**30521**
	Treated	1271	5164	9348	**15783**
Total	**Screened**	**432632**	**467364**	**486103**	**1386099**
	Treated	**240337**	**253477**	**276047**	**769861**

Immunizations & Inocculations:

This is not a new activity and is undertaken both at the BHU and in the field. The staff engaged for some of the Preventive and Promotive Programs (e.g. CDC, EPI, LHWs, Malaria Control Program and Sanitation Programs, etc.) is connected with the BHUs for the purposes of recording attendance and displaying schedule of field work. They also use BHUs for office space and storage of materials etc. There is a certain lack of effective integration of services at the BHU level. Some of these Programs are being run from the national level through Provincial offices and designated officers in Districts. However, there appears to be a lack of integration, at the BHU level, in the design of the vertically run programs. This seriously reduces the ability of the CMIPHC to arrange a higher volume and quality of preventive and promotive services in the catchment area of the BHUs.

The DOH had, in June 2005, written to the Districts to integrate all the preventive services under the leadership of the Medical Officer of the BHU. This important decision is still in the process of being implemented because it was not accompanied by the requisite administrative will. Integration is developing but not at a pace that was possible. The CMIPHC has, therefore, to focus its efforts at a static position at the BHUs. While the numbers have started to change, the optimum is far from achieved. This shall not be possible until vaccination and inocculation in the field are effectively integrated with the BHU and overseen by the MO incharge. The sole argument for ensuring integration is that the MO at the BHU is the nearest medical professional in the area who can supervise this work. All others are remote in comparison and cannot, therefore, supervise effectively. We are only reporting the inocculations and immunizations at the static posts by the BHU staff for the present.

Inocculations / Immunizations at BHUs:

Year	RYK	CKL	VRI	LHR	FSD	SWL	KSR	MI	TTS	HZD	LD	PK
2005	82704	10127	13381	50955	74478	26392	46572	18292	5873	7257	12080	7316
2006	175986	4974	22101	72135	100244	23864	60221	6735	11183	18091	19255	8376
2007	108953	40407	122418	66809	306862	20348	131396	8416	16876	65762	42966	11802
Total	**367643**	**55508**	**157900**	**189899**	**481584**	**70604**	**238189**	**33443**	**33932**	**91110**	**74301**	**27494**

Female Medical Officers (FMOs):

This is a brand new service at the BHUs and a most significant development in the rural Punjab. The number of female medical professionals willing to serve in remote rural areas, in the public and private sectors, has always been small. The rural women are, therefore, exceptionally disadvantaged in their access to essential medical assistance. The CMIPHC has responded with engaging female medical professionals and assigning clusters of five BHUs to each. She goes around each BHU in the cluster every week. On the sixth day (a Friday), she holds Health sessions at a Girls college/school in the area of the five UCs. Time is also taken out on this day for the capacity building of the LHVs and Midwives. The FMO Days are widely publicised and the schedule is strictly adhered to so that women know precisely when consultation and medical assistance are possible. A specialised pharmacy is provided to the FMO. This new window was opened in November 2004 in RYK. So far, the CMIPHC has, with very considerable effort, been able to arrange the services

of 109 FMOs for operating at 545 BHUs in all the 12 Districts. It is noteworthy that no additional finances were sought from the DGs for these new appointments. We have been able to make the same Budget take us much further than before.

It requires some effort to convince the rural women that it is indeed a real "Doctor" that they can consult and receive assistance and medicines from for a mere Rs.1 Parchee Fee! FMOs are now regularly assisting with pregnancies and delivering family planning services. It must be noted that we have arrived at the present strength of FMOs progressively and that this number is subject to variation from month to month. The information here shows the number of females, over the past 36 months, who received medical assistance at the BHUs for gynecological problems.

Female Health Service:

District	2005	2006	2007	Total
RYK	66533	104280	102067	**272880**
CKL	60407	152510	81243	**294160**
VRI	126555	158348	101469	**386372**
LHR	91745	180957	234291	**506993**
FSD	147016	342404	481461	**970881**
SWL	53364	128307	134949	**316620**
KSR	67044	163828	162148	**393020**
MI	22378	54102	57561	**134041**
TTS	10938	69161	90160	**170259**
HZD	5987	17116	9049	**32152**
LD	9411	72269	99410	**181090**
PK	3590	25381	35033	**64004**
Total	**664968**	**1468663**	**1588841**	**3722472**

Family Planning Services:

Care was taken not to make the Family Planning services one of the earliest services to be offered. As the PHC services rolled out, the BHUs are being visited with growing feelings of trust and confidence, specially with the empowered female paramedics and the welcome introduction of female medical professionals. Collaboration has now been developed with the Population Planning offices. Family Planning materials are being regularly procured by all the 12 Districts from the federal warehouses at Karachi. The

provision of FP services at each HF is closely monitored every month. We notice huge possibilities revealing themselves with the presence of a large number of FMOs at nearly 550 BHUs every week. We are endeavouring to build on the success that we have so far had and we expect to add to it in many ways.

We are mindful of how far we need to take our family planning services. But we think that the ground has been sufficiently prepared to build upon it. The number receiving FP services during 2006 and 2007 are indicated here. It must be noted that earlier on, the BHUs have largely refrained from providing FP services. We have been able to put the BHUs firmly on the Family Planning map of the Punjab for the first time.

Family Planning Services Delivered at BHUs:

Year	RYK	CKL	VRI	LHR	FSD	SWL	KSR	MI	TTS	HZD	LD	PK
2006	4524	6869	12894	4323	28951	5806	22434	345	15917	2198	4895	432
2007	8338	6893	12787	8010	40203	6889	39048	1522	16530	2378	5050	2976

Outpatient service:

Much is said to diminish the importance of the numbers receiving medical assistance at the BHUs with the CMIPHC. This rather strange line of argument seems to suggest that (i) the preventive and promotive services are a much higher responsibility and are the central functions of the FLHFs; (ii) that the growing number of patients calling at these facilities is an evidence of the failure of the preventive and promotive services and that (iii) the patients calling for medical assistance at the FLHFs should be referred onward to the appropriate health facilities rather than being given curative treatment at the BHU. The critics seem to be almost implying that the low out-turn of patients at the BHUs in the past had been the result of effective preventive and promotive services!

The CMIPHC strongly disagrees with these arguments. Guided by the list of functions to be performed at a BHU ***(Annex-A)***, it must provide curative services for such common medical problems as can be treated at a FLHF. After all, for what else have the medicines, etc been provided by the Government(s) year after year at the BHUs (and the RDs)? The CMIPHC firmly believes that the poor must be provided all such medical services nearest to home that can be competently provided at that point. Any referral to

another facility for such medical assistance would be cruelly insensitive to the circumstances of the poor.

Numbers clearly show that many more people, compared to the past, are now receiving curative services at these HFs. Whatever the inter se importance assigned to the curative, preventive and promotive services, the CMIPHC attaches importance to the growing number of beneficiaries for all the three services. Numbers are one good indication of public satisfaction. During the twelve months of 2007, the number of patients receiving curative services from the FLHFs in the 12 Districts were 19,889,059. How can this fail to give us satisfaction? The highest during the year 2007 was in the month of August when 2,129,006 new patients received curative services at these 1049 facilities. How can we ignore the importance of this service to the poor? In the same month, prior to the CMIPHC, the comparable numbers were 653,701. Can such an obviously resounding verdict be ignored or disparaged? Can these numbers be assigned a different meaning than the obvious? Can one argue against it from any standpoint without being utterly unaware of what it means to be poor and sick?

CURATIVE SERVICE

Districts (HFs)	2003*	2004*	2005*	2006	2007	Total
RYK (104)	1425686	1666337	2052804	2257546	2287817	**10050763**
CKL (65)	360631	398305	965967	1106920	949783	**3781696**
VRI (77)	421513	461272	1362390	1526943	1614687	**5386805**
LHR (37)	452939	509434	1240077	1295809	1476341	**4974600**
FSD (168)	1575356	1746904	4114342	4959622	5200038	**17596262**
SWL (75)	500965	485036	1346635	1592943	1593966	**5519545**
KSR (81)	501764	542923	967143	1564685	1668164	**5244679**
MI (40)	224064	171940	434719	711025	815245	**2356993**
TTS (66)	260665	274041	557455	1259254	1670808	**4022223**
HZD (31)	306766	446455	491287	630825	658837	**2534170**
LD (48)	320400	293601	459520	891344	1073592	**3038457**
PK (53)	450085	448569	534727	733997	879691	**3047069**
Total (1049)	**6800834**	**7444817**	**14527066**	**18530913**	**19888969**	**67553262**

* CMIPHC was not responsible for the entire year in some of the Districts as has been explained earlier. 2006 is the first full year when the CMIPHC was responsible for the management of all HFs in all the 12 District.

We, at the CMI, are always mindful of all the eight constituents of PHC. We know the importance of each component. We consider it wrong to allow a loss of balance in our efforts and attention devoted to each constituent service. But when the importance of curative services is being played down, the significance of the hundreds of thousands that converge to the BHUs/RDs every day is overlooked. They are predominantly the poor. They drag themselves wearily, carrying the crushing burden of poverty and disease, only because they need to. All of them come to the facilities because they expect to receive a service that they must receive and because they cannot do without it. They had no such expectation earlier. Clearly, that is why they were not visiting in the past. The demand must have always existed. What one sees now is the demand being met for the first time. And to think that some of us want them referred onwards to a distant facility can only be the ultimate insensitivity. A graphic representation of the curative services delivered over the years in each District is at ***Annex-G***. The growth in numbers receiving medical assistance comes out in a telling manner when one looks at the bars.

Capacity Building:

Capacity Building (CB) of the professional staff is a major area of concern. The quality of services delivered is directly related to the professional capacity of the staff. One must acknowledge that the staff that opts for service at the FLHFs is not uniformly of the requisite professional quality. As a result, the quality of services often leaves much to be desired. Alongside this serious inadequacy, there is the problem of acute shortage of Doctors and Paramedics. There are serious limits, therefore, on taking the staff away from their work for the capacity enhancing events. Some measures that we have been able to take for the professional development of the staff are recorded here.

a. At every Monthly Review Meeting (MRM) held in each District during the first week of the month, the first activity is one, or two, interactive capacity building session(s). Resource Persons are invited to speak on important medical issues with which the MOs have to deal and about which it is necessary to know the latest findings and the best practices. Over the years, 846 such sessions have been organized at the MRMs.

b. FMOs use the better part of every Friday for the CB of the female paramedic staff.

c. Full advantage is taken of the opportunities offered by the GOPb for capacity-building of medical and paramedic staff.

A tripartite arrangement is evolving to associate a specialized organization with addressing quality issues and for capacity building of the professional staff. We are pinning high hopes on this arrangement materializing.

Staff at the BHUs/RDs:

By far the most valuable asset at the HFs are the staff who run these facilities. It was a pleasant discovery for the CMIPHC that the staff – medical professionals and para-medics – were not a cause of the dysfunctional health facilities. The centrality in this tragedy seems to have belonged to the management. The CMIPHC has all along received the most enthusiastic support from most of the staff – almost as if they had been eagerly awaiting an opportunity to perform and deliver. They do, however, look for clear signs of ownership from the Provincial and District Governments. Suffering from doubts and uncertainty about the future of the Initiative, when these signs are not seen, is easy to understand.

Clustering…?

Clustering is not an article of faith with the CMIPHC as some may tend to believe. It is the result of local realities at the time the Initiative enters upon a District. While some BHUs are being served by one Medical Professional in clusters of 3, a large number are arranged in clusters of two HFs or are being managed singly by an MO. The arrangements vary from place to place as considered best – given the relevant local conditions. The availability of professionals, medics and para-medics, for serving in remote villages has always been a serious issue. We believe that where a resource is scarce, it must be shared. We continue to be convinced of this view being correct. As of January 1, 2008, the CMIPHC is working in the 12 Districts with only 23 clusters of 3 HFs, as many as 249 clusters of 2 HFs and 412 MOs at a single facility. We do, however, have views on the appropriateness of having a whole-time medical professional at each FLHF.

Facilitation at HFs:

The District Support Unit is designed to provide comprehensive facilitation to each HF for which it is responsible. It keeps in touch with the staff at the

facilities in more than one way. Visits to the HFs are the principal means of facilitation. These are not "inspections". The difference between the two purposes is crucial. Our visits are not intended to announce what is wrong. We visit to help in doing or providing whatever is indicated. We and the BHU staff are together in wanting to run the HFs well.

The staff is able to notice the difference instantly and reciprocates enthusiastically. The visits are always well documented. Just by way of illustration, the facilitation visits made to the HFs during the calendar year 2007 are shown here with the (number) of FLHFs in each district:

Facilitation Visits: 2007

Rahim Yar Khan: (104)	2273	Chakwal: (65)	1971
Vehari: (77)	3090	Lahore: (37)	2468
Faisalabad:(168)	6856	Sahiwal:(75)	2249
Kasur: (81)	2447	Mianwali: (40)	2080
T.T.Singh: (66)	3738	Hafizabad: (31)	1089
Lodhran: (48)	2211	Pakpattan: (53)	1756

These visits are made by the DSM and two Executives from the DSU. Assuming 290 working days in a year, this shows that an average of about 9 HFs are visited by these three every day across the 12 Districts. On a continuing basis, this represents a rigorous schedule. Alongside the visits from the DSU, a network connecting all HFs with telephones and wireless phones has been established. As many as 829 telephone connections have been got installed. A DSU is expected to establish contact with the HFs and record a summary of relevant information obtained by it. This is seen daily by the District Support Manager for appropriate action.

Resource Group:

One of the first things we did was to identify mentors for every major activity at a BHU. Without such guidance, we would have been quite directionless. The CMIPHC has been able to get together a number of very distinguished and eminent medical professionals who have the highest standing in certain key specialties. It is extremely fortunate for the Initiative to be able to draw upon rich guidance in specialized fields like Community Medicine, Public

Health, Dermatology, Gynecology, Pediatrics, Ophthalmology, General Medicine, Pharmacology etc. As a matter of Policy, the management consults with the relevant Resource Person(s) every time a matter warrants such consultations. The Initiative has always found these inputs of huge advantage in taking the best decisions in critical matters.

Medicines:

One important reason for the FLHFs being dysfunctional is believed to be the mismanagement of medical supplies. One of the first priorities with the CMIPHC, therefore, was to ensure availability of the required range of medicines, etc., of acceptable quality at the HFs at all times. So far, the Initiative has had important but partial success in this important area. One reason for it is the extreme pressure of keeping all HFs adequately provisioned for the ever – growing number of patients. Alongside coping with this pressure, efforts have been made to evolve a fresh list which meets the needs better in the light of our experience.

The CMIPHC suffers from a paralyzing fear of shortage of medical materials. It regards a shortage a major failure bordering on a break-down. Avoidance of any shortage is, therefore, a major concern. Secondly, it has not been possible for us to reduce the hitherto decisive importance of price in the procurement process. Quality is unfortunately treated as a somewhat vague factor. Quality considerations, therefore, rarely determine the selection of a product in the public sector. It is difficult to purchase a new quality at a new price in our environment.

Almost all the medicines/materials are purchased relying on the "Rate Contracts" concluded by the Government(s) and reputable Government institutions. As a Policy, the Initiative is always guided by the Drug certification from Government Labs. We have acquired useful experience over the years that recommends moving away from this system. However, we have so far considered it safe to remain a part of the Government system for quality certification.

For the first time, the BHUs are able to promptly provide treatment against rabies and snake-bite. Considering the 1000 + cases annually in which ARV is administered across the 12 Districts, it can only be imagined how such unfortunate individuals were coping earlier. We also have arrangements at the BHU now for diagnostic tests for Hepatitis B and C. These, and Blood sugar,

Pregnancy and Hemoglobin tests, are free of cost – on payment of Rs.1 "Parchee Fee" and were hitherto unknown at the BHU level.

Monthly Review Meetings:

The Monthly Review Meeting (MRM) is a major event in every District during the first week of every month and we have found these of huge advantage. All the MOs/FMOs, members from selected Support Groups and the District Support staff get together to discuss the services delivered during the preceding month, the possibilities of improvements and plans for the new month. The occasion is also used for some necessary capacity building of the MOs through inter-active sessions with specialists of high standing in carefully chosen relevant fields.

A copy of the record of proceedings of one such MRM is at ***Annex H*** as an example of the review undertaken every month in every one of the 12 Districts.

Systems and Transparency:

PRSP has tried to infuse into the CMIPHC the best of its systems. A Manual, extending to all aspects of the operation, was first developed and soft launched in July 2004. It was brought, with some modifications, before the Board of Directors of the PRSP and was formally enforced with its approval from October, 2004. The Manual has been reviewed once again in consultation with all the District Support Units. The observations of the Auditors have also been accommodated in the operational systems. The list of contents of the Manual is at ***Annex-I*** to give an idea of the aspects it deals with.

The Manual of Operations developed by the PRSP was subsequently used, during 2007, for preparing the Manual for the "President's Primary Healthcare Initiative (PPHI)", of which we shall speak later. The Introduction to that Manual which the PRSP helped in preparing, is at ***Annex-J***. It supplements this Introduction and may shed light on some aspects which the desire for brevity has left inadequately explained here.

The accounts of the Initiative are audited under the Companies Ordinance 1984 – PRSP being a company incorporated under that law. PRSP conforms to the "International Accounting Standards" and its financial transactions, processes and records are intended to satisfy the highest and impeccable

standards of probity and transparency. Audited accounts, as required by the Companies law, are regularly submitted to the District Governments. Our Auditors are expected to have an international standing and must figure in Category "A" on the Panel maintained by the State Bank of Pakistan. A rigorous system of Internal Audit is also in place.

In all the twelve Districts, inventories of every physical asset at each Health Facility have been prepared after thorough inspections. This has been done for the first time in the history of these facilities. Copies, hard and soft, have been shared with the various offices of the District Government.

A software has been developed in-house for use by the HFs and it has been piloted in three Districts. The software not only records important data on the curative, preventive and promotive services, it also manages the inventory of the medical store as also guides the proper use of medicines. We have not extended the successful pilot to all the Districts because the GoPb has, in the meanwhile, made it a part of its "Health Sector Reforms Program" (PHSRP). We have, therefore, been awaiting Government funding since 2005.

Rehabilitation of Buildings:

The BHU/RD buildings are a very sorry sight every where in the Punjab. In many cases, these are in a shocking state. The condition of residential buildings is even worse on account of non-use. All these require extensive repairs. In many cases, even minimal rehabilitation requires a large investment. The works are scattered at hundreds of locations, many of which are truly remote and inaccessible. Often, rehabilitation requires numerous small works which attracts only local contractors. This raises the important questions of supervision and quality assurance – possible only if the process is decentralized.

The CMIPHC was able to undertake some urgent rehabilitation at the BHUs/RDs, perhaps for the first time since these were established. There is an extensive regulatory framework in the public sector for original 'civil works' as also for repairs. While the CMIPHC undertakes these works in accordance with PRSP's own systems, a comparison of the two systems can never be avoided. Ways were, therefore, found to undertake these small and scattered works with a healthy synthesis of the two regulatory systems. Our arrangement relied upon the elected Councillors, the MOs, the Support Group,

the DSU and the Buildings Department of the DG to bring together all the appropriate viewpoints and expertise. Priority of items of repair was very carefully determined to ensure that only such restoration is undertaken as cannot wait.

However, the CMIPHC is no longer responsible for rehabilitation and maintenance of these buildings. The Punjab Government, under the PHSRP, has assigned these repairs to the National Logistics Cell.

Financial Cost of the CMIPHC ???

A part of the skepticism is directed at the perceived cost of the Initiative. Claims are sometimes made that if similar financial resources and autonomy were available to another management, including the erstwhile Health management, the same operational efficiency would have been achieved or even exceeded. This argument needs a close look.

The DGs, as said earlier, transfer to the PRSP what is budgeted for salaries and non-salary expenses at the BHUs/RDs. The Initiative does not, therefore, cost a DG anymore than what the operation of BHUs/RDs would have ordinarily cost that DG even without the CMI. The cost of the CMIPHC management, in the form of all expenses at the PSU and the DSUs, is picked up 100% by the Provincial Government – this being a "Chief Minister's Initiative". However, these too are a cost of the operation and must, therefore, be included in the reckoning and not left out.

PRSP had, at the start of the CMIPHC, sought funding from the GOPb for the management of the Initiative on the basis of expressly specified needs for capital, salaries and non-salary expenses at the PSU and at each DSU. All provisions have remained unchanged since 2004. What deserves to be noted, however, is that every year we have requested the GoPb to release a smaller amount – having regularly offered savings to the Government from the last year.

Extreme care in spending has been a highly valued hallmark of the Initiative. The CMIPHC ensures that the average cost of management of one BHU (2 RDs are assumed to be one BHU) does not exceed the upper limit of **Rs. 2,500 per month**. How little this cost is can only be appreciated when compared with the relevant cost during the pre-CMIPHC years or with the

current cost in other Districts of Punjab. A comparison shall highlight the huge difference between the two.

Over the months, the CMIPHC has been able to save significant amounts from the transfers received from the DGs. These savings are now available in the form of "Reserve for Improvements" in every District. These "Reserves" are intended for long-term investment for new and better quality services. It has been a great surprise that the normal year-to-year funding of the BHUs / RDs has yielded more than 20% saving. This has gone into the "Reserves" and strongly reinforces the belief that lack of funds has little to do with the failure of our social sector services. The management and governance issues seem to deserve a close look if one is looking for the reasons.

The powers and autonomy available to the CMIPHC managers are some time cited as a major reason for the outputs that the Initiative is able to claim. It is true that the CMIPHC believes in locating authority where it assigns the responsibility. This appears to us as the only reasonable principle to be guided by. However, in making this assertion, it is conveniently overlooked that some key financial and administrative controls remain – even now – with the GoPb and various officers of the DG in these 12 Districts. The devil is essentially in the exercise of powers and performance of functions. There are some reasons that obstruct the exercise of legitimate authority and impede the performance of functions. These are all too well-known and do not need to be re-stated here. But quite obviously, the malaise is the result of reasons which are rarely acknowledged and remain discretely unstated.

Sustainability….???

One final question that the CMIPHC faces, more than any other question, relates to "sustainability". This question is delivered almost like a coup de grace. In the first sense, though framed like a question, it is, in fact, only a thinly disguised wish. It reflects the eagerness to know when the CMIPHC plans to wrap up its operation. The CMIPHC operations can be a source of embarrassment for some. The success of these operations, though far from being complete in our own reckoning, can raise some awkward questions. What gets highlighted by our work can also be offensive. It is, therefore, simple to understand the wide-spread desire to throw these operations out of the window. Impatiently wanting to know our "exit strategy" is a common way of expressing this desire.

In the second sense, it is a bonafide question. It wishes to know how the delivery of services shall continue over time. And that, if the PRSP cannot see this, how if at all these services shall endure? How these services continue once the PRSP disassociates itself is widely asked and sometimes triumphantly but PRSP has an abiding interest in the delivery of Primary Healthcare services but all decisions on the future are finally for the Government to take. This is commonly overlooked. One cannot help wondering, why?

In the history of our social sector services, interest and commitment have often been fleeting and inconstant. It is on this account, therefore, that the question of sustainability deserves to be raised. We have a history, after all, of going from policy to policy; of lukewarm and half-hearted implementation; of not pausing to reflect on experiences; of not recognizing lessons; of declaring failure when this may not entirely be the case; of celebrating success when it is not entirely established. This is one view. Admittedly, there shall be other views also. But questions of sustainability are being ceaselessly misaddressed at the CMIPHC. At that one can say is that if the interest of the Government(s) in the effective delivery of PHC services endures, there shall always be a CMIPHC and any number of improved versions of it.

Some fundamentals need to be clearly brought out here. First, that the PRSP considers this an assignment with a fixed duration. Whatever the duration, it is not for the "long term". Secondly, that any lessons learnt shall be meaningful only if suitably built into the future management systems succeeding the PRSP. Thirdly, that it is for the Government to lead the process of crafting the successor management in the light of the CMIPHC experience. Fourthly, that it is PRSP's moral obligation to make its best contribution to the process of evolving an appropriate successor management. We shall do everything to meet that obligation but we cannot lead that process. That is a role for the Government. And finally, that whatever its form, only such a management shall have a reasonable ability to deliver social sector services (i) which locates requisite powers at the most appropriate points combined with rigorous accountability, (ii) which ensures the exercise of authority without formal or informal impediments and (iii) which rivets the beneficiaries to the facilities with a well-conceived role for them.

PRSP envisages a major role for the Support Groups. It expects that these Groups can be strengthened as local outposts of assistance and facilitation. The local communities, as the sole beneficiaries of the services, have the highest stake in the HFs delivering the desired volume and quality of services. PRSP

expects that five years, which happens to be the duration of the management assignment from each DG, can initiate the creation of the required capacity in the Support Groups. Such capacity building always takes time to build.

Various possibilities for ensuring 'sustainability' will continue to be debated. But it does not seem right that endeavours such as the CMIPHC should be abandoned merely because the question of "sustainability" has not been adequately answered. The question has also to be raised with the beneficiaries of the services. Somehow, they are never consulted and their views do not, therefore, enrich the solutions and the Policies formulated for them. PRSP believes that the beneficiaries, though they may be poor and suffering from all conceivable disadvantages of poverty, are the premier source for the best solutions in matters such as these. It is by that golden principle that the PRSP undertakings are guided.

We have many leagues to go. The "Millennium Development Goals", whenever mentioned, remind us of how far behind we are. Call it by any name – "sustainability" or "exit strategy" as we like to repeat so often. What the CMIPHC has barely brought to life must somehow remain alive. It is of no consequence which mode of management is considered the most appropriate for it. Unfortunately, one cannot help the inescapable impression that this can be the case of throwing the baby out with the bath water.

A Major Watershed:

The formative phase was crowned by the recognition received from the President and the Prime Minister of Pakistan. In September 2005, they took ambitious decisions for applying the Punjab experience to all Provinces and other areas of the country. In the Punjab, the CMIPHC was given the task of taking its work to the remaining 23 Districts of the Province. It was also decided that all the national and provincial Programs being vertically run in the area of a BHU shall be progressively integrated at and delivered through a BHU. Certain other decisions were also taken to strengthen the delivery of services. Most importantly, it was also decided to re-design the management of PHC services at the District level. That, well and truly hit the nail on the head. Alas, the euphoria was short-lived. It was soon realized that the ground realities were woven around different and altogether unrelated considerations. It was realized very soon that if we were going anywhere at all, it was not likely to be very far.

Epilogue:

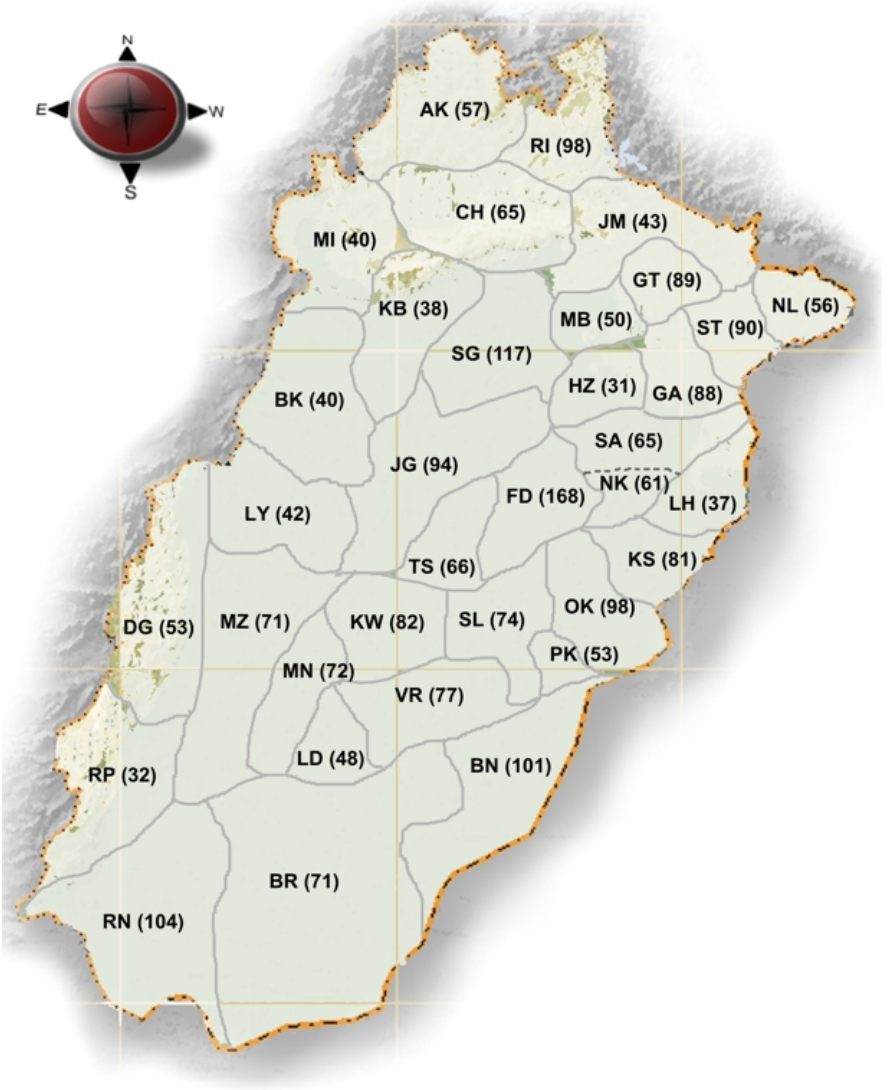
On looking back at the journey which commenced in January of 2003, one is reminded of many seasons; of joys and frustrations; of support generously given and gratefully received. One also remembers the relentless hostility that knows no limits and spares no occasion but has to be borne in silence.

One is overwhelmed by the vast opportunities waiting to be taken. One marvels at chronic and complex problems yielding to uncomplicated and simple solutions. But above all, one is appalled at the worthlessness of the reasons that can weigh with us for throwing away great opportunities and think nothing of it.

Role and Functions of a Basic Health Unit

(From Manual of Instructions for Training, 2000, DOH GOPb)

1. Comprehensive medical care and relief, curative and preventive
2. Prevention and control of communicable and endemic diseases.
3. Maternity and child health services and immunization.
4. School health services.
5. Health education program.
6. Family welfare program.
7. Improvement of environmental sanitation and provision of safe water.
8. Improvement of nutritional status.
9. Collection of vital statistics records.
10. To participate in and discharge such functions as are required by the National and/or Provincial curative and preventive programmes in PHC sector.
11. Training of village health workers, birth attendants, dais, etc.
12. It provides first level referral capability for patients referred by LHW, FHWs for primary level organized curative care using approved essential drugs. BHU in turn refers the patients to RHC as and when necessary.
13. Provision of static and out-reach services for the following:-
    (a) MCH, FP, EPI and advice on food and nutrition.
    (b) Sanitation and health education,
    (c) CDD, CDC, ARI and other special programmes.
14. It is a focal point, where community and the public sector health functionaries come together to resolve issues concerning health.
15. BHU provides support; logistics, and management to LHW, TBAs, dispensaries, MCH centers, sub health centers etc. falling in its assigned geographical limits.



Punjab: Rural Population with (FLHFs)

1. RYK (104)	**2,882,000**	2. Chakwal (65)	**1,044,000**	3. Vehari (77)	**2,018,000**
4. Lahore (37)	**1,343,000**	5. Faisalabad (168)	**2,549,000**	6. Sahiwal (75)	**1,710,000**
7. Kasur (81)	**2,122,876**	8. Mianwali (40)	**1,057,000**	9. T T Singh (66)	**867,316**
10.Hafizabad (31)	**688,419**	11.Lodhran (48)	**1,164,238**	12.Pakpattan (53)	**1,279,686**

AGREEMENT

THIS AGREEMENT made on the _____ day of _____, 20___ between the District Government of _____ through the District Coordination Officer, _____ (hereinafter called the DG_____) of the one part,

AND

The Punjab Rural Support Programme, a company registered under section 42 of the Companies Ordinance, 1984, having its registered office at the LDA Plaza, Kashmir/ Egerton Road, Lahore, (hereinafter referred to as the PRSP) of the other part.

Whereas the DG_____ desires to assign the management of the Basic Health facilities in the rural areas **(**hereinafter referred to as the Basic Health Units (BHUs) which expression shall, for the purpose of this Agreement include besides the BHUs, all Dispensaries formerly run by the defunct Zila Council, Unani Dispensaries and MCH Centres all located in the rural areas of _____ District hereinafter referred to as the District, numbering _____ (BHUs–_____; Rural Dispensaries–_____; Unani Dispensaries–_____ and Mother and Child Health Centres–_____) and of which a list is appended herewith**)**, to the PRSP for a more efficient delivery of all the services for which the said BHUs have been established;

And whereas the PRSP has agreed to re-organize, to re-structure and engine the management of all the BHUs in the District with a central role for community-based Support Groups, organized and fostered by the PRSP, representing the beneficiaries of the said BHUs.

NOW, THEREFORE, this Agreement witnesses as follows:

A. ROLE OF DG_____

1. The DG_____ shall transfer the control, use and management of personnel, buildings, furniture, supplies and equipment of/at the said BHUs to the PRSP which shall not be later than 30 days after the conclusion of this Agreement. An inventory and a list of the said buildings, equipment, supplies, furniture and staff thereat shall be prepared by DG_____ and these properties/assets/personnel shall be taken over by the authorized representatives of the PRSP. The buildings, equipment and furniture so transferred shall be received back by the DG_____ from the PRSP through its authorized representative upon the expiry of the above referred management arrangement.

2. The DG_____ shall continue to pay the salaries and other emoluments of all staff, appointed and posted at the BHUs or otherwise assigned to it, in the same manner as these were being paid prior to the commencement date save such staff, generally or specifically, in respect of which PRSP requests that these salary payments be made through

them. In all such cases the necessary Budget shall be transferred to the PRSP for disbursement of salaries, etc.

3. The DG_____ shall also transfer to the PRSP the budgetary provision relating, inter alia, to all unfilled posts, medicines, maintenance and repair of buildings and equipment, utilities, stores and office supplies, etc. for the relevant financial year or part thereof by the 10th of the month to which the payment relates or in such manner as may be agreed between the parties from time to time.

4. The DG_____ upon a proposal made by the PRSP in this regard, shall re-arrange, adjust and/or increase the budgetary provisions for medicines, maintenance, salaries, utilities, equipment after the consideration of relevant and appropriate arguments in support of the proposal.

5. The DG_____ shall give due consideration and importance to suggestions made by the PRSP on the financial provisions to be incorporated in the next Budget or for amendments in the current Budget.

6. The services of all staff posted or appointed at each BHU or assigned to it on the commencement date shall be made available to the PRSP for the best and most efficient delivery of service. PRSP shall be competent to re-locate staff from one BHU to another in the best interest of the management arrangement.

7. Any Government staff at the BHUs or otherwise allocated to the PRSP under the management arrangement, found guilty of misconduct, lapses, acts of commission and omission requiring action under the current E&D Rules shall be reported by PRSP for such action. DG_____ shall take prompt appropriate action on the report.

8. The DG_____ shall arrange or allocate to the PRSP such reasonable and essential accommodation for office, residential and storage purposes and the services of minimal and necessary support and auxiliary staff as are of direct use to the management arrangement and as may be requested for by the PRSP from time to time.

B. ROLE OF PRSP

1. The PRSP shall receive, through a duly authorized representative, the buildings, equipment, furniture, supplies etc. as per the afore-referred inventory from an authorized representative of the DG_____ within 30 days of the conclusion of this Agreement.

2. The PRSP shall ensure that all BHUs under the new management arrangement continue to provide all the services and perform all the functions that these BHUs were performing and providing before the commencement date.

3. The PRSP shall be responsible for the cost of utilities, for due maintenance of equipment, furniture and buildings of the BHUs at acceptable

and satisfactory standards for the management period and their return to an authorized representative of the DG_____ at the end of the period of management.

4. The PRSP shall make the best possible use of the services of the staff at the BHUs, as on the date of commencement, subject to terms and conditions of their appointment, for the optimum delivery of primary healthcare services.

5. The services of all staff posted or appointed at each BHU or assigned to it on the commencement date shall be made available to the PRSP for the best and most efficient delivery of service. PRSP shall be competent to re-locate staff from one BHU to another in the best interest of the management arrangement.

6. Any Government staff, at the BHUs or otherwise allocated to the PRSP under the management arrangement, found guilty of misconduct, lapses, acts of commission and omission requiring action under the current E&D Rules shall be reported by PRSP for such action. DG_____ shall take prompt appropriate action on the report.

7. The PRSP shall be authorized to allocate and reallocate to the staff appointed, posted or assigned at the BHUs such functions and responsibilities as it considers most appropriate for the best delivery of the services which are or can be expected to be provided at the BHUs.

8. The PRSP shall be authorised to offer such further and additional benefits, advantages or perquisites as it deems justified in the context of functions assigned and performance demanded of the BHU staff.

9. The PRSP shall use the monitoring formats, inter alia, the Health Management Information System (HMIS) of the DG_____ in addition to the compilation of a Quarterly Progress Report (QPR) and shall send a copy of the said Report to the DG_____.

10. The designated officers of the DG_____ shall have the right to visit and inspect the BHUs and its record at any appropriate time and the PRSP shall facilitate such visits and inspections and shall take due notice of and action on the written observations made during these visits, under intimation to the DG_____.

11. PRSP shall arrange due participation of the BHUs and discharge of such functions by the BHUs as are required by the National and/or Provincial curative and preventive Programmes in the Primary Health Care sector.

C. STAFF

1. Throughout the duration of the management arrangement to which this Agreement relates, all staff posted and appointed at the BHUs shall retain their current employment status and shall continue to be governed by the terms and conditions of employment as these stood on the commencement date. The supervisory controls, in all appropriate and logical dimensions, shall during the period be exercised by the PRSP.

Provided further that such changes and fresh arrangements may be made after mutual consultations for the duration of the management arrangement as are considered necessary for the delivery of best service at the BHUs.

2. The PRSP may engage additional staff to work at the BHUs who shall be governed by their contract with the PRSP and who shall not have any claims against the DG_____ and the Government of the Punjab (GOPb) during or upon the conclusion of the management arrangement.

D. FINANCE AND AUDIT

1. The PRSP shall not charge a fee in any form for the performance of the management functions to which this Agreement relates. It shall, however, have a right to charge the actual cost incurred on the performance of management functions whether from the allocation due to it in terms of clause 3 in the section A of this Agreement, or to claim and receive it in addition to the budget transferred to it by the DG_____.

2. The PRSP shall maintain such record of financial transactions and maintain accounts in such manner as is expected of a corporate body.

3. The PRSP shall render accounts of the management operation to the DG_____ within a period of three months after the conclusion of each financial year.

4. The accounts of the management operation shall be audited by the auditors of the PRSP and a copy thereof shall be provided by the PRSP to the DG_____ within thirty days of the approval of accounts in the Annual General Meeting of the PRSP.

5. The DG_____ or the Government of the Punjab in Finance Department may provide Guidelines to the PRSP and suggest forms and procedures that may be used and observed in the maintenance and application of funds transferred by the DG_____.

E. COMMENCEMENT AND DURATION

1. The duration of the management arrangement to be governed by this Agreement shall be five years starting from the date of taking over of the BHUs and the receipt of funds as mentioned in clauses 1, 2 and 3 of Section: A.

2. There shall be an independent third-party assessment of the performance of the said BHUs against indices, mutually agreed between the parties, at the end of the first year of the management arrangement. The continuance of management with the PRSP for the next four

years shall depend upon improvement in performance achieved during the said first year against each index.

3. If at any stage the DG_____ feels that the object of this Agreement is not being adequately achieved or that the PRSP is acting in contravention of this Agreement, it may terminate this Agreement prematurely. Provided that this course shall not be taken without allowing the PRSP to show cause within a reasonable period, of not less than four weeks, why the proposed action should not be taken. Provided further that a reasonable period, for preparatory purposes, shall be allowed before taking over of the staff and possession of buildings, equipment, furniture, etc., upon premature termination of this Agreement.

4. If at any stage the PRSP feels that owing to circumstances beyond its control and/or non-observance of the terms of this Agreement, it is not possible for it to continue the operation, it may after Notice to DG_____ discontinue the management arrangement.

F. REMOVAL OF DIFFICULTIES

For the removal of such difficulties as may arise from time to time in the implementation of this Agreement, the District Coordination Officer of the DG_____ and an authorized representative of the PRSP may resolve the issues in the most appropriate and reasonable manner as found in the best interest of the management arrangement.

G. ARBITRATION

If any dispute arises between the parties on the interpretation of any term of this Agreement or the intention or scope of the management arrangement, DG_____ and PRSP shall refer the matter to a Sole Arbitrator mutually acceptable to both parties.

IN WITNESS WHEREOF the parties hereto have set their hands hereunto on the day and year mentioned above.

_____
For DG_____

Executants:
District Government _____
(DG_____)
Through the District Coordination Officer

_____
For PRSP

Punjab Rural Support Programme (PRSP)
through the Chief Executive Officer

Signed at _____ in presence of:

_____

1. Executive District Officer (Health)
   District Government _____

_____

2. Executive District Officer, (Finance & Planning)
   District Government _____

EVALUATION OF THE RYK DISTRICT BY THE WORLD BANK – 2005
Summary of the Main Findings

Aspect of PHC Services	Main Findings	Methodology
Utilization of BHUs	• 50%-54% greater utilization of BHUs in RYK than BWP based on household survey and HMIS data • Faster increase in RYK over previous 2 years (+ 19 patients per day per BHU vs. + 11 in BWP). • Typical BHUs in PRSP districts see 21 more patients per day than BHUs in non-PRSP districts	Cross-sectional data – household survey Before and after – HMIS HMIS Panel 2002-2005
Community satisfaction	Satisfaction is comparable but the community in RYK indicated a significantly larger improvement in services over the last 2 years than in BWP.	Cross-sectional and recollection household survey
Physical condition of BHUs	BHUs were in significantly better condition in RYK than in BWP	Cross-sectional data – health facility survey
Out-of-pocket expenditures	Out-of-pocket expenditures for BHU services were lower in RYK than in BWP (Rs.1 vs. Rs.5)	Cross-sectional data – household survey
Technical quality of care	• Poor in both districts, worse for children • Knowledge of staff better in BWP	Cross-sectional data – health facility survey
Availability of drugs	Poor in both districts, perhaps slightly better in BWP but it is difficult to be sure.	Cross-sectional data – health facility survey Longitudinal data from records
Staff availability	• Acute shortage of trained female staff in both districts • Availability of staff is slightly worse in RYK but that was a pre-existing issue.	Longitudinal data – Administrative records
Staff morale	Small difference but improving compared to 2 years ago in RYK and declining slightly in BWP	Cross-sectional and recollection data – health facility survey
Preventive service	Few differences in coverage, except child immunization where BWP had higher coverage which was pre-existing	Cross-sectional survey data from this evaluation compared to previous household surveys
Budget, expenditure & cost effectiveness	• Allocations in RYK were similar in 2003-2004 compared to 2002-2003 • Cost per patient visit was significantly lower in RYK that in BWP.	Longitudinal financial data – Administrative records

Annexure – E

SUPPORT GROUP- TORs

STRUCTURE

1. Each BHU would have one Support Group comprising of 20 to 25 male and female members.
2. All male and female members would enjoy equal rights.
3. All members of a Support Group would be residence of the actual catchments of the BHU.
4. The Support Groups would be comprised of the persons responsive towards health issues in particular and social issues in general as per following :-

    a. At least 01 member of Union Council (councilor).
    b. At least 01 Imam Masjid, preferably that of the most prominent Jamia Masjid situated in the catchments.
    c. At least 02 school teachers.
    d. At least 04 senior students (high school and above)
    e. The remaining members may be from any social background i.e. Govt. employees, farmers, shopkeepers, vendors, labourers, drivers, household women etc, if they qualify the condition **"responsive towards the health issues in particular and social issues in general".**

FUNCTIONS/RESPONSIBILITIES OF THE SUPPORT GROUP

1. To Organize Community Health Sessions in the catchments.
2. To identify the children left over by the field staff of EPI.
3. Pursuing women to complete the course of TT injections, and have antenatal and post-natal check ups from trained female Health Care Providers.
4. To organize School Camps at BHUs.
5. To solve security issues of the BHUs.
6. Development of physical infrastructure in coordination with the concerned Incharge Medical Officer and Social Organizer.
7. To identify causes for specific health issues in the area of certain BHUs, and devise ways and means for their solution with the help of concerned CIMO, Social Organizer and DSU.
8. To improve the hygiene / cleanliness in the locality.
9. To coordinate with the outreach staff of the Health Department and ensure effective implementation of National and Provincial Primary Health Programs.

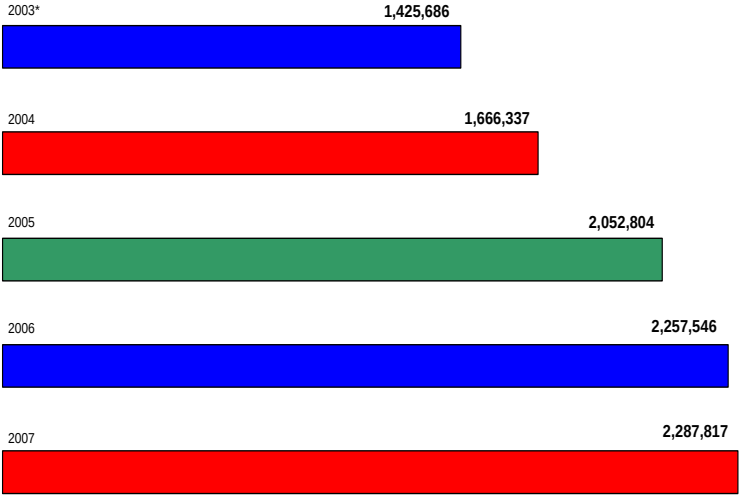
Topics for Community Health Sessions

Anti Natal / Natal care
Acute Respiratory Infection
AIDS
Arthritis
Awareness about Prevention of Scabies
Awareness about skin infection
Balanced Diet and its importance
Cholera
Cleanliness of surrounding
Chronic Dermatitis
Dengue Fever
Diabetes Militias
Diarrheal Diseases
Disposal of wastage
Emergency aid preventive measure in poisoning of agriculture chemicals
Enteric Fever
Gastroenteritis (How to prevent)
Genera Cleanliness
General Healthcare
Head Injury Local Management
Heart Disease
Heat Stroke
Hepatitis (B & C)
Herpes Zoster

Hypertension
Importance of use of Boiled Water
Importance of immunization and inoculation
Inhalation of Orgono Phaphoras Poising
Management of Worm Infestation
Personal Hygiene and its parameters
Positive Thinking & Behavior
Prevention from food poisoning during rainy season
Prevention of Diarrhea
Preventive Measures against Monsoon Diseases
Preventive measures against sun stroke
Removal of Garbage from the area
Sensitization about Dental Hygiene
Sexually Transmitted Diseases (SIDs)
Significance of Family Planning
Significance of TT Vaccination in the Ante-Natal Care
Significance of use of lodized salt
Skin Allergies
Spread of Hepatitis through use of community razor
T.B. (How to prevent it)
Typhoid
Use of ORS (Methods to prepare it at home)
Viral Diseases (Measles, Mumps)
Worm Infection & Renal Stones

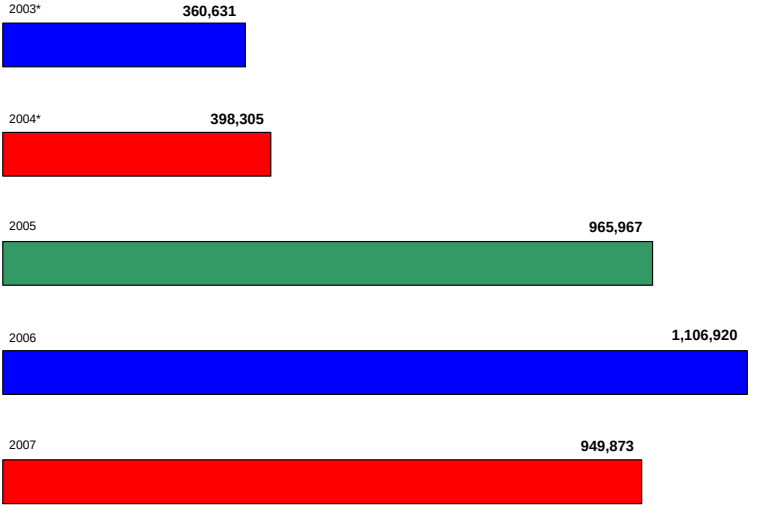
Curative Services at BHUs/RDs

Rahim Yar Khan (HFs-104) Agreement Signed: 11-03-2003 DSM installed: 05-05-2003



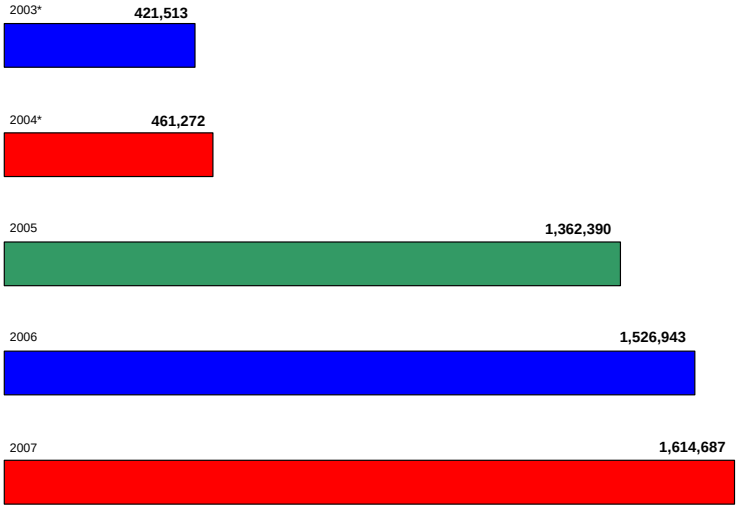
* First half of 2003 was with the DGRYK management.

Chakwal (HFs-65) Agreement Signed: 17-12-2003 DSM installed: 10-08-2004



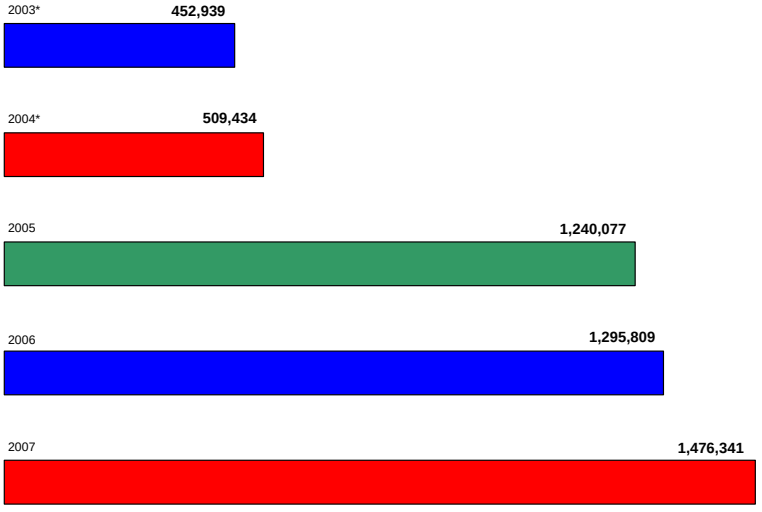
* 2003 was with the DGCKL management. First 8 months of 2004 were also with the same management.

Vehari (HFs-77) Agreement Signed: 19-12-2003 DSM installed: 01-09-2004



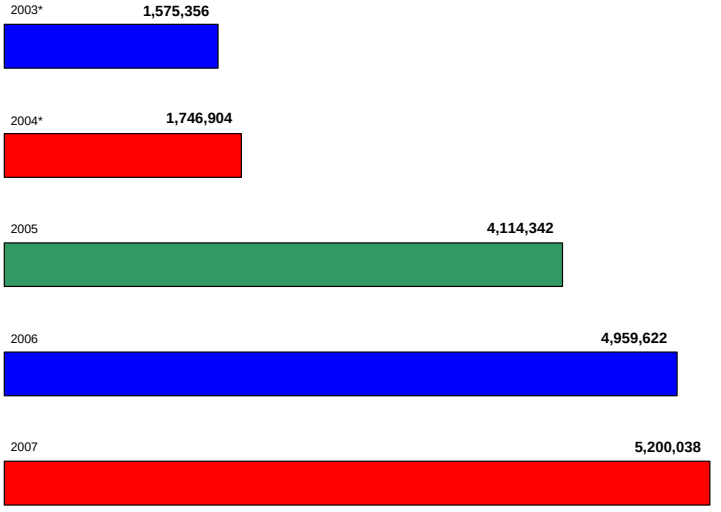
* 2003 was with the DGVRI management. First 8 months of 2004 were also with the same management.

Lahore (HFs-61) Agreement Signed: 01-04-2004 DSM installed: 01-10-2004



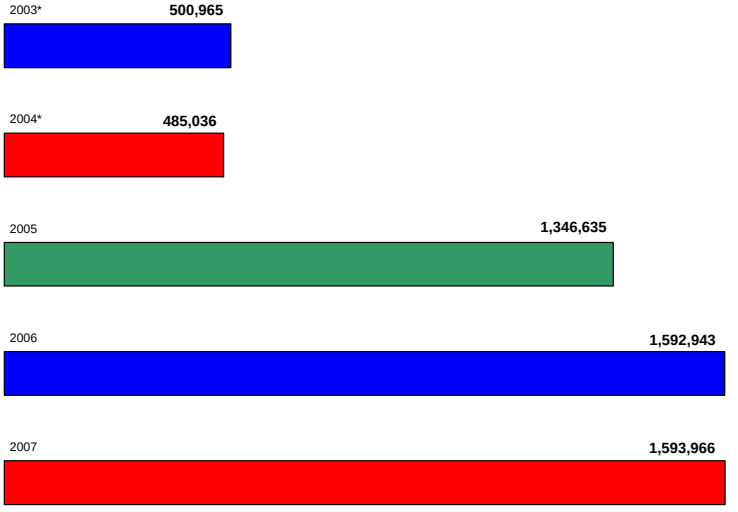
* 2003 was with the DGLHR management. First 9 months of 2004 were also with the same management.

Faisalabad (HFs-236) Agreement Signed: 05-08-2004 DSM installed: 19-07-04



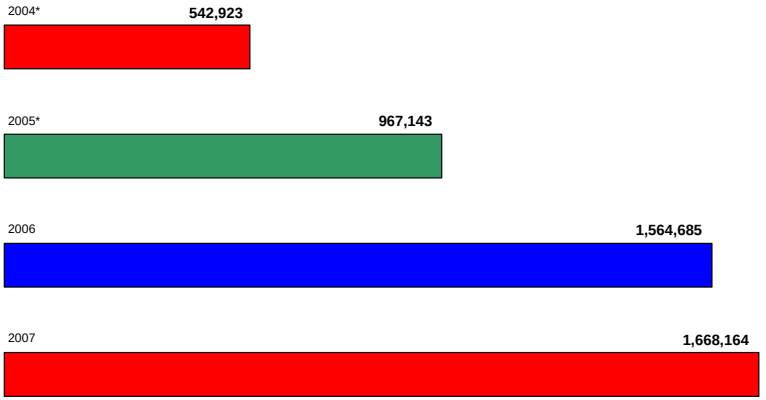
* 2003 was with the DGFSD management. First 7 months of 2004 were also with the same management

Sahiwal (HFs-91) Agreement Signed: 25-09-2004 DSM installed: 21-10-2004



* 2003 was with the DGSWL management. First 10 months of 2004 were also with the same management

Kasur (HFs-104) Agreement Signed: 01-01-2005 DSM installed: 15-01-2005



* 2004 was with the DGKSR management. First month of 2005 was also with the same management

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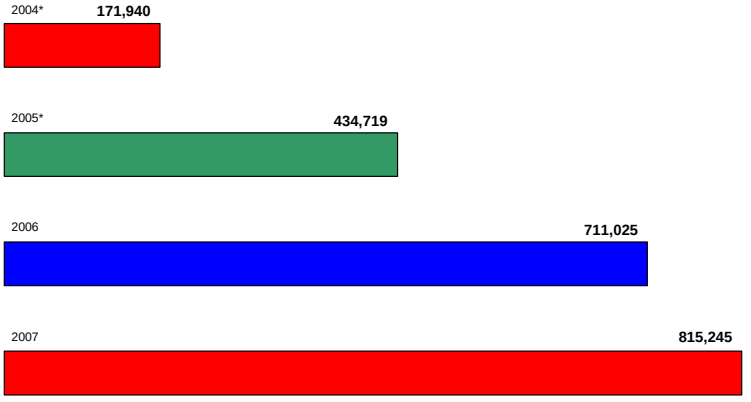
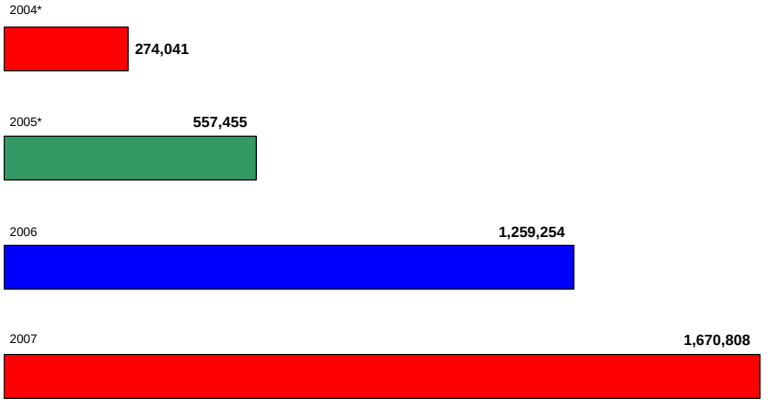
Mianwali (HFs-67) Agreement Signed: 14-01-2005 DSM installed: 25-01-2005



* 2004 was with the DGMI management. First month of 2005 was also with the same management

Toba Tek Singh (HFs-89) Agreement Signed: 24-03-2005 DSM installed: 20-04-2005



* 2004 was with the DGTTS management. First 4 months of 2005 were also with the same management

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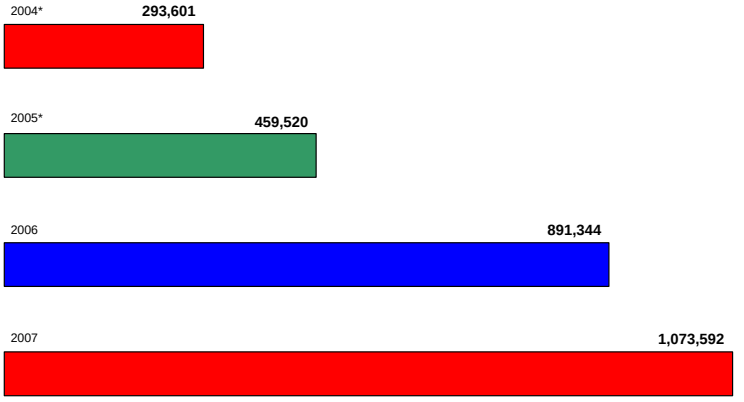
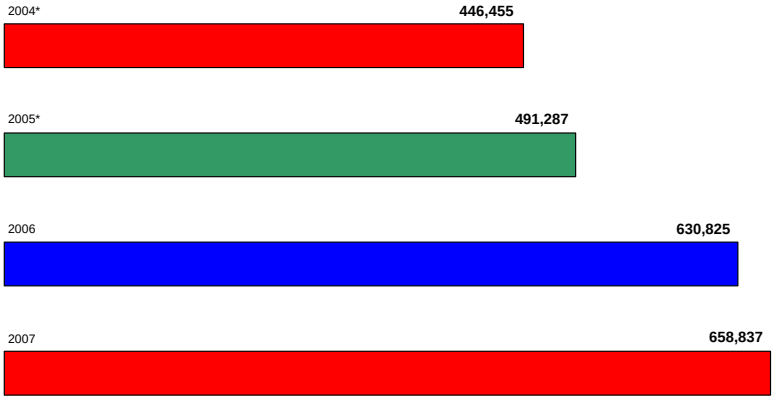
Lodhran (HFs-48) Agreement Signed: 06-05-2005 DSM installed: 13-05-2005



* 2004 was with the DGLD management. First half of 2005 was also with the same management

Hafizabad (HFs-43) Agreement Signed: 05-05-2005 DSM installed: 08-06-2005



* 2004 was with the DGHZD management. First 6 months of 2005 were also with the same management

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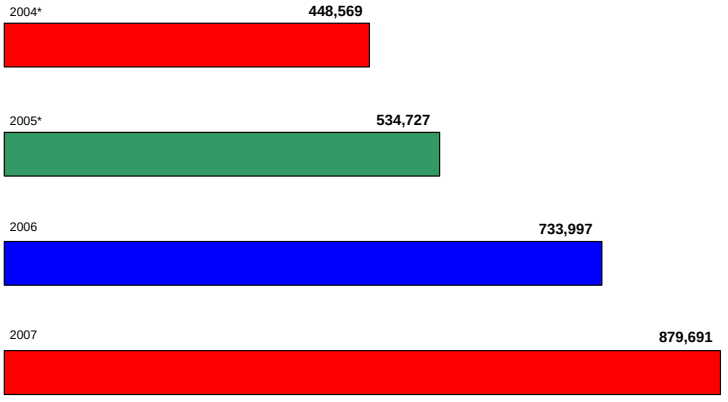
Pakpattan (HFs-61) Agreement Signed: 30-06-2005 DSM installed: 03-07-2005



* 2004 was with the DGPK management. First 7 months of 2005 were also with the same management

Punjab Rural Support Programme
(Licensed under Section 42 of the Companies Ordinance 1984)
Chief Minister's Initiative For Primary Health Care
DISTRICT SUPPORT UNIT LAHORE
EDO(Health) Office, 2nd Floor, 24-Cooper Road, Lahore
Phone: 042-6278826 Fax: 042-6278826
e-mail: dsm_lahore@yahoo.com

DSM-DSU-CMI-PHC/16
January 08, 2008.

Subject: **MINUTES OF THE 40th MONTHLY REVIEW MEETING (MRM) HELD ON JANUARY 05, 2008.**

40th Monthly Review Meeting of District Support Unit Lahore held in the District Health Development Center (DHDC), Lahore on January 05, 2008. Invitations were sent to the Zila Nazim, the DCO, the EDO (H) and the EDO (F&P) as usual. The participants of the meeting were as under:

01. Dr. Cap. (Rtd) Inam ul Haq, EDO(H), CDG Lahore.
02. Dr. Shafqat Mehmood, District Coordinator, National Programme, FP & PHC, Lahore.
03. Mr. Azhar Iqbal, XEN/AQS, NLC. Lahore
04. Mr. Wali M. Sohail, APM, NLC, Lahore.
05. Mr. Rana Sohail, APM, NLC, Lahore
06. Mr. Zeeshan Munawar, Site Engr., NLC Lahore.
07. Mr. Waqas Saddiqie, Site Engr., NLC Lahore.
08. Mrs. Shamsa Naureen, Rep of EDO (F&P) CDG, Lahore.
09. Mr. Tariq Mahmood, District Support Manager, Lahore.
10. Mr. Nazir Ahmad Khan, Executive Finance, DSU, Lahore.
11. Mr. Shakeel Ahmad, Executive Monitoring, DSU, Lahore.
12. Mr. Saif-Ur -Rehman, Social Organizer, DSU, Lahore.
13. Mr. Rashid Mehmood, Social Organizer, DSU, Lahore.
14. Dr. Abida Khalid, Female Medical Officer, BHU Bhaseen.
15. Dr. Nousheen Hasseb, Female Medical Officer, RHD Lakho Dhair.
16. Dr. Rukhsana Jabeen,

Female Medical Officer,
BHU Dograin Kalan.

17. Dr. Khalida Adeeb,
Female Medical Officer,
BHU Arrain.
18. Dr. Sadia Kamran,
Female Medical Officer,
BHU Sultan Kay.
19. Dr. Rabiqa Yasir,
Female Medical Officer,
RHD Theh Punjoo.
20. Dr. Ghazala Shaukat.
Women Medical Officer,
BHU Lidher.
21. Dr. Sara Maryam,
Women Medical Officer,
RHD Mall.
22. Dr. Samina Iftikhar,
Women Medical Officer,
BHU Johdo Dheer.
23. Dr. Sayeda Nasreen,
Women Medical Officer,
BHU Kohrian.
24. Dr. Farrukh Rana Jalal,
Women Medical Officer,
BHU Sahazada.
25. Dr. Shagufta Asif,
Women Medical Officer,
BHU Niaz Baig.
26. Dr. Tahira Wahab,
Women Medical Officer,
BHU Hadyara.
27. Dr. Aliya Waqas,
Women Medical Officer,
RHD Dograi Khurd.
28. Dr. Anjum Bashir,
Women Medical Officer,
RHD Ali Raza Abad (F).
29. Dr. Sidra Shaukat,
Women Medical Officer,
BHU Maraka.
30. Dr. Tayyaba Zaka Ullah,
Women Medical Officer,
RHD Padri.
31. Dr. Rubina Shaheen,
Women Medical Officer,
RHD Badooki
32. Dr. Khalid Pervaiz,
MO, BHU Padhana.
33. Dr. Muhammad Akhtar,
MO, BHU Halloki.
34. Dr. Farouk Qamar Malik,
MO, BHU Karol.
35. Dr. Shahzad Raza,
MO, RHD Bagerian.
36. Dr. Abdul Aleem,
MO, RHD Bhaseen.
37. Dr. Ghulam Sarwar,
MO, BHU Attoki Awan.
38. Dr. Aftab Anwar Ghauri,
MO, RHD Wahga.
39. Dr. Mohammad Tahir,
MO, BHU Jia Bagga.
40. Dr. Irfan Ul Haq,
MO, BHU, Bhunghali.
41. Dr. Khalid Abdullah,
MO, BHU, Leel.
42. Dr. M. Afzal Khan,
MO, BHU Pandooki.
43. Dr. Syed Aziz Ul Hassan,
MO, BHU Kacha.
44. Dr. Tahir Mahmood,
MO, BHU Wahga.
45. Dr. Abdul Jabbar,
MO, BHU Shah Pur.
46. Dr. Asif Aftab,
MO, RHD Ali Hussain Abad.
47. Dr. Khaliqur Rehman,
MO, RHD Lakho Dahr.
48. Dr. Sharafat Ali,
MO, RHD Sheikh Da Kot.
49. Dr. M. Tayyab Butt,
MO, BHU Bhullar.

50. Dr. Zahid Hussain,
MO, BHU Shamke Bhattain.
51. Dr. Amir Nisar,
MO, RHD Kamaha.
52. Dr. Tahir Shabbir,
MO, RHD Heir.
53. Dr. Shakeel Aslam,
MO, BHU Chappa.
54. Dr. Imtiaz Ahmed,
MO, RHD Manawan.
55. Dr. Noman Shahid,
MO, BHU Heir.
56. Dr. Sarwar Sadiq,
MO, RHD Ali Raza Abad (M).
57. Dr. Junaid Saulat,
MO, BHU Sultanke.
58. Dr. Jawad Aslam,
MO, BHU Sarraich.
59. Dr. Sohail Ahmad Mazari,
MO, BHU Ali Raza Abad
60. Dr. Ateeq Ur Rehman,
MO, BHU Narwar.
61. Dr. Sheikh Abid Waheed,
MO, BHU Lakhoki.
62. Dr. Zafar Iqbal,
MO, RHD Mohlan Wal.
63. Dr. Shahzad Wahid,
MO, BHU Manawan.
64. Dr. Nasir Mehmood,
MO, BHU Minhala.
65. Dr. Zahid Iqbal,
MO, RHD Hadyara.
66. Dr. Sikander Ikram,
MO, RHD Asil Suleman.
67. Dr. Babar Ateeque Khan,
MO, BHU Arryian.
68. Dr. Fida Hussain,
MO, BHU Heir.
69. Dr. Sheikh Rizwan Vohra,
MO, BHU Rangeel Pur.
70. Dr. Asif Iqbal,
MO, BHU Jahman.
71. Dr. Muhammad Iqbal Raza,
MO, BHU Bhaseen.
72. Dr. Anayat Ali,
MO, RHD Satto Katla.
73. Dr. Fayyaz Ahmad,
MO, RHD Bhali Ghill
74. Dr. Farukh Hussain Shah,
Medical Officer, BHU Jallo.
75. Dr. Farooq Ahmad,
MO, BHU Ladhekay Uchay.
76. Dr. Usman Masood,
MO, BHU Chappa.
77. Dr. Chand Mehmood,
MO, RHD Theh Punjoo

Note: **All MOs / WMOs of DSU Lahore attended the meeting except Dr. Muhammad Asim Khan, Incharge MO BHU Lidher (Contractee Govt. Of Punjab, Health Department) who is absent from duty since November 24, 2007 on account of dysentery with out proper Medical Certificate. Hakeem Masood Tahir was on Hajj Leave**

The meeting started with recitation from the Holy Quran. Special Prayers and Fathia Khawani was offered for the departed soul of Nephew of Dr. Ghazala Shaukat.
Later on DSM welcomed the participants and briefed them about the agenda of the day.

1st Session **Capacity Building**

Lecture/Discussion

Topic 1: "**HUMAN CASES OF AVIAN INFLUENZA (Bird Flu)"**

Dr. Inam Ul Haq, sensitized the participants about causes, prevention and control of Human Cases of AVIAN INFLUENZA/Bird Flu. The resource person briefed the doctors about the necessary preparedness in this regard in the backdrop of reported one case of Avian Influenza Virus in NWFP. Various preventive and remedial measures to avoid the lethal epidemic of Bird Flu, also came under discussion. The speaker spoke about active surveillance, passive surveillance and reiterated the need of community health education in this regard.
Printed material containing overview of Toolkit for early detection and control of Human Cases of Avian Influenza was also provided to all doctors.

Topic 2: **"FAMILY PLANNING AS A COMPONENT OF PRIMARY HEALTH CARE"**

Dr. Farrukh Tariq discussed Family Planning as a vital component of Primary Health Care. She briefed the participants of side effects of various contraceptive items and contra indications of IUD / Multiload.
Dr. Shafqat Mehmood, District Coordinator, National Programme, FP & PHC, Lahore highlighted the role of LHWs in

connection with creating awareness regarding Family Planning..

The forum was briefed that when we talk of family planning it's all about the family health; an individual's family and that of the family of our nation. For that matter health is not only about the physical health; also, it is about the economic health of the family and that of the nation. The Focus of Family Planning is on to *Plan for Better Life*. Written material was also provided to participants.

Topic 3: "HEALTH HAZARDS OF IMPROPER MEDICAL WASTE DISPOSAL"

Medical waste is posing a substantial hazard to human health and the environment because of mismanagement and the lack of an efficient disposal system. Many Hospitals, Public and Private and other Health Care Concerns like Clinics, Health Centers, Medical Laboratories and Pharmacies usually dump their waste carelessly in piles in the open, bury them in the ground nearby or, worse still, throw them into streams and canals.

Dr. Fida Hussain discussed various types and methods of collection & disposal of solid waste including Infectious and Simple. The need of burial of waste at BHUs / RHDs was also highlighted. The adverse impacts and health hazards of improper management of Medical Waste Disposal including Hepatitis and other diseases were also discussed. Dr. Sarwar Sadiq also gave his valuable input in this regard by mentioning the use of special container & bags of different colors for highly infectious waste and other routine waste. Printed material was also provided to the doctors

2nd Session

01 REVIEW OF HEALTH SECTOR REFORMS PROGRAMME

Dr. Cap.(Rtd) Inam ul Haq, Executive District Officer (Health), CDG Lahore appreciated the services being rendered by Medical, Paramedics and other staff at Rural Health Facilities

under the management of PRSP. He expressed his pleasure over the standards of patient's compliance and satisfaction of common public at the BHUs/RHDs. The performance of Doctors and staff is excellent on the basis of parameters set to evaluate the same under HSRP. He urged the doctors to maintain this spirit and high degree of dedication. Some personal issues of doctors and staff were also discussed like non- payment of HSRP to Dr. Irfan ul Haq Incharge MO BHU Bhungali (Regular Doctor of Health Department Government of Punjab), non disbursement of salary to LHV of BHU Halloki and Leave Encashment issue of Contractee Doctors of HD, Government of Punjab.

DISCUSSION OF AGENDA ITEMS

02 NATIONAL IMMUNIZATION DAYS (POLIO ERADICATION CAMPAIGN)

The Incharge Doctors of BHUs were requested to participate actively in the next Polio Eradication Campaign / National Immunization Days to be launched from January 22 to 26, 2008. The special focus was on the proper functioning of static points (at the BHUs) during these days.

03 REVIEW OF REPAIR & MAINTENANCE OF BHUs

Major Repair Work is in Progress at various BHUs by NLC and same was reviewed as given below in the presence of representatives of NLC and in the light of comments mentioned in a report sent by District Project Manager, NLC, to EDO (Health), CDG Lahore in this regard:

Sr. No.	BHUs	Status Work	Comments of DPM, NLC	Remarks of Incharge MO/WMO
1	Pandoki	• Boundary Wall with Main Gate. • Repair of Hospital Block.	Work in Progress will be handed over by 31-12-07	Work in Progress till today
2	Leil	• Boundary Wall with Main Gate. • Repair of Hospital Block. • Repair of MO's Residence.	Completed & Handed Over	Incomplete
3	Shahzada	• Repair of Hospital Block.	Completed & Handed Over	Completed
4	Shahpur	• Boundary Wall. • Repair of Hospital Block.	Completed & Handed Over	Incomplete & not handed over
5	Lidher	• Boundary Wall. • Repair of Hospital Block.	Completed & Handed Over	Completed
6	Ghawind	• Repair of Hospital Block. • Soaling of Bricks at Approach Passage.	Completed & Handed Over	Copy of the scope work is provided and now work would be verified accordingly
7	Jallo	• Repair of Hospital Block. • Boundary Wall	Completed & Handed Over	Savings of worth Rs. 1.5 Lac is yet to be utilized on sewerage, water bore & Motor Pump, Roof of MO Residence
8	Jia Bagga	• Repair of Hospital Block.	Work in Progress	Work in progress
9	Hadyara	• Repair of Hospital Block.	Completed & Handed Over	Completed
10	Chappa	• Repair of Hospital Block. • Boundary Wall	Completed & Handed Over	Completed
11	Ladhekey Uchay	• Repair of Hospital Block. • Boundary Wall	Completed & Handed Over	Completed
12	Manawan	• Repair of Hospital Block.	Work in Progress will be handed over by 31-12-07	Work in progress till today
13	Halloki	• Repair of Hospital Block. • Boundary Wall	Work in Progress will be handed over by 31-12-07	Work in progress till today
14		• Repair of Hospital Block.	Completed &	Work in

The EDO(Health) asked the Incharge Doctors of these BHUs to pay full attention on the activity of Major Uplift by NLC for the best utilization of funds allocated for this purpose.

04 REPAIR & MAINTENANCE OF RURAL HEALTH DISPENSARIES BY NLC

The Incharge MOs/WMOs of Rural Health Dispensaries (RHDs) invited the attention of Executive District Officer (Health), CDG Lahore towards the poor and dilapidated condition of Buildings of RHDs.

The EDO (Health) informed the forum that for the Major Repair of these RHDs funds have been provided to the Building Department, CDG Lahore but due to some reasons best known to concerned authorities of Building Department, no progress is made on ground which depicts poor response and dismal performance of the department. The chair was of the view that if Incharge MOs / WMOs of RHDs agree, the competent authority of CDG Lahore may be approached to handover the task & work of Major Repair and Uplift of these Rural Health Dispensaries to NLC, which is carrying out the same assignment at BHUs under HSRP efficiently. The forum endorsed the suggestion of EDO(H) with the request to take up the matter with higher authorities in this regard.

05 MUHARRAM MAJALIS AND FIRST-AID ARRANGEMENTS

The Incharge Doctors of BHUs Niaz Baig, Shah Pur, Ali Raza Abad, Attoki Awan, Bhangali and Manawan particularly were requested to make all arrangements for the provision of facility of Medical Coverage to participants of Majalis and Processions during Muharram as per previous practice. The availability of required medicines and stitching material must be ensured.

06 DISPOSAL OF CONDEMN AND NON-SERVICEABLE STORE ITEMS

The progress on this issue was found slow. The Incharge MOs/WMOs of BHUs were of the view that Incharge SMOs may be asked by the EDO(H) to spare some time for this assignment. The Doctors informed that lists of such items have already been prepared and now they are looking for the visit of Incharge SMO of respective RHCs to verify and proceed further. EDO(Health), CDG Lahore is requested to issue necessary instructions in this regard.

07 MONTHLY MEETING OF INCHARGE DOCTORS WITH SMOs OF RHCs TO REVIEW TB-DOTS & PCD ACTIVITY.

While reviewing the TB DOTS Programme and PCD Activity, all Incharge MOs/WMOs of BHUs were requested to regularly hold meetings with respective Incharge SMOs of RHCs to share their problems if any regarding diagnosing of suspected T.B. Patients referred by them and similarly the fate of PCD slides prepared at BHUs of high fevered patients to diagnose malaria.

The activity of TB DOTS Programme during December 2007 was reviewed as:

Suspected Patients referred for Sputum Test at RHCs.	63
TB Patients under treatment at BHUs.	92

The Incharge Doctors were requested to ensure the availability of T.B. Medicine for proper treatment of confirmed patients.

08 SELECTED TOPICS FOR COMMUNITY HEALTH EDUCATION SESSIONS.

Following five Topics were selected by the forum with consultation for Community Health Education Sessions during the Month of January 2008.

1 Risk Factors for Cardio-Vascular Disorder
2 Preventive Measures against Cold Weather Child/Infant Diseases especially Pneumonia.
3 Prevention of Asthma
4 Dust and Food Allergy.
5 Awareness regarding Bird Flu / Human Influenza

09 SELECTED TOPICS FOR SCHOOL HEALTH EDUCATION SESSIONS.

Following five Topics were selected by the forum with consultation for School Health Education Sessions during the Month of January 2008.

1. Awareness about proper Eye Care.
2. Common Cold & Cough.
3. Awareness about Physical and Mental Health.

4. Importance of Hand Washing & Personal Hygiene.
5. Significance of Balanced Diet.

During December 2007 following Top Ten Diseases amongst the children treated were taken care.

Sr. No	Diseases	Sr. No.	Diseases
1	Scabies	6	Tooth/Dental Problems.
2	Upper Respiratory Tract Infections	7	Worm Infection.
3	Diarrhea	8	Ear Infection.
4	Boils / Skin Diseases	9	Allergic Reaction.
5	Eye Infection	10	Chicken Pox

10 REVIEW OF VACCINATION/IMMUNIZATION

The Vaccination / Immunization during December 2007 at the Health Facilities and in the Field by EPI Vaccinators were reviewed as:

(A) No. of Doses of Immunization Administered At Health Facilities Under CMIPHC **2496**

(B) Total Figure of TT Vaccines Provided To Pregnant Women At Health Facilities Under CMIPHC **956**

(C) Total Figure of Immunization & Vaccination Administered By Out Reach EPI Teams **9804**

(D) Total. **13256**

11 COMPUTERIZATION OF EMPLOYEES RECORD

During meeting the information in this regard was collected on the specific proforma for Computerization of Employees Record working at BHUs and RHDs. Same would be now sent to EDO(H) Office.

12 DISTRICT PROFILE & REVIEW OF M.D.G. INDICATORS

M.D.G Indicators regarding Health during December 2007 were reviewed as:

Total No. of BHUs	Number of BHUs Providing Ante-Natel Services	Number of BHUs with Functional Labor Rooms	Number of BHUs Providing Family Planning Services	Number of BHUs Providing EPI Services	Number of BHUs with Functional PCD Posts	Number of BHUs providing Treatment to TB Cases
37	36	*26	36	**35	37	37

* There is no LHV at BHU Pandoki due to non availability of sanctioned post. Moreover at 11 BHUs the Facility of Labour Room is not Functional because NLC is in action for Major Repair.

** The proper and regular services of Vaccinators are not available at BHUs Ladhekey Uchay and Khorian.

13 CARE AND MANAGEMENT OF MEDICINES LIKELY TO BE EXPIRED

The Forum was categorically informed that zero tolerance regarding presence of any expired medicine in the shelves of Medicine Store at the Health Facility. All Incharge Medical Officers were requested to focus on the proper expense and management of Medicines and other Items which are likely to be expired in next three to six months.

"REVIEW OF PROJECT PERFORMANCE"

14 REPORTING OF HIMS AND PRIORITY DISEASES

While reviewing the HIMS and Monthly Reports, all MOs/WMOs were once again requested to ensure the accuracy of Information being provided in reports. The Incharge of Health Facilities must ensure that the data/information given in such reports is correct in all respects.

15 OPD

New patients treated During December 2007	Old patients treated During December 2007	Total OPD During December 2007 (New + Old)
102424	**2522**	**104946**

16 SCHOOL HEALTH SESSIONS/CAMPS

Sr. No	Name of MO	Sessions	Participants
1	Dr. Abdul Aleem	3	84
2	Dr. Abdul Jabbar	3	285
3	Dr. Aftab Anwar Ghauri	3	97
4	Dr. Aliya Waqas	3	190
5	Dr. Amir Nisar	5	315
6	Dr. Anayat Ali	3	70
7	Dr. Anjum Bashir	3	115
8	Dr. Asif Aftab	3	76
9	Dr. Asif Iqbal	3	256
10	Dr. Ateeq-ur-Rehman	3	67
11	Dr. Babar Ateeque khan	3	120
12	Dr. Farooq Qamar Malik	2	55
13	Dr. Farukh Rana Jalal	3	220
14	Dr. Fayyaz Ahmad Rana	3	247
15	Dr. Fida Hussain	2	106
16	Dr. Ghazala Shauqat	1	58
17	Dr. Ghulam Sarwar	3	90
18	Dr. Imtiaz Ahmad	3	90
19	Dr. Irfan il Haq	3	240
20	Dr. Junaid Saulat	3	63
21	Dr. Khalid Abdullah	4	125
22	Dr. Khalid Pervaiz	3	135
23	Dr. Khalida Adeeb	3	162
24	Dr. Khaliqur Rehman	3	86
25	Dr. M. Afzal Khan	3	58
26	Dr. M. Sarwar Saqid	3	85
27	Dr. Muhammad Akhtar	3	28
28	Dr. Muhammad Asif Raza	3	120
29	Dr. Rubina Shaheen	3	310
30	Dr. Muhammad Chand	2	220
31	Dr. Muhammad Iqbal Raza	3	150
32	Dr. Muhammad Saleem	1	56
33	Dr. Muhammad Tahir	3	150
34	Dr. Muhammad Tayyab Butt	3	200
35	Dr. Muhammad Usman Masood	2	67
36	Dr. Nasir Mehmood	3	213
37	Dr. Nouman Shahid	3	96

Sr. No	Name of MO	Sessions	Participants
38	Dr. Rabeqa Yasir	6	380
39	Dr. Sadia Kamran	3	77
40	Dr. Samina Iftihar	3	171
41	Dr. Sara Maryum	1	30
42	Dr. Sayeda Nasreen	3	214
43	Dr. Shahid Ghafoor	0	0
44	Dr. Shahzad Raza	3	94
45	Dr. Shahzad Wahid	2	109
46	Dr. Shakeel Aslam	3	70
47	Dr. Sharafat Ali	3	96
48	Dr. Shaugfta Asif	3	144
49	Dr. Sheikh Abid Waheed	2	221
50	Dr. Sheikh Rizwan	2	150
51	Dr. Sidra Shaukat	3	74
52	Dr. Sikander Ikram	3	56
53	Dr. Sohail Mazari	3	210
54	Dr. Syed Aziz ul Hassan	3	270
55	Dr. Syeed Farukh Hussain Shah	3	147
56	Dr. Tahir Mahmood	3	100
57	Dr. Tahir Shabir	3	103
58	Dr. Tahira Wahab	3	203
59	Dr. Tayyaba Zaka Ullah	3	83
60	Dr. Zafar Iqbal	3	199
61	Dr. Zahid Hussain	3	145
62	Dr. Zahid Iqbal	3	72
63	Dr.Abida Khalid	3	97
64	Dr.Nosheen	2	55
65	Dr.Rukhasana	3	80

The doctors who have not met the standard of holding at least three sessions were requested specifically to pay more attention on this activity.

17 COMMUNITY HEALTH EDUCATION SESSIONS & MEDICAL CAMPS

Sr. No	Name of MO	Sessions	Participants
1	Dr. Abdul Aleem	3	103
2	Dr. Abdul Jabbar	5	190
3	Dr. Aftab Anwar Ghauri	2	46

Sr. No	Name of MO	Sessions	Participants
4	Dr. Aliya Waqas	3	71
5	Dr. Amir Nisar	6	140
6	Dr. Anayat Ali	4	50
7	Dr. Anjum Bashir	3	96
8	Dr. Asif Aftab	3	80
9	Dr. Asif Iqbal	5	251
10	Dr. Ateeq-ur-Rehman	3	70
11	Dr. Babar Ateeque khan	7	169
12	Dr. Farooq Qamar Malik	3	64
13	Dr. Farukh Rana Jalal	10	225
14	Dr. Fayyaz Ahmad Rana	3	153
15	Dr. Fida Hussain	4	196
16	Dr. Ghazala Shauqat	10	318
17	Dr. Ghulam Sarwar	3	79
18	Dr. Imtiaz Ahmad	2	27
19	Dr. Irfan il Haq	3	50
20	Dr. Junaid Saulat	5	70
21	Dr. Khalid Abdullah	4	72
22	Dr. Khalid Pervaiz	3	85
23	Dr. Khalida Adeeb	7	199
24	Dr. Khaliqur Rehman	4	104
25	Dr. M. Afzal Khan	3	58
26	Dr. M. Sarwar Saqid	3	76
27	Dr. Muhammad Akhtar	4	50
28	Dr. Muhammad Asif Raza	3	30
29	Dr. Rubina Shaheen	3	128
30	Dr. Muhammad Chand	2	100
31	Dr. Muhammad Iqbal Raza	5	94
32	Dr. Muhammad Saleem	3	36
33	Dr. Muhammad Tahir	3	40
34	Dr. Muhammad Tayyab Butt	3	31
35	Dr. Muhammad Usman Masood	5	145
36	Dr. Nasir Mehmood	5	116
37	Dr. Nouman Shahid	6	134
38	Dr. Rabeqa Yasir	6	480
39	Dr. Sadia Kamran	3	68
40	Dr. Samina Iftihar	7	191
41	Dr. Sara Maryum	2	38
42	Dr. Sayeda Nasreen	5	144

Sr. No	Name of MO	Sessions	Participants
43	Dr. Shahid Ghafoor	2	35
44	Dr. Shahzad Raza	7	84
45	Dr. Shahzad Wahid	2	85
46	Dr. Shakeel Aslam	5	125
47	Dr. Sharafat Ali	6	132
48	Dr. Shaugfta Asif	6	125
49	Dr. Sheikh Abid Waheed	3	28
50	Dr. Sheikh Rizwan	2	23
51	Dr. Sidra Shaukat	4	83
52	Dr. Sikander Ikram	4	78
53	Dr. Sohail Mazari	3	235
54	Dr. Syed Aziz ul Hassan	6	255
55	Dr. Syeed Farukh Hussain Shah	5	56
56	Dr. Tahir Mahmood	3	105
57	Dr. Tahir Shabir	6	181
58	Dr. Tahira Wahab	7	302
59	Dr. Tayyaba Zaka Ullah	3	78
60	Dr. Zafar Iqbal	3	61
61	Dr. Zahid Hussain	3	70
62	Dr. Zahid Iqbal	6	142
63	Dr.Abida Khalid	3	80
64	Dr.Nosheen	6	189
65	Dr.Rukhasana	2	50

All doctors were generally requested to focus on this activity and do the best to meet the standard of at least three Community Health Education Sessions.

18 GENERAL REVIEW OF OTHER PREVENTIVE & PROMOTIONAL ACTIVITIES.

Sr. No.	Activity	Number
1	Community Health Education Sessions	273
2	School Health Education Sessions	184
3	Passive Case Detection (PCD) Slides	364
4	Active Case Detection (ACD) Slides	1112
5	Visits to Check Sanitation Condition	640
6	Notices issued on account of Poor Sanitation	515
7	Challans sent to Court on account of Poor Sanitation	31
8	No. of Stray Dogs Killed by Strychnine HCL	243

9	Mother Health Care	2359
10	Child Health Care	1523
11	Family Planning Cases	727
12	Atne-Natal Cases	1494
13	Post-Natal Cases	513
14	Reported No. of Death of Mothers (MMR)	3
15	Reported No. of Death of Infant (IMR)	12
16	Reported No. of Death of Children (Less Than Five Year)	9
17	Blood Sugar Test	732
18	Pregnancy Test	674
19	Total Patients Nebulized	663
20	Ultra Sound	35
21	Community/School Health Education Sessions by FMOs	47
22	Visit of Women Health Houses by FMOs	18
23	Deliveries Conducted at BHUs	05

19 PERFORMANCE OF EQUIPMENT

While reviewing the performance of equipment, same was found satisfactory.

Equipment	Performance
Syringes	Satisfactory
Nebulizers	Satisfactory
BP Apparatus	New quality BP Apparatus are being provided
Stethoscope	New Stethoscopes are being provided
Glucometers	Satisfactory

20 AVAILABILITY OF MEDICINES

The overall situation of availability of medicines was reviewed and found satisfactory. DSU has procured maximum number of medicines out of approved list as per policy instructions conveyed by PSU.

21 PROPER MAINTENANCE OF RECORD FOR AUDIT

The Incharge Doctors were requested to pay serious attention towards the maintenance of record especially the entries of OPD Register, Daily Expense of Medicine, Stock Register of Medicine & other store items / assets of Health Facility, Bin Card and attendance/leave register. All entries must be

checked and verified by Incharge MOs/WMOs to avoid any embarrassment during Audit. .

22 REVIEW OF PERFORMANCE OF FMOs

During the month of December 2007, the performance of FMOs was reviewed as:

Sr. No.	Name of WMO	OPD	Community/ School Health Session/Women health Houses	Pregnancy Test
1	Dr.Abida Khalid	1021	10	15
2	Dr.Rukhasana	825	6	10
3	Dr.Nosheen	2599	10	18
4	Dr. Rabeqa Yasir	2079	16	32
5	Dr. Khalida Adeeb	1482	14	35
6	Dr. Sadia Kamran	604	9	20
	Total	**8610**	**65**	**130**

23 MONITORING/SUPERVISORY VISITS BY DSU STAFF

DSM	Other DSU Staff	Total
110	76	186

24 SUPPORT GROUPS

Meetings of Support Groups
35

Due to unexpected off days dated December 28 & 29, 2007, meeting of Two Supports Groups could not held.

25 SUBMISSION OF HMIS & HSRP REPORTS FOR EDO(H) OFFICE

The consolidated set of reports of HMIS & HSRP is being forwarded to District Health Authorities regularly.

26 PROVISION OF FAMILY PLANNING ITEMS

Fresh supply of contraceptive item i.e Injection Norigest has been arranged from the office of District Population Welfare.

27 30th CAPACITY BUILDING SESSION OF LHVs ON DECEMBER 07, 2007

Name of the Speakers	Topic	No. of Participants
Dr. Khalida Adeeb	Significance of Proper Ante-Natal and Post-Natal	45
Dr. Farukh Tariq	Causes and Prevention of AIDS	
Dr. Rukhsana Jabeen	Awareness about HIV	

28 NEXT MRM

The 41st MRM would be held on February 07, 2008 at 8:30 A.M. on Thursday at DHDC, Poonch Road, Lahore. (Insha–Allah).

After the conclusion of agenda items, individual problems and issues of doctors were discussed and resolved.

The meeting ended with a vote of thanks from and to the chair.

District Support Manager
PRSP, CMIPHC, Lahore

PC:

1. Zila Nazim, CDG, Lahore.
2. COO(MSs&Ps), PRSP.
3. Project Director, CMIPHC.
4. District Coordination Officer, CDG, Lahore.
5. EDO (F & P), CDG, Lahore.
6. EDO (Health), CDG, Lahore.
7. All Participants.

CMIPHC
MANUAL OF OPERATIONS
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ANNEXURES

Annexure – J

Delivery of Primary Healthcare Services in Rural Pakistan

Introduction:

It was necessary to provide these few pages as a prefix to the Manual of Operations for two reasons. First, because it is important to sketch a perspective for every one of our associates when he comes aboard and begins to make use of the Manual. It is necessary that he is made familiar with all the important facets of our work and with what makes it difficult, stormy, eventful and educative. The second reason has to do with a moral obligation. All that has been possible to achieve, principally in the Punjab, has been on account of a small group of men. They have persevered in the face of frustrations that would have crushed ordinary men. They have shown themselves to be extraordinary men with a spirit to match. They have been gallantly supported by hundreds of medical professionals and thousands of Paramedics and other staff. They deserve to be recognized for standing their ground against the vested interests and against every conceivable opposition. They have stoutly borne opposition even when it comes from where the well-spring of support should have been. Their story could have been an epic of service to the poor. Instead, this might read like a requiem. All these good men and women deserve someone better to tell their story. However, the inadequacy of this narration is made up by the deepest respect that one feels for their being so very special. May God Bless them for their labours. May He Bless all those who help them serve the poor. And may He Guide those aright who choose to neglect or oppose such work. Ameen.

The Beginning:

It started in August 1999 from a mere three Basic Health Units (BHUs) in Lodhran District in the southern Punjab.*

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* The man behind the Lodhran experiment was Mr. Jahangir Khan Tareen, at that time Chairman of the Task Force of the Punjab Government for the Agriculture sector. In 2003, he was an MNA from Rahim Yar Khan District and an Advisor to the Punjab Chief Minister on "New Initiatives in the Social Sectors". He is now the Federal Minister for Industries, Production and Special Initiatives. He organized support for the RYK Pilot, its extension to 11 other Punjab Districts and, finally, prepared the stage for the PPHI. More is owed to him than can be adequately recorded here.

The management of these BHUs was taken over by the National Rural Support Programme (NRSP) from the Punjab Government (GOPb). The three BHUs were run by one Medical Officer (MO) engaged by the NRSP at an enhanced salary. A "Revolving Fund" of Rs. 100,000 was created, with private philanthropic resources, for maintaining a store of high quality medicines. Patients had the option of purchasing medicines from this store or of receiving free Government medicines that are ordinarily supplied at all BHUs – albeit irregularly. The Fund revolved as many as twenty two times during 36 months. The out-turn of patients at the three BHUs registered a quantum increase during the NRSP management.

It is difficult to say in what way the Lodhran experience inspired the Pilot in District Rahim Yar Khan (RYK). Both were conceived around BHUs and both happened to cluster three BHUs in the care of a single Medical Officer. Similarities may not go beyond these two features but the Lodhran experience must have encouraged the making of more ambitious plans.

The road to the President's Primary Healthcare Initiative (PPHI):

The acknowledged importance of the Primary Healthcare (PHC) to poverty should make it hugely eligible for inclusion in every poverty alleviation program. In January 2003, the GoPb was willing to be persuaded to try new, even unorthodox, measures for the delivery of the PHC services. The GoPb, led by the Chief Minister Chaudhry Pervaiz Elahi, deserves all plaudits for taking courageous and visionary decisions on:

i. sponsoring a Pilot that encompassed all the 104 BHUs of the District RYK. In early 2003, nothing like it had been attempted at this scale in the PHC sector in Pakistan. The last claim may be true even when extended to allied sectors;

ii. providing firm support to the extension of RYK-like management of the "first-level" rural health facilities (RHFs) to other Districts in the Punjab;

iii. providing strong financial and institutional support to the operation which was named the "Chief Minister's Initiative for Primary Healthcare" (CMIPHC). The

nomenclature was intended to proclaim the special status of the operation. Accordingly, the perception of the "most-favoured" status opened doors that normally remain closed and assured support for the Initiative wherever this was required.

Between March 2003, when the first Agreement was concluded with the District Government (DG) of RYK, and June 2005, the unequivocal support of the GoPb steered the extension of the operation to as many as 1049 FLHFs in 12 Districts of the Punjab. During the 30 months ending June 2005, massive support from the Chief Minister, competently reinforced by the senior civil service, made it possible to implement a difficult concept. The Initiative is not as novel as some are apt to think or insinuate. There are at least 8 similar experiences elsewhere in the world which the World Bank has studied and documented.* What has been attempted in the Punjab is, therefore, ninth in that list.

The President of Pakistan apprised himself of the results that had been possible to achieve in the Punjab. He evinced keen interest in extending the scope of the work to other parts of the country. At a high level meeting he and the Prime Minister co-chaired in September 2005, a number of landmark decisions were taken which included:

a. taking the operation to all other Provinces, the Azad Jammu and Kashmir (AJK) and to the Northern Areas (NAs) and extending it to all the Districts in the country in a phased manner;

b. the cost of the Provincial Support Units, and of the Support Units for each taken-up District, to be borne by the Federal Government which would also provide funds for a one-time up-gradation /rehabilitation of each BHU;

c. the District Health management to be re-engineered in the light of the experience of the operation. It shall be to this re-engineered District management that the BHUs shall be handed back ;

* Loevinsohn and Harding, "Buying Results: A Review of Developing Country Experience with Contracting for Health Service Delivery," World Bank, 2004.

d. the operation would be called the "President's Primary Healthcare Initiative" (PPHI) with the President seen as personally driving it.

What is the PPHI?

The PPHI represents a new way of working. It is driven by a passion, by a commitment and a resolve to serve the poor. It is commonly observed that such norms of work are privately subscribed to by individuals but have rarely driven a public service delivery in Pakistan. The sharp focus on the assignment, close oversight and untiring facilitation of every key element of the operation by its managers would have few parallels. It denotes altogether a new work culture. The description may appear immodest, unreal or vague – perhaps even esoteric. However, the spirit that drives the PPHI is precisely what sets it apart from every other public service delivery. To describe the PPHI, it is necessary to describe the driving spirit. To understand the spirit that defines it, it is necessary to observe what it is accomplishing. The test of the pudding, as they say, is in its eating.

The PPHI has been patterned on the CMIPHC in the Punjab. The operation in the Punjab is the mother plant upon which five scion operations have been grafted. In other words, the CMIPHC has matured into the PPHI. Prominent features of the Punjab operation, and its national version, are outlined here.

i. Following broad understanding reached with a Provincial Government, a Program Director (PD) is appointed to lead the Provincial Support Unit (PSU).

ii. Where governance has been devolved, the District Government is competent to assign the management of RHFs. A District Support Manager (DSM) is appointed to lead the District Support Unit (DSU) in every District where the assignment is taken up. A typical Agreement which outlines the terms and conditions of assignment, is annexed at the end of this Manual.

iii. One of the first steps upon the conclusion of the Agreement(s) is the establishment of a "Resource Group". The Group comprises widely respected specialists in every service that the BHU is expected to deliver. The Group is constituted with the greatest care not to lose sight of any of the eight PHC constituents - a balance often not easy to maintain.

iv. After taking a thorough stock of the staff availability, the DSU clusters the RHFs so as to arrange for the medical staff to serve at more than one facility and appoints new contract staff where necessary and possible. The principle in this regard is that scarce resources, like the services of medical professionals, must be as equitably shared as practicable. This assumes that medical professionals are not always available for service at every RHF where vacancies exist.

This is connected with the funds made available by the Government. Budgets for the RHFs can suffice not only for engaging fresh staff but also for financing the incentives linked to the staff performing additional services.

v. A regular and adequate supply of medicines and materials is ensured at the earliest possible stage. This is not only necessary for restoring the confidence of those who visit the RHFs but also makes staff presence purposeful. In the new environment at the RHFs, responsibility with corresponding authority is placed with the medical professionals. This empowerment has always yielded rich dividends.

vi. "Monthly Review Meetings" (MRM) are institutionalized to bring together the medical staff, the District Support staff and the relevant field officers of the Government. These meetings, held during the first week of every month, provide opportunity for participative discussion on the services delivered, on new measures

taken at the RHFs, on resolution of old and new issues, etc. Most importantly, the MRM positions the medical professional at the centre of the operation – this being a corner-stone of the PPHI strategy.

vii. Capacity Building of medical and paramedic staff is a major area of focus. Quality issues are also a serious concern and are addressed in different forms across the entire range of services.

viii. Monitoring work at the RHFs is a major activity and a distinguishing feature of the PPHI. This is undertaken as part of "facilitation" from the District Support Unit. Visits to the RHFs are an important way to observe the staff at work to ascertain ways for supporting them. There is a fine, though obvious, line that sets apart "facilitation" from "inspection." We have a strong preference for the first of the two modes.

ix. Starting new and re-starting dormant services, like the School/Students Health Sessions, Community Health Sessions, Family Planning services, Female Health Program, community participation, computerization, etc to name only a few, is a continuing preoccupation. All these receive reference in this Manual.

The Role of support organizations:

The pioneering work in Lodhran was undertaken through the NRSP. Later, the Punjab Rural Support Program (PRSP) was selected to formally house the RYK operation. The PRSP also housed the operations elsewhere in the Punjab. What were the special qualifications of the RSPs to associate with the delivery of the Primary Healthcare Services? What has been their precise role in designing the management and in delivery of services? Why were Health sector non-government organizations not chosen? What has been expected of a support organization all along? Some clarifications are called for here.

The selection of the support organizations was not on account of relevant experience or special strengths that these have in the primary healthcare sector. The operation had to be housed somewhere. It needed a parking space. This was the solitary consideration. While the strategic and operational leadership vests in a PSU presided over by a PD, an institutional identity was also necessary for the operation. For filling this necessary role, the authors of the operation looked around for credible organizations for providing an institutional umbrella. They turned to the RSPs (and to the AKF-P for the NAs) because they were familiar with these organizations. Comfort was, therefore, the sole reason. Typically, the operation envisages only the following facilitation from a support organization:

a. The Program Directors and District Managers who lead the strategic and operational teams are housed in a support organization in an institutional sense. The selections are made by the Ministry of Industries, Production and Special Initiatives, or the Program Directors by acquiring deputationists from Government(s).

b. A framework to guide and regulate the management of the Healthcare operation i.e. a "Manual of Operations" is the next requirement. This Manual, and its revised versions, have all been the fruits of endeavours outside the support organizations. This is because the expertise, for putting these Manuals together, had to be drawn from the public sector. The framework provided by this Manual is envisaged to work alongside the Government systems and in spaces that can be created within the Government systems. Such is the special need of the operation. This Manual is approved by the National Steering Committee of the PPHI. A support organization is expected to only formally install the Manual because those who are to use it, i.e. at the PSU and the DSU, are institutionally a part of it.

c. The appointment of Statutory Auditors and approval of audited accounts of the Healthcare operations, are the third requirement. Auditors have to be appointed by the

support organization(s) every year as a requirement of the Companies Ordinance, 1984. The same Auditors are expected to audit the PPHI accounts. No special arrangements are, therefore, envisaged from the support organization(s) on this account either.

The three requirements recorded here are obviously formal in character which is why a support organization has never been expected to possess special credentials in the PHC sector.

Why the PPHI ….?

For delivering Primary Healthcare services in rural Pakistan, we have an elaborate network of physical facilities worth billions of rupees. Having seen hundreds of BHUs in the Punjab and elsewhere, one can vouch for these being in a state of advanced neglect. Further, what is often not realized, is that the built spaces are wastefully over-provided. We have thousands of professional staff employed at these, sprawling but dilapidated, facilities. We have medical materials worth billions and huge budgets flowing in, albeit erratically, every year. We also have a labyrinthian network of Rules, Codes, Policies, Procedures, etc. that govern these financial, human and physical resources. Every now and then we launch high-profile Programs while earlier ones roll into oblivion. But what about the services that these resources, systems and Programs are intended to deliver? What is the Judgement of the intended recipients of these services? That Judgment is as unanimous as it is damning. For a reality check, all that one has to do is to go out; stand at the right place and ask the right people who feel free to give the right answers.

One is not convinced that the absence of vital services from our villages, over the past many decades, is fully realized. The common man in the countryside is certainly not convinced of there being such a realization. New ideas and alternatives shall be seen as a necessity only if the realization exists and it is decided to do something about it. New options shall receive serious consideration only if the failure of services is attached importance. The angels that watch over the “poverty sector” have not yet smiled upon the PHC as a vitally important need of the poor. Until then, it is only small and modest undertakings such as ours which shall hold a tiny light in the sea of poverty. Those outside the sea do not notice its darkness nor its vastness.

Opposition, skepticism and frustrations are attached inextricably to our work. Until better men, with better ideas, come forward and take over, this is all that the poor may have. Such, it seems, are the wages of poverty.

The Elusive Beginnings:

The PPHI could not roll out during the first sixteen months since the September 2005 decisions. The relevant power centres had to be brought on board which takes time notwithstanding the illusions of being on a fast-track. Organizing support can be painfully slow. The inaugural phase is as arduous as the support is lukewarm. The only support that matters is the one that can be drawn upon whenever needed. The patronage that looked so awesome and so assured in September 2005, progressively became a fiction. It became easy for the vested interest to oppose the PPHI at every step.

During the opening phase of the PPHI operations everywhere, some problems have always arisen owing to the lack of sufficient knowledge about its objects, its strategy, priorities and strengths. Ironically, support begins to erode as soon as work begins and occasions arise for demonstration of support. There is hostility in the environment, with a tinge of suspicion and contempt for new ideas. When the process is as un-orthodox as the PPHI is, the hostility, gets compounded. It makes work tiresome and complicated. It makes problem-resolution a perennial labour at the Support Units of the PPHI. It holds up much important work for which, finally, it is the poor who suffer. The vested interests are used to winning. The fear that they are not looking so good in this battle, makes their opposition more desperate.

What about "Sustainability"? What about "Exit"?

When questions are raised about the effectiveness, adequacy or appropriateness of the PPHI strategy, an incontrovertible fact is conveniently avoided. The Rural Health Facilities, as these stand, are a sorry sight with very little to show for themselves except decisive failure. Those who share responsibility for the failed services are among the most eloquent critics of every innovation. Their solutions, disregarding the long history of failures, call only for higher public spending. There is not even a shadow of embarrassment at the failure nor at the waste of public resources over the past many years. The need to reflect on the real causes of the failed services is quite unimportant to this line of thinking. It cannot imagine solutions that do not cost money. It cannot understand that management or

mismanagement have no necessary relationship with money. In the world that we live in, this has been recognized and acknowledged for a long time. Can we hope to get anywhere by insisting that even the obvious does not apply with us? Can we invalidate universal experiences? If we do that, it shall only be to our own cost. Will no one pause and think? It is not the investment in the sector. It is primarily the failure of simple, every-day management. It is that which requires correction. It is predominantly this that the PPHI is focusing on.

That the PPHI has brought a dead sector back to life in 12 Districts of the Punjab, is difficult to deny. The evidence in support of this claim is difficult to contest. An honest eye shall not miss the sea change that is causing millions to flock to the HFs which had earlier been a picture of wilderness. That this has been possible with the same - and in some cases less resources - is equally difficult to dispute. But one must hasten to confess here that much more would have been possible to achieve had the patronage, originally given to our work, continued. That patronage has evaporated in thin air. It is easy to understand why. It is impossible to agree with the reasons. The opposition had never diminished. It only assumes new forms. It seems to somehow survive and mutate. Questions are raised about what will happen when the PPHI operations conclude. Will these services not slide back to the earlier state of failure? What about the successor management? If continuity of services with the successor managements is not assured, does it not make the improvements transitory and, therefore, pointless? Such questions continue to be raised. The purpose - to show that the PPHI is no solution.

There are two standpoints from which this scepticism can be answered. The first is from the standpoint of the beneficiaries. Their voices – the voices of the poor – are rarely heard and never heeded. For an answer, one needs to listen to these voices, for a change. As reasonable and rational men, the poor will undoubtedly prefer all improvements, in every service and facility that they use, to be permanent. This goes without saying. But, as reasonable men, they also value every improvement without regard to its duration. It is wrong to argue, even impliedly, that because certain services cannot be sustained for ever or over a long period, therefore, these need not be delivered. It is clearly a perverse argument that the poor shall find an insult to their intelligence. Rather than arguing along such lines, there is a need to focus on

how to ensure continuity of the services over a long period of time even after the PPHI. That in fact is the real challenge.

The second standpoint from which the criticism can be answered is that of the PPHI. The responsibility for the delivery of services, after these revert to Government, is clearly of the concerned Government. The PPHI can, at best share its own experiences with the Government(s) on how the service delivery can, in its view, be best re-organized and managed. How this input is used in re-engineering the future management is finally for the Government(s) to decide and not for the PPHI to preside over. Clearly, therefore, the accusative question is being mis-directed at the PPHI. The responsibility for finding the next mode for delivering the PHC services is of the Government itself and not of the PPHI.

In conclusion, please remember……

that this operation started with some individuals. Now into its fifth year, it is still an enterprise led by a small group of individuals. All those with key roles at the PPHI have remained associated with the large and elaborate systems for which Governments are reputed far and wide. They have, therefore, experienced, at first hand, the infertility of these systems. They have witnessed how thoughtless devotion to means has been depriving us of the ends. They have seen the tail wagging the dog. The services may or may not have failed as a result of the systems but the services have certainly failed inspite of these. No matter where the responsibilities might lie, the sole sufferers of the failed services are the poor. Confronted with the failure of a service, the resourceful are able to plug into other options. The poor have no such ability. They only sink deeper into worsening deprivation when a state service fails. This is what makes the consideration of alternatives such a great necessity.

Some of us have set out to assist the state. For some of us, it is impossible to accept that anyone has the right to waste public resources or mismanage a public service. It was not difficult to find people who were strongly in agreement with that view. We are pleasantly surprised by that discovery. We are assisting the state with simple solutions using simple methods. The results of our work are for all to see – especially those who are interested in the poor and in the fight against poverty. Much can be achieved with simple solutions. Much can be achieved with the existing resources. These were the

two earliest lessons that our work taught us. Can there be a single good reason to deny the poor the improvements that take so little to arrange?

Philosophical debates, specious arguments, fanfares about grand plans and imagined successes can continue to occupy the centre-stage. Often, what receives the loudest acclaim is the packaging. It is the marketing strategy that largely determines the judegment on a program. Even its launching or being scrapped can be determined by the marketing strategy that precedes and accompanies it. The winds, as we know, can blow and change for any number of bizarre reasons. But this is not an occasion to dwell on the factors that can influence and determine the course of important decisions. One only wishes to acknowledge the absence of a strong marketing strategy as a major weakness of the PPHI. We have attached too great an importance, it seems, to the delivery, the quality and volume of services. We have erroneously believed, it seems, that this is all that matters. We recognize now that performance alone does not suffice. It must be accompanied by a powerful and effective projection and promotional complement. We have not yet had the time to attend to this necessity.

Since RYK in the early 2003, our work has travelled many leagues. But RYK has acquired the status of a milestone. It symbolizes a landmark. It gave us the first flush of success. Our services have since grown to feed all the eight streams that constitute "Primary Healthcare." This evolution has often gone un-noticed. While the range and quality of services have grown, we have taken pains to keep our methods and processes simple, efficient and meant-to-deliver. That is why this Manual is based on a few simple, common sense principles and sound practices. We consider its simplicity as its principal strength.

This Manual is intended to light up the way for a clear-sighted, result-oriented and prudent manager who is driven by the desire to achieve and to serve. In putting this Manual together, we have tried to give ourselves a framework which would, if intelligently kept in view, help us in remaining on course in every sense of the expression. This Manual has evolved and it shall continue to evolve in the light of our experience. We believe that each revised version shall provide a more comprehensive facilitation than before. That it shall help us in achieving more and in observing the norms of good management.

And finally, never forget;

a. that we are engaged in delivering a public service. That we are using public resources for performing public functions. In the way we have chosen to work, we treat these services, functions and resources as important for us in a personal sense. We give to our work that something "extra" which is commonly withheld from the performance of 'mere' public functions. We notice that, for some reason, it is considered right not to extend that "extra" interest to official, public or professional functions which we reserve for tasks important to us in a "personal" sense. To the extent that our work is governed by the best of the two sets of considerations - personal and professional – we expect to achieve more in volume and of better quality;

b. that our endeavours must always be guided by the most widely respected professionals in each field and sub-field. Their views, in matters relating to their specialization, must always receive precedence and due respect. It is of priority to us to find ways to accommodate these views in every small sub-field of our work - be it Dermatology, Gynaecology, Community Medicine, Family Planning, computerization or the repair of buildings;

c. that we have to deliver services that have been categorized under eight classifications. This is why an octagon is the highlight of our Logo. At stock-taking, we should never be adjudged having devoted less attention to anyone of the eight components. If we are to run a balanced PHC program, all the eight building-blocks must receive due importance;

d. that our endeavours shall rarely receive encouragement nor will our work earn recognition. This is in the nature of things. We must, therefore, be prepared to suffer hostility where we think support would have been justly due. We

> will need to develop the ability to suffer the most venomous opposition. We have to create in ourselves the ability to survive frustrations. It is admittedly a tall order but necessary to survive. How else shall we labour on with our chosen tasks?
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> The reasons for stopping and opting out of this work are as impressive as these are numerous. We have known these reasons all along. For persevering, there is only one simple reason. It has to do with the heart. One cannot turn away from what one owes to the less fortunate in one's extended family. With the millions of poor receiving assistance at the BHUs that we claim to manage, we cannot opt for the luxury of quitting. One cannot decline to care. That would be dehumanizing oneself. One cannot decide to become less human than one is created!

As one looks around oneself, strong winds are blowing – sweeping upon us from all directions. While we grieve here upon small matters, mountains are tumbling into the valleys and amid all this, our work is like a few straws in the wind. We are truly humbled when we think of our insignificance compared to the great tasks that others, around us, are engaged in. The pity is that our work –so ridiculously unimportant for those of any consequence – is so important for the poor of this country!

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