DRAFT STRATEGY 2012–2020

Health Sector of Punjab

April 2012

phsrp
enabling quality healthcare

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1 INTRODUCTION

1.1 Rationale

Collectively, the people of Punjab are healthier now than at any other point in history. However, despite this progress in the recent decades, there are some important differences in the health of individuals and populations. So whilst the overall health has been improving, the health of the least and less well off has been getting worse. This is what we mean by health inequalities.[1]A number of districts in Punjab experience greater levels of deprivation compared with the provincial average, and as such experiences a greater burden of poor health within the population. Health is influenced by many factors including healthcare services (the focus of much of this strategy document), individual behaviour as well as the wider determinants of health such as literacy, income, employment, housing, security, macroeconomic situation and environmental factors.[2] Tackling the determinants or causes of health inequalities requires a different approach to simply tackling the determinants or causes of ill health. It is about ensuring fairer and more equal society, where people with the least access to resources and opportunities are able to enjoy the standard of living and the opportunities that many take for granted.

The Punjab Government is committed to the principle of universal health care for all members of the society - combining mechanisms for health financing and service provision - and improving the health status of the population. In 2010, Draft National Health Policy was developed but erstwhile to its approval, the 18th Constitutional Amendment decentralised national health programmes to the provinces. This ensued a need of reviewing the current situation of health sector in Punjab and establishing priorities for delivery of healthcare services. Punjab Health Sector Strategy (hereafter referred as “the Strategy”) is designed to pull together the big strands of work that will help make Punjab a healthier place to live in years to come. The Strategy will support the Department of Health (DoH) to progress further with a sense of direction, purpose and urgency by prioritizing policy related interventions consistent with availability of financial resources. In keeping with aid effectiveness principles, development partners will be encouraged to align their investments with the Strategy.

However, a strategy alone will not achieve this. If we are to be successful we must use all the means at our disposal to implement the measures set out in this strategy in order to achieve the targets. Whilst this is a health sector strategy, it is important to recognise that we have to engage other governmental

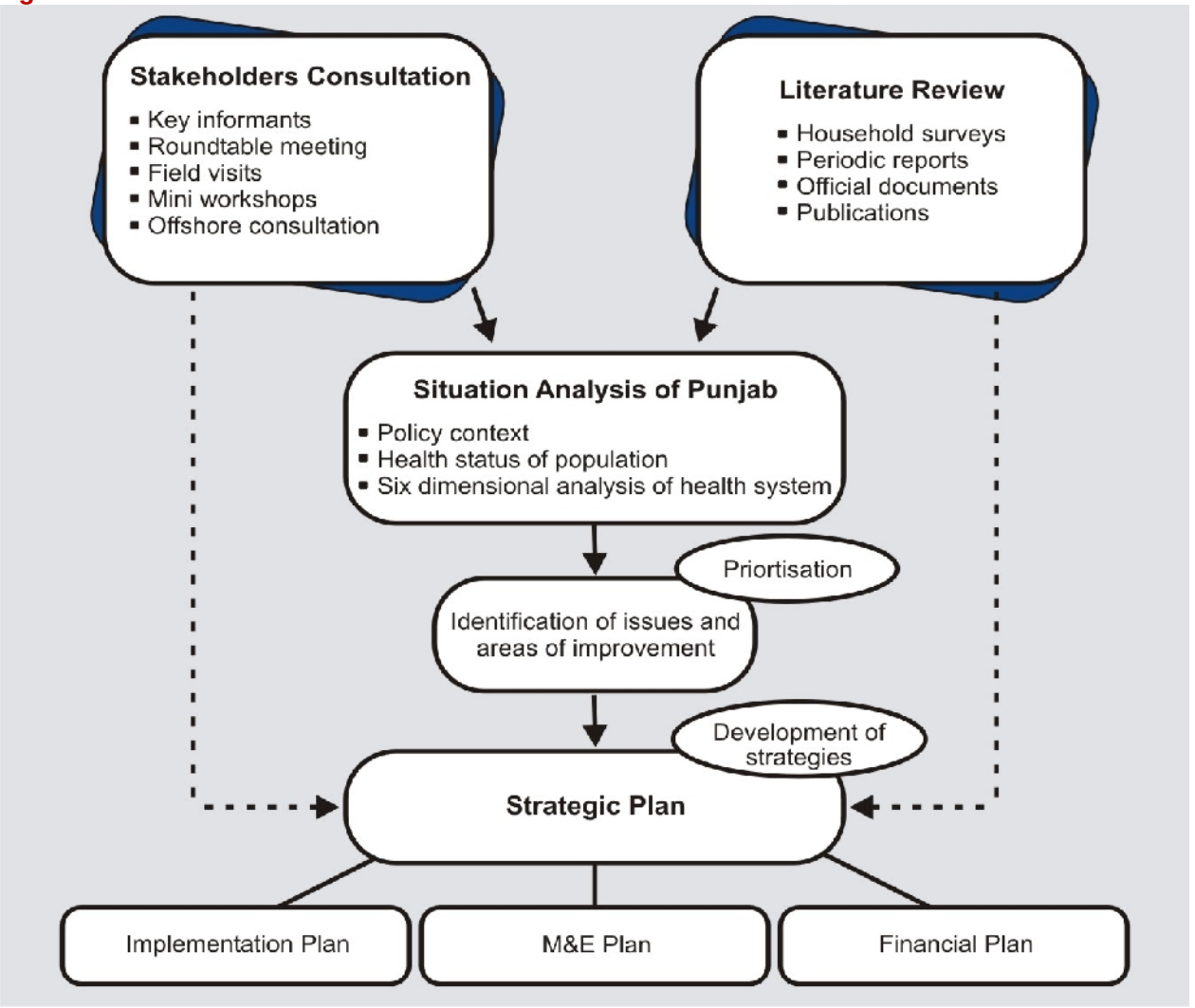
[1] Health Development Agency. Health Inequalities: Concepts, Frameworks and Policies. Briefing Paper, 2004
[2] WHO. Monitoring the Building Blocks of Health System, 2010

departments, community groups, civil society organisations and above all the general public. Improving health is not just the business of the Department of Health, but everybody.

1.2 Process of Strategy Development

The Strategy is the outcome of a great deal of thinking, debate, evidence gathering and consultation across a wide range of stakeholders including governmental departments, health managers, service providers, private sector organisations, NGOs, development partners, individuals and local communities. This has been accompanied by national and international experience and evidence, as there are many interventions from which we can learn a great deal.

Figure 1: The Process



The first step in development of the Strategy is a participatory analysis of current situation of various aspects of health sector in Punjab (Refer to report on “Situation Analysis”). Since, it is important to learn the lessons from implementing previous strategies and to build an evidence-base of what has worked in context of Punjab. Therefore, Situation Analysis lays out the policy context of health interventions in Punjab and analyses the major factors contributing to results in the health sector. The report includes quantitative and epidemiological data as well as information on quantitative and felt needs regarding the health situation, main risks and determinants, trends, and how disease impacts on different groups within Punjab (by gender, age, socio-economic status, geographical location, ethnicity, etc.). Situation Analysis further contains a six dimensional analysis of healthcare in Punjab. The six dimensions reviewed are Service Delivery, Governance and Accountability, Health Workforce, Health Information Systems, Essential Medicines, and Healthcare Financing.

Box: Themes arising from consultations

- Action and accountability on health is urgent and long overdue in Punjab.
- Action will need strong contribution from outside as well as within the health sector, and may involve new partnerships.
- A coordinated and comprehensive approach is needed, rather than the piecemeal approach adapted to date.
- Strong leadership will be needed to drive and coordinate action and achieve targets.
- There will need to be stronger partnerships between all tiers of government, non-government organisations, the private sector and communities, as well as action by individuals and families to improve their own health.
- Emphasis should be placed on the social determinants of health within the Strategy. These determinants should be linked with priorities and action.
- Achieving results will require sustained and significant investment for many years but will ultimately be cost effective and deliver benefits for individuals, families and communities as well as governments.

Through the situation analysis of Punjab, key issues, challenges and areas of improvement are identified. This information has formed the basis for planning a pertinent, appropriate, and comprehensive health sector strategy. The Strategy Development Team received very positive and encouraging feedback from its consultative processes, confirming broad support for the approaches proposed in the discussions. The important themes emerging from these discussions are outlined in Box 1, and they include a range of calls for action on guaranteeing equitable healthcare.

1.3 Current state of affairs in Punjab

The burden of ill health on the population of Punjab is longstanding and well documented. There is now a greater focus on improving the health of our population than ever en before. However, it is unlikely that the province will achieve health related Millennium Development Gaols (MDGs) by 2015. There has been some improvement in terms of health outcomes. Maternal and child health services have been underemphasized within the health system, resulting in a high rate of maternal and child deaths. From childhood to old age, communicable diseases account for a large proportion of deaths and disability in the province. Among children, burden of disease is largely associated with diarrhoea, pneumonia and vaccine preventable diseases, whereas in adults, TB and hepatitis are major contributors to communicable disease burden. While communicable diseases still account for a dominant share of morbidity and mortality in the province, prevalence of non-communicable diseases (NCDs) is rising rapidly. NCDs and injury are amongst the top ten causes of death and disability in Punjab. Yet few significant attempts have been made to study NCD patterns in Punjab and existing data sources do not monitor the incidence and prevalence of NCDs very well. Nutritional status of the population is generally poor especially for the children, women of reproductive age and the elderly. Similarly, micronutrient deficiencies are also frequent and there is widespread lack of awareness about malnutrition.

1.3.1 Challenges in Service Delivery

- Access to healthcare is a major challenge in achieving health outcomes for the populations. Limited access to essential health services is mainly affecting the population residing in rural areas due to persistent urban-rural bias exists in physical accessibility to health services.
- There is a glaring absence of urban primary health care in the public sector that is a necessity as life styles urbanize and life expectancy increases. There are changing patterns and burden of

nutritional, communicable and non-communicable diseases, which can be managed at the primary and preventive level.

- Serious gaps exist in the availability of emergency services at all levels due to lack of availability of skilled staff, equipment, emergency drugs and consumables, and ambulance services. While in the rural communities, there is lack of patient transport services to the health facilities.
- Quality of health care both at the public and private health facilities remains largely questionable. Implementation of government notified MSDS has not really taken place in the true context at the primary and secondary level, while MSDS for tertiary level facilities and private sector have yet to be officially notified.
- Preventive component of primary healthcare is strengthened through vertical programmes but there is lack of functional and management integration among programmes with similar focus.

1.3.2 Challenges for efficient health sector governance and accountability

Health department is overstretched managing service delivery in 36 districts while attending to multiple roles including policy making, planning, resource allocation, responses to emerging situations and leading priority government programmes. Similarly, Health Department is overstretched in its responsibilities especially due to direct management of health programmes, lacking data systems to guide implementation of health policy, weak monitoring of outcomes and response to emerging situations and weak institutional capacity to orchestrate implementation of health policy through decentralization and autonomous entities. Further, Population Welfare Department is providing services in parallel to service delivery arrangements of Health Department. There is an emergent need to merge Health and Population Welfare Departments to avoid duplication of efforts and resources.

- Current centralized system has leaded to systemic delay, lack of initiative at lower tiers and loss of information in decisions making. Autonomy given to hospitals suffered from roll back in some cases. Decentralization could not become optimally functional due to absence of elected local governments since 2009. After the 18th constitutional amendment, the province has been bequeathed with additional responsibilities in the shape of federal health programmes and health policy and planning responsibilities.
- Regulation of healthcare delivery remains weak in Punjab in the absence of well-developed regulatory framework and limited outreach of regulatory bodies. Currently there is no registration and licensing system for private health facilities.

- Institutional and individual performance remains obscure in Punjab and incentives for performance are consequently affected and remain weak. This in turn adversely affects institutional and individual performance toward achievement of health goals.
- Accountability for performance suffers due to absence of appropriately delineated processes and data. Weak systems also lead to varied application of accountability. Further, corruption in the public sector is perceived as widespread, systemic and deeply entrenched at all levels. Lack of standardized procedures for internal means of supervision and control, minimal information provision to the public, protection of government decision and processes from critical scrutiny are the key weaknesses leading to corruption. Traditional public accountability mechanisms such as expenditure audits and legislative reviews seem unequal to the task of ensuring accountability at the micro level.
- Perks and privileges system plays a factor in corruption in many ways. There are significant differences between the benefits of the same grade in different postings leading to political interference and corruption through influence.

1.3.3 Challenges for availability of adequate health workforce

- There is absence of well-defined, coherent, need based and demand driven human resource strategy, policy guidelines, standard protocols and procedures.
- There is dissatisfaction among doctors and allied health professionals community due to non-favourable contractual recruitment policy. Poor remuneration in public sector has resulted in dual job holdings by the healthcare providers, resulting in poor attention to their jobs in public hospitals.
- Health workforce is deficient in many areas in Punjab. Staff shortages are evident at all levels of healthcare delivery but are most prevalent outside large cities especially in rural ad hard-to-reach areas leading to impaired provision of essential life-saving interventions and effective response to various health challenges. Several factors contribute to this shortage and migration of health workers to industrialized countries as well as exit from health sector to other professions has proved to be a significant factor.
- There are a number of impediments to acquisition of skills by workforce in Punjab. There is a lack of induction and orientation trainings for different cadres in the health sector. Further, continued medical education (CME) programmes are deficient in the province.
- Health management, though an important field, is not taken as a specialized field and there are few opportunities for quality professional training in health management in the province.

- Education for all cadres including doctors, nurses and allied health professionals has its challenges. While the number of medical colleges and doctors have increased manifold in the recent years, questions of quality still remain due to out-dated curricula and inadequate faculty who are not trained in teaching methodology. Further, the training of doctors and nurses does not include the "community and needs" oriented perspective.

1.3.4 Challenges in Health Information Systems

- Overall information system in the province is fragmented as existing systems for facility based and community based information suffer lack of integration at district level. Therefore, planning process aiming at informed decision-making remain without this important component of analysis.
- There is no standardized and regular reporting mechanism for autonomous tertiary hospitals in Punjab. Similarly, current HIS does not cover private sector hospitals and healthcare facilities, which deliver healthcare services to a larger proportion of population in Punjab.
- There is limited implementation of DEWS for surveillance of outbreaks and epidemics in public health facilities. Further, there is no inclusion of private sector for establishing an extensive disease surveillance mechanism in the province.
- Despite a number of surveys and research studied conducted every year, there is no mechanism for central storage of data at the provincial level.
- There is no mechanism available for public dissemination of performance of health sector based on information collected through health information system.
- Health related research in the province is still not catering to the research and information needs of the province. Research infrastructure in the province is poorly developed due to lack of expertise, resources and incentives

1.3.5 Challenges in Essential Drugs and Medical Technologies

- Most public sector hospitals and healthcare facilities in Punjab suffer from frequent stock-outs of essential drugs. Issues in supply chain management and lack of quantification skills among the facility staff, cumbersome procurement process, lack of budget, inadequate storage capacities and delayed supplies are associated with stock outs of essential medicines.
- There has been no periodic review of Essential Drugs List (EDL) since 1998. Currently, EDL is out-dated and there is no mechanism for periodic update of the EDL.

- There is lack of storage capacities at district levels as Medical Store Depots (MSDs) are not available in number of districts in Punjab. Similarly, there are poor storage capacities for vaccines, contraceptive and medicines in the districts, resulting in interrupted supply of the essential medicines to the healthcare facilities.

- Drug regulatory system in the province suffers from serious issues of quality because of problems of inadequate staff, low skill level, lack of proper equipment, and inadequate implementation of existing laws. Large quantities of spurious drugs are being supplied in the market as well in the public hospitals. Further, there is little control on the quality assurance of alternative drugs used by hakims and homeopaths.

1.3.6 Challenges in Healthcare Financing

- Health care in Punjab is underfunded (with low government funding); inequitable (overly dependent on out-of-pocket household expenditure); low in population coverage; and low in productivity. Per capita government investment in the health is low as per international standards, currently estimated to be between $6.5 and $7.5 per person per year in 2010-11.

- Out of pocket (OOP) expenditure in Punjab is high and with high poverty rates OOP increases further poverty. OOP is over 70% of the total health expenditure in Punjab.

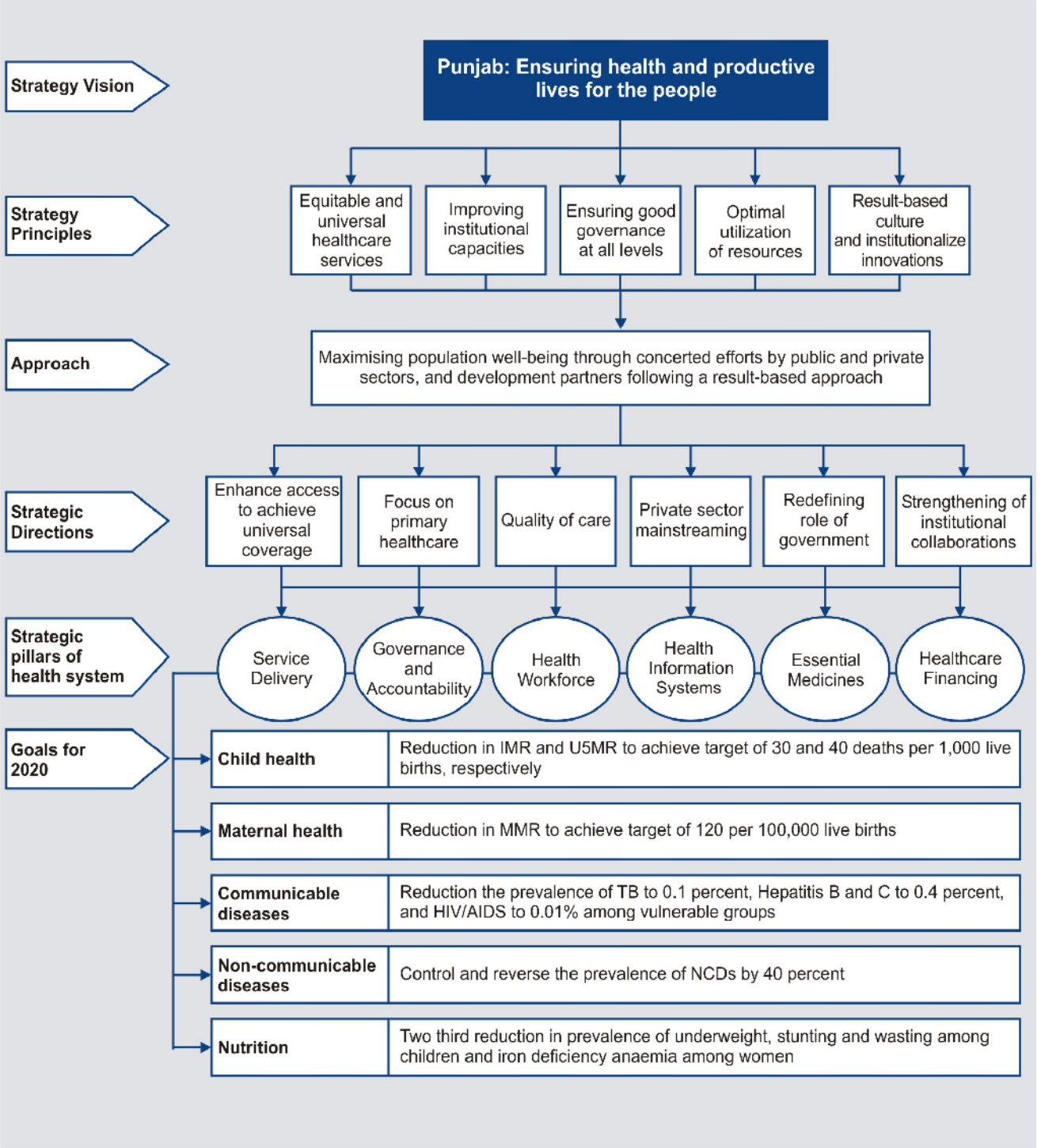
- Measurement of efficiency, effectiveness and economy are not part of regular management practice. Funds utilisation rate at the provincial level is between 70% and 80% of budget. As per 2007-08 and 2008-09 data, around 36% of the districts were able to utilize more than 90% of the original budget allocated. Overall, the budget utilization ratio in districts on health is below 90%.

- Provision of health services in the public sector is mainly by the department of health with comparatively less emphasis on purchaser-provider split. Little investment is made on contracting out of health care services.

1.4 Strategic Plan – The Roadmap

The purpose of the Strategy is to improve the health, wellbeing and life expectancy of the people of Punjab, and to remedy disadvantages in health status across various population groups. Within this context, the components of the Strategy are based on the *roadmap for action* outlining the themes, targets and strategic directions that will bring about the desired results.

Figure 2: The Roadmap for action



1.4.1 Principles

The principles underpinning the Strategy have been identified from evidence from the research literature, and confirmed through consultations conducted by the Strategy Development Team. In this Strategy, these principles guide actions in relation to enhance health status and productive lives of the people of Punjab.

- **Equitable and universal healthcare services –** by building a roadmap with staged approaches for matching differential needs with recognition and response to the causes and effects of health inequality for a wide range of population groups, especially for the vulnerable and disadvantaged.
- **Improving institutional capacities –** by means of progressive development and retention of high quality individual and institutional capacities in the public sector.
- **Ensuring good governance at all levels -** promotion of meritocracy and transparency in every aspect of a responsive health care management.
- **Optimal utilization of resources –** through adoption of health outcomes as achievable programmatic gains by identifying appropriate solutions and efficient deployment of available physical, financial and human resources.
- **Promotion of a results based culture and institutionalization of innovations –** for garnering maximum health benefits in areas requiring urgent actions. Targeted and innovative interventions drawing improvements in the health sector performance should be institutionalized for providing immediate benefits.

1.4.2 Strategic Directions

Based on situation of health status of the people of Punjab and performance of health sector, strategic directions to guide the process of strategy development are set six fold:

- **Enhance access to achieve universal coverage –** by increasing operations in multiple dimensions to remove barriers for meeting the specific needs of various population groups.
- **Focus on primary healthcare –** will be rolled out through improving public expenditures aiming at delivery of essential package of health services for all members of society.
- **Improve quality of care –** through adoption of service standards and making investments in strategic health infrastructure as well as key areas of human resource development.

- **Private sector mainstreaming –** for maximizing health benefits for the population, specifically highly specialized care; and optimizing their service delivery through provision of appropriate regulatory framework.

- **Redefining role of government–** from provider of healthcare services to purchaser and regulator through taking up a facilitating position.

- **Strengthening of institutional collaborations–** for achieving efficiency gains, which are otherwise beyond the scope of health sector.

1.4.3 Expected results

Based on the roadmap for action, the Strategy will be providing a comprehensive motivation for actions in health sector of Punjab and its wide scope will be focusing on outcomes for each of the six pillars of health system, which shall be achieving the following health-related results:

- **Child health** – reduction in IMR and U5MR to achieve target of 30 and 40 deaths per 1,000 live births, respectively

- **Maternal health** – reduction in MMR to achieve target of 120 per 100,000 live births

- **Communicable diseases** – Reduction the prevalence of TB to 0.1 percent, Hepatitis B and C to 0.4 percent, and HIV/AIDS to 0.01% among vulnerable groups

- **Non-communicable diseases** – Control and reverse the prevalence of NCDs by 40 percent

- **Nutrition** – Reduction in prevalence of underweight from 30.1 percent to 10 percent, stunting from 17.6 percent 6 percent, wasting from 14 percent to 5 percent among children, and iron deficiency anaemia among women from 27 percent to 10 percent

2 STRATEGY FOR 2020

Strategic plan is based on issues and areas of improvement identified through the situation analysis of the province. Strategic Plan contains strategies for achieving overall goals in each pillar of health system as well as laid down policy objectives to transport principles and directions into the realm of planning, programming and budgeting that circumscribes the domain in which various programmes, initiatives and activities will be carried out. Details of strategic actions required for each proposed strategy is also provided for facilitating the implementation and subsequent monitoring. Achieving these goals will require a staged approach over time, including substantial new injections of funding and sustained effort.

2.1 Service Delivery

2.1.1 Outcome I: Improved access and quality of healthcare

2.1.1.1 Objectives

- To build an efficient, safe and effective health services delivery system which caters to the specific needs of all population groups with enhanced emphasis on MNCH, emergency care, family planning and nutrition services
- To reduce the morbidity and mortality related to communicable and non-communicable diseases (NCDs)
- To raise community awareness for health promotion and disease prevention
- To institutionalize quality of care in the health services delivery system

Strategies	Strategy Actions	Responsibility
1. Institute Essential Health Services (EHS) Package for primary (including facility-based and outreach services), secondary and tertiary level healthcare facilities	Develop EHS package encompassing infrastructure, workforce, information systems, essential medicines, supplies and equipment	• DoH • PHSRP
	Conduct periodic health facility assessment survey of all primary and secondary healthcare facilities	
	Reposition primary and secondary level facilities on priority basis to deliver EHS package	
	Engage community and civil society in delivery of healthcare service	
2. Establishment of district level health complexes[3] in a phased manner	Upgrade existing DHQ hospital to district health complex having teaching and training facilities for medical students, nurses and allied health professionals	• DoH • PHSRP • DGHS • Private institutions
	Develop two-way linkages for patient referral, staff skill building and clinical supervision through networking of all primary and secondary level facilities with the district health complexes	
3. Strengthen	Develop urban primary healthcare network involving both public and private sector	

[3] District Health Complex (DHC) shall attempt to ensure equitable delivery of healthcare through enhanced access and quality of health care services in deprived and underprivileged districts of Punjab **(Concept details at Annex 5.2.1)**. Establishing a DHC shall include up gradation of the DHQH, setting-up of teaching and training institution for medical, upgrading or setting-up of educational institution for nursing, allied health professionals and health-related other trades. It shall be linked with primary and secondary level health facilities of the district for placements of Senior Registrars and Postgraduate trainees at the linked facilities. Staff at these facilities shall be rotated at the DHCs for continued medical education. These DHCs and teaching institutions shall be developed through public private partnerships and government shall play a facilitative role. In context of redefined role of the government as purchaser of the services, DHCs shall be fully outsourced to the private sector and government can ensure standardized care in public facilities through this innovative strategy.

Strategies	Strategy Actions	Responsibility
urban primary health care	Operationalize and upgrade municipal health facilities in urban areas	• DoH • DGHS • Development partners
	Enhance support to private sector for service delivery in urban areas through Health Foundation[4]	
	Develop communication strategy to raise awareness about urban primary healthcare	
4. Ensuring free of cost, level-specific, 24/7, quality emergency services	Strengthen and upgrade emergency care units at public sector facilities through assessed needs of infrastructure, workforce, medicines and consumables, equipment and ambulance services	• DoH • DGHS • Development partners • DHMT
	Prepare emergency readiness plans	
	Provide free of charge emergency care services to all the patients	
	Develop mechanism for transportation of rural communities to health facilities through community emergency ambulance services	
5. Focus and strengthen MNCH, family planning and nutrition services at all levels	Integrate all MNCH, family planning and nutrition activities at community and primary health facility level	• DoH • DGHS • Development partners • DHMT
	Train and deploy CMWs to ensure safe delivery practices for pregnant women	
	Strengthen routine immunization services for full immunization of all children and women	

[4] Concept details of revamping Punjab Health Foundation are provided at **Annex 5.2.2**

Strategies	Strategy Actions	Responsibility
	Provide family planning services through uninterrupted supply of family planning commodities to all the primary and secondary level health facilities and outreach workers	
	Upgrade a minimum of one third of the BHUs to BHU-plus model for delivery of services on 24/7 basis in 20 low performing districts	
	Ensure full package of 24/7 Basic EmONC services[5] at all RHCs and develop RHCs as hub of primary health care system; with services, management and supervision support fanning out to the adjoining BHUs	
	Upgrade 2 RHCs to RHC-plus model for provision of 24/7 Comprehensive EmONC services in each of 20 low performing districts of Punjab	
	Upgrade and strengthen all THQ and DHQ hospitals to provide full package of 24/7 Comprehensive EmONC services[6], including neonatal intensive care units with qualified staff	
	Upgrade, strengthen and realign all tertiary care level hospitals to cater MNCH related management and referral	
	Institute mass and interpersonal communication focusing key issues of MNCH, family planning and nutrition	

[5] Signal functions for Basic EmONC services include 1) manual removal of placenta, 2) removal of retained products, 3) parenteral oxytocin, 4) parenteral anti-hypertensive 5) parenteral anti-convulsants and 6) basic newborn resuscitation

[6] Signal functions for Comprehensive EmONC services include in addition to Basic EmONC services, include 1) perform caesarean section 2) blood transfusion services and 3) advanced newborn resuscitation

Strategies	Strategy Actions	Responsibility
	Conduct training of staff at all levels on Integrated Management of Newborn and Childhood Illnesses (IMNCI) with a functional follow-up after training mechanism	
	Redesign mobile health units structure and operations to meet the desired service delivery functions	
6. Strengthen prevention and management of infectious diseases	Build the capacity of facility-based and outreach staff on diagnosis and management of acute infections	• DoH • DGHS • Development partners • DHMT
	Functionalize oral rehydration therapy units in all primary healthcare level	
	Establish diarrhoea and pneumonia treatment centres in medical/ paediatrics wards of all THQ and DHQ hospitals for effective management of these health problems	
	Provide laboratory services for diagnosis of major infectious diseases including TB, Hepatitis B and C, HIV/AIDS, Malaria at all RHCs, secondary and tertiary hospitals	
	Cover high risk adult population with Hepatitis B vaccination	
	Establish blood banks in secondary level healthcare facilities lacking such arrangements and ensure safe blood transfusion in all existing public and private blood banks	
	Strengthen inflection control and waste management practices at all public and private sector health facilities with implementation of standard protocols and regular assessment	
7. Strengthen	Commission research on NCDs trends and associated risk factors, disaggregated for gender and geographical prevalence	• DoH • DGHS

Strategies	Strategy Actions	Responsibility
prevention and management of non-communicable diseases (NCDs)	Build capacity of facility-based and outreach staff for diagnosis and management of NCDs	• Development partners • DHMT
	Provide screening services for NCDs at all RHCs, secondary and tertiary hospitals	
	Strengthen disease surveillance and epidemiological unit at the provincial and district level	
8. Strengthening of nutritional services for mothers and children	Integrate nutritional services in pregnancy care both at health facilities and through outreach workers and provide management of severe acute malnutrition in targeted health facilities.	• DoH • DGHS • Development partners • DHMT
	Ensure availability of nutrition supplements and build capacity of healthcare providers, both public and private, on nutritional assessment and management of malnutrition	
	Protect all pregnancies through provision of micronutrient supplements including iron, calcium, zinc, vitamins and folic acid	
9. Strengthen health communication	Develop a communication strategy to raise awareness among population about communicable diseases, their modes of spread and precautionary measures	• DoH • PHDC • IPH • Development partners
	Develop a communication strategy to raise community awareness on risk factors associated with NCDs	
	Raise community awareness through mass media campaigns to motivate household level action against malnutrition	
10. Integration of preventive	Ensure functional and managerial integration of vertical programmes under EPHS at primary level and for the interim period regroup programmes having common	• DoH • PHSRP

Strategies	Strategy Actions	Responsibility
healthcare (vertical) programmes	objectives[7]	
11. Institutionalise inter-sectoral collaboration for better health outcomes	Energize existing mechanisms of inter-sectoral and inter-departmental collaboration at Planning and Development Board	• DoH • Planning and Development Board • PHSRP
	Promote partnership with non-governmental organizations and international agencies for concerted action to improve health	
	Institutionalize operational mechanisms for inter-sectoral coordination at district level	
	Strengthen school health services in collaboration with Education Department and include a strong focus on risk factors associated with communicable and NCDs like personal hygiene, physical activity, tobacco use and dietary habits	
12. Implementation of Minimum Service Delivery Standards (MSDS) and standardization of hospitals and healthcare facilities	Revisit MSDS at primary and secondary level and develop MSDS for tertiary level hospitals in public sector	• DoH • National Standards Committee on Healthcare • Punjab Healthcare Commission • Punjab Health Foundation
	Apply MSDS for private sector through Punjab Healthcare Commission	
	Upgrade health facilities to achieve MSDS	
	Support private sector for implementation of MSDS through a strengthened Punjab Health Foundation	

[7] One example of vertical programmes having similar focus includes National MNCH Programme, National Programme for Family Planning and PHC (LHW Programme) and Nutrition Programme

Strategies	Strategy Actions	Responsibility
	Develop guidelines on quality measures and "quality of care index"[8] at provincial level, and institute clinical audits and clinical assessments through Punjab Healthcare Commission	
	Develop and implement standards for brining culture of accreditation in the province through support of National Standards Committee on Healthcare	

2.1.1.2 **Key performance indicators and targets**

Indicator	Target
1.1 Percentage of health facilities ready to deliver essential health services as per their scope	100 percent
1.2 Percentage of urban population having access to primary healthcare	80 percent
1.3 No of districts having functional health complex	36
1.4 Percentage of RHCs, THQ and DHQ hospitals with functional ambulance services for patient referral	100 percent
1.5 Percentage of health facilities with fully implemented MSDS	80 percent
1.6 Percentage of districts achieving more than 80 percent on Quality of Care Index	36

[8] Quality of care index shall be derived through composite score of districts based on key performance indicators

2.2 Governance and Accountability

2.2.1 Outcome II: An efficient system of health sector governance and regulation

2.2.1.1 Objectives

- To rejuvenate management of health organizations and facilities in Punjab
- To create a higher capacity in DoH for its key roles in health policy making, programming, human resource management, monitoring and evaluation
- To reorganize DGHS and equip it with appropriately designed systems, data and capacities for orchestrating implementation of health policy initiatives in the province
- To seek efficiency, effectiveness and responsiveness gains through decentralized health management and service delivery, optimal autonomy to decentralized districts and autonomous health facilities and integration of vertical programmes
- To establish a robust, comprehensive and responsive regulatory regime to provide optimal regulatory environment to healthcare delivery in the province

Strategies	Strategic Actions	Responsibility
1. Restructure Department of Health for a stewardship and monitoring role	Functional review of Health Department to study organizational structures, mandates and capacities with recommendations for reform and clarification of changing roles of the Department	• DoH • PHSRP
	Reorient departmental systems toward changing role as a steward of health sector, with responsibilities for leadership, financing, regulation, setting targets, programming and monitoring of outcomes	
	Build departmental capacity in policy and programming expertise	
	Strengthen Punjab Health Sector Reform Program as a Strategy and Policy Unit to perform	

	stewardship role of present strategic plan updating and implementation	
	Create of a system of evidence based health policy and programming, including methods for use of DHIS, technical studies and evaluations	
	Develop essential databases as decision support systems including health workforce, disease monitoring, programme monitoring, health monitoring, asset accounting, procurement and logistics, performance measurement and resource utilisation	
	Develop mechanisms to assess expenditure efficiency with legally binding reporting requirements from all implementing agencies	
	Reassess key programmes to prepare programme priming schemes for achieving health goals	
	Create systems of internal communication between health sector organisations to ensure better uptake of policies	
	Create a Health Strategy Ministerial Board with co-opted members from health professions of both public and private sector for overall monitoring of achievement of health sector goals	
2. Restructure DGHS to orchestrate implementation of health policy initiatives	Functional review of DGHS to study organizational structures and mandates, and recommendations for reform and capacity building	• DGHS • PHSRP
	Implementation of leadership, mentoring and enabling roles performed by a reoriented DGHS	
	Create system of evidence based health programming monitoring reports, data analysis, technical studies and evaluations	
	Link DHIS with monitoring and mentoring by DGHS by creating reporting requirements, special studies and evaluations	
	Strengthen information systems for central reviews and monitoring including preparation of monitoring indicators	

	Provision of data analysis capacities through appropriate expertise and building data analysis capacity	
	Develop response protocols to deal with disease outbreaks, emergencies, systemic failures and natural disasters	
	Develop programme review guidelines to carry out periodic assessments of key health programmes	
	Periodic and annual systemic reviews to assess response readiness and priming for service delivery for health organizations, autonomous health facilities and decentralized district departments with DGHS maintaining and following a roster of such reviews; the updated information to be placed on the departmental website.	
3. Optimise decentralisation to districts and autonomy to health facilities	Strengthen health facilities and decentralize district health departments for service delivery by equipping them with appropriate mandates, authorities, resources, systems, capacities and incentives laden accountabilities	• DoH • DGHS • PHSRP
	Create systems for setting health goals for decentralized entities, mentoring and accountability	
	Enhance local capacities for programming and monitoring and strengthen incentives for local initiatives	
	Review of autonomy granted to tertiary hospitals regarding adequacy of management authorities, resources and clearly spelt out responsibilities	
	All districts and institutions to develop and report on annual work plans	
	Periodic and annual reporting requirements in review meetings with legal force behind them to usher in transparency in the decentralized management and operations	
4. Fully operationalize	Develop a system of rule based, comprehensive and responsive regulatory regime	• Punjab Healthcare Commission
	Develop healthcare commission field formations and mechanisms	

Punjab Healthcare Commission	Application of accountability to cases of service delivery failures and medical negligence	
	Create system for registration and licensing of health facilities	
	Create system for registration and licensing of medical laboratories	
	Establishment of Laboratory Certification System	
	Progressive application of Minimum Service Delivery Standards	
	Development of patient rights statements with mandatory display and communication to patients	
	Strengthen regulation and registration of homeopaths and Tibbs. Analysis of information regarding Homeopaths and Tibbs should be done for formulating specific strategies to update their curriculum and improve their role in service delivery	

2.2.1.2 **Key performance indicators and targets**

Indicator	Target
2.1 Functional review reports with reform recommendations of DoH and DGHS developed	Review report developed
2.2 Number of districts reporting progress on basis of annual plans in regular review meetings	36
2.3 Percentage of public health facilities registered/licensed by Punjab Healthcare Commission	100 percent
2.4 Percentage of private health facilities registered/licensed by Punjab Healthcare Commission	80 percent
2.5 Number of districts for whom a complete public and private sector facility data is available	36

2.2.2 Outcome III: A management system that provides incentives for performance and ensures accountability

2.2.2.1 Objectives

- To achieve a higher response for health goals from the public officials and health authorities through institutionalization of performance management
- To realign incentives for healthcare provision through systems of reward and sanctions for performance and accountability
- To strengthen systems for public procurement and institute accountability for results
- To strengthen internal controls for both financial and managerial functions

Strategies	Strategic Actions	Responsibility
1. Develop a comprehensive system for performance assessment and incentives	Institutionalise performance evaluation through mandated performance concepts, indicators, assessment methods and application schedules	• DoH • DGHS • PHSRP • HRPD Unit
	Implement contracting-in models to enhance performance of primary and secondary level facilities	
	Institutionalise and regular update of job descriptions for all cadres	
	Customize performance management tools and processes to the health workforce requirement	
	Develop performance evaluation systems for healthcare institutions and personnel	
	Reorient promotion policy for all health service cadres by linking it to the performance	
	Grant sufficient autonomy to local management to modify performance incentives according to government guidelines	
	Create a system of ‘pay for performance’ and ‘forfeit for failure’ or P4P & F4F to reward innovation, initiative, efficient utilization of available resources and	

	research[9]	
	Review occupation-specific dispensation to ensure appropriate performance based incentives are structured into the remuneration package to attract and retain health professionals[10]	
	Institute a favourable contractual policy for health professionals, which is non-permanent and non-pensionable	
2. Develop a robust system of accountability for performance	Strengthen internal controls[11] for both financial and managerial functions	• DoH • PHSRP
	Develop and apply of codes of behaviour for health workers which should include gender sensitive standards for work place behaviour with legal instruments for institutional accountability	
	Regularly review performance management of district managers based on indicators culled from policy and programmatic goals	
	Conduct continuous performance audit at provincial and district level to review health systems and organisations and take immediate disciplinary actions	

[9] The system will create financial payments to high performing institutions that will be forfeited if performance is below the mark. Under this system, higher performance will be rewarded with additional funds over and above the historical budgetary allocations while low performance will forfeit the opportunities to gain additional funds. It will empower local managers and create strong incentives for higher performance for both institutions and individuals. The institutional incentives will promote teamwork and improve service delivery dependent on combined and coordinated work of different types of health professionals in healthcare institutions. Under this system, enforceable protocols will lead different types of performance to clearly lay down consequentiality. Higher performance will be rewarded with special payments. A schedule of such payments and mechanisms for their administration will be spelt out. On the other hand managers will be empowered to sanction low performance by invoking a consequence under from a menu of management options including retraining, inquiry leading to disciplinary action, work under advisement and reassignment.

[10] The incentive may range from recognition to financial rewards. A special fund will be created to finance performance rewards under the P4P & F4F system. The system will be developed and rolled out in two stages. In the first stage, keeping in view the baseline systemic capacities, a simple P4P will be implemented in a select number of institutions and districts. In the following year the complete P4P & F4F system will be implemented in these locations. After review and calibration a complete roll out followed by sustained implementation will be achieved in the entire province.

[11] Internal controls are those internal systems, procedures, plans and methods, which ensure that an organization's mission, vision, objectives and targets are successfully achieved through the effective and efficient use of scarce public resources.

	All institutions and districts to release annual review reports based on annual work plans	
	Strengthen procurement systems through capacity building	
	Strengthening financial management through capacity building or deployment of specialised personals.	

2.2.2.2 Key performance indicators and targets

Indicator	Target
3.1 Number of districts with systemic change to P4P through	36
3.2 Number of districts whose annual review reports based on annual work plans are available	36
3.3 Punjab Health Contract Service instituted and functional	Complete by 2013
3.4 Number of districts showing satisfactory performance on the basis of laid down performance indicators[12]	36

2.3 Health Workforce

2.3.1 Outcome IV: Adequate and skilled workforce available to fulfil population health needs

2.3.1.1 Objectives

- To establish a governance and leadership structure for HR policy, planning, production and management of health workforce to meet the health needs of the population

[12] Satisfactory performance denotes achievement of more than 80 percent results on the key performance indicators

- To ensure availability of healthcare providers especially that of WMOs in rural health facilities and specialists at secondary level hospitals
- To establish ways of improving quality and productivity of the health workforce
- To develop a favourable and attractive contractual policy for health professionals
- To improve retention of health workers and revitalize the concepts of continuous professional education and training
- To update medical education curriculum with a focus on community-oriented medical education

Strategies	Strategic Actions	Responsibility
1. Establish a Human Resource Planning and Development Unit	Developing a Human Resource Strategy and establishing the Human Resource Planning and Development Unit[13] at the provincial level, placed within the DOH and subsidiary HR units at the district levels	• DoH • PHSRP • Development partners
	Conduct a detailed workforce study to examine the current status and future workforce needs of the critical categories in the province by taking in account migration levels	
	Develop automated database in the form of Human Resource Management Information Systems (HRMIS) for both public and private sector	

[13] Currently, a large number of health care professionals are working in Punjab but we do not have a clear profile of this workforce. For instance, little reliable information is available about the number of workers in different cadres, their skill mix and geographical distribution. Lack of this information presents significant challenges for future health workforce planning. Therefore the PHSS proposes a Human Resource Planning and Development (HRPD) Unit to be established in the Department of Health **(See Annex 5.2.3 for concept details of HRPD Unit)**. It should be aligned with the performance management section of the DGHS. The unit will also create an automated database of the entire public and private health workforce in the province. It will collaborate with Punjab Healthcare Commission for the private sector component of the database. Based on the data, the unit will conduct detailed background studies on all health workforce cadres; determine the future needs and guide planning for fulfilling future health workforce needs in the province.
The Unit will have strong liaison with DGHS, Punjab Healthcare Commission as well as the Health Information System in the province. It will be guided by technical experts and by health workforce experts. Its activities will be monitored and supervised by the health workforce Working Group under the Health Sector Ministerial Board.

	Institutionalize Punjab Health Contract Services	
	Develop a comprehensive HRH communication strategy	
2. Create incentives for WMOs and other HR in rural and hard-to-reach areas	Enhance age bar for entry to be enhanced by 10 years for female health workers in recruitment by Punjab Public Service Commission	• DoH • PHSRP
	Institute a special incentives package for RHCs where there are no WMOs, nurses or other female health staff, including both financial and non-financial incentives	
	Provide market driven incentives to WMOs at THQ and DHQ hospitals to conduct the medico legal cases	
3. Fill all vacant posts of specialists at secondary healthcare hospitals	Implement special incentives package for specialists working in SHC facilities according to the local needs focusing on anaesthetists, paediatricians, radiologists, pathologists and gynaecologists	• DoH • DGHS • CPSP • UHS
	Recognise THQ and DHQ hospitals for placements of PG trainees	
	Rotational placements of the required specialties at the THQ and DHQ hospitals for at least three months from tertiary and teaching hospitals	
	Develop short certificate courses in deficient specialties through CPSP or UHS	
4. Develop a Health Services Academy on the lines of Civil Services Academy for trainings of different categories of health workers	Upgrade and fully resource Provincial Health Development Centre (PHDC) to the level of Punjab Health Services Academy (PHSA)	• DoH • DGHS • PHDC • DHDCs
	Strengthen District Health Development Centre (DHDC) network to conduct district level induction trainings and strengthen linkages with PHDC	
	Update induction training manual “Training 2000” for implementation of training courses	
	Conduct training needs assessment for various cadres and institutionalise all on job training with PHSA and DHDC network	

	Develop category-focused and level-specific training courses with management training separate from clinical cadres	
	Developed linkages with renowned private sector institutions for leadership, management and other specialized trainings to improve quality of HR	
5. Fill faculty positions in all health personnel educational institutions for doctors, nurses and allied health professionals with trained and qualified teachers	Meet standard of faculty needs for medical colleges, nursing schools and allied health professional teaching institutes	• DoH • UHS
	Attract medical graduates/post graduates to areas where there is deficiency e.g. in basic sciences. Institute similar incentives for nurses and allied professionals faculty	
	Identify and implement incentives to attract trained faculty in nursing and allied health professional education institutions	
	Fill all staffing positions in all medical colleges in Punjab according to PMDC regulations	
	Provide training in teaching methodologies and ultimately make it mandatory for teaching in any medical institution in Punjab	
	Institute training programmes for nursing and allied health professional teachers; update and expand existing programmes	
6. Revise the medical education curriculum with more emphasis on preventive and promotive care and incorporate COME at all levels	Adopt and implement the community-oriented medical education (COME) curriculum that was developed for the pilots	• DoH • UHS • PMDC
	Update nursing curriculum with an emphasis on community-oriented perspective	
	Raise awareness about the benefits of using COME approach to increase acceptance among faculty and students	
	Train faculty in the use of COME and appropriate assessment techniques	
	Review and modify the medical college examination system according to the needs of COME	

7. Create CME opportunities for health professionals and over time make CME mandatory for continuation of practice	Make regular CME opportunities available for all health professionals through CPSP, UHS and private institutions	• CPSP • UHS • PMDC • Private institutions
	Make CME opportunities available for private healthcare providers and GPs	
	Create Tele-education and distance learning courses to give CME opportunities to people working in rural and hard-to-reach locations	
	After a certain period of regular provision of CME opportunities, a defined number of CME credits should be made mandatory and linked with continuation of practice/license	

2.3.1.2 **Key performance indicators and targets**

Indicator	Target
4.1 A detailed report on future health workforce needs and strategies in Punjab published by the HR unit	Published by 2013
4.2 Number of reports about HR trends and needs generated by the HR unit	4 per year
4.3 Percentage increase in density of doctors relative to population	30 percent
4.4 Percentage increase in density of nurses relative to population	50 percent
4.5 Percentage increase in density of allied health professionals relative to population	50 percent
4.6 Percentage of RHCs where WMO positions are filled	100 percent
4.7 Percentage of SHC facilities where specialists in all disciplines are available	90 percent
4.8 Percentage of all health care personnel who acquire regular CME	75 percent
4.9 Percentage of health personnel education institutions where all faculty positions are filled	100 percent

Indicator		Target
4.10	Number of districts conducting induction training through network of DHDCs and PHDC	36
4.11	Percentage of medical colleges where COME is completely implemented	100 percent

2.4 Health Information Systems

2.4.1 Outcome V: A comprehensive, timely, accurate and functional information foundation for health policy and planning decisions

2.4.1.1 Objectives

- To enhance scope and contents of health data systems
- To improve access to readily useable data for informed decision making and evidence based policy making
- To plug data gaps by instituting additional approaches for autonomous tertiary hospitals and private sector
- To integrate facility-based and community-based MIS to enhance planning process at the provincial level
- To develop a mechanism for dissemination of the performance of health sector

Strategies	Strategic Actions	Responsibility
1. Strengthen community based information system and its	Institute a mechanism for community-based workers to register all health-related events, specifically neonatal, infant, childhood and maternal deaths	• DoH • DGHS • PHSRP

integration with facility-based information system	Conduct feasibility study for integration of DHIS and community-based MIS* taking into account the functional integration and development of IT linkages at district/provincial levels	
2. Creation of standardized information system for tertiary level hospitals in public sector	Develop and implement a uniform and standardized Tertiary-level Health Information System (THIS)	• DoH • PHSRP • Autonomous tertiary hospitals
	Develop guidelines for all autonomous tertiary hospitals for timely reporting on THIS to provincial level	
3. Linkage of private sector health facilities with provincial level information system	Link private facilities with provincial level information systems for priority infectious disease notification	• DoH • DGHS • Punjab Healthcare Commission
	Validate quality of information collected through quality assurance activities of Punjab Healthcare Commission	
4. Capacity building of district health managers on use of information through support of Provincial and District Health Development Centres	Institute a regular training programme based on training need assessment on use of information by district health managers	• DoH • PHSRP • PHDC • DHDCs
	Build the capacity of PHDC/ PHSA and DHDC through technical assistance to conduct training programmes	
	Develop annual health plans based on use of information	
5. Strengthening Disease	Expand Integrated Disease Surveillance System / DEWS to cover all districts of Punjab	• DoH • DGHS

Early Warning System (DEWS)	Strengthen IDSS/ DEWS implementation[14] in all facilities of Punjab	• Development partners
	Build capacity of relevant staff on recording and reporting of diseases enlisted in IDSS/ DEWS	
6. Institute a mechanism to organize an information database containing research studies, reports, literature and relevant documentation pertaining to health sector of Punjab	Develop a "Knowledge Store" (KS)[15] with physical and virtual presence	• DoH • DGHS • PHSRP • Development partners
	Manage KS through public private partnership	
	Develop linkage with existing HIS, governmental departments, NADRA database, national and international agencies, academia, research organizations in both public and private sector of the province	
	Assure governmental support to KS for acting as a clearing house on research and technical assistance studies in the province	
7. Organize, analyse and publish pertinent health information on health sector performance for a wider dissemination	Prepare and publish Annual Health Report (AHR)[16] based on analysis of district and provincial level data on key performance indicators	• DoH • DGHS
	Dissemination of AHR to districts and general public through knowledge store, electronic and print media	

[14] Upgrade existing laboratories through training of laboratory technicians and provision of all the necessary reagents and materials needed for diagnosis of diseases enlisted in DEWS, provision of DEWS (tools including case definition documents, recording and reporting forms, and watch charts at all level of healthcare facilities in Punjab

[15] Knowledge Store shall perform the functions of storage, cataloguing and retrieval of data **(See Annex 5.2.4 for concept details)**

[16] List of indicators used for publishing Annual Health Report shall be based on the key performance indicators identified for this strategic plan

8. Institutionalize a mechanism for a comprehensive health survey at household level	Institutionalize Punjab Health Survey with a periodicity of five years for specific data requirements of health policy and planning	• DoH • DGHS • Bureau of Statistics • Development partners
	Conduct periodic independent third party health facility assessment	
	Establish linkages and collaboration with Bureau of Statistics and relevant organizations	
8. Strengthen health research in both public and private sector	Operationlize and strengthen Punjab Medical Research Fund through active collaboration with national and international partners and research funds to support and guide research activities in the province	• DoH • UHS • Punjab Medical Research Fund
	Reform Institute of Public Health in Punjab to take up leading role in health research	
	Provide incentives and a supportive environment for students and faculty in medical institutions to engage in quality research in relevant areas	

2.4.1.2 **Key performance indicators and targets**

Indicator	Target
5.1 Percentage of vertical programmes integrated with provincial MIS Cell	100 percent
5.2 Percentage of tertiary hospitals regularly reporting using THIS to the provincial MIS Cell	100 percent
5.3 Percentage of private sector hospitals and healthcare facilities regularly reporting using PHIS	70 percent
5.4 Number of districts preparing annual health plans of actions considering the health issues emerging from the information system	36

5.5 Establishment of Knowledge Store	1
5.6 Annual Health Report published	1 every year
5.7 Number of studies commissioned by Punjab Medical Research Fund annually	5 per year

2.5 Essential Medicines and Health Technologies

2.5.1 Outcome VI: Uninterrupted supply of quality essential drugs for healthcare facilities and outreach workers

2.5.1.1 Objectives

- To improve logistic and supply chain management system for regular, uninterrupted and adequate availability of essential drugs at all levels of health care
- To implement PPRA rules and regulation for public sector procurement
- To regularly review the Essential Drugs List (EDL) for making it response to burden of disease faced by the population of Punjab
- To create strategic assets at district level for assuring proper and sufficient storage of essential medicines
- To improve quality of drugs by enforcement of drug regulation in Punjab at all levels of manufacturing, testing and sale

Strategies	Strategic Actions	Responsibility
1. Enhance existing logistics and supply	Review, assess and recommend appropriate changes through adopting standard operating procedures and guidelines for procurement and distribution system	• DoH • DGHS • DHMT

chain management system	Establishment of a well-equipped, well-staffed procurement and logistics cell at provincial level	
	Restructure medical store depots (MSDs) on modern lines and create a network of MSDs in all districts as part of the supply chain management	
	Adapt and implement an integrated Vaccine Logistic Management Information System (VLMIS), and integrated warehousing and LMIS	
	Strengthen implementation of PPRA rules and regulations for procurement	
	Automate system for quantification, procurement and distribution	
2. Regular review of Essential Drugs List (EDL)	Institute periodic review of the EDL after every three years	• DoH • PHSRP
	Update the EDL while keeping in mind needs of the population and burden of disease	
3. Strengthen drugs regulation	Review Provincial Quality Control Board (PQCB) for adequacy of resources and skills	• Drug Regulatory Authority
	Upgrade DTL through modern drug testing equipment and ensure its regular maintenance	
	Monitor pharmacies to be operated by qualified pharmacists	

2.5.1.2 Key performance indicators and targets

Indicator	Target
6.1 Percentage of BHUs provided with more than 75% of essential drugs	100 percent
6.2 Percentage of RHCs provided with more than 75% of essential drugs	100 percent
6.3 Percentage of SHC hospitals provided with more than 75% of essential drugs	100 percent
6.4 Percentage of lady health workers with stock-out of family planning commodities	5 percent
6.5 Essential drug list includes paediatric formulation of Oxytocin, Magnesium sulphate, Zinc and paediatric formulation of amoxicillin	Period update of EDL
6.6 Percentage of district having medical store depots available for storage of required supply of medicines and supplies	100%
6.7 Number of districts having storage capacity to stock one month supply of vaccines required in the district	36

2.6 Healthcare Financing

2.6.1 Outcome VII: Optimized healthcare financing through fiscal responses

2.6.2 Objectives

- To enhance public sector financing of health service delivery
- To protect the disadvantaged and vulnerable from catastrophic health expenditures
- To enhance the efficiency of public spending by improving budgetary utilisation

- To increase use of private sector participation in provision of publically provided health services by outsourcing through transparent competitive process

Strategies	Strategic Actions	Responsibility
1. Reassess spending priorities with more focus on primary healthcare 2. Increase overall government expenditure on health care	Increase investment in primary health care initiatives by reducing future investments in building new tertiary health care facilities. Facilitate private sector in developing and maintaining healthcare facilities providing highly specialized care	• DoH • PHSRP • Population Welfare Department • DHMT • Private sector
	Consolidate spending to increase focus on primary health through integration of service delivery arrangements having common outcomes, specifically Population Welfare Department and vertical health programmes	
	Enhance investment and improve primary health care facilities in districts with lowest performance in health outcomes	
	Gradually increase investments in health care – to enhance coverage of primary health care facilities. Assess financial needs of districts and discuss revision in Provincial Finance Commission Award or introduce special health grants.	
3. Introduce health voucher scheme	Consolidate Zakat, Bait al Maal and Waseela-e-Sehet initiatives and form a health social security system, devise mechanism for screening low income group and provide free medical services	• DoH • Development partners
	Establish a mechanism for health voucher scheme in collaboration with public health care facilities – targeting vulnerable and disadvantaged	
4. Improve efficiency, effectiveness and economy in health care spending	Embed Output Based Budgeting – OBB (as per Medium-Term Budgetary Framework) at the provincial level and introduce OBB in districts – present provincial OBB to Provincial Assembly as part of the annual budget	• DoH
	Operationalize a 'Budgetary Performance Evaluation Unit' as a part of revamped PHSRP to regularly monitor, evaluate and report performance. Regular reporting to Secretary, Chief Secretary, Office of the Chief Minister, and Cabinet. Introduce regular budget vs.	

5. Increasing budget utilisation rate at the provincial and district governments	actual monitoring, output monitoring and upload original budget, budget released and budget utilized on regular basis on the Department of Health's website	
	Review existing model of PRSP to update and revise existing contracts and develop guidelines for their extension	
	Improve funds release and utilization mechanism together with the Finance Department, Planning & Development Department and Commissioners / District Coordination Officers	
	Specify in rules and regulations specific timelines for audit reports of all major projects available and presented to the public accounts committee – monitor adherence to timelines	
	Eliminate gradually the practice of block-allocations, umbrella schemes, lump provisions and discretionary funds in health sector	

2.6.2.1 **Key performance indicators and targets**

Indicator	Target
7.1 Per capita government funding in US $	8.5 US $
7.2 Percentage of the districts are able to utilise more than 90% of the released funds in the same FY	100 percent
7.3 Out of Pocket as percentage of total health spending	50 percent
7.4 Percentage of vulnerable population covered through health insurance and voucher schemes	90 percent
7.5 Percentage of BHUs outsourced to private sector	100 percent

3 IMPLEMENTATION OF THE STRATEGY

There is no denying the enormity of the tasks that lie ahead in implementing the Strategy. Strategic plan enlists a number of strategies and strategic actions that will contribute towards achievement of desired health outcomes. While the key responsibility lies with the Department of Health (DoH) and the Directorate General Health Services (DGHS), role of the Punjab Health Sector Reform Programme (PHSRP) shall be instrumental rather pivotal in designing the change. Technical inputs shall be required for development of operational plans to implement proposed strategy and PHSRP can take up the role of coordinating technical assistances required for the Strategy. Strengthened role of various organizations like Punjab Healthcare Commission, Punjab Health Foundation, and Provincial and District Health Development Centres is also envisaged for implementation of the Strategy. Further, health is not only the responsibility of DoH as many of the determinants of health are not directly health related such as educational attainment, economic wealth and employment. There are other key players who are directly or indirectly involved in determining health status of the people of Punjab. For brining improvement in health status and overall wellbeing of the people, strong partnership among the various sectors will play a vital role in bringing together key stakeholders and organizations to develop and deliver the required initiatives.

As a means to encouraging and supporting action across the province, the strategy development team proposes the establishment of “Health Sector Ministerial Board” (HSMB), which will be headed by the provincial Health Minister and shall comprise of Secretary of Health, Parliamentary Secretary on Health, Chairman P&D, Secretary Finance, Secretary Schools Education, Secretary Population Welfare Department along with nominated technical experts and representatives from private sector, local governments, businesses and industry, civil society, community groups, families and individuals. The Board may be an expanded version of the present steering committee constituted for the Health Sector Strategy development.

The technical members will be experts with considerable practical experience and must not be directly involved in the implementation of the strategy. Working Groups shall be constituted under the HSMB in each of the six strategy pillars. The Board may also include representatives from other sectors that have considerable impact on health such as education, water and sanitation. Support from the development partners in health sector shall be aligned with the strategy. These partners shall be encouraged to provide on-budget support. In case it is not feasible than a joint TA plan shall be prepared and approved by the HSMB.

At the provincial level, key roles and responsibilities include policy and strategic planning, management of large size contracts, capacity building, M&E and supportive supervision. DGHS shall be involved in the planning, budgeting, performance review, supervision, coordination, recording and reporting of progress to provide basis of budgetary allocations.

3.1 Adopting a phased approach

Phasing and sequencing of the strategic actions over time is necessary as it will not be possible or appropriate to initiate all actions at once. Initial phase shall set in place the urgent priority actions, while subsequent phases shall build on these actions, learning from evidences from implementation carried out in the initial phase. Various proposed interventions require studies and technical assistance during the initial phase. These studies are essential for going forward and priority shall be accorded to such strategy actions so that the implementation of subsequent actions could be timely accomplished.

3.2 Monitoring and Evaluation of the Strategy

During recent years, promotion of a results based culture is evident in health sector of Punjab. Government is making efforts towards making a shift from a planning environment concentrated on the reporting of processes and outputs to outcomes and targets indicators. Therefore, monitoring framework of the strategy shall be based on the strategic outcomes described in strategic framework of this document.

The importance of continuous monitoring for successful implementation of any strategic plan cannot be overstressed. It is especially important given our past experience where plans go off-track and cannot be implemented well because there is inadequate attention to continuous monitoring, re-evaluation, and institution of required modifications. Strong, effective and consistent monitoring, evaluation and accountability must be done to successfully achieve the targets of Punjab Health Sector Strategy. It is necessary to strengthen Punjab's capacity to effectively monitor, evaluate and build evidence around health. A number of ambitious targets have been set and the Strategy has been designed to focus on a cyclical approach of implementation, measurement and accountability. The development of a robust performance framework to underpin the Strategy and inform its implementation is therefore a priority.

The whole process should be guided by the concept of supportive monitoring. While most of the monitoring and supervisory roles discussed here already exist, the needs for capacity building, provision of proper equipment and training as well as capacity building in analysis and use of the information gathered will have to be assessed and addressed for the mechanisms to be effective. The

following description gives an outline of monitoring and evaluation roles throughout the sector. The process of supportive monitoring will flow down to the grass-roots levels. There must be capacity building for staff to perform their roles wherever needed, monitoring and evaluation done and accountability ensured throughout the system from top to bottom. This will be implemented through the performance assessment system being proposed throughout the sector.

3.2.1 Provincial level

At provincial level, HSMB will head the monitoring and evaluation process. The Board will have quarterly meetings to evaluate progress on the strategic targets. Working Groups constituted for each pillar of the strategy will report their performance against specified indicators, identify obstacles and outline remedial actions on quarterly basis. Annual progress report shall be submitted to the provincial Assembly's Standing Committee on Health to review progress and give recommendations for future budget allocations for strategic priorities.

DoH will play the role of an overall provincial supervision and monitoring role. Specific tools shall be developed for assessing the performance in each pillar of the strategy. Assess the achievement of goals against defined criteria, consolidate the information and report to the HSMB. DGHS will have a much more prominent monitoring role in this strategy. It will play a technical backstopping and supportive role in the monitoring and evaluation process. It will coordinate with Provincial and District Health Development Centres to provide technical support and capacity building.

The flow chart (Figure 3) represents the structural mechanism for monitoring and evaluation of Punjab Health Sector Strategy. Where targets are consistently not reached despite addressing obstacles or the reports are untenable; third party evaluations will be conducted. The Board will have auditing arms, which shall facilitate the process of third party evaluations.

3.2.2 District and Community level

At district level, supportive monitoring and supervision will be strengthened by providing appropriate equipment, expertise and capacity building as well as by better use of data and its analysis. While providing needed support, achievement of targets should be linked to performance assessment at all levels. District Health Management Team (DHMT) shall be operationlised in all the districts to improve service delivery through better planning and management. DHMT may serve as a forum for all health related activities in the districts. This shall enhance inter- sectoral coordination and prevent duplication of effort thus preventing wastage of resources. Primarily role and responsibilities may be focused on

planning, monitoring and evaluation; team building and decision making through proactive team design and process, decentralization of various functions to lower levels, advocacy with district assembly and stakeholders for health program support and regulation of non- government providers to assure quality are all critical to the success of DHMTs.

Figure 3: M&E Mechanism for the Strategy

In order to strengthen the role of DHMTs, legislative specification of DHMT authority, responsibilities and accountability is essential for continuity and sustainability. Regular performance assessment of DHMTs on agreed indicators and continued technical support to district management structure should be ensured. Districts shall be preparing annual work plans while taking into consideration the strategic framework and progress shall be reviewed against these plans for individual districts.

Healthcare monitoring is a specialized tasks and community reporting, with time and effort costs, is unlikely to yield sufficient information. However, in order to institute bottom-up monitoring approach in the community, Hospital and Healthcare Committee shall be constituted at the Tehsil and Markaz level, which shall later be brought down to the Union Council level. These committees shall assist the district level management in need assessment, review of progress and planning, and addressing issues and problems through collective efforts. Further, these committees shall also be involved in advocacy for resources allocation.

3.3 Measuring the progress

Progress of the strategy shall be monitored at both levels of health status and outcomes for the population as well as the systemic performance of the health sector. Changes in health outcomes and determinants of health are the long-term measures of the success of this strategy. However, these indicators are most reliably measured over several years at the population level, and changes cannot easily be attributed to specific programme elements. Information from household level surveys like Multiple Indicator Cluster Survey (MICS), Pakistan Social and Living Standard Measurement Survey (PSLM), Pakistan Demographic and Health Survey (PDHS) and National Nutritional Survey (NNS) shall be used to monitor the overall impact of strategic actions on reduction in morbidity and mortality.

Complementing these longer-term measures are the shorter-term programme and system-level performance indicators more closely related to the specific priority actions, programmes and health system strengthening. Current Health Information Systems are needed to be strengthened for periodic review of the strategy. It is proposed that the DGHS shall prepare the annual health report, encompassing programme and system performance measures are summarised in the following M&E Framework.

3.4 M&E Framework

3.4.1 Societal Health Outcomes

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
1. IMR	30 per 1,000 live births	MICS	Four years	77	-	-	50	-	-	-	30
a. Rural community	34 per 1,000 live births	MICS	Four years	86	-	-	56	-	-	-	34
b. Female gender	29 per 1,000 live births	MICS	Four years	73	-	-	48	-	-	-	29
c. Poorest wealth quintile	40 per 1,000 live births	MICS	Four years	102	-	-	67	-	-	-	40
2. U5MR	40 per 1,000 live births	MICS	Four years	111	-	-	70	-	-	-	40
a. Rural community	46 per 1,000 live births	MICS	Four years	126	-	-	80	-	-	-	46
b. Female gender	38 per 1,000 live births	MICS	Four years	106	-	-	67	-	-	-	38
c. Poorest wealth quintile	57 per 1,000 live births	MICS	Four years	156	-	-	99	-	-	-	57
3. MMR	120 per 100,000 live births	PDHS	Five years	227	-	-	160	-	-	-	120
4. Prevalence of TB cases	0.1 percent	MICS	Four Years	0.3%	0.25%	0.2%	0.15	0.15%	0.1%	0.1%	0.1%

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
a. Rural community	0.1 percent	MICS	Four Years	0.3%	0.25%	0.2%	0.15	0.15%	0.1%	0.1%	0.1%
b. Female gender	0.1 percent	MICS	Four Years	0.3%	0.25%	0.2%	0.15	0.15%	0.1%	0.1%	0.1%
c. Poorest wealth quintile	0.2 percent	MICS	Four Years	0.5%	0.5%	0.45%	0.4%	0.35%	0.3%	0.25%	0.2%
5. Prevalence of Hepatitis B and C	0.1 percent	MICS	Four Years	0.7%	0.65%	0.6%	0.55%	0.5%	0.45%	0.4%	0.4%
a. Rural community	0.1 percent	MICS	Four Years	0.7%	0.65%	0.6%	0.55%	0.5%	0.45%	0.4%	0.4%
b. Female gender	0.1 percent	MICS	Four Years	0.7%	0.65%	0.6%	0.55%	0.5%	0.45%	0.4%	0.4%
c. Poorest wealth quintile	0.1 percent	MICS	Four Years	0.7%	0.65%	0.6%	0.55%	0.5%	0.45%	0.4%	0.4%
6. Prevalence of HIV/AIDS cases among vulnerable groups	0.01 percent	PDHS	Five Years	0.03%	0.03%	0.025	0.02%	0.02	0.015	0.015	0.01%
7. Percentage of underweight children in Punjab	10 percent	NNS	Five years	30%	-	-	-	15%	-	-	10%
a. Rural community	12 percent	NNS	Five years	35.7%	-	-	-	18	-	-	12
b. Female gender	11 percent	NNS	Five years	32.8%	-	-	-	17%	-	-	11%
c. Poorest wealth quintile	15 percent	NNS	Five years	43.5%	-	-	-	23%	-	-	15%

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
8. Prevalence of stunting in children	8 percent	NNS	Five years	25%	-	-	-	16%	-	-	8%
9. Prevalence of wasting in children	8 percent	NNS	Five years	24.4%	-	-	-	16%	-	-	8%
10. Percentage of women of reproductive age suffering from iron deficiency anaemia	10 percent	NNS	Five years	27%	-	-	-	15%	-	-	10%

3.4.2 Systemic performance

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Outcome I: Improved access and quality of healthcare											
1.1 Development of Essential Health Services Package (EHSP) for all levels of healthcare facilities	EHSP developed	DoH Report	One time	EHSP Developed	-	-	-	-	-	-	-
1.2 Number of health facilities ready to	34 DHQHs	Health	After 5 years	-	10	15	20	25	30	34	34

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
deliver essential health services as per their scope	84 THQHs	Facility Assessment		-	30	40	50	60	70	80	84
	291 RHCs			-	50	100	150	200	250	291	291
	2454 BHUs			-	500	1000	1500	2000	2454	2454	2454
1.3 Percentage of urban population having access to primary healthcare	80 percent	MIS Report	Annual	Model developed	25	40	50	60	70	80	90
1.4 No of districts having functional health complex	36	DoH Report	Annual	-	-	4	6	10	15	20	24
1.5 Percentage of RHCs, THQ and DHQ hospitals with functional ambulance services for patient referral	100 percent	MIS Report	Five years	-	85%	90%	95%	100%	100%	100%	100%
1.6 Percentage of health facilities with fully implemented MSDS	90 percent	Health Facility Assessment	Five years	-	-	20%	40%	60%	70%	80%	90%
1.7 Percentage of BHUs providing 24/7 services with rural ambulance service through implementation of BHU-plus model in 20 priority districts	33 percent	DoH Reporting	Annual	03%	10%	10%	15%	20%	25%	30%	33%
1.8 Number of RHCs providing 24-7 Comprehensive EmONC services	40 (2 per district)	DoH Reporting	Annual	10	20	30	40	40	40	40	40

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
through implementation of RHC-plus Model in 20 priority districts											
1.9 Number of districts achieving more than 80 percent on Quality of Care Index	36	DoH Report	Annual	QCI developed	12	16	20	24	28	32	36
1.10 CPR	60 percent	DoH Report	Annual	32%	35%	38%	41%	44%	47%	50%	53%
1.11 Full immunisation coverage	90 percent	MICS	Four Years	60%	65%	70%	75%	80%	85%	90%	95%
1.12 Percentage of deliveries conducted by skilled birth attendants	90 percent	MICS	Four Years	43%	50%	60%	70%	75%	80%	85%	90%
1.13 CDR of TB	95%	PTP Report	Annual	85%	87%	90%	91%	92%	93%	94%	95%
Outcome 2: An efficient system of health sector governance and regulation											
2.1 Functional review and restructuring of DoH and DGHS accomplished	Re-structuring completed	DoH Report	One time	Model developed	50%	75%	100%	-	-	-	-
2.2 Revamping of Health Sector Reforms Unit into a full-fledged Policy and Strategy Unit	HSRP revamped into a Strategy and Policy Unit	DoH Report	One time	Completed	-	-	-	-	-	-	-

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
2.3 Number of districts whose annual review reports based on three years rolling plans are available	36	DoH Report	Annual	Rolling plans updated	12	24	36	36	36	36	36
2.4 Number of districts showing satisfactory performance on the basis of laid down performance indicators[17]	36	HRPD Unit Report	Annual	-	12	24	36	36	36	36	36
2.5 Review and revision of autonomy model for tertiary hospitals	Revised autonomy model developed	DoH Report	One time with periodical review	A revised autonomy model implemented	Regular review	Regular review	Regular review	Regular review	Regular review	Regular review	Regular review
2.6 Percentage of public health facilities registered/licensed by Punjab Healthcare Commission	100 percent	Punjab Health Commission Report	Annual	-	50%	75%	100%	100%	100%	100%	100%
2.7 Percentage of private health facilities registered/licensed by	100 percent	Punjab Health	Annual	-	5%	20%	50%	75%	100%	100%	100%

[17] Satisfactory performance denotes achievement of more than 80 percent on the key performance indicators

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Punjab Healthcare Commission		Commission Report									
2.8 Number of districts for whom a complete public and private sector facility data is available	36	Punjab Health Commission Report	Annual	12	24	36	36	36	36	36	36
Outcome 3: A management system that provides incentives for performance and ensures accountability											
3.1 Piloting and scaling up of Contracting-In model for systemic change to P4P	Contracting in model piloted and rolled out in 36 districts	DoH Report	Annual	Model developed including P4P elements	2	10	15	20	30	36	36
3.2 Regular review of performance of district level managers (EDOs, MSs)	Review of performance system in place with regularity	HRPD Unit Report	Quarterly	KPIs developed	Regular review	Regular review	Regular review	Regular review	Regular review	Regular review	Regular review
Outcome 4: Adequate and skilled health workforce available to fulfil population needs											
4.1 Establishment of Human Resource Planning and Development (HRPD) Unit	HRPD Unit established	DoH Report	One time	PC-1 approved	Fully operationalized	-	-	-	-	-	-

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
4.2 A detailed report on future health workforce needs and strategies in Punjab published by the HRPD Unit	Published by 2013	HRPD Unit Report	One time activity	HRMIS developed	Completed						
4.3 Number of reports about HR trends and needs generated by the HRPD Unit	4 per year	HRPD Unit Report	Quarterly	-	4	4	4	4	4	4	4
4.4 Percentage increase in density of doctors relative to population in underserved areas	30 percent	MIS Report	Annual	-	5%	10%	15%	18%	22%	26%	30%
4.5 Percentage increase in density of nurses relative to population	50 percent	MIS Report	Annual	-	10%	20%	30%	35%	40%	45%	50%
4.6 Percentage increase in density of allied health professionals relative to population	50 percent	MIS Report	Annual	-	10%	20%	30%	35%	40%	45%	50%
4.7 Percentage of RHCs where WMO positions are filled	100 percent	MIS Report	Annual	91%	95%	100%	100%	100%	100%	100%	100%
4.8 Percentage of SHC facilities where specialists in all disciplines are available	90 percent	MIS Report	Annual	60%	65%	70%	75%	80%	85%	90%	90%
4.9 Percentage of all health care personnel who acquire regular	75 percent	DoH Report	Annual	-	30%	40%	50%	60%	65%	70%	75%

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
CME											
4.10 Percentage of health personnel education institutions where all faculty positions are filled	100 percent	PMDC Report	Annual	-	80%	90%	100%	100%	100%	100%	100%
4.11 Number of districts conducting staff trainings through network of DHDCs and PHDC	36	DoH Report	Annual	Upgrade PHDC and DHDC	12	24	36	36	36	36	36
4.12 Percentage of medical colleges where COME is completely implemented	100 percent	PHDC Report	Annual	-	50%	80%	100%	100%	100%	100%	100%
Outcome 5: A comprehensive, timely, accurate and functional information foundation for health policy and planning decisions											
5.1 Percentage of vertical programmes integrated with provincial MIS Cell	100 percent	MIS Report	Annual	-	-	100%	100%	100%	100%	100%	100%
5.2 Percentage of tertiary hospitals regularly reporting using THIS to the provincial MIS Cell	100 percent	MIS Report	Annual	-	40%	80%	100%	100%	100%	100%	100%
5.3 Percentage of private sector hospitals and healthcare facilities regularly reporting on priority/	100 percent	MIS Report	Annual	Operationalize legal frame	5%	15%	30%	60%	90%	100%	100%

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
notifiable communicable diseases				work							
5.4 Number of districts preparing three years rolling plans of actions considering the health issues emerging from the information system	36	Three-years Rolling Plans	Annual	-	-	36	36	36	36	36	36
5.5 Establishment of Knowledge Store	1	DoH Report	One time activity	-	1	-	-	-	-	-	-
5.6 Annual Health Report published	1 every year	Annual Health Report	Annual	-	1	1	1	1	1	1	1
5.7 Number of studies commissioned by Punjab Medical Research Fund annually	5 per year	DoH Report	Annual	-	5	5	5	5	5	5	5
Outcome 6: Uninterrupted supply of essential medicines for healthcare facilities and outreach workers											
6.1 Establishment of a well-equipped, well-staffed Procurement and Logistics Cell at DoH	Unit established	DoH Reporting	One time	-.	Unit established	-	-	-	-	-	-
6.2 Percentage of BHUs provided with more than 95% of essential drugs	100 percent	MIS Report	Annual	33%	60%	80%	100%	100%	100%	100%	100%
6.3 Percentage of RHCs provided with more than 95% of essential drugs	100 percent	MIS Report	Annual	25%	60%	80%	100%	100%	100%	100%	100%

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
6.4 Percentage of SHC hospitals provided with more than 75% of essential drugs	100 percent	MIS Report	Annual	25%	60%	80%	100%	100%	100%	100%	100%
6.5 Percentage of lady health workers with stock-out of family planning commodities	5 percent	LHW-MIS Report	Annual	-	80%	50%	30%	10%	10%	5%	5%
6.6 Essential drug list includes paediatric formulation of Oxytocin, Magnesium sulphate, Zinc and paediatric formulation of amoxicillin	Periodic update of EDL	EDL	3 years	-	Up dated	-	-	Updated	-	-	Updated
6.7 Percentage of district having medical store depots available for storage of required supply of medicines and supplies	100%	DoH Report	Annual	-	80%	85%	90%	95%	100%	100%	100%
6.8 Number of districts having storage capacity to stock one month supply of vaccines required in the district	36	DoH Report	Annual			20	30	36	36	36	36
Outcome VII: Optimized healthcare financing through fiscal responses											
7.1 Per capita government funding in US $	8.5 US $			6.1	6.4	6.8	7.2	7.6	8	8.2	8.5
7.2 Share of the provincial government towards preventive programmes as percentage of the development	TBD	DoH Report	Annual	-	-	-	-	-	-	-	-

Indicator	Targets for 2020	Verification		Strategy Timeline							
		Means	Frequency	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
budge											
7.3 Percentage of the districts are able to utilise more than 90% of the released funds in the same FY	100 percent	DoH Report	Annual	-	50%	60%	70%	80%	90	100%	100%
7.4 Number of districts with health sector specific social safety net designed and rolled out	36	DoH reporting with 3rd party evaluation	Annual	-	3	7	12	18	24	30	36
7.5 Percentage of vulnerable population covered through social safety nets like voucher schemes	90 percent	MICS	4 years	-	25%	50%	60%	75%	80%	85%	90%
7.6 Out of Pocket as percentage of total health spending in lowest two wealth quintiles	30 percent decrease from baseline	NHA	5 years	-	10%	15%	20%	25%	30%	30%	30%
7.7 Merger of Health and Population Welfare Departments for efficient spending	Departments merged	DoH Report	One time	Merger complete	-	-	-	-	-	-	-
7.8 Review of PRSP model and revision of existing contracts	Review completed	DoH Report	Annual	Review of Model completed	Revision of contracts	Regular review	Regular review	Regular review	Regular review	Regular review	Regular review

4 FINANCIAL FRAMEWORK

To achieve outcomes presented in the Health Sector Strategy, the financing portion provides the required future costs. The costs are projected over the 10 years period. The base case scenario assumes that a specific level of funding will be available based on fiscal transfers from the Federal Government and Health priority of the Government of Punjab. The increase in fiscal transfers is based on medium-term macroeconomic assumptions of the Federal Government. Secondly, the health sector strategy is costed based on outcomes to be achieved. The fundamental outcome of service delivery includes preventive, primary, secondary and tertiary health care services, and investments in medical education and allied services. Certain assumptions on service delivery are taken that are reproduced below.

4.1 Cost Assumptions

- MSDS at PHC (staff strength and medical stocks as per MSDS)
- Preventive: full EPI coverage, full family planning, LHW and MCH coverage
- No new BHUs
- Upgrade of district HQs hospitals to teaching hospitals
- Creation of district health complex
- Enhancing existing service delivery capacity at Secondary Care Hospitals. Maintaining service delivery capacity at Tertiary Care Hospitals. Gradual reduction of investments in building new Tertiary Care Hospitals / Highly specialised units
- Increase in investment in governance (including formation of Monitoring and Evaluation Unit), management and regulation (including increased investment in Health Care Commission)
- Enhancement of Health Information System
- Redesigning of Mobile Health Units – Creation of new Mobile Health Units
- Starting Community Ambulance Service
- Merging of Ministry of Health and Population Welfare
- Start of targeted health voucher
- MSDS assumed to be Rs.360 per person.
- Inflation Rate of 10%
- Population Growth Rate of 2.5%

4.2 COST OF HEALTH SECTOR STRATEGY

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Outcome 1: Improved Access and Quality of Health Care												
	Essential Health Services Package											
A	Primary Health Care - Community Based											
	Immunization Services:											
	Newborn children (Millions)		1.8	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8	1.8
	Unit cost of vaccination per child (US$)	25.0	26.3	27.6	28.9	30.4	31.9	33.5	35.2	36.9	38.8	40.7
	Coverage (%age)	60%	70%	80%	85%	90%	95%	100%	100%	100%	100%	100%
	Cost (Rs. Billions)		3.2	4.2	5.0	5.7	7.0	8.0	8.9	9.7	10.8	12.1
	Community Mid Wife Services:											
	Community component of Mother and Newborn Health Care											
	Community Mid Wives (Thousands)	2.5	5.5	8.5	11.5	14.5	17.5	17.5	17.5	17.5	17.5	17.5
	Unit cost (US$) per Community Mid Wife		1,500.0	1,575.0	1,653.8	1,736.4	1,823.3	1,914.4	2,010.1	2,110.7	2,216.2	2,327.0
	Cost (Rs. Billions)		0.8	1.4	2.0	2.9	3.8	4.3	4.8	5.3	5.9	6.6

Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Community Ambulance Services											
Rural Union Councils (Thousands)	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1
1 Ambulance for 3 Rural Union Councils		0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Unit Cost of Ambulance + Operating Expenditure (US$)		10,000	10,500	11,025	11,576	12,155	12,763	13,401	14,071	14,775	15,513
Cost (Rs. Billions)		0.7	0.7	0.8	0.9	1.0	1.1	1.3	1.4	1.6	1.8
Community Safe Kits and Traditional Birth Attendants (TBAs)		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
TBAs (Thousands)	25.0	24.0	23.0	22.0	21.0	20.0	19.0	18.0	17.0	16.0	15.0
Unit Cost (US$) per TBA (Orientation and Kit)		20.0	21.0	22.1	23.2	24.3	25.5	26.8	28.1	29.5	31.0
Cost (Rs. Billions)		0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Behaviour Change Communication (Rs. Billions)		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Community based PHC and Family Planning Services (LHWs, Mobilisers):											
Lady Health Workers (Thousands)	49.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0
Unit cost Family Planning and PHC (US$) per		2,100	2,205	2,315	2,431	2,553	2,680	2,814	2,955	3,103	3,258

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	LHW											
	Cost (Rs. Billions)		9.0	10.0	11.2	12.4	13.8	15.4	17.1	19.1	21.2	23.6
	Tuberculosis, HIV, Hepatitis, Nutrition	0.5	0.6	0.6	0.7	0.7	0.8	0.9	0.9	1.0	1.0	1.1
	Total Cost – PHC – Community Based (Rs. Billions)	**7.1**	**14.4**	**17.0**	**19.8**	**22.8**	**26.6**	**29.8**	**33.1**	**36.6**	**40.7**	**45.3**
B	Primary Health Care - Facility Based											
	Minimum Service Delivery Standards (Per Capita US$)	2.9	4.0	4.2	4.4	4.6	4.9	5.1	5.4	5.6	5.9	6.2
	Coverage (%age)		30%	42%	59%	82%	100%	100%	100%	100%	100%	100%
	Cost (Rs. Billions)		11.3	18.0	28.5	45.2	62.2	70.4	79.7	90.1	101.9	115.3
	Non-MSDS Coverage (%age)		70%	58%	41%	18%	0%	0%	0%	0%	0%	0%
	Cost per Unit of Non-MSDS Coverage (%age)		2.5	2.6	2.8	2.9	3.0	3.2	3.4	3.5	3.7	3.9
	Cost (Rs. Billions)		16.5	15.5	12.5	6.1	-	-	-	-	-	-
C	Secondary Health Care Services	9.7	13.1	14.4	15.8	17.2	18.7	20.1	21.7	23.2	24.7	26.2

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
D	Free Medicines (targeted)	6.3	7.0	7.7	8.4	9.1	9.9	10.7	11.5	12.3	13.1	13.9
E	Tertiary Health Care Services	23.6	26.1	28.7	31.4	34.2	37.1	40.1	43.1	46.1	49.1	52.1
	No of BHUs	2,454	2,454	2,454	2,454	2,454	2,454	2,454	2,454	2,454	2,454	2,454
	24/7 Services		10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
	No of BHUs with 24/7 Services		245	245	245	245	245	245	245	245	245	245
	Operational Cost of MSDS (60% of MSDS cost) - Per Capita (US$)		4.8	5.0	5.3	5.6	5.8	6.1	6.4	6.8	7.1	7.4
F	Cost - Rs. Billions		1.1	1.3	1.4	1.5	1.7	1.9	2.1	2.4	2.6	2.9
G	District level Health Complexes (4 per yr)		-	3.0	3.3	3.6	3.9	4.2	4.5	4.8	5.1	5.4
H	Health Complexes - Recurrent Cost - Rs. Billions		-	-	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
I	Nursing Schools		0.9	0.9	1.0	1.1	1.2	1.3	1.4	1.4	1.5	1.6
J	Mobile Health Units - Fixed Cost - Rs. Billions		0.0	0.0	0.0	-	-	-	-	-	-	-
K	Mobile Health Units - Recurrent Cost - Rs. Billions		0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
	Development and strengthening of Urban Primary Health Care											
	Urban Union Councils (UCs)	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Operationalisation of UPHCs		30%	60%	100%	100%	100%	100%	100%	100%	100%	100%
	Unit cost (Rs. Millions)		3.5	3.8	4.2	4.6	5.0	5.4	5.8	6.2	6.6	7.0
L	Cost - Rs. Billions		1.1	2.5	4.6	5.0	5.5	5.9	6.3	6.8	7.2	7.6
	Total Cost of Outcome 1 (A to L): Rs. Billions		**91.6**	**109.1**	**126.9**	**146.1**	**167.1**	**184.8**	**203.8**	**224.2**	**246.6**	**270.9**
Outcome 2: An efficient system of health sector governance and regulation												
	Punjab Health Care Commission (Rs. Millions)	35.0	50.0	55.0	60.2	65.6	71.2	76.9	82.7	88.5	94.2	99.9
	Restructuring of DoH, DoPW, DG Health (Rs. Millions)	187.0	300.0	330.0	361.4	393.9	427.4	461.5	496.2	530.9	565.4	599.3
	Private Sector Involvement and Mainstreaming (Rs. Millions)	1,100.0	1,500.0	1,650.0	1,806.8	1,969.4	2,136.8	2,307.7	2,480.8	2,654.4	2,827.0	2,996.6
	Total Cost of Outcome 2: Rs. Billions		**1.9**	**2.0**	**2.2**	**2.4**	**2.6**	**2.8**	**3.1**	**3.3**	**3.5**	**3.7**
Outcome 3: A management system that provides incentives for performance and ensures accountability												
A	Pay for Performance and Incentives		1.0	1.1	1.2	1.3	1.4	1.5	1.7	1.8	1.9	2.0
B	Internal Controls		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Total Cost of Outcome 3: Rs. Billions		**1.0**	**1.1**	**1.2**	**1.3**	**1.4**	**1.6**	**1.7**	**1.8**	**1.9**	**2.0**
Outcome 4: Adequate and skilled workforce available to fulfil population health needs												
A	HRPD Unit and Staff Trainings		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
B	Creation and management of Health Services Academy		0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
C	Medical Education Services	4.7	5.2	5.7	6.3	6.8	7.4	8.0	8.6	9.2	9.8	10.4
D	Upgrade Existing Medical Education Services		-	-	4.0	4.4	4.7	5.1	5.5	5.9	6.3	6.6
E	New Medical Colleges	1.5	1.5	1.0	0.5	-	-	-	-	-	-	-
F	Operationalisation of Medical Research Board		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
G	Continuous Medical Education for Health Professionals											
	Number of Doctors	10,000	11,000	12,000	13,000	14,000	15,000	16,000	17,000	18,000	19,000	20,000
	Coverage (%age)		0%	40%	40%	40%	40%	40%	40%	40%	40%	40%
	Unit Cost (Rs.)		10,000	11,000	12,045	13,129	14,245	15,385	16,538	17,696	18,846	19,977
	Cost (Rs. Billions)		-	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
	Total Cost of Outcome 4: Rs. Billions		**6.9**	**6.9**	**11.0**	**11.4**	**12.4**	**13.4**	**14.4**	**15.4**	**16.4**	**17.3**

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Outcome 5: A comprehensive, timely, accurate and functional information foundation for health policy and planning decisions												
	(DIHS, IS, Expansion and Integration, Knowledge Centres, Uniform system for Tertiary Health Information System, Development of Linking with Pvt Sector, Evidence based Decision Making)											
A	System Development & Integration		0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
B	Use of Evidence Based System - Capacity Building		0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
C	Knowledge Stores (website, cataloguing, database etc.)		0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4
D	Surveys (District disaggregated on all health indicators)		0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4
E	Punjab Medical Research Fund		1.0	1.1	1.2	1.3	1.4	1.5	1.7	1.8	1.9	2.0
	Total Cost of Outcome 5: Rs. Billions		**1.6**	**1.8**	**1.9**	**2.1**	**2.3**	**2.5**	**2.6**	**2.8**	**3.0**	**3.2**
Outcome 6: Uninterrupted supply of quality essential drugs for healthcare facilities and outreach workers												
A	Logistics and supply chain management system		0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
B	Update of Essential Drug List		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
C	Update of Procurement Processes		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total Cost of Outcome 6: Rs. Billions		**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**
Outcome 7: Optimized healthcare financing through fiscal responses												
A	Creation of Health Insurance System		0.1	0.1	-	-	-	-	-	-	-	-
	Health Voucher Scheme (Rs. per Capita)		4,000	4,400	4,818	5,252	5,698	6,154	6,615	7,078	7,539	7,991

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Coverage (%age of pregnant women)		20%	22%	24%	26%	28%	30%	32%	34%	36%	38%
	Target Population (Millions)		0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7
B	Cost of Health Voucher Scheme (Rs. Billions)		1.5	1.8	2.2	2.5	3.1	3.4	3.9	4.4	5.0	5.6
C	Creation of finance and strategic planning functions at DoH		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
	Total Cost of Outcome 7: Rs. Billions		**1.6**	**1.9**	**2.2**	**2.6**	**3.1**	**3.5**	**4.0**	**4.5**	**5.1**	**5.7**
TOTAL COST OF HEALTH SECTOR STRATEGY			**104.8**	**123.1**	**145.8**	**166.2**	**189.2**	**208.8**	**229.8**	**252.3**	**276.8**	**303.2**
	Per capita (US$)		11.1	12.1	13.3	14.0	14.8	15.1	15.5	15.8	16.0	16.3

4.3 ANALYSIS OF BUDGET AND EXPENDITURE IN CASE OF NO HEALTH SECTOR STRATEGY (BUSINESS AS USUAL SCENARIO)

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	Provincial and District Govts budget on Health and Population Welfare											
	Department of Health and Department of Works	51										
	Department of Population Welfare	3										
	District Government's Health Budget	27										
	Provincial and District Govts budget on Health and Population Welfare	**81**	**89**	**102**	**115**	**132**	**152**	**175**	**201**	**231**	**266**	**298**

	Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
	As %age of total provincial budget	12.4%	12.0%	11.5%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%	11.0%
	Estimated Budget Utilisation %age	75%	71%	73%	76%	79%	82%	85%	88%	91%	95%	95%
A	Estimated Provincial Expenditure	60.8	63.5	74.5	87.3	104.4	124.6	148.6	176.9	210.3	252.5	282.8
	As %age of total provincial expenditure	9.8%	9.0%	8.8%	8.8%	9.1%	9.5%	9.8%	10.2%	10.5%	11.0%	11.0%
	Per capita (US$)	7.0	6.7	7.3	8.0	8.8	9.7	10.8	11.9	13.1	14.6	15.2
	Vertical Health and Population Welfare Programmes Budget (Funded by Federal Govt till 2014-15)	7.1	7.7	8.3	8.9	9.7	-	-	-	-	-	-
	Estimated Budget Utilisation %age	90%	90%	90%	90%	90%	0%	0%	0%	0%	0%	0%
B	Vertical Programmes Expenditure in Punjab	6.4	6.9	7.5	8.0	8.7	-	-	-	-	-	-
	Total Estimated Health Budget in Punjab	88.1	97.2	110.3	123.9	141.8	152.0	174.8	201.0	231.1	265.8	297.7
	Total Estimated Health Spending in Punjab (A+B)*	**67.1**	**70.4**	**81.9**	**95.4**	**113.1**	**124.6**	**148.6**	**176.9**	**210.3**	**252.5**	**282.8**
	Per capita (US$)	7.7	7.5	8.0	8.7	9.5	9.7	10.8	11.9	13.1	14.6	15.2

4.4 ANALYSIS OF FUNDING / SPENDING GAP

Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Estimated Health Sector Budget in Punjab (Rs. Billions)	**88.1**	**97.2**	**110.3**	**123.9**	**141.8**	**152.0**	**174.8**	**201.0**	**231.1**	**265.8**	**297.7**
Per capita (US$)	10.1	10.3	10.8	11.3	12.0	11.9	12.7	13.5	14.4	15.4	16.0
Funding Gap (Rs. Billions)		**7.7**	**12.8**	**21.9**	**24.4**	**37.3**	**34.0**	**28.9**	**21.1**	**11.0**	**5.5**
Gap as %age of total budget on Health Sector in Punjab		8%	12%	18%	17%	25%	19%	14%	9%	4%	2%
Funding Gap (US$ Millions)		80.4	127.0	204.5	215.0	309.3	266.6	213.2	147.4	72.1	33.9
Estimated Health Sector Spending in Punjab (Rs. Billions)	67.1	70.4	81.9	95.4	113.1	124.6	148.6	176.9	210.3	252.5	282.8
Spending Gap (Rs. Billions)		34.4	41.2	50.4	53.1	64.6	60.2	53.0	41.9	24.3	20.3
As %age of total spending on Health Sector in Punjab		49%	50%	53%	47%	52%	41%	30%	20%	10%	7%
Funding Gap (US$ Millions)		360.5	407.5	470.2	467.7	536.5	471.9	391.5	292.4	159.5	126.2

4.5 ASSUMPTIONS

Rs. Billions - unless otherwise indicated	Baseline (FY12)	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Total Provincial Budget (Rs. Billions)	655	746	887	1,045	1,201	1,382	1,589	1,827	2,101	2,416	2,706
Budget Utilisation %age	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Estimated Total Provincial Expenditure (Rs. Billions)	622.3	708.5	842.6	992.5	1,141.3	1,312.5	1,509.4	1,735.8	1,996.2	2,295.6	2,571.1
Punjab's GDP (in current prices) - Rs. Billions	12,213	13,935	15,858	18,046	20,483	23,186	26,178	29,476	33,101	37,074	41,411
Annual GDP growth rate %age	3.5	3.6	3.8	4.3	4.5	4.7	4.9	5.1	5.3	5.5	5.7
Total Population (Millions)	97	99	101	102	104	106	108	110	112	113	115
Population growth rate (%)		1.9	1.9	1.8	1.8	1.8	1.7	1.7	1.6	1.6	1.6
Exchange Rate: (Rupees per USD)	90	95	101	107	114	120	128	135	143	152	161
Inflation (annual growth %age)	11.5	10.5	10.0	9.5	9.0	8.5	8.0	7.5	7.0	6.5	6.0
Provincial Revenue Resources (Rs. Billions) as per MTFF	643.8	745.8	886.9	1,044.7	1,201.4	1,381.6	1,588.9	1,827.2	2,101.3	2,416.5	2,706.4
Inflation in US$ (annual growth %age)	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

Other costing assumptions and sources:

- Punjab's GDP as per Medium-Term Fiscal Framework - MTFF (2011-14)
- Exchange rate, Inflation as per Macroeconomic Framework of Federal Govt (2012-15)
- Provincial Revenue Resources are projected as per Punjab's MTFF (2011-14). Yr4 onwards 15% increase is assumed.

- Population growth rate based on projections by NIPS
- Currency depreciation of 6% annually is assumed
- Funding for vertical programmes is assumed to continue either by the Federal Govt or by Provincial Govt.
- Total Health Spending in Punjab excludes health spending through Employee Social Security Institute, Bait al Maal, Zakat, Benazir Income Support Programme, Military
- Secondly health care services are underfunded by at least 35%
- Budgets / Costs included Health and Population Welfare areas.

5 ANNEXES

5.1 List of Abbreviations

ACR	Annual Confidential Report
ADB	Asian Development Bank
ADP	Annual Development Plan
AE	Assistant Entomologist
AIDS	Acquired Immune Deficiency Syndrome
AJK	Azad Jammu Kashmir
AMS	Assistant Medical Superintendent
APMO	Assistant Principal Medical Officer
APWMO	Assistant Principal Woman Medical Officer
ARI	Acute Respiratory Infection
AWD	Acute Watery Diarrhoea
BCG	Bacille Calmette Guerin
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
BPS	Basic Pay Scale
BTO	Blood Transfusion Officer
CCI	Council of Common Interest
CDC	Communicable Disease Control
CDCO	Communicable Disease Control Officer
CLL	Concurrent Legislative List
CME	Continuing Medical Education
CMO	Chief Medical Officer
CMW	Community Midwives
CNE	Civil Non-Entitled
COME	**Community Oriented Medical Education**

CPD	Continued Professional Development
CPR	Contraceptive Prevalence Rate
CSHP	Career Structure for Health Personnel
DAO	District Accounts Office
DCO	District Coordination Officer
DDC	District Development Committee
DDHO	Deputy District Health Officer
DDO	Drawing and Disbursing Officer
DEWS	Disease Early Warning System
DFID	Department for International Development
DGHS	Director General Health Services
DHDC	District Health Development Centre
DHIS	District Health Information System
DHQ	District Head Quarter
DIHC	District Inspectors Health Centres
DMS	Deputy Medical Superintendent
DoH	Department of Health
DOH	District Officer Health
DOTS	Directly Observed Treatment Strategy
DPT	Diphtheria, Pertussis, Tetanus
DQCB	District Quality Control Board
DSI	District Sanitary Inspector
DSV	District Superintendent Vaccination
DTL	Drug Testing Laboratory
DTL	Drug Testing Laboratory
EDL	Essential Drugs Lists
EDO	Executive District Officer

EmONC	Emergency Obstetric Neonatal Care
EMRO	Eastern Mediterranean Regional Office
ENT	Ear Nose Throat
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
FBR	Federal Board of Revenue
FCPS	Fellow of College of Physicians and Surgeons
FLCF	First Level Care Facility
FP	Family Planning
FWC	Family Welfare Centres
FY	Financial Year
GDP	Gross Domestic Product
HDI	Human development index
HEC	Higher Education Commission
HepB	Hepatitis B
Hib	Haemophilus Influenza Type b
HIS	Health Information Systems
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HPA	Health Professional Allowance
HPS	Health Personnel Pay Scales
HR	Human Resource
HRH	Human Resource for Health
PHSRP	Punjab Health Sector Reform Programme
ICD	International Classification of Diseases
IDA	Iron Deficiency Anaemia
IDD	Iodine Deficiency Disorders

IFA	Individual Financial Assistance
IMR	Infant Mortality Rate
JICA	Japanese International Cooperation Agency
KPK	Khyber Pakhtunkhwa
LGO	Local Government Ordinance
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
LHWP	Lady Health Worker's Programme
LQAS	Lot Quality Assurance Sampling
MCAT	Medical College Admission Test
MCHC	Maternal & Child Health Care
MCPS	Member of College of Physicians & Surgeons
MDG	Millennium Development Goal
MDR	Multi-Drug Resistance
MHU	Mobile Health Units
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNA	Member of National Assembly
MNCH	Maternal, Neonatal and Child Health
MO	Medical Officer
MOH	Ministry of Health
MPA	Member of Provincial Assembly
MPH	Master in Public Health
MS	Medical Superintendent
MSD	Medical Store Depot

MSDS	Minimum Service Delivery Standards
MTBF	Medium-Term Budgetary Framework
MTDF	Medium-Term Development Framework
NCD	Non-Communicable Diseases
NFC	National Finance Commission
NGO	Non-Government Organization
NHIRC	National Health Information Resource Centre
NID	National Immunization Days
NLC	National Logistics Cell
NMNCHP	National Maternal, Neonatal and Child Health Programme
NNS	National Nutritional Survey
NWFP	North West Frontier Province
OOP	Out of Pocket Expenditure
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
P&D	Planning And Development
PDHS	Pakistan Demographic and Health Survey
PDMA	Provincial Disaster Management Authority
PDWP	Provincial Development Working Party
PESSI	Punjab Employees Social Security Institution
PFC	Provincial Finance Commission
PHC	Primary Health Care
PHDC	Provincial Health Development Centre
PIFRA	Project to Improve Financial Reporting and Auditing
PIHS	Pakistan Integrated Household Survey

PMDC	Pakistan Medical & Dental Council
PMDGP	Punjab Millennium Development Goals Programme
PMO	Principal Medical Officer
PMRC	Pakistan Medical and Research Council
PNC	Pakistan Nursing Council
PPP	Public Private Partnerships
PQCB	Provincial Quality Control Board
PRISM	Performance of Routine Information Systems Management
PRSP	Punjab Rural Support programme
PSLM	Pakistan Social and Living standard Measurement
PSQCS	Pakistan Standard and Quality Control Authority
PTP	Punjab TB Control Programme
PUO	Pyrexia of Unknown Origin
PWD	Population Welfare Department
PWMO	Principal Woman Medical Officer
RBM	Roll Back Malaria
RHC	Rural Health Centre
RHS	Reproductive Health Services
SARS	Severe Acute Respiratory Syndrome
SBA	Skilled Birth Attendants
SCN	Standing Committee on Nutrition
SDA	
SECP	Security and Exchange Commission of Pakistan
SHC	Secondary Health Care
SIA	Supplementary Immunization Activities
SMO	Senior Medical Officer
SOP	Standard Operating Procedures

SSC	Sehat Sahulat Card
STD	Sexually Transmitted Diseases
SWMO	Senior Woman Medical Officer
TB	Tuberculosis
TBA	Trained Birth Attendants
THQ	Tehsil Head Quarter
TNA	Training Needs Assessment
TT	Tetanus Toxoid
U5MR	Under-Five Mortality Rate
UC	Union Council
UK	United Kingdom
UNDP	United Nation Development Programme
UNICEF	United National Children's Fund
UPHC	Urban Primary Health Care
US	United States
USAID	United States Agency for International Development
VAD	Vitamin A deficiency
VCT	Voluntary Counselling and Testing
VPD	Vaccine Preventable Diseases
WAPDA	Water and Power Development Authority
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WMO	Woman Medical Officer

5.2 Concept notes on innovative strategies

5.2.1 District Health Complex

5.2.1.1 **Rationale**

Healthcare services in Punjab are not equitable. A review of key health outcomes reveals that certain districts of the province are far below the average and their low performance is attributable to widening disparity in the access, coverage and quality of healthcare. The situation is further aggravated with critical shortage of health workforce and their skewed distribution towards more developed cities of the province. In addition to the doctors, shortage of nurses, allied health professionals and auxiliary services has resulted in limited availability of health workers in the underprivileged and disadvantaged areas of the province. Number of doctors graduating in the province has increased due to large private sector investments in medical education in recent years. However, empirical evidence suggests that emigration of large numbers of graduates, not joining the workforce by others (especially women), and an increasing population have left available pool of doctors less than optimal. However, a similar increasing trend in production is not evident for nurses and allied health professionals. Skewed distribution of health workers towards large urban areas further exacerbates limited availability of health workers for other areas in the province. Most recent investment in medical education has been in large cities mainly due to convenience, supportive infrastructure and profitability for such institutions. This results in concentration of education, training and career advancement opportunities on one end with availability of quality services at other end limited to just a few big cities. Limited professional opportunities in other areas of the province have made retaining health workers there exceedingly difficult.

Keeping in view needs and vulnerabilities of the people in underprivileged and disadvantaged districts of Punjab, concept of *District Health Complexes* (DHCs) is forwarded to deal with issues of access and quality of healthcare. Specific objectives of DHC are as follows.

1. To develop and retrain healthcare professional at all levels (including doctors, nurses, allied health professional and auxiliary services staff) for ensuring availability of trained staff at public healthcare facilities
2. To increase the access of healthcare services through strengthened network of public sector healthcare facilities
3. To enhance quality of healthcare through enhanced capacity of the healthcare providers at primary and secondary level healthcare facilities

5.2.1.2 **Operational Modalities**

DHCs shall be established in a phased manner in ALL districts of the province. Initially, the creation of complexes will be prioritized in districts requiring investment. District Complex will be a service provision, educational and training institution for all health workforce cadres including doctors, nurses, allied health professionals and other health related trades.

Tertiary-level Hospital – shall be created through up gradation of existing DHQ hospital, which shall act as a nucleus of the DHCs. It shall be established at a level to meet the teaching and training requirements of PMDC, PNC and Punjab Medical Faculty.

Medical College – shall be established for training of doctors and specialists to meet the shortcomings of the district.

Nursing Institute – shall be established through up gradation of existing institutes or creation of new institutes in districts currently lacking such arrangements.

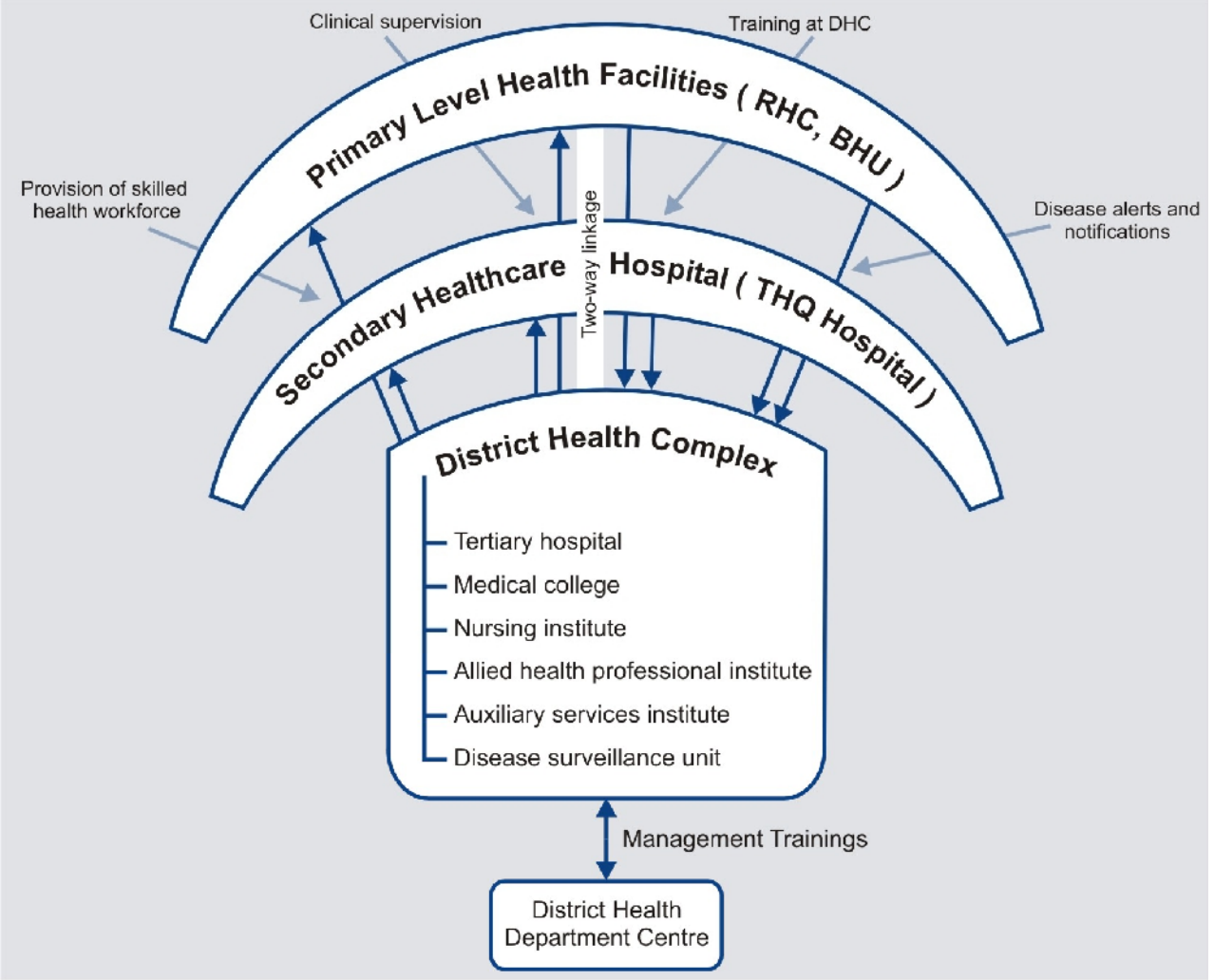
Allied Health Professional Institute – shall be created as part of the DHC to train allied health professionals as well as support staff involved in various auxiliary services in healthcare facilities (like janitorial services, ambulance services, infection control practices).

Formal linkages with primary and secondary level facilities – shall be developed for two-way capacity building and CME of the staff. Complex will not only educate and train new health professionals; it will also create mechanisms for capacity building of health workforce in primary and secondary health facilities within the district. Specialized staff from the DHC will be periodically rotated to primary and secondary level facilities for clinical mentoring and supervision. Simultaneously, staff from primary and secondary level facilities will also be trained at DHC as part of a continuous professional development process. This will lead to improved quality of patient care throughout the district and increase professional satisfaction among workers in lower level facilities.

Disease Surveillance Unit – shall be established at DHC through linkage with the primary and secondary level healthcare facilities. Staff at these facilities shall be trained and equipped for disease surveillance functions at their facilities. Disease Surveillance Unit shall be linked with provincial headquarters also for assuring timely response.

Formal linkages with District Health Development Centres – shall be established with the DHDCs to revitalize its role in conducting management trainings of the district level managers as well as operational research on district-specific healthcare issues.

Figure 4: Conceptual framework of a District Health Complex



Creation of DHCs with critical workforce needs will be achieved through appropriate incentives for investors and public funding. Educational part of Complex will be set up through public private partnership. Private sector will be incentivized to invest in medical colleges while the nursing and allied health professional educational component may be set up through either public funding or public private partnership. This is to ensure that nursing and allied health professional educational institutes are created even if large private sector investment is not forthcoming, since there is critical need for these health workers. Process of setting up of DHC may be monitored by a multi representation District Health Management Team. Annual progress reports will be shared with the provincial Health Sector Ministerial Board.

5.2.1.3 **Expected outcomes**

It is reasonable to presume that creation of tertiary level facilities at district level and its formal linkages with lower level facilities, spreading educational and career advancement

opportunities along with local production of health workers will increase numbers and help retain health workers thus improving access and quality of health services leading to better health outcomes. Specific outcomes of the DHC shall be as follows.

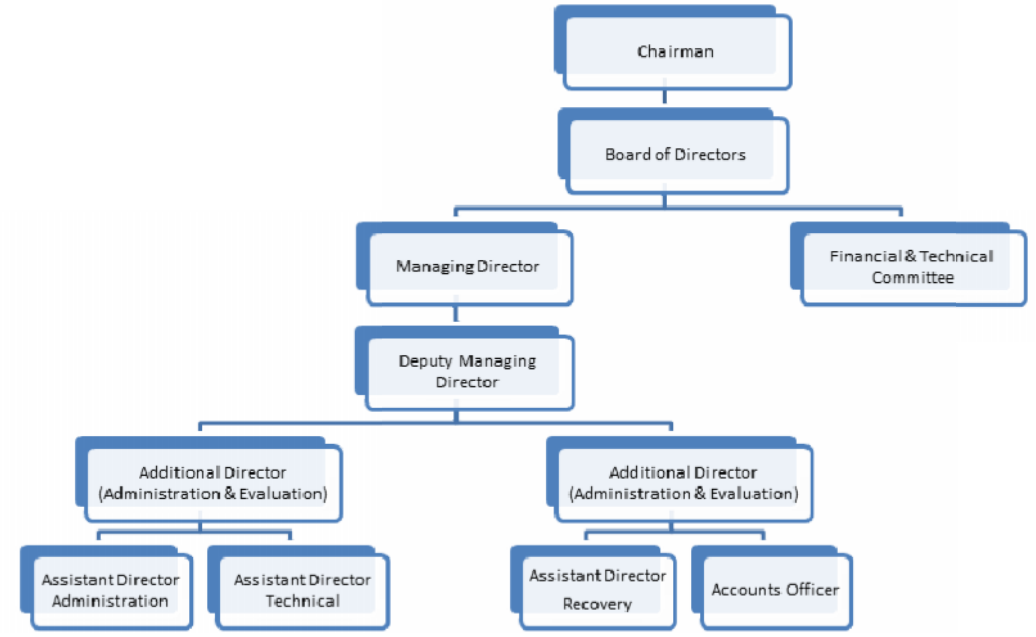
1. DHC shall improve access and quality of healthcare in underprivileged and disadvantaged segments of the province through strengthening of public facilities, provision of tertiary level care close to the communities and enhanced skills and competence of staff at all levels.
2. It is expected that DHC will act as an engine of development and boost local economy of district creating employment and economic growth – another determinant of better health. Resultant economic and social growth at district level will ensure retention of health workers since these factors are important consideration for educated health workers in terms of quality of life.
3. DHC shall help increase health workforce for doctors, nurses and allied health professionals. It shall result in improved population to health workforce ratios in districts through enhanced development and retention of health workers. Further, it shall ensure availability of staff required to deliver Essential Health Services package at primary and secondary level healthcare facilities.

5.2.2 Punjab Health Foundation

Punjab Health Foundation (PHF), a public sector autonomous body, was set up in 1992 through Punjab Health Foundation Act to provide financial assistance to private sector practices and increasing coverage of health services in Punjab. PHF assists individual healthcare providers and institutions in setting up health facilities or upgrading them by providing interest-free loans and facilitates land acquisition.[18]

Health Foundation's two decades of work, however, has not substantially contributed to better coverage or quality of health services by private sector in Punjab. Reasons for this lack of impact lie in issues of structural organization, functional procedures and capacity. The figure below depicts existing organizational structure of the Foundation.

Figure 5: Current structure of PHF



Source: *Punjab Health Foundation*

PHF has been very successful in achieving high loan repayment rates; not surprising for interest-free loans. However, it has not been entirely successful in ensuring appropriate use of loans. Theoretically, the Foundation is supposed to verify that loans are being used for the approved purposes but because of its weak monitoring capacity it has not been able to adequately monitor this. Resultantly, many grantees use the loans for non-approved purposes such as acquiring personal property, travelling abroad for career opportunities, etc. So while the Foundation is financially sustainable – claimed as a measure of success – it is not achieving its intended purpose of improving health services coverage through private

[18] Punjab Health Foundation: Our Functions. Available at: http://phf.punjab.gov.pk/index.php?q=our_functions

sector. Punjab Health Foundation cannot fulfil this mandate without significant structural reorganization and capacity building as outlined below.

5.2.2.1 **Conceptual Framework**

A revamped Health Foundation will be a much leaner organization with its structure following the required functions. The main functions will include the following.

- Facilitating the private sector in standardization and achievement of level specific Minimum Service Delivery Standards (MSDS)
- Providing focused, prioritized support to private sector facilities in disadvantaged areas and underdeveloped districts
- Supporting private sector in provision of preventive and promotive care by building incentives in loans or by providing loans for immunization contracts and other innovative primary health services
- Provide one-window technical assistance to healthcare professionals for setting up and managing a private sector facility
- Incentivize grantees to provide care for health specific social safety net users such as health vouchers and charge reasonable fees from others

To perform these functions PHF will establish crucial linkages with Punjab Healthcare Commission, Department of Health and district offices.

The reorganization required to perform these tasks will include much stronger technical and monitoring capacity. The revamped Foundation will have three specific units for these functions, i.e., technical; administrative and finance; and monitoring and evaluation units.

The Technical Unit will include public health experts and managers. It will identify the desired health outputs and outcomes to which the loans should be linked. This unit will coordinate with Punjab Healthcare Commission to identify geographical areas in the province where private sector services can be used to bridge service gaps. The Foundation must then reserve a number of loans for setting up or expanding practices in these areas. The health experts will also assess feasibility of linking achievement of various preventive and promotive activities and attainment of level specific minimum service delivery standards (MSDS) with continuation of the contracts.

The Financial Unit will be involved in assessment and disbursement of loans while the Monitoring and Evaluation Unit will have monitoring experts to monitor the health inputs, outputs and outcomes as a result of loans. This unit will regularly monitor facilities and documentation to ensure that loans are being used solely for the purposes they were granted for. It will also monitor the facilities to ensure carrying out of required preventive and

promotive activities and progress towards achieving MSDS. If the targets are not achieved grantees may be refused further instalments or asked to repay loans with a mark up.

5.2.2.2 **Expected outcomes**

A revamped Health Foundation will be expected to achieve the following outcomes.

- Improve quality of care by helping private sector providers achieve MSDS
- Improve access to health care services by utilizing private sector potential
- Bridge the health services gaps in underserved areas
- Improve health promotion and prevention by linking loans to preventive and promotive services
- Improve affordability of health services by encouraging reasonable fees and providing services to social safety net users

5.2.3 Human Resource Planning and Development Cell

Currently, a large number of health care professionals are working in Punjab but we do not have a clear profile of this workforce. For instance, little reliable information is available about the number of workers in different cadres, their skill mix and geographical distribution. Although anecdotal evidence suggests a number of health human resource issues in the province including misdistribution between urban and rural areas, high levels of emigration, low proportion of female medical graduates joining the workforce, inappropriate skill mix relative to needs, low job satisfaction; quantifying these issues is difficult given lack of supportive data.

Lack of this information creates significant limitation to workforce planning. Consequently, decision making about health workforce remains reactive and has not been able to account for changing population and health workers' needs.

Health human resource planning is a complex and specialized task and merits focused and sustained attention by a dedicated unit. Therefore, Punjab Health Sector Strategy (PHSS) proposes a Human Resource Planning and Development (HRPD) Unit to perform these functions.

5.2.3.1 **Operational modalities**

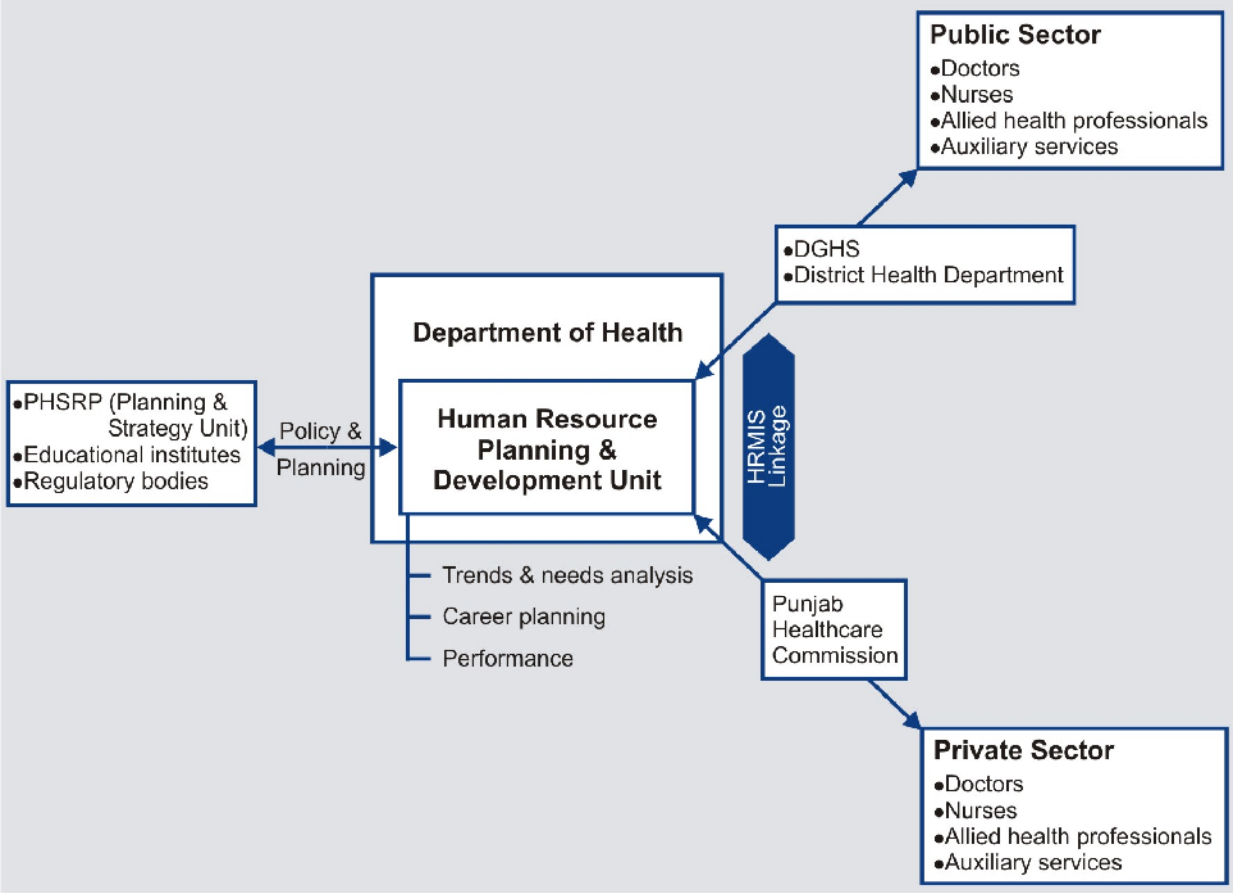
The HRPD unit will be created in the Department of Health. It will be a compact unit with resources for data collection, aggregation and analysis. Broad guidance to the unit will be provided by the technical members of the Working Group on Health Workforce under Health Sector Ministerial Board (HSMB).

The unit will perform the following key functions:

- Provide data on current production of all cadres of health workforce including doctors, nurses, allied health professionals and auxiliary workers
- Create a Human Resource Management Information System (HRMIS)
- Study prospective needs[19] of various cadres and create projections
- Career planning of health workers
- Devise strategies for workforce retention
- Performance management
- Mediation forum for redressing health workers' complaints

[19] This should include consideration of population growth and workforce migration

Figure 6: Conceptual framework of HRPD Unit



HRPD Unit will work closely with the Performance Management Unit in DGHS and the Punjab Healthcare Commission to create a unified database of public and private sector health workers in Punjab.

The analytical part of the unit will work closely with the Punjab Health Sector Reform Program to give policy recommendations and strategize for fulfilling workforce needs in Punjab. The technical experts in the HSMB working group will facilitate the unit in analysis of current workforce trends and future needs assessment.

5.2.3.2 **Expected outcomes**

A fully functioning HRPD is expected to have the following outcomes.

- Evidence based decision making in health workforce planning and policy making
- Adequate number of well trained workforce especially in underserved areas
- Appropriate distribution of skill mix for population needs
- Equitable geographical distribution of health workers
- Optimal use of public sector resources in workforce education and training

5.2.4 Knowledge Store

5.2.4.1 **Rationale**

A number of organizations are conducting health related research in Punjab. Numerous such reports, analyses, evaluations and research papers are published each year in both public and private sector. Yet most are not easily accessible for researchers, practitioners or decision makers. Most are not available online and even relevant online material may be difficult to find through the numerous organizations. A number of research papers are only available for subscription, which are not commonly available. As a result of this all the knowledge created cannot be used optimally in increasing knowledge, assessing research gaps, and informing policy and practice. Apart from these missed opportunities, resources are wasted due to duplication of research studies.

This trend signifies the lack of one unified source of information about the health related knowledge being created. Creation of the 'Knowledge Store' will fill this gap and allow easier access to knowledge in a move towards creating a culture of research and evidence based decision making in the province. Key objectives of the KS shall include the following.

1. To provide a centralized mechanism to capture and store all health-related information in Punjab
2. To develop its linkage with governmental departments operating the services, Bureau of Statistics, academic institutions, development partners and donors involved in health-related research
3. To support the function of "clearing house" regarding health-related research

5.2.4.2 **Conceptual framework**

KS shall be established within the realm of a revamped Punjab Health Sector Reform Programme (Policy and Strategy Unit) of the GoPunjab initially and may later be transferred to a reformed Institute of Public Health. KS will have the task to find, collect and automate all the relevant reports, studies, surveys and analyses relevant to health in Punjab.

Virtual presence – is necessary for convenient access to the databases of KS. Therefore, in addition to its physical presence at the PHSRP (Policy and Strategy Unit), a strong IT component of the KS shall be established. All the databases shall be publically available through the website, which shall be periodically updated.

Data flow linkage – with other departments, organizations, development partners, international agencies, regulatory bodies, national and international academic institutions working on health issues relevant to Punjab.

Linkage with comprehensive health research databases - will be create by making a repository of all the open access relevant literature and provide access to databases such as Pubmed, Cochrane reviews etc. This component should be available to individuals or institutions at subsidized rates to encourage research in the province.

Support to strategic planning – shall be provided by the KS as all relevant public documents such as departmental reports, policy statements, and strategy documents should be available in the store to carry out clearing house functions to avoid duplication of efforts and promote transparent governance through enhanced evidence-based planning.

The store will function under the guidance of Working Group on Health Information Systems under Health Sector Ministerial Board.

5.2.4.3 **Expected outcomes**

KS is an innovative approach to facilitate uniform storage, cataloguing and retrieval of health-related information related to the province. Specifically it shall enhance the evidence based policy and practices through provision of pertinent information related to health in Punjab. It shall identify gaps in knowledge and areas of research to direct future research in the province. Further, availability of a centralized storage shall promote research culture through provision of support to researchers in the province.

5.3 Strategy Development Team

Sr. #	Name	Role in assignment
1.	Dr. Naeem uddin Mian	Team Leader
2.	Dr. Musharraf Rasool Cyan	Public Health Specialist
3.	Mr. Nohman Ishtiaq	Health Financing Expert
4.	Dr. Huma Haider	Research Associate
5.	Dr. Muhammad Adeel Alvi	Research Associate
6.	Dr. Shabana Haider	Technical support
7.	Dr. Wafa Aftab	Technical support

5.4 Process of Strategy Development

An extensive literature review was conducted to analyse the current situation and develop evidence for proposing sound strategies. A wide range of documents including epidemiological and household surveys, periodic reports of the health sector, evaluations and reviews of health programmes, publications, reports of development partners and official documents, Public expenditure reviews, Medium Term Expenditure Frameworks were analysed. Although, a need was felt to commission studies on topics of particular interest to the Strategy Development Team, it could not be accomplished due to scarcity of resources and time.

Formal consultations were held from October 2011 to February 2012 across the province that aimed to understand the views of particular groups on issues of health sector and to encourage debate on these areas for identifying key themes for strategy development.

- **Individual consultations –** were conducted with key informants identified in all the sectors related to healthcare in Punjab. Governmental officials at Departments of Health, Planning and Development, Finance; Directorate General of Health Services; focal persons of professional and regulatory bodies, civil society and educational institutions were consulted in the process of developing the Strategy.

- **Roundtable Meetings –** were conducted with the specific groups of professionals to debate on identifying issues, areas of improvements and appropriate salutations for

addressing these challenges. Total of 4 roundtable meetings were conducted with public sector institutions, private sector institutions, members of the Parliament's Standing Committee on Health, and professionals from international agencies and development partners.

- **Field Visits –** were necessary for adding in the views of the community and district-level health management regarding their perceptions on health needs and priorities. In order to cover the geographical vastness of the province, health managers were consulted from three districts including district Attock from north, district Sargodha from centre and district Rajanpur from south of Punjab. Primary and secondary level health facilities were visited for gaining deeper insight into facility level management, identifying their issues and proposing sound and attainable strategies. Client exit interviews were conducted with the patients availing healthcare services at these facilities. During these field visits, communities were also consulted through focus group discussions to understand their perceptions and felt needs.

- **Mini Workshops –** were conducted with the objective of refining the proposed strategies, their implementation arrangements and ways for measurement. In each dimension of the Strategy, government notified a counter-part teams to work closely with the design team.

- **Offshore Consultations–** included discussions with technical experts in the field of healthcare. These experts formed the "Offshore Resource Group", which were identified across Pakistan and the globe to utilize their knowledge and vast experience in fine-tuning the Strategy.

5.4.1 List of Individual Consultations

Sr. #	Name	Designation	Department
1.	Mr. Arif Nadeem	Secretary Health	Department of Health
2.	Dr. Jahanazeb Khan	Ex. Secretary Health	Department of Health
3.	Mr. Dawood Bareech	Special Secretary, Health	Department of Health
4.	Dr. Muhammad Anwer Janjua	Additional Secretary Technical	Department of Health
5.	Mr. Yawar Hussain	Additional Secretary Admin	Department of Health

Sr. #	Name	Designation	Department
6.	Mr. Usman Moazzam	Additional Secretary Development	Department of Health
7.	Mr. Asfandyaar	Additional Secretary Establishment	Department of Health
8.	Ms. Saliha Syed	Deputy Secretary Performance Management	Department of Health
9.	Mr. Sarfraz Ahmad	Deputy Secretary Budget	Department of Health
10.	Mr. A. Bhatti	Chief Planning Officer	Department of Health
11.	Ms. Saima Saeed	Additional Secretary Social Services	Department of Finance
12.	Mr. M. Arshad	Director Budget	Department of Finance
13.	Mr. Naseem Riaz	Member Social Sector	Department of Planning and Development
14.	Mr. Farasat Iqbal	Project Director	Punjab Health Sector Reform Programme
15.	Dr. Amjad Shahzad	Additional Director	Punjab Health Sector Reform Programme
16.	Mr. Waqar	Deputy Director	Punjab Health Sector Reform Programme
17.	Dr. Arshad Usmani	Director	Provincial Health Development Centre
18.	Dr. Muhammad Khalid	Additional Chief	Provincial Health Development Centre
19.	Mr. Shahid Aslam Mohar	Director General	Benazir Income Support Programme
20.	Dr. Shabnum Sarfaraz	HRH Specialist & Chief Operating Officer	Fatima Memorial College
21.	Dr. Tanveer	Director Planning	Directorate General of Health Services
22.	Mr. Tanveer Baig	Director Finance	Directorate General of Health Services
23.	Dr. Zulfiqar	Director HR	Directorate General of Health Services
24.	Dr. Haroon	Director MIS	Directorate General of Health Services
25.	Dr. Arshad Dar	Director EPI	Directorate General of Health Services
26.	Mr. Farooq	Chief Computer Programme Officer	Directorate General of Health Services

Sr. #	Name	Designation	Department
27.	Dr. Babar Alam	Operational Officer	WHO
28.	Dr. Naila Sarfraz	Programme Officer	Unicef
29.	Dr. Tanveer Anwar	President	Pakistan Medical Association Punjab
30.	Ms. Munawwar Sultana Ghumman	Director General Nursing	Directorate General of Health Services
31.	Dr. Darakshan Badar	Programme Manager	Punjab TB Control Programme
32.	Dr. Salman Shahid	Provincial Director	HIV/AIDS Control Programme
33.	Dr. Akhtar Rashid	Provincial Coordinator	National Programme for FP & PHC, Punjab

5.4.2 Members of Steering Committee on Punjab Health Sector Strategy

Sr. #	Name	Designation	Department
1.	Mr. Arif Nadeem	Secretary Health	Government of Punjab
2.	Mr. Abdullah Sumbal	Project Director	Punjab Resource Management Programme
3.	Mr. Farasat Iqbal	Project Director	Punjab Health Sector Reform Programme
4.	Professor Dr. Tariq Salahuddin	Principal	Post Graduate Medical Institution
5.	Dr. Faisal Sultan	CEO	Shaukat Khanum Memorial Cancer Hospital
6.	Professor Dr. Shakila Zaman	Professor of Preventive Paediatrics	Children Hospital Lahore
7.	Dr. Amjad Saqib	CEO	Akhuwat
8.	Dr. Shabnam Sarfaraz	Health HR Specialist	Fatima Memorial Hospital
9.	Mr. Afeef Mahmood	Health Finance Specialist	Asian Development Bank

5.4.3 Roundtable Workshops

5.4.3.1 Members of the Punjab Parliament's Standing Committee on Health

SN	Name	Designation	Department
1.	Dr. Saeed Elahi	Chairman Standing Committee – MPA	Punjab Assembly
2.	Dr. Samia Amjad	MPA	Punjab Assembly
3.	Mrs. Arifa Khaled Pervaiz	MPA	Punjab Assembly

5.4.3.2 Public Sector Institutions and Organizations

SN	Name	Designation	Department
1.	Professor Dr. Mubashar H. Malik	Vice Chancellor	University of Health Sciences
2.	Professor Dr. Asad Aslam	Acting Vice Chancellor	King Edward Medical University
3.	Professor Dr. Javed Akram	Principal	Allama Iqbal Medical College
4.	Professor Dr. Zafarullah Ch	Professor of Surgery	Allama Iqbal Medical College
5.	Professor Dr. Tariq Rashid	Professor of Dermatology	Fatima Jinnah Medical College
6.	Dr. Arshad Usmani	Director	Punjab Health Development Centre
7.	Dr. Zahid Pervaiz	Medical Superintendent	Mayo Hospital
8.	Dr. Naeem Asghar	Senior Demonstrator	Institute of Public Health
9.	Dr. Zarfishan Tahir	Professor of Bacteriology	Institute of Public Health
10.	Dr. Uzma Tahir	Head Research Evaluation and Monitoring	College of Physician and Surgeons Pakistan
11.	Dr. Tasnim Kausar	Vice principal	Public Health Nursing School
12.	Dr. Asim Hameed	Assistant Medical Superintendent	Services Institute of Medical Sciences
13.	Mrs. Rashida Amjad	Additional Director Nursing	DG Nursing Punjab

5.4.3.3 Private sector institutions and organizations

SN	Name	Designation	Department
1.	Professor Dr. Abdul Majeed Chaudhry	Principal	Lahore Medical and Dental College
2.	Professor Seema Daud	Head Dept. of Community Medicine and Co-Director Medical Education	Lahore Medical and Dental College
3.	Professor Shaheena Manzoor	Head Dept. of Community Medicine	Central Park Medical College
4.	Dr. Ayesha Nauman	Director Human resource	Fatima Memorial Hospital
5.	Mr. Tariq Mansoor	Coordinator AHS	Fatima Memorial Hospital
6.	Dr. Sajid Mushtaq	Consultant Pathologist	Shaukat Khanum Memorial Cancer Hospital
7.	Dr. Misdaq Hussain	Medical Superintendent	Mumtaz Bakhtawar Trust Hospital
8.	Dr. Aqil Qazi	Medical Director	LRBT Lahore
9.	Dr. Tanveer Rana	Executive Director	Hameed Latif Hospital
10.	Dr. Ammar Aslam Bhinder	Medical Director	Ammar Medical Complex
11.	Dr. Arshad Humayun	Vice President	Pakistan Academy of Family Physicians
12.	Dr. Rashid Hussain	DMS	Shalimar Hospital
13.	Dr Amina Khan	Health Consultant	Aesculap Academy

5.4.4 District-level Consultations

SN	Name	Designation	Department
1.	Dr. Mussarat Hussain Abdullah	EDO Health	District Health Department, Attock
2.	Dr. Saeeda	Director MNCH Programme	District Health Department, Attock
3.	Dr. Khalid Mahmood	Medical Superintendent	DHQH Attock
4.	Dr. Saleem	Medical Superintendent	THQH Fateh Jang

SN	Name	Designation	Department
5.	Dr. Shujaat Ali Khan	Senior Medical Officer	RHC Bater, Attock
6.	Dr. Marina Bakhtiar	Women Medical Officer and In-charge	BHU, Attock
7.	Dr. Mushtaq Rasool	EDO Health	Rajanpur
8.	Dr. Habib Ahmed Khan (EDO-H)	EDO Health	District Health Department, Sargodha
9.	Dr.M.Aslam Asad	P.D DHDC	District Health Development Centre, Sargodha
10.	Dr. Tahir Awan	Public Health Specialist	National MNCH Programme, Sargodha
11.	Dr. Capt. Ahmed Naeem	Medical Superintendent	DHQH, Sargodha
12.	Dr. Nazeer Aquib Kokara	Senior Medical Officer and DDHO of Kot Momin	RHC Laliani, Sargodha
13.	Dr. Muhammad Safdar	Medical Officer and In-charge	BHU Chak 43, Sargodha

5.4.5 Community-level Consultation

SN	Methodology	Participants	Number
1.	Focus Group Discussions	Married Women of Reproductive age at RHC Lalliani, Sargodha	30
2.	Focus Group Discussions	Community Notables at RHC Lalliani, Sargodha	6
3.	Patient Perspectives	Patients at secondary level health facilities in Sargodha	3
4.	Focus Group Discussions	Married Women of Reproductive age at RHC Bater, Attock	12
5.	Focus Group Discussion	Community Health Committee at RHC Bater, Attock	4