

A Comparative Study

**Assessment of
Primary Health Care Services
Delivery
in PPHI and Non-PPHI
Districts
in NWFP**

Prepared for



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Acronym

ARI	Acute Respiratory Infections
ANC	Antenatal care
BCG	Bacillus of Calmette Guarin
BHU	Basic Health Unit
BP apparatus	Blood Pressure apparatus
CDR	Case Detection Rate
DOH	Department of Health
DCO	District Coordination Officer
DSM	District Support Manager
DHD	District Health Department
DPT	Diphtheria, Pertussis, Tetanus
EDOH	Executive District Officer Health
ENT	Ear Nose Throat
EPI	Expanded Programme on Immunization
FLCF	First Level Care Facility
FATA	Federally Administered Tribal Area
FMT	Female Medical Technician
FP	Family Planning
FGD	Focus Group Discussion
GM	Growth Monitoring
HMIS	Health Management Information System
HCP	Health Care Providers
HT	Health Technician
HSRU	Health Sector Reform Unit
IMR	Infant Mortality Rate
LHV	Lady Health Visitor
MDGs	Millennium Development Goals
MOU	Memorandum of Understanding
MMR	Maternal Mortality Rate
MNCH	Maternal and Newborn Child Health
MA	Medical Assistant
MO	Medical Officer
NWFP	North West Frontier Province
NGOs	Non Governmental Organizations
NTP	National TB Programme
OPD	Out Patient Department
ORS	Oral Rehydration Salt
PDHS	Pakistan Demographic and Health Survey
PPHI	President's/People's Primary Healthcare Initiative
PHC	Primary Healthcare
SRSP	Sarhad Rural Support Programme
SBAs	Skilled Birth Attendants
SS	Sputum Smear

SG	Support Group
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TSR	Treatment Success Rate
WHO	World Health Organization

Executive Summary:

Background:

Pakistan is the most populated country in the WHO Eastern Mediterranean Region, accounting for 30% of the regional population. Pakistan's health indicators, health funding, and health and sanitation infrastructure are poor, particularly in rural areas.

Maternal and child health is generally poor, especially in rural areas. Maternal and child malnutrition and rates of infant, child and maternal mortality are high. However, health care delivery services are improving over the years as depicted in the Pakistan Demographic and Health Survey (PDHS) report 2006-2007.

In spite of all of the available infrastructure, we are still far from the targets to be achieved under Millennium Development Goals (MDGs) by 2015.

It is believed that despite the extensive primary healthcare (PHC) infrastructure in Pakistan, First Level Care Facilities (FLCFs) are underutilized leading to significant waste. Basic Health Units (BHUs) are First Level Care Facilities (FLCFs) and are primarily concerned with the delivery of PHC services in rural areas.

It is perceived that underutilization of PHC services at BHUs is due to poor management and the limited managerial skills of health managers. To address these issues, the Federal Government through the Ministry of Industries and the Special Initiatives Division launched a country-wide program known as the President's Primary Healthcare Initiative (PPHI) aimed at improving the delivery of primary health care by strengthening the services provided in basic health units (BHUs) through public-private partnerships. In the NWFP, the Program was initiated in 2007 when the targeted District Governments transferred funds to PPHI. After induction of the new Government, the Program was re-designated the *People's Primary Healthcare Initiative* and attached to the Cabinet Division, Islamabad.

The basic objective of PPHI was to improve health service delivery at the primary level through improvement of management of health institutions.

Eleven performance indicators were agreed upon by Sarhad Rural Support Programme (SRSP), which administers PPHI in NWFP, and the Provincial Health Department, NWFP, under a Memorandum of Understanding; these performance indicators were to be assessed by a third party after two years. The selected indicators are:

1. Treatment success rate among TB cases detected (cohort analysis) (per 100,000 population)
2. TB case detection rate (number of sputum positive cases detected as % of target based on estimated prevalence, i.e., case-finding)
3. Fully immunized children before 12 months of age (%)
4. Coverage of antenatal care % of all pregnant women receiving at least 2 antenatal care visits from a skilled provider
5. Proportion of births attended by skilled attendants (excluding trained TBAs)
6. Number of children under one year registered for growth monitoring

7. Contraceptive Prevalence Rate % of women 15-49 years currently using a family planning method (modern)
8. Number of consultancies per person per year
9. Proportion of parents able to spontaneously name the dangers signs of diarrhea ARI and the appropriate response.
10. % of parents who report hand washing with soap after using toilet and before preparing food
11. Score out of 100 on an index of quality of care as judged by 3rd party.

Methodology:

This assessment is based on a descriptive cross sectional study using quantitative as well as qualitative techniques to assess the above objectives by comparison with non-intervention districts.

The assessment survey was carried out in 10 districts of NWFP. Of those districts, seven were districts where healthcare had been under PPHI management for at least two years and three districts were managed by the District Health Department (non-PPHI).

Three non-PPHI intervention districts—Abbottabad, Dera Ismail Khan and Lower Dir—were included in the list. It was very difficult to identify non-PPHI districts that are comparable to PPHI intervention districts as PPHI operates in all of the central districts and in only two districts that are hard to reach. Of the hard-to-reach districts, Chitral nevertheless has quite good health indicators as compared to other districts. To minimize selection bias, three districts were selected from non-PPHI districts with somewhat comparable demographic conditions and that had environmental and socio-cultural similarities to the seven intervention districts.

Survey Districts:

S.No.	PPHI Districts	Non-PPHI Districts
1	Peshawar	Abbottabad
2	Nowshera	Dera Ismail Khan
3	Kohat	Lower Dir
4	Karak	
5	Chitral	
6	Swabi	
7	Upper Dir	

A stratified random sample was drawn for the selection of BHUs. Of the 15 BHUs selected from each district, 20% of the BHUs (3) were taken from hard-to-reach areas and 80% of the BHUs (12) were randomly selected from accessible areas.

Results:

After two years' implementation of PPHI, an assessment was carried out to evaluate whether the objectives had been achieved or not.

In addition to the performance indicators, the availability of health staff, equipment, medicines, BHU building infrastructure and record keeping were also assessed as health services and people's satisfaction are linked to inputs provided to BHUs.

- The condition of the main building, cleanliness, availability of medicines and health staff at BHUs was observed to be better in PPHI-managed districts.
- Community data collected through PPHI assessment report shows that the incidence of antenatal care by skilled birth attendants (SBAs) was almost the same in both PPHI districts and non-PPHI districts, but that a higher percentage of pregnant women received two or more antenatal examinations in non-PPHI districts (68%) than in PPHI districts (60%).
- On the other hand, 45% of deliveries are being conducted by SBAs in PPHI districts compared to 37% in non-PPHI districts. The difference is statistically significant.
- Growth monitoring of children less than one year significantly improved over the two-year period in PPHI districts; however, there is no difference between the PPHI and non-PPHI districts.
- The average number of outdoor patients also showed significant improvement in PPHI districts, increasing from 463 patients per month per BHU to 740 patients per month per BHU. The average number of consultations per person per year increased from 0.39 to 0.66 during the period 2006-2008 in BHUs within PPHI districts versus a decrease from 0.193 to 0.191 visits per person per year in BHUs within non-PPHI districts. The average number of eligible couples using modern contraceptive methods also increased in PPHI-operated BHUs from 173 cases per BHU per year to 243 cases per BHU per year; in non-PPHI-operated BHUs the number increased from 85 to 101 cases per BHU per year.
- No difference was observed in mothers' knowledge regarding danger signs of diarrhoea and acute respiratory infections (ARI) in children.
- Vaccination of children less than one year against measles is 55% in PPHI districts and 63% in non-PPHI districts. The data shows no significant difference in immunization coverage (measles) in children less than one year in PPHI- and non-PPHI-managed districts.
- There was no difference between PPHI and non-PPHI districts regarding hand washing practices after using the toilet and before preparation of food.
- The progress on TB Case Detection and Treatment Success Rates in PPHI and non-PPHI districts was comparable during the assessment period; there was no significant difference within and between groups in this regard: the Case Detection Rate (CDR) in non-PPHI districts was 72% (2006) and 74% (2008) and in PPHI districts 65% (2006) and 76% (2008). In essence, the PPHI districts showed improvement but this improvement only brought it up to the level of the non-PPHI districts.
- Quality of care was assessed based on availability of health staff, medicines, equipment; knowledge of health staff; and community satisfaction as determined through exit polls and community interviews. PPHI-managed districts have an edge over non-PPHI districts in the provision of medicines, availability of staff and staff knowledge of diseases. Collectively, quality of care provided to patients/clients in PPHI districts is better than in non-PPHI districts.
- PPHI contribution to the organization of trainings for healthcare providers (HCPs) is very low (4%). This is in contrast to the Provincial and District Health Departments, which contribute 34% and 37%, respectively (45% is contributed by other organizations).

Analysis of facility-based exit interviews showed that respondents reported higher levels of satisfaction in PPHI-managed BHUs. An analysis of community data collected through exit interviews/exit polls shows the same level of satisfaction in both PPHI and non-PPHI BHUs.

The very ambitious role initially envisioned for Support Group (SG) members in PPHI districts has not been achieved. The Support Group concept was only envisaged for PPHI districts as a novel concept for eliciting community support in catchment areas of the BHUs. Their contribution to the uplift of BHUs either in cash or kind and participation in health promotive activities is not appreciable.

Conclusions:

- The assessment shows that there was more improvement in PPHI-managed districts (as compared to non-PPHI managed districts) in relation to BHU infrastructure, cleanliness of environment, availability of medicines, record keeping of activities, and filling of the vacant positions of doctors and paramedical staff.
- With respect to the provision of preventive services, PPHI districts are more or less the same as non-PPHI districts; however, with respect to the provision of curative services in PPHI districts, there has been significant improvement. PPHI management has paid more attention to the provision of curative services at BHUs than has management in the non-PPHI districts.
- With respect to the availability of health staff, medicines, and equipment and the knowledge of healthcare providers, Quality of Care is relatively better in PPHI-managed BHUs than in non-PPHI managed BHUs.
- Overall, patients/clients are more satisfied with the provision of health services in PPHI-managed BHUs than they are with services in non-PPHI BHUs.
- The role of Support Groups in preventive activities, conduction of health awareness sessions in the community is not appreciable.
- There is no difference between PPHI and non-PPHI districts in knowledge of mothers of the danger signs of diarrhoea and ARI in children.
- The Provincial Health Department, District Health Departments and NGOs played a major role in capacity building of doctors and paramedical staff.
- Mutual distrust has led to a lack of coordination and support between PPHI and the district and provincial Health Department, which viewed each other as rival and parallel agencies encroaching upon their jurisdiction. This distrust manifested itself in activities being carried out independently by PPHI and the provincial health department, which delayed implementation of innovative activities initiated by either party and undermined the potential for joint activities.

- PPHI was given more flexibility with respect to rules and regulations to address gaps/limitations in the health care delivery system. This partly explains those areas in which PPHI showed improved management, especially in the realm of quality of care.
- PPHI has not met all of its reporting commitments assigned under the MOU; specifically, with respect to the submission of monthly National HMIS reports and annual audit reports.
- The analysis of the data does show some improvement in BHU infrastructure and provision of primary healthcare services in the PPHI districts in comparison to the non-PPHI districts. However, there has been no change on the scale originally envisioned as the result of implementing PPHI.

Recommendations:

1. Joint monthly review meetings of all district and provincial stakeholders to resolve audit and reporting issues and to assess progress of activities.
2. Involvement of the District Health Department in recruitment, posting and transfer of staff, purchase of medicines and equipment, and initiation of innovative strategies at the provincial level as well as at the district level.
3. There should be a unanimous decision on who has the authority to write the Annual Confidential Reports of health staff in PPHI and non-PPHI districts.
4. Devise strategies at provincial and district levels that promote improved provision of healthcare services.
5. Health is a provincial subject and the province should resolve conflicts.
6. Confidence-building measures should be adopted through regular meetings and updates at the district level chaired by the DCO.
7. The Provincial Health Department and SRSP should review the MOU to identify changes in administration/management that would reduce the level of distrust between PPHI and the Provincial and District Health Departments.
8. While the PPHI districts do show better results in preventive and promotive services in comparison to the non-PPHI districts, the difference is not substantial. Therefore, we recommend that PPHI consolidate its achievements further and focus on improvements in preventive and promotive aspects of primary healthcare in existing PPHI districts.

Introduction/Background:

Pakistan is the most populated country in the WHO Eastern Mediterranean Region, accounting for 30% of the regional population. ... Socioeconomic development is low, with high levels of poverty and low levels of literacy, especially among women and in rural areas. ...

Access to healthcare and development of infrastructure (including laboratory facilities) are impeded by geopolitical conditions and the low population density of some provinces. At the national level, 80% of the population has access to local health services in rural areas and 100% in cities (Health Management Information System, Ministry of Health); however there are significant regional variations. ...

Maternal and child health is generally poor especially in rural areas (National MNCH report). Maternal and child malnutrition and rates of infant, child and maternal mortality are high. Slow progress in maternal/child health indicators and significant morbidity and mortality from communicable diseases such as malaria, diarrhea, acute respiratory illness and vaccine preventable diseases (measles, hepatitis and neonatal tetanus) constitute major public health challenges. Maternal mortality is attributed to high fertility rates, illiteracy, malnutrition, low skilled birth attendance and poor access to emergency obstetric care. Pakistan has the sixth highest burden of tuberculosis in the world with an estimated incidence of 177 cases per 100 000 population per year. (WHO Country Cooperation Strategy *at a glance*, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_pak_en.pdf).

Pakistan is committed to achieving the MDGs as the national agenda for development as well as reducing the burden of poverty and disease. ... [A] number of initiatives in public sector programmes have been undertaken ... [including] the National Maternal and Child Health Programme 2005-2011. These programmes with current and future interventions should help to reduce premature deaths among women and children and contribute towards the achievement of the MDGs.

Healthcare delivery services have improved over the years as depicted in the PDHS report 2006-2007: 61% antenatal coverage (28% four visits or more); 34% delivery by trained persons (through the public health system, 11%); 39% contraceptive prevalence rate (all types); infant mortality rate (IMR) 78/1000 live births; under five years mortality 94/1000 live births; and maternal mortality rate (MMR) 276/100,000 live births, 80% of which could be prevented. In spite of the entire available infrastructure, Pakistan is still far from the targets to be achieved under the Millennium Development Goals (MDGs) by 2015.

The Medium Term Development Framework 2005-2010 is designed to achieve the MDG targets by reducing poverty, combating diseases, and ensuring improved and equitable availability of services.

Health is an important social sector. Economic and social development is closely linked with a population's state of health. Health facilities are essential not only to provide a clean and disease-free environment in which to live, but also to enhance the efficiency and productivity of a population. The parameters determining a population's state of health include availability of clean drinking water, sanitation facilities, existence of medical infrastructure, availability of medical and paramedical staff and maternity facilities, etc.

It is believed that, despite the extensive primary healthcare (PHC) infrastructure in Pakistan, First Level Care Facilities (FLCFs) are underutilized leading to significant waste. Studies reveal that the optimum utilization of FLCFs is affected by a range of factors from community participation to availability of health staff, medicines, equipment, as well as the attitude of staff, the condition of facilities, the education level of community, accessibility and affordability. Above all political will is required to provide healthcare services to the people.

Basic Health Units (BHUs) are FLCFs and are primarily concerned with the delivery of PHC services in rural areas. Health facility staff has little interaction with the community and do not motivate and involve people in health programs.

It is generally perceived that underutilization of PHC services at BHUs is due to poor management and the limited managerial skills of health managers. This was the inspiration for the PPHI to improve upon these areas and thereby increase PHC services in BHUs.

Introduction – People’s Primary Healthcare Initiative (PPHI):

The Federal Government through the Ministry of Industries and the Special Initiatives Division launched a country-wide program known as the President’s Primary Healthcare Initiative (PPHI) aimed at improving the delivery of primary health care by strengthening the services provided in basic health units (BHUs) through public-private partnerships. In NWFP, the Program was initiated in 2007 when the targeted District Governments transferred funds to PPHI. After induction of the new Government, the Program was re-designated the *People’s Primary Healthcare Initiative* and attached to the Cabinet Division, Islamabad.

The basic objective of PPHI was to improve health service delivery at the primary level through improvement of management of the health institutions.

The Government considers that making the health system equitable and people-centered is an essential step towards the alleviation of poverty. PPHI endeavors to achieve this objective through improvement in the basic infrastructure of health facilities, through ensuring availability of medicines and staff, and through coordination of activities relating to healthcare service delivery at the primary level including promotive, preventive and curative healthcare. The Program is fully owned, and funded by, the Federal and Provincial Governments.

Objectives of the People's Primary Healthcare Initiative (PPHI)

The PPHI program in NWFP has the following objectives;

1. Significantly strengthen the Primary Healthcare (PHC) system in the districts/agencies so as to ensure the delivery of a standard package of preventive, curative, and promotive services that will help NWFP achieve the Health Millennium Development Goals (MDGs).
2. Significantly improve the:
 - Coverage and utilization of services,
 - Quality of care, and
 - Equity of access to the services by geographical areas, by income level, and by women and children.

3. Ensure that patients and communities are increasingly involved and satisfied with the publicly financed health services and facilitate the community's participation in the design, delivery, and evaluation of health services.
4. Build the capacity of health workers so that they can provide better services to the community within an available budget.

The following performance indicators were agreed upon by SRSP and the Provincial Health Department, NWFP, to assess the performance of BHUs in delivery of healthcare services.

Selected Performance Indicators

1. Treatment success rate among TB cases detected (cohort analysis) (per 100,000 population)
2. TB case detection rate (number of sputum positive cases detected as % of target based on estimated prevalence, i.e., case-finding)
3. Fully immunized children before 12 months of age (%)
4. Coverage of antenatal care % of all pregnant women receiving at least 2 antenatal care visits from a skilled provider
5. Proportion of births attended by skilled attendants (excluding trained TBAs)
6. Number of new born registered for growth monitoring
7. Contraceptive Prevalence Rate % of women 15-49 years currently using a family planning method (modern)
8. Number of consultancies per person per year
9. Proportion of parents able to spontaneously name the dangers signs of diarrhea, ARI and the appropriate response.
10. % of parents who report hand washing with soap after using toilet and before preparing food
11. Score out of 100 on an index of quality of care as judged by 3rd party

Study Objective:

To assess the status of the primary healthcare delivery services in intervention and non-intervention districts of the NWF Province of Pakistan.

Specific Objectives:

- To assess the primary healthcare delivery system performance with respect to selected PHC indicators.
- To assess the skills of HCP in delivery of health services.
- To evaluate community satisfaction with respect to the availability of health services.
- To assess the knowledge of mothers of key health problems/issues.
- To assess the role of the community in health and related issues.
- To assess the working relationship of PPHI staff with the District Government and District Health Department.
- To assess the quality of health services.

Methodology:

This assessment is based on a descriptive cross sectional study using quantitative as well as qualitative techniques to assess the above objectives by comparison with non-intervention districts.

The study population was made up of

- BHUs
- Patients/clients
- Mothers with children under two years old
- Community Health Committees (Support Group Members)
- Executives of District Health Departments and district-based PPHI

Survey Districts:

The assessment survey was carried out in 10 districts of NWFP. Of those districts, seven were from districts where healthcare had been under PPHI management for at least two years and three districts were managed by the District Health Department (non-PPHI). (A total of 11 NWFP districts are currently being managed by PPHI.)

Three non-PPHI intervention districts—Abbottabad, Dera Ismail Khan and Lower Dir—were included in the list. It was very difficult to identify non-PPHI districts that are comparable to PPHI intervention districts as PPHI operates in all of the central districts and in only two districts that are hard to reach. Of the hard-to-reach districts, Chitral nevertheless has quite good health indicators as compared to other districts. To minimize selection bias, three districts were selected from non-PPHI districts with somewhat comparable demographic conditions and that had environmental and socio-cultural similarities to the seven intervention districts.

Selected Districts:

S.No.	PPHI Districts	Non-PPHI Districts
1	Peshawar	Abbottabad
2	Nowshera	Dera Ismail Khan
3	Kohat	Lower Dir
4	Karak	
5	Chitral	
6	Swabi	
7	Upper Dir	

Survey Instruments:

Closed and open-ended questions were used for the following data collection instruments:

1. An exit poll for the users of services to ascertain their perception and satisfaction regarding quality of services being rendered by BHUs.
2. A structured interview for Community Health Committees (Support Group members) to determine their role in health activities.
3. An assessment checklist to note health activities carried out related to specific PHC indicators and an observation checklist to record the skills of health care providers and quality of services at BHUs.
4. A structured interview with closed questions for mothers with children under two years of age to assess their knowledge of diarrhea, ARI, hand washing after using toilet and before preparing food, and to collect information regarding most recent pregnancy.

5. A structured interview with open-ended questions for Executive District Officers Health (EDOHs) and District Support Managers (DSMs) to assess working relationships among them.
6. A focus group discussion with stakeholders from the District & Provincial Health Departments and PPHI.

Sample Design:

A stratified random sample was drawn for the selection of BHUs. In the first step, all of the BHUs in each district were categorized as hard-to-reach area BHUs and accessible area BHUs. In the second step, total of 15 BHUs from each district were selected. Of the 15 BHUs from each district, 20% of BHUs (3) were randomly selected from hard-to-reach areas and 80% of BHUs (12) were randomly selected from accessible areas.

Sample Sizes:

- Sample size calculated with confidence level 95% and confidence interval 5 requires 386 respondents for the community survey in each district
- Adding design affect (1.1), the number of respondents comes to 425 in each district
- We then rounded to **450/district**
- Total number of districts under PPHI management for at least two years: 7
- BHUs to be surveyed in PPHI-managed districts $15 \times 7 = 105$
- Non-PPHI districts to be surveyed: 3
- Non-PPHI BHUs to be surveyed (15/district): 45
- Total mothers to be interviewed in PPHI districts= $30 \times 15 \times 7 = 3150$
- Total mothers to be interviewed in non-PPHI districts= $30 \times 15 \times 3 = 1350$

Questionnaires:

- Five types of questionnaires were used to collect data from each BHU and its catchment area:
- Questionnaire for mothers with a child under two years old: 30 respondents/BHU
- Client/patient exit interviews: 10 respondents/BHU
- Questionnaire for Health Committee members/Support Group members: 2 respondents/BHU
- Health Facility questionnaire: 1/BHU
- **Total interviews / questionnaires per Health Facility: 43**
- Interviews with district heads (EDOH and DSM): 2 per district
- Focus Group Discussion (FGD) at provincial level

Assessment Tools and Methods:

There were five assessment tools used for the following areas:

S. N	Assessment Tool	Assessment Method
.	BHU Questionnaire	Direct Observation & Record Checking: BHU infrastructure and performance assessment to assess the status of health infrastructure, staffing, availability of equipment and medicines and performance of activities at BHU level. To assess knowledge and skills of Health Care

		Providers (HCPs) (to be filled out at BHU)
	Exit Poll Interviews	Interview: To assess level of satisfaction of patients and clients who received health services from that BHU (to be filled out at BHU)
	Questionnaire for Mothers	Interview: with mothers with children under two years of age to assess utilization of health services, information related to their last pregnancy and knowledge of mothers of certain diseases. (to be filled out in the community)
4.	Questionnaire for Support Group members	Interviews: with members of community support group to get feedback on the functioning of the Support Group. (to be filled out in the community)
	Questionnaire for EDOH and DSM	Interviews: with EDOH and DSM at district level to get their point of view regarding working relationship. (at district level)
6.	Focus Group Discussion	Focus group discussion with stakeholders of PPHI and Health Department at provincial level

Field Work:

The survey teams visited the EDOH offices and handed over a sealed envelope from each office containing a list of randomly selected BHUs in that district. Household surveys were carried out in three villages in the catchment areas of each of the sampled BHUs. One of the villages was closest to the BHU, one from an area far from the BHU, and one randomly selected from the catchment area of the BHU. Within each village, 10 households were randomly selected, and one woman in each household was interviewed. *The eligible respondents were currently married women with a child under two years of age.* If more than one eligible respondent was present in the household, only one was randomly selected and interviewed.

Data on performance indicators for TB, EPI, growth monitoring, Contraceptive Prevalence Rate, deliveries by skilled birth attendants and OPD cases was gathered from respective MIS reports for the years 2006 and 2008 from sampled BHUs.

Quality of care was assessed by interviewing the Incharge/Health Care Provider of BHU or through observations at BHU.

Data on indicators for antenatal care (2 visits), vaccination status of children, deliveries conducted by skilled birth attendants and mothers' knowledge was collected by interviewing eligible respondents during household visits.

Results:

Health Facilities (BHUs):

Table :-Frequency table of BHUs in Survey Districts

S.No.	Districts	equency	Percent
1	ABBOTTABAD	14	9.6
2	CHITRAL	14	9.6
3	D I KHAN	15	10.3
4	KARAK	14	9.6
5	KOHAT	15	10.3
6	LOWER DIR	14	9.6
7	NOWSHERA	15	10.3
8	PESHAWAR	15	10.3
9	SWABI	15	10.3
10	UPPER DIR	15	10.3
	Total	146	100

Health facility data was collected from 146 randomly selected BHUs from 10 districts of NWFP.

Objective I:

Significantly Strengthen the Primary Healthcare System to ensure Delivery of a Standard Package of Preventive, Curative and Promotive Services.

1:-Vacancy Position of Health Staff:

Table 1.1:- Technical Health Staff Position at BHUs

Technical Health Staff	PPHI Dist. n=103		Non PPHI. n= 43	
	% Filled Posts	% Absent	% Filled Posts	% Absent
Medical Officers(MO)	67	10	44	10
Medical Assistant/MT	63	9	70	14
Lady Health Visitors	75	10	70	27
FHTs/HTs	33	9	46	15

67% position of Medical Officers (MOs) and 75% of posts of Lady Health Visitors (LHVs) are filled at PPHI managed BHUs against 44% MOs and 70% LHVs at BHUs in non PPHI district. There is significant difference in the filled positions of MOs.

Table 1.2:- Availability of Technical Health Staff at BHUs(in days) during Last month

Districts		Days present last month (MO)	Days present last month MA/MT	Days present last month FHT	Days present last month LHV	Days present last month EPI-Tech	
PPHI	N	Count	58	90	45	81	72
		Mean	20.12	23.88	19.82	22.37	22.79
Non PPHI	N	Count	14	42	27	38	36
		Mean	21.00	21.57	17.30	20.97	22.17

On an average, MOs remained present at PPHI managed BHUs for 20.12 days during last month at the time of survey and LHV for 22.37 days. In non PPHI supervised BHUs MO were present for 21 days and LHV for 20.97 days. There was no significant difference in availability of Technical health staff at BHUs

Table 1.3: Provision of Healthcare Services at BHUs

Health Services	n= 103	n= 43
	PPHI Districts	Non PPHI
General. Curative Care	99.00%	93.00%
Antenatal Care	90.30%	83.70%
Delivery Services	47.60%	46.50%
Post natal care	87.40%	83.70%
Growth Monitoring	72.80%	62.80%
Nutritional Advice	85.40%	72.10%
EPI. (center)	81.60%	81.40%
Family Planning Services	89.30%	79.10%
Health Education	93.20%	86.00%
First Aid	98.10%	95.30%
TB-DOTS	49.50%	20.50%

Table 1.4: Provision of Healthcare Services in the Field

Field Services	n= 103	n= 43
	PPHI Districts	Non PPHI
Antenatal	79.60%	81.40%
Midwifery (delivery)	71.80%	93.00%
Postnatal care	75.70%	90.70%
Family Planning	77.40%	81.40%
Health Education	80.60%	76.40%
EPI.	81.60%	83.70%
Others	34.00%	27.90%

There is variation in percentages of BHUs in both groups in the provision of preventive, curative and Promotive services. However, in the field non PPHI districts have an edge over PPHI regarding preventive services. On the other side, PPHI districts dominate in promoting health education activities at BHUs and in the field.

Fig 1.1

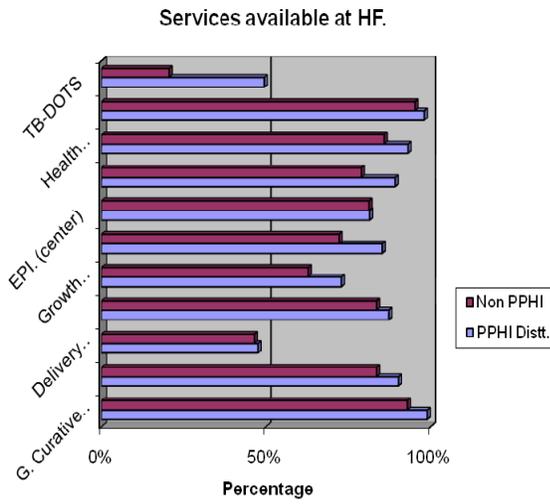


Fig 1.2

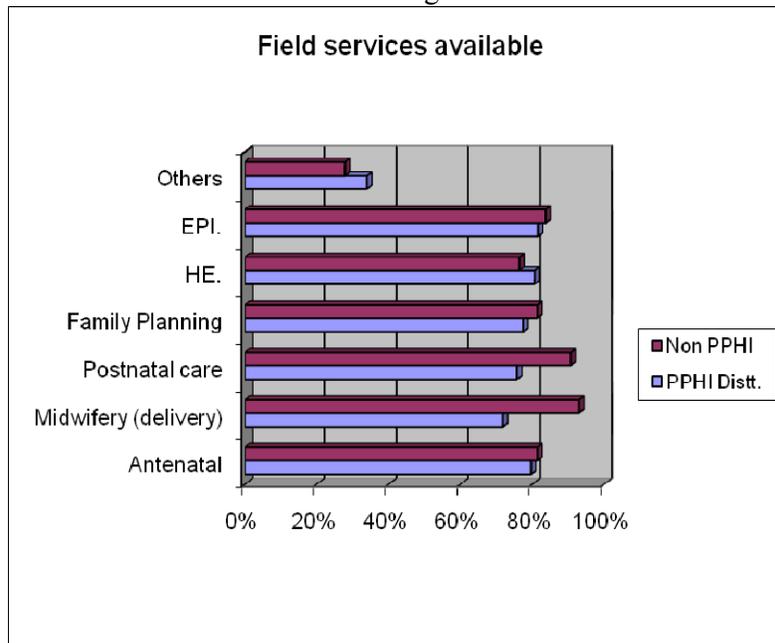


Table 1.5: Percentage of Health Services Utilization by Patients/Clients at BHUs

Health Service	PPHI Districts n = 988	Non PPHI. n = 280
Family Planning	3.60	5
Antenatal Care	6.5	8.9
Tetanus Vaccination	2.6	7.9
Child Immunization	4.7	4.3
Growth Monitoring	1.9	1.8
Nutrition	3.5	1.4
Curative (Adult)	29.4	22.1
Curative (Child)	21.5	16.4
Others	26.2	32.1

Table shows more utilization of curative services than preventive in both groups but people have received preventive services more in non PPHI BHUs (29.3%) as compared to 22.8% in PPHI managed BHUs.

2:- Health Services Delivery:

Table1.6: Service Delivery at BHUs in PPHI and Non PPHI Districts from 2006 – 2008

Districts BHUs		Paired Differences			95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			
PPHI	GM2006 - GM2008	-63.4783	177.0064	21.3091	-105.9999	-20.9567	-2.979	68	.004
	MEASLES06 - MEASLES08	-121.3784	263.2448	30.6016	-182.3673	-60.3895	-3.966	73	.000
	DPT32006 - DPT32008	-68.9595	548.0373	63.7080	-195.9294	58.0105	-1.082	73	.283
	BCG2006 - BCG2008	-116.8400	377.9195	43.6384	-203.7914	-29.8886	-2.677	74	.009
	FP2006 - FP2008	-69.5316	894.7477	100.6670	-269.9442	130.8809	-.691	78	.492
	DELIVERY 2006 - DEL08	-101.3226	638.0250	66.1601	-232.7223	30.0771	-1.531	92	.129
	ANC(new) 2006-2008	-77.3377	720.5058	82.1093	-240.8724	86.1971	-.942	76	.349
	Utilization (OPD) 2006-08	-.2651	.4622	5.104E-02	-.3666	-.1635	-5.193	81	.000
	OPD2006 - OPD2008	-277.4939	403.2182	44.5280	-366.0906	-188.8972	-6.232	81	.000
Non PPHI	GM2006 - GM2008	-8.9032	89.8682	16.1408	-41.8671	24.0607	-.552	30	.585
	MEASLES06 - MEASLES08	5.2500	298.9966	49.8328	-95.9159	106.4159	.105	35	.917
	DPT32006 - DPT32008	29.2703	337.2999	55.4518	-83.1911	141.7316	.528	36	.601
	BCG2006 - BCG2008	48.5833	364.6491	60.7749	-74.7962	171.9629	.799	35	.429
	FP2006 - FP2008	-15.7500	116.9491	20.6739	-57.9147	26.4147	-.762	31	.452
	DELIVERY 2006 - DEL08	-36.8919	160.2496	26.3449	-90.3218	16.5380	-1.400	36	.170
	ANC(new) 2006-2008	37.2000	231.7130	39.1667	-42.3962	116.7962	.950	34	.349
	Utilization (OPD) 2006-08	1.989E-03	.1084	1.946E-02	-3.776E-02	4.174E-02	.102	30	.919
	OPD2006 - OPD2008	11.7903	122.4501	21.9927	-33.1248	56.7054	.536	30	.596

Health care delivery services related to Primary Health Care like OPD, Antenatal Care, Deliveries by staff, Family Planning, Vaccination and growth monitoring of children less than one year have been compared over years in PPHI and non PPHI managed BHUs.

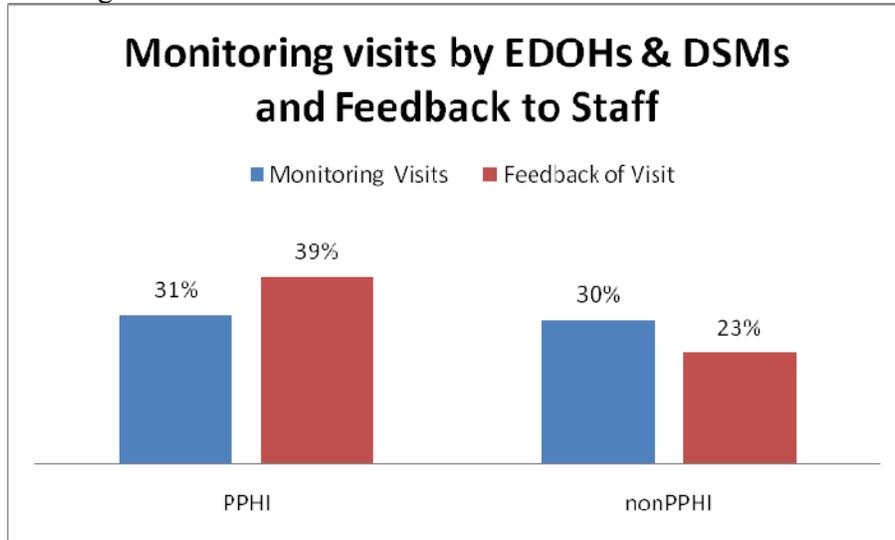
Table 1.7:-

Service Delivery at BHUs in PPHI and Non PPHI Districts from 2006 - 2008

Districts			Mean	N	Std. Deviation	Std. Error Mean
PPHI	Pair	GM2006	70.0000	69	119.1140	14.3396
	1	GM200	133.4783	69	183.7727	22.1236
	Pair	MEASLES0	241.6216	74	384.7698	44.7286
	2	MEASLES8	363.0000	74	354.0895	41.1621
	Pair	DPT32006	329.1081	74	754.0302	87.6542
	3	DPT32008	398.0676	74	390.7683	45.4259
	Pair	BCG2006	328.0400	75	504.0674	58.2047
	4	BCG2008	444.8800	75	426.3758	49.2336
	Pair	FP2006	173.7342	79	580.1303	65.2698
	5	FP2008	243.2658	79	673.3923	75.7626
	Pair	DELIVERY 2006	124.0323	93	148.0963	15.3569
	6	DEL08	225.3548	93	622.6712	64.5680
	Pair	ANC(new) 2006	299.2597	77	632.6654	72.0989
	7	ANC(new) 2008	376.5974	77	582.8939	66.4269
Pair	Utilization 2006	.3978	82	.3969	4.383E-02	
8	Utilization 2008	.6629	82	.6587	7.274E-02	
Pair	OPD2006	463.0945	82	373.1239	41.2046	
9	OPD2008	740.5884	82	442.2537	48.8388	
Non PPHI	Pair	GM2006	150.0968	31	439.5981	78.9541
	1	GM200	159.0000	31	516.3592	92.7408
	Pair	MEASLES0	310.6667	36	290.4188	48.4031
	2	MEASLES8	305.4167	36	287.8855	47.9809
	Pair	DPT32006	389.3514	37	358.1314	58.8764
	3	DPT32008	360.0811	37	356.6725	58.6366
	Pair	BCG2006	385.4167	36	358.4814	59.7469
	4	BCG2008	336.8333	36	313.6585	52.2764
	Pair	FP2006	85.2188	32	129.2077	22.8409
	5	FP2008	100.9688	32	139.7157	24.6985
	Pair	DELIVERY 2006	93.8108	37	102.7829	16.8974
	6	DEL08	130.7027	37	180.0938	29.6072
	Pair	ANC(new) 2006	180.6857	35	257.2192	43.4780
	7	ANC(new) 2008	143.4857	35	152.8693	25.8396
Pair	Utilization 2006	.1938	31	.1440	2.587E-02	
8	Utilization 2008	.1918	31	.1295	2.326E-02	
Pair	OPD2006	270.6532	31	165.5798	29.7390	
9	OPD2008	258.8629	31	170.3229	30.5909	

3:- Monitoring and Supervisory Activities:

Fig 1.3



Monitoring visits by EDOHs and DSMs are almost same but 39% of DSMs had given feedback of their visits to staff of BHUs as against 23% by EDOH.

Objective II:

A:- Significantly Improve the Coverage and Utilization of Services:

1:- Curative Services:

a:-Number of Consultancies per Person per Year (Outdoor Patients (OPD))

Table 2.1:- Average No. of Patients per BHU/month

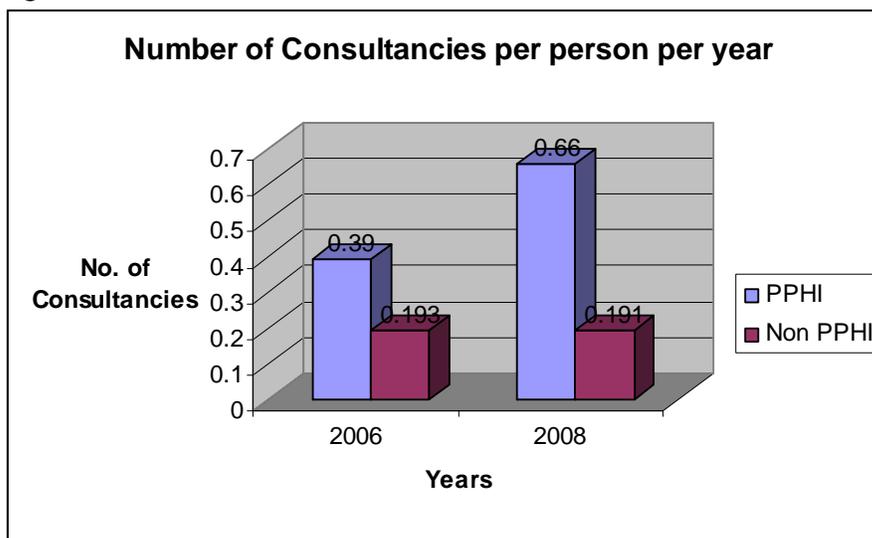
OPD cases	Dist. n=82	PHI n=31
2006	463	270
2008	740	258

Table 2.2:- Number of Consultancies per Person per Year

	Consultancies/person/year	
	Dist. n=82	PHI n=31
	0.39	0.193
	0.66	0.191

Number of consultancies per person per year in PPHI district increased over years from 0.39 to 0.66 whereas it remained same in non PPHI.

Fig 2.1



b:-Tuberculosis-Treatment Success Rate (SS+):**Table 2.3**

PPHI Districts – Year 2006				
S. No.	Name of District	Registered cases	Cured + completed	Percentage
1	Chitral	240	228	95%
2	Karak	160	147	92%
3	Kohat	315	290	92%
4	Nowshera	511	497	97%
5	Peshawar	1650	1502	91%
6	Swabi	607	579	95%
7	Upper Dir	129	122	95%
	Total PPHI Districts.	3612	3365	93%

Table 2.4

Non PPHI Districts – Year 2006				
S. No.	Name of District	Registered cases	Cured + completed	Percentage
1	D.I. Khan	538	477	89%
2	Abbottabad	829	782	94%
3	Lower Dir	321	297	93%
	Total Non PPHI Districts	1688	1556	92%

TB- Treatment Success Rate in PPHI and non PPHI in year 2006 was 93% and 92% respectively.

Table 2.5

(First 2 quarters) PPHI Districts- Year 2008				
S. No.	Name of District	Registered cases	Cured + completed	Percentage
1	Chitral	141	124	88%
2	Karak	116	113	97%
3	Kohat	215	211	98%
4	Nowshera	380	365	96%
5	Peshawar	1010	938	93%
6	Swabi	405	373	92%
7	Upper Dir	163	157	96%
	Total PPHI District.	2430	2281	94%

Table 2.6

(First 2 quarters)Non PPHI Districts – Year 2008				
S. No.	Name of District	Registered cases	Cured + completed	Percentage
1	D.I. Khan	327	300	92%
2	Abbottabad	508	497	98%
3	Lower Dir	203	187	92%
	Total Non PPHI	1038	984	95%

TB- Treatment Success Rate in PPHI and non PPHI in year 2008 (first 02 quarters) was 94% and 95% respectively.

2:- Preventive Services:

a:- Antenatal Care:

Table 2.7:- Antenatal Care Coverage by SBA

Responses	PPHI Districts. n=2731	Non PPHI districts n=992
ANC Coverage	85.00%	85.90%
ANC from BHU	60.90%	57.20%
2 or more Antenatal visits	60.00%	68.00%

Antenatal coverage is 85% in PPHI group and 86% in Non PPHI districts. Mothers who received 02 or more antenatal visits are 60% and 68% respectively.

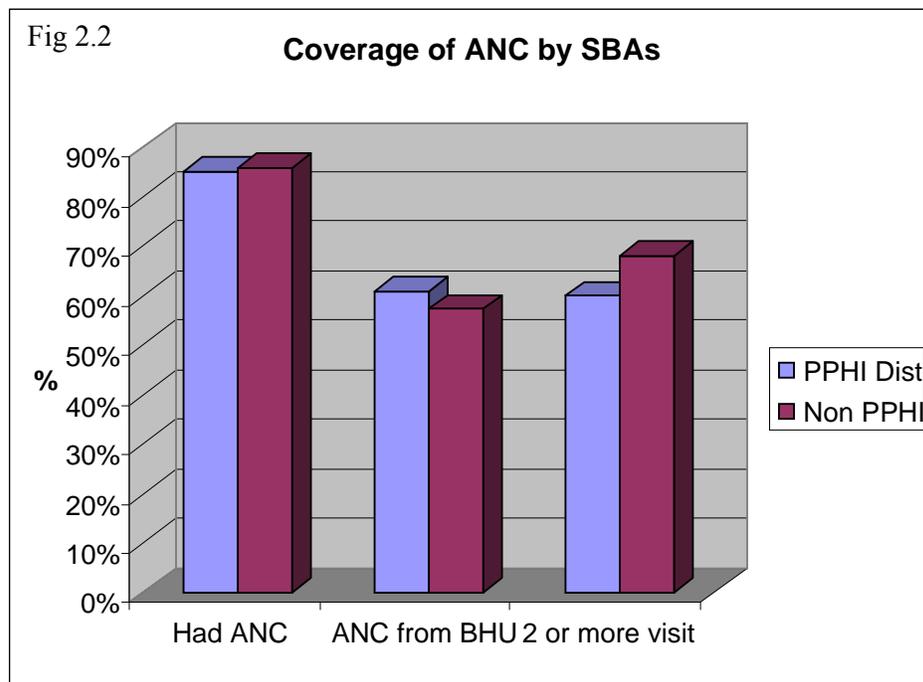
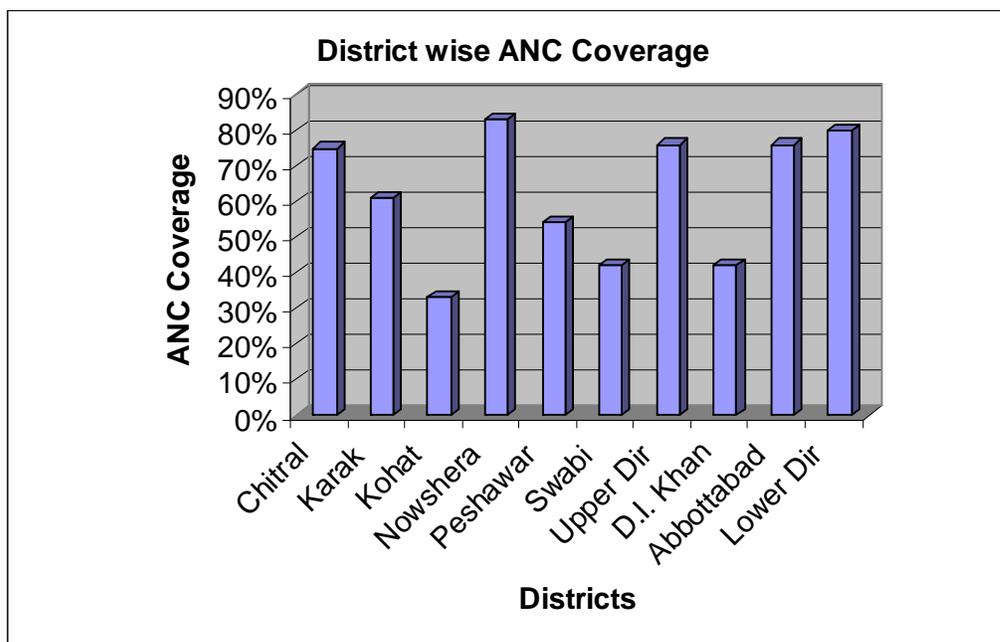


Table 2.8:-District wise Antenatal Coverage – Two & more Visits from SBAs

S. No.	Name of District	2 & more ANC Visit
1	Chitral	75%
2	Karak	61%
3	Kohat	33%
4	Nowshera	83%
5	Peshawar	54%
6	Swabi	42%
7	Upper Dir	76%
8	D.I. Khan	42%
9	Abbottabad	76%
10	Lower Dir	80%

Antenatal coverage (02 & more visits from SBAs) is highest in district Nowshera (83%) and lowest in district Kohat (33%).

Fig 2.3

b:- Deliveries Conducted by Skilled Birth Attendants (SBAs):**Table 2.9:- Preferred place of delivery**

Place of delivery	PPHI Dist.	Non PPHI
Home	58.90%	61.86%
BHU	7.06%	6.17%
Other G. Hosp	15.26%	14.60%
Private Hosp	15.60%	15.58%
Others	3.13%	1.76%

Preferred place of delivery is home 59% (PPHI) and 62% (non PPHI) followed by hospitals both Public and private (15%).

Table 2.10:- Deliveries conducted by different Birth Attendants

Type of birth attendant	PPHI Dist. n=2905	Non PPHI n=1019
Relative	25.19%	23.55%
Dai/TBA	27.40%	38.07%
*LHV/MW	*20.06%	*8.14%
*Lady Doctor	*25.30%	*28.65%
Others	2.03%	1.57%
*SBA	*45.37%	*36.80%

*SBAs means doctor, Charge Nurse, LHV and Midwife

45% deliveries were conducted by SBAs in PPHI districts and 37% in non PPHI. Deliveries conducted by relatives were 25% and 23% respectively.

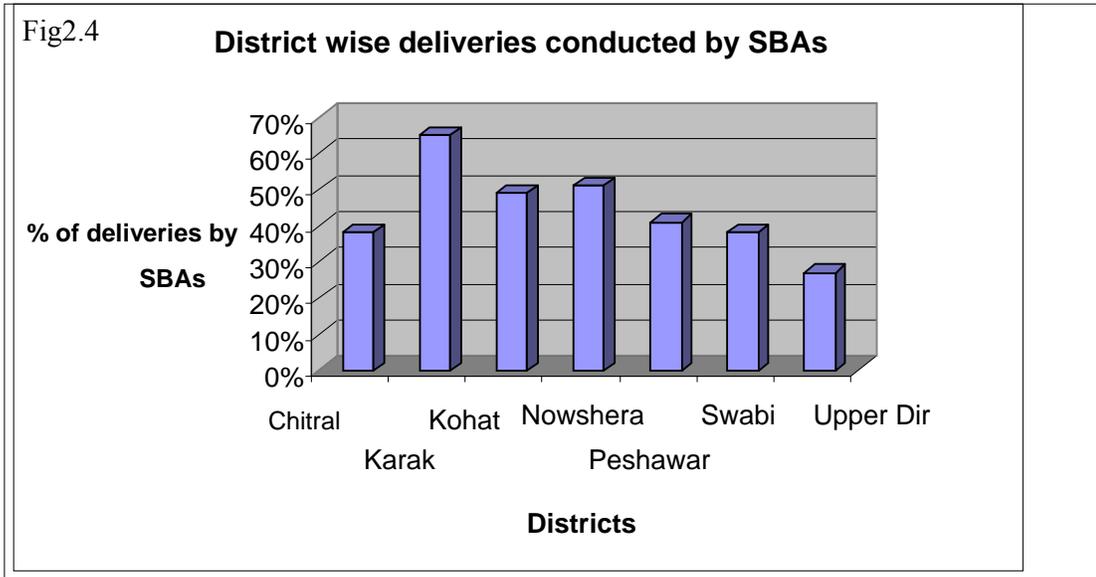
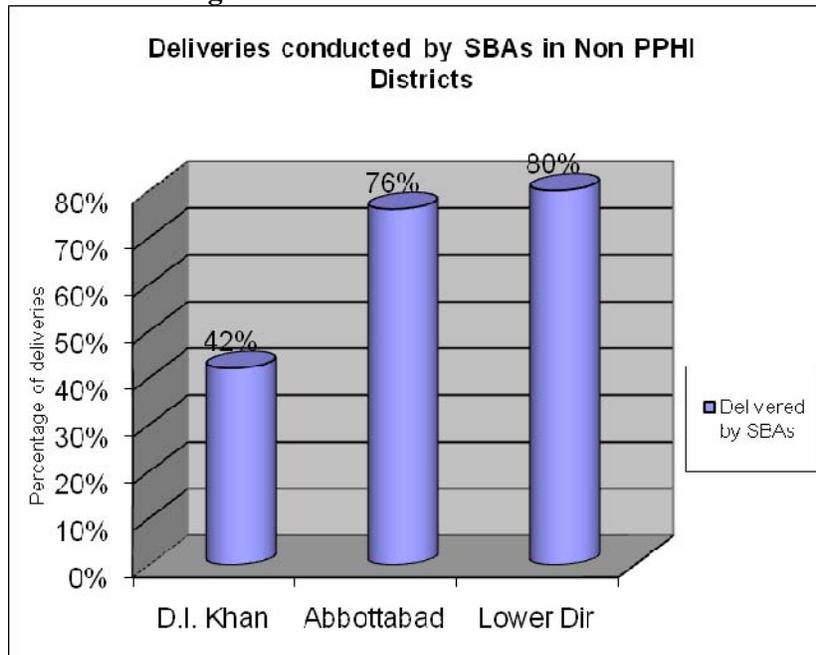


Table 2.11:- District wise, Deliveries Conducted by SBAs

Name of District	Delivered by SBAs
Chitral	38%
Karak	65%
Kohat	49%
Nowshera	51%
Peshawar	41%
Swabi	38%
Upper Dir	27%

Highest percentage of deliveries was conducted by SBAs in district Karak (65%) and Upper Dir is the lowest (27%).

Fig 2.5



Highest percentage of deliveries was conducted by SBAs in district lower Dir (80%) and D.I. Khan is the lowest (42%).

c:- Vaccination of Children:

Vaccination Status of Children under 2 years

Table 2.12:-

			Districts	
			PPHI	NON PPHI
Had vaccination	Yes	Count	2443	850
		% age	82.33%	83.25%
	No	Count	524	171
		% age	17.67%	16.75%
Total		Count	2967	1021

82% children under the age of two years were vaccinated in PPHI districts and 83% in non PPHI districts. No significant difference despite PPHI districts being centrally placed.

Fig 2.6

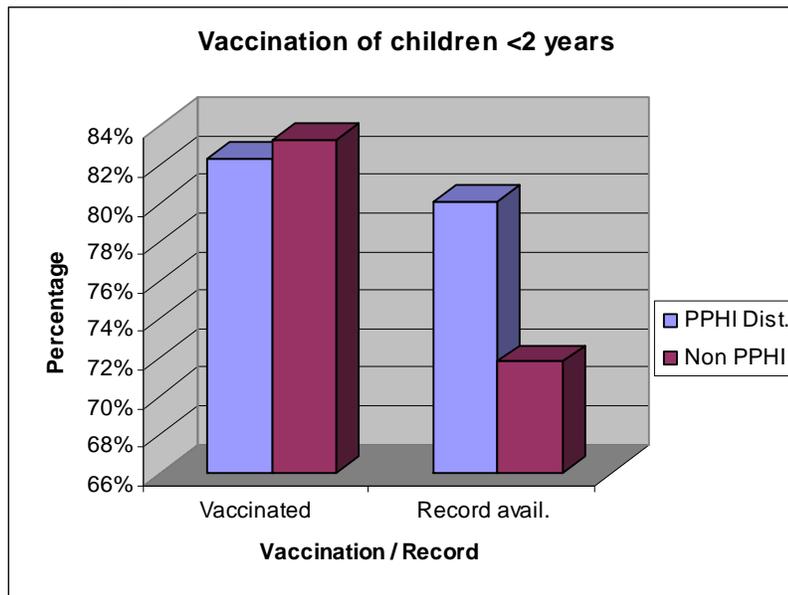


Table 2.13:- Measles vaccination in Children < one year

District	% Measles Vaccination
PPHI	55%
Non PPHI	63%

Children under one year are considered full immunized when they received Measles vaccination. Above table shows that fully immunized children in PPHI districts is 55% and in non PPHI is 63%.

Table 2.14**Measles vaccination in Children < one year in PPHI Districts**

Name of District	Measles Vaccination
Chitral	69%
Karak	52%
Kohat	42%
Nowshera	65%
Peshawar	45%
Swabi	48%
Upper Dir	70%

Table 2.15**Measles vaccination in Children < one year in non PPHI Districts**

Name of District	Measles Vaccination
D.I. Khan	41%
Abbottabad	64%
Lower Dir	60%

Upper Dir (70%) has the highest vaccination coverage against Measles in children less than one year and DI Khan has the lowest (41%).

Fig 2.7

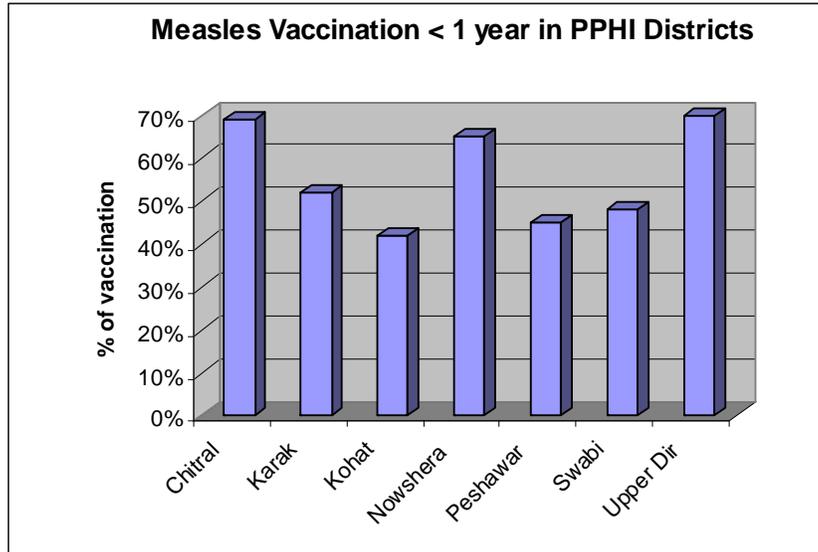
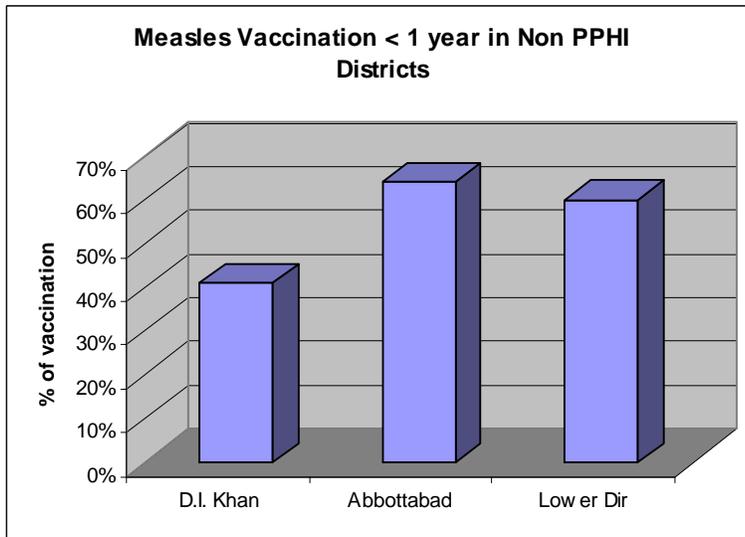


Fig 2.8

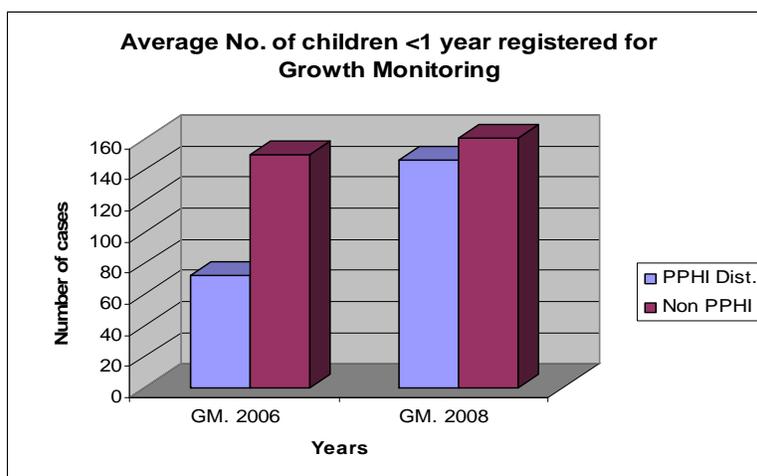


d:-Growth Monitoring**Table 2.16:-Average number of children < 01year registered for Growth Monitoring**

Year	PPHI Dist. n=71/81	Non PPHI n=31/33
GM. 2006	70	150
GM. 2008	133	159

Growth monitoring of children less than one year of age is less in PPHI district.

Fig 2.9

**Table 2.17:- District wise %age of BHUs Recording Growth Monitoring**

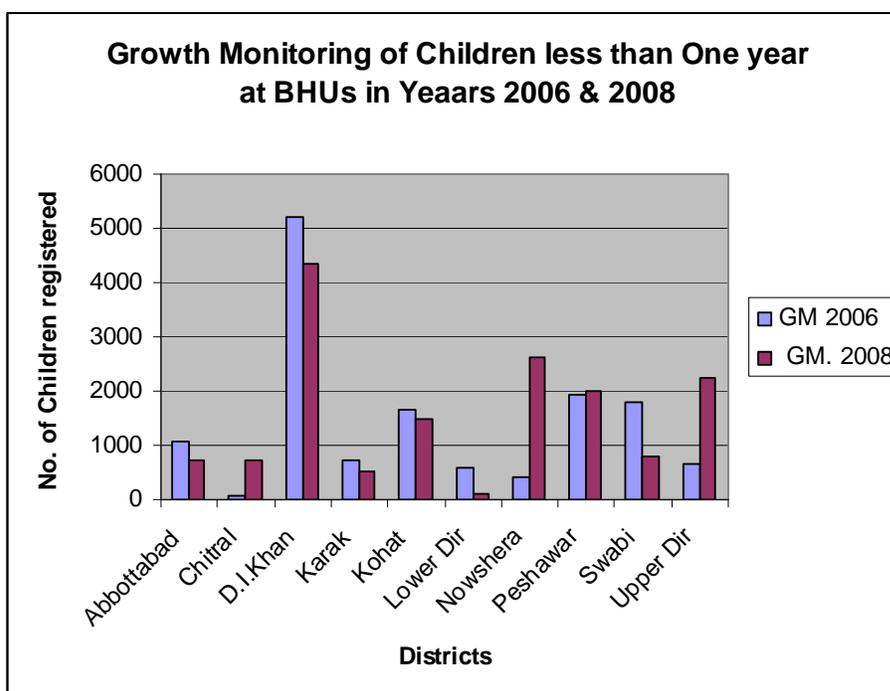
Districts	% BHUs 2006	% BHUs 2008
Abbottabad	14.20%	14.20%
Chitral	0.07%	76.90%
D.I. Khan	60.00%	60.00%
Karak	35.70%	35.70%
Kohat	33.30%	33.30%
Lower Dir	28.50%	21.40%
Nowshera	13.30%	60.00%
Peshawar	53.30%	60.00%
Swabi	46.60%	46.60%
Upper Dir	26.60%	60.00%

Table 2.18-

Average No. of children < 01 year Registered for Growth Monitoring at BHUs in years 2006 & 2008

Districts	Growth Monitoring in 2006	Growth Monitoring in 2008
Abbottabad	1074	711
Chitral	75	723
D.I. Khan	5205	4359
Karak	714	534
Kohat	1659	1491
Lower Dir	582	120
Nowshera	426	2619
Peshawar	1935	2013
Swabi	1785	804
Upper Dir	651	2238

Fig 2.10


e:- Family Planning:
Table 2.19:-
Average No. Family Planning Clients Registered at BHUs during years 2006-2008

FP. Clients	PPHI dist. n=79	Non PPHI n=32
Family Planning. Clients in 2006	173	85
Family Planning Clients in 2008	243	101

The average number of clients who received family planning services from BHUs in PPHI districts are 173/2006 and 243/2008 and in non PPHI group are 85/2006 and 101/2008.

Table 2.20;-

**District wise %age of BHUs Providing Family Planning (FP) Services
in year 2006 and 2008**

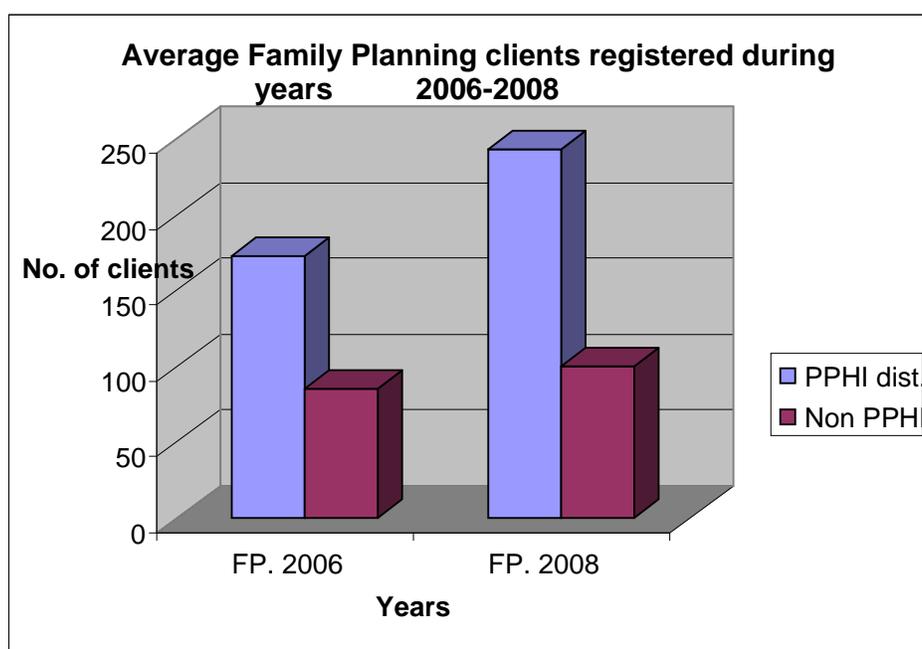
Districts	Year 2006		Year 2008	
	No. of BHUs	Percent	No. of BHUs	Percent
ABBOTTABAD	8	57.10%	12	85.70%
CHITRAL	13	92.90%	13	92.90%
D I KHAN	12	80.00%	13	86.70%
KARAK	10	71.40%	12	85.70%
KOHAT	11	73.30%	13	86.70%
LOWER DIR	12	85.70%	12	85.70%
NOWSHERA	6	40.00%	14	93.30%
PESHAWAR	14	93.30%	14	93.30%
SWABI	14	93.30%	14	93.30%
UPPER DIR	12	80.00%	15	100.00%

Table 2.21:- District wise distribution of Average No. of Family Planning Clients

Districts	Clients_2006	Clients_2008
Abbottabad	450	2661
Chitral	234	5025
D.I. Khan	1497	1872
Karak	1008	6111

Kohat	3768	1542
Lower Dir	780	303
Nowshera	420	2118
Peshawar	1737	2394
Swabi	1296	1140
Upper Dir	5388	2775

Fig 2.11



f:- Tuberculosis – Case Detection Rate (CDR) – (SS+)

Table 2.22-TB - Case Detection Rate (SS+) in 2006

S. No.	Name of District	PPHI Districts		
		Estimated cases	Total cases SS+	Percentage
1	Chitral	304	240	79%
2	Karak	412	160	39%
3	Kohat	537	315	59%
4	Nowshera	835	511	61%
5	Peshawar	1926	1650	86%
6	Swabi	980	607	62%
7	Upper Dir	549	129	23%

Total PPHI Districts.	5543	3612	65%
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Table 2.23- TB - Case Detection Rate (SS+) in 2006

Non PPHI Districts				
S. No.	Name of District	Estimated cases	Total cases SS+	Percentage
1	D.I. Khan	814	538	66%
2	Abbottabad	1860	1572	84%
3	Lower Dir	685	321	47%
Total Non PPHI districts		3359	2431	72%

TB- Case Detection Rate in PPHI districts in 2006 was 65% and in non PPHI was 72%.

Table 2.24- TB - Case Detection Rate (SS+) in 2008

PPHI Districts				
S. No.	Name of District	Estimated cases	Total cases SS+	Percentage
1	Chitral	316	269	85%
2	Karak	428	245	57%
3	Kohat	559	355	64%
4	Nowshera	868	696	80%
5	Peshawar	2004	1814	91%
6	Swabi	1020	743	73%
7	Upper Dir	571	259	45%
Total PPHI Districts.		5766	4381	76%

Table 2.25 -TB - Case Detection Rate (SS+) in 2008

Non PPHI Districts				
S. No.	Name of District	Estimated cases	Total cases SS+	Percentage
1	D.I. Khan	847	565	67%
2	Abbottabad	875	883	101%
3	Lower Dir	713	360	50%
Total Non PPHI		2435	1808	74%

Fig 2.12

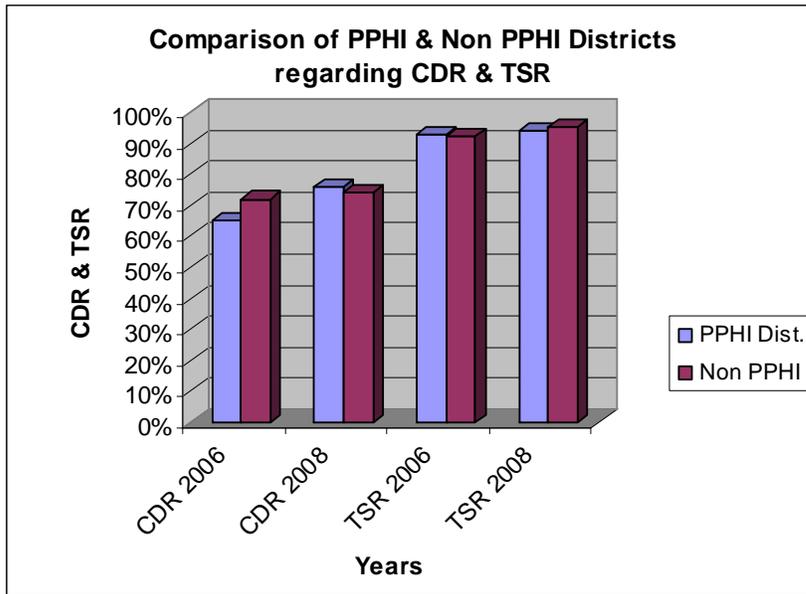


Table 2.26:- Comparison of PPHI and Non PPHI Districts

Districts	CDR 2006	CDR 2008	TSR 2006	TSR 2008
PPHI Districts.	65%	76%	93%	94%
Non PPHI Districts	72%	74%	92%	95%

TB – Case Detection Rate and TB –Treatment Success Rate remained same in both groups over years.

3:- Promotive Services:

Mother's Knowledge on Danger Signs of Diarrhoea and Acute Respiratory Infections (ARIs):

Table 2.27
Knowledge of Mothers Regarding Danger Signs of Diarrhea in Children less than 5 years. n=2378

Danger signs	PPHI Districts	Non PPHI
Unconscious or lazy.	88.60%	85%
Sunken eyes.	7.70%	7.80%
Fever >101F°	15.20%	14.40%
Blood in the stool	3.10%	8.30%
Repeated vomiting	16.80%	22.20%

89% Mothers in PPHI area recognized unconscious/lazy as danger sign in Diarrhoea and 85% in non PPHI followed by repeated vomiting and fever.

Fig 2.13

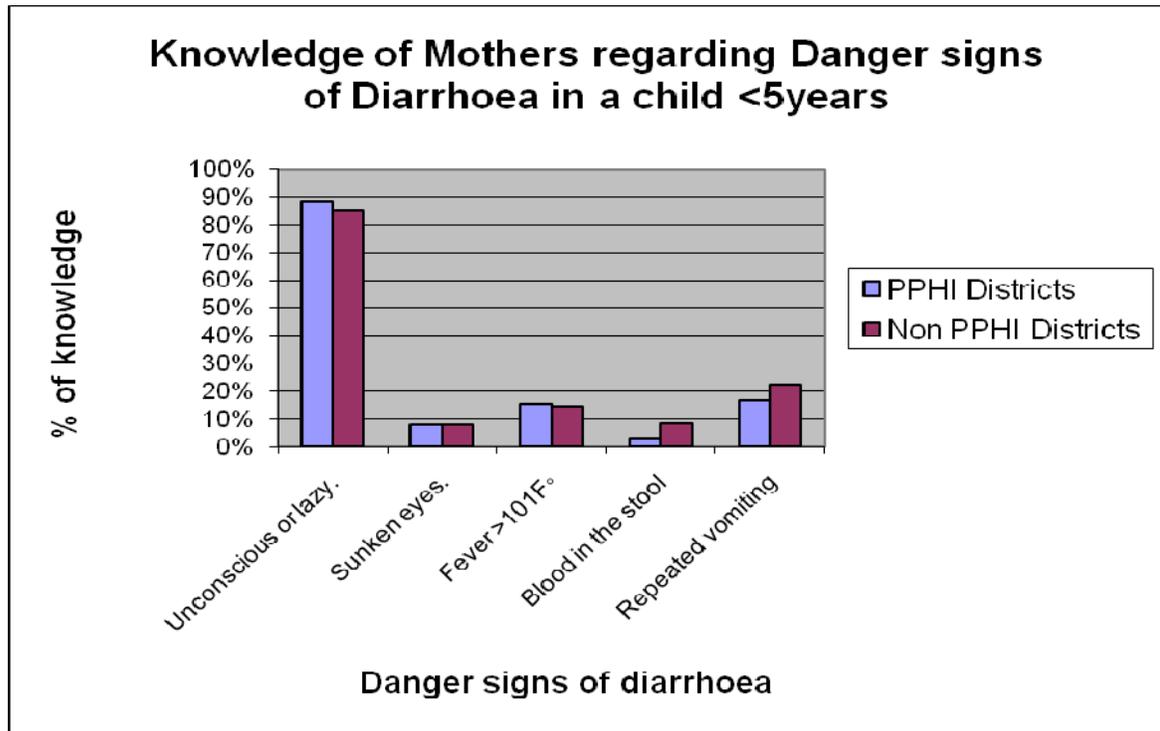


Table 2.28
District wise Knowledge of Mothers regarding Danger Signs of Diarrhoea

Districts	Know at least 2 signs
1 Abbottabad	0.30%
2 Chitral	0.30%
3 D.I. Khan	8.60%
4 Karak	0.00%
5 Kohat	0.40%
6 Lower Dir	7.20%
7 Nowshera	0.00%
8 Peshawar	48.20%
9 Swabi	0.00%
10 Upper Dir	0.00%

Table 2.29
Knowledge of Mothers Regarding Danger Signs of ARI in Children less than 5 years.

Danger signs	PPHI Districts	Non PPHI
Unconscious or lazy.	79.90%	83%
Fits	6.50%	4.80%
Fever >101F°	19.20%	13.00%
Unable to take feed	6.00%	3.50%
Malnutrition	15.30%	21.20%

Similarly, unconscious /lazy was the most common danger sign recognized by mothers in ARI followed by malnutrition and fever.

Fig:2.14

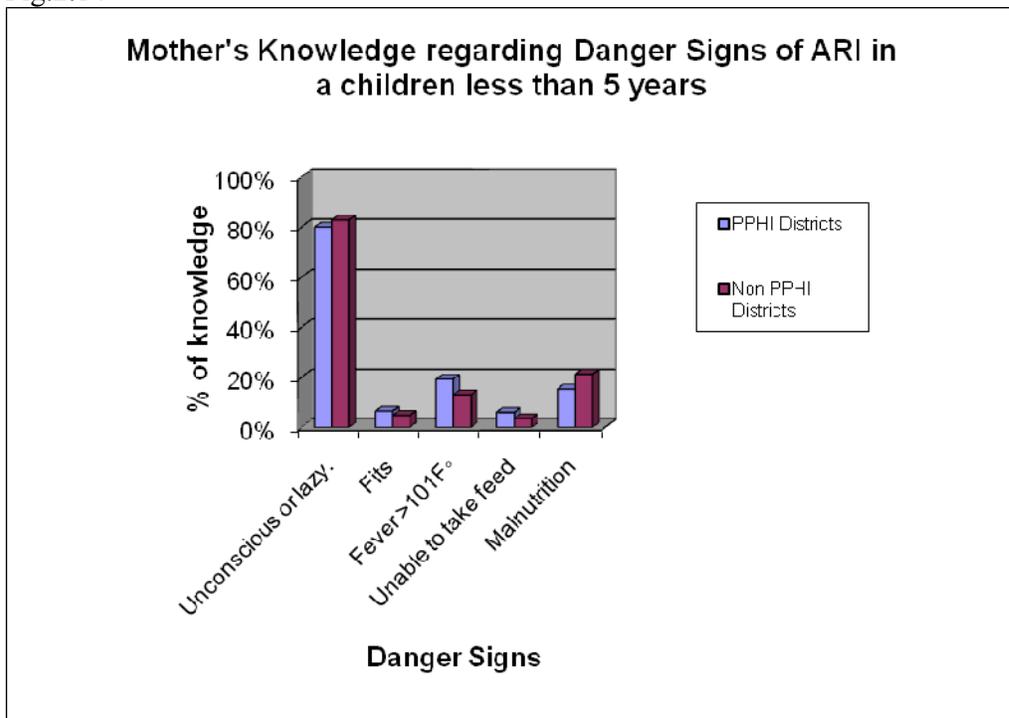


Table 2.30**District wise Knowledge of Mothers Regarding Danger Signs of ARI**

Districts	Know at least 2 signs
1 Abbottabad	0.00%
2 Chitral	0.50%
3 D.I. Khan	4.80%
4 Karak	0.00%
5 Kohat	0.00%
6 Lower Dir	10.20%
7 Nowshera	0.00%
8 Peshawar	29.50%
9 Swabi	0.00%
10 Upper Dir	0.20%

Mothers in district Peshawar have the highest percentage of knowledge regarding danger signs of ARI in children (29%)

9:- Hand Washing with Soap:**Table 2.31:- Hand Washing with Soap after Using Toilet**

			Districts	
			PPHI	NON PPHI
Wash with Soap (toilet)	Yes	Count	2221	647
		%	80.00%	69.80%
	No	Count	233	119
		%	8.40%	12.80%
	Sometimes	Count	323	161
		%	11.60%	17.40%
Total	Count	2777	927	

80% of respondents wash hands with soap after using toilet in PPHI and 70% in non PPHI districts.

Table 2.32
District wise data of Hands Washing with Soap after Using Toilet

	Districts	Yes	NO	Some times
1	Abbottabad	88.30%	1.40%	10.30%
2	Chitral	66.00%	22.20%	11.90%
3	D.I. Khan	61.90%	13.90%	24.20%
4	Karak	80.10%	3.70%	16.20%
5	Kohat	91.70%	0.20%	8.10%
6	Lower Dir	55.20%	24.70%	20.10%
7	Nowshera	82.20%	1.70%	16.10%
8	Peshawar	83.50%	6.60%	9.80%
9	Swabi	88.20%	8.00%	3.80%
10	Upper Dir	68.50%	18.00%	13.50%

Table 2.33:- Hand Washing with Soap before Preparation of Food

			Districts	
			PPHI	NON PPHI
Wash with Soap (food)	Yes	Count	1729	515
		% s	62.10%	56.50%
	No	Count	484	209
		%	17.40%	22.90%
	Sometimes	Count	571	187
		%	20.50%	20.50%
Total	Count	2784	911	

62% of respondents wash hands with soap before preparation of food in PPHI and 56% in non PPHI districts.

Table 2.34
District wise data of Hands Washing with Soap Before Preparation of Food

	Districts	Yes	NO	Some times
1	Abbottabad	74.00%	6.40%	19.60%
2	Chitral	51.60%	30.50%	17.90%
3	D.I. Khan	48.90%	22.30%	28.80%
4	Karak	58.20%	13.90%	28.00%
5	Kohat	62.60%	0.40%	37.00%
6	Lower Dir	42.60%	41.70%	15.70%
7	Nowshera	75.80%	1.90%	22.30%
8	Peshawar	74.40%	10.20%	15.40%
9	Swabi	46.60%	42.20%	11.20%
10	Upper Dir	62.70%	29.90%	7.40%

Objective II: (cont...)

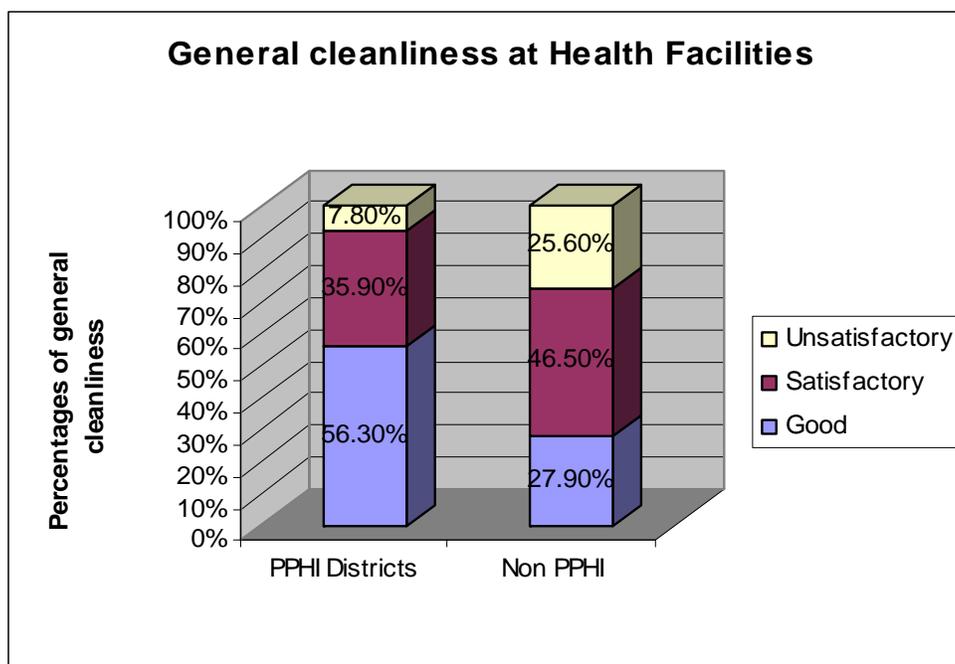
B:- Quality of Care:

i:-Cleanliness

Table 2.35:- General Cleanliness at BHUs

Responses	PPHI Districts	Non PPHI
Good	56.30%	27.90%
Satisfactory	35.90%	46.50%
Unsatisfactory	7.80%	25.60%

Fig:2.15



General cleanliness of building and surrounding premises in PPHI districts is good (56%) and in non PPHI districts is (28%) which is statistically significant (p=0.001)

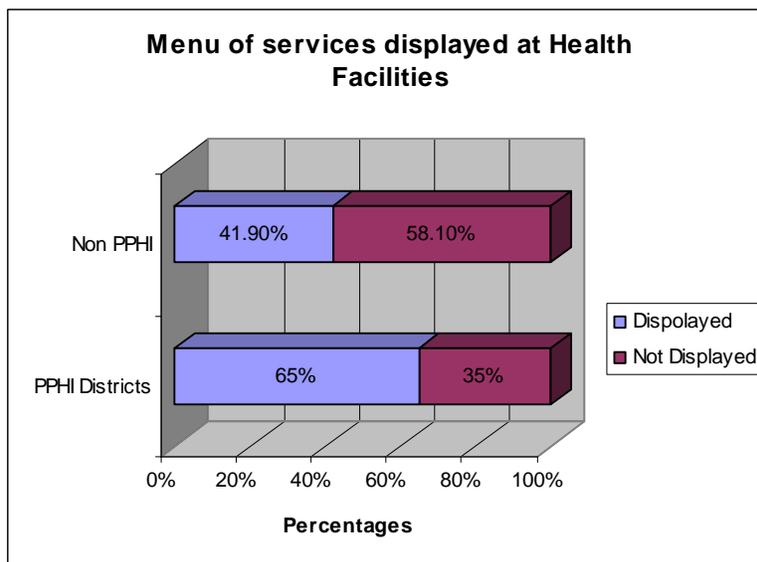
ii:- Menu of Services

Table 2.36:- Menu of services displayed at health facilities

Responses	PPHI Districts	Non PPHI
Displayed	65%	41.90%
Not Displayed	35%	58.10%

Types of health services available at BHUs have been displayed in 65% of BHUs in PPHI districts and 42% in non PPHI (p=0.01).

Fig:2.16



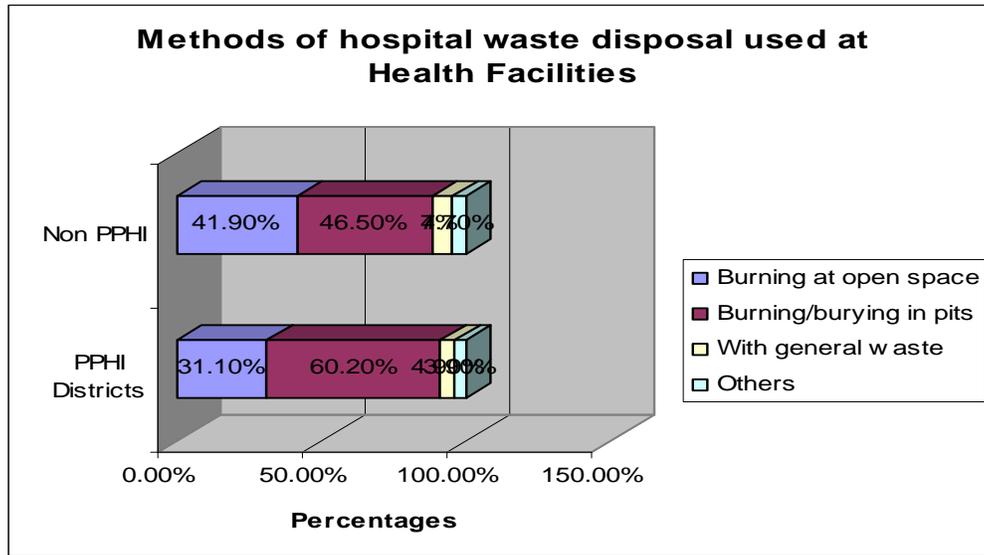
iii:- Waste Disposal

**Table 2.37:-
Methods of hospital waste disposal used at Health Facilities**

Methods	PPHI Districts	Non PPHI
Burning at open space	31.10%	41.90%
Burning/burying in pits	60.20%	46.50%
With general waste	4.90%	7%
Others	3.90%	4.70%

Hospital waste generated at BHUs is disposed off by burning/burying in pits. 60% of BHUs in PPHI managed districts are doing so and 46% of BHUs in non PPHI group.

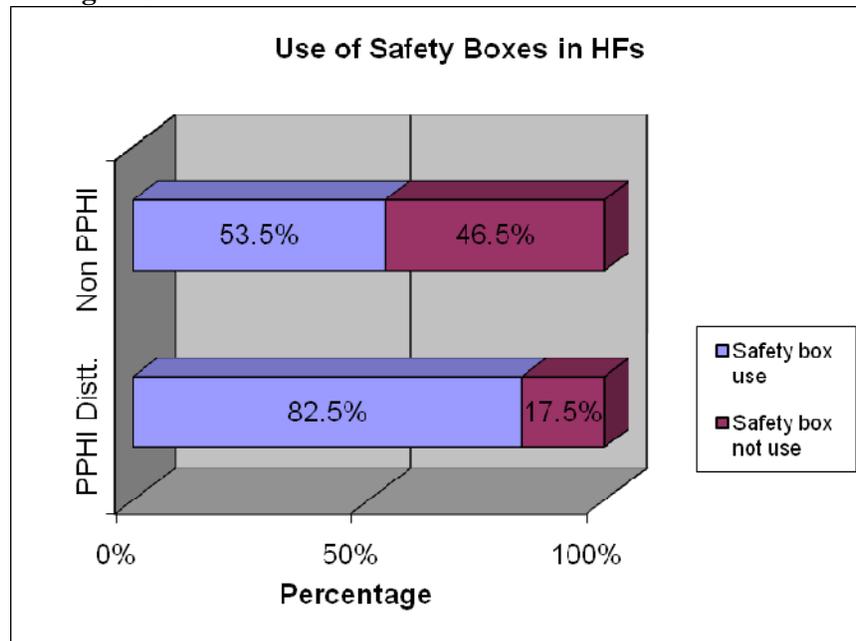
Fig 2.17



iv:- Use of Safety Boxes:-

82% of BHUs in PPHI districts are using safety boxes for disposal of used syringes as compared to 53% in non PPHI. Difference is statistically significant at $p=0.000$.

Fig 2.18



v:- Human Resource, Supplies Availability and Physical Inventory of BHUs
Table 2.38: Availability of Human Resources, Equipment, Medicines and Physical Inventory of BHU Building

Districts		keeping 2.6	main building	STAFFT	support staff	Equipment	Equipment	Medicines
PPHI	Mean	.7412	.6385	.6019	.2233	.8408	.8180	.6893
	N	102	103	103	103	103	103	103
	Std. Deviation	.2094	.1950	.2664	.1978	.1549	.1710	.2143
Non PPHI	Mean	.7317	.5277	.6233	.3198	.7047	.7364	.5271
	N	41	43	43	43	43	43	43
	Std. Deviation	.2207	.2094	.2733	.2398	.2309	.2647	.2277
Total	Mean	.7385	.6059	.6082	.2517	.8007	.7939	.6416
	N	143	146	146	146	146	146	146
	Std. Deviation	.2119	.2050	.2677	.2148	.1903	.2056	.2298

Table 2.39:- Comparison between PPHI and Non PPHI Districts

			Sum of Squares	df	Mean Square	F	Sig.
record keeping	Between Groups	(Combined)	.003	1	.003	.058	.810
	Within Groups		6.376	141	.045		
	Total		6.378	142			
main building	Between Groups	(Combined)	.372	1	.372	9.375	.003
	Within Groups		5.721	144	.040		
	Total		6.093	145			
STAFFT	Between Groups	(Combined)	.014	1	.014	.191	.663
	Within Groups		10.376	144	.072		
	Total		10.390	145			
availability of support staff	Between Groups	(Combined)	.282	1	.282	6.347	.013
	Within Groups		6.405	144	.044		
	Total		6.687	145			
First Aid Equipment	Between Groups	(Combined)	.562	1	.562	17.267	.000
	Within Groups		4.688	144	.033		
	Total		5.250	145			
General equipment	Between Groups	(Combined)	.202	1	.202	4.899	.028
	Within Groups		5.926	144	.041		
	Total		6.128	145			
Medicines	Between Groups	(Combined)	.798	1	.798	16.751	.000
	Within Groups		6.860	144	.048		
	Total		7.658	145			

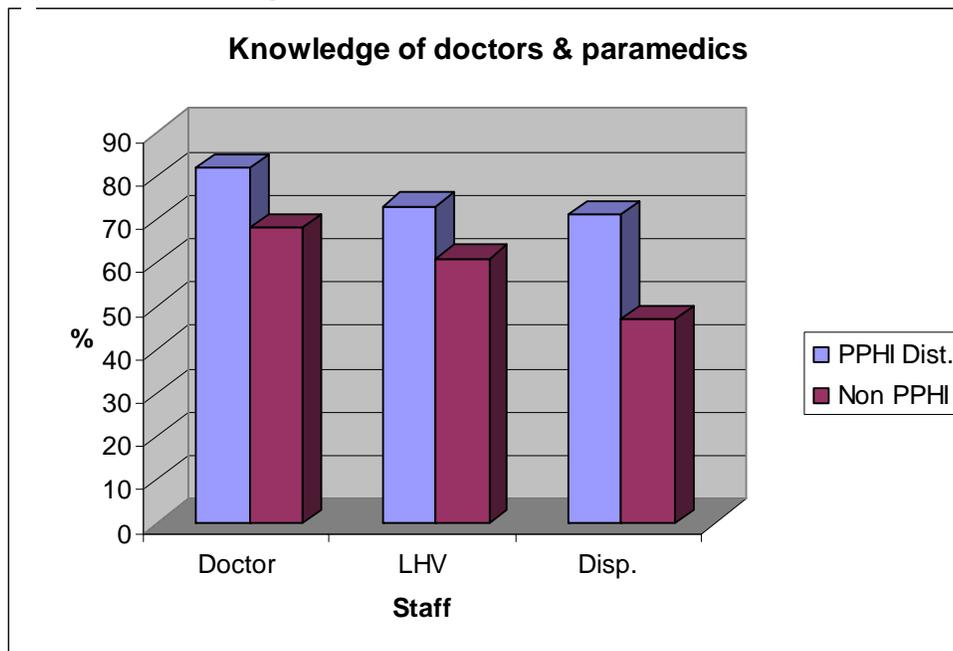
vi:- Knowledge of Doctors and Paramedics:

Table 2.40:- Percentage of Health Staff having Knowledge regarding Diarrhoea, Pneumonia & Neonatal Tetanus and their Management

Staff	PPHI Dist.			Non PPHI		
	%	S.D.	n	%	S.D	n
Doctor	82	0.191	77	68	0.236	34
LHV	73	0.274	62	61	0.338	25
Disp./ HT	71	0.227	51	47	0.279	15

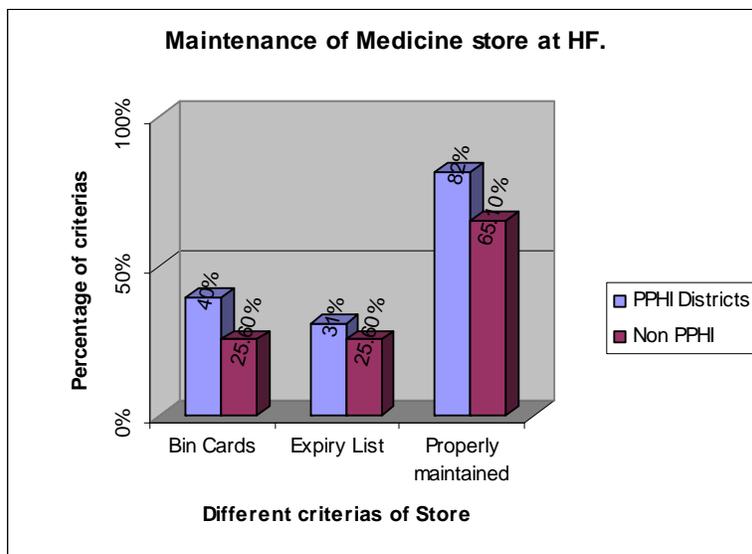
82% of Doctors from PPHI districts have knowledge regarding Diarrhoea, Pneumonia & Neonatal Tetanus and their Management against 68% in non PPHI districts.

Fig 2.19:- Knowledge of doctors and paramedics



vii:- Maintenance of Medicines in Store:

Fig 2.20:-



Medicines are properly maintained in 82% of BHUs with expiry list of medicines (30%) in PPHI and 65% & 26% in non PPHI respectively.

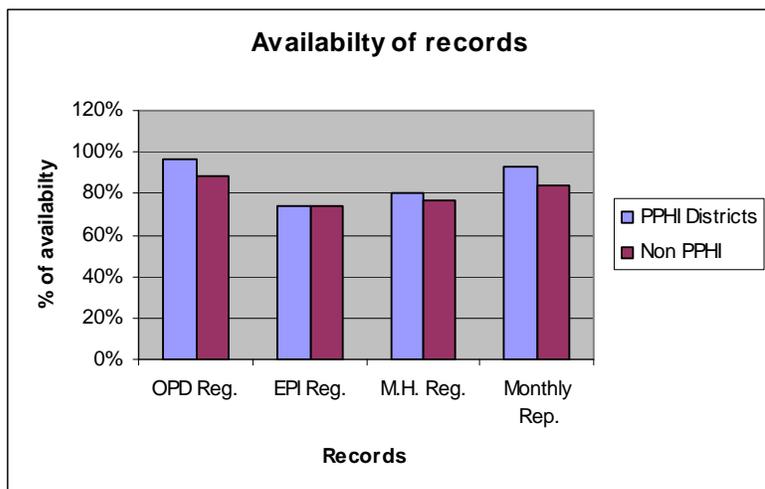
viii:- Availability of Record

Table 2.41:- Availability of Records at BHUs

Items	PPHI Districts	Non PPHI
OPD Reg.	96.10%	88.40%
EPI Reg.	73.80%	74.40%
Mother Health Reg.	80.60%	76.70%
Monthly Rep.	93.20%	83.70%

Table shows availability of various items of record keeping under both types of supervision.

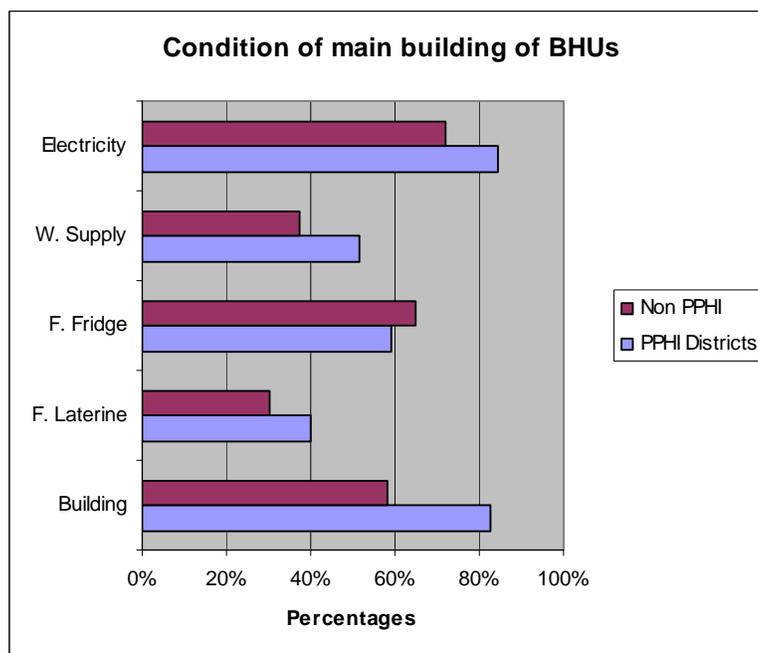
Fig 2.21:-

**ix:- Infrastructure and Services Availability****Table2.42:- Physical Inventory of Main Building of BHUs**

Items	PPHI Districts	Non PPHI
Good Condition of Building	82.50%	58.10%
Functional Latrine	39.80%	30.20%
Functional Fridge	59.20%	65.10%
Water Supply	51.50%	37.20%
Electricity	84.50%	72.10%

Table depicts condition of BHU building and availability of civic facilities under two type of management.

Fig 2.22



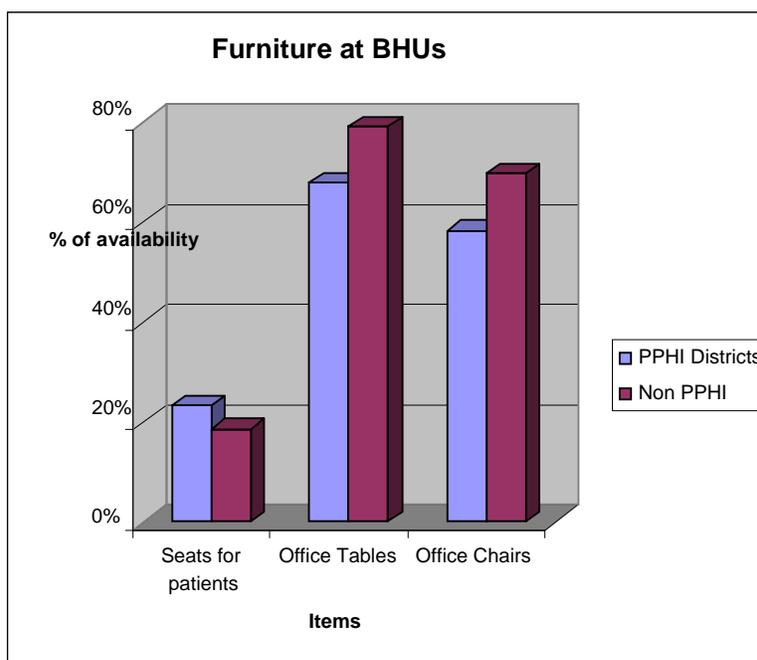
x:- Availability of Furniture:

Table 2,43:- Furniture at BHUs

Items	PPHI Districts	Non PPHI
Seats for patients	23.30%	18.60%
Office Tables	68%	79.10%
Office Chairs	58.30%	69.80%

Table shows office furniture is more in non PPHI BHUs and seating for patients are more in PPHI.

Fig 2.23



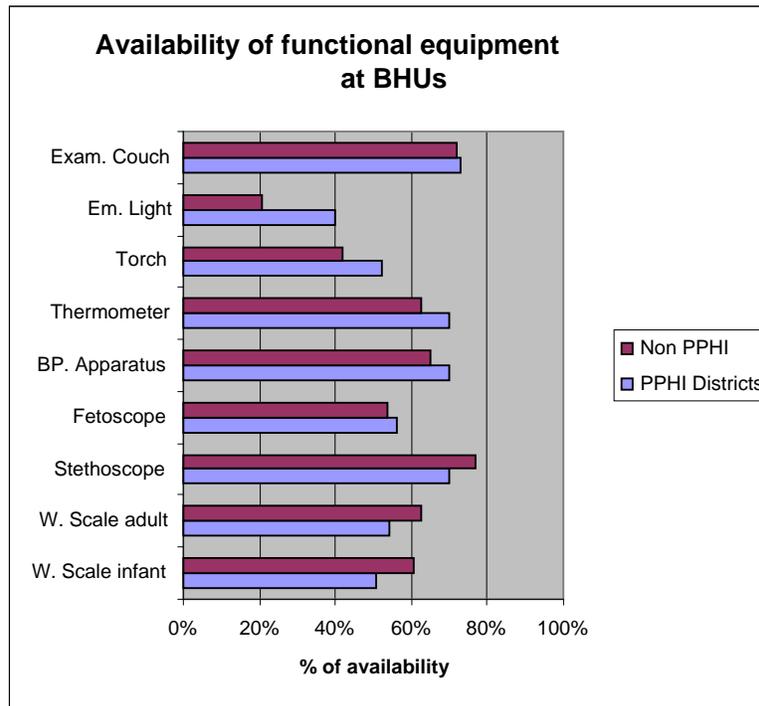
xi:- Availability of Functional Equipments/instruments at BHUs

Table 2.44

Items	PPHI Districts	Non PPHI
Weighing Scale infant	50.50%	60.50%
Weighing Scale adult	54.40%	62.80%
Stethoscope	69.90%	76.70%
Fetoscope	56.30%	53.50%
BP. Apparatus	69.90%	65.10%
Thermometer	69.90%	62.80%
Torch	52.40%	41.90%
Emergency. Light	39.80%	20.90%
Exam. Couch	72.80%	72.10%

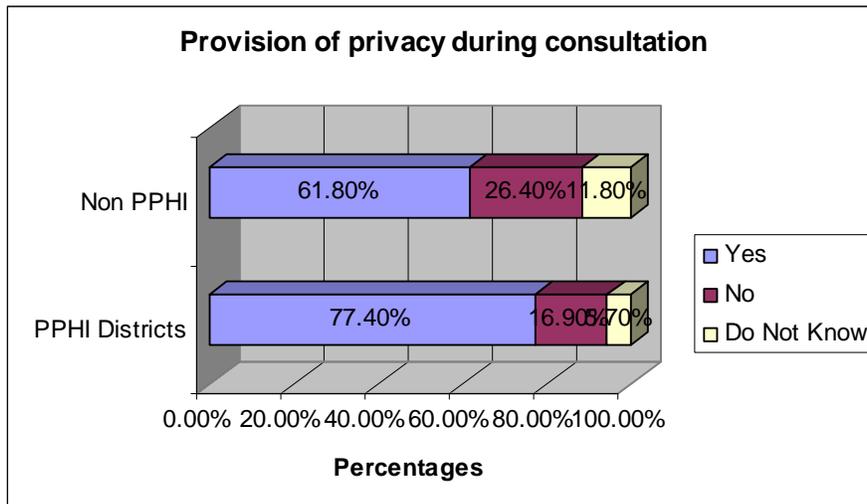
Availability of functional equipment/instruments has been reflected in BHUs.

Fig2.24



xii:- Provision of Privacy during Consultation

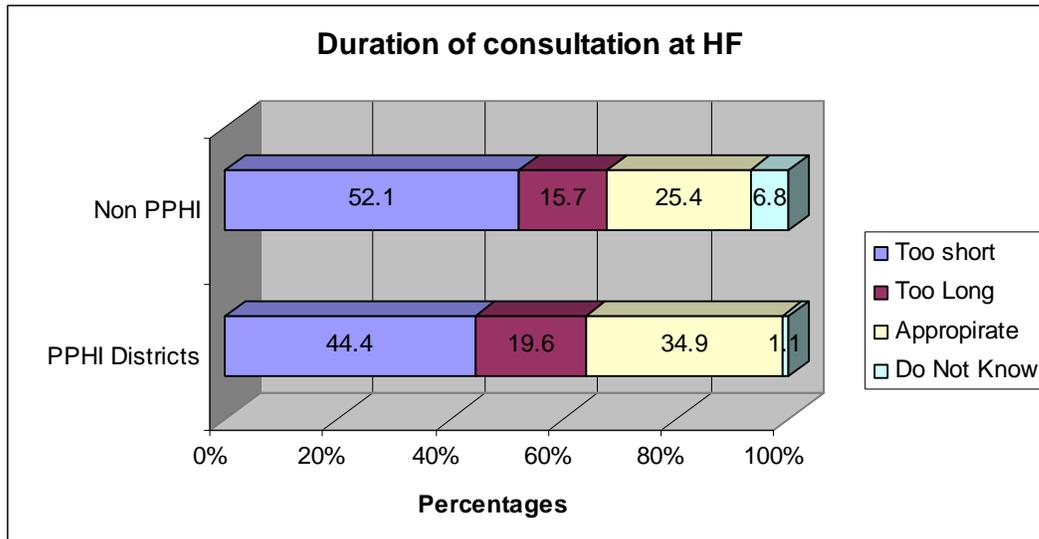
Fig 2.25



More privacy was provided to patients (77%) and (62%) in PPHI and non PPHI districts respectively.

xiii:- Consultation Time:

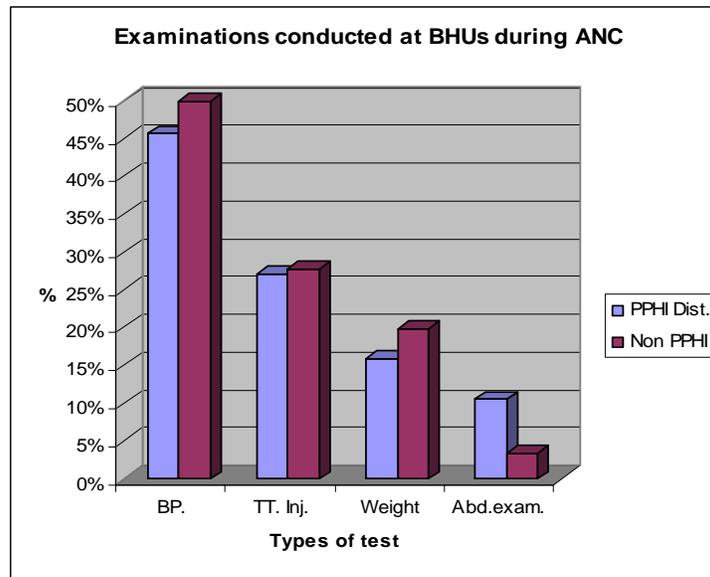
Fig 2.26



44% of respondents from PPHI districts described that consultation time was too short as compared to 52% in non PPHI districts

xiv:- Examination Conducted during Antenatal Care

Fig 2.27



Blood pressure checking is the most common examination conducted at BHUs, 46% PPHI and 50% non PPHI. Abdominal examination is only 10% and 3% in respective districts. Of the four aspects of antenatal examination reviewed, three aspects were better conducted in non PPHI districts depicting better quality of antenatal examination.

C:-Equity:**i:- Distance travelled to reach at BHU****Table 2.45:- Mean Distance from Health Facility**

Districts	Mean	N	Std. Deviation
PPHI districts	2.65	809	4.325
Non PPHI districts	2.71	255	2.589
Total	2.67	1064	3.977

Mean distance travelled by patient/client in reaching BHU is 2.65 Km and 2.71 Km in PPHI and non PPHI districts respectively.

ii:- Utilization of Health Services by Sex:**Table:- 2.46 Sex wise Utilization of Health Services in BHUs**

Districts		Frequency	Percentage
PPHI districts	Male	371	41.8
	Female	517	58.2
	Total	888	100.0
Non PPHI districts	Male	55	24.8
	Female	167	75.2
	Total	222	100.0

Table shows that females have received more health services than males in both groups.

Objective III:

A:-Community Satisfaction:

Health Facility Based Patients/ Clients Interviews (Exit Poll)

Table 3.1:-No. of Respondents:

	Frequency	Valid Percent
PPHI districts	988	77.9
Non PPHI districts	280	22.1
Total	1268	100.0

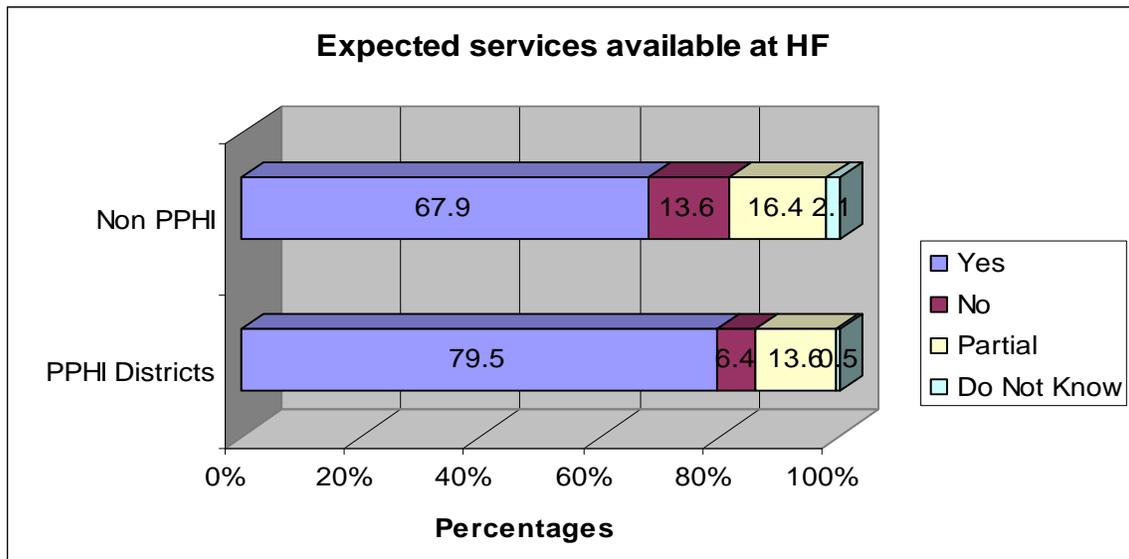
Table 3.2:-District wise No. of Respondents

	Frequency	Percentage
ABBOTTABAD	82	6.5
CHITRAL	130	10.3
D.I. KHAN	99	7.8
KARAK	145	11.4
KOHAT	155	12.2
LOWER DIR	99	7.8
NOWSHERA	131	10.3
PESHAWAR	162	12.8
SWABI	126	9.9
UPPER DIR	139	11.0
Total	1268	100.0

1268 number of patients/clients were interviewed at BHUs in all the 10 districts of NWFP, 988 from PPHI and 280 from non PPHI managed BHUs.

i:- Level of expectation of patients/Clients:

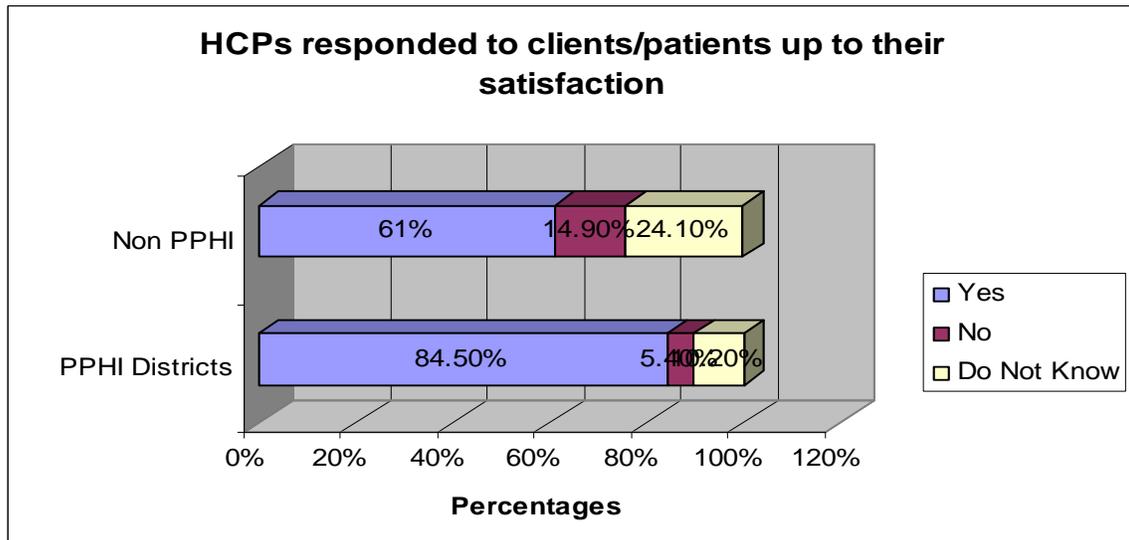
Fig 3.1



79.5% of respondents from PPHI districts rated that they received the expected services against 67.9% in non PPHI districts.

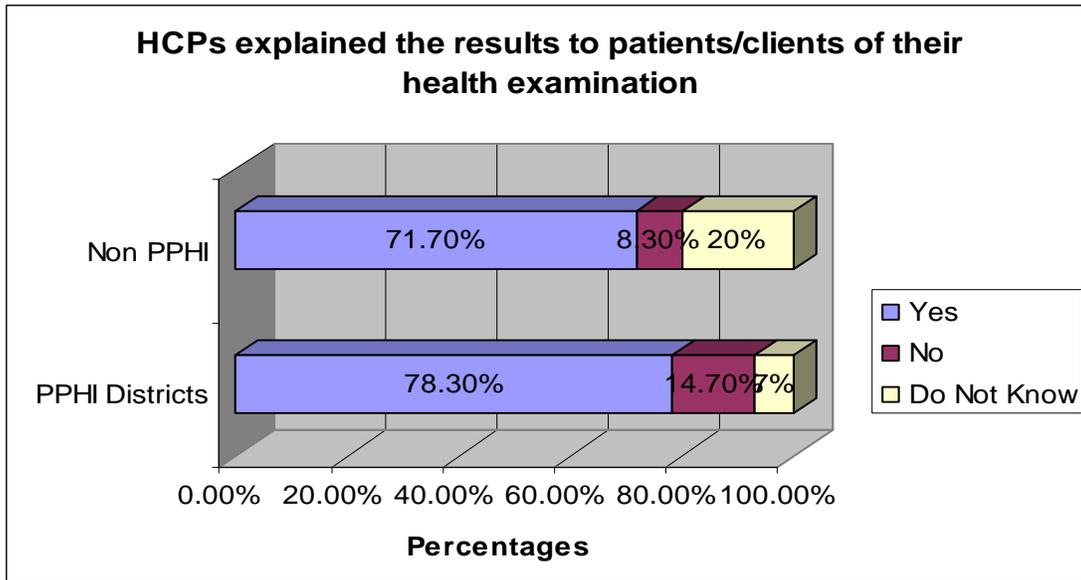
ii:- Attitude of Health Care Providers (HCPs)

Fig 3.2



84% of Health Care Providers (HCPs) responded well to the expectations of patients/clients in PPHI BHUs compared to 61% in non PPHI.

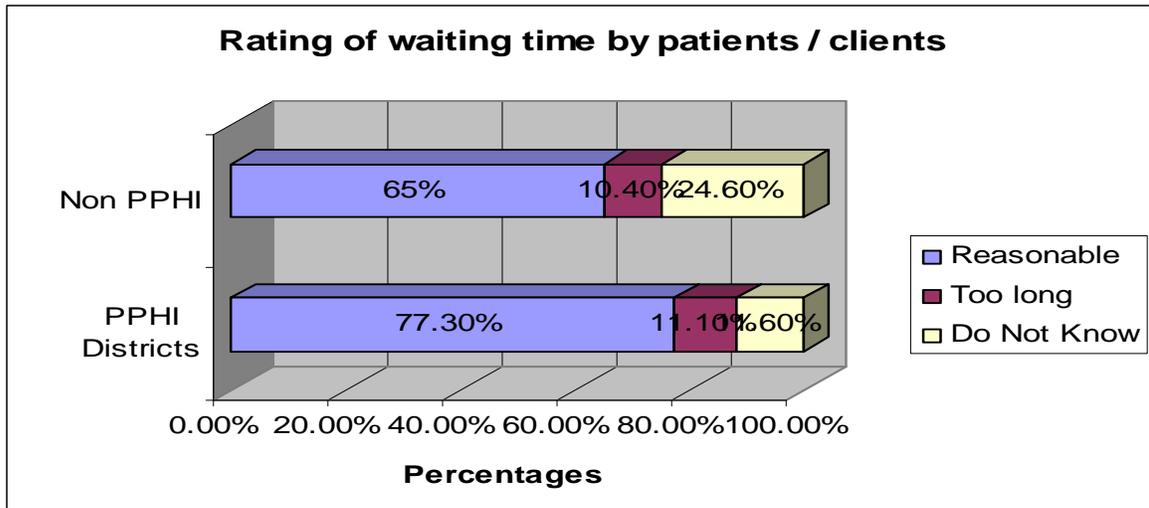
iii:- Fig 3.3:- Use of simple language and provision of privacy to Patients



78% of HCPs from PPHI operated BHUs communicated with patients in simple language as against 72% in non PPHI.

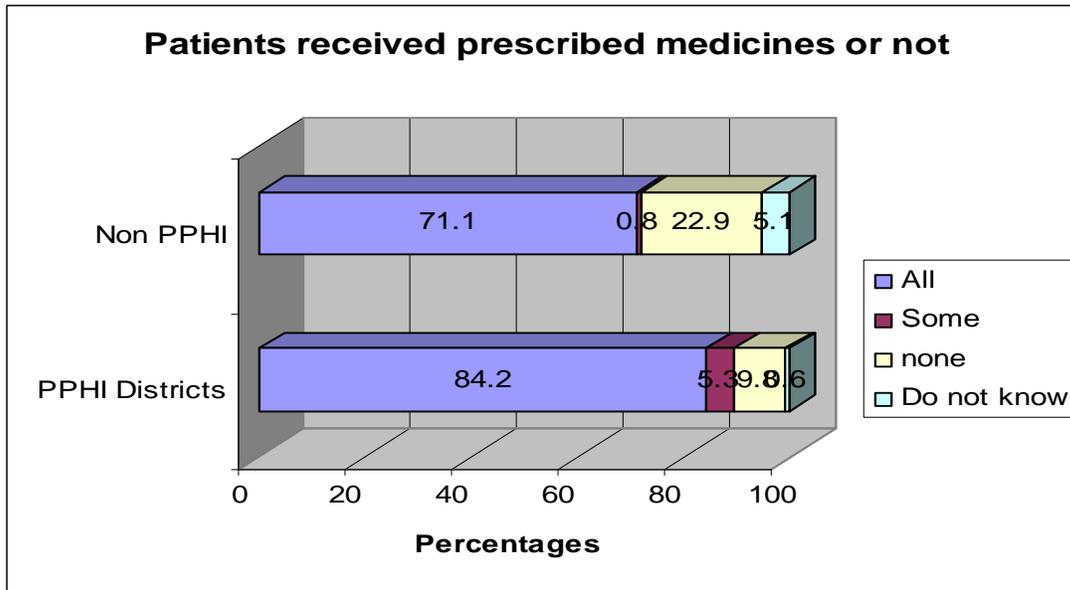
iv:- Waiting Time:

Fig 3.4



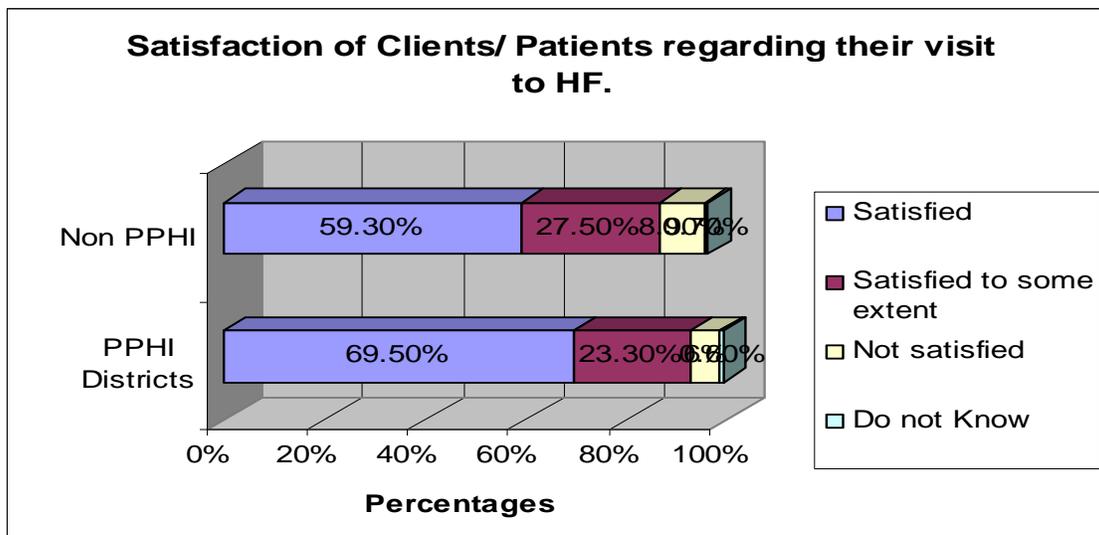
77% patients/clients in PPHI and 65% in non PPHI BHUs described waiting time for getting health service as reasonable.

v:-Receiving of Prescribed Medicines
Fig 3.5



84% patients received prescribed medicines from PPHI managed BHUs as against 71% in PPHI districts.

vi:-Patients/Clients Satisfaction with the Services at BHUs
Fig 3.6



More patients/clients are satisfied (69.5%) with PPHI BHUs than non PPHI (59%).

**Results from Mothers Interviews:
(Community Satisfaction)**

Table 3.3:- Total frequencies of Respondents in PPHI and Non PPHI Districts

	Frequency	Percentage
PPHI District	2967	74.4
NON PPHI	1021	25.6
Total	3988	100

Table 3.4:- District wise frequency of Respondents

Districts	Frequency	Percentage
ABBOTTABAD	361	9.1
CHITRAL	390	9.8
D.I KHAN	269	6.7
KARAK	449	11.3
KOHAT	450	11.3
LOWER DIR	391	9.8
NOWSHERA	421	10.6
PESHAWAR	448	11.2
SWABI	390	9.8
UPPER DIR	419	10.5
Total	3988	100

From 10 districts of NWFP, 3988 respondents took part in interviews, 2967 from PPHI and 1021 from non PPHI districts.

Community data shows that 81% of patients/clients are satisfied with the behavior of BHU staff in PPHI districts as compared to 79% in non PPHI.

Table 3.5:- Community Satisfaction with Behavior of BHU Staff

			districts	
			PPHI	NON PPHI
Satisfied with Behavior Of BHU staff	Yes	Count	1695	497
		%	80.90%	79.00%
	No	Count	270	90
		%	12.90%	14.30%
	Do not Know	Count	129	42
		%	6.20%	6.70%
Total		Count	2094	629

Fig 3.7

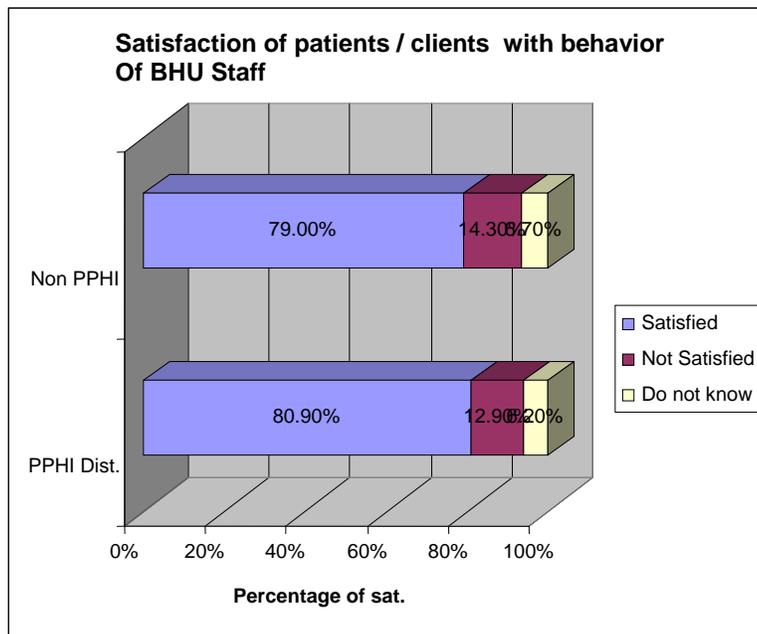
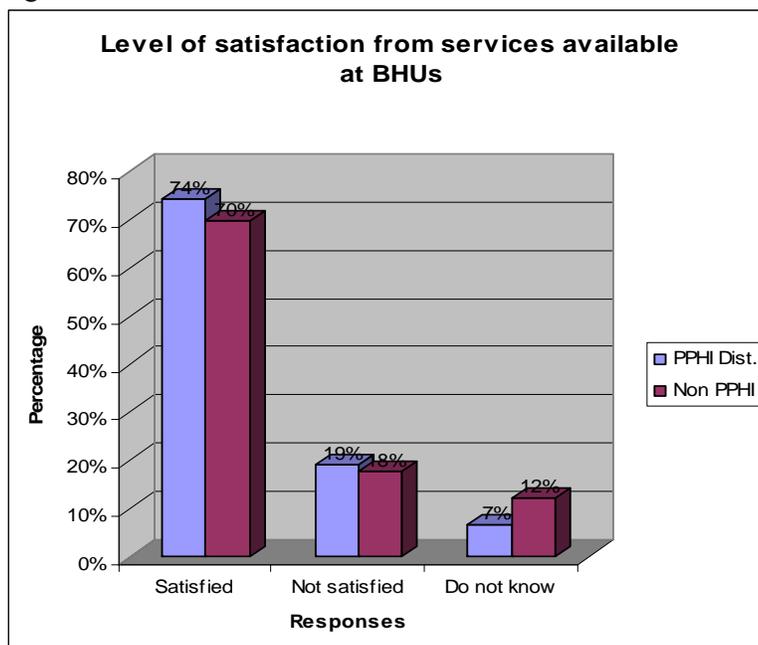


Table 3.6
Community Satisfaction with Availability of Services at BHUs

			Districts	
			PPHI	NON PPHI
Satisfied with services available at BHUs	Yes	Count	1550	441
		% s	74.30%	70.00%
	No	Count	397	112
		%	19.00%	17.80%
	Do not Know	Count	139	77
		%	6.70%	12.20%
Total		Count	2086	630

74% of respondents were satisfied with availability of services at BHUs in PPHI districts and 70% were satisfied in non PPHI.

Fig 3.8



Objective III (cont....)

B:- Community Participation:

Support Group:

i:- Types of SG members interviewed (n = 173)

Table 3.7

Type	%age	Number
Executive members.	24.8%	43
Members	75.2%	130
Total		173

25% executive members and 75% members of Support Group were interviewed in the survey in PPHI managed districts only.

ii:- Preferred place of meeting for SG.(n=173)

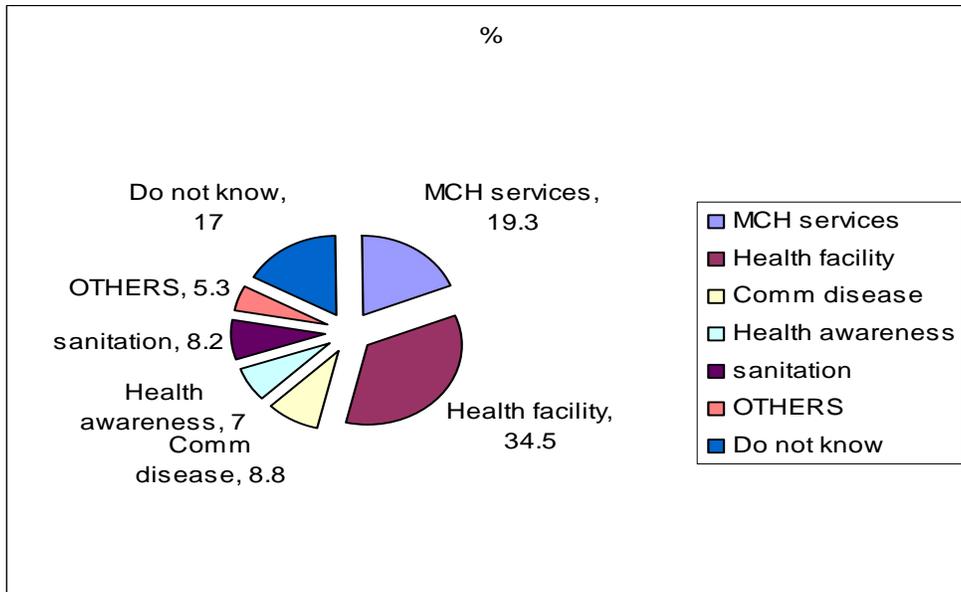
Table 3.8

Place of meeting	%age
BHU	76.9%
Community	5.80%
School	2.30%
Others	3.50%
Do not know	11.60%

Most of Support Group meetings (77%) were arranged at BHUs.

iii:- Issues Discussed in Support Group Meetings:

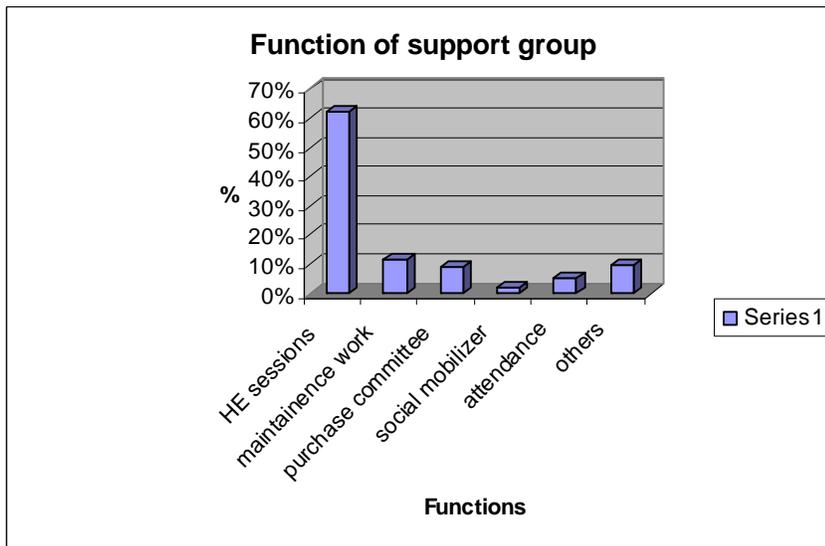
Fig 3.9



In 34.5% of support Group meetings, Health Facility related issues were discussed.

iv:- Functions of Support Group:

Fig 3.10



Main function of Support group was described as conduction of health education sessions in community.

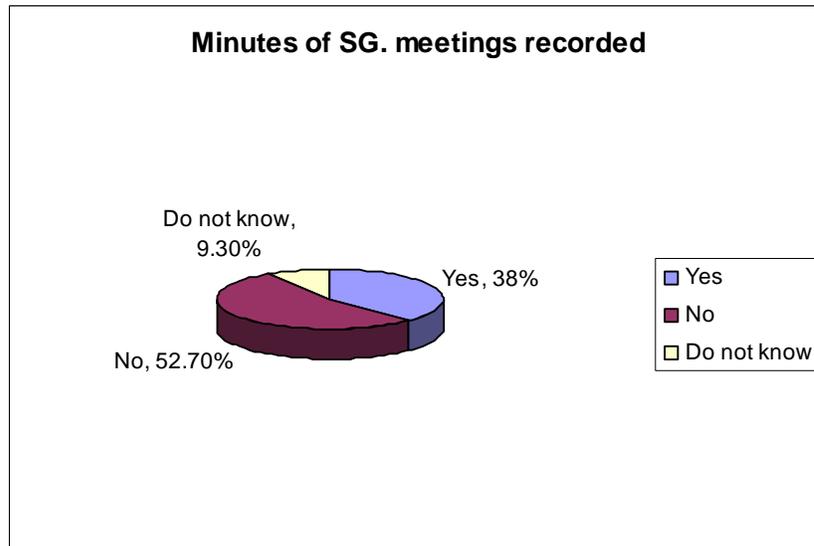
v:- Donations by Support Group Members:

Table 3.9:- Amount of donation either cash or kind (n = 152)

Min.	Rs. 300
Max.	Rs. 50000
Mean	Rs. 9079

vi:- Minutes of Support Group Meetings

Fig 3.11



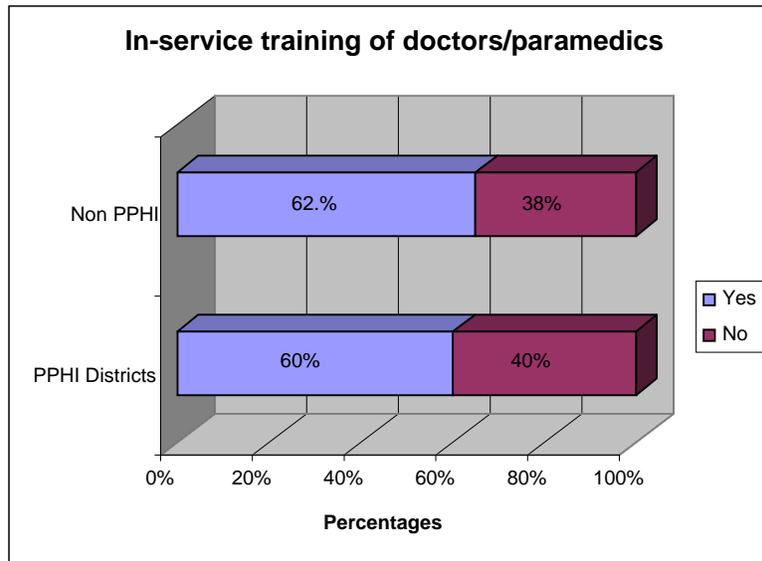
38% of respondents mentioned that minutes of meetings were recorded and 52.7% described no recording of minutes,

Objective IV:

Build the Capacity of Health Workers: In Service Trainings

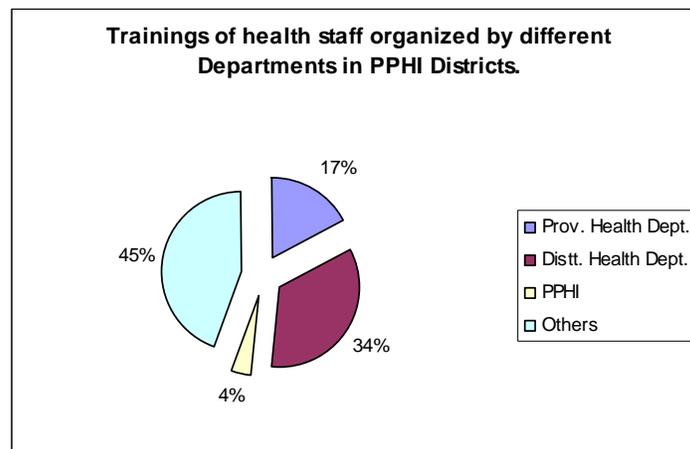
In Service Training of Doctors/Paramedics

Fig 4.1



60% of health staff (Doctors and Paramedics) received training in PPHI supervised districts against 62% in non PPHI districts. 34% and 17% of all trainings were organized by District and Provincial Health Departments respectively.

Fig 4.2



Analysis of Interviews with District Managers:

Executive District Officers, Health (EDOHs) and District Support Managers (DSMs):

It is irony of the fact that the initiative which was undertaken by the NWFP Government in the larger interest of people to provide quality health services to the people through better management has developed a feeling of rivalry across the board. Especially, the people from the District Health Department (DHD) realized President's Primary Health care Initiative (PPHI) as parallel department encroaching upon their domain.

The feelings, attitude and actions are entirely opposite to each other. Environment of non cooperation and lack of coordination prevails all around. Main issues that came on surface are transfer & posting of health staff at BHUs, leave issues, involvement of BHU staff in trainings and activities of vertical Programmes without consultation of others.

PPHI stakeholders are describing their deeds that have been achieved through their management leading to filling of vacant posts of health staff, sufficient and regular supply of medicines and equipment, improving BHU infrastructure, provision of civic facilities and in the last better monitoring and supervision of BHUs.

They claim that under their supervision, health staff availability and punctuality increased and staff became more organized and disciplined.

Combining all those actions, the health care delivery services at BHUs drastically improved reflecting increase in OPD which in turn won the confidence of and trust of the community. Formation of support group and community participation in health and related activities are the success stories.

On the contrary, people from DHD view it differently. Though they accept that there is some improvement in specific areas like increased staff availability and more supply of drugs but other Primary Health Care and vertical Programmes activities have been ignored at BHUs.

PPHI main focus has been to improve OPD and to supply more medicine which has been attributed to more funds allocated to PPHI. Moreover, they have been delegated with more authority regarding hire and fire and recruitment of staff.

Likewise, there appears a complete contrast on reporting issues. District Support Managers (DSM) have mentioned that they have been submitting quarterly HMIS reports and annual audit reports to EDOHs but on the other side there is complete negation in that respect.

The initiative which should have strengthened each other and there should have been augmentation in health activities has been a victim of communication gap and lack of cooperation due to bureaucratic approach.

Focus Group Discussion (FGD):

Two FGDs were conducted at HSRU, Provincial Health Department, Peshawar, NWFP. First group was comprised of 06 representatives from Provincial Health Department, NWFP and second group comprising of 08 persons from PPHI. Both groups were probed to provide an overall idea on issues.

FGD Sessions by Type and Number of Participants in Each Group

	Male	Female	Director General Health	Deputy Program Director	DSM	Doctors	Paramedics	Total
Group-I DoH, NWFP	05	01	01	01	---	02	02	06
Group-II PPHI	08	---	---	01	06	01	---	08

Conclusion: Focus Group Discussion

Prevailing sense of mutual distrust has paved the way for lack of coordination and support. The both sides have viewed each other as rival Departments encroaching upon the jurisdiction of others.

Such rampant environment of non cooperation has initiated undue conflicts like transfers posting of staff and recruitments which could have been settled at district level. Moreover, dispute settlement body, constituted at the National level to resolve issues was never taken to task. More flexibility of rules and regulations was empowered to PPHI to address gaps/limitations in health care delivery system but both sides executed their activities independently thereby waning out the potential effect of joint venture and delay in implementation of innovative activities initiated by either party.

There appeared to be less responsiveness on the part of PPHI with regard to fulfill certain assigned duties under MOU like submission of monthly National HMIS reports and annual audit reports which they were bound to abide by.

Good initiative undertaken by the Government would meet the same fate until and unless all the stakeholders are not involved in the decision making process and making them accountable of their deeds.

Discussion:

Objective I:

Significantly Strengthen the Primary Healthcare System to ensure Delivery of a Standard Package of Preventive, Curative and Promotive Services.

Human Resource Availability at BHUs

The table 1.1 shows that 67% posts of Medical Officer (MOs) and 75% positions of LHVs are filled in PPHI operated districts against 44% and 70% respectively in non PPHI districts. The absenteeism of doctors is same in both groups; however, there is significant difference in LHVs' absenteeism between PPHI (10%) and non PPHI (27%). On the whole, absenteeism in paramedics is more in non PPHI districts.

On an average, MOs and LHVs remained present at their respective BHUs for 20 -22 days during last month in all districts (table 1.2).

Availability of Health Services:

Tables(1.3&1.4) present that PPHI managed BHUs are providing preventive, curative and Promotive services more than non PPHI supervised BHUs. However, preventive services in the field are comparatively better in non PPHI districts.

Utilization of Health Services:

Curative services are being more utilized in BHUs of both groups. Table 1.5 depicts that curative service utilization are 51% of all services in PPHI districts and 38.5% in non PPHI districts. The difference is statistically significant but people have received preventive services more in non PPHI BHUs (29%) as compared to 23% in PPHI managed BHUs.(see tables1.6&1.7)

Monitoring and supervision:

There is no difference in monitoring and supervisory activities carried out by both sides of district managers. Figure 1.3 presents that monitoring visits by EDOH are 30% and by DSM are 31%. However DSM had given feedback (inspection notes, instruction on spot and through letters) of their visits (39%) to their staff at BHUs as against 23% by EDOH.

Objective II:

A:- Significantly Improve the Coverage and Utilization of Services:

Selected Performance Indicators

Survey was conducted to assess health services delivery on 11 selected performance indicators in 10 districts of NWFP as agreed upon under MOU. Data for preventive and curative services was taken from the BHUs as well as from the community through mother and child health questionnaire.

Data on health care services was collected from the BHUs for the months of February, May, August and November of years 2006 and 2008. Considering that health services data for the whole year might not be available at BHUs, hence one middle month from each quarter of the year was selected to represent all quarters of the year. Data so collected was then extrapolated to get yearly figures.

Data from the community was collected to assess two or more antenatal checkups from SBAs, deliveries conducted by SBAs, EPI coverage (BCG, DPT3 and Measles) from catchment area of each BHU in the surveyed districts. Apart from these services, data from community was also collected to assess mother knowledge regarding danger signs of Diarrhoea and Acute Respiratory Infections (ARI) and on personal hygiene like hand washing.

Community satisfaction on the availability, quality of health services and behavior of BHU staff was also assessed through exit poll interviews at BHUs and from the community.

1:- Curative Services:

a:-Number of Consultancies per Person per Year (Outdoor Patients (OPD))

Table 2.1 shows that average outdoor patient number per BHUs per month increased from 463/BHU/Month to 740 pts/BHU/ month in PPHI supervised districts from year 2006 to 2008 against non PPHI districts where mean OPD was registered 271 pts/BHU/month in 2006 and OPD decreased to 259 pts/BHU/month in 2008. There is significant difference ($P = 0.000$) in OPD between PPHI and non PPHI managed BHUs as well as significant improvement in OPD in PPHI supervised BHUs over years.

Average number of consultancies per person per year increased in PPHI districts from 0.39 to 0.66 during period 2006- 2008 and in non PPHI districts it remained same 0.19 visits per person per year.(Table:2.2)

TB- Treatment Success Rate (TSR) - Sputum Smear Positive (SS+):

Tuberculosis (TB) is an old disease prevailing in the world since ages. It is one of the goals amongst others that are to be achieved under MDGs by year 2015. There are around 250,000 new cases in Pakistan every year (NTP). Pakistan stands at 6th position in the world with highest disease burden. Low case detection and poor management of TB cases has lead to increased infectivity and emergence of multi drug resistant TB cases.

TB-DOTS (Directly Observed Treatment Short course) strategy has been adopted by Pakistan National TB Control Programme with the collaboration of WHO to eliminate TB from Pakistan. This strategy has also been successfully implemented in more than 80 countries in the world.

Treatment Success Rate (TSR): it is sum of new smear positive cases cured + new smear positive cases completed treatment out of the total number of new smear positive cases registered. Target is 85% to 100%

Table: (2.26)The TB. treatment success rate in PPHI districts is 93% in 2006 and 94% in 2008 on the other side treatment success rate is 92% in 2006 and 95% in 2008. However, there is no difference (within & between districts) in treatment success rate on both sides over the years. TB treatment success rate target have been successfully achieved by both types of setups.

2:- Preventive services:

Antenatal Care by Skilled Birth Attendants (SBAs)- Community

Antenatal care is one of the important component of MCH related PHC services. Many maternal and neonatal deaths can be averted through provision of proper and timely antenatal services. Though antenatal services from BHUs record shows relatively better antenatal care visits in PPHI managed districts. Table:(1.6 &1.7) Mean Antenatal new cases per BHU per year increased from 299 in 2006 to 376 in year 2008. Whereas in non PPHI districts, antenatal care decreased over period (180 in 206 and 143 in 2008). There is no significant difference ($P=0.349$) in mean antenatal care over the years 2006 to 2008 not only within the PPHI but also between PPHI and non PPHI districts.

Data of community survey of mothers reflects (Table:2.7) that about 85% of women had at least one antenatal visit in both groups. 60% of pregnant women in PPHI districts received two or more antenatal visits during pregnancy from SBAs as compared to 68% in non PPHI districts. Community data for two or more antenatal visits by pregnant women from SBAs does not depict any significant difference in PPHI and non PPHI districts.

Deliveries Conducted by Skilled Birth Attendant (SBA)

Pakistan is a signatory to MDGs and is committed to achieve MDGs by the year 2015. To improve maternal health is one of the goals of MDGs. Of the many factor related to maternal mortality, deliveries attended by skilled birth attendant (SBA) , (includes lady Doctor, LHV, Midwife and Charge nurse) is the main factor in reduction of maternal mortality.

Table: 1.7 shows that data from BHUs reflects the situation of deliveries conducted by SBA's in both types of setup. In PPHI operated BHUs, mean number of deliveries increased from 124 to 225 during years 2006 – 2008. Likewise, in non PPHI supervised BHUs it increased from 94 to 131 during same period. However, both groups have shown some improvement over year 2006 to 2008 but it is not statistically significant ($p=0.129$ & $p=0.170$) Table:1.6.

Community data shows (Table:2.10) that nearly 25% of deliveries in both groups are conducted by relatives. It is important to note that still a large percentage (38%) of deliveries are being undertaken by Dais/TBAs/trained TBAs in non PPHI districts against 27% in PPHI side. However, about 45% deliveries are being conducted by SBAs in PPHI side as compared to 37% in non PPHI districts. The difference is statistically significant ($p=0.002$)

Immunization of Children:

Vaccination services to protect children under one year against 07 communicable diseases are provided through EPI Programme. Immunization of children under one year is very low in Pakistan in spite of availability of large infrastructure (EPI coverage < one year is 60%-PDHS-2008).

Mothers with children under one year were interviewed from the community in all the 10 districts in NWFP to assess the vaccination status of children < one year. Table: 2.13 shows that 55% of them were immunized against Measles in PPHI districts and 63% in non PPHI areas.

It is interesting to note (Fig:2.6) that 80% of mothers in PPHI districts were having vaccination record of their children < 2 years as compared to 72% in non PPHI districts which is quite satisfactory and reflects mother's awareness on EPI Programme.

SN	Indicators	PPHI Districts													
		Peshawar		Nowshera		Kohat		Karak		Chitral		Swabi		Upper Dir	
		Base	Ach	Base	Ach	Base	Ach	Base	Ach	Base	Ach	Base	Ach	Base	Ach
1	** TB Treatment success rate	91	93	97	96	92	98	92	97	95	88	95	92	95	96
2	**TB case detection rate	86	91	61	80	59	64	39	57	79	85	62	73	23	45
3	Fully immunized children before 12 months of age.	--	45	--	65	--	42	--	52	--	69	--	48	--	70
4	Coverage of antenatal care (ANC2)	54	54	56	83	19	33	24	61	44	75	39	42	38	76
5	Proportion of births attended by skilled attendants	41	41	26	51	36	49	38	65	17	38	19	38	17	27
6	*Number of Children <1 Year registered for growth monitoring.	1935	2013	426	2619	1659	1491	714	534	75	723	1785	804	651	2238
7	*Contraceptive Prevalence Rate (modern method)	1737	2394	420	2118	3768	1542	1008	6111	234	5025	1296	1140	5388	2775
8	Number of consultations per person per year	0.25	0.56	0.59	0.81	0.41	0.66	0.42	0.57	0.75	0.92	0.50	0.52	0.55	0.61
9	Proportion of parents able to spontaneously name the danger signs of Diarrhea and ARI and the appropriate response. . (Diarrhea/ARI)	---	Diarrh 48.2	---	0.00	---	0.4	---	0.00	---	0.3	---	0.00	---	0.00
		---	ARI 29.5	---	0.00	---	0.00	---	0.00	--	0.5	---	0.00	---	0.2
10	% of parents who report hand washing with soap after using toilet and before preparing food.	---	Toilet 83	---	82	---	92	---	80	---	66	---	88	---	68
		----	Food 74	---	76	---	63	---	58	---	52	---	47	---	63

BHUs data reflects (Table:1.6) that there is no significant difference in immunization coverage (Measles) in children less than one year in PPHI and non PPHI managed districts over years but there is statistically significant improvement in Measles coverage in PPHI districts from 2006 to 2008.(p=0.000).

Growth Monitoring: To assess the growth of children less than one year his/her weight is recorded at certain intervals according to his/her nutritional status. Every child under 3 years who comes to the health facility must be weighed to check his growth according to the age.

Table: 2.16 presents that registration of children less than one year for growth monitoring increased from an average 70 children/BHU per year to 133 children/BHU per year in PPHI

BHUs during the period 2006 to 2008. Likewise there is small increase in weight recording in non PPHI districts from 150 to 159 per BHU/ year.

Though growth monitoring services at BHUs on both sides are not satisfactory. However, there is significant improvement ($P=0.004$) growth monitoring services in PPHI supervised BHUs over the years 2006 to 2008.(Table:1.6)

Family Planning

Use of any modern contraceptive method by eligible couples (15 to 49 years married women) for birth spacing is 22% in spite of the fact that 96% of the married women know at least one method of family planning (PDHS 2008).

The Table: 2.19 depicts that mean number of family planning cases increased from 173cases/BHU/yr to 243cases/BHU/yr from 2006 to 2008 in PPHI operated districts which is not statistically significant. On the contrary, family planning services remained low in non PPHI districts; 85cases/BHU/yr to 101cases/BHU/yr. Family planning services utilization is poor in all districts.

TB - Case Detection Rate (SS+)- (CDR) is defined as number of new smear positive cases registered during a year out of estimated incidence of new smear positive cases. Estimated Incidence is 81 per 100,000 population.

Table: 2.26 presents that TB Case detection rate was better in non PPHI districts in 2006 (72%) as against PPHI districts (65%) but PPHI has shown improvement in the detection of TB cases in year 2008 (76%) as compared to non PPHI (74%) There is no difference in TB case detection rate.

Table:- District wise Comparison of Key Performance Indicators in PPHI districts:

* Baseline reflects HMIS 2006 reports and achievement has been taken from HMIS 2008 reports.

**District TB-DOTS reports for years 2006 & 2008. Baseline for remaining (EPI, ANC, Deliveries by SBAs & Utilization) from Provincial Indicator Report

Table:- District wise Comparison of Key Performance Indicators in non PPHI districts

SN	Indicators	Non PPHI Districts					
		Abbottabad		DIK		Lower Dir	
		Baseline	Achievement	Baseline	Achievement	Baseline	Achievement
1	**TB-Treatment success rate	94	98	89	92	93	92
2	**TB case detection rate	84	101	66	67	47	74
3	Fully immunized children before 12 months of age.	--	64	--	41	--	60
4	Coverage of antenatal care (ANC2)	71	76	27	42	52	80
5	Proportion of births attended by skilled attendants	26	42	10	35	26	33
6	* Number of Children <1 Year registered for growth monitoring.	1074	711	5205	4359	582	120
7	* Contraceptive Prevalence Rate (modern method)	450	2661	1497	1872	780	303
8	Number of consultations per person per year	0.26	0.22	0.39	0.22	0.64	0.11
9	Proportion of parents able to spontaneously name the dangers signs of Diarrhea and ARI and the appropriate response .(Diarrhea/ARI)	---	Diarrhea 0.3	---	8.6	---	7.2
		---	ARI 0.00	----	4.8	---	10.2
10	% of parents who report hand washing with soap after using toilet and before preparing food.	---	Toilet 88	---	62	---	55
		---	Food 74	---	49	---	43

* Baseline reflects HMIS 2006 reports and achievement has been taken from HMIS 2008 reports

**District TB-DOTS reports for years 2006 & 2008. Baseline for remaining (EPI, ANC, Deliveries by SBAs & Utilization) from Provincial Indicator Report

3:- Promotive services:

Mothers knowledge regarding danger signs of Diarrhoea and Acute Respiratory Infections (ARI)

Morbidity and mortality in children under five years is mainly related to high prevalence of Diarrhoea and ARI. Mortality in children can be minimized if mother could appreciate danger signs of Diarrhoea and ARI and could seek timely medical help.

Mothers with children less than 02 years were interviewed from community about the danger signs in children when they fall ill due to Diarrhoea and ARI. Mothers who answered at least two questions correctly each from Diarrhoea and ARI were considered knowledgeable. In Diarrheal diseases, unconscious or lazy was the most common danger sign followed by repeated vomiting and fever (Table:2.27). Likewise, in ARI unconsciousness, fever and malnutrition were common responses.(Table:2.29). On the whole, there appears no difference in knowledge of mothers regarding danger signs of Diarrhoea and ARI in both PPHI and non PPHI districts. Peshawar has significant difference regarding knowledge of mothers on danger signs of diarrhea (48%) and ARI (29%) as compared to other Districts (tables 2.28 & 2.30).

Hand Washing Practices in the Community:

Many communicable diseases like Diarrhoea, Dysentery, Cholera, Hepatitis, Polio etc spread through feco-oral route which can be prevented by adopting simple habit of hand washing. Health education sessions in the community are conducted by LHWs of National Programme and by support groups organized by PPHI. Mothers from the community were asked about hand washing practices with or without using soap after using toilets and before the preparation of food. Tables (2.31&2.33) that in PPHI, 80% respondents washed hands with soap after using toilet and 62% before the preparation of food as compared to 70% and 56% respectively in non PPHI districts. Hand washing practices using soap were more after using toilet than before the preparation of food. However, there is no significant difference in hand washing practices adopted by mothers in both types of management but it was somewhat better in non PPHI districts.

Objective II (Cont....)

B:- Quality of care

General Cleanliness

General cleanliness means that BHU building and surroundings are free from waste and garbage and things are placed orderly. To be receptive to patient, clean environment has great impact. Clean environment is also conducive to proper working of HCPs as well. It has been

observed that general cleanliness is better in PPHI managed districts (56%) as compared to 28% in non PPHI. The difference is statistically significant $p=0.001$ (Table 2.35)

Menu of Services

Menu of services means the type of PHC services, supposed to be available to patients and clients at BHUs. Generally people do not know the types of services available at health centers.

Fig 2.16 shows display of information regarding availability of PHC services, facilitate people to utilize these services. Though display of PHC services at BHUs was better in PPHI districts (65%) than non PPHI (42%) but it still needs improvement. However, difference is statistically significant ($p=0.010$)

Waste Disposal

On the whole, there was no significant difference in the disposal of hospital waste. Mostly used method for hospital waste disposal was burning and burying the waste in the pit (60% in PPHI and 46% in non PPHI). There were many centers in all the districts (31% PPHI & 42% non PPHI) which were disposing of waste by burning in open space. (Table 2.37),

Use of safety boxes:

Fig 2.18 presents that Safety boxes are used for the disposal of used syringes. The use of safety boxes is more in PPHI operated BHUs (82%) as compared to 53% in non PPHI Districts. The difference is statistically significant at $p = 0.000$.

Knowledge of doctors and paramedics

Doctors, LHV and Dispensers/HT were interviewed to assess their knowledge on Diarrhoea, Pneumonia, neonatal Tetanus and related management. Doctors and paramedics who gave at least 11/15 correct answers were considered knowledgeable. Tables (1.6&2.40) present significant difference in knowledge of Doctors ($p=.004$) and HT/Dispensers ($p=.002$) between PPHI and non PPHI managed staff. PPHI supervised staff (Doctors 82% & Dispenser 71%) has more knowledge regarding Diarrhoea, ARI and neonatal Tetanus and their management as compared to non PPHI (Doctors 68% & HT/Dispensers 47%). However, there is no difference in knowledge of LHVs in both groups.

Maintenance of Medicines store:

- Though medicines were properly maintained (shelved in 82% of PPHI and 65% in non PPHI operated BHUs) but mounting of bin cards and expiry list of available medicines in stores were not displayed in most of the BHUs in both types of districts (30% PPHI and 26% non PPHI). Fig 2.20
- Tables: (2.38&2.39) show that 69% BHUs in PPHI and 53% BHUs in non PPHI districts had selective essential medicines (Tab/syrup Cotrimoxazole, tab Paracetamol, ORS, Chloroquin, Iron & folic acid tab, I/V fluids, Inj. Analgesic & syntocinon, bandages, cotton, disinfectants, contraceptive inj.) at the time of visit;

Availability of Record:

Table:2,41 shows availability of record like OPD registers, vaccination (EPI), Mother Health registers and monthly reports was assessed at BHUs. OPD registers (96% PPHI & 88% non

PPHI) and monthly reports (93% PPHI & 84% non PPHI) were the most available and maintained record.

Infrastructure and Services Availability:

PPHI has given due attention to improve BHU infrastructure and provision of civic facilities like water and electricity. Not all BHUs have improved but there is a significant difference ($p=0.003$) in building condition (64%), availability of water (51%) and electricity (84%) in relation to non PPHI districts (Building 53%, water 37%, electricity 72%). However, availability of functional refrigerator was observed less in PPHI operated BHUs. (Table 2.42)

Availability of Furniture:

Table: 2.43 presents that BHUs in non PPHI districts have better availability of furniture (office table and chairs). However, low priority has been given to seating arrangements for patients. (PPHI 23% & non PPHI 19%)

Availability of Equipment

- Essential equipment (infant & adult weighing scales, stethoscope, BP apparatus, fetoscope, ENT set, thermometer, torch, emergency light, sterilizer and examination couch).
- First Aid Equipment (instrument tray, needle holder, suturing material, suction machine/foot sucker, scissors and drip stand)

These equipments must be available at BHUs and should be functional. Assessment reflected a mixed picture regarding availability of functional equipment in both sides of management. Neither is appreciated in the provision of equipment. The most available and functional equipment are examination couch, BP apparatus, stethoscope and thermometer.

However, Table 2.44 & 2.39 reflect that there is better provision of first aid equipment in PPHI managed BHUs (84%) than non PPHI (70%). The difference is statistically significant ($p=0.000$).

Provision of Privacy and Consultation Time:

Analysis of facility based exit interviews reveals that privacy was observed in the conduction of examination of patients by HCPs more in PPHI supervised BHUs (77% in PPHI & 62% in non PPHI). (Fig: 2.25). Likewise, less time was given to patients/clients during consultation by HCPs in non PPHI operated BHUs (PPHI 44% & non PPHI 52%) Fig 2.26

Examination Conducted during Antenatal Care:

(Fig 2.27) - Four types of antenatal examination were assessed with mother's interviews in the community. Of the four aspects of antenatal examination (Blood pressure, weight, abdominal examination and TT injection) assessed three aspects (BP, TT Injection and weight) were better conducted in non PPHI districts reflecting better quality of antenatal care During ANC examination at health facilities.

C: Equity of access to services:

By Geographical areas:

Keeping in view the geographical accessibility to health facilities the average distance travelled by patients / clients in reaching BHUs is 2.65km in PPHI districts and 2.71km in non PPHI. The distance covered by patient / clients is about same on both sides.(Table 2.45)

Utilization of Health Services by Sex:

Table 2.46 shows that females are the main receiver of health services from the BHUs as 58% of female are getting services from PPHI B Hus and 75% are receiving services from non PPHI BHUs. It is worth mentioning that more females are visiting BHUs in non PPHI districts in spite of the fact that they have to travel a slight longer distance as compared to PPHI to receive the required services.

Objective 'III':

Community Satisfaction:

Patients / Clients satisfied with the behavior of staff at BHUs

Community data reflects that patients/clients satisfaction towards the behavior of BHU staff appears similar in both groups (PPHI 81% & Non PPHI 79%).(Table:3.5)

Putting together all the inputs (availability of health staff, medicines, equipment and knowledge of health staff) and analysis of exit poll reveals that people are more satisfied with the quality of health care provided under PPHI managed BHUs as reflected by increase in curative services OPD.

Analysis of facility based exit interviews reveals that respondents achieved more level of satisfaction after visiting BHUs in PPHI districts (table 3.6). Respondents reflected their satisfaction on the attitude of HCP. Fig. 3.2, the way they communicated and explained the use of medicines to them in simple language (Fig: 3.3) besides the better availability of medicines (Fig:3.5). Moreover patients / clients had to wait for a reasonable length of time in PPHI BHUs Fig. 2.7 and received the expected services more as compared to non PPHI districts Fig. 3.1

On the contrary, data derived from community reflected equal level of satisfaction on the both sides.

Community Participation:

Community support groups have been established in BHUs out of 103 surveyed BHUs in PPHI districts. Total 173 support group members were interviewed, 25% were executive members and 75% were the member of support group.

The over ambitious role of Support Groups (SG) members as envisaged in the formation of SG has not been achieved. Most of the SG members appear to be interested in the affairs of BHUs rather to address the problems/issues of the community Fig3.9. Moreover, there contribution to the uplift of BHUs either in cash or kind and participation in health Promotive activities is also not appreciable. Table 3.9

Health education was described as the main function of support group(Fig.3.10) but it was given least consideration. Fig. 3.11 shows that minutes of meeting were recorded only in 38% of the total meetings.

Objective 'IV': -

Capacity Building of Health Workers:

Capacity building of doctors and paramedics staff is mandatory to keep them abreast with the changing world of knowledge. This would help HCP in the better delivery of quality health services to the people. Fig (4.1& 4.2) show that Doctors and paramedics in non PPHI districts had received relatively more trainings (62%) than PPHI managed staff (60%). Moreover, PPHI contribution in the organization of trainings to HCP is very low (4%). Whereas most of

the credit goes to Provincial and District Health Departments (34% and 37%) and other organizations (45%).

Conclusion

- The assessment reveals that there is improvement in PPHI managed districts in relation to BHUs infrastructure, cleanliness of environment, availability of medicines, record keeping of activities and filling of the vacant positions of doctors and paramedical staff.
- Provisions of preventive services by PPHI districts are comparable to non PPHI districts but there is significant improvement in the provision of curative services in PPHI districts. More consideration has been directed towards the provision of curative services at BHUs by PPHI management.

- Envisaging availability of health Staff ,medicines, equipment and knowledge of Health Care Providers, Quality of Care is relatively better in PPHI managed BHUs.
- Considering collectively, patients / clients are more satisfied with the provision of health services in PPHI managed BHUs.
- The role of Support Group in preventive activities, conduction of health awareness sessions in the community is not commendable.
- There is no difference in Knowledge of Mothers on danger signs of Diarrhoea and Acute Respiratory Infections of children.
- Provincial Health Department, District Health Departments and NGOs have played a major role in Capacity Building of Doctors and paramedical staff.
- Prevailing sense of mutual distrust has paved the way for lack of coordination and support between PPHI and Health Department. Both sides have viewed each other as rival and parallel Departments encroaching upon the jurisdiction of others.
- More flexibility of rules and regulations was empowered to PPHI to address gaps/limitations in health care delivery system but both sides executed their activities independently thereby waning out the potential effect of joint venture and delay in implementation of innovative activities initiated by either party.
- Less responsiveness on the part of PPHI with regard to fulfill certain assigned duties under MOU like submission of monthly National HMIS reports and annual audit reports which they were bound to abide by.
- Though there is comparative improvement in the strengthening of BHU infrastructure and provision of Primary Health Care services but there is no drastic change in health care delivery as envisioned in the implementation of initiative.

Recommendations:

1. Joint monthly review meetings of all district and Provincial stakeholders to resolve issues regarding audit and reporting and to assess progress of activities.
2. Involvement of District Health Department in the process of recruitment, posting and transfer of staff, purchase of medicines, equipment and initiation of innovative strategies at Provincial as well as at district level.
3. There should be unanimous decision on authority regarding writing of ACRs of health staff.
4. Devise strategies at Provincial and District levels that should augment better provision of health care services to the people.
5. Health is a Provincial subject and should remain in the provincial domain to resolve conflicts.
6. Confidence building measures should be adopted through regular meetings and updates at district level under the chair of DCOs.

7. Revisiting of agreement with SRSP addressing administrative/management issues to allay environment of mutual distrust.
8. The third party evaluation concludes that since there is a comparative but not drastic improvement in the preventive & promotive services, therefore, it recommends that PPHI consolidates its achievements further and focus on bringing improvements in preventive & promotive aspects of primary healthcare in existing program districts.

References:

1. Mullan F, Frehywot S. Non-physician clinicians in 47 sub-Saharan African countries.
2. *Heavily indebted poor countries (HIPC) initiative and multilateral debt relief initiative (MDRI) – status of implementation, 28 August 2007*. Washington DC, International Monetary Fund, 2007.
3. *Integrated community-based interventions: 2007 progress report to STAC(30)*. Geneva, United Nations Development Programme/World Bank/World Health Organization Special Programme for Research and Training in Tropical Diseases, 2008 (TDR Business Line 11).

Annexure

Focus Group Discussion
Interviews with EDOHs and DSMs
Survey Tools

Focus Group Discussion (FGD)

Objective of Focus Group Discussion:

1. To get views on whether objectives of PPHI have been achieved or not
2. Staff reaction to program, policies and services.
3. To identify problems, constraints and benefits
4. To obtain more depth of information

Methodology:

Focus Group Discussion (FGD), a widely used procedure for collection of qualitative data has been employed in this study. A focus group interview is a structured group process used to obtain detailed information about a particular topic. It is particularly useful for exploring attitudes and feelings and to draw out precise issues that may be unknown to the researcher

Opinions of respondents from FGDs were utilized to gather data on management experience with private public model, Administrative, financial and HMIS reporting issues. Two FGDs were conducted at HSRU, Provincial Health Department, Peshawar, NWFP. First group was comprised of 06 representatives from Provincial Health Department, NWFP and second group comprising of 08 persons from PPHI. Both groups were probed to provide an overall idea on issues.

FGD Sessions by Type and Number of Participants in Each Group

	Male	Female	Director General Health	Deputy Program Director	DSM	Doctors	Paramedics	Total
Group- I DoH, NWFP	05	01	01	01	---	02	02	06
Group- II PPHI	08	---	---	01	06	01	---	08

Findings:**“Management Experience with Public-Private model”**

Questions	Group – I	Group - II
Roles and Responsibilities	<p>Role should be limited as contractor to fulfill assigned job but PPHI exceeded their role and authority.</p> <p>Rules are flexible for PPHI</p>	<p>Amicably fulfilled roles and responsibilities.</p> <p>Yes, flexibility of rules is there</p>
How successful was experience regarding delivery of health care services	Not satisfactory	<p>Quite successful experience regarding depoliticizing in BHUs affairs, recruitments of staff and enjoyed full support from PPHI higher offices.</p> <p>Due to dearth of doctors, clustering of BHUs has ensured availability of doctors at centers for some days in a week</p>
What should do more to further improve	No comments	Experience has been successful and requires continuity of process
What was the level of Support and Coordination between PPHI, PHD and DHD	Lack of support and coordination from PPHI	Coordination and support from DHD varied from districts to districts but generally it was low

Administrative Issues at Provincial and District Level:

Questions	Group – I	Group - II
Creation of posts and recruitment	<p>No creation of new posts. However, recruitments against vacant positions was carried out by PPHI. No participation / involvement of DHD in the process of recruitment.</p> <p>Recruitment of doctors and paramedics is a technical process and representative from DHD should have been in the</p>	<p>No creation of new posts.</p> <p>According to MOU recruitments were to be made by district recruitment committee constituted by PPHI.</p> <p>No representative from DHD was included in the committee as it was not mentioned in MOU.</p> <p>Recently, PHD has desired to be a part in recruitment process.</p>

	recruitment committee	
Transfer and posting of staff.	Transfers and posting of staff from BHUs by DHD were not acknowledged by PPHI	<p>Transfer of staff within the district by DSM.</p> <p>If any regular member of health staff interfered in the smooth functioning then he was placed at the disposal of EDOH and new person was recruited at his/her place by PPHI.</p> <p>Transfers of regular staff were carried out by EDOH without intimation/consultation of DSM though EDOH was not empowered to transfer staff from BHUs under MOU.</p>
ACRs of staff.	Dispute in writing ACRs of staff between DHD and PPHI. No clear decision in this regard	ACRs of staff are being written by DSM and countersigned by Program Director PPHI.
What type of disputes arose during the implementation process and how they were settled?	<p>Non responsiveness of staff recruited by PPHI towards DHD supervisors.</p> <p>Lack of coordination among DHD and PPHI staff at facility level.</p> <p>No dispute settlement and no issue was taken to steering committee fearing that there was no representation from DoH in the committee</p>	<p>Disputes were somewhat settled at district level mainly with the help of DSM and DCO. No support from EDOH.</p> <p>No dispute was taken to steering committee as it was a tedious process.</p>

.Financial Issues:

Questions	Group – I	Group - II
Regarding provision of Budget	Budget of BHUs is transferred as one line to DSM directly from District Finance Department	Quarterly released by District Finance Department as one line transfer
Salary (Funds Transfer)	Salary of regular staff at BHUs is being paid by DHD. Great difference in salary package of regular and contract employee by PPHI thereby causing frustration among regular staff	Salary of regular staff at BHUs is being paid by DHD. There is a difference in salary package. Staff is better paid.
Incentives to staff	No provision of incentives to doctors and paramedical staff under Government rules.	Incentives are given to good performers after approval from National level (NPD)
Purchases (Medicines, Equip, Furniture)	<p>No consultation of PPHI with DHD regarding purchase of medicines.</p> <p>Rate contracts for purchase of medicines are made by PHD after fulfilling all codal formalities and districts place their demand for medicines to approved firms.</p> <p>Other departments also use rate contracts of PHD but PPHI never used.</p> <p>PPHI purchase medicines directly from market</p>	<p>Purchase quality medicines after fulfilling codal formalities laid down by Government but do not consider lowest market rate.</p> <p>Also select medicines from the approved list of PHD, other Departments even of other provinces.</p> <p>Six fold increase in budget for medicines at BHUs by the efforts of PPHI.</p>
Audit.	No annual Audit report was submitted to DHD by DSM as agreed upon in MOU.	No annual audit report was shared with EDOH in respective districts; however, both year audits reports will be submitted.

Reporting Issues:

	Group – I	Group - II
HMIS Reporting Regularity.	Monthly National HMIS reports were not submitted to EDOH. PPHI made separate data collection tools other than National HMIS.	Regularly submitting National HMIS reports to respective EDOH though they have also developed their own reporting tools in addition to HMIS.
Sharing Analysis of HMIS Reports	No sharing/ exchange of analysis of National HMIS reports. Last report which is available on PPHI website is of first quarter (Jan-March 2009) whereas there should be 3 rd quarter report	PPHI do analyze reports but there is no culture of analysis of reports by DHD. PPHI analyses reports quarterly and submit reports to PHD, DCOs and EDOHs

Summary and Conclusions:

Summarized below are the overarching themes and underlying attitudes woven throughout the FGD discussions. Some of these represent major challenges and have critical implications for managing and improving activities.

Analysis of Findings:

The information obtained through the above discussions provided insight into various issues as well as helped in identifying areas of concern.

Co-ordination:

There appears to be environment of non cooperation, lack of coordination and support not only in the district but also at the provincial level. Ideally, it should be joint venture and both DHD and PPHI should augment each other activities to deliver better health care services to people but there is general expression as if two parallel departments are working to achieve the same task.

There is, however, concurrence of opinion between the groups about the flexibility of rules and regulation empowered to PPHI under MOU which “should have potentiated health activities” on either side, have been perceived as enmity. As perceived initially that flexibility of rules empowered to PPHI would help each other to fill the gaps in health care delivery system but feelings of envious crept in over time thereby leading to “*mutual distrust*”.

PHD views are “*PPHI people have exceeded the assigned authority as contractor*” whereas, other think “*they are more active and this is reaction to their positive actions*”.

Attitude and behavior of district management have strong influence on productivity of lower staff. Conflicts at higher levels caused disruptions in better delivery of health services at lower level as the essence of rivalry and non cooperation trickled down to lower staff as well.

Moreover, some important issues like role of DHD in recruitment of staff, purchase of medicines, ACRs of staff and new initiatives undertaken by either side were not addressed in MOU which further widened the gap.

PPHI has taken an initiative to establish labor rooms and provision of ultrasound machines in BHUs. *“But they have not taken Provincial Health Department into confidence regarding the ultimate fate of initiative when the contract would be over”*.

However, *“in a few districts there have been better level of coordination depending on rapport and understanding of both district managers”*.

Transfers and Postings:

Doctors and paramedic staff is recruited at district level by district recruitment committee constituted by Program director, PPHI with no representation or consultation from DHD. *“Provincial health Department (PHD) has recently raised voice to include his representative in the recruitment committee”*.

Decisions taken by district managers regarding transfer and postings of staff are not honored due to mutual distrust. Point of view of both groups is quite distracting.

Purchase of medicines:

Purchase rules are flexible for PPHI and *purchase quality medicines from reputable firms after observing codal formalities and condition of lowest market rate is not consideration for them* which is a binding on the other side.

Rate contracts for the purchase of medicines are finalized by PHD at Provincial level. *PPHI, however, also uses approved rate lists of medicines from other Departments apart from their own list whenever deemed necessary.*

Pay and Incentives:

Though salary is being paid to regular and contract staff by the respective Departments but there is huge difference in salary package of doctors. A regular doctor from PHD is getting salary of Rs 14000/month against a contract doctor from PPHI who is receiving salary around 40,000/month. Difference in pay package is also causing frustration among regular doctors.

PPHI doctors are mobile and looking after cluster of 02 to 03 BHUs on rotation basis to provide services in areas where no doctor is available whereas regular doctor is performing duties at one BHU. *Both groups, however, realized the salary difference of doctors.*

Moreover, there is no provision of incentives for good workers in PHD. On the contrary, PPHI gave monetary incentives to their good performers though process is tedious and permission has to be taken from National level.

Submission of Reports:

Two types of reports are to be submitted to DHD by DSM under signed MOU. One is National HMIS report on quarterly basis and other is annual audit report

No opinion could be derived regarding HMIS report as both groups' *views were completely opposite. No guidelines were given to PPHI by PHD/DHD.* PPHI has also developed their own tools of data collection as well.

The annual audit reports were not submitted to EDOHs which was the responsibility of DSMs even after two years. PPHI expressed that they *have received annual audit reports late so both years audit reports will be submitted to respective EDOHs soon.*

In the absence of reports, information can not be derived from data for action oriented planning and decision making.

Conclusion:

Prevailing sense of mutual distrust has paved the way for lack of coordination and support. The both sides have viewed each other as rival Departments encroaching upon the jurisdiction of others.

Such rampant environment of non cooperation has initiated undue conflicts like transfers posting of staff and recruitments which could have been settled at district level. Moreover, dispute settlement body, constituted at the National level to resolve issues was never taken to task. More flexibility of rules and regulations was empowered to PPHI to address gaps/limitations in health care delivery system but both sides executed their activities independently thereby waning of the potential effect of joint venture and delay in implementation of innovative activities initiated by either party.

There appeared to be less responsiveness on the part of PPHI with regard to fulfill certain assigned duties under MOU like submission of monthly National HMIS reports and annual audit reports which they were bound to abide by.

Good initiative undertaken by the Government would meet the same fate until and unless all the stakeholders are not involved in the decision making process and making them accountable of their deeds.

Interviews with District Managers regarding PPHI Initiative

1- Advantages of Handing over BHUs to PPHI

District Support Managers(DSM)

The basic aim was to provide Primary Health Care that is accessible, responsive, efficient and effective in meeting health care needs.

Under the perspective of PPHI, many innovative steps have been taken to provide wide range of services including availability of staff and medicines, improvement of infrastructure and community involvement.

- Increased availability of medics and paramedic staff through filling of vacant posts and ensuring their presence by regular monitoring and supervision.
- Infrastructure of health facilities improved a lot with the availability of water, electricity and establishment of labour rooms at BHUs.
- Sufficient quantity of medicines remained available at Health centers round the years and necessary equipment was supplied at all BHUs.
- Staff is disciplined and maintaining proper record of all health activities.
- Community is motivated and participates in health awareness programmes and related activities through the formation of support groups.
- Health care delivery services especially OPD increased many folds during the period.
- Political interference in BHUs affairs has been minimized to negligible level.
- Above all, efficient use of resources has resulted in the provision of better Primary Health Care service that is accessible in terms of staff, medicines and equipment availability, responsive with increased sense of responsibility and discipline.

Provision of quality health services has gained the confidence and trust of community and facilitated the under privileged to a great extent.

Executive District Officer Health (EDO(H))

A few were of the opinion that though there was some improvement in the regularity and presence of staff and availability of medicines but that was mainly due to more authority assigned to District Managers and increased availability of funds for purchase of medicines and repair of health centers.

2:- Disadvantages of Initiative

District Support Managers (DSM)

Absolutely no problems / obstacles and if there would be any so would be tackled amicably.

EDO(H)

On the contrary, it is viewed as “parallel administration comprising of non-technical persons who are running the health affairs”. Their main focus is to increase OPD and tempering of data. Other primary Health Indicators, TB, EPI and Malaria are mainly ignored. BHU Staff is

not permitted to participate in trainings and national level activities like anti-polio National campaigns organized by District Health Department. Health Staff at BHUs is confused to whom they are accountable. District Health Department faced difficulties to detail health staff from BHUs in emergency situations.

3:- Working Relationship

DSM

Most of them described their relationship as “satisfactory” though they have some level of communication gaps and lack of coordination.

EDO(H)

Lack of coordination and non-cooperation from PPHI “has made state within state and BHU Staff is instructed not to participate in trainings of vertical Programmes”. EDO(H) is responsible in the provision of preventive health services in the district on the whole but has no authority on BHU Staff, thereby preventive services are affected. A few have described their relationship with PPHI “satisfactory to some extent” but issues are the same.

4:- Administration Issues

DSM

Accusation prevails on both sides regarding administrative issues. PPHI people have reflected their concern that staff from BHUs is engaged in activities without prior intimation and consultation. Moreover, there is no administrative control over regular staff at BHUs, hence, no disciplinary action can be taken against regular staff on breach of discipline.

EDO(H)

Main issues are transfer and posting of staff, leave sanction, capacity building of staff from BHUs, DSM enjoys more powers for hiring and fire. Lack of coordination and decreased involvement of PPHI in training programs, data sharing and NIDs/TB programs.

5:- Reporting Frequency & Issues

DSM + EDO(H)

Views are entirely contradictory. Whereas, PPHI described submission of quarterly HMIS reporting to District Health Department, the other group explained that only disciplinary and leave cases are brought into notice and submission of HMIS quarterly reports were not satisfactory and DSM send HMIS reports to provincial PPHI office.

6:- Audit

DSM + EDO(H)

There appeared some discrepancy on PPHI side regarding submission of annual audit reports to EDO(H) as statements vary from submission of one or two audit report to “no submission”.

In contrast, there was complete denial by District Health Department in that respect as “Not a single annual audit report was submitted to EDO (H).”

7:- Health Initiatives undertaken by PPHI

DSM

Initiatives have been undertaken by PPHI regarding posting of doctors and LHVs. Clustering of BHUs and rotation of doctors in more than one BHUs to cope with shortage of doctors.

Formation of community support group and conduction of health education sessions in the community were new initiatives besides the availability of more medicines, equipments and civic facilities.

Strengthening of Primary Health Care through staff trainings and establishment of labour room at BHU level.

EDO(H)

Most of EDO(H) had no knowledge about health initiatives undertaken by PPHI due to lack of interaction.

8:- Health Service provision issues

Non-cooperative and lack of coordination has jeopardized effective health care delivery system at the health facility as well as at community level.

PPHI focus on provision of preventive health services like TB, Malaria, EPI appeared less promising.

9:- Feedback on HMIS

Again there was contradiction on that respect and there was disagreement on submission and receiving of HMIS feedback.

Whereas, DSM was giving feedback on HMIS monthly reports to BHUs staff, most of the EDOHs were not apprised of the fact.

10:- Financial issues

As such, there were no financial issues as both the systems were operating separately. However, District Health Departments were mainly concerned with the availability of ample funds and more authority empowered to DSMs.

11:- Human Resource Management Issues

Human Resource Management and administrative issues appeared to be bone of contention between DSM and EDO (H) leading to lack of coordination and cooperation. Both sides blamed each other on issues regarding transfer, posting of staff, involvement of BHU staff in polio activities, sanctioning of leaves to regular staff, taking disciplinary actions against defaulters and sparing of BHU staff for trainings organized by District Health Department.

12:- Working of BHUs under PPHI

DSM

With provision of civic facilities, increased availability of health staff, medicines and equipment and conducive environment of BHUs had brought significant changes in better delivery of Primary Health Care Services especially OPD and exerted a positive impact on the community, thereby community participation increased in health and related activities.

EDO(H)

Though, medicine supply and OPD gone up at BHUs but it was attributed to more availability of funds to PPHI. It is also viewed as there was “no improvement in quality rather BHUs had converted into drug distribution centers to increase OPD. PPHI ignored the point for which BHUs were handed over.

13:- Benefits to Staff

DSM

Hard area allowance / semi hard area allowance / special allowance have been granted to doctors and paramedical staff. Capacity building of staff and conducive environment changed their attitude, motivated them and community developed trust on them.

EDO(H)

Easy recruitment procedures for doctors and paramedical staff and better salary package.

14:- Disadvantages to staff

DSM + EDO(H)

- Difficulty in getting leave
- Decreased chances of capacity building as BHU staff is instructed not to participate in DHD trainings.
- No TA/DA to BHU Staff
- Confusion of Staff – Staff at BHU are answerable to EDO(H) for EPI, Malaria, TB, LHW Program and PPHI staff resists the involvement of staff.

Conclusion, Interviews-

Executive District Officers, Health (EDOHs) and District Support Managers (DSMs):

It is irony of the fact that the initiative which was undertaken by the NWFP Government in the larger interest of people to provide quality health services to the people through better management has developed a feeling of rivalry across the board. Especially, the people from the District Health Department (DHD) realized President's Primary Health care Initiative (PPHI) as parallel department encroaching upon their domain.

The feelings, attitude and actions are entirely opposite to each other. Environment of non cooperation and lack of coordination prevails all around. Main issues that came on surface are transfer & posting of health staff at BHUs, leave issues, involvement of BHU staff in trainings and activities of vertical Programmes without consultation of others.

PPHI stakeholders are describing their deeds that have been achieved through their management leading to filling of vacant posts of health staff, sufficient and regular supply of medicines and equipment, improving BHU infrastructure, provision of civic facilities and in the last better monitoring and supervision of BHUs.

They claim that under their supervision, health staff availability and punctuality increased and staff became more organized and disciplined.

Combining all those actions, the health care delivery services at BHUs drastically improved reflecting increase in OPD which in turn won the confidence and trust of the community. Formation of support group and community participation in health and related activities are the success stories.

On the contrary, people from DHD view it differently. Though they accept that there is some improvement in specific areas like increased staff availability and more supply of drugs but other Primary Health Care and vertical Programmes activities have been ignored at BHUs.

PPHI main focus has been to improve OPD and to supply more medicine which has been attributed to more funds allocated to PPHI. Moreover, they have been delegated authority regarding hire and fire and recruitment of staff.

Likewise, there appears a complete contrast on reporting issues. District Support Managers (DSM) have mentioned that they have been submitting quarterly HMIS reports and annual audit reports to EDOHs but on the other side there is complete negation in that respect.

The initiative which should have strengthened each other and there should have been augmentation in health activities has been a victim of communication gap and lack of cooperation due to bureaucratic approach.



FIRST LEVEL CARE FACILITY INFORMATION (BHU) QUESTIONNAIRE

Name of District _____ Date of Visit: _____

BHU (name): _____ No. of BHU _____

Name of Incharge: _____ Designation _____ Sign of I/C _____

Name of Interviewer: _____ Sign _____

Name of Supervisor _____ Sign of Supervisor _____

Section 1: Availability

(To be asked from the incharge of the Facility)
(if any information is not available at the facility level, it may have to be obtained at the district from EDOH office or PPHI district office/ Provincial Offices):

1.1 Catchment area Population (data source Monthly HMIS report)

Projected Population: in year 2006 _____

Projected Population: in year 2008 _____

General Information:

(Tick the appropriate response).

What is the situation of general Cleanliness of Health Facility.? (Observe)

Good Satisfactory Unsatisfactory

Is the type of Health Care Services available at Health facility displayed at prominent place for the information of general public? (Observe)

Yes NO

Is Health facility working hours (timings) displayed at prominent place? (Observe)

Yes NO

Is there any syringe cutter/safety box available for disposal of used syringes?

Yes NO

Is there a system of hospital waste disposal in the health facility?

Yes NO

If yes, then how it is disposed off (Verify)

- 1- Burning in open space 2- Burning & burying in ditch/pit
 3- Collected & send for disposal as general waste 4- Others

1.2**Does this BHU offer the following Services?**

(Tick the appropriate response).

Type of Health Care Services at BHU	Offered	
	Yes	No
General Curative Care		
Antenatal Care		
Delivery Services		
Post natal care		
Growth Monitoring		
Nutritional Advice		
Expanded Program on Immunization (EPI)(center)		
Family Planning Services		
Health Education		
First Aid		
TB-DOTS		

Field Visits in Catchment Area by Facility Staff	Offered	
	Yes	No
Antenatal		
Midwifery (delivery)		
Postnatal care		
Family Planning		
Health Education on Nutrition, Hygiene & sanitation		
EPI		
Others		

Section 2: FLCF Management

(To be asked from the Incharge of the Facility.)

2.1**Availability of medical staff**

Data Source: Attendance Register (write number or tick in the respective column)

<i>Type of Staff</i>	<i>No. sanctioned</i>	No. Filled	No. Absent	On Leave	Govt duty	Days Present in last month
A. Technical						
MO						
Medical Assistants/ Medical Technician						
Female medical / Health Technician						
LHV						
Midwife/Dai						
Malaria Supervisor						
EPI Technician (Vaccinator)						
LHWs						
Others						

<i>Type of Staff</i>	<i>No. sanctioned</i>	No. Filled	No. Absent	On Leave	Govt duty	Days Present in last month
B. Support						
Naib Qasid						
Sanitary worker						
Chowkidar						
Bahashti						
Other						

2.2 In-service Training and Supervision:

(Tick the appropriate response)

	<i>Yes</i>	<i>No</i>
Have you attended any training courses during the year 2008		
If yes, names of trainings		
Trainings organized by 1 – Provincial Health Department 2- district Health Department 3- PPHI/SRSP 4- Other organizations		
Has any of your staff attended any training courses during the year 2008		
If yes, names of trainings		
Trainings organized by 1 – Provincial Health Department		

2- district Health Department 3- PPHI/SRSP 4- Other organizations		
Do you have any health manuals / books on office record		
If yes, then please specify 1- HMIS 2- TB 3- National Program 4- book on Health Standard 5- others (tick after verification)		
Do you have any person who regularly monitors and supervises your work		
If yes, did they visit your facility during the last three months (verify from Inspection / visit book/ attendance register) write no. of visits against each 1- EDOH ----- 2- District/Tehsil Coordinators ----- 3- DSM ----- 4- PPHI monitoring officer ----- 5- PPHI Social Organizer----- 6- others-----		
Did they give any feedback of visit (letter, inspection notes). Please verify		

2.3 Availability of Management Protocols

Inquire whether standard treatment / management protocols are available for the conditions given below. If yes, verify and tick the appropriate column.

<i>Case Management Protocols on</i>	<i>Displayed</i>	
	<i>Yes</i>	<i>No</i>
*Diarrheal disease		
*Acute respiratory tract infections		
Malaria (or other endemic disease priority)		
Antenatal care		
Delivery care		
*Family Planning		
Tuberculosis (TB)		
Childhood malnutrition		
Other priority disease problems (specify)		

2.4 Drug Management

(Tick the appropriate response)

Do you receive drugs from Medical Stores of District Health Office/PPHI Office?

District Health Office / PPHI District Office

When did you place demand for drugs last time: Date _____

Did you receive your demand for drugs: Yes / No / DNK

Do you generally receive your medicine order within?

1- 02 Weeks 2- 02 – 04 weeks 3- more than 04 weeks

Do you receive medicines as per demand: Yes / No

How long does it usually last: _____ weeks?

In medicine store, check the followings,

Medicines Bin cards are filled and displayed. Yes / No

Expiry list of medicines displayed in store. Yes / No

Medicines are properly placed in store (on shelf, if on ground then something placed under the medicines). Yes / No

How medicines are transported from District office to BHU

1 - District Office Vehicle 2 – by facility Staff 3 - Others

2.5 Planning and Management

(Tick the appropriate response)

	<i>Yes</i>	<i>No</i>
Do you have job descriptions for your technical staff (If yes, ask to see)		
Do you have a job description of yourself (If yes, ask to see)		
Do you hold meetings to discuss schedules and programs with facility staff? If yes, check the last one from record (meeting register).		
Do you develop schedules of planned activities (If yes, ask to see the one for the present period of EPI & LHV/FHT field visits)		
Did Incharge of facility evaluate health activities and take appropriate steps accordingly. If yes, verify from the record.		

2.6 Information on Records

Are records available that provide information on followings (Tick the appropriate response)

Type of Record	Yes	No
No. of out-patient visits (verify from OPD register)		
No. of follow-up visits (old cases) (verify from OPD register)		
Child immunizations record is maintained (EPI Register)		
Antenatal Care (from Mother Health Register)		
Delivery Care (from Mother Health Register & Birth Register)		
Postnatal Care (from Mother Health Register)		
Tetanus Toxoid immunization to pregnant women (verify from record)		
Field Visit activities of facility staff (visiting Register/ reports)		
Are monthly / periodic reports made and submitted to the district / next higher administrative Office (check last month HMIS report)		
Is the data on progress of health services graphically displayed in the office of Incharge. (Check display of Data at least 02 charts)		

Section 3: FLCF physical inventory

(Tick the appropriate response. Before marking Tick, verify the responses)

3.1 Buildings

Main Building	Yes	No
Is the main building generally in good condition		
In the main building(s) are any of the walls, floor(s), roof(s) in need of repair		
Are all the rooms clean		
Can all of the doors and windows be securely locked		
Is there a functional latrine for patients use		
Is it clean and usable		
If a refrigerator is available, has it been working uninterruptedly over the past 04 weeks		
Has there been a constant supply of water in, or convenient to the facility over the last three months		
Is there a refuse pit on the grounds for disposal of solid wastes / rubbish		
Are the grounds around the main building free from rubbish, waste, bushes?		
Are any of the staff quarters in need of repair		
Is the Electricity available in the health facility:		
Are utility bills regularly paid and updated.		

3.2 Stationery, Furniture and Utensils

Check for the presence and integrity of each of the following pieces of furniture and utensils.
 (Tick the appropriate response)

Furniture / Utensils	<i>Available</i>	<i>Functional</i>	<i>non Functioning</i>	<i>Not Available</i>
General Stationery				
Detergents & Soaps				
Towel				
Seating arrangements for patients in waiting area				
Large water container (hammam)				
Lockable cabinet / cupboard				
Office tables				
Office chairs				
Health education material is available in respective offices				

3.3 Equipment and Instruments

Check for the presence and integrity of each of the following pieces of Equipment (Tick the appropriate response)

<i>A. Outpatient Department</i>	<i>Available</i>	<i>Functional</i>	<i>non Functionin g</i>	<i>Not Available</i>
Vaccine Carriers				
Infant weighing scale				
Adult weighing scale				
Stethoscope				
Fetoscope				
Blood pressure apparatus				
ENT set				
Thermometer				
Torch				
Emergency light				
Tongue depressor(s)				
Tape measure				
Sterilizer				
Examination couch				
First Aid Equipment				
Instrument tray				
Kidney bowl				
Lotion bowls				
Dressing forceps				
Needle holder				
Suture needles				
Suture materials				
syringes (< 05 cc>)				
Suction machine/foot sucker				
Scissors				

Scalpel handle				
Scalpel blades				
Drip Stand				

3.4 Drugs and supplies

Check for the presence and integrity of each of the following drugs / supplies in the FLCF pharmacy/store **on survey date** and Tick the appropriate response.

Drugs and Supplies	Store			Drugs and Supplies	Store		
	Availa ble	Not Availa ble	Days stock out in last month		Availa ble	Not Availa ble	Days stock out in last month
Adhesive tape				*Tetanus Toxoid			
Bandages				*BCG vaccine			
Cotton				*OPV vaccine			
Gauze				Penta vaccine			
Disinfectant				*Measles Vaccine			
Paracetamol				*EPI Disposable syringes			
Ophthalmic ointment							
*Cotrimoxazole tab/Ampicillin Cap				*Condoms			
*Cotrimoxazole syrup/Ampicillin syrup				*Oral Contraceptive Pills			
*Oral rehydration salts				*Contraceptive Inj			
*Chloroquine/ Primaquine				*IUCD			
*Iron tablets				*Folic acid Tab			
Anti-helminthic tablets				*Streptomycin Inj			
IV fluids				*Isoniazid tab (INH)			
Inj. Solu cortef				Inj. analgesic			
Inj. Antihistamine				Inj syntocinon			
Inj. Adrenaline							

*enlisted in monthly HMIS report

Section 4: Health Facilities Activities

Instructions:

1. Use records only for the assessment
2. Put numeric value in the respective month column
3. Mark NR where no record is available
4. If the information is not available at the facility level, it may have to be obtained at the district/province HMIS Cell:

4.1 Outpatient Care:

Total number of **outpatient visits** (new +old) to the BHU.
 (data source: HMIS - Monthly report/OPD register)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

4.2 Maternal Health Activities

Antenatal Care

Number of Pregnant women Newly registered for **antenatal care** visits by skilled Health Care Provider at BHU.
 (data source: HMIS - Monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

4.3 Delivery Services:

Number of **Deliveries conducted by skilled birth attendants** (excluding TBAs/ Trained TBAs) at BHU.
 (data source: HMIS - Monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

4.4 Family Planning Services:

Number of clients who used **modern contraceptive** methods from BHU.

(data source: HMIS - Monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

Child Health Activities:

4.5 Immunization Coverage

- Number of **BCG immunizations** given to children under one year in BHU catchment area population/ Union Council.

(data source: HMIS - Monthly report/EPI - monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

- Number of **DPT3/Combo immunizations** given to children under one year in BHU catchment area population/ Union Council.

(data source: HMIS - Monthly report/EPI - monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

- Number of **Measles immunizations** given to children under one year in BHU catchment area population/ Union Council.

(data source: HMIS - Monthly report/EPI – monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

4.6 Growth Monitoring:

Number of Children less than one year newly **registered for Growth Monitoring** at BHU..

(data source: HMIS - Monthly report)

Year 2006				Year 2008			
February	May	August	November	February	May	August	November

Section 5: Quality of Care (Health Staff Knowledge)

Knowledge testing

Indicate which of the following was being tested by assigning a number from 1 to 4 to the respective cadre: Medical Officer; () LHV; () Dispenser/ H. Technician (); other ();

Record the results obtained with each candidate by taking the answer given underneath each health worker's identification number. Mark responses by Y=Yes and N=No

What are the signs of severe dehydration in a child under five years?

(Mark the responses given by a candidate in table below against his/her number and should not be read out).

Health worker's Identification Number				Responses
1	2	3	4	
				Sluggish or unconscious
				Sunken eyes
				Difficulty in drinking or can not drink
				Skin pinch goes back very slowly

How do you manage simple / moderate diarrhea in a under five year child:

Health worker's Identification Number				Responses
1	2	3	4	
				Rehydration with ORS
				continue breast / Other feeding
				Extra Fluids

Name two important signs and symptoms of neo-natal tetanus:

Health worker's Identification Number				Responses
1	2	3	4	
				Inability to suck
				Rigidity / stiffness / convulsions

How do you prevent neo-natal Tetanus:

Health worker's Identification Number				Responses
1	2	3	4	
				Immunize the mother
				cleanliness at delivery / cut cord with sterile instrument/new blade

What are the main symptoms of pneumonia in a under five child:

Health worker's Identification Number				Responses
1	2	3	4	
				Cough & Fever
				Lower chest in drawing (02 months – 5years)
				Fast / difficult breathing (fast breathing = < 02 months 60 or more, 02 months to < 05 years 50 or more)



EXIT POLL INTERVIEW

Interview of Patient/Client Attending Service Delivery Point at BHU

This questionnaire will be used with patients/ clients at the BHU who have come to receive curative or preventive services. Interview will be done after patients/clients' consultation with the Health Care Provider (HCP). Informed consent will have to be obtained by reading a greeting before beginning the interview.

READ GREETING

Assalam-Alaikum. We would like to improve the services provided by the facility and would be interested to find out about your experience today. I would like to ask you some questions about your visit today, and would be very grateful if you could spare some time answering these questions. Everything you tell me will be kept strictly confidential. Also you are not obliged to answer any question you don't want to, and you may withdraw from the interview at any time. May I continue?

(If the patient/client agrees to continue, ask if s/he has any questions and respond to questions as appropriate. If the patient/client does not agree to continue, thank him/ her and go to the next interview.)

Name of District _____ Date: _____

BHU (name): _____ No. of BHU _____

Name of Interviewee: _____ Sex: _____ Age: _____ years

Name of Village: _____ Distance from Health Facility _____ km

Name of Interviewer: _____ Sign _____

Name of Supervisor: _____ Sign: _____

What was the main reason you visited the facility today? (Tick one)?
(Read 1 to 10)

- 1. Family planning
- 2. Antenatal Care
- 3. TT vaccination
- 4. Child immunization
- 5. Child growth monitoring
- 6. Nutrition counseling
- 7. Curative services (adult)
- 8. Curative services (Child)
- 9. Other services

Do you feel that expected services were available to you today?

- 1. Yes
- 2. No
- 3. Partially
- 99. Don't know

How do you feel about duration of your consultation with the HCP?

- 1. Too short
- 2. Too long
- 3. Appropriate
- 99. Don't know

During this visit, did you have any questions you wanted to ask from HCP?

- 1. Yes
- 2. No (go to Q.7)
- 99. Don't know

(If yes) Did the HCP allow you to ask questions?

- 1. Yes
- 2. No (go to Q.7)
- 99. Don't know

(If yes) Did the HCP respond to your questions to your satisfaction?

- 1. Yes
- 2. No
- 99. Don't know

During this visit, did the HCP conduct any health examinations or procedures?

- 1. Yes
- 2. No (to Q.10)
- 99. Don't know

(If yes) Did the HCP explain the examinations or procedures before they were performed?

- 1. Yes
- 2. No
- 99. Don't know

Did the HCP explain the results of the health examinations or procedures?

- 1. Yes
- 2. No
- 99. Don't know

In your opinion, did you have enough privacy during your consultation with the HCP?

- 1. Yes
- 2. No
- 99. Don't know

During the consultation, what was your level of understanding with HCP?

- 1. Easy to understand
- 2. Difficult to understand
- 99. Don't know

How long did you have to wait between the time you arrived at this facility and the time you began receiving the services that you came for?

- _____ minutes
- (If no waiting time, go to Q.14)
- 99. Don't know

How do you rate the waiting time between you first arrived at this facility and the time you began receiving the services that you came for?

- 1. Reasonable
- 2. Too long
- 99. Don't know

14. Did you receive the prescription?

Yes No

15. If yes, did you receive prescribed medicines?

All Some None

16. Did the HCP explain the use of medicines to you?

Yes No

17. What would you say about your level of satisfaction with your visit to the facility today?

- 1. Satisfied
- 2. Satisfied to some extent
- 2. Dissatisfied
- 3. Don't know

If a friend of yours wanted the services that you came here for today, what advice would you give to him/her?

- 1. Come to this facility
- 2. Go some where else
- 99. Don't know

If you could suggest one improvement to the HCP, what would it be?

- _____

Read closing

Thank you very much for answering these questions.

Questionnaire for Mother having a Child less than Two years

Name of District: _____ Name of Surveyor: _____ Date of survey: _____

Name of Village: _____ Name of related BHU. _____ No. of BHU: _____

Name of Supervisor: _____ Sig. of supervisor: _____ Sig. of Surveyor: _____

LHW working in that area: 1. Yes 2. No

After getting consent from mother for interview go for the following questions:

Name of mother: _____ Husband's name: _____ Husband's occupation: _____

What is your level of education (in completed years): _____

What is your age? (In completed years) _____ How many living children do you have? _____

What is the age of your last child (in months)? _____

Q. 1. Did your child receive EPI Vaccines? 1. Yes 2. No 3. DNK

If yes, do you have record available with you? 1. Yes 2. No

Please tick all the appropriate columns after checking record or on verbal information;

BCG	Polio	DPT/Combo + Polio	DPT/Combo + Polio	DPT/Combo + Polio	Measles
	Zero doze	I	II	III	I

Q. 2. Did you visit skilled Birth Attendant (SBA) for ante natal care (ANC) during your last pregnancy? 1. Yes 2. No

If yes; how many times you visited SBA for ante natal care?

Q. 3. Which type of Health Facility you visited for ANC by SBA: 1. BHU 2. Others

Q. 4. What types of tests / examination carried out or vaccine / advice given during ANC

- 1. Blood test
- 2. Urine test

- 3. Checking of blood pressure
- 4. Tetanus toxoid (TT) injection given
- 5. Taken weight
- 6. Advice for place of delivery
- 7. Per abdominal examination

Q. 5. Where did your last baby born?

1. Home	2. BHU	3. Other Govt. Hosp.	4. Private Hospital	5. Others
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Q. 6. Who conducted your delivery?

1. Relative	2. Dai/TBA/TTBA	3. LHV/ MW	4. Lady Doctor	5. Others
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Q. 7. How many married child bearing age (CBA) women are living in this house (Including you)?

Fill the following table for these CBAs; are they using any family planning method:

S. No	Name of married CBA women	FP method Y/N	Age of last child in months	Method*	Source**	Total children	Remarks if any
1							
2							
3							
4							

Method*

1. Condoms 2. OC. Pills 3. Injection 4. Tubal ligation 5. Vasectomy 6. IUCD. 7.

Others

Source**

1. BHU staff. 2. Lady Health Worker (LHW) 3. Private 4. Other Govt. HF. 5.

Others

Q. 8. What are the danger signs of diarrhea in a child less than 5 years? Tick all the correct answers (Do not tell them options)

1	A child is unconscious or lazy.
2	Sunken eyes.
3	Fever more than 101F°
4	Blood in the stool
5	Repeated vomiting

Q. 9. What are the danger signs of ARI in a child less than 5 years? (Do not tell them options)

1	A child is unconscious or unable to awake.
2	Fits
3	Fever more than 101F°
4	Temperature less than 97F°
5	Unable to take feed
6	Malnutrition

Q. 10. Was your baby's weight recorded after birth?

 1. Yes

 2. NO

 3. DNK

If yes; who recorded the weight of your baby?

 1. LHW

 2. BHU staff

 3. Private HF staff

 4. Others

When did they weight your newborn?

 1. < 24 Hr.

 2. 1-7day

 3. After 7 days

Q. 11. Do you wash your hands after using toilet?

 1. Yes

 2. NO

 3. Some times

If yes; did you wash your hands with soap?

 1. Yes

 2. NO

 3. Some times

Q. 12. Do you wash your hands before preparation of food?

 1. Yes

 2. NO

 3. Some times

If yes; did you wash your hands with soap?

 1. Yes

 2. NO

 3. Some times

Q. 13. Where did you go when become sick?

 1. BHU

 2. Private Doctor

 3. Other Govt. HF

 4. Quack

 5. H. Doctor

 6. Hakim

 7. Faith healer

 8. Others

Q. 14. Did you visit BHU during last three months?

 1. Yes

 2. NO

If yes; for what purpose did you visit BHU?

 1. Curative service

 2. Preventive service

 3. Others

Are you satisfied with behavior of BHU staff?

 1. Yes

 2. NO

 3. DNK

Are you satisfied with the services available at BHU?

 1. Yes

 2. No

 3. DNK

Read Closing:

**Thank you very much for answering my questions.
Questionnaire for Support Group (SG) Member**

Name of District: _____ Name of Surveyor: _____ Date of survey: _____

Form No. _____

Name of Village: _____ Name of related BHU. _____ No. of BHU: _____

Name of Supervisor: _____ Sig. of supervisor: _____ Sig. of Surveyor: _____

Name of SG member: _____ Father's name: _____ Occupation: _____

After getting consent from interviewee; go for the following questions:

What is your age? _____ What is your level of education? (in completed years): _____

LHW working in that area: 1. Yes 2. No

Q. 1. Are you a member or executive member of SG? 1. Executive 2. Member

Q. 2. When did you join support group (duration in complete months)? _____

Q. 3. How many members are you in the SG?

Q. 4. When last support group meeting was held (duration in weeks)? _____

Q. 5. When did you attend last support group meeting (duration in approximate weeks)? _____

Where that meeting was held? 1. BHU 2. Community 3. School 4. Others

How many members attended that SG meeting?

What was the purpose of that SG meeting? 1. Improvement of MCH services 2. Improvement of HF 3. Control of comm. diseases 4. Health awareness 5. Hygiene and sanitation 6. Others

Q. 6. How frequently SG meetings conducted (duration in complete weeks)? _____

Q. 7. How many SG meetings were conducted during last three months? _____

Q. 8. How many meetings you attended; during last three months? _____

Q. 9. What are the functions of support group? (Do not tell them options)

	To assist the health facility staff in organizing health education sessions
	To supervise BHU maintenance work
	To act as member of purchase committee for the BHU
	To act as social mobilizer during health campaigns
	To check the attendance of BHU staff
	Others

Q. 10. Did you organize any health education (HE) session?

 1. Yes

 2. No

If yes:

Where did you organize that HE session?

 1. Health House

 2. BHU

 3. School

 4. Community

 5. Others

What was the topic of that HE session?

 1. Mother Health

 2. Infant Health

 3. FP.

 4. ARI

 4. Diarrhea

 5. Personal Hygiene

 6. Cleanliness of area

 7. Others

Q. 11. Did you arrange any donation for the BHU?

 1. Yes

 2. No

If yes, what was approximate amount in rupees? (If it is in kind, write its price)

Q. 12. Did you ever discuss the performance (services provided) of Health Facility in your SG meeting?

 1. Yes

 2. No

Q. 13. Did you ever check the attendance of staff at BHU?

 1. Yes

 2. No

If yes; was any staff member absent?

 1. Yes

 2. No

If yes, did you inform the PPHI Supervisor / DSM.?

 1. Yes

 2. No

If yes, did they take any action?

 1. Yes

 2. No

Q. 14. Do you have any advantages of being SG member?

 1. Yes

 2. No

If yes, what are they? (Do not tell them options)

1. You get more medicine
2. Staff give you more respect
3. Community pay you more respect

4. Others

Q. 15. Do you know the minutes of SG meetings were recorded? 1. Yes 2. No

If yes, who maintain the SG meeting's record? _____

Verify the record from that person / BHU 1. Record not available
 2. Record verified & complete 3. Record not verified 4. Record incomplete

Q. 16. What are the danger signs of diarrhea in a child less than 5 years; Tick all the correct answers

(Do not tell them options)

<input type="checkbox"/>	A child is unconscious or lazy.
<input type="checkbox"/>	Sunken eyes.
<input type="checkbox"/>	Fever more than 101F°
<input type="checkbox"/>	Blood in the stool
<input type="checkbox"/>	Repeated vomiting

Q. 17. What are the danger signs of ARI in a child less than 5 years? (Do not tell them options)

1	<input type="checkbox"/>	A child is unconscious or unable to awake.
2	<input type="checkbox"/>	Fits
3	<input type="checkbox"/>	Fever more than 101F°
4	<input type="checkbox"/>	Temperature less than 97F°
5	<input type="checkbox"/>	Unable to take feed
	<input type="checkbox"/>	Malnutrition

Q. 18. Do you wash your hands after using toilet? 1. Yes 2. NO 3. Some times

If yes; did you wash your hands with soap? 1. Yes 2. NO 3. Some times

Q. 19. Do you wash your hands before taking food? 1. Yes 2. NO 3. Some times

If yes; did you wash your hands with soap? 1. Yes 2. NO 3. Some times

Read Closing: *Thank you very much for answering these questions.*

Questionnaire for EDO (H) / DSM (PPHI) interview
(Only from PPHI Districts)

Name of District: _____ Name of Interviewee: _____

Designation of Interviewee (Tick the appropriate): EDO (H) / DSM (PPHI).

Name of Interviewer: _____ Date of Interview: _____ Sig. of interviewer: _____

After getting consent from interviewee; go for the following questions:

Basic District information:

Total population of the District: In year 2006 _____ In year 2008: _____

No. of Hospital: _____ No. of RHCs: _____ No. of BHUs: _____

No. of Other HFs: _____ No. of Health Facilities (HF) under your direct control: _____

Literacy rate of the District: _____ Male _____ Female _____ (if available)

District EPI Coverage: _____ ANC coverage: _____ HF Utilization rate: _____

Total No. of **TB cases Detected / Diagnosed** (all type) [From District TB-DOTS Coordinator]

(Data source: TB report - 07)

Year 2006				Year 2008			
1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter

TB case detection rate of District in year 2006: _____

TB case detection rate of District in year 2008: _____

Total No. of **TB cases successfully Completed Treatment.** (Data source: TB report - 09)

Year 2006				Year 2008			
1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter

TB treatment Success Rate of District in year 2006: _____

TB treatment Success Rate of District in year 2008: _____

Q. 1. For how long are you working at this position in this District?

- 1. Less than 6 months.
- 2. From 6 months to less than one year.
- 3. From 1 year to less than 2 years
- 4. Over two year

Q. 2. How long PPHI is working in this District?

- 1. Less than one year
- 2. From one year to less than two year.
- 3. Two or more than two years

Q. 3. What are the advantages of giving BHUs to PPHI?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Q. 4. What are the disadvantages of giving BHUs to PPHI?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Q. 5. How is the working relationship of PPHI with District Health Department?

- | | | |
|-----------------|---------------------|--------------------------------|
| 1. Satisfactory | 2. Not satisfactory | 3. Satisfactory to some extent |
|-----------------|---------------------|--------------------------------|

Please explain:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Q. 6. Are there any administrative issues between District Health Department and PPHI?

1. Yes

2. NO

3. Yes to some extent

Please explain:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Q. 7. What is the reporting frequency from PPHI to EDO Health?

Please explain:

Q. 8. How many audit reports were submitted to District Health Department in the last two years?

If Yes (write No.) _____ NO

Are the audits reports evaluated / scrutinized by the District Health Department?

1. Yes

2. No

Q. 9. Are there any Reporting issues between District Health Department and PPHI?

1. Yes

2. NO

3. Yes to some extent

Please explain:

- 1. _____
- 2. _____
- 3. _____

Q. 10. What are the health service delivery initiatives under taken by PPHI?

Q. 11. Are there any Health Service provision issues between District Health Department & PPHI?

- 1. Yes
- 2. NO
- 3. Yes to some extent

Please explain:

- 1. _____
- 2. _____
- 3. _____

Q. 12. Did the BHUs get any feed back on HMIS analysis from District Support Unit?

- 1 Yes
- 2 No
- 3 DNK

Q. 13. Are there any financial issues between District Health Department and PPHI?

- 1. Yes
- 2. NO
- 3. Yes to some extent

Please explain:

- 1. _____
- 2. _____
- 3. _____

Q. 14. Are there any human resource management issues between District Health Department and PPHI? Please explain;

- 1. _____
- 2. _____

Q. 15. Is the working of BHUs improved after handing over to PPHI?

- 1. Yes
- 2. NO
- 3. Yes to some extent

Please explain:

- 1. _____
- 2. _____
- 3. _____

4. _____

Q. 16. Do you think there are advantages / benefits to staff working at BHUs after taking supervision by PPHI?

1. Yes

2. No

3. Yes to some extent

Please explain:

1. _____

2. _____

3. _____

4. _____

Q.17. Are there any disadvantages to the staff working at BHUs after handing over the BHUs to PPHI in a District?

1. Yes

2. No

If yes please explain:

1. _____

2. _____

3. _____

4. _____

Read Closing:

Thank you very much for answering these questions.