Assessing Best Practices in Devolution

Innovative Health Management

Rahimyar Khan District

Syed Mohammad Ali
Documentation/Research Consultant
CDSP

CIDA Devolution Support Project

I Introduction

This assessment of the best practice[1] in health management in Rahimyar Khan builds upon a preliminary identification process, which was initiated and subsequently reviewed by CIDA-DSP to select specific best practices for undertaking further analysis. This more detailed study of selected best practices[2] was meant to lend sharper focus to the actual methods, outputs, and underlying challenges behind the approaches being widely recognized (by government, NGO and international development agencies) as being best practices in devolution in Pakistan. Instead of relying on secondary sources, the following documentation is based on primary field research that sought views of a range of concerned stakeholders, and the views of these respondents are in turn supplemented by observations of ground realities emerging from the implantation of a specific best practice in devolution.

i Stakeholders

The views of the following stakeholders were sought to enable the process of assessment:

i *Institutional Perspective*: The institutional stakeholders of this study are the relevant tier of the local governments

ii *Perspective of Practitioners*: These views are being obtained to contrast and compare opinions of current service delivery providers and of their predecessors

iii *Perspectives of Target Audience*: Feedback from the actual users/clients of service delivery mechanisms being reformed under the devolutionary framework, as well as the intended beneficiaries who are not yet availing the service, are obtained and cross referenced to shed light on the actual and potential impact of a selected best practice.

ii Approach to the Study

Information obtained concerning the following best practice has relied on discussions with all of the above mentioned stakeholders. Given the variance in what can actually constitute a best practice however, led to use of a flexible and interactive approach in posing queries to the concerned stakeholders, so that different types of relevant information specific to a particular best practice could be obtained. Methodologically, this required use of open-ended queries, which were posed keeping in mind the individual

[1] 'Best practices' are being defined as innovative but workable solutions being implemented in the context of Local Government Ordinance 2001, which bolster local governance processes and outcomes, and contribute to bringing about sustainable improvements in service delivery.

[2] The best practices identified for further assessment by CIDA-DSP included the effort to improve water sanitation in Lodhran district, the health care management initiative in Rahimyar Khan district, the formation of CCBs in Sadiqabad, and innovations being undertaken by the Tehsil Municipal Administrations in Jaranwala and Sadiqabad.

stakeholders. The contentions emerging from these discussions were then cross-checked with views of other stakeholders. This multilayered approach enabled a deeper probe concerning the actual meaning of the experiences emerging from the selected best practices, so as to identify and corroborate their intended consequences, to highlight unexpected outcomes if any, and to assess their potential for replication.

A reference to the existing knowledgebase obtained from relevant secondary sources has also been used wherever necessary to help contextualize the consolidated findings of this particular study.

II Health Management in Rahimyar Khan District

Despite the enormous amount of funds spent on Basic Health Units (BHUs), most of the BHUs across the county have not become operational as planned. The district government in Rahimyar Khan has initiated implementation of an interesting strategy to improve the efficiency of BHUs which deserves careful consideration given the dire need to improve access to basic health services for the poor.

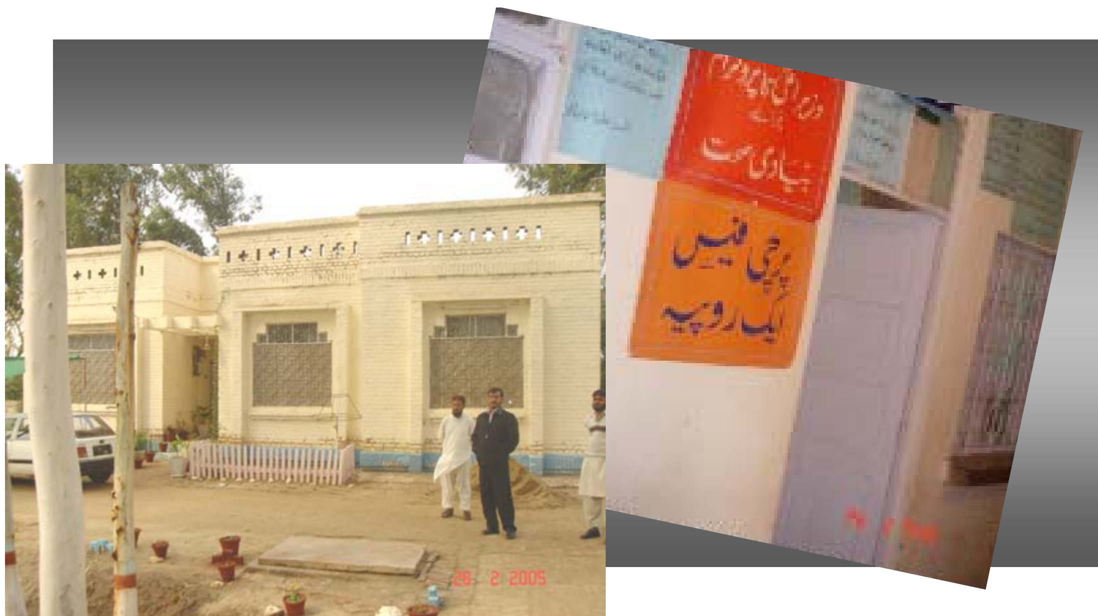
Rahimyar Khan comprises of 4 tehsils with a total population of 3.68 million, 3 million of which are rural inhabitants. The Chief Minister's Initiative on Primary Health Care was launched in Rahimyar Khan in response to the evident failure of the BHUs in the district. Expect for some urban areas, most BHUs in Rahimyar Khan were not functioning properly. Although 40 doctors were drawing salaries from the district health department, their actual presence at their designated BHUs remained sporadic and many of them indulged in private practice as well. In view of this situation, the district government of Rahimyar Khan decided to enter into agreement with the para-statal Punjab Rural Support Program (PRSP) to manage their 104 BHUs.

The District Nazim recalls having a tough time in convincing the provincial health department to concede control of the BHUs to the PRSP. However the credibility and capacity of the PRSP, the demonstrated success of a smaller and albeit less developed project undertaken by the PRSP involving 3 BHUS in the neighboring district of Lodhran, and the personal backing of the Chief Minster of the Punjab helped launch this pilot project in Rahimyar Khan.

i Launching the Initiative

It was in March 2003 that the district government of Rahimyar Khan initiated its proposal to contract out management of all its BHUs to PRSP. Since the contracting process was not competitive, the district government and Punjab health department directly signed an agreement with PRSP to manage the Rahimyar Khan BHUs on the government's behalf and a memorandum of understanding was issued for five years.

The main provisions of the contractual agreement required the district government to transfer the control, management and use of buildings, furniture and equipment of all BHUs to the PRSP as well as budgetary provisions relating to unfilled posts, medicines, maintenance and repair of buildings, equipment, utilities, stores, and office supplies for the relevant year. The financial provisions to be given to PRSP were in the form of aid-in-grant rather than
Being itemized budgets generally used by the government departments. This leeway was given to enable the RPSP to undertake financial redesign and make the BHUs run more effectively. Yet the PRSP was bound by the agreement to render accounts of the management operations to the district government within a period of three months after each financial year. On the other hand, to facilitate management, the competent authority in the district government was meant to relocate staff as requested by the PRSP. All physical assets of BHUs were thus transferred to PRSP, to be returned at the conclusion of the contract.



PRSP is now given the available government budget to run the Rahimyar Kahn district BHUs since mid-2003. The PRSP has divided the 104 BHUs[3] in the district into clusters of three. One doctor has been appointed as the team leader of each cluster. 35 clusters were formed in the district, 34 comprising of 3 BHUs and one cluster comprising of 2 BHUs. 12 MOs already living at BHUs were supported to improve their living conditions and they began to work in the cluster approach. Within a week of the project launch, 14 other MOs expressed their willingness to wok under the new arrangement and they began working by the following month. To help facilitate the mobility of MOs, they were offered an interest-free car loan of Rs. 100,000, installments of which were to be deducted from their salaries. The Government of Punjab granted a special permission to BHU doctors, (referred to PRSP as Medical Officers) working under the Provincial government to sign an agreement with PRSP, which their contracts with the Health Department were to remain secure if the PRSP pilot project did not work out. Subsequently another 9 MOs joined the process and 5 MOs were no longer interested in working with PRSP. One of these MOs was transferred to a Rural Health Centre, while the other four were terminated by the Health department since they remained persistently absent from their duties.

Given that fewer doctors are employed under the clustered approach, their salaries have been enhanced from Rs. 12,000 to Rs. 30,000 but private practice is strictly forbidden. BHU doctors are now in charge of entire clusters rather than a single BHU and they spend alternate days at the three BHUs within their allocated clusters according to a set timetable. MOs are meant to reside in a focal BHU within their cluster and are held responsible for looking after emergencies even after office hours. The MO cannot indulge in private practice and nor does the PRSP allow paramedical staff to charge extra fees on the BHU premises. The MO is held responsible for the overall discipline of the cluster BHUs. The OPD of the BHU is meant to be conducted by the senior most paramedic when the MO is visiting the other two cluster BHUs.

---

[3] A BHU comprises of a Medical Officer, a medical technician and a dispenser (both qualified paramedics), a Lady Health Worker, a Dai (Traditional Birth Attendant) and 3 support staff members.

ii Service Delivery on Ground

The BHUs undertake both curative and preventive approach to medicine. On the curative side, the medical staff deals with general health ailments as per the facilities existing in BHUs. BHUs also focus on mother and child health and implementation of the TB DOTS program. Family planning services are being offered within the BHU where LHVs and Female Medical Officers are available. 3 FMOs are working for PRSP in three tehsils where they visit five different BHUs per week to provide consultation for antenatal and postnatal visits and deal with other reproductive health problems. On the preventive side, there is further innovation extending beyond the immunization within BHUs. Community health sessions, school health sessions, school health camps in BHUs (see tables 1a &b in Annex 2). Support Groups have begun to be formed since October 2004 and 18 such groups currently exist in Sadiqabad and Rahimyar Khan tehsils. Support groups are meant to mobilize communities and increase awareness concerning general sanitation in the area, provide information on diseases specific to the area, besides supporting vaccination and immunization awareness within their communities.

The BHUs are responsible for assistance in ongoing health campaigns. The BHU was devised as the most basic health facility and its functions do still overlap and the MoU requires the PRSP to help the Health department. The fridge for vaccinators is kept at the BHU, although he is not himself a part of the BHU staff. The Medical Officer of the BHU is also meant to supervise monthly meetings of the Lady Health Workers. These are functions being performed but could have been articulated further. The Health department says that procedures need to be laid out for PRSP lending BHU staff in case of an emergency like a flood. The PRSP provides verbal assurances but no protocol in this regard has been established. There is also the issue of referrals from BHUs to the RHCs and Tehsil headquarter hospitals, for which no formal procedure was evident, only PRSP's verbal assurance that their practitioners refer patients to the government health system instead of commercial hospitals, which are often too expensive for poor patients.

iii Issues Concerning Medicines

During the first year of this pilot project, medicines for the BHU were procured by the existing government route. In the second year however (in effect from July 2004), PRSP was given responsibility for sourcing the required medicines for the BHUs itself, for which it follows the government procedure of accepting quotations and selecting the lowest bidder interested in supplying BHU medicines.

At the project inception, the PRSP took the stocks of medicine purchased by district government in FY 2002-2003, since they had not yet been distributed until March 2003. This gave the PRSP the chance to save money since it was provided medicine stocks as well as the cost of medicines for the coming year (2003-2004). While this government delay in purchase of medicines proved a boon for the PPSP, the project staff realized that the need to deliver medicines on time to the BHU should be amongst its most urgent priorities. Subsequently, the PRSP district project office tries to not only obtain the medicines expeditiously but also assists in the delivery of these medicines to the BHUs.

While the stock registers for medicines are on the same format as those used by the district health department, PRSP claims that they are being maintained with much more diligence to ensure lack of misappropriation and availability of required medicines within BHUs. But the PRSP has not been able to do much concerning the quality of medicines

being supplied to the BHUs. While the PRSP procures the medicines itself, it follows the same purchasing process as the government, and to avoid unnecessary controversy the PRSP purchases medicines in view of the contract rates determined by the Punjab government in other districts. PRSP project personnel agree that a more sophisticated quality control mechanism needs to be evolved since there are reported complaints of low quality medicines being supplied to the BHUs. The PRSP itself has referred substandard medicines supplied by contracted companies to the Punjab Drug Testing Laboratory for quality check but has been compelled to use them when the federal appellate body (the National Institute of Health) overruled the provincial drug testing results.

Concerning the quality of medicines issue, the PRSP would do well in drawing upon the experience of WHO, UNICEF and even local organizations like the Consumer Protection Network etc. There is also some indication of preliminary contact having been established in this regard, particularly to prioritize an essential drugs list for BHUs. Closer coordination with such specialized agencies could bring more leverage to PRSP's attempt to improve the quality of medicines being made available to BHUs by either using an alternative mechanism for identifying suppliers or else to check medicine standards.

iv Physical Infrastructure of BHUs

A general plan for repair of BHUs has been executed under the PRSP, using district allocated development funds provided to Union Councilors. This repair includes white wash, electricity fittings, repair of water supply and sewerage of the main buildings, MO residences and quarters of residing staff. Repair of 94 BHUs have been completed at a very nominal price of Rs. 3,204,400. For routine repair and development of infrastructure, MOs are meant to identify the need and submit the detail of work to be done with an estimated expenditure. MOs are then sanctioned to get the work done and

required to submit receipts and physical verification is undertaken by the PRSP if the amount is significant. Although not a significant proportion of PRSP project funds have been spent on the BHUs for this purpose, this provision has allowed for installation of rooter pumps, hand pumps, repair of transformers, generators, minor repairs and plantation to make the BHUs more habitable. Yet in view of the original idea of establishing BHUs to provide accessible and perpetual primary health care across the country was not been realized. The PRPS has made the actual clinics more functional

but it has not been able to turn its attention towards the dismal state of paramedical residences. Despite the enormous amounts of funds invested in the construction of BHUs and the amount of land allocated to them, even the PRSP approach cannot yet activate the BHUs (besides the 33 BHUs were the doctors reside, in most cases without paramedical staff) to become a live-in facility which the surrounding community could always access in times of need.

v Paramedical Staff at BHUs

With the exception of doctors (MOs), all personnel will continue to be paid by the Ministry of Health. The PRSP approach has focused its attention on the doctors, and thus the remaining paramedical and support staff continue to work as government employees within the government pay structures. Yet there is much more pressure on them due to the vigilance of the PRSP as well as the administrative power designated to the MOs by the PRSP. Paramedical staff can no longer ask patients for fees beyond the Rs. 1 service charge for BHU patients.

The PRSP approach has thus placed a lot more pressure on the paramedics and many of them leave the BHU as soon as the official timings are over to go practice in private dispensaries to supplement their incomes. The PRSP does not take any action against this practice since it has attempted to compensate MOs to desist from private practice only, as long as the paramedics do not try charging BHU patients extra fees. An interesting correlation was made by the DO (Health) concerning why the OPDs have surged under the PRSP. Admitting that much of the paramedical staff was taking money from poor patients at the premises, it was in their interest to show lesser OPDs than they were treating particularly where medicines could be shown to be administered to the same patient. It was also in their interest not to leave the BHU too early, which had a spin-off effect of keeping the BHUs open till much later.

The lack of motivation of BHU paramedics translates into the substantial amount of unfilled vacancies. Currently there are 28 medical technician, 62 LHV, 14 dispenser, 44 *dai*, and 85 sanitary inspector posts lying vacant. Not bound by a line-itemed budget, the PRSP has used some of its savings (from unfilled vacancies and from the savings incurred by simultaneous transfer of both medicine stocks and the medicine budget for the first year of its operation) to initially provide a small honorariums to paramedical staff but then it decided to hire female medical officers in selected BHUs to enhance the scope of services made available on the BHU premises.

vi Management Issues

At present, there is a District Support Unit (DSU) of the PRSP which is responsible for management and administration of the BHUs. The DSU is meant to ensure the optimal performance of the staff of the BHUs subject to the terms and conditions of their

appointment for efficient delivery of services. The DSU is also responsible for fulfilling provisions of the agreement between district governments and PRSP and for optimal use of funds. The PRSP financial reporting mechanism has caused some difficulties since its auditors have treated the BHU project in Rahimyar Kahn in a very cursory manner given the broader budget of the PRSP. PRSP accounts for the BHU project are subject to internal as well as external government audits. The Executive District Officer (EDO) Finance has raised an objection to the financial reporting system being used by the PRSP which treats the BHU project in a cursory manner, considering it just of the many projects on which a consolidated financial report has to be prepared. The district government however is not satisfied with a summary statement of accounts issued by the PRSP head office and has thus requested the PRSP to furnish greater details concerning the BHU project expenditures. District government officials also made the valid point that the PRSP should not have been allocated funds from the development funds provided to union councils since they are already being paid the entire amount allocated to the health department for BHUs, which includes money for maintenance and repairs.

The PRSP and the district health department are working together and their coordination was obvious even from the limited interaction evidenced between them during a joint meeting with PRSP and Health Department staff, held at the District Nazim office, during preparing this case study. Yet there are some genuine grievances which do require attention. The PRSP's DSU is supposed to ensure BHUs coordination with all relevant health programs at the district level, including family planning and immunization drives, so there is an obvious need for this coordination. Yet the MoU between the health department and the PRSP could have made greater allowance for joint monitoring of such activities or a mechanism for conflict resolution should a problem arise, which would have ensured a relationship with the district health department. The MOU signed with the PRSP makes little allowance for outcome indicators, monitoring of activities or a mechanism for conflict resolution should a problem arise.

The DSU is responsible for monitoring and supervision of all BHUs, a relatively easier task given that the health department had to supervise not only the BHUs, but also all the rural health centers and tehsil hospitals in the district. Under the new arrangement, all MOs come to the DSU where they can discuss concerns with which they require PRSP assistance. The District Support Manager also makes field trips to the BHUs as does DSU's Monitoring Executive, the Medical Officer on General Duty (who also substitutes for MOs requiring leave). DSU staff members interact with BHU staff and patients during their visits and prepare project performance reports submitted to the Project Support Unit located at the PRSP head office in Lahore. To facilitate evaluation, OPD visits, medicine supply, general store stock; and attendance records are also maintained by the DSU. The MO provides monthly performance reports reflecting all activities at the BHU, a monthly medical expense report and the Health Management Information System report required from BHUs by the provincial health department. MO reports to PRSP specifically include information on the total numbers of OPDs, MO external visits, support group community activities, number of TB patients, immunization at static posts; birth records, antenatal and postnatal visits for BHUs where LHVs are available at the DSU and attendance records of staff. The DSU has also introduced timesheets BHU staff, despite their initial reluctance.

While the PRSP seems comfortable with this vague arrangement, the district health department officials expressed the need for more clear-cut parameters concerning their

working relationship. Whilst no explicit mechanism for coordinating these new management structures of BHUs with the existing public health system exists (e.g. accountability of doctors running BHUs how the PRSP should interact with the Ministry of Health personnel, so far no problems have arisen as a result of these parallel structures. In fact the notion of monitoring PRSP activities by the government was not raised as an issue. Perhaps this is due to a sense of 'trust' of the PRSP as it is a form of quasi-governmental organization itself. (PRSP is a provincial rural support program established by the government to replicate the highly successful Aga Khan Rural Support Program. The majority of PRSP personnel, including the CEO and the principal staff responsible for managing the BHUs, are government officials seconded from their parent departments, PRSP also has government representation on its Board of Governors). According to statements by PRSP personnel, the rationale for hiring government servants is that their experience with government procedures is essential for successful coordination with government departments. PRSP considers itself a government-organized non-governmental organization considered the Community Mobilization arm of the Government of Punjab. Yet despite this fact, the role of the Nazim was much more apparent. However, all relevant stakeholders concurred that an NGO other than the PRSP (and by implication the RSP network in other provinces) would have been able to take over the management of BHUs from the government.

vii Concluding Assessment

The PRSP initiative records 100 percent availability of doctors and medicines at each BHU and a visible improvement in overall staff discipline as a result. While it is still too early to evaluate the performance of the intervention, a preliminary analysis of the numbers of outpatient visits does suggest that greater staff presence at the facilities has translated into a three-fold increase in uptake of services (see table 1c in Annex 2). This greater success of the BHUs in meeting demand at this point must be attributed to different ways of managing heath workers. Yet it must be kept in mind that there have not yet been any changes in the drug procurement system of BHUs. The PRSP has only been able to increase the remuneration of the doctors managing BHUs and assured their residence (not round the clock presence) in 33 focal BHUs, and possibly the degree to which they are supervising other members of the primary health team. It is clear that the para-medics need incentives as well and that more doctors will need to be hired for the PRSP to let go of its clustered approach and assure focus on doctors within one specific BHU.

While acknowledging that PRSP is doing well given the circumstances, other assessment of this initiative[4] concur that the pilot is being scaled up rather quickly with twelve more districts replicating a model which is still in the process of being consolidated.

[4] Natasha Palmer and Zubia Mumtaz, Non-State Provision in the Health Sector of Pakistan, 2004

III Concluding Remarks

Several kinds of agreements and contracts between local governments and non state providers are becoming evident under devolution. There are also varying degrees of difficulty in getting the balance of roles and authority right for the sake of improving the quality and enhancing the access to basic development needs of the average Pakistani citizen. It is difficult to say whether the 'private sector' should best work with and through the government or should it be encouraged to offer parallel systems of service delivery. Some of the various strands of public-private partnership becoming evident under the devolution plan are also struggling with such question. For example, in Rahimyar Khan, collaboration has taken place between an NGO and the district government for health management, yet the NGO in question also works like the government in many ways and this is the reason why it has gained the trust and credibility of taking over government BHUs. Yet the PRSP's attempt to follow government procedures in terms of procuring medicines for example has constrained its ability to improve the quality of medicines. In Lodhran, the TMAs have placed a dual responsibility on their own staff, which allows for greater collaboration but also causes a bit of strain within the TMA. In Jaranwala, there is much more aggressive outsourcing, although NGOs are being involved in some instances as well, such as with regards to waste management.

The above case study has attempted to articulate some of the real life stresses, innovations and opportunities becoming evident from the devolution of power in a specific context. A further attempt has been made to include the viewpoint of different stakeholders, including not only the various implementers but also the intended beneficiaries. It seems that the access and quality of services is improving thus far, which is the basic reason for the mentioned initiative emerging from the devolutionary process to be labeled as a 'best practice'.

Yet there is need for giving more attention on the removal of emerging inconsistencies and the hurdles confronting attempts to improve social service delivery. The issue of sustainability is paramount given that local government officials themselves express doubts about the future of their innovations. This assessment of a specific best practice has thus been an attempt to not only highlight innovative processes but also to identify particular impediments pertaining to sustainability and outreach. Wherever possible an attempt has been made to suggest how given impediments have been, or could have been overcome, in the attempt to draw lessons for the replication of this success in other parts of the country.

Annexure 1

List of People Interviewed

Rakhim Yar Khan

1. District Nazim
2. DCO
3. EDO (Health)
4. DO (Health)
5. Project Coordinator, District Support Unit, PRSP
6. Monitoring Officer, DSU, PRSP
7. BHU Medical Officers
8. Dispensers, BHUs
9. Medical Technicians, BHUs
10. Chief, Monitoring, Planning, Evaluation and Research, PRSP (based in Lahore)

Annex 2

Table 1a: School Health Activities at BHUs in Rahimyar Khan

Months	Number of School Health Education Sessions	Number of School Health Camps	Number of School Children Treated	Number of Community Health Sessions
November 2003	111		-	-
December 2003	102	43	-	-
January 2004	111	37	-	-
February 2004	109	38	-	-
March 2004	107	42	5828	-
April 2004	107	40	5755	-
May 2004	99	38	6246	
June 2004	-	-	-	174
July 2004	-	-	-	129
August 2004	-	-	-	130
September 2004	98	32	1280	121
October 2004	98	33	1419	125
November 2004	100	33	1705	84
December 2004	90	30	1433	131
January 2005	108	34	1144	125
Total	*1173*	*366*	*23666*	*1019*

Table 1b: Immunization at BHUs in Rahimyar Khan

Month	Number of Patients
November 2003	4309
December 2003	4219
January 2004	4843
February 2004	4637
March 2004	6234
April 2004	5203
May 2004	5976
June 2004	5903
July 2004	7084
August 2004	6367
September 2004	4959
October 2004	4299
November 2004	3479
December 2004	3787
January 2005	3793
Total	75103

Table 1c: Comparison of OPD data of BHUs for 2002-2005

	2002								2005			
Month	May	June	July	August	September	October	November	December	January	February	March	April
OPD	48790	3170	42285	44472	63595	46342	63844	19465	62610	47569	65483	69184
Daily Average	1807	1271	1566	1647	2544	1716	2456	749	2319	1982	2484	2661
	2003								2005			
Month	May	June	July	August	September	October	November	December	January	February	March	April
OPD	80622	7975 8	156344	250793	204722	128065	119042	162394	155532	136547	169930	137270
Daily Average	3225	3190	5791	10032	7874	4743	5669	6246	5390	6502	6536	5280
% Increase	165	251	370	564	322	276	186	834	232	287	263	198
	2004								2005			
Month	May	June	July	August	September	October	November	December	January	February	March	April
OPD	121755	1337 95	156745	160940	140544	141896	99376	123316	135659	-	-	-
Daily Average	5073	5146	6270	6438	5406	5458	4517	47445173	5898	-	-	-
% Increase	250	421	371	362	221	306	156	634156	217	-	-	-