Situation Analysis & Planning for Implementing MNCH related Minimum Service Delivery Standards & Packages

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CONTENTS

List of abbreviations

ADB	Asian Development Bank
AJK	Azad Jammu & Kashmir
ANC	Antenatal Care
ARI	Acute Respiratory Tract Infections
BCC	Behavior Change Communication
BHU	Basic Health Unit
CBA	Child Bearing Age
DFID	Department For International Development
DG	Director General
DHMT	District Health Management Team
DHQH	District Head Quarter Hospital
DoH	Department of Health
EmONC	Emergency Obstetric & Neonatal Care
EPI	Expanded Programme of Immunization
FP	Family Planning
FWW	Family Welfare Worker
HMC	Health Management Committees
HMIS	Health Management Information System
HOT	Human Organization Technology
HRH	Human Resource for Health

ICPD	International Conference on Population & Development
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rates
IQHC	Improving Quality of Health Care
Jhpiego	Johns Hopkins International Non-profit Health Organization
JSI	John Snow Inc.
M&E	Monitoring and Evaluation
MCHC	Mother and Child Health Center
MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNCH	Mother Newborn and Child Health
MSDP	Minimum Service Delivery Packages
MSDS	Minimum Service Delivery Standards
MSU	Mobile Service Units
NGO	Non Government Organization
NHP	National Health Policy
NHS	National Health System England
OPD	Outdoor Patient Department
PAIMAN	Pakistan Initiative for Mother and Newborn
PDSSP	Punjab Devolved Social Services Programme
PHC	Primary Health Care

PHSRU	Punjab Health Sector Reform Unit
PPHI	People's Primary Healthcare Initiative
PRIDE	Primary Healthcare Revitalization, Integration and Decentralization in Earth Quake Affected Areas
PSQCA	Pakistan Standards and Quality Control Authority
PWD	Population Welfare Department
QOC	Quality of Care
RHC	Rural Health Center
RQIA	Regulation and Quality Improvement Authority
SBM-R	Standards Based Management and Recognition
SDP	Service Delivery Package
SMP	Standard Monitoring Protocols
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infections
THQH	Tehsil Head Quarter Hospital
TRF	Technical Resource Facility
USAID	United States Agency for International Development
WHO	World Health Organization
WMO	Women Medical Officers

LIST OF TABLES

EXECUTIVE SUMMARY

Minimum Services Delivery Standards (MSDS) lay a benchmark for quality of care. They play a key role in better performance and evaluation of the health systems and are imperative to the achievement of the health-related Millennium Development Goals (MDGs). In addition they have a positive impact on the health services delivery as a whole.

Quality of health care is one of the pillars of the health systems that in addition to laying down standards for the delivery of health services, also has an impact on the cost-effectiveness and equity of interventions. Standards are the main drivers for continuous improvement in quality and define expectations the way a particular healthcare activity will be performed in order to produce the desired results. Standards and packages are important for establishing efficient and effective delivery of quality health services at different levels of the healthcare system thus providing ground for the assessment of the outputs and outcomes as a part of a synchronized and evidence based mechanism. Hence they play a vital role for supporting good governance and best practices.

Looking deeper into the standards and the packages and how they are defined internationally the Minimum Service Delivery Package (MSDP) actually includes or defines the minimum set of services at a specific level of facility i.e. primary, secondary or tertiary. MSDP for a primary level facility would include the agreed set of services that a client can avail from the primary level facility throughout the country whether it is public or private; provided the agreed services for that level are defined within the package. The composition of the packages can vary from very basic to advanced depending upon the status (whether developed or developing) of the country and its resources.

Once the Minimum Service Delivery Package is in place, Minimum Service Delivery Standards can be developed and applied as a next step in the implementation process, as an action for improving or standardizing the services already available through the MSDP. This is to ensure that the health services provided are standardized and uphold the same level of quality throughout the country/geographical focus.

However, this sequence is not always necessarily followed as revealed through the literature review. In the developing countries, when initiatives for improving the quality of care have been undertaken for the existing services, MSDS can be employed as the lead step in the implementation plan. In these countries, standards are employed to define the responsibilities and activities concerning quality as an integral part of all the services offered in primary and secondary level settings like the community, hospitals, or even in form of a health package. The Minimum Service Delivery Standards act as a road map, vision and strategy for future policy development in the developing countries. In low resource settings these standards are more focused on service provision to improve the quality of the existing services and directly address the needs of their people as opposed to the developed countries, where the Minimum Service Delivery

Standards (MSDS) have been used for uplifting of the existing quality of services and to meet expectations of the patients mainly in the tertiary settings, once the Minimum Service Delivery Package (MSDP) was developed and implemented.

Pakistan is committed to goals and targets of International Conference on Population and Development (ICPD)[1] as well as Millennium development goals (MDGs); as a result maternal health and child survival are one of its major priorities.

This assignment was conducted based on the need for developing MSDS as identified in a joint annual review of the National MNCH programme; the objectives were to conduct a situation analysis followed by a road map for the way forward for implementing the MSDS at primary and secondary levels. Exhaustive review of the literature (both international as well as the local) followed by provincial/district visits and detailed stakeholders' consultations and a final national level workshop helped in accomplishing this assignment. A HOT-fit (Human, organization and technology and fit among them) conceptual framework was applied for conducting critical analysis of the current situation of MSDP/MSDS of the individual provinces; the focus on provincial level analysis was emphasized considering the changing institutional context after the 18th amendment and its post devolution scenario which offers more autonomy to the provinces and also the fact that each province is at a different level of progress as regards planning & implementation of MSDS.

At least three provinces in Pakistan offer some experiences of the planning, development, implementation and management of the MSDS; these include PDSSP's MSDS and ISO certification experiences in Punjab; The PRIDE project in AJK and implementation of MSDS in Khyber Pakhtunkhwa; Sindh does not have the experience of implementing the MSDS, but has moved on in developing the standards and there are some plans to implement it. Rest of the provinces i.e. Balochistan and Gilgit-Baltistan are still struggling for ensuring service delivery/access to services mainly due to issues related to human and other necessary resources and geographical terrain.

Considering the experiences within these provinces, each one of them has their own strengths and is performing better in one way or the other. Khyber Pakhtunkhwa has been following a bottom up and process-oriented approach which has been initiated by the government itself and is more sustainable. Punjab has to its credit a set of comprehensively developed detailed standards not only for its primary but also secondary and tertiary level of care which can be adapted by the other provinces.

[1] The United Nations coordinated an International Conference on Population and Development (ICPD) in September 1994 in Egypt. Some 20,000 delegates from various governments, UN agencies, NGOs and the media gathered for a discussion on a variety of population issues. The conference delegates achieved consensus on a Program of Action which has "Reduction of maternal mortality" and "Reduction of infant and child mortality" as two of its main goals

Whereas in AJK the initiative by the PRIDE Project has not only designed the mechanism of incentives and motivation for better performance but also practically implemented it; however it could not be sustained after the life of project as it was a donor funded initiative that came at a cost which the government could not bear. This brings us to a conclusion that the no single example/model of standard can be replicated as a whole because each model has its own strengths which can be adapted by other provinces to fill the gaps in their standards and modify them for better implementation. The detailed description of situation analysis and comparison among the various provincial experiences are shared in the main report.

The road map for implementation has been proposed based on the international/regional and provincial experiences including the consultative process and the national level workshop. Since the standards (MSDS) provide a framework to assess the quality of care provided in public health facilities and a framework to improve quality in a structured manner, they are a useful management tool for managers and staff of primary and secondary health care facilities to identify their strengths, gaps and areas for improvement. Therefore a "Standard Based Management Approach" (SBMA) has been proposed as part of planning or strengthening of the implementation of MSDS. It recommends four steps cyclical approach with a) setting the standards of performance; b) Implementation of the standards; c) Measuring the progress of implementation and d) Recognising the achievements through incentives and motivation.

Since each of the provinces stand at different stage of these four-step implementation processes, the current status vis-a-vis these steps has been highlighted so that each province can plan its further implementation accordingly. The institutional arrangements especially at the provincial level in developing the standards, capacity building of the human resources including resources allocation and monitoring role have been highlighted. Similarly the role of district level managers and providers is also crucial in rolling out the MSDS implementation plan as well as facilitating both internal and external monitoring. The proposed implementation plan also suggests design options especially for those provinces which may need to initiate the whole process from scratch but can also help in further improving the existing MSDS institutionalization processes. Last but not the least a two year tentative work plan has been proposed which would need further discussion and consultation in the phase II of this Project.

Current implementation status of MSDS in individual provinces indicates that Punjab has nearly completed or is in the developmental stages of achievement of the step one of the implementation plan i.e. setting standards of performance. Azad Jammu Kashmir and Khyber Pakhtunkhwa are also making a good progress in step one of implementation phase as these provinces are in the developmental phase with partially implemented processes for service delivery and desired level of performance, further more these provinces are also in the planning phase for identification of services to be improved.

As regards to step two; implementation of standards, AJK has the lead in terms of matured or completely achieved processes related to this phase, while KPK is making good progress with some fully matured processes, with the rest of the processes in planning phase with regards to the step two. Punjab has partially implemented processes with some planning done in this phase. Furthermore, Punjab also has a fully matured process of identification of performance goals in relation to step two.

In implementation plan, step three i.e. measuring progress and step four; recognising achievements, AJK (though through a small project) has the lead as it has completely achieved this phase, Punjab has partially implemented this phase, while Khyber Pakhtunkhwa is in the initial thinking phase with regards to step three, with some planning underway for step four.

Sindh is in the planning phase of step one and step two i.e. setting standards of performance and implementation of the standards, respectively as it has MSDS for Primary Health Care already defined and these MSDS are being followed in every pertinent PC1. However, Sindh is still in the initial thinking phase of the implementation plan in relation to step three and step four, which are measuring progress and recognizing achievements as no formal mechanism for implementation is in place.

The provinces of Balochistan and Gilgit Baltistan are in the initial thinking phase in all of the four steps.

The way forward for undertaking this process would be to follow a detailed consultative process with key stakeholders and identified units/institutions to re-visit the MSDS status in individual provinces and based on the general but comprehensive work plan and 4-step approach of SBMA offer assistance in moving on to the next step and ultimately consolidate implementation of MSDS resulting in improved quality of care of MNCH services and thus contributing towards achievement of MDG 4 & 5.

1 INTRODUCTION AND RATIONALE

Health care system consists of all the organizations, institutions, resources and people that work primarily towards improvement of health. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system[2]. Quality of health care is considered as one of the pillars of the health service system that has a profound impact on the cost-effectiveness and equity of interventions. Standards are the main drivers for continuous improvement in quality. Service provision or delivery is an immediate output of the improvement efforts into the health system and is imperative to the achievement of the health-related Millennium Development Goals (MDGs), which include the delivery of interventions to reduce child mortality, maternal mortality and the burden of infectious diseases.

A ***standard*** is a level of quality against which performance can be measured. It can be described as 'essential' the absolute minimum to ensure safe and effective practice, or 'developmental'-- designed to encourage and support a move to better practice[3]. Standards define expectations for how a particular healthcare activity will be performed in order to produce the desired results. They are 'clear and explicit statements about key elements of a given service'; standards state that 'this is how things should be in this service' and 'this is what the consumers have the right to expect[4]. The "minimum" is considered as the 'essential' services/packages and/or standards which the patients have the right to expect from the providers/health system.

Standards and packages are important for determining the required health inputs and for efficient and effective delivery of quality health services at different levels of the healthcare system[5]. It is also essential for strengthening the health system through good governance and best practices in the policy. Standards state the agreed requirements for a service and help in building quality services. When translated into indicators, standards can be used to measure achievement against the standards. Apart from a focus on service users, it also supports the development of a quality assurance system, with agreed outputs that can be monitored on a periodic basis[6].
In a health care delivery system, standards can be applied to any of the following three components[7]:

- Inputs (the resources needed to provide care or services, such as trained staff, equipment, supplies)
- Processes (activities and tasks intended to establish a particular desired result, such as diagnosis or patient care management)

[2] World health organization, monitoring the building blocks of health systems, a handbook of indicators and their measurement strategies; 2010
[3] Quality standards for health and social care, UK 2006
[4] Helping health care providers perform according to standards. QAP, 2001
[5] Norms and standards for health service delivery: National health sector strategic plan for Kenya 2005-2010 health NGO networks.
[6] Quality measurement: setting standards: Anne Whiteley and Susan Younger-Ross Devon Social Services Department.
[7] Helping health care providers perform according to standards

- Outcomes (the results of inputs plus processes, such as patient clinical status).

Over the past two decades, there has been growing interest on the part of governments, health care organizations, provider associations, and consumer groups in the promulgation of clinical guidelines and other types of standards to improve medical practice, reduce the use of ineffective procedures, and to promote technological and biomedical advances. While this movement to promote standards in healthcare has been most visible in the developed countries, the push for wider use of evidence-based standards (i.e., practices supported by scientifically valid research findings) has begun in developing countries too, particularly in the context of health sector reform. In the 1980s, experiences with basic health programs in many developing countries gave rise to the concern that a major barrier to the effective delivery of services was the lack of clear guidelines for primary healthcare workers[8].

In Pakistan, there has been a growing realization of the need to ensure cost-effective, high quality services which can facilitate in addressing the MDG 4 and 5 targets. Improvement of quality of care by application of services delivery packages and/or standards has been one of the priority reform agenda of various National Programmes[9] as well as the elaborative curative and preventive health services through various level of health care system[10].

[8] Disease control priorities in health. Jamison et al, World Bank 2006
[9] Such as MNCH Programme, LHW Programme, EPI etc
[10] Primary, secondary and tertiary levels of care

2 BACKGROUND & APPROACH

2.1 Background and Purpose

Pakistan is fully committed to the programme of action of ICPD 1994, as well as Millennium Development Declaration 2000. The Government of Pakistan's Poverty Reduction Strategy Paper (PRSP) is devoted to improve public service delivery through structural and programmatic reforms as a key strategy for achieving the MDGs. The Ministry of Health has established the National Maternal Newborn and Child health Programme (NMNCHP) for responding to the health needs of mothers and children. The joint annual review of the NMNCHP suggested that the NMNCH Programme should develop minimum service delivery standards and standardized in-service training curricula and manuals related with MNCH.

TRF (Technical Resource Facility) is committed to support improvements in policy, strategies and systems and to help to build the capacity of government functionaries at federal, provincial and district levels by providing strategic technical assistance, with a focus on the National MNCH Programme. For this purpose a TA commissioned by the Technical Resource Facility (TRF) was established to support the national MNCH programme. The objective of the TA was to develop a plan of action for implementing the MNCH related MSDS at primary, secondary and tertiary level facilities in public sector. (Please refer to Annexure1 for detailed TORs)

The year 2011 can present major opportunities for this agenda in Pakistan as there are high level efforts of the Federal and Provincial governments to mobilize national and external resources for investment in improving women and children's health, as set out in national commitments to the UN Secretary General's Global Strategy for Women's and Children's Health in 2010, and national initiatives such as the Karachi Declaration. Devolution following the 18th Amendment is providing Provincial governments with more possibilities to demonstrate results and value for money.

2.2 Objectives of the assignment:

1. Conducting situation analysis of MNCH related minimum service delivery standards for the facilities and services

2. Coming up with an approach and road map for implementing MNCH related essential health service package and Minimum Service Delivery Standards (MSDS) at primary, secondary and tertiary level of public sector facilities.

However, after the inception meeting with TRF, it was agreed to focus on the situation analysis of MSDS of primary and secondary level care public sector facilities only and to highlight the province-specific situation of not only MNCH but other health related programme/services as well.

2.3 Analysis Framework

A comprehensive analysis framework "HOT-fit" was adapted to carry out this assignment. It looks into the existing standards/packages, human and organizational aspects and incorporates the concept of fit among these components; standards (technology), human (roles and skills), and organization (strategy, structure and management process). See Annexure 2 for details on HOT-fit Model. Following is a brief description of each of its components

2.3.1 Technology

"Technology" dimension incorporates standards and packages. A broader term of "standards" has been applied including service delivery norms & guidelines, standards for single intervention and minimum standards developed by the countries for the purpose of accreditation, and regulation etc. A package includes different types of service packages developed and implemented internationally or at national level.

2.3.2 Human

"Human" dimension incorporates the service providers and consumers. It includes human resource set out to implement standards and packages starting from the organizers, technical/clinical/medical related health personnel, administrative staff, management staff and support staff. This dimension determines the acceptability of standards and packages and performance by the staff. It also includes motivation, incentives and their existing capacity and capability in understanding and practical application of these standards.

2.3.3 Organization

"Organization" incorporates authority or a body/unit that is implementing and setting standards and packages. This includes government, private, donors, stakeholders or any other agency/organization. The important thing is the resources/funding distribution for implementing the standards and packages and the role of each organization for their sustainability and further development.

A fit among the three is required to achieve a successful implementation of standards and packages.

3 Methodological Approach

Situation Analysis was conducted through an in depth desk review of the existing international and national literature along with field visits at the national level followed by consultative workshop with all the provincial stakeholders (Refer to Annexure 3)

Literature review focused on experiences of standards and packages in Pakistan and the rest of the world with special reference to lessons learnt and various implementation strategies. This was followed by consultations and field visits conducted at the Federal and Provincial level i.e. Punjab, Sindh, Khyber Pakhtunkhwa, AJK and Balochistan for assessment of the current status of the individual provinces for implementation of the MNCH related MSDS. The aim was to gather information and fill the gaps identified from desk review and to triangulate the findings from the field visits and desk review. A combination of in-depth interview, focus group discussion and observations were carried out. Details of the tools used can be seen at Annexure 4

The field activities included focal persons of the following cadres please refer to Annexure 5

- Policy makers/planners
- Managers
- Implementers
- Development partners/Donors and
- Direct beneficiaries

A national Consultative Workshop was conducted with the key stakeholders from all the provinces and the federal level for consensus building on the implementation plan and to discuss the way forward for each province regarding the implementation of the MSDS. The consultative workshop was conducted to fulfill the following objectives;

- Share the international and national experiences and lessons learnt for MSDP/MSDS.
- Discuss the issues and challenges for planning and implementing the MSDS for primary and secondary levels of care and share the lessons learnt
- Suggest options for taking this process forward according to the individual and specific status in the provinces/regions
- Develop a consensus for the way forward.

The agenda of the workshop and the list of participants are given in Annexure 6 along with the briefings papers (international and provincial) used in consultative workshop. The workshop proved to be an interesting platform for knowledge sharing as the respective provincial stakeholders became aware of the MNCH related MSDS activities implemented by the other provinces and the participants expressed a common interest in what the other provinces were doing and how far they had come along the implementation plan. Although the provincial stakeholders turnout at the workshop was less than expected by and large there was a consensus on the road map for implementation and the provincial representatives agreed with the consultants regarding lessons learned and the way forward.

4 FINDINGS FROM THE LITERATURE REVIEW

The primary objective for conducting the literature review was to describe various standard/MSDS/package used nationally as well as elsewhere in the world, including experiences, outcomes and lessons learned. The other objectives were to:

- Identify the differences (change) after setting service delivery standards and packages in terms of improvement in the delivery (coverage) of services and the health status of the consumers
- Determine whether the implementation of standards and packages were a success or a failure and the reasons for failure
- Critically analyze the standards & packages and identify theme/s in terms of lessons learnt.
- Suggest recommendation and suggestions for applicability of MNCH related MSDS & MSDP in Pakistan (after corroborating the evidence from the field)

Details of the literature review can be viewed at Annexure 7

4.1 International literature review

A predominant approach for improving quality of care, globally, is by setting standards. Standards define the responsibilities and activities concerning quality as an integral part of all services offered in settings including hospitals and community or as a health package. Standards focus on patients, staff and the organizational management which can be used to regulate the services as in UK; or as an essential guidance for the health care providers as set by Jordan and developed by WHO. In addition most of the countries have developed some way of monitoring of adherence to standards which has shown improvements in the quality of services provided.

In developing countries, standards are more focused on service provision, to improve the existing quality of services offered in order to address the needs of their people. In addition these standards and packages set a road map, vision and strategy for future policy development as in Afghanistan, Sierra Leon, and Liberia. Whereas in developed countries these initiatives are used mainly for uplifting of the existing quality of services and to improve upon and meet expectations of the patients especially in the hospital settings.

A package consists of various components which can be further defined by standards. In other words a package is a parcel consisting of different areas of services according to the priorities such as reproductive health, child health, nutrition, communicable disease treatment, mental health etc. These can be further defined by set of standards in order to improve quality of services as in Afghanistan, Sierra Leon, Sudan and Liberia. The packages designed to address various health priorities, require collaboration and integration among different components of health system (community participation, inter-sectoral collaboration and referral system) for effective service delivery. The literature illustrates that though the packages follow the development and implementation of the standards, but this sequence is not always followed as

demonstrated in some of the developing countries where standards have been developed as a priority by for improving the quality of care and responding to the need of the clients/community.

The packages or standards that have been set through public private partnership (PPP) have found to be more effective and sustainable with improved coverage of population and better results[11]. The lead in almost all the cases has been taken by the governments themselves. Financial source in most of the cases has been a donor agency initially, but once the process was established it was limited or extended according to the funding or the resources available.

The need for in-service training and capacity building is considered mandatory prior to the implementation of standards/ packages. Addressing and prioritizing the community needs forms the basis for setting standards and packages. In addition to this, an adequate pay package, and a good skills-job description mix of the health care providers adds to the motivation and compliance of the health care providers in setting and implementing the standards. Robust planning for monitoring the process should also be predetermined for ensuring better implementation of the standards.

4.2 National literature review

Please refer to Annexure 8 for the list of documents related to standards and packages reviewed for national literature review.

In Pakistan, standards have been the operating norm for MNCH related initiatives with the exception of Punjab that has developed a Package in addition to Standards. On the national level, standards have two principal objectives, Firstly, they provide a common set of requirements applicable to the whole of the health care system and secondly they provide a framework for continuous improvement in overall quality of care. National Health Policy (NHP)[12] states that it is the responsibility of the state to ensure universal access to preventive and curative health services through a package of essential health interventions that are provided without economic, geographical, social or cultural barriers. This vision is expressed in a policy objective that aims to "provide and deliver a package of quality basic essential health services".

Since the implementation and the delivery of health services is a provincial responsibility, the policy mentions that priority actions emanating from the policy objectives would be in accordance with the provinces needs and expectations. The Federal Ministry of Health[13] will support and facilitate the provinces in implementing these strategies by providing the overall vision and the relevant financial and technical resources to ensure that essential health services are accessible to all citizens. The process of the development and institutionalization of MSDS requires a great deal of consultation and consensus building and also certain allowances have to be made owing to unevenness in the quantum of services at the same level of health facilities within individual districts and provinces.

[11] Southern Sudan, Liberia & Nigeria
[12] National Health Policy (Draft), Ministry of Health Government of Pakistan May, 2010
[13] Please note that this assignment has been conducted when 18th amendment was not implemented and Ministry of Health existed at the federal level

A number of issues in the context of basic essential health services for primary health care facilities Basic Health units (BHUs) and Rural Health centers RHCs), across the provinces, have been identified in the draft National Health Policy (NHP). It states that the quality of services is unreliable and standards of services vary between facilities. Inadequate human resource and physical infrastructure, erratic medicine supplies are some of the issues across all the provinces. Other highlighted issues include a need for formalizing the referral pathways along with standardization of services. Also the scope of preventive care is limited to in-facility immunization and antenatal care only. Furthermore as most of the initiatives are donor driven, their sustainability remains to be an issue.

Punjab has well defined MNCH related Minimum Service Delivery Package (MSDP) and standards (MSDS) implemented through various donor and provincial government agencies working together. This includes a comprehensive inclusion of domains that focus on Services-Package, Physical Standards, Drugs and Supplies, Human Resource, HMIS, Supervision, Performance Assessment, EmONC and general services encompassing preventive, curative and rehabilitative services. MSDS is defined for all vertical programmes as well. An effective referral system is also proposed. Most of these initiatives in Punjab are donor supported.

In Azad Jammu Kashmir (AJK) the uniqueness of MNCH related MSDS initiative was the consultation of international and national experts to identify gaps in services and policy. This resulted in identification of 14 key performance areas and 279 standards. 219 primary health care standards (PHC) were identified and implemented, that came at no extra cost and could be improved right away in existing resources. Personal development and self- efficacy were promoted as a means of staff motivation. Advocacy and resource mobilization tools were also developed. These initiatives were client and health care providers oriented. The donors involved were Jhpiego and USAID in partnership with WHO and GIZ.

MNCH related MSDS in Khyber Pakhtunkhwa included written guidelines for management of clients/patients and for the treatment of common ailments. In addition Client/Patient information was registered, coded, analyzed and used as a mechanism of monitoring and planning. System of registration along with timely and fair response to client's complaints was developed. Availability of essential drugs and supplies during all working hours was ensured. A primary care management committee was introduced to plan and manage resources, support the processes of services and to communicate decisions and information to the relevant persons and organizations.

The inclusion of MNCH related Minimum Service Delivery Standards and Packages in these provinces were designed to improve upon the existing facilities and services, However Punjab by virtue of adequate physical infrastructure was the only province that could support and sustain these initiatives, the other two provinces lacked in this area. In addition, Punjab has the most detailed and comprehensive package and standards to cater for its people's needs.

5 INSTITUTIONAL CONTEXT

5.1 Pre 18th Amendment Scenario

The federal government formulated the national health policies and assisted the provincial governments in the implementation and delivery of health services. The role of the federally controlled Ministry of Health (MoH) involved policy-making, coordination, technical support, drug regulation, research, and training. It also operated a few tertiary hospitals and several federally funded preventive health care programmes.

5.2 Post Devolution Opportunities

After the passage of the 18th Constitutional Amendment in 2010, most health programmes in the list of the Constitution, as well as responsibility for the majority of preventive programmes, were transferred to the Provinces. It is envisaged that in post devolution scenario, more opportunities will be available to improve health services as provinces and districts will become directly accountable for health outcomes. Devolution will help to generate services that correspond to local needs. Provinces will have clear policy and programme decision making power. Devolution and restructuring appears to provide opportunities for introducing/embedding MSDS in the regular functioning of the respective health departments. Following devolution, Provincial governments are preparing for a more integrated approach to health service delivery and routine information management, moving away from vertical programme delivery and building on the operational integration already in place at district level. They are taking steps towards integrating some vertical programmes (e.g. Punjab's integrated PC1), strengthening the district based health system, and agreeing key indicators for a unified routine data collection system, the DHIS. The MNCH related MSDS implementation can help reinforce these developments with an aim towards achieving MDG 4& 5.

However, there are risks, such as weaknesses in procurement, and concerns about inter-provincial co-ordination. There is also confusion regarding restructuring of technical committees. Another major challenge for provinces is loss of support of the national programme, with regards to financing, and technical inputs.

6 SITUATION ANALYSIS OF MSDS AND MSDP

The situation analysis of MNCH related MSDS and MSDP in Pakistan has been described for each of the provinces[14]. It describes the evolutionary process; including the need for standards their implementation as well as issues and challenges faced.

6.1 FINDINGS FROM PUNJAB

There are two main standards implemented in Punjab, one is MSDS implemented in 15 districts of Punjab through the PDSSP (Punjab Devolved Social Services Programme) of the Department of Health and the other is the pilot project of ISO certification in Chakwal district supported by the UNFPA.

6.1.1 Need for Standards

Minimum service delivery standards (PDSSP) was conceptualized and initiated by the government in 2009 with support through a TA by DFID and a financial aid from ADB. It was initiated keeping in view the issues of access and coverage, of public health sector in Punjab where about 600 BHUs were non-functional. Quality of care was identified as a major issue. In order to standardize care, service and coverage, minimum service delivery package and standards were proposed. The process involved a situation analysis of Punjab and the documents developed as part of this process, propose a package, physical standards, standard operating procedures (SOP), standard medical procedures (SMP), accreditation, costing and regulatory and monitoring mechanisms. The PDSSP standards focus on primary and secondary care mainly; however tertiary care standards are also being developed.

Pilot project of ISO certification of health services started in 2004 in Chakwal district, supported by the UNFPA .This voluntary certification initiative focused on MNCH services in primary and secondary health facilities. The services and objectives were developed after district consultations. The calibration of the instruments was also part of the standards, and checklists for the various standards were prepared. The clinical standards were mainly on infection prevention, waste disposal and EmONC protocols of MNCH program. Trainings were conducted for skill enhancement and referral system was strengthened. The information system was aligned to compliment the DHIS. The ISO certification was renewed in 2010

6.1.2 Implementation

With the initiation of Punjab Millennium Development Goal Programme (PMDGP) a more focused intervention was developed in relation to PDSSP. Twelve MNCH related indicators (out of which, 10 are service delivery indicators) were prioritized and selected for implementation in the seven districts in the first year and 8 in the next year. The district selection was based on various criteria including socioeconomic status, management capacity, and number of health

[14] This was agreed as part of the "Inception meeting" with stakeholders taking into account the variation in each of the provinces as well as the then impending efforts for devolution of health to the provinces and its follow up for future support for improving the MSDS in each of the provinces

facilities along with percentage of rural population. There is performance based allocation of funds to these districts as it is linked with conditional grant from Asian Development Bank (ADB). It was decided that the Pakistan Devolved Social Services Programme (PDSSP) will be introduced in phases both for primary and secondary care. The availability of the drugs, staff and equipment was ensured. MSDS trainings were imparted to various levels of care providers. The guide maps, list of essential drugs and citizen charter were prominently displayed in the facility. Patient feedback is encouraged by displaying the contact number of the EDO and facility in-.charge in the facility. The current implementation phase does not include the clinical standards

In reference to ISO certification in Chakwal, currently six RHCs, one THQH, and one DHQH are ISO- certified. The RHCs are providing 24/7 basic EmONC and FP services. To cater the sustainability of the project, 90% of the project staff was inducted from the existing government and MNCH staff.

The in-charge of the facility was made responsible for the maintenance of the standards. A management representative, acting as the monitoring supervisor, was selected from either the national program (LHW), DHDC, or Family Planning to ensure independent monitoring or supervision. A yearly internal audit was also performed in which the objectives and standards are reviewed. In addition, external auditors from URS, lead auditors as well as technical advisors evaluated the certification yearly. An innovative way of quality check was in the form of monthly evaluation of the facility by the facility in-charge of another facility. This was to removes bias and for a healthy competition to improve quality. On good performance, awards and appreciation certificates were also distributed to the individual facilities.

6.1.3 Issues and Challenges

Human resource availability especially of the MNCH related female medical officers is an issue in Punjab, though to a lesser extent as compared to the other provinces. The responsibility of the medico legal cases with WMOs deters lady doctors to join RHCs. The RHCs cannot provide round the clock services due to lack of staff, security issues and inadequate residential arrangements. Intra district variation exists regarding human resource, management capacity and services offered at each level. There are 130 vacant posts of midwives in District Rawalpindi which is one of the PDSSP districts. The number of human resource is less than the minimum standards specified and interrupted supply of medicines is another important issue. Clinical standards are not being systematically monitored. School health service and the micronutrient part are not totally implemented. The monitoring is through the EDO of the district. The DG office gets the feedback through the routine DHIS reporting. It was reported that there are various information channels including MNCH, DHIS, and LHW from the same facility with conflicting data questioning the authenticity and quality of the data. A third party evaluation was also planned at the time of this situation analysis.

In ISO certification project, the developed standards are mostly adhered to. However there are no separate checklists or detailed SMPs (Standard Monitoring Protocols) for most of the clinical standards. Only some standards like ANC and infection prevention are monitored through

checklists. It was reported that the supply of drugs is not consistent. Although training was imparted for the use of magnesium sulfate in eclampsia according to the MNCH protocol, there were reports of eclampsia patients being referred from the BHU without treatment with magnesium sulfate. Field visits, also revealed that magnesium sulfate was not available in some facilities

6.2 FINDINGS FROM AZAD JAMMU KASHMIR

6.2.1 Need for Standards

PRIDE Project introduced a practical management tool known as Standard Based Management Recognition (SBM-R) in District Bagh, in partnership with the Department of Health. Pioneered by Jhpiego, this tool was successfully implemented in more than ten countries for improving health services performance against internationally accepted standards of quality. This tool focused on best utilization of available resources along with a robust monitoring mechanism. Initially, for this project, international and national consultations were sought to identify gaps and then SBM-R was implemented. The main aim was to improve quality of care, mainly for primary and secondary MNCH services already available at the facility.

It was a need based initiative with good planning. The local political leaders were made part of the committees for political commitment. The participatory approach helped in solutions for problems, which improved service delivery to the community. The two ways communication resulted in ownership on both sides.

6.2.2 Implementation

14 key performance areas and 279 standards were identified and standards based management and recognition (SBM-R) was implemented in 30 facilities. For appropriate implementation, necessary improvements at primary and secondary care level were taken with respect to technology, human and organizational context; each cadre of the staff was trained according to his/her job description to put the standards into practice. The most effective part of the process was the formal monitoring and supervision plan with checklists for physical, clinical and HR standards.

Monitoring was decentralized by dividing the district in three zones, each supervised by a public health officer of the project who along with the EDO would organize regular, scheduled visits to the various facilities. The other monitoring teams included training co-coordinators and social organizers. In addition a detailed evaluation was also done twice yearly.

Incentives were also given to the staff and the community in the form of monetary benefits for each cadre of staff, enhanced salary, and gifts for newborns for women delivering in the facility. There was a yearly reward/ recognition ceremony for the staff as well

Community awareness activities also helped in improving the health seeking behavior which was further aided by the branding/ naming of the facility in order to make it more users friendly in the local context.

6.2.3 Issues and challenges

PRIDE project was successfully implemented and there was remarkable improvement in the areas specified. However, after PRIDE finished the project in 2008, the quality of health services suffered.

This deterioration is attributed mainly to lack of funds, monitoring mechanism and human resource. PRIDE had ensured sustainability of human resource (HR) by signing a memorandum of understanding (MoU) with the government, that government will absorb the human resource inducted by the project. However, currently only about 60% of the staff has been inducted, receiving government salary which is one third of their salary under PRIDE; this has led to de-motivation and lack of ownership. There are 22 vacant posts of women medical officers which are not filled mainly because of the low salary package. In addition due to lack of funds, salaries are not received on time leading to frustration and lack of interest in the health staff.

Obstetricians were not allowed to have private practice by PRIDE but were offered a good salary package. Government now allows private practice along with the government salary package with the result that there is a shift of focus to private practice by the obstetricians.

Since there is no cadre of TBAs in the government PC-1, they were not inducted, which resulted in the disruption of 24 hour delivery services as LHV finds it difficult to attend the deliveries alone at night. Previously the TBA would accompany her for the late night deliveries. The decline in the services can be appreciated by the example that in DHQ Bagh there were 2121 deliveries in 2009, which dropped to 1489 in 2010-2011.

There is currently lack of funds to carry out monitoring and supervisory visits, which have affected compliance with the standards. Another hurdle is lack of human resource, for example partogram is not being maintained anywhere, though the printed graphs were available apparently because there is lack of skilled staff to maintain it.

Some of the standards which are not dependent upon resources, like infection control, are still being followed at some places only. Health personnel also feel that there is no recognition of good quality work.

The central decision making and red tapeism, duplication of work by different departments, political interference in HR placement and the lack of integration between the MNCH and the government staff are other factors crippling the health system. The disparity in salaries of MNCH and Government staff is also a source of resentment among workers and serves as a challenge for successful implementation of standards.

6.3 FINDINGS FROM KHYBER PAKHTUNKHWA

6.3.1 Need for standards

Health Regulation Authority (HRA) along with the support of GIZ initiated a process that focused on autonomy of the tertiary care hospitals. In pursuance of this initiative, firstly the primary and secondary health care standards were defined. For tertiary care facilities a federal level consultation was done and afterwards the agreed upon standards were submitted to Pakistan Standards and Quality Control Authority (PSQCA) whereas Health System Reform Unit (HSRU) of Khyber Pakhtunkhwa submitted the primary and secondary level care standards. A Primary health care (PHC) manual on Quality of care (QOC) was developed as well. At present HSRU is in process of developing secondary level care manual for QOC. In addition to these initiatives the "improvement of quality" is declared as one of the top priorities in health sector strategy of Khyber Pakhtunkhwa. Thus, under the recent reforms, there is a provision of "demand side financing" where by the beneficiary can actually chose the facility and thus in competition each facility has to perform better by implementing the MSDS

6.3.2 Implementation

Under Improving Quality of Health Care project (IQHC) 10 pilot BHUs were selected and 33 standards were applied. At the District level on-job training of the BHU staff was organized. The training included orientation of the standards along with the way to develop proposals for quality improvement. The latter was meant to involve community living around the BHU in development of schemes aimed at improvement of quality of services. This was to ensure enhanced ownership of the BHUs.

Interest of the staff and patients was given due consideration during the planning process. Client/patient information was registered, coded and analyzed as a mechanism of monitoring and planning. Staff hiring, induction and training was done according to documented procedures and job descriptions. Community was also involved for improving the quality; in some places the health committees were quite proactive. Apart from that the privacy of clients during examination and consultation, waiting areas and female toilets were built/renovated in response to the demand of the patients in few BHU's; this was considered as one of the standard for improving the quality of BHUs. Altogether the ownership of these initiatives by the staff and clients was very high.

The hospital standards consisted of five parts i.e. management, service delivery, auxiliary services, infection control, hygiene, waste management and safe environment. Each part consists of standards and measurable criteria to make standards operational and provide details on structures and processes necessary to ensure high quality of care. There are written guidelines for the management of patients for the treatment of common ailments. A defined process for referral of emergency cases is also in place.

The progress on the initiative is being monitored at the top level in the province, under the chairmanship of the Health Secretary, quarterly meetings are being organized. Key priority

areas are discussed and approval is sought from the cabinet hence the initiative has a strong policy cover. As per the requirement of PC-1, health management committees (HMCs) have been formed, however, on ground monitoring mechanism is still under consideration.

6.3.3 Issues and challenges

Overall the standards have been defined as the "minimum" implying that "these are achievable within the existing resources but have not yet been achieved". There exists some misapprehension among the health care providers that quality of care and service standards is a western agenda, since some development partners have been supporting this initiative.

There is absence of synergies between departments (e.g. DOH with TMA, local administration) due to political influences/interests etc. Capacity building is not being done concomitantly along with material support. Billions of rupees worth equipment is lying unutilized, unpacked even at a number of health facilities, due to lack of trained workers. Also the DHIS is still not capable enough technically to capture all the information of the vertical programmes; and other management related information.

6.4 FINDINGS FROM SINDH

In Sindh, MSDS for Primary Health Care are defined under the ADB funded Sindh Devolved Social Services Project (SDSSP). These MSDS are being followed/referred to in every pertinent PC1. However, at present, there is no formal operational mechanism on ground for full implementation of the standards. Field visits and consultative meetings held with the stakeholders of the province revealed that the participants are of the view that MSDS is ultimately about achieving MDGs. The findings from the meetings and field visits are as follows

6.4.1 Need for standards

Without defining the standards, the success of health packages cannot be measured. Standards also imply increased clientele due to better quality of services. Population Welfare Department has defined a number of standards including National Standards of FWCs (Family Welfare Centers), RHS, MSU, male motivators and male mobilizes, the most important one being the Medical Eligibility Criteria (MEC) for the contraceptives. However Population Welfare Department has not defined standards of ANC and PNC. For the provision of MNCH services at PWD's FWC SOPs need to be defined for meaningful functional integration. The implementation of MSDS will be important for the vertical programs and their integration at district level.

6.4.2 Implementation

The package of services defined in the PC1 needs to be converted into practical and feasible standards and is yet to be done. Integration of vertical programs will require a robust overarching framework by the authorities. This would entail development of SOPs and identification of new roles and responsibilities. These in turn will ensure that vertical programs such as Population Welfare, EPI etc. complement each other. Generating finances for these

initiatives and bearing the cost of implementation of the standards needs to be considered by the Government. DG Health, EDO Health and DCO are the key stakeholders in defining and implementing the MSDS. The political commitment for taking the implementation of MSDS forward is necessary. There is a need for standardized tools for monitoring. There can be committees of notables, chaired by the DCO so as to get key stakeholders engaged in the monitoring process. PAIMAN initiative has demonstrated that a consortium of multiple partners (such as NGOs and GOs) can play an effective role in monitoring and implementation.

6.4.3 Issues and challenges

There are a number of areas that require consideration during development of a meaningful initiative for quality improvement. The biggest hurdles come from an inconsistent flow of funds that has a domino effect on the quality of implementation and hence the services. Also generating and harnessing inter-departmental synergies might be challenging. For instance, it was shared that positioning and getting acceptance of PWD staff in the health institutions is not an easy process.

In addition maintaining standards in a health facility depends on a number of factors. For example, if staff is given effective training on infection prevention and use of chlorine, unless the required supplies are provided on a continuous basis the knowledge imparted to the healthcare providers cannot be practiced for better quality services. It was observed that there is no chlorine available in the facility; even if it is available, sterilization equipment is not available, and even if these issues are catered for, erratic electricity supply will remain a problem.

6.5 FINDINGS FROM BALOCHISTAN

At present Health Department in Balochistan does not have much experience in the area of quality health care service due to various reasons; top of the list being the poor law and order situation in the province, political interference, poor governance and lack of capacity of care providers. Issues relating to Human Resource for Health (HRH) were mentioned frequently during discussions. The influence of TBAs on MNCH is a logical consequence of the absence of skilled human resource in the field. The stakeholders in Balochistan are of the view that ensuring the availability of services is the primary issue and expecting the system to deliver quality care is a secondary one.

Currently in Balochistan no standards are implemented in the public sector facilities. Based on the field visits and consultative meetings the following observations about the current situation of standards in the province are given;

6.5.1 Need for standards

While International standards can be adapted in the local context, the challenge is to implement these in a fragmented, resource poor system with heavy political interference. Since packages have already been defined in PC-1 according to level of health facility, before embarking upon the standards the focus should be on ensuring what has been defined in thePC-1.

6.5.2 Implementation

Implementing standards might require a task force at provincial and/or district level. Regulation should be done by the competent individuals preferably from within the health department. Health department Balochistan, does not favor contracting out and instead believes in strengthening of their own public health care system. However, there might be examples to justify partnership with the INGOs who have demonstrated good results in the underserved areas. Respondents felt that instead of the whole system, some parts of it e.g. M&E can be contracted out. The WHO experience in Mastung District shows that contracting out can be fruitful probably due to less political interference. There is also a need to define standard of supplies and calibration of equipments through periodic checks. Referral system and providing referral services from BHUs to the higher levels, needs to be defined and detailed as well.

6.5.3 Issues and challenges

The biggest hurdle in services delivery was reported to be that of availability as well deployment of skilled human resource. At present majority of the doctors are concentrated in the provincial capital. Security issues, political interference and poor governance are the challenges that need to be addressed prior to implementation of MSDS. Financial constraints are another major hurdle in effective monitoring of the programs. Incentives for public sector healthcare providers need thorough consideration to attract the qualified private practitioner for joining the public sector facilities where the positions are vacant due to non availability of skilled staff.

6.6 FINDINGS FROM GILGIT BALTISTAN

The province of Gilgit Baltistan is currently lagging behind in the provision of quality healthcare services. So far no standards have been formulated or implemented for quality of care and MSDS in the public sector. Although some work has been done by the Aga Khan Foundation and other NGO's but it was beyond the scope of this assignment to map these efforts due to its specific focus on the public sector related quality healthcare initiatives.

Based on the consultative meetings with the stakeholders, the current situation of standards in the province is as follows.

6.6.1 Need for standards

Firstly the Government needs to define and formulate standards keeping in view the initiatives taken by other provinces. Within available resources, minimum services that can be provided should be ensured. There is a dire need for improving upon the quality as well as the quantity of the service delivery facilities. This includes, addressing the issues such as human resource development, trainings, and availability of medical equipment. There is also a need of an established supplies and logistics system, regular repair and maintenance for improving the current status of health facilities.

6.6.2 Implementation

The non availability of well trained and qualified human resource for health is the main reason for lack of quality initiatives in the province. Dearth of educated and skilled female care provider particularly will make the implementation of MSDS a major challenge.

6.6.3 Issues and challenges

Political interference, budgetary constraints and geographic accessibility are the main concerns for the Government of Gilgit-Baltistan when it comes to planning and implementation of any health related initiative. There is no strengthening and support unit for provision of technical assistance for quality improvement initiatives. Besides, the DOH is starting virtually from scratch and needs physical, financial and human resource to run the system. In addition, proper legislation to incorporate the defined minimum standards into the existing health system will be required for the sustainability of the MSDS.

7 COMPARISON OF THE EXISTING NATIONAL STANDARDS & PACKAGES

This section summarizes the comparison between the three main standards that have been implemented in different provinces/regions, focusing on primary and/or secondary level care services. The initiative in Khyber Pakhtunkhwa is being led by the Department of Health along with technical assistance from GIZ, the one in Punjab through PDSSP with support from TAMA (ADB & DFID funded) and in AJK, by Jhpiego (supported by USAID) and was limited to one district. The purpose of the comparison is to identify similarities and strengths and to suggest future recommendations. Please refer to Annexure 9 for details. The main themes of the comparison are summarized as follows;

7.1 Policies, Strategies and Systems

While the stewardship lies with Government of the Punjab and Khyber Pakhtunkhwa for the implementation of package and MSDS, this is not the case with AJK where donor agency was the primary driving force. The Punjab and Khyber Pakhtunkhwa Governments have addressed both the primary and secondary level care facilities and their integration. Punjab has also started developing standards for the tertiary care.

The initiative by Khyber Pakhtunkhwa is more process oriented approach and takes into consideration the demand side financing as well.

7.2 Governance and Management

Punjab has suggested a supervisory framework. The strength of AJKs initiative is the development of field tested technical management tools for the quality of care. Although financial options are provided in Punjab, the costing has not been undertaken anywhere in the reviewed projects. Overall per facility cost has been mentioned for the Khyber Pakhtunkhwa initiative only. In addition, the governance issues, are addressed under legal cover by the Health Regulatory Authority

7.3 Community Dimension and User satisfaction

Punjab has categorically suggested the role of health committees for the sake of close liaison between the community and the health care system. PDSSP has another edge over the other initiatives in terms of clearly defining the patient rights and obligations and has proposed Social Protection and Safety Nets for the poor. Complaint and feedback mechanism have also been proposed in the Punjab and Khyber Pakhtunkhwa initiative. The client and staff satisfaction and priorities are taken into account in the Khyber Pakhtunkhwa initiative right from the beginning hereby increasing the ownership of the community and staff for standards.

7.4 Standards

Khyber Pakhtunkhwa has generally defined cross cutting standards. Punjab has comprehensively addressed the standards for the primary, secondary and tertiary care while

AJK has specifically focused on the standards related to MNCH. Both Punjab and Khyber Pakhtunkhwa have defined clinical governance guidelines.

7.5 Human Resource

All the initiatives have included capacity building of staff; however, minimum standards of HR in qualitative and quantitative terms have been specifically defined only by PDSSP. Costing of the training has not been done in any of the initiatives. AJK has a special emphasis on the performance appraisal and reward system.

7.6 Physical Infrastructure

Khyber Pakhtunkhwa has defined standards for the improved ambiance and infrastructure where as PDSSP defines the minimum acceptable physical standards. All provinces have included improved or upgraded physical surroundings in their respective standards.

7.7 Drugs and Supplies

All the packages have addressed the drug and supplies aspect comprehensively in their standards.

7.8 Conclusion

Minimum Service Delivery Package (MSDP), as defined internationally, should include the minimum set of services that are approved for the specific level of facility i.e. primary, secondary or tertiary. A client should be able to avail the same type of services from any level of facility throughout the country whether public or private. The concept of standards and packages is that all the health services provided throughout the country follow the same quality of standard . In Pakistan, though ESDP[15] has been developed but not implemented as yet, but the package of services are more or less defined for at least primary and secondary level care facilities; the quantity and variety of services within each package however differs at various level of services, within the districts and at the provincial level. Therefore, most of the initiatives in various provinces of Pakistan have been focusing on development and implementation of the standards, rather than following the ideal sequence of developing MSDP followed by implementation MSDS.

MSDS initiative taken by Khyber Pakhtunkhwa seems to be a balanced and more process oriented approach that takes into consideration the demand side financing as well. The client and staff satisfaction is made a priority in this initiative hence by, increasing the ownership of the community and staff. In addition, the idea of scaling up at a later stage was also incorporated in the design of the initiative here by making it easier for implementation in the long run. Also the long term sustainability of the Khyber Pakhtunkhwa initiative is likely as these standards are developed by the Khyber Pakhtunkhwa Government and HSRU with the financing by the

[15] ESDP has been developed in 2008 by Ministry of Health and WHO, but it has not been formally approved and implemented

Government itself. Donor (GIZ) was responsible for the technical inputs and assistance only, thereby lending it a strong foothold when GIZ finally pulls out. Overall, per facility cost has been mentioned in detail for the Khyber Pakhtunkhwa initiative too something that was not done in similar initiatives. It is prudent to mention here that although Punjab has the most comprehensively defined standards but as it is a donor financed initiative the long term sustainability of the project needs to be determined. Furthermore, the implementation of these comprehensive standards was not followed up mainly due to human resources issue- as personnel hired for these services were not equipped with the skills set out in the standards. All in all, although Punjab has the most detailed and extensive package, it cannot compete with the implementation soundness of Khyber Pakhtunkhwa s initiative as the operational agenda of their initiative is defining the minimum standards as achievable within the existing resources but are yet to be achieved. This sound philosophy in design and implementation results in possible achievable outcomes in a low resource setting like Pakistan

8 OVERVIEW OF PLANNING FOR IMPLEMENTATION OF MSDS AND MSDP

Development and institutionalization of MSDS is a cumbersome process. For, it not only requires a great deal of consultation and consensus building but also needs compromises because of the disparity in the quantum of services at the same level of health facilities within districts and provinces. Further it is not only about defining the MSDS but ensuring their implementation which requires investments (man power, money, material, time and technique) and above all administrative will for ensuring the improvements in quality of overall health services, especially the MNCH services.

Following is an overview of planning for implementation of MSDS and MSDP of the provinces

8.1 Punjab

Punjab Government took the initiative and started Punjab Millennium Development Goals Programme (PMDGP) funded by the Asian Development Bank. This programme is to be completed in three sub-programmes i.e. MDGP-SP-I, MDGP-SP-II and MDGP-SP-III[16]. The PMDGP focuses on improvements in healthcare service delivery for achievement of health related Millennium Development Goals, specifically Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and care of mother & child health by implementing the Minimum Service Delivery Standards (MSDS) for the Primary and Secondary Health Care Facilities, developed by the Punjab Devolved Social Services Programme (PDSSP). The Services Package defined in MSDS comprises interventions for the major causes of the burden of disease focusing mostly on all elements of Primary Health Care in the province. Standards were developed keeping in view the international/WHO standards, socio-economic milieu and the feasibility for implementation of these standards. MSDS were aimed to provide useful and credible benchmarks for service delivery in the health sector to the District governments[17].

Minimum Service Delivery Standards (MSDS) have been defined as the minimum set of services to be provided to the population of the Punjab by improving availability of standard human resource, proper training, and availability of equipment, health promotion activities and improved curative services. Although, most of the standards are restatements of existing ones, they are stipulated in different program documents, the notification of the standards enables all districts to revisit their health delivery system and monitoring standards

The MSDS define a set of services to be available at each health facility, and coverage targets for each service. The Government of Punjab has decided that MSDS should be enforced in phases, with the first phase comprising MNCH-related standards. In the, pilot phase, they have been implemented in six to eight District Governments of the Punjab; however on successful completion, they would be extended to the remaining 29 District Governments of the province.

[16] Currently it has moved into SP-III and an external evaluation is being conducted during the time period of this assignment

[17] MSDS for primary and secondary health care in Punjab, PDSSP 2008

The proposed implementation period for the Punjab Millennium development goals programme (PMDGP) sub programme 1 was from January to October 2008. The indicative implementation period for sub programme 2 was November 2008–November 2009; and for subprogram 3, January 2010–December 2010[18]

8.2 Khyber Pakhtunkhwa- GIZ experience

The plan of action 2008-2012 for the implementation of the whole standards for improving the quality of health care services and quality strategy falls under following six broad areas;

- Strengthening the role of stakeholders including the users.
- Increase the competence of the providers in quality management.
- Improve leadership commitment and ownership.
- Improve services through self assessment and external evaluation.
- Use quality improvement mechanism in the health care system.
- Include quality management as a priority area in curricula for education of health professionals[19,20]

8.3 AJK- GIZ experience

The healthcare quality improvement initiatives in AJK by GIZ included of the following steps;

- Development of healthcare standards.
- Quality of care survey in 45 facilitates of AJK.
- Health regulatory authority establishment (under discussion).
- Quality strategy (under discussion)

[18] Proposed Program Cluster and Loan for Subprogram 1 Islamic Republic of Pakistan: Punjab Millennium Development Goals Program, November 2008

[19] GIZ Experiences with Primary Health Care Standards in NWFP, FATA and AJK (GIZ-Health Services Academy 27 march 2008)

[20] Primary Care Standards for Quality Health Services in NWFP- Version-1 January 2007 (Health Regulation Authority-GTZ)

9 PLANNING FOR IMPLEMENTATION OF SERVICE DELIVERY PACKAGES AND STANDARDS

Sound implementation planning is a key element in ensuring the successful delivery of Government policies/strategies. The proposed implementation plan is a management tool that can be adopted or adapted by the individual provinces so as to manage and monitor implementation process effectively. This implementation plan is intended to be scalable and flexible; reflecting the degree of urgency, innovation, complexity and/or sensitivity associated with the existing situation in specific provinces. Therefore, provinces are expected to exercise judgment in this area; however, the level of detail should be sufficient to enable the province to effectively manage the implementation of standards and packages.

The standards (MSDS) provide a framework to assess the quality of care provided in public health facilities and a framework to improve quality in a structured manner. In this way, they are a useful management tool for managers and staff of primary and secondary health care facilities to identify their strengths, gaps and areas for improvement and they will provide a mechanism for the individual provincial Departments of Health to identify priority areas for overall improvements in the healthcare delivery system. It should be flagged that the MSDS is not a onetime business. It would require a cyclical approach of defining of standards based on local priorities, followed by implementation, assessment and further actions as a follow up

The MSDS together with assessment tools (developed/to be developed) provide a framework either for self-assessment or for external assessment and peer review. They can also be used for planning process. Based on an assessment of the strengths and areas for improvement in the health facility, priority areas for improvement can be identified and quality improvement activities started. The standards also provide guidance when problems and questions about quality arise in the daily work of health staff.

9.1 Lessons to be adopted/adapted for implementation of MSDP/MSDS

Globally, the countries which have implemented and institutionalized the service delivery packages and standards have initiated the process by developing a working group/task force followed by consultative meetings to develop a consensus among the stakeholders and defining the institutional arrangements along with roles and responsibilities. The first and foremost step has been developing and/or adopting/adapting the standards followed by their dissemination at all levels. There has been a 3 years roll out plan which commenced by conducting baseline survey to identify the gaps in resources (human, capacity, materials etc.) followed by setting the priorities in terms of resources allocation as well as phasing out of the facilities according to their readiness and community needs. The capacity building of the health care providers and/or managers has been the cornerstone of the implementation process which not only included the training but also offering of the technical support to the provincial and district levels on guiding the facilities in applying the standards. In that context assessment tools, modules and guidelines for both standards and assessments tools and developing monitoring and evaluation

system supported with an information technology (IT) played a crucial role. Mechanisms for transparency and accountability of the providers along with induction of performance based incentives ensured the institutionalization of the whole process. Some of the countries have established a regulatory/accreditation body by calling it as "Health Care Commission". In some countries, some of the services have been contracted out to the private sector for ensuring that standards are followed in true sense.

In Pakistan, though the implementation of standards is at an earlier stage (as described in an earlier section on current status), but it gives mixed and interesting lessons to be learnt for the provinces which have not yet initiated this process. Except for AJK, the Departments of Health in Punjab and Khyber Pakhtunkhwa have taken a lead in implementing the standards; the Health Sector Reform Unit in each of these two provinces has been steering the whole process by developing the standards and rolling it out in a phased manner. The phasing has been for the selective standards as well as the focus (in Punjab more on MNCH and in Khyber Pakhtunkhwa based on the needs and demands of the facilities—top down and bottom up approach respectively). In Khyber Pakhtunkhwa there has been much emphasis on self assessment in addition to the external evaluation in both provinces. There has been allocation of extra resources as well as development of the monitoring system. The standards were developed on the existing and/or recommended packages[21] and no formal sequence of first developing an essential or minimal package (MSDP) has been done which would have followed the development of standards.

9.2 Strategic approaches for implementation

A practical management approach for improving the performance and quality of health services by using the standards has been proposed over here. It is based on the lessons learnt and consists of the systematic, consistent and effective utilization of operational performance standards as the basis for organization and functioning of these services having an inbuilt performance based incentive mechanisms. This approach has been adapted from an approach developed by an international organization which has implemented the standards in a number of developing countries[22].

The team of consultants after the national level consultative process is recommending the application of standards based management approach (SBMA) for implementation of standards. SBMA is an extrapolation and/or adaptation of the already developed materials such as packages, guidelines and protocols (SOPs) and can be translated into the *"operational tools"* containing the standards (MSDS) that can in turn be used as job aids or guides by frontline providers and managers in their daily work. This can be considered as an innovative

[21] Though the packages have been defined/re-defined and/or prioritized

[22] Standard –Based Management and Recognition – A practical approach for improving the performance and quality of health services –JHPIEGO-USAID.

"management" approach consisting of following four steps; these also link up with the proposed analytical framework of HOT[23] and the fit that is essential to achieve the desired results.

1. **Step one**

Setting the standards of performance is about setting/ agreeing and/or adapting level of performance desired; in this context "minimum" need to be defined and agreed among frontline providers[24], mangers and clients. The standards should tell providers not only what to do but also how to do it. The development of standards should include:

a. Identifying the services to be improved
b. Defining in detail the *core processes* (direct services such as preventive services, acute, chronic clinical services etc), *support functions* (managerial system, ancillary services etc) and *strategic directions* (strategic leadership, planning, and partnership etc).
c. Elaborating the performance standards for each process.

2. **Step two**

To implement the standards by

a. Conducting baseline assessment via services and performance assessment tools, this would also help in identifying the gaps,
b. identifying causes of gaps;
c. Identifying the interventions to correct them and
d. Implementing these interventions; implementation may also be considered in phases and slowly evolving process by defining the priorities by the key stakeholders. This also mandates building support for the change process.

3. **Step three**

To measure progress of implementation by follow up assessments using the performance assessment tools; this may be done by

a. Encouraging providers to self-assess their work and can be done as frequently as desired.
b. Conducting internal assessment by bringing other similar healthcare facilities together to share challenges and successes (peer assessment) or the internal monitoring assessment by the mangers.
c. Getting the external assessment done in the form of supportive supervision through some technical assistance.

[23] The HOT refers to H-Human, O-Organization and T-Technology i.e. the standards.
[24] The best definition identified in this assignment has been "the standards that are achievable within the existing resources, but have been not been achieved"

4. Step four

Recognising the achievements by

a. Creating an environment of motivating the staff and providers whereby they can appreciate value of the process and get into some healthy competition.
b. Offering incentives in the form continuous feedback, social recognition (in terms of rewards or certificates) or material recognitions (performance based financial incentives).

It should be noted that these four steps are inter-related just like a puzzle and a sound implementation would require continuous work and support on all of these components of strategic approaches.

10 ROAD-MAP FOR IMPLEMENTATION OF MSDS

The proposed road map for implementation of MSDS though describes an overall and comprehensive process but it focuses on the province-specific approaches, however the specific details and processes have to be further developed as part of the Phase II of this assignment.

Initially the planning and implementation status for MSDS by each of the provinces has been described in the context of the strategic approach for implementation of MSDS (see section 9.2 for strategic approach). This has led to the conclusion that each province is at various levels of maturity and development and further work need to consider that status in order to move to the next strategic step of implementation. This would follow discussing and agreeing on the institutional arrangements and role definitions for having a coherent approach in each of the provinces in terms what may be expected at the provincial, district and health facility levels. The units and or programme taking the lead for either implementing or further strengthening the MSDS need to re-visit and discuss various design options in terms of range of services, level and types of facilities, geographical focus and how the management and assessment of the MSDS will be implemented depending on the resource and capacity available and what needs to be done in future. In the end a draft implementation plan with tentative timelines has been proposed. In provinces where it has to be initiated from the scratch or further developed in terms of the strategic approach (section 9.2 describes four-step approach), there has to be pre-implementation planning phase (of at least 3 months) in which this report of situation analysis need to be further discussed and the key stakeholders from each of the provinces need to agree on their individual status in context of the strategic approach and then plan capacity and resource needs including the monitoring and incentivizing process so as to improve the quality of services in achieving the MDG 4 & 5 targets specific to MNCH.

Following sections describe the detailed road-map for implementation of the MSDS

10.1 Current implementation status of MSDS in individual provinces

The current situation of the standards in all the provinces is critically analyzed and compared through the proposed concept of Standard Based Management Approach (SBMA) in table 1 given below. Base on this schematic illustration, a brief summary for each of the provinces is hereby shared to describe the current situation and what needs to be done to take this process forward.

Table 1: Current implementation status of MSDS in individual province

STEPS/PROVINCES	Punjab	Khyber Pakhtunkhwa	AJK	Balochistan	Sindh	Gilgit Baltistan
Step One- SETTING STANDARDS OF PERFORMANCE[25]						
1.1. Defining the desired level of performance	5	5	3	1	2	1
1.2. Identification of services to be improved	3	4	2	1	2	1
1.3. Detailed definition of service delivery processes	4	3	3	1	2	1
1.4. Elaboration of operational performance standards	5	4	4	1	1	1
Step Two-IMPLEMENTATION OFTHE STANDARDS						
2.1. Baseline and identification of performance goals	5	4	3	1	2	1
2.2. The causes of performance gaps	2	3	4	1	2	1
2.3. Identification of appropriate intervention to correct the performance gaps	2	4	5	1	2	1
2.4. Implementation of intervention	4	2	5	1	2	1
Step Three- MEASURING PROGRESS						
3.1. Types of assessments Self-assessment Internal assessment External assessment	4	1	5	1	1	1
Step Four-RECOGNISING ACHIEVEMENTS						
4.1. Motivation	2	2	4	1	1	1
4.2. Incentives	3	2	5	1	1	1

Level 1 Initial thinking stage
Level 2 Planning or have some plans made
Level 3 Partially implemented
Level 4 In the progress and development stage
Level 5 Matured and completely achieved

[25] Setting/ agreeing and/or adapting level of performance desired; in this context "minimum" need to be defined and agreed among frontline providers, managers and clients

10.1.1 Punjab

Punjab is leading the other provinces in **step one** i.e. **setting standards of performance** as they have developed comprehensive and detailed standards for not only the primary but also the secondary and tertiary levels. Punjab has fully matured and completely achieved processes required in step one and has partially implemented or in the process of developing the rest of the processes in this step. With respect to **step two** i.e. **implementation of the standards**, Punjab is still in the planning phase with only a few processes in the developmental stage. In **step three i.e. measuring progress**, Punjab has made good progress and is in the developmental stage of this step, while in **step four** i.e. **recognising achievements**, Punjab is still in the planning stage with some partially implemented processes.

It needs to be highlighted here that MSDS status in Punjab is being implemented by the provincial government with the help of donors and its sustainability needs to be ascertained, once the donor pulls out.

10.1.2 Khyber Pakhtunkhwa

Khyber Pakhtunkhwa has made good progress in **setting standards of performance- step one** of the implementation plan. The province has fully matured processes with the rest being in developmental stage of the step one. For **implementation of the standards- step two**, while Khyber Pakhtunkhwa has some processes required for this step in developmental stage, a few processes are still in initial thinking phase with some planning done.

With respect to **step three and step four** that are **measuring progress and recognising achievements**, respectively, Khyber Pakhtunkhwa is still in the initial thinking phase with some plans made.

It needs to be stressed here that the MSDS status in Khyber Pakhtunkhwa has a lead on the other provinces with a robust bottom up, process oriented approach, which was initiated and implemented by the government itself, lending it sustainability and enhanced ownership.

10.1.3 Azad Jammu and Kashmir

In relation to **step one- setting standards of performance**, AJK has made steady progress with some processes in developmental stage, with the rest partially implemented or in planning phase. The province is leading the way in **step two-implementation of the standards**, with most processes being fully mature or in developmental phase. AJK has completely achieved **step three- measuring progress** and is in the forefront in **step four- recognizing achievements** with a fully mature process, where the mechanism of incentive and motivation has been incorporated in the design for better performance with a practical implementation on the ground.

Unfortunately, the PRIDE project, being donor funded, could not be sustained after the life of project ended. It needs to be flagged here that the implementation status in AJK is reflective of

the initiative by the PRIDE Project only; it does not reflect the implementation status of the province as a whole. If AJK plans to take this project further, it will have to start from the step two- implementation of the standards, with the rest of the steps in initial thinking phase. AJK will need to rethink the planning involving MSDS if the achievements by PRIDE project are to be captured.

10.1.4 Sindh

Sindh is in the planning phase of **step one** and **step two** i.e**. setting standards of performance** and **implementation of the standards**, respectively. MSDS for Primary Health Care are defined and these MSDS are being followed/referred to in every pertinent PC1. However a formal operational mechanism is not in place in the province. In relation to **step three** and **step four**, which are **measuring progress** and **recognizing achievements**, Sindh is still in the initial thinking phase of the implementation plan.

The provinces of **Gilgit Baltistan and Balochistan** are in the initial thinking phase in all the four steps of the implementation plan

Based on this critical analysis, it can be argued here that there is not a single example or model of standard that can be replicated as a whole, because of each models individual strengths and weaknesses. However, the strengths of each model can be adapted and modified by other provinces to fill the gaps in their own standards leading to a better implementation plan for the respective provinces.

10.2 Institutional arrangements

The experiences in Punjab and Khyber Pakhtunkhwa suggest that the respective Health Sector Reform Units (HSRU) have been steering the process of implementing the MSDS by identifying a focal unit/group responsible for overall management of the whole process. However, in other provinces though there are efforts being made to undertake health sector reforms and even establish the "Reform Units", perhaps it would be a good idea that the Secretary Health of the other provinces (where MSDS has not yet been initiated) be involved in either identifying/nominating a 'working group' or 'task force' to initiate the SBMA process. It should be emphasized that an effective SBMA process requires planning, coordination and technical support. In addition the management of this initiative would also require definition of role of various administrative levels within health systems. During this assignment there was little clarity about Federal roles post devolution. Regarding the scenario post 18th amendment, it is envisaged that more opportunities will be available post devolution to improve the quality of care as provinces and districts will become directly accountable for health outcomes. Devolution will help to generate processes and mechanisms that correspond to local needs. Provinces will have clear policy and programme decision making power. Provinces are perceived to be keen to start integrating programmes through various reform/systems strengthening initiatives. In that context TRF may also consider developing linkages among the various TAs it has commissioned in response to the demands of the government; "Knowledge management" is

one of them and poses some potentials for improving quality along/through better knowledge management.

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Following table suggests the roles envisaged at the various levels of the health system.

Table 2: Institutional Arran ements

INSTITUTIONAL ARRANGEMENTS	
Federal/National level (with limited role after devolution of health sector to provinces)	• Situation analysis conducted and road map proposed (through TRF) • ESHP has been developed but not formally implemented • Coordination role among the provinces can be envisaged • Harmonization of donors' contributions for implementing MSDS • Developing linkages with other initiatives such National HMIS, Knowledge Management Initiative etc
Provincial level	• Conducting rapid programme review for assessing quality of care and packages at primary and secondary levels of care • Developing/strengthening of a health sector strategy and/or reform agenda for improving quality of care and strengthening the health system • Development and/or fine-tuning or further improving the MSDS, • Dissemination of approved standards to the districts/divisions • Development /adaptation of the materials such as manual for implementation, tools for assessment of standards, mechanisms for measuring the progress and institutionalizing the motivation and incentives for managers and providers applying the standards • Development of action plan and provincial scale up plan • Training of master SBMA coaches at the provincial level • Identifying internal and external assessors for measuring the progress of implementation of MSDS • Seeking technical resources according to the needs for initiating or consolidating the process
District level	• Orientation of MSDS and the whole process to the EDO-Health and district health management team • District level mapping and priority setting exercise for phased approaches • Conducting training of the district level SBMA coaches and/or master trainers • Development of district scale up plan in phases • Orientation of health facility managers
Health Facility Level	• Orientation of health facility staff • (Self) assessment of quality OR baseline assessment to identify areas where quality is low and why it is so • Development of a plan to implement MSDS by prioritizing the performance standards • Conducting internal assessment and facilitating external assessment to measure the progress

10.3 Design options for implementation of the MSDS

The situation analysis for MSDS described earlier and the level of progress illustrated in section 7.1 and considering the post 18th devolution context, it is recommended that each province undertakes its own lead in either planning for implementation of MSDS or further strengthening the existing situation. However, with few exceptions the strategic approach will be more or less the same as described in section 7.2. The suggested approach may have to be further discussed and adapted/adopted according to local circumstances. The following design options is proposed here for further discussions with individual provinces and especially applies to the ones where this initiative has to be commenced; however there can be discussion on mid-course changes in the existing efforts by other provinces which have made some headways.

Table 3 Design Options for implementing MSDS

ASPECTS TO BE CONSIDERED	RANGE OF OPTIONS		
Purpose	Short-term promotion of specific services	Improve performance, quality and utilization of services	Ensure consistent level of quality /meet regulatory standards
Type/range of services	Focused on core set of services e.g. MNCH	Core set of services plus other related services e.g. other vertical programmes such as LHW, EPI, Nutrition etc	Comprehensive including preventive and curative services
Type of facility	Primary level care including outreach services for community	First level care facilities (BHU/RHC) & THQ	Primary secondary & tertiary level facilities
Sectoral coverage	One sector (Public or private)	Different but complementary standards for each sector	One set of standards applied across sectors
Geographical coverage	Selected facilities	District/division	Whole province/national
Consequences of performance/incentives	Feedback	Feedback plus social recognition	Material recognition associated with social recognition and feedback
Recognition body	internal	Combined	External
Support and facilitation	Intensively facilitated	Partially facilitated	Not facilitated
Management	Centralized	Shared	decentralized

10.4 Draft Implementation Plan for Implementation of the MSDS

The proposed implementation plan takes into account not only the implementation of the 4 steps as described as part of the strategic approaches but also suggests pre-requisites as part of the planning which would be required for supporting, facilitating and managing the whole process. It should be flagged that it may sound to be more generic but as has been emphasized it offers a road map for each of the individual provinces to discuss and decide where they wish to start their process or build on to their existing status or modify their mid-course processes.

However, it is recommended that in Phase II, a formal work plan will have to be developed and agreed by each of the provinces, based on this proposed plan or be adapted based on the existing situation.

Table 4: Draft plan for implementing MNCH related MSDS and MSDP

Activities	Schedule by three month over two years								
	2011 (9-12)	2012 (1-3)	2012 (4-6)	2012 (7-9)	2012 (10-12)	2013 (1-3)	2013 (3-6)	2013 (7-9)	2013 (10-12)
1 Pre implementation planning									
1.1 MSDS disseminated and discussed in individual provinces	×								
1.2 Identification of the proactive provinces and sourcing of the TAs by TRF and other partners	×								
1.3 Working group/task force established along with ToRs	×								
1.4 Agreeing on the institutional roles, design options and strategic approaches (by Department of Health)	×								
1.5 The working group identifies the gaps and needs to initiate the process in terms of technical resources, SBMA coaches and 'external assessors'	×								
2 Setting standards of Performance (MSDS)									
2.1 Defining the desired level of performance		×							
2.2 Identification of the services to be improved		×							
2.3 Detailed definition of service delivery processes		×							
2.4 Elaboration of operational performance standards		×							
3 Implementation of standards									
3.1 Baseline and identification of performance goals			×						
3.2 The causes of performance gaps				×					
3.3 Identification of appropriate intervention to correct the performance gaps					×				
3.4 Implementation of intervention						×			
4 Measuring Progress							×	×	
5 Recognising Achievement									×××

9 TAKING FORWARD THIS PROCESS/ASSIGNMENT

This report on "Situation Analysis & Planning for Implementing MNCH related MSDS & MSDP" has attempted to share both international and national (especially provincial lessons and experiences) for institutionalizing quality improvement initiatives at primary and secondary levels of care, especially focusing on MNCH. It is proposed that there is no need to invent a new wheel; lessons can be learnt from each other at the provincial level and adapted accordingly. The phased and participatory processes along with consensus on the design and scope of MSDS activities and the adoption of strategic approach and/or its components provide a broader road map for each of the provinces which can be adopted/ adapted accordingly. In addition, the provincial experiences, issues and challenges with few exceptions are more or less the same and can be cross-fertilized.

The team of consultants recommends that the report be printed and widely circulated for getting feedback and further suggestions followed by individual consultative processes for each of the provinces along with all the key stakeholders. The meetings should not only be used for advocating further improvement (where the MSDS is being implemented) but also to sensitize the key policy makers and planners to include this initiative as part of their future strategic planning.

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