FEDERAL OMBUDSMAN OF PAKISTAN

IMPROVING PRIMARY HEALTH CARE SYSTEM IN ISLAMABAD

Wafaqi Mohtasib Secretariat
36-Constitution Avenue, Islamabad, Pakistan
Ph:00-92-51-9216754, Fax:00-92-51-9217224
www.ombudsman.gov.pk

Acronomy

PHC	Primary Health Care
ICT	Islamabad Capital Territory
BHU	Basic Health Unit
RHC	Rural Health Clinics
UHC	Universal Health Care
NHA	National Health Accounts
SAARC	South Asian Association and Regional Corporation
GDP	Gross domestic product
DHO	District Health Office
CDA	Capital Development Authority
MO	Medical Officer
LHW	Lady Health Worker
SSP	Seat- Shaulat Program
EPI	Expanded Program on Immunization
PEI	Polio Eradication program
MCP	Malaria Control Program
TB	Tuberculosis control program
HIV	Human Immunodeficiency Virus
SDG	Sustainable Development Goals
PPHI	People's Primary Healthcare Initiative
SRSO	Sindh Rural Support Organization
OPD	Outpatient Department
PRSP	Punjab Rural Support Program
PHIMC	Punjab Health Initiative Management Company
PPPPA	Public-Private Partnerships in Primary Healthcare
WHO	World Health Organization
MOMS	Midwives or Midwives Skill
CC	Community Clinics
NCD	Non-Communicable Diseases
UC	Union Council
MC	Municipal Council
LHV	Lady Health Visitors
FWC	Family Welfare Centers
IHRA	Islamabad Health Regulatory Authority
CLC	Community Living Centers
ADP	Annual Development Program
M&E	Monitoring and Evaluation

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ACKNOWLEDGMENT

I would like to express my sincere appreciations to Wafaqi Mohtasib (Ombudsman) of Pakistan (Mr. Ejaz Ahmad Qureshi) for his idea of undertaking systemic study regarding public sector Primary Healthcare System in Islamabad Capital Territory and guidance provided through all stages of research, as there were lot of grievances and dissatisfaction among the residents of the city that despite the promise to provide free health services by the government ,the PHC system is suffering from the inefficiencies due to mal- administration .

I would like to express my profound gratitude to the committee members Dr. Amanullah Khan , Chairman , Khyber Pakhtunkhwa foundation and Dr.Shabana Haider , Country Director ((Pakistan),''Think well'' , Maj. Gen. (Rd.) Prof . Dr. Muhammad Aslam , Ex. Vice-chancellor / Advisor, postgraduate education and research & Dr. Mahrukh Durrani of Shifa Tameer- e-Millet University, Islamabad, Mr. Asif Bajwa federal Secretary (Rd.) Dr, Hassan Orooj DG (Rd.), CDA Health Directorate , Islamabad, co-opted members whose thoughtfulness of the issues, objectivity , comments and suggestions helped me to bring more clarity to the work.

I am very thankful to Naila Zahoor, Section officer, Zahra Ibrahim, and Muhammad Ameesh Assistants of Ombudsman Secretariat for their continuous support in data collection, analysis and formation of the report.

Finally, I bow my head to Almighty Allah who has given me the strength and courage to complete this work.

Shaukat Hayat Durrani,

Senior Advisor

Executive Summary

Background and Introduction-Primary Health Care (PHC) system is the backbone of the healthcare system that ensures access and availability to quality, medical responsiveness, and integrated care. Under the constitution of Pakistan, the primary responsibility of healthcare lies with the provincial government. While for federally administered areas, including Islamabad Capital Territory (ICT), the responsibility falls under the Federal government's purview.

Pakistan's public healthcare system suffers as a result of bad governance, poor quality of services, lack of accountability, and insufficient financing. Moreover, a weak political system, poor implementation of laws, difficulties with access to facilities, unequal distribution of resources, poor quality of health management / governance, inefficient health information systems, weak monitoring and evaluation system, and shortage of skilled human resources.

Scope and Methodology- The study was commissioned on the 4th of January, 2023 with the purpose "to review the policy, systems, and regulations of the district health system of ICT after the 18th amendment in the constitution of Pakistan and to evaluate in terms of good governance and service delivery with a focus on primary health care system in both urban and rural areas." A follow-up meeting with the HWM was also held on the 2nd of February, 2023, and further parameters of this systemic study were fixed as follows;

a. The study limits its scope to ICT.
b. The study will highlight the major constraints present and make feasible recommendations to tackle the major constraints in the development of primary health care while also making a risk analysis of all recommendations.
c. As the subject of health has been devolved to the provincial level after the 18th amendment in the Constitution, this study will also review the public-private partnership models adopted by some of the provinces to develop proposals for their replication in ICT.
d. The study will evaluate the existing facilities at Basic Health Units (BHU) in terms of staff, equipment, budget, etc. to highlight shortcomings and make recommendations for further improvement to the facilities.
e. Any proposals for the creation of a new authority or any amendments to the existing laws should be avoided as it would entail protracted working by different bodies without any positive results in the foreseeable future.
f. The committee should, firstly, evaluate strategies and differentiate between the ones that yield results as opposed to those that do not seem to be working. Secondly, the committee should refrain from making recommendations on the strategies that are still being developed.
g. The committee may seek input from additional resources to not only strengthen its analysis of primary healthcare but also to improve its recommendations. The additional resources can be contacted through online video-conferencing tools.

h. The committee may also undertake field visits to better understand the situation on the ground and to interact with the management of the BHUs, Medical Centres (MC) and Dispensaries. These steps would further aid the committee in making concrete proposals in the context of the improvement of primary healthcare in ICT.

i. The committee is also required to undertake systemic research between the parameters laid down.

This report contains five Chapters, **chapter 1** gives an overview of Introduction, scope & methodology, in chapter **2** - Review of Pakistan's Primary Healthcare System and some international experiences are well documented, **Chapter 3 contains** evaluation of Primary Health System of Islamabad Capital Territory, **Chapter 4**, covers Gap Analysis of Primary Health Care System of ICT, and **chapter 5, contains** Conclusions and Recommendations.

Literature Review of Pakistan Primary Healthcare System and International Experiences- A robust PHC system ensures the highest possible level of equitable healthcare for the citizen and the government has extended Universal Healthcare Coverage (UHC) through different initiatives in the healthcare sector. The Government of Pakistan's national healthcare action plan (2019-2023) is based on a vision that aims to ensure the provision of good quality essential healthcare services to all people. It provides a well-thought-out strategic framework for the implementation of good governance parameters that can achieve healthcare-related sustainable development goals and UHC targets within Pakistan. To achieve the national healthcare vision reality, one of the key actions was to develop and implement the UHC Benefit Package for Pakistan, which consists of an Essential Package of Health Services (EPHS) and inter-sectoral interventions/policies.

Primary Health Care in ICT- The healthcare system is comprised of the public and private sectors providing primary, secondary, and tertiary care. A network of primary healthcare system under the public sector in the form of dispensaries, CWCs, Basic Healthcare Units, and Rural Healthcare Centres has developed in both rural and urban settings. The public sector primary healthcare system in ICT is being managed by three different federal government agencies;

District Health Officer, Islamabad mainly operates in rural areas of ICT. The PHC infrastructure is made up of 55 healthcare establishments and operates a budget of PKR 508 million. In the year 2021, the primary health care system of Islamabad was visited by 242,169 patients. There are BHUs (15), CHC (01), dispensaries (1) and RHC (3), Family Welfare Centres (31), and one mobile service unit. Out of 28 Family Welfare Centres transferred to health department in ICT only two have been upgraded as PHC while the fate of remaining 29 is still undecided.

Capital Development Authority (CDA) Medical Centres, comprised of 13 units, are spread over in various urban locations of Islamabad. The sanctioned strength of medical officers is 14, out of which 7 doctors are appointed, one MO is on ex-Pakistan leave and 6 are working. An annual budget of PKR 102 million is incurred for this infrastructure.

Federal Government Polyclinic dispensaries system under the control of Ministry of National Health Services, Regulations and Coordination consists of 25 dispensaries with a

staff of 103 and an annual budget of 122 million. Its average care service per dispensary is **77** patients, per day is 2,147, and per year is 669,864.

Comparative Analysis-From the above data, it is transpired that in the 93 total Primary Health Care establishments, cumulative strength posts of Medical Officers working in CDA Health system, Polyclinic dispensaries and DHO are 357 with a working staff of 1042. The total annual budget of these are PKR.733 million. As far as the service delivery of these health facilities concerns it is 104 per facility, 2,989 patients per day, 81,128 patients per month and 973,548 patients per annum. The current performance of OPD along with the size of annual budget highlight an urgent need for improvement and restructuring.

Gap Analysis Primary Health Care System of ICT area- Islamabad is administratively a District divided into two segments, namely Islamabad Urban and Islamabad Rural, under the name of Islamabad Capital Territory. The federal capital is a distinct constituent unit of Pakistan, under Article 1 of the constitution of the Islamic Republic of Pakistan. Islamabad contributes 1% to the country's GDP contributes and is home to 0.8 % of the country's population. Pakistan's government is spending 1.2 % of its GDP on the public sector health system. Per capita expenditure on health has been determined as 43.9 USD. Overall spending on PHC is 35.2%. Government spending on PHC is 37.9%. Per capita spending on PHC is estimated at $18 while per capita expenditure on health is around $4. The total requirement for an ICT area is estimated at $ 80 million per annum for a population of 2 million.

Non-existence of Central Health body of Islamabad -There are currently three different public sector agencies which are running primary healthcare establishments independently of each other as explained above. There is hardly any coordination between all three agencies with each other. No one at the ICT level is looking into the policy matters of healthcare. During the critical review, the need for a regional/district level health authority responsible for overseeing and monitoring the working of the primary healthcare system both in urban and rural areas is strongly desirable on the pattern of district health authority system in Punjab and Khyber Pakhtunkhwa.

Telemedicine -According to World Bank estimates, **63 %** of the total population resides in rural areas compared to **37 %** in urban areas. Compared to traditional care, telemedicine effectively caters to patients' needs with great convenience and lower cost. It makes healthcare accessible in remote areas by cutting down transportation costs. It saves a lot of commuting time, and patients do not have to take a day off from work which is essential for many rural citizens due to their poor socio-economic conditions. Under the framework of PHC, telephonic consultation is a laid down guideline but it has been found the use of telemedicine is not functional in the public sector in rural areas. According to World Health Organization (telemedicine survey of 2016), Pakistan has no telemedicine laws or regulations in place. Telemedicine solves logistical problems, gives support to weak health systems, and helps to establish worldwide networks of health professionals. Currently, 76 % of hospitals in the United States connect with people at a distance. They do this through video conferencing or other technology. ICT area needs to develop and extend telemedicine facility to its residents.

Strengthen referral system: The referral system in Primary Health Care is an integral part of the PHC but exists in a very rudimentary form. A good referral management system aims to facilitate good communication between the consultant, specialist, healthcare provider, and patient. It increases and decreases inefficiency in care coordination and operational arrangements. If properly implemented, a referral management system can reduce revenue leakage by 20 %.

No Public–Private Partnership Model for Primary Healthcare System - In the ICT area in line with the experiences of Government of Sindh and Punjab where primary healthcare facilities of the provincial government along with budget have been handed over to the private sector hospitals and NGOs for governance and running of PHC system efficiently. In regard to Public–private partnership, laws and rules are well documented. There is a need to undertake some feasibility study by the ICT administration in regard to developing public –private partnership with the existing private sector teaching medical hospitals and NGOs.

Non-existence of District Health Complaint Management System - District health information system/Logistic Information System are desktop-based applications that exist in the DHO office but only catered to the limited needs of the office, as such no particular Complaint Management System exists. There is a need for a complaint management system that should be open to the public (web-based application) where a citizen could lodge their complaints and may suggest measures for improvement of the system.

Branding and creating demand generation in the Primary Healthcare system of ICT- During visits to PHCs, it is obvious that expensive infrastructure is available that needs regular improvement and maintenance. There are no signboards and guidance for the information of citizens in rural or urban areas. A special campaign to create awareness among the local community is the need of the hour to make the population attentive to the available facilities of the PHC system.

Conclusions and Recommendations-Based on the analysis conducted , review of literature / data and briefing by all three agencies responsible for primary health care of ICT area, deliberations in the committee and consultation with resource persons, the gaps identified include uneven dispersal of resources , lack of functional integration and coordination between the responsible agencies, non-existence of ICT centralized body for policy, planning, implementation and monitoring & evaluation . Furthermore, bureaucratic control and resistance to involve community participation in the PHC system, avoidance of third party evaluation, wilful negligence to develop on-line complaint management system raises the questions of transparency and accountability. A weak referral management system and avoidance of telemedicine, are also some of the instances which are visible signs of mal-administration and negligence resulting sufferings of the citizens who are entitled to free healthcare under the constitution of Pakistan. To address the issues and bring good governance in the system, following recommendations are submitted for consideration and approval to improve the PHCs system of ICT;

1. Rationalization of PHCs facilities in line with the principle of equity and functional integration of all federal government agencies for services delivery in ICT primary health system.

2. There are three different federal government agencies managing PHC system and there is a visible lack of unified command which has resulted in maladministration and poor implementation over a period of time . Pending establishment of ICT regional health authority ,Islamabad for better policy, planning and implementation of the PHC system in line with the experiences of province of Punjab and Sindh , an Oversight Committee may be constituted at the level of Chief Commissioner, Islamabad to implement the recommendations of this report.
3. Encourage participation of community in the primary healthcare system of ICT which is the cardinal principle of PHCs system. District administration may be asked to constitute citizen oversight committees for each and every Primary healthcare facility for monitoring and evaluation.
4. People's Health Care Initiative in Sindh, Punjab Rural Support Programme and Indus Hospitals Network in Punjab are well documented experiences with defined laws and rules and are performing much better than existing public sector primary health care network. Analysis reveals that Pakistan has a very high utilization of the private health sector (71%) which is likely to increase unless an improvement in the governance and management of the public sector takes place. Therefore to develop Public-Private partnership for primary healthcare in ICT. The provincial government of ICT (the Chief Commissioner) may investigate the feasibility of developing partnership with private teaching hospitals in ICT area.
5. Branding and creating demand generation in primary healthcare system of ICT through publicity, advertising and social media campaign will improve OPD utilization and the confidence of citizen.
6. To strengthen the referral system through the efficient use of technology.
7. Islamabad Health Regulatory Authority may be asked to undertake inspections of all public sector primary healthcare facilities as a third party evaluator.
8. To immediately introduce Telemedicine, as it is cost effective and satisfactory alternative to save the citizen from extra expenditure .It is already part of PHC system.
9. All federal government agencies delivering PHCs services may be directed to fill all the vacant posts of doctors and other staff under their jurisdiction to improve better delivery of services.
10. To develop complaint management system of primary healthcare system to ensure transparency and provide a voice to the people. Under the system, provision may also be placed for registration of resident of the catchment area so that citizen may know where to go for medical services.
11. Auditor General of Pakistan may be requested to undertake financial and performance audit of all three agencies jointly to assess the value of money being spent on PHC system.

Chapter 1

Background and Introduction

Primary Health Care (PHC) system is the backbone of the healthcare system that ensures access and availability to quality, medical responsiveness, and integrated care. Under the constitution of Pakistan, the primary responsibility of healthcare lies with the provincial government. While for federally administered areas, including Islamabad Capital Territory (ICT), the responsibility falls under the Federal government's purview.

Providing appropriate healthcare to every citizen is the responsibility of the State. However, Pakistan compared to its neighbouring countries with similar socio-economic backgrounds, has consistently lagged in health development indicators.

Pakistan's public healthcare system suffers due to mal-administration as result of bad governance, inconsistent policies, poor quality of services, lack of accountability, and insufficient financing. Moreover, a weak political system, poor implementation of laws, difficulties with access to facilities, unequal distribution of resources, poor quality of health management/governance, inefficient health information systems, weak monitoring and evaluation system, and shortage of skilled human resources have all contributed towards an inefficient public healthcare system. For these reasons, a subpar public healthcare system sees the majority of citizens making private healthcare expenditures

A network of primary healthcare facilities was established in the early 1980s, with basic healthcare units or rural centres within a reach of 5-10 kilometres in most districts. However, over the past 25 years, these primary healthcare facilities have not been functioning at an optimum level. Unavailability of medical staff (due to meagre salary and lack of incentive to work in rural areas), an insufficient supply of medicines and equipment, broken physical infrastructure and lack of information on the location of basic healthcare units have contributed to the deterioration of services at this crucial level . Despite these challenges, the national information system data reflects that the number of people using these facilities rose from 18 patients per day in 1998 to 29 per day in 2000.

In this report, an attempt has been made to provide an overview of the district health infrastructure and organization of primary health care services in the district of Islamabad, the governance, management, and accountability pattern, and the operational significance of health system pillars and their merit for effective service implementation and partnership. Pakistan is a signatory of Alma Atta conference held in 1978 which is a milestone of the 20th century in the field of public health and primary healthcare. Alma Atta primary health care package included physical, social and mental wellbeing and not merely the absence of disease, and affirms health as fundamental human right. The declaration also envisages community participation and emphasizes that health is directly associated with the socio- economic development of nations.

Scope and Methodology

The study was commissioned on the 4th of January, 2023 with the purpose to review the policy, systems, and regulations of the district health system of ICT after the 18th amendment in the constitution of Pakistan and to evaluate in terms of good governance and service delivery with a focus on primary health care system in both urban and rural areas, in line with standards laid down by WHO and other international agencies.

This study evaluates the performance of the ICT primary healthcare system and identifies gaps in its performance. Additionally, it finds factors that influence citizen satisfaction regarding access, availability, coverage, and quality of services.

A follow-up meeting with the HWM held on the 2nd of February, 2023, the scope and further guidelines of the project were set:

- **a.** The study limits its scope to ICT.
- **b.** The study will highlight the major constraints present and make feasible recommendations to tackle the major constraints in the development of primary health care while also making a risk analysis of all recommendations.
- **c.** As the subject of health has been devolved to the provincial level after the 18th amendment in the Constitution, this study will also review the public-private partnership models adopted by some of the provinces to develop proposals for their replication in ICT.
- **d.** The study will evaluate the existing facilities at Basic Health Units (BHU) in terms of staff, equipment, budget, etc. to highlight shortcomings and make recommendations for further improvement to the facilities.
- **e.** Any proposals for the creation of a new authority or any amendments to the existing laws should be avoided as it would entail protracted working by different bodies without any positive results in the foreseeable future.
- **f.** The committee should, firstly, evaluate strategies and differentiate between the ones that yield results as opposed to those that do not seem to be working. Secondly, the committee should refrain from making recommendations on the strategies that are still being developed.
- **g.** The committee may seek input from additional resources to not only strengthen its analysis of primary healthcare but also to improve its recommendations. The additional resources can be contacted through online video-conferencing tools.
- **h.** The committee may also undertake field visits to better understand the situation on the ground and to interact with the management of the BHUs, Medical Centres (MC) and Dispensaries. These steps would further aid the committee in making concrete proposals in the context of the improvement of primary healthcare in ICT.
- **i.** The committee is also required to undertake systemic research between the parameters laid down.

Chapter 2

Literature Review of Pakistan Primary Healthcare System and International Experiences

A robust PHC system ensures the provision of highest possible level of equitable healthcare, including palliative care, access to treatment, and rehabilitation. To provide quality healthcare services to the people, especially to the marginalised communities, the government has extended Universal Healthcare Coverage (UHC) through different initiatives in the healthcare sector. UHC ensures equity and entails that all individuals receive the healthcare services they need despite their differences and socio-economic background.

The Government of Pakistan's national healthcare action plan (2019-2023) is based on a vision that aims to ensure the provision of good quality essential healthcare services to all people through a resilient and equitable healthcare system. It provides a well-thought-out strategic framework for the implementation of good governance parameters that can achieve healthcare-related sustainable development goals and UHC targets within Pakistan.

To achieve the national healthcare vision reality, one of the key actions was to develop and implement the UHC Benefit Package for Pakistan, which consists of an Essential Package of Health Services (EPHS) and inter-sectoral interventions/policies[1].

The healthcare system of Pakistan is comprised of the public and private sectors providing primary, secondary, and tertiary care. A network of primary healthcare system under the public sector in the form of dispensaries, CWCs, Basic Healthcare Units, and Rural Healthcare Centres has developed in both rural and urban settings.[2]

Pakistan has a large healthcare infrastructure including a primary healthcare system. In 2021, the national healthcare infrastructure comprised 1,276 hospitals, 5,558 Basic Health Units (BHUs), 736 Rural Health Centres (RHCs), 5,802 dispensaries, 780 maternity and child health centres, and 416 tuberculosis centres.

The primary healthcare services are supported by a network of 989 secondary care hospitals at the tehsil and district levels to deal with referrals. Despite having a strong public sector primary healthcare network in rural areas, Pakistan lacks a similar network in urban areas. The total availability of beds in the healthcare sector has been estimated at 146,053. There are 266,430 registered doctors, 30,501 registered dentists, and 121,245 registered nurses in the country. Even though nurses play a key role in any country's healthcare field, Pakistan is facing a shortfall of a million nurses against a population of 232 million (2023 UN data) as per the World Health Organization (WHO) estimates. Public sector expenditure on health was estimated at 1.2 percent of the GDP in 2020-2021 which is less than the recommended amount by the WHO i.e., 5% of

[1] Universal Health Coverage, benefits package of Pakistan, a publication of the government of Pakistan, ministry of national health services, regulations coordination). The 12th five-year plan (health chapter).

[2] Challenges faced by Pakistani Health care system, clinician's perspective by Farhan Khalid and Ahmad Nadeem Abbasi, journal of the college of physicians and surgeons Pakistan 2018 .vol.28 (12) 899-901

the GDP. Per capita health care spending was $39 (2019) (Pakistan Economic Survey, 2021-2022). The different institutions that are responsible for the provision of healthcare comprise of provincial and district health departments, social security institutions, non-governmental organizations as well as the private sector. Studies have shown that Pakistan's private sector healthcare system is performing relatively better than the public healthcare system in terms of service quality and patient satisfaction, and it is also serving 70% of the population. There are various government/semi-government organizations, which provide their employees and the employees' dependants healthcare services through their own systems. These organisations include the armed forces, Sui gas, WAPDA, PTCL, railways, Fuji foundations, employee's social security institution, and NUST. However, these organisations cover 10% of the population collectively, while, in comparison, the public sector healthcare system is catering to about 20% of the general population.

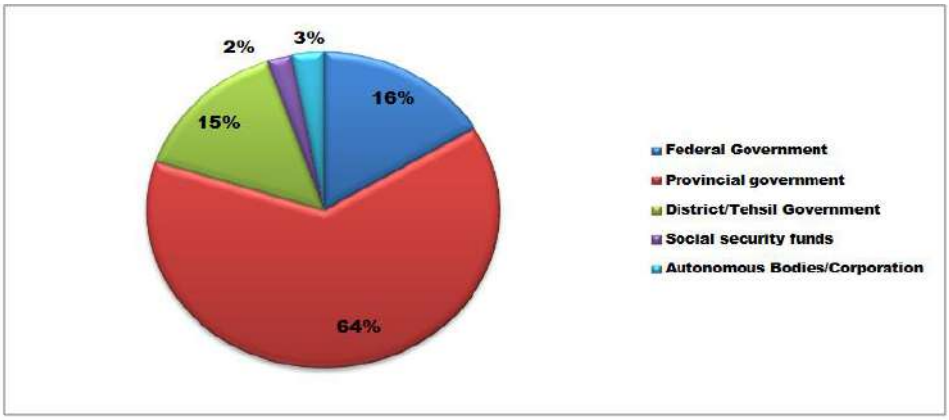
National Health Accounts – Pakistan (2017-18): NHA presents various aspects of the nation's health expenditure and deals with questions like who is financing health care in Pakistan, how much do various financing agents spend, and on what type of services those spending's are made. NHA is a framework that estimates the total healthcare expenditure by both the public as well as the private sector at a national level. The NHA methodology tracks the flow of funds through healthcare sectors by compiling the four selected dimensions i.e. (I) financing sources, (II) financing agents, (III) healthcare providers and (IV) healthcare functions.

According to the National Health Accounts, for the years 2017-2018, out of the total health expenditure in Pakistan, 40.9% of the total funds were used by the general government. Out of which, 16.3% was incurred by the federal government, whereas 54% was used by civilians part and 46% was used by the military.

Around 58.5% of the health expenditure was made through the private sector, out of which 88% of expenditure is made out of pocket (OOP) by private households.

The share of development partners/donors' organizations only makes up 0.6% of the total expenditure of Pakistan. The annual per Capita Health Expenditure (CHE) for Pakistan is Rs. 5283 (48.1 USD). The ratio of CHE to gross domestic product (GDP) is 3.2%, while the ratio of general government health expenditure to total general government final consumption expenditure is 12.2%. The ratio of private sector health expenditure over total household consumption expenditure is 2.5%.

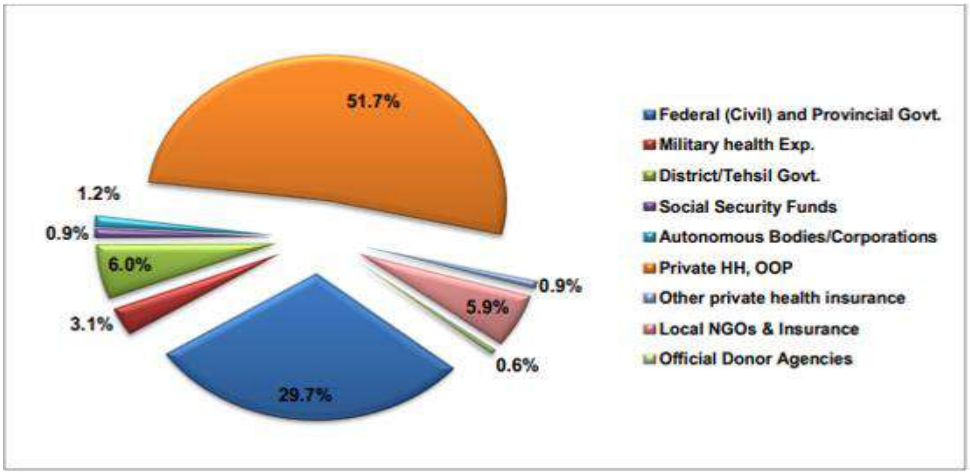
General Government Health Expenditure by its financing agents 2017-18



(Source:https://www.pbs.gov.pk/sites/default/files/national_accounts/national_health_accounts/national_health_accounts_2017_18.pdf)

The healthcare expenditure is being financed by the federal, provincial and district governments in Pakistan. After 18th amendment, the provincial governments share to the overall healthcare expenditure stands at 64%, while the federal government contributes 16% and the district government contributes 15%. It is key to note that the district governments are already contributing towards the district healthcare sector.

Total Health Expenditure by main financing agents 2017-18.



(Source:https://www.pbs.gov.pk/sites/default/files/national_accounts/national_health_accounts/national_health_accounts_2017_18.pdf)

The pie chart above reflects that the largest contribution towards healthcare expenditure is made by the main financing agencies (2017-2018). While the federal (civil) and provincial governments share stand at 29.7%, while the district/tehsil government share remains at 6% of the total contribution.

For comparison, the following table gives an overview of some key healthcare expenditures indicators in SAARC, China and Iran for the years 2017-2018:

Table 1: Key Health Expenditure Indicators, by SAARC countries along-with China & Iran for 2017-18

Main indicators	CHE as % GDP	CHE Per Capita in US$	OOP Health Expenditure as % of CHE
Pakistan	3.2	48	56
India	3.5	73	63
Bangladesh	2.3	42	74
Sri Lanka	3.8	157	51
Nepal	5.8	58	51
Bhutan	3.1	103	13
Maldives	9.4	974	21
Afghanistan	9.4	50	78
Iran	8.7	484	36
China	5.4	501	36

Sources: NHA-Pakistan 2017-18 report & Global Health Expenditure Database, WHO, https://apps.who.int/nha/database/Select/Indicators/en

It is reflected in the above table that in the years 2017-2018, the CHE per capita was 48 USD; however, in the year 2019, the health expenditure per capita for Pakistan was at 39 USD.[3]

Table 2: Key Health expenditure indicators, by SAARC countries, China & Iran for the FY 2018-2019

Sr. No	Country	Indicators		
		CHE as % GDP	CHE Per Capita in US$	OOP Health Expenditure as % of CHE
1	Pakistan[1]	3.4 (3.0)	40 (41)	54 (55)
2	India	3.0	64	55
3	Bangladesh	2.5	46	73
4	Sri Lanka	4.1	161	46
5	Nepal	4.4	53	58
6	Bhutan	3.6	116	18
7	Maldives	8.0	854	17
8	Afghanistan	13.2	66	79
9	Iran	6.7	470	40
10	China	5.4	535	35

(Source: NHA -Pakistan 2018-19 Global Database expenditure database.)

International Experiences (Iran, Bangladesh, India, Sri Lanka)

Iran – The country covers an area of 1.64 million square kilometres with an estimated population of 86.8 million. The GDP of Iran for the year 2021 was USD 359, 7 billion with a per capita income of $ 16540. In 2019, the health expenditure per capita was USD 470. After the establishment of the primary healthcare program in Iran in 1979, the healthcare indicators have improved every year since. According to the structure of PHC system in Iran, each village (sometimes a collection of villages) has "health house" staffed by trained healthcare provider

[3] World Bank https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=PK

named Behavers (multipurpose health care worker) who cover the healthcare of up to 1200 inhabitants. These health houses are the first level contact between families and the healthcare system. In comparison, big villages, in addition to health houses, also have rural "health centres". The staff of a health centre comprises of a qualified physician and a team of up to 10 health workers for more complex health problems. Each rural health centre caters to up to 7000 inhabitants. This healthcare network is managed by the district health centres, under the supervision of medical sciences universities in the country, where each province has at least one medical university.[4]

Bangladesh – The country is situated in the fertile plains of the Ganges (Padma) river delta and borders the Bay of Bengal and occupies an area of 143,998 Kms. The GDP of Bangladesh is estimated at USD 416.26 billion with a per capita income of USD 1684.43 (2021). In 2019, the health expenditure as a share of the gross domestic product remained around 2.48%. Bangladesh's healthcare spending per capita for 2019 was USD 46. The country consists of eight divisions, 64 districts, and 495 sub-districts. The population of the country is estimated 171 million (2021) people. The healthcare service delivery in Bangladesh starts from the community clinics (CC) in villages, unions (collection of villages), and Universal Health Complexes (UHC) at the sub–district level and backed by District Hospitals. A project to expand and improve the delivery of urban primary healthcare services through public–private partnership is in place. Despite having a strong public sector primary health care network system in rural areas, Bangladesh lacks a similar network in urban areas. An urban primary healthcare network is under implementation with the support of Asian Development Bank .The outcome of the project would strengthen the delivery system and organizational capacity for sustainable provision of pro –poor urban primary healthcare services focused on women and children. The project is also expected to increase the commitment of urban local bodies to urban primary health care and public health-relate dated services. (Urban primary health care services delivery project. Bangladesh. (www.adb.org).

India –India is the second most populous country in the world (after China) with an estimated population of 1.37 billion people (2020) with an area of 3287263 km. For the year 2021, the GDP of India was 3.176 trillion USD with a per capita income of 2256.59 USD. The spending on health is 2.1 % of the GDP with a per capita health expenditure of IRs. 1815. Administratively, the country is subdivided into 29 states and seven union territories. Primary Health Centres (PHCs) are state-owned rural and urban healthcare facilities in India. They are essentially single –physician clinics with facilities for minor surgeries. They are part of government funded health system in India and are the most basic units of this system. In 2019, there were 30045 PHCs in India in which 24855 are located in rural areas and 5190 are in urban areas.

According to the National Health profile 2017, India has only 1 million allopath doctors to treat a population of 1.3 billion. Among those one million doctors, only 10 % works at the public healthcare system. According to the WHO, only one in five doctors in rural areas is qualified to practice medicines. Structure and Levels of primary healthcare in India are as follows;

[4] (Status of Iran's primary Health care system in terms of health control knobs. a review article. Iranian journal of public health. (www.ncbi.nih.gov)

- Primary level – The first level of contact between the healthcare institution and the patient. It includes sub-centres and primary health centres.
- Sub-Centre – It is the most peripheral and first contact point between the patient and the healthcare facility. It has three employees i.e., the health worker male, the health worker female and a voluntary worker and located for a population of 5000. The government of India's Ministry of Health and Family Welfare is responsible in providing the 100 % fund for the sub-centres.
- Primary Health centres – It is the first point of contact between the village community and the doctor and is located for a population of 30000.It has strength of at least 15 people. The medical officer is considered as a leader of the team. Each primary health centre acts as a referral point for 6 sub centres. And they have bed strength of four to six beds. It is regulated by state government. Secondary level – is the first level where patient is referred depending upon the seriousness of the issue.

Sri Lanka – Sri Lanka is an island located in Indian Ocean with a population of 22.23 million (2016), 77.4 % people live in rural areas and 18.2 % in urban areas. The land area is 65525 square kilometres with a length of 432 kilometres and a width of 224 kilometres. The GNP per capita is US $ 3813 (2013). In 2013, total health expenditure as a proportion of gross domestic product (GDP) was 3.24 % and expenditure on public sector primary care hospitals was 2 % of current health expenditure according to national health accounts. (Primary Health Care Systems – a case study from Sri Lanka (apps, who. in). Sri Lance's model of primary health care is free of cost through a government health system and is the basis for providing universal health coverage. Primary health care in Sri-Lanka developed, as two parallel services; I- Community health services through a health unit system. The health units have defined catchment areas that coincide with local government administrative units and currently, 341 areas also known as MOH areas are m managed by a medical doctor, supported by public health field staff. II - Curative services consisting of 496 divisional hospitals providing both hospitalization and ambulatory care services (medical services performed on an outpatient basis, without admission to a hospital or other facility) and 474 primary medical care units providing only ambulatory care which function with non-specialist medical doctors and other staff. At the first, management of the primary health care services was devolved to provincial councils. At secondary level, 68 basic hospital and 18 district general hospitals provide diagnosis and treatment facilities and at the tertiary level the central authority manages the national hospital, the teaching hospital and 10 lager specialist hospitals. Free education system is one of the major factor, having a positive effect on female population and has promoted the health seeking behaviour of mothers. **In addition, the permission given to government health personnel to work in the private sector after duty hours has improved the retention of personnel in rural areas by compensating for low salaries. It has also improved the health services at all hours even though this out-of-duty hour service is not free.** Changes to primary care health services and infrastructure include, a national commitment to undertake regular facility and service assessments, a **"Dual practice System" that allows providers to work both in the public and private sectors** to encourage providers to serve the non-urban population. This allows government health sector providers to engage in private practice when off duty, so they can maintain their public sector employment alongside part-time private practice. This is an incentive for providers to practice in

remote areas while maintaining their primary profession in urban areas and help to improve care access in hard-to-reach areas. This has also helped the government retain many of the highly skilled graduates of the country's health education system and broaden availability and training for NCD prevention and treatment services in public healthcare facilities (improvingphc.org.sir). Community Health Centres are located at a population of 120000 with a staff strength of 30 including 4 specialist doctors, i.e., a physician, a surgeon, a Gynaecologist and a paediatrician. Each community health Centre acts as a referral point for 4 primary health centres and is regulated by the state government.

Chapter 3

Primary Health Care System of Islamabad Capital Territory

The primary health system of district ICT sits within the framework of PHC, which links to the Alma Ata Declaration of 1978, and has remained the focus of policymakers. A comprehensive approach to responding to the needs and legitimate health expectations of all citizens is the fundamental responsibility of the state.

District Level Healthcare

In the past decades, Pakistan has seen successful examples of community participation adopted within the policy direction of local government in the country. This was achieved by routing delivery of health services through BHUs and RCHs, and the establishment of hospitals in each Tehsil and supported by District Headquarters Hospitals (DHQs).

Furthermore, in pursuance of the Alma Ata declaration, successive national health policies of Pakistan since 1990 have reiterated their commitment to universal health coverage and affordable access to essential primary health care services. At the grassroots level, the concept of female community health workers led to the inception of the national program for family planning and primary health care in 1994. Commonly known as the Lady Health Workers program (LHW), it links the community with the district health system service delivery network.

With 171 (2023) districts in Pakistan, the district health system has become a critical tier of the Pakistani health care system. It now functions as an independent administrative and organizational set–up under the local government's purview as a result of the devolution policy.

In Punjab, the local government ordinance of 2013 introduced the concept of establishing District Health Authorities for each district and the Punjab District Health Authorities (conduct of business) Rules of 2016 was passed to improve system efficiency.

In Khyber Pakhtunkhwa, Regional and District Health Authorities Act 2019 provides for a comprehensive and efficient healthcare system in the province and devolve authority and accountability at the regional and district level.

At the federal government level, multiple vertical health programs like Sehat-Sahulat Programme (SSP), Expanded Program on Immunization (EPI), Polio Eradication program (PEI), Malaria Control Programme (MCP), Tuberculosis control program (TB), Human Immunodeficiency Virus/ (HIV) / acquired immunodeficiency syndrome (AIDS) control program and civil registration and vital statistics (CRVS) targeting different health conditions in the country are all implemented through the district health system .

Sehat-Sahulat Card is the latest intervention that has been launched on the principle of insurance for reducing health inequality in the country. That also demonstrates the commitment for implementing SDG- 3 by developing an inclusive health system and expanding basic health care in the country.

However, low financial allocation for health, weak governance, and excessive focus on tertiary care rather than primary health care is the problems that need to be focused to be addressed for achieving long-term sustainable economic development (Pakistan economic survey -2021-2022).

Public Healthcare System of Islamabad -

The public sector of the District primary healthcare system in ICT is managed by three distinct agencies:

- The primary healthcare systems under the supervision of the District Health Office, Islamabad.
- CDA medical centres under the control and supervision of DG (Health Services)
- Federal government Polyclinic dispensaries under the Ministry of Health Services.

The main focus of this study is to examine the primary healthcare system and analyse its performance of value of money spent and performance standard in terms of satisfaction of the citizen of Islamabad. Therefore, the performance of all three distinct agencies has been discussed in detail in subsequent chapters.

Furthermore, the other government, semi-government and private sectors are also imparting their role in the Health Service delivery but at mostly at tertiary level. This information is shared for the purpose of reference and to appreciate that government funded hospital do play a very limited role in primary health care and why people are compelled to make out of pocket expenditures on their health needs .

Government Hospitals in Islamabad

- Pakistan institute of medical services (PIMS)
- Federal government hospital
- Capital hospital (CDA hospital)
- National Institute of Health
- Nuclear Oncology and Radiotherapy Institute (NORI)
- NESCOM hospital
- KRL hospital.

Semi–government hospitals in Islamabad

- PNS Hafeez
- Pakistan Atomic Energy Commission (PAECE) hospital
- PAF hospital

Major Private Sector hospitals in Islamabad

- Shifa International hospital
- Ali International Hospital
- Maroof International Hospital
- Kulsum International Hospital
- Integrated Health Care Services
- HS Children Medical Centre

- Islamic International Medical Complex
- Dar-ul-shifa Hospital
- Islamic Specialist Clinic
- Aslam Memorial Medicare Hospital
- Elahi Medical Centre
- Fauji Foundation Hospital
- Hope Medical Dental & Diagnostics
- Quaid-e-Azam International Hospital.

The District Health Office, Islamabad

The DHO **mainly** operates in rural areas of ICT. The PHC infrastructure comprises of 55 units as detailed in the table along with size of staff employed and DHO operates on a PKR 508 million budget annually.

Table-3: DHO Staff and Annual Budget

Sr. #	Name	Total #	Staff	Annual Budget
1.	RHCs	03	156	
2.	BHUs	15	281	
3.	CHC	01	19	
4.	Dispensary	01	06	508,375,000
5.	Family Welfare Canters	31	118	
6.	RHS	03	13	
7.	Mobile Service Unit	01	04	
	Total	**55**	**597**	**508,375,000**

Table-4: Staff Deployment of DHO in PHCs

S. No	Name	Medical Officer	Staff
1.	RHC Taralai	**01**	**56**
2.	RHC Barakahu	**03**	**66**
3.	RHC Sihala	**01**	**29**
4.	BHU Gagri	**01**	**09**
5.	BHU Rawat	**01**	**29**
6.	BHU Bhukar	**01**	**18**
7.	BHU Bimber Tarar	**01**	**14**
8.	BHU Sohan	**01**	**30**
9.	BHU Jagiot	**01**	**27**
10.	BHU Jhang Syedian	**01**	**35**

11.	BHU Chirrah	**01**	**31**
12.	BHU Tumair	**00**	**17**
13.	BHU Pind Begwal	**00**	**20**
14.	BHU Phulgran	**00**	**13**
15.	BHU Shahdara	**00**	**10**
16.	BHU Kirpa	**01**	**03**
17.	BHU Gokina Talhar	**00**	**03**
18.	BHU Golra	**03**	**10**
19.	CHC Shah Allah Ditta	**03**	**16**
20.	Dispensary Model Town Humak	**01**	**5**

Service Delivery Performance - In the year 2021, the Primary Health Care System of Islamabad was visited by 242,169 patients. There are BHUs (15), CHC (01), dispensaries (1) and RHC (3), Family Welfare Centres (31), and one Mobile Service Unit. In fact, 55 health facilities with 579 staff are functional under the primary healthcare structure. Out of 31 Family Welfare Centres, only two have been upgraded as PHC while fate of the remaining FWCs is still undecided. In fact these healthcare establishments were to be integrated with the health care network to improve their efficiency and family welfare facilities were to be opened and operated in every public sector health facility.

According to data analysis provided by the DHO office, the yearly performance of 55 Healthcare establishments in terms of OPD was, 242,169. The average monthly performance of OPD is around 20,180. Accordingly, estimated 672 patients were attended by 55 PHC facilities per day. **The average daily performance of a single health establishment is around 12-13 patients.** Their total staffs under PHCs have been reported as 898, which means, an average of 16 employees are working under one healthcare establishment in the district. But factual position as per information provided reveals that uneven staffing has been made such as at RHC Tarlai, there is one doctor and 56 staff members and at BHU Kirpa ,there is one doctor and 3 staff and at BHU Gokina Talhar, there is no doctor has been appointed and 3 members staff has been posted as reflected in the above table . The above analysis demonstrates that the PHC system is under-performing and needs to be improved.

Weak and inefficient Monitoring & Evaluation System of the DHO Office

The District Health Officer is a highly responsible public health professional responsible for his health district. He is responsible to administer health issues and especially the primary healthcare system for providing medical and leadership to manage and coordinate the effective and efficient delivery of quality health services. The three major roles of DHO include leadership in health, enabler, capacity building, and administering PHC along with other responsibilities. The accomplishment is gauged by three pillars, such as governance, service delivery, regulation, and

efficient utilization of scarce financial resources placed at the disposal of the DHO office. During our study, it has been observed that there is regular inspection and accountability mechanism to ensure the efficient performance of DHO and calls for developing the same i.e. An efficient Monitoring and Evaluation system.

During his briefing, DHO Islamabad made following recommendations;

- Recruiting the lady health workers (LHWs) 1500 for phases -1-(800 including LHV).
- Up gradation of FWCS into BHU level with the merging of FWCs into DHO-ICT - After the 18th constitutional amendment in the year 2010, the ministry of population welfare was devolved and functions of population welfare was transferred to provinces. The infrastructure of 31 family welfare Centres falling in the Islamabad district was brought under the supervision of the DHO office. Two of the FWCs have already been upgraded while the remaining is functioning as usual with 118 staff members. The FWC was to be integrated with the health system to manage the population. It is a matter of concern that over a period of 12 years, they are still not merged with the PHCs.
- Effective, efficient access, and integrated essential health services at the community and PHC Centre level.
- Well-trained health workforce available to deliver EPHS and IDSR.
- HIS (IDSR, generating data on health system response and action)
- Equitable access to medicine, vaccines, contraceptive supplies, and medical technologies (including universal access to Coved-related health tech / PPEs.
- Health financing system insuring that people can afford Essential Services with Financial risk protection measures.
- Leadership and management with effective oversight, regulation, and accountability.
- Contingencies / additional grant

District Health Services Information System

Experts conclude that district health services information systems can provide a powerful tool to improve performance. The very fact that around Rs. 508 million of the budget is spent on the PHC system of ICT under DHO office but only 12-13 patients visit daily the individual facility is a matter of concern and calls for attention of the authorities .

The Iranian model describes, that the PHC functions under the control and supervision of local medical universities which make more sense as efficient M&E is in place and an evaluation of the doctors and health establishment is done by the university. In the ICT area, one of the options could be to invite private sector teaching hospitals (universities) to come forward and suggest the way forward to the authorities. As there is also a need of a supervisory body to oversee the functioning of all infrastructure of PHCs being run by the federal government agencies including the network of dispensaries of government Polyclinic hospital and Capital Development Authority.

Capital Development Authority Medical centres

CDA Medical Centres, comprised of 13 units, and are spread over in various urban locations of Islamabad city. The detail is given in the table below;

Table 5: CDA Medical Centre Staff and Annual Budget

Sr. #	Name	Total #	Staff	Annual Budget
1.	Medical Centre Head Quarter Office F 11/4 Service Road East, Islamabad	01	04	
2.	Medical Centre G-9 Markaz (Morning)	01	04	
3.	Medical Centre G-9 Markaz (Evening)	01	04	
4.	Medical Centre I-10/1 Shaheen Market (Morning)	02	08	
5.	Medical Centre I-10/1 Shaheen Market (Morning)			
6.	Medical Centre G-10 Markaz	01	04	
7.	Medical Centre G-7 Gulshan Market	01	03	
8.	Medical Centre Diplomatic Enclave G-5	01	02	
9.	Medical Centre B Block Pak Secretariat	01	02	
10.	Medical Centre Simly Dam	01	01	
11.	Medical Centre Rawal Town	01	03	
12.	Medical Centre Bhara Kahu	01	02	
13.	Medical Centre I-8	01	04	
		13	**41**	**102,351,380**

The sanctioned strength of medical officers is 14, out of which 7 doctors are appointed, one medical officer is on ex- Pakistan leave while 6 are working. An annual budget of PKR 102 million is spent for running this network of 13 health establishments. CDA data supplied indicate that annually patient (OPD) visit is around 61515 and daily visit of patients against single facility is around 170 patients which are mostly CDA employees and their families as this facility is dedicated for entitled patients with a Cavite for public. The location of CDA medical centres is unfair as in 2 facilities are located in G-9 Markaz and again 2 facilities have been provided in I-10/1 and at some places health facility has been provided where other federal government agency has also provided the facility . It is more a duplication on the part of public sector which calls for rationalization.

Government Polyclinic Hospital Dispensary System.

The network consists of 28 dispensaries with annual budget of Rs. 122,560,325 million. Out of 28 dispensaries, 17 are sanctioned while 9 dispensaries are not sanctioned. Its dispensaries / centres OPDs per annum is 669864, average care provided per month 55822 and average daily service is provided to 2147 patients. Thus the daily average service (OPD) provided by a dispensary is 77 patients.

Table 6: Polyclinic Dispensaries, Staff and Annual Budget

Sr. No	Name	Total #	Staff	Annual Budget
1.	Kohsar Block, Dispensary	01	04	4,115,186

2.	Q Block Dispensary Pak Secretariat	01	03	2,95,342
3.	Foreign Office Dispensary	01	03	3,210,920
4.	Aiwan-e-Saddar Secretariat Dispensary	01	08	4,954,224
5.	Parliament Lodges Dispensary	01	18	19,529,666
6.	Cabinet Secretariat Dispensary	01	03	4,049,444
7.	G-9/2 Dispensary	05	05	3,543,622
8.	I-8/1 Dispensary	01	05	3,770,898
9.	Police Line Dispensary	01	03	3,884,948
10.	AGPR Dispensary	01	03	3,884,948
11.	Supreme Court Dispensary	01	04	3,773,930
12.	PM Staff Colony Dispensary	01	03	2,500,520
13.	Prime Minister Secretariat Dispensary	01	02	2,772,714
14.	f-6/1 Dispensary	01	04	3,402,020
15.	G-7/1 Dispensary	01	03	3,057,156
16.	G-7/2 Dispensary	01	03	5,280,574
17.	K Block Dispensary	01	02	2,981,924
18.	Judges Enclave Dispensary	01	03	3,617,783
19.	G-8.3 Dispensary	01	05	3,928,052
20.	FBR Dispensary	01	03	2,607,222
21.	Parliament House Dispensary	01	04	26,610,528
22.	FPSC Dispensary	01	03	3,513,820
23.	High Court Dispensary	01	03	3,729,198
24.	Election Commission Dispensary	01	03	2,638,782
25.	School Health Clinic 01 G-7/2	01	02	1,066,536
		25	**103**	**122,560,325**

The above table reveals that poly clinic network of 25 healthcare facilities, cater around 66, 9864 patients annually and per day visit against all facilities 2,147. On an average 77 patients visit a single dispensary of poly clinic in a day.

Comparative Analysis of Data Obtained From DHO, CDA, and Polyclinic in ICT

A data analysis of the 96 PHC facilities is presented in the table below. The current PHC structure has 357 sanctioned posts for Medical Officers.

Table 7: Data from DHO, CDA, and Polyclinic Primary Healthcare Centres.

Sr. No	**Establishment Name**	**PHC**	**Sanctioned Posts of Medical Officers**	**Working Staff**	**Annual Budget**	**Average care services provider**

						Per PHC	Per day	Per Month	Per Annum
1.	Polyclinic	28	305	103	122,560,325	77	2,147	55,822	669,864
2.	District Health Office	55	38	898	508,375,000	13	672	20,180	242,169
3.	Health Directorate of CDA	13	14	41	102,351,380	14	170	5,126	61,515
		96	**357**	**1,042**	**733,286,705**	**104**	**2,989**	**81,128**	**973,548**

From the above data, it transpired that for the total 96 total Primary Health Care units, cumulative strength posts of Medical Officers working in CDA Health, Polyclinic and DHO is 357 with working staff of 1,042. The total annual budget of these facilities are PKR.733 million. As far as the service delivery of these health facilities is concerned, it is 104 per facility, 2,989 patients per day, and 973,548 patients per annum. It may be noted that all three agencies are independent from each other and there is no centralized audit to assess their financial performance, therefore it is important to draw attention of the authority for financial and performance audit of PHC system of three federal government agencies jointly. It may be noted that auditor General of Pakistan has conducted audit of District Health Authorities in Punjab as reflected on the website of Auditor General of Pakistan where audits reports of 17 district health authorities are placed. The current performance level and the budget utilization of ICT PHC system highlight an urgent need for joint audit of all these federal government agencies for financial scrutiny and improvement.

Financial Issues –Pakistan's government is spending 1.2 % of its GDP on the public sector health system. Per capita expenditure on health has been determined as 39 USD (2019). Overall spending on PHC is 35.2%. Government spending on PHC is 37.9%. Per capita spending on PHC is estimated at $18 while per capita expenditure on health is around $4. The total requirement for an ICT area is estimated $ 80 million per annum for a population of 2 million. During the research, it has been decided and in line with the scope of the study and due to financial constraints in the country, no recommendation for the additional resource is advisable at this stage for the reason that first combined resources of all three agencies dealing with primary healthcare shall be rationalized in a manner that equity shall prevail.

Non- existence of Centralized Body of ICT for Healthcare System

There are currently three different public sector agencies which are running primary health care establishment independent of each other. DHO functions with 55 healthcare facilities in rural areas under the control of Ministry of Health, CDA directorate of health controls 14 health centres in the city and is supervised by a Director General Health. While FG polyclinic

hospital has a network of 28 dispensaries spread over in different federal government departments and are dedicated to entitled patients. There is hardly any coordination of all the three agencies with each other. However, in times of epidemic, chief commissioner/deputy commissioner plays the role of co-ordinator. No one at ICT level is looking into the policy matters of healthcare. During critical review, the need for a regional/ district level health authority responsible for overseeing and monitoring the working of primary healthcare system both in urban and rural areas is strongly desirable on the pattern of district health authority system in Punjab and Khyber Pakhtunkhwa. ICT is a provincial government for all functions and there appears to be no independent body responsible for policy, planning, and implementation for the ICT area. Furthermore, the province of Punjab and KP had already established district health authorities and this model for-ICT area would address issues of integration and unified authority to supervise the primary health system in both rural and urban areas. It has been informed that ministry of health, regulation and co-ordination is working on a draft law for establishment of ICT health implementation body.

Public - Private Partnership in Healthcare Sector in Pakistan

Public Private Partnership refers to an arrangement between the government and the private sector, with the principal objective of providing public infrastructure, community facilities, and other related services. Such long-term partnerships are characterized by a sharing of investments, risks, rewards, and responsibilities for the mutual benefit of both parties involved. This can take form in multiple ways:

1. The introduction of private sector ownership to state-owned businesses, using the full range of possible structures and with the sale of either a majority or minority stake,
2. Private finance initiatives and other arrangements where the public sector contracts purchase quality services on a long –term basis so as to take advantages of private sector management skills incentivized by having private finances at risk, and
3. Selling government services to wider markets and other partnership arrangements where private sector expertise and finance are used to exploit the commercial potential of government assets, for example, through the various types of Public-private partnership programs.

Sindh Province Experience

There are multiple examples of PPP initiatives within the country. Sindh, **People's Primary Healthcare Initiative (PPHI)** started in district Ashmore in 2007, was gradually scaled up to 25 districts across the province.

Initially, PPHI was given the name of the public-private partnership between the Sindh rural support organizations (SRSO). Later, the name was changed to PPHI –Sindh and converted to a private company registered under section 42 of the Companies Ordinance 1984.

This step was taken by the GOS as the infrastructure in the rural areas, valued around Rs 20 billion, was either sub-optimally operational or altogether dysfunctional. With an abysmal health situation in rural Sindh, the need to increase utilization of existing infrastructure was made a priority.

With the objective to revitalise the delivery health services in rural areas, PPHI Sindh currently manages 1140 primary healthcare services through funding provided by the Government of Sindh. This includes 9 RHCs, 649 BHUs, 35 MCHCs, and 435 dispensaries, and 12 other facilities. In the year 2013-14, the total OPD load was 18,758,635 with an allocated budget of Rs. 2548.34 million while in the year 2020-21, the OPD increased to 26,813,999 and GOS allocated a budget of RS 876,008 million to PPHI. This move resulted in a 42% increase in OPD load.

Punjab Province Experience

In Punjab, the provision of equal access to primary healthcare has been a mammoth task with well-known resource constraints having to cater to a population of 110 million. The Punjab government initiated a two–year health sector reforms program to make the primary healthcare network of 2456 Basic Health Units and 292 Rural Health Centres fully operational. Benefits of the program for medical staff include a substantial salary and an incentive package combined with improved working and living conditions, a pre-service orientation program and regular in-service training, a supportive monitoring and supervisory mechanism, and periodic third-party inspections.

In 2003, a non-governmental organization called **Punjab Rural Support Program (PRSP)** presented a management model termed the Rahim Yar Khan model. The district government of Rahim Yar Khan signed an agreement with PRSP to outsource all management of Basic Health Units in Rahim Yar Khan for a period of five years from April 15, 2003.

Punjab Rural Support Program (PRSP) was incorporated in November 1997 under the Companies Ordinance 1984 (re-enacted by the Companies Act, 2017) with the main objective to develop rural areas, support and subsidize means, programs, plans, and schemes for rural uplift, and socio-economic welfare.

In this model control of all the Basic Health Units in the district of Rahim Yar Khan were transferred to the local PRSP body which pooled all health resources and deployed them according to local priorities. The scheme operated on private financing, without following governmental procedures. The PRSP approach required that a doctor work in three BHUs during the week on a rotation.

The district government provided the budgetary provision relating to unfilled posts, medicine maintenance and repair of buildings and equipment, utilities, and office supplies for the relevant financial year to PRSP. The total BHUs budget in Rahim Yar Khan District was Rs. 72.1 million, of which the non-salary budget was 41.6 percent in FY 04. The financial provision was placed in the form of grants in aid. The PRSP renders accounts of the management operation to the district government within a period of three months at the end of the financial year.

Additionally, through **Punjab Public Private Partnership Authority (PPPPA)** formed in 2019, the government of Punjab has been promoting public-private partnerships. Punjab currently has 0.46 hospital beds per 1000 citizens which is lower than the international benchmark i.e., 2 beds per 1000 citizens which the government hopes to improve. Through its latest initiative, the Punjab Health Initiative Management Company (PHIMC) aims to establish

a pilot health facility in Lahore with a capacity of 500 beds and state-of-the-art technology to cater to a large number of private and government / philanthropic subsidized patients, all under one roof. The PHIMC is entering into PPP arrangements for the construction of general hospitals.

Furthermore, under public–private partnership programs, **Indus Hospital & Health Network** is managing seven government hospitals and 2 regional blood centres in Punjab. All of them are equipped with modern amenities and employ experienced and well-trained healthcare staff. Badean Road hospital, Tehsil Headquarter hospital, Sabari, Tehsil headquarters hospital, Rewind, Tehsil headquarters hospital, Manawa, Muzaffargarh, Multan, and Bahawalpur are a few of the initiatives already implemented. (indushospital.org.pk).

Third-party Evaluation of the PPHI in Pakistan

(www.pphisindh.org)

Under the PPHI model, the district government contracted with the provincial rural support program (RSP) to manage first-level healthcare facilities and was implemented in over 6 % of districts in Pakistan.

A study was undertaken to evaluate the Primary Healthcare Initiative (PPHI) in the provinces of Sindh, Baluchistan, and Khyber Pakhtunkhwa and in 4 health facilities from Gilgit- Baltistan during 2010.

The main objectives were to study and assess the changes caused by the PPHI as compared to the conventional management by the District Department of Health with special reference to the utilization of first-level care facilities (by disadvantaged communities), the range, volume and quality of services, community participation, efficiency and effectiveness of management structures at all levels, from national to provincial to the district to community level.

The impact assessment showed improvements under PPHI, especially in staffing, availability of drugs and equipment, and physical conditions of facilities. The findings showed that the outpatient attendance had increased by 20% in PPHI districts between 2007 and 2010. Attendance of antenatal and postnatal care services also increased.

In terms of safe delivery, the household surveys report a higher percentage of deliveries performed by BHU staff in PPHI districts (37%) than in DDOH districts (18 %). The availability of certain diagnostic tests and treatments for snake and dog bites was found higher in the PPHI BHU. PPHI and BHUs had slightly better record-keeping practices. The availability of telephone communication and transport arrangements was better in PPHI districts. Consumer satisfaction measured through 760 BHU exit polls revealed that users had selected the BHU because it offered a better quality of service than other providers at a rate of 47 % in PPHI and 36 % in DDOH BHU. They also perceived better drug availability in PPHI BHUS (31%) than in DDOH BHUs. They also perceived better drug availability in PPHI BHUs and stated they had received all the prescribed drugs, versus 51 % in DDOH BHUs. This was confirmed by household survey results.

From the experiences of the province of Sindh and Punjab, it can safely be concluded that the PPHI model has made important contributions to PHC delivery in Pakistan, demonstrating that it is possible to increase staffing levels and delivery of essential services within a relatively short period of time.

These improvements have further highlighted the shortcomings of the existing PHC network. More accountability, improved oversight, performance monitoring and introduction of additional services is required. A symbiotic relationship with the private sector would facilitate achieving optimum level of performance.

Currently, it is not only the issues of service delivery but also issues of good governance and management problems for the functioning of BHU at optimum level. In the PHC system, the absence of efficient performance monitoring arrangements in the public sector is the main impediment to assessing the performance and value obtained for the money spent through both private and public service providers.

All the improvements suggested in PPHI model creates a positive and encouraging change. A summary of key findings, conclusions, and recommendations is attached as an annexure at 'A'.

Financial Analysis

Rural Health Centre, Unit Cost (2019 - 20) - According to a report of the ministry of National Health Services Regulations and Coordination (www.nhsrc.gov.pk), the unit capital cost was PKR 88,753,870 ($572,607) and the annual recurrent cost in PKR remained 104,553,607 to 131,434,189 ($674,539 to $847,963).

Community Level – Community-level interventions are implemented through channels that include Lady Health Workers. The estimated unit cost of LHW (covering 1000-1500 people) ranged from PKR 350,232 to PKR 375,948 ($2260 to 2425). According to a recent evaluation in 2019 by Oxford Policy Management, the actual annual unit cost was PKR280,508 ($ 1810) which also indicate serious gaps in capacity building /training, supervision & MIS, governance & planning, and procurement of supplies /equipment amongst other things.

Basic Health Unit – A BHU that caters to a population of 5000 to 25000 operate on a unit cost of PKR 46,335,100 ($ 298935) and annual recurrent cost PKR 14,747,935 to 21,995,925 ($ 95,148 to 141,909) calculated at the prices of 2019-2020.

Community Health Centre – Breakdown of CHC unit cost (includes and annual recurrent at prices of 2019-20) covering a population of 25000 to 40000 is as follows, capital cost PKR 66,047,5450 ($426113) and annual recurrent cost PKR 36,918,673 to 51,950,752 ($238185 to 335166)

Community participation and Role of Midwives in PHC

Midwife is a person who has successfully completed a midwifery education program (approved by Pakistan Nursing council). It is a distinct profession than nursing in its own rights. In Pakistan, there are several midwifery cadres, with different formal education levels, who provide maternal and child health services. There are currently three types of diploma programs

each serving a different cadre. Until 2012, there was no opportunity to obtain higher education in midwifery in the country.

A community midwife in Pakistan requires midwifery diploma program (24 months training). Additionally, a registered nurse requires 3 years diploma program along with a midwifery diploma program (12 months training) and a Lady Health Visitor (LHV) requires midwifery diploma program + LHV training of 2 years

According to WHO (2006), sufficient and competent healthcare providers, specifically those who possess midwife or midwifery skills (MOMS) are essential in reducing maternal and neonatal mortality. Moreover, WHO recognizes the fact that midwives that are allowed to use the full range of their skills can positively impact pre-natal mortality and morbidity rates (WHO, 1995)?

The community midwives are stepping up as maternal healthcare leaders who are reaching out to neglected pregnant women in rural communities of Pakistan. They are responsible for rebuilding trust, delivering comprehensive and respectful maternal care and providing family planning counselling. The role of mid-wives in PHC required to be strengthened as they are the backbone in the infrastructure of PHC system.

Community participation is also missing in the PHC system of Islamabad. In fact, the community paves the way for self- development and contribution for the welfare of its people. The sense of contributing in a project which contribute to the society can give a sense of pleasure and meaningfulness. Community participation ensures self- reliance and sustainability, People come to know the health problems of the community and learn the ways and means of overcoming these. They can demand supplies from the government and District health administration, help to overcome cultural barriers to healthcare, develop better communication with the community and also provide volunteers and financial resources for local healthcare facilities. According to WHO, the most realistic method of attaining community participation is to employ community health workers who always plays the role of first level of contact between the citizen and healthcare system? DHO Islamabad has also recommended recruitment of LHVs in the District which is fully supported. Solution to such problems lies in the indigenous solutions and most of such issues have been dealt with in the local government enactments of the country where function of supervision of PHC is devolved to the District Governments.

Chapter 4

Gap Analysis-Primary Health Care System of ICT

Islamabad is the capital city of Pakistan with a population of 2.2 million (2022) and spread over in an area of 906.5 square kilometres (km). It is a federally administered area under the constitution of Pakistan. Islamabad contributes 1% to the country's GDP and is home to 0.8 % of the country's population. The federal capital is a distinct constituent unit of Pakistan, under Article 1 of the constitution of the Islamic Republic of Pakistan. Islamabad Capital Territory is administratively a district and divided into two segments, namely Islamabad Urban and Islamabad Rural.

Non- existence of Centralized Body to Oversee Primary Health Care System in ICT

After the amendment in Order No.18 of 1980, the President conferred executive authority to an administrator for Islamabad's Capital Territory, later designated as a Chief Commissioner. Chief Commissioner is mandated to perform various administrative functions through its various directorates and exercises the powers of provincial government under various laws to the extent of Islamabad Capital Territory. Furthermore, a Deputy Commissioner is appointed to address the day-to-day administrative affairs of the district. The list under the control of the chief commissioner includes the health department but the DHO has informed that his office function under the control of the Ministry of Health Services. The CDA & Polyclinics are also running their own medical Centres and dispensaries and there is no central authority in ICT areas to oversee and supervise the functioning of the rural and urban primary healthcare setup. The unified monitoring and evaluation system of the ICT is non-existent. The lack of central body has resulted in to lack of decision making at ICT level in regard to policy , planning organizing ,directing and control at the ICT top level . Currently, the system of ICT healthcare is completely disorganised as explained in the preceding chapters. In fact, this responsibility rests with the chief commissioner in the ICT, and after the local government election, it will become the representative of the people (IMC and UCs) who will oversee the working of the PHCs system. The bifurcated health system of ICT without any unified command has led to lack of co-ordination and badly affected the performance of various agencies which are providing health services in Islamabad in isolation. These parallel systems have negatively affected the public health emergencies in the ICT area.

Lack of Participation and Oversight of the Community in the PHC System

Pakistan is a federal republic with three tiers of government, national, provincial and local government. Local government is protected in Articles 32 and 140 – and each province has promulgated its own local government legislation and departments for implementation.

Islamabad Capital Territory Local Government Ordinance of 2021 has already been enacted. The office of Chief Commissioner of ICT is the provincial government for the purpose of local government ordinance, 2021 and a department of local government & rural Development is established and operational. Under the local government laws, ICT consists of 50 union (rural

23 and urban 27) councils which are reputedly increased to 101 and a metropolitan corporation for Islamabad city. Furthermore, on 23 December, 2022, the Senate has passed a bill that as increased the number of Union councils from 101 to 125.The municipal functions under the local government laws are divided between the UCs and the MC. (ecp.gov.pk). On average there are around 6 wards in a union council. Under the local government ordinance 2015, the delimitation was done on the basis of population census 2017 for 50 union councils resulting into estimated 300 elections wards to elect around 430 representatives of the people from Islamabad capital territory consists of 133 villages.

The analysis of the above facts demonstrates that community participation is essential, and it may be delayed for want of local government elections or for any other reasons, ultimately, it is the only solution to improve the system with efficient monitoring and regular evaluation. With the establishment of local bodies system in Islamabad, the CDA would lose many municipal and development functions to the local government and the Islamabad metropolitan corporation and union council would become responsible and monitor the primary healthcare set up as it is mandated in law. The participation of people would ensure stability and efficiency in the primary healthcare system.

Non–Existence of Online Health Complaint Management System in ICT

Islamabad is the 9th populous city, with a population of over 1.2 million. As per World Health Organization, a country should spend its 6% of GDP on the health sector while in Pakistan 3% of the GDP has been spent/allocated to Health Sector. The government has allocated Rs12.65 billion for the health sector in Islamabad and Rawalpindi under the Public Sector Development Programme (PSDP) for FY 2021-2022. Islamabad Capital Territory comprises urban and rural areas.

The three major stakeholders in the health sector for public of Islamabad Capital Territory are; District Health Office (DHO), Islamabad; Federal Government Polyclinic; and Capital Development Authority (CDA).

Non-Existence of Online Complaint management System of DHO.

If we look at the data provided by DHO, Islamabad, the number of health facilities running under the umbrella of the District Health Office, Islamabad is as 3 Rural Health Centres, 15 Basic Health Units, 1 Community Health Centre, 1 Dispensary, 31 family Welfare Centres, 3 Rural Health Service, 1 Mobile Service Unit with an accumulated staff of 597. The annual budget of the District Health Office, Islamabad is Rs. 508 millions. The DHO has not introduced any online complaint management system for the population of 1.2 million living in Islamabad. The available website of the District Health Office i.e., https://www.dhoisb.gov.pk/ is specifically used for the registration of the Pharmacy License, Medical Store License and Distribution License, with the aim to provide a Paperless and Doorstep Facility for Online Processing.

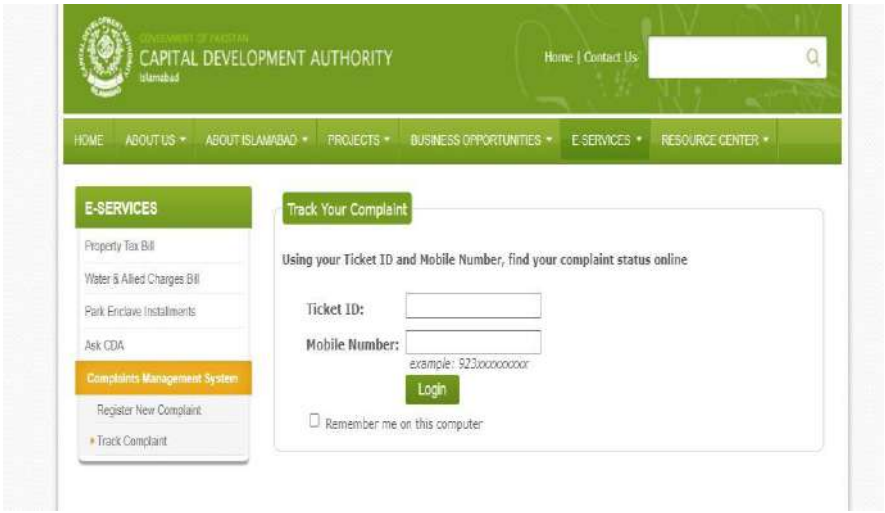
Upon searching on google shows the following options for online complaint

1. Islamabad Health Care Regulatory Authority, https://ihra.gov.pk/complaints/
2. Online Complaint Registration in Wasabi Mohtasib Secretariat. https://complaints.mohtasib.gov.pk/Complaints/precomplaintRegistration.aspx?mohtasib=WMS

In a telephonic communication, the DHO officials informed that District Health Information System (DHIS) are Logistic Information System (LIS) not available for the information of public and these facilities for internal information system installed.

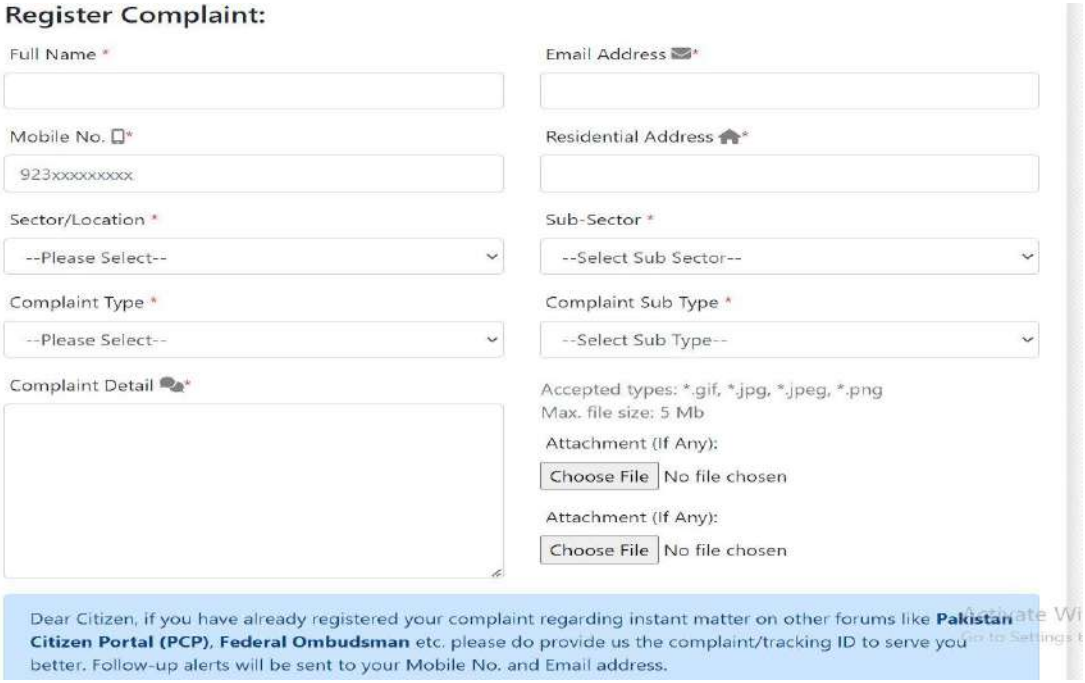
Online Complaint Redressal Mechanism of Capital Development Authority

Capital Development Authority (CDA) also claims to provide primary health services to the general public. It has a tertiary hospital and 13 Medical Centres with total 41 staff with 1.5 million annual budget. Upon analysing the website of the Capital Development Authority (CDA), i.e., https://www.cda.gov.pk/, it has been revealed that there is no designated dashboard for health service-related complaints.



There is a tab of E-service which provides online access to lodge complaints against any issue related to CDA services. A few numbers were also provided in case of emergencies and complaints about CDA.

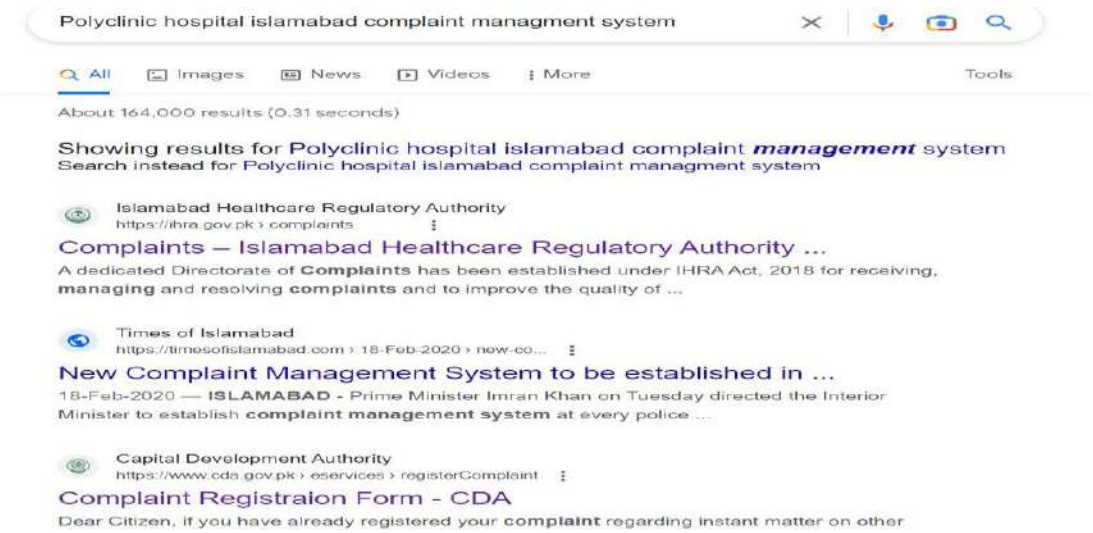
Following information has required to lodge any complaint:



Besides that, the website also runs the option to complain in Prime Minister Citizen Portal and Federal Ombudsman. Hence, there is no online health complaint management service provided by the CDA.

Non - Existence of Online Complaint Redressal Mechanism of Federal Government Poly-Clinic Hospital and Dispensaries

Polyclinic is also considered a key primary health service provider in ICT for the general public. It is running 3 MCHs in ICT with a staff of 95 and a total budget of Rs. 63,463,588. It is also running 25 dispensaries under the Federal government polyclinic network with a total staff of 103 and an annual budget amount of Rs. 122,560,325. Upon searching it is found that there is no official website of Federal Government Polyclinic to address the grievances of the people.



Instead a Facebook page (https://www.facebook.com/FGPC.PGMI/) appeared where location, email address and updates about polyclinic activities were posted. There is no online complaint mechanism/system provided by the federal government Polyclinic. Neither do they have an official website.

It is a matter of serious concern that the ICT health sector has no online complaint management system for its 1.2 million population, which raise serious question on transparency and accountability of these health service delivery departments. Lack of online complaint system is one of the primary reason of mal-administration and in-equal distribution of resources and services in ICT.

Third –Party Inspection - Role of Islamabad Health Regulatory Authority

During review of the performance of the ICT Primary Health System, apart from many instances of mal –administration as mentioned in the preceding chapter, it has been noticed with great concern that the inspection system of the agencies is very weak. There is a need for a third-party inspection on a regular basis. For that purpose, Islamabad Healthcare Regulatory Authority (IHRA) was established through the Act of parliament in the year 2018 (Ihra.gov.pk). The aims of the authority are to improve the quality, efficiency, and safety of healthcare services by adopting evidence–based regulatory standards. Under the law, inspection is one of the functions of ICHA. It has been noted that the authority is not conducting inspections of public sector health establishments. It is more focused on the private sector. There is a need to undertake inspections of all public sector primary healthcare establishments in the ICT area. During research, the research team of WMS visited to six (6) Primary Healthcare Units, an expert of IHRA was requisitioned to facilitate the inspection as per standard. The reports prepared by the expert are part of this report as a primary evidence.

Telemedicine -- According to World Bank estimates, 63 % of the total population resides in rural areas compared to 37 % in urban areas. Compared to traditional care, telemedicine

effectively caters to patients' needs with great convenience and lower cost. It makes health care accessible in remote areas by cutting down transportation costs. It saves a lot of commuting time, and patients do not have to take a day off from work which is essential for many rural citizens due to their poor socio-economic conditions. Telemedicine is essential in both urban and rural; it could ease the burden on understaffed healthcare facilities and prevent overcrowding as many patients receive medical care from the comfort of their houses. (Digital health and telemedicine in Pakistan; improving maternal health care. (www.sciencecredit.com). Technology in all forms is hitting the heights. The benefits of globalization are enormous in the field of technology and telemedicine. Telemedicine is an integration of technology and medicine. Under the framework of PHC, telephonic consultation is a laid down guideline but it has been found the use of telemedicine is not functional in the public sector, PHC in rural areas. According to World Health Organization (telemedicine survey of 2016), Pakistan has no telemedicine laws or regulations in place. Telemedicine has great potential in developing countries like Pakistan. It solves logistical problems, gives support to weak health systems, and helps to establish worldwide networks of health professionals. (The promise of telemedicine in Pakistan, A systematic review.ncb.nlm.nih.gov) Telemedicine's importance is fully recognized but its use is limited to the treatment of patients by means of telecommunications technology. Telemedicine is a term that covers the use of technology to deliver clinical care at a distance. It ensures that a person receives healthcare when needed, especially for those with limited access to care. Telemedicine allows a person to seek a doctor's advice about non-emergency situations that do not require an in–office visit. Currently, 76 % of hospitals in the United States connect with people at a distance. They do it through video conferencing or other technology. According to the department of health and human services, there was a 63 –fold increase in the use of Medicare visits through telehealth from 2019-2020 as a result of COVID -19 pandemic. A 2019, study found that telemedicine saves people travel time, cost and time away from work. Telemedicine helps make healthcare accessible, especially for people living rural areas. Telemedicine consultations may be more affordable than in –person visits and admission to the emergency rooms. A 2020 review found that there was a reduction in health costs by 56 % and travel costs by 94 % when doctors used telemedicine in intensive care unit, paediatrics, dermatology and radiology. Another 2021 review found that telemedicine helps provide timely delivery of preventive care to people with cardiovascular. (Medical News Today, what does telemedicine mean – e -visit Logo).

An existing example of telemedicine in Pakistan is currently implemented by the Pakistan Islamic Medical Association (PIMA). PIMA offers health services through a "tele clinic" that allow patients to contact doctors through WhatsApp either via message or audio message. The services are promoted through WhatsApp and rely on word of mouth.

The DHO office is equipped with telephones, cell phones, internet, and all modern-day application for communication. The district information system of the DHO, Islamabad is operational and has a website for pharmacy registration, etc. and this formalized system can be used for telemedicine by keeping a record of all communication between a citizen and health providers in the public sector.

Weak and Inefficient Referral Management System

The referral system in primary health care is an integral part of the PHC but exists in a very rudimentary form. Referral management system facilitate patient data transmission from one physician to another. A good referral management system aims to facilitate good communication between the consultant, specialist, the health care provider and the patient. If properly implemented, a referral management system can reduce revenue leakage by 20 %. A right referral management system is a solution for all the patient data management issues in the referral process. According to a study titled, The effectiveness of patient referral in Pakistan (research gate .net), in Pakistan, despite a network of over 5000 basic health units and rural health centres, supported by higher –level facilities, primary health care activities have not brought about expected improvements in health status, especially of rural population. A poorly functioning data management and referral system may be one of the reasons for the inefficiency. No well-organized referral system exists in Pakistan, including the ICT area. No rules and regulations exist in this regard. There is dire need to strengthen the referral system in the ICT by well-organized use of technology to facilitate the patient welfare. Referral management system is efficient transfer of patient data to the higher health facility subject to the patient's requirement, based on clinical examination and patient's diagnosis. For strengthening and making improvement in the PHC system, the digitalization of data is essential to catalyse PHC services at every level for acquiring better results.

Referral System in the Province of Punjab

System analysis of patient referral was conducted in the district of Attack (Punjab Punjab) for the purpose of identifying major short comings. Respondents from 225 households were interviewed, of the households experiencing serious illnesses less than half were taken to a nearest first –level care facility (CLCF). Major reasons included dissatisfaction with quality of care offered, non –availability of physician, and patients being too ill to be taken to the CLCF. The CLCF utilization rate was less than 0.6 patient visits /person /year. Only 15 % of patients were referred on the prescribed referral forms. None of the higher –level facilities provided feedback to FLCF. Records of higher-level facilities revealed lack of information on either patient referral or feedback. Seventy –five percent of the patients attending the first-level referral facilities and 44 % of the patients attending higher level facilities had a problem of a primary nature that could well have been managed at the CLCF. The Punjab government is already cognizant of the situation as depicted by a PC-1 where Rs 100 million was allocated for the referral system and as much amount for establishment of clinics in its Annual Development program (ADP for 2014 -15) . The referral system in ICT area is no different than in other parts of the country. This need to be strengthened and linked with the higher-level facility in the interest of public.

Rationalization and Integration of ICT Primary Health System

The current statistics of primary health care system of poly-clinic network demonstrates that out of 25 Polyclinic dispensaries, 17 are located within the radius of 2x2 Km on the Constitution Avenue while the rest are also located in government-controlled buildings like Police Lines and school health clinics.

In the same manner, out of 13 CDA medical Centres, 2 are located in the government controlled premises and out of remaining 11, 2 are located in G-9 sector, 3 are in I-10/1 sector and 6 are in other sectors like F-11/4, G-7, Simli Dam , Rawal Town, Bhara Kahu and I-8 Sector. The analysis reveals that as such, no criteria have been adopted for placing these facilities while major chunk of public has been denied the coverage through PHC facilities.

DHO network in rural areas is located in line with the jurisdiction of Union councils (previously it was 50) which has been increased to 101 and lastly another increase is up to 125. That means that a restructuring exercise has become imminent and would be taken by DHO office in future in line with the criteria of population and distance. In this regard, the very fact that infrastructure of 31 Family welfare Centres had already been integrated with the PHCs network and 2 of the facilities have been upgraded as PHCs. DHO has recommended upgradation of the remaining family welfare centres in line with the precedent of already upgradation of 2 FWCs . It is in the fitness of things that remaining Family Welfare Centres may immediately, be upgraded on priority in line with the criteria of PHC system.

Other secondary and tertiary level medical facilities like NESCOM, defence facilities funded by tax payer's money are operational and provide medical care to the entitled patient but after office hours, these facilities are available for private practice which is termed as 'institutional practice'. In these arrangements, there is a sharing arrangement of revenue between doctors and management. From all standards, this is a discriminatory treatment and underutilization of resources of the country. They are said to be reserved for entitled patients and citizens are treated on payment as a private patient in OPD & hospitalization. These facilities may be considered for opening for citizens to the extent of primary health care facilities. It will create goodwill for the government and also for medical institutions.

Develop public–private partnership for OPD on the pattern of Sehat–Sahulat program and in centralized PHC doctors and support staff to work after office hours on the pattern of tertiary care hospital and charge a prescribed fee, sharing between the government and the doctor as an incentive to the medical professional to work at PHC round the clock. This practice is allowed by Government in case of higher level medical facilities, and this can be extended to PHC system. Currently, it is also creating discrimination. Therefore, it is suggested that incentive system be extended to primary care health professional to keep running the PHCs for 24 hours. With the same staff and same infrastructure, the availability of healthcare will become round the clock and will reduce the pressure on the territory care system and also out of pocket expenditure of citizen.

Public –Private Partnership model for Primary Healthcare System

In line with the experiences of Govt. of Sind and Punjab where primary health facilities of government along with budget have been handed over to the private sector hospitals and NGOs (Punjab rural support program) for governance and running of PHC system efficiently under a well-executed contract. The ICT administration may consider the PPP model as it is time tested in provisional government. In case of PPHI Sindh, there is a board of directors, administrative and financial autonomy, technology-based monitoring mechanism, and key performance indicator are evaluated on regular basis. The proposed healthcare agency may be given the task to develop PPP model in ICT area.

Branding and Creating Demand Generation in Primary Healthcare System of ICT

During visits to PHCs under the supervision of DHO office, CDA and poly clinic dispensaries in ICT area, it is obvious that expensive infrastructure is available which need regular improvement and maintenance. There are no sign board and guidance for the information of citizen in rural or urban areas. Regular publicity campaign to create awareness among the local community is the need of the hour to make the rural population attentive to the available facilities of the PHC system. There are four basic stages of demand generation that is to identify the right audience, attract the audience, engage the audience, and manage the demand. In our analysis, demand generation is not on the agenda of these public sector agencies rather they tend to avoid the visits of the citizen. Big sign boards in the city and rural areas may attract citizens to such facilities. CDA has an old infrastructure but again is dedicated to entitled patients. The whole system is being run with taxpayer money without any oversight of the community. This can be opened to the general public of the area and it would not add any cost. The authorities can make an assessment of such facilities which cannot be opened to the general public for security reasons and it will always bring goodwill for the government.

Chapter 5

Conclusions and Recommendations

Improving Primary Healthcare System in ICT was the focus of this systemic study with the objectives to identify gaps and weaknesses in the system and recommend measures to address the issues of governance and accountability with regard to policy, implementation role of responsible federal government agencies i.e., District Health Office, Islamabad with 55 PHC establishment, thirteen (13) Medical Centres run by Capital Development Authority and a network of twenty five (25) Federal Government Polyclinic Dispensaries managed by the Ministry of National Health Services, Regulation and Coordination. This total network of 93 PHC health establishments is being operated with an annual budget of Rs. 733 million for a population of 2.2 million and spread over an area of 906 sq. km. Further to evaluate service delivery of the PHC system in terms of satisfaction of the citizen of ICT who is suffering out of pocket expenditure despite the availability of the public sector infrastructure in the capital city of country which enjoys the special status of federally administrated area with all the powers of provincial government.

Based on the analysis conducted, review of literature and data in the preceding chapters and briefing by all three agencies responsible for primary health care of ICT area, deliberations in the committee and consultation with resource persons, the gaps identified include uneven dispersal of resources against the principle of equity, lack of functional integration between the responsible agencies, non-existence of ICT centralized body for policy, planning, implementation and monitoring & evaluation. Furthermore, bureaucratic control and resistance to involve community participation in the PHC system, avoidance of third party evaluation, wilful negligence to develop on-line complaint management system raises the questions of transparency and accountability. A weak referral management system and avoidance of telemedicine, are also some of the instances which are visible signs of mal-administration and negligence resulting sufferings of the citizens who are entitled to free healthcare under the constitution of Pakistan. To address the issues and bring good governance in the system, following recommendations are submitted for consideration and approval to improve the PHCs system of ICT;

1. **Rationalization and Strengthening** of PHCs facilities in line with the principle of equity and functional integration of all federal government agencies for services delivery in ICT Primary Health System.
2. There are three different federal government agencies managing PHC system and there is a visible lack of unified command which has resulted in mal administration and poor implementation over a period of time which necessitates for the establishment of ICT Regional Health Authority, Islamabad for better policy, planning and implementation of the PHC system in line with the experiences of province of Punjab and Sindh. Pending the establishment of ICT health authority, an **Oversight Committee** may be constituted at the level of Chief Commissioner, Islamabad to implement the recommendations of this report.

3. Encourage participation of community in the Primary Health Care system of ICT which is the cardinal principle of PHCs system. District administration may be directed to constitute **Citizen Supervisory Committees** for each and every Primary Health Care facility for monitoring and evaluation.
4. People's Health Care Initiative in Sindh, Punjab Rural Support Program and Indus Hospitals Network in Punjab are well documented experiences with defined laws and rules and are performing much better than existing public sector Primary Health Care network. Analysis reveals that Pakistan has a very high utilization of the private health sector (71%) which is likely to increase unless an improvement in the governance and management of the public sector takes place. Therefore to develop **Public-Private partnership for Primary Health Care in ICT.** The Chief Commissioner may investigate the feasibility of developing partnership with private teaching hospitals in ICT area.
5. **Branding and creating demand generation** in Primary Health Care system of ICT through publicity, advertising and social media campaign will improve OPD utilization and the confidence of citizen.
6. To strengthen the **referral system** through the efficient use of technology.
7. Islamabad Health Regulatory Authority may be asked to undertake inspections of all public sector primary healthcare facilities as a **third party evaluator.**
8. To immediately introduce **Telemedicine,** as it is cost effective and satisfactory alternative to save the citizen from extra expenditure .It is already part of PHC system.
9. All federal government agencies delivering PHCs services may be directed **to fill all the vacant posts of doctors and other staff** under their jurisdiction to improve better delivery of service and consider provision of incentive to the PHC doctors in line with the institutional practice scheme as in vogue in tertiary care hospitals to make the PHC system work after office hours and round the clock.
10. To develop **Complaint Management System of Primary Health Care system** to ensure transparency and provide a voice to the people. Under the system, provision may also be placed for registration of resident of the catchment area so that citizen may know where to go for medical services.
11. Auditor General of Pakistan may be requested to undertake **financial and performance audit** of all three agencies jointly to assess the value of money being spent on PHC system in line with the audit being done for district health authorities of Punjab.

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36. No. F. 7(15) / COORD / WMS/ 20223 (Notification Members)

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38. No. FGPC. 1/12/2022 (Federal Government Poly Clinic)

39. Polyclinic (Presentation 1-06)

40. DHO (Presentation Page 1-32)

41. Third-Party Evaluation of the PPHI in Pakistan (Page 01-06)

ANNEXURES

Annex-A

Concept paper

Primary Healthcare System in Islamabad's Capital Territory

The primary Health Care system is the backbone of any health system for providing accessible, good quality, responsive, equitable, and integrated care. Under the constitution, health is the primary responsibility of the provincial government except in federally administered areas. Providing health care to every citizen of Pakistan is the state's responsibility but unfortunately, the majority of residents of Islamabad are making expenditures on health out of their own pockets.

A common perception is that Pakistan's public sector health system suffers from the ailments of bad governance, poor quality of services, lack of accountability and insufficient financing. The primary reasons advanced for this state of affairs are a weak political system especially the local government system and poor implementation of policies, laws, and rules.

As per Pakistan Economic Survey 2021-22, health services delivery infrastructure in Pakistan includes primary, secondary, and tertiary healthcare systems. In 2021, national health infrastructure comprised 1,276 hospitals, 5,558 BHUs, 736 RHCs, 5802 Dispensaries, 780 Maternity & child health centers, the availability of beds have been estimated at 146053. There are 266430 registered doctors, 30501 registered dentists, and 121245 registered nurses in these facilities. Public sector expenditure on health is estimated at 1.2 percent of GDP in 2020-21 which is less than the recommended by WHO i.e.5 percent of GDP.

The health -care delivery system in Pakistan consists of public and private sectors. Service delivery is being organized through preventive, curative, rehabilitative, and promotive services. The curative and rehabilitative are being provided mainly at the secondary and tertiary care facilities while preventive and promotive services are mainly provided through primary healthcare facilities. The state provides healthcare through a three-tiered healthcare delivery system. Some government/semi-government organizations, like armed forces, sui-gas, wapda, railways, fauji foundations, employee's social security institutions, and NUST also provide health services to their employees and their dependents through their own system, however,

these collectively cover about 10 % of the population. Studies have shown that the private healthcare system is covering almost 70% of the population.

It is a general view that Islamabad being the federal capital could be a model district of good governance in primary healthcare which could be replicated in other parts of the country but it suffers from the same weaknesses as reported at the national level.

After the 18th constitutional amendments in April 2010, the provincial health sectors got strengthened as they were given more autonomy whereas the health sector of the capital city got damaged due to fragmentation and uncertainty.

The primary health care system includes Basic and Rural health centers which are the first-level contact of the citizen. Two agencies are handling the affairs of the primary health system District Islamabad i.e., CDA (Health directorate) and District Health officer, Islamabad. The area of Islamabad is 90650 sq.km (urban 220.15 km and rural 466.20 km) with population of around 2,006,572 (census -2017) (urban 1014825 and rural 991747). Administrative divide of ICT area is with urban and rural. Urban area is comprised of Islamabad city and the rural areas consist of twelve union councils.

The concept of the primary healthcare system is often used for rural areas' while urban centers are catered to by a few public sector health dispensaries. There is a call for reforms of ICT health administration as the prevalent confused system has increased the burden on tertiary-care hospitals like PIMS etc. which are meant to deliver specialized services resulting in the quality of specialized healthcare has been compromised. The administrative structure requires improvements, financial issues need to be reassessed with the objective to evaluate the conditions of basic physical infrastructure, operational review in terms of service delivery, and availability of human resources.

At present, different health programs targeting different health conditions in Pakistan are under implementation. Each program has an independent structure at the federal, provincial, district, and first-level care facility. Having universal and integrated primary healthcare is the need of the hour to improve the health status of the people of Pakistan.

The focus of this systemic study would be to evaluate the role of different organizational frameworks responsible for the delivery of primary healthcare services in the ICT area

(Islamabad District) with a focus on the adoption of principles and characteristics of good governance, improved systems, and procedures including laws, rules, and regulations. The impact of the 18th constitutional amendments and the performance of the district health system would be reassessed and to suggest interventions to make the system more responsive to the need of citizens.

The following Terms of Reference are proposed for this systemic study,

"To review the policy, systems, and regulations of the district health system of ICT area after 18th amendment in the constitution of Pakistan and to evaluate in terms of good governance and service delivery with a focus on public sector primary health care system in both urban and rural areas."

Annex-B

S No	Name of Primary Health Centre / Basic Health Unit/ Civil Dispensary/ Mobile Health Unit / MNCH Welfare Centre in public and private sectors	Location with a catchment population	Staffing i.e., Doctors/Dentists Nurses/ LHWs Pharmacists/ LHVs/ Registered Midwives/ para medics Community Health Workers etc.	Estimated annual budget	Distance from another health facility	Remarks/ comments if any
1						
2						
3						
4						
5						
6						
7						

Annex-C

TO BE PUBLISHED IN THE NEXT ISSUE OF THE GAZETTE OF PAKISTAN PART-I

WAFAQI MOHTASIB (OMBUDSMAN)'S SECRETARAIAT
ISLAMABAD

NOTIFICATION

Islamabad, the 4th of January 2023

No. 7(15) WMS/Coord/2022. In exercise of powers vested under Articles 9 (3) of the President's Order No. I of 1983, the Honourable Wafaqi Mohtasib (Federal Ombudsman) is pleased to authorize a systemic study to review systems, functions and procedures relating to public sector primary healthcare provision in Islamabad Capital Territory, and make recommendations for improvement within existing resources allocated to primary health care. In this regard, exercising of powers vested under Articles 18 of the ibid Order, the Honourable Wafaqi Mohtasib (Federal Ombudsman) is pleased to constitute the following Committee for consultation and finalization of the study:

i.	Mr. Shaukat Hayat Durrani, Senior Advisor, Wafaqi Mohtasib Secretariat, Islamabad	Convener
ii.	Dr. Amanullah Khan, Chairman, Khyber Pakhtunkhwa Health Foundation, Peshawar	Member
iii.	Dr. Shabana Haider, Country Director (Pakistan), "Think Well", Islamabad	Member
iv.	Anyone else considered by the Convener of the Committee useful for consultation and finalization of the study	Co-opted Member

2. The Study shall be completed in ten (10) week time frame.

3. **The Terms of Reference (ToRs) of the Committee are as follows:**

   a) To review systems, functions and procedures relating to public sector primary healthcare provision in Islamabad Capital Territory, and make recommendations for improvement within existing resources allocated to primary health care.

   b) Along with the rest of the literature, review the existing Wafaqi Mohtasib reports relating to Pakistan Institute of Medical Sciences (PIMS) and Polyclinic (Federal Government Services Hospital (FGSH), Islamabad.

S. ahmad

(Sohail Ahmad)
Advisor (Coordination)

The Manager,
Printing Corporation of Pakistan Press,
Stadium Road,
Karachi.

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Copy for information to:

- All Members of the Committee listed in para 1 of the Notification.
- Associate Advisor/PSO to HWM, WMS, Islamabad
- Secretary to HWM, WMS, Islamabad
- PS to Secretary WMS, Islamabad

Annex-D

Record notes of 1st meeting held on 18th January 2023 (Wednesday) at 12:15 pm in Wafaqi Mohtasib Secretariat, Islamabad regarding Improving Primary Health Care Services in ICT.

A meeting was held under the Chairmanship of the Senior Advisor (Shaukat Hayat Durrani), in charge/head of the systemic study wing, Wafaqi Mohtasib on 18th January 2023 at 12:15 pm in the conference Room of the Wafaqi Mohtasib Secretariat (WMS), Islamabad with senior representatives of the health sector with the TORs, " **To review the policy, systems, and regulations of the district health system of ICT after 18th amendment in the constitution of Pakistan and to evaluate in terms of good governance and service delivery with a focus on primary health care system in both urban and rural areas .**"

2. A list of participants is attached.

3. The meeting started with a recitation of the Holy Quran and the chair welcomed the participants and members of the committee and participants who at the request of the chair introduced themselves. The chair in his introductory remarks made a presentation and highlighted the main objectives of this systemic research and emphasized that the people of Islamabad don't get efficient proper primary health care services despite the fact that the Government of Pakistan is spending a huge budget on this sub-sector. At an individual level, most of the people around the table do experience the non-availability of public sector primary health care resulting in minor ailments we have to visit tertiary medical care facilities which are already overburdened. Islamabad ICT/ district area has been made the focus of the study of the primary health care system with a view to identifying the impediments and making recommendations for improvements. The other objective is to make District Islamabad, a role model for other districts of Pakistan, and then the reformed system can be replicated in other districts of the country. The main components of primary healthcare services are to provide accessibility, quality services, responsiveness, equitability, and integrated care. There is a strong perception that the available services are of poor quality due to maladministration and fragmentation as there is a clear-cut divide in urban and rural areas which is affecting the chain of command of the primary health care system and the taxpayer's money is underutilized. Further, there is a dispersal of Resources and the impact of the 18th amendment in ICT with regard to community participation is not in place despite the fact that Islamabad Capital Territory Local Government Ordinance,2021 had already been promulgated and there is constitutional protection to local government under Article 32 and 40-A of the constitution of Pakistan. Monitoring and supervision of primary healthcare facilities, preventive health, Hygiene, and population welfare including population control are the responsibilities of the local government system. He also informed that under the Punjab local government Ordinance 2021, it has been mandated to establish a separate district authority for devolved district-level offices and specifically a District Health Authority of primary and secondary healthcare departments to ensure community participation which is the fundamental principle of the primary healthcare system and at present, there is no community participation in rural and even urban areas of ICT area. Moreover, the Chairman referred to a letter that was forwarded to the different health centers and hospitals requesting the provision of information and data regarding primary

healthcare staffing and budget. It was informed that the response of the agencies i.e., District Health Office, Federal Govt Polyclinic hospital, OGDCL Medical Center, Federal General Hospital, Islamabad, and CDA Hospital has been received while from other agencies' information/ data is still awaited. He requested all participants to work for the betterment of the primary healthcare system by sharing their experiences and ideas for the improvement of this sub-sector.

4. Dr. Quaid Seed, Chief Executive Officer, of the Islamabad HealthcareRegulatory Authoritymade a short briefing that the authority is functioning under the Act of Parliament2018, and its main function includes regulating/facilitating the Govt and private health care services including informal and Acupuncturemedical clinics. The other objectives are the provision of medical services, developing a framework for healthcare policies and standards, training healthcare professionals to achieve the standards, and granting licenses to the trained ones for the operation. He further informed me about the health-related services being provided by the BHUs, RHCs, CHCs, and Family Health Centers. According to IHRA, three agencies are responsible for primary healthcare services in ICT Area under NHSR&C i.e., CDA Health Directorate, Polyclinic hospital, and District Health Office, Islamabad. The **CDA Health Directorate is running** 01 (one) CDA hospital and 11 (eleven) Dispensaries in Urban Areas of ICT, a **Polyclinic Hospital** is running 30 (thirty) Dispensaries, and, **District Health Office is running 13 (thirteen)** Basic health units HUs, 3 (three) Rural Health Centers, 4 (four) Community health centers, 1 (one) Dispensaries, one (10 Mobile Units (01), and 28 (twenty-eight) Family welfare centers.

Further, he added that IHRA is undertaking inspections of health establishments on a regular basis. CEO informed about some observations regarding **BHUs of ICT** that the doctors are not appointed regularly resulting in unavailability, general OPD is done by medical technician/assistants/midwife, lack of paramedical staff, no labor room facility available, shortage of medicine, unavailability of other basic facilities i.e. electricity /lights, washrooms, clean drinking water, proper waiting area, poor hygienic condition of overall HCE and waste is not segregated properly. **Regarding RHCs,** IRA informed about the unavailability of appointed doctors, general OPD (outpatient department) is done by a medical technician, lack of paramedical staff, proper OT is not established, only minor OT is functional, diagnostics facilities are not available in the HCE (x-ray & ultrasound) two RHC have established laboratories but they are not fully equipped, shortage of medicine in the HCE, unavailability of other basic facilities. alternate power source, washrooms, clean drinking water, proper waiting area, poor hygienic condition of overall HCE and etc. That his inspection team after a visit to Community Health Centre observed that only one MO (Medical officer) is available to run General OPD (Outpatient Department) and the medical assistant only checks the male patients. No alternative MO (Medical officer) is present. HCE is providing services of EPI (Expanded Program on Immunization), OPD (outpatient department), and ER (emergency room). HCE is deficient in staff, non-functional facility of MCH, Dental Unit & Family Planning. A waiting area and clean drinking water facility are available. Pit protocol is adopted for waste disposal. The patient record is maintained electronically and manually.

5. The District Health Officer stated that the district office is working under the Ministry of National Health Services. He also responded to the observations of the CEO of IHRA and stated that all BHUs, RHCs, and primary care centers are delivering at their best, and doctors are appointed. Medical technicians and other paramedical staff are also available. There is no shortage of medicines and all available facilities are providing their best health delivery services within their limitations. He stated that especially during COVID-19, Dengue, and Polio, the health teams have been working regularly, and efficiently and the performance has been appreciated by all. He said that there is an online health department monitoring system that is very efficient and updated data can be seen. He said that the development budget of health has already been enhanced on the development side and they are constructing and upgrading many buildings in rural areas with the collaboration of CDA. The Community health centers are covering a lot many people within their jurisdiction. He stated that if primary health care needs to be improved, then the concept of a referral system may be introduced to reduce the burden on secondary and tertiary care facilities. He was of the view that effective referral systems from the primary healthcare facility are essential to save lives and ensure quality and a continuum of care. He also said no medicines are deficient and they can easily provide the medicines to the people. He also permitted that they are committed to completing the tasks and providing the best service to the public moving towards betterment.

6. Representative from the Director of General Health, M/O Health highlighted the challenges faced by PHC in Islamabad including lack of coordination, human resource shortages, and lack of adequate budgeting, faced by the health sector mainly due to the merger.

7. Senior Advisor was of the view that after the 18th amendment, the provinces are receiving more transfer of funds and they can enhance the finance of the health sector but ICT is facing problems like duplicity of functions by different health organizations, lack of functional integration, lack of unity of command, poor infrastructure and lack of community participation.

8. Director of the Health directorate, Capital Develop Authority shared his views that the hospital comprises 50 beds with every health care service available. Along with the CDA hospital, other dispensaries and primary healthcare setups were also developed for the CDA employees, families, and pensioners and also to facilitate the general public. He also said there is no conflict between DHO and CDA regarding health services as both works smoothly in urban and rural areas but the location problem does surface in urban areas. The BHU exists in different sectors but the public doesn't find it due to its location as the facility is located at a very unfamous/unfamiliar place. The BHUs should be opened in easy and accessible places in all sections for the conveyance of people.

9. The Medical Officer of the Atomic Energy Commission said they have five general hospitals which provided indoor and outdoor facilities to their commissioned employees. On other hand, these hospitals also cater around their vicinity at a limited level. The KRL and NESCOM hospital are tertiary levels hospitals. They provide all healthcare facilities except cardiac surgery and refer the patients to the Shifa hospital or CMH. The other Secondary care

hospital comprising around 50 beds is working near Nilor where patients visit daily. The Atomic Energy hospitals are financed by SPD and are dedicated to their employees and pensioners.

10. Dr. Farooq, a representative of Polyclinic government hospital, said that they have 28 dispensaries that are scattered and school health clinics are closed and they are not dealing with school clinics anymore. The general public mostly faces the problem of scattered dispensaries and policy problems. He informed the main aim was to open dispensaries in the federal offices and localities to save the time the public. Moreover, the main problem facing the people of poor infrastructure that is not appropriate for the patients, and further, the deficiency of medicines in Govt sector. He was of the view that we should up mark the medical facility and should try to improve and maintain the trust level of the public. The powers should be delegated to the medical officer in dispensaries for any kind of upgradation as per the authority of the government.

11. The Senior Advisor WMS asked DHO about any kind of policy directions or legislation for the primary healthcare framework. The DHO replied they have jurisdiction to prepare layouts for disease control like polio, dengue, etc.

12. The representative of the social security hospital, stated that they are an autonomous body working under the Punjab labor department. They have a filter clinic that checks the patient and then the referral procedure is followed for the detailed checkup. If focused on the GP system, the referral system, it would deliver better and the tertiary load will decrease immediately and they can provide better tertiary-level treatment. Moreover, the labor health department is not spending much and facing the problems of trusting the people. In fact, the general perception is that people do not trust government hospitals. Other main factors are inequality, poor regulation, and poor quality of government hospitals.

13. The representatives of KRL and Nescom stated that they're both hospitals dealing with their entitled patients. They also cater the private patients. Further, they have their filter clinics that identify the referral to the tertiary level facility.

14. Dr. Amanullah was out of the country and he joined the meeting on ZOOM and observed as follows:

a. Coordination is not routine just in emergency cases.
b. Function and Standard of each health care system (BHUs, CHCs, RHCs, etc) must be defined.
c. Mapping of every primary health care system must be done.
d. Split CDA facilities, Polyclinics, and other filter clinics may be reexamined.
e. Ensure the presence of community workers (LHVs, midwives, etc.) in health facilities
f. Define referral strategies
g. Increase awareness and trust in the utilization of public health services
h. Financial analysis needs to be done at different levels.
i. Standardizations of staffing at primary health care facilities
j. Branding of the national health services must be done to build public trust.

15. Dr. Shabana Haider, Country Director of Think well Global and member of the committee suggested the following:

a. Every Primary healthcare unit should be mapped and an HFA (health for all) conducted to assess the gaps
b. Financial Analysis should be conducted and must be transparent
c. HR Gaps should be assisted and a policy made to address them.
d. Decide the package of health services for each dispensary, BHUs, RHCs, CHCs, etc
e. Outsource the health facilities if required with govt stewardship and financing and private sector delivery if required
f. Develop a referral system and link one healthcare facility to another.
g. Provide quality health services and monitor performance through regular stock takes.

16. The Advisor Education and Research, Shifa Tameer-e-Millat university enunciated the delipidated situation of Pakistan's healthcare system and stated that according to the WHO, 6% of the GDP should be spent on the health sector but in Pakistan, the spending is only 1.2% of GDP. Meanwhile also described that they could not do anything administratively, legislatively, or structurally. He has suggested the following points to improve the primary healthcare system,

a. Incentives should be given to the doctors, professionals, and staff working in rural areas
b. Primary health care centers may also be located within the premises of teaching hospitals and schools.
c. Public-private partnership may be encouraged/adopted.

17. Director General of Health joined the meeting at the end and she addressed the comments of the Advisor of Education and research, she stated that the strategy of incentives started at ICT at a very early level but failed because incentives and other allowances are given to those doctors and staff who's working remote areas but in ICT, the tertiary hospitals are situated very near to the primary Care.

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

Annex-E

Record notes of the 2nd meeting held on 1st February 2023 (Wednesday) at 12:00 pm in Wafaqi Mohtasib Secretariat, Islamabad regarding Improving Primary Health Care Services in ICT.

A meeting was held under the Chairmanship of the Senior Advisor (Shaukat Hayat Durrani), in charge/head of the systemic study wing, on 1st February 2023 at 12:00 pm in the conference Room of the Wafaqi Mohtasib Secretariat (WMS), Islamabad with senior representatives of the health sector with the TORs, **"To review the policy, systems, and regulations of the district health system of ICT after 18th amendment in the constitution of Pakistan and to evaluate in terms of good governance and service delivery with a focus on primary health care system in both urban and rural areas.**

2. The meeting started with a recitation of the Holy Quran and the Chair welcomed the participants and members of the committee and the participants introduced themselves. The chair briefed the members that WMS aims to look at the Primary Health Care Service and improve the health service delivery in the district ICT. Its main objective is to identify the gaps in health care and bring some reforms. The gaps and possible recommendations would be highlighted and discussed at the end and everyone would put forward their ideas, suggestions, and experiences that would be appreciated in this discussion. Meanwhile, the best possible ideas and suggestions would be the soul of this study. More, the chair also paid thanks to all the participants for the last meeting which was held on 18th January 2023 in Wafaqi Mohtasib was very fruitful and every participant gave their best output in that meeting. The Chair invited the District Health Officer Islamabad, Dr. Muhammad Zaeem Zia for a presentation.

3. The District Health Officer, briefed that, Previously the District Health office worked under the District Administration Islamabad, later on, it is under the Ministry of National Health Services, Regulations & Coordination, Islamabad. The main objective of the DHO office, the federal government, and their partners is to provide the best possible Primary Health care services to the public without any financial burden, and ensure the proper delivery of preventive and curative health services (HR, Supply Chain, Immunization, Data management i.e.,). Meanwhile, Functioning in Work Force, Finance, Governance, Health Information Systems, Drug Section (Essential medicines, vaccines, supply & chain mechanism), and development section for the last

03 years. The pharmacy Health care section performs the Pharmacal operations to provide the licenses and supply the medicines under the law of 1980 section (6).

They are providing three-level care deliveries to the General **administratively** (Community, Union Council, Tehsil/Tulka, District, Federal, Provisional & large Districts), **Public Health facilities** (Health House, LHWs, Outreach Workers, CDC, EPI, RHCs, BHUs, Tehsil Headquarter Hospitals, District Headquarter Hospital, Tertiary Hospital), and **Private Health Facilities** (Community Based Organizations and Outreach workers, Nursing Homes/ Maternity Clinics/ Clinics, Small Hospitals, Large Hospitals, Tertiary Hospitals.)

He also informed the challenges faced by the District Health Administration, which are increasing day by day and Islamabad is a transit point as its population expansion is rapidly increasing and confronting many challenges. After any kind of pandemic, Endemic, communicable, and non-communicable diseases, financial indicators, and constraints are colossal challenges to strengthening primary healthcare into universal healthcare. Despite these challenges, they are promoting life towards a healthy lifestyle.

He elaborated that the Basic Health Units (BHUs) are working delightfully and daily catered to around 2500-3000 patients which will decrease the referrals to the tertiary level.

They are improving their infrastructure and development side as 2400 million approved by the ministry of health to promote the UHCs. The LHVs/ worker played a very important role in dengue and covid-19 by using these BHUs. **The overall goal of the Health Department is "to provide preventive, promotive and curative health services to the rural population in ICT through a network of three rural health centers, CHCs, Dispensary, and Basic health units".** The initiatives have been taken by DHO for **Basic Health Units**, sara-e-kharbooza, Jhangi Syedan, Golra sharif **CHCs**, bari imam, G-13, Bokra, Shah Allah Dita, Tarnol, Rawat, kirpa, for **MNCHs**, Gohra shahan, Bara Kahu, Badhana Kalan. **tertiary care** level King Salman hospital at Tarlai.

He also described that if the Health Department ICT and Health Directorate CDA can be merged and work under the M/o NHSR&C that would create an effective governance mechanism with a central command responsible for the provision of well-coordinated and integrated health services of acceptable quality, bringing transparency and accountability and progress towards a common strategic direction.

4. The Director Sehat Sahulat Program, described that they only provided services to families which required indoor health care Facilities. They are running four Health insurance Programs. First, is Sehat Sahulat Card runs the KP govt by itself, the Second is run by the Federal govt ministry of Health (ICT, GB, AJK, and Tharparkar), the Third Punjab govt which is run by the Punjab Health Management Company, and Fourth is GilgitBaltistan program which is a Social Health Protection. At this time they can access every province except Sindh and Balochistan. They had 11 tilted hospitals and all registered beneficiaries could be admitted through only an ID card and a B- form, as the beneficiary admitted, got the SMS through their mobile phones. They have a medical doctor / Field officer who glimpsed all these activities. when the beneficiary was discharged from the hospital, they got the expenditure SMS. They had a very efficient mechanism for complaints and resolved 119,000 complaints out of 1,020,000 just pended 1000 complaints. The existing all three programs are integrated and run by the state life insurance company but skin and optical services are excluded. The number of admitted patients were 30,000 per day in this program all the payments can be seen through an online mobile application. It also covered almost 90% of people in ICT and 35 hospitals in Islamabad and Rawalpindi are entitled to this program. The per annum cost is 200 billion for the whole program given to the company. Real-time data and complaints can be resolved which is a big achievement. Moreover, they agreed to take the charge of all BHUs, Dispensaries of CDA, and Federal govt dispensaries by using the infrastructure of these can be catered to all the Out-Patients instead of referral to the tertiary level.

5. The Chair raised a question, as the Sehat Sahulat Program deals with the Secondary and tertiary level programs How they could assist at the primary level?

6. The Director Sehat Sahulat Program replied they proposed a project for Primary Health Care which would be the Pilot project for Urban areas as they would get the response from the govt side the circle of the project may be expended. They would cater to all the peripheries through BHUs for Out-door Patients at the Primary level.

7. The DHO, also agreed on this Pilot project in the future both will run on one track, they also started this pilot in Ali Pur and people will get benefit from this project.

8. The Director General of CDA Health raised concerns over budget constraints and said that in every era they saw things variously and tried to apply the different models like the Japanese model, and the Singapore model but nothing moves towards implementation due to financial

constraints. The CDA and DHO have infrastructure just govt take the commitments everything would be better.

9. The Chair asked the question, as 30% of people were catered to by the govt Hospitals and 70% catered by the Private Hospitals and your all efforts only for 30% why not for all?

10. The DHO replied when it was started only the private hospitals laid on this line but now as a pilot project it is not only for Private Hospitals for all those public and private hospitals that meet the Prime Minster Program modularity. There is no discrimination between public and private hospitals in this pilot project.

11. Dr. Shabana agreed with the Director of CDA Health and said financing is an enormous constraint, and, also expressed her experiences and views as there was no need to out-patient services to open in BHUs, RHCs, and CHCs, Meanwhile, she also disagreed and said no analytical data is existing for Sehat Shulat card, and which quantile getting this facility, and what is the expansion of this services these all the raised questions required the clarification and let's wait for results of all these facilities.

12. Dr. Mahrukh Durrani Co-opted member and Researcher at Shifa Temeer-e- Millit University also disagreed and said there is no need to bring the Outpatient model into BHUs.

13. Dr. Zunera Assistant Professor of Medicines, expressed her point and said OPD is not necessary to finish in tertiary Hospitals and the most important point is diagnostics when people face problems in their tests.

14. The Chair identify the gaps which emerged below:

a. Lack of adequate funding.

b. Inadequate staffing.

c. Poor infrastructure.

d. Limited access to specialized services at the primary level.

e. Inefficient medical record management.

f. No organized referral system.

g. No unified command at the district level

h. No community participation

i. Dispersal of resources.

15. Dr. Asif Bajwa Co-opted member and Retired Secretary of Finance, raised the question of the Location of primary health care centers. primarily, the public doesn't have any idea where these health facility centers are located which is a huge problem. If people got the location, then they faced the staff problem. The Primary Health care system requires the management to utilize their HR and if they have budget problems they make their proposal and submit it to finance that is not a big constraint as finance also approved an additional budget for PIMS in 2006 they required the machines at that time. The primary thing is to get the ways for doing things.

16. Dr. Aslam Advisor Shifa Temeer-e-Millat University, stated that the study aim would be completed at that time when all the recommendations should be fulfilled within the legal framework and available resources on the behalf of the expert knowledge. Moreover, there are a total of around 100 primary health care facilities existing in ICT and 10 to 15 govt hospitals, and others like the atomic energy commission, NESCOM, KRL, etc. He proposed the idea that under this initiative of the Ombudsman, an integration of all the BHUs would be a marvelous achievement. This integration may just increase the medicine expenditure but reduce the pressure on tertiary health care facilities.

17. The representative of the Director of Health, stated that the monitoring evolution must be strong in the health system.

18. Dr. Amanullah Health Expert, praises the excellent performance of DHO Dr. Zaeem Zia stated he is so kind and hard work officer he did a very great job for the last two to three years although it is a very hard but doing all the tasks very well.

Further, he identified the gaps given below;

- **Resources;** existing resources utilize and make management strong.
- **Governances**; DHO may lead the entire Primary Health Care system till the establishment of the District Health Authority ICT.

- **Service Delivery;** Defined standards and protocols to improve the facilities and open them 24/7.
- **Data;** Robust the data system, makes dashboards, and address complaints.
- **Referral System**; Introduce the referral system and the intensity of the emergency through red, orange, and green referrals.
- **Capacity Building;** Arrange the training for LHWs.
- **Innovations;** Outsourcing the resources utilized by a third party makes things easier for the public.

19. Dr. Shabana Haider Co-opted member stated that we should bring accountability to our system using modern technology using software applications to make efficient dashboards, like the Punjab govt they are working and introducing things very efficiently. The population is a major issue in this country that is neglected. The health sector is required to coordinate, collaborate, and take steps to stop the absence of staff. Moderate the digital system to work on one digital platform. There is no emergency base training for staff. The budget condition is not that much good to make any kind of urban family health care system for the public. Healthcare monitoring evolution is a very important component in the health sector which is not proper.

20. The Chair concluded with the following points:

- The committee will view the recommendations and rationalize the gaps.
- Review the Punjab law, Primary Healthcare is not the responsibility of the Local govt it is the responsibility of DHO.
- Administrative control may be given to the DHO and the system and services might be better.

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

Annex-F

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for Rural Health Center (RHC)

Health Care Establishment Name: Community Health Centre ShahAllah Ditta

Address: Village Shah Allah Ditta

Incharge Name: Doctor Sadia

Sr.No.	Description	Yes	No	NA	Remarks
1	Presence of Qualified staff	✓			02 doctors for morning, 01 Evening for doctor
2	Expired reagents/medicine		✓		
3	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
4	Presence of illegal / unathorized medicine in HCE		✓		
5	PNRA Registration (if applicable)			✓	
6	Provision of clean drinking water and waiting area for patients & their attendants	✓			
7	Hygienic Condition	✓			
8	Maintenance of patient record	✓			
9	Waste Management		✓		Pit Protocol was adopted but now they will transfer through ambulance to either PIMS or Polyclinic Hospital
10	Functional stretcher / wheel chair is available.		✓		
11	RHC has adequate facilities and civic amenities for the comfort of the patients and attendants.	✓			
12	RHC has adequate arrangements for the privacy of patients during consultation / examination / procedures etc.	✓			
13	Every medical record has a unique number / identifier. The record contains information regarding patient/client identity, presenting complaint, diagnosis, action taken and details if shifted/ referred/died as the case may be.	✓			
14	A quality assurance and internal monitoring system is in place.		✓		
15	The health education is provided as per guidelines.		✓		
16	Scope of the laboratory services is according to the clinical services provided by the RHC.		✓		
17	The preventive services are provided as per guidelines.	✓			
18	Catchment area(Population)				
19	location with estimated distance from village(time on foot)				
		Daily	Monthly	Yearly (2022)	
20	Daily OPD of Patients (working hours)	107	2778	33335	08:00 AM - 02:00 PM
21	Hourly Average	18			
22	Total budget including Salaries, maintainance, medicine Etc.				
23	%age of expense of BHU/RHC on Salaries, maintainance, medicine Etc.				
24	%age of cost per patient at BHU/RHC			-	

Comments:

HCE is facing HR issues. Doctors claimed that they are getting less salaries, compared to pubjab doctors. HCE is providing OPD, ER(not fully equipped) & EPI.

HCE has non-functional Facilities of MCH, Dental, Family Planning & Labor Room.	
HCE Representative:	**Inspected By:**
Name: _____	**Name:** _____
CNIC: _____	**Designation:** _____
Contact No: _____	**Date/Time:** _____

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for Basic Health Unit (BHU) Golra

Health Care Establishment Name: Basic Health Unit Golra Reg. No.:

Address:

Incharge Name: Dr. Sabeen

Sr.No.	Description	Yes	No	NA	Remarks
1	Presence of Qualified staff	✓			
2	Practicing other system of medicine		✓		
3	Expired reagents/medicine		✓		
4	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
5	Presence of illegal / unathorized medicine in HCE		✓		
6	Provision of clean drinking water and waiting area for patients & their attendants	✓			
7	Hygienic Condition	✓			
8	Maintenance of patient record	✓			Manually maintained
9	Waste Management		✓		
10	Location of the BHU is easily accessible to the people.	✓			
11	BHU has adequate facilities and civic amenities for the comfort of the patients and attendants.	✓			
12	Weekly reports of notifiable / Vaccine Preventable Diseases are submitted regularly.	✓			
13	The BHU has essential arrangements to cater for emergency care.	✓			
14	The BHU has list of contact numbers of the referral facilities, medico legal authorities, concerned police stations, Ambulance/Rescue Services and the Social Services Organizations.		✓		
15	The BHU defines and displays the type of obstetric cases along with their neonates can be cared for or not; and also displays definition of the high risk obstetric cases with referral guidelines.		✓		
16	Obstetric patients / clients and children under five are also assessed for nutritional status.		✓		
17	The BHU has the list of Essential Drugs to treat common diseases, as defined and notified by the Government.	✓			
18	Medicines are stored as per guidelines. Expiry dates / shelf life is monitored and checked prior to dispensing, as applicable.	✓			
19	Catchment area(Population)				
20	location with estimated distance from village(time on foot)				
		Daily	Monthly	Yearly (last 3 months)	
21	Daily OPD of Patients (working hours)	38	990	2970	08:00 AM - 02:00 PM
22	Hourly Average	6			

23	Total budget including Salaries, maintainance, medicine Etc.				
24	%age of expense of BHU/RHC on Salaries, maintainance, medicine Etc.				
25	%age of cost per patient at BHU/RHC			-	

Comments:

HCE is newly established in 2023. Ultrasound ,MCH & Labor Room services are not available in HCE. No LHV is available for HCE. No Health awareness committee is formed yet. 03 doctors are available for HCE, 02 of them are deputed from Polyclinic Hospital for 06 months.

HCE Representative:	**Inspected By:**
Name: _____	**Name:** _____
CNIC: _____	**Designation:** _____
Contact No: _____	**Date/Time:** _____

Annex-G

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for HCE`s

Health Care Establishment Name: CDA Dispensary
Address: G-9 Markaz
Incharge Name: Dr. Saira 0332-5516344

Sr.No.	Description	Yes	No	NA	Remarks
1	Registration Status with IHRA	✓			
2	Presence of Qualified Doctor/staff at the time of Inspection	✓			
3	Practicing other system of medicine		✓		
4	Expired reagents/medicine		✓		
5	Services provided by HCE other than registered facilities		✓		
6	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
7	Presence of illegal / unathorized medicine in HCE		✓		
8	PNRA Registration (if applicable)			✓	
9	Provision of clean drinking water and waiting area for patients & their attendants	✓			
10	Hygienic Condition	✓			
11	Maintenance of patient record	✓			Manually Maintained
12	Waste Management		✓		waste is not properly segregated as per protocols
13	Display / Availibility of tariff List / Cost / fees/charges of services provided			✓	
14	Catchment area(Population)				
15	location with estimated distance from village(time on foot)				
		Daily	**Monthly**	**Yearly (2022)**	
16	Daily OPD of Patients (working hours)				
17	Hourly Average				
18	Total budget (PKR) including Salaries, maintainance, medicine Etc.				
19	expense of HCE on Salaries, maintainance, medicine Etc.				
20	cost (PKR) per patient at HCE per year				

Comments: HCE is providing OPD, Covid-19 Vaccination, Family Planning including IUCD, EPI services. Daily patients OPD is 40-50 Pt. HCE has morning and evening OPD. Dr. Saira duty hours are 08 AM to 02 PM, she is on rotation for 03 days to any other HCE. 01 Doctor and 01 Dispenser is available for HCE. DG CDA Dr. Fayaz Lohdi suggested that HCE should be upgraded to Urban Primary Care Centre by adding Routine Laboratory, X-Ray, Gyne,Peads OPD, Labour Room & Ultrasound Facilities

HCE Representative: **Inspected By:**

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for HCE's

Health Care Establishment Name: CDA Dispensary
Address: CDA flats, Sufi Tabassum Road I-8/1
Incharge Name: Dr. Afshan 0334-6534642

Sr.No.	Description	Yes	No	NA	Remarks
1	Registration Status with IHRA	✓			
2	Presence of Qualified staff as per Registration at the time of Inspection	✓			
3	Practicing other system of medicine		✓		
4	Expired reagents/medicine		✓		
5	Services provided by HCE other than registered facilities		✓		
6	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
7	Presence of illegal / unathorized medicine in HCE		✓		
8	PNRA Registration (if applicable)			✓	
9	Provision of clean drinking water and waiting area for patients & their attendants		✓		
10	Hygienic Condition		✓		
11	Maintenance of patient record	✓			Manually Maintained
12	Waste Management		✓		waste is not properly segregated as per protocols
13	Display / Availibility of tariff List / Cost / fees/charges of services provided			✓	
14	Catchment area(Population)				
15	location with estimated distance from village(time on foot)				
		Daily	**Monthly**	**Yearly (2022)**	
16	Daily OPD of Patients				08:00 AM - 02:00 PM
17	Hourly Average				
18	Total budget (PKR) including Salaries, maintainance, medicine Etc.				
19	Expense of HCE on Salaries, maintainance, medicine Etc.				
20	Cost (PKR) per patient at HCE per year				

Comments: HCE is providing OPD & EPI services. Daily patients OPD is 10-20 Pt. HCE is location is not accessable and reachable.
Dr. Afshan duty hours are 08 AM to 02 PM, she is on rotation for 03 days to any other HCE. 01 Doctor and 02 Dispenser is available for HCE

HCE Representative: **Inspected By:**

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for HCE`s

Health Care Establishment Name: FGPC Dispensary
Address: G-6/1
Incharge Name: Dr. Zara 0347-3544614

Sr.No.	Description	Yes	No	NA	Remarks
1	Registration Status with IHRA	✓			
2	Presence of Qualified staff at the time of Inspection	✓			
3	Practicing other system of medicine		✓		
4	Expired reagents/medicine		✓		
5	Services provided by HCE other than registered facilities		✓		
6	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
7	Presence of illegal / unathorized medicine in HCE		✓		
8	PNRA Registration (if applicable)			✓	
9	Provision of clean drinking water and waiting area for patients & their attendants		✓		
10	Hygienic Condition		✓		
11	Maintenance of patient record	✓			Manually Maintained
12	Waste Management		✓		Sent to Hospital, no record Shown
13	Display / Availibility of tariff List / Cost / fees/charges of services provided			✓	
14	Catchment area(Population)				
15	location with estimated distance from village(time on foot)				
		Daily	Monthly	Yearly (2022)	
16	Daily OPD of Patients	38	987	11839	08:00 AM - 02:00 PM
17	Hourly Average	6			
18	Total budget (PKR) including Salaries, maintainance, medicine Etc.			3,402,020	
19	Expense of HCE on Salaries, maintainance, medicine Etc.				
20	Cost (PKR) per patient at HCE per year			287	

Comments:

HCE Representative: **Inspected By:**

Annex-H

GOVERNMENT OF PAKISTAN
ISLAMABAD HEALTHCARE REGULATORY AUTHORITY (IHRA)

General Safety Chechklist for HCE's

Health Care Establishment Name: FBR Dispensary
Address: FBR office Constitution Avenue
Incharge Name: Dr. Naeem Aslam 0333-5172075

Sr.No.	Description	Yes	No	NA	Remarks
1	Registration Status with IHRA	✓			
2	Presence of Qualified staff at the time of Inspection	✓			
3	Practicing other system of medicine		✓		
4	Expired reagents/medicine		✓		
5	Services provided by HCE other than registered facilities		✓		
6	Non-Compliance of IHRA Directives / Illegal Desealing / Funtional during suspension		✓		
7	Presence of illegal / unathorized medicine in HCE		✓		
8	PNRA Registration (if applicable)			✓	
9	Provision of clean drinking water and waiting area for patients & their attendants	✓			
10	Hygienic Condition	✓			
11	Maintenance of patient record	✓			Manually maintained
12	Waste Management		✓		sent to Hospital, No Record shown
13	Display / Availibility of tariff List / Cost / fees/charges of services provided			✓	
14	Catchment area(Population)				
15	location with estimated distance from village(time on foot)				
		Daily	**Monthly**	**Yearly (2022)**	
16	Daily OPD of Patients (working hours)	61	1595	19135	08:00 AM - 02:00 PM
17	Hourly Average	10			
18	Total budget (PKR) including Salaries, maintainance, medicine Etc.			2,607,222	
19	expense of HCE on Salaries, maintainance, medicine Etc.				
20	cost (PKR) per patient at HCE per year			136	

Comments:

HCE Representative: **Inspected By:**

METROPOLITAN CORPORATION ISLAMABAD
(DIRECTORATE OF HEALTH SERVICES)
****

No. MCI/DHS-14(1)/(62)/2023/60 Islamabad Jan: 17, 2023.

Subject:- **IMPROVING PRIMARY HEALTH CARE SERVICES IN ISLAMABAD.**

Project Coordinator/Consultant ENT Surgeon, Capital Hospital letter No.CDA/CH—4(35)/2023/239, dated 13-01-2023, on the subject noted above.

2. The requisite information on the prescribed proforma is enclosed as desired:-

Sr. #	Name of primary Health Centre/basic Health Unit/Civil Dispensary/ Mobile Health Unit MNCIL Centre/Family welfare Centre in public and private sectors.	Location with a catchment population	Staffing i.e. Doctors/ Dentists/ Nurses/LHWs Pharmacists/ LHVs/Registered Midwives/Para medics Community Health Workers etc.	Estimated annual budget.	Distance from another health facility	Remarks/ Comments if any
1	MC F-11/4	Sr. No.58, Service Road(east), F-11/4 Ibd.	1.Dr. Shahnaz. 2. Rizwan, Sr, Tech: 3. Khalid, Jr. Tech: 4. Zarian Aya	Rs:15 Lac	NESCOM Hospital 2KM PAEC 2KM Pak Air force Hos: 2KM Naval Hospital-2KM	
2	MC G-9 (Morning/ Evening)	G-9 Markaz	**Morning.** 1.Dr. Saira 2.Mr. Raza Ahmed Jr. Tech 4.Mazhar Jr. Tech: **Evening** 1.Mr. Ayub Chief Tech		FG, MC G-9 0.5KM NIRM I KM PIMS 1.5KM NORI 1.5 KM KRL-1KM etc.	
3	MC I-10 (Morning/ Evening)	I-10/1 Shaheen Market IBD	**Morning.** 1.Dr. Afshan 2.Mr. Ijaz, Sr. Tech: 3. Mr. Nasik, Jr. Tech: **Evening** Mr. Bilal, Jr. Tech:		Social welfare MC 1KM FG MC 0.5 KM	
4	MC G-10	G-10 Markaz	1.Dr. Qadeer. 2.Mr. Maqsood, Chief Tech: 3. Mrs. Rakhshanda LHV. 4.Mr. Umer Din, Jr. Tech:		KRL 1KM DHS 1KM NESCAM 1.5 KM PAEC Hosp: 1.5KM	
5	MC G-7	Gulshan Market G-7	1.Dr. Sara 2. Mr. Hameed Sr. Tech: 3.Mrs. Gulshan Midwife.		FGSH 1KM FDG MC 1/5KM MIPS 1.5KM NIRM 1KM	

6	MC Diplomatic Enclave	Diplomatic Enclave G-5 Ibd.	1.Dr. Saira 2.Mr. Saleem, Jr. Tech:		FG MC Bari Imam FGSH 2 KM	
7	MC Pak Sectt:	B.Block Pak Sectt:	1. Dr. Sara 2.Mr. Younis, Chief Tech:		FG A Block FG F Block FG P Block	
8	MC Simly Dam	Simly Dam Colony	Mr. Maseet Ullah		RHC Lethrar. NIH Hosp: Chack Shahzad.	
9	MC Rawal Town	Rowal Town	1.Dr. Qadeer 2. Mr. Obaid, Chief Tech: 3. Mubassar, Jr. Tech.		NIH MC 2km DHO Hosp: Tarli	
10	MC Barakhu	Simly Dam Road	1.Mr. Asif, Sr. Tech: 2. Mrs. Bushra Midwife		FG MC Barakh8u	
11	MC I-8	CDA Block I-8/1 Ibd	1.Dr. Afshan 2.Mr. Rehman, Sr. Tech: 3. Mr. Toufiq, Jr. Tech 4. Mr. Mujeeb, Jr. Tech:		FDG MC I-8/1 NIRM Hosp: 2km	

(Dr. Muhammad Qadeer)
Director Health Services.

Coordinator/Consultant
ENT Surgeon
Capital Hospital, CDA.

GOVERNMENT OF PAKISTAN
OFFICE OF THE DISTRICT HEALTH OFFICER
HEALTH DEPARTMENT
ICT, ISLAMABAD
****

F.No. 5(24)-Health/ICT/2020-/46 Dated 06 /01/2023

Subject: - **IMPROVING PRIMARY HELATH CARE SERVICE IN ISLAMABAD.**

Kindly refer to your letter F.No. 4)1=R/D/WMS/Sr.ADV/2022 dated 29/12/2022 on the subject cited above.

02. In this regard it is submitted that, In order to ensure integration of minimum essential health services the health department Islamabad has planned to consume its scarce resources to ensure proper administration and quality services. Aimed at provision of Health for All the existing health Facilities are upgraded and to cater for the growing population and urbanization of Islamabad's rural areas, The District Health Office, under the MoNHSRC has establishment of new health facilities (Annex 'I) to provide improved, Optimum and integrated health services to the masses of Islamabad at the primary level both at urban and rural levels.

The Health Department through its primary set up is ensuring the door to door services in Dengue control, Immunization, COVID19 vaccination and surveillance across Islamabad. The District Health office, under the M/o NHSR&C has improved the healthcare infrastructure and human resource in Islamabad, both in the rural and urban areas. The department is keen to improve the infrastructure and services in future as per the growing needs of the Islamabad's population.

03. The requisite information is submitted for kind and urgent action on the subject matter, please.

(DR. MUHAMMAD ZAEEM ZIA)
DISTRICT HEALTH OFFICER
HEALTH DEPARTMENT
ICT, ISLAMABAD
PH# 051-9260285

Naila Zahoor,
Section Officer
Wafaqi Mohtasib (Ombudsman)s Secretariat
36-Constitution Avenue, **Islamabad.**

Copy to:-

- Dr. Amanullah Khan, Chairman PKP Health Foundation.
- Dr. Shabana Haider, Country Director, Think Well, Islamabad.
- SPS to Secretary, WMS, Islamabad.
- PS Director General (Admn), WMS Islamabad.
- Director General (Coord), WMS, Islamabad.
- Main File.

1		
RHC TARALAI		
Sr#	Name	Designation
1	Dr. Sadia Naz	Medical Officer
2	Latif Khan	Medical Assistant
3	Shahnaz Gul	LHV
4	Shazia Luqman	LHV
5	Riaz Ahmed	Dispenser
6	Arshad	Lab Tech
7	Safdar Iqbal	Nursing Assistant
8	Muhammad Tariq	EPI Inspector/Technician
9	Tariq Mehmood	Sanitary Inspector
10	Masroor Ali	Ward Master
11	Sher Ali Khan	Vaccinator
12	Shezan Aslam	Vaccinator
13	Akbar Ali Khan	Vaccinator
14	Mr. Sajjad Ali	Vaccinator
15	Ahtesham Abbas	Vaccinator
16	Zeeshan Riaz	Vaccinator
17	Miss. Ayesha	Vaccinator
18	Sayer Khan	Driver
19	Ayub	Driver
20	Shujat Shah	Driver
21	Abdullah Khan	Driver
22	Shabaz	Chowkidar
23	Samina Naz	N/Q
24	Sarfraz	Mali
25	Shoukat Masih	S.W
26	Farida Bibi	LHW
27	Zahida Jabeen	LHW
28	Shahnaz Kausar	LHW
29	Raheela Yameen	LHW
30	Safina Qureshi	LHW
31	Azra Bibi	LHW
32	Zubaida Bibi	LHW
33	Almas Begum	LHW
34	Najma Shaheen	LHW
35	Tahira Parveen	LHW
36	Arb Sultana	LHW
37	Robina Bibi	LHW
38	Hulmat Zahra	LHW
39	Rehana Bibi	LHW
40	Zaheen Akhtar	LHW
41	Khameeza Kausar	LHW
42	Firdoos Shamsher Malik	LHW
43	Safeeda Asif	LHW
44	Gul Nisa Bibi	LHW
45	Zarifa Begum	LHW
46	Nazia Azhar Satti	LHW

47	Najma Bibi	LHW
48	Shazia Tabasam	LHW
49	Saima Naz	LHW
50	Riffat Parveen	LHW
51	Razia Qayyum	LHW
52	Fareeda Bibi	LHW
53	Rabia Bibi	LHW
54	Safoon Bibi	LHW
55	Shareefa Begum	LHW
56	Nuzhat Bibi	LHW
57	Robina Barkat	LHW

2		
RHC BARAKAHU		
Sr#	**Name**	**Designation**
1	Dr. Inam ullah	Medical Officer
2	Dr. Asim	Medical Officer
3	Dr. Aqsa Shabbir	Medical Officer
4	Riffat Ambreen	Nurse
5	Shoukat Iqbal	Medical Assistant
6	Rakhshanda	LHV
7	Ahsan Raza	Lab Tech
8	Waheed Aziz	Nursing Assistant
9	Bushra Ashraf	Nursing Assistant
10	Ehsan Hussain shah	EPI Inspector/Technician
11	Shahid Mehmood	EPI Inspector/Technician
12	Imtiaz Ahmed	EPI Inspector/Technician
13	Nadeem Shah	Sanitary Inspector
14	Atus Rehan Rasool	Sanitary Inspector
15	Junaid Ahmed	Vaccinator
16	Usama	Vaccinator
17	Muhammad Bilal	Vaccinator
18	Tasharaf Hameed	Vaccinator
19	Nauman Ahmad	Vaccinator
20	Sanam Sarfraz	Vaccinator
21	Nasir Mehmood	Vaccinator
22	Aqib Shah	Driver
23	M Nadeem	Driver
24	Gull Hassan	Driver
25	Shakir Azad	N/Q
26	Yasir	N/Q
27	Riffat Shabir	S P
28	Anita Hameed	S P
29	Misbah Saleem	S P
30	Ambreen Kazmi	S P
31	Nageena Zafar	Cleaner
32	Sajjad Masih	S.W
33	Kausar Waheed	LHW
34	Noreen Kausar	LHW

35	Najma Qayyum	LHW
36	Abida Shaheen	LHW
37	Parveen Akhtar	LHW
38	Shahida Parveen	LHW
39	Sajida Parveen	LHW
40	Shamim Akhtar	LHW
41	Yasmin Akhtar	LHW
42	Kalsoom Bibi	LHW
43	Shazia Malik	LHW
44	Raheela Bibi	LHW
45	Shahnaz Parveen	LHW
46	Shagufta Maqsood	LHW
47	Naeem Akhtar	LHW
48	Zarina Alam	LHW
49	Robina Kausar	LHW
50	Shamim Akhtar	LHW
51	Safeera Said	LHW
52	Najma Zakir	LHW
53	Bilquees Bano	LHW
54	Sajida Bibi	LHW
55	Qamar Un Nisa	LHW
56	Asia Iftikhar	LHW
57	Waheeda Abbasi	LHW
58	Nafeesa Maqbool	LHW
59	Shabnam Gul	LHW
60	Noreen Bibi	LHW
61	Naila Shaheen	LHW
62	Ambreen Bano	LHW
63	Robina Kausar	LHW
64	Rehana Riffat	LHW
65	Samina Nazakat	LHW
66	Zakeeda Bibi	LHW
67	Meher Fazoon	LHW
68	Shaista Parveen	LHW
69	Noreen Akhtar	LHW

3		
RHC SIHALA		
Sr#	**Name**	**Designation**
1	Dr. Maryam Farooq	Women Medical Officer
2	Latif Abid	Medical Assistant
3	Farwa Batool	LHV
4	Shahbaz Awan	EPI Inspector/Technician
5	Rasheed Khattak	Senior Microscopist
6	Tanveer	Vaccinator
7	Faizan Iqbal	Vaccinator
8	Ali Raza	CDC
9	Umer Hayyat	Driver
10	Raja Usman	Driver
11	Yousaf	Driver
12	Taimoor	Mali
13	Saeed Ahmed	Mali
14	Adeel Masih	S.W
15	Najma Naheed	LHW
16	Saeeda Yasmeen	LHW
17	Sajida Begum	LHW
18	Ghulam Hafiza	LHW
19	Safeena Bibi	LHW
20	Nasiba Jan	LHW
21	Nasim Akhtar	LHW
22	Zulekha Bibi	LHW
23	Ghazala Shaheen	LHW
24	Nighat Yasmeen	LHW
25	Naheed Akhtar	LHW
26	Shazia Jabeen	LHW
27	Rukhsar Bibi	LHW
28	Saleem Akhtar	LHW
29	Shabnam Abbassi	LHW
30	Nasreen Sultana	LHW

4		
BHU GAGRI		
Sr#	**Name**	**Designation**
1	Dr.Yaman Shahid	Women Medical Officer
2	Abdul Rauf	Medical Assistant
3	Najma Saddique	LHV
4	Ahmed	Vaccinator
5	Kashif	Driver
6	Kamran	N/Q
7	Nazakat	Mali
8	Yasmeen Shaheen	LHW
9	Fehmida Shaheen	LHW
10	Nusrat Bibi	LHW

5		
BHU RAWAT		
Sr#	**Name**	**Designation**
1	Dr. Tahira Aziz	Medical Officer
2	Khuram Shehzad	Medical Assistant
3	Saba	LHV
4	Asif Habib	Dispenser
5	Izhar Ul Haq	Nursing Assistant
6	Nifazullah	EPI Inspector/Technician
7	Ghazanfar Huusaain	Sanitary Inspector
8	Mr. Ahmed Ammad	Vaccinator
9	Wasif Ali	Driver
10	M. Irfan	N/Q
11	M. Khalid	Chowkidar
12	Yasir	Mali
13	Kashif	S.P
14	Tasleem Kausar	LHW
15	Asia Kanwal	LHW
16	Naseem Begum	LHW
17	Rehana Yasmin	LHW
18	Shabnam Bibi	LHW
19	Farzana Jabeen	LHW
20	Nighat Bibi	LHW
21	Asma Mehmood	LHW
22	Shahida Bibi	LHW
23	Safeen Zahoor	LHW
24	Samina Shahnaz	LHW
25	Nagina Shaheen	LHW
26	Nusrat Bibi	LHW
27	Naheed Bibi	LHW
28	Shaista Fayaz	LHW
29	Shahgufta Sabir	LHW
30	Shabnam Bibi	LHW

6		
BHU BHUKAR		
Sr#	**Name**	**Designation**
1	Dr. Sarmad Uzma	Medical Officer
2	Shoaib	Medical Assistant
3	Nargis Bibi	LHV
4	M. Shakeel	EPI Inspector/Technician
5	Matiullah	EPI Inspector/Technician
6	Mozzam	Sanitary Inspector
7	Sami Ul haq	Vaccinator
8	Abdullah Jan	Vaccinator
9	Haroon	Vaccinator
10	Zubair	Driver
11	Saqib	Mali

12	Naseem Farman	LHW
13	Sobia Shoukat	LHW
14	Ghazala Waheed	LHW
15	Farida Bibi	LHW
16	Zainab Bibi	LHW
17	Riffat Shaheen	LHW
18	Zafrana Ashraf	LHW
19	Shreeza Zamir	LHW

7		
BHU BIMBER TARAR		
Sr#	**Name**	**Designation**
1	Maryam Khan Qamar	Medical Officer
2	Munawar Khattak	Medical Assistant
3	Qaisr Abbas	Nursing Assistant
4	Mr. Muhammad Usman	Vaccinator
5	Raees Ahmed	Chowkidar
6	Mussarat Perveen	LHW
7	Robeena Shaheen	LHW
8	Jabeen Zohra	LHW
9	Shamim Akhtar	LHW
10	Nargis Jabeen	LHW
11	Saeeda Noreen	LHW
12	Naheed Musarat	LHW
13	Rozina Bibi	LHW
14	Robeena Bibi	LHW
15	Tehmina Bibi	LHW

8		
BHU SOHAN		
Sr#	**Name**	**Designation**
1	Dr. Maryam Amir	Medical Officer
2	Bakash Bhatti	Medical Assistant
3	Ghazala Tariq	LHV
4	Itibar Khan	EPI Inspector/Technician
5	Touqeer	Malaria Supervisor
6	Mr. Nouman Noor	Vaccinator
7	Junaira Mushtaq	Vaccinator
8	M Shabaz	Vaccinator
9	Kashif	CDC
10	Abdul Rasool	Driver
11	Javed Rasheed	Chowkidar
12	Gulzar	Mali
13	Awais Shah	S.P
14	Nouman Hussain	S.P
15	Zahida Bibi	Cleaner
16	Fozia Abbas	LHW
17	Naheed Zubair	LHW
18	Nargis Bibi	LHW

19	Jamila Bibi	LHW
20	Robina Bibi	LHW
21	Nisar Bibi	LHW
22	Aasia Sattar	LHW
23	Sabina Bibi	LHW
24	Amina Wali	LHW
25	Aziz Un Nisa	LHW
26	Nuzhat Shaheen	LHW
27	Shaheen Akhtar	LHW
28	Ajeeba Taj	LHW
29	Shabana James Kosar	LHW
30	Mumtaz Kamran	LHW
31	Yasmeen Akhtar	LHW

9		
BHU JAGIOT		
Sr#	**Name**	**Designation**
1	Imran ul Khursheed	Medical Assistant
2	Samra Ameen	Nursing Assistant
3	Parveez Naich	EPI Inspector/Technician
4	Mr. Tauseef Abbasi	Vaccinator
5	Uzair Farooqi	Vaccinator
6	Tahir Qayyum	Chowkidar
7	Waqar	Mali
8	Nasreen Akhtar	LHW
9	Shabana Kausar	LHW
10	Rashida Bano	LHW
11	Zeenat Begum	LHW
12	Shamim Akhtar	LHW
13	Irum Ijaz	LHW
14	Farzana Bibi	LHW
15	Farkhanda Ikhlaq	LHW
16	Fukraz Bibi	LHW
17	Naheeda Begum	LHW
18	Shahnaz Bibi	LHW
19	Noreen Akhtar	LHW
20	Safia Begum	LHW
21	Rabia Noreen	LHW
22	Shazia Mehtab	LHW
23	Farzana Bibi	LHW
24	Aaliya Bibi	LHW
25	Nazneen Shaheen	LHW
26	Najma Shaheen	LHW
27	Kishwar Bano	LHW
28	Naheed Akhtar	LHW

10		
BHU JHANG SYEDIAN		
Sr#	Name	Designation
1	Maryam Khan Qamar	Women Medical Officer
2	M. Saleem	Medical Assistant
3	Rukhsana Bushra	FWC
4	Azam	EPI Inspector/Technician
5	Miss.Saba Manzoor	Vaccinator
6	Munir	S.P
7	Toheed Ur Rehman	S.P
8	Hameeda Parveen	LHW
9	Nusarat Parveen	LHW
10	Safia Begum	LHW
11	Shagufta Shaheen	LHW
12	Ihsan Aziz	LHW
13	Samina Altaf	LHW
14	Shazia Sabir	LHW
15	Rubina Kousar	LHW
16	Riffat Naz	LHW
17	Kausar Jabeen	LHW
18	Shaheen Akhtar	LHW
19	Naseem Mehmood	LHW
20	Safina Arif	LHW
21	Niaz Bibi	LHW
22	Shabnam Bibi	LHW
23	Nighat Shaheen	LHW
24	Shahnaz Akhtar	LHW
25	Nighat Batool	LHW
26	Tayyaba Bibi	LHW
27	Shazia Mazhar	LHW
28	Naheeda Kusar	LHW
29	Zahida Perveen	LHW
30	Nighat Ghulam	LHW
31	Noreen Nazakat	LHW
32	Robina Zahoor	LHW
33	Naheed Akhtar Satti	LHW
34	Firdous Binyasmeen	LHW
35	Raheela Bibi	LHW
36	Khalida Yasmin	LHW

11		
BHU CHIRRAH		
Sr#	Name	Designation
1	Dr. Nimra Sattar	Women Medical Officer
2	Najma Choudhary	LHV
3	Mr. Adeel Ahmed	Vaccinator
4	Syed Irfan Shah	Vaccinator
5	Sajid Mehmood	Chowkidar
6	Javed Khan	Cleaner
7	Zohira Khatoon	LHW
8	Abeeda Khatoon	LHW
9	Rehana Parveen	LHW
10	Abida Khatoon	LHW
11	Shahnaz Qamar	LHW
12	Sajida Shaheen	LHW
13	Khair Un Nisa	LHW
14	Fouzia Bibi	LHW
15	Raheela Parveen	LHW
16	Nazakat Bibi	LHW
17	Nusrat Bibi	LHW
18	Abida Parveen	LHW
19	Shaheen Bibi	LHW
20	Zaheen Akhtar	LHW
21	Nighat Basheer	LHW
22	Zatoon Bibi	LHW
23	Shaista Mehboob	LHW
24	Tehmina Bibi	LHW
25	Afshan Naz	LHW
26	Shabnum Bibi	LHW
27	Asia Waheed	LHW
28	Maryum Bibi	LHW
29	Ghazala Batool	LHW
30	Saiqa Bibi	LHW
31	Nosheen Bibi	LHW
32	Firdous Qasir	LHW

12		
BHU TUMAIR		
Sr#	Name	Designation
1	Abdul Shakoor	Medical Assistant
2	Nabeela Shaheen	FWC
3	Rana Faisal Ghaffar	Vaccinator
4	Ilyas	Chowkidar
5	Syed Wasim hussain shah	N.Q
6	Tasleem Kosar	LHW
7	Khizrat Abbas	LHW
8	Shahida Bibi	LHW
9	Najma Shaheen	LHW

10	Shahraz Bibi	LHW
11	Sajida Parveen	LHW
12	Najma Bibi	LHW
13	Surrya Bibi	LHW
14	Musarat Perveen	LHW
15	Tahira Mehmood	LHW
16	Robina Shaheen	LHW
17	Rehana Kausar	LHW

13		
BHU PIND BEGWAL		
Sr#	**Name**	**Designation**
1	Afzal Khan	Medical Assistant
2	Maria Kanwal	LHV
3	Arslan Saiddique	Vaccinator
4	Miss. Umera Bano	Vaccinator
5	Ajmal	N.Q
6	Ghazala Shaheen	LHW
7	Sabeela Kausar	LHW
8	Chaman Fatima	LHW
9	Tahira Zafar	LHW
10	Aqeela Bibi	LHW
11	Gulshan Abbasi	LHW
12	Atia Bibi	LHW
13	Nameeda Sabir	LHW
14	Raheela Bibi	LHW
15	Saima Parveen	LHW
16	Saadia Noreen	LHW
17	Fouzia Noreen	LHW
18	Shakeela Bibi	LHW
19	Sajida Zafar	LHW
20	Naseem Akhtar	LHW

14		
BHU PHULGRAN		
Sr#	**Name**	**Designation**
1	Khalid Mehmood	Medical Assistant
2	Shiraz	EPI Inspector/Technician
3	Ghulam Hussain	Vaccinator
4	Kashif	Vaccinator
5	Syed Ismail shah	Mali
6	Atif Khalil	Cleaner
7	Naeem Bibi	LHW
8	Robina Bibi	LHW
9	Riffat Shaheen	LHW
10	Rasheeda Bibi	LHW
11	Zareeda Bibi	LHW
12	Mazloom Bibi	LHW
13	Aneela Bibi	LHW

15		
BHU SHAHDARA		
Sr#	**Name**	**Designation**
1	Mujahid Nazir	Medical Assistant
2	Nafesssa Bhukhari	LHV
3	Ali Raza	Vaccinator
4	Qamar Zaman	N.Q
5	Shaila Bibi	N.Q
6	Sajida	S.P
7	Ghazala Razzaq	LHW
8	Fareen Bibi	LHW
9	Tehmina Bibi	LHW
10	Sidra Bibi	LHW

16		
BHU KIRPA		
Sr#	**Name**	**Designation**
1	Dr. Amir Saleem	Medical Officer
2	Mr. Kashif Qamar Javaid	Vaccinator
3	Turab	N.Q
4	M. Ismail	S.P
17		
BHU GOKINA TALHAR		
Sr#	**Name**	**Designation**
1	Atif Zahoor	Dispenser
2	Mazhar Sulary	EPI Inspector/Technician
3	Mian Muhammad Azhar	Vaccinator

18		
BHU GOLRA		
Sr#	**Name**	**Designation**
1	Dr Sabeen Haroon	Medical Officer
2	Dr Noor Un Nisa	Medical Officer
3	Dr Kashif	Medical Officer
4	Shakeel	Nurse
5	Shafique	Dispenser
6	Maryam	Nursing Assistant
7	Mr. USman	Vaccinator
8	Malik Nabeel Khan	Vaccinator
9	Ahmed Hanif Malik	Driver
10	Farooq	Driver
11	Nadeem	Chowkidar
12	Aitbar Khan	Chowkidar
13	Baggu Masih	S.W

19		
CHC SHAH ALLAH DITTA		
Sr#	Name	Designation
1	Dr. Sadia Gulzar	Medical Officer
2	Dr Sana Asghar	Medical Officer
3	Dr. Amna Qadeer	Women Medical Officer
4	Shams ur Rehman	Medical Assistant
5	Mr. Rab Nawaz	Vaccinator
6	Mr. Muhammad Rizwan	Vaccinator
7	Luqman	Vaccinator
8	Mr. Zahid Ahmed	Vaccinator
9	Parveez	Driver
10	Rehman Shah	Driver
11	Asim Shah	Chowkidar
12	Bilal Rehman	Cleaner
13	Kousar Parveen	LHW
14	Jamila Bibi	LHW
15	Nighat Shaheen	LHW
16	Attia Batool	LHW
17	Azmat Jan	LHW
18	Robina Bibi	LHW
19	Rashida Latif	LHW

20		
DISPENSARY MODEL TOWN HUMAK		
Sr#	Name	Designation
1	Dr. Maryam Khan	Medical Officer
2	Mehtab Gul	LHV
3	Gulraiz Bano	Nursing Assistant
4	Ayaz Manzoor	EPI Inspector/Technician
5	Junaid Safdar	Vaccinator
6	Sohail Anjum	Mali

Performa

Sr#	Name of Primary Health Center/Basic Health Unit/Mobile Health Unit/ MNCH Center/Famiy Welfare Center in public and private sectors	Location with a catchment Population	Staffing i.e , Doctors/Dentists/ Nurses/ LHWs Pharmacists/ LHVs/ Registered Midwives/ Para Medics Community Health Workers Etc.	Estimated annual budget	Distance from another health facility	Remarks / Comments if any
1	RHC Taralai	Lathrar Road, Taramari Chowk, Tarlai Islamabad 159867	Attached at Annex-A	508,375,000	8 km (BHU Jagiot)	
2	RHC Barakahu	Samaly Dam Raod, RD Makraz, Bhara Kau Islamabad 164160			12 Km (BHU Shahdra)	
3	RHC Sihala	Kahuta Road, opposite Police Collage Sihala, Islamabad 45438			10 Km (Humak Dispensary)	
4	BHU Gagri	Village Gagri. Islamabad 21693			8 Km (RHC Sihala)	
5	BHU Rawat	Main Bazar Rawat, Islamabad 47375			11 Km (Humak Dispensary	
6	BHU Bhukar	Vllage Bhukkhar Islamabad 107933			9 Km (BHU Bhimber)	
7	BHU Bimber Tarar	Village Bhimber Tarar, Islamabad 15310			9 Km (BHU Bhukar)	
8	BHU Sohan	Village Sohan Islamabad 133919			14 Km (RHC Tarlai)	
9	BHU Jagiot	Village Jagiot Islamabad 42398			4 Km (BHU Jhang Syedan)	
10	BHU Jhang Syedian	Lathrar Road, Village Jhang Sheddan Islamabad 105806			4 Km (BHU Jagiot)	
11	BHU Chirrah	Lathrar Road Village Chirrah Islamabad 45476			5 Km (BHU Tumair)	
12	BHU Tumair	Bin Karor Road Village Tumair Islamabad 15956			5 Km (BHU Chirrah)	

13	BHU Pind Begwal	Samli Dame Road, Village Pind Begwal Islamabad 30431			6 Km (BHU Phulgran)	
14	BHU Phulgran	Village Malata Phulgran Islamabad 24238			6 Km (BHU Pind begwal)	
15	BHU Shahdara	Village Shahdra Islamabad 15905			12 Km (RHC Bara Kahu)	
16	BHU Kirpa	Japani Dam Village Kirpa Islamabad 33812			7.5 Km (BHU Chirah)	
17	BHU Gokina Talhar	Village Gokina Islamabad 8890			20 Km (BHU Golra)	
18	BHU Golra	Golra Shareef, near Darbar Peer Mehar Ali Shah 8800			11 Km (CHC SAD)	
19	CHC Shah Allah Ditta	Village Shah Allah Ditta Islamabad 8840			11 Km (BHU Golra)	
20	Dispensary Model Town Humak	Kahouta Road Village Model Town Humk Islamabad 57285			10 Km (RHC Sihala)	

S. No	Name of Primary Health Center/Basic Health Unit/ Civil Dispensary/ Mobile Health Unit/MNCH Center/Family Welfare Center in public and private sectors	Location with a catchment Population	Staffing i.e, Doctors/Dentists/Nurses/LHWs/Pharmacists/ LHVs/Registered Midwives/para medics community Health Workers etc.		Estimated annual budget	Distance from another health facility	Remarks/comments if any
			Name	Designation			
1	Family Welfare Center Rawat	Rawat (40 to 50 thousand)	Tabassum Nisa	FWW		13 km	NIL
			Tahir Mehmood	FWA (M)			
			Tahira Batool	FWA (F)			
			Naheed Akhtar	Aya			
			Muhammad Rasheed	Chowkidar			
2	FWC Sihala	Sihala (40 to 50 thousand)	Farkhanda Bano	FWC		9.4 km	Shifted in the premises of RHC Sihala
			Rafaqat Hussain Qureshi	Social Mobilizer			
			Nasir Mehmood	Social Mobilizer			
			Sofia Yousaf	Aya			
			Muhammad Yasir	Chowkidar			
3	FWC Humak	Humak (40 to 50 thousand)	Aneela Andleeb	FWC		12 Km	NIL
			Shahzad Akbar	FWA (M)			
			Iftikhar Ahmad	Social Mobilizer			
			Khalid Iqbal	Social Mobilizer			
			Rubina Jalil	Aya			
			M.Ismail Butt	Chowkidar			
4	FWC Lohi Bhair	Lohi Bhair (50 to 60Thousand)	Afia Yousaf	FWC		12 KM	NIL
			Samra Sajjad	Aya			
			Muhammad Siddique	Chowkidar			
5	FWC Pind Malkan	Pind Malkan (10 to 20 thousand)	Saima Noureen	FWW		16 KM	NIL
			Saeeda Akhtar	Aya			
6	FWC Koral	Koral (50 to 60 thousand)	Khalida Jabeen	FWC		6.3KM	NIL
			Umar Farooq	FWA (M)			
			Fouzia Naheed	FWA (F)			
			Khasir Mehmood	Social Mobilizer			

7	FWC Khana Dak	Khana Dak (70 to 80 thousand)	Nasim Munir	FWC		3.8 KM	NIL
			Zahida Perveen	FWA (F)			
			Shamshad Bibi	Aya			
			Aurangzaib Qurashi	Chowkidar			
8	FWC Tarlai	Tarlai (30 to 40 thousand)	Atia Taj	FWW		2.9 KM	NIL
			Shukria Malik	FWA (F)			
			Farrukh Iqbal	FWA (M)			
			Samina Bibi	Aya			
9	FWC Ali Pur Farash	Ali Pur Farash (20 to 30 thousand)	Naeema Akhtar	FWC		8.1 KM	NIL
			Nagina Kousar	FWA (F)			
			Dilpazeer Hussain	Social Mobilizer			
			Shaikh Fareed	Chowkidar			
10	FWC Kurri	Kurri (20 to 30 thousand)	Sabia Khatoon	FWC		9.9 KM	NIL
			Muhammad Khalil	FWA			
			Tahir Kiyani	Social Mobilizer			
11	FWC Thanda Pani	Thanda Pani (20 to 30 thousand)	Bilqees Sadiq	FWW		6.7 KM	NIL
			Tahira Tasleem	Aya			
			Tanveer Kiyani	Social Mobilizer			
12	FWC Kirpa	Kirpa (20 to 30 thousand)	Tahira Tasleem	FWA(F)		7 KM	NIL
			Abid Ali	FWA(M)			
			Yasmeen Gul	Aya			
			Muhammad Banaras	Chowkidar			
13	FWC Chirah	Chirah (20 to 30 thousand)	Alia Nisa	FWA (F)		4.1 KM	NIL
			Habib Ur Rehman	Social Mobilizer			
14	FWC Tumair	Tumair (20 to 30 thousand)	Shaheen Akhtar	FWA		13 KM	Shifted in the premises of BHU Tumair
			Muhammad Ishtiaq	Social Mobilizer			
15	FWC Phulgran	Phulgran (20 to 30 thousand)	Samra Sahzadi	FWW		6.2 KM	NIL
			Muhammad Zulfiqar	Social Mobilizer			
			Muhammad Sarfarz	Social Mobilizer			
			Muhammad Dawood	Chowkidar			
			Tahira Perveen	Aya			
16	FWC Satah Meel	Satah Meel (20 to 30 thousand)	Bilqees Fatima	FWC		5.6 KM	NIL
			Muhammad Sajid	FWA (M)			

			Mukhtar Abbasi	Social Mobilizer			
			Muhammad Shafeeq	Chowkidar			
			Nighat Perveen	Aya			
17	FWC Bhara Kahu	Bhara Kahu (40 to 50 thousand)	Surriya Abbasi	FWC		9.9 KM	Shifted in the premises of RHC Bhara Kahu
			Naila Kaleem	FWA (F)			
			Muhammad Jamil	Social Mobilizer			
			Kalsoom Rizwan	Aya			
18	FWC Noor Pur Shahan	Noor Pur Shahan (20 to 40 thousand)	Rubina Ashraf	FWC		11 KM	NIL
			Talat Iqbal	FWA (F)			
			Ruqia Begum	Aya			
			Zaheer Gull	Chowkidar			
19	FWC NIH	NIH Hospital	Ishrat Perveen	FWC		11 KM	NIL
			Muhammad Haroon Zafar	FWA (M)			
			Hasrat Naz	Aya			
20	FWC Sohan	Sohan (30 to 50 thousand)	Shehnaz Bibi	FWA (F)		12 KM	NIL
			Nadeem Hussain	Chowkidar			
21	RHS "A" MCH Aabpara	MCH Aabpara	Dr. Ishrat Parveen	Medical Officer		2.6 KM	NIL
			Naveed Ahmed	FWA (M)			
			Saira Farooq	FWA (F)			
			Najma Bibi	Aya			
22	RHS "A" FGSH	FGSH Hospital	Dr. Farrah Izhar	Medical Officer		3.8 KM	NIL
			Muhammad Hussain	FWA (M)			
			Afshan Ishtiaq	FWA (F)			
			Sahista Nasreen	Theater Nurse			
23	FWC G-7	G-7/2 (40 to 60 thousand)	Farkhanda Perveen	FWC		2.5 KM	NIL
			M.Nawaz	FWA (M)			
			Sumaira Dildar	FWA (F)			
			Razia Khatoon	Aya			
24	FWC PIMS	PIMS Hospital	Iffat Naz	FWW		100 Meter	NIL
			Aqeela Zubi Khan	FWA (F)			
			Anjum Kehkashan	Aya			
25	RHS "A" PIMS	PIMS Hospital	Dr. Alvina Abdullah	Medical Officer		11 KM	NIL
			Bushra Nazeer	FWW			

			Yasmeen Khaliq	FWA (F)			
			Babar Awan	FWA (M)			
			Riaz Bibi	Sanitary Worker			
26	FWC I-10	I-10/4 (40 to 60 thousand)	Naseemat Bibi	FWC		12 KM	NIL
			Munazza Shahid	FWA (F)			
			Muhammad Shakeel	FWA (M)			
			Salma Khatoon	Aya			
			Muhammad Zulfiqar	Chowkidar			
27	FWC Jhangi Syedan	Jhangi Syedan (50 to 70 thousand)	Jameela Bibi	FWW		6.2 KM	NIL
			Farzana Shahnawaz	FWA			
			Bakhan Bibi	Aya			
			Ch. Tanveer	Chowkidar			
28	FWC Turnol	Turnol (40 to 50 thousand)	Naghmana Bibi	FWA (F)		6.3 KM	NIL
			Tariq Mehmood	FWA (M)			
			Asia Gull	FWA (F)			
			Abdul Salam	Chowkidar			
29	FWC Nogazi	Nogazi (30 to 40 thousand)	Amna Bibi	FWW		9.4 KM	NIL
			Nazish Dilawar	FWA (F)			
			Riffat	Aya			
			Sadaqat Ali	Chowkidar			
30	FWC Sang Jani	Sang Jani (30 to 40 thousand)	Farhat Jabeen	FWC		6 KM	NIL
			Nargis Bibi	FWA (F)			
			Azhar Sheraz	FWA (M)			
			Rukhsana Bibi	Aya			
			Rabnawaz	Chowkidar			
31	FWC Sarai Kharbooza	Sarai Kharbooza (30 to 40 thousand)	Kalsoom Akhtar	FWW		17 KM	NIL
			Naveed Hussain	FWA (M)			
			Muhammad Shafaaqat	Chowkidar			
32	FWC Golra	Golra (50 to 60 thousand)	Basharat Perveen	FWC		6.3 KM	Shifted in the premises of BHU Golra
			Muhammad Zaman	FWA (M)			
			Nousheen Ismat	FWA (F)			
			Aitabar Khan	Chowkidar			
			M.Ramzan	Social Mobilizer			

			Nazia Shaheen	Aya			
			Bagu Masih	Sanitary Worker			
33	FWC PAF	PAF Hospital	Bashir Begum	FWA (F)		4.8 KM	NIL
			Saima Ali Dino	FWA (F)			
			Shehnaz Kousar	Aya			
34	FWC CDA Dispensary	G-9 Markaz (40 to 50 thousand)	Shamim Akhtar	FWA			NIL
			Zaib-un-Nisa	Aya			
35	Mobile Service Unit	G-9 Markaz 01 for Islamabad District	Dr. Shazia Gul	Medical Officer			NIL
			Lubna Khalid	FWA (F)			
			Suriya Begum	Aya			
			Fahad Khalid	Chowkidar			

No.FGPC.1/12/2022
Federal Government Polyclinic
(Postgraduate Medical Institute)

Islamabad the 11th Jan, 2023

The Section Officer,
(Naila Zahoor),
Wafaqi Mohtasib (Ombudsman)'s Secretariat,
Islamabad.

Subject:- **IMPROVING PRIMARY HEALTH CARE SERVICES IN ISLAMABAD.**

Please refer to your office letter F.No. 4(1)R&D/WMS/Sr.Adv/2022 dated 29-12-2022 on the subject cited above and to furnish requisite information on prescribed performa as desired please.

10/01/23

(DR. I.U BAIG)
Executive Director

Sr No	Name of Dispensary	Location of Dispensary	Annual Number of Patients	Staffing	Annual Expenditure		Distance from Other health Facility	Remarks
					Medicines	Salaries		
SANCTIONED DISPENSARIES								
1.	MCH Centre Aiwan Sadar Colony	Aiwan Sadar Colony	17929	Medical Officer (02) Jr. Tech Pharmacy (01) Jr. Tech LHV (01) Jr. Tech Midwife (01) Nursing Attendant (01) Bearer (01) Ward Boy (01) Aya (01)	908254	5580120	Within Radius of 01 Km	
2.	MCH Centre Aabpara	Aabpara	15541	Assistant Executive Director(01) Consultant Gynae (1) Associate Gynae (01) Medical Officer (05) Sr. Tech Pharmacy (01) Jr. Tech Pharmacy (01) Private Secretary (01) LDC (01) Assistant Security Officer (01) Sr. Tech Pathology (01) Telephone Operator (01) Assistant Store Keeper (01) Sr. Tech OT (01) Jr. Tech OT (06) LHV (03) Nursing Attendant (02) Dispatch Rider (01) Transport Supervisor (01) Driver (01) Ward Boy (02) Chowkidar (02) Cook (03)	982772	32180244	Within Radius of 01 Km	

				Aya (09) Dai (02) Sanitary Worker (11)				
3.	Medical Centre G-7-3/4	G-7-3/4	89055	Medical Officer (10) Assistant (01) Jr. Tech Pharmacy (01) Jr. Tech Radiology (01) Jr. Tech ECG (01) Jr. Tech Lab (01) Supervisor (01) Naib Qasid (02) Nursing Attendant (03) Sanitary Worker (04) Aya (01)	2413378	21398820	Within Radius of 01 Km	
4.	Kohsar Block, Dispensary	Kohsar Block, Pak Secretariate	7419	Medical Officer (01) Charge Nurse (01) Jr. Tech Pharmacy (01) Sanitary worker (01)	1129214	2985972	Within Radius of 01 Km	
5.	Q Block, Dispensary	Q Block, Pak Secretariate	12073	Medical Officer (01) Jr. Tech Pharmacy (01) Naib Qasid (01)	662934	2262408	Within Radius of 01 Km	
6.	Foreign Office, Dispensary	Foreign Office,	10914	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Tech Dresser (01)	861680	2349240	Within Radius of 01 Km	
7.	Aiwan Saddar Secretariat, Dispensary	Aiwan Saddar Secretariat	7118	Medical Officer (01) Jr. Tech Dispenser (01) Jr. Tech Midwife (01) Jr. Tech LHV (01) Nursing Attendant (01) Aya (01) Bearer (01) Ward Boy (01)	918240	4035984	Within Radius of 01 Km	

8.	Parliament Lodges, Dispensary	Parliament Lodges	27463	Medical Officer (03) Jr. Tech Dresser (04) Jr. Tech Pharmacy (04) Jr. Tech Midwifery (02) Nursing Attendant ()01 Aya (01) Driver (03)	9207890	10321776	Within Radius of 01 Km	
9.	Cabinet Secretariat, Dispensary	Cabinet Secretariat	21116	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Tech Dressing (01)	1700204	2349240	Within Radius of 01 Km	
10.	G-9/2, Dispensary	SectorG-9/2	29740	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Tech Dresser (01) Aya (01) Sanitary Worker (01)	562942	2980680	Within Radius of 01 Km	
11.	I-8/1, Dispensary	Sector-I-8/2	12499	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Technician Dressing (01) LHV (01) Sanitary Worker (01)	703386	3067512	Within Radius of 06 Km	
12.	Police Line, Dispensary	Police Line	35384	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Technician Dressing (01)	1535708	2349240	Within Radius of 1.5Km	
13.	AGPR, Dispensary	AGPR	13103	Medical Officer (01) Chief Tech Pharmacy (01) Jr. Tech Dressing (01)	1376076	2349240	Within Radius of 01 Km	
14.	School Health Clinic 1	SectorG-7/3	6588	Jr. Tech Pharmacy (01) Naib Qasid (01)	348264	718272	Within Radius of 01 Km	
15.	Supreme Court, Dispensary	Supreme Court	13125	Medical Officer (01) Jr. Tech Pharmacy (01) Jr. Tech Dresser (01) Nursing Attendant (01)	1087658	2686272	Within Radius of 01 Km	
16.	PM Staff	PM Staff	15441	Medical Officer (01)	216800	2283720	Within Radius of	

	Colony, Dispensary	Colony, Diplomatic Enclave		Jr. Tech Pharmacy (01) Nursing Attendant (01)			01 Km	
NON-SANCTIONED DISPENSARIES								
17.	Prime Minister Secretariat, Dispensary	Prime Minister Secretariat	12142	Medical Officer (01) Jr. Tech Pharmacy(01)	856026	1946688	Within Radius of 01 Km	
18.	F-6/1, Dispensary	Sector F-6/1	11839	Medical Officer (01) Chief Tech Pharmacy (01) Naib Qasid (02) Security Guard (01)	508172	2893848	Within Radius of 01 Km	
19.	G-7/1, Dispensary	Sector G-7/1	15926	Medical Officer (01) Chief Tech Pharmacy (01) Naib Qasid (01)	794748	2262408	Within Radius of 01 Km	
20.	G-7/2, Dispensary	Sector G-7/2	13860	Medical Officer (01) Chief Tech Pharmacy (01) Naib Qasid (01)	3018166	2262408	Within Radius of 01 Km	
21.	K Block, Dispensary	K Block, Pak Secretariate	14802	Medical Officer (01) Naib Qasid (01)	1122068	1859856	Within Radius of 01 Km	
22.	Judges Enclave, Dispensary	Judges Enclave	2800	Medical Officer (01) Male Nurse (03) Naib Qasid (01)	1034366	2583420	Within Radius of 01 Km	
23.	G-10/3, Dispensary	Sector G-10/3	13054	Medical Officer (01) Chief Tech Pharmacy (01) Jr. Technician Dressing (01)	926060	3001992	Within Radius of 1.5 Km	

				Nursing Attendant (01) Aya (01)				
24.	FBR, Dispensary	FBR, Office	17516	Medical Officer (01) Chief Tech Pharmacy (01) Jr. Technician Dressing (01)	2367982	2349240	Within Radius of 01 Km	
25.	Parliament House, Dispensary	Parliament House	27117	Medical Officer (02) Chief Tech Pharmacy (03) Jr. Technician Dressing (02) Naib Qasid (02)	20878056	5732472	Within Radius of 01 Km	
26.	FPSC, Dispensary	FPSC	8327	Medical Officer (01) Tech Pharmacy (01) Jr. Technician Dressing (01)	1164580	2349240	Within Radius of 01 Km	
27.	High Court, Dispensary	High Court	7810	Medical Officer (01) Chief Tech Pharmacy (01) Naib Qasid (01)	1466190	2262408	Within Radius of 1.5 Km	
28.	Election Commission, Dispensary	Election Commission, Office	4921	Medical Officer (01) Chief Tech Pharmacy (01) Jr. Technician Dressing (01)	289542	2349240	Within Radius of 01 Km	

F. G. POLYCLINIC (PGMI)
ISLAMABAD

OBJECTIVE OF FGPC

To provide:

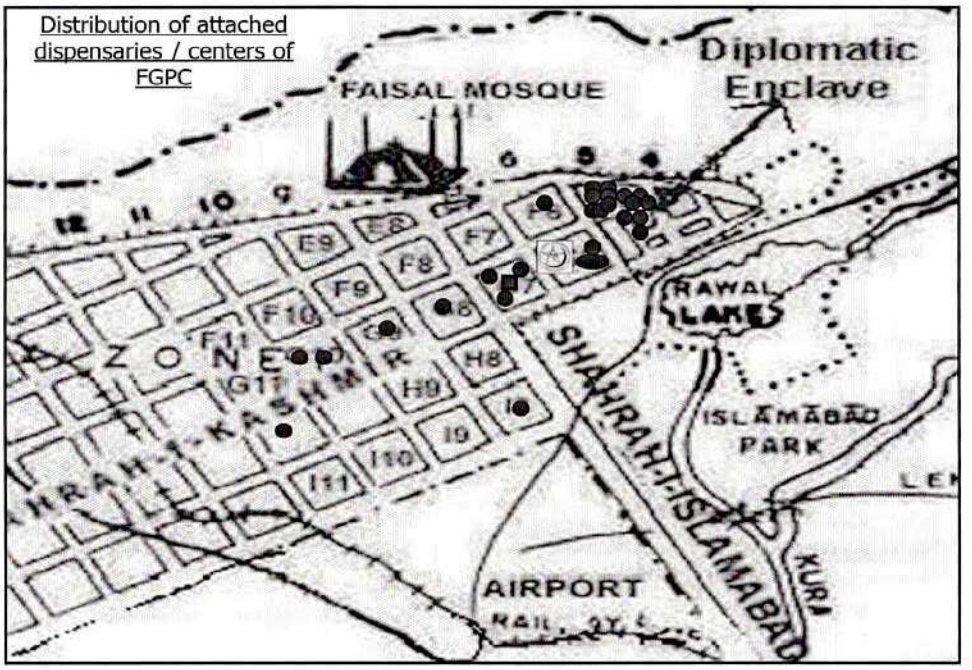
- free of cost
- high quality
- care services

to the federal government employees, their dependents and General population visiting to the hospital and its attached dispensaries.

1

SERVICES OFFERED

DEPARTMENT / CENTRE	Averages of Care Services Provided		
	Per Annum	Per month	Per Day
Outpatients at the Hospital (Morning)	1,427,400	118,950	4,575
Outpatients at the Hospital (Evening)	374,400	31,200	1,200
Emergency Services	468,000	39,000	1,500
Dispensaries / Centers OPDs	669,864	55,822	2,147
Total	2,939,664	244,972	9,422



2

DISPENSARIES WORKING AFTER CREATION/SANCTION OF POSTS

S#	DISPENSARY / CENTER	WORKING SINCE
1.	MCH CENTRE, AIWAN-E-SADR, COLONY	12-01-1986
2.	MCH CENTRE, AABPARA	15-08-1972
3.	CIVIL SURGEON MEDICAL CENTER, G-7/3-4.	15-08-1972
4.	KOHSAR COMPLEX, PAK SECRETARIAT IBD (In replace of PAK. SECRETARIAT 'A' BLOCK dispensary)	00-08-1974
1.	PAK. SECRETARIAT 'Q' BLOCK DISPENSARY.	21-08-1982
2.	FOREIGN AFFAIRS, DISPENSARY.	01-07-1980
3.	AIWAN-E-SADR, SECRETARIAT, DISPENSARY.	12-01-1985
4.	PARLIAMENT LODGES/HOSTEL DISPENSARY.	06-02-1974
5.	CABINET SECRETARIAT DISPENSARY.	19-08-1989
6.	SECTOR G-9/2, DISPENSARY.	26-10-1987
7.	I-8/1 DISPENSARY.	09-08-1988
8.	POLICE LINE DISPENSARY.	04-09-1984
9.	AGPR, DISPENSARY.	12-02-1984
10.	SCHOOL HEALTH CLINIC NO.1, DISPENSARY.	08-07-1969
11.	SUPREME COURT DISPENSARY.	01-07-1980
12.	PM STAFF COLONY	18.12.2017

DISPENSARIES WORKING WITHOUT CREATION/SANCTION OF POSTS

S#	DISPENSARY / CENTER	WORKING SINCE
1.	PM SECRETARIAT.	01-03-1990
2.	F-6/1, DISPENSARY/ACUPUNCTURE.	10-02-1981
3.	G-7/1, DISPENSARY.	31-08-1970
4.	G-7/2, DISPENSARY.	13-11-1970
5.	'K' BLOCK DISPENSARY.	10-11-1991
6.	JUDGES ENCLAVES DISPENSARY.	18-11-2000
7.	G-10/3, DISPENSARY.	10-11-1993
8.	FEDERAL BOARD OF REVENUE DISPENSARY.	25-07-2002
9.	PARLIAMENT HOUSE.	01-09-1986
10.	FPSC DISPENSARY	25-07-2005
11.	ISLAMABAD HIGH COURT DISPENSARY	07-01-2011
12.	ELECTION COMMISSION, IBD	13.08.2021

3

PROPOSALS:

- 1. Primary health Care services of all over ICT may be given under the administrative control of FGPC along post/infrastructure and budget who may make fully functional these dispensaries and use main hospital as referral center. DHO will be responsible for the preventive health services and licensing matters. Advantage of this is that Polyclinic has already a setup of dispensaries and referral will also be not an issue. Second advantage is this that Polyclinic –II is being established at G-11/3 and this will also have sufficient catchment area.

- 2. All Dispensaries located in secretariat area may be shifted to kohsar complex where there is sufficient place available at ground floor and a Day Care treatment center may be established over there. However access of people will remain an issue.

- 3. Islamabad may be divided into four zone in each zone there may be a health authority that authority have further subdivision of Preventive and curative (including Primary, Secondary and Tertiary) . There will be an incharge of each Zonal authority and over all there will be a CEO of the authority to whom these Zonal incharges will be answerable. Issue with this proposal is that this need a lot of infrastructure, Human resource and finance because each zone have its own dispensaries i.e. primary care, Secondary and tertiary care hospital.

4

- 4. There maybe a Technical post of Director General Primary health Care (ICT) under the administrative control of M/o NHSR&C and all these primary health centers may be directly under his administrative control. The advantage is this there will be one chain of command and similar monitoring mechanism. Only issue is to create/ Re-designate one post of BS-21 by M/o NHSR&C.

- 5. CPSP and SZAB Medical University may be approached through M/o NHSR&C and declare the compulsory rotation of post graduate trainee in BHU/Dispensaries as a part of their training. For this intervention no cost is needed

- 6. Private practice may be allowed in these setups Dispensaries /BHU/RHC as pattern of private clinics on 70:30 ratio 70% doctor share and 30% facility share. For this intervention no cost is needed

CONSTRAINTS

- Infrastructure of dispensaries need to be upgraded but despite of approval of summary from prime Minister and NOC from housing and works hospitals are bound to get its repair and maintenance work done from PWD which results a lot of delay. If hospital still do this work they have to face Audit observations and enquires. This results in poor outlook and un-maintained dispensaries.

- There is lack of utilization of Public sector services by the General Public with the concept the medicines provided by the government hospitals are substandard. This is due to PPRA rules which restrict purchase to the lowest one and this results in purchase of low quality medicines and if hospital purchase other than lowest that results in Audit Paras and this lead to lower patient satisfaction and lack of utilization of public sector health facilities.

5

6

METROPOLITAN CORPORATION ISLAMABAD
(DIRECTORATE OF HEALTH SERVICES)
******

No.CDA/DHS-14(1)(32)/2020/61 Islamabad, Jan: 17 2023.

Subject:- **FEDERAL GOVERNMENT HOSPITAL/DISPENSARIES/ MCH CENTER/TB CLINICS ETC STATUS AS 01-01-2020.**

Reference Chief Statistical Officer letter No.PBS.IBD.SS.H(06)/ 2022/ 885, dated 09-01-2023, on the subject cited above.

2. It is to inform that 13 Medical Centres in different sectors are in running position (Morning/Evening shift) to facilite the CDA employees as well as general public within municipal limit but no bed facility is available.

3. Printed performa is attached for information as desired.

(Dr. Muhammad Qadeer)
Director Health Services.

Chief Statistical Officer,
21 Mauve Area, I & T Centre, G-9/1,
Islamabad.

13/1/23.

Copy to:-

Director General; Health, MCI

FEDERAL GOVERNMENT DISPENSARIES/M.C.H. CENTRE SCHOOL HEALTH CLINIC TUBERCULOSIS CLINIC ETC AS ON 01-1-2020

Status as on 01-01-2020

Sr.#	Name of dispensary T B Clinic/MCH Centre/ School/ Health Clinic Etc.	Location	Bed Strength
1.	Medical Centre.	Head quarter office F 11/4, Service Road East, Islamabad	Nil
2.	Medical Centre	B-Block, Pak Sectt. Ibd.	Nil
3.	Medical Centre	Block No 2/5-A, Sl. 10, I 8, Islamabad	Nil
4	Medical Centre	G-7/3, Gulshan Market, Islamabad	Nil
5	Medical Centre	G-9 Markaz, Islamabad. (Morning)	Nil
6	Medical Centre	G-9 Markaz Islamabad. (Evening)	Nil
7	Medical Centre	CDA Colony Simly Dam Ibd.	Nil
8	Medical Centre	CDA Inquiry Office, Rawal Town, Ibd.	Nil
9	Medical Centre	CDA Maint. Inquiry G-10 Maraz, Ibd	Nil
10	Medical Centre	CDA Colony, I-10/1 Ibd (Morning)	Nil
11	Medical Centre	CDA Colony, I-10/1 Ibd (Evening)	Nil
12	Medical Centre	Diplomatic Enclave, Ibd	Nil
13	Medical Centre	Mohallah Sher Zaman Near Karachi Hole' Bhara Kahu Ibd	Nil

Third-Party Evaluation of the PPHI in Pakistan

Findings, conclusions, and Recommendations

Summary of key findings, conclusions, and recommendations

The Volume of the third-Party Evaluation (TPE) of the people's Primary Health Care Initiative (PPHI) provides the main findings and recommendations from the study undertaken in the provinces of Sindh, Balochistan, and Khyber Pakhtunkhwa KP, and in 4 health facilities from Gilgit-Baltistan during 2010. Under the PPHI "mode". District Governments contract the provincial Rural Support Programs (RSP) to manage First Level Health Care Facilities (FLCF) in their district. PPHI has been implemented in over 6% of districts in Pakistan.

The main objectives of the Third Party Evaluation were to study and assess the changes caused by the PPHI as compared to the conventional management by the District Departments of Health (DDOH) with special reference to:

a. Utilization of first-level care facilities, especially by the poor;
b. The range, volume, and quality of services at FLCF
c. Community participation" in delivery of services at and from FLCF;
d. Efficiency and effectiveness of management structures at all levels, from National to Provincial to District to Community level.

The TPE study measured results at three levels.

- In 76 basic Health Units (BHU – the main and most common type of FLCF in Pakistan) and in 2,280 households located in the catchment areas of those BHUs (30 households per BHU);
- In 12 districts i.e. 4 districts in each province, combining PPHI and non-PPHI districts, using HMIS and PPHI data sources:
- In 32 PPHI districts, that is in all the PPHI districts that received the first transfer of funds from the District Government before 31st December 2007.

Impact Assessment

PPHI was launched to overcome the failure of many First Level Care Facilities in Pakistan to deliver PHC services through health facilities that were understaffed, poorly resourced and/or ineffectively managed. It is quite clear that in the districts where PPHI has been operating for the longest time (approximately 2 years since mid or end 2007 until January 2010) PPHI has achieved significant improvements in staffing, availability of drugs and equipment and physical condition of facilities, including rehabilitation and repossession of hitherto dysfunctional BHUs. Improvements have also been measured by this TPE in terms of services delivered from those facilities-summarized in Table form in Annex 2- Such as:

- Outpatient attendance increased by 20% on average in PPHI districts and fell by about the same in DDOH districts between 2007 and 2010 (with unexplained ups and downs in certain months). Significant increases in outpatient attendance were confirmed in

the 32 oldest PPHI districts: in KP Outpatient attendance increased threefold, it doubled in Balochistan and increased by at least 25% in Sindh. The Number of outpatients seen by female Medical Officers in PPHI BHUs increased five-fold in the same period.

- Attendance of antenatal and postnatal care services increased in PPHI districts when compared to the starting point, yet attendance figures for both PPHI and DDOH districts were found to be quite low when population estimates were used. For example, 80% of PPHI and 86% of DDOH BHU reported fewer than 2 ANC users per day between January and March 2010. TT vaccinations to pregnant women were higher in DDOH BHU, where 50% of DDOH BHU reported 60+ vaccinations versus 10% in PPHI BHUs. On postnatal care, 88% of PPHI and 95% of DDOH BHUs reported less than 1 postnatal case per day in the same period.
- In terms of safe delivery, the household surveys report a higher percentage of deliveries performed by BHU staff in PPHI districts (37%) than in DDOH districts (18%), although most of these deliveries took place at home rather than in BHUs. This was matched by an accompanying reduction of births attended by unskilled birth attendants in PPHI areas (59%) when compared to DDOH areas (71%). Quality of delivery care was given as the main reason for using BHU staff in (60%) of households from PPHI districts against 20% of households in DDOH districts.
- Availability of certain diagnostic tests (e.g., Malaria) and treatment for snake and dog bites was found higher in PPHI BHUs. Which also conducted a larger number of school and community health sessions than DDOH-managed ones.
- PPHI and BHUs had slightly better referral record-keeping practices, although much more can be done in both PPHI and DDOH districts to better follow up with referred patients, particularly women in complicated delivery.
- Availability of telephone communications and transport arrangements was better in PPHI districts.
- Consumer satisfaction measured through 760 BHU exit polls revealed that users had selected the BHU because it offered a **better quality** of service than other providers at a rate of 47% in PPHI and 36% in DDOH BHUs. They also perceived better drug availability in PPHI BHUs (31%) than in DDOH ones (19%). In addition, 81% of users in PPHI BHUs stated that they had **received all the prescribed drugs,** versus 51% in DDOH BHUs. This was confirmed by household survey results.

All these improvements are very encouraging but are nowhere near enough, particularly when population denominators are used to assess service coverage, a practice that was seldom used by either PPHI or DDOH district managers. When catchment population estimates were used by the TPE it became apparent that utilization of essential MNCH services remains low and that reproductive health services are simply abysmal, in both DDH and PPHI BHUs, so the room for improvement is huge if MDGs 4 and 5 are to be achieved.

The impact assessment exercise undertaken by this TPE revealed substantial limitations in the reliability of HMIS data, suggesting that a simple comparison between PPHI and DDOH BHUs was not always possible, particularly in the absence of baseline data or simply Baseline data for some districts of KPK was indeed available but the TPE team could not use it as it learned too late about its existence Because two years of implementation is probably not long enough to demonstrate unequivocal results at service delivery level. Therefore,

information on impact should be interpreted carefully; the data collected tells a story, but it may not always tell the full story. For example, our regression analysis suggests that the **PPHI BHUs are serving a higher proportion of poorer consumers** than DDOH BHUs, and while this reflects positively on the PPHI model it should be interpreted with caution given the modest sample size and quite a few confounding variables (location of BHU, distance to BHU, distance to BHU, variations in poverty mappings within districts, etc.).

PPHI funding and expenditure

The following issues have been highlighted in the section looking at the financing of the PPHI scheme:

- Funding for the PPHI program comes from a number of sources – practice varies from province to province. Some provinces have demonstrated a significant commitment to PPHI by devoting discretionary resources to the program.
- PPHI funding only represents a share of total BHU spending. BHUs receive inputs from other sources including in-kind flows. Individual BHUs do not keep separate accounts where all these inputs are included and therefore it was not possible for the TPE to get a comprehensive picture of funding at the BHU level.
- There is a wide variation in resource allocations between districts irrespective of whether they are PPHI districts or not. In many cases funding appears way below what is required to deliver an essential health care package. Thus, much of the difference in performance between districts and facilities may reflect differences in per capita resource allocation rather than the impact of PPHI itself.
- PPHI districts have been accorded more flexibility in the use of district programmatic budgets, including the possibility of funds between salary and non-salary budgets. PPHI districts are also allowed to keep unspent yearly balances which DDOH districts are not authorized to do. As a result of the latter, some PPHI districts have been accumulating significant balances by carrying over unspent allocations from the previous year(s). In some cases, over a year's allocation. It is not clear whether this represents a rational response to the additional flexibility provided to PPHI.
- Given the inability to get a comprehensive picture of inputs (staffing salaries, budget, national program allocations, and other allocations by external sources) and conclusive results in terms of improved outputs, a Value for Money assessment was not feasible as part of this TP>
- Though private-of-pocket spending is extremely high in Pakistan there is little evidence that financial cost through official fees is a significant barrier to access. Charges tend to be low revenue raised is negligible. Only around 5% of patients cite financial cost as a major driver in their choice of facility.

Assuming an average of a year for PPHI to assess the needs, rehabilitate, staff, and equip a BHU following the transfer of funds from the District Government, the first BHUs taken over by PPHI in 2007 only became fully operational in mid to late 2008. This means that impact on services measured even in the oldest PPHI BHUs and districts is often less than 2 years old by March 2010, the last measurement made for impact assessment.

The PPHI model and its implementation

The data collection methodology adopted by the TPE necessitated casting a wide net and applying a process of triangulation to arrive at the best estimates. Even so, there are limits to what the empirical data can demonstrate, and much of this TPE has been concerned with evaluating the structure and process of the PPHI program against what is being learned elsewhere about delivering primary care, institutional change, and contracting. It is here, in fact, where action-oriented lessons are to be learned and hopefully applied to improve the delivery of services.

The most salient features relating to the PPHNI model and the way it has been applied are the following:

- In its original design PPHI was conceived as a trigger for management reforms to improve PHC management by district and provincial departments of health. However, these reforms were neither defined nor implemented by either provincial or district governments and, as a result, the changes that were introduced by PPHI have not permeated into the relevant government structures.
- Key elements of a contracting arrangement (see figure) have not been operationally defined for PPHI in relation to, for example, the service package to be delivered, the institutional relations between contractor and contracted, or the means to oversee contract implementation or performance monitoring of service providers. Deficiencies have been also observed in the technical competence of district and BHU managers affecting Both PPHI and DDOH districts that would require a more robust approach to induction training and continued professional development of these cadres.
- The absence of performance monitoring arrangements (a framework) in the public sector is currently the main impediment for the GOP to assess the performance and the value obtained for the money spent through both private and public service providers. The HMIS and DHIS should be the main instruments to monitor the performance of service providers. Using the HMIS/DHSI would provide powerful incentives for improving the quality of its data.

Most shortcomings such as the ones above relating to the institutional context in which PPHI has been operating one often characterized by suspicion and opposition by those who as per the MOUs and contracts should have been supporting it. The PPHI model has made important contributions to PHC Delivery in Pakistan, demonstrating that it is possible to increase staffing levels and delivery of essential services within a relatively short period of 3 years. These improvements have also paved the way for introducing more accountability for service provision (subject to improved oversight and performance monitoring) and for bringing in additional service providers to the PHC network in Pakistan. At this point it is no longer a question of whether contracting can work for PHC, but about **how to make itwork for improved PHC delivery** using a well tested model covering more than 60% of districts in Pakistan.

Main Recommendations

On the basis of our analysis we would like to make the following broad recommendations (more detailed, specific recommendations can be found within each section of Volume 1);

a. The institutional framework under which the PPHI and DDOH models operate should be reformed and strengthened along the lines suggested in Chapter 5. In essence, provincial and district health administrations should focus on overseeing the performance of service providers, whether these be public or private, and seek incremental improvements.
b. I PPHI districts the DDOH should be assisted to change its role to one of a contractor (purchaser) focusing on performance monitoring of service providers. DDOH staff should acquire further competence in performance monitoring and provide with technical support to become informed purchasers (contractors). They should be rewarded for their success, first in completing their management training and subsequently for performance in public health indicators, thus encouraging them to get good results from service providers (the DSU in PPHI districts).
c. In PPHI districts, provincial governments, and district administrators should consider the merits of allowing PPHI to take responsibility for the management of RHCs (on an incremental basis and linked to performance) so as to enhance the management of referrals and thus deliver a more integrated service package in the district.
d. Disease-specific program staff integrated into the national programs should plan and report monthly plans and activities at the BHU level to achieve more effective integration of outreach and facility-based services in BHU catchment areas. This would enable Mos in charge to become accountable for coverage with essential health care in entire catchment areas, not just at the BHU level. There is no contradiction between being part of a national program and reporting to the local BHU, as many preventive program staff actually do in many countries.
e. The PPHI model relies on competent management and public health skills – skills different from those learned by the civil servants who have typically taken on the DSM roles and also different from the clinical skills of the doctors who are taking the MO or EDOH roles. Neither has received sufficient appropriate training to perform the functions expected of them and neither receives sufficient ongoing training and technical support. At national and provincial levels, PPHI should now develop basic training and continued support packages for its district and facility-level staff, and ensure that these are rolled out across the PPHI network. Delivering public health is a complex business and the medium-term vision should be to develop a cadre of competent PHC managers in Pakistan (there are various examples and options for doing this from around the world). This will require investments in training and incentives for staff interested in becoming professional healthcare managers.
f. Experience from Datagram district, from other parts of Pakistan (the Aga Khan Health Services network), and from the rest of the world (Cambodia, Nepal, India, and many more) suggests that as the contracting capabilities of the DDOH have improved the door should be opened to contracting other potential health care providers using similar arrangements to the PPHI scheme. The country is too diverse and the delivery of PHC is too complex to expect a single contracted to do it all. Under the right contracting arrangements, other NGOs could help reach those currently badly served.
g. Experimentation is needed in reward for performance and in DSUs networking with private sector providers (including TBAs) in their districts to improve their quality and access to services by consumers. This might be achieved by employing a

franchise-type model to supplement the work of its own staff – the RSPs do not have to employ all health care providers but might 'piggyback' on the investment that private skilled and unskilled workers have made and the credibility they have in their communities. Pakistan has the experience of working with PSI/ Greenstar and Marie Stopes International in reproductive health services to build on.

h. The financing of PPHI is of great concern to the TPE (as are the very low levels of funding for PHC that were observed in many PPHI and DDOH districts during our study). Our concern related to the impact that resource shortages in PPHI districts would have on access to health care, particularly among poor women and children in rural Pakistan.

i. Funding from the federal government for PPHI was intended as a temporary measure and may now be directed to or shared by the provincial governments, following the 18th constitutional Amendment, in which the funding of the entire PHC network is being revised. In order to avoid disruption to service delivery we recommend that the Federal Government should ensure that the management costs of PPHI are covered until such time as a definitive arrangement or formula can be put in place. More rather than less financial and technical support is needed now to embed the contracting arrangements and to develop management capacities.

j. The external development partners who support health care in Pakistan might prove key partners in these efforts to support and sustain PHC in the provinces. They are likely to be attracted by schemes such as PPHI where strengthened contracting could lead to various forms of performance-based financing to deliver an essential health care package through the PHC network. In other words, the greater the performance orientation of the PHC network the more attractive it will be for donors, particularly large donors supporting the principles of Results-based Aid (RBA).

Sehat Sahulat Program

Introduction

1. Sehat Sahulat Program is a health insurance initiative of the Federal Government of Pakistan in partnership with the provincial Governments.
2. The goals of the Sehat Sahulat Program are to improve the health status of the population, especially the poor, and to reduce poverty through a reduction in out-of-pocket (OOP) expenditure on health care.
3. Under this program, those having a Sehat Insaf Card are entitled to free health services in case they are admitted to a hospital. Currently, outpatient (OPD) services are not covered.
4. Every provincial government is managing its Sehat Sahulat program under its own management structures. For detailed information about the provincial programs, please follow the links provided on this page.

Entitlement

1. Sehat Sahulat Program was launched to ensure access to health services for people living below the national poverty line. The poor families were identified through the data of the Benazir Income Support Program. Those with a poverty score of 32.5 or lesser were entitled to a Sehat Insaf Card
2. Now different provinces are adopting different entitlement strategies. For example, the Government of Khyber Pakhtunkhwa has covered 100% of the province's population under the program. Similarly, 100% population of Peshawar while FATA districts will be covered under the scheme
3. Since different provinces have different proportions of population coverage, it is advisable that you check your entitlement under your respective provincial scheme.
4. You can check your eligibility by following this lin. You can also get detailed information by calling the **Sehat Helpline on 0800 09009 or 0800 89898**

Benefits Package

(Diseases covered)

- Benefits package refers to a list of diseases covered under an insurance program. Since Sehat Sahulat Programmed is a health insurance scheme, it has a defined benefits package.
- The benefits package varies from province to province. Generally, it covers almost all the surgical procedures and medical diseases for which hospital admission is required. Currently, the various provincial streams of the Sehat Sahulat Program do not cover outpatient (OPD) services. The Provincial Government of Khyber Pakhtunkhwa is planning to cover OPD services on an experimental basis in four districts in 2021

alient Features	Sehat Sahulat Program, Khyber Pakhtunkhwa	Sehat Sahulat Program, Federal
Initial coverage for secondary care (Basic Treatment)	200,000 PKR per family per year	60,000 PKR per family per year
Additional coverage for secondary care (Basic Treatment)		60,000 PKR per family per year
Secondary care (Basic Treatment).	• Emergency treatment requires admission. • Maternity Services (Normal deliveries, C-section). • Fractures and Injuries. • General Surgeries (Gallbladder, biopsy, colon, prostate, hernia). • General Medicine (diabetes, hypertension, cardiac).	• Patient Services (All Medical and Surgical Procedures). • Emergency Treatment requiring admission. • Maternity Services (Normal Delivery and C – Section). • Maternity Consultancy / Antenatal Checkups (4 times before delivery and one follow-up after delivery). • Maternal Consultancy for family planning, immunization, and nutrition. • Fractures / Injuries. • Post hospitalization. • Local Transportation Cost of PKR 1,000 (thrice per year). • Provision of transport to tertiary care hospitals.
Coverage for tertiary care (Advanced Treatment)	400,000 PKR per family per year	300,000 PKR per family per year

alient Features	Sehat Sahulat Program, Khyber Pakhtunkhwa	Sehat Sahulat Program, Federal
	400,000 PKR per family per year **(Additional Coverage)**	300,000 PKR per family per year **(Additional Coverage)**
Tertiary care (Advanced Treatment)	• Cardiovascular (Angioplasty, bypass) • Diabetes • Artificial Limbs (Prosthesis) • Kidney Diseases (Dialysis) • Breast Cancer Screening • Management of Neurosurgical Diseases • Cancer Treatment (Chemo, Radio, Surgery) • Kidney Transplant • Accident and Emergency • ICU Care	• Patient Services (All Medical and Surgical Procedures). • Heart diseases (Angioplasty/bypass). • Diabetes Mellitus Completion. • Burns and RTA (Life, Limb Saving Treatment • End-stage kidney diseases/ dialysis. • Chronic infections (Hepatitis/ HIV/ Rheumatology). • Organ Failure (Liver, Kidney, Heart, Lungs). • Cancer (Chemo, Radio, Surgery). • Neurosurgical Procedure.
Total coverage for treatment	Health expenditure of up to 1,000,000 PKR per family per year	Health expenditure of up to 720,000 PKR per family per year
Amount of wage loss	250 PKR per day for three days	
Maternity Allowance	1,000 PKR (transportation)	1,000 PKR (transportation)
Transportation Allowance	2,000 PKR	1,000 PKR (three times per year)
Funeral Allowance	10,000 PKR	

* Wage-loss replacement will start from the second day of hospitalization.

* Maternity allowance will be paid for the need for transportation after childbirth.

* Transportation allowance will be paid in case a person is referred by a secondary care hospital to a tertiary care hospital.

* Funeral allowance will be paid to the family if a member dies during hospital admission.

For further details, **download** the brochure.

- For a detailed list of diseases and procedures covered under the different provincial streams of the Sehat Sahulat Program, **follow the link** for each provincial program. You can also get detailed information by calling the **Sehat Helpline on 0800 09009 or 0800 89898**

Financial protection

(Financial coverage)

1. Sehat Sahulat Program was launched to enable the poor population to utilize health services without further impoverishment due to spending on healthcare.
2. Since inpatient care is associated with higher spending, with the potential to make people poor, these services were covered under the scheme.
3. The different provincial streams for Sehat Sahulat Programmes have different limits for treating secondary and tertiary care.
4. The programs also provide financial assistance in the form of wage loss during treatment, maternity allowance, travel allowance, and financial support to a family for a funeral if death happens during hospital admission.

Salient Features	Sehat Sahulat Program, Khyber Pakhtunkhwa	Sehat Sahulat Program, Federal	Sehat Hifazat Program, Gilgit Baltistan (SHP-GB)
Area covered	All districts in Khyber Pakhtunkhwa	Islamabad, Former FATA, Azad Kashmir and all districts in Punjab.	All districts in Gilgit Baltistan
Population covered	100% population	Households having a PMT <= 32.5	
Premium	The Government of KP pays the premium	The Federal Government pays the premium	The Government of GB pays the premium
Annual premium per family	2850	1850 (estimated)	
Initial coverage for secondary care (Basic Treatment)	200,000 PKR per family per year	60,000 PKR per family per year	

Salient Features	Sehat Sahulat Program, Khyber Pakhtunkhwa	Sehat Sahulat Program, Federal	Sehat Hifazat Program, Gilgit Baltistan (SHP-GB)
	• Management of Neurosurgical Diseases • Cancer Treatment (Chemo, Radio, Surgery) • Kidney Transplant • Accident and Emergency • ICU Care	• End-stage kidney diseases/ dialysis. • Chronic infections (Hepatitis/ HIV/ Rheumatology). • Organ Failure (Liver, Kidney, Heart, Lungs). • Cancer (Chemo, Radio, Surgery). • Neurosurgical Procedure.	
Total coverage for treatment	Health expenditure of up to 1,000,000 PKR per family per year	Health expenditure of up to 720,000 PKR per family per year	Health expenditure of up to 250,00 PKR per family per year
Amount of wage loss	250 PKR per day for three days		
Maternity Allowance	1,000 PKR (transportation)	1,000 PKR (transportation)	
Transportation Allowance	2,000 PKR	1,000 PKR (three times per year)	
Funeral Allowance	10,000 PKR		

* Wage-loss replacement will start from the second day of hospitalization.

* Maternity allowance will be paid for the need of transportation after childbirth.

* Transportation allowance will be paid in case a person is referred by a secondary care hospital to a tertiary care hospital.

* Funeral allowance will be paid to a family if a member dies during hospital admission.

For further details, **download** the brochure.

Hospitals

(Panel Affairs)

1. Like other insurance schemes, Sehat Sahulat Program has a list of predefined hospitals where the Sehat Insaf Cardholders can utilize the services. These are called panel hospitals.

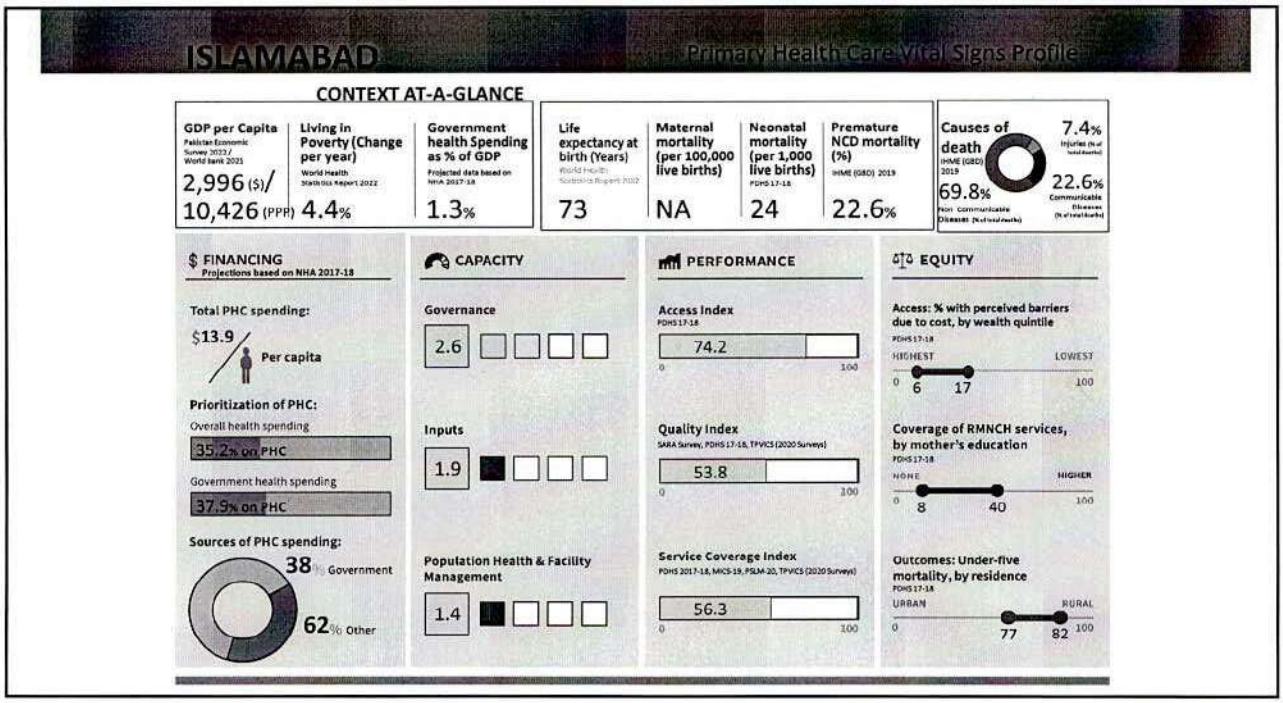
2. If you are seeking secondary care for minor illnesses, you will be treated at a panel hospital within your district. If treatment is not possible at a panel hospital in your district, the insurance staff will refer you to a bigger hospital in another city, and the treatment will be provided under the program.
3. With the exception of an emergency like a road traffic accident, if you go to a panel hospital outside your district without a referral letter, your treatment may be refused under the scheme, and you will have to pay for your own treatment.
4. Every program maintains its own list of panel hospitals. The list of hospitals changes from time to time. Therefore, you should always check if the hospital you are visiting is currently on the panel.
5. In case you receive treatment outside the panel hospitals, the program will not pay for this treatment. You will have to pay from your pocket.

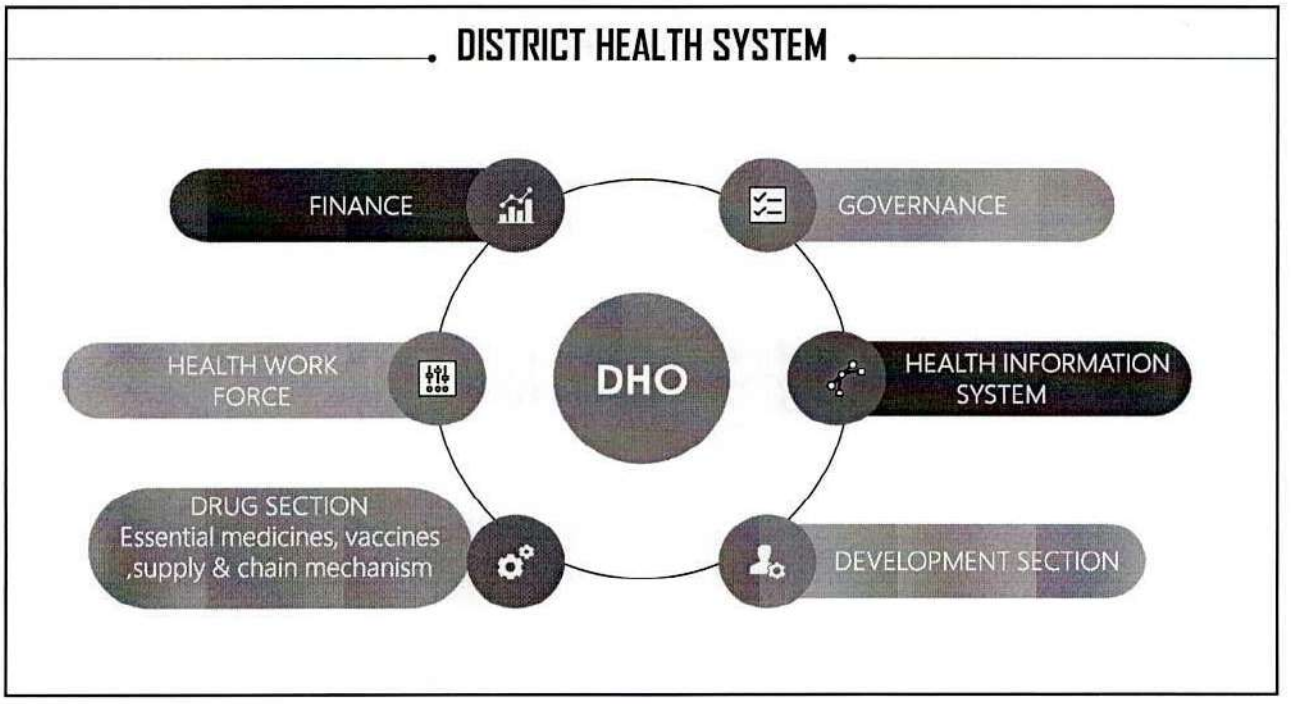
DHO Presentation

Government of Pakistan
Ministry of National Health Services, Regulations & Coordination

UHC-PHC-ICT
District Health Office

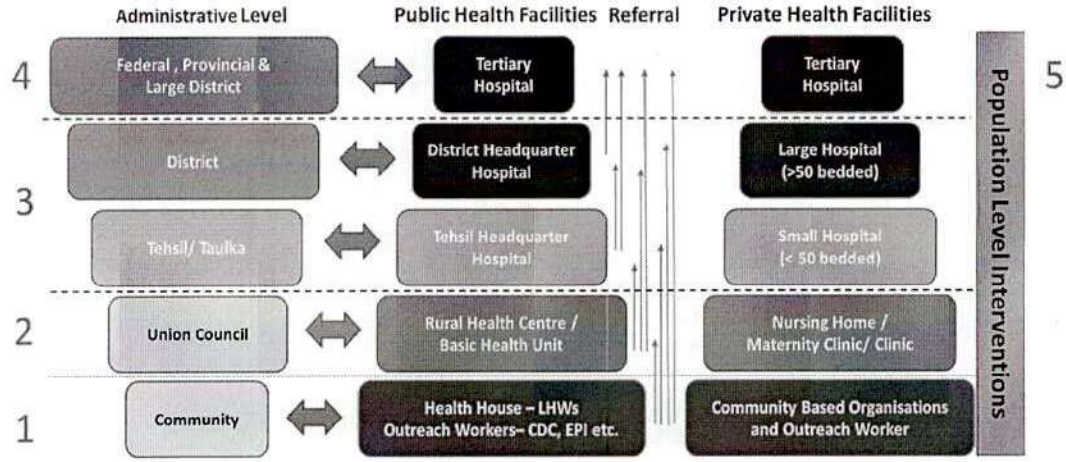
Dr. Muhammad Zaeem Zia, District Health Officer, Islamabad




DISTRICT HEALTH SYSTEM
FINANCE
GOVERNANCE
HEALTH WORK FORCE
DHO
HEALTH INFORMATION SYSTEM
DRUG SECTION
Essential medicines, vaccines ,supply & chain mechanism
DEVELOPMENT SECTION


Health Service Delivery

Five platforms of health care delivery system



Detail of existing and New Health Facilities

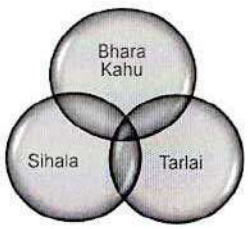
Existing Initiatives

Basic Health Units (BHUs) -16

Health Units

- Gagri.
- Bhukhar
- Bhimber Tarar.
- Sohan.
- Jhang Syeddan.
- Chirrah.
- Tumair.
- Phulgran.
- Gokina
- Hummak

Rural Health Centers



Mother & Child

Gagri	Shahdrah	Jagiot
Bhimber Tarr	Rawat	Bhara Kahu
Chirah	S.A.D	Tarlai
Pind Begwal	Sihala	

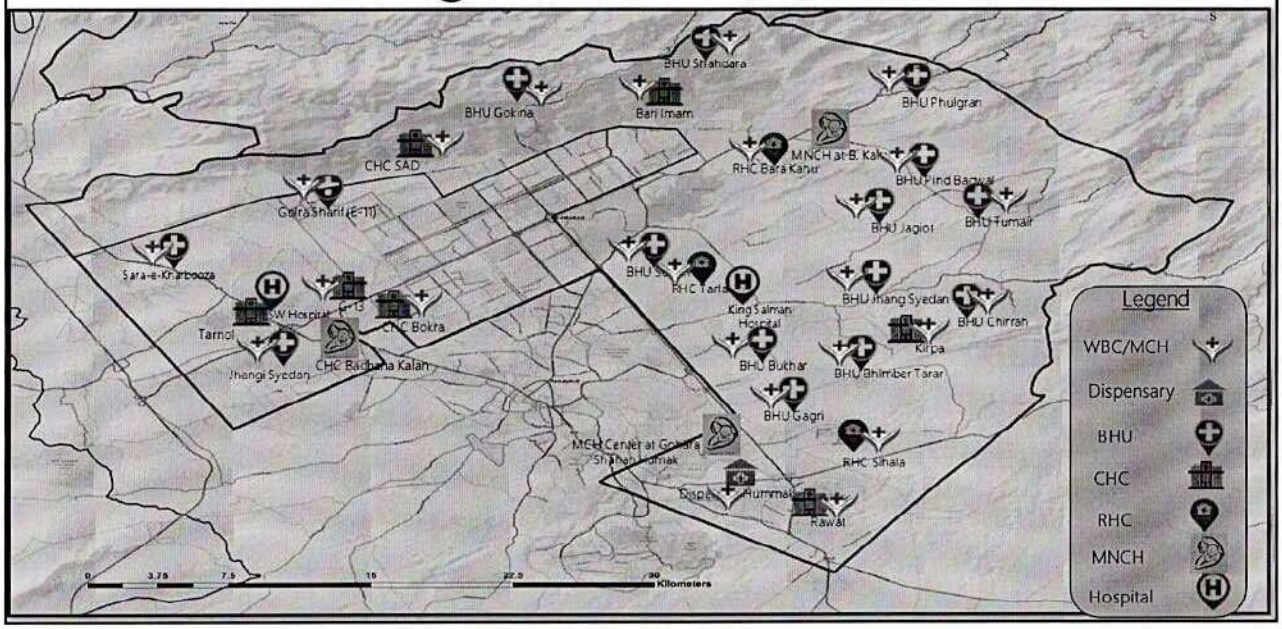
New Initiatives

New BHUs & MCH Units	New Community Health Centers	New MNCH Centre	Tertiary Care Level
• Sara-e-Kharbooza 01 • Jhangi Syedan 02 • Golra Sharif 03	Bari Imam G-13 Bokra Shah Allah Ditta Tarnol Rawat Kirpa	Gohra Shahan Bhara Kahu Badhana Kalan	King Salman Hospital at Tarlai

6

3

All Existing & New Health Facilities

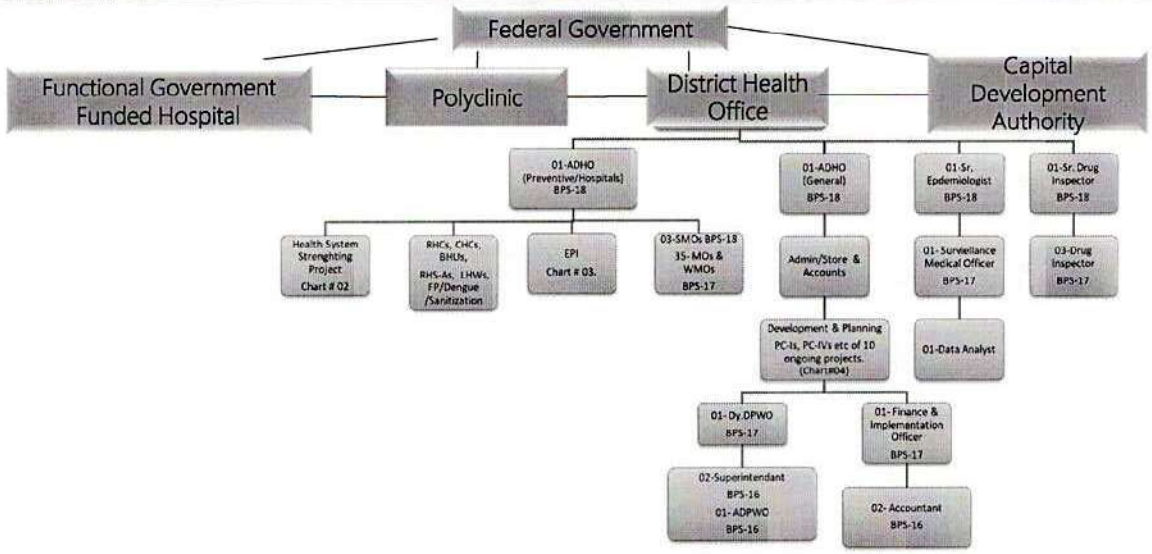


Health Care Facilities

The overall goal of Health Department is "to provide preventive, promotive and curative health services to the rural population in ICT through a network of three rural health centers, CHCs, dispensary and Basic health units".

4

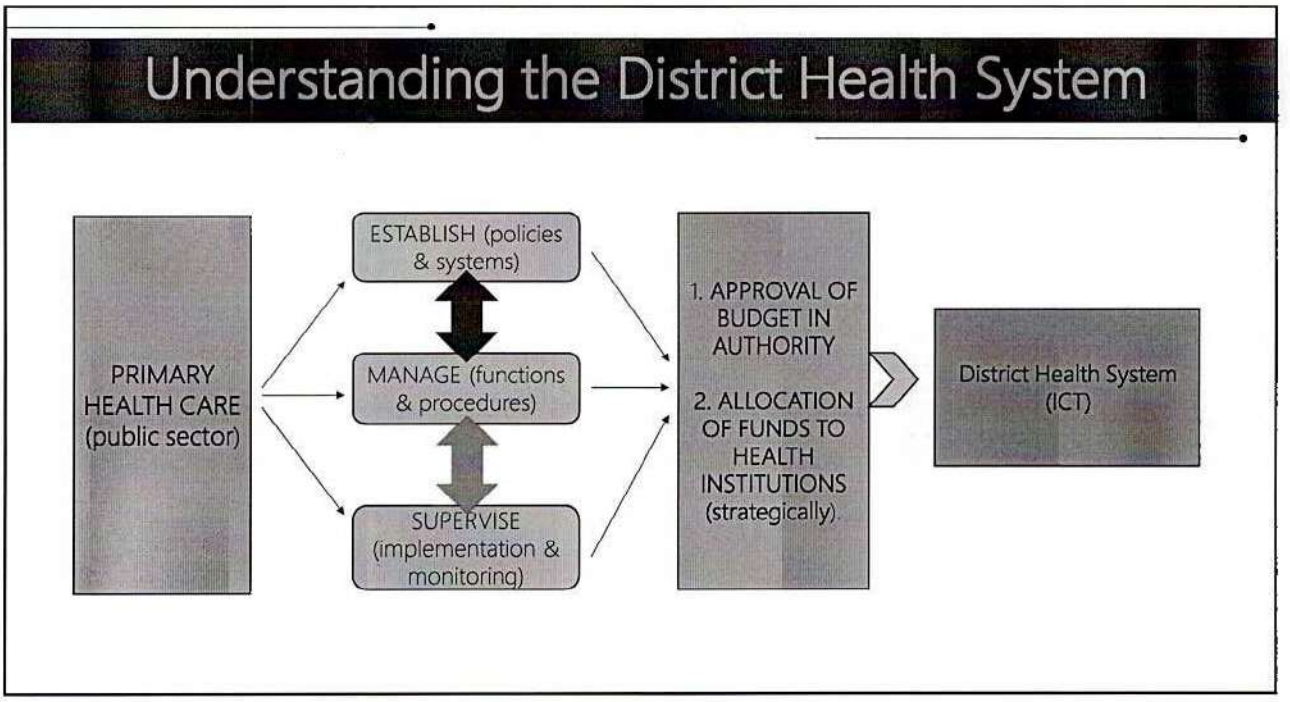
Proposed Merger-Organogram

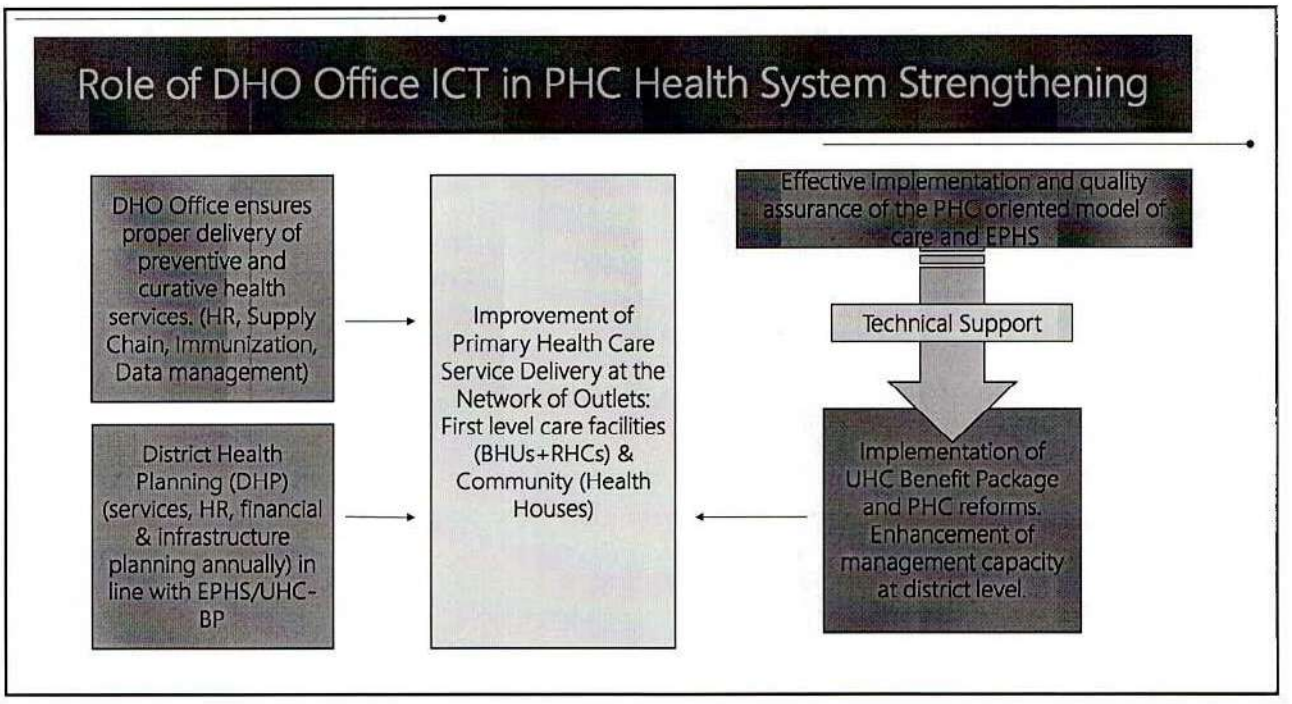


Rationale-Mergering CDA with DoH

- Merger of the Health Department ICT and Health Directorate CDA under the M/o NHSR&C will create an effective governance mechanism with a central command responsible for provision of well-coordinated and integrated health services of acceptable quality, bring transparency and accountability and progress towards a common strategic direction.

5


Understanding the District Health System
PRIMARY HEALTH CARE (public sector)
ESTABLISH (policies & systems)
MANAGE (functions & procedures)
SUPERVISE (implementation & monitoring)
1. APPROVAL OF BUDGET IN AUTHORITY
2. ALLOCATION OF FUNDS TO HEALTH INSTITUTIONS (strategically).
District Health System (ICT)


Role of DHO Office ICT in PHC Health System Strengthening
DHO Office ensures proper delivery of preventive and curative health services. (HR, Supply Chain, Immunization, Data management)
District Health Planning (DHP) (services, HR, financial & infrastructure planning annually) in line with EPHS/UHC-BP
Improvement of Primary Health Care Service Delivery at the Network of Outlets: First level care facilities (BHUs+RHCs) & Community (Health Houses)
Effective Implementation and quality assurance of the PHC oriented model of care and EPHS
Technical Support
Implementation of UHC Benefit Package and PHC reforms. Enhancement of management capacity at district level.

6

Role of DHO office as per law and regulations

As per constitutional Rights,1980 law:

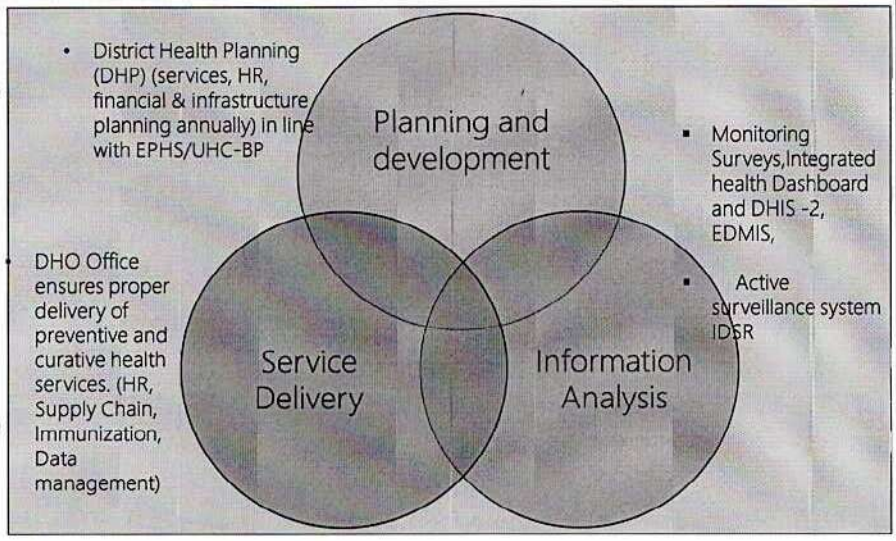
- The curative as well as preventive activities(previously being carried out by DHO Rawalpindi &CDA) in the Federally administered Rural area will be carried out by Administrator, Islamabad.
- As such the Federal Ministry of Health and social welfare decided to transfer one chief health officer and two Health Officers to the office of administrator Islamabad.

Role of District Health Office

UHC-UNIT-ICT

HPSIU
Analyse | Strategize | Action
Shaping Pakistan's Future Health

Linkages with Provincial/ Area Strategies



- District Health Planning (DHP) (services, HR, financial & infrastructure planning annually) in line with EPHS/UHC-BP
- DHO Office ensures proper delivery of preventive and curative health services. (HR, Supply Chain, Immunization, Data management)
- Monitoring Surveys,Integrated health Dashboard and DHIS -2, EDMIS,
- Active surveillance system IDSR

7

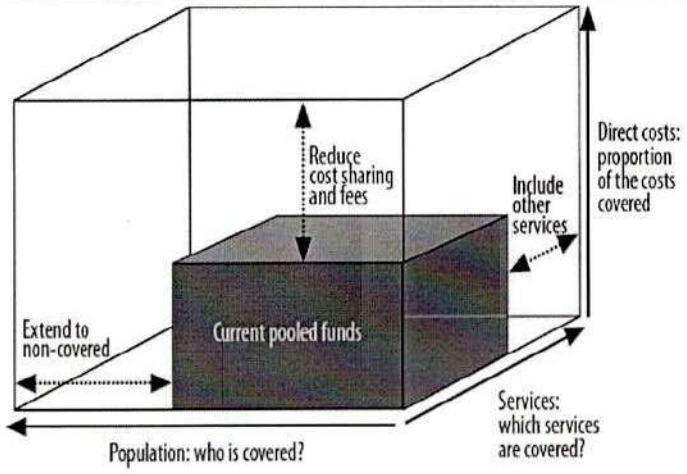
What is PHC?

- A whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution by focusing on people´s needs as early as possible.
- Health promotion and disease prevention, treatment, rehabilitation and palliative care.

What is UHC?

Universal Health Coverage means that all individuals and communities receive the health services they need without suffering financial hardship

Universal Health Coverage



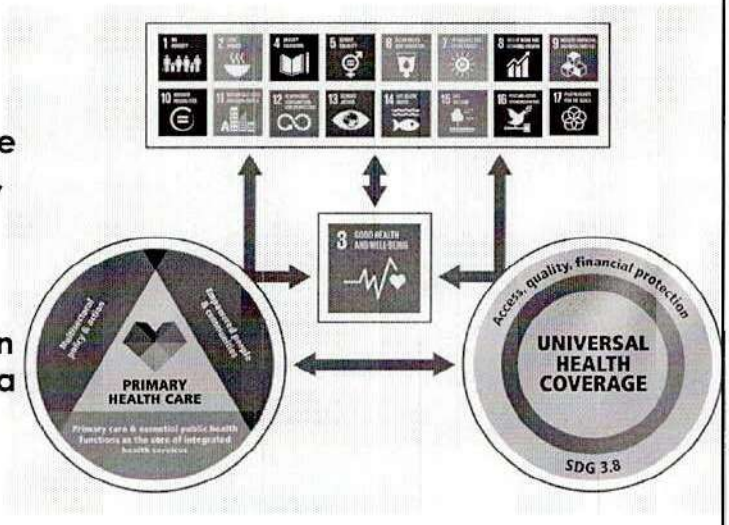
8

PHC is the Foundation for UHC

1. **PHC allow the** health system to adapt **and respond to complex & changing world**

2. **PHC has proven to be a highly** effective & efficient **way to address the main causes of, and risk factors for, poor health and handling the emerging challenges that may threaten health**

3. UHC and the health-related SDGs **can only be sustainably achieved with a stronger emphasis on PHC**

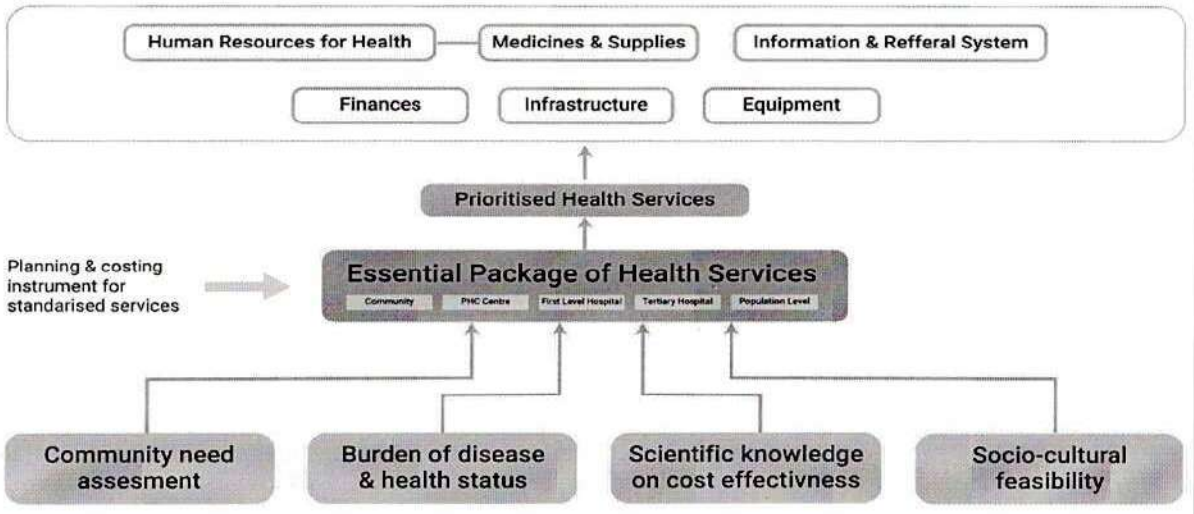


Objective of the UHC reforms in Pakistan

The objective of the UHC reforms in Pakistan **is to improve universal access to affordable, quality essential health services, delivered through a resilient and responsive health system** leading to an increase in the UHC Index from a baseline of 40% in 2015 to more than 65% by 2030.

9

Key Concept of EPHS



EPHS –based on DCP-3

Community & PHC Essential Package of Health Services

Preventive, Promotive, Curative, Rehabilitative & Palliative Healthcare Services

- Family Planning services
- Antenatal care
- Delivery & Postnatal care
- New-born care
- Nutrition
- Child care including immunization
- School-age child care
- Adolescent health
- Infectious diseases
- Non-communicable diseases
- Health services access (basic surgery and diagnostic services)
- Dental Services
- Wash & environmental health
- Nutrition services

43 High Priority Evidence-based Interventions

FREE

Population interventions for all.

80% of patient care can be catered for at community & PHC centre level

20% will need First level & Tertiary hospital care

10

Priority service areas of UHC-BP in four clusters

Reproductive, maternal, newborn and child health
1. Family planning (FP)
2. Antenatal care 4+ visits (ANC)
3. Child immunization (DTP3)
4. Care seeking suspected pneumonia (Pneumonia)

Infectious disease control
1. TB effective treatment (TB)
2. HIV treatment (ART)
3. Insecticide-treated nets (ITN)
4. At least basic sanitation (WASH)

Noncommunicable diseases
1. Normal blood pressure (BP)[a]
2. Mean fasting plasma glucose (FPG)[b]
3. Cervical cancer screening
4. Tobacco non-smoking (Tobacco)[d]

Service capacity and access
1. Hospital bed density (Hospital)[e]
2. Health worker density (HWD)[f]
3. Access to essential medicine
4. IHR core capacity index (IHR)

Community and PHC level interventions and services

UHC
3.8.1 – Service Coverage Index

3.8.2 – Financial Risk Protection

YEAR WISE UHC SCI							
Province/Area	2015	2016	2017	2018	2019	2020	2021
Islamabad	44.7	47.7	48.9	48.5	51.3	56.0	56.3
Punjab	40.6	42.8	45.6	47.3	48.2	52.0	53.8
Azad Jammu & Kashmir	39.0	40.7	43.6	46.2	47.9	49.8	50.2
Khyber Pakhtunkhwa	36.2	40.7	45.8	47.3	47.6	50.3	49.8
Gilgit Baltistan	35.8	39.3	41.0	42.6	43.5	45.2	48.5
Sindh	37.6	40.6	43.9	45.0	46.7	48.6	48.0
Balochistan	27.1	29.3	32.3	33.5	35.0	35.2	35.7
Pakistan	39.7	42.1	45.3	46.3	47.1	49.9	52.0

Engagement with Private Sector

11

EPHS at Community Level

- Expanding the coverage of **the Lady Health Workers' Programme** (140,000)
- **Option** of **private sector/GP/FP to manage the LHWs programme** in their catchment area and linking them with the UC PHC system
- Registration of all households for **'Smart Card'** with public and GP/FP clinics in the same UC
- **Digitized referral system** 'From Doorstep to Hospital'

Bed Registry — IT infrastructure — Ambulance/ Health Facility

EPHS at PHC centre level

Public sector

- Rural PHC
  - BHU
  - RHC
- Urban PHC
  - Dispensary
  - Medical centre

- Public sector alone can't ensure UHC – fiscal constraints
- Delays in execution while following processes

Public Private Partnership

- Contracting out
- Contracting in

- To ensure efficiency & effectiveness
- Quick to respond- Ease of business
- Empowering local NGOs

Private sector

- GP/ FP clinic
- Medical centre
- Nursing Home

- Vital for expansion of UHC coverage
- Commitment towards public health
- Establishing new professionals through financial support (Loan facility)

12

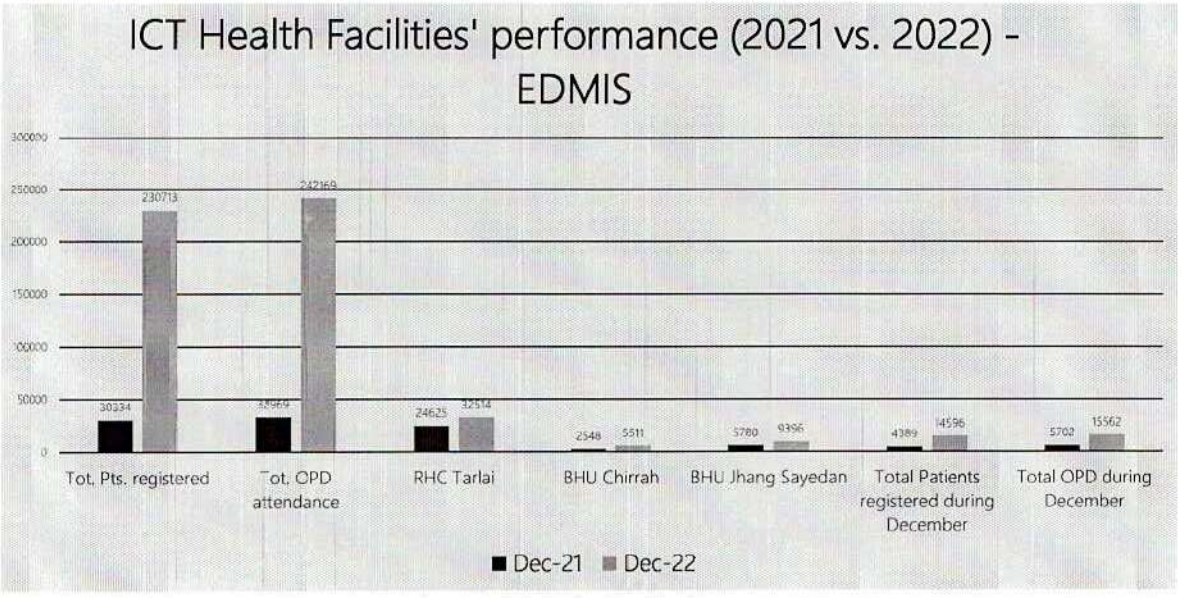
PHC and Family Physicians/GPs

- Effective **partnership** with the private sector **including GPs/ FPs**
- **Facilitate GPs/FPs** (especially new graduates) to establish their Clinics/ Nursing homes – creating more job opportunities for health workforce
- **Loan facilities** (e.g. Health Foundation) and pay for service modalities
- **Linking academic institutions** - Provide learning opportunities on 'Family Medicine' diploma to those involved in the initiative (both public & private) – equivalent to FCPS Part I

Strengthening Referral Mechanism

- Hospitals **PIMS,POLYCLINIC,FGH** that provide tertiary care should not charge patients who are referred by PHC levels or need emergency services. In the absence of a referral from a PHC care level institution, the patient will be charged for using the services while going straight to tertiary care.
- The functionality and service reach of PHC-level facilities would be improved by this mechanism.
- Let's **deliberate on options** for achieving PHC & UHC in Pakistan – Functional PHC delivery system and on how to reduce patient load in hospitals

13



Capacity Building- DHO Staff

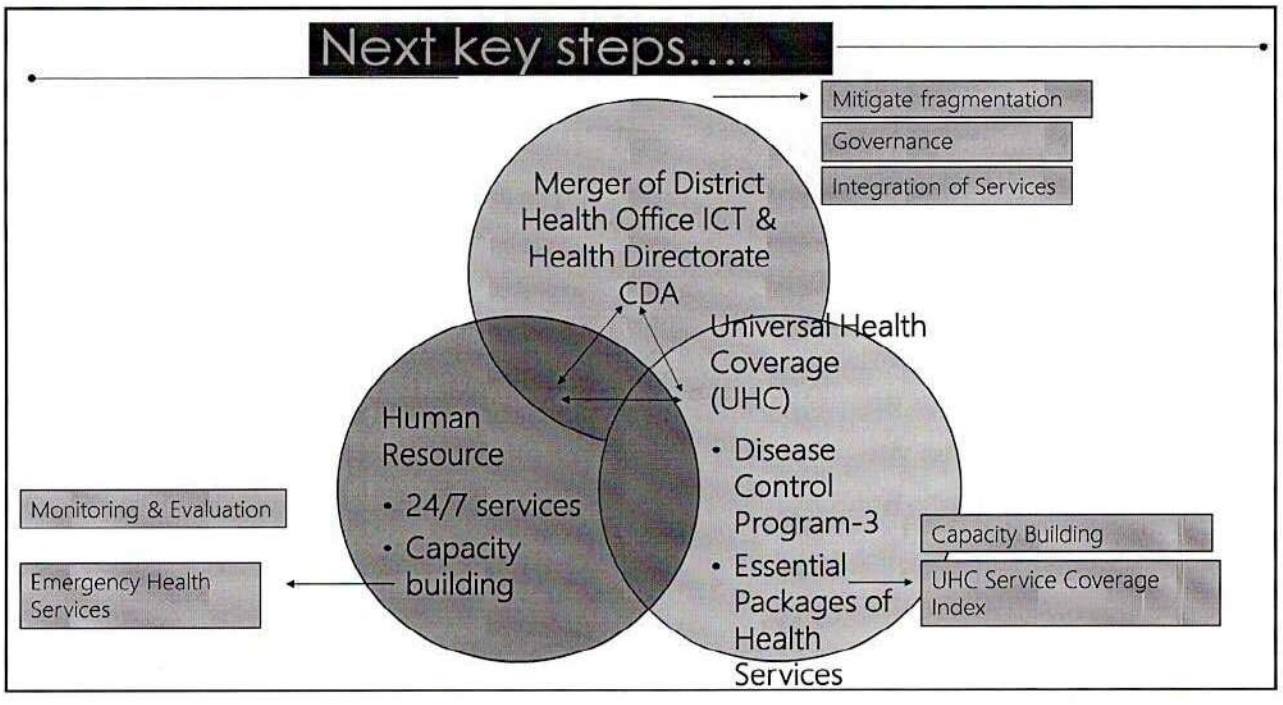
On Going Activities

- Lady Health Worker **LHW Curriculum**- FLCF Cascade training
- Electronic Data Management Information system **EDMIS** , District Health Information System **DHIS-2** Training
- Infection Prevention control- Facility based
- Training on Logistic Management Information system **LMIS**

14

PC-1 AGENDA-Recommendations

- Recruiting the Lady Health Workers LHWs 1500 (for phase-1 -800 including LHVs)
- It is necessary **to upgrade these FWCS into BHU level** with the merging of have FWCs into DHO-ICT in order to cater to EPHS at PHC levels and hire workers.
- Effective, efficient, accessible and **integrated essential health services at community and PHC center level** especially in the awake of COVID outbreak
- A well trained **Health work force** available to **deliver EPHS and IDSR**
- HIS (IDSR, generating Data on Health system response and action)
- **Equitable access to medicine, vaccines, contraceptive supplies**, and medical technologies (including universal access to COVID related health tech/PPEs
- **Health Financing System** insuring that people can **afford Essential Services with Financial risk protection measures.**
- **Leadership and management** with effective oversight ,regulation and accountability
- Contingencies/ additional grant



15

MOVING TOGETHER
TO BUILD A HEALTHIER PAKISTAN
UNIVERSAL HEALTH COVERAGE

Universal Health Care Unit For Primary Health Care Islamabad

UHC for PHC

HPSIU
Analyse | Strategize | Action
Shaping Pakistan's Future Health

UHC-ICT Team


Dr. Namrah Malik


Mr. Saqib Yaqoob


Dr. Nadeem Gondal


Dr. Nadia Waqas


Ms. Nazil Danish

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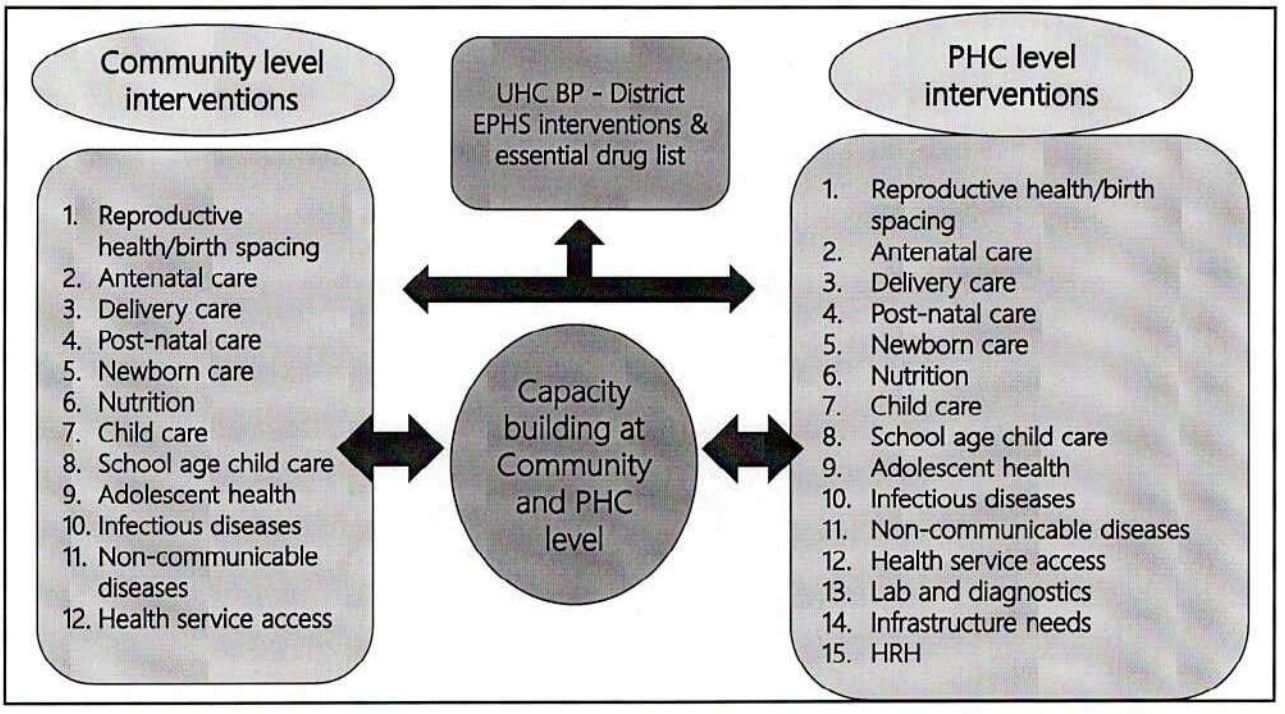
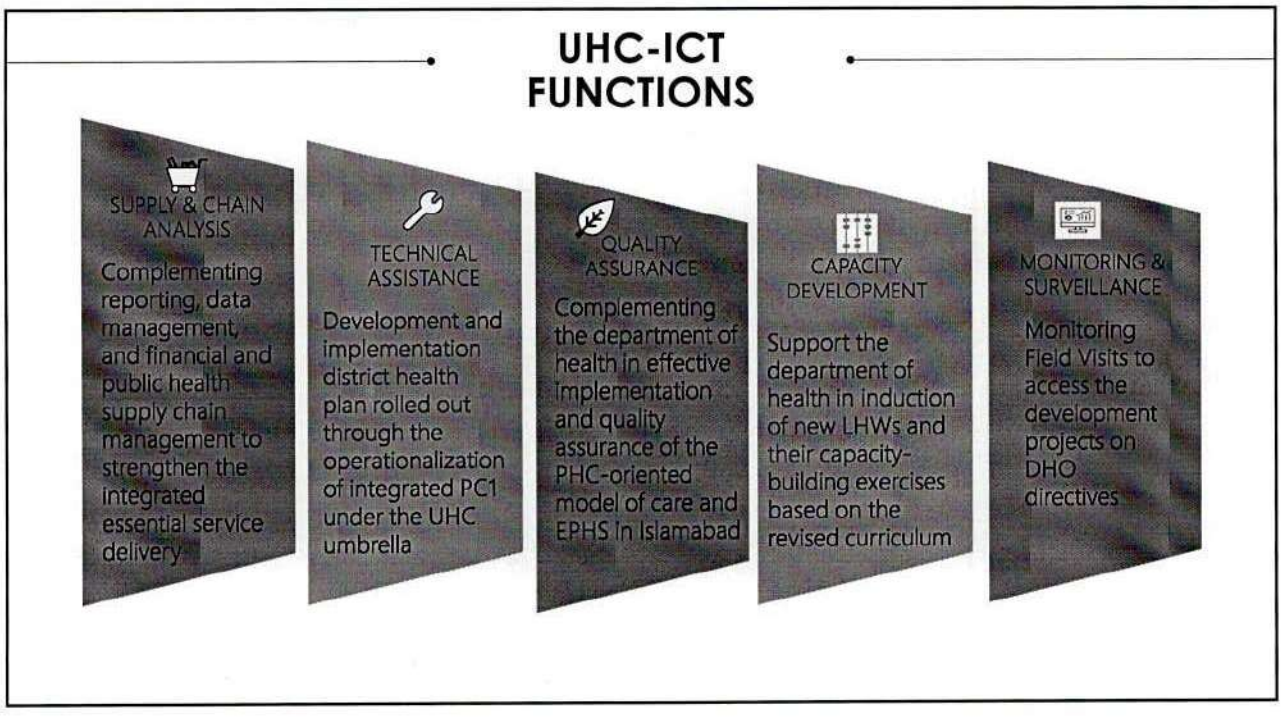
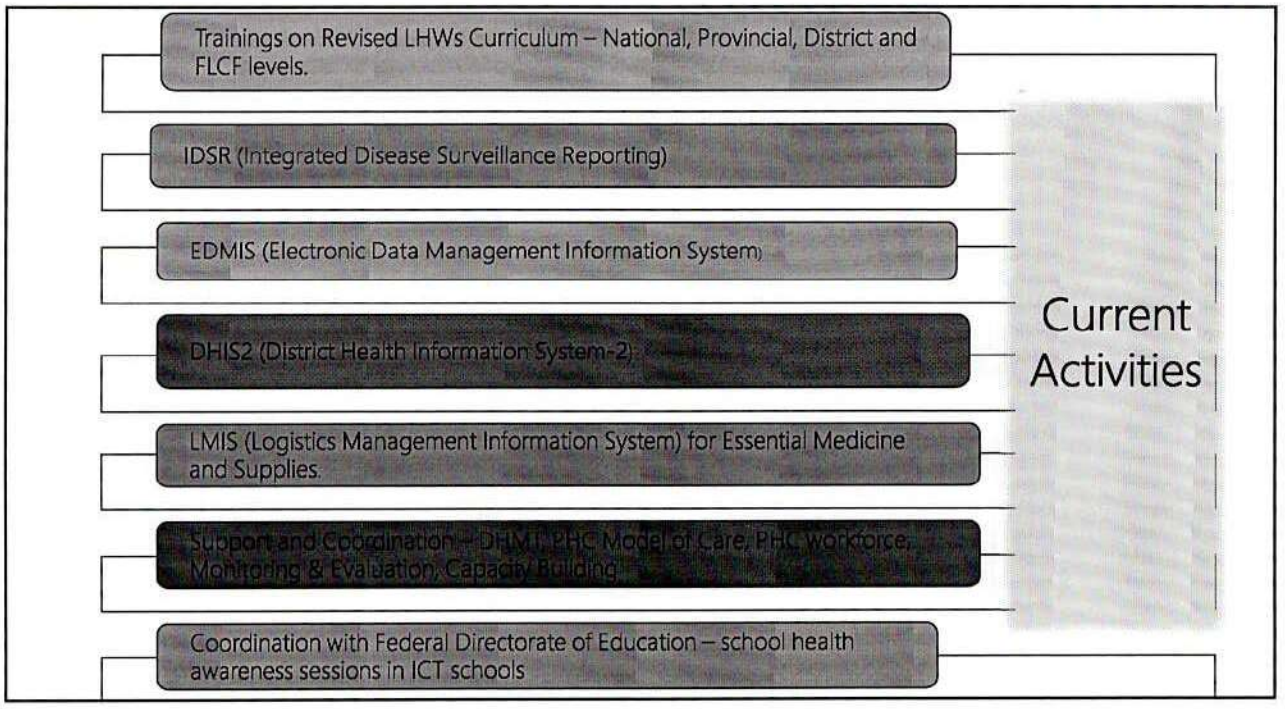
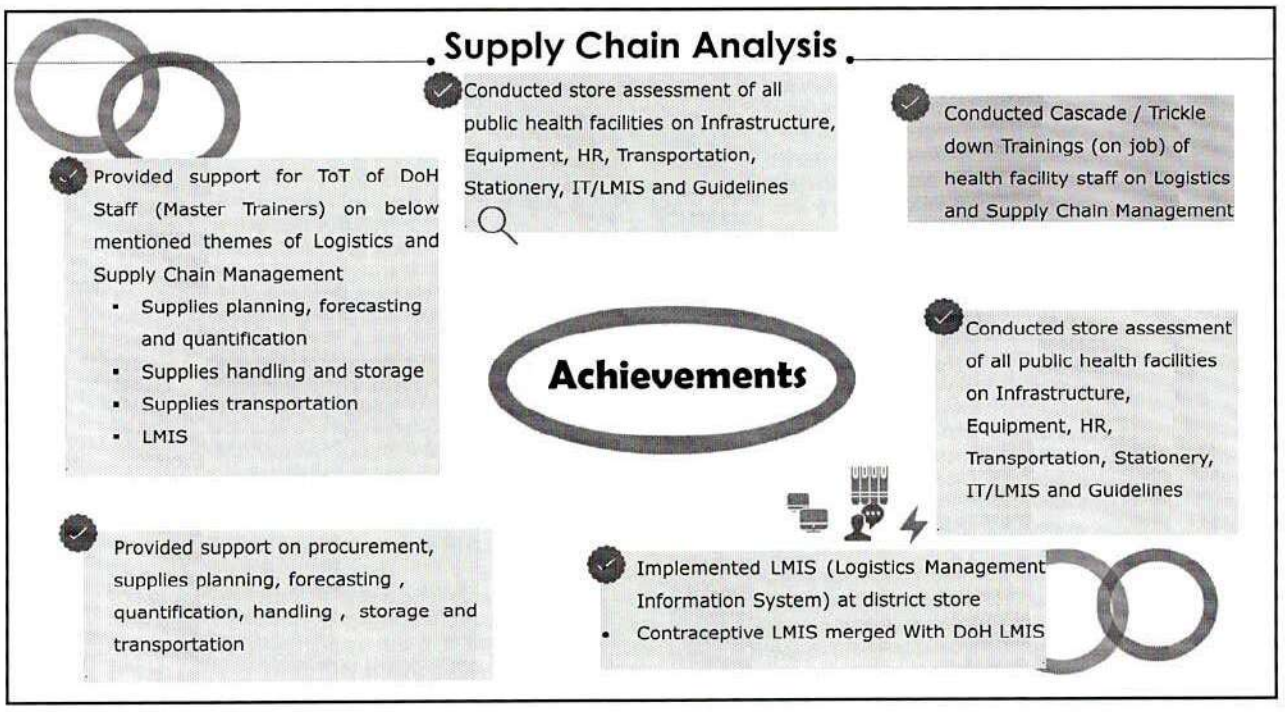

Community level interventions
1. Reproductive health/birth spacing
2. Antenatal care
3. Delivery care
4. Post-natal care
5. Newborn care
6. Nutrition
7. Child care
8. School age child care
9. Adolescent health
10. Infectious diseases
11. Non-communicable diseases
12. Health service access
UHC BP - District EPHS interventions & essential drug list
Capacity building at Community and PHC level
PHC level interventions
1. Reproductive health/birth spacing
2. Antenatal care
3. Delivery care
4. Post-natal care
5. Newborn care
6. Nutrition
7. Child care
8. School age child care
9. Adolescent health
10. Infectious diseases
11. Non-communicable diseases
12. Health service access
13. Lab and diagnostics
14. Infrastructure needs
15. HRH


UHC-ICT FUNCTIONS
SUPPLY & CHAIN ANALYSIS
Complementing reporting, data management, and financial and public health supply chain management to strengthen the integrated essential service delivery
TECHNICAL ASSISTANCE
Development and implementation district health plan rolled out through the operationalization of integrated PC1 under the UHC umbrella
QUALITY ASSURANCE
Complementing the department of health in effective implementation and quality assurance of the PHC-oriented model of care and EPHS in Islamabad
CAPACITY DEVELOPMENT
Support the department of health in induction of new LHWs and their capacity-building exercises based on the revised curriculum
MONITORING & SURVEILLANCE
Monitoring Field Visits to access the development projects on DHO directives

17


Trainings on Revised LHWs Curriculum – National, Provincial, District and FLCF levels.
IDSR (Integrated Disease Surveillance Reporting)
EDMIS (Electronic Data Management Information System)
DHIS2 (District Health Information System-2)
LMIS (Logistics Management Information System) for Essential Medicine and Supplies.
Support and Coordination – DHMT, PHC Model of Care, PHC workforce, Monitoring & Evaluation, Capacity Building
Coordination with Federal Directorate of Education – school health awareness sessions in ICT schools
Current Activities


Supply Chain Analysis
Provided support for ToT of DoH Staff (Master Trainers) on below mentioned themes of Logistics and Supply Chain Management
Supplies planning, forecasting and quantification
Supplies handling and storage
Supplies transportation
LMIS
Conducted store assessment of all public health facilities on Infrastructure, Equipment, HR, Transportation, Stationery, IT/LMIS and Guidelines
Conducted Cascade / Trickle down Trainings (on job) of health facility staff on Logistics and Supply Chain Management
Achievements
Conducted store assessment of all public health facilities on Infrastructure, Equipment, HR, Transportation, Stationery, IT/LMIS and Guidelines
Provided support on procurement, supplies planning, forecasting , quantification, handling , storage and transportation
Implemented LMIS (Logistics Management Information System) at district store
Contraceptive LMIS merged With DoH LMIS

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Governance

ACCOMPLISHMENTS

- Dengue Fever Surveillance, Prevention & Control
- Epi/Pei Initiative
- Covid-19 Surveillance And Response
- Covid-19 Vaccination
- Development Projects
- Drug Sale Licenses, Islamabad
- POLIO Sias

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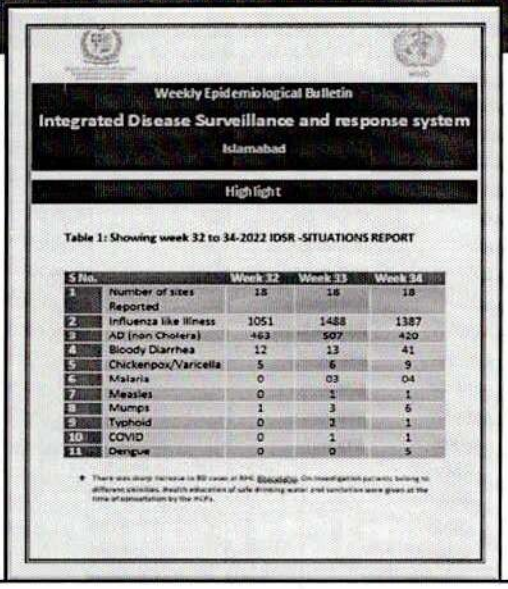
Strengthening Disease Surveillance and Response Unit (DSRU) in ICT

- Support in Integrated Disease Surveillance and Response (IDSR)
- Alerts generated on communicable diseases in general (including threats from emerging pathogens) and timely responded
- Infectious diseases data analysis and maintenance
- Monitoring on Daily situation report on COVID-19 and Dengue fever
- Preparation of Epidemiological bulletin of ICT since 27 week 2022 to date



Weekly Epidemiological Bulletin

Integrated Disease Surveillance and response system

Islamabad

Highlight

Table 1: Showing week 32 to 34-2022 IDSR -SITUATIONS REPORT

S No.		Week 32	Week 33	Week 34
1	Number of sites Reported	18	18	18
2	Influenza like illness	1051	1488	1387
3	AD (non Cholera)	463	507	420
4	Bloody Diarrhea	12	13	41
5	Chickenpox/Varicella	5	6	9
6	Malaria	0	03	04
7	Measles	0	1	1
8	Mumps	1	3	6
9	Typhoid	0	2	1
10	COVID	0	1	1
11	Dengue	0	0	5

Coordination and monitoring of the medical camps in ICT

Community outreach programs/ Medical camps

- Routine activity to improve the health of women and children by providing quality essential health services including the rural and far flung areas of ICT Provide FP and free medical services
- It also provides screening of
- COVID-19,
- Tuberculosis
- Hepatitis B & C ,
- Diabetes
- hypertension along with.
- Diagnosed Hep. C Patients are referred to FGH after coordination.
- Family Planning FP clients are send to FG clinic for surgical services.

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Monitoring Field Visits of health facilities on DHO directives

- To develop an in-depth understanding of the health system in ICT
- Discussions on Infrastructure and services (with regard to UHC Benefit Package)
- Coordination with health facility staff in smooth working and to access the supply of essential medicines in health facilities
- The main outcome of this activity is that this will help in facilitating the planning exercise and support in development of district health plan for ICT Islamabad.

GOVERNMENT OF PAKISTAN
M/O NATIONAL HEALTH SERVICES, REGULATIONS & COORDINATION
DISTRICT HEALTH OFFICE
ISLAMABAD

MONITORING VISIT TO HEALTH FACILITY

Type of Health Facility: Community Health Centre

Name of Centre: CHC

Attendance of Staff: Total No: 5 Present: 4 On leave: __ Absent: Vaccinator in field

Date of Inspection: 12-10-2022, Time in of Inspection:10-40 am, Time Out of Inspection: 12.30 PM

A: GENERAL ATTRIBUTES OF HEALTH FACILITY

Sr. #	Description	Yes	No	Remarks
1.	Cleanliness	✓		
2.	Direction Board		✓	
3.	Boundary Wall	✓		
4.	Building	✓		
5.	Offices	✓		
6.	Waiting Area	✓		
7.	Labor Room	-		
8.	Laboratory	-		
9.	Lawn		✓	
11.	Toilet	✓		
12.	Electricity	✓		
13.	Telephone	NA		
14.	Sui Gas		✓	
15.	Water Supply	✓		

(P.T.O)

1

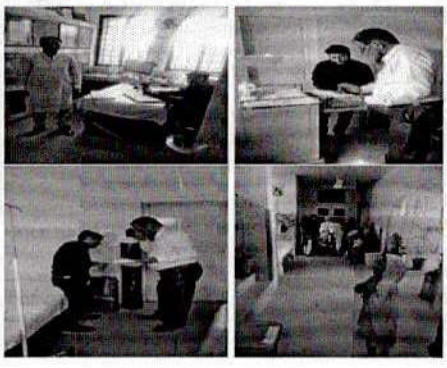
Remarks:

The center was having only one MO, one NO, One Vaccinator, One Chowkidar and one FH worker whereas CHC should have 40 HR including 4 MOs along with many other. The cleanliness require a constant sanitary worker placement. The inflow of patient was good therefore the space cleanliness seems to be compromised. The HT got recently retired with no replacement.

Special Notes:

The center is having the installation of incinerator, which require certain prerequisites like separate electric meter, water supply, which is in process. The site for incinerator have been prepared.

Few Snap shots



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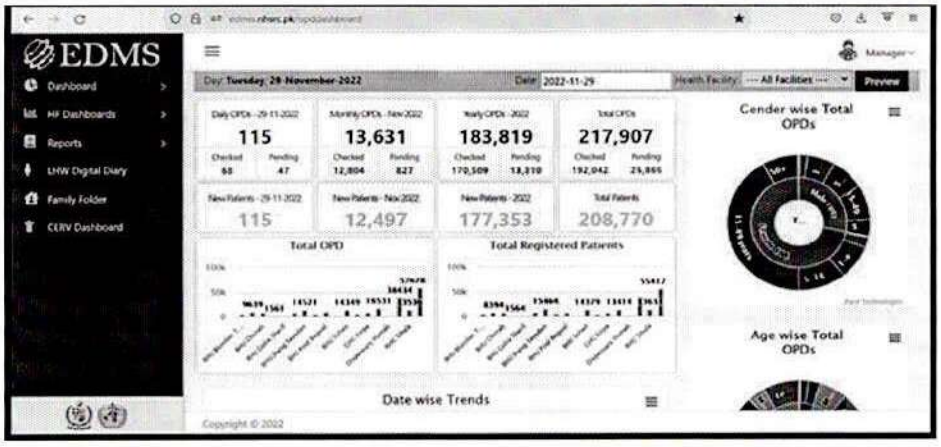
Electronic Data Management System (EDMIS)

Health Facilities Level



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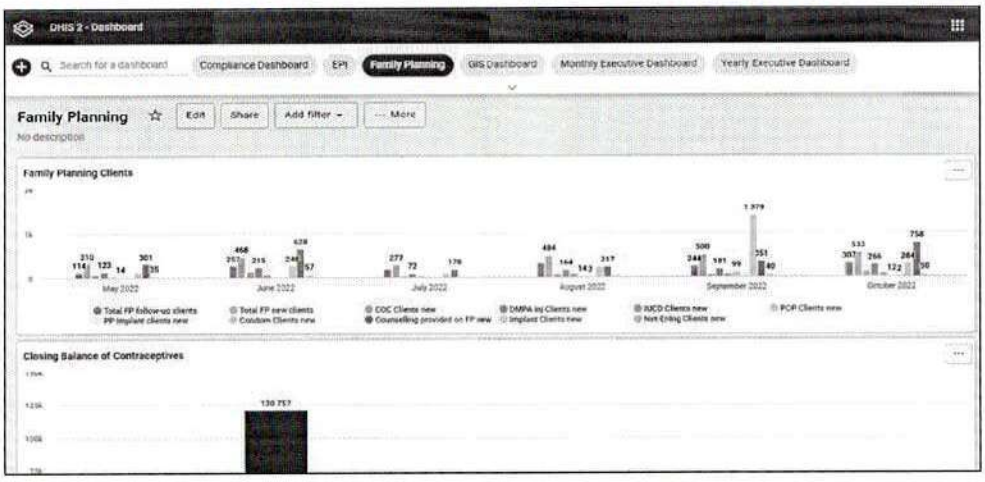
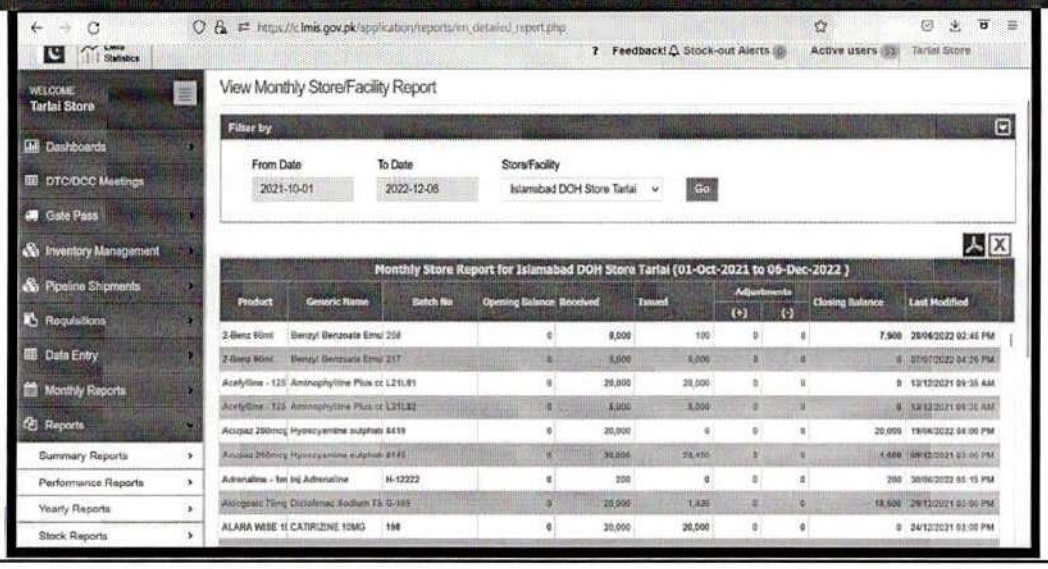
District Health Information System (DHIS-2)

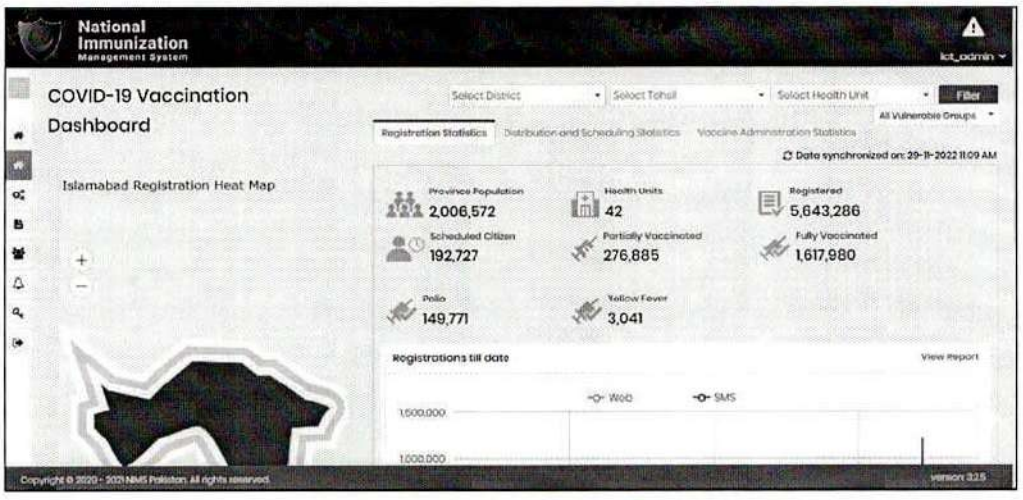


Logistics Management Information System (LMIS)

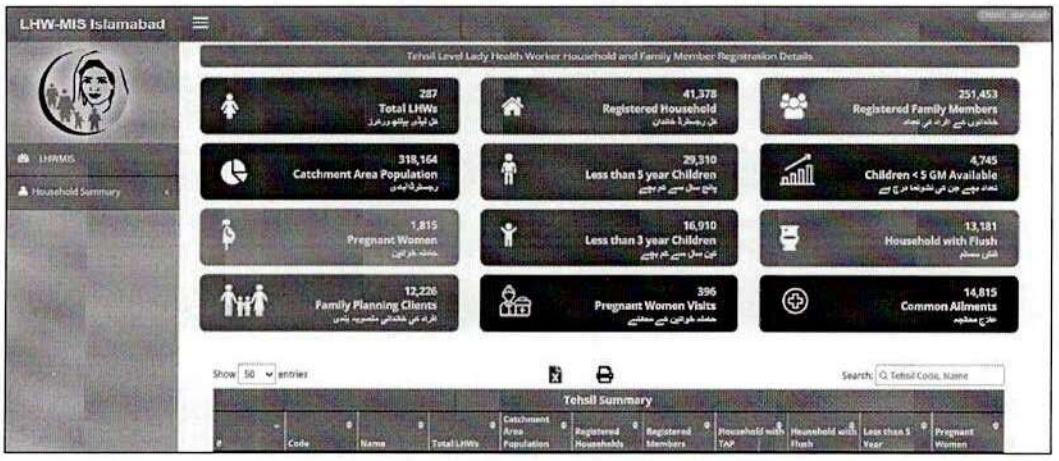
LOGISTIC MANAGEMENT INFORMATION SYSTEM



COVID -19 Vaccination Dashboard



LHW Digital Diary



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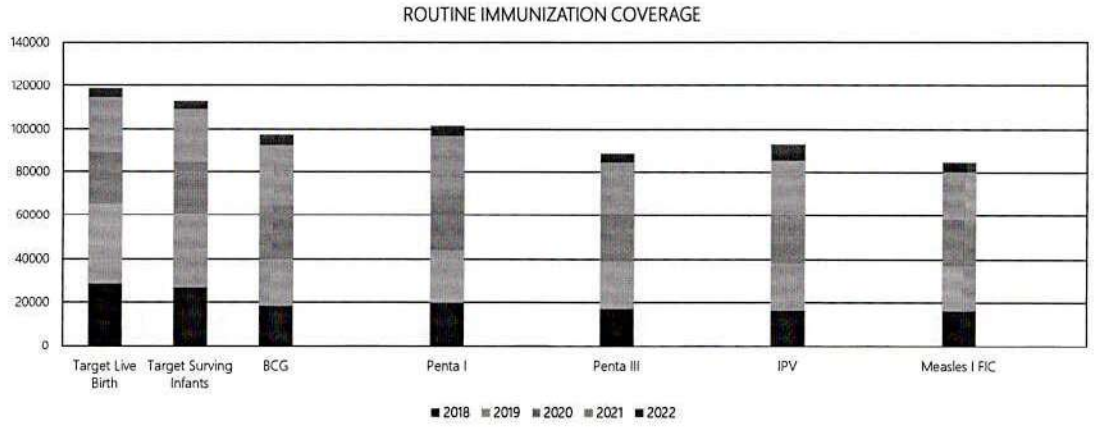
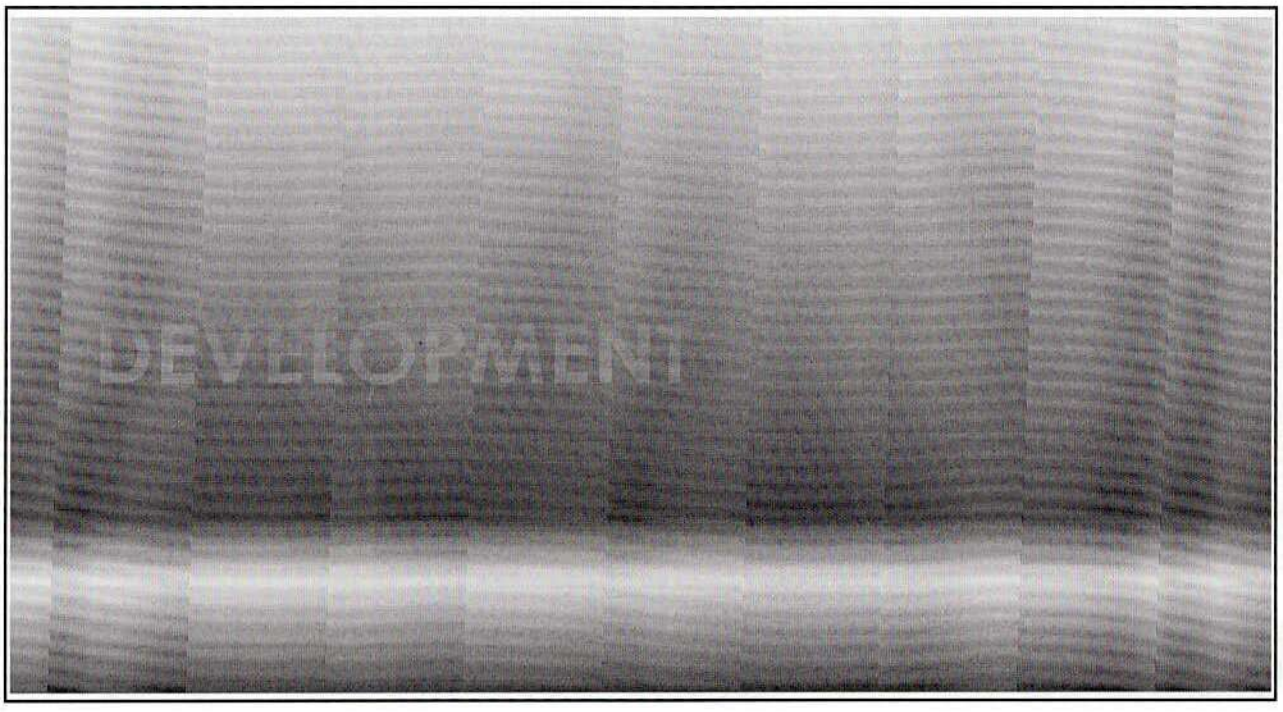
Year Wise Routine Immunization Graph





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Establishment of 04 BHUs in ICT Islamabad

- Issue/Constraints:

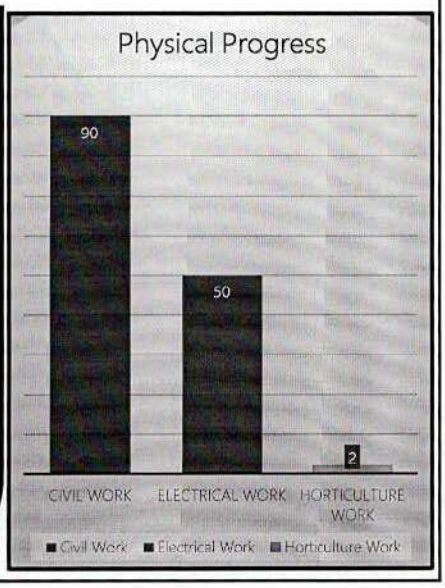
i. Land for BHU Jhangi Syedan was acquired on 03-12-2021 however, possession was taken over 05-11-2022 by ICT Administration, handed over to this office on the same date Tendering process is being initiated by PWD to construct the BHU

ii. Possession of land at Sara-e-Kharbooza was handed over in January, 2022 Civil work was started by the PWD, however, the contractor has refused to continue the work because of escalation in cost, hence, the work has stopped, The PWD is re-hiring another contractor;

iii. Project has completed its life, time extension has not yet received, two BHUs are yet to establish

iv. PC-Is had submitted to Ministry for DDWP for its revision to complete the Procurement of ambulances (04), furniture and equipment as in last F.Y 2021-23 process could not be completed because of fluctuation in items cost

Establishment of Basic Health Unit at Golra Shareef, Islamabad



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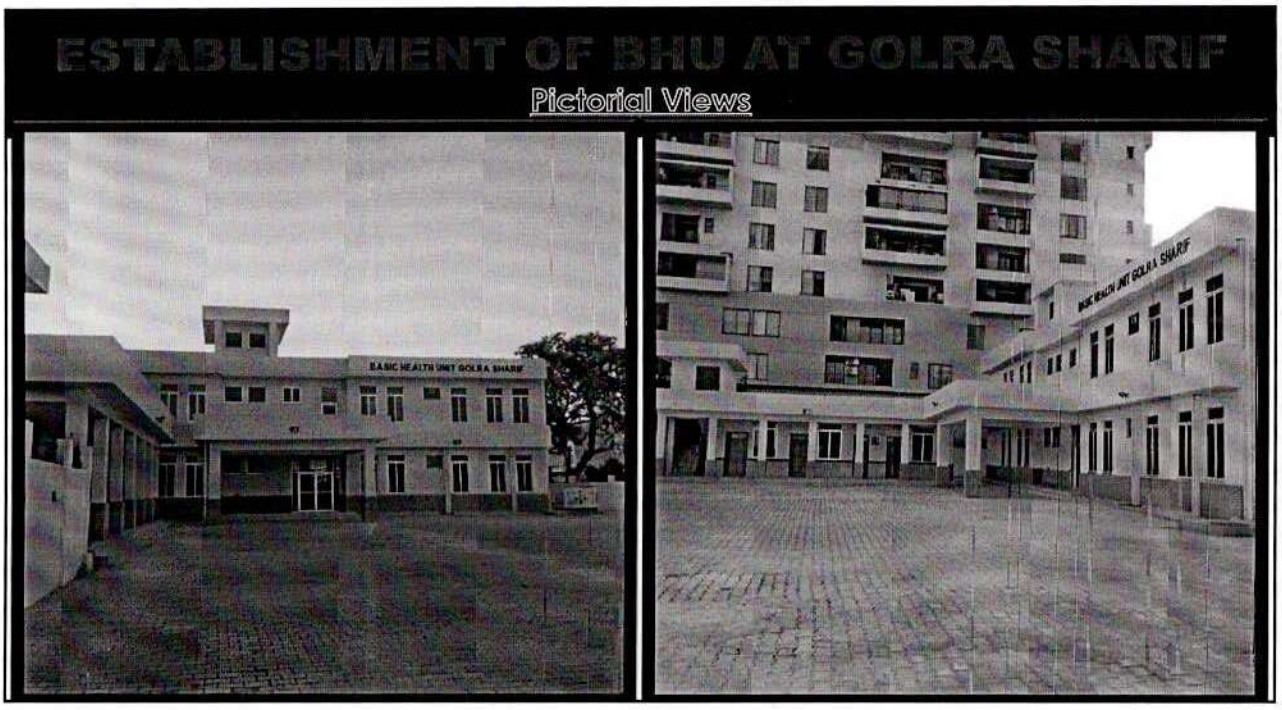
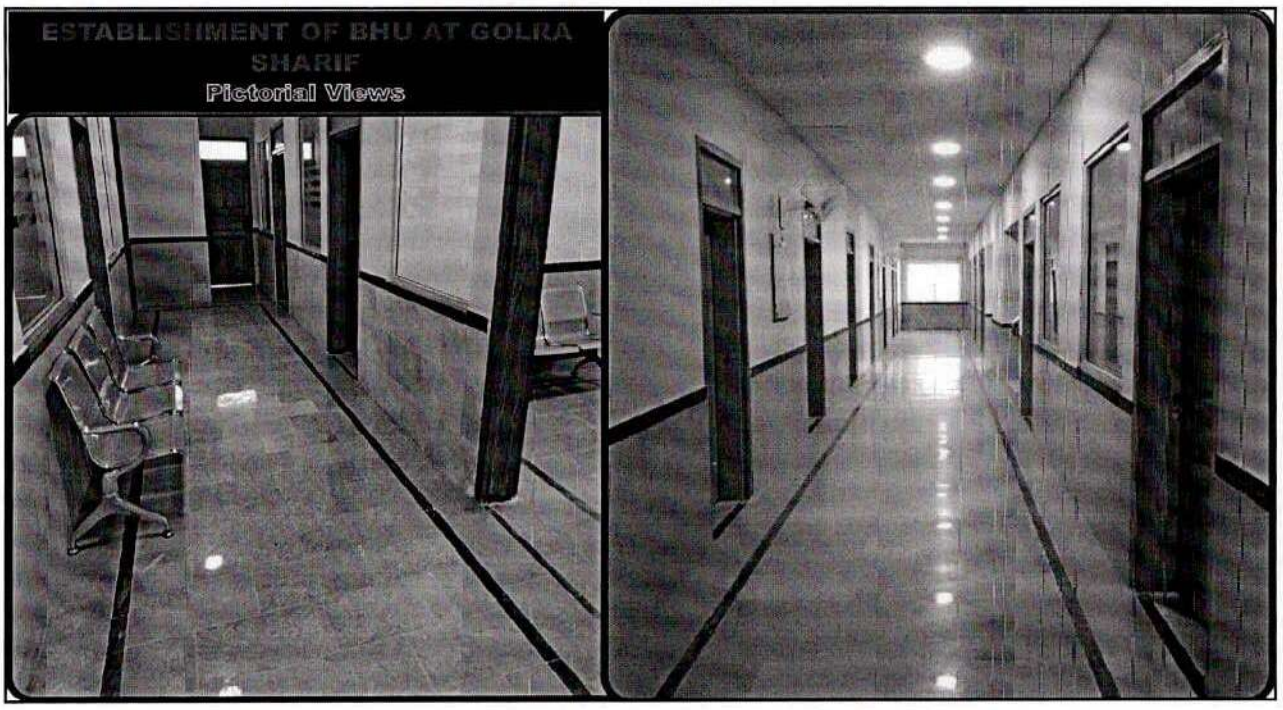

ESTABLISHMENT OF BHU AT GOLRA SHARIF
Pictorial Views
BASIC HEALTH UNIT GOLRA SHARIF
BASIC HEALTH UNIT GOLRA SHARIF


ESTABLISHMENT OF BHU AT GOLRA SHARIF
Pictorial Views

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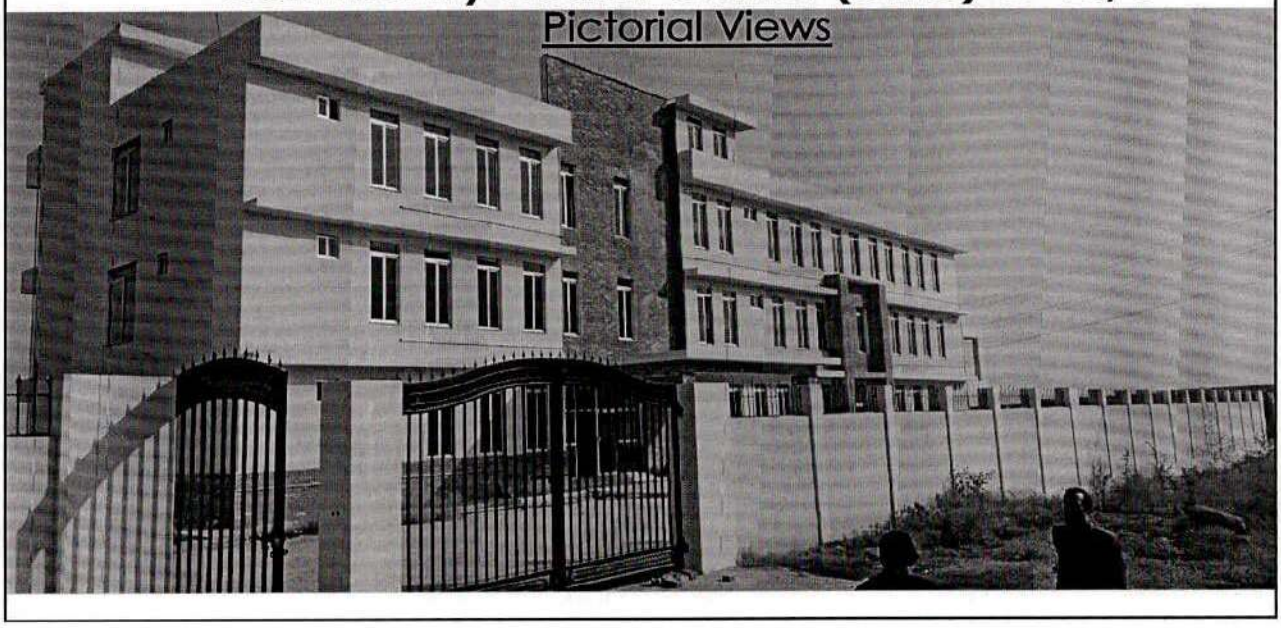
Community Health Center (CHC) G-13/3

Pictorial Views



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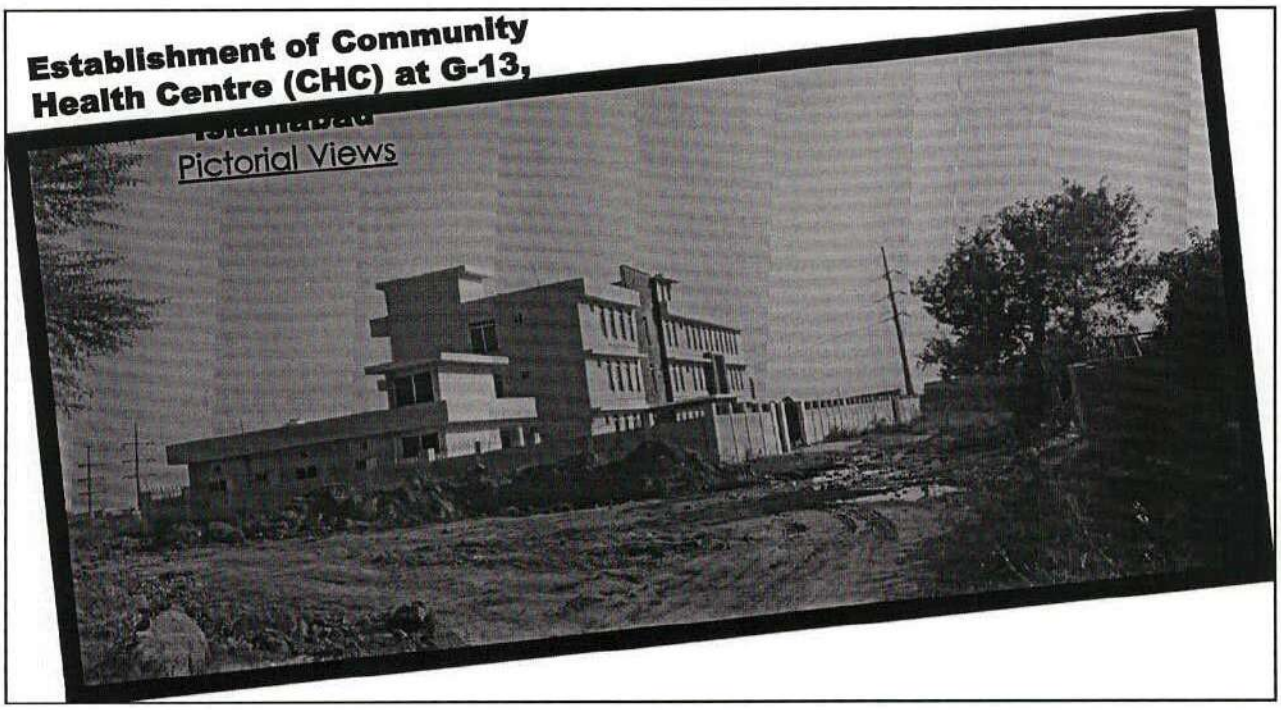
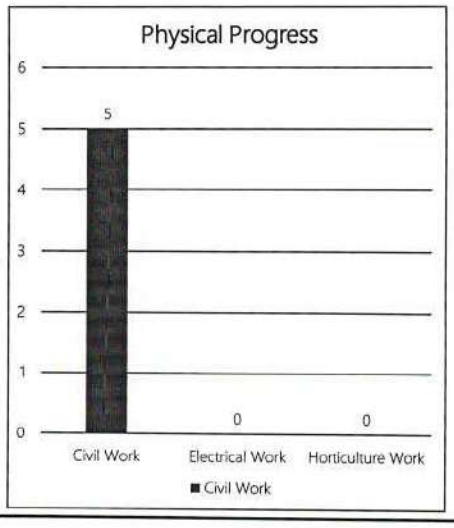
Establishment of Community Health Centre (CHC) at G-13, Islamabad

Pictorial Views



03- Establishment of Basic Health Unit at Sara-e-Kharbooza, Islamabad



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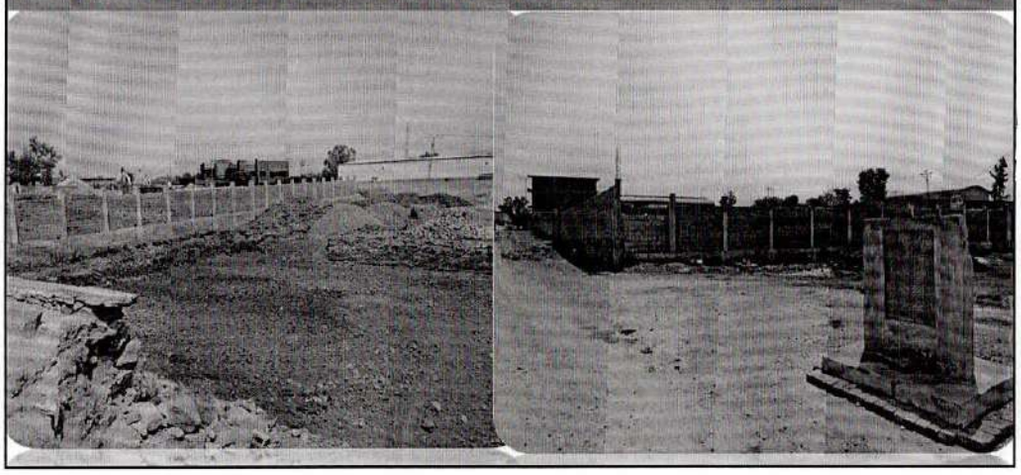
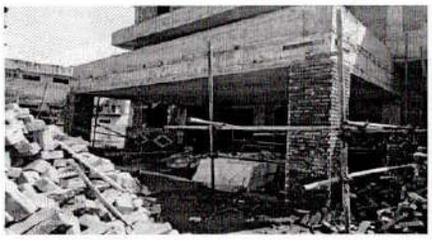
03- Establishment of Basic Health Unit at Sara-e-Kharbooza, Islamabad

Pictorial Views



MONITORING OF HEALTH PROJECTS

Monitoring of health projects. Under construction District Health Office building. Displeasure conveyed to contractor for inability to achieve the sets targets regarding civil work.



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Health Department ICT is ensuring optimum quality and pace of undergoing projects. CHC Barri Imam project shall be completed by the end of this year thus enabling the locals to get medical facilities at door step.

Thank You