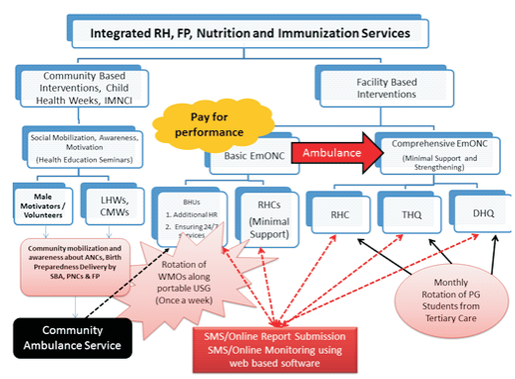
Assessment of Chief Minister's Health Initiative for Attainment & Realisation of Millennium Development Goals (CHARM)

صحت زندگی

Chief Ministers' Health Initiative for Attainment and Realization of MDGs 4 & 5 (CHARM) was launched in seven of the worst flood affected districts of Punjab in 2010, with the assistance from UNICEF & UNFPA. The main objective was to improve MNCH services and reduce maternal and neonatal morbidity in selected health facilities of districts Rahim Yar Khan, Rajanpur, Muzaffargarh, D.G.Khan, Layyah, Bhakkar and Mianwali.

The programme was designed as an extension and support of the existing district health system (Figure 1) by providing trained human resource where needed, stronger monitoring, ambulance services, promoting community mobilization, increasing awareness about maternal and child health and ensuring availability of women medical officers.

Figure 1: CHARM model



Assessment of CHARM Project

CHARM project was launched for a period of three years in 2011- December 2013. Expansions of the project was proposed by introducing this initiative in 16 districts having poor health indicators relating to MDGs 4 & 5 and later expand it further to 20 districts of Punjab by 2016. A comprehensive study was thus designed (Table 1) to assess the project accomplishments and provide specific recommendations for scaling up.

Table 1: Objectives of assessment

The objected were to assess

- Project design including its linkages with other Programmes and outreach workers
- Effectiveness of the management and governance structures
- Financial and administrative autonomy provided to managers
- Ownership level and role of EDOs (H) in CHARM interventions
- Outputs/increased utilization of EmONC and PHC services
- Community and clients satisfaction
- Overall costs per BHU and RHC as compared to non-CHARM districts
- Lessons learnt and key recommendations on scaling up and sustainability of project

Assessment covered seven CHARM project districts (within CHARM districts both CHARM and non-CHARM health facilities were included) and two non-CHARM districts; 66 First Level Care Facilities (FLCF) were covered. Through a mixed methods approach, primary data was collected at four levels, which included provincial, district, facility and community . Table 2

Table 2: Methodology

- Consultative meetings at provincial and district level
- In Depth Interviews (IDIs) with health facility in charges, health care providers and skill assessment for Active Management Of Third Stage Of Labour (AMTSL)
- Assessment of community satisfaction, referral system and reasons for accessing public health facilities for EmONC and PHC services

Assessment Findings

1. Governance and Management

The stewardship role of district managers, expected to emerge as a result of devolution has not materialized and role of the Executive District Officer for Health (EDOH) remain limited in implementation of CHARM project. Administrative authority of EDOH is diluted among many functionaries limiting their capacity to make timely and efficient decisions. Managers lacked financial autonomy and were also not empowered for re-appropriation of budget. Other significant findings from Governance and Management assessment includes

a. Human Resource Management
Written policy and operational guidelines developed for the CHARM project were not formally shared by provincial authorities with district managers. EDOH had limited power of taking disciplinary actions and were permitted to hire regular staff up till Grade 10 only

b. Management Information System
In CHARM Mobile phone technology and text messaging system was used, in addition to DHIS and MIS reports. Computers were available in 1/3rd of facilities but were nonfunctional due to non-availability of computer operators. In non-CHARM facilities control districts sent their reports through special messenger or courier service. Monitoring visits to facilities were occasional and infrequent. There was no evidence how the issues identified during those visits were resolved.

c. Community Feedback
districts, the cell phone numbers of focal person of CHARM were prominently displayed at all facilities for complaints/comments. Complaints were reviewed monthly and redressal was ensured. In non-CHARM facilities no mechanism for community feedback existed

d. Facility Management
Job descriptions were available with over 70% of Medical Officers (MOs) at CHARM BHUs and 61% of MOs at non CHARM BHUs. Most of the service delivery protocols for ANC, NVD, PNC, Newborn resuscitation; Vaccination (EPI), Partograph and AMTSL were displayed at majority of CHARM BHUs and RHCs; less commonly by non-CHARM BHUs and RHCs. Most CHARM and Non-CHARM BHUs and RHCs routinely conducted performance review meetings.

e. Linkages, Coordination and Collaboration
CHARM initiative did not bring any change in terms of effective linkages with vertical programs and community. Pairing of LHWs and CMWs did not develop, as conceived in CHARM concept note. In the Non-CHARM districts no mechanism existed to ensure coordination between LHW and other vertical programs

2. Service Delivery

Health facilities were assessed for services, inputs and readiness, the findings of which are given in table 3

Table 3: Service delivery assessment findings

Indicator	CHARM Facilities	Non-CHARM Facilities
Healthcare Services	Most of the surveyed facilities (BHUs and RHCs) provided Primary Healthcare, Preventive MNCH and Basic EmONC Services	
Inputs: Marginal disparity was noted between BHUs and RHCs of each study group for the availability of most amenities (electricity, water supply and telephone)	Significantly more CHARM facilities had alternate source of energy than those in non - CHARM districts: 50% versus 9% Human Resources: The overall staff position was better in CHARM -BHUs and RHCs compared to other facilities 20% staff positions were vacant at RHCs of CHARM districts Majority of RHCs of CHARM districts (67 -83%) had designated space for both MOs and WMOs All essential equipment and furniture was available at only 18% of BHUs and 25% of RHCs in CHARM districts Availability of FP services was better in CHARM districts	100% of non-CHARM districts had designated space for both MOs and WMOs None of the BHUs and RHCs had all the essential drugs Ambulance drivers were not available at any BHU
Facility Readiness	Labour room was found functional in over 80% of all surveyed facilities	Cold chain was properly maintained in 75% of the faiclities

RHC Rural Health Center, EmONC - Emergency Obstetric and Newborn Care, FP - Family Planning

3. Service Output

Service outputs (utilization) are key performance indicators which were assessed against 19 indicators. Overall, positive change was witnessed in all the assessed facilities; however in CHARM facilities the change was found more significant statistically. The findings are described in Table 4

Table 4: Service output indicators findings

Indicator	CHARM Facilities	Non CHARM Facilities
1st BHU Visits	BHUs showed a 40% increase in first antenatal care visits during the assessment period Number of clients visiting RHCs for ANC-1 actually dropped in 2013 compared to 2010	BHUs showed a 15% increase in first antenatal care visits during the assessment period
Normal Vaginal Deliveries	Higher percentage increase was noticed in normal vaginal deliveries (NVDs) by CHARM-BHUs. Total number of NVDs increased from 88 (2010) to 381 (2013) An increase in NVDs was also noticed in CHARM RHCs	From 56 in 2010 to 82 in 2013

1st Post Natal Visits (PNC 1)	Mean number of PNC-1 in CHARM-BHUs increased by 121% from 207 to 458 in CHARM facilities after intervention	10% increase was seen in PNC visits to non-CHARM BHUs and 7% increase in Control BHUs
Tetanus Vaccination	A declining trend was noted in number of pregnant women receiving TT2 vaccine during the assessment period in CHARM and Control BHUs despite availability of vaccine	
Fully Immunized Children (< 23 months old)	An overall decline was observed in number of fully immunized children (less than 23 months) A lower percentage decline was found at CHARM BHUs compared to Non -CHARM or Control BHUs The mean number of children fully immunized declined by 6% (from 941 to 882) in CHARM BHUs and by 21% (from 369 to 293) in Control districts	
Family Planning Visits	Higher percentage increase was observed in number of family planning (FP) visits at BHUs and RHCs in CHARM districts during assessment period	
Diarrhoea/Dysentery in <5 yrs. old	An overall decline was observed in number of diarrhoea / dysentery cases in under 5 years age group visiting BHUs and RHCs during the assessment period; decline was more significant in Non-CHARM BHUs	
Pneumonia in <5 yrs. Old	An overall percentage decline was observed in number of pneumonia cases treated at facilities in CHARM districts during the assessment period	

4. Outreach Services

As frontline health care workers interacting with the community members, feedback from and assessment of Lady Health Workers (LHWs) and Community Midwives (CMWs)was also solicited.

a. Feedback from LHWs and CMWs

Focus group discussions (FGDs) were used to gain in sights from the community health workers. LHWs and CMWs reported various challenges, such as

- Lack of transportation facilities
- Conflicting roles of CMWs and LHWs due to contradictory approach of objectives of CHARM and MNCH program. (CMWs are required to practice home based deliveries and charge a fee, whereas LHWs encourage women to go to the facilities where no fee is charged and free ambulance services are provided).
- Delayed payments of salaries
- No mechanism for performance based incentives or appreciation for services
- Lack of respect and support from seniors and management

b. Referral Services

LHWs refer clients needing services of SBA with referral slips to facilities, and sometimes accompany them as well. This was reported both at CHARM and Non-CHARM districts. However, more referrals were sent to CHARM district health facilities.

5. Community Perspective

Qualitative data collection methods (FGDs) were used to solicit feedback from the community members.

- Generally there was more acceptability for services provided by the LHWs as compared to CMWs; women also requested that LHWs' scope of work be increased to conducting home deliveries as well.
- General perception about services available at public service facility, including CHARM, was mixed. There was a preference for private facilities due lack of essential functioning equipment (including oxygen, ultrasound), medicines, ambulance services and attitude of healthcare providers at public sector facilities.

a. Client Satisfaction

Exit interviews of five (5) clients were conducted at each of 198 facilities surveyed. A total of 990 interviews were conducted (178 BHUs and 20 RHCs). Most clients availing services at CHARM BHUs and RHCs were satisfied with the level of care received. Perceptions of community noted during focus group discussions were less positive than noted through Eis. No significant variation was observed in the responses of clients attending BHUs or RHCs; whether CHARM or Non-CHARM.

The results are summarised as under

- Over 70% clients were able to reach Health Facility (HF) within 30 minutes
- Over 80% reported that waiting time was <15 minute
- Education material was received by <15% at BHUs and by less than 10% visitors at RHCs
- Over 85% preferred public sector facility for treatment
- Over 50% preferred public sector HF for proximity to home and good care

b. Knowledge and Skills Assessment of LHVs

A hundred and seventy eight BHUs and 20 RHCs were visited at 7 CHARM and 2 non-CHARM districts to assess knowledge of LHV posted at each facility. The skill set of care providers was observed on adherence to Active Management of Third Stage of Labour (AMTSL) protocols by the concerned LHV during management of labour.

- Only 48% LHVs of sampled BHUs scored more than 50% in knowledge test
- LHVs of CHARM BHUs performed relatively better in areas of antenatal, natal, post natal care of mothers; while most LHVs of non-CHARM BHUs performed better in area of immediate post-partum new born care.
- Skill assessment of LHVs, based on direct observation on adherence of AMTSL protocols revealed that LHVs of CHARM and Non-CHARM BHUs were better trained than LHVs of control group.

7. Value for Money

A financial and value for money (VFM) analysis was undertaken to identify all possible impacts of CHARM interventions in context to efficiency and cost effectiveness.

Government of Punjab supported 80% of the operating cost (salary and non-salary) of CHARM BHUs while 18% was by UNICEF & UNFPA and 2% was through indirect support in form of ambulances.

Table 5: Value for Money analysis

Unit	CHARM BHU	Non-CHARM BHU
Average cost per annum	PKR 4.76 million	PKR 3.22 million
Average cost per month	PKR 396976	PKR 268228
Average Out-patient unit cost	PKR 244	PKR 183
Benefit to Cost Ratio (BCR)	1.03	1.26
BCR = 1, benefit and cost are equal; <1 (Less than one) = cost is more than benefits; >1 (above than one) = benefits are more than cost.		

The benefit to cost ratios indicated that both CHARM and Non-CHARM BHUs are cost effective interventions, providing more value for the money invested.

Recommendations

CHARM initiative has been successful in achieving most of its objectives; based on this up-scaling and expansion may be considered. However, systematic efforts could further improve value for money. Recommendations for improvement are as below

1. Improved Governance and Management

- Realign CHARM Policy with Punjab Health Sector Strategy (HSS) and MNCH Policy
- Empower administrative authority of EDOH, including hiring & firing of staff
- Ensure implementation of Essential Health Services Package

2. Strengthen Human Resources

- HR Planning should focus on developing skills and capacity through regular trainings and filling vacant posts

3. Healthcare Financing – Focus on Equity

- Ensure equitable distribution of resources through need based budgetary allocations
- Enhance fiscal authority of district managers to warrant evidence based planning and budgeting

4. Enhanced Monitoring and Evaluation

- Refine M&E framework, mechanisms and its operational guidelines
- Develop and institutionalise a supportive supervision framework
- Ensure availability of operational guidelines at each health facility so that health care providers adhere to optimal service delivery standards

5. Networks and Linkages

- Improve the LHW and CMW linkage for ensuring home-based through SBAs and timely referrals
- Clearly define mechanisms for coordination and collaboration with in the public sector including PRSP, LHW program, MNCH program and other existing health systems
- Strengthen the referral system

CHARM initiative has achieved some of its objectives and may be up-scaled and expanded to other districts. However, there is a need to improve systematic factors to further improve value for money. The design of the CHARM Model 'needs to be refined in accordance with the evaluation results and ensuing recommendations. The project design lacked emphasis on capacity building of HCPs. Scaling up of this intervention should be aligned with HSS and MNCH programme. A robust M & E system must be in place to monitor the progress of planned activities and gauge outcomes and impact of the program. Moreover ownership and empowerment (administrative and fiscal) of districts should be ensured, as it is essential for successful implementation of planned activities for desired results.

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