



**Provincial Report of
1st Quarter 2012**

**A Report Based on
24 Districts**

**In
Khyber Pakhtunkhwa**

FOREWORD

It gives me great pleasure to be a part of a team that has started preparing the Quarterly Reports of DHIS on a regular basis and I hope the effort and the desire to improve continues. The team's dedication has inspired me in person and made me appreciate the value of information sharing. We have come a long way from presenting crude data to the age of analyzing the same and attempted to find tangible results from the available resources. Our colleagues from all other programs, the Health Directorate and the Health Secretariat have not been miserly in encouraging us to improve further. The invaluable contributions have added to the clarity and value to the reports though the process is still in its infancy and there is plenty of room for improvement. The generosity of our colleagues in other programs sharing their immense knowledge and experiences shall add to the improvements in the reports and it is hoped that this joint venture shall add further impetus to spirit of cooperation and enterprise. It also came as a pleasant surprise to note that the management of the three teaching hospitals in Peshawar and three prominent Non- Governmental Organizations responded promptly to assist this program in data collection, their cooperation deserves our appreciation.

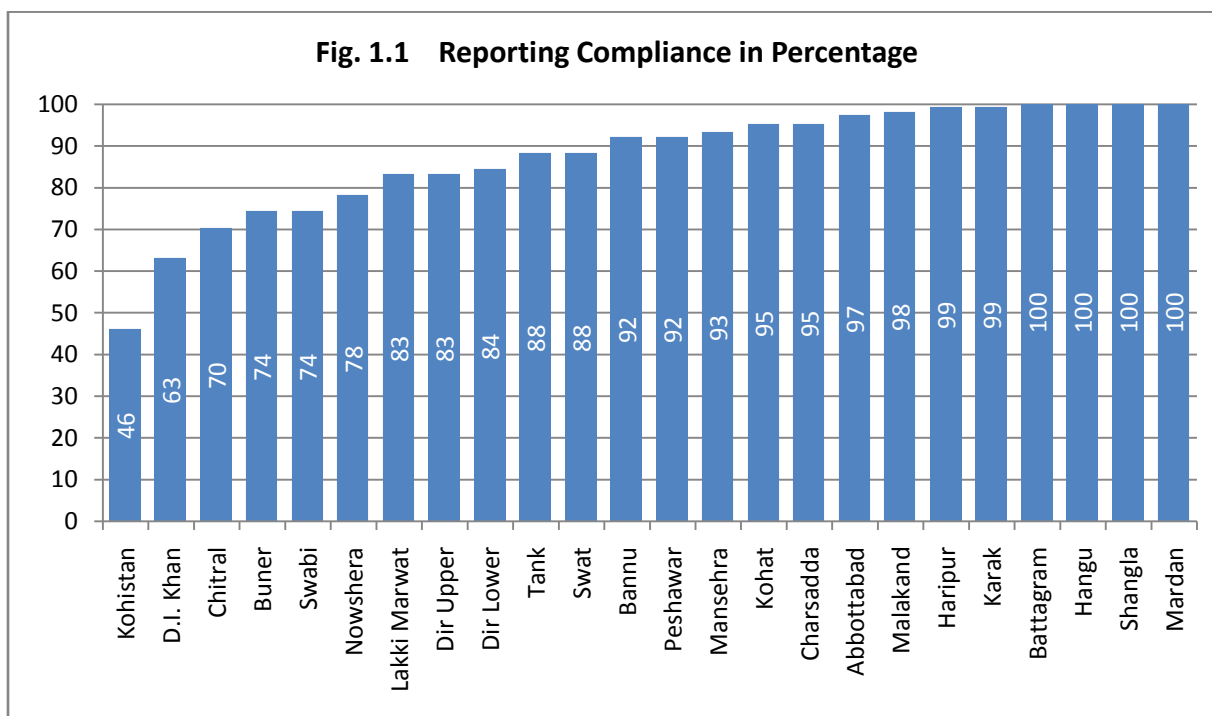
Though the program still has a long way to go towards its ultimate aim of gathering all the health related data for analysis the beginning is indeed encouraging. The new PC-1 is in the anvil to address some issues still hampering the project and to make changes in the both the reporting format and means of transmission of reports and to make it more user friendly with the utmost possible reduction in the paperwork. An integral part of the software improvement would be the direct reporting through an interface provided to all the users including all the districts as well as the programs. Forays have been made into uncharted territories to sensitize the partners towards the projection of their activities and to further encourage them to maintain their own data banks and share them.

It is hoped that the discerning reader would find subtle improvements in overall data management and the credit is richly deserved by the reporting institutions and we appreciate the value of their endeavors. The quarterly format for data presentation would be done away in consultation with partners and it would become a bi-annual feature with the addition of several other indicators like the rate of infections in indoor patients and a mortality audit would be encouraged in all reporting facilities. A small presentation would be made in the next coordination meeting regarding the up gradation of the software. Inputs from the colleagues are a source of strength and inspiration for us and I hope they do continue their assistance. For the convenience of the reader the old format for narrative shall continue for this and the next quarterly report and then when the reports become a bi-annual feature several changes shall be incorporated. An attempt has been made to use a non-technical language where ever possible in the text to facilitate our colleagues in other department to appreciate the significance of the program and to add their valuable inputs.

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1. REPORTING COMPLIANCE

As per the forecast of our previous the Reporting compliance has shown a consistent improvement and some districts have outpaced the others in prompt reporting. Fig. 1.1, 1.2 shows the graphic presentation of the reporting trends.



It can be seen that out of the 24 districts reporting, 10 have posted a figure of more than 95% compliance which is a great improvement on the previous report where only 4 districts have crossed the 95% limit. This time only two districts have been below par with a reporting compliance rate of less than 70%. It is heartening to note that districts like Nowshera have improved by leaps and bounds and its reporting compliance has gone up from a dismal 31% in the previous report to a much improved figure of 78% and matching the general trend.

Four districts have done extremely well on this parameter i.e. Mardan, Shangla, Hangu and Battagram whose compliance rates are 100% whereas the one best districts mentioned in the previous report i.e. Swat has gone down to 88% but for a plausible reason with problems in the software but it is hoped that it will top in reporting compliance in the days to come after the repair of the system by this office.

A perennial source of worry is the reporting compliance from the district of Kohistan which had only 55% compliance in the previous quarter has dropped down further to a dismal 46% this quarter. Another source of worry is the compliance shown by Dera Ismail Khan where reporting compliance has down from 72% in the previous quarter to 63%. Surprisingly the two districts with poor reporting have no similarity in geography, demography or culture and customs, while Kohistan is a remote underdeveloped district of the province; Dera Ismail is a relatively well off district with a much improved socioeconomic status since the start Chasma Right Bank Canal and easy accessibility through the National Highway. Reasons for this have to be determined.

Fig. 1.2 Reporting Performance based Grouping.

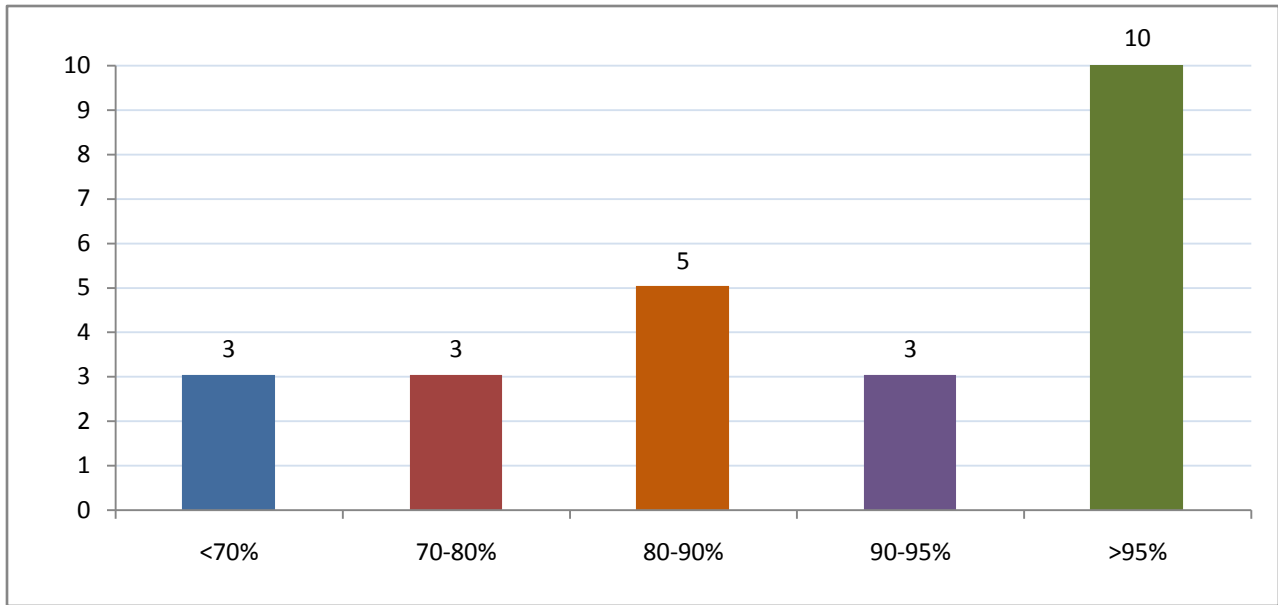
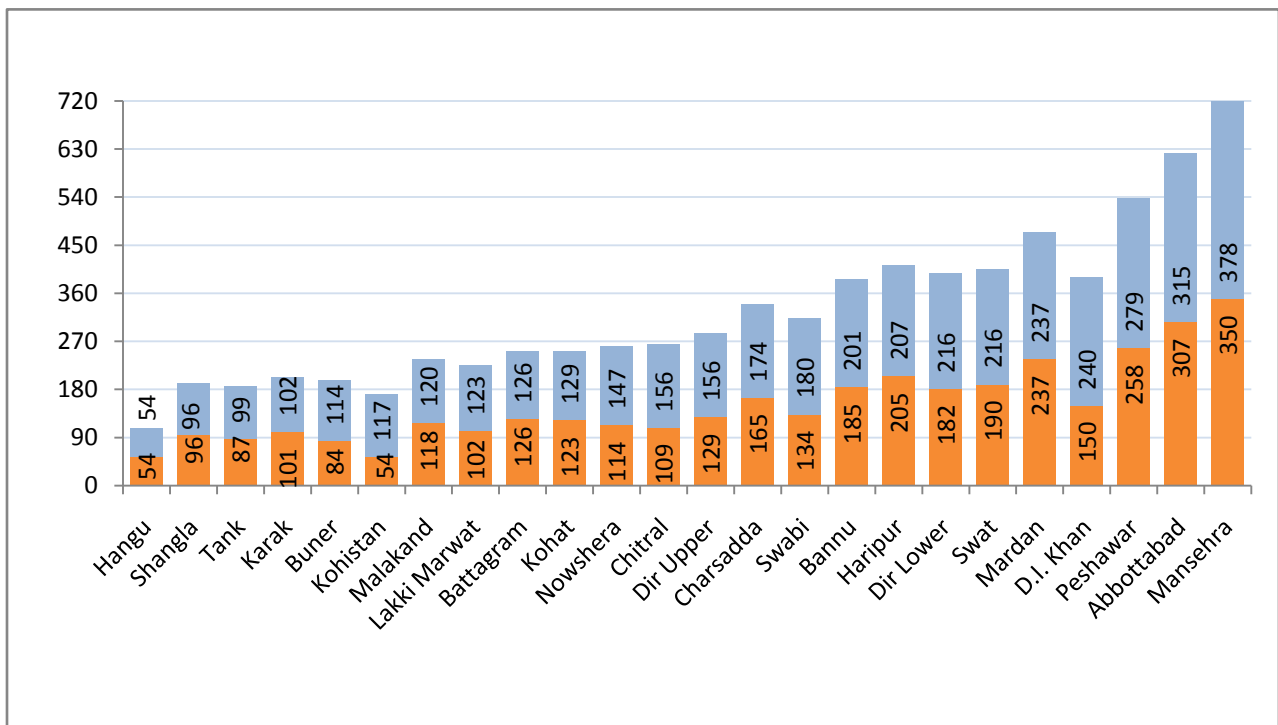


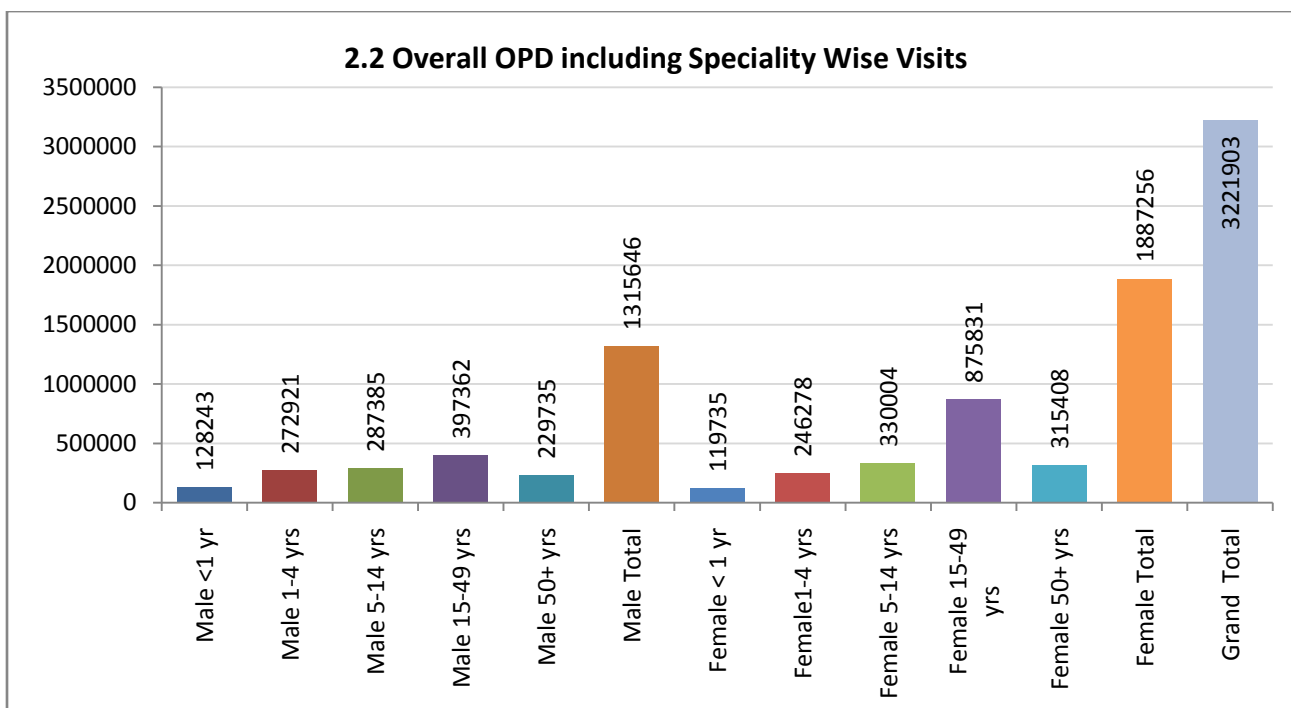
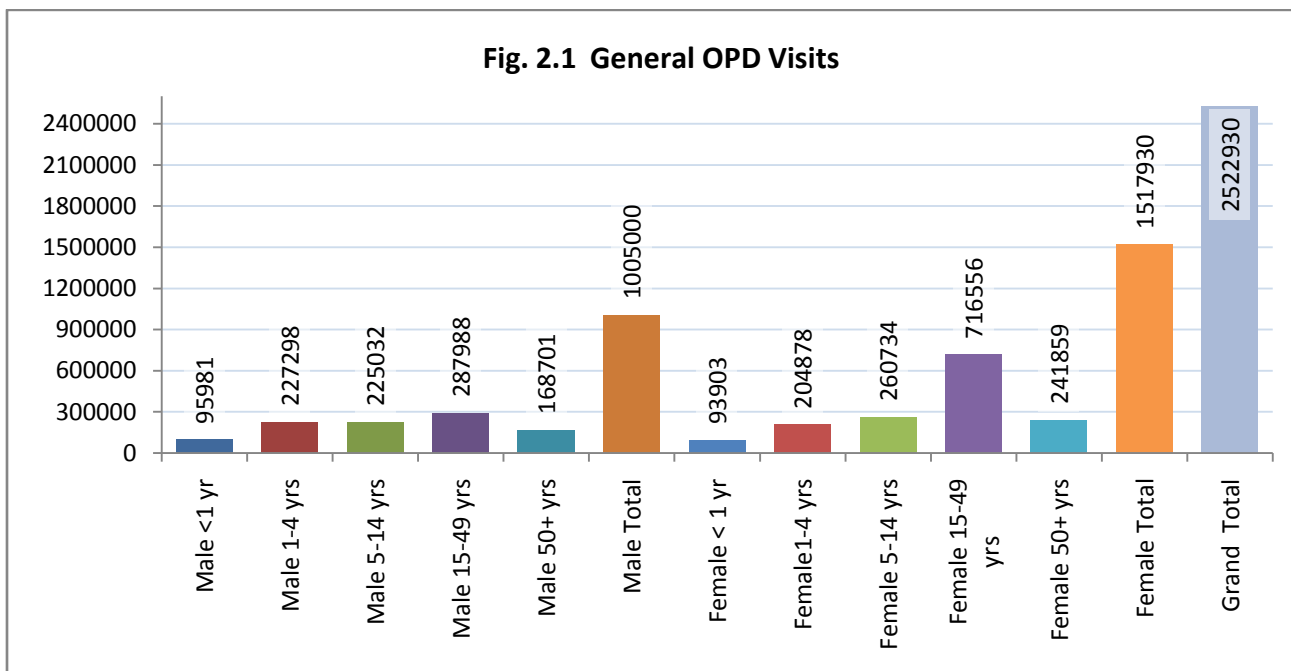
Fig. 1.3 Detail Breakup of Expected Reports and Received Reports from Districts.



On the part of the program this indicator reflects the commitment, zeal and vigor of the reporting staff as well as the adequacy of the trainings imparted to them. This project would continue to encourage the staffs involved in this activity and ensure that the timely support services are available from the project.

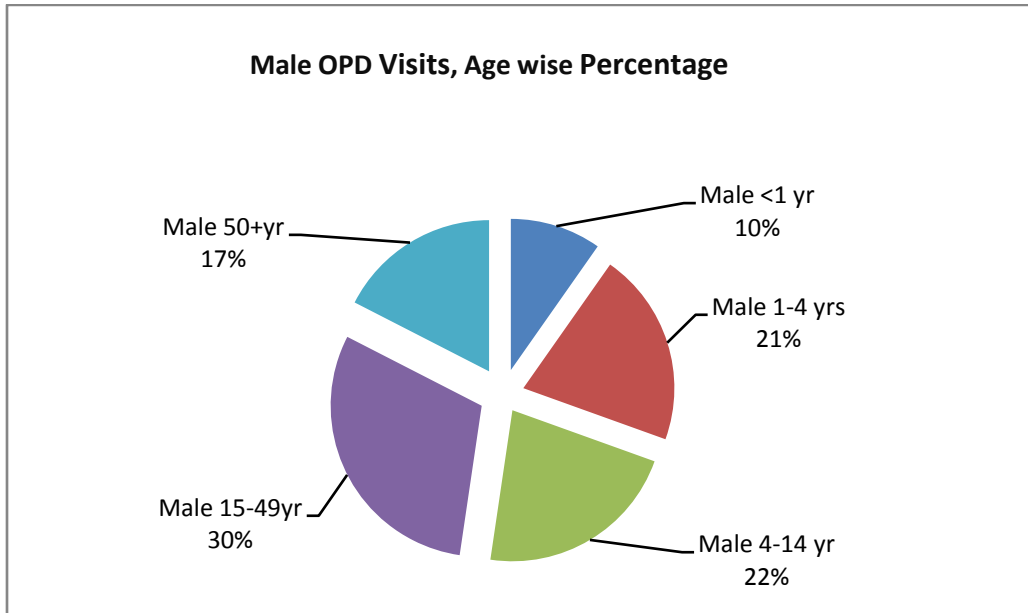
2. OUTPATIENT ATTENDANCE (OPD)

Fig 2.1 and 2.2 represent the graphic presentation of the total number of Outpatients utilizing the government health facilities. Total number of patients in the OPDs has registered a minor increase from the previous quarter i.e. 2522930 Vs 2345978 and the total number of patients including the Specialist visits has risen to 3221903 compared to 2829110 in the previous quarter. Even if the data from the Tertiary care facilities is added it would emerge that the generally held view that 30% of the patients utilize public facilities is based on a myth and the number being far lower than the generally accepted figures, though further observation is still required to find a consistent pattern.

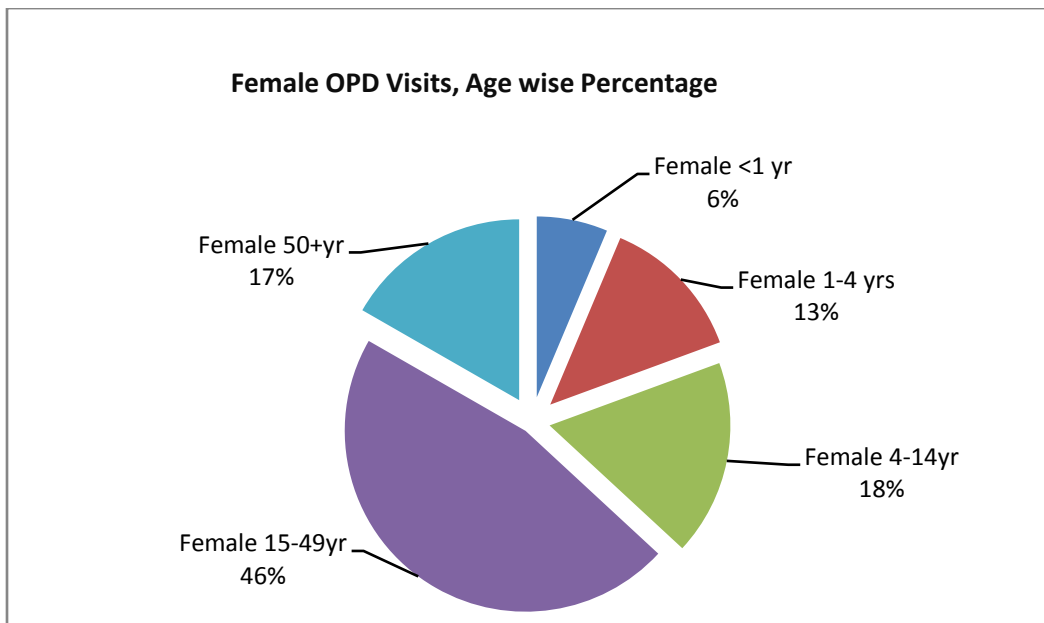


The Age wise breakup of the data once again the corroborates the figures of the previous quarter and it is seen that a full 45% of the patients are below the age of 15 years with others following the same pattern as per the last quarterly report. A Gender wise analysis of the figures reveals that more women utilize the facilities than men 59% vs. 41%.

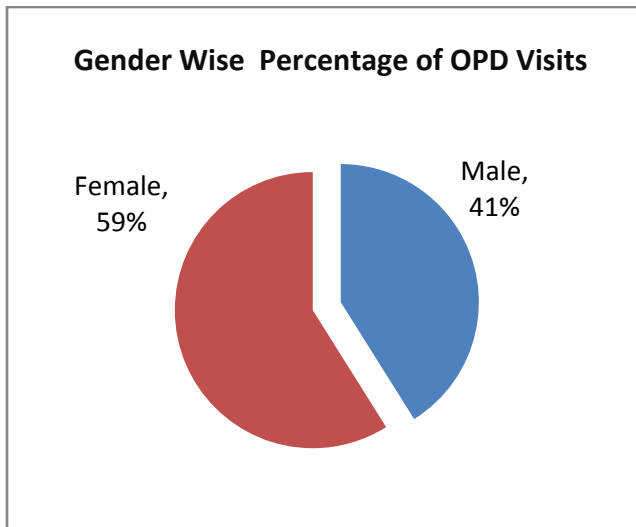
2.2. a. Male OPD Visits, Age wise Percentage



2.2. b. Female OPD Visits, Age wise Percentage

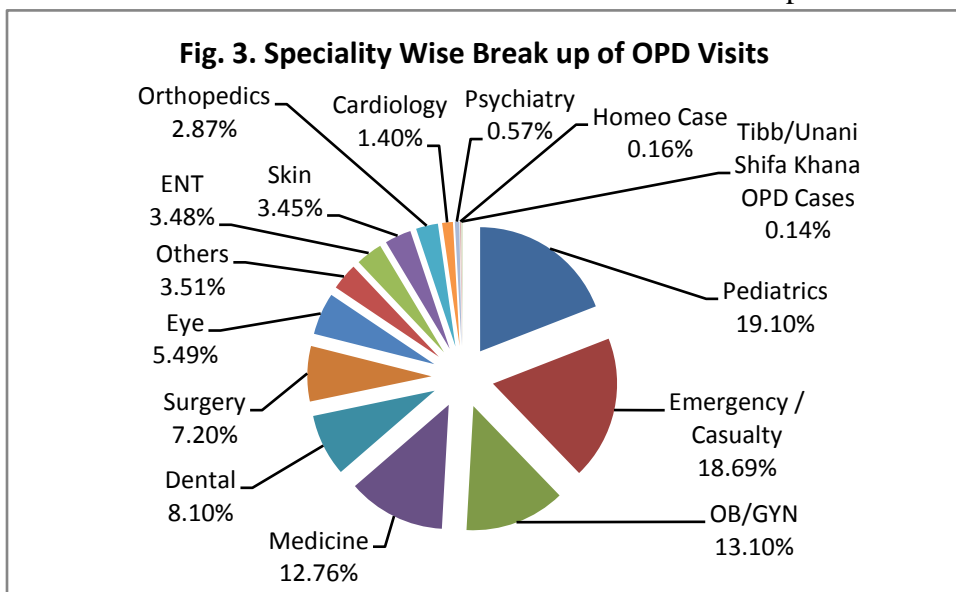


2.2. c. Gender Wise Percentage of OPD Visits



3. SPECIALTY WISE BREAKUP OF PATIENTS.

Fig 3 and 3.1 reveals the Specialty wise distribution of patients. Unfortunately the continual trend witnessed in the previous quarter regarding the visits to Hakims and Homeopaths in the government hospitals, out of the total patients attending the General OPDs i.e. 2522930 only 964 patients visited these professionals, comprising only 0.3% of the caseload, that is even worse than the figures reported in the previous quarter that is 0.33% and it can be assumed that the trend would continue in the coming months and the whole idea of having the Hakims and Homeopaths in the Government institutions would become redundant in the near future. Despite the introduction of the Output Based



Budget it is felt that much needed funds required in the sector elsewhere is being thrown into this bottomless pit. A serious debate is required and decision taken to offload this totally unnecessary burden which was created in the first place for considerations other than professional.

The figures for Psychiatric consultations are below the expected rate standing at less than 1% in both the reporting quarter. The worldwide figures are at around 60% of all medical visits and Pakistan along with this province would show a similar rate. Can this be attributed to the absence of Psychiatrists in the District Health setups or some other unfathomable reason could explain this that is

not clear. It is expected that the situation might take a turn for the better by stationing of proper staffs at the DHQs after current lot of Specialists is inducted into service albeit on an ad hoc basis.

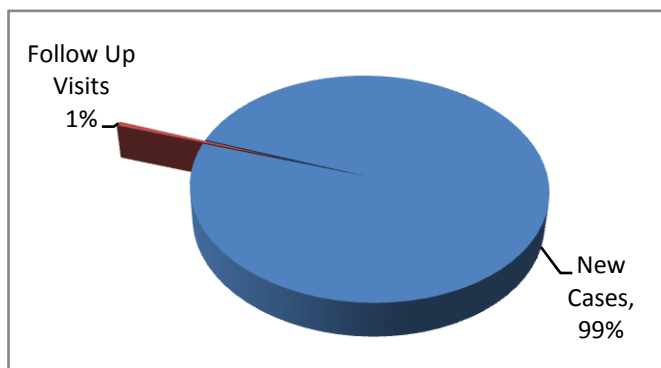
S#	Specialty	Total Visits
1	Pediatrics	133656
2	Emergency / Casualty	130838
3	OB/GYN	91663
4	Medicine	89278
5	Dental	56677
6	Surgery	50373
7	Eye	38406
8	Others	24587
9	ENT	24372
10	Skin	24130
11	Orthopedics	20078
12	Cardiology	9828
13	Psychiatry	3999
14	Homeo Case	1088
15	Tibb/Unani Shifa Khana OPD Cases	964
	Specialty Total	699937

Fig.3.1
Pediatric consultations constitute the largest group of patients at 19.1% of the total patients following the general trend of OPD patients. It would be interesting to find out the number of children needing admissions as indoor patients and the breakup of the disease pattern. Now having defined the largest group of patients visiting the health facilities and it would be worthwhile to find how much of the budget for procurements is used for this specific population group though there might be some overlap especially in the use of intravenous antibiotics that are also used by the adult population.

The percentage of dental patients is 8.10% which is a much nigner percentage than reported in the previous quarter. It can be expected that only the people from the lower strata of the population uses the public facility for dental treatments. The prohibitive cost of private dental treatment would be a major incentive in inducing the public to use the government facilities in this specialty. A valid question would be to assess the resources being allocated for dental treatment and procedures and necessary corrections should be made in line with the objectives of the Output Based Budgeting with up gradation of the current facilities to the minimum basic requirements of dental requirement.

4. NEW VISITS AND FOLLOW UP VISITS

Figure 4 reflects the number of patients visiting the OPDs for the first time and the numbers of patients visiting as follow up patients. Surprisingly only 1% of the patients make a follow up and the other 99% patients are declared as new patients putting a serious question mark on the incidence and prevalence of any disease. **Fig.4.**



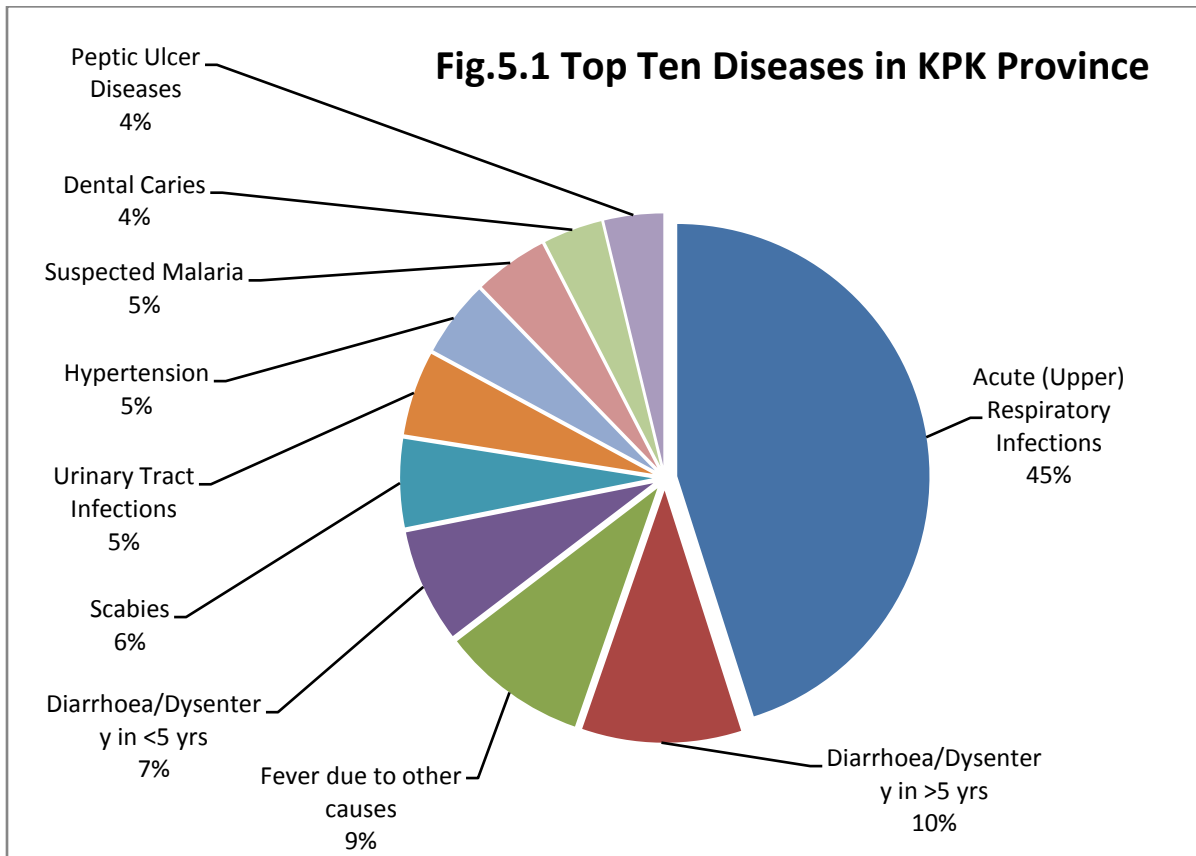
This ludicrous state of affair calls for a serious inquiry to determine a reason for this. Two reasons can be forwarded for this serious error in the data collection firstly that the medical staffs at the facility are unaware of the importance of the data in this regard and the second plausible reason for this could be the lack of trainings of the staffs on this instrument. An effort shall be made to address both these issues.

5. DISEASE PATTERN IN OUT PATIENT DEPARTMENT.

Fig.5.

S#	Diseases	No. of Patients
1	Acute (Upper) Respiratory Infections	691325
2	Fever due to other causes	143497
3	Diarrhoea/Dysentery in <5 yrs	110601
4	Diarrhoea/Dysentery in >5 yrs	89118
5	Scabies	86281
6	Urinary Tract Infections	82289
7	Hypertension	73946
8	Suspected Malaria	72217
9	Dental Caries	58357
10	Peptic Ulcer Diseases	57542
11	Worm Infestations	46875
12	Pneumonia <5 years	44008
13	Pneumonia >5 years	32847
14	Asthma	30277
15	Dermatitis	26040
16	Otitis Media	25867
17	Depression	24775
18	Diabetes Mellitus	24593
19	Enteric / Typhoid Fever	21022
20	Road traffic accidents	14871
21	TB Suspects	11119
22	Cataract	8770
23	Chronic Obstructive Pulmonary Diseases	8223
24	Fractures	7689
25	Dog bite	4684
26	Suspected Viral Hepatitis	4017
27	Ischemic Heart Disease	3906
28	Trachoma	3702
29	Burns	3577
30	Suspected Measles	2505
31	Nephritis/Nephrosis	2438
32	Sexually Transmitted Infections	2392
33	Epilepsy	2316
34	Benign Enlargement of Prostrate	1708
35	Drug Dependence	1624
36	Cirrhosis of Liver	1618
37	Suspected Meningitis	1226
38	Cutaneous Leishmaniasis	1133
39	Glaucoma	1096
40	Suspected Neo Natal Tetanus	626
41	Suspected HIV/AIDS	477
42	Acute Flaccid Paralysis	187
43	Snake bites (with signs/symptoms of poisoning)	97
Total		1831478

Fig 5 and 5.1. illustrate the pattern of disease burden in the facilities. As expected Acute ARI still constitutes at 45% still constitutes the largest group of patients visiting the health facilities. As previously elaborated that there might be some overlap with conditions like Asthma especially the Childhood Asthma which as per prevalent practice it is still treated with antibiotics without any scientific rationale. Having conceded an overlap the numbers affected by ARIs is quite significant and deserves attention in planning, trainings and procurements.



Diarrhea and Dysentery in patients <5years and >5years is another very important group of patients comprising 17% of the case load. A pertinent observation is that somehow children >5 years of age have a higher incidence than those <5 years i.e. 10 Vs 7%. The combined case load of ARI and Diarrhea/ Dysentery would constitute a total of 62% of all the patients visiting the government facilities and a serious soul searching would be required on the part of all concerned to assess the allocations for the management of these major causes of mortality and morbidity. Health Education would be another critical area of intervention to bring this case load down to an acceptable levels and a close coordination would be required with other related department to evolve a strategy for the control of these disorders.

As discussed earlier Scabies at 6% of the caseload constitutes a major group which though not fatal in the short term is a major cause of morbidity and with a potential for rapid spread within the households and closely knit communities. In this case health education would be required for the community and the medical professionals have to be sensitized to issue and adequate trainings at the provincial level have to be provided to ensure prompt and rational treatment with then necessary budgetary support provided in the institutions. It is one of the few diseases whereby health education, hygiene and proper management of the episode of illness can result in dramatic improvements in the overall prevalence.

As mentioned earlier in this report the prevalence of Dental Caries/ Dental disorders stands around 4% and the recommendations made earlier may be put into practice of alleviate the sufferings. Some words about the diseases that are not represented in the graphics. Though Dog bites whether rabid or not constitute only 4684 or 0.25% but considering the devastating results that can ensue from the rabid dog bite it should be mandatory to have the latest vaccines at all DHQs and the cumbersome process in use at presently should be done away immediately to ensure certain access to the treatment. It should be ensured that proper anti-sera against snake bites should be available at all large facilities and small facilities despite the fact that the number of cases is small but it will not cost much to have a provision for proper treatment.

Another alarming fact emerging out of this quarter's figures is the more than five-fold increase in the number of suspected HIV/AIDS going up from 97 in the previous quarter to 477, and if the figures from the Tertiary Care Hospitals and NGOs are added the total comes to 489 which is a significant number by all standards though it is not clear whether the data is from the high risk groups or from the healthy volunteers and the reader would notice that the data from the Tertiary Care facilities and NGOs is from the healthy donors apparently. With the AIDS Control Program in difficulty from various fronts vis-à-vis finances and other issues, a critical analysis is required and prompt response is in order and the most proper scenario would be for the provincial government to take up the full responsibility of the program till such time that other donors/ agencies step in to take up the responsibility but this current state of uncertainty should be resolved immediately.

The appearance 626 cases of Suspected Neonatal Tetanus is another cause of major discomfort. With the ambitious aim of bringing down the cases to zero and a variety of interventions in the areas of Maternal and Neonatal health the figures are indeed disappointing. Concerns would be raised since the figures from the Afghan Refugees Health Program reveal not a single case of NNT has been reported in this quarter and comparison with our plethora of programs in this area that are providing interventions in the Government sector the results have deteriorated from the previous. It reflects very poorly of the preventive efforts in the public sector judging from the outstanding success of the much smaller refugee's sector health program.

It is also high time to rid of the jargon used to define patients of Hepatitis and Malaria with the word "SUSPECTED" totally deleted otherwise the justifications for funding the diagnostic facilities in the government would be stupendous waste. The program managers must come up with plans to utilize the funding and provide a clearer picture of diseases like Malaria and Hepatitis with the types clearly defined. Any gaps in the provision of diagnostic services in this area have to be filled on a priority basis though it has to be said both these disease very few high-tech instruments and equipments but extensive trainings would be required.

Cutaneous Leishmaniasis is making a comeback with figures of 1133 cases reported this quarter. It is hoped that with the launch of the program for the control of all disease vectors significant strides would be made in the control of this disease and not responding to sensational stories in the press. A close coordination would be required between the Health Department, the Afghan Refugees Health

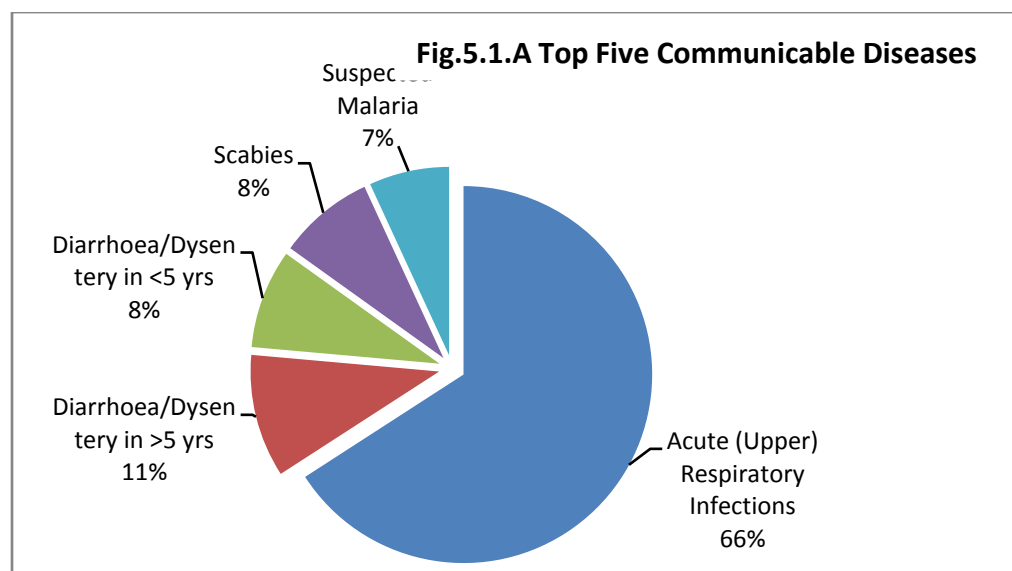
Program and the institutions working with the IDP to control the spread before any formal program is launched in the sector which of course would take some time to take off.

5.1 Diseases Breakup (Communicable & Non-Communicable)

The breakup of the diseases in the form of **Communicable** and **Non-Communicable** Diseases is illustrated in Fig 5.2, 5.3 and 5.4. The narration has already been recorded earlier and these figures are included to make a comprehensive picture of the disease prevalence.

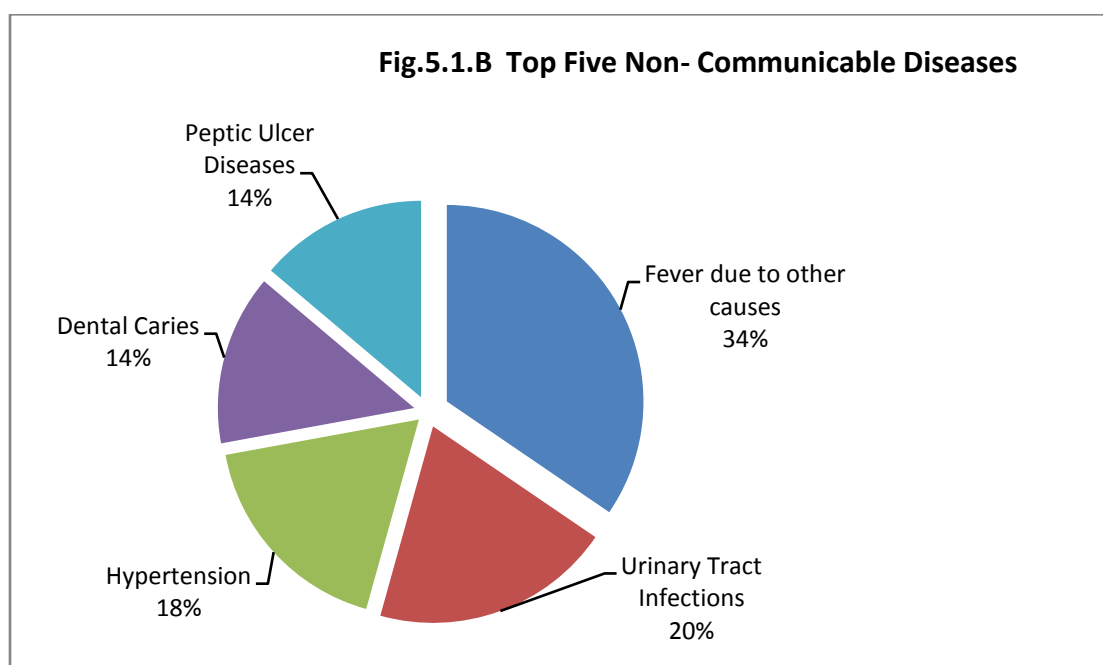
A. COMMUNICABLE DISEASES

S#	Diseases	No. of Patients
1	Acute (Upper) Respiratory Infections	691325
2	Diarrhoea/Dysentery in >5 yrs	110601
3	Diarrhoea/Dysentery in <5 yrs	89118
4	Scabies	86281
5	Suspected Malaria	72217
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17	Suspected Neo Natal Tetanus	626
18	Suspected HIV/AIDS	477
19	Acute Flaccid Paralysis	187
	Total	1221678



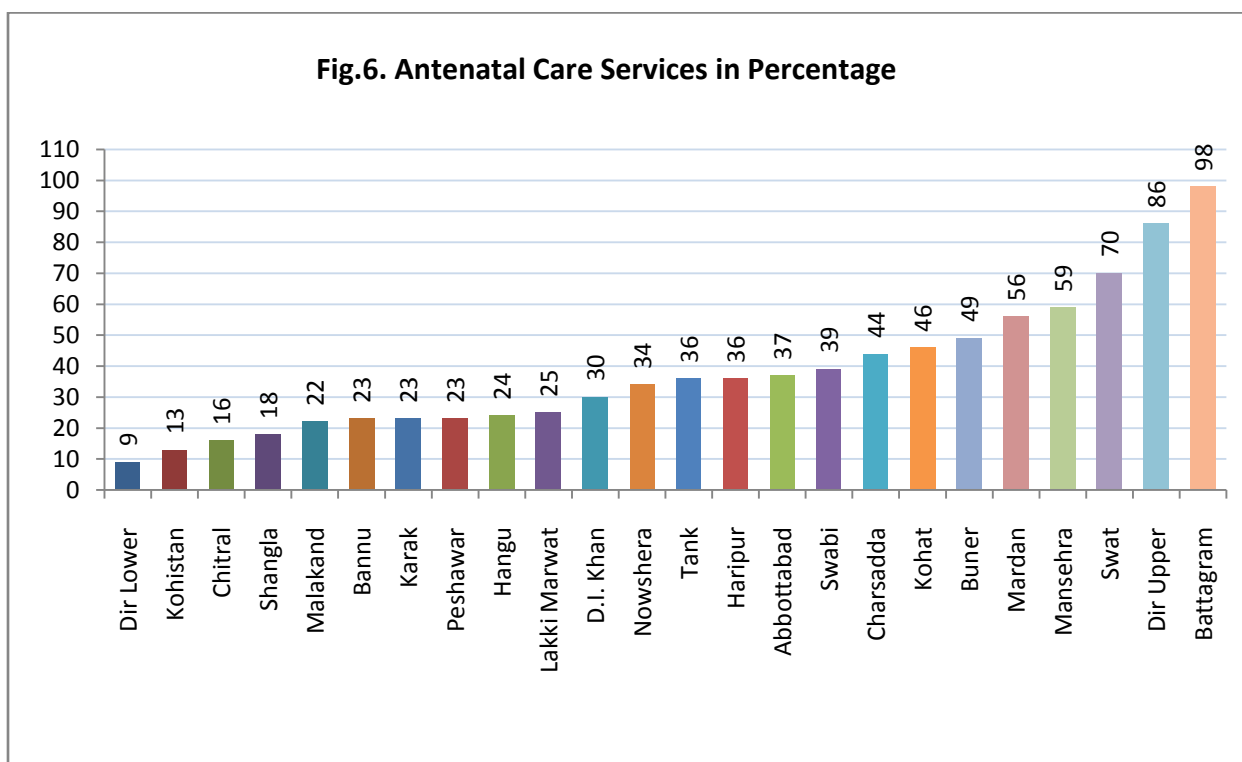
B. NON-COMMUNICABLE DISEASES

S#	Diseases	No. of Patients
1	Fever due to other causes	143497
2	Urinary Tract Infections	82289
3	Hypertension	73946
4	Dental Caries	58357
5	Peptic Ulcer Diseases	57542
6	Asthma	30277
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19	Epilepsy	2316
20	Benign Enlargement of Prostrate	1708
21	Drug Dependence	1624
22	Cirrhosis of Liver	1618
23	Glaucoma	1096
24	Snake bites (with signs/symptoms of poisoning)	97
Total		609800



6. ANTENATAL CARE SERVICES

ANC services form the backbone of any reproductive health initiative and accepted as one of the most important areas of interventions in the maternal and child health program whereby the outcome improves dramatically by timely provision of ANC. The full ANC coverage would include regular contact between the expectant mother and her health care provider, would provide an opportunity to immunize the mothers against various disorders, monitor any medical conditions that may cause deterioration in the outcome of pregnancy.



Examining figures 6 and 6.1 provides an insight into the state of affairs in relation to this parameter. Dir Lower remains a standout district and tops the list of the districts doing woefully short of expectations, the 9% antenatal coverage is dismal, to put it mildly. This office shall look at the budget being provided to this district to compare the resources and the performance. The reasons for this performance are hard to fathom and clearly not beyond the control of the health department and remedial measures are required. It has done even worse than Kohistan which is the second from the bottom (13%) in this area. Even if a charitable view of the figures is taken 11 districts have a performance at 30% or below including Peshawar reporting ANC coverage of 23% which is indeed surprising even if the presence of large network of private health care providers is present in the area. Not surprisingly all the poor performers have been mentioned elsewhere in the report suffice to say here that a review is required to ascertain the reasons for this output and hopefully the office responsible for the dispensing of the performance based budget will look into this matter from a cost benefit aspect as well.

Fig.6.1

S#	District	Total Population	Exp Pregnancies in a Month	% ANC for Jan	% ANC for Feb	% ANC for Mar	Average %
1	Dir Lower	1124000	9554	2.54	6	19.47	9
2	Kohistan	478000	4063	16.76	12.7	8.05	13
3	Chitral	444000	3774	18.2	21.14	7.95	16
4	Shangla	667000	5669	19.42	16.83	18.84	18
5	Malakand	703000	5975	24.65	22.54	20.03	22
6	Bannu	980000	8380	19.2	28.45	22.47	23
7	Karak	661000	5618	24.99	22.85	19.92	23
8	Peshawar	3219000	27361	22.61	19.92	26.23	23
9	Hangu	482000	4097	4.03	11.94	57.26	24
10	Lakki Marwat	742000	18550	19.98	21.02	34.77	25
11	D.I. Khan	1308000	11118	26.52	15.6	47.76	30
12	Nowshera	1280000	10880	35.87	31.49	35.27	34
13	Tank	359000	3051	48.86	40.7	19.17	36
14	Haripur	924000	7854	34.72	34.99	37.36	36
15	Abbottabad	1120000	9520	35.29	37.85	37.97	37
16	Swabi	1515000	12877	26.23	48.78	42.54	39
17	Charsadda	1493000	12690	36.12	47.33	47.21	44
18	Kohat	862000	7327	64.32	33.98	40.37	46
19	Buner	838000	7123	51.47	40.73	54.04	49
20	Mardan	2168000	18428	56.29	44.8	65.88	56
21	Mansehra	1582000	13447	50.49	45.56	79.85	59
22	Swat	1956000	16626	69.31	52.29	89.88	70
23	Dir Upper	828000	7038	70.67	101.71	86.83	86
24	Battagram	422000	3587	95.01	102.2	97.77	98

The top performing district with the ANC coverage in excess of 50% are just five with the rest falling in between. Battagram unsurprisingly retains its tops position in this area Dir Upper the second best coverage district. As the reader would recall all the indicators that are currently listed in the DHIS and the ones that will follow shall show a consistent trend in performance of the districts measured in light of the coverage. In this case it is clearly visible that districts that are matching well in other areas of healthcare are better off here i.e. Swat and Battagram which have done well in other areas like EPI. The trend is not visible from the reports of Dir Upper which has no significant performance in other areas but has good performance in ANC; this office is trying to find a reason for this inconsistency.

7) DISTRICT WISE COMPARISON OF PREGNANT WOMEN HAVING THE FIRST ANC WITH AN HB< 10 %

This indicator reflects the general nutritional status of the population especially that of the pregnant in particular and women in general. The configuration of the data reveals that the districts who have registered the maximum of the pregnant women for ANC have a higher percentage of the women suffering from the disorder. The importance of this indicator accrues from the fact that this is an easily treatable disorder despite its linkage to the other socio-economic indicators.

Kohistan and Chitral reporting 0% cases clearly indicating the Hb level are not determined at all. The rest of the districts follow the general trend whereby more Ante Natal bookings show a greater number of patients suffering from the disorder. The performance of Swabi and Tank are commendable at 40.8% and 38.25% respectively. Though Mardan has most number of booking for ANC the rate of anemia is at 8.95% generally indicating figures for a relatively well off population though vigilance and prompt treatment would still be required. Swat has similar figures for the disorder and it is expected that the figures would fall further in the last quarter due to the active interventions of the health staffs.

Fig.7. District Wise Breakup of Pregnant Women Having HB<10g/dl

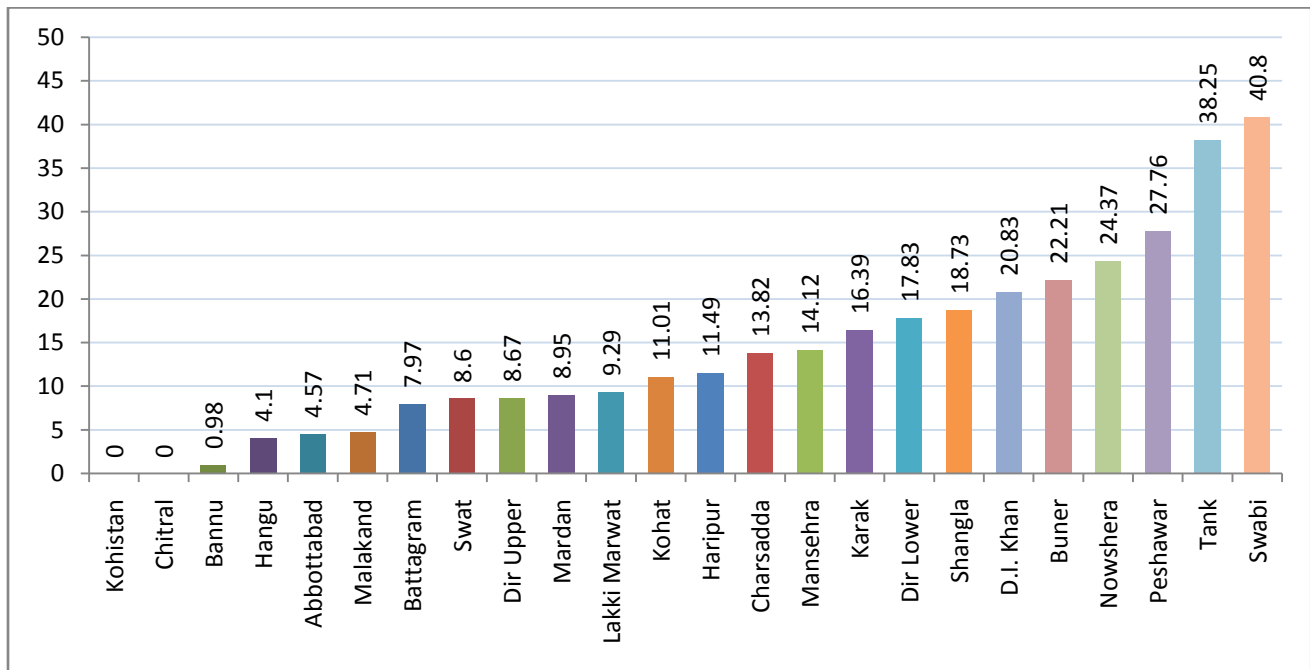
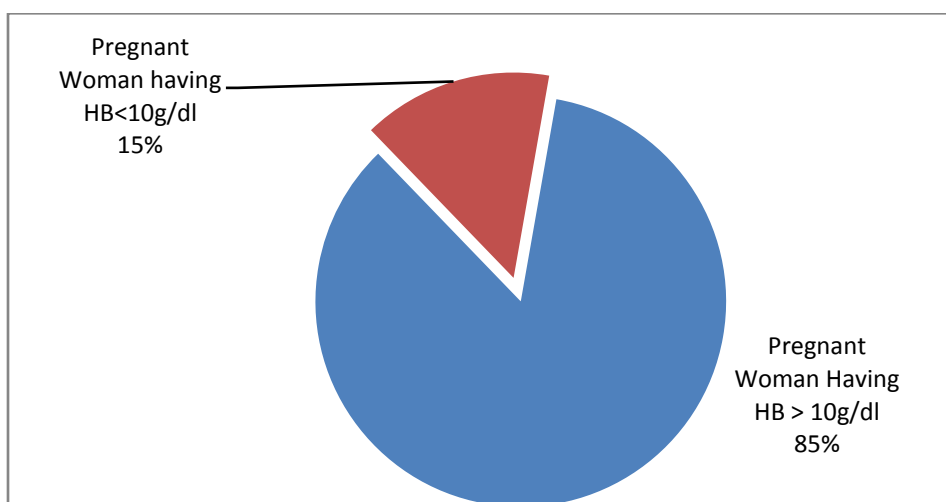


Fig.7.1

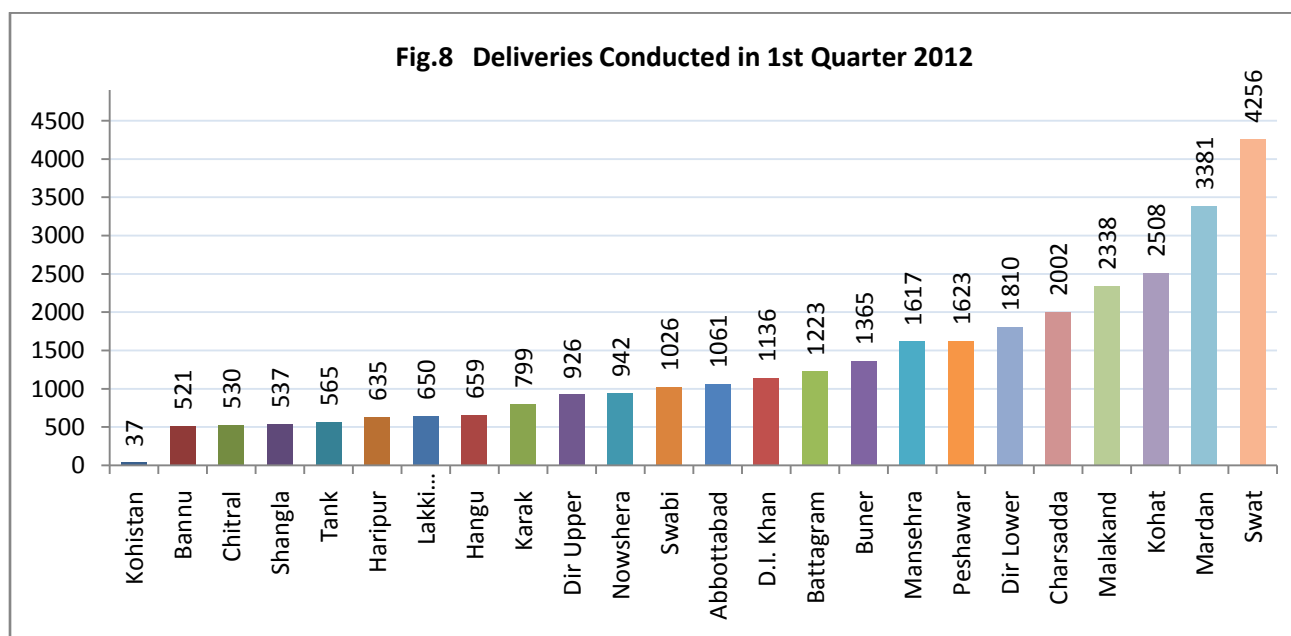


District wise breakup of ANC-1 with Hb.<10 g/dl is given in the table on next page.

Fig.7.2

S#	Districts	(ANC-1)	ANC-1 with Hb.<10 g/dl	Percentage
1	Kohistan	508	0	0
2	Chitral	595	0	0
3	Bannu	1947	19	0.98
4	Hangu	1000	41	4.1
5	Abbottabad	3526	161	4.57
6	Malakand	1339	63	4.71
7	Battagram	3527	281	7.97
8	Swat	11720	1008	8.6
9	Dir Upper	6081	527	8.67
10	Mardan	10257	918	8.95
11	Lakki Marwat	1593	148	9.29
12	Kohat	3387	373	11.01
13	Haripur	2803	322	11.49
14	Charsadda	5527	764	13.82
15	Mansehra	7884	1113	14.12
16	Karak	1269	208	16.39
17	Dir Lower	892	159	17.83
18	Shangla	1041	195	18.73
19	D.I. Khan	3331	694	20.83
20	Buner	3472	771	22.21
21	Nowshera	3722	907	24.37
22	Peshawar	6271	1741	27.76
23	Tank	1106	423	38.25
24	Swabi	5046	2059	40.8

8. DELIVERIES CONDUCTED IN GOVT FACILITIES



This indicator has been included in the report to highlight the response of the general public towards the use of facilities being provided by the public sector. As the reader would realize there is no dearth of funding for up gradation of various health facilities during any given financial year but the optimal utilization of these facilities especially those related to the reproductive health remains an elusive goal. It is also not clear whether pregnant women with complications arrive at government centers or some percentage also come for normal deliveries. **Fig.8.1**

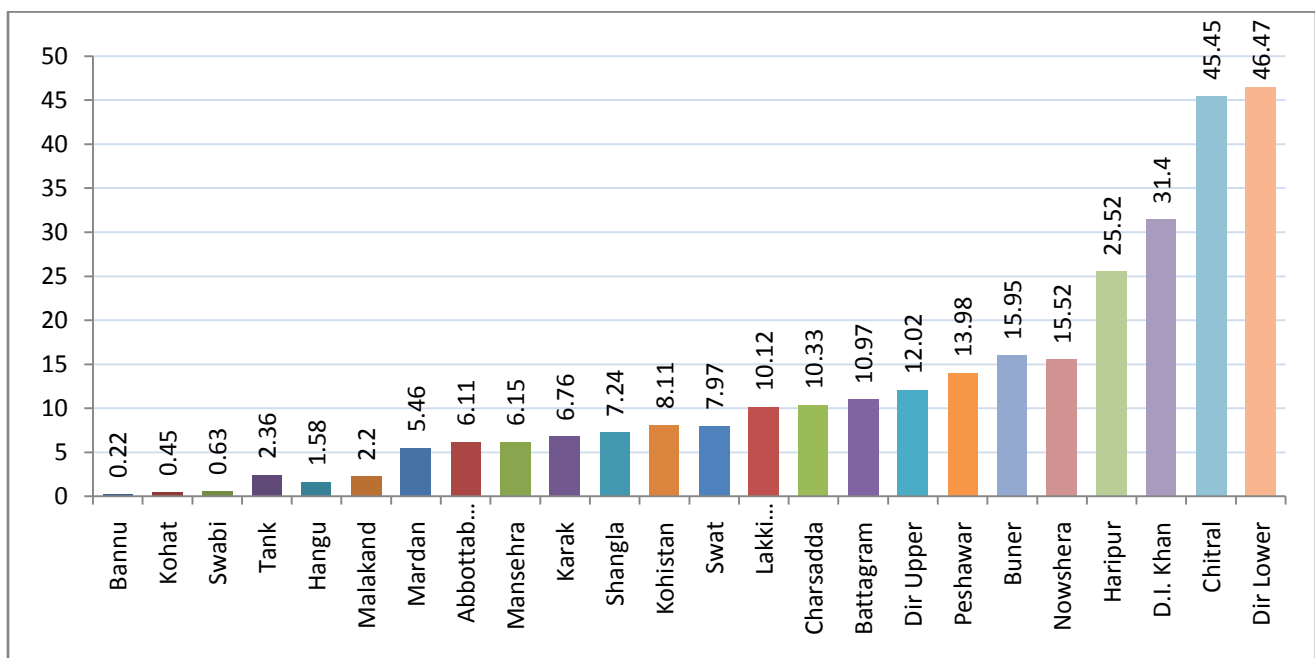
S#	Districts	Estimated Population	Exp-Deliveries in 1st Quarter 2012	Deliveries Conducted in whole Quarter	% age
1	Kohistan	478000	3466	37	1.07
2	Bannu	980000	7105	521	7.33
3	Chitral	444000	3219	530	16.46
4	Shangla	667000	4836	537	11.1
5	Tank	359000	2603	565	21.71
6	Haripur	924000	6699	635	9.48
7	Lakki Marwat	742000	5380	650	12.08
8	Hangu	482000	3495	659	18.86
9	Karak	661000	4792	799	16.67
10	Dir Upper	828000	6003	926	15.43
11	Nowshera	1280000	9280	942	10.15
12	Swabi	1515000	10984	1026	9.34
13	Abbotabad	1120000	8120	1061	13.07
14	D.I. Khan	1308000	9483	1136	11.98
15	Battagram	422000	3060	1223	39.97
16	Buner	838000	6076	1365	22.47
17	Mansehra	1582000	11470	1617	14.1
18	Peshawar	3219000	23338	1623	6.95
19	Dir Lower	1124000	8149	1810	22.21
20	Charsadda	1493000	10824	2002	18.5
21	Malakand	703000	5097	2338	45.87
22	Kohat	862000	6250	2508	40.13
23	Mardan	2168000	15718	3381	21.51
24	Swat	1956000	14181	4256	30.01
	Total	26155000	189628	32147	16.95

Kohistan again emerges as the district with the lowest i.e. 1.07% of the deliveries being conducted at public facilities. Malakand district claims a top position at 45.87% performance in this area with Kohat and Battagram following closely behind with Swat at 30.01%. The performance of Peshawar at 6.95% is a cause for concern after taking into consideration the other factors mentioned earlier but it does put a question mark over the performance of a district with several inherent advantages. It is felt that with the addition from the Tertiary Care hospitals the figures for Peshawar shall improve considerably but the fact remains that it the alignment between Primary and Tertiary care is not clear and patients who can easily be handled in a primary care facility often make the unnecessary journey to the teaching hospital and patient attendance attract finances so the primary health care system would remain on the side lines for times to come if necessary changes are not incorporated into the system.

9. DISTRICT WISE COMPARISON OF LIVE BIRTH <2.5 KG BABIES BORN IN GOVERNMENT FACILITIES.

This indicator provides a useful insight into the prevalence of low birth weight babies born in the facilities and also is reflection upon the quality of the Antenatal Care available and practices involved. Going from the lowest prevalence i.e. Bannu at 0.22% to Dir Lower at 46.47% the figures might sound alarming but several factors play a part in the genesis of this indicator. A more realistic approach would be to examine the details of expected pregnancy figures in the district and the number of pregnant women using the facilities. Out of the 8575 pregnancies expected Bannu only 465 or 5.42% of the expectant mothers have delivered in a government facility. The figures for Lower Dir reveal that out of the 9835 expected pregnancies 822 or 8.35% delivered their babies in the government facilities.

Fig.9. Live Birth <2.5 kg in Percentage



As is quite evident from the figures the numbers of pregnant ladies utilizing the government health facilities for deliveries is less than 10% of the expected deliveries both in the best performing district and least performing district. Even taking the figures from the provincial capital it out of the expected 28166 pregnancies only 2182 patients or 7.7% of the total delivered in the government facilities. Several questions arise out of the analysis of this data like are the government facilities not convenient to public vis-à-vis transportation? Are the services poorer qualities wise than the ones provided in the private sector? Are the services more expensive than the ones provided by the private sector? These questions need to be answered in a comprehensive manner by all concerned and a great effort should be made to make these services public friendly responsive to the changing needs. The questions raised in the analysis should in no way be taken as an attempt to either ridicule or underestimate the invaluable services provided by the public but as an attempt to reinvigorate our system in the provision of services in the area of reproductive health.

Fig.9.1

S#	Districts	"Live births in the facility "	"Live births With LBW <2.5 kg"	%age
1	Bannu	465	1	0.22
2	Kohat	1998	9	0.45
3	Swabi	951	6	0.63
4	Tank	552	13	2.36
5	Hangu	507	8	1.58
6	Malakand	2133	47	2.2
7	Mardan	3333	182	5.46
8	Abbottabad	868	53	6.11
9	Mansehra	1610	99	6.15
10	Karak	281	19	6.76
11	Shangla	152	11	7.24
12	Kohistan	37	3	8.11
13	Swat	3024	241	7.97
14	Lakki Marwat	573	58	10.12
15	Charsadda	1259	130	10.33
16	Battagram	1057	116	10.97
17	Dir Upper	674	81	12.02
18	Peshawar	2182	305	13.98
19	Buner	1260	201	15.95
20	Nowshera	335	52	15.52
21	Haripur	580	148	25.52
22	D.I. Khan	844	265	31.4
23	Chitral	11	5	45.45
24	Dir Lower	822	382	46.47
	District Total	25508	2435	9.55

10. IMMUNIZATION STATUS

Figures 10, 10.1, 10.2 10.3 shows the performance of the EPI excluding the NIDs and the SNIDs. Several indices have been used to present a comprehensive data and to throw light on the performance of the department.

a) CHILDREN <12 MONTHS WHO RECEIVED THE 3RD PENTAVALENT.

The first three graphs reflect interconnected indicators. Starting from a dismal 5% coverage in this activity for Kohistan to an excellent coverage in Charsadda, Mardan and Battagram, all exceeding the 100% mark which would in line with the general trends especially regarding the District of Kohistan. Remarkable improvements have been witnessed in the coverage from Charsadda and Mardan. Charsadda jumping from 69% in the last quarter to 110% in this quarter whereas Mardan going up from a disastrous 12% to a 106%. The results from Dir Upper showing a figure of 264% in the last quarter has fallen to 39%, an explanation is in order to find a reason for this massive variations in the coverage. Swat and Haripur have followed a consistent pattern of coverage in excess of a 100%

comparable to the results shown in the previous quarter. The coverage figures from Peshawar are encouraging as well going up from 13% to 79%. Chitral has submitted a 0% percent report in this area and explanations have already been called from the concerned staffs of the DHIS stationed in the district and a strict disciplinary action shall be taken if the responsibility is fixed. Though this office considers the performance and reporting of the district as more consistent in this quarter the role of the Health Secretariat and Directorate General should receive appreciation for their constant support to the program and resultant improvements.

Fig.10.

S#	Districts	"Exp Children <12 Months (2.7 Expected Live Birth)"	"Children<12 Months received 3 rd Pentavalent Vaccine"	% age
1	Bannu	6615	3876	59
2	D.I. Khan	8829	3112	35
3	Lakki Marwat	5009	2658	53
4	Tank	2423	2195	91
5	Abbottabad	7560	6479	86
6	Haripur	6237	7070	113
7	Kohistan	2849	138	5
8	Mansehra	10679	8753	82
9	Battagram	2849	3086	108
10	Karak	4462	3491	78
11	Kohat	5819	4063	70
12	Hangu	3254	2161	66
13	Buner	5657	2978	53
14	Chitral	2997	0	0
15	Dir Lower	7587	1463	19
16	Malakand	4745	5650	119
17	Swat	13203	14411	109
18	Dir Upper	5589	2179	39
19	Shangla	4502	1822	40
20	Mardan	14634	15527	106
21	Swabi	10226	6802	67
22	Charsadda	10078	11093	110
23	Nowshera	8640	7389	86
24	Peshawar	21728	17188	79

The figures also shows that some of the districts have still not met the national standards of 80% immunization target a little prodding and encouragement shall markedly improve the performance in this area and once the health sector achieves its desired targets the needs for repeated and time consuming interventions like the NIDs and SNIDs shall lose their rationale.

b) CHILDREN <12 MONTHS RECEIVING 1ST MEASLES VACCINE.

Figure 10.1 reveal the figures for this indicator. This is indicator clearly defines the direction of our routine immunizations which forms the main thrust of our preventive health care reducing the

mortality and morbidity in general and greatly reducing the financial burden on parents in this age of high inflation and other deteriorating economic indicators. **Fig.10.1**

S#	Districts	"Exp Children <12 Months (2.7 Expected Live Birth)"	<12 Months received 1st Measles vaccine	%age
1	Bannu	6615	3141	47
2	D.I. Khan	8829	3085	35
3	Lakki Marwat	5009	1337	27
4	Tank	2423	1856	77
5	Abbottabad	7560	5360	71
6	Haripur	6237	4167	67
7	Kohistan	3226	151	5
8	Mansehra	10679	7333	69
9	Battagram	2849	3138	110
10	Karak	4462	1598	36
11	Kohat	5819	3657	63
12	Hangu	3254	2124	65
13	Buner	5657	2643	47
14	Chitral	2997	0	0
15	Dir Lower	7587	1518	20
16	Malakand	4745	5277	111
17	Swat	13203	14436	109
18	Dir Upper	5589	2072	37
19	Shangla	4502	1541	34
20	Mardan	14634	10283	70
21	Swabi	10226	7046	69
22	Charsadda	10078	6542	65
23	Nowshera	8640	4441	51
24	Peshawar	21728	12717	59

Kohistan again attains the dubious distinction of the rate of Measles vaccine administration at 5%. The districts of Battagram, Malakand and Swat have maintained their high standards at more than 100%. A special note of appreciation is recorded for the performance of District Tank which has gone up from 25% coverage in the last quarter to a highly creditable 91% of this quarter despite its sharing many of the disadvantages that are present in Kohistan. The performance of Tank should be eye-opener to all those who attribute poor performance to reasons beyond their control citing excuses like geographical disadvantages and cultural and social constraints. The provincial headquarter Peshawar has improved in this area from 6% to 59% though not satisfactory by the facilities available, the advantage of location and advantages associated with being the provincial capital, a sense of purpose and direction is visible with further improvements on the horizon. The problem related to Chitral have already have elaborated earlier.

Shangla, Dir Upper, Karak, Lakki Marwat and DI Khan remain problem areas with coverage of less than 40% especially in light of the outstanding performance of the EPI in Tank, questions have to be asked for the reasons of this highly unsatisfactory performance by the districts enumerated earlier. Gaps need to be identified in these district and remedial measures taken accordingly.

c) CHILDREN FULLY IMMUNIZED:

Figure 10.2 reveal the rate for fully immunized children. The sad saga of the performance of District Kohistan continues in unabated and the coverage has shrunk to 3% only. Now it is beyond an iota of doubt that strong corrective measures are required immediately infuse some sense of direction and responsibility in the staffs and clearly find reasons for this performance. Malakand, Swat and Battagram continue to excel. Another welcome addition to the performing districts is the report from Hangu with the coverage rates 98%.

Fig.10.2

S#	District	"Exp Children <12 Months (2.7 Expected Live Birth)"	Fully Immunized	%age
1	Bannu	6615	4297	65
2	D.I. Khan	8829	2556	29
3	Lakki Marwat	5009	1520	30
4	Tank	2423	1800	74
5	Abbottabad	7560	5760	76
6	Haripur	6237	3824	61
7	Kohistan	3226	74	3
8	Mansehra	10679	7515	70
9	Battagram	2849	2470	87
10	Karak	4462	1389	31
11	Kohat	5819	4732	81
12	Hangu	3254	3196	98
13	Buner	5657	2889	51
14	Chitral	2997	0	0
15	Dir Lower	7587	1435	19
16	Malakand	4745	5887	124
17	Swat	13203	13529	102
18	Dir Upper	5589	1946	35
19	Shangla	4502	1448	32
20	Mardan	14634	11659	80
21	Swabi	10226	5407	53
22	Charsadda	10078	7736	77
23	Nowshera	8640	5104	59
24	Peshawar	21728	14035	65

Dir Upper, Shangla, DI Khan and Lakki Marwat continue to buck the general trend in improvements seen in other district and suboptimal performances are a serious cause for concern. These entire districts show a coverage of less than 40% which is not acceptable by any standard. It is suggested that a high level meeting of the EDO (H) of the districts with the inclusion of Kohistan may be convened immediately to deliberate upon their performance and suggest ways and means to rectify the deficiencies otherwise our aim of eliminating vaccine preventable diseases would be exercise in futility and considerable waste of public and donor finances with little improvement in the health conditions of the common folks.

d) WOMEN RECEIVING TT-2 VACCINES.

This indicator reflects upon the two indicators at the same time. One is that the pregnant woman who has received 02 TT vaccines has visited the health facility at least twice during her pregnancy indicating a strong link between patients and health care providers, one of the stated goals of health policy of this country. Secondly it provides a chance to health care provider to ascertain and detect other problems related to pregnancy preventing pre partum and post partum complications.

S#	District	"Exp Pregnancies (3.4)"	Women Received TT-2 vaccine	%age
1	Bannu	8575	2612	30
2	D.I. Khan	11445	2027	18
3	Lakki Marwat	6492	1341	21
4	Tank	3141	1232	39
5	Abbottabad	9800	3921	40
6	Haripur	8085	3254	40
7	Kohistan	4182	280	7
8	Mansehra	13842	5647	41
9	Battagram	3692	1409	38
10	Karak	5783	1704	29
11	Kohat	7542	2995	40
12	Hangu	4217	1206	29
13	Buner	7332	2498	34
14	Chitral	3885	0	0
15	Dir Lower	9835	1593	16
16	Malakand	6151	3803	62
17	Swat	17115	11784	69
18	Dir Upper	7245	1921	27
19	Shangla	5836	567	10
20	Mardan	18970	9409	50
21	Swabi	13256	3446	26
22	Charsadda	13063	7095	54
23	Nowshera	11200	3474	31
24	Peshawar	28166	9854	35

The administration of 02 TT vaccines during pregnancy can prevent Neo Natal Tetanus which unfortunately is still a major public health issue and one of the easiest to control vaccine preventable disease. The reader would recognize that the treatment of NNT requires specialized units for treatment and the cost is quite significant. It is quite disappointing to report that our figures for this disorder have jumped nearly four-fold from 260 in the last quarter to 805 in this quarter and it is assumed that a vast majority of these patients have expired. It point of disappointment for the whole department where scarce resources have to be allocated to the so called "Tetanus Rooms" in this country whereas these concepts have become extinct worldwide.

The analysis of the district reports reveal that Kohistan as expected with coverage of 7%, the lowest in the province whereas Malakand and Swat were top performing districts with coverage of 62 and 69%

respectively. Surprisingly Battagram district one of the consistent performers has lagged behind at only 41% coverage.

The least performing again includes DI Khan, Lakki Marwat, Dir Upper, Dir Lower and Shangla besides Kohistan where the coverage is below 30%. Tank has again done creditably well in this area with a coverage of 39% compared to one of the top performing districts like Battagram at 41%. By the general trend of the statistics available for this indicator no district has gone beyond 70% which would be cause for concern. It is also worthwhile to point out here that the restriction of only pregnant women receiving TT vaccine can be done away with and a system introduced whereby all women of Child Bearing Age should receive the vaccine regardless of their marital status and unrelated to pregnancy. A program similar to the one being practiced in the Afghan Refugees Health setup can be introduced which followed the principle enunciated above and no wonder that their data shows “No Neonatal Tetanus case” in this quarter. It provides food for thought for all of us and we should be ready to address the challenge and do as well as the refugee program if not better.

11. INFECTION RATES IN DONORS DONATING BLOOD TO GOVERNMENT AND NON-GOVERNMENTAL ORGANISATIONS:

S#	Name of Organization	Total No. Registered Patients	Total No. of Blood Transfusions Conducted This Quarter.
1)	Lady Reading Hospital, Peshawar.	---	9572
2)	Khyber Teaching Hospital, Peshawar.	---	4801
3)	Hayatabad Medical Complex, Peshawar.	---	3412
4)	Frontier Foundation, Peshawar.	2296	3235
5)	Hamza Foundation, Peshawar.	845	2030
6)	Fatimid Foundation, Peshawar.	3027	4603
	Total		27653

From the figures it is evident that Government Lady Reading Hospital Peshawar has performed 9572 transfusions this quarter with blood collected from healthy related donors of the patients as is the normal practice, a total number of 10040 bags of blood were screened.

Table showing the detailed view is on next page.

Fig.11

S#	Organization	Total No. of Blood units Screened this Quarter	HIV +ive	HBV +ive	HCV +ive	Others
1)	Lady Reading Hospital, Peshawar.	10040	12	250	210	VDRL-52
2)	Khyber Teaching Hospital, Peshawar.	4801	1	100	66	---
3)	Hayatabad Medical Complex, Peshawar.	3412	Nil	84	37	---
4)	Frontier Foundation, Peshawar.	3187	Nil	46	17	VDRL-02
5)	Hamza Foundation, Peshawar.	1933	Nil	46	6	VDRL-06
6)	Fatimid Foundation, Peshawar.	3169	8	59	33	VDRL-02
	Total	26542	21	585	369	62

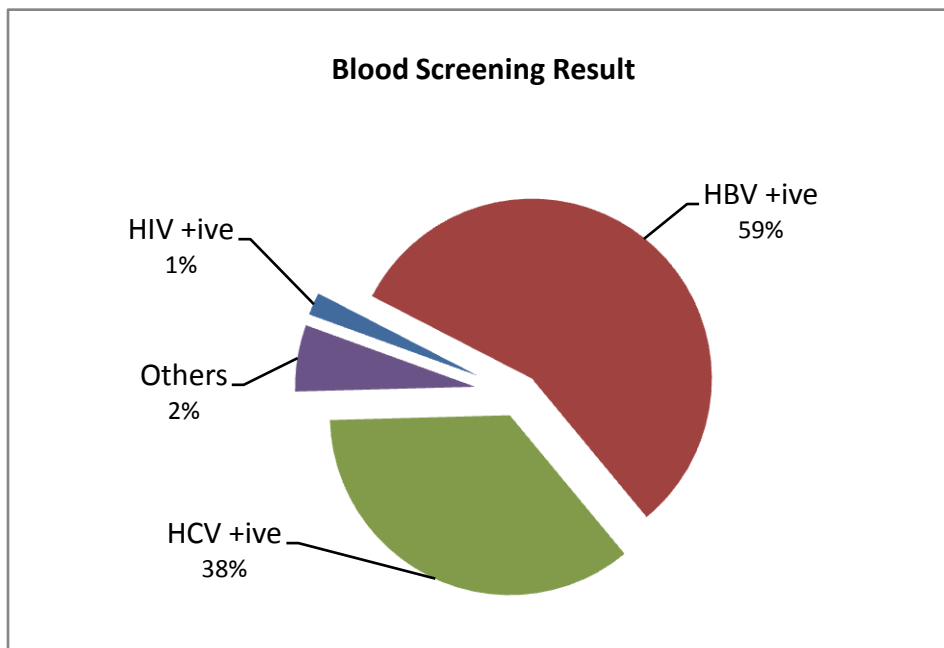
Though the presence of professional blood donors in government institutions cannot be ruled out it can be assumed that the vast majority of donors were healthy at presentation without any evidence of a serious physical disorder or evidence of any drug addiction especially intravenous drug use. The HIV prevalence rate in this quarter was **12 or 0.11%** of blood screened in this hospital. On our previous assumption that the majority of the donors were healthy volunteer even this miniscule rate of 0.11% assumes importance since the samples tested are not from the high risk groups. The combined figures for HBV and HCV positivity rates touch a figure of **460 or 4.6% of** the screened blood at LRH. It is felt that this ratio of prevalence of HBV and HCV amongst the healthy volunteers is lower than the generally assumed figure of >10% prevalence in the population and in coming days, when the next set of data arrives a consistent figures shall emerge which would be reflective of the accurate prevalence rather than an assumed figure. Another interesting observation is the prevalence of Syphilis based on the VDRL results. Though the figure is small i.e. **62 or 0.6% of** the total blood bags screened it should awaken us to the presence of the long standing scourge of mankind in our midst despite the availability of excellent drugs for its treatment and it is felt that not taking these figures seriously would result in boom in the prevalence of other disorders like HIV since a direct correlation always exists amongst the sexually transmitted disease and this latest scourge.

The figures from Khyber Teaching Hospital Peshawar also show a similar trend with only one positive case of HIV out of 4801 bags of screened blood. The prevalence rate for HBV and HCV positivity is at 3.45 % and thankfully no VDRL positive case was discovered in the current quarter. In Hayatabad Medical Complex a similar picture emerges with a combined prevalence rate of HBV and HCV positivity rates of 3.54% reflecting a general trend and no VDRL positive blood bag.

While bringing this indicator into the fold of the DHIS reporting some of the large NGOs operating in the Blood Services were included to have a broader perspective and have a reliable tool for comparison between the services provided by the Governmental and the Non-Governmental sector.

Three of the largest organizations operating out of Peshawar and other places within the province were included.

Fig. 11.1



Almost all of them i.e. The Frontier Foundation, Fatimid Foundation and Hamza Foundation primarily cater to the transfusion needs of the patients with Hemophilia and Thalasaemia with minor part of their activities directed towards the provision of services to the government sector. On enquiry it was revealed that all of their donors are volunteers from various tiers of the

society and different areas since their major blood collecting activity is based on the concept of organizing blood collection camps in different areas and based on the concept of voluntary donations. The figures indicate that the Frontier Foundation screened and transfused a total of 3187 bags of blood with no HIV positive case whereas HBV and HCV positive cases comprised a total of 63 cases or 1.9% of the screened samples and 02 cases of VDRL positive Syphilis was also detected. Hamza Foundation screened a total of 1933 bags in this quarter with no positive HIV bag, HBV and HCV at 2.7% and VDRL positive cases at 06. The Fatimid Foundation screened a total of 3169 bags of blood with a total of 08 HIV positive cases or 0.25%, HBV and HCV at 2.98% and again positive 02 cases of VDRL positive cases of Syphilis.

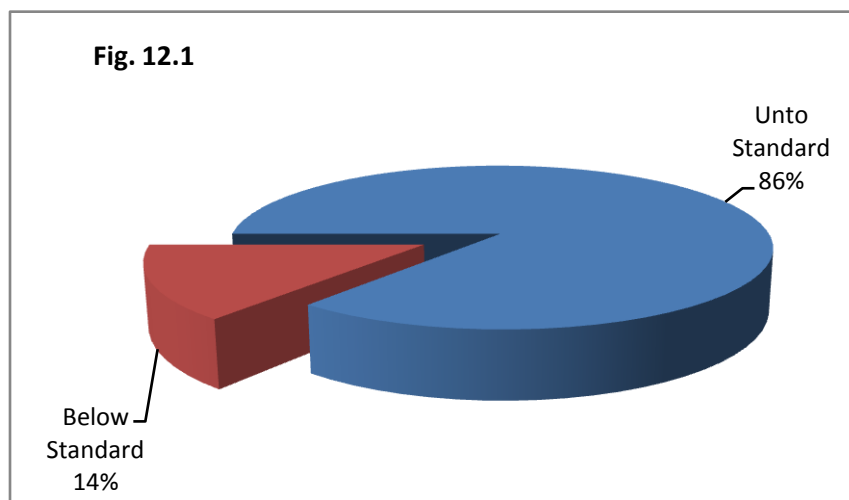
Now coming to the conclusions it is seen that out of the 26542 bags screened in the Tertiary care Hospitals and NGOs the various blood borne disease infection rates are at: HIV –positive blood samples with a total case load of 21 or 0.079%, HBV- positive blood samples at 585 or 2.2%, HCV- positive blood samples at 369 or 1.4%, VDRL- positive rate of 0.23%. Looking at the overall picture it is quite evident that the right decisions have been made to control the menace of HIV and Hepatitis but serious steps need to be taken to tackle the emerging problem of Syphilis which in itself could have a devastating effects on the individual as well as the off springs resulting in severe congenital disorders, and it has also been proven that the prevalence of other STDs and HIV/ AIDS have a directly proportional relationship so intervention is needed and awareness created. It is worth noting here that the next report shall have more participation of the tertiary care hospitals and more NGOs and a clearer picture shall emerge regarding the prevalence of blood borne disorders in the healthy donors and with a potential to provide a picture of disease burden in the general population excluding the

High Risk Groups for which a dedicated program is already in place and their data would provide an insight of the HIV prevalence in high risk groups and the latest report from UNAIDS would illustrate the importance of both AIDS Control Program and Hepatitis Control Programs in tandem and the relevant part of the report says” *According to the Joint United Nations Program on HIV/ AIDS (UNAIDS), about 33 million people are infected with HIV worldwide, and majority of them live in Asia and Africa. Approximately 10% of the HIV-infected population has concurrent chronic Hepatitis B, with co-infection more common in areas of high prevalence for both viruses. In areas where both the viruses are highly endemic the rate can be as high as 25%*” This report would provide a lot of food thought to all and sundry to consider the consolidation of both the control programs on a top priority basis to avoid the situation currently being encountered in some parts of the world.

12. REPORT OF THE DRUG TESTING LABORATORY KHYBER PUKHTUNKHWA FOR THE FIRST QUARTER 2012.

Considering the media coverage and judicial proceedings on this particular issue, it was thought that it would be appropriate to include this aspect of health care in the review. This office shall remain thankful to the administration of the Drug Testing Laboratory Khyber Pakhtunkhwa for their prompt reply to the request of this office regarding the provision of data for the first quarter report 2012 on drug testing. As is evident from the figures, a total of 84 samples arrived in the laboratory for analysis in January 2012, 527 samples in February 2012 and 476 samples in March 2012 for testing in this facility. **Fig.12**

S#	Months 2012	Sample Received	Tested	Samples unto Standard	Samples below standard
1	January	84	68	44	24
2	February	527	157	115	42
3	March	476	461	430	31
	Total	1087	686	589	97



On analysis it was revealed that in the month of January 2012 out of the 84 samples collected 68 were tested. A total of 44 drugs were declared conforming to the standards which comes to 64.71% of the total figures. Substandard drugs during this month comprised 24 or 35.29%. Unregistered drugs recovered were 15 or 17.85% and misbranded drugs were 06.

In February 2012 a quantum jump was observed in the number of samples being sent to the laboratory i.e. a total of 527 more than a fivefold jump in the number of samples. Out of the tested samples 73.15% conformed to the standards whereas 26.75% were declared substandard. Unregistered drugs were 19 and misbranded drugs were 09.

In March 2012 a total of 476 samples were presented to the laboratory for analysis and the results showed that 93.28% of the drugs were of standard quality whereas 6.72% were declared substandard. The number of unregistered drugs stood at 19 whereas misbranded drugs number was 03. One important addition to the reporting of the Provincial Drugs Testing Laboratory would be the identification of the source of the sample whether from government facility or the open market since that would be good starting point in determining if the drugs provided to the government institutions and the market vary in quality or otherwise.

A detailed look into the report indicates that the arrival of samples at the laboratory was miniscule compared to the figures for the next two months. It would suggest effective oversight at the field level or may be a response to the judicial interest in the case but in both cases the activity has certainly improved and bears a good omen for the future. As is seen a significant number or almost all the drugs that have no registration originate from a Herbal Laboratory or a Homeo Laboratory or the combination of both and all have tall claims of increase instant cure for almost any disorders. If the reader recalls in the previous quarterly report it was mentioned that only 0.3% of the patients in the government hospitals ever consult a Hakeem or Homeopath but it is felt that with regulation in place and powers of the management of these dubious companies vis-à-vis the media and the ignorance of the general public, their businesses are thriving regardless of the results and the harm caused to the public. A robust regulatory oversight would be in order to end this malpractice with penalties imposed on the prescribing medical professionals, the promoters and the manufacturers of these medicines.

Another interesting fact emerging out of the figures is the fact that 100% of the samples collected are those being manufactured in this country by local companies. No sample has been taken of a multinational pharmaceutical firms assuming that these firms manufacture only high quality medicines or there are other reasons for this, if the former is correct than a lot of soul searching is required on the part of the members of the purchase committee to make the right decisions regardless of the cost for bulk purchases in the government hospitals. Some local manufacturing companies which have been consistently mentioned in the report of the drug laboratories need to be blacklisted from the process of bulk purchases on a most immediate basis to send out a clear message to all participants in the bidding process to improve the quality of the medicines offered to the government institution. A survey into the medicine sale licenses issued by the EDOs (Health) and the actual number of outlets selling medicines would give an insight into the problem of sale of substandard or unregistered drugs since it is most likely that these drugs or a majority of them originate from unlicensed sale points.

A constant constraint in the area of the drug control has been the lack of the coordination amongst the organizations within the government sector to form a cohesive network of oversight on the whole process. The post 18th Amendment scenario has provided an opportunity to the planners to consolidate the process, instead of having a multitude of organization working to regulate the various aspects of healthcare it would be worthwhile to provide a single umbrella to all these organizations to form

responsive setup to the changes. The process of the establishment of the Appellate Drug Laboratory has to be expedited and the current setup of the Provincial Drugs Laboratory has to be strengthened in the areas of human resource and finances to have realistic analytical results. The recent incidents of deaths at PICO Lahore should be a eye-opener since the samples had to be analyzed in the UK for credible results and no laboratory in Pakistan was found worthy enough to analyze the sample.

13. AREAS OF UNCERTAINTY:

Despite the increase in allocation of budget for the health sector on a consistent few areas remain untouched which raises more questions than providing more answers. The Mortality Audit remains a distant dream though it is felt it is vital and practicable in most circumstances prevalent in our health institutions requiring only diligence, interest and a sense of responsibility on the part of the professionals. Even in this advanced age rapid information transmitting system the department is made to believe that all the deaths in hospitals are attributable to “ Cardio-Pulmonary Arrest” with little background information regarding the reason for admission, the confirmed diagnosis, the procedure and treatment provided and causes for deterioration in unexpected situation, like a young individual dying without an explicable reason. The project has sights on addressing this issue in the next quarterly report by analyzing the death reports from the three teaching hospitals in Peshawar and expanding the contents later on. The purpose of including this parameter in the report is not intended to pinpoint responsibility but rather to incite a mature debate on the issue with all the stakeholders on board since the practice of routine autopsy for determination of the cause of death are not visible in the near future. In the field the process utilized by the UNHCR Health Program known as the “Verbal Autopsy” may be introduced to ascertain the cause of death in Women and Neonate keeping the cultural sensitivities in mind with the LHWs, CMVs and LHVs playing a lead role.

The next report shall also attempt to enter another uncharted territory by inquiring into the rates of infections in hospitals. This indicator assumes great importance in areas of proper antibiotic use and also to prevent the emergence of the “Superbug” through the unnecessary and indiscriminate use of antibiotics especially in hospital settings. The rate of infections in hospital would reflect upon the hygienic situation of the hospital in general with particular reference to waste disposal and other contributory factors like overcrowded wards and other facilities.

The merger of the Health Department with the Population Welfare though a step in the right direction is still in the conceptual stage and it is not known whether it is going to happen at all. A serious implication from point of view of this project is that if the process is not completed in time it would definitely lead to duplication from both sides and making it sense of it all would be become an insurmountable challenge.

The general public and medical profession is well aware of the organ trade that is becoming more prevalent by the day and with the introduction of the 18th Amendment to the constitution, the provincial government has to assume the regulatory role in this area since almost all the affectees are from the lower segments of the society with very little influence anywhere in places where it matters thus become easy victims of the exploiters and would be at the mercy of dysfunctional system.

The diseases that are included in the DEWS system of WHO also needs to be looked and a common ground found to make the provincial health system more responsive to the outbreak of the unusual diseases like CHHF and Bird Flu etc. The government shall be benefit early information on these diseases and subsequent planning for the same.

A valuable addition would be report on the number of vacancies in the peripheral health facilities and the number of professionals based in these. Since the appointments of many Specialists have been approved for the secondary care hospitals recently the next report would have a section illustrating the available human resource.

CONCLUSIONS:

Though considerable gaps still exist in the areas within the health system to be brought into the ambit of the reporting system a beginning has certainly been made and it is hoped that each report shall be more comprehensive than the previous one. A PC-1 designed to cater to the future needs of the DHIS in which ever form that it may exist, is in the anvil and hopefully shall be submitted before the distribution of this report.

A few words about the upcoming PC-1 of the DHIS for a further three years would not be out of place. The document envisages a comprehensive reporting system covering all the districts and the Tertiary Care Hospitals, and all the health programs currently operating in the Khyber Pakhtunkhwa. The system is intended to be user friendly with an interface provided to all the facilities to directly access the central server and enter the data doing away with a lot unnecessary paperwork and preventing a considerable loss of time with a positive environmental impact. A system based on GIS is also being looked into to provide instant information in real time to the program and pinpointing the locality in case of a disease outbreak.

With the system of Output Based Budgeting starting in the health department, this program needs to redouble its efforts to justify its existence and utility and it is hoped that the program will keep on marching on with improvements in the overall reporting and addition of other indicators as and when required.

As conceded earlier the reports are far from presenting an accurate data on the health system as a whole and it is hoped the quality of the reporting shall improve over a period of time and the intention would remain neutral, non-critical and non-judgmental and effort would be towards greater coordination, cooperation and increase in output and inefficiency. The report published in the **New England Journal of Medicine May 10, 2012** illustrates our predicament and relevance to our settings. The emergence of Measles is the title of the report and the relevant Para- graph is quoted for the benefit of the reader:

“By 2008, the WHO and partners were struggling with Polio Eradication, which had missed its 2000 global target. On scientific and public health grounds , the feasibility, the desirability and timing of the measles eradication should not be dependent on the ongoing polio eradication effort. In practice however, the two efforts are inextricably linked. Because of the same donors that fund polio-eradication will be called on to support measles eradication, the shifting resources could jeopardize polio-eradication efforts. Some argue that if polio-eradication is really feasible, it should be completed before measles eradication efforts are launched: yet in by 2008 continuing polio transmission in India, Nigeria and Pakistan, and other countries where the virus was endemic was leading to growing skepticism about the feasibility of eradication.”

Finally India has not reported any case for the last 12 months and Pakistan must respond now to match the achievement and cross the line within the shortest possible time.