Revised PC-I

PUNJAB

Integrated Reproductive Maternal Newborn & Child Health (IRMNCH) & Nutrition Program

July, 2015 – June, 2017

Approved Cost of 24/7 & Nutrition PC-1 Rs. 9,814.171 Million (2013-16)
1st Revision(24/7 & Nutrition) approved cost Rs. 9,392.027 Million (2013-16)
2nd Revision(MNCH, 24/7 & Nutrition) Proposed Cost Rs.9,495.240Million (2015-17)

Department of Health
Government of the Punjab

ACRONYMS

ADP	Annual Development Plan
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BHU	Basic Health Unit
CMAM	Community based Management of Acute Malnutrition
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CPSP	College of Physicians and Surgeons
DFID	Department for International Development
DHQ	District Headquarter Hospital
DOH	Department of Health
DMU	District Program Management Unit
ECOSOC	Economic & Social Council (UN)
EDO	Executive District Officer
EDO (H)	Executive District Officer (Health)
EmONC	Emergency Obstetric and Newborn Care
EPHS	Essential Package of Health Services
ENC	Essential Newborn Care
FP	Family Planning
HTSP	Healthy Time Spacing of Pregnancy
ICPD	International Conference for Population & Development
IEC	Information Education and Communication
IMNCI	Integrated Management of Newborn & Childhood Illness
IMR	Infant Mortality Rate
IYCF	Infant & Young Child Feeding
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MAM	Moderate Acute Malnutrition
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MO	Medical Officer
MSDS	Minimum Service Delivery Standards

NEB	Nursing Examination Board
NNMR	Neonatal Mortality Rate
OPD	Out Patient Department
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
OTP	Out Patient Therapeutic Program
P&D	Planning and Development Department
PC-1	Planning Commission – Performa 1
PDHS	Pakistan Demographic Household Survey
PDS	Pakistan Demographic Survey
PG	Postgraduate
PHC	Primary Health Care
PIHS	Pakistan Integrated Household Survey
PMU	Provincial Program Management Unit
PNC	Pakistan Nursing Council
PPFP	Post partum family planning
PSLM	Pakistan Social and Living Standards Measurement survey
RHC	Rural Health Center
RUTF	Ready to Use Therapeutic Food
RUSF	Ready to Use Supplementary Food
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SOP	Standard Operational Procedures
TBA	Traditional Birth Attendants
THQ	Tehsil Headquarter Hospital
UC	Union Council
UNGA	United Nations General Assembly
UNFPA	United Nation's Population Fund
UNICEF	United Nation's Child Fund
WASH	Water & Sanitation for Hygiene
WB	World Bank
WHO	World Health Organization
WMO	Women Medical Officer

PC-1 PERFORMA

Code Number for Project_____
(To be filled in by Planning Commission)

PART "A"

PROJECT DIGEST

1.	**Name of the Project**	Integrated Reproductive Maternal Newborn & Child Health &Nutrition Program
2.	**Location**	All 36 districts of the province of Punjab
3.	**Authority responsible for:**	
i.	**Sponsoring**	Government of Punjab
ii.	**Execution**	Department of Health, Punjab and District Governments in Punjab
iii.	**Operation and maintenance**	Department of Health, Punjab
iv.	**Concerned Federal Ministry**	Planning & Development Division
4.	**a. Plan Provision**	
	i. If the project is included in the Medium Term/five-year plan, please specify actual allocation.	The National Programmes i.e. Lady Health Workers' Programme (LHWP), National Maternal, Newborn and Child Health (MNCH) Programme and Nutrition Program, were included in the Ten-Year Perspective Development Plan 2001-11 and Medium Term Development Framework 2005-10. The Programs have also been identified as major health sector interventions in the Poverty Reduction Strategy Papers-I and II. This document proposes the integration of MNCH programme within IRMNCH and Nutrition. The proposed programme does not include the LHW programme but has functional integration with LHWs in the field. The Government of Pakistan is a signatory to the Millennium Declaration and this effort is aimed to achieve health related goals. The integrated efforts under these programmes will help the Government of Punjab in achieving health goals laid out in approved Health Sector Strategy (HSS) 2012-2020 and the three key health & nutrition sector reforms (Reduce micronutrient deficiencies, value for

		money and reduce fertility) laid out in the Economic Growth Framework announced by the Planning Commission in May 2012[1]. Total Block Provision: Rs. 40.28 Billion for PHC Programs for the period 2005-10. After the 18th Constitutional Amendment, the Federal Government committed to continue funding for vertical national health programs till 2014-15 i.e. by the announcement of the next National Finance Commission Award. As of now the new NFC has not been announced, hence it is recommended to fund the programme from provincial resources. The Programme will require federal funds if approved prior to the National Finance Commission Award. Some donor funding may also be available in the form of grants, results based aid and technical assistance.
	iii) If the project is proposed to be financed out of block provision for a program, indicate.	N/A

[1]Pakistan: Framework for Economic Growth, 2012, Planning Commission , Govt. of Pakistan

5.	**Project objectives and its relationship with Sectoral Objectives**	**Background** **International Perspective** Pakistan is obligated to fulfill a number of International commitments being signatory to international declarations and conventions including Millennium Summit 2000, which commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women; World Summit for Children: committed to improve the well-being of children worldwide; the Programme of Action agreed at the International Conference on Population and Development; the Beijing Declaration and Platform for Action agreed at the Fourth World Conference on Women: which highlights reproductive health rights of women; the Economic & Social Council (ECOSOC) UN Ministerial Review on Global Health further strengthens the commitments made at the International Conference for Population & Development (ICPD) and Millennium Summit; United Nations General Assembly (UNGA) side session, "Healthy Women, Healthy Children: Investing in Our Common Future. The International Human Rights Council has also recently adopted a specific resolution on maternal mortality. More than three decades after the Alma-Ata Declaration, the state of primary health care for mothers, newborns and children remains poor. Recent years have seen a major emphasis on the persisting burden of maternal, newborn and child mortality worldwide with a particular focus on the Millenium Development Goals (MDG) for maternal and child health. MDGs which are ending in 2015, will now be followed by Sustainable Development Goals (SDG) which are a proposed set of targets relating to future international development. The SDGs were first formally discussed at the United Nations Conference on Sustainable Development held in Rio de Janeiro in June 2012. Investing more in women's and children's health is not only the right thing to do; it also builds stable, peaceful and productive societies. Evidence from many countries confirms that increasing investments in health of women and children has many benefits i.e. it reduces poverty, stimulates economic productivity and growth, is cost-effective, helps women and children realize their fundamental human rights. In addition, the "Global Strategy for Women's and Children's health", recommends integrated package of essential interventions and services for women and children delivered through functioning health systems, is more likely to enhance coverage compared to vertical or

		piecemeal interventions[2]. Integration of primary health-care service has been defined as "a variety of managerial or operational changes to health systems to bring together inputs, delivery, management and organisation of particular service functions" with the aim of improving efficiency and quality of services and making the best use of resources and opportunities[3]. Case studies of MNCH indicators in Pakistan and Uganda show how primary health-care interventions can be used effectively. Inclusion of evidence-based interventions in MNCH programmes in primary health care at pragmatic coverage in these two countries could prevent 20–30% of all maternal deaths (up to 32% with capability for caesarean section at first-level facilities), 20–21% of newborn deaths, and 29–40% of all postneonatal deaths in children aged less than 5 years[4]. Strengthening the maternal, newborn and child health care at the primary level with referral support from the secondary level should be a high priority if we want to reduce maternal, child mortality. **Post Devolution Scenario** The 18th Constitution amendment provided a number of opportunities to the provinces. On the strategic side, it provided the opportunity of taking on responsibility of all functions of the health sector, including those previously performed by the Ministry of Health i.e. policy, planning, management, implementation, disease surveillance and evaluation. While on the financial front under the new NFC Award, it provided much needed additional ***fiscal space*** to the provinces to increase investments in the social sector by defining their own priorities and targets. Responding to the new situation, Health Department, Punjab developed a Health Sector Strategy (HSS) 2012-20 to provide strategic direction to the Government which aims at maximizing health outcomes by developing vibrant policies and launching initiatives, relevant within local context. It also aims to make all out efforts for creating synergies between public and private sectors for enhancing coverage while avoiding duplication in service provision with initiatives

2http://www.who.int/pmnch/activities/advocacy/fulldocument_globalstrategy/en/index2.html. The partnership for Maternal, Newborn and Child Health; WHO. Cited on 24 May 2015

3Briggs CJ, Garner P. Strategies for integrating primary health services in middle- and low-income countries at the point of delivery. *Cochrane Database Syst Rev* 2006; **2:** CD003318.

4Bhutta ZA, Ali S, Cousens S, et al. Interventions to address maternal, newborn and child survival: what difference can integrated primary health care strategies make; Alma Ata rebirth and revision 6; Lancet 2008; 372: 972-89

like ‘contracting out’ health care services. In addition, Government of Punjab is taking steps to improve the governance in health sector in accordance with the newly assigned roles of stewardship, regulation of health service provision, managing innovations in the financing mechanisms for health care provision.

The Current Proposed Project (IRMNCH)

The approved IRMNCH programme (2013-16) will be ending in 2016 while the MNCH programme is ending on 30 June 2015. The current proposed project (IRMNCH) is an integration of MNCH programme within the approved IRMNCH programme (24/7) and nutrition with an extension till 2017.

This will increase accessibility of MNCH services by provision of 24/7 service delivery at selected BHUS, all RHCs, THQs and DHQs. Thirty percent BHUs have already been selected and notified for 24/7 services.

The program will contribute to all health& nutrition sectoral priorities set in the ‘Economic Growth Framework’ of the Planning Commission, i.e.

1: Revamping/management of primary, secondary and tertiary healthcare;

2: Healthcare Financing Reforms; and

3: Governance reforms in health sector (especially setting quality standards; essential services package; aid effectiveness, service structure; capacity; access to affordable medicine; etc.)

The Health Sector Strategy (HSS 2012-20) provides the necessary opportunity and space to the health department for realizing the dream of having fully functional health systems that is geared at meeting the needs of the population. Using integrated approach for service delivery, it aims to improve the health outcomes, especially among women and children, by enhancing coverage and access to essential health services for the poor and vulnerable by implementing the Essential Package of Health Services (EPHS). Within the above preview, the integrated PC-1 being developed aims to translate into action the vision of HSS by improving the maternal and child health outcomes among the population.

This Programme will constitute the main thrust of outreach and facility

based services in rural and less developed urban areas for provision of improved reproductive, maternal, newborn, child health and nutrition services in all districts of Punjab.

Goal

To improve maternal, new-born and child health in Punjab, especially of the poor thereby making progress towards achieving health related MDGs and contribute to reduction in:

- maternal mortality ratio from 178/100,000 live births in 2014 to less than 170/100,000 live births by end 2017;
- under-five mortality rate from 96/1000 live births in 2014 (MICS 2014) to 84/1000 live births beyond 2017;
- total fertility rate from 3.5 in 2014 (MICS 2014) to 3.1 by end 2017; up to the limitation of family planning apart from other social determinants.
- Prevalence of wasting (moderate & severe) from 17.5% in 2014 (MICS 2014) to 13.5% by end 2017; and
- prevalence of stunting from 34% in 2014 (MICS 2014) to 31% by end 2017

Purpose and Objectives

The Program objective is to improve access to quality Reproductive health, Child health and Nutrition services in the province especially for the poor through:

- improving contraceptive prevalence rate for modern methods from 38% in 2014 (MICS 2014) to 53.7% by end 2017;
- increasing skilled birth attendance from 64.7% in 2014 (MICS 2014) to 69% by end 2017;
- increasing institutional deliveries from 60.8% (MICS 2014) to 75% by end 2017;

The principal sources for the verification of Program performance against set targets will be independent Program evaluations; National and Provincial surveys e.g. Punjab MICS, PDHS and PSLM, in addition to Program monitoring and supervisory systems. Projections

		and targets for 5 indicators (MMR, NMR, IMR, <5MR and SBA) have been calculated using the SPECTRUM software, a policy development and planning tool, developed and being used by UN agencies.*(Log frame, Annexure A Page 57).*
6.	Description, justification and technical parameters	**Background** The poor health situation in the province is the result of many factors i.e. poorly managed health infrastructure plagued by lack of equipment, staff, medicines and other essential supplies in most of the health facilities. Service delivery has been adversely affected by high levels of absenteeism and lack of qualified personnel especially females. Although public sector is still used by a larger majority of population, but increasingly private sector preference is on the rise. Punjab has been implementing the national health programs. However, as an implication of the 18th Constitutional Amendment, these programmes have now been completely devolved to the provinces from 30 June 2012. As per decision of the Council of Common Interest, the Federal Government agreed to continue funding these national programmes till the next Finance Commission Award (NFC) in 2014-15, except the LHWP which will be funded till 2017. The Government of Punjab sees 18thconstitutional amendment as an opportunity for the health sector to develop policy and deliver health care using integrated and cost effective approaches as opposed to continuing with vertical programmes.Moreover, the province also has the opportunity to complete the reform cycle by introducing reforms in service delivery like introduction of Essential Package of Health Services (EPHS) and integration of vertical programmes which was not possible earlier with bifurcated system of financing. This will also help the provincial government to shift its priorities from curative care/private goods to predominantly primary and preventive health care/public goods. Recent devolution of the vertical national health programmes will help the government in materializing the concept of delivery of EPHS at the district level initially for primary health services. However, a phased approach is required first to integrate primary and preventive health care services through an integrated provincial programme for a period of three years; in the meantime enabling districts to take over all primary & preventive health care implementation responsibilities for the delivery of EPHS.

Progress in indicators during the last 4 years

Comparison of selected maternal and child health related indicatorsbetween MICS 2011 and the latest MICS 2014 shows an improvement which is encouraging and endorses the inputs of mother and child health related programmes of Punjab Health Department. However there is still a long way to go and much more needs to be achieved. Table 1 gives a comparison of selected indicators between MICS 2011 and 2014

Table 1: Comparison of selected indicators between MICS 2011 & 2014

~~Indicator~~	MICS 2011	MCIS 2014
Infant Mortality Rate (IMR)	82/1,000 lb	76/1,000 lb
Under 5 Mortality Rate	104/1000 lb	96/1000 lb
Total Fertility Rate (TFR)	3.6	3.5
Stunting (moderate & severe) prevalence	36%	34%
Contraceptive Prevalence rate (Modern methods)	23%	38.7%
Skilled Birth Attendance (SBA)	59%	64.7%
Institutional Deliveries	53%	60.8%

Rationale for Integration

Punjab with an estimated population of 96 million has poor health outcomes in comparison to other countries of the region. Despite all efforts, inter-district inequities in service provision and slow progress in improving health status of the poor are key challenges for the province.

The vertical approach, contributedin weakening of health services primarily by duplication of activities, drawing resources away from much needed primary health care services, resulting in weakened service delivery.

In the post devolution scenario,policy, strategy and programme level debates surrounding development in the health sector show an inclination towards using an integrated approach to improve general healthcare, which is argued to be a prerequisite for smooth functioning of vertical health programmes.In view of time bound financing from the Federal Government, and need for additional resources for these projects from the provincial government's budget, Health Department weighed the following 3 **options:**

		1. Continuing with the existing vertical approach; 2. Partial integration of programmes having same objectives with fully integrated services using EPHS at the PHC level; 3. Complete integration of all vertical programmes into the health systems. It was agreed that the best results could be achieved using a phased approach with gradually progressing to complete integration of the vertical programmes.It was agreed that currently option one was being implemented therefore it is time to move on to optiontwo which is partial integration at the Provincial level of a set of programmes predominantly related to maternal and child health (including MNCH, FP, 24/7 BHUs and nutrition); LHW programme will continue as an independent programme, however the integrated programme (IRMNCH) will involve LHWs at the operational level. **The Proposed Integrated Reproductive, Maternal, Newborn and Child Health & Nutrition Programme (IRMNCH&N)** As the federal government funding will be closed in June 2015 the MNCH activities for 2015-17 are being made part of the already approved IRMNCH&N Programme under Punjab Government. Thisrevision of approved IRMNCH&N PC-I is to integrate MNCH with IRMNCH & N Program Punjab. The IRMNCH&N programme in its present form includes 24/7 BHUs and nutrition.An independent PC-I was launched and approved in 2013 with the cost of Rs. 9,814.171 Million, which was revised and approved on the desire of Chief Minister of Punjab in 2014-15 with the cost of Rs. 9,392.027 Million. The proposed PC1 will be a continuation of the approved PC1 with the addition of MNCH programme.*(Annexure B, page 66 for leftoveractivities, Annexure C page 69 for proposed programme costing & Annexure H, page 109 for comparison of approved and proposed PC-1)* **Posting of ADGHS** The first step in functional integration was the posting of Additional Director General Health Services (ADGHS)in January, 2014. The ADGHS is looking after IRMNCH and nutrition program and administrative Supervision of MNCH program and LHW program. Development of this programme is a way forward not only to continue existing interventions through an integrated approach but to expand their scope and introduce new interventions. Some programmes are

		not part of this PC1 and are independent, but they will be integrated at the functional level. The programmes / interventions which will be integrated and implemented through this proposed programme are as following: 1. The National Programme for Family Planning and Primary Health Care, also known as the Lady Health Workers Programme (LHWP), has been working since 1994. The Programme contributes to the overall health sector goals of improvement in maternal, newborn & child health and provision of Family Planning services. This country wide initiative extended outreach health services to rural populations and urban slum communities through deployment of over 100,000 Lady Health Workers (LHWs) and contributed to bridge the gap between health facilities and communities. LHW programme is an independent vertical programme and not part of this integrated PC1. However there are some interventions in the IRMNCH programme which will involve LHWs at the operational level. 2. National Maternal, Newborn and Child Health (MNCH) Programme (2006-2012) was launched nationwide with a goal to improve maternal, newborn and child health of the population, particularly among its poor, marginalized and disadvantaged segments. The programme is contributing to strengthen Emergency Obstetric care services at DHQ, THQ hospitals and RHCs. Further, this program has introduced a new cadre of Skilled Birth Attendants (SBA) called Community-Midwives (CMWs) for skilled deliveries at community level. CMWs are potentially a very valuable resource when seeking to make safe motherhood available to poor and marginalised women in Pakistan and the concept of them as independent practitioners, who are linked closely to the District Health System is both potentially sustainable and efficient. The Value for Money (VFM) analysis indicates that for the financial year 2012 to 2013 visits made by CMWs were at substantially lower cost than visits to LHVs in BHUs. It is estimated that the cost of a visit to an LHV is in the region of Rs. 240 whilst comparable costs for a visit to a CMW was Rs. 148 in Punjab. The cost/benefit ratio for Punjab is 3.11 which indicates that benefits are greater than cost and that the Programme is cost

		effective. This programme is part of the proposed IRMNCH PC-1. 3. A network of BHUs, RHCs, THQ and DHQ hospitals which are managed by the District Governments play a critical role in provision of reproductive, maternal, newborn and child health services. Some of the resource gaps related to MNCH services are proposed to be filled by the proposed programme. 4. Punjab is also moving towards functional integration of Family Planning services offered through the Population Welfare Department (PWD). This initiative of functional integration will be strengthened through the proposed program. 5. The Chief Ministers' Health Initiative for Attainment and Realization of MDGs 4 & 5 (CHARM) was launched in seven districts of Punjab, with the assistance of UNICEF & UNFPA, following severe floods in the year 2010. The programme is helping in revival and utilization of the existing infrastructure of the Department of Health and expansion of round the clock Basic EmONC services through skilled paramedical staff in selected RHCs and BHUs. This initiative is being expanded to 700 BHUs by 2015 (last approved revised PC1). Further expansion with an addition of 300 BHUs is proposed in this PC1 to take the total figure to 1000 by 2016. 6. The preventive nutrition interventions are being proposed for all 36 districts; additionally, curative component addressing malnutrition is proposed in alldistricts in phased manner. The proposed IRMNCH programme will strengthen the health system by integrating different interventions, improving service delivery and introducing innovative strategies. The programme will: • Strengthen district health system through integration of quality reproductive, maternal, newborn, child health and nutrition services at community, BHU, RHC, THQ and DHQ level, focusing on rural areas and move towards delivery of primary and secondary level Essential Package of Health Services (EPHS) at the district level; • Strengthen linkages of community based health services with

		health facilities through CMWs and LHWs focusing on rural areas & urban slums. Although LHW programme is separate from this PC1, there will be functional integration in some areas of the two programmes, hence LHWs are mentioned here; • Streamline and strengthen services for provision of Basic and Comprehensive Emergency Obstetric and Newborn care (EmONC); • Enhance comprehensive Family Planning services at community and facility level; • Enhance Nutrition services at community and facility level through support of multi-sectoral coordination mechanism for the implementation of multi-sectoral Nutrition Strategy; • Establishment of stabilisation centres (with availability of RUTF (Ready to Use Therapeutic Food) and Outpatient Therapeutic Programme (OTP) centres. • Increase coverage of micronutrient supplementation and fortified food through advocacy from consumer to production line; • Implement a Woman Focused Approach by using the 1000 days Plus Model for nutrition, which focuses on the critical window of 1000 days from conception to the first 24 months of the child's life; • Involve local communities at different levels to enable them to participate in health improvement process; • Improve technical and managerial capacities at all levels of health care delivery system and expand accountability mechanism vis a vis performance based incentives in health care delivery system; • Introduce and implement e- monitoring and e-reporting system; • Increase demand for preventive and primary healthcare services through targeted, socially acceptable communication strategies; • Strengthen referral linkages between community outreach staff, primary facilities and secondary facilities;

- Improve client/ patient satisfaction from provision of services;
- Increase the number of Basic EmONC facilities (24/7 BHUs) to 1000 by the end of 2016.
- Increase the number of DHQ and THQ hospitals providing complete package of 24/7 comprehensive EmONC services to 80% by 2017.
- Upgrade 36 RHCs to RHC+ model to provide Comprehensive EmONC services 24/7. All RHCs will provide Basic EmONC services.

Project Description

The proposed integrated programme is of two years duration from 2015 to 2017. The programme envisages to achieve its goal of improving maternal and child health through the following four strategic outputs:

Output 1: Improved delivery of maternal, child, family planning and nutrition services under Essential Package of Health Services
Output 2: Improved practices and health seeking behavior for Reproductive, Maternal, New born and Child Health and Nutrition
Output 3: Effective management of the Program at provincial and district level
Output 4: Evidence based decision making through efficient monitoring and evaluation

1. Output 1: Improved delivery of maternal, child, family planning and nutrition services under Essential Package of Health Services: *(Annexure C-2, page 70, output 1 costing)*

In order to improve the delivery of maternal, child, family planning and nutrition services under the EPHS, the activities for output 1 are divided into 4 components: 1) Building capacity of community outreach services, 2) Implementing community outreach services focusing on Nutrition including MNCH/RH and family planning, 3) Improving Basic EmONC services at primary level health facilities and 4) Improving Comprehensive EmONC services at secondary level health care facilities. Following are the activities to achieve the 4 components:

1.1 Component 1: Building capacity of community outreach services

1.1.1 Increasing the number of CMWs

At present there are 7818 CMWs enrolled on one for 10,000 population basis out of which 5233 were trained and 4681 were ever deployed. 2566 have either completed the bond period (2 years) or have left the programme. The number of currently deployed CMWs is 2115, while 409 are awaiting deployment.

The proposed IRMNCH programme (2015-17) plans to recruit additional CMWs, one for 5,000 population in rural areas and one for 10,000 population in urban slums. Priority of deployment of newly recruited CMWs will be given to non-LHW covered areas. The following table gives the year wise CMW positions throughout the proposed project:

Table 2: CMWs proposed positions

Sr. No	Position Name	Approved Scale	Proposed Scale	Year I Strength	Year II Strength	Year III Strength
1	CMWs Deployed	Lumpsum	Lumpsum	2,400	3,400	4,120
2	CMWs Students			2,200	2,200	2,000
Total Year wise CMWs				**4,600**	**5,600**	**6,120**

1.1.2 Introducing new retention model for CMWs

One of the issues being faced by the current MNCH programme is the attrition of CMWs before and after deployment. It is now being seen that the retention period of two years with a stipend of Rs. 2000 per month in the initial model is not working well and is no longer attractive to the CMWs. According to a study conducted by UNFPA in 2014 "Development of a workforce plan to match demand for Community Midwives with Supply in Pakistan," the two year retention period is too short a time to expect CMWs to start generating enough revenues to sustain their business and the stipend of Rs 2000 per month is not attractive enough for them to stay on[5].The attrition rate at present is 18% which is a cause for concern because skilled birth attendants (SBA) are moving out of the system after the government has spent a large amount of money to train them.

The proposed programme plans to increase the retention period of CMWs from 2 to 5 years and the stipend from Rs. 2000 to Rs. 5000 per month. It is envisaged that increased stipend will be attractive

[5]Retention Strategies, Development of a workforce plan to match demand for Community Midwives with Supply in Pakistan; UNFPA 2014.

enough for them to stay on for a period of 5 years which will give them the opportunity of establishing their private practices.

The new retention model alsolays emphasis on refresher trainings of CMWs. It is proposed that need-based refreshers should be offered to CMWs at least once a year. CMWs' clinical supervisors should regularly record their observations to identify training needs and provide inputs to the EDO Health to plan for tailored courses accordingly. CMWs who have completed their bond period can also be given the refresher trainings. This would encourage them to continue reporting to the programme.

In order to reach the poorest of the poor the programme proposes to introduce cash transfer voucher scheme. The extremely poor clients will be selected and will be given a cash return voucher which she will provide to her attending CMW. The CMW will provide services free of cost to the woman and claim Rs. 500 from the programme on submission of the voucher.

In areas where the CMWs cannot be recruited because the available girls do not fulfil the criteria, two following options are proposed. 1) Special incentives for hard to reach areas for CMWs from nearest community where girls are available and 2) reduce selection criteria and increase the period of training. The programme will work out the details and implement whatever option is feasible to specific areas. Additionally the programme will also work out the details of training new CMWs according to requirement of specific districts. Districts with a higher SBA coverage may not require as many CMWs as a district with low SBA coverage.

An efficient referral system from community to basic and comprehensive EmONC facilities is required to ensure that timely appropriate health care is given to high risk clients. In order to encourage CMWs to refer high risk clients to basic or comprehensive EmONC facilities, it is proposed that they may be given an incentive of Rs. 300 per referral. Details of the referral system are discussed later in the document.

1.1.3 Training of outreach workers LHWs and CMWs (initial and refresher)

Initial and refresher trainings will be conducted for outreach workers (LHWs and CMWs) in IMCI, IYCF, screening, management of moderate and severe malnutrition, FP, PPFP and nutrition counseling and data reporting. LHWs and CMWs will be made aware of the

		background and evidence behind the new approaches to family planning and maternal health services and will be trained to use national standards of family planning, care during pregnancy and post-partum period in their daily practice. It is envisaged that this will improve their knowledge and skills on Integrated Management of Neonatal and Childhood Illness (IMNCI), assessment and counseling on child growth, nutrition and development by participation in specially organized training sessions. Training will also focus on how to improve quality of family planning, preventive, nutritional, maternal and neonatal and child health services in the district. Both class room and on the job trainings will be provided to LHWs at the facility level, while CMWs will be trained at the Midwifery schools using the standardized training curriculum and manuals. Both LHWs and CMWs will be required to attend refreshers with especial focus on family planning counseling techniques, IYCF, IMNCI, CMAM etc. Furthermore the curriculum will be reviewed in light of the needs of the programme and revised rules, where necessary. Training materials will be translated into urdu for ease of understanding. Translation and printing of training materials and modules will ensure effectiveness of training and will have a direct impact on quality of maternal and child health services. Previously translated materials will be reviewed, updated and improved. **1.1.4 Developing horizontal linkages between CMWs and LHWs.** Linkages will be established between CMWs and LHWs working in the community. Both will work closely with each other under the guidance of the health facility incharge. LHWs will be responsible for antenatal care, family planning and nutrition services by ensuring implementation of the EPHS at the outreach level. CMWs will provide domiciliary midwifery functions and will actively conduct deliveries in their catchment area. They would work in close collaboration with the LHWs of their area for identification and referral of high risk pregnancies and complicated cases to the most appropriate health facilities. It is expected that the number of referrals for pregnancy complications will increase over time and the information will be verified through hospital records and referral registers. In addition, they will also be responsible for identification of cases of malnutrition among women of reproductive age and children, manage moderate malnutrition, ensure implementation of CMAM and refer complicated

malnutrition to the nearest Outpatient Therapeutic Programme (OTP) or Stabilization Centre (SC).

The development of linkages between LHWs and CMWs may not be a very straight forward task. The programme understands that vested interests of the two very important outreach workers may hinder their cooperation with each other, resulting in non-cooperation. However it is envisaged that with innovative measures, the integration of LHWs and CMWs will directly contribute to increase in number of skilled birth attended deliveries, improvement in referrals for complicated pregnancies and subsequent reduction in maternal and neonatal morbidity and mortality. Moreover, they are expected to directly contribute to increase in CPR by providing family planning counseling services, reduction in acute malnutrition through identification, management and referral of complicated cases.

The package of services to be provided by outreach workers and list of medicines and supplies required for the given task are as per EPHS.

1.2 Component 2: Community outreach services focusing on Nutrition including MNCH/RH and Family Planning

1.2.1 Provision of supplies to CMWs as per their specified kits

The CMWs will receive regular supply from the health facility for domiciliary services and family planning. CMWs will be supported with additional equipment to assist in their practices. The equipment will include onetime equipment like delivery table, office furniture and CMW kit bag and recurrent supplies like basic medicines, family planning supplies and clean delivery kits. All procurements will be conducted as per Punjab Procurement Rules. *(Annexure C-6, page 87, CMW & delivery related working)*

1.2.2 Community outreach MNCH/RH services focusing on Nutrition and Family Planning

LHWs and CMWs will be fully trained on the preventive package of nutrition (Nutrition Education Package) including Infant and Young Child Feeding (IYCF), micronutrient deficiency,Water And Sanitation for Hygiene (WASH), use of iodized salt and fortified flour messages, provision of iron folic acid to all pregnant and lactating women and micronutrient sachet to all identified MAM children and followup with them. This preventive Nutrition Package will be used for addressing micronutrient deficiencies and awareness raising especially for

		promoting healthy behaviors among the population, especially, women, children and adolescent girls. Additionally, in areas where the therapeutic component will be undertaken, LHWs & CMWs will be strengthening the Nutrition program through effective screening, referral, default tracing and follow-up. LHWs & CMWs will screen, refer and follow up severely malnourished children to the health facility where OTP services are being provided. The outreached teams will focus on Severe Acute Malnourished (SAM) and Moderate Acute Malnourished (MAM) children and pregnant and lactating women (PLW). LHWs and CMWs will screen the children and pregnant women in the community and treat the ones who do not have complications and are treatable under the Community based Management of Acute Malnutrition (CMAM) protocols. The malnourished children with complications or the ones who are severely affected will be sent to appropriate referral facility for specialized care. These referral facilities are Outpatient Therapeutic Programme (OTP) sites established at all basic EmONC facilities and Stablization Centres (SC) in all 36 districts at the DHQ or tertiary care hospitals. ***Ensuring Essential Newborn Package Services in the Field*** Under this programme, the Comprehensive Newborn Package prepared by MNCH program in consultation with UNICEF, WHO and Save the Children will be implemented at the health facility and community level through CMWs and LHWs. This programme will translate training manual on community essential newborn package in Urdu and will include it in LHWs and CMWs curriculum. Refresher training will be given and all the LHWs and CMWs will be trained in neonatal care which include immediate and critical life support to a new born by mouth-to-mouth resuscitation, prevention from hypothermia by keeping baby warm through Kangaroo mother care/skin to skin contact and delayed bathing, early initiation of breast feeding and ensuring cord care with chlorhexidine. The LHWs and CMWs will educate pregnant women and their family on Essential Newborn Care (ENC) package during antenatal visits. The LHW will also assist the birth attendant in resuscitation of newborn at the time of delivery. She will conduct follow up visits for postnatal and neonatal care on within 48 hours, day 3, 7, 14 and 28th days of birth. The LHWs and CMWs will be trained in identification of any sign of illness and to provide immediate pre-referral care to the newborn and refer to health facility.

		Community IYCF Services in the Field Infant & Young Child Feeding (IYCF) interventions are very effective for the physical and intellectual development of children, as the damage caused to intellectual development by childhood malnutrition is generally found to be irreversible. The premise of the IYCF includes breastfeeding and complementary feeding. The principles of IYCF include: i) newborn breastfeeding is initiated within one hour of birth; ii) exclusively breastfed for the first six months of life; and iii) should receive nutritionally adequate, safe and age appropriate complementary foods starting at 6 months while continuing breastfeeding up to two years. The LHWs and CMWs will play a critical role in the improvement of quality of breast feeding practices. A curriculum has already been prepared by the LHWs programme. The same manual will be used to train all the LHWs and CMWs through a 5 days training session. The training will focus on identification of breast related problems during the pregnancy and referral of pregnant lady to the health facility for corrective action. The field staff will be promoting breast feeding since the inception of pregnancy through educating the whole family specially the mother in law and sister in law to counter any negative influences if present. They will also promote optimal complementary feeding and refer the child to the health facility if there is any problem or issue. The concept of involvement of community in IYCF is a new one in Pakistan. This has been successfully implemented in Bangladesh and the same model was piloted in two districts of Punjab. The results showed remarkable improvement in the behavior of community towards IYCF. The same model will be used to involve community and notables in a setting. This will be replicated in a phase-wise manner to cover the entire province while initially 10 districts will be included in this intervention. Provision of supplementary foods for distribution among identified cases is being supported by WFP in selected districts. This support will continue and expand to six districts. The programme will augment the support from WFP by providing trainings and doing operations research. The following commodities are being used for treatment of identified cases: • Provision of Fortified Blended Food (FBF) to MAM PLWs • Provision of Micro nutrient tablets to MAM PLWs • Provision of RUSF (Ready to Use Supplementary Food) for MAM Children 6-59 months in two districts

		• Provision of High Energy Biscuits (HEB) to siblings of identified SAM & MAM children • Provision of Micronutrient sachet to MAM children and • Provision of Nutrition advocacy package (IYCF, immunization Wash, Fortification) ***Integrated Management of Neonatal & Childhood Illness (IMNCI)*** Integrated management of neonatal and childhood illness (IMNCI) strategy will be an essential part of this programme. The community component of IMNCI will be implemented through LHWs and CMWs who will be trained through a six days structured training. The community and family practices will be improved through education of parents with focus on exclusive breastfeeding, proper weaning, immunization, improving personal hygiene and health seeking behaviors, care at home and overall health promotion. The LHWs will treat simple Pneumonia and ARI with Amoxicillin and refer cases of severe Pneumonia to their respective BHU. She will also treat diarrhea without dehydration and will refer the child with some or severe dehydration. The training module is already included in LHWs refresher training package. The medicine required for community IMNCI will be provided to all LHWs and strong referral linkages will be established with the BHU and other referral health facilities. ***Ensuring Child Spacing Services*** Child spacing is an essential part of CMWs training. The CMWs will educate their respective communities on importance of Healthy Time Spacing of Pregnancy (HTSP). They will offer child spacing health education with information on their side effects, and help the willing women in selecting a method of their choice and provide them with that method or refer them to BHU to obtain that method. The CMWs will counsel the women facing any side effects of child spacing methods and refer them to BHU, for appropriate treatment and guidance.Basic Objective of the program is to strengthen the comprehensive Family Planning(FP) services with a main focus on Post-Partum Family Planning (PPFP). **1.3 Component 3: Improving Basic EmONC services at primary level health care facilities** Direct obstetric causes such as postpartum hemorrhage, sepsis and complications of abortion are responsible for close to 50% of maternal deaths. A majority of these maternal and early newborn deaths can be

avoided by provision of prenatal, delivery, postnatal and newborn care services within reasonable travel distance & travel time.

According to an estimated figure, 85% of the pregnancies end up normally while 15% of them undergo complications. It is imperative that every district should be mapped and it should be ensured that there are basic and comprehensive EmONC services available within an acceptable distance. The acceptable number of EmONC facilities is 5 for every 500,000 population, out of which 1 must provide Comprehensive EmONC[6].

The following table gives an average interval between onset of major obstetric complications and death, in the absence of medical interventions:

Table 3: Estimated average interval between onset of major obstetric complications and death, in the absence of medical interventions

Complication	Hours	Days
Haemorrhage • Postpartum • Antepartum	 2 12	
Ruptured uterus		1
Eclampsia		2
Obstructed labour		3
Infection		6

(Source: Maine, D. *Prevention of Maternal Deaths in Developing Countries: Program Options and Practical Considerations, in International Safe Motherhood Conference*. 1987. Unpublished data: Nairobi.)

As seen in the table above, it is important to ensure that the travel time to an EmONC facility from anywhere in the catchment population does not exceed the minimum acceptable time and preferably should be less than one hour.

Under the proposed IRMNCH programme allRHCs except the 36 RHCs which will be upgraded to RHC+, and the 1000 24/7 BHUs would provide Basic EmONC services. 700 selected BHUs are being upgraded to provide basic EmONC under the previous MNCH programme and the remaining 300 will be part of this proposed PC1.

1.3.1 Upgradation of selected BHUs (24/7) and all RHCs for basic EmONC facilities

Pakistan faced devastating floods in 2010, affecting millions of people. Unfortunately, the flood affected districts in Punjab were those where

[6]Monitoring Emergency Obstetric Care, a handbook. WHO, UNFPA, UNICEF & AMDD 2009

		indicators of maternal, newborn and child health were not good even before they became flood-hit. The situation would have been aggravated if extra ordinary measures were not taken to improve reproductive health services in these areas. The Government of Punjab, with financial and technical support from UNICEF and UNFPA, started provision of 24/7 basic EmONC services in selected BHUs and RHCs in 7 worst flood effected districts. By December 2011, 81 BHUs and 60 RHCs were equipped and had started functioning round the clock, providing Basic EmONC services. The progress shown by converting almost nonfunctional BHUs to round the clock maternal and child care centers is remarkable and community feedback to these services is extremely positive. This model was later expanded to select BHUs in all 36 districts through the current IRMNCH PC1 and this process of expansion is still going on. The current programme intends to include 700 BHUs by the end of 2015. Further expansion by adding 300 more BHUs will be achieved by the proposed PC1 taking the total number to 1000 by 2016. The selection of BHUs is on the basis of geographical distances, ensuring maximum coverage in each district. The *Basic EmONC* services include but are not limited to: intravenous and intra-muscular administration of medicines such as antibiotics, oxytocin and anticonvulsants; assisted vaginal delivery; manual removal of placenta; manual removal of retained products of an abortion or miscarriage; and stabilization, referral and transferring the patients of obstetric emergencies not managed at the basic level to referral facility. In terms of newborn care, the required services at the basic EmONC level include resuscitation, management of neonatal infection, very low birth weight infants, complications of birth asphyxia and severe neonatal jaundice. Furthermore, skills and supplies for intravenous fluid therapy, thermal care including radiant warmers, Kangaroo mother care, oxygen supply, parenteral antibiotics, intra-gastric feeding, oral feeding using alternative methods to breast feeding and breast feeding support. The network of LHWs, CMWs and BHUs working as a team in the proposed programme will enable the teams of health care providers at various levels to effectively perform their specific functions through provision of regular antenatal care and advice on nutrition and supplements.*(Annexure C-4, page 85, 24/7 BHU equipment and furniture detail)*

Basic EmONC at RHCs

The programme proposes to provide basic EmONC services at each of 306 RHCs on 24/7 basis. This will be done by ensuring the presence of existing human resource. The RHCs that come within the 20 low indicator districts may be provided support in the form of missing equipment and/or supplies, etc. on a need basis as identified by the district health teams. However, efforts will be made to ensure the availability of services from the existing budget and resources allocated for the RHCs by the Department of Health.

Outpatient Therapeutic Program (OTP)

All Basic EmONC facilities including 1000 24/7 BHUs and all RHCs will have Outpatient Therapeutic Programme (OTP) centres within their premises. The CMWs and LHWs will refer the Severe Acute Malnourished (SAM) children who do not have any complications to the OTP centres where they will be given Ready to Use Therapeutic Food (RUTF) and routine medicine followed up till they are cured. The OTP centre will also provide advocacy about IYCF, immunization, WASH and fortification.*(Annexure C-7, page 89, detailed costing of RUTF).*

1.3.2 Availability of minimum agreed staff at the 24/7 basic EmONC facilities

The proposed project intends to expand the area which is covered by basic EmONC facilities to ensure lifesaving procedures are available and accessible to maximum number of women and infants. As the services will be enhanced, and will be provided round the clock, it is necessary to increase the number of staff at these facilities. The following table gives the approved and proposed staff positions at 24/7 BHUs:

Table 4: Approved & proposed staff position at 24/7 BHUs

Sr.No	Position Name	Facility	Existing approved Strength	Proposed Strength	Total Approved/ Proposed Strength
1	Nutrition Assistant OTP (LHV)	Basic EmONC	0	30	30
2	LHVs	Basic EmONC	1,400	600	2,000
3	Aya	Basic EmONC	1,400	600	2,000
4	Ambulance drivers	Basic EmONC	466	0	466
5	Guards	Basic EmONC	1,400	600	2,000
6	Sweepers	Basic EmONC	0	700	700

Total		**4,666**	**2530**	**7,196**

As can be seen in the table above a new post of nutrition assistant (LHV) is being proposed for selected OTP sites. The total OTP sites will be in 1000 BHUs (24/7) and 270 RHCs. However the number of nutrition assistants being proposed are 30. Keeping in view the prevalence of severe acute malnutrition, it is being assumed that the case load at the OTP sites will be limited to a few cases every day and dedicated staff for all OTP sites may not be a good intervention at the beginning. The strategy to run the OTP sitesis, to utilize the services of LHVs or school health and nutrition supervisorswho are already working in thesefacilities. However there may be facilities which are under staffed or have a heavy case load and the available staff cannot run the OTP centres. In such cases Nutrition Assistants will be posted in 30 selected facilities.

At the RHC level, the existing staff will be trained in provision of EmONC services. The additional staff (WMO & LHV) may be filled on contract basis, afterwards on completion of the project, they can be shifted to the regular budget.

The existing staff will be trained in provision of EmONC services. The requirement of additional staff may be fulfilled through temporary contract on a need basis.

1.3.3 Availability of logistics, equipment, medicines and supplies for all HF designated for provision of 24/7 basic EmONC services

The availability of minimum equipment and supplies required to ensure provision of basic EmONC package at 24/7 BHUs and RHCs has to be ensured.

Physical Infrastructure: The provision of basic EmONC services in the facility requires a functioning labor room/operation theatre and indoor ward. The RHCs may be provided with funds for minor repairs but not for new construction. Most of the RHCs already have provision for 20 beds for treatment of indoor patients, an operation theater, laboratory and X-ray facility.

Equipment and Supplies: The equipment and supplies required to ensure basic EmONC package at RHCs include laboratory support and equipment for a minor operation theatre. The supplies include contraceptives, medicines, IMNCI package of medicines, basic

		newborn care kit, clean delivery kits, and other basic equipment. Ultrasound machines are important equipment for any facility providing basic EmONC services. However due to their high cost, it may not be possible to provide them to every 24/7 BHU. It is proposed that one machine may be provided to a cluster of 4 BHUs and placed in the most accessible and centrally located facility amongst the 4. **1.3.4 Capacity building of staff at basic EmONC facilities** Provision of basic EmONC services is a big undertaking and will require trained and skilled staff readily available to provide lifesaving support to the women and children. To ensure round the clock availability of trained staff, it is proposed to provide skill based training to two woman medical officers in obstetrics and one to two medical officers in pediatrics/neonatology. These trainings can be imparted by providing three months attachment at the nearest teaching hospital or at a DHQ hospital having a qualified specialist. Two doctors will be trained from each RHC and one doctor from each 24/7 BHU. These trainees shall be entitled for an allowance of Rs 15,000 per month for the period of attachment. The lodging will be arranged by the programme, preferably at doctors' hostels, for the length of training period. The trainer shall be entitled for an allowance of Rs. 40,000 per month for a group of 5-7 trainees. This means each trainer will receive an allowance of Rs. 120,000 for training 5-7 doctors in their respective specialties for three months against minimum acceptable targets set for trainers. The selection of doctors for this training program will be done by the respective hospital in consultation with district program management unit and EDO (H) and approved by provincial program management units. The minimum criteria shall include six months service at that hospital and a commitment to continue working after the training for at least 2 years. It is proposed that a mechanism should be developed and institutionalized with College of Physicians and Surgeons of Pakistan (CPSP) to recognize this period in regular post graduate training afterwards. Each district program management unit (DMU) will figure out its requirements for staff and will make a yearly plan in coordination with EDO (H). The plan will be submitted to provincial program management unit (PMU). The PMU will consolidate district

requirements and will arrange for training of doctors from the districts in coordination with health department and teaching hospitals. This component shall be operational within six months of commencement of the program.

1.4 Component 4: Improving Comprehensive EmONC services at secondary level health care facilities

1.4.1 Upgradation of selected RHCs to Comprehensive EmONC facilities (RHC+)

As discussed earlier, presence of a comprehensive EmONC facility is essential for every 500,000 population. Another consideration is that the travel time from farthest corner of the catchment area should not be more than one hour. Going by these standards it is necessary to increase the number of comprehensive EmONC facilities selecting them strategically so that the whole population is covered. DHQs and THQs are secondary care hospitals and by default should be able to provide comprehensive EmONC as part of their routine services. However to increase the coverage of comprehensive EmONC so that more and more area is covered and these lifesaving services are closer to the community, selected RHCs may be upgraded to provide comprehensive EmONC. This initiative is being called the RHC+ model.

The current PC1 proposes to upgrade one RHC in every district for the provision of comprehensive EmONC services. All district EDOs after district mapping using the WHO criteria of having one Comprehensive EmONC health facility for a population of 500,000 will identify one most suitable RHC for this purpose and the program would provide support for this. In order to go for the RHC+ model, all technical staff and resources required for cesarean section and blood transfusion have to be made available at the RHC.The integrated programme proposes to ensure complete package of basic EmONC services at all the RHCs and comprehensive EmONC at 36 selected RHCs (RHC+).

The *Comprehensive EmONC Services* include all of the services provided at the basic level, with the addition of cesarean section, blood transfusion services, and newborn special care at the advanced level, such as intensive care neonatology units.*(Annexure C-5, page 86, RHC equipment details).*

Referral System

The establishment of a functional and efficient referral system is considered as the key to ensuring adequate access to healthcare delivery services for the programme area population. An efficient

		referral system plays a vital role in saving lives. It is essential to develop referral protocols for referral of high risk cases to basic and comprehensive EmONC. One of the main components of a referral system is an ambulance service readily available to transport the patient in need to an appropriate referral facility. Most of the health facilities have an ambulance available but as there is no referral mechanism the ambulances are underutilized or misused. More than a hundred ambulances are being procured by health department with funds from DFID as per the business plan. This PC1 does not intend to buy any new ambulances, however an efficient referral system needs to be established. Following are the main components of the proposed referral system: • Establishment of a central call centre with a dedicated short telephone number which will be widely circulated so that it can be easily memorized. This coordination centre will receive all calls and instruct the nearest ambulance to respond. • Establishment of a referral desk at every comprehensive EmONC facility. This desk will keep a record of all incoming and outgoing referrals. The desk will followup on all referrals. • Develop gender sensitive protocols containing Standard Operating Procedures (SOP) for referrals at all levels. First level would be from community to health facility. Second level be from primary health care facility to higher level facility and the third level would be from secondary care facility to tertiary care facility. • Referral system protocols and SOPs will be displayed in all facilities and work places of community workers. • Training of ambulance drivers and paramedics in basic life support during transportation. The referral system will need support on an ongoing basis. As mentioned earlier a fleet of ambulances will be purchased for BHUs through the DFID funds under the PHNP business plan. However the proposed programme will ensure availability of POL. Drivers will be recruited under this PC1 for the ambulances at the 24/7 BHU level so that round the clock service is available for referrals. The drivers and paramedic staff will be given trainings so that they can provide basic

life support to the patients while being transferred.*(Annexure G, page 108)*.

1.4.2 Availability of minimum agreed staff at the Comprehensive EmONC facilities

As the services will be enhanced, and will be provided round the clock, it is necessary to increase the number of staff at these facilities. The following table gives the approved and proposed staff positions at RHCs and DHQ level facilities:

Table 5: Approved & proposed staff position at RHCs and DHQ

Sr.No	Position Name	Facility	Existing approved Strength	Proposed Strength	Total Approved/ Proposed Strength
1	MO (Stabilization Centre)	DHQH	0	36	36
2	Nursing Staff (Nutrition)	DHQH	72	72	72
3	WMO	RHC	292	0	292
Total			**364**	**108**	**400**

Human Resource Requirement and Strategy: In addition to staff required to ensure basic EmONC services at RHCs, some additional staff will be required to provide comprehensive EmONC services at selected RHCs. These include a gynecologist, anesthetist and pediatrician.

The program proposes following ways to engage these professionals in provision of comprehensive EmONC services at selected RHCs:

a) *Contracting specialists on regular basis:* There is apprehension that they will not be available in such a large number and perhaps will not be willing to serve at RHCs on regular basis. However where possible they shall be contracted;
b) *Engaging public sector specialists on need basis:* The specialists working at THQ and DHQ hospitals may be called on as and when required basis. They may be compensated on a case to case basis on already agreed upon terms and conditions.
c) *Engaging private sector specialists on need basis:* The specialists practicing nearby may be contracted to provide services on, as and when required basis on mutually agreed upon terms and conditions. They shall be paid on market rates for their services.
d) Appointment of postgraduate (PG) trainees at RHCs, THQs and DHQs on rotation basis.

e) The attachment of RHC staff for hands on training in gynecology, anesthesia, pediatrics and neonatology.

The program will ensure services of specialists through implementing a mix of the above given strategies, however the programme may not be limited to these and innovative measures may be tried out to serve the purpose.

Lab technicians already posted at each of the 36 upgraded RHCs will be trained in blood transfusion techniques and relevant equipment will be made available.

1.4.3 Availability of logistics, equipment, medicines and supplies for all RHC+

The provision of comprehensive EmONC services in the facility requires a functional labor room/operation theater and inpatient ward. The RHCs will be provided with funds for minor repairs but not for new construction. Most of the RHCs have provision for 20 beds for treatment of indoor patients, an operation theater, laboratory and X-ray facility.At each of these RHCs beds will be allocated for EmONC services in the inpatient wards.

The equipment and supplies required to ensure comprehensive EmONC package at RHCs include laboratory support, blood transfusion services, and equipment for operation theatre and a functioning ambulance/vehicle. The supplies include contraceptives, medicines, IMNCI package of medicines, newborn care kit, clean delivery kits, and other basic equipment.

1.4.4 Capacity building of staff at Comprehensive EmONC facilities

Keeping in view the scarcity of available trained human resource, there may be a delay in finding the number of specialists required at the facilities providing comprehensive EmONC services as discussed earlier. To counter the shortfall, a short term solution is being proposed to train the doctors already working at these facilities.

For each facility being setup for Comprehensive EmONC services, it is proposed that one to three woman medical officers may be trained in Obstetrics (C-section), two woman medical officers or medical officers in pediatrics/neonatology and one medical officer in anesthesia and one additional according to the need of the hospital. It is estimated that a total of 958 doctors will be trained.

Table 6: Number of doctors to be trained at Comprehensive EmONC facilities

Sr. No	Facility	Number of trainees	Total trainees
1	RHC	2	578
2	THQ	3	240
3	DHQ	4	140
Total			**958**

Lab technicians will be trained where required to run the blood bank at selected RHCs and THQ hospitals. Paramedics will also be trained along with doctors to assist them as operation theatre assistants (OTA).

Each district program management unit (DMU) will figure out its requirements for staff and will make a yearly plan in coordination with EDO (H). The plan will be submitted to provincial program management unit (PMU). The PMU will consolidate district requirements and will arrange for training of doctors from the districts in coordination with health department and teaching hospitals.

1.4.5 Strengthening of neonatal units at Comprehensive EmONC facilities

At all THQ and DHQ hospitals, newborn care units would be established to become part of the comprehensive and basic emergency obstetric care services. All the facility staff handling deliveries would be trained in essential newborn care. However, for emergency newborn care specialized units would be established with adequate staff and equipment. Staff would be given specialized training for the purpose and will be permanently deployed in the unit rather than on rotation basis (especially the nursing staff).All health facilities providing comprehensive EmONC services will have functional neonatal units.

Each neonatal unit will require minimally the presence of a pediatrician, one medical officer / woman medical officer specifically for the unit in addition to at least two staff nurses to run the unit. This staff strength is included in the minimum staff requirement for 24/7 EmONC services which is given in the staffing section above.

2. Output 2: Improved practices and health seeking behaviour for Reproductive, Maternal, New born and Child Health and Nutrition*(Annexure C-2, page 73 for output 2 costing)*

		Provision of services to the community is one part of any health programme. The other and equally important part is the improvement in health seeking behavior of the community so that they know what service is available to them and when and from where should they seek it. There is a dire need to sensitize the community at large and especially the women towards behavioural change, not only to understand what quality services that respond to their needs are but also to seek and demand for such quality services as their fundamental right. Along with communication efforts focused at ultimate beneficiaries, the proposed project will initiate advocacy interventions targeted at key stakeholders especially target population, policy makers and other players to gather relevant allocation of resources, oversight and support. The health department intends to make use of all available channels of communication to raise awareness and mobilize the community on importance of nutrition, immunization, family planning, maternal and child health issues using specific themes, identified either through research or based on the policy recommendations that needs to be addressed, among the general populace as well as specific segments of the society i.e. religious leaders, opinion leaders and other influencers. Following are the main activities for advocacy and a strong social mobilization campaign. **2.1 Develop tools and materials for communicating key gender sensitive messages for behavior change** The intervention will use multiplicity of channels, including face-to-face communication sessions, social mobilization and IEC materials. The scope of communications component will focus on pregnant & lactating women and will address issues like breastfeeding, complementary feeding, use of multiple micronutrients, & use of iodized salt. The provincial office will have the main responsibility of health promotion. The health promotion team at the provincial office will be responsible for development of; • Health messages, • Communication strategy • Designing of Posters and flip chartetc. • Guidelines for district on health promotion and communication

		strategy. • Develop the tools and materials for communicating the key gender sensitive messages for behavior change and field test them before actual implementation. • Development and printing of IEC material with information on antenatal, natal and post natal care, child health, immunization, Reproductive health, FP and IYCF, CMAM and nutrition supplementation. The district programme office will be responsible for the implementation of communication strategy. They will ensure the display of all messages, posters etc at appropriate materials. The intervention will use multiplicity of channels, including face-to-face communication sessions, social mobilization and IEC materials. The scope of communications component will focus on pregnant & lactating women and will address issues like breastfeeding, complementary feeding, use of multiple micronutrients, & use of iodized salt. In line with the use of latest technologies and methods for promoting healthy behaviors. **2.2 Increased Community Participation and involvement in health Actions** The outreach workers will establish linkages with the community by establishing Health committees (male and female) in their catchment area and develop linkages of these committees with Primary Care Management Committees (PCMCs) of the facility for ensuring both mobilization and participation of the community in achieving health outcomes. LHWs will conduct regular community sessions for both male and females with the support of Health facility staff, PCMCs and community leaders. She will arrange sessions with male and female health committee's at least once every month and keep record of these sessions. She will also ensure follow up of the decisionsmade by the committee and present un-acted upon decisions in the next meeting of the committee. Wherever necessary, she will seek support from the PCMC members especially in ensuring immunization coverage or motivating the community for enhancing ANC, natal and post-natal coverage and to improve status of nutrition. **2.3 Improved Family and Community practices to support better health outcomes**

		Identification of negative behaviors will be done through Inter personal communication of outreach workers and group discussions with health committees etc. These will be addressed through building capacity of outreach workers through trainings and skill development. In addition health facility staff will work with Community groups/ committees to address the negative behaviors for the purpose the capacity of Health staff will also be developed through training. It will be ensured that all the messages are aligned with communication strategy andare not in contradiction with each other. **2.4 Dissemination of specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using innovative approaches** During the communication campaign it is important to ensure that the appropriate messages get to the right audiences using the most effective way for that particular audience. It is essential to sought political support (community leaders, government authorities, CSOs/NGOs, journalists, political leaders, corporate sector players, other stakeholders). This support should be coordinated both at the provincial and district levels. There is a need to develop unified standard messages developed by the provincial office to be disseminated through outreach workers, health facilities, community groups and media(print as well as electronic). Once finalized the messages can be adapted at the district levels or by other stakeholders to ensure consistency of messaging. **Message delivery proposals** Mass media campaign using electronic media can be the most effective. Above the line message delivery systems can deliver messages to a wide range of audience in a very short duration of time. A range of mass media outlets like local cable TV, FM radio, provincial or national TV networks can be used to deliver already developed material by Technical Resource Facility (TRF). This material includes documentaries, docu-dramas, talk shows and cooking shows. Below the line message delivery systems may not be as effective as electronic media but it does have a specific community group which can be targeted through local newspapers, brochures, flip charts, pamphlets, postersand articles. To delivery these messages there is a need to strengthen already established linkages with Girl Guide

		association who have received training. Similarly boy scouts or similar groups can also be involved in dissemination of message. In addition videos developed by TRF can be shown by the LHW in the health houses during her sessions with the community. Series of advocacy seminars, meetings and events at provincial level with donors, agencies, the media, parliamentarians, senior bureaucrats, religious leaders and the private sector. These seminars are important both at the provincial and district levels. Engaging journalists as advocates, encouraging them to become MNCH aware through dedicated programmes, awards and workshops. It is envisaged that this work will develop into a 'Journalists for MNCH' involving a structured approach to build a network of informed and committed journalists towards MNCH issues. This will also involve media houses who can be approached to air programmes on mother and child health as part of their social responsibility. Direct face to face interaction and discussions with women in groups and as individuals within communities, ensuring women understand what they need to do to maintain their health and that of their child throughout pregnancy and after birth is at the heart of the whole MNCH Programme. Lady Health Workers, CMWs and many other field workers will be essential partners who can help ensure that women have the opportunity to hear and discuss the critical information in ways that they are comfortable with, and which are appropriate to their wider role and responsibilities. Involving fathers and wider families, and orientation of community groups working with men. The PC-1 document and the overarching IRMNCH Programme strategy acknowledges the vital role played by men in households, and upon whom some communications activity must be focused to change perceptions and behaviour in order for the IRMNCH Programme to succeed. The districts therefore propose advocacy work focused on fathers and men's groups within communities. This needs to work closely in line with the activities aimed at women and at community leaders. It is important that even if the specifics and tone of the messaging may be different, the overall substance is the same, hence the importance of the unified messages. **Celebration of MCH Week (Twice a year)** MCH week will be a community based event celebrated twice a year. The purpose of MCH week will be to raise the awareness of the community about the mother and child health issues and their

		remedies through a participatory approach. Mothers and their children will be involved during the week activities. Focus will be on specific interventions like hand washing before and after meal and after using the washrooms. *Key Interventions of MCH Week* • Children will be given Mebandazole tablet through LHWs for their better growth. • Children who have not received EPI vaccination earlier upto the age of 2 years will be vaccinated. • LHWs will provide awareness to mothers and children about the protection from various diseases and will distribute pamphlets and brochures. • Mothers will be taught how to make ORS at home • During the week, LHWs will vaccinate pregnant women with TT. Pregnant women will also be checked by CMWs. • Mothers will be given orientation on family planning. • Mass media campaign will be launched to deliver important messages. • Screening will be done to identify malnourished children. **3. <u>Output 3: Effective management of the Program at provincial and district level</u>***(Annexure C-2, page 74, costing of output 3)* **3.1 Strengthening Programme Management Unit (PMU)** The present programme management unit (PMU) of MNCH and approved IRMNCH programme will be the PMU of the proposed IRMNCH programme and will be headed by Additional Director General Health Services (Programme Manager). The PMU under the leadership of ADGHS shall be overall incharge of the integrated programme including approved IRMNCH (24/7 BHUs), MNCH programme, LHW programme and nutrition. Although the LHW programme has a separate PC1, it will be functionally integrated with IRMNCH. The PMU will: • Play steward ship role in formulation of program policy guidelines in consultation with all stakeholders and dissemination of the same to all district managers. • Constitute and notify the technical advisory groups (TAG) on different themetic areas for formulation of technical guidlines • Development of training and capacity building strategies, training modules, training of master trainers • Monitoring and evaluation of program activities, internal

evaluations, coordination for third party evaluations

- Conduct performance audit and internal financial audit of the districts
- Hearing of appeals against the district management unit

The team of the existing PMU will continue their functions but now in accordance with their role in the integrated programme. However as the overall programme is now expanding with nutrition as a major component, there is a need to strengthen the PMU with specialist positions. The proposed new positions are given in the table below:

Table 7: New proposed PMU positions

Sr. No	Position Name	Existing Number	Proposed Number (Additional)	Total
1	Additional Program Director (Nutrition)	0	1	1
2	Procurement Specialist	0	1	1
3	Communication Specialist	0	1	1
4	Incharge Sexual Harassment Cell	0	1	1
5	Research Officer	0	1	1
6	MIS coordinator	0	1	1
7	Data Analyst	0	4	4
8	Software engineer	1	1	2
9	Admin Officer	0	1	1
10	Office Superintendent	0	1	1
11	Call attendants (Sexual Harassment Cell)	0	3	3
12	Computer operators(08-posts)/steno Typist (03-Posts)	0	11	11
13	Junior software engineer	0	1	1
14	Network administrator	0	1	1
15	Drivers	6	3	9
16	Naib Qasid	4	5	9
17	Security Guards	0	9	9
18	Mali	1	1	2
19	Sanitary Worker	0	6	6
Total PMU Staff		**12**	**53**	**65**

Three new positions, Additional Director Nutrition, Procurement Specialist and Communication specialist need special mention here as they have very specialized roles and their inclusion in the team will strengthen the overall programme and make it more effective.

In order to strengthen overall program management the program will:

- Develop standard operational procedures (SOPs) for program operations, personnel management and logistics management;

- Set minimum service delivery standards (MSDS) for each of the program interventions with specified levels and dimensions;

- Develop modalities for pre-service and induction training for various staff categories working in the program;

- Develop and implement monitoring and supportive supervision system consisting of monitoring checklists, schedules, data base and mechanism for feedback and follow up on suggested corrective actions.

3.2 Sexual Harassment Cell

The IRMNCH programme has a large female work force who exposed to a number of risks during their outreach activities and facility based work. One of the risks is sexual harassment. The proposed programme intends to establish a Sexual Harassment Cell (SHC) at the PMU level with a dedicated toll free number and round the clock services. The cell will be run by incharge SHC and 3 call attendants who will be available round the clock in shifts.

3.3 Strengthening District Management Units (DMU)

Implementation of the program at operational (district) level will be through the current Government structure of the Health Department. The District Management Unit (DMU) staff of MNCH Program will work under the Umbrella of IRMNCH & Nutrition Program which will be implemented with integrated approach. For all practical purpose three programs will be implemented under one umbrella.

Considering the enhanced role of DMU, following new positions are being proposed in the table below:

Table 8: New proposed DMU

Sr.No	Position Name	Existing Number	Proposed Number (Additional)	Total
1	Field Program Officers	0	19	19
2	Aaya CMW Schools	42	42	84
3	Cook CMW Schools	42	42	84
4	Naib Qasid (DMU)	0	36	36
5	Sweeper (DMU)	0	36	36
Total DMU Staff		**84**	**175**	**259**

3.4 Operationalizing DMUs in their enhanced role

As the role of DMUs will now be enhanced it is assumed that they will be more responsive, structured and reliable in their functions. Each DMU will be responsible for making their specific annual plans. These plans will be developed in coordination with EDO (H). The plans will be submitted to provincial program management unit (PMU). The PMU will consolidate district requirements and will make arrangements accordingly.

The plans will be regardingtheir training requirements and their requirement of specialists or post graduate (PG) trainees as specialists in district CEmONC facilities where they are not available. Thetraining component shall be operational within six months of commencement of the program. The second component of placing specialists at CEmONC facilities will be operational within one year of the commencement of the programme. Some prerequisites need to befulfilled before the placement is started. The main requirement would be the provision of secure and comfortable residence facilities for the specialists or PG trainees.

3.5 Budget

Budget of the Program will be prepared by PMU, in accordance with the provisions of the PC-1. Finance Officer of PMU will prepare budget statements for coming financial year(s) and he will submit it to Health Department for approval. The budget will include a detailed activity plan with costs, responsibilities and timelines.

3.5.1 Releases and Fund Flow Mechanism at PMU Punjab.

The PMU will submit the budget release request as per PC-1 allocation or according to government instructions regarding release/ utilization of funds to the Health Department Government of the Punjab (GoPb) for release of funds from Finance Department. Health Department, GoPb will forward the budget request of PMU to the Finance Department, of Punjab for release of budget. Finance Department GoPb will release the funds into the Assignment a/c maintained in NBP Main branch Lahore and in a/c-IV of all districts in Punjab on the request of Provincial PMU. The ADGHS/Program Director will have full authority to allocate/re-allocate the program funds under different heads of accounts out of released budget, as and when he deems it necessary to run the program activities efficiently in the province, after recording proper justifications. After revision of this PC-1, any funds of MNCH Program, released by

Federal Government or DFID, will be placed in the Assignment Account of IRMNCH. The savings of MNCH Program will also be re-validated into the Assignment Account of IRMNCH.

3.5.2 Releases and Fund Flow Mechanism at District Level.

On request of PMU, the Finance Department, GoPb through the Health Department will release the budget (online) to all the districts in Punjab and send asealed copy of release to District Accounts Offices (DAO) concerned and intimation copies to all the relevant departments. The DAO concerned on receipt of sealed budget copy from Finance Department,will place the funds in into A/C IV of the District Coordinator, IRMNCH. The District Coordinator IRMNCH of concerned district will sign all object head claims and will forward to DAO concerned for pre-audit and after pre-audit, the DAO will issue the cheque. The budget of DMUs will comprise of funds provided by PMU. PMU will be fully authorized to re-adjust / re-allocate the fundsunder different heads on the request of DMU. The request of re-allocation / re-adjustment of funds must be supported by proper justification.All kind of payments like, Payments of salaries / stipends to LHWs, LHSs, retention fee of CMWs and salaries of all Programs employees including employees working at DMU levels will be made from the funds released under different heads in account IV of all districts by District Coordinator of the Program. District Coordinator of the Program and his staff will carry out reconciliation of the receipts and expenditure with DAO on monthly basis.

3.5.3 Assignment Accounts of PMU

Finance Department will place the funds of the Program into the assignment account being maintained. The AG Punjab will then issue sealed authority letter to Treasury Officer Lahore for its crediting through challan form/receipt voucher into Assignment A/c maintained at NBP Main branch, Lahore for admitting expenditure. The PMU will have funds on account of employee related expenses; Operating Expenses Purchase of assets and for all PMU operational costs/expenses. ADGHS will abide by the prevailing government rules and regulations while making expenditure out of the assignment account and will be fully competent to allocate/reallocate the funds of PMU and districts. Two authorized signatories will operate the Assignment Account. The schedule of the cheques will be sent to the concerned NBP branches. Finance Section of PMU will carry out reconciliation of the receipts and expenditure pertaining to the AA on monthly basis.

3.5.4 Reconciliation with DAO/TO and Banks

Finance Officer of PMU will responsible for reconciliation with NBP for Assignment Account and the District Coordinators and Accounts Supervisors will responsible for reconciliation with District Accounts Offices for account IV, on monthly basis. The DMUs will be bound to submit reconciled statements to PMU on monthly basis.

3.5.5 Finance and Accounts Staff

Finance Officer, Audit Officers, Cashiers and other relevant staff of PMU will be preferably hired and posted from the Health Department, otherwise they may be hired on deputation basis from AGP/CGA however, and the existing officers/staff will continue to work if they have been appointed with the approval of competent authority. In case AGP/CGA offices do not fill the position within four (4) months of the submission of requisitions and repeated requests, the position will be filled in on contract basis in consultation/approval of the Department of Health. Accountants and Senior Auditor posts will be filled on contract basis however during the recruitment on contract basis; PMU will give priority to existing staff.

3.5.6 Internal Audit

Internal audit of Program units i.e. PMUs and DMUs will be carried out by the Internal Audit Wing of Health Department as and when required by the competent authorities. PMU will monitor the financial activities of DMUs through frequent visits to districts.

3.5.7 External Audit:

Audit Team of the Auditor General of Pakistan will conduct audit of accounts of the Program at PMU and DMUs level. Audit Officer of PMU will coordinate external audit task.

4. Output 4: Evidence based decision making through efficient monitoring and evaluation *(Annexure C-2, page 75, costing of output 4).*

No project can be termed successful without having a fully developed and functional system for monitoring and evaluation. A robust program management information system at all levels is important to record the implementation of programme activities at ground level, preparation of program performance reports and planning of subsequent activities.

4.1 Improved data availability & data quality

Reviewing and updating the health information system enables users at all levels to collect and use relevant and reliable information on

		reproductive, maternal, neonatal and child health, FP and nutritional status of the population. Such an update will allow for monitoring especially health of mothers and children, evaluating the effectiveness of relevant policies, making comparisons of country' progress towards the targets set in under MDGs and improving the process of developing informed policy recommendations. The Health department with this in mind plans to develop a robust monitoring and evaluation system integrating the existing information systems like DHIS, MNCH MIS and LHW MIS. The integrated system will capture the requisite information for monitoring of various activities e.g. implementation status of EPHS at the outreach level, quality of care, review of routine reporting data and operations research.There is a dire need to integrate the new initiatives like the e-monitoring and e-reporting systems with linkages with the existing information systems. The comprehensive integrated information system will aim to monitor the resources invested, the activities implemented, services delivered and evaluate outcomes achieved. Mechanisms will be put in place to improve data collection and information flow mechanisms to ensure quality, valid, and accurate data. The objectives of the integrated information system is to collect and provide information that will be used to: • Track progress on implementation of all components of the project; • Identify gaps and weaknesses in service provision; • Assess impact of EPHS on women, children, vulnerable and disadvantaged; • Plan, prioritize, allocate and effectively manage resources; • Monitor the impact of health communication on reproductive, maternal, neonatal and child health and nutrition behaviors; and • Measure effectiveness of interventions at Primary and secondary care levels. A district monitoring and reporting mechanism will be developed which will generate monthly reports. This mechanism will be based on Key Performance Indicators (KPI) and will be the responsibility of district coordinators. A framework is available in annexure I of this document which will guide the programme to develop monitoring instruments. Progress of each district will be measured for establishing a results based incentive and accountability system. Based on the monthly district reports, a quarterly report will be generated at the provincial

level by the programme for wider circulation among the development partners and other stakeholders. The provincial programme will monitor the district monitoring system and validate data through random spot checks in the field. This data validation exercise will be conducted in 4 districts each month. *(Annexure I page 120, district monitoring framework)*

4.2 Use of Information for informed decision makingPerformance

The Health Department will design and implement an internal performance monitoring and evaluation system. The Programme's success will largely be determined by its capacity to assist in trying out new approaches, learn from experiences with both proven and new approaches, and apply lessons learned. This calls for a systematic and continuous assessment of performance that goes beyond merely monitoring project inputs. It calls for mechanisms that allow us to apply the results of this assessment to improve our performance. Ongoing monitoring and assessment will permit us to identify project activities that are progressing as planned and need to be continued, introduce corrections to activities that are not progressing as planned, and identify activities that achieve their objectives ahead of schedule and can be terminated early.

The administrative data will track basic project management information. It will provide information on major activities completed, status of activities by tasks, resources utilized, resources available, etc. and other deliverables are provided to the stakeholders in a timely manner. The data will also be used to produce the following tables:

- The Project Activity Inventory will set forth the desired result for each activity, tasks to be accomplished, and resources required for each district.
- The Annual Work Plan will incorporate the Activity Inventory and will set forth the staff, time frame, and resource requirements for the project activities for the coming year.
- The Results-Oriented Project Activity Schedule will summarize the results-specific information from the Annual Work Plans.The Schedule will show each activity mapped to a project result and intermediate result, the period of performance, lead responsibility, and status for the reporting period. This schedule will also provide information to project management and stakeholders to see at a glance the number of weeks that each staff member will devote to the Project as a

whole and to each project activity.

The Health Department recognizes that external evaluators' best carry out the assessment of impact. To conduct a useful evaluation, however, external evaluators need to know the specific results we intend to achieve. By clearly defining our intended results from the start, we help focus external evaluations on the critical issues for the results package. External evaluators also are faced with the challenge of obtaining data to inform their evaluation. The project itself is best positioned to meet evaluator's data needs and therefore will be responsible for providing baseline data. Our internal system will be designed and implemented to collect quality data and to report on process, performance, and impact to meet the schedule and needs of external evaluations.

Special training for staff at all levels will be conducted in the use of data for problem solving and solution development. Through databased decisions, it is expected that the programme will become more proactive in supporting client-centered nutrition, family planning and maternal and child health services.

4.3 Functional Maternal, Neonatal and Infant Mortality Surveillance system;

A functional maternal and infant mortality surveillance systems needs to be set at the provincial and district levels to monitor local maternal and infant mortality and provide the evidence for maternal & infant health interventions needed to reduce these preventable deaths. The surveillance system will have the following components:

- Reporting on maternal, neonatal and infant mortalities from communities and health facilities.
- Verbal autopsies of all the reported mortalities by the health facility staff;
- Analysis of the cause of death data and its use in planning and management of Health services.
- Mortality reviews and death audits at Health facilities.

4.4 Improved supportive supervision and Supervisory mechanism at various levels of the programme.

The monitoring and supervisory system will be set up in three overlapping tiers as follows:

a) *The First Tier - LHS:* At the immediate level the Lady Health Supervisor (LHS) will be entrusted to conduct supervisory visit

		to CMW at least once every month to perform following tasks: i. Review of records being maintained by the CMWs for antenatal, postnatal visits, normal deliveries conducted, complications referred, referrals from LHW entertained, Family Planning referrals, etc.; ii. Inspect logistics i.e., safe delivery kits, status of medicines, condition of equipment; iii. Assist CMW in developing linkages with the LHWs and the LHV of the health facility; iv. Write monitoring report and submit to the health officer. v. She will present these findings to the health officer in the monthly meetings who will then share these finding with district program management unit of the program. **b)** *The Second Tier – Technical Support and Supervision by Midwifery Tutors:* The midwifery tutors will be the technical supervisors of CMWs. The midwifery tutors will distribute the CMWs depending upon the number of CMWs in the district and number of tutors available. During the supervisory visit the midwifery tutor will perform the following tasks: i. Assess knowledge and skills of CMW; ii. Observe CMWs interaction for antenatal care, postnatal care and child care and provide guidance to further improve her performance; iii. If CMW is conducting a delivery, tutor will provide on spot technical assistance to the CMW; iv. If a referral is immediately required, the vehicle of the tutor may be utilized for this purpose; v. Write monitoring report and submit to the district program management unit. vi. If the CMW is found to have below par performance the midwifery tutor can recommend a refresher for 1-2 weeks at the nearest health facility providing 24/7 EmONC services. In case the CMW does not improve after three refresher courses she may be asked to take a long refresher. **c)** *The Third Tier –Support and Supervision by District &Provincial Office:* The district program management unit will regularly receive information on monitoring and supervision of CMWs by first and second tiers. The finding will be consolidated at DMU and shared with provincial program management unit. After

		carefully monitoring this information, where required the officers from district program management unit and provincial program management unit will visit the district and CMWs. In order to get maximum benefit from monitoring and supervision activities, the supervisors will be adequately trained in conducting monitoring and supervision of CMWs. **E-Monitoring** Introduction of innovative methods are needed to improve the overall monitoring system to make it more effective and efficient. In this regard the proposed programme plans to introduce E-Monitoring system through Lady Health Supervisors. Lady Health Supervisors and some selected LHWs will be given tablets to record data during their field visits. It is envisioned that the introduction of tablets will not only increase efficiency but also ensure fast data transfer to the district and provincial levels. With the E-Monitoring system the LHS can register expecting mothers, collect data on vital indicators at each facility, followup with patients through reminders on services and messages on health. **Establishing Data Center/Server Room, E-Monitoring/E-Reporting System And A Web-Based Program MIS** A strong Data Center/Server Room in MIS Cell is necessary to ensure proper functioning of the programme in order to achieve the desired outputs and outcomes. E-reporting and monitoring system will be prepared and launched at provincial level for example the monitoring reports submitted by all levels of supervisors and monitors (LHS, supervisors, district managers, provincial monitors, and provincial monitors) will be entered directly into the software through text messages, mobile phone based web applications and online MIS. MIS team will be appointed on Provincial implementation unit level, they will be responsible for the up gradation of this reporting and monitoring software. The monitoring reports of these monitors will be submitted using web based mobile phone applications, online MIS. A robust program management information system is important to record the program implementation activities at ground level, preparation of program performance reports and planning of subsequent activities as well as policy designs. The program MIS will be web-based and deployed on a central server at the provincial office. District offices will be able to access and add

information to the MIS by logging in at the program website. District monthly reports will be submitted online through web based data entry forms. A dashboard will be developed on the program website for provision of live streaming data based on the reports received. The software will generate analyzed reports for each level of management staff. These reports will be available to the managers on logging in to their personal accounts at the website.

4.5 District Technical Monitoring Officers (DTMO)

The present programme with the support of UNFPA has appointed 3 DTMOs in Lahore, Multan and Rawalpindi divisions. DTMOsare appointed at the divisional level and visit CMWs in their districts to monitor their activities on a regular basis and report to the PMU. This support will end in 2015. The programme now proposes through this PC1 to appoint additional 6 DTMOs to cover the whole province. After UNFPA support ends the 3 DTMOs will also be included in the proposed programme.

Table 9: New proposed DTMOs

Sr.No	Position Name	Existing Number	Proposed Number (Additional)	Total
1	DTMO	3	6	9

5. Exit Strategy

The full role out and execution of EPHS will be the exit strategy of the proposed project. This is expected to done in a phased manner. Through this PC-1 the maternal, neonatal and child health including nutrition activities defined in the EPHS will be taken care off. It is expected that by the end of the three years of the programme, all districts will be fully implementing complete set of activities in this regard.

During the implementation of the PC-1, special attention will be paid to capacity building of district level staff to enhance their capacities in management and technical areas. This will be essential as according to plan after the completion of the project life, all activities will be taken on the recurrent side. This activity will go a long way in ensuring smooth transition of the project.

Moreover, following the closure of this PC-1 all the activities including procurement of medicines, supplies, and staff hired under the

		programme both at provincial and district levels, will be taken on the recurrent budget and mainstreamed in the health department annual programme. In addition, it will be ensured by the Health Department that activities started under the PC-1 especially for nutrition, will not only be continued but also enhanced over time to ensure sustainability and scaling up. The integration of the key programmes will lead to strengthening of the overall health systems, which had been undermined and weakened over the years. Further, the initiative will contribute maximally to strengthening of the district health systems. Moreover, the project will help build the capacity of both provincial and district staff in the area of nutrition, which has been a neglected area to date. Further, the activities for nutrition started under the project will be mainstreamed in the overall health care delivery services. The interventions under the programme will strengthen the neglected areas of MNCH, family planning and nutrition. The EPHS implementation will provide the necessary foundation to create not only a need among the population at the same time building the confidence in the public health system.

7	**THE PROJECT COST** Local: GOP: Foreign exchange cost: Total:	Date when capital expenditure estimates were prepared**: February 2013** this is revised in June 2015.The costs have been estimated on the prevailing rate of the market and based on previous work done.

Description	**Cost PKR Millions**		
	Original	**First revision**	**Second revision**
Govt. of Punjab Share	**9,814.171**	**9,392.027**	9,495.240

Integrated Reproductive Maternal Newborn Child Health and Nutrition Programme

Summary of Cost Estimates for PC-1

Outputs	Cost Estimates - PKR million			(%)
	Year 1	Year 2	Total	
Output 1: Improved delivery of maternal, child, family planning and nutrition services under essential package of health services	3,584.131	4,377.354	7,961.485	83.8%

		Output 2: Improved Practices and Health Seeking Behaviour for Reproductive, Maternal, Newborn and Child Health and Nutrition	39.560	39.560	79.120	0.8%
		Output 3: Effective Management of the Programme at Provincial and District Level	572.753	559.031	1,131.784	11.9%
		Output 4: Evidence Based Decision Making through Efficient Monitoring and Evaluation	239.688	83.163	322.851	3.4%
		Grand Total - PKR	4,436.312	5,059.108	9,495.240	**100%**
8	**ANNUAL OPERATING AND MAINTENANCE COST AFTER COMPLETION OF THE PROJECT: (ITEM WISE ANNUAL OPERATING COST)**	**Approved Average Operating Cost is Rs 3271.390 millions for the FY 2013-16.** **Approved Average Operating Cost is Rs. 3130.676 millions for the FY 2015-17.** **Revised average operating cost is Rs. 2,956.416Million for the FY 2015 - 17**				
9	**SOURCES OF FINANCING:**	The source of funding will be the Provincial Government (Provincial ADP) Funds may also be available from bilateral and multilateral donors and lending agencies. This project will direct available funds at the District level for providing services.				
10	**DEMAND AND SUPPLY ANALYSIS**	The proposed program will attempt to fulfill the unmet health needs of the general population in the province through provision of family planning, maternal, newborn and child health care, EmONC services and nutrition services. The program aims to achieve its objectives through strengthening health system through improving facility based and community based interventions and ensuring community participation at all levels. One of the important aspects that the program plans to address is to restore the trust of communities on public sector health services. The increased utilization of public sector, in turn, will reduce per capita costs of healthcare delivery, particularly with regard to general health and MNCH. A major constraint in improving availability and quality of health services is inadequate financial space available for provision of these services. The proposed program will increase cost-effectiveness and efficiency of health services by increasing their quality and access through synergistic				

		action with the ongoing initiatives. The distribution of health services is unequal with a majority of skilled health personnel being concentrated in urban areas. This program will improve the quality, access, affordability and utilization of health services in the rural areas by providing 24/7 EmONC services at selected BHUs and all RHCs. The number of deliveries conducted by skilled birth attendants has recently increased from 59% (MICS 2011) to64.7% in Punjab (MICS 2014) but still significant deliveries are being conducted by unskilled traditional birth attendants or family members. In case of obstetric and newborn complications, the availability of emergency care is severely limited. An efficient ambulance service is required to bridge the gap in service utilization through improved physical access of community members to healthcare services, especially in emergency situations. Provision of emergency transport services from house hold to Basic & Comprehensive EmONC services, will increase accessibility of communities to MNCH services, reducing the second delay in provision of EmONC services and will directly reduce the maternal & newborn mortality.To Streamline and strengthen emergency transport services from house hold to Basic & basic to Comprehensive EMONC centers, the project proposes to establish a call response centre in each district. Functioning round-the-clock and connected through a toll free number, emergency calls for ambulance services will be attended by operators. On the model of Rescue 1122, the ambulance service will provide 24/7 ambulance services for emergency transfer of pregnant women to health facilities in time of need. By linking patients to 24/7 EmONC facilities, this emergency transport will significantly improve facility utilization and reduce maternal and neonatal mortality by reducing transport barriers. Each ambulance will be stationed to serve a group of three geographically contiguous BHUs; thus each ambulance will cater to a population of about 85,000. The supply side of health services especially in the public sector is limited due to non-availability of trained human resources, and appropriate equipment, in spite of availability of a vast network of health facilities throughout the province. Although at present the share of individual household's out of pocket expenditure on health care is very high, the total expenditure on health is still below the optimum levels when compared internationally. This can only be improved through infusion of additional resources into health system either through Government expenditures, or alternative financing mechanisms. Given the level and distribution of poverty the need for a Government subsidy essentially remains and therefore the best mechanism would be targeting the subsidy to the poorer part of the population. This would create a healthier population base which has access to higher quality of care. The program targets rural areas and

		urban slums for provision of subsidized services and will lead to a decreased out of pocket expenditure on health care while providing improved quality of care to the population.
11	**FINANCIAL PLAN AND MODE OF FINANCING**	1. Punjab ADP 2. Grants/Results Based Aid from multilateral and bilateral donors are expected to cover the program. 3. In addition, TA support from DFID, USAID, UNICEF, WFP, UNFPA, WHO, and other international agencies are also expected.
12	**PROJECT BENEFITS AND ANALYSIS:** **a) Financial, Social and environmental Benefits** Financial Social Benefits with Indicators Employment generation (direct and indirect)	No direct financial gains are expected from the program. However, reduction in morbidity and mortality in the population, control in population and improvement in nutritional status would lead households to have more resources and spend on improving quality of their lives, better learning on children and health life styles. Considering that health is a basic right of every human being, the program will improve access to health care to all individuals of the society, especially the poor and deprived. Access to primary, reproductive and nutrition health care will improve health status of communities leading to improvement in the overall quality of life. Improvement in social benefits will be measured by reduction in: 1. Neonatal Mortality Rate; 2. Maternal Mortality Ratio; 3. Wasting and stunting (moderate and severe) 4. Population Growth Rate; 5. Total Fertility Rate Health and poverty are closely linked with each other; already poor people who are also unhealthy and vice versa. It is envisaged that health status improvements will enable individuals to avail more choices/opportunities that can help in improving quality of their lives like attaining education, competing for better employment opportunities and contributing towards their families and society's betterment, hence enjoying their life. Improved health behaviors and ensured access to primary health care services will not only reduce the suffering at individual level but will also reduce the cost of treatment if preventive measures are taken on time or when treated at an early stage. In the end, investment on treatment of complicated cases will be decreased and would allow planning for the development projects. It is difficult to put these benefits in figures but their significance cannot be overlooked. Another feature of the program is to organize communities in such a manner that ensures their active participation in planning, administration and management of

		health care system in their area. This will facilitate the functioning of health delivery system on one hand and empowering the communities on the other hand. Moreover, in the process, the organized communities are expected to take other development initiatives to identify and solve their local issues. Programme will build capacities of local communities by increasing their awareness regarding health issues and adopting healthy behaviors; of local staff by enhancing their skills and knowledge in health care services provision; of community representatives in planning small projects, administering and managing health services; and district health management teams in management, supervision, target setting & better planning for health care delivery system. Although majority of service providers and management cadre are currently working, but over the programme period efforts would be made to absorb service providers in the Health Department and District Health Office as part of the structural reforms. Indirect employment opportunities will also emerge related to the management/ organizational functions of the Programme. The program will certainly have a positive impact on the environment, with improved reproductive health outcomes. The improved health behaviors will lead to healthy life styles which are not possible without maintaining self-cleanliness (including hand washing), cleanliness at the household, street and society level. The appropriate disposal of human, liquid and solid wastes will further help improving the environment. There is enormous amount of hospital waste which is not handled safely and generally leads to spread of killer diseases like hepatitis, etc. The programme will make sure that, in all health facilities, hospitals and at community level, waste is adequately disposed of through implementation of infection control protocols.
	Environmental impact	
	Impact of	This program is a high priority for the government to make speedy progress on health & nutrition outcomes. Delays in the undertaking will lead to increased cost in achieving health and nutrition targets. Majority of the interventions in the programme are having very low cost per DALYs provided these are implemented on time. Delay in implementation will lead to continued high burden of mortality and morbidity and serious cost implications on the households. Currently, the government is indicating commitment to absorb different interventions as regular function of the public health sector. The program will be having four major outputs: 1. Improved delivery of maternal, child, family planning and nutrition services under Essential Package of Health Services 2. Improved practices and health seeking behaviour for Reproductive, Maternal, New born and Child Health and Nutrition

	delays on project cost and viability **b) Project Analysis:** Quantifiable outputs of the project:	3. Effective management of the Program at provincial and district level 4. Evidence based decision making through efficient monitoring and evaluation Please refer to the Logical Framework (Annex A) of the Programme which includes indicators for each output along with milestones and targets.
13	**MANAGEMENT STRUCTURE & MANPOWER REQUIREMENT**	The ultimate objective for implementation of the programme at operational level will be through the current Government structure of the Health Department. The PMU/DMU staff of MNCH Program will work under the Umbrella of IRMNCH & Nutrition Program which will be implemented with integrated approach. For all practical purpose three programs will be implemented under one umbrella. Staff employed for the management of the programme through development budget will be shifted to recurrent side as part of structural reforms at Provincial and District levels and this process is ongoing. The program management and manpower requirement is discussed in detail in the section on strengthening PMU and DMU on page 38 and 39 respectively.Table 6 and 7 provide information on new positions at the PMU and DMU levels.

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APPROVED BY:	
Approved By:- **Mr. Jawad Rafique Malik** **Secretary Health** **Department of Health, Punjab**	
Dated:	

ANNEXURE A

LOGICAL FRAMEWORK

PROGRAM NAME	Integrated Reproductive Maternal Newborn & Child Health &Nutrition Program					
GOAL	**Indicator**	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	**Assumptions**
To improve maternal, new-born and child health in Punjab especially of the poor thereby making progress towards achieving health related MDGs	Maternal Mortality Ratio (MMR)	178/100,000 lb	175/100,000 lb	172/100,000 lb	170/100,000 lb	
		Source				
		WB, UNFPA & UNICEF 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Neonatal Mortality Rate (NMR)	63/1,000 lb (PDHS)	53	52	51	
		Source				
		Pakistan Demographic & Health Survey (PDHS) 2012-13				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Infant Mortality Rate (IMR)	76/1,000 lb –MICS 2014	66	65	64	
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Under 5 Mortality Rate	96/1000 lb - MICS 2014	86	85	84	
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Total Fertility Rate (TFR)	3.5	3.3	3.2	3.1	
		Source				

		Multiple Indicator Cluster Survey (MICS) 2014			
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**
	Wasting (moderate & severe) prevalence	17.50%	15.50%	13.50%	11.50%
		Source			
		Multiple Indicator Cluster Survey (MICS) 2014			
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**
	Stunting (moderate & severe) prevalence	34%	33%	32%	31%
		Source			
		Multiple Indicator Cluster Survey (MICS) 2014			

PURPOSE	**Indicator**	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	**Assumptions**
To improve access to quality Reproductive health, Child health and Nutrition services especially for the poor	Contraceptive Prevalence rate (Modern methods)	38.7% - MICS 2014	43.7%	48.7%	53.7%	Macro-economic situation (both at national & provincial level) improves and economic growth accelerates Political and security situation in the country improves No major humanitarian disaster in the province Institutional risks related to devolution and formation of new administrative areas are appropriately mitigated Improvement in literacy rate Health, Population and Nutrition
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Skilled Birth Attendance (SBA)	64.7% - MICS 2014	66%	67%	69%	
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Institutional deliveries	60.8%	65%	70%	75%	
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator	**Baseline**	**Milestone 1 2015-16**	**Milestone 2 2016-17**	**Target 2017**	
	Average number of deliveries at 24/7 at	96 deliveries - DHIS 2014	157 deliveries	162 deliveries	167 deliveries	

	facility (BHU) per month	**Source**				programs, projects and interventions are harmonized provincial and district level
		District Health Information System (DHIS) - 2014				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Average number of deliveries at 24/7 at facility (RHC)	312 deliveries - DHIS 2014	515 deliveries	530 deliveries	546 deliveries	
		Source				
		District Health Information System (DHIS) - 2014				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Exclusive breastfeeding till age of 6 months	16.80%	19%	22%	25%	
		Source				
		Multiple Indicator Cluster Survey (MICS)- 2014				
	Indicator	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2015-17**		
	% of mothers able to identify at least 2 danger signs in early childhood illness (e.g. Pneumonia & diarrhea)	25% of mothers able to identify at least 2 danger signs in childhood illness	30% of mothers able to identify at least 2 danger signs in childhood illness	40% of mothers able to identify at least 2 danger signs in childhood illness	45% of community members able to identify at least 2 danger signs in childhood illness	
		Source				
		Program database				

OUTPUT 1	**Indicator 1.1**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	**Assumptions**
			2015-16	**2016-17**		
Improved delivery of maternal, child, family planning and nutrition services under Essential Package of Health Services	Average number of FP visits per month at primary level facilities	Average 43 FP visits per month for primary level facilities in 2014 – DHIS	Average 80FP clients per month per facility	Average 100FP clients per month per facility	Average 120FP clients per month per facility	Increased and sustained political commitment to reproductive, maternal and child health service delivery reflect increased government investment in health sector

		Source				Funding support from federal government continues/ enhanced and fiduciary risks mitigated
		District Health Information System (DHIS) - 2014				Provincial funding and donor assistance is available to fill the funding gaps
	Indicator 1.2	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Average number of FP visits per month for secondary level facilities	Average 149 FP visits for secondary level facilities - DHIS	Average 160FP clients per month per facility	Average 180FP clients per month per facility	Average 200FP clients per month per facility	
		Source				
		District Health Information System (DHIS) - 2014				
	Indicator 1.3	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	Appropriate skilled human resource (particularly female) available/ deployed especially in hard to reach/ remote areas
			2015-16	**2016-17**		Devolution of powers does not have negative impact on service delivery
	Average FP users per month per LHW catchment population	Average 50 FP users per month per LHW catchment population	Average 53 FP users per month per LHW catchment population	Average 56 FP users per month per LHW catchment population	Average 60 FP users per month per LHW catchment population	Effective coordination between IntegratedPrograms and effective joint coordination and supervision mechanism.
		Source				Regular and un-interrupted supply of essential medicines and contraceptives to districts.
		Programme database				Districts ownership to the program and reforms.
	Indicator 1.4	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Number of DHQs & THQs providing Comprehensive EmONC services 24/7	27/27 DHQ, 107/107 THQ	27/27 DHQ and 107/107 THQ	27/27 DHQ and 107/107 THQ	27/27 DHQ and 107/107 THQ	
		Source				
		District Health Information System				

Indicator 1.5	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
		2015-16	**2016-17**		
Number of complicated obstetric cases attended by DHQ & THQ	DHQ:18737, THQ:14690 (per year)	5% increase from baseline	10% increase from baseline	10% increase from baseline	
	Source				
	DHIS 2014				
Indicator 1.6	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
		2015-16	**2016-17**		
Number of RHCs and BHUs providing Basic EmONC services (24/7)	150/306 RHCs and 550/1000 BHUs	200/306 RHCs and 700/1000 BHUs	250/306 RHCs and 1000/1000 BHUs	275/306 RHCs and1000/1000 BHUs	
	Source				
	Third party validation for functionality of established facilities, Program Management Information System				
Indicator 1.7	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
		2015-16	**2016-17**		
Number of Community Midwives (CMWs) a) deployed, b) completing monthly reporting	Deployed: 2141, Completing monthly reporting: 1858 (compliance 87%)	Deployed: 2400, Completing monthly reporting: 2160 (compliance 90%)	Deployed: 3400, Completing monthly reporting: 3230 (compliance 95%)	Deployed: 4120, Completing monthly reporting: 4000 (compliance 97%)	
	Source				
	Programme database				
Indicator 1.8	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
		2015-16	**2016-17**		
Percentage of deployed CMWs with an average of two or below deliveries per month	17%	15	12	10	
	Source				
	Programme database				
Percentage of deployed CMWs with an average of 2-5 deliveries per month	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
		2015-16	**2016-17**		
	67%	69	71	73	
	Source				
	Programme database				

	Percentage of deployed CMWs with an average of >5 deliveries per month	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
		16%	16	17	17	
		Source				
		Programme database				
	Indicator 1.9	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Number of Stabilization Centers (SC) established	18 in priority districts	36	36	36	
		Source				
		Programme database				
	Indicator 1.10	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	% of cases cured and discharged at SC	92%	95%	96%	97%	
		Source				
		Programme database				
	Indicator 1.11	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Number of OTP sites at 30% BHUs and all RHCs established	BHU-371 OTP sites established, RHC-0	BHU-700, RHC-50	BHU-850, RHC-100	BHU-1000, RHC-179	
		Source				
		Programme database				
	Indicator 1.12	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Percentage of identified SAM children registered in OTPs	20%	25%	38%	48%	
		Source				
		Programme database				
	Indicator 1.13	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Per cent of Children suffering from diarrhea treated with ORS and Zinc	25%	30%	35%	40%	
		Source				
		Programme database				
OUTPUT 2	**Indicator 2.1**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	**Assumptions**

			2015-16	**2016-17**		
Improved practices and health seeking behaviour for Reproductive, Maternal, New born and Child Health and Nutrition	Early initiation of breastfeeding	10.60%	12%	14%	16%	Increased and sustained political commitment to reproductive, maternal and child health service delivery reflect increased government investment in demand side interventions. Human resources (particular women) required available, deployed and retained. Private sector facilitates the public sector in creating awareness and changing behaviors related with RCN. Effective coordination between program and projects for coordinated communication interventions. System of regular monitoring/ assessment functional.
		Source				
		Multiple Indicator Cluster Survey (MICS) 2014				
	Indicator 2.2	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Percentage of children receiving age appropriate complimentary feeding	20%	30%	35%	40%	
		Source				
		Programme database				
OUTPUT 3	**Indicator 3.1**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	**Assumptions**
			2015-16	**2016-17**		
Effective management of the Program at provincial and district level	Office of Integrated Implementation Unit established, fully staffed and equipped at provincial and district levels	80%	100%	100%	100%	Strong strategic leadership at provincial and district level reflected through performance of steering committee and DHMTs
		Source				
		Administrative data				Required competent health managers/ staff available and deployed at appropriate level
	Indicator 3.2	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	Macro-economic stability and availability of appropriate funds
			2015-16	**2016-17**		
	Days out of stock for 4 contraceptive methods, Paracetamol, Amoxillin, Iron, Folic Acid, ORS and Zinc	100% in 2015	50%	30%	25%	Fiduciary and institutional risks appropriately mitigated
		Source				
		District Health Information System (DHIS)				Effective system of performance of managers functional

	at RHC and BHU level.					
	Indicator 3.3	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Days out of stock for 3 contraceptive methods, oxytocin, Magnesium Sulphate, Mesoprostol and Safe Delivery Kit at CMW level	100% in 2015	50%	30%	20%	
		Source				
		Program database				
	Indicator 3.4	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Days out of stock for 3 contraceptive methods, Iron, Folic Acid, ORS and Zinc at LHW level	100% in 2015	50%	30%	20%	
		Source				
		Program database				
OUTPUT 4	**Indicator 4.1**	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	**Assumptions**
			2015-16	**2016-17**		
Evidence based decision making through efficient monitoring and evaluation	Performance review of districts conducted at provincial level using KPI system	Quarterly review held	Quality review meetings	Quality review meetings	Quality review meetings	Strong commitment at provincial level to integrate health information systems with strong leadership
			Annual performance review	Annual performance review	Annual performance review	Availability of effective organizations able to produce quality evidence and influencing policies
			Annual District performance disseminated through DOH website	Annual District performance disseminated through DOH website	Annual District performance disseminated through DOH website	Effective strategic partnership among development partners and the government to generate demand and provision of quality RCN services
		Source				Security situation conducive to research and advocacy in all provinces/ areas.
		KPI dashboard				

	Indicator 4.2	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Improved quality of data	LQAS in DHIS only	Internal validation of data	External validation review	Internal validation of data	
		Source				
		Validation results				
	Indicator 4.3	**Baseline**	**Milestone 1**	**Milestone 2**	**Target 2017**	
			2015-16	**2016-17**		
	Verbal autopsy system functional for maternal deaths	Irregular implementation (no system in place)	10 districts having functional system	25 districts having functional system	All districts having functional system	
			Annual provincial report published	Annual provincial report published	Annual provincial report published	
		Source				
		Verbal autopsy reports				

ANNEXURE B

ACTIVITY STATUS AND JUSTIFICATION FOR CONTINUATION

S. No	Activity	Progress	Carrying the activity forward
1.	Availability of minimum agreed staff at the identified health facilities by the year 2015 for provision of 24/7 Basic and Comprehensive EmONC services	WMO = 153/292 LHV = 642/1400 Nurses = 12/72 Aya = 281/1400 Driver = 67/466 Security Guard = 217/1400	Induction of remaining staff for 700 BHU 24/7 is under process. Staff for additional 300 24/7 BHUs is being proposed in this PC1
2.	Availability of logistics, equipment, medicines and supplies for all HF designated for provision of 24/7 Basic and Comprehensive EmONC services	UPS and Foetal Heart Doppler provided to 150 24/7 BHUs. Remaining items for all 700 24/7 BHUs are under process of procurement No budget was released during the year 2013-14.	Equipment for additional 300 24/7 BHUs is being proposed in this PC1
3.	Strengthening of neonatal units at the Comprehensive EmONC health Facilities.	CTG machines have been provided to THQs / DHQs as per requirement	
4.	Implementation of MSDS and SOPs relevant to provision of Basic and Comprehensive EmONC services at the health facilities like protocols for antenatal, normal delivery, surgical procedure and postnatal procedures	In process	This will be an ongoing process to strengthen and improve Basic and Comprehensive EmONC services at the designated health facilities
5.	Training &Capacity building of staff at Basic and Comprehensive EmONC facilities on Basic and Comprehensive EmONC, IYCF and Nutrition, IMNCI, ENC, HTSP/FP and Infection Prevention and Control	10% staff has been trained	90% staff will be trained in the proposed PC1. These trainings and refreshers are essential for the staff to ensure quality MNCH & Nutrition.
6.	Development and implementation of transport services, including: • Provision of ambulances at the 24/7 Basic EmONC facilities • Ensure availability of POL and other logistics for transport • Provision of drivers for ambulances • Training of Ambulance drivers and paramedics staff on basic life support	39 ambulances provided to 24/7 BHUs Purchase of 194 more ambulances is under process POL has been issued to 10 District where ambulances are funded 67 drivers are working (as per serial No 1)	No new ambulances will be procured through the new PC1. However running expenses have been included to ensure an efficient and effective referral system. Out of 466 drivers, only 67 could be hired. The remaining have been included in the proposed PC1. A strong referral system requires a fleet of running ambulances.

S. No	Activity	Progress	Carrying the activity forward
7.	Strengthening of health facilities for the provision of Basic and Comprehensive EmONC services • Provision of conducive environment for female HCPs by provision of separate waiting area, wash room and ensuring safety	Separate washrooms are available Separate waiting area for females is also available	
8.	Monitoring and supervision of Health Facilities for the provision of Basic and Comprehensive EmONC services in terms of accessibility, availability and quality of EmONC services	Monitoring & Supervision is ongoing process. DC IRMNCH, CMW Tutor, EDO(H), DO(H), Provincial IRMNCH Officer, regularly visit the centres	To further strengthen the monitoring system and ensure quality, E-monitoring system is being proposed in the new PC-1
9.	District mapping for calculation of total Comprehensive and Basic EmONC facilities to be made available according to UN standards.	District mapping for calculation of Basic and Comprehensive EmNOC centre has been done	
10.	Short training courses of 3-4 months for WMOs/MOs on C- section working at THQ Hospitals and selected RHCs which are not performing EmONC services due to shortage of specialists	28 WMOs have been trained or are undergoing training.	This activity will be continued in proposed project. There is a shortage of specialists. To overcome this, WMO/MO are being trained to perform C Sections and provide anaesthesia ensuring provision of comprehensive EmONC services in some areas. This is being done as a last resort.
11.	Short courses for Charge nurses/Paramedics for 3 months on Spinal Anesthesia working at THQ Hospitals and selected RHCs which are not performing C-EmONC services due to shortage of specialists	31 Nurses have been trained or are undergoing training	This activity will continue in the proposed project with the same rationale as discussed above.
12.	One month short course for lab technicians to run the blood bank at selected RHCs and vacant THQ hospitals for the provision of Comprehensive EmONC services	30 laboratory technicians and 28 lab assistants / dispenser / LHV have been trained	This activity will continue in the proposed project with the same rationale as discussed above.
13.	Availability of logistics, equipment, medicines and supplies for all HF designated for provision of Basic and Comprehensive RH/MNCH and FP services accordingly	As per serial No. 2 Procurement of FP & Nutrition supplies also in process	Will continue in proposed programme to ensure the provision of Basic and Comprehensive EmONC services in designated facilities.
14.	Ensure provision of essential package of health services (EPHS) at all Health Facilities	In process	Will continue in proposed programme
15.	Capacity building of Staff at Basic and Comprehensive EmONC facilities on Basic and Comprehensive EMONC, IMNCI, ENC and Infection Prevention and Control	As per serial No. 5	This is an ongoing process and will continue in the proposed PC-1.

S. No	Activity	Progress	Carrying the activity forward
16.	Strengthening of health facilities for the provision of Basic and Comprehensive EmONC services	700 BHUs has been strengthened and 36 RHC+ have been strengthened	This activity will continue and further 300 BHUs will be added.
17.	Develop system for rotation of PG students in identified health facilities after following process • Approval notification from the concerned authorities; • Identification of hospitals for rotation on need basis • Remuneration package and logistic arrangements for PG rotation	This system has not been formalized and needs to be structured after consultations and involvement of stakeholders including Medical Colleges, CPSP and DOH	PG students are a good resource to utilize in the absence of specialists for provision of comprehensive EmONC services. This option is still open for facilities where specialists are not available. The activity will continue. There is a need to involve different stakeholders to make this a viable intervention.
18.	**RHC-plus model**. In every district one RHC will be identified for up-gradation for the provision of Comprehensive EmONC services.	One RHC in each district has been identified through a laid down selection process. There are 36 RHC+ now and are being strengthened with regards to human resource and equipment.	Strengthening of RHC+ is ongoing on and will continue in the proposed programme.

COSTING OF IRMNCH PROGRAMME FOR FY 2015-16 TO 2016-17

Annex C1: Cost Estimates Summary

Cost Estimates Summary by Outputs

Outputs	Cost Estimates - PKR			(%)
	Year 1	Year 2	Total	
Output 1: Improved delivery of maternal, child, family planning and nutrition services under essential package of health services	3,584,131,062	4,377,354,160	7,961,485,222	83.8%
Output 2: Improved Practices and Health Seeking Behaviour for Reproductive, Maternal, Newborn and Child Health and Nutrition	39,560,000	39,560,000	79,120,000	0.8%
Output 3: Effective Management of the Programme at Provincial and District Level	572,753,456	559,030,749	1,131,784,205	11.9%
Output 4: Evidence Based Decision Making through Efficient Monitoring and Evaluation	239,687,800	83,162,800	322,850,600	3.4%
Grand Total – PKR	4,436,132,318	5,059,107,708	9,495,240,026	100%
Grand Total - PKR million	4,436.132	5,059.108	9,495.240	

Cost Estimates Summary by Input Type

Input Type	Cost Estimates - PKR			(%)
	Year 1	Year 2	Total	
Contraceptives	385,000,000	385,000,000	770,000,000	8.1%
Drugs and Supplies	380,977,908	628,460,380	1,009,438,288	10.6%
E-Monitoring	65,825,000	20,650,000	86,475,000	0.9%
Equipment	555,497,468	80,941,080	636,438,548	6.7%
Furniture and Fixtures	52,850,000	-	52,850,000	0.6%
Human Resource	2,307,559,456	2,881,834,749	5,189,394,205	54.7%
Incentives	67,680,000	84,816,000	152,496,000	1.6%
Information Education Communication	39,560,000	39,560,000	79,120,000	0.8%
Monitoring and Evaluation	43,432,800	43,432,800	86,865,600	0.9%

Input Type	Cost Estimates - PKR			(%)
	Year 1	Year 2	Total	
Nutritional Commodities	123,300,000	618,840,000	742,140,000	7.8%
Operational Expenditure	85,746,000	82,146,000	167,892,000	1.8%
Purchase of vehicles	16,000,000	-	16,000,000	0.2%
Referral System	104,712,000	104,712,000	209,424,000	2.2%
Trainings	201,991,686	82,714,700	284,706,386	3.0%
Transportation of Goods	6,000,000	6,000,000	12,000,000	0.1%
Grand Total - PKR	4,436,132,318	5,059,107,708	9,495,240,026	100%
Grand Total - PKR million	4,436.132	5,059.108	9,495.240	

Annex C2: Detailed Cost Sheets

Output 1: Improved delivery of maternal, child, family planning and nutrition services under essential package of health services

Sr. No.	Activity Details	Unit			Total Cost - PKR	Working Note	Physical Targets		Financial Cost - PKR	
		Defined	Cost - PKR	Number			Year I	Year II	Year I	Year II
1.1	Payment of stipends to CMWs (including increase in numbers)	CMW-year	60,000	10,200	612,000,000		4,600	5,600	276,000,000	336,000,000
1.2	Provision of equipment and instruments to newly deployed CMWs	CMW	45,941	1,259	57,839,820		259	1,000	11,898,740	45,941,080
1.3	Provision of Delivery Tables for CMWs	CMW	35,000	4,500	157,500,000		3,500	1,000	122,500,000	35,000,000
1.4	Provision of medicines and consumables to CMWs for deliveries	Delivery	2,782	319,200	888,046,288	W1	115,200	204,000	320,497,908	567,548,380
1.5	Payment to CMWs for referrals	Referral	300	58,320	17,496,000	W2	21,600	36,720	6,480,000	11,016,000
1.6	Payment to CMWs for voucher redemption	Voucher	500	97,200	48,600,000	W3	36,000	61,200	18,000,000	30,600,000
1.7	Capacity building of staff at Basic EmONC facilities	Batch	534,876	230	123,174,286	T4	230	-	123,174,286	-
1.8	Training of outreach workers - LHWs	See notes (T)			85,962,300	T1	-	-	43,875,800	42,086,500
1.9	Training of outreach workers - CMWs	See notes (T)			50,777,000	T2	-	-	22,545,200	28,231,800
1.10	Training of SBAs	See notes (T)			24,792,800	T3	-	-	12,396,400	12,396,400
1.11	Provision of Nutritional Commodities (e.g. RUTF, IFA, Mebandazole etc.)	See notes (W)			742,140,000	W12	-	-	123,300,000	618,840,000
1.12	Provision of basic equipment to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	506,688	300	152,006,400	W4	300	-	152,006,400	-
1.13	Provision of basic furniture and fixtures to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	9,500	300	2,850,000	W5	300	-	2,850,000	-
1.14	Provision of bed to BHUs for upgradation to provide 24/7 Basic EmONC services (2 beds for each)	BHU	25,000	2,000	50,000,000		2,000	-	50,000,000	-
1.15	Provision of glucometers to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	3,000	1,000	3,000,000		1,000	-	3,000,000	-
1.16	Provision of USG machines to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	450,000	250	112,500,000		250	-	112,500,000	-
1.17	Provision of lump sum amount to BHU for procuring medicines (Rs. 2,500 per month)	BHU-year	30,000	2,000	60,000,000		1,000	1,000	30,000,000	30,000,000
1.18	Pay for performance for two best performing BHUs from each district	BHU	600,000	144	86,400,000		72	72	43,200,000	43,200,000

Sr. No.	Activity Details	Unit			Total Cost - PKR	Working Note	Physical Targets		Financial Cost - PKR	
		Defined	Cost - PKR	Number			Year I	Year II	Year I	Year II
1.19	Provision of glucometer test strips to BHUs for upgradation to provide 24/7 Basic EmONC services	Strip	18	744,000	13,392,000		360,000	384,000	6,480,000	6,912,000
1.20	Provision of consumables to 24/7 BHUs providing basic EmONC services (lab kits and gloves Rs. 2000 per month per BHU)	BHU-year	24,000	2,000	48,000,000		1,000	1,000	24,000,000	24,000,000
1.21	Provision of contraceptives to CMWs and health facilities	Year	385,000,000	2	770,000,000		1	1	385,000,000	385,000,000
1.22	Provision of equipment for upgrading one RHC in each district to a comprehensive EmONC facility (RHC+ model)	RHC+	1,173,398	36	42,242,328		36	-	42,242,328	-
1.23	Provision of funds for hiring additional HR staff at RHC+ on case basis or any other arrangements as agreed (Rs. 50,000 per month)	RHC+ per year	600,000	72	43,200,000		36	36	21,600,000	21,600,000
1.24	FTA for WMOs (Rs. 15,000 per month) for RHCs	WMO-year	180,000	584	105,120,000		292	292	52,560,000	52,560,000
1.25	Provision of funds for hiring additional HR staff at THQH on case basis or any other arrangements as agreed (Rs. 25,000 per month)	THQH-year	2,550,000	24	61,200,000		12	12	30,600,000	30,600,000
1.26	Payment of salaries for ensuring availability of minimum agreed staff at the identified health facilities for provision of 24/7 Basic and Comprehensive EmONC services and nutrition.	See notes (S)	-	166,674	3,393,822,000	S1	71,922	94,752	1,442,712,000	1,951,110,000
1.27	Provision of POL for ambulances to establish an efficient and effective referral system (Rs. 17,000 per month per ambulance)	Ambulance-year	204,000	466	95,064,000		233	233	47,532,000	47,532,000
1.28	Cost of repairs and maintenance of ambulances to establish an efficient and effective referral system (Rs. 5,000 per month per ambulance)	Ambulance-year	60,000	466	27,960,000		233	233	13,980,000	13,980,000
1.29	Operational cost support to call response centres	Centre-month	3,600,000	24	86,400,000		12	12	43,200,000	43,200,000
Total Cost of Output 1					7,964,266,942				3,586,912,782	4,377,354,160

Output 2: Improved Practices and Health Seeking Behaviour for Reproductive, Maternal, Newborn and Child Health and Nutrition

Sr. No.	Activity Details	Unit			Total Cost - PKR	Working Note	Physical Targets		Financial Cost - PKR	
		Defined	Cost - PKR	Number			Year I	Year II	Year I	Year II
2.1	Cost of disseminating specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using TV shows	Show	450,000	24	10,800,000		12	12	5,400,000	5,400,000
2.2	Cost of disseminating specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using advocacy seminars, meetings and events.	Year	30,000,000	2	60,000,000		1	1	30,000,000	30,000,000
2.3	Cost of disseminating specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using TV spots - two spots per week	Spots	35,000	208	7,280,000		104	104	3,640,000	3,640,000
2.4	Cost of disseminating specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using Radios - two spots per week	Spots	5,000	208	1,040,000		104	104	520,000	520,000
Total Cost of Output 2					79,120,000				39,560,000	39,560,000

Output 3: Effective Management of the Programme at Provincial and District Level

Sr. No.	Activity Details	Unit			Total Cost - PKR	Working Note	Physical Targets		Financial Cost - PKR	
		Defined	Cost - PKR	Number			Year I	Year II	Year I	Year II
3.1	Provision for payment of salaries to PMU staff	See notes (S)			104,538,709	S2			51,843,528	52,695,181
3.2	Provision for payment of utilities for PMU	Month	211,667	24	5,080,000	W7	12	12	2,540,000	2,540,000
3.3	Provision of repairs and maintenance for PMU	Month	150,000	24	3,600,000	W8	12	12	1,800,000	1,800,000
3.4	Provision for allowances and honorarium for PMU staff	Month	223,333	24	5,360,000	W9	12	12	2,680,000	2,680,000
3.5	Provision for transporting goods and medicines	Year	6,000,000	2	12,000,000		1	1	6,000,000	6,000,000
3.6	Provision of office stationary, supplies, printing and other consumables for PMU	Year	9,270,000	2	18,540,000	W10	1	1	9,270,000	9,270,000
3.7	Provision for payment on account of advertisements	Year	2,000,000	2	4,000,000		1	1	2,000,000	2,000,000
3.8	Provision for holding quarterly review meetings at PMU	Quarter	1,800,000	8	14,400,000		4	4	7,200,000	7,200,000
3.9	Provision for POL of PMU Vehicles	Vehicle-month	375,000	24	9,000,000		12	12	4,500,000	4,500,000
3.10	Provision for repairs and renovation of PMU	PMU-year	650,000	2	1,300,000		1	1	650,000	650,000
3.11	Provision for payment of salaries to DMU staff	Man-Year			820,298,640	S3			407,780,520	412,518,120
3.12	Provision for payment of utilities for DMU	DMU-Month	144,000	24	3,456,000	W11	12	12	1,728,000	1,728,000
3.13	Provision of office stationary, supplies and other consumables for DMU	DMU-Month	360,000	24	8,640,000		12	12	4,320,000	4,320,000
3.14	Provision of petty cash to DMU (Rs. 10,000 per month per DMU)	DMU-Month	360,000	24	8,640,000		12	12	4,320,000	4,320,000
3.15	Provision for holding monthly review meetings at district level (Rs. 10,000 per month per DMU)	DMU-Month	360,000	24	8,640,000		12	12	4,320,000	4,320,000
3.16	Provision for POL of DMU Vehicles	Vehicle-month	25,000	864	21,600,000		432	432	10,800,000	10,800,000
3.17	Provision for one-time repairs and renovation of DMU	DMU	100,000	36	3,600,000		36	-	3,600,000	-
3.18	Purchase of vehicles for PMU	Vehicle		4	16,000,000	W13	4	-	16,000,000	-
3.19	Provision of uniform for drivers, guards, naib qasid, sweeper	Uniform	1,500	23,768	35,652,000		11,884	11,884	17,826,000	17,826,000
3.20	Provision for payment of salaries to NEB staff	Man-Year			7,574,016	S4			3,747,708	3,826,308
Total Cost of Output 3					1,131,784,205				572,753,456	559,030,749

Output 4: Evidence Based Decision Making through Efficient Monitoring and Evaluation

Sr. No.	Activity Details	Unit			Total Cost - PKR	Working Note	Physical Targets		Financial Cost - PKR	
		Defined	Cost - PKR	Number			Year I	Year II	Year I	Year II
4.1	Printing of reporting tools etc.	District-Year	3,600,000	2	7,200,000		1	1	3,600,000	3,600,000
4.2	Provision for paying salaries of DTMOs	Man-month	60,000	216	12,960,000		108	108	6,480,000	6,480,000
4.3	Provision of TA/DA for staff	See notes (D)			56,625,600	D1			28,312,800	28,312,800
4.4	Establishing E-Monitoring system through provision of training and hardware (andriod tablets etc.)	See notes (W)			45,775,000	W14			45,475,000	300,000
4.5	Operational cost for running the Andriod Based E-Monitoring System	See notes (W)			40,700,000	W15			20,350,000	20,350,000
4.6	Provision of computers and printers to 24/7 BHUs	Computer	110,000	1,000	110,000,000		1,000		110,000,000	-
4.7	Recurring cost to run internet and printing facilities at 24/7 BHU	BHU	24,000	2,000	48,000,000		1,000	1,000	24,000,000	24,000,000
4.8	Provision of computers for MIS Cell and Data Centre/Server Room	Computer	100,000	8	800,000		8	-	800,000	-
4.9	Provision of laptops for software engineers and computer operators - MIS cell	Laptop	110,000	5	550,000		5	-	550,000	-
4.10	Annual fee for dedicated web-server (on-line)	Web-server	60,000	4	240,000		2	2	120,000	120,000
Total Cost of Output 4					322,850,600				239,687,800	83,162,800

Annex C3: Detailed Workings – Salaries, Trainings, TA/DA and Others

(W) Working Notes – Others

Working Ref.	Activity		UOM	Cost per unit-PKR	Year I		Year II		Total	
					Q	C	Q	C	Q	C
W1	1.4	Provision of medicines and consumables to CMWs for delivery	Delivery	2,782	115,200	320,497,908	204,000	567,548,380	319,200	888,046,288
W2	1.5	Payment to CMWs for referrals	Referral	300	21,600	6,480,000	36,720	11,016,000	58,320	17,496,000
W3	1.6	Payment to CMWs for voucher redemption	Voucher	500	36,000	18,000,000	61,200	30,600,000	97,200	48,600,000
W4	1.12	Provision of basic equipment to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	530,388	300	159,116,400	-	-	300	159,116,400
W5	1.13	Provision of basic furniture and fixtures to BHUs for upgradation to provide 24/7 Basic EmONC services	BHU	9,500	300	2,850,000	-	-	300	2,850,000
W6	1.2	Provision of consumables to 24/7 BHUs providing basic EmONC services (lab kits and gloves Rs. 2000 per month per BHU)	BHU-year	24,000	1,000	24,000,000		-	1,000	24,000,000
W7	3.2	Provision for payment of utilities for PMU	Month	211,667		2,540,000		2,540,000		5,080,000
		Electricity Charges	*Month*	*75,000*	*12*	*900,000*	*12*	*900,000*	*24*	*1,800,000*
		Water Charges	*Month*	*15,000*	*12*	*180,000*	*12*	*180,000*	*24*	*360,000*
		Gas Charges	*Month*	*5,000*	*12*	*60,000*	*12*	*60,000*	*24*	*120,000*
		Telephone and trunk call charges	*Month*	*35,000*	*12*	*420,000*	*12*	*420,000*	*24*	*840,000*
		Communication (Internet & fax)	*Month*	*15,000*	*12*	*180,000*	*12*	*180,000*	*24*	*360,000*
		Courier Charges	*Month*	*25,000*	*12*	*300,000*	*12*	*300,000*	*24*	*600,000*
		Rates and taxes	*Month*	*41,667*	*12*	*500,000*	*12*	*500,000*	*24*	*1,000,000*
W8	3.3	Provision of repairs and maintenance for PMU		150,000		1,800,000		1,800,000	-	3,600,000
		Repair of Vehicle	*Month*	*100,000*	*12*	*1,200,000*	*12*	*1,200,000*	24	2,400,000
		Repair of IT Equipment	*Month*	*20,000*	*12*	*240,000*	*12*	*240,000*	24	480,000
		Repair of Machinery & Equipment	*Month*	*20,000*	*12*	*240,000*	*12*	*240,000*	24	480,000
		Repair of Furniture & Fixture	*Month*	*10,000*	*12*	*120,000*	*12*	*120,000*	24	240,000
W9	3.4	Provision for allowances and honorarium for PMU staff		223,333		2,680,000		2,680,000		5,360,000
		Overtime Allowance	*Month*	*5,000*	*12*	*60,000*	*12*	*60,000*	24	120,000
		Honorarium for PMU staff	*Month*	*208,333*	*12*	*2,500,000*	*12*	*2,500,000*	24	5,000,000
		Medical Charges	*Month*	*10,000*	*12*	*120,000*	*12*	*120,000*	24	240,000
W10	3.6	Provision of office stationary, supplies, printing and other consumables for PMU		9,270,000		9,270,000		9,270,000	-	18,540,000
		Stationery	*Year*	*1,000,000*	*1*	*1,000,000*	*1*	*1,000,000*	2	2,000,000

Working Ref.		Activity	UOM	Cost per unit-PKR	Year I		Year II		Total	
					Q	C	Q	C	Q	C
		Newspapers, Periodical and Books	*Year*	*10,000*	*1*	*10,000*	*1*	*10,000*	2	20,000
		Law Charges	*Year*	*50,000*	*1*	*50,000*	*1*	*50,000*	2	100,000
		Other Miscellaneous	*Year*	*1,000,000*	*1*	*1,000,000*	*1*	*1,000,000*	2	2,000,000
		Entertainment and Gift	*Year*	*10,000*	*1*	*10,000*	*1*	*10,000*	2	20,000
		Printing	*Year*	*7,200,000*	*1*	*7,200,000*	*1*	*7,200,000*	2	14,400,000
W11	3.12	Provision for payment of utilities for DMU		144,000		1,728,000		1,728,000	-	3,456,000
		Telephone and trunk call charges	*District-Month*	*54,000*	*12*	*648,000*	*12*	*648,000*	24	1,296,000
		Communication (Internet)	*District-Month*	*54,000*	*12*	*648,000*	*12*	*648,000*	24	1,296,000
		Courier Charges	*District-Month*	*36,000*	*12*	*432,000*	*12*	*432,000*	*24*	*864,000*
W12	1.11	Provision of Nutritional Commodities (e.g. RUTF, IFA, Mebandazole etc.)				123,300,000		618,840,000		742,140,000
		Cost of RUTF	*Sachet*	*36*	*-*	*-*	*13,702,500*	*493,290,000*	*13,702,500*	*493,290,000*
		Cost of providing Mebandazole to Children Under Age of 5	*Tablet*	*9*	*-*	*-*	*250,000*	*2,250,000*	*250,000*	*2,250,000*
		Cost of providing IFA tablets to women	*Tablet*	*0.4*	*27,000,000*	*10,800,000*	*27,000,000*	*10,800,000*	*54,000,000*	*21,600,000*
		Cost of providing MMS Sachets	*Sachet*	*2.25*	*50,000,000*	*112,500,000*	*50,000,000*	*112,500,000*	*100,000,000*	*225,000,000*
W13	3.18	Purchase of vehicles for PMU				16,000,000		-		16,000,000
		Double cabin	*Vehicle*	*6,000,000*	*2*	*12,000,000*	*-*	*-*	*2*	*12,000,000*
		Jeep	*Vehicle*	*2,000,000*	*2*	*4,000,000*	*-*	*-*	*2*	*4,000,000*
W14	4.4	Establishing E-Monitoring system through provision of training and hardware (android tablets etc.)				45,475,000		300,000		45,775,000
		Cost of Android tablets including cover, replacement cost and additional warranty	*Tablet*	*17,500*	*2,530*	*44,275,000*	*-*	*-*	*2,530*	*44,275,000*
		Software developer	*Man-Month*	*100,000*	*6*	*600,000*	*2*	*200,000*	*8*	*800,000*
		Content developer	*Man-Month*	*100,000*	*6*	*600,000*	*1*	*100,000*	*7*	*700,000*
W15	4.5	Operational cost for running the Android Based E-Monitoring System				20,350,000		20,350,000		40,700,000
		Training of relevant staff on use of E-Monitoring system	District	*125,000*	*36*	*4,500,000*	*36*	*4,500,000*	*72*	*9,000,000*
		Annual data package cost	*Tablet-year*	*4,500*	*2,300*	*10,350,000*	*2,300*	*10,350,000*	*4,600*	*20,700,000*

Working Ref.	Activity		UOM	Cost per unit-PKR	Year I		Year II		Total	
					Q	C	Q	C	Q	C
		Cost of reminder SMS, feedback, IVR calls etc.	*Annum*	*5,500,000*	*1*	*5,500,000*	*1*	*5,500,000*	*2*	*11,000,000*

UOM – Unit of Measurement, Q – Quantity, C – Cost

(S) Salary Working Details

S1 - Payment of Salaries under activity 1.26 - Health Workers

Sr. No.	Designation	Positions	Salary per month - PKR		Number - Man Months		Salary - PKR		
			Year I	Year II	Year I	Year II	Year I	Year II	Total
1	MO Stabilisation centre – DHQ	36	58,000	60,900	324	432	18,792,000	26,308,800	45,100,800
2	Nursing Staff (for DHQ Nutrition)	72	32,000	33,600	432	864	13,824,000	29,030,400	42,854,400
3	WMO for RHCs	292	58,000	60,900	3,504	3,504	203,232,000	213,393,600	416,625,600
4	Nutrition Assistant OTP (LHV)	30	20,000	21,000	270	360	5,400,000	7,560,000	12,960,000
5	LHVs (CHARM)	2,000	20,000	21,000	18,600	24,000	372,000,000	504,000,000	876,000,000
6	Aya /Midwife (CHARM)	2,000	17,000	17,850	18,600	24,000	316,200,000	428,400,000	744,600,000
7	Ambulance drivers (CHARM)	466	17,000	17,850	5,592	5,592	95,064,000	99,817,200	194,881,200
8	Guards (CHARM)	2,000	17,000	17,850	18,600	24,000	316,200,000	428,400,000	744,600,000
9	Sweeper (CHARM)	1,000	17,000	17,850	6,000	12,000	102,000,000	214,200,000	316,200,000
Total		7,896			71,922	94,752	1,442,712,000	1,951,110,000	3,393,822,000

S2 - Payment of Salaries under activity 3.1 - PMU Staff

Sr. No.	Designation	Positions			BPS	Salary per annum - PKR		Salary - PKR		
		Existing	New	Total		Year I	Year II	Year I	Year II	Total
1	Program director/ADGHS - (20/21)	1	-	1	20	2,545,404	2,573,604	2,545,404	2,573,604	5,119,008
2	Additional Program Director (HR & Trainings) - (19/20)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
3	Additional Program Director (Community base intervention) - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
4	Additional Program Director (Nutrition) - (18/19)		1	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
5	Procurement Specialist - (18/19)		1	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
6	Deputy Program director (HR) - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
7	Program Manager Nutrition/ Deputy program Director (Nutrition) - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
8	Deputy Program director (M&E) - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200

9	Program Director (Facility Based Intervention) MCH - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
10	Finance Officer - (18/19)	1	-	1	19	1,827,000	1,846,200	1,827,000	1,846,200	3,673,200
11	Communication Officer/ HEO - (17)	1	-	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
12	Nutrition Officer+M&E Officer - (17)	2	-	2	17	1,206,168	1,220,568	2,412,336	2,441,136	4,853,472
13	Research Officer - (17)	-	1	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
14	Data Analyst - (17)	-	4	4	17	1,206,168	1,220,568	4,824,672	4,882,272	9,706,944
15	Software Engineer - (17)	1	1	2	17	1,206,168	1,220,568	2,412,336	2,441,136	4,853,472
16	Statistical Officer - (17)	1	1	2	17	1,206,168	1,220,568	2,412,336	2,441,136	4,853,472
17	Internal Auditor - (17)	1	-	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
18	Procurement Officer - (17)	1	-	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
19	Admin Officer - (17)	-	1	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
20	Office Superintendent - (16/17)	-	1	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
21	Stenographer - (16/17)	1	-	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
22	Accounts Assistant (14)	1	-	1	14	373,584	380,904	373,584	380,904	754,488
23	Office Assistant/Computer Operators(08-Posts) /Steno Typis (03-Posts) (14)	11	-	11	14	373,584	380,904	2,988,672	3,047,232	6,035,904
24	Cashier/Accounts Clerk (12)	2	-	2	12	354,132	360,132	708,264	720,264	1,428,528
25	Diary/Dispatch Clerk (7)	1	-	1	7	250,488	254,328	250,488	254,328	504,816
26	Store Keeper (11)	1	-	1	11	333,564	339,084	333,564	339,084	672,648
27	Drivers (4)	6	3	9	4	229,968	232,728	2,069,712	2,094,552	4,164,264
28	Naib Qasid (2)	4	5	9	2	220,968	223,008	1,988,712	2,007,072	3,995,784
29	Security Guard (2)	2	-	2	2	220,968	223,008	441,936	446,016	887,952
30	Mali (2)	1	1	2	2	220,968	223,008	441,936	446,016	887,952
31	Sanitary Worker (2)	-	6	6	2	220,968	223,008	1,325,808	1,338,048	2,663,856
32	In charge Sexual Harassment Cell	-	1	1	17	1,206,168	1,220,568	1,206,168	1,220,568	2,426,736
33	MIS Coordinator	-	1	1	18	1,408,068	1,426,068	1,408,068	1,426,068	2,834,136
	Sub-Total (Scale based staff)	42	28	70		37,669,680	38,102,400	53,030,172	53,659,212	106,689,384
34	Computer Operator	-	8	8	Fixed	258,132	271,039	2,065,056	2,168,309	4,233,365
35	Security Guard	-	9	9	Fixed	204,000	214,200	1,836,000	1,927,800	3,763,800
36	Communications Specialist	-	1	1	Fixed	2,100,000	2,205,000	2,100,000	2,205,000	4,305,000
37	Call attendants for Sexual Harassment Cell	-	3	3	Fixed	600,000	630,000	1,800,000	1,890,000	3,690,000
38	Junior Software Engineer/programmer	-	1	1	Fixed	420,000	441,000	420,000	441,000	861,000
39	Network administrator	-	1	1	Fixed	420,000	441,000	420,000	441,000	861,000
	Sub-Total (Fixed salary Staff)	-	23	23		4,002,132	4,202,239	8,641,056	9,073,109	17,714,165
	Grand-Total	45	51	96		41,671,812	42,304,639	61,671,228	62,732,321	124,403,549

S3 - Payment of Salaries under activity 3.11 - DMU Staff

Sr. No.	Designation	Positions			BPS	Salary per annum - PKR		Salary - PKR		
		Existing	New	Total		Year I	Year II	Year I	Year II	Total
1	District Coordinator (IRMNCH & Nutrition Program)	36	-	36	19	1,827,000	1,846,200	65,772,000	66,463,200	132,235,200
2	Field Program Officers	-	19	19	17	1,206,168	1,220,568	22,917,192	23,190,792	46,107,984
3	M&E Officer	36	-	36	17	1,206,168	1,220,568	43,422,048	43,940,448	87,362,496
4	CMW Tutor (CMW Schools)	126	-	126	17	1,206,168	1,220,568	151,977,168	153,791,568	305,768,736
5	Accounts Assistant (DMU)	36		36	14	373,584	380,904	13,449,024	13,712,544	27,161,568
6	Store Keeper (DMU)	36		36	11	333,564	339,084	12,008,304	12,207,024	24,215,328
7	Driver (1 for DMU+CMW School)	78		78	5	239,568	242,688	18,686,304	18,929,664	37,615,968
8	Security Guards (DMU+CMW School)	120		120	2	220,968	223,008	26,516,160	26,760,960	53,277,120
9	Aaya CMW Schools	42	42	84	2	220,968	223,008	18,561,312	18,732,672	37,293,984
10	Cook CMW Schools	42	42	84	2	220,968	223,008	18,561,312	18,732,672	37,293,984
11	Naib Qasid (DMU)	-	36	36	2	220,968	223,008	7,954,848	8,028,288	15,983,136
12	Sweeper (DMU)	-	36	36	2	220,968	223,008	7,954,848	8,028,288	15,983,136
Total		552	175	727		7,497,060	7,585,620	407,780,520	412,518,120	820,298,640

S4 - Payment of Salaries under activity 3.19 - NEB Staff

Sr. No.	Designation	Positions			BPS	Salary per annum - PKR		Salary - PKR		
		Existing	New	Total		Year I	Year II	Year I	Year II	Total
1	Assistant Controller Midwifery	1	-	1	18	808,068	826,068	808,068	826,068	1,634,136
2	Training Monitor	4	(1)	3	17	726,168	740,568	2,178,504	2,221,704	4,400,208
3	Computer Operator	2	-	2	14	277,584	284,904	555,168	569,808	1,124,976
4	Driver	1	-	1	4	205,968	208,728	205,968	208,728	414,696
Total		8	(1)	7		2,017,788	2,060,268	3,747,708	3,826,308	7,574,016

(T) Training Working Details

T1 - LHWs training cost

Sr. No.	Detail	Number			Unit Cost	Number of Days		Cost - PKR		
		Districts	Batches	Unit		Year I	Year II	Year I	Year II	Total

Sr. No.	Detail	Number			Unit Cost	Number of Days		Cost - PKR		
		Districts	Batches	Unit		Year I	Year II	Year I	Year II	Total
Provincial Level Training										
1	Trainer Allowance		4	2	1,000	4	3	32,000	24,000	56,000
2	Trainers Travelling Allowance		4	2	8,000			64,000	64,000	128,000
3	Trainers Daily Allowance		4	2	1,600	4	3	51,200	38,400	89,600
4	Trainers Lodging		4	2	4,800	4	3	153,600	115,200	268,800
5	Trainees Daily Allowance		4	18		4	3	-	-	-
6	Trainees Travelling Allowance		4	18	5,000	4	3	1,440,000	1,080,000	2,520,000
7	Trainees Lodging		4	18	4,800	4	3	1,382,400	1,036,800	2,419,200
8	Lunch Charges		-	80	220	4	3	70,400	52,800	123,200
9	Tea Charges		-	80	30	4	3	9,600	7,200	16,800
10	Stationery Charges		4		8,000			32,000	32,000	64,000
11	Training Manual Cost			80	500			40,000	40,000	80,000
Total Provincial Level Cost								3,275,200	2,490,400	5,765,600
District Level Training										
1	Trainer Allowance	36	2	2	1,000	4	3	576,000	432,000	1,008,000
2	Trainers Travelling Allowance	36	2	2	8,000			1,152,000	1,152,000	2,304,000
3	Trainers Daily Allowance	36	2	2	1,600	4	3	921,600	691,200	1,612,800
4	Trainees Daily Allowance	36	2	39		4	3	-	-	-
5	Trainees Travelling Allowance	36	2	39	500	4	3	156,000	4,212,000	4,368,000
6	Lunch Charges			82	220	4	3	72,160	54,120	126,280
7	Tea Charges			82	30	4	3	9,840	7,380	17,220
8	Stationery Charges		2		5,000			10,000	10,000	20,000
9	Training Manual Cost			82	500			41,000	41,000	82,000
Total District Level Cost								2,938,600	6,599,700	9,538,300
FLCF Level Training										
1	Trainer Allowance	36	54	2	600	5	3	11,664,000	6,998,400	18,662,400
2	Trainers Travelling Allowance	36	54	2	500			1,944,000	1,944,000	3,888,000
3	Trainees Daily Allowance (LHWs)	36	54	25		5	3	-	-	-
4	Stationery Charges		54		1,000			54,000	54,000	108,000
5	Training Manual Cost			48,000	500			24,000,000	24,000,000	48,000,000
Total FLCF Level Cost								37,662,000	32,996,400	70,658,400
Total Cost								43,875,800	42,086,500	85,962,300

Note: LHWs training on IYCF and HTSP, Refresher Training of LHWs for, Breast feeding, Nutrition and family Planning.

T2 - CMWs training cost

Sr. No.	Detail	Number			Unit Cost	Number of Days		Cost-PKR		
		Districts	Batches	Unit		Year I	Year II	Year I	Year II	Total
Provincial Level Training										
1	Trainer Allowance		4	2	1,000	6	4	48,000	,000	80,000
2	Trainers Travelling Allowance		4	2	8,000			64,000	64,000	128,000
3	Trainers Daily Allowance		4	2	1,600	6	4	76,800	51,200	128,000
4	Trainers Lodging		4	2	4,800	6	4	230,400	153,600	384,000
5	Trainees Daily Allowance		4	18	1,600	6	4	691,200	460,800	1,152,000
6	Trainees Travelling Allowance		4	18	5,000	6	4	2,160,000	1,440,000	3,600,000
7	Trainees Lodging		4	18	4,800	6	4	2,073,600	1,382,400	3,456,000
8	Lunch Charges		-	80	220	6	4	105,600	70,400	176,000
9	Tea Charges		-	80	30	6	4	14,400	9,600	24,000
10	Stationery Charges		4		8,000			32,000	32,000	64,000
11	Training Manual Cost			80	500			40,000	40,000	80,000
Total Provincial Level Cost								5,536,000	3,736,000	9,272,000
District Level Training										
1	Trainer Allowance	36	2	2	1,000	6	4	864,000	576,000	1,440,000
2	Trainers Travelling Allowance	36	2	2	8,000			1,152,000	1,152,000	2,304,000
3	Trainers Daily Allowance	36	2	2	1,600	6	4	1,382,400	921,600	2,304,000
4	Trainees Daily Allowance	36	2	39	600	6	4	280,800	6,739,200	7,020,000
5	Trainees Travelling Allowance	36	2	39	500	6	4	234,000	5,616,000	5,850,000
6	Lunch Charges			82	220	6	4	108,240	72,160	180,400
7	Tea Charges			82	30	6	4	14,760	9,840	24,600
8	Stationery Charges		2		5,000			10,000	10,000	20,000
9	Training Manual Cost			82	500			41,000	41,000	82,000
Total District Level Cost								4,087,200	15,137,800	19,225,000
FLCF Level Training										
1	Trainer Allowance	36	10	2	600	6	4	2,592,000	1,728,000	4,320,000
2	Trainers Travelling Allowance	36	10	2	500			360,000	360,000	720,000
3	Trainees Daily Allowance (LHW's)	36	10	25	150	6	4	8,100,000	5,400,000	13,500,000
4	Stationery Charges		10		1,000			10,000	10,000	20,000
5	Training Manual Cost			3,720	500			1,860,000	1,860,000	3,720,000
Total FLCF Level Cost								12,922,000	9,358,000	22,280,000
Total Cost								22,545,200	28,231,800	50,777,000

Note: Trainings on IMNCI, EmONC, FP, Nutrition, ENC and refreshers.

T3 - SBA's training cost (Charge nurses, LHVs, Midwifes)

Sr. No.	Detail	Number			Unit Cost	Number of Days		Cost - PKR		
		Districts	Batches	Unit		Year I	Year II	Year I	Year II	Total
Provincial Level Training										
1	Trainer Allowance		4	2	1,000	3	3	24,000	24,000	48,000
2	Trainers Travelling Allowance		4	2	8,000			64,000	64,000	128,000
3	Trainers Daily Allowance		4	2	1,600	3	3	38,400	38,400	76,800
4	Trainers Lodging		4	2	4,800	3	3	115,200	115,200	230,400
5	Trainees Daily Allowance	36	4	25	350	3	3	3,780,000	3,780,000	7,560,000
6	Trainees Travelling Allowance	36	4	25	500	3	3	5,400,000	5,400,000	10,800,000
7	Lunch Charges		-	80	220	3	3	52,800	52,800	105,600
8	Tea Charges		-	3,000	30	3	3	270,000	270,000	540,000
9	Stationery Charges	36	4		8,000			1,152,000	1,152,000	2,304,000
10	Training Manual Cost			3,000	500			1,500,000	1,500,000	3,000,000
Total Trainings Cost								12,396,400	12,396,400	24,792,800

Note: SBAs Refresher training for 3 days each year

T4 - Capacity Building of staff at Basic EmONC facilities

Batches required

Sr. No.	Details	Unit	Number	Participants	Total
1	BHU 24/7	Facility	1,000	1	1,000
2	RHC	Facility	306	2	612
Total participants					1,612
Batches Required				7	230

Cost of trainings

Sr. No.	Details	Unit Cost – PKR	Number	Total Cost - PKR
1	Trainees allowance for 3 months	45,000	1,612	72,540,000
2	Trainers allowance for 3 months	120,000	230	27,634,286
3	Accommodation and other misc. costs	100,000	230	23,000,000
Total cost				123,174,286
Cost per batch				534,876

(D) TA/DA Working Details

D1 - Calculation of TA/DA amount for PMU and DMU staff

Sr. No	Name of Post	BPS	Posts	Monthly field visits	Annual Field visits	TA	Cost - PKR						
							Daily allowance	Total DA	Lodging allowance	Total Lodging	Year I	Year II	Total
1	Program director/ADGHS	20	1	5	60	Tours will be conducted on Government vehicles	2,050	123,000	6,150	369,000	492,000	492,000	1,476,000
2	Additional Program Director (HR & Trainings)	19	1	6	72		2,050	147,600	6,150	442,800	590,400	590,400	1,771,200
3	Additional Program Director (Community base intervention)	18	1	8	96		2,050	196,800	6,150	590,400	787,200	787,200	2,361,600
4	Additional Program Director (Nutrition)	18	1	8	96		2,050	196,800	6,150	590,400	787,200	787,200	2,361,600
5	Procurement Specialist	18	1	2	24		2,050	49,200	6,150	147,600	196,800	196,800	590,400
6	Deputy Program director (HR)	18	1	1	12		2,050	24,600	6,150	73,800	98,400	98,400	295,200
7	Program Manager Nutrition/ Deputy program Director (Nutrition)	18	1	8	96		2,050	196,800	6,150	590,400	787,200	787,200	2,361,600
8	Deputy Program director (M&E)	18	1	10	120		2,050	246,000	6,150	738,000	984,000	984,000	2,952,000
9	Deputy Program Director (Facility Based Intervention) MCH	18	1	8	96		2,050	196,800	6,150	590,400	787,200	787,200	2,361,600
10	Finance Officer	18/19	1	4	48		2,050	98,400	6,150	295,200	393,600	393,600	1,180,800
11	Communication Officer/ HEO	17	1	2	24		1,600	38,400	4,800	115,200	153,600	153,600	460,800
12	Nutrition Officer	17	2	8	192		1,600	307,200	4,800	921,600	1,228,800	1,228,800	3,686,400
13	Research Officer	17	1	4	48		1,600	76,800	4,800	230,400	307,200	307,200	921,600
14	Data Analyst	17	1	3	36		1,600	57,600	4,800	172,800	230,400	230,400	691,200
15	Software Engineer	17	1	3	36		1,600	57,600	4,800	172,800	230,400	230,400	691,200
16	Statistical Officer	17	1	3	36		1,600	57,600	4,800	172,800	230,400	230,400	691,200
17	Internal Auditor	17	1	8	96		1,600	153,600	4,800	460,800	614,400	614,400	1,843,200
18	Procurement Officer	17	1	2	24		1,600	38,400	4,800	115,200	153,600	153,600	460,800
19	Admin Officer	17	1	2	24		1,600	38,400	4,800	115,200	153,600	153,600	460,800
20	Office Superintendent/Stenographer	16	1	1	12		1,600	19,200	4,800	57,600	76,800	76,800	230,400
21	District Coordinator (IRMNCH & Nutrition Program)	18	36	18	7,776		1,025	7,970,400	Logging Not Allowed	-	7,970,400	7,970,400	23,911,200
22	Social Organizer/ M&E Officer	17	36	18	7,776		800	6,220,800		-	6,220,800	6,220,800	18,662,400
23	CMW Tutor (CMW Schools)	17	126	4	6,048		800	4,838,400		-	4,838,400	4,838,400	14,515,200
Total								21,350,400		6,962,400	28,312,800	28,312,800	84,938,400

Annex C4: 24/7 BHU Equipment and Furniture Details

Equipment Detail

Sr. No.	Items	Unit Cost - PKR
1	Adult ambu bag & mask	3,000
2	Adult Weighing Scale	22,500
3	Baby Weighing Scale	13,500
4	Blood Pressure apparatus	2,500
5	Delivery Table	65,000
6	Step Stool(Steel)	2,000
7	Episiotomy set	2,500
8	Delivery Set	2,900
9	Electrical Instrument Steriliser 12x 6	3,000
10	Adult Bed pan with cover	2,000
11	Sim's vaginal speculum	600
12	Bulb Sucker	88
13	Examination Light	90,000
14	Radiant Warmer with Resuscitation Trolley	170,000
15	Medicine Trolley	50,000
16	Fetal Stethoscope	100
17	UPS Power Supply System	50,000
18	UPS Battery	15,000
19	Wall Clock with second hand that can be easily seen	500
20	Macintosh /Plastic apron	1,200
21	Fetal Heart Detector	30,000
22	IUD Insertion kit	1,500
23	Adult Stethoscope	2,500
Total		530,388

Furniture and Fixtures Detail

Sr. No.	Name of Item	No. of Units	Unit Cost – PKR	Cost per BHU – PKR
1	Office Table (Medium Size)	1	5,000	5,000
2	Office Chairs (Top With Cushions)	3	1,500	4,500
Total				9,500

Sr. No.	Name of Item	No. of Units	Unit Cost – PKR	Cost per BHU – PKR
1	Provision of bed to BHUs for upgradation to provide 24/7 Basic EmONC services (2 beds for each)	2,000	25,000	50,000,000
2	Provision of glucometers to BHUs for upgradation to provide 24/7 Basic EmONC services	1,000	3,000	3,000,000

Annex C5: RHC+ Equipment Details

Sr. No.	Name of Item	Cost - PKR
1	Adult ambu bag & mask	3,070
2	Adult Weighing Scale	22,500
3	Baby Weighing Scale	13,500
4	Blood Pressure apparatus	2,500
5	Examination Light	90,000
6	Step Stool(Steel)	2,000
7	Episiotomy set	13,000
8	Delivery Set	19,000
9	Electrical Instrument Steriliser 12x 6	4,500
10	Adult Bed pan with cover	2,000
11	Fetal Heart Detector	30,000
12	Sim's vaginal speculum	600
13	Bulb Sucker	88
14	Fetal Stethoscope	100
15	UPS Power Supply System	26,500
16	UPS Battery	20,000
17	Wall Clock with second hand	500
18	Macintosh /Plastic apron	1,200
19	IUD Insertion kit	1,500
20	Adult Stethoscope	2,500
21	Emergency Movable Light	107,210
22	Baby Resuscitation Trolley 94500	130,290
23	C. Section Kit	66,000
24	Incubator	125,000
25	CTG Machine	109,000
26	Emergency Medical Trolleyb1800	25,000
27	Baby Warmer	234,000
28	Feto scope	100
29	Weight Machine Adult	1,510
Total		1,053,168

Annex C6: Details - CMW and Deliveries Related workings (equipment, deliveries etc.)

CMW Kit and Equipment Cost

CMWs Kit	Unit Price-PKR
Episiotomy Scissors	2,000
Small Artery Forceps	
Medium Artery Forceps	
Allis forceps	
Non Toothed forceps	
Needle Holder	
Fetoscope	
Vaginal Speculums	
Scissors Plain Blunt	
Scissors Plain Sharp	
Kidney Tray	1,325
Instrument Tray with Lid	
Bowl 10"	
Bowl6"	
CMW Kit Bag	2,000
Total A	5,325
CMWs Equipment & Instrument	
Syringe Cutter	350
Safety Box	70
Haemoglobin meter	8,375
AMBU Bag (adult)	3,154
AMBU BAG (BABY)	3,154
CMW sign Board (standard size)	2,800
Save Delivery Kits	260
Instrument Kit for CMW	
BP Apparatus	5,500
Stethoscope	1,100
Weighing Machine Adult	3,600
Baby Weighing Machine	4,660
Measuring tape	18
Sterilizer	2,650
Bulb Sucker	88
Instrument Cabinet Wall mounted	8,000
Office Chair	4,000
Office Table 2' x 2'1/2	8,500
Clinic Stool (Steel)	2,500
Total B	40,616
Grand Total A+B	45,941
Delivery Table	35,000

CMW Related Information

CMWs training and deployment

Details	No of Posts for FY 2015-16	No of Posts for FY 2016-17
CMWs Deployed	2,400	3,400
CMWs (Under Training)	2,200	2,200
Total CMW's salary	4,600	5,600
Additional Deployment	259	1,000

Expected Deliveries by CMWs

Details	2015-16	2016-17
Out of bond CMWs	700	700
Expected number of deliveries per CMW per year	60	72

Details	2015-16	2016-17
Expected number of referrals per CMW per Year	9	11

CMW Requirement of Medicine and Supplies per Delivery

Sr. No.	Name of Medicines and Supplies	Cost - PKR
Medicines for Delivery		
1	Inj. Lignocaine10 ml	9
2	Cap / Tab Amoxicillin (500 mg)	3
3	Tab. Lomofloxaline/ Lovofloxaine 200mg	27
4	Metronidazole tablets (400 mg)	1
5	Clotrimazole cream / Gel (vaginal) 1 %	13
6	Inj. Ringers lactate IL 9 % 500ml	86
7	Injection Magnesium Sulphate	16
8	Tablet Misoprostol 200 mcg	6
9	Tablet Paracetamol	0
10	Pyodine Antiseptic solution	174
11	Injection Oxytocin	4
12	Capsule Ferrous Sulphate 150 mg + Folic acid + Vitamin	2
13	Antiseptic cream (Polyfax)	45
14	Tab. Clotrimazole 500 mg with applicator	13
15	4% CHX (Chlorhexidine)	25
16	I/V Fluid, Polygealine 3.5 % 500 ml 500ml 4%.	282
17	Tab. Elemental Calcium Salt 400 mg + Vitamin-D 2.5 mcg,	2
18	Tab. Multi Vitamin	2
Sub-Total Medicines		708
Disposable supplies for delivery		
19	Disposable delivery kit	260
20	Disposable syringes 5cc	5
21	I/V Cannula, with injection Port and Integrated Closing Cone Size 20 G	46
22	Cotton roll (500gm)	163
23	Surgical gauze	17
24	Surgical tape	15
25	Gloves Surgical	42
26	Mask	7
27	Caps	10
28	Cat Gut No 1 with non-cutting, round body needle, 40 mm Box of 36 or less	1,500
29	Cord Clamp plastic (Disposable). Standard Size. Pack of 10	10
Sub-Total Disposables		2,074
Grand Total		2,782

Expected Deliveries in 24/7 BHUs

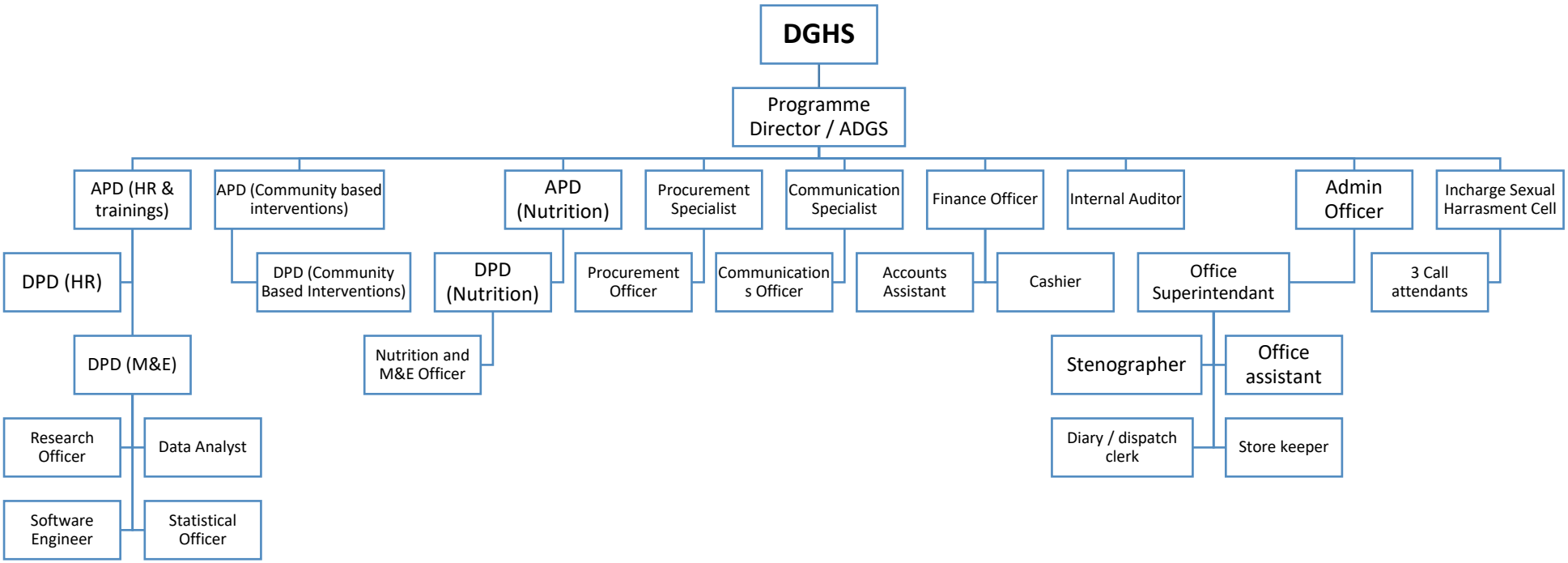
Details	2015-16	2016-17
Average deliveries per annum at BHU (24/7)	360	384
Operational BHUs (24/17) for test strips	1,000	1,000
Estimated number of strips required	360,000	384,000

Annex C7: Detailed Working RUTF Requirement

Sr. No.	District	Population per UC	Year II			
			OTP-Sites	Target Children (Under 5)	Sachets required	Cost of Sachet - PKR
1	Bhawalnagar	19,622	51	3,600	540,000	19,440,000
2	Bahawalpur	34,625	42	2,970	445,500	16,038,000
3	Bhakkar	33,558	18	1,280	192,000	6,912,000
4	Chiniot	26,406	17	1,210	181,500	6,534,000
5	D. G. Khan	37,451	33	2,300	345,000	12,420,000
6	Gujranwala	22,688	50	3,500	525,000	18,900,000
7	Hafizabad	24,032	22	1,520	228,000	8,208,000
8	Jhang	27,293	33	2,330	349,500	12,582,000
9	Layyah	34,079	20	1,410	211,500	7,614,000
10	Mianwali	23,568	27	1,900	285,000	10,260,000
11	Multan	36,219	34	2,360	354,000	12,744,000
12	Muzaffargarh	38,950	43	3,010	451,500	16,254,000
13	Narowal	20,794	30	2,090	313,500	11,286,000
14	Rahimyar Khan	34,773	61	4,300	645,000	23,220,000
15	Rajanpur	35,268	27	1,920	288,000	10,368,000
16	Gujrat	20,839	47	3,300	495,000	17,820,000
17	Jhelum	19,524	24	1,650	247,500	8,910,000
18	Khushab	22,256	21	1,450	217,500	7,830,000
19	Sargodha	18,942	52	3,640	546,000	19,656,000
20	Faisalabad	23,548	75	5,240	786,000	28,296,000
21	Lahore	55,464	20	1,420	213,000	7,668,000
22	Lodhran	20,726	24	1,680	252,000	9,072,000
23	Rawalpindi	16,034	47	3,300	495,000	17,820,000
24	Khanewal	25,663	40	2,790	418,500	15,066,000
25	Vehari	30,311	44	3,080	462,000	16,632,000
26	Attock	20,847	29	2,050	307,500	11,070,000
27	Pakpattan	25,685	26	1,850	277,500	9,990,000

28	Sahiwal	25,000	41	2,870	430,500	15,498,000
29	Sialkot	27,630	43	2,990	448,500	16,146,000
30	Kasur	26,759	46	3,240	486,000	17,496,000
31	Okara	24,341	50	3,500	525,000	18,900,000
32	Sheikhupura	26,079	42	2,930	439,500	15,822,000
33	Nankana Sahib	21,750	26	1,820	273,000	9,828,000
34	M.B. Din	23,477	29	2,030	304,500	10,962,000
35	Chakwal	21,039	37	2,600	390,000	14,040,000
36	T.T. Singh	24,182	32	2,220	333,000	11,988,000
Total			1,305	91,350	13,702,500	493,290,000

ORGANOGRAM



Note: LHW Programme will be an integrated part of the proposed IRMNCH, however they have not been included in the organogram as they are not part of this PC-1 and their integration will be functional.

ANNEXURE E

MANAGEMENT STRUCTURE

ADMINISTRATIVE ARRANGEMENTS

The administrative arrangements for program implementation consist of establishment of:

1. Provincial and district steering committees
2. Provincial and district management units

Provincial Steering Committee (PSC)

Provincial steering committee shall comprise of:

1. Chairman P&D /Member Social Services	Chairperson
2. Secretary Health	Member
3. Director General Health Services	Member
4. Program Director PSPU	Member
5. Program Director IRMNCH&N	Secretary
6. Director General Population Welfare Department	Member
7. Secretary Finance Department	Member

District Steering Committee (DSC)

District steering committee shall comprise of:

1. District Coordination Officer	Chairman
2. Executive District Officer (Health)	Member
3. District Coordinator	Secretary
4. District Officer Health	Member
5. EDO F&P	Member

Provincial Level Management Committee

A Provincial level Management Committee will be notified for the purpose of selection of Districts and health facilities for implementation of the proposed programme activities. Headed by Secretary Health, the Committee will comprise of the following memberships:

- Programme Director IRMNCH

- Representative from DGHS Office
- Representative from PSPU Office

Roles and Responsibilities of IRMNCH&N, Management

PMU	Overall management of the programme, PHC policy advice, National reporting, Internal supervision and monitoring &evaluation, Procurement and distribution of equipment & commodities, Operational planning and budgeting, Financial accounting, Managing LHW and CMW MIS systems, Data analysis, Programme reporting
DMU	District management of the programme, LHW, CMW, LHS-District Supervision, Trainings, Operational Plan Implementation, Financial accounting, Managing MISs, collection and analysis of data, District reporting
FLCF (all)	Training of LHWs, LHS, Collation of MIS, Organizing Kit replenishment, Providing meeting point for LHWs and LHS, and collaboration with CMWs and PWD staff.
RHC+ for Comprehensive EmONC Services	Provision of comprehensive EmONC services and serve as a referral facility for obstetric cases
All RHCs and Selected BHUs for 24/7 Basic EmONC & Nutrition Services	Provision of basic EmONC services round the clock, provision of outdoor obstetric care, routine EPI, family planning services and nutrition services (CMAM/OTP). Additional HR, equipment and supplies will be ensured to enhance the capacity of these facilities for provision of services beyond the existing ToRs.
LHW	PHC & FP service provision to community, community organization
CMW	MNCH & FP service provision to community

ANNEXURE F

IRMNCH, JOB DESCRIPTIONS

Project Management Unit (PMU) Staff

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
1	**Programme Director/ADGHS, IRMNCH & N Programme Punjab** BPS 20 by transfer / Deputation from DoH	Medical doctor with post graduate qualification in public health. At least 15 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects.	The Programme Director/ ADGHS, IRMNCH reporting to the DG Health Punjab, and as head of provincial programme management unit, is responsible for overall management, planning and successful implementation of the programme. He will be employed through transfer or an open competitive recruitment process. 1. He will provide all necessary management and technical skills to the project as may be required by the project management unit for all programme components. 2. He will supervise the PIU in the implementation and Monitoring of activities. 3. He will provide leadership in planning, technical, and Financial Management, disbursement, and auditing issues arising from implementation of the various project activities. 4. He may associate with other, for example management consultants. Trainers, contract management or others fields relating to management and supervision to provide the full range of services and interdisciplinary topics. 5. Ensuring effective communication and consultations with all stakeholders. 6. Monitoring and facilitating all programme components within the implementation, legal financial and technical requirements of the project. 7. undertaking the monitoring and evaluation of performance indicators and outcomes against the targets, as agreed with the development partners and Department of Health 8. Prepare the periodic reports for Government and Donors as required. 9. He shall gather and record information about progress and results of subcomponents and other components.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
			10. He will prepare detailed reports to compare actual result with plan, highlight difficult problems in implementing subproject and suggest solutions. 11. A key activity of the national coordinator will be the transfer of knowledge so as to leave the PMU of the project with a cadre of trained staff, having the necessary experience, and appropriate skills, to enable them to be capable of managing the later stage of the subproject and similar future projects. 12. This transfer of knowledge and skills will be both through working closely with PMU staff as day to day tasks are carried out, formal training (e.g. small classes, workshops, etc.) and regularly reviews of duties of PMU staff and their implementation. 13. Review, development and testing of new intervention of the Programme. 14. Supervise monthly meetings of project officers and quarterly meeting of provincial project coordinators. 15. Supervise and monitor the recruitment process, capacity building and training of staff. 16. Monthly update of Programme activities and publication of quarterly, biannual and annual reports. 17. Matters related to research activities including new research initiatives. 18. Perform other functions required for implementation of project objectives.
2	Additional Programme Director (HR and trainings) BPS 19/20 by transfer / Deputation from DoH	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Additional Programme Director (HR & trainings) reporting to the PD, shall be responsible for affairs related to human resource and trainings and assignments given by the PD if and when required. He will be assisted by a team of deputy director, one for each of the major tasks.
3	Additional Programme Director (Community based interventions) BPS 18/19 by transfer / Deputation from DOH	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of	Additional Programme Director (Community based interventions), reporting to the PD, shall be responsible for affairs related to community based and facility based operations and assignments given by the PD if and when required. He will be assisted by a team of deputy directors, one for each of

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
		project management experience for implementation of field basedprojects	the major tasks.
4	Additional Programme Director (Nutrition) BPS 18/19 by transfer / deputation from DOH	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Additional Programme Director (Nutrition), reporting to the PD, shall be responsible for affairs related to nutrition activities, and assignments given by the PD if and when required. He will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
5	Procurement Specialist BPS 18/19 by transfer / deputation from DOH / open competition	The potential candidate should have a post graduate degree (MBA, MPA, Economics or relevant field). Minimum of 8 years of practical experience in the social sector, preferably in health sector projects in procurement of goods, works and routine services and consultancy services and conductions of related trainings.	The procurement Specialist reporting to the PD shall be responsible for the affairs related to all procurements by the programme. S/he shall manage each step of the procurement cycle, supply chain management, warehousing and distribution systems. S/he shall develop procurement documents (Procurement Plan, SBDs, RFP, IFB, Evaluation Criteria, Prequalification documents etc) and transfer her/his knowledge and offer formal and on-the-job skills training in procurement to the programme staff. S/he shall ensure that all procurements are done in accordance with Punjab Procurement Rules S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
6	Communications Specialist	The potential candidate should have a master's degree in mass communication. Minimum 8 years practical experience in social sector preferably in health.	The Communications Specialist reporting to the PD shall be responsible for the affairs related to advocacy and communication by the programme. S/he will prepare a communication strategy and implementation plan. S/he will utilize messages and material already developed and prepare new ones if the need arises. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
7	Deputy Programme	A medical doctor with post graduate	Deputy Programme Director (HR) reporting to the Additional

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
	Director (HR) BPS 18/19 by transfer / Deputation from DOH	qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Programme Director (HR and trainings), shall be responsible for affairs related to human resources and assignments given by the PD if and when required. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
8	Deputy Programme Director (Nutrition) BPS 19/18 by transfer / Deputation / open competition	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Deputy Programme Director Nutrition reporting to Additional Programme Director (Nutrition) shall be responsible for affairs related to all nutrition interventions and assignments given by the PD if and when required. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
9	Deputy Programme Director (M&E) BPS 19/18 by transfer / Deputation / open competition	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Deputy Programme Director M&E, reporting to PD, shall be responsible for monitoring and evaluation of all activities and assignments given by the PD if and when required. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
10	Deputy Programme Director (community based interventions) BPS 19/18 by transfer / Deputation / open competition	A medical doctor with post graduate qualification in public health At least 10 years of experience at mid and senior level positions including 5 years of project management experience for implementation of field based projects	Deputy Programme Director (Community Based Interventions) reporting to the Additional Programme Director (Community based interventions), shall be responsible for affairs related to community based and facility based operations, and assignments given by the PD if and when required.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
11	Finance Officer (BPS-18/19) by transfer / Deputation from DoH/ CGA	A finance professional, with a relevant degree in accounting and finance or commerce graduate with PIPFA / SAS. At least 7 years of experience of working at mid and senior level positions in public sector organization	The Finance Officer, reporting to the ADGHS, shall be responsible for managing programme finances and assignments given by the PD if and when required. To fill this post an Audit / Accounts Officer (B-18/19) will be hired preferably fromHealth Department through transfer or on deputation basis from AGP/CGA. In case AGP/CGA Offices does not respond within 4 months to the request for posting of officer, the post may be filled on contract basis through open competition.
12	Communication Officer / HEO (BPS-17) by transfer / Deputation from DoH or by Initial Recruitment	The potential candidate should have a master's degree in mass communication. Minimum 3 years practical experience in social sector preferably in health.	The Communications Officer reporting to and assisting the Communication Specialist for all advocacy and communication related activities. S/he will assist the communication specialist in the preparation of a communication strategy and implementation plan. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
13	Nutrition + M&E Officer (BPS -17) by transfer / Deputation from DOH or by initial recruitment	The potential candidate should have a Masters degree in Nutrition alongwith atleast 02 years experience in Public Health Sector or implementing nutrition based projects.	Nutrition Officer will report to the Additional Programme Director (Nutrition) and Deputy Progamme Director (M&E). He will assist the programme in planning and implementation of nutrition and M&E activities. S/he will be employed through transfer/deputation from Health Department. In case Health Department not depute any officer within six months after the requisition by this office and repeated requests the officer may be appointed on contract basis through open competition.
14	Research Officer (BPS 17)	The potential candidate should have a masters degree in Statistics alongwith 2 years' work experience preferably in the social sector. S/he should have practical skill in the use of computerized database & statistical analysis software.	Research Officer will be reporting to the Deputy Programme Director responsible for overall management, planning, provision of technical support. In addition S/he will perform assignments given by the PD or Deputy Programme director (nutrition) if and when required.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
15	Data Analyst (BPS-17)	The potential candidate should have atleast a BS Hons degree recognized by UGC/HEC. Two years' experience in Data Processing/ Analysis preferably in public sector	Verification of programme data, analysis and generation of reports. Any other duty assigned
16	Software Engineer (BPS-17)	The potential candidate should have atleast a BS Hons degree in computer sciences. Atleast two years working experience in developing software preferably in public sector	Developing software for programme activities Trouble shooting hardware issues if and when they arise Any other duty assigned
17	Statistical Officer (BPS-17)	The potential candidate should have atleast a BS Hons degree in statistics. Two years working experience preferably in public sector	The statistician will collect, analyze, interpret and present programme quantitative data to PD and team on a regular basis. S/he will design and manage operations research looking for patterns to help make decisions. S/he will advise on findings and recommend strategies to the team. Any other duty assigned
18	Internal Auditor (BPS-17) by transfer / Deputation / Initial recruitment	At least Commerce graduate or equilant with atleast 8 to 10 years of experience in internal/external audit preferably in government sector.	Internal Auditor will report to the PD through Finance Officer of the Programm. S/he will conduct Pre and post internal audits of the programme.
19	Procurement Officer (BPS-17) by transfer / Deputation / Initial recruitment	The potential candidate should have atleast a BS Hons degree with additional training in procurement. Two years working experience preferably in public sector Well versed with Punjab Public Procurement Rules	The procurement officer will report to the Procurement Specialist. S/he will assist the procurement specialist in all procurement related activities by the programme.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
20	Incharge Sexual Harrasment Cell, (BPS-17) by transfer / deputation / initial recruitment	The potential candidate should have atleast a Bachelor's degree with 5 years of experience in gender based initiatives preferably in the social sector.	Incharge of the sexual harrasment cell will report directly to the PD. S/he will collect, compile and analyse all sexual harrasment complaints and present them to the PD for further action.
21	Admin Officer (BPS-17) by transfer / Deputation / Initial recruitment	The potential candidate should have atleast a Bachelor's degree with atleast 7 years additional experience in office administration	The Admin Officer will be responsible for maintaining day to day administrative and personnel services in order to meet programme requirements and to ensure the smooth running of programme activities.
22	Office Superintendant (BPS-16) by transfer / Deputation / Initial recruitment	The potential candidate should have atleast a Bachelor's degree with atleast 3 years additional experience in office administration.	The office superintendant will assist the Admin Officer in day to day running of the office.
23	Stenographer (BPS-16) by transfer / Deputation / Initial recruitment	The potential candidate should have atleast a Batchelor's degree with atleast 5 years of experience of working with a reputable organization.	The Stenographer/ Personal Assistant, reporting to the Programme Director, is responsible for performing duties of Personal Assistant at the provincial programme management unit.
24	Accounts Assistant (BPS-14)	The potential candidate should have atleast a Batchelor's degree with atleast 3 years of experience of working with a reputable organization.	The Accounts Assistant will be work under Finance Officer and shall be responsible for preparing various sorts of bills S/he shall help Accountant / Assistant Accounts Officer in collection of reconciled SOEs from DMUs and its consolidation/preparation at PMU level. Further will also help cashier for release of salaries from bank and treasury office level.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
25	Office Assistant/Computer Operators /Steno Typist (BPS-14)	The potential candidate should have atleast a Batchelor's degree in computer sciences or a bachelor's degree with certificate course in computer applications. For Steno Typist Intermediat/equivalent. Atleast 3 working experience in any Programme/ organization as Computor Operator & For Steno Typist one Working experience is required.	Computer Operator /Office Assistant shall be responsible for maintaining and organizing the paper and electronic documents and sorting them properly for future reference. Filing documents as per requirement of the office manager. Making documents, as assigned by the office managers and also according to the needs of the office. Assisting the concerned authorities in matters related to preparation of reports and concerned files.
26	Cashier/ Accounts Clerk (BPS-12)	The potential candidate should have atleast a Batchelor's degree with one years experience or D-Com/ I-Com with three years experience in a Programme or Organization.	The Casheir will work under Finance Officer and is responsible for preparing all sorts of bills, contingent bills/Salary Arrears bills and will help Accountant / Assistant Accounts Officer in collection of reconciled SOEs from DMUs and its consolidation/preparation at PMU level. Further will also help with cashier for release of salaries from bank and treasury office level.
27	Diary / dispatch clerk (BPS-7)	The potential candidate should be atleast a matriculate	The diary / dispatch clert will keep an updated record of all outgoing and incoming correspondence
28	Call attendants	The potential candidate should have a bachelor's degree.	S/he will attend calls at the sexual harrasment call centre.
29	Store keeper (BPS-11)	The potential candidate should be at least Matric with science with 3 year experience or I-Com with one years experience in a Programme or Organization.	Store keeper will be responsible for maintaining the store as per SOPs and will help procurement Officer /Accountant Officer in collection & storage of procured stores .
30	Drivers (BPS-4)	At least Middle with 05 years experience and LTV license holder. OR Matriculate with 03 years experience with LTV license.	He will be responsible for maintainance of vehicle/Log book/History Book/Movement Register issued to him for field visit with PMU Officers as per duty assigned to him time to time by the office.
31	Naib Qasid (BPS-2)	At least Middle pass having experience of	He will work in office as per duty assigned to him.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
		two years in relevant field.	
32	Security Guard (BPS-2)	At least Middle pass having experience of two years in relevant field. Preferably Ex-Armed service man with two personal guarantees of reputable persons.	He will be responsible for the security of movable/immovable assets of office and will work as per duty assigned to him on roaster basis.
33	Mali (BPS-2)	At least Primary pass having good health.	He will work in office as per duty assigned to him.
34	Sanitory worker (BPS-2)	At least Primary pass having good health.	He will work in office as per duty assigned to him.
35	MIS Coordinator (BPS-17)	M.C.S/M.I.T/BS. (CS. 16 Years).atleast 7 years work experience at mid and senior level in IT industry after completion of the 16 years of education. Preference will be given if worked as MIS Manager/Coordinator in reputable National or International organization. Having hands on experience of Software Development, Databases with good understanding of Networks/LAN.	A Management information systems (MIS) Coordinator will be responsible for planning, development and implementation of hardware, software applications, programming and systems network and integration of a management information system. The MIS also has personnel, and supervisory responsibilities as well as creating plans for the use of telecommunications integration with existing information systems. MIS Coordinator will also be responsible for supervision and to insure timely collection and analysis (qualitative and quantitative) of Provincial Monthly Reports and the preparation of feedbacks accordingly. MIS Coordinator duties may extend to developing training programs for personnel on system features, supervising programmers and data processing personnel.
36	Junior Software Engineer (BPS_16)	BS(CS)/MCS/Bachelors in Software Engineering Skills: •Strong coding skills with an emphasis on Object Orientated Programming, Experience with APIs and Web Services, Experience with HTML5, CSS3, XML, Javascript libraries such as JQuery, Strong work ethic and ability to self-manage, Strong analytical and problem solving skills CSS3, HTML5, PHP, C#, .Net, ASP.NET	•Plan, design, develop, debug, implement and support web-based applications and services. •Modify existing software to: correct errors, allow it to function in new operating environments, or improve performance. •Adheres to and recommends improvements to project coding standards. •Work remotely in a team environment with shared code, disciplined use of source code control and process documentation. •Improve software quality by conducting systems analysis, and recommending changes in policies and procedures.

S No	Designation &Pay scale	Eligibility Criteria	ToRs / Responsibilities
		and MVC, MySQL, MS SQL Server One year minimum experience in software development/related field	
37	Network Administrator (BPS-16)	BS(CS)/MCS/MCS with One year minimum experience in LAN/WAN with related field	Comprehensive know how of LAN & WAN Network Designs & Implementation , To be able to configure & manage network Switches & Routers Network Monitoring & Troubleshooting Fully trained on DHCP, DNS, Email, Print Server, Application Server, Webserver Administration Experience of Installing & Configuring Firewall Devices To be able to install Hardware & Software & troubleshoot Wireless LAN Administration Experience Good knowledge of Database Applications To be able to plan & implement comprehensive Backup & Disaster Recovery Able to provide technical support over telephone/email. Carry out daily maintenance on all ICT equipment Apply operating system patches and software upgrades Ensure network security through regular audits and testing Optimize network and systems by employing industry best practices and automation Provide technical support and assistance to staff Provide telephonic and remote support assistance as and when needed

District Management Unit (DMU)

	Designation & Pay scale	Eligibility Requirement	Roles & Responsibilities
1	District Programme Manager (IRMNCH & Nutrition Programme) (BPS-18) by transfer / Deputation from DOH / Initial Recruitment	Medical doctor with post graduation in public health or MNCH or DCH At least 7 years of experience in public health with at least three years experience at mid/senior level management position	The District Programme Manager, reporting to the Executive District Officer Health of the district and the Additional Programme Director at PMU, and as head of district programme management unit, is responsible for overall management, planning and successful implementation of the programme in the district.
2	Monitoring & Evaluation officer/Social Organiser (BPS-17) by transfer / Deputation from DOH / Initial Recruitment	Masters in Social Sciences with Three years Experience in any Public Health Programme/ Organization	Monitoring and Evaluation of outreach and facility based programme activities Coordination of programme with EDO and PMU Social Mobilization Verbal Autopsy Initially all existing incumbents working as social organizers will continue their services as Monitoring & Evaluation Officer.
3	CMW Tutor BPS-17 by transfer / Deputation from DOH / Initial Recruitment	As per criteria of General Nursing Council	CMW Training Technical Monitoring of CMWs S/he will be employed through open competition/Tranfer/ Deputation.
4	Accounts Assistants BS-14 by transfer / Deputation from DOH / Initial Recruitment	Bachelor's degree in Coommrece having 3 years experience in a reputable organization.	District Accounts Assistant shall report to the District Programme Manager and will be responsible for preparation of budget, release of funds, reconciliation with District Accounts Office, pre and post audit of bills and preparation of statement of expenditure. S/he will be employed through an open competitive process / transfer / deputation. Initially all existing incumbents working as Accounts Assistants will

	Designation & Pay scale	Eligibility Requirement	Roles & Responsibilities
			continue their services as Accounts Assistant.
5	Store Keeper/DMU (BPS-8)	Atleast Matric with science with 3 years experience or I-Com with one years experience in a Programme or Organization.	Store keeper will be work under DPM and is responsible for maintaining the store as per SOPs and will be helpful in procurement / collection & storage of store items . S/he will be employed through an open competitive process / transfer / deputation
6	Drivers for DMU and CMWs school officers (1 for each) BS-4	Middle with 05 years experience and LTV license holder. OR Matriculate with 03 years experience with LTV license.	He will be responsible for maintainance of vehicle/Log book/History Book/Movement Register issued to him for field visit with DMU/ CMW School Officers as per duty assigned to him time to time by the office.
7	Security Guard (BPS-02)	At least Middle pass having experience of two years in relevant field. Preferably Ex-Armed service man with two personal guarantees of reputable persons.	He will be responsible for the security of movable/immovable assets of office and will work as per duty assigned to him on roster basis. Initially, all existing incumbents working as Security Guards will continue their services as Security Guards.
8	Naib Qasid	At least middle pass having experience of two years in the relavant field	He will be responsible for the work as an office boy and will be responsible for cleanliness of moveable/imoveable assets of office. He will also work as per duties assigned to him on roster basis

District Level Field Staff - Health Workers

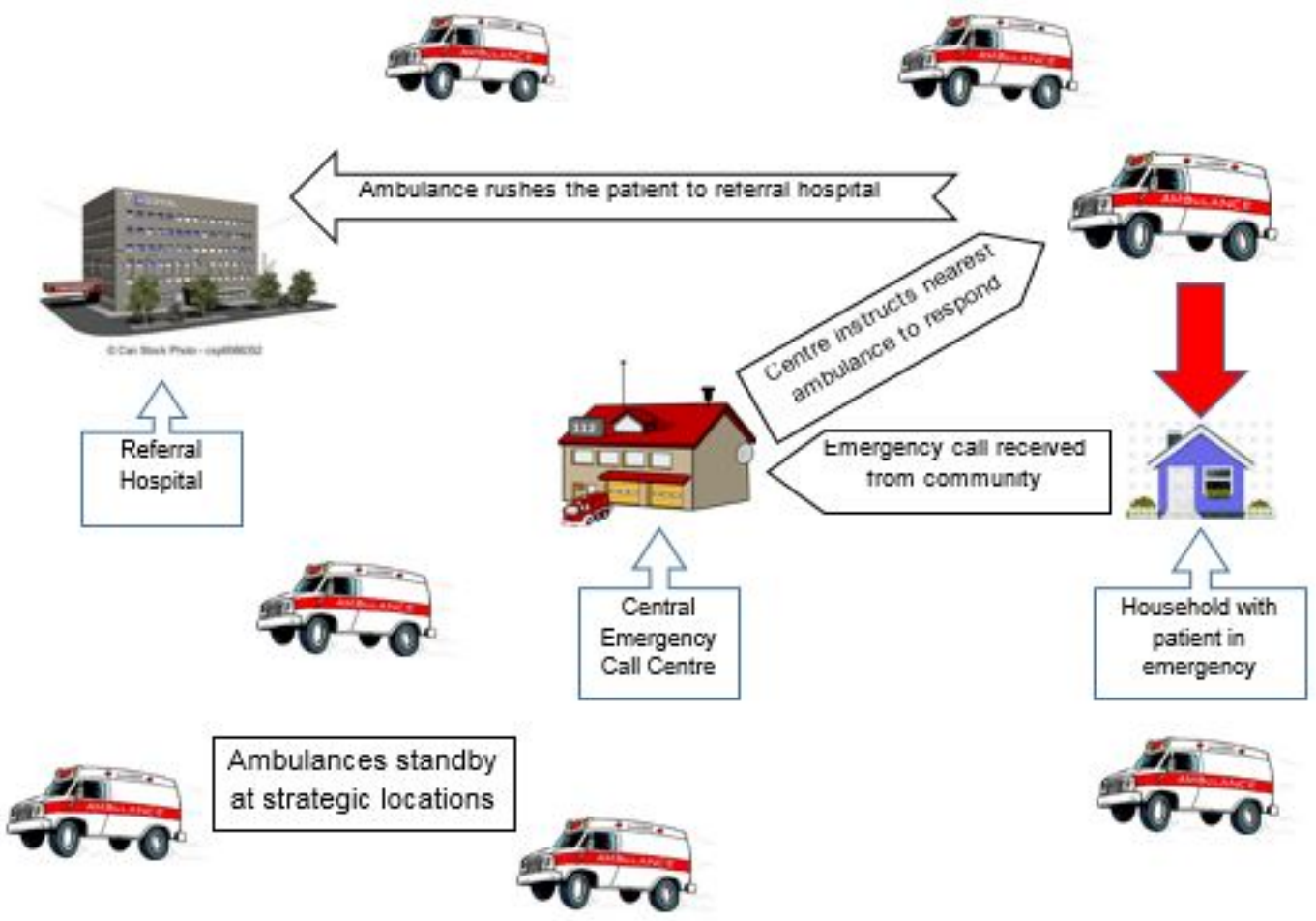
	Designation & Pay scale	Eligibility Requirement	Roles & Responsibilities
1	Medical Officer (MO) stabilization centre - DHQH	Medical doctor with at least 3 years of clinical experience preferably in management of malnourished children.	Medical Officer will be the overall in-charge of the unit and will be responsible for clinical management of children admitted in the Stablization Centre. The MO will examine each patient every day and will attend to emergency calls as per the need.
2	Nursing staff (for DHQH	Diploma in Nursing with at least 3	The nurses posted in the unit will be responsible for nursing care including

	Nutrition)	years of clinical experience preferably in management of malnourished children.	weight record; measure, mix and dispense feed; give oral drugs; supervise intra venous fluids; assess clinical signs and record the routine information. The nurse will also counsel mothers/caregivers on the emotional needs of her child and encourage them to give sensory stimulation.
3	Woman Medical Officer (WMO) for RHCs	Medical doctor with at least 3 years of clinical experience in obstetrics and gynaecology	Ensure smooth operation of all MNCH services in cooperation and under the supervision of district programme manager Ensure high level of clinical care to woman and children attending the RHC for their health needs Conduct deliveries at the RHCs Prepare training lectures and provide training to LHVs, LHWs and CMWs
4	Nutrition Assistant OTP (LHV)	Qualified LHV registered with PNC with 2 years of work experience with 1 year working in CMAM	Work closely with district and facility staff to ensure all aspects of the programme are understood and agreed and appropriate referrals take place to and from the OTP and the programme is well integrated into the health systems. Supervise the activities of the CMAM team (LHW and CMW) Work closely with the teams to ensure all children are screened correctly Ensure comprehensive health checks and treatment according to the protocols. Enusre correct clinical diagnosis at the time of assessment so that the patient receives appropriate treament in the relavant program. Timely identification of complications, non responder, and referrals to the SC.
5	LHV (24/7 BHU)	Qualified LHV registered with PNC with 2 years of work experience	Provide ANC and PNC care to pregnant and lactating women Provide safe delivery services for pregnant women Give health and hygiene education to women of reproductive age Ensure cleaning, sterilization and disinfection of all MNCH related material Supervise outreach staff (CMW & LHW)

			Collect data on regular basis
6	Aya/Midwife (24/7 BHU)	Primary pass women preferably married	To assist the staff in houskeeping
7	Ambulance drivers (24/7 BHU)	Middle with 05 years experience and LTV license holder. OR Matriculate with 03 years experience with LTV license.	He will be responsible for maintainance of vehicle/Log book/History Book/Movement Register issued to him for transfering patients to referal facilities.
8	Guards (24/7 BHU)	At least Middle pass having experience of two years in relevant field. Preferably Ex-Armed service man with two personal guarantees of reputable persons.	He will be responsible for the security of movable/immovable assets of BHU and will work as per duty assigned to him on roster basis.
9	Sweeper (24/7 BHU)	At least Primary pass having good health.	He will work in 24/7 BHU as per duty assigned to him.

ANNEXURE G

Referral System



ANNEXURE H
IRMNCH & NUTRITION PROGRAM (Comparison of approved & Proposed PC-I's)

Object Heads		Approved Cost FY 2013-14	Approved 1st Revised Cost Financial Year 2013-14	Approved Cost FY- 2014-15	Approved 1st Revised Cost Financial Year 2014-15	Approved Cost FY- 2015-16	Approved 1st Revised Cost Financial Year 2015-16	Proposed 2nd Revised Cost Financial Year 2015-16	Proposed 2nd Revised Cost Financial Year 2016-17
A01	**EMPLOYEE RELATED EXPENSES**	**588,210,384**	**53,560,000**	**789,970,384**	**691,694,864**	**1,090,684,384**	**1,117,632,185**	**2,339,203,756**	**2,913,269,609**
	PAY	**1,719,600**		**1,719,600**	**1,212,400**	**1,719,600**	**1,273,400**	**469,851,756**	**475,519,609**
	PAY OF OFFICERS	**1,719,600**		**1,719,600**	**1,212,400**	**1,719,600**	**1,273,400**	**469,851,756**	**475,519,609**
A01101	Basic Pay	600,000		600,000	600,000	600,000	600,000	469,851,756	475,519,609
A01102	Personal Pay	-		-	11,200	-	29,000		
A01105	Qualification Pay	-		-		-	-		
A01106	Pay of Contract Staff	1,119,600		1,119,600	601,200	1,119,600	644,400		
A01150	Others								
	PAY OF OTHER STAFF	**-**		**-**	**-**	**-**	**-**	**-**	**-**
A01151	Basic Pay								
A01152	Personal Pay								
A01153	Special Pay								
A01156	Pay of Contract Staff	-		-	-	-	-		
A01170	Others								
A012	**ALLOWANCES**	**586,490,784**		**788,250,784**	**690,482,464**	**1,088,964,784**	**1,116,358,785**	**1,869,352,000**	**2,437,750,000**
	REGULAR ALLOWANCES	**53,930,784**		**53,930,784**	**54,503,964**	**71,450,784**	**71,628,785**	**52,560,000**	**52,560,000**
A01202	House Rent Allowance	229,296		229,296	229,296	229,296	229,296		
A01203	Conveyance Allowance	240,000		240,000	240,000	240,000	5,809		
A01226	Professional Health Allowance				134,400		134,400		
A01985	Computer Allowance				36,000		36,000		
A01994	Adhoc Relief Allowance (10% 2013)				120,120		124,440		
A01270-001	Adhoc Relief Allowance (10% 2014)				120,120		124,440		
A01209	Special Additional Allowance								
A01217	Medical Allowance	146,544		146,544	146,544	146,544	146,544		
A01224	Entertainment Allowance	-		-		-	4,000		
A01226	Computer Allowance	-		-		-	-		
A01227	Project Allowance								
A01230	Dusting Allowance								
A01234	Training Allowance (20%)								
A01236	Deputation Allowance	72,000		72,000	72,000	72,000	72,000		
A01243	Special Travelling Allowance (FTA)	52,560,000	52,560,000	52,560,000	52,560,000	70,080,000	70,080,000	52,560,000	52,560,000

A01252	Non Practicing Allowance	48,000		48,000	48,000	48,000	48,000		
A01964	Special Additional Allowance (50% 2010)	488,400		488,400		488,400	-		
A01262	15% Special Relief Allowance								
A01964	Special Additional Allowance (50% 2010)				410,700		355,200		
A01985	Professional Health Allowance	-		-	-	-	-		
A0 1970	Adhoc Relief Allowance (15% 2011)	146,544		146,544	146,544	146,544	139,776		
A01990	Special Additional Allowance (200% 2012)				240,240		128,880		
	OTHER ALLOWANCES	**532,560,000**	**1,000,000**	**734,320,000**	**635,978,500**	**1,017,514,000**	**1,044,730,000**	**1,816,792,000**	**2,385,190,000**
A01271	Over Time Allownace	10,000		10,000	10,000	10,000	10,000		
A01273	Honorarium/Incentive for performance (Pay For Performance For Two Best BHU's from every District)	44,160,000	1,000,000	44,160,000	43,200,000	44,160,000	43,200,000	67,480,000	67,480,000
A01274	Medical Charges	50,000		6,804,000		6,804,000			-
A01277	Contingent Paid staff (Additional Human Resource For RHC+THQ)	25,500,000		25,500,000	52,200,000	18,300,000	52,200,000	30,600,000	30,600,000
A01278	Leave salary								-
A01299	Other (Stipend of LHVs, Ayas, Ambulance Drivers & Guards)	462,840,000		657,846,000	540,568,500	948,240,000	949,320,000	1,718,712,000	2,287,110,000
A03	**OPERATING EXPENSES**	**553,534,213**	**509,417,213**	**602,678,846**	**627,817,846**	**696,046,618**	**716,206,618**	**896,622,394**	**1,537,071,880**
A032	**COMMUNICATION**	**1,160,000**		**1,160,000**	**1,160,000**	**1,160,000**	**1,160,000**	**22,978,000**	**22,978,000**
A03201	Postage and Telegraph	20,000		20,000	20,000	20,000	20,000		
A03202	Telephone and Trunk Calls Charges	100,000		100,000	100,000	100,000	100,000	1,068,000	1,068,000
A03203	Telex. Teleprinter and Fax	40,000		40,000	40,000	40,000	40,000	180,000	180,000
A03204	Electronic communication (E - Governance + Internet Charges)	800,000		800,000	800,000	800,000	800,000	20,998,000	20,998,000
A03205	Courior and Pilot Services	200,000		200,000	200,000	200,000	200,000	732,000	732,000
A033	**UTILITIES**	**600,000**		**600,000**	**600,000**	**600,000**	**600,000**	**1,140,000**	**1,140,000**
A03301	Gas Charges							60,000	60,000
A03302	Water Charges							180,000	180,000
A03303	Electricity Charges	600,000		600,000	600,000	600,000	600,000	900,000	900,000
A03304	Hot & Cold Weather Charges								-
A034	**OCCUPANCY COSTS**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**
A03402	Rent of Office Building								-
A03403	Rent of Residential Bilding	-		-	-	-	-		-
A03404	Rent for Other Building								-
A03407	Rates & Taxes(Vehicles Tax & Toll Tax)	500,000	500,000	500,000	500,000	500,000	500,000	500,000	500,000
A03410	Security								-
A038	**TRAVEL & TRANSPORTATION**	**131,860,000**	**107,350,000**	**57,874,000**	**51,493,000**	**75,996,000**	**75,996,000**	**299,136,486**	**179,859,500**
	GOVT. SERVANTS	**131,860,000**	**107,350,000**	**57,874,000**	**51,493,000**	**75,996,000**	**75,996,000**	**299,136,486**	**179,859,500**

A03801	Training -Domestic (all training s &TOT) for 03 trainings	82,350,000	82,350,000	22,300,000	20,800,000	27,750,000	27,750,000	201,991,686	82,714,700
A03805	T.A (Govt. Servants)	500,000		500,000	500,000	500,000	500,000	28,312,800	28,312,800
A03806	Transportation of Goods	25,000,000	25,000,000	3,000,000	3,000,000	3,000,000	3,000,000	6,000,000	6,000,000
A03807	POL Charges	24,000,000		32,064,000	27,183,000	44,736,000	44,736,000	62,832,000	62,832,000
A03808	Local Conveyance Charges	10,000		10,000	10,000	10,000	10,000		-
A03809	CNG Charges	-		-	-	-	-		-
A039	**GENERAL**	**419,414,213**	**401,567,213**	**542,544,846**	**574,064,846**	**617,790,618**	**637,950,618**	**572,867,908**	**1,332,594,380**
A03901	Stationary	100,000	100,000	100,000	100,000	100,000	100,000	13,590,000	13,590,000
A03902	Printing and Publication (MIS Tools, Training manuals , BCC Material etc	4,000,000	4,000,000	4,000,000	600,000	2,000,000	2,000,000	3,600,000	3,600,000
A03903	Conference /Siminars/Workshops/Symposium/ Review Meetings	600,000		600,000	600,000	600,000	600,000	41,520,000	41,520,000
A03905	News Papers, Periodicals & Books	10,000		10,000	10,000	10,000	10,000		-
A03906	Uniform & Protective Clothing								-
A03907	Advertising & Publicity	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	11,560,000	11,560,000
A03917	Law Charges	5,000		5,000	5,000	5,000	5,000		-
A03918	Exibition, Fairs and Other National Celebrat.								-
A03919	Payment to Other for Service Rendered								-
A03927	Purchase of Drug and Medicines (Nutrition Cost Tab Iron Folic Acid+ Tab Mobendazole+ Cost Per Multinutrient And Medicine Cost of RHC+BHU)	410,299,213	395,467,213	533,429,846	545,309,846	612,115,618	612,115,618	473,797,908	1,216,388,380
A03934	Reimbursement of T. T. Charges to bank of home remittance								-
A03970	Others (DSU +BHU Petty Cash+ MRM at District)	2,400,000		2,400,000	25,440,000	960,000	21,120,000	28,800,000	45,936,000
A04	**EMPLOYEES RETIREMENT BENEFITS**	**312,804**		**312,804**	**312,804**	**312,804**	**312,804**	**-**	**-**
A041	**PENSION**	**312,804**		**312,804**	**312,804**	**312,804**	**312,804**	**-**	**-**
A04101	Pension Contribution	140,004		140,004	140,004	140,004	140,004		-
A04115	Social Security Benefits to Contract Employees (30%)	172,800		172,800	172,800	172,800	172,800		-
A06	**Entertainment & Gift**	**10,000**		**10,000**	**10,000**	**10,000**	**10,000**	**-**	**-**
A06301	Entertainment & Gift	10,000		10,000	10,000	10,000	10,000		
A09	**PHYSICAL ASSETS**	**1,302,996,603**	**1,085,246,603**	**2,108,327,890**	**2,625,627,890**	**2,077,909,344**	**1,961,334,344**	**1,019,934,188**	**540,353,080**
A092	**COMPUTER EQUIPMENT**	**5,200,000**		**2,600,000**	**10,800,000**	**2,400,000**	**-**	**88,675,000**	**43,500,000**
A09201	Hardware								-
A09202	Software (Call Response center+ Web based MIS etc)	2,000,000		1,000,000	3,600,000	800,000	-	43,200,000	43,200,000
A09203	IT Equipment (Laptop, PC, desktop, Printer, Fax For DSU)	3,200,000		1,600,000	7,200,000	1,600,000	-	45,475,000	300,000

A094	**OTHER STORE AND STOCK**	**1,117,946,603**	**1,074,746,603**	**1,975,427,890**	**1,949,027,890**	**1,926,534,344**	**1,943,334,344**	**430,378,740**	**461,853,080**
A09401	Medical Stores (Contraceptives)			550,000,000	550,000,000	300,000,000	300,000,000	385,000,000	385,000,000
A09404	Purchase of Lab kits & Consumeables				16,800,000		16,800,000	45,378,740	76,853,080
A09470	OTHER STORE AND STOCK (Cost Per PLW +SAM Children Cost+ SC Cost F-75 & F100)	1,117,946,603	1,074,746,603	1,425,427,890	1,382,227,890	1,626,534,344	1,626,534,344		-
A095	**PURCHASE OF TRANSPORT**	**-**		**-**	**-**	**-**	**-**	**16,000,000**	**-**
A09501	Purchase of Transport							16,000,000	-
A096	**PLANT AND MACHINERY**	**177,000,000**	**10,500,000**	**128,400,000**	**657,350,000**	**147,150,000**	**18,000,000**	**309,530,448**	**-**
A09601	MACHINERY AND EQUIPMENT (THQ/DHQ+RHC+BHU Cost+USG Portable+UPS With Batteries & Nutrition Anthropometry Equipment)	177,000,000	10,500,000	128,400,000	657,350,000	147,150,000	18,000,000	309,530,448	-
A097	**FURNITURE AND FIXTURE**	**2,850,000**		**1,900,000**	**8,450,000**	**1,825,000**	**-**	**175,350,000**	**35,000,000**
A09701	Furniture and Fixture (BHU Furniture+ DSU/RSU Furniture)	2,850,000		1,900,000	8,450,000	1,825,000	-	175,350,000	35,000,000
A13	**REPAIRS AND MAINTENANCE**	**948,000**	**948,000**	**948,000**	**948,000**	**948,000**	**948,000**	**20,030,000**	**16,430,000**
A130	**TRANSPORT**	**848,000**	**848,000**	**848,000**	**848,000**	**848,000**	**848,000**	**13,980,000**	**13,980,000**
A13001	Transport	848,000	848,000	848,000	848,000	848,000	848,000	13,980,000	13,980,000
A131	**MACHINERY AND EQUIPMENT**	**-**		**-**	**-**	**-**	**-**	**-**	**-**
A13101	Machinery and Equipment	-		-	-	-	-		
A132	**FURNITURE AND FIXTURE**							**-**	**-**
A13201	Furniture and Fixture								
A133	**BUILDING AND STRUCTURE**	**-**		**-**	**-**	**-**	**-**	**6,050,000**	**2,450,000**
A13301	Office Buildings	-		-	-	-	-	6,050,000	2,450,000
A13303	Other Buildings	-		-	-	-	-		
A137	**COMPUTER EQUIPMENT**	**100,000**	**100,000**	**100,000**	**100,000**	**100,000**	**100,000**	**-**	**-**
A13701	Hardware	-		-	-	-	-		
A13702	Software	100,000	100,000	100,000	100,000	100,000	100,000		
A13703	IT Equipment								
	TOTAL	**2,446,012,005**	**1,649,171,817**	**3,502,247,924**	**3,946,411,404**	**3,865,911,150**	**3,796,443,951**	**4,275,790,338**	**5,007,124,569**

	Object Heads	Total Approved Cost FY- 2013-16	Total Approved 1st Revised Cost Financial Year 2013-16	Total Proposed 2nd Revised Cost Financial Year 2015-17	Average approved Cost FY 2013-16	Approved Average 1st revised Cost FY 2013-16	Proposed Average 2nd revised Cost FY 2015-17
A01	**EMPLOYEE RELATED EXPENSES**	**2,468,865,152**	**1,862,887,049**	**5,252,473,365**	**822,955,051**	**620,962,350**	**2,626,236,683**
	PAY	**5,158,800**	**2,485,800**	**945,371,365**	**1,719,600**	**828,600**	**472,685,683**
	PAY OF OFFICERS	**5,158,800**	**2,485,800**	**945,371,365**	**1,719,600**	**828,600**	**472,685,683**

A01101	Basic Pay	1,800,000	2,400,000	945,371,365	600,000	800,000	472,685,683
A01102	Personal Pay	-	40,200	-	-	13,400	-
A01105	Qualification Pay	-	-	-	-	-	-
A01106	Pay of Contract Staff	3,358,800	1,245,600	-	1,119,600	415,200	-
A01150	Others			-			-
	PAY OF OTHER STAFF	**-**	**-**	**-**	**-**	**-**	**-**
A01151	Basic Pay			-			-
A01152	Personal Pay			-			-
A01153	Special Pay			-			-
A01156	Pay of Contract Staff	-	-	-	-	-	-
A01170	Others			-			-
A012	**ALLOWANCES**	**2,463,706,352**	**1,806,841,249**	**4,307,102,000**	**821,235,451**	**602,280,416**	**2,153,551,000**
	REGULAR ALLOWANCES	**179,312,352**	**126,132,749**	**105,120,000**	**59,770,784**	**42,044,250**	**52,560,000**
A01202	House Rent Allowance	687,888	458,592	-	229,296	152,864	-
A01203	Conveyance Allowance	720,000	245,809	-	240,000	81,936	-
A01226	Professional Health Allowance	-	268,800	-	-	89,600	-
A01985	Computer Allowance	-	72,000	-	-	24,000	-
A01994	Adhoc Relief Allowance (10% 2013)	-	244,560	-	-	81,520	-
A01270-001	Adhoc Relief Allowance (10% 2014)	-	244,560	-	-	81,520	-
A01209	Special Additional Allowance	-	-	-	-	-	-
A01217	Medical Allowance	439,632	293,088	-	146,544	97,696	-
A01224	Entertainment Allowance	-	4,000	-	-	1,333	-
A01226	Computer Allowance	-	-	-	-	-	-
A01227	Project Allowance	-	-	-	-	-	-
A01230	Dusting Allowance	-	-	-	-	-	-
A01234	Training Allowance (20%)	-	-	-	-	-	-
A01236	Deputation Allowance	216,000	144,000	-	72,000	48,000	-
A01243	Special Travelling Allowance (FTA)	175,200,000	175,200,000	105,120,000	58,400,000	58,400,000	52,560,000
A01252	Non Practicing Allowance	144,000	96,000	-	48,000	32,000	-
A01964	Special Additional Allowance (50% 2010)	1,465,200	-	-	488,400	-	-
A01262	15% Special Relief Allowance	-	-	-	-	-	-

A01964	Special Additional Allowance (50% 2010)		765,900	-		255,300	-
A01985	Professional Health Allowance	-	-	-	-	-	-
A0 1970	Adhoc Relief Allowance (15% 2011)	439,632	286,320	-	146,544	95,440	-
A01990	Special Additional Allowance (200% 2012)		369,120	-			-
	OTHER ALLOWANCES	**2,284,394,000**	**1,681,708,500**	**4,201,982,000**	**761,464,667**	**560,569,500**	**2,100,991,000**
A01271	Over Time Allownace	30,000	20,000	-	10,000	6,667	-
A01273	Honorarium/Incentive for performance (Pay For Performance For Two Best BHU's from every District)	132,480,000	87,400,000	134,960,000	44,160,000	29,133,333	67,480,000
A01274	Medical Charges	13,658,000	-	-	4,552,667	-	-
A01277	Contingent Paid staff (Additional Human Resource For RHC+THQ)	69,300,000	104,400,000	61,200,000	23,100,000	34,800,000	30,600,000
A01278	Leave salary	-	-	-	-	-	-
A01299	Other (Stipend of LHVs, Ayas, Ambulance Drivers & Guards)	2,068,926,000	1,489,888,500	4,005,822,000	689,642,000	496,629,500	2,002,911,000
A03	**OPERATING EXPENSES**	**1,852,259,677**	**1,853,441,677**	**2,433,694,274**	**617,419,892**	**617,813,892**	**1,216,847,137**
A032	**COMMUNICATION**	**3,480,000**	**2,320,000**	**45,956,000**	**1,160,000**	**773,333**	**22,978,000**
A03201	Postage and Telegraph	60,000	40,000	-	20,000	13,333	-
A03202	Telephone and Trunk Calls Charges	300,000	200,000	2,136,000	100,000	66,667	1,068,000
A03203	Telex. Teleprinter and Fax	120,000	80,000	360,000	40,000	26,667	180,000
A03204	Electronic communication (E - Governance + Internet Charges)	2,400,000	1,600,000	41,996,000	800,000	533,333	20,998,000
A03205	Courior and Pilot Services	600,000	400,000	1,464,000	200,000	133,333	732,000
A033	**UTILITIES**	**1,800,000**	**1,200,000**	**2,280,000**	**600,000**	**400,000**	**1,140,000**
A03301	Gas Charges			120,000			60,000
A03302	Water Charges			360,000			180,000
A03303	Electricity Charges	1,800,000	1,200,000	1,800,000	600,000	400,000	900,000
A03304	Hot & Cold Weather Charges			-			-
A034	**OCCUPANCY COSTS**	**1,500,000**	**1,500,000**	**1,000,000**	**500,000**	**500,000**	**500,000**
A03402	Rent of Office Building			-			-
A03403	Rent of Residential Bilding	-	-	-	-	-	-
A03404	Rent for Other Building	-	-	-	-	-	-

A03407	Rates & Taxes(Vehicles Tax & Toll Tax)	1,500,000	1,500,000	1,000,000	500,000	500,000	500,000
A03410	Security			-			-
A038	**TRAVEL & TRANSPORTATION**	**265,730,000**	**234,839,000**	**478,995,986**	**88,576,667**	**78,279,667**	**239,497,993**
	GOVT. SERVANTS	**265,730,000**	**234,839,000**	**478,995,986**	**88,576,667**	**78,279,667**	**239,497,993**
A03801	Training -Domestic (all training s &TOT) for 03 trainings	132,400,000	130,900,000	284,706,386	44,133,333	43,633,333	142,353,193
A03805	T.A (Govt. Servants)	1,500,000	1,000,000	56,625,600	500,000	333,333	28,312,800
A03806	Transportation of Goods	31,000,000	31,000,000	12,000,000	10,333,333	10,333,333	6,000,000
A03807	POL Charges	100,800,000	71,919,000	125,664,000	33,600,000	23,973,000	62,832,000
A03808	Local Conveyance Charges	30,000	20,000	-	10,000	6,667	-
A03809	CNG Charges	-	-	-	-	-	-
A039	**GENERAL**	**1,579,749,677**	**1,613,582,677**	**1,905,462,288**	**526,583,226**	**537,860,892**	**952,731,144**
A03901	Stationary	300,000	300,000	27,180,000	100,000	100,000	13,590,000
A03902	Printing and Publication (MIS Tools, Training manuals , BCC Material etc	10,000,000	6,600,000	7,200,000	3,333,333	2,200,000	3,600,000
A03903	Conference /Siminars/Workshops/Symposium/ Review Meetings	1,800,000	1,200,000	83,040,000	600,000	400,000	41,520,000
A03905	News Papers, Periodicals & Books	30,000	20,000	-	10,000	6,667	-
A03906	Uniform & Protective Clothing	-	-	-	-	-	-
A03907	Advertising & Publicity	6,000,000	6,000,000	23,120,000	2,000,000	2,000,000	11,560,000
A03917	Law Charges	15,000	10,000	-	5,000	3,333	-
A03918	Exibition, Fairs and Other National Celebrat.	-	-	-	-	-	-
A03919	Payment to Other for Service Rendered	-	-	-	-	-	-
A03927	Purchase of Drug and Medicines (Nutrition Cost Tab Iron Folic Acid+ Tab Mobendazole+ Cost Per Multinutrient And Medicine Cost of RHC+BHU)	1,555,844,677	1,552,892,677	1,690,186,288	518,614,892	517,630,892	845,093,144
A03934	Reimbursement of T. T. Charges to bank of home remittance	-	-	-	-	-	-
A03970	Others (DSU +BHU Petty Cash+ MRM at District)	5,760,000	46,560,000	74,736,000	1,920,000	15,520,000	37,368,000
A04	**EMPLOYEES RETIREMENT BENEFITS**	**938,412**	**625,608**	**-**	**312,804**	**208,536**	**-**
A041	**PENSION**	**938,412**	**625,608**	**-**	**312,804**	**208,536**	**-**

A04101	Pension Contribution	420,012	280,008	-	140,004	93,336	-
A04115	Social Security Benefits to Contract Employees (30%)	518,400	345,600	-	172,800	115,200	-
A06	**Entertainment & Gift**	**30,000**	**20,000**	**-**	**10,000**	**6,667**	**-**
A06301	Entertainment & Gift	30,000	20,000		10,000	6,667	-
A09	**PHYSICAL ASSETS**	**5,489,233,837**	**5,672,208,837**	**1,560,287,268**	**1,829,744,612**	**1,890,736,279**	**780,143,634**
A092	**COMPUTER EQUIPMENT**	**10,200,000**	**10,800,000**	**132,175,000**	**3,400,000**	**3,600,000**	**66,087,500**
A09201	Hardware			-			-
A09202	Software (Call Response center+ Web based MIS etc)	3,800,000	3,600,000	86,400,000	1,266,667	1,200,000	43,200,000
A09203	IT Equipment (Laptop, PC, desktop, Printer, Fax For DSU)	6,400,000	7,200,000	45,775,000	2,133,333	2,400,000	22,887,500
A094	**OTHER STORE AND STOCK**	**5,019,908,837**	**4,967,108,837**	**892,231,820**	**1,673,302,946**	**1,655,702,946**	**446,115,910**
A09401	Medical Stores (Contraceptives)	850,000,000	850,000,000	770,000,000	283,333,333	283,333,333	385,000,000
A09404	Purchase of Lab kits & Consumeables		33,600,000	122,231,820		11,200,000	61,115,910
A09470	OTHER STORE AND STOCK (Cost Per PLW +SAM Children Cost+ SC Cost F-75 & F100)	4,169,908,837	4,083,508,837	-	1,389,969,612	1,361,169,612	-
A095	**PURCHASE OF TRANSPORT**			**16,000,000**			**8,000,000**
A09501	Purchase of Transport			16,000,000			8,000,000
A096	**PLANT AND MACHINERY**	**452,550,000**	**685,850,000**	**309,530,448**	**150,850,000**	**228,616,667**	**154,765,224**
A09601	MACHINERY AND EQUIPMENT (THQ/DHQ+RHC+BHU Cost+USG Portable+UPS With Batteries & Nutrition Anthropometry Equipment)	452,550,000	685,850,000	309,530,448	150,850,000	228,616,667	154,765,224
A097	**FURNITURE AND FIXTURE**	**6,575,000**	**8,450,000**	**210,350,000**	**2,191,667**	**2,816,667**	**105,175,000**
A09701	Furniture and Fixture (BHU Furniture+ DSU/RSU Furniture)	6,575,000	8,450,000	210,350,000	2,191,667	2,816,667	105,175,000
A13	**REPAIRS AND MAINTENANCE**	**2,844,000**	**2,844,000**	**36,460,000**	**948,000**	**948,000**	**18,230,000**
A130	**TRANSPORT**	**2,544,000**	**2,544,000**	**27,960,000**	**848,000**	**848,000**	**13,980,000**
A13001	Transport	2,544,000	2,544,000	27,960,000	848,000	848,000	13,980,000
A131	**MACHINERY AND EQUIPMENT**	**-**	**-**	**-**	**-**	**-**	**-**
A13101	Machinery and Equipment	-	-	-	-	-	-
A132	**FURNITURE AND FIXTURE**	**-**	**-**	**-**	**-**	**-**	**-**
A13201	Furniture and Fixture	-	**-**	-	**-**	**-**	-

A133	**BUILDING AND STRUCTURE**	**-**	**-**	**8,500,000**	**-**	**-**	**4,250,000**
A13301	Office Buildings	-	-	8,500,000	-	-	4,250,000
A13303	Other Buildings						-
A137	**COMPUTER EQUIPMENT**	**300,000**	**300,000**	**-**	**100,000**	**100,000**	**-**
A13701	Hardware	-	-	-	-	-	-
A13702	Software	300,000	300,000	-	100,000	100,000	-
A13703	IT Equipment			-			-
TOTAL		**9,814,171,078**	**9,392,027,172**	**9,282,914,907**	**3,271,390,359**	**3,130,675,724**	**4,641,457,453**

ANNEXURE I

Framework for Monthly Monitoring Report of District Coordinator

Name of District Coordinator:_____ **District:**_____

Reporting Month:_____ **Date:**_____

	Monitoring Activity	Target	Information required
A	**Monitoring of CMWs training**	04 visits to nursing school (Once in a week)	1. Attendance 1.1. Tutors 1.2. Students 2. Quality of training as per Schedule and revised curriculum 3. Availability of training material 4. Availability of vehicle and POL
B	**Monitoring Deployed CMWs including interaction with CMW clients**	1/3rd of total CMW's (To complete the round in a quarter)	1. CMW code: _____ 2. CMW Name: _____ 3. UC: _____ 4. CMW deployment date:_____ 5. Birthing station established 6. Equipment Available 6.1. Functional or non functional 6.1.1. Weighing Machine 6.1.2. Stethoscope 6.1.3. BP Apparatus 6.1.4. Safe Delivery Kit 6.1.5. Sterilizer 6.1.6. Delivery Instruments 6.1.7. FP Supply 7. Follow up
C	**Health Facilities monitoring visits** (To monitor Comprehensive & Basic EmONC services and hands on training of	DHQ (one visit per month)	1. Name of DHQ 2. MNCH related staff position, filled or vacant 2.1. Gynecologist 2.2. BTO 2.3. Anesthetist

Monitoring Activity	Target	Information required
attached CMWs to these facilities)		3. No. of deliveries (Normal, Assisted V.D. & C-section) in last month 4. Availability of MNCH related medicine 4.1. IV canulas 4.2. IV Fluids 4.3. Parenteral antibiotics 4.4. Inj. Oxytocin 5. Infection prevention practices (cleanliness, handwashing etc) 6. Status of CMW training attached 7. ENC
	THQ (one visit per month).	1. Name of THQ 2. MNCH related staff position, filled or vacant 2.1. Gynecologist 2.2. BTO 2.3. Anesthetist 3. No. of deliveries (Normal, Assisted V.D. & C-section) in last month 4. Availability of MNCH related medicine 4.1. IV canulas 4.2. IV Fluids 4.3. Parenteral antibiotics 4.4. Inj. Oxytocin 5. Infection prevention practices (cleanliness, handwashing etc) 6. Status of CMW training attached 7. ENC
	RHCs (2 in a month)	1. Name of RHC 2. MNCH related staff position, filled or vacant 2.1. Gynecologist 2.2. BTO 2.3. Anesthetist 3. No. of deliveries (Normal, Assisted V.D. & C-section) in last month 4. Availability of MNCH related medicine 4.1. IV canulas 4.2. IV Fluids 4.3. Parenteral antibiotics

Monitoring Activity		Target	Information required
			4.4. Inj. Oxytocin 5. Infection prevention practices (cleanliness, handwashing etc) 6. Status of CMW training attached 7. ENC
		BHUs (4 in a month)	1. Name of BHU 2. MNCH related staff position, filled or vacant 3. No. of deliveries (normal & assisted VD) in last month 4. Availability of MNCH related medicines 4.1. IV cannulas 4.2. IV fluids 5. Infection prevention practices (cleanliness, handwashing etc)
D	**Capacity Building Session (CMW Tutor / CMWs / HCPS).**		1. No. of CMWs who attended 2. No. of CMW tutors who attended 3. Topic of session 4. Duration of training
E	**Liaison and Coordination activities with sectors other than health**	Social welfare department, Education department and NGOs. (3 in a Month)	1. Name of department/NGO 2. Description of coordination activity 3. Outcome of activity