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USAID's MCH Program Component 5: Health Systems Strengthening

Assessment of the Provincial Health Development Center Sindh

April 2014

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Table of Contents

Annexures

Acronyms

ADP	Annual Development Program
AKU	Aga Khan University
ANC	Antenatal Care
A-NEAP	Augmented National Emergency Action Plan
BCC	Behavior Change Communication
BHU	Basic Health Unit
BoD	Board of Directors
B.Sc	Bachelor of Science
BTUS	British thermal unit
CME	Continuing Medical Education
CPD	Continued Professional Development
CPR	Contraceptive Prevalence Rate
DEWS	Disease Early Warning System
DFID	Department for International Development
DG	Director General
DGHS	Director General Health Services
DHDC	District Health Development Center
DHIS	District Health Information System
DHMT	District Health Management Teams
DHO	District Health Officer
DHQ	District Headquarters Hospital
DoH	Department of Health
EDO(H)	Executive District Officer Health
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
FHP	Family Health Project
FP	Family Planning
GOS	Government of Sindh
HE	Health Education
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Development
HRDU	Health Resource Development Unit
HS	Health Secretariat
HSA	Health Services Academy
HSRU	Health Sector Reform Unit
HSS	Health Sector Strategy
IBA	Institute of Business Administration
ICPD	International Conference on Population and Development
ICR	Information Communication Resource and Advocacy Program
ICT	Information and Communication Technology
IHDC	Independent Health Development Center
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IPH	Institute of Public Health
JSI	John Snow Inc
KP	Khyber Pakhtunkhwa
LGO	Local Government Ordinance
LHV	Lady Health Worker

LHW	Lady Health Worker
LUMHS	Liaquat University of Medical and Health Sciences
LUMS	Lahore University of Management Sciences
M&E	Monitoring and Evaluation
M.Phil	Master of Philosophy
MBBS	Bachelor of Medicine & Bachelor of Surgery
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDU	Management Development Unit
MHSDP	Minimum Health Services Delivery Package
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health
NGO	Non-government organization
NIPA	National Institute of Public Administration
NMR	Neonatal Mortality Rate
NWFP	North West Frontier Province (present Khyber Pakhtunkhwa)
ODA	Overseas Development Administration
PAD	Project Appraisal Document
PC-1s	Planning Documents
PD	Program Director
PDHS	Pakistan Demographic Health Survey
PHC	Primary Health Care
PHD	Provincial Health Department
PHDC	Provincial Health Development Center
PKR	Pak Rupees
PRSP	Poverty Reduction Strategy Paper
PSLM	Pakistan Social and Living Standards Measurement
PTCL	Pakistan Telecommunication Company Ltd
RAF	Research and Advocacy Fund
RHC	Rural Health Center
SAP	Social Action Plan
SCF	Save the Children Fund
SOP	Standard Operating Procedure
SoSec	Social Sector
SWOT	Strength, Weakness, Opportunities and Threat
TA	Technical Assistance
THQ	Taluka/Tehsil Headquarters Hospital
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

In Sindh province, as in other parts of the country, the quality of health services is generally poor, resulting in a waste of both government and household resources and producing a minimal impact on health outcomes. Women and children are particularly disadvantaged by socioeconomic and cultural barriers; it is estimated that only 30% of women and children have access to medical care.[1] The total fertility rate is high (3.9 children per woman) and the CPR (29.8 percent)[2] is not rising quickly enough to achieve the MDGs. The situation is further compounded by high maternal and infant mortality rates (74/1000 live births)[3] and insufficient services. Public and private services focus on curative care, with little attention to promotive, preventive care and rehabilitative care. Health facilities are under-utilized due to shortages of staff and supplies. Chronic staff shortages, a lack of skilled staff and the non-availability of essential medicines are common. Due to poor quality of care in the public sector, 76% of the population seeks health services from the private sector[4]. The province has shown poor progress in overall health outcomes. Health sector performance needs to improve, starting with guaranteeing that health sector workers at all levels are sufficiently trained and managed.

In order to achieve better health outcomes, every health system requires highly skilled staff for all levels of health care, from planning to delivery. Examples from around the world show that no health system can perform optimally without well-trained health providers. The health workforce is of crucial importance for a strong health system, serving as its backbone to manage resources and ensure the smooth running of the health services system. The health sector is labor intensive, and human resources are the most important input for its effective operation. As such, it represents the largest share of the health budget (>60%)[5].

The Department of Health (DoH), Government of Sindh (GoS), is responsible for ensuring that the healthcare delivery system is equitably accessible, effective and efficient. However, the DoH is facing ongoing challenges in the provision of health services. This is largely due to limited access, poor quality of services, and non-availability of trained staff for critical positions. In order to address the acute need for in-service training for various cadres of health providers, the Sindh DoH wants the Provincial Health Development Center (PHDC) to take the lead role in managing Continued Professional Development (CPD). The PHDC is attached to a network of District Health Development Centers (DHDCs), which mirror the functions of PHDC at the district level. Taking devolution as an opportunity, the DoH is planning to focus on strengthening the health system and has identified human resource strategy as one of the key areas to improve the healthcare delivery system.

1.1 Purpose and Objectives of the Study

The purpose of this study was to conduct a detailed assessment of PHDC Sindh, review current capacities of PHDC, and propose recommendations for strengthening and/or upgrading the institution. The specific objectives of this assessment were:

I. Assess the capacities of PHDC Sindh related to:

   a. Designing and implementing an effective in-service training program based on the training needs of health personnel, directed toward the overall service

[1] http://www.ayubmed.edu.pk/JAMC/PAST/20-4/
[2] PDHS 2012-13
[3] http://www.ciet.org/en/documents/projects_library_docs/2006224175348.pdf
[4] Finance Department website
[5] PSLM 2010-11

requirement and enhancement of efficiencies of health department in particular context of post devolution requirements

b. Providing assistance to the Department of Health for preparation of policy guidelines and in planning, implementation and evaluation of all health care programs
c. Assisting individuals and organizations in conducting health systems research
d. Assessing the capacities of existing faculty and other staff available at PHDC for human resource development and research, including training needs assessment; designing and development of training packages and modules; conducting and coordinating training courses; operational research; and data analysis and management.

II. Assess the availability of budgetary resources allocated for all essential human resource development activities and their utilization patterns during the last three to five years.

III. Assess the PHDC's abilities for guiding and training policy-makers, senior and mid-level managers, health care providers, and trainers for effective planning and management.

IV. Analyze the performance of the PHDC over the last three years against the objectives outlined in the project's PC-1 and the achievements to date.

V. Analyze the PHDC's existing linkages with national and provincial training institutes, donors, and development partners in implementing its activities.

VI. Determine current operational research and human resource development activities of the PHDC conducted to date both for government and non-government sector and private institutions (i.e., for NGOs, etc).

VII. Identify the PHDC's strengths and weaknesses.

VIII. Outline specific recommendations to strengthen the PHDC.

1.2 Research Methodology

To assess the current status of the PHDC, the team adopted a multi-pronged, qualitative approach which comprised a document review, observation, facility assessment using a check list, in-depth interviews, individual face-to-face meetings, and focus group discussions.

The assessment was designed to include a broad spectrum of key stakeholders from the Sindh Department of Health including: the Director General of Health Services; Health Sector Reforms Unit; faculty/staff members of PHDC; Managers of EPI; and MNCH Programmes. While the partner organizations representatives interviewed were from UNICEF, WHO and UNFPA. In addition, two focus group discussions (FGD) were held, one with the current PHDC staff and one with former and current staffs of DHDCs. Specific interview guides were prepared for the in-depth interviews and FGDs.

- Preliminary planning for this assignment was conducted in collaboration with the JSI offices (Islamabad and Karachi); SoSec office, Islamabad; and the Department of Health, Government of Sindh. Participants reached a consensus on intended assessment protocol, tools, and outcomes, and they deliberated on approaches that could be taken to generate the information needed to propose various options needed for reviving PHDC.

- The team reviewed all documents in order to thoroughly understand the human resource (HR) capacity development needs in the provincial context and the relevance to the needs identified and targets defined under the Provincial Health Sector and HR Strategies, DoH, Sindh.

- A qualitative methodology was adopted to understand the issues/bottlenecks responsible for the current status of the PHDC and also to explore various options. A set of interview guides were prepared for in-person interviews/meetings with various stakeholders including those from the health department, development partners, UN agencies, and the PHDC staff.

- The team visited the PHDC and held interviews with key staff; administered the HR assessment template (using a modified rating scale for self-assessment by each staff member); assessed institutional infrastructure, training capacities, in-house training facilities, available curriculum, training aides and support materials availability, budgetary allocations versus expenditures, training records, and the capacity for residential training, including hostel accommodation.

- In addition to individual interviews, the team conducted focus group discussions (FGDs) with the PHDC staff to understand the issues involved in organizing various trainings and to explore options for PHDC revival and strengthening. The FGDs explored the degree of relationships with district health development centers (DHDCs). FGDs were then held with DHDCs to understand the current level of working. In addition, the working relationship between the provincial and district centers too were reviewed to understand the operational status in comparison to when both level of institutions i.e. PHDC and DHDCs were fully functional. The situation was also assessed to review type of future linkages between both levels of institutions, if the PHDC is made fully functional and is carrying out continuous professional development activities.

1.1.1 Team Composition

The team comprised two public health specialists, each having over twenty years of experience of working in the health sector in Pakistan. The consultants worked together to collect the relevant information, conduct interviews, facilitate focus group discussions, and to collate and analyze information.

1.1.2 Data Analysis

All information was reviewed and edited. The information from the interviews was reviewed to look for commonalities and differences. The focus group information was analyzed using Microsoft Excel and the information derived was reviewed and analyzed together with that of the individual interviews. For the final analysis (i.e. data from interviews, focus group discussions, document reviews, and staff assessment), all available information was contextually reviewed and categorized under identified titles for the purpose of gap identification and possible linkages was used for final report writing.

2. Background

During the early 1990s, Pakistan's demographic and health characteristics were similar to those of many developing countries: high fertility, low life expectancy, widespread infectious and communicable diseases, and high maternal and child mortality, coupled with a young age structure and increasing urbanization. Health and demographic indicators remained very

poor. The socio-cultural barriers to improving health status, particularly for women and children, were high.

The country was growing at an annual rate of 3.1 percent, with 45% of the population under age 15, fertility among the highest in Asia, and low contraceptive. Together, these factors presented very serious problems and constraints to further the economic and social development of the country. To promote development, the Pakistani government, with assistance from the World Bank, developed a project aimed at increasing investments in the social sectors. The project was titled the Family Health Project, and its first phase was implemented in Sindh and NWFP (present Khyber Pakhtunkhwa).

The project had three main objectives:

a. to improve the health status of the population within the provinces of Sindh and North West Frontier (NWFP);

b. to increase the effectiveness of the existing health care network; and

c. to build the institutional capacity to realize the above objectives and to set the stage for future interventions.

Project Description: The project had three main components: (a) strengthening health services in Sindh and NWFP in two priority fields through: (i) introducing an enhanced package of maternal health services, including family planning, and (ii) integrating and expanding communicable disease control activities, mainly in rural areas, but with some experiments in urban areas.

Together, these objectives aimed to improve access to, quality, and utilization of health services; (b) staff development aimed at improving staff capabilities and performance, and increasing the number of female paramedical staff through: (i) a comprehensive, in-service training program, and (ii) expanded female paramedical training capacity and improved staff retention through job enhancement and incentives.

The above two objective were further envisaged to be strengthened by (c) management and organizational development aimed at improving management capabilities through (i) increased institutional capacity, and (ii) improved management quality and efficiency.

In 1993, under the Family Health Project, the Provincial Health Development Center (PHDC) Sindh was established. It operated under the direct supervision of the Director General Health Services, Sindh. It was envisioned as a center of excellence for teaching, training, and research. It was hoped that, from there, various technical activities, such as operational research, human resource development, institutional development, health systems management, and community involvement, were to be carried out and spread to the lowest level of health care through 19 DHDCs. The mission of the PHDC was to improve the health status of the people through evidence-based policy-making, rational planning, human resource capacity building, management development, operational research, quality assurance in health care delivery system, and community development.

3. Situational Analysis

The greater emphasis on health during the early 1970s and 80s led to an expansion of health infrastructure and services and an emphasis on preventive health services rather than curative care. This changed the roles of health delivery managers and care providers while

adding to their workloads. The development of in-service training programs was necessary to equip and prepare the providers to fulfill their changing roles. The issue was formally addressed under the Social Action Plan (SAP) during the early 1990s under the Family Health Project-I (implemented in Sindh and KP) through the establishment of provincial and district health development centers.

These centers performed optimally during the project implementation period; however, once the project closed and these were handed over to the provincial government, the decline started. Increasingly limited resources led to fewer training activities. The vertical programs did not coordinate and establish linkages for training activities with PHDC for implementation of capacity building components under their programs. This situation discouraged the trained staff at the PHDC and DHDCs, many of which left to take on other positions in the health department or to join the private sector or international organizations.

The institution suffered further with the passing of the Local Government Ordinance (LGO) of 2001, which devolved and shifted working of all DHDCs to the district health offices under the administration of Executive District Officer Health (EDO(H) including the financial allocations for conduct of all activities and staffs, while, the PHDC was under the administrative and financial control of the provincial health department. Further, with one line budget allocation for health under the district government, the allocations for DHDC activities declined over the years other than salaries of the staff. After sometime, the staffs from DHDCs were also either posted out or assigned other duties in the EDO(H) offices. This situation led to progressive diminishing of linkages between DHDCs and PHDC. With a lack of ownership by the health department, many DHDCs were either taken over by the local government or the district health offices. Most staff of the DHDCs was either made to work in the EDO(H) or was transferred to other health facilities. As a result, most DHDCs are no longer performing as they were meant to. The situation at the PHDC, Jamshoro, was not much different, except that it continued to receive a small budget and conducted some training each year. Many staff moved or was transferred to other positions within the health department.

At the same time, the National Health Policy 2001, despite having capacity development of health staff as a focal area, failed to be fully implemented. In July, 2011, the 18th amendment to the Pakistani constitution was added. This established that provinces, rather than the federal government, are responsible for their own health care programs. A Ministry of Health and Regulation has been created, but it's solely responsible for coordination.

The 18th amendment provides more opportunities to the provinces to develop and initiate health reforms. The Sindh health department, with technical support of development partners has laid down its reform agenda and initiated a number of steps including establishment of Health Sector Reform Unit (HSRU). A number of reforms has been introduced or are in the process of development. Among these include the ones related to improved service delivery i.e. development and introduction of MHSDP, development of standards for health services at primary and secondary level, options for integration of vertical programs. All these reforms and developments necessitate the need to prepare health providers through capacity development for taking on the new challenges. In the backdrop of reform agenda the important role the PHDC can play is clearly highlighted. The health department strengthening both for leadership and service delivery is incomplete without staff's skill enhancement. The PHDC can be a pivotal institution to build staff capacities through in-service training to manage and deliver health services.

Historically, the PHDC Sindh has had a limited budget for HRD activities; even when available, its untimely releases, lack of dedicated staff at DHDCs are some of the key

challenges faced by the PHDC and its satellite arms, i.e. DHDCs for implementation of training plans. As a result of factors mentioned above, preparing short and long term training plans for HRD systems was not deemed possible. These were the reasons that the consultants were not able to find any annual training plans for HRD activities.

3.1 Desk Review

The team of consultants reviewed a number of documents (listed below) to understand the context needed to strengthen the PHDC. Original project documents from the PHDC and DHDCs were also reviewed. These documents provided insight into the overall aim and objectives of the capacity development component of the PHDC and DHDCs and the level of achievement to date.

- Situation Analysis for Post Devolution Health Sector Strategy for Sindh Province
- Sindh Health Sector Strategy 2012-2020
- Road Map for Health Systems Strengthening in Sindh Province
- Human Resource Strategy for Sindh
- Annual Development Programme (ADP) of last three to five years
- Planning Documents (PC-1s) of PHDC and DHDCs
- Annual progress review reports of PHDC and DHDCs
- Family Health Project – Project Appraisal Document (PAD)
- Family Health Project ICR by the World Bank.

The Maternal Mortality Ratio is believed to be the most sensitive indicator of women's status in a society and of the quality and accessibility of maternal health services available to women. Although the lack of provision of adequate basic health services, trained staff, adequate medical supplies and equipment have a direct impact on maternal mortality, underlying factors such as socio-cultural structures and dynamics which operate at the state, community and household levels to discriminate against women and girls, prevent them from accessing and utilizing quality health services. The situation analysis document clearly highlights the role of health sector staff in poor health outcomes especially high maternal and neonatal mortality in the province.

Similarly, the expanded immunization program identifies acute skilled staff shortages as a key reason for poor coverage and high dropout rates. The Situation Analysis for Post Devolution Health Sector Strategy (HSS) identifies the need for a staff development strategy to ensure the development of a staffing plan for district health systems and to fill staff capacity gaps through in-service training programs. In addition to improving the quality of health service delivery, this will also improve governance at the district level trough better planning, priority setting, financial efficiency and improved health outcomes. In view of staff shortages, lack of appropriate skills, task shifting and training for skill enhancement is needed to make clinical services functional and more efficient. Such measures may include the production and deployment of trained family physicians to specialist vacancies in THQs and DHQs; task shifting from doctors to paramedics at more remote BHUs through the aggressive training of paramedics to provide services in remote, front-line facilities; handling of emergency care in ambulances and hospitals; and the provision of specialized in-patient care in hospitals.

To address the gap identified in the Situation Analysis document, the Health Sector Strategy Sindh was developed using a consultative and participatory approach. Outcome 3 of the HSS focuses on streamlining human resource production, retention and capacity to support priority heath needs in the province. The strategies are designed to address the acute

shortage of female doctors, nurses and female paramedic staff across rural areas in Sindh. Even when available, nurses and female paramedics are especially poorly trained and, therefore, usually perform below potential. This gap is addressed through targeted skill enhancement activities for the female staff, especially those from the rural areas.

There are 10,908 staff in the general cadre which forms the single largest concentration of staff in the public sector and is involved in performing both administrative and clinical services. This concept needs rationalization and separation of administrative staff from general practitioners with clearly laid out roles and responsibilities with mechanisms in place for recruitments and promotions. Further, staff appointed on administrative posts is not exposed to pre-service and in-service training, and career progression to senior leadership posts is made on the basis of departmental promotions, committee recommendations and not linked to any process of public health certification. There is also a need for widening management skills to incorporate the new demands of planning, evidence based monitoring, and financing. This is envisaged by providing in-service training to the general cadre staff and "developing a trained administrative cadre to improve efficiency of health administration at district and provincial level"[6].

Further, no training needs assessment has ever been done by the Department of Health to define what should be done to achieve the desired health outcomes and meet the MDG targets. The DoH has yet to establish human resource requirements for the province and steer human resource production and deployment to fill existing gaps. There is lack of a centralized database within the DoH for public sector staff and a similar lack of information about the private sector. There are pressing training needs for different cadres. The gap is addressed in the strategy through strengthening human resource management by establishment of a permanent unit within the Health Secretariat (HS). This unit should determine the health provider need at various levels of health services; identify the requisite needs for type of staff and skills required, and liaison with both the public and private sector medical training institutions for production of the requisite cadre needed by the health department.

The HSS for Sindh also stresses the importance of developing a Human Resource (HR) strategy for the province. The Department of Health, realizing the importance of the issue and with assistance of USAID, has developed a strategy that focuses on the career development of available staff and recommends staff development through in-service trainings for health sector staff at different levels of service delivery including management and administrative categories. The strategy document recommends conduct of trainings through various institutions in the public and private sectors. However, PHDC and DHDCs are institutions of choice for in-service trainings component. Further, the document clearly recommends strengthening of PHDC and DHDCs before implementation of in-service training component of the HR strategy. The strategy document stresses out time and again the need and importance of in-service training programmes and the role of PHDC and DHDCs for improving health outcomes in the province of Sindh.

The HR Strategy, under the objective of staff development, gives specific activities which include: strengthening the capacity of training institutions (PHDC and DHDCs) so that they can carry out CPD activities; and enhancing the capacity of health managers in leadership skills by introduction of induction training for new staff. While it also recommends leadership and management development program for existing staff. Additionally, if fully implemented, then completion of the leadership and management program will be mandatory for job promotions. As per the strategy, the PHDC will also establish linkages with institutions like

[6] Taken from HSS

LUMS, IBA, AKU, NIPA, etc. The strategy envisages that these institutions will play a significant role in the enhancement of leadership skills, particularly among potential health staff selected for the trainings.

The PHDC will be responsible for implementing the HR strategy. This highlights the importance of strengthening the PHDC to effectively implement all the components of the strategy. Under the technical guidance from HSRU, the PHDC will be required to periodically review, update, and implement HR policies and guidelines. The HSRU will work as a secretariat to ensure effective and efficient HR strategy implementation through the provision of technical assistance to the PHDC. The HR strategy document clearly highlights the roles and responsibilities of both HSRU and the PHDC, which are vital for the process of its implementation.

The Department of Health has drafted two PC-1s; the first will strengthen Sindh PHDC at a cost of PKR 100 million, the other proposes to strengthen and upgrade the PHDC into Health Services Academy (HAS) at a cost of PKR 174 million. The objectives of both projects are similar, but the latter offers post graduate education and training to doctors in health planning. The PC-1s build on existing structures and focus on improving available resources through investments in infrastructure, staff skills, and upgrading of teaching methodologies. While the PC-1 focusing on PHDC conversion into a HSA lacks understanding and insight into what changes are required for the transitions. Further, there is complete lack of clarity on what are the key differences between an in-service training institution and an academic institution; what type of infrastructure, additional staffs and graduate and post graduate training programmes are required. Most importantly the whole document is completely silent about the process and how all these changes will actually take place.

The importance of a detailed feasibility study cannot be stressed enough if converting PHDC into Health Services Academy is desired. The document has many gaps, from lack of clarity in objectives to neglected details of infrastructure requirements. It is important to understand the need of such an institute within the context of the health department's pressing need for in-service training programme to address the gaps in current health services delivery at various levels for ensuring improved quality of health care for better outcomes versus production of doctors with post graduate public health degrees. The situation has to be justified in view of available multitude of academic institutions in the province and the country.

3.2 Organization of the PHDC

Sindh's PHDC has the following four units:[7]

1. Management Unit: This unit is responsible for supporting policy guidelines, strategic planning, and management development of the health sector by undertaking research studies. The unit also assists in designing and implementing management training courses.

2. In-service Unit: This unit's functions include assessing both clinical and management training needs, designing and developing training packages and modules, training of trainers, and conducting and coordinating all provincial level training courses.

[7] PHDC PC-1 and initial concept note from FHP-1

3. Health and Nutrition Education Unit: This unit is responsible for: a) developing and conducting trainings on communication techniques, nutrition, and health education; b) designing needs-based health education material; c) designing and conducting human behavior studies and operational research related to nutrition; and d) designing mass media campaigns and developing linkages with other sectors and NGOs to carry out collaborative health education activities.

4. Health System Research Unit: This unit is responsible for health system research training, designing research proposals, and conducting research studies focusing mainly on operational research. This unit is also responsible for providing technical assistance to all other units of the PHDC and other programs/projects in developing research protocols, evaluation tools/mechanisms, and computer software programming dealing with data management and developing linkages with other research-related organizations.[8]

Each unit is headed by a Program Director (PD) and assisted by officers and support staff. The Senior Program Director also acts as a PD in-charge of the PHDC and PD of the Management Unit.

3.2.1 Historical Perspective

Conceptual Background: The late 1980s and early 1990's was a time of change for the health sector in Pakistan. Due to the effects in the social sector of Pakistan's minimal economic progress, there was a need for government investment to keep social systems functioning. This became the basis of the Social Action Program, which targeted increased investment in health, education and sanitation, among other things. In addition, to address the need of improving and strengthening health systems and human resource capacity for improved performance, each province developed health systems strengthening projects financed by the government and the World Bank, with technical and financial assistance from ODA (now DFID) and Save the Children Fund (SCF).

Objective and Development: The project aimed to support implementing primary health and capacity building systems and services to address the challenges faced by the health sector. The project's objective, besides increasing the effectiveness of the existing health care network, was to build the institutional capacity to set the stage for future interventions. In Sindh, the Family Health Project became the basis of proposed developments and had three components: (a) strengthening health services (MCH/FP, communicable disease, and experiments in urban areas); b) staff development with a comprehensive in-service training program and expanded female paramedical training capacity; and (c) management and organizational development. The project to be implemented by the provincial Department of Health was comprehensive, but it was implemented at a time of significant political change and macroeconomic challenges. It was ambitious given the provincial capacity of the Department of Health. A critical area of emphasis was the development of in-service training systems for staff skills and capacity development linked with career growth.

The project supported the institutionalization of in-service training and management development through a network of provincial and district health development centers (a total of 17 institutions). The PHDC was established at the provincial level, reporting to the DGHS office, and had four key functions: in-service training and human resource development; management and organizational development, operational research, and institutional development. A cadre of staff from the Department of Health with interest in public health

[8] Taken from PHDC document

and development were placed in the PHDC and trained in health systems and human resources development with technical support from Aga Khan University. The process of development included: a) identification of interested young professionals; b) classroom and field-based training in facilitation and communication; c) learning and building skills by doing; and d) field exposure and research.

Support was also provided for capacity building of PHDC staff in curriculum designing and development, conducting trainings as per accepted international standards. The PHDC, over time developed and implemented a number of training packages for health staff on communication skills, child survival, nutrition etc. The PHDC, in addition to the in-service training programme, also collaborated with the DGHS office in management strengthening and organizational development at the directorate and district levels. This component of the Family Health Project (FHP) also provided technical support for roll-out of HMIS, development and implementation of the concept of District Health Management Teams (DHMTs), piloting of urban primary health care projects in selected districts. Training was conducted in key areas, including family planning, health education (HE), nutrition etc. In addition, systematic management training was introduced for DHOs and collaboration was established with pre-service training public sector institutions for alignment of training curriculum.

A number of steps were taken to fully institutionalize the various components of the PHDC under the FHP on the regular budget of the health department i.e. staff salaries, in-service training programme, research component and operational costs. However, the process could not be fully streamlined owing to lack of ownership by the health department. The situation was further aggravated by parallel standalone initiatives for conduct of training activities by the vertical health programmes. This contributed to further fragmentation of institutional training concept through PHDC/DHDCs, wherein all trainings being conducted, continued to be run vertically by programs that never had the skills to effectively manage or sustain such staff training systems. After the project was over, budget allocation and releases for activities other than staff salaries for the PHDC and DHDCs was far less than the actual requirements needed for performing optimal functions. A situation that resulted in gradual deterioration of PHDC and DHDCs, which led to cessation of in-service training activities completely at the DHDCs level, while at the PHDC level, the magnitude of these training activities was reduced by more than 80 percent. And generally the system failed to develop. The skilled staff was allowed to either move away for career development or most if not all skilled staff left the program to obtain jobs in other healthcare fields or with or international partners.

3.2.2 Current Status

The current status of the PHDC, as of January 2014, is explained below. Lack of ownership by the health department over the years has adversely affected the PHDC, from infrastructure to human resources and overall operation.

a. **Infrastructure, furniture and fixture (PHDC and hostel facilities):** The PHDC comprises two, two story-buildings: one with an office and training hall and the other with hostel facilities. In spite of the fact that PHDC is across the street to District Health Office, Jamshoro, the buildings and the boundary wall give a very weather-beaten look. The office building that contains the offices and training hall are operational but need minor refurbishment. The hostel building requires major refurbishment. The doors of the ground floor need replacement, as they have been badly affected by termites. The boundary wall also needs to be painted.

The furniture and fixtures (as per the list in Annex I) comprises an extensive list of 42 items but the functionality of the electronics needs to be assessed. Some of the items on the list are missing. For example, the air conditioner is gone, which the staffs were unable to explain. The wood furniture can be restored with minimal refurbishment. Many furniture items and fixtures in the hostel building need to be repaired or replaced.

b. **Human resources and capacities:** The PHDC Sindh was established in 1993 under the World Bank assisted Family Health Project Sindh and operates under the Director General Health Services, Sindh. It was envisioned as a center of excellence for teaching, training, and research, from which operational research, human resource development, institutional development, health systems management, and community involvement were to be carried out and spread to lowest level of health care through DHDCs. The mission of the PHDC is to improve the health status of the people through evidence-based policy-making, rational planning, human resource capacity building, management development, operational research, quality assurance in the health care delivery system, and community development.

As per PC1, Sindh's PHDC was to have four units: each unit is headed by a program director (PD) and assisted by officers and support staff. The senior program director also acts as a PD in charge of the PHDC and PD of the Management Unit.

Currently, PHDC has a project director, one additional (deputy) project director, one program director for Health and Nutrition Education Unit and one program director for the Research Unit. Management Development and Human Resource Development Units are managed by the Project Director PHDC. Health and Nutrition Education and Research Units have qualified technical staff working for them.

The following table details of the responsibilities of each unit and its current status.

Name and Responsibilities of Units as per PC-1	**Current Status**
Management Development Unit (MDU): This unit is responsible for supporting the provincial planning cell and relates its functions to management systems, management information systems, logistics, communication, budget/finance, assisting in the design of and implementation of provincial level management training, training trainers of district health development centers, developing management training material and providing management consulting services to the divisions and districts. Furthermore, this unit will work closely with other units and provide necessary guidance.	This unit is not performing the designated tasks.
Human Resource Development Unit: This unit is responsible for in-service training development on both technical and non-technical aspects: assess training needs; design and develop course modules, curriculum outlines, participant materials; train master trainers at the district level; conduct provincial-level courses; coordinate overseas study tours and fellowships; and design training evaluation procedures for district-level training. The unit will maintain a database of human resources belonging to different public health areas in health sector in the Sindh	Non-functional: Neither needs assessments nor has training been conducted. Additionally, the DHDC staffs have been assigned other responsibilities within the district

Name and Responsibilities of Units as per PC-1	Current Status
Province. The HRDU, in collaboration with MDU, will develop revised job descriptions and service rules for different cadres of the Health Department, in cooperation with the Directorate General of Health Services, Punjab, and the administrative wing of the Health Department.	health offices.
Health and Nutrition Education Unit: This unit is responsible for: a) developing and conducting trainings on communication techniques, nutrition and health education; b) designing needs-based health education material; c) designing and conducting human behavior studies and operational research related to nutrition; and d) designing mass media campaigns and developing linkages with other sectors and NGOs to carry out collaborative health education activities.	Minimally functional as trainings are conducted for dengue, swine flu and other specific topics on the limited budget available. However, the other envisaged roles are not fulfilled.
Research Monitoring and Evaluation Unit: The unit promotes field-based, action-oriented research and evaluation and is responsible for coordinating district-based research projects. This group will also integrate and coordinate various monitoring systems, which are currently used or under development. This unit will also develop a capacity to monitor what is going on in the community in terms of health problems, needs, community organization and the management of health service/activities, government health facility/services problems, and community health information needs and services. This unit will capitalize on the research and monitoring capacity and experience of other units of the DoH involved in operational research, like IPH in Punjab, and develops linkages for integrated research and monitoring in the public health sector.	Non-functional: Researches are undertaken for donor funded specific projects e.g., RAF and the research staff is hired from the market for conducting the researches. However, PHDC staff is not involved due to their inefficiency.

a. **Training equipment and modules:** Currently, basic training equipment, like overhead and multimedia projectors, are available and operational. Thus, training activities can be conducted. The training modules were developed at the inception of the PHDC; they are now outdated and need to be revised to reflect the current needs of the province. The library also needs to be re-established, as it has deteriorated considerable: the materials in the metal cabinets cannot be locked and are not managed properly.

   Furthermore, the PHDC is used for training activities by NGOs and other agencies, but the PHDC staffs were not involved and no charges were given to the PHDC.

b. **Teaching, training and research activities**: Minimal teaching training and research activities are carried out. Two RAF research projects have been undertaken, of which one is still occurring. Neither operational research nor any tailor made trainings have been done recently.

c. Coordination with preventive health programs: PHDC collaborates effectively with the MNCH program, and has undertaken some IMNCI trainings for them, but with

external resource persons. Other than that, no preventive program undertakes capacity building activities in collaboration with the PHDC.

3.2.3 Linkages with District Health Development Centers (DHDCs)

The DHDCs were supposed to be the extension wings of the PHDC into districts. In this context, DHDCs were to serve as in-service training centers for all types of district health staff, particularly mid-level female health personnel. The proposed functions of the DHDCs are outlined below:

- Health and Nutrition Education Center, including planning campaign and local initiatives and activities for health education, producing simple HE material, and training staff in HE/nutrition.
- District health meeting center for holding workshops, conferences, and seminars, including the training of community leaders.
- Library and resource material service for district health personnel.
- Adapt procedures for management development and provide in-service management training.
- MIS coordination, training, and operation.
- Define manpower training needs in health at the district level.
- Carry out integrated monitoring.
- Act as the brain of the district health system and as a district software resource in health.
- Provide operational support to district health authorities and community-based organizations working with PHCs of the health department in the district.
- Promote and facilitate the decentralization process within the district health system.

During the period of the Family Health Project, the PHDC and DHDCs network was fully operational and achieving its objectives; however, after the introduction of the Local Government Ordinance, the administrative structure changed and thus the district government was managed by the *Nazims*. The link between the PHDC and DHDC was broken and to-date has not been re-established, even after devolution. It needs to be highlighted that despite the trained staff of the DHDCs being absorbed into the overall district health force, they are still available at the district level. Any efforts related to establishing the extension wing of the PHDC into the district can be done through refresher training of the staff.

3.2.4 Financial Situation

The PHDC has regular budgetary allocation since inception. In this context, over the past three years they received a total of PKR 17,277,900/- for 2010-11, PKR 19,897,200/- for 2011-12, and PKR 24,918,000/- for 2012-13 respectively. The detailed financial budget is at Annex II.

It is important to note that, except for the current fiscal year, there has been minimal allocation for training, with most of the budget spent on salaries, allowances, and operating expenses. The total amount allocated for FY 2010-11 was PKR 500,000/-, 2011-12 PKR 630,000/-, and PKR 662,000/- for 2012-13 The budget details for the last three years, in Pakistani rupees, under key head of accounts (according to Controller General of Accounts classification of accounts) are given below:

Head of Accounts	2010-11	2011-12	2012-13
Officer pay	4,010,000	5,738,000	7,963,000
Total pay for other staff	1,929,800	2,963,600	2,920,000
Allowances	8,036,600	7,451,100	10,864,000
Operating expenses, including training	2,195,500	2,480,700	2,496,000
Physical assets	256,000	370,000	-
Repair and maintenance	350,000	393,800	425,000
Grants, subsidies, and write-off loans	500,000	500,000	250,000
Total	**17,277,900**	**19,897,200**	**24,918,000**

Due to severe budget constraints, the PHDC has been able to organize only a limited number of trainings, i.e. approximately 10-12 over the past three years. Most of the trainings were conducted for preventive programs, especially the MNCH Programme, and were clinically based. No management training has been organized in the past three years.

In addition, due to the lack of linkages with the district health offices and vertical programs, the PHDC has been unable to develop a training plan. Despite being meager, most of the training budget was still unspent at the end of the year, owing to a lack of planning and interest. Another factor responsible was the frequent change of leadership and self interest of some to downgrade the position of the project director.

In addition, the Department of Health reduced funding to the PHDC over the years, except for salaries and operating costs. The amount allocated for training faced budget cuts.

Audit objections over the years have not been cleared. This creates a negative environment for any possible increase in funding for the PHDC.

Another possible reason for this could be an increasing trend by UN agencies and vertical health programs to conduct trainings in hotels. There was also no desire by the district health authorities to conduct management trainings. This led to underutilization of the PHDC for in-service trainings, despite the availability of trained faculty.

3.3 Stakeholders Perspectives

3.3.1 PHDC Key Staff Perspectives

The current PHDC staff comprises a blend of people, ranging from MBBS to those holding a Master of Public Health degree or an M.Phil. Most employees hold a Master of Public Health degree in addition to being a medical doctor. A majority of the staff have been there for more than 5 years, and some since 1990s, i.e. since the establishment of the PHDC. The staffs are demotivated, as they feel that the Department of Health does not own the institution and in this context have left it as an isolated entity. Although PHDC gets regular budgetary allocation, but unfortunately majority of the funds are for salary of the staff, allowances and fixed communication utility charges. The allocations for research and training are not sufficient for undertaking a significant training program. For 2012-13, they were allocated PKR 630,000/-, but that is not enough to undertake a systematic capacity building program. No substantive papers have been published in years. The bespoke training modules once developed are outdated and need to be refreshed. Two studies for the Research and Advocacy Fund (RAF) were undertaken, but local staffs were not involved.

In order to have an in-depth understanding of the senior PHDC staff, a qualitative Rating Scale Tool was used for individual assessment with eight key staff members (Annex III). This tool captures views of individuals with a multidimensional and multipronged approach for various aspects of the program, in this case the PHDC and gives the participants an opportunity to express their opinion which sometimes are not mentioned in interviews and FGDs. Eight key PHDC staff participated in the Rating Scale Tool Exercise. The collated assessment of the rating scale tool is as follows:

Program Design: A majority of the staffs agree that the outputs of the PHDC identify needs and priorities of the health workforce to some extent; however, they do not agree that the input and strategies are appropriate. They agree that if newer initiatives are adopted, they will positively affect the overall performance of the PHDC.

Program Relevance: The staff agree to some extent that the PHDC priority and objectives are aligned with government priority and policies, and that the outputs and outcomes contribute toward international commitments such as MDGs; however, they do not agree that gaps were addressed during the implementation of various project-related activities in the PHDC.

Program Management: A disagreement exists pertaining to various components of program management at the staff level. They feel that human, technical, and financial inputs have not been used efficiently: the management of various activities has not been efficient, technical assistance offered over a period of time was neither appropriate nor adequate, and the inputs did not improve the performance of the implementing partner funded projects. Furthermore, there is no established appropriate monitoring system and they feel strongly that staffs are not involved in any sort of monitoring system; thus, monitoring and evaluation do not facilitate effective program decision making in any way.

Program Effectiveness: The entire staff in the assessment agree that the planned outputs and outcomes are not achieved and that they do not meet acceptable standards of quality. There is no record of data available on any indicators that provide information and evidence PHDC achievements over the past three years.

Program Efficiency: The staff unanimously agrees that the expected outputs do not justify the costs incurred and that no efforts have been made to address and overcome the overlap and duplication. They disagreed with the fact that any improvement in quality of services/activities/intervention can be undertaken without compromising the cost. The PHDC activities have neither complimented nor synergized with interventions of other public, private, and donor agencies.

Program Impact: The staffs are clear about the PHDC progress over recent years of not having achieved any specific outcomes and, thus, had no impact.

Program Sustainability: A majority of the staff agrees to some extent that DoH programs/projects have an in-built strategy/mechanism for supporting the PHDC, but they strongly disagree that projects/activities are integrated into current activities for counterpart institutions/programs and that resources have been efficiently allocated. Additionally, they also disagree with the fact that over the years the PHDC has built partnerships with other government agencies and partners for effective implementation. Based on this, there has been no substantial return from the investments made in the PHDC.

Cross Cutting Issues: A majority of the staff are of the view that the management and governance mechanisms of the PHDC are not geared toward implementation of the PHDC

activities at the provincial and district levels, but they do agree to some extent that the PHDC builds on partnerships and collaboration with government and non-governmental partners to enhance outputs and outcomes. Additionally, they did agree to some extent that the PHDC lacked on coordination and linkages development with vertical programs such as EPI, LHW and Population welfare program.

Overall, from the above assessment it is evident that the senior PHDC staffs are fully abreast of the current status of the PHDC, and they have their reservations about what the future holds. It is rather surprising that a team of qualified professionals do not come together for development of any strategic plan for the betterment of this institution. Moreover, with the current inclination of the health department to revive this very important institution, the staff prefers to operate in their comfort zone, maintaining the status quo. The PHDC is suffering from ownership issues and is being used as a reason to stay in the education hub of Jamshoro and in close proximity to the Health Department in Hyderabad.

3.3.2 Health Department Perspectives

Senior health department personnel for preventive programs strongly feel that the PHDC should be revitalized according to the objectives for which it was established. Additionally, its role should be further enhanced to meet today's needs. In this context, it is imperative to debate whether preventive programs have a considerable inbuilt component of capacity building and trainings, for example the MNCH Program, and EPI Program. These activities have considerable funds allocation within the PC-I. The program managers are willing to share the costs of these activities with the PHDC, provided the PHDC exhibits the confidence and the capacity to undertake capacity building trainings that ensure quality.

The senior management at the Department of Health are enthusiastic about the revival and effective operationalization of the PHDC as an in-service institution, as well as with a new, defined role. In this context, they are also willing to experiment with viable, innovative models to build the capacity of the health workforce of the province of Sindh.

The MNCH Program has a very important component of community midwives with training schools in almost all districts of Sindh. The program envisages the PHDC, once operational, to be the hub for all of the community midwives training schools, providing refresher courses for master trainers and tutors. Additionally, they hope that the PHDC will undertake third party evaluation and operation research for various components of the MNCH Program. The PHDC can also conduct all MNCH-related trainings, such as IMNCI, EmONC and other donor-funded projects.

The PHDC can also serve as the hub for District Health Information System (DHIS). With the requisite skills in place, a DHIS analysis unit can be hosted within the premises of this institution, responsible for undertaking in-depth analysis of the DHIS monthly reports. A trend analysis based on the reports can be forwarded to the health department on a quarterly or biannual basis for effective planning and intervention. The DEWS unit of the health department can also work in collaboration with the DHIS analysis unit of the PHDC.

The EPI Program/Polio Eradication Initiative undertakes a lot of training and planning activities at the provincial, district, and union council levels. Furthermore, with reference to the Augmented National Emergency Action Plan (A-NEAP), each union council prepares a micro-plan that forms the basis for the overall polio campaign throughout the province. With requisite skills in place, the PHDC can facilitate the communities to effectively prepare the micro-plan and training of the vaccination teams throughout the province through extension activities.

3.3.3 International Implementation Partners Perspectives

The international implementation partners support the decision of reviving and effectively operationalizing the PHDCs. They are of the view that once a very well-known and effective institution, the PHDC has progressively declined over the years. The PHDC is now a little known entity even within the health sector itself. They feel that the decline of the PHDC can attributed to a number of reasons, ranging from lack of support from the health department to the Local Government Ordinance and devolution 2010. Additionally, frequent leadership change and disconnect from the DHDCs has further damaged the institutional capacity of PHDCs. The Local Government Ordinance led to administrative change that negatively impacted the overall PHDC DHDC linkages.

The WHO and other international implementing partners have used the PHDC for training activities, but only the premises. The PHDC staffs were not part of the training and no funds were paid to PHDC for the use of premises.

The international funding partners are willing to support PHDC provided that basic requisites pertaining to staff and skill are provided by the DoH and there is exhibited commitment by them to make PHDC operational. They would prefer to support an institute with effective leadership and a strategic plan in place. Their support can include the establishment of a high-tech resource center, refurbishment of training halls/equipment, audio/visual facilities for all level training and capacity building activities, operational research, third party evaluations etc. They can also facilitate in upgrading the skills of the PHDC staff in-country and abroad.

Lastly, they can offer technical assistance for the development of the PHDC strategic plan and business plan.

4. SWOT Analysis of PHDC

Strengths	Weaknesses
• The PHDC is the only public sector, in-service training/development institution to take the lead role in managing continued professional development in the health sector for diverse strands of human resources with reference to type and skill level in the health sector • It was envisioned as a center of excellence for teaching, training, and research from which various technical activities, such as operational research, human resource development, institutional development, health systems management, and community involvement, were to be carried out and spread to the lowest level of health care through DHDCs, and had been performing as a quality institution for years. • In the past, PHDC has enjoyed being a very effective institution, fulfilling the mission for which it was built; thus, it can be revived and	• Progressively, it has lost its mission. The roles initially designated to the PHDC have been taken over by other entities. • Lacks connectivity with the health sector generally and preventive programs specifically • Unmotivated staff • Run-down infrastructure and premises, including hostel facilities • Staff use PHDC as a stepping stone by gaining relevant experience and title, and then join private sector or UN organizations • Staff focused on activities outside of the PHDC for personal benefit • Previously, lack of interest of Department of Health, Sindh, in improving the status and workings of this institution • Lack of confidence of the international

modified to meet the needs of today • Current staff are qualified and willing to contribute effectively if the PHDC is revived • The current staff available at PHDC is well qualified and can be made more efficient with necessary capacity building and motivation • DHDC trained staff are still available in the district health network to serve as extension wing of the PHDC • The PHDC is contained within its own custom building • Custom built hostel building • Available extra piece of land for possible extension • Ongoing annual financial allocations • Commitment and support from DoH, Sindh	implementation partners in DoH for effective revival of the PHDC • Weak leadership • No specific HR policy for PHDC staff, *(DoH Policy can be useful to PHDC for planning of DoH staff development)* • No strategic plan • No annual implementation plan • No business plan • As per the PC-I, there is a staff of sixteen from grade 16-20 and thirty seven support staff from grade 1-12; a majority of the budget is allocated for staff salary • Budgets are used annually with no objective outputs • Two RAF research studies were conducted, but new staff were hired and the PHDC regular staff did not participate • Political influence prevails in hiring/placement of PHDC staff • Technical and support staff are involved in activities outside of the PHDC, often receiving salaries from both the PHDC and other institutions
Opportunities	**Threat**
• As an in-service institution, the PHDC can cater to the needs of the public and private sector health workforce • Health personnel associated with PHDC in the past and now are at senior positions have strong feelings of ownership about the institution • Strong commitment of the senior health offices for operationalization and/or with innovation of PHDC • Strong will of international partner organizations to extend support toward operationalization of PHDC • Adjacent to LUMS • Once the PHDC staffs have received refreshers, the PHDC can conduct fast track management courses such as planning, result base management, financial management, disease forecasting, and forecast budgeting for public health specialists and other levels of the health care delivery network as part of the DoH management cadre initiative. The international funding partners are willing to support these activities. It needs to be	• If not operationalized, the PHDC might be abolished, leaving no in-service institution in the province • As there are no objectives outputs from the PHDC, funding might cease to exist in view of financial constraint in the province generally and for the health department specifically • If the PHDC closes, the premises will also be allocated for some other purpose and thus the revival options will be limited

highlighted that the current technical staff of the PHDC are adequately qualified and experienced. The PHDC can collaborate with the Health System Reform Unit (HSRU) Sindh for donor coordination and other activities. • Once the institution is revived with hostel facilities, it will attract non-profit and private sector groups for trainings at a cost much lower than the hotels that will contribute toward a self-reliant PHDC. However, it needs to be highlighted that In order to revive the PHDC, the DoH has to take decisions to give necessary autonomy to the PHDC. Under the devolved situation, it is a possibility. The private sector may eventually get interested in collaboration and support for training activities related to marketing and management.	

5. Proposed Models for Operationalization of PHDC

When it was established under the Family Health Project, the PHDC was considered a quality, in-service training institution: it had a qualified and motivated staff who worked effectively and efficiently toward the achievement of its objectives. Over a period of time, due to multiple internal and external factors, governance and management issues led to its deterioration. Qualified and trained staff explored other lucrative options and moved on. Members of the health department workforce trained and groomed by the PHDC who currently work in senior positions exhibit a strong sense of ownership toward the PHDC.

In light of the need for a comprehensive training and research institute, international implementing partners are also dedicated toward revitalizing the PHDC, extending technical and financial assistance to support the institute.

The DoH is also inclined to make the PHDC a viable option, and it has exhibited the will to opt for innovative approaches. The DoH has also taken on the responsibility to address the issue of political interference so that the revival efforts of the PHDC are not hindered. With such an enabling environment, it is imperative that a well thought out, phased plan is developed. This plan should take into account the current status of the PHDC and, over three years, transform it into a well-established center of excellence. That is, the PHDC would be revived, made functional, and then become an Independent Health Development Center (IHDC).

A fully operational, semi-autonomous IHDC under the minor administrative control by the health department is vital to ensure the quality of healthcare service provision by the public and private sector healthcare providers (general health practitioners) of the province through quality capacity building program. The overall objective of the Independent Health Development Center would be to improve the quality of care delivered by the health workforce to citizens in the most efficient and effective way. The IHDC would be responsible for, but not limited to, the following:

- Becoming a center of excellence for teaching, training, and research from which various technical activities, such as operational research, human resource

development, institutional development, health systems management, and community involvement for clients from public, private, nonprofit, and for profit organizations. Each client will be charged according to a scale defined by the BoD. Special subsidized rates/arrangements will be worked out for the public sector.

- Undertaking an extensive capacity building program related to the quality of the health care workforce, whether in the public or private sector. In this context, specific, tailor-made certification training courses will be offered and marketed to organizations and individuals as per the training calendar prepared by PHDC staff and approved by the BoD. Credible resource persons will be invited to conduct these courses. Progressively these courses may develop into diploma courses.
- Setting and developing health service organizational and clinical standards in conjunction with key stakeholders.
- Developing and standardizing the culture and practice of clinical governance.
- Identifying, documenting, disseminating, and advocating best practices for the cost effective and efficient delivery of health services.
- Strengthening the capacity of health service delivery to promote the effective management of quality health care.
- Developing service delivery standards for all providers in the health sector: public and private; primary, secondary, and tertiary levels.

A proposed phased approach over 2-3 years to transform the current PHDC to a revived PHDC, then to an IHDC.

Indicator	Current Stage	Revival Stage	Autonomous Stage
Pre-Inception Phase			
Necessary pre-inception requisites	Not applicable	Notification of all vertical program and donor funded trainings for public sectors done in coordination with the PHDC • Advance notice for scheduling • Joint training and shadow training by PHDC staff • Database to track all trainings	• Propose an act for establishment of an Independent Health Development Center by the health department or another statutory body • Terms of reference and general conditions of service for the board members • Indemnification agreement for the board of directors • Policy document for the board of directors • Rules of governance for the board of directors • Governance monitoring checklist • Code of conduct for members of the technical advisory committee • Service rules • Human resource policy • Strategic plan • Business plan • Communication strategy • Financial framework • Corporate planning briefing document These documents (drafts) will be prepared with the technical assistance of the international implementation partners by a core group of consultants, to be initiated as early as possible. A core internal team from the DoH and the

			PHDC will be established to facilitate the process of documentation development.
Area: Mission and Plans			
Organizational Mission Statement; Formulation of Program Objectives; Annual and Long-Term Planning;	A mission statement exists but is not generally known and is not used to guide decisions. Long-term strategic planning is not conducted.	Update the mission statement, given other changes in the sector/DoH and the capacity of PHDC through development of an organizational planning framework (strategic plan for 3 years) that will enable the PHDC to clearly identify its priority goals and specify activities to reach those goals. Annual plan for PHDC activities.	Formation of a board of directors (BoD), which will hire an executive director and key staff members on a contract-basis. Core group of consultants to conduct orientation sessions for board of directors, executive director, and key staff members. Planning team to be formed, responsible for finalization of the prepared draft documents. The board of directors is responsible for overseeing all processes and documents.
Area: Leadership			
Decision Making and Delegation; Introduction of Change Leaders' Experience and Competence	Only the executive director attends meetings with outside organizations.		The board and executive director take initiative to implement activities. The executive director and senior staff should collaborate on this activity. Senior and technical staff to attend meetings with outside organizations so that they can expand their knowledge and experience in program areas for which they are responsible. Draw up calendar of activities.
Area: Organizational Structure and Lines of Communication			
<u>Organizational structure</u> Formalized Management Practices Reporting and MIS; External	Organizational chart shows supervisory relationships but relationships are not always followed.	Development of an organizational chart that clearly identifies staff roles and responsibilities in the form of a policy/manual. SOPs for supervisory functions.	The Independent Health Development Center will have a clear policy regarding the roles, functions, and tasks of staff and it should prepare procedures for carrying out various functions. Modifications of roles and responsibilities should be incorporated into the personnel policy/manual.

Communications			The human resources manager should be the person responsible for undertaking the above mentioned activities.
Area: Financial Management			
Financial and accounting Procedures Financial Stability	Financial records are maintained for all public- and donor-supported projects	Develop a 2-3 year financial plan to relate organizational program expenditures to income from donors, revenue-generating activities, and other sources. Correct all problems identified by the external audit. These activities should be carried out over a 1-2 year period and linked with the overall development of a strategic plan.	The IHDC should review program activities and operations to find ways of bringing about cost efficiencies without compromising program objectives. A financial sustainability plan should be developed (as part of the planning process) to increase self-reliance. Identify feasible activities for income generation. The financial director should be in charge of technical support for the process and be responsible for correcting audit problems. The executive director should be in charge of organizing the process. The board of directors should oversee this process.
Area: Human Resource Management			
Human Resource Policy: Job Descriptions and Responsibilities; Staff Supervision; Staff Training and Development; Personnel Policies;	No human resource policy. Job descriptions exist but are out of date and have not been reviewed for years.	The PHDC should undertake a training needs assessment and develop an annual capacity building plan for short- and long-term training on the basis of the training needs assessment for various cadres of DoH staff. Review and revision of job descriptions should take place over the next 6 months.	With a human resource policy in place, the IHDC will undertake a comprehensive review of all job descriptions, compare them with current and anticipated job responsibilities, and update job descriptions as necessary. Develop a timetable for reviewing and updating job descriptions. Use new job descriptions as the basis for performance reviews.

			Conduct a performance review and training needs assessment for all current technical and administrative personnel. Necessary decisions regarding the fate of the existing PHDC staff to be made on the basis of their qualification and performance. This should be overseen by the executive director and director of human resource management. The training needs assessment and training plan should be carried out by the training manager in collaboration with an external consultant.
Area: Infrastructure			
Basic offices; Training halls; Library/resource center; Hostel facilities;	Basic infrastructure present, but needs refurbishment ranging from moderate to massive.	Necessary refurbishment should be undertaken to make the PHDC a viable facility for hosting training and other activities. Upgrading of the library/resource center should be initiated. Possibilities for donor support should be explored.	At the onset, both the buildings (IHDC and hostel facility) should be refurbished to accommodate the new setup. The hostel facilities can be shifted to other premises, such as the adjoining LUMS Hostel. An new hostel building can be built on the available land once the IHDC becomes self-reliant.
Area: Training equipment and modules			
Training equipment; Training modules; Tailor-made courses	Training equipment present; multimedia training conducted as per specific modules	Training equipment: multimedia and overhead projector present.	Status of training equipment and material should be reviewed and necessary additions should be made. Possibilities of sponsorships should be

			explored. Executive director is responsible, BoD to facilitate.
Area: Teaching /training and research activities			
<u>Continued Professional Development</u> activities for diverse types of human resources with reference to type and level of skills in health sector; general & operational research. Trainings of preventive health programs.	No program/activities in place. Limited trainings conducted; primarily utilized by the MNCH program on an ad hoc basis, but only the premises are used. PHDC staffs are infrequently part of trainings. Isolated research undertaken (two for RAF).	Specific training activities should be initiated as per the annual implementation plan based on the training needs assessment as soon as possible. These may include, but are not limited to, management, quality of care in service delivery, infection prevention, DHIS management, procurement, and inventory management. Collaboration with preventive health programs should also be initiated through DoH immediately. Upgrade skills of PHDC faculty Formalize arrangements with universities and other institutions to provide training outside of the DoH capacity.	Complete package of continued professional development activities for diverse types of human resources with reference to type and level of skills in health sector should be initiated at the earliest. Additionally, specialized, tailor-made training/modular training for preventive health programs should also to be conducted. The Director of capacity building is responsible for this task. General and operational research to commence in collaboration with provincial and national institutions and donor funded projects. The director of research is responsible; executive director and BoD to facilitate.
Area: Extension Activities			
<u>Linkages</u> with DHDC; Outreach Activities	Currently no linkages with DHDCs; DHDCs exist in only two districts.	The trained staffs of the DHDCs are still present in district health offices, working in various capacities. They should be identified, put into a database, and used for undertaking training in the districts. No formal	A comprehensive review of the DHDC staff should be undertaken to be identified possible personnel who can serve as extension trainers for the IHDC on honorarium. Database to be maintained. Refresher courses should be conducted to enhance

		DHDCs are required.	skills and formalize continual education focus. Database of independent consultants to be developed with reference to specific expertise. The director of capacity building should be in charge of the process under the guidance of the executive director.
Area: Sustainability			
Community* Contributions; Membership for resource center/library Innovations **"community" means the health workforce of the province, NGOs working in health, medical students, etc.*	No program or activity in place.	Not applicable in the revival stage	The IHDC should emphasize integrating community members in its program activities as per the business plan. The business plan should cater to the community* for the innovative services offered by the IHDC, such as online courses in collaboration with international universities, fast track management courses, various short courses, and training of master trainers. Renting out the hostel to other organizations for a fee. The executive director should work with the BoD to advocate for collaboration with institutions and individuals from public, private and corporate sectors for IHDC membership. These formal collaborations can include conducting capacity building activities for them, development and conduction of tailor-made courses, organizing events and seminars, undertaking market research, etc. against a market-driven cost.

6. Conclusions

Over the years, the PHDC has been neglected. A lack of investment by the Department of Health led to severe damage to the PHDC and DHDCs. This transformed the once fully operational PHDC, with a highly motivated and qualified staff, into an almost non-functional institution with an unmotivated staff and pitiable premises/hostel facilities. Poor human resource management, a lack of skill enhancement, and political influence in appointment and postings has resulted in low levels of performance. During the same period, the health sector suffered from capacity issues in the health workforce and the dearth of continuous medical education (CME). Very little was known about competencies of health managers, their skills, training, and specifically the policy for deployment. It is worth mentioning that in the PHDC's early years, senior level management did not acquire higher management qualifications other than a basic medical degree. Other than their initial trainings, health providers were rarely exposed to in-service training programs for skill enhancement with the objective of improving health care.

The key function of the health department is the delivery of quality health care services, which depends on having motivated and qualified staff. Staffing is a key input, but it is also the main cost in most health systems. Without effective and committed staff, it is unlikely that health sector reform will be successful. In order to fulfill this need, it is imperative for DoH to have an effective and efficient in-service and CME program in place.

Leadership skills of employees at the managerial level are essential for achieving the goals and objectives of the DoH. It cannot be denied that capacity and opportunity for leadership development among DoH employees are limited. Training institutions already exist at the provincial and district levels, but they need strengthening and revitalization so that they can carry out continuous professional development activities. In addition, there are a number of institutions offering post graduate trainings to doctors and other managers both in the public and private sectors. However, there is an absence of institutions and training programs focusing on in-service trainings for various cadres of health providers, especially in the public sector, other than the PHDC. The department must revive and enhance in-service training programs. This will improve the quality of services in the public health sector.

There is a dire need to undertake a training needs assessment of the health staff and develop a comprehensive training plan aligned with the findings. If the province wants to improve health outcomes and all investments in the health care delivery services, it must ensure implementation of such a program through a quality, in-service training institution. There is also need to undertake operations research to guide the service packages development process, and to continuously revise them according to the latest international research findings.

The PHDC is the institution that can address as well as facilitate the needs of the DoH to meet the needs of a quality, effective health care delivery system. Based on the findings pertaining to the current status of the PHDC, a two-step model is proposed whereby initially it should be revived, and then ultimately transformed into an autonomous institution. The process involves a series of consultations with key stakeholders and a detailed feasibility study before implementation.

7. Recommendations

In order to revive the PHDC and transform it into an Independent Health Development Center, the following are recommended:

i. The DoH to ensure that pre-service induction training and in-service programs are made mandatory and are designed to enhance the professional competence of health care providers, especially those in the rural areas who teach at college and university levels. In this context, the PHDC may be upgraded as a full-fledged in-service training institute, modeled on the Civil Services Academy Lahore or NIPA (National Institute of Provincial Administration), with a full time head/director and professional trainers. In-service training may be made mandatory for all newly selected health providers in the health department. Preference may be given to those health providers who have undertaken at least one training management course from the PHDC.

ii. The PHDC should review and update all training modules in line with the current needs of the DoH. This will involve assessing the training needs of the various cadres of the service delivery and management staff. Furthermore, efforts should be made to access technical assistance to introduce additional tailor-made training courses as per the needs of public and private sector health providers. The course duration for a pre-service induction training program should be three weeks and a six week in-service program may be instituted for other cadres of health staff.

iii. The PHDC should undertake operations research activities for guiding the DoH to improve service delivery and address the health challenges in the province. They can be assisted by the health sector reform unit in policy level research to guide the health department in setting its priorities.

iv. Courses related to the preparation and presentation of lectures, research paper writing and computers training, specifically emphasizing the use of e-mail and the internet may be included in the program. A more extensive and participatory approach may be used for training, while training about the use of modern audio-visual aids, like video conferencing, multi-media, the internet, and projectors may be offered. Additional experts in various disciplines will also be invited, including those from foreign universities.

v. The DoH should take necessary actions pertaining to the fiscal autonomy of the PHDC to generate revenue.

vi. Efforts should be initiated for the preparation and approval of the ACT for making PHDC into the Independent Health Development Center. The DoH should identify and form a body to initiate and oversee the process over a period of 2-3 years.

Annexure

Annex-1:	Tools
Annex-2:	List of Machinery Equipment and Furniture
Annex-3:	Financial Allocations and Expenditure
Annex-4:	Human Resource Assessment Template
Annex-5:	Equipping a Training Center
Annex-6:	Rating Scale Tool - Filled by the PHDC eight (8) key staff members
Annex-7:	Budget PHDC Hyderabad

ANNEX 1: List of Machinery Equipment and Furniture

Sr.#	Page #	Name of Item	Working Qty.	Remarks
1	1	Air Conditioners PEL 1900 BTUS	3	
2	2	Binder Spiral Machine	1	
3	3	Video Cassettes	7	
4	4	Audio Cassettes	10	
5	6	Gas Burner	1	
6	12	Bicycle Sohrab	1	
7	29	TV Sony 21"	1	
8	32	Slide Projector	1	
9	47	Pedestal Fan Khurrum	1	
10	52	Microscopes Model XSP	19	8 issued to DHOs
11	55	Mazda Coaster 26 Seators GS-4084	1	Required funds for repairing
12	57	Air Conditioners General 2 Tonnes	1	
13	58		2 sets	
14	60	Over Head Projector with Screen (Widehux)	2	
15	61	Telephone Exchange with 39 Telephone set	1	
16	68	Scanner HP	2	
17	78	Multi Media Projector (Acer X 1130P)	1	
18	80	DVD Player Philips	1	
19	81	Television 25" Sony	1	
20	82	Cannon Laser Fax Machine	1	
21	83	Refrigerator 9 CFT Dawlance	1	
22	86	Now Born Examination Doll SUSIE USA	1	
23	87	Newborn Head for Intubations	1	
24	88	Laser Printer Samsung ML-2550	1	
25	89	Flip Chart Stand	2	
26	90	Soft Board 6' x 4'	2	
27	91	White Board 6' x 4'	2	

Sr.#	Page #	Name of Item	Working Qty.	Remarks
28	92	Split AC with Remote GZ-1002 A-E 3 PEL	1	
29	93	Sound System Indonesia	1 set	
30	94	Gas Generator Singer 5 KV 6500	1	
31	95	Computer P-4 USA black casing with TV device	1	
32	96	Geezer 55 Galen (PIXMA)	2	
33	97	Mike TOA	3	
34	98	Multi Media with remote (Panasonic)	1	
35	99	Water Dispenser	1	
36	100	Microwave Oven	1	
37	101	Split AC PEL 2 tonnes	1	
38	102	UPS Intex Company	2	
39	103	Laser Printer Samsung ML-1660	2	
40	104	Computer P-4 black casing	2	
41	107	Panda 8 switch	2	
42	108	Laptop Core i5 HP	1	
43	109	Laptop HP DV-6	1	
44	110	EVO USB PTCL	1	
45	111	Telephone set Thomson 2010	1	
46	112	Computer Dual core	3	
47	113	Laser Printer HP	4	
48	114	Photostat machine	1	

ANNEX 1: List of Machinery Equipment and Furniture

Sr.#	Page #	Name of Item	Working Qty.	Remarks
1	1	Sign Board size 4' x 3'	1	
2	3	Iron Stand board sixe 2' x 3'	1	
3	6	Notice Board size 3' x 4' made from chipboard with s.pati	3	
4	9	Office Table 5' x 3' 2½ 3 drawers other rack 4' x 1½	5	
5	11	Office Table 4' x 2½' 3 drawers	4	
6	12	Computer table 3½' x 2' with revolving chairs	4	

Sr.#	Page #	Name of Item	Working Qty.	Remarks
7	14	Magic Board size 36" x 48" with stand	1	
7	15	Committee room tables 3 pieces 8' x 4' x 2½ 2 piece round shape	1	
8	17	Executive revolving chairs	5	
9	19	Office chairs tali wood leg 2" x 2"	15	
10	21	Visiting chairs standard size shesham wood	16	
11	22	Revolving Chairs, cushion master molty foam tilting	11	
12	23	Sofa set 5 seater	3	
13	25	Steel Almirah size 6' x 4' x 2½	10	
14	26	Steel Almirah size 6' x 3' x 1½	1	
15	27	Steel Show case size 6' x 4' x 2½	8	
16	29	File rack steel 3' x 3' x 1½	2	
17	31	Rostrum 48" x 24" x 18"	2	
18	33	Notice Board size 4' x 3' glass doors	1	
19	34	Frame small size	3	
20	36	Majic Board size 4' x 3'	1	
21	38	Steel file cabinet 24" x 20" x 19"	10	
22	39	Wooden stools 2' x 1' x 1'	5	
23	51	Refrigerator Stand wooden	1	
24	60	Name Plates	11	
25	61	List Board	1	
26	62	TV trolley	1	
27	66	File Rack Iron	8	
28	67	Revolving chairs for computers	4	
29	69	Office Table and side rack (black Formica)	1	
30	71	Office Table 4' x 2½ Wooden	6	
31	72	Notice Board size 4' x 3' x 6"	3	
32	75	Table for Lecture Hall	8	
33	76	Office Chairs tali wooden armless	25	
34	77	Protocol Board	6	
35	78	Chairs steel with foam and Raxin cover	12	
36	79	Sofa set 7 seaters Molty Foam orange color	1 set	consisting 4 pieces
37	80	Sofa set 7 seaters black and white Molty Foam	2 sets	
38	81	Catalog table iron	1	

Sr.#	Page #	Name of Item	Working Qty.	Remarks
39	82	Dining Chairs in wooden and foam	24	
40	83	Dining table wooden size 4' 24' 3 pieces	1 set	
41	85	Matrix Molty Foam	3	
42	86	Double Bed wooden size 6'½ x 5'	3 sets	

Annex 2: Financial Budget PHDC Hyderabad

09 093 0931 093102 HD - 4087	EDUCATION AFFAIRS & SERVICES (CURRENT) TERTIARY EDUCATION AFFAIRS & SERVICES TERTIARY EDUCATION AFFAIRS & SERVICES PROFESSIONAL / TECHNICAL UNIVERSITIES PHDC / HOSTEL HYDERABAD (Old code: HD-4039)		2011 - 2012 TO 2013 - 2014		
PARTICULARS			Budget	Budget	Budget
YEARS			2011-12	2012-13	2013-14
A01	**TOTAL EMPLOYEES RELATED EXPENSES**		**13,976,400**	**16,152,700**	**21,747,000**
A011	**TOTAL PAY**		**5,939,800**	**8,701,600**	**10,883,000**
A011-1	**TOTAL PAY OF OFFICERS**		**4,010,000**	**5,738,000**	**7,963,000**
A01101	**Total Basic Pay of Officers**		**4,000,000**	**5,738,000**	**7,963,000**
P123	PROJECT DIRECTOR	(BPS-20)	-	455,500	-
A826	ADDITIONAL PROGRAM DIRECTOR	(BPS-19)	-	500,000	696,000
P115	PROGRAMME DIRECTOR (H-EDU)	(BPS-19)	329,900	455,500	634,000
P116	PROGRAMME DIRECTOR (HSR)	(BPS-19)	279,800	383,800	534,000
P121	PROJECT DIRECTOR	(BPS-19)	330,000	-	634,000
H083	HOSPITAL ADMIN TRAINER	(BPS-18)	223,600	309,000	430,000
P031	PHC MANAGEMENT TRAINER	(BPS-18)	283,500	382,300	532,000
A069	ADMN CUM ACCOUNTS OFFICER	(BPS-17)	249,400	345,300	481,000
H057	HEALTH EDUCATION TRAINER	(BPS-17)	74,400	103,600	144,000
H058	HEALTH EDUCATOR (Health Education Officer)	(BPS-17)	803,900	500,000	696,000
N010	N.E. RESEARCH OFFICER	(BPS-17)	659,800	987,300	1,352,000
R045	RESEARCH OFFICER	(BPS-17)	420,600	591,000	822,000
T063	TRAINER M.O. CLINICAL	(BPS-17)	174,200	250,400	349,000
L058	LIBRARIAN	(BPS-16)	-	238,000	330,000
S236	SUPERINTENDENT	(BPS-16)	170,900	236,300	329,000
A01102	Personal Pay		10,000	-	-
A011-2	**TOTAL PAY OF OTHER STAFF**		**1,929,800**	**2,963,600**	**2,920,000**
A01151	Total Basic Pay of Other Staff		**1,924,800**	**2,963,600**	**2,920,000**
C146	COMPUTER OPERATOR	(BPS-12)	121,600	169,100	167,000
C147	COMPUTER OPERATOR / TYPIST	(BPS-12)	101,300	140,900	139,000
D026	DATA PROCESSING ASSISTANT	(BPS-12)	33,900	47,100	47,000
A020	ACCOUNTANT	(BPS-11)	115,800	161,000	159,000
A119	ASSISTANT	(BPS-11)	-	183,600	182,000
H089	HOUSE KEEPER	(BPS-09)	225,000	320,300	317,000
J014	JR. CLERK	(BPS-07)	75,200	107,700	107,000
E021	ELECTRICIAN	(BPS-06)	77,400	107,600	106,000
S206	STORE KEEPER	(BPS-06)	77,400	107,600	106,000
T022	TELEPHONE OPERATOR	(BPS-06)	77,400	107,600	106,000
D161	DRIVER	(BPS-04)	73,600	102,400	90,000
B015	BEARER	(BPS-01)	244,200	339,600	336,000
C089	CHOWKIDAR	(BPS-01)	196,200	272,900	270,000
C167	COOK	(BPS-01)	159,200	221,400	219,000
M022	MALI	(BPS-01)	62,400	86,700	86,000
N003	NAIB QASID	(BPS-01)	149,500	207,900	206,000
P061	PLUMBER	(BPS-01)	62,400	86,700	86,000
S008	SANITARY WORKER	(BPS-01)	72,300	193,500	191,000
A01152	Personal Pay		5,000	-	-
A012	**TOTAL ALLOWANCES**		**8,036,600**	**7,451,100**	**10,864,000**
A012-1	**TOTAL REGULAR ALLOWANCES**		**7,836,600**	**7,251,100**	**10,664,000**
A01202	House Rent Allowance		1,334,700	1,425,900	1,659,000
A01203	Conveyance Allowance		620,800	793,900	1,592,000
A01204	Sumptuary Allowance		5,000	-	-
A01205	Dearness Allowance		510,000	-	-
A01207	Washing Allowance		4,000	15,600	17,000
A01208	Dress Allowance		5,000	-	-
A01209	Special Additional Allowance		234,000	-	-
A0120D	Integrated Allowance		8,700	14,100	14,000
A0120D	Adhoc Relief Allowance - 2009		780,600	-	-
A0120X	Adhoc Allowance		2,481,800	2,562,800	3,224,000
A01217	Medical Allowance		861,400	863,000	1,036,000
A0121A	Ad-hoc Allowance - 2011		-	969,800	967,000
A0121B	Health Professional Allowance		-	-	-
A0121M	Adhoc Relief Allowance - 2012		-	-	2,103,000
A01224	Entertainment Allowance		18,000	18,000	29,000
A01225	Instruction Allowance		5,000	-	-
A01226	Computer Allowance		27,000	36,000	23,000
A01239	Special Allowance		5,000	-	-
A01244	Adhoc Relief		433,900	-	-
A01252	Non Practicing Allowance (NPA)		67,200	552,000	-
A01262	Special Relief Allowance		434,500	-	-

A012-2	**TOTAL OTHER ALLOW (EXCL: TA)**	**200,000**	**200,000**	**200,000**
A01274	Medical Charges	200,000	200,000	200,000
A03	**TOTAL OPERATING EXPENSES**	**2,195,500**	**2,480,700**	**2,496,000**
A032	**TOTAL COMMUNICATIONS**	**101,000**	**110,000**	**110,000**
A03201	Postage & Telegraph	25,000	25,000	25,000
A03202	Telephone & Trunck Call	76,000	85,000	85,000
A033	**TOTAL UTILITIES**	**780,000**	**790,000**	**790,000**
A03301	Gas	50,000	50,000	50,000
A03302	Water	30,000	40,000	40,000
A03303	Electricity	700,000	700,000	700,000
A034	**TOTAL OCCUPANCY COSTS**	**75,000**	**100,000**	**100,000**
A03407	Rates & Taxes	75,000	100,000	100,000
A038	**TOTAL TRAVEL & TRANSPORTATION**	**299,500**	**346,100**	**305,000**
A03805	Travelling Allowance	86,200	99,100	99,000
A03806	Transportation of Goods	10,500	12,100	12,000
A03807	P.O.L. Charges A.Planes, S.Cars, M/Cycle (etc)	152,800	184,900	194,000
A03809	CNG Chrages (Govt)	50,000	50,000	-
A039	**TOTAL GENERAL**	**940,000**	**1,134,600**	**1,191,000**
A03901	Stationery	45,000	49,900	52,000
A03902	Printing & Publication	35,000	38,900	41,000
A03905	News Papers Periodical & Books	100,000	115,500	121,000
A03906	Uniform & Protective Clothing	100,000	115,500	121,000
A03970	Others	**660,000**	**814,800**	**856,000**
1	Others	160,000	184,800	194,000
184	TRAINING & RESEARCH	500,000	630,000	662,000
A05	**TOTAL GRANTS SUBSIDES & WRITE OFF LOANS**	**500,000**	**500,000**	**250,000**
A052	**TOTAL GRANTS-DOMESTIC**	**500,000**	**500,000**	**250,000**
A05216	Fin. Asis. To the families of Govt. Serv. Who expire.	500,000	500,000	250,000
A09	**TOTAL PHYSICAL ASSETS**	**256,000**	**370,000**	**-**
A092	**TOTAL COMPUTER EQUIPMENT**	**91,000**	**150,000**	**-**
A09201	Hardware	91,000	150,000	-
1	Hardware	-	-	-
18	Four Laser Printers	-	60,000	-
44	One Laptop Computer	91,000	-	-
372	Three Computer Pentium IV	-	90,000	-
A095	**TOTAL PURCHASE OF TRANSPORT**	**65,000**	**-**	**-**
A09501	Transport	65,000	-	-
193	One Motrocycle	65,000	-	-
A096	**TOTAL PURCHASE OF PLANT & MACHINERY**	**-**	**120,000**	**-**
A09601	Plant & Machinery	-	120,000	-
10	One Photo Copier	-	120,000	-
A097	**TOTAL PURCHASE OF FURNITURE & FIXTURE**	**100,000**	**100,000**	**-**
A09701	Furniture & Fixture	100,000	100,000	-
001	Furniture & Fixture	100,000	100,000	-
A13	**TOTAL REPAIR & MAINTENANCE**	**350,000**	**393,800**	**425,000**
A130	**TOTAL TRANSPORT**	**150,000**	**173,300**	**187,000**
A13001	Transport	150,000	173,300	187,000
A131	**TOTAL MACHINERY & EQUIPMENTS**	**100,000**	**115,500**	**125,000**
A13101	Machinery and Equipments	100,000	115,500	125,000
A132	**TOTAL FURNITURE & FIXTURE**	**100,000**	**105,000**	**113,000**
A13201	Furniture and Fixture	100,000	105,000	113,000
HD 4087	**GRAND TOTAL PHDC-HOSTEL HYDERABAD**	**17,277,900**	**19,897,200**	**24,918,000**

Annex 3: Rating Scale Tool - Filled in by Eight Key Staff of PHDC

SECTION I: ASSESSMENT QUESTIONS							
No		1	2	3	4	5	6
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
A	**PROGRAMME DESIGN**						
1	Outputs of the Programme describe solutions to identified needs and priorities						
2	The inputs and strategies are appropriate and achievable						
3	The external factors and assumptions are catered for and countered in Programme design						
4	The design of the Programme has the flexibility to incorporate the newer needs/demands as they emerged						
5	The inclusion/incorporation of the newer initiatives influenced the overall performance of the ongoing Programme activities.						
B	**PROGRAMME RELEVANCE**						
1	The Programme priorities and objectives are in alignment with government priorities and policies						
2	The outputs and outcomes contribute towards achievement of the ICPD goals and the MDGs						
3	Various gaps have been addressed, during the execution/implementation of various projects related activities						
C	**PROGRAMME MANAGEMENT**						
1	The Programme inputs (human, technical, and financial) have been used efficiently						
2	To improve efficiency, progress in management of various activities has been made (without compromising quality)						
3	The technical assistance offered is appropriate and adequate						
4	The technical assistance provided, facilitates in improving the performance of implementing partners						
5	An appropriate monitoring system has been established						
6	Monitoring activities are conducted exclusively by the staff						
7	The work load of implementing partners duplicated or increased by the monitoring &/or supervisory activities						
8	Monitoring allows for adequate assessment of changes in risks and opportunities in the internal environments						
9	The M&E system captures Programme outputs and						

SECTION I: ASSESSMENT QUESTIONS							
No		1	2	3	4	5	6
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
	outcomes						
10	Monitoring contributes, in the progress and/or quality of the implementation of activities						
11	The M&E system facilitates effective program decision-making						
D	**PROGRAMME EFFECTIVENESS**						
1	The planned outputs and outcomes have been achieved satisfactorily						
2	The outputs and outcomes meet acceptable standards of quality						
3	The available data and indicators provide evidence regarding achievements of Programme outputs and outcome						
4	Sufficient evidence is produced & shared for Programme achievement						
E	**PROGRAMM EEFFICIENCY**						
1	The expected outputs justify the costs incurred						
2	Efforts have been made to address & overcome the overlap & duplication						
3	Improvement in quality of services/activities/intervention is included without compromising the cost						
4	Programme activities complement and synergize with interventions by other agencies						
F	**PROGRAMME IMPACT**						
1	The Programme is well on its way in achieving the desired outcomes through its specific projects/interventions						
2	Various activities of the programme contribute in terms of achieving the desired outcome/output.						
G	**PROGRAMME SUSTAINABILITY**						
1	The DoH programmes/projects have an in-built strategy /mechanism for supporting PHDC						
2	Programme activities are integrated into current activities/practices of counterpart institutions/programmes						
3	The resources have been efficiently allocated						
4	The programme has built partnerships with other government agencies and partners for the effective implementation						
5	There is substantial return from the investment in equipment (e.g. medical equipment, furniture, ICT equipment, etc)						

SECTION I: ASSESSMENT QUESTIONS							
No		1	2	3	4	5	6
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
Section II: Cross -cutting issues							
A	**Management, Governance, Institutional Links, Finance and Partnerships**						
1	Management and governance mechanisms are in place for the implementation of PHDC activities at provincial and district levels						
2	PHDC builds on partnerships and collaboration (integration and linkages) with other government and non-government partners to enhance outputs and outcome						
3	The Programme is able to meet specific targets including integration and linkages with other Programmes at strategic level and downward to implementation level						
4	PHDC can be viewed as value for money						
5	PHDC builds on coordination and linkages with vertical programmes such as EPI,LHW and Population welfare programme						
B	**Monitoring and Evaluation**						
1	Evidence exists to show that objectives have been achieved						
2	The capacity of key PHDC staff been strengthened for their monitoring and evaluation role						
C	**Innovations**						
1	Innovations introduced have a potential for scaling up and replication						
D	**Lessons Learnt**						
1	Lessons learnt have been well documented throughout the programme so far						

Annex 4: Matrix for Data Collection

1.	Desk Review	**Reviewing Existing Documents**: This involves researching and noting what is going on – „getting the feel of the needs of the sector/region. This may include reviews of sector specific reports, alignment and linkages with health sector plans, reviews of plans or policy statements. Key documents to be provided by JSI and/or to be collected from PHDC or other relevant stakeholders.	
2.	In-Depth Interviews Annex-1	PROVINCIAL • Secretary Health • DG Health • HSRU • Donors/supporting partners • Key staff of PHDC	
3.	Focus Group Discussions Annex-2	PHDC Staff	DHDC staff
4.	Rating Scale Assessment Annex -3	Key staff of PHDC • Management (administrative + Financial) • Technical/Trainers	
5.	Facility Assessment (as per PC1 and any donor support) Annex -4	Following key areas will be assessed in detail as per attached checklists: • Infrastructure • Human resource (both technical and administrative) - Data base of trainers/subject specialists • Training equipment and material	
6.	Financial Assessment (as per PC1 and expenditure statements)	• Financial resources - budget – last 3 yrs - Cash Flow - expenditure Statements – last 3 financial year - audit reports (if any) • External support - In kind - Financial Aid (budgetary details/statements) - Technical Support	

Tool 2: FGD Guidelines for Provincial Key stakeholders/Donors

	Questions
1.	**Are you aware of or familiar with PHDC?** *Probe: Does he/she know about the goal/objectives/role of PHDC?*
2.	**What role have you played (if any) in setting up/operationalization of PHDC?** *Probe: What Projects and/or support are you offering for improving this institution?*
3.	**Is effective and efficient PHDC important for strengthening health sector in the province?** *Probe Does it meet the needs of health professionals? Relevant to country policies (PRSP & health policy), strategies, MDGs etc. Is PHDC as an institution still relevant to strengthening of the health services i.e. by providing in service training, capacity development and undertaking research to guide policy and programme design? If not playing any role, how can it contribute towards health sector strengthening? What are implications of devolution on this set up, if any?*
4.	**How effective has been the role of PHDC in strengthening health services in the past? (Has it worked)?** *Probe: What are in-service training component achievements i.e. Objectives vs. outputs and target? Effects on services (positive and negative), Impact on service providers (preparedness)? Satisfaction with quality of outcomes, give examples?*
5.	**Do you think PHDC is working efficiently at present (activities plan as scheduled, in time, in line with budget, and managed efficiently)?** *Probe. On time? (disbursement and utilisation of funds, supplies, equipment etc) Do outputs justify costs (value for money)? Is TA appropriate (timely, adequate, needs based, quality)? Is support/logistics adequate (monitoring supervision, feedback, MIS, training and clinical support)? Integration/synergy with other programmes (government and donor). Management and institutional arrangements since devolution (Coordination)? Plans in place to support devolution? Are there other better options available based on past experience that can be replicated – best practices & innovations?*
6.	**Do you consider PHDC a sustainable intervention?** *Probe: Can the DoH sustain PHC effectively and efficiently? Dependence on donor support (TA), effects in post devolution scenario, initiatives/steps taken to support future activities (partnerships, networks and linkages)*
7.	**Do you think interventions of the PHDC i.e. trainings and research, has had any impact on overall health service delivery, if yes, how?** *Probe: What has happened as a result of the programme training/ research etc? has it impacted service delivery in health, effected quality of care. Progress with immediate outcomes? Roles of partners in realising outcomes?*

	Questions
8.	**What are the gaps/issues? What lesson can be learnt from implementation to date?** *Probe:* design stage, planning, operational and management levels
9.	**If you are asked to suggest solutions to the issues identified, what would they be, so as to make PHDC an important partner of the health deptt. in the future for guiding policy and improving/strengthening services?** *Probe:* for solutions at - planning, operational and management levels
10.	**Do you have any comments, suggestions to give?**

Tool 3: FGD Guideline for DHDC Key Staff and *PHDC Staff

	Questions
1.	**How long have you been working with the DHDC and in what capacity?** Probe: position, qualification and involvement in training programmes, if any.
2.	**Were you given any management training for capacity building with respect to your role in DHDC? If yes, what sort of training was given and for how long**? Probe: Regular refresher courses; Was the staff in your organization given any such training; Is it meeting the programme needs; How are the capacity building needs of the staff assessed and met; what technical assistance has been offered; has it made any difference;
3.	**Are you aware of any role played by PHDC in coordinating with DHDC programmes?** Probe: mechanisms and/or institutional arrangements; any records; mechanisms regarding alignment of development partners initiatives with health system; role of steering committees in decision making and implementation?
4.	**Do you have M&E system in place at DHDC? Is the information generated used for improving the institution's working or re designing the training component?** Probe: software used; how info is collected, who collects and analyse, consistency in data collection and dissemination techniques across the provinces; please give an example
5.	**How did PHDC strengthen the health service delivery system through DHDC?** Probe: for any assessments/research etc undertaken; any strategic planning exercises etc
6.	**Was there any skill enhancement activity done for healthcare providers at (BHU/RHC) by PHDC? What types of trainings were conducted?** Probe for type of need assessment done; Type of skills enhanced; EmOC, ENC and

	Questions
	IMNCI trainings; Days of trainings and schedule/manual followed; role of LHV as static vaccinator at RHC? etc
7.	**Was there any skill enhancement activity conducted for healthcare providers at DHQ/THQ by PHDC? What types of trainings were conducted?** Probe for type of need assessment done? Ask for any attachments at Teaching Hospitals for staff providing EmONC Services, Rotation of Postgraduate students at DHQ hospitals, Management Trainings for Doctors (one year courses), Post Graduate Trainings for Nurses (BSc Nursing), Essential Newborn Care (ENC), Competency Based Training on Emergency Obstetric Care EmONC Services , Integrated Management of Newborn & Child Hood Illness (IMNCI), Integrated Management of Pregnancy and Childbirth (IMPAC)
8.	**What are the monitoring mechanisms used by PHDC?** Probe: type of monitoring activities, frequency, participation in DHDC activities, feedback etc
9.	**How effective is the operationalization of PHDC in the past? (Has it worked)?** *Probe: Achievement of component outputs and objectives, on target? Changes in services (positive and negative), Impact on service providers (preparedness)? Satisfaction with quality of outcomes, give examples?*
10.	**What are the current issues facing the effective working of DHDC? What are the solutions?** *Probe:* for reasons - planning, operational level, and management level

** PHDC staff other than the section heads that were interviewed as key stakeholders*

Tool 4: Interview Guidelines for Key PHDC Staff

Name: _____. Designation: _____

Working on current position since: _____

Qualifications: _____

	Questions
1.	**Are you familiar with the concept behind PHDC?** *Probe: Does he/she know about the goal/objectives/role of PHDC?*
2.	**What role you play/played in PHDC?** *Probe: What are your inputs and/or support for improving this institution e.g. training, research etc?*

	Questions
3.	**Did you receive capacity building training e.g. subject specific, management or in training techniques for equipping you and enhancing your role in PHDC improvement? If yes, what sort of training was given and for how long?** *Probe: specialized trainings; Regular refresher courses; Was the staff in your organization given any such training; Is it meeting the programme needs; How are the capacity building needs of the staff assessed and met; what technical assistance has been offered; has it made any difference in improving PHDC environment;*
4.	**Is an effective PHDC important to the province? In what way and how** *Probe Does it meet the needs of health professionals? Undertake research relevant to country/provincial policies (PRSP & health policy), strategies, MDGs. Is the PHDC initial concept and design still relevant? Any implications of devolution?*
5.	**How effective has been the role of PHDC in the past in health sector development or strenthening? (Has it worked)?** *Probe: Achievement of objectives vs. outputs and target? Changes in health services status (positive and negative), Impact on service providers (preparedness)? Satisfaction with quality of services and outcomes, give examples?*
6.	**Are PHDC activities being implemented efficiently currently (timeliness, as per budget, and managed efficiently)?** *Probe. On time? (disbursement and utilisation of funds, supplies, equipment etc) Do outputs justify costs (value for money)? Is TA appropriate (timely, adequate, needs based, quality)? Is support/logistics adequate (monitoring supervision, feedback, MIS, training and clinical support)? Integration/synergy with other programmes (government and donor). Management and institutional arrangements since devolution (Coordination)? Plans in place to support to support devolution? Are there other better options – best practices & innovations?*
7.	**What is the role played by PHDC in coordinating with provincial health (vertical) programmes?** *Probe: mechanisms and/or institutional arrangements; any records; mechanisms regarding alignment of development partners initiatives with health system; role of steering committees in decision making and implementation?*
8.	**Has PHDC made any contributions towards strengthening the health service delivery system?** *Probe: for any assessments/research etc undertaken; any strategic planning exercises etc and by providing in service trainings of providers*
9.	**Did PHDC played any role in skill enhancement of healthcare providers at (BHU/RHC)? What types of trainings were conducted and how frequently?** *Probe for type of need assessment done; Type of skills enhanced; EmOC, ENC and IMNCI trainings; Days of trainings and schedule/manual followed; role of LHV as static vaccinator at RHC? Etc. post training follow up mechanisms, if any.*

	Questions
10.	**Was there any skill enhancement activity conducted for healthcare providers at DHQ/THQ by PHDC? What types of trainings were conducted?** *Probe for type of need assessment done? Ask for any attachments at Teaching Hospitals for staff providing EmONC Services, Rotation of Postgraduate students at DHQ hospitals, Management Trainings for Doctors (one year courses), Post Graduate Trainings for Nurses (BSc Nursing), Essential Newborn Care (ENC), Competency Based Training on Emergency Obstetric Care EmONC Services , Integrated Management of Newborn & Child Hood Illness (IMNCI), Integrated Management of Pregnancy and Childbirth (IMPAC)*
11.	**Do you think the programme has had an impact on overall health service delivery, if yes, what type and at which level?** *Probe: What has happened as a result of the programme training/ research etc? Progress with immediate outcomes? Roles of partners in realising outcomes?*
12.	**Do you consider PHDC to be a sustainable initiative?** *Probe: Can the DoH sustain PHC effectively and efficiently? Dependence on donor support (TA), impact of devolution, steps taken to support future activities (partnerships, networks and linkages)*
13.	**Do you M&E system in place for monitoring progress and identifying gaps?** *Probe: software used; consistency in data collection and dissemination techniques across the provinces; please give an example*
14.	**What lesson have been learnt to date?** *Probe:* at planning, operational and management levels
15.	**What are the current issues facing the effective working of PHDC? What are the solutions?** *Probe:* for reasons at - planning, operational and management levels
16.	**Did PHDC undertake any advocacy for resource mobilization and harmonization of support from other partners? If Yes, How and with whom** *Probe: linkages, partnerships*
17.	**Do you have any further comments, suggestions?**
18.	**Would you like to share any published and/or unpublished reports or information with the team?**

Tool 5: RATING SCALE TOOL (To be filled by the PHDC key staff only)

INTRODUCTION TO THE TOOL:

Dear Participant,

Kindly reply to the following questions in view of the legend provided (from 1 strongly disagree to 6 strongly agree). Section I consists of general information which is to be filled accordingly. Programme refers to PHDC.

SECTION I: ASSESSMENT QUESTIONS							
No		**1**	**2**	**3**	**4**	**5**	**6**
		STRONGLY DISAGREE	**DISAGREE**	**NEITHER AGREE OR DISAGREE**	**AGREE TO SOME EXTENT**	**AGREE**	**STRONGLY AGREE**
A	**PROGRAMME DESIGN**						
1	Outputs of the Programme describe solutions to identified needs and priorities						
2	The inputs and strategies are appropriate and achievable						
3	The external factors and assumptions are catered for and countered in Programme design						
4	The design of the Programme has the flexibility to incorporate the newer needs/demands as they emerged						
5	The inclusion/incorporation of the newer initiatives influenced the overall performance of the ongoing Programme activities.						
B	**PROGRAMME RELEVANCE**						
1	The Programme priorities and objectives are in alignment with government priorities and policies						
2	The outputs and outcomes contribute towards achievement of the ICPD goals and the MDGs						
3	Various gaps have been addressed, during the execution/implementation of various projects related activities						
C	**PROGRAMME MANAGEMENT**						
1	The Programme inputs (human, technical, and financial) have been used efficiently						
2	To improve efficiency, progress in management of various activities has been made (without compromising quality)						
3	The technical assistance offered is appropriate and adequate						

SECTION I: ASSESSMENT QUESTIONS							
No		1	2	3	4	5	6
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
4	The technical assistance provided, facilitates in improving the performance of implementing partners						
5	An appropriate monitoring system has been established						
6	Monitoring activities are conducted exclusively by the staff						
7	The work load of implementing partners duplicated or increased by the monitoring &/or supervisory activities						
8	Monitoring allows for adequate assessment of changes in risks and opportunities in the internal environments						
9	The M&E system captures Programme outputs and outcomes						
10	Monitoring contributes, in the progress and/or quality of the implementation of activities						
11	The M&E system facilitates effective program decision-making						
D	**PROGRAMME EFFECTIVENESS**						
1	The planned outputs and outcomes have been achieved satisfactorily						
2	The outputs and outcomes meet acceptable standards of quality						
3	The available data and indicators provide evidence regarding achievements of Programme outputs and outcome						
4	Sufficient evidence is produced & shared for Programme achievement						
E	**PROGRAMM EEFFICIENCY**						
1	The expected outputs justify the costs incurred						
2	Efforts have been made to address & overcome the overlap & duplication						
3	Improvement in quality of services/activities/intervention is included without compromising the cost						
4	Programme activities complement and synergize with interventions by other agencies						
F	**PROGRAMME IMPACT**						
1	The Programme is well on its way in achieving the desired outcomes through its specific projects/interventions						
2	Various activities of the programme contribute in terms of achieving the desired outcome/output.						

SECTION I: ASSESSMENT QUESTIONS							
No		1	2	3	4	5	6
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
G	**PROGRAMME SUSTAINABILITY**						
1	The DoH programmes/projects have an in-built strategy /mechanism for supporting PHDC						
2	Programme activities are integrated into current activities/practices of counterpart institutions/programmes						
3	The resources have been efficiently allocated						
4	The programme has built partnerships with other government agencies and partners for the effective implementation						
5	There is substantial return from the investment in equipment (e.g. medical equipment, furniture, ICT equipment, etc)						

Section II: Cross -cutting issues							
		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE TO SOME EXTENT	AGREE	STRONGLY AGREE
		1	2	3	4	5	6
A	**Management, Governance, Institutional Links, Finance and Partnerships**						
1	Management and governance mechanisms are in place for the implementation of PHDC activities at provincial and district levels						
2	PHDC builds on partnerships and collaboration (integration and linkages) with other government and non-government partners to enhance outputs and outcome						
3	The Programme is able to meet specific targets including integration and linkages with other Programmes at strategic level and downward to implementation level						
4	PHDC can be viewed as value for money						
5	PHDC builds on coordination and linkages with vertical programmes such as EPI,LHW and Population welfare programme						

B	**Monitoring and Evaluation**						
1	Evidence exists to show that objectives have been achieved						
2	The capacity of key PHDC staff been strengthened for their monitoring and evaluation role						
C	**Innovations**						
1	Innovations introduced have a potential for scaling up and replication						
D	**Lessons Learnt**						
1	Lessons learnt have been well documented throughout the programme so far						

Annex 5: Financial Allocations and Expenditure

BUDGET & EXPENDITURE REPORT FOR 03 YEARS (2010-11 TO 2012-13) OF PROVINCIAL HEALTH DEVELOPMENT CENTRE, JAMSHORO

1) Department: **Health Department**
2) Grant No. and Name: Grant No:024, "SC21024-09-EDUCATION (Medical Colleges / Schools)"
3) Functional Classification: Under Head of Account 09 Education Affairs & Services, 093102 Professionals / Tech: Univesities,**HD-4087** PHDC / Hostel, Hyderabad
4) Budget Type: **Permenent / Regular** S.N.E **X**

(05)	(06)	(07)		(08)	(09)	(10)	(11)	(12)	(13)
Object Code	Object Classification	BPS & No: of Posts		Budget Estimate (Revised)	Actual Expenditure	Budget Estimate (Revised)	Actual Expenditure	Budget Estimate (Revised)	Actual Expenditure
		BPS	# of Post	2010-11	2010-11	2011-12	2011-12	2012-13	2012-13
A01	Total Employee Related Expenses	-		**12,863,000**	**10,951,447**	**17,285,300**	**16,559,240**	**18,951,200**	**18,332,436**
A011	**TOTAL PAY**	-	**44**	**5,258,000**	**4,453,468**	**7,955,500**	**8,241,983**	**9,477,300**	**8,492,553**
A011-1	**TOTAL Pay of Officers**	-	**15**	**3,708,000**	**3,225,592**	**5,755,500**	**6,041,403**	**6,938,600**	**6,223,833**
A01101	**TOTAL Basic Pay of Officers**	-	**15**	**3,700,000**	**3,220,412**	**5,750,000**	**6,037,803**	**6,924,000**	**6,201,233**
P123	Project Director	20	1						
A826	Addl: Program Director	19	1						
P115	Program Director (H-EDU)	19	1						
P116	Program Director (HSR)	19	1						
H083	Hospital Admn Trainer	18	1						
P031	PHC Management Trainer	18	1						
A069	Admn: Cum Accounts Officer	17	1						
H057	Health Education Trainer	17	1	3,700,000	3,220,412	5,750,000	6,037,803	6,924,000	6,201,233
H058	Health Educator	17	1						
N010	N.E Research Officer	17	1						
R045	Research Officer	17	2						
T063	Trainer M.O. Clinical	17	1						
L058	Librarian	16	1						
S236	Superintendent	16	1						
A01102	Personal Pay	-	-	8,000	5,180	5,500	3,600	14,600	22,600
A011-2	**TOTAL Pay of Other Staff**	-	**29**	**1,550,000**	**1,227,876**	**2,200,000**	**2,200,580**	**2,538,700**	**2,268,720**
A01151	**TOTAL B. Pay of Other Staff**	-	**29**	**1,550,000**	**1,227,876**	**2,200,000**	**2,200,580**	**2,538,700**	**2,268,720**
C146	Computer Operator	12	1						
C147	Computer Operator / Typist	12	2						
D026	Data Processing Assistant	12	1						
A020	Accountant	11	1						
A119	Assistant	11	1						
H089	House Keeper	09	2						
J014	Junior Clerk	07	1						
E021	Electrician	06	1						
S206	Store Keeper	06	1						
T022	Telephone Operator	06	1	1,550,000	1,227,876	2,200,000	2,200,580	2,538,700	2,268,720
D161	Driver	04	2						
B015	Bearer	01	2						
C089	Chowkidar	01	3						
C167	Cook	01	2						
M022	Mali	01	1						
N003	Naib Qasid	01	3						
P061	Plumber	01	1						
S008	Sanitary Worker	01	3						
A01152	Personal Pay	-	-	-	-	-	-	-	-

Contd.....P -2

(05)	(06)	(07)		(08)	(09)	(10)	(11)	(12)	(13)
A012	**TOTAL ALLOWANCES**	-	-	**7,605,000**	**6,497,979**	**9,329,800**	**8,317,257**	**9,473,900**	**9,839,883**
A012-1	**TOTAL Regular Allowances**	-	-	**7,355,000**	**6,448,229**	**9,129,800**	**8,121,614**	**9,273,900**	**9,639,883**
A01202	House Rent Allowance	-	-	1,300,000	1,100,744	1,400,000	1,297,895	1,442,300	1,292,298
A01203	Conveyance Allowance	-	-	500,000	461,195	705,000	644,700	1,384,700	1,238,249
A01204	Sumptuary Allowance	-	-	-	-	5,000	-	-	-
A01205	Dearness Allowance	-	-	500,000	418,235	28,000	18,645	-	-
A01207	Washing Allowance	-	-	4,000	3,536	14,000	12,500	14,900	13,200
A01208	Dress Allowance	-	-	2,000	-	-	-	-	-
A01209	Special Additional Allowance	-	-	225,000	183,842	11,600	7,750	-	-
A0120D	Integrated Allowance	-	-	5,400	5,250	15,000	10,800	12,200	10,800
A0120P	Adhoc Relief 2009	-	-	774,000	724,305	238,400	185,630	-	-
A0120X	Adhoc Allowance (50%F)	-	-	2,355,000	2,119,357	2,700,000	2,553,156	2,803,600	2,495,569
A01217	Medical Allowance	-	-	761,200	681,306	850,000	791,367	900,700	801,716
A0121A	Adhoc Allowance 2011 (15%F)	-	-	-	-	800,000	655,251	840,700	748,364
A0121B	Health Professional Allowance	-	-	-	-	1,450,000	1,290,000	-	1,360,968
A0121M	Adhoc Relief Allow: 2012 (20%R)	-	-	-	-	-	-	1,828,900	1,654,123
A01224	Entertainment Allowance	-	-	25,000	19,516	40,000	29,500	25,600	23,048
A01225	Instruction Allowance	-	-	-	-	-	-	-	-
A01226	Computer Allowance	-	-	27,000	18,000	27,000	18,000	20,300	18,000
A01239	Special Allowance	-	-	3,500	-	-	-	-	-
A01244	Adhoc Relief	-	-	410,700	327,508	22,900	15,255	-	-
A01252	Non Practicing Allow:	-	-	62,200	55,177	800,000	575,910	-	(16,452)
A01262	Special Relief Allowance	-	-	400,000	330,258	22,900	15,255	-	-
A012-2	**Total Other Allowances**	-	-	**250,000**	**49,750**	**200,000**	**195,643**	**200,000**	**200,000**
A012273	Honouraria	-	-	50,000	-	-	-	-	-
A012274	Medical Charges	-	-	200,000	49,750	200,000	195,643	200,000	200,000

(05)	(06)	(07)		(08)	(09)	(10)	(11)	(12)	(13)
HD4087	**TOTAL NON SALARY**	-	-	**3,317,100**	**2,257,318**	**3,454,100**	**2,270,322**	**3,230,200**	**2,571,040**
A03	**TOTAL OPERATING EXPENSES**	-	-	**2,214,700**	**1,566,228**	**2,323,100**	**1,639,922**	**2,266,400**	**1,935,745**
A032	**TOTAL Communication**	-	-	**101,000**	**101,000**	**110,000**	**86,700**	**95,000**	**76,750**
A03201	Postage & Telegraph	-	-	25,000	25,000	25,000	7,870	10,000	-
A03202	Telephone & Trunck Calls	-	-	76,000	76,000	85,000	78,830	85,000	76,750
A033	**TOTAL Utilities**	-	-	**775,000**	**369,534**	**790,000**	**204,922**	**790,000**	**508,631**
A03301	Gas	-	-	50,000	30,030	50,000	22,920	50,000	50,000
A03302	Water	-	-	25,000	24,980	40,000	40,000	40,000	31,200
A03303	Electricity	-	-	700,000	314,524	700,000	142,002	700,000	427,431
A034	**TOTAL Occupancy Cost**	-	-	**50,000**	**9,200**	**20,000**	-	**20,000**	-
A03407	Rates & Taxes	-	-	50,000	9,200	20,000	-	20,000	-
A038	**TOTAL Travel & Transp:**	-	-	**354,900**	**354,900**	**322,600**	**296,661**	**296,100**	**296,100**
A03805	Travelling Allowance	-	-	82,100	82,100	94,000	94,000	99,100	99,100
A03806	Transportation of Goods	-	-	10,000	10,000	10,500	4,700	12,100	12,100
A03807	P.O.L. Charges	-	-	152,800	152,800	168,100	160,406	184,900	184,900
A03809	C.N.G. Charges	-	-	110,000	110,000	50,000	37,555	-	-
A039	**TOTAL General**	-	-	**933,800**	**731,594**	**1,080,500**	**1,051,639**	**1,065,300**	**1,054,264**
A03901	Stationery	-	-	44,800	44,800	47,500	47,325	49,900	49,227
A03902	Printing & Publication	-	-	35,000	35,000	37,000	17,500	38,900	38,900
A03905	News Paper, Periodical & Books	-	-	100,000	100,000	110,000	107,754	115,500	115,500
A03906	Uniform & Proctative Clothing	-	-	100,000	100,000	110,000	103,060	92,400	84,940
A03970	**TOTAL OTHERS**	-	-	**654,000**	**451,794**	**776,000**	**776,000**	**768,600**	**765,697**
1	Others	-	-	154,000	154,000	176,000	176,000	138,600	135,697
184	TRAINING & RESEARCH	-	-	500,000	297,794	600,000	600,000	630,000	630,000
A05	**TOTAL Grants Subsides & Write Off Loans**		-	**400,000**	-	**500,000**	-	**200,000**	-
A052	**TOTAL Grants-Domestic**	-	-	**400,000**	-	**500,000**	-	**200,000**	-
A05216	Fin. Assis. To the families of Govt.....	-	-	400,000	-	500,000	-	200,000	-
A09	**TOTAL PHYSICAL ASSETS**	-	-	**356,000**	**354,300**	**256,000**	**255,600**	**370,000**	**249,600**
A092	**TOTAL Computer Equipments**	-	-	**146,000**	**144,300**	**91,000**	**90,800**	**150,000**	**150,000**
A09201	Hardware	-	-	146,000	144,300	91,000	90,800	150,000	150,000
20	Two Laser Printer	-	-	40,000	39,000	-	-	-	-
31	Two UPS Backup 15 minutes	-	-	11,000	10,800	-	-	-	-
6	Two Computer Pentium IV	-	-	95,000	94,500	-	-	-	-
44	One Laptop	-	-	-	-	91,000	90,800	-	-
18	Four Laser Printer	-	-	-	-	-	-	60,000	60,000
372	Three Computer Pentium IV	-	-	-	-	-	-	90,000	90,000
A095	**TOTAL Pur: of Transport**	-	-	-	-	**65,000**	**65,000**	-	-
A09501	**Transport**	-	-	-	-	**65,000**	**65,000**	-	-
193	One Motorcycle (70cc)	-	-	-	-	65,000	65,000	-	-
A096	**TOTAL Purchase of Plant & Mach:**	-	-	**60,000**	**60,000**	-	-	**120,000**	**99,600**
A09601	Plant & Machinery	-	-	60,000	60,000	-	-	120,000	99,600
10	One Photo Copier	-	-	-	-	-	-	120,000	99,600
257	One Split AC 2.0 Ton	-	-	60,000	60,000	-	-	-	-

Contd.....P -4

(05)	(06)	(07)		(08)	(09)	(10)	(11)	(12)	(13)
A097	**TOTAL** Purchase of Furniture & Fixture	-	-	**150,000**	**150,000**	**100,000**	**99,800**	**100,000**	-
A09701	Furniture & Fixture	-	-	150,000	150,000	100,000	99,800	100,000	-
001	Furniture & Fixture	-	-	150,000	150,000	100,000	99,800	100,000	-
A13	**TOTAL REPAIR & MAINTENANCE**		-	**346,400**	**336,790**	**375,000**	**374,800**	**393,800**	**385,695**
A13001	**TOTAL Transport**	-	-	**146,400**	**146,400**	**165,000**	**165,000**	**173,300**	**165,195**
A13001	Transport	-	-	146,400	146,400	165,000	165,000	173,300	165,195
A131	**TOTAL Machinery & Equip:**	-	-	**100,000**	**90,390**	**110,000**	**110,000**	**115,500**	**115,500**
A13101	Machinery	-	-	100,000	90,390	110,000	110,000	115,500	115,500
A132	**TOTAL Furniture & Fixture**	-	-	**100,000**	**100,000**	**100,000**	**99,800**	**105,000**	**105,000**
A13201	Furniture	-	-	100,000	100,000	100,000	99,800	105,000	105,000
HD4087	**GRAND TOTAL**	-	44	**16,180,100**	**13,208,765**	**20,739,400**	**18,829,562**	**22,181,400**	**20,903,476**

Signed

Name (Dr. Versi Mal)

Designation PROJECT DIRECTOR
PHDC-Sindh, Jamshoro

Telephone No: PHONE NO.....022-3878228
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Annex 6: Human Resource Assessment Template

Institution Name:

No of Employees:

Rank the Skills Required as follows: 1 = Qualified, 2 = Some basic skills, 3 = Inadequate

Name	Qualification	Key Skills in specific training Area/ Job role	Priority Ranking	Number of staff in Specific area	Training needs and skills deficiencies

Annex 7: Equipping a Training Center

This list assumes that the center has two full-time staff, one training coordinator and one assistant, but no in-house trainers in addition to the Director/Officer Incharge. It also assumes that the center has at least 2-3 training rooms with each having capacity of 30-35 people, at least three offices for staff, one storage/supply room, and one reception area with two restrooms attached to each training room, one for men and one for women.

Recommended Items for Office, Reception Area, and Storage/Supply Room

Technology

- ☐ Computers
- ☐ Printers
- ☐ Phones
- ☐ Copier
- ☐ Fax machine
- ☐ Camera (digital camera preferred)
- ☐ Extensión cords
- ☐ Surge protectors for the computers

Furniture

- ☐ Desks
- ☐ Chairs
- ☐ Front desk for the reception area
- ☐ Sofa for the reception area
- ☐ Table for the reception area
- ☐ Message boards for the reception area
- ☐ File cabinets
- ☐ Bookshelves
- ☐ Lamps

Office Supplies

- ☐ Pens, pencils and markers
- ☐ Pads and notebooks
- ☐ Paper for printing and photo copying
- ☐ Blank disks and CD ROMs
- ☐ Envelopes
- ☐ Blank labels
- ☐ Staplers
- ☐ Tapes
- ☐ Paper clips
- ☐ Scissors
- ☐ Country map
- ☐ Calendar (preferably for the wall)

If the center develops training materials on site, it will also need:

- ☐ Three-hole paper punch (for preparing training materials)
- ☐ Heavy duty staplers
- ☐ Binders (see the section of “suggested materials for participants”)
- ☐ Binding machine

Recommended Items for Training Room (with a capacity of 30-35 persons)

Audio-Visual Equipment

- ☐ Slide projector (with carousel)
- ☐ Overhead projector
- ☐ Laptop computer
- ☐ LCD projector
- ☐ TV for showing video
- ☐ DVD Player
- ☐ Laser pointer (or a long stick for pointing)
- ☐ Microphone, if appropriate for room size (wireless preferred)
- ☐ Amplifier or speaker (for microphone)
- ☐ Projection screen (or clear and flat white wall)
- ☐ Extension cords

Furniture and Room Specifications

- ☐ (10-15) Tables
  (ideally, rectangular-shaped portable tables to accommodate different training formats; number of tables depends on size of the tables)
- ☐ (40) Comfortable chairs
- ☐ (1) Podium or table for speakers
- ☐ (1) Stand or table for projector
- ☐ (1) Clock
- ☐ Adequate ventilation and temperature
- ☐ Blinds or curtains for windows
- ☐ Adequate light
- ☐ Electricity outlets

Office Supplies

- ☐ Large white board (or blackboard)
- ☐ Several white board markers (or chalk for blackboard)
- ☐ Several flip charts (good to have a stock of them in case of a power outage)
- ☐ Several flip chart markers
- ☐ Easel or other stand for flip chart
- ☐ Several adhesive tapes for flip charts

Notes:

1) Access to a restroom is important.
2) A water dispenser is a nice item to have. If there is no water dispenser, bottled water can be offered to the participants.