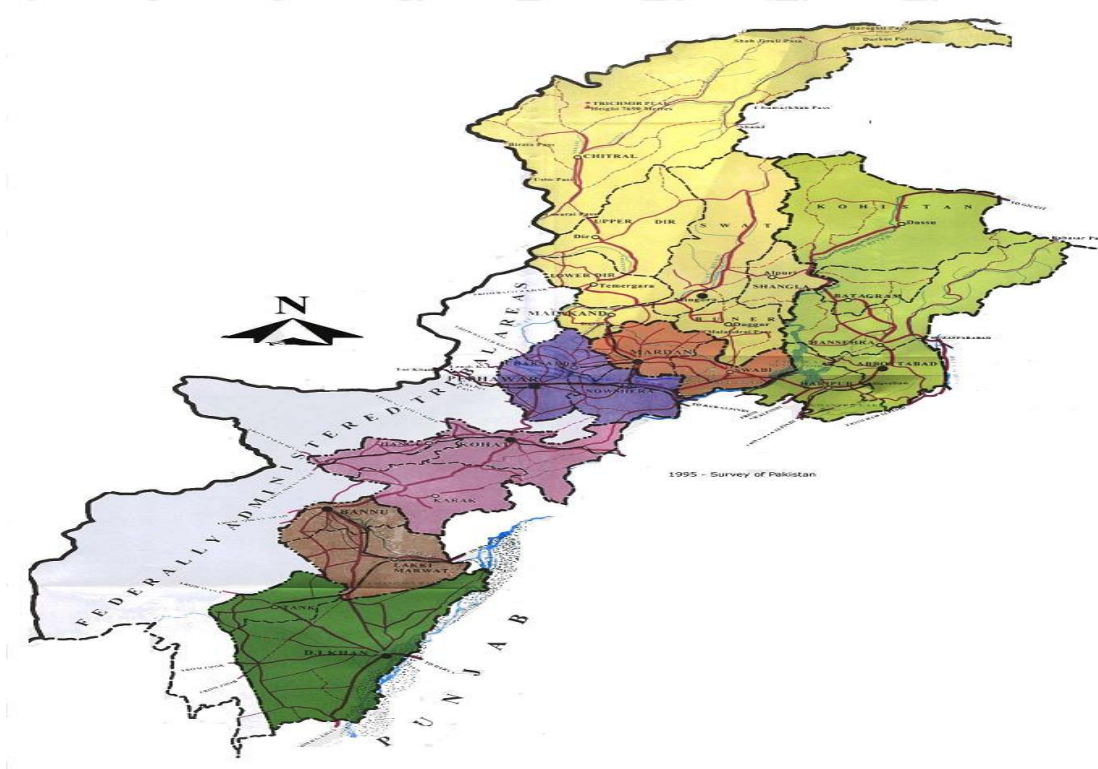


Government of Khyber Pakhtunkhwa Health Department



Integrated PC-1

**Integration of Health Service Delivery with Special
Focus on MNCH, LHW, EPI and Nutrition Program
(Aus-Aid& DFID Assisted) (PSDP: 6594.000**

Provincial: 7332.000, Donor: 8925.66)

ADP # 172/120888 (2013-14)

Estimated Cost: Rs: 22,851.457 Million



PC-I Performa

1.	Name of the Project	Integration of Health Service Delivery with Special Focus on MNCH, LHW, and Nutrition Programme (Aus-Aid& DFID Assisted) (PSDP: 6594.00, Provincial: 7332.00, Donor: 8925.66 ADP # 172/120888 (2013-14))
2.	Location	Khyber Pakhtunkhwa
3.	Authority responsible for:	Health Department, Khyber Pakhtunkhwa
i.	Sponsoring	Federal Government, Government of Khyber Pakhtunkhwa, DFID, Aus-AID
ii.	Execution	Health Department, GoKP
iii.	Operation and maintenance	Health Department, GoKP
iv.	Concerned Federal Ministry	Ministry of National Health Service Regulation and Coordination of Pakistan
4.	a. Plan Provision	
	(i) If the project is included in the current Five Year Plan specifies actual allocation.	<p>These federal vertical programmes, in post devolution scenario, are being integrated i.e. National Programme for PHC and FP (LHWP), National Maternal, Newborn and Child Health (MNCH) and Expanded Programme on Immunization (EPI) were included in the Ten-Year Perspective Development Plan 2001-11 and Medium Term Development Framework 2005-10. In addition, these being also identified as major health sector interventions under PRSP I and II. Government of Pakistan, signatory to the Millennium Declaration 2000 is also committed to meet targets set under goals 1, 4, 5 and 6. The integrated efforts under these programmes will help the GoKP in achieving health imperatives laid out in Vision 2030¹ and the three key health & nutrition sector reforms (Reduce micronutrient deficiencies, value for money and reduce fertility) laid out in the Economic Growth Framework announced by the Planning Commission in May 2012².</p> <p>The project is reflected in the Annual Development Plan of Khyber Pakhtunkhwa 2012-13 for integrated PC-1, envisaged under the Health Sector Strategy 2010-2017. Additionally, project will be funded through Federal PSDP share of KP for relevant vertical programmes and Donor funds (DFID and Aus-Aid)</p>

¹Pakistan in the 21st Century: Vision 2030, Planning Commission, Govt. of Pakistan

²Pakistan: Framework for Economic Growth, 2012, Planning Commission, Govt. of Pakistan

	(ii) If not included in the current Plan how it is now proposed to be accommodated (Inter/intra sect-oral adjustments in allocation or other resources may be indicated).	N/A
	iii) If the project is proposed to be financed out of block provision for a program, indicate.	<p>After 18th constitutional amendment, the Federal Government committed to continue funding for all vertical national health programmes till announcement of the next National Finance Commission Award.</p> <p>These federal vertical programmes, in post devolution scenario, are being integrated i.e. National Programme for PHC and FP (LHWP), National Maternal, Newborn and Child Health (MNCH) and Expanded Programme on Immunization (EPI) were included in the Ten-Year Perspective Development Plan 2001-11 and Medium Term Development Framework 2005-10. In addition, these being also identified as major health sector interventions under PRSP I and II. Government of Pakistan, signatory to the Millennium Declaration 2000 is also committed to meet targets set under goals 1, 4, 5 and 6. The integrated efforts under these programmes will help the GoKP in achieving health imperatives laid out in Vision 2030³ and the three key health & nutrition sector reforms (Reduce micronutrient deficiencies, value for money and reduce fertility) laid out in the Economic Growth Framework announced by the Planning Commission in May 2012⁴.</p> <p>The Integrated PC-1 will have share from federal funds i.e. share from PSDP, Provincial ADP and donor funding will also be available in the form of grants, results based aid and technical assistance to fill the gaps in implementation of these programmes.</p> <p>Federal Share (PSDP) up till 2012-17:</p> <p>National Programme for PHC and FP Rs.10181.88Million;</p> <p>MNCH ProgrammeRs.1486.546 Million</p> <p>EPI Rs. 1247.01 Million (EPI+GAVI HSS)</p>

³Pakistan in the 21st Century:Vision 2030, Planning Commission , Govt. of Pakistan

⁴Pakistan: Framework for Economic Growth, 2012, Planning Commission , Govt. of Pakistan

		Khyber Pakhtunkhwa ADP: Rs.7332.00 Million (FY 2012-13) Donor: DFID: GBP 40 million (PKR:6920.2 Million) @ conversion rate GBP 1.00= PKR 173.005 Aus-AID: Australian \$ 20 million (PKR:2005.46 Million @ conversion rate Australian \$ 1.00= PKR: 100.273)	
Total Block Provision from PSDP as Provincial Share for 3 programs	Amount Already Committed	Amount Utilized so far	Balance Available
	Rs.12703.12 Million		
	Amount Proposed for this Project Rs: 22,851.457 Million	N/A	N/A

5.	Project objectives and its relationship with Sectoral Objectives	<p>BACKGROUND:</p> <p>INTERNATIONAL AND CONSTITUTIONAL PERSPECTIVE:</p> <p>The Constitution of Pakistan guarantees that all citizens are equal before the law. It also empowers the state to make <i>special provisions for the protection of women and children and the vulnerable sections of the society</i> (Articles 25, 27, 34, 35 and 37). In addition, Pakistan is also obligated to fulfill a number of <i>International commitments</i> being signatory to international declarations and conventions including Millennium Summit 2000: which commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women; World Summit for Children: committed to improve the well-being of children worldwide; <i>the Programme of Action agreed at the International Conference on Population and Development</i>; <i>the Beijing Declaration and Platform for Action agreed at the Fourth World Conference on Women</i>: which highlights reproductive health rights of women; <i>the ECOSOC Ministerial Review on Global Health</i> further strengthens the commitments made at the ICPD and Millennium Summit; UNGA side session, “Healthy Women, Healthy Children: Investing in Our Common Future. The International Human Rights Council has also recently adopted a specific resolution on maternal mortality.</p> <p>Investing more in women’s and children’s health is not only the right thing to do; it also builds stable, peaceful and productive societies. Evidence from many countries confirms that increasing investments in health of women and children has many benefits i.e. it reduces poverty, stimulates economic productivity and growth, cost-effective, helps women and children realize their fundamental human rights. In addition, the <u>“Global Strategy for Women's and Children's health”, recommends integrated package of essential interventions and services for women and children delivered through functioning health systems, is more likely to enhance coverage compared to vertical or piecemeal interventions.</u></p> <p>PRE DEVOLUTION (18th Amendment) SITUATION:</p> <p>Pakistan has a long history of implementing vertical programmes in the health sector, most of which have or had originated as a result of similar global initiatives e.g. Malaria Eradication Programme (later changed to Malaria Control Programme) in the 1950’s to Hepatitis Prevention and Control Programme in 2000’s. Some of these programmes continue to run as vertical programmes e.g. Malaria Control Programmes, others have closed successfully (Smallpox eradication programme) or unsuccessfully (TB Control Programme was closed in 1980’s but reinitiated with new strategy in early 2000’s) and some of these programmes overtime have been more or less integrated in health care delivery system. Despite being run as vertical, most of the programmes have always been considered part of the health system.</p> <p>In context of Pakistan’s development system (how PC-1s were</p>
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developed) - some were termed umbrella projects (EPI & LHW programme) and some were called comprehensive projects (separate provincial PC-1 with national PC1 for federal functions (HIV/AIDS). On the basis of this explanation, the currently implemented vertical programmes can be classified into following categories;

- a) Truly vertical programmes which continued to be run and financed vertically – National Programme for PHC and FP (LHWs) programme, with very little or no provincial financing,
- b) Partially vertical programmes, which either have been provincialized or de-federalized (Malaria Control program; EPI, Population Welfare) with provincial financing of the programmes through either development or recurrent budget,
- c) Partially vertical programmes which have been conceived as provincial programmes with federal functions limited to policy and stewardships (HIV/AIDS and TB Control programmes) – a critical feature which differentiates these programmes being major provincial contribution towards financing of the programmes,
- d) Provincial vertical programmes which are run and financed vertically but are province specific e.g. Thalassemia control programme being such a case.

It has been observed that Vertical approach leads to

- Duplications of services resulting in Inefficiency of resources in terms of human resource, finances, time and logistics etc.
- Uniformity of services is not ensured as different vertical programmes are in different phases of implementation and focused on different geographic areas/target population.
- Quality of care is compromised.

All the above factors lead to fragmented & weak health system.

The Advantages and disadvantages of vertical approach are summarized in the following table:

Table 1: Vertical Approach - Opportunities and Challenges

Opportunities	Challenges
Rapid specialized response to health needs	Cost- and time-effective to generate information pertaining to general health indicators
Effective surveillance systems, particularly under EPI and HIV/AIDS control program	Do not enjoy sustainability as do not enjoy support from the general health system
Successful in generating information for population-specific or controversial diseases such HIV/AIDS	Structural fragmentation and discoordination at all levels which results in duplication of efforts and services and creation of parallel structures within the health system
Enjoy clarity about budgets and roles	Direct financial, program and technical

		and responsibilities and therefore possess more transparent governance arrangements and clearer lines of accountability	resources from other significant general health problems and populations	
		Enjoy large amounts of donor funding due to rapid response, high profile and better accountability and transparency	Recently donors have been recognizing the merit of funding government run general health systems to improvement overall environment	
		Staff enjoy better salary and incentives	Duplication of services and specialization may lead to waste, overburdening of staff for instance through multiple reporting structures.	
		Healthcare providers are skilled in disease specific management and can provide respective services and technologies	Duplication of communication and advocacy across programmes, such as awareness raising on HIV/AIDS, safe sex and safe blood transfusion	
		In an overall weak information base, vertical programmes have stronger mentoring and evaluation and HIS, such as the LHW program	Sustainability may become difficult, or even impossible, if donor funding ceases.	
		Better chances of success in states in conflict as well as those with weak health since delivery of at least selected priority services is ensured	Vertical programmes can create interest groups which may show resistance to reforms aimed at integration. Moreover, vertical programmes discourage comprehensive development approaches	
		<p>Post Devolution Scenario:</p> <p>The 18th Amendment to the Constitution provided a number of opportunities to the provinces. On strategic side, it meant taking on responsibility of all functions of the health sector, including those previously performed by the Ministry of Health i.e. policy, planning, management, implementation, disease surveillance and evaluation. While on the financial front under the new NFC Award, it provided much needed additional <i>fiscal space</i> to the provinces to increase investments in the social sector by defining their own priorities and targets.</p> <p>Under the new situation, Health Department, Khyber Pakhtunkhwa aims at maximizing health outcomes by developing vibrant policies and launching initiatives, relevant within local context. It also aims to make all efforts for creating synergies between public and private sectors for enhancing coverage while avoiding duplication in service provision. In addition, Government of KP is taking steps to improve the governance in health sector by reviewing “Rules of Business” & “Organizational structure” of Health department in accordance with the newly assigned roles of stewardship, regulation of health service provision, managing innovations in the financing mechanisms for health care provision etc.</p>		

	<p>Promulgation of Khyber Pakhtunkhwa Local Government Act 2012</p> <p>Following are the health related decision in pursuance of the above said ordinance;</p> <ul style="list-style-type: none"> • The district set of government departments will stand segregated from local government institutions established under the Khyber Pakhtunkhwa Local Government Ordinance 2001 and shall re align with their administrative departments at provincial level under the new Act, • The position of EDO at district level shall stand abolished, • Health Department at district level shall be reorganized under the District Health Officers (DHOs) assisted by the Deputy District Health Officers (DDHOs) and Coordinators. <p>Planning Commission Decision:</p> <p>The Planning Commission vide its letter No. 6(86) HPC/2012-Vol-IV dated 23rd July, 2012, has enhanced the share of the provinces (Annex - 1).</p> <p>Relevance of the Project to Health Sector Strategy (2010-2017):</p> <p>The Health Department, Khyber Pakhtunkhwa using guidance from Compressive Development Strategy (CDS), developed the <i>Health Sector Strategy 2010-17(HSS)</i>, which aims to contribute towards achieving targets set under MDG Goals 1, 4, 5 and 6 by 2015. The Health Sector Strategy provides the necessary opportunity and space to the health department for realizing the dream of having fully functional health systems that is geared at meeting the needs of the population. Using integrated approach for service delivery, it aims to improve the health outcomes, especially among women and children, by enhancing coverage and access to essential health services for the poor and vulnerable by developing and implementing a <i>Minimum Health Service Delivery Package (MHSDP)</i> at Primary Health Care level for a measurable reduction in morbidity and mortality.</p> <p>Within the above preview, the integrated PC-1 being developed aims to translate into action the vision of HSS by improving the maternal and child health outcomes among the population.</p> <p>The project is contributing to the goals, objectives and targets of Health sector strategy which are as under;</p> <p>GOAL:</p> <p>To improve the health status of the population in the province through ensuring access to a high quality, responsive healthcare delivery system which provides acceptable and affordable services in an equitable manner.</p>
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		<p>HSS Outcome:</p> <ul style="list-style-type: none"> • Enhanced coverage and access to minimum health services especially for the poor and vulnerable • A measurable reduction in morbidity and mortality rates due to common preventable diseases especially among women and children • Improved Human resource management • Improved Governance and Accountability. • Improved Regulation and Quality Assurance. <p>General Objective:</p> <p>In view of the areas outlined under the Health Sector Strategy, the PC-1 objective is “to integrate vertical programmes (LHW, MNCH, EPI and Nutrition) to enhance coverage and access to effective and quality maternal neonatal and child health services including nutrition with the strong focus on value for money and efficiency, especially for the poor and vulnerable”.</p> <p><u>Specific Objectives:</u></p> <ul style="list-style-type: none"> • To improve Access to RMNCH and Nutrition services of MHSDP at outreach level • To improve Access to RMNCH and Nutrition services of MHSDP at Primary care facility level • To improve Access to Maternal, newborn, child health and nutrition interventions at Secondary care level • To integrate and strengthen programme management at provincial and district level • To introduce integrated Monitoring & Evaluation and Surveillance Systems for evidence based decision making through use of good quality data. <p>The above objective will contribute towards achievement of the following performance targets envisaged in the HSS;</p> <ol style="list-style-type: none"> 1. Reduce the maternal mortality rate from 275/100,000 to 200/100,000 live births. 2. Increase CPR from 25%⁵ to 40%. 3. Increase skilled birth attended deliveries from 41% to 55%. 4. Reduce the infant mortality rate from 63/1000 to 50/ 1000 live births with emphasis on reducing newborn deaths. 5. Reduction in prevalence of stunting from 69.5% to 55% in children under 5 years old i.e. from 37% to 27% through use of nutrition intervention programmes. 6. Increase exclusive breastfeeding to 75% from current levels of 45% in rural and 35% in urban areas. 7. 90% of children under five would have received appropriately timed Vitamin A supplementation.
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⁵ PDHS 2006-7

		<p>8. An increase in coverage of fully immunized children aged 12-23 months from 68% to above 90%.</p> <p>9. An increase in TT-2 immunization coverage amongst pregnant female from 64% to 80%.</p>
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6.	Description, justification and technical parameters	<p>The recent natural and manmade disasters in Pakistan including 2010 and 2011 floods and War on Terror have had a tremendous impact on Khyber Pakhtunkhwa (KP) province in general and health sector in particular. The overall health situation in general and maternal and child health in particular is still far below desirable levels despite having shown progress on key MNCH indicators in comparison to other provinces over the past decade.</p> <p>The population of the province have suffered tremendously from natural and manmade disaster over the last decade; earthquake, militancy, IDPs & floods etc. which have claimed the lives of thousands of innocent citizens, mass destruction of physical infrastructure especially schools and health facilities resulting in mass displacement of population. All these calamities, natural or otherwise, have had considerable negative impact on the health status of the population of KP.</p> <p>Further, the recent disasters have seriously impeded progress across all MDG targets, especially those related to MDG 1, 4, 5 and 6. The impact of disasters, compounded by socio-political and economic instability resulted in increased marginalization of women and children especially access to services. In this backdrop and existing patriarchal structure of society, women's education and health continue to remain neglected with gender disparity clearly visible almost across all MDG indicators⁶.</p> <p>The GOKP sees 18th Amendment to the Constitution as an opportunity for the health sector not only to develop capacity to discharge newly assigned roles and responsibilities of policy and planning, but also to deliver primary and preventive health care intervention using integrated and cost effective approaches as opposed to continuing with vertical programmes, thereby shifting priorities from curative care/ private goods to predominantly primary and preventive health care/ public goods.</p> <p>Within this context, Health Department, KP long before announcement of 18th Amendment, had initiated a series of reforms including;</p> <ul style="list-style-type: none"> • improving quality of health care services: <ul style="list-style-type: none"> ○ Introduction of quality standards at Primary and secondary level. ○ Baseline survey for assessment of Quality of Care at Primary and secondary standards.
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⁶Khyber Pakhtunkhwa Millennium Development Goals report. United Nations Development Programme. October 27th, 2011. <<http://undp.org.pk/khyber-pakhtunkhwa-government-and-undp-release-first-ever-millennium-development-goals-report.html>>

		<ul style="list-style-type: none"> ○ Approval of quality strategy. ○ Development of Reference manual for Primary and secondary care. ○ Implementation of Quality standards through IQHCS project. ● Public Private Partnership: <ul style="list-style-type: none"> ○ Contracting out 17 districts to PPHI districts ○ Using innovative approaches i.e. contracting out service delivery after competitive selection at the primary level to non government organizations. ● Strengthening of Governance and regulation: <ul style="list-style-type: none"> ○ Establishment of the Health Regulatory Authority in 2002 ○ Strengthening of drug regulation etc. ○ Restructuring of the health department and defining key roles, responsibilities and functions at all levels to improve efficiency. ○ strengthening of M &E systems ○ Introduction of management cadre. <p>Moreover, the 18th amendment provided further opportunity to the province to complete the reform cycle by introducing reforms at service delivery like introduction of MHSDP and integration of vertical programmes which was not possible with bifurcated system of financing.</p> <p>Rationale for Integration</p> <p>Over the past decade, vertical programmes have become increasingly unpopular as they tend to drive away resources from general health issues resulting in weakening of the health system. Policy, strategy and program level debates surrounding development in the health sector show an inclination towards using an integrated approach to improve general healthcare, which is argued to be a prerequisite for smooth functioning of vertical health programmes. While, proponents of vertical programmes assert that in certain weak and conflict ridden states, where health sectors are already collapsing, as is the case in a number of developing countries, vertical programmes may be the only means of ensuring delivery of at least basic health services⁷ and improving health outcomes.</p> <p>In presence of weak health systems, vertical programmes allow concentration on a few well-focused interventions to maximize the effect and time response of available resources⁸. These, stand-alone programmes become particularly significant in attainment of objectives, where quick response is required to meet targets. But despite opportunities, the vertical approach, contributed to weakening</p>
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⁷Atun, R.A., Bennett,S. & Duran,A. When do Vertical Programmes have a place in the Health System? Policy Brief- Health Systems and Policy Analysis.WHO- European Ministerial Conference on Health Systems. Tallinn, Estonia, 25-27,2008

⁸Atun, R.A., Bennett,S. &Duran,A. When do Vertical Programmes have a place in the Health System? Policy Brief.Health Systems and Policy Analysis.WHO European Ministerial Conference on Health Systems. Tallinn, Estonia, 25-27,2008.

	<p>of the health systems primarily by duplication of activities, drawing resources away from much needed primary health care services, extra burden on the already overworked and underpaid service providers.</p> <p>Despite all efforts through vertical programmes over the last few decades, KP with an estimated population of 21 million has poor health outcomes in comparison to Punjab and other countries of the region. Despite all efforts, inter-district inequities in service provision and slow progress in improving health status of the poor are key challenge for the province. Although statistics reveal health outcomes to be better compared to other provinces but still a long way from meeting MDG targets; wherein 47% of the target population is fully immunized against the national average of 47.3%⁹, Tuberculosis case notification rate of about 73% and treatment success rates of 93% for the year 2011¹⁰, contraceptive prevalence rate (CPR), being recorded at approximately 40%. High infant mortality rate of 76 per thousand live births¹¹ and high maternal mortality 275/100,000 live births¹², coverage by Skilled Birth Attendants (SBAs) at 42.3%⁸, lady health worker coverage at 58%¹³.</p> <p>The poor health situation in the province is the result of many factors i.e. poorly managed health infrastructure plagued by lack of equipment, staff, medicines and other essential supplies in most of the health facilities. The service delivery has been adversely affected by high levels of absenteeism and lack of qualified personnel especially females. Although public sector is still used by a larger majority of population, but increasingly private sector preference is on the rise. All of the above is contributing to slow progress in achieving Millennium Development Goals (MDGs) contrary to the satisfaction of local, provincial, national and international stakeholders.</p> <p>These challenges are deeply linked to weak health systems, processes and institutions overwhelmed by structural fragmentation, absence of effective monitoring and evaluation, absence of results based management culture, inadequate knowledge management mechanisms/structures, gaps in policy implementation, scarcity of technical and financial resources leading to limited accessibility and utilization. In addition, frequent and continuous emergencies and natural disasters faced by the province over the past few years also have had a negative impact on health care provision, a situation further precipitated by increasing security related incidents. Consequently, as a result of ongoing militancy, armed conflict and natural disasters, access to general health services and overall wellbeing of individuals has further been highly compromised due to resultant large scale internal displacement of populations.</p> <p>To address issues mentioned above, in post devolution scenario the</p>
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⁹ PDHS(2006-07)

¹⁰ NTP Annual Report(2011)

¹¹NWFP-Multiple Indicator Cluster (MICS) Survey 2008

¹² PDHS(2006-07)

¹³ Fourth External Evaluation of the National Programme for Family Planning and Primary Health Care 2009

		<p>government of KP, envisages to realize its goal laid out in the HSS, by integrating vertical programmes through development of integrated PC-1, as a way forward for delivering services through MHSDP to expand scope of preventive, curative and promotive services at the primary health care level for a period of three years.</p> <p>Through this programme, the health department plans to undertake health system strengthening through a number of initiative including capacity building across all spheres, address critical shortages in the skilled workforce especially women for improving access to services and meeting the social and cultural challenges, increasing knowledge base for informed decision making and undertaking research for evidence based policy planning are some of the themes consistent with the principles defined in Comprehensive Development Strategy 2010-2017.</p> <p>Through this initiative, the province plans to take forward and sustain not only national initiatives but also introduce new interventions to improve maternal and child health situation in the province. In addition to new interventions for improving nutrition services for women and children, the key programmes to be integrated through this PC-1 include:</p> <ol style="list-style-type: none"> 1: The National Programme for Family Planning and Primary Health Care, also known as the Lady Health Workers Programme at the cost of PKR: 26 billion for five years was developed to improve the primary health care and family planning outcomes. The hallmark of the programme was taking primary health care to the doorsteps by introduction of a cadre of community based workers. The initiative aimed at improving maternal and child health outcomes and improving coverage of family planning services. Currently, there are 13,200 LHWs serving in the province and providing outreach health services to rural and urban slum communities. 2: National Maternal, Newborn and Child Health (MNCH 2006-12) Programme at the cost of PKR: 19.99 billion was launched with the objective to reduce maternal, newborn and child morbidity and mortality especially among the vulnerable segments of the population focusing on rural areas . A new cadre of community midwives was introduced to increase coverage by skilled birth attendants, in addition to strengthening of referrals and facilities for emergency obstetric care. The programme trained 1828 CMWs in the province of KP, of which 500 has been deployed to provide services among the rural communities of the province. 3: Expanded Programme of Immunization (EPI) was launched in the early 1970s to protect children against five vaccine preventable diseases. The scope of the programme was later expanded to include two more antigens i.e. HIB and hepatitis. The key objective of the programme is to strengthen the EPI programme in KP by upgrading and maintaining the cold chain system for vaccine storage. The programme received major in
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		<p>kind supplies and other funding through the national programme.</p> <p>As mentioned earlier, the Health Department plans to undertake integration in a phased manner together with the process of health systems strengthening simultaneously. It is envisaged that the project will be taken on the recurrent side after the expiry period of this PC-1. The integrated approach is proposed for implementation with the vision to;</p> <ul style="list-style-type: none"> • avoid duplication of interventions and bringing in economies of scale by implementing a minimum health service delivery package (MHSDP), • strengthen overall management capacities especially of districts, • reorganize health information system for evidence based planning and efficient use of resources, • integrate and strengthen M&E systems across these programmes, • introduce new health financing models for public-private partnership to improve health care delivery. • human resources development across all levels of health care delivery through the routine institutions of the department, • strengthening of referrals from the community to the facility by bridging the gap between communities and facilities (PRISM MODEL) • design and implement new communication development models for enhancing demand for services by the communities, • provide technical assistance to improve overall implementation, • enhance stewardship, accountability and transparency for improved functioning at provincial and district level, • integrate services and support restructuring of health department to be able to cater for newly assigned roles and responsibilities, • strengthen procurement, surveillance, knowledge management, programmatic and financial management at provincial and district levels for the integrated services. • Enhance the capacity of health care providers and management towards better health outcomes. <p>In the post devolution scenario, the desire for integration originated out of the need for sustaining vertical programmes in view of squeezed/time bound financing from the Federal Government, and need for additional resources for these projects from the provincial government's budget for implementation. In this backdrop, Health Department weighed a number of options i.e.</p> <ol style="list-style-type: none"> 1. Continuing with the existing vertical approach; 2. Partial integration of programmes having same objectives with fully integrated services using Minimum Health Services Delivery Package (MHSDP) at the PHC level to; 3. Complete integration of all vertical programmes into the health
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		<p>systems.</p> <p>However, after much deliberation, it was agreed that the best results could be achieved using a phased approach instead of adopting one option or the other, with gradually progressing to complete integration overtime of these vertical programmes in the overall health system. In this context, it was agreed that currently option 1 is being implemented therefore; target is to progress to Option 2 which is the Phase 2 for rolling out the integration process i.e.</p> <p>Phase 2:Partial integration at the Provincial level of set of programmes under one thematic area e.g. MNCH (including MNCH, FP, LHW and nutrition); Communicable Diseases control (Hepatitis TB Malaria) etc along with full integration of the health services through delivery of MHSDP.</p> <p>Project Description:</p> <p>Pakistan faces enormous challenges in terms of improving health outcomes for the poor and marginalized population especially mothers and children. Historically the provinces had been looking towards the federation for setting directions and system strengthening. The Ministry of Health, for addressing the international commitments has been adapting vertical approach to achieve the objectives instead of focusing on developing capacities and strengthening health systems in the provinces. This led to fragmentation of the system with narrow focus on specific health problems and diseases. Moreover, this fragmentation resulted in the dysfunctional health system not able to achieve the desired results. This lack of coordination and unclear roles at all levels contributed to the slow progress on MDGs and other international commitments.</p> <p>Though Pakistan has made progress during the last couple of decades towards achieving these health targets, but the pace has been very slow. Despite reductions in the MMR and the infant mortality rate, Pakistan is lagging far behind other developing countries at similar level of development, with respect to these indicators. The slow progress is attributed to a number of factors such as low social status of women in the society, poor nutrition, widespread poverty, illiteracy, inappropriate health-seeking behavior, a poorly functioning health system and a rapidly growing population. The situation has been further compromised by the precarious situation of the province due to ongoing militancy and recent natural disasters such as earthquake and floods,</p> <p>Further, maternal and neonatal mortality and morbidity constitute a high proportion of the burden of ill-health in Pakistan. It is increasingly recognised that the principal barrier to achieving large-scale reductions in maternal and newborn mortality rates is not only the service availability but lack of attention paid to the broader, social, cultural and political factors at work in particular contexts which affect women's access to health services. Poor outcomes for women and girls</p>
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	<p>are reflected in Pakistan's fertility, maternal and infant mortality rates, which are amongst the highest in South Asia</p> <p>Evidence from many countries confirms that increasing investments in health of women and children has many benefits i.e. it reduces poverty, stimulates economic productivity and growth, and helps women and children realize their fundamental human rights. Although the health outcomes in KP are better compared to other provinces, but in attaining the MDG targets they still have a long way to go, some of the MDG related health indicators for KP, as reported by the PDHS 2006/07 and MICS 2008 are:</p> <ul style="list-style-type: none"> • MMR: 275/100,000 live births; • Neonatal mortality: 41/1000 live births; • CPR: 25% • Unmet need for FP: 27% • IMR: 63/1000 live births; • Deliveries by trained birth attendant: 38%; • Antenatal care: 51%; • Postnatal care: 19.3 %; • Women whose last pregnancy was protected by T.T: 51 %; <p>Government of KP and Health Department, while realizing its commitment to improve health status of its population has embarked on improving its health system and its strategic direction for achieving better health outcomes for their population. This integrated programme is the first step towards its implementation.</p> <p>The programme is of three years duration. The programme envisages to achieve its goal of improving maternal and child health through the following five strategic objectives:</p> <p>Output 1: Improved Access to RMNCH and Nutrition services of MHSDP at outreach level:</p> <p>The public sector being the significant provider of Primary Health Care services has been deploying outreach workers like LHWs, CMWs etc to improve access to services on one hand and bridge the gap between the communities and health facilities for improved utilization through various interventions including referral, creating awareness, health promotion and improving health seeking behavior. In addition, providing services in an equitable manner in rural areas is always a challenge further precipitated by staff absenteeism and non availability of appropriate female staff. Whereas the private sector mainly gravitates towards the urban areas thus further accentuating the issue of equity in the rural areas.</p> <p>Despite introduction of outreach workers in the community certain challenges were faced by the Department of Health , which are as under:</p>
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		<ul style="list-style-type: none"> ➤ It was conceptualized that outreach workers will be an integrated part of the health system but during design and implementation of the interventions significant verticality(Policy and management level) remained there resulting in a completely vertical set up which was never owned by the department as part of health system. ➤ The variety of outreach workers working under the different set of managers were not coordinating with each other for the following reasons: <ul style="list-style-type: none"> a) The different cadres of outreach workers were not aware of the presence of each other. b) Do not understand the role of other worker. c) Problems / policies at managerial level do not allow different cadres of health workers to work with each other. ➤ Various cadres of health workers reported either to the facility or directly to the district health office using different formats showing different numbers. Health facilities was found playing very limited role in data reporting, and were not involved in data analysis, planning etc. ➤ Various programmes have different practices, however Health facility has very little role in hiring and firing of the outreach workers. It further undermines the role of the health facility with relation to its responsibility of health status of catchment area population. <p>The lady health workers form an invaluable body of skilled human resource, the services of whom are often utilized for many other programs. LHWs have mostly succeeded in establishing trust and community acceptability and are providing essential PHC services across the country.</p> <p>Scientific evidence suggest that women, families, and providers typically do not focus their attention on how to prepare and plan for the delivery of a baby, or for potential pregnancy and birth related health emergencies. In addition, few women, families or birth attendants are even aware of potential newborn complications such as birth asphyxia, respiratory problems, prematurity and cord infection. Awareness of perinatal and post-partum complications is equally low and often misunderstood among target audiences. Further, evidence strongly suggests that interventions, beginning before pregnancy and covering the prenatal, delivery and post-partum periods, including immunization coverage and addressing the individual health of the women and children directly contribute to reduction in morbidity and mortality.</p> <p>Nutrition Services has remained the most neglected part of service delivery at different levels of health care system. Nutrition related</p>
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	<p>services though being significant part of the LHW curriculum have made no significant headway in nutrition outcome. This is clear from the current situation of nutrition indicators like early initiation of breast feeding, exclusive breast feeding and appropriate complementary feeding etc. Moreover recent NNS¹⁴ highlights deterioration in nutritional status of mothers over the last decade.</p> <p>The importance of correct knowledge, attitudes and behaviors about the services is therefore of immense importance.</p> <p>Activity 1: Increase coverage of RMNCH and nutrition services of MHSDP at outreach level:</p> <p>The coverage of maternal, children and nutrition services at outreach level will be increased by</p> <ul style="list-style-type: none"> ➤ Increasing the number of Outreach workers i.e LHW coverage from 58% to 80 % and CMW from 18% to 80 % coverage. ➤ Introduction of Vaccinators in LHW uncovered area ensuring 100% routine immunization. ➤ Provision of supplies to LHWs and CMWs as per their specified kits. The CMWs will receive regular supply from the health facility including contraceptives .While LHWs in addition to their routine supplies will receive micronutrients and other additional supplies in their kits. ➤ Horizontal linkages will be developed between CMWs and LHWs who will be linked using principles of PRISM Model. ➤ All trainings will be ensured by supervised and coordinated by PHSA through its network. <p><u>1.1 Increasing the number of Outreach workers i.e LHW coverage from 58% to 80 % and CMW from 18% to 80 % coverage:</u></p> <p>At present LHW coverage is 58% which in phased manner will be increased to 80 % especially focusing on rural areas and urban slums to address the issue of equity of services. Total number of LHW working at present is 13200 which will be increased to 16800 (2850 provided through this PC-1 and 750 under the MCHIP (USAID) initiative in Malakand Division). The recruitment of LHWs will be done by the district on the recommendation of health facility In charge against the allocated quota by the Health Directorate to the district as per policy guidelines issued by the department.</p> <p>Under MNCH programme (2007-12) 1828 CMWs were trained across the province. However, only 500 CMWs could be deployed and are currently providing services in the rural areas. Under this PC-1 the remaining 1328 CMWs will be deployed and linked with the facilities at the primary health care level to provide domiciliary midwifery services including family planning and nutrition counseling. Additional 250 (22 provided through MCHIP Project in Malakand Division) CMWs will be trained and recruited as per the prescribed criteria in a</p>
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¹⁴National Nutrition Survey 2011

	<p>phased manner. These CMWs will be deployed especially in areas with low maternal health indicators and has major gaps in coverage of maternal services</p> <p>(Recruitment criteria , the mechanism for recruitment and job description of each cadre are at Annex II, III,IV,V)</p> <p>One LHW is responsible for a population of 1000 or 200 household. However, keeping in with demographic variations between districts and geography of the province, this distribution needs to be revisited. The issue for determining LHW to population ratio will be referred to the Technical Committee on Health, which will make recommendations to the relevant forum. The decision making for the purpose will be responsibility of the Provincial Steering Committee, which will review and approve the recommendation. (The composition and TORs of both Committees at Annex- VI & VII)</p> <p>LHW will be working six days a week while on holidays she will be responsible for providing emergency services and follow up of critical patients/ clients like children with acute watery diarrhea, women for postnatal care or neonatal care, referral of complicated delivery etc. in her catchment area.</p> <p>In order to enhance coverage of fully immunized children, the LHWs will ensure 100% coverage as per schedule in the respective catchment areas. In addition, LHWs will also undertake outreach activities with the objective of motivation and mobilization of the community on all aspects of reproductive health including family planning, exclusive breast feeding and nutrition.</p> <p>The salary component of the LHWs for the programme period will be through the development budget, however it is foreseen that in the long run it will be taken on the recurrent side as part of MHSDP during the third phase of integration.</p> <p>1.2 <u>Recruitment of Vaccinators in LHW uncovered area .</u></p> <p>Presently, outreach services for routine immunization are not provided because of the involvement of EPI technicians in Polio Eradication Initiative (PEI) activities. In order to ensure 100% coverage of routine immunization for children 0-23 months, 500 vaccinators will be recruited at the ratio of 1:5000 populations, to provide outreach services in the LHW uncovered area. While in areas covered by LHWs, it will be the responsibility of LHW to provide outreach services for routine immunization of all the children in her catchment area.</p> <p>Vaccinators will be selected through the district selection committee as per allocated quota by Health directorate. The vaccinators will be attached to the nearest facility. He will map out all the uncovered area and submit the tour programme to the facility in charge for approval. Field Supervisor Vaccination (FSV) will supervise as per guidelines and submit the report to Health facility In charge. (Annex VIII)</p>
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	<p>Vaccinator will report to the facility nearest to the catchment area and Health Facility In charge will incorporate his report into the consolidated report of the facility.</p> <p>1.3 <u>Provision of supplies to LHWs and CMWs as per their kits.</u></p> <p>The CMWs will receive regular supply from the health facility for domiciliary services and Family planning. This will include drugs and contraceptives. LHWs will also be provided with LHW kits. The kit will include micronutrients and MUAC etc. LHW will as per plan ensure immunization of children in her catchment area for which the vaccine and supplies will be provided by the EPI centre of the facility.</p> <p>All procurement will be conducted as per guidelines issued by the Central Procurement Cell in the DGHS office. Standard lists of supplies for LHW and midwife including Midwifery Kits, LHW kits, supplies, stationary are at Annex - IX,X& XI</p> <p>Details of Procurement mechanism are discussed under Output 4.</p> <p>1.4 <u>Horizontal linkages will be developed between Midwives and LHWs who will be linked through PRISM Model.</u></p> <p>Linkages of community based workers (LHWs and CMWs) with the health facilities have not been established to the extent it was desired due to various reasons which may be poor quality of health services, limited scope, non availability of health care providers, poor physical access and improper provider's behavior and direct and indirect cost associated with use of health care. At the same time socio cultural barriers are equally important in utilization of health care. One of the important reasons is the absence of well established referral protocols at the health facilities and referred patients/clients are not treated on priority basis. Therefore it is necessary to improve the access and availability of well trained and competent human resources at the health facilities.</p> <p>CMW and LHWs will work in a network fashion thereby linking the community with the health facility and strengthening referrals as envisaged in PRISM Model (at Annex XII).</p> <p>Taking guidance from the PRISM Model, linkages will be established between the outreach workers and health facility and further strengthened for improved referrals mechanisms. Both the LHWs and CMWs will work closely with each other under the guidance of the health facility incharge to improve maternal, child health and nutritional outcomes. LHWs will be responsible for delivery of antenatal, immunization, family planning and nutrition services by ensuring implementation of the MHSDP at the outreach level. CMWs will provide domiciliary midwifery functions and will actively conduct deliveries in their catchment area. They would work in close collaboration with the LHWs of their area for identification and referral</p>
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	<p>of high risk pregnancies and complicated cases to the most appropriate health facilities. It is expected that the number of referrals for pregnancy complications will increase over time and the information will be verified through hospital records and referral registers. In addition, they will also be responsible for identification of cases of malnutrition among women of reproductive age and children, manage moderate malnutrition, ensure implementation of CMAM and refer complicated malnutrition to the nearest OTP or Stabilization Centre (SC).</p> <p>The CMW to LHW ratio will be 1:8 as described under the PRISM model. Moreover, in areas with no CMWs, CMWs will be selected from amongst the senior LHWs, meeting the prescribed criteria; suitable candidates will be selected and trained as CMWs at the approved Midwifery Schools recognized by the Pakistan Nursing Council using standardized training curriculum.</p> <p>The deployment of already trained CMWs and future CMWs will be in the context of Prism model, explained above.</p> <p>It is envisaged that LHWs and CMWs will directly contribute to increase in number of skilled birth attended deliveries, improvement in referrals for complicated pregnancies and subsequent reduction in maternal and neonatal morbidity and mortality. Moreover, they are expected to directly contribute to increase in CPR by providing family planning counseling services, reduction in acute malnutrition through identification, management and referral of complicated cases.</p> <p>The integrated programme will focus on Severe Acute Malnourished (SAM) and Moderate Acute Malnourished (MAM) among children and pregnant and lactating women. LHWs and CMWs will screen the children and pregnant women in the community and refer the SAM and MAM cases to CMAM sites (Outdoor therapeutic program, OTP) that will be established at selected BHUs and all RHCs.</p> <p>In this backdrop, activities under this component will focus on not only enhancing the skills of the LHWs for delivery of preventive and promotive services defined under the MHSDP at the outreach level but also help strengthen the referral linkages for improving maternal, neonatal and child health outcomes.</p> <p>The package of services to be provided by outreach workers and list of medicines and supplies required for the given task are as per MHSDP.</p> <p><u>1.5 Training of outreach workers i.e. LHWs, CMWs and vaccinators (initial and refresher) in areas of IMCI, IYCF, CMAM, management of mild to moderate malnutrition, immunization, FP and nutrition counseling and data reporting.</u></p> <p>LHWs and CMWs will be made aware of the background and evidence behind the new approaches to family planning and maternal health services and will be trained to use national standards of family</p>
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	<p>planning, care during pregnancy and post partum period in their daily practice. They will improve their knowledge and skills on Integrated Management of Neonatal and Childhood Illness (IMNCI) and assessment and counseling on child growth, nutrition and development by participation in specially organized training sessions. Training will also focus on how to improve quality of family planning, preventive, nutritional, maternal and neonatal and child health services in the district.</p> <p>Both class room and on job trainings will be provided to LHWs at the facility level, while CMWs will be trained at the Midwifery schools using the standardized training curriculum and manuals. Vaccinators will also be trained in selected facilities under organized training programme using specially developed training curriculum through specifically organized training courses. (Training schedules of LHWs, & CMWs is attached at Annex – XIII & XIV).</p> <p>The vaccinators already having certificates of training, however, will be mandated to undergo refresher trainings. Technical review committee will also explore options of using multipurpose workers in various districts. In that case incentives will be provided to already available multipurpose worker.</p> <p>Likewise the LHWs and CMWs too will be required to attend refreshers with especial focus on family planning counseling techniques, IYCF, IMNCI, CMAM etc. Furthermore the curriculum will be reviewed in light of the needs of the programme and revised rules, where necessary most training materials will be translated into urdu for ease of understanding and training. Each LHW and CMW will undergo at least 6-8 days as refresher training for the Year. While the lady health supervisor will undergo 6-8 days /year as refresher.</p> <p>Translation and printing of training materials and modules on IYCF, CMAM, IMNCI, reproductive, maternal, neonatal and child health will ensure effectiveness of training and will have a direct impact on quality of maternal and child health services. (Previously translated materials will be updated, improved and translated whenever deemed necessary).</p> <p>Activity 2: Increased Community Participation and involvement in health Actions;</p> <p><u>2.1.Organize inter-personal and group sessions.</u></p> <p>The outreach workers will establish linkages with the community by establishing Health committees (male and female) in their catchment area and develop linkages of these committees with Primary Care Management Committees (PCMCs) of the facility for ensuring both mobilization and participation of the community in achieving health outcomes.</p> <p><u>2.2.Community mobilization through male and female health</u></p>
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	<p><u>committees, community elders and PCMCs.</u></p> <p>LHWs will conduct regular community sessions for both male and females with the support of Health facility staff, PCMCs and community leaders. She will arrange sessions with male and female health committee's at least once every month and keep record of these sessions. She will also ensure follow up of the decisions made by the committee and present un-acted upon decisions in the next meeting of the committee. Wherever necessary, she will seek support from the PCMC members especially in ensuring immunization coverage or motivating the community for enhancing ANC, natal and post natal coverage and to improve status of nutrition.</p> <p>Activity 3: Improved Family and Community practices to support better health outcomes;</p> <p>The proposed activities are as under:</p> <p><u>3.1 Identification of negative behaviors and opportunities for change,</u></p> <p>Identification of negative behaviors will be done through Inter personal communication of outreach workers and Group discussions with health committees etc.</p> <p>These will be addressed through building capacity of outreach workers through trainings and skill development. In addition health facility staff will work with Community groups/ committees to address the negative behaviors for the purpose the capacity of Health staff will also be developed through training. Furthermore a post of the health promotion officer is also introduced at Provincial and District level, which will support the provincial and district offices in developing important messages/strategies to address the negative behaviors.</p> <p>It will be ensured that all the messages are aligned with communication strategy and are not in contradiction with each other.</p> <p><u>3.2 Dissemination of specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using innovative approaches,</u></p> <p>Provincial Health Promotion officer will develop messages which will be disseminated through outreach workers, facilities, community groups, media(print as well as radio). Messages can be brochures, Flip charts, pamphlets, posters, Articles, and Programmes or advertisements. In addition videos can be used to convey the messages. For the purpose a specific type of mobile phone will be provided to LHWs which can display videos.</p> <p><u>Output 2: Improved Access to RMNCH and nutrition services through MHSDP at Primary care facility level :</u></p>
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	<p>Pakistan is the most important service provider of primary health care services (PHC) especially for rural and peri-urban communities. However, despite public sector being the key provider of services in the rural areas, health facilities still remain underutilized. The main factors responsible for this situation are; poor governance and management systems of public sector, lack of and consistent supply of essential medicines, lack of availability and retention of skilled staff especially females.</p> <p>The implementation of MHSDP at Primary health care facility level will be ensured through two new initiatives of the Health Department i.e. this PC-1 (19 districts) and “Revitalization of Health services in crises affected districts” project supported through MDTF Funds (6 districts). MHSDP is attached (Annex XV)</p> <p>It is envisaged that by the end of the implementation period of this PC-1, 60% of the districts will be delivering MHSDP at the primary health care level. Moreover, in districts where PHC services are already contracted out to PPHI, the contracts will be reviewed and modified to ensure delivery of services as per MHSDP. In addition, for delivery of those services not included in the contract or where rational justification is provided by contractor, gaps in services being provided will be identified and filled through this PC-1.</p> <p>Activity 1: Preparation and implementation of Union Council health plans using Result based planning and management techniques.</p> <p>The district health systems will be strengthened in evidence based planning and result based management. The concept of output based budgeting will be introduced and the district management trained in using to improve health outcomes by achieving the targets set for each intervention. This will help enhance the district capacity in planning and preparation of health plans against agreed targets.</p> <p>At the Union Council (UC) level, the Facility in charge will be responsible for development of the UC level Health Plan, which will be consolidated at district level into overall district health plan.</p> <p>In case of Public private partnerships where the facilities are being managed by partners, partner agency will get the plans from the facility and then submit their plan to the DHO for approval by and incorporation into the district plan.</p> <p>Following steps will be followed for development of District plan for the implementation of the programme:</p> <ol style="list-style-type: none"> 1. Self Assessment of the health facilities against a Standardized check list developed in light of MHSDP by facility in charge. 2. Identification of gaps at facility level against the MHSDP for
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		<p>available services. (Both for Outreach as well at first level health facility of the catchment area).Compilation of the needs at district level in light of identified needs by the facility.</p> <ol style="list-style-type: none"> 3. Development of costed District plan for Implementation of MHSDP by the district. 4. Submission of District Plans to Directorate General Health Services. 5. Verification/validation by third party of District plans. 6. Recommendation of District plan by Technical Committee. To the Technical committee will also be authorized to approve for additional ties of Rs. 5 million in the already approved plan. 7. Approval by steering committee of proposals. 8. Release of funds to district for implementation of programme. <p>At the end of the year the progress of each district will be measured against the baseline, gaps identified and grading of each district done as per performance. Warning will be issued to poor performing districts, while rewards in form of Performance certificates or bonuses will be given to district that show achievements against the approved targets. This will form the basis for planning for the subsequent years District plan.</p> <p>Activity 2: Increased availability of RMNCH and nutrition services of MHSDP against the approved quality standards.</p> <p>The key activities under the component include;</p> <p>2.1 <u>Recruitment of staff:</u></p> <p>Staff will be recruited on contract basis against the gaps identified in district health plans. Composition of Selection committees and Recruitment procedures are at Annex - XXI.</p> <p>The recruitments will be done only when the post is not sanctioned on regular side and is required as per MHSDP or against vacant posts where the Department gives NOC for the said post.</p> <p>2.2 <u>Procurement of supplies, medicines, stationary, equipment and printing :</u></p> <p>Standard lists of Medicines, supplies and equipment for PHC facilities are at Annex–XV which will be provided at replenishment basis. Facility is supposed to keep a buffer stock for 1 month. Most of the procurement will be done at district level in light of the guidelines provided by central procurement cell.</p> <p>The details of procurement processes are discussed at output 4.</p>
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2.3 Service Delivery at PHC facility level

- Supporting the facilities in provision of quality services against the quality standards (it includes repairs and renovations of the facilities, construction of waiting areas for female patients/clients, repair of toilets and infection control activities etc.
- Ensuring 24/7 services as per MHSDP proposed in the district plans.

The nutritional interventions to be delivered at various levels as per National Guidelines are at **Annex XVII and details of stabilization centre and CMAM are attached at XVIII & XIX.** *These interventions will be targeted at children less than five years of age, adolescents, pregnant and lactating women* in order to improve the nutritional status of target population. Identified malnourished children, screened through mid upper arm circumference measurement (MUAC) and other mechanisms e.g. growth monitoring by LHWs will be identified at the community level and referred and managed at the level of OTPs and those with complications will be referred to the stabilization centers (SC) at District hospitals. Guidelines/SOPs for referral mechanism and referral points will be developed during the programme implementation and will be mandated for use at appropriate levels.

The facilities will be strengthened with appropriate training of staff, distribution of IFA and Zinc supplements, ready to use therapeutic food (RUTF) and ready to use supplementary food (RUSF) and other related medicine and supplies.

The IYCF and CMAM guidelines will direct the future course of action of either referring the complicated cases of children to strengthened secondary health care facilities (THQs / DHQs) for further clinical and rehabilitation management, or to the communities (SFPs) to be linked through the respective LHWs and NGO's.

The community-based management of moderate and acute malnutrition (CMAM) without complication will be done by LHWs and CMWs who will screen, and manage the children, pregnant and lactating women diagnosed with severe acute malnutrition to the health facility, and refer cases of malnutrition with complications to the secondary care facilities.

Outreach workers will also provide supplementation for Micronutrient deficiencies such as vitamin A, iron deficiency anemia, Zinc etc. DHOs in the District Health plan will submit a detailed plan of Nutritional Screening & interventions in LHW uncovered area.

2.4 Preventive and promotive services for clients as per MHSDP

		<ul style="list-style-type: none"> ○ Health promotion sessions by Facility staff at the facility and community level. Facility will ensure at least 1 meeting of Primary Care Management Committee/community groups. ○ Distribution of necessary/ relevant IEC material to the patient/client. As already mentioned, the IEC material will be provided by outreach worker. IEC material will be displayed in the Health facility .In addition the relevant IEC material will also be provided to concerned client. <p>2.5 <u>Training of health facility staff</u></p> <p>Trainings of different cadres of health providers will be done in delivery of the primary care services as per MHSDP specially focusing on enhancing their skills in areas of IYCF, IMNCI, ENC, Pregnancy Childbirth Post Natal Care (PCPNC), EmONC, SAM, CMAM, FP counseling, Maternal, Neonatal and child health, immunization, communication, community mobilization and communicable disease control. In addition, skills will also be built in record keeping, information management and importance of quality reporting.</p> <p>All the trainings at the facility and district will be organized through PHSA and will be monitored and supervised by PHSA staff. Trainings of Outreach level workers will be conducted by district under the overall guidance of PHSA. While various trainings of Health facility staff will be conducted by PHSA on the request of District. Funds for these trainings will be released to PHSA which will carry out all the trainings through its training network i.e. DHDCs and training institutes etc. PHSA will also be responsible for the monitoring as well. (Annex XX)</p> <p>2.6 <u>Ambulance service for referrals</u></p> <p>Ambulances are available at all RHCs with the objective to transport serious or complicated cases. However, a number of these vehicles are non functional due to minor issues e.g. missing or damaged parts, worn out wheels, funds for POL, non availability of driver. This PC-1 envisages to make these vehicles functional through the following;</p> <ul style="list-style-type: none"> ○ Ensure availability of functional ambulances by providing repair/maintenance of ambulances at the facility providing 24/7 Basic EmONC facilities. ○ Ensure availability of POL and other logistics for transport. ○ Ensure availability of drivers for ambulances.
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Activity 3: Enhanced community participation in service Delivery Planning, Management and oversight:

Community's role is important in service delivery as its involvement helps identify gaps, need for services and most importantly in utilization of services. By involving the community at all levels i.e. from planning to delivery of services, ownership is created that serves as both a trigger for increased use by community but also they quickly point out issues and render solutions. The PC-1 focuses on improved coordination and communication linkages of health facilities with all stakeholders in catchment area by;

- Constitution and notification of PCMC, which will be made functional.
- Establishment of linkages with private sector health providers and health related NGOs, CSOs working in the catchment area.

Introduction, development and implementation of family and community mobilization interventions will be done to strengthen relations between the community and health providers. This will be done by getting both women and community's perspective on quality of care and services being provided under the MHSDP. It is envisaged that the implementation of the family and community mobilization will lead to improved utilization of family planning, nutrition, maternal, newborn and child health services by the communities resulting in improved health outcomes. In addition, community feedback on quality of services will act as mechanism of monitoring of service standards.

Activity 4: Improved recording and reporting on Maternal, neonatal and Infant deaths for Improved Mortality surveillance at union Council level.

Registration of vital statistics is not part of mainstream system at present. Neither is there organized mechanism for mortality surveillance at the UC level. Most deaths are not reported and neither neonatal nor infant deaths. Through this PC-1, it is planned to introduce a system to capture this information which is to be done through the following steps;

- Health Facility In charge will analyze the reports submitted by Outreach workers (LHW, Midwives and vaccinator) and LHS and Field Supervisor and give feedback to them for improvement in service delivery.
- Facility staff will conduct verbal autopsies on the reported maternal, neonatal and infant deaths in their catchment area population and will submit the reports to the district focal point.
- Health Facilities will report to DHO on the prescribed DHIS format.
- District health office will verify and validate the

	<p>information, while providing feedback to the facility as well.</p> <p><u>Output 3: Improved Access to Maternal, child and nutrition Interventions at Secondary care level</u></p> <p>Activity 1: Ensure provision of 24/7 comprehensive EMONC and nutrition service at secondary care level.</p> <p>A number of essential steps are a pre-requisite to ensure safe delivery:</p> <ul style="list-style-type: none"> - skilled attendants at childbirth; - access to emergency obstetric care in case of a complication; and functional referral systems. <p>There is a well documented correlation between the level of maternal and neonatal health services available and chances for survival of very low birth weight newborn babies. Regionalized systems of peri-natal care are recommended to ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her health care needs, and to facilitate the achievement of optimal outcomes.</p> <p>The referral mechanisms for complicated pregnancies are unfortunately not well developed throughout the province because antenatal coverage is still very low and the deliveries are mostly home based in rural areas. A large majority of complicated cases go undetected in the early period as mostly women are not aware of the ten danger signs of pregnancy. Further, in rural as well urban communities there is a lack of planning for both pregnancy and delivery with most decisions being usually last minute resulting in unfavorable outcomes.</p> <p>Through implementation of the MHSDP, it is envisaged to address this gap by enhancing antenatal coverage, early detection of pregnancy related complication and timely referrals to the secondary level of health care facilities both in the public and private sector providing 24/7 EmONC services.</p> <p>The services will be ensured at secondary health facilities at district level by recruitment against vacant positions of the WMOs and gynecologists, anesthetists and pediatricians filled by selection of appropriately trained staff against standard Staffing of comprehensive EmONC services. All these gaps will be identified in district plans and relevant staff will be appointed through District selection committee.</p> <p>High prevalence of macro and micronutrient deficiencies in women during pregnancy renders them more vulnerable to morbidity and adverse pregnancy outcomes with increased neonatal morbidity and mortality. According to NNS 2010-11, over 40% of the women are either underweight, overweight/obese, anemic, iodine deficient or zinc deficient while 30.3% of children under 5 years are underweight; 49.2% stunted and 16.8% are wasted¹⁵. In addition, 62.1% of children</p>
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¹⁵ National Nutrition Survey 2010-11, Ministry of Health

	<p>below five years of age are anemic, 56% vitamin A deficient, 36.5% zinc deficient, 36.7% iodine deficient and 41.1% have low levels of vitamin D. In view of the situation, it is recommended to create a position of Nutrition Officer at the level of district HQ hospital, especially districts identified as high risk by the NNS. The district hospital will be responsible for management of malnutrition with complications by establishment of stabilization centre (SCs), identified and referred by the LHWs at the community level and PHC facility.</p> <p>Different cadres of health providers will be trained at the district level on IMNCI, SAM, CMAM, IYCF, FP and nutrition counseling, maternal and child health care, management of mild to moderate malnutrition and immunization, danger signs of pregnancy, infection control practices and quality standards. Trainings will be done using standardized national and WHO recommended guidelines and training modules recommended by the concerned Technical Specialist in the Health Department. Most of these trainings would be in field training and would focus on improving the counseling and management skills of the LHWs/CMWs on nutrition, family planning and on orienting them to initiate affirmative action for the poor and disadvantaged.</p> <p>SOPs will be developed and implemented for management of complicated/referred cases for maternal, neonatal, child health and nutrition and the relevant health providers be trained in their execution. A system of verbal autopsy will be introduced to investigate all cases of maternal mortality.</p> <p>Procurement of all supplies, equipment and medicines will be done as per the standard lists for maternal, neonatal, child health and nutrition interventions. The procurement will be done using the standardized procedures while ensuring quality standards.</p> <p>In addition, innovations will be introduced using Public-Private partnerships models e.g. the private health providers in the area can be approached for 24/7 service provision for EmONC. While on the other hand, in addressing the transportation delay, local ambulance services of NGOs, CSOs or private ambulance service will be contracted on pilot basis in 3-4 districts to ensure availability of transport for women needing advanced care for maternal or delivery complications.</p> <p>Some of the key activities under the component include;</p> <p><u>1.1 Recruitment of staff against vacant posts of Medical Officer and Nurses at each district headquarter hospitals</u></p> <p>Each MS of the DHQ hospital will notify two medical officers and two nurses for the nutritional interventions for placement at the Stabilization Centers of the respective hospital. The notified staff will be imparted special training on nutritional interventions and the management of complicated cases of malnutrition. In addition, the medical officers and nurses will be provided additional incentive of Rs. 10,000/month to the medical officers and Rs. 6000/month for nurses.</p>
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		<p>The MS of the DHQ hospitals will ensure availability of 24/7 comprehensive EmONC services at respective facilities as per SOPs. He /She will submit proposal in this regard to the DHO for inclusion in the district health plan.</p> <p><u>1.2 Procurement of medicines, supplies, stationary, printing equipment as per Procurement guidelines given by the central procurement cell</u></p> <p><u>1.3 Management of complicated/ referred cases for maternal, neonatal, child health and nutrition cases on priority basis</u></p> <ul style="list-style-type: none"> • Setting up of OTPs at identified spots and SCs at all DHQ hospitals • Piloting 24/7 transport facilities through Public Private Partnership models with local transport services for ensuring timely referral and management of complicated cases in 3 to 4 districts <p>The Technical Committee will develop criteria for district selection and identification of pilot sites. The MS of the respective DHQ hospital in the selected district will sign MOU with a locally identified transport services as per PPRA approved procedures.</p> <ul style="list-style-type: none"> • Indoor management of acute malnutrition at all secondary level hospital where pediatricians are available. • Provision of nutritional supplements (RUSF and RUTF) according to standardized packages • Training of health care providers' especially nursing staff at secondary level. • Regular audit of all pregnancy related and neonatal deaths <p>5. Preventive and promotive services for women and children e.g. vaccination, Antenatal, postnatal, FP and Nutritional counseling</p> <ul style="list-style-type: none"> • Printing and distribution of IEC materials • Arrangement for display of Audio visual material for patients /clients. • Provision of FP services including awareness and counseling services <p>6. Reporting, feedback and coordination.</p> <ul style="list-style-type: none"> • Reporting on prescribed DHIS format to DHO office • Feedback to the referring facility on prescribed format. • Technical capacity building of the referring facility staff. • Conduct clinical audit of maternal & child deaths as per SOPs.
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Output 4: Improved Governance and Programme Management at provincial and district level

Over the last three decades, not enough emphasis has been accorded to health system strengthening at provincial and district levels. Lack of achievements in health is attributed to a number of gaps in the managerial capacity, programme planning, dearth of organizational reforms within the management structures responsible for planning and managing health care delivery programmes and services. Evidence suggest that for very same reasons public health sector in Pakistan is generally under-performing and is unable to effectively translate limited resources into results.

Utilization of public facilities remains low, absenteeism is common leading to slow implementation of projects and programs. Though improvements in the health new projects are launched but necessary reforms, based on the lessons learnt, are not undertaken. Generally, there is poor management, lack of will to undertake or implement reforms, poor motivation, lack of information and diminished accountability.

Activity 1: Develop district and provincial level health plans using Result based planning and management techniques.

4.1.1 Recruitment of appropriate staff as per proposed provincial and district Organogram (**Annex–XXIII&XXIV**).

4.1.2 Development of district plans as per need against the given targets.

4.1.3 Training of Provincial and District management on planning, procurements, financial management, Logistic management etc.

Provincial level:

In the post devolution scenario and following restructuring of the health department, the Directorate General Health Services needs to be strengthened to be able to fully discharge its technical and oversight functions. After the promulgation of Local Government Ordinance 2012, the DGHS office has become fully responsible for all aspects of implementation.

Following integration of the vertical programmes, there will be one management Unit under the DGHS, which will be responsible for implementation of the programme.

Director General will be facilitated by a team of Deputy Director Technical in various fields such as MNH, Family Planning, Nutrition and M & E etc. Deputy Director EPI will also be considered as technical specialist for EPI.

In addition support will also be provided for strengthening of procurement cell, Financial unit, M & E system, logistic supply

	<p>management, health promotion and education at provincial level.</p> <p>PHSA will be provided with technical and Financial support in provision & supervision of training of health care providers. The proposed structure is given at Annex- XX.</p> <p>The programme unit under the DGHS will be managed by Director of Health Services in BPS 20. He /She will be supported by a team of Technical Specialist who will be selected from amongst the Public sector managers, meeting the requisite criteria, through competitive selection by a selection committee. Composition is at Annex - XXI.</p> <p>The key functions of this management unit will be to provide oversight and technical guidance in the specific area. The team will also be responsible to monitor all RMNCH and nutrition activities in the field. The Unit will be supported by a team of support staff. Details of staff and their Job description are attached at Annex –XXII. Already available staff of directorate will also be assisting the project in its activities especially that of EPI, MNCH and Nutrition.</p> <p>Another important task of the technical Specialist will be periodic review of technical guidelines, training manuals and supporting materials, providing feedback and making recommendations in case changes are needed. Further, external technical assistance will be hired, through competitive methods or from relevant technical public sector institutions, for tasks like curriculum Developments, Development of software, and development of M &E Frameworks etc.</p> <p>It is suggested that all the curriculum of outreach workers should be in urdu for better understanding of outreach workers and better understanding of Facilitators. Similarly the available modules on nutrition, immunization, reproductive, maternal, neonatal and child health may also be translated into Urdu which will ensure effectiveness of training and will impact on quality of maternal and child health services (previously translated materials will be improved and translated further if necessary).</p> <p>Capacity building and technical support for the development of national clinical guidelines for antenatal and postpartum care, nutritional management will be provided in order to strengthen implementation of evidence based practices and continuum of care for mothers and their newborn babies.</p> <p>In addition, capacity building of provincial and district level staff will be done in areas of programme management, procurement and financial management to improve efficiencies and avoid wastage of resources.</p> <p>Technical Assistance is an important aspect of all development activities. For the very same the sub component of TA both national/provincial and international has been inbuilt in the PC-1. The need and area for TA will be proposed and submitted to the Technical</p>
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	<p>Committee on Health constituted for the programme, for approval.</p> <p>The technical staff will be encouraged to write and publish articles and papers based on experience from the field. Those individuals whose papers will be accepted for international or national events and conferences will be financed for participations as an incentive.</p> <p>During implementation of the programme, oversight will be the responsibility of two committees, to be constituted under the PC-1 :</p> <ol style="list-style-type: none"> 1. Provincial Steering committee 2. Technical Committee on Health. <p>These will provide policy and technical guidance to the programme from time to time.</p> <p>District Level:</p> <p>However, in order to strengthen the service delivery, it is imperative that the district health systems are strengthened. The current set up for health at the district level is not geared up to meet the new challenges. In order to create a system of performance and financial accountability, the revised structure is proposed at the district level is attached at Annex-XXIV.</p> <p>Each district will be required to develop their district health plan for implementation of MHSDP and Maternal & child health interventions and nutrition interventions at secondary level.</p> <p>Steps for finalization of district health plans are as under:</p> <p>Following steps will be followed for development of District plan for the implementation of the programme:</p> <ol style="list-style-type: none"> 1. Self Assessment of the health facilities against a Standardized check list developed in light of MHSDP by facility In charge. 2. Identification of gaps at facility level against the MHSDP for available services. (Both for Outreach as well at level health facility of the catchment area).Compilation of the needs at district level in light of identified needs by the facility. 3. Development of costed District plan for Implementation of MHSDP by the district. 4. Submission of District Plans to Directorate General Health Services. 5. Verification/validation by third party of District plans. 6. Recommendation of District plan by Technical Committee. Technical committee will also be authorized to approve for
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		<p>additional ties of Rs. 5 million in the already approved plan.</p> <p>7. Approval by steering committee of proposals.</p> <p>8. Release of funds to district for implementation of programme.</p> <p>At the end of the year the progress of each district will be measured against the baseline, gaps identified and grading of each district done as per performance. Warning will be issued to poor performing districts, while rewards in form of Performance certificates or bonuses will be given to district that show achievements against the approved targets. This will form the basis for planning for the subsequent years District plan.</p> <p>Activity 2: Improved Procurement and Financial Management system at provincial and district level.</p> <p><u>Procurement mechanism</u></p> <p>The procurement of all supplies and medicines described in the MHSDP will be carried out through a rate contracting mechanism at Provincial level by using the prequalified firms selected by the Central Procurement Cell in the Directorate General of Health Services except for vaccines which will be centrally procured.</p> <p>For Equipment's and furniture, Provincial health department through the central procurement cell, will develop and provide specifications and share with the districts. While, the supply order will be issued by the district as per Departmental procurement rules and procedures, in addition to settling bills.</p> <p>Each district will have a designated Assistant logistic officer for ensuring proper procurement and logistics management of the programme. Capacity building of the district staff involved in procurement and logistics will be the responsibility of the provincial procurement cell and their capacities will be build in areas of forecasting using data from the facilities, on reducing wastage, record keeping, logistic management, condemnation and improvement in storage conditions.</p> <p>Support will also be provided to the district for proper storage of medicines & supplies and other logistics as per guidelines.</p> <p>Financial Management:</p> <p>Financial Management is an integral and important part of the overall health care services. There is general lack of trained financial managers and logistic officers at all levels but especially so at the districts. Therefore, in order to ensure smooth, timely and transparent use of resources, it is proposed to create a post of Assistant Accounts officer in all districts (detailed terms of reference are at Annex - XXII).</p>
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In addition, the department is also cognizant of the possibilities of the duplications between the support to be provided through various means e.g. MDTF, District Conditional Grants and support by other partners like EU, USAID (MCHIP and PARRSA) and UN Agencies. The targets to the districts will be agreed / reviewed by the technical review committee in light of all the supports going to the districts. Detailed analysis of the plan identifying the sources of funding for the districts and agreed targets for each intervention will help the technical review committee in getting approval of appropriate targets for the districts. This responsibility of scrutiny of plan with regard to duplications stands with Knowledge management wing and FM wing providing proper inputs to DGHS on the subject.

While the posts of the coordinators proposed in the provincial and district structures are to be filled by transfers or postings, the vacancy of procurement specialist, biomedical engineer, finance manager and logistic officer will be filled through open advertisement on merit basis and will be on market based salary.

Performance Bonuses:

Global literature suggests that to promote focus on results, performance bonuses to staff working towards defined objectives can make a big difference in achieving these results. In line with the international evidence, the male and female staff working in a district will be eligible to performance bonus if the district achieves specified performance criteria as judged through annual assessments by a third party.

The payment of the bonus will be based on improving performance of the district on the defined set of maternal and child health, EPI, FP and nutrition indicators as judged by the third party hired on contract. The staff eligible for performance bonus of the district achieving the benchmark set for the assessment will include: DHO/DDHO, Coordinators, District Manager PPHI, Health Facility Staff involved in implementation of activities, all LHWS, LHSs and CMWs working in the district. A condition for payment of the bonus will be that the person would have to stay in the position for a minimum period of at least one year before assessment.

Fund Flow Mechanism.

Upon approval of the project, Planning Cell of the Health department will be responsible to provide copies of Administrative approval and Audit copy. For the said project, an assignment account will be opened at DGHS level, Director health services and DGHS will be signatories of the concerned account, and similarly an assignment account will be opened at District health office where DHO and coordinator Reproductive Health will be cosignatories for the account.

	<p>The funds will flow to the programme through the office of the DGHS, where an assignment account will be opened. In view of the repeal of the LGO, the Finance Department will release money as earmarked in the budget book .The Director Health Services under the guidance of the DGHS will be responsible to prepare Cash Plan/Work Plan for the approved budget In light of the plan submitted by the DHO of the implementing districts to the DGHS. All plans will be consolidated and submitted to Technical committee for approval. The budget for districts will be released to the concerned districts after approval of DGHS, The recurrent section of the budget for districts will be released as per procedure chalked out by the Finance department. Detailed fund flow is explained in at Annex XXV.</p> <p>Reconciliation and Accounting of Funds:</p> <p>DGHS will carry out monthly reconciliation of funds released / expenditure with Provincial Accountant General office, Peshawar.</p> <p>Reconciliation of the funds for the district level will be carried out with District account office while Provincial budget will be reconciled at provincial level.</p> <p>Finance and Accounts Staff</p> <p>It is preferable that the Finance Officers, Audit Officers, Assistant Accounts Officers, Cashiers/other accounts staff be hired / or deputed from Auditor General of Pakistan (AGP)/Controller General of Accounts (CGA).In case AGP/CGA offices do not fill in the position(s) the position(s) will be filled in on contract basis with the approval of the competent authority.</p> <p>Post of Financial Manager/Assistant Account officer and account section at district level will be filled in similar manner.</p> <p>Internal Audit</p> <p>Internal audit of all spending units would be conducted and in order to strengthen the internal control system, an internal audit system within the Programme would be established. It will be the primary duty of the health department to carry out internal audit at all levels of execution of activities at districts. The function of internal audit is to ensure that public money is expended in accordance with government rules, regulations and books of accounts and store stock record have been kept properly and presents true and fair position. The internal audit reports should be discussed and their Compliance should be made.</p> <p>An internal Audit unit will be established at secretariat level directly reporting to principal Accounting Officer. Internal Auditors will regularly monitor the activities of programme at district level.</p>
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External Audit

Audit Team of the Auditor General of Pakistan will conduct annual audit of accounts of the programme funds at the provincial and districts level.

Activity 3: Improved Health Promotion and Communication:

The health department intends to make use of all available channels of communication to raise awareness and mobilize the community on importance of nutrition, immunization, family planning, maternal and child health issues using specific themes, identified either through research or based on the policy recommendations that needs to be addressed, among the general populace as well as specific segments of the society i.e. religious leaders, opinion leaders and other influencers.

At provincial level there will be a separate unit for Health promotion which will be responsible for

- Development of;
 - Health messages,
 - Communication strategy
 - Designing of Posters and flip chart.etc.
 - Guidelines for district on health promotion and communication strategy.
- Develop the tools and materials for communicating the key gender sensitive messages for behavior change and field test them before actual implementation.
- Development and printing of IEC material with information on antenatal, natal and post natal care, child health, immunization, Reproductive health, FP and IYCF, CMAM and nutrition supplementation.
- Communication campaigns using local FM channels
- Coordination with stakeholders/media
- Advocacy seminars.

Health Promotion and advocacy officer at district officer will be responsible for the implementation of communication strategy. He will ensure the display of all messages, posters etc at appropriate materials.

Output5: Integrated Monitoring & Evaluation Systems for evidence based decision making through use of good quality data

Activity 1: Improved data availability & data quality

Reviewing and updating the health information system enables users at all levels to collect and use relevant and reliable information on reproductive, maternal, neonatal and child health, FP, nutritional status of the population and communicable diseases. Such an update will allow for monitoring especially health of mothers and children, evaluating the effectiveness of relevant policies, making comparisons of country' progress towards the targets set in under MDGs and

	<p>improving the process of developing informed policy recommendations.</p> <p>No project can be termed successful without having a fully developed and functional system for monitoring and evaluation. A robust program management information system at all levels is important to record the implementation of programme activities at ground level, preparation of program performance reports and planning of subsequent activities.</p> <p>The Health department with this in mind plans to develop a robust monitoring and evaluation framework and an implementation plan. The framework will capture the requisite information for monitoring of various activities e.g. implementation status of MHSDP at the outreach level, quality of care, review of routine reporting data, operations research under the guidance of the Technical Committee.</p> <p>The comprehensive M&E Framework will aim to monitor the resources invested, the activities implemented, services delivered and evaluate outcomes achieved. Mechanisms will be put in place to improve data collection and information flow mechanisms to ensure quality, valid, and accurate data. Existing data collection mechanisms as of the District Health Information System (DHIS) will be used and new systems/software / monitoring tools will be developed to respond to the data needs of the project. (Annex XXIII)</p> <p>The objectives of the M&E framework is to collect and provide information that will be used to:</p> <ul style="list-style-type: none"> • Track progress on implementation of all components of the project; • Identify gaps and weaknesses in service provision; • Assess impact of MHSDP on women, children, vulnerable and disadvantaged • Plan, prioritize, allocate and effectively manage resources; • Monitor the impact of health communication on reproductive, maternal, neonatal and child health and nutrition behaviors; and • Measure effectiveness of interventions at Primary and secondary care levels. <p>Implementing the recommendations will contribute to standardization of the reporting tools and strengthening of the quality assurance component of child and maternal health, FP and nutrition services. It will also directly contribute to facilitation of the process of integrating maternal and child health services into primary health care.</p> <p>Activity 2: Use of Information for informed decision making Performance Monitoring and Results Evaluation Plan</p> <p>The Health Department will design and implement an internal performance monitoring and evaluation system that will serve the following two separate but related objectives:</p>
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a. To improve performance and monitor progress

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

The department aims to develop a Management Information System (MIS) to enable technical specialists and management team to manage and control all aspects of the programme at both macro and subproject levels. In creating the MIS, it is proposed to develop such a system that will provide useful information to technical staff and partners. This goal will be achieved through the creation of a series of interlocking relational databases. Each database will be designed to stand alone in its functional area (financial, subproject activities, administrative/deliverables), but will also link with the other databases for exchange of information and report generation. This will ensure that the complexity of each database is kept to a minimum while providing for flexibility and efficiency in aggregating across databases. It will also avoid duplication of information and functions. (**Annex XXIV & Annex XXV**)

Administrative Records Database: The administrative database will track basic project management information. It will provide information on major activities complete, status of activities by tasks, resources utilized, resources available, etc. and other deliverables are provided to the stakeholders in a timely manner. The administrative database will link with the subproject database to obtain data on the status of key subproject activities. It will also link with the procurement/logistics databases. The database will also be used to produce the following tables:

- The Project Activity Inventory will set forth the desired result for each activity, tasks to be accomplished, and resources required for each district.
- The Annual Work Plan will incorporate the Activity Inventory and will set forth the staff, time frame, and resource requirements for the project activities for the coming year. (**Annex XXIV**)
- The Results-Oriented Project Activity Schedule will summarize the results-specific information from the Annual Work Plans. The Schedule will show each activity mapped to a project result and intermediate result, the period of performance, lead responsibility, and status for the reporting period. This schedule will also provide

		<p>information to project management and stakeholders to see at a glance the number of weeks that each staff member will devote to the Project as a whole and to each project activity. (Annex XXV)</p> <ul style="list-style-type: none"> • The Annual Resource Allocation Table will be derived from the Project Activity Schedule. It will highlight for each Task level of effort (short-term and long-term), travel and subsistence allowance, other resource commitments (research, trainings, IE&C, Conditional grants, equipment). • To define our intended results and provide accurate, relevant, and timely data for external evaluations <p>The Health Department recognizes that external evaluators' best carry out the assessment of impact. To conduct a useful evaluation, however, external evaluators need to know the specific results we intend to achieve. By clearly defining our intended results from the start, we help focus external evaluations on the critical issues for the results package. External evaluators also are faced with the challenge of obtaining data to inform their evaluation. The project itself is best positioned to meet evaluator's data needs and therefore will be responsible for providing baseline data. Our internal system will be designed and implemented to collect quality data and to report on process, performance, and impact to meet the schedule and needs of external evaluations.</p> <p>Special training for staff at all levels will be conducted in the use of data for problem solving and solution development. Through data-based decisions, it is expected that the programme will become more proactive in supporting client-centered nutrition, family planning and maternal and child health services.</p> <p>Program Evaluation and Strategy Modification.</p> <p>The programmes internal Management Information System (MIS) will provide information on inputs, including level of effort (LOE), and other items. Client and provider interviews, facility visits, review of records will be other primary sources of information. Interviews with policy makers and health department management teams will provide information about changes in planning and management systems as a result of the project inputs. The Demographic and Health Survey will be a critical source for assessing changes in knowledge, attitudes, and practices among married women of reproductive age, while mid-term and end project evaluation will be conducted to assess the achievements of targets against the result framework.</p> <p>Some of the key activities will be grouped under the following heads</p> <ol style="list-style-type: none"> 1. Recruitment of Technical staff for monitoring at Provincial level of health care (where needed) (Annex- XVI and XXVII) <ul style="list-style-type: none"> • IT Officer (BPS 17) • Statistician (BPS 18) • Sr. Research Officers (BPS 18)
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		<ul style="list-style-type: none"> • Provincial Epidemiologist (BPS 18) • M&E Officers (BPS 18) <p>2. Information Dissemination through Seminars and media</p> <p>Activity 3: Functional Maternal, Neonatal and Infant Mortality Surveillance system;</p> <ol style="list-style-type: none"> 1. Reporting on Maternal, neonatal and Infant Mortalities from communities and health facilities. 2. Verbal Autopsies of all the reported mortalities by the health facility staff; 3. Analysis of the cause of death data and its use in planning and management of Health services. 4. Mortality reviews and death audits at Health facilities. <p>Activity 4: Improved supportive supervision and Supervisory mechanism at various levels of the programme.</p> <ul style="list-style-type: none"> ○ LHS will supervise LHWs and midwives (each LHW and midwife will be supervised twice a month against a checklist.) Lady Health supervisor will submit the report to the in charge of the facility and coordinator IV at district level. ○ Vaccinators will be supervised by FSVs. Each FSV will be responsible for 6 vaccinators. Each vaccinator will be visited 3 times in a month in the field by the FSV. FSV will submit the report to Facility in charge of the concerned catchment area and to the RMNH cell at the district level. ○ Facility staff is also responsible for supervision of outreach workers in the facility catchment area. ○ Supervision & Monitoring of all district level activities by the District Health Office. ○ Directorate General Health Services at Provincial level will also monitor the programme activities at district level. ○ Reporting will be ensure on DHIS format , which will be regularly analyzed and feedback on regular basis from province to district, district to facility and by the facility in charge to the health care providers at facility and community level. ○ Quarterly monitoring reviews will be conducted at provincial level .while at district level all the facility in charge will be invited for Review. Similarly a separate review will be conducted with the lady health
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		<p>supervisors and FSVs.</p> <ul style="list-style-type: none"> ○ Third Party monitoring: Third party will be hired following the provincial Procurement rules .It will conduct regular monitoring and submit periodic reports to district government as well as to the office of Director General Health services. ○ Evaluation – baseline will be established where it is not available against the indicators already defined in the log frame. Midterm and End-evaluation will also be conducted to assess the results. <p>Exit Strategy</p> <p>The full role out and execution of MHSDP will be the exit strategy of the proposed project. This is expected to done in a phased manner. Through this PC-1 the maternal, neonatal and child health including routine immunization programmes and nutrition activities defined in the MHSDP will be taken care off. It is expected that by the end of the three years of the programme, all districts will be fully implementing complete set of activities in this regard.</p> <p>During the implementation of the PC-1, special attention will be paid to capacity building of district level staff to enhance their capacities in management and technical areas. This will be essential as according to plan after the completion of the project life, all activities will be taken on the recurrent side. This activity will go a long way in ensuring smooth transition of the project.</p> <p>Moreover, following the closure of this PC-1 all the activities including procurement of medicines, supplies, staff hired under the programme both at provincial and district levels, will be taken on the recurrent budget and mainstreamed in the health department annual programme. In addition, it will be ensured by the Health Department that activities started under the PC-1 especially for nutrition, will not only be continued but also enhanced over time to ensure sustainability and scaling up.</p> <p>The integration of the key programme will lead to strengthening of the overall health systems, which had been undermined and weakened over the years. Further, the initiative will contribute maximally to strengthening of the district health systems. Moreover, the project will help build the capacity of both provincial and district staff in the area of nutrition, which has been a neglected area to date. Further, the activities for nutrition started under the project will be mainstreamed in the overall health care delivery services. The interventions under the programme will strengthen the neglected areas of MNCH, routine immunization, family planning and nutrition. The MHSDP implementation will provide the necessary foundation to create not only a need among the population at the same time building the confidence in the public health system</p>
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7.	Capital cost of project:	Nil																						
		Rs. in Million																						
8.	Annual operating and maintenance cost after completion of the project.	<table><tr><td>Employees Related Expenses/Salary</td><td>0.00</td></tr><tr><td>Behavior Change Communication & Advocacy</td><td>46.18</td></tr><tr><td>Procurement and distribution of Ready to use therapeutic food (metric tons)</td><td>165.10</td></tr><tr><td>Procurement and distribution of F75 & F100</td><td>2.86</td></tr><tr><td>Procurement of drugs, non drug items & contraceptives</td><td>0.00</td></tr><tr><td>Procurement of Vaccines</td><td>0.00</td></tr><tr><td>Procurement of Syringes & Safety Boxes</td><td>0.00</td></tr><tr><td>District Management Plan</td><td>2066.22</td></tr><tr><td>Cold Chain & Logistics</td><td>0.00</td></tr><tr><td>Operating office expenses, rent of buildings, POL/CNG , TA/DA, transportation of medicines/supplies and other items to Districts/FLCFs, utilities, communications, office stationery, repairs of physical assets etc.</td><td>144.53</td></tr><tr><td>Total</td><td>2,424.89</td></tr></table>	Employees Related Expenses/Salary	0.00	Behavior Change Communication & Advocacy	46.18	Procurement and distribution of Ready to use therapeutic food (metric tons)	165.10	Procurement and distribution of F75 & F100	2.86	Procurement of drugs, non drug items & contraceptives	0.00	Procurement of Vaccines	0.00	Procurement of Syringes & Safety Boxes	0.00	District Management Plan	2066.22	Cold Chain & Logistics	0.00	Operating office expenses, rent of buildings, POL/CNG , TA/DA, transportation of medicines/supplies and other items to Districts/FLCFs, utilities, communications, office stationery, repairs of physical assets etc.	144.53	Total	2,424.89
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District Management Plan	2066.22																							
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Operating office expenses, rent of buildings, POL/CNG , TA/DA, transportation of medicines/supplies and other items to Districts/FLCFs, utilities, communications, office stationery, repairs of physical assets etc.	144.53																							
Total	2,424.89																							
9.	Demand and supply analysis.	<p>The population of Khyber Pakhtunkhwa has increased from 17.7 million in 1998 to about 21 million. In addition it is estimated that there are more than 3 million Afghan refugees living in the province.</p> <p>Over half the population is illiterate and 31 percent of the population is living below the poverty line with the highest levels of poverty in Shangla, Upper Dir, Buner, Kohistan and Battagram. There is also a wide variation between districts in resource allocation, disease prevalence, malnutrition, gender inequality and illiteracy.</p> <p>Household out-of-pocket (OOP) spending remains the main source for financing healthcare. There is minimal social protection and a lack of access to health insurance. Khyber Pakhtunkhwa share of out-of-pocket expenditure for health care (76.6%) is the highest of all provinces. An analysis in 2002 showed that over 90% of expenditure on drugs and medicines in the Province was private and that nearly 60% of expenditure on health was paid by households.¹⁶ With the high percentage of people below the poverty line, the cost of healthcare can result in families becoming completely impoverished.</p> <p>Women and children are particularly disadvantaged by socioeconomic and cultural barriers with estimates of only 30% of them having access to medical care. The total fertility rate is high and the contraceptive prevalence rate (CPR) is not rising fast enough to achieve the MDG</p>																						

	<p>goals. There is high maternal and infant mortality and services are insufficient.</p> <p>Public as well as private services focus on curative care, with little attention to promotive, preventive or rehabilitative care. In addition, there is little known about the community's priorities in relation to primary health care services.</p> <p>Chronic staff shortages and non-availability of essential medicines is common and leads to health facilities being underutilized due to shortages of staff and supplies. In the Community Information Empowerment and Training (CIET) survey (2004), only 9% of the patients who had used a government facility had received all of their prescribed medicines.</p> <p>The quality of service provided by public health care providers is variable. Typically consultations between patient and health worker are short¹⁷, antibiotics are over-used, poly-pharmacy, there is poor communication between patient and dispensing staff and inadequate dispensing techniques.</p> <p>The project intended services are needed for the following purpose:</p> <ul style="list-style-type: none"> • Access to quality services at the door steps are going to be enhanced • Burden on secondary & tertiary level is going to be minimized • In time provision of desired services is going to be enhanced • Referral system is going to be strengthened • Trust over the public sector is going to be improved. <ul style="list-style-type: none"> • Existing capacity of services and its supply <p>The current number of health facilities are neither adequate as per standards set in by the planning commission nor is the quality of health care services within acceptable limits. A survey was conducted to find out the quality of health care services against approved Primary & Secondary Health Care Standards of Khyber Pakhtunkhwa in 2007. Results of this survey show that the score of Primary Health Care facilities on scale of 1-4 is 1.8 and that of secondary health care facilities is 1.3 on the same scale.</p> <ul style="list-style-type: none"> • Projected demand for ten years <p>The demand of better health services always exists; it will be there for an infinite time period. The project is designed to provide better health services and improve the health status of the people of the province.</p>
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¹⁷ Mention study. One study found that the contact time of doctors per patient is less than two minutes. The average number of drugs per prescription was nearly 3 with only 1.5 drugs being dispensed from the facility. Half of the prescriptions contained antibiotics and 17% of patients were prescribed with injectibles.

		<ul style="list-style-type: none"> • Capacity of projects being implemented both in the public & private sector <p>Based on the experience of existing projects there is anecdotal evidence that the public sector health delivery system is not cost effective where as private sector is also incapable of delivering in far flung areas due to low return on investment. Therefore initiatives of public private partnership will be considered for implementation of the project.</p> <ul style="list-style-type: none"> • Supply – demand gap <p>Multiple Indicator Clusters Survey 2008 (MICS) of the project show poor health indicators. Supply side further deteriorated due to the recent floods and conflicts. With such a bleak picture on the supply side it becomes impossible to meet the demand side.</p> <p>On the demand side, there has always been a demand for better health care services in the selected areas. Demand has increased in the wake of the recent crises.</p> <p>This project is designed to ensure health care services to meet the existing gaps between the supply side and increased demand side.</p> <p>Designed capacity & output of the proposed project Already discussed in Project Description.</p>
10	Financial plan and mode of financing.	Financial flow and mode of financing is attached at Annex-XXV and financing plan and its break up is attached at Annex XXVIII.
	Federal Government	PSDP Share Rs: 6594.00 million
	Provincial Government	PKR: 7332.00 million – ADP
	Donors	Total: 8925.66 million DFID Grant: GBP 40 million (PaK. Rs 6980 Million) Aus-Aid Grant: Australian \$ 20 million (PaKRs1979.2 Million)
	General Public	N/A
	Foreign equity (indicate partner agency)	N/A
	NGOs Beneficiaries	N/A
11	Project benefits and analysis.	
i.	Financial	The project will help to reduce the burden of disease in mainly poor strata of the population which is more vulnerable to diseases. The reduction in disease burden will reduce expenditures by the government on the health sector and indirectly help cut down financial impact of being sick on the poor. International evidence suggests that

		<p>investing in health of women and children reduces poverty, stimulates economic productivity and growth and are cost-effective.</p> <p>Evidence across the world suggests that economic costs of malnutrition are high—the World Bank estimates that 2–3 percent of GDP is lost every year in Pakistan on account of vitamin and mineral deficiencies alone. Nutritional intervention through the programme aims to contribute in reduction of this cost.</p> <p>The investment in the programme will generate employment across different cadres of health and management, develop systems and subsequently increasing revenue for the government by promoting and producing healthy population.</p>
ii.	Social benefits with indicators	<p>This project is aimed at increasing the overall quality of life, through decreasing maternal, newborn and infant mortality, improving availability of services for maternal and child health, and increasing awareness of the community for safe delivery, nutrition, birth spacing leading to smaller families, and self-development initiatives. The program aims to work in tandem with other government initiatives for poverty reduction. The estimated population benefiting from the programme is approximately 21 million.</p> <p>Additional social benefits accruing include the reduction of poverty from the population, decreased disease burden and increased awareness especially in the vulnerable segments of the society i.e. women and children. Increased access to preventive, reproductive health and nutrition services will help to reduce burden of disease among the population, which will be measured using the following indicators;</p> <ul style="list-style-type: none"> • Maternal Mortality Rate • Under 5 Mortality Rate • Infant Mortality Rate • Population growth Rate • Total Fertility Rate • Contraceptive Prevalence Rate • Immunization coverage rate • Prevalence of moderate and severe malnutrition in children <5yrs • Service utilization rate <p>The progress on the indicators will be monitored regularly using information from DHIS and through various national and provincial levels surveys e.g. PDHS, MICS and PSLMS.</p>
iii	Environmental impact	<p>With increase in utilization of services due to MHSDP, the project is expected to have minimum degree of environmental impact due to production of waste from health facilities. It is expected that initially increased utilization of health services will produce more hospital waste, however, at the same time a reduction of waste from home deliveries at household level is expected, which was previously improperly disposed. The new policy of the health department for Quality Standards necessitate proper disposal of waste. Another</p>

		<p>initiative is the pilot project for Infection Control recently launched in Mardan. The project is likely to be expanded to other districts.</p> <p>The project therefore, is unlikely to pose any serious environmental hazards; on the contrary by promoting healthy behaviors and practices, it is likely to contribute towards improvements in environment with more and more people adopting healthy life styles.</p>
12	Implementation strategies and schedule.	<p>Implementation Strategies:</p> <p>The Health Department, GoKP through the integrated PC-1 aims to roll out the Health Sector Strategy vision of strengthening the health systems with the focus on improving not only efficiencies but also effectiveness of the maternal, child health and nutrition services. Over the years, vertical programmes has led to considerable weakening of the health systems, HD has developed a comprehensive plan for strengthening the systems, among this one key exercise is integration of various vertical programmes in a phased manner. Within the context, the health department is integrating MNCH, LHW, Immunization and nutrition interventions, to improve services delivery effectiveness using innovative efficient approaches. The integrated programme aims to improve maternal, neonatal, child and nutrition outcomes by:</p> <ol style="list-style-type: none"> 1. Strengthening district health systems by introduction of district health planning and output based budgetary approaches for introduction and implementation of Minimum Health Services Delivery Package (MHSDP) at primary health care level; 2. Improve coverage by LHW and CMW from current 58% and 18% to 80 % at the outreach level; 3. Increased awareness about MHSDP through targeted, socially acceptable communication strategies for enhancing demand for preventive and curative services; 4. Involvement of community in planning of UC level health plans and oversight processes through constitution and operationalization of Primary care Management committees; 5. Enhance comprehensive Family Planning and Nutrition services at outreach and facility level through specialized outreach counseling services; 6. Strengthening of basic and comprehensive EmONC services and establishment of referral linkages between outreach workers and levels of health facilities i.e. BHU, RHC, THQ and DHQ; 7. Up-gradation and strengthening of secondary care facilities for provision of comprehensive EmONC and management of complicated cases of malnutrition; 8. Improve technical and managerial capacities at all levels of health care delivery system and expand accountability mechanism in health care delivery system; 9. Introduction and strengthening of result oriented integrated M&E mechanism at all levels for enhanced accountability; 10. Introduction of client centered quality services for increased patient satisfaction and improved health outcomes; 11. Strengthening of financial transparency and accountability at all

		<p>levels of services;</p> <p>12. Introduction of public private partnership models for enhancing access to quality services;</p> <p>13. Inculcating a culture of research for evidence based planning and monitoring;</p> <p>Detailed Attached at Annex XXVIII</p>
13	Management structure and manpower requirements.	<p>The programme aims to enhance coverage of maternal, neonatal, child health, family planning and nutrition services at the outreach level through recruitment of additional 2850 females as LHWs and 272 as community midwives in the rural areas. In addition, for non LHW covered area to enhance immunization coverage 500 vaccinators will be recruited to provide outreach services to ensure 100% immunization coverage.</p> <p>In addition 3279 staff of essential categories will be employed on contract/deputation basis for provincial and district level. <i>Annex–XXVII</i></p> <p><i>The project will have no PIU rather it will be the responsibility of DGHS to implement the project. Director Health Services will be the focal person for its implementation, supported by technical experts in various predefined fields for implementation.</i></p> <p><i>Further, at the district level the DHO will be responsible for overall execution of the project. He will be supported /strengthened by coordinators and by newly introduced posts of financial manager and supply chain Officer etc.</i></p>
14	Additional Projects/ decisions required to maximize socio-economic benefits from the proposed project.	<p>There is no need for additional projects since the intervention under the project will lead to strengthening of the health systems at the PHC level through implementation of the MHSDP. All the interventions being part of the MHSDP will be taken gradually on regular budget.</p>
15	Certificate	<p>PC-1 has been prepared as per instructions for the preparation of PC-1 for social sector Projects.</p>

Annexure A

Log Frame for the Integrated PC-1

Log Frame for the Integrated PC-1

	Key performance Indicators	Means of Verification	Assumptions/Risks
Goal To contribute to the improved health status of the population in the province through ensuring access to a high quality, responsive healthcare delivery system which provides acceptable and affordable services in an equitable manner.	MMR U5MR IMR NMR TFR Stunting	PDHS MICS PSLM	Improved macro-economic situation (at national & provincial levels) with accelerated economic growth -Fiscal constraints - Weak governance
Outcome Enhanced coverage and access to effective and quality maternal neonatal and child health services including nutrition with the strong focus on value for money and efficiency, especially for the poor and vulnerable	-% of pregnant women having access to ANC services -% of pregnant women with skilled attendance for birth -% of mothers with time appropriate post natal care -% of children 0-23 months who are fully immunized - CPR(modern methods) -Number of Children under age five treated for moderate or severe acute malnutrition - % of population with knowledge of birth spacing, high risk pregnancies, basics of nutrition and routine	DHIS Special surveys Third Party Evaluations Financial Management Information System	-Political stability and improved security situation -No major natural/manmade humanitarian disaster occur in the province - Smooth transition of all functions in post 18 th Amendment scenario -Improvement in literacy rate - Continued federal financing for the programmes till the next NFC - DOF committed to improving recurrent budget and MTBF -Project has created momentum to sustain use of health services showing changed health behavior

	<p>immunization.</p> <p>- % of primary care facilities providing Minimum Package of Health Service (MHSDP).</p> <p>-Number of timely quarterly and annual reports produced.</p> <p>-% of expenditures against annual allocations</p>		
Key Outputs and Activities			
<p>Output 1: Improved access to RMNCH and Nutrition services of MHSDP at outreach level :</p> <p><u>Activity 1.1: Increase coverage of RMNCH and nutrition services of MHSDP at outreach level</u></p> <p>1.1.1. Recruitment of staff against a set criteria LHWs, CMW and Vaccinators (to be appointed in uncovered areas)</p> <p>1.1.2. Training of outreach workers (initial and refresher)</p> <p>1.1.3. Procurement of supplies, stationary, printing equipment (as per standardizes lists of supplies for LHW and midwifery kits)</p> <p>1.1.4. Build horizontal linkages through PRISM Model between Midwives and LHWs</p> <p>1.1.5. Provision of outreach services including behaviour change and risk identification and referral at</p>	<p>-% of population covered by outreach services</p> <p>-Number of LHWs, CMWs and vaccinators recruited & trained</p> <p>-No. of CMWs deployed</p> <p>-No. of CMWs and LHWs who received refresher training</p> <p>- No of outreach workers reporting stock out of modern FP methods</p> <p>- Number of UCs reporting operational linkages</p> <p>- Reduction in number of Drop-out from BCG to Measles 1</p>	<p>District Health records</p> <p>Facility record</p> <p>District Health records</p> <p>LHS Reports</p> <p>LHW MIS</p> <p>CMW MIS</p> <p>DHIS</p>	<p>- Adequate allocations for service provision at PHC level</p> <p>-Health Centers achieve minimum required staffing levels and resources</p> <p>-Quality in-service training</p> <p>-Adequate female staff fulfilling requisite criteria is available for recruitment</p> <p>Unstable and ineffectively functioning central and district teams</p> <p>Poor involvement of key stakeholders including inter-sect oral collaboration and involvement of communities and families</p>

community level	<ul style="list-style-type: none"> - Number of children screened and referred for management of malnutrition - Proportion of pregnant and lactating woman provided 180 tablets of IFA -Episodes of diarrhea in children between the age of 6 and 59 months treated with zinc and ORS - No of deliveries conducted by CMWs 		
<u>Activity 2: Increased Community Participation and involvement in health Actions</u> 1.2.1. Organize inter-personal and group sessions 1.2.2.Community mobilization through male and female health committees, community elders and PCMCs <u>Activity 3: Improved Family and Community practices to support better health outcomes</u> 1.3.1. Identification of negative behaviors and opportunities for change 1.3.2.Dissemination of specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using innovative approaches	<ul style="list-style-type: none"> -No of sessions held - No of meetings of PCMCs with agenda and minutes. -Number of messages developed and disseminated 		
Output 2: Improved Access to RMNCH and nutrition services through MHSDP at Primary care facility level			Districts do not have sufficient capacity to develop district plans. Insufficient commitment

<u>Activity 1: Preparation and implementation of Union Council health plans using Result based planning and management techniques</u>			of the central and peripheral health authorities - Delay in implementation of activities
2.1.1. Preparation and implementation of Union Council health Plans.	-No of plans developed and approved.	District Report.	-Obstacles in setting up and implementing quality improvement mechanisms
<u>Activity 2: Increased availability of RMNCH and nutrition services of MHSDP against the approved quality standards</u>			-Delayed procurement of medicines and supplies
2.2.1 Recruitment of staff against sanctioned positions	-No of vacant positions in the BHU and RHC		
2.2.2. Procurement of supplies, stationary, printing equipment (Standard lists of supplies for PHC facilities)	- No of BHU with stock out of contraceptives	Facility record	
2.2.3. Delivery of preventive and promotive services for clients as per MHSDP	-No of PHC facilities providing 24/7 basic EmONC services.	OPD register of referral facility	
	-Proportion of pregnant and lactating women receiving Iron and Folic Acid (IFA) supplements	KAP Survey	
	-Children 6-24 months fed in accordance with all the three IYC feeding practices (Food diversity, feeding frequency and consumption of breast milk or milk)	Training records	
	-Children age 6-59 months receiving Vit A supplementation every 6 months. No of Training sessions conducted.	District and facility record	
2.2.4. Training of health care		District records	
		Surveillance	

<p>Providers</p> <p>2.2.5. Ambulance service for referrals</p> <p><u>Activity 3: Enhanced community participation in service Delivery Planning, Management and oversight</u></p> <p>3.1.1. Establishment of coordination and communication linkages with all stakeholders in catchment area</p> <p><u>Activity 4: Improved recording and reporting on Maternal, neonatal and Infant deaths for Improved Mortality surveillance at union Council level</u></p> <p>4.1.1. Improved recording and reporting on Maternal, neonatal and Infant deaths and malnutrition for Improved Mortality and morbidity surveillance at union Council level with the support of District level M & E Cell.</p>	<p>-No of facilities with operational ambulances</p> <p>-No of health committees meetings reports with list of participants</p> <p>- No. of timely reports received and feedback provided</p> <p>-No. of health facilities reporting on prescribed format regularly</p>	<p>reports</p>	
<p>Output 3: Improved Access to Maternal, child and nutrition Interventions at Secondary care level</p> <p><u>Activity 1: Ensure provision of 24/7 comprehensive EMONC and nutrition service at secondary care level.</u></p> <p>3.1.1. Recruitment of staff against vacant posts of Medical Officer and Nurses at each district headquarter hospitals</p> <p>3.1.2.Procurement of supplies, stationary, printing</p>	<p>-No of hospitals with optimal staffing for stabilization centre.</p>	<p>District Report</p> <p>DHIS</p>	

<p>equipment (Standard lists of supplies for maternal, neonatal, child health and nutrition)</p> <p>3.1.3. Management of complicated/ referred cases for maternal, neonatal, child health and nutrition cases on priority basis according to set standards.</p>	<p>- No. of Sec. care hospitals providing Comprehensive EmONC services</p> <p>-No. of facilities with OTPs</p> <p>-Number of health care providers having basic nutrition knowledge</p> <p>-Number of pregnant/lactating women, adolescent girls and children under 5yrs reached by basic nutrition services</p>	<p>District and facility record</p> <p>Periodic cross sectional surveys</p> <p>DHIS and facility record</p> <p>-periodic cross sectional surveys</p>	
<p>3.1.4. Preventive and promotive services for women and children e.g. vaccination, Antenatal, postnatal, FP and Nutritional counseling</p>	<p>- No of health education sessions organized</p> <p>-number of women with correct knowledge of nutrition practices,</p>		
<p>3.1.5. Training of Doctors and health care providers</p>	<p>-Number of health care providers trained</p>		
<p>Output 4: Improved Governance and Programme Management at provincial and district level</p> <p><u>Activity 1: Develop district and provincial level health plans using Result based planning and management techniques</u></p>		<p>Provincial and District Records</p>	<p>- Results based provincial and district program support is being implemented</p>
<p>4.1.1. Recruitment of staff as per prescribed criteria at provincial and district levels</p>	<p>-No. of new posts filled on merit</p>	<p>District procurement record</p>	<p>-Health information systems strengthened and implemented</p>

4.1.2. Development of district plans as per need against the given targets	-Number of district health plans produced and implemented	Recruitment record	
4.1.3. Training of provincial and District management on planning, procurements, financial management, Logistic management and M&E	-No. of trainings held on programme and financial management, M&E and procurement	Training records Meeting records Third Party Validation report	
4.1.4.Procurement of supplies, stationary, printing equipment (Standard lists of supplies	-Timely procurement of supplies and equipment according to standard specifications -Number of monthly reviews with minutes of the meeting	Health Department record	
4.1.5. Quarterly Provincial Review meeting and district level monthly review meetings.		Quarterly reports Report of TPV	
4.1.6.Development and dissemination of Technical Standards and Guidelines	-No of Technical guidelines and standards developed		
<u>Activity 2: Improved Procurement and Financial Management system at provincial and district level</u>			
4.2.1. Strengthening of financial systems and introduction of Internal Audit mechanisms	-Appointment of financial managers at district level		
4.2.2.Introduction of result based funding mechanism to the districts	-No. of districts preparing output based budget Plans		
4.2.3.Strengthening of procurement Unit at DGHS	-Provincial Procurement Cell established and made functional -Standardized Procurement guidelines developed and distributed -Standardized list of medicines developed		

<p><u>Activity 3: Improved Health Promotion and Communication:</u></p> <p>4.3.1. Establishment of Health Promotion and communication Unit at district and provincial levels.</p> <p>4.3.2. Participation in National Technical events and trainings</p> <p>4.3.3. Coordination with other Stakeholders through regular steering and technical committee meetings</p> <p>4.3.4. Develop and Implement supportive supervision and Supervisory mechanism at various levels of the programme.</p>	<p>and shared</p> <p>-Health education unit established and operationalized</p> <p>-Number of events participated in</p> <p>-Number of steering and Technical committee meetings held and minutes issued</p> <p>-Number of supervisory reports generated at various levels</p>		
<p>Output 5: Integrated Monitoring & Evaluation Systems for evidence based decision making through use of good quality data</p> <p><u>Activity 1: Improved data availability & data quality</u></p> <p>5.1.1. Recruitment of Technical staff for monitoring at all levels of health care</p> <p>5.1.2. Procurement of supplies, stationary, printing equipment</p> <p>5.1.3. Trainings of staff on M & E and research methodology.</p>	<p>Regular Performance review of districts organized at provincial and district levels using information data held</p> <p>-Number of positions filled on time as per prescribed criteria</p> <p>-Supplies and equipment procured and made operational</p> <p>-No of trainings held for provincial and district level providers on M&E</p>	<p>Third party validation reports(TPV)</p> <p>-Report of Midterm review Report of Mid Term review</p>	<p>-Availability of appropriate staff and skill mix (particularly female) and deployment in hard to reach/ remote areas</p> <p>-Donors are committed to working together</p>

<p><u>Activity 2: Use of Information for informed decision making</u> <u>Performance Monitoring and Results Evaluation Plan</u></p> <p>5. 2.1.Data validation by the districts at community and facility levels</p> <p>5.2.2. Operations Research.</p>	<p>-No. of quarterly reviews conducted at the district and provincial level</p> <p>-No. of researches conducted</p>		
<p><u>Activity 3: Functional Maternal, Neonatal and Infant Mortality Surveillance system;</u></p> <p>5.3.1. Establishment of a Functional Maternal, Neonatal and Infant Mortality and Nutrition Surveillance system.</p> <p><u>Activity 4: Improved supportive supervision and Supervisory mechanism at various levels of the programme.</u></p> <p>5.4.1. Regular Performance review of districts organized at provincial and district levels using information data</p>	<p>-Number of surveillance reports generated and reviewed</p> <p>-Number of M&E visits conducted and reports submitted, analyzed and actions taken.</p>		

List of Acronyms:

AGP	Auditor General of Pakistan
ANC	Antenatal Care
ADC	Assistant District Coordinator
BHU	Basic Health Unit
CBO	Community Based Organization
CDS	Comprehensive Development Strategy
CGA	Controller General Accounts
CMW	Community Midwife
CMAM	Community Management of Acute Malnutrition
CPR	Contraceptive Prevalence Rate
HD	Health Department
HSS	Health Sector Strategy
DHIS	District Health Information System
DGHS	Director General Health Services
DHQ	District Head Quarter
DSVs	District Supervisor Vaccinators
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Programme of Immunization
ECOSOC	Organization for Economic and Social Cooperation
EDO	Executive District Officer
FP	Family Planning
FSVs	Field supervisor Vaccination
GoKP	Government of Khyber Pakhtunkhwa
HSS	Health Sector Strategy
ICPD	International Conference on Population and Development
IEC	Information education and C
IMNCI	Integrated Management of neonatal and child illness
IMR	Infant Mortality Rate
IYCF	Infant young Child Feeding
LGO	Local Government Ordinance
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System
MMR	Maternal Mortality Ratio
MDTF	Multi Donor Trust Fund
MNCH	Maternal Neonatal and child health
NFP	National Finance Commission
NGO	Non Governmental Organization
NNS	National Nutrition Survey
OPD	Out Patient Department
OTP	Out-patient Treatment Point
PCMC	Primary Care Management Committee
PHSA	Provincial Health Services Academy
PNC	Pakistan Nursing Council
POL	Petrol Oil Lubrication
PC-1	Planning Commission -1
PNC	Pakistan Nursing Council
PHC	Primary Health Care
RHC	Rural Health Centre
RUTF	Ready to use therapeutic food

SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant SBA
SOPs	Standard Operating Procedure
TA	Technical Assistance
THQ	Tehsil Head Quarter
TORs	Terms of Reference
TBA	Traditional Birth Attendant
UC	Union Council
WMO	Woman Medical Officer

Community Midwives

Selection will be made at district level after advertisement in at least three widely circulated newspapers.

a. Selection Criteria

The community midwives shall be selected only from the rural areas and urban slums. EDO(H) will be the final appointing authority

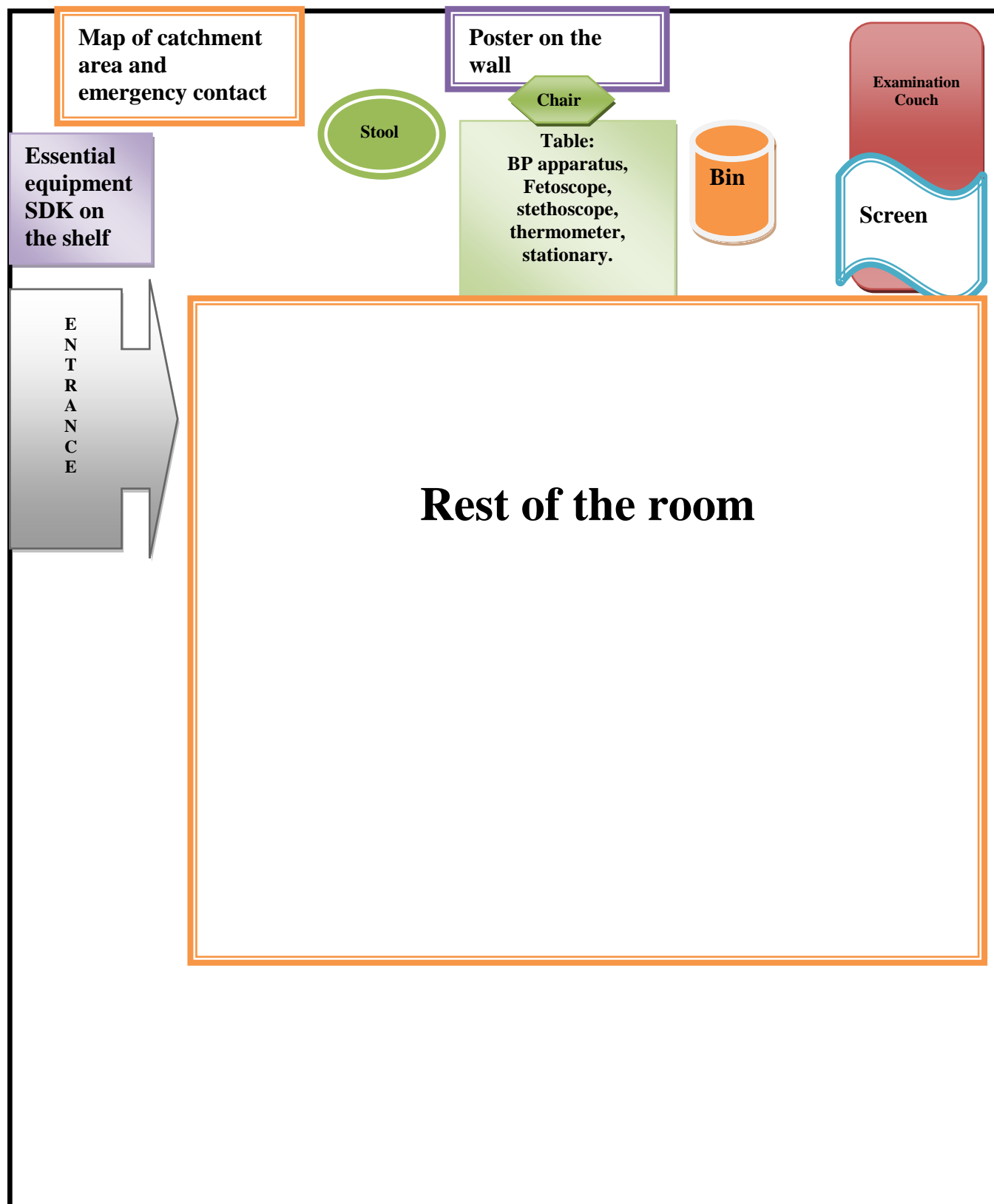
The selection criteria of Community Midwives are as under:-

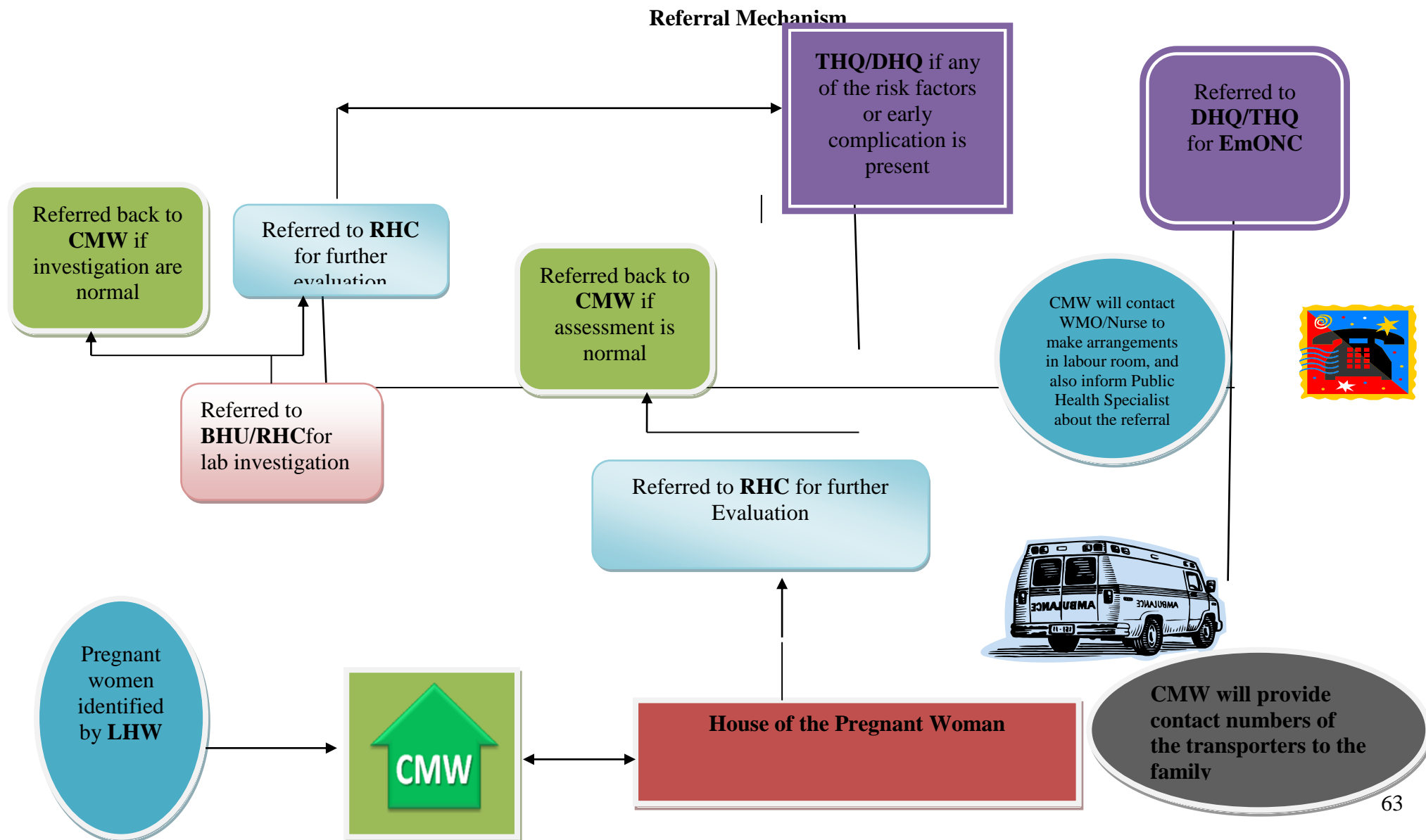
- Female, preferably married.
- Should be 18 – 35 years of age.
- Permanent resident of the area, for which she is applying.
Minimum qualification should be at least Matric with Science subjects obtaining 45% marks.
- Have experience of working in the community.

b. Selection Committee

- | | | |
|--|----------|-----------|
| ○ District Health Officer | Chairman | |
| ○ A representative of District Government | | Member |
| ○ Principal of Midwifery School
where training is to take place | | Member |
| ○ Medical Superintendent of the concerned hospital | | Member |
| ○ A representative of DGHS office | | Member |
| ○ Coordinator Reproductive health | | Secretary |
- Verification of the residential status shall be done through the Lady Health Supervisors, and third party monitors/provincial representative.
 - The selection committee will also send the matriculation certificate for verification to the concerned board. However, if the candidate fulfills all other requirements will be allowed to start training without waiting for the confirmation from the board.

Proposed Layout of a Working Station for CMW





Selection and Recruitment of LHWs

The LHWs will be women residing in the same community for which they are recruited, acceptable to their communities. The appointing authority is DHO based on the recommendations of selection committee.

a. Selection criteria for LHWs

The selection criteria of Lady Health workers are as under:-

- Female, preferably married.
- Permanent resident of the area, for which she is recruited.
- Minimum 8 years of schooling preferably matriculate.
- Should be between 18 to 45 years. (For unmarried 20-45 years)
- Preference will be given to women with past experience in community development.
- She should be willing to carry out the services from her home (which will be designated a 'health house') ensuring effective linkage between the community and the public health care delivery system.

b. Composition of Selection committee for LHWs

- Medical Officer/In-charge -FLCF (chairman)
- Women Medical Officer / Lady Health Visitor (LHV) / Female Medical Technician (FMT) -FLCF
- Lady Health Supervisor of concerned catchment area.
- One eminent member of the local community
- One representative of District Health office.

The final selection of the LHWs will be made after careful scrutiny of the documents and the residential status of the applicants by Lady Health Supervisor and Third party.(third party will scrutinize 20% of the recommended candidates on random basis)

During selection process a written test will have to be qualified (to be kept in her personal file after selection) to ascertain the educational status of the candidate.

The selection committee will be bound to forward the list of recommended candidates to the DPIU within 3 days of the interview. The DHO in turn should forward it to DGSH within 7 days of receipt of lists. DGHS will ensure the completion of spot verification of the candidates and submission of final Recommended list to DHO within 60 days (depending upon the number of candidates) for appointment.

The office of the District Health Officer will issue recruitment orders within 15 days of receipt of verified list of LHWs from DGHS.

c. Recruitment and Termination of LHW

LHWs will be employed in BPS 5 after completion of 15 months training. Initially for one year on probation followed by the renewal of contract after every 3 years.

The LHWs not fulfilling the selection criteria would be liable to termination of contract. The DGHS office can also recommend to DHO to immediately terminate such LHW or LHS found to be not fulfilling selection criteria. If such LHW/LHS is not terminated by DHO, the DGHS is authorized to issue the termination order after a period of one month of recommendations.

It is further clarified that those LHW showing continuous overall poor performance (at least three warnings, within a period of less than 06 months) may also be terminated by the DHO.

Although DHO of the district have hiring/ firing authority for LHW, however once an LHW is terminated then the same LHW could only be reinstated with the DHO recommendations (based on the findings of termination review committee at DGHS or findings of Enquiry Committee constituted by DGHS).

The members of the committee are

Category	Position
1. Director Health Services	Chairman.
3. Concerned DHO	Member
2. Technical Advisor MNH,	Member
4. DD Reproductive Health	Secretary

d. Retirement age:

The LHW upon reaching the age of 60 years will retire from the services.

Job Description of LHW

The scope of work of LHW will be to provide PHC services to the communities in her catchment's area. These include;

- To register all family members in the catchment area especially the eligible couples (married women age 15-49 years) in their respective area, and maintain up to date information about her catchment area population.
- To organize community by developing women groups and health committees in her area. She will arrange meetings of these groups in order to effectively involve them in primary health care, family planning and related community development activities. She will keep close liaison with influential women of her area including lady teachers, Community midwives, traditional birth attendants and satisfied clients.
- To visit 5-7 households every day to ensure that all registered households are visited once every month.
- To discuss with the community, issues related to better health, hygiene, nutrition, sanitation and family planning emphasizing their benefits towards improved quality of life.
- To coordinate with local Community midwives or other skilled birth attendants and local health facilities for appropriate antenatal, natal and postnatal services. She will also conduct antenatal, natal and postnatal care as described in her training.
- Act as a liaison between formal health system and her community as well as ensure coordinated support from NGOs and other departments.
- As part of their tasks, LHWs will undertake nutritional interventions such as anemia control, growth monitoring, assessing common risk factors causing malnutrition and nutritional counseling. They will be able to treat iron deficiency anemia among all women especially pregnant and lactating mothers as well as anemic young children.
- LHWs will promote nutritional education with emphasis on early initiation and exclusive breast-feeding for six months and weaning practices, maternal nutrition and macronutrient malnutrition.
- To coordinate immunization of mothers against tetanus and children against communicable diseases. The LHWs trained in giving vaccines themselves will ensure timely vaccinations (in her catchment's area only) with support from the local health facility staff. The LHWs will also participate in various campaigns for immunization against EPI target diseases e.g. polio, MNT, measles etc in her catchment's area only. The LHWs will be involved in the surveillance activities in her catchment's area only.
- To motivate and counsel clients for adoption and continuation of family planning methods. She will provide condoms, oral pills and administer injectable contraceptives, as per defined protocols, to eligible couples in the community and inform them about proper use and possible side effects.

- To refer clients needing IUCD insertions, contraceptive surgery to the nearest health facility in the government preferably (RHCs,/ THQ/DHQ Hospital etc) or NGO sector (FWC, RHS Centers,)..
- To carry out prevention and treatment of common ailments e.g. diarrhea diseases, acute respiratory infections, tuberculosis, intestinal parasites, malaria, primary eye care, scabies. First aid for injuries and other minor diseases using essential drugs. She will refer cases to nearest centers as per given guidelines. For this purpose a kit of certain inexpensive basic drugs will be provided to LHW. LHWs will also be involved in TB, AIDs, Hepatitis and Malaria prevention/control.

a. Remuneration for LHWs.

In Compliance with the Order of honorable Supreme Court of Pakistan dated 7th September, 2010, the LHWs has been regularized in BPS 5. During initial training of three months LHWs will be paid Rs.200/- per day. On successful completion of three months training she will be getting regular monthly stipends of working LHWs. An Annual increase of 5% will be granted to LHWs commencing from July 2012

b. Incentive for LHWs:

In addition to stipend, good performing LHWs would be given honor certificates, prizes, shields, monetary awards, etc

Responsibilities of CMWs:

- Providing individualized care to the pregnant women throughout the maternity cycle and the newborn, in her own environment and helping her in self-care.
- Monitoring the physical, social and emotional well being of the pregnant woman as needed.
- Providing guidance and counseling to the community for healthy habits, and involving the family in preparation for childbirth and for unforeseen emergencies.
- Identifying actual or anticipated conditions, requiring medical attention and making timely referrals.

Practicing midwifery within the legal framework and following the professional code of conduct provided by the relevant authority.

STEERING COMMITTEE FOR HEALTH

The Steering Committee will make strategic and policy decisions regarding the implementation and activities of the program.

Membership

1. Minister for Health	Chairperson
2. Secretary, Department of Finance	Member
3. Secretary, Planning and Development Department	Member
4. Secretary, Department of Health	Member
5. Secretary, Department of Population Welfare	Member
6. Director General Health Services, Health Department.	Member
7. Chief, HSRU, Health Department	Member
8. Chief Planning Officer	Member
9. Director Health Services	Secretary

Terms of Reference.

The Steering Committee on Health will meet twice a year or earlier if required. The Secretary of the Committee will prepare a working paper, and circulate two weeks before the proposed date of meeting. The TORs for the Steering Committee on Health are as follows:

1. Provide overall policy guidelines especially in areas relating to advocacy and use of NGO/private sector institutions for delivery of services
2. Oversight of overall program progress of all implementing entities, both technical and financial, on the basis of approved implementation plans
3. Re-appropriation of funds within the project heads
4. Review periodic assessment reports and accord approval for changes in implementation modalities, if required.
5. Provide support for approval of new regulations, if and when needed
6. Co-ordinate & liaise with Donors/ International organizations for obtaining assistance for the integrated programme

TECHNICAL COMMITTEE ON HEALTH

This committee is conceived with the objective to closely oversee the technical aspects of the Program with special emphasis on vertical and horizontal linkages, technical guidelines etc.

Membership

1. Director General Health Services, Government of KP	Chairperson
2. Director Health Services	Co- Chair
3. Deputy Director (RH)	Secretary of Committee
4. Chief HSRU, Health Department	Member
5. Technical Specialists, Health Department	Member
6. Representative from Department of Population Welfare	Member
7. Representative from Research/ Academic Institutions (need basis)	Member
8. DHIS Expert	Member
9. Project Director IQHCS	Member
10. Representative from NGOs/DHOs/International agencies/ Development Partners (Need basis)	Co-opted Members

The Technical Advisory Committee will meet quarterly. Secretary of the Committee will prepare working paper, and circulate two weeks before the proposed date of meeting.

Terms of Reference for the Technical Advisory Committee on Health are as follows:

1. Provide policy and health care guidelines to the districts
2. Technical review and approval of district health plans
3. Conduct quarterly reviews of the progress on district health plans (DHP) with districts
4. Identify, review and approve all technical assistance related to programme development and implementation provided by international agencies/donors/development partners
5. Approval of operations research proposals submitted.
6. Provide technical input for the development of relevant policies and technical guidelines.
7. Provide guidance to districts for implementation of technical and operational guidelines, quality management and review of ongoing research studies.
8. Review and approve all new interventions related to programme.

Selection and Recruitment of Vaccinators:

The vaccinators will be males preferably residing in the same community for which they are recruited. The appointing authority is DHO based on the recommendations of selection committee.

e. Selection criteria for Vaccinator

The selection criteria of vaccinator are as under:-

- Male, preferably married.
- Preference to permanent resident of the area. In case of non availability of suitable candidate, they will recruit from the adjacent districts for which she is recruited.
- Minimum FSc. with science subjects
- Should be between 20 to 45 years.
- Preference will be given to candidates with previous experience of working in the community development.
- Willing to perform outreach tasks assigned to him and establishes effective linkage between the community and the public health care delivery system.

f. Composition of Selection committee for Vaccinators

Category	Position
1. Medical Officer/In-charge -FLCF	Chairman.
3. Women Medical Officer / Lady Health Visitor (LHV) / Female Medical Technician (FMT) -FLCF	Secretary
4.Lady Health Supervisor of concerned catchment area	Member
5. One eminent member of the local community	Member
6. Representative of District Health office	Member

c. Retirement age:

The vaccinator upon attaining the age of 60 years will automatically retire as per the government rules from the services.

Annex IX

Requirement of drugs/non drugs & contraceptives for LHWs

S. No	Name of Item	Unit	Monthly consumption per LHW	Annual Requirement
1	Paracetamol Tablets	Tablets	200 tablets	38520000
2	Paracetamol Syrup	Bottle	10 bottles	192,6000
3	Chloroquine Tablets	Tablets	100 Tablets	19260000
4	Chloroquine Syrup	Bottle	5 Bottle	963,000
5	Ferrous Fumerate+ Folic Acid	Tablets	1000 tablets	192600000
6	Antiseptic Lotion 1.5%	Bottle	1	192,600
7	Amoxil Suspension	Bottle	10	1926000
8	Eye Ointment	Tube	10	1926000
9	Sticking Plaster 1.5 M	Roll	1 roll every 2nd month	96,300
10	Cotton Wool (non sterile)	Roll	1 roll every 2nd month	96,300
11	Cotton Bandage 4 x 3 m	Pack of 12	1 pack every 2nd month	96,300
12	Low osmolarity ORS (20.5 gm)	Sachet	20 Sachets	385,2000
13	Zinc Sulphate Syrup	Bottle	8 bottles every 2nd month	770.400
14	Mabendazole Tablets	Tablets	100 tablets every 6months	321,0000
15	Benzyle Benzoate Lotion	Bottle	3 bottles every month	625,950
16	LHW Kit bags	Piece	Replaced after 2 years	16050
17	Thermometers	Piece	12 /year.	192600
18	Salter Scales	Piece	Replaced after 3 years	16050
19	Scissors	Piece	Replaced after 2 years	16050
20	Oral Pills	Cycles	10 cycles per month or replenishment as per number of clients	1926000
21	Condoms	Piece	100 condoms/month or replenishment as per number of clients	19260000
22	Injectibles with syringes	Vial	3 injections per month or replenishment as per number of clients	557800
23	Health House Boards	Piece	Replaced every 3 years	16050

Estimation of Printed Material for LHWs, LHS, Health Facilities

Total Allocation of LHWs		16800	LHSs allocation	695	Districts
Working LHWs		13200	LHS Working	561	FLCFs
To be recruited		2850	To be recruited	111	
S.No	Item	Requirement/LHS	Total Annual requirement	Safety stock (10% of the total requirement)	Net Annual requirement
1	Trainers Manual (TOT)	1 for each trainer	900	90	990
2	LHW Manuals 3 months (Urdu)	1 for each LHW	2000	200	2200
3	Register Khandaan	1/LHW/2 yrs	7000	700	7700
4	Register Curative & FP	1/LHW/ 1 years	16800	1680	18480
5	Register monthly report for LHW	1/LHW/ 1 years	16800	1680	18480
6	Facility Monthly Report	1/FLCF for 2 years	1000	100	1100
7	Community Chart (Urdu)	1 for each LHW for years	16800	1680	18480
8	Stock Register	1 for each FLCF for 2 years	900	90	990
9	Growth cards for LHWs	35 cards per LHW per year	588000	58800	646800
10	Referral Pad	2 pad/LHW/yr	33600	3360	36960
11	Movement register for vehicles	1 for each vehicle/2 years	672	67	739
12	Checklist & feedback report for Supervisor	4 sheets/LHW/ year for LHS 4 SHEETS /midwife/year	67200 8400	6720 840	73920 9240
13	Monthly Report for Supervisor	1 for two months	5000	500	5500
14	Checklist for LHWs trainings	1 for LHS+1 for dist management, 1 for rep. of PHSA.	800	80	880
15	Eye disease Chart (Urdu)	1 for each LHW/year	16800	1680	18480
15	Eye Card	1 for each LHW/year	16800	1680	18480
16	LHW manual 12 months (Urdu)	1 for each LHW/year.	2000	200	2200
17	Supervisor Manual Trainer	1 for each trainer/year	150	15	165

18	Supervisor Manual Participants	1 for each trainer & LHS	1595	159	1754
19	Poster set of 6 (Urdu)	1/LHW, 1/ trg centre & 1/district	20000	2000	22000
20	Diary for LHW	1 for each LHW for 2 years	16800	1680	18480
21	Diary for Supervisor	1 for each LHS for 2 years	702	71	773
22	Bin cards	As per reqt for all levels	54250	5425	59675
23	Logistics Consumption Register (Drugs)	1 register for each FLCF for 2 years	750	75	825
24	Logistics Consumption Reg (N- Drugs)	1 register for each FLCF for 2 years	750	75	825
25	Plastic cards for child health	4 cards/LHW/ 2year	75364	7536	82900
26	JaizaKarkardagi of LHW	2/LHS/year	1344	134	1478
27	Maternal Mortality Proforma	3/LHW/year	50400	5040	55440
28	CRC (Urdu)	10/LHW/year	168000	16800	184800

Auxiliary midwifery kit for CMWs - No. 2078(1828 existing+ 250new)

S. No	Name of Item	Quantity	Annual Requirement
1	Kidney basin, 25 cm, 825 ml, stainless steel	1 piece	2078
2.	Bowl, sponge, 600 ml, stainless steel	1 piece	2078
3	Apron, surgical, plastic, heavy duty	1 piece	2078
4	Mucus extractor, with mucus trap, for newborn babies, disposable	10 pieces	20780
5	Gloves, surgical, latex, size 7.5, sterile	2 packs	4156
6	Sheeting, plastic, 90 x 140 cm (washable)	1 piece	2078
7	Bottle, dropper, 10 ml, glass with cap including dropper	2 piece	4156
8	Thermometer, clinical, 26-42 °C for pre-matures/infants	1 piece	2078
9	Thermometer, clinical, oral/rectal/armpit, oval Celsius/Fahrenheit scale, in cover	1 piece	2078
10	Nailbrush, surgical, resterilizable, nylon	1 piece	2078
11	Case, midwife, aluminum, carrying handle, 305 x 215 x 150 mm	1 piece	2078
12	Cotton wool 100 g (100 % pure cotton)	1 piece	2078
13	Gauze pads 7.5 x 7.5 cm, 8 ply, N17, sterile	4 piece	8312
14	Nail clipper with file	1 piece	2078
15	Soapbox, plastic, 2 pieces	1 piece	2078
16	Soap, toilet, 100 g	6 piece	12468
17	Weighing scale, baby, tubular, hanging model, 5 kg/25 gram color coded graduation	1 piece	2078
18	Trousers for baby weighing scale 5 kg/100 gram(hanging model)	1 piece	2078
19	Umbilical tape, 25 m x 3 mm	4 piece	8312
20	Tape measure, 150 cm	1 piece	2078
21	Blanket, rescue, 210 x 160 cm, (heat/cold protection)	1 piece	2078
22	Hand towel 45 x 45 cm, 70 gram	4 piece	8312
23	Sphygmomanometer, aneroid, 300 mm Hg, with adults cuff	1 piece.	2078
24	Stethoscope, binaural, standard, dual head	1 piece	2078
25	Stethoscope, foetal, Pinard, aluminum	1 piece	2078
26	Forceps, haemostatic, Péan, straight, 16 cm	2 piece	4156
27	Scissors, surgical, straight, 14 cm, b/b	1 piece.	2078
28	Bottle, narrow mouth, 50 ml, amber glass, with screw cap	1 piece.	2078
29	Bottle, wide mouth, 50 ml, amber glass, 1 with screw cap	1 piece.	2078
30	Methyl ergometrine maleate 0.125 mg (methergin)	1 piece.	2078

31	Notepad A-5	1 piece.	2078
32	Pen, ballpoint, blue	1 piece.	2078
33	Disposable Delivery kits	50 pieces	103900
Medicines			
34	Micronutrients	80 sachets	166240
35	Antibiotics Amoxicillin tablets (250 & 500 mg) and Suspension, Ciprofloxacin tablets 500 mg, Metronidazole tablets (200 & 400 mg)	80	166240
36	Analgesics	100	207800
37	Antiseptics	2 bottles	4156
38	Injections required for delivery	20	41560
39	Antifungal Vaginal Tablets with applicator	6 per month	149616
40	Contraceptives Condoms Pills Injections	100/month 10 cycles/month 3 vials/month	207800 249360 74808
Stationery items			
41	Sign Board	1 piece	2078
42	Partograph chart	100 pieces	207800
42	Health Education material	1 set/CMW	2078
44	Data recording and reporting instruments	1 set/CMW	2078

CMW

CMW coordinates with LHWs and report all deliveries and refer complicated pregnancies and nutrition cases to the health facility

Annex XII
PRISM MODEL

LHW who is centrally placed and fulfills the section criteria OF CMW will be trained and inducted.

LHW

LHW

LHW

LHW

LHW

LHW

LHW

LHW

LHWs will identify and refer cases to CMWs and report all referrals

LHS will monitor CMWs and LHWs in the field and report to facility Incharge

Health Facilities

TRAINING OF LHWs:

The training of LHWs will be conducted in two main phases for a total of fifteen months

Initial phase - 3 months basic training

2ndPhase - 12 months

Post training assessment will be conducted after 15th months of training by the evaluators identified by the district management. Purpose of the assessment will be to analyse the knowledge & skills of the LHW for the field activities. The LHWs which score less than 70% will undergo further training of 2 months after which she will be reassessed. If she is still not able to achieve 70% marks then she will not be appointed as LHW. The Appointment of LHWs will only be done after completion of successful training.

For health facilities where 10 or more LHWs under training (in Basic Training) there will be three trainers; in health facilities where less than ten LHWs are under training, there will be two trainers one of the trainers has to be a female(WMO, LHV or FMT) to facilitate training in areas such as family Planning and maternal health.

No training session should have less than 5 and more than 15 LHWs. In case less than 5 or more than 15 candidates for trainings are selected in FLCF and they cannot be attached with other FLCF, approval shall be sought from “Technical Committee on Health”.

“Integrated training:” (initial 3 months training)

The first phase of basic training will be for Five days a week for three months. The newly recruited LHWs will be trained to cover the major PHC subjects, which include immunization, diarrhea control, reproductive health including maternal and child health & family Planning, nutrition, common ailments, personal hygiene along with education on community organization and interpersonal communication skills. For this period, LHWs will be paid 200 rupees / day. Team of trainers will also receive 20% of basic pay as training allowance.

“Task Based Training”: (12 months training)

The second phase of training lasts for 12 months with three weeks of fieldwork followed by one week (5 days) of classroom training each month. Lesson Plans have been prepared for the training, which give special emphasis to fieldwork and practical training on health center patients. This training builds on the first three months to strengthen the competence and skills of LHWs. The training will be job specific, focused on carrying out instructions/ procedures related

to the work of LHWs. During this phase, LHW will receive Rs 5000/month., whereas team of trainers will also receive 20% of basic pay as training allowance.

“Continuing on the job Training”: (after completion of 12 months training)

All LHWs will attend their respective health facility/ training center for one day each month to get refresher training on an identified topic. In addition, problems faced by LHWs in providing services will be discussed with the trainers. LHWs will also submit their monthly report, discuss with trainers/ supervisors and will collect supplies for one month.

Refresher (In-Service) Training:

On the recommendation of third external evaluation the refresher training for LHWs was introduced. The results of the 4th evaluation also indicated positive results of these trainings. It is, therefore, envisaged that the LHWs will be given maximum of 3-8 days (1-2 sessions) training each year after the completion of the twelve -month training in addition to the monthly 1 day continuing education at their respective FLCFs and that for LHSs 4-6 days per year at their districts. For this purpose refresher TOT workshops (2-4 days in 1-2 session) for the trainers at Provincial/District level will be organized. Trickle down approach will be used in refresher trainings.

At FLCF level LHWs batch will be 20 with two trainers (one male and one female both trained on Basic Module), in case of non availability of female trainer, The district managers/coordinators including Lady health supervisor will not be allowed to work as trainers nor will they be entitled for trainer's allowance.

Training of Midwives:

The existing training curriculum developed for the community midwives and approved by Pakistan Nursing Council will be used for training of the CMWs. It is preferred that the curriculum is translated in Urdu.

Training Schedule:

The community midwife shall receive initial training at the midwifery school for a period of one year which shall cover the theoretical and practical aspects of the curriculum and will also receive six months supervised training at a Practical Training Site (DHQ/THQ/RHC) where she will perform both home based and institutional deliveries.

In addition to classroom teaching, simulation and compulsory hands on training will be imparted. It is required that each CMW should have practical training minimally 25 deliveries each noted in a log book. Each trainee should attend at least 15 and 10 deliveries in hospital and home settings respectively. The total number of deliveries would be split accordingly. All the modalities of the training would be catered in the module as to when the trainees would start their practical training in the attached hospital.

Remuneration for Community Midwives;

During Initial Training: Rs 250/day

During Practical Training: Rs 5000 per month

Appointment letter will only be issued on provision of license from Pakistan Nursing council.
After Deployment in the field: salary equivalent to LHW.

Deployment Guidelines:

These guidelines are meant to facilitate smooth deployment of Community Midwives (CMWs) in the field after they have successfully completed their 18-month basic training.

After completing her 18-month training, a CMW will have to pass a written examination to get the license for practicing her work in the community. The examination is conducted by the provincial Nursing Examination Board (NEB). Provincial NEBs will organize Midwifery examinations periodically for a cluster of districts. The District Evaluation Committees (DEC) will notify to the Provincial NEB when a batch of midwives has completed its training (Theory and Clinical) and is available to take the examination.

Provincial NEB will collect and maintain such information from the districts and once an adequate number of midwives are available, it conducts the examination at a venue convenient to the enrolled midwives.

- Upon successful completion of examination (Written examination and maintenance of log book containing record of deliveries conducted during the training. Minimum 25 required for registration; 15 hospital based and 10 in the community). The Principal of the school after completing all the codal formalities will request the Pakistan Nursing Council for registration and licensing.

It has been recognized that many CMWs did not get enough hands on practice to conduct the deliveries during their training. This coupled with post training time lag before the deployment in the community raise the concern of retaining the required clinical competency, and hence their readiness to start independent field work. It is recommended that those CMWs who have been trained and not deployed for one year and more must receive 3 months refresher training. However, this is not applicable to those who have been deployed immediately after graduation.

- Once a new batch of CMWs is ready for deployment, the DD RH, in consultation with the EDO Health will arrange a meeting of CMWs with the key staff of BHU/RHC/THQ and DHQ including the Medical Superintendents, Obstetricians, In-charges of labour rooms, Lady Health Visitors, and also the Lady Health Supervisors. The purpose of this meeting will be to establish formal linkage between CMWs and the government staff for ensuring effective working relationship in the future, particularly in the context of referrals. CMWs will also get the opportunity to meet their supervisors and exchange contact numbers. In addition, they will obtain the information and prepare a list of available ambulance and other support available for referrals.
- A room in the house of CMW will be her Work Station, which is a place where pregnant mothers will contact a CMW for consultation and examination. The programme intends to gradually replace TBAs with trained CMWs, and it is very important that they compete with TBAs for the socially acceptable practices for the place of birth without compromising the quality.
- A CMW needs a small place of not more than 4x6 feet in a room near the exit door in her house for establishing her Working Station. The programme will provide an examination couch to place there for ANC and PNC checkups. CMW will keep her equipments, medicines and supplies in a secured corner. A suggested layout of a typical Work Station is shown in the following figure:
- Integrated Programme will assist a CMW in establishing her work station and provide all essential equipment including an examination table, medicines, contraceptives, Safe Delivery Kit (SDK) and other supplies. The supplies including SDK, medicines and contraceptives

will be replenished through the Health Facility. (Annex V, VI, VII- for list of supplies in CMW Bag), based on replenishment basis.

- Once the work station has been established and all equipment and supplies have been provided, the LHS will visit these work stations with the staff member of the facility nominated by Incharge of the facility..

Strategies for Retention and Motivation

There is a need to provide an appropriate salary package for retaining and keeping them motivated for provision of services. The following monetary and non-monetary incentives are suggested.

a. Fixed Stipend

It is recommended that CMWs should receive Rs. 5000 per month as retainer fee from the time of their deployment in order to maintain a working relationship with the Department of Health. This in turn gives the right to the health authorities to implement an accountability, monitoring and supervisory mechanism. Integrated PC-1 will bear the cost till its completion in 2015. To ensure its sustainability, a smooth transition from development budget to DoH budget should take place well before the completion of this PC-1 i.e. 2016.

b. Refresher Training

It is recommended that a need-based refresher should be offered to CMWs at least once a year(10 days/year). CMWs' clinical supervisors will regularly record their observations to identify training needs and suggest to the DHO to plan for tailored courses accordingly.

Minimum Health service Delivery Package

1. Technical Report

2. Costing Report

3. Detailed Costing

Recruitment Procedures for Provincial and District Level Appointments

At the provincial level, the health department will undertake recruitments against posts for Grade 18 and above. The Director General Health Services, in line with the Government's approved recruitment procedures will invite applications against the vacant post in a transparent manner through open advertisement in local and national dailies; carry out short listing according to approved job descriptions, share the short list with the members of the selection committee, arrange for conduct of interviews giving notice of minimum seven days for local and two weeks for out station candidates and ensure timely appointment of selected candidates.

Departmental Selection Committee

1. The Departmental Selection Committee shall consist of the following:-

(1)	Secretary Health	Chairman
(2)	Representative of the Finance department	Member
(3)	Representative of P&D department	Member
(4)	Director General Health Services	Member
(5)	Relevant Technical Expert	Member
(6)	Director Health Services	Member/ Secretary

2. The Committee shall also make recommendations for appointment by promotion or transfer to all posts in Basic Pay Scale 18 and above and shall also assess fitness /suitabilityof candidates in light of the approved job descriptions.

District:

Appointments against posts for Grade 1-17 will be made at the District level by a District Selection Committee constituted and notified by the Health Department GoKP. The DHO will invite applications against the vacant post through open advertisement in local and national dailies; carry out short listing according to approved job descriptions, share the short list with the members of the selection committee, arrange for conduct of interviews giving notice of minimum seven days for local and two weeks for out station candidates and ensure timely appointment of selected candidates.

District Selection Committee

1. The District Selection Committee shall consist of the following:-

- | | | |
|-----|---------------------------------|----------------------|
| (1) | District Coordination Officer | Chairman |
| (2) | EDO Budget and Planning Officer | Member |
| (3) | DHO | Member (4) |
| | Provincial HD Representative | Member |
| (5) | Deputy DHO | Member/
Secretary |

2. The Committee shall also make recommendations for appointment by promotion or transfer to all posts in Basic Pay Scale 1-17 and shall also assess fitness/suitability of candidates in light of the approved job descriptions.

Nutritional interventions at various levels:

The premise of the IYCF includes breastfeeding and complementary feeding. The principles of IYCF include: i) infants should be breastfed within one hour of birth; ii) exclusively breastfed for the first six months of life; and iii) should receive nutritionally adequate and safe complementary foods starting at 6 months while continuing breastfeeding up to two years and beyond. IYCF interventions for children are most effective for their physical and intellectual development, as the damage caused by childhood malnutrition for intellectual development is irreversible.

The nutrition focal point at the provincial level will adapt the global IYCF strategy to the local situation. The IYCF strategy will chalk out the responsibilities at various levels where LHW and Health facility will be primarily responsible for promotion of exclusive breast feeding, appropriate complementary feeding etc. All the relevant activities will be incorporated in District Health plans and will be reviewed by the Technical review committee.

IYCF interventions will serve as one of the platforms for early detection of malnutrition in children under five and timely referral of malnourished children. Pakistan has a high burden of children under 5 who are **severely malnourished** and therefore are at very high risk of dying during childhood. There is evidence that the management of these children using WHO-approved protocols can reduce mortality rates by half. The community-based management of severe acute malnutrition (CMAM) focuses on community health workers who, screen, refer and manage the children and pregnant and lactating women who have severe acute malnutrition to the health facility.

The National Guidelines for the Community Based Management of Acute Malnutrition for children and pregnant and lactating women have four main components:

- i) **Community outreach:** Under this principle the community is sensitized to identify a possible case of severe acute malnutrition and seek health care through the lady health worker in their covered area and selected private sector organizations / NGOs, (in LHWs uncovered areas) at the appropriate level of health care delivery system.
- ii) **Outpatient Therapeutic Program (OTP):** Following this principle, children with severe acute malnutrition with appetite and without complication are treated with ready to use therapeutic food (RUTF). The child is managed at home with periodic regular visits to the health care provider/ health facility for three months. Upon completion the management at OTP, children are referred to the supplementary feeding program where one exists.
- iii) **Inpatient Care:** Children without appetite and with complications are treated in inpatient care until stabilized. Children may present at inpatient care without being transferred from OTP. Wherever possible these children are referred to OTP once they are stabilized. Where there is no OTP, children are treated in inpatient care using RUTF until they meet the discharge criteria.
- iv) **Supplementary Feeding Program:** Children with moderate acute malnutrition are provided with ready to use supplementary food which they seek from the first level primary health care facilities. An essential constituent of this intervention is to provide

supplementary food to the pregnant and lactating mothers, through the supplementary feeding program initiative.

National Nutritional Guidelines

PREPARDNESS:

As the SC's at secondary level health facilities are once setup with all equipment. This will always have possibility of up scaling or widening up of the operations, the necessary human resource can be trained by introduction of facility based management of severe malnutrition training as a pre-service training for all paediatrics post graduate trainee medical officers.

Minimum Human Resource Requirements for a 24/7 Functional Stabilization Centre

<i>S.No.</i>	<i>Staff Cadre</i>	<i>Minimum Qualifications</i>	<i>Number</i>	<i>Responsibility</i>
1	Paediatrician	Post Graduation in Paediatrics (FCPS or any other as recognized and registered by PMDC) with 2 years clinical experience after post graduation.	01	Work as Paediatrics Consultant and manager on day to day operations and provide round the clock emergency support
2	Medical Doctors	M.B.,B.S. (with one year experience in paediatrics and Registered with PMDC)	04	Work in Morning, Evening and Night Shifts for routine medical care and counselling
3	Nurses	BSc Nursing with 2 yrs experience Recognized by Pakistan Nursing Council	04	Working in Shifts for routine nursing care and counselling
4	LHV	Qualified from recognized Midwifery school with minimum 1 years experience	04	(in absence of nurses) Working in Shifts
5	Food Handler/ Cooks	Middle pass with 3 years experience as cook or food handler	01	(Preparation of Therapeutic Feed)
6	Sanitary Workers	Primary pass	03	Work in Shifts

MANDATORY TRAININGS FOR HEALTH CARE WORKERS DEPLOYED AT STABILIZATION CENTERS

All the health care workers are required to be trained WHO standard tools and case management guidelines on facility based management of severe malnutrition.

RECOMMENDED TRAININGS

Trained on IYCF, CMAM and IMNCI.

List of Standard Equipment for SC

S No	Items Detail	Quantity Needed
1	Adult Weighing Scale	2
2	Sphygmomanometer -Infant -Adult	3 1
3	Tarred Baby weighing scales	3
4	Feeding Cups	10
5	Height Scales (Standardized)	3
6	Children Hospital Beds with side Collapsible arms	10
7	Linen bed sheets white colour	20
8	Medicine cupboards wooden with locks	2
9	Stretchers	2
10	Table size 3x4 feet with chairs local revolving chairs	4
11	Microwave 20 Litres	1
12	Refrigerator 14cubic feet (No Frost)	1
13	Infant meter (Measuring mats / board for infants)	3
14	Length Boards Standardized	6
15	Mid upper arm Circumference (MUAC) Tapes	300
16	Glass stainless steel	20
17	Serving bowls stainless steel	20
18	Serving spoons stainless steel	6
19	Spoons for food preparation stainless steel	6
20	Juicer Blender set	2
21	Tea Spoons Stainless steel	20
22	Cooking Range 4 burner	1
23	Thermometers (2 Rectal and 6 oral)	8
24	Air conditioners (1.5 Tons)	1

Medical Supplies and Disposable Kit for Stabilization Centre

S. No.	Item	Quantity
1.	Third Generation Cephalosporin IV500 mg	100 Vials
2.	10% glucose IV 500ml	50 Drips
3.	Ringer's lactate IV 500 ml	50 Drips
4.	Half-normal saline with 5% dextrose IV 500 ml	50 Bottles Drips
5.	Infusion Metronidazole 100mg	100Bottles.
6.	Syrup Paracetamol 120mg	200 Bottles
7.	Nystatin oral drops,	200 Bottles
8.	Syrup Zinc Sulphate	200 Bottles
9.	Zinc oxide cream	100 Bottles
10.	Injection Vitamin D3 IM 300,000 IU,	100 Vials

11.	Disposable syringes (5cc, 10 cc, 20 cc and 50 cc)	500 Numbers
12.	Intra Venous (IV) Catheter 22 and 24 size	200 Numbers
13.	Infusion Chambers/Burette 100milliliters	100 Numbers
14.	Infusion sets	250 Numbers
15.	Nasogastric (NG) Tubes size 8 and 10	200 Numbers
16.	ReSomal (low osmolarity Oral Rehydration Solution)	200 Packets
17.	Tablet Mebendazole 500mg	1000 Tablets
18.	Injection /Infusion Calcium gluconate	1000 Injections
19.	Folic Acid	100 tablets
20.	Vitamin A	300 capsules

LIST OF KITCHEN UTENSILS EQUIPMENT

S. No.	Item Specifications	Quantity
	Bowl 0.5 Litres Plastic	100
	Bucket (food proof Plastic) 10 Liters grad, stackable+ white lid	3
	Bucket (food proof Plastic) 10L Graduated, stackable+ Red lid	3
	Cooking Pot 10 Litres Aluminium (lathe work) + handles and lid	3
	Cups 20 or 30 millilitres hard plastic reusable	100
	Cups 500 millilitres hard plastic reusable	100
	Ladle 250 millilitres Aluminium	2
	Measuring Jugs 1 Litres graduated, plastic, non rigid, transparent	2
	Measuring Jugs 2 Liters graduated, plastic, non rigid, transparent	2
	Paddle Spoon Wooden 90 cm	2
	Scale Kitchen Type 0-5 kilograms with 10 grams graduations	1
	Scoop Aluminium 30 centimetres long (10-12 centimetres dia)	1
	Spoon Coffee stainless steel 5 millilitres	50
	Scoop Red	5
	Bowl 10 Litres plastic	2
	Brush Scrubbing for washing up	4
	Aprons Cotton	5
	Jerry cans 20 Litres	5

Nutritional Supplies

Formula -75, Formula -100, Mineral Mix and Ready to use Therapeutic Food (RUTF)

RECIPIES FOR LOCAL PREPARATION OF F-75 AND F-100 (water used must be safe and clean)

Monitoring of SC's

Once operationized it is recommended that the implementing agency together with Department of Health, Nutrition Focal Person gives monitoring visits every 2 weeks to each SC to ensure smooth working. The monitoring tools are given below. It is significant that the monitoring officers are trained in facility based management of SAM along with a medical background.

It is necessary that each SC, hygiene for preparation of food, neat environment, proper medical and nursing care and rational utilization of antibiotics and medicines are ensured. Apart from that it may also be noticed that whether the consultant paediatrician is monitoring the average weight gains and there cords as suggested in the manual “Training course on the management of severe malnutrition” are well maintained. Apart from that the IYCF counselling for the mother and care givers is another significant thing which needs to be checked at each SC.

An overview of CMAM

The guidelines focus on integration of the management of acute malnutrition into ongoing routine health services for children under five. The guidelines, however, should also be used by NGOs working in collaboration with the MOH in the emergency context. In Pakistan, the community based management of acute malnutrition (CMAM) approach includes acutely malnourished children under five and acutely malnourished pregnant and lactating women in supplementary feeding programmes. The CMAM approach consists of four components: community outreach; outpatient therapeutic programme (OTP), inpatient care and supplementary feeding. These components are described briefly below.

Community outreach: The community is sensitized so that they are aware of malnutrition, how to identify and treat it. This stimulates understanding and participation. Malnourished children are identified using colour coded mid upper arm circumference (MUAC tapes) and simple techniques. They are given a referral slip to the health centre. Some children will require follow up at home. Community providers follow up with children who are absent, default or have other problems with their treatment and recovery.

Outpatient therapeutic program (OTP): Children with severe acute malnutrition (SAM) WITH appetite and without complications are treated with ready to use therapeutic food (RUTF) and systematic medications. Treatment is at home with regular visits to the health centre. The child comes to the health centre every week or two weeks for a medical checkup and to receive RUTF. Children without appetite and/or with complications are transferred to inpatient care until stabilized. They then continue their treatment at home in OTP. On discharge from OTP, children should be referred to SFP where it exists. The majority of children (>85%) can be treated successfully at home without any need for inpatient care.

Inpatient care: Children without appetite and with complications are treated in inpatient care until stabilized. Children may present at inpatient care without being transferred from OTP. Wherever possible these children are referred to OTP once they are stabilized. Where there is no OTP, children are treated in inpatient care using RUTF until they meet the discharge criteria.

Supplementary feeding program (SFP): Children with moderate acute malnutrition are provided dry take home rations every two weeks or every month. SFP often includes acutely malnourished pregnant and lactating women. SFP also includes children discharged from OTP and in some cases children discharged from inpatient care (where there is no OTP). SFP is not always available outside of NGO programs and emergency context. Where there is no SFP, the discharge criteria for OTP are increased.

Transfer between components: Good coordination and communication between inpatient and out-patient care and with community providers is essential to make sure children do not get lost. Careful monitoring and tracking helps prevent this. Transfer slips in duplicate copies are used between OTP and inpatient care. Community providers are informed when a child is transferred from OTP to inpatient care or when a child is absent/defaulted in OTP so that they can follow up the child and mother/caretaker at home and investigate the reasons.

Fig 1: CMAM Components

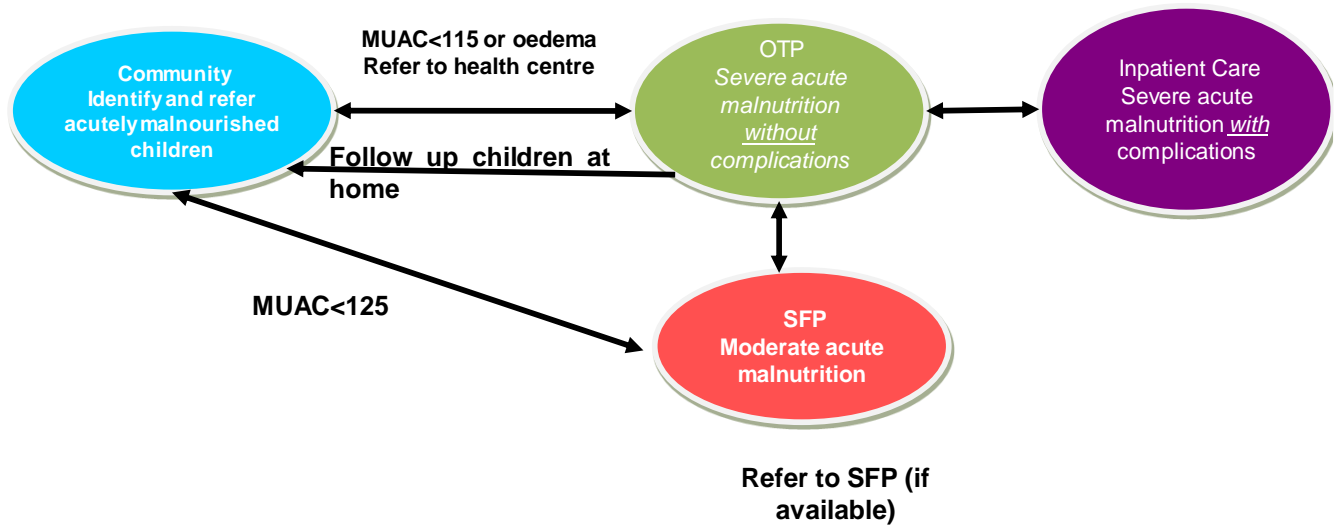
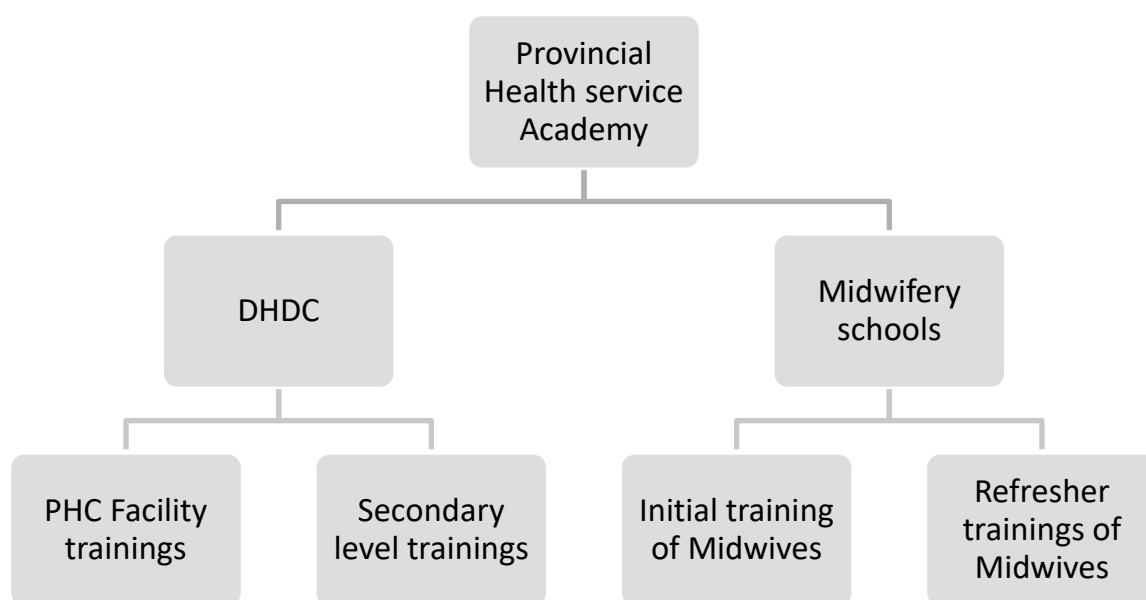


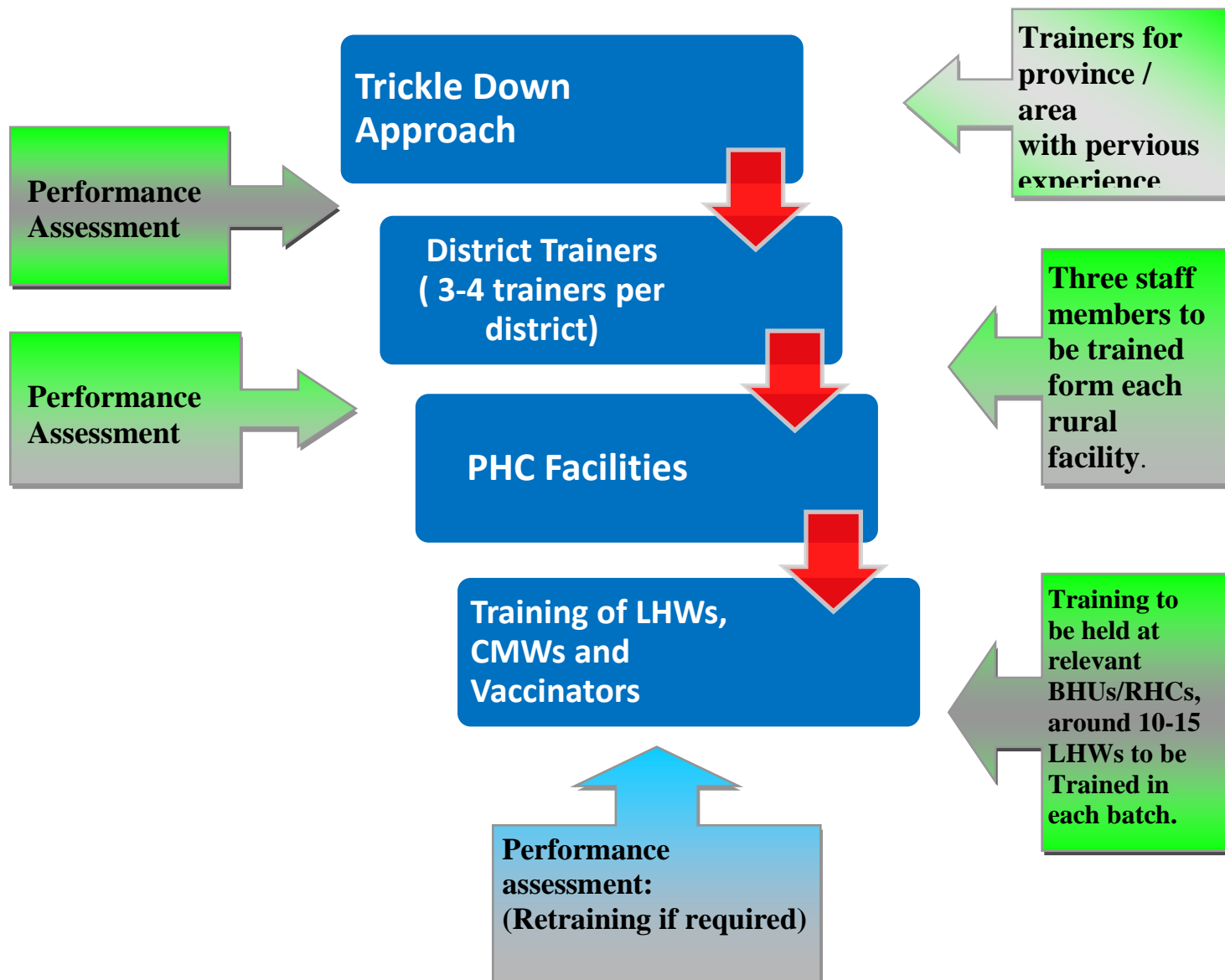
Table 1: Enrolment and exit criteria for inpatient, OTP and SFP

Inpatient care <u>Children 0 - 59 months</u>	OTP <u>Children 6-59 months</u>	SFP <u>Children 6-59 months *</u>
<p>Any of the following:</p> <ol style="list-style-type: none"> 1. Bilateral pitting oedema +++ 2. Marasmic-Kwashiorkor (= W/H < 70% or MUAC <115mm with any grade of oedema) 3. MUAC <115mm or W/H <70% or O edema + or ++ <p><u>WITH</u> any of the following complications:</p> <ul style="list-style-type: none"> ▪ Anorexia, no appetite ▪ Severe vomiting/intractable vomiting ▪ Hypothermia <35°C/<95°F ▪ Fever >39°C/>102°F ▪ Respiratory tract infection ▪ Severe dehydration ▪ Severe anemia ▪ Not alert (alert (very weak, lethargic, unconscious, fits or convulsions) ▪ Conditions requiring infusion or NG tube feeding <p><u>Infants < 6 months</u> Severely malnourished infants <6 months (or < 3kg) who meet criteria for inpatient admission. <i>See section on infants</i></p>	<p>MUAC <115mm</p> <p>or W/H <70%</p> <p>or Bilateral pitting oedema + and ++</p> <p>AND ALL OF FOLLOWING:</p> <ul style="list-style-type: none"> ▪ Appetite ▪ Clinically well ▪ Alert 	<p>MUAC 115-124mm</p> <p>or W/H = 70-79.9%</p> <p>and No bilateral pitting oedema</p> <p>AND</p> <ul style="list-style-type: none"> ▪ Appetite ▪ Clinically well ▪ Alert
		<p><u>Pregnant women</u> Second and third trimester MUAC <220mm</p>
		<p><u>Lactating Women</u></p> <p>MUAC <220mm and infant is under 6 months</p>
Exit Criteria		

<p>Transfer to OTP when:</p> <ul style="list-style-type: none"> ▪ Appetite returned (eats at least 75% of RUTF) ▪ Medical complications controlled/resolved ▪ Oedema decreasing 	<ul style="list-style-type: none"> ▪ W/H >80% (refer to SFP) ▪ W/H >85% (no SFP) ▪ MUAC >115mm ▪ No oedema <p>AND Minimum two months stay in the programme</p>	<p><u>Children 6-59 months</u></p> <ul style="list-style-type: none"> ▪ W/H>85% ▪ MUAC>125mm <p>AND Minimum 3 months stay in the programme</p> <p><u>Pregnant and lactating women</u> MUAC>220mm</p> <p>AND Minimum of 3 months stay in programme</p>
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Development of Human Resources for outreach levels



Deputy Director Technical	<p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • MBBS/BDS or Equilant withMasters in Public Health or equilant. • Eight years progressively responsible professional work experience in development in the relevant field such as in areas of reproductive, maternal, child health, family planning, nutrition at project administration, monitoring and evaluations • Additional qualification in any of the following areas will be given appropriate weightage. • Knowledge of current developments in the fields of development learning theory, community organization and participation. Ability to research, analyse, evaluate and synthesize information. • Ability to express clearly and concisely ideas and concepts in written and oral form. <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Provide technical guidance to the programme in the relevant technical areas and participate in assessment, monitoring and evaluation of activities, including surveys, and health education and promotion. • Develop and maintain excellent relationships with partners, local organizations and community groups. • Under the guidance of the Director Health Services provide ongoing assistance, capacity building and training for partners and community groups. • Facilitate programme implementation by partners and community groups. • Provide regular feedback from key persons, including partners, residents, and vulnerable groups, on programme activities. • Participate in development of evaluation tools, and compile and enter data into computer data base for program evaluations and surveys. • Provide information for analysis and reporting
Deputy Director Technical Nutrition	<p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • MBBS/BDS or equilant with post graduation in Nutrition or Public Health or equilant • Eight years progressively responsible professional work experience in development- preferably in areas of nutrition • Knowledge of current developments in the fields of development learning theory, community organization and participation. Ability to research, analyse, evaluate and synthesize information. • Ability to express clearly and concisely ideas and concepts in written and oral form. <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Provide technical guidance to the programme in the relevant technical areas and participate in assessment, monitoring and evaluation of

	<p>activities, including surveys, and health education and promotion.</p> <ul style="list-style-type: none"> • Develop and maintain excellent relationships with partners, local organizations and community groups. • Under the guidance of the Director Health Services provide ongoing assistance, capacity building and training for partners and community groups. • Facilitate programme implementation by partners and community groups. • Provide regular feedback from key persons, including partners, residents, and vulnerable groups, on programme activities. • Participate in development of evaluation tools, and compile and enter data into computer data base for program evaluations and surveys. • Provide information for analysis and reporting 	
Finance Manager (Market based Salary)	<p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Develop financial forecasts in line with approved budget in accordance with the activities to be undertaken in line with the approved work plan for forthcoming quarters and submit to EDO (H) for review and approval. • Ensure disbursement of funds in accordance with approved financial forecasts and according to specified guidelines. • Ensure compliance of GFR requirements and laws of the land. • Update on a regular and timely basis the EDO (H) on finance related issues. • Review, analyze, report and take/ recommend appropriate action on financial reports • Preparation/ review of quarterly financial statements and compilation of annual financial statements in accordance with legal framework, including Statutory/ AGPR regulations applicable • Approval of payments for procurements as per approved procurement plan. • Review the work of accounting and finance staff. <p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • CA/ACCA with articleships or equivalent. • 5 years of financial management experience relating to above tasks preferably with public sector. • Or MBA finance with 10 year experience in the relevant field preferably in Public sector. • Experience of preparing accounting and budgeting statements for large projects. • Experience in the usage of computers and office software packages • Advanced knowledge of a well known accounting software package(s). • Ability to work in a team environment with aggressive deadlines • Ability to lead strategic planning, results-based management and 	

	<p>reporting;</p> <ul style="list-style-type: none"> • Solid knowledge in financial resources management, contract, asset and Public procurement, information • Ability to lead processes re-engineering, implementation of new systems • Consistently approaches work with energy and a positive, constructive attitude; • Demonstrates good oral and written communication skills; • Demonstrates openness to change and ability to manage complexities; 	
Health Education Advisor (BPS 19)	<p>Qualification</p> <ul style="list-style-type: none"> • Masters Degree in Mass Communication or Journalism • Five years experience of working in similar position in Govt/semi Govt/private sector organization. <p>Responsibilities</p> <ul style="list-style-type: none"> • To develop Communication and Advocacy Strategy for the Programme • Responsible for all activities related to health education and promotion • Review and provide technical inputs organization of behavior change communication campaigns, development of materials, orientation and sensitization seminars • Provide guidance to district health offices in designing and planning their awareness and BCC campaigns • Provide technical inputs into development of IEC materials, content of messages, pretesting and implementation. • Identify topics in areas of communication and BCC to undertake operation research and oversee its implementation. • Organize training activities for district level staff through PHDC and DHDCs. 	
Logistics Officer (BPS 17)	<p><u>Qualification:-</u></p> <ul style="list-style-type: none"> • 1st class Masters Degree in Public Administration/Business Administration from a University recognized by H.E.C. • Certification in Supply Chain Management from reputed Institute • 10 years experience in Logistics Management in a public sector related to Health Services. • Have vast experience of procurements and supplies in Health Sector • Must be aware of medical terminologies and drugs and non drug items. <p><u>Responsibilities:-</u></p> <ul style="list-style-type: none"> • Advise the Provincial Coordinator regarding the timely procurement and inform the Provincial/ District PIUs about the delivery schedule of commodities. • Prepare/calculate the annual requirements for Programme 	

	<p>commodities and forward these to the Competent Authority.</p> <ul style="list-style-type: none"> • Train and advise the lower levels logistics staff in calculating the storage space and plan for utilizing that space. • Supervise day-to-day activities of the storekeeper. • Assessment and preparation of specifications for the purchase, repairs and maintenance of durable goods. • Monitor logistics system and take physical inventory and verification of the PPIU warehouse/stores annually and of the District PIU stores. • Prepare periodic summary of obsolete, unusable and expired materials and manage disposal in accordance with Programme policy. • Inspect National Programme contraceptives at Central Warehouse & Supplies, Karachi. • Prepare distribution plans of Programme commodities and submit to competent authority for approval. • Verify Issue and Receipt Vouchers (IRVs). • Manage the timely transportation of Programme commodities to DPIUs. • Undertake and manage all procurements (National/International). • Collaboration with donor agencies for management of donations/grants received. • Coordinate with other health Programmes/Projects, Departments and concerned Ministries/Divisions with regards to logistics. • Plan and coordinate quarterly meetings of Provincial/Regional Logistics Officers. 	
Health Education Officer (BPS 17)	<p><u>Qualification:-</u> Masters in Public Health/Health promotion or equivalent qualification with 5 years experience in the relevant field.. Candidates need to show evidence of the following:</p> <ul style="list-style-type: none"> • excellent oral and written communication skills; • an understanding of health issues; • initiative; • problem-solving skills; • time management skills; • creativity and the ability to think strategically; • research skills; • computer literate (MS word, excel and Power Point) • Project management skills. <p>They should also be good at building and maintaining relationships with individuals and organizations, including public, private, community and voluntary bodies.</p> <p><u>Responsibilities:-</u></p> <ul style="list-style-type: none"> • developing policies and strategies for promoting health at local, regional level; • developing the health awareness of individuals, groups and organisations 	

	<p>and empowering them to make healthy choices;</p> <ul style="list-style-type: none"> • developing and supporting local partnerships to broaden the local response to health inequalities; • identifying training needs arising from strategic and local agendas and developing and delivering appropriate training for people such as health professionals and volunteers; • ensuring that work is underpinned by sound, up-to-date knowledge of health promotion theory and making sure that projects are based on evidence of effectiveness; • lobbying for increased recognition of preventive and promotional measures that can take place at a population level and which have a positive impact on the health of a community; 	
Senior Account Officer (BPS 18)	<p><u>Qualification:-</u></p> <ul style="list-style-type: none"> • 1st class Master degree in Management with focus on Finance • CA inter with article ship • ACMA • ACCA • 10 years experience in the field of finance and Accounts in public sector <p><u>Responsibilities:-</u></p> <ul style="list-style-type: none"> • Preparation of budget • Releases of funds • Reconciliation with <ul style="list-style-type: none"> ✓ AGPR ✓ AG ✓ DAOs • Pre audit of salary bills, TA bills and financial claims • Preparation of Statement of Expenditure of PPIU/DPIUs and making consolidated reports of all types of expenditures. • Ensure timely disbursement of salaries of Provincial as well as field offices • Monitoring of all financial activities of donors, NGOs and other partners having joint ventures with the National Programme. • Any other duty assigned by the management 	
Procurement Specialist (Market based Salary)	<p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • S/He carries the overall responsibility for all the Procurement & Contract Management functions at the Provincial/District Offices; • Provide technical guidance and advice as appropriate in accordance with GoKP Procurement Rules/policies and procedures. • Develop Procurement guidelines for Health Department taking into consideration Pakistani Public Procurement Rules (2004); • Supervise the preparation on the basis of the approved budget, the initial procurement plan indicating the method of procurement and the proposed time frame and manage their approvals from relevant fora; 	

	<ul style="list-style-type: none"> • Supervise the procurement of goods, works, non-consulting services, consultants and individual consultants during the entire procurement process, including the call for tenders, review of tender documents, selection of firms / applicants following procurement guidelines; • Facilitate the preparation of Terms of Reference (TOR), Requests for Proposals (RFP) and evaluations of Expression of Interests (EOI) for procurement of consultants and services whenever required; • Provide guidance in preparation of tender and bidding documents for purchase of goods as per PPRA standard formats; • Manage the complete procurement cycle, including advertising process for procurement, procurement correspondence, bid/proposals receipt and bid/proposals opening in strict accordance with rules & regulations and agreed procurement procedures; • Formulate procurement policy and procedures, and Contract management/administration instructions; • Coordinate the harmonization of procurement policy with other development agencies; • Lead projects/assignments involving moderate to high levels of risk with many variables, requiring constant review of deliverables and process, and multi-discipline including those outside of own field of expertise; • Design/ update and facilitate the management of the overall procurement and inventory management record and filing system; • Establish and maintain procedures for the receiving, inspection, testing and acceptance of goods and selection of consultants; • Establish in coordination with the M&E coordinator a monitoring system for procurement and ensure the completion of the procurement process according to the procurement plan besides the Contract Management adhering to the Contract Agreements/Supply Orders; • Ensure adherence of the ongoing contract agreements/supply orders with all the defined conditionality and processing of the payments after taking compliance report on deliverables from concerned wing/section; • Conduct Field visits to District Procurement Officers to ensure that rules and regulations for procurement are respected; • Process monitoring of the Procurement applications/procedures specifically: - <ul style="list-style-type: none"> ○ Looking after the level of transparency in procurement process ○ Dispute Resolution ○ Reviewing the whole supply chain and identification of any gaps and their plugging measures. ○ Assessing and identifying the risks like institutional, political, organizational, procedural, etc that may negatively affect the ability of the agency to carry out the procurement process. ○ Managing the process of procurement complaint resolution ○ Conducting Post Review Procurements and ensuring all requirements
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	<p>as per the Procurement Guidelines are met.</p> <p><u>Qualification:</u></p> <ul style="list-style-type: none"> • MS in management Sciences/Statistics/Economics/ or related field from reputable local or foreign institution with a diploma/degree in the field of Procurement Management from reputable local or foreign institution. • Substantial experience of at least ten (10) years in the field of procurement at a senior level in a large programme preferably government. • Amongst ten years experience, the candidate must have at least five (05) years of Procurement Experience at progressively senior levels on public / private projects of value not less than Rs 100 million involving procurement of works, goods and services including Information and Communication Technology. • Excellent knowledge of relevant rules and legislation of PPRA and other donor agencies including international procurement best practices. • Demonstrates openness to change and ability to manage complexities 	
<p>Sr. Research Officer (BPS 18)</p>	<p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • Master degree in a relevant area including applied sciences, social research or statistics, preferably with experience in health sector. • 5 years of work experience preferably in the public sector, private sector or semi government organization • Research officers must have proven academic skills in social trends, demographic trends, quantitative and qualitative research methods • Familiarity with medical terminology <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Gathers, analyzes and reports auditing or investigative information in a concise and cohesive document in an expeditious manner; • Compiles monitoring and audit reports of measurable data sets and conducts evaluation of the results; • Analyzes data, recommends remedial action and assists Principal Investigators and research staff with the development of relevant action plans; • Ensures that internal control systems are in place to properly account for compliance with regulatory guidelines; • Ensures that the integrity and quality of research is being maintained including but not limited to informed consent process, study inclusion/exclusion criteria and reporting of adverse events; • Communicates research compliance goals, objectives and achievements to internal and external stakeholders; and • Performs all other duties as assigned 	

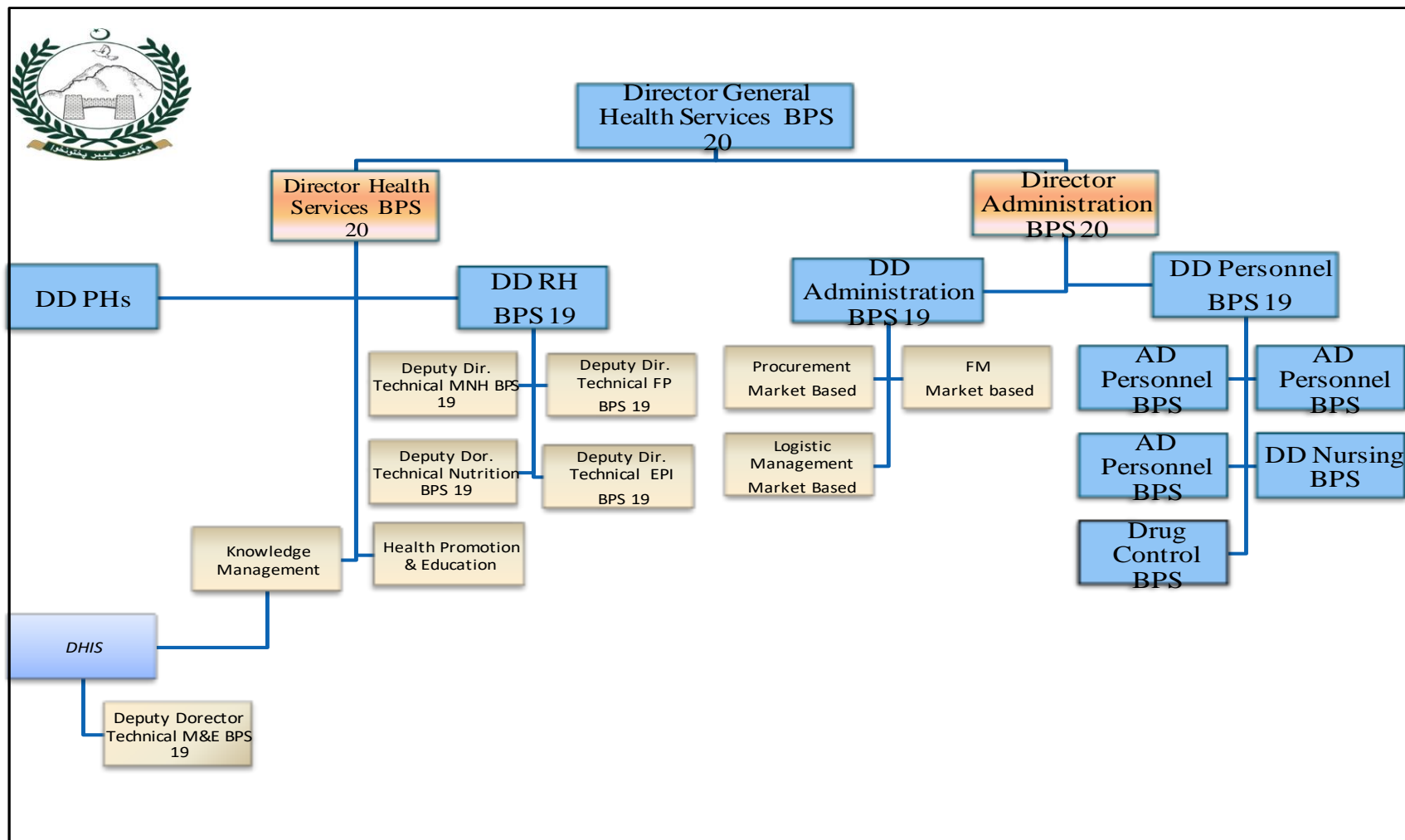
<p>Sr. Surveillance Officer (BPS 18)</p>	<p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • Master degree in Epidemiology and Biostatistics. • At least 5 years experience in midlevel Management • At least 2 years technical experience in conducting monitoring and evaluation of development programmes • Data analysis and report writing skills • Computer literacy with working knowledge of Microsoft Office (Excel), MIS and HIS • Work experience in the either public sector/private sector/Research Institution <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Plans all routine data activities on an annual basis • Provides inputs into M&E's annual work plan and the Integrated Action Plan • Provide inputs into the M&E system revision process • Supports districts to develop and strengthen M&E plans • Ensure routine monitoring and oversight of activities at the provincial and district levels 	
<p>M&E Officer (BPS 18)</p>	<p><u>Qualification</u></p> <ul style="list-style-type: none"> • MBBS with MPH, • 5 year experience in Public Health, or a related field with a strong foundation in statistics, research design/analysis, and qualitative/quantitative evaluation. • Knowledge of analytical methods, procedures, and practices, to include research software. • Knowledge of information gathering techniques, procedures, and practices. • Knowledge of project planning and management procedures, practices, and techniques. <p><u>Skills</u></p> <ul style="list-style-type: none"> • Skill in operating a personal computer and utilizing Microsoft software, and database software. • Good computer skills, proficient with ms office applications. • Analytical and problem solving skills. • At least two years of experience in M&E. <p>Experience with government funding process is an asset.</p> <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Operating and monitoring the data management system; • Conducting quality assurance (QA) and quality improvement (QI); • Providing support to department and districts on data collection, management and use; 	

	<ul style="list-style-type: none"> • Assisting in data and report analysis and building the M&E plan • Helping to develop and guiding the process for identifying and designing the key indicators for each activity/component, to record and report the data collected. • Supporting to set up the periodical action plans in the technical aspects of data use/management and quality improvement (QI). • Assisting in developing a plan for project-related capacity building on M&E and for any computer-based support that may be required • Assisting in organizing and undertaking training with stakeholders in M&E skills. 	
Statistician (BPS 18)	<p><u>Qualifications:</u></p> <ul style="list-style-type: none"> • Master degree in mathematics or statistics. • 5 years of work experience preferably in health sector • Familiarity with medical terminology. <p><u>Responsibilities:</u></p> <ul style="list-style-type: none"> • Adapt statistical methods in order to solve specific problems in reported data. • Analyze and interpret statistical data in order to identify significant differences in relationships among sources of information. • Apply sampling techniques or utilize complete enumeration bases in order to determine and define groups to be surveyed. • Design research projects that apply valid scientific techniques and utilize information obtained from baselines or historical data in order to structure uncompromised and efficient analyses. • Develop and test experimental designs, sampling techniques, and analytical methods. • Evaluate sources of information in order to determine any limitations in terms of reliability or usability. • Evaluate the statistical methods and procedures used to obtain data in order to ensure validity, applicability, efficiency, and accuracy. • Examine theories, such as those of probability and inference in order to discover mathematical bases for new or improved methods of obtaining and evaluating numerical data. • Identify relationships and trends in data, as well as any factors that could affect the results of research. • 10) Plan data collection methods for specific projects, and determine the types and sizes of sample groups to be used. • Process large amounts of data for statistical modeling and graphic analysis, using computers. • Report results of statistical analyses, including information in the form of graphs, charts, and tables. • Develop an understanding of fields to which statistical methods are to 	

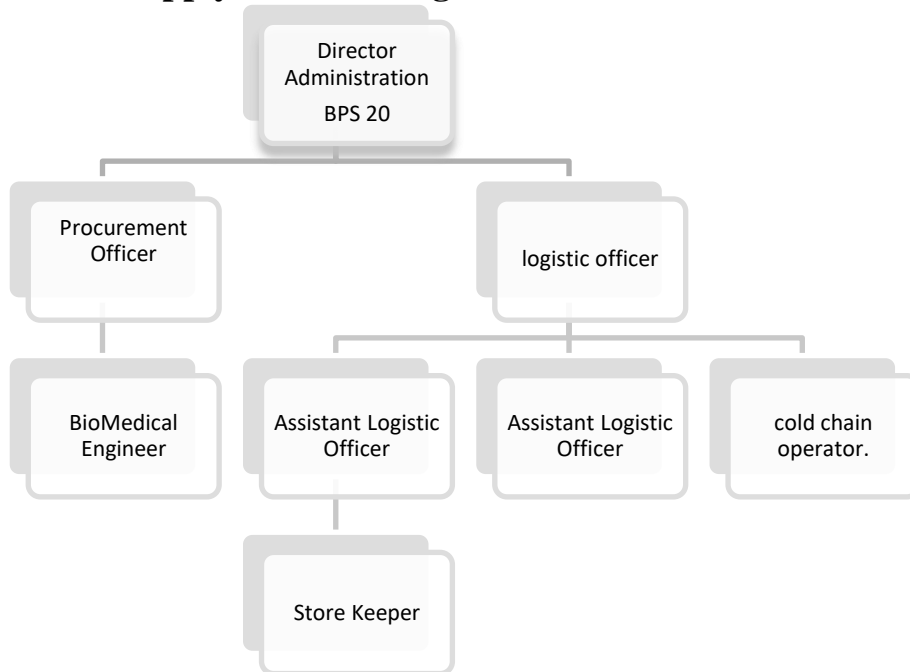
	<p>be applied in order to determine whether methods and results are appropriate.</p> <ul style="list-style-type: none"> • Prepare data for processing by organizing information, checking for any inaccuracies, and adjusting and weighting the raw data. • Supervise and provide instructions for workers collecting and tabulating data. 	
Data Analyst/ Computer Programmer / IT Officer (BPS-17)	<p>Qualification</p> <ul style="list-style-type: none"> • MBA IT / Bachelors in system or communication engineering • Three years experience in the field of information technology in Government / Semi Government / reputable Private Organization. <p>Responsibilities</p> <ul style="list-style-type: none"> • installing and configuring computer hardware operating systems and applications; • monitoring and maintaining computer systems and networks; • walking staff/clients through a series of actions, either face to face or over the telephone to help set up systems or resolve issues; • troubleshooting system and network problems and diagnosing and solving hardware/software faults; • replacing parts as required; providing support, including procedural documentation and relevant reports; • following diagrams and written instructions to repair a fault or set up a system; • supporting the roll-out of new applications; setting up new users' accounts and profiles and dealing with password issues; • responding within agreed time limits to call-outs; working continuously on a task until completion (or referral to third parties, if appropriate); • prioritizing and managing many open cases at one time; • conducting electrical safety checks on computer equipment 	
Assistant Accounts officer (BS 16)	<p>Qualification</p> <ul style="list-style-type: none"> • M Com / MBA (Finance) with PIPFA • 5 year experience in Accounting / Auditing / Public Finance in Government / Semi Government / reputable Private Organization. 	
Senior Auditor (BPS-16)	<p>Qualification</p> <ul style="list-style-type: none"> • Masters degree in Commerce (M Com) / MBA (Finance). • Three years experience in the field of Accounting / Auditing / Public Finance in Government / Semi Government / reputable Private Organization. • Having qualified PIPFA exam <p>Responsibilities</p> <ul style="list-style-type: none"> • Internal Audit of DGHS and Districts health offices • Preparation of reply of previous Audit reports if any. • Pre Auditing and processing of payrolls / FTA Bills / Claims of DPIUs 	

	etc. <ul style="list-style-type: none"> Any other duty assigned 	
Procurement and Assistant Logistics Officer (BPS-16)	<p>Qualifications</p> <ul style="list-style-type: none"> MPA/M Com / M Sc Economics Two years experience in procurement and logistics management, preferably in public sector Should be computer literate Acquaintance and knowledge of PPRA and GFR would be given preference. Preference will be given to the employees having experience in LHW program To be responsible for the activities carried out by the Logistics Officer in his absence. <p>Responsibilities</p> <ul style="list-style-type: none"> Assist in: Developing / preparation of bidding documents Procurement of drugs and medical equipments, contraceptive, vehicles, printed / training material and other office equipments in accordance with the Government as well as World Bank Procurement procedures. Pre and post delivery inspections at the premises of firms. Warehousing and Inventory Central Management. Transportation / distribution of Logistic from the point of production to the point of consumption. Monitoring and evaluation of Logistic System up to districts and facility level 	
Data Analyst (BPS-16)	<p>Qualification</p> <ul style="list-style-type: none"> Masters in computer science Two years experience in Data processing/ analysis. <p>Responsibilities</p> <ul style="list-style-type: none"> Verification / analysis of data, generation of proper feedback reports and final verification of data clinic. Any other duty assigned. 	
IT Assistant / Computer Operator (BPS-15)	<p>Qualification</p> <ul style="list-style-type: none"> Second class or grade “C” Bachelors degree in Computer sciences At least two year experience of working in similar position in Govt/semi Govt/private sector organization. <p>Responsibilities</p> <ul style="list-style-type: none"> To assist officer In charge in keeping database operational. To maintain and ensure upkeep of data networks. Effective data storage, maintenance and utilization. Ensure data validation/reconciliation. Familiar with RDBMS, SQL and MS Office Tools. Able to do preliminary hardware testing and troubleshooting 	

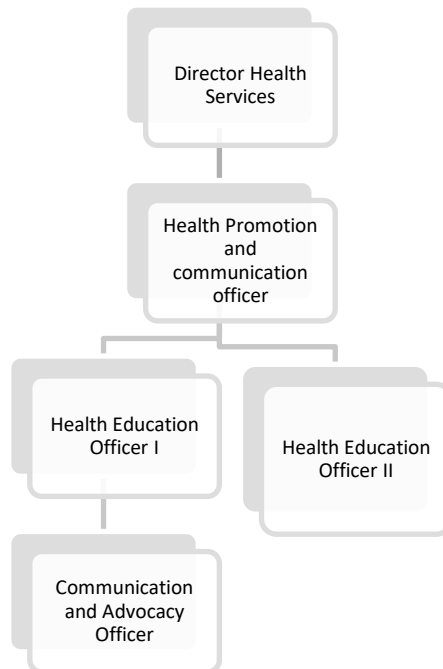
Naib Qasid	<p>Qualification</p> <ul style="list-style-type: none"> • Second class or grade “C” Matric certificate holder • At least one year experience of working in similar position. <p>Responsibilities</p> <ul style="list-style-type: none"> • Courteous interaction with all visitors with helpful attitude. • Handling/movement of files within or outside the office premises. • Run errands of the office of the circle in-charge. • Submission of documents e.g. pays bills etc. • To ensure order and cleanliness in the office. • To serve refreshments to visitors and office employees. • Any other responsibility assigned by the competent authority 	
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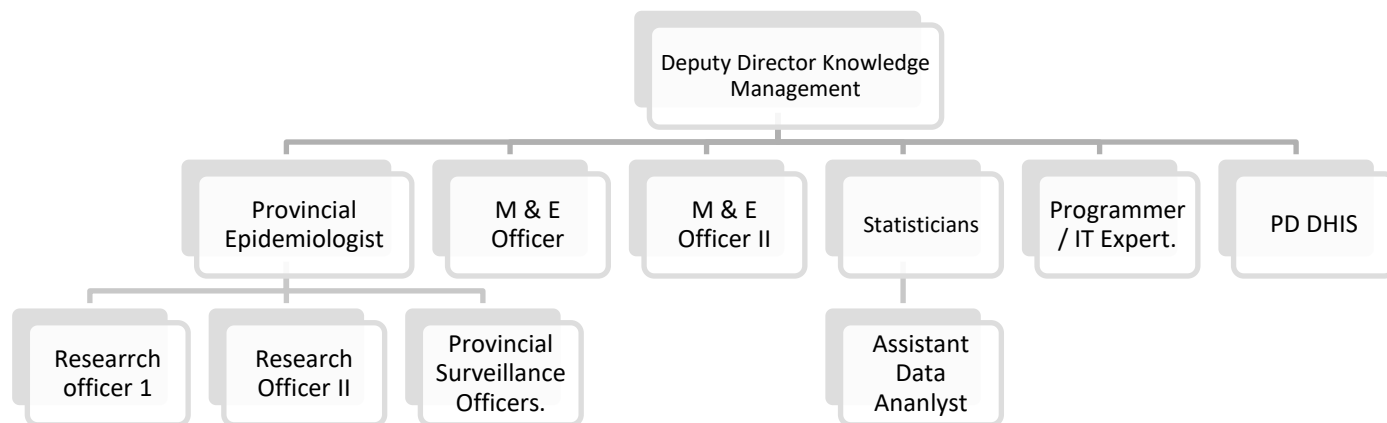
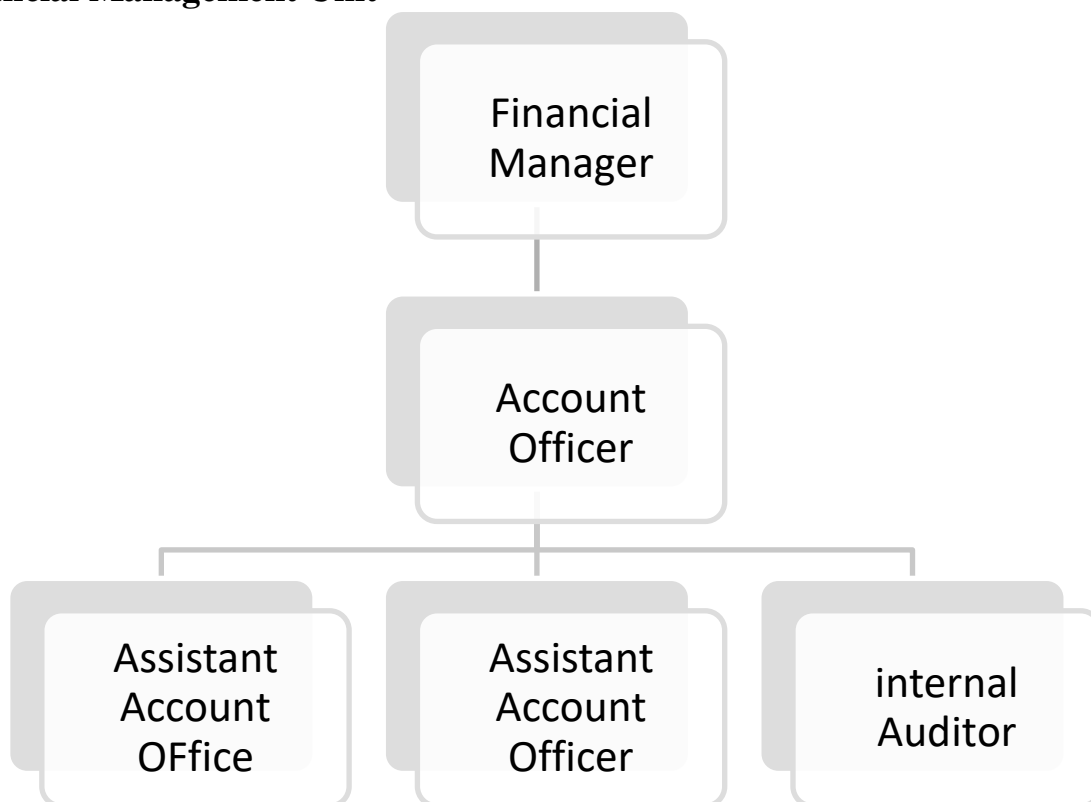


Procurement and supply chain Management Unit.



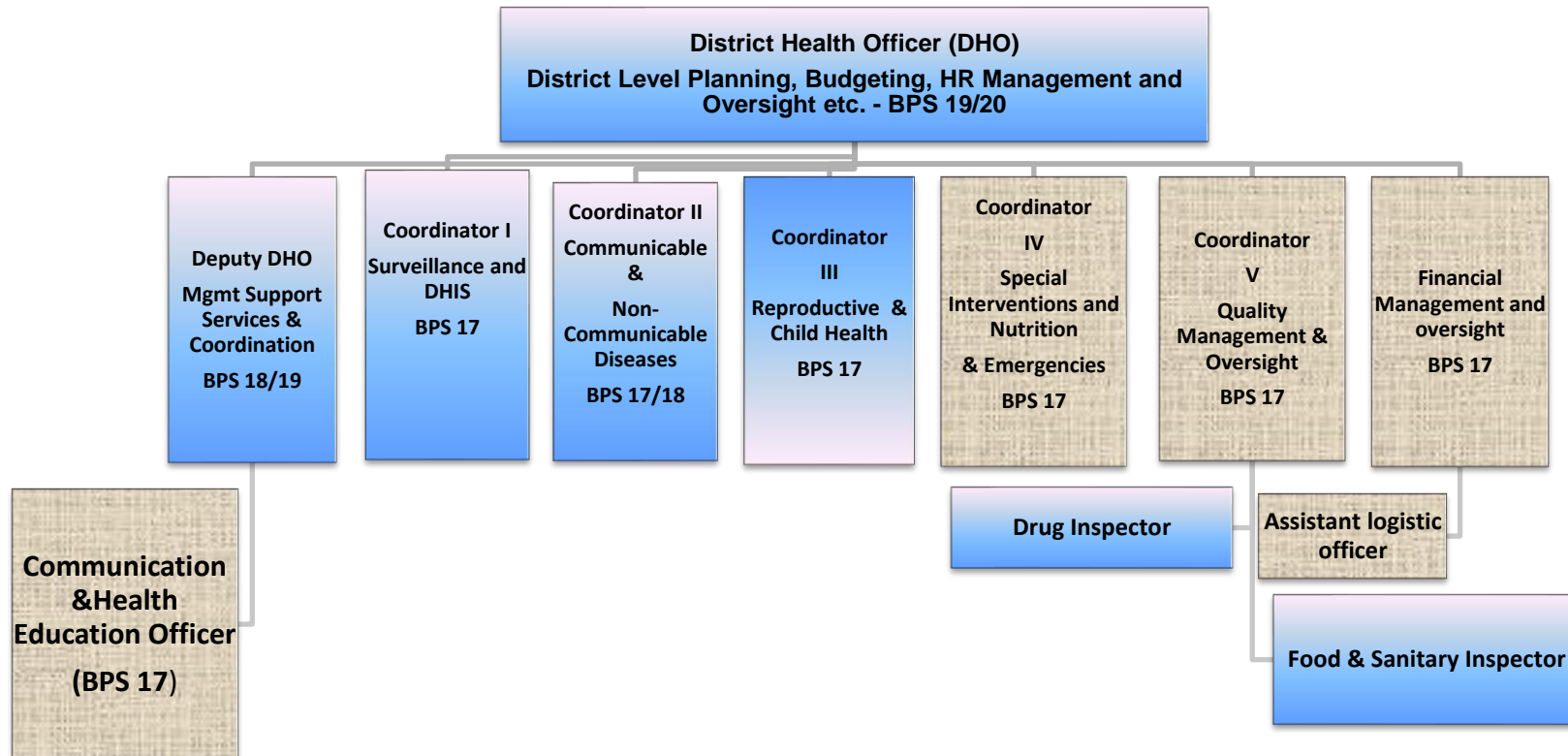
Health Promotion Unit



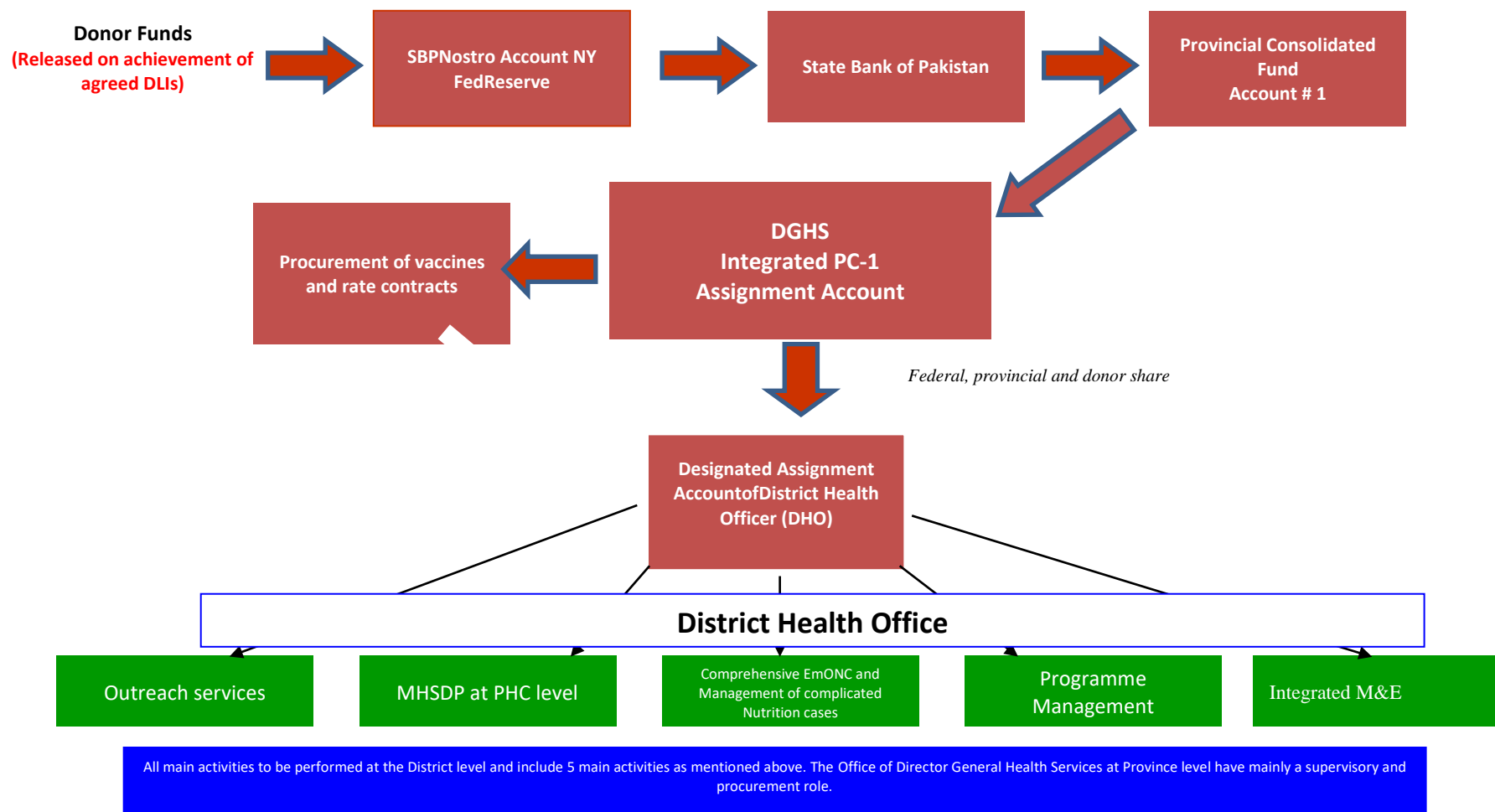
Knowledge Management Wing**Financial Management Unit**

Organogram at District Level

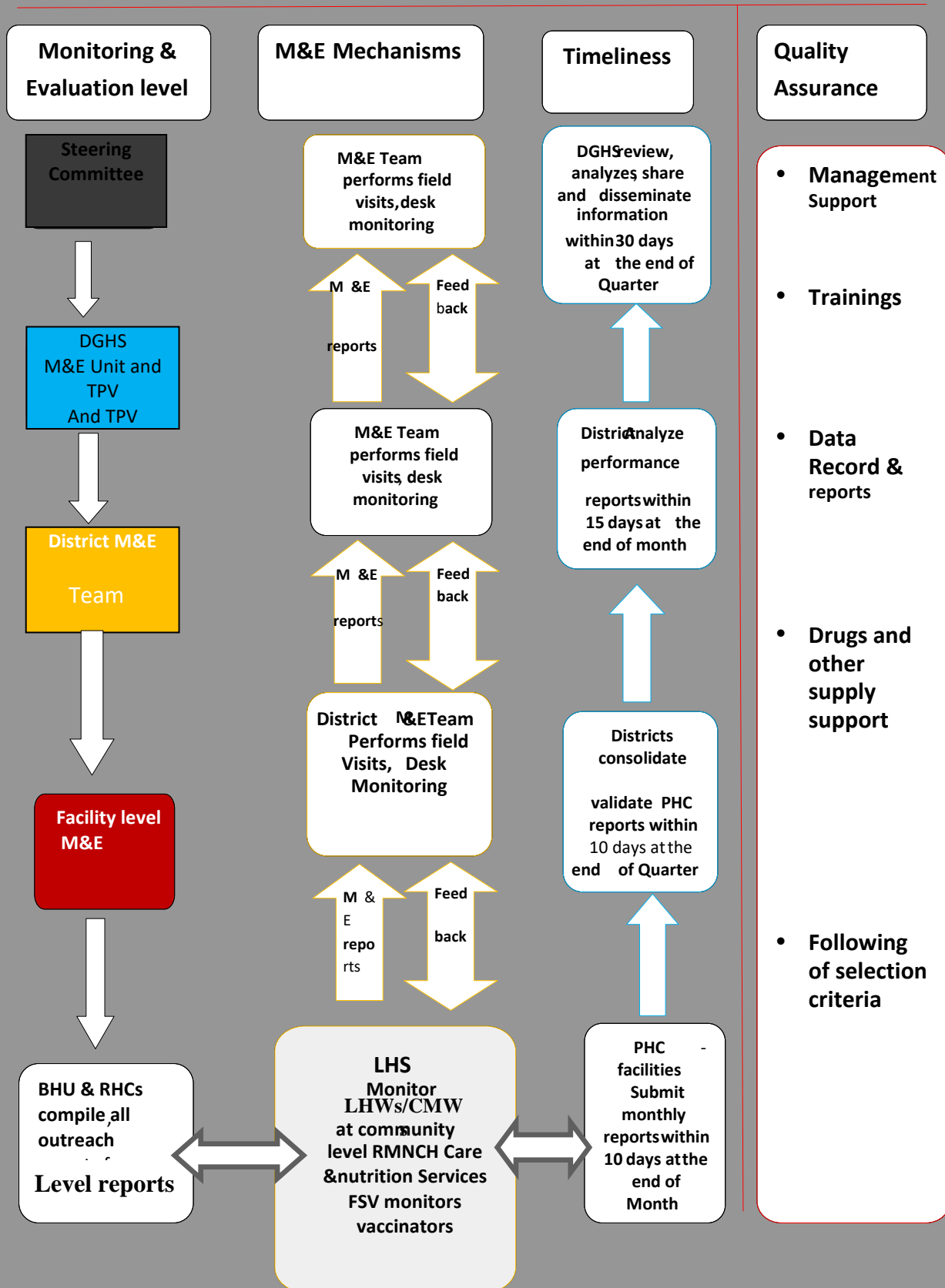
Annexure XXIV



FUNDS FLOW MECHANISM



M&E System Frame Work for Integrated PC- for RMNCH



Annex -XXVII

S. No	Name Of The Post	Basic Pay Scale	No. Of Posts
1.	Deputy Director Technical	(BPS 19)	5
2.	Health Education Advisor	(BPS 19)	1
3.	Procurement Specialist	(Market Based)	1
4.	Finance Manager	(Market Based)	1
5.	Provincial Epidemiologist	(BPS 18)	1
6.	Sr. Research Officer	(BPS 18)	2
7.	Sr. Accounts Officer	(BPS 18)	1
8.	Sr. Surveillance Officer	(BPS 18)	2
9.	Monitoring & Evaluation Officer	(BPS 18)	2
10.	Field Monitoring Officers	(BPS17)	6
11.	Statistician	(BPS 18)	1
12.	Logistic Officer	(BPS 17)	1
13.	Nutrition Officer	(BPS 17)	1
14.	Administrative Officer	(BPS 17)	2
15.	Data Analyst/Computer programmer/IT	(BPS 17)	1
16.	Assistant Accounts Officer	(BPS 16)	2
17.	Assistant Logistics Officer	(BPS 16)	2
18.	Assistant Auditor	(BPS 16)	1
19.	Data Analyst	(BPS 16)	3
20.	IT Assistant/ Computer Operators	(BPS 15)	10
21.	Receptionist/telephone operator	(BPS 10)	2
22.	Chowkidars	(BPS 01)	3
23.	Naib Qasid	(BPS 01)	3
24.	Sanitary Worker	(BPS 01)	3
25.	Driver	(BPS 04)	7

District Level Staff

25	Lady Health Supervisors	(BPS 7)	111
26	Lady Health Workers	(BPS 5)	2850
27	Community Mid Wives	Contract	2078
28	Vaccinators	Contract (BPS 8)	500
29	Coordinators for DHO Office 2*19 districts	(BPS 17)	36
30	Finance Manager/Assistant Accounts officer for DHO Office 25 districts	(BPS 16)	25
31	Health education Officer 19 districts	(BPS 17)	19
32	Procurement & Assistant Logistic officer 25 districts	(BPS 16)	25
33	Driver	(BPS 04)	111
34	Accounts Supervisors	(BPS 12)	25
Total			5857

Integration of Health Service Delivery with Special Focus on MNCH, LHW, EPI & Nutrition Services
Department of Health: PC-I 2013 - 2017
Summary of Total Program Cost By Components

Sr. No.	Components		Cost Estimates				Total	% of Base Cost
			Year I	Year II	Year III	Year IV		
1	Improved Access to MHSDP at Outreach Level		3,136.92	3,371.35	3,669.59	2,979.88	13,157.73	58%
2	Improved Access to MHSDP at Primary Care Facility Level		806.77	1,359.75	1,852.81	2,095.01	6,114.34	26.8%
3	Improved Access to Maternal, Child and Nutrition Interventions at Secondary Care Level		117.77	190.11	289.70	531.72	1,129.30	4.9%
4	Improved Program Management at Provincial and District Level		471.89	371.55	371.68	241.63	1,456.75	6.4%
5	Strengthening Monitoring & Evaluation Systems for Evidence Based Decision making through use of Good Quality Data		272.23	288.55	292.04	140.50	993.33	4.3%
Total Program Cost:			4,805.58	5,581.31	6,475.82	5,988.74	22,851.46	100%

1. Standard Staff Salaries have been derived from MoF notification O.M. F.4 (9) R-3/2008-499 dated 12.08.2009 modified further through Monthly Salary as per Finance Division OM No. 1(9) R3/2008-396/2001 dated: 12.12.2011 for contract employment except Project Manager. The highest limits of the Standard Pay Packages have been taken and annual increments have been added in the following years. The Project may negotiate the salary for having cushion of annual increment if desired so, otherwise, the highest bracket can be given for the duration of the contract. The Project Manager shall be a regular civil servant and working on deputation, therefore, the salary for this post is based on Revised Basic Pay Scales of 2011 and allowances as modified by Finance Division in year 2012.
2. For providing comfortable environment to the participants of the meeting during meeting/workshop/seminar/training sessions, Daily Allowance @ Rs. 2050x3 apropos accommodation has been fixed. Besides a rate of Rs. 3000 has also been defined for payment of daily training/facilitator allowance to the Facilitators.
3. The target activities along with item costs are flexible.
4. Re-appropriation of funds may be done within component or from a component to another component on need basis on recommendation of Project Steering Committee.
5. Need based changes in activities during implementation may be done with the approval of Project Steering Committee.

Integration of Health Service Delivery with Special Focus on MNCH, LHW, EPI & Nutrition Services
Department of Health: PC-I 2013 - 2017
Total Program Costs by Expenditure Categories

Sr. No.	Components		Program Cost by Year				Total	% of Base Cost
			Year I	Year II	Year III	Year IV		
A.	Investment Cost							
1	Procurement of computers, office equipment, furniture etc.		112.75	11.60	4.10	-	128.45	0.56%
2	Procurement of Vehicles		104.54	-	-	-	104.54	0.46%
3	Procurement of Equipment & Supplies strengthening of facilities		104.46	91.86	146.54	292.10	634.96	2.78%
4	Seminars/meetings		19.29	31.46	24.46	21.09	96.31	0.42%
5	Printing		27.74	29.35	32.58	0.00	89.67	0.39%
7	Third Party Evaluation		0.00	15.38	7.69	15.38	38.45	0.17%
8	Monitoring of districts programs/activities & MIS		3.53	3.53	3.53	0.00	10.58	0.05%
9	Trainings of LHWs, CMWs, LS, Vaccinators, Health Department staff etc.		363.22	403.37	306.99	244.98	1318.56	5.77%
10	Capacity Building (Country) of Health Professionals and presentation of papers at National level		5.98	6.60	6.60	5.70	24.88	0.11%
11	Capacity Building (abroad) of Health Professionals and presentation of papers at international level		2.34	2.34	2.34	2.34	9.36	0.04%
12	Research, Studies, Surveys, Services etc.		49.00	64.02	26.86	18.00	157.88	0.69%

13	Small grants for testing new innovations		4.19	4.19	-	-	8.38	0.04%
	Sub Total		797.05	663.69	561.69	599.58	2622.01	11.47%
B	Recurrent Cost							
14	Employees Related Expenses/Salary		2332.66	2659.86	3002.84	3091.88	11087.24	48.52%
15	Behavior Change Communication & Advocacy		44.23	65.88	68.73	32.83	211.67	0.93%
16	Procurement and distribution of Ready to use therapeutic food (metric tons)		17.03	51.10	96.13	165.10	329.37	1.44%
17	Procurement and distribution of F75 & F100		0.30	0.89	1.67	2.86	5.71	0.02%
18	Procurement of drugs, non-drug items & contraceptives		522.77	559.46	645.36	0.00	1727.59	7.56%
19	Procurement of Vaccines		100.00	113.10	127.96	0.00	341.06	1.49%
20	Procurement of Syringes & Safety Boxes		15.00	16.96	19.19	0.00	51.15	0.22%
21	District Management Plan		516.55	1033.11	1549.66	2031.05	5130.37	22.45%
22	Cold Chain & Logistics		46.00	52.02	58.83	0.00	156.85	0.69%
23	Operating office expenses, rent of buildings, POL/CNG , TA/DA, transportation of medicines/supplies and other items to Districts/FLCFs, utilities, communications, office stationery, repairs of physical assets etc.		413.99	365.24	343.76	65.44	1188.44	5.20%
	Sub Total		4,008.54	4,917.62	5,914.13	5,389.16	20,229.44	88.53%
	Total Program Cost		4,805.58	5,581.31	6,475.82	5,988.75	22,851.46	100.00%

Component 1. Improved Access to MHSDP at outreach level

All Figs in Million (Rs.)

S. No.	Activities	Unit		Physical Target				Financial Targets				Total
		Defined	Cost	Year I	Year II	Year III	Year IV	Year I	Year II	Year III	Year IV	
1.1	Sub Component 1.1: Recruitment & Training of Staff											
1.1.1	Staffing											
1.1.1.1	Lady Health Workers	Person year	0.1399	13,200	14,800	16,800	16,800	1,846.15	2111.11	2395.82	2,402.06	8,755.15
1.1.1.2	Community Mid Wives	Person year	0.0600	1,828	1,978	2,100	2,100	109.68	118.68	126.00	300.26	654.62
1.1.1.3	Vaccinators	Person year	0.1800	300	400	500	500	54.00	72.00	90.00	71.49	287.49
	Sub Total			15,328	17,178	19,400	19,400	2,009.83	2301.79	2611.82	2,773.81	9,697.26
1.1.2	Training											
1.1.2.1	One year Training for CMWs	Training	0.062	150	178	-	-	9.26	10.99	-	-	20.25
1.1.2.2	Six months on-site job training for CMWs	Training	0.005	-	150	178	-	-	0.75	0.89	-	1.64
1.1.2.3	Training of Mater Trainers for conducting trainings of CMWs (Batch of 25)	Training	0.52	1	2	2	1	0.52	1.03	1.03	0.52	3.10
1.1.2.4	Re-fresher trainings of CMWs (batch of 25 CMWs/training)	Training	0.20	14	14	14	14	2.72	2.72	2.72	2.72	10.87
1.1.2.5	Integrated Training of five days a week for three months for LHWs	Training	0.012	850	1250	-	-	10.54	15.50	-	-	26.04
1.1.2.6	Task Based Trainings for twelve months for LHWs	Training	0.06	850	1250	-	-	51.00	75.00	-	-	126.00

1.1.2.7	Training of Master Trainers for conducting refresher trainings of LHWs (Batch of 20)	Training	0.40	2	3	2	2	0.81	1.21	0.81	0.81	3.64
1.1.2.8	Re-fresher training - 3-8 days each year (batch of 30 LWHs/training)	Training	0.47	100	125	125	100	47.31	59.14	59.14	47.31	212.90
1.1.2.9	Training of Mater Trainers for conducting trainings of Vaccinators (Batch of 25)	Training	0.41	3	1	1	-	1.23	0.41	0.41	-	2.05
1.1.2.10	Re-fresher trainings of Vaccinators (batch of 20/training)	Training	0.20	8	8	8	-	1.58	1.58	1.58	-	4.74
	Sub Total			1978	2981	330	117	124.96	168.33	66.58	51.35	411.23
1.2	Sub Component 1.2 Procurement of medicines, supplies, stationary, printing equipment											
1.2.1	Annual purchase of drugs, non-drugs & contraceptives for LHWs (List attached at Annex - VII)	LHW/ Month	0.00277 2	13200	14800	16800	16800	439.08	479.00	558.84	-	1476.92
1.2.2	Annual purchase of auxiliary midwifery kits (drugs, non-drugs, contraceptives) for CMWs (List attached at Annex - IX)	CMW/ Month	0.00381 5	1645	1780	1890	1890	83.69	80.46	86.52	-	250.67
1.2.3	Stationery items	lump sum	0.05	1828	1978	2100	2100	91.40	98.90	105.00	-	295.30

1.2.4	Annual Printing (Manuals, Referral Pads, Referral Card, Registrations Cards etc.) (List attached at Annex - VIII)	LHW/Month	0.000112	13200	14800	16800	16800	17.74	19.35	22.58	-	59.67
1.2.5	Renovation/partitioning for Working Station for CMW	Stations	0.05	1828	150	-	-	91.40	7.50	-	-	98.90
1.2.6	Furniture/Fixtures for Working Station for CMW	Stations	0.05	1828	150	-	-	91.40	7.50	-	-	98.90
	Sub Total			33529	33658	37590	37590	814.71	692.71	772.94	-	2280.36
1.3	Sub Component 1.3: Outreach activities for service delivery and behavior change											
1.3.1	Identification of negative behaviors and opportunities for change	Consultancy	7.69	1	-	1	-	7.69	-	7.69	-	15.38
1.3.2	Printing for Dissemination of specific messages developed on maternal and child health, IYCF, exclusive breast feeding, nutrition and immunization using innovative approaches	Lump sum	3.00	1	1	1	-	3.00	3.00	3.00	-	9.00
1.3.3	Organize inter-personal and group sessions	Sessions	1.69	3	3	3	3	5.07	5.07	5.07	5.07	20.28

1.3.4	Identify barriers to accessing MCH services by families, specifically mothers on periodic basis and inform relevant program areas	Consultancy	7.69	1	-	1	-	7.69	0.00	7.69	-	15.38
1.3.5	Promote MHSDP services in areas/communities through community leaders/events and local media	Annual	2.000	-	20	15	15	-	40.00	30.00	30.00	100.00
	Training											
1.3.6	Trainings of Master Trainers, LHWs & CMWs of 3 - 5 dates at district level *(See foot note)	Training	0.794	200	200	200	150	158.85	158.85	158.85	119.14	595.69
1.3.7	Provincial level seminars on VAS with the line departments and development partners for advocacy and sensitization on VAS	Seminar	0.92	1	1	1	-	0.92	0.92	0.92	-	2.75
1.3.8	Training of LHS x 01 day at facility level with 03 facility trainers on sprinkles	Training	0.17	25	4	30	3	4.19	0.67	5.03	0.50	10.40
	Sub Total			232	229	252	171	187.41	208.51	218.25	154.71	768.88
	Component 1: Total			51067	54046	57,572	57,278	3,136.92	3371.35	3669.59	2,979.88	13157.73

() These trainings include trainings of Mater Trainers, CMWs & LHWs on IMCI, IYCF, CMAM, IFA, Zinc & Sprinkles.*

Unit Cost Assumptions

1.1.2.1	One year Training for CMWs				
		Unit Price	Quantity	Days	Total
	Per Day Allowance during Year based Training	250	1	247	61,750
	Cost				61,750
	Total Cost (in million)				0.06

1.1.2.2	Six months on-site job training for CMWs				
		Unit Price	Quantity	Month	Total
	Per Month Allowance during Six Months' Training	5,000	1	1	5,000
	Cost				5,000
	Total Cost (in million)				0.0050

1.1.2.3	Training of Mater Trainers for conducting trainings of CMWs (Batch of 25)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	3	4,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000
	Average daily allowance per participant = 2050 x 3	6,150	20	3	369,000

Supplies per participant	200	20	1	4,000
Meal & teas per participant	300	20	3	18,000
Facilitator				
Daily Lecture's allowance	3,000	3	3	27,000
Average travel cost per facilitator	3,000	-	-	-
Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-	-
Meal & teas per facilitator	400	3	3	3,600
Venue/Hall charges	10,000	1	3	30,000
Cost				517,100
Total Cost of one batch (in million)				0.52

1.1.2.4	Re-fresher trainings of CMWs (batch of 25 CMWs/training)		Unit Price	Quantity	Days	Total
	Local participants					
	Supplies per participant		200	25	1	5,000
	Meal & teas per participant		300	25	3	22,500
	Average travel cost per participant (Rs. 10/Km, Average Distance 20 km)		200	20	3	12,000
	Average daily allowance per participant (Half daily of BS - 17)		-	20	3	-
	Facilitator					
	Daily Lecture's allowance		3,000	3	3	27,000
	Average travel cost per facilitator		3,000	3	1	9,000
	Average daily allowance per facilitator = DA 2050 x 3		6,150	3	5	92,250
	Meal & teas per facilitator		400	3	3	3,600
	Venue/Hall charges		10,000	1	3	30,000
	Cost					201,350
	Total Cost of one batch (in million)					0.20

1.1.2.5	Integrated Training of five days a week for three months for LHWs				
		Unit Price	Quantity	Days	Total
	Per Day Allowance during three months' training	200	1	62	12,400
	Cost				12,400
	Total Cost (in million)				0.0124

1.1.2.6	Task Based Trainings for twelve months for LHWs				
		Unit Price	Quantity	Month	Total
	Per Month Allowance during twelve Months' Training	5,000	1	12	60,000
	Cost				60,000
	Total Cost (in million)				0.0600

1.1.2.7	Training of Master Trainers for conducting refresher trainings of LHWs (Batch of 20)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	3	4,500
	Out-station participants				
	Average travel cost per participant	3,000	15	1	45,000
	Average daily allowance per participant = 2050 x 3	6,150	15	3	276,750
	Supplies per participant	200	15	1	3,000
	Meal & teas per participant	300	15	3	13,500
	Facilitator				

	Daily Lecture's allowance	3,000	3	3	27,000
	Average travel cost per facilitator	3,000	-	-	-
	Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-	-
	Meal & teas per facilitator	400	3	3	3,600
	Venue/Hall charges	10,000	1	3	30,000
	Cost				404,350
	Total Cost of one batch (in million)				0.40

1.1.2.8	Re-fresher training - 3-8 days each year (batch of 30 LWHs/training)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	30	1	6,000
	Meal & teas per participant	300	30	8	72,000
	Average travel cost per participant (Rs. 10/Km, Average Distance 20 km)	200	25	8	40,000
	Average daily allowance per participant (Half daily of BS - 17)	-	25	8	-
	Facilitator				
	Daily Lecture's allowance	3,000	3	8	72,000
	Average travel cost per facilitator	3,000	3	1	9,000
	Average daily allowance per facilitator = DA 2050 x 3	6,150	3	10	184,500
	Meal & teas per facilitator	400	3	8	9,600
	Venue/Hall charges	10,000	1	8	80,000
	Cost				473,100
	Total Cost of one batch (in million)				0.47

1.1.2.9	Training of Mater Trainers for conducting trainings of Vaccinators (Batch of 25)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	10	1	2,000

Meal & teas per participant	300	10	3	9,000
Out-station participants				
Average travel cost per participant	3,000	15	1	45,000
Average daily allowance per participant = 2050 x 3	6,150	15	3	276,750
Supplies per participant	200	15	1	3,000
Meal & teas per participant	300	15	3	13,500
Facilitator				
Daily Lecture's allowance	3,000	3	3	27,000
Average travel cost per facilitator	3,000	-	-	-
Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-	-
Meal & teas per facilitator	400	3	3	3,600
Venue/Hall charges	10,000	1	3	30,000
Cost				409,850
Total Cost of one batch (in million)				0.41

1.1.2.10	Re-fresher trainings of Vaccinators (batch of 20/training)					
			Unit Price	Quantity	Days	Total
	Local participants					
	Supplies per participant		200	20	1	4,000
	Meal & teas per participant		300	20	3	18,000
	Average travel cost per participant (Rs. 10/Km, Average Distance 30 km)		300	15	3	13,500
	Average daily allowance per participant (Half daily of BS - 17)		-	15	3	-
	Facilitator					
	Daily Lecture's allowance		3,000	3	3	27,000
	Average travel cost per facilitator		3,000	3	1	9,000
	Average daily allowance per facilitator = DA 2050 x 3		6,150	3	5	92,250
	Meal & teas per facilitator		400	3	3	3,600
	Venue/Hall charges		10,000	1	3	30,000
	Cost					197,350
Total Cost of one batch (in million)		0.20				

1.3.1	Identification of negative behaviors and opportunities for change		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)					
	Team Leader		400,000	1	3	1,200,000
	Other Professionals		350,000	3	3	3,150,000
	Support Staff		150,000	4	4	2,400,000
	Sub-total =					6,750,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)		lump-sum			540,000
	C. Dissemination Workshop		lump-sum	1		400,000
	Total A,B & C = D					7,690,000
	Total D =					7,690,000
	Total Cost of Consultancy in million					7.69

1.3.4	Organize inter-personal and group sessions		Unit Price	Quantity	Days	Total
	Local participants					
	Supplies per participant		300	50	1	15,000
	Meal & teas per participant		500	50	1	25,000
	Out-station participants					
	Average travel cost per participant		3,000	100	1	300,000
	Average daily allowance per participant = DA 2050 x 3		6,150	100	2	1,230,000
	Supplies per participant		300	100	1	30,000
	Meal & teas per participant		500	100	1	50,000
	Facilitator					
	Daily Lecture's allowance		3,000	-	-	-
	Average travel cost per facilitator		3,000	-	-	-
	Average daily allowance per facilitator = DA 2050 x 3		6,150	-	-	-
	Meal & teas per facilitator		400	-	-	-
	Venue/Hall charges		40,000	1	1	40,000
	Cost					1,690,000
	Total Cost of Seminar (in million)					1.69

1.3.6	Identify barriers to accessing MCH services by families, specifically mothers on periodic basis and inform relevant program areas				
		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	3	1,200,000
	Other Professionals	350,000	3	3	3,150,000
	Support Staff	150,000	4	4	2,400,000
	Sub-total =				6,750,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum			540,000
	C. Dissemination Workshop	lump-sum	1		400,000
	Total A,B & C = D				7,690,000
	Total D =				7,690,000
	Total Cost of Consultancy in million				7.69

1.3.8	Trainings of Master Trainers, LHWs & CMWs of 3 - 5 dates at district level *(See foot note)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	5	7,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000
	Average daily allowance per participant = 2050 x 3	6,150	20	5	615,000
	Supplies per participant	200	20	1	4,000
	Meal & teas per participant	300	20	5	30,000
	Facilitator				
	Daily Lecture's allowance	3,000	3	5	45,000
	Average travel cost per facilitator	3,000	-	-	-
	Average daily allowance per participant = 2050 x 3	6,150	-	-	-
	Meal & teas per facilitator	400	3	5	6,000

	Venue/Hall charges	10,000	1	5	50,000
	Cost				818,500
	Total Cost of one batch (in million)				0.82

1.3.9	Provincial level seminars on VAS with the line departments and development partners for advocacy and sensitization on VAS				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	300	50	1	15,000
	Meal & teas per participant	800	50	1	40,000
	Out-station participants				
	Average travel cost per participant	3,000	50	1	150,000
	Average daily allowance per participant = DA 2050 x 3	6,150	50	2	615,000
	Supplies per participant	300	50	1	15,000
	Meal & teas per participant	800	50	1	40,000
	Facilitator				
	Daily Lecture's allowance	3,000	-	-	-
	Average travel cost per facilitator	3,000	-	-	-
	Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-	-
	Meal & teas per facilitator	400	-	-	-
	Venue/Hall charges	40,000	1	1	40,000
	Cost				915,000
	Total Cost of Seminar (in million)				0.92

1.3.10	Training of LHS x 01 day at facility level with 03 facility trainers on sprinkles				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500

	Out-station participants				
	Average travel cost per participant	3,000	15	1	45,000
	Average daily allowance per participant = 2050 x 3	6,150	15	1	92,250
	Supplies per participant	200	15	1	3,000
	Meal & teas per participant	300	15	1	4,500
	Facilitator				
	Daily Lecture's allowance	3,000	3	1	9,000
	Average travel cost per facilitator	3,000	-	-	-
	Average daily allowance per participant = 2050 x 3	6,150	-	-	-
	Meal & teas per facilitator	500	3	1	1,500
	Venue/Hall charges	10,000	1	1	10,000
	Cost				167,750
	Total Cost of one batch (in million)				0.17

Component 2. Improved Access to MHSDP at Primary care facility level

All Figs in Million (Rs.)

S. No.	Activities	Unit		Physical Target				Financial Targets				Total
		Defined	Cost	Year I	Year II	Year III	Year IV	Year I	Year II	Year III	Year IV	
2.1	Sub Component 2.1: Training of Health Facility Staff on MHSDP in 19 districts											
2.1.1	Trainings of health care facility staff for 25 days at District level *19 districts on MHSDP (* See foot note)	Training	1.43	33	33	33	33	47.23	47.23	47.23	47.23	188.92
	Sub Total			33	33	33	33	47.23	47.23	47.23	47.23	188.92
2.2	Sub Component 2.2: Strengthening the PHC facilities of various types to provide services as per MHSDP											
2.2.1	Equipment	Annual	Lump sum	184	-	-	-	34.14	-	-	-	34.14
2.2.2	Repair & Maintenance of Cold Rooms	Annual	Lump sum	184	184	184	-	6.00	6.78	7.67	-	20.45
2.2.3	Vaccines All Antigens (50% added through MHSDP)	Annual	Lump sum	184	184	184	-	100.00	113.10	127.96	-	341.06
2.2.4	Syringes and Safety Boxes (50% added through MHSDP)	Annual	Lump sum	184	184	184	-	15.00	16.96	19.19	-	51.15
2.2.5	Stationary EPI (50% added through MHSDP)	Annual	Lump sum	184	184	184	-	7.50	8.48	9.59	-	25.57
2.2.6	Cold Chain & Logistics at facility levels	Annual	Lump sum	184	184	184	-	30.00	33.93	38.37	-	102.30
2.2.7	Cold Chain & Logistics Repair at facility levels	Annual	Lump sum	184	184	184	-	10.00	11.31	12.79	-	34.10

2.2.8	Repair & Maintenance of Ambulances at the facility providing 24/7 Basic EmONC facilities	Annual	0.20	97	97	97	-	19.40	19.40	19.40	-	58.20
	Sub Total			1385	1201	1201	-	222.04	209.96	234.97	-	666.97

(*) These trainings include trainings of Health Facility Staff on IMCI, IYCF, CMAM, IFA, Zinc & Sprinkles.

2.3	Sub Component 2.3: District Strengthening											
2.3.1	Training of Health staff on district planning 5*19 districts	Training	0.42	6	6	6	5	2.33	2.33	2.33	2.12	9.10
2.3.2	District Plan for implementation of MHSDP * 19 districts	Annual	Lump sum	1	1	1	1	516.55	1033.11	1549.66	2031.05	5130.37
2.3.3	Introduction of maternal and child morbidity and mortality surveillance * 19 districts	Consultancy	40.50	-	1	-	-	-	40.50	-	-	40.50
2.3.4	Development of software for maternal and child morbidity and mortality surveillance	Consultancy	8.00	-	1	-	-	-	8.00	-	-	8.00
2.3.5	Development and printing of tools	Lump sum	4.00	1	1	1	-	4.00	4.00	4.00	-	12.00
2.3.6	Training of health care facility staff (BHU, RHC) on use of tools x 03 days with 03 district facilitators at district level *19 districts	Training	0.43	34	34	34	34	14.62	14.62	14.62	14.62	58.48
	Sub Total			42	44	42	40	537.503	1102.557	1570.611	2047.73	5,258.45₃
	Component 2: Total			1460	1278	1276	73	806.77	1359.75	1852.81	2095.01	6,114.34

Unit Cost Assumptions

2.1.1	Trainings of health care facility staff for 25 days at District level *19 districts on MHSDP (* See foot note)				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	25	25	125,000
	Meal & teas per participant	300	25	25	187,500
	Average travel cost per participant (Rs. 10/Km, Average Distance 20 km)	200	25	25	125,000
	Average daily allowance per participant (Half daily of BS - 17)	-	25	25	-
	Facilitator				
	Daily Lecture's allowance	3,000	3	25	225,000
	Average travel cost per facilitator	3,000	3	1	9,000
	Average daily allowance per participant = 2050 x 3	6,150	3	26	479,700
	Meal & teas per facilitator	400	3	25	30,000
	Venue/Hall charges	10,000	1	25	250,000
	Cost				1,431,200
	Total Cost of one batch (in million)	1.43			
2.1.6	Training of Health staff on district planning 5*19 districts				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	95	1	19,000
	Meal & teas per participant	300	95	3	85,500
	Average travel cost per participant (Rs. 10/Km, Average Distance 30 km)	300	95	3	85,500
	Average daily allowance per participant (Half daily of BS - 17)	-	95	3	-
	Facilitator				
	Daily Lecture's allowance	3,000	3	3	27,000
	Average travel cost per facilitator	3,000	3	1	9,000
	Average daily allowance per participant = 2050 x 3	6,150	3	4	73,800
	Meal & teas per facilitator	400	3	3	3,600
	Venue/Hall charges	40,000	1	3	120,000
	Cost				423,400
	Total Cost of one batch (in million)	0.42			

2.3.3	Introduction of maternal and child morbidity and mortality surveillance * 19 districts				
		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	4	1,600,000
	Other Professionals	350,000	10	8	28,000,000
	Support Staff	150,000	10	8	12,000,000
	Sub-total =				41,600,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum			3,328,000
	C. Workshops including Dissemination	lump-sum	2		400,000
	Total A,B & C = D				45,328,000
	Total D =				45,328,000
	Total Cost of Consultancy in million				45.33
2.3.4	Development of software for maternal and child morbidity and mortality surveillance				
		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	3	1,200,000
	Other Professionals	350,000	3	3	3,150,000
	Support Staff	150,000	4	4	2,400,000
	Sub-total =				6,750,000
	B. Direct Cost				
	Feedback and information dissemination seminars with stakeholders	400,000	1		400,000
	Sub-total =				700,000
	C. Firm's fee, Admin, rental, equipment etc.	lump sum			596,000
	Sub-total A,B & C =				8,046,000
	Total A,B,C & D =				8,046,000
	Total Cost of Consultancy in million				8.05

Component 3. Improved Access to Maternal, Child and Nutrition Interventions at Secondary Care Level

All Figs in Million (Rs.)

S. No.	Activities	Unit		Physical Target				Financial Targets				Total
		Defined	Cost	Year I	Year II	Year III	Year IV	Year I	Year II	Year III	Year IV	
3.1	Sub Component 3.1: Strengthening/operationalization of Health facilities as OTPs (BHUs and RHCs)											
3.1.1	Provision of OTP supplies and equipment	Equipment/Supplies	0.22	285	370	595	1137	63.84	82.88	133.28	254.69	534.69
3.1.2	Procurement and distribution of Ready to use therapeutic foods	Cartons	0.006627	2553	7658	14405	24741	16.92	50.75	95.46	163.96	327.09
	Sub Total			2838	8028	15000	25878	80.76	133.63	228.74	418.65	861.78
3.2	Sub Component 3.2: Strengthening/operationalization of stabilization centers at DHQ level											
3.2.1	Establishment of Stabilization Centers (Honorarium & Renovations)	Number	0.97	5	7	11	25	4.86	6.80	10.69	24.30	46.66
3.2.2	Provision of SC supplies and equipment	Equipment/Supplies	0.40	5	7	11	25	1.98	2.78	4.36	9.91	19.03
3.2.3	Procurement and distribution of F75	Cartons	0.00329	48	144	270	464	0.16	0.47	0.89	1.53	3.05
3.2.4	Procurement and distribution of F100	Cartons	0.0070	20	59	111	191	0.14	0.41	0.78	1.33	2.66
3.2.5	Procurement and distribution of Ready to use therapeutic food	Cartons	0.006627	18	53	100	172	0.12	0.35	0.66	1.14	2.27
	Sub Total			95	270	503	877	7.26	10.82	17.38	38.21	73.67

3.3	Sub Component 3.3: Strengthening Comprehensive EmONC services at DHQ Hospitals											
3.3.1	Strengthening of EmONC Centers at selected secondary hospitals	Number	0.50	3	4	7	25	1.50	2.00	3.50	12.50	19.50
3.3.2	Provision of supplies and equipment	Equipment/Supplies	0.60	5	7	9	25	3.00	4.20	5.40	15.00	27.60
3.3.3	PPP with private sector for 24/7 EmONC services	Contract	0.72	5	7	9	25	3.60	5.04	6.48	18.00	33.12
3.3.4	Contracting local transport services	Contract	0.36	5	7	9	25	1.80	2.52	3.24	9.00	16.56
3.3.5	Printing of IEC Material	Lump sum	1.00	1	1	1	-	1.00	1.00	1.00	-	3.00
3.3.6	Audio Visual material for patients /clients	Lump sum	2.00	1	1	1	-	2.00	2.00	2.00	-	6.00
3.3.7	Awareness and counseling sessions on FP	Session	0.10	120	240	170	150	12.00	24.00	17.00	15.00	68.00
3.3.8	Wireless internet facility at DHQ level for reporting	Number	0.025	5	7	9	25	0.125	0.175	0.225	0.625	1.15
	Sub Total			145	274	215	275	25.03	40.94	38.85	70.13	174.93
3.4	Sub Component 3.4: Training											
3.4.1	Training of health care facility staff of DHQ on EmONC 03 days with 03 district facilitators at district level	Training	0.43	6	6	6	6	2.37	2.37	2.37	2.37	9.46
3.4.2	Refresher training of health care facility staff of DHQ on EmONC 02 days with 03 facilitators at district level	Training	0.43	6	6	6	6	2.37	2.37	2.37	2.37	9.46
	Sub Total			12	12	12	12	4.73	4.73	4.73	4.73	18.92
	Component 3: Total			3090	8584	15731	27042	117.77	190.11	289.70	531.72	1129.30

Unit Cost Assumptions

3.1.1	Provision of OTP supplies and equipment				
		Unit Price	Quantity	Centers	Total
	Medical Equipment/Supplies (prices inclusive of taxes, freight, handling & transportation)				
	Scale, electronic, mother/child 150Kgx100g	18,900	1	1	18,900.00
	Scale, electronic, baby, 10Kgx<5g> for SCs	25,650	1	1	25,650.00
	Weighing Trousers (PAC of 5)	2,700	10	1	27,000.00
	Infant Spring Scale	2,700	1	1	2,700.00
	Height Measuring Board	2,700	1	1	2,700.00
	IEC/Registration Material (OPT Card, Ration Card, Referral Slip to SC etc.)	2,700	24	1	64,800.00
	MAUC Tape Child 11.5 Red (Pack of 50)	365	50	1	18,250.00
	MAUC Tape Adult without color code (Pack of 50)	1,080	50	1	54,000.00
	Thermometer	100	100	1	10,000.00
	Total Cost				224,000.00
	Total Unit Cost in million				0.22
3.1.2	Procurement and distribution of Ready to use therapeutic foods				
	Annual Requirement (Cartons containing 150 sachets)	Unit Price	Quantity		Total
	Yr. 1	6,627	2,553		16,917,176
	Yr. 2	6,627	7,658		50,751,529
	Yr. 3	6,627	14,405		95,463,626
	Yr. 4	6,627	24,741		163,961,273
	In the unit price, taxes, freight, handling and carriage charges related procurement have been added @ 12% of unit cost. In addition, distribution charges @ 10% of the unit cost have also been added.	-	-		-
		-	-		-
		-	-		-
	Total Cost	-	-		-
	Total Cost (in million)	0.00662704			327.09

3.2.1	Establishment of Stabilization Centers (Honorarium & Renovations)				
		Unit Price	Quantity		Total
	Monthly Incentive Bonus to Staff				
	Medical Superintendent	10,000	12		120,000.00
	Medical Officer	10,000	12		120,000.00
	Nurses	5,000	12		60,000.00
	Cook	3,000	12		36,000.00
	Cleaner	3,000	12		36,000.00
	Sub-total				372,000.00
	Other Costs				
	Running Cost	20,000	12		240,000.00
	Operational Cost for Patient Care (e.g. food etc.)	30,000	12		360,000.00
	Renovation	20,000	1		20,000.00
	Sub-total				600,000.00
	Cost				972,000.00
	Total Unit Cost in million				0.97

3.2.2	Provision of SC supplies and equipment				
		Unit Price	Quantity	Centers	Total
	Office Equipment/Supplies				
	Computer	80,000	1	1	80,000.00
	Printer (Laser)	35,000	1	1	35,000.00
	UPS	25,000	1	1	25,000.00
	Office Table	30,000	1	1	30,000.00
	Office Chair	10,000	1	1	10,000.00
	Visitor Chair	4,000	6	1	24,000.00
	Almirah	5,000	2	1	10,000.00
	Jug/Cups	1,500	1	1	1,500.00
	Chiller/Water Dispenser	8,000	1	1	8,000.00
	Sub-total				223,500.00

	Medical Equipment/Supplies (prices inclusive of taxes, freight, handling & transportation)				
	Scale, electronic, mother/child 150Kgx100g	18,900	1	1	18,900.00
	Scale, electronic, baby, 10Kgx<5g> for SCs	25,650	1	1	25,650.00
	Weighing Trousers (PAC of 5)	2,700	5	1	13,500.00
	Infant Spring Scale	2,700	1	1	2,700.00
	Height Measuring Board	2,700	1	1	2,700.00
	IEC/Registration Material (OPT Card, Ration Card, Referral Slip to SC etc.)	2,700	24	1	64,800.00
	MAUC Tape Child 11.5 Red (Pack of 50)	365	24	1	8,760.00
	MAUC Tape Adult without color code (Pack of 50)	1,080	24	1	25,920.00
	Thermometer	100	100	1	10,000.00
	Sub-total				172,930.00
	Total Cost				396,430.00
Total Unit Cost in million					0.40

3.2.3	Procurement and distribution of F75	Unit Price	Quantity	Total
	Annual Requirement (Cartons containing 20 Sachets) - 30% coverage			
	Yr. 1	3,294	48	157,618
	Yr. 2	3,294	144	472,854
	Yr. 3	3,294	270	889,438
	Yr. 4	3,294	464	1,527,633
	In the unit price, taxes, freight, handling and carriage charges related procurement have been added @ 12% of unit cost. In addition, distribution charges @ 10% of the unit cost have also been added.			
	Total Cost			3,047,542
Total Cost (in million)		0.0033		3.05

3.2.4	Procurement and distribution of F100	Unit Price	Quantity		Total
	Annual Requirement (Cartons containing 30 Sachets) - 30% coverage				
	Yr. 1	6,978	20		137,649
	Yr. 2	6,978	59		412,947
	Yr. 3	6,978	111		776,753
	Yr. 4	6,978	191		1,334,094
	In the unit price, taxes, freight, handling and carriage charges related procurement have been added @ 12% of unit cost. In addition, distribution charges @ 10% of the unit cost have also been added.				
	Total Cost				2,661,442
	Total Cost (in million)	0.0070			2.66

3.2.5	Procurement and distribution of Ready to use therapeutic food	Unit Price	Quantity		Total
	Annual Requirement (Cartons containing 150 sachets) - 30% coverage				
	Yr. 1	6,627	18		117,630
	Yr. 2	6,627	53		352,890
	Yr. 3	6,627	100		663,786
	Yr. 4	6,627	172		1,140,070
	In the unit price, taxes, freight, handling and carriage charges related procurement have been added @ 12% of unit cost. In addition, distribution charges @ 10% of the unit cost have also been added.	-	-		-
		-	-		-
		-	-		-
		-	-		-
	Total Cost				2,274,375
	Total Cost (in million)	0.00662704			2.27

Component 4. Improved Program Management at Provincial and District levels

All Figs in Million (Rs.)

S. No.	Activities	Unit		Physical Target				Financial Targets				Total
		Defined	Cost	Year I	Year II	Year III	Year IV	Year I	Year II	Year III	Year IV	
4.1	Sub Component 4.1: Program Staff											
4.1.1	Procurement Specialist (Market Based)	Person year	1.950	1	1	1	1	1.950	2.145	2.360	2.595	9.050
4.1.2	Finance Manager (Market Based)	Person year	1.950	1	1	1	1	1.950	2.145	2.360	2.595	9.050
4.1.3	Deputy Director Technical (BPS 19)	Person year	1.581	5	5	5	5	7.904	8.694	9.564	10.520	36.682
4.1.4	Provincial Epidemiologist (BPS 18)	Person year	1.199	1	1	1	1	1.199	1.319	1.451	1.596	5.566
4.1.5	Sr. Research Officer (BPS 18)	Person year	1.121	2	2	2	2	2.243	2.467	2.713	2.985	10.407
4.1.6	Sr./Accounts officer (BPS 18)	Person year	1.121	1	1	1	1	1.121	1.233	1.357	1.492	5.204
4.1.7	Surveillance Officer (BPS 18)	Person year	1.199	2	2	2	2	2.399	2.638	2.902	3.192	11.131
4.1.8	Monitoring & Evaluation Officer (BPS 18)	Person year	1.121	2	2	2	2	2.243	2.467	2.713	2.985	10.407
4.1.9	Statistician (BPS 18)	Person year	1.199	1	1	1	1	1.199	1.319	1.451	1.596	5.566
4.1.10	Logistic Officer (BPS 17)	Person year	0.826	1	1	1	1	0.826	0.908	0.999	1.099	3.831
4.1.11	Nutritionist (BPS 17)	Person year	0.826	1	1	1	1	0.826	0.908	0.999	1.099	3.831
4.1.12	Administrative Officer (BPS 17)	Person year	0.826	2	2	2	2	1.651	1.816	1.998	2.197	7.662

4.1.13	Data Analyst/Computer Programmer/IT Officer (BPS 17)	Person year	0.748	1	1	1	1	0.748	0.822	0.904	0.995	3.469
4.1.14	Field Monitoring Officer (BPS 17)	Person year	0.748	6	6	6	6	4.485	4.934	5.427	5.970	20.815
4.1.15	Assistant Accounts Officer (BPS 16)	Person year	0.523	2	2	2	2	1.047	1.151	1.266	1.393	4.857
4.1.16	Assistant Auditor (BPS 16)	Person year	0.523	1	1	1	1	0.523	0.523	0.523	0.523	2.093
4.1.17	Data Analyst (BPS 16)	Person year	0.523	3	3	3	3	1.570	1.727	1.899	2.089	7.285
4.1.18	Assistant Logistic Officer (BPS 16)	Person year	0.523	2	2	2	2	1.047	1.047	1.047	1.047	4.186
4.1.19	IT Assistant/ Computer Operators (BPS 15)	Person year	0.374	10	10	10	10	3.738	4.111	4.522	4.975	17.346
4.1.20	Receptionist/Telephone Operator (BPS 10)	Person year	0.224	2	2	2	2	0.449	0.493	0.543	0.597	2.081
4.1.21	Driver (BPS 04)	Person year	0.288	7	7	7	7	2.016	2.218	2.439	2.683	9.356
4.1.22	Chawkidars (BPS 01)	Person year	0.288	3	3	3	3	0.864	0.950	1.045	1.150	4.010
4.1.23	Naib Qasid (BPS 01)	Person year	0.288	3	3	3	3	0.864	0.950	1.045	1.150	4.010
4.1.24	Sanitary Worker (BPS 01)	Person year	0.288	3	3	3	3	0.864	0.950	1.045	1.150	4.010
	District Health Office Staff (25 Districts)											
4.1.25	Coordinators for EDO Office (BPS 17) 2*19 districts	Person year	0.826	38	38	38	38	31.369	34.506	37.956	41.752	145.584
4.1.26	Finance Manager/ Assistant Accounts Officer for EDO Office (BPS 16)	Person year	0.826	25	25	25	25	20.638	22.701	24.971	27.469	95.779
4.1.27	Health Education Officer for EDO Office (BPS 17)	Person year	0.762	19	19	19	19	14.478	15.926	17.518	19.270	67.192
4.1.28	Data Analyst/Computer Programmer/IT Officer (BPS 17)	Person year	0.748	25	25	25	25	13.081	14.389	15.828	17.411	60.710

4.1.29	Procurement and assistant Logistic Officer (BPS 16)	Person year	0.523	25	25	25	25	13.081	14.389	15.828	17.411	60.710
4.1.30	Accounts Supervisor (BPS 7)	Person year	0.185	25	25	25	25	13.081	14.389	15.828	17.411	60.710
4.1.31	Deputation Allowance Prov (lump sum provision)	Annum	0.066	11	11	11	11	0.794	0.794	0.794	0.794	3.168
4.1.32	Project Allowance Prov (lump sum provision)	Annum	0.400	11	11	11	11	5.040	5.040	5.040	5.040	20.160
	Sub Total			242	242	242	242	155.288	170.069	186.335	204.231	715..918
4.2	Sub Component 4.2: Strengthening coordination mechanisms for effective implementation											
4.2.1	Provincial Steering Committee	Meeting	0.017	2	2	2	0	0.033	0.033	0.033	0.000	0.099
4.2.2	Technical Committee on Health	Meeting	0.020	4	4	4	0	0.079	0.079	0.079	0.000	0.238
4.2.3	Thematic Working Group	Meeting	0.022	4	4	4	0	0.088	0.088	0.088	0.000	0.264
4.2.4	District Coordination Committee	Meeting	0.022	4	4	4	0	0.088	0.088	0.088	0.000	0.264
	Sub Total			14	14	14	0	0.288	0.288	0.288	0.000	0.865
4.3	Sub Component 4.3: Capacity Building											
4.3.1	4 weeks course on epidemiology and biostatistics at Aga Khan University	Training	0.050	4	5	5	4	0.200	0.250	0.250	0.200	0.900
4.3.2	Induction course on nutrition for staff working at Nutrition Program	Training	0.050	3	3	3	3	0.150	0.150	0.150	0.150	0.600
4.3.3	Presentation of research papers in national research symposiums	Seminar	0.083	6	6	6	6	0.501	0.501	0.501	0.501	2.003

4.3.4	International short courses on nutrition	Training	0.780	3	3	3	3	2.340	2.340	2.340	2.340	9.360
4.3.5	In country Diploma in policy and planning for district level staff (2*25)	Training	0.285	18	20	20	17	5.130	5.700	5.700	4.845	21.375
	Sub Total			34	37	37	33	8.321	8.941	8.941	8.036	34.238
4.4	Sub Component 4.4: Procurement & Supplies											
4.4.1	Server (Network, Web, Data)	Number	0.400	1	-	-	-	0.400	-	-	-	0.400
4.4.2	Desktop Computes	Number	0.080	20	-	-	-	1.600	-	-	-	1.600
4.4.3	Network Pinter	Number	0.060	2	-	-	-	0.120	-	-	-	0.120
4.4.4	Printers (Laser)	Number	0.035	6	-	-	-	0.210	-	-	-	0.210
4.4.5	Color Printer (Laser)	Number	0.350	1	-	-	-	0.350	-	-	-	0.350
4.4.6	Heavy Duty UPS for Server	Number	0.070	2	-	-	-	0.140	-	-	-	0.140
4.4.7	UPS for Computers	Number	0.025	20	-	-	-	0.500	-	-	-	0.500
4.4.8	Laptops/Notebooks	Number	0.120	7	-	-	-	0.840	-	-	-	0.840
4.4.9	Webcam (Still digital Camera)	Number	0.020	1	-	-	-	0.020	-	-	-	0.020
4.4.10	Handicam with Hard Disk	Number	0.050	1	-	-	-	0.050	-	-	-	0.050
4.4.11	Multimedia HD LCD Smart TV 65"	Number	0.250	1	-	-	-	0.250	-	-	-	0.250
4.4.12	Multimedia HD LCD Smart TV 42"	Number	0.100	1	-	-	-	0.100	-	-	-	0.100

4.4.13	Licensed Computer Software (Windows for Server, Computers, Anti-virus) (Corporate Editions for 100 users)	Software	1.800	1	2	2	2	1.800	3.600	3.600	-	9.000
4.4.14	Telephone Exchange for 5 lines (35 extensions) with installation	Number	0.500	1	-	-	-	0.500	-	-	-	0.500
4.4.15	Telephone Sets	Number	0.008	30	-	-	-	0.240	-	-	-	0.240
4.4.16	Local Area Networking (wire and/or wireless)	Number	1.000	1	-	-	-	1.000	-	-	-	1.000
4.4.17	Microphones	Number	0.005	10	-	-	-	0.050	-	-	-	0.050
4.4.18	Computer accessories (flash drives, external HDD, numeric pads, DSL etc.)	Lump sum	0.500	1	1	1	-	0.500	0.500	0.500	-	1.500
4.4.19	Photocopying Machine - heavy duty with RADF	Number	0.500	2	-	-	-	1.000	-	-	-	1.000
4.4.20	Photocopier Color	Number	0.500	1	-	-	-	0.500	-	-	-	0.500
4.4.21	Facsimile machine (Laser)	Number	0.040	2	-	-	-	0.080	-	-	-	0.080
4.4.22	Multimedia Project with Screen & wall Mounting	Number	0.015	1	-	-	-	0.015	-	-	-	0.015
4.4.23	Air conditioner (Split Wall Mounted)	Number	0.060	10	-	-	-	0.600	-	-	-	0.600
4.4.24	Air conditioner Floor Standing	Number	0.120	2	-	-	-	0.240	-	-	-	0.240
4.4.25	Chillers/Water Dispensers	Number	0.008	10	-	-	-	0.080	-	-	-	0.080

4.4.26	Heavy Duty Generator (100 KVA)	Number	2.500	2	-	-	-	5.000	-	-	-	5.000
4.4.27	Heaters	Number	0.015	25	-	-	-	0.375	-	-	-	0.375
4.4.28	Office Lamps	Number	0.003	15	-	-	-	0.045	-	-	-	0.045
	Sub Total			177	3	3	2	16.605	4.100	4.100	-	24.805
4.5	Sub Component 4.5: Furniture											
4.5.1	Office tables (Officer)	Number	0.030	42	-	-	-	1.260	-	-	-	1.260
4.5.2	Office tables (Staff)	Number	0.015	13	-	-	-	0.195	-	-	-	0.195
4.5.3	Reception Desk	Number	0.030	1	-	-	-	0.030	-	-	-	0.030
4.5.4	Office Chairs (Officers) - Revolving Hydraulic	Number	0.010	42	-	-	-	0.420	-	-	-	0.420
4.5.5	Office chairs (visitors)	Number	0.004	150	-	-	-	0.600	-	-	-	0.600
4.5.6	Computer tables	Number	0.005	55	-	-	-	0.275	-	-	-	0.275
4.5.7	Computer/staff chairs - Revolving Hydraulic	Number	0.005	22	-	-	-	0.110	-	-	-	0.110
4.5.8	Conference Room Table	Number	0.100	1	-	-	-	0.100	-	-	-	0.100
4.5.9	Conference Room Chairs	Number	0.005	50	-	-	-	0.250	-	-	-	0.250
4.5.10	Office Shelves/Almirahs	Number	0.005	120	-	-	-	0.600	-	-	-	0.600
4.5.11	Store Shelves/Racks/ Almirahs (Steel)	Number	0.005	50	-	-	-	0.250	-	-	-	0.250
4.5.12	Office Safe	Number	0.070	1	-	-	-	0.070	-	-	-	0.070

4.5.13	Sofa Set (five seated) for Program Manager	Number	0.040	7	-	-	-	0.280	-	-	-	0.280
4.5.14	Sofa Sets (three Seated) for Officers	Number	0.020	13	-	-	-	0.260	-	-	-	0.260
4.5.15	Sofa Sets (Seven Seated) for Reception	Number	0.040	1	-	-	-	0.040	-	-	-	0.040
	Sub Total			568	-	-	-	4.740	-	-	-	4.740
4.6	Sub Component 4.6: Operational Vehicles											
4.6.1	Field Monitoring Vehicle for PD; Double Cabin 4x4 (2500 cc) including freight & registration charges	Number	3.520	1	-	-	-	3.520	-	-	-	3.520
4.6.2	Operational Vehicle (1300 cc) including freight & registration charges (Province)	Number	1.860	2	-	-	-	3.720	-	-	-	3.720
4.6.3	Operational Vehicle (800 cc) including freight & registration charges 25 for Districts + 75 LHSs	Number	0.725	136	-	-	-	98.600	-	-	-	98.600
	Sub Total			139	-	-	-	105.840	-	-	-	105.840
4.7	Sub Component 4.7: Others (Operations & Maintenance Cost)											
4.7.1	Rent of Building of Provincial Program	Month	0.200	12	12	12	12	2.400	2.400	2.400	-	7.200
4.7.2	Office equipment maintenance cost	Annual	1.000	1	1	1	1	1.000	1.000	1.000	-	3.000
4.7.3	POL for operational vehicles (Province)	Annual	0.480	3	3	3	3	1.440	1.440	1.440	-	4.320
4.7.4	Vehicle maintenance (Province)	Annual	0.200	300	200	100	0	60.000	40.000	20.000	-	120.000

4.7.5	POL for Generator	Annual	2.400	1	1	1	1	2.400	2.400	2.400	-	7.200
4.7.6	Generator Maintenance	Annual	0.500	1	1	1	1	0.500	0.500	0.500	-	1.500
4.7.7	Electricity charges	Annual	0.600	1	1	1	1	0.600	0.600	0.600	-	1.800
4.7.8	Gas Charges	Annual	0.060	1	1	1	1	0.060	0.060	0.060	-	0.180
4.7.9	Telephone Exchange Connection (five lines)	Lump sum	0.015	5	-	-	-	0.075	-	-	-	0.075
4.7.10	Telephone Charges (five lines)	Line	0.120	1	1	1	1	0.120	0.120	0.120	-	0.360
4.7.11	Broad Band Internet Services (Installation)	Number	0.200	1	-	-	-	0.200	-	-	-	0.200
4.7.12	Broad Band Internet Services (Charges)	Annual	0.060	1	1	1	1	0.060	0.060	0.060	-	0.180
4.7.13	Wireless Internet Connection (Charges)	Number	0.025	15	15	15	15	0.375	0.375	0.375	-	1.125
4.7.14	Stationary & Expendable Items	Annual	3.000	1	1	1	1	3.000	3.000	3.000	-	9.000
4.7.15	Postages and courier	Annual	0.300	1	1	1	1	0.300	0.300	0.300	-	0.900
4.7.16	Journals and newspaper	Annual	0.500	1	1	1	1	0.500	0.500	0.500	-	1.500
4.7.17	Printing	Annual	2.000	1	1	1	1	2.000	2.000	2.000	-	6.000
4.7.18	TA/DA	Annual	11.7	1	1	1	1	11.700	11.700	11.700	-	35.100
4.7.19	Repair/Renovation/ Alterations and maintenance of building	Annual	2.000	1	1	1	1	2.000	2.000	2.000	-	6.000
4.7.20	Costs for Advertisement	Annual	1.500	1	1	1	1	1.500	1.500	1.500	-	4.500
4.7.21	Local Area Network Maintenance	Annual	0.200	1	1	1	1	0.200	0.200	0.200	-	0.600
4.7.22	Mis. /Other Cost	Annual	0.848	1	1	1	1	0.848	0.848	0.848	-	2.543
4.7.23	Performance Incentive Bonus to LHWs, CHWs, HF Staff etc. (20% Districts of each phase)	Annual	9.810	5	5	5	5	49.050	49.050	49.050	-	147.150

4.7.24	Transportation	Annual	1.00	1	1	1	1	1.00	1.00	1.00	1.00	4.000
	Sub Total			358	252	152	52	140.33	120.05	100.05	-	364.433
4.8	Sub Component 4.8: Behavior Communication											
4.8.1	Formative Research through a competitively hired Firm	Consultancy	7.690	1	-	-		7.690	-	-	0.000	7.690
4.8.2	Strategy designed based on the findings of the research	Consultancy	3.480	1	-	-		3.480	-	-	0.000	3.480
4.8.3	Material Field tested and implemented	Consultancy	3.000	1	-	-		3.000	-	-	0.000	3.000
4.8.4	Third Party Monitoring	Consultancy	0.870	-	6	8	0	-	5.220	6.960	0.000	12.180
4.8.7	Radio production of commercial for general population duration 50-60 sec.	Number	0.060	5	-	5	-	0.30	-	0.30	0.00	0.600
4.8.8	Air time of radio spots (60 sec) (Prime Time)	Number	0.014	280	725	800	300	3.93	10.13	11.20	4.20	29.460
4.8.9	Talk Show (30 mins)	Number	0.200	4	4	4	3	0.80	0.80	0.80	0.60	3.000
4.8.11	Day long Cable TV Advertisement through tickers	Number	0.150	50	110	110	100	7.50	16.50	16.50	15.23	55.730
4.8.12	Radio Production of commercial for general population/sub-groups in regional languages (60 Sec)	Number	0.060	5	-	5	-	0.30	-	0.30	0.00	0.600

4.8.13	Air time of Radio Spots, each spot for 20-30 seconds, with a focus on women of reproductive age	Number	0.014	350	800	720	300	4.90	11.20	10.04	4.20	30.340
4.8.14	Day Branding	Number	1.000	1	1	1	-	1.00	1.00	1.00	0.00	3.000
4.8.15	Printing of IEC Material (per package)	Printing	0.002	500	8000	8000	4000	1.00	16.00	16.00	8.00	41.000
4.8.16	Publication of Supplements in newspapers (3 newspapers)	Number	0.300	1	3	5	2	0.30	0.90	1.50	0.60	3.300
4.8.17	Seminar for Media professionals	Seminar	0.500	1	1	1	-	0.50	0.50	0.50	0.00	1.500
4.8.18	Newsletter	Printing	0.82	2	2	2	0	1.63	1.63	1.63	0.00	4.890
4.8.19	Development of Integrated Health Programmers' Website	Consultancy	5.900	1	-	-	-	5.90	-	-	0.00	5.900
4.8.20	Annual Hosting of Website	Annual	2.000	1	1	1	0	2.00	2.00	2.00	0.00	6.000
	Sub Total			1204	9653	9662		44.23	65.88	68.73	32.83	211.67
4.9	Sub Component 4.9: Training (**)											
4.9.1	Contract out capacity building of provincial and district managers to PHSA	Contract	5.00	-	1	1	-	-	5.00	5.00	-	10.000
4.9.2	Training of health managers in program and financial management 10 participants per district 10*25 in batches of 25 participants each	Training	0.34	2	3	3	2	0.68	1.02	1.02	0.68	3.387

4.9.3	Training of health managers in Monitoring and supervision 10 participants per district 10*25 in batches of 25 participants each	Training	0.34	2	3	3	2	0.68	1.02	1.02	0.68	3.387
4.9.4	Training of health managers in procurement and logistics management 10 participants per district 2*25 in batches of 25 participants each	Training	0.34	2	1	2	1	0.68	0.34	0.68	0.34	2.032
4.9.5	Training of health managers in project planning and design 10 participants per district 2*25 in batches of 25 participants each	Training	0.34	2	1	2	1	0.68	0.34	0.68	0.34	2.032
4.9.6	Training of health managers in Nutrition 10 participants per district 2*25 in batches of 25 participants each	Training	0.34	2	1	2	1	0.68	0.34	0.68	0.34	2.032
	Sub Total			10	10	13	7	3.39	8.05	9.06	2.37	22.87
	Component 4: Total			2723	10188	10100	313	471.89	371.55	371.68	241.63	1,485.379

*from year 4 onwards of the project all salary and management cost will be on the regular budget of the health department

Unit Cost Assumptions

4.1 Human Resource							
	Monthly Salary as per Finance Division OM No. 1(9) R3/2008-396/2001 dated: 12.12.2011 has been calculated for contract employment except Project Manager who will be a regular civil servant.	BPS	Lump-sum salary	Non-practice Allowance	Salary/ Month	Conveyance Allowance for Travel/annum	Annual Salary
4.1.1	Procurement Specialist (Market Based)	--	150,000	-	150,000	-	1,950,000
4.1.2	Finance Manager (Market Based)	--	150,000	-	150,000	-	1,950,000
4.1.3	Deputy Director (BPS 19)	19	115,600	6,000	121,600	-	1,580,800
4.1.4	Provincial Epidemiologist (BPS 18)	18	86,250	6,000	92,250	-	1,199,250
4.1.5	Sr. Research Officer (BPS 18)	18	86,250	-	86,250	-	1,121,250
4.1.6	Sr./Accounts Officer (BPS 18)	18	86,250	-	86,250	-	1,121,250
4.1.7	Surveillance Officer (BPS 18)	18	86,250	6,000	92,250	-	1,199,250
4.1.8	Monitoring & Evaluation Officer (BPS 18)	18	86,250	-	86,250	-	1,121,250
4.1.9	Statistician (BPS 18)	18	86,250	6,000	92,250	-	1,199,250
4.1.10	Logistic Officer (BPS 17)	17	57,500	6,000	63,500	-	825,500
4.1.11	Nutritionist (BPS 17)	17	57,500	6,000	63,500	-	825,500
4.1.12	Administrative Officer (BPS 17)	17	57,500	6,000	63,500	-	825,500
4.1.13	Data Analyst/Computer programmer/IT Officer (BPS 17)	17	57,500	-	57,500	-	747,500
4.1.14	Field Monitoring Officer (BPS 17)	17	57,500	-	57,500	-	747,500
4.1.15	Assistant Accounts Officer (BPS 16)				40,250	-	523,250

4.1.16	Assistant Auditor (BPS 16)	16	40,250	-		40,250		523,250
4.1.17	Data Analyst (BPS 16)	16	40,250	-		40,250	-	523,250
4.1.18	Assistant Logistic Officer (BPS16)	16	40,250	-		40,250		523,250
4.1.19	IT Assistant/ Computer Operators (BPS 15)	15	28,750	-		28,750	-	373,750
4.1.20	Receptionist/telephone operator (BPS 10)	10	17,250	-		17,250	-	224,250
4.1.21	Driver (BPS 04)	4	11,500	-		11,500	-	149,500
4.1.22	Chowkidar (BPS 01)	1	11,500	-		11,500	-	149,500
4.1.23	NaibQasid (BPS 01)	1	11,500	-		11,500	-	149,500
4.1.24	Sanitary Worker (BPS 01)	1	11,500	-		11,500	-	149,500
District Health Office Staff								
4.1.25	Coordinators for EDO Office (BPS 17)	17	57,500	6,000		63,500	-	825,500
4.1.26	Finance Manager/ Assistant Accounts Officer for EDO Office (BPS 17)	17	57,500	6,000		63,500	-	825,500
4.1.27	Health Education Officer for EDO Office (BPS 17)	17	57,500	6,000		63,500	-	825,500
4.1.28	Data Analyst/Computer programmer/IT Officer (BPS 17)	17	57,500	-		57,500	-	747,500
4.1.29	Procurement and assistant Logistic Officer (BPS 16)	16	40,250	-		40,250	-	523,250
4.1.30	Accounts Supervisor (BPS 7)	12	14,254	-		14,254	-	185,302
4.1.31	Deputation Allowance Provincial (lump sum provision)	-	-	-	-	66,000		7,92,000
4.1.32	Project Allowance Provincial (lump sum provision)	-	-	-	-	4,20,000		50,40,000
Total Unit Cost in million		23.767						

(*) One month salary has been added owing payment of annual honorarium.

4.2.1	Provincial Steering Committee				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Out-station participants				
	Supplies per participant	300	5	1	1,500
	Meal & teas per participant	800	5	1	4,000
	Cost	16,500			
	Total Cost of Meeting (in million)	0.02			

4.2.2	Technical Committee on Health				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	300	8	1	2,400
	Meal & teas per participant	800	8	1	6,400
	Out-station participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Cost	19,800			
	Total Cost of Meeting (in million)	0.02			

4.2.3	Thematic Working Group				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Out-station participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Cost				22,000
	Total Cost of Meeting (in million)				0.02

4.2.4	District Coordination Committee				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Out-station participants				
	Supplies per participant	300	10	1	3,000
	Meal & teas per participant	800	10	1	8,000
	Cost				22,000
	Total Cost of Meeting (in million)				0.02

4.3.1	4 weeks course on epidemiology and biostatistics at Aga Khan University				
		Unit Price	Quantity		Total
	Course Registration Fee	50,000	1		50,000
	Travel Cost (Return)	15,000	-		-
	Daily Allowance = 825*5	4,125	-		-
	Cost	69,125			50,000
	Total Unit Cost in million				0.05

4.3.2	Induction course on nutrition for staff working at Nutrition Program				
		Unit Price	Quantity	Days	Total
	Course Registration Fee	50,000	1		50,000
	Travel Cost (Return)	15,000	-	-	-
	Daily Allowance = 825*5	4,125	-	-	-
	Cost	69,125			50,000
	Total Unit Cost in million				0.05

4.3.3	Presentation of research papers in national research symposiums				
		Unit Price	Quantity	Days	Total
	Registration	50,000	1		50,000
	Travel Cost (Return)	15,000	1		15,000
	Daily Allowance = 2050*3	6,150	1	3	18,450
	Cost	71,150			83,450
	Total Unit Cost in million				0.08

4.3.4	International short courses on nutrition				
		Unit Price	Quantity	Days	Total
	Air Travel Cost (Return)	180,000	1	1	180,000
	Daily Allowance	60,000	1	10	600,000
	Cost	240,000			780,000
	Total Unit Cost in million				0.78

4.3.5	In country Diploma in policy and planning for district level staff (2*25)				
		Unit Price	Quantity	Months	Total
	Registration & Tuition Fee	120,000	1		120,000
	Travel Cost (Return)	15,000	1		15,000
	Living Expenses = 50,000*3	50,000	1	3	150,000
	Cost	185,000			285,000
	Total Unit Cost in million				0.29

4.6.1	Vehicle (2500 cc) including freight & registration charges (Province)				
		Unit Price	Quantity		Total
	Field Monitoring Vehicle for PD; Double Cabin 4x4 (2500 cc) including freight & registration charges	35,20,000	1		35,20,000
	Cost	35,20,000	1		35,20,000
	Total Unit Cost in million				3.520

4.6.2	Operational Vehicle 1300cc including freight & registration charges (Province)				
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		Unit Price	Quantity		Total
	Car (13000 CC) including freight & registration	18,60,000	2		37,20,000
	Cost	18,60,000			37,20,000
	Total Unit Cost in million				3.720

4.6.3	Operational Vehicle (800 cc) including freight & registration charges (Districts & LHS)				
		Unit Price	Quantity		Total
	Carry (Bolan) (800 CC) including freight and registration	7,25,000	136		9,86,00,000
	Cost	725,000	136		9,86,00,000
	Total Unit Cost in million				98.600

4.7.18	TA/DA				
		Unit Price	Quantity	No.	Total
	Travel Allowance for five officers	15,000	25	12	4,500,000
	Daily Allowance (=1600 x3) for five officers in a month			60	

		4,800	25	7,200,000
	Cost	19,800		11,700,000
	Total Unit Cost in million			11.70

4.7.22	Performance Incentive Bonus to LHWs, CHWs, HF Staff etc. (2 Districts in each phase)				
	For one Phase	Unit Price	Quantity	No.	Total
	Highest CHW of a District (Quetta)	10,000	1	933	9,330,000
	Health staff at Health Facilities	-	-	-	-
	Medical Officer	25,000	1	2	50,000
	Nurses	10,000	1	2	20,000
	Cook	10,000	1	2	20,000
	Cleaner	10,000	1	2	20,000
	Misc.	10,000	1	2	20,000
	EDO Office	-	-	-	-
	EDO, EDO Staff	40,000	1	2	80,000
	EDO Staff	25,000	2	2	100,000
	PPHI Staff	-	-	-	-
	Provincial Coordinator	30,000	1	2	60,000
	District Coordinator	30,000	1	2	60,000

Misc.	25,000	1	2	50,000
Cost				9,810,000
Total Unit Cost in million				9.81

4.8.1	Formative Research through a competitively hired Firm					
			Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)					
	Team Leader	400,000	1	3	1,200,000	
	Other Professionals	350,000	3	3	3,150,000	
	Support Staff	150,000	4	4	2,400,000	
	Sub-total =	6,750,000				
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum	540,000			
	C. Dissemination Workshop	lump-sum	1	400,000		
	Total A,B & C = D	7,690,000				
		7,690,000				
Total Cost of Consultancy in million		7.69				

4.8.2	Strategy designed based on the findings of the research					
			Unit Price	Quantity	Man-months	Total

	A. Indirect Cost (Consultant's professional fees)				
	Media/Communication Consultants	400,000	2	2	1,600,000
	Other Professionals	350,000	2	2	1,400,000
	Sub-total =				3,000,000
	B. Dissemination Workshop/Sharing with stakeholders	lump-sum	1		400,000
	C. Printing	400	200		80,000
	Total A,B & C = D				3,480,000
	Total D =				3,480,000
Total Cost of Consultancy in million					3.48

4.8.3	Material Field tested and implemented				
		Unit Price	Quantity		Total
	A. Indirect Cost (Consultant's professional fees)				
	Media/Communication Consultants	400,000	2	2	1,600,000
	Other Professionals	350,000	2	2	1,400,000
	Sub-total =				3,000,000
	Total A =				3,000,000
Total Cost of Consultancy in million					3.00

4.8.4	Third Party Monitoring				
	Validation of aired/printed/posted Media Activities	Unit Price	Quantity		Total
	A. Direct Cost (per month)				
	TV Channels Monitoring (All Channels)	450,000	1		450,000

Radio Channels monitoring (All Channels)	200,000	1	200,000
Print Media Monitoring (All Papers)	200,000	1	200,000
Internet Monitoring (All websites)	20,000	1	20,000
Sub-total =			870,000
Total A =			870,000
Total Cost of Consultancy in million			0.87

4.8.18	Newsletter					
			Unit Price	Quantity	man-months	Total
	A. Indirect Cost (Consultant's professional fees) for Development					
	Media/Communication Consultants	400,000	1	2		800,000
	Other Professionals	350,000	1	2		700,000
	Sub-total =					1,500,000
	B. Printing	1000	200			200,000
	Total A & B = C					1,700,000
	Total C =					1,700,000
	Total Cost of Consultancy in million					1.70

4.8.19	Development of Integrated Health programs Website					
			Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)					
	Team Leader	400,000	1	1		400,000
	Other Professionals (Web Developer, Web Designer, Business/Scrip Writer, Web Architect)	350,000	4	2		2,800,000

Support Staff	150,000	6	2	1,800,000
Sub-total =				5,000,000
B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum			400,000
C. Annual Domain Subscription	Annual	1	1	500,000
Total A,B & C = D				5,900,000
Total D =				5,900,000
Total Cost of Consultancy in million				5.90

4.8.20	Annual Hosting of Website				
		Unit Price	Quantity		Total
	Domain Subscription	Annual	1	1	500,000
	Hosting	Annual	1	1	1,500,000
	Total Cost of Consultancy in million				2.00

4.9.2	Training of health managers in program and financial management 10 participants per district 10*25 in batches of 25 participants each				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500
	Out-station participants				
	Average travel cost per participant				

		3,000	20	1	60,000	
	Average daily allowance per participant = DA 2050 x 3	6,150	20	2	246,000	
	Supplies per participant	200	20	1	4,000	
	Meal & teas per participant	300	20	1	6,000	
	Facilitator					
	Daily Lecture's allowance	3,000	3	1	9,000	
	Average travel cost per facilitator	3,000	-	-		-
	Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-		-
	Meal & teas per facilitator	400	3	1	1,200	
	Venue/Hall charges	10,000	1	1	10,000	
	Cost				338,700	
	Total Cost of Seminar (in million)					0.34

4.9.3	Training of health managers in Monitoring and supervision 10 participants per district 10*25 in batches of 25 participants each				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000

Average daily allowance per participant = DA 2050 x 3	6,150	20	2	246,000	
Supplies per participant	200	20	1	4,000	
Meal & teas per participant	300	20	1	6,000	
Facilitator					
Daily Lecture's allowance	3,000	3	1	9,000	
Average travel cost per facilitator	3,000	-	-		-
Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-		-
Meal & teas per facilitator	400	3	1	1,200	
Venue/Hall charges	10,000	1	1	10,000	
Cost				338,700	
Total Cost of Seminar (in million)					0.34

4.9.4	Training of health managers in procurement and logistics management 10 participants per district 2*25 in batches of 25 participants each				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000

Average daily allowance per participant = DA 2050 x 3	6,150	20	2	246,000	
Supplies per participant	200	20	1	4,000	
Meal & teas per participant	300	20	1	6,000	
Facilitator					
Daily Lecture's allowance	3,000	3	1	9,000	
Average travel cost per facilitator	3,000	-	-		-
Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-		-
Meal & teas per facilitator	400	3	1	1,200	
Venue/Hall charges	10,000	1	1	10,000	
Cost				338,700	
Total Cost of Seminar (in million)					0.34

4.9.5	Training of health managers in project planning and design 10 participants per district 2*25 in batches of 25 participants each				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000

Average daily allowance per participant = DA 2050 x 3	6,150	20	2	246,000
Supplies per participant	200	20	1	4,000
Meal & teas per participant	300	20	1	6,000
Facilitator				
Daily Lecture's allowance	3,000	3	1	9,000
Average travel cost per facilitator	3,000	-	-	-
Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-	-
Meal & teas per facilitator	400	3	1	1,200
Venue/Hall charges	10,000	1	1	10,000
Cost				338,700
Total Cost of Seminar (in million)				0.34

4.9.6	Training of health managers in Nutrition 10 participants per district 2*25 in batches of 25 participants each				
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	5	1	1,000
	Meal & teas per participant	300	5	1	1,500
	Out-station participants				
	Average travel cost per participant	3,000	20	1	60,000
	Average daily allowance per participant = DA 2050 x 3				

		6,150	20	2	246,000	
	Supplies per participant	200	20	1	4,000	
	Meal & teas per participant	300	20	1	6,000	
	Facilitator					
	Daily Lecture's allowance	3,000	3	1	9,000	
	Average travel cost per facilitator	3,000	-	-		-
	Average daily allowance per facilitator = DA 2050 x 3	6,150	-	-		-
	Meal & teas per facilitator	400	3	1	1,200	
	Venue/Hall charges	10,000	1	1	10,000	
	Cost				338,700	
	Total Cost of Seminar (in million)					0.34

Component 5. Strengthening Monitoring & Evaluation Systems for Evidence Based Decision Making through use of Good Quality Data

All Figs in Million (Rs.)

All Figs in Million (Rs.)

S. No.	Activities	Unit		Physical Target				Financial Targets				Total
		Defined	Cost	Year I	Year II	Year III	Year IV	Year I	Year II	Year III	Year IV	
5.1	Sub Component 5.1: Development of M&E Framework											
5.1.1	Develop and Institutionalize M&E framework	Consultancy	11.07	1	-	-	-	11.07	-	-	-	11.07
5.1.2	Develop and institutionalize MIS	Consultancy	6.37	1	-	-	-	6.37	-	-	-	6.37
5.1.3	Monitoring provincial / district programs (10 days/month)	Annual	3.53	1	1	1	1	3.53	3.53	3.53	-	10.58
	Sub Total			3	1	1	1	20.97	3.53	3.53	-	28.03
5.2	Sub Component 5.2: Operations Research											
5.2.1	Annual Assessments/Third Part Validation	Evaluation	7.69	-	1	1	1	0.00	7.69	7.69	7.69	23.07
5.2.2	Review of MIS/Integration of Information System	Review	5.48	-	1	-	-	-	5.48	-	-	5.48
5.2.3	Mid and End Term Evaluations	Evaluation	7.69	-	1	-	1	-	7.69	0.00	7.69	15.38
5.2.5	Baseline Survey for missing indicators	Survey	12.58	1	-	-		12.58	-	-	0.00	12.58
5.2.4	Monthly reviews at District Level *25 districts	Meeting	0.17	1	2	2	1	0.17	0.34	0.34	0.17	1.01
5.2.6	Review meetings at provincial level with 35 participants	Meeting	0.28	3	3	3	3	0.85	0.85	0.85	0.85	3.41

5.2.7	Small Grants Innovation / scaling up	Study	4.19	1	1	-	-	4.19	4.19	-	-	8.38
	Sub Total			6	9	6	6	17.79	26.23	8.88	16.40	69.30
5.3	Sub Component 5.3: Supervision and Oversight											
5.3.1	Recruitment of additional Lady Health Supervisors (LHS)	Person year	0.171	561	617	672	672	95.96	107.96	117.61	117.85	439.38
5.3.2	Training of LHS - 6-8 days each year (batch of 15 LHS/training)	Training	0.447	3	4	4	3	1.34	1.79	1.79	1.34	6.25
5.3.3	Refresher trainings for LHS	Training	0.197	8	9	9	8	1.57	1.77	1.77	1.57	6.69
5.3.4	Supervisory visits by the LHS	Annual	0.075	561	617	672	672	42.34	46.57	50.72	0.00	139.64
5.3.5	Supervisory visits by the District Health staff	Annual	13.320	1	1	1	1	13.32	13.32	13.32	0.00	39.96
5.3.6	Fixed T.A for LHS not having vehicles	Annual	0.138	11	11	11	11	1.52	1.52	1.52	1.52	6.07
5.3.7	Drivers for services through LHS	Person year	0.138	561	611	661	0	77.42	85.87	92.90	1.82	258.01
	Sub Total			1706	1870	2030	1367	233.47	258.79	279.63	124.10	896.00
	Component 5: Total			1715	1880	2037	1374	272.23	288.55	292.04	140.50	993.33

Unit Cost Assumptions

5.1.1 Develop and Institutionalize M&E framework		Unit Price	Quantity	Man-months	Total
A. Indirect Cost (Consultant's professional fees) for Development of M&E Guidelines/User Manual & Training Modules					
Team Leader		400,000	1	3	1,200,000
Other Professionals		350,000	4	3	4,200,000
Support Staff		150,000	4	4	2,400,000
Sub-total =					7,800,000
B. Direct Cost					
Biannual Feedback and information dissemination seminars with stakeholders		400,000	2		800,000
Printing of M&E Guidelines/Monitoring tools with CD		1,000	500		500,000
Printing of Quarterly, Annual and/or Special Reports (7 reports)		500	700		350,000
Training on use of Monitoring Tools		400,000	2		800,000
Sub-total =					2,450,000
C. Firm's fee, Admin, rental, equipment etc.		lump sum			820,000
Sub-total A,B & C =					11,070,000
Total A,B,C =					11,070,000
Total Cost of Consultancy in million					11.07

5.1.2 Develop and institutionalize MIS		Unit Price	Quantity	Man-months	Total
A. Indirect Cost (Consultant's professional fees) for Development of MIS Guidelines/User Manual & Training Modules					
Team Leader		400,000	1	2	800,000
Other Professionals		350,000	3	2	2,100,000
Support Staff		150,000	4	3	1,800,000
Sub-total =					4,700,000

	B. Direct Cost			
	Biannual Feedback and information dissemination seminars with stakeholders	400,000	1	400,000
	Printing of MIS Guidelines/Tools with CD	1,000	500	500,000
	Training on use of MIS Tools	300,000	1	300,000
	Sub-total =			1,200,000
	C. Firm's fee, Admin, rental, equipment etc.			
	Sub-total A,B & C =	lump sum		472,000
	Total A,B,C =			6,372,000
Total Cost of Consultancy in million				6.37

5.1.3	Monitoring provincial / district programs (10 days/month)					
			Unit Price	Quantity	Days	Total
	Travel Allowance for four officials	24,000	24	1		576,000.00
	Daily Allowance (= 2050 x 3) for four officials	24,600	24	5		2,952,000.00
		-	-			-
		-	-			-
		-	-			-
	Total Cost					3,528,000.00
Total Unit Cost						3.53

5.2.1	Annual Assessments/Third Part Validation					
			Unit Price	Quantity	Man-months	Total
	One Term Evaluation		-	-		-
	A. Indirect Cost (Consultant's professional fees)					
	Team Leader	400,000	1	3		1,200,000
	Other Professionals	350,000	3	3		3,150,000
	Support Staff	150,000	4	4		2,400,000

	Sub-total =		6,750,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum	540,000
	C. Dissemination Workshop	lump-sum 1	400,000
	Total A,B & C = D		7,690,000
	Total D & E =		7,690,000
Total Cost of Consultancy in million			7.69

5.2.2 Review of MIS/Integration of Information System		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	2	800,000
	Other Professionals	350,000	3	2	2,100,000
	Support Staff	150,000	4	3	1,800,000
	Sub-total =				4,700,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum			376,000
	C. Dissemination Workshop	lump-sum 1			400,000
	Total A,B & C = D				5,476,000
	Total D & E =				5,476,000
	Total Cost of Consultancy in million				5.48

5.2.4 Mid and End Term Evaluations		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	3	1,200,000
	Other Professionals	350,000	3	3	3,150,000
	Support Staff	150,000	4	4	2,400,000
	Sub-total =				6,750,000

	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum		540,000
	C. Dissemination Workshop	lump-sum	1	400,000
	Total A,B & C = D			7,690,000
	Total D & E =			7,690,000
Total Cost of Consultancy in million				7.69

5.2.6 Monthly reviews at District Level *25 districts					
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	20	1	4,000
	Meal & teas per participant	300	20	1	6,000
	Out-station participants				
	Average travel cost per participant	3,000	10	1	30,000
	Average daily allowance per participant = DA 2050 x 3	6,150	10	2	123,000
	Supplies per participant	200	10	1	2,000
	Meal & teas per participant	300	10	1	3,000
	Cost				168,000
	Total Cost of Meeting (in million)				0.17

5.2.7 Review meetings at provincial level with 35 participants					
		Unit Price	Quantity	Days	Total
	Local participants				
	Supplies per participant	200	20	1	4,000
	Meal & teas per participant	300	20	1	6,000
	Average travel cost per participant (Rs. 10/Km, Average Distance 30 km)	300	20	1	6,000
	Out-station participants				
	Average travel cost per participant	3,000	15	1	45,000
	Average daily allowance per participant = DA 2050 x 3	6,150	15	2	184,500

	Supplies per participant	200	15	1	3,000
	Meal & teas per participant	400	15	1	6,000
	Venue/Hall charges	10,000	1	3	30,000
	Cost				284,500
	Total Cost of Meeting (in million)				0.28
5.2.8	#REF!				
		Unit Price	Quantity	Man-months	Total
	One Term Evaluation	-	-		-
	A. Indirect Cost (Consultant's professional fees)				
	Team Leader	400,000	1	3	1,200,000
	Other Professionals	350,000	4	3	4,200,000
	Support Staff	150,000	5	5	3,750,000
	Sub-total =				9,150,000
	B. Direct Cost (Firm's fee; Admin, printing etc. Cost)	lump-sum			732,000
	C. Dissemination Workshop	lump-sum	1		400,000
	Total A,B & C = D				10,282,000
	Total D & E =				10,282,000
	Total Cost of Consultancy in million				10.28

5.2.9	Small Grants Innovation / scaling up				
		Unit Price	Quantity	Man-months	Total
	A. Indirect Cost (Fee/Honorarium)				
	Principal Investigator	300,000	1	3	900,000
	Co-investigator(s)	250,000	2	3	1,500,000
	Support Staff	100,000	4	3	1,200,000
	Sub-total =				3,600,000
	B. Direct Cost (Admin, equipment, testing, printing etc. Cost)	lump-sum			288,000
	C. Dissemination Workshop	lump-sum	1		300,000
	Total A,B & C = D				4,188,000
	Total Cost of Grant in million				4.19

5.3.2 Training of LHS - 6-8 days each year (batch of 15 LHS/training)					
		Unit Price	Quantity	Days	Total
Local participants Supplies per participant Meal & teas per participant Average travel cost per participant (Rs. 10/Km, Average Distance 50 km) Average daily allowance per participant (Half daily of BS - 14/16) Facilitator Daily Lecture's allowance Average travel cost per facilitator Average daily allowance per facilitator = DA 2050 x 3 Meal & teas per facilitator Venue/Hall charges Cost		200	5	1	1,000
		300	5	8	12,000
		500	10	8	40,000
		450	10	8	36,000
		3,000	3	8	72,000
		3,000	3	1	9,000
		6,150	3	10	184,500
		500	3	8	12,000
		10,000	1	8	80,000
	Total Cost of one batch (in million)				0.45
5.3.3 Refresher trainings for LHS					
		Unit Price	Quantity	Days	Total
Local participants Supplies per participant Meal & teas per participant Average travel cost per participant (Rs. 10/Km, Average Distance 50 km) Average daily allowance per participant (Half daily of BS - 14/16) Facilitator Daily Lecture's allowance Average travel cost per facilitator Average daily allowance per facilitator = DA 2050 x 3 Meal & teas per facilitator Venue/Hall charges Cost		200	5	1	1,000
		300	5	3	4,500
		500	10	3	15,000
		450	10	3	13,500
		3,000	3	3	27,000
		3,000	3	1	9,000
		6,150	3	5	92,250
		500	3	3	4,500
		10,000	1	3	30,000
	Total Cost of one batch (in million)				0.20

5.3.4 Supervisory visits by the LHS			Unit Price	Quantity	Month	Total
	Travel Expenses (40 Liters/month)		101	40	12	48,480.00
	Half Daily Allowance of BS 14/16 (= 450)		450	5	12	27,000.00
	Total Cost					75,480.00
	Total Unit Cost					0.08

5.3.5 Supervisory visits by the District Health staff			Unit Price	Quantity	No.	Total
	Travel Allowance for two officers		6,000	25	12	1,800,000
	Daily Allowance (=1600*3) for two officers for 4 days/month		9,600	25	48	11,520,000
	Cost		15,600			13,320,000
	Total Unit Cost in million					13.32

5.3.5 Fixed T.A for LHS not having vehicles			Unit Price	Total Working Days/Annum	No.	Total
	Travel Allowance for two visits/day		300	230	2	138,000
	Cost		300			138,000
	Total Unit Cost in million					0.14