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PC-1

National Programme for Family Planning and Primary Health Care

"The Lady Health Workers Programme"

January 2010 – June 2015

Government of Pakistan
Ministry of Health

ABBREVIATIONS

AA	Assignment Account
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AIHS	Assistant Inspector Health Services
ARI	Acute Respiratory Infection
BHU	Basic Health Unit
CBR	Crude Birth Rate
CDD	Control of Diarrheal Diseases
CDR	Crude Death Rate
CDWP	Central Development Working Party
CMAM	Community management of Acute malnourishment
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CYP	Couple Year Protection
DFID	Department for International Development
DHQ	District Headquarter Hospital
DOTS	Directly Observed Treatment Short course
ECNEC	Executive Committee of National Economic Council
EDO (H)	Executive District Officer (Health)
EPI	Expanded Programme on Immunization
FEC	Foreign Exchange Component
FHT	Female Health Technician
FLCF	First Level Care Facility
FMT	Female Medical Technician
FP	Family Planning
FPSC	Federal Public Service Commission
FWC	Family Welfare Center
GONGOs	Government organized nongovernmental organizations.
HEO	Health Education Officer
IACC	Inter Agency Coordination Committee
IDD	Iodine Deficiency Disorders
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
IYCF	Infant and Young Child Feeding
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDG	Millennium Development Goals
MICS	Multiple Index Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal and Child Health
MNT	Maternal & Neonatal Tetanus
MO	Medical Officer
MTDF	Medium Term Development Framework
MTDP	Medium Term Development Plan
NGO	Non Governmental Organization
NID	National Immunization Day
NTT	Neonatal Tetanus Toxoid
OPV	Oral Polio Vaccine
ORS	Oral Re-hydration Salt
PC-1	Planning Commission – Proforma 1

PCSP	Pakistan Child Survival Project
PHC	Primary Health Care
PIU	Programme Implementation Unit
PL	Pregnant Ladies
PRSP	Poverty Reduction Strategy Paper
PSDP	Public Sector Development Programme
RHC	Rural Health Center
RHP	Reproductive Health Project
RHSC	Reproductive Health Service Center.
PLA	Personal Ledger Account
TB	Tuberculosis
TBAs	Traditional Birth Attendants
THQH	Tehsil Headquarter Hospital
UNFPA	United Nation's Population Fund
UNICEF	United Nation's Child Fund
VBFPW	Village Based Family Planning Worker
WAN	Wide Area Network.
WB	World Bank
WHO	World Health Organization
WHP	Women Health Project
WMO	Women Medical Officer

PC-1 Performa

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

1. Name of the Project:	National Programme for Family Planning and Primary Health Care (NP-FP&PHC) "The Lady Health Workers' Programme" (LHWP)
2. Location	The programme will be implemented all over the country.
3. Authorities responsible for:	
i. Sponsoring.	Federal Government
ii. Execution.	·Ministry of Health (MoH), Provincial Health Departments and District Health Offices.
iii. Operation & maintenance.	Ministry of Health
iv. Concerned federal ministry	Ministry of Health
4. (a) Plan provision	Included in the Ten-Year Perspective Development Plan 2001-11 and Medium Term Development Framework. The Programme has also been identified as a major health sector programme for the PRSP and included in priority area of Vision 2030.
(b) Provision in the current year PSDP (2009-10)	Rs. 7,000 millions
5. Project objectives and its relationship with sectoral objectives	**RELATIONSHIP WITH SECTORAL OBJECTIVES** Being a signatory to the Alma Ata Declaration of 1978, the Government of Pakistan (GoP) is committed to the goal of achievement of "Health For All". The NP for FP&PHC is a major step in that direction. The GoP has indicated its continuing commitment to tackling the country's major health priorities in four major national strategy papers; the National Health Policy 2001, the 10 Year Perspective Development Plan, Medium Term Development Framework (MTDF) 2005-10 and the National Poverty Reduction Strategy.

In these strategy papers the NP for FP & PHC performs a central community level role in providing services for achieving national health objectives. As an indication of its commitment the government has already planned to extend the Programme by including it in priority area of Vision 2030.Setting up a country wide programme of family Planning and primary health care with community participation is the most important component of the agenda for change. The Programme has constituted the main thrust of the extension of outreach health services in the rural and less developed urban areas through deploying 110,000 Lady Health Workers (LHWs). Further expansion of the programme to the less developed and disadvantage areas as well as quality and performance of the LHW Programme will be the main focus of this PC-I.

LHWs will receive comprehensive training to deliver family Planning and primary health care services at the doorstep of community.

Being the signatory to MDGs, the government of Pakistan has committed to improve the indicators of Goals. The programme contributes directly to goal number 1, 4, 5 & 6 and indirectly to goal number 3 & 7.

The programme is designed as an integral part of the existing health care delivery system in the country through extension of the health care delivery infrastructure right into the communities (health houses) through locally identified and recruited literate female volunteers who are trained by the health system and placed in the communities to which they belong. These volunteers are paid a compensation package as part of the social contract to provide promotive, preventive, minor curative, referral and rehabilitative services appropriate to their level of literacy and availability of referral support through the district health system. Thus the program aims to achieve objectives by acting as a catalyst for change and linkage between the communities and the health system which serves them.

Mission Statement

The mission statement of the program is:
Promoting Health; Reducing Poverty
... by bridging the gap between the Health Services and Communities by providing high quality integrated health services through Lady Health Workers to the doorsteps of our communities

NATIONAL GOALS

The program will contribute to the broad goals of the Government of Pakistan as outlined in the National Health Policy:

1. Reduce IMR from 75 to 40 per 1000 live births,
2. Reduce MMR from 275 to 140 per 100,000 live births

NATIONAL OBJECTIVES

The program will contribute to achieving the following objectives by 2015 in areas covered by the program:

1. An increase in the Contraceptive Prevalence Rate from existing 34 % to 48%.
2. An increase in coverage of fully immunized children aged 12-23 months from 68%[1] to above 90%.
3. An increase in TT-2 immunization coverage amongst pregnant female from 64%[1] to 80%.
4. An increase in proportion of pregnant women receiving antenatal care by SBA (at least 1visit) from 76%[1] to 90% and at least 4 ANC by SBA from 29%[1] to 42 %.
5. An increase in births assisted by skilled birth attendant from existing 48%[1] to 60%.
6. An increase in postnatal visits within 24 hours (of home deliveries only) from existing 10%[1] to above 60%.
7. An increase in Exclusive Breast Feeding from existing 49%[1] to 65%.

Specific Program Objectives:

1) To reduce the proportion of poor performer LHWs (Scoring 25% or below) from existing 25% to less than 10%.
2) To phase wise expand the coverage of the programme by increasing the average population registered by LHWs (1000/LHW) in the already covered areas as well as reaching out to the uncovered/underserved areas by increasing the overall numbers of LHWs to 130,000 all over the country by 2015. In new recruitments special focus will be on the disadvantaged areas (rural areas and disadvantaged urban slums) by deploying about 10,000 LHWs in these areas.
3) Strengthening program Accountability and Governance.

The principal sources for verification of performance against these targets will be the "Independent" Programme Evaluations, national surveys like PDS, PIHS etc in addition to the Programme MIS.

6. Description, justification and technical parameters

Pakistan's estimated population of 163.8 million[2] is growing at an annual rate of 1.9; the total fertility rate is currently reported at 4.1. which is 30 percent higher than its South Asian neighbors. Both the Infant Mortality Rate (IMR) and Under 5 Mortality Rate (U5MR) have steadily declined since 1990; however, the rate of decline over the last fifteen years has been considerably slower than its South Asian neighbors — IMR declined by 21 percent in Pakistan during 1990 and 2005, less than half the decline in Bangladesh and Nepal where IMR declined 46 and 44 percent respectively — and Neonatal Mortality Rate has remained relatively stagnant. In addition, available data suggest that there has been no change in

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[1] OPM LHWP 4th Independent Evaluation, Quantitative Survey Report

[2] www.statepak.gov.pk

malnutrition levels in children, with the percentage of under 5 children who are underweight ranging from 33-45 percent.

This Snapshot of health status indicates that Pakistan is far from achieving the health related MDG targets. To achieve these targets Pakistan will have to significantly improve the performance of its health sector.[3]Despite the slow progress towards health related MDGs and other health outcomes, there is evidence that Pakistan has made some level of progress particularly at the intermediate outcome level.

This can be attributable, in part to the increase in public expenditure on health as envisaged in the PRSP-1 and PRSP-II and to the sustained focus on prevention and control of preventable diseases. Expansion of the Lady Health Workers Programme in the rural areas has contributed to improving primary healthcare, although many gaps still remain to be addressed. In addition, intermediate maternal and child health outcomes have also shown improvement during the last 5 years; this is evidenced by the increase in antenatal and postnatal care (ANC & PNC) — ANC increased from 35 to 61 percent and PNC increased from 9 to 43 percent (27% with in 4 hour of Birth)[4] during this period of time, as reported by the PDHS 2007.
Similarly, skilled attendance at birth increased from 24 to 39 percent during the last 5 years; the percentage of fully immunized children increased from 53 to 76 percent, and Tetanus Toxoid (TT-2) coverage in women improved from 35 to 58 percent during the same timeframe.

In the National Health Policy, priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on Tertiary Care – with the National Programme for FP & PHC as its centerpiece.

The implementation of the Programme at the operational level will be carried out by the provincial health departments, district health offices and with maximum authority up to the FLCF level.

IMPLEMENTATION STRATEGIES

The objectives will be achieved through the following Implementation Strategies:

- **Phase I**, (Jan 2010-June 2012).
  - By end 2010 terminating all NR, Overlapping, under educated, dual job LHWs/LHSs.
  - Expanding the coverage to underserved and poor areas, by increasing the Programme size to 120,000 LHWs by June 2012.

[3] Poverty Reduction Strategy Paper PRSP-II
[4] PDHS 2006-07

- Improving mix and scope of services in line with Program priorities.
- Prepare grounds for consolidation
- Piloting Devolution in selected districts

- **Phase II**, (July 12- June 2015), :
  - Improving the productivity and quality of service delivery of the Lady Health Worker
  - Strengthening Programme accountability and governance
  - Strengthening Programme management and systems.
  - Prepare grounds for expansion in disadvantaged areas and deploying addition 10,000 LHWs in disadvantage and underserved areas from July 2014 to June 2015.

Overall Implementation Strategy.

The program will be implemented in close collaboration and coordination with all the national priority programs to ensure efficient and effective utilization of public resources.

The program is designed as a support and extension of the district health system and therefore it will ultimately be devolved to the district health system. However during the interim phase till the capacity of the district health systems evolves to the level where they can provide effective implementation of the program, the Ministry of Health shall continue to provide management support to the provincial and district level in addition to its main roles of policy formulation, monitoring and quality assurance of service provision.

This PC1 is designed for the interim period where the focus shall be on improving the capacities both at the district and provincial level to manage and implement the program, in addition to maximizing the benefits of this major public sector investment in health through improvement in the quality of service delivery. The program strategies during this phase of the PC1are:

Strengthening the health systems

- Enhancing the capacity of Provincial and district health management for program implementation through phased devolution of responsibilities
- Improvement of the utilization of health facilities by bridging the gap between the community and health services in the country through LHWs.
- Provision of early prevention and treatment of minor ailments like ARI, diarrhea, anemia, intestinal worms, primary eye illnesses, malaria, scabies and simple injuries through LHWs.
- Creation of an efficient supply system on a continuing basis in order to assure the regular delivery of essential drugs, vaccines and family planning materials.
- Strengthening Monitoring and Evaluation mechanisms for health systems to monitor implementation progress of the

programme.

- Expansion of the program into poor and underserved areas to target the most vulnerable populations.

Integrating Existing service delivery programs

Integration of existing health care delivery programmes like EPI, MNCH, Nutrition, Malaria, TB & National AIDS Control, and the National Programme for Family Planning and Primary Health Care into the district health system.

- Promotion of immunization activities and increasing EPI coverage for prevention of vaccine preventable communicable diseases in liaison with the EPI programme.
- Improvement of the nutritional status of mothers and children and reduction of malnutrition in children and adolescent females in collaboration with the National Nutrition Program.

Inter-sectoral and Community Actions for Health

- Inter-sectoral action and coordination at all levels between the health sector and other relevant agencies.
- Bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support

Expanding Service Delivery Mechanisms

- New innovations: pilot testing for expansion and consolidation.

In case of revised Projects, provide:
Projects approval history year- wise PSDP allocation, releases and expenditure.

NA

8. Capital Cost Estimation (for Project)

Date when Physical Expenditure estimate were prepared: October 2009.The cost is based on the prevailing rate of the market and based on previous work done.

Sources of funding:

GOP — **Rs. 77,100.904 Million**

(a) Local currency/Pak rupees — **Rs.76,324.281 Million**

(b) Foreign exchange cost — **Rs. 776.623 Million** (To be met from GOP Sources)

Item-wise, year wise actual expenditure (Rs in Million) and Physical Progress — **Given on next page**

Component-wise, Year-wise Physical Activities

Items	Unit	Jan -Jun 2010	2010-11	2011-12	2012-2013	2013-2014	2014-15
A01 Employees	LHW (Cumulative No.)	110,000	120,000	120,000	120,000	120,000	130,000
	LHS (Cumulative No.)	4783	5217	5217	5217	5217	5652
	Staff (Cumulative No.)	1509	1509	1509	1509	1509	1509
A09 Physical Assets	Vehicles	4284	4484	4484	4484	4484	4484
A038 Travel and transportation and Training	TOT (Basic Nat.)	1	1	1	1	1	1
	TOT (Basic Prov.)	5	15	15	10	15	15
	TOT (Basic Dist)	100	200	200	150	150	150
	TOT (Ref Nat.)	1	2	2	2	2	2
	TOT (Ref Prov)	10	20	25	25	25	30
	TOT (Ref Dist))	225	450	460	460	460	500
	LHWs Ref FLCF (Batches)	2000	4500	4500	4500	4500	5000
	TOT (Basic LHS Nat.)	1	1	1	1	1	
	TOT(Basic LHS Prov.)	50	100	100	120	150	100
	TOT (Ref LHS Nat.)	1	1	1	1	1	1
	TOT. (Ref LHS Prov)	10	20	20	20	20	20
	LHS Refresher	240	250	250	250	260	270
	Induction Training (Nat)	1		1		1	
	Induction Training (Prov)	8	16	16	16	16	8
A039 General Procurement (Consumable Item)	Medicine/ Contraceptive	On Consumption	On Consumption	On Consumption	On Consumption	On Consumption	On Consumptio n
	Printed Material	On Consumption	On Consumption	On Consumption	On Consumption	On Consumption	On Consumptio n

The Details of the total FLCF and the FLCF involved with the programme is at Annex XIIX.

YEAR WISE FINANCIAL PHASING JAN 2010 to FY 2014-15 (Rupees in million)

Activities	Jan -June 2010			2010-11			2011-12			2012-2013			2013-2014			2014-15			Total		
	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC
Employees Related Expenses (Salaries/stipends/pay and allowances)	2,213.542	2,213.542		11,079.380	11,079.380	.	11,098.123	11,098.123		11,117.804	11,117.804		11,138.469	11,138.469		12,042.117	12,042.117		58,689.435	58,689.435	-
Management and Monitoring including FPOs. Project Allowances for deputationists working against the sanctioned posts of LHWP is also included. Honrarium is also part of this component	44.023	44.023		374.868	374.868		393.612	393.612		413.292	413.292		433.957	433.957		455.655	455.655		2,115.408	2,115.408	-
Other(Stipends of LHWs,LHSs & LHS's drivers)	2,447.664	2,376.070	-	10,628.775	10,628.775	-	10,628.775	10,628.775	-	10,628.775	10,628.775	-	10,628.775	10,628.775	-	11,488.140	11,488.140	-	56,450.903	56,450.903	-
LHWs Stipends	2,121.918	2,121.918		9,827.382	9,827.382		9,827.382	9,827.382		9,827.382	9,827.382		9,827.382	9,827.382		10,646.336	10,646.336		52,077.783	52,077.783	-
LHWs Supervison (Lady Health Supervisors + LHS's vehicels drivers)	254.151	254.151		749.580	749.580		749.580	749.580		749.580	749.580		749.580	749.580		785.674	785.674		4.038.144	4.038.144	-
LHWs stipends during intial three months trainings	71.595	71.595		51.813	51.813		51.813	51.813		51.813	51.813		51.813	51.813		56.131	56.131		334 976	334.976	-
Fixed Travelling Allowannce for LHSs(a)	4.918	4.918		46.031	46.031		46.031	46.031		46.031	46.031		46.031	46.031		66.140	66 140		255.183	255 183	-
Training Allowance (20% of basic pay)	13.682	13.682		29.706	29.706		29.706	29.706		29.706	29.706		29.706	29.706		32.182	32.182		164.687	164.687	-
	-	-		-	-		-	-		-	-		-	-		-	-		-	-	-
Procurements of drugs, contraceptives, printed material and Health Education Campaign/BCC	861.013	811.030	49.983	2,043.009	1,925.476	117.533	2,140.769	2,003.309	137.460	2,918.589	2,755.706	162.884	3,022.720	2,821.353	201.367	1,310.458	1,388.403	107.396	12,296.559	11.705.277	776.623
Printing & Publications	51.000	51.000		102 500	102.500		52.200	52 200		102.700	102.700		32.100	32.100		22.400	22,400		362 900	362.900	-
BCC/Advertising & Publicity	52.850	52.850		67 840	67.840		67.250	67.250		68.000	68.000		68.000	68.000		68.100	68.100		392.040	392.040	-
Purchase of drugs & medicines	600.054	600.054		1,554.225	1,554.225		1,647.479	1,647.479		2,311.052	2,311 052		2.449.715	2,449.715		1,165.649	1,165.649		9.728 174	9.728 174	-
Contraceptives	157.109	107.126	49.983	318.444	200.911	117.533	373.841	236.381	137.460	436.837	273 954	162 884	472.905	271.538	201.367	239.650	132.254	107.396	1.998 786	1.222.163	776 623
	-			-	-		-	-		-			-	-		-	-		-	-	-
Trainings, Travel & Transportation, PoL	117.299	117.299		715.852	715.852	-	751.754	751.754	•	792.844	792.844		835.081	835.081		888.105	888.105		4,100.934	4,100.934	-
Trainings (Inservice trainings of LHWs, LHSs and trainings at District, Provincial and National Level)	9.290	9.290		248.047	248.047		247.370	247.370		251.414	251.414		250.734	250.734		262.058	262.058		1 268 913	1.268.913	-
TA/DA	12.870	12.870		89.070	89.070	-	95.090	95.090		101.090	101 090		109.100	109.100		113.100	113.100		520 320	520.320	-
Transportation Charges(b)	7.839	7.839		129 163	129.163		139.416	139.416		150.489	150.489		162.449	162.449		175 364	175.364		764.721	764.721	-
POL/CNG Charges	87.300	87.300		249 572	249.572		269.878	269.878		289.850	289.850		312.798	312.798		337.582	337.582		1.546.961	1.546.931	-
Employees Retirement Benefits/entertainments	2.560	2.560		6.220	6.220		6.500	6.500		6.550	6.550		7.650	7.650		7.550	7.550		37.030	37.030	-
Pension Contribution of depiutionst	1.960	1.960		4.750	4.750		4.950	4.950		5 050	5 050		6.050	6.050		6.050	6.050		28.810	28 810	-
Entertainments/gifts	0 600	0.600		1.470	1 470		1.550	1 550		1 500	1 500		1 600	1.600		1.500	1 500		8 220	8 220	-
	-	-		-	-	-	-	-		-	-		-	-		-	-		-	-	-

YEAR WISE FINANCIAL PHASING JAN 2010 to FY 2014-15 (Rupees in million)

Activities	Jan -June 2010			2010-11			2011-12			2012-2013			2013-2014			2014-15			Total		
	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC	Total	Local	FEC
Physical Assets (Vehicles, Medical Store, Computers and other Equipments etc.)	11.460	11.460		341.300	341.300		27.709	27.709		7.942	7.942		57.592	57.592		1.612	1.612		447.615	447.615	-
Procurements of new vehicles and replacements of old vehicles	-			300.000	300.000		-	-		-	-		-	-		-	-		300.000	300.000	-
Computers/MIS equipments	-			10.700	10.700		6.950	6.950		-	-		-	-		-	-		17.650	17.650	-
Machines and Equipments for office	-			7.300	7.300		1.800	1.800		2.700	2.700		1.000	1.000		-	-		12.800	12.800	-
Medical Store Items	11.460	11.460		2.300	2.300		2.459	2.459		5.242	5.242		56.592	56.592		1.612	1.612		79.665	79.665	-
Warehouse items (pellets, racks etc)	-			21.000	21.000		16.500	16.500		-	-		-	-		-	-		37.500	37.500	-
Repairs and Maintenance of Vehicles and other items	22.914	22.914		95.641	95.641		103.673	103.673		92.510	92.510		93.813	93.813		95.304	95.304		503.856	503.856	-
Repairs and Maintenance of Vehicles and other Physical Assets	22.914	22.914		95.641	95.641		103.673	103.673		92.510	92.510		93.813	93.813		95.304	95.304		503.856	503.856	-
Project Pre-investment Analysis	-			-	-		3.000	3.000		-	-		2.000	2.000		-			5.000	5.000	-
Research /Innovations	-			-	-		3.000	3.000		-	-		2.000	2.000		-			5.000	5.000	-
Consultancy and Contractual Work/innovations	-			-	-		-	-		63.000	63.000		64.000	64.000		-	-		127.000	127.000	-
Public Private Partnersip/Colloboration with NGOs	-			-	-		-	-		-	-		-	-		-	-		-	-	-
Evaluations of the Program (Third Party/Internal Evaluation)	-			-	-		-	-		3.000	3.000		4.000	4.000		-	-		7.000	7.000	-
Innovations (Accelarated education etc)	-			-	-			-		60.000	60.000		60.000	60.000		-	-		120.000	120.000	-
Sub Total	3,228.787	3,178.804	49.983	14,281.403	14,163.869	117.533	14,131.529	13,994.069	137.460	14,999.239	14,836.355	162.884	15,221.325	15,019.958	201.367	14,530.487	14,423.092	107.396	76,392.770	75,616.147	776.623
Contingencies/other operational expenses (4% excluding Employees Related Expenses)	40.610	40.610		128.081	128.081		121.336	121.336		155.257	155.257		163.314	163.314		99.535	99.535		708.133	708.133	-
Grand Total	3,269.397	3,219.414	49.983	14,409.484	14,291.950	117.533	14,252.865	14,115.405	137.460	15,154.496	14,991.613	162.884	15,384.639	15,183.272	201.367	14,630.022	14,522.626	107.396	77,100.904	76,324.281	776.623

Item-wise comparison of revised cost with the approved cost and reasons for variation	N.A

8. Item wise annual Operating Cost (Rs. in million)

Item	Recurrent Cost (Rupees in million)
Employees Related Expenses	12042.117
Printing and Publications	0.000
BCC/Advertising	68.100
Medicines & Contraceptives	2810.598
In service trainings of LHWs/LHSs	262.058
TA/DA, Transportation & POL	626.047
Purchase of Physical Assets	0.000
Repair and Maintenance of Physical Assets	95.304
Research	0.000
Innovations	0.000
Others	0.000
Total	**15904.225**

9. Demand Supply Analysis

This programme is increasing the overall awareness of the community for the improvement of their quality of life by having smaller families, self-development initiatives and community social programmes. Further improvement may occur from an intersectional collaboration that will result from the Programme implementation. By improving health status, investments in the Programme contribute to poverty reduction in the country.

With deployment of 130,000 LHWs, the program would be covering approximately 71% of the total population of the Pakistan by Jun 2015 (32% Urban and 90% rural).

Besides providing other basic PHC services, the program would be focusing on the provision of FP services to fulfill the gap of the unmet need of 30% of FP services.

10. Financial Plan

- **a. Sources of Financing**
  - Federal PSDP for Health
- **b. Debt:**
  - **NA**
- **c. Grants:**
  - **NA**

11 Project benefits and analysis:

(a) Project benefits:

- **Financial:**

Improvements in health outcomes are an important determinant of economic growth as better human health leads to increased productivity, improved learning ability, and reduced population growth rate. The LHWs contributing to the improvements in health outcomes do contribute towards poverty reduction and economic benefits.

- **Social:**

The Programme will continue to contribute to improvement of community access to FP and PHC services. This will lead to the improvement of all health indicators such as increase in CPR, Ante Natal Care, EPI coverage, exclusive Breast feeding, health education and utilization of health facilities. This, in turn will improve the impact indicators such as fertility rate, infant and maternal mortality, nutrition etc. By improving contraceptive prevalence rate, the rate of growth of population will be brought down. The estimated population covered and served by the LHWs will be around **130 million** by 2015.

- **Environmental:**

NA

(b) Project Analysis:

- **Quantifiable output of the project:**

In the programme covered areas, programme will
1) 32% increase in immunization coverage of children 12-23 months of age

2) 25% increase in TT coverage of pregnant women

3) 41% increase in contraceptive prevalence rate

4) 20% Increase in proportion of pregnant women receiving One antenatal care by SBAs and 42% increase in 4 ANC by SBAs.

5) An increase of 30% in births assisted by skilled birth attendants

6) An increase above 40 percentage points in post natal visits within 24 hours of home deliveries.

6) 50% increase in early initiation of breast feeding immediately after birth.

7) 32% increase in the exclusive breast feeding up to six months of age.

- **Unit cost analysis**

As the LHWs provide all services included in PHC, calculation of cost of individual service may be difficult, therefore unit yearly cost of fully operational LHWs is shown at **Annex IV & V.**

The average cost per LHW per year is **Rs. 107,833.** The cost per beneficiary per year therefore comes to approximately **Rs.108** only.

- **Employment generation (direct and indirect)**

The Programme will create 130,000 jobs for LHWs and around 7000 LHSs, and other staff like ADCs, District Office Assistants (Logistics and MIS) and Drivers.

12. Implementation of the Project:	
• **Indicate starting and completion date of the project:**	• Starting date Jan 2010 • Completion date June 2015
• **Item-wise/year-wise implementation schedule co-related with the phasing of physical activities.**	Shown earlier.
b) Result Based Monitoring-RBM indicators	**Annexed - XVII**
13. Management structure and manpower requirements;	The implementation of the Programme at the operational level will be carried out by the provincial health departments, district health offices and with maximum authority up to the FLCF level.
• **Administrative arrangements for implementation of the project.**	The administrative structure and functions at various levels has been described in the text to follow.
• **Manpower requirements during execution and operation of the project be provided by skills/profession**	Existing manpower of the health departments at Districts, Tehsil and RHC/BHU level supported by deployed LHWs. As per number of districts, one Assistant District Coordinator for up to 50 LHSs , two ADCs for more than 50 LHSs will be deployed at district level (one recruited by Programme and one drawing salary from DoH). one District Office Assistants (DOA) in districts with less than 20 FLCF, two DOA with more than 20 FLCF. One Lady Health Supervisor for on the average 25 LHWs will be selected i.e. about 6000 LHWs' Supervisors will be in field for supportive supervision of 130,000 LHWs by 2015.
• **Job description, qualification, experience, age and salary of each job be provided.**	See **Annexure XVI**
14. Additional projects/decisions required.	NA

15. Certificate: PC-1 has been prepared as per instructions for the preparation of PC-1 for social sector projects.

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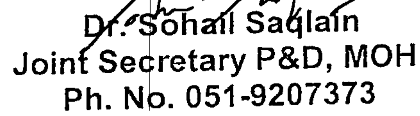

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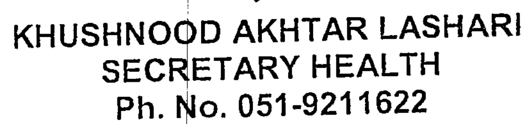

Approved by KHUSHNOOD AKHTAR LASHARI
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Dated - -2010

1. INTRODUCTION

The Government of Pakistan (GoP) recognizes that poverty will not be eliminated unless the causes of poverty are addressed and eliminated and that restoring economic growth and improving access to basic needs such as primary education, preventive health care and population welfare services is essential for winning the fight against poverty *(Interim Poverty Reduction Strategy Pakistan 2002).*

Pakistan is at an early stage in the epidemiological transition and simple technological solutions are appropriate to prevent or treat a majority of illnesses *(Pakistan towards a Health Sector Strategy – World Bank April 1998).* To this end the GoP launched the Prime Minister's Programme for Family Planning and Primary Health Care (PMP-FP&PHC)[5] through the Ministry of Health (MoH) in 1994 with the aim of preventing and treating common ailments at the community level in a cost effective manner. This programme now covers all districts of Pakistan providing essential primary health care services to the community through female community health workers (the Lady Health Worker).

It has been demonstrated that the Programme is certainly having more of an impact on health outcomes and health status, per unit of cost than comparable alternative services provided through the public health system. Already the Programme is providing more services to low income and poor households than any alternative service provider in the public sector.

Given the achievements of the Programme the GoP has decided to continue it and has included the Programme in its 10 year Perspective Development Plan and in the priority area of planning commission document Vision 2030.

II. MATERNAL AND CHILD HEALTH – AN ENTRY POINT FOR SOCIAL DEVELOPMENT

The Programme places special emphasis on maternal and child healthcare. The protection of mothers and children is singled out because of their special needs that must be met to ensure not only the survival but also the healthy development of the fetus, child and mother. Promotive, preventive and curative healthcare makes it possible to minimize health problems or disabilities in adult life and bring about improvement in the overall health of the population and in the quality of life of the individuals. Investment in the health of women and children is a direct entry point for improved human resources, social development and productivity.

Trained LHWs will deliver preventive MNCH services such as antenatal (e.g. screening of pregnant women to identify those at risk, immunization of

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[5] The PMP-FP&PHC has since been renamed as the National Programme for Family Planning and Primary Health Care (NP-FP&PHC) and is commonly referred to as The Lady Health Worker Programme (LHWP). Throughout the rest of this document it is referred to as the Programme.

pregnant women with tetanus toxoid to prevent neonatal tetanus and tetanus in the mother[6]), providing iron folic acid tablets to pregnant mothers, counseling on nutrition, natal (e.g. helping the mothers get access to skilled birth attendants and proper care during delivery) postnatal (identification of danger signs for mother and new born, early initiation of breast feeding, delayed bathing, weight at birth). Raising awareness about birth spacing and providing contraceptives. Immunization of children under 02 year and childcare for prevention of diarrhea and respiratory diseases.

It must be recognized however that health centers and Tehsil headquarter hospitals must be able to deliver effective care of antenatal and postnatal complications, FP services , ensuring a functional chain of comprehensive MNCH services. It is imperative that Midwives as well as other Skilled Birth Attendants in these communities work hand in hand with the LHWs and are provided adequate support from the health center staff.

I. THE LHW: AN AGENT OF CHANGE

The Programme is entirely dependent on the LHW for service delivery. She has proven to be a true 'agent of change'. Various studies and evaluation reports have established the usefulness of the LHWs. The evaluation of the Programme has conclusively shown that Programme is having a significant impact on a range of health outcomes – this is a result that is very rarely found in community health programmes of this size.

FRONT LINE SERVICES

However there is a need for continuing provision of peripheral PHC services where the LHW is the front-line. The LHW establishes direct contact with families ensuring accessibility of the Programme to all primary health care target groups in the community.

At the end of the first three months of training, these health workers are capable of delivering family Planning services and carrying out MNCH activities such as ante natal care, advice on natal and post natal services, increased coverage of immunization against the major infectious diseases, promotion of health education, nutrition promotion and basic sanitation, prevention and control of locally endemic diseases, treatment of common diseases and injuries and provision of essential drugs.

During the second phase of training LHW's knowledge and skills are further strengthened through in-service fieldwork. The LHW will ensure coverage by providing the above services to the entire population of her catchments area.

The LHW through her limited monthly supply of essential drugs is able to treat simple illnesses, such as diarrhea and minor cases of upper respiratory

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[6] The LHWs have already demonstrated their worth in these areas by vaccinating more than five million women of childbearing age against Tetanus in 54 selected districts of the country.

infections, which together constitute the cause of mortality for more than 60% of the under five year of age children. Common illnesses managed by the LHW include; fever, malaria, eye infections, intestinal parasites and anemia. In areas where iodine deficiency is endemic, the tasks of the LHW include provision of IDD Programme services. The LHWs are involved in the management of TB patients under the agreed DOTS strategy with the National TB Control Programme as well as in giving immunization to children and pregnant female.

The programme is evaluated four times by the third party the last in 2008 by the Oxford Policy Management group. The conclusions of the 4th Third party evaluation over various aspects of the programme are as under.

Coverage; Service Levels; the Poor; Health Impact –

"The Programme has expanded substantially since 2000, at the same time as facing the challenges due to decentralisation. **As it has expanded, it has penetrated into more rural and less advantaged areas, although it is still not reaching the most disadvantaged areas. Coverage rates, work levels, knowledge and delivery of services have generally improved.**

LHWs play a substantial role in preventive and promotive care, and in delivering some of the basic curative care in their communities, as well as providing a link to emergency and referral care. Even taking into account other differences between served and unserved populations, modern contraceptive use is more prevalent in served areas, pregnant women are significantly more likely to receive tetanus toxoid vaccination, and children in served areas are significantly more likely to be fully vaccinated. The LHWs are also appreciated by the communities in which they are based. There are a number of areas where the Programme, as a whole, is not having the intended impact, however, including in hygiene and sanitation behaviour, breastfeeding, growth monitoring and attendance at deliveries. Additional attention by the programme to the performance of LHWs might bring substantial health benefits in these areas.

The Programme has managed to introduce a number of improvements that were identified as important in the 3rd evaluation. It has improved supervision and has increased average levels of knowledge. The level of service delivery has increased. However, there remain a group of underperforming LHWs whose working practices must be improved, and gaps in LHWs' knowledge. There remain significant failures in supply systems, both in medicines and equipment. These are issues that must still be addressed going forwards."

Lady Health Workers – the Benefits of Employment in the Programme

"Although the limited nature of this study suggests that conclusions should be interpreted as indicative rather than definitive, that the **Programme is having a positive effect on the well-being and empowerment of women it**

employs. LHWs are relatively more empowered compared with other working women."

The Systems Review

"The performance required of the LHWP systems is relatively well specified in the Strategic Plan and the PC-1. Overall, the systems of the LHWP have coped with the large expansion of the Programme from 40,000 LHWs in 2000 to almost 90,000 LHWs in 2008. The systems have operated to: recruit LHWs and LHSs (although there was a failure to recruit drivers); provide training, including continuing training at the health facility and refresher training courses; improve the level of supplies to LHWs (although there are still problems); improve the payment of salaries (although, again, there are still unacceptable delays); and increase the level of supervision of LHWs.

The core design of the systems appears robust, and has been sustained over the 15 years of the life of the Programme. Poor systems performance occurs most often when there is a shortage of inputs, or non-compliance with the systems standards. For example, there was insufficient procurement of supplies for the LHWs (logistics system); non-compliance with residency criteria in Sindh (selection and recruitment system); and lack of funds for salary payments was evidenced at the time of the Quantitative Survey. These problems are management and governance problems, not systems problems.

Three particular areas of non-performance in systems need to be highlighted:

- The system for dealing with non-performance of LHWs requires improvement so that, where there is evidence of non-performance and a non-willingness to work, the LHW can be terminated efficiently;
- The process for condemnation of vehicles is not operating;
- The procurement process conducted by the MoH and the FPIU has experienced problems resulting in long delays in purchasing.
-

Systems also need to undergo continuous improvement (not necessarily be radically changed), and planned systems developments were generally not implemented. This cannot be attributed to lack of funding, as many of the developments did not require additional funds; neither can this be due to the tensions of rapid expansion, as most of the expansion of the Programme had occurred by 2003.

Our conclusion is that there is a lack of management attention focused on systems improvements: attention is absorbed by operational concerns. It is also difficult to build up the necessary experience to deal with systems development when there are frequent changes in senior management in the Programme and in the Ministry of Health (see also Management Review). There is also a lack of accountability to the Ministry of Health for developments budgeted for and approved in the Strategic Plan and PC-1."

The Management Review

"The Programme's management has been able to both expand its coverage and improve the service levels and impact of the Programme during the period under review.
However, whilst the Programme has made significant progress the strategic plan and PC-1 have not been fully implemented, and important initiatives and systems developments have not taken place.

Any organization has limits on the amount of management attention available. In a bureaucracy working in a challenging environment, such as rural Pakistan, this attention is quickly absorbed by day-to-day operations. And so it is with the Programme.

The governance arrangements of the Programme are there to allow management (both internal and within the Ministry and Departments of Health) to provide leadership and strategic management. The governance arrangements are there also to demand appropriate levels of performance reporting, and to ensure accountability.

The governance arrangements generally failed to deliver these functions, and many issues identified in the Management Review may have been addressed if a stronger governance arrangement had been in place.

Some of the issues that were not addressed are: options for decentralisation, non-compliance with residency criteria in Sindh, issues of integration with BHUs that have been contracted out to non-governmental organisations, and further expansion in urban areas at the expense of development of the Programme into poorer rural areas. These are issues that needed to be exposed by the National Coordinator of the Programme, addressed through the governance committees, and on which decisions needed to be taken to resolve the issues by the Secretary of Health and the central agencies."

The Financial and Economic Analysis

"Budgets and expenditure per LHW have increased since 2002. The Programme is not as under funded as it was in the previous analysis, published in March 2002, which concluded that the Programme needed to spend significantly more resources per LHW to improve the quality of its service delivery. Budgets and expenditure per LHW did increase. Sufficient funds were provided for the Programme to expand from approximately 70,000 to 100,000 LHWs (if donor contributions are included).

As the Programme develops further and to ensure efficient service delivery by the LHWs, the Programme needs to budget on the basis of an appropriate unit cost, and spend accordingly. The cost structure of the PC-1 (2003–08) appears appropriate for future budgeting.

The main improvements in cost-effectiveness are likely to be generated in four areas:

a. through improved performance from the 25% of LHWs who are currently delivering low levels of service;

b. through increased mobility of Lady Health Supervisors;
c. through increased availability of LHW supplies; and
d. through improvements in management and monitoring.

The main recommendations of the 4th Evaluation are

EXPAND INTO MORE DISADVANTAGED AREAS

- Ensure funding mechanisms support this
- Advocate with the Departments of Health for improvements in functioning of health facilities
- Require support by Provinces and Districts to improve the functioning of health facilities to meet the criteria for the recruitment of LHWs in more disadvantaged areas
- Ensure that facilities have the mandate for outreach services- some one delegated to take responsibility for the Programme
- Implement initiatives in the strategic plan e.g. accelerated learning programmes if necessary for particular Provinces
- Provide support to Districts to expand into poorer areas backed up with feedback and acknowledgement
- Maintain catchment areas for LHWs
- As the Programme expands into more remote rural areas, need to ensure mobility of supervisors and inspectors

IMPROVING QUALITY OF SERVICES

- Keep the focus on top priority and core services- aim to improve breast feeding practices, sanitation and hygiene and growth monitoring.
- Ensure new services being introduced have the necessary training, supervision and monitoring e.g. Injectable, Vaccinations and liaison with Community Mid-Wives
- Improve LHW and LHS knowledge scores
- Continue refresher training and increase overall quality to standard of Counselling Cards. Ensure training at monthly meeting.
- Deal with non-performing LHWs including supporting LHS in dealing with them
- Ensure compliance with selection criteria and population registration criteria.
- Improve support to District Management including increasing management staff at the DPIU for districts with large Programme size
- Advocate for facilities to remain responsible for outreach services and remain as a part of the Departments of Health

STRENGTHEN ORGANISATION AND MANAGEMENT: IF IT ISN'T BROKE –DON'T FIX IT

- The EDO-H views the DPIU as a part of his responsibility and the DC as part of his management team. Districts with active EDO-Hs and DCs have higher performing LHWs- Give them support
- Strengthen the roles and capacity for DCs and ADCs to **enable** the EDO-H to provide coordinated outreach services

- Use FPIU-PPIU meetings to stay focused on the Strategic Directions of the Programme and the bigger management issues. Compensate for high turnover of senior managers
- Implementation units and systems generally work well with but need sufficient inputs- e.g. salary system, logistic system.
- Training is working well- training large numbers but improve quality of trainers and materials to increase knowledge.
- Planned systems development initiatives need to be implemented to strengthen the efficiency and effectiveness of the Programme and to have a culture of on-going improvement and collaboration

IMPROVE CONTROL SYSTEMS

- The Programme needs enough control to protect Programme purpose, strategy and performance standards
- Ensure the functioning of the oversight committees for key strategic initiatives
- Ensure compliance with Programme policies:
    - Selection criteria;
    - Not charging for services;
    - Working within catchment areas e.g. for NIDs;
    - Not working for other organisations e.g. MICS survey
    - Attending only approved training programmes
- Adherence to processes that ensure checks and balances e.g. for determining scope of services; for changes to the drugs lists
- Introduce annual reporting on meaningful KPIs
- Improve management information for decision making and problem solving

OVERALL CONCLUSION

- The Programme's staff and workers know that the priorities are Maternal Health, Family Planning and Child Health
- The Programme's services make a difference to health in poor communities
- Committed and knowledgeable LHWs make a significantly bigger contribution to health impacts.
- There are some services that need reviewing- breast feeding advice, growth monitoring, health knowledge and sanitation.
- The Programme's organization and management is capable of producing high performing LHWs.
- What it needs to do to increase impact is:

    Expand into poorer more disadvantaged areas
    Deal with non-performing LHWs
    Increase the effectiveness of some of the LHWs services
    Ensure compliance with Programme policies and standards

THE IMPLEMENTATION PLAN

In order to address the gapes identified by the evaluation and to consolidate upon the strengths the programme intends to increase its coverage and performance simultaneously. In this PC-1 there would be horizontal and vertical expansion via expanding the geographical coverage; increasing the numbers of LHWs with special focus on the more disadvantage areas as well as enhancing the services. The focus would be on performance monitoring to increase the number of high performer in the current PC-1 Life. In this PC-1 life Programme with consensus of the provinces and regions would develop the road map for the devolution of the programme to the provinces.

This would be achieved in phased manner through;

- **Phase I**, (Jan 2010- June 2012).
  - **Improving mix and scope of services in line with clinical priorities and clinical efficacy.**
    - By Dec 2011, clear guidelines will be produced based on Programm priorities about LHW service delivery by the Programme Review Committee.
    - By Dec 2011:
      - Development of the role of LHWs as vaccinators in their communities
      - Provision of Injectable contraceptives
      - Ensuring Safe Delivery in their catchment areas (through skilled birth attendants /midwives)
    - An action plan for development of any additional services will be approved by the Programme Review Committee for the period July 2012-June 2015.
    - Revision and strengthening the role of TCI.
  - **Expanding the coverage to underserved and poor areas, increasing the size of the Programme to 120,000 LHWs by June 2012.**
    - By end of Feb 2010, clear guidelines to identify slum and disadvantaged areas
    - Based on these guidelines a mapping exercise at the district level identifying areas where LHWs are needed.
    - Each District will develop a draft plan by Jun 2010 for expansion into new health facilities that meet the criteria. The plan will include issues that need to be resolved in order to ensure successful expansion.
    - The PPIUs and FPIUs will develop a master plan for expansion which addresses issues raised by the Districts in

their draft expansion plans to enable programme induct addition 10,000 LHWs by June 2012.

- **Prepare grounds for Consolidation**

    - The supervision system will be strengthened by the recruitment of ADCs on contract for every district.
    - There will be one FPO for two districts, one big and one medium /small district. He will spend 13 working days in big and 07 working days in medium/small districts.
    - The ratio of LHS:LHWs will be on average 1:25
    - The Program will provide 04 day Induction training to all new inducted managers of FPIU/PPIU/DPIU followed by 02 days Refresher training every 02 years.
    - The Programme will review reducing (but not eliminating) the role of the LHW focused information systems, to make system more efficient.
    - By end 2010 terminating all NR, Overlapping, under educated, dual job LHWs/LHSs.

- **Piloting devolution in 20 Districts (2010-12).**

A committee on devolution is notified by the secretary health which would

- Prepare road map and firm up recommendations along with modified PC-1 which will be submitted to the planning commission for preparation of summary for ECNEC for complete devolution of the Programme to provinces.
- The committee will also assess the ways and means for complete transfer of the programme to the provinces.

The Devolution pilot will be carried out as per direction of the CDWP and according to the recommendations of the notified committee in selected districts; it will start in phase-1 but could continue through phase-II as per recommendation of the committee.

PHASE II: , (July 2012- June 2015),.

From July 2012-June 2015 the activities of the Programme will be consolidated.

1. Improving the productivity and quality of service delivery of the Lady Health Workers.
2. Strengthening Programme accountability and governance
3. Strengthening Programme management and systems.
4. Preparing grounds for expansion in disadvantaged areas(underserved and poor areas)

1. **Improving the productivity and quality of service delivery of the Lady Health Workers**
    a. Dealing with poor performing LHWs/LHSs/FPOs
        - Identification of poor performing LHWs/LHSs/FPOs by PPIU and DPIU.

- Additional need based training program for LHWs/LHSs/FPOs.
- Re assessment of performance score and decisions of fate of these poor performing LHWs/LHSs/FPOs after codal formalities.

b. Capacity building of managers.
   - Induction course
   - Biannual Refresher training
   - High level domestic management courses.

c. Priority focused areas.
   - Family Planning
   - Maternal and Child health(Immunization)
   - Nutrition.

d. **Training quality**

The quality of training will be improved through the on-going development of the quality control system for training. The aim is to reinforce knowledge and skill acquisition for all LHWs and LHSs

- Refresher trainings of LHWs focusing on FP, Mother &child health and nutrition will be on priority.
- Enhancement in supervisory skills of LHSs and FPOs and district level managers

2. Strengthening Programme accountability and governance

- External evaluations and the Programme's management information system will provide the evidence necessary to ensure internal, public and community level accountability of all managers and supervisors for performance and programme development.
- The Programme will put in place the revised MIS system (if needed after review).
- The Programme will assess the feasibility of using mini-surveys on a regular basis. (internal / External)
- Increasing accountability to enable delegation/decentralization of responsibilities and functions

2. Develop guidelines and an action plan for decentralizing decision making based on Provincial/Regional and District demand and capabilities. These will include:
   - Requirements for accountability and reporting
   - A tool for districts and provinces to use for assessment of their readiness
   - A mediation process to resolve problems and conflicts

- Penalties for non-compliance.
- Better financial management at the all levels.
- Strengthening Logistic system to ensure availability of Program items(drugs, non drugs, printing material and equipments)

3. Strengthening Programme management and systems

- Appointment on merit/selection criteria at all levels.
- Accurate management information will be made available on a timely basis to the Programme managers that enable measurement of all the standardized objectives.

- Management Development
  - The Program will ensure that all new managers have received the induction trainings.
  - The Programme will provide a core high quality domestic management development programme for managers up to ten days training every two years. This programme will cover effective management practices, systems management, and use of management information.
  - There will be increased management support provided to the supervision system to deal with non-performing LHWs.
  - All health facilities will have a person designated as the focal person for the Programme and they will attend quarterly meetings at the DPIU.
  - The programme will ensure that adequate number of ADC is in place.
  - There will be one FPO for two districts, one big and one medium /small district. He will visit the districts as per guidelines of monitoring and supervision of FPIU.
  - Computer access All managers will have a functioning computer with up-to-date software.
  - Transportation All managers will have full-time access to a vehicle with sufficient POL and repair and maintenance budget to conduct their duties in the field.
- Advocacy for review and revision of MoUs with stakeholders to strengthen the preventive aspect.

3. **Preparing grounds for expansion in underserved and poor areas.**
   - Based on Developed guidelines for disadvantage areas carry out a mapping exercise at the district level identifying areas where LHWs are needed.
   - Then identification of facilities to function as training and logistic sites for the LHWs/ LHS
   - Identifying the training capacity at these facilities
   - A comprehensive plan for recruitment for the Provincial and District levels
     - Each District will identify areas for starting accelerated education by Dec 2012.
     - By Jun 2013, Identify and develop the capacities of the Health facilities, with the support of Health Departments, which have the potential for achieving the recruitment target of addition 10,000 LHWs in these new FLCFs, From July 2014.
   - Adopting different innovative approaches to ensure availability of eligible candidates (e.g. Accelerated Education)

By end of this phase there will be about 130,000 LHWs in field and 30% of the urban (Urban slums) would be covered by programme.

II. GOALS AND OBJECTIVES

GOALS

The program will contribute to the broad goals of the Government of Pakistan as outlined in the National Health Policy:

1. Reduce IMR from 75 to 40 per 1000 live births,
2. Reduce MMR from 275 to 140 per 100,000 live births

OBJECTIVES

The program will contribute to achieving the following objectives by 2015 in areas covered by the program:

1. An increase in the Contraceptive Prevalence Rate from existing 34 %[7] to 48%.
2. An increase in coverage of fully immunized children aged 12-23 months from 68%[7] to above 90%.
3. An increase in TT-2 immunization coverage amongst pregnant female from 64%[7] to 80%.
4. An increase in proportion of pregnant women receiving antenatal care by SBA (at least 1visit) from 76%[7] to 90% and at least 5 ANC by SBA from 29%[7] to 42 %.
5. An increase in births assisted by skilled birth attendant from existing 48%[7] to 60%.
6. An increase in postnatal visits within 24 hours (of home deliveries only) from existing 10%[7] to above 60%.
7. An increase in Exclusive Breast Feeding from existing 49%[7] to 65%.

Specific Program Objectives:

1. To reduce the proportion of poor performer LHWs (Scoring 25%) from existing 25% to less than 5%.
2. 10,000 additional allocations of LHWs recruited in the disadvantaged areas.(underserved and poor areas)
3. Strengthening program Accountability and Governance.

The principal sources for the verification of the Programme's contribution to these targets will be through independent Programme Evaluations, CWIQ and the PIHS. In addition there will be a strengthened programme of internal monitoring and evaluation.

KEY PERFORMANCE INDICATORS

The expected key performance indicators to measure the performance of the program by 2015 in areas covered by the program:

Input/ Process Indicators

1. 90% LHWs, by mid 2015, will have an average Performance Score of 65 %.((Internal / 3rd party evaluations)
2. 90% LHWs by mid 2015 are scoring a minimum of 70 on the LHS checklist (Programme M&E systems and 3rd party evaluations)

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[7] OPM LHWP 4th Independent Evaluation, Quantitative Survey Report

3. 90 percent of LHWs and LHS, by mid 2015, score over 80% on the Knowledge Test in mid 2015.(Internal / 3rd party evaluations)
4. All registered households are regularly visited by the LHW. (Programme M&E systems and 3rd party evaluations)
5. 90% of LHWs have been paid full salary in the last month (Programme M&E systems and 3rd party evaluations)
6. 90% of LHWs receive a Supervisory visit by LHS once per month (Programme M&E systems and 3rd party evaluations)
7. All Supervisors have full-time access to a vehicle or getting their FTA (Programme M&E systems and 3rd party evaluations)
8. 90% of LHSs use LHWs JKR to monitor the LHWs performance at Health house.
9. 80% of Infant deaths are verified by LHSs using Verbal Autopsy Reports form.
10. All PPIUs & DPIUs have current Annual Work plan prepared and available at office by the end of July every year. (Programme M&E systems and 3rd party evaluations).
11. 90% of Maternal Deaths are verified by DPIU using Verbal Autopsy Reports form.
12. 95% of DPIU conduct 12 Maternal Mortality Conferences every year.
13. 90% of DPIUs utilize 80% of their LHWs allocation.
14. All PPIUs & DPIUs are following agreed procedures for recruitment, Monitoring & Supervision, training, Finance and logistics (Programme M&E systems and 3rd party evaluations).
15. 75% of LHWs have at least 10 Health Committees meetings conducted every year with minutes recorded.

Outcome Indicators

1. An increase in the Contraceptive Prevalence Rate from existing 34[8] % to 48%.
2. An increase in coverage of fully immunized children aged 12-23 months from 68% to above 90%.
3. An increase in TT-2 immunization coverage amongst pregnant female from 64% to 80%.
4. An increase in proportion of pregnant women receiving antenatal care by SBA (at least 1visit) from 76% to 90% and at least 4 ANC by SBA from 29% to 42 %.
5. An increase in births assisted by skilled birth attendant from existing 48% to 60%.
6. An increase in postnatal visits within 24hours of home deliveries from existing 10.% to 60%
7. An increase in Exclusive Breast Feeding from existing 49 % to 65%.
8. To reduce the proportion of poor performer LHWs (Scoring 25%) from existing 25% to less than 5%.
9. 10,000 additional allocations of LHWs recruited in the disadvantaged areas.

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[8] OPM LHWP 4th Independent Evaluation, Quantitative Survey Report

LHWs' Programme Logical Framework

Narrative Summary	Key Performance Indicators	Means of Verification	Critical Assumptions
Goal: To contribute to poverty reduction by improving the health of the people of Pakistan and contributing towards reduction in Maternal and Infant mortality.	• Infant mortality rate • Maternal Mortality Rate • Total fertility rate	• Pakistan Integrated Household Survey • Other National Surveys	• Stable political environment in country. • Consistency of donor support.
1. Expanding the Programme into underserved/poor areas **Actions** Guidelines for defining poor and "underserved" rural areas and urban slums and provide assistance to PPIUs and DPIUs in identifying such areas. • Based on these guidelines a mapping exercise at the district level identifying areas where LHWs are needed • The next step is identification of facilities to function as training and logistic sites for the LHWs/ LHS • Identifying the training capacity at these facilities • A comprehensive plan for recruitment for the Provincial and District levels.	1. By 2015 there will be 130,000 LHWs deployed 2. Expansion of the Programme in areas that are more disadvantaged. 3. Average population coverage by per LHW is 1000 people. 4. All registered households regularly visited by LHW (LHW visiting at least 30 households a week.) 5. All LHWs continue to fulfil the Programme selection criteria.	Programme MIS & Third party evaluation PIHS Survey Programme MIS and third party evaluation. Programme MIS and third party evaluation.	

• Adopting different approaches to ensure availability of eligible candidates			
2. Raising the level and quality of service delivery through improving the productivity of low performing LHWs. **Actions.** ▸ Priority will be those services which impact on mother and child health and family planning. ▸ Provide clear leadership messages to all Implementation Units, LHSs and LHWs on the priority being given to improved service quality. These messages will be backed up with improvements in the management of the programme and in the accountability of managers for improved quality standards. ▸ The Programme will support the District Health Management in developing a clear statement of the necessary management and training services necessary for health facilities with Lady Health Workers. These facilities are important in contributing to the productivity and service delivery of the LHWs attached to their	1. All LHWs, by mid 2015, will have an average Performance Score of 65 %. 2. All LHWs by mid 2015 are scoring a minimum of 70 on the LHS checklist 3. 90 percent of LHWs and LHS, score over 80% on the **Knowledge Test** in mid 2015. 4. All registered households are regularly visited by the LHW (30 HH/week) The **Performance Score** is a standardized measure of LHW performance that has been used in the external evaluations of 2001 and 2008. The **Knowledge Test** is a standardized measure of LHW and LHS knowledge that has been used in the external evaluations of 2001 and 2008.	• Third Party Evaluation • Third Party Evaluation • Third Party Evaluation • Third Party Evaluation • LHWs-MIS and Third Party Evaluation • LHW-MIS • LHW-MIS and 3rd Party	• Stable macro-economic and political situation • Timely availability of resources • Limited political interference in selection process of LHWs • Strengthened district health system

facility. ▸ For Lady Health Supervisors to provide performance feedback monthly to their LHW using the checklist; having visited the LHW and her households (with and without her). ▸ For the LHW to receive training at the monthly meeting at the health facility. ▸ For all Lady Health Supervisors to attend a refresher three day programme once a year during PC-1 life on managing Lady Health Workers for performance. ▸ Policy of LHWs only attending program approved Trainings will be enforced. ▸ Training needs for poor performing LHWs.	All LHSs using checklist and providing feedback to LHWs on performance score. All LHWs receive training at the monthly meeting at FLCF. 90% LHWs attending Program approved trainings. Reducing the percentage of LHWs attending Program unapproved trainings to <10% All LHWs at or below 60% score on LHS ˛hecklist have received additional training	Evaluation • LHW-MIS and 3rd Party Evaluation • LHW-MIS and 3rd Party Evaluation	
3. Improving the scope of services in line with Program priorities: **Goal:** ▸ Services delivered by LHWs have maximum impact on mortality reduction and fertility choices while at the same time being safe and within the capabilities of both	• By June 2010, clear guidelines will be produced in line with Program priorities and LHW scope of work by the Programme Review Committee.	• Third Party Evaluation	• Political support and commitment of provincial/ district departments of health. • Stable relationship between provincial

LHWs and the Programme. ▸ Core package of services in light of global evidence based interventions and MNCH continuum of care ▸ Performance based payments and incentives Referrals ▸ Enhancing monitoring and supervision , according to areas of service delivery to be emphasized **Prioritized Area.** ▸ Family Planning – ▸ Maternal and Child Health-Immunization ▸ Nutrition. **Action** ▸ Collaboration with skilled community midwives through the MNCH Programme ▸ LHSs will provide the field supervision and monitoring of midwives in collaboration with the MNCH Programme ▸ LHWs will refer their clients for family planning and ANC/natal/post-natal services to their community midwives. ▸ LHWs will provide health education, encouraging the use of the community midwives. ▸ Development of the role of LHWs	• By June 2014, 90 % of LHWs will be providing the three new services All LHWs are supervised by their LHS twice a month and CMWs at least once a month. %age of referral clients to CMWs/FLCF. All LHWs acting as Vaccinator in their communities (catchment area) Not more than 02 months out of stock. FP skills of all LHWs strengthened through regular and refresher trainings.	• Third Party Evaluation • LHW-MIS and Third Party Evaluation • LHW-MIS and Third Party Evaluation • LHW-MIS and Third Party Evaluation	and district harmony.

as vaccinators in their communities in collaboration with the EPI Programme at Federal and Provincial levels ▸ Supply sufficient Contraceptives for national coverage ▸ Provide training at the monthly meeting to ensure confidence and skills of all LHWs in administering the Injectable Contraceptives. ▸ Enhancement of knowledge and skills of LHWs through refresher trainings on CIMNCI approach. ▸ Enhancement of knowledge and skills of LHWs through refresher trainings on IYCF and CMAM.	90% of LHWs can assess sick child through CIMNCI approach 90% of LHWs are trained in IYCF and CMAM	• LHW-MIS and Third Party Evaluation • LHW-MIS and Third Party Evaluation	

4. Strengthening Programme Accountability
3. **Goal:** To enhance accountability through internal, public and community level mechanisms. The Programme will be accountable for providing services to the community with priority given to services in mother and child health and family planning.
Actions:
4. **Evidence base** To strengthen the evidence base to ensure accountability for Programme
	1. FPIU, PPIU and DPIU prepare regular performance reports.
	2. Annual Report against PC-1 and Key Performance Indicators
	    1. will be submitted within three months of the end of FY, approved by Programme Review Committee.
	    2. Briefings and presentations made to key
		3rd Party Evaluation	• Management and Staff continuity

design, management and performance: ▶ External evaluations and the Programme's management information system will provide the evidence necessary to ensure internal, public and community level accountability of all managers and supervisors for performance and programme development.	decision makers/ development partners on the annual report at both the Provincial and Federal levels of government.		
5. The Programme will review reducing (but not eliminating) the role of the LHW focused information systems, to make system more efficient.	3. At least 01 mini survey by Program by the end of Consolidation Phase. 4. 90% communities report visit by LHW in last month. 5. Client and LHW satisfaction 6. Timely releases (consider bi-annual -45 day lagtime)	• Third Party Evaluation • Third Party Evaluation	
6. The Programme will assess the feasib::ty of using mini-survey's on a regular basis. These mini-surveys could be used to independently monitor key indicators of Programme performance e.g. LHW test scores, client coverage, adherence to selection criteria. These results would be used in annual reporting.	All PIUs having Annual Action Plan by end July in each FY		
▶ A Research Unit will be established at FPIU.	Performance Evaluation Tools available and in use at all levels.	• Internal/External Audit Third Party Evaluation	

7. **Increasing accountability to enable delegation/decentralisation of responsibilities and functions**			
8. Piloting of Devolution of the programme to provinces.	• Devolution pilot implemented in selected districts of during the period 2010-2012.	Committee notified by Secretary Health. Minutes of the Devolution committee meetings.	• Political support and commitment of provincial/ district departments of health. • Stable relationship between provincial and district.
9. Develop guidelines and an action plan for decentralising decision making based on Provincial/Regional and District demand and capabilities. These will include: o Requirements for accountability and reporting o A tool for districts and provinces to use for assessment of their readiness o A mediatior. process to resolve problems and conflicts o Penalties for non-compliance. o Better financial management at the all levels. o Strengthening Logistic system to ensure availability of Program items(drugs, non drugs, printing material and equipments)	90% Budget Utilization at all levels. Not more than 02 months out of stock.		

10. **Donor contributions** A management accounting system will be introduced from 2009/10 that accounts for donor contributions to the Programme, both in cash and in kind. ▸ TA at FPIU and PPIUs for maintenance of accounts and internal audit. **Partnerships** Develop a policy and standard protocols for partnership arrangements with NGOs, Citizen Based Organisations, Citizens Community Boards and Women's Groups.			
Biannual meeting of the programme review committee to asses the progress of the programme, intersectoral and inter ministry collaboration and to guide the devolution process.	Two meeting held annually.	Minutes of the meetings with action plans	
Quarterly meeting of the management m DPIU managers with the PPIU and of the PPIU with the FPIU to review committee to asses the progress of the programme and to guide the devolution process.	75% of the planned meeting held	Minutes of the meetings with action plans	

Selection and Recruitment Process

A. Selection and Recruitment of LHWs

The LHWs will be women residing in the same community for which they are recruited, acceptable to their communities, trained to deliver family Planning services, to promote positive health behaviors and deal with health problems of individuals and the community through a PHC approach.

i. Catchment's area for LHWs.

One LHW will be selected to serve on average a catchment's area with a population of 1,000 residents. The catchment's area in densely populated areas may be up to1200

In urban/densely populated areas the minimum catchment population will be 1200/LHW and in areas where Pop/LHWs is less there in case of drop outs/termination the catchment population will be readjusted to ensure the above mentioned population coverage instead of new recruitments.

In hard areas where the population tends to be scattered, the population in the catchment's area of the LHW may be low e.g. 700.

The catchment's area of LHWs will be such that it does not take them more than one hour to walk to the furthest house in the catchment's area. There should be only one LHW in a cluster of 100 to 150 households.

To ensure pro poor expansion of the programme as desired by the prime minister only those facilities will be considered for expansion which have not been involved in the programme. However, attritions/ dropouts may be adjusted in the existing programme facilities.

ii. Selection criteria for LHWs

The following selection criteria should be adhered to at all times:

- Female, preferably married.
- Permanent resident of the area, for which she is recruited.
- Minimum 8 years of schooling preferably matriculate.
- Should be between 20 to 45 years. (up to 18 years only if she is married)
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- 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.

iii. The selection committee for LHWs

It will be constituted as follows:

- Medical Officer/In-charge -FLCF (chairman)
- Women Medical Officer / Lady Health Visitor (LHV) / Female Medical Technician (FMT) -FLCF
- Male Health Technician (MHT)/ Dispenser
- One eminent member of the local community.

In specific/difficult/uncovered areas the DPIU with prior approval of PPIU may substitute the members of the selection committees to meet the desired objective.

iv. Selection and Verification Process

Selection of the LHW will be made by the selection committee and approved by the EDO-H/DHO after verification by FPO/PPIU ensuring that selection criteria have been met. The final selection of the LHWs will be made after careful scrutiny of the documents and the residential status of the applicants.

During interview, the selection committee will ask the candidate to read and write a simple paragraph (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 DPIU in turn should forward it to PPIU within 7 days of receipt of lists for verification by PPIU. PPIU will ensure the completion of spot verification of the candidates and submission of final list to DPIU within 60 days (depending upon the number of candidates) after receipt of list from DPIU for verification.

v. Recruitment and Termination of LHW

LHWs will be employed on contract initially for one year but their services are likely to continue for the life of the Programme. The appointment of LHWs will be made by the EDO (H)/DHO based on the recommendations of the LHW selection committees and spot verification by the DPIU/PPIU. The office of the Executive District Officer (Health)/DHO/DOH will issue recruitment orders within 15 days of receipt of verified list of LHWs from PPIU.

The LHWs not fulfilling the selection criteria would be liable to termination of contract by the District Head of the health office i.e. EDO(H)/DHO, on provision of evidence by the LHS/District coordinator/ADC and verified by FPO or personal verification by officer of PPIU/ FPIU.
The National/ Provincial Coordinator can also recommend to EDO (H)/ DHO to immediately terminate such LHW or LHS found to be not fulfilling selection criteria (with proof). If such LHW/LHS is not terminated by EDO (H)/DHO, the PPIU / FPIU 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 EDO(H)/DHO.

Although EDO (H) 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 PPIU recommendations (based on the findings of termination review committee at PPIU or findings of Enquiry committee constituted by PC).
To ensure transparency in the process of reinstatement for those cases which are recommended by DPIU for reinstatement, DPIU will forward such cases on the Reinstatement Performa duly verified by the concerned LHS, DCNP& FPO and counter signed by EDO. The committee will only take up those cases for which Reinstatement Performa have been filled and submitted by DPIU to PPIU within three months of termination. The committee will meet on need basis but not more the once a month. The members of the committee are

1. Provincial Coordinator	Chairman.
2. Representative from FPIU	Member
3. Concerned FPO	Member

However, those terminated LHWs/LHSs who appeal to PPIU/FPIU for reinstatement directly; Provincial coordinator may nominate an enquiry committee to investigate the appeal. After the enquiry PC may recommend to EDO for reinstatement or otherwise.

vi. Remuneration for LHWs.

In pursuance of the orders of honorable Supreme Courts of Pakistan date 7th September, 2010 (Annex- XXIX), the monthly stipend of LHWs is proposed to be Rs,7000 wef Sep 2010. During initial training of three months LHWs will be paid Rs.100/- per day for first three months of her basic training After successful completion of three months training she will be getting regular monthly stipends of working LHW.

vii. Provision of Leave

The field staff of the program like LHWs, LHSs, and Drivers would be entitled to leaves such as maternity leave, sick leave, hajj leave, Iddat Leave etc. However these leaves would be subject to the approval of the relevant competent authority and based on detail guidelines to be provided by the National Coordinator/FPIU.

viii. Incentive for LHWs:

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

ix. The Scope of Work for 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 house holds 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 (with in one hours) and exclusive breast-feeding for six months and weaning practices, maternal nutrition and macronutrient malnutrition.
- To coordinate with EPI for 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/EPI 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 IUD 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.

- To disseminate health education message on individual and community hygiene and sanitation as well as information regarding preventive measure against spread of AIDS, Hepatitis, etc.
- To attend monthly continuing education session at her base facility to share progress regarding all activities carried out by her including the home visits, number of family planning acceptors by methods and stock position of contraceptives with FLCF in-charge. She will also attend education session, submitted her monthly report and collect one month supplies from FLCF.

LHWs will not be involved in any other activity without the prior permission from the PPIUs/RPIUs who will seek guidance from FPIU if not already issued on case to case basis.

1.2 INCREASE SKILLS THROUGH COMPETENCY-BASED TRAINING

The health facility staff acts as trainers and the health facilities as training sites. This results in considerable cost savings and also facilitates integration and collaboration between the LHWs and the Health facility staff. The quality of the training has generally been satisfactory; however there have been some areas of considerable weakness.

The challenges that will need to be addressed by the training system include:

1) Greater supervision and control over the training system in order to ensure improved quality,
2) The development of regular refresher courses and testing systems in order to ensure that all LHWs reach the same levels of knowledge, as only the best performing LHWs now possess.

Objective:

To enhance the knowledge and skills of LHWs by strengthening pre-service and in-service training through better competency based training

Key Performance Indicators:

- 90% of LHWs score over 80% on the Checklist/knowledge test
- Strengthen capacity of PPIU/DPIU to monitor quality of training

Strengthen training systems through:

- Focus on quality control.
    - Develop pool of Trainers as per criteria at all levels.
    - Training allowance to the trainers
    - FPIU/PPIUs would undertake assessment of training quality on regular basis in different districts. The results would be used to start dialogue with DPIUs to improve quality standards of training.
    - Develop and implement quality tool for training assessment
    - Introduction of LHWs/LHSs/FPOs assessment system.
    - Phasing of refresher trainings at FLCF levels.
- Deployment of training coordinators at PPIUs to ensure quality training

i. TRAINING OF LHWs:

The training of LHWs will be conducted in two main phases for a total of twelve months (3 months basic training and 9 months task based training) using Programme training manuals and curriculum. This will be followed by continual training at the health facility along with refresher training.

For health facilities where 10 or more LHWs are under training (in Basic Training) there should be three trainers; in health facilities where less than ten LHWs are under training, there should be two trainers. It is highly desirable that one member of the training should be a female to facilitate training in areas such as family Planning and maternal health. No training session should be of more than 25 LHWs.

"Integrated training:" (initial 3 months training)

The first phase of basic training will be for six 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.

"Task Based Training": (09 months training)

The second phase of training lasts for nine months with three weeks of fieldwork followed by one week (6 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 full stipend equal to working LHW, whereas team of trainers will also receive full 20% training allowance.

"Continuing 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.

FLCF is the delivery point of all the resources of NP; generally the FLCF staff does not own the responsibility to the desired level. To enhance the commitment of FLCF staff, one of the trainers of the FLCF preferably Medical Officer/ Women Medical Officer will be appointed as the Focal Person for looking after all the activities related to NP as per Program policy. The Focal Person will be notified by District management.

The Focal person will be responsible for:

- Maintaining database of LHWs.
- Receiving and imparting trainings.
- Maintaining logistics and MIS tools.
- Timely submission of Reports to DPIU.
- Regular conduction of One day continuing Education session as per protocols.
- Timely submission of demand of supplies (Medicines, drugs/non-drugs items)

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 2-4 days per year at their districts. For this purpose refresher TOT workshops (2-4 days in 1-2 session) for the trainers at Federal/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 LHSs will act as trainer and entitled for training allowance at FLCF trainers rates . For better monitoring of LHWs level refresher trainings, these will not be conducted in all the NP facilities all over the province/region but phased out, and plane shared with FPIU in advance.

The overall cost of the training has increased as compared to the previous PC-1. Previously part of these training was financed through partners, however to make these sustainable these have now been made part of this PC-1. In addition to the increase in the number of LHWs/LHSs in the current PC-1, the remunerations paid to LHWs/LHSs during training have also been increased to meet the actual expenses of LHWs/LHSs while attending these trainings. Further to this to improve the quality of these training and involve quality trainers for these trainers the trainers allowance have also been increased.

During the **refresher (In- Service) training** sessions, the LHWs would be paid **Rs.100/-** as traveling and refreshment expenses per day, in addition to her regular stipends. In order to provide incentive to the trainers at the FLCF level, **Rs.300/-** per day would be paid to the FLCF trainers actually involved in refresher (in-service) training of the LHWs. While the National, Provincial and District trainers involved in the refresher training will be paid on the analogy of the rates of training of the trainers (on LHWs Basic Manual) given below.

ii. TRAINING OF TRAINERS (On LHWs Basic Manual):

The objective of the training in programme is to improve the performance of LHWs. To achieve this and keeping in view large number of LHWs and FLCF

to which LHWs are attached a trickle down approach for training of LHWs is adopted.

In this scheme of training the provincial master trainers are trained at Federal level who in turn training District master trainer at provincial level. The district master trainers train FLCF trainers at the district level who in turn will train LHWs at their respective FLCF.

The provincial team will be oriented for **nine days** by a team of national level trainers followed by **3 days** of assessment sessions. The provincial trainers will be senior health professionals with previous exposures to teaching methodology, interpersonal communication and specific content-areas in MNCH and Family Planning. During their training they will be reacquainted with training skills required to train district trainers and LHWs as well as supervisory skills necessary for the Programme. The participants would be paid TA/DA/lodging etc. At this level of training National level trainers actually involved in the training would be paid **Rs. 1000 per day** as facilitator allowance in addition to his usual TA/DA etc., admissible as per federal govt. rules.

Provincial teams will subsequently train the district level trainers from their own province. Again, training sessions will be conducted for a period of **9 days followed by 3 days** of assessment workshop to ensure the quality of training. The participants would be paid TA/DA/lodging etc as per GFR. At this level of training Provincial level trainers actually involved would be paid **Rs. 700 per day** in addition to his usual TA/DA etc., admissible as per federal govt. rules. **Only those district personnel who have attended the provincial training course will be retained as district master trainers.**

The district training team will comprise of suitable officers from the following categories of staff, preferably, selecting those who have attended relevant training programmes in the past and who will be able to participate in such training activities without affecting their assigned duties:

1. Senior Medical Officer
2. Medical Officer
3. Women Medical Officer
4. Lady Health Visitor

The district team will in turn train the FLCF trainers. The FLCF level team consists of the MO (Male / female), the LHV/ FHT, and the MHT/ Dispenser or any suitable paramedic/health personnel in the health facility. The team is the primary training unit for the LHWs. It is expected that the Medical Officer (MO) and the FHT will take primary responsibility for training components of community organization, EPI, CDD, ARI and management of minor ailments and the LHV will be responsible for the maternal health and family Planning components. In case of non-availability of all 3 members of team at FLCF, training sessions will be conducted by the available members but EDO-Health / District Health Officer (DHO) should ensure that at least 2 members, of whom one should be female, must be present at FLCF before the initiation of training.

During district level training, the participants would be paid TA/DA etc. At this level of training, district level trainers actually involved would be paid **facilitator allowance of Rs.500** per day in addition to their TA/DA etc., admissible as per federal govt. rules.

Since the initiation of the Programme, more than twelve thousand LHW trainers have been trained. The FLCF training team (MO/LHV/FHT/MHT/Dispenser or any suitable paramedic/health personnel available in the health facility) will be paid 20% training allowance of their substantive pay every month during the 12 months training of LHWs.
Any person working on management post such as EDO(H), MS of Hospital, District Coordinator, Assistant District Coordinator, FPOs will not act as trainers in these trainings at any level.

1.3 Improving Supervision of LHWs & LHSs;

The performance of LHWs will be closely monitored through the supervisors. A strong supervisory mechanism has been adopted by programme employing supervisors at different level. The performance of programme activities and of LHWs/LHSs is assessed and suitable remedial measures including additional training are initiated as per given guidelines. If LHWs/LHSs fail to perform satisfactory even after repeated training, they will be relieved of her assignment.

a. Lady Health Supervisors (LHS)

She is the immediate supervisor of LHWs, attached with FLCF and supervises 20-25 LHWs of that facility. The ratio of the Supervisor to LHW will be 1:25, however based on the needs of the Programme and terrain of the area, this ratio may be reduced to 1:20 with approval of FPIU.

i. Selection Criteria of Lady Health Supervisor:

- Female
- Age: 22-45 years
- Education: (In order of preference)
- LHV or
- Graduate or LHW Intermediate with one year experience (after completion of full training) as LHW or
- Intermediate (in exceptional cases with prior approval of PPIU).
- Preferably one-year relevant experience.
- Local resident of the area (permanently reside in the area and registered with one of the LHWs under her supervision)

ii. Selection Committee for Lady Health Supervisors:

The selection committee for the recruitment of Lady Health Supervisors includes:

- The District head of the Health Department i.e. Executive District Officer (Health)/ District Health Officer – Chairman

- The District Coordinator, National Programme for FP & PHC – Secretary
- Representative from the relevant Provincial PIU- Member
- MNCH program District coordinator

iii. ***Selection Process Of LHSs***

- Identification of uncovered areas/ Health facilities
- Advertisement in newspapers
- Application at DPIU
- Scrutiny of Documents and short listing
- Test and Interview at DPIU
- Spot verification by PPIU.
- Approval by PPIU
- Appointment by DPIUs

iv. ***Termination Of LHS***

The services of the Supervisors will be liable for termination by the EDO (H)/DHO (with prior approval of the PPIU) in case of non fulfillment of selection criterion, bogus documents or unsatisfactory performance etc.

Although EDO (H) of the district have hiring/ firing authority of LHS, however once an LHS is terminated then same LHS can only be reinstated by recommendations of termination review committee at PPIU. The members of the committee are

1. Provincial Coordinator — Chairman.
2. Representative from FPIU — Member
3. Concerned FPO — Member

To ensure transparency in the process of reinstatement DPIU will fill the reinstatement Performa duly verified by the concerned DCNP& FPO and counter signed by EDO. The committee will only take up those cases for which reinstatement Performa have been filled and submitted by DPIU to PPIU within three months of termination. The committee will meet on need basis but not more than once a quarter.

v. ***Main Responsibilities of LHSs***

- To carry out extensive supervision and monitoring of the field activities of LHWs. She should visit the Health House of LHW under her supervision at least twice a month.
- Provide supportive supervision and on job training to LHWs under her supervision and provide verbal and written feed back to LHWs. She may act as trainer in the refresher training as and when required by the DPIU.
- To attend the continued education session in all the relevant health facilities.
- Carry out verbal Autopsy of Infant Death reported by her LHWs.
- To assist the DPIU in the preliminary scanning for verification of LHWs.

- To attend the monthly Maternal Mortality conferences at DPIU.
- To liaise between district and FLCF for the effective coordination of the activities of the program.
- To execute the above duties and functions under the supervision and technical guidance of DPIU, FPO and FLCF In charge.
- To ensure regular maintenance of vehicle and its movement register.
- To provide administrative supervision to the CMWs in her catchment areas.

The Lady Health Supervisors, at the time of recruitment, will be required to provide a notarized affidavit stating that they would perform their duties to the satisfaction of their supervisors for at least one year after the completion of their training failing which they will have to return the salaries they have received.

vi. REMUNERATION FOR LADY HEALTH SUPERVISORS:

Lady Health Supervisors will be employed on contract initially for one year but their services are likely to continue for the life of the Programme. In pursuance of the orders of honorable Supreme Courts of Pakistan date 7th September, 2010 (Annex- XXIX), the monthly stipend of LHSs is proposed to be Rs.7000 wef Sep 2010.

LHS fresh recruited will get salary at par with the existing incumbents/working LHS. If any additional increase in salary is allowed through special orders/sanction by GoP the same would be paid to them. The rural LHSs will be given preference over urban LHSs in allocation of vehicle. Those LHS working without vehicles will get **Rs.150/-**(may be reviewed on annual basis to consider inflation) as Fixed Travel Allowance (FTA) per field visit day.

LHS will be provided petrol for the vehicles 70 liters/ month/ LHS (additional up to 30 liters with permission of EDO(H)/ DHO), depending upon geographical terrain , type of vehicle, population density and number of LHWs. The actual amount of petrol provided to the supervisors may vary according to the type of vehicle, the terrain and the distances involved during field duty of the supervisors.

LHSs will receive the POL and FTA claims through bank account.

vii. TRAINING OF TRAINERS FOR LADY HEALTH SUPERVISORS:

The trainers for the LHSs would be from amongst the senior health staff; at least one of them should be female, with adequate clinical knowledge and experience. The trainers for the LHSs will receive ToT for a total of 12 days comprising of 6 day training on the ToT manual and 6 days training on supervision.
LHS training would be at district level and the rates for training allowances for LHS-ToT would be as those for "Training of the trainers" (ii, 1.2) mentioned above.

viii. TRAINING SCHEDULE FOR LADY HEALTH SUPERVISORS:

The total duration of the training for LHSs will be one year. The LHSs will start their field activities after the first three months. The training will be carried out in two phases;

1. 03 months (13 weeks): 08 weeks TOT manual + 05 weeks LHS manual

2. 09 months field / on job training: One week (6 working days) in the class room and rest of three weeks in field. LHS manual with more emphasis on practical training with audiovisual support and role-Play in the areas of EPI, pediatrics, safe motherhood and family Planning.

The venue for the training of LHSs will be District or Tehsil headquarter hospital (in addition - for practical purposes RHS Center for FP services, EDO (H) office for MIS etc). The theoretical training may also be held at the District Health Development Centers and the Nursing/paramedic training schools.

ix. REFRESHER (In-Service) TRAINING OF LHSs

LHSs will also receive refresher (In-Service) training given to LHWs as a participant of District Level TOT conducted for "LHWs Refresher (In-service) trainings".

In addition 2-4 day LHS refresher (In-Service) training per year will be imparted to LHS focusing mainly on supervisory technique and managerial issues etc. For this purpose refresher TOT workshops will be arranged at the federal, provincial and district level and the training allowance to trainers will be paid on the analogy of "training of Trainers". TA/DA to the trainers and participants will be paid as per prevailing Government rules.

For participation in the refresher (In-Service) training at the district level the LHS will be provided an allowance at the rate of Rs. 300/Day in lieu of DA and Rs.200/training for Traveling etc.

b. Field Programme Officers:

A cadre of Field Programme Officers has also been introduced in the Programme for supervision. The Field Programme Officer is a BPS 17 position. The selection criteria for FPO include a minimum education of MBBS/ *MA Sociology/ MA Social Sciences with experience of at least two years in public health; Candidates with Post Graduation in Public Health from HEC recognized university will be preferred.*
In order to provide an incentive to the good performing staff among the Lady Health Supervisors (LHS), the Supervisors with Masters Degree in any field (for LHS only) with five years experience of working and presently performing duty for program as LHS after completion of training, will also be eligible for selection as FPOs.

FPOs will be recruited after due circulation of the vacancy notice in national newspapers. The Provincial Coordinator will chair the selection committee for the FPO and its Secretary will be the Deputy Provincial Coordinator. Other members will include a representative of the Department of Health (not below BPS 18) and a nominee of the Federal PIU. The approval of selection will be accorded by DG Health.

One FPO will be required to cover two districts. The FPO will be provided with a 4x4 jeep along with a driver and POL for the vehicle. FPO will be provided petrol on an average of 240 liters/ month/ FPO (additional 50 liters with permission of Provincial Coordinator. depending upon geographical terrain. population density and number of LHSs.

FPO Performance Assessment:

Annual performance assessment will be carried out by team of FPIU and PPIU headed by provincial Coordinator on a prescribed performa in the first quarter of every financial year. On unsatisfactory performance, warning will be issued and those not performing their duties up to the mark will be liable to termination of contract by the team of FPIU and PPIU. If no action is taken by PPIU within 30 days of decision, FPIU will take over the case.

Federal/Provincial PIUs officers (Coordinator, Deputy Coordinators and Filed Monitoring Coordinators, MIS coordinator, Logistic officer, Finance officer, HEO, Training Coordinator) will also conduct regular supervision activities in the districts and support to FPOs.

c. FEDERAL MONITORING OFFICERS

To strengthen supervision activities, 3 Field supervision and Monitoring Officers (BPS-18) will be recruited to work at FPIU, two for all four provinces and one for all regions.

The Federal Monitoring Officer will preferably have a postgraduate degree/diploma in Public health or at least five years working experience in Programme related to the public health.

d. LOGISTICS SUPPORT TO THE SUPERVISORS:

For each vehicle for supervisors, one driver from the same community will be recruited on contract basis. In pursuance of the orders of honorable Supreme Courts of Pakistan date 7th September, 2010 (Annex-XXIX), the monthly stipend of LHS Driver is proposed to be Rs.7000 wef Sep 2010. While the drivers assigned with the vehicles provided for the LHS have to travel within the catchment's area, they would not be entitled to DA.

As the driver of LHS is recruited with the consent of relevant LHS therefore as soon as the LHS leaves the program (terminated or resigned) the driver will automatically stand terminated.

Drivers of LHS will be recruited after completing all codal formalities and with the written consent of relevant LHS, by a committee consisting of EDO (H)/DHO, District Coordinator, representative of PPIU and relevant supervisor. On the termination/ resignation of LHS, the driver will be automatically terminated.

Those LHSs who are not provided with vehicles will be paid Rs.150/- per day of field visits as Fixed Travel Allowance (FTA).

The drivers at the FPIU, PPIU and DPIU including the drivers of the FPOs and those recruited by FPIU/PPIUs for vehicle donated by partners will be recruited on contract basis equivalent to BPS- 5. The drivers for the FPIU, PPIU and DPIU, including the drivers of the FPOs will also be eligible to receive DA/lodging as per government rules. The drivers

e: Condemnation process of Vehicles:

At present a high level Vehicle Condemnation Committee (VCC) has been formulated by the Cabinet Division. The Program has large number of vehicles meant for supervision and monitoring of grass root level workers. These vehicles are widely spread over all over the country even at the union council level. Therefore it is not possible for this committee to visit the entire district for physical verification of these vehicles. Furthermore, this strategy is also not cost effective for the Program.

The program will approach the Cabinet division to review the VCC for applying the provincial process and protocols for condemnation of the Program vehicles.

It is proposed that a program VCC be setup, which shall report directly to the cabinet committee. The Program committee shall comprise of National Coordinator/Deputy National Coordinator, Federal Logistic Officer (in case of FPIU vehicle) Provincial Coordinator/Deputy Provincial Coordinator, provincial Logistic Officer representative of DG Health Services of the relevant province, EDO/DOH of the relevant district, Mechanic/inspector from any government workshop in the district and FPO of the district.

This committee will physically inspect the vehicles either at the district headquarters or at their place of posting/parking and prepare a detailed report including photographs. The committee will forward its findings and recommendations to the cabinet committee for approval of the condemnation process within 01 month of inspection. Once approval is accorded, the EDO health shall call for tenders and a committee consisting of EDO/DOH, FPO, representative of DGHS, representative of

PPIU shall open the tenders and prepare the comparative statement which will be forwarded to the FPIU for further action as required.

1.4 STRENGTHENING PROCUREMENT & DISTRIBUTION OF DRUGS, CONTRACEPTIVES AND SUPPLIES:

A: CONTRACEPTIVE MATERIALS:

The LHWs will be provided with oral contraceptive pills, Contraceptive injections and condoms. The LHWs will distribute these contraceptives free of cost as decided by Chief Executive (President) of Pakistan in 2002. The LHWs will promote the use of other contraceptive methods as well i.e. IUCDs, vasectomy and tubaligation and will refer the willing clients to the appropriate facilities.

The contraceptive requirement will be determined and updated on semi-annual/ annual basis according to contraceptive prevalence rate (CPR), couple year's protection (CYP) and consumption trends for each province. The purchase will be carried out on annual requirement basis while six months stock will be maintained at Central warehouse, 6 months stock at the Provincial Warehouses or Medical Store Depots to be operated by the provincial health departments, 3 months stocks in district health office and 3 months stocks at all health centers (Maximum stock level is 18 months).

B: ESSENTIAL DRUGS AND NON-DRUGS ITEMS:

The control and eradication of many diseases depends on the systematic and proper use of essential drugs. Moreover, the credibility of the LHWs and the Programme often depend on the regular availability of essential drugs and non-drug items. LHWs will be provided with a limited range of essential drugs and non-drug items (See Annexure XII) for those health problems that are common. The Programme will take steps to ensure timely supply of drugs and non-drug items to the LHWs. Programme has already advertised for the procurement of 18 month drugs/contraceptives and non drugs item, some of the cost of this purchase will be met from this PC-1 for which amount has been allocated in Jan-Jun 2010. As programme will be focusing on the consolidation of various processes especially drugs forecasting, distribution and storage as well as addressing the issue of poor performer therefore it will procure the reduced quantity of drugs for the year 2010-11-12. In the 2nd phase of this PC-1 2012-13-14 programme will revert to full quota of medicine. Allocation for the purchase of medicine and contraceptive for six months has been made in the last financial year of this PC-1, however if there were savings in the PC-1, these will be utilized for procurement of drugs and contraceptives.

C: PRINTED MATERIAL:

Printed materials are required for training, MIS and IEC purposes in the LHWs' Programme. The list of printed material is given at Annexure XIII; however, the materials can be added according to the requirement of programme in the field. After compiling needs identified from different PPIUs, procurement of printed material will be done at federal level by a

notified committee. However specific printed material will be procured at PPIU level. Stationary items will be procured at PIU level at federal, provincial and district level

D: OFFICE EQUIPMENT AND FURNITURE/FIXTURE:

FPIU/ PPIU will procure these items as per rules and regulations for their own needs. To meet the needs of DPIUs, PPIUs will procure these items and will supply to district.

EXISTING PROCUREMENT PROCEDURE:

A National committee for procurement headed by Federal Director General (Health), all Provincial DGHS /their representatives and National Coordinator as Secretary has been constituted. The committee can co-opt any member whenever required. This committee is responsible for annual procurement of essential drugs / non-drug items. The procurement is based on the requirements indicated by the provinces by following good procedures for local procurement. Efforts are made to procure essential drugs in special packing and by placing orders in strip/blister packing or monthly dosage supplies.

Minor amendments in the specification and quota in the drug and non-drug items may be made on the recommendation of TCI and approval of DG (Health) and Secretary Health.

1.5 Strengthen Programme management:

The Federal PIU will be headed by the National Coordinator who would be a senior health professional with sufficient public health experience. In order to have a person being able to give his full attention and focus to the program activities, the National Coordinator would be selected on merit basis. Monthly salary of National Coordinator will be Rs. 150,000 with other entitlements equivalent to BPS-20. National Coordinator will be controller of supporting development partners like UNICEF, UNFPA and WHO etc. The Federal PIU will be provided adequate human, material and financial resources to perform its functions. Considering the amount of communication involved, National Programme Coordinator will be entitled to grade 20 limits for telephone expenditure.

The Provincial Coordinators will be the employees of the Provincial Departments of Health. For this purpose a separate position of Provincial Coordinator (BPS 19/20) will be created by the relevant DoH. The salary of the PC will be drawn from the Department while other office expenses, such as TA/DA etc will be borne by the programme. The provincial coordinator will be posted/ transferred in consultation of National Coordinator and assigned duties of the National Program for FP & PHC. The tenure of posting will be at least 03 years based on performance

Close co-ordination and co-operation between the managers of the FPIU and the PPIUs with regular meetings and monitoring mechanism has been a hallmark of the program. Provincial/ Regional Coordinators will be provided residential STD phone facilities with a monthly ceiling allowed to B-19 officer of federal government.

The Executive District Officer (Health) /District Health Officer (DHO) will be the chairperson of the District Programme Implementation Units (DPIU). In order to strengthen the programme activities with in the districts it is proposed that one position of District Coordinator National Programme for FP & PHC (DCNP) in BPS-18 may be created at every district by the relevant department of health. The salary of the DCNP will be from the Department while other office expenses, TA/DA etc will be borne by the programme. The tenure of posting as Dsitrict Coordinator will be at least 02 years except for administrative grounds.

To support the federal and provincial PIUs certain positions are created the details of which are at Annexure IX. To retain the experienced programme employees of the programme, the pay scale of some of the positions at PPIUs/RPIU have been upgraded. A committee comprising of representatives from FPIU, respective DGHS office and PPIU will asses the performance of the current incumbent and promote him/her based on performance with effect from the date of commencement of this PC-1. In addition at the district PIUs following positions will be created at every district.

Assistant District Coordinator (ADC)

For better monitoring of the programme in the district a cadre of ADC was introduced in the programme since early days. To ensure better interaction with the field force it was mandatory that the ADC should be a female. Up-till now Female medical officer or senior female paramedic from department of health was performing the duties of ADC as additional assignment. Due to shortage of female staff in many districts and other reasons the post of ADC remained vacant thus compromising the programme implementation.

To overcome this problem a cadre of Assistant District Coordinator BPS-14 will be introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Capacity Building of ADC

The newly selected ADC will be given 4-6 days induction training at provincial level, to orient them on the programme Monitoring and supervision systems and her role and responsibilities. Furthermore she will attend as participant in the 1st available district master trainers workshop, whoever she will not be allowed to act as District Master Trainer for FLCF trainers. She will also attend the LHWs/LHS district level refresher trainings.

A. Selection Criteria of ADC:

1. Female
2. Permanent resident of the district where to be posted

3. Age: 22-40 years
4. Education: (In order of preference)
5. Graduate LHS with two year of experience of working in NP after completion of 12 months training or
6. LHV with 2 year experience in PHC or
7 Graduate with Sociology as one major subject with three years of experience in community organization.

B. Selection Committee for Selection ADC:

The interview may be conducted at the relevant district. The selection committee for the recruitment of ADC includes:

1.	The Provincial Coordinator –	Chairman
2.	Representative of Department of Health-	Member
3.	Deputy Provincial Coordinator-	Member
4.	Representative of FPIU-	Member
5.	The DCNP of the concerned District-	Member

C. Selection Process for selection of ADC

1. Identification of Vacant position of ADC.
2. Advertisement in newspapers
3. Application at PPIU
4. Scrutiny of Documents and short listing
5. Test and Interview at PPIU.
6. Appointment by PPIU.

Repositioning of Account Supervisors As District Office Assistant

To facilitate the routine office work at the district level a cadre of supervisor Accounts have been introduced on the same salary package as of LHS. In a district having less than 800 LHWs there was one position of Supervisor account where in the rest of district there were two positions. Due to higher qualification required for the post there have been difficulties in finding and sustaining suitable persons against the salary package which has led to higher turnover.

Hence it is proposed that cadre of account supervisors may be replaced by District Office Assistant. Furthermore with the expansion of the programme it is felt that there should be one District Office Assistants (DOA) in districts with less than 20 FLCF two DOA with more than 20 FLCF. The District Office Assistant will be in BPS-14 with the following qualification.

- o B.Sc/B-Com/B.A with three Months computer/ office Automation certificate course from recognized university/institution or
- o I/Com with 01 year diploma in Computer Sciences/ office Automation.

A committee would be notified by PC to assess the performance of existing Account Supervisor fulfilling the above mentioned criteria and on the committee recommendation may extend their contract or otherwise.

In a district where there are two office Assistants one will be looking after routine office work and Logistics while the other one will look after Accounts and MIS. In districts where there are three one will look after MIS and payroll while the two will look after accounts, Logistics and routine office work.

Collaboration with National And international NGOs

Following the government policy of fostering public – private partnership, the Programme will develop linkages and enter into partnerships with NGOs and CBOs in selected areas. These partnerships will be formed to mutually benefit from experience and resources of the NGOs and the Programme to promote strategies for sharing all resources available at the grass roots level including support for piloting innovations.

Mechanisms will be developed to fund these collaborative projects. The government funds from the concerned PPIU allocations will be used to serve as seed money for these initiatives. However to coordinate these activities a National level committee will be constituted which will approve such collaborative projects.
No unit of the Programme will be authorized to initiate collaborative projects on its own and also it would be obligatory for the collaborating NGOs to keep all concerned units of Program in loop. The National Coordinator will chair the committee and its members will include one Deputy National Coordinator and all Provincial/Regional Coordinators

Linkages with autonomous government organizations/Other Ministries.

Under new initiatives of government several BHUs have been out sourced to various GONGOs such as PPHI. Under the prevailing MoUs between the provincial governments and relevant GONGOs, the preventive activities of BHUs have been undermined. Therefore, there is need to revisit and re-write the MoUs with these GONGOs to support and strengthen the preventive health aspect including LHWs Program.

- The provincial governments will also take necessary steps to avoid overlap of the National Programme with ongoing projects of the Ministry of Population Welfare and other similar initiatives.
-
- The Provincial governments will be approached and advocated to sort out this issue.

1.6 STRENGTHEN MONITORING:

The Programme not only needs to continue the use of third party and independent evaluations, particularly in support of major new initiatives where additional resources or key policy and programmatic decisions are to be made, but also needs to use more routine monitoring and evaluation systems to ensure that management understands how effective and efficient the Programme is in achieving its goals.

Key Performance Indicators:

- All three management tiers (FPIU, PPIU, DPIU) are provided with regular performance reports

- Performance reports are regularly used in supervisory meetings & performance reviews
- Programme management and strategic directions linked to monitoring evidence
- Key decision makers/sponsors regularly briefed on performance and issues in programme implementation

Reappraise and refine existing instruments

- Further develop Management Information System using the Programmes' administrative records
- Reduce/refine LHW/LHS reporting systems to reflect management capabilities/practices in using information.
- Introduce mini surveys through Research unit to verify and validate performance.
- Continue to implement third party reviews and evaluations

Capacity Building of managers in management skills

- As part of an expansion of programme manager's capacity will be build in use of information and supervision /monitoring techniques.
- The Program will provide 04 day Induction training to all new inducted managers of FPIU/PPIU/DPIU followed by 02 days Refresher training every 02 years.

The Programme will provide a core high quality management development programme for managers with ten days training every two years. This programme will cover effective management practices. systems management, and use of management information.

Develop Advocacy Strategy around Evidence of Programme Impact

- Continue to implement third party reviews and evaluations (as above) and initiation of mini surveys/Rapid appraisal methodology.
- Develop advocacy strategy around evidence of programme performance

Procedures and instruments will be developed to collect data in key areas having impact on the health status of the communities through the LHWs. This data will be passed on to the FLCF, district, provincial and federal level for compilation and analysis.

Necessary support in terms of staff, training, reporting instruments i.e. registers, forms etc and equipment i.e. computers etc will be provided where required. The federal, provincial and district PIUs will be equipped with computers and printers for proper compilation and analysis of the reports on monthly, quarterly and annual basis. The federal, provincial and district PIUs will be linked through WAN or e-mail for timely and efficient transfer of data

- **Monitoring Indicator**

Different process and output indicators have been developed to monitor the progress of the Programme at district level:

INPUT/ PROCESS Indicators:	OUTPUT/ OUTCOME Indicators:
• No. of trainers identified/trained	• Contraceptive Prevalence Rate
• No. of TOT workshops conducted	• Number of Condoms distributed by LHWs

• No. of supervisors selected/trainer • No. of LHWs deployed in district • No .of LHW training workshops conducted • %. of functional vehicles in use by field supervisors • % age of population covered by LHWs in rural areas • % age of population covered by LHWs in urban areas • %age of FLCF involved in the activities of the Programme • % of expected reports submitted by LHWs • %. of expected reports submitted by health facilities.	• Number of contraceptive cycles distributed by LHWs. • Number of Injectable Contraceptives distributed by LHWs. • Number of Women visited for Antenatal Care per worker per month. • Number of post natal visits within 24 hours of home deliveries per worker per month. • Number of Children weighed per worker per month • % of Low Birth Weighed Babies • % of Children fully Immunized • TT coverage among pregnant women • Number of ORS packets distributed by LHWs • Number of ARI cases/LHW/ month • Number of Diarrhea cases/LHW/ month • Total Number of TB suspect cases referred. • Number of functional health committees

- **EVALUATIONS THROUGH THIRD PARTY CONTRACT OR INTERNAL SURVEY AND RESEARCH IN THE PROGRAM.**

The MoH, as part of the LHWs' Programme, would recruit a firm or engage the FPO's which can carry out independent evaluations of Programme over the coming years. The objective of the consultancy is to provide the MoH and other stakeholders with accurate, credible and usable information to track progress on key components of the Enhanced LHWs' Programme and allow course correction to improve performance. The firm will be responsible for designing and carrying out the evaluation studies.

LHWs' effectiveness studies will be carried out using household surveys similar to the one used in the 3rd evaluation that compares rural areas with LHWs to those without LHWs.

District level household survey data would be obtained from CWIQ, MICS etc on key indicators such as infant immunization coverage, TT coverage of pregnant women, contraceptive prevalence rate, and proportion of births attended by skilled birth attendants

The firm would be contracted through international/ national bidding process. In case of internal survey, firm will be engaged for data processing, analyzing and report writing. In all probability, either third party or internal survey, methodology remains the same or the program trends could be seen.

- **RESEARCH:**

The Programme will promote operational research Some funds will be provided out of the government sources while funding and technical assistance from the donors and academic institutions will also be solicited. Seed money of Rs.7 Million rupees is being proposed for the purpose. Any one interested in the research will submit concept paper/ proposal to the National Coordinator. The proposal will be assessed by TCI and if recommended, can be conducted with approval of the competent authority. (PMRC or TPE model for the payment will be adopted).To strengthen the research component, constitution of Research and Publication cell at FPIU will be undertaken.

- **Programmatic expansion**

Programmatic expansion would include countrywide introduction of already pilot tested innovation e.g. immunization, behavior change communication, TB DOTS, Use of BP apparatus and Stethoscope for screening of Pregnant Women for eclampsia.

2.1 *EPI*

The process of involving LHWs in Routine EPI was initiated in 2003-04 after the success story of MNT (Maternal & Neonatal Tetanus Elimination) campaign launched in 2001-02 in 57 high risk districts of the country. In this campaign, the LHWs have proven their worth of capability and acceptability. After wards, the modalities of involving LHWs in routine EPI could not be finalized due to several factors. However, the findings of DHS survey 2007 were an eye opener for all the stake holders in which the routine EPI coverage was found to be 47% only. GAVI-HSS supported in the revival of role of LHWs as vaccinators.

In collaboration with National EPI Program and with the support of GAVI-HSS, the guidelines for involvement of LHWs in routine immunization in their catchment areas have been finalized in August 2008.

It was agreed to initiate the activity in phase wise manner. In Phase-1, 44 Districts based on EPI performance all over the country are involved since December 2008. In next phase, the remaining districts will be covered.

Training of LHWs will be done in phases. In phase-1, 6 days theoretical training at facility level will be imparted. Vaccinator of fixed site will be among the training team. After this, 1 month observing session at HF (once/twice a week on the day of vaccination) followed by 3 month practice under supervision in the health facility (once/twice a week on the day of vaccination). In the last phase, 2 months practice under supervision of LHS and vaccinator will be done in the health house.

Initially LHWs will give OPV, Combo/Penta, Measles, TT independently after completion of all phases of training and certification by trainers while BCG will

preferably be given in EPI fixed center on a fixed date every week to address the wastage.

The supply of vaccines/syringes from district to FLCF will remain the responsibility of National EPI Program. The distribution of vaccines in the field will be carried out by the concerned LHS/Vaccinator as per agreed guidlines.

The Phase-1 of involvement is completely funded by GAVI-HSS. The GAVI-HSS has assured the support in the reaming districts as well (2010-2012) However, in case, GAVI-HSS fails to fulfill the support; the Program will complete the assignment with its own funds/budget.

2.2 *Screening of Pregnant Ladies (PL) For eclampsia and strengthening post natal care.*

Pakistan being signatory to Millennium Development Goals is trying to focus on improvement of MDG 4 & 5 by 2105. There is significant improvement in maternal and infant mortality rates but still more needs to done. Major causes of maternal deaths include ante partum and post partum hemorrhage, Pre-eclampsia and eclampsia (more than 20%). The trend of home based deliveries through TBAs in Pakistan is still high (around 45%) due to social and cultural barriers, non availability of female skilled staff and confidence of communities in the health care providers. Similarly, neonatal deaths contribute nearly two third of the infant mortality. The most critical time to provide care to mothers is screening of mothers during and after delivery and newborns is within the first week of birth. If properly screened nearly half of these deaths can be avoided.

The main objective of LHWs program is to create awareness in the community about mother and child health. LHW counsels the mother on ANC through SBAs, prepares birth plan with mothers and families, helps in identification of appropriate health facility for delivery, care of new born, explain them the danger signs of pregnancy and delivery through group counseling.

It is evident from the studies that community health workers can play a crucial role in early detection and screening of pre eclampsia through quality trainings and taking blood pressure using BP apparatus and stethoscope. In order to enhance the skills of LHWs in screening of high risk pregnancies, the Program initiated the trainings of LHWs for screening of pregnant females through regular checkup by taking BP. To strengthen the post natal visit component, LHWs presence at the time of home delivery will be ensured. However, the WHO protocol for post natal visits in the light of latest UN Joint Statement will be promoted to prevent the maternal and newborn morbidity and mortality. Besides this, the skill of identification of danger sign during pregnancy, delivery and post delivery period were improved with the help of use of plastic charts, based on international guidelines of integrated management of pregnancy and childhood (IMPAC). The trainings were imparted in selected districts with the support of UNFPA and UNICEF. BP apparatus along with stethoscope was provided. During trainings clinical and community sessions were arranged for practical session. The monitoring

reports showed that this intervention has not only resulted in increase in ANC and PNC visits in health facilities as well as by LHWs but has also boosted the image of LHWs in their community.

Based on these findings, LHWs Program is planning to replicate this activity across the country. The Program will equip all the LHWs with BP apparatus, stethoscope and weighing scales.

2.3 *IYCF and CMAM*

In its expansion phase another area of the programme focus will be IYCF. Appropriate feeding practices are essential for the nutritional status, growth, development and survival of infants and young children. These feeding practices, known collectively as infant and young child feeding (IYCF) practices[9], include breastfeeding and complementary feeding. Infants should be breastfed soon after birth, exclusively breastfed for the first six months of life, and thereafter should receive nutritionally adequate and safe complementary foods while continuing breastfeeding up to two years.

In Pakistan many aspects of infant and young child feeding are far from optimal. The initiation of breastfeeding is often delayed, only 37.1% of infants aged less than six months are exclusively breastfed, complementary feeding frequently begins too early or too late, over one in three of infants aged under 6 months are bottle-fed. Complementary foods given to infants and young children are often nutritionally inadequate and unsafe leading to malnutrition. Such inappropriate infant and young child feeding practices are among the most serious obstacles to maintaining adequate nutritional status, and contribute to levels of malnutrition in Pakistan that are amongst the highest in the world. Optimal infant and young child feeding requires substantial behavior change on the part of a mother and community.

The National IYCF Strategy calls for updating of knowledge and the integration of skilled counseling and support for infant and young child feeding at all points of contact between mothers and health service providers including Lady Health workers during pregnancy and the first two years of life of a child, including antenatal care, delivery care, postnatal care, provision of iron and folic acid tablets to the pregnant and lactating mothers. Immunization visits, growth monitoring and promotion, and child health services.

The topic of nutrition has been addressed extensively in the basic curriculum of LHWs It focuses on counseling of adolescents and mothers on nutritional requirements but also concentrates on early initiation of breast feeding, exclusive breast feeding up to 06 months of age and appropriate weaning at after 06 months of age. The services provided by LHWs include weigh the children up 03 years of age and monitor the growth of children using growth monitoring cards, provision of iron foilc acid tablets to pregnant and lactating mothers

[9] In the context of this National Strategy, infant and young children are defined as aged less than 3 years.

The programme in its expansion phase will inter alia focus on the nutrition by resorting to the IYCF and lately developed Community Management of Acute Malnutrition (CMAM) strategy of MoH. The CMAM has been developed to address the issue of malnutrition through catering for challenges in the operating environment and is endorsed by WHO, WFP and UNICEF and has also been successfully implemented in Pakistan in KP and in Balochistan. The MoH aims to integrate it into ongoing routine health services for children under five and to scale up CMAM throughout the country.

Role of LHWs in IYCF and CMAM

- Actively screen all children in her catchment area for malnutrition and their referral to the nearby centers.
- Ensure effective therapeutic feeding of sick and malnourished children, including the provision of skilled breastfeeding support when required.
- Give adequate follow up care to acutely malnourished children, i.e., therapeutic feeding for severe malnutrition and supplementary feeding for moderate malnutrition, as per protocols.
- Promote good nutrition for pregnant women and lactating mothers.
- Counseling and assistance skills needed for breastfeeding and complementary feeding,
- Provide guidance on appropriate complementary feeding with emphasis on the use of suitable, locally available foods which are safely prepared and fed to young children.
- Monitor growth and development of infants and young children through mid arm circumference approach as a routine nutrition intervention, with particular attention to low birth weight and sick infants, and those born to HIV positive mothers; and to ensure that mothers and families receive appropriate education and counseling.

A special training package focusing on skilled based training in line with the role of LHWs will be developed and as part of refresher trainings, all LHWS will be trained in new IYCF and CMAM strategy through support of Nutrition Wing of MoH. Through continuous educational activities the messages will be reinforced and environment for sustained behavioural change will be developed.

2.4 *Mother Child Week*

Pakistan is not on track for achieving MDGs 4 & 5 and need some extraordinary efforts to achieve its targets. Pakistan has an under five mortality rate of 94 and infant mortality rate of 77 per 1000 live births. Almost two-thirds of these deaths are due to newborn causes (birth asphyxia, infections and low birth weight). These causes are strongly related to care of mothers during pregnancy, delivery and during post natal period. After the burden of neonatal causes, pneumonia (13%) and diarrhea (11%) are the main killers of children under the age of five years. Among children under five, diarrhea prevalence is 22 percent. Of all children with diarrhea 47% receive ORS or recommended home made fluids. Breastfeeding practices show that

though 94% of Pakistani children are breastfed, only 37% of children under six months of age are exclusively breastfed and only one third of all children receive complementary feeding at the age of 6-8 months. 89% of households do not treat drinking water and three in ten Pakistani households do not have a toilet facility. All these factors combine to affect the situation of child health and nutrition status.

What can be done?

Pneumonia and diarrhea both have seasonal occurrence and can benefit from focused mass awareness campaigns. Health facilities need to be equipped with essential medicines like ORS & antibiotics to cope with the demand and the referrals. In a drive to reach every mother and child, catch-up immunization and de-worming can also be done. Pregnant mothers can be targeted for TT vaccination and dissemination of awareness on antenatal care, services of skilled attendant at delivery, danger signs among mothers and newborns and the key messages on breast feeding & newborn care. Thus an integrated service delivery approach is required at each district. Similar experience in Ghana has shown reduction in Infant mortality rate by half within a period of 3 years.

Strategy Adopted:

The initiative was scaled up with UNICEF support to six districts (3 in Punjab, 1 each in KP, Sindh and Balochistan) in months of April and October, 2008. It was called "Child Health & Sanitation Week" to acknowledge the impact of hygiene and sanitation practices on incidence of pneumonia and diarrhea. Last time the Week was observed in 29 districts all over Pakistan and in November 2009, the Week will be upscale to 136 districts.

Activities:

The series of activities during the week include public awareness activities at village and union council level; supplemented by immunization and de-worming for children, tetanus toxoid vaccination for pregnant mothers, refresher trainings for health workers, and strengthened public health systems to ensure that Oral Dehydration Salts (ORS) and other essential supplies are available and correctly used. Each pregnant woman also receives counseling on recognition of danger signs among mothers and newborns, the importance of at least four ANC visits, delivery by a skilled birth attendant, post natal care, early initiation of breast feeding, exclusive breast feeding, immunization of the child and optimal birth spacing.

Lady Health Workers and community volunteers are trained to reinforce health and hygiene messages and are equipped with pictorial materials for inter-personal and group sessions. Special sermons in form of mosque leaflets are given out to religious leaders who use mosques to disseminate the information focusing on the religious teaching that "practicing cleanliness is half of the Islamic belief". Village committees and municipal corporations are mobilized to undertake an enhanced sanitation drive. Each health facility is the hub of all training activities for teachers, lady health workers and

community volunteers. The facility staff is given refresher training on the IMNCI management of diarrhea and counseling skills to deliver better hygiene & sanitation messages.

Supplies of ORS and intra-venous fluids along with vaccines and EPI cards are ensured to cater for an increased community demand for services. Schools are at the forefront to hold special events for children including display of posters and banners, organizing plays, special classes and distribution of stationary with relevant Meena messages. Male and female teachers serve as community volunteers in areas/villages where there are no lady health workers.

Logistics.

The strategy of giving single stat dose of Tablet Mebendazole 500mg, after an interval of 06 months in children of aged 2-5 years has been adopted by the Program and Tab. Mebendazole-500mg has been included in the drug list of Program. However, because of financial crunch, for initial two years UNICEF will support the program for provision of tab Mebendazole 500mg and afterwards programme would procure it from its own funds. Provision of Vaccines and Syringes will remain the responsibility of National EPI Program. In addition to this Advocacy, printed material, and Trainings required for Mother &Child Week will be supported by National Program in collaboration with development partners.

Testing Innovations

The interventions will continue through out period of PC-1. Program will also start testing new models and innovations from FY 2009-15. An allocation of Rs. 175 million rupees has been made in the budget. This component would comprise the following sub-components:

1. Programmatic Expansion and field-testing interventions that could be added to LHWs scope of work that would have a large health impact.
2. Pilot test management/organizational innovations.
3. Piloting Devolution of the Programme

There is considerable indication that the LHW do have the time and capabilities available such that their roles, within a Programme context, might be extended. There is evidence that the program has an impact in many key areas such as vaccination coverage, perinatal and newborn care, the Program will aim to make significant strides in improving the health impact of its services.

The Programme aims to take advantage of important new evidence on the impact of certain maternal and child health inte ventions in order to fine-tune the package of services provided by the LHWs. Though the evidence on some of these interventions appears to be quite promising, some would need to be pilot-tested prior to their introduction in the program. Some programmatic interventions to be pilot-tested would be chosen following a screening process by the **"Technical Committee on Interventions"** with membership from within Programme and technical experts on maternal health, child health and public health with experience of using scientific research methods and tools.

i) Reaching the underserved and disadvantage Areas.

a.) Accelerated Education.

In order to enhance the coverage and find middle pass girls in low literacy areas, efforts will be made to identify primary pass girls and with accelerated education these primary pass girls will be awarded middle certificate in one and a half year time. Program is piloting the initiative with financial support of PAIMAN/JS and technical support of Allama Iqbal Open University in Balochistan. The module would further scaled up in the remote and disadvantaged rural areas with the technical support of AIOU and partners for which seed money of Rs.140 Million has been year marked in this PC-1.

b.) Pilot testing Couple Health Workers

In order to expand the programme services to the most disadvantage areas, programme with the support of partners will pilot the couple health workers scheme on the analogy of "Behvarz Iranian model" in some of the hard to reach and disadvantage areas of the country.

II) Mobilization of Health committees of LHWs through Male Mobilizers MoPW.

LHW is responsible for mobilizing the community to promote and improve health through her participation in the health committees consisting of male member mainly and in the Women groups comprising of influential females of the community. From the fourth 3rd Party evaluation it has been evident that there has been significant increase in the activity of Health

Committee has been improved since last evaluation(65% met in the past month) but not to the extent of working of Women Group(80% of these have under taken some activity in the past year).

Lady Health workers are the main outreach mechanism and already mandated to provide FP services; supplies of condoms and pills, 2nd dose of injectables and referrals for clinical methods and further counseling. By means of her Women Group, LHW is contributing a lot in promotion of primary health care including FP among females. As due to cultural and social constraints, at most of the places, the LHWs cannot communicate directly to the males of her community. Whereas; the Health Committees can play a crucial role in counseling and promotion of FP among males.

MoPW has introduced a cadre of male mobilizers in recent past at union council level (01 mobilizer for a UC) with the objective to promote FP among males. Program considered it as an opportunity to support LHWs in effective working of health Committees by involving male mobilizers.

The mobilizers will hold meetings with the health committee of LHWs every month. The dates of visit of mobilizer will be decided in the One- Day Continuous Education Meeting of LHWs.(Mobilizer will attend the session each month) There will be no direct contact of male mobilizers with the LHWs in the field however he will interact with one of the members of HC nominated as the focal person of health committee. The male mobilizer will conduct meetings with the males of the community to promote FP. These meetings will be planned in concurrence with the focal person of HC.

Initially the theme will be piloted in 20 districts of FALLAH in 2010-2011. After evaluation, the same may be replicated all over the country.

IV) Contracting Out Identification, training of LHWs in Hard to reach and disadvantage rural areas to third party.

One of the challenges which the programme will be addressing in this PC-1 is to reach out to the disadvantage/ hard to reach rural areas. Some of the constraints are the socio cultural barriers, low literacy etc. In 2005 earth quack UNICEF piloted community health worker project with the help of national and international NGO for locating and training the community workers in areas where LHWP had no coverage. The project was successful in number of districts. Programme will study the project, modify it as per the needs of the programme and pilot test it in selected areas.

IV) Piloting for Health Insurance of LHWs:

The Program is working on the proposal of providing health protection to the LHWs and her spouse and children mainly the hospitalization for common ailments including maternity care. In the initial stage the proposal will be piloted in two districts and may be expended after positive evaluation. According to rough estimate cost impact is around 50 million rupees for insurance of 4500 LHWs and their family members. Program is negotiating with different insurance funds to fine tune the proposal.

IV) LHWs/ LHSs Welfare Fund:

The LHWs, LHSs are not regular government servant/employees and they are not entitled for pension/gratuity etc. Therefore Program is considering

for a welfare scheme of LHW/ LHSs etc so that they could get benevolence after death and dire needs. At this stage Program is working on the proposal for chalking out the detailed modalities of identifying the deserving individuals and disbursing the support money to them. Nominal seed money can be allocated at this stage and the remaining financial support may be obtained from development partners to pilot this intervention.

V). **Devolution of the Programme.**

Pakistan is committed to achieve MDGs, however the current trends of health indicators are not in line to achieve these. The health sector therefore needs interventions to achieve these targets. LHW program is one such intervention and the successive evaluation of the program has shown its effectiveness in contributing towards achieving MDG targets.

The LHWs program for the last Sixteen years remained federally funded and provincially implemented. However due to new development and decision of the CDWP after revision of the NFC award and shelving of the concurrent list, there is decrease in the federal share and consequently in the PSDP funds. In the current scenario the CDWP has recommended to devolve the program to the provinces in phased manner through piloting the devolution in 20 districts initially in two years (2010-2012) and subsequently complete devolution in agreed timeframe.

In the light of CDWP decision Secretary Health has notified the Committee (Annex XXV) with following TORs

- Prepare road map and firm up recommendations along with modified PC-1 which will be submitted to the planning commission for preparation of summary for ECNEC for complete devolution of the Programme to provinces.
- The committee will also assess the ways and means for complete transfer of the programme to the provinces

The meeting of the committee was held on 6th July, 2010 at Conference Room of Block C, Pak Secretariat in which the following course of action for devolution of the programme was proposed. (Minutes of meeting at Annex XXVI)

1. **Discussion**

   After the presentation house was open for discussion. All the participants took part in the discussion; various issues regarding process of devolution were discussed in details. The discussion remained focused around the following key points

2. **Piloting of Devolution in Twenty Districts**

   Opening the discussion the representative of Punjab said that pilot phase will provide a breathing space to the provinces to prepare themselves for

complete devolution. However, there was lengthy discussion on the distribution of districts among the provinces and regions. Gilgit Baltistan wanted to do the pilot in all the districts while Khyber Pakhtunkhwa was not willing to take more than two districts. The representative wanted distribution of districts as per the LHWs seats allocation formula. It was pointed out by the NC National Programme that if the districts are distributed according to this formula then G&B and AJK would get only one district each. As programme wants to make the devolution a meaningful exercise therefore the districts of Punjab have been reduced from 10 to 8 to create space for G&B and AJK. The representative of Sindh volunteered to take one additional districts. The representative agreed on flowing distribution

S.#	Province/Region	# of district for piloting
1	Punjab	08
2	Sindh	04
3	Khyber Pakhtunkhwa	02
4	Baluchistan	02
5	AJK	02
6	Gilgit Baltistan	02

3. Devolution of the Programme

The level of devolution at district or provinces was discussed at length. The participants were of the view that keeping in view the current political situation and the capacities at the districts level, it would be better that in the pilot phase the program be devolved to the provinces. However, the representative said that, as this decision would require concurrence of the provincial governments therefore they will discuss it with their respective government and would furnish their comments accordingly at earliest.

4. District Selection for Pilot

The following criterion was discussed for selection of districts for piloting, all the participants with consensus agreed on the following broader guidelines for selection of pilot districts;

- ✓ Geographic Diversity
- ✓ Functioning of the district health system
- ✓ Number of LHWs in the district
- ✓ Performance of the districts
- ✓ Disadvantageous/advantageous districts

5. Financing of the devolution

The NC raised the issue of financing the gap between PC-1 cost and allocated fund for the year 2010-11. He further said that unit cost as per PC-1 (2010-15) is Rs. 75000/LHW /Year while as per the PSDP allocation for the

year 2010-11 the unit cost is Rs. 48,000 so there is a gap of Rs. 27,000 in funding.

The representative of Punjab explained that province is also facing the resources crunch therefore would not be able to fill this gap. The argument was supported by all other provincial representative. The Khyber Pakhtunkhwa representative added that as provincial health department has already finalized its development programme and provincial budgets approved, therefore, making it difficult to allocate any resources for the pilot at this juncture.

6. **Time Frame for devolution.**

The provinces agreed on the time frame of piloting as per decision of CDWP meeting i.e. from 2010 to 2012 provided that federal government is committed to provide the required funding.

7. **Procurement of Logistics in the pilot districts**

Following different modalities were discussed

1. Rate contract is done at the federal level and funds are transferred to the provinces to do procurement for the selected district.
2. Transfer funds to districts; provinces do the central rate contract at provincial level and allow the district to do the purchase themselves under the provincial procurement rules on their need basis.
3. Funds are transferred to the provinces to do the purchase for the pilot district.

With consensus all the participants opted for Option 3.

8. **Monitoring, Supervision, Performance and Financial Audit and Quality Control & Assessment**

The provinces agreed that the current mechanism of monitoring, supervision and auditing for performance and funds utilization as well as quality control will be maintained. In which the provincial and district health department as well as relevant PPIU will have responsibility and accountability.

The Federal Unit will play its role for monitoring and supervision and auditing for performance and fund utilization in devolved districts. Further at the end of 2nd year a rapid assessment will be carried out in pilot districts.

9. **Complete Transfer of Program to the Provinces**

The provinces were given the following options;

- Scaling up of District devolution pilot with provincial cost
- Component Wise funding of program by provinces

The provinces were of the view that as the details of the concurrent list, NFC award are still to be unfolded and the provinces have not been provided the funding promised in NFC award therefore it is a bit early to commit at this stage. Moreover, the provinces have their own fund priorities like the security situation in KPK and Baluchistan.

10. Decisions

i. Programme will be devolved to 20 districts on pilot basis within first 02 year of the project (2010-12).

ii. Distribution of 20 districts for piloting among the provinces/regions.

S.#	Province/Region	# of district for piloting
1	Punjab	08
2	Sindh	04
3	Khyber Pakhtunkhwa	02
4	Baluchistan	02
5	AJK	02
6	Gilgit Baltistan	02

iii. Provinces will send their recommendations/views on the level of devolution at early dates.

iv. Provinces will submit the fund flow mechanism after getting the concurrence of provincial competent authorities.

v. Current mechanism of monitoring, supervision and auditing for performance and funds utilization as well as quality control will be maintained.

vi. Decision on the complete transfer of programme to the provinces was deferred till next meeting.

IV) STRENGTHENING MANAGEMENT & ORGANIZATION.

In order to improve the functioning of the program at the Federal, Provincial and district level and as a source of motivation, an option of providing project Allowance to the program staff as per the government Notification No.F.4(9)R-3/2008-592/09 dated 18th August, 2009 would be introduced throughout the country. Some of the staff of the programme are working since the 1996 and they are drawing salary in excess of the maximum of the prescribed pay package of the relevant scale. To save them from recurring monitory loss, It is therefore proposed that these employees may be granted service benefit @ 5% increase per annum for the purpose of pay fixation only in order to save them from recurring monitory loss and they may also be allowed to avail hiring facility in addition to Pay Package as a special case. Furthermore, additional charge allowance to the Provincial, Regional and District coordinators will be also be introduced.

The allowance has a small effect on the over all budget but may have profound performance boosting effect.

#	Category	Allowances/Incentives
1	Working on Deputation	Project Allowance
2	Working on contract basis	Standard Pay Package
3	Employees of Department of Health and serving for Program.	Additional Charge Allowance

I. ASSUMPTIONS

The ability of the Programme to pursue the above-mentioned goals, objectives and activities rests on three major assumptions:

1. The Programme remains accountable to the Federal Ministry of Health;
2. The level of funds and the flow of funds remains consistent with the coverage and quality goals of the Programme
3. The Programme and LHWs/Supervisors receive optimum support from the Provincial and district health authorities and from functional local First Level Care Facilities (FLCFs) for training, supervision and supply of medicines etc.

ACCOUNTABLE TO THE FEDERAL MINISTRY OF HEALTH

The strategy assumes that the Programme is regarded as a public health sector investment in both the Government of Pakistan's Poverty Alleviation Plan and as key in the implementation of the National Health Policy (2001) and as such remains accountable for results to the Federal Ministry of Health.

It is assumed that the Programme remains the main health service available at the community level in poor rural areas of Pakistan and that is targeted to women and children.

THE LEVEL AND FLOW OF FUNDS

It is also assumed that the Programme management has the necessary level of funds and that these funds are available at predictable times in order to develop the Programme over the period.

SUPPORT FROM PROVINCIAL & DISTRICT DEPARTMENTS OF HEALTH & FLCFs

The National Programme is being implemented through coordinated and collaborative efforts of the federal and provincial governments, while the main implementation unit is the district health office. Therefore continued support from all these levels is imperative for implementation of the Programme activities. The FLCFs serve as the training units for the LHWs and also as referral centers for the LHWs. The LHWs are supposed to submit their monthly reports to the FLCFs and receive their 'continuing' education and refresher training as well. The support from a functional FLCF is critical for the performance of the LHWs.

The Third Evaluation recommended that 'if the requisite resources are not made available to fully fund the LHWP, the Programme should not continue to expand at the expense of providing appropriate supplies and support to the existing LHWs'. In other words the Programme should ensure adequate funding for effective service delivery amongst a smaller number of LHWs rather than lower funding for larger numbers of less effective LHWs.

II. RISKS AND OPPORTUNITIES

Risks	Opportunities
• Risks associated with a rapid decentralisation of Social Sector Financing and Management to Districts. Unclear whether districts will prioritise expenditure to LHW programme. Not all districts have the management experience to manage the development of the programme. Costlier service provision if the benefits of large-scale procurement are lost. • Risks associated with federal level financing, including continued financing gap, leading to low expenditure per LHW, which in turn lead to poor quality services and low / no health impact. • Risk to quality of service provision when the flow of funds are unpredictable e.g. failure to procure as per plan; failure to ensure motivation due to salary delay etc. • That factors which are critical to the success of the Programme are ignored. For example, recruitment criteria, the use of female health workers • Tension between expansion targets and the need to keep the Programme focused on the underserved and rural poor. • Dilution of LHW focus on health prevention and simple curative care	• There is scope to further increase service coverage to the underserved and poor • To consolidate the Programme as a national institution that is successful in providing a public service at the community level • LHWs and their Supervisors have a reasonable level of knowledge but there is the opportunity to provide substantially more on-going and refresher training • To substantially increase the performance of the twenty-five percent of LHWs who serve on average only seventeen percent of their eligible clients • To develop strategies for improving the performance of the Programme in particular locations/provinces • To conduct cost effectiveness analyses for any additional service to be provided by the LHW

III. ROLES AND RESPONSIBILITIES

Keeping in view the program activities to be implemented by the National Programme for FP & PHC, its coordination role with various stakeholders including donors and the Provincial /Regional PIUs, the roles and responsibilities for various functions have been developed. The area wise responsibilities are as follow:

A: PROGRAMME REVIEW COMMITTEE

A Programme Review Committee will be established to review the progress of the Programme periodically (at least once in a year) and to discuss and agree on modifications that may become necessary during the course of implementation. In this way the Committee will function as a **'Steering Committee'**. The members of the Committee will include:

• Secretary Health, Ministry of Health/Director General (Health)	Chairman
• Joint Secretary (F&D), Ministry of Health	Member
• National Coordinator for NP for FP&PHC	Secretary
• Provincial Health Secretaries/DGHS	Member
• Representative of Ministry of Population Welfare	Member
• Representative of Ministry of Finance	Member
• Representative of Ministry of P&D	Member

The Committee will be able to co-opt additional members as and when required. Furthermore the programme review committee will constitute a sub-committee on devaluation and it would guide the process for decentralization and delegation of the programme to provincial/district level. This process should be in alignment with the decentralization and devolution of administrative and financial authorities to the local level along with community oversight as per the NHP. After getting approval from the programme review committee programme would pilot the model in selected districts. for which support would be solicited from the partners.

B: INTERAGENCY COORDINATION COMMITTEE

The National Program has been able to achieve the success credited to it because of the support it has been receiving from the development partners. However the support from these partners would become even more crucial as the programme progresses further.

The main purpose for organizing the IACC is to help the Programme coordinate its activities with different development partners in order to optimize the use of existing resources, look for alternate sources and to ovoid duplication of activities. This forum should help the program in identifying problems, their solutions, different sources of resources and a channel for exchange of information and ideas in a formal and timely manner. The committee should be a forum. which helps the program in achieving the long-term objectives of the program.

The Committee would be chaired by the Federal Secretary Health and would meet annually. However the Program Management, with the approval of the Secretary Health, could convene it as and when needed. The committee would focus on issues relating to program activities, resources needed and coordination of support from different sources and it will include technical presentations and discussions as appropriate. The committee would help in coordinating the activities of the program besides channelizing the resources for the program

TORs for IACC

- To provide a platform for coordination between the NP for FP and PHC, the Development Partners /Agencies and Provincial Health Departments.
- The committee will act as a forum enabling exchange of information and dialogue between the program and the development partners.
- Provide an opportunity to the development partners to assess the progress of the program and look for the weaker areas where efforts can be made to further strengthen the program
- The Committee would provide a forum to the program to enable it to present its case to seek further funding from the donor agencies
- Enabling the program from benefiting from the technical assistance of the development partners by seeking appropriate policies, advices and tools
- Using the forum by the program for advocacy purposes
- Getting the help of the development partners through their partner NGOs in getting optimum mobilization of the communities.
- Providing the development partners to review the progress of the program and helping in Planning for the future
- Ensuring that the required data, information and material available with the development partners are also made available to the program.
- Research and Innovations.

Composition of the IACC:

The committee would comprise of representatives from the following organizations/Programs

- Ministry of Health
- National Managers of all vertical National Programs.
- Provincial Health Departments
- World Health Organization (WHO)
- Japanese International Cooperation Agency (JICA)
- Canadian International Development Agency (CIDA)
- World Bank (WB)
- United Nations Population Fund (UNFPA)
- United Nations Children Funds (UNICEF)
- Asian Development Bank (ADB)
- Department for International Development (DFID)
- European Commission (EC)
- United States Agency for International Development (USAID)
- Save the Children (SC/US)
- National Commission for Human Development (NCHD)
- Any other member may be opted with approval of Secretary (Health)

C: TECHNICAL COMMITTEE ON INTERVENTIONS

Following the government policy of fostering public – private partnership, the Programme will develop linkages and enter into partnerships with NGOs and CBOs in selected areas. These partnerships will be formed to mutually benefit from experience and resources of the NGOs, Research Institutions and the Programme to promote strategies for sharing all resources available at the grass roots level. Mechanisms will be developed to fund these collaborative projects. The government funds will be used to serve as seed

money for these initiatives. However to coordinate these activities a National level committee has been constituted to approve such collaborative projects No unit of the Programme will be authorized to initiate major collaborative projects on its own. The committee is chaired by the Director General Health as chairperson and National Coordinator as secretary. Its members include the provincial/ regional coordinators from with in the program and experts from child, maternal and public health from outside the program.

The technical committee on interventions will outline a streamlined process for reviewing interventions related to the LHW Program. A modus operandi for selecting and reviewing interventions will be agreed upon that will guide the process of vetting proposed interventions and including future innovations.

The Technical Committee on Interventions is being expanded with the requisite participation of national experts from academia and public health as well as representation from the International experts. In addition the committee would have the power to co-opt additional members as required. The committee will meet at annually to review the program contents and implementation progress and scrutinize any new intervention being proposed by any organization. The committee would classify the proposed programmatic interventions as: a) deserving nationwide implementation immediately; b) needing pilot testing; or c) excluded.

When classifying interventions, the TCI will apply the following criteria:

i) Quality of scientific evidence supporting the intervention with randomized trials being given the greatest weight.
ii) the size of the interventions impact on important outcome indicators
iii) the feasibility of LHWs implementing the interventions
iv) the cost of implementing the intervention
v) whether the intervention addresses diseases and problems of the poor people, particularly poor women and children; and
vi) whether the intervention fits with the objectives and scope of the LHW Program
vii) Addresses the priority areas like Family Planning, MCH and Nutrition.

No project shall be undertaken under following conditions:

a) if it does not fits within the mission and objectives of the Programme;
b) which contravenes any major government policies
c) which requires medical experimentation directly on the beneficiaries of the Programme;
d) which is culturally insensitive and my expose the programme staff to unreasonable risk;
e) where the down stream costs falls on the Programme to the extent that these are unsustainable for the Programme to replicate and continue;
f) which develops a parallel/vertical health system;
g) which results in promotion of any particular brand, product or organization and;
h) which might have a detrimental impact on the expected outcome of the

existing program or project.

i) The tasks involved would result in involving LHWs, Supervisors and other Programme staff in activities that are not according to the stated objectives of the Programme thus risking 'overburdening' them.

The final report on the projects after its conclusion shall be submitted to the Programme for review and comments by the TCI to review achievements and lessons learned.

All requests for the addition of tasks to the LHW's scope of work or additions to the program generally, coming from any agency, including the government's own departments, will be presented to the committee initially for its consideration. The committee would recommend its findings to the Program Steering Committee. The process will consist of the following:

1. Submission of a request should include the following information:

    a. a reasonably detailed description of the intervention and its safety;
    b. the scientific justification favoring the introduction of the intervention including the burden estimates of the problem, likelihood of impact based on available efficacy and effectiveness data (original articles should be submitted), cost estimates including recurrent costs, assessment of feasibility, as well as training and monitoring implications;
    c. the proposed methodology for evaluating the intervention including a schedule and a proposed location;
    d. the cost of testing the intervention; and
    e. the proposed source of financing for the pilot test.

2. For interventions without a particular sponsoring group or champion, but nonetheless appearing worthwhile, the National and Provincial Program Coordinator's may submit a proposal to the TCI;

3. The Deputy Program Coordinator on the Committee will prepare a working paper for the TCI, which will consider the merits of the proposals including the evaluation methodology. The TCI will aim to review proposals within 3 months of their submission and either approve, reject, or recommend changes;

4. New interventions will almost always need to be pilot tested with the collection and assessment of data that will allow for transparent and complete assessment of effectiveness, feasibility, burden to the LHWs and the program, and cost.

5. The pilot tests for interventions will be undertaken in representative districts i.e. both well functioning and intermediate districts so that an actual assessment of barriers can be made. These pilots must be done in partnership or liaison with established research groups of sufficient standing (usually academia or large credible NGOs) and must be undertaken with the requisite scientific rigor and depth.

6. The TCI may recommend that the pilot be financed using donor funds and may ask the LHW program to advertise and select organizations on a competitive basis to carry out the pilot;

7. The organization undertaking the pilot will report to the TCI on a regular basis, not less than once a year, on the progress of the pilot;

8. The results of the pilots (of a reasonable size) would be discussed in the Technical Committee on Interventions before a decision is made to include the intervention in the core contents of the program.

It is recognized that this process will be both thoughtful and infrequent, as too frequent alteration in the intervention mix of the LHW program will impact on its stability and efficiency.

TERMS OF REFERENCE

1. Further refine the criteria for selection of interventions for piloting; nationwide expansion and implementation and exclusion;

2 Review the present interventions being undertaken by the program, to decide on retaining all or excluding some of the interventions not meeting the selection criteria;

3 Classify the proposed programmatic interventions as:

- Scientific evidence of both efficacy and field effectiveness strong enough to start implementing the intervention nationally (there will normally be few of these).
- Scientific evidence is strong but field effectiveness needs to be piloted before implementation nationally.
- Scientific evidence not strong enough to warrant pilot testing the intervention.

4. Ensure that the proposed pilot tests will provide the LHW program with important and usable results through an in-built mechanism of evaluation.

5 Track the implementation of the pilot tests and give spontaneous recommendations and suggestions.

6 Review the results of the pilot tests to be disseminated to the Program Managers and the Review Committee

7 To emphasize and ensure the transparent and fair competitive bidding of interventions in those cases where an organization is not able to provide complete financing;

8 The Committee would ensure a mechanism for capacity building of the program's officials as part of piloting new interventions

9 The TCI would help in.developing a strong MOU, outlining certain areas. to be inked with organizations proposing any new interventions.

SECRETARIAT FOR TCI

The Secretariat for committee will be FPIU. The secretariat will be responsible for organizing the TCI meeting, preparation of working paper for the meetings, collection and distribution of relevant material to the members and preparing agenda and minutes of the meeting.

D: ROLES AND RESPONSIBLITIES OF PIUS:

Programme design, policy and funding occurs with the approval of the Ministry of Health and the Secretary of Health with service delivery being the responsibility of the Implementation Units through to the FLCFs and the LHW.

Table: Levels of Responsibility

Federal MoH	PHC Policy for NP-FPPHC, Service specification, Funding, Programme Monitoring and Evaluation
FPIU	PHC Policy Advice, National Reporting, Internal Supervision and Monitoring, Evaluation, Training, Programme. Procurement/Distribution. Operational Planning and budgeting. Financial Accounting, LHW-MIS System
PPIU	Internal Supervision and Monitoring, Programme Reporting, District LHW Allocation, Operational Plan Implementation, Accounting and Budgeting, Organization of Training, Distribution, LHW-MIS Data Collation and analysis
DPIU	LHW-District Allocation, Supervision, LHW & LHS Hiring /Firing, Training, Operational Plan Implementation, Distribution, Vehicle maintenance, Accounting Programme Reporting, LHW-MIS Data Collation, analysis and use of information in management.
FLCF	Training of LHWs, Collation of LHW-MIS Data, Organizing Kit replenishment, Providing meeting point for LHWs and LHS
LHW	PHC service provision to community, community organization

In its current structure, the Programme can be seen to be centrally funded and directed from the federal level, but with key operational decisions taken at the provincial and district levels. These operational decisions have a major impact both on the efficiency with which services are delivered and their impact on health outcomes.

For the smooth running and better implementation and supervision, it was decided to form Programme Implementation Units (PIUs) at federal, provincial and district levels. Roles of different units are following:

a: FEDERAL PROGRAMME IMPLEMENTATION UNIT:

The Federal PIU will be headed by the National Coordinator who would be a senior health professional with sufficient public health experience. In order to have a person being able to give his full attention and focus to the program activities, the National Coordinator would be selected on merit basis. Monthly salary of National Coordinator will be Rs. 150,000 with other entitlements equivalent to BPS-20. National Coordinator will be controller of supporting development partners like UNICEF, UNFPA and WHO etc. The Federal PIU will be provided adequate human, material and financial resources to perform its functions. Considering the amount of communication involved, National Programme Coordinator will be entitled to grade 20 limits for telephone expenditure.

The National Coordinator will be able to comprehend clearly the content and scope of the programme. He should have good knowledge of donor supported projects preferably of USAID, WHO, WB, KICA, UNICEF etc particularly of procurement procedures, contract documentation and preparation. He should

have strong and sustainable inter-personal and conflict management skills such as to develop good working relations with team members at all management echelons as well as other involved with the project.

The NC should have good knowledge and be familiar with the new and emerging trends in the field of public health management. He should have good report writing abilities and knowledge management skills based on evidence generated through project databases and can demonstrate strong skills of organization and management of project activities according to project work plan to produce the envisaged outputs.

The national coordinator should develop and maintain a database of project, local and international experts as well as database of project stakeholders and beneficiaries. He should be able to write funding proposals for operational research and should demonstrate creative and proven problem solving skills in financial management and administration with ability to adjusting project estimates according to resources constrained environment.

The national coordinator should have the capacity and experience to align monitoring and evaluation with implementation activities of the programme; and should have knowledge of outsourcing of monitoring and evaluation to third party. He should have the understanding of connecting the project activities and subsequent activities through networking techniques like Virtual Private Network (VPN) and Wide Area Network (WAN).

The Federal PIU will be provided adequate human, material and financial resources to perform its functions. Considering the amount of communication involved, National Programme Coordinator will be entitled to grade 20 limits for telephone expenditure.

The FPIU will perform the following functions:

1. Policy development in all aspects of the Programme in consultation with the Provincial & District PIUs under the established government procedures and the guidance of the ministry of Health, P&D and Finance.
2. National reporting on all Programme activities.
3. Monitoring and evaluation of the Programme activities throughout the country.
4. Development of Training material and Planning of training activities based on the policies of the Programme to ensure uniformity across the country.
5. Procurement and distribution of drugs, medicines and other supplies with active involvement of the Provincial governments and other related departments in the government i.e. the Ministry of Health and Finance
6. Resource mobilization from government sources and through partnerships with other donor agencies as per government approved procedures.
7. Distribution of funds to the PPIUs.
8. Operational Planning and budgeting, Financial Accounting and internal auditing.

9. Development and implementation of an effective MIS.
10. Development and implementation of campaign for mass awareness creation through mass media.
11. Inter-sectoral collaboration with other government and non government organizations

Since the FPIU will need to evolve a viable strategy for a sustainable Programme owned and fully managed by the provinces and districts there will be a need for extensive technical assistance on a continual basis. While technical assistance for specific issues may be provided by different donor agencies, the position of the National Programme Advisor will be maintained to support the FPIU in coordinating activities with the provinces and Planning and piloting strategies for the future. The National Programme Advisor will be a Public Health Specialist with extensive experience and will be hired on competitive salary with support from International agencies.

The FPIU office is presently located at a government hired building of which rent is being paid by the MoH. If at any stage situation arises FPIU is authorized to hire office building from its own resources.

b: PROVINCIAL PPROGRAMME IMPLEMENTATION UNIT:

A total of eight PPIUs will be established: 4 in the Provinces i.e Sindh, Punjab, Baluchistan, and KP and one each in the 4 'regions' i.e. Gilgit/Baltistan, FATA, ICT and AJK. The Director General Health Services will be the Chairman of the PPIU and will oversee the performance of the PPIU. The PPIU will be headed by the Provincial / Regional Coordinator who will be responsible for all operational matters and the day-to-day functions of the PPIU and the activities of the Programme in the respective Province/Region with a minimum of three years experience and post graduate qualification in Public Health. The Provincial/Regional Coordinator will be an officer of the respective Health Department, who would be selected on deputation on the criterion elaborated above. PC/ RC will be posted / transferred by concerned health department with consultation of National Coordinator. In order to facilitate timely and speedy implementation of the Programme, Provincial/ Regional Coordinators are proposed to be delegated financial powers at par with Category-I Officer of the Provincial/ Regional governments. The provincial/ regional coordinator with the approval of NC/ their respective Secretary Health/GDHS could seek financial support from Development partners for the joint collaborative activity which have already been agreed with the consensus of FPIU.

The functions of the PPIU will include:

1. Planning and implementation of all Programme activities at the provincial level under the guidance of the FPIU and department of Health
2. Preparation and implementation of Operational Plan
3. Monitoring of the Programme activities at the Provincial level
4. Preparation and submission of reports related to the Provincial programme
5. Allocation of LHWs, Supervisors, drivers, vehicles etc to the districts as per the proportional target population ratio.
6. Recruitment of FPOs allotted to the PPIU

7. Involved in selection of LHW Supervisors, Accounts Supervisors and drivers.
8. Accounting and Budgeting: Disbursement of salaries and allowances.
9. Planning and organization of Training
10. Warehousing, distribution and monitoring of supplies to the districts
11. MIS Data Collection and analysis

The Provincial Coordinator will be authorized to identify and acquire on rent suitable premises for establishment of the offices of PPIU and warehouses at the Provincial level in case appropriate accommodation is not available in government buildings. The ceiling for such Office buildings will depend upon the working strength for PPIUs (including a Conference Hall, Library, Data Base Centre, Parking space for vehicles, etc), however, it is estimated that monthly rent may be from Rs. 40,000 to Rs.100, 000/- per month for PPIUs or prevailing market rate subject to the fulfilling codal requirements. The rental assessment and physical verification should be done by the committee comprising as follow:-

- National Coordinator /Deputy National Coordinator –FPIU-Chairman.
- Provincial Coordinator
- Representative of Health Department B-18 or above.
- Finance Officer (FPIU)
- Finance Officer (P/RPIU)
- Logistic Officer PPIU & FPIU

The limit for rent of warehouse will depend upon the rental values in various cities and quantum of medicines, contraceptives, printed material, non-drug items and other commodities and in accordance with the standards being adopted for maintenance of warehouses/ stores. The rent assessment & physical verification for office and warehouses/ stores would be made by the said committee.

c: DISTRICT PROGRAMME IMPLEMENTATION UNIT:

The District Programme Implementation Unit (DPIU) is the most important field level functional unit. The DPIU will be chaired by the head of the district health office i.e. Executive District Officer Health or the District Health Officer. The day-to-day functions of the DPIU will be supervised by the District Coordinator. The District Coordinator will be an officer of the district health office and will be assigned the duties of the District Coordinator. Panel for the position of District Coordinators shall be nominated by the EDO/DHO to PPIU. PPIU will make the final selection. In order to facilitate timely and speedy implementation of the Programme, EDO-H/ DHO/DCNP are proposed to be delegated financial powers at par with Category-I Officer of the Provincial/ Regional governments. The functions of the DPIU will include:

1. Preparation and implementation of Annual Plan at the district level
2. Allocation and selection of LHWs at the FLCFs as per the proportional target population ratio,
3. Supervision of all activities.

4. Inter sectoral collaboration : The DPIU may co-opt additional members from the department of health or other related organizations on voluntary basis as a means of promoting inter sectoral collaboration
5. Hiring/Firing of LHWs, LHS, Supervisors (Logistics/ Accounts and MIS), drivers.
6. Training of district level trainers, supervisors,
7. Distribution & monitoring of drugs and other supplies to the FLCFs and LHWs,
8. Accounting/budgeting
9. Preparation and timely submission of Pay roll. FTA and Training claims to PPIUs.
10. Vehicle maintenance,
11. Programme Reporting,
12. MIS Data Collection, analysis and use of information in management.

The DPIU will consist of following members.

- DHO/EDO (H) Chairman
- District Coordinator Secretary
- Assistant District Coordinator Member

Support staff

District Office Assistants
Sanitary Worker

FINNACIAL MANAGEMENT

1.1 Budget:

Budget of the Programme will be prepared separately by FPIU, P/RPIUs, whereas DPIUs budgets will be included in P/RPIUs budgets. FPIU will consolidate all budgets. FPIU is responsible to verify that the budgetary proposals are in accordance with the provisions of the PC-1. Finance Officer of FPIU will prepare NISs (New Items Statements) i.e. budget statements for coming financial year(s) for each province/region, (mentioned in Table-A below) according to accounting circles and he will submit the NISs to Ministry of Health for signature of Section Officer (Development) and endorsement of Deputy Financial Advisor (Health).

S. No.	NISs of each office of the Program	Accounting Circles
1	FPIU, Islamabad.	AGPR, Islamabad.
2	PPIU-Punjab, Lahore (includes budgets of DPIUs).	AGPR, sub-office, Lahore.
3	PPIU-Sindh, Hyderabad (includes budgets of DPIUs).	AGPR, sub-office, Karachi.
4	PPIU-KP, Peshawar. (includes budgets of DPIUs)	AGPR, sub-office, Psh.
5	PPIU-Balochistan, Quetta (includes budgets of DPIUs)	AGPR, sub-office, Quetta.
6	PIU-FATA, Peshawar (includes budgets of DPIUs).	AGPR, sub-office, Psh.
7	PIU-FANA, Gilgit (includes budgets of DPIUs).	AGPR, sub-office, Gilgit.
8	PIU-ICT, Islamabad	AGPR, Islamabad.
9	PIU-AJK, Muzafarabad (includes budgets of DPIUs).	AGPR, Islamabad.

1.2 Releases and Fund Flow Mechanism.

The Development Section of the Ministry of Health will provide copies of New Items Statements (NISs) and budget book [Pink Book] to the FPIU and all P/RPIUs, AGPR Islamabad and concerned sub-offices of AGPR as detailed above. FPIU will monitor and co-ordinate to ensure that the budget documents have been timely received by P/RPIUs and AGPR sub offices.

The P/RPIUs will submit the budget demand as per approved cash plan or according to instructions of Ministry of Finance regarding release/ utilization of funds for a particular financial year. All P/RPIUs should submit release of funds requests in 1st week of each quarter. Finance Section of FPIU will submit release of funds requests of FPIU and of all P/RPIUs to Ministry of Health and FA's Organization. Timely release of funds to FPIU, P/RPIUs and DPIUs is primary responsibility of the FPIU.

There are two mechanisms for disbursement of Program funds, one lapsable Assignment Account (AA) and the other payments through District Accounts/Treasury Offices. Following lapsable AAs have been approved by Finance Division and authorized by the AGPR Islamabad: -

Sl.No.	FPIU/PPIUs	Assignment Accounts	Accounting Circles
1	FPIU, Islamabad.	National Bank of Pakistan, Main Branch Civic Centre, Islamabad.	AGPR, Islamabad.
2	PPIU-Punjab, Lahore.	National Bank of Pakistan, Main Branch, Lahore.	AGPR, sub-office, Lahore.
3	PPIU-Sindh, Hyderabad.	National Bank of Pakistan, Main Branch, Hyderabad.	AGPR, sub-office, Karachi.
4	PPIU-KP, Peshawar.	National Bank of Pakistan, Cantt/Main Branch, Peshawar.	AGPR, sub-office, Peshawar.
5	PPIU-Balochistan, Quetta.	National Bank of Pakistan, City Branch, Quetta.	AGPR, sub-office, Quetta.
6	RPIU-FATA, Peshawar.	National Bank of Pakistan. Cantt/Main Branch, Peshawar.	AGPR, sub-office. Peshawar
7	RPIU-FANA, Gilgit.	National Bank of Pakistan, Cantt/Main Branch, Gilgit.	AGPR, sub-office, Gilgit.
8	RPIU-ICT, Islamabad.	National Bank of Pakistan, Main Branch Civic Centre, Islamabad.	AGPR, Islamabad.
9	RPIU-AJK, Muzaffarabad	National Bank of Pakistan, Chatter Domail, Muzaffarabad.	AGPR, Islamabad.

1.3 Federal Assignment Account.

Federal Assignment Account has the approval of Finance Division. Finance Division places funds in the Federal AA through the funds ceiling sanction letter addressed to the AGPR, Islamabad. The AGPR, Islamabad then issues seal authority letter for allowing NBP Main Branch, Islamabad for admitting expenditure upto the amount mentioned in the sanction letter.In Federal AA all funds relating to employees' related expenses, procurements at federal level and other items will be placed/ credited. Two authorized signatories will operate the AA. All payments from the AA will be made by FPIU with the approval of competent authority. The AA cheques will be issued under the signature of two authorized signatories. The schedule of the cheques will be sent to NBP main branch Islamabad by FPIU, whereas cheques will be handed over to payees concerned. The payees will present the same in the NBP main branch for payment, through their respective banks. Finance and Accounts (F&A) Section of FPIU will carry out reconciliation of the receipts and expenditure pertaining to the AA on monthly basis. It is responsibility of the F&A Section that outstanding cheques are cleared for payments and no outstanding balance will remain in the AA.

It has been proposed by the provinces particularly by Health Department Punjab that funds should be released to them on annually basis instead of

quarterly basis. However it is recommended that keeping in view the strong recommendations of the provincial health departments ½ yearly funds may be released to PPIUs/DPIUs as a special case to avoid delay in disbursement of salaries/stipends to LHWs/LHSs and other program staff

1.4 Assignment Accounts of PPIUs/ RPIUs [except AJK]

P/RPIUs Assignment Accounts have the approval of Finance Division. Finance Division places funds in the P/RPIUs AAs through the funds ceiling sanction letter addressed to the AGPR Sub Offices. The AGPR sub offices then issue seal authority letters for allowing concerned NBPs Main Branch for admitting expenditure upto the amount mentioned in the sanction letters. The AAs of PPIUs will contain funds on account of employee related expenses, purchase of assets and for all PPIU/RPIU operational costs/expenses. Payments of stipends of LHWs, LHSs, and all Programs employees including employees working at DPIUs levels are made from Provincial AAs. Two authorized signatories will operate the AA. All payments from the AA will be made by PPIU with the approval of competent authority. The AA cheques will be issued under the signature of two authorized signatories. The schedule of the cheques will be sent to the concerned NBPs. Finance and Accounts (F&A) Section of PPIU will carry out reconciliation of the receipts and expenditure pertaining to the AA on monthly basis and a copy of the same will be sent to FPIU. It is responsibility of the F&A Section of P/RPIUs that outstanding cheques are cleared for payments and no outstanding balance will remain in the AA.

1.5 Release of funds and Payments – AJK

Ministry of Finance places funds in the RPIU AJK, Muzafarabad Assignment Accounts through the funds ceiling sanction letter addressed to the AGPR, Islamabad. The Drawing and Disbursing Officer of AJK Council on the basis of subject sanction letter issued by the Ministry of Finance will present bill in the AGPR, Islamabad and the AGPR, Islamabad will issue a cheque in favour of Accountant General, AJK Muzafarabad. Thereafter the AG, AJK will make disbursements of funds to DPIUs as per distribution Plan to be issued by the Programme Coordinator RPIU AJK, Muzafarabad. It is added that AJK Government has authorized lapseable AAs at districts level through all expenses including salaries/stipends to LHSs/LHWs, etc. are made.

1.6 Operational costs/expenses to DPIUs (except of AJK)/[payments from District Accounts Offices counter]

Finance Division has approved system for release of funds for the operational costs/expenses to DPIUs. The funds are placed with Districts Accounts Offices/Treasury Offices through the respective AGPR sub offices. The items of expenditure for operational cost/expenses for which budget/funds are released to DAOs/ TOs are: -

- POL
- Repair and Maintenance of Government vehicles.

- Stationery
- Postage and courier services
- Misc.
- Other items of expenses as per requirements.

When the Finance Division has approved/issued sanction for release of funds, the concerned AGPR sub offices will authorize release of funds in respect of DAO/TO concerned. The DPIUs will present bills/claims at the counter of DAO for making payments.

1.7 The Fund Flow Mechanism

The Fund Flow Mechanism is annexed. **(Annex-XIII)**

1.8 Reconciliation with DAO/TO and Banks

Reconciliation with AGPR Islamabad and AGPR sub offices will be made on monthly basis by the Finance Officers of FPIU & PPIUs/ RPIUs. The DDOs/District Coordinators and Accounts Supervisors will make reconciliation with the TOs on monthly basis as per instructions issued by FPIU (FPIU will make /issue amendments, if necessary). The Finance Officer of R/PPIUs on monthly basis will make reconciliation of "Assignment Accounts" and he will send a copy of the same to FPIU through PPIU.

1.9 Finance and Accounts Staff

Finance Officers, Audit Officers, Cashiers will be hired on deputation basis from AGP/CGA however, existing working officers/staff will continue to work if they have been appointed on contract basis with the approval of competent authority. In case AGP/CGA offices do not fill in the position within four (4) months of the submission of requisitions and repeated requests, the position will be filled in on contract basis in consultation/approval of the FPIU/Ministry of Health.

1.10 Internal Audit:

Internal audit of Program units i.e. FPIU, PPIUs and DPIUs will be carried out by the FPIU/ Ministry of Health on regular basis. Internal audit of FPIU and PPIU will be carried out annually whereas PPIUs will conduct internal audit of their districts in such a way that each district should be audited once in 02 years. However, P/RPIU should also conduct internal audit of DPIUs.

1.11 External Audit:

Audit Team of the Auditor General of Pakistan will conduct audit of accounts of the Program at FPIUs, P/RPIUs and DPIUs level. Audit Officer of FPIU will coordinate external audit task.

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Annexure– I

National Programme for Family Planning and Primary Health Care

Allocation Selection & Training of LHWs

National Programme For Family Planning and Primary Health Care

Status of Lady Health Workers

Year	**2009-10**	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	110000	120000	120,000	120,000	120,000	130,000

Annexure – II

Year wise cost estimate of /Financial Phasing (Jan 2010 to Jun 2015) (Rupees in million)

	Jan- June 2010	2010-11	2011-12	2012-2013	2013-2014	2014-15	Total
Employees Related Expenses (Salaries/stipends/pay and	2213.542	11079.380	11098.123	11117.804	11138.469	12042.117	**58689.435**
Printing & Publications	51	102.5	52.2	102.7	32.1	22.4	**362.900**
BCC/Advertising & Publicity	52.85	67.84	67.25	68	68	68.1	**392.040**
Purchase of drugs, medicines	757.163	1872.669	2021.319	2747.889	2922.620	1405.299	**11726.960**
In service trainings-LHW, LHSs,	9.290	248.047	247.370	251.414	250.734	262.058	**1268.913**
TA/DA, Transportation, POL/CNG	108.009	467.805	504.384	541.430	584.347	626.047	**2832.021**
Purchase of Physical Assets including vehicles	11.460	341.300	27.709	7.942	57.592	1.612	**447.615**
Repair and maintainar..e of Phsical Assets	22.914	95.641	103.673	92.510	93.813	95.304	**503.856**
Project Pre-investment Analysis	0	0	3	0	2	0	**5.000**
Consultancy and Contractual Work/Innovations	0	0	0	63	64	0	**127.000**
Others	43.170	134.301	127.836	161.807	170.964	107.085	**745.163**
Total	3269.397	**14409.484**	14252.865	**15154.496**	15384.639	14630.022	**77,100.904**

Annexure –III

PROGRAM IMPLEMENTATION UNITS WISE FINANCIAL PHASING JAN 2010 to FY 2014-15 (Rupees in million)

Activities	Federal	Punjab	Sindh	Khyber PukhtunKhwa	Balochistan	AJK	Gilgit & Bultistan	FATA	ICT	Total
Employees Related Expenses (Salaries/stipends/pay and allowances)	399.585	29,438.919	12,188.660	8,363.128	4,337.788	1,709.823	833.257	1,202.534	215.741	58,689.435
Management and Monitoring including FPOs. Project Allowances for deputationists working against the sanctioned posts of LHWP is also included. Honrarium is also part of this component	399.585	419.926	294.282	286.835	282.381	138.870	127.332	131.764	34.432	2,115.408
Other(Stipends of LHWs,LHSs & LHS's drivers)		28,807.990	11,815.658	8,037.674	3,996.809	1,557.255	700.542	1,059.029	179.200	53,739.858
LHWs Stipends	-	25,780.236	10,457.402	7,120.550	3,538.080	1,349.548	608.248	943.488	158.313	49,955.865
LHWs Supervison (Lady Health Supervisors + LHS's vehicels drivers)	-	1,891.771	781.822	557.565	280.140	122 128	56 973	81 564	12.031	3,783.993
LHWs stipends during intial three months trainings	-	135.984	55.160	37.559	18.662	7 118	3.225	4 977	0.696	263 381
Fixed Travelling Allowannce for LHSs(a)	-	127.039	43.266	15.335	47.098	9.105	3.214	8.571	1.555	255.183
Disrtrict Coordinator on market based	-	-	-	-	-	-	-	0.000	0.000	-
Training Allowance (20% of basic pay)	-	83.964	35.453	23.284	11.500	4.593	2.169	3.170	0.554	164.687
Sub Total	-	-	-	-	-	-	-	0 000	0.000	-
Procurements of drugs, contraceptives, printed material and Health Education Campaign/BCC	12,426.960	15.700	8.700	7.600	6.600	5.200	5.200	5.200	0.740	12,481.900
Printing & Publications	350.000	3.700	2.700	2.200	1.600	0.800	0 800	0.800	0.300	362.900
BCC/Advertising & Publicity	350.000	12.000	6.000	5.400	5.000	4 400	4.400	4.400	0.440	392.040
Purchase of drugs & medicines	9,728.174	-	-	-	-	-	-	0.000	0.000	9,728.174
Contraceptives	1,998.786	-	-	-	-	-	-	0 000	0.000	1,998.786
	-	-	-	-	-	-	-	0 000	0.000	-
Trainings, Travel & Transportation, PoL	138.973	1,673.736	759.215	625.486	444.561	189.540	115.470	135.597	18.358	4,100.934
Trainings (Inservice trainings of LHWs. LHSs and trainings at District. Provincial and National Level)	8 835	631 103	232 103	186 657	80.950	47 043	36 835	40 966	4 422	1,268.913
TA/DA	99.000	110.520	95 300	79.800	79.800	18 550	18.500	18.400	0.450	520.320
Transportation Charges(b)	5.500	239.440	110.467	118.626	157.631	65 950	25 590	37.684	3.832	764.721
POL/CNG Charges	25 637	692 673	321 344	240.402	126.180	57 998	34 545	38 547	9.654	1,546 981
	-	-	-	-	-	-	-	0.000	0.000	-
Employees Retirement Benefits/entertainments	14.225	6.275	3.155	3.155	3.055	2.405	2.405	1.885	0.470	37.030
Pension Contribution of depiutionst	13.000	5.100	2.080	2.080	2.080	1 580	1 580	1.060	0.250	28.810
Entertainments/gifts	1.225	1 175	1 075	1 075	0 975	0 825	0 825	0 825	0 220	8 220
	-	-	-	-	-	-	-	0.000	0.000	-

PROGRAM IMPLEMENTATION UNITS WISE FINANCIAL PHASING JAN 2010 to FY 2014-15 (Rupees in million)

Activities	Federal	Punjab	Sindh	Khyber PukhtunKhwa	Balochistan	AJK	Gilgit & Bultistan	FATA	ICT	Total
Physical Assets (Vehicles, Medical Store, Computers and other Equipments etc.)	**382.315**	**16.000**	**12.800**	**11.300**	**9.300**	**4.500**	**4.500**	**5.000**	**1.900**	**447.615**
Procurements of new vehicles and replacements of old vehicles	300.000	-	-	-	-	-	-	0.000	0.000	300.000
Computers/MIS equipments	1.650	3.000	3.000	2.500	2.500	1.500	1.500	1.500	0.500	17.650
Machines and Equipments for office	1.000	3.000	1.800	1.800	1.800	1.000	1.000	1.000	0.400	12.800
Medical Store Items	79.665	-	-	-	-	-	-	0.000	0.000	79.665
Warehouse items (pellets, racks etc)	-	10.000	8.000	7.000	5.000	2.000	2.000	2.500	1.000	37.500
	-	-	-	-	-	-	-	0.000	0.000	-
Repairs and Maintenance of Vehicles and other items	**15.025**	**226.778**	**103.195**	**77.415**	**37.539**	**18.119**	**10.619**	**12.311**	**2.854**	**503.856**
Repairs and Maintenance of Vehicles and other Physical Assets	15.025	226.778	103.195	77.415	37.539	18.119	10.619	12.311	2.854	503.856
Project Pre-investment Analysis	**5.000**	-	-	-	-	-	-	**0.000**	**0.000**	**5.000**
Research /Innovations	5.000	-	-	-	-	-	-	0.000	0.000	5.000
	-	-	-	-	-	-	-	0.000	0.000	-
Co..sultancy and Contractual Work/Innovations	**127.000**	-	-	-	-	-	-	**0.000**	**0.000**	**127.000**
Public Private Partnersip/Colloboration with NGOs	-	-	-	-	-	-	-	0.000	0.000	-
Evaluations of the Program (Third Party/Internal Evaluation)	7.000	-	-	-	-	-	-	0.000	0.000	7.000
Innovations (Accelarated education etc)	120.000	-	-	-	-	-	-	0.000	0.000	120.000
Sub Total	**13,509.083**	**31,377.408**	**13,075.725**	**9,088.083**	**4,838.843**	**1,929.587**	**971.451**	**1362.527**	**240.063**	**76,392.770**
Contingencies/other operational expenses (4% excluding Employees Related Expenses)	524.380	77.540	35.483	28.998	20.042	8.791	5.528	6.400	0.973	708.133
Grand Total	**14,033.463**	**31,454.948**	**13,111.208**	**9,117.081**	**4,858.885**	**1,938.378**	**976.979**	**1368.927**	**241.036**	**77,100.904**

Note (a) LHSs working without vehicle will be paid Fixed Travelling Allowance as mentioned in the PC-1, if at any point of time there is shortage of funds under this component, payment will be made from savings of other emplpyees related expenses

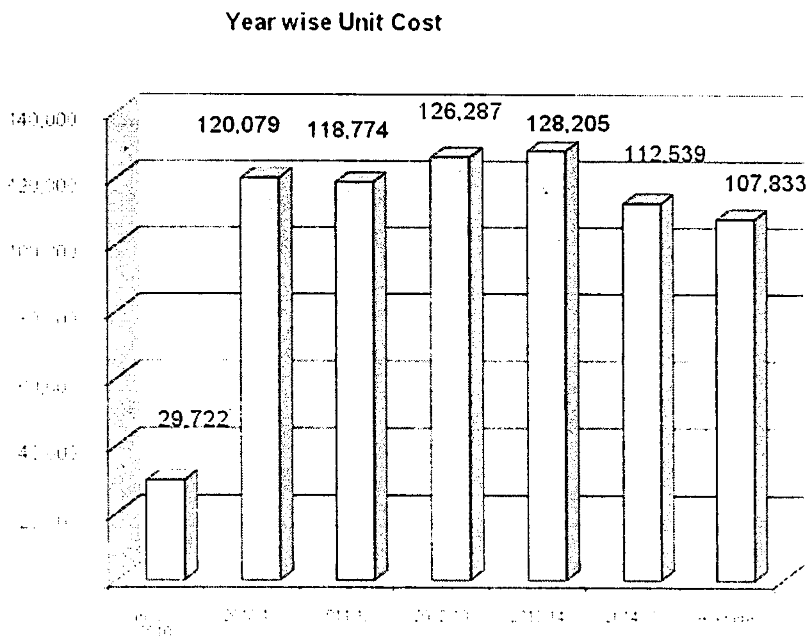
Annexure – IV

Planned Expenditure per LHW per Year
2010-2015

Activities	Total Cost	Unit Cost in Rupees
Employees Related Expenses	58689.435	82083
Printing and Publications	362.900	508
BCC/Advertising	392.040	548
Medicines & Contraceptives	11726.960	16401
In-service trainings of LHWs/LHSs	1268.913	1775
TA/DA, Transportation & POL	2832.021	3961
Purchase of Physical Assets	447.615	626
Repair and Maintenance of Physical Assets	503.856	705
Research	5.000	7
Innovations	127.000	178
Others	745.163	1042
Total	77100.904	107833

Annexure –V

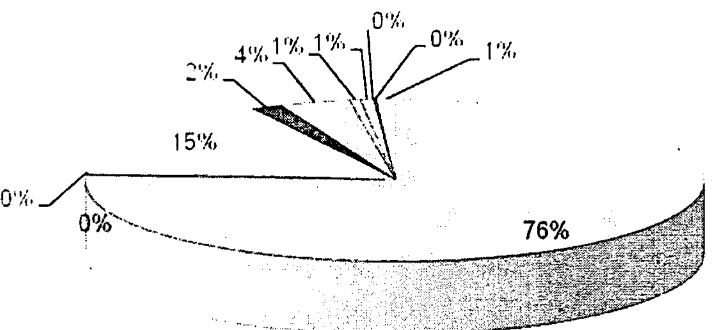
Year Wise Unit Cost
2010-15



Annexure – VI

Expenditure per LHW per Year (Pie Chart) 2010-2015

Distribution of Cost by Category of Estimated Expenditure



Annexure – VII

Recurrent Expenditure/ Cost

Activities	Total Cost	Recurrent Cost (Rupees in million)
Employees Related Expenses	**58689.435**	12042.117
Printing and Publications	**362.900**	0.000
BCC/Advertising	**392.040**	68.100
Medicines & Contraceptives	**11726.960**	2810.598
In serivce trainings of LHWs/LHSs	**1268.913**	262.058
TA/DA, Trasnportation & POL	**2832.021**	626.047
Purchase of Physical Assets	**447.615**	0.000
Repair and Maintainance of Physical Assets	**503.856**	95.304
Research	**5.000**	0.000
Innovations	**127.000**	0.000
Others	745.163	0.000
Total	**77100.904**	**15904.225**

Annexure –VIII

Schedule of Vehicles to be Procured/Replaced				
Category	**Fresh/Replacement**	**No**	**Rate**	**Total Cost**
Jeeps (4X4)	Replacement of old vehicle	200	1,500,000	300,000,000
Pick-up/double cabin upto 1000 CC	Replacement of old vehicle		550,000	-
Grant Total				**300,000,000**

Note: The prices are estimated and increase in the prices will be met out of contingencies cost provision

Position of Officers/Staff of the Program Implementation Units (FY Jan 2010-2015)

Positions/Designations	BPS	Federal	Punjab	Sindh	NWFP	Balochistan	AJK	G&B	FATA	ICT	Total
National Coordinator	20	1									1
Deputy National Coordinator	19	3									3
Deputy Provincial Coordinator	18	0	3	3	2	2	1	1	1	1	14
Finance Officer	18	1	1	1	1	1					5
Research Officer	18	1									1
Monitoring Officer	18	3									3
Section Officer	18	1									1
Law Officer	18	1									1
Procurement Officer	18	1									1
Health Education Officer	18	1	1	1	1	1					5
MIS Coordinator	18	1	1	1	1	1					5
Training Coordinator	18	1	1	1	1	1					5
Field Monitoring Coordinator	18	0	3	2	2	2					9
Logistic Officer	18	1	1	1	1	1					5
Audit Officer	18	1									1
Net Work Administrator	17	1									1
Media Officer/PRO	17	1									1
Audit Officer	17	0	1	1	1	1					4
Computer Programmer	17	1									1
HEO	17						1				1
MIS Coordinator	17						1	1	1		3
Field Monitoring Coordinator	17						1	1	1		3
Finance Officer	17	0	0	0	0	0	1	1	1		3
Budget & Payroll Officer	17	1									1
MIS & Payroll Officer	17	0	1	1	1	1	1	1	1		7
Field Program Officer	17	0	18	12	12	12	3	3	3	1	64
Logistic Officer	17						1	1	1		3
Assistant Accounts/Audit Officer	16	3	3	3	2	2	1	1	1	1	17
Assistat Logistic Officer	16		2	1	1					0	4
Superintendent	16	1	1	1	1	1	1	1	1	1	9
Data Analyst	16	2	2	2	2	1	1	1	1	1	13
Stenographer	15	1									1
Assistant	14	8	3	2	2	2	2	2	2	1	24
Store Keeper	14	1	1	1	1	1					5
Senior Auditor/Cashier	14	1	1	1	1	1	1	1	1	0	8
District Office Assistant	14		72	45	45	32	13	10	10	0	227
Assistant District Coordinator	14		36	24	24	29	10	8	10	1	142
Steno Typist/PA to Coordinator	12	4	2	2	2	2	2	2	1	1	18
Assistant Store Keeper	12		2	1	1	1	1	1	1	1	9
Data Entry Operatior	12	8	11	6	6	5	4	4	4	1	49
Receptionst	11	1	1	1	1	1	1	1	1		8
UDCs	9	3	1	1	1	1	1	1	1		10
LDCs	7	4	1	1	1	1	1	1	1	1	12
Drivers for F/PPIUs)	5	12	10	10	10	10	4	4	4	0	64
Drivers (for FPOs)	5	0	18	12	12	12	3	3	3	1	64
Drivers (DPIUs)	5	0	72	48	48	54	20	16	20	2	280
Naib Qasids (F/PPIU)	2	10	5	5	5	5	3	3	3	0	39
Naib Qasids (DPPIU)	2		36	23	23	30	8	7	10	1	138
Chowkidar PPIU/RPIU	2	6	6	6	6	6	6	6	6	3	51
Sanitory Worker DPIUs	2		36	23	23	30	8	7	10	1	138
Sanitory Worker PPIUs	2	6	4	4	4	4	2	2	2	0	28
Total		91	357	247	245	254	103	91	102	19	1509

Annexure –X

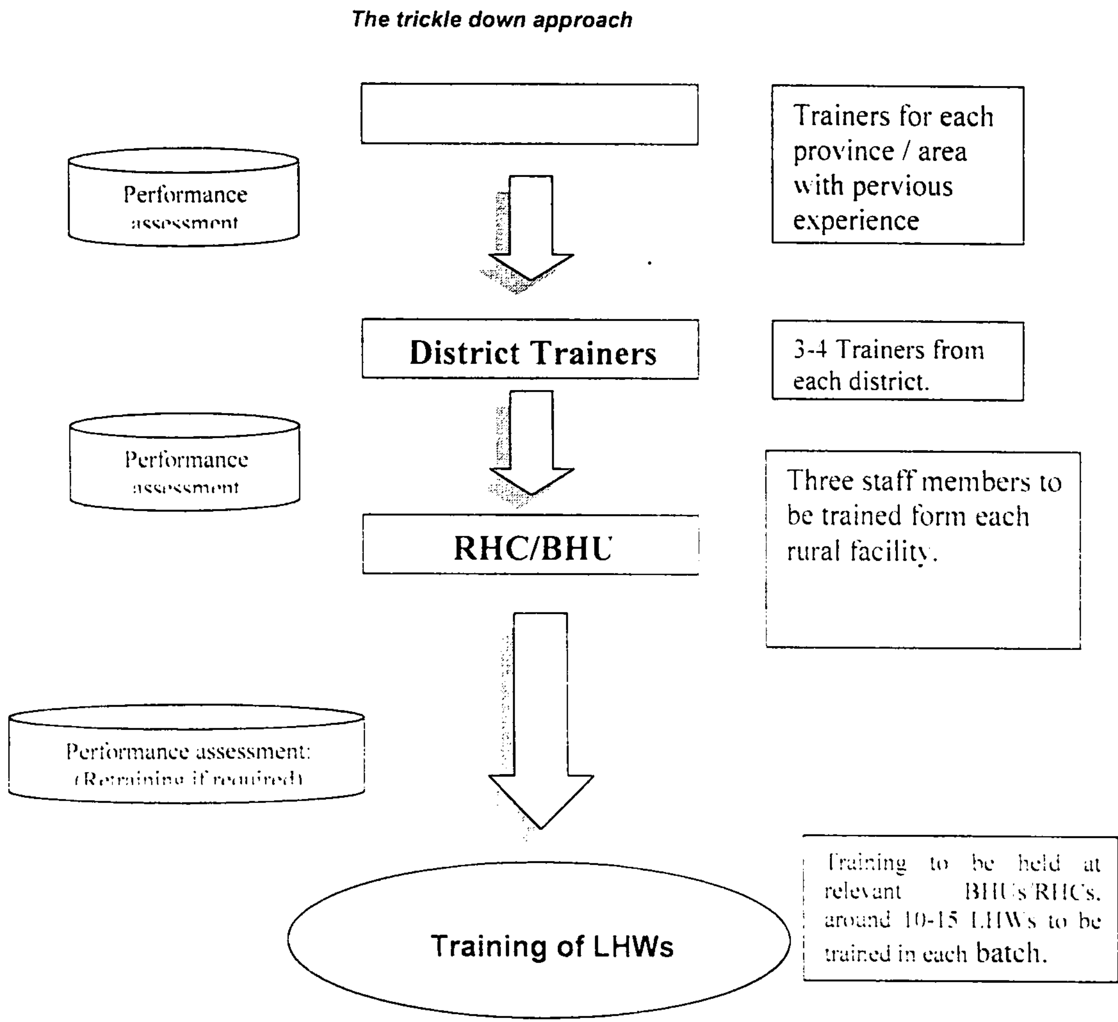
Requirement and Proposed Procurement of Contracpetives January 2010 to June, 2015

Fiscal Year	Per Unit	Accounting Unit		Jan -June 2010	2010-11	2011-12	2012-2013	2013-2014	2014-15	Total
Population covered by LHW		Per LHW		93060000	103500000	104400000	105300000	108000000	108000000	
% Eligible couples per population registered by LHW	0.16			14889600	16560000	16704000	16848000	17280000	17280000	
User of Contraceptives				5.211.360	6.127.200	6.514.560	7.076.160	7.776.000	8.294.400	
Quantities Required										
Condoms Required	144	No of Condom		60.220.160	70.803.200	82.807.296	96.122.752	121.305.600	64,696,320	497.955.328
OC Pills Required	13	No of Cycle		6.774.768	6.372.288	5.928.250	5.439.306	6.066.280	2.156.544	33.736.435
Injectable Required	5	No of injections		1.641.578	2.481.516	3.224.707	3.821.126	3.849.120	4.478.976	19.497.024
Cost Estimates										
Estimated Cost for Condoms	1.66	144 Condoms	Rs.	49.982.733	117.533.312	137.460.111	162.883.768	201.367.296	107.395.891	776.623.112
Estimated Cost for OC Pills	10.50	A Cycle of 28 tables	Rs.	62.803.283	66.909.024	62.246.621	57.612.709	63.686.440	11.321.856	334.578.932
Estimated Cost for Injections	54.00	Injection with syranges	Rs	44.322.617	134.001.864	174.134.189	206.340.826	207.852.480	120,932.352	887.584.327
Total Estimated Budget in Pak Rupes (Condoms, OC Pills and Injections)			Rs.	157.108.632	318,444,200	373,840,921	436,837,303	472,905,216	239,650,099	1,998,786,371
Foreign Exchange in US $ required for procurement of condoms		US $ (exchge rate 83)		602.202	1.416.064	1.656.146	1.962.455	2.426.112	1,293.926	9,356.905

Annexure – XI

Development of Human Resources for PHC

The trickle down approach



Annexure – XII

Basic Drugs /Medicines The following drugs/ medicines along with the monthly allocation (to be issued on replenishment basis), Chloroquine and Multi-micronutrient syrup would not be procured from 2010-11.

S. No	Items Name	Strength	Packing	Monthly allocation Jan 10- Jun 2012	Monthly allocation 2012-15
1	Paracetamol Tablet	500mg	Stripe/Blister	100 Tab	200 Tablets
2	Paracetamol Syrup	125mg/5ml	60 ml bottle	7 bottles	10 bottles
3	Chloroquine Tablets	150 mg	Stripe/Blister	50 Tablets	
4	Ferrous Fumerate+Folic Acid Tablets	(150mg+0.5mg)	Stripe/Blister	1000 Tablets	1000 Tablets
5	Chlorohexadine Gluconate 1.5 Solution Antiseptic Lotion (1.5%solution)- 50ml	(1.5% solution)	50ml Lotion bottle	1 bottle	1 bottle
6	Amoxil Suspension	250mg/5ml	60 ml bottle	7 bottle	10 bottles
7	Eye Ointment.	Tetracycline BP 500 units per gm)	4gm tube	7 Tubes	10 Tubes
9	Benzyl Benzoate lotion/emulsion	25%,25W/V	60 ml bottle	2 bottles	6 bottles
10	Sticking Plaster	1"X 5 meter per roll	Roll	1 roll every 2nd month	1 Roll
11	Mebindazole Tablets	500 mg	Stripe/blister	100 tablets every 6th month	100 tablets every 6M during MCW.
12	Non Sterile Registered Absorbent Cotton Wool	100 gm	Rolls	1 roll every 2nd month	1 Rolls
13	Cotton Bandages	2"X3 Meters per bandage	Pack of 12 bandages	1 pack every 2nd month	1 pack
14	Low Osmolality ORS (20.5gm)	20.5gm	Sachets	20 Sachets	20 Sachets
15	Zinc Syrup20 mg.	60 ml	bottle	8 bottle	10 bottle
16	Multi –Micronutrient Syrup	120 ML	120 Bottle	10 bottle	-

. B. CONTRACEPTIVES		
Condoms (1 piece)	100 condoms per months or replenishment as per number of clients	
Oral Pills Cycle/strip	10 cycles per month or replenishment as per number of clients	
Contraceptives Injection (Depo-Medroxyprogestrone acetate 150 mg/ml. 150 mg per ml. 1 ml per vial) along with 2 ml disposable syringe	3 injections along with disposable syringes per months or replenishment as per number of clients	
C. NON-DRUG ITEMS: **ONE TIME SUPPLY FOR EACH LHW**		
Pencil Torch with battery cells (Piece each)	1	Replaced after two years
Thermometer (Piece each)	2	Replaced ANNUALLY
Scissors (Piece each)	1	Replaced after two years
LHW Kit Bag (Piece each)	1	Replaced after 3 years
Baby Weighing Scale (piece /each)	1	-do-
Bathroom scale for antenatal/ childcare may be considered. (after piloting with partner support).	1	-do-
BP apparatus with Stethoscope (after piloting with partner support).	1	-do-

The specifications for each of the above items would be devised by the program management and finally approved by the Secretary Health. Amendments in the specification and quota in the drug and non-drug items may be made on the recommendation of TCI and approval of DG (Health) and Secretary Health

Annexure – XIII

Estimation of Printed Material for LHWs, LHS, Health Facilities and PIUs under National Programme for FP & PHC

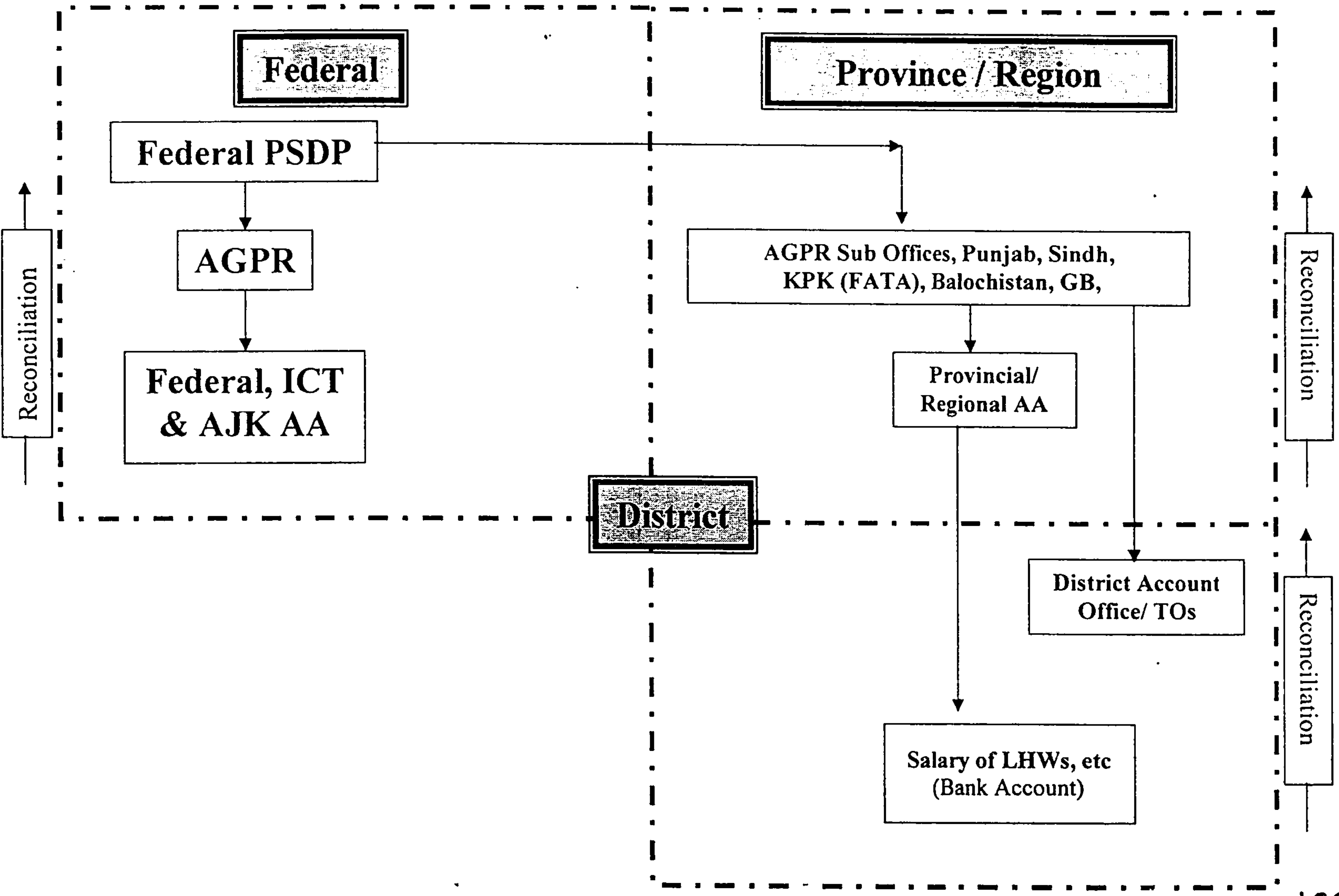
S.No.	Name of Item	Requirement
1	Trainer's Manual	One for each Trainer
2	LHW Manual for 03 month (Urdu)	One for each LHW
3	LHW Manual for 03 month (Sindhi)	One for each LHW
4	Register Khandan	One for each LHW for 2 years
5	Register Curative	One for each LHW for 2 years
6	Register Monthly Report for LHWs	One Register for each LHW for 2 years
7	Facility Monthly Report	One Register for each facility for 2 years
8	Community Chart (Urdu)	One for each LHW for 2 years
9	Community Chart (Sindhi)	One for each LHW for 2 years
10	Stock Register for Medicines	One for each health facility for 2 years
11	Growth Cards for LHWs	35 Cards per LHW per year
12	Referral Pad	2 Pads per LHW per year
13	Log book for vehicles.	One for each Vehicle for 2 years
14	Movement register for vehicles	One for each Vehicle for 2 years
15	Checklist and Feedback for Supervisor	4 sheets per LHW once in a year + 120 sheets per supervisor
16	Monthly Report for Supervisor	One Register for two months and each LHS need 6 registers yearly
17	Checklist for Training of LHWs	One for each LHS and one for each for PIU members
18	Eye Disease Chart (Urdu)	One for each LHW
19	Eye Disease Chart (Sindhi)	One for each LHW
20	Eye Card	One for each LHW
21	District Monthly Report	One for each DPIU for 2 years
22	Provincial Monthly Report	One for each PPIU for 2 years
23	LHW Manual for 12 month (Urdu)	One for each LHW
24	LHW Manual for 12 month (Sindhi)	One for each LHW
25	Supervisor Manual Trainer	One for each trainer
26	Supervisor Manual (Participant)	One for each trainer and Supervisor
27	Three type Poster (Urdu)	One set (3posters) for each LHW, one set for each training center and one for each PIU
28	Three type Poster (Sindhi)	One set (3 posters) for each LHW, one set for each training center and one for each

		PIU
29	Diary for LHW	One for each LHW for 2 years
30	Diary for Supervisor's	One for each LHS for 2 years
31	Bin Card	As per requirement for all levels of programme
32	Logistic Consumption register Drug	One Register for each facility for 2 years
33	Logistic Consumption register Non- drug	One Register for each facility for 2 years
34	Plastic Card for Child Health	4 cards per LHW per year
35	Jaiza Ke Kargardadi of LHW	2 per Supervisor pere year
36	Maternal Mortality Proforma	3 per LHW per year
37	CRC Card (Urdu)	10 cards per LHW per year
38	CRC Card (Sindhi)	10 cards per LHW per year
39	Training Manual Injectable for LHW (Urdu)	One for each LHW
40	Training Manual Injectable for LHW (Sindhi)	One for each LHW
41	Manual for TB Dots (Urdu)	As per requirement
42	Manual for TB Dots (Sindhi)	As per requirement
43	Trainer Manual of OBSI for LHS	As per requirement
44	Trainer Manual of OBSI for LHW (Urdu)	As per requirement
45	Trainer Manual of OBSI for LHW (Sindhi)	As per requirement
46	Counseling Cards (Set of nine) (Urdu)	As per requirement
47	Counseling Cards (Set of nine) (Sindhi)	As per requirement
48	Batchay Ki Sehat (Trainers Guide)	As per requirement
49	Batchay Ki Sehat (LHWs Manual)	As per requirement

Note: Training material may be added or subtracted on need basis. Training material for refresher trainings will also be printed.

Annex-XIV

Flow of Funds



Annexure XV

Behaviour Change Communication & Advocacy strategy:

The National Programme for FP & PHC aims to design interventions that will empower the communities to work for the improvement of their own health leading them to practice illness prevention and health promotive behaviors. The selection and implementation of an appropriate set of behavior change interventions can help to directly improve a wide range of health practices that influence the health status of the community.

Promoting positive behavior change however, is a complex process that requires a thorough understanding of what motivates people to adopt or resist new behaviors. Individuals are greatly influenced not only by their own knowledge and perceptions about issues but also by social pressures exerted onto them by their peers, culture, societal norms, laws and policies. Therefore, behavior change interventions often extend beyond conventional communication and links with capacity building, health systems improvement, product and service improvements, social norm change and even new or improved policies.

The process is used to assess current behaviors and underlying factors, propose key behaviors for change, and identify contributing factors, and work to develop effective, feasible change interventions. Interventions are designed such that they respond to the information, and supportive needs of targeted groups of individuals who move to different stages of continuum of change at any given time.

The approach

The following board objectives will be adopted by the Programme in developing the strategy:

1. Research and evidence based scaling up
Provide essential knowledge, skills, and scientific evidences and rationales for adopting healthy practice and be able to negotiate a less risky behavior within the context of traditional existence.

2. Designing and strategizing
Mobilize and involve individuals, families, communities, social groups, policy makers, health institutions, influencers and decision makers to create a supportive environment that will influence individuals to adopt the recommended positive behavior.

3. Testing innovations and collecting evidence for behavioral outreach
Enhance the health providers' behavioral capacity to respond to the increased demand for information, support and services.

4. Capacity building and strategic partnerships
Invite partnership to fit into the strategic framework and to have uniform interventions and outreach throughout the country.

5. Monitoring & Evaluation + Documentation & Dissemination
Incorporated BCC monitoring at all levels. Tools that will easily fir within the existing framework and help in tracking changes and quality of interventions is made

The Strategic framework

The framework comprises of five major communication components. These components are interrelated and interdependent on each other. Selecting any one or some of the five components when designing communication interventions for behavior change in isolation cannot bring about desired behavioral impact. Thus, in order to bring about sustained behavior change all five components have to be implemented together within the implementation design. Such a design not only determines the level of intervention but the type of communication and information suitable for particular level. The desired outputs will be specific to each level and yet inform and relate with each other. There are different levels of interventions being implemented with focus on different health aspect. There are limited projects that have designed interrelated and interwoven approach for any specific health behavior. This is could be because of the specific expertise and interest in the level of approach. NP will determine the holistic framework and seek partnerships based on areas of interest, expertise and outreach to meet the nationwide outreach for any specific health behavior. The BCC framework will encompass a full five components framework being:

1. Advocacy
2. Social mobilization
3. Institutional mobilization
4. Health promotion
5. Mass media partnership

Underlying principles

The underlying principles that form the foundation of any communication interventions are

- Appropriate design formation,
- Behavioural based message development,
- Adequate and acceptable utilization of IEC materials

The strategy

There are some underlying concepts and experiences of the overall National Program (NP) that will provide direction and guidance to the development of the strategy. The underlying concepts are

1. Existing BCC approaches by different agencies
2. Focused and targeted priority behaviors
3. Thematic approach
4. Interrelated and interdependent communication implementation approaches
5. Role of media and types of media
6. Capacity of the implementation units
7. Determining partnership strategies
8. Integrated M & E Plan

1. Existing BCC approaches by different agencies

The program intends to .build its strategic Plan based on the many BCC interventions that are in SDAce by different partner agencies. The strategy will look towards learning from their experiences to achieve increased effectiveness and extended outreach. Three strategic interventions are proposed to achieve this:

- Identifying BCC interventions that are proven effective and facilitating processes to expand their application and delivery within the country in a phased manner.
- Analyze interventions and programs that are not fully effective, to establish the factors inhibiting their effectiveness and act on those factors that are amenable to change, so as to increase effectiveness. In some situations, approaches and interventions whose effectiveness cannot be significantly improved through such analysis and modification may need to be discontinued.
- Develop new BCC interventions that may be necessary to address specific determinants of behavior that have not been adequately and/or appropriately addressed

2. Focused and targeted priority behaviors

The current package of services is a multi-focus package that encompasses several behaviors. The challenge that the program faces is to list out the prevailing and current risky behavior through social research and to then prioritize the behaviors. The program interventions will address those prioritized behaviors and their contributing factors to promote reSDAceable or modified, less-risky, culturally acceptable and scientifically proven positive behavior.

3. Thematic approach

Documented experiences from countries have shown that health workers skills and performance is compromised when they have too many messages to deliver within a short span of time and with added other tasks. Approximately 3 thematic areas will be addressed through each of the communications channels during one year, in order to gain a saturation effect at the behavior change/community level. For example, key behaviors for hygiene, immunization, and family Planning/birth spacing could be the guiding themes for the first year in the context of integrated family health.

4. Interrelated & interdependent communication implementation approaches

There are three integrated steps to formulating the communication interventions/design. They are

1. Pre-Planning phase, and
2. Planning phase
3. implementing phase

Pre Planning phase explores and outlines through stakeholder consensus the desired impact on the overall health indicators. The process assesses and identifies behaviours that impact those health outcomes. This exercise is done by comparing the NP's determined health indicators and the information collected from formative and other social researches conducted in concerned areas.

Planning phase interventions are designed to influence individuals to adopt/adapt to the recommended illness prevention and health promotive practices by either forgoing and reSDAcing the risky behaviours or modifying it to make it less risky This is done in a logistic sequence of answering the following four intervention framing questions:

- **Whose behaviour** needs to change to bring about the desired health outcomes? (Mother's; pharmacist's; hospital administrator's; neighbor's?) How are they impacted the health outcomes? How risky are they what are

creating the risk? Who is the practicing audience? Who is the influencing audience?

- **What behaviours we want to promote?** Is it feasible? Is it effective? What attitude and knowledge, information is required at each level of the BCC continuum?
- **Why are these healthy behaviours not being practiced now**? How best can they be influenced and supported to adopt/adapt the recommended behaviors? What barriers exist? Why are some people currently doing it and others not? What is making the difference?
- **When and what activities/interventions will address those factors** that are identified as most influential in changing the behavior?
- **What material** is required to support those activities? What products can be used to initiate trial?

At this point it is important to highlight the importance of appropriate utilization of Information, Education and Communication (IEC) material. IEC material are visual communication tools that convey and support verbally stated messages or at times used to carry messages independently for reach out to a larger audiences.

Implementation phase begins only after the tools of communication that are required at each level of intervention are in SDAce. The priority of the four integrated approaches is decided in consensus with the stakeholders prior to the implementation. The approaches are prioritized based on the internal and external environmental scan on sensitivity scale of the targeted message and its anticipated reaction. e.g., a program may decide to take off with advocacy efforts in order to set some policies and resources in SDAce before it can begin to intervene at lower levels. e.g. in issues like child marriages, sexual abuse etc.

At another time a program may decide to begin intervention with consultations and sensitizing with the religious leaders which could Play a neutralizing role and minimize the possibilities of undue reactions in matters like Sexually transmitted diseases, Family Planning, AIDs etc.

These priorities of intervention approaches can be same or different in different communities. This approach does not however negate the importance of achieving a phase of full-fledged multilevel interventions. On the contrary the process of prioritizing and phased process of intervention is an implementation mannerism to develop acceptance of the new message and prepare ground for a full fledged implementation phase of interrelated and interdependent interventions which is actually expected to bring about real and lasting behavior change and positive health impact at the community level

5. Role of media and types of media

Media is a channel that is used to reach out to mass audiences. This channel is most effective when it is used as a *"re-enforcer"* so that it will enhance the effect of the other interventions. In principle, the messages conveyed through masse media should be those that are common knowledge and easy to understand. They should be able to respond to the information needs, questions, and misconceptions for making better choices. These "re-enforcers" are effective when provided in continuous, sustained amounts with regular updates on the changing trends of the behaviours. Ongoing **monitoring and tracking** feeds into the need for modifying messages as required.

Issues facing media

There is focus and separate allocation for developing, designing, and implementing communication through the media. This is primarily meant to address the health education and communication needs for promoting healthy behaviors. The approach faces the following concerns:

1. The existing approach to message development and its utilization is "agency driven". There is no identification, nor clarity of the areas and aspects that need to be covered. There exists no transmission calendar on the complete health coverage. The other sectors as well as the NGOs have their own individual Plan inspite of over lapping messages. There is no sequencing so that there is a logic and sequential layout of the transmission.

2. There are some behavior change messages that are Planned and implemented by NGOs and other private sectors. The information provided in those messages are related to new approaches and are not necessarily similar to the NP's messages. The ground level communication interventions made by such private/NGOs are limited to some districts because their program outreach is designed to limited geographical catchments whereas the media campaigns run by such implementing agencies are usually nation wide. This is an issue because the people and the health care providers of non-intervention areas of the country have not heard of these approaches and lack the transcribing needs for those messages. The reaction to such one-way communication and un-scanned, tested and non- sensitized can be harmful.

3. One of the purposes of media campaign is to support and give credit to the messages and healthy recommendations provided by the health care providers at all levels. All change models highlight the need for individuals to have complete knowledge and clear perceptions, and feel the importance or advantage of specific behavior in order to adopt them. If the health care providers are to be the **change agents** then they require to be fully on board with the messages that are being communicated so that they can further influence and Play the change agents role. The nation wide transmission of new messages in areas where knowledge and information related to the behaviors is not reached to the health care providers, where people are not sensitized to the messages should not be encouraged unless supplemented with either verbal or print sampling etc. National campaigns of such types are based on is a social marketing theories but it is important to realize that social marketing is most feasible when promoting one item that provides **safe options**.

4. Only electronic media is mainly used with very little supportive communication like print e.g. pamphlets, information flyers etc. The electronic is limited to TVC spots and other channels are not fully explored. e.g. traditional theater, cinema, etc.

5. Media is mostly used and Planned on a "campaign approach". Media campaigns is seen and utilized as one time aggressive and intensive efforts to achieve results. Such an approach is appropriate when the desired output is to have an immediate increase of certain behavior. This behavior is based on the response factor where people are influenced to "DO" a certain thing within a limited time span so that certain results can be achieved. e.g. MNT, e.g. polio etc. But whether people will adopt the said behavior without an extensive campaign efforts and the advantages attached to it is not to be

said. The results derived from "Campaigns" are not long lasting because they are based on immediate gain theory, which motivates individuals to act or behave in a certain manner. We cannot be certain that the behavioral results of such campaigns can be sustained.

6. New materials are designed for repeating the older messages through nation wide campaigns every year. This is done because it is conceived that people get tired of seeing the same commercial. The argument I would like to provide here is that the design of this message should not be a commercial spot like selling soap, It is a health message and therefore it should be designed to create and generate value to the message and not perceived as an entertainment product. The approach of "entertainment education" encourages the use of entertainment channels for education but it does not transcribe into making education an entertainment.

7. Another aspect of just using TV commercials and limiting media message designing to fit the viewer-ship needs limits our approach to commercials and jingles that are expected to carry higher attract response and even higher forget response because one is competing with the high tech commercial advertising of products. Therefore the retention and usability of the communicated message being transmitted into practice seems very limited. In order to convince on the affectivity and usability of commercials, advertising agencies provide reports and the programs allocations and Planning is based on the # of people expected to view the commercials. (prime time allocation) This is an incomplete measure for any behavior change process. Another report provided by the agencies is the Plan of transmission. There is no report on whether the transmission actually reached out. It could be most possible that there was an electric cut-down at that time that prevented the viewer-ship. Such reporting is very accurate of measuring the performance of the advertising agency but unfortunately is not suitable for measuring a health education objectives leave side the health promotive objectives.

Recommended media strategizing approaches

1. Media Plan will be based on the health objectives that have to be achieved. The media agencies and their creative designers will be facilitated to enhance their knowledge about health and behavioral frameworks on which they will create the identified products. A complete capacity enhancement package on "Using media and designing media campaigns for behavior change" will be developed and agencies that are in partnership with the MOH will be trained and only certified agencies that meet the competency requirements will be involved in developing the campaigns. This package will be adopted for capacity enhancement of all partners, and stakeholders within and outside the program.

2. The areas and boundaries that is required to be addressed/focused for each component of health by individual sectors, projects will be well defined in order to minimize duplication and encourage effective and collaborative utilization of the resources. New researches and approaches in any selected areas will feed into and provided to the concerned sector responsible for campaigning that specific aspect.

3. Campaigns will be based on the behavior change approach that will meet the process requirements of individuals and communities to adopt to specific

behaviors. Therefore all independent health messages will be approved by the concerned programs for its promotional need, parameters of outreach, monitoring Plans, and its part within the full context of the media Plan. All supportive, partner agencies / NGOs will participate and collaborate in implementing the media Plan and will be discouraged to run individual campaigns. This is effective at all levels of campaigning from community to national level.

4. All campaigns will be based on formative research and will integrate a process of tracking based on tools that will be designed for establishing the need of the campaign, designing the campaign, implementing and monitoring of the campaign. Media agencies and other stakeholders will be part of this process.

5. A challenge faced by the program is to design campaigns that are evidence based and expected to bring lasting change. The challenges therefore is to use media for retention, recall and decision-making based on another experiences conveyed in order to minimize same hazards and risks faced/ suffered by the persons who experienced. Productions like true life experiences, dramatized, or fiction serials that is closely related to real life, program like a mothers day, The changing roles of human being from birth to old age, decisions made, bring couples and families and discuss their life styles and decisions they made through life "Reach Out" Discovering how people define Health and what they do to maintain their health talk- shows, competitive debates where schools and colleges are invited to participate on different health topics, help lines etc. Such programs will provide meaning and health value for the people through their involvement and help them in understanding health within the social context where people have the power to decide for themselves and make right choices that will determine their health status. Productions of this kind are expected to bring longer lasting impact by acting as influencing factors for positive behaviour change.

6. The target of such campaigns will be to reach out all levels of people through not only electronic media but traditional theater and folk media. All the productions will hold a similar design and the message will be packaged such that it becomes a branded recognition where it may not be new faces, new spots, new commercials with same "TO DO" messages but a common feature from the community known by all like *Chacha, Masi* etc.

7. One of the biggest disadvantage of using only one media and same type of productions is that one continues to reach out to the same audiences. The wide range of choice in entertainment media and the choices of people have to be kept in mind when devising the media campaigns. The use of only commercials, bill boards etc continues to reach out to the same audiences, the people who watch that show or the people who travel on that road thus not catering to those who do not fall in this category. The increase i

8. The viewer ship is not significantly by efforts of that communication intervention (commercial).

9. Health message would carry branded identification and be recalled and recognized as the Health message and not entertainers. The main objective of the media message will be to make the message so common that the knowledge conveyed is conceived by people of all ages as "common sense"

10. Media will be used to prevent loss of positive behavioral results achieved through past efforts and re-enforce new messages being introduced at various levels of interventions. This approach is essential in today's environment of commercial and social marketing. Regular, continuous modern and attractive media messages with role model projections, (advocates of health) will minimize the chances of people adapting harmful choices. An example of commercial items promoted through media as healthy products are energy drinks, gripe water, Ghutti preparations, weaning foods etc.

11. Electronic and print media has been used as one way communication tool in the past. This role of media will begin to change by designing interventions that are interactive.

12. Media campaigns in the past have emphasized on delivering health messages that advice people *on what to do* instead of providing people information for making better health choices. This is because media agencies are engaged to design messages in isolation from the whole context and thus lack the strategic direction. This concern will be addressed by encouraging media agencies involvement in more then just developing electronic messages but be partners in the whole behavior change context and have a more aggressive role to Play in designing and implementing of the BCC strategic approaches. NP will invest for enhancing the capacity of media agencies and in building partnership models for effective communication at all levels.

8. Capacity of the implementation units

There is limited existing capacity within the program to implement the BCC approach. There is fear of the unknown and rejection as this being a foreign promoted jargon. There is limited understanding of the approach and experiences of its components. This approach and intervention are presently being designed and implemented by foreign NGOs and they have been unable to involve the local partners into the approach. This has created an arena of distrust and lack of ownership of the approach among the health workers. National and international level courses will be incorporated within this aspect to address ownership and gain commitment for the approach.

9. Determining partnership strategies

Implementing BCC interventions requires broad based infrastructure, adequate resources, community and various level outreach and networking, and most of all multiple level specialized knowledge and skills to effectively deliver or carry out the interventions. In order to bring together all these abilities and skills, potential and existing partner agencies will be invited to either strengthen or reallocate their strategic direction to fit into the NP's BCC strategic Plan. Multi level and multiple partnership approach with clearly defined roles will be encouraged so that there is equal and fully concentrated distribution of any specific service throughout the country. (Possible partners include POP council, RSPN, SC-US, FPAP, SPO, AKHSP, IED, UNFPA and Unicef etc).

10. Integrated M & E Plan

The monitoring and evaluation of activities is usually Planned as a separate component. The strategy will encourage regular monitoring and reporting on the Planned activities Where the activities done as Planned? Did they achieve the immediate output that was Planned? The quality assurance tools will be incorporated within the system and the supervisors and monitors will share

responsibilities with the implementers of the activities. Regular feedback and monthly performance based on the work-Plan of individual districts will be evaluated biannually and be discussed at all levels in the monthly meetings. The strategy will incorporate midterm valuation and ongoing surveillances during the implementation phase in order to track the changing trends and feed into the program. There will be another supplement Plan for external evaluations.

11. Establishing a NP communication center (CC for documentation & research)

Keeping the wide variety of communication intervention needs, it is recommended that a full fledged center be established with the resource capacity for: social research, Documentation and dissemination, capacity building, MIS, and conducting trainings besides being a resource link for national and international partnerships. A team of following expertise will be employed: Social researcher, research associate, Media Officer/PRO (journalist), etc.

Annexure – XVI

NATIONAL PROGRAMME FOR FAMILY PLANNING AND PRIMARY HEALTH CARE

Name of post with BPS	Qualification & Experiences	Job description	Maximum age limit	Method of appointment
National coordinator (BS-20)	1. MBBS or Equivalent 2. Postgraduate Higher Diploma/Degree in Medical Administration or Health Services Administration or Public Health recognized by PMDC. 3. Persons having additional higher qualification will be preferred. 4. 17 years experience in public health administration/reproductive health/primary health including 7 years experience in Mega Project planning. implementation and monitoring in the health sector. 5. Preferably have a good working level familiarity	1. He will provide all necessary management and technical skills to the project as may be required by the project management unit for all program components. 2. He will supervise the PIU in the implementation and Monitoring of activities. 3. He will provide leadership in planning. technical. and Financial Management. disbursement. and auditing issues arising from implementation of the various project activities. 4. He may associate with other. for example management consultants. Trainers, contract management or others fields relating to management and supervision to provide the full range of services and interdisciplinary topics. 5. Ensuring effective communication and consultations with all stakeholders. 6. Monitoring and facilitating all program components within the implementation. legal financial and technical requirements of the project. 7. undertaking the monitoring and evaluation of performance indicators and outcomes against the targets. as agreed with the development partners and Ministry of Health 8. Prepare the periodic reports for Government and Donors as required. 9. She shall gather and record information about progress and results of subcomponents and other components.	55 years	Contract/ Deputation

	with computer based modern Project Management Techniques like Gantt Chart, Logic Network, Program Evaluation & Review Technique (PERT) and work breakdown structures. 6. Preferably have good knowledge of computer software packages like MS. Word. MS. Excel. MS Power Point etc. 7. Have good command of English language. Knowledge of regional languages will be an added advantage. 8. A candidate who has carried out consultancy service as technical expert in public health will be a plus point for the competing candidate.	10. She will prepare detailed reports to compare actual result with plan, highlight difficult problems in implementing subproject and suggest solutions. 11. A key activity of the national coordinator will be the transfer of knowledge so as to leave the FPIU of the project with a cadre of trained staff, having the necessary experience, and appropriate skills, to enable them to be capable of managing the later stage of the subproject and similar future projects. 12. This transfer of knowledge and skills will be both through working closely with FPIU staff as day to day tasks are carried out. formal training (e.g. small classes. workshops, etc.) and regularly reviews of duties of FPIU staff and their implementation. 13. Review, development and testing of new intervention of the Programme. 14. Supervise monthly meetings of federal project officers and quarterly meeting of provincial project coordinators. 15. Supervise and monitor the recruitment process. capacity building and training of staff. 16. Monthly update of Programme activities and publication of quarterly, biannual and annual reports. 17. Matters related to research activities including new research initiatives. 18. Perform other functions required for implementation of project objectives.	

Federal					
S. No.	Name of the Post	BPS & Qualification & Experience	Job Description	Maximum age-limit	Method of Appointment
1	Deputy National Coordinator (DNC) 03 positions **a) DNC for management support & logestic** **b) DNC for supervision, monitoring & training** **c) DNC for research & interventions**	BPS-19 (i) MBBS (ii) Postgraduate qualification in Public Health/Relevant field recognized by PMDC UGC/HEC. (iii) Five years experience in Public Health preferably in RH / Primary Health / Child Health. (iv) Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMDC/UGC/HEC	• planning, implementation and monitoring of programme activities. • Supervision and review of the ongoing activities. • Follow up of Provincial and District Monthly Reports. • Monthly update of Programme activities, Publication of Quarterly, Biannual and Annual report (through MIS Coordinator) • In charge of the Field Programme Officers and follow up on their reports. • Development and review of curriculum with Training coordinator. • Keep tract of all training activities at all levels with the help of Training Coordinator • Monthly submission of status report of LHWs/LHSs stipend. • Arrange Monthly Meetings of Officers of Federal PIU and Quarterly meetings of Provincial Coordinators. • Supervise and Monitor the Recruitment process, training and deployment of LHWs and other staff. • Coordination with stake holders at National, provincial and district level, line ministries and development partners. • Review, development and testing of new intervention in the programme • Administrative, Finance and Logistic management. • Procurement of Drugs/non-drug items/contraceptives and other logistic supplies and related matters including forecasting, and distribution and storage) in collaboration with relevant officers/departments. • Procurement and repair of vehicles in collaboration with relevant officers/departments. • Correspondence and reply of queries by President/Prime Minister Secretariat's/Parliament. • Printing of stationary items, printing material and related matters in collaboration with relevant officers/departments • Ensure timely disbursement of stipends to LHWs, LHSs, etc. • Preparation of programme Budget in collaboration with FO/FA • Administrative issues related to MOH and FPIU, etc. • Preparation of the Annual plan of Action of National Programme for FP&PHC • Actively participate in the Health Education Component of LHW Programme and media Campaign. • Collaborative activities with the all other National Programme.	50 Years	Contract/ Deputation

			• Matters related to Research Unit, including new research initiatives. • Collaborative activities with National and International development partners and NGOs. • In charge of all matters related to the reproductive Health Project. • To be involved in Third Party Evaluation and Validation of NP for FP &PHC. • Any other duty assigned.		
2.	Finance Officer	BPS-18 (i) Second Class or Grade 'C' Master's Degree or equivalent qualification in Commerce / Business Administration (Finance/Accounts) ICMA. CA foundation recognized by UGC/HEC (ii) 05 years experience in the field of Finance and / or Accounts in Government / Semi Government / reputable private organization	• Supervise the Preparation of budget, release of funds, • Reconciliation with FTO, AGPR, pre-audit of salary bills, TA bills, and media, medicine/non-drug items, printing etc. • Preparation of statement of expenditure of Federal PIU and consolidate report of expenditure of programme. • Ensure timely disbursement of stipends/ salary to LHWs, LHSs drivers, and other staff. • Monitor all financial activities of donor agencies/NGOs projects running under NP. Any other duty assigned.	50Years	Deputation
3.	Research Officer	BPS-18 (i) MBBS and/or (ii) Second Class or Grade 'C' Master's Degree in Epidemiology/Demography/Bio-Statistics/Population studies/ Public Health or equivalent/Recognized by UGC/HEC./PMDC (ii) 05 years experience in the field of Primary Health Care and / or RH/Child Health (iii) Proficiency in Computer Desirable.	• To coordinate research activities for the National Programme for Family planning and Primary Health Care in collaboration with different partners and stake holders. Focusing mainly on interventions related to improvement of maternal and child health, hygiene and sanitation by means of Operations Research and Desk research • Proposal development for Technical committee for interventions to be adopted /introduced by the National Programme for Family planning and Primary Health Care • Analysis/ scrutiny of proposals submitted by different partners. • To develop Research proposals on the new/old interventions adopted by the NP for FP & PHC. • To work in close liaison with BCC consultant and adviser and to be Involved in developing and implementation of Behavior change communication strategy for National Programme for Family planning and Primary Health Care. • Supervision and review of the ongoing PHC/LHW activities in the areas covered by National Programme for FP&PHC. • To be involved in various training for district master trainers of National Programme for Family planning and Primary Health Care. • To be involved in Curriculum development of LHW/LHS • Member of National Committee on Maternal Health and national Committee in Child Health • Any other duty assigned.	45 Years	Contract/ Deputation
4	Federal Monitoring Officer	BPS-18 (i) MBBS. (ii) Postgraduate qualification in Public Health/public health related field recognized by PMDC/ UGC/HEC (iii) 05 years experience of supervision and monitoring in field of Primary Health Care and / or Reproductive health	(i) Collection and analysis (qualitative and quantitative) of Provincial monthly reports and then feedback. (ii) Biannual consolidation of national reports. (iii) Strengthening of provincial / district capacity to review/ analysis of LHW MIS. (iv) To provide immediate feed back to the provinces and districts. (v) To spend at least 10-15 days in field to monitor programme activities (vi) To supervise, monitor the field work and guide Field Program Officers (vii) To attend the Review meetings of FPOs, District Coordinators, collaborating partners	45 Years	Contract/ Deputation

		(iv) Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMDC/ UGC/HEC.	and other Program meetings. (viii) Any other duty assigned		
5.	Health Education Officer	BPS-18 1)MBBS/ master in health education or sociology 2) 03 years experience in public health related project or organization 3) work experience with mass media will be preferred.	❖ Design ongoing health education strategies based on the changing trends ❖ Develop and analyze Health Education Material for the NP, in accordance with the program policy. ❖ Provide supervision and needed guidance to the health team members. and lady health workers and staff in FPIU in their health education work. ❖ Develop guidelines for designing health education material ❖ Distribute health education materials and monitor its utility ❖ Design Capacity building of health education training programmes ❖ Participate as technical member on the Health Education media committee i.e. radio television, press etc. ❖ Prepare quarterly reports on Health Education Activities for all relevant quarters through the National Coordinator. ❖ Conduct small size KAP and impact studies on Health Education programme. ❖ Any other duty assigned.	45 Years	Contract/ Deputation
6.	MIS Coordinator	BPS-18 • Second Class or grade 'C' Master's degree in Business Administration / Computer Science / Statistics recognized by UGC/HEC. • 06 months diploma / certificate in Computer Software / Hardware. Relaxable for those holding Master's degree in computer science. • Five years experience in MIS preferably in Health sector in Government / Semi government / reputable private organization	• To supervise and ensure timely Collection and analysis (qualitative and quantitative) of Provincial monthly reports and then feedback. • To work in close liaison with the Monitoring and Supervision officer • To help in strengthening of provincial / district capacity to review/ analysis of LHW MIS. • To upgrade database and to maintain the upgraded database • To spend at least 7 days in field to monitor program activities • Any other duty assigned	40 Year	Contract
7.	Training Coordinator	BPS-18 (i) MBBS (ii) Postgraduate qualification in Public Health or public health related fields recognized by PMDC /UGC/HEC (iii) 05 years experience of conducting training in the field of Primary Health Care and / or Family planning (iv) Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMDC UGC/HEC	• Develop training material and planning of training activities based on polices of the programme to ensure uniformity across the country. • To collect and review the suggestions from Provincial/District Trainers/managers for any changes in the manual. • To review the training material for the trainers/LHWs and supervisors working under NP for FP &PHC with assistance of provincial training coordinators within stipulated time • To incorporate changes in the curriculum in view of the advances and changes where applicable in the PHC and/or assignments of the LHWs • To solicit and review inputs from experts in relevant subjects for review of the manual. • To suggest any changes in the above mentioned manuals and forward to the National Coordinator for approval.	45 Years	Contract/ Deputation

			• To prepare a draft manual in light of the suggested changes. • To organize a workshop of the selected manager/trainer/expert for the review of manual and to prepare final draft of manual in light of recommendations of workshop. • Prepare annual training plans at the National/provincial/regional levels in consultation with the Federal/Provincial and regional PIUs. • Conduct and assist training of Master Trainers of National Programme at Federal and Provincial level and assist in trainings at the district level. • Ensure that all-necessary training materials, teaching aids and other supplies are available before commencement of trainings at Provincial and District level. • Ensure beforehand that trained trainers provincial and district levels are available for training and the trainers possess necessary knowledge and skills to provide training. • Monitor trainings at different level to asses the quality of training, identify deficiencies and suggest/advice remedial measures to improve the training. • Lead and provide guidance and collaborate with the Provincial Training Coordinator in reviewing, preparing, upgrading the curriculum of different cadres of health workers in the National Programme. • Provide guidance and collaborate with NGOs and international agencies in developing any training or IEC material for different cadres of health workers and suggest any deficiency/changes if necessary to further improve the training modules. • Maintain liaison with various donors and agencies including, WHO, UNICEF, UNFPA, USAID, and WFP for capacity building of national program staff working at all levels.		
8.	BCC Coordinator	BPS-18 (i) Masters in Behavior Sciences/Communication/Journalism recognized by UGC/HEC. Experience of Public Health Programme, preferred, in particular in child survival, maternal health and community based program. (ii) 05- 7 years of relevant experience and extensive field experience with bcc program. (iii) Experience relax able by two years for those holding higher diploma in the requisite specialty recognized by UGC/HEC	(iv) To identify effective mechanisms and action plan for the implementation of the BCC strategy and campaign of NP for FP &PHC with the involvement of all key partners and stakeholders. (v) Undertake small scale studies on KAP to identify gaps and actions for incorporation n the BCC strategy. (vi) Assist in the capacity building of FPIU and PPIU staff and district level staff in Health education, community mobilization and interpersonal communication. (vii) Provide expertise in the development and application of useful theories and models for communication Planning framework and processes. (viii) Provide technical assistance for the development of comprehensive communication Plan, based on formative research, through participatory process with the concerned stakeholders. (ix) Provide TA for adapting existing tools and media programs/materials or in the design of new communication tools, programs and material for application in the IPC, group-communities and mass media channels. (x) Participate as a team member in the expansion and development of the in house communication tools and materials, especially in the process of their adoption/adaptation for enhancing the impact of the program. (xi) Contribute to the program strengthening technical and institutional capabilities at all levels. (xii) Provide inputs in the strategic Planning process with special focus on the BCC	40 years	Contract

			component. (xiii) Contribute to the staff development and capacity building activities focusing on behavior change communication.		
9.	Logistic Officer	BPS-18 (i) Second Class or Grade 'C' Master's Degree in Public Administration / Business Administration recognized by UGC/HEC (ii) 05 years experience of logistic work in a Government / Semi Government / reputable Private Organization	(iii) Developing / preparation of bidding documents (National & International). (iv) Procurement of drugs/non-drug items and medical equipments. contraceptive, vehicles, printed / training material and other office equipments in accordance with the procedures of Government of Pakistan or development partners. (v) Pre and post delivery inspections at the premises of firms. (vi) Warehousing and Inventory Central Management. (vii) Transportation / distribution of Logistic from the point of production to the point of consumption. (viii) Organize and Facilitate Logistic Management Trainings for district staff across the country. (ix) Keep liaison with the multi-sectoral donor assisted integrated development projects, particularly in the health and population sectors. (x) Monitoring and evaluation of Logistic System upto districts and facility level (xi) Any other duty assigned.	45 Years	Contract
10.	Procurement Officer	BPS-18 I MPA/MBA with 03 year experience of procurement, preferably with National and International bidding procedures.	I. Will report to DNC(MS) II. Preparation, review and revise the bidding document in consultation with DNS (MS). III Floating Tender and development of proposal of tender opening meeting. IV. Organization of meeting. Preparation of minutes and keeping record of all the meetings of procurement committees and sub-committees. V. Organization technical and financial evaluation of bids VI. Organizing physical verification of all potential pharmaceutical companies. VII. Coordinate with CDL for quality assurance VIII. Coordinate with PPIUs for clearance of all commodities and timely submission of bills IX. Responsible for timely clearance of all bills by PPIU	45 years	Contract
11.	Law Officer	BPS-18 I.MA.LLB II.Should hold a valid practice license III.Should have enrolment of high court IV.Minimum three years experience of higher/lower courts V.Preference would be given to computer literate	Responsible for the litigation at all levels on behalf of the program Would be responsible for vetting of program documents/MOUs/Contracts/innovations etc from the law division. Would be responsible for looking after any legal requirements during any other task assigned to him.	35 years	Contract
12	Logistic Officer	BPS-17 I Masters in Public Administration or Business administration II. Four years experience in logistics management and warehousing III. Computer literacy is essential	• 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 • Responsible for maintenance of all the relevant record and reporting for the logistic management.	45 years	Contract
13.	Net Work	BPS-17	❖ Responsible for creating and managing Local Area Networks.	40 years	

	Administrator	(i). Second class Master Degree in Computer Sciences recognized by the UGC.HEC. (ii) At least Three year experiences in the field of Networking. maintenance of Local Area Network & troubleshooting. (iii) Preference will be given having certification in MCSE / CCNA , ISA Server and Exchange Server	❖ Install, configure, and maintain servers, workstations Computers. printers and different networking devices. ❖ Plan and implement user rights. network security, backup, and disaster recovery ❖ Investigate user complains and provide best possible solutions ❖ Prepare Repair and Maintenance logs along with spare part consumptions ❖ Source hardware and prepare comparative statements. ❖ Maintain Email Server & Proxy Server for internet ❖ Create email accounts assign quota and maintain database and backup on regular basis. ❖ Knowledge of website designing and hosting		Contract
14	Audit Officer	BPS-18 (i) Second Class or grade 'C' Master's Degree in Commerce / Business Administration (Finance / Accounts) or ICMA / CA (Inter) recognized by HEC/UGC. (ii) Two years experience in the field of Accounting / Auditing / Public Finance in Government / Semi Government / reputable Private Organization. **OR** (i) Second class or grade 'C Bachelor Degree recognized by HEC/UGC (ii) Having qualified SAS. (iii) 05 years experience or Accounting / Auditing in Government sector preferably in foreign Audit projects.	(i) Internal Audit of FPIU. PPIUs and DPIUs and preparation of reply of previous Audit reports if any. (ii) Any other duty assigned	45 Years	Deputation
15	Media Officer/Public Relation Officer	BPS-17 (i) Second Class or grade 'C Master's Degree in Journalism / Mass communication / Media Production/ Sociology/ Journalism recognized by HEC/UGC. (ii) Should be able to design and produce general health awareness Material etc (iii) Two years experience in Journalism / Media production preferably in producing programmes on Radio / Television.	• Publicize and coverage of events relating to NP • Dissemination of ongoing information • Media campaign/ News letters in collaboration with HEA and Deputy Coordinator (Planning). • Work in close Liaison with Ad agencies to improve/clarify program position/image on Health issues. • Participate and arrange media coverage of the program at different events • Make arrangement to publish articles/features in different news papers and magazines given to her through different department/units of the program. • To liaison with all implementing officers for information gathering and events programming • Arrange to publish the regular Monthly / annual progress report provided to him/her by the management • Scrutiny and payment of bills pertaining to electronic/press media • Disseminate ongoing progress and activities of the program • Design and develop dissemination materials Advertisements/Supplements on special occasions.	40 Years	Contract

			• Ensure telecast and transmission Dramas. Radio regarding the NP • Any other duty assigned.		
16.	Data Base Administrator	BPS-17 (i). Second class Master Degree in Computer Sciences recognized by the UGC.HEC. (ii) At least Three year experiences in main ting the Databases & Programming in Visual Basic/.net using SQL, PL/ SQL and SQL Server. (iii) Preference will be given having certification in MCDBA / ORACLE (DBA Track).	• Database Administrator will be responsible for creating new databases ,implementation and administration and its procedures to support the HR database environment, including: a) Procedures for performance monitoring and tuning. b) Disk space management. c) Data Achieving, data Backup and data recovery. d) Database disaster recovery. • In depth SQL Server Database Administration. • Database Synchronization, bridging together the structure including all objects of database. • Implements data models, database designs, data access and table maintenance codes. • Resolves database performance issues, database capacity issues, replication, and other distributed data issues. • Coordinate LHW-MIS Database Designing and implementation testability elements - Perform other day to day operational tasks as required by the management. • Evaluates, selects and implements software to aid in database support tasks. • Assists analysts in resolving database related problems • Coordinate and/or provide support to systems for various departments. • Identify business systems problems and evaluate, design and develop solutions. • Development new database using programming languages	40 years	Contract
17	Computer Programmer	BPS-17 (i) Second Class or grade 'C' Master's degree in computer science Recognized by UGC.HEC. OR (i) Second class or grade 'C' Bachelor's degree in Software Engineering / System Engineering / Computer Engineering recognized by /UGC/HEC (ii) Two years experience in the field of programming / networking.	(iii) Development/maintenance of software, maintenance and reSDAces of website double shouting need analysis of MIS issues. ARDT (iv) Any other duty assigned	40 Years	Contract
18.	Budget & Payroll Officer	BPS-17 MBA/MBA(IT)/MIT/MCS/DPGD.	He will be responsible for payroll. Responsible of preparation of budget releases support in preparation of cash Plan/work Plan and preparation of reports and compilation of SOE etc at FPIU.	35 years	Contract
19.	Assistant Account Officer	BPS-16 (a) (i) Second Class or Grade 'C' Bachelor's Degree in Commerce / Business Administration with Accounting, recognized by UGC/HEC	• Preparation of Budget. • release of funds • reconciliation with FTO, AGPR • Pre-audit of salary bills, TA bills medicine, printing etc. • Preparation of statement of expenditure of Federal PIU and consolidated report of	35 Years	Deputation

		(ii) 02 years experience in Accounting / Auditing / Finance / Budget OR i ICMA (Foundation) / CA (Inter). ii. One year experience in Accounting / Auditing / Finance / Budget **(b)** Proficiency in computer. desirable. **(c)** The employee of the program preferable of finance & accounts wing will be considered for appointment to these posts if they have more then four year experience of finance & accounts in the program.	expenditure of programme. Appropriation account. maintenance of release register and expenditure register. • Maintenance of record paid vouchers. • Internal audit and replies of audit paras • Any other duty assigned		
20.	Assistant Logistic Officer	BPS-16 Minimum Bachelors education in Public Administration or Business Administration./ B.Com 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 LHW program.	Assist the Procurement /Logistic Officer in: • Developing / preparation of bidding documents (National & International). • 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	35 years	Contract
21	Data Analyst	BPS-16 (i) Second Class or grade 'C' Bachelor degree in Computer Science recognized by UGC/HEC. (ii) Two years experience in Data Processing / Analysis (iii) If a program employee having experience 5 years in MIS he will be given additional marks	Verification of data analysis generation of proper and feedback reports final verification data clinic	35 Years	Contract
22.	Superintendent	BPS-16 (i) Second Class or grade 'C' Bachelor's degree recognized by UGC/HEC. (ii) 03 years experience in Administration including Establishment / Accounts / Budget matters.	To supervise all matters relating to the Administration in RHP at Federal and its offices at provincial level.	45 Years	Deputation

S. No.	Name of the Post	BPS & Qualification & Experience	Job Description	Maximum age-limit	Method of Appointment
			Provincial		
1.	Deputy Coordinator	BPS- 18 (i) MBBS (ii) Postgraduate qualification in Public Health recognized by PMDC/HEC/UGC. (iii) Five years experience in Public Health preferably in Reproductive Health / Primary Health / Child Health. (iv) Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMD/HEC/UGC	• To be responsible for the activities carried out by the PC in his absence. • Supervision and review of the ongoing PHC/LHW activities in the areas covered by National Programme for FP&PHC • Follow up of Provincial and District Monthly Reports on LHW activities in the areas covered by National Programme for FP&PHC. • Monthly update of programme activities in the areas covered by National Programme for FP&PHC. • In charge of the Field Programme Officers and evaluation of their reports. • To attend meeting in Provincial PIU. • To be involved in the design/Planning of any research activity in the province. • To carry out supervisory and monitoring activities. • To strengthen the capacity of staff in carrying out monitoring activities • Establishment and Capacity Building / Strengthening of District Monitoring Units. • To prepare short-term monitoring Plan. implementation and analysis of findings with assistance of DCs and Field Programme Officers. • Planning, implementation and monitoring of programme activities. • To be involved in the Administrative. Finance and Logistic management of the PPIU. • To spend at least 5 days • in field to supervise program activities. • Any other duty assigned	45 Years	Contract/ Deputation
2	Field Monitoring Coordinator (50% field duty)	BPS-18 • MBBS • Postgraduate qualification in Public Health recognized by PMDC/HEC/UGC. • Thee years experience in Public Health preferably in RH / Primary Health / Child Health. • Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMDC/HEC/UGC	• Member of provincial monitoring unit under DPC (SMT) and responsible for field supervision of FPOs in the region under his supervision. • Prepare monthly update for discussion in Provincial Monitoring Unit (PMU) meeting. of programme and partners activities in the districts under his supervision. • Ensure that all the reports of districts under his supervision are submitted in time to PPIU. • Carry out analysis of FPO reports and give feed back to FPOs and prepare consolidated report. • Prepare district performance report on quarterly basis for submission to DPC (SMT) for on ward submission to FPIU. • Ensure the validity and reliability of data generated through LHW MIS including LMIS. • Ensure monitoring/supervision of maximum programme trainings at all levels. • Innovative approach to further strengthen the LHW-MIS instruments and reporting mechanism. • Establishment and Capacity Building / Strengthening of District Monitoring Units • To prepare short-term monitoring plan. implementation and analysis of findings with assistance of District Monitoring Unit members. Field Programme Officers Identify gaps in the monitoring and supervisory system and suggest for its	45 years	Contract/Deputatio n

			improvement.		
4.	Training Coordinator (BPS 18 in PPIUs. BPS 17 in RPIUs)	BPS-17 & 18 • MBBS • Postgraduate qualification in Public Health recognized by PMDC. (i) 05 years experience of conducting training in the field of Primary Health Care and / or RH/Child Health. (ii) Experience relaxable by two years for those holding higher diploma in the requisite specialty recognized by PMDC/HEC/UGC	• Prepare annual training Plans for the all the province/districts in consultation with the FPIU. • Conduct and assist training of Master Trainers of National Programme at Provincial level and assist in trainings at the district level. • Ensure that all-necessary training materials, teaching aids and other supplies are available before commencement of trainings at Provincial and District level. • Ensure beforehand that trained trainers provincial and district levels are available for training and the trainers possess necessary knowledge and skills to provide training. • Monitor trainings at different level to asses the quality of training, identify deficiencies and suggest/advice remedial measures to improve the training. • Provide guidance and collaborate with the Provincial Training Coordinator in reviewing, preparing, upgrading the curriculum of different cadres of health workers in the National Programme. • Provide guidance and collaborate with NGOs and international agencies in developing any training or IEC material for different cadres of health workers and suggest any deficiency/changes if necessary to further improve the training modules. • Any other duty assigned.	45 Years	Contract/ Deputation
5.	MIS Coordinator (BPS 18 in PPIUs. BPS 17 in RPIUs)	BPS-17& 18 • Second Class or grade 'C' Master's degree in Business Administration / Computer Science / Statistics / recognized by UGC/HEC. • Five years experience in MIS preferably in Health sector in Government / Semi government / reputable private organization.	• To supervise and ensure timely Collection and analysis (qualitative and quantitative) of District monthly reports and then feedback. • To work in close liaison with the Monitoring and Supervision officer. • To help in strengthening of provincial / district capacity to review/ analysis of LHW MIS. • To upgrade database and to maintain the upgraded database. • To spend at least 7 days in field to monitor program activities. • Any other duty assigned	45 Years	Contract
6.	Finance Officer (BPS 18 in PPIUs. BPS 17 in RPIUs)	BPS-17& 18 (i) Second Class or Grade 'C' Master's Degree or equivalent qualification in Commerce / Business Administration (Finance/Accounts). ICMA. CA foundation recognized by UGC/HEC. (ii) 05 years experience in the field of Finance and / or Accounts in Government / Semi Government / reputable private organization	• Preparation of budget. release of funds • Reconciliation with FTO AGPR. pre-audit of salary bills. TA bills, and media medicine/non-drug items. printing etc. • Preparation of statement of expenditure of PPIU and consolidate report of expenditure of programme. • Ensure timely disbursement of stipends/ salary to LHWs. LHSs. drivers, and other staff. • Monitor all financial activities of donor agencies/NGOs projects running under NP. • Any other duty assigned	45 Years	Deputation
7.	Logistic Officer (BPS 18 in PPIUs. BPS 17 in RPIUs)	BPS-17& 18 i. Second Class or Grade 'C' Master's Degree in Public Administration / Business Administration recognized by	• Developing / preparation of bidding documents (Provincial) • Procurement of drugs/non drug items and medical equipments, contraceptive vehicles. printed / training material and other office equipments in accordance with the Government procedures. • Pre and post delivery inspections at the premises of firms.	45 Years	Contract

		PMDC/UGC/HEC. ii. 05 years experience of logistic work in a Government / Semi Government / reputable Private Organization.	• Warehousing and Inventory Central Management. • Transportation / distribution of Logistic from the point of production to the point of consumption. • Organize and Facilitate Logistic Management Trainings for district staff across the country. • Keep liaison with the multi sectoral donor assisted integrated development projects, particularly in the health and population sectors. • Monitoring and evaluation of Logistic System up to districts and facility level. • Any other duty assigned.		
8.	Field Programme Officer	BPS-17 1. MBBS/ MA Sociology/MA Social Sciences, with two year experience in Public Health; Candidate with MS/Diploma in Public Health will be preferred.	• To assist and participate in the implementation, supervision and monitoring of the Program's interventions and promote health services through fieldwork, community involvement for health development, in a sustainable basis. • To assist in the training activities for different categories of health personnel at provincial, district and sub-district staff and Lady Health Workers. • To undertake extensive field visits to FLCFs and the areas under the National Programme ensuring necessary leadership and coordination to: o Support and supervise the Training Programme. o Monitor the process of selection of LHWs and use of resources. o Ensure proper reporting of the activities of the program. o Monitor supplies and logistics. • To liaise between district, provincial and federal PIUs for the effective coordination of the activities of the programme under the supervision and technical guidance of National and Provincial Coordinator. • To promote the required district and sub-district inter-sectoral collaboration in support of the Programme ensuring the necessary leadership and coordination skills.	35 Years	Contract/
9.	Audit Officer	BPS-17 (iii) Second Class or grade 'C' Master's Degree in Commerce / Business Administration (Finance / Accounts) or ICMA / CA (Inter) recognized by HEC/UGC. (iv) Two years experience in the field of Accounting / Auditing / Public Finance in Government / Semi Government / reputable Private Organization. **OR** (iv) Second class or grade 'C' Bachelor Degree recognized by HEC/UGC. (v) Having qualified SAS. (vi) 05 years experience or Accounting / Auditing in Government sector preferably in foreign Audit projects.	i. Internal Audit of PPIUs and DPIUs ii. preparation of reply of previous Audit reports if any. (iii) Any other duty assigned	45 Years	Deputation

10	MIS & Payroll Officer	BPS-17 MBA/MBA(IT)/MIT/MCS/DPGD.	• He will be responsible for HR Module updating and maintenance of Pay roll module in LHWs MIS software and payroll generation through LHWs MIS software. Responsible of preparation of budget, releases reports and compilation of SOE etc.	35 years	Contract
11.	Superintendent	BPS-16 i. Second Class or grade 'C' Bachelor's degree recognized by UGC/HEC ii. 03 years experience in Administration including Establishment / Accounts / Budget matters	• To supervise all matters relating to the Administration at provincial level and its offices at district level. • Any other duty assigned	40 Years	Contract/ Deputation
12	Data Analyst	BPS-16 • Second Class or grade 'C' Bachelor degree in Computer Science recognized by UGC/HEC. • Two years experience in Data Processing / Analysis	• Verification of data analysis generation of proper and feedback reports final verification data clinic. • Any other duty assigned	35 Years	Contract/ Deputation
13.	Assistant Accounts Officer.	BPS-16 **(a)** i.(i) Second Class or Grade 'C' Bachelor's Degree in Commerce / Business Administration with Accounting recognized by UGC/HEC. (ii) 02 years experiehce in Accounting / Auditing / Finance / Budget. **OR** iii. ICMA (Foundation) / CA (Inter). iv. One year experience in Accounting / Auditing / Finance / Budget. **(b)** Proficiency in computer, desirable. **(c)** The employee of the program preferable of finance & accounts wing will be considered for appointment to these posts if they have more then four year experience of finance & accounts in the program.	• Preparation of Budget. • Preparation of cases for release of funds. • Reconciliation with TO. AGPR. and bank. • Pre-audit of all bills/claims etc. • Preparation of statement of expenditure of PPIU and support in reconciliation of DPIUs and consolidated report of expenditure of programme. • Appropriation account, maintenance of release register and expenditure register. Maintenance of record paid vouchers. • And any other duties to be assigned by Finance Officer or Provincial Coordinator.	35 Years	Contract/ Deputation

Annex-XVII

Result Based Monitoring (RBM)

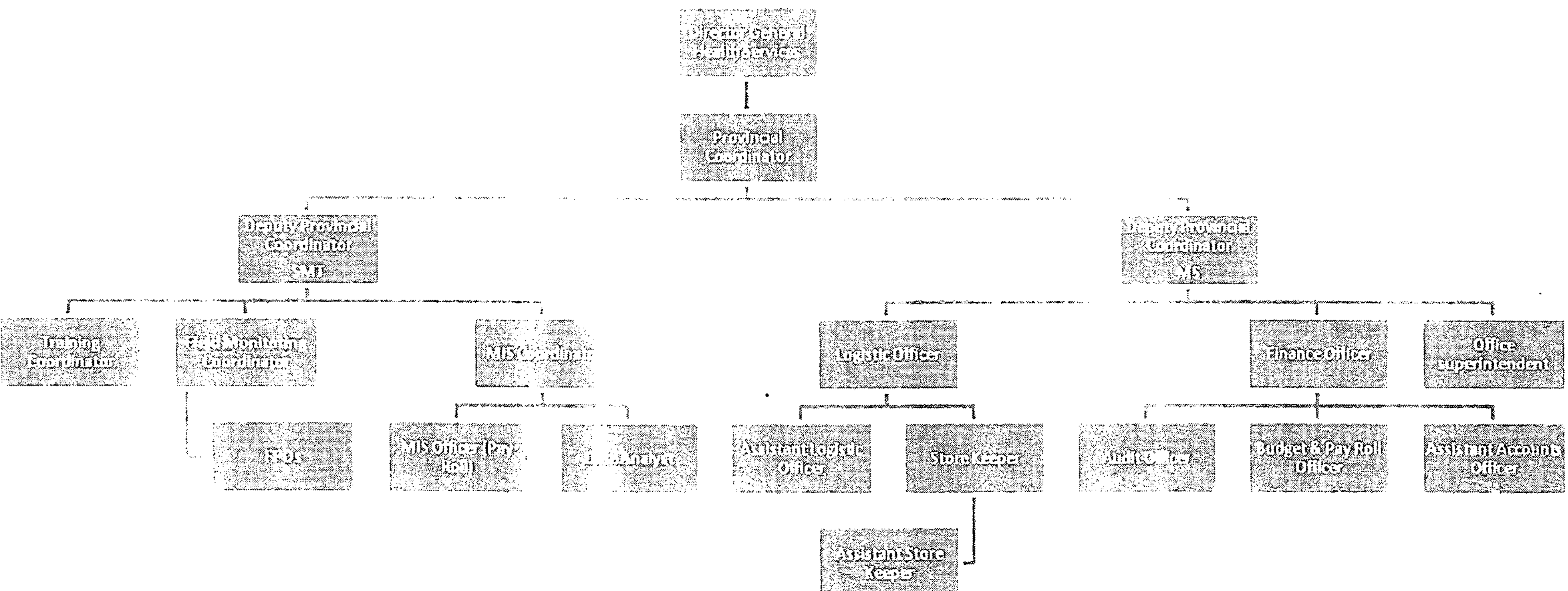
Input	Output	Outcome		Targeted Impact
		Baseline Indicators (2009)	Targets after completion of Project (2015)	
LHWs, LHSs , Field Program Officers, Trainings (basic & refresher), Medicines, contraceptives, non medical items, vehicles, BCC etc.	Increase immunization in children 12-23 months of age	68%	80%	Reduce IMR from 75 to 40per thousand live births.
	Increase in TT coverage	69%	80%	Reduce MMR from 275 to 140 per hundred thousand live births.
	Increase in CPR	34%	48%	
	Increase in ANC(01 visit by SBA)	73%	90%	
	Increase in SBA	46%	60%	
	Increase in post natal visit	10.6%	70%	
	Exclusive Breast Feeding	50%	65%	

National Programme For FP and PHC
Federal Programme Implementation Unit

- Director General Health
  - National Coordinator
    - Deputy National Coordinator
      - Training Coordinator
      - Federal Monitoring Officer
      - MIS Coordinator
        - Net Working Administrator
        - Data Base Admin
        - Computer Programmer
    - Deputy National Coordinator
      - Logistic Officer
        - Assistant Logistic Officer
        - Store Keeper
          - Assistant Store Keeper
      - Procurement Officer
      - Section Officer
        - Superintendent
    - Finance Officer
      - Audit Officer
      - Budget & Pay roll Officer
      - Assistant Accounts Officer
    - Deputy National Coordinator
      - Research Officer
      - Media Officer
      - HEO

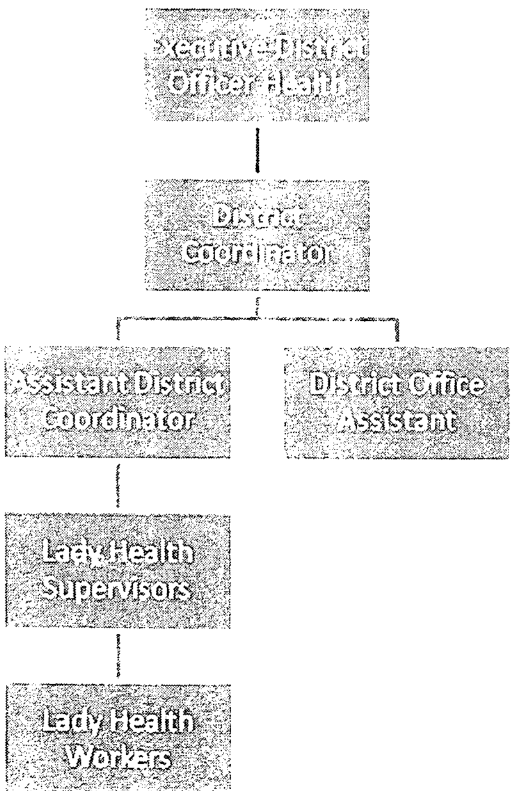
Annexure-XIX

Organogram
Provincial Program Implementation Unit



Annexure-XX

Organogram
District Program Implementation Unit



Provincial and Regional Chapters

Punjab

Punjab having 36 districts constitutes approximately 52% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 3,758 first level health facilities (FLCF) of the province 2,654 are involved in the programme activities. Programme is currently covering 50% of total Punjab population (64% of target population). With this PC-1 Programme is targeting to increase the coverage in the rural area to 100% and urban to 30%.

Human Resource

Provincial and District PIUs

Programme will be employing about 80,000 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	Punjab
Deputy Provincial Coordinator	18	3
Finance Officer	18	1
Health Education Officer	18	1
MIS Coordinator	18	1
Training Coordinator	18	1
Field Monitoring Coordinator	18	3
Logistic Officer	18	1
Audit Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	18
Assistant Accounts/Audit Officer	16	3
Assistant Logistic Officer	16	2
Superintendent	16	1
Data Analyst	16	2
Assistant	14	3
Store Keeper	14	1
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	2
Data Entry Operator	12	11
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	10
Drivers (for FPOs)	5	18
Naib Qasids (F/PPIU)	2	5
Chowkidar	2	6
Sanitary Worker PPIUs	2	4

Total			105

DPIU Staffing Position

Positions/Designations	BPS	Numbers	Remarks
District Coordinator	18	36	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department Punjab. Reporting Authority EDO(H) and Provincial Coordinator
District Office Assistant	14	72	Contract
Assistant District Coordinator	14	36	Contract
Drivers (DPIUs)	5	72	36 for District Coordinators, 36 drivers for ADCs.
Naib Qasids (DPPIU)	2	36	Contract
Sanitary Worker DPIUs	2	36	Contract
Total		288	

Lady Health Workers

The larger proportion of the LHWs and LHSs are in Punjab, in the 2008-2008 PC-I LHWs, LHSs were allocated to Punjab at the ratio of 57.18%. However keeping in view of the very low coverage of the programme in Balochistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Balochistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of Punjab would be 48.07%. The year wise allocation of LHWs, LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	57187	61994	61994	61994	61994	66801

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of Punjab would be 1000/- people, while that in the Urban Slums (Katchi Abadies) will be 1200/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. The proposed ratio is 1 LHSs for an average of 25 LHWs.

Each LHS will be provided a vehicle and driver; however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district-level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff, effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There

will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Sindh

Sindh with 23 districts constitutes approximately 22% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 1,723 first level health facilities (FLCF) of the province 842 are involved in the programme activities. Programme is currently covering 43% of total Sindh population. With this PC-1 Programme is targeting to increase the coverage in the rural coverage to 100% and urban to 30%.

Human Resource

Provincial and District PIUs

Programme will be employing about 32,000 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	Sindh
Deputy Provincial Coordinator	18	3
Finance Officer	18	1
Health Education Officer	18	1
MIS Coordinator	18	1
Training Coordinator	18	1
Field Monitoring Coordinator	18	2
Logistic Officer	18	1
Audit Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	12
Assistant Accounts/Audit Officer	16	3
Assistant Logistic Officer	16	1
Superintendent	16	1
Data Analyst	16	2
Assistant	14	2
Store Keeper	14	1
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	1
Data Entry Operator	12	6
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	10
Drivers (for FPOs)	5	12
Naib Qasids (F/PPIU)	2	5
Chowkidar	2	6
Sanitary Worker PPIUs	2	4

Total		84

DPIU Staffing Position

Positions/Designations	BPS	#	Remarks
District Coordinator	17/18	23	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department Sindh. Reporting Authority EDO(H) and Provincial Coordinator
District Office Assistant	14	45	Contract
Assistant District Coordinator	14	24	Contract
Drivers (DPIUs)	5	48	1 for District Coordinators. 1for drivers for ADCs in districts
Naib Qasids (DPPIU)	2	23	Contract
Sanitary Worker DPIUs	2	23	Contract
Total		186	

Lady Health Workers

In the 2008-2008 PC-1 LHWs, LHSs were allocated to Sindh at the ratio of 21.36%. However keeping in view of the very low coverage of the programme in Baluchistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Baluchistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of Sindh would be 19.6%. The year wise allocation of LHWs. LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	23185	25145	25145	25145	25145	27105

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of Sindh would be 1000/- people, while that in the Urban Slums (Katchi Abadies) will be 1200/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport. in-service training etc. Similarly the LHS. LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 25 LHWs.

Each LHS will be provided a vehicle and driver: however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff. effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Khyber Pakhtunkhwa

Khyber Pakhtunkhwa with 24 districts constitutes approximately 12% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 1,407 first level health facilities (FLCF) of the province 752 are involved in the programme activities. Programme is currently covering 53% of total population. With this PC-1 Programme is targeting to increase the rural coverage to 100% and urban to 30%.

Human Resource

Provincial and District PIUs

Programme will be employing about 21,000 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	KPK
Deputy Provincial Coordinator	18	2
Finance Officer	18	1
Health Education Officer	18	1
MIS Coordinator	18	1
Training Coordinator	18	1
Field Monitoring Coordinator	18	2
Logistic Officer	18	1
Audit Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	12
Assistant Accounts/Audit Officer	16	2
Assistant Logistic Officer	16	1
Superintendent	16	1
Data Analyst	16	2
Assistant	14	2
Store Keeper	14	1
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	1
Data Entry Operator	12	6
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for	5	10
Drivers	5	12
Naib Qasids	2	5
Chowkidar	2	6
Sanitary Worker	2	4
Total		**82**

DPIU Staffing Position

Positions/Designations	BPS	#s	Remarks
District Coordinator	17/18	24	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department KP. Reporting Authority EDO(H) and Provincial Coordinator
Assistant District Coordinator	14	24	Contract
Drivers (DPIUs)	5	48	Contract
Naib Qasids (DPPIU)	2	23	01 for Coordinators. 01 drivers for ADCs in districts.
Sanitary Worker DPIUs	2	23	Contract
Assistant District Coordinator	14	24	Contract
Total		166	

Lady Health Workers

In the 2008-2008 PC-1 LHWs, LHSs were allocated to KP at the ratio of 14.46%. However keeping in view of the very low coverage of the programme in Balochistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Balochistan and FATA was doubled. proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of KP would be 13.27%. The year wise allocation of LHWs. LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	15796	17123	17123	17123	17123	18450

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of KP would be 1000/- people, while that in the Urban Slums (Katchi Abadies) will be 1200/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. Similarly the LHS, LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 24 LHWs.

Each LHS will be provided a vehicle and driver: however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff. effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district. two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Baluchistan

Baluchistan with 30 districts constitutes approximately 7% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 1,339 first level health facilities (FLCF) of the province 207 are involved in the programme activities. Programme is currently covering 28% of total population. With this PC-1 Programme is targeting to increase the coverage to the rural coverage to 100% and urban to 30%.

Human Resource

Provincial and District PIUs

Programme will be employing about1100 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	Baluchistan
Deputy Provincial Coordinator	18	2
Finance Officer	18	1
Health Education Officer	18	1
MIS Coordinator	18	1
Training Coordinator	18	1
Field Monitoring Coordinator	18	2
Logistic Officer	18	1
Audit Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	12
Assistant Accounts/Audit Officer	16	2
Superintendent	16	1
Data Analyst	16	1
Assistant	14	2
Store Keeper	14	1
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	1
Data Entry Operator	12	5
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	10
Drivers (for FPOs)	5	12
Naib Qasids (F/PPIU)	2	5
Chowkidar	2	6
Sanitary Worker PPIUs	2	4
Total		79

DPIU Staffing Position

Positions/Designations	BPS	#	Remarks
District Coordinator	17/18	29	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department Baluchistan. Reporting Authority EDO(H) and Provincial Coordinator
District Office Assistant	14	32	Contract
Assistant District Coordinator	14	29	Contract
Drivers (DPIUs)	5	54	01 for Coordinators, 01 drivers for ADCs in districts.
Naib Qasids (DPPIU)	2	30	Contract
Sanitary Worker DPIUs	2	30	Contract
Total		204	

Lady Health Workers

LHWs/LHSs were allocated to Balochistan at the ratio of 6%. However keeping in view of the very low coverage of the programme in Balochistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Balochistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of Balochistan is 12% . The year wise allocation of LHWs, LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	7200	8400	8400	8400	8400	9600

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of Balochistan would be 700/- people, while that in the Urban Slums (Katchi Abadies) will be 1100/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. Similarly the LHS, LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 20 LHWs which in scattered area could be 15.

Each LHS will be provided a vehicle and driver; however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff, effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Azad Jamu Kashmir (AJK)

AJK with 10 districts constitutes approximately 2% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 718 first level health facilities (FLCF) of the region 158 are involved in the programme activities. Programme is currently covering 57% of total population. With this PC-1 Programme is targeting to increase the rural coverage to 100% and urban to 30%.

Human Resource

Regional and District PIUs

Programme will be employing about 4000 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	AJK
Deputy Provincial Coordinator	18	1
Health Education Officer	17	1
MIS Coordinator	17	1
Field Monitoring Coordinator	17	1
Finance Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	3
Logistic Officer	17	1
Assistant Accounts/Audit Officer	16	1
Superintendent	16	1
Data Analyst	16	1
Assistant	14	2
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	1
Data Entry Operator	12	4
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	4
Drivers (for FPOs)	5	3
Naib Qasids (F/PPIU)	2	3
Chowkidar	2	6
Sanitary Worker PPIUs	2	2
Total		44

DPIU Staffing Position

Positions/Designations	BPS	#	Remarks
District Coordinator	17/18	10	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department AJK. Reporting Authority EDO(H) and Provincial Coordinator
District Office Assistant	14	13	Contract
Assistant District Coordinator	14	10	Contract
Drivers (DPIUs)	5	20	01 for Coordinators, 01 drivers for ADCs in districts.
Naib Qasids (DPPIU)	2	8	Contract
Sanitary Worker DPIUs	2	8	Contract
Total		69	

Lady Health Workers

LHWs. LHSs were allocated to AJK at the ratio of 2.78%. However keeping in view of the very low coverage of the programme in Balochistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Balochistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of AJk would be 2.48%. The year wise allocation of LHWs. LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	2998	3246	3246	3246	3246	3494

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of AJK would be 700/- people, while that in the Urban Slums (Katchi Abadies) will be 1200/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. Similarly the LHS, LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 23 LHWs which in scattered area could be 20.

Each LHS will be provided a vehicle and driver; however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff, effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Gilgit and Biltistan

Gilgit and Biltistan with 7 districts constitute approximately 1% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 283 first level health facilities (FLCF) of the province 66 are involved in the programme activities. Programme is currently covering 71% of total population. With this PC-I Programme is targeting to increase the rural coverage to 100% and urban to 30%.

Human Resource

Regional and District PIUs

Programme will be employing about 19,00 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGHS and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

RPIU Staffing Positions

Positions/Designations	BPS	G&B
Deputy Provincial Coordinator	18	1
MIS Coordinator	17	1
Field Monitoring Coordinator	17	1
Finance Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	3
Logistic Officer	17	1
Assistant Accounts/Audit Officer	16	1
Superintendent	16	1
Data Analyst	16	1
Assistant	14	2
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	2
Assistant Store Keeper	12	1
Data Entry Operator	12	4
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	4
Drivers (for FPOs)	5	3
Naib Qasids (F/PPIU)	2	3
Chowkidar	2	6
Sanitary Worker PPIUs	2	2

Total		43

DPIU Staffing Position

Positions/Designations	BPS	#	Remarks
District Coordinator	17/18	8	One position of District Coordinator National Programme for FP & PHC (DCNP) will be created at every district by the health Department G&B. Reporting Authority EDO(H) and Provincial Coordinator
District Office Assistant	14	10	Contract
Assistant District Coordinator	14	8	Contract
Drivers (DPIUs)	5	16	01 for Coordinators, 01 drivers for ADCs in districts.
Naib Qasids (DPPIU)	2	7	Contract
Sanitary Worker DPIUs	2	7	Contract
Total		56	

Lady Health Workers

In the 2003-2008 PC-I LHWs, LHSs were allocated to Gilgit and Baltistan at the ratio of 1.2%. However keeping in view of the very low coverage of the programme in Balochistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Balochistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new provincial allocation the share of Gilgit and Baltistan (FANA) would be 1.1%. The year wise allocation of LHWs, LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	1361	1471	1471	1471	1471	1581

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of Gilgit and Baltistan would be 700/- people, while that in the Urban Slums (Katchi Abadies) will be 1200/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. Similarly the LHS, LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 22 LHWs which in scattered area could be 20.

Each LHS will be provided a vehicle and driver; however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff, effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver.

Federally Administered Tribal Areas (FATA)

FATA with 9 Agencies and FR regions constitute approximately 2% of the Pakistan population. Currently programme is working in all the districts of the province. Out of the 748 first level health facilities (FLCF) of the agencies 70 are involved in the programme activities. Programme is currently covering 29% of total population. With this PC-1 Programme is targeting to increase the rural coverage to 100% and urban to 30%.

Human Resource

Provincial and District PIUs

Programme will be employing about 19,00 people (LHWs, LHSs, Drivers, DPIU and PPIU Staff) in the province. To ensure the provincial ownership of the programme and to develop better coordination between the provincial, district health departments and the ministry of health for the smooth implementation of the programme the provincial and district coordinators will be the employee of the health department and working full time on these positions. For this the provincial health department will create positions of Provincial Coordinators and District Coordinators at the provincial and districts level under DGH and EDO (H) respectively. The details of PPIU and DPIUs positions are as under

PPIU Staffing Positions

Positions/Designations	BPS	FATA
Deputy Provincial Coordinator	18	1
MIS Coordinator	17	1
Field Monitoring Coordinator	17	1
Finance Officer	17	1
MIS & Payroll Officer	17	1
Field Program Officer	17	3
Logistic Officer	17	1
Assistant Accounts/Audit Officer	16	1
Superintendent	16	1
Data Analyst	16	1
Assistant	14	2
Senior Auditor/Cashier	14	1
Steno Typist/PA to Coordinator	12	1
Assistant Store Keeper	12	1
Data Entry Operator	12	4
Receptionist	11	1
UDCs	9	1
LDCs	7	1
Drivers for F/PPIUs)	5	4
Drivers (for FPOs)	5	3
Naib Qasids (F/PPIU)	2	3
Chowkidar	2	6
Sanitary Worker PPIUs	2	2
Total		**42**

DPIU Staffing Position

Positions/Designations	BPS	#	Remarks
Agency Coordinator National Programme for FP & PHC	17/18	10	One position of Agency Coordinator National Programme for FP & PHC (ACNP) will be created at every Agency by the FATA Health Department Directorate. Reporting Authority EDO(H) and Agency Coordinator
District Office Assistant	14	10	Contract
Assistant Agency Coordinator	14	10	Contract, Same as ADC in Districts
Drivers (DPIUs)	5	20	01 for Coordinators, 01 driver for ADCs in Agency.
Naib Qasids (DPPIU)	2	10	Contract
Sanitory Worker DPIUs	2	10	Contract
Total		70	

Lady Health Workers

In the 2003-2008 PC-1 LHWs, LHSs were allocated to FATA at the ratio of 1.6%. However keeping in view of the very low coverage of the programme in Baluchistan and FATA as well as the poor state of the health indicators there, government decided to revise the allocation of LHWs. The share of Baluchistan and FATA was doubled, proportionally reducing the share of other provinces/regions. As per the new regional allocation the share of FATA would be 3.2%. The year wise allocation of LHWs, LHSs is as under

Year	2009-10	2010-2011	2011-12	2012-2013	2013-14	2014-15
LHWs	1920	2240	2240	2240	2240	2560

Note. In 2011-12 the allocation criterion will be reviewed and if needed revised accordingly.

The average population to be covered by LHW in the rural areas of FATA would be 700/- people, while that in the Urban Slums (Katchi Abadies) will be 1000/- per LHW.

Lady Health Supervisors.

LHSs plays the critical role in the performance of LHWs therefore programme has taken various initiative to strengthen this cadre of supervises like enhancement in salary, provision of transport, in-service training etc. Similarly the LHS, LHWs ratios has also been revised to give more time to LHSs for supportive supervision of LHWs and monitoring LHWs performance in the community. The proposed ratio is 1 LHSs for an average of 22 LHWs which in scattered area could be 20.

Each LHS will be provided a vehicle and driver; however in case of shortage of vehicle they will be paid Fixed Traveling Allowance (FTA).

Other Supervisory Cadre (FPOs & ADCs)

Assistant District coordinator (ADC) plays a key role in the monitoring of the programme activities at the district level as well as in the supervision of LHSs. Previously the position was filled by either WMO or senior LHV of the DoH. However due lack of female staff at the district level the position either remained vacant or filled through a part time staff, effecting the monitoring activities of the programme. To overcome this problem a cadre of Assistant District Coordinator BPS-14 is introduced in the Programme for supervision. There will be one ADC in each district, two where there are more than 50 LHS but in such case one ADC will be financed through programme while the other will be from the health department drawing her salary from the provincial/regional health department but entitled for TA/DA from programme for programme related activities. There will be only one vehicle along with a driver for supervisory visits of ADCs at the DPIU.

Similarly there will be one FPO for two districts. Each FPO will be provided a vehicle and a driver..

Annexure-XXII

PROVINCE	Districts	Total FLCF in the Districts	Total FLCF involved in the Programme
Punjab	36	3,814	2,697
Sindh	23	1,723	842
KP	24	1,407	752
Balochistan	29	1,339	207
AJK	8	718	158
FANA	6	283	66
FATA	7	478	70
ICT	1	49	19
Total	134	9,811	4,811

Programme Review and Supervision Activities

1. Quarterly review meetings of all Provincial Coordinators at FPIU

This would be quarterly meeting organized by the FPIU, attended by provincial and regional coordinator along with their DPCs and other relevant staff of PPIU. Representative of the collaborating partners as well as other government departs like population welfare; working in the sector would be requested to attend. The objectives of the meeting are

1. To review the progress of programme implementation in provinces and regions.
2. To review performance of programme on out put indicators.
3. To discuss bottle necks and look for their solution.
4. To discuss emerging threats, opportunities and agree upon strategies to handle threats and capitalize opportunities.
5. Review the work load on LHWs.
6. To review progress on the inter-sectoral collaboration with other collaborating partners, especially Population Welfare department and other international development partners.
7. To review progress on devolution.

2. Quarterly review meetings of District Coordinators at respective PPIUs/RPIU

This would be quarterly meeting organized by the R/PPIU, which is attended primarily by the District coordinators. However DHO/EDOs and ADCs could also participate in this meeting. The meeting is organized by P/RPIUs under the chair of DG HS/Director health with representation from the FPIU and other stack-holders. The objectives of the meeting are

1. To review the progress of programme implementation across the districts
2. To review progress on the inter-sectoral collaboration with other collaborating partners, especially Population Welfare department and other international development partners.
3. To review performance programme on out put indicators.
4. To discuss bottle necks and look for solutions.
5. To discuss emerging threats, opportunities and agree upon strategies to handle threats and capitalize opportunities.
6. Review the work load on LHWs.
7. To review progress on devolution.

3. Monthly review meetings of FPOs at respective PPIUs

This would be a monthly meeting organized by the R/PPIU, it is attended by the FPO, officers of the R/PPIU, DGHS/ DH or his representative, and FPIU representative. The objectives of the meeting are

1. To review the progress on input and out put indicators.

2. To review the performance of programme staff at the district, FLCF and LHWs level.

4. Monthly review meetings of LHSs at respective DPIUs (MMC)

This would be a monthly meeting organized by the DPPIU, it is attended by the LHSs, officers of the DPIU, EDO/DHOs or his representative and PPIU representative along with other stack-holders such DPO of Population welfare department etc. The objectives of the meeting are

1. To review the progress on input and out put indicators.
2. To review the performance of programme at the FLCF and Health House level.
3. To discuss the status causes of maternal and infant deaths verification and remedial measure.

5. Regular field visits of F/R/P PIU officers/FPOs to the districts.

Each officer of the programme would be required to carry out supervisory visit for specific day to observe the implementation of the programme. He is suppose to visit every implementation level to abreast himself of the strengths of and challenges faced by the programme. All visiting officer are required to use standard checklist during the field visit to record their finding. The guidelines for visit for different cadre of programme officers are as follow

5.1 Guidelines for FPIU

No. of days to be spent in the field by officers of FPIU

National Coordinator	**04 Days**	**02 PPIUs & 02 Districts**
Deputy National Coordinator	**Minimum 08 Days**	**02 PPIUs & 02 districts i.e. 3 Days / District**
Other FPIU Staff	**Minimum 08 Days**	**02 PPIUs & 02 Districts i.e. 3 Days / District**

5.2 Guidelines for PPIU

No. of days to be spent in the field by: PPIU Officers

Provincial Coordinator	06 Days	(03 Days / District)
Deputy Provincial Coordinator	09 Days	(03 Days / District)
Field Monitoring Coordinator	09 Days	(03 Days / District)

FO, LO, MISC,PTC & HEO each	09 Days	(03 Days / District)
Other staff of PPIU	06 Days	(03 Days / District)

5.3 **Guidelines for Field Programme Officer**
Having One Districts

No. of days to be spent in the District : 20 Days,	Days in DPIU 2
No. of facilities to be visited / day	01 /Day
No. of Lady Health Supervisors to be met/day (from the facility being visited)	01/ Day
No. of LHWs to be visited / day	02-03/ Day

Having Two Districts

10 days each Districts	
DPIU (1 beginning + 1 end)	02 Days
MMC at DPIU and not more than 12-16 supervisor/ meeting	2 Days
No. of remaining days in field	6
No. of facilities to be visited	4-6
No. of LHSs to be visited	6
No. of LHWs to be visited	12-18

Having Three Districts

Days to be Spent In Each District	07 Days
DPIU	02 Days
Meeting of supervisors	1-2 Days
No. of remaining days in the field	3-4 Days
No. of Facilities to be visited	3-4
No. of LHSs to be visited	3-4
No. of LHWs to be visited	6-8

6. **Field visits by DC/ADCs and LHS.**

DCNP and ADC would be in field for 8-12 days in a month. They will plan their visits such that one of them is present at DPIU. However they could also conduct joint visit if situation demand. ADC will use the DPIU vehicle for field visits. They will submit to PPIU an approved (Signed by EDO/DHO) advance tour schedule before the start of month and actual tour schedule along with the tour notes at the end

of the month under the signature of EDO/DHO. They will use the standard programme supervisory checklist for the visits and reporting form for their reports.

Guidelines for DCNP and ADC

No. of days to be spent in the field by: DPIU Staff

District Coordinator	8-12 Days
Assistant District Coordinator	8-12 Days
No. of FLCF to be visited / day	01
No. of LHSs to be visited / day	01
No. Of HH to be visited/Day	02-03

Annexure-XXIV

Allocation Criterion for LHWs Seats

Province/ Region	District	Revised Allocation (PM Directives)
Punjab	35	48.07%
Sindh	23	19.60%
NWFP	24	13.27%
Balochistan	29	12.00%
AJK	10	2.48%
Gilgit Baltistan	8	1.10%
FATA (Including FR)	10	3.20%
ICT	1	0.28%
Total	132	100.00%

R/PPIU	LHWs Allocation			
Punjab	52,380(52.38%)	57,187 (48.07%)	61,994	66,801 (48.07 %)
Sindh	21,225 (21.36%)	23,185 (19.6%)	25,145	27,105 (21.36%)
KP	14,469 (14.46%)	15,796 (13.27%)	17,123	18,450 (13.27%)
Balochistan	6,000 (6.0%)	7,200 (12 %)	8,400	9,600 (12%)
AJK	2,800 (2.7%)	2,998 (2.48%)	3,246	3,494 (2.48%)
Gilgit Baltistan	1,251 (1.2%)	1,361 (1.10%)	1,471	1,581 (1.1%)
FATA	1,600 (1.6%)	1,920 (3.2 %)	2,240	2,560 (3.2%)
ICT	325 (.3%)	353 (.28%)	381	409 (.28%)
Total	100,000	110,000	120,000	130,000

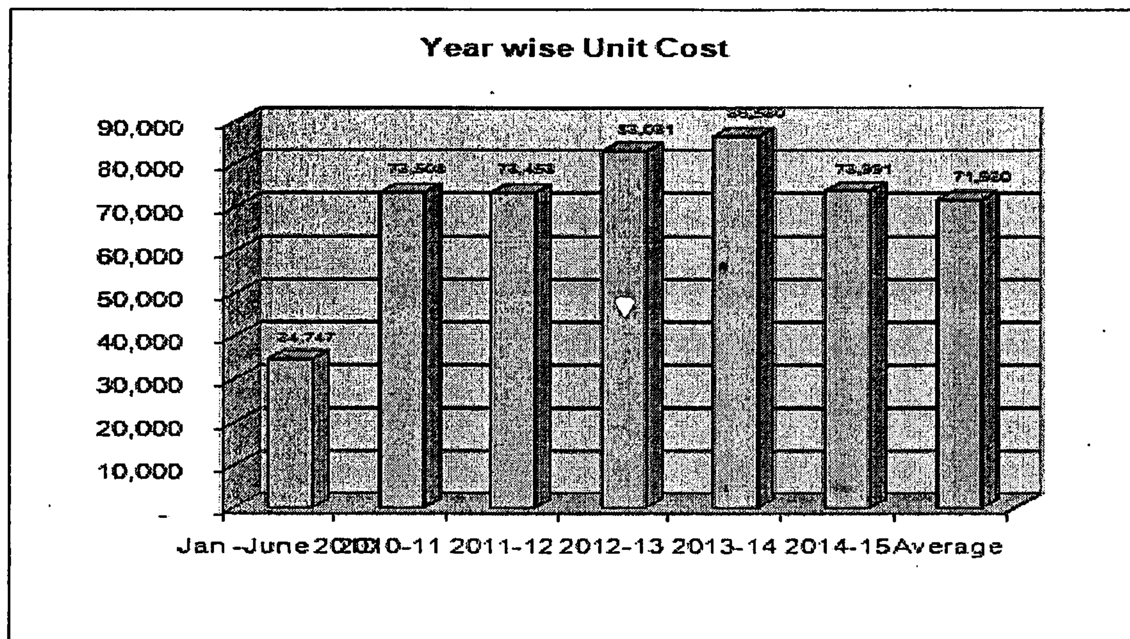
Annexure-XXV

Other Costing Options

Year wise Financial phasing (LHWs stipends 3190 with 100 rupees annual increase)

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Employees Related Expenses	2555.50248	5494.718528	5664.106876	5909.570597	6083.020055	6747.156009	32454.07455
Printing & Publications	51	102.5	52.2	102.7	32.1	22.4	362.900
BCC/Advertising & Publicity	52.85	67.84	67.25	68	68	68.1	392.040
Purchase of drugs, medicines	837.570	1872.669	2021.319	2765.900	2981 127	1677.523	12156.108
In service trainings-LHW, LHSs,	0.680	251.733	251.053	255.100	254.421	266.043	1279.031
TA/DA, Transportation, POL/CNG	224.701	475.869	513.093	550.836	594.505	637.018	2996.022
Purchase of Physical Assets including vehicles	11.460	341.300	27.709	7.942	57.592	1.612	447.615
Repair and maintainance of Phsical Assets	37.138	80.206	87.003	78.218	79.521	81 012	443.098
Project Pre-investment Analysis	0	0	3	0	2	0	5.000
Consultancy and Contractual Work/Innovations	0	0	0	63	64	0	127.000
Others	51.278	134.153	127 665	162.480	173.287	118.000	766.864
Total	3822.180	8820.989	8814.400	9963.747	10389.573	9618.865	51,429.753

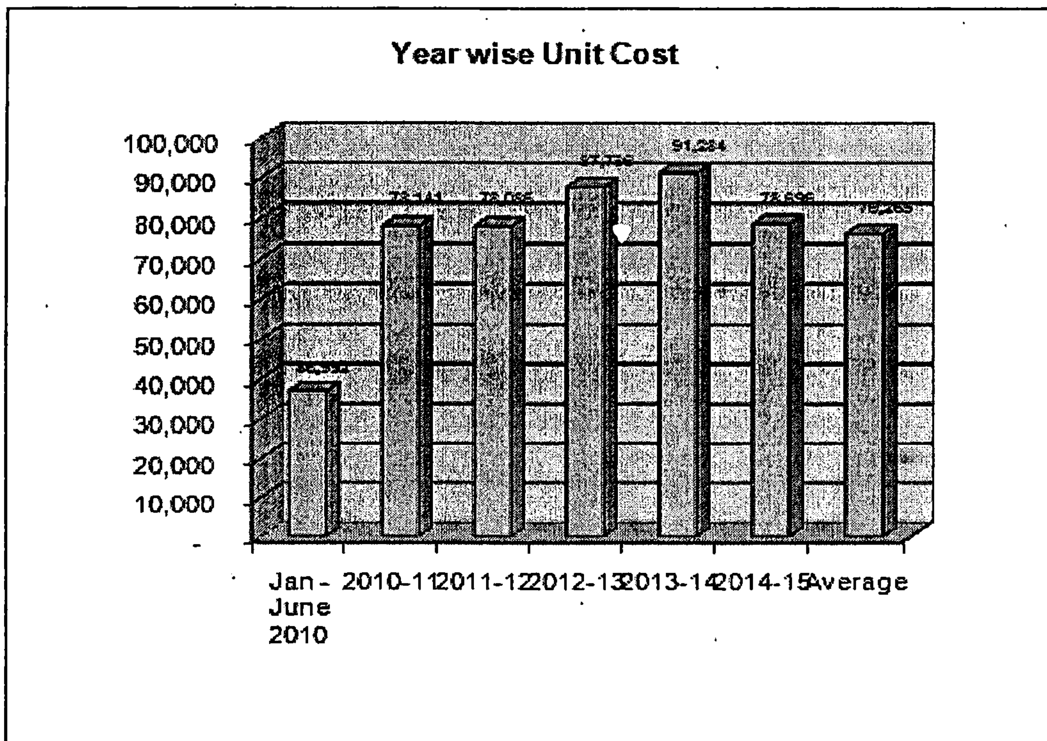
Year wise Unit Cost (Average unit cost Rs. 71930)



Year wise Financial phasing (LHWs stipends are Rs. 3,588 with 100 rupees annual, increased 20% increase on 2008 Pay, As per PM directive # 655, F. 3(175) Annou-PR/G-i/PAW/07 dated May 05,2007))

	[illegible]	2010-11	2011-12	2012-2013	2013-2014	2014-15	Total
Employees Related Expenses	2802.42168	6050.672223	6220.06[illegible]71	6474.093797	6647.543255	7358.722809	35553.51433
Printing & Publications	51	102.5	52.2	102.7	32.1	22.4	362.900
BCC/Advertising & Publicity	52.85	67.84	67.25	68	68	68.1	392.040
Purchase of drugs, medicines	837.570	1872.669	2021.319	2765.900	2981.127	1677.523	12156.108
In service trainings-LHW, LHSs,	0.680	251.733	251.053	255.100	254.421	266.043	1279.031
TA/DA, Transportation, POL/CNG	224.701	475.869	513.093	550.836	594.505	637.018	2996.022
Purchase of Physical Assets including vehicles	11.460	341.300	27.709	7.942	57.592	1.612	447.615
Repair and maintainance of Phsical Assets	37.138	80.206	87.003	78.218	79.521	81.012	443.098
Project Pre-investment Analysis	0	0	3	0	2	0	5.000
Consultancy and Contractual Work/Innovations	0	0	0	63	64	0	127.000
Others	51.278	134.153	127.665	162.480	173.287	118.000	766.864
Total	4069.099	9376.943	9370.353	10528.270	10954.096	10230.431	54,529.192

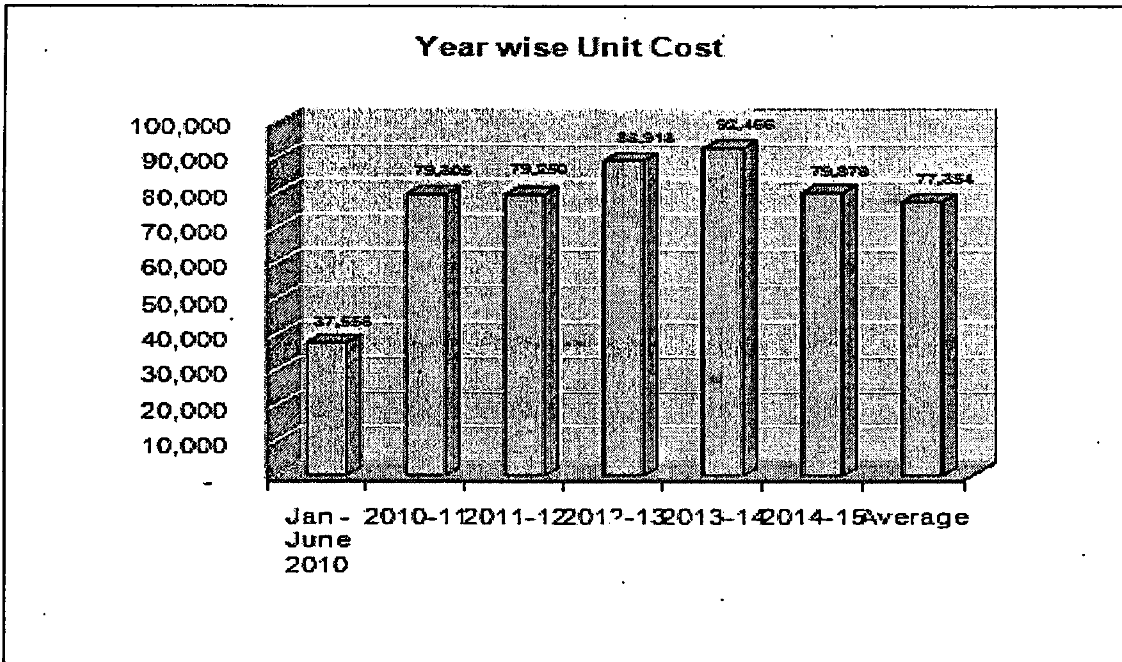
Year wise Unit Cost (Average unit cost Rs. 76,283)



Year wise Financial phasing (LHWs stipends Rs. 3,688 with 100 rupees annual increase due to 20% increase on 2008+100 increase of 09-10 Pay, As per PM directive # 655, F. 3(175) Annou-PR/G-i/PAW/07 dated May 05,2007))

	Jun-Dec 2010	2010-11	2011-12	2012-2013	2013-2014	2014-15	Total
Employees Related Expenses	2864.46168	6190.359081	6359.747429	6615.933797	6789.383255	7512.382809	36332.26805
Printing & Publications	51	102.5	52.2	102.7	32.1	22.4	362.900
BCC/Advertising & Publicity	52.85	67.84	67.25	68	68	68.1	392.040
Purchase of drugs, medicines	837.570	1872.669	2021.319	2765.900	2981 127	1677 523	12156.108
In service trainings-LHW, LHSs.	0.680	251.733	251.053	255.100	254.421	266 043	1279.031
TA/DA, Transportation, POL/CNG	224.701	475.869	513.093	550.836	594.505	637.018	2995.022
Purchase of Physical Assets including vehicles	11.460	341.300	27.709	7.942	57.592	1.612	447.615
Repair and maintainance of Phsical Assets	37.138	80.206	87.003	78.218	79.521	81.012	443.098
Project Pre-investment Analysis	0	0	3	0	2	0	5.000
Consultancy and Contractual Work/Innovations	0	0	0	63	64	0	127.000
Others	51.278	134.153	127.665	162.480	173.287	118.000	766.864
Total	4131.139	9516.630	9510.040	10670.110	11095.936	10384.091	55,307.946

Year wise Unit Cost (Average unit cost Rs. 77,354)



Annexure-XXVI

GOVERNMENT OF PAKISTAN
MINISTRY OF HEALTH

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Islamabad, the 1st July, 2010

NOTIFICATION

No. F. 1-10-2009/PHC-(PC-1) In pursuance of the CDWP decision contained in Planning Commission, Minutes of the Meeting dated 18th, March 2010. The following committee is constituted;

1	Mr. Khushnood Akhtar Lashari Secretary Health, Ministry of Health	Chairman
2	Mr. Javed Aslam Chairman Planning and Development, Gover. .nent of Punjab	Member
3	Mr. Aurangzeb Haq Addl. Chief Secretary, Government of Sindh	Member
4	Dr. Ghulam Dastgir Akhtar Addl. Chief Secretary, Government of Khyber Pukhtunkhwa	Member
5	Mr. Ali Zaheer Hazara Addl. Chief Secretary, Government of Balochistan	Member
6	Mr. Babar Yaqoob Chief Secretary, Gilgit Baltistan	Member
7	Mr. Tariq Mehmood Khan Additional Chief Secretary, Government of AJ & K	Member
8	Mr. Habib Ullah Khan Additional Chief Secretary, FATA	Member
9	Mr. Fawad Hassan Fawad Provincial Secretary, Health Department, Government of Punjab	Member
10	Syed Hashim Raza Zaidi Provincial Secretary, Health Department, Government of Sindh	Member
11	Dr. Syed Sohail Altaf Provincial Secretary, Health Department, Government of Khyber Pakhtunkhwa	Member
12	Mr. Muhammad Jalal Provincial Secretary, Health Department, Government of Balochistan	Member
13	Dr. Ghulam Ali Provincial Secretary (Acting), Health Departm..nt, Government of Gilgit Baltistan	Member
14	Brig. Liaqat Ali Khan Provincial Secretary, Health Department, Government of AJ & K	Member
15	Dr. Iqbal Ahmed Lehri, National Coordinator, NP for FP & PHC	Member/Secretary

Contd....p/2

The terms of reference of the Committee would include:

i) Prepare road map and firm up recommendations along with modified PC-1 which will be submitted to the Planning Commission for preparation of summary for ECNEC for complete devolution of the Program to the provinces.

ii) The committee will also assess the ways and means for complete transfer of the Program to the provinces.

(AGHA NADEEM)
Additional Secretary Health

Distribution

All Members

Copy to:

1. Joint Secretary (P&D), M/o Health, Islamabad
2. Deputy Director General (P& D), M/o Health, Islamabad
3. P.S to Secretary Health, M/o Health, Islamabad
4. ... National Coordinator NP for FP & PHC, B/Area, Islamabad

Minutes of the Meeting Held to Implement CDWP Meeting Decisions dated March 18, 2010 with provincial representatives on July 6, 2010

In order to implement decisions of the CDWP meeting dated March 18, 2010, a meeting was called by the Secretary Health which was held in the Committee Room Block C, Pak Secretariat Islamabad on 6th July, 2010.

List of Participants is attached at **Flag "A"**.

1. Proceedings:

The meeting started with recitation from the Holy Quran which was followed by introduction of the participants.

While welcoming the participants, the chair elucidated the objectives of the meeting and informed that for the last sixteen years, the LHWs program remained federally funded and provincially implemented. National Program submitted its new PC-1 (January 2010 to June 2015) which was discussed in CDWP meeting held on 18th March, 2010. The Project was recommended with following decision:

"The project was recommended for approval of ECNEC at a total cost of Rs. 53,405.927 million with FEC of Rs. 776.623 million subject to the following conditions:

I. The Programme will be devolved to 20 districts on pilot basis within first 02 year of the project (2010-12).

II. A committee will be constituted under chairmanship of Secretary (Health) with representation of provincial Additional Chief Secretaries (Dev) and Secretaries, Health Departments to assess the ways and means for complete transfer of the Programme to the provinces. The committee will give its report within one month for consideration of ECNEC.

III. Ministry of Health will submit report of the above committee along with modified PC-I to Planning Commission for preparation of summary for ECNEC."

Chair pointed out that in the background of CDWP decisions, today's discussion will be mainly focused on the process of devolution of the Program. He requested that while proposing a model for piloting it may be kept in consideration that the devolution of the programme can only be successful if we build consensus and adopt structured approach to carry out meaningful interventions by designing implementation modalities.

National Coordinator LHW programme made a detailed presentation regarding current status of the programme and the way forward for the implementation of the CDWP decision. A copy of the presentation is enclosed. **Flag "B"**

2. Discussion

After the presentation house was open for discussion. All the participants took part in the discussion; various issues regarding process of devolution were discussed in details. The discussion remained focused around the following key points

Piloting of Devolution in Twenty Districts

Opening the discussion the representative of Punjab said that pilot phase will provide a breathing space to the provinces to prepare themselves for complete devolution. However, there was lengthy discussion on the distribution of districts among the provinces and regions. Gilgit Baltistan wanted to do the pilot in all the districts while Khyber Pakhtunkhwa was not willing to take more than two districts. The representative wanted distribution of districts as per the LHWs seats allocation formula. It was pointed out by the NC National Programme that if the districts are distributed according to this formula then G&B and AJK would get only one district each. As programme wants to make the devolution a meaningful exercise therefore the districts of Punjab have been reduced from 10 to 8 to create space for G&B and AJK. The representative of Sindh volunteered to take one additional districts. The representative agreed on flowing distribution

S.#	Province/Region	Number of district for piloting
1	Punjab	08
2	Sindh	04
3	Khyber Pakhtunkhwa	02
4	Baluchistan	02
5	AJK	02
6	Gilgit Baltistan	02

Devolution of the Programme

The level of devolution at district or provinces was discussed at length. The participants were of the view that keeping in view the current political situation and the capacities at the districts level, it would be better that in the pilot phase the program be devolved to the provinces. However, the representative said that, as this decision would require concurrence of the provincial governments therefore they will discuss it with their respective government and would furnish their comments accordingly at earliest.

District Selection for Pilot

The following criterion was discussed for selection of districts for piloting, all the participants with consensus agreed on the following broader guidelines for selection of pilot districts;

- ✓ Geographic Diversity
- ✓ Functioning of the district health system
- ✓ Number of LHWs in the district
- ✓ Performance of the districts
- ✓ Disadvantageous/advantageous districts

Financing of the devolution

The NC raised the issue of financing the gap between PC-1 cost and allocated fund for the year 2010-11. He further said that unit cost as per PC-1 (2010-15) is Rs. 75000/LHW /Year while as per the PSDP allocation for the year 2010-11 the unit cost is Rs. 48,000 so there is a gap of Rs. 27,000 in funding.

The representative of Punjab explained that province is also facing the resources crunch therefore would not be able to fill this gap. The argument was supported by all other provincial

representative. The Khyber Pakhtunkhwa representative added that as provincial health department has already finalized its development programme and provincial budgets approved, therefore, making it difficult to allocate any resources for the pilot at this juncture.

Time Frame for devolution

The provinces agreed on the time frame of piloting as per decision of CDWP meeting i.e. from 2010 to 2012 provided that federal government is committed to provide the required funding.

Procurement of Logistics in the pilot districts

Following different modalities were discussed

1. Rate contract is done at the federal level and funds are transferred to the provinces to do procurement for the selected district.
2. Transfer funds to districts; provinces do the central rate contract at provincial level and allow the district to do the purchase themselves under the provincial procurement rules on their need basis.
3. Funds are transferred to the provinces to do the purchase for the pilot district.

With consensus all the participants opted for Option 3.

Monitoring, Supervision, Performance and Financial Audit and Quality Control & Assessment

The provinces agreed that the current mechanism of monitoring, supervision and auditing for performance and funds utilization as well as quality control will be maintained. In which the provincial and district health department as well as relevant PPIU will have responsibility and accountability.

The Federal Unit will play its role for monitoring and supervision and auditing for performance and fund utilization in devolved districts. Further at the end of 2nd year a rapid assessment will be carried out in pilot districts.

Complete Transfer of Program to the Provinces

The provinces were given the following options;

- Scaling up of District devolution pilot with provincial cost
- Component Wise funding of program by provinces

The provinces were of the view that as the details of the concurrent list, NFC award are still to be unfolded and the provinces have not been provided the funding promised in NFC award therefore it is a bit early to commit at this stage. Moreover, the provinces have their own fund priorities like the security situation in KPK and Baluchistan.

3. Decisions

I. Programme will be devolved to 20 districts on pilot basis within first 02 year of the project (2010-12).

II. Distribution of 20 districts for piloting among the provinces/regions.

S.#	Province/Region	Number of district for piloting
1	Punjab	08
2	Sindh	04
3	Khyber Pakhtunkhwa	02
4	Baluchistan	02
5	AJK	02
6	Gilgit Baltistan	02

III. Provinces will send their recommendations/views on the level of devolution at early dates.

IV. Provinces will submit the fund flow mechanism after getting the concurrence of provincial competent authorities.

V. Current mechanism of monitoring, supervision and auditing for performance and funds utilization as well as quality control will be maintained.

VI. Decision on the complete transfer of programme to the provinces was deferred till next meeting.

Meeting ended with a vote of thanks and with the commitment that each province will furnish their views/comments regarding implementation modalities, funding mechanism and any other information if they would like to share at an early date.

Tentative piloting cost & Funding Gap

			As Per PC-1 (2010-11)			As per PSDP Allocation (2010-11)			
Province Name	Average LHWs/District	Number of Districts	Avg. Unit Cost/LHW/Y	Cost per District (M)	Total Cost (M)	Unit Cost/LHW/Y	Cost per District (M)	Total Cost (M)	GAP
Punjab	1500	8	108,625	162.94	1,303.50	48,000.00	72.00	576	727.50
Sindh	1200	4	108,625	130.35	521.40	48,000.00	57.60	230.4	291.00
KPK	600	2	108,625	65.18	130.35	48,000.00	28.80	57.6	72.75
Baluchistan	220	2	108,625	23.90	47.80	48,000.00	10.56	21.12	26.68
AJK	350	2	108,625	38.02	76.04	48,000.00	16.80	33.6	42.44
GB	226	2	108,625	24.55	49.10	48,000.00	10.85	21.696	27.40
Total		20		444.93	2,128.18		196.61	940.416	1,187.77