

PC-1



**National Programme for
Family Planning and Primary Health Care**

“The Lady Health Workers Programme”

2003 - 2008

**Government of Pakistan
Ministry of Health**

ABBREVIATIONS

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 Diarrhea Diseases
CDR	Crude Death Rate
CDWP	Central Development Working Party
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 Currency
FHT	Female Health Technician
FLCF	First Level Care Facility
FMT	Female Medical Technician
FP	Family Planning
FPSC	Federal Public Service Commission
FWC	Family Welfare Centre
HEO	Health Education Officer
IDD	Iodine Deficiency Disorders
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health

MMR	Maternal Mortality Rate
MNT	Maternal & Neonatal Tetanus
MO	Medical Officer
NGO	Non Governmental Organization
NID	National Immunization Day
NTT	Neonatal Tetanus Toxoid
ORS	Oral Re-hydration Salt
PCSP	Pakistan Child Survival Project
PHC	Primary Health Care
PIU	Programme Implementation Unit
PLA	Personal Ledger Account
PSDP	Public Sector Development Programme
RHC	Rural Health Centre
RHP	Reproductive Health Project
RHSC	Reproductive Health Service Centre
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
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)

PART "A"

PROJECT DIGEST

- 1. Name of the Project:** National Programme for Family Planning and Primary Health Care (NP-FP&PHC) "The Lady Health Workers' Programme" (LHWP)
- 2. Authorities responsible for:**
- i. Sponsoring. Federal Government
 - ii. Execution. Ministry of Health (MoH) and Provincial Health Departments.
 - iii. Operation & Maintenance. Ministry of Health
- 3. Time required for completion:** Until June 2008, in two phases:
 - ◆ Phase I till June 2005
 - ◆ Phase II till June 2008The extension into Phased III will be after 2008 for which modalities will be worked out based on the guidelines given in the Strategic Plan, the experience from the implementation of the Programme and the different pilot initiatives - in consultation with provincial governments.
- 4. Plan Provision:**
- a)
- i. **If the project is included in the current five-year plan, please specify actual allocation.** Included in the Ten-Year Perspective Development Plan 2001-11. The Programme has also been identified as a major health sector Programme for the I-PRSP.
 - ii. **If not included in the five-year plan, how is it now proposed to be accommodated (Inter/Intra Sectoral adjustments in allocation or other sources may be indicated).**
 - iii. **If the project is proposed to be financed out of block provision for a programme indicates.**

- b)
i. **If the project is not planned what warrants its inclusion in the plan.**

5. Relationship of the project objectives of the sector indicate:

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-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 three major national strategy papers; the National Health Policy 2001, the 10 Year Perspective Development Plan and the National Poverty Reduction Strategy. In these three strategy papers the NP-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 till 2011, and has announced an initial budgetary commitment of Rs.23 billion for this new phase.

The Programme provides an important strategic arm both for the new National Health Policy (2001) and for poverty reduction. The overall vision of the Policy is to ensure 'Health-For-All' with priority attention directed towards the primary and secondary levels of the health care system.

The National Health Policy-2001 outlines ten key areas of reform and the implementation strategies to address them. Of these ten strategic areas, five sets of strategies are directly relevant to the work of the National Programme for Primary Health Care. They include:

- 1. The reduction of the widespread prevalence of communicable diseases (i.e. the EPI cluster of childhood diseases, TB, Malaria, Hepatitis-B and HIV-Aids) (Key Area 1).*
- 2. Addressing the inadequacies in Primary/Secondary Health Care Services (Key Area 2)*
- 3. Promoting greater gender equity in the*

Health Sector (Key Area 4)

4. *Bridging the basic nutrition gaps in the target population i.e. amongst children, women and vulnerable population groups (Key Area 5), and*
5. *Creating mass awareness of in public health matters (Key Area 8).*

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 will constitute the main thrust of the extension of outreach services in the rural and less developed urban areas through deploying 100,000 Lady Health Workers (LHWs) in six phases (87,600 LHWs under this PC-1). The LHWs will receive comprehensive training to deliver family planning and primary health care services at the doorstep of community.

6. Capital Cost for the Project:

Local:	Rs. 21,513.932 million (Excluding the cost of support from WHP and RHP)
Foreign exchange cost:	[Approx. Rs. 8 billion of the total cost will be provided from donors/ lending agencies.]
Total:	Rs. 21,513.932 million (Excluding the cost of support from WHP and RHP)

7. Annual expenditure after completion:	recurring after	Rs. 4,448.164 million
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8. Objective of the Project

GOALS

1. to develop the necessary health manpower in support of the Programme by selection, training and deployment of 100,000 LHWs (87,600 under NP, 8,000 under WHP and 4,400 under RHP) throughout the country.
2. to address the primary health care problems in the community, providing promotive, preventive, curative and

appropriate rehabilitative services to which the entire population has effective access.

3. to bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support.
4. to expand the family planning services availability in urban slums and rural areas of Pakistan.

SPECIFIC OBJECTIVES

The Programme targets include contributing to:

1. A reduction of IMR from 85 to 55 per 1000 live births,
2. A reduction of MMR from 400 to 180 per 100,000 live births,
3. An increase in the Contraceptive Prevalence Rate from existing 22% to 42% in rural area and from 40% to 58% in urban area.
4. An increase in immunization coverage in children aged 12-35 months fully vaccinated from 45% to 80% in rural areas, and from 64% to above 90% in urban areas. (In liaison with EPI),
5. An increase TT-5 immunization coverage amongst women of childbearing age from 12% to 40%.
6. An increase in the percentage of children being exclusively breastfed till age of 6 months from existing 18% to 50%.
7. An increase in births assisted by skilled birth attendant from existing 12% to 30% in rural areas and from 43% to 80% in urban areas covered by the Programme.

Comment: Zulfi – these targets needs to match those in Table 1...I think that you will need to make the judgement on this one and not me.

The principal sources for the verification of the Programme's performance against these targets will be the "independent" Programme Evaluations and PIHS and in addition the Programme monitoring and supervisory system.

IMPLEMENTATION STRATEGIES

The objectives will be achieved through the following Implementation Strategies:

- ◆ Improvement of the utilization of health facilities by bridging the gap between the community and health services in the country through LHWs.
- ◆ Gradual integration of existing health care delivery programme like EPI, malaria Control, Nutrition, MCH within the National Programme.
- ◆ Prevention and treatment of minor ailments like primary eye illnesses, malaria, scabies, intestinal worms, anemia, ARI, diarrhea and simple injuries.
- ◆ Promotion of immunization activities and prevention of communicable diseases. This will be done in liaison with the EPI programme.
- ◆ Improvement of the nutritional status of mothers and children and reduce the prevalent malnutrition by half.
- ◆ Reorganization and integration of HMIS through the data generated by 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.
- ◆ Inter-sectoral action and coordination at all levels between the health sector and other relevant agencies.

Further details given in Section IV.

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Dated

PART 'B'

PROJECT COST AND FINANCING

- 9. Location of project:** Federal Ministry of Health
- a. Give name of place and administrative districts in which the services Centre will be provided. Family planning, MCH, Nutrition and Primary health care services will be provided to the entire country especially to less developed areas.
- b. Indicate total areas, which will be served. The entire country. Initially 100,000 LHWs (87,600 LHWs` under this PC-1) will be deployed in rural and less developed urban communities (like slums & katchi abadis). The increase in number of LHWs may be considered at a later stage.
- 10. Existing facilities:**
- a) For Health Scheme, give information about public and private sector institution in the area, their staff and equipment and the number of persons served organizations. Indicate population of the area and economic characteristics of the category of persons who are being provided services at present. The comparison of the health status of the areas to be covered by LHWs cannot be made precisely as the Programme will cover close to 70% of the communities. However Table 1 below shows basic socioeconomic characteristics of the communities covered by LHWs.
- Give statistical data about morbidity and incidence of epidemics during the last five years. Highlight the data for the area by comparing on with national average e.g. number of hospital beds in the area compared with national average. Indicate water supply and sewerage facilities in the area. Tables 2, 3 & 4 given below
- b) For family planning, give the statistical data about population age group, number of females of the fertile group. Indicate the results of knowledge attitude practice surveys and enclose copies of such reports.

Table 1

Measure	LHW Areas
General:	
% Urban	26
Income and income poverty:	
Median food and other consumption (Rupees per month) ¹	1019
% below relative poverty line ²⁺	25
Facilities and utilities:	
% of households with any toilet	63
% of households with a protected water supply	83
% of households with an electricity connection	86
% of households with a telephone connection	12
Literacy	
% of adult women literate	32
% of adult men literate	61
Media	
% of adult women ever listening to the radio	34
% of adult men ever listening to the radio	45
% of adult women ever watching television	59
% of adult men ever watching television	65
women's work, mobility and role in decision making³	
% women who do work other than household work	23
% who work away from home, of those who work	50
% who can keep some or all of the money earned, of those who work	70
% of women who approve of working outside the home	73
% who went out the village in past month unaccompanied, of those who went outside village	27
% who can go alone to clinic or hospital outside village	42
% who would usually take a decision by herself to buy medicine for a sick child	38
Community characteristics⁴	
% within 2 km of a health facility	83
% with 2 km of a female doctor	59
% with a good road into village / mohalla	77
% with mostly paved streets	57
% with a sewerage or drainage system	68
% within 2 km of a mandi market	34
Median daily wage (unskilled man, Rupees)	100

¹ Consumption per adult equivalent, standardize for price faced (household weighted).

² Relative poverty line set at two thirds of mean household consumption per adult equivalent (Rs.774/month)

³ Ever married women aged 15-49 years.

⁴ Community characteristics analyzed at household level using household weights.

Table 2
Estimated population by age group
as of mid 2003.

(Figures in Thousand)

MID 2003				
Age Group	Both sexes	%	Female	%
Under 15	63563	42.87	30640	42.87
15-19	16697	11.26	8119	11.36
20-24	13524	9.12	6604	9.24
25-29	11018	7.43	5368	7.51
30-34	8749	5.90	4224	5.91
35-39	7118	4.80	3381	4.73
40-44	5776	3.90	2752	3.85
45-49	4864	3.28	2323	3.25
49+	16979	11.45	8062	11.28
Total	148287	100	71473	100

Source: Based on Projections made by National Institute of Population Studies.

Table 3

Estimated number of fertile and married women of age group 15-49, number of acceptors and acceptors as percent of married women for midyear 2002-03.

(Figure in 000)

		2002-03
1.	Number of female in fertile age group (15-49).	32770
2.	Number of married women in the fertile age group (15-49).	22984
3.	Number of acceptors including carry over.	6895
4.	Acceptors as percent of married women aged (15-49)	30.00%

Estimates of CBR, CDR and rate of population growth for the mid year 2003, 2008 and 2011

	2003	2008	2011
* 1. CBR	30.0	28	25
* 2. CDR	9.0	8	7.5
* 3. Growth Rate	2.13	1.75	1.6

iv. **Information about knowledge, attitude and practice based on the Pakistan Reproductive Health and Family Planning Survey 2000-2001 conducted by the National Institute of Population Studies.**

1. **Awareness about contraceptives.**

The survey revealed that 95.7 percent of the respondents had knowledge of at least one contraceptive method. The most commonly known methods were oral pill (91.1%) female sterilization (88.8%) injectables (90.2%) and IUD (84.4%).

2. **Contraceptive Use (2000-2001)**

	Ever used	Current use
Pakistan	40.2%	27.6%
Major Urban	56.5%	45.6%
Other Urban	39.2%	29.8%
Rural	31.8%	21.7%

3. **General awareness of the need to regulate fertility.**

- (a) More than one-third (33 percent) of women reported that they wanted no more children in the future.
- (b) Another 12.1 percent women said that they wanted to wait at least for two years before having another child.

11. **Description of Project**

For Health Sector give brief history, proposed of facilities & justification of the project. This should be elaborated to reveal balance between preventive and curative services and between the various facilities in hospital e.g. out-door and in-door surgical medical facilities etc.

Pakistan's health indicators such as life expectancy of 63 years, infant mortality rate 85/1000, crude birth rate of 30/1000, crude date rate of 9/1000, the maternal mortality rate, the state of prevalence of infectious diseases and access to health care facilities are among the worst even in South Asia. The less than 3.8% of allocation for health in national budget compares unfavorably with Iran (7.9%), Sri Lanka (4.8%) Thailand (7.4%), Philippines (4.2%), Bangladesh (4.8%) and Nepal (4.7%). While the government's allocation towards health care has remained well below 1% of the GNP, the total expenditure including that of the private sector has never exceeded 3.5% of the GNP. Figures for India, read 1.6% of the GNP in public sector

and 6% in total. The baseline figure prescribed by the World Health Organization (WHO) is 5% of the GNP. Since independence public health financing in the country has given priority to curative sector. Although a considerable number of health facilities have been made, the rate of their utilization is limited. Recognizing this, the government of Pakistan launched in 1994 the Prime Minister's Programme for Family Planning and Primary Health Care (PMP-FPPHC) a country wide Programme, under the Ministry of Health, for delivering essential primary health care services to the community through female community health workers. The name of the Programme was later changed to the National Programme for Family Planning and Primary Health Care (NP-FPPHC), but the essential characteristics of the Programme have remained the same. The National Programme for Family Planning and Primary Health Care is funded through 2003. The government of Pakistan, considering its importance and achievements, has decided to continue the Programme till 2011 including the Programme in its 10 year Perspective Development Plan.

In the National Health Policy of 2001, 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.

For Social Sector Projects, give proposed facilities justification and targets from year to year. For all the projects given details of administrative structure for implementing the projects.

The implementation of the Programme at the operational level will be carried out by the provincial health departments, with maximum authority up to the FLCF level. The administrative structure and functions at various levels is attached.

12. Give date when capital expenditure estimates were prepared. If prepared more than one year ago, confirm if they are still valid.

5th December 2002

13. Give breakdown capital cost year wise covering the whole of investment as indicated below.

ANNEXURE II

14. Basic cost of estimates details

The costs have been estimated on the prevailing rate of the market.

15. Estimates of annual recurring expenditure after completion of project (also indicate the source of financing recurring expenditure).

Rs. 4,448.164 million. The source of funding will be the GoP resources from Federal, Provincial &/or district funds. Funds may be available from donor/lending agencies.

Establishment Charges

Salaries/Over Time/Medical/Allowances/Honorarium/Residential Rent & Pension Contribution of PIUs' Staff	102.916
Salaries of LHWs	2,371.793
Salaries of Supervisors	190.384
Salary of Drivers (with Supervisors, FPO & in PIUs)	164.640
Total Establishment Charges	2,829.733

Repair of Durable Goods

Repair/Maintenance of vehicles	107.949
Repair of Equipment & Other Stores	5.000
Total Repair of Durable Goods	112.949

Commodities and Services

TA / DA for all staff	25.693
Transportation Charges (PPIUs & DPIUs)	8.094
POL	179.535
Rent of Official Building/Warehouse	12.260
Media Campaign	106.838
Purchase of Medicines, Contraceptives & Non Drug Items	1,085.844
Total Commodities and Services	1,418.263

Total **4,360.945**

Contingencies @ 2% (to cater for expenditure on postage, telephone, utilities, stationary, etc.) **87.219**

GRAND TOTAL **4,448.164**

Present position regarding availability, component of project:

Sources	Amount of Capital expenditure	Amount for recurring expenditure.
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a) Government Sources:-

i. Grant	Rs. 8 billion	
ii. Loan		
iii. Direct Government Expenditures.	Rs. 22,460.660 million	4,448.164 Millions per year

b) Sponsoring Agency's own fund.

c) Local body service, if any

d) Non Government borrowing

e) Other Sources (e.g. recoveries)

21. Results of the Project:-

- i) Direct benefits:
No of persons served
- 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 decrease in IMR, MMR and increase in CPR, Ante natal care, EPI coverage, ORS utilization, health education and utilization of health facilities. This, in turn will improve the impact indicators such as infant and maternal mortality, nutrition of children 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 is close to 100 million.**
- ii) Indirect and other benefits contribution towards specific targets/social objectives.
- 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.
- Providing means of respectable livelihood to women in the rural communities of the country will contribute towards women empowerment. The LHWs will also be helpful in promotion of girls' education.

22. a) Approximate number and category of job opportunities likely to be created indirectly as result of.

- i. Implementation project The Programme will create 100,000 jobs for females at the grass root level (87,600 jobs under this PC-1), 4,000 LHWs' supervisors and supporting staff like drivers in District Health System etc.

- ii. Operation of project Certain essential posts have been requested for effective supervision and operation of the Programme. The detail is at **Annexure**.

- b) Economic life of component of Project (building, equipment etc.)
 - i. No buildings are involved
 - ii. Motor vehicles will have an economic life of 7 years.

PART “C”

PROJECT REQUIREMENTS

23. (a) Manpower

1. Professional & Teaching
2. Administrative, Executive Managerial.
3. Clerical
4. Sales
5. Services
6. Skilled
7. Un-Skilled
8. Other

Existing manpower of the health departments at Districts, Tehsil and RHC/BHU level supported by newly deployed LHWs. Four thousand drivers will be recruited for supervision. About 120 account supervisors, one in each district will be recruited for financial management at District Level, the number may increase depending on the number of districts and the number of LHWs in districts. For districts with more than 800 LHWs, two Accounts Supervisors may be recruited. One Supervisor for every 25 LHWs (1 LHS for every 20 LHWs in hard areas) will be selected i.e 4000 LHWs' Supervisors (3,544 LHS under this PC-1) will be recruited for supportive supervision of 100,000 LHWs (87,600 LHWs under this PC-1). In addition certain staff members of essential categories will be employed on contract/ deputation basis for federal and provincial PIUs for effective implementation of the Programme. Details in ANNEX XIII.

(b) Likely shortage of manpower by occupation.

There may be some shortage of adequately educated women in certain areas for recruitment as LHWs.

(c) Steps to be taken to assure availability of manpower.

The appointments will be made on contract/ deputation/ transfer basis for the project life in accordance with govt. rules and required qualifications/ experience for staff of the federal and provincial PIUs. However, to expedite the process, appointments will be conducted through the Programme coordinator without referring the cases to Federal Public Services Commission. Recruitment and deployment of LHWs, Supervisors and Drivers will also be conducted by PIUs on contract under special rules.

To address the likely shortage of adequately educated women for

recruitment as LHWs, steps would be taken in collaboration with the education Dept., NGOs and certain donors for designing and implementing condensed educational courses.

(d) Approximate number of persons required to be trained per year (locally and abroad) and the kind of skills to be learnt.

The training of 100,000 LHWs in phased manner has been started in 1994-95 and will be completed in 2005. About 70,000 LHWs are providing services in the community in the year 2002. Under WHP 8,000 and 4,400 under RHP will also be recruited by the end of the year 2005. The LHWs recruited under WHP and RHP will be transferred to National Programme for FP & PHC.
The target of training 100,000 LHWs will be achieved by June 2005.
The Training of Trainers for the LHWs will also be carried out.
In order to meet shortfall due to attrition, 5000 LHWs and corresponding number of Supervisors will be trained annually for the life of the Programme.

(e) Give total capital outlay, give the capital cost of mobilizing one worker for one shift.

NA

24. Physical and other facilities required for project.

NA

Items	Total	To be provided from the project itself.	To be provided from the public utility.
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- a) Access road
- b) Power supply.
- c) Water & other utilities
- d) Education facilities
- e) Housing by type
- f) Others.

25. Materials, supplies and equipment requirements.

The RHC/BHUs. THQ/MCH/ Municipal hospitals and other FLCF will be the venue of training and will manage necessary logistics, supply and supervision etc to LHWs. The requirements will include drugs, medicines, contraceptives, vehicles, training manuals, charts, MIS instruments (forms/registers etc), computers, LHW kit bags, weighing scales, health house boards etc.

26. In the case of imported material and equipment for execution, indicate:

Limited quantity of supplies and equipments required by the Programme may be imported if not obtained locally (LHW kit, supplies, essential drugs, contraceptives, vehicle etc).

Contraceptives will be procured through International Competitive Bidding or through UNFPA. Foreign exchange would be required for this activity.

a) Justification for imports.

Only if not available locally or cheaper commodities are available internationally.

b) Proposed source/
sources of supply.

International manufacturers, suppliers and Donor agencies e.g. UNICEF, UNFPA, DFID etc

I. INTRODUCTION

The health status of the people of Pakistan is well below the averages for all low-income countries in key indicators, although its GNP per capita is above the average for low-income countries. While the health of the population in Pakistan has improved over the past decades, the level of improvement has not been satisfactory. Contributing factors include poverty, low literacy, lack of proper sanitation and water. There are also weaknesses in the health care delivery system including insufficient focus on preventive interventions, gender imbalances, weak human resource development and insufficient funds.

Total health expenditure on health as a percentage of GDP declined between 1991-92 and 1997-98 from 0.76 to 0.71. The percentage of total government health expenditure in relation to GDP in Pakistan is very low by Asian standards.

There is need therefore for enhanced budget allocation to the health sector.

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 almost all districts of Pakistan providing essential primary health care services to the community through female community health workers (the Lady Health Worker). The Programme is funded till June 2003.

It has been demonstrated that the Programme is almost 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 until 2011 and has included the Programme in its 10 year Perspective Development Plan with an allocation of Rs. 23,120 million.

⁵ The PMP-FP&PHC has since been renamed 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.

A strategic plan (2002) has been prepared (see annexure XVIII) through a consultative process with the involvement of key stakeholders and forms a basis for the development of this PC-1. The consultative process included senior officers of the Ministry of Health, Ministry of Population Welfare, Ministry of Planning & Development, Ministry of Finance, Provincial Departments of Health, Finance, P&D, elected representatives i.e. Nazims/councilors, representatives from National Reconstruction Bureau, National Commission for Human Development, donor agencies, NGOs, teaching/academic institutions and LHWs/Supervisors. This was achieved through a series of workshops and meetings. Five provincial and one national workshop was organized during which inputs from different stakeholders were obtained.

The PC 1 is prepared for the period of 2003 – 2008, however the guidelines given in the Strategic Plan, along with the experience from the implementation of the Programme and the different pilot initiatives will be utilized for further extension of the Programme.

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

The Programme places special emphasis on maternal and child healthcare (MCH). 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 MCH services such as antenatal (e.g. screening of pregnant women to identify those at risk, immunization of pregnant women with tetanus toxoid to prevent neonatal tetanus and tetanus in the mother⁶), natal (e.g. helping the mothers get access to skilled birth attendants and proper care during delivery) postnatal, childcare. It must be recognized however that health centers and Tehsil headquarter hospitals must be able to deliver effective care of antenatal and postnatal complications, thus, ensuring a functional chain of comprehensive MCH services. It is imperative that the Traditional Birth Attendants (TBAs) and the 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.

The government has identified the high maternal mortality as a major problem and is working on various strategies for addressing this problem. One of the strategies is to increase the availability of skilled birth attendants across the country. The training of an adequate number of Midwives is being considered. The National Programme for FP & PHC as the major initiative of the government to provide MCH services to the communities provides a logical base for the launch of these activities. Based on the strategies adopted by the government, the National Programme funds may be used for providing supervisory support for the activities in the overall MCH Programme. The funds available for drugs and training may be used for strengthening the MCH Programme.

The LHWs will be provided additional training in Safe motherhood to enable them provide the expectant mothers better advice, counseling and referral. The LHWs will be encouraged to work and provide support to the expectant mothers and the birth attendants in ensuring better ante natal, natal and post natal care.

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.

III. THE IMPLEMENTATION PLAN

There will be two phases of implementation.

PHASE I: Consolidation and Expansion From July 2003-June 2005, the activities of the Programme will be consolidated and services will be expanded. At the end of this phase there will be 100,000 fully trained LHWs (87,600 LHWs under this PC-1, 8,000 under WHP and 2,200 under RHP), and 4000 LHW Supervisors along with other necessary staff, equipment and supplies. The improved training, implementation, monitoring and supervision mechanisms will be put in place. At the end of this phase there will be an extensive evaluation of the Programme.

PHASE II: Development of a Sustainable Programme From July 2005-June 2008, the capacity building process at the Provincial and District levels will be completed. During these three years different models for the development of a sustainable and viable structure for the Programme including the possibility of transferring management functions to the Provinces and the Districts will be piloted in selected districts. At the end of this period, there would be another evaluation of the Programme.

Based on the Strategic Plan, the findings from the implementation of the Programme and the Pilot initiatives, a comprehensive Plan for the future structure and activities of the Programme will be prepared in consultation with major stakeholders and the Provincial governments. If required a new PC1 will then be prepared. By the end of 2011 and the current Perspective Plan period, it is expected that a viable structure will be developed with assured sources of funding.

IV. OBJECTIVES

GOALS

The goals of the Programme are to:

1. Develop the necessary health manpower in support of the Programme by selection, training and deployment of 100,000 LHWs throughout the country.
2. Address the primary health care (PHC) problems in the community, providing promotive, preventive, curative and rehabilitative services to which the entire population has effective access.
3. Bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support.
4. Expand the family planning services availability in urban slums and rural areas of Pakistan.

SPECIFIC OBJECTIVES:

The Programme targets include contributing to

1. A reduction of IMR from 85 to 55 per 1000 live births,
2. A reduction of MMR from 400 to 180 per 100,000 live births,
3. An increase in the Contraceptive Prevalence Rate from existing 22% to 42% in rural area and from 40% to 58% in urban area.
4. An increase in immunization coverage in children aged 12-35 months fully vaccinated from 45% to 80% in rural areas, and from 64% to above 90% in urban areas. (In liaison with EPI),
5. An increase TT-5 immunization coverage amongst women of child bearing age from 12% to 40%.
6. An increase in the percentage of children being exclusively breastfed till age of 6 months from existing 18% (current) to 50%.
7. An increase in births assisted by skilled birth attendant from existing 12% to 30% in rural areas and from 43% to 80% in urban areas covered by the Programme.

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

IMPLEMENTATION STRATEGIES

The objectives will be achieved through the following implementation strategies

- Developing health manpower by selecting, training and deploying 100,000 LHWs (87,600 under this PC-1, 8,000 under WHP and 4,400 under RHP) throughout the country.
- Improving the utilization of health facilities by bridging the gap between the community and health services in the country through the referral services of the LHWs.
- Gradually integrating existing health care delivery programmes like EPI, malaria Control, Nutrition, MCH within the NP-FP&PHC.
- Preventing and treating minor ailments like primary eye illnesses, malaria, scabies, intestinal worms, anemia, ARI, diarrhea and simple injuries.
- Promoting immunization activities and prevention of communicable diseases in liaison with the EPI programme.
- Improving the nutritional status of mothers and children and reducing the prevalent malnutrition by half.
- Reorganizing and integrating the Health Management Information System (HMIS) through data generated by LHWs.
- Creating an efficient supply system on a continuing basis in order to assure the regular delivery of essential drugs, vaccines and family planning materials.
- Promoting inter-sectoral action and coordination at all levels between the health sector and other relevant agencies.
- Ensuring close coordination and collaboration between the Federal, Provincial and District governments.
- Providing technical support for introducing necessary structure and administrative changes (including revision of job descriptions) to the Provincial and District governments, to provide necessary support mechanism to LHWs.
- Ensuring satisfactory staff levels at health centers where LHWs are recruited including the deployment of at least one female worker (WMO, LHV, FHT) at each facility.
- Utilizing technologies that are scientifically sound, adaptable to local circumstances, acceptable by those who use these and affordable in the context of available resources.
- Developing appropriate managerial capacity to support the Programme implementation.
- Mobilizing effective support of opinion leaders, youth, women groups, teachers, religious leaders (particularly at the local level)
 - Organizing health committees and women's groups for the purpose of systematic institution based creation of awareness, and changing attitudes. Review and develop role of health committees
 - Supporting and strengthening the existing family planning services.
 - Making optimum use of the mass media.

- Organizing operations research to support, improve and refine the strategies for more effective implementation of the Programme activities.
- Focusing the leadership messages of the managers and staff in the Implementation Units at the Federal, Provincial and District levels on improved service quality
- Provision of better service quality and service levels through:
 - improving support systems (training, supervision, supplies, salaries)
 - addressing issues impacting on motivation of staff throughout the Programme (e.g. providing adequate resources, salaries paid on time and keeping pace with inflation, clarity of role, clear leadership)
 - supporting development of management capabilities to address expansion and service quality
 - enhancing accountability through district and programme level mechanisms
- Reviewing role of partnership arrangements with NGOs, CBOs, Citizens Community Boards and Womens' Groups
- Decentralizing decision making within the system based on readiness criteria in Provincial and District capabilities along with development of accountability mechanisms.
- Further development of Management Information Systems (MIS)
- Prioritizing recruitment to underserved and poor rural areas.

V. 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 most recent study 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 (*Report of the Third Evaluation – Oxford Policy Management*).

PROGRAMME IMPACTS INCLUDE:

- *A large and positive impact on childhood vaccination rates,*
- *A large and positive impact on reversible methods of contraception (pills, condoms) especially in rural areas, and on all methods of modern contraception in rural areas,*
- *The increased uptake of antenatal services,*
- *The increased provision of iron tablets to pregnant women,*
- *Increased levels of child growth monitoring,*
- *Lower rates of childhood diarrhea,*
- *More positive attitudes to family planning.*

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 training, these health workers are capable of delivering family planning services and carrying out MCH 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 of 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.

There is a special provision for educating people regarding AIDS and STIs prevention.

IMMUNIZATION

At the community level the immunization services against the six vaccine preventable disease are primarily carried out through the use of portable vaccine carriers as outreach activities by the designated Vaccinators. The LHWs will receive training in giving vaccines through a phased strategy. Half

of the LHWs have been trained in giving vaccines and have proven their abilities in vaccinating more than five million women of child bearing age for Tetanus. In the areas where LHWs have not been trained in giving vaccines, they will operate as a liaison between the existing EPI services and the community. Detailed Policy document annexed at Annexure XVII.

SIMPLE CURATIVE CARE

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 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 also involved in the management of TB patients through the DOTS strategy of the National TB Control Programme.

VI. DEVELOPMENT OF HUMAN RESOURCES

The development of human resources at all levels- not just the LHWs is very important for the Programme. Efforts will be made over the life of the Programme to provide the highest quality of trainers, supervisors, managers and monitoring officers.

SELECTION AND RECRUITMENT

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.

There have been concerns regarding the equity between the different parts of the country in terms of selection of LHWs. In the remote and underserved areas of the country where the need for having LHWs may be the greatest there is less chance of finding suitable local women with 8 years of education. Intensive, accelerated education courses of 6 months to a year will be designed and implemented with the support from government and NGO adult literacy programmes to enable the girls with primary education get middle school competency (no stipend will be paid to the trainees during the accelerated education courses). This strategy will expand the pool of potential LHWs in remote rural areas.

The main criteria for allocating LHWs to different catchments areas are the population and literacy rates. The Programme will also make efforts to consider factors such as population, maternal and infant mortality rates, literacy rates, state of the health facilities etc while allocating LHWs to different areas.

A. Target

The Programme will achieve the recruitment and training target of 100,000 LHWs and 4000 Supervisors in Phase one (see below) by June 2005. *It has been shown that the attrition rate for LHWs is about 5% per annum. The Programme will carry out recruitment and training activities in the remaining two phases to cope with the attrition. This will require recruitment and training of around 5000 LHWs annually. It will also be important for vacant supervisor positions to be filled.*

B. Catchment area for LHWs.

One LHW will be selected to serve a catchment area with a population of 1,000 residents. In hard areas where the population tends to be scattered, the population in the catchment area of the LHW may be low e.g. 700, while the catchment area in densely populated areas may be 1200. The catchment 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 area. There should be only one LHW in a cluster of 100 to 200 households.

C. 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 50 years. (up to 18 years only if she is married)
- 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.

The final selection of the LHWs will be made after careful scrutiny of the documents and the residential status of the applicants. The selected LHWs will be issued recruitment orders from the office of the Executive District Officer (Health)/DHO/DOH on the recommendation of the Selection Committee at the FLCF.

D. The selection committee

It will be constituted as follows:

Medical Officer In-charge -FLCF (chairman)

Women Medical Officer- FLCF

Lady Health Visitor (LHV) / Female Medical Technician (FMT) -FLCF

Male Health Technician (MHT)/ Dispenser

Member nominated by the local community preferably the local elected Union Council Nazim/ councilor.

Selection of the LHW will be made by the selection committee and approved by the EDO-H after verification that selection criteria have been met by the Programme.

E. Identification of LHWs

The Selection Committee should meet with community organizations if active in the area and seek their support and guidance in identifying appropriate candidates. In areas where community organizations do not exist, the committee should meet with key members of that community, to discuss and obtain their support for the Programme. There should be dissemination of information through print media, and local announcements.

F. Training of LHWs

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

The district and FLCF staff involved in training of LHWs will not be transferred during the 15 months training period of LHWs to ensure continuity of training. The Programme will train adequate number of health facility staff in all the districts so that even if staff has to be transferred, they should be replaced by staff that are already trained as LHW trainers.

“Integrated training:” (initial 3 months training)

The first phase of basic training will be for five days a week for three months. The newly recruited LHWs will be trained to cover the major PHC subjects, which include immunization, diarrhea control, reproductive health including maternal and child health & family planning, nutrition, common ailments, personal hygiene along with education on community organization and interpersonal communication skills. As the Programme consolidates and strengthens its impact over the next few years additional subjects will be considered for introduction in a phased manner.

“Task Based Training”: (12 months training)

The second phase of training lasts for twelve months with three weeks of fieldwork followed by one week 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. The training of LHWs will be linked to their scope of work, to the problems they have to solve and to their ability to carry out specified tasks. The training will be participatory and instrumental in the process of helping LHWs to develop new skills, acquire knowledge, and apply what they are learning to their day-to-day working environment.

They will be trained at the FLCF where they were recruited and received their initial three-month training. During this phase, the LHWs will work in their communities for three weeks and come to the training site for one week each month.

“Continuing Training”: (after completion of 15 months training)

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

Refresher Training:

One of the issues identified during routine supervision and the evaluation studies has been the need for periodic refresher training for the LHWs. Special training packages will be designed for refresher training sessions for the LHWs in key areas. It is envisaged that the LHWs will be given fifteen days training each year after the completion of the fifteen-month training and in addition to the continuing education.

During the refresher training sessions, the LHWs would be paid Rs 50 per day in addition to salary to cover travel costs and refreshment etc. In order to provide incentive to the trainers at the FLCF level, Rs 200 per day would be paid to the FLCF trainers actually involved in refresher training of the LHWs.

Training on safe Motherhood:

In view of the high maternal mortality in the country, the LHWs will be provided additional training on common problems related to maternal health especially in antenatal, natal and post natal care. Efforts will be made to provide opportunities to the LHWs to observe child deliveries in different settings. This will enable the LHWs to provide counseling to the mothers and also help them ensure that the birth attendants provide better services to the communities.

G. Training of Trainers

It has been shown conclusively in various Programmes around the world that training plays an important role in achievement of service delivery targets. In the case of the NP-FP&PHC various evaluations and monitoring reports have demonstrated that better quality training leads to improved knowledge leading to better performance among the LHWs and their Supervisors. The Third Evaluation of the Programme has also reported that LHWs with better knowledge levels have performed better. The Evaluation has also shown that the training system adopted in the National Programme has low financial costs as it uses FLCF staff and facilities for the training. The training of LHWs in a manner that is able to ensure that LHWs, acquire the necessary ability and competence, needs to be preceded by adequate training of provincial, district and FLCF trainers.

The provincial team will be oriented for nine days by a team of federal 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 MCH 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.

Provincial teams will subsequently train the district level trainers from their own province. A team of five to seven provincial trainers will be assigned for each province. 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:

- Assistant District Health Officer
- Medical Officer
- Women Medical Officer
- Senior Technician
- Assistant Inspectors Health Services
- Senior Lady Health Visitor
- Senior Nurse at DHQ

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. 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 Officer of Health (DOH) should ensure that at least 2 members, of whom one should be female, must be present at FLCF before the initiation of training.

The district and FLCF training sessions will be conducted for a period of 9 days followed by 3 days of assessment workshop to ensure the quality of training. While training FLCF trainers, the district trainers will be assisted by provincial trainers to guarantee the quality of training and ensure that the training objectives are being met. This interaction makes it possible to identify performance problems and provide timely and appropriated support.

Since the initiation of the Programme, close to eight thousand LHW trainers have been trained. The training of 9000 trainers has been planned in alternate years. This will be directed at refresher training to the experienced trainers in addition to training new trainers when and where required. The Programme will maintain a database of the staff trained at various levels.

H. Training allowance

The FLCF training team (MO/LHV/FHT/MHT/Dispenser) will be paid 20% of their current salary per month during the 15 months training of LHWs. For refresher training, the trainers involved in training will be paid Rs 200 per day.

I. Training sites for LHWs

FLCFs like Basic Health Units (BHUs), Rural Health Centres (RHCs), Tehsil hospitals, MCH centers, municipal dispensaries and other health centers in the area both in the government and non-government sectors will be used as training centers. Facilities will be preferred as training sites where doctors and LHVs /FHTs are in position.

VII. THE SCOPE OF WORK FOR LHWS

The scope of work of LHWS will be to provide PHC services to the communities in her catchment area.

- 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 family planning, primary health care and related community development activities.
- To discuss with the community, issues related to better health, hygiene, nutrition, sanitation and family planning emphasizing their benefits towards improved quality of life.
- Act as a liaison between formal health system and the people and ensure coordinated support from NGOs and other departments.
- To register all family members in the catchment area especially the eligible couples (married women age 15-49 years) in their respective area, and maintaining up to date information. LHWS will visit 5-7 households every working day and ensure a re-visit every two months. She will keep in close liaison with influential women of her area including lady teachers, traditional birth attendants and satisfied clients.
- To motivate and counsel clients for adoption and continuation of family planning methods. She will provide condoms, oral pills to eligible couples in the community and inform them about proper use and possible side effects; to refer clients needing IUD insertions, contraceptive surgery and injectables to the nearest FLCF in the government or NGO sector (FWC, RHSC, RHCs,/ THQ/DHQ Hospital etc).
- To coordinate with local TBAs/midwives or other skilled birth attendants and local health facilities for appropriate antenatal, natal and postnatal services.
- 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 breast-feeding and weaning practices, maternal nutrition and macronutrient malnutrition.
- To coordinate with EPI for immunization of mothers against tetanus and children against six immunizable diseases. The LHWS trained in giving vaccines themselves will ensure timely vaccinations 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 etc. the LHWS will be involved in the surveillance activities.
- To carry out prevention and treatment of common ailments e.g. malaria, diarrhea diseases, acute respiratory infections, tuberculosis, intestinal parasites, primary eye care, scabies, snake bites, 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 DOTS and Malaria control.

- To disseminate health education message on individual and community hygiene and sanitation as well as information regarding preventive measure against spread of AIDS.
- To submit monthly progress report to In charge health center containing information regarding all activities carried out by her including the home visits, number of family planning acceptors by methods and stock position of contraceptives and medicines.

While recognizing that PHC is a broad and comprehensive concept, it is recommended that the focus of the LHWs should be on maternal and child health. The demands on LHWs will be many especially in view of the double burden of disease i.e. the communicable diseases and the non-communicable diseases. It will therefore be necessary for the Programme to guard against overburdening the LHWs. The involvement of LHWs in new areas will have to be cleared by the Programme Review Committee after a detailed study and analysis of the benefits for the community and the Programme. For piloting of adoption of new strategies and involvement of LHWs in additional assignments, proposals will be cleared by the committee headed by National Coordinator and comprising of National Advisor, Deputy National Coordinator and two Provincial Coordinators.

VIII. RECRUITMENT / REMUNERATION FOR LHWS

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 letter for recruitment of LHWS will be issued by the EDO (H)/DHO based on the recommendations of the selection committees at the FLCF level. During initial training of three months they will be paid Rs. 50 per day for first three months followed by Rs.1600/- per month. In order to cope with the inflation and as an incentive an annual increase of Rs 100 in the stipend will be awarded every year to the LHWS. This increase will be applicable to the salaries of newly recruited LHWS as well. The LHWS, 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 full training failing which they will have to return the salaries and equipment (LHWS kit bag, weighing scales etc) they have received. The LHWS selected will be supervised closely to ensure provision of quality services to the communities. Those LHWS not fulfilling the selection criteria or those not performing their duties satisfactorily will be liable to termination of contract by the District Head of the health department i.e. EDO (H)/DHO.

IX. SUPERVISION

Adequate supervision is one of the key components for a successful community health programme. The National Programme for FP & PHC has an elaborate and multi tiered supervisory system. The cadre of LHW Supervisors has been developed to provide supervisory support to the LHWs on day-to-day basis.

The LHS uses a structured checklist for monitoring purposes. The Programme has a provision for one LHS for 25 LHWs. At the Provincial level- Field Programme Officers (FPOs) are employed on contract to monitor the Programme in two or three districts and report back to the FPIU/PPIU /DPIU on monthly basis.

In the case of non-performance the DHO has the authority to end the LHW's contract. Feedback to the DHO and the District Coordinator can occur via the community, the health facility, other DoH professionals, the LHS and the Field Programme Officer.

The quality of support received by LHWs forms an important dimension of the successful implementation of the Programme. The supervisory support both from the FLCF staff and the community is of considerable importance in order to ensure the adequate performance of family planning and PHC activities by the LHWs.

The performance of LHWs will be closely monitored through the field supervisors. A special strategy has been devised to assess their performance and suitable action including additional training will be initiated as per given formula. If LHWs fails to perform satisfactory level even after repeated training, LHW will be relieved of her assignment. 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.

A. Selection criteria for LHW supervisors:

- Female
- Age: 22-45 years
- Education: (In order of preference)
 - LHV/Graduate or
 - LHW Intermediate with one year experience as LHW or
 - Intermediate
- Preferably one-year relevant experience.
- Local resident of the area

B. Selection committee for supervisors:

The selection committee for the recruitment of LHW Supervisors will include:

- 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

- Representative of the community preferably Elected Union Council Nazim / Councilor etc.

The procedures followed for recruitment of LHW Supervisors will include the circulation of the vacant positions in the newspapers, proper scrutiny of the documents and residential status of the applicants and test/interview by the selection committee. The appointment letters for recruitment of Supervisors will be issued by the EDO(H)/DHO after the approval of the PPIU concerned. The services of the Supervisors will be liable for termination in case of unsatisfactory performance etc by the EDO(H)/DHO.

The LHW 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 full training failing which they will have to return the salaries they have received.

C. Remuneration for supervisors

LHW-supervisors will be employed on contract initially for one year but their services are likely to continue for the life of the Programme. They will be paid Rs. 3300 per month as training allowance for three months and later on the same amount will be paid as fixed salary. An annual increase of Rs 200 per month will be given.

Those LHW-supervisors working without vehicles will get Rs.70/- as fixed travel allowance per field visit day.

LHS will be provided POL for the vehicles on an average of 70 liters/ month/ LHS. 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.

The vehicles provided for the Programme will not be a part of the common general pool vehicles at the district level. The use of the vehicles will be restricted to the Programme activities in the district.

D. Training of Trainers for Supervisors

The trainers for the Supervisors would be from amongst the senior health staff, at least one of whom should be female with adequate clinical knowledge and experience.

The trainers for the Supervisors will receive ToT for a total of 15 days comprising of 9 day training on the ToT manual and 6 days training on supervision.

E. Training schedule for supervisors

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

1. 02 months TOT manual + 03 weeks LHS manual + one week practical training.

2. 03 months field / on job training (First two weeks in the field and last two weeks of every month class room training) on LHS manual with more emphasis on practical training with audiovisual support and role-play.
3. 46 months training (first 3 weeks of every month in the field and last week for class room training) more emphasis in practical training in the areas of EPI, pediatrics, Eye, midwifery/Gynae/ Obs.

The venue for the training of Supervisors will be District or Tehsil Headquarter hospital (RHS Center for FP services EDO (H) office for HMIS and CDC lab for slide preparations). The theoretical training may also be held at the District Health Development Centers and the Nursing/paramedic training schools.

The Supervisors will be given refresher training as and when required.

F. 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, or MA Sociology, experience of preferably two years in public health. In order to provide an incentive to the good performing staff among the Lady Health Worker Supervisors (LHS), the Supervisors with Masters degree (in any field) with two years experience of working as LHW Supervisor will 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.

One FPO will be required to cover two to three districts. The FPO will be provided with a vehicle along with a driver and POL for the vehicle.

Field Programme Officers will also be recruited at the FPIU – 2 each for all the four provinces and one each for the regions i.e. FANA, FATA, ICT & AJ&K. The FPOs at the FPIU will be in BPS 18. The FPOs at the FPIU under the supervision and guidance of the Monitoring Officer will monitor the performance of the FPOs and the monitoring units of the Provincial PIUs. The FPOs at the FPIU will preferably have a postgraduate degree/diploma in Public health or two years working experience in the Programme.

G. Logistics support to the supervisors

To ensure close monitoring/ supervision, regular field visits of all level public health managers, including programme coordinators, field programme officer, EDO-Health/ DOH, district coordinators will be undertaken. To facilitate these field visits Locally manufactured 800cc Pick-ups will be provided for LHW-Supervisors while Locally manufactured 800cc vans for district PIUs and 4x4 Locally manufactured jeeps for provincial, federal PIUs and field programme officers will also be provided. For certain hard areas, the jeeps will also be given to district PIUs and LHW-supervisors instead of pick-ups. For each

vehicle for supervisors, one driver from the same community will be recruited on contract basis. The salary of the drivers with the Supervisors and the FPOs will be Rs 2400 per month, with an annual increase of Rs 100 in their salary. While the drivers assigned with the vehicles provided for the LHS have to travel within the catchment area, they would not be entitled to DA. The drivers assigned for the vehicles for field duty by the FPOs will be provided Rs 100 as DA for nights spent outside their duty stations (maximum of 20 days). The drivers at the FPIU, PPIU and the DPIU will be recruited on contract basis in BPS 4. The drivers for the FPIU, PPIU and DPIU will also be eligible to receive DA as per government rules.

Those LHW Supervisors who are not provided with vehicles will be paid Rs 70 per day of field visits as Fixed Travel Allowance (FTA).

H. Supervisory functions

The field supervisors will be trained on specially designed curriculum and they will use the Programme checklist during field visits. Specific checklist and feedback report for supervisors will also be developed. Their main functions are:

- To provide support and guidance.
- To ensure adequate performance of LHWs regarding delivery of primary health care and Family planning services.
- To assess the level of community participation and involvement in support of LHW and the Programme.
- To identify deficiencies in communication skills.
- To check whether the eligible couples have been registered and contacted regularly for motivation and delivery of family planning services and to find out reasons for non-acceptance and to assist in the motivation and service delivery of hard-core cases.
- To provide support and supervise for access to skilled birth attendants.
- To carry out corrective measures for improve the performance of LHWs as per given guidelines.

X. URBAN COMPONENT

The National Programme for FP & PHC activities were launched in the urban slums following a decision of the Social Sector Committee of the cabinet in 1995. Only the urban slums, where the health facilities and health indicators are comparable to the rural areas were to be covered.

One of the conclusions of the third evaluation of the Programme was that “there is less evidence for the Programme having had an impact in urban areas. This suggests that future expansion should be largely focused on rural areas; the cost effectiveness of any further expansion in urban areas needs to be carefully considered, although the survey data does not provide sufficient grounds to reject it outright.” Based on this recommendation coming out of an elaborate and extensive evaluation, the further recruitment in urban areas will be stopped in the coming years. The LHWs and Supervisors already working will continue to be supported however no new recruitments will be made in urban areas.

XI. PROGRAMME IMPLEMENTATION UNITS (PIUS)

For the smooth running and better implementation and supervision, it was decided to form Programme Implementation Units (PIUs) at federal, provincial and district levels.

FEDERAL PIU

The Federal PIU will be headed by the National Coordinator. In order to promote integration of the PHC activities the Deputy Director General, PHC will be assigned the responsibilities of the National Coordinator. 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:

- 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.
- National reporting on all Programme activities.
- Monitoring and Evaluation of the Programme activities throughout the country.
- Development of Training material and planning of training activities based on the policies of the Programme to ensure uniformity across the country.
- 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.
- Resource mobilization from government sources and through partnerships with other donor agencies as per government approved procedures.
- Distribution of funds to the PPIUs.
- Operational Planning and budgeting, Financial Accounting and internal auditing.
- Development and implementation of an effective MIS.
- Development and implementation of campaign for mass awareness creation through mass media.
- 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 role of the FPIU after 2008 will be reviewed in light of the government policies, discussions with Provincial and district governments and the results of the pilot initiatives through the Inter provincial Committee on the Decentralization of the Programme.

PROVINCIAL PIU:

A total of eight PPIUs will be established; 4 in the Provinces i.e Sindh, Punjab, Baluchistan, and NWFP and one each in the 4 'regions' i.e. FANA, 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 assigned the duties of the Provincial / Regional Coordinator. In order to facilitate timely and speedy implementation the Provincial Coordinators will be delegated powers of a Category I officer, like the Medical Superintendents/EDOs. The DGHS and the Provincial Coordinator will be provided 20% project allowance.

The functions of the PPIU will include:

- Planning and implementation of all Programme activities at the provincial level under the guidance of the FPIU and department of Health
- Monitoring of the Programme activities at the Provincial level
- Preparation and submission of reports related to the Provincial programme
- Allocation of LHWs, Supervisors, drivers, vehicles etc to the districts.
- Recruitment of FPOs allotted to the PPIU
- Involved in selection of LHW Supervisors, Accounts Supervisors and drivers.
- Preparation and implementation of Operational Plan
- Accounting and Budgeting
- Planning and organization of Training
- Distribution and monitoring of supplies to the districts
- HMIS Data Collation

The PPIUs will be allowed to have their Personal Ledger Accounts (PLAs). 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 rental buildings will be Rs 20,000 to Rs 45,000 for PPIU depending on size of the unit in terms of staff and rental values in various cities. The limit for rent of warehouse will be from Rs 25,000 to Rs75,000 per month depending on the space required and rental values in various cities.

DISTRICT PROGRAMME IMPLEMENTATION UNIT

The District Programme Implementation Unit (DPIU) will be 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. District Coordinators shall be nominated by the EDO/DHO in consultation with the PPIU. The functions of the DPIU will include:

- Preparation and implementation of operational plan at the district level
- Allocation and selection of LHWs at the FLCFs,
- Supervision of all activities
- Hiring/Firing of LHWs, LHS, Accounts Supervisors, drivers,
- Training of district level trainers, supervisors,
- Distribution & monitoring of drugs and other supplies to the FLCFs and LHWs,
- Accounting/budgeting
- Payments of salaries and allowances to staff at the district level i.e LHWs, Supervisors, Drivers, trainers etc
- Vehicle maintenance,
- Programme Reporting,
- HMIS Data Collation

The DPIUs will be allowed to have their PLAs or operate bank accounts in commercial banks to ensure timely and speedy payments of salaries to all staff.

The DPIU will consist of five members. Three of the members will be:

DHO/EDO (H)	Chairman
District Coordinator	Secretary
Assistant District Coordinator	A Woman Medical Officer or a senior LHV

The EDO/DHO/DOH may nominate two other members of the District Health team to be part of the DPIU. These members will be actively involved in the day-to-day functions of the DPIU. The five members of the DPIU will be paid 20% of their basic pay per month. The DPIU may also co-opt other related staff to be members of the DPIU, however they will not be entitled to the payment of the 20% allowance.

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.

For supervision and data entry and compilation of MIS reports, maintenance of accounts, and distribution/maintenance of stores at the district level, one post of **Accounts Supervisor** will be provided at each DPIU with salary package similar to LHS. The Accounts Supervisor could be male/female with prescribed education qualifications and selection procedure. The Accounts

Supervisor will be a member of the DPIU but will not be entitled to the 20% allowance. In districts with more than 800 LHWs may have two Accounts' Supervisors.

The above-mentioned functions will be performed by the respective PIUs till 2008. After 2005 alternate models will be piloted in selected areas. Based on these models alternate strategies will be more widely implemented. From 2008 onwards, there may be changes in the management of the Programme with roles at the different levels i.e. Federal, Provincial and District being redefined.

RESOURCES FOR THE PIUS

The list of the staff required at federal and provincial PIUs is annexed. These appointments will be made on contract/deputation basis by the Programme coordinators and it should not require the involvement of FPSC. The staff appointed/working for the implementation and supervision of the Programme at the federal and provincial PIUs will be given 20% of the running basic pay as project allowance while up to 5 officials will be entitled for project allowance in each district PIU. The federal, provincial and district programme coordinators (presently working against regular posts) will continue to head the federal and provincial PIUs and will not be transferred for 3 years to prevent any adverse affect on programme implementation.

For effective and smooth implementation of the Programme, certain degree of administrative and financial authority is required for the Programme coordinators at the federal and provincial level. The proposed authority in this regard is:

- To hire and fire staff (as per approved PC-I)
- Authorized to call quotations/tenders (as per requirements) and to place orders up to Rs. 40,000
- Authorized to transfer funds to districts from Programme accounts (every quarter)
- Permission to establish PIU at locations with adequate office and storage space
- Availability of equipment like computers, Fax, internet & telephone with special ceiling for telephone and fax monthly bills.

If required, adequate space will be hired for the establishment of federal and provincial PIUs and will be equipped with telephone, fax, computers and other electronic equipments from the project cost. Similarly, maintenance contract under the rules will be maintained with relevant agencies for computers, fax and other equipment at the PIUs. Arrangements for connecting federal and provincial and district PIUs through E-mail and electronic modem would also be made. Computers, printers, telephones and other such equipment will also be provided to the DPIUs. The expenditure involved on all these activities and certain other unforeseen items will be met through the project funds, while additional support may also be solicited from donors' agencies.

The Programme is able to solicit support from donor agencies for certain collaborative projects. The donor agencies also provide additional different

types of vehicles for monitoring and supervision of the Programme. The FPIU and the PPIUs will be authorized to incur expenditure on POL and maintenance of these vehicles. The FPIU and PPIUs will also be authorized to hire drivers for these vehicles on terms and conditions similar to those for the drivers of Supervisors.

XII. PROCUREMENT OF CONTRACEPTIVES, MEDICINES AND LOGISTICS SUPPLIES

CONTRACEPTIVE MATERIALS

The contraceptive requirement will be determined and updated on semi-annual/ annual basis according to contraceptive prevalence rate 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 Warehouse or medical store depots to be operated by the provincial health departments, 3 months stock in district health office and 3 months stock at all health centers.

The LHWs will be provided with oral contraceptive pills and condoms. The LHWs will distribute these contraceptives among the eligible couples and will charge Rs 3/cycle of pills and Rs.0.50 per condom. The LHWs will keep the money earned from the sale of these contraceptives. The LHWs will promote the use of other contraceptive methods as well i.e. IUCDs, injectables, vasectomy and tubal ligation and will refer the willing clients to the appropriate facilities.

ESSENTIAL DRUGS

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. LHWs will be provided with a limited range of inexpensive essential drugs for those health problems that are common. The Programme will take steps to ensure timely supply of drugs and medicines to the LHWs. The list of drugs and other related items is given in ANNEX.

TRANSPORT FACILITIES

Constraints in the logistic system usually disrupt programme field operation particularly those related with supervision. To ensure the regular implementation of supervisory activities, and the timely distribution of the supplies of the equipment, arrangements are being made for the provision of transport facilities to field supervisors. Budgetary arrangements are planned for the purchase, maintenance and operation of these vehicles. Locally manufactured Pick Ups will be provided for LHW-Supervisors while locally manufactured vans for district PIUs and 4 x4 locally manufactured Jeeps for FPOs, Provincial and Federal PIUs will also be provided. For certain hard areas, locally manufactured Jeeps will also be given to district PIUs and LHW-supervisors instead of locally manufactured Pick-ups.

The vehicles procured by the Programme have a life of seven years. A number of the vehicles have exceeded their economic life and are increasingly in need of major repairs therefore the Programme vehicles which have been in use beyond ten years will be replaced with new vehicles. The

vehicles, which exceed their economic life will be disposed off as per prevailing govt. rules.

PROCUREMENT PROCEDURE

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

The Programme procures drugs/medicines and non-drug items, vehicles, contraceptives and printed material besides computers, and other office equipment furniture etc. The procurement process will comprise the following steps under each category:

I. Drugs/ medicines and non-drug items

1. Calculation of annual demand on the basis of information received from PPIUs/ RPIUs.
2. Preparation of specifications of each item to be procured.
3. Preparation of bidding documents.
4. Submission of procurement request to the competent authority in the Ministry of Health for approval.
5. Floating of tender notice in the national newspapers.
6. Opening of tenders by Federal Procurement Cell.
7. Selection of bidders on the basis of lowest bids and samples which meet the tendered specifications and corresponding quality standards.
8. Inspection of factories/ manufacturing plants (pre-award inspection) of the short listed bidders.
9. Issuance of supply orders to the successful bidders.
10. Pre-delivery inspection and collection of samples by the Federal Inspector of Drugs for laboratory analysis (in case of drugs/medicines) from the manufacturers' premises.
11. Receipt of goods and commodities in accordance with the approved/ standard samples at PPIUs.
12. Post-delivery inspections at PPIUs/ RPIUs by Inspection Committee.
13. Submission of bills to Federal PIU for clearance.

J. Contraceptives

1. Calculation of annual demand at Federal PIU on the basis of performance information received from PPIUs /RPIUs and/or available indicators i.e. CYP, CPR and /or the assignment of quota.
2. Preparation of specifications of contraceptives to be procured by Federal PIU.
3. Preparation of bidding documents.

4. Submission of procurement request to the competent authority in the Ministry of Health for approval.
5. Floating of tender notice in the national newspapers.
6. Opening of tenders by Federal Procurement Cell.
7. Selection of bidders on the basis of lowest bids and samples which meet the tendered specifications and corresponding quality standards.
8. Issuance of supply orders to the successful bidders.
9. Pre-delivery inspection
10. Receipt of goods and commodities in accordance with the approved/ standard samples at PPIUs.
11. Post-delivery inspections at PPIUs by Inspection Committee.
12. Submission of bills to Federal PIU for clearance.

Procurement through UNFPA

In case of procurement through UNFPA, after the calculation of the requirements of the contraceptives and approval by the competent authority, the following steps will be followed;

1. Submission of requisition to UNFPA
2. Receipt of Proforma Invoice.
3. Payment of funds in advance to the UNFPA after approval of the competent authority
4. Confirmation of payments by UNFPA.
5. Receipt of purchase orders.
6. Receipt of consignment at Karachi Port Trust (KPT).
7. Release of consignments from Karachi Port Trust through approved Clearing Agents.
8. Receipt of consignments of contraceptives and devices at Central Ware House.
9. Calculation of exact expenditure and payment of balance amount (if any from the advance paid) by UNFPA to the Programme.

K. Printed material

1. Calculation of annual demand on the basis of information received from PPIUs/ RPIUs.
2. Preparation of specifications of each item to be printed.
3. Preparation of tender documents.
4. Submission of procurement request to the competent authority in the Ministry of Health for approval.
5. Floating of tender notice in the national newspapers.
6. Opening of tenders by the Tender Committee.
7. Site inspection of the printing presses of lowest bidders.
8. Selection of bidders on the basis of lowest bids and recommendation of Inspection Committee.
9. Issuance of supply orders to the successful firms.
10. Submission of samples by the successful firms for approval.
11. Receipt of printed material by PPIUs/ RPIUs.
12. Post delivery inspections of consignments at PPIUs/RPIUs by the Inspection Committee.

13. Submission of bills for clearance to Federal PIU.

Considering the importance of the Programme and to avoid delays in training activities, the Programme will be exempted from getting NOC from Printing Corporation of Pakistan Press and printing work may be processed through competitive bidding.

L. Vehicles

1. Assessment of demands at Federal PIU received from PPIUs/ RPIUs.
2. Rate enquiry on specified vehicles and acquisition of terms and conditions of sale from local manufacturer.
3. Preparation of contract agreement between the Federal PIU and locally manufacturer.
4. Obtain concurrence from Law & Justice Division on contract agreement.
5. Getting NOC from the Cabinet Division.
6. Submission of procurement request to the competent authority/Finance Division for payment in advance against approved contract agreement.
7. Signing of contact agreement and payment through Bank Draft to the local manufacturer.
8. Issuance of Purchase Order.
9. Confirmation by the locally manufacturer regarding the completion of Purchase Order.
10. Pre-delivery inspection of vehicles at the company's premises by the designated committee from FPIU.
11. Delivery of vehicles to FPIU/ PPIUs.
12. Acknowledgement of receipt of vehicles at Provincial/ Regional PIUs.

WAREHOUSING

The National Programme for FP & PHC procures large quantities of medicines and drugs, which require proper storage conditions. Proper warehouses will be established at the Federal and Provincial levels for which appropriate premises may be hired. For security, 'chowkidars' will be hired for round the clock presence. At the district level the different government buildings may be used for the storage.

DISTRIBUTION

After procurement the contraceptives will be kept in the central warehouse. The Central Warehouse will dispatch the contraceptives to the provincial PIUs as per requirement based on actual consumption. Provincial PIUs will distribute the contraceptives directly to the respective health centers through district PIUs. The requirement of contraceptives on the basis of CYP or CPR for each year with contraceptives mix distribution has been estimated. Similarly the drugs and other logistic supplies will also be adequately stored at the provincial level warehouses as per requirement based on actual consumption. The logistics will be provided on annual requirement basis while supplies to FLCF through district PIUs will be sent on quarterly basis for distribution among LHWs on monthly basis. But in the first instance, four months supply will be given to health centers so that there is a reserve stock of one month at the beginning of each quarter. The list of essential drugs,

contraceptives and other supplies along with provisional cost is annexed. Adequate record will be kept for supplies under the Programme for which stock registers will be provided to provincial and district PIUs. Funds will be provided to the PPIUs and DPIUs for transportation of drugs medicines etc to districts and FLCFs.

At the beginning of the Programme, a monthly supply of contraceptives and essential drugs will be distributed to each LHW. This supply will be replenished every month based on actual consumption and the requisite amounts in LHWs Kit. The composition of monthly LHW's kit is annexed XI.

XIII. MIS COMPONENT

In view of its wide scope of work in terms of the population and health problems covered, and widely expanded infrastructure, in terms of health facilities, staff, drugs and supplies etc. there is a need for the Programme to have an efficient information system, responding to the information needs of various decision making levels of the health system.

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.

Since mid 1990, Federal Ministry of Health, in collaboration with the international donor agencies (PCSP/USAID, UNICEF WHO etc) and the Provincial Health Departments, is in the process of implementing Health Management Information System (HMIS). However the HMIS in its present form is limited to the First Level Care Facilities (FLCFs), without incorporating the data from the community level.

Therefore, under the National Programme initiative, efforts would be made to interlink community information/data, generated through community based LHW with the institution-based information, collected through HMIS. A computerized database and programme soft ware will be developed to link the National Programme activities with the existing HMIS.

In order to keep abreast with the latest developments, a Geographical Information System will also be developed and maintained by the Programme.

XIV. PUBLIC HEALTH EDUCATION AND MEDIA CAMPAIGN

The focus of the Programme is on interventions for prevention of illness and promotion of good health, which requires educating the public on issues related to health. Public Health Education and communication is an important element of the National Programme on Family Planning and Primary Health Care. The Public is to be motivated to become an active partner for the improvement of the health status of the nation. The communities are to be empowered to work for the improvement of their health. This can be only achieved when they have been provided with knowledge and skills to improve their health. This will be achieved through well-planned health education and communication activities by using electronic and print media; teaching aids and inter personal communication instruments. Efforts will be made to document and record all vital events and achievements of the Programme to highlight and disseminate the Programme objectives. The expert agencies will be given contracts to carry out this job.

The public health education and communication programme will use all the available channels of communication in order to empower the communities to improve their health. The overall objectives of the public health education activities will be to develop communities, which are responsive to the National Programme on Family planning and Primary Health Care. The different steps taken in this respect in the health sector are bound to have a positive impact, as 'in a free society public health activities ultimately rest on public understanding & support, not on the technical judgment of experts. Expertise is made effective only when combined with sufficient public support' (*The Future of Public Health. National Academy Press, Washington DC 1988.*)

The Programme will develop and implement a well planned social mobilization, awareness raising and advocacy campaign through all relevant media. The Behavior Change Communication strategy will be promoted. This campaign will be implemented through the Programme staff which includes the Health Education Officer and the Media Officer at the Federal PIU, and the Provincial PIU staff especially Health Education Officers. An effective mechanism will be developed for formulation and implementation of the strategies and the campaign with involvement of all key partners and stakeholders.

In order to assess the impact of various interventions in this important area, the Programme may carry out small-scale KAP (Knowledge, Attitudes & Practices) studies at local level. Efforts will be made for capacity building of the PPIU and district level staff in Health Education, community mobilization activities.

XV. COMMUNITY ROLE IN FAMILY PLANNING AND PRIMARY HEALTH CARE.

Through the process of community organization for PHC and family planning, members of the community will become organized for participation in health-promoting activities. These activities will include participation in:

- Decision making during project planning/project implementation at the local level.
- Monitoring and evaluation.
- Various primary health care services (e.g., immunization, improved sanitation etc)

Community organization will involve various segments of local populace including male population through motivational and education campaigns at the local level by LHWs with support from the staff at FLCF and at the broader national level by the sectors and agencies involved.

Possible approaches that will be employed for initiating contact with community are through advocacy and awareness raising activities aimed at political leaders, NGOs, voluntary organizations, established community leaders and by establishing organizations like health committees, women groups and through health care delivery outlets.

The involvement of local women as LHWs will help the Programme as women have the traditional and natural role of health care providers both within the family and in communities. Also, frequent contact with other women of the community ensure that valuable information is shared.

XVI. IMPLEMENTATION AND MONITORING

Provincial health departments and district governments will be responsible for implementation of training, deployment and monitoring of LHWs programme. *The Programme Review Committee will review the progress of the Programme periodically and will discuss and agree on modifications that may become necessary during the course of implementation. The provincial governments will also take necessary steps to avoid overlap of the National Programme with ongoing project of the Ministry of Population Welfare.*

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

INPUT/ PROCESS Indicators:	OUTPUT/ OUTCOME Indicators:
No. of trainers identified/trained No. of TOT workshops conducted 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.	Contraceptive Prevalence Rate Number of Condoms distributed by LHWs Number of contraceptive cycles distributed by LHWs Number of Women visited for Antenatal Care per worker per month Number of Children weighed per worker per month % of Low Birth Weighed Babies % of Children fully Immunized Number of ORS packets distributed by LHWs Infant Mortality Rate (per 1000 LB) Maternal Mortality Ratio (per 100,000 LB) Number of ARI cases seen by LHWs Number of Diarrhea cases seen by LHWs Total Number of TB cases reported Number of functional health committees

PROGRAMME REVIEW COMMITTEE

A Programme Review Committee will be established to review the progress of the Programme periodically 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
National Coordinator
National Programme Advisor
Provincial Health Secretaries/DGHS
Representative of Ministry of Population Welfare
Representative of Ministry of Finance
Representative of Ministry of P&D

Secretary

The Committee will be able to co-opt additional members as and when required.

DEVOLUTION

The government of Pakistan has embarked on the devolution of Powers Plan since 2000 as it is realized that strengthening local government institutions, decentralizing management of locally oriented expenditures, and expanding local resource bases and mobilization are critical to address major problems being faced in the country. The design of the National Programme from its very inception has encouraged community involvement – in selection of LHWs, their performance and supervision etc. The Programme has been designed in a manner that provides maximum authority to the district PIUs and the Provincial PIUs.

Further decentralization of powers will be carried out in a phased manner over the next 3 – 5 years. This decentralization/devolution will be piloted in selected districts/provinces in tandem with the development of mechanisms to ensure accountability for results. This will need to be accompanied by capacity building at all levels, strengthening Programme Management information systems and demonstration of increased involvement at the district and provincial levels.

INTER PROVINCIAL COMMITTEE on DECENTRALIZATION

In order to guide the process of crystallization of the further decentralization and devolution of powers in the context of the National Programme for FP & PHC, a high-powered committee will be constituted. This committee will be an Inter-Provincial Committee to be chaired by the Federal Secretary Health. The members of the Committee will include the Provincial Additional Chief Secretaries (development), Provincial Health Secretaries, representative from the Planning Commission i.e. the Member Social Sector or the Chief Health. The National Coordinator of the Programme will be the Secretary of this Inter Provincial Committee.

The Committee will meet biannually to discuss the plans and review progress towards decentralization of the Programme activities. The committee will also explore the possibility of allocation of resources to the Programme from the Provincial funds.

XVII. PARTNERSHIP BUILDING

The tasks facing the government to achieve the targets set by the Programme are enormous. This requires a policy framework backed by a managerial arrangement in which the direct cooperation between the government, the international and bilateral technical and donor groups is consolidated in a coordinated manner. Through the establishment of coordinating mechanisms and by continuing dialogue, implementation of the operational plans in support of the Programme strategies will be ensured.

Moreover, the government will ensure and coordinate technical cooperation from all national and international agencies including NGOs on issues related to the objectives and strategies of the Programme. In this context critical programme areas where collective efforts are needed will be identified.

COLLABORATION WITH 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.

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 will be constituted which will approve such collaborative projects. No unit of the Programme will be authorized to initiate major collaborative projects on its own. The committee will be chaired by the National Coordinator and its members will include the National Advisor, one Deputy National Coordinator and two Provincial Coordinators.

RESEARCH ACTIVITIES

The Programme will promote Research activities including operations 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.

XVIII. EVALUATION OF THE PROGRAMME

Periodic and extensive evaluation of the Programme at critical junctures will be the key feature of the Programme. Evaluation of the Programme activities will be carried out in 2005 and 2008 to assess the progress of the Programme implementation as well as provide insight into the future strategies. These Evaluations will also assess the viability of various alternate models that would be piloted for the development of viable strategies for the future.

XIX. FINANCIAL AND MATERIAL RESOURCES

The successful implementation of the Programme will depend on mobilizing the necessary and timely financial and material resources. Although this implies first of all making the most efficient use of existing resources, additional resources will be needed. To assess the magnitude of the total financial needs to implement the Programme, an analysis of the cost of programme components has been undertaken.

Article 38 of the Constitution of Pakistan 1973 emphasizes the provision of health care to the people of Pakistan. Along with the expansion of health facilities, the financial allocation for the health sector has also been rising steadily, although the expenditure remains low at around 1% of the GNP. The LHWs are largely providing preventive and promotive health services with some curative services to poor population of the rural areas of the country. These services being public goods, it is desirable that they be made available to the communities without any direct cost. The cost of a LHW per year is approximately Rs 45,000 and she is providing services to approximately 1000 population the cost per person per year therefore comes to Rs. 45. It therefore is a low cost intervention with major benefits, providing adequate justification for the government to support this Programme and allocate resources. Although the resources for the Programme during its first two phases of implementation will be undertaken by the Federal Government, alternative ways of financing of this priority health programme have to be considered. This includes action to utilize/involve the resources of the provincial and district governments or seek local community solutions.

BUDGETING

The Programme will prepare and submit budget according to the objective heads of budget commonly followed in the government of Pakistan financial procedures (i.e. establishment charges, purchase of durable goods, repairs & maintenance of durable goods and works, commodities and services and miscellaneous expenditure). The funds will be released preferably under a single budget line as is common for development projects or according to the mentioned objective heads.

Finance Officers with adequate relevant experience will be posted in the FPIU and all PPIUs for proper financial management, planning and monitoring. The Finance Officers in the Federal (BPS 18) and Provincial PIUs (BPS 17) will be posted from the government departments involved in financial matters e.g. Auditor General, the Controller General Accounts/AGPR etc. on deputation basis

AUDIT

In order to ensure conscientious, judicious and prudent expenditure of the government resources effective pre and post audit procedures will be implemented. The various levels of the Programme will carry out regular internal audit exercises. An Audit Officer will also be posted at the Federal PIU in BPS 17 for continuous internal audit of the different units of the

Programme. The Audit Officer will be preferably requisitioned from the Auditor General's office on deputation basis.

Annual external audit of the government funds will be carried out by the Federal Audit. The Programme will ensure that the audit procedures agreed with the donor agencies are also followed in accordance with policy of the donors in case of funds provided by the donor agencies.

XX. PROGRAMME IMPACT AND EFFECTIVENESS

The Government of Pakistan (GoP) recognizes that improving access to basic needs such as primary education, preventive health care and population welfare services is essential for winning the fight against poverty. The National Programme for FP & PHC is an important and major step towards providing preventive health care and family planning services at the doorsteps of the communities as a part of the poverty alleviation strategy. It has also been shown that the launch of the National Programme in remote areas has motivated communities to educate their girls. The Programme by providing respectable employment opportunities to more than 100,000 women in the rural areas will also play an important role in empowering women in the rural communities.

The Programme will improve the community access to FP and PHC services to the target population. It will raise immunization coverage, with quick reduction of polio, measles and tetanus prevalence. The programme has a strong maternal and child health care component. It will deliver FP services effectively. It will facilitate follow-up of acceptors, strengthen antenatal, natal and postnatal services, while nutritional status of mothers and children will be ensured. The availability of oral re-hydration salt in the community will increase the number of mothers who can use oral re-hydration therapy; hence the children with diarrhea will be prevented from dehydration and death. Strong community awareness of its real needs and priorities will bring about the required change of attitude and behavior resulting in a general improvement in the "Quality of Life" and poverty reduction.

During its course, progress reports on the Programme implementation will be published and periodically reviewed by Provincial and Federal health management committees. The services of expert agencies will be obtained to prepare these reports. Through this process, the progress made towards the attainment of the set programme targets, and the effectiveness of the strategy will be evaluated. This mechanism emphasizes the importance of mobilizing and generating the necessary human, technical and financial resources to achieve programme objectives within the country's social and economic capacities.

XXI. 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; and
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.

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Annexure – I

**National Programme for Family Planning and
Primary Health Care**

Time Table for Selection & Training of LHWs

**National Programme For Family Planning and Primary Health Care
Status of Lady Health Workers**

Year	No. of LHWs			TOTAL
	NP	WHP	RHP	
2002-03	67,000	8,000	--	75,000
2003-04	79,800	8,000	2,200	90,000
2004-05	87,600	8,000	2,200	97,800
2005-06	95,600		4,400	100,000
2006-07	95,600		4,400	100,000
2007-08	100,000			100,000

**National Programme for Family Planning and Primary Health Care
Yearwise Break Down of Expenditure from 2003-2008**

							Amount in Millions (Rs.)
S.No.	Component	2003-04	2004-05	2005-06	2006-07	2007-08	Total
A	Establishment Charges						
A-1	Salaries/Over Time/Medical/Allowances/ Honorarium, Pension Contribution of PIUs' Staff & Residential Rent**	77.063	82.843	89.056	95.735	102.916	447.613
A-2	Salaries of LHWs	1776.000	1909.200	2052.390	2206.319	2371.793	10315.702
A-3	Salaries of Supervisors	142.560	153.252	164.746	177.102	190.384	828.044
A-4	Project Allowance (FPIU, PPIU, DPIU)	22.221	23.888	25.680	27.606	29.676	129.071
A-5	Fix TA allowance to Supervisors	*	*	*	*	*	*
A-6	Salary of Drivers (with Supervisors, FPO & in PIUs)	123.283	132.529	142.469	153.154	164.640	716.074
	Total Establishment Charges	2141.127	2301.712	2474.340	2659.916	2859.410	12436.505
B	Purchase of Durable Goods						
B	Purchase of Vehicles *	808.236	117.975		348.348		1274.559
B	Purchase of Furniture, Fixtures & Other Stores	20.000				20.000	40.000
	Total of Purchase of Durable Good	828.236	117.975	0.000	348.348	20.000	1314.559
C	Repair of Durable Goods						
C-1	Repair/Maintenance of vehicles	80.832	86.894	93.411	100.417	107.949	469.504
C-2	Repair of Equipment & Other Stores	5.000	5.000	5.000	5.000	5.000	25.000
	Total Repair of Durable Goods	85.832	91.894	98.411	105.417	112.949	494.504
D	Commodities and Services						
D-1	TA / DA for all staff	25.693	25.693	25.693	25.693	25.693	128.464
D-2	Transportation Charges (PPIUs & DPIUs)	8.094	8.094	8.094	8.094	8.094	40.470
D-3	POL	134.436	144.519	155.358	167.009	179.535	780.857
D-4	Printing (Training & Other Materials)	56.594	21.894	55.683	4.696	64.337	203.203
D-5	Rent of Official Building/Warehouse	9.180	9.869	10.609	11.404	12.260	53.321
D-6	Evaluation & HMIS ***	3.000	3.000	8.000	3.000	10.000	27.000
D-7	Training (10000 LHWs 3 months Stipend) ****	37.500	0.000	0.000	0.000	0.000	37.500
D-8	Media Campaign	80.000	86.000	92.450	99.384	106.838	464.671
D-9	Purchase of Medicines, Contraceptives & Non Drug Items	1048.382	1271.546	1016.856	1038.793	1085.844	5461.421
	Total Commodities and Services	1402.879	1570.614	1372.742	1358.073	1492.600	7196.907
E	Research & Pilot Studies	5.000	5.000	5.000	5.000	5.000	25.000
F	Colaboration with NGOs	10.000	10.000	10.000	10.000	10.000	50.000
G	Entertainment Charges	1.000	1.000	1.000	1.000	1.000	5.000
H	Workshops (material & training cost)	154.082		165.638		178.061	497.780
	Other Sub-Total	170.082	16.000	181.638	16.000	194.061	577.780
	Total	4,628.156	4,098.195	4,127.132	4,487.754	4,679.018	22,020.255
	Contingencies @ 2% (to cater for expenditure on postage, telephone, utilities, stationary, etc.)	92.563	81.964	82.543	89.755	93.580	440.405
	GRAND TOTAL	4,720.719	4,180.159	4,209.675	4,577.509	4,772.599	22,460.660

* The Pension Contribution and Rent for Residence Building has been calculated assuming that only 50% of the staff will avail the provision

** In case of non provision of required vehicles, the amount will accordingly be utilized towards payment of FTA

*** The Evaluation costs are included in the year of 2005, 2008

**** The cost of training of LHWs against drop outs will be met from LHWs salary component

***** Workshop cost includes TA/DA, Facilitator allowance etc. plus 1% of the cost for stationary, audio visual equipment etc

NOTE :

Inflation rate of 7.5% have been applied in year 2004-2008

Drug calculations do not have any inflation rate

The all above calculations are based on assumptions and current rates, hence there is room for any adjustments

Liabilities of one FY (including FY 2002-03) will be paid in the future FY.

WOMEN HEALTH PROJECT (Support to National Programme for Family Planning and Primary Health Care)							
Yearwise Break Down of Expenditure from 2003-2008							
Amount in Millions (Rs.)							
S.No.	Component	2003-04	2004-05	2005-06	2006-07	2007-08	Total
A	Establishment Charges						
A-1	Salaries/Over Time/Medical/Allowances/ Honorarium, Pension Contribution of PIUs' Staff & Residential Rent**						0.000
A-2	Salaries of LHWs	150.000	118.000				268.000
A-3	Salaries of Supervisors						0.000
A-4	Project Allowance (FPIU, PPIU, DPIU)						0.000
A-5	Fix TA allowance to Supervisors						0.000
A-6	Salary of Drivers (with Supervisors, FPO & in PIUs)						0.000
	Total Establishment Charges	150.000	118.000	0.000	0.000	0.000	268.000
B	Purchase of Durable Goods						
B-1	Purchase of Vehicles *						0.000
B-2	Purchase of Furniture, Fixtures & Other Stores						0.000
	Total of Purchase of Durable Good	0.000	0.000	0.000	0.000	0.000	0.000
C	Repair of Durable Goods						
C-1	Repair/Maintenance of vehicles						0.000
C-2	Repair of Equipment & Other Stores						0.000
	Total Repair of Durable Goods	0.000	0.000	0.000	0.000	0.000	0.000
D	Commodities and Services						
D-1	TA / DA for all staff						0.000
D-2	Transportation Charges (PPIUs & DPIUs)						0.000
D-3	POL						0.000
D-4	Printing (Training & Other Materials)	2.000					2.000
D-5	Rent of Official Building/Warehouse						0.000
D-6	Evaluation & HMIS ***						0.000
D-7	Training (10000 LHWs 3 months Stipend) ****						0.000
D-8	Media Campaign						0.000
D-9	Purchase of Medicines, Contraceptives & Non Drug Items	38.000	17.000				55.000
	Total Commodities and Services	40.000	17.000	0.000	0.000	0.000	57.000
E	Research & Pilot Studies						0.000
F	Colaboration with NGOs						0.000
G	Entertainment Charges						0.000
H	Workshops (material & training cost)						0.000
	Other Sub-Total	0.000	0.000	0.000	0.000	0.000	0.000
	Total	190.000	135.000	0.000	0.000	0.000	325.000
	Contegencies @ 2% (to cater for expenditure on postage, telephone, utilities, stationary, etc.)						0.000
	GRAND TOTAL	190.000	135.000	0.000	0.000	0.000	325.000

REPRODUCTIVE HEALTH PROJECT (Support to National Programme for Family Planning and Primary Health Care)							
Yearwise Break Down of Expenditure from 2003-2008							
Amount in Millions (Rs.)							
S.No.	Component	2003-04	2004-05	2005-06	2006-07	2007-08	Total
A	Establishment Charges						
A-1	Salaries/Over Time/Medical/Allowances/ Honorarium, Pension Contribution of PIUs' Staff & Residential Rent**						0.000
A-2	Salaries of LHWs	21.120	44.880	47.520	50.160	26.400	190.080
A-3	Salaries of Supervisors	1.742	3.686	3.907	4.118	2.165	15.629
A-4							0.000
A-5	Fix TA allowance to Supervisors (from POL if vehicles are not available)						0.000
A-6	Salary of Drivers (with Supervisors, FPO & in PIUs)		2.850	2.964	5.184	5.376	16.374
	Total Establishment Charges	22.862	51.426	54.391	59.462	33.941	222.083
B	Purchase of Durable Goods						
B-1	Purchase of Vehicles *		36.000		22.000		58.000
B-2	Purchase of Furniture, Fixtures & Other Stores	1.000	0.500	0.500	0.500	0.500	3.000
	Total of Purchase of Durable Good	1.000	36.500	0.500	22.500	0.500	61.000
C	Repair of Durable Goods						
C-1	Repair/Maintenance of vehicles		4.000	11.088	13.167	13.167	41.422
C-2	Repair of Equipment & Other Stores	0.200	0.300	0.300	0.350	0.350	1.500
	Total Repair of Durable Goods	0.200	4.300	11.388	13.517	13.517	42.922
D	Commodities and Services						
D-1	TA / DA for all staff	0.100	0.150	0.150	0.200	0.200	0.800
D-2	Transportation Charges (PPIUs & DPIUs)						0.000
D-3	POL	6.584	9.009	11.088	13.167	13.167	53.015
D-4	Printing (Training & Other Materials)	0.300	0.300	0.300	0.450	0.450	1.800
D-5	Rent of Official Building/Warehouse						0.000
D-6	Evaluation & HMIS ***						0.000
D-7	Training (10000 LHWs 3 months Stipend) ****						0.000
D-8	Media Campaign						0.000
D-9	Purchase of Medicines, Contraceptives & Non Drug Items	5.000	25.000	43.000	52.000	58.000	183.000
	Total Commodities and Services	11.984	34.459	54.538	65.817	71.817	238.615
E	Research & Pilot Studies						0.000
F	Colaboration with NGOs		1.000	5.000	8.000	6.000	20.000
G	Entertainment Charges						0.000
H	Workshops (material & training cost)						0.000
	Other Sub-Total	0.000	1.000	5.000	8.000	6.000	20.000
	Total	36.046	127.685	125.817	169.296	125.775	584.619
	Contegencies @ 3% (to cater for expenditure on postage, telephone, utilities, stationary, etc.)	1.081	3.831	3.775	5.079	3.773	17.539
	GRAND TOTAL	37.127	131.516	129.592	174.375	129.548	602.158

**National Programme for Family Planning and Primary Health Care - PC-1 Cost
Yearwise Break Down of Expenditure from 2003-2008**

S.No.	Component	Amount in Millions (Rs.)					
		2003-04	2004-05	2005-06	2006-07	2007-08	Total
A	Establishment Charges						
A-1	Salaries/Over Time/Medical/Allowances/ Honorarium, Pension Contribution of PIUs' Staff & Residential Rent**	77.063	82.843	89.056	95.735	102.916	447.613
A-2	Salaries of LHWs	1604.880	1746.320	2004.870	2156.159	2345.393	9857.622
A-3	Salaries of Supervisors	140.818	149.556	160.839	172.983	188.220	812.415
A-4	Project Allowance (FPIU, PPIU, DPIU)	22.221	23.888	25.680	27.606	29.676	129.071
A-5	Fix TA allowance to Supervisors	*	*	*	*	*	*
A-6	Salary of Drivers (with Supervisors, FPO & in PIUs)	123.283	129.679	139.505	147.970	159.264	699.700
	Total Establishment Charges	1968.265	2132.286	2419.949	2600.463	2825.469	11946.422
B	Purchase of Durable Goods						
B-1	Purchase of Vehicles *	808.236	81.975	0.000	326.348	0.000	1218.559
B-2	Purchase of Furniture, Fixtures & Other Stores	19.000	-0.500	-0.500	-0.500	19.500	37.000
	Total of Purchase of Durable Good	827.236	81.475	-0.500	325.848	19.500	1253.559
C	Repair of Durable Goods						
C-1	Repair/Maintenance of vehicles	80.832	82.894	82.323	87.250	94.792	428.092
C-2	Repair of Equipment & Other Stores	4.800	4.700	4.700	4.650	4.650	23.500
	Total Repair of Durable Goods	85.632	87.594	87.023	91.900	99.432	451.582
D	Commodities and Services						
D-1	TA / DA for all staff	25.593	25.543	25.543	25.493	25.493	127.664
D-2	Transportation Charges (PPIUs & DPIUs)	8.094	8.094	8.094	8.094	8.094	40.470
D-3	POL	127.853	135.510	144.270	153.842	166.368	727.842
D-4	Printing (Training & Other Materials)	54.294	21.594	55.383	4.246	63.887	199.403
D-5	Rent of Official Building/Warehouse	9.180	9.869	10.609	11.404	12.260	53.321
D-6	Evaluation & HMIS ***	1.000	3.000	8.000	3.000	10.000	27.000
D-7	Training (10000 LHWs 3 months Stipend) ****	37.500	0.000	0.000	0.000	0.000	37.500
D-8	Media Campaign	80.000	86.000	92.450	99.384	106.838	464.671
D-9	Purchase of Medicines, Contraceptives & Non Drug Items	1005.382	1229.546	973.856	986.793	1027.844	5223.421
	Total Commodities and Services	1350.895	1519.155	1318.204	1292.256	1420.783	6901.293
E	Research & Pilot Studies	5.000	5.000	5.000	5.000	5.000	25.000
F	Colaboration with NGOs	10.000	9.000	5.000	2.000	4.000	30.000
G	Entertainment Charges	1.000	1.000	1.000	1.000	1.000	5.000
H	Workshops (material & training cost)	154.082	0.000	165.638	0.000	178.061	497.780
	Other Sub-Total	170.082	15.000	176.638	8.000	188.061	557.780
	Total	4402.110	3835.510	4001.315	4318.458	4553.243	21110.636
	Contengencies @ 2% (to cater for expenditure on postage, telephone, utilities, stationary, etc.)	91.482	78.133	78.768	84.676	89.807	422.867
	GRAND TOTAL	4493.591	3913.643	4080.083	4403.134	4643.051	21533.502

* The Pension Contribution and Rent for Residence Building has been calculated assuming that only 50% of the staff will avail the provision

** In case of non provision of required vehicles, the amount will accordingly be utilized towards payment of FTA

*** The Evaluation costs are included in the year of 2005, 2006

**** The cost of training of LHWs against drop outs will be met from LHWs salary component

***** Workshop cost includes TA/DA, Facilitator allowance etc. plus 1% of the cost for stationary, audio visual equipment etc

NOTE :

Inflation rate of 7.5% have been applied in year 2004-2008

Drug calculations do not have any inflation rate

The all above calculations are based on assumptions and current rates, hence there is room for any adjustments

Liabilities of one FY (including FY 2003-04) will be paid in future FY.

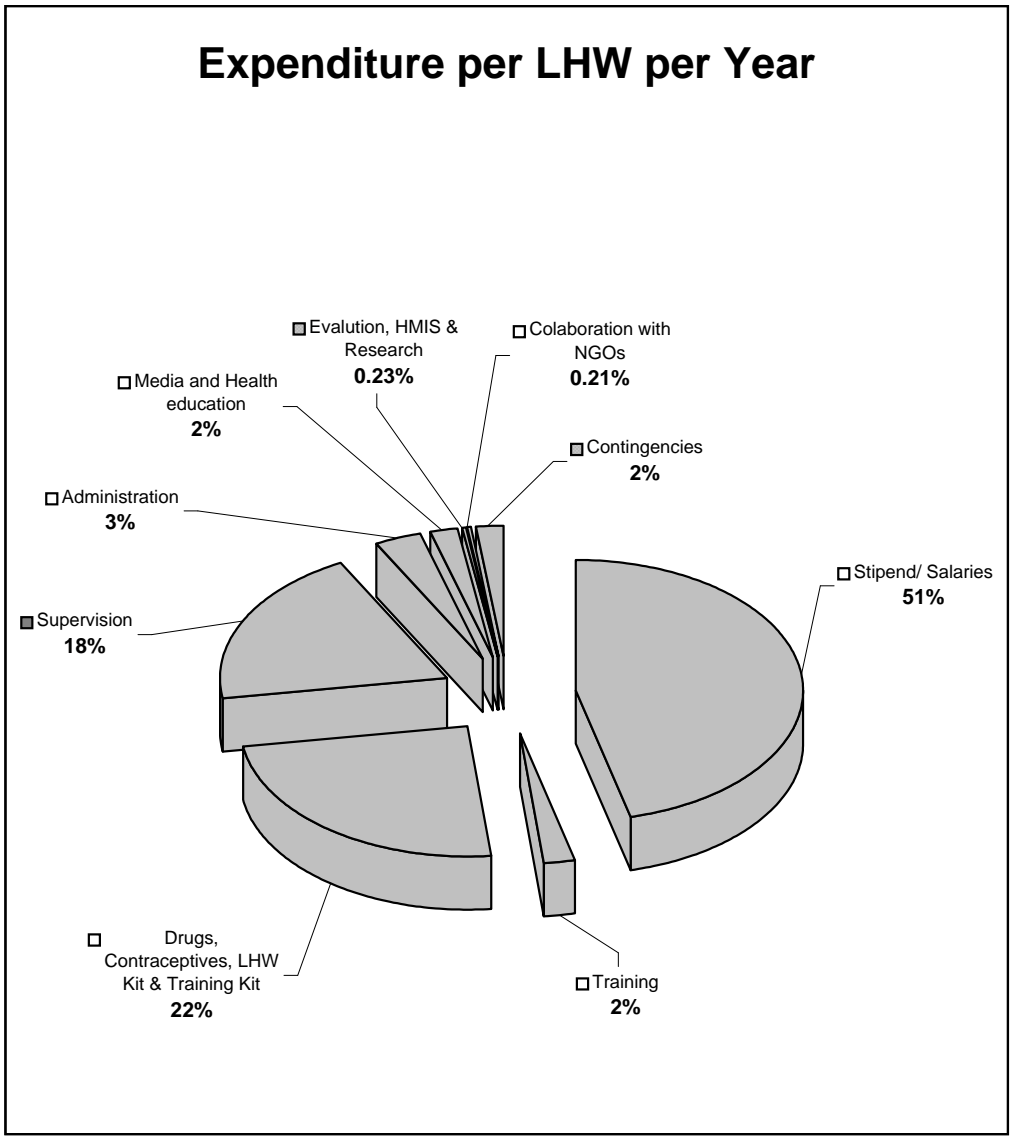
Annexure – III (A)

**Expenditure per LHW per Year
2003-2008**

S. No.	Activity	Detail Cost/LHW (Rs.)
1	Stipend/ Salaries	20,706
2	Training Training material Training workshops	996
3	Drugs, Contraceptives, LHW Kit & Training Kit	10,923
4	Supervision Supervisors salaries, training and materials TA/DA Vehicle Purchase Petrol Repair & Maintenane Driver salaries	8,801
5	Administration Staff salary Project allowance Procurment Repair & Maintenane Transportation (PPIU-DPIU) Rent of Official Building Entertainment	1,481
6	Media and Health Education	929
7	Evaluation, HMIS & Research	104
8	Colaboration with NGOs	100
9	Contingencies	881
	Total:	44,041

Annexure – III (B)

Expenditure per LHW per Year



Annexure – IV

**National Programme for FP & PHC
Recurring Expenditure (2008-2009)**

Component	
Establishment Charges	
Salaries/Over Time/Medical/Allowances/ Honorarium/Residential Rent & Pension Contribution of PIUs' Staff	102.916
Salaries of LHWs	2,371.793
Salaries of Supervisors	190.384
Salary of Drivers (with Supervisors, FPO & in PIUs)	164.640
Total Establishment Charges	2,829.733
Repair of Durable Goods	
Repair/Maintenance of vehicles	107.949
Repair of Equipment & Other Stores	5.000
Total Repair of Durable Goods	112.949
Commodities and Services	
TA / DA for all staff	25.693
Transportation Charges (PPIUs & DPIUs)	8.094
POL	179.535
Rent of Official Building/Warehouse	12.260
Media Campaign	106.838
Purchase of Medicines, Contraceptives & Non Drug Items	1,085.844
Total Commodities and Services	1,418.263
Total	4,360.945
Contegencies @ 2% (to cater for expenditure on postage, telephone, utilities, stationary, etc.)	87.219
GRAND TOTAL	4,448.164

Annexure – V

XXII. SUMMARY OF PROGRAMME ACTIVITIES

Year 1994-2002

	Punjab	Sindh	NWFP	Baloch	AJK	FATA	FANA	ICT	Total
No. of districts/ Agencies	34	20	24	22	7	7	5	1	120
No. of districts/ Agencies involved in NP activities	34	20	23	22	7	7	5	1	119
%age	100%	100%	96%	100%	100%	100%	100%	100%	99%
No. of Health facilities involved in NP activities	1713	738	546	129	104	27	49	22	3327
Total No of LHWs (Including transferred VBFPWs)	35509	17220	8473	3905	2250	339	1265	325	69286
Total No of Supervisors	1180	574	282	130	102	11	42	11	2332
No. of Provincial Master Trainers	20	7	14	15	15	1	4	7	83
No. of District Master Trainers	187	96	93	46	28	20	39	7	516
No. of Health Facilities Trainers	4046	1655	1993	398	431	169	100	66	8858

Annexure – VI

**National Program for Family Planning and Primary Health Care
FY 2003-04 and onwards**

Available vehicles			Total of existing vehicles	Pipeline quantity (approved)		To be procured upto June 2003	To be available upto June 2003	Desired procurement during 2003-04	Total of Required Vehicles <u>during and after</u> 2003-2004	Average cost of vehicle (Rs)	Total cost (Rs)
Suzuki Pick-up	Suzuki Bolan	Suzuki Potohar Jeep		Suzuki Pick-up	Suzuki Potohar Jeep	Suzuki Pick-up	All types				
1269	115	100	1484	200	40	600	2324	1884	4208	429,000	808,236,000
									Rupees (Millions)	808.236	

Cont.....

PLAN FOR REPLACEMENT OF VEHICLES (AFTER COMPLETION OF 10-YEARS ECONOMIC LIFECYCLE)						
PHASE	YEAR OF REPLACEMENT	YEAR OF PURCHASE	QUANTITY OF VEHICLES	UNIT COST (2003-04 estimates)	COST IMPACT	
					Rupees	Million Rs.
1	2004-2005	1994-95	275	429,000	117,975,000	117.975
2	2006-2007	1996-97	812	429,000	348,348,000	348.348

Annexure – VII (A)

Budget Estimates for the Training of Trainers

Trainees (BPS 17)				
	# of Trainees	# of Days	Rate	Total
Daily Allo.	3,000	12	350	12,600,000
Hotel Charges	3,000	12	525	18,900,000
Trainees (BPS 11)				
	# of Trainees	# of Days	Rate	Total
Daily Allo.	6,000	12	120	8,640,000
Hotel Charges	6,000	12	180	12,960,000
Total (millions)				53100000.000

No. of Trainers = 900				
	# of Trainers	# of Days	Rate	Total
Facilitator Allo.	900	12	200	2,160,000
Total (millions)				2160000.000

Refresher Training				
	No	# of Days	Rate	Total
LHWs	100,000	15	50	75,000,000
Trainers	5,000	15	200	15,000,000
Total (millions)				90000000.000

Grand Total (in millions)				145.260
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Annexure – VII (B)
Budget Estimates for the Training of Trainers (Provincial break down)

Training (Materials & Workshops) - Punjab					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		34	5,000	510,000
Daily Allo.	3	10	34	350	357,000
Hotel Charges	3	10	34	1,050	1,071,000
Total (millions)					1.995

Training (Materials & Workshops) - Sindh					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		20	5,000	300,000
Daily Allo.	3	10	20	350	210,000
Hotel Charges	3	10	20	1,050	630,000
Total (millions)					1.197

Training (Materials & Workshops) - NWFP					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		24	5,000	360,000
Daily Allo.	3	10	24	350	252,000
Hotel Charges	3	10	24	1,050	756,000
Total (millions)					1.425

Training (Materials & Workshops) - Balochistan					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		22	5,000	330,000
Daily Allo.	3	10	22	350	231,000
Hotel Charges	3	10	22	1,050	693,000
Total (millions)					1.311

Training (Materials & Workshops) - AJK					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		7	5,000	105,000
Daily Allo.	3	10	7	350	73,500
Hotel Charges	3	10	7	1,050	220,500
Total (millions)					0.456

Training (Materials & Workshops) - FANA					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		5	5,000	75,000
Daily Allo.	3	10	5	350	52,500
Hotel Charges	3	10	5	1,050	157,500
Total (millions)					0.342

Training (Materials & Workshops) - FATA					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		7	5,000	105,000
Daily Allo.	3	10	7	350	73,500
Hotel Charges	3	10	7	1,050	220,500
Total (millions)					0.456

Training (Materials & Workshops) - ICT					
Provincial Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of PPIU	Rate	Total
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
District Master Trainers (Alternate Year)					
	# of Trainers	# of Days	# of DPIU	Rate	
Travelling Allo.	3		1	5,000	15,000
Daily Allo.	3	10	1	350	10,500
Hotel Charges	3	10	1	1,050	31,500
Total (millions)					0.114

Annexure – VIII

POL

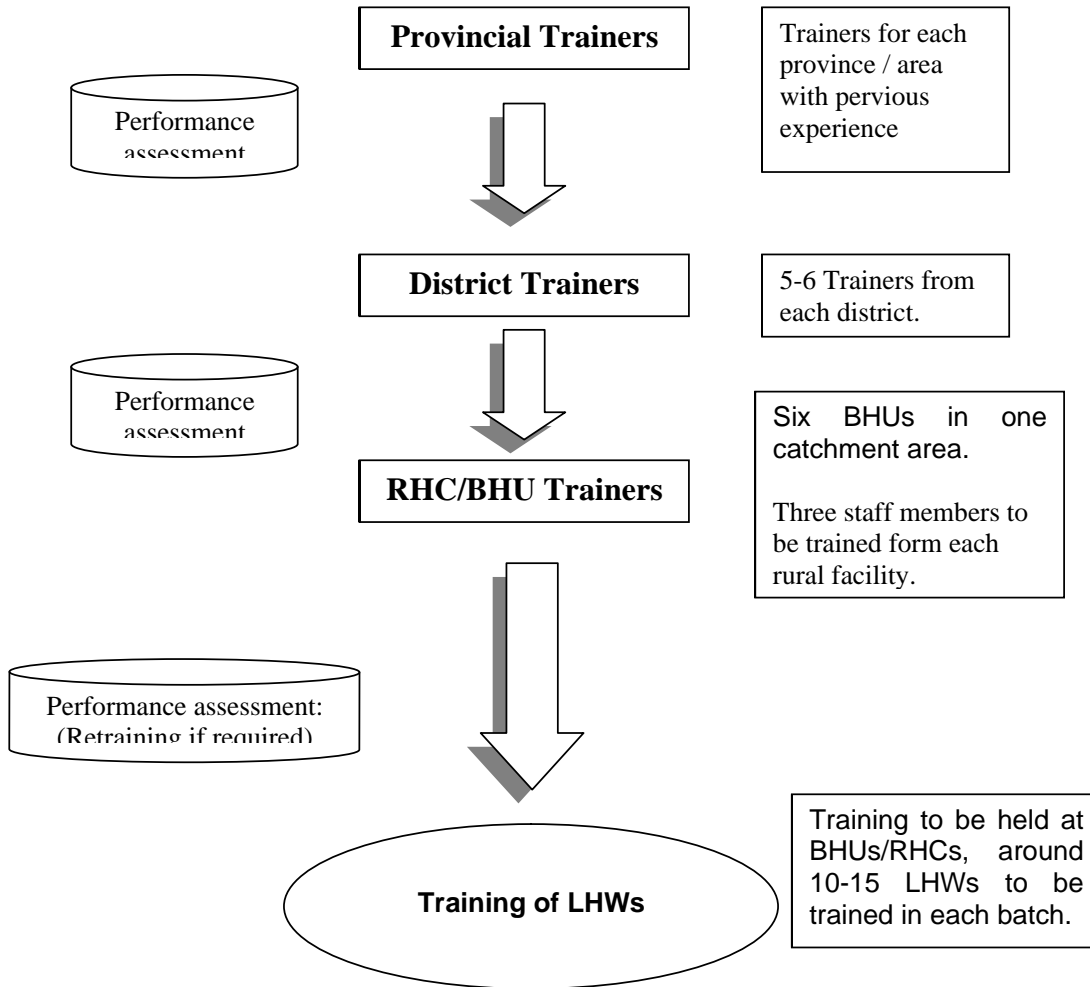
	# of Vehicle	Liters	Rate/Liter	Months	Total
Supervisor	4,000	70	34	12	114,240,000
DPIU	120	240	34	12	11,750,400
PPIU	24	300	34	12	2,937,600
FPIU	5	300	34	12	612,000
FPO	50	240	34	12	4,896,000
Total (millions)					134.436

Vehicle Maintenance

	# of Vehicle	Rate	Months	Total
Supervisor	4,000	1,500	12	72,000,000
DPIU	120	3,500	12	5,040,000
PPIU	24	4,000	12	1,152,000
FPIU	5	4,000	12	240,000
FPO	50	4,000	12	2,400,000
Total (millions)				80.832

Development of Human Resources for PHC

The trickle down approach



Annexure – X (A)

Annexure - X(A)

Estimated Procurement Planning of Drug and Non-Drug Items for LHWs

S. No	DESCRIPTION	ANNUAL EXPENDITURE	FY	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008
			No. of LHW	90,000	100,000	100,000	100,000	100,000
	Targeted Contraceptive			32.5%	35%	37.5%	40%	42.5%
	Eligible Couples			10,935,000	12,150,000	12,150,000	12,150,000	12,150,000
1	Medicines/Drugs	7,044.24	x	633,981,600	704,424,000	704,424,000	704,424,000	704,424,000
2	Contraceptives (with targeted increase of 2.5% per annum)	4,387.20	x	236,911,392	285,171,120	307,107,360	329,043,600	350,979,840
3	NON DRUG ITEMS	Annual Replenishment (Thermo-Scissors)	x	4,792,500	5,325,000	5,325,000	5,325,000	5,325,000
4		3-Yrly Replenishment (Torch-Kit Bag-Scale)	x	0	17,580,500	0	0	25,115,000
5		(New LHW)	x	172,696,800	259,045,200	0	0	0
TOTAL ANNUAL EXPENDITURE				1,048,382,292	1,271,545,820	1,016,856,360	1,038,792,600	1,085,843,840
				1,048	1,272	1,017	1,039	1,086
Notes: Basics: Present number of LHW is 73,000						TOTAL OF FY-2003~2008	5,461,420,912	
2. Calculation of cost based on monthly cost of essential drugs/misc monthly supply						(Rs.)		
3. In FY-2003-2004 number of LHWs will increase by 20,000						Rs. (Millions)	5,461.42	
4. In FY-2004-2005 number of LHWs will increase by 10,000 from the previous year and will remain the same for following years.								
** Current CPR is 30, that includes ALL methods (OCP, Condoms, IOU, Vasectomy, TL, etc). It is estimated that Program contributes 50% of the mix methods. In order to increase the effectiveness of the program an increase in contraceptive prevalence rate by								

Annexure – X (B)

Year-wise Requirements of Contraceptives

Fiscal Year			2003-2004	2004-05	2005-06	2006-2007	2007-08	
Total Number of LHW			90,000	100,000	100,000	100,000	100,000	
Population covered by LHW	900	Per LHW	81,000,000	90,000,000	90,000,000	90,000,000	90,000,000	
Eligible couples per LHW	13.5	Percent Per LHW	10,935,000	12,150,000	12,150,000	12,150,000	12,150,000	
Condom Requirements	144	Per LHW	93,312,000	112,320,000	120,960,000	129,600,000	138,240,000	
Pills Requirements	13	Per LHW	8,424,000	10,140,000	10,920,000	11,700,000	12,480,000	
Cost of Condoms in US\$ (million)	0.0211	Per Condom	1.969	2.370	2.552	2.735	2.917	
Cost of Condoms in Rs. (million)	1.266	Per Condom	118.133	142.197	153.135	164.074	175.012	
Cost of Cycles of Pills in US \$ (million)	0.235	Per Cycle	1.980	2.383	2.566	2.750	2.933	
Cost of Cycles of Pills in Rs. (million)	14.1	Per Cycle	118.778	142.974	153.972	164.970	175.968	
Year -wise funds requirements for Contraceptives.			US \$	3.949	4.753	5.118	5.484	5.850
			Rs.(M)	236.911	285.171	307.107	329.044	350.980
			Rs.	236,911,392	285,171,120	307,107,360	329,043,600	350,979,840
(FY-2003~2008)			\$					
Total Cost Contraceptives			25.154	Rs.		1,509.213		

Annexure – XI

Basic Drugs and Miscellaneous Items for the LHWs

Description	Accounting Unit	Monthly Need
Paracetamol Tablets 500 mg	Pack of 200 tab	200 tab
Paracetamol Syrup, 125mg/6ml	Bottle of 60ml	10 bottle
Chloroquine Tablets ,150mg	Pack of 100 tab	100 tab
Chloroquine Syrup,50mg/5ml	Bottle of 60ml	5 bottle
Ferrous Fumerate + Folic Acid Tab (150 mg + 0.5mg)	Pack of 1000 tab	1000 tab
Cholorohexadine Gluconate 1.5 Solution Atiseptic Lotion (1.5% Solution)	Bottle (50 ml)	1 Bottle
Cotrimexazole Syrup (200 mg + 40mg/5ml)	Bottle of 60ml	5 Bottle
Eye Ointment Polymyxin “B” Sulphate (Polymaxine “B” Sulphate BP 10000 Unit Zinco Bacitracine BP 500 Unit *	Tube (4 mg	10 Tubes
B.Complex Syp (Riboflarine (BZ) SP Thiamine HCL (B) USP	Bottle (60 ml)	7 Bottle
Benzyle Benzoate, lotion, 25%, 25W/V	Bottle (60 ml)	2 Bottle
Sticking Plaster , 1” X 5 Meter	Roll (1X5 meter)	1 Roll
Mebendazole Tab 100mg	Pack of 150 tab	150 tab
Cotton Wool, Non Sterile Registered Absorbent 250 Gram	Roll	1 Roll
Cotton bandages, 3” X 4 M	Pack of 12 bandages	1 Roll
Piperazine Syp (500mg/5ml)	Bottle of (30 ml)	5 Bottles
ORS Plain (27.5 gm Sachets)	Pack of 20 sachets	20 Sachets

<u>B. CONTRACEPTIVES</u>		
Condoms (1 piece)	100 per pack	100 condoms
Oral Pills Cycle/strip	10 table per cycle	100 Pills
<u>ONE TIME SUPPLY FOR EACH LHW</u>		
Pencil Torch (Piece each)	1	REPLACED BIANUALLY
Thermometer (Piece each)	1	REPLACED ANNUALLY
Scissors (Piece each)	1	REPLACED BIANUALLY
LHW Kit Bag (Piece each)	1	REPLACED EVERY 3 YEARS
Baby Weighing Scale (piece /each)	1	-do-
Bathroom scale for ante-natal care may be considered at a later stage.	1	-do-

Annexure – XII

PRINT MATERIAL REQUIRED FOR TRAINING, ANNUAL ISSUANCES AND REPLACEMENTS

S. #	NAME OF TRAINING/ PRINTED MATERIAL	Requirement/ Recipients	Issued after x years	REQUIREMENTS	REQUIREMENTS	REQUIREMENTS	REQUIREMENTS	REQUIREMENTS
				BASED ON 90,000	BASED ON 100,000	BASED ON 100,000	BASED ON 100,000	BASED ON 100,000
				2003-04	2004-05	2005-06	2006-07	2007-08
				TOTAL AMOUNT	TOTAL AMOUNT	TOTAL AMOUNT	TOTAL AMOUNT	TOTAL AMOUNT
1	LHW Manual for 03 months Training	LHW	0	6,608,000	1,742,850	624,500	671,350	721,700
2	LHW Manual for 12 Months Training	FACILITY (As per No. of LHWs)	0	1,807,400	445,500	159,650	171,600	184,500
3	Family Register (Khandan Register)	LHW	2	8,728,200	557,750	11,992,000	644,550	13,858,000
4	Family Planning & Curative Register	LHW	2	6,660,000	425,600	9,150,000	491,850	10,574,000
5	Monthly Report (LHW)	LHW	2	2,511,000	160,450	3,450,000	185,100	3,986,000
6	Community Chart	LHW	2	311,400	19,900	428,000	23,000	494,000
7	Growth Card	LHW	1	6,079,500	7,805,000	8,365,000	449,750	9,660,000
8	Referral Pads	LHW	1	1,285,200	1,642,000	1,766,000	94,900	2,040,000
10	Monthly Report for Supervisor	SUPERVISOR	1	744,000	855,840	919,920	0	1,063,200
11	Information for LHWs	LHW	0	0	0	7,300	7,850	8,400
12	Eye Disease Chart	LHW	0	0	0	0	57,100	0
		T-CENTER	0	0	0	0	0	0
13	Eye Card	LHW	2	111,600	7,150	154,000	8,250	178,000
		T-CENTER	2	4,340	0	5,390	0	6,230
14	Posters (6 types)	LHW	1	8,820,000	563,600	605,900	651,350	700,200
	ARI 3 Types	T-CENTER	1	343,000	394,520	424,130	0	490,140
	FP 1 Type	DPIU	1	11,760	13,526	14,542	15,632	16,805
	Diarrhea 1 type		1	0	0	0	0	0
	Maternal Health 1 Type		1	0	0	0	0	0
15	Supervisors Manual	SUPERVISOR	1	340,000	391,080	420,400	0	485,840
		TRAINER	1	765,000	879,930	945,900	0	1,093,140
16	Checklist for Training of Supervisor	SUPERVISOR	1	127,600	146,760	157,760	0	182,320
		PIU MEMBERS		0	0	0	0	0
17	(Checklist & feedback) for Supervisor	LHW	1	824,400	52,600	56,600	60,800	65,400
		SUPERVISOR	1	1,099,200	1,262,400	1,358,400	0	1,569,600
18	Trainer's Manual	TRAINER	1	2,231,820	2,567,160	2,759,760	0	3,189,240
19	Stock Register for Medicines	FACILITY	2	457,745	0	566,004	0	654,092
20	Log Book for vehicles	VEHICLE	2	248,320	0	307,040	0	354,832
21	District Monthly Report	DPIU	1	9,090	10,456	11,239	0	12,989
22	Provincial (Monthly Report)	PPIU	2	1,200	0	1,480	0	1,710
23	Diary for LHW	LHW	2	5,737,900	1,414,350	10,136,000	544,800	11,713,000
24	Diary for Supervisors	SUPERVISOR	2	260,000	0	321,480	0	371,520
25	Bin Card	FACILITY	When Needed	465,835	535,493	574,675	618,211	661,747
		DPIU	When Needed	0	0	0	0	0
		PPIU	When Needed	0	0	0	0	0
TOTAL				56,593,510	21,893,915	55,683,070	4,696,094	64,336,605
TOTAL IN MILLION RUPEES				56.594	21.894	55.683	4.696	64.337

- Notes:
- 1 In the year 2003-2004, 50,000 LHW manuals will be replaced plus new recruitment of 10,000 will be made. Moreover, most of the items that are issued after 2- years will have to be re-issued.
 - 2 Inflation factor in printing cost @7.5% per annum from the previous year has been estimated and added in the cost.
 - 3 The cost goes higher when replacements will be issued, like registers and cards etc. and falls in the years when not re-issued
 - 4 Based on the studies, average of new 5000-LHWs per year will have to be inducted in lieu of resignations, migrations and terminations.
 - 5 Change in the list may be made depending upon the need of the Programme.

Annexure – XIII

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

S.No.	NAME OF PRINTED ITEM	REQUIREMENT
1	Trainer's Manual	One for each Trainer
2	LHW Manual (Urdu)	One for each LHW
3	Register Khandan	One for each LHW for 2 years
4	Register Curative and Family Planning	One for each LHW for 2 years
5	Register Monthly Report for LHWs	One Register for each LHW for 2 years
6	Register Summary Monthly Report for BHU	One Register for each LHW for 2 years
7	Community Chart	One for each LHW for 2 years
8	Stock Register for Medicine	One for each health facility for 2 years
9	Growth Cards for LHWs	35 Cards per LHW per year
10	Referral Pad	2 Pads per LHW per year
11	Log Book for Vehicles	One for each Vehicle for 2 years
12	Checklist and Feedback for Supervisor	4 sheets per LHW once in a year + 120 sheets per supervisor
13	Monthly Report for Supervisor	One Register for two months and each LHS need 6 registers yearly
14	Checklist for Training LHWs Supervisor	One for each LHS and one for each for PIU members
15	Eye Disease Chart	One for each LHW
16	Eye Card	One for each LHW
17	District Monthly Report	One for each DPIU for 2 years
18	Provincial Monthly Report	One for each PPIU for 2 years
19	LHWs Manual for 12 Months Training (Urdu)	One for each LHW
20	Supervisor Manual	One for each LHS and one for each trainer
21	Poster (Set of Six)	One set (6 posters) for each LHW, one set for each training center and one for each PIU
22	Diary for LHW	One for each LHW for 2 years
23	Dairy of Supervisor	One for each LHS for 2 years
24	Information for LHWs	One for each LHW
25	BIN Card	As per requirement for all PIUs and health facilities
26	Reheumatic Card for LHW	One for each LHW
27	Reheumatic Card for BHU/RHC	One for each health facility
28	LHWs Manual for 12 Months Training (Sindhi)	One for each LHW
29	LHW Manual (Sindhi)	One for each LHW
30	Community Chart (Sindhi)	One for each LHW for 2 years
31	Eye Disease Chart (Sindhi)	One for each LHW, one for each training center and one for each PIU
32	Poster (Set of Six) (Sindhi)	One set (6 posters) for each LHW, one set for each training center and one for each PIU
33	Refresher Training Module for LHW	One for each LHW (up to phase IV)

Note: Training material may be added or subtracted on need basis.

Annexure – XIV (A)

Staff Strength of Programme Implementation Units

DISTRICT PIUs		FEDERAL PIU		
Post	NO.	Post	BPS	NO.
Accounts Supervisor (Assistant)	1 for each DPIU, in districts with more than 800 LHWs, there may be two Accounts Supervisors.	National Advisor		1
		Deputy Coordinators	18	2
		Finance Officer	18	1
		Audit Officer	17	1
		Research Officer	18	1
		Monitoring Officer	18	1
		Section Officer	18	1
		Health Education Officer	18	1
		MIS Coordinator	18	1
		Training Coordinator	18	1
Selection of LHWs, LHS and drivers in all districts will be in phased manner, on contract basis under special rules.		Field Programme Officers	18	(2 each for Punjab, Sindh, NWFP, Balochistan and one each for AJ&K, FATA, FANA, ICT)
		Logistic Officer	18	1
		Media Officer/ P.R.O	17	1
		Computer Programmer	17	1
		Assistant Accounts Officer	16	2
		Superintendent	16	1
		Data Analyst	16	2
		Steno Typist	12	2
		Assistant	11	6
		Receptionist	11	1
		Store Keeper	11	1
		Cashier	11	1
		Data Operator	9	6
		UDCs	7	3
		LDCs	5	3
		Drivers	4	6
		Naib Qasid	1	6
		Chowkidars	1	5
		Sanitary Worker	1	2

Annexure – XIV (B)

Staff Strength of Programme Implementation Units

PROVINCIAL PIU-Punjab			PROVINCIAL PIU-Sindh		
Post	BPS	NO.	Post	BPS	NO.
Deputy Coordinator	18	2	Deputy Coordinator	18	2
Assistant Coordinator	17	2	Assistant Coordinator	17	1
Health Education Officer	17	1	Health Education Officer	17	1
Training Coordinator	17	1	Training Coordinator	17	1
MIS Coordinator	17	1	MIS Coordinator	17	1
Finance Officer	17	1	Finance Officer	17	1
Field Programme Officer	17	12	Field Programme Officer	17	7
Logistics Officer	17	1	Logistics Officer	17	1
Superintendent	16	1	Superintendent	16	1
Data Analyst	16	1	Data Analyst	16	1
Accountant	16	1	Accountant	16	1
Stenotypist	12	2	Stenotypist	12	2
Assistant	11	2	Assistant	11	2
Cashier	11	1	Cashier	11	1
StoreKeeper	11	1	StoreKeeper	11	1
Receptionist	11	1	Receptionist	11	1
Data Entry Operator	9	3	Data Entry Operator	9	3
UDC	7	1	UDC	7	1
LDC	5	1	LDC	5	1
Drivers	4	4	Drivers	4	4
Naib Qasid	1	5	Naib Qasid	1	4
Chowkidar	1	5	Chowkidar	1	5
Sanitary Worker	1	2	Sanitary Worker	1	2

Annexure – XIV (C)

Staff Strength of Programme Implementation Units

PROVINCIAL PIU-NWFP			PROVINCIAL PIU-Balochistan		
Post	BPS	NO.	Post	BPS	NO.
Deputy Coordinator	18	1	Deputy Coordinator	18	1
Assistant Coordinator	17	1	Assistant Coordinator	17	1
Health Education Officer	17	1	Health Education Officer	17	1
Training Coordinator	17	1	Training Coordinator	17	1
MIS Coordinator	17	1	MIS Coordinator	17	1
Finance Officer	17	1	Finance Officer	17	1
Field Programme Officer	17	6	Field Programme Officer	17	5
Logistics Officer	17	1	Logistics Officer	17	1
Superintendent	16	1	Superintendent	16	1
Data Analyst	16	1	Data Analyst	16	1
Accountant	16	1	Accountant	16	1
Stenotypist	12	2	Stenotypist	12	2
Assistant	11	2	Assistant	11	2
Cashier	11	1	Cashier	11	1
StoreKeeper	11	1	StoreKeeper	11	1
Receptionist	11	1	Receptionist	11	1
Data Entry Operator	9	3	Data Entry Operator	9	3
UDC	7	1	UDC	7	1
LDC	5	1	LDC	5	1
Drivers	4	4	Drivers	4	4
Naib Qasid	1	4	Naib Qasid	1	3
Chowkidar	1	5	Chowkidar	1	5
Sanitary Worker	1	2	Sanitary Worker	1	2

Annexure – XIV (D)

Staff Strength of Programme Implementation Units

PROVINCIAL PIU-AJK			PROVINCIAL PIU-FANA		
Post	BPS	NO.	Post	BPS	NO.
Deputy Coordinator	18	1	Deputy Coordinator	18	1
Assistant Coordinator	17	1	Assistant Coordinator	17	1
Health Education Officer	17	1	Health Education Officer	17	1
MIS Coordinator	17	1	MIS Coordinator	17	1
Finance Officer	17	1	Finance Officer	17	1
Field Programme Officer	17	2	Field Programme Officer	17	2
Logistics Officer	17	1	Logistics Officer	17	1
Superintendent	16	1	Superintendent	16	1
Data Analyst	16	1	Data Analyst	16	1
Accountant	16	1	Accountant	16	1
Stenotypist	12	2	Stenotypist	12	2
Assistant	11	2	Assistant	11	2
Cashier	11	1	Cashier	11	1
StoreKeeper	11	1	StoreKeeper	11	1
Receptionist	11	1	Receptionist	11	1
Data Entry Operator	9	3	Data Entry Operator	9	3
UDC	7	1	UDC	7	1
LDC	5	1	LDC	5	1
Drivers	4	3	Drivers	4	3
Naib Qasid	1	3	Naib Qasid	1	3
Chowkidar	1	3	Chowkidar	1	3
Sanitary Worker	1	2	Sanitary Worker	1	2

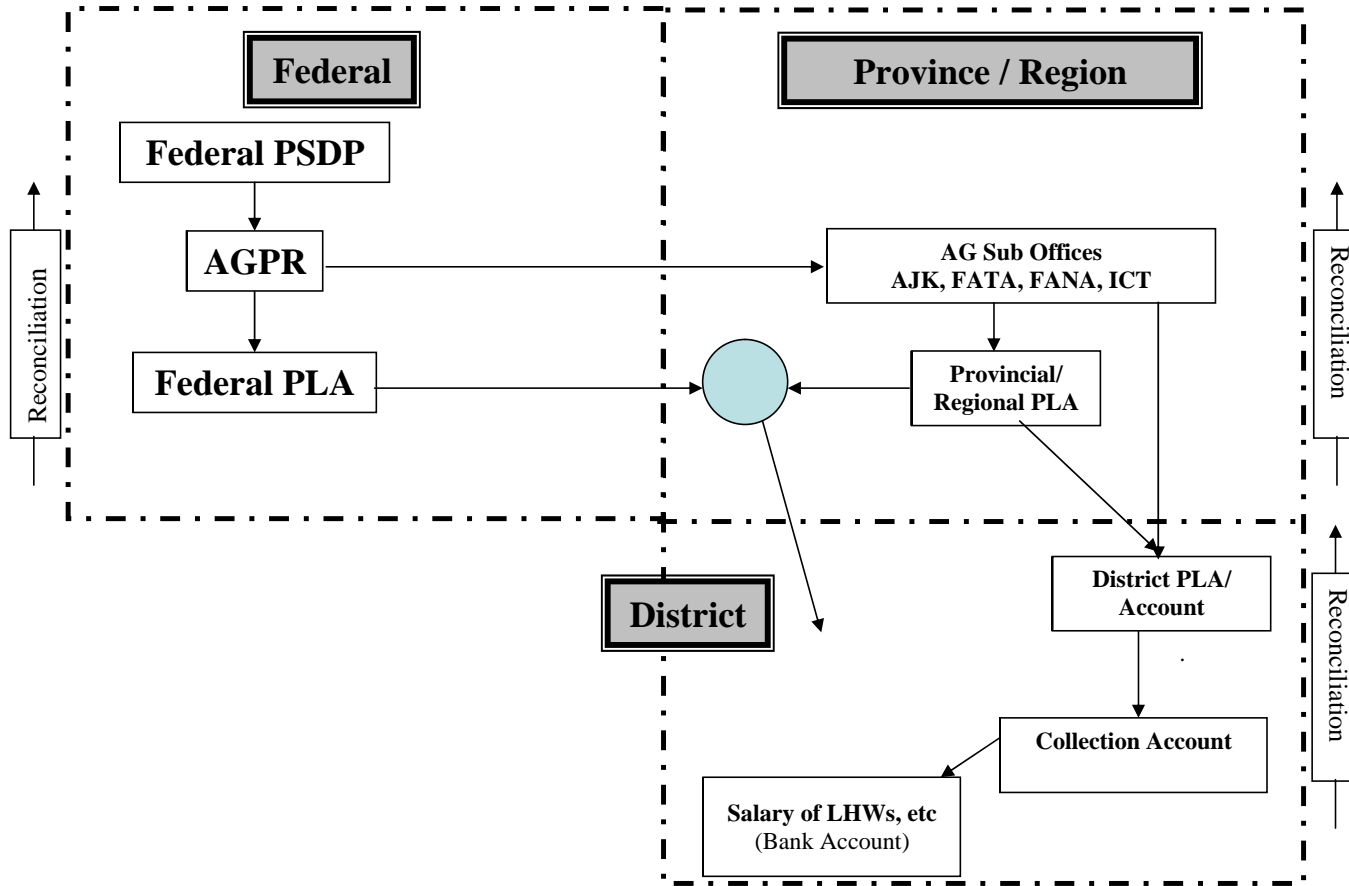
Annexure – XIV (E)

Staff Strength of Programme Implementation Units

PROVINCIAL PIU-FATA			PROVINCIAL PIU-ICT		
Post	BPS	NO.	Post	BPS	NO.
Deputy / Assistant Coordinator	18	1	Deputy / Assistant Coordinator	18	1
Field Programme Officer	17	2	Field Programme Officer	17	1
Superintendent	16	1	Data Analyst	16	1
Data Analyst	16	1	Superintendent	16	1
Accountant	16	1	Accountant	16	1
Stenotypist	12	1	Stenotypist	12	1
Assistant	11	1	Assistant	11	1
Cashier	11	1	StoreKeeper	11	1
StoreKeeper	11	1	Data Entry Operator	9	1
Data Entry Operator	9	1	LDC	5	1
UDC	7	1	Drivers	4	2
LDC	5	1	Naib Qasid	1	1
Drivers	4	2	Chowkidar	1	2
.Naib Qasid	1	2	Sanitary Worker	1	1
Chowkidar	1	2			
Sanitary Worker	1	1			

Flow of Funds

Annexure – XV



**POLICY FOR
STRENGTHENING EPI SERVICES THROUGH
LADY HEALTH WORKERS**

Using LHWs for motivation and communication for immunization has already been well tested during routine EPI activities but especially during the National Immunization Days (NIDs). However the main role envisaged for involving LHWs in EPI activities are as follows:

Initially, LHWs and vaccinators would work as a team, where LHWs would motivate and convince the community members especially women to have their children (under one year) vaccinated, starting with OPVO and BCG injection soon after birth. LHWs would be trained in administering TT to CBAs initially and subsequently undertaking EPI injections to the targeted children after requisite training. Eventually, LHWs themselves would assume the responsibility of vaccinating children in their assigned areas.

EPI vaccinators would remain responsible for immunization of children and women outside the specified areas of trained areas of trained LHWs, besides maintaining cold chain for proper storage of EPI vaccines and helping LHWs keeping proper record of the immunization done by her. Needless to say, the needed vaccines, auto-disable (AD) syringes and needles would be provided to LHWs on as and when required basis by vaccinators.

LHWs will be trained in administration all EPI vaccines using the new auto-disable syringes and they will act as vaccinators in their catchments areas.

TRAINING OF LHWs AS VACCINATORS.

Considering the education level and training in PHC of LHWs it is safe to presume that they can be trained as Vaccinators.

Training of the LHWs in immunization can be organized at the health facilities using their own trainers (i.e. Medical Officer, LHV and MHT) and Vaccinators. However these trainers can be trained at the district level by district trainers. The basic training for LHWs EPI will be of two weeks and on-job training will continue for six months. The National and Provincial and selected District managers of the two programmes may mutually decide on the content and duration of the training for LHWs. The training plan shall be made according to the functions to be assigned to LHWs.

MANAGEMENT ISSUES:

The main issue in the plan for involvement of LHWs in the immunization program may be that of logistics, supplies and cold chain. The EPI is facing difficulties in ensuring timely supplies to its vaccinators. The increase in the number of staff to be provided vaccines would burden the Program further. This problem could be partly addressed by utilizing the logistic system developed by the two programs working in conjunction.

The EPI Programme would be assigned the responsibility of providing vaccines and other supplies to the District and Health Facility level from where the vaccinator or health facility staff could provide vaccines and cold chain to Lady Health Workers once a month. However in order to enable the LHW to perform her work in a planned manner, she will assign one day per month for the immunization functions. She will receive the vaccines from EPI / health facility staff and will return the un-used vaccines along with report of the vaccination on the same day. By doing vaccination on only one day per month, the need for cold chain equipment is limited and may be served by a simple vaccine carrier with ice pack. This would also minimize distribution problems, as each LHW of a health facility would have a different vaccination day, which may remain constant for her particular area.

The provision of cold chain equipment may also be partially addressed by starting this initiative in tandem with planning for GAVI and NNT eradication activities under which supplies and cold chain equipment provision can be taken.

The logistics of vaccine and syringe distribution will need to be worked out on a local level with detail micro plans. An improved inventory tracking and needs forecasting system will be required.

A waste disposal plan will also be needed for each facility. Increased number of vaccination mean increased medical waste which need disposal. Used syringes will be collected from LHWs and a mechanism will be developed to collect used syringes from health facilities at the time of pick up of new supply. Periodic studies should be done to ensure that all used material is being returned.

An argument advanced is that the move to assign LHWs the role of immunization children and women against EPI diseases could raise fears among the vaccinators that they would become redundant and may be declared surplus subsequently. This is not true as EPI is seriously short of vaccinators. The present strength of vaccinators was determined twenty years ago and it has not gone up although the population has grown considerably. The induction of LHWs would in fact help vaccinators to do the task in their assigned area properly. Vaccinators would also continue to serve as resource persons for LHWs, doing continuous training and monitoring of their EPI related activities.

Another argument is that LHWs would be overburdened as they have a number of other tasks to perform. On average, LHWs is responsible to look after a population of 800 to 1000 dwelling in 200 houses. Therefore, they would only look after children under one year to be immunized against EPI diseases and four

pregnant mothers to be immunized, with TT in one month. As a matter of fact, this arrangement would allow the vaccinator to give more attention to the following important functions:

- Focus on outreach and mobile activities
- Check the cold chain regularly
- Train and guide LHWs in administering EPI vaccines including the use of syringes.
- Provide immunization at fixed centers where manpower is not available.

In order to provide favorable conditions to the field staff to work optimally, the following proposals need consideration:

a) **FEDERAL LEVEL:**

- The National Coordinator of the NP for FP & PHC and the National Program Manager of the EPI will coordinate in policy formulation and joint collaboration with other partners.
- A Task Force will be formed to plan and monitor the progress of the Integration activities. This Committee will comprise of the National and Provincial Manager/Coordinators of the two Programmes, two DHOs and one representative each from the WHO, UNICEF, UNFPA, JICA, DFID, WB etc. This task force will meet on quarterly basis.
- As and when required, review meetings will be held of the two Programs attended by the respective National and Provincial Managers/Coordinators.

b) **PROVINCIAL LEVEL:**

- The Provincial Programme Coordinators of NP for FP & PHC and the EPI Provincial Managers will be responsible for planning, implementation and monitoring of the collaboration activities.
- The Provincial Programme Manager, EPI will be nominated as the honorary member of the Provincial Implementation Unit (PIU) of the NP for FP & PHC. Both the Provincial managers/Coordinators will be invited to attend review meetings of the two programs.
- Both the programs will undertake monitoring and supervision of the two programs at the district level jointly.

c) **DISTRICT LEVEL:**

- A Joint district team shall be constituted in each district; representing stakeholders of the two Programmes i.e. ADHO/DSV/FSMO and the District Coordinator of NP for FP & PHC. They will work as a team under the supervision of the DHO. Assigning responsibility of both the Programmes to one person where feasible may also be considered.
- The ADHO/DSV/FSMO will be an honorary member of the District PIU.

- The FSMO/DSV in consultation with the District Coordinator will prepare advance monthly plans for outreach vaccination activities. These plans will be shared with the NP for FP & PHC staff.

d) HEALTH FACILITY LEVEL:

- All vaccinators will attend the monthly meetings/one day training sessions of the LHWs at their respective health facilities in order to plan immunization activities jointly.
- Training of LHWs in vaccine administration and other related activities would be carried out at the health facility.
- The Medical Officer in charge will look after the work of both the LHWs and the Vaccinators.

e) COMMUNITY/FIELD LEVEL:

- The LHWs will maintain record of all children and mothers eligible for immunization in their assigned area.
- The LHW will emphasize the importance of immunization and motivate the mothers for immunizing themselves and their children.
- The LHWs trained in vaccination will administer vaccines according to the policies of the program.
- In areas where LHWs are not trained in vaccination, she will identify and help the vaccinator in vaccinating mothers and children due for vaccination on assigned date of visit of the vaccinator, agreed in advance. The vaccinators will visit the areas of the LHWs as per monthly plan and will vaccinate all eligible children and mothers.
- The LHW-Supervisors of the National Programme for FP & PHC will monitor the immunization activities of LHWs and submit reports to the higher authorities.

E: IMPLEMENTATION

The strategy can be implemented in three phases:

Phase I: Strategy will be adopted in 5 pilot districts of integrated PHC project i.e. Mardan in NWFP, Jhelum in Punjab, Sukkar in Sindh, Pishin in Balochistan and Mirpur in AJK and 9 High Risk districts for National Tetanus.

Phase II: Rest of 57 High-Risk districts for neonatal tetanus will be involved i.e. Punjab: (15 districts), Sindh: (20 districts), NWFP/FATA: (15 districts), and Balochistan: (7 districts)

Phase III: Rest of the districts.

LHWs will be assigned the role of vaccinators and they will perform this duty in a phased manner. Initially they will start by immunizing mothers for TT. Later on DPT may be introduced and lastly they may vaccinate children for Measles and BCG.

F: FUNDS/BUDGET

Allocations already exist in the EPI Programme, the National Programme for FP & PHC, WHO and UNICEF Country Programme. The options may be tested in pilot districts of integrated PHC project before nation wide implementation. The cost implications and budget may be worked out after identifying supplies & training needs.

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