Terms of Reference (ToR) – Deployment of Human Resource under KP-HCIP Health

Background

The Khyber Pakhtunkhwa Human Capital Investment Project – Health (KP-HCIP Health) is a World Bank-funded initiative aimed at strengthening primary healthcare services in Khyber Pakhtunkhwa (KP). KP hosts the highest number of Afghan refugees in Pakistan, with more than half of the refugees residing in four urban districts: Peshawar, Nowshera, Haripur, and Swabi. This influx has placed additional strain on health services in these districts, particularly for women and children. The KP-HCIP Health project focuses on improving the performance of the health sector – especially primary healthcare (PHC) – as the first point of care for communities, including vulnerable groups such as women and refugees. A key priority is to enhance maternal, newborn, and child health services at the community level by upgrading selected Basic Health Units (BHUs) to provide Basic Emergency Obstetric and Newborn Care (BEmONC). These upgraded BHUs are intended to offer essential services – **antenatal care (ANC)**, safe delivery and **postnatal care (PNC)**, along with immunization, nutrition, and family planning – closer to where people live.

In line with this strategy, the Health Department seeks to **engage a qualified firm** to hire Human Resources for targeted BEmONC-designated BHUs (HR) across Peshawar, Nowshera, Swabi, and Haripur. Lady Health Visitors are mid-level health providers trained in maternal and child health; their presence will enable these facilities to operate on extended hours (24/7 where possible) for childbirth and other essential services. This intervention will fill critical human resource gaps (specify the cadres of HR), improve the quality and utilization of BHU services, and ultimately contribute to better maternal and neonatal health outcomes in the target districts. The assignment is part of a 06-month duration under KP-HCIP Health, after which the results will inform future scaling or integration into the public health system.

Objective of the Assignment

The primary objective of this assignment is **to recruit, deploy, and manage skilled Human resource** at selected BEmONC BHUs (24/7) in the districts of Peshawar, Nowshera, Swabi, and Haripur for a period of 06 months through a transparent and competitive process. The engaged firm will ensure that each target BHU consistently has qualified HR available to provide maternal, newborn, and child health services (including round-the-clock delivery care and related services). Through this deployment, the project aims to:

- **Strengthen Service Delivery:** Enhance the availability of skilled female healthcare providers at the primary care level, thereby improving ANC coverage, safe delivery services, PNC, family planning, and other essential PHC services for women and children.
- **Improve Health Outcomes:** Contribute to reductions in maternal and neonatal morbidity and mortality in the target communities by ensuring timely and quality care at BHUs.

- **Capacity Building and Continuity:** Build local capacity by training and mentoring the HR, ensuring they are well-oriented to government protocols and community sensitivities, thus laying groundwork for sustainable improvements in service delivery. The deployed Lady Health Visitors (LHVs) shall receive structured mentorship through a dual supervision framework:
    - Functional Supervision: LHVs will work under the clinical oversight of the BHU Medical Officer/Women Medical Officer and the District Health Officer, in accordance with Government of KP protocols and reporting lines. Moreover, KP-HCIP will also supervise the implementation, performance monitoring, and quality assurance aspects of the program in coordination with the district health authorities.
    - Supportive Mentorship by the Firm: The contracted firm shall appoint a qualified MNCH/Clinical Supervisor responsible for providing regular on-site mentoring visits (at least monthly), reviewing clinical practices, ensuring adherence to BEmONC protocols, conducting case discussions, and organizing periodic refresher training sessions.

  This arrangement ensures quality assurance, professional development of LHVs, and integration within the government health system while maintaining contractual accountability of the firm.
- **Operational Support:** Provide a stop-gap human resource solution in these facilities while longer-term government staffing is strengthened, thereby maintaining continuity of care and community trust in public health services.

Ultimately, the firm's engagement will support KP-HCIP Health in demonstrating effective models for human resource outsourcing in healthcare and ensure that the targeted BHUs can function at the standards required for BEmONC services over the contract period. *The firm's engagement will align with GoKPs goals for health system strengthening and safeguards compliance.*

Scope of Work

The scope of work outlines the comprehensive responsibilities of the contracting firm. The firm is expected to undertake all activities necessary to deploy and manage the HR effectively, including but not limited to the following:

- **Recruitment of HR:** Identify and **recruit skilled/qualified HR** to fill the positions. The firm will develop transparent recruitment criteria after approval of PMU Health Department. Each staff must possess the requisite qualifications (recognized STAFF diploma or equivalent midwifery training, with valid registration/certification) and preferably local

language skills and familiarity with the culture. The firm will handle advertising of positions (if needed), shortlisting, interviewing, and verification of credentials. Priority should be given to candidates from within or near the target districts (where possible) to encourage community acceptance and reduce relocation issues. A detailed list of selected HR with their qualifications and posting locations should be submitted to the PMU/DOH for approval before deployment.

Types of HR required are;

Proposed Staff for BEmONC Facilities				
Sr. No.	**HRH**	**24/7 BHU (Rural)**	**24/7 RHC (Rural)**	**Total Staff**
1	Women Medical Officer	1	1	93
2	Lady Health Visitor	3	3	279
3	Technician	2	2	186
4	Dai/Aya	4	4	372
5	DEOs	1	1	93
	Total			1023

Summary of the Proposed Technical HR Plan (CEmONC Staff)						
S.No	**Category**	**Minimum Required**	**Swabi**	**Peshawar**	**Haripur**	**Total Staff**
			Cat-D Hospital Yar Hussain	**ESH Nahaqi**	**Category D Hospital Khanpur Haripur**	
1	Gynecologists	1	1	1	1	3
2	Medical Officers	2	2	2	2	6
3	Anesthesia Staff	2	2	2	2	6
4	Midwives / LHV	5	5	5	5	15
5	Staff Nurses	4	4	4	4	12
6	OT / Surgical Staff	3	3	3	3	9
7	Pediatrician/TMO	1	1	1	1	3
8	Lab Staff	2	2	2	2	6
9	DEO	1	1	1	1	3
10	Total staff per Facility	21	21	21	21	
					Grand Total Staff Required	63

- **Timely Deployment and Placement:** Ensure **prompt deployment** of the recruited HR to the **designated BEmONC BHUs**. The firm is expected to have all HR in place and on duty within a reasonable mobilization period (e.g. within 2 weeks of contract signing, or as agreed with the client). This includes coordinating with District Health Officers (DHOs) and BHU in-charges to place each STAFF at the correct facility and shift (to ensure coverage of

both day and night duties). The firm will provide each STAFF with an official deployment letter/contract and facilitate introductions to local health facility staff and community representatives. HR should be scheduled in a manner that the BHU can offer extended or 24/7 maternal health services (one STAFF may cover day shift and one night shift, or in rotations as appropriate). The firm must also establish a system for **backup or relievers** in case a STAFF is on leave, so that service continuity is maintained with no BHU left without STAFF coverage for an extended period.

- **Human Resource Management and Administration:** Serve as the **employer-of-record** for the HR, handling all HR matters throughout the 06-month period. This includes maintaining personnel files, managing attendance and leave records, and ensuring discipline and motivation among the HR. The firm should clearly communicate job descriptions, duty hours (aligned with BHU schedules), code of conduct, and performance expectations to each STAFF at the time of hiring. If any STAFF position becomes vacant (due to resignation, termination, etc.), the firm will promptly recruit and deploy a replacement STAFF with equivalent qualifications, subject to approval by the Health Department, to avoid any service disruptions.

- **Payroll Processing and Compensation:** Manage the **monthly payroll** for all deployed HR in a timely and transparent manner. The firm will be responsible for disbursing salaries to HR each month (preferably via bank transfer to individual accounts for accountability), ensuring no undue delays. Salaries and any allowances must be in line with the amounts agreed in the contract or as per government norms for similar positions (BPS-12 scale or market-equivalent, as appropriate). The firm will handle all statutory deductions or benefits (such as taxes, EOBI, social security, if applicable) on behalf of the HR, and keep records of all payments. A payroll report shall be provided to the client monthly, including confirmation of disbursement. The firm must also facilitate resolution of any salary-related issues or discrepancies immediately (this tie into grievance handling as well). In summary, the firm guarantees that **HR are paid accurately and on time each month**, which is crucial for morale and retention.

- **Training and Orientation of HR:** Organize an initial **training and orientation program** for all hired HR before their deployment. This orientation (of at least a few days) should cover: introduction to the KP-HCIP project and its objectives, the roles and responsibilities of HR at a BEmONC BHU, clinical protocols for basic emergency obstetric and newborn care, infection prevention practices, data recording and reporting requirements, referral pathways for complications, and an orientation on the specific BHU's operations. The firm may coordinate with the Health Department's trainers or utilize existing government training materials (e.g. standardized clinical protocols and guidelines) to ensure the HR are aligned with public sector practice. All HR should also be briefed on the cultural

context and community engagement approach, given that they will serve diverse populations including refugees and host communities. If needed, the firm will arrange **refresher trainings or on-site coaching** during the course of the assignment (for example, quarterly refresher sessions or mentorship by senior public health nurses) to continually build the HR' capacity. A training completion report (listing attendees, topics, and outcomes) will be submitted to the client.

- **Grievance Handling Mechanism:** Establish and operate a **grievance redressal mechanism** for addressing any issues or complaints that arise during the course of STAFF deployment. This mechanism should handle two types of grievances: (1) **Grievances of the HR** – e.g. complaints regarding their working conditions, interpersonal conflicts at the facility, salary/payment issues, harassment or safety concerns – and (2) **Grievances from other stakeholders** (such as BHU staff, community members, or project authorities) related to the HR – e.g. concerns about an STAFF's performance or conduct. The firm will designate a focal person (or team) to receive grievances (via phone hotline, email, or in-person reporting), document them, and take prompt action to investigate and resolve the issues. A clear protocol should be in place: minor issues can be resolved by the firm's field supervisors or project manager in coordination with the BHU in-charge, whereas serious issues (e.g. allegations of misconduct, harassment, or abuse) must be escalated to the firm's senior management and immediately reported to the Health Department/PMU for joint action. The firm must ensure **confidentiality and non-retaliation** in handling complaints, especially those raised by HR (given power dynamics as outsourced staff) – any STAFF should feel safe to report problems without fear of losing her job. All grievances and their resolution status should be logged, and a summary included in routine reporting to the client. If a grievance indicates a breach of contract or serious misconduct by a STAFF or any firm staff, the firm will take disciplinary action (including termination or replacement of staff) in consultation with the client. The grievance mechanism will also serve as a feedback tool to improve the working environment and address any systemic issues that might affect performance (for example, if multiple HR complain about lack of essential supplies at facilities, the firm can bring that to the Health Department's attention).

- **Compliance with World Bank Regulations:** The firm shall adhere to:
    - World Bank's "Procurement Regulations for IPF Borrowers" Dated July 2016, revised November 2017, July 2018, November 2020, September 2023, February 2025 and September 2025 ("Procurement Regulations").
    - **Environmental and Social Framework (ESF)**, including gender inclusion and community safeguards.
    - **Financial Management Guidelines** (transparent payroll, statutory deductions).
    - Screen BHU waste management systems against WB **Environmental Standard**

- Conduct **gender-sensitive consultations** with refugee/host communities
- Submit quarterly environmental compliance reports.

- **Coordination and Support:**

- In addition to the above primary tasks, the firm shall coordinate closely with government health authorities to ensure smooth integration of the deployed HR into existing facility structures. The deployed staff will work side by side with the regular facility staff and will report directly to the respective Facility In-Charge (FIC) in accordance with the prevailing government reporting hierarchy. No parallel management or supervisory structure shall be created at district or facility level.

- The firm will maintain coordination with the KP-HCIP Project Management Unit (PMU) and the District Health Offices strictly for contractual oversight, performance monitoring, and administrative support purposes. Any coordination meetings (monthly or quarterly, as required) will focus on reviewing overall deployment status, addressing operational challenges, and ensuring alignment with government priorities.

- Field-level oversight by the firm, if required, will be limited to contractual compliance, attendance verification, and administrative facilitation. Such oversight will not interfere with the technical supervision, duty allocation, or day-to-day operational control of the deployed staff, which shall remain under the authority of the Facility In-Charge and the District Health Office.

- The firm will support deployed HR by ensuring timely payments, facilitating communication with government supervisors when needed, and addressing welfare or logistical concerns. The objective is to strengthen and complement the existing public health system—not to establish a parallel structure—so that service delivery improvements are achieved within the government's institutional framework.

(Note: A detailed list of the target BHUs, along with their locations and any specific local considerations, will be provided as an annex to these ToRs. The firm should familiarize itself with these facilities. Travel logistics for HR (if residing far) are generally their own responsibility, but the firm should consider proximity during recruitment and address any extreme cases to ensure HR can reliably attend their duties. The firm is also encouraged to propose any additional innovative approaches within this scope that could enhance outcomes, such as community mobilization to increase service uptake, though the core focus remains on STAFF deployment and management.)

Roles and Responsibilities

To ensure clarity in execution, this section delineates the roles and responsibilities of the consulting firm (the Contractor) and the key oversight authorities or stakeholders (the Client and its designated bodies). A collaborative approach is expected among all parties for the successful implementation of this assignment.

- **The Contracted Firm (Consulting Firm):** The firm will bear full responsibility for executing the scope of work as described above. Key responsibilities of the firm include:
    - **Human Resource Management:** Serving as the direct manager and employer of the HR, including handling all recruitment, contracting, supervision, and if necessary, replacement of HR. The firm must ensure that all HR remain continuously in place and effective at their assigned BHUs, meeting the service standards required. Day-to-day management of the HR (attendance, duty scheduling, leave approval) falls under the firm's purview, in coordination with facility in-charges.
    - **Quality Assurance and Performance Management:** Monitoring the performance of HR and the quality of services they deliver. The firm should set up internal performance indicators (aligned with those in this ToR) and regularly review each STAFF's work (through field supervisors or feedback from BHU in-charges). If any STAFF is underperforming or faces challenges, the firm will mentor or retrain her; if performance or conduct remains unsatisfactory, the firm is responsible for taking corrective action, which could include relocating or replacing the STAFF, in consultation with the client.
    - **Reporting and Communication:** Preparing and submitting all required deliverables (inception report, monthly reports, etc., detailed in a later section) on time. The firm will maintain open communication lines with the KP-HCIP PMU and DHO offices – promptly informing them of any critical issues (e.g. an STAFF resigning, a serious incident at a facility, or any factor that could impede service delivery). Regular meetings should be attended as requested by the client to discuss progress. The firm must also respond to ad-hoc information requests or audits by the client or its partners (e.g. providing data for a project review or facilitating site visits).
    - **Compliance and Liaison:** Ensuring compliance with all contractual clauses, including ethical standards, and liaising with relevant government structures. The firm shall coordinate with BHU in-charges and Medical Officers on a daily operational basis (for example, the BHU in-charge will assign tasks to HR during duty hours, include them in facility rosters, etc., while the firm manages HR/payroll behind the scenes). The firm should also cooperate with any third-party evaluators

or monitors (like IMU or external auditors) and provide them access to information or sites as needed. In essence, the firm is the accountable party for delivering the outputs of this assignment and must be proactive in problem-solving and ensuring that all stakeholders are kept informed and engaged throughout the process.

- **KP-HCIP Project Management Unit (Health Department) – "the Client":** The PMU (within the Health Department, Government of KP) will act as the executing agency for this assignment. Its roles include:
    - **Oversight and Guidance:** Providing overall supervision of the project and guidance to the firm. The PMU will introduce the firm to district health authorities and facilitate initial mobilization (including endorsement letters to DHOs for cooperation). It will clarify any policy or technical questions (e.g., required qualifications for HR, allowable activities, etc.) and provide the firm with necessary background documents or tools (such as reporting formats, clinical guidelines for BHUs, etc.). The PMU may also organize an initial orientation session for the firm and relevant government stakeholders to ensure alignment of understanding.
    - **Contract Management:** Monitoring the firm's compliance with contract terms and the achievement of deliverables. The PMU will review reports submitted by the firm and provide timely feedback. It will also verify the firm's reported results (through its own mechanisms or via the IMU/DHOs as detailed later) to ensure accuracy before approving invoices. The PMU is responsible for processing payments to the firm as per the agreed schedule, upon confirmation that performance indicators are met. If the firm is falling short of expectations, the PMU will formally communicate concerns and require corrective measures; persistent non-performance can lead to actions as per contract (e.g., withholding payments or contract termination, though that would be a last resort).
    - **Facilitation and Support:** The PMU will facilitate coordination between the firm and other parts of the Health Department. For instance, if there are training resources available (master trainers, training institutions, curricula), the PMU can help connect the firm to these. If the firm faces administrative hurdles (e.g., issues getting access to a facility or data), the PMU will intervene to resolve them. The PMU will also ensure that other parallel initiatives of KP-HCIP Health complement this assignment (for example, if medical equipment or drugs are being supplied to those BHUs under another component, the PMU will coordinate so that HR have the tools they need). Essentially, while the firm handles implementation, the PMU ensures an enabling environment and addresses higher-level issues beyond the firm's control.

- Monitor compliance with World Bank's anti-corruption policies and facilitate independent financial audits.

- **District Health Officers (DHOs) and District Health Offices:** The DHO in each of the four target districts is a key on-ground stakeholder for successful implementation. Their roles and responsibilities include:

  - **Local Supervision and Integration:** Overseeing the integration of HR into the district's health system. DHOs (through their Medical Superintendents or other officials) will introduce the HR and the firm's field supervisors to the BHU staff and ensure that HR are welcomed as part of the facility team. The DHO should instruct BHU Medical Officers/In-charges to involve HR fully in service delivery and include them in duty rosters, staff meetings, and reporting lines. While HR are not civil servants, for the duration of this project they will function alongside government staff; thus, DHOs will treat them as part of the workforce for all practical purposes (assigning tasks, monitoring attendance, etc., just as they would for government employees, while any formal HR action will be taken by the firm).

  - **Monitoring and Verification:** Monitoring STAFF attendance and performance at the facility level. The DHO may utilize existing structures (such as the BHU in-charge, or district supervisors for the Lady Health Worker program, etc.) to keep an eye on whether HR are present and providing services as expected. DHOs are expected to verify the monthly attendance reports submitted by the firm – e.g., by signing off on timesheets or by providing an official letter each month confirming that HR X, Y, Z were present at BHU A, B, C for the required days/hours. If a particular STAFF has unexplained absences or performance issues reported by a BHU in-charge, the DHO should communicate this to the firm promptly for action. The DHOs will also collaborate in any formal monitoring (for instance, joining the PMU or IMU on monitoring visits in their district).

  - **Feedback and Coordination:** Serving as the primary point of contact for the firm in the district. The DHO (or a DHO-nominated focal person for the project) should be available to meet with the firm's representatives regularly (e.g., monthly) to discuss operational issues. They can provide feedback from the community or other staff about the HR' impact. In case of any incidents or complaints at the facility level, the DHO may be involved in joint problem-solving with the firm (for example, if an STAFF reports harassment by someone at a facility, the DHO must work with the firm to investigate and ensure a safe workplace). The DHO will also help in logistic arrangements such as including HR in any government training or immunization drives if relevant. Essentially, DHOs ensure local-level support and

accountability, bridging the gap between the firm's external role and the government health system's internal functioning.

- **Independent Monitoring Unit (IMU), Health Department:** The Independent Monitoring Unit is an existing arm of the Health Department that conducts regular field monitoring of health facilities' performance across KP. Although the IMU reports to the Department, it operates with a degree of independence in verifying on-ground realities. For this assignment, the IMU's role will be:
    - **Independent Verification:** Conduct **spot checks and performance audits** of the BHUs in question to independently verify that the deployed HR are present and functional. The IMU data collectors/monitors who routinely visit facilities will include checks related to this project in their visits – e.g., verifying whether the STAFF posts are filled, whether the HR were on duty on the day of visit, and possibly collecting simple service data (like number of ANC visits or deliveries conducted by the STAFF in the last month, if that falls under their standard indicators). These observations will be fed into IMU's reporting system.
    - **Reporting to Decision-makers:** The IMU will share its findings with the Health Department's higher management and the KP-HCIP PMU. Since the IMU is an established system for monitoring public health services, its reports will lend credibility to the information on STAFF performance. For example, if the firm's report claims 100% attendance but IMU's independent visit found an STAFF absent without substitute, this discrepancy would be noted and raised. Conversely, positive performance (e.g., an STAFF is noted as managing many patients effectively) would also be recognized. The **IMU's feedback will be used in evaluating the firm's performance and triggering any corrective actions or payment decisions**. The firm is expected to facilitate IMU's access to the facilities and staff – all HR should be instructed to cooperate fully with IMU monitors (answering questions, providing data from registers, etc. as requested).

(Note: The IMU's involvement provides an extra layer of accountability and aligns with the government's practice of evidence-based monitoring. The firm should view IMU not as an adversary but as a partner in transparency; any issues flagged by IMU will typically be communicated to the firm via the PMU or DHO for resolution.)

- **BHU Facility In-Charges and Other Staff:** While not a separate authority, it is important to outline the expected role of the BHU in-charges (e.g., Medical Officer or Women Medical Officer heading the BHU) in relation to the HR: they will supervise the HR' **day-to-day clinical work** and ensure integration into facility operations. This includes assigning duties (e.g., antenatal clinic, labor room, outreach activities), guiding the HR in managing cases

or referrals, and including their service data in the BHU's routine reporting. The BHU in-charge is typically the first line to observe the HR' work and provide on-site feedback or mentorship. If any issue arises at the facility level, the in-charge will report upward to the DHO and/or to the firm's district coordinator. **In summary, the BHU staff will treat HR as part of their team**, and HR will be expected to follow the instructions of the in-charge for all clinical and administrative matters within the BHU. This cooperation is critical to avoid parallel systems; the outsourced HR should complement and strengthen the existing workforce, not function in isolation. The firm should ensure that HR understand this reporting line (they have dual reporting – administratively to the firm, functionally to the BHU in-charge).

All parties above share the common goal of improved healthcare delivery through this intervention. Clear communication channels and mutual respect of roles will be maintained. Any disputes or misunderstandings in roles will be addressed through coordination meetings led by the PMU. In case of emergencies or extraordinary circumstances (e.g., a disease outbreak or natural disaster in one of the districts), the Health Department may redirect the HR to assist as needed; the firm is expected to comply with such temporary role adjustments, with the understanding that it will be within reason and in consultation with the firm.

Key Performance Indicators and Payment Terms

This contract will be **performance-based**, meaning the firm's payments are tied to the achievement of specific Key Performance Indicators (KPIs). The following KPIs will serve as the primary metrics for evaluating the firm's performance on a monthly and overall basis. The firm is expected to meet or exceed these targets; failure to do so may result in payment deductions as per the agreed formula, whereas meeting targets will ensure full payment, and exceptional performance may be incentivized (if provisioned in the contract). The KPIs include:

- **Full Deployment of HR:** *Indicator:* 100% HR deployed (100% deployment) across the BHUs by the agreed mobilization deadline. *Target:* 100% of positions filled on time. *Measurement:* List of HR at each BHU verified by PMU/DHOs. *Link to Payment:* The firm will receive an initial mobilization or placement fee only upon successfully deploying all required HR. If, for example, only 78 HR are in place by the deadline, a proportional deduction may be applied or the mobilization payment withheld until full deployment is achieved.

- **Position Vacancy Rate:** *Indicator:* Percentage of STAFF positions filled throughout the contract period. *Target:* At least 95% of positions filled at all times after initial deployment (allowing a maximum of 5% vacancy to account for unexpected turnover, but vacancies must be temporary). *Measurement:* Monthly roster vs. positions – e.g., no more than required posts vacant in any given month, and any vacancy filled within 2 weeks. *Link to*

Payment: If the firm fails to maintain filled positions (e.g. a post remains vacant beyond the grace period), the payment for that position for that period may be deducted. Conversely, maintaining full staffing continuously could be tied to a performance bonus at the end of the contract.

- **Staff Attendance and Availability:** *Indicator:* Attendance rate of HR as per duty rosters. *Target:* HR are present on duty for **at least 90% of scheduled working days/hours** each month (allowing legitimate leave or days off as per contract). *Measurement:* Attendance registers at BHUs, monthly attendance reports cross-verified by DHO and IMU spot checks. *Link to Payment:* Monthly invoices will reflect only the days actually worked by HR. If attendance falls below the 90% threshold (without approved leave or justified reasons), a penalty or deduction can be applied (for instance, non-payment for days an STAFF was absent without replacement, and an additional fine if absenteeism is excessive). On the other hand, perfect attendance across all sites in a month could trigger a small incentive or commendation, reinforcing the performance focus.

- **Service Delivery Performance:** *Indicator:* Utilization of maternal health services at the targeted BHUs (as an indirect measure of STAFF effectiveness). *Target:* **Baseline to be determined** – for example, an increase in the number of antenatal visits, facility-based deliveries, or family planning clients at each BHU compared to pre-deployment baseline. *Measurement:* BHU routine health reports (e.g., from DHIS or facility registers) for key indicators such as ANC first visits, number of deliveries conducted, etc., compiled quarterly. *Link to Payment:* This will be primarily used as a monitoring indicator rather than strict payment determinant (since service uptake depends on community behavior too). However, if the contract includes a Results-Based component, a portion of payment could be tied to achieving certain service targets (e.g., each BHU conducting at least X deliveries per month by mid-project). The details would be refined in consultation with the firm and based on realistic projections. Importantly, this indicator would be used to encourage the firm to not just place bodies in facilities, but to ensure those HR are actively contributing to health outcomes. It must be noted that no punitive measures will be taken solely on service numbers if the firm has done its due diligence in deployment and support; rather, low service stats would prompt a joint review to identify bottlenecks (such as need for community awareness or supply issues).

- **Training and Capacity Building:** *Indicator:* Completion of orientation and ongoing training activities. *Target:* 100% of HR received initial orientation training within the first month of deployment; at least one refresher training or review meeting is held after six months. *Measurement:* Training attendance records, training report submission. *Link to Payment:* The successful conduction of training is usually tied to a deliverable. For instance, a certain percentage of the contract value might be payable upon completion of the inception

training and submission of a satisfactory training report. If training is not completed as planned, the corresponding payment milestone can be withheld until fulfilled.

- **Reporting Compliance:** *Indicator:* Timely submission and quality of required reports (monthly, quarterly, etc.). *Target:* 100% on-time submission rate, with reports meeting the quality criteria (complete, accurate, and use the required format). *Measurement:* Log of report submissions vs deadlines; PMU's assessment of report quality. *Link to Payment:* While reporting is a basic requirement, persistent delays or poor-quality reporting could trigger payment delays or a small penalty. Conversely, consistent timely reporting may be a precondition to release monthly payments. Typically, the client will not process an invoice for a given period until the narrative performance report for that period is received.

- **Grievance Resolution:** *Indicator:* Functioning grievance redressal with issues resolved. *Target:* 100% of recorded grievances are acknowledged within 2 working days and resolved within a stipulated timeframe (e.g., 2 weeks) to the satisfaction of the complainant or referred to appropriate authority. *Measurement:* Grievance log and resolution status in reports. *Link to Payment:* While hard to quantify for payment, the client will monitor this qualitatively. Significant unresolved grievances or evidence of the firm ignoring serious complaints could result in contractual actions (since it ties into ethical compliance). This indicator is more about accountability and will be noted in performance evaluations.

The **payment schedule** will be structured around these KPIs and key deliverables. An indicative payment structure (to be finalized in the contract) might be:

- *Mobilization Advance/First Payment:* A certain percentage (e.g. 10-15% of contract value) upon signing and presentation of a deployment plan and recruitment advertisement (if applicable), to kickstart activities (this could be secured against a bank guarantee as per standard practice).

- *Deployment Milestone:* A payment installment (e.g. 15-20%) released once all HR are hired, trained, and deployed to the BHUs (verified by the client). This corresponds to the "Full Deployment" KPI above.

- *Regular Monthly/Quarterly Payments:* The bulk of the contract value would be divided into equal monthly or quarterly tranches, payable upon submission of monthly reports and invoices, and verification of KPI compliance for that period. For instance, each month the firm may invoice for the salaries and management fee; the client will pay after confirming attendance and other indicators via DHO/IMU reports. Any shortfall (e.g. an STAFF missing, or days not covered) will be deducted from that invoice. It's possible to

structure a withholdings system – e.g., the client withholds 5-10% of each invoice as a performance reserve, to be paid at the end if performance has been satisfactory.

- *Final Payment:* A small percentage (e.g. 10%) upon completion of the assignment and submission of all final documents (final report, financial reconciliation, asset handover of any supplies, etc.), and after a final performance evaluation by the client. This ensures the firm completes all obligations.

All payment terms will strictly follow the Government and World Bank procurement guidelines (in case of any conflict, the later will prevail) (e.g. using National Competitive Bidding rules). The firm's financial proposals should be priced according to these performance expectations. The contract will include clear formulas for deductions for non-performance (for example, a rupee amount per day of STAFF absence or per position vacant). Likewise, if any bonus or incentive for surpassing targets is intended, it will be clearly defined (subject to budget availability). The overarching principle is that **the government will pay for results delivered, not just effort expended**. This aligns with the results-oriented approach of the KP-HCIP and similar programs.

The firm is advised to maintain meticulous records to substantiate performance (attendance logs, service statistics, etc.) because payments will rely on evidence. Both the client's monitoring (through DHO, IMU) and the firm's own reports will be used to triangulate data. In case of discrepancies, the client will discuss with the firm to determine the factual performance before finalizing payment for that period. A collaborative stance is expected – the intent is not to unduly penalize but to ensure accountability and value for money in achieving the health objectives.

Monitoring and Evaluation Arrangements

Robust monitoring and evaluation (M&E) mechanisms will be in place to track progress of the assignment, ensure accountability, and facilitate timely decision-making. These arrangements involve the firm's internal monitoring, the Health Department's routine supervision (including IMU and DHO inputs), and periodic joint reviews. Key elements of the M&E plan are as follows:

- **Internal Monitoring by the Firm:** The consulting firm must establish an internal monitoring system to continuously oversee STAFF deployment and performance. This includes maintaining up-to-date records of each STAFF's attendance, the services they provide (e.g., number of patients seen, clinics conducted, etc.), and any issues encountered. The firm's **Project Manager and district supervisors** should conduct regular visits to the BHUs (e.g., each BHU at least once a month) to directly observe the HR at work, gather feedback from BHU in-charges, and spot-check registers (for example, check maternity register to see entries by HR). These visits should be documented with brief field reports noting any findings and actions taken. If the firm employs a digital solution (for instance, a simple mobile app or WhatsApp group for daily check-ins), that can

complement physical visits by capturing real-time attendance or service data. The firm will use the information gathered to manage performance proactively – for example, if internal monitoring shows a particular BHU has very low service uptake, the firm might investigate reasons (supply issues? community awareness?) and liaise with DHO to address them. The monthly progress report from the firm to the client should summarize key internal monitoring findings (e.g., "95% average attendance achieved, except BHU X had issues due to security lockdown on two days", or "training identified need for refresher on newborn resuscitation which we plan next quarter").

- **Routine Supervision by DHOs and BHU Management:** As noted in Roles/Responsibilities, the DHOs and BHU in-charges will carry out day-to-day supervision. Each BHU will continue its normal practice of maintaining registers for attendance and service delivery. The **District Health Office's supervisory staff** (such as the District Coordinator of the Lady Health Workers Program, or other paramedical supervisors available) can be tasked by the DHO to include the HR in their supervisory rounds. For example, when a supervisor visits a BHU for any reason, they should also review what the HR are doing – check that they are present, inspect the cleanliness of the labour room, verify that they have the supplies needed, etc. They would report any notable observations to the DHO. The DHOs might also require the BHU in-charge to submit a simple weekly update on the STAFF's performance (e.g., "STAFF A conducted 10 ANC clinics and 3 deliveries this week, all well" or "STAFF B was on approved leave for 2 days, covered by STAFF A"). These supervisory inputs, while informal, are crucial to catch problems early and provide immediate on-site corrections (like coaching an STAFF if a gap is found). The firm should maintain good communication with the DHOs so that any critical feedback from these routine supervisions is quickly relayed to the firm as well (for instance, if a DHO finds an STAFF routinely arriving late, the firm should be informed to take action).

- **Independent Monitoring Unit (IMU) Involvement:** The Health Department's IMU will incorporate relevant checks into its monitoring activities. Typically, IMU data collectors make unannounced monthly visits to BHUs to record various performance indicators (e.g., staff presence, stock availability, service utilization). For this project, the PMU will ensure that **IMU's checklist** or tablet-based survey includes specific fields related to HR – such as "Is the STAFF (or HR) on duty today?", "How many HR are posted vs sanctioned at this facility?", and possibly "Services provided by STAFF in last month" (these could be number of ANC, PNC, etc., which IMU often collects as part of DHIS verification). The IMU's data will provide an **objective validation** of the firm's reports. Each month, the PMU can retrieve the IMU report for the four districts and cross-reference it with the firm's submitted data. If IMU notes any discrepancies (e.g., an STAFF reported as present by firm but found absent by IMU, or facility lacking some promised supply), the PMU will flag this

to the firm for clarification. The IMU also often scores facilities on certain indices – if BHUs with HR show improved scores in maternal health service availability, that is a positive outcome that will be noted. In addition to routine IMU visits, the PMU may request **joint monitoring visits** where PMU staff, IMU monitors, and perhaps DHO representatives visit a sample of BHUs to formally assess the situation on ground and interact with the HR and community. These joint visits could be quarterly and would produce a brief evaluation report.

- **Progress Review Meetings:** Monitoring information will be synthesized and discussed in regular progress review meetings. The KP-HCIP PMU will convene **monthly or bi-monthly review meetings** (frequency to be decided based on need) with the firm's project team and key stakeholders (e.g., DHOs or their nominees, and possibly a representative from IMU or Health Secretariat if needed). In these meetings, the following will be reviewed: progress against KPIs, major challenges faced in the last period, any grievances lodged, and planned activities for the next period. Minutes of the meeting will document decisions (for example, "DHO Swabi to ensure BHU X night duty accommodation is arranged for HR by next month" or "Firm to replace STAFF at BHU Y by [date] due to extended absence"). These meetings serve as an opportunity for course-correction and support – if the firm is struggling with something (say, community resistance in one area), the collective brain trust can find solutions (maybe involve local elders or female health workers to build trust). At least one **quarterly review** should be more comprehensive, possibly chaired by the Project Director of KP-HCIP, to take stock of overall outcomes and make any strategic adjustments (e.g., reallocate an STAFF from a low-volume site to a busier site if that makes sense, or initiate a complementary health education campaign to boost facility deliveries if numbers are low).

- **Data Collection and Reporting:** The firm will utilize and strengthen existing data systems rather than create parallel ones. All HR should record their service delivery in the standard government registers at BHUs (e.g., ANC register, labour room register, family planning register). The firm can design a simple **monitoring template** to extract key metrics monthly from these registers for their report – such as number of new ANC registrations by STAFF, number of facility deliveries assisted by STAFF, number of postnatal visits, etc., along with qualitative notes (success stories or issues). This data, combined with attendance and HR metrics, forms the core of the firm's monthly report to PMU. The PMU may also ask the firm to track certain indicators related to project goals (for instance, how many community health education sessions the HR held, if any, or referrals made to higher facilities). Ensuring good data quality is important – the firm might need to train HR on proper record-keeping and perhaps do periodic **data validation** (spot-checking a few registers or comparing DHIS reports to their collected data). The PMU's M&E specialist (if

available) will also review the data for consistency. In the final analysis, these data will help demonstrate the impact of having the HR in place, so both the firm and the client have a stake in getting accurate numbers. The firm shall use DHIS-2 for service data and submit quarterly safeguards compliance reports.

- **Mid-Term and End-of-Term Evaluations:** If the 06-month period is significant for the project, the PMU might commission a **mid-term evaluation** (around month 6) to formally assess progress, possibly by a third-party evaluator or through an internal assessment. The firm would be expected to cooperate by providing data and facilitating field visits for such evaluation. The evaluation would look at how well objectives are being met, any unintended outcomes, and recommendations for the remaining term. Similarly, at the end of the assignment, a summative evaluation may be done (especially if considering renewal or scale-up). The firm's final report will feed into this. The evaluations are not part of the firm's deliverables, but the firm's performance will be judged in these, so they should aim for positive findings (e.g., increased institutional deliveries, positive feedback from community, etc.).
- **Risk Monitoring:** Part of M&E is also monitoring risks and assumptions. The firm should maintain a risk register for the project, identifying potential risks (e.g., security issues in certain areas, high turnover risk of staff, cultural barriers for female staff in remote areas, etc.) and update it periodically with status/mitigation measures. This helps in proactively addressing issues. For example, if a risk of "HR not accepted by existing staff" is identified, the mitigation might be to hold joint meetings with staff to clarify roles – and the monitoring would check if any friction is reported and address it.
- **Use of Monitoring Results:** All the data and reports gathered through the above mechanisms will be used to inform management decisions. If monitoring shows excellent performance, the PMU might consider scaling the intervention or extending the firm's contract (subject to procurement rules). If it shows persistent weaknesses in certain areas, targeted interventions (like additional training or management changes) will be implemented. Monitoring results will also be shared with higher authorities and possibly the World Bank as part of project reporting to demonstrate progress. It is crucial that the firm treats monitoring not as a punitive exercise but as a mutual learning and accountability tool. The client is committed to working with the firm to achieve the desired outcomes, and monitoring provides the evidence base for that collaboration.

In conclusion, a multi-tiered monitoring framework – combining the firm's efforts, government oversight (DHO, IMU), and joint reviews – will be in place to ensure the assignment stays on track. The firm should allocate sufficient resources for M&E on their side and remain responsive to

findings. Timely adjustments based on monitoring will be critical to the success of deploying HR for improved health services.

Qualification and Experience Criteria for the Firm

Firms submitting proposals for this assignment must demonstrate that they have the necessary qualifications, experience, and capacity to successfully carry out the described scope of work. The evaluation of firms during the bidding process will heavily weigh these criteria (EOI Evaluation Sheet as Annex-A). Interested firms should ensure their technical proposals clearly address the following minimum requirements:

- **Legal Status and Registration:**

  The firm (or lead firm, in case of a consortium) must be a legally registered entity in its country of incorporation and eligible to enter into contracts. Proof of incorporation/registration under the applicable laws of the country of origin shall be provided.

  In the case of international firms, the successful firm shall ensure compliance with all applicable laws of Pakistan, including registration with relevant tax authorities (e.g., obtaining NTN and, where applicable, KP Revenue Authority registration) prior to contract signing or commencement of services.

  The firm shall not be under a declaration of ineligibility for corrupt or fraudulent practices issued by the Government of Pakistan, the World Bank, or any other recognized international organization. A self-declaration confirming that the firm has not been blacklisted or declared ineligible by any government or donor agency shall be submitted as part of the proposal.

- **Geographical Experience and Understanding of Local Context:** Prior work in Khyber Pakhtunkhwa (and specifically in the target districts or nearby areas) will be an advantage. The firm should demonstrate familiarity with the sociocultural context of KP, including working norms for female healthcare staff, challenges in rural health delivery, and any security or cultural considerations in Peshawar, Nowshera, Swabi, and Haripur. Knowledge of the local languages (Pashto/Hindko) within the team will be a plus for communication with staff and community. If the firm has an existing field presence or offices in KP, or partnerships with local organizations, that should be mentioned as it shows readiness to operate on the ground.
- **Organizational Capacity and Staffing:** The firm must have adequate **professional and management capacity** to handle this contract. This includes:

Sr.	Position	Minimum Qualification	Minimum Experience	Key Responsibilities
1	**Project Manager (Team Lead)**	Bachelor's or Master's degree in Public Health, Health Management, Business Administration, or related field	7–10 years of relevant experience in managing health programs, HR deployment contracts, or large service delivery projects; at least 3 years in a leadership/managerial role	Overall contract management, coordination with PMU & DHOs, performance oversight, reporting, stakeholder engagement
2	**Senior Technical/Clinical Expert (MNCH/Public Health Specialist)**	Master's degree in Public Health (MPH) OR MBBS with postgraduate qualification in Public Health/MNCH OR BSc Nursing with advanced specialization	Minimum 7 years of experience in maternal, newborn & child health programs; experience in clinical supervision, mentoring, or training; familiarity with government clinical protocols preferred	Technical oversight, clinical mentorship, quality assurance, training support, ensuring adherence to national guidelines
3	**District Field Coordinators / Supervisors (Minimum 1 per District)**	Bachelor's degree in Nursing, Public Health, Social Sciences, or related health discipline	Minimum 5 years of experience in community health programs, facility supervision, or HR field coordination; experience working with BHUs/RHCs preferred	Field-level coordination, attendance monitoring, liaison with Facility In-Charge, troubleshooting operational issues, reporting to central team
4	**HR / Administrative Manager**	Bachelor's or Master's degree in Human Resource Management, Business Administration, or related field	Minimum 5 years of experience in recruitment, contract management, and HR administration; experience in managing payroll for large teams preferred	Recruitment, HR documentation, contract administration, grievance handling, compliance with labor laws
5	**Finance & Accounts Officer**	Bachelor's or Master's degree in Finance, Accounting, Commerce (B.Com/M.Com/MBA Finance) or equivalent	Minimum 5 years of experience in financial management, payroll processing, and project accounting; experience with	Payroll management, financial reporting, accounting, tax compliance

			donor-funded projects preferred	
6	**Organizational Capacity (Firm-Level Requirement)**	Legally registered firm with demonstrated organizational structure	Demonstrated experience managing multi-site HR deployment (preferably 50+ staff across districts)	

Deliverables and Reporting Schedule

The contracted firm will be responsible for producing a set of deliverables according to the schedule agreed in the final contract. All reports should be submitted in **clear, professional English** (with executive summaries in Urdu if required by the client) and in both electronic format (MS Word/PDF) and hard copy. They should follow any templates provided by the client, or, if no template is given, they should contain all the necessary information in a logical structure with appropriate section headings. The expected deliverables and their timelines are as follows:

1. **Inception Report and Deployment Plan:** *Due within 2-4 weeks of contract signing.* This report will outline how the firm plans to execute the assignment. It should include: a refined work plan and timeline, details of the recruitment process and criteria for HR, the finalized list of target BHUs (as confirmed with the client) and specific deployment schedule, an overview of the training/orientation plan for HR, the management and supervision arrangements put in place (including organogram of project staff, communication protocol with DHOs/PMU), initial risks identified and mitigation strategies, and any immediate support needed from the client. The inception report essentially sets the baseline for implementation. The client will review and approve this report, and it may be discussed in an inception meeting. (This report is linked to an initial payment milestone, as described earlier.)
2. **Monthly Progress Reports:** *Due by the 5th of each subsequent month (covering the previous calendar month's activities).* The firm will submit brief but comprehensive reports every month throughout the assignment. Each monthly report should include:
    - An update on STAFF staffing (any changes in personnel, new hires, resignations, etc.), with an updated roster of HR by facility.
    - Attendance summary for the month (percentage of days each STAFF was present, any absences and reasons, any replacements used).

- Summary of key services delivered by the HR (e.g., number of ANC visits conducted, number of deliveries assisted, PNC visits, immunizations or health education sessions by HR if applicable – these should be data the firm collects from BHU records).
- Narrative of major activities or achievements (for instance, "conducted community meeting in village X to encourage antenatal visits" or "HR participated in a district health fair on Safe Motherhood Day"), as well as any notable clinical success stories or testimonials (if a mother's life was saved due to timely care by an STAFF, etc., without identifying patient info for confidentiality).
- Issues and challenges encountered during the month (e.g., stock-outs of certain medicines affecting service, cultural barriers, any security concerns, conflicts between staff, etc.) and how they were addressed or plan to be addressed.
- Status of grievances received and resolved (if any during that month, per the grievance log).
- Supervision and monitoring activities done (e.g., "District supervisor visited 5 BHUs this month; IMU visited 10 BHUs – findings attached/discussed").
- Plans for the next month (upcoming trainings, holidays staffing plan, any changes).
- Annexes: could include the raw data tables, updated risk log, detailed attendance sheets (signed by BHU in-charges), etc., as needed for transparency.

The monthly report should not exceed, say, 8-10 pages main text, with additional annexes as required. It must be factual and evidence-based (client may ask for supporting documents for any claim). The client (PMU) will review these reports and provide feedback if any clarification is needed. The report for the last month of the project might be superseded by the final report, but until then monthly reporting is expected. Monthly reports form the basis for monitoring KPIs and processing payments, thus timely submission is critical.

3. **Quarterly Performance Reviews:** *Due every 3 months (Quarterly).* In addition to monthly reports, the firm will prepare a more analytical quarterly report or presentation. This aligns with quarterly review meetings. The quarterly report should highlight trends over the past three months, analyze data (for example, increase or decrease in facility deliveries quarter-over-quarter and possible reasons), compare achievements to targets/KPIs, and recommend any course corrections. It can be structured as an expanded version of the monthly report with more graphs and analysis. The first quarterly report (at 3 months) will serve as an early performance review, while the one at 6 months is essentially a mid-term report. While not explicitly asked in the ToR list, quarterly reports are implied good

practice; if the client requires them, they will be explicitly mentioned. At minimum, the firm should be prepared to present quarterly progress to the client in meetings, and any presentation or slide deck used should be shared as a deliverable.

4. **Training/Workshop Reports:** *Due as per occurrence.* Whenever the firm conducts a major training, orientation, or capacity-building activity (e.g., initial STAFF training, any refresher training, or quarterly STAFF review workshop), a brief report for that event should be submitted. This report would include the objectives of the training, date and venue, agenda, participants list (with designations), key topics covered, name of facilitators, any training materials developed, and an evaluation of the training (feedback from participants, pre/post-test results if any). For the initial orientation training of HR, this report is particularly important and should be submitted within a couple of weeks after the training concludes. It can be an annex to the monthly report of that month or a standalone deliverable referenced in the inception phase deliverables.

5. **Grievance Log and Resolution Report:** *Interval: included in monthly reports, with a compiled report at mid-term and end-term.* As part of the grievance mechanism, the firm will maintain a log of all grievances (with details such as date, complainant (anonymized if needed), nature of issue, steps taken, resolution status). While the monthly report will give brief updates, at mid-term (6 months) and end of project, the firm should submit a comprehensive summary of grievances handled. This is to ensure transparency and that lessons can be learned. For example, "In the past 6 months, 5 grievances were received: 3 by HR about delayed salary (resolved by clarifying banking process), 1 by a community member about an STAFF's behavior (resolved through counseling the STAFF), 1 by an STAFF about harassment by a male attendant (resolved by DHO intervention and transfer of the attendant)." The client may also require immediate reporting of any severe grievances (like misconduct cases) outside of regular reports.

6. **Mid-Term Progress Report (if required):** *Due at approximately 6 months.* This would be a comprehensive report similar to an expanded quarterly report. It should cover the first half of the project duration in detail, consolidating data and insights. It can serve as a standalone review document for the client and stakeholders (like World Bank) to assess interim results. If a formal mid-term evaluation by a third party is planned, the firm's mid-term report will provide necessary input to that evaluator.

7. **Draft Final Report:** *Due 4 weeks before contract end date.* The firm will prepare a **draft final report** summarizing the entire 06-month intervention. This will include: an executive summary of key achievements and challenges; background and context (briefly); the methodology/approach taken by the firm; a summary of services delivered (cumulative figures of ANC, deliveries, etc., across all sites); performance against each KPI and target

(with a table showing targets vs achieved values and commentary); an assessment of outcomes/impact (e.g., any evidence of improved health indicators or community feedback); a discussion of major challenges and how they were overcome (or not overcome); lessons learned and recommendations for the future (for sustainability or scale-up, including any suggestions for government if they are to integrate HR or improve BHU functioning); and annexes containing detailed data, list of HR deployed (with any turnover), training conducted, etc. The draft will be reviewed by the client and feedback given.

8. **Final Report:** *Due by contract completion (after incorporating feedback on draft).* The final report will be the revised version of the draft final, addressing any comments from the PMU and other stakeholders. Once approved, this becomes the definitive record of the assignment's results. The final report should be high quality, possibly including photographs (if taken with consent during the project) or quotes from beneficiaries, to vividly document the project's achievements. Along with the final report, the firm should hand over all project documentation and data (in soft copy) to the client – e.g., the complete database of STAFF attendance and service statistics, electronic copies of training materials developed, etc. This ensures the client retains knowledge for future use.

9. **Financial Reports and Statements:** In addition to narrative progress reports, the firm may be required to submit periodic financial statements of project expenditures (especially if the payment is structured as cost-reimbursable or if any advances need liquidation). While the contract is likely a lump-sum or unit-rate contract for service (hence not requiring detailed expense reporting), any **reconciliation of advances** or **statements of expenditure** requested by the client should be provided. At the end, a financial reconciliation of the contract (amount received vs deliverables met) may be done, especially if any performance-based holdbacks were in place. Financial reports must align with World Bank auditing standards.

10. **Other Deliverables:** This includes any ad-hoc report or output requested by the client. For example, if there is a need to prepare a policy brief on the experience of outsourcing HR, the firm might be asked to contribute. Or if an external monitoring mission (World Bank or government) asks for a special analysis (like impact on refugee women vs host community women), the firm should be ready to compile and provide that information as feasible. Another possible deliverable is documentation of case studies or success stories: the client may want 3-4 short case studies (1-pagers) of how the deployed HR made a difference in particular communities or families. Though not explicitly in the TOR list, such knowledge products add value and the firm is encouraged to produce them proactively or as requested.

Reporting Format and Quality: All reports should be written in a clear and concise manner. Use of tables, charts, and infographics is encouraged to present data (for instance, a graph showing monthly increase in ANC visits is more digestible than just numbers in text). Reports should include a cover page, project title, reporting period, and date. They should be signed off by the Project Manager of the firm. Language should be free of jargon where possible and explain any technical terms. The client might provide a specific template for monthly reports, which the firm should follow. If the reports are found incomplete or unsatisfactory, the client will request corrections or additional information, and the firm is obliged to resubmit accordingly.

Submission and Distribution: The firm will submit reports to the KP-HCIP PMU (likely to the Project Director or his designate, e.g., M&E officer). Copies (hard or soft) may also be required for other stakeholders: e.g., one copy to each DHO for district-specific data, possibly a copy to the Health Department's Planning Cell or Donor Coordination cell, and for IMU if needed. This will be clarified by the client. The primary mode will be electronic submission via email, plus signed hard copies for official record if required.

Approval of Deliverables: The contract will stipulate that deliverables are only considered delivered upon acceptance by the client. Typically, the PMU will review a report within a certain number of days (e.g., 10 working days) and either approve it or provide comments. Payment tied to that deliverable will then be processed. The firm should build in some time for this review in their work plan (for example, submit a draft a bit earlier if they want official approval by a set date).

To summarize, the deliverables are designed to track the project from start to finish: inception planning, regular monitoring outputs, and final evaluation. Meeting the reporting schedule is a key responsibility of the firm and contributes to transparent, effective project management. The firm's attention to detail and timeliness in reporting will reflect on its professionalism and will be a factor in the overall performance assessment.

Duration of Assignment

The duration of the assignment is **six (06) months** from the effective date of the contract, unless extended or terminated earlier as per contract provisions. The expected timeline is as follows:

- **Commencement:** The assignment is expected to commence by [exact start date to be filled in final contract,], after the completion of the procurement process and signing of contract. There may be a brief mobilization period immediately after signing during which the firm readies its team and resources.
- **Implementation Period:** The full 06-month period will cover all activities from recruitment and training of HR, through continuous deployment, monitoring, and reporting, up to the final month of service delivery. The major milestones during this period include:

completing STAFF deployment in the initial 1-2 months, the mid-term review around month 6, and wrapping up field activities by month 06.

- **Closing Phase:** At the end of 06 months, there will be a closing phase (within the same 06th month) for final reporting, handing over any project materials, and facilitating any transition (for example, if the Health Department intends to absorb some HR or continue services by another mechanism, the firm should assist in knowledge transfer).

If there is a need to **extend** the services beyond 06 months (due to project needs or unutilized funds or to avoid gap before a new procurement), it will be at the discretion of the client and subject to necessary approvals (e.g., contract amendment or new procurement per rules). Any extension would be communicated well in advance of the contract end. The firm should however plan to fully execute and achieve the objectives within the 06-month timeframe.

During the contract period, the firm must adhere to the agreed work schedule. In case of any significant delays or pauses (for example, due to unforeseen events like natural disasters, security issues, etc.), the firm should notify the client immediately and a joint decision will be made regarding adjusting timelines. Minor adjustments not affecting the end date (like shifting a training by a week) can be managed in consultation with the client's focal person.

Time is of the essence in this assignment because it aligns with the KP-HCIP project timelines and goals. The firm is therefore expected to deploy adequate resources from the outset to meet all deadlines. The 06-month duration will start ticking from contract signature, not from when the firm finishes recruitment, so any initial delay on the firm's side will compress the time available for implementation (which is not desirable). Bidders should propose a realistic but efficient timeline in their proposals.

Finally, at the end of the assignment, the contract will be closed following the acceptance of the final report and any other pending deliverables, and settlement of final payment. Any HR hired under this contract will **not automatically continue** beyond the contract unless a formal arrangement is made; the firm should budget and plan personnel contracts accordingly (preferably aligning HR' hiring for 06 months with maybe a provision for extension if needed). The Health Department is not obligated to hire any of the firm's staff after contract completion, though the experience may inform government decisions for the future.

Ethical Considerations and Data Confidentiality

Given the sensitive nature of healthcare service delivery and the involvement of communities (including vulnerable populations like women and infants), the assignment must be carried out with the highest ethical standards and respect for confidentiality. *The firm's Code of Conduct must align with World Bank's policies on SEA/SH, fraud, and environmental safeguards.* The firm and its deployed staff will adhere to the following provisions:

- **Professional Ethics and Code of Conduct:** The firm shall enforce a strict **Code of Conduct** for all its personnel involved in this project, particularly the HR and any field supervisors. This code should align with both the Government of KP's regulations for healthcare workers and the World Bank's guidelines on professional and ethical behavior. Key aspects include:
    - Respectful and non-discriminatory service to all patients regardless of gender, ethnicity, religion, refugee status, or socioeconomic status.
    - Prohibition of any form of **harassment, exploitation, or abuse**. This covers sexual exploitation and abuse (SEA) and sexual harassment (SH) – HR must not engage in inappropriate relations or behavior with patients, and equally, they should be protected from any form of harassment by colleagues or community members. The firm should sensitize all staff on these issues and the code of conduct should explicitly forbid such behaviors, with clear disciplinary actions (up to termination) for violations.
    - Maintaining a professional demeanor and cultural sensitivity: HR will be working in culturally conservative areas; they should dress modestly (the uniform will help ensure this), use culturally appropriate language, and be mindful of local norms (for example, if visiting homes, go with lady health workers or respect gender segregation norms as needed).
    - Compliance with clinical ethics: obtaining consent from patients for any procedure, maintaining patient dignity and privacy during examinations or labor, not refusing care to anyone in emergency, etc.
    - Integrity and honesty: zero tolerance for fraud (such as falsifying data or attendance), corruption (demanding bribes or favors from patients), or any misuse of project resources. The firm should have policies to prevent and address corruption – e.g., if any staff is found charging patients for services that should be free, that is a serious breach.

All HR and project staff should **sign the Code of Conduct** as a condition of employment on this project, and copies of signed codes should be kept on file (and available for client inspection). The firm will provide a copy of its Code of Conduct in its proposal or before contract signing for the client's review (the PMU may provide input to ensure it meets necessary standards). The Code of Conduct should also be explained verbally to all staff so they fully understand it. Periodic reminders or refresher sessions on the code (for instance, discussing a scenario of patient confidentiality or harassment in a monthly meeting) are encouraged to keep ethics in focus. The firm's leadership must model these ethical behaviors as well.

- **Child Protection and Vulnerable Adult Safeguards:** Although the HR mainly deal with women and infants, they may also interact with minors (e.g., adolescent girls or accompanying children) and other vulnerable individuals. The firm must ensure that its staff observe child protection principles – for example, no STAFF or staff should be alone with a child in a way that could be misinterpreted, physical examination of minors should have a chaperone or guardian present, and any suspicion of abuse (like if an STAFF suspects a patient is a victim of domestic violence or child abuse) should be reported through proper channels (the firm should have guidance on this aligned with local law). Similarly, treat persons with disabilities, the elderly, etc., with extra care and patience.
- **Data Confidentiality and Patient Privacy:** The HR, by virtue of their work, will have access to **sensitive personal health information** (PHI) of patients – such as medical histories, pregnancy status, etc., recorded in registers or shared in counseling sessions. It is imperative that they maintain confidentiality. They should not disclose any patient's identity or medical details to anyone outside the health team, except in official referrals or reports that require it (and even then, within professional boundaries). The firm should train HR on privacy – e.g., not discussing a patient's condition loudly in public, keeping registers secured, and avoiding any stigmatizing behaviors (like gossiping about a patient's illness). Any data collected as part of this project (attendance records, service statistics) should be treated as property of the Health Department. The firm cannot use the data for any other purpose (like research or publicity) without explicit permission from the department and compliance with applicable data protection rules. If the firm is keeping any electronic records of patients (though primarily data will be on paper at BHUs), they must ensure secure storage (password protection, etc.).

Additionally, any photographs of patients or community taken during the project should only be done with consent and for official purposes. Publishing or sharing such photos or stories in media requires clearance. The contract may include a clause that the firm shall not publish any material (reports, articles, social media posts) related to the project without prior approval, to control information release and maintain confidentiality.

- **Compliance with Local Laws and Regulations:** The firm and all staff must comply with the laws of Pakistan and regulations of Khyber Pakhtunkhwa. This includes labor laws (ensuring no exploitation of workers, providing at least minimum wages, reasonable work hours, granting of leave, etc.), health regulations (following the guidelines of KP Health Care Commission or DGHS for clinical practices), and any security regulations (e.g., if curfews or travel advisories are in place in certain areas, they must be respected). The firm must ensure all HR are appropriately registered with the **Pakistan Nursing Council (PNC)** or relevant regulatory body for HR – working only with certified professionals is both a

legal and ethical requirement to ensure patient safety. If any STAFF's registration expires during the contract, the firm should facilitate renewal.

Also, the firm must obtain any necessary permissions to operate in the target areas. For example, if required, coordinate with district administration for smooth operations, especially in refugee communities or sensitive localities. If any of the BHUs are in or near refugee camps or areas requiring special clearance, the firm should liaise with authorities accordingly (the PMU can assist in identifying such needs).

- **Preventing Sexual Exploitation, Abuse and Harassment (SEAH):** We reiterate this aspect due to its critical importance. The World Bank and Government have strict standards for preventing SEAH in projects. The firm must have measures in place: training for all staff on appropriate behavior, multiple channels for reporting any SEAH incidents (HR should know how to report if they experience or witness harassment – either within the firm's hierarchy or directly to a designated government or World Bank hotline, which the PMU can provide), and prompt investigation and action on any allegations. A known practice is to have all project staff sign an acknowledgement of understanding the **ZERO TOLERANCE** for SEAH policy. The firm should also be mindful of power dynamics – e.g., HR might be in positions of relative power over very vulnerable patients (like a refugee woman in labor). Under no circumstance should any staff exploit that (even something seemingly minor like asking for personal favors in exchange for better care is absolutely forbidden). The firm's code and training must emphasize that **any form of sexual exploitation or abuse is grounds for immediate dismissal and legal action**.

- **Grievance Mechanism for Ethical Concerns:** Apart from the operational grievances, any ethical concerns or complaints (such as an STAFF reporting harassment by a supervisor, or a patient reporting misconduct by an STAFF) should trigger a special investigation by the firm in coordination with the PMU. The firm should have an Ethics or Compliance Officer (this could be a role taken by the project manager or a senior manager in the firm) who leads such investigations confidentially. The firm must protect whistleblowers in these cases – someone raising an ethical issue should not face retaliation. Outcomes of serious ethical breach investigations should be shared with the PMU and relevant authorities (keeping identities confidential as needed) to decide further action (including law enforcement if a law was broken). The contract may require the firm to report certain serious allegations to the World Bank as well, depending on project protocols.

- **Use of Project Resources and Transparency:** Ethical compliance also extends to how project funds and resources are used. The firm should ensure that all funds provided (e.g., for salaries, training, supplies) are used solely for the intended purposes. No kickbacks, no diversion of funds. Procurement of any goods (like uniforms) by the firm should be done

with integrity (e.g., follow a fair procurement process to avoid conflicts of interest or fraud – the client might request documentation of how major purchase decisions were made). If the firm is providing assets (equipment) to HR, those assets remain property of the project and should be accounted for at the end.

- **Environmental and Safety Considerations:** While not explicitly mentioned in the TOR list, an ethical approach includes keeping in mind infection control and waste disposal (since HR will presumably generate some medical waste like used gloves, etc.). The firm should instruct HR to follow BHU protocols for sharps and waste disposal so that no harm comes to the environment or community (especially crucial if BHUs have incinerators or waste pits – HR should use them properly). If HR do any outreach, they should safely carry and dispose of materials. Also, the firm should ensure HR have a safe work environment – if an STAFF feels unsafe (e.g., having to travel at night for shifts), the firm should work with the DHO to find solutions (like secure accommodation near BHU or transport arrangements). Staff safety is a responsibility – ethically and contractually – so the firm must not force staff into undue risk. Any incidents of workplace violence or threats in the community must be taken seriously and addressed with local authorities.

- **Confidentiality of Contract Information:** Beyond patient data, the firm should also keep **confidential all proprietary or sensitive information** related to the contract and the KP-HCIP project. For example, details of project budgets, internal strategies, or any data shared by the government that is not public, should not be disclosed to unauthorized persons. The firm's staff may be asked to sign Non-Disclosure Agreements (NDAs) if necessary. This extends to after the contract – the firm cannot use or divulge confidential information gained during the project for any other purpose without consent.

- **Ethical Exit Strategy:** As the contract nears its end, the firm should handle the closure ethically – HR should be informed in advance of contract closure, paid all dues, and guided on any next steps (like how to apply to health department if positions open, etc., though employment beyond contract is not guaranteed). They should not be abandoned abruptly. Similarly, any patient or community expectations should be managed – e.g., if HR will cease working after 06 months, the BHU staff and community should be made aware near the end, to avoid confusion (this communication would be done with DHO guidance).

The firm's compliance with these ethical and confidentiality clauses will be monitored throughout the project. Non-compliance can lead to penalties or contract termination. The **IMU and PMU will also keep an eye** on ethical aspects during monitoring visits (for example, checking if patient confidentiality is maintained, or if any complaints of misbehavior surface). The contract will include standard clauses on **Fraud and Corruption** as per World Bank guidelines, which the firm must adhere to strictly.

By signing the contract, the firm agrees to uphold all these principles. The technical proposal of the firm should ideally include a section on how they plan to enforce ethical compliance (e.g., training modules on ethics, internal checks) and how data confidentiality will be maintained (e.g., who has access to data, data encryption if any, etc.). The evaluation may award points for robust plans in this regard.

In summary, the success of this assignment is not just measured in numbers of HR deployed or services delivered, but also in **how** those services are delivered. Ethical, respectful, and confidential treatment of beneficiaries is paramount. The firm and its staff are ambassadors of the KP Health Department in these communities, and they must uphold the trust placed in healthcare providers. Any deviation can harm community trust and project reputation, hence will be dealt with seriously. The client is committed to supporting the firm in maintaining these standards – for example, if an STAFF faces harassment from a community member, the department will support legal action – but the firm must ensure the frontline workers are well-prepared and supported to follow the right practices.

End of Terms of Reference

(This ToR document is intended to guide the procurement and implementation of the described services. Bidders should use this as the basis for preparing their technical and financial proposals. The actual contract may contain additional standard clauses (e.g., force majeure, dispute resolution) as per the procurement rules of the Government of Khyber Pakhtunkhwa and the World Bank. All prospective bidders are advised to read the ToR carefully and seek clarification in the pre-bid meeting if any part is unclear. The KP-HCIP Health Department looks forward to innovative and committed proposals to make this initiative a success for the betterment of maternal and child health in the province.)