



mercycorps.org

October 29, 2014
Meredith Crews
USAID/GH/HIDN/NUT
1300 Pennsylvania Avenue NW
Room 3.6-90
Washington, DC 20523-3700

**RE: Submission of Second Annual Report for Saving Mothers and Newborns
in Communities USAID Cooperative Agreement No. AID-OAA-A-12-00093**

Dear Ms. Crews,

Mercy Corps is pleased to submit the second Annual Report for the Child Survival and Health Grants Program, Saving Mothers and Newborns in Communities, in Balochistan Pakistan for the reporting period of September 30, 2013 to September 29, 2014.

Please find enclosed one original hard copy of the Annual Report double-sided and bound and fifteen annexes (note that Annex 3 Project Data form will be completed as soon as it is active and Annex 4 is not applicable). One electronic copy of the Annual Report and annexes will be submitted to your email address.

This annual report presents the accomplishments of Saving Mothers and Newborns in Communities and the project's partners in the second year of implementation. Our team is available to answer any question that you have on the report and its annexes.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Norman".

Jennifer Norman
Director of Public Health



Second Annual Report

Saving Mothers and Newborns in Communities

Mercy Corps' Second Annual Report for:
Saving Mothers and Newborns in Communities
September 30 2012 – September 29 2016
USAID CA No. AID-OAA-A-12-00093

Implemented in:
Quetta, Kech, and Gwadar Districts
Balochistan Province
Pakistan

Report submitted on:
October, 29th 2014

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mercy corps.org

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List of Annexes

1. Project Workplan
2. Updated Performance Monitoring Indicator Table
3. Project data form: *not required at this time due to technical errors with the website*
4. Reports and information products requested during the SW consultation : *does not apply*
5. BCC Products
 - a. BCC Strategy
 - b. BCC Flipcharts & Counseling Cards
 - c. VOIP Messages (English)
 - d. VOIP Recordings
6. SMNC News Coverage
7. Refresher Training Results (Theory and Practical) – Batch 2
8. MNCH reporting tools (English translated version)
9. Notification Natal Service Provision in CMW Workstation
10. CMW Selection Criteria (revised for second batch)
11. MNCH Strategic Plan ToR
12. Comprehensive Table of Year 2 Activities and Outputs
13. Risk Management Plan
14. Success Stories (CMWs Rahat Noor and Zohra Hanif)
15. Summary of Security incidents in SMNC Districts

Acronym List

AKF	Aga Khan Foundation
CMW	Community Midwife
CSHGP	Child Survival and Health Grants Program
DHF	District Health Forums
DHO	District Health Officer
DoH	Department of Health
EmONC	Emergency Obstetric and Neonatal Care
FO	Field Officer
GOB	Government of Balochistan
GOP	Government of Pakistan
IR	Intermediate Result
KPC	Knowledge, Practice, and Coverage
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MC	Mercy Corps
MCH	Maternal and Child Health
MCHI	Maternal and Child Health Integrated Program
MFI	Microfinance Institute
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
OR	Operations Research
PHD	Provincial Health Department
PME	Performance Monitoring and Evaluation
PMP	Performance Monitoring Plan
PMRC	Pakistan Medical Research Council
PNC	Pakistan Nursing Council
PSC	Provincial Steering Committee
RAC	Research Advisory Committee
RAF	Research Advocacy Fund
SDKs	Safe Delivery Kits
SMNC	Saving Mothers and Newborns in Communities
TBA	Traditional Birth Attendant
TRF	Technical Resource Facility
TWG	Technical Working Group
UC	Union Council
UoA	University of Alberta
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VOIP	Voice Over Internet Protocol
WRA	Women of Reproductive Age
WSG	Women Support Groups

I. Introduction, Key Progress, and Main Accomplishments

Saving Mothers and Newborns in Communities (SMNC) – Mercy Corps’ (MC) four year (Sep 30 2012-Sep 29 2016) SCALE program in Quetta, Kech, and Gwadar districts of Balochistan seeks to **improve maternal and newborn health status, especially for poor and marginalized women of Balochistan** (Goal). The project was developed in response to the high maternal (758 per 100,000 live births)¹ and newborn (63 per 1,000 live births)² mortality ratio/rates in Balochistan and limited access to skilled birth attendants (18%), and will serve 373,367 direct beneficiaries.³ The overall project strategy calls for deployment of 90 private-sector Community Midwives (CMWs) to offer quality maternal, newborn and child health (MNCH) services to underserved communities. Key interventions include: a 4-week clinical refresher course to ensure CMWs meet the Pakistan Nursing Council’s (PNC) minimum competency standards; high quality technical and easily-accessible financial assistance to CMWs, in the form of micro-loans repaid through Telenor’s *EasyPaisa* service, a small grant of standardized equipment and, business skills training; Women Support Groups (WSGs) conducted jointly by CMWs and Lady Health Workers (LHWs) to improve healthcare seeking practices and demand for CMW services; mobile technology to improve quality of data collection, clinical decision making, client reminders and Behavior Change Communication (BCC) efforts; and a revolving emergency transport fund called *Mamta* fund to support referrals to higher levels of care in cases of emergencies or high-risk patients. The Operations Research (OR), led by Principal Investigator Dr. Zubia Mumtaz with the University of Alberta (UoA), will investigate whether CMWs in the SMNC initiative are providing essential MNCH care in a financially self-sustaining manner. Successful components of the program, identified through this OR, will be taken up by the Balochistan Department of Health (DoH) in its forthcoming five-year MNCH strategy (2015-2020), which is being developed through support from this initiative.

During Year 2 (Oct 01 2013 – Sep 30 2014), the project made significant progress in *implementing activities* set forth in the Strategic Workplan across all four objectives. This report documents what was implemented, how it worked (or did not work) in the context of insecure and underserved Balochistan, and how this contributes toward SMNC’s Strategic Objective to **increase use of quality essential maternal and newborns care, through private-sector community midwives**.

SMNC Year 2 Main Accomplishments

- 1 Stakeholder engagement platforms continue to support project oversight and policy analysis of project findings: Provincial Steering Committee (PSC), Technical Working Group (TWG), and District Health Forums (DHF)
- 2 Selected, trained and provided essential equipment for 50 CMWs (second batch) to establish their workstations.
- 3 Completed Business Skills training for 90 CMWs (both batches)
- 4 Established *Mamta* funds in the catchment areas of 40 CMWs (batch 1)
- 5 Connected not-for-profit ambulance service providers to *Mamta* funds for emergency transport (both batches)
- 6 Initiated supportive supervision of CMWs by Lady Health Visitors (LHVs) and Lady Health Supervisors (LHSs)
- 7 Finalized and deployed mobile phone applications for CMWs reporting, BCC messages, and client reminders
- 8 Developed BCC strategy, WSG methodology, and BCC tools based on formative research findings, and trained master trainers (field teams) on WSG curriculum and tools
- 9 Completed Baseline OR Survey (modules 1 and 2)
- 10 86 CMWs have provided quality midwifery services to 4,940 individual clients. This included 3,670 ANC visits, 939 skilled deliveries, 568 PNC visits and 1,135 family planning services (Dec 2013-Sept 2014 data)

¹ Pakistan Demographic and Health Survey (PDHS) 2006-2007

² Pakistan Demographic and Health Survey (PDHS) 2012-2013

³ Note: this is the *actual* figure of beneficiaries served collected from the field, and replaces the estimated figure of 450,000 reported in the Strategic Workplan and First Annual Report.

Table 1: Summary of Major Project Accomplishments

See Annex 12 for Comprehensive Table

Inputs	Activities	Outputs
<p>Staff:</p> <ul style="list-style-type: none"> Maintained project staff in Quetta Received technical inputs from Islamabad health team and HQ Technical Backstop <p>Partners/consultants:</p> <ul style="list-style-type: none"> Frequent consultations with the government of Balochistan Frequent consultations with the PNC SubAward signed with University of Alberta for conducting OR <p>Curriculum for CMW trainings:</p> <ul style="list-style-type: none"> PNC approved 18 month curriculum and manual used to prepare refresher training curriculum <p>Equipment/Supplies:</p> <ul style="list-style-type: none"> Vehicles rented in Quetta and districts for monitoring & supervision 	<p>IR 1: Increased availability of quality maternal and newborn care in communities</p> <p>Selection & Registration of CMWs</p> <ul style="list-style-type: none"> Selected second batch of 50 CMWs through selection committee based on revised selection criteria (see Annex 10) Project orientation sessions held and MoU signed with second batch Completed registration for first batch, except for two. Initialized registration process with PNC for the 24 selected CMWs of Batch 2 who were not already registered <p>CMW Refresher Training (for second batch of 50 CMWs)</p> <ul style="list-style-type: none"> Four week clinical refresher course held (see Annex 7 for exam results) <p>Financial and structural support to CMWs:</p> <p><i>Business Skills training</i></p> <ul style="list-style-type: none"> Five day Business Skills training for both batches (i.e. 90 CMWs) held <p><i>Equipment and CMW Birth Kits</i></p> <ul style="list-style-type: none"> CMW equipment and birth kits distributed to Batch 2 CMWs (all districts) and Batch 1 CMWs (Kech only) <p><i>Microloans</i></p> <ul style="list-style-type: none"> Loan agreement with Tameer bank (MFI) signed Risk assessment of CMWs to finalize loan amount in process <p>CMW Deployment</p> <ul style="list-style-type: none"> District launching ceremonies held in Kech and Gwadar followed by community inaugural meetings <p>Technical & Administrative Supportive Supervision of CMWs:</p> <ul style="list-style-type: none"> All CMWs are regularly supervised by LHVs and LHSs (checklists and other MNCH tools in Annex 8) 	<p>1.1 86 CMWs (38 batch 1 and 48 batch 2) selected, trained and working within properly furnished home-based workstations</p> <p>1.2. 86 CMWs supervised by MC and government staff</p> <p>1.4. DoH tracks uptake of CMW services⁴</p>
<p>Equipment/Supplies:</p> <ul style="list-style-type: none"> Vehicles rented in Quetta and districts for monitoring & supervision 	<p>IR 2: Improved knowledge and demand for essential maternal and newborn care</p> <p>Mobile Phone (Note: as depicted in the SW logframe, this activity contributes to both IRI and IR2)</p> <ul style="list-style-type: none"> PakVista tested and finalized the mobile phone application First batch of CMWs trained on application Database and server established where data are automatically updated and report generated and shared with DOH (http://smnc.mercycorps.org) Mass VOIP BCC messages and client reminder symbols developed, messages translated in 4 local languages VIOP messages (Balochi and Urdu) are being sent to pregnant women and their family members of catchment area of 40 CMWs <p>Women Support Groups:</p> <ul style="list-style-type: none"> BCC strategy developed based on formative research (See Annex 5a) WSG existing methodology reviewed and adapted; BCC tools finalized District teams trained on WSGs. 	<p>2.1 Batch 1 CMW clients and family members receive health promotion messages through VOIP</p>
<p>Policies/</p>	<p>IR 3: Improved access to emergency transport in remote communities</p> <p>Transport Fund:</p>	<p>3.1 40 functioning</p>

⁴ Reports are shared in the DHF, TWG and PSC forums on quarterly basis, while the DHOs, PHS-MNCH of all three districts are shared with the summary of the CMWs services in Internal Review Meetings. Online access to DOH to track progress will be provided in October 2014

<p>guidelines:</p> <ul style="list-style-type: none"> • CMW deployment guidelines reviewed, referenced, and followed • Planning Commission – Performa 1 (PC-1) for MNCH program reviewed, referenced and followed <p>Evaluations:</p> <p>Continuous review of available research and evaluations related to CMWs to ensure our strategy builds on lessons learned, best practices, and challenges experienced in similar context</p>	<ul style="list-style-type: none"> • <i>Mamta</i> funds established for first batch of 40 CMWs • MOU signed with Edhi Foundation and Al-Falah Ambulance services for providing emergency transport • CMWs also identified local transport vehicles for emergency transport • Both transport options linked to the <i>Mamta</i> funds <p>IR 4: Improved policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research</p> <p>Operations Research</p> <ul style="list-style-type: none"> • Received IRB approval from University of Alberta and Pakistan Medical Research Council (PMRC) • Subaward package for University of Alberta approved by USAID • Baseline survey data collected in all 3 districts (Module 1) • Baseline financial data collected in Quetta and Gwader (Module 2) <p>Research Advisory Committee (RAC)</p> <ul style="list-style-type: none"> • Research Advisory Committee formed • First RAC meeting held <p>Provincial MNCH Steering Committee and Technical Working Group</p> <ul style="list-style-type: none"> • Four (quarterly) PSC meetings held • Four (quarterly) TWG meetings held. • TWG and PSC endorsed provision of natal services by CMWs in their workstations. (Annex 9). <p>District Health Forum (DHF)</p> <ul style="list-style-type: none"> • Four (quarterly) DHF meetings held <p>Draft 5 year MNCH Strategy (2015-2020)</p> <ul style="list-style-type: none"> • Scope of Work developed on the basis of consultation meetings held with DoH and other key stakeholders • Consultant identified on the basis of competitive bidding process 	<p>revolving funds for emergency transport</p> <p>3.2 Vehicles linked with each of 40 revolving fund</p> <p>4.1 OR protocol developed with stakeholder involvement and approved by USAID and IRB (UoA and PMRC)</p> <p>4.2 First RAC meetings with high participation of all 5 members</p> <p>4.3 1 publication of OR protocol in BMC</p> <p>4.4 Provincial Steering Committee and Technical Working Group met quarterly</p> <p>4.5 District Health Forums met quarterly</p>
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II. Discussion of Implementation Activities and Results

IR 1: Increased availability of quality maternal and newborn care in communities

Status: By the end of year two, 86 CMWs have been trained and are providing quality MNCH services. During year two, 50 CMWs (i.e. batch 2) were: i) selected by selection committee based on criteria developed/revised with the DoH (see Annex 10); ii) graduated from a 4-week competency-based refresher course where each CMW individually conducted at least 5 deliveries; iii) completed the business skills and reporting training; iv) received essential equipment (as a grant) to set up their workstations; and v) deployed as per the government’s MNCH guidelines. Twenty-one out of 86 CMWs (both batches) opted for a loan, while the remaining 65 CMWs have filled basic upgrades, furniture and medicine and supply gaps through their own resources. These 21 CMWs will receive a microloan from Tameer bank in November 2014. District level inaugural ceremonies (to introduce the CMWs to key district-level stakeholders) were held in Kech and Gwader, to complement the ceremony in Quetta in year 1. These ceremonies were followed by community inaugural meetings to introduce CMWs to the community as a skilled provider and promote her services. Since December 2013 (when batch 1 first started providing services), these 86 CMWs have served a total of 4,940 clients and provided a total of: 3,670 ANC, 939 deliveries, 568 PNC and 1,135 family planning services.

What facilitated progress? Several key factors facilitated progress. First, active participation of key stakeholders, specifically the DoH, continued to be critical in smooth implementation of all activities.⁵ Second, facilitating activities with batch 2 CMWs was much easier as we could capitalize and build on our experience and resources from batch 1. Further, coincidentally the second batch of CMWs were new graduates from the standard 18 month course, which made it relatively easier to bring their knowledge and skills up to PNC standards. Finally, there were several key activities which have greatly helped advance our overall project objective:

The *Business Skills training* proved particularly helpful for CMWs in establishing their own practices. During field visits, the project team observed CMWs practicing key business skills such as active marketing of services and financial management. (See Annex 14 for a success story). The project's monitoring data also reports increased income over the last two quarters.

Secondly, concerted efforts to enable the *LHS to administratively support CMWs* has helped strengthen coordination between CMWs and LHWs and enable ownership of the program by the DoH. This coordination also helped introduce CMWs as a SBA.

What was challenging? Despite these successes, many aspects of IR 1 were challenging and, thus, slowed progress toward achieving our overall objective. First, it was challenging to find CMWs who met all of our selection criteria⁶. As result, the criteria were slightly adjusted (see annex 10) and Field Officers, with support from the first batch of CMWs, community leaders and the DoH, visited targeted communities to identify eligible candidates.

Second, 10 of the trained and deployed SMNC CMWs (from both batches) stopped providing midwifery services, despite efforts by the SMNC team to persuade them to continue. These 'dropouts' resulted from a variety of reasons, namely: 1) recruitment of CMWs into private hospitals and 2) CMWs got married and either moved to other districts or were not allowed, by their in-laws, to practice. Six new CMWs were replaced and deployed after completing clinical refresher training while four are completing their training and will then deploy.

Third, technical and administrative supportive supervision of CMWs proved challenging in some areas due to unavailability of LHVs/LHSs and mobility issues of these female providers. To address this, LHVs and LHSs from other areas were requested to supervise CMWs in our catchment areas. Moreover, LHVs and LHSs are not trained on technical and administrative supervision of CMWs and thus the project conducted on the job trainings for them.

Fourth, the loan component of SMNC has proved to be, perhaps, the most challenging component of the entire project. As the provision of loans to CMWs is an innovation in Pakistan, it took MC and Tameer the majority of the first year of the project to agree upon terms that would best enable the CMWs to eventually become viable microloan clients who would not need a guarantee from a third party, like MC. While MC Headquarters, MC Pakistan, and Tameer Headquarters (Karachi) were all on the same page with respect to the loan terms, there was inconsistent messaging about the loan to the community (particularly with respect to the guarantee). For example, the CMWs were told by MC that their loans were 100% guaranteed, while the branch managers from Tameer were not made aware of this agreement. This confusion deterred many CMWs from taking a loan. This required significant efforts on the part of the

⁵ Other key stakeholders, with whom SMNC has MoUs, include: DG Health Services, LHW program, MNCH Program, and DHOs (submitted in the SW) and Midwifery Schools (submitted with first AR)

⁶ Selection Criteria: already trained by the government, no multiple CMWs from same catchment area, at least 2,500 underserved catchment population, and willingness to participate in the program.

MC's Quetta team to reassure CMWs about the loan terms and to encourage them to take advantage of this opportunity. These complications have significantly delayed the loan component. As a result, 21 of the current 86 CMWs will receive their loan in Q1 of year 3.

Finally, the political and security situation in Balochistan remained tense during the entire year. Incidents of assassinations, abductions, bomb blasts, kidnappings, protests, strikes and demonstrations delayed program activities and posed challenges for recruitment. In response to this, the project team avoided road travel from Quetta to Kech and Gwadar, operated with low profile and visibility, reduced unnecessary exposure, and ensured surveillance measures.

IR 2: Improved knowledge and demand for essential maternal and newborn care

Status: On the basis of thorough formative research and in consultation with key stakeholders, the SMNC team prepared its BCC strategy to guide IR 2 implementation (see Annex 5a). This strategy outlines a holistic approach where women are motivated for improved MNCH practices through counseling sessions with the CMW, participation in WSGs, and through receiving BCC VOIP messages and SMS reminders about upcoming ANC visits through the mobile platform. During year two, trainings were conducted for the SMNC management team (Quetta), and master trainers (district teams), on the WSG methodology and tools which included the development of district-specific WSG plans. Following the district trainings, CMWs and LHWs started identification of Lead Mothers in their respective communities, who will each cascade messages to around 10-15 women of reproductive age (WRA) in their neighborhoods, called a WSG. The first Lead Mother Group (i.e. groups of 10-15 Lead Mothers) will start meeting in November 2014. The BCC tools (flipcharts and counseling cards) were prepared, finalized, and printed by a local media firm, *M Communications*. (See Annex 5b for the tools). In addition to the WSG work, Pakvista finalized, piloted, and deployed the mHealth application. The first batch of CMWs was trained on the mobile phone application in June, and started reporting through the application thereafter. VOIP messages were developed in four local languages (Balochi, Brahvi, Pashto and Urdu) and recorded in two languages (Balochi and Urdu). Clients registered for messages with CMWs are receiving VOIP messages and SMS reminders for their next ANC visit. In November 2014, the VOIP messages will also be available in Brahvi and Pashto.

What facilitated progress? Active participation of stakeholders, including the Health Education Cell (DOH), the LHW program and other NGOs active in BCC work was critical for the formative research and development of the BCC strategy, WSG methodology and BCC tools. The pretesting of the flipcharts and counseling cards in SMNC communities helped to ensure the tools are appropriately contextualized. Review, feedback and inputs by TWG members helped facilitate ownership of this component. Further, incorporating lessons learned from Save the Children's WSG work in Pakistan and global best practice with respect to peer-led education models (i.e. Care Group) helped in the development of the WSG methodology. Finally, it was easier than expected to train most of the CMWs on the mobile application as most are young, already have a mobile, and are keen to learn new technologies to support their work.

What was challenging? The development of the BCC Strategy was delayed significantly, due to unexpected delays by the external consultants who led the formative research. This, in turn, delayed the development of the WSG methodology, BCC tools, and VOIP messages since these were contingent on the BCC strategy. In addition to the time delay, several activities were more challenging than expected. First, some of the *CMW clients are reluctant to register for VOIP messages* because most women are hesitant to answer calls from an unknown number. To

address this, CMWs and Field Officers are encouraging clients to save the number of the VOIP messages in their phone so they know the purpose of the calls.

Secondly, some CMWs are not reporting client data using their mobile phone and MC is still experimenting how best to motivate CMWs for data reporting. While the SMNC project will cover the data package charges for most of the project period, we need to create a sustainability plan to ensure the CMWs continue to use their phones and report on the data after the project ends. The Government's MNCH program is planning to introduce mobile-based reporting for CMWs in the coming years, so this pilot will provide valuable lessons learned. Finally, some (i.e. 2 CMWs in Kech) face problems with network coverage and a few need extra support on how to use a smart phone. The field teams are actively following-up on these issues.

IR 3: Improved access to emergency transport in remote communities

Status: The first batch of 40 CMWs established *Mamta* funds in their communities; the second batch of 50 CMWs will establish these funds in November 2014. Further, MC signed MoUs with not-for-profit ambulance service providers to enable referrals for emergencies or complicated cases. MoUs were signed with Edhi (for Quetta and Gwadar) and with Al-Falah (for Kech).

What facilitated progress? The combination of cooperation by ambulance service providers and willingness of communities to provide personal vehicles when ambulances are unavailable has helped us to link a vehicle to each *Mamta* fund.

What was challenging? In the absence of the WSG, it has been challenging to motivate women to contribute money to the *Mamta* fund. As designed, women have the opportunity to contribute during each ANC visit. However, to date, almost all women have preferred to arrange for emergency transport through their own families, rather than contribute to a communal fund. Our goal is to emphasize the reliability of this fund during the WSG meetings which, we hypothesize, will encourage more women to contribute to the fund, while not dissuading women from organizing funds on their own, as long as it enables them to cover emergency transport costs.

Further, while each *Mamta* fund is linked to an emergency vehicle, there are challenges to ensure the vehicle is ready at all times. For example, the ambulances provide emergency transport for all needs, not just the CMW clients. Similarly, the community vehicles, identified by CMWs, may be preoccupied with other purposes at the time of an emergency. For this reason, it is important that each *Mamta* fund is linked to several emergency transport options.

IR 4: Improved policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research

Status: Our three levels of policy platforms – a PSC supported by a TWG and DHFs – all continue to meet regularly to provide oversight to the program and discuss policy implications of project findings. The ownership of the DoH in SMNC is evidenced by the fact that this year the provincial Minister Health, Secretary Health, Director General Health Services and other high level health delegations visited SMNC supported CMWs workstation and catchment areas, solicited feedback from CMWs clients and appreciated their work in underserved areas of Balochistan. Further, in year 2, SMNC helped facilitate a critical policy decision in Balochistan – i.e. the ability of CMWs to conduct deliveries within their workstation. After significant debate, the PSC recommended that CMWs should offer natal services within their workstation which motivated the Secretary Health to officially endorse this decision. (See Annex 9).

DHFs regularly review district level progress and plans and recommended context specific corrective measures. Members of the DHF also contributed to CMWs capacity building by

providing refresher trainings to CMWs in Kech, while the DOH in Gwadar provided contraceptives, Safe Delivery Kits and other consumables to CMWs.

The ToR for the 5 Year MNCH Strategy was developed in close consultation with key stakeholders in Balochistan, to ensure this activity complements (and does not duplicate) other policy initiatives in Pakistan. The final ToR is available in Annex 11. Apex Consulting was selected to lead this work based on a competitive bid. Their work will begin in Q1 of year 3.

What facilitated progress? The policy platforms developed offered significant support during year two for project work plans, review and feedback on progress, technical inputs in the development of the BCC strategy and tools, mobile phone application and strengthening coordination with stakeholders. Joint monitoring visits of the project team and forum members to CMW workstations and communities helped promote ownership by district health authorities and communities. Further, this ownership and interest has been very motivating to CMWs.

What was challenging? The constant flux of DOH staff, especially the provincial head of the MNCH program, required MC to expend additional time and energy to build relationships with the new stakeholders. DHF members are sometime not available which requires the project team to postpone or reschedule meetings. Ensuring joint monitoring visits with Provincial and District health authorities are often difficult due to their busy schedules.

Conclusion: We conclude that activities implemented in year two made significant progress toward achieving our strategic objective. With the exception of the loan component, WSGs, and the Operations Research, our activities are on track against the workplan submitted with the Year 1 Annual Report. MC was able to achieve these results despite a volatile and insecure environment, and has made significant advances in improving the overall MNCH program and policies in Balochistan through lessons learned from SMNC.

Implementation Lessons Learned: Table 2 describes our analysis of what worked, what did not work and why, the stakeholders engaged in the analysis, lessons learned and recommendations and use of findings related to five key results.

Stakeholder engagement in activities and learning: Through the DHF, TWG, PSC and RAC project lesson learned are discussed for policy recommendation and improvement. Key issues addressed through these forums include: BCC strategy, WSGs, BCC tools, 5 year MNCH strategy, CMW selection, provision of loan to CMWs, technical and administrative supervision of CMWs, OR protocols, mobile phone component and sustainability of the project.

Two specific examples of other stakeholder engagement are:

- A DoH delegation in April 2014, headed by the Provincial Health Minister Mr. Rahmat Saleh Baloch, visited one of MC's supported CMWs and expressed their appreciation of Mercy Corps' contribution to improving maternal and newborn health in coordination with the DoH.
- In May, 2014 the Provincial Health Minister held another meeting with SMNC CMWs and requested that MC a) develop the capacity of the health department to replicate the loan component for other CMWs; and b) support the DoH to strengthen referral health facilities

SMNC continues to collaborate closely with the local USAID mission. This program was discussed with the new Director of Health Office, Randolph Augustine, in April 2014 and a presentation regarding overall progress against the strategic workplan was given to the Team Lead USAID MCH program, Monica Villanueva in September 2014. SMNC continues to align closely with USAID Pakistan's flagship program in Sindh, which has a strong CMW component.

Specific Information Requested: Not applicable.

Table 2: Summary of Key Analysis and Use of Findings

<i>Expected Results</i>	<i>Actual Results</i>	<i>Analysis (what worked, what didn't, and why)</i>	<i>Stakeholders Engaged in Analysis</i>	<i>Lessons Learned and Recommendations</i>	<i>Use of Findings (for course corrections, policy, etc.)</i>
All CMWs will want and need a loan for basic upgrades, medicine and supplies	Only a portion of CMWs wanted/needed a loan, while the rest arranged for the upgrades, medicine and supplies from their own resources	Due to the challenges managing expectations and fears by the CMWs about the loan, many of the CMWs have not requested a loan. Instead, they have borrowed money from friends or family. All CMWs are expected to meet minimum quality standards (including levels of medicine and supply), regardless if they receive a loan or not. The project will capture lessons learned about the advantages/ disadvantages of setting up a business with a formal bank-loan, versus an informal one from friends and family.	DHF TWG Tameer bank	In future, the loan terms need to be determined as quickly as possible so District Branch Managers can clearly communicate these to possible clients. Further, it is important to expect that not all CMWs will require a loan to set up their workstations. CMWs should be able to seek a loan if it helps serve their business purposes, but it should not be a requirement.	These findings will be discussed in TWG and will be incorporated in the 5 year MNCH strategy to make it easier for CMWs to get a loan, if they wish to do so.
Pregnant women will contribute to Mamta funds, even before WSG sessions	Few pregnant woman have contributed to the Mamta fund	In April, the first batch of 40 CMWs were given seed money to establish the Mamta fund. While CMWs have explained the Mamta fund to their clients, few have contributed to the fund.	DHF TWG Community elders CMWs	The establishment of a functional revolving fund requires significant mobilization in order to take root, such as envisioned under WSGs.	Emphasize the importance and reliability of the Mamta fund through WSGs
All CMWs receive supportive supervisory visits on a quarterly basis	70% of the CMWs receive supervisory visits on quarterly basis	In some communities LHVs and LHSs are not available at the required time due to their other commitment (LHSs are involved in Polio campaigns) while in other cases the target villages do not have LHSs and LHVs.	DHF LHWs program	Joint Monitoring visits by the district and provincial stakeholders help motivate CMWs to improve their work. However, some LHSs and LHV's face challenges to do so. One concrete recommendation is to include supervision of CMWs in the Job Description of LHSs and LHVs to institutionalize this role	The recommendation has been taken up in the TWG which will be endorsed by the PSC in the next quarterly meeting
90 CMWs selected, trained and working within properly furnished home-based workstations	90 CMWs selected and trained, 86 CMWs working in properly furnished home-based workstations	While 90 CMWs were selected and trained, 10 dropped out due to reasons outside of the control of the project (as described in the narrative)	DHF MNCH program TWG	The project team has found that CMWs who are selected from underserved areas are the most motivated/committed to serve. SMNC will continue to advocate for proper selection of CMWs.	This recommendation will be included in the Five year MNCH strategy

III. Operations Research (OR) Annual Progress Report

The OR was launched with the collection of baseline survey data for the quasi-experimental arm in Quetta and Gwader and pre-post arm in Kech (Module 1) and baseline financial data in Quetta and Gwader (Module 2) in May/June 2014. For collection of survey data, supervisors and enumerators were hired in all three districts and provided 1.5 days training. The data collection tools were corrected for translation and piloted. A total of 26 SMNC and 26 control clusters were surveyed in Gwader and Quetta and a total of 1,523 eligible women were interviewed. In Kech, 14 SMNC-CMW clusters were selected and 417 eligible women were interviewed.

Baseline financial data was collected from a randomly selected sample of 14 SMNC-CMWs in Quetta and 6 in Gwader. In-depth interviews were also conducted with these same CMWs to understand the organizational, social, and financial challenges they face in establishing and running their practices and attracting new clientele. The survey data were analyzed, and the report is being finalized by the UoA. MC will submit this report to USAID as soon as it is completed, which is expected by the end of November 2014.

Table 3: OR Study Progress and Achievements in Year 1

Related Specific Objective/s of the Task/s	OR Study Key Activities/ Tasks Addressed during this Reporting Period	Any important Findings, Data, and/or Discussion of Progress (positive/negative)	Use and/or Dissemination of Results to Stakeholders
Module 1: Collect baseline survey data for the quasi-experimental arm in Quetta and Gwader and pre-post arm in Kech	<ol style="list-style-type: none"> 1. Enumerators recruited and trained 2. Seven questionnaires of each language (Pushto, Balochi and Brahvi) piloted 3. Women's sample for survey data drawn 4. Household survey data collected in 3 districts 5. Data entered in Excel 6. Data analyzed by PI in Canada. 7. Report writing ongoing 	<p>Module 1 data are still being analyzed, but some of the key findings are:</p> <ol style="list-style-type: none"> 1. At baseline (i.e. before SMNC project interventions) the CMWs in all 3 districts are nearly non-functional. In Quetta and Gwadar, between 0-2% of women reported having received ANC or childbirth care from a CMW. However, 10% of women in Kech reported childbirth attendance by a CMW. Our hypothesis is that the SMNC intervention will help make these non-functional CMWs functional, sustainable, and quality service provides 2. The overall MNCH indicators from the baseline survey are much higher than expected and the provincial average. There are two major issues that we think explain these preliminary results: 1) the majority of CMWs initially selected and recruited by the MNCH program, unfortunately, are from urban and relatively better-off areas. Since SMNC is working with a select portion of these already trained CMWs, SMNC could not select the most vulnerable areas in these 3 districts if they did not have a CMW residing in the area. 2) Security concerns in these 3 districts presented some challenges with ensuring accurate data. These issues will be fully explored in the final baseline survey report. <p>Module 2 Findings will be analyzed in year 3.</p>	<p>The first Research Advisory Committee (RAC) meeting was conducted jointly by MC staff and the Principle Investigator, Zubia Mumtaz in June 2014. The OR plan was shared with Government of Balochistan personnel (Director Public Health and Deputy Director MNCH Program) donors (Research and Advocacy Fund, Pakistan), and NGOs (Aga Khan Foundation, Save the Children, and JHPIEGO). The second RAC is planned for December 2014, where the findings of the baseline survey will be shared.</p> <p>Results from the Financial Sustainability Module 2 will be disseminated in December 2015, after a follow-up survey using the same tool is conducted in the spring of 2014.</p>
Module 2. Collect baseline CMW financial data in Quetta and Gwader.	<ol style="list-style-type: none"> 1. Piloted financial analysis tool in Quetta 2. Collected baseline CMW practice financial status data from 20 CMWs 3. Data entered 4. Analysis & report writing planned for year 3 		

Research Products

- Module 1 Survey Tool: KPC Baseline Survey
- Module 2: Financial analysis tool
- Publication of the Operations Research Protocol in BMC: Mumtaz, Z, Cutherell, A, and Bhatti, A. *Saving mothers and newborns in communities: strengthening community midwives to provide high quality essential newborn and maternal care in Baluchistan, Pakistan in a financially sustainable manner*. BMC Pregnancy and Childbirth 2014, 14:131.
<http://www.biomedcentral.com/1471-2393/14/131>

Problems/Challenges: There were two key challenges to the Operations Research.

- 1) **Delays in UoA Subaward:** As described in the Strategic Workplan and the Year 1 Annual Report, there have been a series of delays in finalizing the OR partner, as the initial partner HSA was no longer available for the assignment, there were challenges in re-bidding the partnership arrangement, and lack of funds, which meant that the subaward with UoA was not approved by USAID until early 2014. This resulted in the postponement of the OR start date to May 1, 2014, which has reduced the research timeline to 28 months down from 42 months.
- 2) **Security/mobility:** The security concerns may have compromised the quality of the data training and collection. In Gwadar and Kech, UoA's Research Manager was unable to visit the data collection sites given security constraints. In Kech, the Research Manager could not even visit the district capital to train the enumerators in person, and thus did so via skype. Given these concerns about the data quality, MC/UoA conducted a survey quality assurance visit to verify some of the data collected (through a subsample of 12 questionnaires). These security challenges, and potential concerns with data quality, will be fully explored in the final baseline survey report.

Changes Made to Original OR Plans: In our proposed sampling plan, a SMNC intervention cluster was defined as a SMNC-CMW and the women living in her catchment area. The control groups was to consist of non-SMNC-CMWs catchment areas, separated from SMNC-CMW clusters by at least one Union Council (UC). However, in reality, the government supported CMWs were clustered in a portion of the UC. Since SMNC CMWs are selected from these existing government trained CMWs, it was not possible to select control CMWs which were separated by at least 1 UC. Further, in the proposed sampling plan an equal number of CMWs were to be selected from each district. However, since SMNC has trained a different number of CMWs in each district (based on the total available CMWs), the sampling plan had to be changed. Given this, the following, new sampling plan was followed:

1. A control cluster consisted of a randomly selected, non-SMNC-CMW from a UC (or neighborhood) next to a SNMC-CMW cluster.
2. The sample of CMWs was distributed proportional to their availability in the two districts. All 7 CMWs in Gwader were included and 19 randomly selected from Quetta to complete a sample size of 26 CMWs.

Major OR Plans for Coming Year

1. Second RAC meeting to share Baseline Survey findings (Dec 2014)
2. Data entry and analysis of baseline Module 2: Financial sustainability – ongoing
3. Midline data collection and analysis of Module 2 – Q3 & Q4 (Year 3)
4. Module 3: CMW quality of care; data collection and analysis – Q3 & Q4 (Year 3)

Annex 1. Project Workplan

Note: boxes shaded in blue indicate activities related to Batch 2 CMWs only; those in red relate to either Batch 1 or both batches

SMNC Work plan			Key Personnel	Collaboration Assumptions	Year 3 (Oct 1 2014 – Sept 30 2015)													Year 4				
					Yr 1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
Strategic Objective: Increased use of essential maternal and newborn care services and behaviors, through private-sector community midwives																						
Intermediate Result 1: Increased availability of quality maternal and newborn care in communities																						
1.1	Selection & Registration of CMWs				Yr 1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
	1.1.1	Develop selection criteria, Job Descriptions, and MoU for CMWs	PO	PM																		
	1.1.2	DHO/MC committee selects CMW applicants meeting selection criteria	Selection committee	PM, PO																		
	1.1.3	MC facilitates registration of selected CMWs with PNC	PM, PO	TL																		
	1.1.4	Sign MoUs with CMWs (Batch 1 & Batch 2)	PM, PO	DOH																		
1.2	CMW Refresher Training				Yr 1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
	1.2.1	Refresher training curriculum adapted	PM,PO	TL																		
	1.2.2	Master Training from consulting firm: Midwifery Tutors trained on the refresher curriculum (3 days, Quetta)	Master Trainer	PM, PO																		
	1.2.3	CMW Refresher Training: Midwifery school Tutors conduct refresher course for CMWs (4 weeks, District CMW Schools) -- 40 CMWs Batch 1; 50 CMWs Batch 2	PM	PO, PA																		
1.3	Financial & Structural support to CMWs				Yr 1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
	1.3.1	Mercy Corps opens bank accounts for loan repayment , provides bank guarantees, and arranges for loan																				
	1.3.2	CMW Business Training: MC trains CMW in business skills and tools to set up their home-based clinic (including loan repayment, Mamta fund, and supply chain management) (1 weeks, District CMW Schools or DHO) 40 CMWs Batch 1, 50 CMWs Batch 2	Consultant	PM, PO																		
	1.3.3	MC procures and provides equipment, consumables, and CMW Birth Kits to CMWs (Batch 1 & 2)	PM	Operations																		
	1.3.4	During Business training, connect CMWs to pharmacies at the sub-district level for medicines and supplies	PO, FO and PA	PM																		
1.4	CMW Deployment				Yr 1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
	1.4.1	Introduce CMWs with key stakeholders (District	PO	FO, PA																		

FO (Field Officer), MEL (Monitoring Evaluation, and Learning); PA (Project Assistants), PI (Principal Investigator), PM (Project Manager), PO (Project Officer), TL (Team Lead), DDHP (Deputy Director of Health Programs), WSG (Women Support Group)

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		Health Staff; Facility Staff; Community members)																				
1.4.2		Brand CMW homes as per DOH guidelines	FO, PA	PO																		
1.5	Supervision of CMWs in field				Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Ma y	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
1.5.2		Train MC Staff on use of monitoring checklists and supervision expectations	M&E Officer	PM																		
1.5.3		Joint technical and administrative Supervision: LHV & Field Officer (monthly basis -- project officer joins quarterly) LHS & Field Officer (monthly -- project officer joins quarterly)	DGHS, Provincial coordinator LHWs program, Provincial Coordinator MNCH program, DHO, LHS	PM, PO, M&E Officer																		
1.6	Develop mobile phone application for CMWs				Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Ma y	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
1.6.1		Pak Vista develops, test and finalizes mHealth Solution, including the sever and applications	Pak Vista	DDHR																		
1.6.2		Train CMWs in Mobile application	Pak Vista	PM, PO, M&E O																		
1.6.3		Maintain the server and submit monthly reports to government	MEL dep	M&E Officer																		
Intermediate Result 2: Improved knowledge and demand for essential maternal and newborn care																						
2.1	Mobile Phone Mass SMS (See activity 1.6)				Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
2.1.1		Send weekly mass SMS through the server for awareness raising, demand generation and behavior change	Pak Vista	PM																		
2.2	Formation of Women Support Groups																					
2.2.1		Develop WSG Methodology and BCC material based on formative research	Consultant	PM, PO and M&E officer																		
2.2.2		WSG Training: MC Trains CMWs & LHWs on WSG methodology and Tools -- 40 CMWs & 200 LHWs in Batch 1; 50 CMWs & 250 LHWs in Batch 2	PM	PO and M&E officer																		
2.2.3		Conduct monthly meetings of WSGs with the women of reproductive age and track attendance	FO	PO																		
2.2.4		Exchange learning visits among CMWs to participate in WSG meetings	FO	PO, PA																		
Intermediate Result 3: Improved access to emergency transport in remote communities																						
3.1	Transport Mamta Fund (TMF) Formation				Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
3.1.1		Sign Agreement between Mercy Corps and	PM																			

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Annex 1. Project Workplan

Note: boxes shaded in blue indicate activities related to Batch 2 CMWs only; those in red relate to either Batch 1 or both batches

		Ambulance service providers (Edhi)																			
3.1.2	Support CMWs to identify a local vehicle in their catchment and prepare agreements for emergency transport	FO	PA																		
3.1.3	Provide CMWs initial seed money for Mamta Fund, and train CMWs in maintaining of Mamta Fund (integrated in business training)-	FO	PO, PA																		
3.1.4	WSGs discuss Mamta Fund during monthly meetings	WSGs	FO																		
3.1.5	Pregnant women contribute to Mamta Fund	WSGs	FO																		
Intermediate Result 4: Improved policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research																					
4.1	Provincial MNCH Steering Committee			Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
4.1.1	Establish ToRs of the provincial MNCH steering committee of Balochistan	PM	TL																		
4.1.2	Notify the MNCH steering committee by the department of health in Balochistan	PM	TL																		
4.1.3	Conduct quarterly meeting of the provincial MNCH steering committee on regular basis and share the meeting minutes	PM	TL																		
4.2	Provincial Technical Working Group			Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
4.2.1	Establish ToRs of the Provincial Technical Working Group of Balochistan	PO	PM, TL																		
4.2.2	Notify the Provincial Technical Working Group by the department of health in Balochistan	PM	PM, TL																		
4.2.3	Conduct quarterly meeting of the Provincial Technical Working Group on regular basis and share the meeting minutes (Year 1 only)	PM	PM, TL																		
4.3	District Health Forum			Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
4.3.1	Establish ToRs of the District Health Forum of Balochistan	M&E O	PM, PO, TL																		
4.3.2	Notify the District Health Forum by the department of health in Balochistan	PO	PM																		
4.3.3	Conduct quarterly meeting of the District Health Forum on regular basis and share the meeting minutes	PO	PM																		
4.4	Develop 5 Year MNCH Strategy			Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4
4.4.1	Consulting Firm develops initial 5 year strategic plan, with input from TWG and PSC	Consultant	PM																		
4.4.2	Submit the final Strategy to the department of Health Govt of Balochistan	Consultant	PM																		
4.4.3	Consulting Firm revises 5 Year Strategic Plan based on OR Findings, including input/recommendations from the TWG and PSC	Consultant	PM																		
4.4.4	Submit the revise and final Strategy to the department of Health Govt of Balochistan	Consultant	PM																		

FO (Field Officer), MEL (Monitoring Evaluation, and Learning); PA (Project Assistants), PI (Principal Investigator), PM (Project Manager), PO (Project Officer), TL (Team Lead), DDHP (Deputy Director of Health Programs), WSG (Women Support Group)

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4.5	Operations Research			Y1	Yr 2	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Q1	Q2	Q3	Q4	
4.5.1	Form Research Advisory Committee	Sr. Health Advisor	PI																			
4.5.2	Prepare & Submit OR IRB Application	PI	DDHP																			
4.5.3	Research Advisory Committee Bi Annual Meeting	PI	DDHP																			
4.5.4	Baseline KPC & Follow-up KPC Surveys	PI	DDHP MEL Dept																			
4.5.5	Other OR Data Collection	Consultant	Project team																			
4.5.6	OR Final Dissemination of Results	Consultant	Project team																			
4.6	Final Evaluation	PM	M&E Officer & MEL Dep																			

FO (Field Officer), MEL (Monitoring Evaluation, and Learning); PA (Project Assistants), PI (Principal Investigator), PM (Project Manager), PO (Project Officer), TL (Team Lead), DDHP (Deputy Director of Health Programs), WSG (Women Support Group)

Annex 2. Performance Monitoring Indicator Table

Note: text in **red** indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
Strategic Objective: Increased use of essential maternal and newborn care services and behaviours, through private-sector community midwives										
1	Antenatal Care	<p>Survey: Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child.</p> <p>Routine: Percentage of estimated pregnancies with at least four antenatal visits with CMW</p> <p>** Also reported for 1, 2, or 3 visits to track drop off</p>	<p>Survey: Numerator: # of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child Denominator: Total # of mothers of children age 0-23 months in the survey</p> <p>Routine: Numerator: # of pregnant women receiving antenatal care from CMW in visit 1 / 2 / 3 / 4 Denominator: total # of estimated pregnant women in CMW's catchment area during reporting period</p>	Impact	KPC 30-cluster population survey	2x (baseline & final survey)	Consultant /M&E team	Y	Gwader: 71.72% Kech: 70.2% Quetta: 64.53%	Routine ANC1 = 38% ANC4= 5%
				Proxy	CMW mobile phone patient records	Tabulated mly & qly	M&E team		Total: 62.9%	
2	Skilled Birth Attendant	<p>Survey: Percentage of children age 0-23 months whose births were attended by skilled personnel</p> <p>Routine: Percentage of estimated births in CMW catchment area that were attended by or referred by the CMW</p>	<p>Survey: Numerator: # of children age 0-23 months whose birth was attended by a doctor, nurse, midwife or auxiliary midwife Denominator: Total # of mothers of children age 0-23 months in the survey</p> <p>Routine: Numerator: # of births attended by or referred to facility by the CMW in the reporting period Denominator: Total # of estimated births in the catchment area of the CMW in the reporting period</p>	Impact	KPC 30-cluster survey	2x (baseline & final survey)	Consultant /M&E team	Y	Gwader: 88.35% Kech: 93.01% Quetta: 81.62%	21%
				Proxy	CMW mobile phone patient records	Tabulated mly & qly	M&E team		Total: 86.7%	

¹ The results of the baseline survey, conducted in June 2014 by the University of Alberta, indicate a much higher status of MNCH indicators than expected and than any other agency has measured for those three districts. Mercy Corps and University of Alberta are actively looking into these discrepancies (including repeating the questionnaire in a small sample of households as a part of a data quality back-checking exercise). The results will be fully described in the full Baseline Survey Report, which will be submitted to USAID as soon as completed – expected November 2014.

Annex 2. Performance Monitoring Indicator Table

Note: text in red indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
3	Maternal TT Vaccination ** Also calculate for TT1 to check drop-out	<i>Survey:</i> Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child <i>Routine:</i> Percentage of estimated pregnant women who received at least two Tetanus toxoid vaccinations from CMW	<i>Survey:</i> Numerator: # of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child Denominator: Total # of mothers of children age 0-23 months in the survey <i>Routine:</i> Numerator: # of pregnant women receiving at least two Tetanus toxoid vaccinations from CMW Denominator: total # of estimated pregnant women in CMW's catchment area during reporting period	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qly	Consultant /M&E team M&E team	Y	Gwader: 0.72% Kech: 1.2% Quetta: 50.5% Total: 20.71%	TT2= 4% TT1= 7%
4	Post-natal visit to check on mother / newborn within the first 2 days after birth	<i>Survey:</i> Percentage of children age 0-23 who received a post-natal visit from an appropriate trained health worker within two days after the birth of the youngest child <i>Routine:</i> Proportion of deliveries with a postnatal visit from the CMW within two days after birth (additional to immediate postpartum checkup by birth attendant)	<i>Survey:</i> Numerator: # of mothers of children age 0-23 months who received a post-partum visit within two days after birth by an appropriate health worker Denominator: Total # of children age 0-23 months in the survey <i>Routine:</i> Numerator: number of deliveries with a postnatal visit from the CMW within two days after birth (additional to immediate postpartum checkup by birth attendant) Denominator: total number of expected deliveries in the catchment area of CMW during the reporting period	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qly	Consultant /M&E team M&E team	Y	Gwader: 65.53% Kech: 57.83% Quetta: 57.39% Total: 58.94%	13%
5	Current	<i>Survey</i>	<i>Survey:</i>	Impact	KPC 30-	2x	Consultant	Y	Gwader:	8% ²

² This indicator is low, likely because data was not collected until May 2014.

Annex 2. Performance Monitoring Indicator Table

Note: text in red indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
	Contraceptive Use Among Mothers of Young Children:	<p>Percentage of mothers of children age 0-23 months who are using a modern contraceptive method</p> <p><i>Routine</i> Proportion of CMW clients who received at least one session of counselling on family planning methods during ANC visit and/or PNC visits</p>	<p>Numerator: # of mothers with children age 0-23 months who using a modern contraceptive method</p> <p>Denominator: Total # of mothers of children age 0-23 months in the survey</p> <p><i>Routine</i> Numerator: # of CMW clients who received at least one session of counselling on family planning methods during ANC visit and/or PNC visits</p> <p>Denominator: total number of expected pregnancies in the catchment area of CMW during the reporting period</p>	Proxy	<p>cluster survey</p> <p>CMW mobile phone patient records</p>	<p>(baseline & final survey)</p> <p>Tabulated mly & qly</p>	<p>/M&E team</p> <p>M&E team</p>		<p>75.73%</p> <p>Kech: 57.11%</p> <p>Quetta: 48.45%</p> <p>Total: 56.11%</p>	
6	Hygienic cord care	<p><i>Survey</i> Percentage of newborns with cord cut with clean instrument</p> <p><i>Routine</i> Proportion of newborns from CMW with cord cut with clean instrument</p>	<p><i>Survey:</i> Numerator: # of children age 0-23 months with cord cut using new blade or boiled instrument (non-facility births only) at time of birth</p> <p>Denominator: Total # of mothers of children age 0-23 months in the survey that delivered outside health facility</p> <p><i>Routine:</i> Numerator: # of newborns from CMW deliveries with cord cut using new blade or boiled instrument</p> <p>Denominator: Total # of estimated births in the catchment area of CMW during the reporting period</p>	<p>Impact</p> <p>Proxy</p>	<p>KPC 30-cluster survey</p> <p>CMW mobile phone patient records</p>	<p>2x (baseline & final survey)</p> <p>Tabulated mly & qly</p>	<p>Consultant/M&E team</p> <p>M&E team</p>	N	<p>Gwader: 94.74%</p> <p>Kech: 95%</p> <p>Quetta: 81.89%</p> <p>Total: 88.68%</p>	21%
7	Cord care	<p><i>Survey</i> Percentage of newborns with nothing (harmful) applied to cord³</p>	<p><i>Survey:</i> Numerator: # Number of newborns with nothing (harmful) applied to cord</p>	Impact	KPC 30-cluster survey	2x (baseline &	Consultant/M&E team	N	Gwader: 9.09%	21%

³ Interviewer records all substances put on the cord from cutting until it falls off. Harmful substances are determined during analysis.

Annex 2. Performance Monitoring Indicator Table

Note: text in red indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
		<i>Routine</i> Proportion of newborns from CMW with nothing (harmful) applied to cord ⁴	Denominator: Total # of mothers of children age 0-23 months in the survey that delivered outside health facility <i>Routine:</i> Numerator: # of newborns from CMW deliveries with nothing (harmful) applied to cord Denominator: Total # of estimated births in the catchment area of CMW during the reporting period born outside a facility	Proxy	CMW mobile phone patient records	final survey) Tabulated mly & qly	M&E team		Kech: 8.75% Quetta: 6.09% Total: 7.46%	
8	Thermal care: drying	<i>Survey</i> Percentage of newborns dried after birth <i>Routine</i> Proportion of CMW deliveries that were dried after birth	<i>Survey:</i> Numerator: # of children age 0-23 months that were dried after birth Denominator: Total # of mothers of children age 0-23 months in the survey <i>Routine:</i> Numerator: # of newborns from CMW deliveries dried after birth Denominator: Total # of estimated births in the catchment area of CMW during the reporting period	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qly	Consultant /M&E team M&E team	N	Gwader: 96.81% Kech: 87.69% Quetta: 94.78% Total: 92.57%	21%
9	Thermal care: delayed bath	<i>Survey</i> Percentage of newborns with delayed bath after birth <i>Routine</i>	<i>Survey:</i> Numerator: # of newborns with first bath delayed at least six hours ⁵ after birth Denominator: Total # of mothers of children age 0-23 months in the survey	Impact	KPC 30-cluster survey	2x (baseline & final survey)	Consultant /M&E team	N	Gwader: 91.08% Kech: 39.24%	21%

⁴ Interviewer records all substances put on the cord from cutting until it falls off. Harmful substances are determined during analysis.

⁵ Timing could be modified based on WHO/country policy

Annex 2. Performance Monitoring Indicator Table

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
		Proportion of CMW deliveries with delayed bath after birth	<i>Routine:</i> Numerator: # of newborns from CMW deliveries with first bath delayed at least six hours ⁶ after birth Denominator: Total # of estimated births in the catchment area of CMW in reporting period	Proxy	CMW mobile phone patient records	Tabulated mly & qtly	M&E team		Quetta: 62.17% Total: 54.18%	
10	Thermal care: skin-to-skin contact	<i>Survey</i> Percentage of newborns placed on the mother's bare chest after delivery <i>Routine</i> Proportion of CMW deliveries that were placed on the mother's bare chest after delivery	<i>Survey:</i> Numerator: #of newborns placed on the mother's bare chest after delivery Denominator: Total # of mothers of children age 0-23 months in the survey that delivered outside health facility <i>Routine:</i> Numerator: # of newborns from CMW deliveries placed on the mother's bare chest after delivery Denominator: Total # of estimated births in the catchment area of CMW during the reporting period born outside a facility	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qtly	Consultant /M&E team M&E team	N ⁷	Gwader: 42.11% Kech: 44.79% Quetta: 25.4% Total: 35%	21%
11	Early initiation of breastfeeding	<i>Survey</i> Proportion of children born in the last 24 months who were put to the breast within one hour of birth <i>Routine</i> Proportion of CMW deliveries that were put to the breast within one hour	<i>Survey</i> Numerator: Children born in the last 24 months who were put to the breast within one hour of birth Denominator: Children born in the last 24 months <i>Routine</i> Numerator: # of deliveries that were put to the breast within one hour of birth	Impact Proxy	KPC 30-cluster survey CMW mobile	2x (baseline & final survey) Tabulated mly	Consultant /M&E team M&E team	N	Gwader: 32.04% Kech: 18.07% Quetta: 18.73%	21%

⁶ Timing could be modified based on WHO/country policy

⁷ Requested by USAID/MCHIP

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
		of birth	Denominator: Total # of estimated births in the catchment area of CMW during the reporting period		phone patient records	& qtly			Total: 20.78%	
12	Exclusive breastfeeding	<i>Survey</i> Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours <i>Routine: NA</i>	<i>Survey</i> Numerator: # of children age 0-5 months who drank breast milk in the previous 24 hours AND Did not drink any other liquids in the previous 24 hours AND Was not given any other foods or liquids in the previous 24 hours Denominator: Total # of children age 0-5 months in the survey	Impact	KPC 30-cluster survey	2x (baseline & final survey)	Consultant /M&E team	Y	Gwader: 82.05% Kech: 83.66% Quetta: 38.52% Total: 65.92%	NA
13	Birth weight	<i>Survey</i> Percentage of live births with a reported birth weight <i>Routine</i> Proportion of CMW delivered live births with a reported birth weight	<i>Survey</i> Numerator: Number of live births to women ages 15-49 in the 2 years prior to the survey with a reported birth weight Denominator: Total number of live births to women ages 15-49 in the 5 years prior to the survey <i>Routine</i> Numerator: Number of CMW delivered live births to women ages 15-49 with a reported birth weight Denominator: Total # of estimated births in the catchment area of CMW during the reporting period	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qtly	Consultant/M&E team M&E team	N	Gwader: 61.98% Kech: 47% Quetta: 48.75% Total: 50.41%	20%

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
14	Postnatal care signal functions	<p><i>Surveyt</i> Percentage of newborns that received postnatal care within 2 days and at least 2 signal functions⁸ were done</p> <p><i>Routine</i> Proportion of CMW delivered newborns that received postnatal care within 2 days and at least 2 signal functions⁹ were done</p>	<p><i>Survey</i> Numerator: Number of newborns s that received postnatal care within 2 days and at least 2 signal functions were done Denominator: Total # of mothers of children age 0-23 months in the survey</p> <p><i>Routine</i> Numerator: Number of CMW delivered newborns s that received postnatal care within 2 days and at least 2 signal functions were done Denominator Total # of estimated births in the catchment area of CMW during the reporting period</p>	Impact Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qtly	Consultant/M&E team M&E team	N	Not measured	13% ¹⁰

⁸ Signal functions are 1) Checking the cord, 2) Counseling on danger signs, 3) Assessing temperature, 4) Observing/counseling on breastfeeding, and 5) Weighing the baby (where applicable).

⁹ Signal functions are 1) Checking the cord, 2) Counseling on danger signs, 3) Assessing temperature, 4) Observing/counseling on breastfeeding, and 5) Weighing the baby (where applicable).

¹⁰ The SMNC team is concerned about the relatively low rates of PNC. The reason, so far, is that most deliveries are conducted within the CMW workstation and few clients seek PNC from the workstation. During year 3, the SMNC will prioritize PNC to seek to increase coverage of this key service.

Annex 2. Performance Monitoring Indicator Table

Note: text in red indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
15	CMW Availability	#/% of active CMWs working within their catchment area NB: active means a CMW has at least 5 registered clients from her catchment area	#/Numerator: of active CMWs working within their catchment area Denominator: # of targeted CMWs NB: active means a CMW has at least 5 registered clients from her catchment area	Outcome	Mobile phone records	Qtly	M&E Team	No		76%
16	CMW quality assurance	Proportion of CMWs who scored at least 80% on the Technical Supervisory Checklist ¹¹	Numerator: number of CMWs who score at least 80% on the Technical Supervisory Checklist Denominator: number of CMWs supervised during reporting period	Output	Technical Supervisory Checklist	Qtly	Field Officer	No		100%
17	Operational CMW work stations	Proportion of CMWs with operational work station NB: operational work station means the home contains all essential refurbishments, furniture, and equipment as per CMW guidelines inclusive of vaccine supply (when electricity is available) and medicine stock	Numerator: # of CMWs with operational work station Denominator: # of CMWs monitored by MC staff within the reporting period	Output	Admin Supervisory Checklist	qtly	M&E team	No		92% (82/90)
18	CMWs trained	#/% of CMWs completed 4-week refresher training scoring at least 60% on the post-test	#/Numerator of CMWs completed 4-week refresher training scoring at least 60% on the post-test Denominator: # CMWs participated in refresher training	Output	Pre/Post Test Training Records	2 times during life of project	M&E/Program team	No		90 = 100%

¹¹ This is the MNCH based checklist tool# 10, slightly modified for the project purposes. Scoring is given for skills, equipment, and supplies.

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
19	CMWs selected	#/% of CMWs selected according to MC's selection criteria NB: See Annex 12 for the selection criteria	#/Numerator: of CMWs selected according to MC's selection criteria Denominator: # of CMWs meeting selection criteria NB: See Annex 12 for the selection criteria	Output	Selection records	2 times during life of project	M&E/Program team	N		90 = 100%
20	CMW supervision	Proportion of CMWs supervised by MC/DoH joint monitoring teams during the reporting period	Proportion of CMWs supervised by MC/DoH joint monitoring teams during the reporting period Numerator: # of CMWs supervised by MC/DoH joint monitoring teams during the reporting period Denominator: Total # of active CMWs	Output	MC field visit records	Qtly	Program team	N		Qtly 63 = 70% Yearly 100%
21	CMWs repaid loans	#/% of CMWs that repaid their full loan 3 months before the end of the project	#/Numerator: of CMWs that repaid their full loan 3 months before the end of the project Denominator: # of targeted CMWs	Output	MFI online records	1x (3 months before end of project)	M&E team	N		NA
22	CMWs repaying loans	Average percent of loan repaid by CMWs	Numerator: Total amount of loan repaid by CMWs (excluding interest) Denominator: Total loan provided to CMWs	Output	MFI online records	Qtly	M&E team	N		NA
23	CMWs repaying loan	#/% of CMWs that are in the: 1. Red zone: 2. Yellow zone: 3. Green zone: As defined by the loan repayment schedule	#/Numerator: of CMWs that are in the: 1. Red zone: 2. Yellow zone: 3. Green zone: Denominator: # of targeted CMWs As defined by the loan repayment schedule	Output	MFI online records	Qtly	M&E team	N		NA
24	DoH tracks CMW	# of government personnel (DHO, provincial coordinators, DG) provided with a summary CMW mly report	# of government personnel (DHO, provincial coordinators, DG) provided with a summary CMW mly report	Output	Sending record	Mly	Program team	N		6 personnel Note: Data is shared

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
										with the DHOs and PHSs of 3 districts, mly)
25	PNC registration	# of selected CMWs registered with PNC	# of selected CMWs registered with PNC	Input	PNC Registration copies	Qtly	Program team	N		64 =71%
26	Loan	#/% of CMWs provided with loan from Tameer Bank	#/Numerator: of CMWs provided with loan from Tameer Bank Denominator: # of targeted CMWs	Input	Project records	Qtly	Program team	N		0%
27	CMW equipment	#/% of CMWs provided with essential equipment	#/Numerator: of CMWs provided with essential equipment Denominator: # of targeted CMWs	Input	Project records	Qtly	Program team	N		86 = 96%
28	Mothers knowledge of newborn danger signs	Percentage of mothers of children age 0-23 months who know at least two danger signs for newborns immediately after birth for which it is necessary to seek medical advice / treatment	Numerator: # of mothers of children age 0-23 months who know at least two danger signs for newborn immediately after birth for which it is necessary to seek medical advice / treatment Denominator: total number of mothers of children age 0-23 months in the survey	Outcome	KPC 30-cluster survey Annual mini-KPC survey (using LQAS)	2x (baseline & final survey) Annual (2x) using mini-KPC LQAS method	PI Project Team	N	Gwader 59.2% Kech: 23.02% Quetta: 73.81% Total: 53.8%	NA
29	Husbands known	Percentage of fathers of children age 0-23 months who know at least two danger signs for newborns immediately	Numerator: # of fathers of children age 0-23 months who know at least two danger signs for newborn immediately after birth for which it is necessary to	Outcome	KPC 30-cluster survey	2x (baseline & final	PI	N	Not included in the	NA

Annex 2. Performance Monitoring Indicator Table

Note: text in red indicates slight changes in definitions of the indicator since the Strategic Workplan and the First Annual Report. These definition changes don't change the meaning of the indicator, rather just clarify the metric.

#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
	ge of newborn danger signs	after birth for which it is necessary to seek medical advice/treatment	seek medical advice / treatment Denominator: total number of fathers of children age 0-23 months in the survey		Annual mini-KPC survey (using LQAS)	survey) Annual (2x) using mini-KPC LQAS method	Project Team		questionnaire ¹²	
30	Mothers knowled ge of maternal danger signs	Percentage of mothers of children age 0-23 months who know at least two danger signs during pregnancy for which it is necessary to seek medical advice / treatment	Numerator: # of mothers of children age 0-23 months who know at least two danger signs during pregnancy for which it is necessary to seek medical advice / treatment Denominator: total number of mothers of children age 0-23 months in the survey	Outcome	KPC 30-cluster survey Annual mini-KPC survey (using LQAS)	2x (baseline & final survey) Annual (2x) using mini-KPC LQAS method	PI Project Team	N	Gwader 55.83% Kech: 24.1% Quetta: 70.27% Total: 51.87%	NA
31	Husband s knowled	Percentage of husbands of mothers of children age 0-23 months who know at least two danger signs during	Numerator: # of fathers of children age 0-23 months who know at least two danger signs during pregnancy for which it is necessary to seek medical advice /	Outcome	KPC 30-cluster survey	2x (baseline & final	PI	N	Not included in the	NA

¹² After inclusion of this indicator in the PMP, the research team (i.e. University of Alberta) determined it was too time intensive and costly to add this one indicator which was asked of husbands.

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
	ge of maternal danger signs	pregnancy for which it is necessary to seek medical advice / treatment	treatment Denominator: total number of fathers of children age 0-23 months in the survey		Annual mini-KPC survey (using LQAS)	survey) Annual (2x) using mini-KPC LQAS method	Project Team		questionnaire ¹³	
32	Mass SMSs received VOIP messages	Percentage of those surveyed who received at least one BCC SMS in the past month	Numerator: # of individuals surveyed who received at least one BCC SMS in the month prior to the survey Denominator: # of CMW clients <i>Routine:</i> Numerator: # of individuals answered / received the VOIP messages and listened it completely OR pressed 1 Denominator: # of total VOIP messages' Calls	Output	KPC 30-cluster survey Annual mini-KPC survey (using LQAS) Mobile Server records	2x (baseline & final survey) Annual (2x) using mini-KPC LQAS method Tabulated Mly & Qtly	PI Project Team	N		0%
33	Households reached by mass	Number of married women of reproductive age and/or their family members who received educational messages on their mobile phones	# of unique numbers registered on Mobile Server	Output	Mobile Server records	Qtly	M&E team	N		26

¹³ As above, after inclusion of this indicator in the PMP, the research team (i.e. University of Alberta) determined it was too time intensive and costly to add this one indicator which was asked of husbands.

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
	SMS / VOIP message									
34	WSG attendance	<p><i>Survey:</i> Percent of WRA who attended a WSG in the last month.</p> <p><i>Routine</i> Percentage of married WRA who attended an WSG in the last month</p>	<p><i>Survey:</i> Numerator: # of WRA who attended a MSG in the last month Denominator: total number of WRA in the survey</p> <p><i>Routine</i> Numerator: # of married WRA who attended a MSG WSG meeting in the last month Denominator: total number of estimated married WRA in the LHW's catchment area</p>	Output Proxy	KPC 30-cluster survey WSG attendance sheets	2x (baseline & final survey) Tabulated mly & qly	Consultant/M&E team M&E team	N		NA
35	Mobile Phones	# of CMWs with mobile application on their phone	# of CMWs with mobile application on their phone	Input	Training records	2x during project	Pak vista/program team			37 = 41%
36	Mobile phone training	# of CMWs trained on mobile application	# of CMWs trained on mobile application	Input	Training records	2x during project	Pak vista/program team			37 = 41%
37	Mass SMS/VOIP	# of mass SMSs sent through server for awareness raising and demand generation on mly basis	# of mass SMSs sent through server for awareness raising and demand generation on mly basis	Input	Mobile Server	Mly	MC communication section			38
38	WSG training	#LHWs and CMWs trained on WSG methodology	#LHWs and CMWs trained on WSG methodology	Input	Training records	Mly	Program team			NA
39	WSG LMG (Lead Mothers Group) meeting	# of WSGs LMG (Lead Mothers Group) formed in the catchment population of CMWs	# of WSGs LMG (Lead Mothers Group) formed in the catchment population of CMWs	Input	Attendance sheets	Qtly	Program team			NA
40	Emergen	<i>Survey:</i>	<i>Survey:</i>	Outcome	KPC 30-cluster	2x (baseline	Consultant / M&E	N		0%

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
	cy Transport for Mothers	Percentage of women with children 0-23 months who accessed emergency transport during their last delivery NB: emergency transport is any vehicle <i>Routine:</i> Percentage of estimated women who gave birth that accessed emergency transport during delivery	Numerator: # of women with children 0-23 months who access emergency transport during their last delivery Denominator: total number of women with children 0-23 months in the survey <i>Routine</i> Numerator: # of CMW clients who accessed emergency transport Denominator: total number of estimated deliveries during the reporting period	Proxy	survey CMW mobile phone patient records	e & final survey) Tabulated mly & qtly	team M&E team			
41	Emergency Transport for Newborn	<i>Survey:</i> Percentage of women with children 0-23 months who accessed emergency transport for their youngest child within one month after birth NB: emergency transport is any vehicle <i>Routine:</i> Percentage of estimated women who gave birth that accessed emergency transport for their newborn	<i>Survey:</i> Numerator: # of women with children 0-23 months who access emergency transport for their youngest child within one month after birth Denominator: total number of women with children 0-23 months in the survey <i>Routine</i> Numerator: # of CMW clients who accessed emergency transport for their newborn Denominator: total number of estimated newborns during the reporting period	Outcome Proxy	KPC 30-cluster survey CMW mobile phone patient records	2x (baseline & final survey) Tabulated mly & qtly	Consultant / M&E team M&E team	N		0%
42	Functioning revolving funds	Percentage of CMWs monitored that have a functioning revolving fund NB: functioning is defined as: 1) Registers exists that matches cash in fund 2) Register shows activity (i.e. money in and money out)	Percentage of CMWs monitored that have a functioning revolving fund NB: functioning is defined as: 1) Registers exists that matches cash in fund 2) Register shows activity (i.e. money in and money out) within the past 1 month	Output	Mamta Fund Monitoring Tool	Qtly	M&E team	N		0%

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
		within the past 1 month								
43	Linked vehicles	# of vehicles linked with revolving funds NB: linked means CMW has agreed with the vehicle driver that they are willing to provide emergency transport and that states the rate for reimbursement	# of vehicles linked with revolving funds NB: linked means CMW has agreed with the vehicle driver that they are willing to provide emergency transport and that states the rate for reimbursement	Output	Agreements between CMW and vehicle owner	Qtly	Program team	N		90
44	Seed money provided	# of CMWs provided seed funds from MC	# of CMWs provided seed funds from MC	Input	Project records	Qtly	Program team	N		40 = 44%
45	Ambulances	# of CMWs introduced to ambulances or other vehicles (by MC Field Officer) during training as an option for emergency transport	# of CMWs introduced to ambulances or other vehicles (by MC) during training as an option for emergency transport	Input	Project records	Qtly	Program team	N		40
IR4: Improved policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research										
46	Provincial MNCH Plan	Five year MNCH Provincial Strategic Plan revised and approved, based on evidence from the Operations Research	Five year Provincial Strategic Plan for MNCH revised, based on evidence from the Operations Research	Outcome	Approved document	1x (end of project)	Consultant/Program team	N		NA
47	Provincial MNCH Draft	First draft of the 5 year Provincial Steering Plan for MNCH approved	First draft of the 5 year Provincial Steering Plan for MNCH approved	Outcome	PSC & TWG mtg minutes	1x (year 2)	Consultant/Program team	N		NA
48	Provincial MNCH Steering meetings	# of Provincial Steering Committee Meetings conducted	# of Provincial Steering Committee Meetings conducted	Output	Meeting minutes	Qtly	Program team	N		8

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#	Indicator	Definition	Metric	Type	Data source	Freq	Responsibility	Rapid CATCH?	Baseline (OR) – June 2014 ¹	Sept 2014 status
49	TWG meetings	# of Technical Working Group Meetings conducted	# of Technical Working Group Meetings conducted	Output	Meeting minutes	Qtly	Program team	N		8
50	District Health Forum meetings	# of District Health Forum Meetings conducted	# of District Health Forum Meetings conducted	Output	Meeting minutes	Mly	Program team	No		12 (Quetta 4, Gwadar 4, Kech 4)

SAVING MOTHERS AND NEWBORNS IN COMMUNITIES

September 30th 2012 – September 29th 2016

USAID CA No. AID-OAA-A-12-00093

BEHAVIOUR CHANGE COMMUNICATION STRATEGY



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1 BACKGROUND AND INTRODUCTION

Mercy Corps is implementing a four year Maternal, Neonatal and Child Health (MNCH) Project ‘Saving Mothers and Newborns in Communities’ (SMNC) in Quetta, Gwader, and Kech Districts of Balochistan with support from USAID and the Scottish Government. The project seeks to *improve maternal and newborn health status*, through an innovative model that will enable Community Midwives (CMWs) to become self-sustaining, private MNCH service providers. One of the components of Mercy Corp’s SMNC program is to develop a Behavior Change Communication (BCC) strategy and materials based on formative research in order to improve RMNCH practices.

A team of public health specialists hired by Mercy Corps undertook a formative research (during November 2013 – January 2014) to identify the key barriers and enablers for Married Women of Reproductive Age (MWRA) regarding life-saving Reproductive Maternal Neonatal and Child Health (RMNCH) practices and to identify the key influencing groups for these practices in the three target districts. Besides in-depth literature review, the perceptions and views of policy makers, health managers and facility and community based service providers in this regard were captured through 5 In-Depth Interviews (IDIs) and 7 Focus Group Discussions (FGDs) in the target districts.

1.1 RMNCH behaviours and practices- Findings from formative research

The purpose of identifying key RMNCH behaviours and practices is to assist in developing a focused BCC strategy that can contribute to sustainable change in three district of Balochistan namely Quetta, Kech and Gwadar. The priority areas identified in relation to on which the RMNCH practices and behaviours listed in table 1.

1.1.1 Antenatal Care

a. ANC visits

Community members are aware of the concept of ANC but it is not sought routinely. Among those who seek ANC checkups usually do so only 1-2 times during the whole pregnancy and mostly after the 5th month of pregnancy. The checkup in the early months of pregnancy is usually not done as mother- in-law thinks it is not necessary or sometimes it is perceived that early disclosure of pregnancy might result in unfortunate effects or termination due to bad eye (“*Nazar lag jai gi*”). Even literate people do not complete the prescribed ANC schedule.

Table 1: Priority areas for RMNCH practices and behaviours

- | | |
|----|-----------------|
| 1. | Antenatal Care |
| 2. | Delivery |
| 3. | Postnatal care |
| 4. | Newborn care |
| 5. | Child care |
| 6. | Family planning |

b. Tetanus Toxoid (TT) vaccination

Referring to TT vaccination patterns, they vary among the three districts

- In **Quetta**, people are not convinced of the importance of TT vaccination during pregnancy. The practice is not very common as there is fear of abortion, pain, fever, abscess and allergy. Among those who get TT vaccination, the majority get only one shot. Distance of vaccination facility from the community, vaccination by the male vaccinators, low priority for TT vaccination among health staff and poor coverage through mobile teams due to resource constraints are among the main barriers.
- In **Kech**, the TT vaccination trends are encouraging as majority of women receive two TT shots during every pregnancy. It is generally perceived that the TT vaccine protects the baby (but little

awareness that it protects mother as well). There is increasing trend of receiving TT among unmarried girls but still the prevalence is not very high.

- In **Gwadar**, there is higher trend of TT vaccination during pregnancy as up to 70-80percent of women complete the TT schedule. However, there are few families who do not encourage TT vaccination for the misconception that TT may damage the baby or cause abortion. There is an encouraging sign that even unmarried girls above age 15 also complete the TT schedule, although prevalence is low.

c. Recognition of danger signs in pregnancy

- In **Quetta**, there is little awareness among the community about the danger signs of pregnancy. They correlate the signs with the local myths. For example, fits are considered as act of Jinns. The woman is usually taken to local spiritual healer for spells and amulet (“Dum aur taweez”) for the treatment of fits. The other prevailing practices in case of different complications are oil massage or giving oil and butter to drink and sometime specific taweez in muddy water. The medical care, if sought, is usually very late.
- In **Kech**, swelling, headache, bleeding, blurring of vision, no fetal movement and excessive vomiting are considered to be danger signs in pregnancy. A woman is rushed to the hospital if these signs are present. It is also common to seek treatment both from health care providers as well as spiritual healers.
- In **Gwadar**, bleeding, backache, no fetal movement, fits and swelling are considered danger signs. If any of these signs are found the mother is taken to spiritual healers. Medical care is usually sought late.

1.1.2 Delivery

a. Generally the community prefers Traditional Birth Attendant (TBA) over the SBA

- In **Quetta**, community does not avail the services of CMWs as they are considered too young and therefore socially less acceptable. The community has more confidence in local TBA also known as *dais*, as they are part of community and are serving them since a long time. Moreover, TBA provides other caring services throughout forty days of postnatal period, like massage to mother, combing her hair and washing clothes during pregnancy and after delivery.
- In **Kech**, community assumes that a well-mannered healthcare provider is also an expert. There is general understanding that the doctors at hospitals are the skilled people, however, at the time of delivery the community prefers to approach the person with better behavior towards patient.
- In **Gwadar**, only doctors are considered to be the skilled birth attendants, even the LHVs are not considered more than a learner.

b. Danger signs during delivery

In general the danger signs during delivery are misperceived and are associated with the local myths.

- In **Quetta**, prolonged labor is thought to be a result of harsh attitude of the pregnant woman with her Mother In Law (MIL) and in such a case the woman is sometimes asked to seek an apology from her MIL. Postpartum hemorrhage (PPH) is thought to be a healthy sign as it is considered to clean the body. In some areas if a girl child is born, PPH is believed to be good as it will clean the uterus

and may result in birth of a male child the next time. In some areas if a woman is fainting (due to PPH or any reason) gun fires are shot to make a noise and restore her consciousness and for relief from jin.

- In **Kech**, during bleeding or fits and in some cases of prolong labor pains the mother is taken to hospital. However, the treatment from spiritual healer is also sought side by side. Excessive bleeding in mother is termed *Tarain haal* (wet condition). The community seeks spiritual treatment for it. In case of a delayed delivery it is said that a *jin* named *sobhani* has taken over the mother. An charm is tied around the right thigh of mother for decreasing the intensity of labor pains.
- In **Gwadar**, local healers and mullahs are consulted for herbal and spiritual treatment of complications. Medical care is usually sought very late.

The respondents shared some encouraging practices as well. For example, in Quetta the use of new blade, disinfectants (Dettol) and clean cloth/linen or plastic sheet (*Moam Jama*) for delivery and preference of warm and clean room for delivery. In some cases male doctor can sit outside the delivery room for guidance to *dai*.

1.1.3 Postnatal care

In all the three districts routine postnatal care is not a usual practice unless there are some severe complications. However, in most cases, women self-medicate (e.g. use of injectable muscle contractor such as ergometrine by TBAs) or seek local healers and traditional medicines before seeking skilled care.

- In **Quetta**, taking the mother after delivery during *puerperium*¹, out of the residence is against norms. The mother is confined to home and is not encouraged to meet a lot of visitors for the fear of haunting “*saya na per jaey*”. Mother is given a high energy local recipe called ‘*laiti*’.
- In **Kech**, routine postnatal care is not prevalent. It happens only in case of any complications (bleeding and fits). However, community usually opts for postnatal care if it is advised by the health care provider.
- In **Gwadar** Postnatal care through SBA is not common, however, TBAs visit the mothers and offer belly massage and treatment with local ‘*Balochi*’ medicine (known as *gurdar, aalgh, mort, dasi oil, gojath, mur, ghonjath*).

1.1.4 Newborn care

a. Practice of giving bath to the new born

The secretions covering the newborn are considered filthy and therefore the baby is given bath immediately after birth in most of the cases. Drying and wrapping with a piece of dry linen is done immediately after giving bath. The baby is given bath usually in half an hour of birth, in a cozy room. Baby’s head is covered but s/he is usually laid separate from mother (no skin contact).

In Kech and Gwadar, baby is covered immediately with a piece of cloth after delivery and is put on mother’s breast. Bathing is usually delayed for 6-24 hours after birth, however, in some cases *Dais* usually give bath to baby immediately after birth.

¹ The puerperium covers the 6-week period following birth.

b. Danger signs in newborns and traditional practices

- **In Quetta**, certain traditional practices were quoted in case of complications in the newborn. For example, in case of asphyxia, baby's nose is pinched or cold water is splashed on the face to start breathing. In some places the part of placenta still attached with the baby is burnt in a tub. If a baby starts turning blue, it is said that jin has entered the body and the baby is taken to spiritual healer for "dum and taweez". If the newborn doesn't start crying, it is said that s/he has acquired the nature of the father – that of being shy. In case of cord infection, masala, ash and surma are applied the on the cord.
- **In Kech**, some signs like absence of cry, inability to feed, froth in mouth and yellow discoloration of skin are considered to be the danger signs and in these cases the baby is taken to healthcare provider. Sometimes traditional remedies, such as local herbs mashed and mixed in mother's milk are given. If the baby is unconscious, water is sprinkled over his/her face.
- **In Gwadar**, traditional practices are adopted until there are severe complications (such as baby turns green or yellow, has severe vomiting, excessive crying, baby is unable to take feed or baby is too weak- sookha pan).

c. Initiation of breastfeeding

In Quetta, breastfeeding is usually initiated after 3 days as colostrums is considered dirty and full of germs. In some areas giving *colostrums* is considered forbidden in the religion- "*colostrums is haram*". Some pre-lacteals like "*Ghuti*", butter, oil, qahva (black tea), *arq*, *shehad* (honey), *bartung* are commonly given to baby.

In Kech, breastfeeding is usually started immediately after delivery. Only in some cases it is delayed for few hours. In Gwadar, breastfeeding is usually initiated in half to one hour after birth.

d. Cord care practices

Most of the participants from the community shared that applying oil, spirit and Morth (Balochi herbs) on the newborn cord helps in early healing of the cord. Only few participants from Quetta were of the opinion that they follow what doctor recommends

1.1.5 Child care

a. Exclusive breast feeding (EBF) practices

In Quetta, herbs are given in addition to milk to "clean the gut". There is common perception that mother's milk is insufficient "*Doodh kum hay*". In Kech, EBF practices are not prevalent. Baby is given sugar mixed water along with cumin, honey or syrup of dates. In Gwadar, health managers perceive that EBF is not more than 20 percent. Usually the baby is started with traditional supplementary diet (like honey, sugar in water and goat milk) within 40 days.

b. Weaning practices

Usually the weaning is started at an earlier age (3-4 months). However, in some places in Quetta weaning is delayed up to one year. Usual weaning foods are described below.

- **In Quetta**, baby is given *suji*, banana, roti dipped in tea, half boiled egg or 'Cerelac'.

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- **In Kech**, weaning is usually started after 4 months, however, in some cases it is started as early as the second month. Biscuits, juices, tea, top milk and Cerelac are commonly given.
- **In Gwadar**, bottle milk, biscuits, milk cream (*balai*), juices and rice are commonly given. Opiates (*Hashish ka chilka*) are given to babies after 40 days to induce sleep and keep them calm.

c. Child immunization

Generally the community is aware of child immunization and majority starts giving injections, however, dropout rates are high due to either fear of side effects, distance of vaccination center, or specific days for some of the vaccines (e.g. measles and BCG). People are not in favor of excessive polio campaigns and usually resist the teams and do not open the doors for them. The first injection (BCG) is usually delayed till 40 days as the mother is home bound during this period and the vaccinators do not visit home. The community level healthcare providers from Kech stated that there exists a myth of infertility associated with the childhood immunization.

1.1.6 Family planning

In general family planning awareness is high but practice is very low. Following are some of the reason for low practice

- There is general lack of knowledge of optimal birth spacing interval.
- Women believe their husbands are satisfied if they give birth to a child every year (Quetta).
- Even if a woman has no desire for having more babies there is pressure from husband and/or in laws
- Myths or fears of side effects e.g. bleeding with contraceptive injection or pelvic inflammatory disease (PID) with intrauterine contraceptive device (IUCD)

1.1.7 Increasing popularity of electronic mass media and mobile phones

The analysis of various channels of communication indicates that television and mobile phone are most popular, accessible and acceptable channels, followed by radio. The IPC, despite its low coverage, is considered to be the most effective channel of communication. The print media is not considered an effective channel of communication due to poor literacy status, particularly among women. Docudrama and puppet shows are culturally not acceptable.

2 DEVELOPMENT OF BCC STRATEGY

Based on the findings mentioned, the BCC strategy has been developed that outlines communication interventions with an aim to address key RMNCH behaviors and practices of target audiences, divided into primary and secondary audiences. The Primary Audience include women of reproductive age WRA, and the secondary audience include husbands, mothers in law (MILs), spiritual/traditional healers, opinion makers (religious leaders, tribal elders and councilors etc.), TBAs, community and facility based healthcare providers.

2.1 BCC Outcome

Improved RMNCH seeking behaviors and practices through engaging WRA, families and community

2.2 BCC strategy matrix

BCC strategy matrix shared at Table 1 details the current and desired behaviours of the community. It also shares the target audience for the BCC strategy along with the activities to be carried out and tools to be utilized.

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Table 2: BCC Strategy matrix indicating the target audience, activities and tools

Current behaviors	Desired behavior	Target audience	Activities	Proposed tools
BCC outcome : Improved RMNCH seeking behaviors and practices through engaging WRA, families and community				
1. Antenatal Care				
1.1 Routine antenatal care is not a usual practice	<ul style="list-style-type: none"> - Women of reproductive age knows about benefits of antenatal care - Pregnant women is encouraged to seek antenatal care 	<p>Primary:</p> <ul style="list-style-type: none"> - Pregnant women, - Women of child bearing age, - Community based health providers <p>Secondary:</p> <ul style="list-style-type: none"> - Community members - Husbands - Decision makers (Mother-in-law, head of the family) 	<ul style="list-style-type: none"> - IPC and WSG sessions at household and community with WRA - Health education of pregnant women and other target audience on the benefits of ANC, importance of TT and recognition of danger signs - Social mobilization for the promotion of ANC - District health forums with the members of provincial steering committee, the local opinion/spiritual/religious leaders, traditional healers, development partners, corporate sector and media managers - Dissemination of VoIP messages through mobile phones pregnant woman on importance of routine ANC, TT vaccination during pregnancy and danger signs of pregnancy 	<ol style="list-style-type: none"> 1. Flip charts indicating importance of pregnancy care 2. Counseling cards for pregnant women 3. Discussion guides for WSG meetings 4. VOIP messages
1.2 Routine TT Vaccination is not a usual practice (especially in Quetta)	<ul style="list-style-type: none"> - Pregnant woman receives 2 TT shots during every pregnancy 			
1.3 The communities do not recognize the danger signs of pregnancy	<ul style="list-style-type: none"> - Pregnant women should know about dangers signs in pregnancy 			
2. Delivery				
2.1 The community prefers TBA over the SBA	<ul style="list-style-type: none"> - Deliveries should be conducted by SBA 	<p>Primary:</p> <ul style="list-style-type: none"> - Pregnant women - Husbands <p>Secondary:</p> <ul style="list-style-type: none"> - Community leaders - Women groups - Men - Decision makers (Mother-in-law, head of the family) 	<ul style="list-style-type: none"> - IPC and WSG sessions at household and community with WRA through CMW on importance of delivery through SBA and recognition of danger signs during delivery - Social mobilization through district and sub-district seminars, display of posters and banners at public places and social/religious gatherings. 	<ol style="list-style-type: none"> 1. Flip charts and pictorial brochures to be used by community based health care providers in counseling and health education sessions. 2. Discussion guides for WSG meetings 3. VOIP messages
2.2 Misperceptions about various danger signs during delivery	<ul style="list-style-type: none"> - Pregnant women/husbands have clear understanding of various danger signs during delivery. 			
3. Postnatal care				
3.1 Routine postnatal care is not common in	<ul style="list-style-type: none"> - Pregnant women encouraged to seek 	<p>Primary:</p> <ul style="list-style-type: none"> - Pregnant women, 	<ul style="list-style-type: none"> - IPC and WSG sessions at household and community with MWRA 	<ol style="list-style-type: none"> 1. Flip charts, wall charts indicating importance of Post partum care

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most areas	postnatal care	<ul style="list-style-type: none"> - Women of child bearing age, - Husbands - Community based health providers 	<ul style="list-style-type: none"> - Health education of pregnant women and other target audience on importance of postnatal care and recognition of danger signs in postnatal period. - Social mobilization for the promotion of PNC - District health forums with the members of provincial steering committee, the local opinion/spiritual/religious leaders, traditional healers, development partners, corporate sector and media managers. - Dissemination of VoIP messages through mobile phones to pregnant woman on importance of routine PNC and danger signs during postpartum period. - Dissemination of messages through consumer products on PNC and danger signs in postnatal period 	<ol style="list-style-type: none"> 2. Discussion guides for WSG meetings 3. VOIP messages
3.2 Most pregnant women do not know about danger signs in the postpartum period.	- Pregnant women recognizes the dangers signs in the postnatal period	Secondary: <ul style="list-style-type: none"> - Community members - Decision makers (Mother-in-law, head of the family) 		
3.3 Usually postnatal complications are treated through self medication/ local healers	- Improved health seeking behaviors and practices for postnatal complications			
4. Immediate care of the newborn				
4.1 Using unsterilized delivery kit or materials/ cutting the cord with an unsterilized material	- Delivery conducted through SBA utilizing clean delivery kits	Primary: <ul style="list-style-type: none"> - Pregnant women, - Women of child bearing age, - Community based health providers 	<ul style="list-style-type: none"> - IPC and WSG sessions at household and community with WRA through CMW and LHW on proper thermal care, early initiation of breastfeeding, hygienic cord care, recognition of danger signs and need for professional care in case of danger signs of newborns - District health forums with the members of provincial steering committee, the local opinion/spiritual/religious leaders, traditional healers, development partners, corporate sector and media managers - Institutional mobilization through display of IEC material, delivery of IPC/group counseling/health education sessions at health facilities on proper thermal care, early initiation of breastfeeding, hygienic cord care and need for professional care in case of danger signs in newborn - Dissemination of VoIP messages through mobile phones to pregnant women on proper thermal care, early initiation of breastfeeding, hygienic cord care and need for professional care in case of danger signs of newborns 	<ol style="list-style-type: none"> 1. Flip charts indicating importance of Post partum care 2. Discussion guides for WSG meetings 3. VOIP messages
4.2 Separating baby from mother after delivery (no skin to skin contact)	- -Skin to skin contact of mother with newborn	Secondary: <ul style="list-style-type: none"> - Community members - Husbands - Decision makers (Mother-in-law, head of the family) 		
4.3 Bathing not delayed up to 6 hours	- Keeping of newborn warm and bathing delayed for 6 hours			
4.4 Early initiation of breastfeeding is not very common in many areas	- Initiation of Breast feeding within 1 hour of delivery			
4.5 Routine Cord care practices are unhygienic	- Nothing harmful applied on the cord and proper cord care followed			
4.6 Non recognition of danger signs in newborn	- Recognition of danger signs in newborns			
4.7 In case of danger signs in newborns, traditional practices are preferred over	- Improved health seeking behaviors and practices for newborn complications			

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professional care				
5. Child care				
5.1 There is low practice of Exclusive Breast Feeding (EBF)	- Exclusively breast feeding up to 6 months of age	Primary: - Pregnant women - Husbands Secondary: - Community leaders - Women groups - Men - Decision makers (Mother-in-law, head of the family)	- IPC and WSG sessions at household and community with WRA through CMW and LHW on exclusive breastfeeding for 6 months, weaning after 6 months of age and completing child immunization course as per recommended schedule - Institutional mobilization through display of IEC material, delivery of IPC/group counseling/health education sessions at health facilities on exclusive breastfeeding for 6 months, weaning after 6 months of age and completing child immunization course as per recommended schedule	1. Flip charts 2. Discussion guides for WSG meetings 3. VOIP messages
5.2 Weaning is not started at appropriate time	- Weaning delayed up to 6 months			
5.3 Child Immunization is usually started but dropout is high	- Immunization course of child completed before 2nd birthday -			
Current behaviors	Desired behavior	Target audience	Activities	Proposed tools
6. Family planning				
Birth spacing is very low due to desire for a larger family	- Optimal birth spacing for at least 3 years between two births	Primary: - Pregnant women - Husbands Secondary: - Decision makers (Mother-in-law, head of the family)	- IPC and WSG sessions at household and community through CMW and LHW on advantages of optimal birth spacing and proper knowledge regarding side effects of modern contraceptives - Social mobilization through district and sub-district seminars, walks, display of posters and banners at public places and social/religious gatherings. Dissemination of messages through consumer products on advantages of optimal birth spacing and proper	1. Flip charts 2. Discussion guides for WSG meetings
Use of modern contraceptives is very low due to fears of side effects	- Improved knowledge and practices on contraceptives use.			

2.3 Target Audiences

Following target audience have been identified through the formative research report for SMNC BCC component

- a. **Woman of Reproductive age groups (WRAs):** To increase the number of WRAs who undertake routine ANC, receive TT shots during every pregnancy, recognize danger signs of pregnancy, and seek care form a skilled person for delivery, during postnatal period and for newborn care.
- b. **Family members (mother in laws and husbands):** To increase the number of motivated husbands and other family members (MILs) who realize that pregnancy is a special condition requiring special attention and are aware of the importance of routine ANC, support and encourage the pregnant woman for TT vaccination, recognize danger signs of pregnancy and are motivated to seek urgent professional care for the mother at any time during pregnancy, delivery and postnatal period.
- c. **Community Midwives/Lady health workers:** To increase the number of community based healthcare providers who can undertake counseling sessions on routine ANC, TT vaccination, delivery care, PNC, newborn care and family planning.

2.4 Key Messages for BCC

The following table provides details of the key messages for the key areas identified. These key messages have been developed keeping in view the community practices and behaviours as identified through formative research report.

Key Messages	
1. Target audience	1. Pregnancy and Nutrition
<ul style="list-style-type: none"> – Pregnant women – Women of Reproductive Age (WRA) 	<ol style="list-style-type: none"> 1. Pregnancy is a special condition that requires preparation, nutritious food and adequate rest to help you cope well with your pregnancy. You need to eat foods that are high in protein and iron such as eggs, lamb, beef, dark leafy green vegetables and fresh fruits. Babies get all their nutrition through what you eat. If you eat well, you are more likely to have a healthy baby. 2. Women need emotional and physical support during pregnancy. It is normal to be concerned about your pregnancy. Talk to your husband and family about your condition regularly. Ask for help when you need it. 3. During your pregnancy you should visit a skilled provider at least 4 times. ANC helps in early identification of any complication in mother and baby. The provider can help you prepare for your delivery and can make good decisions about your antenatal care. 4. Many women have low iron when they are pregnant which makes them tired. You need to take iron supplements during your pregnancy so you are not tired. 5. You should also get 2 tetanus injections during your pregnancy as advised by your skilled care provider. 6. Even a healthy looking pregnancy can have complications. It is important to deliver with a

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	<p>skilled birth attendant who knows what to do in case of complication. Make a plan before your delivery and find out who is trained to assist you.</p> <p>7. Talk to your husband about special preparations needed for the delivery. You may need to be transported to a facility, in case of an emergency. Make a transportation plan with your husband.</p> <p>8. If you have a complication, you may need money to pay for transportation, treatment, blood etc. start saving now for any possible complications.</p> <p>9. Find out where the nearest facility is located in the event you need emergency care during your pregnancy. Know the danger signs of pregnancy, delivery and post-delivery and talk to your husband about getting care at a facility if they arise.</p> <p>10. Danger signs during pregnancy include:</p> <ol style="list-style-type: none"> a. Bleeding even if it is a single spot b. Swelling face and feet c. Severe abdominal pain d. Fits e. Blurring of vision f. High blood pressure <p>In case of appearance of any of the danger signs, IMMEDIATELY rush to a facility</p> <p>11. Never take complications during pregnancy lightly- these can threaten your life and may harm the baby.</p>
	<p>2. Delivery</p>
<ul style="list-style-type: none"> - Pregnant women - WRA - Family members 	<ol style="list-style-type: none"> 1. Only trained persons such as doctor, nurse, LHV and midwife have the necessary skills to deliver the baby safely. 2. Delivery is a special event requiring assistance by skilled birth attendant 3. Whoever delivers the baby needs to use a clean delivery kit 4. In case of any of the given below complications appearing during delivery IMMEDIATELY rush to hospital. <ol style="list-style-type: none"> a) Significant and prolonged bleeding b) Labor pains for more than 8 hours c) Headache, fits d) Unable to deliver despite of intense pain e) Drowsy mother, pulse greater than 100/min, cold skin f) High fever 5. In case of danger signs during delivery, any delay in health seeking from a hospital can threaten the life of mother and baby 6. Never take complications during delivery in mother lightly- these can threaten her life and may harm the baby 7. There is a drug called misoprostol which can prevent and treat postpartum hemorrhage (PPH), which means heavy bleeding. In Pakistan, PPH is the leading cause of deaths of women during the time of delivery. Three small tablets should be taken immediately after the baby is born but before the placenta is delivered to prevent PPH.
	<p>3. Postnatal care</p>
<ul style="list-style-type: none"> - Pregnant women - WRA - Family members 	<ol style="list-style-type: none"> 1. Routine examination of mother and baby through Skilled Birth Attendant within 6 hours after delivery helps in early identification of any complication 2. In addition to this visit within 6 hours after the delivery, you should see a skilled provider within 48 hours of the delivery for them to check up on you and your newborn. 3. In case of any of the given below complications appearing in mother after delivery

	<p>IMMEDIATELY rush to hospital.</p> <ol style="list-style-type: none"> a. Excessive Bleeding b. Fits c. If placenta is not expelled within half an hour of delivery d. Foul smelling discharge e. High grade fever f. Swollen or sore breasts <p>4. Never take complications after delivery in mother lightly- these can threaten her life and may harm the baby</p>
	<p>4. Immediate care of the newborn</p>
<ul style="list-style-type: none"> - Pregnant women, - WRA - Mother-in-law - Family members 	<ol style="list-style-type: none"> 1. The health, intellect and well being of newborns depend on their mothers. Take care of your health, nutrition and rest during pregnancy and after delivery. 2. Even a healthy looking pregnancy can have complications for the baby, if delivery is not conducted by skilled birth attendant. Make sure you deliver by a SBA. Make preparations by arranging money, transport and selecting proper health facility in case of emergency. 3. Skin to skin to contact between the mother and baby immediately after birth helps in preserving heat in baby's body 4. Do not give bath to newborn for at least 6 hours of birth- it can result in heat loss from the body which may lead to death of the baby. 5. Immediate initiation of breastfeeding is beneficial for both mother and baby 6. The first milk, called Colostrum, is rich in vitamins and minerals, and protects your baby from disease. Newborn babies are very fragile, and rely on their mothers' milk to protect them from disease. Other food sources, including water, could contain diseases. They are not safe for your baby. Only breast milk is safe for your baby, for the first six months. 7. Make sure your baby is weighed immediately after birth. If you baby is underweight (i.e. less than 2.5 kg) then you should immediately take your baby to a hospital where extra care is available. 8. The newborn is in danger if s/he has any of the following signs and needs IMMEDIATE hospital care <ol style="list-style-type: none"> a. Unable to feed b. Difficulty in breathing c. Drowsiness, unconsciousness d. Bleeding from cord or rectum e. Blue discoloration of skin f. Birth weight less than 2.5 kg 9. Do not apply anything on cord, unless you have access to 7.1% chlorhexidine digluconate (which delivers 4% chlorhexidine). 10. Applying the material such surma, masalah or ash can be harmful for the baby 11. Seeking skilled care in case of appearance of any danger sign in baby can save baby's life 12. Women who are breastfeeding need to eat frequently, and eat extra food. They should drink plenty of liquids, so that they can adequately feed their baby.
	<p>5. Child care</p>
<ul style="list-style-type: none"> - Pregnant women - WRAs - Family members 	<ol style="list-style-type: none"> 1. Exclusively breast feed child up to 6 months of age 2. The mother's milk contains all the nutrients (including water) required to the baby till 6 months of age 3. The appropriate time to start weaning is after 6 months of age 4. The mother's milk should be continued along with weaning foods till 2 years of age 5. Complete the immunization course of child before 2nd birthday 6. Complete course of child immunization prevents the child from many illnesses

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	Disease	Vaccine	Doses	Age of administration
	Childhood TB	BCG	1	Soon after birth
	Poliomyelitis	OPV	4	OPV0: soon after birth OPV1: 6 wks OPV2: 10 wks OPV3: 14 wks
	Diphtheria	Pentavalent vaccine (DTP+Hep B + Hib)	3	Penta1: 6 wks Penta2: 10 wks Penta3: 14 wks
	Tetanus			
	Pertussis			
	Hepatitis B			
	Hib pneumonia and meningitis			
	Pneumonia and meningitis due to <i>S. pneumonia</i>	Pnumococcal conjugate vaccine (PCV10)	3	Pneumo1: 6 wks Pneumo2: 10 wks Pneumo3: 14 wks
	Measles	Measles	2	Measles1: 09 months Measles2: 15 months
6. Family planning				
<ul style="list-style-type: none"> - WRAs - Mother-in-law, family members 	<ol style="list-style-type: none"> 1. The optimal spacing between two births is at least three years 2. Maintaining optimal space between births is beneficial for mother, father, baby and family 3. Seek assistance of professional healthcare providers for proper knowledge of side effects of modern contraceptives 			

2.5 Activities for BCC

The key messages will be disseminated to the target audiences at various levels using different channels of communication as proposed below

- a. At community level counseling sessions with women including WRAs and older women through WSG can be held. These can be carried out by community based healthcare providers including CMWs and LHWs.
- b. VoIP messages on the key messages can be disseminated to the clients registered with CMWs. These messages can be sent to the husbands and other family members (MILs) through mobile phones.
- c. At district and sub-district level, the District Advocacy Forum will gain support of local leaders, corporate sector managers, for the promotion of healthy RMNCH behaviors and practices.
- d. At provincial level support of policy makers and Technical Working Group (TWG) and Provincial Steering Committee (PSC) members will be solicited through advocacy events and meetings.

Annex 5c. VOIP Messages

Annex 5c. VOIP Messages (tailored to the stage of pregnancy of the client)

VOIP MESSAGES		
MONTH	WEEK	AUDIO MESSAGES
1	4 th	14
		<p><i>Assalmo Alykum, these messages are intended to provide you and your family with information which is required to have a safer pregnancy. We will be with you for next 6 months and will provide you adequate information to keep you and your baby healthy.</i></p> <p>Message 1</p> <p>This is your fourth month of pregnancy You will need at least four check-ups during your pregnancy. Regular check-ups will reassure you that your baby is growing well.</p> <p>In case if any of the following appear visit your CMW immediately</p> <ol style="list-style-type: none"> 1. Bleeding even if it is a single spot 2. Swelling of face and feet 3. Severe abdominal pain 4. Fits 5. Blurring of vision <p>In addition, visit your CMW and ask her about tetanus vaccination. She will provide information related to tetanus. Tetanus is a disease that is due to germs and can occur at any age. However it has been reported to be high in mothers and children's. Giving birth puts you and your baby at risk of getting tetanus. It can be prevented by the Tetanus vaccine. Your CMW may recommend two doses. First dose is given immediately once the pregnancy is confirmed and 2nd dose is give 4 weeks after the first dose.</p> <p>Vaccines don't work as a cure but they do protect you from disease. So make sure you get your tetanus vaccine</p> <p>If you have already received tetanus vaccine during this pregnancy its great otherwise please go to the CMW this week for your tetanus vaccine</p>
2	4 th	16
		<p><i>Assalmo Alykum</i></p> <p>Message 2</p> <p>Today I will inform you about three simple ways that will keep both you and your baby healthy.</p> <p>One: Eat well. Try to make each meal contain some fruits and vegetables. You should also get some protein from meat or fish, or lentils, peas or beans. Also drink lots of clean water</p> <p>Two: Go and visit your CMW. Regular check-ups will help spot any problems early. You will then be able to get treatment and keep your baby safe.</p> <p>Three: Take iron and folic acid pills, as well as calcium pills if your health worker gives them to you. These pills will help you to get enough iron and folic acid so that your baby can grow well. The iron pills might make your stools dark, but this is normal.</p>

Annex 5c. VOIP Messages

VOIP MESSAGES		
MONTH	WEEK	AUDIO MESSAGES
		Have a safe pregnancy
3	5 th	20 <p>Assalmo Alykum Message 1 Congratulations! You are halfway through your pregnancy! It's exciting when you first feel your baby move! If this is your first pregnancy, you may not be sure what the movements are at first. They feel like gentle butterflies fluttering in your belly. In the next few weeks, your baby's movements will get stronger and more regular. Your baby won't move all the time. Sometimes he'll just want to rest and sleep You can get used to recognising the movements. If you haven't felt your baby move yet, speak to your health worker. She will be able to check that everything is well.</p>
4	5 th	22 <p>Assalmo Alykum Message 2 Dizziness is common during pregnancy. You might get dizzy if you haven't eaten for a while, If you feel dizzy, sit or lie down. If you're in a stuffy room, go outside. Dizziness can be a sign of anaemia. Anaemia is caused by not having enough iron in your blood. Anaemia can make you feel weak and tired, too. You can get iron by eating red meat and green leafy vegetables. Your clinic may also give you some iron pills. If you want to do one good thing for your baby this week, visit your health worker and ask about iron pills.</p>
5	6 th	24 <p>Assalmo Alykum Message 1 You may be thinking about where to have your baby. Only doctor, nurse, LHV and Community Midwife has the necessary skills to deliver the baby safely. Here are some reasons why it's best to choose a clinic or a hospital birth or a birth with a skilled attendant. First: a clinic is a clean place to have your baby. When you go into labour, you become open to infection, and so does your baby. If you can't have your baby at a clinic, have a community midwife as an attendant with you. Second: being with a Community midwife means that if something does go wrong, there will be someone there to keep you and your baby safe. If you want to do one good thing for your baby this week, choose to have your baby in a clinic or with a skilled birth attendant</p>
6	6 th	26 <p>Assalmo Alykum Message 2 With your baby growing fast, you need to make sure that you are eating enough. Try eating a couple of extra mouthfuls at every meal. Explain to your family that</p>

Annex 5c. VOIP Messages

VOIP MESSAGES			
MONTH	WEEK	AUDIO MESSAGES	
		<p>you need to make sure that you get enough to eat to feed your growing baby. Try eating protein with every meal. Protein helps your baby grow. You can get protein from fish, meat, lentils, beans and peas. You will also need to eat plenty of iron to keep you and your baby strong. You can get iron from meat, fish, lentils, peas, beans and dark, leafy vegetables. Try to have some iron-rich food with every meal.</p>	
7	7 th	28	<p>Assalmo Alykum, Message 1 You may be having some discomforts now. Slightly swollen hands and feet are caused by the extra blood in your body. Try to rest with your feet raised. If you have sudden swelling and headaches, go and visit your community midwife. You may have very high blood pressure which is dangerous for you and your baby.</p>
8	7 th	30	<p>Assalmo Alykum, we hope that you have a safe pregnancy Message 2 If you get bleeding, headaches or a pain down one side of your stomach, go to the CMW and get yourself checked.</p>
9	8 th	32	<p>Assalmo Alykum, we hope that you have a safe pregnancy Message 1 By now, you should have decided where you want to have your baby and have arranged transport. Make sure you know the fastest route. It is vital to have a skilled attendant. Make sure your family knows how to contact the attendant. Your attendant will have a birth kit. Most babies are born in the ninth month. But some babies are born earlier, especially if they are twins. If your baby arrives early, she will need lots of milk and warmth. The first milk you make is very thick, creamy and full of goodness. Give your baby this precious gift to help prevent illness.</p>
1	8 th	34	<p>Assalmo Alykum, we hope that you have a safe pregnancy Message 2 You may be wondering how to know when you are in labour. When you start labour, you may see a jelly-like discharge. This can happen a day or two before labour, but you may not notice it. For most women, the main sign is contractions. Labour contractions are regular and painful. At first, they may feel like mild tummy cramps or low backache. As your labour goes on, the contractions will come faster and harder. Sometimes the first sign of labour is the breaking of waters. Your baby has been sitting in a bag of fluid. If the bag breaks when labour starts, there could be a trickle or a gush. The water will be almost clear with a yellow tinge. It may be blood-stained. Once your waters have broken, you are open to infection. Fetch your attendant or head to the clinic.</p>
1	9 th	37	<p>Assalmo Alykum, we hope that you have a safe pregnancy Message 1</p>

Annex 5c. VOIP Messages

VOIP MESSAGES		
MONTH	WEEK	AUDIO MESSAGES
		<p>The big day is almost here. It won't be long before you can cuddle your baby. Once your baby is born you need to look after him/her properly. Make sure you go to the CMW this week for another check-up. Have at least two cloths ready. You will need one to dry your baby and a clean cloth to wrap him in to keep him warm. Make sure that a clean delivery kit is being used for the delivery. Keep the baby's cord stump clean and dry until it drops off. Don't put anything on it. The cord will heal gradually and drop off in about a week. It will look quite black and odd but that is part of the healing. Applying material such as <i>surma</i>, <i>masalah</i> or ash can be harmful for the baby. If the cord stump is red, bleeding or smelly, take your baby to the clinic. For the first six hours of your baby's life, clean only the cord. The rest of your baby does not need to be bathed. Bathing your baby too soon could make her sick and cold. The only food your baby needs is your breastmilk. Your milk is full of goodness and protects him/her from some diseases. Feeding honey or ghee is bad for baby and a waste of your special milk. Your baby will need nothing else apart from breastmilk for the first six months. Water can make your baby sick but your breastmilk is safe. Breastfeeding will also help you recover after the birth.</p>
1	9	<p>38-40</p> <p>Assalmo Alykum, we hope that you have a safe pregnancy</p> <p>Message 2</p> <p>After your baby is born, see your CMW several times. She will check that you are both doing well. Having your baby with trained attendants also help prevent heavy blood loss. The bleeding can last for a few weeks. It will look like a heavy period. It should reduce slowly. You might bleed a lot at the beginning, but it will slowly get lighter. Go to the clinic:</p> <ol style="list-style-type: none"> If you are experiencing heavy bleeding Fits If placenta is not expelled within half an hour of delivery Foul smelling discharge High grade fever <p>If your baby is still not here by next week, visit the clinic. Being pregnant for too long can cause problems. After the birth, your body needs time to heal. You may feel tired and sore, but every day things will improve. Wrap the new born completely especially the head and feet to avoid heat loss. Start weaning along with breast feed after 6 months of age. The optimal spacing between two births should be at least 3 years. Complete the immunization course of child before 1st birthday and in case of any of the given below complications appearing in new born immediately rush to hospital.</p> <ol style="list-style-type: none"> Unable to feed Blue discoloration of skin Difficulty in breathing Birth weight less than 2.5 kg



Annex 6 of Second Annual Report
Saving Mothers and Newborns in Communities
 Newspaper coverage of the PSC and TWG meeting during
 second year of the project

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کوئٹہ اور حبیہ شائع ہونیوالا واحد قومی روزنامہ

Daily MASHRIQ QUETTA

اللہ ہی کے لئے ہیں مشرق و مغرب (قرآن حکیم)

روزنامہ
مشرق
کوئٹہ

ایگزیکٹو ایڈیٹر سید کامران ممتاز

جلد 43	ہفتہ 3 ذیقعد 1435ھ	30 اگست 2014ء	صفحات 12	شمارہ 79
رجسٹرڈ BC-m-1	ایم ایچ پی سی ایف 2829164	فیس 2821538-2821626	2835934	قیمت 12 روپے
			2830228	

زچہ پکی شرح ہوا میری کیلئے؟ ہماری رہت ام صون ہل کیا جانے ڈاکٹر عا شہ صدیقہ

ڈاکٹر ایل ایچ ویز، ایل ایچ ڈبلیو سی ایم ڈبلیو کو ٹریننگ دینے کی اشد ضرورت ہے، ڈاکٹر نیلہ سلطان
حاملہ عورتیں ماہانہ چیک اپ اور عالمی ادارہ صحت کی تجویز کردہ ادویات کا استعمال یقینی بنائیں ورنہ گروپ کے اجلاس سے ڈاکٹر نسیم بلوچ، ڈاکٹر سعید احمد و دیگر کا خطاب

“To reduce maternal and newborn mortality World Health Organizations protocols should be followed”, Dr. Ayesha Siddiqa Chairperson TWG

“Doctors, LHVs, LHWs and CMWs need further trainings”, Dr. Nabila Sultan PC MCH

“Pregnant women should complete the ANC checkups and must use the WHO-recommended medicines”, Dr. Naseer Ahmed Baloch, Director General Health Services

کوئٹہ (خبرنگار) چیئر پرسن ٹیکنیکل ورکنگ گروپ (ایم این ایچ) ڈاکٹر عا شہ صدیقہ نے کہا ہے کہ ماں اور نوزائیدہ بچوں کی شرح اموات کو کم کرنے کیلئے عالمی ادارہ صحت کی تجویز کردہ ادویات کو صوبائی ادویات کی لسٹ میں شامل کرنا ناگزیر ہے عالمی ادارہ صحت کے ہیلتھ سروسز پروڈانیزر کیلئے طے شدہ گائیڈ لائنز پر عملدرآمد کرانے کیلئے ڈاکٹر زائل ایچ وی ایل ایچ ڈبلیو سی ایم ڈبلیو کو ٹریننگ دینے کی اشد ضرورت ہے یہ بات انہوں نے ٹیکنیکل ورکنگ گروپ کی میٹنگ سے صدارتی خطاب کرتے ہوئے کہی اس موقع پر خطاب کرتے ہوئے ڈائریکٹر جنرل ہیلتھ ڈاکٹر نسیم بلوچ نے کہا کہ محکمہ صحت ماں اور بچے کی صحت کو لاحق خطرات کو کم کرنے کیلئے ہنگامی بنیادوں پر کام کر رہا ہے اس سلسلے میں سرسی کوری کارکردگی قابل تحسین ہے ماں اور بچے کی صحت پروگرام کی صوبائی کوآرڈینیٹر ڈاکٹر نیلہ سلطان نے اظہار خیال کرتے ہوئے کہا کہ ماؤں کی شرح اموات میں کمی کے بجائے اضافہ ہو رہا ہے اسی طرح ہماری کوتاہیوں کی وجہ سے نوزائیدہ بچوں کی شرح اموات بھی بڑھتی جا رہی ہیں ہمیں اپنے طرز عمل میں سنجیدگی لانے کی ضرورت ہے سرسی کوئی ٹیم لیڈر بلوچستان ڈاکٹر سعید اللہ خان نے ادارے کی محکمہ صحت کیساتھ ملکر ماں اور بچے کی صحت کو لاحق خطرات کم کرنے کے حوالے سے کی جانے والی کوششوں پر روشنی ڈالی سولنگ ہڈ ڈائریکٹر نیو برن ان کیونٹی (SMNC) ٹیکنیکل ورکنگ گروپ کی میٹنگ میں ملے کیا گیا کہ حاملہ عورتوں کے ماہانہ چیک اپ کیلئے سی ایم ڈبلیو ایل ایچ وی کے کردار کو مزید فعال بنایا جائے حاملہ عورتوں کا ماہانہ چیک اپ اور بلڈ پریشر کنٹرول کیلئے عالمی ادارہ صحت کی تجویز کردہ ادویات اور نوزائیدہ بچوں کی ناف کاٹنے کے بعد سات روز تک نگہانی جانے والی لوشن کو صوبائی سطح کی زندگی بچانے والی ادویات کی لسٹ میں شامل کیا جائے میٹنگ میں سرسی کوری کے صوبائی ایڈوکیٹی کوآرڈینیٹر نسیم بلوچ، ڈاکٹر شیخ ریاض، ڈاکٹر امجد خان، ڈپٹی ڈائریکٹر ہیلتھ سروسز ڈاکٹر فاروق اعظم، ڈاکٹر عیسیٰ خان عالمی ادارہ صحت کی ڈاکٹر طاہر کمال صوبائی ہیلتھ پلاننگ آفیسر غلام رسول زہری، مایل ایچ وی پروگرام کے کوآرڈینیٹر ڈاکٹر قاضی سمیت دیگر ماہرین نے شرکت کی۔

Dr. Ayesha Siddiqa, Chairperson Technical Working Group MNCH, while addressing the Group members, said that if we want to

reduce the maternal and newborn death then the recommended medicines of WHO should be added to the list of provincial DOH medicine list. There is a dire need to train the health care providers including Doctors, Nurses, LHVs, CMWs and LHWs on the WHO's treatment guidelines. Director General Health Services Balochistan, Dr. Naseer Baloch, added that the Department of Health is taking emergency steps to reduce the MMR and NMR and Mercy Corps is playing a vital role in this regard. Dr. Nabila Sultan Provincial Coordinator MCH added that the mortality of Mothers and Newborns is increasing and the reasons behind this is lack of commitment from our side (DOH). Team Leader Mercy Corps-South, Dr Saeed Ullah Khan updated the forum about the efforts of Mercy Corps in collaboration with the Department of Health in reducing the maternal and newborn deaths. He added that under the umbrella of **Saving Mothers and Newborns in Communities (SMNC)** project, CMWs are making sure that the pregnant women in their catchment areas are routinely being visited for ANC checkups. He further added that after delivery, cord care is being ensured by the CMWs and very soon chlorhexidine will be added to the lifesaving drugs list of provincial health department.



Daily Mirror

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mirrorqta@gmail.com

Tuesday, April 08, 2014

Outdated ways main reason of early deaths of newborn babies

By Ch Imtiaz

QUETTA: Experts while shedding light on causes of death of new born babies underlined the need to take effective steps to arrest this trend. These views were expressed by the experts during a meeting of technical working group of Mercy Corps here the other day. The meeting was attended by Dr Rukhsana Kasi, Dr Nabeela, Dr Taj Raisani, and Dr Noor Qazi. Provincial head of Mercy Corps Dr Saeed Ahmed

Khan who while giving the briefing on the issue told the participants that 4 million children die after birth across the birth. He said that in under developed world like Pakistan 36 percent children fail to celebrate their first ever birthday. he said that in Balochistan different ways are used to overcome this thing but these are all outdated ways. He further said in Balochistan pregnant women are kept with

animals, event they do not have clean drinking water, food and necessary medicines. He said that malnutrition of women and children becoem basic reason of early deaths of new born babies. He stressed upon therole of society and provincial health department to overcome this trend. On the occasion provincial advocacy coordinator Hamal Baloch put light on lean project. PR



DAILY MASHRIQ Dated 5th November 2013

بلوچستان میں ماؤں اور نوجوانوں کی صحت کی بہتر سہولیات کی فراہمی ناگزیر ہے۔ اس سلسلے میں محکمہ صحت اور عالمی قومی اور صوبائی سطح پر صحت کے شعبے میں کام کرتے والے اداروں میں شعور ضروری ہے۔ صحت کے شعبے کے تمام اہلکار اپنا بہر ممکن کردار ادا کریں۔ عیسیٰ خان ڈیکور کا تقریب سے خطاب

“Provision of improved maternal and newborn healthcare is awful in Balochistan”, Dr.

Ayesha Siddiq

“In this regard, advocacy by DoH along with the provincial, national and international organizations working on health is critical”

Stakeholders of Health Departments may perform their active role to promote health facilities, addressed by Dr Essa Khan and others.

To address the issues related to the maternal and newborn health, improved MNCH services can be provided through the collaborative efforts of DoH and organizations working on provincial, national and international levels, addressed by Dr. Essa Khan *Deputy Director General Health services Balochistan* and Prof. Dr. Ayesha Siddiq *Chairperson Technical Working Group on Maternal and Newborn Health and CMW program*, during the meeting of the group organized by Mercy Corps. The successes and OR research updates– on the role of CMW in Maternal and newborn in Health on provincial, national and international levels; were presented in the meeting. Participants shared their feedback and recommendations on the research updates. Speakers appealed to all the health stakeholders to make their efforts – utilizing their best services; in provision of MNCH services, and improving maternal & newborn health status. Speakers further expressed their hope to carry on their active part in provision of improved Maternal and newborn healthcare services, while esteeming the practical steps of Mercy Corps in this regard.





Daily "Awam" Quetta, September 14, 2014

ماں اور نیا جنم کی صحت کیلئے تجویز کردہ ایچ ایچ وی ایچ کے لیے طبی اور نرسنگ کی تربیت یافتہ اور سرکاری طور پر تسلیم شدہ نرسوں کی مدد سے ماں اور نیا جنم کی صحت کیلئے تجویز کردہ ایچ ایچ وی ایچ کے لیے طبی اور نرسنگ کی تربیت یافتہ اور سرکاری طور پر تسلیم شدہ نرسوں کی مدد سے

مرسی کور نے بلوچستان میں ماں اور بچے کی صحت کو لاحق خطرات کم کرنے کیلئے گراں قدر کام کیا، ڈاکٹر عائشہ صدیقہ زچگی کے دوران پیدا ہونے والی پیچیدگیوں سے مریضوں کی تعداد بلوچستان میں خطرناک حد تک پہنچ چکی ہے، چیئر مین سینیٹرنگ کمیٹی

Lifesaving drugs for Mothers and Newborns recommended by World Health Organization (WHO) enlisted with Government

Mercy Corps has taken remarkable initiatives to provide health facilities to mothers and child in Balochistan. Dr. Ayesha Siddiqua.

The mortality rate in Balochistan has alarming high, Chairman Steering Committee.

کوئٹہ (این این آئی) صوبائی سٹیئرنگ کمیٹی برائے ماں اور شامل کرنے کی منظوری دیدی۔ صوبائی سٹیئرنگ کمیٹی کا ہیلتھ سروسز ڈائریکٹر نصیر بلوچ، ڈائریکٹر ہیلتھ سروسز ڈاکٹر داؤد نواز ائیڈہ بچوں کی صحت نے عالمی ادارہ صحت کی تجویز کردہ اجلاس زیر صدارت چیئر پرسن پروفیسر ڈاکٹر عائشہ صدیقہ محمد کاکڑ، ڈاکٹر نبیلہ سلطانہ، نیشنل پروجیکٹ مینجر شعیب احمد ادویات کو انتہائی ضروری ادویات کی سرکاری فہرست میں مقامی ہونٹل میں منعقد ہوا۔ اجلاس میں ڈائریکٹر جنرل شہزاد، ڈاکٹر فاروق اعظم، (بقیہ نمبر 69 صفحہ 7 پر)

Provincial Steering Committee' Mothers and Newborns has granted approval to enlist Lifesaving drugs recommended by WHO in the essential list of medicine of Government. The Provincial Steering Committee Conference was held under the Chairmanship of Chair Person 'Professor Dr. Ayesha Siddiq'

Director General Health Services Dr. Naseer Baloch, Director Health Services Dr. Dawood Muhammad Kakar, Dr. Nabeela Sultana, National Project Manager Mr. Shoaib Ahmed Shehzad, Dr. Farooq Azam (WHO) and Dr. Tahira Kamal participated in the conference.

Chairperson Dr. Ayesha Siddiq said that Mercy Corps has taken remarkable initiatives to eradicate the endangerments persisting to the life of mothers and newborns. The mortality rate of mothers in Balochistan due to complications during deliveries has reached upto alarming figures. The health department is making efforts to give awareness of the lifesaving drugs recommended by WHO and providing training of modern techniques to the professionals was impossible for the Provincial Government. International Organizations are making serious efforts to overcome and eradicate the endangerments persisting to the life of mothers and newborns utterly. We too have to assess our responsibilities and accept our weaknesses while performing our duties and have to correct them.

Director General Health Services Dr. Naseer Baloch, said Health Department regarding the health facilities of mothers and newborns are trying to overcome the flaws. Doctors including the health workers may be provided trainings and their appointment and presence should be ensured. He said that the current Government has taken serious attention over health department and have increased the funds due to which people are able to get better health facilities in the Hospitals and Health centers.

National Project Manager Mr. Shoaib Ahmed Shehzad informed the Steering Committee of the remarkable initiatives taken by Mercy Corps through its Health

ڈبلیو ایچ او لی ڈاکٹر طاہرہ کمال سمیت دیگر نے شرکت کی۔ چیئر پرسن سٹیئرنگ کمیٹی ڈاکٹر عائشہ صدیقہ نے کہا کہ مرسی کور نے بلوچستان میں ماں اور بچے کی صحت کو لاحق خطرات کو کم کرنے کیلئے گراں قدر کام کیا ہے زچگی کے دوران پیدا ہونے والی پیچیدگیوں سے مرنے والی ماؤں کی تعداد بلوچستان میں خطرناک حد تک پہنچ چکی ہے عالمی ادارہ صحت کی تجویز کردہ ادویات کے بارے میں شعور و آگاہی پھیلانے کے ساتھ محکمہ صحت کے تمام پروفیشنل کی جدید تقاضوں سے ہم آہنگ ٹریننگ کرانا صوبائی حکومت کیلئے ناممکن تھا عالمی ادارے بلوچستان میں ماں اور بچے کی صحت کو لاحق خطرات کم کرنے کے لئے سنجیدہ کوششیں کر رہے ہیں ہمیں بھی اپنے فرائض کی انجام دہی کے حوالے سے اپنی غلطیوں کو تسلیم کرتے ہوئے اپنی اصلاح کرنا ہوگی۔ ڈائریکٹر جنرل ہیلتھ سروسز ڈاکٹر نصیر بلوچ نے کہا کہ محکمہ صحت ماں اور بچے کی صحت کے حوالے سے خامیوں کو ختم کرنے کی کوشش کر رہی ہے ڈاکٹر سمیت ہیلتھ ورکرز کی تربیت اور جائے تعیناتی پر حاضری کو یقینی بنانے پر توجہ دی جا رہی ہے۔ انہوں نے کہا کہ موجودہ حکومت نے اقتدار سنبھالتے ہی صحت کے شعبے پر خصوصی توجہ

Projects and indicated the challenges. Provincial Advocacy Coordinator (RAF) Mercy Corps gave briefing to the participants of the survey conducted and its impact on the civil society.



Daily "AZADI" Quetta, September 14, 2014

بلوچستان میں دوران زچگی اموات کی تعداد خطرناک حد تک پہنچ چکی ہے، ڈاکٹر عائشہ صدیقی
مرسی کور نے ماں اور بچے کی صحت کو لاحق خطرات کم کرنے کیلئے گراں قدر کام کیا ہے

The mortality rate of mothers in Balochistan due to complications during deliveries has reached to an alarming situation. Dr. Ayesha Siddiq.¹

Mercy Corps has taken remarkable initiatives to eradicate the endangerments persisting to the life of mothers and newborns.

¹ The two articles have exactly the same content, as it covers the same meeting (PSC meeting held on 11th Sep 2014) in two different Newspapers (Azadi and Awam).

فہرست میں شامل کرنے کی منظوری دیدی صوبائی
سٹرنگ کمیٹی کا اجلاس زیر صدارت چیئر پرسن
پروفیسر ڈاکٹر عائشہ صدیقہ (بقیہ نمبر 32 صفحہ نمبر 7 پر)

کوئٹہ (این این آئی) صوبائی سٹرنگ کمیٹی برائے
ماں اور نوزائیدہ بچوں کی صحت نے عالمی ادارہ صحت کی
تجزیہ کردہ ادویات کو انتہائی ضروری ادویات کی سرکاری

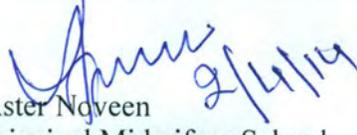
Provincial Steering Committee' Mothers and Newborns has granted approval to enlist Lifesaving drugs recommended by WHO in the essential list of medicine of Government. The Provincial Steering Committee Conference was held under the Chairmanship of Chair Person 'Professor Dr. Ayesha Siddiqa' Director General Health Services Dr. Naseer Baloch, Director Health Services Dr. Dawood Muhammad Kakar, Dr. Nabeela Sultana, National Project Manager Mr. Shoaib Ahmed Shehzad, Dr. Farooq Azam (WHO) and Dr. Tahira Kamal participated in the conference.

Chairperson Dr. Ayesha Siddiqa said that Mercy Corps has taken remarkable initiatives to eradicate the endangerments persisting to the life of mothers and newborns. The mortality rate of mothers in Balochistan due to complications during deliveries has reached upto alarming figures. The health department is making efforts to give awareness of the lifesaving drugs recommended by WHO and providing training of modern techniques to the professionals was impossible for the Provincial Government. International Organizations are making serious efforts to overcome and eradicate the endangerments persisting to the life of mothers and newborns utterly. We too have to assess our responsibilities and accept our weaknesses while performing our duties and have to correct them. Director General Health Services Dr. Naseer Baloch, said Health Department regarding the health facilities of mothers and newborns are trying to overcome the flaws. Doctors including the health workers may be provided trainings and their appointment and presence should be ensured. He said that the current Government has taken serious attention over health department and have increased the funds due to which people are able to get better health facilities in the Hospitals and Health centers.

National Project Manager Mr. Shoaib Ahmed Shehzad informed the Steering Committee of the remarkable initiatives taken by Mercy Corps through its Health Projects and indicated the challenges. Provincial Advocay Coordinator (RAF) Mercy Corps gave briefing to the participants of the survey conducted and its impact on the civil society.

نامی ہوئیں میں منعقد ہوا۔ اجلاس میں ڈائریکٹر جنرل ہیلتھ سروسز ڈاکٹر
نسر بلوچ، ڈائریکٹر ہیلتھ سروسز ڈاکٹر داؤد محمد کاکر، ڈاکٹر نابیلا سلطان، پیشل
وجیکٹ مینجر شعیب احمد شہزاد، ڈاکٹر فاروق اعظم، ڈیپٹی ایجوکیشنل آفیسر
اہرہ و کمال سمیت دیگر نے شرکت کی۔ چیئر پرسن سٹرنگ کمیٹی ڈاکٹر عائشہ
مدیقہ نے کہا کہ مری کور نے بلوچستان میں ماں اور نوزائیدہ بچوں کی صحت کو لاحق
خطرات کو کم کرنے کیلئے گراں قدر کام کیا ہے جس کی وجہ سے دوران پیدا ہونے
والی پیچیدگیوں سے مرنے والی ماؤں کی تعداد بلوچستان میں خطرناک حد
تک پہنچ چکی ہے عالمی ادارہ صحت کی تجویز کردہ ادویات کے بارے میں
شعور آگاہی پھیلانے کے ساتھ محکمہ صحت کے تمام پروفیشنل کی جدید
تقاضوں سے ہم آہنگ ٹریننگ کرانا صوبائی حکومت کیلئے ناممکن تھا عالمی
ادارے بلوچستان میں ماں اور نوزائیدہ بچوں کی صحت کو لاحق خطرات کم کرنے کے
لئے سنجیدہ کوششیں کر رہے ہیں ہمیں بھی اپنے فرائض کی انجام دہی کے
حوالے سے اپنی غلطیوں کو تسلیم کرتے ہوئے اپنی اصلاح کرنا ہوگی
ڈائریکٹر جنرل ہیلتھ سروسز ڈاکٹر نصیر بلوچ نے کہا کہ محکمہ صحت ماں اور
بچوں کی صحت کے حوالے سے خامیوں کو ختم کرنے کی کوشش کر رہی ہے
ڈاکٹر سمیت ہیلتھ ورکرز کی تربیت اور جائے تعیناتی پر حاضری کو یقینی بنانے
پر توجہ دی جا رہی ہے۔ انہوں نے کہا کہ موجودہ حکومت نے اقتدار
سنبھالنے ہی صحت کے شعبے پر خصوصی توجہ دیتے ہوئے اسکے بجٹ میں کو
گنا اضافہ کیا ہے جس سے ہسپتالوں میں عوام کو صحت کی بہتر سہولیات
فراہم کرنے میں مدد مل رہی ہے۔ پیشل پروجیکٹ مینجر شعیب احمد شہزاد
بلوچستان میں مری کور کے ہیلتھ پروجیکٹس کی کامیابیوں اور حامل مشکلات
کے بارے میں سٹرنگ کمیٹی کو آگاہ کیا۔ صوبائی ایڈوکیٹوریٹ کی کوارڈینیٹر
برائے (ریف) مری کور نصیر حمل نے مری کور کے پروجیکٹ
معاشرے پر مثبت اثرات کے بارے میں کرائے گئے سروس کے بارے
میں شرکت کو تشیخا بریڈنگ دی

CMW Refresher Training Batch -2					
Deliveries Exposure Table & Refresher Course Results					
District			Quetta		
S. No	Names of CMWs	Independent Deliveries	Total Deliveries: Assisted, Under-supervision and Independent	Results (% age)	
				Post test	Observational Checklist
1	Mahjabeen	5	22	87	96
2	Sadaf Yaqoob	5	28	78	94
3	Sajida Shameem	5	27	86	96
4	Sadiqa Rustum	5	26	73	94
5	Samina Ramzan	5	26	83	98
	Shahida Azad	5	22	82	94
	Tasleem	5	30	83	98
	Anum Mir	5	31	80	95
	Farzana	5	29	83	94
	Tahira Adil	5	19	82	94
	Fareeda	5	25	83	94
	Sadaf Naz	5	28	71	94
	Fatima Abdul Hakeem	5	24	85	96
	Naz Bibi	5	30	82	94
	Sanober Naz	5	31	88	98
	Saeeda Irum	5	27	87	96
	Alia	5	25	84	94
	Sadia Naz	5	31	71	94
	Zahida	5	21	72	94
	Saeeda Kareem	5	19	84	94
	Rukhsana Arshad	5	20	83	94
	Ruqaya Shabir	5	26	84	96
Total		110	567	81	95


 Aster Noveen
 Principal Midwifery School
 Quetta

CMW Refresher Training Batch -2

Deliveries Exposure Table & Refresher Course Results

District			Kech		
S. No	Names of CMWs	Independent Deliveries	Total Deliveries: Assisted, Under-supervision and Independent	Results (% age)	
				Post test	Observational Checklist
1	Fahmeeda	5	10	76	75
2	Nageena	5	11	84	83
3	Gulbano	5	8	81	78
4	Waseela	5	11	78	77
5	Saima	5	10	76	75
6	Shereen	5	13	81	75
7	Sharaf jan	5	13	81	78
8	Yaqoot	7	14	80	95
9	Humaira	5	9	79	75
10	Abida	5	11	86	77
11	Shahnaz	5	9	79	75
12	sameera	5	7	83	77
13	Najama	5	13	78	82
14	Kausar	5	9	75	75
15	Zuhra	7	17	79	77
16	Gul nisa	5	12	84	75
17	Saba	5	8	83	75
18	Khan bibi	5	11	84	75
19	Gulshan	5	9	79	75
20	Nazeera	5	7	84	75
Total		104	212	81	77

Verified by:



Dr. Farzana Magsi

Principal

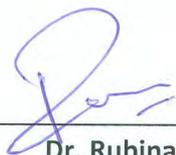
Public health school Turbat

District kech

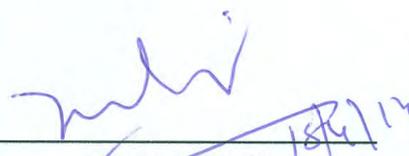
PRINCIPAL
Public Health School
TURBAT

CMW Refresher Training Batch -2					
Deliveries Exposure Table & Refresher Course Results					
District			Gwadar		
S. No	Names of CMWs	Independent Deliveries	Total Deliveries: Assisted, Under-supervision and Independent	Results (% age)	
				Post test	Observational Checklist
1	Sultana	5	8	82	90
2	Gulnisa	5	7	89	95
3	Hafeeza	5	7	86	97
4	Sakeena	5	7	83	94
5	Shazia	5	6	89	95
6	Tahera	5	6	87	90
7	Nadia	5	7	83	95
8	Khalida	5	6	86	90
Total		40	54	86	93

Verified by:



Dr. Rubina
Principal
Midwifery School Gwadar



Dr. Fazal Khaliq
Medical Supretendent
DHQ Hospital Gwadar

CMW Catchment Area Population Chart

Section -1

Year: _____

Name of CMW: _____ Registration No: _____ Reporting Health Facility Name: _____

Union Council: _____ District _____ Province: _____

Section -2

S. No	Village Name	Total Population	Distance from CMW Work Station (in KM)	Number of LHWs	Registered Population of LHWs	Number of Traditional Birth Attendants	Emergency Transport phone number
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total							

Section -3

	Name	Distance	Phone Number
Referral Health Facility (Basic EmONC)			
Referral Hospital (Comprehensive EmONC)			

Section -4

Target Groups	Standard percentage in Population	Estimated Annual Number	Estimated Monthly Number
Expected Pregnancies	3.4%		
Expected Birth	2.9%		
Number of Woman age 15-49 Years	22%		
Number of Married Woman age 15-49 Years	16%		
Number of Under 1 Year Children	2.7%		
Number of Under 5 Year Children	16%		

CMW name
CMW registration #
Health facility name
Affiliated LHW name
Basic information of mother
Yearly Number
Name of pregnant woman
Husband name
Address
Total deliveries
<input type="text" value="0"/>
Total pregnancies____ Total live birth____
Youngest child age is less than 2 years
Age_____
Age of pregnant_____
Height ft_____
Weight_____
Blood group _____
TT injection date
Present & past health information
Any chronic disease
Does mother using any medications
Past pregnancies and deliveries information
Previously miscarriage
Previously dead birth
Previously long duration delivery
During pregnancy BP or stocks
Previously cesarean for delivery
Previously bleeding after any delivery

Last menses date	Current pregnancy	Expected delivery date							
Pregnancy duration	First 3 months	4	5	6	7	8	9	10	
	First 12 weeks	18	22	27	31	36	40	44	
Checkup date									
Problems									
Anemia	No								
	Yes								
Swelling	No								
	Yes								
Child moment	No								
	Yes								
Vaginal bleeding	No								
	Yes								
Vaginal discharge	No								
	Yes								
Breast related problems	No								
	Yes								
Instructions about iron tables									
Weight	Normal								
	Over/under								
Blood pressure	Less than 140/90								
	Greater than 140/90								
Child heart beat	No								
	Yes								
Height									
Direction of child	Straight								
Urine test	Normal								
	Sugar presence								
	Protein presence								
Hemoglobin	Greater than 10gm/dl								
	Less than 10gm/dl								
Suggestion about place of delivery	Home	Health center	hospital						
In case of emergency vehicle is available	Yes	No							

Mother information		
Pain duration	Less than 12 hrs	Greater than 12 hrs
Date of birth	_____	
Place of birth	Home	Hospital
Who has done the delivery	TBA	SBA
Position of child at the time of delivery	Normal	
	Yes	No
Method for delivery	Normal	Cesarean
Nothing (harmful) applied to cord	Yes	No
Immediate checklist for mother (within first 2 hours of delivery)		
Mother is alive		
Birth of child	Live	Dead
Placenta left inside	No	Yes
Blood pressure	Normal	More/Less
Sign of convulsions	No	Yes
Unconsciousness	No	Yes
Pulse speed	Less than 100	Greater than 100
Speed of breath	Normal	More/less
Vaginal bleeding	No	Yes
Pain in breast, lower part of abdomen	No	Yes
Temperature	Normal	More
Newborn dried after birth	Yes	No
Immediate start of breast feeding	Yes	No

Newly born immediate checkup

1. Child Name _____
 2. Father's name _____
 3. Date of birth _____
 Birth time _____ Sex Male/Female
- With the help of **APGAR** score estimate the situation of child

Symptoms	0	1	2
Heart beat	Not existed	Less than 100/m	Greater than 100/m
Difficulty in breathing	Not existed	Slow and irregular	Good and child is weeping
Muscular stress			
Color	Nothing	Very less	Coughing, Sneezing
Face color	Blue, Yellow	Body pink – Hand & pink	Whole body is pink

- Is there any need for artificial breathing
- Has warm environment provided to newly born
- Seasonal cloth provided to newly born
- Newly born immediately brought in contact with mother skin and breast feeding started
- Newly born was bath after 6 hours
- Weight at the time of birth _____ kg

For mother							For mother foot blue							For newborn							
#	Questions	1 st day	3 rd day	7 th day	18 th day	42th day	#	Questions	1 st day	3 rd day	7 th day	18 th day	42th day	#	Questions	1 st day	3 rd day	7 th day	18 th day	42th day	
Ask and investigate (* mean, disease is not a middle state)							Ask and investigate (* mean, disease is not a middle state)							Ask and investigate (* mean, disease is not a middle state)							
1	Tiredness						16	Change is habit						1	Fits						
2	Problem in breathing						17	Constipation						2	Unconsciousness						
3	Pain in chest						18	Check perineum						3							
4	Pain in legs						19	Examination of C section stiches						4							
5	Headache						20	Vaginal discharge						5							
6	Swelling in hands, foots and face						21							6	Cord checkup						
7	Blurring of eye sight						22							7	Jaundice						
8	Convulsions						23	Sore nipple						8	Newborn weight						
9							24	Pulse speed						9	Heath beats						
10	Investigating quantity of blood						25	Breath speed						10	Temperature						
11	Frequent need to urinate						26	Temperature						11	Breath speed						
12							27	Blood pressure						12	Eyes checkup						
13							28	Measure HB						13	Examination in						

Community Midwife (CMW) Daily Register

Name of CMW: _____

Registration No.: _____

Reporting Hospital/Health Center Name: _____ **Reporting Hospital Code:** _____

Union Council: _____

Tehsil & District: _____

CMW Technical Monitoring Checklist

Date _____ Month _____ Year _____

Section 1: Basic Information

1	CMW Name		7	Union council	
2	Registration #		8	Tehsil	
3	Reporting health center name		9	District	
4	Reporting health center ID		10	Technical supervisor name	
5	Total population		11	Designation	
6	Postal address		12	Technical supervisor signature	

Section 2: Observation/ Information

In the following section the answers will be written in the form of Yes or No. For yes use 1 and for no use 0

S. No	Interpersonal Skills	Yes/No
1	Does CMW greet properly the client/patient and their family members?	
2	Does the behavior of CMW with clients and family member friendly?	
3	Speaks in easy to understand language for the client?	
4	Review client's previous records?	
5	Encourage client to ask questions?	
6	Responds to questions of clients in easy and understandable language?	
7	Use appropriate IEC materials?	
8	Wash hands before and after client's physical examination?	
Total marks		

S. No	Observe MNCH Card	Yes/No
1	Numbers of deliveries and living children are recorded on the card?	
2	Information on previous pregnancy (spotting during pregnancy, Ante partum hemorrhage, Postpartum hemorrhage, convulsions, prolonged labour, still birth) section is complete?	
3	Information on chronic diseases (Diabetes, high blood pressure, TB, and Asthma) is complete?	
4	Anemia observation (through conjunctiva and palm) is done?	
5	Are the TT vaccinations recorded ?	
Total marks		

S. No	Health Education (Observe during the interaction with client)	Yes/No
1	Has birth preparedness and safe delivery plan discussed with the client?	
2	Has the pregnant mother informed about the complications and danger signs of pregnancy?	
3	Has client advised for TT vaccination?	
4	Has the client advised additional food and balanced diet during pregnancy?	
5	Has the client informed about the birth spacing and its benefits?	
Total marks		

Skills Assessment

Assess at least three skills during each visit. Mark her achievement on the basis of checklist and guidelines

In the following section the answers will be written in the form of Yes or No. For yes use 1 and for no use 0

Question 1. Examination of pregnant women abdomen

Skill 1: Antenatal Examination

S. No	Health Promotion (Observe during the interaction with client)	Yes/No
1	Does CMW explain the detail of examination to the pregnant woman before examination?	
2	Does CMW ask the pregnant woman if she has passed urine recently? if not, does she tell her to empty her bladder?	
3	Does CMW measure the fundus height correctly with figures/measuring tape?	
4	Does CMW identify fetal presentation correctly?	
5	Does CMW recognize the presenting parts of the fetus correctly if the duration of pregnancy is more than 36 weeks?	
6	Does CMW correctly recognizes the position of fetal heart sounds and capable of counting the fetal heart beats?	
Total marks		

Skill 2: Filling of Partograph**Guidelines for supervisor:**

- Please ask the midwife to show all filled Partographs.
- Select 2 randomly and mark them according to given guidelines in the table below.
- In case she has no record available, give her scenario and ask her to fill Partograph.
- Check it and mark it
- Appreciate the good points and provide technical guidance at all points (mistakes/left, unfilled) or weak areas immediately.

Scenarios:

- A primary gravida was admitted in the latent phase of labor at 5:00 AM.
- Fetal head 4/5 palpable
- Cervix dilated 2 cm
- 3 contractions in 10 minutes, each lasting 20 seconds
- Normal maternal and fetal condition

Note: This information is not plotted on the Partograph (Tutor should record if the CMW starts filling, as it is a negative point)

At 9:00 AM

- Fata head is 4/5 palpable
- Cervix dilated for 5 cm

Note: Woman was in the active phase of labor and this information is plotted on the Partograph. Cervical dilatation is plotted on the alert line

- Contraction in 10 minutes each lasting 40 seconds
- Cervical dilatation progressed at the rate of 1 cm per hour

At 2:00 PM

- Fetal head is 0/5 palpable
- Cervix is fully dilated
- 5 contractions in 10 minutes each lasting 40 seconds
- Spontaneous vaginal delivery occurred at 2:20 PM

Give **1 mark** for each step and attach the filled Partograph with completed evaluation tool. Partograph should be signed by supervisor.

S. No	Steps	Yes/No
1	Start filling of partograph when OS is dilated 4cm?	
2	Plotting of information on dilatation of cervix is plotted on alert line according to the duration of time?	
3	Proper plotting of descend of fetal head?	
4	Proper filling of uterine contraction information in the relevant box?	
Total marks		

Skills 3: Active management of third stage of labor (AMTSL)

Directions for Supervisor:

- Pre-schedule the visit according to Expected Delivery Date
- Give 1 mark for each correct step and zero for the missing or wrongly conducted step.

S. No	Steps	Yes/No
1	Does CMW give inj; oxytocin correctly within one minute after delivery (after confirming there is no other fetus)?	
2	Does CMW apply the controlled cord traction and counter traction method correctly with the increase of cord length?	
3	Does CMW observe the uterus for contraction?	
4	Does CMW observe the movements of the cord and examine the uterus/vaginal bleeding after 3 minutes of the delivery and cut the cord?	
5	Does CMW observe the uterine contraction after the cord cutting?	
6	Does CMW apply proper pad after cleaning and drying the perineum?	
Total marks		

Skill 4: Post natal care

Directions for Supervisor:

- Pre-schedule the visit
- Give 1 mark for each correct step and zero for the missing or wrongly conducted step.

S. No	Steps	Yes/No
1	Does CMW examine the mother according to the mother/ newborn checklist?	
2	Does CMW record the pulse rate and fill in the card in correct place?	
3	Does CMW record the temperature through thermometer and record?	
4	Does CMW record the BP through BP apparatus?	
5	Does CMW write the blood pressure correctly?	
6	Does CMW observe the blood discharge per vagina?	
7	Does CMW observe the vaginal discharge color, smell and quantity?	
8	Does CMW examine the breast for breast feeding, breast engorgement and breast tenderness?	
9	Does CMW examine the conjunctiva for anemia?	
10	Does CMW advise for additional and balanced diet?	
11	Does CMW advise for Family Planning?	
Total marks		

Skill 5: Immediate care of Newborn

Directions for Supervisor:

- Observe patient if case is being conducted by CMW
- Select any subject if case not available and ask the midwife to demonstrate according to protocol.
- For worst situation keep a baby doll with you and ask the midwife to demonstrate all steps on doll.
- Give one mark for each correct step and zero for the missing or wrongly conducted step.

S. No	Steps	Yes/No
1	Does the CMW Immediately dry the Newborn with clean, dry and soft cloth and wrap in another dry cloth after that?	
2	Does the CMW observe the respiration of Newborn properly? And counts the respiratory rate properly and enter it in card?	
3	Does the CMW immediately put the Newborn to the mother's breast to start the breast feeding?	
4	Does the CMW educate the mother and family to give bath at least after 6 hours?	
5	Does the CMW advise the mother for vaccination of the Newborn?	
6	Does the CMW educate the mother on general danger signs in Newborn? (For example stop breast feeding, drowsiness, unconsciousness, rapid breathing and fever)	
7	Does the CMW advise mother on personal cleanliness of Newborn?	
8	Does the CMW encourage the mother to ask questions about Newborn health?	
Total marks		

Skills 6: Family Planning

S. No	Steps	Yes/No
1	Does the CMW counsel the mother on the birth spacing and appropriate timing of pregnancy?	
2	Does the CMW educate the mother on modern contraceptive methods?	
3	Does the CMW educate mother on side effects of the selected conceptive methods?	
4	Does the CMW prepare the mother according to the prescribed principles for IUCD insertion; follow all the step for sterilization of instruments and IUCD insertion?	
5	Does the CMW call client for follow-up visits?	
Total marks		

Skill 7: Steps for injecting the contraceptives

Required Material: New syringe, injection, doll/ dummy

Question: Practice the steps for injecting the contraceptives (Filling Injection, Injecting and discarding syringe)

S. No	Steps	Yes/No
1	Does the CMW fit the needle inside the packing while opening the new syringe?	
2	Does the CMW open/ cut the vial or bottle properly?	
3	Does the CMW fill the injection as per the required quantity?	
4	Does the CMW inform the client about the procedure before giving the injection?	
5	Does the CMW select the proper place for injecting?	
6	Does not the CMW rub the place of injection? (Remember: rubbing after injection increases the pace of absorption in blood instead of gradual absorption)	
7	Does the CMW safely discard the syringe after use?	
8	Does the CMW inform the client about the side effects?	
9	Does the CMW make entries in the client recordf?	
Total marks		

Skill 8: Steps for IUCD insertion

Material required: IUCD (Multi-load or Cooper-T) Dummy

Question: Practice steps for IUCD insertion on Dummy. (Ask CMW to tell along with practicing IUCD placement on dummy)

S. No	Steps	Yes/No
1	Does the CMW slightly open the Cooper-T packing and load it inside the packing?	
2	Does the CMW first of all, position the client in a comfortable manner while bending the legs at the knee joint position?	
3	Does the CMW wash hands and wear the gloves?	
4	Does the CMW prepare the Cooper-T after opening and put the Cooper-T into a plastic tube?	
5	Does the CMW first of all, examine the external genitalia of the client?	
6	Does the CMW insert the speculum after applying anti-septic cream in the vagina smoothly? (Remember: Speculum's blades should be closed while inserting) Tighten the speculum after full insertion with the help of screw.	
7	Does the CMW examine cervix for position, color, fluid or discharge?	
8	Does the CMW hold properly the upper portion of the external OS of the uterus with forceps?	
9	Does the CMW use the sound for measuring the size of uterus and note the size?	
10	Does the CMW insert the Cooper-T loaded in plastic tube in the uterus through external OS and remove back the plastic tube slowly?	
11	Does the CMW cut off the extra thread coming out of the vagina and leave approximately 3 cm of the thread?	
12	Does the CMW unscrew the speculum to close it and slightly tilting it removes it gently?	
13	Does the CMW educate the client about the side effects and checking the thread off and on.	
Total marks		

Does the CMW need refresher training on any specific topic?

If yes, then give details

Way of scoring:

Write down the complete of number of questions from all sections and calculate the number of correct answers. Now calculate the percentage.

(Correct answers / Total number of questions) X 1000 = _____

Obtained Percentage	Performance Standard
90% and above	Very Good
80-90%	Good
70-80%	Satisfactory
70% and below	Non-satisfactory (needs refresher training)

Summary of Feedback:

Give verbal and written feedback to CMW on her performance.

2-B									
S. No.	Required stationary	Yes	No	Comment	S. No.	Required stationary	Yes	No	Comment
1	CMW daily register				5	Mother/Newborn health card			
2	Monthly report				6	Partograph chart			
3	Referral slip				7	Work station signboard			
4	Stock register				8	Midwifery kits bag			

Section 3: Drugs. This section should be filled on the basis of kit bag observation, information gathered from CMW and records of the stock register.

S. No.	Medicine	Available quantity	Absent days	S. No.	Medicine	Available quantity	Absent days
1	Condom			12	Metronidazole tablets 200mg		
2	Contraceptive pills			13	Metronidazole tablets 400mg		
3	Contraceptive injection with syringe			14	Amoxicillin capsule 250mg		
4	IUCD			15	Amoxicillin capsule 500mg		
5	Injection Oxytocin 10 iu			16	Anti-fungal vaginal tablets with applicator		
6	injection Magnesium sulphate 50%			17	Savelone antiseptic lotion		
7	Injection Lignocaine 2%			18	Disposable Syringe (5 & 10cc)		
8	Iron tablets			19	Canola (Gauge 16x18)		
9	Folic acid tables 5mg			20	Cotton roll		
10	Misoprostol tables 200mcg			21	Drip with set		
11	Paracetamol tables 500mg						

Section 4: Verification of information and safe disposal of Placenta and other injurious materials

Verification of information	Yes	No	Proper disposal of injurious material	Yes	No
Does monthly report tally with daily register data?			Is the Placenta appropriately buried?		
Has technical supervisor of CMW visited during last three months?			Have the sharps been (blade/syringe) disposed of properly?		

Section 5: Feedback from community

Does the CMW have friendly attitude?			Does the CMW provide medicines and contraceptives free of cost?		
--------------------------------------	--	--	---	--	--

Are the clients satisfied with the ante-natal, delivery and post natal checkups?			Does the CMW arrive within one hour after the call for delivery ?		
--	--	--	---	--	--

Comments – (If you have noticed anything important apart from these observations then write down here. Make suggestion for improvement)

- After under taking the monitoring, provide feedback and suggestion for improvement to CMW

LHS signature: _____ Date: _____

Annex – Section 2: Information of necessary and miscellaneous equipment.

S. No.	Equipment & other items	Available in working condition		Not available	Out of Stock (# of days)	S. No.	Equipment & other items	Available in working condition		Not available	Out of Stock (# of days)
		Yes	No					Yes	No		
1	Delivery Kit					11	Large blanket				
2	Kidney Tray					12	Kidney Tray 8"				
3	Large Bowl					13	Emergency Tray 12"x10"				
4	Small Bowl					14	Equipment Trolley				
5	Gauze Piece					15	Dressing Drum				
6	Kit bag					16	Surgical Gloves 7"				
7	Tissue holding forceps					17	Disposable Gloves				
8	Delivery table					18	OT Light (stand)				
9	Cord clamps					19	Patient bed				
10	Small blanket					20	Mobile Phone Set				

Annex – Section 3: Medicine & Supplies

S. No.	Form	Generic name	Potency	Available Quantity	Absent Days
1	Inj.	Tranexamic Acid	250mg/5ml		
2	Inj.	Diclofenac Sodium	75mg/3ml		
3	Inj.	Dexamethasone	4mg/1ml		
4	Inj.	Phloroglucinl Hydrate	4ml		
5	Inj.	Nootropil	5ml		
6	Capsule	Tranexamic Acid	Capsule, 250mg		
7	Capsule	Diclofenac Sodium	50mg		
8	Tab	Phloroglucino + trimethyphloroglucinol	80mg		
9	Bottle	Sodium biphosphate	135ml(Approx)		
10	Bottle	Dettol Brown	1 Litter		
11	Bottle	Dettol Pink	500ml		
12	Bottle	Bleach	500ml		
13	Pack	Face Mask			
14	No.	Surgical plaster			

Annex: Other general items

S. No.	Item	Available		S. No.	Item	Available	
		Yes	No			Yes	No
1	Refrigerator			7	Drip Stand		
2	Curtains			8	Mattress		
3	Soft Board			9	Pillow with cover		
4	Sign Board			10	Bed sheet		
5	Buckets			11	Repair and Renovation of CMW home		
6	Step for delivery table						

Is there a separate room for client care (antenatal visits, delivery, etc)

Observe the environment of this room:

- 1) Is the room generally hygienic (white washed with no stains, etc.)
- 2) Is an infection control guideline available?
- 3) Is running water and soap available?
- 4) Are there any glaring needs for repairs?

Is this CMW Work Station operational? Yes/No

(Operational work station means the home contains all essential refurbishments, furniture, and equipment as per CMW guidelines inclusive of vaccine supply (when electricity is available) and medicine stock)

Please write down comments:

- a) How many "Yes" answers in Section 2-A?
- b) How many "Yes" answers in Section 3?
- c) How many "Yes" answers in Annex Section 2-A?
- d) How many "Yes" answers in Annex Section 3?

CMW Monthly Report

CMW name: _____

Registration number: _____

Reporting hospital/health center name: _____

Reporting hospital code: _____

Union Council: _____

Tehsil & District: _____

CMW Monthly Report

Month _____ Year _____

Report submission date: _____	Basic information
Health center name: _____	CMW name: _____
Health center code: _____	PNC Registration #: _____
NHS name: _____	Total population: _____
UC: _____ Tehsil: _____	Total # of LHW in target population: _____
District: _____ Province: _____	Total # of traditional birth attendant in area: _____

Section 1: Pregnant/Mother and Newborn information

S. No.	Ante natal Information	Total		S. No.	Natal Information	Total	
1	Total pregnant women (new & follow-up)			3	Total register expected deliveries		
1.1	Total pregnant with 1 st antenatal visit			3.1	Total who facilitated by CMW during delivery		
1.2	Total pregnant with 2 nd antenatal visit			3.2	Total live birth		
1.3	Total pregnant with 3 rd antenatal visit			3.3	Total still birth		
1.4	Total pregnant with 4 th antenatal visit			3.4	Total miss carriage		
1.5	Total pregnant with more than 4 antenatal visit			4	Total Maternal death (Out of total registered pregnant woman)		
2	Total pregnant women with TT vaccination	1 st	2 nd				
S. No.	Complications during pregnancy	Total		S. No.	Complications during Natal and Post-natal	Total	
5	Number of pregnant who were referred due to complication			6	Total # of mother referred due to complication caused during natal or post natal		
5.1	# of pregnant who referred to District hospital			6.1	# of mother who referred to District hospital		
5.2	# of pregnant who referred to Tehsil hospital			6.2	# of mother who referred to Tehsil hospital		
5.3	# of pregnant who referred to basic health unit			6.3	# of mother who referred to basic health unit		
5.4	# of pregnant referred to other than above mention facilities			6.4	# of mother referred to other than above mention facilities		
5.5	# of pregnant examined/referred due to APH	Examined	Referred	6.5	# of mother examined/referred due to more release of blood	Examined	Referred
5.6	# of pregnant examined/referred due to high blood pressure			6.6	# of mother examined/referred due to high blood pressure		
5.7	# of pregnant examined/referred due to fits			6.7	# of mother examined/referred due to fits		
5.8	# of pregnant examined/referred due to delayed in delivery			6.8	# of mother examined/referred due to fever		
5.9	# of pregnant examined/referred due to Vaginal discharge			6.9	# of mother examined/referred due to other than above mentioned reasons		
5.10	# of pregnant examined /referred due to other reasons			7	# of mother with post natal checkup		

S. No.	Newborn information	Total	S. No.	Complications in newborn	Total
8	Total # of newborn started with mother's breast feeding immediately		14	Total newborn referred due to any complication	
9	Total # of newborn weighted after birth		14.1	# of newborn who referred to District hospital	
10	Total # of underweight newborn		14.2	# of newborn who referred to Tehsil hospital	
11	Total # of newborn with first vaccination		14.3	# of newborn who referred to basic health unit	
12	Total # of newborn deaths (within 28 days of birth)		14.4	# of newborn referred to other than above mention facilities	
13	Total # of newborn with post natal checkup		14.5	Total # of newborn examined/referred due to difficulty in breathing	Examined Referred
			14.6	Total # of newborn examined/referred due to Pneumonia	
			14.7	Total # of newborn examined/referred due to infection of cord or any other infection	
			14.8	# of newborn examined/referred due to other than above mentioned reasons	

Section 2: Information about cases referred from LHWs

S. No.	Referred cases	Total
1	Total # of cases (Antenatal, delivery, post natal, newborn) referred by LHW	
2	Total # of pregnant women referred	
3	Total # of pregnant women referred at the time of delivery	
4	Total # of women referred after delivery	
5	Total # of newborn who were referred	

Section 3: Information about family planning

S. No.		New	Follow-up	Referred by LHW
1	Total # of clients who are using modern methods for family planning			
2	Total # of clients provided with contraceptive pills			
3	Total # of clients provided with condom			
4	Total # of clients provided with contraceptive injection			
5	Total # of clients using IUCD			
6	Total # of clients referred for Tubal Ligation/Vasectomy			

Section 4: Logistics**4.1. Equipment/miscellaneous items**

S. No.	Equipment	Available in working condition		Comment	S. No.	Equipment	Available in working condition		
		Yes	No				Yes	No	
1	BP apparatus				13	Sterilizer (12x16)			
2	Stethoscope				14	Ambo bag mask			
3	Thermometer				15	Emergency light			
4	Baby weighing machine				16	Examination table with screen			
5	Adult weighing machine				17	Office table/chair/stole			
6	Bulb sucker				18	Episiotomy kit			
7	Fetoscope				19	IUC kit			
8	Measuring tape				20	Pregnancy kit			
9	Plastic sheet				21	Urine dipsticks			
10	Safety Box				22	Blood grouping kit			
11	CMW kit bag				23	CMW work station			
12	HB meter				24	Rubber Catheter			

4.2. Medicine

S. No.	Medicine	Available quantity	Absent days	S. No.	Medicine	Available quantity	Absent days
1	Condom			12	Metronidazole tablets 200mg		
2	Contraceptive pills			13	Metronidazole tablets 400mg		
3	Contraceptive injection			14	Amoxicillin capsule 250mg		
4	IUCD			15	Amoxicillin capsule 500mg		
5	Oxytocin Injection 10 iu			16	Anti-fungal vaginal tables along with applicator		
6	Magnesium sulphate injection 50%			17	Selone antiseptic lotion		
7	Lignocaine Injection 2%			18	Disposable syringe (5 & 10cc)		
8	Iron tables			19	Canola (Gauge 16x18)		
9	Folic acid tables 5mg			20	Cotton roll		
10	Misoprostol tables 200mg			21	Safe delivery kit		
11	Paracetamol tables 500mg			22	Drip along with set		

Comments – (If you have noticed anything important apart from these observation then write down here. Make suggestion for improvement)

Date of LHS visit: _____ Date of technical supervisor visit: _____

CMW signature: _____ Signature health facility in-charge: _____

Referral Slip

National MNCH Program (Referral Slip)
For CMW record
Referral slip (record copy)

Name of patient/client/newborn _____
Yearly Number: _____
Husband/Father Name: _____
Age: _____ In case newborn sex: _____
Client address: _____
Reason for referral: _____
Facility/treatment provided: _____
Additional instruction: _____
CMW name: _____
CMW Registration #: _____
Signature of CMW: _____ Date: _____

National MNCH Program (Referral Slip)
Filled by CMW and for hospital record
Referral slip

Name of patient/client/newborn _____
Yearly Number: _____
Husband/Father Name: _____
Age: _____ In case newborn sex: _____
Client address: _____
Reason for referral: _____
Treatment by CMW: _____
Hospital referred to: _____
CMW name: _____
CMW Registration #: _____
Signature of CMW: _____ Date: _____

National MNCH Program (Referral Slip)
Filled by doctor and given back to patient for CMW
record
Referral slip (feedback slip)

Name of patient/client/newborn _____
Yearly Number: _____
Age: _____ In case newborn sex: _____
OPD/ Emergency admission #: _____
Name of referee CMW: _____
Reason for referral: _____
Facility/treatment provided: _____
Additional instruction: _____
Doctor name: _____
Hospital name: _____
Signature of doctor: _____ Date: _____

Emergency

National MNCH Program (Referral Slip)

For CMW record
Referral slip (record copy)

Name of patient/client/newborn _____
Yearly Number: _____
Husband/Father Name: _____
Age: _____ In case newborn Sex: _____
Client address: _____
Reason for referral: _____
Facility/treatment provided: _____
Additional instruction: _____
CMW name: _____
CMW Registration #: _____
Signature of CMW: _____ Date: _____

National MNCH Program (Referral Slip)

Filled by CMW and for hospital record
Referral slip

Name of patient/client/newborn _____
Yearly Number: _____
Husband/Father Name: _____
Age: _____ In case newborn Sex: _____
Client address: _____
Reason for referral: _____
Treatment by CMW: _____
Hospital referred to: _____
CMW name: _____
CMW Registration #: _____
Signature of CMW: _____ Date: _____

National MNCH Program (Referral Slip)

Filled by doctor and for CMW record return to patient
Referral slip (feedback slip)

Name of patient/client/newborn _____
Yearly Number: _____
Age: _____ In case newborn Sex: _____
Emergency admission #: _____
Name of referee CMW: _____
Reason for referral: _____
Facility/treatment provided: _____
Additional instruction: _____
Doctor name: _____
Hospital name: _____
Signature of doctor: _____ Date: _____

To be published in the next
issue of Balochistan Gazette.



**GOVERNMENT OF BALOCHISTAN
HEALTH DEPARTMENT
(Planning Cell)**

Dated Quetta, the 7 July, 2014

NOTIFICATION

NO.PC(H)/NOTI/MNCH/2014/4018-36. Consequent upon recommendations of Provincial Steering Committee on MNCH-Balochistan with Technical inputs from Technical Working Group (TWG) Balochistan, the Community Midwives (CMW) trained and deployed under Maternal Newborn and Child Health (MNCH) Program are allowed to provide natal services in their workstations alongwith provision of services in communities.

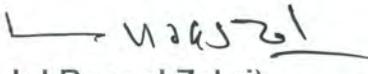
**ARSHAD HUSSAIN BUGTI
SECRETARY HEALTH**

The Controller
Govt. Printing Press
Balochistan, Quetta.

NO. EVEN. DATED. EVEN.

C.c to:-

1. The Director General, Health Services Balochistan, Quetta.
2. The Provincial Coordinator MNCH Program Balochistan, Quetta.
3. All Members of Provincial Steering Committee MNCH.
- ✓ 4. Team Leader MC Balochistan, Quetta.
5. The PS to Secretary Health, Government of Balochistan, Quetta.
6. Master File.


(Abdul Rasool Zehri) 7.7.14
Chief Planning Officer

Annex 10. CMW Selection Criteria (Revised)

90 CMWs will be selected in partnership with the District Health Offices (DHO) based on the following criteria. These criteria were developed in partnership with the government of Balochistan to ensure that the project is most likely to succeed, while still serving the needs of vulnerable and marginalized communities. Based on learning from the selection of first batch of CMWs, minor changes were made in the selection criteria for the second batch. Those changes are indicated in **red** and ~~crossed-out text~~.

Required

- Completed 18 month training, and passed National Examination Board
- Resident of catchment area
- Catchment population at least **2,500** ~~3,000~~ (i.e. the CMW can reach communities/households in her catchment area within 1 hour travel distance, using transport available to the CMW)
- Willingness to complete the tasks of the CMW's job description, including:
 - Work as skilled birth attendance
 - Participate in trainings
 - Repay loans **if taken from bank**
- Computerized National ID Card (CNIC) (Most CMWs should already have this, as it's a requirement to register in CMW training course.)
- Local/domicile certificate
- Space available in home and willingness to utilize space for work station
- Only one CMW will be selected from a catchment area
- ~~Mobile network coverage in home community~~

Preference Given to:

- Married women
- Currently uses mobile phones
- **Mobile network coverage in home community**
- PNC Registered

TERMS OF REFERENCE
CONSULTANTS/FIRM FOR DEVELOPMENT OF
A FIVE YEAR PROVINCIAL MNCH STRATEGY (2015-2020)
FOR DEPARTMENT OF HEALTH, BALOCHISTAN

PROJECT Saving Mothers and Newborns in Communities	DUTY STATION Quetta (preferred) or Islamabad with frequent travel to Quetta
POST TITLE Consultants/firm	DURATION 30 days spread over 3 months

INTRODUCTION AND BACKGROUND

In Pakistan each year approximately 14,000 women die due to complications of pregnancy or childbirth, and at least 216,000 newborns die before they reach their first month of age. High levels of maternal, neonatal and child mortality are attributed to a number of factors which includes high fertility rates, lack of appropriate prenatal care, lack of skilled birth attendance, low levels of female literacy, malnutrition among women of reproductive ages, and lack of access to emergency obstetric and newborn care (EmONC).

Balochistan is the largest province of Pakistan (geographically speaking) and is lagging behind MNCH indicators in the country. According to Pakistan Demographic and Health Survey (PDHS) 2012-13 the mortality indicators of Balochistan are higher than the national averages. The U5MR is 111/1000 live births and the Infant Mortality Rate (IMR) is 97/1000 live births, compared to the national average of 89/1000 live births and 74/1000 live births. Neonatal mortality is also higher in Balochistan (63/1000) than the national average (55/1000). Maternal Mortality Ratio is alarmingly high at 785/100,000 live births against the national average of 276/100,000 live births. Balochistan has a Total Fertility Rate (TFR) of 4.2 children per woman (compared with Punjab 3.8) and modern Contraceptive Prevalence Rate (CPR) of 16 percent (Punjab 29%). Across the country, Balochistan has shown least performance in Expanded Program on Immunization (EPI) where 21% children received no vaccination at all in as per PDHS 2012-13.

The Government of Balochistan (GOB) is aware of the huge burden of mortality and morbidity among women and children and is fully committed to improving their health status. In this regard, Mercy Corps in close collaboration with the Department of Health Balochistan launched a four year program, ***Saving Mothers and Newborns in Communities (SMNC)***, in Quetta, Kech and Gwadar districts of Balochistan. The program, implemented with support from USAID and the Scottish Government, seeks to *improve maternal and newborn health status*, through an innovative model that will enable CMWs to become self-sustaining, private MNCH service providers. The program was designed jointly with the Balochistan DoH, upon their request, to offer evidence for how to scale up high impact MNCH interventions in Balochistan through the CMW. The model is being tested with 90 CMWs in Quetta, Gwadar, and Kech districts of Balochistan and contains the following main components:

1. To ensure quality, Mercy Corps offers **4-week clinical refresher training**, facilitates registration with the PNC for those who are not already registered, and offers joint-supervision visits
2. To enable CMWs to set-up home based clinics, Mercy Corps is facilitating CMWs to access loans from **Tameer Bank**. Further, Mercy Corps is providing standard equipment and business skills training to the CMW.
3. Through MC's partnership with Pak Vista Shared Technologies, CMWs will use their **mobile phones** to track patient data, send automatic reminders to clients, and offer voice messages for awareness raising. Through automatic data transfer, the DoH will be able to track uptake of the CMWs services in real time.
4. For behavior change and demand creation, Mercy Corps will reinvigorate the **Women Support Groups** conducted by CMWs and Lady Health Workers. These groups will also generate support for the **Mamta fund**, a revolving transport fund to facilitate access to emergency transport.
5. For timely referrals, Women Support Groups and CMWs will be linked with not-for-profit **ambulance services**.
6. At the policy level, Mercy Corps will assist the provincial DOH to develop a **five-year MNCH strategy**. The plan will be revised and updated based on findings from the **Operations Research** which will explore whether CMWs can become self-sustaining private providers, while increasing access and utilization of high impact, quality MNCH interventions.

PURPOSE OF THIS CONSULTANCY

The purpose of this consultancy is to support the development of a 5 year MNCH Strategy for the provincial DoH (see component 6 in the list above).

In preparation for this consultancy, Mercy Corps carried out a series of consultations with representatives from Balochistan DoH and various development partners (list attached as Annex A) to identify the needs of DoH in relation to MNCH strategy. The purpose of these consultations was to understand the current, existing strategy for MNCH which is being followed by DoH, confirm whether any other development partner is supporting the DoH in the development of a strategic plan (to prevent duplication of efforts), and to understand the DoH's needs for a new strategy going forward. The main findings of these consultations are shared below:

1. Currently there is no Balochistan-specific MNCH strategy which is followed by DoH. In the absence of a provincial strategy, they are using the national MNCH PC1 which will expire in June 2015.
2. No other development partners are supporting the DoH Balochistan in developing a comprehensive, provincial MNCH strategy. However, various other provincial strategies such as nutrition strategy, communication strategy, health sector strategy have been developed by other development partners in consultation with DoH. The Provincial Health Department emphasized that a comprehensive MNCH Strategy should be well synchronized with these existing strategies, which are currently being developed and include:
 - **Community Midwives (CMWs):** CMWs deployment guidelines have been developed by TRF, yet they have not been endorsed by PNC/MNCH programme. During the consultations it was recognized that the DoH would like this component to be a part of proposed 5 year MNCH strategy. Further, Mercy Corps (through support from RAF), developed a provincial CMW Strategic Roadmap (based on a desk

review, situation analysis, consultative meetings, and a synthesis paper) to support the government's future strategies for training, deploying and supporting CMWs. This roadmap has been endorsed by the Balochistan Department of Health

- **Nutrition:** Save the children and UNICEF are in the process of developing multi-sectoral nutrition strategy for DoH. Nutrition was also indicated by the stakeholders to be a part of MNCH strategy, and thus the MNCH strategy should align with this nutrition strategy.
 - **Advocacy/communication:** Save the Children is in process of developing communication strategy. However participants shared that there is need to create demand for health services through targeted, socially acceptable communication strategies.
3. In addition, key stakeholders emphasized that the comprehensive MNCH Strategy should include the following components:
- **Emergency Obstetric Neonatal Care (EMONC) services/Basic Obstetric Neonatal Care (BMONC) services:**The stakeholders shared that upgrading institutional capacity at the provincial and district level and ensuring basic and comprehensive EmONC services and integration of all MNCH related services at the district level is important and the proposed strategy should clearly focus on these services
 - **Monitoring and evaluation:** The consultations indicated that the monitoring and evaluation component is deficient in the current national PC1 for MNCH. These gaps need to be addressed properly in the proposed MNCH strategy. All the stakeholders shared that a strong and clear M&E component should be provided in the proposed 5 year MNCH strategy.

In summary, these consultation meetings identified the need of developing a *comprehensive* MNCH strategy for a period of *five years* (2015-2020) catering all the components of the MNCH which includes:

- Community Midwives (CMWs)
- Nutrition
- Primary health care/Integrated Management of Neonatal and Childhood Illness (IMNCI)/Immunization
- Emergency Obstetric Neonatal Care (EMONC) services/Basic Obstetric Neonatal Care (BMONC) services
- Advocacy and communication
- Program management
- Comprehensive family planning services
- Monitoring and evaluation

This comprehensive MNCH strategy is expected to comprise both an **implementation plan** along with **costing** for each activity or component

In response to these consultations, Mercy Corps is seeking consultants/firm to support the MNCH program in Balochistan to develop its five-year MNCH strategy (2015-2020). The strategy should be developed under the leadership of the DoH and MNCH program and in close

consultation with other key stakeholders, such as government partners including Health Reform Unit, Lady Health Worker (LHW) program, MNCH program and development partners including Save the Children, Technical Resource Facility (TRF), UNICEF and WHO.

Objectives

1. To carry out a Rapid assessment to identify the gaps/ bottlenecks related to MNCH services in Balochistan
2. To develop a comprehensive five-year MNCH strategy in consultation with DoH and development partners.

Scope of Work

This consultants/firm will undertake following activities to complete the assignment:

- A. **Develop detailed workplan** clearly indicating the activities and timelines required to meet the deliverables; finalized in consultation with MC.
- B. **Conduct a rapid assessment** related to MNCH in Balochistan: The consultants will conduct a desk review and conduct consultative meetings to a) identify the major MNCH service delivery (and demand) gaps in Balochistan in order to b) propose the structure and content for the 5 year MNCH Strategy. This is a 4 stage process as follows:
 - i. *Desk review:* the consultants will review and draw lessons from the existing literature, documents, and MNCH strategies of Balochistan (and perhaps other provinces). Specifically, the consultant should make use of the CMW Roadmap, developed by Mercy Corps under a RAF funded project in 2013 and other strategies listed on page 3
 - ii. *Develop tools:* for the stakeholder interviews/consultation
 - iii. *Conduct consultative meetings/interview:* to build on Mercy Corps' consultative work which was used to develop this ToR. The purpose of these consultative meetings is to understand stakeholder needs with respect to the development of the MNCH strategy and to ensure this strategy does not duplicate existing efforts.
 - iv. *Prepare Rapid Assessment Report:* and brief PowerPoint presentation on the desk review and consultative meetings.
- C. **Develop the 5-year provincial MNCH strategy (2015-20120)**
 - a. Draft the 5-year provincial MNCH Strategy
 - b. Conduct workshop in Balochistan with various stakeholders to seek their feedback on the draft 5-year provincial MNCH strategy
 - c. Finalize the strategy including the costing
- D. **Conduct dissemination workshop** of final strategy

The development of the strategy will be based on following of key principles

1. The Provincial MNCH Steering Committees and Technical Working Groups will provide leadership and oversight for the strategy

Mercy Corps, through its ongoing SMNC project, has assisted the Balochistan DoH in establishing Provincial MNCH Steering Committee (PSC) and Technical Working Group (TWG). In the proposed project, the TWGs and PSC will take a lead in providing specific recommendations on the documents of situation analysis and will take the lead in the development of evidence-based, province-specific recommendations for changes in policy and practices regarding MNCH, which will be endorsed by the MNCH steering committee. This will

ensure that the provincial DoHs, UN agencies, Pakistan Nursing Council (PNC), and civil society organizations take ownership of the strategy.

2. In 2016, the draft 5 year MNCH strategy (developed under this consultancy) will be revised and informed by recent research, including the Operations Research conducted under SMNC

The Operations Research (OR) which is currently under way will inform whether the CMWs can become self-sustaining private providers, while increasing access and utilization of high impact, quality MNCH interventions. The OR results will be made available in spring/summer 2016. As such, we anticipate to revise the strategy and plan developed under this consultancy to reflect emerging evidence related to the CMW program, including the findings from the OR conducted by the University of Alberta under SMNC.

3. The MNCH strategy should emphasize reaching the poorest and marginalised

Accessing appropriate healthcare, especially maternal and newborn care, is a critical challenge for the poor and marginalised women. The strategy should re-emphasise this as a core issue to ensure that poor women are able to access services.

The strategy is expected to be used by several key stakeholders including, but not limited to, Provincial Minister for Health, senior officials of DoH, planning and finance departments and technical experts. This will assist various stakeholders to work in unison to improve the overall components of MNCH programme. For example, it will play a critical role in improving coordination between various programmes such as MNCH and LHW programmes. It will also play an important role in helping the provincial DoH's to reach out to the donors for additional assistance, beyond what is available through the provincial governments and will guide the development of future PC-1s. In addition, it may also be used by the provincial governments, civil society and donors to oversee implementation, and monitor progress against results.

DURATION AND WORKPLAN

The scope of work will be carried out by the consultant(s) per the below table from July 1 through October 1, 2014. If Quetta is not the duty station (which is the preferred option), then frequent field travel will be required to the Quetta for carrying out the consultative meetings/workshop in finalizing the strategy.

The following table offers an indicative workplan, description of activities and deliverables and required LoE (level of effort).

S. No.	Activity/Deliverable	LoE	Remarks
1.	Initial meeting with Mercy Corps	1/2	The consultant(s)/firm will meet with Mercy Corps team to clarify scope of work and agree on a tentative workplan. This meeting will be in Islamabad. Following this discussion, the consultants/firm will submit a workplan and get Mercy Corps' approval
2.	Development of detailed	1/2	This will include methodology and timelines of

	workplan clearly identifying the activities to be carried out under this assignment		activities defined under the scope of work.
3.	Desk review	5	Review of available material including, but not limited to, existing MNCH strategies, CMW deployment guidelines, Health Sector Strategy, National PC-1 for MNCH, National MNCH Strategic Framework, Provincial Strategic Roadmap for expanding skilled birth attendance, etc. The consultant is expected to submit the list of final documents for the desk review.
4.	Develop tools for rapid assessment (interviews/ meetings/ workshop)	1	
5.	Conduct consultations with stakeholders	4	
6.	Preparation and submission of Rapid Assessment report	2	
7.	Finalize Rapid Assessment report and PowerPoint presentation, incorporating feedback from Mercy Corps	1	
8.	Develop and submit draft MNCH strategy	5	
9.	Conduct individual meetings and a workshop with key stakeholders to review draft MNCH strategy	4	
10	Finalize five-year costed strategy, based on feedback from MC and consultative workshop	6	
11	Dissemination workshop	1	
	TOTAL	30	

The travel plan of the consultancy will be agreed with the consultant prior to signing of the contract.

KEY DELIVERABLES

The consultants/firm will submit:

- Work plan and methodology
- Desk Review
- Tools for consultations
- Rapid Assessment report & PowerPoint presentation
- Balochistan MNCH costed strategy (2015-2020)

The deliverables will be the property of Mercy Corps, copyright vesting with Mercy Corps.

MERCY CORPS REVIEW TEAM

- Director of Health Programs
- Team Leader South
- CSHGP Project Manager
- CSHGP Project Officer
- Representative, Mercy Corps Operations Dept.

REPORTING

The consultant(s) will report directly to the Director of Health Programs and liaise closely with the Project Officer based in Islamabad and as well as the CSHGP Project Manager based in Quetta.

INVITATION TO TENDER

Consultants/firms are invited to submit technical and financial proposals for the above scope of work. The technical proposal must contain the following:

1. Technical approach/methodology to deliver the assignment
2. At least one sample report from a previous similar assignment (e.g. provincial or national level strategies/plans, ideally costed)
3. CVs of the team of consultants: The team must include, at a minimum, a Team Lead, MNCH Technical Specialist, and a Costing Expert.

The financial proposal must provide a breakdown of the consulting fees. Mercy Corps will cover the cost of the consultative workshops. Any additional costs the consultant anticipates incurring during this assignment (including all travel) should be included in the financial proposal.

QUALIFICATIONS AND EXPERIENCE OF THE THREE KEY PERSONNEL

Mercy Corps requires a consultant/firm to carry out the above mentioned scope of work. The required qualifications and experience are as follows:

Team Lead

- Public Health specialist with demonstrated experience developing health strategies for government institutions
- Experience leading desk reviews, rapid assessments, and consultative workshops
- Experience engaging with senior policy makers
- Excellent analytical and professional report writing skills with proven experience
- Ability to work in Quetta

MNCH Technical Specialist

- Excellent background of Maternal, Newborn, and Child Health(MNCH) with over seven years of technical experience
- Should have knowledge of projects and programs in Balochistan working on MDG 4 and 5 including research projects
- Should have experience in analyzing secondary data
- Ability to facilitate technical meetings
- Excellent analytical and professional report writing skills

- Ability to work in Quetta

Costing Expert

- Relevant qualification in costing (such as MBA, ICMA)
- Demonstrated experience costing provincial level strategic plans, PC-1s etc.
- Ability to work in Quetta

SELECTION CRITERIA

S. No.	Criteria	Score
1.	Proposed approach/methodology	30
2.	CVs of key team members– qualifications, relevant experience, length of experience (per the criteria provided above for each of the three key personnel)	25
3.	Quality of the sample report (or strategy) from a previous similar assignment	15
4.	Financial proposal	30

Annex A: Stakeholders consulted by Mercy Corps for developing ToRs for MNCH strategy

S. No.	Name	Designation	Department
1.	Dr. Naseer Ahmed Baloch	DG Health Service	DoH Balochistan
2.	Dr. Dad Mohammad Kakar	Director Public Health	DoH Balochistan
3.	Mr. Taj Raisani	Provincial coordinator MNCH	DoH Balochistan
4.	Dr. Farooq Azam Jan	In charge Health Reforms Unit and Divisional Director Quetta	DoH Balochistan
5.	Dr. Yousaf Bezinjo	Former Program coordinator MNCH	DoH Balochistan
6.	Dr. Nabeela Sultan	Project Manager MCH	DoH Balochistan
7.	Dr. Noor Qazi	Provincial Coordinator, LHWs program	DoH Balochistan
8.	Dr. Tariq Jaffar	Ex- Provincial Coordinator Balochistan	TRF
9.	Dr. Tahira Kamal	Operations Officer	WHO
10.	Mr. Abdullah Khan	Project Director, IMNCI	Save the Children

Annex 12. Comprehensive Table of Year 2 Activities and Outputs

Annex 12. Comprehensive Table of Year 2 Activities and Outputs

Inputs	Activities	Outputs
Staff:	Intermediate Result 1: Increased availability of quality maternal and newborn care in communities	
<ul style="list-style-type: none"> • Maintained project staff in Quetta • Received technical inputs from Islamabad health team and HQ Technical Backstop 	<p>Selection & Registration of CMWs</p> <ul style="list-style-type: none"> • Selection committee (notified by DoH in year 1) selected second batch of 50 CMWs (22 for Quetta, 20 for Kech and 8 for Gwadar) based on selection criteria and procedures revised in year 2 (see Annex 10) • In consultation with LHW Program, project team verified 50 CMWs location and space for workstation • Project orientation sessions held with second batch of CMWs and Memorandum of Understanding (MoUs) between CMWs and MC signed • Completed registration for first batch of 40 CMWs, except for two. • Initialized registration process with PNC for the 24 selected CMWs of Batch 2 who were not already registered (Quetta-11, Kech-6 and Gwadar-7); finalized registration for one. In total 65 out of the 86 CMWs are registered. <p>CMW Refresher Training (for second batch of 50 CMWs)</p> <ul style="list-style-type: none"> • Four week clinical refresher course held in midwifery/public health schools attached to hospitals in each district, including pre/post-tests to evaluate theoretical improvement and observational checklists to gauge clinical skills (see Annex 7 for results of tests). <p>Financial and structural support to CMWs:</p> <p><i>Business Skills training</i></p> <ul style="list-style-type: none"> • Five day Business Skills training for 90 CMWs completed <p><i>Equipment and CMW Birth Kits</i></p> <ul style="list-style-type: none"> • CMW equipment and birth kits procured and distributed to 50 CMWs in Quetta, Kech and Gwadar (batch 2) and 14 CMWs in Kech (batch 1) in all three districts <p><i>Microloans</i></p> <ul style="list-style-type: none"> • Loan agreement with Tameer bank (MFI) signed • List and required data of CMWs, willing to avail loan, shared with the Bank (MFI) • Tameer Bank is in process of physical verification of the CMWs data by visiting CMWs communities <p>CMW Deployment</p> <ul style="list-style-type: none"> • District launching ceremonies held in Kech and Gwadar (conducted in Quetta in year 1) followed by community inaugural meetings to generate ownership of the CMW and her services as a skilled birth attendant • TWG endorsed provision of natal services by CMWs in their workstations and PSC sought official approval from the DoH (Secretary Health). Notification is attached as Annex 9. <p>Technical & Administrative Supportive Supervision of CMWs:</p>	<p>1.1 86 CMWs (38 batch 1 and 48 batch 2) selected, trained and working within properly furnished home-based workstations</p> <p>1.2. 86 CMWs supervised by MC and government staff</p> <p>1.4. DoH tracks uptake of CMW services¹</p>
Partners/consultants:		
<ul style="list-style-type: none"> • Frequent consultations with the government of Balochistan • Frequent consultations with the PNC • SubAward signed with University of Alberta for conducting OR 		
Curriculum for CMW trainings:		
<ul style="list-style-type: none"> • PNC 		

¹ Reports are shared in the DHF, TWG and PSC forums on quarterly basis, while the DHOs, PHS-MNCH of all three districts are shared with the summary of the CMWs services in Internal Review Meetings. Online access to DOH to track progress will be provided in October 2014

Annex 12. Comprehensive Table of Year 2 Activities and Outputs

<p>approved 18 month curriculum and manual used to prepare refresher training curriculum</p>	<ul style="list-style-type: none"> • 40 CMWs (first batch) are regularly supervised by LHVs (Technically) and LHSs (administratively) on quality assurance/supportive supervision checklists which was finalized based on existing MNCH tools in last reporting period. The English translated versions of these checklists are attached as Annex 8. • Technical & Administrative Supportive Supervision of the second batch of 50 CMWs initiated in July 2014 	
<p>Intermediate Results 2: Improved knowledge and demand for essential maternal and newborn care</p>		
<p>Equipment/Supplies:</p> <ul style="list-style-type: none"> • Vehicles rented in Quetta and districts for monitoring & supervision 	<p>Mobile Phone (Note: as depicted in the SW logframe, this activity contributes to both IR1 and IR2)</p> <ul style="list-style-type: none"> • Pak Vista tested and finalized the mobile phone application to enter patient date, mass BCC VOIPs, client reminder (the application was developed, based on DoH R&R forms and in collaboration with key stakeholders -MC, PakVista, CommCare, PSC, and TWG) • Pak Vista trained three master trainers on Mobile phone application • First batch of 37 CMWs provided with smart phones and trained on application by master trainers • 17 CMWs out of 37 trained, have been reporting through mobile phone application; second batch of CMWs are planned to report from October/November • Database and server established where data are automatically updated and report generated and shared with DOH (http://smnc.mercycorps.org) • Mass VOIP BCC messages and client reminder symbols developed, messages translated in 4 local languages (Balochi, Brahvi, Pashto and Urdu) • VIOP messages (Balochi and Urdu) are being sent to pregnant women and their family members of catchment area of 40 CMWs; messages in other two local languages (Brahvi and Pashto) will be disseminated starting October 2014 <p>Women Support Groups:</p> <ul style="list-style-type: none"> • BCC strategy developed based on formative research (Annex 5a) • On the basis of formative research and BCC strategy, WSG existing methodology reviewed and adapted; BCC tools for WSG sessions and CMWs developed, finalized and sent to printer • District teams (Master Trainers) trained on Women Support Group methodologies and curriculum; plans for LHWs and CMWs training on WSG methodology and curriculum developed during the training. CMWs and LHWs training and WSG session are planned for October 2014. 	<p>2.1 Batch 1 CMW clients and family members receive health promotion messages through VOIP</p>
<p>Policies/guidelines:</p> <ul style="list-style-type: none"> • CMW deployment guidelines reviewed, referenced, and followed • Planning Commission – Performa 1 (PC-1) for MNCH program reviewed, referenced and followed 	<p>Intermediate Result 3: Improved access to emergency transport in remote communities</p>	
<p>Evaluations:</p> <p>Continuous</p>	<p>Transport Fund:</p> <ul style="list-style-type: none"> • <i>Mamta</i> funds established for first batch of 40 CMWs (seed money provided by MC) while Mamta funds are planned to be established for second of 50 CMWs in October/November 2014 • MOU signed with Edhi Foundation, (with Al-Falah Ambulance service in case of Kech) not-for-profit ambulance service, to partner on SMNC for promoting referrals for emergency or complicated cases • CMWs also identified local transport vehicles, in their respective catchment areas, for emergency or high risk patients to complement Edhi’s services. This is particularly important for remote communities who are not well served by Edhi. (completed in remaining areas in batch 1, and some areas from batch 2) • Not-for-profit ambulance services and local transport options linked to the <i>Mamta</i> funds 	<p>3.1 40 functioning revolving funds for emergency transport</p> <p>3.2 Vehicles linked with each of 40 revolving fund</p>

Annex 12. Comprehensive Table of Year 2 Activities and Outputs

<p>review of available research and evaluations related to CMWs to ensure our strategy builds on lessons learned, best practices, and challenges experienced in similar context</p>	<p>Intermediate Result 4: Improved policy environment for improved maternal, newborn and child healthcare based on evidence from the Operations Research</p> <p>Operations Research</p> <ul style="list-style-type: none"> • Received IRB approval from University of Alberta and Pakistan Medical Research Council (PMRC) Subaward package for University of Alberta approved by USAID • Baseline survey data collected for the quasi-experimental arm in Quetta and Gwader and pre-post arm in Kech for Module 1 of the OR. A total of 26 SMNC and 26 control clusters were surveyed in Gwader and Quetta and a total of 1508 eligible women interviewed. In Kech, 14 SMNC-CMW clusters were selected and 420 eligible women were interviewed. • Baseline financial data collected in Quetta and Gwader for Module 2 for OR. Baseline financial data was collected from a randomly selected sample of 14 SMNC-CMWs in Quetta and 6 in Gwader. • In-depth interviews were also conducted with these same CMWs to understand the organizational, social, and financial challenges they face in establishing and running their practices and attracting new clientele. • Prior to the collection of survey data, local supervisors and enumerators were hired in all three districts and provided training. <p>Research Advisory Committee (RAC)</p> <ul style="list-style-type: none"> • Research Advisory Committee formed; members include, Director General Health Services, GOB, PC MNCH Balochistan, Director Health and nutrition, Save the Children, representatives from USAID Pakistan, TRF, AKF, TRF, PMRC, PNC, MCHIP-Jhpiego, RAF and MC • First RAC meeting held to orientate members on SMNC and its prospective contributions in improved policy environment for MNCH and to orientate them on SMNC OR, incorporate their feedback to best utilize the finding for policy improvement <p>Provincial MNCH Steering Committee and Technical Working Group</p> <ul style="list-style-type: none"> • Four (quarterly) PSC meetings held; Recommended natal services by CMWs in their workstations and got this notified from DOH (Secretary Health); monitored CMWs in all three district • Four (quarterly) TWG meetings held. Members quarterly reviewed project work plans, progress against plans, (review and provided inputs in development of BCC strategy and tools; VOIP messages, flipcharts, counseling cards), mobile phone application • Monitored CMWs in all three district <p>District Health Forum (DHF)</p> <ul style="list-style-type: none"> • Four (quarterly) DHF meetings held; reviewed plans and progress on district level. Jointly visited CMWs workstation and communities with project team <p>Draft 5 year MNCH Strategy (2015-2020)</p> <ul style="list-style-type: none"> • Scope of Work for draft 5 year MNCH strategy developed on the basis of consultation meetings held with DoH and other key stakeholders • Consultant for the development of draft strategy identified on the basis of competitive bidding process
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- 4.1 OR protocol developed** with stakeholder involvement and **approved** by USAID and IRB (UoA and PMRC)
- 4.2 First RAC meetings** with high participation of all 5 members
- 4.3 1 publication** of OR protocol in BMC
- 4.4 Provincial Steering Committee and Technical Working Group** met quarterly
- 4.5 District Health Forums** met quarterly

Saving Mothers and Newborns in Communities Risk Management Plan **Updated September 2014**

Vulnerabilities	Quantify			Label	Response					Action
	Probability	Impact	Product (PxI)		Avoid	Transfer	Mitigate	Accept	Other	
Security situation and political situation in target districts hampers project implementation	0.4	8.0	3.2	Medium			X			<ul style="list-style-type: none"> • Prevailing security situation will be regularly monitored and Mercy Corps' security management plan and standard operating procedures will be regularly updated, as required, and followed during the course of project implementation. Moreover, coordination with communities and staff of DoH and other stakeholders will be further strengthened. These stakeholders will be kept informed regularly. Specific actions include; staff will develop travel Plan, Security officer will assess the situation and will decide accordingly. Travels can only be allowed after the approval by Security Officer. Staff will update Security officer and/or vehicle tracker assistant regularly throughout the travel

Annex 13. SMNC Risk Management Plan (updated September 2014)

Vulnerabilities	Quantify			Label	Response				Action
Ability of CMWs to repay their loan	0.7	7.0	4.9	High			X		<ul style="list-style-type: none"> • Ensure that doable and context based loan repayment plans are developed. • Ensure that CMWs services charges based on socioeconomic conditions of the area • Ensure that viable and practical marketing plan are developed for CMWs • Regular monitoring and assessment of CMWs business and timely support to CMWs how face problems in repayment. Motivation of CMWs in running their business efficiently • Ensure that CMWs understand that items provided to CMWs of Kech through grant amount are based on project design , in case there is any reaction from CMWs of Gwader and Quetta
CMWs Services fail to reached the most deserving individuals in their communities	0.5	8.0	4.0	Medium			X		<ul style="list-style-type: none"> • Baseline surveys should recommend measures to reach the most deserving communities/individuals • Some assessments in the communities need to be conducted the analysis of the data should suggest ways to reached the most needy • BCC strategy based on formative research is implemented properly • CMWs are sensitized on the equity issues during refresher course and Business skill training • Mini KPC surveys should assess CMWs services coverage
CMWs are not properly supervised in the field while they are providing services	0.5	8.0	4.0	Medium			X		<ul style="list-style-type: none"> • CMWs clinical refresher course covers topic regarding provision of effective services by CMWs in communities • Mechanism need to be in place for the supervisor of CMWs in communities (FOs regular monitoring visits, technical and administrative supervision by LHVs and LHSs) • Ensure proper collection and analysis of service delivery data

Annex 13. SMNC Risk Management Plan (updated September 2014)

Vulnerabilities	Quantify			Label	Response				Action
Regular drop-out of CMWs	0.6	8.0	4.8	High			X		<ul style="list-style-type: none"> • Ensure that doable business plans are developed during Business Skill Training. • Ensuring Government supervision system for CMWs • Effective community sensitization meeting • Ensure MoU, specifying terms and conditions, is signed with every selected CMW • Ensure that CMWs understand the concept and value of SBAs. Ensure the support of family and community members for CMWs through regular coordination and ensure that communities understand the value of CMWs. Ensure that research based WSG methodology is developed and implemented • If CMWs are dropped will be replaced and the new CMWs will be provided clinical refresher training before deployment.
Delays in implementation of activities as per project schedule due to unforeseen issues	0.8	5.0	4.0	Medium				X	<ul style="list-style-type: none"> • Regular review of the program implementation against schedule • Identify bottle necks and take corrective measures • Solicit support from Islamabad office and DoH and other stakeholders • Strong coordination with support departments is ensured • Strong coordination with DoH and keep them informed about upcoming activities
Mobile phone application are not understood by CMWs (Batch 2)	0.3	7.0	2.1	Low			X		<ul style="list-style-type: none"> • Ensure effective and efficient mobile application training • Support CMWs on regular basis on mobile phone application

Annex 13. SMNC Risk Management Plan (updated September 2014)

Vulnerabilities	Quantify			Label	Response				Action
Ensuring m-Health reporting by all CMWs	0.8	7.0	5.6	High			X		<ul style="list-style-type: none"> • CMWs are regularly supported to properly report on m-health application, by giving them orientation in monthly review meetings • Feedback on regular basis from the dashboard updates to keep them motivated • CMWs registers are checked against the mHealth entries and properly guided for corrective measures during field visits •
Communities do not accept communication through mobile phones or don't take BCC messages seriously	0.3	6.0	1.8	Low					<ul style="list-style-type: none"> • Ensure that BCC strategy is based on proper assessment • Ensure the support of WSG in awareness creation and demand generation through regular meetings and solicit and encourage their view in making the appropriate communication strategies • Motivate communities that messages are important for their and their family health through communicating the nexus between health and awareness • The calling number of VOIP messages will displayed in CMWs workstation and CMWs will guided to inform their clients about these VOIP messages
CMWs are not accepted by community as SBAs because, among others, TBAs are already working	0.2	8.0	1.6	Low			X		<ul style="list-style-type: none"> • Take TBAs on-board in WSG forum • Strong coordination of CMWs with TBAs to refer patients to CMWs on timely basis • Ensure that CMWs have required skills before deployment through analyzing pre and posttest and clinical skills assessments. • Ensure CMWs are introduced in their communities as skill birth attendants in collaboration with DOH and community elders • Ensure establishment and effective functioning of WSG • Awareness and demand generation is communities

Annex 13. SMNC Risk Management Plan (updated September 2014)

Vulnerabilities	Quantify			Label	Response				Action
Community is unable to pay for CMWs services	0.2	7.0	1.4	Low				X	<ul style="list-style-type: none"> • Free/ minimum fee or payment or payment in-kind for poor members • Project team motivate CMWs to work with commitment in their workstations to build strong coordination with community influential and trust on community members who can further motivate other community members for payment • Project team guide CMWs to manage their income and expenses in a way to already consider a number of clients in a month who wouldn't pay, in order to sustain their business – financially.
2 nd Batch of CMWs in Kech react against grants given to CMWs in Batch 1	0.6	7.0	4.2	Medium				X	<ul style="list-style-type: none"> • Bound CMWs in contracts/MoUs signed with them • MoU on loan with Tameer bank • Ensure that CMWs understand that the arrangements are based on project design

Calculations:

Impact Score is from 1 to 9 (1 = Very Low, 9 = Very High)

Probability is 0.1 to 0.9 (0.1 = Very Low, 0.9 = Very High)

Product:

0.1 to 2.0

Low

2.1 to 4.4

Medium

4.5 to 8.1

High

Zohra Hanif (Successful Entrepreneur)

I learned ways to expand my entrepreneurial setup and business skills and now I am earning a better livelihood.

Zohra Hanif is a very poor widow from an insecure and volatile area (Sariab Road) of Quetta. Her father is not alive anymore and her siblings pay no interest to her piteous life. She has a four year old son and two daughters, 7 and 8 years old respectively. Being a widow and alone has been difficult for her. She registered all three children in a nearby private school and it has been challenging to manage everything, particularly the school fees and transportation. She used to cater their expenses by sewing clothes to community members and improvised her living within that low earning.

In mid 2013, she was selected as a Community Midwife (CMW) in her community (Killi Kamalo, Sariab) for Mercy Corps' SMNC project. She received clinical refresher training on midwifery where she improved her skills on maternal and newborn healthcare. Soon after the training, the program provided her with the necessary equipment to offer midwifery services at her home. Though there was no room for all the equipment, she promised to arrange it in two months. In October 2013, she received training on business skills and ways to expand her small business by developing linkages with influential women in her community and providing value-added packages with the basic midwifery services.

She was very active providing maternal and newborn services and continued sewing clothes as a value added package. At first she had no room for a workstation but from her little savings she managed to establish one. The space of her workstation was not ideal, yet she carefully looked after the hygiene of that unpaved mud-made room.

In December 2013 she submitted her first monthly report, on the government MNCH reporting tool, for the services she had delivered at her workstation. She attended 15 antenatal clients and 2 deliveries, in a catchment area of approximate of 2800 persons. Zohra developed good coordination with a TBA (*Dai*), of her community who referred her with clients. .

“I had low acceptance in my community as a skilled birth attendant due to the well known TBAs. I negotiated terms with the TBA to refer clients to me and in return, I agreed to pay her a considerable amount for those referrals. Now she refers clients not only from my community but whoever consults with her, she refers them to me. These clients and sewing children clothes have helped me to earn a better livelihood and now I can easily manage my basic needs and the education of my children.” says Zohra.

Now, Zohra's children study in a better English medium school, and in the evening take after school classes using a paid van for transportation. The family lives in a rented well paved home. She is one of the best CMWs of our First Batch in Quetta. She has established strong coordination mechanisms with the TBAs (*Dai*) who bring her delivery cases. Until August, 2014 or during the last eight months she has served around 250 clients including 144 antenatal visits and 26 deliveries. .

A skillful person never sleeps hungry but paves path to success

Prepared by: Mazhar Iqbal, M&E Officer | SMNC Project | Mercy Corps Pakistan

Rahat Noor (Nominee of *Excellence in Midwifery: 2014 International Midwifery Award*) –A Success Story

Rahat Noor, a midwife saves lives in Balochistan

Community Midwives are not well known as skilled birth attendants (SBA) in the communities of Pakistan, particularly in the area of Malikabad in the Kech district of Balochistan where the influx of the *Marrri* tribe –coming from the other volatile areas of Balochistan – is high. These people earn their livelihoods by breeding cattle and working in the agricultural farms of the local community. They are normally reluctant to use the health facilities for pregnancies and deliveries. In addition, Traditional Birth Attendants (*Dais*) are quite active in such settings given the community members’ preference to avoid traveling to the health facilities. *Dais* have good income from this community, however they don’t practice good Maternal Neonatal and Child Health (MNCH) standards for deliveries, particularly those related to hygiene. In this scenario, having a community based SBA, who doesn’t only provide quality MNCH services but also raises awareness among the community, is a blessing.

In 2008, when Rahat Noor was in tenth grade, a woman died while giving birth to a baby: “*A woman died in my neighborhood while giving birth to her baby and no one in our community was trained enough to save her life*”, said Rahat. Thus, she opted to be a community midwife. In 2009 she graduated as a midwife after completing the government’s 180month course at the Turbat Public Health School. Afterwards she worked voluntarily in the Turbat District Headquarters hospital for two years. She did not have the resources to offer midwife services in her community, but she didn’t let her morale down. She was accepted in the Saving Mother and Newborns Communities (SMNC) project and she completed the four-week refresher training as one of the best trainees –conducting nine independent deliveries against a minimum standard of five, which was more than any other Community Midwives (CMW) of her batch in the Kech district. Later she was re-deployed as a CMW in her community Malikabad.

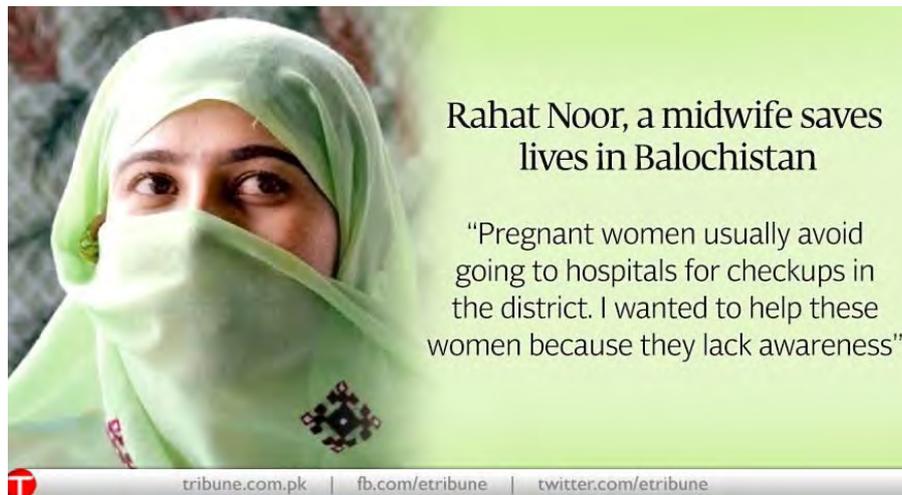


Rahat Noor, monitoring her clients blood pressure at her workstation in Malikabad, district Kech

In December 2013, Rahat received the necessary equipment and medicines to install a midwifery workstation at her home. Pursuing her objective, Rahat started serving her community: “*Pregnant women usually avoid going to the hospitals for check-ups in the district, I wanted to help these women because they lack awareness*” she said. Being a well-known SBA in such communities is a complicated job, but today she ensures a high clientele, by

providing quality care and raising awareness among the pregnant women she sees. Only a few women came to her in the early days, but this helped her to develop confidence not only in Malikabad but also in the surrounding areas. On the basis of her quality services provision, she was nominated for the *Excellent in Midwifery: 2014 International Midwifery Award* for the International Confederation of Midwives conference held in Prague, summer of 2014. “*I was overexcited when I heard about my nomination for an International Award but I am equally satisfied with the efforts I have been making to bring behavioral change in my community*” said Rahat.

In April 2014, an international organization selected Rahat Noor from district Kech and another CMW from Peshawar as the two best CMWs in Pakistan. The organization celebrated the Midwifery Day 2014 in Quetta where the Chief Guest – the Health Minister of Balochistan – presented the awards and cash prizes to Rahat and the other CMW. The Tribune Newspaper, April 23rd 2014, published the story of Rahat Noor as a CMW.



Based on her prior achievements, in May 2014, Rahat Noor participated and delivered a presentation about her services in a conference on maternal health, held in Islamabad.

Rahat is one of the most active CMWs of the SMNC project who ensures her presence in every meeting and training organized by the project. She reports regularly using a smart phone based application, provided by the project.

A commitment to excellence will enable you to attain the success you seek!

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Annex 15
SUMMARY OF SECURITY INCIDENTS IN CSHGP DISTRICTS; KECH,
GWADER AND QUETTA
(OCTOBER 2013 TO SEPTEMBER 2014)
SAVING MOTHERS AND NEWBORNS IN COMMUNITIES

QUETTA– SECURITY SITUATION ASSESSMENT

Quetta district is sharing an international border with Afghanistan and bordering with Noshki, Mastung, Harnai, Ziarat and Pishin districts. Quetta city as a whole is being affected by deteriorating security situation on a daily basis.

Below mentioned table summarizes the nature of incidents;

Terrorism	There have been witnessed efforts from Provincial government and Law Enforcement Agencies to curb down the hideouts of extremist/militant groups operating the district. But on the other hand almost all militant and extremist groups are continuously involved in deteriorating the peace keeping initiatives of government in the city by exploding VBIEDs, RCIEDs, stand-Off attacks, armed attacks and SAF attacks against Shias, law enforcers, government installations. The havoc of terrorizing the masses is floating up and down from time to time.
Armed Groups	It looks little hard to count upon the armed groups because from very rightist divergent extremist groups TTP, L-e-J, A-u-I to nationalistic insurgents BLA, BRA, UBA are found active in length and width of Quetta district. However, there has reported very recently in news called United Baloch Front (UBF) claiming for many incidents against settlers over the period of last 2 months in Quetta city.
Crimes	News track records have been observed with up-going grades with regard to street crimes of abduction, robbery, car/motorcycle snatching, and bank robberies in the city. It is therefore, good governance has become a dream in the city and people feel insecure due to the crimes rate in the city. Every city good person is concerned with its safety and security against the rampant criminalities in the district.
Civil unrest	It may not be wrong to say that all communities in Quetta standing at the brinks of mental agony due to effects of wrong place and wrong time incidents. Business in the city is also very much disturbed due to the incidents of hand grenade attacks, robberies and car-snatching.

TREND ANALYSIS OF SECURITY INCIDENTS IN DISTRICT QUETTA (OCTOBER 2013 TO SEPTEMBER 2014)

Nature of incidents	Description
Stand-Off Attacks	
Suicide Attacks on Shia Community	There has been seen a downwards tendency in sectarian killings as compare to previous years, only one suicide attack reported during the year on January 1 st at Akhtar Abad area of Quetta city when unidentified armed men targeted convoy of buses carrying returnee pilgrims of Shia community by a car fitted with 100 kg of explosive material. Resulting in 3 persons were killed and 35 others were injured. The pilgrims were coming from Iran after performing religious rituals. The spokesman of Jesh-ul-Islam (J-u-I) claimed responsibility. Moreover, very few incidents of sectarian target killing were reported in the city.
Stand-Off Attacks	Only 3 Stand-Off Attacks reported during the year without any casualties in the month of august
IED Attacks	55 IED explosions were reported against the security forces, LEAs, government installations and political parties.
IEDs Defused	17 IEDs were recovered and defused by LEAs
Bullet-riddled bodies	119 bullet-riddled dead bodies were recovered.
Target killings	Total 56 incidents of target killing reported during the period in which 68 persons including shia community, Policemen, political workers, government employees and settlers were killed.
Abduction	46 persons were kidnapped during the year
Criminal incidents	186 persons were killed in different violent criminal incidents.

KECH – SECURITY SITUATION ASSESSMENT:

Kech district is sharing an international border with Iran, and bordering with district Gwadar, Awaran and Panjgur. Kech has been observed with most devastating IED attacks, armed attacks, and stand-off attacks against security forces, law enforcement agencies and private construction companies.

Below mentioned table summarizes the nature of incidents;

Terrorism	The evil of ambush and non-locals killings by Baloch militants and the forced disappearances and the cases of bullet riddled bodies by unknown actors have become the order of the day in the district.
Armed Groups	Almost all Baloch Militant organizations are involved with a vigorously high strength in deteriorating the law and order situation of district by planting IEDs, launching armed attacks, and taking part in ambush incidents against security forces' personnel. Among armed groups Baloch Republican Army and Baloch National Front (BLF) have the record of greater share for attacks on security forces and alleged local informers of Intelligence Agencies. The most volatile areas

	for such incidents are Thump and Mund tehsils.
Crimes	The absence of the writ of the government in the peripheries of the district contribute more in increase of street crimes such are the cases of abduction (forced disappearances), car snatching, robbery and smuggling.
Civil unrest	Very frequent demonstrations, shutter-down strikes and the feelings of insecurity by pro-Pakistan political parties' workers have dragged the masses around the precincts of social unrest because local business suffers lots due to closure of markets and government offices. People are hopeless owing to their instable social structure which is getting tarnished. Thus, Terrorism, militancy and other street crimes have inculcated civil unrest among the people.

TREND ANALYSIS OF SECURITY INCIDENTS IN DISTRICT KECH (OCTOBER 2013 TO SEPTEMBER 2014)

Nature of incidents	Description
Stand-Off Attacks	Only 8 Stand-Off Attacks reported against construction company camps and security forces checkpoints
IED Attacks	11 IED explosions were reported against the security forces, LEAs, government installations.
Armed Attacks and grenade attacks	Total 93 incidents of RPG and SAF attacks were reported against security forces convoys, checkpoints, police & levies checkpoints and private construction companies and political parties' workers
Bullet-riddled bodies and assassinations	41 bullet-riddled dead bodies were recovered from different areas of the districts – most of them haven't been claimed by any group.
Abduction	19 persons were kidnapped during the year

GWADAR – SECURITY SITUATION ASSESSMENT

Gwadar shares the international border with Iran and a coastal area of Balochistan and has improved to a reasonable degree against militant Baloch ideology. However, its Pasni Tehsil is observed with some IED and armed attacks over the period.

Below mentioned table summarizes the nature of incidents;

Terrorism	Target killings and the forced disappearances and the cases of bullet riddled bodies by unknown actors have caused the district to a state of terrorist activities.
Armed Groups	There are many Baloch Militant organizations operating in the district such are BLF, BRA and BLA. But Baloch Liberation Front (BLF) secures the greater booty for armed attacks against security forces, moderate political workers and alleged local informers.
Crimes	The lack of governance and lawlessness in the outskirts has inspired an increase in street crimes. Very few but still existent threats of abduction and car-snatching and robberies have caused fear and chaos among common masses
Civil unrest	People have gone economically bankrupt due to the hegemony of oil smugglers

	on sea water. Majority of the fishermen couldn't earn their livelihood due to the control of oil smugglers on sea water by polluting the sea and creating threat to the poor fishermen due to the nature of their business. So, social and economic instability origin social unrest among the inhabitants of the district.
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TREND ANALYSIS OF SECURITY INCIDENTS IN DISTRICT GWADER (OCTOBER 2013 TO SEPTEMBER 2014)

Nature of incidents	Description
Stand-Off Attacks	Only 2 Stand-Off Attacks reported against construction company camps and security forces checkpoints
IED Attacks	03 IED explosions were reported against the security forces including the RCIED attack near the vehicle of MNA's son in Pasni Town
Armed Attacks and grenade attacks	Total 17 incidents of RPG and SAF attacks were reported against security forces convoys, checkpoints, police & levies checkpoints.
Bullet-riddled bodies and assassinations	06 bullet-riddled dead bodies were recovered from different areas of the districts – most of them haven't been claimed by any group.
Abduction	Only 3 incidents of abduction were reported during the period

Analysis of Significant Incidents and Developments (Challenges)

1. The sectarian killings once gaining strength in capital city and adjacent districts, conversely the insurgent clashes with security Forces and as well as settler killings have been with a rise in the Province
2. TTP attacks on prominent government installations in Quetta attacking the Samangli and Khalid Air-bases and the very frequent IED attacks, hand grenade attacks have shown the capability of extremist/militant groups to strike the symbol of the Provincial power.

Most Significant Risks to MC operations/staff

S.#	Risk	Current Risk Level	Residual Risk Level (After Implementation of SOPs)
1	Kidnaping for ransom	Medium	Low
2	Abduction	Medium	Low
3	IED	High	Medium
4	Earthquake	Medium	Medium

5	Complex terrorist attack	Medium	Medium
6	Traffic accident	Low	Very Low
7	Direct small arms attack	Low	Very Low
8	Crossfire	Medium	Low
9	Car theft/ hijacking	Low	Low
10	Sectarian killing	Low	Very Low

General Advisories for staff travelling in the field:

Road travel is potentially the most hazardous activity INGO staff undertake; it is estimated that around 70% of safety and security incidents involving INGOs take place when they are traveling by road. Journeys need to be planned and executed properly if they are to be carried out safely.

It is strictly advised that non local staff members (not belonging to Balochistan/settlers) should avoid travelling to Gwadar and Turbat. In case it's very necessary, the staff member must avoid road travel and use air travel instead.

Air travel to these two districts should be the preferred mode of travel from Quetta.

Staff must avoid all kind of political discussions and should remain completely apolitical.

TRIP PLANNING AND PREPARATION

- Always get information from the Security Focal Point (SFP) before the journey and make a final check just before leaving for the field visit to districts.
- Always travel in an approved vehicle, whether it is official vehicle, locally hired vehicle or personal transport.
- Complete the Mercy Corps Field Trip Request (FTR) form, attached as Appendix 1 to Travel SOP in Annex-C refers to S&SMP. The signed FTR has to be submitted for clearance to Security Officer. Once cleared, signed copy of the FTR must be submitted to the Transport Movement Assistant.
- Plan your journey to keep within timing restrictions. These are:
 - No travel after dark except in an extreme emergency e.g. lifesaving journeys
 - Travel only during hours of daylight
- Have the correct communications and ensure they are working – mobile phone (according to the concerned company network availability) with the main networks and enough credit. Ensure the batteries are fully charged.
- Make sure you have any emergency contact information along the route e.g. rural police telephone numbers/locations

- When visiting sites, be careful about giving out advance information regarding your plans. Provide your travel information only to the people who need to know.
- Ensure a full vehicle check is completed before and after journeys in accordance with Appendix 2 to Travel SOP in Annex-C refer to S&SMP.
- Avoid law enforcement agency buildings, military installations and political public gatherings
- Enhance your internal communication with SO/TMA and report immediately about any planned or ongoing demonstrations, any suspicious activity, or any security-related incident

TRAVELING

- Never stop for a vehicle that appears to hit you deliberately – it might be an attempt to rob or kidnap you
- Keep vehicle doors locked at all times and never open windows more than 4 or 5 cms where necessary
- Expatriates should sit in the back of the vehicle where they are less noticeable to an onlooker. Removable window blinds are also recommended.
- Stopping on the way during traveling is strictly prohibited; avoid taking pictures unless necessary for project activities and after taking consent from the beneficiaries
- Strictly avoid carrying laptops, expensive/attractive mobile phones, and official documents about Mercy Corps, project or the donor.
- Try not to be alone on the road. Follow a public transport vehicle or a group of vehicles at a safe distance.
- Always maintain a safe distance from security forces convoys and vehicles
- Vary time, route and vehicle to office/field if possible
- Ensure high value items are stored in the trunk and out of view
- Be vigilant and strictly following all travel, communication and counter-surveillance techniques/protocols of Mercy Corps' Security Management Plan and SOPs
- Drivers and staff have to remain vigilant, keep watching side and rear view mirrors, be aware of anyone chasing you. Most of the abduction/kidnapping incidents follow intensive surveillance and planning. In such cases, go fast or stop near public crowded/busy place and inform your Security Officer/Team Leader. You may be advised to inform nearby police stations/checkpoint.

VEHICLE:

- Ensure the driver always remains within legally permitted speed limits and appropriate to road conditions
- Make sure that the driver has checked the vehicle according to Mercy Corps vehicle checklist
- Make sure original documents are in the vehicle; license, insurance etc. The passenger should support and remind the driver from time to time about SOPs and brief him accordingly.
- During travelling vehicle speed limits must be followed
- *For detailed SOPs, please refer to the Vehicle protocols in Annex-C "SOPs" of Security Management Plan*

TRACKING:

- Complete the Field Trip Request (FTR,) Inform the transport officer, SFP and Transport Movement Assistant (TMA) of movements and contact details

- Ensure that your position is known at all times, provide a communication plan, detailing what time the vehicle passenger will make the first location report. Subsequent reports are to be made every 30 minutes to check on your progress and location. Tracking is done through mobile text messaging; however a reply must be received in order to confirm communications.
- Two way tracking must be ensured throughout the trip. In the event of location calls not being received, the TMA will contact the driver or other passengers. If contact is not established, the TMA/SFP will immediately inform the Security Advisor/Team Leader who will initiate the missing staff Contingency plan.

CHECKPOINTS:

- The vehicle should come to a complete stop at all checkpoints. Open the window and exchange courteous conversation with the policeman or soldier.
- Let the driver do the talking or if anyone can communicate in the local language
- Do not operate any communication equipment at checkpoints
- In case of authorized night travel, dim the headlights and turn the interior light on
- Switch off radio or stereo well before reaching the checkpoint
- Stay in the vehicle and keep the doors locked. Talk through a partially opened window if you have to. Keep the engine running.
- Make sure you can account for everything in the vehicle e.g. packages, cargo etc.
- Comply with requests for search of the vehicle but always accompany the searcher to make sure nothing is planted or stolen. If traveling alone, switch off the engine and lock the doors when the trunk is being searched
- Have the necessary documents (NIC, vehicle registration etc.) ready, if requested. Do not move quickly to reach the documents whilst stopped at a checkpoint. Keep hands in sight.
- Always be polite, calm, cooperative and respectful
- While leaving the checkpoint keep watching in the side/rear-view mirrors, you might be asked or signaled to stop again
- Do not transport unauthorized passengers

LOW PROFILE AND VISIBILITY:

- Mercy Corps adopts low visibility and in certain cases a no visibility approach. This is to support our security strategy and help for mitigating the risks
 - Low visibility includes; project identification, advertisements, or any other public activity or event.
 - Mercy Corps identification/logo will not be used at project sites, vehicles and documents.
-