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ANNEXES: MID-TERM EVALUATION OF THE USAID/PAKISTAN MATERNAL, NEWBORN AND CHILD HEALTH PROGRAM

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PAIMAN REPORT ANNEXES

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACRONYMS

AMTSL	Active management of the third stage of labor
ANC	Antenatal care
BCC	Behavior change and communication
BEmONC	Basic emergency maternal and newborn care
CAM	Communication, advocacy, and mobilization
CCB	Citizen Community Board
CDK	Clean delivery kits
CHW	Community health worker
CIDA	Canadian International Development Agency
CMW	Community midwife
CEmONC	Comprehensive emergency maternal and newborn care
COP	Chief of Party
DFID	United Kingdom Department for International Development
DHIS	District Health Information System
DHMT	District health management team
DHQ	District headquarters hospital
EDO	Executive District Officer
EPI-MIS	Expanded Program on Immunization Management Information System
EMNC	Essential maternal/newborn care
ENC	Essential newborn care
FATA	Federally Administered Tribal Areas
FBC	Facility-based committees
FGD	Focus group discussion
FOM	Field Operations Manager
GOP	Government of Pakistan
HCP	Health care provider
HMIS	Health Management Information System
ICHP	Improved Child Health Project
IMCI	Integrated Management of Childhood Illness
IPC	Interpersonal communications
JHU/CCP	John Hopkins University Center for Population Programs
JSI	John Snow, Inc.
JICA	Japanese International Cooperation Agency
LHV	Lady health visitor
LHW	Lady health worker
LHW-MIS	Lady Health Worker Management Information System
LQAS	Lot quality assurance sampling technique
MAP	Midwifery Association of Pakistan
M&E	Monitoring and evaluation
MIS	Management information system
MNCH	Maternal, newborn, and child health

MNH	Maternal and newborn health
MOH	Ministry of Health
MOPW	Ministry of Population and Welfare
Norad	Norwegian Aid
PAIMAN	Pakistan Initiative for Mothers and Newborns
PDHS	Pakistan Demographic and Health Survey
PIMS	Pakistan Institute for Medical Science
PNC	Postnatal care
QIT	Quality improvement team
RHC	Rural Health Center
RMOI	Routine monitoring of output indicators
SBA	Skilled birth attendant
SO	Strategic objective
TBA	Traditional birth attendant
THQ	Tehsil headquarters hospital
TT	Tetanus toxoid
VHC	Village health committee
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WMO	Woman medical officer

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ANNEX A: SCOPE OF WORK

MID-TERM EVALUATION MATERNAL NEWBORN AND CHILD HEALTH PROGRAM USAID/PAKISTAN

(FINAL: 04/27/08)

I. PURPOSE

The purpose of the subject evaluation is to provide the United States Agency for International Development's Mission to Pakistan (USAID/Pakistan) with an independent mid-term evaluation of its Maternal Newborn and Child Health (MNCH) programs. The MNCH programs are managed by the Office of Health and implemented primarily by two organizations, John Snow Inc.¹ and Save the Children,² both functioning under Cooperative Agreement mechanisms. The evaluation team will also be asked to include suggestions for the program design component (e.g., future directions) for potential expansion of the MNCH program. A program design activity by a separate team will follow this evaluation activity.

As part of USAID/Pakistan's due diligence, a mid-term evaluation is being commissioned to assess the effectiveness of the program components, document lessons learned, present results achieved to date, and provide recommendations for overall program improvement and strengthening.

Recommendations for the follow-on project after the completion of the current projects will also be presented in a separate section of the report but as part of the evaluation for internal USAID use only. Suggestions for program design and scaling up for a more substantial program expansion should also be included in the evaluation report.

Taking into consideration the challenges and constraints of the current working environment, the objectives of the evaluation are to

- Assess whether the MNCH program partners are achieving intended goals and results and meeting benchmarked activities in the cooperative agreements and work plans.
- Evaluate the effectiveness (objectives and results) of the management structures, administrative support, cost and partnerships, and collaborative plans.
- Evaluate the effectiveness of key technical components and approaches of the MNCH program given the health status and sociocultural and religious context in Pakistan.
- Establish whether the overall demand for maternal child health services is growing in project districts as a direct or indirect result of these projects.
- Document lessons learned and provide discrete management, administrative, and technical recommendations for improving overall efficiency and effectiveness in the context of the Ministry of Health programs in maternal and child health and related areas.
- Review the findings, conclusions, and recommendations and provide brief suggestions/options for future directions of the program with the potential for program expansion at various levels of additional funding. For example, what would the program look like with an additional \$5–\$20 million per year? What would be the team's recommendations

¹ JSI PAIMAN \$50m five-year Cooperative Agreement 2005–2009.

² SAVE The Children \$11.5m three-year Cooperative Agreement 2007–2009.

for expanding the program in the current programmatic or geographic areas or adding program areas and districts?

- Provide key inputs, background information, and methodology suggestions that can be incorporated into an SOW for the final project evaluation in 2009.

Findings and recommendations will be used to ensure that the MNCH program serves the overall objective of improving maternal, newborn, and child health in Pakistan in the most effective way.

This mid-term evaluation will be shared with partners but not widely distributed. Sections of the evaluation may be shared with outside sources at the discretion of USAID management. The separate design/future directions section of the report will be kept for internal USAID use only.

II. BACKGROUND

Pakistan's maternal and newborn mortality rates are high despite an extensive health service delivery network. The problem is well described in a qualitative study conducted by JSI's MotherCare Project that found that awareness of major maternal and newborn complications among women, families, and attendants is insufficient. Most maternal and newborn deaths occur at home without a skilled health provider attending. According to available statistics, over 65 percent of women deliver at home. Trained health professionals conduct only 5 percent of these deliveries. Also, a high total fertility rate (4.1) continues to expose women and children to increased risks of mortality and morbidity.

Many traditional social values discriminate against women, lowering their status and affecting their food intake and nutrition, education, decision making, physical mobility, and health care. Husbands, in-laws, and religious and community leaders all play significant roles in these customs. Women, families, and providers focus little attention on behaviors related to preventive care and planning for potential maternal and newborn emergencies. In addition, only a few women, families, or attendants are aware of newborn complications like fever, respiratory problems, pre-maturity, and cord infection.

Although Pakistan has an extensive network of public sector delivery facilities, they reach only about a third of the country's population: the rest (70 percent) is served by the private sector, at least for curative services. The public sector health program is still the main service delivery mechanism for isolated rural communities and for preventive services. It needs improvements in several areas, including physical facilities, safe water supply, privacy for female clients, supply of drugs, logistics and equipment, and provider capabilities, especially in counseling and clinic management.

Health facilities are underutilized. They require better linkages with the communities they intend to serve. Lack of availability of providers, especially female providers, at public health facilities needs to be addressed. While most curative services are provided through private providers, private sector health services in Pakistan are unregulated, raising questions of quality. While the Government of Pakistan (GOP), as part of its devolution strategy, promotes delegation of health services planning and management responsibilities to the districts, management systems at the district level, including referral systems, supervisory systems, health information systems, and coordination between public and private sectors, are weak.

The Constitution of Pakistan guarantees basic human rights to all citizens, which includes equitable access to health and social services. The GOP is aware of the huge burden of preventable deaths and morbidity among women and children and is committed to improving their health status. Unfortunately, concerted efforts to improve the health of mothers and children have been lacking. Short-term localized programs and projects have failed to achieve significant and sustainable improvements in MNCH indicators. Such improvements can only be achieved

through a national-level, comprehensive, focused, and effective program that is owned and managed by the districts and is customized to meet each district's specific needs.

In 1990 Pakistan adopted its first National Health Policy to provide vision and guidance to the development of the national healthcare delivery system. Its goal was to provide universal coverage through enhancement of trained health manpower. The policy put emphasis on maternal and child health and primary health care. The National Health Policy was revised in 1997 to introduce a vision for health sector development by 2010.

The National Reproductive Health Services Package (NRHSP) was introduced in 2000 jointly by the Federal Ministries of Population Welfare and of Health. Its effectiveness and application since its introduction have remained incomplete and unsatisfactory.

In June 2001 the Federal Cabinet approved the current National Health Policy, which envisages health sector reforms as a prerequisite for poverty alleviation, gives particular attention to strengthening the primary and secondary tiers of health services, and calls for the establishment of good governance practices in order to achieve high-quality health services.

The Population Policy of Pakistan (2002) focuses on integration of reproductive health services with family planning, building on the successful elements of the program, increased participation of the private sector, greater emphasis on social marketing, and enlarging the scope of family planning services. The Ministry of Population Welfare has shifted its emphasis in mass communication campaigns from population control to women's health.

The Ten-Year Perspective Development Plan 2001–2011 places emphasis on improving the service delivery mechanisms for reducing preventable diseases. The policy focus is on a continuous shift from curative to promotion and preventive services through primary health care.

Pakistan is signatory to several international agreements regarding improving MNCH, including the Millennium Development Goals (MDG) in MNCH, which are:

Goal 4—Reduce child mortality by two-thirds, between 1990 and 2015. The indicators to measure progress toward this MDG include under-5 mortality rate, infant mortality rate (IMR), and proportion of 1-year-old children immunized against measles. Pakistan's target is to reduce IMR to 40 per 1,000 live births and to increase the measles immunization rate to >90 percent by 2015.

Goal 5—Improve maternal health by reducing the maternal mortality ratio (MMR) by three-quarters, between 1990 and 2015. The indicators to measure progress toward this MDG include the MMR and the proportion of births attended by skilled health personnel. Pakistan's target is to reduce MMR to 140 or less, and to increase skilled birth attendance to 90 percent by 2015.

In addition, Pakistan envisions increasing the contraceptive prevalence rate to 55 percent, increasing the proportion of pregnant women receiving antenatal care from the current 61 percent to 100 percent, and reducing the total fertility rate from 4.1 to 2.1 by 2015 (DHS 2006–07).

The Pakistan Planning Commission Form 1 (PC-1) for the National Maternal Newborn and Child Health states that in all districts of Pakistan maternal newborn and child health care services will be strengthened for the population through improving primary health facilities, secondary hospitals, and referral systems and placement of skilled birth attendants at the community level in rural areas and underserved urban slums. One of the most important areas identified by the government of Pakistan has been a focus on poverty reduction. The current Minister of Health emphasizes "pro-poor" activities as his focus as well. The MNCH development partners are working on the development and revision of a Logical Framework of activities for the National MNCH Program prior to the actual start of the program in early 2008, likely following the national elections.

Several other foreign assistance programs are focusing efforts on MNCH, including the British, Norwegians and Australians. United Nations programs addressing MNCH include UNICEF and UNFPA. The two primary MNCH implementing partners for USAID are John Snow Inc. (JSI) and Save the Children. Their project summaries are included here.

Pakistan Initiative for Mothers and Newborns (PAIMAN) John Snow Inc.

Effective maternal and newborn care consists of a continuum of health care interventions, beginning before pregnancy and covering the prenatal, delivery, and postpartum periods, and addressing the individual health of women and children. In the Pakistan context, in order to have an immediate effect on mortality rates, the focus must be on labor, delivery, and the immediate postpartum period—from the onset of labor through day 7. The PAIMAN project promotes skilled attendance as the long-term goal for all deliveries in Pakistan. The project LOP is 10-08-04 to 09-30-09; funding level is \$56,243,858 (Annex 5).

Evidence in the public health literature shows that the maternal and neonatal survival depends upon a whole set of sociocultural, economic, and geographic determinants in the Pakistan context. These factors need to be addressed to generate comprehensive and sustainable solutions to the problem of maternal and neonatal mortality. The MNCH program therefore calls for a multipronged strategic approach, combining individual health care with public health and community-based interventions.

The JSI team bases the continuum of care represented in the MNCH program on a strategic framework referred to as “The Pathway to Care and Survival,” which follows a series of steps necessary to increase the likelihood of survival of a mother and her baby in the event of complication or illness. At each step, Pakistani women and children face various interrelated issues that prevent them from reaching quality care and threaten their subsequent survival. We have classified these issues in five main categories:

1. Lack of awareness of risks and appropriate behaviors related to reproductive and neonatal health issues, resulting in poor demand for services
2. Lack of access (both geographic and sociocultural) to and lack of community involvement in MNCH services
3. Poor quality of services, including lack of adequate infrastructure in health facilities
4. Lack of individual capacity, especially among skilled birth attendants
5. Weak management environment and lack of health services integration.

For each of these “problem categories” PAIMAN has defined a program objective and a series of interventions to address them.

PAIMAN Program Goal and Objectives

Goal: To reduce maternal, newborn, and child mortality in Pakistan, through viable and demonstrable initiatives and capacity building of existing programs and structures within health systems and communities to ensure improvements and supportive linkages in the continuum of health care for women from the home to the hospital.

Objectives:

Based on the “Pathway to Care and Survival” framework, PAIMAN has the following program objectives, interventions, and outcomes:

- 1. Increase awareness and promote of positive maternal and neonatal health behaviors.**

Outcomes:

- Enhanced demand for maternal, child health, and family planning services through a change in current patterns of health-seeking behavior at the household and community level.
 - Increased practice of preventive MNH-related behaviors.
- 2. Increase access (including emergency obstetric care) to and community involvement in maternal and child health services and ensure services are delivered through health and ancillary health services.**

Outcomes:

- Higher use of antenatal and postnatal care services, births attended by skilled birth attendants, contraceptive use, tetanus toxoid coverage, enhanced basic and emergency obstetric care, and reduced case fatalities.
 - Reduced cost, time, and distance to obtain basic and emergency care, ultimately saving newborn and maternal lives.
- 3. Improve service quality in both the public and private sectors, particularly related to the management of obstetrical complications.**

Outcomes:

- Greater utilization of services to improve maternal and newborn health outcomes.
 - Decreased case-fatality rates for hospitalized women and neonates.
- 4. Increase capacity of MNH managers and care providers.**

Outcomes:

- Increased skilled attendance for deliveries in the target districts.
 - Decreased case-fatality rates for hospitalized women and neonates.
- 5. Improve management and integration of services at all levels.**

Outcomes:

- District MNH plans and budgets available.
- HMIS information used for MNH decision making.
- Better coordination between public, private, and community health services.

Beneficiaries:

The project will work with communities, government, and local nongovernmental organizations (NGOs) to strengthen maternal, neonatal, and child health to increase the health status of women and children. It is estimated that the program will reach an estimated 2.5 million couples, and nearly 350,000 children under 1 year of age will benefit from the program. As beneficiaries of the program, PAIMAN has identified married couples at reproductive age (15–49) and all children under 1 year of age.

PAIMAN Time Frame

PAIMAN originally planned to begin working in three or four districts and gradually phase in the remaining districts. In actuality they started activities in all ten districts from the beginning of the project. In December 2007 PAIMAN expanded activities in the FATA in Khyber and Kurram

Agencies and Frontier Regions Peshawar and Kohat. PAIMAN also began working in Swat district in April 2008.

Improved Child Health in FATA, Save the Children

Pakistan is lagging behind most countries in South Asia in terms of child health indicators. The under-5 mortality rate (U5MR) is estimated at 103/1,000 live births and IMR at 81/1,000 live births. Of the 560,000 under-5 deaths reported in 2001, 19 percent were due to pneumonia and diarrhea each, 18 percent to perinatal causes, 7 percent to measles, 5 percent to malaria, and 32 percent to other causes. Only 60 percent of children are immunized for measles at 1 year of age, and the overall chronic malnutrition rate among children less than 5 is 58 percent. A recent *Lancet* article estimated the neonatal mortality rate (NMR) at 57/1,000 live births, almost as high as Afghanistan and considerably higher than India or Bangladesh. Eighty percent of deliveries are conducted by an unskilled provider. Exclusive breastfeeding (4 months) is quite low as reported at 16 percent.

FATA Overview

FATA is a belt of seven semi-autonomous tribal agencies stretching north to south along the border between Pakistan and Afghanistan. With respect to population and health system administration, an agency can roughly be equated to a small district in Pakistan. Each has its own characteristics, with wide inter- and intra-agency variations in socioeconomic, cultural, and health status parameters. Project LOP is 09-01-06 to 08-30-09; funding level is \$14,750,000 (listed in Annex 5).

The people of FATA are almost exclusively ethnic Pashtun. The last national census in 1998 estimated the population at 3.6 million people, of which the government estimates 21 percent (756,000) are women of reproductive age (WRA) and 8.8 percent (316,800) are children under the age of 5. As children under 5 represent nearly 14 percent of the overall population in Pakistan, this figure may reflect substantial undercounting. More than 97 percent of the population lives in rural areas, with the average household size between 8.5 and 10.6 people across the seven agencies.

Child Health

While the number and type of health facilities varies widely, facilities are characteristically under-equipped with high staff absenteeism. Community level maternal and child health care coverage through lady health workers (LHWs) is low, ranging from 13 percent in Bajaur Agency to 55 percent in Kurram. Facility-based reports for 2004 reflect newly registered pregnant women for antenatal care (ANC) at 11 percent, far less than the national average (43 percent).

In a recent GOP report, maternal mortality in FATA was estimated at 600/100,000 live births and infant mortality at 83/1,000 live births. Health Management Information System (HMIS) data from Bajaur Agency for the first half of 2005 reflect an estimated U5MR of 135/1,000 live births. In a report published in the *Bulletin* of the World Health Organization (WHO) in 2002, tetanus was estimated as the cause of approximately 22 percent of all infant mortality in FATA and 36 percent of neonatal deaths. Overall, only 50 percent of pregnant women are vaccinated against tetanus. In 2004 antenatal care ranged from 0 percent in South Waziristan to 18 percent in Orakzai, and fewer than one out of six mothers deliver with a skilled birth attendant.

Currently there are 926 LHWs in FATA covering approximately a third of the population based on the government's commitment to have one LHW per 1,000 population. More than 2,500 additional LHWs are needed to provide this optimal level of coverage. It is not realistic within the scope and timeframe of this project to expect that this optimal coverage will be achieved

Socioeconomic Conditions

FATA is a socially conservative society with very limited mobility for women and girls and the lowest levels of literacy for females in South Asia. Socioeconomically FATA is poorer than Pakistan in general. The economy is chiefly pastoral, with some agriculture practiced in the region's few fertile valleys. In the past, some areas of FATA produced significant quantities of opium; however, this has been reduced in recent years.

Communications in FATA are generally dispersed, although some are clustered in relatively accessible valley areas. In 1999–2000, FATA had a road density of approximately half the national figure. Approximately half of the total area is considered physically inaccessible; however, recent funding from the Asian Development Bank and other donors to build roads will likely substantially improve the situation in some areas.

Security

The political agent currently does not allow UN and WHO staff to enter North and South Waziristan Agencies, regardless of their nationality. Some places in Khyber, Bajaur, Mohmand, and Orakzai Agencies are also designated as “no-go” areas. An unusually high number of criminals and proclaimed offenders (nearly 17,000) are now taking shelter in FATA, where provincial police are prohibited from entering. Tribal law, kidnappings, and a range of other criminal activities combined with post-Afghanistan conflict factors pose a formidable range of operating and security concerns for project implementation and monitoring in some areas. Local NGOs report freedom of movement and fewer restrictions on WHO/UN/INGO representative visits. [A local firm will be hired as needed to do any evaluation visits in FATA.]

Improved Child Health in FATA Goal and Objectives

To Improve the Health Status of Children in FATA is the overall goal of this project. To achieve this goal the strategic objective is “Increased Use of Key Health Services and Behaviors,” which will be achieved through the following:

1. Increasing access to and availability of health services
2. Improving the quality of health services
3. Increasing the knowledge and acceptance of key services and behaviors at the community level.

To improve the health of children up to 12 years, including health and nutrition programming in schools, Save will expand and package the project's key interventions into the following groups:

- EPI - Immunization
- ARI - Acute respiratory infection
- CDD - Control of diarrheal diseases
- ENC - Essential newborn care
- Nutrition and micronutrients

Beneficiaries

There are an estimated 1,512,000 men and women of reproductive age in FATA. All of these will be project beneficiaries through community mobilization, particularly community awareness sessions. For children under 5 years of age, direct beneficiaries will be the two-thirds who suffer from either diarrhea or ARI—a total of 209,000 children. The rest of the under-5 population comprises indirect beneficiaries, approximately 108,000.

Improved Child Health in FATA Time Frame

Phase I – start-up activities, including Agency Headquarters (AHQ) Hospital improvement and capacity building of health care providers at the AHQ level, launched simultaneously in all seven districts. Health facility strengthening and training of LHWs in rural health centers (RHCs) and basic health units (BHUs) will be carried out in Mohmand, Bajaur, and Kurram Agencies.

Phase II – health facility strengthening and training of LHWs in Khyber and Orakzai.

Phase III – health facility strengthening and training of LHWs in North and South Waziristan.

Each phase is staggered by approximately six months. Community mobilization will accompany the above activities and agencies in the same sequence. As of January 2008, this project is working in all seven agencies and six frontier regions (FRs) of the FATA.

Fit with the Mission's Strategic Objective

In May 2003 USAID/Pakistan approved an Interim Strategic Plan for fiscal years (FY) 2004–2006, with the overall goal to “promote equality, stability, economic growth and improved well-being of Pakistani families.” Strategic Objectives (SOs) relate to education (SO3); democracy and governance (SO4); economic development (SO6); and health (SO7). USAID/Pakistan signed a new Strategic Objective Agreement (SOAG) with the GOP in 2005 and amended it to extend through September 2008; it outlines development activities agreed to by both parties.

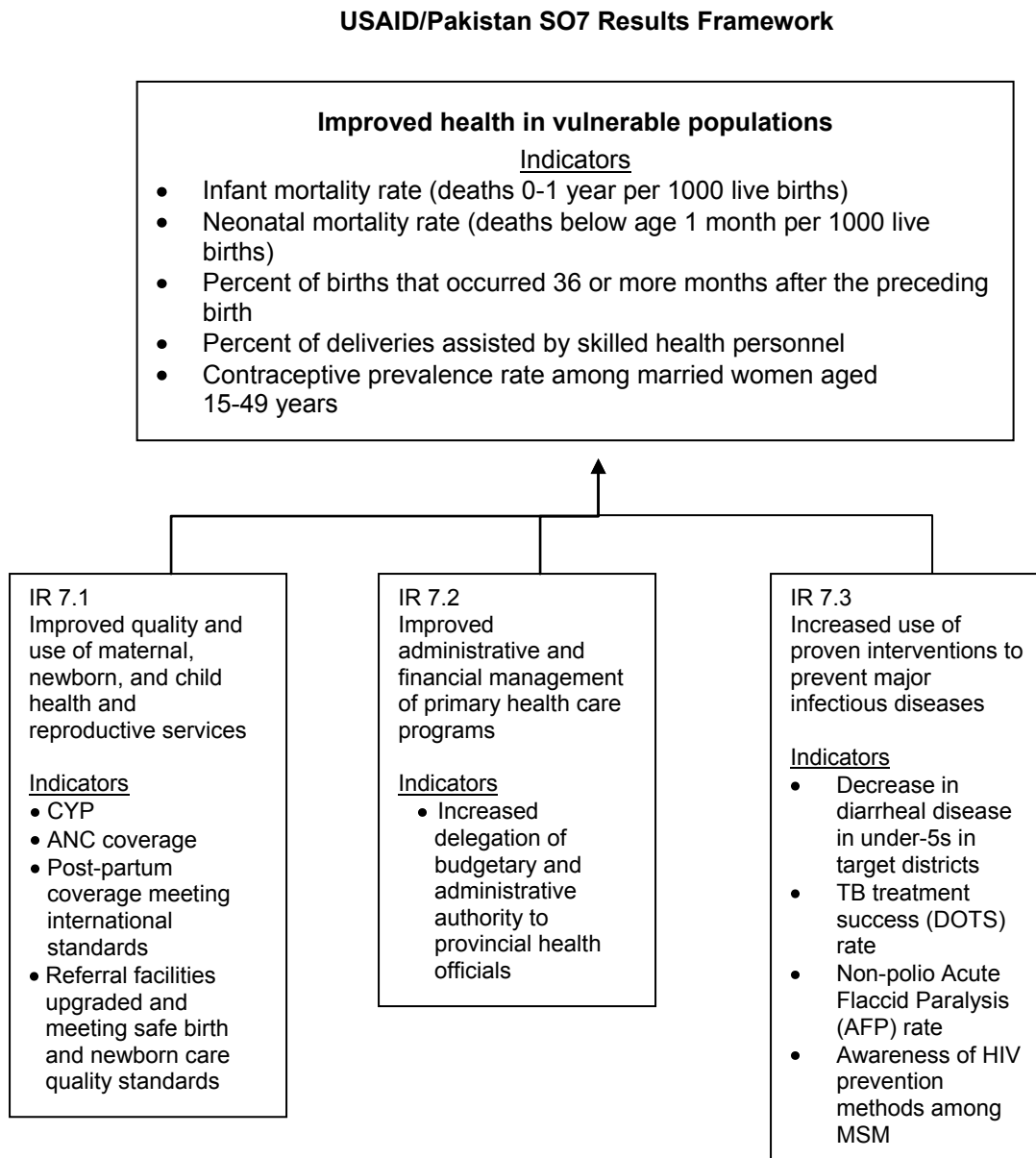
USAID's SO7 aims “to improve health in vulnerable populations in Pakistan.” Intermediate Results (IRs) include the following:

IR7.1 Improved quality and use of maternal, newborn, and child health and reproductive services

IR7.2 Improved administrative and financial management of primary health care programs

IR7.3 Improved use of proven interventions to prevent major infectious diseases.

Figure A.1 depicts the Results Framework for SO7.



Illustrative indicators in support of IR7.1 include (1) couple years of protection, (2) antenatal care coverage, (3) postpartum coverage meeting international standards, and (4) referral facilities upgraded and meeting safe birth and newborn care quality standards.

USAID Assistance in Health

The health program began in 2003 and includes activities to improve maternal and newborn health services, promote family planning, prevent major infectious diseases, and increase access to clean drinking water. The program is nationally focused, working in underserved rural and urban districts in Sindh, Balochistan, Punjab, North West Frontier provinces, and the Federally Administered Tribal Areas (FATA).

Current health program areas include:

- *Health Systems Strengthening (HSS)*: The HSS program seeks to support the Ministry of Health and the Ministry of Population Welfare in strengthening the community midwifery program; targeting health information for raising citizen's awareness and holding government accountable; addressing health system challenges through modest grant assistance; and improving essential drugs and contraceptive logistics management system. (Implementing Partner: ABT Associates)
- *Diversification of Family Planning Activities in Pakistan (DFPAP)*: USAID/Pakistan's project to address the need to increase and improve family planning services includes capacity building, monitoring and evaluation, and project management. (Implementing Partner: The Population Council)
- *Maternal and Newborn Health*: The Pakistan Initiative for Mothers and Newborns (PAIMAN) is USAID's flagship project designed to reduce maternal and neonatal mortality. The project is being implemented in 10 districts in all four provinces of Pakistan. (Implementing Partner: John Snow Incorporated)
- *HIV/AIDS Program*: USAID provides grants to seven local NGOs to increase HIV/AIDS awareness and to promote health behaviors in high risk groups. (Implementing Partner: Research Triangle Institute)
- *Strengthening TB Control*: USAID assists the GOP to consolidate and accelerate complete treatment of TB patients. (Implementing Partner: WHO)
- *Polio Eradication*: USAID provides assistance to national polio immunization campaigns and surveillance to eliminate polio from Pakistan. (Implementing Partners: WHO and UNICEF)
- *Demographic and Health Survey (DHS)*: USAID provides funding and technical assistance for the Pakistan DHS and Maternal Mortality Study. (Implementing Partners: Macro International and National Institute of Population Studies)
- *Disease Surveillance and Response*: USAID supports the design of a National Integrated Disease Surveillance and Response Program and a Field Epidemiology and Laboratory Training Program. (Implementing Partner: U.S. Centers for Disease Control)
- *Child Health in the Federally Administered Tribal Areas (FATA) of Pakistan*: USAID is working to improve the availability, quality, and demand for child health services throughout the FATA. (Implementing Partner: Save the Children, USA)
- *Safe Drinking Water and Hygiene Promotion*: USAID is providing technical assistance in hygiene and sanitation promotion and community mobilization along with extensive capacity building in order to complement the GOP's installation of water treatment facilities nationwide. (Implementing Partner: ABT Associates)

III. STATEMENT OF WORK

The independent mid-term evaluation team will review the technical, managerial, and programmatic strengths and weaknesses of the two major program MNCH components as approved and financed by USAID: *Maternal and Newborn Health: The Pakistan Initiative for Mothers and Newborns (PAIMAN)* and *Child Health in the Federally-Administered Tribal Areas (FATA) of Pakistan*. Based on the findings, the team will formulate lessons learned as well as recommend future technical, programmatic, and administrative actions that will support overall strengthening of programmatic efficiencies and effectiveness.

The team is expected to answer the following key strategic and priority questions:

1. Is the MNCH program meeting its benchmarked activities as outlined in the original cooperative agreements and presented in annual work plans?
2. What are the trends in terms of improvements in MNCH indicators (increased prenatal visits, tetanus toxoid [TT] boosters received during pregnancy, improved immunization coverage, etc.) in project districts in Pakistan and compared to GOP contributions to the program in those project districts?
3. What are the key outputs and outcomes of these two programs, PAIMAN and Improved Child Health in the FATA, that have been achieved to date?
4. What have been the major obstacles to program coverage and access, and what should the GOP, USAID, and other donors do to facilitate demand and utilization in rural and higher poverty areas?
5. What are the most important steps that USAID, the GOP, and other donors should take to increase effectiveness, coverage, quality, and sustainability of the MNCH program?

In addition, the evaluation team is expected to use creative techniques and approaches to address the tasks listed in Annex 6, which includes illustrative questions to guide the evaluation.

IV. SUGGESTED METHODOLOGY

The evaluation team will use a variety of methods for collecting information and data. The team will work in a participatory manner with the partners of the MNCH program. The following essential elements should be included in the methodology as well as any additional methods proposed by the team.

- Reviewing briefing materials/pre-evaluation planning: A package of briefing materials related to the MNCH program will be made available to the evaluation team at least one week prior to the commencement of the mid-term evaluation. A complete list of background documents is attached in Annex 2.

In addition to reviewing background documents, the evaluation team will have a preliminary planning period in which they will review the scope of the mid-term evaluation, begin to come to a consensus on the key evaluation questions, develop a proposed schedule, and begin the development of data collection tools. The data collection tools that the team will develop will include the following:

- Interview Guides
- Interview Questionnaires (for the evaluation team and the local firm to use during site visits with persons that interact with the PAIMAN and Save projects, i.e., LHWs, LHVs, physicians, nurses, district officials, etc.)

- Survey Questionnaires (brief client surveys conducted by the local firm in the PAIMAN and Save districts)

The data collection tools will be presented to USAID/Pakistan for discussion and approval prior to their application to verify their appropriateness. These tools will be used in all data collection situations, especially during team site visits and consulting firm site visits, in order to ensure consistency and comparability of data.

- SO7 Team Briefing: The evaluation team will meet with the USAID/Pakistan Health Strategic Objective Team (S07 Team) in Islamabad to review the scope of the mid-term evaluation, the proposed schedule, and the overall assignment. The initial briefing will also include reaching agreement on a set of key questions and will take place over one day (or could be incorporated into the Team Planning Meeting).
- Team Planning Meeting (TPM): A two-day team planning meeting will be held in Islamabad before the evaluation begins (depending on the location of consultants, the TPM may be held in the United States prior to the team's departure for Islamabad). This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:
 - clarify team members' roles and responsibilities;
 - establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
 - review and finalize the assignment timeline and share it with USAID;
 - develop data collection methods, instruments, tools, and guidelines;
 - review and clarify any logistical and administrative procedures for the assignment;
 - develop a preliminary draft outline of the team's report; and
 - assign drafting responsibilities for the final report.
- Document Review: In addition to reviewing briefing materials that will be provided to the team, the evaluation team will be expected to collect and annotate additional documents and materials for the team's and USAID/Pakistan's future use.
- Self-Assessment Questionnaire: A self-assessment questionnaire will be given to both organizations by USAID prior to the team's arrival in country. Prior to the team's arrival, USAID will draft the self-assessment and administer it accordingly. The team will have access to the self-assessment results for their review and use.
- Information Collection: The information collected will be mainly qualitative guided by a key set of questions. As mentioned, information will be collected mostly through personal and telephone interviews with key contacts and through document review. The full list of stakeholders and contacts will be provided. Additional individuals may be identified by the evaluation team at any point during the mid-term evaluation. Key contacts include:
 - USAID/Pakistan Senior Management, S07 Team Members, Health Director, Deputy Director, CTO for MNCH Programs;
 - PAIMAN and Save briefing with key personnel;
 - PAIMAN and Save subgrantees, subcontractors, and other local partners;
 - MOH and MOPW officials; and

- Donors and international organizations working in the health and population welfare sector.
- Site Visits: The evaluation team will travel with JSI-PAIMAN and/or Save the Children project staff and/or the local contracted firm to project sites for face-to-face interviews and discussions with local stakeholders and beneficiaries. The mission has suggested four sites for the evaluation team to visit: Rawalpindi, Lahore, Khanewal, and Peshawar (Annex 7).

Site visits will focus on pilot activities (DHIS, midwifery training, birthing centers, family planning integration, GoodLife clinics, Child Health Days). The areas of focus of the site visits will be clinical practices, behavior change communications (BCC), community mobilization, and training/supervision. Questions about equipment and ambulances or the emergency transport plan, facility upgrades, and improved access and quality should be included during discussions with the district officials.

In some sites other donor agency staff may request to accompany the team as well. Several interviews should be arranged and done in one day. The site visit to Rawalpindi will be done from the team’s base in Islamabad. The travel time to Lahore is an hour by air, visits can be done during one day, move on to Multan to stay overnight, conduct interviews on day 2 in Khanewal, and return to Islamabad after 2, possibly 3, days depending on flight schedules. Peshawar would be a 2-day visit by car. Thus an estimated 5-6 days are needed for site visits by the evaluation team. (Annex 7)

Should travel be restricted, conference calls or other mechanisms will need to be substituted. The Team Leader in collaboration with USAID will determine the appropriate course of action. The team will rent a vehicle locally in Islamabad for travel to some sites and travel to sites with project staff.

Local Data Collection and Site Visit Support: A local firm will be recruited and hired to assist in conducting interviews, coordinate and manage in-country logistics, set up appointments and meetings, make travel arrangements, and assist with site visits for the evaluation team. The local firm will visit and be responsible for interviews and field visits in Sukkur, Lasbella, and a FATA site (Annex 7). Sukkur and Lasbella are PAIMAN sites. The FATA sites are Save sites. The local firm will have a team of two persons, at least one being a female interviewer. They may choose to conduct group interviews or focus groups to gather information needed. They should meet with beneficiaries, local community members, NGOs, district officials, and any persons who have interacted with or are aware of PAIMAN or Save activities.

The firm will need to have experience working in the FATA. Important: The local firm must understand that USAID programs operating in the FATA function as part of the Government of Pakistan MOH programs and are completely “invisible” in that sense, with no branding to distinguish the program in any way. The local firm will need to be briefed on how to conduct interviews with this in mind in that region. The firm will be engaged by GH Tech prior to the evaluation team arrival in country and will take direction from the Team Leader. Some of the tasks that the local firm will assist with may include but are not limited to the following:

Conduct beneficiary interviews as available with:

- families (wives, husbands, mothers-in-law)
- imams
- midwifery students and midwives receiving refresher training
- traditional birth attendants (TBAs)

- physicians and LHVs who were trained
- civil servants trained in management.

Some topics to include in the questioning include:

- Have they heard health messages from NGOs, LHWs, or in or through support groups? Any benefit or behavior change?
- Have they used health services in refurbished facilities? What was the quality? Can they identify any improvements?
- Are they aware that additional ambulances have been placed at facilities? Do they expect the community to benefit? (PAIMAN only)
- Have they participated in any MNCH event? What was the impact for them, if any?
 1. Interview or otherwise involve all levels of government where available in the evaluation (illustrative):
 - 1) National, including EAD, provincial, and district as well as FATA Secretariat and FATA Health Directorate
 - 2) Pakistan Medical and Dental Council, Pakistan Nursing Council, principals of midwifery schools
 - 3) LHW Program, MNCH Project Head
- Donor involvement in evaluation, for identifying gaps and complimentary programs (illustrative):
 - 1) Open-ended questionnaires to donors
 - 2) One-to-one interviews
 - 3) Inbrief/outbrief
 - 4) Invitation to participate
 - 5) What's working? Not working?
 - 6) UNICEF, UNFPA, DFID, WB, Norad, AusAID, WHO, JICA, CIDA
 - 7) Who is working where doing what? Mapping. Extent to which projects are integrating FP into MNCH now. How much work are other projects doing on vaccination, IMNCI, HSS, infection control and hospital waste management, male involvement, private sector involvement?
- What are donors' future plans in MNCH? Best practices? Integrated FP? Child vaccination? Systems strengthening?
 - What role is each donor taking in planning, implementing, funding, policy development, and support?

V. DELIVERABLES

Debriefing Meetings: At least two days prior to ending the in-country evaluation, the team will hold three meetings to present the major findings and recommendations of the evaluation: (1) SO7 team—that will focus on the accomplishments, weaknesses, and lessons learned in the MNCH program, including recommendations for improvements and increased effectiveness and efficiency of the MNCH program; (2) senior Mission management—incorporating the insights gained in the first debrief; and (3) Final briefing—for MNCH (Save and PAIMAN) personnel, other donor partners, and key stakeholders (GOP officials), focusing on major findings and recommended changes to increase program effectiveness for the life of the project. No evaluation or future directions recommendations will be shared outside of the USAID/Pakistan Mission staff. Succinct briefing materials will be prepared appropriate for each audience. Each meeting will be planned to include time for dialogue and feedback.

Draft Report: The evaluation team will provide, prior to departure, a draft report which includes all components of the mid-term evaluation to the USAID/Pakistan Health Office Director and relevant SO7 Team members in hard copy (4 copies) and on diskette in MSWord format. USAID will provide comments on the draft report to the evaluation Team Leader within 5 working days. This will be followed by final unedited content that the contractor is required to submit within 10 working days after USAID feedback on the draft Report. Upon USAID approval of this final content, GH Tech will edit and format the report. The edited and formatted final report will be submitted within 30 days of receiving USAID final approval of the content. The final report is to be submitted to the Health Office Director, both in hard copy (6 copies) via express mail and in electronic form. The report will be presented in 12-point font, single spacing.

Evaluation Report: The final evaluation report should include, at a minimum, the following: (1) Table of Contents; (2) List of Acronyms; (3) Executive Summary; (4) Background Statement; (5) Findings and Lessons Learned; (6) Prioritized Recommendations; (7) Future Directions, including scaling up and potential expansion possibilities; and (8) Annexes as appropriate, including list of people met and sites visited. A Report Outline will be prepared by the evaluation team before starting the field work and approved by the Mission. Pertinent information for the final program evaluation in 2009 should be presented in a separate document.

GH Tech makes the results of its evaluations public on the Development Experience Clearinghouse and on its project web site unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, we are requesting Mission confirmation that it will be acceptable to make a version of this document publicly available, which will exclude the recommendations and future directions sections. The Mission will provide final approval of the public version before it is posted on any web site to ensure that all sensitive information has been removed.

VI. DURATION, TIMING, AND SCHEDULE

It is anticipated that the period of performance of this evaluation will be for six/seven weeks beginning in May/June 2008. A possible schedule of this activity follows (illustrative):

Task/Deliverable	Team Leader LOE	Team Members LOE (2)
1. Review background documents/pre-evaluation planning (out of country)	6 days	5 days
2. Travel to Islamabad	2 days	2 days
3. SO7 Team briefing	1 day	1 day
4. Team planning meeting	2 days	2 days
5. Meetings with <ul style="list-style-type: none"> • COPs of PAIMAN and Save • GOP officials in Islamabad (MOPW, MOH) • Local consulting firm • MNCH donors and other partners 	7 days	7 days
6. Visit field sites, including training centers, clinics, etc.	4 days	4 days
7. Debriefings with Health Office, USAID senior management, PAIMAN and Save, other stakeholders	1 days	1 days
8. Internal discussion meeting with local firm and international team	1 day	1 day
9. Analysis, discussion, and draft report writing	14 days	14 days
10. Presentation of draft report and discussion	1 day	1 day
11. Return travel	2 days	2 days
12. Complete final evaluation report (out of country)	5 days	2 days
Total # days	46	42

A six-day work week is approved when the team is working in country.

VII. TEAM COMPOSITION

The team should have the following skills mix: maternal and child health service provision, project assessment and evaluation, program design, reproductive health care and service provision, health worker training, behavior change communication, community mobilization and participation, health systems services/management information systems, among others. Familiarity with the health service delivery system (both public and private sectors) in Pakistan would be a major advantage. Ideally, the Team Leader would be an expert with international experience while other consultants could be recruited from available contractors or consultant pool. A suggested team composition is given below:

Team Leader: The team leader should be a public health generalist and an evaluation expert with practical knowledge in monitoring and evaluation of international public health programs in developing countries. A broad background in MCH is preferable. S/he should have an advanced

degree in public health. A minimum of 7 years experience in managing, monitoring, or researching international public health programs is required. S/he should also have a comprehensive understanding of maternal, newborn, and child health principles and practices.

In addition, the Team Leader should have at least 5 years experience strengthening health systems, health sector reform, program component cost analysis, logistics of essential medicines and contraceptives, and addressing issues of quality and access improvement in health systems in developing countries. Identifying appropriate technical assistance needs to make improvements in the health systems, building capacity of local institutions and organizations, including the Pakistan Nursing Council, the Midwifery Association of Pakistan, and other interventions will be included in this position's SOW. S/he should also have a keen awareness of health management information systems scenarios and the ability to recommend effective solutions for improvements to health data collection and reporting systems in the country.

It is imperative that the Team Leader have excellent English language skills (both written and verbal) as s/he will have the overall responsibility for the final report, and will have a major role in drafting and finalizing the deliverables. The individual considered for the Team Leader position is expected to provide a sample of a written report for consideration by the Mission.

Maternal Health Specialist: The second team member should have an advanced degree in health sciences or public health and at least 5 years experience in program management, implementation, and monitoring and evaluation of internationally based maternal and child health programs, as well as a comprehensive technical knowledge of and experience in maternal newborn and child health programs, especially service provider training. S/he should have a strong appreciation of partnership building and service provision in challenging environments. A nurse/nurse midwife is preferred for this position.

BCC/Community Mobilization Expert: This team member should have an advanced degree in medical anthropology or a related discipline and at least 5 years experience in the implementation of field behavior change communication and community mobilization strategies. A comprehensive knowledge of the application of BCC strategies to alter behaviors related to maternal and child health is desirable.

The evaluation team will be authorized to work a six-day work week while in country. Travel expenses and other communication costs incurred during the course of duty are authorized. The final travel itinerary of the evaluation will be contingent on the security situation and relative predictability of access to the project sites in general and target areas in particular.

It is possible that evaluation team members will be asked to provide input and feedback in the redesign of the follow-on project or revision of the current Maternal and Child Health program. Team member involvement will be determined during the development of the scope of work for the redesign/revision.

VIII. RELATIONSHIPS AND RESPONSIBILITIES

1. Overall Guidance: The Health Office Director and Deputy Director of USAID/Pakistan will provide overall direction to the evaluation team. Other USAID/Pakistan Health Office staff will interact with the evaluation team as needed to complete the evaluation activities.
2. Responsibilities:

USAID/Pakistan will introduce the evaluation team to relevant implementing partners, government officials, and other individuals key to the accomplishment of this evaluation through introductory letters or advance phone calls.

- USAID/Pakistan will provide observers throughout the review from the PAIMAN and Save programs as feasible.

- USAID/Pakistan will be responsible for providing security notices issued by the American Embassy in Pakistan to which the evaluation team must adhere. The evaluation team will provide mobile phone contact numbers to the USAID Health Office so that contact can be maintained as needed.

GH Tech Evaluation Team will be responsible for coordinating and facilitating evaluation-related field trips, interviews, and meetings. USAID will review and approve the schedule.

- The evaluation team will be responsible for making all logistical arrangements.
- The evaluation team will be responsible for all costs incurred in carrying out this review. The proposed costs may include, but not be limited to, (1) regional travel; (2) lodging; (3) M&IE; (4) in-country transportation; and (5) other office supplies and logistical support services (i.e., laptop, battery pack, paper, communication costs and teleconferencing cost, if needed, due to current travel restrictions).
- The local consulting firm will be responsible for assisting the evaluation team with site visits and conducting interviews in restricted travel areas as indicated in section IV above. This work will be coordinated by the evaluation Team Leader.
- The evaluation team will be responsible for arranging meetings and meeting spaces, laptop rentals, local travel, hotel bookings, working/office spaces, printing, photocopying, and other administrative support, as required. USAID may be able to assist the team on a limited basis.

ANNEX B: REFERENCES

- DFID, Skilled Attendance at Birth Report
- District Government Khanewal, Health Department, District Health Plan 2008–2009
- Government of Pakistan, Safe Motherhood Alliance Assessment
- Government of Pakistan, Ten-Year Perspective Plan 2001–2011
- Government of Pakistan, Unified Health Messages from One-Day Workshop, 2008
- Ministry of Health, Community Midwifery Curriculum
- Ministry of Health, MNCH Logframe, 2008
- Ministry of Health, Maternal and Child Health in Pakistan: Challenges and Opportunities: 2004. MCH-PC1
- National Program for Population and Family Health, Government of Pakistan, LHW newsletter
- NORAD, Baseline Survey in Sindh
- NORAD, Maternal, Newborn, and Child Health Project Document
- Pakistan Demographic and Health Survey 2006–2007, Preliminary Report
- PAIMAN, Annual Report 2006–2007
- PAIMAN, Annual Workplan 2007–2008
- PAIMAN, Assessing Routine Health Information System in PAIMAN Districts by Using LQAS Technique, 2007
- PAIMAN, Behavior Change Communication Success Stories
- PAIMAN, Communication, Advocacy, and Mobilization Strategy
- PAIMAN, Community LQAS, 2007
- PAIMAN, Concept Paper: District Health Management Teams
- PAIMAN, District Baselines (Upper Dir, Buner, Jafferbad, Lasbella, Sukkur, DG Khan, Rawalpindi, Jhelum, Khanewal), 2006
- PAIMAN, District Communication Action Plans, 2007–2008, Upper Dir, Buner, Rawalpindi, Jhelum, Khanewal, DG Khan.
- PAIMAN, District-level Decision Space Analysis in Pakistan
- PAIMAN, EMNH Pre-Post-Test and Checklists
- PAIMAN, EMNH Training Curriculum
- PAIMAN, FATA Government Program, presentation, June 2008
- PAIMAN, Functional Integration of Services in Rawalpindi District: Assessment and Way Forward, 2008
- PAIMAN, Functional Integration of Services in Rawalpindi District: Pilot Study 2007

PAIMAN, Health Facility Assessments (Upper Dir, Buner, Jafferbad, Lasbella, Sukkur, DG Khan, Rawalpindi, Jhelum, Khanewal), 2006–07

PAIMAN, Health Facility LQAS

PAIMAN, Health System Strengthening, An Update, presentation

PAIMAN, IEC Materials (LHW flipchart, support group manual, family booklet, Good Life materials)

PAIMAN, M&E Presentation, June 15, 2008

PAIMAN, Mid-term Evaluation Briefing, presentation, June 11, 2008

PAIMAN, Monitoring and Evaluation Plan, January 2007

PAIMAN, NGO Reports from NRSP, HANDS, PAIMAN Project, and Pakistan Lions Youth Council, Jan–March 2008

PAIMAN, Performance Assessment, Strategy, and Workplan of EMNC Trained Public Sector Health Care Providers

PAIMAN, Qualitative Formative Research Findings—Summary, July 2006

PAIMAN, Quarterly Report, Jan–March 2008

PAIMAN, Rawalpindi, District Health Annual Operations Plan

PAIMAN, Review of Safe Motherhood Programs, Policies, and Research

PAIMAN, Routine Monitoring of Output Indicators

PAIMAN, Self-Assessment Questionnaire MNH Evaluation, April 2008

PAIMAN, Strategic Framework 2005 and Revised Framework 2006

PAIMAN, Television Talk Show Evaluation Report

PAIMAN, Training Plan for Health Care Providers, 2006

PAIMAN/Greenstar, “Increasing Demand for Maternal and Neonatal Health Care Services,” Training Strategy–Private Health Care Providers, December 2006

PRIDE Project, Antenatal Care, Childbirth and Post-Natal Care Standards

Save the Children, Partnership Defined Quality Manual

Social Policy and Development Center, List of Districts Ranked by Level of Poverty

USAID, Operational Plan Indicators, Pakistan 2006–07

USAID Pakistan Interim Strategy, May 2003–September 2006

USAID, Pakistan Population Welfare and Health Logistics, 2006

USAID, SOAG–Health and Amendments 2005, 2006, 2007

USAID/Pakistan, Award of Cooperative Agreement 391-A-00-04-01037-00

ANNEX C: PERSONS CONTACTED

ISLAMABAD

USAID

Anne Aarnes, Mission Director

Susan Thollaug, Health and Population Director

William Conn, Acting Health and Population Director

Maureen Norton, Senior Technical Advisor, Population and Reproductive Health

Dr. Muhammad Ahmed Isa, Program Management Specialist, Health

Saedar Talat Mahmud, SO7 Team

Khalid Mahmood, SO7 Team

Rushna Ravni, SO7 Team

PAIMAN/JSI

Dr. Nabeela Ali, Chief of Party

Lauren Mueenuddin, Deputy Chief of Party

Dr. Tariq Azim, Technical Advisor Program and M&E

Dr. Schuaib Khan, Director of Programs and Grants

Mohammad Babar Hussain Khan, Director of Finance

Maj. Javade Khawaja, Director of Administration

Mrs. Munazza, Deputy Programs and Grants

PAIMAN/JHU

Fayyaz Ahmed Khan, JHU BCC Team Leader

Zayeem, BCC Deputy Team Leader

Shareen, Senior Team Associate

PAIMAN/POPULATION COUNCIL

Dr. Arshad Mahmood

PAIMAN/GREENSTAR

Dana Tilson, Country Representative/PSI

Mr. Haris, Program Manager

Dr. Syed Abdul Qayoom, Senior Manager Interpersonal Communications, Greenstar

Dr. Qayoom, Director, IPC

Mr. Riaz, IPC Officer/Rawalpindi

Dr. Firdos, Assistant Manager, IPC Regional

PAIMAN/SAVE THE CHILDREN

Dr. Masood Ahmed Abbasi, Senior Manager Health, Save the Children

Rukhsana Faiz, Senior Officer, Community Mobilization

Sajjad Nayyer, Senior Officer, Community Mobilization

PAIMAN/CONTECH INTERNATIONAL

Dr. Muhammad Anwar Janjua, Executive Director, Policy Planning and Health Systems

Dr. Naeem Uddin Mian, Health Specialist and CEO

Dr. Shabana Haider, Manager, Marketing and Communications

Dr. Ahmed Nadeem, Public Health Consultant

Dr. Shahzad Hussain Awan, Consultant

MINISTRY OF HEALTH

Dr. Asad Hafeed, Director, LHW Program

Dr. Fazle Manla, Deputy National Coordinator

Dr. Saleem Mali Khan, Technical Advisor

MINISTRY OF POPULATION WELFARE

Mrs. Mumtaz Esker, Director General

PAKISTAN NURSING SCHOOL

Nighat Durrani, Director

Patrice White, Technical Advisor

UNITED NATIONS CHILDREN'S FUND

Ibrahim El-Ziq, Chief of Health and Nutrition

WORLD HEALTH ORGANIZATION

Dr. Ahmed Shadoul, Medical Officer, MNCH

UNITED KINGDOM DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

Dr. Michael O'Dwyer, Health Advisor

GERMAN TECHNICAL COOPERATION

Paul Ruckert, Principal Advisor

CANADIAN INTERNATIONAL DEVELOPMENT AGENCY

Pamela Sequiera, Program Officer

ROYAL NORWEGIAN EMBASSY

Abdul Aziz Akhtar, Programme Officer

JAPAN INTERNATIONAL COOPERATION AGENCY

Masaharu Maekawa, Project Formulation Advisor

Sohail Ahmad, Senior Programme Officer

Dr. Ajmal Hamid, Chief Advisor Health

LAHORE**PAIMAN PROVINCIAL STAFF**

Dr. Fazal Mehmood, Field Office Manager, North Punjab

Dr. Nuzhat, Field Office Manager, South Punjab

Dr. Akhtar Rasheed, Save Provincial Manager, Punjab

PUNJAB MINISTRY OF HEALTH MEETINGS

Dr. Aslam Chaudhary, Director General, Health

Dr. Akram Zahid, Director, PHDC

Dr. Ameer Uddin, PHDC Program Director

Dr. Tanveer, Provincial Coordinator, FP and PHC

Dr. Sabiha Khurshid Ahmad, Provincial Program Coordinator, NMCH Program

Dr. Usmani, Representing the DG Health

MIDWIFERY SCHOOL, UNITED CHRISTIAN HOSPITAL

Mrs. Naseem Pervaz, Principal, Midwifery School

Mrs. Shabana Yousz, Clinical Teacher

Mrs. Balqees Yousf, Nursing Superintendent

Mrs. Teresa Niaz, Nurse

20 midwifery students

KHANEWAL**MINISTRY OF HEALTH**

Dr. M. Tariq Gillani, Executive District Officer, Health

GREENSTAR

Greenstar private provider (Ob/Gyn) trained in comprehensive emergency obstetric care

Greenstar private provider (LHV) trained in basic emergency obstetric care

MIDWIFERY SCHOOL, KHANEWAL

Mrs. Awest Aziz, Asst. Nursing Instructor

Mrs. Bilques Akttar, Nursing Instructor

Mrs. Tasmia Caveed, PH Nursing Supervisor

Mrs. Riffat Pauveen, Nursing Instructor

Mrs. Masarat Parveen, Nursing Instructor

20 community midwives

THQ/DHQ

Dr. Naeem Saidle Nachi, THQ Hospital, Medical Superintendent

Dr. Lubaria Asad, THQ Hospital, Ob/Gyn

Dr. Muhamed Rati, DHQ, Medical Superintendent

Dr. Noshaba Ali, DHQ, Ob/Gyn

23 LHWs and 1 support group of 17 women

RHC KACHA KU

1 LHV, 23 LHWs

PAKISTAN LIONS YOUTH COUNCIL (NGO)

Dr. Quaiser Javaid, Chairman

Birthing center (LHV, 17 CHWs and TBAs, 20 beneficiaries)

RAWALPINDI**EDO HEALTH**

Dr. Zafar Gondal, Executive District Officer, Health

Dr. Javad Iqbal Chaudhary, District Coordinator, National Program for FP/PHC

Mr. Ali Ahsan, HMIS District Coordinator

Dr. Khalid Randhawa, District Officer Health

NAZIM

Dr. Raja Javed Ihhlas, Zila Nazim

POPULATION WELFARE DEPARTMENT

Ms. Sheeren Sukhan, District Population Welfare Officer

Mr. Babar, District Technical Officer

RHC MANDRA

Romana Kanwal, LHV

Dr. Fayzana Mulojeia, WMO

Dr. Khalid, Medical Officer

Dr. M. Ilyas, Senior Medical Officer

Women's Support Group: 13 women, 1 LHW, 1 LHS

Yasmin, LHW Health House

Male health committee (31 members)

DISTRICT POPULATION WELFARE OFFICE

Dr. Shirine Sukhunl

THQ G. KHAN

Dr. Swalindie Mir, WMO

NATIONAL RURAL SUPPORT PROGRAMME (NGO)

Asim Nazeer, Programme Officer, Health

PESHAWAR

PAIMAN

Fazle Jamal Afridi, Field Operations Manager

Dr. Roomane Andleds, Provincial Coordinator

PROVINCIAL HEALTH SERVICES ACADEMY

Dr, Fazal Mahmood, Director

Dr. Mahmood Alzal, Deputy Director

NWFP/FATA MINISTRY OF HEALTH MEETINGS

Dr. Muhammad Zaffar, Additional Secretary of Health

Dr. Muhammid Zubair Khan, Director, FATA Health Service

Pervez Tamal, Director, MNCH

ANNEX D: FOCUS GROUP DISCUSSION (FGD) FINDINGS

KHANEWAL

Lady Health Workers

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 10:00 To: 11:30 (AM)

Location: Khanewal (RHC Kucha khoo) Number of Participants: 23

Moderator: Mrs. Fahmida Recorder: Mrs. Saima

Traditional Birth Attendants

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 01:30 To: 02:45

Location: Khanewal (RHC Kucha khoo) Number of Participants: 20

Moderator: Mrs. Fahmida Recorder: Mrs. Saima

Beneficiaries (Community Women)

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 12:00 To: 01:15

Location: Health Centre (Kucha khoo) Number of Participants: 18

Moderator: Mrs. Fahmida Recorder: Mrs. Saima

Summary of Findings, Khanewal

- **Knowledge and Awareness Levels:** Knowledge and awareness levels among LHWs were found to be considerably higher than among TBAs, and those of TBAs were higher than among beneficiaries. LHWs and TBAs were comparatively more knowledgeable about all PAIMAN messages in comparison to beneficiaries. Many key messages were not yet properly understood by the project's beneficiaries.
 - All three groups were aware of the importance of antenatal visits and TT vaccination, even though most beneficiaries were not yet receiving the care needed.
 - Understanding of the importance of early breastfeeding ranged widely, from within the first half hour to three days after birth. The majority of respondents could not explain the benefits of early breastfeeding and spoke mainly of their traditional beliefs and practices. In contrast, both LHWs and TBAs had proper knowledge about the importance of immediate breastfeeding.
- **Trainings:** LHWs reported receiving 5-6 trainings, including one PAIMAN training of five days, whereas TBAs got one training one month before the FGD took place.
- **Messages:** Most of the LHWs do not regularly visit the households in their catchment area, though some mentioned that they do conduct monthly visits to pregnant women only. Supporting this, the majority of the community women were reluctant to comment on

receiving PAIMAN messages from LHWs through home visits. Primarily, LHWs conveyed messages to beneficiaries through support groups.

- **Difference/Change in the Last Four Years:** The majority of LHWs spoke of a marked difference in the last four years due to PAIMAN trainings, support groups, and health committees. Similar views were expressed by TBAs about the training they had received. TBAs also added other BCC activities as a source of change, awareness, and improvement in healthy behavior. In contrast, only a few beneficiaries had yet adopted improved behavioral changes due to LHWs, support groups, and health committees. Some did say that now they could discuss their problems with their families more easily and have more updated knowledge about MNH issues.
- **Danger Signs:** The majority of LHWs could identify danger signs of both pregnancy and delivery, whereas only some of TBAs could identify some of the danger signs. However, minor danger signs were not easily differentiated from those that were life-threatening (i.e., nausea and spotting versus signs of pre-eclampsia and heavy bleeding). Significantly smaller proportions of beneficiaries could identify complications and danger signs like excessive bleeding, positioning of the baby, and obstructed labor. Considerable work needs to be done regarding clarification of an obstetrical complication and when there is need for immediate action.
- **Referral System:** Both LHWs and TBAs emphasized that they knew to refer pregnant women to SBAs but that they could not confidently say when, where, and to whom they should refer. While the importance of referrals has been conveyed, there is still no proper referral system at the community level for them to follow. Beneficiaries knew they should have adequate funds for delivery, but saving was very difficult and beyond this they had no set birth preparedness plan (such as emergency transport).
- **Support Systems:** Family (especially men) and other community members were generally reported to be more cooperative although equally unaware of some key MNCH messages, such as birth preparedness, referrals, and danger signs.
- **Source of Information:** Only two mothers indicated LHWs; the majority mentioned elderly women in the family as the most important source of information.

SUKKUR

Lady Health Workers

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 09:30 To: 10:45

Location: Sukkur Number of Participants: 26

Moderator: Ms. Rubina Recorder: Ms. Kalsoom

Traditional Birth Attendants

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 11:00 To: 12:30

Location: Sukkur Number of Participants: 20

Moderator: Ms. Rubina Recorder: Ms. Kalsoom

Beneficiaries (Community Women)

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 Time: From: 12:30 To: 01:45

Location: Sukkur Number of Participants: 16

Moderator: Ms. Rubina Recorder: Ms. Kalsoom

Summary Findings, Sukkur

- **Knowledge and Awareness Levels:** LHWs demonstrated better knowledge of pregnancy and ANC issues than of childbirth, neonatal, and infant care. Mixed knowledge was observed among TBAs about pregnancy, childbirth, and neonatal and infant care. Knowledge and awareness levels of TBAs in Sukkur were higher than that of LHWs. Messages transferred to the beneficiaries was still relatively low.
- **Trainings:** The majority of both LHWs and TBAs reported receiving one PAIMAN training in the last year. LHWs requested more trainings on delivery and complications in labor.
- **Messages:** There was a noticeable variation in responses about community awareness about ANC/PNC, danger signs/referrals, birth preparedness, and SBAs. Responses indicated that both TBAs and LHWs were less knowledgeable and that is why beneficiaries were not receiving appropriate information.
- **Difference/Change in Last Four Years:** The majority of LHWs and TBAs believe there has been a positive change in the last four years due to PAIMAN trainings, support groups, and health committees. TBAs added that in the past they used to work on their own but presently they work with LHWs who visit them and conduct meetings with them to guide them on appropriate maternal and neonatal health practices. Conversely, there were mixed opinions about changes in recent years among community members. Some beneficiaries said that change has been occurring gradually due to LHW meetings at the community level, and others because LHWs came to their homes to educate them about MNH issues.
- **Danger Signs:** Mixed understanding of danger signs in pregnancy and childbirth was noted. Both LHWs and beneficiaries made minimal and superficial contributions about identifying

complications and danger signs of both pregnancy and delivery. Lack of understanding of the difference between a minor and a serious complication was once again noted.

- **Referral System:** Generally, communities reported going to unskilled TBAs because the RHC/Kindhra is only open until 2 PM. One of the women interviewed had 15 children, and she had given birth to all of them at home with TBAs. LHWs reported knowing about the importance of ANC visits but did not know enough about skilled delivery and complications in delivery to be able to recommend timely referrals. There was no proper referral system known or established in the community.
- **Source of Information:** Some respondents indicated LHWs, but the majority mentioned elderly women and TBAs in the community as their first source of information.
- **Practice:** There was little evidence noted among TBAs of change in practice regarding use of syntocin (the brand name for oxytocin), which is used inappropriately to induce labor, or for timely referrals. Similarly, LHWs also suggested the incorrect and dangerous use of syntocin injections to speed delivery. They also commented that pelvic examinations should be done when the patient feels pain. Correction of the inappropriate use of oxytocins needs immediate attention.

LASBELA

Lady Health Workers

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 **Time:** From: 09:45 To: 11:00

Location: Lasbela **Number of Participants:** 20

Moderator: Ms. Rubina **Recorder:** Ms. Kalsoom

Traditional Birth Attendants

FOCUS GROUP DISCUSSION

Date: / / 06 / 2007 **Time:** From: 11:00 To: 12:30

Location: Lasbela **Number of Participants:** 21

Moderator: Ms. Rubina **Recorder:** Ms. Kalsoom

Beneficiaries (Community Women)

FOCUS GROUP DISCUSSION

Date: 18 / 06 / 2007 **Time:** From: 01:00 To: 02:15

Location: Lasbela **Number of Participants:** 17

Moderator: Mrs. Fahmida **Recorder:** Ms. Kalsoom

Summary Findings, Lasbela

- **Knowledge and Awareness Levels:** Knowledge and awareness levels of LHWs were found to be higher than those of TBAs and beneficiaries. The majority of TBAs were unaware of the importance of or need for antenatal care, signs of obstetrical emergencies, obstructed labor, and what to do if these occur.

- **Trainings:** LHWs reported receiving numerous trainings, including government training and PAIMAN training (for MNCH and support group). TBAs also received a one-day training from PAIMAN. Both LHWs and TBAs requested more trainings to improve upon and update knowledge and awareness of MNH issues.
- **Message:** Most beneficiaries were aware of the importance and need for timely ANC and PNC checkups, TT vaccinations, birth preparedness, and timely referrals. However, danger signs in both pregnancy and childbirth were not clearly understood, particularly the difference between those that are life-threatening and those that are not.
- **Difference/Change in Last Four Years:** All three groups, in general, believe that there has been positive change in the last four years due to PAIMAN trainings, support groups, and health committees. The majority of TBAs said that as a result of trainings they advocated against unhealthy customs such as discouraging early breastfeeding and giving honey and ghuti as first food.
- **Danger Signs:** Positive evidence has been seen of LHW awareness about danger signs of pregnancy and childbirth, such as heavy bleeding; high blood pressure; headaches; swelling in feet, arms, and face; lack of fetal movement; no weight gain or abnormal gain during pregnancy; delay in birth during delivery; release of placenta or amniotic fluid; excessive bleeding post-childbirth, and fever.
- **Referral System:** Most deliveries among respondents were done by doctors and LHVs but those by TBAs who received training from PAIMAN were also noted as using clean delivery kits.

ANNEX E: ACTIVITIES OF OTHER DONORS IN MNCH AND HSS

DONOR	MNCH ACTIVITIES	HSS ACTIVITIES	TIMEFRAME	LOCATION	BUDGET	FUTURE PLANS
CIDA	Planning to support UNICEF for a MCH project in 3 districts of Balochistan	Health systems strengthening activities in 2 districts of Punjab	HSS: 5 years, began in 2006	MCH: 3 districts in Balochistan HSS: 2 districts in Punjab	HSS: CAN\$10 m MCH: CAN\$18 m	Health is not a priority for CIDA
DFID	Budget and TA support to central government MNCH program		5 years, began in 2006	National	Total MNCH budget support: £60 million	New project to focus on systems assistance based on specific needs (£150 m)
GTZ		HSS in AJK Health sector reforms in NWFP and FATA	Ongoing assistance	AJK NWFP FATA	Total agency budget €5 m annually	Plans to support health financing mechanisms and HR development
JICA	Safe motherhood project: training of midwifery teams at PIMS	Development of DHIS and implementation in 4 pilot districts	DHIS: 2004–2007 SM: 2003–2008	DHIS-4 districts SM- nationwide	DHIS: Total budget US\$2.5 m SM: US\$16 m	Additional support for DHIS for next 3 years
NORWEGIAN EMBASSY	MCHN program to be implemented by UN agencies (still in planning stage)	MCHN program will include management assistance	5 years, beginning in 2008	10 districts in Sindh	US\$45-50 m for 5 years	
WHO	Policy and TA support for MCH/RH/FP	HMIS, community participation	Ongoing assistance	National	Annual MCH budget: US\$1.5 million	MCH will stay as a priority
UNICEF	Policy and TA support for maternal, newborn, and child health, child spacing	Planning HSS national support for 5 years, US\$16 million	MNCH: 6 years, began in 2004	17 districts in all provinces	Total MNCH budget: US\$57 million	
UNFPA	Reproductive health with a focus on safe motherhood and child spacing	Program includes improving management systems, e.g., logistics management	7 th country program: 2004–2008	10 districts in all provinces	US\$35 m for 5 years	

ANNEX F: PAIMAN INTERVENTIONS: PRIORITIZATION AND SUSTAINABILITY ASPECTS

SO	INTERVENTION	PRIORITY	SUSTAINABILITY	COMMENTS
SO1: Increase awareness	Training of LHWs	H	H	Clarification of danger signs and SBAs is needed.
	Theater shows	L	L	Needs evaluation.
	Mass media interventions	H	L	Too early to evaluate impact
	Advocacy with religious leaders/ journalists	H	H	
	Other BCC events	L	L	Need evaluation to determine which should and can be scaled up or dropped.
SO2: Increase access to SBA	NGOs: Initiation of Citizen Community Boards (CCBs)	H	L	Most NGOs will not be able to continue without external assistance. They should focus on establishing CCBs.
	NGOs: Birthing centers	H	M	Will be sustained only where the MOH or CCBs can take on management.
	Community-based committees	L	L	This should focus on establishing CCBs.
	Emergency transport: provision of ambulances	H	M	Should only continue through CCBs.
	Orientation of TBAs	H	H	TBAs are present in the community and provide manager services, not just deliveries
	Support establishment of community midwives	H	M	Finalize plans for introduction into community; clarify relationships with LHWs/TBAs, access to supplies, supervision, reporting and referral systems
	Private provider networks	H	H	Training needs to include clinical practicum. Reporting system needs to be improved. Private sector provider a large portion of MNH services. All private providers should be trained on partograph and AMTSL.

H: High; M: Medium; L: Low.

SO	INTERVENTION	PRIORITY	SUSTAINABILITY	COMMENTS
SO3: Improve Quality	Upgrade MOH facilities	H	M	Staff is a key limitation of the facilities. If more money is available, the 7 other THQs and key RHC (28) should be upgraded.
	Supervision	H	H	DHMT has been trained on supervision, but this is still a challenge. Most supervision still has an administrative focus rather than being supportive.
	Referral system	H	H	Providers do not know where (public or private providers) to refer for specific complications. It is essential that this be mapped out and communicated to providers and women.
	Reporting/data analysis	H	H	There is confusion about obstetric complications. More support is needed for more accurate reporting and data analysis in both the public and the private sector.
SO4: Increase capacity	Train providers in EMNC	H	H	Need to add a clinical practicum. Should only train providers in facilities that receive regular support.
	Partograph and AMSTL training	H	H	All public providers trained on EMNC (941) should receive this training. All private providers should also receive this training
	Infection prevention	H	H	Private providers should be trained on this.
SO5: Health system	Management training	H	M	Sustainability varies depending on each district's willingness to continue training.
	Strengthening District Health Management Teams	H	M	Sustainability varies depending on each district's willingness.
	Integration of family planning	H	N/A	This would be a high priority activity for the FALAH project rather than PAIMAN. It is too early to assess sustainability.

H: High; M: Medium; L: Low.

ANNEX G: ROUTINE OUTPUT MONITORING INDICATORS, JANUARY 2007–MARCH 2008

	ROUTINE OUTPUT MONITORING INDICATORS	JAN-MARCH 07	APR-JUNE 07	JULY-SEP 07	OCT-DEC 07	JAN-MAR 08
SO 1	# of beneficiaries of mothers' support groups	83,056	70,238	110,328	139,638	213,198
SO 2	# pregnant women visited by LHW in the last month	120,025	152,664	155,957	147,528	156,343
	# pregnant women receiving at least 2 TT shots during the current pregnancy	45,509	53,226	58,674	54,755	62,971
	# women with obstetrical complications treated in upgraded PAIMAN EmONC facilities	1,421	1,598	1,616	1,362	1,608
	# of pregnant women registered for ANC in target districts	38,191	42,012	44,833	45,994	50,438
	# postnatal cases visited by LHW within 24 hrs of delivery	22,649	18,872	27,843	27,758	26,830
	Total # of Cesarean sections	372	379	501	533	453
	# of emergency C-sections	178	230	292	348	309
	# of elective C-sections	194	149	209	185	144
	# of intra-uterine fetal deaths (IUFD)	159	183	169	183	216
	# facilities with basic EmONC in public sector	13	13	13	13	13
	# facilities with comprehensive EmONC in public sector (see Note 2)	13	13	13	13	13
	# facilities with basic EmONC in Greenstar Good Life Clinics network	123	207	343	432	432

	ROUTINE OUTPUT MONITORING INDICATORS	JAN-MARCH 07	APR-JUNE 07	JULY-SEP 07	OCT-DEC 07	JAN-MAR 08
	# facilities with comprehensive EmONC in Greenstar Good Life Clinic network	0	13	42	42	42
	# births in upgraded health facilities	3,498	3,379	5,098	4,731	4,816
	# communities with functioning local transport system for emergency obstetric cases	182	301	308	362	388
SO 3	Case fatality rate for major obstetrical complications	9	13	13	21	9
SO 3	Case fatality for major newborn complications	59	69	194	146	163
SO 4	# of effectively functioning DHMTs	7	8	9	7	7

ANNEX H: ROLES AND RESPONSIBILITIES OF PAIMAN CONSORTIUM PARTNERS

CONSORTIUM PARTNER	ROLE AND RESPONSIBILITY
JSI Research and Training Institute	Primary administrative and financial responsibility Monitoring of project implementation Health and training facility renovations Management of NGO grants Support for community midwives Training on infection prevention
Contech International Health Consultants	District level health systems strengthening
Department of Pediatrics and Child Health, Aga Khan University (AKU)	Training of trainers for EMNH and CEMOC Training in CEMOC Performance assessment of trainees
Greenstar Social Marketing	Establishment of private health care network Orientation of TBAs Marketing and sales of clean delivery kits Birth preparedness campaign
Johns Hopkins University Center for Communications Programs (JHU/CCP)	Development of communications strategy Mass media and interpersonal communication interventions
Pakistan Voluntary Health and Nutrition Assistance (PAVHNA)	Community mobilization in Sindh
Mercy Corps*	Community mobilization in Balochistan
The Population Council	Evaluation, operations research Leadership training Development of TBA curriculum
Save the Children US	Training for public sector Community mobilization in Punjab and NWFP

*Mercy Corps is not a consortium partner; it is a subcontractor of PAVHNA.

ANNEX I: PAIMAN PROJECT BUDGET ANALYSIS

BUDGET LINE ITEM		JSI	AKU	PAVHNA	CONTECH	GS	JHU	SC/US	PC	TOTAL
Management Costs										
	Salaries	4,160,545	281,590	306,190	258,377	693,366		1,229,588	925,105	7,854,761
	Overhead	1,297,578	137,108	150,199	131,844		314,776	934,237	1,237,556	4,203,298
	Travel/allow	1,454,550	77,573			14,080	309,092	193,920	265,661	2,314,876
	Equipment	1,151,843	121,756	40,167	12,667			39,500	28,694	1,394,627
	Other direct	768,569	20,228	167,981	95,508	48,333	69,402	152,225	187,483	1,509,729
Subtotal Management		8,833,085	638,255	664,537	498,396	755,779	693,270	2,549,470	2,644,499	17,277,291
Program Costs										
	HSS				1,010,435					1,010,435
	Renovations	7,971,679								7,971,679
	BCC			486,987		2,278,040	5,515,294	1,716,273		9,996,594
	C-B Training	850,000	412,907			1,908,560		2,034,589		5,206,056
	M&E	702,029				189,097			1,590,676	2,481,802
	Subgrants	6,000,000								6,000,000
Subtotal Program		15,523,708	412,907	486,987	1,010,435	4,375,697	5,515,294	3,750,862	1,590,676	32,666,566
TOTAL		24,356,793	1,051,162	1,151,524	1,508,831	5,131,476	6,208,564	6,300,332	4,235,175	49,943,857

* The Cooperative Agreement Budget including all expenses and obligations to date, and excluding additional budget for the FATA and Swat district As of March 2008, total expenses were \$ 30,314,097 and \$43,470,371 has already been obligated.

ANNEX J: SAMPLE DISTRICT COMMUNICATIONS PLAN

DISTRICT:	Khanewal	# UCS:	101	# LHWs:	2,040
POPULATION:	2,452,800	# Communities:	717	#CHWs:	63
WRA:	117,734	% rural:	82.50%		

Coverage 85% of pregnant women were reached through LHWs and CHWs

Objectives: 60% of rural UCs were reached with one health mela (4 per month)

60% of all rural villages receive at least one puppet show (30 per month).

45 QIT were set up around functioning health facilities (50% of existing facilities).

X% of QITs were turned into CCBs.

X% of Ulamas give Friday prayers that included messages for men on male responsibility.

BCC/CM ACTIVITY	PREGNANCY			CHILDBIRTH			POST/NEONATE CARE			MALE RESPONSIBILITY		
	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC
<i>CM ACTIVITIES:</i>												
Health melas	X	X	X	X	X	X	X	X	X	X	X	X
Puppet theater	X	X	X	X	X	X	X	X	X	X	X	X
QIT/CCBs	X	X	X	X	X	X	X	X	X	X	X	X
AD: pregnancy	X	X	X			X						
AD: childbirth				X	X	X						
AD: breastfeeding							X	X	X			
AD: men							X		X	X	X	X
Video aired										X	X	X
Ulama		X			X			X		X	X	X

<u>LHWS/CHWS:</u>										
Support groups	X	X	X	X	X	X	X	X	X	X
Home visits	X	X	X	X	X	X	X	X	X	X
Key messages:	1) good nutrition and iron folate 2) 4 antenatal visits 3) 2 TT shots 4) danger signs	1) SBAs 2) birth preparedness 3) CDKs for TBAs 4) danger signs 5) first pregnancies should deliver in a health facility	1) visit within 24 hours 2) breastfeed within 1 hour 3) wrapping and delayed bathing of baby 4) exclusive breast-feeding is best for baby 5) danger signs	1) pregnant women need extra food and care 2) support your wife to get help through pregnancy and childbirth 3) birth preparedness 4) danger signs						

ANNEX K: PAIMAN KEY MESSAGE AND TARGET GROUP TABLE

COMMUNITY EDUCATION AND MOBILIZATION MESSAGES FOR WOMEN AND GATEKEEPERS		
MESSAGE	TARGET GROUP	COMMENTS
<p>There are 7 key danger signs in pregnancy and childbirth, and 5 for neonates.</p> <p><u>Pregnancy and birth</u></p> <ul style="list-style-type: none"> • Heavy bleeding in pregnancy, childbirth, and immediately after birth • Fever in mother with foul smelling discharge • Maternal swelling in face and hands, severe headache, blurred vision • Convulsions • Lack of fetal movement • Labor for more than 12 hours • Malpresentations <p><u>Newborns</u></p> <ul style="list-style-type: none"> • Fever or low body temperature • Does not feed. • Difficulty breathing • Redness around the cord • Blue lips and/or nailbeds 	<ul style="list-style-type: none"> • Women of reproductive age • Gatekeepers (husbands, in-laws, family members, community members) must support a woman or newborn who is suffering from danger signs at any stage to get to a health facility. 	<ul style="list-style-type: none"> • These messages are consistent with internationally recognized standards. • Clarification on how a woman or LHW can determine if bleeding is heavy or not (number of pads used per hour, etc.). • Swelling in feet alone does not indicate pre-eclampsia. • Vomiting and spotting are not signs of obstetrical complications. • Language used to explain danger signs to LHWs and women is different to that used for providers (e.g., swelling in face and hands versus hypertension). Simplification of these messages will help women and families to seek care when truly needed.
<p>There are 3 key messages for antenatal care.</p> <p><u>Antenatal care</u></p> <ul style="list-style-type: none"> • Four ANC visits are necessary: one in the first trimester, one in the second, and two in the third. • Two tetanus toxoid shots in pregnancy can save your babies life. • Nutritious foods, including eggs, chicken, meat, fish, fruits, and vegetables, are vital to the health of the mother and fetus. Iron tablets will also keep a mother and growing baby strong. 	<ul style="list-style-type: none"> • Women of reproductive age <p>Gatekeepers:</p> <ul style="list-style-type: none"> • Husbands • In-laws • Community 	<ul style="list-style-type: none"> • Unified health messages says TT shots are “useful” – sounds optional.
<p>There are 5 key messages for childbirth.</p> <ul style="list-style-type: none"> • Delivering with a skilled birth attendant can save the lives of mother and baby. Community midwives and LHVs are the only skilled providers at the community level. • If delivering at home, ensure that your assistant has a CDK. • Birth preparedness can save lives: make a plan in your family and 	<p>Gatekeepers:</p> <ul style="list-style-type: none"> • Women of reproductive age • Husbands • In-laws • Community 	<ul style="list-style-type: none"> • There is an unfortunate amount of confusion about whether trained TBAs count as SBAs. The reentry of CMWs is likely to cause further confusion since both were trained by PAIMAN. The LHW can help clarify this as she helps the CMWs to integrate alongside TBAs into communities.

COMMUNITY EDUCATION AND MOBILIZATION MESSAGES FOR WOMEN AND GATEKEEPERS

MESSAGE	TARGET GROUP	COMMENTS
<p>community for money and transport in case an emergency arises.</p> <ul style="list-style-type: none"> • Do not delay: at first sign of a problem, immediately move the mother to the nearest health facility. • At least one postpartum checkup is required for a woman delivering at home. <p>Special message for prima gravidas:</p> <ul style="list-style-type: none"> • It is highly recommended that you deliver your first baby in a health facility with a skilled provider. 		
<p>There are 4 key messages for postpartum and neonatal care.</p> <ul style="list-style-type: none"> • Mother should have at least one postpartum checkup within 24 hours of delivery. • Baby should be wrapped in warm clothes and not bathed for at least six, but preferably 24, hours after birth. • Breastfeeding must begin within the first hour of a birth. • Exclusive breastfeeding is best for the baby's health. 	<p>Gatekeepers:</p> <ul style="list-style-type: none"> • Women of reproductive age • Husbands • In-laws • Community 	<ul style="list-style-type: none"> • The UHMs indicates PNC should occur six hours of delivery. • The UHM messages do not give timing for delay in bathing the baby. CAM strategy says two hours.
<p>NOTE: While some danger signs in pregnant and birthing mothers may be inappropriate to discuss with men (especially religious leaders and political officials), to the extent possible all key messages should be shared, using consistent language, with these influential groups.</p>		

ADVOCACY	
MESSAGE	TARGET GROUP
<p>There are 12 key messages regarding maternal and neonatal health for advocates:</p> <ul style="list-style-type: none"> • 22,000 women die every year in Pakistan from pregnancy-related causes. It is your duty as a leader to help reduce maternal and neonatal mortality in your area. • Maternal and newborn deaths can be averted if you help families to get the information and help they need. • Help those in your area to understand the following key messages: <ul style="list-style-type: none"> - Any woman showing a danger sign in pregnancy, childbirth, or postpartum should be taken to hospital as fast as possible, - Pregnant women require rest, nutritious foods, and iron folate tablets to maintain their health and that of their baby. - All pregnant women require 4 antenatal visits, - 2 TT shots during pregnancy can save a baby's life. - Women must deliver with skilled birth attendants only. - If delivering at home, women must have CDKs to ensure a clean procedure. - In case of emergency, families should have a plan for money and transport to the nearest health facility. Encourage them to do so. - Newborns must be breastfed within an hour of birth. This will provide them vital strength in their infancy. - Newborns must not be bathed for at least six hours and must be wrapped warmly to avoid illness. - Advocate for improved EmONC services in your areas. This can save many lives. 	<ul style="list-style-type: none"> • Community leaders • Ulamas • Journalists • Government officials

ANNEX L: PRIVATE PROVIDERS

Studies indicate that the private sector provides 35 to 60 percent of maternal and delivery care services. The private sector is quite complex, with a wide variety of types of providers and levels of care and quality. For example, many public sector providers also have private practices, but there are also unqualified providers.

Women go to private providers because they are female and have medicines and diagnostics (ultrasounds) that are not available in public health facilities. Greenstar identified providers on the following criteria: (1) located in low-income areas; (2) owner of the facilities for one year or longer; and (3) adequate facilities and equipment to provide quality maternal and newborn care services. While these are useful indicators, a mapping exercise of where women are currently seeking services was not conducted. This would be a useful process to conduct in the future, particularly in selecting rural health providers.

Greenstar, through its Good Life Clinics, have trained 550 female private providers on maternal and newborn care services; ANC/PNC (8 hrs.); and EMNH care (12 hrs.). The training used PAIMAN's master trainers and the essential maternal and newborn care (EMNC) training curriculum. The materials are available in both English and Urdu; the training schedule was adapted to facilitate greater participation of private providers, and desktop protocols were developed to better serve their needs. It should be noted that this training did not include use of the partograph.

As part of the training these providers have to provide three free consultation clinics. The aims of these clinics are two-fold, (1) to introduce the community to these providers; and (2) to serve as supervised training sessions for the provider. During each session, the majority of clients are FP (15) followed by ANC (5), and one postpartum and newborn client. It is unclear how many new clients attend these clinics. A key weakness of this training is that there is no observation of delivery care or management of maternal or newborn complications. Greenstar has WMO who provide educational information in short sessions, but there is no direct observation, refresher training, or third-party monitoring.

Table L.1 shows the distribution of BEmONC and CEmONC Good Life clinic facilities by district; they are primarily located in urban areas. The table also shows that there are dramatic variations in reporting levels across districts. Much more attention needs to be paid to ensuring that private providers are reporting and that the data collected accurately reflect the services, particularly the understanding of how to classify and report obstetric complications.

TABLE L.1. DISTRIBUTION OF GREENSTAR-TRAINED PROVIDERS BY TYPE OF TRAINING, DISTRICT, AND REPORTING LEVEL					
Districts	#BEmONC	#CEmONC	Total	Total	% of health care providers
	Providers	Providers	Provider	Reporting	Reporting
Upper Dir	10	0	10	0	0
Buner	16	0	16	15	93.8%
Rawalpindi	203	14	217	85	39.2%
Jhelum	47	0	47	35	74.5%
DG Khan	72	10	82	0	0.0%
Khanewal	61	3	64	10	15.6%
Sukkur	114	14	128	10	7.8%

TABLE L.1. DISTRIBUTION OF GREENSTAR-TRAINED PROVIDERS BY TYPE OF TRAINING, DISTRICT, AND REPORTING LEVEL

Districts	#BEmONC	#CEmONC	Total	Total	% of health care providers
	Providers	Providers	Provider	Reporting	Reporting
Dadu	32	1	33	0	0.0%
Jaffarabad	7	0	7	1	14.3%
Lasbella	7	0	7	3	42.9%
Total	569	42	611	159	

ANNEX M: INCREASING QUALITY OF SERVICES

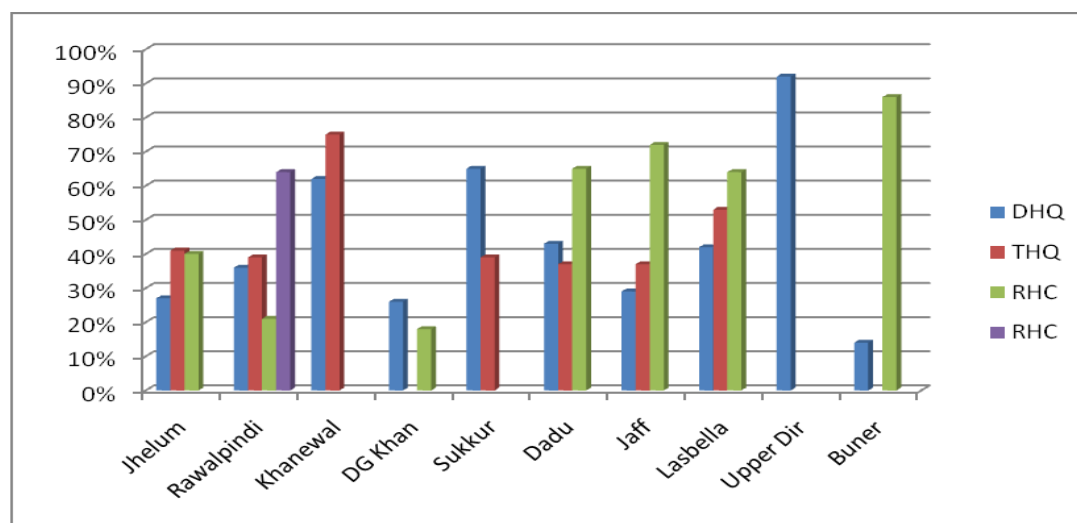
The key PAIMAN activities to enhance the quality of maternal and newborn care service are minor renovations, advocating for adequate staffing, and equipping 9 district headquarters hospitals (DHQs) and 9 tehsil headquarters hospitals (THQs) to provide CEmoNC services and 13 RHCs to provide BEmONC services. Three facilities were selected in each district to be upgraded. Health care providers, both public and private, received training to update their skills, as is further discussed under SO4.

AVAILABILITY OF FACILITIES FOR NORMAL MATERNAL AND NEWBORN CARE

The first aim of upgrading health care facilities and increasing the capacity of both public and private providers was to increase access to skilled birth attendants (SBAs) who could provide quality services. Many of these facilities, due to lack of staff and medicines, were previously not able to provide basic antenatal, normal delivery, or post-partum care, let alone manage complications. This has been a major task for the project, coordinating a variety of different inputs. PAIMAN has been successful in upgrading 31 MOH facilities to provide basic maternal and newborn care.

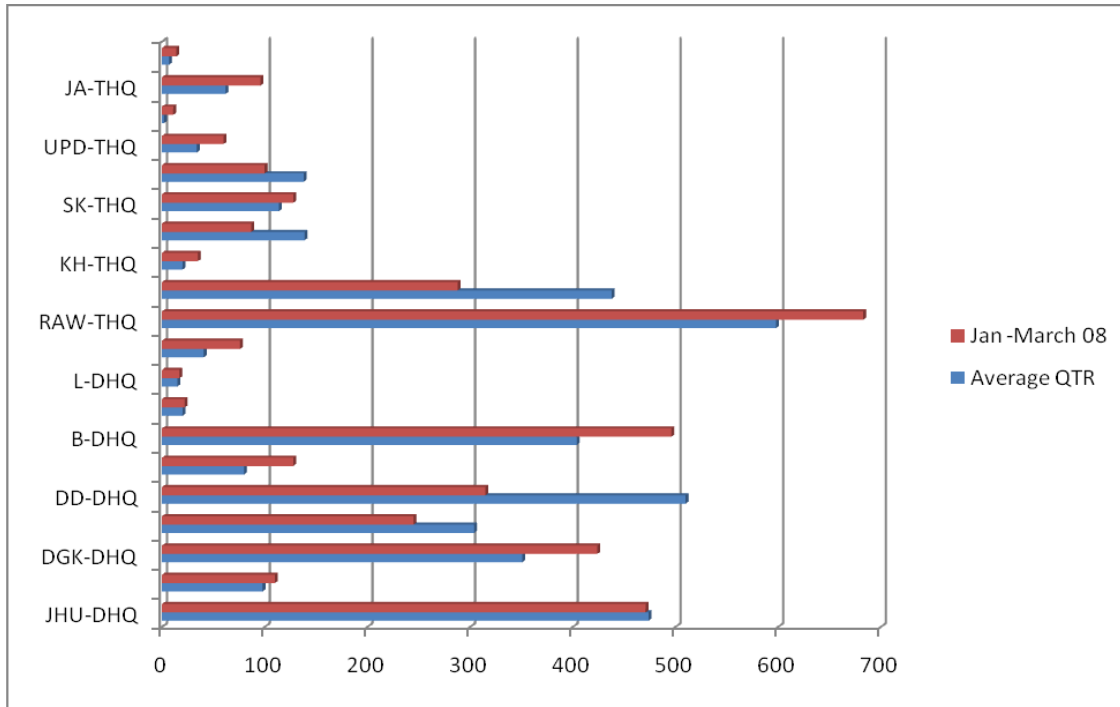
In 2007, many of the facilities were being renovated and health care providers (HCPs) were being trained. Despite these limitations the total number of births in the facilities increased. Since many of the facilities did not provide any delivery services prior to this project, the percentage increase is quite large, as shown in Figure M.1. It is interesting to note that in Labella, Dadu, Jafferbad, and Buner the greatest increases are in the RHCs.

Figure M.1. Percentage Increase of Births In MOH Upgraded Facilities, 2007



We compared the average number of deliveries in 2007, as a target, to assess if this increase continued in the first quarter of 2008. Most of the DHQ/THQ (12/18) met or exceeded the average number of births in 2007, as shown in Figure M.2.

Figure M.2. Comparison of Total Births from 2007 to 2008 in CEmOC Facilities



It seems that the greatest percentage increases were in DHQ/THQ; only 2/13 RHCs were able to sustain the 2007 levels, as shown in Figure M.3.

Figure M.3. Comparison of Total Births from 2007 to 2008 in BEmOC Facilities

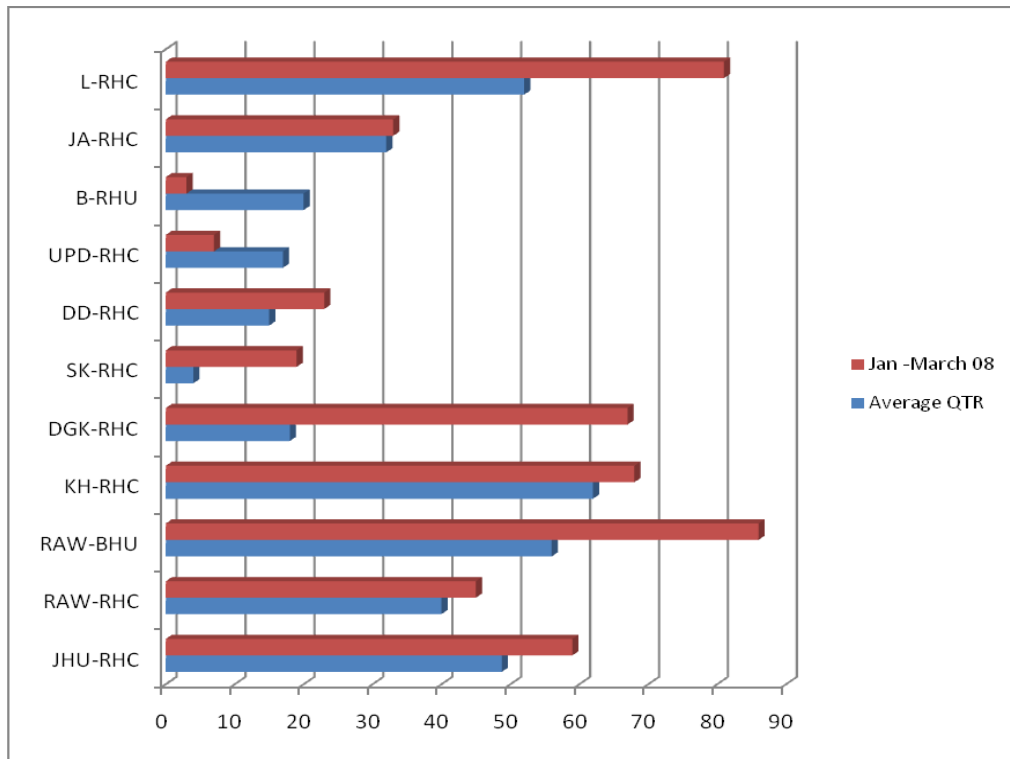
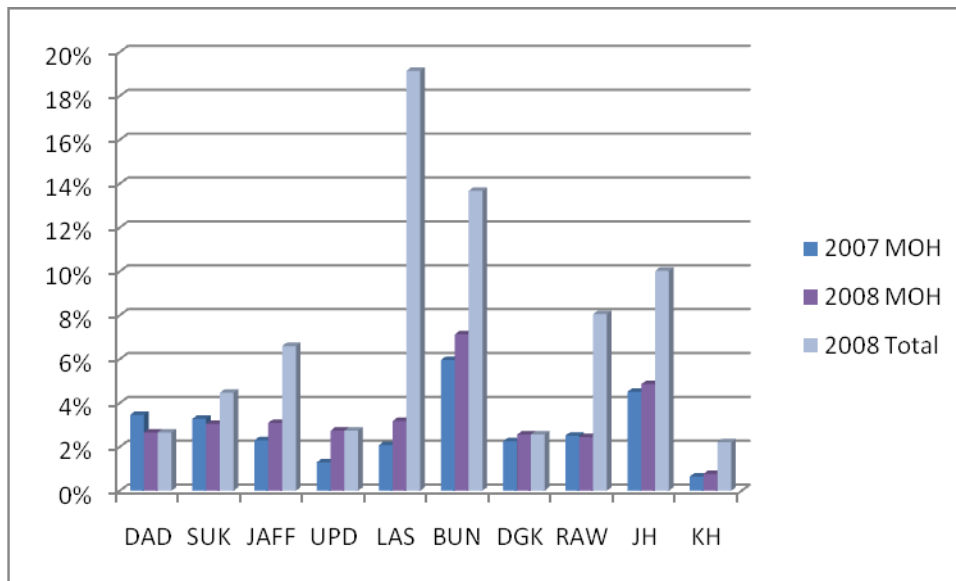


Figure M.4 shows that while there have been increases in the total number of births in these facilities, their overall population coverage is still quite low; in 2007 only about 4 percent of births were in the upgraded facilities, which is not surprising at this point in the project.

As previously stated the majority of women who deliver with SBA seek services in the private sector. While there are major reporting issues among the Good Life providers as mentioned under SO2, Figure 2 indicates that in Lasbela where only 42 percent of private providers reported the coverage of PAIMAN trained HCPs is about 19 percent. While there are some issues with reporting that need to be strengthened among the private providers, we believe that this is the type of analysis should be conducted by the project.

Figure M.5. Population Coverage of Total Births by Upgraded Providers

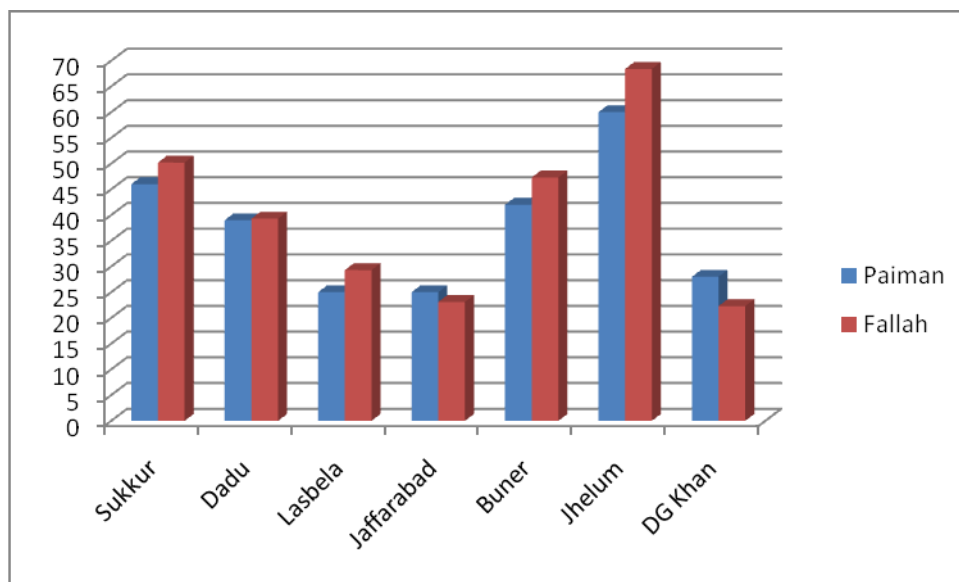


It should be noted that most (67%) of the HCPS that were trained on EMNC were not based in the upgraded facilities. Some of these providers may have been able to attend more deliveries after the training, although we know that training is limited and other inputs are not provided at the facility level. Currently the project is not collecting information on births at facilities that have not been upgraded, though that would be a useful exercise.

Thus, PAIMAN has been able to increase the numbers of HCPs and facilities that can provide basic maternal and newborn care, which is a major accomplishment. Since this is the early phases of these facilities providing such services, population coverage is quite low, which is not surprising. It is clear, however, that sustained supported is required to achieve major population impact changes that will translate into reductions in maternal and neonatal mortality.

The comparison of the baselines to the Fallah baseline in 8 districts found that delivery with SBAs increased significantly in Jhelum (8.4%); Sukkur (6.7%) and Buner (5.3%), and modestly in Lasbela (3.7%); and there was no change or a decline in Dadu (0.3%), Jafferbad (-1.9%), and DG Khan (-5.7%).

Figure M.6. Deliveries by Skilled Birth Attendants



AVAILABILITY OF FACILITIES TO MANAGE MATERNAL AND NEWBORN COMPLICATIONS

This intervention also aimed to enhance access to and quality of services that could appropriately manage maternal and newborn complications.

International standards recommend that there should be at least one CEmOC facility and four BEmOC facilities per 500,000 population. In rural areas, more facilities may be required because of the geographical distances. Table M.1 outlines the number of required facilities, based on district populations, and of facilities upgraded by PAIMAN.

TABLE M.1: AVAILABILITY OF EMOC FACILITIES BASED ON INTERNATIONAL RECOMMENDATIONS							
	CEMOC	MOH	Good	Total	BEMOC	MOH	Good
	Needed	Upgraded	Life		Needed	Upgraded	Life
Dadu	3.4	2*	1	2	13.6	2	32
Sukkur	2.3	2	14	16	9.1	3	114
Jaffarabad	0.9	1	0	1	3.5	2	7
Upper Dir	1.3	2	0	2	5.1	3	10
Lasbela	0.6	1*	0	1	2.5	2	7
Buner	1.3	1	0	1	5.1	2	16
DG Khan	4	2	10	12	16	3	72
Rawalpindi	8	2	14	16	32	3	203

TABLE M.1: AVAILABILITY OF EMOC FACILITIES BASED ON INTERNATIONAL RECOMMENDATIONS							
	CEMOC	MOH	Good	Total	BEMOC	MOH	Good
	Needed	Upgraded	Life		Needed	Upgraded	Life
Jhelum	2.2	2	0	2	8.8	3	47
Khanewal	4.9	2	3	5	19.6	3	61

On paper there seem to be ample facilities to manage complications, but the facilities vary greatly in their ability to provide quality EmONC services. This is particularly true among private providers.

PAIMAN has upgraded 13 RHC to provide BEmOC and 18 DHQ/THQ to provide CEmOC. However, 5 of the 18 CEmOC facilities (THQ KH Shah in Dadu and 4 hospitals in Balochistan) are not able to provide CEmONC because of shortages of blood supplies and lack of key staff (gynecologist, anesthetist). PAIMAN has advocated for these inputs, but this is beyond their control. However, they have been quite successful in facilitating 24/7 services, which are available in most of the facilities. This is an ongoing process, as there is frequent staff turnover and reassignments.

In discussion with HCPs, many said that they had shortages of partograph forms and injectable antihypertensives; all of them said that there is no magnesium sulfate to manage pre-eclampsia. That will need to be addressed by the DOH. PAIMAN has developed a scoring index to assess progress in a facility's ability to provide services; as of March 2008 most of the facilities scored above 95 percent. There are 7 THQ facilities (CEmOC) and 28 RHCs (BEmOC) that have not yet been upgraded in these districts.

Routine monitoring of output indicators (RMOI) tracks obstetric complications at each of the upgraded facilities. The number of complications has increased, but as discussed below there is considerable confusion about what is an obstetric complication, so there may be some overreporting.

TABLE M.2. NEEDS FOR OBSTETRIC COMPLICATIONS MET IN MOH UPGRADED FACILITIES IN 2007						
	Expected # Women w/ Complications	# of Obstetric Complications	Total C-Sections	% Emer C-Section	C-Section as % of Complications	Overall Met Need
Dadu	11,501	1603	409	45.0%	25.5%	13.9%
Sukkur	7,725	990	520	55.0%	52.5%	12.8%
Jaffarabad	2,928	91	0	0.0%	0.0%	3.1%
Upper Dir	4,273	315	86	98.0%	27.3%	7.4%
Lasbela	2,115	128	0	0.0%	0.0%	6.1%
Buner	4,292	199	101	60.0%	50.8%	4.6%
DG Khan	13,530	1,216	266	45.0%	21.9%	9.0%
Rawalpindi	27,060	411	70	45.0%	17.0%	1.5%
Jhelum	7,482	160	257	82.5%	160.6%	2.1%
Khanewal	16,574	868	118	56.0%	13.6%	5.2%
Average						6.58%

Once again, it is a major achievement of have health facilities providing 24/7 EmOC services. Many of the facilities have only recently become functional, so it is not surprising that the numbers are low. However, it is important to have a baseline to move forward with; while the building blocks have been put in place, it indicates that much more work is needed to see significant changes at a population level.

Even though the private sector is a major provider of maternal health services, their capacity and quality is a big unknown, particularly in terms of managing complications. Table M.3. looks at the achievements of upgraded MOH facilities and Good Life providers for January–March 2008.

TABLE M.3. NEED FOR OBSTETRIC COMPLICATIONS MET IN MOH AND GOOD LIFE CLINICS, JANUARY–MARCH 2008]					
	Expected # Women with Complications	# of Obstetric Complications in MOH	# of Obstetric Complications in Private	Total Complications	Overall Met Need
Dadu	3,506	391	0	391	11.2%
Sukkur	2,355	249	129	378	16.1%
Jaffarabad	892	37	5	42	4.7%
Upper Dir	1,302	91	0	91	7.0%
Lasbela	644	33	0	33	5.1%
Buner	1,308	60	448	508	38.8%
DG Khan	4,125	183	0	183	4.4%
Rawalpindi	8,250	145	5,474	5,619	68.1%
Jhelum	2,281	57	215	272	11.9%
Khanewal	5,053	194	61	255	5.0%
Average					17.23

Although the same issues persist in terms of the quality of reporting on obstetric complications, with the inclusion of the private sector providers the met need increased 6.5 percent to 17.2 percent. While it is challenging to determine denominators for met need, the project is entering a phase where this is something that should be included as part of their yearly analysis. The TAG may provide valuable insight into how the denominators may be best calculated.

SUPERVISION OF PUBLIC SECTOR PROVIDERS

The project also provided training on supervision. Very few staff have specific supervisory responsibilities, which vary greatly by province and district. From our discussions, it does not appear that PAIMAN conducts joint facility-level supervision training with DOH staff. The facility scoring sheets indicate that supervision visits have been conducted, but it is unclear what is reviewed during these visits, based on discussions with facility staff.

HEALTH INFORMATION SYSTEM

Throughout the project documents there is considerable confusion about the difference between minor pregnancy and newborn ailments (e.g., urinary tract infection (UTI), anemia, vomiting) and major obstetrical complications that lead to maternal and newborn deaths. The confusion began with the way the baseline findings are reported, leading to the development of the behavior change communication messages on danger signs, the HCP training curriculum, and record keeping. For example, the Buner baseline states that 49.7 percent of women experienced a complication, but we know that only 15 percent

of all pregnant women can be expected to have an obstetric complication. Of the 49 percent of women who had a complication, only 39 percent reported conditions that are obstetric complications; the other 61 percent reported minor ailments. A similar pattern was seen in all the district baselines. As a result, the BCC messages and training curriculum are not specific enough to make the necessary distinctions, adding to the confusion.

PAIMAN provided registers to track obstetric complications and C-sections and also some training on complication definitions. It does not appear that there are any registers of newborn complications. The facilities that the team visited had total births, IUDs, and maternal obstetric complication as bar graphs on the wall. There was no information about newborn complications or deaths. Although the staff understood the key aspects of the data and what it meant, there was not a good understanding of how these figures related to basic population data (estimates of pregnant women in the area).

Although registers have separate columns for the complications, they are reported as aggregates. It would be useful for facilities to track types of complications so they could see which are the most common complications.

In discussions with HCPs during the field visit, they seemed to consider any reason that a woman was admitted as a complication (e.g., treatment of UTIs), even though the registers had the five major complications. This seemed to be most problematic for antepartum complications. As a result a significant percentage of what are reported as obstetric complications are incorrect.

In the facilities visited, the majority of complications occurred during the antepartum period (see Table M.4). In addition, between 35-50 percent of these complications are due to incomplete abortions before the 20th week with the usual treatment being D&C. A provider told me that in 2007 these figures were not included in their obstetrical complication reports but in 2008 they have been included.

TABLE M.4. COMPLICATIONS AND C-SECTIONS REPORTED			
	May 2008		
	Total Births	Total Complications	Total C-Sections
Khanewal DHQ	37 vaginal deliveries 48 total deliveries 4 IUD 44 total births	42 complications 11 C-section (2 IUD); 4 eclampsia; 2 PPH;2 APH; 19 UTI, false labor pain, incomplete abortion	11 C-sections 1 eclampsia 2 previous C-section 2 CPD;1 malpresentation 3 fetal distress
Khanewal THQ	11 vaginal deliveries 13 total deliveries 13 total births	12 complications 2 anemia; 1 sepsis 9 incomplete abortion/D&C	2 C-sections
Rawalpindi THQ	201 vaginal deliveries 209 total births 10 IUD 210/200 total births	39 complications 7 C-sections 8 APH; 2 PIH;1 Spotting 1 N/V; 3 preterm 17 incomplete abortion/D&C	7 C-sections 1 twins 3 previous C-section E eclampsia 2 fetal distress

These limited findings indicate that there are very few complications during childbirth, and women with postpartum hemorrhage are probably not able to reach the facilities. Thus, it would be useful for staff to track the five key complications. They will need more training to clarify both the diagnosis and reporting of these complications.

The RMOI also tracks case fatality rates, but since the numbers are quite small, at this point in the project this is probably not a very useful indicator.

As noted, basic reporting by private providers is a major problem. It is unclear what training these providers have had in reporting complications; that will need to be greatly strengthened.

STILLBIRTHS AND NEWBORN DEATHS

While there has been some progress in tracking maternal complications, there has been less emphasis on tracking newborn deaths and complications, which vary greatly by district (see Table M.5). It may be useful to have further discussions with HCPs to understand the causes of these deaths.

TABLE M.5. STILLBIRTHS AND NEWBORN DEATHS					
	Stillbirths			Newborn deaths	
District	Jan-Dec 07	Jan-Mar 08	Jan-Mar 08	Jan-Dec 07	Jan-Mar 08
	MOH	MOH	Private GL	MOH	MOH
BUN	44	6	32	58	30
UPD	24	16		15	4
Jaff	16	7	7	7	3
LAS	9	4	2	19	2
SUK	116	49	1	85	30
DADU	135	5		184	50
JHE	41	15	2	40	11
RAW	138	18			1
KHA	15	4	24	11	3

All HCPs the team met with commented that they feel more confident in doing neonatal resuscitation. It might be useful to track this as an indicator instead of case fatality rate, because the numbers are still quite small and not very meaningful at this stage in the project.

ANNEX N: INCREASING CAPACITY OF HEALTH CARE WORKERS

Training on Normal Delivery: PAIMAN provided a one-month clinical training for 497 LHVs, nurses, and midwives on managing normal deliveries (see Table N.1). Unfortunately, the training did not include the use of the partograph or active management of the third stage of labor (AMTSL), which are key aspects of normal delivery. In addition, most of the DHQ/THQs used as training sites did not use these practices, so the LHVs did not learn these skills. However, in discussions with HCP who attended the training, they found it very useful.

TABLE N.1. COMPARISONS OF HCPS WHO RECEIVED ONE MONTH CLINICAL TRAINING AND EMNC TRAINING, BY DISTRICT			
District	# LHVs, FMT, Nurses	# HCPs	%HCP* received
Name	Clinical Training	EMNC Training	Both training
Dir	28	30	107.1%
Buner	27	16	59.3%
Sukkur	42	14	33.3%
Dadu	35	14	40.0%
Jaffarabad	45	16	35.6%
Lasbella	29	12	41.4%
Rawalpindi	98	90	91.8%
Jhelum	79	25	31.6%
Khanewal	58	67	115.5%
DG Khan	56	29	51.8%
Total	497	313	63.0%

As shown on average about 63 percent of HCPs who received the one-month clinical training also received the EMNC training. Not surprisingly, this ranges from a high of 115 percent in Khanewal to less than a half in Dadu, Jafferbad, Lasbella, Jhelum, and Sukkur.

Essential Maternal and Newborn Care (EMNC) Training: Essential maternal care includes antenatal and postnatal care, management of normal deliveries, and management of nonsurgical maternal complications. The newborn component includes essential newborn care (ENC) and management of neonatal asphyxia, sepsis, jaundice, and low birth-weight babies.

This is a five-day training with lectures and practice on models, but no clinical practicum. The training does not include use of the partograph and has only small sections on AMTSL, communication skills, and infection prevention. Training materials and protocols are in English; PAIMAN is currently translating the materials into Urdu.

While the majority of the information in the EMNC curriculum is correct, it would be useful to conduct a technical review of the content to strengthen the training. For example, several of the danger signs listed (e.g., epigastric pain, vomiting in the fourth month) are not indicators of the five major causes of maternal mortality; they are minor ailments that can be addressed at the primary care level of the health system and are not urgent. These distinctions need to be made clearer to enhance the ability of HCPs to effectively

communicate which are the most important and where a woman should go if she experiences any of these conditions.

Based on the information provided, HCPs need to complete four checklists during the EMNC training: (1) antenatal care, for use in the wards; (2) immediate care of the newborn; (3) management of postpartum hemorrhage; (4) newborn resuscitation. It does not appear that there is a checklist for normal delivery, AMSTL, or management of pre-eclampsia/eclampsia. On the ANC checklist, in the second trimester it would be useful to give the first dose of TT, take blood pressure, and provide counseling on key topics. Management of postpartum hemorrhage could be simplified, indicating that AMTSL had been conducted; thus, this is a case of uterine atony requiring bimanual compression. On the newborn checklist it would be useful to assess the one-minute and five-minute Apgar levels, provide eye ointment, and weigh the baby.

There are several questions on the pretest that are very confusing. For example, question #5 states, a low birth weight baby is one who weighs: (a) less than 1.5 kg; (b) less than 2.0 kg; (c) less than 2.5 kg; or (d) less than 3 kg. These are overlapping answers, which means that a, b and c are all correct. The same problem occurs with question #2. On question #7, the EMNC training manual (p. 123) says that gentian violet should be given and the mother should be taught to do this, but this is not provided as an answer. In addition, there are no questions on AMTSL or maternal and newborn danger signs.

To date a total of 1,599 providers have been trained on BEomNC. Of these, on average 60 percent were female. In the Punjab districts about 70 percent of the trainees were female, but less than a third in Upper Dir (33%) and Dadu (23%) were female. Because of the shortage of female HCPS in NWFP, PAIMAN is supporting training of 107 LHVs rather than CMWs. These providers will graduate in September and be placed in MOH facilities, which should increase access to SBAs in these districts.

TABLE N.2. EMNC TRAINING BY PROVIDER TYPE AND DISTRICT

Cadre	Dir	Buner	Sukkur	Dadu	Jaffar- abad	Lasbela	Rawal- pindi	Jhelum	Khanewal	DGKhan	Total
Pediatrician	0	0	2	1	0	0	2	0	2	0	7
Obstetrician	0	0	2	0	0	0	2	0	3	1	8
Anesthetist	0	0	0	0	0	0	0	1	2		3
MO	26	19	71	115	35	56	51	34	58	30	495
MT/dispes	82	34	0	0	16	15	3	0	1	2	153
WMO	3	2	40	16	3	20	38	14	15	23	174
FMT'	2	52	0		20	16	2	4	3	14	113
LHV'	30	16	14	14	16	12	90	25	67	29	313
Nurse	20	43	28	4	12	18	35	29	53	38	280
Midwife	0	0	4	2	0	0	0	40	7		53
Total	163	166	161	152	102	137	223	147	211	137	1599
Female providers	55	113	88	36	51	66	167	112	148	105	941
Total BEMOC Trained	163	166	161	152	102	137	223	147	211	137	1581
% of female trainees	33.7%	68.1%	54.7%	23.7%	50.0%	48.2%	74.9%	76.2%	70.1%	76.6%	59.5%

Having upgraded 31 MOH health facilities to provide BEmONC and CEmONC services, PAIMAN's strategy is to train HCPs from both the upgraded facilities and those that have not been upgraded in the ten districts. The majority of HCPs (67%) that received EMNC training are from facilities that have not been upgraded (see table N.3).

TABLE N.3. DISTRIBUTION OF HCPS WHO RECEIVED EMNC TRAINING BY UPGRADED AND NONUPGRADED HEALTH FACILITIES				
District	HCPs Trained in Upgraded MOH Facilities	HCPs Trained in Facilities Not Upgraded	Total # trained	% of HCPs Trained in Upgraded Facilities
Buner	85	81	166	51.20%
Upper Dir	83	80	163	50.92%
DG Khan	35	102	137	25.55%
Jhelum	36	111	147	24.49%
Khanewal	58	153	211	27.49%
Rawalpindi	22	201	223	9.87%
Dadu	49	103	152	32.24%
Sukkur	54	107	161	33.54%
Lasbella	62	75	137	45.26%
Jaffarabad	38	64	102	37.25%
Total	522	1077	1599	32.65%

While training is a key input, experience has shown that providing training alone without adequate facility-level inputs and trainee follow-up has limited success. The team found that some of the upgraded facilities lack basic inputs (e.g., mag. sulfate) that limit their ability to use the information gained during training. It is unclear what follow-up support is provided to these trainees. In addition, data are only collected from the 31 upgraded facilities so it was not possible for the team to understand what, if any, changes have resulted from training HCPs in facilities that have not been upgraded.

Training on Use of the Partograph and Active Management of Third Stage of Labor: It does not appear that PAIMAN had identified use of the partograph and AMTSL as a weakness of EMNC training, despite studies that show health facilities and staff in Pakistan, including teaching hospitals, do not regularly utilize these tools. It was fortunate for the project that the Midwifery Association of Pakistan (MAP) developed this training, under different funding. The MAP training is three days with a clinical practicum; the PAIMAN training is two days without a clinical practicum. PAIMAN added the MAP training in June 2007 for one year.

HCPs interviewed stated that none of them had used the partograph or AMSTL routinely before the training. To date 268 female HCPs have been trained, out of a target of 400, which constitutes 42 percent of the total female HCPs that received EMNC training. HCPs reported that the training was very useful; many said that they are regularly practicing these skills. The subcontract with MAP ends in July 2008; they have submitted a request for a no-cost extension through December 2008 and are awaiting approval.

A key weakness of the ENMC and MAP training was that they did not include a clinical practicum, which is necessary to effectively change HCP practices. International BEmOC training curricula are at least 10 days with a clinical rotation. UNICEF's training on BEmOC in Pakistan is for 15 days, including a clinical practicum. Another weakness was omission of the partograph in the EMNC training.

Overall, however, the EMNC training content is quite good, though several areas could be enhanced. Urdu training materials and protocols will enhance understanding of materials particularly for LHVs and CMWs. The ability of HCPs to understand the difference between minor ailments and major complications could be enhanced, as well as their ability to provide this information in a way that is easy for women to understand.

Based on the performance assessment, it appears that the training has been effective in enhancing providers' knowledge and ability to manage normal deliveries. It has been harder for them to retain their knowledge and skills for managing maternal and newborn complications.

FATA REPORT ANNEXES

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

ACRONYMS

ARI	Acute respiratory infections
AHQH	Agency headquarters hospital
AHMT	Agency health management team
ANC	Antenatal care
BCC	Behavior change communication
BHU	Basic health unit
CCM	Community case management
CD	Civil dispensary
CDD	Control of diarrheal diseases
CH	Civil hospital
CHC	Community health center
CHD	Child Health Days
CHW	Community health worker
CMS	Community mobilization strategy
ENC	Essential newborn care
FATA	Federally Administered Tribal Areas
FMT	Female medical technician
FR	Frontier regions
HCP	Health care provider
HF	Health facility
HMIS	Health management information system
ICHP	Improved Child Health Project
IMNCI	Integrated management of newborn and childhood illnesses
IMR	Infant mortality rate
IR	Intermediate result
LHV	Lady health visitor
LHW	Lady health worker
M&E	Monitoring and evaluation
MCHC	Maternal and Child Health Center
MNCH	Maternal, neonatal, and child health
MO	Medical officer
NGO	Nongovernmental organization
NMR	Neonatal mortality rate
ORS	Oral rehydration salts
QIT	Quality improvement team
RHC	Rural health center
SC	Save the Children
TBA	Traditional birth attendant
TT	Tetanus toxoid

USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of reproductive age

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ANNEX A: SCOPE OF WORK

MID-TERM EVALUATION MATERNAL NEWBORN AND CHILD HEALTH PROGRAM USAID/PAKISTAN

(FINAL: 04/27/08)

I. PURPOSE

The purpose of the subject evaluation is to provide the United States Agency for International Development's Mission to Pakistan (USAID/Pakistan) with an independent mid-term evaluation of its Maternal Newborn and Child Health (MNCH) programs. The MNCH programs are managed by the Office of Health and implemented primarily by two organizations, John Snow Inc.³ and Save the Children,⁴ both functioning under Cooperative Agreement mechanisms. The evaluation team will also be asked to include suggestions for the program design component (e.g., future directions) for potential expansion of the MNCH program. A program design activity by a separate team will follow this evaluation activity.

As part of USAID/Pakistan's due diligence, a mid-term evaluation is being commissioned to assess the effectiveness of the program components, document lessons learned, present results achieved to date, and provide recommendations for overall program improvement and strengthening.

Recommendations for the follow-on project after the completion of the current projects will also be presented in a separate section of the report but as part of the evaluation for internal USAID use only. Suggestions for program design and scaling up for a more substantial program expansion should also be included in the evaluation report.

Taking into consideration the challenges and constraints of the current working environment, the objectives of the evaluation are to

- Assess whether the MNCH program partners are achieving intended goals and results and meeting benchmarked activities in the cooperative agreements and work plans.
- Evaluate the effectiveness (objectives and results) of the management structures, administrative support, cost and partnerships, and collaborative plans.
- Evaluate the effectiveness of key technical components and approaches of the MNCH program given the health status and sociocultural and religious context in Pakistan.
- Establish whether the overall demand for maternal child health services is growing in project districts as a direct or indirect result of these projects.
- Document lessons learned and provide discrete management, administrative, and technical recommendations for improving overall efficiency and effectiveness in the context of the Ministry of Health programs in maternal and child health and related areas.
- Review the findings, conclusions, and recommendations and provide brief suggestions/options for future directions of the program with the potential for program expansion at various levels of additional funding. For example, what would the program look like with an additional \$5–\$20 million per year? What would be the team's recommendations

³ JSI PAIMAN \$50m five-year Cooperative Agreement 2005–2009.

⁴ SAVE The Children \$11.5m three-year Cooperative Agreement 2007–2009.

for expanding the program in the current programmatic or geographic areas or adding program areas and districts?

- Provide key inputs, background information, and methodology suggestions that can be incorporated into an SOW for the final project evaluation in 2009.

Findings and recommendations will be used to ensure that the MNCH program serves the overall objective of improving maternal, newborn, and child health in Pakistan in the most effective way.

This mid-term evaluation will be shared with partners but not widely distributed. Sections of the evaluation may be shared with outside sources at the discretion of USAID management. The separate design/future directions section of the report will be kept for internal USAID use only.

II. BACKGROUND

Pakistan's maternal and newborn mortality rates are high despite an extensive health service delivery network. The problem is well described in a qualitative study conducted by JSI's MotherCare Project that found that awareness of major maternal and newborn complications among women, families, and attendants is insufficient. Most maternal and newborn deaths occur at home without a skilled health provider attending. According to available statistics, over 65 percent of women deliver at home. Trained health professionals conduct only 5 percent of these deliveries. Also, a high total fertility rate (4.1) continues to expose women and children to increased risks of mortality and morbidity.

Many traditional social values discriminate against women, lowering their status and affecting their food intake and nutrition, education, decision making, physical mobility, and health care. Husbands, in-laws, and religious and community leaders all play significant roles in these customs. Women, families, and providers focus little attention on behaviors related to preventive care and planning for potential maternal and newborn emergencies. In addition, only a few women, families, or attendants are aware of newborn complications like fever, respiratory problems, pre-maturity, and cord infection.

Although Pakistan has an extensive network of public sector delivery facilities, they reach only about a third of the country's population: the rest (70 percent) is served by the private sector, at least for curative services. The public sector health program is still the main service delivery mechanism for isolated rural communities and for preventive services. It needs improvements in several areas, including physical facilities, safe water supply, privacy for female clients, supply of drugs, logistics and equipment, and provider capabilities, especially in counseling and clinic management.

Health facilities are underutilized. They require better linkages with the communities they intend to serve. Lack of availability of providers, especially female providers, at public health facilities needs to be addressed. While most curative services are provided through private providers, private sector health services in Pakistan are unregulated, raising questions of quality. While the Government of Pakistan (GOP), as part of its devolution strategy, promotes delegation of health services planning and management responsibilities to the districts, management systems at the district level, including referral systems, supervisory systems, health information systems, and coordination between public and private sectors, are weak.

The Constitution of Pakistan guarantees basic human rights to all citizens, which includes equitable access to health and social services. The GOP is aware of the huge burden of preventable deaths and morbidity among women and children and is committed to improving their health status. Unfortunately, concerted efforts to improve the health of mothers and children have been lacking. Short-term localized programs and projects have failed to achieve significant and sustainable improvements in MNCH indicators. Such improvements can only be achieved

through a national-level, comprehensive, focused, and effective program that is owned and managed by the districts and is customized to meet each district's specific needs.

In 1990 Pakistan adopted its first National Health Policy to provide vision and guidance to the development of the national healthcare delivery system. Its goal was to provide universal coverage through enhancement of trained health manpower. The policy put emphasis on maternal and child health and primary health care. The National Health Policy was revised in 1997 to introduce a vision for health sector development by 2010.

The National Reproductive Health Services Package (NRHSP) was introduced in 2000 jointly by the Federal Ministries of Population Welfare and of Health. Its effectiveness and application since its introduction have remained incomplete and unsatisfactory.

In June 2001 the Federal Cabinet approved the current National Health Policy, which envisages health sector reforms as a prerequisite for poverty alleviation, gives particular attention to strengthening the primary and secondary tiers of health services, and calls for the establishment of good governance practices in order to achieve high-quality health services.

The Population Policy of Pakistan (2002) focuses on integration of reproductive health services with family planning, building on the successful elements of the program, increased participation of the private sector, greater emphasis on social marketing, and enlarging the scope of family planning services. The Ministry of Population Welfare has shifted its emphasis in mass communication campaigns from population control to women's health.

The Ten-Year Perspective Development Plan 2001–2011 places emphasis on improving the service delivery mechanisms for reducing preventable diseases. The policy focus is on a continuous shift from curative to promotion and preventive services through primary health care.

Pakistan is signatory to several international agreements regarding improving MNCH, including the Millennium Development Goals (MDG) in MNCH, which are:

Goal 4—Reduce child mortality by two-thirds, between 1990 and 2015. The indicators to measure progress toward this MDG include under-5 mortality rate, infant mortality rate (IMR), and proportion of 1-year-old children immunized against measles. Pakistan's target is to reduce IMR to 40 per 1,000 live births and to increase the measles immunization rate to >90 percent by 2015.

Goal 5—Improve maternal health by reducing the maternal mortality ratio (MMR) by three-quarters, between 1990 and 2015. The indicators to measure progress toward this MDG include the MMR and the proportion of births attended by skilled health personnel. Pakistan's target is to reduce MMR to 140 or less, and to increase skilled birth attendance to 90 percent by 2015.

In addition, Pakistan envisions increasing the contraceptive prevalence rate to 55 percent, increasing the proportion of pregnant women receiving antenatal care from the current 61 percent to 100 percent, and reducing the total fertility rate from 4.1 to 2.1 by 2015 (DHS 2006–07).

The Pakistan Planning Commission Form 1 (PC-1) for the National Maternal Newborn and Child Health states that in all districts of Pakistan maternal newborn and child health care services will be strengthened for the population through improving primary health facilities, secondary hospitals, and referral systems and placement of skilled birth attendants at the community level in rural areas and underserved urban slums. One of the most important areas identified by the government of Pakistan has been a focus on poverty reduction. The current Minister of Health emphasizes "pro-poor" activities as his focus as well. The MNCH development partners are working on the development and revision of a Logical Framework of activities for the National MNCH Program prior to the actual start of the program in early 2008, likely following the national elections.

Several other foreign assistance programs are focusing efforts on MNCH, including the British, Norwegians and Australians. United Nations programs addressing MNCH include UNICEF and UNFPA. The two primary MNCH implementing partners for USAID are John Snow Inc. (JSI) and Save the Children. Their project summaries are included here.

Pakistan Initiative for Mothers and Newborns (PAIMAN) John Snow Inc.

Effective maternal and newborn care consists of a continuum of health care interventions, beginning before pregnancy and covering the prenatal, delivery, and postpartum periods, and addressing the individual health of women and children. In the Pakistan context, in order to have an immediate effect on mortality rates, the focus must be on labor, delivery, and the immediate postpartum period—from the onset of labor through day 7. The PAIMAN project promotes skilled attendance as the long-term goal for all deliveries in Pakistan. The project LOP is 10-08-04 to 09-30-09; funding level is \$56,243,858 (Annex 5).

Evidence in the public health literature shows that the maternal and neonatal survival depends upon a whole set of sociocultural, economic, and geographic determinants in the Pakistan context. These factors need to be addressed to generate comprehensive and sustainable solutions to the problem of maternal and neonatal mortality. The MNCH program therefore calls for a multipronged strategic approach, combining individual health care with public health and community-based interventions.

The JSI team bases the continuum of care represented in the MNCH program on a strategic framework referred to as “The Pathway to Care and Survival,” which follows a series of steps necessary to increase the likelihood of survival of a mother and her baby in the event of complication or illness. At each step, Pakistani women and children face various interrelated issues that prevent them from reaching quality care and threaten their subsequent survival. We have classified these issues in five main categories:

- Lack of awareness of risks and appropriate behaviors related to reproductive and neonatal health issues, resulting in poor demand for services
- Lack of access (both geographic and sociocultural) to and lack of community involvement in MNCH services
- Poor quality of services, including lack of adequate infrastructure in health facilities
- Lack of individual capacity, especially among skilled birth attendants
- Weak management environment and lack of health services integration.

For each of these “problem categories” PAIMAN has defined a program objective and a series of interventions to address them.

PAIMAN Program Goal and Objectives

Goal: To reduce maternal, newborn, and child mortality in Pakistan, through viable and demonstrable initiatives and capacity building of existing programs and structures within health systems and communities to ensure improvements and supportive linkages in the continuum of health care for women from the home to the hospital.

Objectives:

Based on the “Pathway to Care and Survival” framework, PAIMAN has the following program objectives, interventions, and outcomes:

1. Increase awareness and promote of positive maternal and neonatal health behaviors.

Outcomes:

- Enhanced demand for maternal, child health, and family planning services through a change in current patterns of health-seeking behavior at the household and community level.
 - Increased practice of preventive MNH-related behaviors.
- 2. Increase access (including emergency obstetric care) to and community involvement in maternal and child health services and ensure services are delivered through health and ancillary health services.**

Outcomes:

- Higher use of antenatal and postnatal care services, births attended by skilled birth attendants, contraceptive use, tetanus toxoid coverage, enhanced basic and emergency obstetric care, and reduced case fatalities.
 - Reduced cost, time, and distance to obtain basic and emergency care, ultimately saving newborn and maternal lives.
- 3. Improve service quality in both the public and private sectors, particularly related to the management of obstetrical complications.**

Outcomes:

- Greater utilization of services to improve maternal and newborn health outcomes.
 - Decreased case-fatality rates for hospitalized women and neonates.
- 4. Increase capacity of MNH managers and care providers.**

Outcomes:

- Increased skilled attendance for deliveries in the target districts.
 - Decreased case-fatality rates for hospitalized women and neonates.
- 5. Improve management and integration of services at all levels.**

Outcomes:

- District MNH plans and budgets available.
- HMIS information used for MNH decision making.
- Better coordination between public, private, and community health services.

Beneficiaries:

The project will work with communities, government, and local nongovernmental organizations (NGOs) to strengthen maternal, neonatal, and child health to increase the health status of women and children. It is estimated that the program will reach an estimated 2.5 million couples, and nearly 350,000 children under 1 year of age will benefit from the program. As beneficiaries of the program, PAIMAN has identified married couples at reproductive age (15–49) and all children under 1 year of age.

PAIMAN Time Frame

PAIMAN originally planned to begin working in three or four districts and gradually phase in the remaining districts. In actuality they started activities in all ten districts from the beginning of the

project. In December 2007 PAIMAN expanded activities in the FATA in Khyber and Kurram Agencies and Frontier Regions Peshawar and Kohat. PAIMAN also began working in Swat district in April 2008.

Improved Child Health in FATA, Save the Children

Pakistan is lagging behind most countries in South Asia in terms of child health indicators. The under-5 mortality rate (U5MR) is estimated at 103/1,000 live births and IMR at 81/1,000 live births. Of the 560,000 under-5 deaths reported in 2001, 19 percent were due to pneumonia and diarrhea each, 18 percent to perinatal causes, 7 percent to measles, 5 percent to malaria, and 32 percent to other causes. Only 60 percent of children are immunized for measles at 1 year of age, and the overall chronic malnutrition rate among children less than 5 is 58 percent. A recent *Lancet* article estimated the neonatal mortality rate (NMR) at 57/1,000 live births, almost as high as Afghanistan and considerably higher than India or Bangladesh. Eighty percent of deliveries are conducted by an unskilled provider. Exclusive breastfeeding (4 months) is quite low as reported at 16 percent.

FATA Overview

FATA is a belt of seven semi-autonomous tribal agencies stretching north to south along the border between Pakistan and Afghanistan. With respect to population and health system administration, an agency can roughly be equated to a small district in Pakistan. Each has its own characteristics, with wide inter- and intra-agency variations in socioeconomic, cultural, and health status parameters. Project LOP is 09-01-06 to 08-30-09; funding level is \$14,750,000 (listed in Annex 5).

The people of FATA are almost exclusively ethnic Pashtun. The last national census in 1998 estimated the population at 3.6 million people, of which the government estimates 21 percent (756,000) are women of reproductive age (WRA) and 8.8 percent (316,800) are children under the age of 5. As children under 5 represent nearly 14 percent of the overall population in Pakistan, this figure may reflect substantial undercounting. More than 97 percent of the population lives in rural areas, with the average household size between 8.5 and 10.6 people across the seven agencies.

Child Health

While the number and type of health facilities varies widely, facilities are characteristically underequipped with high staff absenteeism. Community level maternal and child health care coverage through lady health workers (LHWs) is low, ranging from 13 percent in Bajaur Agency to 55 percent in Kurram. Facility-based reports for 2004 reflect newly registered pregnant women for antenatal care (ANC) at 11 percent, far less than the national average (43 percent).

In a recent GOP report, maternal mortality in FATA was estimated at 600/100,000 live births and infant mortality at 83/1,000 live births. Health Management Information System (HMIS) data from Bajaur Agency for the first half of 2005 reflect an estimated U5MR of 135/1,000 live births. In a report published in the *Bulletin* of the World Health Organization (WHO) in 2002, tetanus was estimated as the cause of approximately 22 percent of all infant mortality in FATA and 36 percent of neonatal deaths. Overall, only 50 percent of pregnant women are vaccinated against tetanus. In 2004 antenatal care ranged from 0 percent in South Waziristan to 18 percent in Orakzai, and fewer than one out of six mothers deliver with a skilled birth attendant.

Currently there are 926 LHWs in FATA covering approximately a third of the population based on the government's commitment to have one LHW per 1,000 population. More than 2,500 additional LHWs are needed to provide this optimal level of coverage. It is not realistic within the scope and timeframe of this project to expect that this optimal coverage will be achieved

Socioeconomic Conditions

FATA is a socially conservative society with very limited mobility for women and girls and the lowest levels of literacy for females in South Asia. Socioeconomically FATA is poorer than Pakistan in general. The economy is chiefly pastoral, with some agriculture practiced in the region's few fertile valleys. In the past, some areas of FATA produced significant quantities of opium; however, this has been reduced in recent years.

Communications in FATA are generally dispersed, although some are clustered in relatively accessible valley areas. In 1999–2000, FATA had a road density of approximately half the national figure. Approximately half of the total area is considered physically inaccessible; however, recent funding from the Asian Development Bank and other donors to build roads will likely substantially improve the situation in some areas.

Security

The political agent currently does not allow UN and WHO staff to enter North and South Waziristan Agencies, regardless of their nationality. Some places in Khyber, Bajaur, Mohmand, and Orakzai Agencies are also designated as “no-go” areas. An unusually high number of criminals and proclaimed offenders (nearly 17,000) are now taking shelter in FATA, where provincial police are prohibited from entering. Tribal law, kidnappings, and a range of other criminal activities combined with post-Afghanistan conflict factors pose a formidable range of operating and security concerns for project implementation and monitoring in some areas. Local NGOs report freedom of movement and fewer restrictions on WHO/UN/INGO representative visits. [A local firm will be hired as needed to do any evaluation visits in FATA.]

Improved Child Health in FATA Goal and Objectives

To Improve the Health Status of Children in FATA is the overall goal of this project. To achieve this goal the strategic objective is “Increased Use of Key Health Services and Behaviors,” which will be achieved through the following:

- Increasing access to and availability of health services
- Improving the quality of health services
- Increasing the knowledge and acceptance of key services and behaviors at the community level.

To improve the health of children up to 12 years, including health and nutrition programming in schools, Save will expand and package the project's key interventions into the following groups:

- EPI - Immunization
- ARI - Acute respiratory infection
- CDD - Control of diarrheal diseases
- ENC - Essential newborn care
- Nutrition and micronutrients

Beneficiaries

There are an estimated 1,512,000 men and women of reproductive age in FATA. All of these will be project beneficiaries through community mobilization, particularly community awareness sessions. For children under 5 years of age, direct beneficiaries will be the two-thirds who suffer

from either diarrhea or ARI—a total of 209,000 children. The rest of the under-5 population comprises indirect beneficiaries, approximately 108,000.

Improved Child Health in FATA Time Frame

Phase I – start-up activities, including Agency Headquarters (AHQ) Hospital improvement and capacity building of health care providers at the AHQ level, launched simultaneously in all seven districts. Health facility strengthening and training of LHWs in rural health centers (RHCs) and basic health units (BHUs) will be carried out in Mohmand, Bajaur, and Kurram Agencies.

Phase II – health facility strengthening and training of LHWs in Khyber and Orakzai.

Phase III – health facility strengthening and training of LHWs in North and South Waziristan.

Each phase is staggered by approximately six months. Community mobilization will accompany the above activities and agencies in the same sequence. As of January 2008, this project is working in all seven agencies and six frontier regions (FRs) of the FATA.

Fit with the Mission’s Strategic Objective

In May 2003 USAID/Pakistan approved an Interim Strategic Plan for fiscal years (FY) 2004–2006, with the overall goal to “promote equality, stability, economic growth and improved well-being of Pakistani families.” Strategic Objectives (SOs) relate to education (SO3); democracy and governance (SO4); economic development (SO6); and health (SO7). USAID/Pakistan signed a new Strategic Objective Agreement (SOAG) with the GOP in 2005 and amended it to extend through September 2008; it outlines development activities agreed to by both parties.

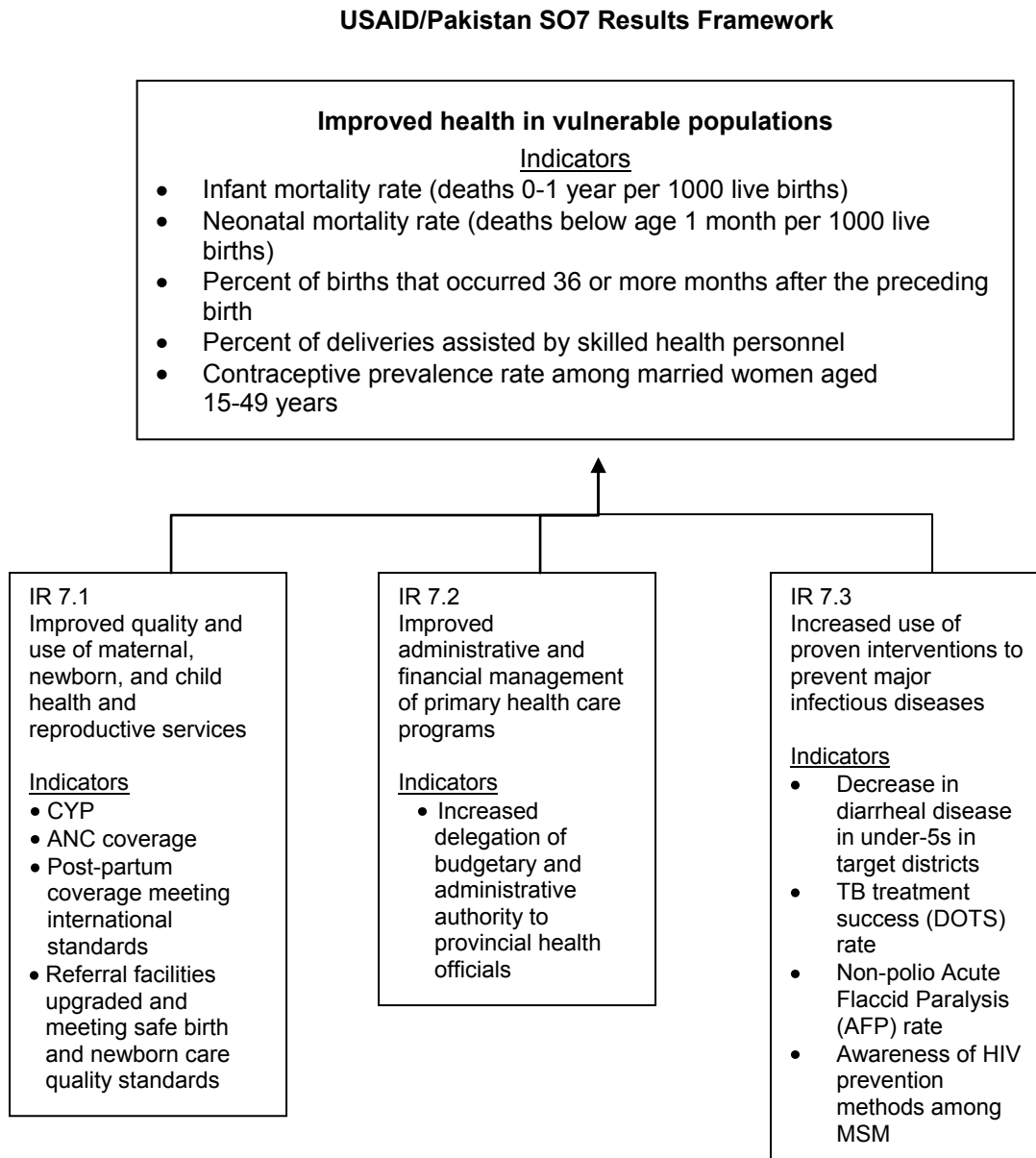
USAID’s SO7 aims “to improve health in vulnerable populations in Pakistan.” Intermediate Results (IRs) include the following:

IR7.1 Improved quality and use of maternal, newborn, and child health and reproductive services

IR7.2 Improved administrative and financial management of primary health care programs

IR7.3 Improved use of proven interventions to prevent major infectious diseases.

Figure A.1 depicts the Results Framework for SO7.



Illustrative indicators in support of IR7.1 include (1) couple years of protection, (2) antenatal care coverage, (3) postpartum coverage meeting international standards, and (4) referral facilities upgraded and meeting safe birth and newborn care quality standards.

USAID Assistance in Health

The health program began in 2003 and includes activities to improve maternal and newborn health services, promote family planning, prevent major infectious diseases, and increase access to clean drinking water. The program is nationally focused, working in underserved rural and urban districts in Sindh, Balochistan, Punjab, North West Frontier provinces, and the Federally Administered Tribal Areas (FATA).

Current health program areas include:

- *Health Systems Strengthening (HSS)*: The HSS program seeks to support the Ministry of Health and the Ministry of Population Welfare in strengthening the community midwifery program; targeting health information for raising citizen's awareness and holding government accountable; addressing health system challenges through modest grant assistance; and improving essential drugs and contraceptive logistics management system. (Implementing Partner: ABT Associates)
- *Diversification of Family Planning Activities in Pakistan (DFPAP)*: USAID/Pakistan's project to address the need to increase and improve family planning services includes capacity building, monitoring and evaluation, and project management. (Implementing Partner: The Population Council)
- *Maternal and Newborn Health*: The Pakistan Initiative for Mothers and Newborns (PAIMAN) is USAID's flagship project designed to reduce maternal and neonatal mortality. The project is being implemented in 10 districts in all four provinces of Pakistan. (Implementing Partner: John Snow Incorporated)
- *HIV/AIDS Program*: USAID provides grants to seven local NGOs to increase HIV/AIDS awareness and to promote health behaviors in high risk groups. (Implementing Partner: Research Triangle Institute)
- *Strengthening TB Control*: USAID assists the GOP to consolidate and accelerate complete treatment of TB patients. (Implementing Partner: WHO)
- *Polio Eradication*: USAID provides assistance to national polio immunization campaigns and surveillance to eliminate polio from Pakistan. (Implementing Partners: WHO and UNICEF)
- *Demographic and Health Survey (DHS)*: USAID provides funding and technical assistance for the Pakistan DHS and Maternal Mortality Study. (Implementing Partners: Macro International and National Institute of Population Studies)
- *Disease Surveillance and Response*: USAID supports the design of a National Integrated Disease Surveillance and Response Program and a Field Epidemiology and Laboratory Training Program. (Implementing Partner: U.S. Centers for Disease Control)
- *Child Health in the Federally Administered Tribal Areas (FATA) of Pakistan*: USAID is working to improve the availability, quality, and demand for child health services throughout the FATA. (Implementing Partner: Save the Children, USA)
- *Safe Drinking Water and Hygiene Promotion*: USAID is providing technical assistance in hygiene and sanitation promotion and community mobilization along with extensive capacity building in order to complement the GOP's installation of water treatment facilities nationwide. (Implementing Partner: ABT Associates)

III. STATEMENT OF WORK

The independent mid-term evaluation team will review the technical, managerial, and programmatic strengths and weaknesses of the two major program MNCH components as approved and financed by USAID: *Maternal and Newborn Health: The Pakistan Initiative for Mothers and Newborns (PAIMAN)* and *Child Health in the Federally-Administered Tribal Areas (FATA) of Pakistan*. Based on the findings, the team will formulate lessons learned as well as recommend future technical, programmatic, and administrative actions that will support overall strengthening of programmatic efficiencies and effectiveness.

The team is expected to answer the following key strategic and priority questions:

6. Is the MNCH program meeting its benchmarked activities as outlined in the original cooperative agreements and presented in annual work plans?
7. What are the trends in terms of improvements in MNCH indicators (increased prenatal visits, tetanus toxoid [TT] boosters received during pregnancy, improved immunization coverage, etc.) in project districts in Pakistan and compared to GOP contributions to the program in those project districts?
8. What are the key outputs and outcomes of these two programs, PAIMAN and Improved Child Health in the FATA, that have been achieved to date?
9. What have been the major obstacles to program coverage and access, and what should the GOP, USAID, and other donors do to facilitate demand and utilization in rural and higher poverty areas?
10. What are the most important steps that USAID, the GOP, and other donors should take to increase effectiveness, coverage, quality, and sustainability of the MNCH program?

In addition, the evaluation team is expected to use creative techniques and approaches to address the tasks listed in Annex 6, which includes illustrative questions to guide the evaluation.

IV. SUGGESTED METHODOLOGY

The evaluation team will use a variety of methods for collecting information and data. The team will work in a participatory manner with the partners of the MNCH program. The following essential elements should be included in the methodology as well as any additional methods proposed by the team.

- Reviewing briefing materials/pre-evaluation planning: A package of briefing materials related to the MNCH program will be made available to the evaluation team at least one week prior to the commencement of the mid-term evaluation. A complete list of background documents is attached in Annex 2.

In addition to reviewing background documents, the evaluation team will have a preliminary planning period in which they will review the scope of the mid-term evaluation, begin to come to a consensus on the key evaluation questions, develop a proposed schedule, and begin the development of data collection tools. The data collection tools that the team will develop will include the following:

- Interview Guides
- Interview Questionnaires (for the evaluation team and the local firm to use during site visits with persons that interact with the PAIMAN and Save projects, i.e., LHWs, LHVs, physicians, nurses, district officials, etc.)

- Survey Questionnaires (brief client surveys conducted by the local firm in the PAIMAN and Save districts)

The data collection tools will be presented to USAID/Pakistan for discussion and approval prior to their application to verify their appropriateness. These tools will be used in all data collection situations, especially during team site visits and consulting firm site visits, in order to ensure consistency and comparability of data.

- SO7 Team Briefing: The evaluation team will meet with the USAID/Pakistan Health Strategic Objective Team (S07 Team) in Islamabad to review the scope of the mid-term evaluation, the proposed schedule, and the overall assignment. The initial briefing will also include reaching agreement on a set of key questions and will take place over one day (or could be incorporated into the Team Planning Meeting).
- Team Planning Meeting (TPM): A two-day team planning meeting will be held in Islamabad before the evaluation begins (depending on the location of consultants, the TPM may be held in the United States prior to the team's departure for Islamabad). This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:
 - clarify team members' roles and responsibilities;
 - establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
 - review and finalize the assignment timeline and share it with USAID;
 - develop data collection methods, instruments, tools, and guidelines;
 - review and clarify any logistical and administrative procedures for the assignment;
 - develop a preliminary draft outline of the team's report; and
 - assign drafting responsibilities for the final report.
- Document Review: In addition to reviewing briefing materials that will be provided to the team, the evaluation team will be expected to collect and annotate additional documents and materials for the team's and USAID/Pakistan's future use.
- Self-Assessment Questionnaire: A self-assessment questionnaire will be given to both organizations by USAID prior to the team's arrival in country. Prior to the team's arrival, USAID will draft the self-assessment and administer it accordingly. The team will have access to the self-assessment results for their review and use.
- Information Collection: The information collected will be mainly qualitative guided by a key set of questions. As mentioned, information will be collected mostly through personal and telephone interviews with key contacts and through document review. The full list of stakeholders and contacts will be provided. Additional individuals may be identified by the evaluation team at any point during the mid-term evaluation. Key contacts include:
 - USAID/Pakistan Senior Management, S07 Team Members, Health Director, Deputy Director, CTO for MNCH Programs;
 - PAIMAN and Save briefing with key personnel;
 - PAIMAN and Save subgrantees, subcontractors, and other local partners;

- MOH and MOPW officials; and
- Donors and international organizations working in the health and population welfare sector.
- Site Visits: The evaluation team will travel with JSI-PAIMAN and/or Save the Children project staff and/or the local contracted firm to project sites for face-to-face interviews and discussions with local stakeholders and beneficiaries. The mission has suggested four sites for the evaluation team to visit: Rawalpindi, Lahore, Khanewal, and Peshawar (Annex 7).

Site visits will focus on pilot activities (DHIS, midwifery training, birthing centers, family planning integration, GoodLife clinics, Child Health Days). The areas of focus of the site visits will be clinical practices, behavior change communications (BCC), community mobilization, and training/supervision. Questions about equipment and ambulances or the emergency transport plan, facility upgrades, and improved access and quality should be included during discussions with the district officials.

In some sites other donor agency staff may request to accompany the team as well. Several interviews should be arranged and done in one day. The site visit to Rawalpindi will be done from the team’s base in Islamabad. The travel time to Lahore is an hour by air, visits can be done during one day, move on to Multan to stay overnight, conduct interviews on day 2 in Khanewal, and return to Islamabad after 2, possibly 3, days depending on flight schedules. Peshawar would be a 2-day visit by car. Thus an estimated 5-6 days are needed for site visits by the evaluation team. (Annex 7)

Should travel be restricted, conference calls or other mechanisms will need to be substituted. The Team Leader in collaboration with USAID will determine the appropriate course of action. The team will rent a vehicle locally in Islamabad for travel to some sites and travel to sites with project staff.

Local Data Collection and Site Visit Support: A local firm will be recruited and hired to assist in conducting interviews, coordinate and manage in-country logistics, set up appointments and meetings, make travel arrangements, and assist with site visits for the evaluation team. The local firm will visit and be responsible for interviews and field visits in Sukkur, Lasbella, and a FATA site (Annex 7). Sukkur and Lasbella are PAIMAN sites. The FATA sites are Save sites. The local firm will have a team of two persons, at least one being a female interviewer. They may choose to conduct group interviews or focus groups to gather information needed. They should meet with beneficiaries, local community members, NGOs, district officials, and any persons who have interacted with or are aware of PAIMAN or Save activities.

The firm will need to have experience working in the FATA. Important: The local firm must understand that USAID programs operating in the FATA function as part of the Government of Pakistan MOH programs and are completely “invisible” in that sense, with no branding to distinguish the program in any way. The local firm will need to be briefed on how to conduct interviews with this in mind in that region. The firm will be engaged by GH Tech prior to the evaluation team arrival in country and will take direction from the Team Leader. Some of the tasks that the local firm will assist with may include but are not limited to the following:

Conduct beneficiary interviews as available with:

- families (wives, husbands, mothers-in-law)
- imams
- midwifery students and midwives receiving refresher training

- traditional birth attendants (TBAs)
- physicians and LHWs who were trained
- civil servants trained in management.

Some topics to include in the questioning include:

- Have they heard health messages from NGOs, LHWs, or in or through support groups? Any benefit or behavior change?
- Have they used health services in refurbished facilities? What was the quality? Can they identify any improvements?
- Are they aware that additional ambulances have been placed at facilities? Do they expect the community to benefit? (PAIMAN only)
- Have they participated in any MNCH event? What was the impact for them, if any?

Interview or otherwise involve all levels of government where available in the evaluation (illustrative):

- National, including EAD, provincial, and district as well as FATA Secretariat and FATA Health Directorate
- Pakistan Medical and Dental Council, Pakistan Nursing Council, principals of midwifery schools
- LHW Program, MNCH Project Head
- Donor involvement in evaluation, for identifying gaps and complimentary programs (illustrative):
 - Open-ended questionnaires to donors
 - One-to-one interviews
 - Inbrief/outbrief
 - Invitation to participate
 - What's working? Not working?
 - UNICEF, UNFPA, DFID, WB, Norad, AusAID, WHO, JICA, CIDA
 - Who is working where doing what? Mapping. Extent to which projects are integrating FP into MNCH now. How much work are other projects doing on vaccination, IMNCI, HSS, infection control and hospital waste management, male involvement, private sector involvement?
- What are donors' future plans in MNCH? Best practices? Integrated FP? Child vaccination? Systems strengthening?
 - What role is each donor taking in planning, implementing, funding, policy development, support?

V. DELIVERABLES

Debriefing Meetings: At least two days prior to ending the in-country evaluation, the team will hold three meetings to present the major findings and recommendations of the evaluation: (1) SO7 team—that will focus on the accomplishments, weaknesses, and lessons learned in the MNCH program, including recommendations for improvements and increased effectiveness and efficiency of the MNCH program; (2) senior Mission management—incorporating the insights gained in the first debrief; and (3) Final briefing—for MNCH (Save and PAIMAN) personnel, other donor partners, and key stakeholders (GOP officials), focusing on major findings and recommended changes to increase program effectiveness for the life of the project. No evaluation or future directions recommendations will be shared outside of the USAID/Pakistan Mission staff. Succinct briefing materials will be prepared appropriate for each audience. Each meeting will be planned to include time for dialogue and feedback.

Draft Report: The evaluation team will provide, prior to departure, a draft report which includes all components of the mid-term evaluation to the USAID/Pakistan Health Office Director and relevant SO7 Team members in hard copy (4 copies) and on diskette in MSWord format. USAID will provide comments on the draft report to the evaluation Team Leader within 5 working days. This will be followed by final unedited content that the contractor is required to submit within 10 working days after USAID feedback on the draft Report. Upon USAID approval of this final content, GH Tech will edit and format the report. The edited and formatted final report will be submitted within 30 days of receiving USAID final approval of the content. The final report is to be submitted to the Health Office Director, both in hard copy (6 copies) via express mail and in electronic form. The report will be presented in 12-point font, single spacing.

Evaluation Report: The final evaluation report should include, at a minimum, the following: (1) Table of Contents; (2) List of Acronyms; (3) Executive Summary; (4) Background Statement; (5) Findings and Lessons Learned; (6) Prioritized Recommendations; (7) Future Directions, including scaling up and potential expansion possibilities; and (8) Annexes as appropriate, including list of people met and sites visited. A Report Outline will be prepared by the evaluation team before starting the field work and approved by the Mission. Pertinent information for the final program evaluation in 2009 should be presented in a separate document.

GH Tech makes the results of its evaluations public on the Development Experience Clearinghouse and on its project web site unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, we are requesting Mission confirmation that it will be acceptable to make a version of this document publicly available, which will exclude the recommendations and future directions sections. The Mission will provide final approval of the public version before it is posted on any web site to ensure that all sensitive information has been removed.

VI. DURATION, TIMING, AND SCHEDULE

It is anticipated that the period of performance of this evaluation will be for six/seven weeks beginning in May/June 2008. A possible schedule of this activity follows (illustrative):

Task/Deliverable	Team Leader LOE	Team Members LOE (2)
13. Review background documents/pre-evaluation planning (out of country)	6 days	5 days
14. Travel to Islamabad	2 days	2 days
15. SO7 Team briefing	1 day	1 day

Task/Deliverable	Team Leader LOE	Team Members LOE (2)
16. Team planning meeting	2 days	2 days
17. Meetings with <ul style="list-style-type: none"> • COPs of PAIMAN and Save • GOP officials in Islamabad (MOPW, MOH) • Local consulting firm • MNCH donors and other partners 	7 days	7 days
18. Visit field sites, including training centers, clinics, etc.	4 days	4 days
19. Debriefings with Health Office, USAID senior management, PAIMAN and Save, other stakeholders	1 days	1 days
20. Internal discussion meeting with local firm and international team	1 day	1 day
21. Analysis, discussion, and draft report writing	14 days	14 days
22. Presentation of draft report and discussion	1 day	1 day
23. Return travel	2 days	2 days
24. Complete final evaluation report (out of country)	5 days	2 days
Total # days	46	42

A six-day work week is approved when the team is working in country.

VII. TEAM COMPOSITION

The team should have the following skills mix: maternal and child health service provision, project assessment and evaluation, program design, reproductive health care and service provision, health worker training, behavior change communication, community mobilization and participation, health systems services/management information systems, among others. Familiarity with the health service delivery system (both public and private sectors) in Pakistan would be a major advantage. Ideally, the Team Leader would be an expert with international experience while other consultants could be recruited from available contractors or consultant pool. A suggested team composition is given below:

Team Leader: The team leader should be a public health generalist and an evaluation expert with practical knowledge in monitoring and evaluation of international public health programs in developing countries. A broad background in MCH is preferable. S/he should have an advanced degree in public health. A minimum of 7 years experience in managing, monitoring, or researching international public health programs is required. S/he should also have a comprehensive understanding of maternal, newborn, and child health principles and practices.

In addition, the Team Leader should have at least 5 years experience strengthening health systems, health sector reform, program component cost analysis, logistics of essential medicines and contraceptives, and addressing issues of quality and access improvement in health systems in developing countries. Identifying appropriate technical assistance needs to make improvements in the health systems, building capacity of local institutions and organizations, including the Pakistan Nursing Council, the Midwifery Association of Pakistan, and other interventions will be

included in this position's SOW. S/he should also have a keen awareness of health management information systems scenarios and the ability to recommend effective solutions for improvements to health data collection and reporting systems in the country.

It is imperative that the Team Leader have excellent English language skills (both written and verbal) as s/he will have the overall responsibility for the final report, and will have a major role in drafting and finalizing the deliverables. The individual considered for the Team Leader position is expected to provide a sample of a written report for consideration by the Mission.

Maternal Health Specialist: The second team member should have an advanced degree in health sciences or public health and at least 5 years experience in program management, implementation, and monitoring and evaluation of internationally based maternal and child health programs, as well as a comprehensive technical knowledge of and experience in maternal newborn and child health programs, especially service provider training. S/he should have a strong appreciation of partnership building and service provision in challenging environments. A nurse/nurse midwife is preferred for this position.

BCC/Community Mobilization Expert: This team member should have an advanced degree in medical anthropology or a related discipline and at least 5 years experience in the implementation of field behavior change communication and community mobilization strategies. A comprehensive knowledge of the application of BCC strategies to alter behaviors related to maternal and child health is desirable.

The evaluation team will be authorized to work a six-day work week while in country. Travel expenses and other communication costs incurred during the course of duty are authorized. The final travel itinerary of the evaluation will be contingent on the security situation and relative predictability of access to the project sites in general and target areas in particular.

It is possible that evaluation team members will be asked to provide input and feedback in the redesign of the follow-on project or revision of the current Maternal and Child Health program. Team member involvement will be determined during the development of the scope of work for the redesign/revision.

VIII. RELATIONSHIPS AND RESPONSIBILITIES

11. Overall Guidance: The Health Office Director and Deputy Director of USAID/Pakistan will provide overall direction to the evaluation team. Other USAID/Pakistan Health Office staff will interact with the evaluation team as needed to complete the evaluation activities.

12. Responsibilities:

USAID/Pakistan will introduce the evaluation team to relevant implementing partners, government officials, and other individuals key to the accomplishment of this evaluation through introductory letters or advance phone calls.

- USAID/Pakistan will provide observers throughout the review from the PAIMAN and Save programs as feasible.
- USAID/Pakistan will be responsible for providing security notices issued by the American Embassy in Pakistan to which the evaluation team must adhere. The evaluation team will provide mobile phone contact numbers to the USAID Health Office so that contact can be maintained as needed.

GH Tech Evaluation Team will be responsible for coordinating and facilitating evaluation-related field trips, interviews, and meetings. USAID will review and approve the schedule.

- The evaluation team will be responsible for making all logistical arrangements.
- The evaluation team will be responsible for all costs incurred in carrying out this review. The proposed costs may include, but not be limited to, (1) regional travel; (2) lodging; (3) M&IE; (4) in-country transportation; and (5) other office supplies and logistical support services (i.e., laptop, battery pack, paper, communication costs and teleconferencing cost, if needed, due to current travel restrictions).
- The local consulting firm will be responsible for assisting the evaluation team with site visits and conducting interviews in restricted travel areas as indicated in section IV above. This work will be coordinated by the evaluation Team Leader.
- The evaluation team will be responsible for arranging meetings and meeting spaces, laptop rentals, local travel, hotel bookings, working/office spaces, printing, photocopying, and other administrative support, as required. USAID may be able to assist the team on a limited basis.

ANNEX B: USAID'S HEALTH AND POPULATION PROGRAM

In FY 2005 and beyond, USAID will improve the quality of health care in Pakistan by focusing on three objectives identified in collaboration with the Government of Pakistan (GOP): improve the quality and use of maternal, newborn, child health, and reproductive services; improve administrative and financial management of primary health care; and increase the use of proven interventions to prevent major infectious diseases.

The Strategic Objective for health—*Improved health in vulnerable populations in Pakistan*—helps the GOP provide accessible and quality health and reproductive health programs, especially for women and children. If it is successful, the Ministry of Health, provincial health departments, and district hospitals will also adopt planning and management systems—particularly planning, budgeting, financial management, and reporting on health expenditures—that will in turn improve delivery of quality health programs. Both the improved management and the improved services are captured at the IR level.

The program also focuses on improving the health status with respect to infectious diseases of vulnerable groups, including infants, adolescents, and young adults. Success will be measured by readily available and standard measures that demonstrate the effectiveness of efforts in relationship to maternal and child health and reproductive health, including percent of births occurred 36 or more months after preceding birth, percent of deliveries assisted by skilled health personnel, and the contraceptive prevalence rate among married women aged 15–49 years.

Among the major infectious diseases are water and blood-borne hepatitis, diarrhea and enteric diseases, polio, tuberculosis, and, in certain areas, leishmaniasis. HIV/AIDS is a growing problem, and Pakistan is now considered to have a concentrated epidemic. USAID supports GOP health programs and coordinates closely with other donors and partners.

USAID funds health activities in the following areas:

- Developing new and improved maternal and newborn health care throughout the country by improving health services and upgrading essential equipment at selected health facilities;
- Continuing efforts to eradicate polio through vaccination programs;
- Improving surveillance and control of diseases of major public health importance (e.g., hepatitis, TB, HIV);
- Promoting greater awareness of HIV/AIDS and encouraging healthier behaviors among the most at-risk groups;
- Improving water and sanitation systems, including health and hygiene education to better ensure safe drinking water, storage, and end-use.
- Providing training and technical assistance to reproductive health service providers to improve the availability and quality of care in underserved areas, in accordance with the Mexico City Policy; and
- Helping health officials and local governments improve the planning, implementation, and monitoring of health programs.

The program supports 10 out of 12 objectives outlined in the GOP's reform strategies for the health and population sectors outlined in its Ten-Year Perspective Development Plan 2001–11. The program will promote the health of women and children through interventions that can be

sustained over the long term by improving the utilization and quality of health services. The objective of this assistance is to help the GOP develop and deliver accessible and quality health and reproductive health interventions.

USAID/Pakistan is in the process of awarding a two-year Health Systems Strengthening project to address health sector reform, capacity building of local institutions, including the Nursing Council and Midwifery Association of Pakistan, logistics management of essential drugs and contraceptives, and improving effectiveness of health systems and quality and access to healthcare services.

ANNEX C: LIST OF DOCUMENTS

(to be provided to the Evaluation Team one week in advance)

1. USAID/Pakistan's Interim Strategy
2. SOAG-Health and amendments 2005, 2006, 2007
3. Operational Plan indicators
4. Pakistan 2006-07 Demographic Health Survey (DHS)
5. Program Descriptions
 - Pakistan Initiative for Mothers and Newborns (PAIMAN)
 - Save the Children's Child Health Program in the FATA
 - Work Plans; Annual and Quarterly Reports
 - PAIMAN
 - Save
6. SO7 Performance Management Plan (with SO7 Results Framework)
7. Ministry of Health documents and materials
8. Obligations and expenditures to date by fiscal year
9. Ten-Year Perspective Plan 2001-2011, Government of Pakistan
10. MNCH PC-1
11. Safe Motherhood Alliance Assessment
12. EMNC and EmONC training assessments
13. Save the Children agency baseline surveys and health facility and household surveys
14. Aga Khan training assessment
15. JSI district baseline surveys
16. JSI component evaluations
17. JSI audit report
18. Maps of districts
19. List of districts ranked by level of poverty (Social Policy and Development Center)
20. Other donor documents with program areas and geographic areas covered
21. Norway MNCH Project document
22. Baseline survey in Sindh (NORAD)
23. Provincial Health Plans, Sindh, FATA, NWFP, Balochistan, Punjab
24. FATA Sustainable Development Plan

25. WHO Systems reports
26. MNCH Logframe
27. EPI Program documents, IMCI materials
28. Evaluation of UNICEF and UNFPA projects
29. JICA HMIS Report
30. UNICEF, UNFPA, DFID reports

ANNEX D: KEY PERSONNEL

3.1 JSI / PAKISTAN INITIATIVE FOR MOTHERS AND NEWBORNS (PAIMAN)

	POSITION/PERSON	CONTACT NUMBERS
1	Chief of Party	111 000 025
	Dr. Nabeela Ali	03005550473
2	Deputy Chief of Party	
	Lauren Mueenuddin	03008565461
3	Operations	
	Javade Khawaja	03005551230
4	M&E and HIS Advisor	
	Tariq Azim	03005309126
5	Financial Officer	Ext 109
	Babar Hussain	03005001369
6	Grants Manager	
	Dr. Shuaib Khan	03005551233

3.2 SAVE THE CHILDREN / IMPROVED CHILD HEALTH IN THE FATA

	POSITION/PERSON	CONTACT NUMBERS
1	Chief of Party	
	Dr. Amanullah Khan	03008580720
2	Deputy Chief of Party	
	Fayyaz Ali Khan	03018546997
3	Operations	
	Qamar Khursheed	03008565823
4	M&E	
	Dr. Salim Sadruddin	03008522863
	Dr. Sanam	091 5703363
5	Financial Officer	
	Mr. Nauman	03215172556
6	Grants Manager	
	Mr. Aziz Zamir	03085052938

ANNEX E: ILLUSTRATIVE LIST OF KEY STAKEHOLDERS

1. USAID/ Pakistan, SO7 core team, other SO team leaders as appropriate
 - Mary Skarie, Health Office Director
 - William Conn, Public Health Advisor
 - Dr. Qadeer Ahsan, Project Management Specialist, Health
 - Dr. Ahmed Isa, Project Management Specialist, Health
 - Khalid Mahmood, Program Assistant
 - Dale Lewis, Agreement Officer, Acquisition and Assistance Office
2. PAIMAN Staff
 - Dr. Nabeela Ali, Chief of Party
 - Lauren Mueenuddin, Deputy Chief of Party
 - Dr. Shuaib Khan, Director Programs
3. Save the Children
 - Dr. Amanullah, Chief of Party
 - Fayyaz Ali Khan, Deputy Chief of Party
4. Ministry of Health
 - Project Director, National MNCH Program
 - Project Director, National FP and PHC
5. Ministry of Population Welfare
 - Project Director, Technical Advisor
6. Development Partners
 - DFID
 - UNICEF
 - UNFPA
 - WHO
 - CIDA
 - JICA
 - AusAID
 - NORAD
7. Pakistan Nursing Council
8. Midwifery Association of Pakistan

9. District Nazims and EDOs Health in the project districts
10. Local community leaders, NGOs and beneficiaries in the districts where PAIMAN and Save work

ANNEX F: COOPERATIVE AGREEMENT INFORMATION

PROJECT	LIFE OF PROJECT	TOTAL OBLIGATION TO DATE
JSI - Pakistan Initiative for Mothers and Newborns (PAIMAN)	\$56,243,858 5 years 2005-2009	\$42,288,371
Save the Children - Child Health in the FATA	\$14,750,000 2 years 2007-2009	\$4,078,088

ANNEX G. ILLUSTRATIVE QUESTIONS TO GUIDE THE EVALUATION

TASK 1: GOALS AND RESULTS

Overall Aim: To establish whether the Maternal Child Health Program has achieved intended goals and results given the program design and operating assumptions.

1.1 PROGRAM DESIGN

- a) Review the original and subsequent assumptions in the program design and assess their validity. Are the program designs of both PAIMAN and Improved Child Health in FATA appropriate vehicles for USAID to achieve the Mission's Strategic Objective 7 (SO7): "Improved health of women and children"?
- b) Are the two designs appropriate within the sociocultural and religious context of Pakistan?

1.2 Program Goals and Objectives

- a) To what extent have the two programs met their respective goals and objectives? Based on what evidence and indicators?
- b) To what extent are the USAID MNCH program achievements contributing to USAID/Pakistan's SO7 and the Government of Pakistan's health objectives? What is the evidence?
- c) What were the key constraints or setbacks that may have hindered the achievement of greater results?

1.3 Sustainability

- a) To what extent is the MNCH program sustainable from financial, institutional, and programmatic perspectives? What strategies are the two projects using to move toward institutionalization of these activities?
- b) Does each project have an exit strategy, and to what extent is each project accomplishing any benchmarks leading to exit?
- c) Which aspects of the program will be taken over by the national MCH program and to what extent?

1.4 Project components

(strengths, weaknesses, challenges, sustainability, recommendations)

Note: Project inputs will have to be stated/summarized for each component,

- **HMIS:** look for successes and challenges at district level where HMIS is implemented fully or partially (in Punjab, only Khanewal).
 - What is the impact of working with the District Health Management Teams (DHMT)?
 - Are staff and civil servants understanding how to use data in the interest of effective program management?

- Is the HMIS component in Khanewal working to improve and strengthen the project and MNCH services?
- **Quality** in public and private sector (Good Life clinics)
 - Are midwifery training and services provided, such as refresher midwifery training and quality of midwife services delivered post-training?
 - Quality of counseling services provided on MNCH by project-trained physicians, Lady Health Visitors (LHV), Lady Health Workers (LHW) (counseling only)?
- **Behavior change communication (BCC)**
 - Interpersonal communication through LHWs, women’s and men’s support groups, mega events, mass media (PAIMAN only)?
 - Opportunities to integrate BCC with MOH, with donors, across projects?
 - Describe key BCC strategies and demand creation being used by each project.
 - Have the projects made progress in reaching vulnerable populations, how?
 - Are key messages technically valid and communicated appropriately?
- **Community mobilization**
 - To what extent have different community mobilization components been effective?
 - How can they be strengthened?
 - Which should be discontinued?
- **Family planning/birth spacing**
 - To what extent has FP has been integrated into MNCH, with a focus on Rawalpindi functional integration pilot project, LHW work in districts, and any FP services in Rural Health Centers (RHC), Tehsil Headquarters Hospitals (THQH) (PAIMAN only)?
 - What are opportunities to work more closely with Ministry of Population Welfare programs?
- **Child Health Indicators**, numbers of children treated and services provided compared with targets of the following:
 - Nutrition/malnutrition
 - Birth weight and monitoring
 - Diarrhea treated (CDD)
 - Acute respiratory infections (ARI)
 - Emergency neonatal care clients served
 - Number of Child Health Days conducted

- **Immunization:** Save (childhood and TT) and JSI (TT only)
 - Approaches used to increase TT and children’s vaccination?
 - Any efforts to strengthen data quality of reporting?
 - Linkage to government HMIS?
 - Efforts in Good Life clinics?
 - Linkage to polio campaigns?
 - Systems issues affecting success?
- **Renovation, equipment**
 - What has been the impact of upgrading and equipping 31 health facilities and in the FATA?
 - Was enough done, too much, or too little? Interview district officials, get community and services statistics.
- **Midwifery schools** and tutor preparation (Khanewal, Holy Family Hospital, Lahore, by interview)
 - What can be done in midwifery schools now that could not be done before inputs were provided?
 - What are the remaining gaps? Challenges? Recommendations?
 - What inputs were most important, and which made little difference?
- **Infection control**
 - To what extent have infection control and hospital waste management practices been addressed in the projects?
 - What has been accomplished to date in the Rawalpindi pilot (JSI)?
- **Health systems,** Interviews with district officials, project staff?
 - What has changed as a result of systems interventions?
 - What has not changed?
 - What do they think needs more emphasis?
 - What is the status of drug supplies for MNCH in project- supported facilities?
- **Project management, including financial management**
 - Are the projects being effectively managed?
 - Is the management structure appropriate?
 - How can management be improved?
 - How can USAID improve its oversight of the programs?

- **Project monitoring and evaluation**

- To what extent are project results being achieved to date?
- Are the indicators appropriate in number and content? Too many? Too few?
- Are the project methods of evaluation (baseline/endline surveys, Lot Quality Assessment Surveys [LQAS]) timely, efficient, reliable?

TASK 2: MANAGEMENT REVIEW

Overall Aim: Conduct a management review to assess the effectiveness of the management structures, administrative support, cost, and partnerships

2.1. Administration and Management

- a) Do the implementing partner's administrative and management structures appropriately support implementation of activities?
- b) Are the staffing plans and organizational structures of the two implementing partners adequate and appropriate to meet objectives?

2.2. Cost Analysis

- a) Review each partner's financial management, expenditures, and program income use. Present the approved obligations versus expenditures to date in overall percentages and determine the cost-effectiveness against both deliverables and performance.
- b) Analyze cost per beneficiary to the extent possible, if applicable at this time.
- c) Based on the analysis, what are the implications for cost effectiveness for each implementing partner and the MNCH program as a whole?

2.3 Monitoring and Evaluation

- a) Do JSI and Save's M&E systems support USAID/Pakistan's PMP/Operational Plan? Does the reporting meet program management needs and USAID/Pakistan's needs?
- b) Review program monitoring and evaluation plans, including program indicators and impact indicators in relation to the approved intermediate results/subresults.
 - Do the indicators reflect the true nature of the activity and will they permit accurate impact analysis? Are the indicators comparable/uniform between the two programs?
 - Have the two projects established reasonable mechanisms for gathering data for monitoring progress and impact?

2.4 Coordination, Collaboration, and Partnerships

- a) To what extent have the projects been successful in developing partnerships with the public sector, such as the MOH and MOPW?
- b) To what extent and how effectively did the MNCH teams coordinate and consult with others outside the MNCH network of partners, such as other bilateral and multilateral donors, universities, NGOs, and the private sector?
- c) To what extent is the MNCH program coordinating with other USAID Health Office program activities? What if anything should be done to improve collaboration?

TASK 3: TECHNICAL REVIEW

Overall Aim: Evaluate the effectiveness of key technical components and approaches of the MNCH program given the health status and sociocultural and religious context in Pakistan.

3.1 Training Approaches and Technical Assistance

- a) To what extent has the technical assistance (TA) provided under the MNCH program been adequate to meet host country needs?
- b) Review the training approaches, materials, and guidelines of both JSI and Save. Do the training materials reflect best practices in MNCH and are they consistent with established international guidelines and protocols?
- c) Assess the mechanisms and methodology for delivering training (e.g., training of trainers, working with subcontractors, through the MOH). Are delivery mechanisms effective and scalable?
- d) To what extent has the MNCH program contributed to maintaining and enhancing the “Maternal and Newborn Health Standards” of the MOH and “Reproductive Health Standards” of the MOPW so that standards of care, protocols, training and counseling materials, and information strategies promote consistent and uniform provider behaviors and practices?
- e) To what extent, if any, has the PAIMAN project supported optimal birth spacing, directly or through collaboration? Is the PAIMAN project using the training and counseling materials developed for this initiative?
- f) Are there opportunities for both JSI and Save to collaborate on training? If yes, please describe.

3.2 Quality

- a) What are the mechanisms, tools, and approaches being used to ensure quality of care and adherence to MNCH and reproductive health standards among providers?
- b) Assess the effectiveness, strengths, and weaknesses of the quality assurance techniques being used.
- c) What approaches might be adopted and/or enhanced to further pursue the transfer of skills and increase local ownership for quality health services provision?

3.3 Reaching the Underserved

- a) How do JSI and Save define the “underserved” within the context of Pakistan?
- b) Based on these definitions, to what extent have the two grantees reached the underserved? What is the evidence?
- c) To what extent has coverage extended into rural areas? What is the evidence?
- d) What approaches can be applied to expand outreach to the underserved?

3.4 Overarching/Other Aspects of Evaluation

Evaluators should look for examples where integration was attempted, such as in functional integration of FP and MNCH at district level in Rawalpindi. What worked? What didn't? What are the recommendations for next steps, future?

- To what extent were the projects able to involve men in MNCH? What have been the challenges? Benefits?
- Were the project districts for JSI best suited for the MNCH project? After reviewing the site selection approach, should different criteria be applied in future? Ask of project staff and of provincial government.
- To what extent are gains in project components sustainable? How can these be enhanced?
- How should project results be most effectively disseminated?
- To what extent do beneficiaries and government recognize these projects as USAID?
- Re: New government MNCH Project, other donor projects (UNFPA, UNICEF) vis-a-vis PAIMAN and Child Health in FATA (from discussions and interviews)
 - Complementarities
 - Duplications
 - Lessons learned that should be disseminated
 - Quality and extent of collaboration, such as shared curricula, planning
 - Degree of inclusion of FP
- What are the policy gaps/issues that were identified during interviews with the government and donors/UN?
- How are different levels of government (including FATA) enhancing or impeding the success of the projects? (project staff views; government views)
- What are the likeliest interventions for scaling up efforts that would help Pakistan achieve the MDGs?

TASK 4: RECOMMENDATIONS

Overall Aim: To document lessons learned and provide discrete management/administrative and technical recommendations for improving overall efficiency and effectiveness in the context of the Ministry of Health's program.

4.1 Recommendations for Continued or New activities and Program Changes

- a) Based on current experience and lessons learned, identify essential activities that should be continued or expanded over the life of the projects.
- b) What changes, if any, should be considered by the Mission to make the MNCH program more responsive in improving access to effective MNCH and reproductive health services?

In view of experiences to date under the MNCH, suggest alternate management and administrative models and mechanisms, as deemed appropriate, to ensure overall effectiveness and efficiency.

ANNEX H. MNCH EVALUATION SITE VISITS

MNCH EVALUATION SITE VISITS				
	Meetings at Site	Project Components to Visit at Site	Point of Contact	Travel / Date
Evaluation Team (with local firm)				
1. Rawalpindi, Punjab	PAIMAN staff EDO Health Nazim NGOs Lady health workers Community members DHMT	Upgraded facilities Support groups Midwifery school Good Life clinics EMNC training Integrated family planning Sanitation/hospital waste pilot LHW training	Dr. Shuaib Program and Grants Director 0300 5551233 JSI/PAIMAN Office Islamabad	Car: 1 day Date TBD
2. Lahore, Punjab	PAIMAN staff DG Health	PAIMAN office Midwifery schools PHDC	Dr. Nuzhat Rafiq Field Operations Manager Punjab North 0300 5551240	Air / car: 1 day
3. Khanewal, Punjab	PAIMAN staff EDO Health Nazim NGOs DHMT	Upgraded facilities Midwifery school DHIS Birthing center Good Life clinics EMNC training	Dr. Fazal Mehmood Field Operations Manager Punjab South 0302 8506985	Air / car: 2 days
4. Peshawar, NWFP	FATA Secretariat EDOs Health-Buner & Upper Dir Save staff PAIMAN staff	Midwifery school; Provincial Health Development Center	Mr. Jamal Afridi Program Manager PAIMAN- FATA 0300 9596070	Car: 2 days
Local Firm only				
5. Sukkur, Sindh	PAIMAN staff EDO Health Nazim NGOs	Upgraded facilities Good Life clinics Trainings	Dr. Iftikhar Mallah Field Operations Manager Sindh 0300 5551238	Air / car: 1 day
6. Lasbella, Balochistan	PAIMAN staff EDO Health Nazim NGOs	Upgraded facilities Good Life clinics Trainings Birthing center	Dr. Syed Mehdi Zaidi Field Operations Manager Balochistan 0300 5551239	Air / car: 2 days

MNCH EVALUATION SITE VISITS				
	Meetings at Site	Project Components to Visit at Site	Point of Contact	Travel / Date
Evaluation Team (with local firm)				
8. FATA site	FATA Secretariat NGOs Save office Agency management team in 2 sites Health facility staff Community members	Save sites Child Health Days ENC trainings Resource Center Agency stores PDQ training Check clinic records	Dr. Amanullah Khan 0300 858 0720	Car: 2 days

ANNEX I: REFERENCES

- Save the Children, Household Survey in FATA, March 2008
- Save the Children, Improved Child Health in FATA, Annual Progress Report No. 1 October 2006-September 2007
- Save the Children, Improved Child Health in FATA, Community Mobilization Strategy for LHWs and Non-LHW Covered Areas
- Save the Children, Improved Child Health in FATA, Health Facility Assessment, March 2008
- Save the Children, Improved Child Health in FATA, Monitoring and Evaluation Plan 2006
- Save the Children, Improved Child Health in FATA, PowerPoint presentation, June 12, 2008
- Save the Children, Improved Child Health in FATA, Quarterly Report, Jan.-Mar. 2007
- Save the Children, Improved Child Health in FATA, Quarterly Report, April-June 2007
- Save the Children, Improved Child Health in FATA, Quarterly Report, July-Sept. 2007
- Save the Children, Improved Child Health in FATA, Quarterly Report, Oct.-Dec. 2007
- Save the Children, Improved Child Health in FATA, Quarterly Report, Jan.-Mar. 2008
- Save the Children, Improved Child Health in FATA, Training Strategy 2008
- Save the Children, Improved Child Health in FATA, Year One Workplan (06-07)
- Save the Children, Improved Child Health in FATA, Year Two Workplan (07-08)
- Save the Children, Self-Assessment Questionnaire Responses for the MNCH Evaluation, April 2008

ANNEX J: PERSONS CONTACTED

ISLAMABAD

USAID

Anne Aarnes, Mission Director

Susan Thollaug, Health and Population Director

William Conn, Acting Health and Population Director

Maureen Norton, Senior Technical Advisor, Population and Reproductive Health

Dr. Muhammad Ahmed Isa, Program Management Specialist, Health

Saedar Talat Mahmud

Khalid Mahmood

Rushna Ravni

Cecilia Scull, USAID Peshawar

SAVE THE CHILDREN

Dr. Amanullah Khan, Deputy Director

Dr. Masood Ahmed Abbasi, Senior Manager Health

Rukhsana Faiz, Senior Officer, Community Mobilization

Sajjad Nayyer, Senior Officer, Community Mobilization

MINISTRY OF HEALTH

Dr. Asad Hafeed, Director, LHW Program

Dr. Fazle Manla, Deputy National Coordinator

Dr. Saleem Mali Khan, Technical Advisor

MINISTRY OF POPULATION WELFARE

Mrs. Mumtaz Esker, Director General

UNICEF

Ibrahim El-Ziq, Chief of Health and Nutrition

WHO

Dr. Ahmed Shadoul, Medical Officer, MNCH

DFID

Dr. Michael O'Dwyer, Health Advisor

GTZ

Paul Ruckert, Principal Advisor

CIDA

Pamela Sequiera, Program Officer

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Abdul Aziz Akhtar, Programme Officer

JICA

Masaharu Maekawa, Project Formulation Advisor

Sohail Ahmad, Senior Programme Officer

Dr. Ajmal Hamid, Chief Advisor Health

PESHAWAR**NWFP/FATA MINISTRY OF HEALTH**

Dr. Muhammad Zaffar, Additional Secretary of Health

Dr. Muhammad Zubair Khan, Director, FATA Health Service

Pervez Tamal, Director, MNCH

FATA Secretariat

Mr. Habibullah, Additional Chief Secretary (ACS)

Mr. Ghulam Qadir Assistant Chief Secretary

Mr. Faheem Alam

Agency Political Agent, Khyber Office

Mr. Ghulam Habib, Political Agent, Khyber Agency.

Community Elders Meeting

SAVE THE CHILDREN/PESHAWAR

Michael McGrath, Country Director

Mr. Fayyaz Ali Khan, Project Director

Dr. Saima Abid, Manager, ICH-FATA

Dr. Murad Ali Afridi, Manager FR

Dr. Khizar hayat, Manager, Training ICH-FATA

Afnan Aleem, Manager, Security

Dr. Khizat Hayat, Manager, Training

Dr. Sanam Gul, Manager, M&E

Mumtaz Ahmad Mehsud, Manager, CM

CMDO (NGO)

Fazie Mateen, Programme Manager

PAIMAN ALUMNI TRUST (NGO)

Ayesha Dia-ul-Dam, Regional Coordinator

Zarmina Rafeeq, Programme Officer

HOSPITAL STAFF

Professor Liaqat Ali, Chief of Pediatric Services

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