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TACMIL END OF PROJECT REPORT DECEMBER 2007 - DECEMBER 2009

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ACRONYMS

AASA	Anjum Asim Shahid Associates (Pvt.) Limited
ACNM	American College of Nurse Midwives
AGAHE	Association for Gender Awareness and Human Empowerment
AKU	Aga Khan University
AMAN	Association for Mothers and Newborns
AMTSL	Active Management of the Third Stage of Labor
AQWD	Al Qaim Women's Development Organization
BMC	Bolan Medical College
CMW	Community Midwife
COE	Center of Excellence
COP	Chief of Party
COTR	Contracting Officer's Technical Representative
CPDI	Centre for Peace and Development Initiatives
CSG	Community Support Group
DG	Director General
DHB	District Health Board
DHMC	District Health Management Committee
DWTA	Diploma in Ward and Teaching Administration
ECC	Establishing Community Midwives in the Community
EHSP	Essential Health Systems Package
FALAH	Family Advancement for Life and Health
GoP	Government of Pakistan
GRHO	Gender and Reproductive Health Organization
HANDS	Health and Nutrition Development Society
HMC	Health Management Committee
HMN	Health Media Network
HRH	Human Resources for Health
HRIS	Human Resources Information Systems
IEC	Information, Education and Communication
iHRIS	Software developed by the USAID funded CAPACITY project to manage Human Resources Information Systems
HSSPU	Health Systems Strengthening Policy Unit
INC	Immediate Newborn Care
IT	Information Technology
LEAD	Leadership for Environment and Development
LF	Logical Framework
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMI	Logistic Management Institute

LMIS	Logistics Management Information System
LRH	Lady Reading Hospital
M&E	Monitoring and Evaluation
MAP	Midwifery Association of Pakistan
MCHS	Mission Christian Hospital, Sialkot
MDGs	Millennium Development Goals
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MoU	Memorandum of Understanding
MTOT	Master Trainer of Trainers
NASG	Non-pneumatic Anti-Shock Garment
NATPOW	National Trust for Population Welfare
NEB	Nursing Examination Board
NGO	Non-Governmental Organization
NIPS	National Institute of Population Studies
NWFP	North West Frontier Province
PDHS	Pakistan Demographic and Health Survey
PDIC	Professional Development in Intrapartum Care
PHC	Primary Health Care
PIMS	Pakistan Institute of Medical Sciences
PMP	Performance Monitoring Plan
PNAC	Pakistan National Accreditation Council
PNC	Pakistan Nursing Council
PNFWH	Pakistan National Forum on Women's Health
RM	Registered Midwife
RN	Registered Nurse
SAMA	South Asia Midwives Association
SBA	Skilled Birth Attendant
SoW	Scope of Work
SPO	Strengthening Participatory Organization
STTA	Short-Term Technical Assistance
SWWS	Swabi Women Welfare Society
SWIL	Support of Women In Labor
TACMIL	Technical Assistance for Capacity Building in Midwifery, Information and Logistics
TBA	Traditional Birth Attendant
TF	Takhleeq Foundation
TNA	Training Needs Assessment
UC	Union Council
UNFPA	United Nations Fund for Population Assistance
UK	United Kingdom
USA	United States of America
USAID	United States Agency for International Development

UTi
WHO
YO

Union Transport Inc (UTi Pakistan (Pvt.) Limited)
World Health Organization
Youth Organization

ACKNOWLEDGMENTS

The TACMIL Project was successful only because of the cooperation and contribution of our many partners and counterparts. We would like to acknowledge the contributions of:

The Government of Pakistan, specifically, the Ministry of Health (MoH), Ministry of Population Welfare (MoPW), and the Directorates of Health Services of Punjab, Sind, Baluchistan, and the North West Frontier Province, for their ongoing support of the project and its activities.

The institutions within Pakistan that accepted our technical assistance and worked with us to develop programs and systems that will continue after the project's end. These include the Midwifery Association of Pakistan; the Pakistan Nursing Council; the Pakistan National Accreditation Council; the National Institute of Population Studies; the Maternal, Neonatal and Child Health Program; Memorial Christian Hospital Sialkot; and our additional grantees: The Centre for Peace and Development Initiatives, Strengthening Participatory Organization, Health and Nutrition Development Society, Al Qaim Women Development Organization, Association for Gender Awareness and Human Empowerment, Leadership for Environment and Development, Takhleeq Foundation, Youth Organization, Gender and Reproductive Health Organization, and the Swabi Women Welfare Society.

Our implementing partners for making the project a success. For assisting with the development and implementation of Component 1: American College of Nurse Midwives and Banyan Global, whose technical contributions were critical and superb. For the implementation of Component 2: Internews, Pakistan National Forum on Women's Health, Association for Mothers and Newborns, National Trust for Population Welfare, and Anjum Asim Shahid Associates (Pvt.) Limited. And for Component 4: Logistic Management institute and Union Transport Inc. Pakistan (Pvt.) Limited.

WHO, UNICEF, UNFPA, and the following USAID-funded programs in Pakistan – Pakistan Initiative for Mothers and Newborns, Family Advancement for Life and Health, GreenStar and PRIDE – whose mutual support and cooperation were essential to our successes.

USAID for its continued guidance and support, specifically our Contracting Officer's Technical Representatives (COTR), Mr. William Conn and Ms. Mary Cobb, and the USAID Health Office.

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And above all, the beneficiaries who will keep the legacy of the project interventions alive by continuing to implement activities initiated with TACMIL support.

EXECUTIVE SUMMARY

Pakistan faces high levels of maternal and neonatal mortality. The Government of Pakistan (GoP) has made efforts to address this through various initiatives, including the introduction of new cadres of health care provider and services packages, and has made a commitment to work to reach Millennium Development Goals 4 and 5. To assist the GoP in these efforts the US Agency for International Development (USAID) created and funded the Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL) project. Implemented from 2007 through 2009 by Abt Associates Inc. and its partners, the TACMIL project worked in 20 districts of Pakistan over a two-year period to address maternal, newborn, and child health issues. The project had four components: 1) Capacity Building, 2) Targeted Health Information, 3) Grants Program, and 4) Strengthening of Essential Drugs and Contraceptive Logistical System.

The purpose of the Capacity Building of Midwifery and Nursing Professions component (Component 1) was to build institutional capacity, increase sustainability, and improve the performance of services provided by selected organizations and health care providers whose role in the health sector is critical to improved health outcomes for low-income and vulnerable populations. Activities focused on: strengthening administrative and governing capacity of the Pakistan Nursing Council (PNC) and Midwifery Association of Pakistan (MAP); and training midwives, Lady Health Visitors (LHV), and nurses to improve midwifery clinical and business skills, and making recommendations for a midwifery tutor specialization. Also within this component, the TACMIL project worked to Develop Government Capacity in Health Systems Development and Administration. Through technical assistance the project provided support in: a countrywide human resources for health (HRH) roadmap as well as an assessment of the current HRH status; research; pharmaceutical management; logistics; and development of a hospital accreditation system that was piloted in seven hospitals around the country.

The Targeted Health Information component (Component 2) provided technical support to government officials in using data for decision making and policy making, and trained journalists and the general community in maternal and child health issues. These awareness-raising activities included disseminating the results from the Pakistan Demographic and Health Survey, aimed to raise citizens' awareness and encourage them to advocate with government officials and with the private sector to provide quality health services.

The purpose of the Grants Program component (Component 3) was to address health systems challenges in the public and private sectors through innovative programs within a period of one year through activities designed and implemented locally by subgrantees. The TACMIL project awarded \$1 million in grants to 11 organizations whose programs ranged from implementing an output-based voucher scheme for maternal health to creating community support groups to monitor and advocate for quality health care provision in their community. Each organization also received capacity-building training and support in proposal and budget development, technical program implementation, reporting, monitoring and evaluating project performance, and preparing and keeping transparent financial records.

Lastly, the Strengthening of Essential Drugs and Contraceptive Logistical System component (Component 4) worked to strengthen the logistical system of essential medicines and contraceptives in the public sector.

Through the implementation of these components the TACMIL project:

- built the capacity of and provided support to several key organizations essential for improving the status of health systems and midwifery in the country, including the Midwifery Association of Pakistan (MAP), the Pakistan Nursing Council (PNC), the National Institute for Population Studies (NIPS), and the Ministry of Health (MoH);
- provided training in clinical and teaching, and entrepreneurial skills to more than 2,000 midwives, nurses, and LHVs on topics such as supporting women in labor, active management of the third stage of labor (AMTSL), use of the partograph, infection prevention and control, immediate newborn care including newborn resuscitation, and basic business skills for starting private birthing centers;
- provided training on advocacy skills and basic maternal, neonatal, and child health issues for communities, policymakers, and journalists;
- increased the capacity of eleven Pakistani nongovernmental organizations to implement innovative health systems strengthening initiatives through small grants, and improved their understanding of and ability to comply with and with USAID rules and regulations; and
- conducted a countrywide assessment of the state of Pakistan's contraceptive logistics management system.

Pakistan has made a commitment to improving the health of its mothers and children, and future efforts to assist them in this are crucial. This effort can be empowered by supporting the midwifery profession; educating and providing accurate information to policymakers to create an environment that promotes access to and quality of health care and to civil society to hold their elected officials accountable; and continuing to build the capacity of indigenous organizations to create programs offering innovative solutions to basic health problems.

The NGO community in Pakistan has a varied and broad reach within the country with varying technical capacities, abilities to manage projects of different scales, geographic and technical scopes of work, and interest in carrying out the activities envisioned by USAID. It is important to continue to support these organizations and build their capacity for implementing effective MNCH programs. TACMIL's experiences showed that despite their size and level of experience, Pakistani grantees and NGOs and subcontractors continue to need support in project design, coordination, implementation, and monitoring as well as to improve their management capacity. Specific to implementing USAID-funded programs, the NGOs to which the TACMIL project awarded grants needed the most assistance with reporting requirements and branding requirements. Subcontractors needed support with management issues, understanding the importance of financial transparency, and compliance with funding rules and regulations. To appropriately and successfully build their capacity, the supporting organization needs to provide continuous, day-to-day monitoring and hands-on mentoring in addition to orientation workshops and one-off trainings. Through this ongoing support and guidance, organizations can put into practice the processes needed to adhere to regulations that are new to them, and eventually these actions will become habitual.

I. GENERAL PROJECT DESCRIPTION

COUNTRY CONTEXT

Pakistan's health statistics point to high infant and maternal mortality and very high morbidity across the board. However, health indicators in Pakistan are improving and the Government of Pakistan (GoP) has made a commitment to try to reach Millennium Development Goals (MDGs) 4 and 5 by 2015. These goals, established as part of the United Nations Millennium Declaration adopted in 2000, serve as guideposts for improving health outcomes in developing countries. Specifically, MDG 4 aims to reduce the under-five mortality rate by two-thirds between 1990 and 2015; MDG 5 aims to improve maternal health by reducing the maternal mortality ratio by three-quarters between 1990 and 2015 and achieving universal access to reproductive health by 2015. The most recent Pakistan Demographic and Health Survey (PDHS), conducted in 2006-07, demonstrates the changes in health status since 1990 and the changes still needed to reach the MDGs. Table I lists several indicators related to reaching MDGs 4 and 5, and the progress made.

TABLE I. INDICATORS FOR MEETING MDGS 4 AND 5

Indicator	PDHS 1990/91	PDHS 2006/07	MDG target
Proportion of fully vaccinated children aged 12-23 months	50%	47%	>90%
Infant mortality ratio (deaths/1,000 live births)	100	78	40
Under-five mortality ratio (deaths/1,000 live births)	130	94	45
Maternal mortality ratio (deaths/100,000 live births)	533	276	140
Proportion of births attended by skilled health personnel	19%	39%	>90%
Unmet needs for family planning	32%	25%	
Proportion of pregnant women receiving prenatal care	27%	61%	
Modern method contraceptive prevalence rate (women between 15-39 yrs)	15%	22%	55%

Source: PDHS 1990-1991, PDHS 2006-07, Ministry of Population Welfare (MoPW)

A lack of institutional capacity to appropriately manage available limited resources remains a large cause of poor health outcomes. Therefore, continued assistance to Pakistan to strengthen its health system is needed. These are the challenges that the USAID-funded Technical Assistance for Capacity Building in Midwifery, Information and Logistics (TACMIL) project was meant to address.

OVERVIEW OF PROJECT

Abt Associates Inc. (Abt) was competitively awarded a two-year task order under the Technical Assistance and Support Contract (an indefinite quantity contract managed by USAID/Washington). The two-year TACMIL project, initially referred to as the "Strengthening Health Systems in Pakistan" project, was awarded in December 2007 and began implementation in January 2008. TACMIL, which stands for Technical Assistance for Capacity Building in Midwifery, Information and Logistics (and which means "completion" or "bridging the gap" in the Urdu language) was designed to help support USAID/Pakistan's overall goal to "promote quality, stability, economic growth and improved well-being of Pakistani families." In particular, at its inception, the project aimed to contribute to the achievement of USAID's Strategic Objective 7: Improved health in vulnerable populations in Pakistan and, specifically, to Intermediate Result (IR) 7.1: Improved quality and use of maternal, newborn, and child health and reproductive services and IR7.2: Improved administrative and financial management of primary health

care programs. The project set out to work toward achieving these objectives, and assisting Pakistan to meet MDGs 4 and 5, by providing technical assistance and institutional capacity building to the public and private health sectors to improve health service delivery with particular focus on maternal, reproductive, and child health in selected districts. Specific interventions complemented and reinforced existing health assistance programs (USAID's Pakistan Initiative for Mothers and Newborns [PAIMAN] and Family Advancement for Life and Health [FALAH] projects in particular) and targeted components that are critical to the operation of a strong health system. The TACMIL project was linked to and interacted with a broad range of stakeholders, including communities at the grassroots level, elected representatives, government ministries, semi-governmental institutions, and private sector organizations (through public-private partnerships).

TACMIL's scope of work included four technical components:

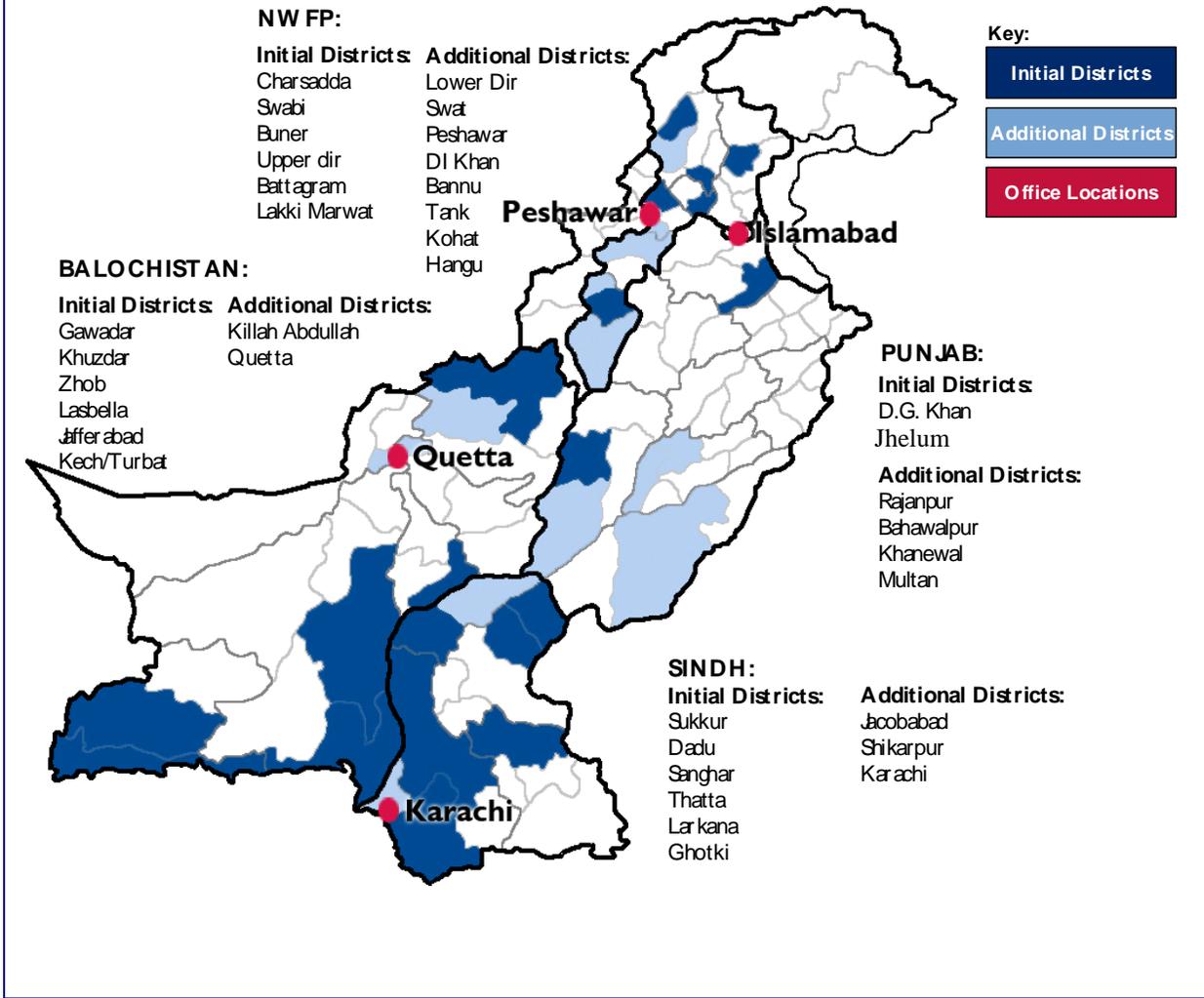
- Component 1: Capacity Building of Midwifery and Nursing Professions and Developing Government Capacity in Health Systems Development and Administration
- Component 2: Targeted Health Information
- Component 3: Grants Program
- Component 4: Strengthening of Essential Drugs and Contraceptive Logistics System (discontinued in April, 2009)

These components and their achievements are described in more detail in Section 2 of this report.

PROJECT STRUCTURE

Abt, which held the prime contract for TACMIL, implemented project activities with several international partners: the American College of Nurse Midwives (ACNM), Banyan Global, Internews, and Logistics Management Institute (LMI) as well as Union Transport Inc. Pakistan (Pvt.) Limited (UTi). In addition, during implementation, portions of the project were subcontracted to several Pakistani organizations and institutions including: Aga Khan University (AKU), Anjum Asim Shahid Associates Pvt. Limited (AASA), Association for Mothers and Newborns (AMAN), Maalik Creative Engineer, Memorial Christian Hospital, Sialkot (MCHS), National Trust for Population Welfare (NATPOW), Pakistan National Forum on Women's Health (PNFWH), and Spectrum Y&R. A project headquarters office was located in Islamabad, where the majority of the staff were based, with regional coordinators based in Karachi, Quetta, and Peshawar. The project worked throughout the four provinces of Pakistan, (see map on next page).

DISTRICTS OF TACMIL HEALTH PROJECT



2. PROJECT SUMMARY

This section describes activities and achievements under each project component, as defined in the TACMIL project's Performance Monitoring Plan (PMP) (see Section 4). Success stories submitted to USAID throughout the life of project are in Annex B.

A. COMPONENT 1A - CAPACITY BUILDING OF NURSING AND MIDWIFERY PROFESSIONS

Specific Objective of the Component

The central objective of this component was to develop capacity, increase sustainability, and improve the performance of services provided by two organizations whose roles are critical to improved health outcomes for low-income and vulnerable populations. This component comprised three foci: Developing Administrative and Governing Capacity of the Pakistan Nursing Council (PNC) and Midwifery Association of Pakistan (MAP); Midwife, Lady Health Visitor (LHV), and Nursing Training; and Midwifery Tutor Strengthening. The component was implemented with assistance from subcontractors Banyan Global and ACNM.

RESULT:

Overall management and financial sustainability of Nursing Council and Midwifery Association are improved; nursing and midwifery regulatory systems for licensure/registration are strengthened nationwide; and efforts to advocate for the needs of nurses and nursing/midwives and midwifery are increased.

(This corresponds to Expected Result A.1.2a.1 in the contract)

Principal Activities

To initiate project relationships with both the PNC and MAP, the project signed memoranda of understanding (MoUs) with both organizations at the start of implementation. The MoUs provided a framework that promoted clear working relationships from the start; indeed, cooperation flourished during project implementation.

Building the capacity of the Midwifery Association of Pakistan (MAP)

The concept of a professional association in Pakistan is embryonic and the concept of a midwifery professional association is still fragile because of the lack of professional identity as detailed elsewhere in this report. As Dr. Gwen Brumbaugh-Keeney, the ACNM consultant who conducted the leadership and development workshop noted, “MAP is in the very early stages of organizational development. As a professional association, activities are managed on a voluntary basis by officers and members. While MAP officers are highly respected and experienced professionals, there are few with professional association experience or knowledge, which impacts the organizational and leadership capacity.”

MAP, the professional association for all cadres of midwives in Pakistan and a member organization in the International Confederation of Midwives (ICM), was formally registered in 2006. When the TACMIL project began, MAP had a national board, but only 325 members and no local chapters. The central office, located in Karachi and primarily reliant on volunteer staff, was limited in its ability to maintain membership records or communicate with members.

Due to the general confusion related to midwifery in Pakistan¹ TACMIL focused on supporting MAP to communicate the purpose of a professional midwifery association and build a professional midwifery identity. The project did this through sponsoring Emerging Leaders’ attendance at international and regional professional midwifery meetings, helping present and future MAP members update their clinical skills in in-service trainings, and holding a leadership and development workshop with a panel of midwifery leaders from four other countries; the panel discussed leadership development and governance, and professional identity development.



Midwives register for the 2nd National Midwifery Conference in Lahore.



Panel of international midwifery leaders presenting to MAP leaders

¹ Since the 1990s, a Presidential mandate requires all female registered nurses (RNs) to study an extra year to become qualified as registered midwives (RMs) even though few ever practice clinical midwifery. Three additional cadres of direct-entry midwives exist: LHVs, Midwives (i.e., pupil midwives or RMs whose educational program is being phased out) and Community Midwives (CMWs). There is much confusion between nurses and midwives because all female nurses are dually licensed. All four midwife cadres (RN/RM, RM, LHV, and CMW), fit the International Confederation of Midwives definition of midwife and World Health Organization (WHO) definition of skilled birth attendant (SBA), but there is little understanding of this in Pakistan, where a midwife is commonly perceived as a *dai*, Urdu for untrained traditional birth attendant (TBA).

During in-service courses, project staff gave evening presentations on MAP's distinctive purpose and goals and distributed membership applications. This was often the first time that the midwives had heard of the professional association for midwives. Project staff supported the formation of five chapters of MAP - in Jhelum, Lahore, Quetta, Rawalpindi/Islamabad, and Sialkot. By the end of the project, pre-chapter formation meetings had been held in Hyderabad, Mardan, Multan and Sukkar. Mardan and Sukkar have the requisite number of members for chapter formation, which should be achievable in early 2010. Chapter members will play a pivotal role in developing midwifery identity and serving an advocacy role in future. Every effort was made to highlight and explain this role during membership recruitment and chapter formation meetings.

Principal Achievements with MAP

- Membership increased to 868 (167% increase) and five chapters formed
- 14 emerging leader MAP members sponsored to attend International Confederation of Midwives Triennial Meeting in Glasgow, May-June 2008
- Pakistan's first-ever National Midwifery Annual Conferences sponsored (December 1–2, 2008 in Islamabad and November 12–13, 2009 in Lahore)
- Leadership and governance workshop held for 37 chapter and national executive board members and other key leaders
- A public relations campaign promoting midwives conducted
- Website developed and operational
- Computerized database developed for membership, and MAP volunteers and staff trained in its use
- 27 chapter leaders trained to conduct in-service course, Support of Women in Labor (SWIL)
- 311 midwives trained in SWIL in-service course by MAP chapter leaders
- Workplans made for all existing MAP chapters through end of 2009
- One midwife sponsored to attend regional professional meeting in Bangladesh
- Equipment provided to national MAP office: multimedia unit with screen, camera, computer, printer/ scanner/ photocopier, storage



MAP President Mrs. Imtiaz Kamal addressing 2nd National Midwifery Meeting in Lahore



Midwives practice pain management techniques during a SWIL in-service course taught by MAP chapter



Fourteen “Emerging Leaders” will help elevate the role of midwives as maternal and child health clinical providers and lend their expertise to discussions about addressing maternal and infant mortality in Pakistan. Emerging Leaders are midwives that the TACMIL staff mentored and trained, and were invited to participate in global interchanges and clinical updates on midwifery. TACMIL sponsored their attendance at the International Conference of Midwives in Glasgow, Scotland, in June 2008. Above, the emerging leaders wave Pakistani flags, while gathering before one of the sessions at the conference. One emerging leader, Mrs. Humera Khushnud (far left), RN/RM, DWTA, BScN, MSc Community Health and Nutrition, who is Nursing Superintendent at the Maternal and Child Health Department of the Pakistan Institute of Medical Sciences (PIMS) in Islamabad, said “As an emerging leader I have been given exposure to midwifery that I would not have otherwise received.” After returning from Glasgow, Mrs. Khushnud met with the head of Ob/Gyn at her hospital and discussed allowing midwives to take responsibility for managing the pregnancies and deliveries of low-risk women. Now seven midwives based in two cubicles of the outpatient maternity clinic at PIMS deliver antenatal care to women with normal pregnancies. In the labor ward, midwives now have the exclusive use of two beds in which they do 55 percent of the normal deliveries. This care by midwives has greatly reduced wait times for antenatal care and improved the overall environment for women giving birth.

Building the Capacity of the Pakistan Nursing Council (PNC)

The PNC, an autonomous, regulatory body constituted under the Pakistan Nursing Council Act (1952, 1973) is empowered to license nurses, midwives, LHVs, and nursing auxiliaries to practice in Pakistan. As a result of an earlier project funded by the Canadian International Development Agency (CIDA), over a decade ago, PNC has used a computerized database at its national office for registration and licensure. The system was updated in 2002 to address issues of devolution but required paper documents from provincial Nursing Examination Boards (NEBs) and nursing schools to be sent to the PNC for inputting, which required physical space and human resources to manage. All NEBs sent PNC complied hard copy examination results in a spreadsheet twice a year for new registration verification. PNC data entrants then needed to cross check each individual result and enter data from the spreadsheets. Both the cross check process and data entry was time and labor intensive and potentially fraught with error.

After analyzing that system, TACMIL project staff worked with PNC staff to upgrade to the web-based iHRIS (Human Resources Information System) Qualify software, designed by the USAID-funded Capacity project, as a possible solution to the issues with the existing system. TACMIL supported customization of the software for PNC. The project piloted the adapted software, using it to link one school in Punjab (Faisalabad) directly with the PNC. In addition, subcontractors designed an application specifically for provincial NEBs and piloted its use linking the Punjab NEB with the PNC so that examination results can be directly communicated. TACMIL held trainings on the iHRIS and NEB applications for PNC staff, the pilot school, and the NEB site. At project end, there was capability for direct linkage between nursing/midwifery schools and the PNC and provincial NEBs and the PNC, and actual links for both in pilot sites.

In July 2009, the PNC leadership decided that, while the goal was to eventually be able to renew licenses online, the HRIS system would have to be phased in because the PNC does not have the requisite banking arrangements, and the time needed to obtain them would be longer than the life of the project. They also determined that a totally online system for original registration was unfeasible due to the fact that few of the students applying for initial registration have credit cards or the computer access or ability to electronically scan original documents. The TACMIL project delivered a system which has the capacity for being fully online, a capacity PNC can activate when it is ready.



Ribbon-cutting event on November 11, 2009, at the new PNC computer lab, one of several upgrades to the PNC office in Islamabad. PNC President Dr. Asim opens the computer lab, as Mrs. Nighat Durrani, PNC Registrar, and Ms. Janet Paz-Castillo, Chief, USAID Health Office, look on (top photo). Ms. Paz-Castillo tours the computer lab



In addition, TACMIL designed and hosted a website and trained all relevant PNC staff in its use and administration. The project supported the launch of the website in November 2009, as well as the new lab in which the software will be used.

Principal Achievements with PNC

- iHRIS Qualify software customized for PNC and for linking PNC directly with schools.
- Online registration system developed, for linking schools to NEBs to the PNC.
- 48,270 person records and 113,513 registration records migrated from old system to iHRIS Qualify.
- Website for PNC redesigned and launched.
- PNC wired for both cable local area network and wireless Internet access.
- Queue Management System procured and installed for managing queues of applicants and people visiting PNC for information.
- Computer Server, operating system and allied hardware procured and installed.
- Staff at the PNC trained for management and administration of the website.
- Staff at the PNC, School of Nursing Faisalabad trained in iHRIS software.
- Search engine optimization for the PNC website carried out so that people searching the Internet are able to find it on first page of search engine results.
- Staff at pilot NEB and PNC trained in NEB application software.
- Online system with the School of Nursing Faisalabad piloted.
- Quality assurance systems for testing system developed, data migrated from old to new system, and data entry developed and used.

Additional Activities at PNC

When the TACMIL project began, no final qualifying examination existed for the new cadre of CMWs completing their 18-month training. Donor agencies sponsored the training of the first groups of CMWs, and the groups developed examinations on an ad hoc basis. To start the process of developing a standardized, competency-based final qualifying exam for the CMW program, in September 2008 the project convened a two-day stakeholder meeting led by Ms. Della Sherratt, an international midwifery educator consultant familiar with midwifery issues in Pakistan. Participants discussed how to design and implement the exam, and the elements the exam needed to contain. The participants reached the following conclusion:



Group work during CMW examination workshop

“Neither the system or tools currently used to assess midwifery competence fully meet the essential criteria for quality assessment that was fair, just, equitable and trustworthy i.e. need to be able to demonstrate content and context validity, reliability, discrimination and practicability.”

During that day the group discussed how to design and implement a competency-based, final qualifying exam for the new CMW program.

A task force of NEB controllers and examiners was formed to address recommendations from the September 2008 meeting.² The task force met three times in July/August 2009 with Dr. Catherine Carr and Ms. Christine Hunter, ACNM consultants from University of Washington, and finalized exit competencies for CMWs, developed a blueprint for the examination, and finalized a question bank of over 200 multiple choice questions. Some remaining policy issues exist including:

- No standardization of the content of the examination by topic area, type of question (multiple choice, essay, short answer) and length of exam
- Variance from province to province regarding who can write and score the exam
- Lack of test bank security.³

During the task force meetings it became apparent that lines of decision making authority between PNC and the provincial NEBs are unclear, and without clarity it is difficult to make final policy decisions about qualifying examinations. While a standardized examination for CMWs⁴ had not been finalized by project end, examiners and controllers from each province had learned how to write appropriate multiple-choice questions that reflect the CMW curriculum according to a blueprint and tested levels of knowledge higher than rote memory. Project staff distributed CD copies of the question bank to the PNC registrar and NEB controllers, many of whom subsequently used multiple choice questions from the bank for the CMW qualifying examinations held in October/November 2009.



² Examination blueprints specify content of the exam weighted to reflect the curriculum and specify the level of questions—i.e., how many are allocated to test higher level knowledge (application and analysis) vs. lower levels of knowledge (knowledge and comprehension). Historically, qualifying examinations administered by NEBs have focused on lower levels of knowledge only.

³ Currently a new test is written for every exam, and old questions are not kept. Changing this requires changes in custom and logistics on a national level.

⁴ It became apparent during task force meetings that this was an unrealistic outcome since provincial NEBs determine the final examinations, not PNC

Achievements

- Exit competencies for CMWs written and approved by task force
- Blueprint for CMW qualifying examination developed
- 205-item question bank developed for qualifying CMW examination

Career ladder for midwives

Mr. Geoffrey King, an international human resources for health (HRH) consultant, analyzed in depth career histories collected by project staff from a group of high level nursing leaders (all RN/RM) to determine career progression and how long they spent in clinical service delivery, supervisory/instructor positions before reaching highest leadership positions.⁵ He then conducted interviews with key informants to gather information about current employment prospects for the various categories of midwives, the strengths of the present practices, and the disadvantages of the current situations.

His findings suggest that most top nursing/midwifery leaders in Pakistan progress up the ladder by becoming educators; few have worked for the bulk of their career in service delivery. In the group he had in-depth details on, they had collectively studied midwifery for 16 years (16 people studied midwifery for a year each) but only one had ever practiced midwifery for 6 months.

His recommendations were to base the midwifery career ladder on actual service delivery requirements. More hard data will be forthcoming from the HRH assessment which should be incorporated into any specific recommendations for the career ladder.

Incentive package for midwives

Mr. Marc Luoma, a HRH specialist based at Abt/Bethesda, analyzed data collected by project staff through focus group interviews and key informant interviews supplemented by an international review of literature and additional interviews on arrival in Pakistan. His recommendations for retention at all posts included:

- Posting the midwife in the same location as her husband
- Assessing accommodation issues
- Clarifying private practice policy
- Offering supportive supervision training
- Implementing a performance review system
- Recognizing good performance

Specific recommendations for retention in rural/remote postings included:

- Fixed/required length of posting and adherence to policy
- Adherence to new career ladder
- Availability of clinical training
- Improved transportation allowance
- Equipment supply and maintenance

⁵ Including representatives from Pakistan Nursing Council, Director of Health Services, MNCH Program, Secretary of Health (Planning), member of group working on career ladders with PMRC, Public Service Commission, Midwifery Association of Pakistan, and GTZ

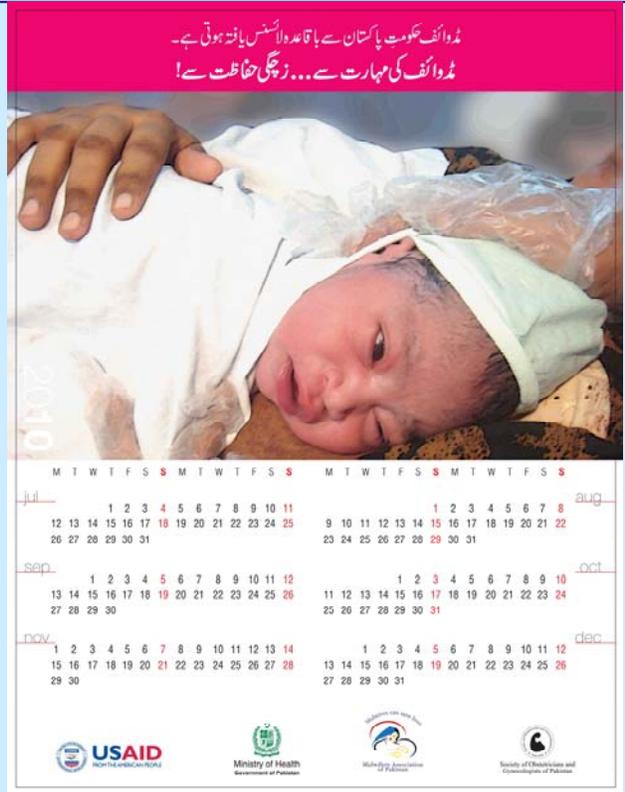
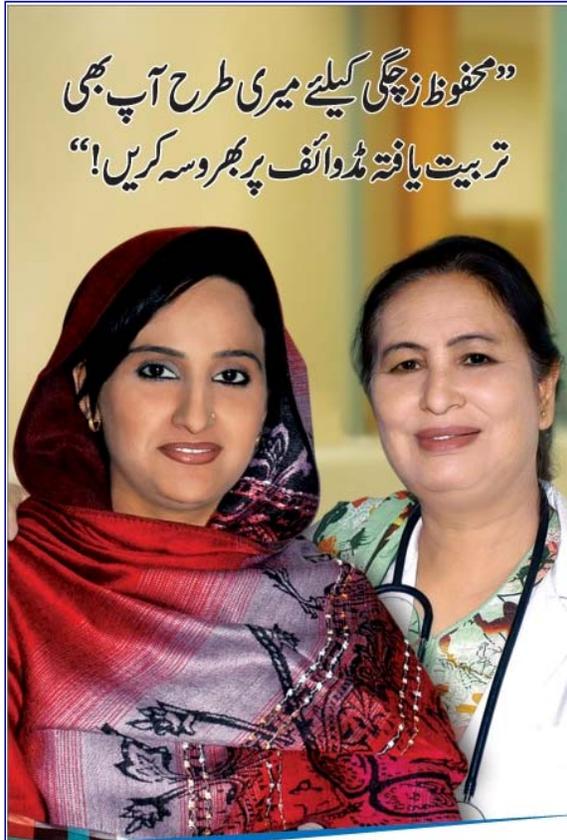
Findings of both the career ladder and incentive package for midwives were presented to Director General of Health (DG Health) at the Ministry and the reports are available.

Midwifery Public Relations Campaign

The project engaged a local subcontractor, Spectrum Y&R, to develop a public relations (PR) campaign to highlight the role and promote midwives throughout Pakistan with a focus on target districts. The campaign included use of TV commercials, radio spots, print advertisements, SMS (text messages), billboards, and information, education and communication (IEC) leaflets. Key messages for the general population and for doctors were developed in collaboration with stakeholders and field tested with focus groups before dissemination. Spectrum staff held four media seminars for over 120 journalists in Lahore, Karachi, Quetta, and Peshawar to kick off the PR campaign and to sensitize journalists to the role of professional midwives and their educational background and to promote their image as valuable members of the health care team. A newspaper supplement including messages from the US Ambassador, Federal Minister of Health, and President of MAP was released the opening day of the 2nd National Midwifery Conference in Lahore (Nov 12-13, 2009) and the TV commercial aired at the conference.

Principal Achievements

- Career ladder and financial and incentive package designed and presented to the DG Health.
- PR campaign to enhance image of midwives in Pakistan completed, with activities that included:
 - 740 TV commercials aired
 - 1,044 radio spots aired
 - Print ads published in 18 newspapers
 - Full-page newspaper supplement published in six newspapers
 - 77 billboards placed in priority districts
 - 3,900 banners displayed in 39 districts
 - 100,000 leaflets inserted in newspapers in 39 districts
 - 50,000 posters distributed
 - 5,000 wall calendars distributed
 - At least one of five health promotion SMS stressing the role of midwives delivered to 13.9 million cell phones in local languages.



A poster and a bag distributed at the National Midwifery Conference in Lahore as part of the PR campaign to increase visibility and general understanding of the role midwives can play in promoting maternal and child health in Pakistan. The poster reads: Like me, you should also trust a trained midwife for safe labor-Safe delivery... through the midwife's expertise. Calendar for PR campaign: Midwives are licensed by the government so they have the expertise to save lives-Safe delivery... through the midwife's experience

RESULT:

Scope and quality of in-service education for all nursing cadres improved.

(This corresponds to Expected Result A.1.2b in the contract)

Principal Activities

Clinical Training

USAID staff advised TACMIL staff in initial meetings to focus on nursing cadres delivering midwifery care, so LHVs, RMs and RN/RMs currently working in labor wards or RHCs or BHUs were the primary target group for in-service courses. After communication with key government stakeholders, visits to Colleges of Nursing with advanced midwifery programs, visits to key urban teaching hospitals with attached midwifery schools, and discussion with staff from other donor-funded projects focused on midwifery education or training, project staff determined that most midwifery staff had limited opportunities for in-service training and that trainings held were often didactic, not participatory, and theoretical, not focusing on clinical competencies. In addition, in all sites they visited, project staff observed that clinical practices of normal delivery were outdated and not evidence-based. Therefore the project decided to focus in-service content on best practices directly related to maternal and infant mortality and morbidity reduction, namely:

- Support of woman in labor⁶
- Management of labor with partograph
- Active management of third stage of labor (AMTSL)
- Management of postpartum hemorrhage with bimanual compression and oxytocic drugs
- Infection prevention practices throughout labor and birth
- Delayed cord clamping



Midwives practice determining gestational age during a training.

⁶ Particularly important in Pakistan, where only 34 percent of women deliver in a facility and 39 percent deliver with a skilled provider (2006-07 PDHS). One reason women choose to deliver at home is the fear that they will be left alone and ignored or ill treated by hospital staff during the birth. If staff know how to emotionally and physically support birthing women and implement this knowledge, the number of women giving birth with SBAs and/or in facilities should increase.

- Immediate mother/newborn skin to skin after birth
- Immediate breastfeeding
- Delayed newborn bathing
- Infant resuscitation with ambu-bag or mouth to mouth

In visits to four government teaching hospitals, project staff found none that met the criteria of adequate caseload, midwifery staff actually managing and conducting deliveries, and basic infection prevention procedures in place. MCHS, a private sector hospital, did meet all the criteria and therefore was subcontracted to serve as a clinical training site.

“This is my first training through which I got all information which I didn’t know. The most important topic is partograph which was not taught to me in 18 months [of CMW training]. In four days of training, our trainers taught us very well, and I must appreciate their attitude.”

Newly graduated CMW, PDIC participant,
Baluchistan

Ms. Diana Beck, ACNM Senior Technical Advisor, in consultation with TACMIL’s Senior Nursing/Midwifery Advisor, designed a course to reflect principles of participatory adult learning and competency-based clinical education and address the contextual specifics of Pakistan. The initial training lasted 10 days and incorporated all the content listed above. Feedback from participants indicated the course content was new to them, and they reacted positively to the new educational methodology as well as the opportunity for supervised clinical practice. For some who had taught for decades, it was their first opportunity to clinically practice midwifery since they had finished school.

To deliver the essential training to 1,000 midwives, the course content was divided into two shorter trainings: a three-day Immediate Newborn Care (INC) course and a four-day Professional Development in Intrapartum Care (PDIC) course. Ten master trainers for the PDIC course were selected from those who had attended the 10-day course and trained with ACNM consultants. DGs Health at the provincial level and the Federal DG Health nominated hospitals to serve as sites for PDIC clinical and classroom training. These hospitals, proposed as centers of excellence (CoEs) to incorporate and model the new/updated PDIC clinical practices, were the Federal Government Services Hospital in Islamabad (Federal); Bolan Medical College Hospital, Quetta (Baluchistan); Government Maternity Hospital, Peshawar (NWFP); and Countess Dufferin Fund Hospital, Hyderabad (Sindh) in addition to the original private site, MCHS (Punjab).

After consultation with the federal Maternal, Neonatal and Child Health (MNCH) Program, the INC course was launched through the provincial MNCH cell at the district level in three districts in Punjab (Chakwal, Gujrat, and Lodhran) and two in Sindh (Larkana and Shirkarpur). The INC course targeted LHVs, RN/RMs, and midwives working at the District Headquarters Hospital level and below (rural health center and basic health unit).

“I am feeling now that I can give better care to newborn babies. I can resuscitate any newborn baby that needs [resuscitation]. I can also educate a woman during labor. I am thankful to my trainers for their guidance.”

INC participant, Punjab

ACNM’s Diana Beck, with senior TACMIL staff, facilitated the master trainings of trainers (MTOTs) for both courses. ACNM consultants and/or project staff were present for initial site strengthening activities

and rollout of at least one initial round of the course taught by all new trainers. This was vitally important both to ensure that those in clinical sites were “on board” with and supportive of the new practices as well as to support new trainers who were inexperienced in the new adult-centered, participatory methodologies and were learning new practices themselves. Ideally, the project would have continued support on an ongoing basis but was unable to do so due to staff resignations at end of project and need to focus on other activities (see below).

Every effort was made during the trainings to assess whether participants acquired both the knowledge and skills presented in the course. Pre- and post-assessment scores illustrate that trainers were successful in their delivery of new concepts/knowledge. During each training, participants were evaluated in their individual ability to perform key new clinical skills taught in the course (AMTSL and infant resuscitation) using a checklist. Results from clinical check-outs suggest that the majority of participants left the course with the ability to perform the skills taught. For the reasons given above, project staff was unable to monitor and evaluate the results of these trainings to the extent desired. It should be noted that most of the trainers themselves did not know how to do AMTSL or the updated version of infant resuscitation before they attended these courses. The fact that they were able to transmit both the knowledge and skill to participants to such a high degree using new educational methods is a noteworthy achievement.



An important component of adult competency-based learning methodologies, particularly in clinical training, is to have students practice new skills in the classroom with models, then practice with actual patients while being supervised by a competent clinician. For many students attending TACMIL trainings, this was the first time they had ever had the opportunity to practice clinical skills with patients since graduation from their midwifery training. Above trainees practice infant resuscitation, first in the classroom and then in the hospital.

TABLE 2. RESULTS OF PDIC AND INC TRAININGS

	PDIC (AMTSL, SWIL, partograph)	INC (newborn care, infant resuscitation, infection prevention)
% of participants scoring > 80% in skill check-off	81% (AMTSL)	79% (infant resuscitation)
Average score in skill check-off	85% (AMTSL)	86% (infant resuscitation)
% of participants scoring > 80% in post-assessment	74%	75%
percentage point improvement in pre/ post-assessment	19	27
% improvement in pre/post-assessment	30%	47%

By self report, the practices taught to PDIC master trainers including AMTSL, skin-to-skin contact, partograph, delayed cord clamping, support of women in labor and infection prevention were incorporated into regular practice in all five sites after rollout of the course. While the project was unable to verify self report data at the very end of implementation, it is clear that all sites had progressed in their incorporation of the best practices as evidenced during our supervision during rollout. The table below details the practices in each site before training of master trainers.

TABLE 3. BASELINE PRACTICE AT COES BEFORE PDIC COURSE

Practice	FGS, Islamabad	GMH, Peshawar	CDF, Hyderabad	MCH, Sialkot	BMC, Quetta
AMTSL	Yes	Yes	No	Yes	No
Skin to skin	No	No	No	No	No
Partograph	No	No	No	Yes	No
Delayed cord clamping	Yes	No	No	No	No
Support of women in labor	No	No	No	No	No
Infection prevention	No	No	No	Yes	No

Note: FGS=Federal Government Services Hospital, BMC=Bolan Medical College Hospital, GMH=Government Maternity Hospital, CDF=Countess Dufferin Fund Hospital, MCHS=Memorial Christian Hospital, Sialkot

Similarly, by self report and follow-up visit data from four of the five districts, participants were practicing immediate newborn care taught in the INC course (skin-to-skin, immediate breastfeeding, delayed cord clamping) and infection prevention after the training. In some of the sites visited, support of women in labor wasn't practiced because few births occurred in the facility, and most that took place were brought in as emergencies. Participants stated they were going to teach the support of women in labor content to pregnant women during their antenatal care appointments so that if they came ready to deliver, they could practice what they'd learned. Some participants who had private practices reported that they'd been able to completely incorporate course content in their private settings. In a visit to a private hospital in one district where a master trainer worked, it appeared to project staff that all of the practices were being incorporated. See Lessons Learned section on page 36 for more discussion of in-service course effectiveness.

Business Skills Training

CMWs are a new cadre of midwife developed to deliver care in peripheral remote areas; as such, they are a linchpin in the GoP's plan to address MDG 5. Young women are chosen from their communities to attend an 18-month course in midwifery with the expectation that they will return and set up a

private practice in their communities. The GoP plans to train 12,000 CMWs by 2012. While their course covers clinical aspects of midwifery, it does not cover skills needed to run a private midwifery practice. After performing a training needs assessment, Ms. Bonnie Kligerman, education consultant from Banyan Global, designed a two-day business skills training course entitled Establishing Community Midwives in the Community (ECC). The course trained CMWs in basic business concepts within the overall context of empowering these young women to provide a necessary service at the village level and enhance their capacity to generate income. The course focused on specific business and marketing skills needed for CMWs to be successful as private midwifery providers including how to approach the community, market their services, order and keep track of drugs and equipment, officially register their business, open a bank account and write checks, and develop a business plan.

After two pilots of the course, MTOTs were held in May and July for 44 participants; 29 of the participants facilitated rollout of the course.

“Before this training I did not have an idea of what I was supposed to do. Now I have a good idea how to plan and how to start a birthing station.”

CMW from Punjab who participated in ECC training

I have learned how to fill in a supply card, write a check and open an account in the bank. The first thing I am going to do is open a bank account.

CMW from Punjab who participated in ECC training



During an ECC training, CMWs learn important skills for running a business, such as writing a check (top) and presenting a business plan developed in small groups.

Principal Achievements

- 1189 midwifery providers⁷ trained in PDIC and INC courses
- 19 master trainers prepared to teach and taught PDIC course
- 18 master trainers prepared to teach and taught INC course

⁷ i.e. RN/RMs, LHVs, RMs or CMWs; the balance were MBBS doctors.

- 61 rounds of PDIC course conducted for 619 participants, 591 of whom were midwifery providers
- 45 rounds of INC course conducted for 628 participants, 598 of whom were midwifery providers
- Training packages with facilitators and participant’s manuals, detailed lesson plans, and overhead transparencies developed for both PDIC and INC.
- Five clinical sites providing intrapartum care strengthened/supported to provide new/ updated practices
- 948 CMWs trained in business skills course
- Training package with facilitator and participant manuals designed for ECC
- 44 master trainers prepared to teach ECC course; 29 of these taught ECC course
- 49 rounds of ECC course conducted for 984 CMWs

RESULT:

Pre-service education of midwives improved.

(This corresponds to Expected Result A.1.2c in the contract)

Principal Activities

Clinical Skills Update for Midwifery Tutors

Because there is no midwifery tutor designation at the federal or provincial levels, TACMIL developed specific midwifery clinical skills and understanding of the role of midwives among those nursing instructors teaching midwives. Since no separate track for midwifery exists in the GoP civil service, the only way faculty can progress is through nursing career pathways. For example, project staff met a tutor who was “Acting” Director of the advanced midwifery program at one federal institution who had taught a nursing specialty for 20 years and never delivered a baby since qualifying as a registered midwife.

Over the two years of the project, 160 midwifery tutors participated in the PDIC course and therefore had exposure to new/updated knowledge about clinical midwifery (i.e., care during birth) as well as exposure to new adult teaching/learning methods.

“I have got new techniques and new methods in this training. I think these types of trainings are good for the tutors and for midwives to perform safe deliveries. I hope the facilitators would consider us in future for these trainings because these trainings are useful for the tutors; if the tutors are competent, then the tutors will teach the students effectively.”

Tutor from Baluchistan who participated in PDIC

Thirty-nine of the 160 tutors also participated in a five-day workshop on adult education methods. The workshop, led by an ACNM consultant who is a skilled midwifery educator, focused on the teaching of the topics covered in the INC and PDIC courses using the facilitator’s manual, lesson plans, and participatory approaches. During the workshop, the tutors had opportunity to practice teach and get feedback from peers and the ACNM consultant.

Dr. Carr and Ms. Christine Hunter, ACNM consultants who are midwifery educators from the University of Washington, conducted a five-day assessment workshop for midwifery educators in conjunction with members of the task force developing the CMW qualifying examination. The 19 participants learned about blueprinting an examination and about testing different levels of knowledge, as well as specifics of multiple-choice question development.

“Although I have a good and diversified teaching experience before joining this workshop, this five-day workshop has enhanced my teaching skills. It has given me new and modern ways to evaluate my students and has made me more capable of teaching with further modern methods. In the short time period of five days, it was very difficult to cover all the topics, but it was done so efficiently that nothing during the course was irrelevant.”

Midwifery tutor



Midwifery tutors received updates on clinical skills at a PDIC training. A midwife practices delivering an infant in the classroom (top photo); a tutor demonstrates how to use a partograph to monitor and manage labor.

Teaching Requirements and Skills Training

TACMIL engaged Dr. Carr,⁸ to draft Guidelines for Midwifery Educators in Pakistan. The resulting document reflects the philosophy that all cadres of professional midwives must meet the WHO criteria for skilled birth attendants and be taught by faculty who also meet those criteria; in addition, all cadres of health professionals who attend births (CMW, LHV, RN/RM, or MBBS doctor) must possess essential competencies, which include:

- Competence in clinical area
- Clinical experience as a midwife (at least one year of practice as a midwife after graduation and have delivered 10 babies in past year)
- Formal teaching preparation
- Ongoing education

Recommendations for the short term focused on the first three areas. The consultant noted that the DWTA (Diploma in Ward and Teaching Administration, i.e., Diploma in Nursing Management and Teaching Administration), the current requirement for all nursing instructors, does not have an identified clinical scope of practice. Those who earn the diploma do not practice clinically but rather work in management or administrative positions. This effectively removes nurses with formal education/preparation from clinical care.

Principal achievements

- 163 tutors participated in PDIC course
- 28 tutors participated in INC course
- 39 tutors attended educational update
- Eight tutors attended CMW examination workshop
- 19 tutors attended assessment update workshop
- 14 tutors are MAP officers
- 12 tutors attended ICM
- Standards for Midwifery Tutors written and accepted by USAID

Additional Activities

During rollout of the PDIC course, project staff became aware of the critical need to improve infection prevention practices at the facilities chosen as Centers of Excellence (CoEs). Staff at MCHS had over a decade of experience teaching infection prevention, so TACMIL staff worked with them to determine topics needed for staff at the other CoEs. MCHS staff conducted two 5-day trainings, which focused on adoption of universal/standard precautions, aseptic technique including gowning and gloving, disposal of biological waste and infection prevention housekeeping practices. Participants identified “infection



NEB members and midwife tutors develop sample exam questions.

⁸ In addition to being an associate professor in the University of Washington's Midwifery Education Program, Dr. Carr has extensive experience in Pakistan preparing master trainers in both classroom and clinic components of PDIC and INC courses.

prevention” (concept of universal/standard precautions), hand washing, instrument processing (including decontamination), and waste disposal as the most useful content.

“I suggest that you should spread the training and knowledge of your institution to all institutions of Pakistan and then all over the world. Meetings should be arranged with Directors and Medical Superintendent of all hospitals. Waste disposal should be taught to all personnel who are directly involved like sweepers, and media should give coverage”

Physician participating in infection prevention training

After seeing its use at MCHS, the first clinical site for the PDIC training, project staff made the decision to procure non-pneumatic anti-shock garments (NASG) and train medical professionals on their use in Pakistan. The NASG has been used in many countries with good results in reducing blood loss as well as in reducing time to recover from shock. In Pakistan, 27 percent of maternal mortality is due to postpartum hemorrhage (2006-07 PDHS). Prevention and treatment of shock can significantly decrease death from postpartum hemorrhage. Staff at MCHS have used NASG for most of the past decade and successfully treated hundreds of patients. The senior nursing/midwifery advisor and ACNM consultant, Dr. Carr, in consultation with the obstetrician who had used NASG for almost a decade in Sialkot, developed a protocol for their use. Trainings and dissemination were supported by the project and carried out by PNFWH in Multan, Quetta, Karachi and Abbotabad. A total of 200 personnel who manage labor and deliveries nominated by the provincial Directors General, MOH and from the private sector received these trainings and garments.



A Component I staff member demonstrates how the NASG is placed on a patient. The neoprene and velcro garment helps to prevent and/or treat shock in women who experience postpartum hemorrhage, one of the leading causes of maternal mortality in Pakistan.

After these trainings, the Federal MoH requested additional assistance in this area; TACMIL procured an additional 270 NASGs and 300 sets of training models for teaching best practices in birth and immediate newborn care. Project delivered the equipment to the Federal DG Health for distribution.

Additional Achievements:

- Two rounds of five-day infection prevention training at MCHS for 34 hospital staff including 15 from TACMIL CoEs.
- 200 medical personnel participated in four training sessions on the use of NASGs.
- 200 NASGs were purchased and distributed to medical personnel and institutions within Pakistan and an additional 270 were purchased and delivered to the MoH for distribution.

B. COMPONENT 1A - DEVELOPING GOVERNMENT CAPACITY IN HEALTH SYSTEMS DEVELOPMENT AND ADMINISTRATION

Specific Objective of the Component

The goal of the second part of this component was to assist the MoH in identifying and addressing specific health care reform areas. This was accomplished through providing long- and short-term technical assistance to support the MoH Health Systems Strengthening Policy Unit (HSSPU) and Research Unit and providing international short-term technical assistance in the areas of human resources for health (HRH) and hospital accreditation.

RESULT:

Short-term consultants on health systems issues are available to address the GoP's expressed needs in a timely fashion.

(This corresponds to Expected Result A.2.2 in the contract)

Principal Activities

Direct Short-term Technical Assistance to MoH

Over the course of the project, TACMIL responded to several requests from the MoH to provide direct assistance for improving Ministry health systems development and administrative capacities. This included hiring short-term technical assistance to implement specific studies and identifying long-term personnel seconded to the MoH to support the HSSPU and Research Unit.

Specific studies for which the TACMIL project provided short-term technical assistance include:

- Assessment of primary health care (PHC) models in Pakistan: to review the performance of the PHC models in terms of accessibility, acceptability, infrastructure, resources, knowledge of service providers, service delivery and utilization, community participation, and quality of care. The study found a need for a results-oriented PHC model to address the community health care needs and inefficiencies in the public sector, recommended the establishment of a Health Management Cadre in each province to ensure that administrative/ managerial positions are staffed by trained and experienced managers who can effectively implement reforms in good governance, accountability, and performance monitoring and incentives.
- Needs assessment of legislative and functional reforms for the MoH's Drug Control Organization: to propose a revision of the National Drug Policy, which covers drug registration, management and supply, price regulation and control, rational use, and research and development, as well as the HRH who perform these tasks, and make recommendations for new legislation and strengthening of the Drug Control Authority.

The project hired and seconded two local consultants to the Office of DG Health in Islamabad in May 2009. Dr. Assad Hafeez, a health systems strengthening (HSS) specialist, and Dr. Adnan Ahmed Khan, a health economist, assisted the GoP to address gaps identified in the 2007 GAVI Alliance HSS assessment, and assist the MoH to meet the criteria to qualify for a GAVI HSS grant.

Dr. Hafeez was designated as the Public Health Advisor for the MoH. His primary duty was to develop the HSSPU.⁹ In this position, Dr. Hafeez led the development of the National Health Policy that focuses on reaching the MDGs and a monitoring framework to assess implementation of the policy. This work toward the MDGs, on the national and provincial levels, will be the HSSPU's major focus for the next five years. Dr. Hafeez has also taken on other assignments for the DG Health including an assessment of the polio situation in Pakistan and a study tour to the United Kingdom to learn about their health financing system.

Dr. Hafeez's impact on the HSSPU was immediately palpable; after a year of inactivity, it became fully functional in June 2009. According to a GAVI assessment in April 2009, only 55 percent of the targets set by the original assessment had been met. In the first four months of Dr. Hafeez's tenure, 75 percent of targets were met, qualifying the GoP to receive the next installment of GAVI funds through the HSS grant mechanism. Dr. Hafeez noted that "the creation of the HSSPU is providing an opportunity for a think tank for policy development and the possibility to develop the capacity of the MOH to analyze evidence to turn into policy."

To assist the GoP in growing its capacity to use evidence to inform the National Health Policy and other policy initiatives, Dr. Khan is directly supporting the DG in the MoH Research Unit. Dr. Khan's first evaluation of available research showed that Pakistani researchers do not contribute significantly to indexed journals, and of those articles published by Pakistanis, 28 percent were produced by the AKU, indicating a concentration of capacity to supply the information needed to make sound policy. Dr. Khan sees his role largely as promoting the use of evidence to inform MoH policy, saying "it is the 'invisible' success of increasing the discussion around results of research that will be the most important in the future for policy making in Pakistan. By introducing the importance of results and continuing to discuss it, we have taken steps towards the MoH's common use of research to inform policy."

Human Resources for Health

The health workforce is one of the most important pillars of the health system. Successful implementation of any health intervention depends on adequate numbers and quality of the health workers involved. For example, to improve the health of its citizens, the GoP's rollout of the Essential Health Services Package (EHSP) strengthened referral pathways up to tertiary hospitals. The health workforce must be able to accommodate this vital effort. To assist them in accomplishing this, the TACMIL project worked with the MoH and WHO to develop a HRH Roadmap. Abt's Marc Luoma, an international HRH specialist, assisted in Roadmap development. A dissemination meeting took place in late December to review this.

The Components of the HRH Roadmap

- 1) Needs assessment and workforce modeling
- 2) Development of HRIS
- 3) Training rationalization
- 4) Development of HR Management (HRM) standards
- 5) Implementation of HRM activities such as:
 - Employee satisfaction
 - Retention improvement
 - Productivity improvement
 - Performance improvement
 - Supportive supervision
 - HRM capacity building at all levels

The TACMIL project was able to assist the GoP in implementing the first part of the Roadmap, the HRH assessment, again in partnership with the MoH and WHO. The purpose of the assessment was twofold.

⁹ The former Health Policy Unit assumed all health systems functions; in May 2009, it was renamed the HSSPU, reporting directly to the Secretary of Health and charged with providing technical assistance and support to the provinces. Through UNICEF and WHO, the HSSPU is receiving \$16.9 million, most of which is designated to procurement, and the remainder to capacity building. The unit hired nine staff and wrote a three-month workplan.

First, to collect accurate and complete data on many aspects of the current HRH situation in Pakistan, including the following:

- Numbers/distribution of providers, by cadre
- Skill mix of the workforce
- Performance and productivity
- Numbers of incoming HRH
- HRH attrition
- Overall country climate for HRH
- Workplace climate/job satisfaction

Second, analysis of the data provided information to strengthen the GoP strategy for HRH development.

The assessment involved sampling approximately 350 public and 350 private health care institutions in the country to consult their HRH records, and interview health care workers; it also included interviews with health care managers at the province level to assess their current HRH management practices. At the end of the project, the draft report was turned over to the MoH for finalization.

Hospital Accreditation

Pakistan lacks an established system for accrediting hospitals to ensure consistent quality of care in the country's many public and private institutions. At the DG Health's request, the TACMIL project identified an international hospital accreditation specialist, Dr. Thomas Schwark, to assist the GoP with establishing such a system. Dr. Schwark traveled to Pakistan twice to assist a core group of hospital administrators, physicians, and nurses from six institutions in different cities identified by the DG Health to establish the standards and develop a strategy for accrediting hospitals. He first reviewed the nearly 100 draft standards that the group proposed, and then worked with the group to pare the list down to a manageable 30 phase-one standards; he also developed a "survey guide" that defined the objective elements of each standard, the evidence to look for to determine compliance with the standards, and how to score the objective element for each standard. In addition, he trained 42 surveyors to assess hospitals.

The TACMIL project identified the Pakistan National Accreditation Council (PNAC) as the ideal organization to manage the hospital accreditation process. In 2007, the Ministry of Science and Technology created this council as the accrediting body for scientific institutions in Pakistan. The PNAC is already familiar with international accreditation standards, and has embraced its new responsibility, creating a Health Division that will oversee both medical lab and hospital accreditation.

Implementation of the hospital accreditation process was piloted in seven hospitals. The hospitals self-assessed using the trained surveyors and 30 phase-one standards, and developed a plan for addressing any unmet standards. Dr. Schwark and Ateeq-ur-Rehman Memon, Director of the PNAC Health Division, conducted site visits to the pilot hospitals. Director Memon noted that while hospitals had not yet started adhering to standards for accreditation, it was significant that their administrators were starting to think about quality and be aware that accreditation standards exist. PNAC's Deputy Director General, Capt. Najamuddin, said they were particularly impressed by Dr. Schwark's assistance: "He had thorough knowledge of accreditation, and brought international standards, but he also understood the cultural issues in Pakistan that face the accreditation process." The steps taken during the TACMIL project are just the beginning of a process that will take several years to implement fully; nevertheless, the project assisted the PNAC and core group to focus their time and effort on hospital accreditation, and gave them the tools to move forward after the project's end.

The PNAC will continue the work on hospital accreditation in collaboration with the MoH. Based on their experience with other accreditation processes, PNAC staff believe that once hospitals begin competing with each other and understand the benefits of accreditation, there will be less need for outside financial and logistical support for the process.

Principal Achievements

- The HSSPU was established and key dialogue about using evidence to inform policy is becoming standard practice.
- The HRH Roadmap was developed with MoH and WHO and the first step (an HRH assessment) was completed, providing data on which to base HRH policy.
- The hospital accreditation process and accompanying surveys were developed and piloted in seven hospitals.

Additional Activities

Procurement of Emergency Drugs and Supplies

Due to the recent high incidence of terrorist attacks in the area surrounding Peshawar, demand for emergency medicine and supplies has significantly increased. At USAID's request, working directly with the GoP, the TACMIL project quickly mobilized to procure a large consignment of supplies and materials for the Lady Reading Hospital (LRH). During the last two months of project implementation, truckloads containing an estimated worth of \$500,000 in emergency supplies were delivered to LRH. The shipments contained infusions, antibiotics, anesthetics, steroids, analgesics, sutures, syringes, cotton, gauze, bags, and other miscellaneous emergency medical and surgical items. The first half of this shipment was carried out in just five days.

The procurement also included 1,000 hemostatic¹⁰ bandages and gauze of various sizes, which were turned over to the Federal DG Health for distribution to Pakistan's busiest trauma hospitals.

Workshops on Management of Bomb Blast Injuries, Use of Hemostatic Bandages and Anti-shock Garments

TACMIL held two workshops on Management of Bomb Blast Injuries and Use of Hemostatic Bandages and NASGs. Seventy-eight doctors and paramedical staff from Punjab, Sindh, and Baluchistan attended the training in Lahore, and 73 doctors from NWFP attended the same training in Peshawar at LRH. The training provided a brief on basic trauma care skills for bomb blast injuries. As a result of the workshops, attendees and TACMIL staff identified the following needs for further assistance: training for medical



Dr. Schwark tours a hospital during an accreditation pilot site visit.

¹⁰ Hemostatic bandages and gauze are dressings used in emergencies situations; they prevent haemorrhage and stimulate blood clotting until a patient can be treated in a proper surgical facility.

students in trauma management; hospital guidelines for managing mass casualties; a standardized skill set for doctors; dedicated teams of doctors and nursing staff to deal with mass casualties.

C. COMPONENT 2 – TARGETED HEALTH INFORMATION

Specific Objective of the Component

This component's objective was to disseminate the findings of the PDHS 2006-07 to a range of stakeholders including legislators, GoP officials, representatives of research and academia, NGOs, and media as "information for action," that is, information to encourage community members to take action to find a solution. The TACMIL project provided technical support and capacity building to the National Institute of Population Studies (NIPS), the GOP entity that had conducted the PDHS. TACMIL advocated for use of PDHS results for evidence-based policy and decision-making and to prioritize funding and promote MDGs 4 and 5. The component also sought to raise citizens' awareness and to encourage them to hold government officials more responsible for providing quality health services, through education campaigns and training media to identify and report on health issues. This component was implemented with our partners Internews, AASA, NATPOW, AMAN, and PNFWH.

RESULT:

Increased public health advocacy activities carried out by societal leaders.

(This corresponds to Expected Result B.1.2 in the contract)

Principal Activities

Advocating for evidence-based policy-making in the health sector

To promote the use of information for action, it was important to build NIPS' capacity as a key resource in Pakistan for information to inform policy and decision-making. After signing an MoU with NIPS, the TACMIL project assisted in several ways: 1) disseminating PDHS 2006-07 findings at national, provincial, and district levels; 2) improving the in-depth research and analysis skills of NIPS researchers through on-the-job mentoring and encouraging them to use relevant research resources; and 3) upgrading and improving NIPS research labs and website to improve capacity to conduct and publicize research.



Top: Presenters discuss the findings of the PDHS 2006-07

Bottom: Group at dissemination event discusses the implications of PDHS 2006-07 findings for health programs in Pakistan

TACMIL organized five events for the dissemination of PDHS 2006-07 at provincial and district levels. In attendance were stakeholders including legislators, GoP officials, representatives of research and academia, civil society organizations, medical institutions, media, and the donor community. Participants in the initial dissemination events identified current and future health care service providers as key to contributing to addressing MNCH issues and achieving MDGs 4 and 5 and the participants composed a brief to be shared with the providers. The brief, which both the MoPW and the MoH endorsed, highlighted the progress that the PDHS had documented over the past 18 years on issues now targeted by the MDGs, suggested ways to track MDGs, and made recommendations for how all citizens of Pakistan can contribute to achieving the MDGs. Twenty-seven awareness and dissemination sessions entitled “PDHS: Tracking the MDGs” were held and attended by 5,448 faculty and students of public and private sector medical institutions, focusing on how they can help the GoP achieve the MDGs.

*“I never knew about the MDGs and how much responsibility lies on us,
now I will be more responsible to address MNCH issues.”*

Participant at PDHS: Tracking the MDGs

The TACMIL project hired a senior researcher who had worked on the PDHS to provide on-the-job mentoring to 13 NIPS researchers. The mentoring improved the ability of the researchers to identify topics relevant to development of policy and programs and then to individually carry out the research and data analysis needed. Ultimately, the mentored researchers prepared seven secondary analyses of the PDHS and produced research papers on their work. TACMIL also sponsored four researchers from NIPS and the Health Services Academy to attend a USAID-MEASURE/Evaluation advanced training course, “Impact Evaluation of Population, Health and Nutrition Programs,” held at the Public Health Foundation of India, in New Delhi, in October 2009. The workshop aimed to increase the attendees’ ability to use impact evaluation studies to analyze population, health, and nutrition programs. Participants also learned to appropriately interpret monitoring and evaluation (M&E) results and deduce programmatic implications.

As a key information dissemination tool, the TACMIL project developed a state-of-the-art website for NIPS. The site features the PDHS, reports on its key findings, reports in Urdu and Sindhi, and contains a database of articles and research reports on a variety of topics. To enhance NIPS’ capacity to support the website and other research, the project provided one 20 KVA electric power generator and 24 UPS devices.

TACMIL organized a workshop, held in Karachi in January 2009, to establish an applied research agenda on national health priorities. The workshop was attended by various stakeholders including one federal minister, four provincial ministers, members of the National Assembly and provincial assemblies, representatives of research and academic institutions and the media, and health program managers. Participants discussed and selected themes for research required.



Federal and provincial ministers at the National Workshop on Applied Research Agenda on National Health Priorities

With technical support from TACMIL partner AASA, TACMIL staff conducted three awareness and advocacy sessions for a range of stakeholders at national, provincial, and district levels: members of the Senate Standing Committee on

Health, Federal and Provincial Ministers for Health and Population Welfare, and District *Nazims* (local officials similar to mayors). These events included technical guidance for the use of information for action. Simultaneously, the project organized community sensitization and mobilization sessions in collaboration with district-level legislators and GoP officials, to mobilize communities to use public services.

The information sessions have contributed to a significant increase in the level of stakeholders' ownership and responsibility for the health status of citizens. For example, one sensitized legislator presented a bill to her provincial legislature on reproductive health and women's rights. She also mobilized other legislators to highlight MNCH as a priority issue and to take required measures to "Save Mothers." According to her, "more women are dying in Pakistan owing to reproductive health causes than people dying altogether due to security and political reasons."

As another result of TACMIL advocacy, the GoP formed a Parliamentary Commission on Health and Reproductive Health, a legislative oversight and advisory body to oversee health and reproductive health systems at the national level. The commission when fully functional is designed to promote evidence-based policy making, act as an oversight and advisory body to strengthen health and reproductive health systems, and facilitate inter-ministerial coordination.

In addition, the TACMIL project developed communications materials such as posters and leaflets focused on danger signs during pregnancy and in newborns and the three delays leading to complications during delivery. The project shared these materials with lady health workers (LHWs) and encouraged them to use them for community awareness activities.

Principal Achievements

- PDHS 2006-07 findings were disseminated to policymakers, health care service providers, and the community at large through several workshops.
- NIPS capacity was improved through the upgrade of its computer lab, development of a website that can host the PDHS data and other research findings, and researchers trained in secondary and in-depth analysis, improving their ability to produce information that can be used to inform policy and public health programs.
- Successful results-oriented sessions were held with the Senate Standing Committee on Health, Federal and Provincial Ministers for Health and Population Welfare, legislators, and GoP officials. As a result, at least one sensitized legislator has presented a bill on reproductive health and rights of women, to her provincial assembly; the bill is now under discussion.



Ms. Humera Alwani, a Member of the Sindh Provincial Assembly, is one political leader who has taken the information learned at TACMIL-organized sessions and used it to hold her fellow legislators accountable for addressing MCH issues and taking steps toward achieving MDGs 4 and 5. Following the PDHS dissemination event that she attended in October 2008, Ms. Alwani returned home and visited the government health facilities in her district, where substandard conditions further encouraged her to bring MCH issues to the forefront of her political agenda. Ms. Alwani said "My colleagues don't think it is an important issue, but I keep raising it."

Raising Awareness on Maternal and Child Health Issues in Local Communities

The TACMIL project worked with government officials to sponsor festivals, contests, and other constituent events focused on specific health themes such as “Happy, Healthy Children,” and to facilitate advocacy and discussions around such topics as maternal and child health, birth spacing and good nutrition for healthy mothers and children, and to help build trust in public sector health facilities.

To create linkages and synergies with other project activities, messaging centered on the “danger signs during pregnancy,” “danger signs in newborns,” and “three delays leading to complications in delivery.” District coordination officers, executive district officers, and departments of health and population welfare were involved in hosting *melas* (health fairs), which featured interactive theater as a mode of communication and community mobilization. A total audience of 11,563 community members, including family decision makers, attended 63 events. These events effectively contributed to the objective of raising awareness about these key MNCH issues.

*“I never knew that these signs are danger signs in the newborn,
thanks to you for giving us this information.”*

Female participant

*“We thank you for coming here, you are the first ones who are so caring and care
enough for us to come all the way to this place and tell and guide us about our
health, you have even brought LHWs here, who have been a dream for us to consult.
We have always been the deprived ones but you really care and you are not our
government you are from America.”*

Male member of Keti Bander community in Thatta District

Principal Achievements

- Communications materials and a public awareness campaign, including 63 community events with interactive theater sessions, effectively raised the community’s understanding of MNCH issues and confidence in public health facilities.
- 27 education sessions entitled “PDHS: Tracking the MDGs” were organized for faculty and students of public and private sector medical institutions, targeting those members society who can contribute the most to addressing MNCH issues and achieving MDGs 4 and 5 through their provision of care, training and informed advocacy with policymakers.

Engage and Educate Journalists on Key Health Issues to Improve the Frequency and Accuracy of Responsible Reporting

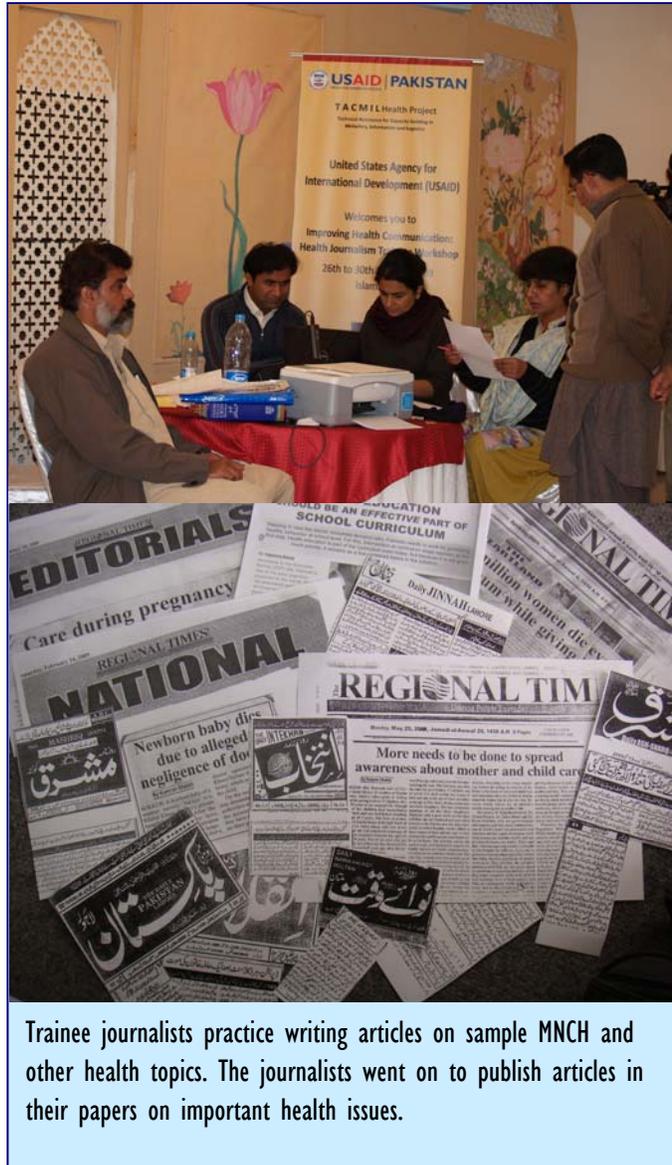
With the technical support of project partner Internews, TACMIL engaged the media to synergize its efforts toward achieving “information for action” theme. Media coverage in Pakistan tends to focus largely on security and political issues; this component aimed to increase coverage of health topics. Internews developed and implemented trainings on health journalism, in particular on MNCH issues and health communication strategies. TACMIL then held five health journalism trainings for 67 print journalists.

Immediately following the training, the journalists received on-the-job-mentoring to produce articles and trainings focused on MNCH. An electronic platform for sharing information and stories was formed. Through this e-group, the TACMIL project provided the journalists with data, statistics, and links to relevant resources for information.

The trained journalists went on to publish 175 health-related articles/stories in national and district media outlets.

A Health Media Network (HMN) was developed to promote MNCH-focused health journalism. HMN members, each with more than five years of experience in print or electronic journalism, received an orientation and briefing on health journalism and MNCH issues and were provided with data and information to promote “information for action.” They produced articles, stories, and radio programs highlighting MNCH issues and progress made in addressing MNCH problems in Pakistan. TACMIL identified a volunteer coordinator and manager, ensuring HMN sustainability after the project ends. 13 members of HMN have produced 284 media pieces and TACMIL has recognized three of these members with achievement awards.

TACMIL also engaged, trained, and mobilized 17 non-media health sector stakeholders to interact with and use media for information dissemination and community awareness. The two trainings targeted health communication officers from the public sector because they have firsthand access to important public health information and are the best cadre for information dissemination. The trainings aimed to change the attitude of these stakeholders, encouraging them to have a positive working relationship with the media and to promote the use of the media as a tool for health information dissemination.



Trainee journalists practice writing articles on sample MNCH and other health topics. The journalists went on to publish articles in their papers on important health issues.

Principal Achievements

- Media relations and health journalism curricula were developed.
- Five health journalism trainings resulted in 67 media personnel trained; they published more than 175 articles/ stories in national and district media.
- The HMN was developed and volunteer coordinators and managers identified, ensuring its long-term sustainability.
- Two media-relations training were held for HMN members, who then produced 284 media pieces/articles.
- A total of 457 media pieces focused on MNCH were produced and published.

D. COMPONENT 3 - GRANTS PROGRAM

Specific Objective of the Component

The principal objective of the grants component is to address health systems challenges in the public, private, or commercial sectors which can be resolved with modest financial assistance within a period of

RESULT:

A minimum of 10 grants awarded.

(This corresponds to Expected Result C.1.2 in the contract)

one year by concerted effort of local NGOs. A total of US\$1 million was awarded to selected grantees in two rounds with each grant totaling no more than US\$100,000. The grants included a requirement for grantees to participate in a 15 percent cost share as a way to promote ownership and demonstrate commitment. This component was implemented with our subcontractor AASA.

Principal Activities

Process for awarding grants

The grants program began with the drafting and approval of a grants manual, which USAID approved in June 2008. The TACMIL project then hosted information exchanges with other implementing partners including other USAID-funded projects, GoP counterparts, and NGOS, and held internal brainstorming sessions to identify key themes around which innovative health systems and service delivery projects could be designed. The project formed a grants committee to ensure transparency, competitiveness, and a complete assessment of the technical and financial merit of proposals throughout the entire grants solicitation process, whose membership was approved by USAID in July 2008.

TACMIL project Grants Committee members included:

- Chief of Party, TACMIL project
- USAID COTR for TACMIL project
- Senior M&E Advisor, TACMIL project
- Director of Administration and Financial Management, TACMIL Project
- Grants Officer, Abt Associates Inc., Headquarters (as available)
- Portfolio Manager, Abt Associates Inc., Headquarters (as available)

The solicitation and award of the grants took place in two rounds as follows:

Round I: The first round of grants started in June 2008 when requests for applications (RFAs) were issued. TACMIL also organized and held two information seminars in Islamabad and Karachi to promote the program and explain the application process to interested parties. This resulted in 143 applications from 108 NGOs.

Two independent consultants conducted a desk review and screened the more than 200 applications and provided a shortlist of grantee candidates to the grants committee in August, 2008. The committee conducted a quick review of the applications itself, and ultimately the committee agreed with the consultants' shortlist and selected six organizations to work in seven districts under Round I. This list was submitted to USAID for approval.

Following negotiations over scopes of work and budget, and pre-award technical and financial assessments, seven grant agreements were finalized with six local NGOs. The project held a Grants Orientation workshop in Islamabad on November 11, 2008, to further enhance grantees' understanding of its grant implementation process.

Round II: The second round of grants had a more thematic structure. This round of 'Structured and Strong District Health Systems' grants targeted all 20 project districts and focused on the following four thematic areas:

- Strengthening district health management teams
- Strengthening accountability mechanisms
- Strengthening public private partnership
- Introducing innovative health financing schemes

In September 2008, TACMIL issued requests for concept papers. Concept papers required an overview of the plan for the grant; geographic and demographic coverage; implementation approach; a proposed partnership with a government or NGO partner; a plan for sustainability; and linkages with the current district health management system.

The TACMIL project conducted a technical and compliance screening of the 185 concept papers and presented a recommended short list to the grants committee. In October 2009, the committee decided to request technical applications covering the districts that had not been covered under Round I, and requested applications from seven of the shortlisted applicants which were proposing to work in districts that did not already have a Round I grant.

Because this round focused on the organizations' proposed concept, a one-day Grant Application Development workshop was held in Islamabad in November 2009 for all shortlisted Round II applicants to help them correctly prepare an application. Participants received an orientation to the TACMIL project and a brief training on how to write a technical application and prepare a budget so that they could revise their applications. Finally, five organizations were selected to work in 11 districts.

Mentoring and Building the Capacity of Grantees

A system of participatory monitoring was developed as part of the capacity building and mentoring program for grantees. This system began with an introduction to USAID rules and regulations, detailed explanations of reporting expectations for programmatic and financial activities, and guidelines for convening events, seminars, and other activities under the grant agreement. The grantees also received training in USAID family planning regulations.

Next, the grantees were trained in the preparation of IEC and training materials. TACMIL staff provided advice on the technical content of these materials to ensure that they were relevant to the program objective, but also appropriate for the target audience(s). Special emphasis was given on compliance with USAID regulations and branding requirements.

Staff worked closely with grantees to prepare a logical framework (LF) for monitoring and evaluation of each individual grant. The purpose of preparing LFs was to create guidelines within which the NGO could easily monitor and document all program activities with little assistance. Each LF contained specific objectives, activities focused toward achieving those objectives, and process and activity indicators and their related mode of verification and frequency of reporting. The grants team in collaboration with M&E team periodically visited all grantees to monitor the grant activities and provide technical mentoring for the implementation of the activities.



Technical Advisor provides grantees with an orientation on program reporting

“The project staff has helped us a lot in the development and reshaping of the proposal and providing timely support to the organization in the management of the project activities. . . This is all happening due to project mentoring visits and guidelines given to us for managing the events and reporting those events.”

Roqia Bano, Al Qaim Women Development Organization

Throughout the mentoring process, and based on results of activities, the grants team worked with the grantees to revise their activity plans when necessary in order to help them meet their objectives. This ensured that targets of pilot models were appropriate with changing environments and increased the effectiveness of the activities.

Similarly a rigorous mentoring and monitoring plan was implemented for financial management and compliance with the grant agreement requirements. A comprehensive monitoring checklist was prepared to ensure that expenditures were being recorded appropriately in the finance reports, grant requirements were being adhered to, cost share obligations were being fulfilled, and inventory had been through a proper procurement process.

“The experience gained through this short span of project duration is indeed worth mentioning. It has contributed to enhancing our organizational development and capacities in terms of leadership skills, time management, project cycle management, financial management, and report writing. The project not only broadened aspects of the issues of health systems of the target districts and the communities as well but also capacitated us in finding the possible and innovative solutions to them.”

Muhammad Yaqub, Takhleeq Foundation, Karachi

Grantees' Activities

In total, 12 grants were awarded to 11 NGOs to implement innovative and replicable models in 18 districts through the two rounds of solicitation. The following summarizes each grantee, their activity and the innovative model piloted under their grant. Annex D provides detailed descriptions of work and geographic coverage of the grants.

- Leadership for Environment and Development (LEAD), an NGO with a strong community network, received a grant in Round II. Their model focused on activating Health Management Committees (HMCs) at district, tehsil, and union council levels to improve referral mechanisms and health care service delivery and accountability systems by forming Community-based Support Groups (CSG) and Health Watch Networks. The pilot project included a baseline survey on the roles and responsibilities of health committees in selected health facilities. This informed a process to activate and build the capacity of the eight HMCs/Sehat Committees¹¹ (SCs)/CSGs through trainings and mentoring visits. The project also developed effective linkages between these groups and district health management teams, private sector health care providers, NGOs, various corporate entities, and charities to mobilize additional resources for community health needs. Through this activity, eight communities, with a total population of more than 60,000, benefitted from improved health services.
- Health and Nutrition Development Society (HANDS), an NGO based in Karachi, created a pilot voucher scheme that could be used in both public and private health facilities for maternal health services to promote safe motherhood. The output-based aid voucher scheme was created through a partnership between public and private health facilities and HANDS acting as a Voucher Management Agency. HANDS used community mobilization techniques to motivate the community to use health services and identified voucher recipients based on pre-identified eligibility criteria. In turn, private health facilities provided pre-determined services to clients with vouchers, and



Woman leads a CSG, formed through the LEAD grant to facilitate debate and discussion about MNCH issues and ways to address them.

¹¹ Sehat Committees are village level health committees

redeemed the vouchers with HANDS to recover their service fees. The program referred 598 patients to voucher scheme participating referral facilities during the project period.

- Strengthening Participatory Organization (SPO) received two grants – one to work in Charsadda (NWFP) and one to work in Gwadar (Baluchistan) – both of which aimed to enhance the capacity of HMCs and health boards to identify weaknesses in the public health system, articulate community health needs, and participate in decision making. The project in Charsadda focused on grassroots participation in the health sector by monitoring public health facilities. The project formed 25 HMCs at the union council level, as well as one district-level HMC and one district health board (DHB) to hold the HMCs accountable. Approximately 426,428 community members in 150 villages in Charsadda benefited from this project. Through the project, 235 community members participated in 11 capacity-building trainings. According to an annual review, 40 percent of the recommendations made by the HMCs during the grant period were implemented, resulting in improved availability of services at facilities and an increase in the number of clients going to public health facilities.

Similarly, in Gwadar, SPO formed seven HMCs at the union council level, as well as a district-level HMC and a DHB to implement a similar activity, building their capacity for health service monitoring and advocacy. Approximately 168,110 community members from 125 villages were touched by the Gwadar project. Six trainings were implemented for 127 community members, and similar improvements in public health facilities were seen.

- The Takhleeq Foundation (TF) of Karachi was awarded grant to improve public-private partnerships by activating Citizen Community Boards, linking the development of communities with health care service providers. TF conducted social mobilization and awareness-raising campaigns that included interactive theater, and development and dissemination of IEC materials and audio/video public messages. TF also implemented a campaign to build TBAs' and LHWs' skills and knowledge in reproductive health issues, safe motherhood, behavior change communication, gender development, and referral mechanisms. TF also renovated and repaired two health facilities in collaboration with district health authorities.
- Midwifery Association Pakistan (MAP) received a grant to improve intranatal care skills which are important to improving maternal and neonatal health outcomes. They implemented skills trainings in AMTSL and the use of the partograph for SBAs at public and private health facilities. In total, 272 SBAs were trained in 17 trainings at different locations in three districts.



TBA receiving safe delivery kit by Takhleeq representative during a training session

- The Centre for Peace and Development Initiatives (CPDI), an organization based in Islamabad, piloted a model to facilitate the process of evidence-based and participatory planning including need-based budgeting at district and lower levels in Jhelum district. It also created awareness among local communities about health issues, the availability of health care services, and community members' rights to access to good quality health through a public awareness campaign. As a result of this

intervention, the Chief Minister of Punjab province introduced and enacted a law on freedom of information.

“The knowledge and experience gained through this project will form the basis of future advocacy campaigns and projects.”

Amer Ejaz, Senior Program Manager, CPDI

- The Al Qaim Women Development Organization (AQWD) used a scorecard technique to ascertain gaps in the health care service delivery system in close consultation with community and health management authorities. As a result, they were able to make recommendations for development plans to improve health facilities.
- Association for Gender Awareness and Human Empowerment (AGAHE) focused its efforts on increasing use and quality of maternal health care services. The activities included a project orientation workshop, health information sessions targeting both males and females, an orientation for TBAs and LHWs on referral services, a training and refresher course for TBAs on safe delivery and with LHWs on Emergency Obstetric Care, the formation of Voluntary Network – a group youths who will supplement and continue the work of AGAHE, the revitalization and strengthening of District Health Management Committees (DHMC) and SCs, and the delivery of safe delivery kits to SBAs.
- Gender and Reproductive Health Organization (GRHO) implemented a program to strengthen district health management systems by addressing first and third delays¹² through awareness-raising programs and interactive theaters with special focus on referral mechanism for public health facilities.
- Youth Organization (YO) developed two strategies for addressing the use of health facilities in their three districts. The first was to strengthen district health management. YO mobilized the community and worked to raise awareness about reproductive health issues through seminars, focus group discussions, and the formation and engagement of volunteer groups to interact with important community members such as religious leaders, school teachers and media representatives. They also activated health management committees, and trained the members on health issues, referral mechanisms and evidence-based decision making. YO's other strategy was to introduce referral slips. The referral slips can be used for subsidized transportation and services at private health facilities where public health facilities were not available. Through this arrangement, YO successfully extended subsidized services to 134 poor women in three districts.
- Swabi Women Welfare Society (SWWS) worked in three districts greatly affected by the civil strife and military operations in NWFP. Their activities focused on expanding basic maternal health interventions to under-served populations through behavior change communications (advocacy and sensitization) and creating a family friendly health-care system with proper referral mechanisms. To ensure sustainability of the interventions, all community mobilization and awareness raising activities were undertaken in consultation with Sehat Committees and district health management authorities.

Principal Achievements

The TACMIL project implemented innovative approaches with technical and financial assistance to Pakistani NGOs under the grants program. Twelve pilot programs were implemented in 18 districts of the country through 11 NGOs. The scope of work of these activities can be classified into the following areas: Capacity Building, Governance, Health Financing, Service Delivery, and Mass Media Campaigns. Table 4 lists the participating NGOs and the respective areas their activities focus on.

¹² The three delays are delay in decision, non-availability of transport, and non-availability of emergency services.

TABLE 4. NGO PARTICIPANTS IN THE TACMIL GRANTS PROGRAM

NGO	Capacity Building	Governance	Health Financing	Service Delivery	Mass Media Campaigns
HANDS			X	X	X
CPDI	X	X			X
SPO Chr	X	X			
SPO Gwr	X	X			
AQWD	X	X			
AGAHE	X			X	X
LEAD	X	X			X
TF	X			X	X
GRHO	X			X	X
YO	X			X	X
SWWS	X				X
MAP	X				X

Key achievements through implementation of grant activities were:

- 2,214 health care providers (1,297 females and 917 males) received training on AMTSL, partograph, danger signs during pregnancy, three delays, or other skills for providing maternal and newborn health services;
- 6,686 targeted community stakeholders (1,487 females and 5,199 males) received training in monitoring health service delivery quality, needs-based budgeting, freedom of information, consumer rights, referral mechanisms, or safe-motherhood;
- 1,118,173 community members (656,113 males and 462,060 females) received awareness-raising information through mass media campaigns using radio messages, cable TV messages, SMS messages, posters, flyers, banners, brochures, billboards/ signboards, and press coverage;
- 70,416 community members (28,689 males and 41,727 females) participated in various advocacy events;
- MNCH emergency services were provided to 3,521 females, 1,865 males, and 309 neonates;
- 107 health committees at various administrative levels (village/ sehat/ district) were activated/ reactivated involving 781 male and 337 female community members;
- 48 CSGs and network forums were formed and activated;
- One law freedom of information law was enacted as a result of grant interventions.

E. COMPONENT 4 - STRENGTHENING OF ESSENTIAL DRUGS AND CONTRACEPTIVES LOGISTICAL SYSTEM

Specific Objective of the Component

The GoP has three major government bodies in the health sector that procure, store, and distribute drugs/medicines and contraceptives: 1) MoPW and two MoH programs: 2) the National Maternal, Newborn and Child Health Program and 3) the National Program for Family Planning and Primary Health Care, also referred to as the Lady Health Workers Program. While efforts have been made to improve the system through several international donor-funded projects, the situation has remained unchanged to a large extent during recent years. The main objective of Component 4 was to work with both ministries to improve the Logistics Management Information System (LMIS), storage facilities and practices, the mechanism for managing inventory, and the general capacity for forecasting supply needs.

This component was implemented along with two subcontractors: LMI and UTi. During implementation, the project faced multiple challenges to implementing this component. As a result, in April 2009, activities in this component were discontinued.

Principal Activities

RESULT:

A fully functional contraceptive and essential drug logistics system within the 20 targeted districts.

(This corresponds to Expected Result D.1.1 in the contract)

Logistics System Needs Assessment and Situation Analysis

To upgrade the current logistics and inventory management systems for contraceptives and essential drug supplies, a study team conducted a situational analysis of the existing systems. The study team visited district stores in 18 of 20 TACMIL project districts,¹³ and provincial warehouses in all four provinces. It collected data through structured questionnaires and observation checklists. These tools allowed a detailed examination of product selection, forecasting, procurement, and distribution by reviewing warehousing, distribution, information and communication technology, and finance and governance.

As part of this initial assessment, project staff met with UNFPA, FALAH, MoPW, MoH, Greenstar Social Marketing, UTi, and the Japan International Cooperation Agency (JICA) as well as numerous government officials, both in Islamabad and in the provinces. Although an assessment of the MoPW's Central Warehouse in Karachi had been planned, in the end, the MoPW would not allow this to take place.

Results of the study indicated that a reduction of duplicate systems, and applying consistent logistics operations practices that were more in line with industry best practices across the various ministries, provinces, and district levels would improve the reliability of the supply chain. Specifically the study identified the following problems:

- Procurement committees function differently in all four provinces and select drugs in a vacuum.
- Insufficient, non-formal forecasting methods were being used.
- Warehouses were inadequately equipped and organized for proper storage of medicines.

The study team recommended a comprehensive program to improve and properly maintain physical infrastructure supporting logistics operations and better information sharing and processes across organizations to enhance the efficiency and effectiveness of supply chain management. Because of the complexity and cost implications of these management issues, the team devised a five-phase approach to guide the MoPW and MoH in implementing a transition from the current systems to one more in line with global best practices. Under this contract, the TACMIL project was able to begin to support the ministries in implementing Phase I of this process – Upgrading the Current Logistics Operations.

Provide Training on Forecasting Contraceptives and Essential Drugs

TACMIL sponsored seven participants' attendance at an international course on "Managing Drug Supplies in Developing Countries," conducted in Holland in October 2008 by IDA Solutions in collaboration with WHO. Two participants from the MoH, three from the MoPW, and two from the TACMIL project attended the course.

¹³ The needs assessment exercise did not visit Lukki Marwat and Zhob due to the security situation at the time.

Participation in M&E Training

The TACMIL project sponsored six participants in the “Monitoring and Evaluation for Development” training implemented by IMA International, in Brighton, UK, in April 2009. Participants included three delegates from the MoPW, one from the MoH, and two from the TACMIL project staff. IMA International, a British consulting firm working on capacity building for development, conducted the training. The 10-day training covered various M&E theories and tools, from basic biostatistical concepts and principles to the steps for developing a M&E system and methodology for carrying out impact assessment.

Principal Achievements

- Needs assessment studies of the logistics systems were conducted in 18 of the 20 project districts.
- Five ministry staff were sponsored to attend training in drug supply management.
- Four ministry officials attended a 10-day training on M&E for development projects.

3. LESSONS LEARNED AND RECOMMENDATIONS

LESSONS LEARNED

Implementation of the TACMIL project revealed challenges that cut across project components, generating lessons learned about the best ways to implement a HSS project in Pakistan. TACMIL staff have also identified component-specific lessons they observed. These lessons can inform the future implementation of similar work.

General

- The NGO community in Pakistan has a varied and broad reach within the country with varying technical capacities, abilities to manage projects of different scales, geographic and technical scopes of work, and interest in carrying out the activities envisioned by USAID. It is important to continue to support these organizations and build their capacity for implementing effective MNCH programs. Our experiences showed that despite their size and level of experience, Pakistani grantees and NGOs and subcontractors continue to need support in project design, coordination, implementation, and monitoring as well as to improve their management capacity. Specific to implementing USAID-funded programs, the NGOs to which the TACMIL project awarded grants needed the most assistance with reporting requirements and branding requirements. Subcontractors needed support with management issues, understanding the importance of financial transparency, and compliance with stated regulations. To appropriately and successfully build their capacity, the supporting organization needs to provide continuous, day-to-day monitoring and hands-on mentoring in addition to orientation workshops and one-off trainings. Through this ongoing support and guidance, organizations can put into practice the processes needed to adhere to regulations that are new to them, and eventually these actions will become habitual.
- Providing decision makers with accurate and up-to-date information through repeated sensitization and mobilization is required to see the desired policy and legislative outcomes.

Component-specific

Component 1

- **Participatory Adult Learning Methods and Competency-based Training Methods:** Methods that TACMIL used in both PDIC and INC courses were seemingly new to many participants, especially clinicians working in the public sector. The norm, in at least midwifery education, appears to be lecture-based transmission of knowledge with little focus on higher levels of learning other than basic recall of facts; there is little, if any, focus on clinical skills. Participants repeatedly commented on evaluations that they had learned from and enjoyed the case studies, demonstrations, and opportunities for mentored clinical practice. Tutors stated they planned to use course materials including checklists and case studies with students. Many stated that they had learned about the partograph in other trainings but only after taking the PDIC course did they really understand how what they plotted on the graph could be used to manage labor and detect complications. Based on the experience of this project, once participants overcame their initial skepticism of something new, these participatory, competency-based training methods were very well received.
- **In-service Course Effectiveness:** Clinical training in isolation rarely results in change in actual clinical

practice anywhere in the world, and Pakistan is no different. An “enabling environment” is required for new practices to be successfully adopted. In the case of the PDIC and INC trainings, the enabling environment included:

- Physicians and administrators knowledgeable about and supportive of the new practices
- Equipment and supplies needed to implement the practices (buckets and chlorine solution, copies of partographs, oxytocin, syringes)
- Adequate staffing – no one can manage labor using a partograph if they are alone on a night shift with one non-professional helper (ayah) attending to 8-10 women in varying stages of labor
- Ongoing reinforcement and/or supportive supervision, especially for those in solo private practice or those practicing in rural health centers or basic health units where, due to a limited caseload, they may need longer to become proficient practicing new skills

To achieve the targets set by the contract, the project focused on performing the trainings with full knowledge that more inputs were needed to ensure that the practices taught were actually implemented. A small number of key doctors working with midwives were invited for trainings, but due to the need to focus primarily on the contractual target for training nurses and midwives, the number of doctors reached was very limited. In Pakistan, the buy-in of doctors was essential for any change in the clinical practice for midwives to occur. From experience of this project, it was most essential in the government sector but required in both public and private clinical settings. Abt Associates recommends to USAID/Pakistan to include more doctors and medical superintendents in future trainings even where nurses and midwives are the primary targets - in order to maximize the chances of real change occurring in clinical settings post-training.

- **Midwifery Educators:** At present, few RN/RMs teaching midwives in Pakistan meet the proposed standards for midwifery educators (see TACMIL’s report on “Proposed Standards for Midwifery Tutors”). Many never had opportunities to deliver a baby or manage a pregnancy during their one-year midwifery program. Because nurses/midwives are so outnumbered by doctors, they have little opportunity for clinical practice in teaching hospitals, which often have high caseloads and are chosen as clinical sites for midwifery students. Because midwifery is so embedded within nursing, most midwives (RN/RMs) do not view themselves as midwives, yet they form the bulk of those teaching all cadres of midwives. As the ACNM consultant noted, “Midwifery education (doing the one-year RM) is seen as a necessary component to career advancement rather than a distinct professional goal. Although almost all nurses are also registered midwives, very few have ever practiced as midwives. Instructors who are midwives in title only and have not practiced midwifery should not be teaching the next generations of midwives.” This conundrum is difficult to untangle and yet it must be untangled if competent midwives are to be capable of practicing independently at the peripheral level and decreasing maternal and infant mortality.

While midwifery and nursing overlap in knowledge base and clinical skills, midwifery has distinct skills and responsibilities that make it radically different from nursing. Midwives, unlike nurses, have individual responsibility for managing a normal pregnancy and birth and for recognizing deviation from normal and making timely intervention or referral. These skills must be developed and mentored; however, they cannot be developed and mentored by people who do not possess them. TACMIL focused on building midwifery clinical skills and role identity, both needed attributes for midwifery educators in order for them to prepare competent midwives. Without competent midwives practicing at peripheral levels, no reduction of maternal and infant mortality will occur.

- **Recognizing the Role of Midwives:** Confusion exists amidst many provincial and federal officials regarding scope and role of CMWs and their relationship with official government health care system. While the intent, as specified in the planning document for MNCH, appears to be for CMWs to return to their home villages and operate private birthing stations, project staff heard government officials at both the district and provincial levels express skepticism that CMWs could

or should be expected to do this and to compete with other existing providers. In some settings CMWs are staffing peripheral health facilities but have not been paid or officially appointed to posts in the rural health centers or basic health units.

- **Assisting the GoP in HSS Efforts:** Short- and long-term technical assistance in the form of an international consultant or the secondment of personnel to an agency here – be it the PNAC or MoH – enables the completion of activities that have otherwise been slow to start because it adds a sense of priority, allows one person the time to concentrate on the activity as their sole responsibility, and brings in a new perspective and ideas about more efficient ways to accomplish activities.

Component 2

- **Supportive Working Relationships:** Relationships should be formed by involving GOP officials in all activities from the very beginning. For TACMIL, this created an environment in which the project was able to fast-track activities, especially because of our relationship with district-level officials. Likewise, regular interactions – sharing ideas and progress updates – keeps the attention and interest of decision makers and influential leaders on the need for and benefits of maternal and child health interventions. During implementation, the project found that the GoP facilitated and supported both the project and our partners when relationships of trust had been formed.
- **Media Involvement in Health Information Dissemination:** Information dissemination on a mass scale can be sustainable if regular information is provided to journalists over time. Consistent support and provision of information allows media personnel to realize the importance of and the need to highlight health issues. It also improves their capacity for health reporting and ultimately leads them to choose health as the focal theme for their reporting.

Component 3

- **Grants Program:** Even small grants at the community level can create visible impact. Despite the short time period and relative size of the grants under this contract, Pakistani NGOs were able to spend the money in a concentrated manner to create effective community advocacy and monitoring groups and awareness campaigns, improve access service provision at the district and village level, and provide clinical skills trainings where needed. This was possible with technical support from the project, and assistance in developing short-term implementation and monitoring plans.

Component 4

- Data collection tools for the logistics system assessment could have been more refined to improve their internal validity according to the local needs with more time.
- Two districts, Lukki Marwat and Zhob, were not visited during the needs assessment exercise due to the security situation at the time. Outsourcing this task to local technical persons after a brief orientation and training on data collection tools would have enabled us to provide a review and analysis despite security concerns.

RECOMMENDATIONS:

The following recommendations were generated as a result of the lessons learned, or in some cases where further work will be needed to truly understand the lessons at hand, and are directed both to USAID/Pakistan and our partners in the GoP. They are meant to serve as ideas for both donor-supported activities, and practices and strategies that can be directly implemented by the GoP.

General

1. When security issues prevent travel to an area or the participation of international or Islamabad-based staff, the use of technical assistance already based in that area (when available) is the best way to ensure the activity continues without disruption. Technical training in Islamabad or an appropriate alternate location is necessary to ensure the outcome results are aligned with project targets.¹⁴
2. Time is necessary to develop relationships of trust that are necessary for implementing health systems strengthening plans. It also takes time to develop sustainability through supportive supervision and continued monitoring after training interventions. Furthermore, appropriate evaluation and adjustments to programs when necessary can only happen after the activities have been in process for six months to a year. Therefore TACMIL recommends that all interventions with a goal of development and capacity building, rather immediate relief, be allocated three to five years for implementation. To see and measure long-term impact, a longer period of time is imperative; otherwise programs simply address gaps at best. Similarly, any focus on safe motherhood interventions or strengthening midwifery will take up to 5 years to achieve a demonstrable effect in reducing maternal and newborn mortality. The skills are simple and easily transmitted. Creating an enabling environment where the skills can be effectively implemented takes much longer and requires ongoing mentoring, monitoring and encouragement before the new practices are routinely practiced.
3. The TACMIL project conducted numerous trainings during its implementation – both clinical practices and managerial business processes. Throughout these trainings, project staff consistently saw better uptake of the lessons learned where trainees were provided with opportunities to practice what they were being taught through role plays, participating in demonstrations and practice exercises, and when hands-on follow-up was provided to remind trainees of the lessons learned and assist them in implementing the practices with supervision to build their confidence and ensure correct habits are adopted. Therefore TACMIL recommend that trainings in adult education theories and practices, as well as the introduction of supportive supervision be provided through any intervention in Pakistan.¹⁵
4. It is important to build relationships with stakeholders that demonstrate the value of technical assistance. On its face value, some stakeholders may have more interest in assistance that provides products and commodities. USAID and technical assistance projects should work together to develop relationships with stakeholders, and provide explanations of the importance of technical assistance and its long-term sustainability until the project is able to provide high quality assistance whose value is self-evident.

Component-specific

Component 1

- In order to reduce maternal and infant mortality, clinically competent midwives must be developed. Much confusion about the role and scope of practice of midwives exists, which is compounded by the fact that most of the midwifery work force are also nurses. A utilization study should be undertaken as soon as possible to determine how many RN/RMs currently practice or have ever practiced midwifery. Based on this data, recommendations can be made based on data. Anecdotal data suggest that the government is spending a lot of money for this extra qualification for all female nurses for very little return on their investment.
- As soon as HRH data is available, clear retention policies and career ladder for all midwifery cadres should be enacted.

¹⁴ TACMIL does not recommend continuing the activity even with counterparts who are from the area in question if their participation in our activity will put them at risk.

¹⁵ No training can result in long-term behavior change if the supplies and resources necessary to implement the learned skill are not made available following the training. In addition to using appropriate learning techniques, the guarantee of long-term support with supplies and resources are key to ensuring long-term change and improvement in Pakistan.

- Infection prevention (IP) requires immediate attention on an urgent basis. IP content covered in the INC course should be incorporated into all midwifery curricula (especially for CMWs) as soon as possible. Any future PHC projects should include IP as a focus in any facility strengthening activities. Based on the experience of this project, this is an area which needs much attention.
- All the specific life-saving clinical content and best practices (AMTSL, support of women, partograph, immediate newborn care, infant resuscitation, use of non-lithotomy positions for birth, avoidance of routine episiotomies, etc) taught in INC and PDIC courses should be incorporated into all midwifery curricula (especially for CMWs) as soon as possible.
- Project produced lesson plans and clinical checklists, which have been tested and proven to work in Pakistan, should be incorporated into midwifery curricula and more midwifery educators (after undergoing the clinical updates themselves) should be trained in their use.
- ECC course content could be easily incorporated into pre-service curricula depending on final policy decisions regarding CMW's role and scope/site of practice.
- Support for the implementation and completion of Phase I of the HRH Roadmap will yield substantial benefits at minimal cost. Therefore TACMIL recommend that it continue to be supported at least through completion of Phase I.
- As a means for increasing impact with fewer resources, medical lab accreditation could be rolled out along with the rollout of hospital accreditation programs.
- Further training should be delivered/supported to deal with the recent high incidence of bomb blast injuries. This support should include: the development of medical school curriculum in trauma management, the development of hospital guidelines for managing mass casualties, and refresher trainings in emergency trauma care for hospital staff.

Component 3

- Based on lessons learned while implementing pilot projects through the grants component, TACMIL recommend continued support, replication, and/or scale-up of innovative HSS programs at the community and district levels, for example:
 - Bridging missing links between the beneficiaries and policymakers, for example: creating fora in which citizens can participate in identifying needs and vet plans for health policy reforms and legislation, and mobilizing civil society to monitor the quality of health care services available.
 - Finding ways to use utilize the large existing human capital in the health sector, and to pass down skills through cascading training mechanisms.
 - Identifying ways to fill gaps in financial resources through institutionalized and regulated public/community or public-private partnerships, for example, using corporate social responsibility funds.
- To enhance the impact of the activities piloted through a grants program, longer-term support would allow for impact analysis and the adjustment of interventions to ensure both their impact and sustainability.
- Specific recommendations for the scale-up of effective grantee programs can be found in Annex D.

Component 4

- The MoPW Central Warehouse in Karachi should be assessed, and recommendations for improvements addressed. However, TACMIL does not recommend that improvements be made without a proper assessment first.

4. PERFORMANCE MONITORING PLAN

METHODOLOGY

The TACMIL PMP is based on the commonly used “Results Chain” framework – the results expected of the project; focusing on the project’s inputs, processes, or activities; outputs; and, where relevant, outcomes. In this case, due to the short duration of the project, the PMP focuses solely on outputs and outcomes rather than long-term impact, and in reality acts as a monitoring plan. To enable assessment of whether project activities have been completed as planned and whether results (outputs and outcomes) have been achieved, the PMP includes a set of corresponding indicators for each of the four components, and lists the sources of information to be used (“means of verification”) for measuring these indicators. The PMP was revised in October 2009 to realign it with modifications of the contract over the life of the project.

Tracking progress of project activities was a participatory process, led by the project’s M&E Unit. Many stakeholders contributed to data collection and analysis; these included the three provincial coordinators and technical team leaders, as well as TACMIL project partners and stakeholders, for example, the MoH, MoPW, NIPS, subcontractors, partner NGOs, other USAID-funded projects, and beneficiary communities. Data sources most commonly used included the training sign-in sheets; minutes of project meetings; project workshops/seminars reports; direct observations/ supervisory visit checklists; task completion reports (such as reports from a grant project); and media content analysis (newspaper reports, articles, etc). Most performance monitoring data were qualitative in nature, but some quantitative data were used as well. Data were analysed drawing on specific themes and lessons learned and were segregated and analyzed by gender, whenever possible, and reported to USAID on a quarterly basis.

SUMMARY OF ACHIEVEMENTS

A final compilation and analysis of data was conducted during the first half of December 2009 as the project activities were coming to a close. Tables demonstrating progress and achievements over the life of the project follow in Annex A.

ANNEX A. PERFORMANCE MONITORING INDICATOR TABLES BY COMPONENT

Note: Indicators shown in bold are contractual indicators

A. COMPONENT I: CAPACITY BUILDING – PMINFOSHEET

Expected Result A.1.2.a:

***Overall management and financial sustainability of Nursing Council and Midwifery Association are improved;
¹⁶nursing and
 midwifery regulatory system for accreditation of teaching institutions are strengthened nationwide, and efforts to
 advocate for the needs of midwifery and nursing services increased***

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year I (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
A.1.2.a.1 Percent increase of MAP membership	Membership list of MAP	200%	51% (325 to 490)	69% (325 to 550)	94% (325 to 631)	107% (325 to 677)	167% (325 to 868)
A.1.2.a.2 Percent increase of MAP chapters over course of the project	Reports of chapter formation	500%	0	300%	400%	500%	500%
A.1.2.a.3 Number of MAP chapters formed over course of the project	Reports of chapter formation	5	0	3	4	5	5
A.1.2.a.4 Number of hits received by MAP website over life of the project	MAP's website*	200	0	0	68 hits 280 pages	295 hits 1214 pages	462 hits 1923 pages
¹⁷ A.1.2.a.5 Revised monitoring systems to measure accreditation standards adopted and implemented by end of project	Activity not in contract	Activity not in contract	N/A	N/A	N/A	N/A	N/A
¹⁸ A.1.2.a.6 Number of institutions monitored using new standards	Activity not in contract	Activity not in contract	N/A	N/A	N/A	N/A	N/A
¹⁹ A.1.2.a.7 Number of institutions sanctioned for failing to meet standards	Activity not in contract	Activity not in contract	N/A	N/A	N/A	N/A	N/A

¹⁶ The activities under the following part of Result A.1.2a, “nursing and midwifery regulatory systems for accreditation of teaching institutions are strengthened nationwide” have been removed from the SOW on Feb 13, 2009 under modification # 1 to task order contract. Accordingly progress is not being tracked & reported on indicators relevant to this.

¹⁷ Same as footnote 1 above.

¹⁸ Same as footnote 1 above.

¹⁹ Same as footnote 1 above.

A.1.2a.8 Number of professionals registered in an updated PNC computerized registration system by the end of the project	Reports from PNC	50	0	0	0	0	100
A.1.2a.9 Number of professionals registered using the online registration system by the end of the project	List of professionals registered online PNC website	100	-	-	-	-	50
A.1.2a.10 Online registration system developed for PNC	Functional registration system on PNC website	YES	-	-	-	-	YES
A.1.2a.11 Number of emerging nurse/midwife leaders identified and involved in advocacy and governance activities	List of identified emerging leaders TACMIL's quarterly reports	14	14	14	14	14	14
A.1.2a.12 Number of mass media messages disseminated regarding nursing/midwifery image building	# of advertisement aired on FM radio/TV	FM Radio spots: 30	-	-	-	-	1044
		TV spots: 15	-	-	-	-	740
	Number of advertisement published in newspapers	48	-	-	-	-	18
A.1.2a.13 Number of hits received by PNC website over life of the project	PNC's website	200	-	-	-	456 visits 1739 pages	1118 visits 4475 pages
A.1.2a.14 Number of outcome-oriented learning opportunities provided to emerging nursing/midwifery leaders through study tours to developing countries with strong functioning nursing/midwifery associations or through focused courses held in Pakistan by external STTA from countries with strong professional associations	Study tour reports (TACMIL's quarterly report)	2	2	2	2	2	2

A.1.2a.15 Financial and incentive package to increase midwife retention designed and advocated	Copy of financial package Minutes of advocacy meetings	YES	-	-	-	-	YES
A.1.2a.16 Career ladder structure designed and advocated that includes and links Lady Health Workers, Lady Health Visitors, Community Midwives and Registered Nurses	Copy of career ladder structure Minutes of advocacy meetings	YES	-	-	-	-	YES

Expected Result A.1.2b:

Scope and quality of in-service education for all nursing cadres improved

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year 1 (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
A.1.2b.1 In-service nursing and LHV courses designed/redesigned to incorporate competency-based maternal and child health and reproductive health skills along with supervised clinical practice; trainers trained and 1,000 nurses/LHVs trained in USAID focus districts as directed by COTR	Copies of curricula	2	2	2	2	2	2
A.1.2b.2 Number of trainers trained	List of trained trainers with contact information	40	-	-	19	37	37
A.1.2b.3 Number of Nurses/midwives/LHVs trained	Lists of trained nurses/LHVs with contact information	1000	32	58	162	543	1189
A.1.2b.4 Number of doctors trained	Lists of trained doctors	40	1	7	21	23	58
A.1.2b.5 Percentage of trainees who achieved at least 80% in clinical skill checkouts (AMSTL or infant resuscitation)	Clinical Checklist Score	80%	-	-	-	Data not available: PMP with this indicator devised after quarterly report	INC 79% PDIC 81%

A.1.2b.6 Number of MAP chapter members trained to deliver continuing education training course	List of trained Nurses /LHVs Training reports Quarterly Report	30	-	-	-	27	27
A.1.2b.7 Developed strategy and procedure for clinical audit for monitoring and determining the effectiveness of in-service trainings in improving practice skills among nurses/midwives	Clinical audit reports	YES	-	-	-	YES	YES
A.1.2b.8 Number of midwives trained through small business courses designed for developing private midwifery practices, train trainers, and assist the Midwifery Association to provide the course to 900 trained midwives	Copies of curricula Training reports	900	-	-	160	984	984

Expected Result A.1.2.c:

Midwifery tutor strengthening/preparation - Pre-service education of midwives improved

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year I (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
A.1.2.c.1 Standards for preparing midwifery tutors developed and approved	Copy of Standards Letter of approval	YES	-	-	-	-	YES
A.1.2.c.2 Number of qualified long and short-term midwifery instructors prepared (strengthened through specific educational and/or clinical updates)	Training reports including list of midwifery tutors attended clinical and/or educational knowledge updates	150	-	Clinical 19	Clinical 36	Clinical 119 Education 19 Total 138	Clinical 188 Education 58 Total 246

Expected Result A.2.2:

Short-term consultants are available to address GOP expressed needs

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year I (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
A.2.2.1 Ninety percent of consultants requested for technical assistance identified and on the ground within six weeks of request or on the date requested, should the required assistance be more than six weeks from the date of the request.	Date of request by USAID Copy of contract for consultant Travel record of home office STTA	90%	100%	100%	100%	100%	100%
A.2.2.2 Number of person days of international STTA utilized for developing an HRH Road Map for MOH.	Copy of contract Time sheet Payment invoice	52 (Int'l) 30 (local)	-	-	21.31 (Int'l)	49.69 (Int'l)	75.76 (Int'l) PROJECTED
A.2.2.3 HRH Roadmap document prepared	Copy of Roadmap	YES	-	-	YES	YES	YES
A.2.2.4 HRH National stakeholder meeting held	Minutes of meeting	YES	-	-	-	-	-
A.2.2.5 National Public and Private sector HRH assessment supported	Report on assessment	YES	-	-	-	-	YES
A.2.2.6 Number of person days of international and local STTA utilized for hospital accreditation activities.	Copy of Contract Time sheet Payment Invoice	180 person-days (Int'l) 190 person-days (local)	-	-	15.5 person-days (Int'l) A full time staff was hired for providing the 190 person days	64.5 person-days (Int'l)	64.5 person-days (Int'l)

A.2.2.7 A phased approach to hospital accreditation standards developed	Copy of developed hospital accreditation standards	YES	-	-	YES	-	YES
A.2.2.8 A "survey guide" developed, with explicit instructions on evidence is required to demonstrate compliance and how to score each standard	Copy of developed "survey guide"	YES	-	-	YES	-	YES

B. COMPONENT 2: TARGETED HEALTH INFORMATION – PMINFOSHEET

Expected Results B.1.2:

Increased public health advocacy activities carried out by societal leaders

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year 1 (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
B.1.2.1 Number of individuals, both male and female, provided with technical assistance for strategic information activities	Lists of individuals participated in strategic information activities Reports of strategic information activities	5000	864	864	2177	5000	17512
B.1.2.2 Number of government officials attending awareness sessions	Lists of government officials participated in awareness sessions Reports of awareness sessions	150	0	0	80	150	736
B.1.2.3 Number of public health events for constituents led by government officials who attended awareness sessions on key public health issues	Reports of constituent events	20	0	0	0	63	63
B.1.2.4 Number of journalists trained in public health reporting	Lists of training participants Training Reports	45	0	13	67	67	67
B.1.2.5 Number of public health media pieces published by trained journalists and others from project related activities on the internet, electronic and print media	Copies of published articles/media pieces	400	0	0	131	400	459
B.1.2.6 Number of fact sheets and other tools developed in collaboration with NIPS and other partners, to support use of data for decision making.	Tools to support use of data for decision-making	Tools = 6	1 0	1 0	1 5 (First drafts under review)	6	6

B.1.2.7 Number of trainings focused on responsible reporting on health issues – targeted for journalists and other media-related stakeholders, such as, health communications officers.	Training reports	7	0	3	7	7	7
B.1.2.8 A “Pakistan Health Media Network” formed in order to facilitate awareness of and advocacy on MNCH issues, through published media pieces.	Pakistan Health Media Network Meeting reports	YES	N/A	N/A	YES	YES	Yes

COMPONENT 3: GRANTS PROGRAM – PMINFOSHEET

Expected Results C.1.2:							
<i>A minimum of 10 grants awarded</i>							
Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year I (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
C.1.2.1 Number of local organizations provided with technical assistance for institutional capacity building and/or in technical areas	Grants management record	10	11	11	11	11	11
C.1.2.2 Number of health systems strengthening models successfully introduced	Quarterly reports of individual projects Reports of completed projects Monthly reports by Provincial Coordinators (PCs)	10	12	12	12	12	12
C.1.2.3 Amount of in-country public and private financial resources leveraged by grants program	Project completion report	\$165,454	\$ 6,816	\$ 29,191	\$ 55,336	\$ 98,857	\$ 174,678

D. COMPONENT 4: STRENGTHENING OF ESSENTIAL DRUGS AND CONTRACEPTIVES LOGISTICAL SYSTEM – PMINFOSHEET²⁰

Expected Results D.I.I:

A fully functional contraceptive and essential drug logistics system within the twenty targeted districts

Objectively Verifiable Indicators	Mean/s of Verification	Life of Project Target	Achieved by the end of Year I (December 31, 2008)	Achieved by March 31, 2009	Achieved by June 30, 2009	Achieved by Sep 30, 2009	Achieved by Dec 31, 2009
D.I.I.1 LMIS software prototype is developed	Copy of LMIS software	YES	NO	YES	-	-	-
D.I.I.2 Training manual on Logistics Management developed	Copy of manual	YES	NO	YES	-	-	-
D.I.I.3 Number of staff trained in an international course in M&E	List of trainees Training report	7	0	0	6	-	-
D.I.I.4 Number of staff trained in an international course in Essential Management Skills	List of trainees Training report	1	0	0	1	-	-

²⁰ The activity under this component ceased on April 03, 2009 upon USAID instructions; accordingly progress tracked & reported is up to this date.

ANNEX B. SUCCESS STORIES

COMPONENT 1

Increasing the use of Evidence Based MCH Care in Pakistan



Midwife giving demonstration for use of partograph



Immediate skin to skin contact with mother and breast feeding saves baby's life

Pakistan is one of many countries committed to reaching the Millennium Development Goals (MDGs), set by members of the United Nations in 2000, in an effort to improve development outcomes by the year 2015. In particular Pakistan hopes to meet MDG 5 which targets decreasing the maternal mortality ratio by three quarters.

Poverty exacerbates poor health outcomes, in particular for women and young children, and complicates Pakistan's ability to meet this goal. For example currently the Maternal Mortality Ratio is as high as 276 per 100,000 live births and infant and under-five mortality rates 78 per 1000 live births and 94 per 1000 live births respectively are far from ideal. As the sixth most populous country in the world with an estimated population of 167 million, a population growth rate at 2% and a total fertility rate of 4.11 the Government of Pakistan's (GOP) is faced with a significant burden on its health systems and resources.

Proper care in hospitals could assist in improving health outcomes for women and children in Pakistan; however, the majority of the population prefers not to seek health care services in public sector hospitals. Past experiences and evaluations reveal that the main reason for poor performance of these hospitals comes from following out dated practices for provision of health care and an insufficient emphasis on infection prevention, which contribute to an increased number of complications and generally poor health service in public sector hospitals. Improving this situation is imperative, as the majority

Pakistanis are dependent on government hospitals for financial reasons.

The USAID-funded TACMIL Health Project is making efforts to help the GOP achieve MDG 5. A vital part of these efforts is training health care providers in Maternal and Child Health issues at established Centers of Excellence (COEs) across Pakistan. The project initially organized Trainings-of-Trainers (TOTs) to educate health care providers about using evidence based practices through a course titled Professional Development in Intrapartum Care (PDIC). These trainings were facilitated by international experts from the American College of Nurses Midwives and TACMIL staff. The attendees of the TACMIL Health Project's PDIC TOTs have facilitated follow-up trainings to staff members and health care providers of different hospitals from the catchment areas of the COEs. Since October 2008, TACMIL Health Project has conducted 29 PDIC trainings training 287 healthcare providers from all over the country.

The scope of the PDIC course is wide. It includes using family friendly measures to support women in labor, active management of the third stage of labor, updated immediate newborn care practices and most importantly use of the partograph to document and make clinical decisions while managing labor. All these practices are evidence-based and globally renowned for their effectiveness and positive outcomes.

Prof. Dr. Shehnaz Baloch, Head of Department OBGyn, Bolan Medical College (BMC), Baluchistan appreciated interventions of the TACMIL Health Project, after the nurses, community midwives (CMWs), and doctors from her hospital received PDIC training. In a letter to Dr. Zafarullah Gill, the Chief of Party for the TACMIL Health Project, she wrote: “We are [also] grateful to TACMIL Health Project for the orientation of evidence-based practice of Intrapartum Care and site strengthening trainings, after these types of trainings, the attitude has been changed and the health providers have developed the sense of responsibility for the care provision to women and specially the mother and child”.

Dr. Shehnaz also noted that the nurses of BMC were using up-to-date practices such as early skin-to-skin contact and delayed bathing of newborn babies to facilitate breastfeeding, decrease risk of hypothermia and promote overall bonding between baby and mother. Furthermore, she said that the trainings also increased her staff's awareness and use of infection prevention practices and as a result staff is wearing personal protective equipment and the numbers of postnatal complications are decreasing.

As a result of the interventions learned through PDIC, there has been an increase in number of births taking place in COEs. According to Prof. Dr. Shehnaz, women treated at BMC are much more satisfied with the services they have received at BMC and are now showing health seeking behaviors. The use of evidence based practices and the provision of clean environment and woman friendly care provided by the sensitized and trained health care providers has made this possible. She is hopeful that these trainings will continue in future through the support of USAID and women and their families in of all the districts in Baluchistan will benefit from them.

As demonstrated by BMC, the trainings have brought very positive results and change in the behavior and attitudes of CMWs, Lady Health Visitors and Nurses in the related sites. The changes made in the COEs, and the resulting interest in women and their families to seek care at the COEs is one step toward helping Pakistan reach MDG 5.

Changing attitudes for Safe Motherhood

USAID project builds awareness through village-based training



Photo courtesy USAID/Mary Cobb

Thanks to USAID-sponsored health awareness training, mothers in villages across Pakistan are delivering healthy babies like this one.

"The session really opened my eyes. A short visit to the doctor alerted us to a situation where my daughter-in-law could have died. Now I have a healthy grandson."

- Haji Muhammad

Like most other people living in the village of Qureshi Wala in central Pakistan, Haji Muhammad Ramzan respects traditional beliefs and is resistant to change. One such belief is that pregnancy is a natural process, so there is no need for women to have prenatal care.

Haji Muhammad's daughter-in-law Shahiba Bibi wasn't so sure about that. Her first baby died shortly after birth from respiratory problems, and now pregnant with her second child, she wanted to see a doctor for a checkup. With her husband working abroad, she approached her father-in-law for permission, but he stubbornly refused.

"After losing my first baby, I worried that there was something I could have done differently while I was pregnant," Shahiba said. "This time, I knew it was important to see a doctor."

Taking a different approach, Shahiba instead asked Haji Muhammad instead to accompany her to a community health education session sponsored by a USAID-funded health project called [Technical Assistance for Capacity Building in Midwifery, Information and Logistics](#), or TACMIL.

During the session, trainers explained the importance of prenatal checkups, including tetanus vaccination, general health, hygiene and nutrition; and danger signs and precautionary measures to take during pregnancy.

After the course, Haji Muhammad decided that Shahida should be allowed to visit a woman doctor, and took her to a local hospital for a prenatal checkup. During the visit, the doctor discovered the baby was incorrectly positioned, which would make the delivery impossible to manage at home. On the doctor's advice, Shahida delivered a healthy baby boy at a local hospital.

"The session really opened my eyes," Haji Muhammad said. "A short visit to the doctor alerted us to a situation where my daughter-in-law could have died. Now I have a healthy grandson."

Since the training, members of the Qureshi Wala community - as well as more than 250 others in Pakistan - have been participating in screening programs and pre- and post-natal care at camps run by health volunteers under guidelines outlined by project staff.

Awareness building sessions have also helped dispel myths about tetanus vaccinations, explaining their importance, especially for pregnant women.

Saving a New Life

USAID-supported training of birth attendants prevents needless infant deaths in Pakistan



Photo courtesy TACMIL

Noreen makes a follow-up visit to Rizwana and Misbah check on mother and baby.

"The feeling of saving a life is unlike any other," Noreen said. "It was really the happiest moment of my life, and I never could have done it without the skills I acquired during the training."

Misbah was a lucky baby to have been born with a trained community midwife by the side of his mother Rizwana. After only a few minutes in the world, his life was already in jeopardy. Misbah didn't cry, then stopped breathing altogether and began to turn blue. "He is no more!" Rizwana began to wail, using a common expression of mourning in the Punjabi language.

But midwife Noreen Iqbal, who had recently completed a USAID-supported immediate newborn care training program, wasn't so sure. She made a quick assessment of the situation, told Rizwana not to panic, and performed mouth-to-mouth re-suscitation on the baby.

After about eight minutes, Misbah began to breathe on his own, and his color gradually turned from pale blue to white, then pink. Rizwana burst into tears of joy. Her mother began to kiss Noreen's hands.

"The feeling of saving a life is unlike any other," Noreen said. "It was really the happiest moment of my life, and I never could have done it without the skills I acquired during the training."

The need for such training here, in the remote village of Ta-lagang in Western Punjab province, is acute. In Pakistan, 65 percent of all women deliver their babies at home, a mere 8 percent of these in the presence of a trained health care professional. The result is an estimated infant mortality rate of more than 70 per 1,000 births - placing Pakistan 192nd out of 224 countries around the world.

Even before the incident on the day of delivery, Rizwana wasn't sure Misbah would ever be born. After delivering her first child successfully without assistance, she suffered two consecutive miscarriages. It was only then that she approached Noreen in the village one day.

Noreen promised Rizwana that she would do her best to take care of her during pregnancy and labor, and counseled her on maintaining a healthy pregnancy. When the crisis arose, she saved the day.

In Talangang, word has gotten around that Noreen saved Misbah's life, and pregnant women have begun to approach her asking for pre-natal consultations, and listened to her advice on breastfeeding, skin-to-skin contact between baby and mother, and to delay bathing the baby for 24 hours - all important to saving new lives in the village.

Training in Intrapartum Care results in systematic use of evidence-based care in labor and delivery ward

Recent Participants in PDIC training implement lessons learned.



Trainers and their trained staff are using infection control measures, evidence based delivery techniques, and supportive care for mothers at FGHS Polyclinic in Islamabad. Above Head Nurse In Charge of the Labor Room, Nasreem Malik, who is also a Master PDIC Trainer, practices what she preaches, removing her gloves properly and placing them in the correct wastebin.

Standards of care and infection control in maternity wards vary in Pakistan. The USAID-funded TACMIL project developed and implemented a course called “Professional Development in Intrapartum Care (PDIC)” in five hospitals in different cities to bring staff up-to-date on evidence-based clinical practices and infection control protocols. The training encompasses several aspects of providing care during labor and delivery: infection control, evidence based clinical practices and supportive care for mothers during birth. This is one of many USAID funded activities taking place in Pakistan in an effort to improve maternal and child mortality rates.

Sixteen staff from the Federal Government Services Hospital (FGSH) in Islamabad attended two rounds of trainings in June 2009, four of the staff from FGSH have become master PDIC trainers. Following the training, staff have made physical changes to the wards and have begun implementing the infection control practices learned in the training. FGSH staff are now ensuring that personal protective equipment such as clean slippers, masks and gowns are available and worn in the delivery room, and practicing proper disposal of gloves and other waste is practiced, and signs have been posted explaining in Urdu which procedures require gloves. Trained staff is also passing on the skills learned at the TACMIL PDIC trainings to their colleagues. During a recent visit, Fourth Year Nursing student Nasim explained the process for cleaning instruments which she had been taught by the nurses who had attended the PDIC training: “We place the [dirty delivery] instruments in the chlorine solution for 10 minutes, and then we rinse them.”

In addition to infection control practices, the trainees are practicing the new labor and delivery and supportive skills they learned, resulting in fewer complications and more comfortable experiences for mothers. Midwife Shakeela noted that she thought the most important lessons she learned during the training were breathing exercises and different labor positions[not lying on their backs with feet in stirrups]. Staff also learned to monitor

labor for danger signs with a partograph, and use active management of the third stage of labor (AMSTL), which prevents post-partum hemorrhage. Since June there has been no incidence of post-partum hemorrhage at the hospital, and episiotomies, which have no benefit but were once routine for all first time mothers, have only been performed rarely demonstrating the direct impact of the PDIC trainings on the lives of women in Islamabad.

COMPONENT 2

Training Strengthens Journalists' Capacity to Address Health Issues in Pakistan

Print and electronic media are the fastest and most effective means of communication in today's dynamic



environment and play a vital role in spreading important health information and messages to the public. However, important health topics are often ignored or lack attention in newspapers and main stream media in Pakistan, and are not seen as priority issues by journalists and publishers. The USAID-funded TACMIL Health Project works with professional journalists from across Pakistan, training them to more effectively cover health topics including Maternal, Neonatal and Child Health (MNCH) issues. These trainings are designed to teach journalists how to research and produce information-based, investigative articles that raise awareness of key health issues and opportunities facing the Pakistani health system, emphasize accountability of decision makers, and encourage healthy behavior amongst the population. The training educates journalists on how to find and interpret important health data and information to better understand what health issues and topics are most significant and important to the population.

Ms. Jamila Achakzai (on right), a participant in TACMIL's health journalism training program, recently won a silver medal for "Best Investigative Report Print" category in the First National Health Media Awards.

"TACMIL's Health Journalism Training Workshop was an eye opener for me" said Shireen Somroo, one of the participants who attended the training workshop. Shireen has been working as a journalist for about five years, but had never focused on covering a specific topic area, though she had touched upon health issues in the past. The information she learned about MNCH issues and Pakistan's progress towards achievement of

millennium development goals greatly increased her awareness about the dire need to highlight health issues in Pakistan, and the role that the media can play in increasing awareness. Through her training, Shireen has learned to write evidence-based articles about key health issues, presenting the story from its various perspectives, and using language that is easily understood by her readers. Shireen acknowledges the important capacity building that the TACMIL project trainings have provided to journalists. "The training was not a typical exercise. There was more learning especially due to the practical work, interactive discussions, experience sharing and use of modern learning methods. The books and handouts provided during the training introduced me to various other MNCH issues in Pakistan," she said. Since participating in the training workshop, she has focused her topics on covering key health issues, and realizes importance of building awareness about health related problems among her readers, and its potential for positive impact in society.

Another workshop participant, Haleema, has been praised by senior colleagues for her work following her TACMIL training in health journalism. Her confidence in writing about health topics has increased significantly, and her editor recently rewarded her efforts by printing one of her health articles on the cover of her magazine- marking the first time in her career that Haleema has written a cover story. As a

result of her progress, she has also been given the opportunity to write for "Patient Guide", the monthly health magazine of Shifa International, a renowned hospital in Pakistan. Haleema recounted her pride when one of the readers of her article published in Regional Times wrote back to the newspaper saying, "the article made me come out of darkness." Like many women who are pregnant for the first time, the reader was unaware of important health information related to pregnancy and pre-natal care needs.

Ms. Jamila Achakzai was raised in rural Pakistan, and encountered resistance from her family when she made the decision to pursue a career in journalism. Her passion for this work led her to leave her home town in order to follow her career choice. After participating in TACMIL Health Project trainings, and with first hand information about the issues in her area, she is now able to discuss important health problems faced by women and children and highlight possible solutions through her writings. Her lifelong efforts have been recognized, and she was recently awarded a silver medal for "Best Investigative Report Print" during the First National Health Media Awards conducted by the Federal Ministry of Health in collaboration with UNICEF. Ms. Achakzai recognizes the benefit she gained from the TACMIL trainings, recounting that "the information learnt through the trainings was very value able as it gave me pertinent information about the status of health indicators. It made me realize how journalists can address mother and child health problems and that our role is very vital in solving these problems."

Over the past year, the TACMIL Health Project has trained almost seventy journalists who have produced over 80 news articles published in newspapers across the county, covering important health topics such as the incidence of maternal deaths during delivery, the leading causes of high mortality rates among pregnant women, and the shortages of health care providers and medicine in particular areas of the country.

TACMIL mobilized politician educates her peers and the public on MNCH

Member of Sindh Provincial Assembly is working to address the health of women and children in her province and Pakistan as a whole.



The most recent Pakistan Demographic and Health Survey 2006-07 (PDHS) showed that Maternal Mortality and Infant Mortality ratios are some of the highest in the region – one in every 89 women die from a cause related to childbirth and approximately 8 of every 100 children born die before reaching age five. As one of many efforts in Pakistan to address this, the USAID-funded TACMIL Health Project has been working to educate members of Parliament and other political leaders about these statistics through dissemination sessions on the current PDHS findings and the Millennium Development Goals (MDGs) 4 and 5 which address maternal and child health (MCH).

“My colleagues, especially my male colleagues, are always worrying about other political issues like bomb blasts. I tell them that a bomb blast kills a few hundred people maximum, while maternal mortality is killing thousands people a year. MCH is an important issue.”

Ms. Humera Alwani,

Ms. Humera Alwani, a Member of the Sindh Provincial Assembly, is one such political leader who has taken the information learned at TACMIL organized sessions and used it to hold her fellow legislators accountable for addressing MCH issues and taking steps towards achieving MDGs 4 and 5. Previously, Ms. Alwani had been very active in the areas of human and women’s rights, but the TACMIL dissemination sessions have shifted her priorities. Following the session she attended in October 2008 she returned home and visited the government health facilities in her district, where below standard conditions further encouraged her to bring MCH issues to the forefront of her political agenda. Ms. Alwani says “My colleagues don’t think it is an important issue, but I keep raising it.”

Some of the activities that Ms. Alwani has undertaken to raise the awareness of her colleagues about MCH issues include:

- Submitting the first ever MCH issue-focused questions to the Sindh Assembly. Generally, the submission of the questions and their answers lead to a resolution, which can then be turned into a piece of legislation. By submitting the questions, Ms. Alwani has started the ball rolling towards a policy in Sindh specifically addressing MCH.
- Briefing the Chief Minister of Sindh, the head of the provincial government, on MDGs 4 and 5 explaining their significance and the role that the provincial government should play in helping Pakistan reach them.
- Highlighting MCH issues in the media, calling on policy and decision makers to take responsibility for the health status of Pakistan’s citizens.
- Writing several articles in national newspapers informing her constituents of the importance of basic health, their rights to proper health care and key issues that need to be addressed in Pakistan, for example, emphasizing the important role that midwives play in safe delivery and care for women and children.

- Briefing a group of colleagues on policy initiatives other countries are undertaking to address MCH.

In addition Ms. Alwani continues to take a hands-on approach to addressing MCH in Sindh, visiting the only maternity ward in her district and inviting officials and partners to come see the situation on the ground outside of the capital city. TACMIL's sensitization of leaders like Ms. Alwani is key to improving the health and well being of women and children in Pakistan by working to raise the issue's importance on the broader political agenda.

COMPONENT 3

Voucher Program Saving Lives in Dadu, Sindh

Nineteen year old Sahibzadi and her husband live in the village of Jat Shahdad, about 25 kilometers outside of the main town of Dadu District in Sindh Province. Shortly after their wedding, Sahibzadi



Sahibzadi being treated at Ramsha Medical Center

became pregnant, and soon her health worsened as she became anemic and weak. Unable to afford to visit a doctor, she consulted a local traditional birth attendant, who assured Sahibzadi and her husband that her delivery would be safe and without complications.

Sahibzadi went into labor late one night in April. Her husband contacted the traditional birth attendant, who again assured them that the delivery would be ok. After eight hours of painful labor without progress, Sahibzadi's family and neighbors had become very anxious. It was suggested that Sahibzadi be taken to the nearest health center, but they did not have the money to afford travel and treatment.

A lady health worker living in the vicinity informed the family that the "NARI" program could help them by

providing vouchers to cover and reimburse the cost of transportation and care. Through the USAID-funded TACMIL Health project, the Health and Nutrition Development Society (HANDS) NGO receives a grant to implement the NARI (sindhi word meaning woman) program in Dadu district. NARI is an innovative program designed to strengthen referral mechanisms and increase utilization of public and private health facilities for safe motherhood services. The program works by mobilizing communities to use these services through a voucher scheme that helps to cover the costs associated with transportation and health services that would otherwise be unaffordable to many pregnant women and their families.

With the understanding that the NARI program could help to cover the expenses, Sahibzadi was rushed to the nearest health facility, where the doctor on duty diagnosed her condition as critical due to severe blood loss and low blood pressure. The doctor issued a "NARI referral slip", and she was rushed on to Ramsha Medical Center, where she immediately underwent surgery to deliver the baby. As a result of the NARI program and voucher scheme, Sahibzadi accessed the skilled medical care she required, and safely delivered a healthy daughter.

Since its inception in November 2008, the NARI program has helped 302 pregnant women and 74 infants from around Dadu district get critical medical care that they otherwise would not have been able to access. It is one of 12 grant programs that the USAID-funded TACMIL Health project is supporting to introduce new and innovative solutions to improve access to quality primary health care and maternal and child health at the community level.

Grant Program Restores BHU in Ban Bilar

The Ban Bilar Basic Health Unit (BHU), established in 1980, fell to ruins when the medical officer was moved to a different clinic in 2007. There were no medical facilities and no signs of basic medical equipment at the BHU, to make things worse building which was supposed to be used to save human lives was then being used as an animal shelter. Residents were forced to travel long distances to seek care in other BHUs. Often poor health and/or finances prevented these trips and residents had to go without care. Through the innovative health systems strengthening grants of the TACMIL Health Project the Strengthening Participatory Organization (SPO) was able to renovate and secure a medical officer, restoring access to health care to the residents of Ban Bilar and its surrounding areas.



BEFORE After the medical officer was transferred, other staff neglected to come in to the BHU, and the building became used as an animal shelter.



AFTER Fully functional again, the paramedic Mr Anwar, treats patients on a regular basis at the BHU. The SPOs training and sensitization exercises with the District Health Board enabled them to advocate for and secure the restoration of the BHU in Ban Bilar – so that it now provides basic care services to the remote village.

Restored Health Clinic Brings Comfort and Inspiration to the town of Ban Bilar

Both the elderly and the young are affected by the change.



I am 86 years of age and live alone. After the BHU Ban Bilar was closed, I thought I would pass away without receiving any health care as I could not afford to go to other health facilities for health and financial reasons. Access to immediate and basic health care became like a dream for me until the revival of services at BHU Ban Bilar.

Said Alam Badshah a resident of Ban Bilar

health officials at the district administration level. Following these trainings, district level health management approached the offices of Peoples Primary Healthcare Initiative (PPHI) and Executive District Officer (EDO) Health requesting the restoration of the BHU. Meanwhile, Health Monitoring Committees and local media were mobilized to highlight the issue throughout the community. Through these efforts, the BHU Ban Bilar was reopened in the fall of 2008, and is now fully functional. New paramedical staff, Mr. Mohmmad Anwar, was appointed to the BHU, and appropriate disciplinary action was taken to ensure that the other posts were staffed. Elderly villager, Mr. Said Alam Badshah is comforted that he can get basic medicine in his own village without traveling to another town and says he is grateful for the comfort and ease it has brought to him and hundreds of others in Ban Bilar. But Mr. Badshah was not the only one affected by the outcome. A young man named Abdullah, who recently was treated by Mr. Anwar, has been inspired by the changes he has witnessed. He says that he plans to study hard and become a community activist when he grows up so that he can continue to help his community.

The town of Ban Bilar is situated in Southwest Pakistan along the coast, and is often isolated due to extreme weather. Between 1980 and 2007, the people of Ban Bilar received primary health care services through a Basic Health Unit (BHU) that had been established there by the Government of Pakistan. This particular BHU was a proper building which included residential accommodation for the Medical Officer. However, the BHU closed suddenly when the Medical Officer was re-posted to another town. In the absence of Medical Officer, the community based nurse midwife - a Lady Health visitor (LHV) - and the support personnel neglected their duties and stopped staffing the BHU. The villagers of Ban Bilar had to travel long distances for essential basic health care, an expensive and potentially dangerous trip for the elderly and infirm.

Strengthening Participatory Organization (SPO) is a recipient of one of the USAID-funded TACMIL Health Project's grants for innovative health systems strengthening activities. Through this grant, SPO is building the capacity of Health Management Committees (HMC) at the community level, and assisting them to identify health issues and address them. SPO is also working to increase community mobilization for health in the same communities through corner meetings and awareness sessions.

In Ban Bilar, SPO worked with the District Health Board educating them on how to advocate and exert pressure on

Correct Information Leads Good Labor and Delivery Practices



Mai Safooran attending a training session



Women of the village attending an awareness session to learn about proper care during labor and delivery.

Maternal mortality threatens the lives of Pakistani women throughout the country. In the community of Taluka Khangareh, a remote village in Sindh, efforts to correct harmful traditional practices commonly used by traditional birth attendants (TBAs) are working to reverse this threat and help the Government of Pakistan meet Millennium Development Goal 5 – reducing maternal mortality by three quarters by 2015.

The Takhleeq Foundation (TF) Pakistan is implementing the BAAKH project for health system strengthening in Taluka Khangareh with support from TACMIL through a grant. The BAAKH project, which means “ray of hope” in the Sindhi language, is educating community based health care providers and community members to improve access to good maternal and child health care. After collecting some basic information, it became clear to TF that women in Taluka Khangareh depend extensively on TBAs for care: TBAs who unfortunately were commonly using some incorrect practices such as restricting food and liquids during labor and performing episiotomies too often and unnecessarily.

To improve access to evidence based delivery practices for Taluka Khangareh’s women, BAAKH conducted meetings and training sessions with TBAs and community health workers. These trainings focused on pre- and post-delivery care and introduced safe delivery kits to reduce the incidence of infection through the provision of clean basic delivery instruments (a blade, chord clamps, a towel, a plastic sheet, and soap)

One TBA who received five safe delivery kits, Mai Safooran, exhausted her supply immediately while attending deliveries in her village. She said, “after attending the trainings I have learnt use of this new kind of user-friendly equipment. I didn’t know anything about these before and it has helped me a lot. These kits increased my skills and ensured safety of mothers and children during birth process.” She asked for, and received more safe delivery kits during TF’s follow-up visits to Taluka Khangareh.

TF is partnering with the USAID-funded TACMIL Health Project, as one of its grant recipients for health systems strengthening programs. The TACMIL project aims to provide technical assistance to the public and private health sector to improve health service delivery with a focus on maternal, reproductive and child health.

ANNEX C. CONSULTANT ROSTER

Throughout implementation, the TACMIL project used several national and international consultants to provide unique expertise and in-depth technical assistance. Table A-I provides a list of selected consultants and summary of their specific expertise.

TABLE A-I. TACMIL CONSULTANTS

Consultant	Expertise
Abt Associates Consultants	
Nancy Brown, MBA	International IT Specialist, Abt Headquarters Staff
Geoffrey King	Human Resources for Health Expert
Marc Luoma	Human Resources for Health Expert, Abt Headquarters Staff
Thomas Schwark, MD	Hospital Accreditation and Health Systems Management Expert, Abt Headquarters Staff
ACNM Consultants	
Catherine A. Carr, CNM, PhD	Associate Professor, Nurse/Midwifery Education Program, University of Washington, Department of Family and Child Nursing
Della Sherratt, SRM, BEd, MA	Senior International Midwifery Advisor and Trainer
Christine A. Hunter, CNM, ARNP, MSN	Director of the Nurse/Midwifery Education Program, University of Washington, Department of Family and Child Nursing
Diana Beck, CNM, MS	Senior Technical Advisor, ACNM, Department of Global Outreach
Gwen Brumbaugh-Keeney, RNC, CNM, PhD	International Health Consultant, Clinical Assistant Professor, University of Illinois at Chicago, College of Nursing, Department of Maternal Child Nursing
Banyan Global Consultants	
Bonnie Kligerman, MEd	Instructional Design and Training specialist with 20 years of international and domestic experience
National Experts	
Assad Hafeez, MBBS, MSc, PhD (ABD)	Health Systems Strengthening Expert with more than 20 years of experience implementing health programs, including working directly with the MoH in Pakistan
Adnan Ahmed Khan, MBBS, MS	Infectious Disease Physician and Health Economist
Atiqa Hameed, MBBS, MPH	Public Health Physician with specialties in MCH, Family Planning and Training and more than 20 years experience working for international and national NGOs and development organizations in Pakistan

ANNEX D. DETAILS ABOUT GRANTS AWARDS

Grantees were selected in two rounds of solicitation.

TABLE B-I. GRANTS SUMMARY FOR ROUND I

Name of Applicant	Target District	Description of Activity
Midwifery Association of Pakistan (MAP)	Thatta and Larkana	Strengthen intranatal care skills through training of 'AMTSL' and 'partograph' techniques and its implementation at public health facilities.
Centre for Peace and Development (CPDI)	Jhelum	Strengthen local governance and civil society for need based health budget in public sector and dissemination of budget information to the beneficiaries.
Strengthening Participatory Organization (SPO)	Charsadda	To form and strengthen 'Health Monitoring Committees' at UC & district levels and create awareness among the masses about their basic right to good quality health services.
Strengthening Participatory Organization (SPO)	Gwadar	To form and strengthen 'Health Monitoring Committees' at UC & district levels and create awareness among the masses about their basic right to good quality health services.
Health And Nutrition Development Society (HANDS)	Dadu	Strengthen a referral mechanism and increase use of public health facilities by mobilizing communities. To promote safe motherhood through a voucher scheme for both public and private health facilities.
Association for Gender Awareness and Human Empowerment (AGAHE)	DG Khan	Improve access to family friendly clinics and reproductive health services using advocacy and capacity building
Al Qaim Women Development Organization (AQWD)	DG Khan	Promote health care service delivery system through score card technique.

TABLE B-2. GRANTS SUMMARY FOR ROUND 2

Name of Applicant	Target District	Description of Activity
Lead Pakistan	Sukkur and Ghotki of Sindh	Strengthen health systems through capacity building of Health Management Committees at district, tehsil and UC levels, improving referral mechanisms and awareness. Also, forming Community Support Groups (CSGs) and Health Watch Networks to increase accountability and improving service delivery.
Takhleeq Foundation	Sanghar and Ghotki of Sindh	Strengthening public private partnership through activation of CCBs, linkage development of communities and health service providers, developing capacity of stakeholders and mobilizing the communities for improving referral mechanism to reduce first & third delay factors and malnourishment of child bearing age women.
Swabi Women Welfare Society	Swabi, Buner, Upper Dir of NWFP	Strengthen health management system through networks of public and private health facilities, capacity building of care providers and advocacy to improve maternal and child health.
Gender and Reproductive Health Organization	Jaffarabad and Turbat/Keach of Balochistan	Strengthen district health management system by addressing first and third delays and also improving MNCH service through awareness raising and sensitization, improving referral mechanism, capacity building of health care providers.
Youth Organization	Lasbella, Khuzdar and Zhob of Balochistan	Strengthening district health management by establishing CSGs for awareness raising programs on health and hygiene, referral mechanisms and building the capacity of public and private health care providers to address the three delays and reduce pregnancy related mortality and morbidity at the grassroots (BHU) level.

EFFECTIVE GRANTEE PROGRAMS

The following outlines the most effective NGO programs piloted by the TACMIL grantees that should be scaled up and replicated in the future. In the short-term, these activities have been shown to help increase utilization of health facilities, improve quality of health services and ensure access to services for marginalized parts of society. However longer-term support is still necessary to ensure the ownership and sustainability of these pilot projects. Therefore, scale-up and replication of these initiatives demands that they be part of a larger program with clear objectives.

Leadership for Environment and Development (LEAD):

The objective of LEAD's pilot project was to strengthen community health committees and community groups to make them effective bodies for improving health service delivery in their catchments areas. LEAD focused its attention on the missing links between the district health committees at the BHU and the PPHI. Project activities also aimed to mobilize and build the capacity of district health committees to perform their standard functions. Both of these activities should be replicated in other districts. This model is closely connected to SPO's activities, which ensured monitoring of functions of health committees at different levels, and can be scaled-up in tandem with a scale-up of SPO activities.

Strengthening Participatory Organization (SPO):

The pilot project by SPO was implemented in two districts of two different provinces. The results from the both districts are very encouraging. The focus of the activities was to create grassroots/community participation and activate effective and efficient monitoring committees to improve public health service delivery. All the activities in this project resulted in established linkages between civil society networks and their local government, District Health Management Committee and District Health Board, with a special focus on monitoring health facilities. These activities should be continued and scaled-up as

evidence becomes available that committee activation has increased the quality and use of public health sector resources.

Center for Peace and Development Initiative (CPDI):

CPDI implemented a two-fold strategy: 1) improve the management of available health resources and 2) improve availability of information to the community to increase their participation in needs-based budgeting for health. The pilot project has shown very encouraging results in the target district. Health management authorities' capacity was improved in both needs based budgeting and resource management. Also, based on CPDI's advocacy campaign, the government of Punjab has taken steps to initiate a freedom of information law in the province. These activities have brought improvements to a critical stage, and will need continued support to ensure complete results. Similar initiatives should be taken in other provinces to ensure public participation in decision making.

Health and Nutrition Development Society (HANDS):

The HANDS's initiative was unique in its nature as it made MNCH services available to marginalized parts of society where public facilities had been closed. These services were provided through subsidized care at private health facilities, using a voucher scheme. This scheme can be up-scaled with financial assistance already available in the form of zakat, baitul mall and CCB funds. This initiative also ensures collaboration between the public and private health sectors.

Midwifery Association Pakistan (MAP):

Through the grants program MAP conducted trainings to promote AMTSL and use of the partograph in all normal deliveries. The use of these techniques has been shown to have a positive effect on the incidence of PPH; although statistics are not available, trends show that PPH has decreased with the training of TBAs. Should this program be scaled up, it should also include a review the deployment plan of trained TBAs and monitoring/supervision of their use of these techniques.

Al Qaim Women Development Organization (AQWD):

The 'Score Card Technique' is meant to improve health care service delivery through a community based monitoring process. To this end, AQWD involved community members to sort out issues related to performance of public health facilities and their use. AQWD revitalized Sehat committees in target union councils, who are now working closely with the staff of concerned BHUs and RHCs to address these issues. The committees are also working closely with the health department to develop and improve public health facilities. Given the nature of this pilot model, the results of these activities will continue to be seen in the near future, and it is recommended that similar models be implemented for a period of at least two years at a time.

