



**State of the Art Workshop
Reproductive and Newborn Health
Islamabad**

October 27-30, 1997



PN-ACH-795

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Foreword

Reproductive Health (RH) is the basic right of all human beings to complete physical, mental and social well-being in all matters relating to the reproductive system, to its functions and processes. Reproductive Health implies that people have the capability to reproduce and the freedom to decide if, when, and how often to do so.

This requires access to safe, effective, affordable and acceptable methods of family planning and health care services. It also requires that women get exposure to knowledge and ideas, thereby empowering them to make informed and responsible decisions for their own health. Addressing the critical areas of reproductive health and safe motherhood today remains the most urgent need of women in developing countries. Consequently, it is essential that governments, international agencies, the private sector, NGOs, communities and families all make a concerted effort for implementation of an effective family planning and safe motherhood program that are the top priorities for Pakistan.

This document is published to provide programs managers and policy makers from NGOs, government and the private sector and donor participants an overview of "The State of The Art Workshop" organized by MotherCare, The Asia Foundation, and collaborating NGO Partners in October 1997.

I would like to take this opportunity to thank all participants from the Government, NGO and private sector who took out their time to participate, for attending and contributing to the success of this workshop. Special thanks are due to Ms. Mary Ellen Stanton of USAID for sharing with us Global Lessons learnt in safe motherhood over the past decade. Thanks are also due to Ms. Judith Standley health and nutrition Specialist for her support and mentorship in preparation of the agenda, and preparation of the comprehensive paper on MotherCare's Global Lessons. Special thanks go to Mr. Tahir Khilji for visiting NGO projects and helping us in preparing the case studies, and organization of the workshop. Tahir is an International Health and Development specialist working in the area of Reproductive Health and HIV/AIDS. Thanks are also due to Ms. Najam Saighal for preparing the initial draft and for documenting and editing the report.

I thank TAF and UNFPA for their financial and administrative support that made this workshop possible. It is, indeed, like laying the foundation of a forum on reproductive health and can be instrumental in bringing the NGO, Government and the private sector groups together to continue sharing the lessons for effective implementation of reproductive health programs.

I look forward to further broad based coordinated initiatives under the Phase-II of the Pakistan NGO Initiative.

Ms. Naveeda Khawaja
Program Coordinator, MotherCare
Health Advisor, PNI.

ACRONYMS/ABBREVIATIONS

AKF	Aga Khan Foundation
AKU	Agha Khan University
AKHS	Aga Khan Health Services
CBO	Community Based Organization
CHW	Community Health Worker
CP	Cooperating Partners (MotherCare, BASICS, Wellstart)
EOC	Emergency Obstratic Care
FHW	Female Health Worker
FPHC	Frontier Primary Health Care
GOP	Government of Pakistan
LHV	Lady Health Visitor
LHW	Lady Health Worker
WMO	Woman Medical Officer
MC	MotherCare
MOH	Ministry of Health
MOPW	Ministry of Population Welfare
NGO	Non-Governmental Organization
Pak-CDP	Pakistan Community Development Project
PNI	Pakistan NGO Initiative
SAP	Social Action Program
TAF	The Asia Foundation
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Executive Summary

As part of the USAID funded Pakistan NGO Initiative (PNI), MotherCare (MC), BASICS and Wellstart (Cooperating Partners - CPs) have been working with The Asia Foundation (TAF) and the Aga Khan Development Network since 1995, to strengthen NGO capacity building for delivering effective maternal and child health services. In December 1996, PNI partners held a 'Planning Together' meeting with selected NGOs, where a health plan of action was outlined for the remaining 20 months of the project.

One of the key activities agreed upon in this meeting was to hold a State of the Art Workshop followed by 2-3 technical workshops to inform NGOs and strengthen their ability in planning for and implementing effective program strategies, as well as networking, and documenting lessons learnt globally and nationally.

As agreed in the Planning Together meeting, a 'State of the Art Workshop in Reproductive and Newborn Health' took place October 26-29 1997 in Islamabad. The workshop goal was to improve the capacity of NGOs to develop, integrate and carry out reproductive health activities. Sixty professionals representing NGOs, government, and research organizations attended the workshop. Participation during the workshop was very productive, and the majority of participants felt that the main objectives of the workshop were met.

The State of the Art Workshop took place at the Margalla Motel in Islamabad from 26-29 October 1997. The overall goal of the workshop was to improve the capacity of NGOs to develop, integrate and carry out reproductive health activities. Over one hundred participants were invited; eighty people were present on the first day, and sixty remained as active participants for the workshop's duration. The majority of participants came from NGOs, with about a third coming from the government and a few from donor agencies.

The three day workshop included presentations, group analysis of case studies, self-assessment of participant's own programs, group discussions, and an excellent poster exhibition. Ms. Mary Ellen Stanton set the tone for the workshop with her presentation on 'Reproductive Health - The Global Perspective; What We Know and What We Are Learning'. This was followed by a presentation on 'ICPD: Policy issues in Pakistan', and a 'Review of the Reproductive Health Situation in Pakistan.' The morning session of the first day was completed with presentations on the government's programs through the Ministry of Health (MOH) and the Ministry of Population Welfare (MOPW).

After lunch, the participants were divided into 8 groups. The pre-workshop questionnaire revealed that the NGOs were working in four program areas (health education/promotion, service delivery, family planning, RTIs/STDs). The data was used as a warm-up exercise for the overview of the scope of services (or lack thereof) it provided for the larger group.

The second day started with presentations on abortion, social marketing, and breast-feeding in Pakistan. The group work using case studies commenced after tea, with deliberations lasting until lunch. Guidelines for the Case Study Review were distributed to each group along with one of four cases studies. The case studies were anonymous, although based on

actual projects, in Pakistan. The presentations were thorough, although each group - on the whole - were very critical of the NGOs depicted! Discussions following the presentations were interactive, with important issues on community participation, working with government, choosing effective interventions etc, coming to the surface.

While the process and outcome of the case study exercise was interesting, participant reaction was mixed. When asked during the evaluation if the objective 'using case studies to critically analyze projects' was met, sixteen people responded yes (well met and met) and five said this objective was not met. Suggestions included giving more time to the activity, and having the projects write their own case study. Those of us working on the case studies felt the questions should have been less inclusive, perhaps by using one case study and dividing the questions among the different groups, or using 4-case studies but asking participants to look at one aspect of the program. The case studies themselves should have had more information in key areas.

The third day started with an overview of the points brought out in the previous day's presentations/discussions. The participants were then asked to look at their own organizations, and with the information learned in the past two days, come up with a specific plan for strengthening their programs. Before lunch, the individual groups came together by region; presentations started after lunch and lasted through most of the afternoon. Because the individual groups were asked to develop a regional presentation, the recommendations - although interesting - were very broad. Within the context of this workshop, it was difficult to focus on specific interventions to strengthen the reproductive health activities of individual NGOs.

Themes brought out during the workshop were presented by Erik Jensen, Judith Standley and Rushna Ravji (World Bank). This was followed by a review of the workshop's evaluation. The evaluation shows that most of the objectives were met; and the participants benefited through interactive analysis and were able to identify successful reproductive health strategies.

1. INTRODUCTION

1.1. Background

The Pakistan NGO Initiative (PNI) is a collaborative program between The Asia Foundation, MotherCare, BASICS and Wellstart International, funded under a grant from the U.S. Agency for International Development. Under the health component of the PNI, the collaborating partners and the Aga Khan University have been working together to strengthen the capacity of the NGOs and CBOs to provide health education, and deliver effective maternal and child health services.

To date, fifteen NGOs/CBOs have been involved with PNI in activities to strengthen their capability to assess community health needs (autodiagnosis), develop and use health education materials, improve the quality of care, and forge formal and informal networks for advocacy and support.

In December 1996, TAF, the Collaborating Partners, and partner NGOs discussed the need to identify specific maternal and child health interventions to assist the NGOs/CBOs in implementing maternal and neonatal health programs. One area for improvement was to build the capacity of the NGOs to conduct the assessment, development, and monitoring/evaluation of reproductive and neonatal health programs.

MotherCare, in collaboration with TAF, organized a 3-day State of the Art Workshop in Islamabad. The workshop was held at the Margalla Motel from October 26-29, 1997.

This workshop provided the participants with an opportunity to review and discuss reproductive health issues and approaches at the global and national level, identify successful strategies, and reflect on ways to improve their own work. A list of workshop participants is enclosed (Annex-A).

1.2. Inaugural Session

1.2.1 Welcome address

Eric Jensen, the Representative for TAF Pakistan, welcomed the participants to the workshop. He emphasized the role of such forums in bringing about improvement in maternal and neonatal health in Pakistan. He requested that the participants and resource persons introduce themselves, their organizations, and what they expected to achieve from the workshop proceedings.

The participants were skilled public health officials working in diverse areas of public health, and belonging to NGOs, the government, and the private sector. Everyone agreed on the importance of focusing on the subject of maternal and neonatal health in Pakistan. They were of the opinion that the workshop would provide them with a platform to address issues from prenatal/postnatal complications during pregnancies, service delivery, referrals, nutrition, family planning, and the quality of care issues.

The inaugural session ended with a video presentation called "Mamta Ki Hafazat" (Making Motherhood Safe), which showed the death of a woman who did not receive Emergency Obstetric Care (EOC) in time. The question of why this woman died set the tone for the next three days of the workshop. The imperative question that the workshop addresses for the next few days is that can anything be done to prevent such deaths?

2. PROCEEDING OF DAY ONE

2.1. Introduction - First Session

The overall goals and objectives of the workshop were summed up by Mark McKenna, Assistant Representative for TAF, in his opening remarks. He commented upon the general status of women in Pakistan, linking the general subordination of the female population in the country with the overall negligible focus on maternal health.

2.1.1 Workshop Objectives

The workshop's goals were to improve the capacity of NGOs to develop, integrate, and carry out reproductive and neonatal health activities. The workshop's objectives were to familiarize the participants with the correct trends and lines in reproductive and neonatal health, to strengthen their ability to analyze reproductive health programs, and consequently design effective activities.

The specific objectives of the workshop were to:

- Share the global reproductive health situation;
- Identify the major issues in reproductive and neonatal health in Pakistan;
- Identify the most effective strategies for improving reproductive health, and reducing mortality and morbidity; and
- Use the case study method for participants to critically analyze their own programs, and identify areas needing improvement.

2.1.2 Workshop Methodology and Evaluation

The methodology of the workshop included group discussions, case study analysis, self-assessment of the participants' own programs, and evaluation of the workshop (See **Annexure B** for Agenda and **Annexure C** for Evaluation Framework).

2.1.3 Poster Exhibition

The special features of the workshop was the poster exhibitions from various projects. Details of the Exhibition are given below in **Box 2.1**.

2.2. Opening Statement by Mrs. Imtiaz Kamal

In her opening statement, the representative from NCMH (spell out), **Mrs. Imtiaz Kamal**, a respected authority in the field of maternal and child health, set the stage for the next two days'

deliberations. She summed up the plight of Pakistani women, specifically the Pakistani mother, by reciting a heart moving Punjabi poem written by her (see back of cover).

Box 2.1: Post Exhibition

- Sexual Health Project, Karachi, by Ms. Shaista Siddiqui
- Breast-feeding Promotion/IEC: GOP/MC/TAF and Behavioral Research Maternal Nutrition/Child Feeding/Pregnancy Related Care, MotherCare, Pakistan.
- Promotion of iodized salt-SMP and Green Star Clinic Network Pilot Project - Social Marketing, Pakistan, SMP
- SECERT Sexual Health Project, Sabiha Syed of the Family Planning Association of Pakistan
- The Model Clinic Approach to Integrated Reproductive Health Care, Shamim Najmi of the Family Planning Association of Pakistan
- Safe Motherhood Intervention Study – Korangi, Dr. Faryal Fikree and the AKU Teams.
- Abortion Study in Karachi's Squatter Settlements, Sarah Jamil, AKU, Karachi.

2.3. Reproductive And Newborn Health: Global Perspective and Lessons We Are Learning

2.3.1 Historical Evolution of Reproductive Health

USAID's Mary Ellen Stanton's paper on *'Reproductive And Newborn Health: Global Perspective and Lessons we are Learning'* started with the historical evolution of reproductive health. She took the participants through the Alma Alta Conference in 1978, which ambitiously aimed for "Health for All by the Year 2000", to the Safe Motherhood Conference in Nairobi in 1987 and the Cairo International Conference on Population and Development (ICPD) in 1994. The ICPD recognized the complexity of the factors influencing health and well-being, and institutionalized the term "reproductive health."

As understood at the Cairo Conference, reproductive health is an inclusive and broad concept. It not only deals with the biomedical needs of women during their reproductive years, but also the social and political realities of life that influence the women's health status and well-being.

2.3.2 Maternal Mortality – How Big is the Problem

Ms. Stanton elaborated upon the extent of the problem of maternal mortality. She believes that maternal mortality has been underestimated in the past. Model-based estimates (WHO/UNICEF 1996) project 585,000 maternal deaths worldwide each year. More than half of these (323,000

women) occur in Asia, 40% in Africa, and less than 1% of the total in developed countries. A woman's lifetime risk of maternal death can be 100 times higher in a developing country than in a developed country. Indeed, the maternal mortality ratio (MMR) is the indicator of the great disparity between the developed and the developing world.

2.4. Causes of Maternal Mortality

The causes of maternal mortality are mainly hemorrhage, sepsis, sequella of an unsafe abortion, hypertensive diseases of pregnancy (HDP), and obstructed labor. Additional significant causes of maternal mortality include anemia and Hepatitis (see **Table 2.1**).

Table 2.1. Maternal Mortality
Direct Medical Causes – 86% of Maternal Mortality

Causes of Maternal Mortality	
Hemorrhage	28%
Sepsis	11%
Pre-eclampsia/Eclampsia	17%
Obstructed Labor	11%
Consequences of Unsafe Abortion	19%
Other & Unknown	14%

Source: 1 Maine, 1990 Population Based Study in West Africa

She explained that apart from biomedical causes, there are other social and cultural factors which effect maternal survival. For instance, women who are not empowered do not have access to income, and if illiterate, are more likely to have poor pregnancy outcomes. Also, maternal mortality is far more likely in populations which are undernourished, and live in environments with inadequate water and sanitation.

2.4.1 Lessons Learnt - Effective Program Strategies

Previous lessons reflect that the risk identification approach has not been effective because every pregnancy faces some risk. It has been observed that antenatal care's contribution to maternal survival is limited, but antenatal care has demonstrated its effectiveness in reducing perinatal mortality. If the objective is to reduce maternal mortality, the evidence clearly shows that a different approach is required. Furthermore, the participants were informed that the TBA programs alone cannot substantially reduce maternal mortality, and that it could not be assumed that upgrading tertiary care services alone will substantially reduce maternal mortality in the near future.

Ms. Ellen said that maternal death can occur when a woman becomes pregnant, develops maternal complications, and the complications result in death. This implies several points of intervention:

- Prevention of pregnancies;
- Prevention of complications; and
- Early recognition and management of life threatening complications to prevent death.

To address these interventions, effective program strategies should include pin-pointing and understanding the underlying non-medical factors, such as why women are dying. Mary Ellen explained that researchers had identified three delays which can lead to maternal mortality:

- delay in deciding to seek care;
- delay in reaching a medical facility; and
- delay in receiving adequate and appropriate treatment at the health facility.

She said that the decision to seek care is a complex one, since it involves the woman's status in the family, the family's ability to recognize complications and their severity, the woman's relationship with her husband and mother-in-law, the opinion of the influential individuals including the attending TBAs, the family's financial situation, the distance to the referral site, the availability of transport, and the perceptions of the kind of care available at the referral site. In light of the above, Ms. Stanton suggested that where maternal mortality was high, effective programs must include:

- A community based IEC component to teach avoidance of harmful practices;
- Awareness programs by a trained health worker to prepare families for the delivery, and to highlight hygiene if the delivery is at home;
- Training to enhance the family's ability to recognize complications and their severity, and the correct utilization of services in the face of life threatening complications;
- Upgrading tertiary case services to deal with the EOC;
- Competency based training for all levels of health care providers to enhance their skills in managing normal and complicated deliveries; and
- Provisions to make facilities and service providers become woman friendly, so that the services should address the existing need.

A number of programs in various countries have designed successful interventions. (see Box 2.2)

Box 2.2: Successful Maternal Survival Interventions

Kigma, Tanzania	Quality of Care
Matlab, Bangladesh	Community based midwives and a referral system
Inquisivi, Bosnia	Auto-diagnosis in women's group

Ms. Stanton stated that successful interventions have the same properties: avoiding the three delays, but implementing the three preventions. This has formed the basis of all maternal mortality reduction strategies. Programs should consequently be designed to effect the behaviors and strengthen the skills of the healthcare providers at every level of care.

She also said that measurement indicators of progress in maternal survival programs include:

- Maternal Mortality Ratio (MMR);
- Coverage (antenatal care and delivery by a trained birth attendant); and
- Quality of Care (case fatality ratio, admission intervention interval).

2.4.2 What Can NGOs Do?

Ms. Stanton concluded her presentation with the messages from the 1997 Sri Lanka Conference. She suggested the following guideline for NGOs in Pakistan to improve their maternal and newborn child health programs, see **Box 2.3**, and see **Annexure D** for detailed paper.

Box 2.3: What NGOs Can Do

- | |
|---|
| <ul style="list-style-type: none">■ Support women's empowerment■ Develop program for income generation■ Promote female education■ Support efforts to improve the quality and quantity of food supply and improve water and sanitation■ Assist communities to develop normal birth and emergency plans■ Provide community education■ Promote advocacy with local personnel and facilities■ Provide direct services■ Network with other NGOs and coordinate with the government |
|---|

2.5. ICPD Cairo: Reproductive Health Policy Issue in Pakistan

2.5.1 ICPD Challenge to Pakistan

Shahida Fazil provided an insight to the 1994 ICPD Cairo Conference and Reproductive Health Policy Issues in Pakistan. She talked about the 15 defining principles associated with the population and the development of the Program of Action, as set forth at the ICPD Cairo in 1994. Ms. Fazil talked about the ICPD follow-up in Pakistan, specifically emphasized the principle number eight (8) which presents the most direct challenge to many of the developing countries including Pakistan (see **Box 2.4**).

She concluded her presentation by stressing the need for focusing on the family unit, the communities, and the schools for composing, creating, and evolving the messages on reproductive health.

Box 2.4: Principle Number Eight Suggests

- Appropriate measures to ensure equality of men and women, universal access to health services including those related to reproductive health care, which includes family planning and sexual health.
- All couples and all individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.
- Reproductive Health is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being, by preventing and solving reproductive health problems.
- Reproductive Health care programs should be designed to serve the needs of women including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, and evaluation of services.
- Innovative programs should be developed to make information, counseling, and services for the reproductive health accessible to adolescents and adult men.
- The government should make greater community participation in reproductive health accessible to adolescence and adult men.
- The government should promote greater community participation in reproductive health care services by decentralizing the management of the public health programs, and by forming partnerships in cooperation with the local NGOs and the private health care providers.

2.5.2 Progress on Reproductive Health Rights and Policy Formulation in Pakistan

Ms. Fazil also emphasized that implicit in the actions associated with achieving these objectives are the formulation of national policies relevant to Pakistan. She highlighted the progress made, as well as the constraints in policy formulation areas, some of which are given below (see Box 2.5).

Box 2.5: Reproductive Health Policy and Reproductive Rights

Progress	Constraints
<ul style="list-style-type: none"> ■ Pakistan has made substantial progress particularly at the leadership and implementation level ■ Social Marketing of reproductive health services is ongoing ■ The Prime Minister's Program for FP and PHC is a step in the right direction to address the unmet needs of the family planning services 	<ul style="list-style-type: none"> ■ Non-participation of women in the planning, decision-making, management and evaluation activities and components of their reproductive rights ■ Still need to make information, counseling, and services for reproductive health accessible to adolescents and adult men. ■ Complementarity between government and NGO programs

2.6. Reproductive Health Situation in Pakistan: Review of Current Health Data

2.6.1 Health Status of Women in Pakistan

Dr. Faryal Fikree presented the data on the Reproductive Health situation in Pakistan, compiled by Professor (Rtd.) Dr. Sadeqa Jaffery of the Jinnah Post-Graduate Medical Center (JPMC). The presentation entitled 'The Reproductive Health Policy Situation in Pakistan: Review of Current Health Data' provided a situational analysis of reproductive health, concentrating on maternal health and the repercussions of perinatal morbidity and mortality. The data on the health status of women in Pakistan, taken from hospitals and community-based surveys, are shown in Table 2.2 and Table 2.3.

Table 2.2. Maternal Mortality Ratios per 100,000 livebirths - (Hospital Based) Pakistan 1981-1991

Hospital based (1989-90)	670
Private Hospitals	90
Public Hospitals	740
JPMC (1981-90)	710
Booked	27
Un-Booked	1,270

Table 2.3. Maternal Mortality Ratios per 100,000 Livebirths, Community-Based (MIMS) Pakistan 1989-1991

Karachi, Sindh	281
Pishin, Balochistan	289
Loralai, Balochistan	593
Khuzdar, Balochistan	673
Lasbela, Balochistan	463
Abbottabad, NWFP	360
Mansehra, NWFP	523
Overall MIMS	433
UNICEF	340

2.6.2 Maternal Mortality Ratio in Pakistan

Dr. Faryal Fikree further talked about the situation of safe motherhood in Pakistan, as well as discussed the newly revised MMR ratio, maternal morbidity, malnutrition and maternal weight during pregnancy, and perinatal morbidity and mortality.

Other data in her presentation included pregnancy intervals, infertility (both primary and secondary), as well as domestic violence. She elaborated that the MMR is determined by the number of maternal deaths per 100,000 live births. Information from a hospital-based survey in 1981-91, undertaken by the Society of Obstetricians and Gynaecologists of Pakistan, was also explained, bringing out the alarming difference between the registered and unregistered cases. Community-based data from different areas showed vast differences in the figures for maternal mortality. The UNICEF figure was 340. Currently, according to Maternal Health Statistics around the World, Pakistan is in the 500-and-above range for MMR.

The clinical causes of maternal mortality were found to be hemorrhage and sepsis in the community based surveys, but in the hospital-based surveys, sepsis was the leading cause. The level of ante-natal care in Pakistan, when compared to other countries of the region, showed that Pakistan lagged far behind in the number of women immunized with TT, the number of births attended by trained TBAs, and the use of family planning methods for child spacing (See **Figure 2.1**, **Figure 2.2**, and **Figure 2.3**).

A comparison between the rural and urban contraceptive prevalence rate showed that there was a significant increase in the use of contraceptives in the urban population.

Other topics discussed were sexually transmitted diseases, infertility and the problems and stigma attached to it, and the necessity to involve the male member of the family in its treatment.

Figure 2.1: Percentage of Immunized Against Tetanus, 1992-96

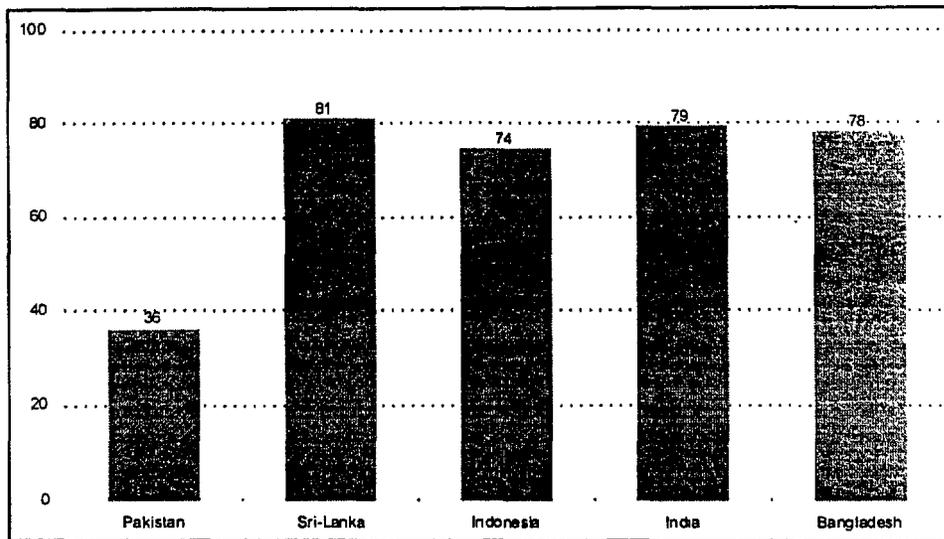


Figure 2.2: Percentage of Birth Attended by TBAs

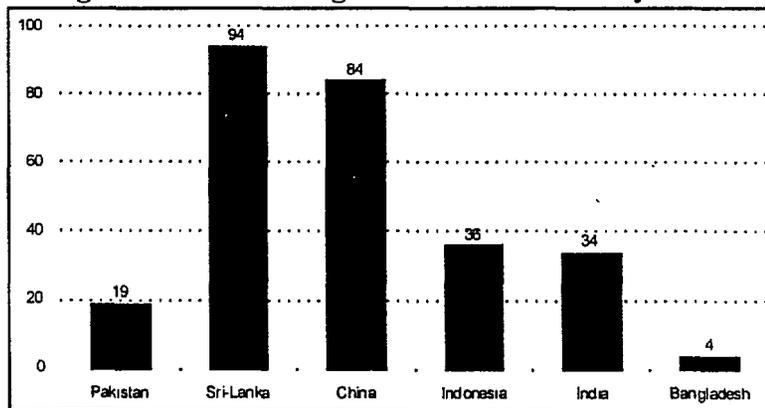
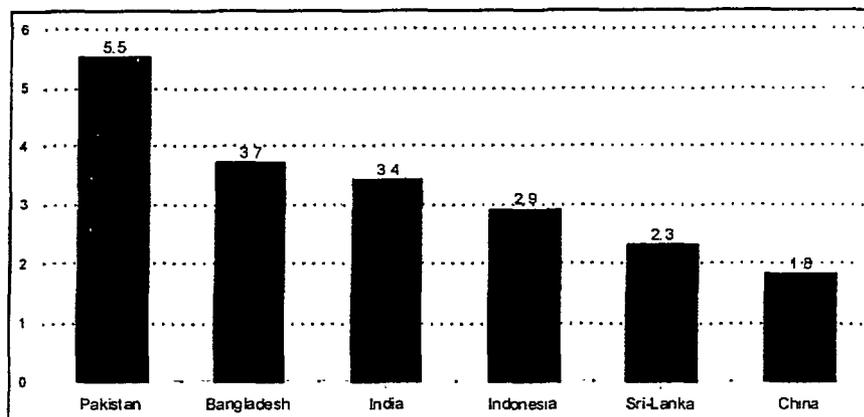


Figure 2.3: Total Fertility Rate



Dr. Fikree stressed the need to focus on women's empowerment as an integral issue of women's health. A study showed that 30% of the women interviewed said that they had to seek permission from their husbands before seeking emergency obstetric care. However, the men denied this, and claimed that the women were free to seek health care on their own. Health workers need to target the decision-maker within the family on seeking obstetric emergency care.

Dr. Fikree summarized the existing health status in Pakistan as being high in maternal mortality, high in maternal morbidity, and as having significant differences in the urban, rural, and ethnic groups. She recommended qualitative research, followed by quantitative as well as operational research. The findings could be effective in changing the health status of women (**Annexure E**).

2.7. Ministry of Health's Reproductive Health Program: A Review of Recent Initiatives

Mubashar Riaz Sheikh of the MoH, in his paper 'The Ministry of Health's Reproductive Health Program: A Review of Recent Initiatives' presented the review of initiatives, policies, and plans of the Government of Pakistan (GOP) in the field of reproductive health. According to Dr. Sheikh, reproductive health is an issue which requires government agencies to work collaboratively. At present, limited collaboration was evident between different government agencies.

2.7.1 Introduction to the Prime Minister's Program for Family Planning and Primary Health Care

The GoP's Lady Health Workers (LHW) program is a primary health care program (PHC), in which the lady health worker serves as a link between the government and the district/ static service delivery system. Dr. Mubashar explained the steps undertaken in this program.

2.7.2 Government of Pakistan's Efforts to Introduce a District Level PHC-based Health Support System

Within PHC, the GoP is trying to provide broad based affordable services to the community. The goal of the Prime Minister's Program for Family Planning and Primary Health Care is to involve the community at all stages, and make them aware of the present reproductive health care system.

LHWs are provided 15 months training in two phases, after which they operate from their homes. Their basic job is to be familiar with the community, its composition, the number of families, and age groups. The LHWs' two specific target groups are children under three, and women between 15-45 years of age. Working through LHWs, the GoP counsels community members on maternal care, antenatal care, registration for antenatal care, safe delivery, and on-time health care facilities.

The program was initially launched in 1994, and from July 1997 it was launched in all parts of the country. There are currently about 40,000 LHWs providing a network of 40,000-health houses directly attached to Basic Health Units (BHUs). A large number of cases can therefore be handled at the community level. Dr. Mubashir emphasized the need to promote District Head Quarter Hospitals as the first levels of referral for Emergency Obstetric Services (EOC), because these services are not available at the BHUs and RHCs.

2.7.3 Government's Interaction with NGOs

The GoP is also attempting to work along with NGOs (Box 2.6), to interact with them and establish networks, share resources, experiences, etc. This is beneficial for both. A comparative study has recently been undertaken to obtain information about family planning, new and follow-up clients, women registered for antenatal care, and the number of maternal deaths reported both from the Health Management Information System (HMIS) and Lady health Workers (LHWs).

Box 2.6: Collaboration with NGOs

Family Planning Association of Pakistan

- Training Female Supervisors on counseling and advocacy
- Referrals support through FWCs and BHUs
- Out of reach services through field camps and mobile units

Baltistan Health and Education Foundation

- Training illiterate women as LHWs
- Community financing and cost sharing

Box 2.6: Collaboration with NGOs (continued)

Health and Nutrition Development Society

- Model-I: Health committees to manage program financially and administratively
- Model-II: Management by women groups through micro credit and saving system

Medicine du Monde

- Improving the quality of Emergency Obstetrics, Child, and Reproductive Health Care
- Training health workers of a different level
- Community Participation
- Establishing a referral system

2.8. Expansion of the Ministry of Population Welfare's Programs

2.8.1 Integrating Reproductive Health Services

Dr. Naushaba Chaudhry of the Ministry of Population Welfare (MoPW). in her paper 'Expansion of the MoPW's Program: Integrating Reproductive Health Care Services.' explained the role of the MoPW in the provision of the reproductive health care package. This Ministry played a leading role in the ICPD Cairo Conference, and worked in close collaboration with other Muslim countries to bring the draft agenda of the ICPD in line with the socio-cultural norms which could be both acceptable and useful to Muslim countries.

2.8.2 Proposal of Reproductive Health Package

The final outcome from the agenda of the ICPD Cairo Conference (**Box 2.7**), suggests the following essential services package: comprehensive family planning services; safe motherhood, including maternal health care; pre- and post-abortion management; child health care: the treatment of minor ailments; control of HIV/AIDS and STDs /RTIS; infertility management; cancer detection; the management of reproductive health-related problems of adolescents and the elderly; enhanced male involvement. A comprehensive reproductive health package was drafted by the MoPW, with input from the MoH, as a follow up to the ICPD in 1994. Apart from provision of services the package includes development of information education and communication (IEC) materials and strategies would be devised to implement it.

Box 2.7: Comprehensive Reproductive Health Services Package

- Provision of Comprehensive Family Planning Services
- Safe Motherhood:
 - Maternal Health Care
 - Pre & Post Abortion Management
- Child Health Care
- Treatment of Minor Ailment
- Control of HIV/aids and STD/RTIS
- Infertility Management
- Cancer Detection
- Management of RH related problems of Adolescents and Elderly
- Enhanced Male Involvement

* Note: IEC material for the above components will be developed & disbursed also.

2.8.3 Efforts to Expand and Improve the Quality of Family Planning Services/Integrate Other Reproductive Health Services

Dr. Chaudhry elaborated on the current work being done by the MoPW in providing comprehensive family planning services through a carefully planned, village-based, family planning workers' scheme. The focus is on providing services to the rural population, which constitutes 70 percent of the total population of Pakistan. The MoPW and MoH are sharing their experiences and resources, and assisting each other in the development of curricula for training LHWs. This program assumes that the number of workers will increase from 12,000 to 30,000 during the ninth five-year-plan. It is expected that provision of contraceptives thru the LHWs will increase the contraceptive prevalence rate. National efforts are ongoing to improve the quality of services, being provided by LHWs. Training workshops are arranged involving doctors, paramedics, and female doctors at the tehsil level to improve their skills to provide better reproductive health services.

Training of trainers to improve the capacity of health care providers to manage Reproductive Tract Infections (RTIs) is being done. Training curriculum for in-service training of health staff is being revised. The plan is to provide orientation to 62,000 personnel from the MoH, NGOs, and the private sector to up-grade the skills of healthcare providers in management of RTIs.

A major area for improvement is the somewhat limited male involvement, considering that 27 percent of the population consists of adolescents between 5 to 14 years of age, and 18 percent between 15 to 24 years. However, since re-training of doctors and master trainers is being conducted, male doctors and male attendants will also be posted in all the training centers, and at the District Head Quarter Hospitals (DHQs) to ensure the provision of counselling services in all male-related family planning methods.

A monitoring and supervisory system to improve logistics and supplies of contraceptives is being developed. Telephone help lines are also envisaged, so that those who feel shy coming to clinics, or cannot gain access due to constraints, may still obtain information. With the collaboration of the MoH, the target of increasing the use of contraceptives upto 2.7 percent has been set from the present 2.6 percent. For the next five year plan(1999-2003).

Dr. Chaudhry ended her presentation with the hope that donors can assist the ministry in implementing its objectives by providing the necessary support and cooperation.

2.9. Group Activity-I

2.9.1 Current Involvement of NGOs in Reproductive Health

A questionnaire was attached to the workshop invitation letter, asking participants to provide information on the scope and focus of the reproductive health services that each participant's organization provides. Twenty five NGOs, about 10 GoP officials, and two Donors sent back their questionnaires. The information was collected, assimilated in a data base, and separated into four program areas:

- Health Education/ Promotion;
- Service delivery;
- Family planning; and
- Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs).

Mark Reade McKenna presented the data on the current NGO/GoP involvement in the area of Reproductive Health. Most of the NGOs are involved in Family Planning, Safe Pregnancy, Health Promotion, and STDs. The data shows that the NGOs/GoP have been working in these areas for the last 25-years. (Table 2.4).

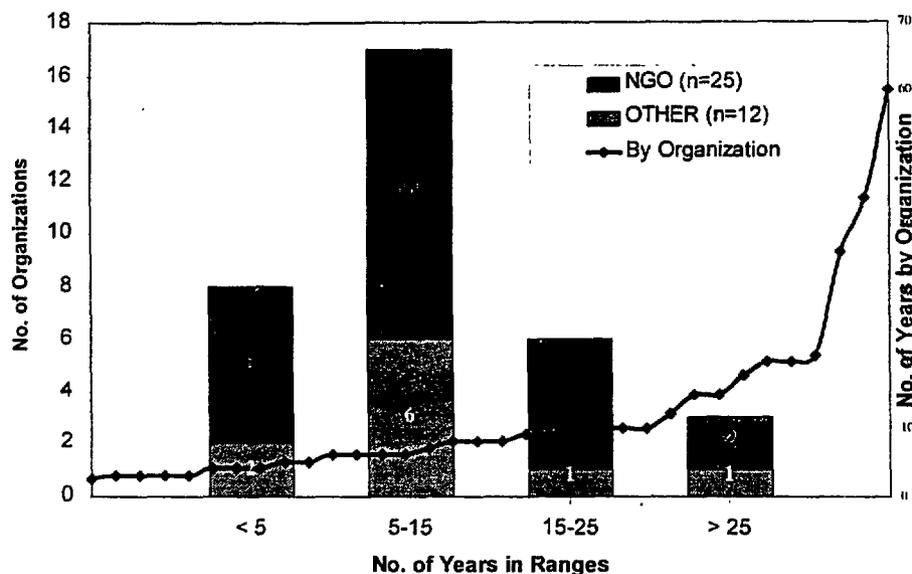
Table 2.4: Type of Activity by Area of Activity (n=37)

	Service Delivery	IEC	Training	Referrals
Family Planing	62%	92%	73%	68%
Safe pregnancy	57%	84%	73%	59%
Health Promotion	54%	89%	81%	54%
STDs	22%	57%	41%	30%
Total	49%	80%	67%	53%

Most of them work in the major areas such as Reproductive Health, Safe Motherhood, and

RTIs. Fifty four percent of the NGOs/GoP organizations were involved in service delivery activities, and 80% in IEC interventions (Figure 2.4).

Figure 2.4: Numbers of Years Working in Reproductive Health



However, these activities are too general, and the NGOs need to be more specific. All three sectors mentioned health promotion is one of their important activities, see Table 2.5. They were asked to reflect upon the interventions used to measure the impact of their programs (see data on the indicators used). It was observed that none of them had behavioral indicators to measure what they were doing (see Annexure K, Current Database on Reproductive Health Activities).

Table 2.5: Health Promotion Activities and Their Overall Importance by Type of Organization

	IEC	Most Important	Very Important	Somewhat Important	No Ranking
NGOs (n=25)	92%	44%	40%	0%	16%
GOVT. (n=10)	100%	40%	50%	0%	10%
DONOR (n=2)	0%	0%	50%	0%	50%
TOTAL	89%	41%	43%	0%	16%

The participants were later divided into eight groups, and asked to reflect on their programs with reference to the indicators they were using. Two of the eight groups analyzed one of the four program areas. The two groups analyzing the same data joined to prepare a joint presentation. This was the first opportunity for the groups to work together.

Rapporteur's from each group presented a summary of their group discussions, suggesting a variety of indicators that can be used to measure impact of interventions. The presentation of groups are given in **Table 2.6**.

Table 2.6: Presentation of Groups

Groups	Indicators	Suggestions
Group A & B: Safe Motherhood/ Safe Pregnancy	<ul style="list-style-type: none"> ■ Currently used IMR & MMR ■ Regular morbidity indicators not included 	<ul style="list-style-type: none"> ■ accurate evaluation of poverty, ■ Health education, once again IMR not needed for this. ■ Use of IMR and MMR to be replaced by the behavioral indicators, after conducting the qualitative studies. ■ Change in the KAP (pre and post), number of the patients attending for ante, post and pre-natal care TT, ■ number of deliveries conducted by trained people after interventions, ■ qualitative/quantitative auditing through health system research, number of deliveries conducted by trained personnel help to lower MMR included in monthly report by community health workers.
Group C & D: Sexually Transmitted Diseases	<ul style="list-style-type: none"> ■ Sexually transmitted diseases are an important health concern for Pakistan. The concern is due to the nature of the spread of the diseases. This is compared to the irresponsible and unsafe use and acceptability of injectable medication by medical practitioners. This practice has widespread acceptance by the community ■ The current indicators mentioned are mostly confusing. 	<ul style="list-style-type: none"> ■ An important indicator for national/provincial level is the number of new cases reported from different areas. This will help to concentrate services and public health in the high risk areas. ■ An indicator for the organizational level is knowledge of STDs among health professionals. ■ Another important indicator at the organizational level must monitor the quality of services. This indicator needs to be developed.

Table 2.6: Presentation of Groups (continued)

<p>Groups E & F: Family Planning</p>	<ul style="list-style-type: none"> ■ Separate for different levels, number of new cases in high risk group, ■ Organizational level, awareness of health professionals at each level from service delivery to contact people, ■ Disease prevalence, ■ Service utilization, ■ Awareness indicators. 	<ul style="list-style-type: none"> ■ Data collection, comparative statement between last year and current year. ■ Non referrals, ■ Number of pills and condoms used in the area, ■ Number of couples using contraceptives for child spacing, ■ Change in STD prevalence, ■ Utilization of STD related services, ■ Prevalence of disease, ■ Number of training organized ■ Impact studies, contraceptive methods being used (proportions), awareness of the people, clinical examination (number : cases dispensed, referred and cured).
<p>Groups G & H: Health Promotion/ Health Education</p>	<ul style="list-style-type: none"> ■ Disparity between objectives and indicators 	<ul style="list-style-type: none"> ■ Improving the knowledge attitudes and practices, ■ increase/decrease in breastfeeding practices, decrease in common diseases , ■ utilization of services, ■ control of diarrhea and acute respiratory infections, ■ healthy satisfied mothers and babies, ■ weight and height of baby.

2.10. Presentation on Male Involvement in Reproductive Health Programs

Dr. Anwar Aaqil, a consultant to TAF, presented a paper on 'Men and Sexuality: the Unspoken Elements of Reproductive Health.' Building on the theme of the workshop on Reproductive and New-Born Health, Dr Aaqil's presentation highlighted the role of men and sexuality in reproductive health. He said that the concept of reproductive health has three components. Sexual health, reproduction, and fertility regulation. Sexual health and reproduction affect each other, and are in turn affected by the fertility regulation. Thus, emphasizing one aspect will not advance the cause of reproductive health of the population.

In the past, attention was given to reproduction i.e. maternal and child health (MCH.) and fertility regulation (family planning services). Sexuality, being a cultural taboo, was always neglected. This affected the family planning program adversely as no counseling was carried out to allay the fears and apprehensions of the clients regarding sexuality. Both sexes suffer

from sexual problems, but feel constrained to talk about them. With an increase in STDs and AIDS, it became imperative to inform the public about safe sexual practices. By default, this scenario opens up the opportunity to talk about the sexual health aspects of reproductive health.

Interestingly, the program planners and managers always placed the responsibilities of the reproduction and fertility regulation on women. This assumption overlooks the fact that the Pakistani culture is male-dominated. Women are supposed to obey and act on the wishes of their male partners, or other male members of the family. The dominant psyche permeates the sexual relationship as well.

The sexual taboos leads to the spread of various mis-perceptions. Dr Aaqil cited several beliefs from some popular sex literature. He stressed that reproductive health cannot be improved without involving men, paying attention to the gender issues in sexual relationships, and demystifying the old myths, beliefs, values and practices regarding reproductive health. He stated that the medical establishment should open up and advocate reproductive health, and its social dimensions.

Dr Aaqil concluded that reproductive health is not only a medical issue, but also a social concern. It should be addressed from a broad psycho-socio-biological perspective that combines contextual and individual variables. He presented a model to improve reproductive health. The model states that contextual variables affect cognitive factors, which in turn influence sexual practices and improve reproductive health. The contextual variables regarding reproductive health include policy issues, cultural values, norms, beliefs and practices, relationship systems (social networks, information received and shared, reciprocity etc.), gender role and responsibilities, availability and accessibility of reproductive services, biological conditions, etc. The individual cognitive processes include social interaction skills (communication, negotiation, assertiveness, and consensus building), motivation (outcome expectancy, self-efficacy, goal-setting, etc.), problem solving skills and actions, and procedural schemes.

2.11. An Update on the South Asia Regional Safe-Motherhood Meeting in Sri-Lanka

In 'Lessons Learnt from Sri Lanka', **Imtiaz Kamal** talked about the Technical Consultation which took place in Sri Lanka during the 18-23 October, 1997. The conference was attended by several national and international agencies, as well as donors.

The three representatives from Pakistan were Faryal Fikree, Sadeqa Jafri and Imtiaz Kamal. Mrs Kamal highlighted the following key issues raised during the Colombo meeting:

2.11.1 Measuring the Progress of the Safe-Motherhood Meeting

In order to assess the progress of the safe motherhood program, it was decided that collecting data on the number of maternal mortalities is not essential, but the cause of death is, since every death is viewed as a failure of the maternal health care program that could have saved a life instead.

The management of safe abortions and unsafe abortions was discussed in detail. The topic with the most debate was 'adolescent sexuality,' since the participants hailed from different backgrounds and had different ideas about it. In maternal care, four models of delivery were established. The first was that in which TBAs had no help, the second type was the one which used skilled attendants with some help, while the third was that where birth attendants were present, and the fourth was that in which complete hospital care is available.

2.11.2 Role of Vitamin-A in Saving Lives

An interesting research study was also reported during the meeting, where high doses of vitamin A are believed to save lives, particularly in hemorrhage cases. Reporting on lesson learnt from Safe Motherhood Initiatives.

Overall the Colombo meeting was an opportunity to share some of the success stories. However there was an overwhelming environment of frustration, anger, and even guilt over the number of maternal deaths still taking place.

2.11.3 Are Midwives the Answer?

From a historical perspective, it was interesting to note that England was also cited as an example of where the mid-wife emerged as an essential component of health care. Alternatively, countries like the United States had discarded the concept of the midwife, requiring all patients to go to hospitals instead, and doctors to handle every case. It took the U.S a long time, and great expense, to bring their maternal mortality down, only to recently usher the midwives back in. Participants of the meeting felt that each country needs to look into its own healthcare structure as well as cultural settings to see if mid-wives could be trained and utilized.

2.11.4 The Role of Communications & Social Marketing in Reproductive Health Care

2.12. Safe-Motherhood Interventions

Rationale of the Project

Dr. Faryal Fikree made a presentation on the Safe Motherhood Intervention, a Project funded by US AID and the World Bank under the technical assistance of MotherCare. The project has been implemented by the Community Health Sciences (CHS) department of the Agha Khan University.

The rationale for this project is based on two studies by Dr. Sadiqa Jaffri and Dr. Razia Junejo that were published in the Journal of Social Science & Medicine, one of which was the follow-up study of mothers who were brought in dead to Jinnah Post Graduate Medical Center, Karachi (JPMC). The study showed that out of 601 maternal deaths in the department of Gynecology at JPMC over a 12 year period, 75% of the deaths were at the hospital, while 166 were within

half an hour of reaching the hospital. Out of 601, 25% were already dead on arrival.

Explaining the causes of death for the women who were brought dead, Dr. Fikree explained that there were three main issues:

- ❑ Inappropriate services (21%), or improper referrals at the primary levels.
- ❑ Delayed referrals, usually caused either by the family's hesitancy, the husband not being present, or a lack of awareness of the problem. Mostly, it was the household dynamics which played a role in the delayed referrals.
- ❑ Access issues, transport, and the lack of services (36%).

The MIMS study conducted by the Agha Khan University (AKU) involved 1000-households in the urban squatter settlements of Karachi. One hundred and thirty five deaths are reported in the 10 years preceding this study. One hundred and twenty one interviews were conducted with the relatives of deceased females (aged 15-49). Verbal autopsies were also conducted to determine the cause of death.

The maternal death count was 34, whereas non-maternal deaths were 87. Looking at the overall cause of death between the ages 15 and 49, there were 35% excess deaths of women in comparison to men of the same age group, all of which were maternal related.

The consequences of maternal mortality caused the ratio to come up from 281 per 100,000 live births, whereas the maternal mortality rate was 48 for 100,000 women. The main cause of maternal death was hemorrhage-eclampsia, and sepsis. While conducting verbal autopsies, what was interesting to note was the health seeking behavior of these women when they had problems, and what happened at each stage.

In the case of hemorrhage and eclampsia, the delays were not only at home but at almost every level of healthcare delivery system. The women were often referred back and forth by the different health care centers, until they were finally sent to the tertiary health care facility. When further referred to a hospital, additional delays were often caused by issues such as provision of equipment and supplies at the hospital. The recommendation for this investigation led to the suggestion for an intervention for improving timely referral, and up-grading hospitals.

Goals and Objectives of the Safe-Motherhood Intervention Project

Fariyal summarized the goals and objectives of the project as follows:

Goal: The project goal was to increase the number of women with obstetric complications who utilized appropriate medical services.

Objective: The primary objective of this project was to assess the impact of the training of the health care providers, and community-based IEC (Information, Education and communication) strategies on access to, and use of essential obstetric services for women with maternal complications.

The objective was expected to be met through the following interventions:

1. Training three *cadres* of reproductive health care providers at the primary and secondary health care facilities located in the selected area.
2. Developing a community -based IEC programs for women, men, as well as family and community decision makers, aimed at improving the utilization of maternal services through participatory meetings of the various groups in the community. and person-to person contact.
3. Establishing the referral system from the community to the clinics, and then on to hospitals for the immediate transfer of women with complications, including puerperal sepsis and prolonged /obstructed labor.

Ms. Fariyal explained that the Safe motherhood Project intervention site was Korangi-8, comprising of two Karachi Municipal Corporation (KMC), with a population of approximately 50-60,000. Prior to starting the project, little information was available regarding the number and type of healthcare facilities, and the providers in the area. SMP surveyed the area, and found that there were 28 private clinics, 5 private maternity homes, and one government dispensary.

The clinics are open in the morning and evening, while the maternity homes offer 24 hour service. Twelve clinics are being run by qualified MBBS doctors, and 16 by health assistants. Maternity homes are being run by LHVs/Midwives. JPMC and Korangi Landhi Medical Center (a private secondary care level hospital) in Korang #5 are the main referral hospitals.

The Intervention strategy was divided into two parts. Phase-I was the qualitative assessment of what is the number of health care facilities available, and who are the reproductive health care providers.

Phase-II was community diagnosis: What do women and men think about pregnancies, their complications, and if there is obstetric complications, what is the course of action that they follow? Finally, the development of a simple health information system that would give some idea of the development of the referral chain.

Phase-II also included the administration of the continued training and monitoring of the health care providers in the area, launching the community-based IEC campaign through participatory community meetings, as well as monitoring and evaluating the training and IEC strategy.

Ms. Fariyal presented some of the findings from the focus groups, which were later used to design the KAP surveys, and are listed below:

High risk pregnancy, as discussed by doctors nurses and midwives, varied. Multi-parity was the most common cause listed by doctors, high blood pressure by nurses and midwives.

- Doctors reported that the antenatal care they provide included a hemoglobin check-up, blood pressure, blood type, and RH factor. LHVs reported checking blood pressure, fetal height, fetal position & fetal heart rate. TBAs conducted abdominal massage and look for anemia.

-
- Health care providers suggested Antepartum hemorrhage and abnormal presentations as the leading complications where further referral was necessary. Nurses, LHVs and mid-wives suggested heavy bleeding and abnormal position. TBAs mentioned abnormal positions. All of them mentioned abnormal position as the factor for which they would refer the case further. Only 5 health care providers mentioned bleeding as a complication that required additional referral, others did not feel that bleeding was a major problem.
 - Referrals were usually made because the healthcare provider did not feel they had sufficient facilities to handle the case, and they think that they are better handled in the hospital. The LHVs lacked confidence in themselves for treating obstetric complications, while TBAs mentioned lack of knowledge.

The KAP survey was developed to ask healthcare providers (doctors, unqualified doctors, LHVs and TBAs) what they would they do in the situations of pregnancy related complications cited above?

Designing and the IEC Strategy

Ms Fariyal explained that the community diagnosis process was used to collect information and to design the IEC strategy. She presented some of the findings from this process:

- Twenty seven percent of the women, and 33% of the men reported having any knowledge of complications during pregnancy, delivery and post-partum. This lead to the understanding that women and men are not aware of the fact that pregnancy related complications may well lead to severe morbidity or mortality.
- Precautions women took during pregnancy were stated as avoiding carrying heavy loads, and inter-course. Men added that they should have good nutrition, which was a positive factor. Women reported check-ups, but were not really sure what a checkup in the context of ante-natal care meant for them.
- Ninety percent of the men and women said that the local clinics provided good health care, but were not satisfied with the quality of care being provided at Jinnah Post-Graduate Medical Center, which was the major hospital where women were being referred. This dissatisfaction with the service was not towards the professional staff like doctors and nurses, but the lower staff such as the sweepers, guard and security men, who made it difficult for them to gain access. Once they gained access, it was reported that everything proceeded smoothly.
- The community men and women reported that transport was easily available.

-
- ❑ Women reported that they rely on mothers and sister-in-laws, but 93% said that their husbands make the final decision to go to the health facility during any time of the pregnancy. Talking to men, they said that their mothers and dais are the sources for advice, and they were the ones who made the final decision to go to the health care facility.
 - ❑ The sources of information for the women were the LHWs, doctors, in-formal gatherings of women, and television. Thirty men and 7 women who responded reported doctors, newspapers, and the television as their source of information. They specially named the family planning advertisement. The literacy rate among men was around 60%, whereas the literacy rate among the women was about 20%.
 - ❑ Another aspect looked at identifying the complicated cases through Jinnah Hospital, as well as through the community work done in that area. In depth investigations of all the women who died, as well as those who had complications and survived, were conducted. A women with post-partum hemorrhage was interviewed to find-out the details as to when it first occurred, what happened, and what were the household dynamics related to her seeking care either early or late.

One case which came up was that of eclampsia. A young woman was having convulsions, and the first health care provider that was sought was a religious leader, after which two or three others were consulted before they finally decided to go to the nearest health care provider, and from there to Jinnah hospital. She was lucky she survived, but the baby died.

The result of an in-depth community based study investigation of men and women regarding 10 obstetric complications were also shared. The main issues were discovered to be problematic within the community, and needed inclusion in the IEC strategy. They were identified as follows:

- ❑ Lack of an appropriate referral chain;
- ❑ Lack of recognition of an emergency; and
- ❑ Lack of female autonomy in the decision making.

The IEC material is being developed by the researchers to address the information needs, as well as strategies regarding barriers such as the negative attitude of the lower staff at Jinnah Post-Graduate Medical Center. The material being developed includes a booklet, which has a detailed case study describing what steps to take during an emergency, and a poster which creates awareness about four common complications. Overall, it is being stressed to people that when there is a complication, they should go directly to Jinnah Hospital.

The target audience for the IEC strategy is pregnant women, their husbands, and their immediate family members which include their in-laws as well as their own mothers and sisters. They are the ones who play the main role in the internal household dynamics when an emergency occurs, and they will be the ones contacted through the health care providers including the LHW in their area, by the field teams, as well as community groups.

The dissemination process would be counseling by health care providers at all levels, including the un-qualified doctors, community groups, and even individuals.

The study includes a pre and post baseline KAP survey to evaluate if there is a change in their knowledge of obstetric complications, and where to go during an obstetric emergency. The sample for the KAP survey includes women and their husbands who had recently delivered in the past eight months. There was found to be substantially more awareness regarding the knowledge of referral, for emergency obstetric conditions, the knowledge of when and where to refer for the four common obstetric complications hemorrhage, eclampsia, sepsis and obstructed labor, the knowledge of nutrition and ante-natal care, and the utilization of iron following tetanus toxide injections.

To design the training program for health care providers, a training needs assessment was conducted of 28 doctors, 11 un-qualified doctors, 10 mid-wives and 24 TBAs. The result of this was incorporated to design the 3 day training program. The training programs consists of:

1. Presentations of case studies on major obstetric complications;
2. Discussions on the management of these complications, and how best to handle them;
3. Separate training for different health care providers i.e. trained doctors, untrained doctors, LHV's & TBAs. This is followed by a discussion in a joint session of all health care providers discussing one case study. This is also helping to build a lot of rapport between the different cadre of health care providers. (Refer to **Annexure F** for IEC material).

2.13. Women Living in the Squatter Settlements of Karachi/Pakistan: A Qualitative Study on Abortions

2.13.1 Introduction

Dr. Faryal Fikree introduced the study undertaken by herself and **Dr. Sarah Jamil** on the Qualitative Study of Abortions. About 20 million unsafe abortions take place each year worldwide; nearly 90 per cent of these occur in developing countries. Women from Latin America and Asia, where abortion laws are restrictive, tend to be older, married, not wishing for more children, or wanting to space their pregnancies. Pakistan reports a new figure for the maternal mortality ratio of 340 per 100,000 live births. Various studies from different areas of Pakistan report even higher figures. A country-wide facility-based study for the time period 1989-1990 determined a maternal mortality ratio of 670 per 100,000 live births. Eleven per cent of the deaths were due to induced abortions.

The presentation at the workshop was predominantly on women living in the squatter settlements of Karachi. The selection criteria for the focus group discussions was:

1. Married women of reproductive age with a history of at least one pregnancy, irrespective of having had an induced abortion.

2. The participants belonged to a mixed background of conservative Muslim Pathan and Baloch tribes, and the less conservative Punjabi Christian community.
3. Local health workers of the respective areas were asked to form a group of at least 6-8 women.

The conclusions drawn from the study were as follows:

1. The focus group and in-depth discussions strengthens the fundamental hypothesis that induced abortion occurs frequently in a society that prohibits abortions.
2. The authors assumed that the prevalence of induced abortions is high in the communities. Women stated different methods of inducing abortions (Box 2.8). In almost every group, there were more than three females who had undergone the experience of an induced abortion, or knew someone who had the experience. Women defined weakness as an after affect of having a long induced abortion. (Box 2.9)
3. Misconceptions about the use and side effects of family planning methods are highly prevalent, and need to be removed.

Opting for an induced abortion is a social dilemma as indicated by the frequently used terminology of 'majburi' (responsibility under duress).

Box 2.8: Different Methods of Inductions of Abortion

- Home remedies taken orally like a concoction of choaray, ajwain, garamchiese, or moving heavy objects, jumps etc.
- Herbal concoction taken orally commonly known as "AKARA"
- Intra vaginal placement of indigenous medicines, alcohol, opium, IUCD, special wooden stick, allopathic vaginal tablets
- Injections and drips
- D&E
- Homeopathic medicine mufeed-un-nissa taken orally.

Box 2.9: After Affects of Having an Induced Abortion

Weakness	Death of a woman
Bleeding	Poison
Infertility	Low Blood Pressure
Uterus get weak	High Blood Pressure

2.14. The Green Star Clinics: An Evaluation Report

'The Green Star Clinics : An Evaluative Response' was the presentation by **Carol Squire** of the Population Services International, Social Marketing, Pakistan. The presentation focused on the elements of design and evaluation. (Box 2.10) It started with an introduction of the organization, and its programmes in Pakistan. SMP is a non-governmental, non-profit corporation that specializes in using social marketing for behavior change in the health field. It has two major divisions: Nutrition and Family Planning. The Nutrition Division currently implements the UNICEF-funded Iodized Salt Support Facility, which is a major component of the Government of Pakistan's Iodine Deficiency Disorder Elimination Campaign.

Box 2.10: Evaluation Design of Green Starr Clinic Pilot Project

- Results form a series of extremely administered survey
- Information gathered and used in the internal project management information System (MIS), and
- Qualitative information provided by Green Star field staff.

Carol Squire went on to discuss the Green Star Clinic Project, formed mainly to include IUDs in a social marketing programs. The goal of the Green Star Clinic is to increase the capacity of Pakistan's private medical sector to provide high quality family planning services and products to low income populations, in order to increase the number of new family planning acceptors as well as improve contraceptive rates. Details of the objectives and project components are listed below.

2.14.1 Project Objectives:

- To train 20,000 registered Medical practitioners in family planning counseling, IUD insertion, hormonal methods prescription and administration, side effects management, and infection prevention by the year 2000;
- To create a demand for the services of the Green Star Doctors; and
- To ensure quality services by supporting and monitoring the Green Star Members.

2.14.2 Project Components:

- Training;
- Demand Creation;
- Contraceptive Supply; and
- Support and Monitoring.

The evaluation of the pilot project was elaborated. The main objectives of the evaluation were:

- ❑ To measure the improvement in new acceptors, overall clientele, and the sale of contraceptives;
- ❑ To measure the improvement in the quality of the family planning services provided;
- ❑ To assess the effectiveness of the programmatic inputs; and
- ❑ To make recommendations for the expansion of the Green Star Clinic Network.

The principal findings revealed that good quality FP services can be effectively provided through the private sector in Pakistan if medical providers are given thorough training, and regular contraceptive supplies. However, it was observed that service charges for IUDs and injectable contraceptives quoted by doctors to the clients are often higher than what poor people are able and willing to pay.

The project progress was elaborated, and future plans devised. The presentation ended with a list of general recommendations that related to the choice of participants, training, field support, monitoring and evaluation. (See details in **Annexure G**).

2.15. Ms. Judith Standley – Introduction to Case Study Methodology

This was the last session, and at the end of the day Ms. Judith Standley introduced the Case Studies to the participants of the workshop, to be used during the second day.

2.15.1 Lessons Learnt DAY-I

- ❑ A women's lifetime risk of maternal mortality (MM) can be 100 times higher in a developing country like ours.
- ❑ Causes of Maternal Mortality are mainly hemorrhage, sepsis, unsafe abortion, hypertensive diseases of pregnancy (HDP), and obstructed labor. Additional underlying causes of maternal mortality include anemia and hepatitis. Apart from biomedical causes, there are other social and cultural factors which effect maternal survival. For instance, women who do not have access to income, and if illiterate, are more likely to have poor pregnancy outcomes.
- ❑ Experience has shown that every pregnancy faces a risk, and antenatal care alone cannot reduce MM, but can reduce prenatal mortality.
- ❑ NGOs can play an effective role to support women's empowerment through developing programs for promoting female education, income generation, and assisting the community to develop EOC, and provide direct services or establish a network through other NGOs and coordinate with the GOP.
- ❑ Pakistan is one of the developing countries with a high MMR, with a major cause of MM being hemorrhage and sepsis, hence both GOP and NGOs need to focus on:

-
- Community campaigns to promote recognition of pregnancy related complications;
 - all levels of healthcare providers need competency based training to enhance their skills in managing complicated deliveries
 - The GOP has initiated the "Prime Ministers Program for Lady Health Workers " in an effort to introduce the district board PHC system, and trained a cadre of nearly 40,000 LHWs working with BHUs. There are plans to integrate reproductive health services (RHS) to the portfolio of these workers.
 - The MoPW proposed a comprehensive reproductive health service package. Efforts are ongoing between the MoPW and MoH to coordinate and collaborate their efforts to improve the quality of service for family planning. The curriculum is being developed to train health workers to deal with RTIs.
 - Efforts are being made to train male doctors in counseling on male methods. Targets are set to improve logistic and supplies, and set-up a telephone help line.

Future GoP and NGO reproductive health interventions need to involve men, pay attention to gender issues in sexual relationships to demystifying the old myths, beliefs and practices that are conducive to reproductive health.

The qualitative study on abortions revealed that it is common in communities. Also misconceptions about the use and side effects of family planning methods are highly prevalent, and need to be removed. More advocacy is required to highlight the issues of unsafe abortion in Pakistan

Based on the lessons from Sirilanka the MoH needs to look into training of midwives and to link vitamin A supplementation with ongoing safe motherhood interventions.

The principal findings from the green star clinic reveals that Family Planning services can be effectively provided through the private sector in Pakistan if medical providers are given thorough training and regular contraceptive supplies.

Executive Summary

As part of the USAID funded Pakistan NGO Initiative (PNI), MotherCare (MC), BASICS and Wellstart (Cooperating Partners - CPs) have been working with The Asia Foundation (TAF) and the Aga Khan Development Network since 1995, to strengthen NGO capacity building for delivering effective maternal and child health services. In December 1996, PNI partners held a 'Planning Together' meeting with selected NGOs, where a health plan of action was outlined for the remaining 20 months of the project.

One of the key activities agreed upon in this meeting was to hold a State of the Art Workshop followed by 2-3 technical workshops to inform NGOs and strengthen their ability in planning for and implementing effective program strategies, as well as networking, and documenting lessons learnt globally and nationally.

As agreed in the Planning Together meeting, a 'State of the Art Workshop in Reproductive and Newborn Health' took place October 26-29 1997 in Islamabad. The workshop goal was to improve the capacity of NGOs to develop, integrate and carry out reproductive health activities. Sixty professionals representing NGOs, government, and research organizations attended the workshop. Participation during the workshop was very productive, and the majority of participants felt that the main objectives of the workshop were met.

The State of the Art Workshop took place at the Margalla Motel in Islamabad from 26-29 October 1997. The overall goal of the workshop was to improve the capacity of NGOs to develop, integrate and carry out reproductive health activities. Over one hundred participants were invited; eighty people were present on the first day, and sixty remained as active participants for the workshop's duration. The majority of participants came from NGOs, with about a third coming from the government and a few from donor agencies.

The three day workshop included presentations, group analysis of case studies, self-assessment of participant's own programs, group discussions, and an excellent poster exhibition. Ms. Mary Ellen Stanton set the tone for the workshop with her presentation on 'Reproductive Health - The Global Perspective; What We Know and What We Are Learning'. This was followed by a presentation on 'ICPD: Policy issues in Pakistan', and a 'Review of the Reproductive Health Situation in Pakistan.' The morning session of the first day was completed with presentations on the government's programs through the Ministry of Health (MOH) and the Ministry of Population Welfare (MOPW).

After lunch, the participants were divided into 8 groups. The pre-workshop questionnaire revealed that the NGOs were working in four program areas (health education/promotion, service delivery, family planning, RTIs/STDs). The data was used as a warm-up exercise for the overview of the scope of services (or lack thereof) it provided for the larger group.

The second day started with presentations on abortion, social marketing, and breast-feeding in Pakistan. The group work using case studies commenced after tea, with deliberations lasting until lunch. Guidelines for the Case Study Review were distributed to each group along with one of four cases studies. The case studies were anonymous, although based on

actual projects in Pakistan. The presentations were thorough, although each group - on the whole - were very critical of the NGOs depicted! Discussions following the presentations were interactive, with important issues on community participation, working with government, choosing effective interventions etc, coming to the surface.

While the process and outcome of the case study exercise was interesting, participant reaction was mixed. When asked during the evaluation if the objective 'using case studies to critically analyze projects' was met, sixteen people responded yes (well met and met) and five said this objective was not met. Suggestions included giving more time to the activity, and having the projects write their own case study. Those of us working on the case studies felt the questions should have been less inclusive, perhaps by using one case study and dividing the questions among the different groups, or using 4-case studies but asking participants to look at one aspect of the program. The case studies themselves should have had more information in key areas.

The third day started with an overview of the points brought out in the previous day's presentations/discussions. The participants were then asked to look at their own organizations, and with the information learned in the past two days, come up with a specific plan for strengthening their programs. Before lunch, the individual groups came together by region; presentations started after lunch and lasted through most of the afternoon. Because the individual groups were asked to develop a regional presentation, the recommendations - although interesting - were very broad. Within the context of this workshop, it was difficult to focus on specific interventions to strengthen the reproductive health activities of individual NGOs.

Themes brought out during the workshop were presented by Erik Jensen, Judith Standley and Rushna Ravji (World Bank). This was followed by a review of the workshop's evaluation. The evaluation shows that most of the objectives were met; and the participants benefitted through interactive analysis and were able to identify successful reproductive health strategies.

3. PROCEEDING OF DAY TWO

Ms. Naveeda Khawaja gave a brief introduction on the agenda for day-II of the workshop. Dr. Thaver gave his presentation on Women Seeking Help for Abortion - the Unmet Need.

3.1 Abortion Study: Women Seeking Help for Abortion

Dr. Inayat Thaver, the participant from Baqai University, Karachi, presented a study on women seeking help for abortion-- the unmet needs. Women from 10 Family Planning clinics were interviewed. They were all married, with a mean age between 29-30 years. about half were illiterate, 4% were above metric and had 5 children on average. an equal number of which were boys and girls. About 54.8% were actually practicing some kind of Family Planning (Table 3.1).

The current pregnancy status was 1.4 months. Almost 64% gave the reasons why they got pregnant—about 44% said it was related to the use of contraceptives (Table 3.2).

Table 3.1: Current Contraceptive Use, Before Getting Pregnant

Currently Using	54.8% (N=93)
Types of Contraceptives Used	(N=52)
■ Condoms	55.8%
■ Pills	19.2%
■ Withdrawal	11.5%
■ IUD	5.8%
■ Injections	3.8%
■ Breast-Feeding:	1.9%
■ Given by TBA	1.9%

Table 3.2: Alleged Reasons for Current Pregnancies, N=59

Related to Condoms	44.1%
■ Tearing of condom	27.1%
■ Condom didn't work	10.2%
■ Forgot to use condoms	6.8%
Didn't take Precautions	28.8%
Forgot to take pills	11.9%
Was Breast-feeding	6.8%
Stopped taking injections	3.4%
Remove IUD due to pain	1.7%
Medicine did not work	1.7%
God's will	1.7%

3.1.1 The Reasons for Wanting the Abortion

The reasons for wanting abortions were as follows: 50% were concerned about their own and their children's health; some were working women; some were concerned about social taboos; and some were bound by financial constraints. The knowledge and practice of getting an abortion was probed. Most of the women had used pills and injections. Approximately 25% did not take permission from their husbands in seeking an abortion. All the women felt that abortion was not allowed in their religion (Table 3.2).

These women were told by the Family Planning personnel that there was nothing that could be done for them. However, Dr. Thaver was of the view that since these women were using contraceptives and become pregnant, such cases should have access to abortions in the FP clinics so that they would not go to unqualified practitioners, or use other inappropriate methods, thereby risking their lives (Table 3.3). The scope of the FP clinics should be widened, and these should be converted into Reproductive Health Clinics.

Table 3.3: Knowledge and Practices of Abortion Methods (N=59)

Knowledge of any method: 29
Practiced some methods: 37

Methods for Abortion	Knowledge (N=27)	Practice (N=34)
Dilatation & Curettage or Evacuation	37%	2.9%
Pills	14.8%	50.0%
Injections	22.2%	23.5%
Pills & Injections	7.4%	
Injections and Dilatation & Curettage	14.8%	
Traditional Medicines		8.8%
Traditional Remedy by Dai		5.9%
Home Remedy	14.8%	8.8%
Note:		
Pills and/or Injections	44.4%	73.5%
Traditional Approach	3.7%	23.5%

3.2 The Role of Communication and Social Marketing in Reproductive Health Care

3.2.1 Introduction to Social Marketing

Richard Pollard, a leading consultant to Social Marketing programmes, in his paper 'Social Marketing — A Summary' over the last 25 years, said that many commercial advertising and marketing experts have joined forces with health, nutrition, and population professionals in developing a new branch of marketing that uses marketing techniques to serve a specific social good—hence the term Social Marketing (SM).

In its original form, SM concentrated on issues of how to motivate a desired behavioral

change through the use of persuasive techniques learned from the commercial advertising experience.

Social Marketing has developed two distinct tracks:

- Health and Nutrition programmes, where the primary emphasis is on behavioral and social change; and
- Population programmes, which is Social Marketing practice in relation to population (and STD/AIDS) programmes, with an interest in product development, distribution and promotion. Most notably, this applies to condoms but also to hormonal contraceptives, and long-term methods.

3.2.2 Examples of Social Marketing Projects

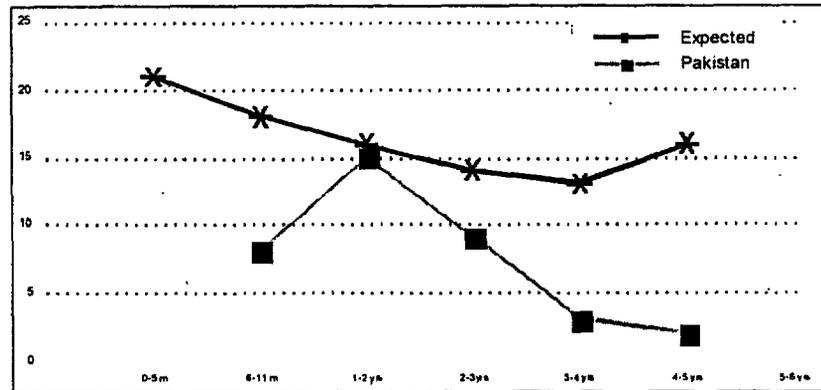
Many Social Marketing projects have undertaken programs for adult, maternal, and child health and nutrition activities. Some of these programs have included extensive service and product delivery components. These include growth monitoring, immunization, services to pregnant women, vitamin A capsules; and iron tablets and iodized salt distribution. Others have essentially not contained product or service delivery components, relying exclusively on communicating health messages. These include weaning and breast-feeding programs, vitamin A-rich foods consumption, home-made oral rehydration solutions, and programs designed to gain community support for a development-project, such as a dam or irrigation system.

Developing relationships between the commercial and social sectors has not been an easy task. But where both sides of the equation have joined forces and utilized their unique experiences and skills together, a new dynamism is created which has led to success. (Social Marketing summary by Richard Pollard, **Annexe-H**)

3.3 Breast-feeding in Pakistan – From Policy to Action

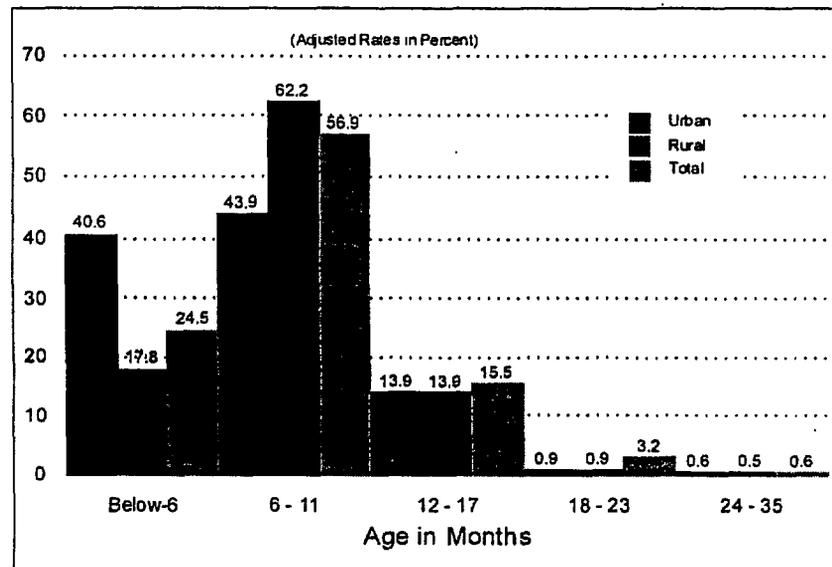
Judith Standley, a MotherCare consultant, made a presentation on '*Breast-feeding in Pakistan -- Policy to Action*', in which she said that over 57% of Pakistani children under five years of age suffered from malnutrition, with an unusually high prevalence (more than 20%) of infants under 6-months with acute malnutrition (wasting) (**Figure 3.1**). Surveys showed that the vast majority of women in Pakistan (> 95%) breast-fed their infants, although the lack of a clear definition of exclusive Breast-feeding obscured the real situation. They also showed that while most women breast-fed, they also practiced other behaviors that undermined the benefits received by exclusively breast-feeding babies.

Figure 3.1: Wasting in Young Children in Pakistan and Expected Pattern



These practices were found in both rural and urban areas, and were bolstered by traditional beliefs, hospital practices, and aggressive marketing of infant milk formulas. In view of the seriousness of the situation, a policy was made and action taken at the national and provincial levels to rectify the situation. Amongst these, the National Breast-feeding Steering Committee was set up to coordinate Breast-feeding activities. The Baby Friendly Hospital Initiative (BFHI) was launched by UNICEF and WHO. Action was also taken at the community level, and the GoP included Breast-feeding components in the curricula for traditional birth attendants (TBAS) and Lady Health Workers. NGOs have also been promoting Breast-feeding in communities (Figure 3.2).

Figure 3.2: Age of Starting Food: Children in Pakistan

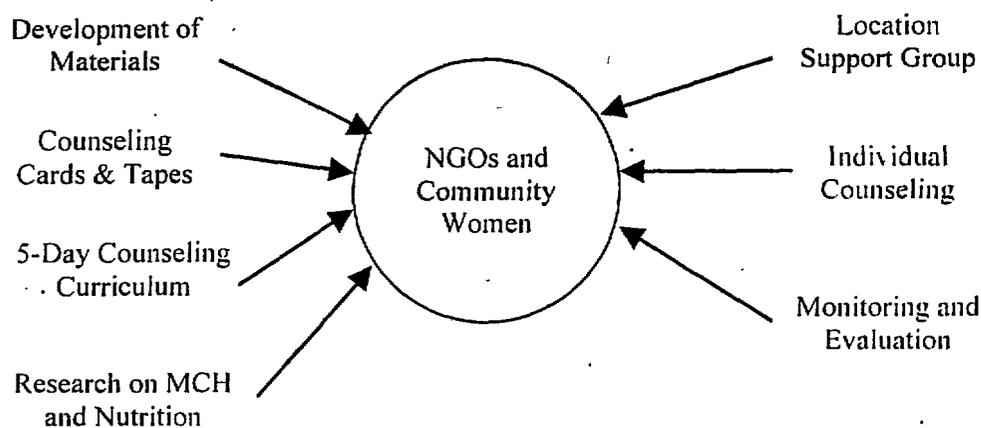


Source: National Health Survey of Pakistan, Pakistan Medical Research Council, 1990-94

In 1995, under the PNI, TAF in collaboration with the collaborating partners (CPs) MotherCare and Wellstart/Manoff, brought together a group of NGOs to discuss Breast-feeding promotion in the community. Through the establishment of Support Groups and specially developed materials, the idea is to eventually train the women in the group as facilitators and peer counselors.

The process was to develop counseling material/curriculum, based on findings from qualitative data to be used by the NGOs and community women for group and individual counseling (**Figure 3.3**). Improving the nutritional status is a complex task that needs to be executed at the policy level by passing legislation to regulate the distribution of breastmilk substitutes at the service delivery level, by ensuring hospitals and health staff promote and support positive Breast-feeding practices, and promoting this in the community and in people's homes where all the key decisions are actually made.

Figure 3.3: Community



3.4 Group Activity – II

The group-work used case-studies and the guidelines for the Case Study Review (**Annex-I**) were distributed to each group, along with one of four case studies (**Annex-J**). The case studies were anonymous, although based on actual projects in Pakistan. The case studies were analyzed to look at the process of community participation, interventions being used, male involvement, and communications strategies involved by each NGO. Each case study was reviewed using the SMART criteria (**Box 3.1**). The analysis done by the groups and the subsequent recommendations are presented below in the boxes. After reviewing the groups' suggested recommendations to each NGO to increase their efforts, the analysis of the case studies using the above criteria was presented by the following rapporteur;

- Rapporteur for Group A & B : Dr. Tanveer Sheikh of HANDS
- Rapporteur for Group C & D : Dr. Zahra Qureshi of Pak-CDP
- Rapporteur for Group E & F : Dr. M. Ashraf of APPNA-Sehat

- Rapporteur for Group G & H : Ms. Bushra Kazmi of OPD

Box 3.1: SMART Criteria

Specific:	The objective should measure one thing, such as one behavior or one key point of knowledge
Measurable:	The objective should be verifiable by independent observers. that is different observers should arrive at the same conclusion when measuring progress against the objective
Appropriate:	The objective should be technically correct and describe an aspect of the intervention whose success will have significant consequences
Realistic:	The target set by the objective should be something which can be reasonably accomplished through program efforts
Time-limited:	The objective should clearly state the period within which the objective is to be accomplished.

Evaluations of these NGO case studies using the SMART criteria were:

Objectives	Communication Strategy
Program Design	Training
Program Strategy	Service Delivery
Supervision & Evaluation	Referrals and Follow-ups, Organizational Capacity & Susta.

The major recommendations that emerged from the case study analysis review is given below:

3.4.1 Case Study # 1 (Group A and B)

Background of Project

The program was originally established more than seven years ago as a model pilot project to serve Afghan refugees. Approximately three years ago, the NGO expanded its coverage to include the Pakistani population living in its project areas. The NGO currently provides curative and preventive health services to a total population of 70,000. Services are provided from four health clinics and two sub centers, with outreach through LHVs and community volunteers.

The NGO runs four health clinics. Each health clinic has one male doctor and one female doctor who spend alternate days at each clinic. There are also two LHVs and a trained TBA at each clinic. The clinics, however, do not have labor room facilities. The NGO has a four person training unit lead by an experienced female doctor.

The NGO uses visual health education aides and charts in Urdu and Pushto to discuss hygiene, child nutrition, healthy Breast-feeding practices, polio, tuberculosis and malaria prevention. The materials on Breast-feeding have been pre-tested with women from the local community. Over the past year, the NGO's staff has received training in the use of participatory methodologies.

The first level of care within the framework of this NGO's program is the male community health supervisor, who is available in the community 24 hours a day and is well-known by everyone in the community. He is supported by community volunteers, female volunteers, female community health workers and the traditional birth attendant (TBA). The NGO has also trained TBAs from the community, and assists them in conducting home deliveries. Recently the organization has strengthened its community outreach services by organizing women's support groups in several communities where women are provided counseling on Breast-feeding, maternal nutrition, and child health issues. The support groups are supervised by the LHVs who travels regularly to meet with women in each community as part of the support group monitoring process. The NGO's clinic-based health program provides ante-and post-natal services and family planning services, runs EPI and nutritional rehabilitation programs, and conducts IEC activities through home visits and a school program.

Analysis of Case Studies:

- ❑ The community is not involved in the monitoring or supervision aspects of the program. The community pays to the TBAs directly. The Community, Health Supervisors, TBAs, and volunteer's involved from the community, involved in the process of support group.
- ❑ They have a male community health supervisor, who is present in the community, 24-hours a day.
- ❑ The NGO staff has been trained in participatory approaches. They have education charts/aids but are not really using them with mothers. They have communication with mothers through home visits and have initiated support groups.
- ❑ The NGO has a program strategy to provide curative and preventive strategies. The community was not involved in the monitoring and supervision of the NGO program; Process indicators were not defined; process indicators need to be developed and included in the evaluation design; the community pays the TBAs but other staff members are yet to get their salaries from the NGO; no user charges have been mentioned; and there is no clear idea of the sustainable issues. Communication strategies are health education through clinics and support groups- recently initiated through male supervisors, TBAs, and community volunteers who are involved in the program: They do not have an ongoing process of community participation, however, they have recently received the training in participation methodologies and are trying to strengthen out-reach services through mother's support groups.

Recommendations

The NGO should not go into the community with pre-determined objectives. More community participation is needed in the design, implementation and evaluation: more volunteerism is required as that will make the program more sustainable. More work is required in the community organization for the development of CBOs, female groups, etc. The basic literacy program is not clear, that needs to be developed. The IEC part needs to be developed with more community participation. Water and sanitation programs need to be developed. User charges need to be introduced in order to make the program more sustainable. More staff training needed.

Discussions – Issues Raised

- To empower the community, ask the community as to what their needs are, and then empower them accordingly.
- In order to use MMR as an indicator, a large segment of the population is needed, and is therefore not a good indicator for small projects
- Regarding the question of sustainability, there was no clear indicator to measure this. The question raised was; What exactly does this term imply? Does it mean money or the holistic approach, the strategy, staff, ability to generate funds or acceptance by the community.
- Did the group look at the interventions? Were they effective and workable? The group did not mention the details. The NGO was working in ante natal and post natal categories, but not the whole reproductive health. If there was no maternal mortality in 2000 cases of deliveries and no hemorrhage, that was considered good.
- Hemorrhage was in fact a rare event, and a very large segment of the population would have to suffer from it if this factor is to be considered. Most of the time, pre-determined objectives help the community in the identification of the identification of their needs. As long as the NGO is open and receptive, pre-determined objectives are not negative/determining factor.
- In an ideal partnership, the NGOs should not go to communities with pre-determined objectives. Instead, they should ask them their needs first using the needs analysis techniques.
- If the community requests an intervention which is not the priority of the NGO, what steps should be taken? The advice was to start with finding out the needs, and then go on to satisfy the wants. In order to work with communities, the use of the PRA techniques was advised.

3.4.2 Case Study # 2 (Group C and D)

Background of Project

The NGO started about a decade ago as a project for refugees, but four years ago expanded its activities to cater to the local population. The NGO has developed an expertise in water

and sanitation but in the past two years has been expanding its activities to include primary health care. Overall, the NGO works with several dozen communities in 7 districts. The case study focuses on the NGO's program in 10 villages in 4 districts, which is representative of the organization's general program strategy and approach. The NGO has a total staff of 42, including a director and various administrative staff at the central office.

Some of the specific objectives for the NGO's work in these communities are to equip CBOs to implement and sustain development within their community by undertaking a sanitation, hygiene and water supply project. NGOs must also assist CBOs to construct 50 PF latrines and install 20 hand-pumps in schools located within the target communities and to assist 5 CBOs to implement female literacy programs within their communities.

The main focus of this NGO's program is on its collaboration with the existing CBO(s) in each village. Training is provided to representatives from the community, and in return the NGO emphasizes the importance of the community sharing in the cost of the implementation. Areas of training include how to manage and implement development programs; latrine construction and the installation of hand pumps; and, health education and literacy especially for women. The NGO also works with the CBO and community members to motivate behavioral and social change, and promote the formation of women's organizations.

The NGO's LHV's provide information and guidance on prenatal and natal health issues.

Analysis of Case Studies:

- Initially, the participation was negligible, and there was no input from the community. However, as the work evolved the NGO listened to the views of the community, and participation increased, resulting in the NGO having to revise its strategy by bringing in the elements of PHC.
- No real indicators were developed to monitor interaction. This was a weakness of the program and the NGOs. There was minimal involvement of men in the family planning aspect of the program, but the NGO plan to involve men more in the future.
- In reviewing the objectives, the NGO it did not come up with the SMART criteria because there were no inbuilt measures.
- The process of designing has not been mentioned. Initially it was NGO-driven, but the objectives changed along with time.
- There was no coherence in the program strategy; this partially contributed to achieving the objectives. There were different components of the strategy; it was felt that the communication strategy was partially achieved. The training strategy was coherent. The service delivery was not up to par, and the follow-up was absent except in the family planning section. There was no supervision at all and neither was there any system for evaluation. The NGO had the capacity and flexibility to respond to people in the community.
- The activity at the level of the community was sustainable, however sustainability was missing at the organizational level. It lacked structure, process, and systems.

Recommendations

The NGO was making a good effort in the education, awareness, mobilization in sanitation and water programs. However, it needed to specify objectives more clearly. The supervision and management system was also weak; more male involvement was needed at the community level. There was a need by the service delivery to have a referral chain. A basic emergency system should be developed with stronger links with the GoP institutions working in the area. Cost sharing should be introduced.

Discussions – Issues Raised

- ❑ If the service delivery is not coherent it means that the strategy has to be clearer.
- ❑ NGOs should not be criticized, rather the efforts being made by NGOs should be acknowledged.
- ❑ There is no NGO that has been working in all the eight aspects of the primary health care as declared in the Alma-Ata declaration. Most of them work in the areas of water, sanitation and, health, education etc.

3.4.3 Case Study # 3 (Group E & F)

Background of the Project

Maternal mortality rates were difficult to assess due to the absence of a vital registration system. The project predicted that maternal mortality could be as high as 800 to 1000 for every 100,000 live births.

Training is a major component of the project. A three-day workshop for master trainers will be conducted in the near future through an NGO teaching hospital. At the community level, the project is working with the Prime Minister's Program for PHC and FP, to provide supervision and supplemental training to the LHWs, with the emphasis on identifying and referring high risk obstetric cases to referral facilities, and engaging in community organizing and empowerment.

A supervisory committee of experts, including members of the NGO, members of the government collaborating departments, and select staff from donor agencies, is responsible for regular monitoring the project. The evaluation missions will be conducted by management and health specialists from the head office of the organization. The multilateral donors will also conduct monitoring and evaluation activities, as per their own guidelines.

Analysis of Case Studies:

- ❑ The strengths included the level of coordination and cooperation with the GoP; the utilization of existing GoP facilities; community involvement; the epidemiology survey being completed; and focus on training.

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- The weaknesses noted were that the budgets were not very clear. The total size of resources were not clear; the baseline was not available; there was no refresher or follow-ups training; training for doctors and LHVs was not clear; bench mark of knowledge was missing. Apparently, there were no CBOs in the project and it was developing outreach links through the Prime Minister's Program for PHC and family planning. Though the project has a good program strategy and is a model of public/NGO partnership, however, the sustainability issue for program continuity was questioned. The model is a pilot project heavily funded by donors, and being implemented by an international NGO.

Recommendations:

The system between the GoP and the NGO should not be informal; a system should be developed; the objectives should be specific; SMART criteria should be used.

Discussions – Issues Raised

- The community's concerns, the magnitude of the problem, the feasibility to manage the resources, and manpower are all factors that should be taken into account by the NGOs.
- Community Health Workers should motivate the people to use the GoP facilities.
- The question to be asked by all NGOs is that are the interventions suited to meet the objectives?

3.4.4 Case Study #4 (Group G & H)

Background of Project

The NGO was founded 17 years ago by a physician, with the aim to create awareness in disadvantaged communities on different health issues. In the initial stages, interventions were largely focused on improving child health. Over the years, the organization's focus has grown to include provision of primary health care services to women as well as children, and also to strengthen the community's capacity to solve its own problems in health, education, and water/sanitation.

The NGO's overall mission is "the provision of basic health and education services for the under privileged communities, and grooming the communities till they are empowered and independent in most of their daily needs". The NGO's specific objective is to improve the health status of women and children .

The implementation methodology of the NGO is to provide health services through mobile teams which visit each village catchment. Each team is comprised of a doctor, an LHV, and three CHWs. The NGO had developed a set criteria for selecting villages and initiating activities: the prospective community has to have, or be willing to form, a CBO and the community has to be interested in starting a health center and a school. In addition, the community has to agree to be responsible for providing the space for these activities and

nominate male and female volunteers who will be trained as CHWs. Since CHWs are expected to be literate, most of the female CHWs are teenage girls.

The MCH center is the site of the weekly clinic attended by the mobile team and the local CHWs. Clients are charged Rs.5 per visit. The organization is trying to connect with a teaching hospital located 22 kilometers from one of the catchment areas to create links for referrals. Family Planning services are provided in coordination with a national family planning service delivery NGO. Training is a major activity of this NGO. CHWs participate in a 3-month training course when they join. Doctors and LHVs working for the NGO receive periodic in-service training to upgrade their skills, and linkages and contractual arrangements have been made with other NGOs to train their staff. The staff have monthly and quarterly meetings.

Analysis of Case Studies:

- The community is not involved in the program design, evaluation and monitoring. There is no community role in supervision.
- There are too many interventions; these should be decreased so that they can concentrate more on the specifics. These interventions can be implemented in a more effective manner.
- There is no male participation; no training is being imparted to them as regards female health.
- There are no communication strategies. The mother-in-law and the male members should be involved so that the same message can be advocated more effectively; religious and male leaders should be involved in meetings of the CBOs .
- This aspect had been integrated in the program but it was not complete. It was carried out through support groups. More was needed.
- The program is too ambitious; the NGO should proceed step by step. The strategy for the provision of child health services is through mobile clinics.
- The strategy was too broad and it was difficult to determine how flexible is the organizational strategy.
- The objectives are not specified, in response to community needs. There is no coherent strategy.
- There are no reliable reports. The community should supervise at the NGO level and the community level.
- The indicators were missing. There is no time-frame regarding the objectives.
- The program is going to be sustainable as long as the NGO is there. The community cannot handle the program by itself as it has not been involved in it from the very beginning.

Recommendation

The objectives should be time bound. Efforts should be utilized in particular areas: selection of CHWs should be realistic as they are hired at too young an age; good supervision system is needed; the involvement of males is very important to support females, they should be by the side of the females; the maintenance of the records should be kept.

Discussions - Issues Raised:

- ❑ The NGO should not be too ambitious in the parameters of its program. The program design should be efficient and effective.
- ❑ The NGO should be very critical of the guidelines formulated. If it has not started the program by involving the community, it should look into involving them at a later stage.
- ❑ As the NGO is going through a process of evolution, it's members should look at the aspect of community participation, and ensure its inclusion in their program.

3.5 Summary of Lessons Learnt-Day 11

- ❑ Data from community based studies of urban slums in Karachi shows that the rate of induced abortions is high, which is an indicator of unwanted pregnancies. Women opt for abortions because the failure of contraception is high.
- ❑ In a study gathered from family planning clinics seeking help for abortion, the failure of contraceptive method was cited the main reason. It was suggested that the scope of family planning clinics should be widened and expanded into RH clinics.
- ❑ Social marketing needs to be adopted as a policy by government and NGOs if they want to focus on behavioral intervention for health and nutrition programs.
- ❑ Health Networks under PNI are collaborating with the NGO intervention on breast feeding promotion, and is being used as an entry point to establish support groups for women. The training packages are developed introducing individual, peer, and group counseling to improve the health and nutrition status of women and children.
- ❑ NGOs need to develop clear objectives and specific intervention strategies through which they can achieve their goals.
- ❑ The NGOs' Programs/Intervention are too broad. Indicators do not reflect the scope of the interventions they are involved in. From a program design and implementation perspectives, a source of the constraints can be found in the unclear strategies, poor indicators to measure behavior change, poor counselling, and lack of information about RHS. The NGOs also face budgetary and human resource limitations, weak management and logistics, and dependance on donor funds.

4. INTEGRATION OF REPRODUCTIVE HEALTH ACTIVITIES INTO THE NGO/GOP PROGRAM

4.2. Group Work

The NGOs were asked to reflect on their own individual programmes. Based on their own presentations of the last two days, they were asked to come up with ideas to integrate/link RH activities into their own programmes. After this, the NGOs were divided into five groups as follows:

1. first as NGOs and then
2. according to region -- Punjab, Sindh, Balochistan, North West Frontier Province & National.

The NGOs were advised by the organizers to look at their program strategy, the objectives, and their activities. Based on learning from the last two days the groups discussed the global lessons, ideas to clarify objectives, and prioritize interventions for their own programs, and to come up with ideas for a viable strategy to implement RH interventions. The questions to be addressed are as follows;

3. Can formative research /development of IEC strategies lead to behavior change ?
4. Is the concept of community participation there? where is it, and should/could NGOs engage more?

The focus was on how reproductive health interventions can be designed and integrated into the on-going health programs. The groups were asked to present proposed steps. Recommendations were to be addressed to NGOs, Donors and the GoP. They were then asked to present the key suggestions to the larger group.

4.2. National and Provincial Program Recommendations Made by the Groups

All participants expressed their thanks to TAF and MotherCare for providing them with the opportunity to meet with each other, discuss issues, and look for solutions. Rapporteur from various groups presented the following recommendations.

4.2.1 Sindh

The following key findings on Sindh were presented by Dr. Mohammad Saleem. The Sindh group includes the following organizations:

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- NGOs:
 - Karachi Reproductive Health Project;
 - Health and Nutrition Development Society (HANDS);
 - Thardeep Rural Development Program;
 - The Private Sector :
 - Liaqat National Hospital; and
 - Baqai Hospital.

They all had their own focus areas of work, but liaised with the GoP health facilities to provide a number of services. These services include registration, natal and antenatal services, pre-natal services to pregnant women including obstetric emergency care, the EPI program, family planning services and nutrition prescriptions for anemia, breast feeding, and the provision of micro nutrient substitutes. Training and health education courses were also conducted, including the monitoring and evaluation of programs.

The main objectives were primarily to reduce maternal mortality and morbidity. The sub-objectives were the provision of adequate MCH services, family planning services, the prevention of sexually transmitted diseases, and infertility management.

The organizational set-up of health service delivery was desired. There were many constraints faced by the health providers, such as chronic absenteeism of staff members, a non functioning referral system, shortage of drugs, shortage of contraceptives and supplies, and the in-appropriate allocation of resources.

The difficulties which contribute in many ways to the high maternal mortality and morbidity in Pakistan were listed. These include the 'Vadera' system, the over powering influence of the social taboos and superstitious beliefs, and the improper transport system.

The recommendations emphasized collaboration and networking between the NGOs, the GoP health department, and the private hospitals. The need to device and define a referral system with the help of the NGOs was also emphasized.

Summary of Discussions

- The GoP provides extensive health coverage through its health facilities located in all parts of the country. But because of this very factor, it cannot provide efficient service.
- How can NGOs help the GoP? There are ways for them to collaborate. They should begin by recognizing each other's needs, strengths, and weaknesses. There should be coordination meetings between the NGOs and GoP, and district technical committees composed of representatives of the GoP and the NGOs should meet regularly.

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- ❑ Field Health Workers were previously not charging for contraceptives. The result was that as they were not adequately paid, resulting in inefficiency. Recently, this has been changed, and they are being allowed to charge for them.
 - ❑ GoP officials are not paid good wages, which leads to in-controllable corruption.
 - ❑ Referrals often do not have staff or supplies. However, district hospitals are better equipped and staffed since they have key people who are trained. It is the individuals who make the difference.

4.2.2 Punjab

The following is a synopsis of the presentation by Dr. Shaheena Manzoor.

There were a number of constraints faced by the GoP, as well as the NGOs in the province of Punjab. The reasons for these are manifold and were listed by the presenter.

The NGOs list of constraints included lack of finances, non-realistic or too ambitious objectives, un-availability of baseline data, poor referral, improper evaluation, and a lack of communication between the NGOs and the community. The reasons for these were donor dependence and the non existence of fund raising schemes, involvement of non-technical decision makers, non-availability of analysts, and the lack of interpersonal communication skills.

Constraints for the GoP policy point to an unfocussed and inappropriate allocation of resources, non-functional referral, and weak monitoring and supervision. The reasons for the constraints were listed as low resources (only 1% of the total GNP of Pakistan is allocated for health), service delivery at unsuitable locations, lack of incentives, and untrained supervisors.

Recommendations were elaborated upon for both the NGOs and the GoP. These were as follows:

- ❑ For NGOs
 - fund raising schemes;
 - Objectives to be more specific; and
 - Appropriate training strategies developed.
- ❑ For the GoP
 - Appropriate policies;
 - Adequate implementation;
 - Accurate evaluation.

Summary of Discussions

- ❑ The problem with the data on MMR is that it is not reliable. However, the effort must continue to attempt to lower the MMR. It is time to begin implementation, instead of continuing to conduct surveys.
- ❑ The community is not considered to be an integral part of the programs. Their involvement should be considered seriously by the GoP and NGOs, and their views as expressed in the district coordination committees and district health authorities, should be taken into consideration.
- ❑ Health facilities in the private sector, and those run by NGOs, play a vital part in the service of the people. Without their contribution, the GoP facilities would be overburdened.

4.2.3 North West Frontier Province

The presentation for the above province was made by Dr. Rehana Hashmi from SPO.

The NGOs with a comparatively better Reproductive Health System were listed as APPNA SEHAT, F.P.H.C., S.P.O., and the SUNGI Dev. Foundation. Their main activities included providing primary health care services, education, preventive, promotive, creative and reproductive health, capacity building to empower female and male groups, advocacy, education and social mobilization, and providing information on sexually transmitted diseases.

Recommendations were made for the NGOs, GOP, as well as donors. NGOs were advised to have strong links with each other, avoid overlapping, and advocate reproductive health. It was felt that the GoP should have a health policy on reproductive health, consult the NGOs for identifying the local resources, include the NGOs on the steering committees with gender balance, equip the BHUs and RHCs, and provide comprehensive training to upgrade the skills of the health workers. Donors in this field were recommended to have better coordination amongst each other so as to avoid overlapping, include reproductive health in their programs, influence the GoP to recognize that the NGOs support long term programs and long term commitment, and support documentation.

Summary of Discussion

- ❑ There is enough data available on Pakistan's social, cultural, and health issues. We are now at the stage where we should be looking for solutions. The objective is to be realistic, since donor support is not long-term. Instead, we should be looking for ways to enable the programs to sustain themselves.
- ❑ NGOs are catalysts in the process of change, but like all catalysts, they require time to bring about that change. Unlike the GoP which has been on the scene for the last 50 years, NGOs are new.

4.2.4 Balochistan

The presentation on the province of Balochistan was made by Dr. Munazza Harris.

The common needs in Balochistan were listed as resource distribution and utilization, expansion in family planning services, the referral system, training and skill development of medical and paramedical staff, and incentives and research. The activities of the NGOs included training, links, and water and sanitation. The GoP's activities included strengthening the gynae/obstetrics/paeds departments, training the under-graduate medical and para-medical staff, running MCH centers, and training for production of the IEC materials.

The recommendations included: training regarding IEC, and personnel recruited from the local communities; adequate allocation of resources for the MCH services at the doorstep of people from remote areas; collaboration between the NGOs and the GoP departments; strengthening the referral system; and security and residential facilities for the female staff.

Summary of Discussion

- Training should be further highlighted. Training of undergraduates, as well as in-service training of health care providers in reproductive health, should be emphasized; and
- Training methodologies need to be reviewed.

4.2.5 National

The National group was represented by Dr. M.S. Lashari from T.V.O.

A list of the national organizations were listed, along with their scope of work. These included the Trust for Voluntary Organizations, the Population Council, the Family Planning Association of Pakistan, the Small projects Office, PAVHNA, and SMP. Overall, their scope of work included funding, research, IEC development, supplying contraceptives, addressing issues of quality of care, capacity building, and networking.

The future strategies of these national NGOs were listed. Amongst these were funding more projects for reproductive health and training, research on demand, expanding the scope of the referral system, training medics and paramedics in management, the developing IEC materials, increasing the training for maternal health, and provide services through the NGOs.

The recommendations of the national group for the NGOs included sharing the IEC material, improving the referral network, and experience sharing through seminars and workshops. For the GoP, the advice was to cultivate political commitment, utilize mass media to support the program, and remove policy barriers. For donors, it was recommended that they provide sufficient funds and technical services, and have a clear understanding of the RTIs and STDs.

Summary of Discussions

- Although the problems and their solutions have been aired, there still remains a feeling of helplessness.
- The country should attempt to follow the model of a village, in which everyone makes their particular contribution. The next step to join hands, find out the resources, the problems, the solutions, and implement change.
- Those plans that can be effective immediately should be implemented first, and then the medium and long term plans.

4.3 Major Trends and Gaps: Summary by Mary Ellen, Judith Standley, and Richard Pollard

Ms. Mary Ellen: There is a need for community participation, and not only in the design of the programs, but also in their monitoring and evaluation. Male involvement in the health care services and education needs to be built into the programming. More specifically, communication strategies should be thought out. More coherent strategies are needed, like linking interventions with the possibility of referral. If, however, there is no referral available, the NGOs administer iron tablets, and spread awareness in the communities regarding clean births. There is much talk of referrals, and private practitioners can also be considered a possibility. Supervision and monitoring means more than just collecting data, they also mean identifying needs and reinforcements. The geographic focus is also an important issue in the cases where the communities do not want health interventions, and the NGOs can keep the dialogue open by trying to find out what the communities feel they need. Overall, it should be kept in mind that organizations are a process of change and response to the community they are serving.

Judith Standley: Community participation is important not only in the activity phase, but also in the design, monitoring, and evaluation stages.

With regard to monitoring and evaluation, using indicators to look at just outputs is not enough. With regards to the quality of care, there are ways to turn qualitative indicators into quantitative measures. How to provide services to men, and how to address their concerns more specifically should be thought out by NGOs. It is better to start the design of the programmes by stating at the outset that the main objective is to change behaviors, rather than start with a biomedical intervention. It was advised that efforts be made to collect the community's KAP before planning for service delivery.

Richard Pollard: To develop marketing strategies from the Social Marketing viewpoint, the following guidelines were suggested:

Try not to plan the program based on a service delivery model and then ask IEC people to come up with messages and materials to support it.

Think of the program from the outset using the viewpoint of its behavioural change objectives. For instance, what behaviors does the program want to change, and whose behaviors does it target?

What this means is that behaviors cannot be changed until the existing behaviors are known. Consequently, formative research study needs to be undertaken before the design stage of the program and helps to probe into the requirements the program is designed to address. The research should be able unearth all sorts of interesting inputs on the nature and character of what the program is all about, including its service delivery aspects.

Only after this in-depth qualitative study has been done can the programmes' strategies be developed in detail. A quantitative baseline is then conducted which should indicate what the present KAPs are of each of the target audiences to the behavioural actions that the program is trying to promote. Quantitative objectives can be set from this baseline that can track the progress of the program. This means that we are not just tracking how much service delivery was performed, but how much the KAPs have changed.

4.4 Closing Ceremony and Concluding Remarks

Mr. Eric Jensen, the representative for TAF Pakistan, said that the heart rendering Punjabi poem written and delivered by Imtiaz Kamal was a befitting start to the workshop. The emotion in it needs to be duplicated. Policy makers need to visualize the suffering of the women. The question still remains as to what can be done to alleviate the suffering. All those present at the workshop are trying to make a difference in their own way. TAF's agenda is based on the information gathered locally from Pakistanis that indicates the need for education, reproductive health, roads, and clean drinking water.

Bringing the planning phase to the action phase requires mobilization at the macro level. There is also a need to involve the communities, harness civil society, and listen to each other. Reproductive health is also a serious governance issue. However, there is no incentive for public officers to act in the public's interest. There is a need for incentives, such as adequate salaries, transparent benefits, performance-based promotions, and merit-based recruitment.

Any discussions regarding NGOs always involves the funding aspect. From 1990, very little or no endowment will be available. Therefore the aim should be to achieve self-sufficiency and build capacity. Human Resources Development protocol needs to be thought through, because NGOs are not as effective as they could be. It is the same with the GoP. Relations between the GoP the NGO and the private sector need to be systematically thought out and addressed.

Ms. Judith Standley, the representative for MotherCare, felt that the case studies by the groups at the workshops revealed a constellation of services from the macro to the micro level. She advised the participants to go back to their offices, and take a close look at what they had presented, whether they thought it made sense, and was it effective?

Tetanus toxoid, inoculations, iron, clean birth are the basic requirements for maternal health. The husband and the in-laws should be ready to move the mother to the nearest health facility, if required. The ante-natal and peri-natal periods require special care. The quality for care issue can be measured using the number of people trained. The aim should be to back the support worker. We should go, observe, talk with the communities' members, and in this way improve the programs at the grass roots' level.

Regarding referred, much more networking is required, and possible. To improve the public and private health sectors, a social marketing strategy may be required to make the best use of them. It was suggested that the strategies be brain stormed, and then implemented. The problems and the shortcomings were known to all those working in the field, the idea was to think of ways to overcome them. NGOs were welcome to seek the advice of TAF, and MotherCare who would be most happy to help them work towards solutions.

Rushna Ravji, MSU, World Bank, said that she was most impressed by what she had heard both from the GoP and the NGO representatives at the workshop. The facts presented were very real, and the problems so clear. The collaboration between the Government and the NGOs needs to be strengthened. The presence of the NGOs is needed because they are flexible and available, and the government provides the basic services. Consequently, there has to be a joint effort between the two to ensure the greatest productivity.

The SAP's role is to bring the NGOs and the GoP closer together by collaborative means through the participating development programs (PDP) funds. It was the first time that many donors had come together through the SAP. There was the need to indicate the objectives of the programmes so that the donors how their funds would be utilized. It was also the first time that the government had come up with a clearly defined strategy and sectoral policy, as well as direction at the institutional level, the grass roots level, and the service delivery level. Ms. Ravji concluded her address by inviting the NGOs to apply for the SAP/PDP funds.

4.5 Evaluation of the Workshop

Participants were asked to fill charts to evaluate the workshop. Mr. Mark Reade McKenna shared the overall feedback from the participants with the group (table -8 evaluation results).

While the process and outcome of the case study exercise was interesting, participant reaction was mixed. When asked during the evaluation if the objective 'using case studies to critically analyze projects' was met, sixteen people responded in the affirmative, while five felt the objective was not met. The suggestions put forward included giving more time to the activity, and having the project members write their own case study. Those individuals working on the case studies felt that the questions should have been less inclusive, perhaps by using one case study only and dividing the questions among the different groups, or using 4-case studies but asking participants to look at one aspect of the program. The case studies themselves should have had more information in key areas.

4.6 Vote of Thanks

Ms. Khawaja thanked the audience for their enthusiastic participation in the workshop, specially TAF/USAID and MotherCare Washington, for providing technical, financial, and logistical support for State of the Art Workshop.

4.7 Conclusion

- ❑ The workshop was claimed successful in terms of participation, as a hundred representatives from the NGOs, the GOP, and the Private Sector were present.
- ❑ It was an opportunity to bring together National and Provincial Government Colleagues, as well as donors. In a way, it created the opportunity to begin the Pakistan NGO Health Network.
- ❑ The major objectives of the workshop were achieved, and the findings presented were from the Global Lessons Learnt of Safe Motherhood Interventions, to sharing with the on-going interventions and studies in the country from the GOP, the NGOs, the private, and social sectors.
- ❑ Through presentations and case study analysis, participants were familiarized with the historical evolution of Reproductive Health, the problems of maternal mortality and its causes (Global/Pakistan situation), effective program strategies, successful interventions, and recommendations on how to improve their own programs.
- ❑ Social Marketing needs to be adopted as a policy measure by the government and NGOs while designing behavioral interventions for other reproductive health, primary education, and credit programs.
- ❑ NGOs can and should play an active role in devising community based interventions to affect cultural and social barriers, look at transport systems, and devise referral systems with the help of the government and the private sector.
- ❑ NGOs need continued local technical assistance and funding to improve the design and implementation of their health programs.
- ❑ One of the suggestions was that the Reproductive Health Network, organized by TAF, the NGOs, the government, and the private sector, needs to continue through collaborative efforts, and sharing lessons with each other as the program is implemented in other key areas of Reproductive Health in Pakistan.

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MSU	The World Bank, Shahr-e-Jamhuriat, Islamabad	Tel:819781	Dr. Rushna Ravji Dr. Sirajul-Haq (AIDAB) Mr Tauseef Ahmed (ADB)
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Participant List

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Annexure B: Agenda of the Workshop

**State of the Art Workshop
Reproductive and Newborn Health
Islamabad, Pakistan
October 27-29, 1997**

AGENDA

**Inaugural Session
Sunday, 26th October**

- | | |
|------|--|
| 1900 | Registration |
| 1930 | Welcome Address, Erik Jensen, Representative, The Asia Foundation |
| 1940 | Self Introductions |
| 2015 | Presentation: Excerpt from the video, "Mamta Ki Hifazat"
Followed by Dinner |

Monday, 27th October

Day 1

- | | | |
|------|-------------------------------|---|
| 0900 | Mrs. Imtiaz Kamal, NCMH | Opening Statement |
| 0905 | Mr. Mark Reade McKenna, TAF | Introduction/Objectives of the Workshop |
| 0915 | Ms. Mary Ellen Stanton, USAID | Reproductive and Newborn Health: Global Perspectives
and Lessons We are Learning |

0940 Discussion and Questions

Moderator— Mrs. Imtiaz Kamal

- | | | |
|------|---|---|
| 1000 | Ms. Shahida Fazil, UNFPA | ICPD Cairo: Reproductive Health Policy Issues in
Pakistan |
| 1100 | Dr. Sadiqa Jaffrey, NCMH
(Presented by Fariyal Fikree) | The Reproductive Health Situation in Pakistan: Review
of Current Health Data |
| 1120 | Tea Break | |

1130 Dr. Mubashar Riaz Sheikh, MOH The Ministry of Health's Reproductive Health Program:
A Review of Recent Initiatives

1200 Dr. Naushaba Chaudhry Expansion of MOPW Programs: Integrating
Reproductive Health Care Services

1215 Discussion and Questions Moderator — Dr. Zeba Sathar

1230 Lunch Break

1315 Group Activity Current Involvement of NGOs in Reproductive Health

1345 Group Presentations On Reproductive Health Care Service/Activities in
Pakistan

1400 Dr. Anwar Aqil, TAF Male Involvement in Reproductive Health Programs

1415 Mrs. Imtiaz Kamal An Update on the South Asia Regional Safe Motherhood
Meeting in Sri Lanka

1430 Group Activity

The Role of Communications and Social Marketing in Reproductive Health Care.

1500 Dr. Fariyal Fikree, AKU Safe Motherhood Intervention Study

1520 Dr. Sara Jamil, AKU Qualitative Study on Abortions

1540 Ms. Carol Squire, PSI/SMP The Green Star Clinics: An Evaluative Response

1600 Discussions & Questions Moderator — Mr. Mark Reade McKenna

1630 Tea Break

1645 Ms. Judith Standley Introduction to case study methodology

1030 Tea Break

1045 Group Work: Participants, grouped geographically, together identify areas of common need, as well as areas where the needs of each organization may be different. Prepare group presentations.

Group 1 Programs with a National Scope
Group 2 Programs working in Balochistan
Group 3 Programs working in Punjab
Group 4 Programs working in NWFP
Group 5 Programs working in Sindh

1230 Lunch Break

1330 Group Presentations

1445 Tea Break

1500 Mr. Erik Jensen

Priority Areas of Need: Recommendations that Emerge for GOP and Donors

1530 Discussion of Recommendations Moderator— Ms. Judith Standley

1600 Mr. Mark Reade McKenna

Evaluation of Workshop

1630 Ms. Naveeda Khawaja

Resolution/Vote of Thanks

Note : The following poster exhibitions will be on display during the workshop:

1. Sexual Health Project Karachi by Ms Shaista Siddiqui
2. Breastfeeding Promotion/IEC: GOP/MC/TAF and Behavioral Research Maternal Nutrition/Child Feeding/Pregnancy Related Care
3. Promotion of Iodized Salt-SMP and Green Star Clinic Network Pilot Project--Social Marketing Pakistan, SMP
4. SEC-RT Sexual Health Project Bombay, Sabiha Syed of Family Planning Association of Pakistan
5. The Model Clinic Approach to Integrated RH Care, Shamim Najmi of Family Planning Association of Pakistan
6. Safe Motherhood intervention Study -Korangi
7. Abortion Study in Karachi's Squatter Settlements

Annexure C: Evaluation Framework of Workshop

WORKSHOP EVALUATION

	WELL MET	MET	NOT MET	COMMENTS
I. OBJECTIVES: Do you feel the workshop has met the following objectives:				
1. Participants are familiar with current trends & issues in Reproductive Health				
* Have knowledge of global Reproductive Health situation				
* Can identify major issues in Reproductive Health in Pakistan				
2. Participants are able to critically analyze Reproductive Health projects using the Case Study Methodology				
3. Participants are able to identify successful Reproductive Health strategies & design interventions for improving reproductive health				

of

WORKSHOP EVALUATION

	EXCELLENT	ADEQUATE	NEEDS IMPROVEMENT	SUGGESTIONS
<u>II. ACTIVITIES</u>				
1. Presentations (Please give specific suggestions where indicated)				
2. Case study approach				
3. Self assesment of participants own program				
4. Poster exhibitions				
5. Workshop material				

WORKSHOP EVALUATION

	EXCELLENT	ADEQUATE	NEEDS IMPROVEMENT	SUGGESTIONS
III. LOGISTICS				
1. Invitations				
* Recieved on time				
* Clarity of Workshop Objectives				
* Clear instructions				
2. Lodging				
3. Food				
4. Workshop facilities				

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**Annexure D: Reproductive Health: The Global
Perspective**

REPRODUCTIVE HEALTH - THE GLOBAL PERSPECTIVE

WHAT WE KNOW AND WHAT WE ARE LEARNING

Judith Standley, MotherCare
Mary Ellen Stanton, USAID
October 27, 1997

It is a pleasure to be here with you today, and to be part of this workshop. Whether you represent an NGO partner in the Pakistan NGO Initiative (PNI), the Pakistan government, or a donor organization, we are here with a common purpose: to discuss reproductive health issues--and in particular, maternal health--to review approaches in providing services, and to identify effective interventions within the Pakistani context.

Where has the concept of "reproductive health" come from? Over the past thirty years, a variety of approaches has been promoted. Experience, research, politics, and socio-economic realities have all influenced these trends.

EVOLUTION OF REPRODUCTIVE HEALTH

Reacting to the divergence in health status and care accessibility between rich and poor nations and between rich and poor within developing countries, the UN-sponsored International Conference on Primary Health Care meeting in Alma Alta in 1978 coined the slogan "Health for All by the Year 2000." Primary health care (PHC) was promoted as the model for improving health indices for women and children. The primary health care concept decentralized care--from expensive tertiary centers serving a small minority of people to the creation of health centers in communities--and brought services closer to the people. PHC includes maternal child health and family planning interventions, and looks at the "whole" person in the family context. While this approach was promising, reductions in maternal mortality were not seen. Also, child health advocates were not happy. They felt the PHC approach was too broad and that a few targeted interventions (immunization, breastfeeding, oral rehydration therapy, growth monitoring) could more effectively reduce under five mortality. This is when the "child survival revolution" was launched.

Participants in the Safe Motherhood conference in Nairobi in 1987 were shocked at the continuing high rates of maternal mortality in the developing world and, asking "where is the 'M' in MCH," initiated the Safe Motherhood Initiative (SMI). Emphasis was placed on training traditional birth attendants (TBAs) in hygienic birth practices, providing antenatal care, and providing contraceptives. Yet, five years later WHO found the same high levels of maternal mortality.

In 1994, the participants at the Cairo International Conference on Population and Development (ICPD) recognized the complexity of factors influencing health and well-being, and institutionalized the term "reproductive health." As understood at Cairo, reproductive health is an inclusive and broad concept. It not only deals with the biomedical needs of women (and men) during their reproductive years, but also the social and political realities of life that influence women's health status and well-being. Empowering women (and ultimately men, as well), by reversing gender bias and providing equal access to education and to a wide range of reproductive health services, is the promise of ICPD. The conference affirmed that reproductive health care is an integral component of primary health care and should be provided in that context.

Reproductive health care includes, at the very minimum, prevention and management of reproductive tract infections (RTIs); family planning information and services that permit people to choose the timing, spacing and number of their children; and Safe Motherhood services to assist women to go safely through pregnancy and childbirth and have healthy infants.

The limited time available today makes it impossible to review all aspects of reproductive health care (which may also include adolescent nutrition; treatment of infertility, menstrual irregularities, reproductive cancers; and so on). Findings over the last few years on the factors affecting maternal mortality, and the distressing fact that the huge number of maternal deaths each year is not declining significantly, in part because of inadequate program approaches, justify focusing more closely on maternal mortality. In this presentation, I propose to review briefly the nature and extent of maternal mortality; explore the causal relationships between maternal mortality, perinatal mortality and maternal morbidity; and examine approaches which hold promise for reducing maternal death and morbidity.

EXTENT OF THE PROBLEM

Maternal mortality has been seriously underestimated in the past. Model-based estimates (WHO/UNICEF 1996) project 585,000 maternal deaths worldwide each year. More than half of these (323,000 women) die in Asia. 40% in Africa, and less than 1% of the total die in developed countries. A woman's lifetime risk of maternal death can be 100 times higher in a developing country than in a developed country. Indeed, the maternal mortality ratio (MMR) is the indicator with the greatest disparity between the developed and the developing world.

Yet, as tragic as it is, the number of maternal deaths is only the tip of the iceberg. Approximately 23 million women each year suffer dangerous complications of pregnancy, 20 million women terminate pregnancy through unsafe abortions, and 15 million women develop chronic disabilities like obstetric fistulas and prolapse (WHO). Approximately 125 million women acquire a sexually transmitted disease each year, and 500 million--50% of all women of reproductive age in the world--have nutritional deficiencies such as anemia.

Infants fare no better. An estimated 7.6 million perinatal deaths (stillbirths and first-week deaths) occur each year in developing countries (WHO, 1996); 600,000 infants die from tetanus, and 22 million babies are born with a low birth weight (<2500 gms).

CAUSES OF MATERNAL MORTALITY

The major direct causes of maternal mortality are hemorrhage, sepsis, sequelae of unsafe abortion, hypertensive diseases of pregnancy (HDP), and obstructed labor. While the percentage of each cause of maternal death vary by country, where maternal mortality is high, these five major direct causes of maternal remain largely constant. Additional significant causes of maternal mortality include anemia, hepatitis and malaria.

However, the causes are not all biomedical, nor do they arise only when a baby is conceived. Beyond the immediate obstetric causes lie intermediate and distal determinants which are profoundly influential in affecting maternal survival. Women who are not empowered, do not have access to income, and are illiterate are far more likely to have poor pregnancy outcomes (for themselves and for their children) than are those who are educated and have the funds and the power to use those funds to improve their nutritional status and to access health care. Furthermore, maternal mortality is far more likely in populations which are undernourished and in environments with inadequate water and sanitation.

LESSONS LEARNED

A phenomenal realization has taken place in the international health community, which is slowly being translated into revised programming in the field. Critical analysis and research have demonstrated that screening for obstetric emergencies, and providing good prenatal care, are not enough to reduce maternal deaths. Screening for obstetric complications has poor predictive value (Freedman and Maine, *The Health of Women*, 1993). Screening programs often identify "high risk" women who go on to deliver normally (false-positives) and fail to identify "low risk" women who then develop life-threatening complications (false-negatives). In fact, most women who have life threatening complications--15% of all pregnancies--have no prior risk factors. Once a serious complication develops, even a woman in superb physical condition will have little chance of survival without access to

emergency care (Freedman and Maine). The risk identification approach has not been shown to be effective: every pregnancy faces risk.

This is not to say that antenatal care, improved nutrition, and proper hygiene are useless. Certainly these can be important in averting some "indirect" obstetric deaths (those caused by underlying disease, exacerbated by the pregnancy) by preventing and treating these conditions. Furthermore, antenatal care can prevent some maternal deaths through presumptive treatment (of severe anemia--which increases a woman's chance of dying from hemorrhage and heart failure), immunization (for tetanus--while mostly a killer of newborns, it also kills some mothers) and counseling to teach families how to recognize complications and their severity and where to go for treatment if life-threatening complications occur. Nevertheless, antenatal care's contribution to maternal survival is limited. Antenatal care has demonstrated its effectiveness in reducing perinatal mortality. If, however, the objective is to reduce maternal mortality, the evidence clearly shows that a different approach is required.

The example of infant and maternal mortality trends in developed countries earlier this century is revealing in this regard. Infant and child mortality in the US and Europe declined dramatically between 1900 and 1930 because of significant improvements in maternal nutrition and sanitation that accompanied broad based socio-economic development. Yet, maternal mortality did not improve. It was not until the mid-1930's, when antibiotics, blood transfusions, improved surgical techniques used in caesarean sections, and safe abortions became available, that maternal mortality declined dramatically. Striking confirmation of this comes from a religious group in the United States, whose members are well-educated, well-fed and relatively well-educated, but who do not accept medical treatment even in emergencies, and whose maternal mortality ratio is over 100 times that of the US as a whole--comparable to rural India (Kaunitz, A.M. et al, "Perinatal and Maternal Mortality in a Religious Group Avoiding Obstetric Care" Am Journal of Obstetrics and Gynecology 1984, 150:826-831). Life-saving interventions, including manual procedures, intravenous medication, blood transfusion and surgery, must be available to treat obstetric complications in order to reduce maternal mortality to the levels experienced in northern Europe and the United States. This does not mean that there should be a swing back to the days when tertiary hospitals received all the attention and resources. However, access to essential obstetric care (EOC) must be a major component in strategies to reduce maternal deaths. For this reason, reliance on TBA programs alone cannot substantially reduce maternal mortality.

Understanding of the underlying non-medical factors of why women were dying needed to be clarified. Researchers identified three delays:

- delay in deciding to seek care
- delay in reaching a medical facility
- delay in receiving adequate and appropriate treatment

The decision to seek care is a complex one, involving the woman's status in the family, recognition of complications and their severity, her relationship with her husband and mother-in-law, the opinion of other influentials (including TBAs), the family's access to money, the distance to the referral site, available transport, and perceptions of care at the referral site--to name a few. In Africa and Asia where 95 % of maternal deaths occur, the majority of women deliver at home with the assistance of a traditional birth attendant (TBA) or a family member. Where maternal mortality is high, effective programs must include a community component to teach avoidance of harmful practices and to promote birth preparedness and utilization of services in the face of life-threatening complications. This aspect of successful programming cannot be overemphasized. The preference for home birth in high maternal mortality areas is usually very strong and it cannot be assumed that upgrading tertiary care services alone will substantially reduce maternal mortality in the near future.

The delay in identifying and reaching a medical facility is affected by the distribution and location of facilities, the distance to the referral institution, the available transport and the cost. Once the woman gets to the facility, problems of insufficient staff and supplies, as well as inadequately trained and poorly motivated personnel, come into play. An example from the National Maternal Mortality Study in Egypt (1992-93), shows that 92% of the 718 deaths investigated were avoidable. Avoidable factors included:

- 33% no or poor quality of antenatal care
- 42% patient's delay in seeking care

47% medical team negligence (the total is more than 100% due to multiple causes)
Quality assurance programs should be institutionalized to assure client satisfaction and provider adherence to current, high quality standards of practice. To ensure this high quality care, competency-based training for frontline and referral level providers is often needed in normal care, treatment of complications, and interpersonal communications. In addition, other steps need to be taken to improve provider performance and overall quality of care: development of policies to ensure that frontline providers have the mandate to provide life-saving treatment; incentives (need not necessarily be financial) for workers to provide care in rural communities; provision of adequate supplies, equipment and medications; a system which ensures supervision and accountability at all levels; and so on.

EFFECTIVE PROGRAM STRATEGIES

A maternal death occurs when three events happen: a woman becomes pregnant, she develops maternal complications and the complications result in death. This implies several points of intervention:

Preventing pregnancies – It is estimated that voluntary family planning services to time and space pregnancies, as well as to prevent unwanted pregnancies, could reduce maternal mortality by approximately 25%. However, since pregnancy is not a disease and often pregnancy is desired, other strategies are needed.

Prevention of complications - While such a public health approach would seem optimal, many obstetric complications are unpreventable and unpredictable. Proven, evidence-based interventions such as provision of iron folate to decrease iron deficiency anemia, tetanus toxoid to prevent maternal tetanus, and malaria chemoprophylaxis should be provided where the incidence of these problems is high. However, since most maternal deaths result from other causes, the prevention strategy alone will not be sufficient.

Early recognition and management of life threatening complications to prevent death - This strategy implies a medically trained provider at birth, since most deaths occur around the time of birth. It also implies knowledge of life-threatening problems and access to services which can occur at any time. There needs to be capability for manual procedures (such as manual vacuum aspiration, manual removal of the placenta), medications (such as intravenous oxytocics and antibiotics), blood transfusion and surgical capability--often referred to as essential obstetrical care (EOC). Not all of this needs to be done at a tertiary care facility. A number of countries with low MMRs provide some of these services in the home. In addition, these services are not necessarily only *emergency* services, since focus ideally will be on early recognition of obstetric complications before they become emergencies.

SUCCESSFUL INTERVENTIONS

The nature of the three delays combined with the opportunities of intervening in the pathway to death (preventing births, preventing and treating complications) has formed the basis for maternal mortality reduction strategies. Programs have been designed to effect behaviors and strengthen skills in the community and at the first and second referral sites. There have been a number of programs in various countries which have demonstrated effective interventions in maternal mortality reduction:

Kigoma, Tanzania - Providing a focus on quality of care, this program included training of health care providers, improving the supply of medicine and equipment, improving the physical facility of the hospital, and strengthening supervision. As a result, the case-fatality ratio (number of deaths/100 obstetric complications), which is highly correlated with the MMR), was reduced from 12.6 to 3.7 over a seven year period.

Matlab, Bangladesh - This well-known program provided a community intervention with a referral system. Midwives, who could treat 40% of the complications themselves and refer more complicated cases to a clinic with a medical doctor with more severe complications sent to the referral hospital, were trained and posted at the village level. While recent reanalysis of the data shows the difficulty in identifying causal relationships--even in such a well defined study--maternal mortality decreased substantially.

Inquisivi, Bolivia - In the remote Andean highlands, women's groups were formed and taught to identify their own problems through a process call "autodiagnosis." The women prioritized their concerns and developed plans to address them. With the introduction of literacy groups, training of TBAs, and health education in the community, perinatal mortality decreased, as well as the number of maternal deaths.

These are just a few examples of a number of approaches which have been found to be effective in pilot studies and well-supported research areas. Many other experiments are now in progress. One of the challenges the Safe Motherhood Initiative is to study these success stories in order to pinpoint, where possible, the causal relationships--and to determine which of these approaches are amenable to expansion to larger geographic areas.

MEASUREMENT OF PROGRESS

Another challenge in maternal survival programs--in contrast to the more established and mature family planning and child survival programs--has been the difficulty in finding practical and meaningful measures of program achievement. The maternal mortality ratio (MMR = the number of maternal deaths/100,000 live births) is used by WHO to describe the severity of the problem. It is, however, an indicator with serious deficiencies due to under reporting (especially when related to abortion), the relative rarity of the event, and the resultant expenses in carrying out meaningful population-based studies.

It is generally recognized that the perinatal mortality rate (PMR = stillbirth plus death in the first week of life/1,000 live births) would be a good proxy for maternal mortality. This recognition is based upon the premise that the health and nutritional status of the mother and her care during pregnancy and birth are the same proximal determinants for both the survival of the mother and the perinate. Nevertheless, this indicator also requires accurate reporting in expensive, population-based studies.

In order to measure quality of programs, there are process indicators which may give a good measure of program elements which reflect service utilization or are commonly understood to be essential to high quality maternal health programs. These include the percentage of women utilizing services (usually antenatal, but could also include postpartum) and the percentage of women attended at birth by a medically trained birth attendant. Also important is quality of care. Indicators of quality which are now being field-tested are the case-fatality ratio and the admission-intervention interval (average time from admission to a health facility for a complication and treatment of the complication).

What is most important is that measurement of program progress is based on the specific elements of the actual program being assessed. For example, if advocacy and policy work is being carried out, an important indicator of success may be the proportion of health facilities providing 24 hour coverage for obstetric complications, or the proportion of facilities with a female doctor posted. If a community breast feeding program is being introduced, the indicator may be the number of functioning breast feeding groups six months after the groups were formed. What is important is that indicators, insofar as possible, reflect program results.

MESSAGES FROM SRI LANKA, 1997

This year marks the tenth anniversary of the Safe Motherhood Initiative which was launched in Nairobi in 1987. Last week, a technical consultation was held in Colombo to mark the event, assess progress made to date, and look to the future. At this meeting, which included safe motherhood program managers, researchers, and government, NGO and donor representatives, Safe Motherhood messages were refined. In brief, they include the following:

1. Establish Safe Motherhood as a Human Right
2. Safe Motherhood is a Vital Economic and Social Investment
3. Empower Women: Ensure Choices

4. Delay Marriage and First Birth
5. Every Pregnancy Faces Risks
6. Ensure Skilled Attendance at Delivery
7. Improve Access to Quality Reproductive Health Services
8. Address Unwanted Pregnancy and Unsafe Abortion
9. Measure Progress
10. The Power of Partnership

WHAT NGOS CAN DO

Because NGOs support initiatives in a number of different sectors beyond the Health and Population sectors and because of their powerful relationships with communities, NGOs have a critical role to play in the Safe Motherhood Initiative. Specifically, NGOs can do the following:

Support women's empowerment - Women need to be able to make decisions about becoming pregnant. Once pregnant, they need the strength to assert their right to a reasonable share of family food, time for rest, and ability to access health care services.

Develop programs for income generation - Women with funds that they control are better able to actually access health care services, buy needed medicines and purchase food.

Promote female education - Women who are educated are far more likely to understand messages regarding care for their own health and that of their child. They are also more likely to become involved in activities which promote health in their communities.

Support efforts to improve the quality and quantity of the food supply and to improve water and sanitation - Without access to these basic needs, women are more likely to suffer illness, pregnancy loss, and death.

Assist communities to develop normal birth and emergency plans - With expertise in savings plans and community decision making, NGOs are in a unique position to help communities to plan for funds and transport to assist women at a time of need, which is often unpredictable.

Provide community education - Awareness is the first step to understanding and, ultimately, to behavior change. Importantly, communities (all men and women) should know about birth preparation, requirements for adequate nutrition, hygiene, and appropriate postpartum and newborn care.

Promote advocacy with local personnel and facilities - With support of NGOs, communities can demand convenient, client-centered care including 24 hour coverage of obstetric complications, informed consent for procedures, respectful care, and so on.

Provide direct services - At the community level, NGOs may provide iron folate, tetanus toxoid, safe birth kits, prenatal, postpartum and newborn care--even in the absence of a formal health facility. Furthermore, NGOs can promote better quality services through training village health workers, including TBAs, in safe birth practices, identification of obstetric and newborn complications, and promotion of child spacing and optimal breast feeding practices.

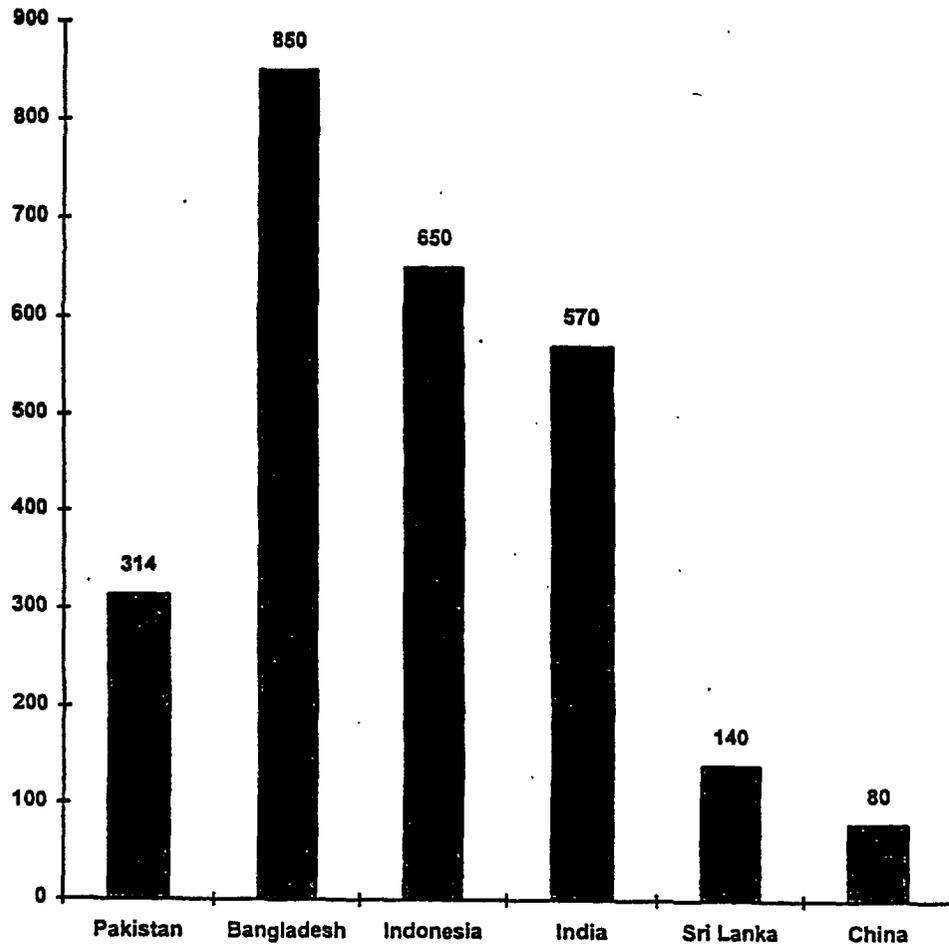
**Annexure E: Reproductive Health Situation on Pakistan:
Review of Current Health Data**

Table 2: Gender and age specific mortality rates (deaths per 1,000)

Age Group	Both Sexes	Male	Female	M/F ratio
All ages	9.8	10.4	9.2	1.13
Below 1	142.3	144.5	140.0	1.03
1 - 4	6.9	6.4	7.3	.88
5 - 9	1.3	0.9	1.8	.50
10 - 14	1.0	0.9	1.2	.75
15 - 19	1.6	1.8	1.3	1.38
20 - 24	2.4	1.6	3.1	.52
25 - 29	2.3	1.8	2.7	.67
30 - 34	2.1	2.5	1.8	1.39
35 - 39	2.8	3.2	2.4	1.33
40 - 44	4.5	5.5	3.6	1.53
45 - 49	5.3	7.5	3.0	2.50
50 - 54	8.6	9.8	7.3	1.34
55 - 59	11.6	12.2	10.9	1.12
60 - 64	28.0	31.3	24.4	1.28
65 +	64.0	68.2	58.9	1.16

Source: Based on Federal Bureau of Statistics 1990

**Table 14: Maternal Mortality Ratio, Selected Asian Countries
(Maternal Deaths per 100,000 live births)**



Source: Population Reference Bureau 1996

Table 5: Frequency distribution of causes of maternal deaths by study area, 1989-1992.

Clinical Causes	Karachi		Balochistan		NWFP		Total	
	n	%	n	%	n	%	n	%
Direct Maternal Causes	30	88.2	96	77.4	27	71.1	153	78.1
Post-partum hemorrhage	12	40.0	33	34.4	10	37.0	55	35.9
Antepartum hemorrhage	4	13.3	17	17.7	5	18.5	26	17.0
Eclampsia	7	23.3	12	12.5	3	11.1	22	14.4
Puerperal Sepsis	4	13.3	18	18.8	3	11.1	25	16.3
Abortion	2	6.7	6	6.3	-	-	8	5.2
Cephalopelvic Disproportion	1	3.3	6	6.3	3	11.1	10	6.5
Others	-	-	4	4.2	3	11.1	7	4.6
Indirect Maternal Causes	4	11.8	28	22.6	11	29.9	43	21.9
Hepatitis	-	-	5	17.9	1	9.1	6	14.0
Congestive Cardiac Failure	1	25.0	2	7.1	1	9.1	4	9.3
Tuberculosis	1	25.0	2	7.1	1	9.1	4	9.3
Thrombosis	-	-	1	3.6	1	9.1	2	4.7
Anemia	-	-	1	3.6	-	-	1	2.3
Puerperal Psychosis	-	-	1	3.6	-	-	1	2.3
Others	-	-	9	32.1	6	54.5	15	34.9
Unknown	2	50.0	7	25.0	1	9.1	10	23.3

Notes: Clinical causes reported are restricted to maternal deaths identified in the four year recall period for Balochistan and five year recall period for other areas. Karachi data is limited to the low socioeconomic settlements.

Source: Fikree, Ahmed et al 1996

Table 4: Percent Prevalence of Anemia

Group	NWFP	Punjab	Sindh	Balochistan	Pakistan	Ref. Val.
Children						
< 5 years	46.5	58.6	70.8	87.2	62.9	< 11 g/dl
5-14 years	26.8	36.5	56.9	65.6	41.8	< 12 g/dl
Males						
≥ 15 years	7.5	21.5	24.3	41.5	21.2	< 13 g/dl
Females						
≥ 15 years	14.7	36.2	51.7	60.5	40.3	< 12 g/dl
Pregnant						
15-44 years	26.9	37.9	53.2	57.5	41.4	< 12 g/dl

Source: NHSP 1996

Table 3: Problems for which Medical Care was Sought in the Past 14 days Among Female Population by Province and Adjusted Rates in Percent

PROBLEM	Area														
	PUNJAB			SINDH			NWFP			BALOCHISTAN			PAKISTAN		
	U	R	T	U	R	T	U	R	T	U	R	T	U	R	T
Respiratory	36.9	25.2	29.5	20.0	30.7	24.7	3.5	4.1	3.9	26.5	21.8	22.8	29.7	23.2	25.8
Stomach	8.2	6.9	7.4	6.8	4.8	6.0	3.5	12.1	10.2	5.0	20.4	17.3	7.4	7.6	7.5
Pain body	13.9	17.3	16.1	8.9	9.0	9.0	10.1	14.0	13.1	27.5	16.9	19.0	12.2	15.7	14.3
Headache	2.4	4.3	3.6	3.1	4.1	3.5	9.3	2.1	3.7	2.2	2.3	2.3	3.0	3.9	3.6
Skin	4.1	4.4	4.3	6.7	0.6	4.3	9.7	4.3	5.5	5.0	6.4	6.1	5.3	3.9	4.5
Reproductive	4.5	5.2	5.0	2.4	2.1	2.3	16.6	17.4	17.2	11.6	9.3	9.8	4.5	6.5	5.7
Urinary	0.4	1.3	1.0	1.7	0.0	1.0	0.0	1.2	1.0	2.1	0.0	0.4	0.8	1.1	1.0
Bowel	3.1	1.7	2.2	5.1	4.3	4.8	0.0	2.8	2.2	0.0	0.9	0.7	3.6	2.2	2.8
Others	26.5	33.5	31.0	44.4	44.5	44.4	47.3	42.1	43.2	20.0	22.1	21.6	33.4	35.9	34.9

(Reference age = 5 years and above)

Source: NHSP 1996

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**Table 6: Age specific fertility rates by province, 1990-1991
(per 1,000 women)**

PROVINCES

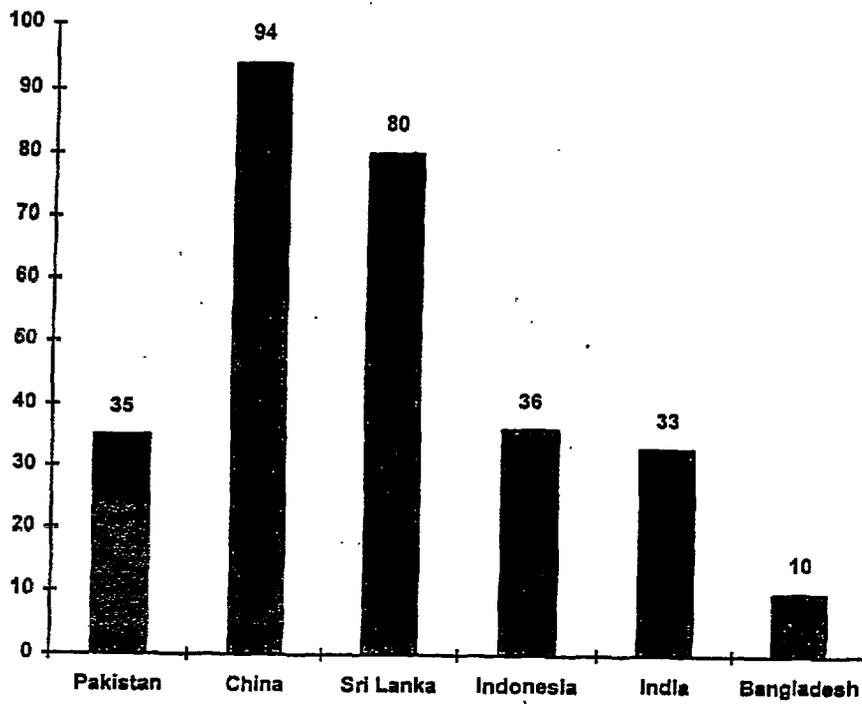
Age	Punjab	Sindh	NWFP	Balochistan
15-19	79	88	86	149
20-24	226	235	227	267
25-29	275	242	287	251
30-34	237	211	233	190
35-39	159	118	149	116
40-44	(70)	(79)	(77)	(82)a
45-49	(30)	(51)	(41)	b

Note: a: Based on fewer than 500 person-months of exposure

b: Based on fewer than 250 person-months of exposure, rates not shown

Source: Based on PDHS 1992

**Table 15: Percentage of Births Attended by Trained Birth Attendant,
Selected Asian Countries**

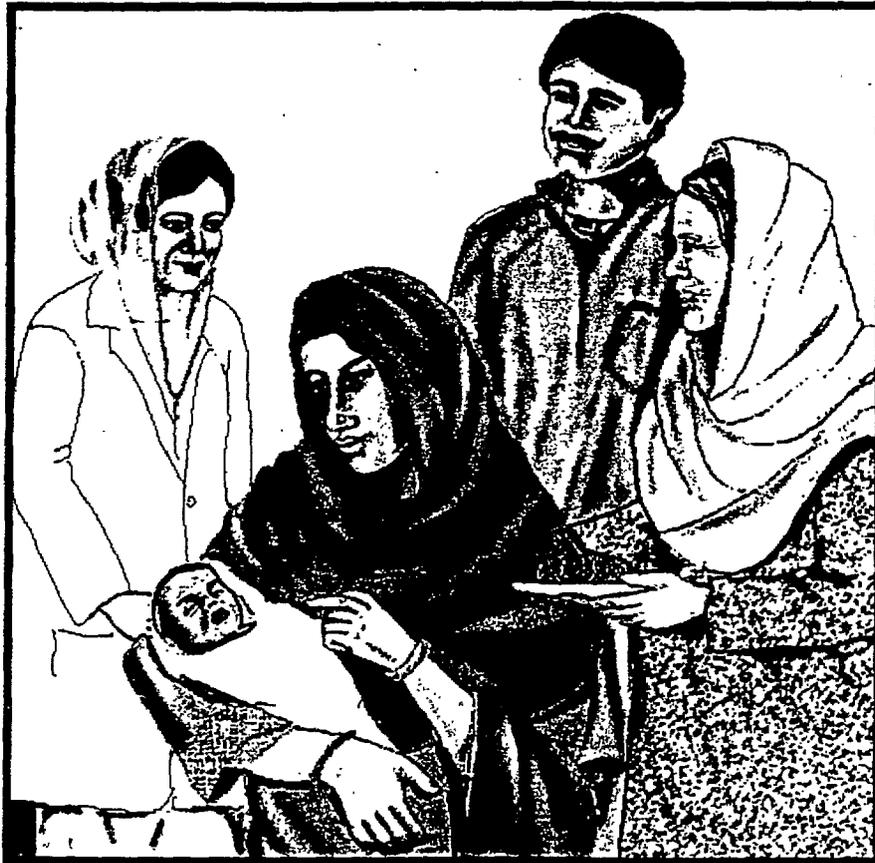


Source: UNICEF 1996

Annexure F: IEC Material: Safe Motherhood Interventions



SAFE MOTHERHOOD



SOME IMPORTANT MESSAGES



Sponsored by USAID

Acknowledgment

We would like to thank all the individuals who provided assistance in conceptualizing and producing this booklet and the other IEC materials (antenatal card and posters) as well as the agencies involved in providing administrative (The Department of Community Health Sciences, The Aga Khan University) and financial support (MotherCare/USAID and The World Bank) for the IEC component of the Safe Motherhood Intervention in Korangi 8, Karachi. In particular, we are indebted to the leadership provided by Mr. Richard Pollard, for technical input, and Dr. Shehla Naseem, Mr. Aslam Bashir, and the field team members, for development of the IEC materials.

We also wish to thank the women of Korangi 8, who participated in the process of sharing their painful experiences in order to provide sound material necessary to create appropriate IEC materials and to meet the objectives of the Safe Motherhood Intervention.

Dr. Fariyal Fikree Dr. Sadiqua Jafarey Nazo Kureshy

This booklet was made possible through support provided by John Snow, Inc./MotherCare Project and The Office of Health and Nutrition, Bureau for Global Field Programs, Field Support and Research, U.S. Agency for International Development, under the terms of Contract Number HRN-5966-C-00-3038-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development or MotherCare.



The doctors and staff of The Department of Community Health Sciences at The Aga Khan University are holding community meetings in our area to help our pregnant women in prevention, early diagnosis and treatment of obstetric emergencies. Simultaneously, they are implementing a training program for all the health care providers in our area in order to improve their ability to manage life threatening obstetric complications. This training will assist them in providing better care/services to our pregnant women who may experience complications during pregnancy, delivery, and postpartum periods.



During pregnancy, check-ups are essential for maintaining the health of a pregnant woman and her baby. These check-ups should be done by a doctor at least three times, i.e during 3-4 months, 6-7 months, and 8-9 months of pregnancy. Check-ups will ensure normal progression of pregnancy and will reveal any complications in a timely manner.



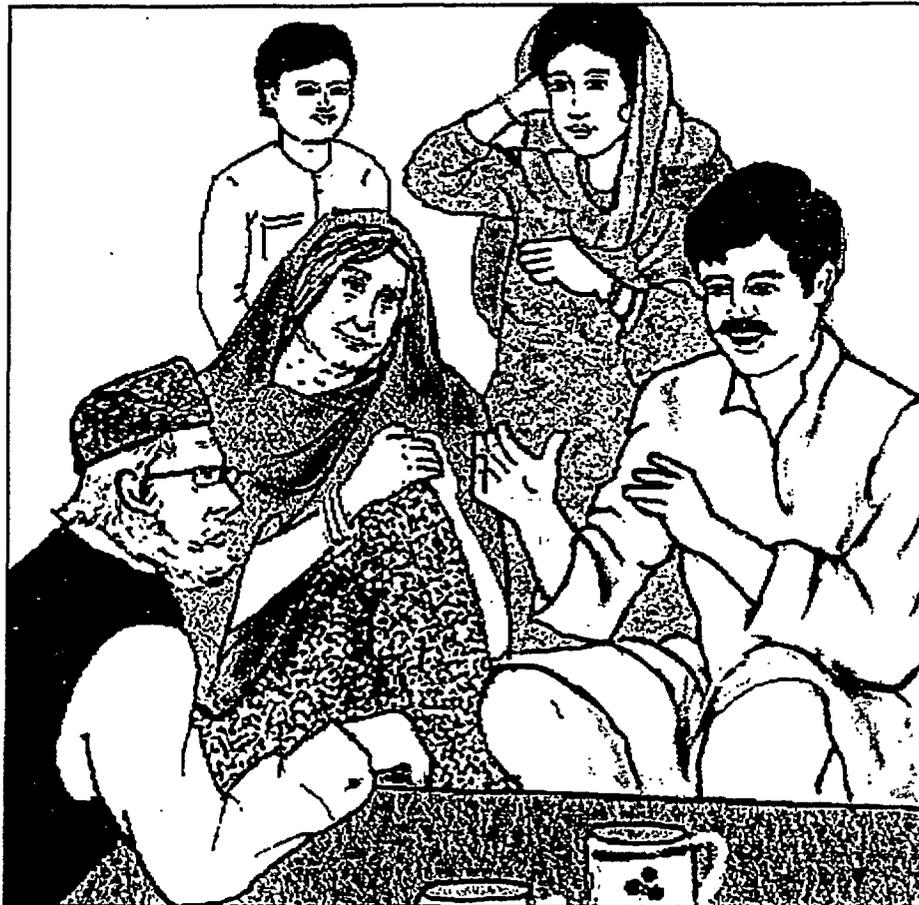
Every pregnant woman should take iron and folic acid tablets. These tablets will make her healthier and reduce tiredness. These tablets are not expensive and can be obtained from a chemist.



A pregnant woman sometimes cannot eat a full meal. In such instances, she should try to eat less but more frequently. A pregnant woman needs more food than normal to ensure proper development of the baby. If possible, lentils, vegetables, eggs, meat, and fruit should be included in a pregnant woman's diet.

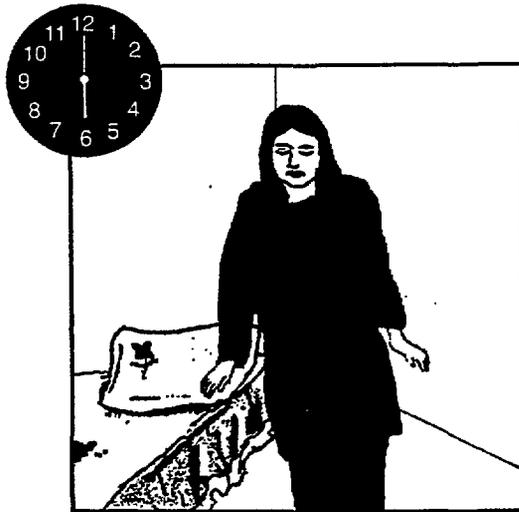


During pregnancy, tetanus toxoid vaccination is important for the protection of the mother and her baby against tetanus. These injections should be given during the 6th and 7th months of pregnancy.



Even if a pregnant woman has regular checkups, takes iron and folic acid tablets every day, eats well, and has tetanus toxoid injections, emergency situations can arise either during her pregnancy, at the time of delivery, or after delivery. A wise family understands this and makes a plan for actions they would take if an emergency arises.

In order to understand what can happen in an obstetric emergency, we would like you to listen to a story about a pregnant woman who experienced a complication.



Shaista was pregnant for the first time. During the 7th month of her pregnancy, she woke up and found some blood on the bedsheets.



Shaista's husband had to go to work, so Shaista's mother-in-law prepared a tiffin (lunch box) for him to take to work.



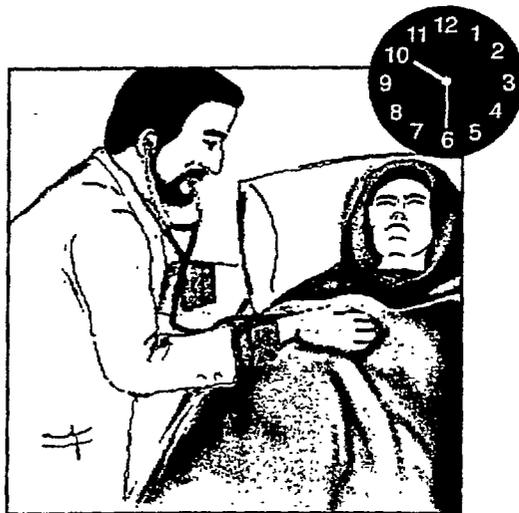
Two hours after Shaista's husband's departure, her bleeding and weakness increased so her mother-in-law assisted her to get into bed.



Shaista's mother-in-law then sent her younger son, Arif, to ask the dai to come to their home.



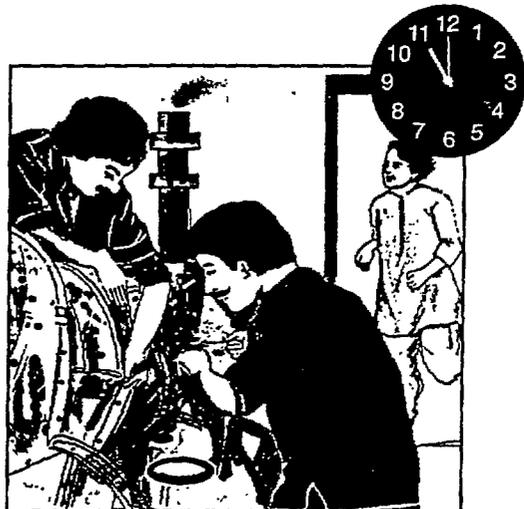
Seeing Shaista's condition, the dai sent for the nearest local doctor.



After examining Shaista, the doctor advised the family that she needed to be taken to a nearby maternity home/clinic.



Since Shaista's husband, Jamal, was not home, Arif, his younger brother, was sent to his workplace to bring him home.



Arif found Jamal busy at work in the factory.



Both brothers took a taxi home.



Jamal and his mother escorted Shaista to the taxi.



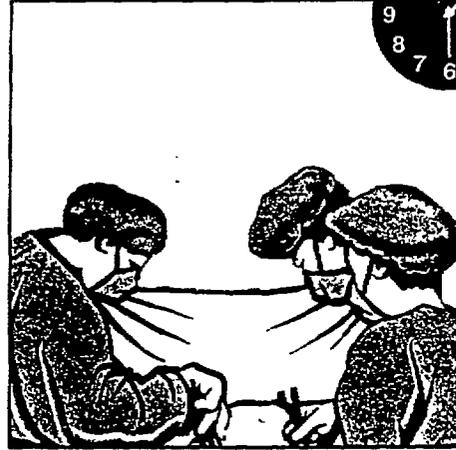
Shaista was taken to a maternity home nearby. Upon hearing Shaista's history, the doctor there advised the family to take her to Jinnah Post Graduate Medical Centre (JPMC) immediately.



Shaista was taken to the Main Emergency at JPMC and was directed to the Obstetrics & Gynecology Emergency (Wards 8 & 9).



By that time, Shaista had bled a lot. She was immediately received by the Department of Obstetrics & Gynecology (Wards 8 & 9).



After making necessary arrangements for blood and anesthesia, an emergency operation was performed.



The doctor at JPMC informed Shaista's family that she was all right but the baby was delivered dead. The doctor also told the family that if Shaista had been brought to the JPMC (Wards 8 & 9) earlier, the life of the baby could have been saved.

WHAT CAUSED THE DELAY?

Shaista experienced a serious bleeding problem at six in the morning. From that time until two in the afternoon, when she was operated upon, eight hours had elapsed. The doctor at JPMC told her family that the baby could have been saved if they had brought her to the hospital earlier.

What delayed the arrival of the woman to the hospital?



When Shaista initially began to bleed, her family could have recognized it as a serious condition and called a doctor immediately.



When Shaista's husband, Jamal, was going to work, he could have given permission to his family that if an emergency arose, they could take her immediately to the hospital in his absence. It is essential for families to discuss emergency plans.



Shaista's mother-in-law called a dai to the home, when she could have called a doctor.



The local doctor should have referred Shaista directly to JPMC (Wards 8 & 9) rather than sending her to a small maternity home/clinic with inadequate facilities.



Arif lost valuable time in going to the factory and searching for his brother, Jamal. Jamal should have given permission and arranged for his wife to be taken to the hospital even if he was not at home.



Shaista was first taken to the Main Emergency at JPMC. Her family should have taken her directly to Obstetrics & Gynecology Emergency (Wards 8 & 9) within JPMC.

Posters



POSTPARTUM HEMORRHAGE



1 Samina delivered her fifth baby at home with a *dai*'s assistance. There was a delay in the delivery of the placenta but the *dai* managed to remove it. It was 7 o'clock in the evening when the *dai* left for her own home.



2 Samina's family was excited by the newborn and gathered around him. Samina was lying on the bed, covered by a blanket, and she was feeling weak.



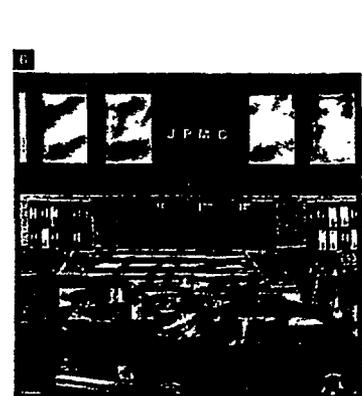
3 Around 10 PM, Samina started having cold sweats. She told Anjum, her sister-in-law, that she was feeling faint. Anjum became worried and immediately sent for the *dai*.



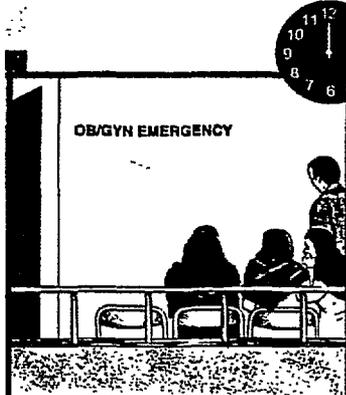
4 When the *dai* arrived at 11 PM and removed Samina's blanket to examine her, she found the bed sheet soaked with blood.



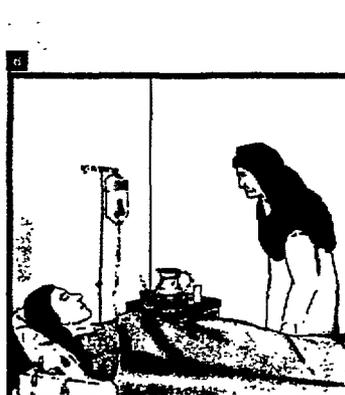
5 The *dai* became worried and immediately asked the family to call a doctor.



6 The doctor came, and upon seeing Samina's condition, he advised the family members that Samina should be taken to JPMC immediately since she was in shock and had lost a lot of blood.



7 Samina's husband, Shafiq, took her to JPMC Obstetrics & Gynecology Emergency (Wards 8 & 9), where she was admitted.



8 Samina was given three bottles of blood and the doctors explored and evacuated the uterus.



9 The doctors told Samina's family that a piece of the placenta had been left in the uterus, due to which she lost a lot of blood. They explained to her *dai* that the placenta should not be removed forcibly and that it should be examined for completeness after it is expelled. Moreover, patients such as Samina should be observed for a while for occurrence of bleeding. If bleeding is heavy, then they should immediately be referred to JPMC (Wards 8 & 9).



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ANTEPARTUM HEMORRHAGE



Shamim was pregnant for the first time. One evening during her 7th month of pregnancy, she experienced some spotting which turned to frank bleeding by the next morning.



Her husband worked in a nearby factory, and he left for work, as usual, early in the morning.



Shamim's mother-in-law sent her younger son, Arif, to call a *dai* to their home. The *dai* came but suggested that they call a doctor also.



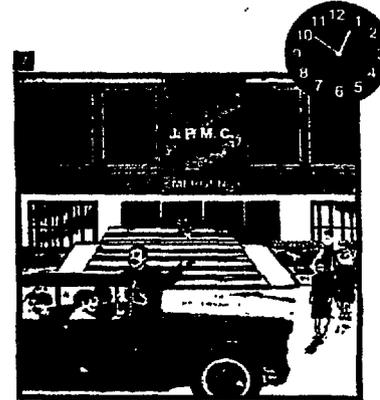
When the doctor came and saw Shamim's condition, he advised that she should be taken to JPMC immediately.



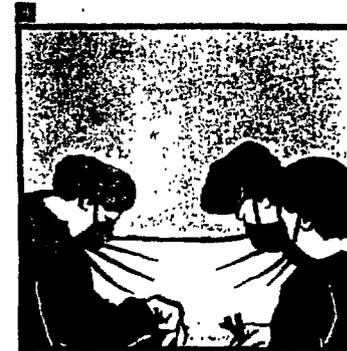
Arif was sent to the factory to look for Saleem and, after some time, found him working on a machine.



Both of them arrived home in a taxi and took Shamim to JPMC in a taxi.



When they reached the Obstetrics & Gynecology Emergency (Wards 8 & 9) at JPMC, Shamim's condition was poor.



She was admitted there and operated upon. The efforts of the doctors saved her life but the baby could not be saved.



The hospital surgeon told Shamim's family that the serious situation could have been avoided, and the life of the baby could have been saved also, if the family had brought her to the JPMC (Wards 8 & 9) earlier.



ECLAMPSIA



1 Ameena was full term pregnant with her first baby. She often suffered from headaches. Her hands and feet had also become swollen.



2 One night her husband, Saeed, woke up hearing noises. He saw that Ameena's condition was abnormal. Froth was coming out from her mouth and she was having fits.



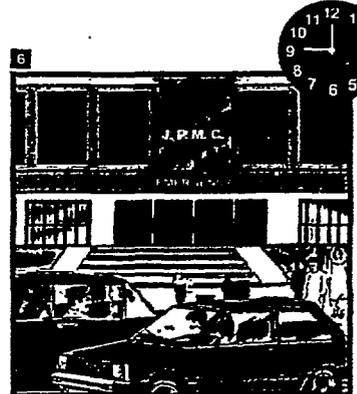
3 Saeed woke up his family and they called an *Amil Baba* to dispel the evil spirits. Despite the *Amil Baba's* attempts, Ameena's condition did not improve.



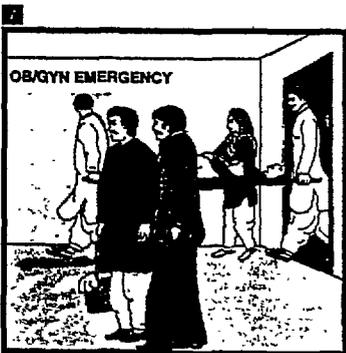
4 The family then called a doctor, who advised them to take Ameena to JPMC immediately.



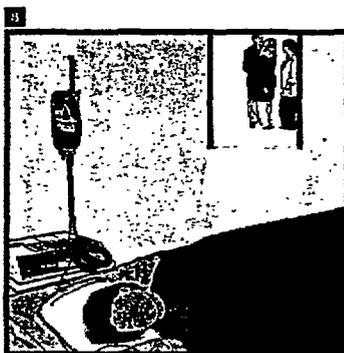
5 Ameena was taken to the hospital in a taxi.



6 They reached the main emergency at JPMC.



7 From there, they were sent to the Obstetrics & Gynecology Emergency (Wards 8 & 9) at JPMC, where Ameena was admitted.



8 Ameena was kept in isolation, and a drip was started immediately. She was also given some medications. One hour later, she delivered a baby who died soon after being born.



9 The doctors at JPMC told Ameena's family that her condition could have been prevented if she had antenatal check-ups, especially blood pressure checks, done during her pregnancy. The baby could also have been saved if the family had brought Ameena to JPMC (Wards 8 & 9) earlier.



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OBSTRUCTED LABOR



1 Salma was expecting her third baby any day. She planned to have her baby delivered at home by a *dai*. Her husband Ahmed, was a pick-up driver and sometimes remained away from home for several days.



2 Early one morning, Salma started to have labor pains. Ahmed was not home, so she sent her son to call Rubina, her sister-in-law, and Sakina, a *dai*.



3 Both of them lived nearby and arrived soon. *Dai* Sakina examined her and said that the delivery would most probably take place in the evening and went away.



4 Salma experienced labor pains all day. When *Dai* Sakina came to see her again in the evening, she was worried since there was no progress in labor. She called the more experienced *Dai* Basra, who gave Salma an injection to hasten the delivery.



5 Some more hours passed and Salma's condition became worse. She started sweating and felt drowsy. Therefore, both *daïs* advised that Salma should be taken to JPMC. Since it was midnight, Rubina waited for Salma's husband Ahmed, or her brother Haleem, to arrive. Salma asked Rubina to wake up her children so she could see them one last time.



6 Around 1 AM, Haleem arrived with a pick-up and began to make preparations to take Salma to the hospital. Some of the neighbours also accompanied them so that they could donate blood at the hospital, if needed.



7 At approximately 2 AM, they arrived at the Obstetrics & Gynecology Emergency (Wards 8 & 9) at JPMC



8 Salma was immediately taken in and examined. The doctors decided to operate immediately, since the baby's position was wrong and the uterus had ruptured. Salma needed three bottles of blood and delivered a dead baby by an abdominal operation.



9 The timely efforts of the doctors saved Salma's life. The doctors told her family that the baby could have been saved if they had brought Salma to JPMC (Wards 8 & 9) earlier.

ANY WOMAN WITH A FIRST BABY HAVING LABOR PAINS FOR MORE THAN 18 HOURS, AND THOSE WITH SUBSEQUENT BABIES HAVING PAINS FOR MORE THAN 12 HOURS, SHOULD IMMEDIATELY BE TAKEN TO JPMC (WARDS 8 & 9)

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PUERPERAL SEPSIS



1 Shahida delivered a live baby boy in a small clinic near her house. It was a difficult delivery.



2 Shahida was feeling weak and unwell, but she was very anxious to go home. Therefore, she left the hospital two days after the delivery.



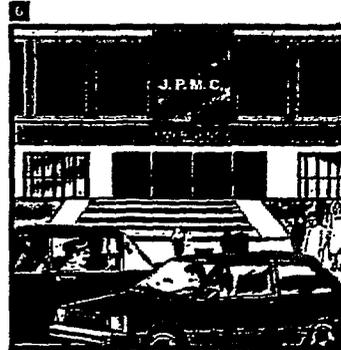
3 The day after Shahida came home, she felt feverish.



4 When her husband, Hameed, arrived home from work in the evening, Shahida's face was flushed due to high fever and she had severe pain in the abdomen, due to which she was unable to move. Hameed's mother was worried and was sitting by Shahida's side.



5 Hameed became very worried and immediately rushed to call a doctor from the nearby clinic. The doctor, after examining Shahida, said that she had a severe infection and advised that she should immediately be taken to JPMC.



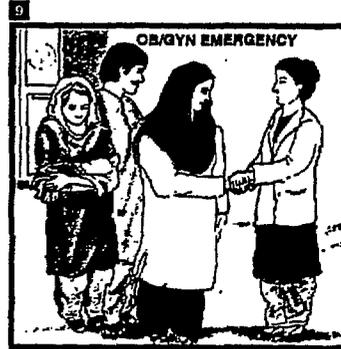
6 Hameed did not delay taking Shahida to JPMC Obstetrics & Gynecology Emergency (Wards 8 & 9).



7 She was admitted to the Obstetrics & Gynecology (Wards 8 & 9) at JPMC.



8 Shahida was given several drips, injections and a bottle of blood. She remained in the hospital for approximately one week.



9 The doctors appreciated the quick decision taken by Hameed to bring his wife to JPMC (Wards 8 & 9) without delay. Due to Hameed's timely decision, Shahida was able to receive treatment at the hospital. Otherwise, she could have died of complications due to infection.

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CARE OF PREGNANT WOMEN



During pregnancy, check-ups are essential for maintaining the health of a pregnant woman and her baby. These check-ups should be done by a doctor at least three times, during 3-4 months, 6-7 months, and 8-9 months of pregnancy. Check-ups will ensure normal progression of pregnancy and will reveal any complications in a timely manner.



Every pregnant woman should take iron and folic acid tablets. These tablets will make her healthier and reduce tiredness. These tablets are not expensive and can be obtained from a chemist.



Pregnant women sometimes cannot eat a full meal. In such instances, she should try to eat less but more frequently. A pregnant woman needs more food than normal to ensure proper development of the baby. If possible, lentils, vegetables, eggs, meat, and fruit should be included in a pregnant woman's diet.



During pregnancy, tetanus toxoid vaccination is important for the protection of the mother and her baby against tetanus. These injections should be given during the 6th and 7th months of pregnancy.

**Annexure G: The Green Star Clinics: An Evaluation
Report**

The Green Star Clinic Network: Harnessing the Private Sector

Presentation of 27 October 1997

Introduction

My instructions from Naveeda were quite clear: to use the case of the Green Star Clinic Project as an illustration of how effective programmes use the twin secret weapons of solid design and evaluation, and how these two secret weapons reinforce each other. This presentation will therefore focus on the elements of design and evaluation. But, just to set the context, I'll briefly introduce my organization and its programs in Pakistan. (TRANSPARENCY)

SMP/PSI

The Green Star Clinic Network is a project of SMP: Social Marketing Pakistan. SMP is a non-governmental, non-profit corporation that specializes in using social marketing for behaviour change in the health field. Social marketing, as we will learn tomorrow during the Manoff presentation, harnesses the strength of the private sector in order to educate, motivate and enable people to take responsibility for their own lives. It is a strategy that simultaneously creates demand for a given action or product and makes sure that it is widely accessible.

Worldwide

SMP's international partner is Population Services International, or PSI. PSI currently operates social marketing projects in nearly 50 countries in Asia, Africa, Eastern Europe, South and North America. PSI uses social marketing techniques to promote family planning, STD/AIDS prevention, diarrhoeal disease prevention and control, malaria prevention, safe drinking water, and good nutrition.

In Pakistan

Here in Pakistan, SMP, with technical support from PSI, has two major divisions: Nutrition and Family Planning. The nutrition division currently implements the UNICEF-funded Iodized Salt Support Facility which is a major component in the Government of Pakistan's Iodine Deficiency Disorder Elimination Campaign. There is a poster presentation of this program which I hope you'll take a few minutes to study as we've particularly highlighted the ways in which we monitor both staff performance and overall project progress. Many of the NGOs present today have helped us spread the word about IDD and iodized salt through their social mobilizers. I thank you and hope that our collaboration will continue to improve and save lives.

The Family Planning Division actually began before SMP. Under the USAID-funded Contraceptive Social Marketing Program, PSI assisted the program to promote and distribute SATHI condoms. After USAID pulled out, PSI stayed on to assist the Government of Pakistan distribute the remaining

SATHI. In the meanwhile, SMP was founded and KfW, the German Development Bank, decided to take over funding of the CSM project. Today, SATHI condoms alone represent approximately 20% of all modern method birth spacing in Pakistan. Early this year, the 500 millionth SATHI condom was sold. Under KfW funding and with the support and encouragement of the Ministry of Population Welfare, SMP now markets much more than SATHI: there is a second condom brand targeting the upwardly mobile lower middle class, TOUCH, the Multiload IUD, NOVA contraceptive pills, and NOVA-JECT injectable contraceptives.

Green Star Project

But while we're proud of our expanded product line which now allows couples much greater access to many more contraceptive methods, we're particularly excited about something that has not been done anywhere in the world before: our Green Star Clinic Network Project. For simplicity's sake we've separated the project into two main components: (TRANSPARENCY)

We call the project designed primarily to deliver all methods up to and including the IUD, the GS-1.

While we call the project designed primarily to concentrate on the prescription and management of hormonal contraceptives the GS-2 project. In order to illustrate the design process, I'll be describing only the GS-1 project today.

Green Star Clinic Project Design: Initial Pilot Project

In 1995, recognizing the success of Sathi condoms as well as the almost insignificant use of any other spacing method, the Ministry of Population Welfare asked SMP to develop a proposal for the social marketing of the IUD. Now here was a real challenge -- not only was the IUD a method that could not be sold in Utility Stores like condoms, but it required trained, skilled medical providers to ensure that it was properly inserted, infection was avoided and cases were properly followed up. We cast about to see if there was any international experience to learn from, but nowhere had the IUD been included in a social marketing program. We were faced with a number of questions, the answers to which ultimately formed the basis of our design strategy: (TRANSPARENCY)

1. What group of medical providers could potentially serve our target audience -- the lower income groups. How could they be trained and by whom?
2. Once trained, what motivation would they have to use their training to encourage FP use?
3. Why would potential FP clients go to SMP-trained providers?
4. How could we ensure quality FP services from our trained providers?
5. How would we get the IUDs and other methods to the clients?
6. How could we overcome the misconceptions which so greatly inhibit the use of IUDs and hormonal contraceptives by the Pakistani public?

Rationale (TRANSPARENCY)

Our first decision was to involve the Private Sector. Statistics vary, but somewhere between 60-80% of Pakistanis across all income groups go to private sector health providers for their family's health needs. Then we needed to decide which private sector providers could best serve our population. Since the examinations for and insertion of the IUD are intrusive procedures, the doctors would have to be women. Since our target population is the lower income groups, these lady doctors would have to have existing clinics in low income areas. When we conducted an assessment of such doctors, it was found that very few had any formal training in family planning methods beyond the 4-5 hours they had received in Medical School and were very eager for such training.

We now knew who we needed. But why would these lady doctors help us? After all, this is the private sector. Again, the assessment helped us to realize that, while there was no one clear answer, there was a certain blend of incentives that would motivate most of our potential Green Star members to first attend a training course that would take them away for their clinics for up to 10 days, to agree to put up the Green Star Signboard, and then take the additional time to counsel potential family planning clients in spite of long lines of other paying clients waiting. These incentives included:

- ▶ Increased knowledge and skills. Unlike the government sector, private practitioners, especially the General Practitioners with small clinics in poor neighbourhoods rarely get training opportunities.
- ▶ A belief that family planning is necessary in Pakistan, both for demographic reasons and for the health of their clients.
- ▶ Increased business. Being identified with a nationally promoted program was seen to confer a certain status on private clinics that would encourage both increased loyalty among clients because doctors could now serve their family planning needs in addition to general ailments, and also to bring new clients in. Simply put, they could make more money.

We now felt that we had the beginnings of a project design: a target group with a good potential vehicle for serving them. We then took a step back and worked from a logical framework to develop the full design.

Goal (TRANSPARENCY)

The goal of the Green Star Clinic project is to increase the capacity of Pakistan's private medical sector to provide high quality family planning services and products to low income populations in order to:

1. Increase the number of new family planning acceptors and
2. Improve contraceptive method continuation rates

Objectives

Specific project objectives are: (TRANSPARENCY)

- ▶ To train 2,000 Registered Medical Practitioners in family planning counselling, IUD insertion, hormonal methods prescription and administration, side effects management and infection prevention by the year 2000.
- ▶ To create demand for the services of the Green Star Doctors
- ▶ To ensure high quality services by supporting and monitoring the Green Star Members

Project Components

With our goals and objectives clear, we were now ready to design the actual project which ultimately consisted of five main components: (TRANSPARENCY)

Training

The Green Star Providers are trained using a competency based curriculum which consists of 5 half day classroom sessions and 5 days of clinical training. We depend heavily on our NGO partners during the clinical phase and I thank those of you, like FPAP, who are here today for your support and encouragement.

Demand Creation

A communications campaign centred around the Green Star logo promotes certified clinics and high quality contraceptive services and products. Large signs with the Green Star logo are painted and personalised for each member clinic. All contraceptive product packaging also carries the Green Star logo. The demand creation campaign featuring Atiqa Odho provides generic family planning messages through both local and mass media.

Contraceptive Supply

All Green Star contraceptives are supplied at wholesale prices directly to Green Star Clinics by the SMP national detailing force. Current policy is to sell the Green Star Multiload IUD only to trained Green Star providers and partner NGOs, and not through the pharmaceutical network. Other Green Star contraceptive products are distributed to pharmacies with assistance from a commercial pharmaceutical distributor.

Support and Monitoring

Full time SMP medical professionals support trained providers by regular clinic visits to answer technical questions, assist with procedures and solve any problems with family planning clients the providers might face. A computerised management information system (MIS) tracks clinic performance in terms of contraceptive sales and supervisory visit results.

Green Star staff trainers visit each clinic at least once a month. This is designed particularly to help those providers who are unsure of their skills, those who are not yet receiving enough family planning clients, and those who might need remotivation to offer quality family planning services.

Evaluation

Even though we conducted extensive research to develop all of the above components, we had to go with quite a few hypotheses that needed to be tested. We also knew that there were many issues affecting project performance that would surface only once the project was implemented. We therefore decided to do an initial pilot project that would serve to test our hypotheses, to refine our project model and to serve as a basis for the national expansion of the project. An integral part of the pilot project was an extensive evaluation strategy. The report of this evaluation has proven to be invaluable in correcting errors and seizing opportunities for the most effective expansion of the Green Star Clinic Project. At this point I'd like to briefly describe how this evaluation was designed and what it taught us.

Pilot Project Evaluation

Objectives

The objectives of the evaluation were to: (TRANSPARENCY)

- ▶ Measure improvement in new acceptors, overall clientele, and sales of contraceptives
- ▶ Measure improvement in the quality of the family planning services provided
- ▶ Assess the effectiveness of the programmatic inputs
- ▶ Make recommendations for the expansion of the Green Star Clinic Network

Design

A key word in the objectives is "improvement". If we just went out and surveyed the clinics after 6 months of work with the Green Star Network and found that they had 2 Family Planning clients per day, what would that tell us? Really nothing. To put those 2 clients into context, we need to

know how many clients the clinic had before it joined the network. Had we made any improvement or were there even more clients before?

It was therefore crucial to have a baseline and we designed the evaluation to get both ongoing information as well as snapshots taken around the time of training and again 6 months later. Three types of data were used to evaluate the Green Star Clinic pilot project: (TRANSPARENCY)

► **Results from a series of externally administered surveys**

An external research agency conducted two rounds of three survey instruments at pilot project clinics to measure changes over time. These surveys were closely modelled on the Population Council's Situation Analysis approach to evaluating family planning clinic facilities:

1. The Inventory of Facilities survey's objective was to measure quality via physical elements which can contribute to the quality of family planning services: staffing, number and type of rooms and equipment, IEC materials, contraceptive supplies, and record-keeping.
2. The Simulated Client survey's objective was to evaluate a provider's counselling skills during an actual client/provider interaction. To avoid bias, the survey was conducted by a trained surveyor disguised as an actual client.
3. The Full Day Client Count survey determined if the Green Star clinic project had an impact on increasing the number of family planning and total clients at participating clinics. Information was also gathered regarding how and how far clients travelled to the clinics, the reasons for choosing the clinics, the purpose of the visit and whether or not family planning was discussed during the consultation.

► **Information gathered and used in the internal project Management Information System (MIS)**

Our computerized MIS system was developed to provide regular information to project management. It records and tracks:

1. Static data on clinics and providers. Who are they? Where are they? What qualifications do they have?
2. Daily family planning client records. We wanted to look at return visits, management of side effects and, eventually continuation rates. But, don't get your hopes up here as we'll see how poorly this aspect fared.
3. Contraceptive sales to clinics.
4. Project staff performance

► Qualitative information provided by Green Star field staff

As any field worker will tell you, formal evaluations often miss out by not understanding the field realities. In this evaluation we used the qualitative assessment by the Green Star field staff to provide important perspective when analysing trends perceived by analysis of the quantitative data.

Principal Findings

What were the results of the evaluation? Well, first the good news: (TRANSPARENCY)

1. The evaluation showed that good quality FP services can be effectively provided through the private sector in Pakistan if medical providers are given thorough training and regular contraceptive supply. We found that:

- Green Star doctors counselled effectively. They had very positive interpersonal relations with their clients, gave them information on multiple FP methods and didn't impose their choice of method on the client.
- A range of contraceptive methods (usually all 4 spacing methods) were present in the clinics.

2. Most importantly, we found that the continuing support after training had a positive impact on clinic and provider performance. I must confess that the baseline data gathered on the clinics was actually conducted in most cases immediately following training, rather than before. We expected to find that the doctors' performance in counselling, in particular, would decline somewhat after 6 months when the enthusiasm generated by the course died down. We found the exact opposite. Every counselling indicator improved significantly in the second round of surveys.

3. Overall, there was an increase in the number of FP clients at Green Star Clinics of 120% after 6 months. The average number of FP clients increased from less than 2 to 4 per day. Interestingly, a substantially higher proportion of FP clients came for revisits while the absolute numbers of first visitors also increased. This is promising both for numbers of new acceptors and for continuation rates.

There was also an average increase of 43% among total clients. This should substantially increase the profitability and long term sustainability of the Green Star Clinics.

4. The evaluation results were not all rosy, however. One area of concern is that service charges for the IUD and injectables quoted by doctors to the simulated clients are often substantially higher than what we believe the poorest people are able and willing to pay.

Recommendations

An important objective of the evaluation of the Green Star Clinic Pilot Project was to provide specific recommendations for the national expansion of the project. Even before the report was finalized, SMP management had taken the results of the evaluation and used it to improve the project. I'd like to give you a few examples of how that was done. (TRANSPARENCY)

General Recommendations

- ▶ As we found that clinic records were not kept consistently, we were worried about how FP acceptors could be effectively followed up. We've therefore begun to experiment with several community motivator schemes that would track individual clients for participating doctors.
- ▶ As we found that service charges were often too high, we've begun to reward those clinics that maintain recommended charges and to put up recommended price lists in clinics.

Choice of Participants

- ▶ Some categories of clinics and providers were more cooperative than others. We have therefore developed an ideal provider profile which is used during recruitment of doctors for training programs.

Training

- ▶ We've improved our training programme to highlight areas that the evaluation showed to be weakest. For example, we have put more emphasis on the importance of maintain low prices, and better explanation of the management of side effects.

Field Support

- ▶ The experience of the pilot project has shown that a high level of field support is basic to the success of the project. This is obviously labour intensive and costly, but thanks to these results, management has determined that it should be continued as designed for the expansion phase.

Monitoring

- ▶ Not all information gathered during the pilot phase was ultimately essential. We have therefore re-designed the internal MIS to give us more of what we need without overburdening the data entry function.

Evaluation

- ▶ External evaluation is important to provide information that regular internal monitoring cannot and also to confirm the veracity of internal monitoring. Although the pilot project evaluation strategy is too ambitious for the expanded project, we have developed a strategy that will use both the full day client count and the simulated client surveys on a sample of expansion phase clinics. A third round of data for the pilot project clinics is currently being gathered so that we can see if the trends suggested in the first two rounds are holding steady.

Project Progress

I would like to end by stressing that careful project design including a solid evaluation strategy cannot remain just an academic exercise of elegant log frames and SMART objectives. Neither should it be an ironclad framework that prevents projects from innovating and evolving. An effective project design gives structure to a project while allowing for flexibility and constant fine tuning. The evaluation is the component that shows us what needs to be changed and how. In the case of the Green Star Clinic Network Project, we're still constantly experimenting and evaluating, but we're not letting that process slow us down. To close let me share our latest figures:

Green Star - 1

Since the pilot project ended in December 1996, the Green Star Clinic Network has grown from the original 300 clinics in Karachi and Rawalpindi to close to 1,000 clinics in 7 urban centres as of end September. Training is on-going and we plan to add 5 new cities every year until we achieve our target of 2000.

Green Star - 2

The less intensive course for all interested doctors, both male and female, is being conducted by our three regional training teams. To date we have over 2,000 GPs trained to counsel for Family Planning and to responsibly prescribe and manage any side-effects of hormonal contraceptives. We have begun training both chemists and paramedics and hope to have trained over 10,000 in all by the end of 1999.

Presented to the State of the Art Workshop, Reproductive and Newborn Health, Islamabad

Annexure H: Paper by Mr. Richard Pollard

Social Marketing

A Summary

Richard Pollard

Social Marketing sprang out of a simple observation. Why was it that in many low income countries it could be seen that a majority of families were regularly purchasing commercial products - such as toothpaste, soap and analgesics - and yet, after years of intensive promotional efforts by government ministries and aid agencies, the utilisation of free maternal and child health care services was falling far short of expectation ?

Perhaps those commercial marketing people knew something we didn't !

The question was, what ?

The search was on to find out.

Over the last 25 years many commercial advertising and marketing experts have joined forces with health, nutrition and population professionals and, together, they have gone a long way towards convincingly answering this question. Out of this collaboration a new branch of marketing has been developed; the use of marketing techniques to serve a specific social good - hence the term Social Marketing.

In its original form Social Marketing concentrated on issues of how to motivate a desired behavioral change through the use of persuasive techniques learned from the commercial advertising experience. Innovative ways to utilise mass media to support direct counselling

and community participation activities were also explored. Later issues of improvements to service delivery were added to the Social Marketing equation. Finally Social Marketing practice was used to develop, distribute and promote a wide range of specific health and population products such as condoms, fortified foods or oral rehydration salts.

The initial experience in implementing Social Marketing programs was gained in developing country environments. Subsequently this experience was transferred into more 'mature' markets; in the promotion of healthy lifestyles and in anti-drug and AIDS prevention programs for example.

Where are we today ?

Social Marketing has developed down two distinct tracks :

1. Health and Nutrition programs - here the primary emphasis is on behavioral and social change. Social Marketing managers have developed a systematic analytical and intervention methodology designed to lead to real and sustainable social and behavioral change.

Social Marketing managers have taken traditional health education approaches - which have most commonly relied on education as the key to addressing behavioral change - and introduced formative research techniques designed to more thoroughly unearth the many blocks and resistances that impede the take-up of a desired practice and to search for convincing ways to overcome them. These may be purely practical constraints or they may be imbedded within social or cultural contexts.

Systematic explorations are also undertaken of how best to motivate a desired practice and what benefits or rewards will be perceived by target audiences as the most compelling.

Experience has shown that the benefit or reason why someone may take up a new behaviour may not be so obviously apparent. For example, programs to reduce blindness in children through consumption of vegetables have found that fears of blindness are poor motivators. Program managers have had to search for ways to 'position' vegetables as essential for the overall good health of a child before mothers will react positively to adding them to their child's diet.

In the past, health education, health promotion or I.E.& C. activities were often perceived as almost incidental to more 'technical' or 'clinical' program issues - the development of delivery mechanisms for immunization or growth monitoring, for example.

Now, Social Marketing managers (taking their cue from their commercial marketing experience) are being asked to manage the integration of the 'clinical' and service delivery components of programs with the behavioral change components.

In addition the behavioral change components have been expanded beyond primary target audiences to include provider systems as well and issues of quality of service and customer satisfaction. This integration of effort has led to significant improvements to the acceptance and use of these services by target audiences.

Many Social Marketing projects have been undertaken, world-wide, for adult, maternal and child health and nutrition programs. Some of these programs have included extensive service or product delivery components. These include growth monitoring; immunization; services to pregnant women; vitamin A capsules, iron tablets and iodized salt distribution. Others have, essentially, contained no product or service delivery components, relying exclusively on communicating health messages. These include weaning and breastfeeding programs; vitamin A-rich foods consumption; home-made oral rehydration solutions and programs designed to gain community support for a development project, such as a dam or irrigation system.

Some programs have made extensive use of community-based counselling and communications systems with or without the use of mass media; others have involved extensive use of mass media either as a support to counselling or as the prime communications medium.

2. Population Programs - Social Marketing practice in relation to population (and STD/AIDS) programs has concentrated more fully on product development, distribution and promotion - most notably for condoms but, also, for hormonal contraceptives and long-term methods.

It is for this reason, and because they are promoting distinct products - often distributed through commercial channels and promoted through the mass media - that Social Marketing has been associated more closely with population

programs than with the many other fields in which it has been employed.

Efforts to achieve some level of cost recovery have also been more strongly addressed in Contraceptive Social Marketing (CSM) programs - although it is worth pointing out that Social Marketing practice can be an important tool to promote cost recovery in the provision of any health service. Success may be dependent upon improvement to those services before introducing fees for them; a role that Social Marketing practice ideally fulfills.

Dozens of successful CSM programs are being managed world-wide.

Contraceptives are often sold under their own Social Marketing brand names at subsidised prices to reach lower income groups. Alternatively, the Social Marketing function may assist manufacturers to expand use of their own brands by lower-income groups through the Social Marketing management of promotional support funded by donor agencies.

Social Marketing practice has not been restricted to health and population programs only. In fact, any program that requires a target population to change an existing practice or behaviour - or to take up a new practice or behaviour - can benefit from the systematic use of Social Marketing techniques. Social Marketing has been employed, successfully, in Eastern Europe to assist factory management and workers to face the challenges of worker health and safety issues. Projects have been developed, also, to trigger community involvement in the development of environmental legislation in local governments.

Social Marketing has also been used to introduce new agricultural practices; to promote tree planting and environmental awareness within communities.

What's in a name ?

Social Marketing may be an adequate description of these methodologies but the word 'marketing' is still troubling to many. It is for these reasons that we can find many programs that are using the latest "Social Marketing" experience but prefer to continue to call what they do "Health Promotion", "Health Education" or "I.E.& C". To many, however, these definitions are too limiting. They suggest that the communications task is, somehow, a separate one from the development of the program as a whole.

There is a growing preference for the use of terms such as "Management for Social Change" to describe what we do, leaving the term Social Marketing to projects that are promoting specific products through commercial sector distribution channels, as is the case in Contraceptive Social Marketing (CSM) programs.

The Social Marketing Experience

The Social Marketing experience spans the whole world, and the practice has been constantly improved over the last 25 years.

Developing relationships between the commercial and social sectors has not been an easy task. Advertising and marketing managers have had to significantly adapt their experience in the commercial world to the far more complex needs of social and community

development programs. The social sector, too, has not necessarily found it an easy task to appreciate that the commercial world has a great deal to offer them. But where both sides to the equation have joined forces and adapted their unique experiences and skills together a new dynamic is created which has been proven to succeed.

Social Marketing has no preconceived philosophy as to what concepts, ideas or strategies will best trigger the take-up of a new or revised social activity. It is a methodology for finding out what approaches will be most acceptable to the community which is to be addressed. Social Marketing is, therefore, a neutral observer in the resolution of controversial social issues. Deep-seated social changes can only occur through the willing participation of the society itself. It is an understanding of this, coupled with a proven methodology for finding out how to trigger these changes in non controversial ways, that makes Social Marketing practice such an important tool for social change.

Social Marketing programs succeed because :

- It is accepted that new ideas, services or products can only be successfully introduced into a society if the intended beneficiaries see them as fulfilling their own aspirations and well-being and not, as has often been the case, that they are asked to become the servants to programs that appear to want to force them to accept the new ideas and technologies being introduced.
- Program development strategies are seen as part of the Social Marketing and social change process itself; a process that is then an on-going one throughout the implementation phase right through to evaluation. Program design can no longer, therefore, take place independently of the process itself. This is well expressed in regard to the appraisal and approval work required to build a bridge, say. In this case, no donor agency would approve such a program until the bridge had been designed and costed in detail. Social change programs, however, need to begin with only a concept - in this case the need for a bridge. But what exact form this bridge will take and how it will be built must essentially be learned over the course of the project itself. And as the project matures and begins to trigger the social changes required, so the design of the program must be constantly revised and adapted to that change.
- They provide a disciplined methodology of management to integrate the technical (or clinical) aspects of the program with service or product delivery and with the behavioral change objectives to be triggered within the community.
- They appreciate that not all target audiences are the same and that each segment needs to be identified and addressed differently.
- They follow a disciplined series of program development and implementation steps that start within the community itself and constantly receive feedback from that

community : with formative research to formulate the whole program's strategies; the testing of those strategies; the evolution of messages; the testing of those messages; the production of communication materials; the testing of the communications materials; the launch of the program; on-going monitoring and tracking of the program and to revise it accordingly.

- The focus is on behaviour; on understanding existing attitudes and practices to a desired intervention and the social contexts in which these practices exist; the blocks and resistances that will impede take up of desired practices - social, cultural, cost concerns, availability, poor service, lack of appeal and so on - and how these constraints may be overcome.
- Rigorous discipline is enforced in the message development processes to ensure that messages always call for, and will motivate, a desired action; resolve all known resistances convincingly; offer meaningful benefits; are memorable and are presented by a convincing authority.
- Special attention is given to service personnel (their training and morale) and to training them in sound counselling practice as real motivators of behavioral and social change.
- Communications strategies are based upon sound research to ensure that reach and frequency objectives are established and met, and generate a sufficient weight of effort to achieve

the required behavioral change objectives. Communications channels may include direct counselling from fixed sites or door-to-door; the generation of word-of-mouth within the community; traditional drama or singing troops or puppet shows; promotional 'events'; contact point display material and innovative use of available mass media.

- A careful balance is achieved between centrally managed activities and locally developed initiatives within target communities themselves.
- The coordination and integration of the program is managed within the broader contexts of other intersectoral or related programs; to ensure synergies are created and objectives are compatible.
- Careful tracking and monitoring are undertaken after launch, so that as the program takes effect and changed behaviors occur, the program is revised accordingly; to ensure that drop-out or unreached target audiences are identified and approached; to understand the processes that will lead to self-sustainability in the most cost effective ways possible.
- They open up opportunities for implementing cost recovery strategies, where appropriate.

Richard Pollard is a leading consultant to Social Marketing programs. He has previously spent over 20 years working in senior positions in advertising and marketing management in developing countries. He has specialized in Social Marketing practice for the last 10 years. He is a British subject with resident status in the USA.

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- Social Marketing has gone a long way towards bridging the gap between the commercial and social sectors.
 - Commercial sector advertising practice has significantly improved the ways that social sector programs present themselves to their target audiences and motivate meaningful social action.
 - Social Marketing of contraceptives programs, where own brands are promoted, have developed a new social form of business which is now developing new product lines such as impregnated mosquito nets, fortified foods and nutritional supplements.
 - Social Marketing programs have opened up new markets for commercial firms where, because of social constraints or where consumers have not been able to afford their products, they have been unwilling to invest in the wide promotion of their products.
 - Social Marketing practice has also been employed in Micro-credit programs; another important example of private and social sector cooperation.
 - Social Marketing has pioneered the practical application of public, social and private sector collaboration and offers important experience in the growing emphasis on private sector participation in development.

Annexure I: Guidelines for Case Studies

**State of the Art Workshop
Reproductive and Newborn Health**

GUIDELINES FOR CASE STUDY REVIEW

There are four case studies; each is on a different NGO health program. The purpose of the case study is to provide essential information for reflection and analysis on critical issues in the design and implementation of community-based health interventions. To the extent possible references to the specific NGO program and its location have been removed from the case study so as to focus our discussions on the principles of program design, monitoring and evaluation, rather than on the details or merits of any particular program. However, each case study is genuine, and reflects a significant NGO effort to address the health needs of a specific community or target group.

It is expected that using the case studies participants in the workshop will gain "hands on" experience in analyzing the strengths and weaknesses of NGO health programs, in order to be able to apply this understanding to the analysis of their own programs. Please read your case study carefully, and consider the program described in the case study in light of the key issue areas listed below. These include both general concerns that impact on all aspects of a program, and specific concerns about different aspects of program design and implementation. (Not all may be relevant to each of the four case studies; address the ones you feel are most critical.) Be prepared to discuss the case study with the other members of your group. The benefits of the case study method come from the opportunity to learn from each other. There is no right answer, but working together we can increase the effectiveness of our individual and collective efforts to improve the health of women and newborns in Pakistan.

GENERAL CONCERNS

- **PARTICIPATION:** How have communities been involved in the program's design, implementation, monitoring or evaluation? Has the NGO incorporated the views and priorities of those it aims to serve in the program's design? Are program priorities set by the community, by the NGO, by another agency (the donor, the government, etc.)? Has the NGO revised its program strategy in response to feedback from the community?
- **INTERVENTIONS:** Is the NGO doing things which are known to be effective? Are there any other interventions they might include? How is the NGO measuring the quality of services? Are there measures the NGO could take to improve the quality of the services they provide?
- **MALE RESPONSIBILITY:** Women are the focus of concern in improving reproductive and newborn health. But men play critical roles in the household and in the community in assuring that women receive the health care they need to protect their own health and that of their newborn infants. How has the NGO involved men in addressing the health needs of women and newborns under their program? Has the involvement of men in the program been effective in improving the health status of women and newborns?
- **COMMUNICATIONS:** Improving the health status of women and newborns requires better access to services, but also the promotion of better health practices. What is the NGO

doing to motivate people to change their behavior around health issues? Has the NGO's communications strategy been integrated into the overall program design? Is it likely to be effective? Why, or why not?

SPECIFIC CONCERNS

1. **OBJECTIVES:** Are the program's objectives clear and precise? Has the NGO made a distinction between its overall mission and its specific program objectives? Would these objectives help the program's managers to monitor the effectiveness of their efforts? If yes, how? If not, why not? (The box at right summarizes the SMART criteria which are a useful basis for thinking about objectives. But feel free to use your own criteria.)
2. **PROGRAM DESIGN:** Think about the structure and process used to design the program. Who was involved in the designing the program? Has the program design changed over time? If you were to advise this organization on steps it could take to improve its program, what would you recommend?
3. **PROGRAM STRATEGY:** Do the program's components contribute to achieving the program's objectives? Why, or why not? Are the program components linked in a coherent strategy? You may want to consider the following typical components of a community health program when looking at the program strategy of the case study organization:

SMART CRITERIA

SPECIFIC: The objective should measure one thing, such as one behavior or one key point of knowledge

MEASURABLE: The objective should be verifiable by independent observers, that is different observers should arrive at the same conclusion when measuring progress against the objective

APPROPRIATE: The objective should be technically correct and describe an aspect of the intervention whose success will have significant consequences

REALISTIC: The target set by the objective should be something which can be reasonably accomplished through program efforts

TIME-LIMITED: The objective should clearly state the period within which the objective is to be accomplished

- Communication Strategy
- Training
- Service Delivery
- Referrals and Follow-Ups

4. **SUPERVISION:** How does the organization monitor its performance and supervise staff? What would you suggest the organization do to strengthen the supervision and monitoring? How would these changes contribute to increasing the effectiveness of the program or program impact?
5. **EVALUATION:** How does the organization evaluate the effectiveness of its program? Given the objectives of the program, what would be appropriate indicators for measuring impact? Is the organization collecting the information it needs to measure program impact? How could the organization increase the efficiency of its data collection?
6. **ORGANIZATION CAPACITY:** An important component of the organizational capacity is the ability to adapt to change. From the information provided in the case study, does the organization appear to have the flexibility and capacity to reassess its objectives and change its program strategy? What is the basis for this assessment?
7. **SUSTAINABILITY:** What is your view of the sustainability of the program? How could the organization make its program more sustainable?

SUMMARY

- **RECOMMENDATIONS:** As a group, what are your concerns about this organization's health program? If your group were asked to consult with this organization about steps to increase the effective of their efforts, what suggestions would you make?

Annexure J: Case Studies

CASE STUDY #1 (Group A/B)

The program was originally established more than seven years ago as a model pilot project to serve Afghan refugees. About three years ago the NGO expanded its coverage to include the Pakistani population living in its project areas. The NGO currently provides curative and preventive health services to a total population of 70,000. Services are provided from four health clinics and two sub-centers with outreach through LHVs and community volunteers.

The overall aims of this organization as summarized in its most recent annual report are:

1. To provide a preventive, health promotive, rehabilitative and curative service to the people in the catchment areas.
2. To give special emphasis to the needs of women and children, by programs of care before, during and after delivery, immunization, child and school health, health education and family planning.
3. To develop and operate specific programs for the control of endemic and communicable diseases.
4. To involve communities in the provision of their own health care, by local consultation, and by recruiting and training volunteers as Community Health Worker (CHWs) and Traditional Birth Attendants (TBAs).
5. To provide basic literacy, health education and craft training to girls 8-12 years in the catchment areas.
6. To introduce new programs, i.e. Mental Health and Early Education.
7. To develop the organization as a model of service.

As stated above, the NGO runs four health clinics. Each health clinic has one male doctor, and one female doctor spends alternate days at each clinic (the NGO is recruiting additional female doctors). There are also two LHVs and a trained TBA at each clinic. The clinics, however, do not have labor room facilities, and the TBA is not an NGO staff member. She has been trained by the NGO, but is paid by the community for her services. The NGO has a four-person training unit led by an experienced female doctor. The NGO recently opened two new sub-centers that provide basic health services to women. These centers do not have male doctors, but are visited weekly by the female doctor.

The NGO has done a baseline survey in each catchment area and established a file for each family. Volunteers are selected from the community are trained as community health supervisors and community health workers (CHWs). A team consisting of a lady doctor and 2 female and 2 male trainers trains the supervisors, who in turn train the CHWs. The training covers both promotive and preventive health care practices and is provided through demonstrations, charts and presentations. The NGO uses visual health education aides and charts in Urdu and Pushto to discuss hygiene, child nutrition, healthy breastfeeding practices, polio, tuberculosis, and malaria prevention. The materials on breastfeeding have been pre-tested with women from the local community.

In our community there is lot of illiteracy, mainly among women. We did have materials in Pushto but now increasingly we are looking for materials in Urdu. We feel that the medium of instruction in schools is Urdu, therefore, the materials should also be in Urdu. We do not have enough funding, however, to make our training program comprehensive. -- Health Supervisor

Over the past year the NGO's staff has received training in the use of participatory methodologies. On a pilot basis, they are experimenting with the application of these methods to the design of their program in one community. Based on the lessons learned from this experience they intend to use a more participatory process in designing the further expansion of their program.

The first level of care within the framework of this NGO's program is the male community health supervisor, who is available in the community 24 hours a day and is well-known by everyone in the community. They can be contacted in case of emergency and when the NGO's health clinics are closed. The community health supervisor is supported by community volunteers, female community health workers and traditional birth attendant (TBA). After training, CHWs are given first aid kits to enable them to provide first aid services in the community. They also motivate and organize the community, identifying pregnant women and others and assisting them in making use of the clinic's health services. The NGO has also trained TBAs from the community and assists them in conducting home deliveries. Recently, the organization has strengthened its community outreach services by organizing women's support groups in several communities where women are provided counseling on breastfeeding, maternal nutrition and child health issues. The support groups are supervised by the LHVs, who now travel regularly to meet with women in each community as part of the support group monitoring process.

The NGO's clinic-based health program provides ante- and post-natal services, and family planning services (since 1995), runs EPI and nutritional rehabilitation programs, and conducts IEC activities through home visits and a school health program. The LHVs supervise home deliveries which are done by the TBAs. Each clinic has a functioning laboratory, a kitchen where food is prepared for infants with severe malnourishment and food preparation demonstrations are conducted, and an ORT corner for ORS counseling, demonstration and treatment. The NGO also manages three craft centers where 8-12 years old girls are taught to read, trained in sewing and weaving, and provided with health information.

The clinic is informed by the TBA's whenever a woman is pregnant. Each TBA is responsible for 25-50 households. TBAs are given a Rs.50 incentive to bring expecting mothers to the clinic for periodic check ups -- Rs.10 when she brings the mother to the clinic to register; another Rs.10 after the third check up following registration; Rs.20 at the time of delivery; and a final Rs.10 when the TBA brings the child in for his/her first BCG vaccination. The NGO's aim is to start antenatal monitoring from the 4th month of the pregnancy, and to have mothers come to the clinic once a month till the 8th month, and twice in the 9th month. Thereafter, mother's are strongly urged to come in to the clinic for weekly visits. During each check up, LHVs take the mother's blood pressure, check the hemoglobin count, weigh the mother and checks the fetal position. Each mother is provided with folic acid tablets. All check ups are conducted only at the clinic.

Family planning services include group counseling by the LHV and the TBA as part of the NGO's health education program. The TBA is also responsible for motivating women in the community to use family planning. If a client does not show up when expected the TBA goes to her house, taking along pills for clients using that method. Otherwise, after finding the reason for her absence, the TBA counsels her to come to the clinic. Clients are provided with contraceptives free of cost. The NGO does not provide surgical contraception, but refers clients to the nearest clinic run by a national family planning service NGO.

When a condition develops that cannot be managed by the clinic, the client is referred to a nearby hospital. During clinic hours (8 am to 2 pm), referrals are made by the doctor in the clinic. If an emergency occurs during working hours, the NGO provides transportation to take the patient to the closest health facility. When faced with an emergency situation after clinic, the patient normally contacts the CHW. The CHW is supposed to refer the person to the closest medical facility, and may or may not accompany the patient. In such situations transport to the hospital is the responsibility of the patient and family. The NGO has also developed a three part referral form. The first part the NGO's doctor documents the diagnosis and describes whatever treatment has been given, including all medications provided to the patient. The sheet is then given to the patient to take to the hospital. The second part of the sheet should be used by hospital staff for their observations and a description of treatment provided by the hospital. The NGO asks that the hospital send the third part back to the referring doctor for the clinic's records.

Referrals are a problem. I personally feel that proper coordination is needed between the District and Tehsil level hospitals and the health centers working under the umbrella of this organization. The women come back with lots of complaints from the hospitals that they are commonly referred to. The consistent problems that they face at these facilities is a long wait, doctor's callous attitude, and lack of proper care by the hospital staff. They also report that the referral sheet is considered a meaningless piece of paper which is thrown in the garbage right in front of their eyes. I am now trying to manage the referrals through my own personal contacts. I have friends and acquaintances in nearby hospitals and I try to send more patients to these facilities with a personal letter. -- Director of the NGO.

Supervision is frequent, with both oral and written feedback and monthly meetings. The director personally visits each clinic at least once a week and provides overall supervision. The doctor at each clinic, as team leader, supervises the work of the LHV(s) at his/her clinic. Each LHV supervises the work of the TBAs and female CHWs in her designated areas. The community health supervisors motivate and supervise the activities of the male CHWs. As an example of the monitoring process, in the family planning program a client's willingness to use contraception is documented on their first visit, and a record is maintained of follow up visits. Once a woman begins using contraception, if she misses a visit the TBA from that community goes to her house and tries to find out the cause for her absence.

Monitoring indicators have been developed for each program component. The indicators used for antenatal care, deliveries and women immunized for tetanus are summarized in the table below. The program's overall effectiveness is measured by the annual change in the number of the clients registered with each clinic. Periodic evaluations are also conducted to assure the quality of the services provided and, since 1995, the NGO has published an annual report.

The NGO has received funding from a number of international donors and the government of Pakistan. One of the principle reasons for expanding its client basis to include the local Pakistani population was to reduce the NGO's dependence on funding for Afghan relief activities. The NGO currently charges a fee of Rs.10 from each patient who comes to its health clinics. The NGO has also developed linkages with the government to obtain vaccines for immunization free of cost. The NGO is able to obtain contraceptives from the government free of cost, and through a national NGO at subsidized rates.

ANTENATAL CARE					
	Clinic 1	Clinic 2	Clinic 3	Clinic 4	TOTAL
Cases left from last year	182	297	--	93	572
Registered	916	737	157	470	2,280
Discharged	831	753	73	397	2,054
Cases at end December	297	281	84	166	798
Referred or repatriated	--	5	--	3	8
Lost	--	6	--	--	6
Still Births	3	3	1	13	20
Abortions	5	--	--	3	8
Total Visits	3,869	3,355	326	1,725	9,275
DELIVERIES					
Normal deliveries	825	738	63	374	2,000
Abnormal deliveries	1	5	12	21	39
Total deliveries	826	743	75	395	2,039
Total live births	811	739	72	364	1,986
Still births	3	3	1	13	20
Complications: haemorrhage	--	--	--	--	--
infection	--	--	--	4	4
perineal tear	--	--	--	4	4
Premature babies	4	1	2	11	18
Babies weighing under 3 kg	3	--	1	49	53
Deliveries by trained staff	826	740	73	387	2,026
Deliveries by others	--	3	2	8	13
WOMEN IMMUNIZED FOR TETANUS					
Estimated number of women aged 15-45 in 1996 : 10,130					
Women (15-45)	Total Doses - 3,531				
	T.T. 1	T.T. 2	T.T. 3	T.T. 4	T.T. 5
Pregnant	745	594	189	181	130
Non-Pregnant	487	421	413	214	157
Total	1,232	1,015	602	395	287

CASE STUDY #2 (Group C/D)

The NGO started about a decade ago as a project for refugees, but four years ago expanded its activities to cater to the local population. The NGO has developed a recognized expertise in water and sanitation, but in the past two years has been expanding its activities to include primary health care. At present, the program emphasizes the implementation of community-based sanitation, water supply and hygiene projects, working closely with community groups and government departments. Its activities include service delivery, training and health education. In collaboration with two other NGOs it is providing training and institutional support to two government departments to increase their capacity to work effectively with communities in the implementation of water and sanitation projects.

Overall, the NGO works with several dozen communities in 7 districts. This case study focuses on the NGO's program in 10 villages in 4 districts, which is representative of the organization's general program strategy and approach. The NGO has a total staff of 42, including a director and various administrative staff at the central office. The staff for its work in these four districts consists of a field coordinator, a female supervisor, ten field officers, ten LHVs, three trainers and two sewing teachers. The NGO's specific objectives for its work in these communities are:

1. To reduce the incidence of diarrhoea, tetanus and measles within communities
2. To equip CBOs to implement and sustain development within their community by undertaking a sanitation, hygiene and water supply project
3. To mobilize Government Organizations to facilitate Community Based Organizations (CBOs) to implement development
4. To train 50 Female Health Workers (FHWs) to take responsibility for improved health practices within their community and mobilize community females to form Women Organizations (WOs)
5. To assist teachers to implement health education in schools within the target communities
6. To assist CBOs to construct 50 PF latrines and install 20 hand pumps in schools located within the target communities
7. To assist CBOs to construct 650 PF and 150 VIP household latrines utilizing a revolving fund approach and sanitation/hygiene awareness raising
8. To train 20 masons in latrine construction and well improvement for the CBO
9. To facilitate CBOs to install 50 communal hand pumps and train 50 community members as hand pump caretakers
10. To assist CBOs to improve the service delivery of the existing PHED tubewell schemes by undertaking self-management of these facilities
11. To assist 5 CBOs to implement female literacy programs within their communities

The main focus of this NGO's program is on its collaboration with the existing CBO(s) in each village. Through this collaboration the NGO aims to enhance the capacity of the CBO to implement and manage their own community development efforts. The community's primary health care needs serve as the entry point for this collaboration, with an emphasis on the community's need for clean water, sanitation and health education. Generally, the community's primary motivation for collaborating with the NGO is to gain access to services and assistance in the installation of hand pumps. Training is provided to representatives from the community, and in return, the NGO emphasizes the importance of the community sharing in the cost of implementation. Areas of

training include, how to manage and implement development programs; latrine construction and the installation of hand pumps; health education; and literacy, especially for women. The NGO also works with the CBO and community members to motivate behavioral and social change and promote the formation of women's organizations.

The second component of the NGO's approach focuses on the development of linkages with government line department. The NGO has been able to access construction materials for latrines and water projects through the government. These were initially provided to the community free of cost, but now the NGO helps the CBO to set up a cost recovery mechanism, with the funds generated to be used to purchase additional materials from the local market. The NGO also seeks to strengthen the government line department's capacity to provide technical assistance and training to communities on the construction, installation, operation and maintenance of latrines and hand pumps.

The process used by the NGO to identify the problems faced by the community has been going through a constant evolutionary process. The initial project design was to supply hand pumps to villages to create communal safe water channels. Due to complaints from the community that it was culturally inappropriate for the women to go to communal water facilities in the neighborhood, this was changed to providing individual hand pumps for households. Eventually, the NGO saw that it was facing a similar problem in promoting its sanitation program since the issue of sanitation goes beyond just the disposal of human waste. At that point the organization changed its strategy to a more participatory approach. In addition to constructing latrines and installing hand pumps, it began to hold public meetings in the community to build awareness of water, sanitation and hygiene practices. CBOs were invited to a demonstration on sanitation, as well as to discuss their views on the issue, and the NGO increasingly assumed a facilitating role in helping the community to solve its own health and sanitation problems.

To improve its sanitation efforts the NGO sought to train women from the community to provide health information. But when this training started there were a lot of drop outs because the training was not seen as relevant by the participants.

Community participation is a new trend. We have started working with this new approach. Our main focus is sanitation. However, we are increasingly finding that sanitation may not be the immediate need of the communities, although, according to World Health Organization (WHO) just 3% of the people in these communities have access to proper sanitation facilities. It has been a challenging job to change the focus of the community to sanitation, while primary health care is something that the communities want to address. - male field coordinator/motivator

The NGO is now introducing primary health care issues into its program. Using a participatory approach, communities are engaged in discussions on the importance of vaccination, the various diseases they've experience, and the health status of mothers and children in the community. The NGO's LIIVs provide information and guidance on prenatal and natal health issues.

This is a new community, I am the lady health visitor here, I do not live in this community. I come here every day at 9:30 a.m. and leave at 2:30 pm. I provide them with health education on different health issues. I also train mothers on breastfeeding, on healthy eating practices, and on using toilets and the washing of hands after use. I do door to door visits, talking with women and counselling and motivating them. I have also trained local women as female health workers (FHWs), they can now help in prenatal or post natal situations and emergencies. - lady health worker

The LHV is responsible for identifying women from the community who are interested in being trained as FHWs. This training is for 3 months and includes information on:

- the main sources of the common illnesses in the community and their prevention
- sanitation and health issues related to the environment
- antenatal care and post natal care
- child care and nutrition
- family Planning
- AIDS/STDs awareness
- breastfeeding

The training is provided to women in groups, and is largely verbal and visual, using visual aids such as diagrams and photographs.

I am glad that Baji (LHV) is here and has selected this community for training. Before this training we did not even know how to talk properly. She has been very kind to us. She has taught us things that we did not know before. Baji is also very patient with us. She uses pictures for training, I follow the pictures and the verbal lecture. Sometimes I understand things, at times I do not. The pictures are not confusing. May be I am dumb. - female health worker

The breastfeeding component includes the setting up breastfeeding support groups in these communities to promote the practice among mothers of child bearing ages. The LHV motivates women to join these groups, and also encourages them to form their own women's organizations. The FHWs are trained in breastfeeding counselling techniques. The government's lady health workers have also been involved in the support group process, providing an opportunity for closer interaction between them and the FHWs and promoting a greater sharing of knowledge and skills that should enable both the government and the NGO to better meet the needs of these communities.

The NGO also intends to train the male community volunteers working on sanitation so that they can run support groups for men to increase their involvement in addressing the health needs of their families and the community. Though they do not have a defined strategy for work on family planning and sexually transmitted diseases, the NGO is doing some work in this area, particularly in creating awareness among men on these issues.

The old and illiterate men in the community are normally resentful towards family planning. But we still approach men on issues like family planning. We are also

creating awareness on Sexually Transmitted Diseases (STDs), especially AIDS. Just a few months back, a driver who returned from one of the Arab states tested positive on HIV, his wife and the newborn child were also positive. This provided us an opportunity address the issue of AIDS, and I think we were quite successful in disseminating information on HIV/AIDS awareness building. - male field coordinator/motivator

The NGO does not provide clinical services and does not have a system to refer patients to any of the area hospitals. Often the members of these communities have identified a clinic or hospital where they take people in an emergency. Transportation, however, is a serious problem. It is expensive and difficult to find at any time, and especially in an emergency. The NGO has set up a referral system for surgical contraception as part of its family planning activities.

I have been trained in antenatal and post natal care. I don't have an education, but have been helping community women in delivering babies even before this training, so this kind of work is not at all new for me. I can gauge the position of the fetus by looking at it. Baji (the LHV) has taught us how to assess whether or not the fetus is in a normal position. I also know the exact location of the maternity clinic in the area. But still there are problems. When my sister-in-law had a baby, he was delivered by the Dai from the clinic, since we have no doctor. I could tell that the child was not well so we took the child to the hospital but he died on the way. I could not reach the office of this organization that trained us. - female health worker

The NGOs LHVs keep statistics from the prenatal and post natal examinations they conduct, including the name of the patient, the services provided, and the name of the FHW who referred the woman to the LHV. In addition, the LHV visits the community daily during the week to see whether the community is keeping the surroundings and their houses clean. The LHV also makes home visits to meet with individual women and their families.

The NGO prepares quarterly and bi-annual reports on progress and achievements. Among the key indicators that have been identified for purposes of evaluation are:

- the percentage reduction in child morbidity due to diarrhea
- changes in the villagers' attitude towards hygiene
- a comparison of cleanliness and hygiene conditions before and after the program
- the number of persons benefiting from the program (calculated as a ratio of cost per beneficiary per year)

The NGO receives funding support from several international and bilateral donors, as well as from the government. As described above, it has also developed linkages with the government line departments through which it receives in-kind support (materials and supplies), and it has provided training to government agencies and other NGOs in sanitation technology and program management on a fee-for-service basis.

CASE STUDY #4 (Groups G/H)

This NGO was founded 17 years ago by a physician, with the overall aim of creating awareness in disadvantaged communities on different health issues. In the initial stages interventions were largely focussed on improving child health. Over the years the organization's focus has grown to include provision of primary health care services oriented to women and children, and to strengthening the community's capacity to solve its own problems in health, education and water/sanitation. The organization works in rural and peri-urban villages from offices located in nearby urban centers. Health services are provided through mobile teams, who visit project villages on a weekly basis, and through community health worker volunteers who are based in the villages.

The NGO states that it's overall mission is "the provision of basic health and education services for the under privileged communities, grooming the communities till they are empowered and independent in most of their daily needs." The NGO's specific objectives are to improve the health status of women and children by:

1. Formation of CBOs
2. Establishing MCH center at each village
3. Establishing or strengthening at least one non-formal school or literacy center in each village
4. Decreasing the infant mortality rate to about 50% of the national figures
5. Decreasing the maternal mortality rate to about 50% of the national figures
6. Studying and reporting on possible methodologies of rural development
7. Initiating the development process in the target villages
8. Providing at least two model hand pumps
9. Providing at least five pit hole latrines

As stated above, the NGO provides health services through mobile teams, which visit each village in their catchment area once a week. Each team is comprised of a doctor, an LHV, and three CHWs. LHVs and doctors work out of the main office in a large city, and from a sub-office in a city closer to one of the project areas. The NGO also works with CBOs to start at least one home school in each village. The teacher is nominated by the community. The NGO is working in 75 villages in different areas of the province, serving a population of 150,000 people. There has been rapid expansion of the program in recent years; this trend seems to be changing, with more emphasis currently being placed on strengthening ongoing activities and increasing the scope of activities in already established project areas.

The NGO had developed a set criteria for selecting villages and initiating activities: the prospective community has to have, or be willing to form a CBO, and the community has to be interested in starting a health center and a school. In addition the community has to agree to be responsible for providing the space for these activities, and to nominate male and

female volunteers who will be trained as CHWs. CHWs are expected to be literate, with the result that most of the female CHWs are teenage girls (ages 13-15).

We work in the community, we come to this centre once a week. We come walking as our village is 7 km away. We know the Dai and do communicate with her. We motivate pregnant women to come to the centre for their check ups, and also educate our people on different health and sanitation issues. We do not face any problem because of our age. People take us seriously and listen to us." - female community health worker

Before the project starts, the CHWs, with the assistance of the mobile team, carry out a baseline survey in their own village. The baseline survey is analyzed and the results are discussed with the community.

The MCH center is the site of the weekly clinic attended by the mobile team and the local CHWs. Clients are charged Rs. 5 per visit, which is collected by the CBO and used for the purchase of basic medicines and the upkeep of the premises. Minor ailments are treated by the doctor, children are vaccinated and their growth measured. Health education is given to mothers about breastfeeding, adding supplemental foods, care of the child with diarrhea or acute respiratory infections. Women are given prenatal care -- usually consisting of measuring the uterus, looking for fetal movement, and taking a blood pressure reading.

A child was born in our community. There was no doctor or LHV, there was just one Ayah at the time of the delivery. The child did not cry. The Ayah slapped the child and the child started crying. At night the child had fever and his one side started shaking. Next morning we took the child to the doctor in the closeby community. He monitored the child for two days, but when there was no change in child's condition then we took the child to the hospital in the city. The child was admitted in the hospital for several days till he fully recovered. There are several dispenser and unqualified doctors in the area. The Dais also do not give any clear directions in emergency situations. - a male community health worker

The organization is trying to connect with a teaching hospital located 22 kilometers from one of the catchment areas to create linkages for referrals. Family Planning services are provided in coordination with a national family planning service delivery NGO.

Most of the health services are delivered at the village MCH center during the weekly clinic by the mobile team. Recently, lactation support groups have been established in 8 villages. The women in these groups do not meet in the MCH center but in women's homes. These groups are facilitated by the NGO's LHVs and include village women who are pregnant,

lactating or simply interested. The local dai/TBA and government Lady Health Worker have also been invited to attend.

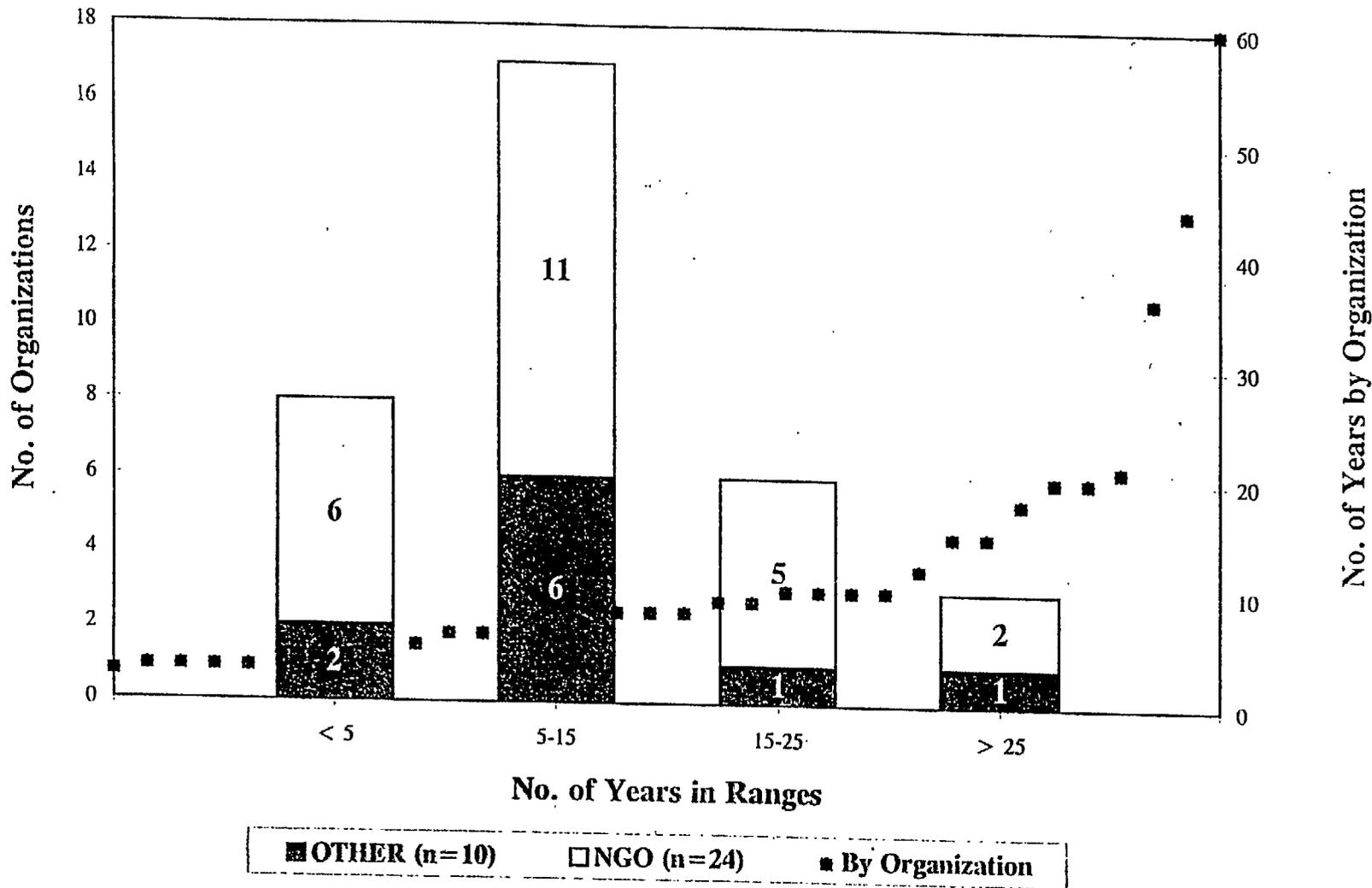
In past years, 135 TBAs were trained by the NGO under an arrangement with the provincial health department, however this training has since ended. The NGO is now working with the provincial government on the LHW program, helping workers organize village committees and helping the government to monitor performance. The NGO receives support from a variety of donors; the Pakistan government, bilateral programs, non-governmental organizations, and from development banks. The NGO also has a network of private contributors who provide core support for its program. It expects to withdraw from villages with established programs when the CHWs are well trained, the CBO is actively involved in activities, and there is sufficient recovery from user charges. To date, however, the NGO has not withdrawn from any of the villages where it has initiated programs.

Training is a major activity of this NGO. CHWs participate in a 3-month training course when they join. To date over 35 CHW training courses have been given. Doctors and LHVs working for the NGO receive periodic in-service training to upgrade their skills, and linkages and contractual arrangements have been made with other NGOs to train their staff.

LHV and Medical supervisors periodically attend the mobile team's sessions and the LHV supervisor monitors the lactation support groups. The staff have monthly and quarterly meetings, and review monthly/quarterly reports. Reports are compiled from data collected from the management information system (MIS). The NGO produces a newsletter which is sent to participating CBOs and other NGOs/donors. The organization compiles an annual report, has an annual meeting and undertakes an annual internal evaluation. This past summer, the NGO completed an external evaluation which looked at a random sample of 8 out of 24 villages in one of its project areas.

**Annexure K: Current NGO/Government/Donor
Database on Reproductive Health
Activities**

NUMBER OF YEARS WORKING IN REPRODUCTIVE HEALTH



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Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	HP Rating	Health Promotion Indicators
GOVT		Maternal; Child Health Services	Nutrition of mothers and infants, Breastfeeding and provision of Micro nutrient substitutes to the pregnant ladies and nursing mothers.	Most Important	The key indicators are decreased in Maternal Mortality and Morbidity rate and healthy satisfied mothers and babies
GOVT	8	child health; MCH		Very Important	
GOVT	5	Education; training at graduate & post graduate levels; health		Very Important	We have initiated what is called as "social obstetrics" yet to develop impact indicators
NGO	18	Quality care at offerdable prices; academics		Very Important	
NGO	8	Women's political participation; reproductive health; Women's legal rights; Women's rural issues	Infectious diseases, epidemics e.g. in floods arranging medical camps etc., nutritional problems for women and children under 5 years of age	Very Important	Qualitative analysis
NGO	3	Women in low income communities	General sexual health (a better understanding of the body, building confidence to talk about and seek help regarding one's body, Safe sex (condom usage) (sexual health awareness program with males in the community), involvement of non registered medical practitioners	No Rating	CFP service form referral forms number of training impact study
NGO	10	Health; nutrition; family planning HRD training	Human resource development	Most Important	Number of cases of RTI/STDs that are diagnosed and treated at our CBD clinics by LHVs or referred to our surgical centres, number of couples practicing contraception in our service areas, number of mother and children who come to CBD centers for MCH service

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Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	HP Rating	Health Promotion Indicators
DONOR	6	health; family planning; education; poverty alleviation	TVO has been supporting projects of MCH centers and primary health care	Very Important	AGE OF LAST BORN OR LAST TWO CHILDREN
DONOR	6	poverty alleviation	world bank works at policy level to minimize gender imbalances and assist governments in improving public private partnership	No Rating	
GOVT	4	Health		Most Important	IMR & MMR, decrease infant mortality, morbidity
GOVT		preventive; curative; health education		Very Important	Increase/decrease in breast feeding practices, decrease in common diseases met with pregnancies and utilization of services
GOVT	60	Obstetrics; Gynecology	JPMC is one of the largest institutions of the country providing undergraduate and postgraduate training for medical students, nurses, midwives and paramedics. The department of Obstetrics and gynaecology is recognised for training by the college of physicians and surgeons Pakistan, various universities of the country and the Royal College of Obstetricians and gynaecologists London.	Very Important	
GOVT	21	Province of sindh		Most Important	% of mother breastfeeding, control of diarrhea nd ARI
GOVT	8	Different diciplines of public health	Qualitative research methods, communications	Most Important	Behavior change, but as we are involved in training only?
GOVT	3	Public health	Research particularly operations research in-service training in planning and management	No Rating	AS ABOVE
GOVT	10	maternal; child health	Teaching, training, refresher course, workshops, seminars, administrator	Very Important	Number of information campaign number of training number of breast feeding mother, number of referrals, morbidity and mortality

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	HP Rating	Health Promotion Indicators
NGO	6	Advertising; strategy marketing	Development of health improvement material; audio tapes for breast feeding and contraceptives, print material, training and counselling, docu drama, audio-visual	Very Important	
NGO	5	Community Development	Astore (population 80,000-90,000) No single health centre just to deliver the pregnant lady.	Most Important	(1) weight of baby; and (2) weight of mother
NGO	12	primary health care; education	preventive (malaria and TB control, CDD), treatment of common diseases, health education, EPI, school health, training of CHWs and TBAs, informal education for small girls	Most Important	As in B above
NGO	3	Gender; advocacy; capacity building ; HR		No Rating	
NGO	15	health; nonformal education; development	child care, adolescence girl, nutrition, girlchild educator	Most Important	number of children exclusively breastfeed, MMR, NMR, perinatal mortality rate
NGO	9			Most Important	Promotion of B/F practices, clean and safe child birth, control of diarrhoeal diseases, nutritional diet for mothers and child, good hygiene practices for mother and child reduce the incidence of breast cancer
NGO	20	Integrated MCH; family planning services	Involvement of men and their shared responsibility in fertility control and parenthood	Most Important	Improved maternal and child health reduced maternal and infant mortality
NGO	2.5		emergency obstetric care, community based health education	Very Important	Field supervision of LHWs, number fo referrals by LHWs to health centers, number of complications evacuated to centers
NGO	36	reproductive health; healthy child survival	complete immunization of children under , complete immunization of expectant mothers	Very Important	Decrease in maternal mortality, reproductive tract infection
NGO	20	MCH care	we provide a community based PHC services to more than 250,000 people	Very Important	% of mother breastfed their infants maternal mortality

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	HP Rating	Health Promotion Indicators
NGO	4	social mobilization; advocacy; HES; SED;NRM	to supply neat drinking water at the doors of women particularly pregnant women, we provide technical assistance/loan for construction of household latrines, kitchen gardening, poultry with all assistance	Very Important	Monthly reports of CHWs and TBAs.
NGO	10	Health; education; income generation; poverty alleviation		Most Important	People follow medical advice continue breastfeeding upto 2 years start wearing after 4 months
NGO	44	reproductive health care	research in trends and acceptance of available FP methods, research in newer contraceptives for their acceptability affordability, and efficacy in our own (south East Asain) set up, profile of acceptors, training of other NGOs Government medical and paramedic service providers	Very Important	Number and type of IEC material distributed, number of doctors/paramedics trained, number of meeting held with field workers, number of cases provided counselling on AIDS and HIV, number of training activities, number of women who received obstetric care
NGO	6	family planning; public health nutrition	Since G.Ps chair 80% of the clients we aim at training these to provide quality family planning services through these outlets. A referral system strengthens these services.	No Rating	
NGO	15	health; community health services		No Rating	Decrease in maternal mortality and decrease in the incidence of complications related to pregnancy delivery and post partum period
NGO	4	Maternal health; maternal mortality		Most Important	decreased infant mortality and all there mentioned under 6 a
NGO	10	national level	women integrated development programes, education	Most Important	Mother club, medical camps
NGO	7	13 districts fo balochistan (rural)	Water and sanitation activities are also carried out, vaccination, staff training, exposures to the trained TBAs (for practical demonstration), basic health training, community health worker training	Very Important	
NGO	3	maternal; child health		Most Important	

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<u>Type</u>	<u>RH Yrs</u>	<u>Health/Geog. Focus</u>	<u>Other Areas of Activity</u>	<u>HP Rating</u>	<u>Health Promotion Indicators</u>
NGO	9	primary health care	CDD control of diarrhea diseases, immunization, nutrition education, water and sanitation	Most Important	Mean duration of breastfeeding number of women dying of childbirth % of newborns with normal birthweight tation of member of women appropriately referral for coplication proportion of birth handled by trained staff etc.
NGO		sanitation ;credit		Very Important	Though meetins with the target group

RANKING OF IMPORTANCE
By Area of Activity (n=37)

	Most Important	Very Important	Somewhat Important	No Rating
Family Planning	41%	46%	5%	8%
Safe Pregnancy	49%	38%	0%	14%
Health Promotion	41%	43%	0%	16%
STDs	16%	24%	19%	41%
TOTAL	36%	38%	6%	20%

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AREAS OF ACTIVITY
By Type of Organization

	FAMILY PLANNING	SAFE PREGNANCY			HEALTH PROMOTION				SEXUALLY TRANS- MITTED DISEASE
		Prenatal Care	Neonatal Care	Post Natal Care	Breast- feeding	Maternal & Neonatal Health	Safe Motherhood	RTIs	
NGOs (n=25)	92%	84%	72%	80%	76%	84%	80%	64%	54%
GOVT (n=10)	100%	90%	100%	90%	100%	100%	100%	90%	70%
DONOR (n=2)	100%	100%	100%	100%	50%	50%	50%	50%	50%
TOTAL	95%	86%	81%	84%	81%	86%	84%	70%	59%

SAFE PREGNANCY ACTIVITIES AND THEIR OVERALL IMPORTANCE
By Type of Organization

	Service Provision	IEC	Training	Referrals	Most Important	Very Important	Somewhat Important	No Rating
NGOs (n=25)	52%	84%	68%	60%	48%	32%	0%	20%
GOVT (n=10)	70%	90%	90%	70%	50%	50%	0%	0%
DONOR (n=2)	50%	50%	50%	0%	50%	50%	0%	0%
TOTAL	57%	84%	73%	59%	49%	38%	0%	14%

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	SP Rating	Safe Pregnancy Indicators
GOVT		Maternal; Child Health Services	Nutrition of mothers and infants, Breastfeeding and provision of Micro nutrient substitutes to the pregnant ladies and nursing mothers.	Most Important	The key indicators are a decrease in the infant and maternal mortality rate.
GOVT	8	child health; MCH		Very Important	Hospital data
GOVT	5	Education; training at graduate & post graduate levels; health		Very Important	A hospital record system and a primitive MIS for PHC
NGO	18	Quality care at offerdable prices; academics		Most Important	Regular maternal morbidity and mortality meetings and audit
NGO	8	Women's political participation; reproductive health; Women's legal rights; Women's rural issues	Infectious diseases, epidemics e.g. in floods arranging medical camps etc., nutritional problems for women and children under 5 years of age	Very Important	Qualitative studies, evaluation surveys, change in the behaviour and attitudes of the people
NGO	3	Women in low income communities	General sexual health (a better understanding of the body, building confidence to talk about and seek help regarding one's body, Safe sex (condom usage) (sexual health awareness program with males in the community), involvement of non registered medical practitioners	Very Important	CFP service form, referral forms, number of training impact study
NGO	10	Health; nutrition; family planning HRD training	Human resource development	Very Important	Pre-post natal service deliver records, follow up of activities
NGO	6	Advertising; strategy marketing	Development of health improvement material; audio tapes for breast feeding and contraceptives, print material, training and counselling, docu drama, audio-visual	Very Important	Per and post advertising research

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	SP Rating	Safe Pregnancy Indicators
NGO	5	Community Development	Astore (population 80,000-90,000) No single health centre just to deliver the pregnant lady.	Most Important	(1) data collection and comparison of number of clients half yearly and yearly; (2) reduced postnatal complications of mother and child like infection and ?; and (3) measuring the birth weight of baby
NGO	12	primary health care; education	preventive (malaria and TB control, CDD), treatment of common diseases, health education, EPI, school health, training of CHWs and TBAs, informal education for small girls	Most Important	Infant and maternal mortality rate, supervised deliveries by trained persons, EPI coverage (especially TT) nutrition state of under two children etc.
NGO	3	Gender; advocacy; capacity building ; HR		No Rating	
NGO	15	health; nonformal education; development	child care, adolescence girl, nutrition, girlchild educator	Most Important	Rafers of pregnant women attended by trained personal, number of antenatal followup number of post natal followup
NGO	9			Most Important	Reduce the incidence of maternal and infant mortality rate reduce the incidence of tatnus postpartum hamorreage
NGO	20	Integrated MCH; family planning services	Involvement of men and their shared responsibility in fertility control and parenthood	Most Important	Number of women and children attending FW/MCH centers improved health of mothers and children
NGO	2.5		emergency obstetric care, community based health education	Very Important	number of pre-natal, neo-natal, post-natal checkups conducted in health centers
NGO	36	reproductive health; healthy child survival	complete immunization of children under , complete immunization of expectant mothers	Very Important	the newborn in the target area
NGO	20	MCH care	we provide a community based PHC services to more than 250,000 people	Most Important	number of deaths of neonates, % of ppherperal infection
NGO	4	social mobilization; advocacy; HES; SED;NRM	to supply neat drinking water at the doors of women particularly pregnant women, we provide technical assistance/loan for construction of household latrines, kitchen gardening, poultry with all assistance	Very Important	monthly reprots received by community health workers

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	SP Rating	Safe Pregnancy Indicators
NGO	10	Health; education; income generation; poverty alleviation		Most Important	Decrease rate of referral, post partal diseases decreases
NGO	44	reproductive health care	research in trends and acceptance of available FP methods, research in newer contraceptives for their acceptability affordability, and efficacy in our own (south East Asain) set up, profile of acceptors, training of other NGOs Government medical and paramedic service providers	No Rating	Numbers provided FP services, number of doctors/paramedics trained, numbers provided reproductive health services, number of referrals generated, quality services provided number of CYP achieved, method mix available number of advocay activities regarding PNC
NGO	6	family planning; public health nutrition	Since G.Ps chair 80% of the clients we aim at training these to provide quality family planning services through these outlets. A referral system strengthens these services.	No Rating	
NGO	15	health; community health services		No Rating	
NGO	4	Maternal health; maternal mortality		Most Important	Have developed an educational film
NGO	10	national level	women integrated development programes, education	Most Important	Mother club, medical camps satisfied client meeting
NGO	7	13 districts fo balochistan (rural)	Water and sanitation activities are also carried out, vaccination. staff training , exposures to the trained TBAs (for practical demostration), basic health training , community health worker training	Very Important	number of deliveries conducted , number of referrals live births and maternal deaths
NGO	3	maternal; child health		Most Important	
NGO	9	primary health care	CDD control of diarrhea diseases, immunization, nutrition education, water and sanitation	Most Important	T.T coverage, antenatal visits by health assistants, risk pregnancy, neonatal mortality, pregnancy outcome, pregnancy westage, delivery conducted by trained health personal
NGO		sanitation ;credit		No Rating	

Type	RH Yrs	Health/Geog. Focus	Other Areas of Activity	SP Rating	Safe Pregnancy Indicators
DONOR	6	health; family planning; education; poverty alleviation	TVO has been supporting projects of MCH centers and primary health care	Very Important	
DONOR	6	poverty alleviation	world bank works at policy level to minimize gender imbalances and assist governments in improving public private partnership	Most Important	IMR, number fo women registered for antenatal care (trend) (3) % of pregnant women who got two or more doses of T.T vaccine
GOVT	4	Health		Most Important	IMR, MMR
GOVT		preventive; curative; health education		Very Important	Utilization fo services, decrease in common incidences/disease in prenatal stages and decrease in IMR, MMR
GOVT	60	Obstetrics; Gynacology	JPMC is one of the largest institutions of the country providing undergraduate and postgraduate training for medical students, nurses, midwives and paramedics. The department of Obstetrics and gynaecology is recognised for training by the college of physicians and surgeons Pakistan, various universities of the country and the Royal College of Obstetricians and gynaecologists London.	Most Important	As discussed previously
GOVT	21	Province of sindh		Most Important	% of pergnancy with risk factor, % of LBW babies
GOVT	8	Different diciplines of public health	Qualitative research methods, communications	Most Important	Same as above
GOVT	3	Public health	Research particularly operations research in-service training in planning and management	Very Important	AS ABOVE
GOVT	10	maternal; child health	Teaching, training, refresher course, workshops, seminars, administrator	Very Important	Number of patients attends under can

ماں دی رالھی

ماں نے ماں دھی بہن وی ماں اے
تینویں - نوہنہ - دھوئی پوتی وی ساں اے
جو دیت بھابھیں فالگم - ماں اے
بھابھیں رانی گوتی - ساں اے

ساواں جاناں نہ بچے بلہے
نہ اے چلھے جو ننگ جلدے
جبت ماں دے پیراں تھلے
ساں مر جائے تے دھرتی تلے

بھری تے پھوٹری پے جانہی
و دھوی تے کوٹھی ویل آکھانہی
و نہ لہجے تے مایے تاوے
گھراں دے طعنے جے دا ج نہ پوادے

جے لٹ جاوے تے چو رالوہا وے
جد تائیں چا گواہ نہ بیا وے
ان پڑھ کھکھی ساہنی - ساہنی
و کدی - لٹاں کھانہی

آ و ا ج رل قسماں لھائے
ا بچے دیس دی ماں لڑاں بچائے
سب تو پہلا فرض کیناں دا
خاوند - پتر - پیو - بھرا دا

گھوڑا ابو جھہ خلومت چا وے
گھوڑا پیر خلومی ادا وے
پھلوں اپنے فرض بنا لہے
فیرالٹے اگے ہمتہ پھیلا لہے

ماں دا رتہ تے رب نے جوتا
ایہنوں لڈی وی آکھو اینہ سکدا

سیرے دیس جے کوئی نہ ویکھے
ایس بھانی ماں دے لہیہ

دھیماں جتے تے مینے کھا وے
بال نہ بہوں تے سواں آ وے

سب لٹش سمنہی سب لٹش جردی
ہر پیل ہر دم آک ماں سردی

ماواں بھئی لٹش بھارا کھاون
ایہیاں جاناں آ پ بچا وون

ماں دی عزت عھت جہانی
تاج اوہناں دی ہریچے رالھی
(استانز تاج کماں)