FINAL EVALUATION

CHITRAL CHILD SURVIVAL PROJECT, CHITRAL, KHYBER PAKHTUNKHWA, PAKISTAN

June 2014

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Disclaimer: The Consultant has made every effort to provide the most accurate information, data, statistics, facts, figures, drawings and procedural descriptions contained in this document. However, the limitations of the accuracy of the information at the source remain. The conclusions and recommendations herein are based on the data and information available to him.

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CHITRAL CHILD SURVIVAL PROGRAM, PAKISTAN

CSHGP Cooperative Agreement Number: GHN-A-00-08-00010-00

June, 2014

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ACRONYMS

AKDN	Aga Khan Development Network
AKF GVA	Aga Khan Foundation, Geneva
AKF, P	Aga Khan Foundation, Pakistan
AKF USA	Aga Khan Foundation, United States
AKHS, P	Aga Khan Health Services, Pakistan
AKRSP, P	Aga Khan Rural Support Program, Pakistan
AKU	Aga Khan University
ANC	Ante-Natal Care
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHU	Basic Health Unit
BPCR	Birth Preparedness and Complications Readiness
CBA	Child Bearing Age
CBSG	Community-Based Savings Groups
CCSP	Chitral Child Survival Project
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHW	Community Health Worker
CMW	Community Midwife
CSHG	Child Survival Health Grant
DAC	District Advisory Committee
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DoH	Department of Health
DHQ	District Headquarters
FGD	Focus Group Discussion
HMIS	Health Management Information System
KII	Key Informant Interview
KPC	Knowledge, Practice and Coverage
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDG	Millennium Development Goal
MIS	Management Information System
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
MTE	Mid-Term Evaluation
NMNCHP	National Maternal, Neonatal and Child Health Program
OR	Operations Research
PAIMAN	Pakistan Initiative for Mothers and Newborns
PC-I	Planning Commission - I
PNC	Post-Natal Care
PPP	Private-Public Partnership
RHC	Rural Health Center
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
UC	Union Council
USAID	United States Agency for International Development
VHC	Village Health Committee

"Final Evaluation Report of Chitral Child Survival Project"

EXECUTIVE SUMMARY

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

Evaluation Purpose and Evaluation Questions

The purpose of Final Evaluation (FE) was to conduct a performance evaluation of Chitral Child Survival Project (CCSP) and assess whether expected results were achieved. The evaluation is further intended to document project processes and learning which can be used by the provincial government to replicate or scale up activities. The findings of FE will also inform the broader CMW strategy at the national level and may contribute to global learning for reducing maternal mortality.

Besides assessing project performance against plans and indicators approved by USAID, the overarching question for the evaluation was whether the original development hypothesis held true. Three key questions supported by various sub-questions were set for the FE summarized as follows:

1. To what extent did the project accomplish and/or contribute to the results (goals and objectives) stated in the detailed implementation plan (DIP), how were these results achieved or what impeded achievement of the results?
2. What are the key factors for sustainable community midwife (CMW) uptake within the government and community?
3. Which components of the project strategy (CMW training and deployment, behavior change strategy, community mobilization and community-based savings groups (CBSG) had an impact on improving maternal and newborn care practices?

Key Findings:

- Overall community MNCH knowledge and practices improved greatly showing that the original development hypothesis was validated
- Innovative Village Health Committee (VHC)and Community Based Savings Group (CBSG) strategies are effective in supporting the uptake of Community Midwives (CMW) and improving Maternal Newborn and Child Health outcomes
- Steady increase of uptake of CMWs in target areas
- Limited government support structures and commitment for CMW uptake and integration
- Need for more conclusive project transition strategy to increase sustainability.

Project Background

The Chitral Child Survival Project (CCSP) was implemented from 2008 to 2014 in 28 of the most remote and isolated mountainous community clusters in Chitral District, the northernmost district of Khyber Pakhtunkhwa (KPK) Province of Pakistan which borders Afghanistan. The CCSP's strategic objective was to reduce maternal and neonatal mortality and morbidity by increasing the access to and utilization of the obstetric and neonatal continuum of care in the target communities. The four intermediate results were envisaged to contribute to the project purpose through 1) increased awareness of obstetric and neonatal complications, increased utilization of 'Birth Preparedness and Complications Readiness' (BPCR) plans, and an improved enabling environment for maternal, neonatal and child health (MNCH), 2) strengthened community midwife (CMW) referral linkages for obstetric and neonatal services, 3) increased availability of trained CMWs and, 4) reduced financial barriers to accessing obstetric and neonatal continuum of care.

Evaluation Questions, Design, Methods, and Limitations

The FE design consisted of a participatory mixed-methods approach using both quantitative and qualitative data. The full final evaluation consisted of the quantitative endline survey, OR report, CSBG reports, MIS data, and the qualitative work of field observations, and focus group discussions (FGD) and key informant interviews (KII) with stakeholders. The FE objectives were achieved by answering key questions and sub-questions which can be summarized as the following:

a. To what extent did the project accomplish and/or contribute to the results (goals and objectives) stated in the detailed implementation plan (DIP), how were these results achieved or what impeded achievement of the results?
b. What are the key factors for sustainable CMW uptake within the MOH and community?
c. Which components of the project strategy (CMW training and deployment, behavior change strategy, community mobilization and community-based savings groups had an impact on improving maternal and newborn care practices?

Limitations: The project had already completed several qualitative and quantitative community level surveys in the target area, resulting in interview fatigue on the part of beneficiaries and stakeholders so we were cautious to ensure that engagement with community stakeholders focused only on information gaps. The evaluator could not interview everyone originally planned because of their unavailability for various reasons. The two U.S.-based members of the evaluation team were unable to travel to Pakistan due to visa and security issues, limiting them to remote participation, through providing guidance to the consultant hired in Pakistan, assisting with the evaluation design, and reviewing documents and quantitative results.

Findings and Conclusions

Project achievements and results: Data from the end line survey report, the Community Based Savings Group (CBSG) assessment reports, and project Management Information System (MIS) show that the project has achieved remarkable results in terms of overall outcomes and outputs particularly in improving skilled birth attendance, continuum of care and increasing use of maternal care services by women participating in CBSGs. These improvements will contribute to reducing morbidity and mortality of mothers and neonates in the program population, however, overall impact on maternal and infant deaths has to be measured in the longer run.

The Operations Research (OR), conducted by Aga Khan University, showed that the package of project activities to deploy and support Community Midwives (CMW) was successful in improving access to skilled birth attendants in a remote area. The OR report documents the project strategy, identifies the critical components of the package, the challenges encountered and the remaining concerns about sustainability by the provincial health system.

Key Findings by Intermediate Result

Intermediate Result	Key Findings
1. Increased awareness of obstetric and neonatal complications, increased utilization of BPCR plans, and an improved enabling environment for maternal, neonatal and child health	• Among women with children under two, awareness of danger signs for pregnancy, delivery, or post-partum or in the newborn had more than doubled from ~40% to 80+% - statistically significant to <.001. • CCSP used BCC based on formative research and multiple communication channels including male change agents to reach women, men, and opinion leaders. • Delivery with a skilled birth attendant increased from 33% to 82% over the life of the project.
2. Strengthened CMW referral linkages for obstetric and newborn services	• Referral linkages were established within the community from other community health workers to the CMW. • CMWs referred complications to health facilities with high levels of compliance by those referred. • 40% of those referred used the Village Health Committee emergency transport system.

	• 50% of women delivered by a CMW had completed a Birth Preparedness and Complication Readiness Plan. • Feedback to the CMW from the health facility about cases referred is weak.
3. Increased availability of community midwives.	• 28 CMWs were trained and deployed in their home communities. • After just two years of deployment, about 25% of women who had delivered a child in those two years had availed of one or more maternal services from the CMW.
4. Reduced financial barriers to obstetric and newborn services.	• 421 Community Based Savings Groups were formed and show potential for self-sustainability. • Women who participate in CBSG are four times more likely to avail of CMW services.

The qualitative interviews showed that CMWs are now quite well-accepted and there is growing confidence in their skills. Traditional birth attendants are overcoming their fear of competition and beginning to refer their clients to the CMWs. Development of the Village Health Committees and Community Health Teams have both supported establishment of the CMWs and their acceptance by the communities.

Coordination with the government was constrained due to new devolution policy and poor clarity on post 18th amendment scenario, whereby the national MNCH program was altogether dismantled and was delegated to the provinces. The coordination with the district health authorities particularly with DHO and MNCH Program were limited to participation in the meetings and for endorsement of minor programmatic decisions. Progress towards sustainability therefore remained the weakest part of project implementation. Government staff were not involved in the supervision of the CMWs, thus, did not feel ownership of the CMWs and other transition aspects had not been worked out by the time of the final evaluation.

Conclusions: The CCSP CMW model has great potential for scale up in other districts of Khyber Pakhtunkhwa provided provincial government ensures commitment, integration with existing MNCH Program, strengthened coordination among different cadres of the health workforce, revitalizing the role of advisory committee and improved supervision and monitoring mechanisms with earmarked resources.

Recommendations:

- The CCSP model provides an opportunity for government to strengthen the community health work force, especially CMWs. At the same time, lessons learnt from CCSP must be adopted by the government to enhance midwifery and business skills of CMWs.
- Formation and functioning of CBSGs proved to be effective in provision of a social development fund in rural communities; therefore government must plan and strategize functioning of such innovative social funds at gross root level.
- The health department of KPK must allocate enough resources for having a functional referral system in place in Chitral as well as other similar geographic terrains.
- Strong government commitment would be imperative to promote better coordination of CMW program with other programs working on MNCH related services.
- CCSP developed an effective and efficient monitoring and evaluation system for CMW supervision which the DoH should continue to ensure quality control and assurance of newly deployed skilled birth attendants in the health system of Pakistan.
- The absorption of the 28 CCSP CMWs into the KPK health system is direly needed.
- Provincial DoH must liaison with district departments as well as vertical programs to solve long standing issues of CMWs remuneration.

The Chitral Child Survival Project (CCSP) in District Chitral, Pakistan is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The CCSP is managed by Aga Khan Foundation, Pakistan under Cooperative Agreement No. GHN-A-00-08-00010-00. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about Chitral Child Survival Project, visit: www.akdn.org/usa_health_ccsp.asp

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of FE was to conduct a performance evaluation of Chitral Child Survival Project (CCSP) and its contribution towards achieving key results envisaged in the original proposal. Though it is premature to learn about impact of the CCSP especially when CMWs have only spent two years in the communities after deployment, the evaluation had enough information to identify gaps and to strategize for transition and sustainability. The FE findings and results are intended to be broadly accessible to various audiences including Ministries of Health (MOH), and particularly to provincial health decision-makers across Pakistan.

The FE provided an opportunity for all project stakeholders to take stock of accomplishments to date and to listen to the beneficiaries at all levels, including mothers and other community members and opinion leaders, health workers, policy makers, and district and provincial health authorities.

EVALUATION QUESTIONS

The evaluation questions required by USAID CSHGP included:

1. To what extent did the project accomplish and/or contribute to the results (goals/objectives) stated in the DIP?

- What is the quality of evidence for project results?
- How were results achieved? If the project improved coverage of high-impact interventions simultaneously, what types of integration enabled this? Specifically, refer to project strategies and approaches and construct a logic model describing inputs, process/activities, outputs, and outcomes. Describe the extent to which the project was implemented as planned, any changes to the planned implementation, and why those changes were made.

2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

- What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics,[1] and so forth that affected implementation and outcomes?
- What capacities were built, and how?
- Were gender considerations incorporated into the project at the design phase or midway through the project? If so, how? Are there any specific gender-related outcomes? Are there any unintended consequences (positive and negative) related to gender?

3. Which elements of the project have been or are likely to be sustained or expanded (e.g., through institutionalization or policies)?

- Analyze the elements of scaling-up and types of scaling-up that have occurred or could likely occur (dissemination and advocacy, organizational process, costs and/resource mobilization, monitoring and evaluation using the ExpandNet resource for reference).[2]

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[1]See Table 1 in the document here: http://heapol.oxfordjournals.org/content/20/suppl_1/i18.long

[2]http://expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf

4. What are stakeholder perspectives on the OR implementation, and how did the OR study affect capacity, practices, and policy?

AKF was interested in using the full final evaluation (comprised of the OR, CBSG assessment, quantitative survey, and qualitative component) to assess the validity of the original development hypothesis: *Through enhancing CMW training, and implementing supportive accompanying deployment strategies (MOH and community), the project will improve access to quality continuum of care services for pregnant women in remote and isolated villages in Chitral Pakistan; and contribute to the achievement of all four project Intermediate Results:* 1) increased awareness of obstetric and neonatal complications, increased utilization of 'Birth Preparedness and Complications Readiness' (BPCR) plans, and an improved enabling environment for maternal, neonatal and child health (MNCH), 2) strengthened community midwife (CMW) referral linkages for obstetric and neonatal services, 3) increased availability of trained CMWs and, 4) reduced financial barriers to accessing obstetric and neonatal continuum of care.

The full Scope of Work/Terms of Reference for the FE is in Annex VIII. USAID approved both members of the evaluation team (one U.S.-based and one Pakistan-based) and the Scope of Work for the final evaluation. The evaluation consultants were hired by AKF with CSHGP funding, but had no conflicts of interest.

ADDITIONAL EVALUATION QUESTIONS

The FE objectives were achieved by answering key questions and sub-questions set specifically for the study and these were meant to not only look at various project performance indicators, achievements and overall results, but also the testing of the development hypothesis spelled out for CCSP model. The following final evaluation key and sub-questions were identified:

1 To what extent did the project accomplish and/or contribute to the results (goals and objectives) stated in the DIP?
   a. Did the CCSP structure and functions (interventions) relevant to achieve project results?
   b. Are the beneficiaries satisfied by quality of healthcare services?
   c. What is the contribution of project interventions in terms of service delivery and utilization performance?

2 Do CBSGs reduce the economic barriers to health care?
   a. Does membership in a CBSG impact health care seeking behavior, especially use of CMW services?
   b. Does CBSG increased community KPC, access and utilization of health care services?

3 What are the key factors for sustainable CMW uptake within the MOH and community (VHC, LHW, TBA) health care provider's structures and referrals, etc?
   a. Did the CCSP strategies and interventions influence the uptake of the CMW services?
   b. What were the factors (social contexts, challenges, facilitators) that impacted?
   c. What are the lessons learned around gender equity and gender outcomes that facilitate program success – male involvement, women empowerment?

PROJECT BACKGROUND

Problem Statement

Pakistan is among the countries in South Asia that continue to have poor maternal and child health indicators. Although there have been some improvements in recent years, maternal and child mortality remain high. In Pakistan, the Maternal Mortality Ratio (MMR), ranges from 340 to 600 per 100,000 live births. According to PDHS 2012-13, the infant mortality rate is 74/1000 live births whereas under-five mortality rate is 89/1000 live births.

The service delivery indicators for maternal and child health care are below par despite devolution of the health sector which is a window of opportunity to revamp service delivery structures in the conventional health system of Pakistan[3]. Approximately two-thirds of all births (61%) take place at home and are usually attended by traditional birth attendant (TBA) or a family member in rural Pakistan. The preliminary findings of the PDHS 2011-12 depict that 52% of women are delivered by skilled birth attendant whereas 48% of women had traditional deliveries***Error! Bookmark not defined.***. In the province of Khyber Pakhtunkhwa, about 48% of women seek skilled birth care and 40% deliver in a health facility. Because of the scarcity of emergency obstetric care facilities and issues of physical accessibility to first level care facilities, encouraging institutional deliveries at present is not a feasible option for improving maternal outcomes[4].

As a national response to help rural women deliver safely, the Government of Pakistan launched the national MNCH program in 2006[5]. The aim of the National MNCH Program (2006-2012) program was to train and place 12,000 community midwives (CMWs) in rural areas. This initiative to deploy CMWs is expected to contribute to achieving Millennium Development Goals (MDGs) 4 and 5 by reducing MMR and IMR through appropriate ANC, delivery and PNC care and early detection and timely referral of obstetric and newborn complications.; however, the deployment of these workers has been limited[6].

Project Context

The CCSP was implemented in Chitral district of Khyber Pakhtunkhwa (KPK) from 2008-2013, a remote and mountainous district of KPK. Chitral in winter is cut off from the rest of the country; thus making living conditions difficult. The existing, limited road network is vulnerable to natural hazards which restricts communities' access to vital health services and hinders their socioeconomic development. The annual growth rate is 2.4% with scattered villages located in isolated and deep valleys. During the last decade, Chitral has acquired tremendous strategic significance because it shares a border with northeastern Afghanistan to the west and north, and with the Northern Areas to the east. The Aga Khan network has a long history working in Chitral.

The overall vision of the CCSP was to develop a CMW model that enhances utilization of CMW services in a mountainous area of Pakistan and can be replicated in other parts of country, thus, the OR was not distinct from the CCSP, but rather, encompassed the major project effort of training and

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[3] Mazhar A, Shaikh BT. Reforms in Pakistan: Decisive times for improving maternal and child health. *Healthcare Policy* 2012; 8(1):24-32.

[4] Mir AM, Wajid A, Gull S. Helping rural women in Pakistan to prevent postpartum hemorrhage: A quasi experimental study. *BMC Pregnancy and Childbirth* 2012;12:120.

[5] Government of Pakistan. PC1 National Maternal Newborn & Child health Program 2006-2012. Ministry of Health, Islamabad: Government of Pakistan; 2009.

[6] Wajid A, Rashid Z, Mir AM. Initial assessment of community midwives in rural Pakistan. Islamabad: Population Council; 2010.

deploying CMWs. This was accompanied by a concerted community-level intervention to increase family awareness of maternal and newborn risks, to promote birth planning, and to mobilize communities to recognize and respond to maternal and newborn complications.

The CCSP was built upon the National MNCH Program by implementing an additional set of targeted activities that aim to improve the uptake of CMW services and foster sustainability over time. This included formation of Village Health Committees (VHC) to support the CMWs and Community Based Savings Groups, through which women were able to save and readily access funds for medical care.

AKHS,P trained the CMW candidates, using the nationally-approved training curriculum with one enhancement. Immediately after the 18-month theoretical and practical training, CCSP graduates, who were awaiting their license, held five to six-month internships at medical Centers, where they got an opportunity to further practice maternal and other child health skills and to stay engaged with what they had learned in the training. The National MNCH Program's group of recently-trained CMWs, however, spent this time at home with no formal opportunities to practice midwifery or learn other primary health care skills.

Target Population

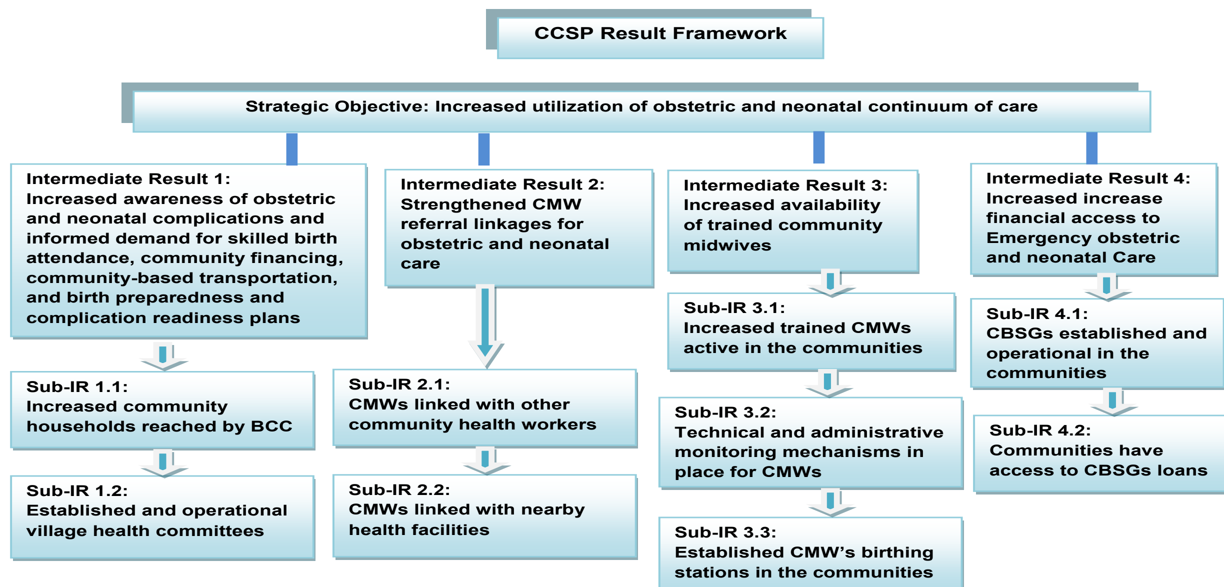
The project area was limited to all villages within a two-hour travel radius around the three secondary care facilities that offer comprehensive Emergency Obstetric and Neonatal Care (EmONC) i.e. the government District Headquarters Hospital (DHQ) in Chitral town, AKHS P's Booni Medical Center and the government Rural Health Center (RHC) in Shagram, Torkhow. The population of the intervention area is 200,000, about 57% of the total population of the district covering 243 villages. However, the project area did not include towns within a 30-minute walk of secondary care or Basic EmONC facilities to ensure project resources were targeted to underserved, more remote locales without easy access to skilled care.

Total population of target area

Beneficiary Groups	Population
Children: 0-59 months	16,001
Infants: 0-11 months	2,667
Children: 12-23 months	3,556
Children: 24-59 months	9,778
Women: 15-49 years	24,000
Total Population in Project Area	88,889

Federal Bureau of Statistics estimates for 2012

The **Strategic Objective (SO)** of the project was: to reduce maternal and neonatal mortality and morbidity in the district of Chitral, North West Frontier Province (now Khyber Pakhtunkhwa), Pakistan.



There were four project Intermediate Results (IRs) as shown is project result framework.

The key strategies and interventions were to train and deploy CMWs to provide a comprehensive package of maternal and newborn services in their own communities. The work of the CMW was supported by rolling out a community financing scheme of women's savings groups, assuring referral linkages to Basic and Comprehensive EmONC facilities, while providing supportive supervision to the CMWs to maintain quality of care; and implementing a Behavior Change Communications (BCC) strategy and social mobilization campaign.

The project was in line with the Government of Pakistan's Community Midwifery Initiative under MNCH program, and generated evidence to support and enhance this program as well as providing lessons learned on how to replicate and scale up such a project in difficult areas of Pakistan. This project was in line with the aim and objectives of the CSHGP initiative of USAID to test innovations. The CCSP model was robustly evaluated through multiple evaluation designs to assess whether the innovative model for training and supporting CMWs would overcome some of the challenges in implementing the CMW program. (Please see the full Operations Research Report in Annex XV.)

Collaborations and Partnerships

CCSP was implemented in partnership with the Department of Health (DOH) of KPK, Aga Khan Health Services, Pakistan and Aga Khan Rural Support program (AKRSP). AKF USA was the grantee while AKF-Pakistan (AKF,P) coordinated, managed and monitored the CCSP. AKF-Geneva provided technical support and guidance, and Aga Khan University (AKU) of Karachi designed and conducted the operations research study.

EVALUATION METHODS AND LIMITATIONS

Design

The final evaluation consisted of a participatory mixed-methods approach comprised of qualitative data collection complementing the quantitative data previously collected by AKF, triangulating the qualitative data collected in the OR and the CBSG assessment and an extensive document review. The project documents and relevant studies carried out during the project life were reviewed and the collated information used to guide design of qualitative data collection tools and instruments. The detailed description of the qualitative methods presented in Annex IX.

Evaluation Questions

The required USAID questions are listed on page 5 earlier in this report and the specific questions posed by AKF are found on page 6. AKF wanted the final evaluation (comprised of OR results, CBSG assessment, final KPC survey, and qualitative component) to discern whether their development hypothesis had been valid. The development hypothesis stated: *Enhancing CMW training, and implementing accompanying deployment strategies (MOH and community) will contribute to the achievement of all four project Intermediate Results, and improve access to quality continuum of care services for pregnant women in remote and isolated villages in Chitral Pakistan.*

Review of literature and documents

The project documents and reports of relevant studies carried out during the project life were reviewed by the consultants. The list of documents reviewed and data sources is shown in Annex IX: This information fed into the design of the evaluation and contributed to the findings.

Qualitative Data Collection Methods

A variety of qualitative methodologies were used during the final evaluation of CCSP including field observations, informal discussions with stakeholders, in-depth interviews with key informants and focus group discussions (FGD) with beneficiaries and service providers. Participants are listed in Annex XI. The guides used for qualitative data collection are found in Annex X.

Limitations to Qualitative Data Collection

The project had already completed several qualitative and quantitative community level surveys in the target area, so we were cautious to ensure that engagement with community stakeholders focused only on information gaps. The evaluator could not interview district MNCH Program focal persons due to their frequent transfers and unavailability. The weather conditions and long distances in Chitral hampered access to non-traditional communities. Furthermore, government deployed CMWs were unable to attend the FGD because they could not get permission from their supervisor, and therefore only CCSP deployed CMWs gathered for a FGD at the venue.

Limitations to the Overall Final Evaluation

Due to security and visa issues, neither the U.S.–based consultant nor the U.S. headquarters backstop was able to travel to Pakistan when the evaluation was scheduled. (Dates were not flexible due to coming winter in the Chitral region.) A separate Scope of Work was developed and approved by USAID for hiring an experienced local consultant, who was also approved by USAID. He received technical support from the U.S.-based consultant to develop the data collection tools and analyze the information, but the conclusions and recommendations reported here are his. The U.S.-based consultant focused on document reviews and a thorough review of the KPC results, which became available after the field work. The U.S.-based consultant provided some oversight to preparation of the slides for the de-briefing and preparation of the draft report, subsequently addressing USAID feedback and adding discussion of quantitative findings as well as findings from the OR and CBSG assessments to the results section of this report.

Data Analysis

CMW Performance Data: AKF, P developed a well-structured and comprehensive Management Information System (MIS) for the project, particularly useful for tracking the CMWs and CBSG, as well as other project inputs such as BCC and training. During review of the final evaluation, some discrepancies within data sets and the data base were observed. Some of the indicators of CMWs services were not part of the data base, while some data was not entered although they were reported during the interviews. Despite these limitations, data was accurately collected, collated and analyzed. Findings of the qualitative evaluation were consistent with project findings in the MIS, in spite of the missing indicators reported by CMWs.

Quality of KPC Data: For both the baseline and final surveys, AKF,P hired a very qualified research firm to collect and analyze the data using the standardized KPC questionnaires. There were no issues with the quality of their work and final survey findings are completely comparable to the baseline. The final survey report is included as Annex VI. The results for the Rapid Catch indicators and project indicators are shown in tables in Annex V.

CBSG Assessment: Because the CBSGs were an important component of the project strategy and this was the first time AKF had tried women's savings groups in Pakistan, AKF,P commissioned an independent assessment of the formation of the groups and their functionality in regards to maternal health care to document the experience and lessons learned. The assessment drew on the MIS data, and collected both qualitative and quantitative data from CBSG participants. To validate the findings and tease out factors leading to high use of maternal health services among women associated with CBSGs, AKF, P held an in-depth analysis exercise. The full report, of high quality, is presented in Annex XIX.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

FINDINGS

Overall Project Implementation: The Chitral Child Survival Project was implemented according to the plans laid out in the DIP. (See Annex IV for the up-dated work plan table.) According to interviews with key project staff and management of AKF Pakistan, there were no major difficulties in management by either AKF- USA or AKF Pakistan (see Annex III). The one major change that deviated from the original project design was the devolution of health services from Central MOH control to provincial management and financing. This ultimately, had little impact on the project success, although the transition did affect the engagement with the government health authorities and the ability of CCSP to develop and carry-out a sustainability plan with them.

The highest level objective of the project was: *Increased utilization of the obstetric and neonatal continuum of care.* The continuum of care was defined to include four antenatal visits, delivery with a skilled birth attendant, postpartum care for both mother and newborn, breastfeeding, and timely care-seeking for sick infants. A comparison of KPC data between the baseline and final surveys for mothers of children 0-23 months shows that the CCSP accomplished this objective. All results are significant to <.001 with the exception of the indicator for care-seeking for respiratory illness which is presented as a proxy for timely care-seeking for sick infants.

CCSP Achievements in Increasing Utilization of Continuum of Care

Indicator	Baseline %	Final %
Four or more antenatal care visits	22.1	44.9
Delivery with a skilled birth attendant	33.0	82.0
Postpartum care for mother	17.5	28.3
Postpartum care for newborn within two days of birth	6.5	11.0
Exclusive breastfeeding during the previous 24 hours	60.4	93.7
Children with symptoms of pneumonia taken to health worker	65.0	79.0

Findings by Project Outcomes/Intermediate Results

1. Increased awareness of obstetric and neonatal complications, increased utilization of BRCR plans and an improved enabling environment for MNCH.

The very positive changes in the knowledge indicators from baseline to final KPC show the impact of the awareness created as a result of the BCC activities of the CCSP. These changes are significant to <.001.

Awareness of obstetric and newborn danger signs among mothers of children 0-23 months

Indicator	Baseline %	Final %
Knowledge of at least 2 danger signs in newborns	46.9	82.0
Knowledge of at least 2 danger signs in pregnancy	44.9	82.8
Knowledge of at least 2 danger signs during delivery	66.0	95.0
Knowledge of at least 2 danger signs during post-partum period	64.4	82.5

It is important to note here that the BCC strategy was based on well-designed formative research conducted early in the project across a variety of communities which revealed the prevailing beliefs and attitudes, barriers, and potential enabling factors. The BCC strategy took into account cultural norms, existing gender issues and family decision-making roles, thus, targeting influential secondary audiences. The importance of the BCC strategy based on formative research should not be overlooked when considering the success of the CMW implementation and potential package for replication.

One additional activity added upon recommendation of the mid-term evaluator was the formation of Community Health Teams (CHT) comprised of the CMW, LHW, TBAs and CHW. This not only facilitated communication and support between these different community health resources, but also enabled them to disseminate the same messages around MNCH and to reach a much broader audience than was possible for the CMWs alone.

The project detected early on that there were nine communities where there was resistance to deployment or utilization of CMWs. This resistance was due to traditional cultural norms about women's roles and limitation of their mobility away from home. In these conservative communities, there was also concern about AKDN's intent, since AKDN had not worked there for long. The project responded by hiring one man from each community as a "mobilizer". His role was to orient other men in the community, particularly opinion leaders, about maternal and newborn risks, the role a CMW could play in reducing the risks, and to garner their support for deployment of a CMW. This strategy was very successful as shown in the Learning Brief in Annex I and underlines the importance of engaging men for programs around the world which aim to reduce maternal and newborn mortality.

2. Strengthened CMW referral linkages for obstetric and neonatal services.

CCSP had two kinds of referral systems, one within the community and the other from the community to a health care facility. All the health care providers within the community (CMW, LHW, TBAs, and CHWs) were linked together in the CHT and encouraged to meet regularly under the auspices of the Village Health Committee to discuss the health issues and cases within the community, thus, building relationships that resulted in referrals to the CMW CMWs were also linked with the first and secondary level health care facilities and could receive guidance from the LHV or even can call her for support if for the reasons of weather and road condition, a patient cannot be transferred to health care facilities.

The health services were expected to give feedback on the referrals. The project MIS closely tracked this information and all referrals as well as client compliance with presumptive shifting, client compliance with emergency referrals, and the number of referrals the CMWs received from TBAs and other

community health workers which was facilitated by the CHTs described above. According to the MIS records the following was achieved:

- ✓ Client compliance with CMW presumptive shifting - 80%
- ✓ Presumptive shifting feedback from facility to CMW - 9.1%
- ✓ Client compliance with CMW emergency referral to health facility - 97%
- ✓ Emergency referral feedback from facility to CMW - 10%
- ✓ Neonatal referrals and compliance - 0%
- ✓ Referrals from community-level health workers to CMW - 38%

It is apparent more work needs to be done with health facilities to persuade them to send feedback to the CMWs. The fact that there were no neonatal referrals may be related to the low coverage of postnatal checks by the CMWs.

A mechanism to support women's referral in times of emergency was the development of an emergency transport plan by the VHC with the support of people who have means of transport in the community. They are included in the VHC and ready to transfer women to and EmOC facility in case of emergency. The emergency transport system still needs proper support by VHCs and other community programs. As depicted by the end project MIS report, in 40.7% of cases for complicated delivery were shifted to health facility, the pregnant woman used the VHC transportation plan and in 53.2% of referred deliveries, the families of the women arranged for other transport to the nearest hospital for delivery. This data raises questions as to whether families were unaware of the VHC transport plan or could find other transport more rapidly,

Another action to mobilize families to prepare in advance in case of emergency was to promote that each pregnant woman and her family prepare individual plans called Birth Preparedness and Complications Readiness (BPCR) plans. This process oriented families to the idea of saving money, making decisions about transportation in advance, and designating who would donate blood, if needed. The MIS showed that over half of the women delivered by a CMW had made these arrangements in advance.

3. Increased availability of trained community midwives

Considering that the CMWs were only deployed and working in their communities the last two years of the project, the up-take of their services is impressive. The final KPC survey found that younger, more educated women were the ones most like to use their services. The chart below shows their utilization by the sample of 603 mothers of children under 23 months who were interviewed during the final KPC survey:

CMW Up-take in the Two Years of Their Deployment

Services provided	% of women availing of services
Deliveries attended by CMWs	26.5
Antenatal care provided by CMW	24.0
Postnatal care provided by CMW	24.0
Completion of maternal care cycle provided by CMW	14%

It is a good program, CMWs received quality training and they were timely deployed." (KII-DHO Chitral)

The original plan was for CMWs to attend deliveries in birthing stations they set up. However, the final survey and OR qualitative studies found that women preferred to have the CMWs come to their homes to attend the deliveries due to amenities available and to avoid having to go out in inclement weather or walk over rough terrain while in labor. See

the OR report in Annex XV for more details.

The VHCs were instrumental in supporting the CMWs, promoting their services, and establishing the fees to be charged for services. They promoted compliance with referrals and established emergency transport plans with owners of vehicles. In the original plans, the VHCs were to provide some oversight and supervision to the CMWs but it is unclear how much this happened although AKF, P took three VHCs where CMW performance was weak to visit three VHCs where the CMW was strong to enable the VHC members to see the level of performance to expect from the CMW.

Now we trust the CMW's skill and go to her. She handles cases with care. In our community women go to CMW for antenatal checkup and delivery. (FGD- Female Community members, Herth Karimabad)

"Transport is a problem, when there is a referral case. Local transport is used to transfer maternity and or sick child to the bigger hospital. CBSG is helpful in providing financial support". (FGD-CMWs)

Generally speaking, from the FGDs, it is evident that the communities have whole heartedly accepted CMWs and have used their services because they are available in villages and know and respect the local culture and norms. The local people stated they can call them any time for conducting deliveries and providing other services, sometime even free or on the basis of payment later on. The beneficiaries interviewed expressed their satisfaction about CMW services and commented that after the deployment of CMWs, they send their family members to them for mother and child related care or even sometimes, for blood pressure check-up and getting some basic medicine for headache, and fever etc. They always find the CMW available at her work station. They also showed satisfaction with her skills and work. The fee paid to CMW is also acceptable. Satisfaction varies from community to community, but even in the most conservative communities, there has been evidence of respect for the CMW and increasing utilization of her services.

The OR report in Annex XV documents the steps taken to assure quality training of the CMWs and their practical training. Regular supervision and monitoring of deployed CMWs was done well by the project staff. However, MNCH Program PC1 recognizes the LHV of the BHU/or CMW school tutor for technical supervision and LHS of LHW Program for administrative supervision of CMWs. Ideally, AKHS (P) should have engaged these government staff effectively at the time of deployment of CMWs for better ownership and doing the supervision through their workers but this was never the case and has hampered the ownership of project-deployed CMWs by government health authorities.

4. Reduced financial barriers to the obstetric and neonatal continuum of care

The CCSP envisioned Community Based Savings Groups as a means of helping families overcome the financial barriers to accessing care, and to increase the potential that families would be willing to pay for CMW services. A total of 421 CBSGs were eventually organized and functioning. Initially, CCSP promoted the CBSGs for saving only for maternal health care, but found that interest of members lagged. The CBSG purpose was then changed to saving for the sake of saving, leaving it up to the members how they used their savings or why they took out loans, which greatly increased enrollment in the groups. The CBSG studies found that members used savings for many needs, such as school expenses of children, with few using the money for maternal health services.

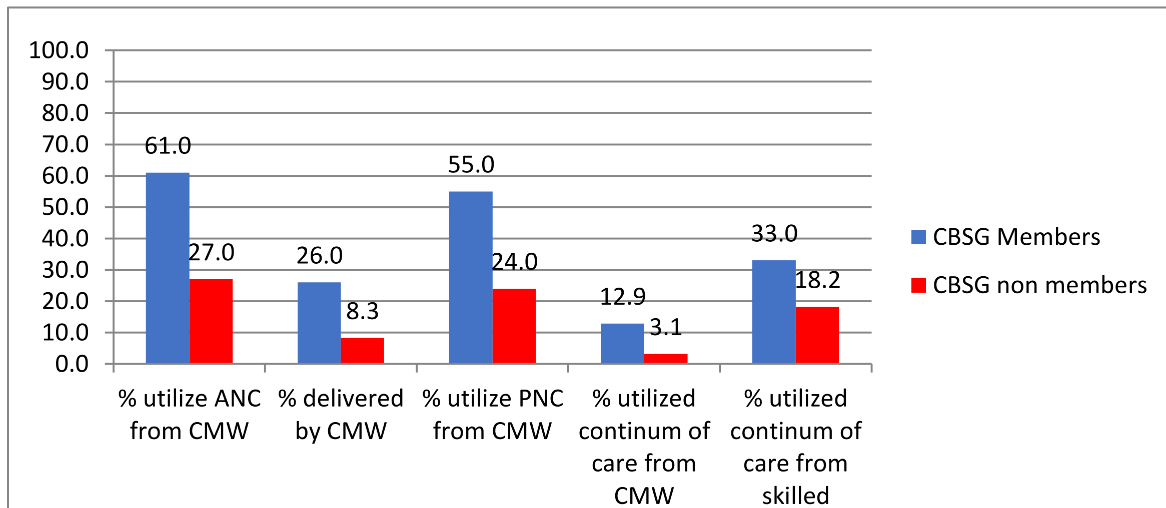
Quantitative data was used to construct evidence of the impact the CBSGs had on accessing maternal newborn health services. This data showed that women associated with CBSGs (either as members or with a family member participating) are four times more likely to use CMW services than those who do not have an association with the CBSGs. To fully understand the finding, AKF, P undertook a thorough

verification exercise and learned the following: The CMWs used the CBSGs as a platform to disseminate the messages around maternal and newborn health, including the need for a skilled birth attendant and directly promoted their services. Therefore, CBSG members were exposed to more direct BCC than other community members. It may be the combination of savings, familiarity with the CMW and message exposure that greatly increased coverage of the continuum of care among CBSG members as well as social support gained from being in the group. (See Annex XIX for the full report on the assessment of CBSG effectiveness.)

That report and the final evaluation interviews both found that the CBSGs are useful for the following purpose: i) to save money, ii) availability of credit at village level as they availed CBSG loans to meet their different needs including healthcare; and iii) a platform for social interactions and women's empowerment. However, after the in-depth assessments and a careful analysis of the monitoring data and community discussion, AKF,P acknowledges that another strategy beyond the CBSGs is need to reach the ultra-poor with a means of overcoming their cost barriers to health care and providing the other benefits received by CBSG participating families. The ultra-poor could not join the CBSG because they do not have enough cash to meet the savings quota.

Role of Advisory Committee, "Not very effective, in fact it was the most important element for promoting CCSP model and ensuring its sustainability" (KII- Program manager, AKHSP, Karachi)

Coordination and Collaboration: Review of the project documents revealed that the coordination and collaboration mechanism of AKDN partners was defined for the CCSP project. AKF (P) coordinated, managed and monitored project whereas AKHSP led training, BCC, referrals, and supervision of CMWs. AKRSP role was defined in terms of mobilization of the communities to support CMW program and form/oversee CBSGs. Results of the qualitative research were consistent with the project documents.
However, the coordination with the district health authorities particularly with DHO and MNCH Program were limited to participation in the meetings and for endorsement of minor programmatic decisions but not bigger challenges nor producing tangible results. These efforts were further constrained due to new devolution policy and poor clarity on post 18th amendment scenario, whereby the national MNCH program was altogether dismantled and was delegated to the provinces. Despite these constraints, coordination between community and service providers was improved due to formation and pro-active functioning of VHCs.



Gender: The CCSP took gender into account from project design onwards due to prevailing cultural norms in the project area. VHCs were required to have an equal number of males and females. The young women selected by their communities to become CMWs became empowered through their training and gained self-confidence to move about their community clusters and reach out to other women, thus serving as role models. The concept of the CBSGs is to empower women financially and enable them to make health care (and other) decisions for themselves. As the project progressed, the need to engage men to a greater degree resulted in hiring and training the male motivators and engaging religious leaders to bring attention to men the health care needs of women and children.

Operations Research

The Operations Research was carried out according to plan insofar as possible. The plans and implementation of the OR are spelled out in the OR report in Annex XV. The original design called for a comparison of AKF trained and deployed CMWs with a group trained and deployed by the government. Unfortunately, due to changes in the government program (devolution to provincial level) and red tape, the CMW trainees of the government were still not deployed after three years when the AKU researchers had to conduct their final assessments. Therefore, the OR ended up being a measure of improvements over time of only the AKF-deployed midwives. This was the only possible solution. In this way, the OR was able to document the quality of training and supervision, the challenges faced by the newly-deployed CMWs in their communities, and concerns for their continued support by the KPK Department of Health.

The operations research was carried out by the Aga Khan University which is well-known for excellence in research and highly credible among stakeholders in Pakistan. A joint team from the School of Nursing and the Department of Community Health Sciences was responsible for the OR. They have conducted other research on the CMW program in Pakistan and are very familiar with the aims and the government implementation issues.

Since the OR activity and the project strategy are inextricably linked, it is not possible to comment on implementation or outcomes of the OR as separate from the overall project. Project performance is discussed above.

The final OR report has many implications for support and enhancements of the CMW program across Pakistan and, particularly in KPK. (Please see Annex XV.) The results were shared in a national-level dissemination workshop and will be further shared by AKF,P and AKU with provincial health authorities, bi-lateral programs, donors, and NGOs in Pakistan. Now that the report has been completed, AKU will pursue opportunities for journal articles and peer-reviewed presentations. Please see Annex II for the list of publications related to the OR and the CCSP.

Impact, Effectiveness, Sustainability and Replicability of CCSP Model: The CCSP model is effective as a complete package of intervention. It is effective because the project emphasized community ownership – VHC for administrative supervision of CMWs, defining fee structure for the services, development of local transport mechanism and social development fund. Findings of the qualitative evaluation also showed that model is effective, and replicable due to timely training and deployment of CMWs, and empowerment of women to utilize savings for maternity care. Please see Annex XX for a description of the "package" for replication and lessons learned.

Transition and exit strategy: CCSP CMW model was well designed to provide MNCH services to people living in a mountainous region and has shown good results, however, it could have been more useful if there was a clear transition/ exit strategy inbuilt in the proposal and initial design. In terms of strengths and weaknesses of this model, various stakeholders were agreed that CCSP trained and

deployed 28 CMWs, established 421 functional CBSGs to provide integrated MNCH services with robust supervision and monitoring and evaluation system. However, a number of important bottlenecks has been identified and also endorsed by key stakeholders, which would contribute to impact and sustainability of the project. In this respect, lack of written transition/exit strategy (although some options were mentioned in the original proposal), weak coordination between AKHS,P health center, and staff, weak role of advisory committee of CCSP, and lack of clear understanding with provincial health authorities about future of CMWs are worth mentioning.

CONCLUSIONS

CCSP introduced an innovative package to reduce maternal morbidity and mortality, which included deployment of well-trained CMWs, community support through VHCs, an effective BCC strategy and development of a social development fund through CBSGs. The CCSP strategies and interventions truly influenced the uptake of the CMW services.

a) Most of the service users appreciated deployment of the CMWs, which improved coverage of antenatal care, skill birth attended delivery and postnatal care indicators.
b) The knowledge and competencies of CMWs were positively improved after deployment in their respective areas and were applauded by CMW supervisors and the local notables for their prompt assessment and immediate management with referral of complicated maternity cases.
c) The women participating in CBSGs had four times more often accessed/completed the continuum of care from a CMW and other skilled health care providers.
d) Gender equity and equality were ensured in the four components of the project. Establishment of VHCs and CBSGs ensured gender equality and therefore led to gender empowerment through increased control over social development fund. The involvement of males in VHCs and women ownership in the CBSGs was meaningful to facilitate gender balance. Women's empowerment led to women's increased control over decisions regarding antenatal, natal and postnatal care.
e) The project interventions have had a significant impact on key MNCH indicators. Skilled birth attendance increased from baseline values of 33% to 82% by the end of the project with market share of CMWs found to be 26.5%. Proportion of children age 12-23 months who were fully vaccinated increased from 68% to 89%., although this was not a project intervention. Overall continuum of care increased from 3% to 15%, which is quite significant.
f) The women associated with CBSGs had four times more often accessed/completed the continuum of care from a CMW and other skilled health care providers.
g) Gender equity and equality were ensured in the four components of the project. Establishment of VHCs and CBSGs ensured gender equality and therefore led to gender empowerment through increased control over social development fund. The involvement of males in VHCs and women ownership in the CBSGs was meaningful to facilitate gender balance. Women empowerment led to increase control over decisions regarding antenatal, natal and postnatal care.

Strengths of CCSP: The review of the project documents concluded that CCSP model has many strengths as well as weaknesses. During the project duration, 28 trained and skilled CMWs were deployed in the communities, 421 CBSGs, were established and most of them are functional, and a strong M&E and MIS system was purposely built. The key strengths are: adoption of an integrated approach and selection of CMW from the community in CCSP model. Moreover, community ownership and better coordination with the health department were rated as other strengths of the project. The public-private partnership between the department of health and AKDN added value to the achieve project targets. *"The local group of women, pooling in money for rainy days, socializing, talking to each other,*

listening to the CMW sessions was strength. Another strength was local trained girl deployed, and welcomed by the communities" (KII-Director Health and Built Environment, AKFP, Islamabad). "This project is for cohesive community". (KII- Manger CBSG, AKRSP, Chitral) "Community Ownership and good collaboration at the district level is strength." (KII-Senior Program Officer, AKFP, Islamabad)

Weaknesses of CCSP: The findings of the project documents and qualitative research revealed number of weaknesses in the CCSP model. One of the key weaknesses was that there is no documented exit strategy to plan and strategize sustainability of the project. Another, also noted in the MTE, was weak coordination between the AKHSP and the department of health. KII findings also suggested issues with future sustainability of the CMWs due to low monetary benefits. Qualitative findings also highlighted that lack of interim arrangements such as technical assistance to provincial health departments in wake of recent devolution which hampered many of the coordination activities with the department of health.

There is no written transition/exit strategy, although some options were mentioned in the original proposal. Lack of proper coordination between AKHSP and the department of health staff and understanding based on shared values is the weakness. (KII-Senior Program Officer, AKF,P, Islamabad)

"Yet some weaknesses were marked clearly in the project such as future of CMWs after the project life was not clear, though discussion with DoH KPK is quite ground breaking and will result in absorption of the 28 CMWs into the main stream but it might take some more time. Devolution also to some extent affected smooth transition of our CCSP into national MNCH. (KII-Director Health and Built Environment, AKFP, Islamabad)

RECOMMENDATIONS

CCSP CMW Model as an Opportunity

1. CCSP model provides an opportunity to government to strengthen community health work force, especially CMWs. Recent promulgation of health reforms has shifted administrative and financial powers to the provinces. The department of health, KPK must realize this opportunity and fortify MNCH program for effective deployment of CMWs. At the same time, lessons of CCSP must be learnt and adopted by the government to enhance skills of CMWs.
2. Effective deployment of CMWs under CCSP not only improved service delivery indicators but also developed trust in the community on this newly deployed cadre. Department of health must strengthen this initiative through regular training, supervision and incentives for CMWs, so that they continue working in hard and difficult terrain of district Chitral.
3. Formation and functioning of CBSGs proved to be effective in provision of social development fund in rural communities. During the exit phase of the project, government must plan and strategize functioning of such innovative social development funds at gross root level.

Functional Referral System

4. Development of referral mechanism is imperative not only to save life of mothers but also to prevent their high out of pocket expenditures. Health department KPK must allocate enough resources for having a functional referral system in place in Chitral as well as other similar geographic terrains.

Coordination and Collaboration Mechanisms

5. In the wake of recent reforms in Pakistan, coordination mechanisms ought to be improved within department of health. Provincial department of health must envisage an integrated approach for effective

coordination between provincial and district health departments as well as with MNCH and LHW programs. VHCs formed in the CCSP can act as meaningful coordination forum between the community and the health service providers. District health department can play effective role in survival of these VHCs and hence promotion of CBSGs.

6. There is need to develop better communication and coordination strategy in the non-traditional areas of AKDN. At the same time, learning experiences for better coordination mechanisms of AKDN ought to be shared nationwide.
7. Nonetheless to get to an eventual success, it is essential that both LHWs working under programs for Family Planning and Primary Health Care (FP & PHC) and CMWs should have effective communication, coordination and complementation with department of health.
8. Strong government commitment would be imperative to promote better coordination of CMW program with other programs working on MNCH related services.

Monitoring and Supervision

9. Monitoring and supervision is imperative to ensure availability of CMWs in the community. This will lead to more acceptability and responsiveness of the community towards maternity services. To safeguard utilization of maternal services and to strengthen referral mechanisms, VHCs must be supported in future. Likewise, CBSGs which proved effective in development of social development fund must not be overlooked by department of health.
10. CCSP developed an effective and efficient monitoring and evaluation system for CMWs supervision. This supervision mechanism is an example for the MNCH program and DoH which needs to be carried forward to ensure quality control and assurance of newly deployed skilled birth attendants in health system of Pakistan.
11. Deployment of CMWs is currently the only strategy to promote skilled deliveries in rural Pakistan. There is dire need to allocate sufficient funds for the monitoring of CMWs. This is window of opportunity for the provincial health department in wake of recent reforms to strengthen CMWs monitoring through allocation of funds.
12. As the CCSP is phasing out, there is need to advocate DoH to develop feedback mechanism for technical and administrative supervision of CMWs. AKHSP supervisors must be consulted while developing feedback mechanism for CMWs.
13. To supervise CMWs, DoH must focus on development of management information system to avoid data duplication and discrepancies. In this regards, training of midwives to fill in CMW registers and pro-active involvement of LHVs and LHSs in supervision of CMWs would be pivotal.

Sustainability and Replicability

14. The absorption of the 28 CCSP CMWs in the mainstream of KPK health system is direly needed. Provincial health department must make every effort to retain these trained CMWs in Chitral district, where availability and accessibility to health services is a long standing concern.
15. Sustainability and maintenance of CMWs as service providers requires reallocating monetary benefits for the CMWs which are matter of concern in health system of Pakistan. Provincial health department must take a lead role to solve remuneration related issues of CMWs. Better coordination of provincial department with Planning Commission of Pakistan is direly needed to benefit MNCH program. Meanwhile, AKDN should strive to provide continuous supervision and support to the CMWs from its own resources or through some other projects. Formal signing of MoU with DoH could be meaningful in ensuring sustainability of the CCSP model.
16. Sharing of CCSP experiences at national and international level can be meaningful to replicate this model in other parts of Pakistan.

Remuneration and Business Skills of CMWs

17. Devolution has had many implications on the administrative and technical functioning of MNCH program. In terms of technical assistance, In order to strengthen four components of the CCSP, provincial DoH must liaison with district department as well as vertical programs to solve long standing issues of CMWs remuneration and continuous skills enhancement.
18. In order to enhance business skills of CMWs and to develop their confidence, department of health must realize the importance of supervision to develop skilled and competent CMWs in future. AKHSP having the local presence will surely have an instrumental role.

Advisory Committees

19. Formation of an advisory committee was pivotal in a project, implementing public private partnership (PPP) model. At the same time, pro-active future engagement of these committees is essential to benefit from deliberations.

AKF's role in transition to transfer the program to DoH-KPK

20. The role should be more of advocacy and continuous engagement with the DoH for ensuring that while the department is envisaging its strategy to be rolled out for 2013-2017 in health sector in KPK, these 28 CMWs must be integrated in the mainstream MNCH provincial program and get the equal reward and recognition as do government CMWs across the KPK province. The integrated PC1 has been approved in KPK and it would encompass MNCH, FP, Nutrition and LHW program and AKF is hopeful that keeping in consideration the remarkable result s of the CCSP project, KPK government must take into account the efforts of AKDN and USAID to eliminate the gaps which have already been recognized by the DoH for the difficult area like Chitral, where AKDN embarked upon the ground-breaking initiative in the shape of CCSP.

SUMMARY OF INPUTS, ACTIVITIES AND OUTPUTS THAT CONTRIBUTED TO KEY OUTCOMES

Project Inputs	Activities	Outputs	Outcome/ Result (Baseline for IRs 2,3, and 4 is 0 unless given)
Project Intermediate Result 1: Increased awareness of obstetric and neonatal complications, increased utilization of birth preparedness and complications readiness (BPCR) plans, and an improved enabling environment for maternal, neonatal, and child health (MNCH)			
Formative research BCC Materials Trainers BCC & Community Mobilization strategy	- Training of Trainers in BCC - Training of **652** change agents (VHCs, CMWs, other community health providers) in BCC - **105** Health Campaigns conducted for **6154** participants - Established VHCs in **28** communities, through the Local Support Organizations - **5186** health sessions held for **63922** beneficiaries and **49185** BCC materials have been disseminated - **847** Counseling sessions for couples & CBAs - **604** announcements on different health topisc for general communities - **314** community meetings - 27 Valley conferences: one each CMW area to introduce CMWs with their communities - **2** regional conferences organized for the VHCs and notables of CMWs areas - **3** local BCC advisory group workshop to share the progress and discuss issues - 11 Sign boards having with deferent messages were placed - **7** Health festival celebrated for **313** participants - **Key health messages** on BPCR, and information on maternal and Child health care relayed through Radio FM 97	- Households reached by BCC campaign (public events, group discussions, and individual counseling) - Village Health Committees active in all 28 communities	1.0.1 Financial arrangements for delivery increased from 43 to 59% 1.0.2 Transport arrangements for delivery increased from 34 to 56.2% 1.0.3 Blood donor arrangements for delivery increased from 15 to 49% 1.0.4 Utilization of VHC transportation plan increased from 0 to 38% 1.0.5 Community Knowledge, Practices and Coverage (KPC) 82%

Project Inputs	Activities	Outputs	Outcome/ Result (Baseline for IRs 2,3, and 4 is 0 unless given)
	- **3** quality assurance monitorings to assess the quality of BCC and social mobilization activities		
Project Intermediate Result 2: Strengthened CMW referral linkages for obstetric and neonatal services			
Formative work & situation analysis to develop referral protocol and guidelines Referral tools and protocols Referral strategy	- 4 referral Facility staff and 28 CMWs were trained in referral tools - 42 TBAs and other community health providers trained BCC to strengthen referral - 63 LWs and 20 LHS were trained and given orientation to strengthen referral	- CMWs linked with other community health workers (LHW, TBAs, or CHWs) – several referrals made by TBAs - CMWs linked with nearby health facilities (no referrals made to date)	2.0.1 Client compliance with CMW presumptive shifting 80% 2.0.2 Presumptive shifting feedback from facility to CMW 9.1% 2.0.3 Client compliance with CMW emergency referral to health facility 97% 2.0.4 Emergency referral feedback from facility to CMW 10% 2.0.5 Neonatal referrals and compliance 0% 2.0.6 Referrals from community-level health workers to CMW 38%
Project Intermediate Result 3: Increase availability of trained community midwives			
CMW curriculum from PNC CMW tutors Government public health building for Midwifery school CMW Supervisors IMNCI, family planning, etc. curriculum for additional training	- 30 CMWs identified for training - 2 CMW tutors identified and attended a 6 month training program at Qatar Hospital, Karachi - Midwifery School Chitral accredited - 18 month standard PNC training conducted (12 month classroom; 6 month practical) - Monitoring system established for classroom and practical training - CMW additional 6 months skills enhancement plan and internship conducted - One month addition training on IMNCI, Newborn care ,Infection Control, Family Planning and immunization - Working stations prepared and equipped in **28** communitie - **11** days refresher training conducted for three times for CMWs each year during the project period	- 28 CMWs received licenses and registration from PNC to work as CMW - 28 CMWs active within communities - Supervisors recruited and trained to supervise CMWs - CMW birthing stations functioning in 28 community clusters	3.0.1 Deliveries attended by CMW 26.5%, 82% (SBA) 3.0.2 Antenatal care provided by CMWs 24 % 3.0.3 Postnatal care provided by CMWs 24 % 3.0.4 Completion of continuum of care provided by CMWs 15% 3.0.5 Completion of maternal care cycle provided by CMWs 14% 3.0.6 Initial breastfeeding in CMW deliveries 100%

Project Inputs	Activities	Outputs	Outcome/ Result (Baseline for IRs 2,3, and 4 is 0 unless given)
	- **4** weak performing CMWs were placed at referral facility BMC to enhance their practical skill on conducting deliveries - **500** meetings conducted with VHCs - Cross visits for the VHC members of three CMWs areas (who were not performing well) to good performing VHCs		
Project Intermediate Result 4: Reduced financial barriers to the obstetric and neonatal continuum of care			
Formative work/ research analysis for intervention design	- Mobilization of communities to concept of CBSGs through regional Local Support Organization meetings - MIS developed for CBSGs - 421 CBSGs formed - CBSG Baseline conducted	- 421 CBSGs established and active - Loans made for health purposes	4.0.1 Delivery coverage by Community Based Savings Groups 4.0.2 Utilization of CBSG funds for maternal health 4.0.3 Average monthly CMW income from service fees It varies from month to month ranging from 1000PKR to 2000PKR

SUMMARY OF KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Finding	Conclusion	Recommendation	Action	Who Is Responsible
Deployment of 28 CMWs under CCSP (17% skilled deliveries, 24% antenatal care and 24 % postnatal care provided by CMWs	CMWs contributed in birth preparedness, ANC, skilled birth attendance, access and knowledge	Retention of 28 CMWs by department of health	Supervision and required support for CMWs by government	MNCH Program, District health department, Provincial health department
Establishment of VHCs in 28 communities	VHCs provided the ownership and support of the CMWs and communities	Sustainability and pro-active involvement of VHCs in MNCH care and management	CMWs presence in the VHCs must be ensured	AKHSP and district health department

Finding	Conclusion	Recommendation	Action	Who Is Responsible
5186 health sessions and 847 counseling sessions held for 63922 beneficiaries	BCC strategy was implemented effectively and linked with utilization of social development fund for seeking maternal care	Continuation of BCC messages within structures of AKDN and department of health	Ensure availability of existing BCC materials and interventions with health workers	AKHSP and District department of health
38% referral from community-level health workers to CMW	Presence of CMWs in VHCs was meaningful to develop referral linkages	Involvement of LHWs, TBAs and CMWs in the referral linkages	In order to strengthen referrals, TBAs must be involved at community level. TBAs should be incentivized for each referral	Provincial health department
Utilization of CBSG funds for maternal health (421 CBSGs established and active) Women having CBSGs membership are 4 times more likely to avail CMWs services	Social development fund not only influenced behavior change but also augmented skilled care	Sustainability and Replicability of CBSGs model	Continuous supervision, motivation and technical assistance Need to be linked with local support organizations (registered with government)	AKRSP
Gender equality led to women empowerment and more utilization of MNCH services	Establishment of VHCs and CBSGs ensured gender equality and therefore led to gender empowerment	Gender equality must be ensured in VHCs and DHMTs	Social mobilization and communication strategy to ensure gender equality Role of VHCs in management of health issues must be ensured	District health department and AKRSP and ,AKHSP
Close monitoring and supervision of CMWs by AKHSP supervisors for quality control and assurance	There is poor supervision & monitoring mechanism within department of health. However, under CCSP, it was strengthened	LHS of LHW program is responsible for administrative whereas LHV of FLCF for technical supervision of CMWs.	Government must play pivotal role in monitoring and supervision of CMWs	Provincial and district department of health
Lack of project transition/exit strategy in the original design and DIP	CMWs are concerned about their future support and assistance after project completion	DOH should absorb these CCSP deployed CMWs through integrated PC 1 but during interim period, AKHSP should use this window of opportunity and continue supervision and support to CMWs	AKHSP must continue its support to CMWs, particularly those working in non-traditional communities.	AKHSP during interim phase and Department of Health

ANNEXES

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U.S. Agency for International Development

1300 Pennsylvania Avenue NW

Washington, DC 20523

ANNEX I

Program Learning Brief: Evidence Building

Key Findings:

- The involvement of men is critical for creating enabling environment for uptake of the MNCH services
- Any health program needs to have flexible strategy to incorporate changes with evolvement of the health program.
- Health strategies have to be tailored to address the specific challenges and concern of the program population particularly in non-traditional areas.

Aga Khan Foundation-Pakistan

PROGRAM LEARNING BRIEF

Chitral Child Survival Program

[October 2008 to September 2013]

The Chitral district is one of the most remote and isolated districts of Khyber Pakhtunkhwa Province, Pakistan which has some of the highest levels of maternal and infant mortality and morbidity due to high levels of poverty and female illiteracy, cultural practices favoring childbirth at home, women's limited mobility outside of the home, and the sheer distances to health facilities, which are compounded by remote and isolated valleys and harsh climates. Considering the contextual challenges related Maternal, Neonatal and Child Health in the Chitral district, the Agha Khan Health Service, Pakistan implemented the Chitral Program (CCSP) which aims at contributions toward reducing Maternal and Neonatal Mortality and Morbidity in the District Chitral.

Background

The Chitral Child Survival Programme (CCSP) was initiated in 2008 as a pilot project to complement the Government's Maternal Neonatal and Child Health (MNCH) program to demonstrate approaches to increase competence, sustainability, and utilization of Community Midwives. This program was implemented by Aga Khan Health Service, Pakistan with the technical support of Aga Khan Foundation (Pakistan) and in collaboration with the MNCH program. Other key partners include: Aga Khan Rural Support program and KPK Government Department of Health.

Project Design

The CCSP was designed and implemented taking into consideration the contextual challenges in the area.. The four outcome areas of the project were: increase availability of skilled Birth Attendants; increase awareness about obstetric and neonatal complications and increases utilization of Birth Preparedness and Complication Readiness plans at community level; strengthen referral system and reduce financial barriers to accessing maternal and child health care services.

Under the CCSP, 28 young women were identified from remote and isolated areas of Chitral district and they were trained and deployed in their respective communities in June 2011 as Community Midwives (CMW). With the deployment of CMWs in the field, the awareness programs for utilization of the CMW services were started in each CMW area. Change Agents (Social Activist, Religious Leader and Health workers) were selected and trained in Behavior Change and Communication (BCC) to disseminate the messages related to importance of skilled delivery, birth preparedness and complication

readiness to the all members of community. Village Health Committees[1] (VHCs) were formed in each CMW area to ensure community support in strengthening services of the CMWs.
In order to strengthen referral system all the CMWs were linked with the Community Health Workers (CHW) including Lady Health Workers (LHWs) and Traditional Birth Attendants (TBAs); and also with referral facilities in their respective communities. Community health workers were provided training in BCC to enhance their role as link provider. All the CMWs were introduced to the staff of their nearest secondary health care facilities to facilitate the emergency referrals.

To reduce financial barriers in accessing to maternal and child health care services, the CCSP has established Community-Based Savings Groups (CBSGs), which are composed of approximately 10 to 30 self-selected women who deposit and pool their savings, and then lend out internally through group consensus at a pre-defined, mutually agreed upon interest rate. The project staff in consultation with village health committee identified local women in each CMW area to supervise the CBSGs. The CBSG supervisors were provided training in formation and management of CBSGs. Women of reproductive age particularly pregnant women are encouraged to participate in these groups. The purpose of formation of these saving groups is to empower the women in terms of her access to cash money for timely decision making at the time emergency and also use the money for different types of MNCH care services during pregnancy, delivery and after delivery.

Methodology

The performance of individual CMWs was monitored through Project MIS. Field observation and formal and informal discussion with the key stakeholders were systematically carried out and documented by field supervisory team in order to review the progress and emerging issues and challenges to take corrective actions.

One year after deployment of CMWs in the field it was observed that in some areas the CMWs were performing well, whereas, the performances of CMWs were comparatively weak in nine non-traditional areas.

Under the CCSP project the AKHS, P had selected nine non- traditional areas where the Aga Khan Development Network (AKDN) had limited presence prior to this intervention. In these areas the mobility of women was restricted due to socio-cultural barriers; therefore, the CMWs have had difficulties in marketing their services and making personal contact with their clients. During project review meetings, it came out strongly that the problem around female mobility is the key restraining factor in CMWs' performance; therefore, the project team felt the need to involving men to address this issue, as they are the key decision makers related to health matters of women.

Subsequently, the BCC strategy of CCSP which was initially designed focusing more on women's knowledge, altitude and practices was tailored to raise awareness of men as well.

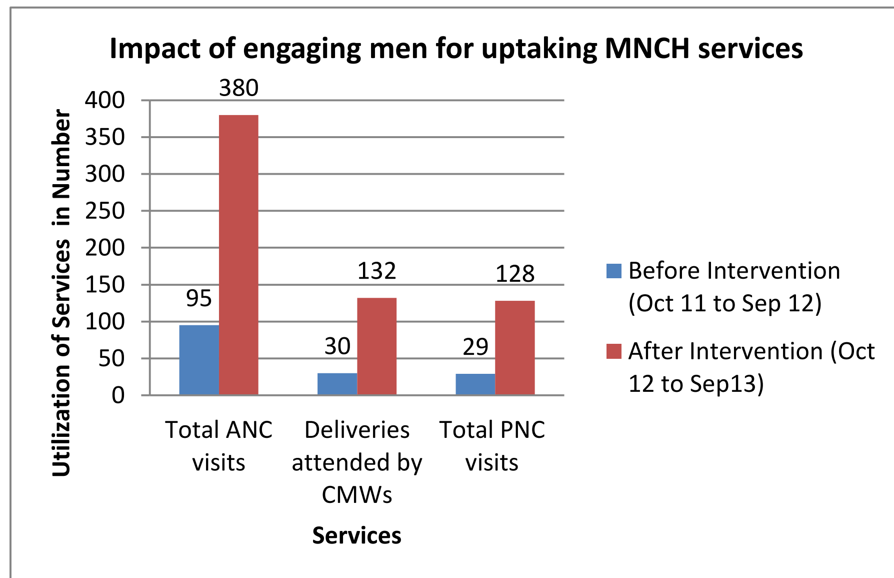
Considering the importance of the involvement of men in creating an enabling environment for uptake of MNCH services, the project team decided to recruit nine paid male motivators for a one year period to approach men with BCC messages. All nine male motivators were identified, recruited and trained in BCC and social mobilization and they were taught how to involve men in their respective areas for facilitating women's access health care services from

[1] A committee comprised of community elders, social activists and health workers at village level to work as a bridge between CMW and the local Community. The members of the village health committees were selected through a consultation process with the local community and Village Organization (VOs) which were already existed in the area

CMWs. The project team reviewed the progress of male motivators on quarterly basis and provided them required technical support whenever they faced any problem. The use of male motivators showed encouraging results in the one year period in terms utilization of CMW services particularity Antenatal Care, delivery and Postnatal care. The following graph shows the impact of engaging men for up taking MNCH services on utilization of CMW services in nine non-traditional areas.

Findings

- The involvement of men is critical for creating enabling environment for uptake of the MNCH services



Conclusions and Lessons Learned

- The strategy of recruitment of male motivators worked well in terms of engaging men to supporting women of their household to access MNCH services form CMW and other skilled health care providers.

Recommendations and Use of Findings

- Any health program needs to have flexible strategy to incorporate changes with evolvement of the health program when project data indicate the need for adjusting the strategy.
- Health strategies have to be tailored to address the specific challenges and concern of the program population particularly in non-traditional areas.
- Engaging men to reach other men is key when addressing gender issues.

The *Chitral Child Survival Program* in *District Chitral, Khyber Pakhtunkhwa*, *Pakistan* is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health G*rants Program. The Chitral Child Survival Program* is managed by *Aga Khan Health Service Pakistan* under Cooperative Agreement No. GHN-A-00-08-00010-00
. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about Chittral Child Survival Project visit: ww

PROGRAM LEARNING BRIEF

Annex II. List of Publications and Presentations Related to the Project

AKF, AKF,P, AKU and others involved in the operations research and other investigations related to the CCSP are in the process of preparing manuscripts and presentations, but nothing has yet been published or presented in a peer-reviewed forum.

AKF, P has prepared a number of presentations and some short briefs to share with government, and peer organizations within Pakistan.

Briefs:

1. Role of community based savings groups (CBSGs) enhancing the utilization of community midwives in Chitral district of Pakistan
2. Role of women saving groups in facilitating the continuum of maternal and newborn health care by skilled providers: Findings of a cross sectional study from Pakistan.
3. Community perspective on the role of Community Midwives to provide Maternal and Neonatal Health services; a qualitative assessment.
4. Can Savings Groups Facilitate Poor Women's Access to Health Services? Lessons from the Chitral Child Survival Project, Pakistan

Project Brochure and Postcard

1. CCSP Brochure
2. CCSP Postcard

Presentations:

1. Power point presentation on CBSG model for district and national dissemination purposes
2. Power point presentation on CMW model for district and national dissemination purposes
3. Power point presentation on Operations Research done by AKU-SONAM team
4. Power point presentation on BCC strategy for district and national dissemination purposes
5. Power point presentation on two innovative models of Chitral Child survival Program Group
6. Power point presentation on CCSP CBSGs in the Service of Maternal and Child health. This presentation includes a presentation guide document.

ANNEX III. PROJECT MANAGEMENT EVALUATION

The CCSP project was designed to facilitate a collaborative model to complement existing AKHSP and government health facilities to improve women's access to essential MNCH services in Chitral district. In Chitral several different factors including physical, socio-cultural and financial impede women's mobility to acquire health services and hence CMWs model was chosen to provide them the needed services at village level. Therefore, this project was conceived strategically as an important project by all partners.

In order for effective implementation management structure of the project was housed inside AKHSP and the general manager AKHSP Chitral was mandated to support the project and several key team members were hired including a Project Coordinator, Manager Monitoring and Evaluation, social mobilizers and a separate manager for CBSGs as this component was given to AKRSP for implementation. The Aga Khan University (AKU) was engaged for the Operation research (OR) piece of the project and terms of reference were defined for each partner according to Manager AKF (P) and a mechanism for coordination and project review was established. A senior level researcher of AKU School of Nursing (SON) was given the lead for OR. AKU-SON was provided all the technical and logistic support from AKF-P and this was appreciated too by the lead OR researcher. The CCSP project manager explained that this complexity of partnership was a key strength and a challenge too in this project. However, according to him it worked well because AKF (P) played a key role in facilitating coordination and linking project team with provincial health department, establishing provincial advisory committee, establishing links with Pakistan Nursing Council and conducting regular reviews. The existing organizational structures of AKHSP and AKRSP and their strong association with communities played a vital role in the implementation of the project

During the course of implementation several management challenges were confronted but were managed effectively through formation of District and provincial advisory committees and VHCs:

1. Identification of eligible women in non-traditional communities in Chitral to be trained as community midwife as a lot of resistance came from the communities, however, the District Advisory Committee of the project played a key role in addressing this issue. At the same time 40 CMWs were already trained by the government health department but their deployment was a big issue and most of them were selected on the basis of political patronage
2. Arranging accommodation facility for 28 young girls in Chitral town and security management. Some of the CMWs were found to be pregnant during the training which also delayed the process of their training
3. Lack of clear guidelines for deployment and support of CMWs
4. In the midst came devolution which also created some uncertainty
5. Tug of war between CMW and TBAs after deployment
6. Accreditation and certification of CMWs also delayed the process of their deployment

The project adopted strong supervisory and logistical systems for implementing the two key innovations; CMWS and CBSGs. The supervisors used checklist during their supervision on monthly basis and kept proper records of the information collected which was then used to improve things prospectively. Vehicular fleet was made available to facilitate supervisors and to ensure supply of drugs and essential commodities required at the work stations of CMWs. A revolving drug model was used in this project that helped the CMWs to ensure availability of essential drugs all the time. Village Health Committees (VHCs) were established to ensure proper support to CMWs at community level. The VHCs worked very well and they also helped the CMWs in instituting user fee for their services and also strengthening

their linkages with TBAs and other community based workers including LHWs. Another key strength identified was capacity building and exposure of project staff, CMWs and VHCs and that's pretty much sustainable as they all will stay in Chitral and will contribute in one way or another to the people in Chitral.

One major drawback identified by the manager AKF (P) was that although AKHSP implemented the activities envisaged in the project work plan but didn't come up with a proactive strong strategy to ensure sustainability of CMWs beyond the project life and AKHSP remained dependent on provincial government's MNCH strategy which is still at approval stage.

Annex IV Work Plan Table

ACTIVTIES		Update
Overall Program Activities		
1,01	Formation and Meetings of District Advisory Committee	Committee was formed in Dec 2008 and since that quarterly meeting was conducted till the end of the project life. Progress was reviewed an issues were discussed in the DAC meeting and follow up actions were taken.
1,02	Formation and Meetings of National Advisory Committee	National Advisory committee was formed in November 2008; two meetings per year were initially planned; however, due to unavailability of the committee members one meeting was conducted each year during the project life. The committee was responsible to strengthen coordination and partnership with Department of Health Khyber Pakhtunkhwa and with National MNCH program.
1,03	Supervision visits of management to monitor progress across program areas	Project Manager, coordinator and focus person at AKF-P on periodic basis visited the project intervention area to review the progress and to address the emerging issues.
1,04	Baseline Survey-development of tools, data collection, and analysis	Completed in March 2009
1,05	DIP workshop	Conducted in April 2008
1,06	Midline evaluation	Conducted in Sep 2011
1,07	Developing HMIS	Developed in June 2011 before the deployment of the CMWs at field level
1,08	Operations Research	Conducted in three phases. Phase1- was conducted in 2011, phase-II in 2012and phase-III in 2013.
1,09	Annual review workshop	During project life the annual review workshops was conducted each year
1,10	Final evaluation	Conducted in Nov 2013
1,11	End of project national dissemination workshop	District l level dissemination held in Dec 2013 and national level held in January 2013
Outcome Area A: Increased awareness of obstetric and neonatal complications, increased utilization of birth preparedness and complications readiness (BPCR) plans, and an improved enabling environment for MNCH		
2,01	Developing formative research tools	Completed in August 2009
2,02	Conducting Formative Research & data analysis	November 2009
2,03	Drafting Key Messages, IEC Tools/Materials	Completed in June 2010
2,04	BCC advisory group meetings	Conducted in regularly after implementation of BCC activities to review the progress and to take remedial action for identified issues
2,05	Planning workshop using the	Conducted in June 2010, where all partner organizations

ACTIVTIES		Update
	BEHAVE framework	were involved to finalize BCC strategy
2,06	Finalizing Key Messages, IEC Tools/Materials	Key messages finalized in September 2010
2,07	Building Capacity of Trainers of Trainers	Conducted in January 2011; 14 staff including field staff of AKHS,P and project staff were trained as master trainer to train change agents
2,08	Building Capacity of CMWs, TBAs and social workers in BCC	Till the end of the project 569 change agents were trained
2,9	Message dissemination-interpersonal channels	849 couple counseling sessions were conducted
2,10	Message dissemination-group communication	5186 group communication were organized for 63922 beneficiaries
2,11	Message dissemination-mass media/ public events	137 mass level dissemination sessions were organized for 10502 beneficiaries
2,12	Performance Review Meetings with CMWs	Conducted twice in a year to review the progress and to share the best experiences for provide feedback to CMWs and villages Health Committees on implementation gaps and follow up actions required
2,13	QA visits by AKHS, CHD persons	After implementation of the BCC strategy the technical team from Central office of the AKHS,P visited the project intervention area once in a year to assess the BCC strategy in terms quality implementation
Outcome Area B: Strengthened CMW referral linkages for obstetric and neonatal services		
3,01	AKHS, P leads development of protocols for each level of referral	Tools were developed in June 2011
3,02	CMWs & health provider training in referrals	Conducted in October 2011
3,03	Application of referral protocols and monitoring for validation of protocols	Project team regularly reviewed protocols and ensured its implementation in true spirit through using checklist and reporting on loopholes to ensure follow up actions.
3,04	Revision of protocols through monitoring and feedback mechanism	Referral protocols were developed and implemented; however, it did not require further revision.
Outcome Area C: Increased availability of trained community midwives (CMWs)		
4,01	Identification & selection of 30 CMWs	Identified and selected in February 2009
4,02	Establishment of Library, Skill Lab, Lecture Hall and Hostel for CMWs and provision of supplies to DHDC Training Facility	Clinical Lab was established in April 2011
4,03	Accreditation of AKHS,P CMW Training Program and initiation of	Accreditation of Midwifery School by Pakistan Nursing Council was accomplished in September 2009

ACTIVTIES		Update
	licensure procedure	
4,04	Classroom training of CMW students	Classroom training started in March 2009
4,05	Development of protocols & checklists for monitoring the quality of CMW classroom and practical training	Protocols & checklists for monitoring the quality of CMW classroom and practical training were developed in April 2009
4,06	Ongoing practical training of students (at community and district level health facilities)	During classroom training CMWs were provided practical training from Government District Head Quarter Hospital Chitral which was close to the training venue.
4,07	Internal examinations of CMW students	Internal examinations held as per standard examination schedule on quarterly basis
4,08	External Board Examinations (PNC) of students	External examination was conducted by Peshawar Nursing Examination Board in August 2010
4,09	Graduation Ceremony & licensure	Graduation ceremony held in June 2011
4,10	Develop and provide HMIS registers/tools and other necessary documents to CMW	HMIS was developed tested and finalized and data collection tools were provided to CMWs in June 2011
4,11	Introduction of CMW with community and community leaders and deployment	Introduction of CMWs with community was started in June 2011
4.12	Supportive supervision activities	Project team provided supportive supervision to CMWs till the end of the project life
4,13	Refresher trainings (one week per year)	After deployment of the CMWs at field level refresher trainings were every year based on the field observation during supervision.
Outcome Area D: Reduced financial barriers to accessing obstetric and neonatal continuum of care		
5,01	Design and finalization of SDF Fund	The Safe Delivery Fund was an idea for insurance scheme that all the women of child-bearing age would be invited to contribute to. After consideration, it was rejected for several reasons, including likely adverse selection risk, limited size, and high administrative costs relative to the amounts of premiums and projected pay-outs. AKHS/P rightly perceived that the CCSP was a health project, and so supposed that the CBSGs would be health savings groups. It was perplexing to some of the health staff that members were not told to save for MNCH, since that was after all the objective of the project. The AKF staff argued that it was important to have strong CBSGs, and that to be autonomous they needed to be able to make their own decisions. AKF's consultant quoted Rich

ACTIVTIES		Update
		Rosenberg of CGAP who said about MFIs, "The more restrictions you place on your loans, the more you require your clients to be liars"; that is to say, members have burning needs outside of health, and it is not reasonable to ask someone not to pay, say, school fees with their savings if that is their most pressing need.
5,02	Staff Orientation on SDF and transportation	International consultant Paul Rippy provided training to CCSP staff on formation and management of the CBSGs in January 2010
5,03	Social mobilization for SDF and transportation	Social Mobilization was started in the project intervention area in June 2010.
5,04	Women register with SDF	7988 women were registered with CBSGs at the end of the project
5,05	Experience sharing conference at regional level	Experience sharing workshops were organized at different point in time to share the experience of the best performing CBSGs with other CBSGs

ANNEX V. RAPID CATCH INDICATORS TABLE

S.No	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denominator	Percent		
1	Percentage of mothers with children 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	411	657	62.6	544	659	82.5	8.3	<0.001
2	Percentage of children age 0-23 months whose births were attended by skilled health personnel	217	657	33.0	494	603	82.0	17.5	<0.001
3	Percentage of children age 0-23 months who received postpartum visit within 2 days after birth by a health professional	43	657	6.5	74	670	11.0	2.9	0.004
4	Percentage of children 6-23 months who received a dose of vitamin A in the last 6 months	240	518	46.3	143	460	31.1	4.6	< 0.001
5	Percentage of children age 0-5months who were exclusively breast fed during the last 24 hours	84	139	60.4	149	159	93.7	6.9	< 0.001
6	Percentage of children age 12-23 months who received a measles vaccination	261	320	81.6	186	272	68.4	3.7	< 0.001
7	Percentage of children 12-23 months who received DPT1 according to the vaccination card or mothers recall	304	320	95.0	218	272	80.0	5.6	< 0.001
8	Percentage of children 12-23 months who received DPT3 according to the vaccination card or mothers recall	289	320	90.3	224	272	82.4	2.8	0.005
9	Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended homemade fluids	26	67	38.8	114	196	58.2	2.7	0.006
10	Percentage of children age 0-23 months with chest related cough and fast and/or difficult breathing in the last 2 weeks who were	66	102	65.0	103	130	79.0	2.4	0.017

S.No	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denominator	Percent		
	taken to the health provider								
11	Percentage of households of children age 0-23 months that treat water effectively	166	657	25.3	31	628	4.7	10.3	<0.001
12	Percentage of households where soap was available at hand washing designated place	442	657	67.3	591	669	88.3	9.2	<0.001
13	Percentage of children 6-9 months who received breast milk and complementary foods	101	118	85.6	112	114	98.2	3.5	<0.001
14	Percentage of children 0-23 months whose eight-for-age were below minus 2SD, classified as underweight child	90	503	17.6	103	309	33.6	5.2	<0.001

Other key MNCH indicators

S.no	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denominator	Percent		
1	Percentage of mothers of children 0-23months who took calcium tablets or syrup for at least 2 months during last pregnancy	94	657	14.3	243	659	36.8	9.4	<0.0001
2	Percentage of mothers of children 0-23months who took iron tablets or syrup for at least 2 months during last pregnancy	167	657	25.4	308	659	46.7	8.0	<0.0001
3	Percentage of children age 12-23 months who were fully vaccinated	218	320	68.1	186	272	68.4	0.1	0.938
4	Percentage of mothers of children 0-23months who know at least two danger signs in newborns soon after birth that indicate the need for treatment	308	657	46.9	552	659	82.0	13.3	<0.001

S.no	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denominator	Percent		
5	Percentage of mothers of children 0-23months who know at least two danger signs in newborns within 7 days of birth that indicate the need for treatment	415	657	63.2	656	659	99.5	16.9	<0.001
6	Percentage of mothers of children 0-23months who know at least two danger signs during pregnancy that indicate the need for treatment	295	657	44.9	545	658	82.8	14.3	<0.001
7	Percentage of mothers of children 0-23months who know at least two danger signs during child birth delivery that indicate the need for treatment	434	657	66.0	655	658	99.5	16.1	<0.001
8	Percentage of mothers of children 0-23months who know at least two danger signs during postpartum that indicate the need for treatment	436	657	64.4	544	659	82.5	7.4	<0.001
9	Percentage of households with designated place for hand washing	424	657	64.6	448	*735	61.0	1.4	0.166
10	Percentage of mothers of children 0-23months who had four or more antenatal visits when they were pregnant with the youngest child	145	657	22.1	296	659	44.9	8.8	<0.001
11	Percentage of mothers of children 0-23months who were using a modern method for contraception	166	657	25.3	260	655	39.7	5.6	<0.001
12	Percentage of mothers of children 0-23months who received a postpartum visit within 2 days after birth by a health professional	115	657	17.5	187	659	28.3	4.7	<0.001

Multiple responses

ANNEX VI

CCSP: Edline Household Survey Chitral District

Report

Endline Household Survey Chitral District

Chitral Child Survival Programme (CCSP)

November, 2013

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DISCLAIMER

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ABBREVIATIONS

AKFP	Aga Khan Foundation- Pakistan
AKHSP	Aga Khan Health Services, Pakistan
AKRSP	Aga Khan Rural Support Programme
ANC	Ante Natal Care
BCC	Behavior Change Communications
CCSP	Chitral Child Survival Program
CMW	Community Midwives
EmONC	Emergency Obstetric and Neonatal Care
FP	Family planning
IUD	Intra-Uterine Device
KP	Khyber Pakhtunkhwah
LHV	Lady Health Visitors
PDHS	Pakistan Demographic and Health Survey, 2006-07
TT	Tetanus Toxoid
USAID	United States Agency for International Development

Foreword

Indispensible services and intervention for Health in Chitral was necessary to reduce neonatal and maternal mortality in vulnerable remote areas. The Chitral Child Survival Program (CCSP) was a five year project funded by USAID and executed in 28 cluster of District Chitral with component of Community Mid Wife (CMW) Behavior Change Communication Strategies (BCC) and Community Based Saving Groups (CBSGs). The end-line survey was conducted to gather information on maternal and child health indicators for the project and compare changes followed by the intervention with the baseline survey benchmark.

The findings of survey in this report demonstrate significant increase in women's awareness about danger sings during pregnancy, at delivery and about neonatal health. Component of CMW in the intervention areas was found to be an associated factor for boosting rate of birth delivery from skilled birth attendant. In addition to this trends related to the ante-natal care services and visit to the health service providers also increased significantly. In this regard research is evident for improvement in utilization of essential allied services such as laboratory and radiology investigations. However, child health indicators such as vaccination presented a mixed picture, some of the indicators like measles vaccination showed declining trends. Furthermore, this report provides information on household related indicators to assess the overall socio-economc situation of the project areas, availability, accessibility, affordability and acceptability of maternal and neonatal services; health seeking behavior of the people especially of women and children; and the factors that influenced maternal, neonatal, infant and child health in the project area.

Completion of the end-line survey task would not have been possible without collective efforts of the team: technical advisory committee of SEDCO, Dr. Hassan Bin Hamza - Senior Technical Advisor, Muhammad Ali-Project Manager and Miss Huma Binte Nayyer-Research Officer.

In addition to this, I recognize the efforts of enumerators, supervisors and monitors who really struggled hard to bring quality data and accomplish the task in due time frame. I must take the opportunity to thank AFK local teams, regarding guidance and facilitation for the

identification of the areas. Lastly I recognize the cooperation of community for their assistance, accommodation and hospitality.

Uzma Athar
Chief Executive Officer SEDCO

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Survey operations were made manageable through the Chitral office of Aga Khan Health Services Pakistan. We are thankful to Mr. Mirajuddin Miraj - Manager (M&E), CCSP and his team for their effective support during implementation of the survey activities. Mr. Muzaffar Baig and Ms. Aisha Maab were specially instrumental in facilitating survey activities and coordination with key personnel in the field. Ms. Jamila personally visited a number of remote areas with our teams to facilitate interaction with the local communities.

The survey could not have been completed successfully without the active participation of the supervisors, interviewers and the team leaders of the data collection teams. The team members were motivated and were resolved to work in a hard area. Often they had to walk for considerable distances, start early in the day and work till late in the evening in order to finish assigned tasks in the given time. Their hard work was the key to successful completion of field operations.

We are in debt to Mr. Jamil Chitrali, Lecturer, Department of Anthropology, University of Peshawar, who accompanied our team to Chitral and helped us in identifying and selecting a good team of local individuals. His personal knowledge of the area helped us better plan our activities.

Finally, one would like to thank Ms. Uzma Athar - CEO, SEDCO Associates for managing a highly efficient unit of qualified personnel, all of whom had a substantial role in making this venture a success.

Dr. Hasan Bin Hamza
Senior Technical Advisor
CCSP End line survey

Executive Summary

The Chitral Child Survival Program (CCSP),is a 5 year United States Agency for International Development(USAID) funded project that aimed to reduce maternal and neonatal mortality and morbidity in the district of Chitral. Project implementation started in October 2008 and ended in September 2013. The reduction in maternal and child health mortality and morbidity as well as an improvement in health awareness was planned to be achieved through interventions such as 1) strengthened community mid wife (CMW) referral linkages with TBAs and LHWs, 2) a behavioural change communication (BCC) strategy and its key messages for enhanced knowledge on neonatal and maternal complications and birth preparedness plans, 3) increased availability of skilled birth attendants at the community level, and increased financial access by formation of village bodies and 4) Community Based Saving Groups (CBSGs).

Prior to commencement of the project a baseline survey was conducted to measure important project indicators for future evaluations. The baseline survey was useful in bench marking key performance indicators. The end line survey gauged the impact of the intervention by measuring the same set of indicators assessing the changes in knowledge, attitude and practices of the respondents after the implementation of the program. This is the report of the end-line survey, conducted at the end of project completion and uses a pre-post assessment to ascertain the effect of project interventions on indicators. The findings of the survey are presented in chapters, the first discusses the background of the project in brief and describes the methods used for the end line survey. The second chapter sets the context of the study by describing the demographic and socio-economic characteristics of the households and women participants. Maternal health indicators such as access to skilled birth attendants, ante-natal and post natal care are evaluated in Chapter 3. Findings on child health indicators and baseline and end line issues comparisons are discussed in Chapter 4. Knowledge and practices of contraceptives and knowledge of HIV/AIDS along with hepatitis B & C are assessed and described in Chapters 5 and 6 respectively. The last chapter discusses the salient findings from the study in detail and presents key recommendations based on the inferences of these findings.

The end line study encompassed a cross sectional household survey. The survey was conducted in 28 intervention clusters and included married women between the age of 15-49 with at least one child less than 24 months alive. The salient findings of the CCSP end line survey can be categorized broadly into five major areas by key outcome indicators.

First, there has been a positive impact on reproductive health knowledge a key outcome indicator of the BCC strategy aiming to increase knowledge on neonatal and maternal complications and birth preparedness plans. This is demonstrated by a substantial increase in the proportion of women aware of the danger signs during pregnancy, at delivery and amongst neonates. Percentage of mothers who knew at least two danger signs in newborns increased from 47% at baseline to 82% at end line. Similarly the proportion of women who knew at least two danger signs during pregnancy almost doubled from 45% percent at baseline to 83% at end line. The findings suggest that women being more aware of the risks are likely to seek timely care or treatment for their health problems.

Second, a significant effect on the availability of skilled birth attendants has been demonstrated intervention areas which can be attributed to the introduction of CMWs through the project. The proportion of women whose delivery was attended by a skilled birth attendant more than doubled between the start of the project and by the time it ended. Women for whom delivery was attended by a skilled birth attendant increased from a low of 33 % at baseline to 82% at end line. The key aspect of the project which catered to the provision of CMWs at local level increasing accessibility and mobilization by way of behavioural change communication and community participation through formation of local health committees in each CMW area would have an integral role to play in improving this critical outcome. Provision of skilled birth attendants has an essential role to play in reducing maternal mortality in the developing country context.

Third, reproductive health service delivery showed marked improvement as seen in increased access to and utilization of ante-natal care services in the project areas. This would have been possible due to a combination of skilled birth attendant's provision at the community level, strengthened referral linkages between SBAs and increased financial access through village bodies. Besides the increase in number of ante-natal care visits women are accessing ante-natal care earlier in their pregnancy. Women availing ANC increased from 22% to 45%

between baseline and end line. At baseline around 30% women had not visited a prenatal care provider even once throughout their last pregnancy whereas at end line this had decreased to 17%. This change was also observed in women accessing ANC services earlier as those who had their first antenatal check-up in the first trimester increased from 24% at baseline to 46% at end line. The availability and increased utilization of essential allied services such as laboratory and radiology investigations also is a positive development.

Fourth, contraceptive use was markedly increased in the intervention areas. A comprehensive BCC strategy, focusing on counselling rather than providing free contraceptives, appears to have led to enhancing CPR at the community level during the course of this project. At the baseline approximately 25% women were using some form of contraceptive. However, at the end line the proportion of women using contraceptives had increased to 40%. In the methods mix injectable contraceptives recorded an increase from 12.5% at baseline to 54% at end line. The overall contraceptive use (40%) is 10 percentage point higher than the national average of 30 percent.

Last, child health indictors such as vaccination presented a mixed picture. The proportion of fully vaccinated children remained the same between the baseline and end line surveys, individual vaccines such as measles demonstrated a drop in coverage. Measles vaccine had been received by about 81% of children aged 12-23 months at the baseline, however at the end line this proportion had decreased to 68.4%. While the decrease in measles vaccine coverage may largely be due to the lack of supplies generally in the Province of KPK and Chitral/country, it does highlight a specific area of concern and future intervention. The vaccination coverage however was better than that reported in the recently released brief reported of PDHS 2012-13 and has been discussed later in this report.

Overall it appears that the project interventions have had a significant impact on key MNCH indicators. Albeit areas for improvement have also been identified. For a detailed discussion on the findings and relevant recommendations please see Chapter 7.

A list of rapid catch indicators has been provided below to summarize the main findings and provide at a glance comparison between baseline and end line results for these selected indicators.

Rapid CATCH Indicators

S.No	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denominator	Percent		
1	Percentage of mothers with children 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	411	657	62.6	544	659	82.5	8.3	<0.001
2	Percentage of children age 0-23 months whose births were attended by skilled health personnel	217	657	33.0	494	603	82.0	17.5	<0.001
3	Percentage of children age 0-23 months who received postpartum visit within 2 days after birth by a health professional	43	657	6.5	74	670	11.0	2.9	0.004
4	Percentage of children 6-23 months who received a dose of vitamin A in the last 6 months	240	518	46.3	143	460	31.1	4.6	< 0.001
5	Percentage of children age 0-5months who were exclusively breast fed during the last 24 hours	84	139	60.4	149	159	93.7	6.9	< 0.001
6	Percentage of children age 12-23 months who received a measles vaccination	261	320	81.6	186	272	68.4	3.7	< 0.001
7	Percentage of children 12-23 months who received DPT1 according to the vaccination card or mothers recall	304	320	95.0	218	272	80.0	5.6	< 0.001
8	Percentage of children 12-23 months who received DPT3 according to the vaccination card or mothers recall	289	320	90.3	224	272	82.4	2.8	0.005
9	Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended homemade fluids	26	67	38.8	114	196	58.2	2.7	0.006
10	Percentage of children age 0-23 months with chest related cough and fast and/or difficult breathing in the last 2 weeks who were taken to the health provider	66	102	65.0	103	130	79.0	2.4	0.017
11	Percentage of households of children age 0-23 months that treat water effectively	166	657	25.3	31	628	4.7	10.3	<0.001
12	Percentage of households where soap was available at hand washing designated place	442	657	67.3	591	669	88.3	9.2	<0.001
13	Percentage of children 6-9 months who received breast milk and complementary foods	101	118	85.6	112	114	98.2	3.5	<0.001
14	Percentage of children 0-23 months whose eight-for-age were below minus 2SD, classified as underweight child	90	503	17.6	103	309	33.6	5.2	<0.001

Other key MNCH indicators

S.no	Indicators	Baseline			End line			Chi-square statistic	Significance
		Numerator	Denominator	Percent	Numerator	Denomi n-ator	Percent		
1	Percentage of mothers of children 0-23months who took calcium tablets or syrup for at least 2 months during last pregnancy	94	657	14.3	243	659	36.8	9.4	<0.0001
2	Percentage of mothers of children 0-23months who took iron tablets or syrup for at least 2 months during last pregnancy	167	657	25.4	308	659	46.7	8.0	<0.0001
3	Percentage of children age 12-23 months who were fully vaccinated	218	320	68.1	186	272	68.4	0.1	0.938
4	Percentage of mothers of children 0-23months who know at least two danger signs in newborns soon after birth that indicate the need for treatment	308	657	46.9	552	659	82.0	13.3	<0.001
5	Percentage of mothers of children 0-23months who know at least two danger signs in newborns within 7 days of birth that indicate the need for treatment	415	657	63.2	656	659	99.5	16.9	<0.001
6	Percentage of mothers of children 0-23months who know at least two danger signs during pregnancy that indicate the need for treatment	295	657	44.9	545	658	82.8	14.3	<0.001
7	Percentage of mothers of children 0-23months who know at least two danger signs during child birth delivery that indicate the need for treatment	434	657	66.0	655	658	99.5	16.1	<0.001
8	Percentage of mothers of children 0-23months who know at least two danger signs during postpartum that indicate the need for treatment	436	657	64.4	544	659	82.5	7.4	<0.001
9	Percentage of households with designated place for hand washing	424	657	64.6	448	*735	61.0	1.4	0.166
10	Percentage of mothers of children 0-23months who had four or more antenatal visits when they were pregnant with the youngest child	145	657	22.1	296	659	44.9	8.8	<0.001
11	Percentage of mothers of children 0-23months who were using a modern method for contraception	166	657	25.3	260	655	39.7	5.6	<0.001
12	Percentage of mothers of children 0-23months who received a postpartum visit within 2 days after birth by a health professional	115	657	17.5	187	659	28.3	4.7	<0.001

* Multiple responses

Chapter 1

INTRODUCTION

1.1. Background

The Chitral Child Survival Program (CCSP) was a 5-year project that aimed to improve maternal, neonatal and child health indicators in selected intervention areas of district Chitral, Khyber Pakhtunkhaw (KPK) province, Pakistan. The project was implemented between October 2008 and September 2013 by the Aga Khan Foundation, Pakistan AKF (P) in collaboration with Aga Khan Health Service, Pakistan (AKHSP) and Aga Khan Rural Support Program (AKRSP). Funding for the CCSP was provided by Aga Khan Foundation USA and the United States Agency for International Development's (USAID) Child Survival and Health Grants Program (CSHGP). The main objectives of the project were to improve maternal, neonatal and child health (MNCH) indicators in selected intervention areas of district Chitral by 1) increasing awareness of obstetric and neonatal complications, 2) increased utilization of birth preparedness and complication readiness plans along with providing an improved enabling environment for MNCH, 3) ensuring appropriate referrals for obstetric and neonatal complications and sustainable quality of care [strengthening Community Mid Wife (CMW) referral links], 4) increasing the availability of skilled birth attendants at the community level, and 5) reducing financial barriers to Emergency Obstetric and Neonatal Care (EmONC)services in project intervention areas. These objectives were proposed to be achieved by training and deploying of CMWs at the local village level and establishing local community financing initiatives.

Chitral district is located at the northern end of Pakistan and is the largest district in KP province covering an area of 14,850 square kilometres. According to the 1998 census the population of Chitral was 318,689(Population Census Organization, 2000) while recent estimates suggest an increase in population to about 400,000. It is a remote and isolated

district and is home to one of the highest mountains of the world, the Tirich Mir. Chitral is connected by air and road to Peshawar the provincial capital and Islamabad the national capital. However, access to and within Chitral by road is across difficult and rough terrain frequently blocked by landslides and flooding.

Prior to implementation of the CCSP a baseline survey was conducted in March and April 2009 to provide situational analysis with respect to project indicators and establishing benchmarks for future evaluations. The baseline survey collected information on household related indicators to assess the overall socioeconomic situation of the project area; the survey also assessed the availability, accessibility, affordability and acceptability of MNCH services; health seeking behaviour of the people especially with respect to women and children; the extent and frequencies of health indicators in order to investigate factors that could affect maternal, neonatal and child health in the project areas. The project was implemented in 30 intervention clusters and included 30 clusters as control areas. The target population in the CCSP Project area was estimated to be around 112,406 including almost 30,350 women of reproductive age (15-49) and about 20,233 children under the age of five years.

The CCSP completed its five year implementation phase on 30th September 2013. In order to measure changes in health seeking behaviours of targeted communities in post implementation period of CCSP and its impact on MNCH outcomes an end line survey was commissioned by the AKF(P) based on the Result Framework of the project. SEDCO Associates was hired by the AKF (P) through a competitive bidding process to implement the end line survey for the CCSP in Chitral district. The data collection for the end line survey was conducted between September 8th and September 18th, 2013 in selected intervention clusters to assess the impact on key knowledge, attitude and practices as well as MNCH outcome indicators, utilizing a pre-post intervention assessment.

1.2. Objectives of the End line survey

The research study presented is an end line evaluation of the CCSP and endeavours to determine the extent to which the objectives have been achieved since project initiation.

The CCSP end line survey has the following objectives:

1. Measure improvements according to major targets
2. Assess the overall impact on knowledge, attitude and practices in the project area on maternal and child health issues
3. Determine state of all health indicators and provide comparative analysis with baseline
4. Explore factors in the post project scenario that will affect maternal, neonatal, infant and child health
5. Describe how the CMWs and community bases support groups (CBSGs) are perceived by the respondents
6. Generate discussion and derive conclusion based on analysis

1.2. Methods

1.2.1. Study design

The CCSP end line study was designed as a cross sectional household (HH) survey. The survey was conducted in intervention clusters only.

1.2.2. Study area

The project encompassed 28 intervention clusters in district Chitral.

Table 1.1: List of CCSP end line survey clusters

S. No	Cluster Name	S. No	Cluster Name
1	Mori Lasht	15	Gohkir
2	ParsanKarim Abad	16	Shunjuran
3	OweerArkari	17	YarkhunLasht
4	ShaliArkari	18	Morder
5	HertKarimabad	19	Barenis
6	Bumborat	20	Raman
7	Gobore	21	Sore Laspoor
8	Besti	22	Awi
9	TerichPayeen	23	Melp
10	Terich Centre	24	Lot Oweer (Bala)
11	TerichBala	25	Lot Oweer (Payen)
12	Phashk	26	Kushum
13	Meragam 1	27	Orghoch
14	Khuz	28	JinjeratKuh

1.2.3. Study population

The baseline survey was conducted among ever married woman, aged 14-49, with at least one child alive aged 0-23 months. For the end line survey findings to be comparable and consistent with the baseline, eligibility criteria for the survey was ever married woman, aged 14-49 years, with at least one child alive aged 0-23 months.

1.2.4. Sample size

Sample size for the CCSP end line HH survey was calculated using the following assumptions. Alpha 0.05, power 90%, baseline report indicates a quarter (25%) of women in intervention areas received postnatal care [indicator selected for sample size calculation], expected difference between baseline and end line measure of the selected indicator - 10%, and a design effect of 1.5. The resultant sample size was at least 660 households.

Overall, 670households were sampled and women found eligible were interviewed for the survey. However, in 11 instances women with youngest child older than 23
Months were also interviewed. The response rate for women who were eligible was 99.8 percent with only one refusal due to shortage of time. Women with children more than 2 years of age were excluded from the final analysis.

1.2.5. Sampling strategy

A two-stage sampling technique was used for the HH survey. A list of 28 intervention clusters was provided by AKFP. Cluster was defined as a group of villages under one CMW providing MNCH services for the purpose of the project. The HH survey was conducted in all 28 intervention clusters.

Villages from within each cluster were selected for the survey using simple random selection methods (RAND command in MS Excel). This selection was from the list of villages available for each cluster. Since the total sample size was 660 households, distributing it over 28 clusters meant selecting 23-24 households per cluster. For village selection within each cluster one third villages were selected for inclusion in the survey. However, if this resulted in less than 10 households per village the number of villages per cluster was reduced to

ensure at least 10 households per village. In situations where 10 households were not available from a village the sample size was completed from the nearest adjoining village.

At the second stage HHs were sampled in each selected village. In these villages recruitment was done by line listing the eligible respondents. First, all eligible respondents in a village were listed by gathering information from relevant community health workers and/or other knowledgeable informants such as lady health workers and lady health visitors. Second, potential respondents were selected from this list randomly if there were more eligible respondents than the required sample size for the village. Else all respondents were interviewed and the sample size completed from the nearest adjoining village using line listing. From each sampled household one ever married woman (14-49 years of age with at least one living child aged 0-23 months) was interviewed. For HHs with more than one eligible respondent, only one eligible woman was selected for interview. Firstly, all eligible respondents in the HH were enumerated and their names recorded on separate pieces of paper. Subsequently, a non-eligible person from the HH was asked to choose one respondent by selecting one piece of paper in order to achieve randomness in selection of respondents from within HHs. HH was defined as number of people sharing a kitchen and was determined by the interviewer prior to selection of respondent.

1.2.6. Questionnaire design

Information was obtained at the household, eligible woman and at the community levels through three separate questionnaires. These questionnaires were reviewed in detail within SEDCO and in collaboration with AKFP technical advisors. These questionnaires had already been pre-tested at the baseline survey stage and were adopted for the end line survey with minor adjustments. The questionnaires were prepared in English language and then translated into Urdu which is the common language used for communication in Pakistan. The questionnaires have been attached as appendices at the end of this report.

1.3. Data management and analysis

Data were transcribed by the interviewers in the field on paper based forms which were organized by area of survey and kept in safe custody with individual team leaders. The data management team included a data manager and four data entry operators. Data entry program

for the questionnaire was prepared in EpiData by the data manager. Data entry checks and skips were incorporated into the entry program to minimize entry errors. Data quality was ensured by conducting double data entry and performing data validation.

Analysis of data was done using the Statistical Package for Social Sciences (SPSS) software version 17. Descriptive statistics were obtained including mean (±SD) for continuous normally distributed variables, median and inter quartile range for skewed continuous variables, and proportion/frequencies for categorical variables. To compare differences between groups where applicable relevant statistical tests for continuous variables (t-test) and for categorical variables (chi square) were employed, comparative analysis was conducted between baseline and end line surveys for key indicator variables.

WEALTH INDEX

The wealth index was calculated as a composite measure of a household's cumulative living standard. The index uses easy-to-collect data on a household's ownership of selected assets, such as televisions and bicycles; materials used for housing construction; and types of water access and sanitation facilities. For the CCSP end line survey we used the following questions from the data to calculate the wealth index:

- Main source of drinking water - piped on the dwelling being the best.
- Toilet facility - flush to sewer system to be the best
- All the durables (TV, radio other electrical appliances)
- Ownership of other durables (watch, motor cycle, bicycle, car scooter)
- Main source of energy for cooking (gas, wood)

Wealth index was generated employing principal components analysis (PCA). PCA places individual households on a continuous scale of relative wealth. Each household asset for which information was collected was assigned a weight generated through PCA. The resulting asset scores were standardized in relation to a standard normal distribution with a mean of zero and a standard deviation of one. These standardized scores were then used to create wealth quintiles: Poorest, Poor, Middle, Rich, and Richest.

Each household was assigned a standardized score for each asset, where the score differed depending on whether or not the household owned that asset. These scores were summed by household, and individuals were ranked according to the total score of the household in

which they resided. The sample was then divided into population quintiles, five groups with the same number of individuals in each.

1.4. Project management

Qualified personnel with previous experience of conducting quantitative interviews well versed with local language (Urdu and local dialect, i.e. Chitrali) were recruited to conduct the HH survey. Interviewers and supervisors were recruited locally to allow for language and cultural familiarity. The implementation of the survey in the field was led by the Senior Technical Advisor (STA) on part of SEDCO.

1.4.1. Team structure

There were three teams of interviewers each led by a field supervisor. Each team in the field constituted of4 interviewers (including the field supervisor) who were all women. Each team was overseen by one team leader who ensured quality data collection and managed local logistics. Team leaders worked directly with the teams in the field to ensure quality and provide another layer of supervision. Senior technical advisor (STA) ensured that the overall study is conducted according to the study protocol.

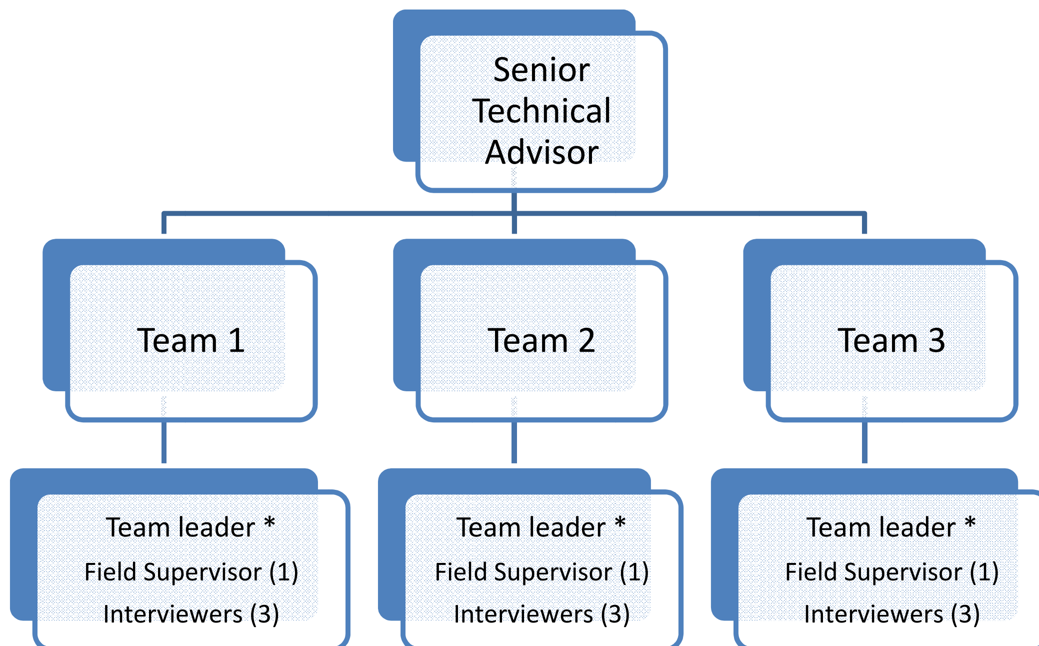


Figure 1.1: Team structure: CCSP end line survey

*STA functioned as team leader with the team for which monitoring was undertaken. Team leaders switched between teams for monitoring and evaluation.

1.4.2. Quality control

Data quality was ensured by incorporating a rigorous team selection process, relevant and appropriate training and active monitoring of data collection at three levels.

1.4.2.1. Team recruitment

SEDCO team, comprising Chief Executive Officer (CEO) SEDCO and senior Technical Advisor shortlisted candidates for data collection by interviewing potentially suitable candidates on August 24, 2013. Final selection of enumerators for the survey was as listed in table 2 below.

Table 1.2: Survey team - identification, training and selection of data collectors

S. No	Activity	Number
1	Interviewed	21
2	Shortlisted for training	16
3	Participated in training	15
4	Dropped during training	2
5	Dropped after training	2
6	Additional recruitment	1
	Total	**12**

1.4.2.2. Training

Training was held for 2 full days on August 25-26, 2013. After explanation of the study objectives, a question by question detailed discussion, along with each question's specific instructions was conducted with the interviewers. All the participants were divided into pairs for role play activity in which one partner was the respondent and the other the interviewer. They then switched roles. SEDCO trainers assessed individual performance after the role play and provided feedback question by question. At the end of two days of training unsuitable candidates were filtered out.

For the third day of the training, key portions of the study tools and the sampling methodology were discussed. The team was due to undertake a field visit to fill sample questionnaires by each data collection team member on the third day of training. However, due to an untoward incident at the training site, in AKHSP Chitral office, on August 26th, 2013 the training had to be postponed (Please see Section 1.5 below for further details).

Upon recommencement of survey field activities and before starting data collection half day refresher training was held for each specific team by respective team leaders.

1.4.2.3. Monitoring

Monitoring of data collection activity was performed at three levels, of field supervisor, team leader and monitoring & evaluation officer, to ensure data quality, consistency and completeness.

Field supervisors

Field supervisors were responsible to coordinate the movement of teams in the field, identification of the sampled household and supervision of data collectors. The field supervisors reviewed the questionnaires during data collection for consistency and completion. Logical errors and missing information were identified and interviewers were asked to rectify those on the field. At the end of each day the supervisors collected all questionnaires from the teams and reviewed them along with the team leader.

Team leader

The team leader conducted spot checks on the data collectors and field supervisors. The team leader monitored the work of the entire team in the field, including the supervisor. Both the team leader and the supervisor ensured that data collection was appropriate and correct according to the specified methods. Team leader also reviewed completed questionnaires at the end of each day along with the field-supervisors. Team leaders also filled the specifically designed M&E checklist to record monitoring activities.

Monitoring and evaluation officer

The senior technical advisor of the project conducted M&E of data collection. The M&E officer supervised data collection activities through spot checks and review of a selection of questionnaires. The M&E officer also functioned as team leader for the team for which a monitoring visit was undertaken for closer assessment of the working of the team. The M&E officer recorded monitoring activities using the monitoring checklist developed for the survey.

1.4.2.4. Reliability checking (enhanced quality assurance)

SEDCO conducted reliability checking of a sample of completed questionnaires. This was done by 1) selecting of forms to be rechecked by the team leader for each team of data collectors, 2) assigning the task of reliability checking to supervisor/interviewer other than the person who originally completed the form, 3) data collection of a set of variables by the nominated person, 4) verification of reconciliation of the primary and reliability checking forms by team leader or M&E officer. Greater than 5% discrepancy lead to rejection of the original form and required a refilling of the questionnaire. As a result of reliability checking it was ensured that the interviewers actually did visit the specific household and interviewed the relevant respondent. The overall discrepancy was below 5%. A grid for reliability checking was developed and implemented to ensure that reliability checks are performed for each individual interviewer. Overall 30 forms were checked for reliability.

Action taken: As a result of monitoring activities, forms of unsuitable quality were rejected (4 forms), interviewers sent for revisits of households in cases of missing information and a full day refresher training was held for one team. As a result of the refresher training, the team was more confident and able to collect data with fewer errors.

1.5. Field issues

Initially the field plan envisaged commencement of data collection activities from August 27, 2013. SEDCO initiated and completed the assigned tasks till August 25th. However, on August 26th, 2013 there were fatalities at the local AKHSP office in Chitral. After discussions between AKFP and SEDCO personnel present on the ground it was mutually decided to postpone the survey till the time AKHSP officials in Chitral made an assessment

of the security situation on the ground and gave a go ahead indicating that it was safe to re-commence survey activities. AKFP gave the go ahead to SEDCO to begin survey activities from Sep 5th, 2013. SEDCO team reached Chitral on Sep 6th, 2013.

The rough and rugged topography of district Chitral presented significant challenges in timely completion of survey activities. Landslides due to flash floods caused delays. Twice our teams were blocked in remote areas due to landslides and had to stay overnight locally. It took significant time to cover travel distances although these were not that long in kilometres. Initial advice about travel time was different from the actual situation on the ground for example in *YarkhunLasht* and it took significantly longer to reach the destination that initially anticipated.

These issues led to a delay of two days in completion of the survey. The motivation and determination of the field teams was instrumental in completing the survey activities despite the difficulties and without significant delays.

Chapter 2

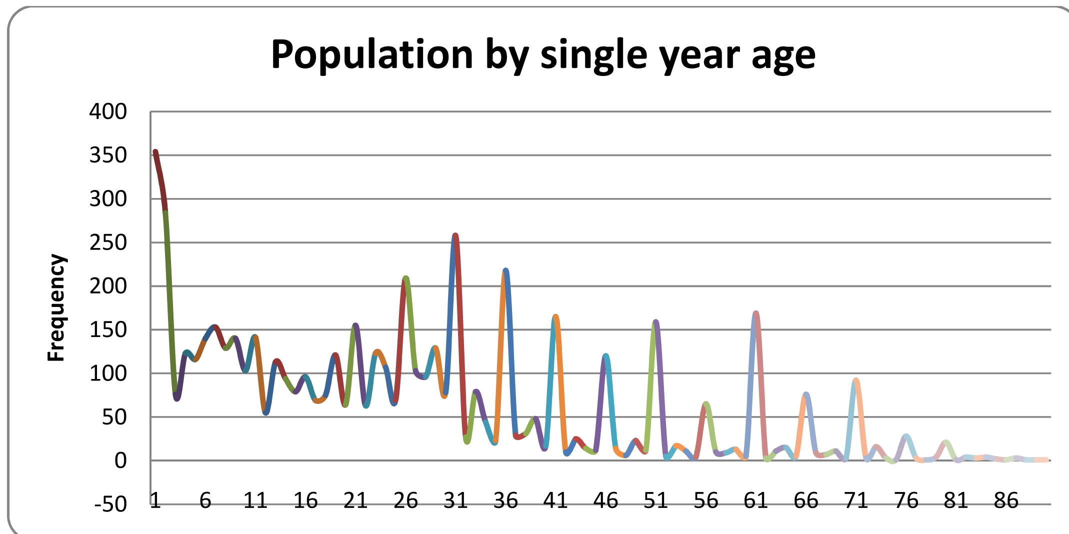
SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

This chapter highlights some of the important socio-economic and demographic characteristics identified in the household population surveyed for the end line and compares them to the results of the baseline survey. The end line survey covered 670 households involving 4,487 people.

2.1. Age-Sex Distribution of Household Population

The distribution of the household population by single year age is given in Figure 2.1. The trend largely follows its baseline counterpart. As indicated in the baseline report as well, the data exhibits evidence of age misreporting and heaping, particularly due to the inclination towards providing information on age by digit preference by the surveyed population. This means that people prefer to round off age in years when replying to questions on age.

Figure 2.1a: Population by Single Year Age



The percentage distibution of the household population by five year age groups and sex in the intervention areas is provided in Table 2.1. The overall sex ratio of the Chitral district calculated in the 1998 census was 103 (Population Census Organzation, 1998). The endline

survey registered an overal sex ratio of 108 in the intervention areas as compared to 103 at the baseline. The percentage of population below 15 years of age is 37.1 percent of the total in the intervention areas, a decrease from the 43.6 percent in the 2009 baseline, indicating a lowering of the fertility rate in Chitral since 1998. The dependent population in the intervention areas is 42.4 % indicating a growing workforce between 15-65 years of age.

Table 2.1: Percent Distribution of Household Population by age groups and sex

Age groups	Male	Female	Total	Sex Ratio
0-4	16.7	16.8	16.7	99
5 - -9	10.6	13.0	11.8	82
10--14	8.2	8.9	8.6	92
15--19	7.3	7.9	7.6	92
20--24	7.6	10.8	9.2	70
25--29	10.1	12.0	11.0	84
30--34	8.8	6.5	7.7	135
35--39	7.5	4.4	6.1	170
40--44	5.1	2.9	4.0	176
45--49	3.1	3.2	3.1	97
50--54	3.2	3.8	3.5	84
55--59	1.6	1.9	1.8	84
60--64	3.6	3.6	3.6	100
65+	6.8	3.6	5.3	189
Total	100	100	100	108
Number	2935	2705	5644	

2.2. Household Composition

The definition of a household in the end line remains consistent with that of the baseline survey as a group of people living together in the same dwelling, who acknowledge one adult member as the household head and have common cooking arrangements. Table 2.2 tabulates the results of the survey in terms of household head, household size, and room use. An overwhelming majority of the households (80.3%) reported having a male head while the rest (19.7%) reported having a female head. The reported female head ratio is higher than the 16% registered by the baseline survey in the intervention areas.

In terms of the household sizes, the average number of persons per household has decreased from 8.8 persons per household to 8.4 persons per household in the areas of intervention. However, the end line result is still higher than the national average of 7.1 persons per household. The households in the area of intervention continue to be overcrowded with almost 56% of total households bearing 8 or more inhabitants as compared to 60% in 2009. Only a small percentage of households (6.7%) have 4 or fewer occupants. On average, households had barely over 2 rooms to use for sleeping.

Table 2.2: Socio economic characteristics

Characteristics		Number	Percentage
Household head	Male	539	80.3
	Female	132	19.7
		671	100
Household size	<= 4	45	6.7
	5	52	7.8
	6	100	14.9
	7	96	14.3
	8+	376	56.1
	Total	669	100
Average household size	8.42		
Number of rooms for sleeping purposes	1	185	27.7
	2	266	39.8
	3	124	18.5
	4+	94	13.8
	Total	669	100
Average total number of rooms	4		
Average number of rooms for sleeping	2.3		

2.3. Educational Attainment

In the end line survey, information regarding the status of educational attainment was collected from both male and female respondents. The results show a positive change in the degree of education attained in the overall household population that was surveyed. The effect is more marked in the female population. Post intervention, the percentage of male and female population that had some form of education was recorded at 71.5 and 48, respectively, as compared to 65.9 and 41, respectively, in the baseline survey. Keeping in mind the five year gap between the base and end line surveys, and the decline in birth rates in the same period, a general rise in education levels can be seen for both males and females. However,

female population still lags behind the males. Tables 2.3a and 2.3b tabulate the results from the end line survey.

Table 2.3a: Status of educational attainment for males

Age groups	No education	Up to primary	Up to middle	Up to secondary	Above secondary	Total (N)
5—9	31.8	67.4	-	-	-	242
10--14	3.4	49.2	39.0	7.2	1.3	236
15-19	3.9	3.9	16.5	50.5	25.2	206
20-24	10.1	3.7	11.5	34.9	39.9	218
25-29	15.6	7.3	10.7	43.6	22.8	289
30-34	19.4	4.0	14.6	38.7	23.3	253
35-39	22.6	6.5	14.7	32.3	24.0	217
40-44	31.0	4.8	15.9	28.3	20.0	145
45-49	37.8	4.4	15.6	21.1	21.1	90
50-54	69.9	6.5	8.6	10.8	4.3	93
55-59	77.1	4.2	6.2	10.4	2.1	48
60-64	71.2	7.7	6.7	7.7	6.7	104
65+	78.6	6.6	5.1	5.1	4.6	196
Total	28.5	16.2	13.6	25.0	16.7	2339

Table 2.4b: Status of educational attainment for females

Age groups	No education	Up to primary	Up to middle	Up to secondary	Above secondary	Total (N)
5—9	34.3	65.7	-	-	-	271
10—14	9.5	42.3	39.4	8.3	0.4	241
15-19	22.3	6.2	14.7	31.8	25.1	211
20-24	34.3	6.6	8	19.2	31.8	286
25-29	50.8	7.8	7.5	15	19	321
30-34	62.4	4.6	8.1	6.9	17.9	173
35-39	75.4	2.5	4.1	9.8	8.2	122
40-44	81	8.9	1.3	2.5	6.3	79
45-49	98.8	0	1.2	0	0	82
50-54	96.1	1	1.9	0	1	103
55-59	100	0	0	0	0	51
60-64	99	0	0	1	0	97
65+	97.1	1.9	1	0	0	104
Total	52.1	16.7	9.4	10.1	11.8	2141

2.4. Housing Characteristics

The end line survey gathered information from respondents about certain characteristics about their housing units including construction structure type, materials and cooking fuels type etc to get an understanding of the economic and environmental conditions that the respondents face.

Fewer people (78%) live in kaacha houses as compared to the baseline (95%). More people (15.7%) than before (3.6%) live in semi-pacca houses. The percentage of people living in pacca houses similarly has gone up from 1.2% to 5.9%. The same trend is reflected in the materials used for roofing. The use of natural (palm leaves/thatching) and rudimentary (plastic/cardboard) materials has gone down from 95.9% to 87.3% and 6% to 4.6% respectively.

1. **Table 2.5: Distribution of housing characteristics**

Characteristics	Sub-Characteristics	Number	Percentage
Floor	Kaacha	524	78.2
	Semi-Pacca	105	15.7
	Pacca	11	1.6
	Constructed house – Bungalow	29	4.3
	Other	1	0.1
Roof	Thatching\Palm	585	87.3
	Cardboard\Plastic	31	4.6
	Iron sheets-Asbestos	45	6.7
	T-Iron-Wood-Brick	8	1.2
	Reinforced brick cement	1	0.1
Walls	Mud-stones	574	85.7
	Bamboo-sticks-mud	45	6.7
	Unbaked bricks – mud	9	1.3
	Plywood sheets	2	0.3
	Stone blocks	8	1.2
	Baked bricks	10	1.5
	Cement blocks-cement	20	3
	Other	2	0.3
Main source of Energy for Cooking	Wood (solid fuel)	665	99.3
	Cow Dung	5	0.7
Total		670	100

In the use of finished roofing materials the use of iron sheets-asbestos has gone up from 2.1% to 6.7%, whereas the use of T iron-wood-brick has remained constant at 1.2%, and the use of

reinforced brick cement has gone down from 2% to 0.1%. In terms of materials used to construct walls, most houses still use natural materials (92.4%) although the percentage has come down a little from 97.6% at time of the baseline. The use of cement blocks as wall construction material has risen from 1.5% to 3%. There is only a marginal decrease in use of wood as fuel for cooking from 99.7% to 99.3%.

2.5. Availability of drinking water

The end line questioned the respondents about the source of drinking water available in their dwellings. A majority obtain their drinking water from a spring (63.1%) which is a marked change from the baseline survey where a majority (68.3%) had access to piped water in their plot/house. At the end line only 15.7% of houses have the facility of drinking water through pipes.

Table 2.6: Distribution of sources for drinking water

Source of Drinking water	Percentage	Number
Piped into dwelling	4.2	28
Piped to yard plot	11.5	77
Public tab	0.1	1
Tube well or bore hole	0.1	1
Covered well	0.3	2
Uncovered well	0.9	6
Spring	63.1	423
River – Stream	18.7	125
Pond – Lake	0.4	3
Dam	0.1	1
Rain water	0.3	2
Cart with small tank	0.1	1
Total	100	670
Time to obtain drinking water		
Less than 30 minutes	51.3	344
More than 30 minutes	6.3	42
On Premises	30.0	201
Don't Know	12.4	83
	100	670

At the end line only 30% of people now have a water source on or near their premises as compared to the 68.8% at the time of the baseline. Over half the respondents (51.3%) have to

spend less than 30 minutes to get drinking water while at the baseline only 18.6% people reported the same. There has been a shift of access to drinking water from the baseline and about 2.7 times more people are spending less than 30 minutes to get drinking water compared to the baseline.

2.6. Sanitation facilities

The sanitation facilities have improved in the intervention areas during the five year period. 42.4% respondents now record having flush-to-sewer toilet facilities as compared to just 1.2% in the baseline survey. Similarly, the percentage of people who report flush-to-septic tank has decreased from 91% to 55.1%. The percentage of respondents who don't have any indoor toilet facility has halved from 4.2% to 2.1%.

Table 2.7: Distribution of water sanitation facilities

Toilet facility used by households		Percentage
Flush to sewer system		42.4
Flush to sceptic tank		55.1
Pit latrine without slab – open pit		0.3
Bucket toilet		0.1
No facility – Bush field		2.1
Total	Percent	100
	Number	670

2.7. Ownership of consumer goods and livestock

The possession of durable consumer items has been considered a reliable indicator of a household's socio-economic position. There is a sizeable increase in all consumer items considered necessary for modern living. Compared to the baseline, more people now posses televisions (41.6%, up from 28.6%), refrigerators (14.6%, up from 4.4%), telephones (45%, up from 22%), washing machines (21.3%, up from 7.4%) and even personal computers (9.4%, up from 5%). The proportion of people having bicycles, motorcycles and cars has gone up from 2.3%, 2.7% and 2.7% to 4.3%, 9.3% and 4.5%, respectively. Tables 2.7a and 2.7b show results over a broad range of durable consumer items.

Table 2.8a: Ownership of consumer goods and livestock

Household possessions	Percentage
Electricity	99.0
Radio	43.0
Television	41.6
Refrigerator	14.6
Mobile telephone or land line telephone	45.0
Heater	17.7
Washing Machine	21.3
Water Pump	7.90
Bed	50.3
Chairs	52.0
Almirah / Cabinet	38.5
Clock	83.0
Sofa	18.5
Sewing Machine	43.7
Camera	8.5
Personal Computer	9.4
Total Responses	670

Table 2.9b: Distribution of household possessions

Household possessions	Percentage
A Watch	93.0
A Bicycle	4.3
A Motorcycle or motor Scooter	9.3
A Car or Truck or Tractor	4.5
Total Responses	670

Respondents were also asked about the livestock they owned. 92.4% of the respondents owned cows, while 76.4% and 50.6% reported owning chicken and sheep, respectively. Table 2.7c lists percentage of people who own some livestock. These figures are considerably different from those recorded in the baseline. The proportion of people that reported owning cows, chicken, and goats in the baseline were 38.2%, 3.9% and 4.8% respectively.

Table 2.10c: Distribution of livestock ownership

Animals	Responses	Percentage
Bulls	Don't have	63.6
	Have	36.4
Cows	Don't have	7.6
	Have	92.4
Donkeys or mules or horses	Don't have	94.9
	Have	4.5
	Missing	0.6
Goats	Don't have	50.0
	Have	49.6
	Missing	0.4
Sheep	Don't have	49.1
	Have	50.6
	Missing	0.3
Chickens	Don't have	23.6
	Have	76.4
Total	670	100

2.8. Illness and health facilities

Table 2.8a lists all the sources of medical treatment people visited for their last illness. Only 8.2 percent of people reported being ill in the past one month of the survey. Out of these, almost 87% sought medical treatment. DHQ was the source of medical intervention for 34.7% people; 17.3% got treatment from a private clinic and 14.1% from AKHS hospital. The proportion of respondents visiting DHQ hospital at the baseline was 22% while 28% were going to AKHS facilities for seeking care. More people are now visiting DHQ hospitals. However, when asked specifically which facility would they prefer to go to women's health related issues almost 27% (Table 2.9) indicated their preference for AKHS facilities.

Table 2.8 a: Distribution of illness and health care seeking from facilities

Characteristics		Percentage	Number
Ill during past month	Yes	8.2	459
	No	91.8	5157
	Total	100.0	5616
Sought any treatment for illness	Yes	86.8	389
	No	13.2	59
	Total	100.0	448
Place from where treatment received	DHQ hospital	34.7	130
	THQ hospital	5.9	22
	MCH centre	2.1	8
	RHC	1.6	6
	BHU	9.3	35
	AKHS hospital	14.1	53
	Private clinic hospital	17.3	65
	DAI birth attendant	0.8	3
	Lady health worker	4.3	16
	Other	9.9	37
	Total	100.0	375

In terms of expenditure on health, a majority of respondents spend over PKR 200 on expenses related to transport to a health facility (67.6%), consultation (56.2%), medicine (82.2%) and lab tests (85.6%). This is in contrast to the result of the baseline where medicine was the only head for which a high proportion of respondents spent more than PKR 200. Table 2.8b lists the detailed end line results for expenses related to medical treatment.

Table 2.8 b: Type and amount of Expenditures

Type of Expenditure	Expenditure in Rupees (PKR)					
	No fee	Up to Rs 20	21-50	51-100	101-200	Above 200
Transport	18.8	-	2.9	3.8	6.8	67.6
Consultation	9.6	12.7	7.1	7.9	6.5	56.2
Medicine	3.6	0.6	1.5	3.3	8.9	82.2
Laboratory test	-	2.4	1.0	1.9	9.1	85.6
Miscellaneous	46.1	2.0	0.5	2.9	10.7	37.9

2.9. Preference of medical facility

Respondents were asked in the end line survey to provide information about the medical facility they would visit in certain situations. For information, it was calculated that the DHQ hospital was at an average of 68 km from the respondents. The route till the DHQ hospital was via an unpaved road for three fourths of the respondents.

Table 2.9 : Distribution of medical facility preference

Characteristics		Percentage	Number
Where would the women with problem go for treatment (multiple responses)	DHQ hospital	16.2	6
	THQ hospital	10.8	4
	MCH centre	8.1	3
	RHC	10.8	4
	BHU	2.7	1
	AKHS hospital	27.0	10
	Lady health worker	2.7	1
	DAI-traditional birth attendant	10.8	4
	CMW	8.1	3
	Other	2.7	1
	Total Responses	100	37
		Mean	**S.D**
How long would it take her to reach to the facility		115	106
How much would it cost (PKR)		2331	2058
		Percentage	**Number**
Where do community people usually go for minor ailment	DHQ hospital	6.1	2
	THQ hospital	3.0	1
	BHU	39.4	13
	AKHS hospital	9.1	3
	Lady health worker	9.1	3
	Self	6.1	2
	CMW	3.0	1
	Local Made	3.0	1
	Dispensary	6.1	2
	Other	12.1	4
For a serious illness is a transport available at night	Yes	84.4	27
	No	15.6	5
	Total Responses	100	32
		Mean	**S.D**
Average time it will take to reach the facility using this means (in minutes)		97	55
How much would it cost (PKR)		2778	2574

The responses show that the women go to a variety of medical facilities for treatment in case of a problem. 27% responses mentioned AKHS hospitals. An equal percentage of respondents (10.8%) mentioned THQ, RHC, and local Dai as the medical facility they go to. The average time for women to reach their mentioned facility was 115 minutes while the average cost of reaching the facility was PKR 2331. For minor medical ailments, a large proportion of people (39.4%) visited the BHUs. For serious medical issues transport was available for 84.4% of the respondents which would take an average time of 97 minutes and cost PKR 2778 on average.

The average cost of delivery in the intervention areas was reported to be PKR 3680 with a standard deviation (SD) of $\pm$ 8051PKR.

Table 2.10: Distance to health facilities and providers

Facility	Distance	Percentage	N
Distance to BHU	Within community	16.1	5
	1-5 km	19.4	6
	6-10 km	32.3	10
	11+	32.3	10
	Don't know		
	Total	**100**	**31**
Distance to Dai	Within community	61.3	19
	1-5 km	19.4	6
	6-10 km	9.7	3
	11+	9.7	3
	Don't know		
	Total	**100**	**31**
Distance to RHC	Within community	3.4	1
	1-5 km	10.3	3
	6-10 km	24.1	7
	11+	55.2	16
	Don't know	6.9	2
	Total	**100**	**29**
Distance to Government dispensary	Within community	25.8	8
	1-5 km	29	9
	6-10 km	12.9	4
	11+	29.0	9
	Don't know	3.2	1
	Total	**100**	**31**
Distance to Maternal and child health center	Within community	9.7	3
	1-5 km	12.9	4
	6-10 km	22.6	7
	11+	38.7	12
	Don't know	16.1	5
	Total	**100**	**31**

Facility	Distance	Percentage	N
Distance to Private male doctor	Within community	-	-
	1-5 km	9.7	3
	6-10 km	16.1	5
	11+	67.7	21
	Don't know	6.5	2
	Total	100	31
Distance to Private female doctor	Within community	3.5	1
	1-5 km	6.5	2
	6-10 km	16.1	5
	11+	74.2	23
	Don't know	-	-
	Total	100	31
Distance to Dispenser or compounder	Within community	43.8	14
	1-5 km	28.1	9
	6-10 km	9.4	3
	11+	18.8	6
	Don't know	-	-
	Total	100	32
Distance to Family welfare center (FWC)	Within community	11.1	3
	1-5 km	11.1	3
	6-10 km	11.1	3
	11+	29.6	8
	Don't know	37	10
	Total	100	27
Distance to Lady health worker (LHW)	Within community	71.9	23
	1-5 km	15.6	5
	6-10 km	6.3	2
	11+	6.3	2
	Don't know	-	-
	Total	100	32
Distance to Community midwife (CMW)	Within community	59.4	19
	1-5 km	31.3	10
	6-10 km	9.4	3
	11+	-	-
	Don't know	-	-
	Total	100	32
Distance to Trained Birth Attendant (TBA	Within community	55.6	15
	1-5 km	7.4	2
	6-10 km	11.1	3
	11+	11.1	3
	Don't know	14.8	4
	Total	100	27

Facility	Distance	Percentage	N
Distance to Hakim or Homeopath	Within community	22.2	6
	1-5 km	-	-
	6-10 km	7.4	2
	11+	51.9	14
	Don't know	18.5	5
	Total	100	27
Distance to Tehsil HQ hospital	Within community	-	-
	1-5 km	6.3	2
	6-10 km	3.1	1
	11+	90.6	29
	Don't know	-	-
	Total	100	32
Distance to HQ hospital	Within community	-	-
	1-5 km	3.0	1.0
	6-10 km	-	-
	11+	96.9	32
	Don't know	-	-
	Total	100	33
Distance to Traditional healer	Within community	53.3	16
	1-5 km	10.0	3
	6-10 km	-	-
	11+	16.7	5
	Don't know	20.0	6
	Total	100	30
Distance to laboratory services	Within community	6.3	2
	1-5 km	6.3	2
	6-10 km	12.5	4
	11+	65.6	21
	Don't know	9.4	3
	Total	100	32

Chapter 3

REPRODUCTIVE HEALTH

Promotion of maternal and child health is one of the most important objectives to achieve MDG 4 and 5.It includes prenatal care with at least three antenatal care visits, iron supplements for pregnant and lactating women, two doses of Tetanus Toxoid (TT) vaccine, detection and treatment of anemia in mothers, encouragement of institutional deliveries by trained health personnel, postnatal care and identification and treatment of reproductive tract and sexually transmitted infections.

This end line survey has gathered information on various aspects of reproductive health including prenatal care during pregnancy, number of visits to a health provider, reasons for seeking health care during pregnancy, prevalence of health care during pregnancy from a skilled health provider, administration of Tetanus Toxoid injections, use of calcium and iron tablets, preparedness for delivery, place of delivery and person attending delivery, postnatal care and problems encountered during pregnancy, delivery and postpartum period.

This chapter illustrates issues related to reproductive health of women aged 15-49 years who had a living child of 0- 23 months of age. Data are presented for the intervention areas.

3.1. Community-pooled resources

Community information was obtained through a separate community questionnaire the respondents for which were community leaders, chairmen of local organizing committees, religious leaders, school teachers and other key informants. Community information was obtained from 33 respondents in total.

According to information provided by the respondents60.6% (20/33) of them were aware of a community organization in their areas, 60.6% (20/33) were aware of a male volunteer organization and 39.2% (13/33) were aware of a female volunteer organization in their area. More than half (54.5%) of the respondents stated that these organizations discussed health

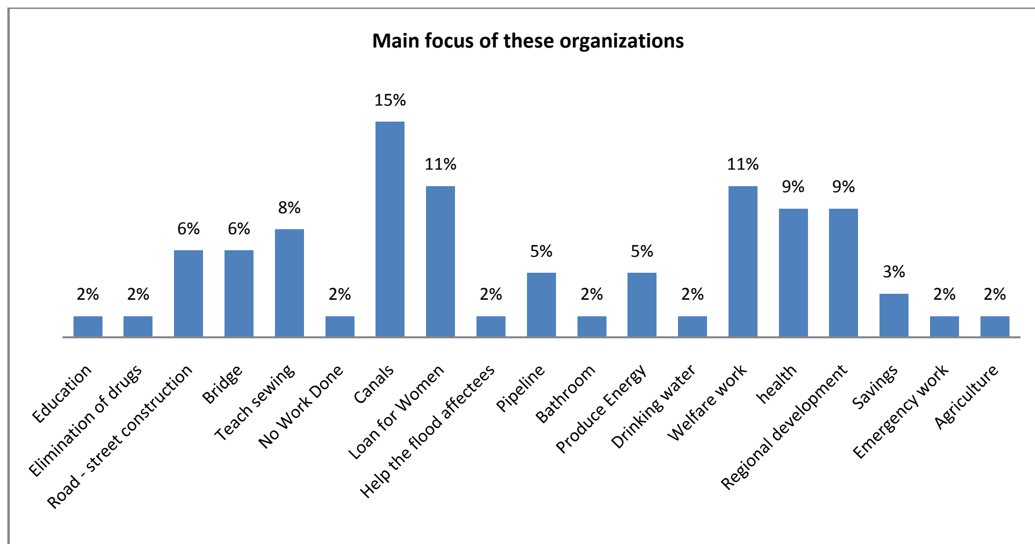
issues while 48.5% believed that health care during pregnancy was also an issue discussed specifically by these organizations. However, health is only one of the many focuses of such organizations as can be seen in Figure 3.1.

Overall less than a third of the respondents (n=10, 30.3%) mentioned that there was any community-pooled fund available for health issues. Regarding the use of these funds70% respondents mentioned that the funds pooled could be used for emergency treatment while funds utilization for transportation and welfare of the poor was reported by 50% of the respondents.

Table 3.1: Distribution of community pooled resources

		Percentage	Responses n=33
Community organization	Yes	60.6	20
	No	33.3	11
	Don't Know	6.1	2
Male volunteer organization	Yes	60.6	20
	No	9.1	3
	Don't Know	30.3	10
Women organization	Yes	39.4	13
	No	3.0	1
	Don't Know	57.6	19
Organizations discuss health issues		54.5	18
Organizations discuss health care during pregnancy and delivery		48.5	16
Community pool resources funds for seeking health services	Yes	30.3	10
	No	69.7	23
What is the use of these funds	Emergency treatments	70.0	7
	Arrange transports for the referrals	50.0	5
	Welfare of the poor	50.0	5

Figure 3.2: Main focus of community organizations



* n=64, multiple responses

3.2. Prenatal care

The prenatal check-ups include monitoring a pregnancy for signs of complications, detection and treatment of pre-existing and concurrent problems of pregnancy, provision of advice and counselling on preventive care, diet during pregnancy, delivery care, postnatal care and related issues. It is recommended that as part of the prenatal care, a woman must receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid to prevent or treat anemia, monitoring of blood pressure etc. The baseline survey collected information from ever married women of reproductive age with a living child less than two years of age regarding specific problems they may have had during their last pregnancy and whether they received any prenatal check-ups. Women who did not receive prenatal check-ups were asked why they did not get prenatal service. Women who received prenatal check-ups were asked about the care provider, the timing of the first prenatal check-up, the total number of checkups and whether they received any tetanus toxoid injections.

Table 3.3: Percent distribution of women with 0-23months children who had antenatal check up

Characteristics		At least one antenatal check-up		Four or more ante natal checkups	
Age groups	<25	90.30	187	53.10	110
	25-34	82.80	284	45.20	155
	35+	72.30	86	28.60	34
Birth Order	1	86.60	175	59.90	121
	2--3	86.70	234	42.20	114
	4--5	78.70	107	37.50	51
	6+	64.40	38	18.60	11
Education	No education	73.10	258	34.80	123
	Up to primary	84.60	33	43.60	17
	Middle	92.50	49	54.70	29
	Up to Secondary	93.60	88	52.10	49
	Secondary+	98.40	124	63.50	80
Wealth Index	Poorest	76.90	103	40.30	54
	Poor	80.60	108	41.00	55
	Middle	80.60	108	49.30	66
	Rich	88.00	117	46.60	62
	Richest	89.60	120	45.50	61
Total		83.5		44.5	

Table 3.3 presents information on number of prenatal care visits and selected background characteristics of respondents of the survey. The information was collected for the last birth only. The respondents were asked whom did they consult for prenatal checkups. Overall 83.5 percent visited a service provider at least once during their last pregnancy which has increased from 67% at baseline. However, only **a quarter of women (25 percent) visited a service provider four or more times during the prenatal period at baseline and at end line it rose to 44.5%.**

Visits, both one ANC and at least 4 visits are positively correlated with increasing education and wealth status. Interestingly young primiparous women have more visits (both at least one

and four or more visits)as compared to multiparous older women.ANC care visits drop to almost half when comparing one ANC visit to four ANC visits, and this stands among all stats of age, parity ,education and wealth. The same findings were observed when base line trend analysis was done. A need for focusing women of all ages and parity and those who are poor and uneducated is evident from the findings of the end line survey. The quality of prenatal care can be assessed by the number of prenatal visits, and the timing of the first visit. Prenatal care can also be monitored through the content of services received and the kind of information mothers are given during their visit.

3.3. Number and timing of prenatal checkups

The number of prenatal checkups and the timing of the first check-up are important for the health of mother and the outcome of the pregnancy. The conventional recommendation for normal pregnancies is that once pregnancy is confirmed, prenatal checkups should be scheduled at four week intervals during the first seven months, then two weeks until the last month, and weekly thereafter. Four antenatal checkups –one each during the third, sixth, eighth and ninth month of pregnancy-have been recommended as the minimum necessary. The conventional recommendation is to schedule the first check-up within six weeks of a woman's menstruation period; however, even if the initial check-up is initiated as late as the third trimester, chances of peri-natal mortality are substantially reduced (Ramachandran, 1992).

Figure 3.3a shows the percent distribution of women seeking prenatal care for their last pregnancy. **At baseline, around 30% women did not visit a prenatal care provider even once throughout their last pregnancy whereas at end line this decreased to 17%.** It was noted in baseline that 24% women had their first antenatal check-up in the first trimester, 31% in the second trimester and 15% in the third trimester. **At end line 46% women had their first antenatal check-up in the first trimester, 25% in the second trimester and 12% in the third trimester.**

Figure 3.3 a: Antenatal visits by month of pregnancy - Baseline

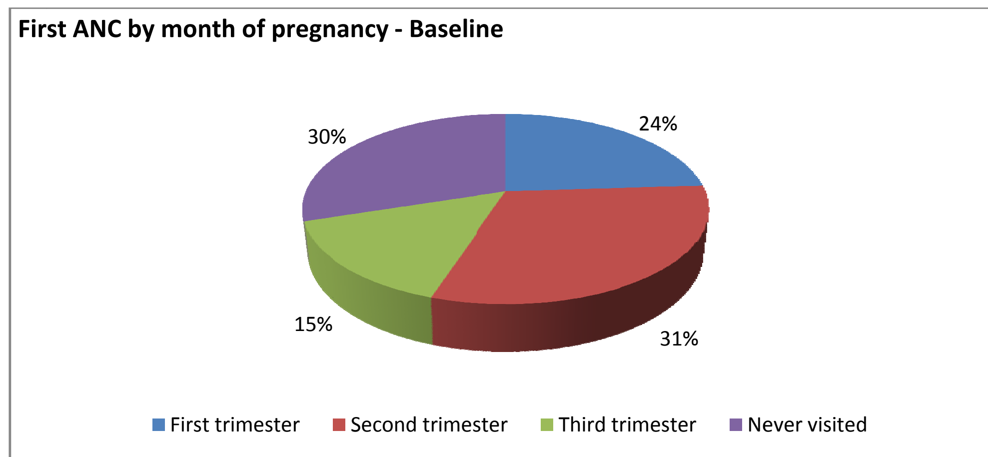
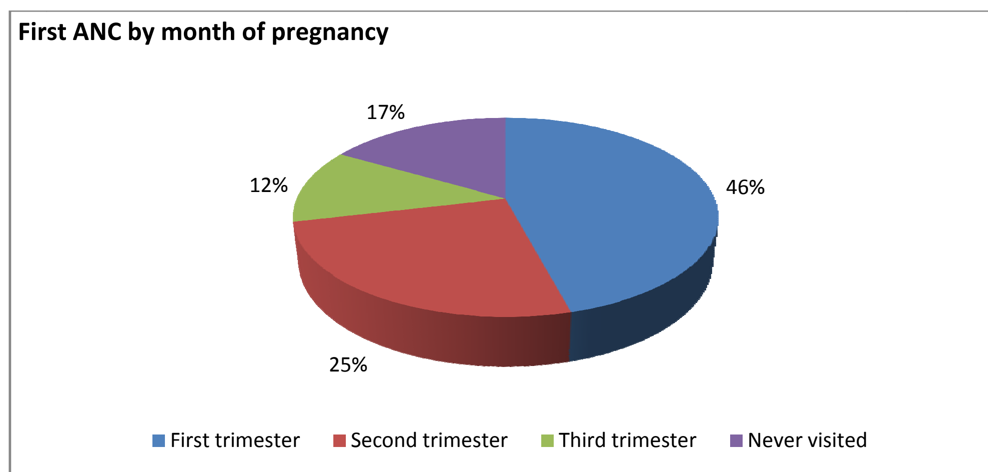


Figure 3.3 b: Antenatal visits by month of pregnancy – End line



Overall at baseline, 45% women had visited a health provider 1-3 times, 22% 4-7 times and less than three percent had visited 8 or more times (Figure3.3c). At end line, 39% women had visited a health provider 1-3 times, 40% 4-7 times and 5% had visited 8 or more times (Figure 3.4).**This shows an improvement as more women are making more number of ANC visits compared to baseline**.

Figure 3.3 c: Percentage distribution by number of antenatal visit during pregnancy - baseline

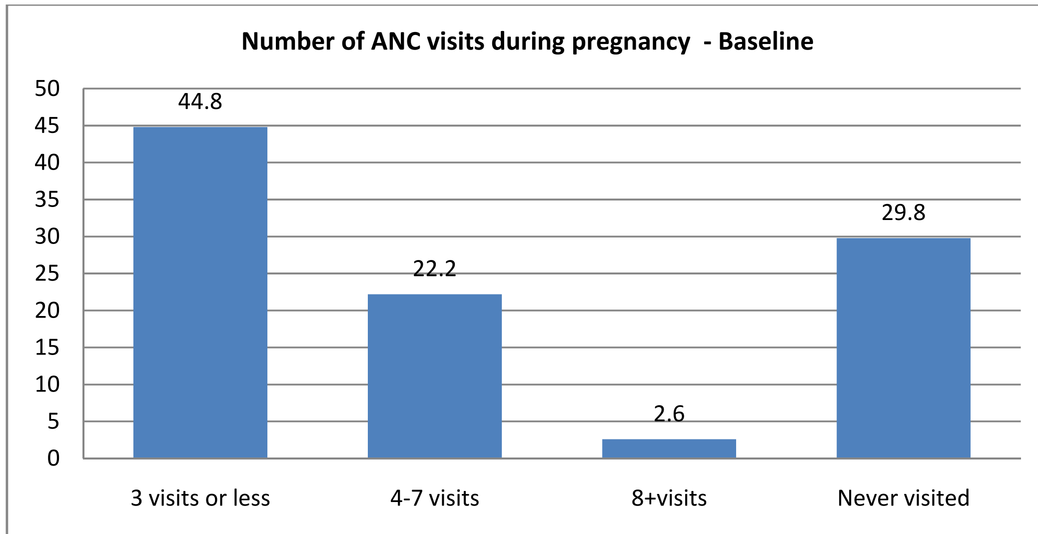
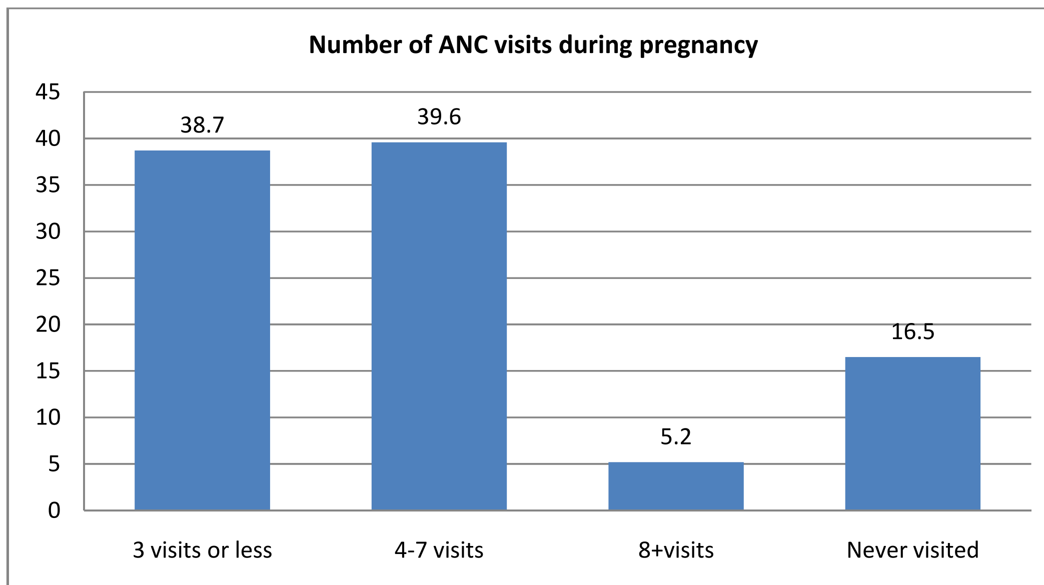


Figure 3.3 d: Percentage distribution by number of antenatal visit during pregnancy - end line

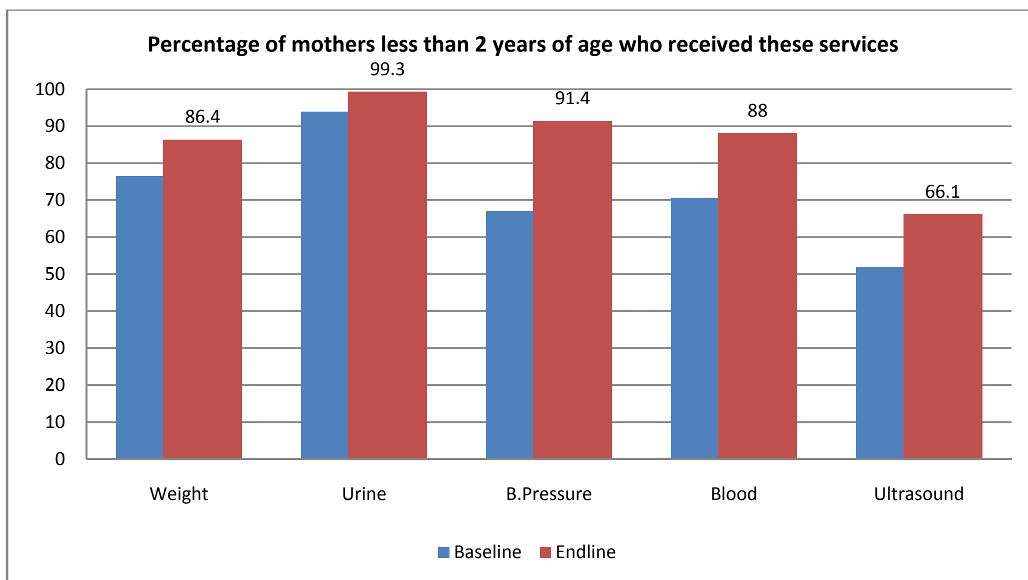


3.4. Tests done / services received during pregnancy

Women who had visited a health provider for prenatal check up were asked whether any test was performed during any of their visits and what other services they had received. Table 3.4 and Figure 3.4 show the proportion of women who had undergone specific tests or received specific services during their visits. At baseline, those who had visited a source for prenatal checkups, majority of them (94%) reported that their blood pressure was taken while ultrasound was done for only half of the visitors (52%) which increased to 61% at end line. Also at baseline three-fourths (77%) of women were weighed and at end line it increased to 87%. Urine was tested for two-thirds (67%) of care seekers and at end line it was done universally for all women.

Blood was also tested for seven out of ten women (71%) who visited a source for prenatal care during pregnancy; a positive increase was seen at end line where 88% of the omen received blood tests.

Figure 3.4 4: Percentage of mothers of children less than 2 years of age who received these services – Baseline & End line



Women who visited a source more than once were also likely to undergo tests a number of times. Table 3.4 also shows multiplicity of such tests over the pregnancy period for many women.

Table 3.4: Percentage of mothers who visited a source and received following prenatal services

	Percentage of women received services	Number of times					Number of women
		1	2	3	4+	Total	
Weight	86.4	22.50	19.70	26.70	31.10	100.00	476
Urine	99.3	17.90	16.40	25.20	40.50	100.00	548
Blood pressure	91	48.20	29.80	11.30	10.70	100.00	504
Blood	88	55.80	25.10	11.50	7.60	100.00	486
Ultrasound exam	66	39.90	25.80	18.00	16.30	100.00	361

3.5. Tetanus Toxoid vaccination

Tetanus Toxoid vaccination is given during pregnancy for the prevention of neonatal tetanus which is one of the principal causes of death among infants in many developing countries. To achieve protection for herself and her newborn baby, a pregnant woman should typically receive at least two doses of tetanus toxoid.

Table 3.5 shows the percentage of women who had a living child less than two years of age and who received at least one TT shot and percentage of women who received two or more TT shots according to area and background characteristics during the last pregnancy.

The baseline survey had shown that overall 71% women in the sample areas received at least one shot of TT injection and two-thirds (66%) received 2 or more TT shots during their last pregnancy. **The proportion of such women was higher (85% received at least one TT shot and 83% received 2 or more TT shots) in the end line survey in the intervention areas. Compared with national average of 53% (PDHS, 2008) the situation with regard to TT injection is better in the Chitral valley. Women who are younger in age, low parity are more likely to have TT shots during pregnancy compared to their counterparts who are older and multiparous.** Education and economic empowerment increases the chances of getting TT vaccination, those who have some middle or secondary education and are economically better off get more TT injections.

Table 3.5: Percentage of women with 0-23months youngest child receiving TT injections

Characteristics		TT more than one	TT more than two	Number of women
Age groups	<25	90.80	87.00	207
	25-34	86.00	84.30	343
	35+	71.40	69.70	119
Birth order	1	89.10	87.10	202
	2—3	89.60	85.60	270
	4—5	80.90	80.10	136
	6+	57.60	57.60	59
Education	No education	75.60	73.40	353
	Up to primary	84.60	79.50	39
	Middle	94.30	90.60	53
	Up to Secondary	95.70	94.70	94
	Secondary+	98.40	96.00	126
Wealth Index	Poorest	79.10	76.90	134
	Poor	82.80	79.90	134
	Middle	85.10	83.60	134
	Rich	87.20	83.50	133
	Richest	90.30	88.80	134
Total		84.90	82.50	669

3.6. Reasons for not seeking prenatal care

Women who had not visited a skilled or any other health provider for antenatal care were asked about the reasons for such behaviour. Majority of women (22%) at baseline had thought that since they had not encountered any problem, they did not think it necessary to visit a health professional for checking on their pregnancy. However this increased to 26% at end line. This attitude can be potentially harmful and needs further input in future campaigns. However, since a greater majority of women is now accessing ante-natal care compared to baseline, these perceptions are of women who do not seek ante-natal care. It is important to understand what describes these women. Table 3.3 above shows that women with high parity who are uneducated and of old age are the ones who are not accessing ante-natal care services. This demographic should be one of the focal points in future scaling up projects. At baseline 29% women in the intervention area reported economic/poverty reasons, which decreased to 19% at end line. At baseline 26% identified lack of access as a barrier and this stayed constant even at end line at 24%. Nineteen percent (19%) had reported non-

availability of transport as a cause of not seeking prenatal care during pregnancy (Table 3.6) and this decreased to 9% at end line.

Table 3.6: Percentage of women having 0-23 month's youngest child who did not receive ANC

Reasons for not receiving ANC	Percentage	Responses
Not necessary/no problem	26.30	65
Costs too much	19.00	47
Too far	24.30	60
No transport	9.30	23
No one to go with	2.40	6
Service not good	2.00	5
No time to go	0.40	1
Did not know where to go	0.40	1
Did not want to see a male doctor	1.20	3
No ultra machine here	1.60	4
Not allowed to go	3.60	9
Not give importance	3.20	8
Facility is not available	5.70	14
Family does not allow	0.40	1
Total	100	247

3.7. Use of iron tablets or syrup and calcium tablets

The components of ANC are important in assessing the quality of prenatal care services. Tables 3.7a and 3.7b present information on the percentage of women who took iron tablets or syrup and calcium tablets during their last pregnancy.

Among women with a child less than 24 months age, 59% had taken iron tablets during their last pregnancy in the baseline survey and this rose to 76% at end line, while 26% continued the use of iron tablets for at least two months at baseline and this doubled at the end line evaluation. The quality of prenatal care is particularly related to mother's age, education, wealth status and parity. Women who were younger in age, low parity, more educated and economically better off were more likely to be aware and take iron supplements during pregnancy.

Table 3.7 a: Percentage of women with 0-23months youngest child receiving iron tablets

Background characteristics		Percentage given /buy iron tablets	Number of women	Percentage who received iron for more than two months	Number of women
Age groups	<25	84.20	203	56.40	204
	25-34	74.30	335	45.90	333
	35+	68.60	118	34.50	116
Birth order	1	84.10	195	57.10	196
	2--3	75.70	268	46.00	265
	4--5	72.70	132	42.00	131
	6+	59.30	59	28.80	59
Education	No education	67.20	345	35.80	341
	Up to primary	84.20	38	47.40	38
	Middle	75.50	53	62.30	53
	Up to Secondary	84.60	91	50.50	93
	Secondary+	92.00	125	68.50	124
Wealth Index	Poorest	68.70	131	39.70	131
	Poor	72.50	131	42.60	129
	Middle	78.80	132	47.30	131
	Rich	80.90	131	49.20	130
	Richest	80.20	131	56.80	132
Total		76.30	657	46.70	654

At baseline only four out of ten women used Calcium tablets in both the areas and 14% continued its use for two or more months. At end line this improved to two thirds of the women taking calcium supplements and more than one third of these women continued it for more than two months. However, the pattern of its use is similar and age and birth order which are found to be important determinants.

Table 3.7 b: Percentage of women with 0-23months youngest child receiving Calcium tablets

		Percentage who took calcium	Percentage who got calcium for more than two months	Number of women
Age groups	<25	68.10	42.60	204
	25-34	63.40	38.40	333
	35+	56.40	21.40	117
Birth order	1	71.90	43.40	196
	2--3	61.80	34.80	267
	4--5	61.50	38.50	130
	6+	45.80	18.60	59
Education	No education	53.80	27.60	344
	Up to primary	73.70	28.90	38
	Middle	62.30	39.60	53
	Up to Secondary	76.70	43.30	90
	Secondary+	77.60	56.80	125
Wealth Index	Poorest	61.10	30.50	131
	Poor	61.80	35.90	131
	Middle	61.40	35.60	132
	Rich	68.20	35.70	129
	Richest	64.90	45.80	131
Total		63.5	36.6	655

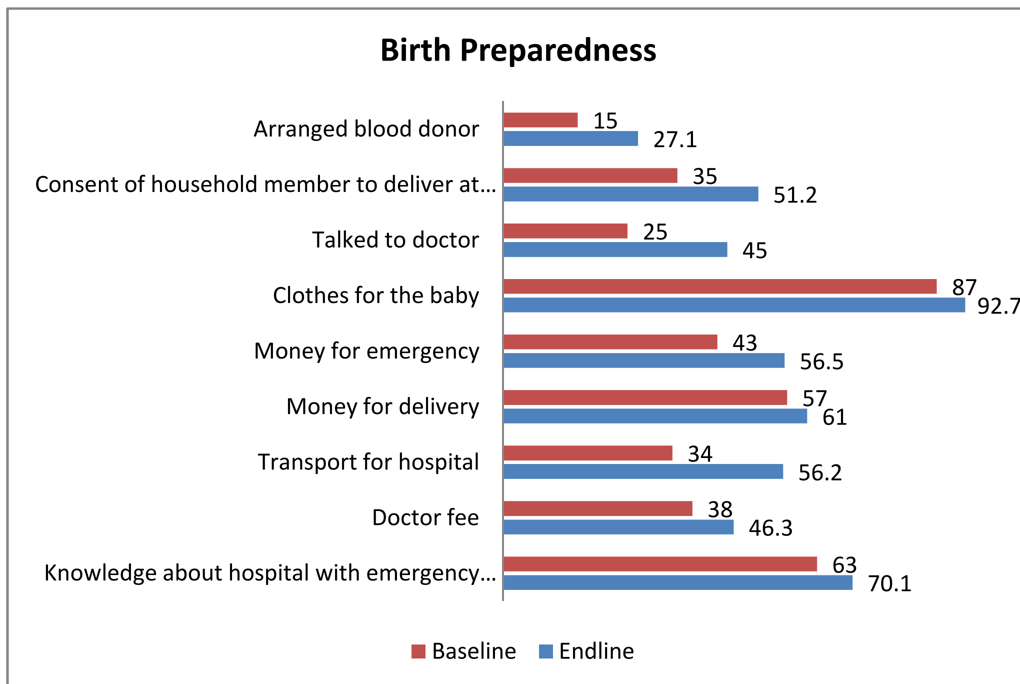
3.8. Preparedness for delivery

Birth preparedness refers to advance planning and preparation for delivery by setting aside personal funds to cover the costs of travel and knowing and identifying the place for delivery and as to what transport can be used to get to the hospital. Delivering with a skilled provider who has the required supplies can do much to improve maternal health outcomes. Birth preparedness helps ensure that women can reach professional delivery care when labour begins. In addition, birth preparedness can help reduce the delays that occur when women experience obstetric complications, such as recognizing the complications and deciding to seek care, reaching a facility where skilled care is available, and receiving care from qualified providers at the facility.

Figure 3.5 shows that arranging for blood donor, talking to the doctor and arranging transport all doubled up from the baseline assessment. At the baseline majority of the women were

concerned about preparing clothes for the baby, the same universal concern held even at the end line where 92.7% of the women expressed concern about and preparation of clothes for the baby during their pregnancy. Only four out of ten women (43%) made arrangement of money for any kind of emergency during delivery and this increased to 5 out of ten women at end line. One third women (35%) at baseline had the consent of their husbands/in-laws to deliver at a health facility however at the end line this had increased to fifty percent women who had the consent from their husbands/in-laws. This could be an indicator of better BCC strategies involving male members of the community. It also demonstrates that gender equity is improving as the needs women with respect to health are being recognized more by men and the larger families in general.

Figure 3. 5: Percentage distribution of women who are prepared for birth by type of preparation



3.9. Place of delivery

Another important thrust of the reproductive and child health programmes is to encourage deliveries under standardized conditions supervised by trained health professionals. Mothers in their reproductive ages having a child less than 24 months of age were asked about the place of delivery and the person attending the delivery. It was noted at baseline, that 76 percent women had delivered their last babies at home and the remaining one-fourth (24 percent) had either delivered at AKHS-P (16 percent) or at the government hospitals/centres. However, 67% of deliveries at end line were conducted at home and this decreased by 12 points from baseline. Another interesting finding at end line was that 14% of deliveries were conducted by CMWs which was a new addition. Otherwise 17% were conducted at AKHSP and rest at other hospitals. The introduction of a new cadre of workers through the program led to a positive impact on deliveries assisted by trained SBA.

Figure 3.8 a: Place of delivery - Base line

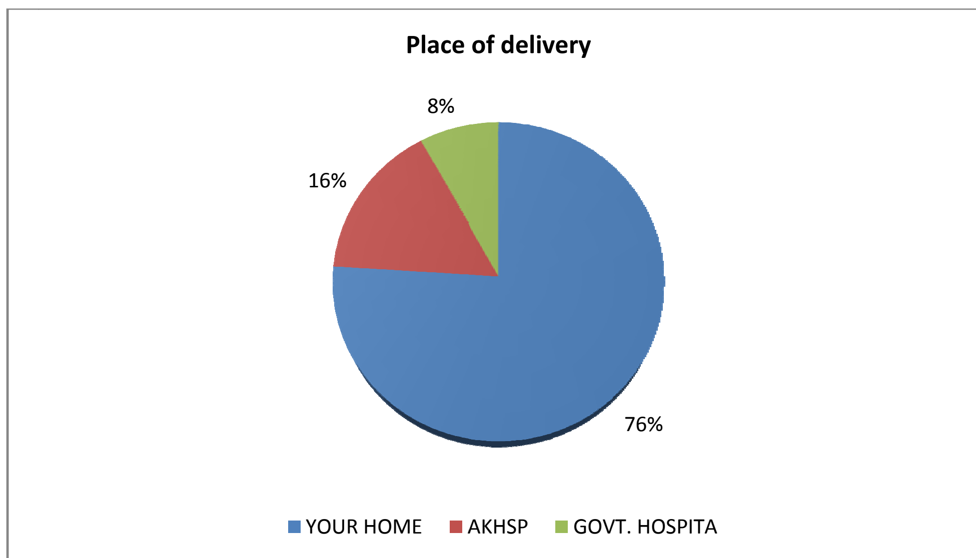


Figure 3.8 b: Place of delivery – End line

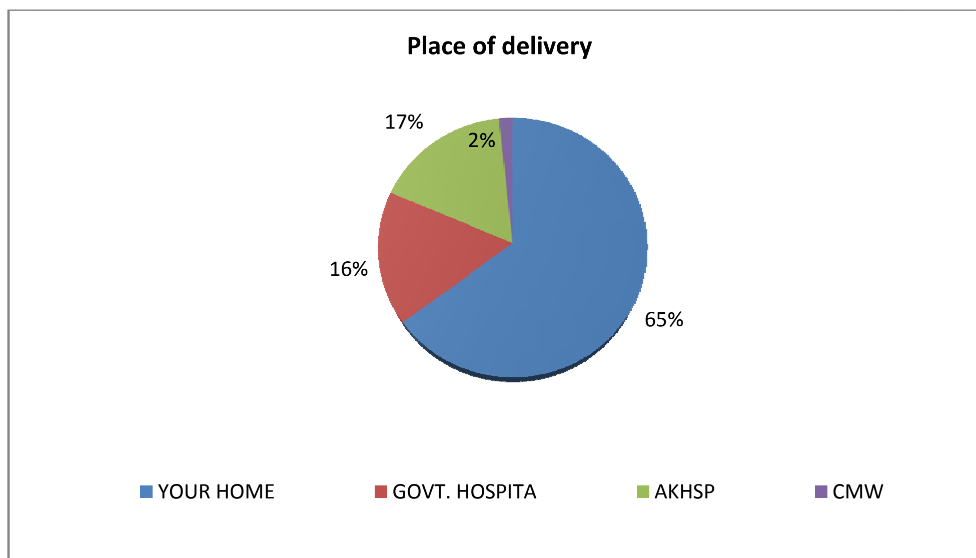


Table 3. 8: Percentage of women with 0-23months children whose delivery was attended by skilled birth attendant

		Delivery attended by health professional	
		Percentage	**N-Mothers**
Age	<25	81.0	165
	25-34	83.2	256
	35+	77.2	79
Birth order	1	84.4	167
	2—3	81.0	194
	4—5	75.5	106
	6+	87.0	31
Education	No education	74.0	228
	Up to primary	93.3	30
	Middle	85.4	41
	Up to Secondary	81.7	82
	Secondary+	91.3	115
Wealth Index	Poorest	69.0	94
	Poor	80.6	103
	Middle	81.6	98
	Rich	86.0	100
	Richest	88.6	105
Total		81.4	501

Women, who are relatively economically well off, educated, low on parity are more likely to get a delivery assisted by skilled health providers. The trend is similar both in end line and baseline. In intervention areas the delivery assisted by SBA has gone up from 33% at baseline to 55% at end line. This is also supported by Table 3.9, which shows data for all women assisted by the type of birth assistant during their delivery. At baseline, majority of women of all categories were primarily assisted by traditional birth attendants - TBAs (31%), but at end line it decreased to 14% for dai/TBA. At baseline, 'others' category (26%), which includes family members and other unskilled persons contributed to a major chunk of deliveries. Only 29% women were assisted by a doctor/nurse/ during their last pregnancy at baseline, where as in end line this increased substantially to 52%. The proportion of mothers who were assisted by a health professional was generally younger in age, had higher education and was more economically well off.

Table 3. 9: Percentage of women with 0-23 months children whose delivery was attended by trained health care provider by type of provider

		DOCTOR	NURSE/ LHV	MID-WIFE	DAI /TBA	LHW	FWW	CMW	Number of women
Age groups	<25	27.30	33.30	4.80	15.80	5.50	0.60	35.20	165
	25-34	25.40	38.70	4.30	17.60	3.10	0.00	31.20	256
	35+	20.30	40.50	2.50	17.70	7.60	0.00	27.80	79
Birth order	1	28.70	36.50	4.20	12.60	5.40	0.60	36.50	167
	2—3	21.10	39.20	5.70	20.60	3.60	0.00	29.40	194
	4—5	23.60	40.60	1.90	20.80	4.70	0.00	27.40	106
	6+	35.50	19.40	3.20	6.50	6.50	0.00	38.70	31
Education	No education	18.00	31.10	4.40	21.10	7.00	0.00	32.90	228
	Up to primary	23.30	46.70	6.70	10.00	3.30	3.30	33.30	30
	Middle	22.00	39.00	0.00	17.10	0.00	0.00	41.50	41
	Up to Secondary	30.50	36.60	3.70	18.30	3.70	0.00	34.10	82
	Secondary+	37.40	47.00	5.20	8.70	2.60	0.00	24.30	115
Wealth Index	Poorest	14.90	29.80	3.20	20.20	9.60	1.10	36.20	94
	Poor	23.30	35.00	8.70	19.40	3.90	0.00	35.00	103
	Middle	16.30	32.70	6.10	19.40	3.10	0.00	39.80	98
	Rich	30.00	41.00	3.00	18.00	3.00	0.00	31.00	100
	Richest	40.00	47.60	0.00	8.60	3.80	0.00	18.10	105
Total		21.0	31.0	3.50	14.1	3.80	0.20	26.50	603

3.10. Knowledge of danger signs

3.10.1. Danger signs during pregnancy

In the survey, both at end line and baseline women were asked whether they were aware of any danger signs during pregnancy and childbirth. Those who did not spontaneously indicate any knowledge regarding different illnesses or complications were prompted by naming the illness or complication. The answers were then coded as being spontaneous or prompted. The danger signs during pregnancy listed in the questionnaire are: severe vomiting; shortness of breath; pallor, weakness or fatigue; severe headache; blurring of vision; swelling over ankles; swelling over face; severe lower abdominal pain; spotting; frank vaginal bleeding; jaundice; high fever with or without rigors; diagnosed high blood pressure; fits or convulsions; unconsciousness; anemia; and burning of urine. Majority of women gave spontaneous responses to identifying danger signs of excessive vaginal bleeding. When prompted, universally women could identify all major danger signs of pregnancy except unconsciousness, depression and anxiety and leaking of urine from vagina. This identifies areas for future awareness campaigns.

Table 3.10 a: Danger signs during pregnancy for which treatment is necessary

Danger signs	Spontaneous	Prompted yes	Total
Excessive vaginal bleeding	83.6	14.6	98.2
Fits or convulsions	27.6	63.0	90.6
Unconsciousness	20.0	58.7	78.7
Prolapsed uterus	47.0	44.8	91.8
Offensive discharge from vagina	40.2	49.3	89.5
High fever with or without rigors	49.0	40.9	89.9
Lower abdominal pain	56.8	37.5	94.3
Extreme weakness parlour and fatigue	42.6	48.7	91.3
Anxiety, Depression, Nervousness	16.4	62.8	79.2
Difficulty, pain or burning while passing urine	41.0	49.0	90.0
Kidney pain	28.1	58.3	86.4
Leaking of urine from vagina	33.1	45.8	78.9

At baseline it was observed that the most known complications that women thought to be amongst the danger signs of pregnancy were severe vomiting (65%) followed by severe headache (42%) and lower abdominal pain (41%). Other danger signs reported by almost

one-third women were high fever (35%), high blood pressure (34%), anemia (33%). At the end line (Figure 3.9) women seem to be more aware of the danger signs of pregnancy. Previously what they were not able to identify as danger signs, they are now better able to recognize them. Women answered correctly to most signs almost universally, except for jaundice which only 63% of women could identify as a danger sign.

Figure 3. 9: Percentage distribution of women with 0-23 month's children according to Illness or symptoms that can be dangerous during pregnancy

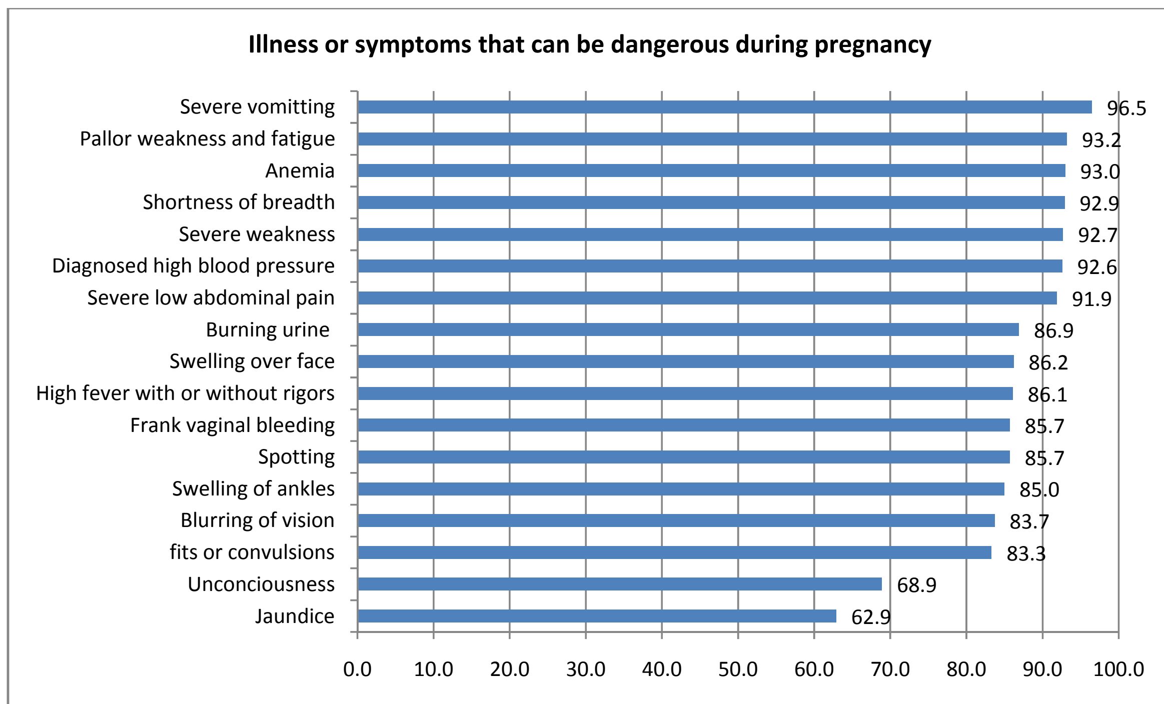


Table 3.10b presents spontaneous knowledge about one, two, three or four or more danger signs or complications during pregnancy. At baseline, one-fourth of women in the intervention areas (25%) and at end line 1percent of women did not know any danger sign during pregnancy. Majority of such women were 25-34 years of age and this was a transition from baseline where young, low parity and poorer women were not able to identify the danger signs of pregnancy. The reporting of knowledge of more than 4 danger sign significantly increased from 8% at baseline to 82% at end line. This can largely be attributed to the reproductive health awareness campaigns under the CCSP.

Table 3.10 b: Percentage distribution of women with 0-23 month children according to awareness of danger signs during pregnancy

		Number of danger signs during pregnancy					Number of women
		0	1	2	3	4+	
Age group	<25	12.70	0.00	0.00	1.00	86.30	205
	25-34	20.60	0.60	0.00	0.00	78.80	335
	35+	15.40	0.00	0.90	0.00	83.80	117
Birth order	1	15.20	0.00	0.00	1.00	83.80	197
	2--3	18.40	0.40	0.00	0.00	81.30	267
	4--5	18.90	0.00	0.00	0.00	81.10	132
	6+	15.30	1.70	1.70	0.00	81.40	59
Education	No education	16.00	0.60	0.30	0.60	82.60	344
	Up to primary	15.80	0.00	0.00	0.00	84.20	38
	Middle	18.90	0.00	0.00	0.00	81.10	53
	Up to Secondary	22.60	0.00	0.00	0.00	77.40	93
	Secondary+	16.00	0.00	0.00	0.00	84.00	125
Wealth Index	Poorest	19.10	0.80	0.80	0.00	79.40	131
	Poor	13.00	0.00	0.00	0.80	86.30	131
	Middle	15.90	0.00	0.00	0.00	84.10	132
	Rich	21.40	0.80	0.00	0.80	77.10	131
	Richest	16.70	0.00	0.00	0.00	83.30	132
Total		17.30	0.20	0.30	0.30	82.10	658.00

3.10.2. Danger signs during delivery

At the Chitral baseline survey, the most common danger sign during child birth/ delivery was identified as prolonged labour reported by three-fourths of women. The second and third most dangerous signs were delay in delivery of placenta (51%) and mal-positioning of fetus (45%). Excessive abnormal bleeding as a danger sign was reported by four out of ten women. Almost thirty percent women reported that obstructed labor, excruciating pain and retained placenta were also serious complications requiring urgent attention. At end line, Table 3.12 depicts the level of the respondents' understanding of complications during delivery. Compared with end line, the knowledge and perception of danger signs during pregnancy has dramatically increased and now majority of women know about the danger signs, except for tear in vagina which only 79% of the women perceived as being a danger signs during delivery.

Figure 3. 10: Percentage distribution of women with 0-23 month's children aware of complication on delivery day

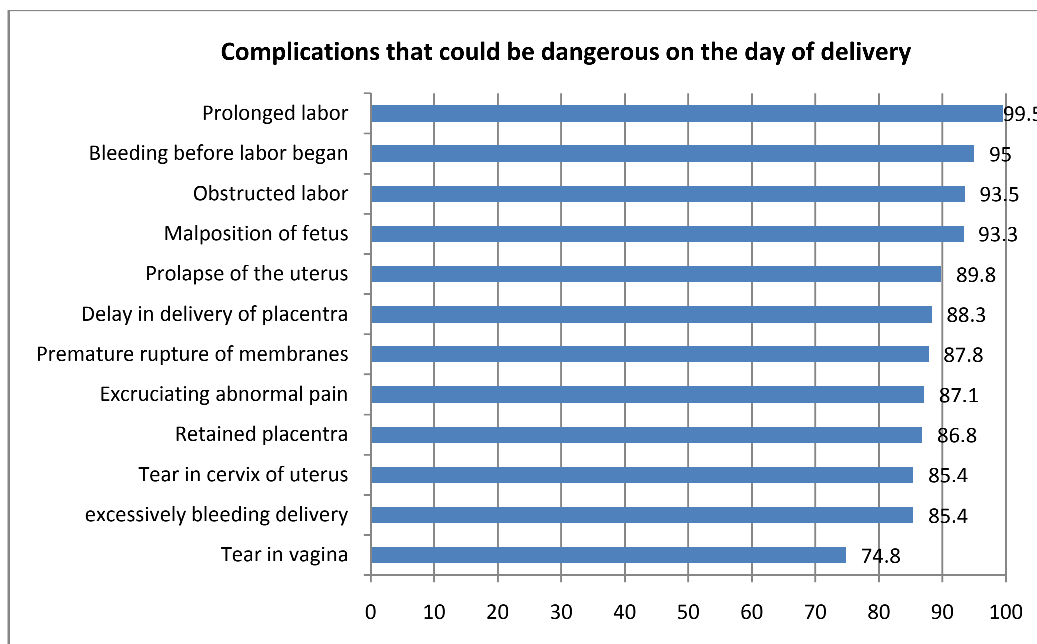


Table 3.10 c: Percentage distribution of women with 0-23months children according to danger signs on the day of delivery

Background Characteristics		Number of danger signs on day of delivery					Number of women
		0	1	2	3	4+	
Age group	<25	12.70	0.00	0.50	0.50	86.30	205
	25-34	21.20	0.00	0.00	0.00	78.80	335
	35+	15.30	0.80	0.00	0.80	83.10	118
Birth order	1	15.20	0.00	0.00	0.50	84.30	197
	2--3	19.00	0.40	0.40	0.00	80.20	268
	4--5	18.90	0.00	0.00	0.80	80.30	132
	6+	15.30	0.00	0.00	0.00	84.70	59
Education	No education	16.50	0.30	0.30	0.00	82.90	345
	Up to primary	15.80	0.00	0.00	0.00	84.20	38
	Middle	18.90	0.00	0.00	0.00	81.10	53
	Up to Secondary	22.60	0.00	0.00	2.20	75.30	93
	Secondary+	16.00	0.00	0.00	0.00	84.00	125
Wealth Index	Poorest	18.90	0.80	0.80	0.00	79.50	132
	Poor	14.50	0.00	0.00	0.80	84.70	131
	Middle	15.90	0.00	0.00	0.00	84.10	132
	Rich	21.40	0.00	0.00	0.00	78.60	131
	Richest	16.70	0.00	0.00	0.80	82.60	132
Total		17.50	0.20	0.20	0.30	81.90	659

Table 3.10c shows that eight out of ten women knew of four or more danger signs during delivery which has improved 8 folds since baseline. Knowledge of four or more danger signs during pregnancy was uniformly distributed across age groups, parity, education and wealth index. This is a dramatic shift from baseline where knowledge of more than 4 danger signs was higher (12.1 and 12.5 percent respectively) among younger and older women compared to women aged 25-34; among high parity, educated and economically well off women compared with women having low or no education and women not economically well off.

3.10.3. Knowledge of danger signs during postpartum

Women were asked whether they knew about danger signs during the postpartum period for which it is necessary to seek medical advice and or treatment. Both spontaneous and prompted information regarding complications like: excessive bleeding; fits or convulsions; unconsciousness; prolapsed uterus; offensive discharge; high fever; lower abdominal pain; extreme weakness, pallor and fatigue; anxiety, nervousness or depression; difficulty, pain or burning while passing urine; kidney pain and conditions of fistula, was collected.

Figure 3.11shows that 99 percent of women in Chitral district were aware that excessive vaginal bleeding in the postpartum period is a complication which requires to be treated urgently to avoid serious consequences. This is a great improvement from baseline where only three fourths of women knew this. However, they still need to be made aware of the consequences of leaking urine, anxiety and depression and that may follow if deliveries are not attended by skilled health professionals and postpartum treatment is not provided in case of emergencies.

Table 3.10d shows data on knowledge about danger signs during postpartum period. About 17 percent of women had no knowledge about any sign of danger during pregnancy in both the intervention area. Majority of the women in the intervention (82 percent) knew about more than four danger signs during postpartum period, for which medical advice is necessary. No specific pattern has emerged regarding knowledge about danger signs by age, parity, education or economic well being.

Figure 3. 11: Percentage distribution of women with 0-23months children according to danger signs in post partum period

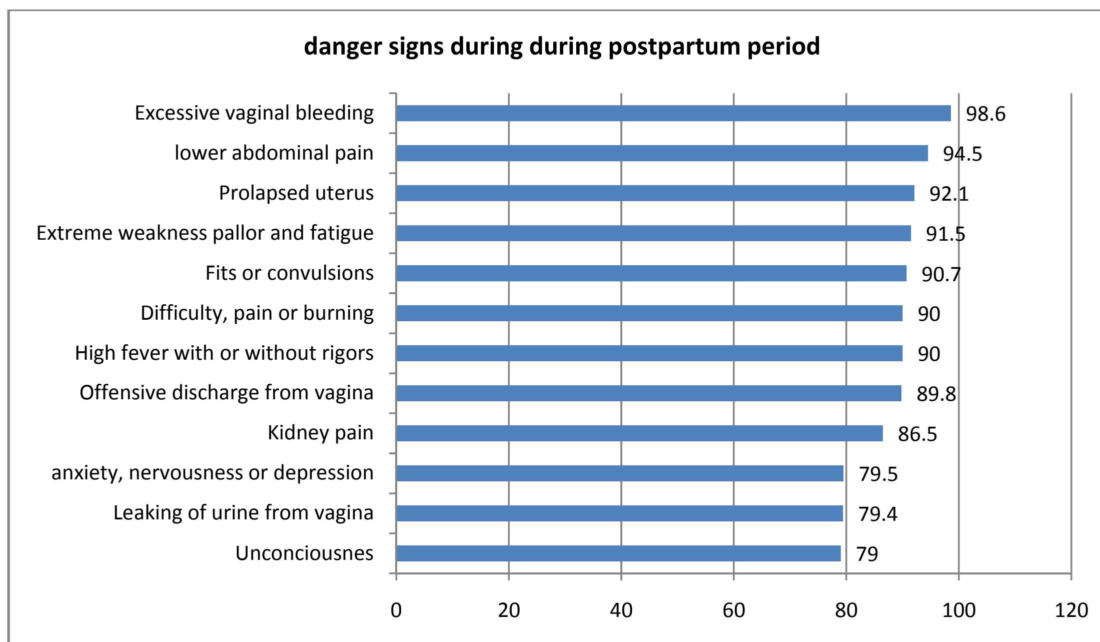


Table 3.10 d: Percentage distribution of women with 0-23months children according to danger signs of post partum

		Number of danger signs during post partum period					Number of women
		0	1	2	3	4+	
Age group	<25	13.20	0.00	1.00	0.50	85.40	205
	25-34	20.60	0.30	0.30	0.00	78.80	335
	35+	16.10	0.00	0.00	0.00	83.90	118
Birth order	1	15.70	0.00	0.50	0.50	83.20	197
	2--3	18.70	0.40	0.70	0.00	80.20	268
	4--5	18.90	0.00	0.00	0.00	81.10	132
	6+	15.30	0.00	0.00	0.00	84.70	59
Education	No education	16.50	0.30	0.90	0.00	82.30	345
	Up to primary	15.80	0.00	0.00	0.00	84.20	38
	Middle	18.90	0.00	0.00	0.00	81.10	53
	Up to Secondary	22.60	0.00	0.00	1.10	76.30	93
	Secondary+	16.00	0.00	0.00	0.00	84.00	125
Wealth Index	Poorest	19.70	0.00	0.80	0.00	79.50	132
	Poor	13.70	0.80	0.80	0.80	84.00	131
	Middle	15.90	0.00	0.00	0.00	84.10	132
	Rich	21.40	0.00	0.80	0.00	77.90	131
	Richest	16.70	0.00	0.00	0.00	83.30	132
Total		17.50	0.20	0.50	0.20	81.80	539

Chapter 4

CHILD HEALTH AND NUTRITION

4.1. Child Immunization

Pakistan's EPI program follows the recommendations and protocols issued by the WHO. Like the baseline, the end line survey asked various questions regarding the immunization of children. Table 4.1a documents the basic questions regarding the vaccination record respondents keep of their children.

Table 4.1 a: Details of vaccination records kept by respondents

Characteristics		Percentage	Responses
Do you have a card where (NAME'S) vaccinations are written down?	Yes Seen	80.0	536
	Yes Not Seen	16.7	112
	No Card	3.3	22
	Total	100	670
Received any vaccinations that are not recorded on this card including vaccinations received in national immunization day campaign	Yes	44.6	299
	No	36.1	242
	Don't know	0.3	2
	Missing values	19.0	127
	Total	100	670
Receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization campaign?(From women who did not have a card)	Yes	16.0	107
	No	2.5	17
Total		100	670

Information on vaccination status of children was obtained through vaccination cards if available or through mother's recall in cases where the card was not available. Based on information on the cards and recall the end line survey reports the vaccination status for BCG (94.8%), polio 1 (61.8%), polio 3 (59.7%), DPT 1 (73.1%), DPT 3 (61.8%), HBV 1 (76.3%),

HBV 2 (57.5) and measles (40.1%). These figures are however, for children between ages 0-23 months.

Table 4.1 b: Details of vaccination received for each disease across all age groups

Vaccine	Percent	Responses n=670
BCG	94.8	635
Received Polio 1 based on card + recall	61.8	414
Received Polio 3 based on card + recall	59.7	400
Received DPT 1 based on card + recall	73.1	490
Received DPT 3 based on card + recall	61.8	414
Received HBV1 based on card + recall	67.3	451
Received HBV 3 based on card + recall	57.5	385
Received measles based on card + recall	40.1	269

When vaccination was analysed for children aged between 12 and 23 months the following results were obtained (Table 4.1c). BCG was received by 98.9%, three doses of polio had been received by close to 77%, DPT 3 by 86%, HBV 3 by 82.4% and measles by 68.4% of the children aged 12-23 months. Compared to baseline there has been a drop in measles vaccination from 81.6% to 68.4% at the end line. The proportion of children fully vaccinated against BCH, Polio 3, DPT 3, HBV 3 and measles remained the same at 68% both at base line and end line. Table 4.1c below provides details on full vaccination status for children aged 12-23 months.

Table 4.1 c: Full vaccination status among children 12-23 months

Vaccine	Percent	Responses n=272	National coverage PDHS 2012-13 %
BCG	98.9	269	85.0
Received Polio 3 based on card + recall	76.8	209	85.0
Received DPT 3 based on card + recall	86.0	234	65.0
Received HBV 3 based on card + recall	82.4	224	50.0
Received measles based on card + recall	68.4	186	61.0

The findings show that children are being vaccinated at a later age than recommended for essential childhood vaccines.

4.1.1. DPT Vaccinations

In the baseline the percentage of children who received DPT vaccination was around 90%. In the end line, the coverage of the DPT vaccination appears to have dropped to 86% of the children. The coverage, however, is in line with national figures of 85% vaccination for DPT recently reported in the PDHS 2012-13 (PDHS 2012-13). The decrease in DPT vaccination in the intervention areas should be explored further and is an area of future intervention.

4.1.2. Measles Vaccination

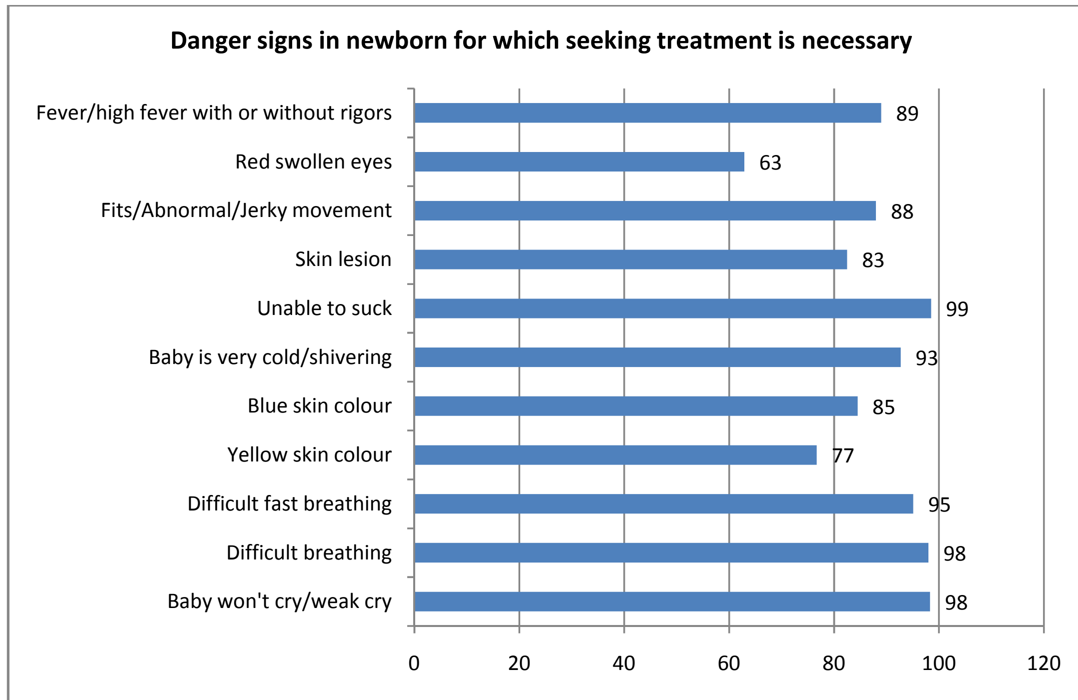
The coverage of measles vaccination has reduced between the baseline and end line surveys from 81% to 68% respectively. This reduction in measles vaccination could be explained by the overall low measles vaccination (61%) across the country documented in the PDHS 2012-13. It is important for programme managers to look at the source of measles vaccination supply and how that can be improved in the project areas.

4.2. Danger signs in neonates

Women with children of less than two years of age were asked whether they recognized certain signs of danger in newborn and up to seven day babies. Signs of danger in newborns include fever, red swollen eyes, fits/abnormal/jerky movements, skin lesions, unable to suck, cold/shivering, blue skin color, yellow skin color, difficult deep breathing, difficult breathing, and no/weak crying. Signs of danger in upto seven days old babies are: high fever with rigor, rigidity, frequent water stools, failure to pass urine, red swollen eyes, fits/abdominal pains, skin lesion, unable to suck, shivering/cold, blue skin color, yellow skin color, and difficult fast breathing.

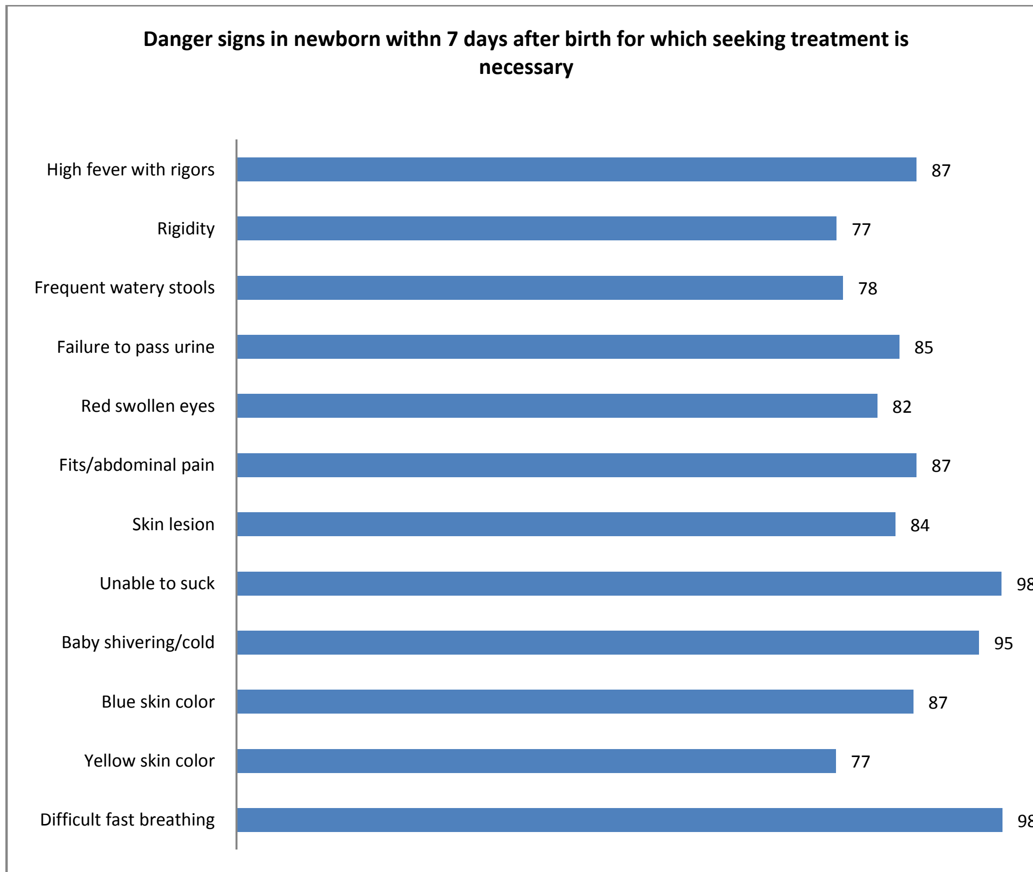
With regards to new born babies, the most well known dangers are: baby unable to suck (98.5%), no\weak cry (98.3%), difficulty in breathing (98%), and difficult fast breathing (95.1%). The recognition of all danger signs is up from the baseline considerably. For the top four known danger recognition level mentioned earlier in order, the corresponding figures were 67%, 73.1%, 45%, and 57.4% respectively in the baseline. Figure 4.2a lists the level of knowledge for all the dangers.

Figure 4.2 a: Details of danger signs in newborn babies for which seeking treatment is necessary



With regards to danger signs in babies who are up to seven days old, the top most recognized signs are: difficult fast breathing (98%), unable to suck (97.9%), shivering/cold (95%), and high fevers with rigors and fits/abdominal pains (87%). Compared point to point with the baseline, the figures for these very signs were: 57.4%, 73.3%, 51.2%, 46.1% and 12.5% respectively. **This shows a major improvement in the knowledge of mothers about danger signs in neonates since the baseline.**

Figure 4.2 b: Danger signs in newborns within 7 days after birth



The number of women who can identify four or more danger sings in new born babies has gone up considerably across all social factors compared to the baseline. In fact, almost all the women when asked the question recognized four or more danger signs in new born babies. This is up from single digit percentages at the baseline. The same applies to women who can recognize four or more danger signs in babies less than a week in age. These findings are an indication of the impact of the BCC intervention on project outcomes.

4.3. Childhood Diseases

4.3.1 – Diarrhea

Pakistan has a high incidence of morbidity and mortality due to severe diarrhea. Around 27% of post-neonatal deaths are due to dehydration can be attributable to diarrhea in Pakistan (PDHS 2006-07). The CCSP end line survey asked respondents a variety of questions to determine the prevalence and treatment of diarrhea.

Table 4.3.1.a: Background characteristics of children who have had diarrhea in the last two weeks

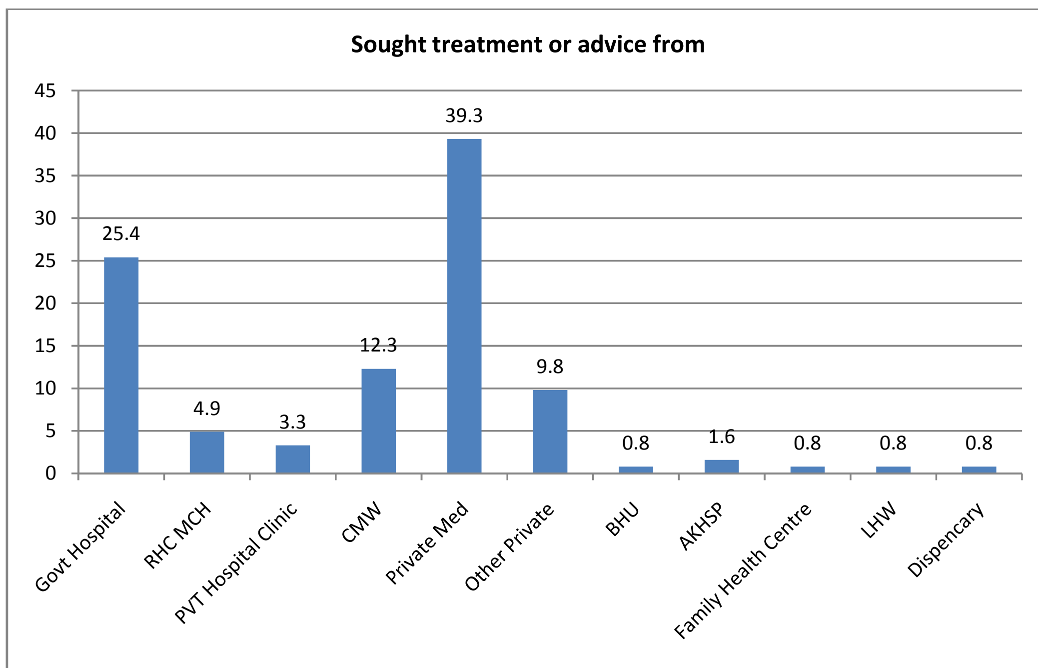
Background Characteristics		**Had diarrhea in the last two weeks (%)**	**Responses**
Age groups	<25	33.20	205
	25-34	28.10	335
	35+	28.00	118
Birth order	1	28.90	197
	2—3	28.00	268
	4—5	28.00	132
	6+	45.80	59
Education	No education	31.90	345
	Up to primary	28.90	38
	Middle	24.50	53
	Up to Secondary	30.10	93
	Secondary+	26.40	125
Wealth Index	Poorest	33.30	132
	Poor	31.30	131
	Middle	28.80	132
	Rich	32.10	131
	Richest	23.50	132
Total		29.70	659

According to the end line survey responses, around 30% of women reported a child who had diarrhea in the two weeks preceding the survey. The proportion of women who report a child with diarrhea was highest (45.8%) among women with six or more children. The percentage of children with diarrhea was within the late 20% and early 30% range for all other socio economic conditions and factors including age, education, and wealth index. The burden of diarrhea as reported in the last two weeks prior to the survey has gone up since the baseline. The increase in diarrhea between baseline and end line may be explained by seasonal

variation and the availability of clean drinking water. As demonstrated earlier the source of drinking water has moved to spring water from piped water while respondents treating water has also decreased, both surprising and alarming. The detailed nexus between various factors and incidence of diarrhea is given in table 4.3.1a.

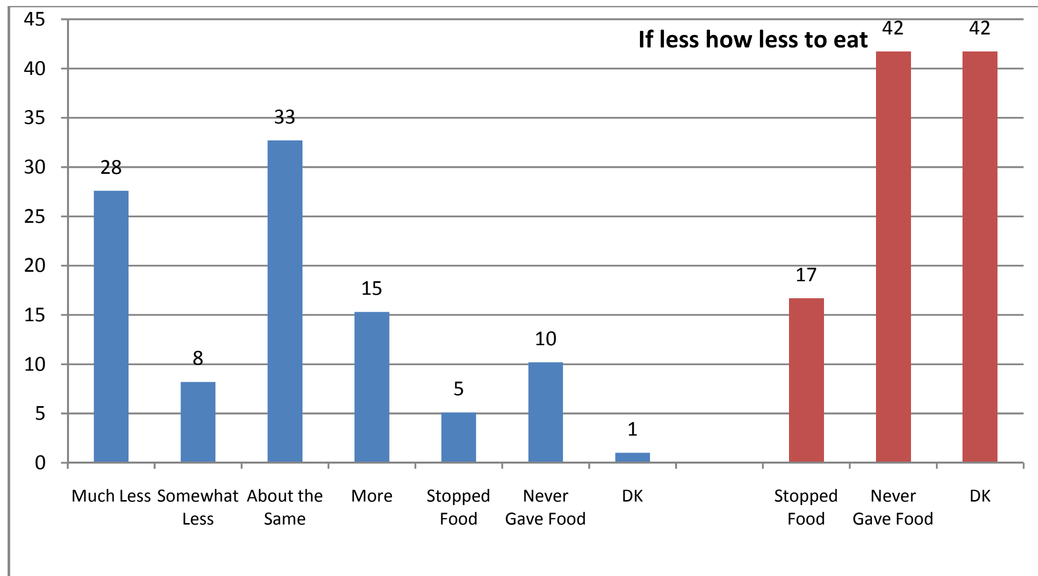
Fluid replacement is normally recommended during diarrhea. Respondents were asked about the medical facility they consulted for treatment. Figure 4.3.1a lists the responses. Around 39% of respondents went to a private clinic to get advice on their children's diarrhea treatment while 25% went to a government hospital.

Figure 4.3.1.a: Distribution of health facilities/providers where diarrheal treatment was sought



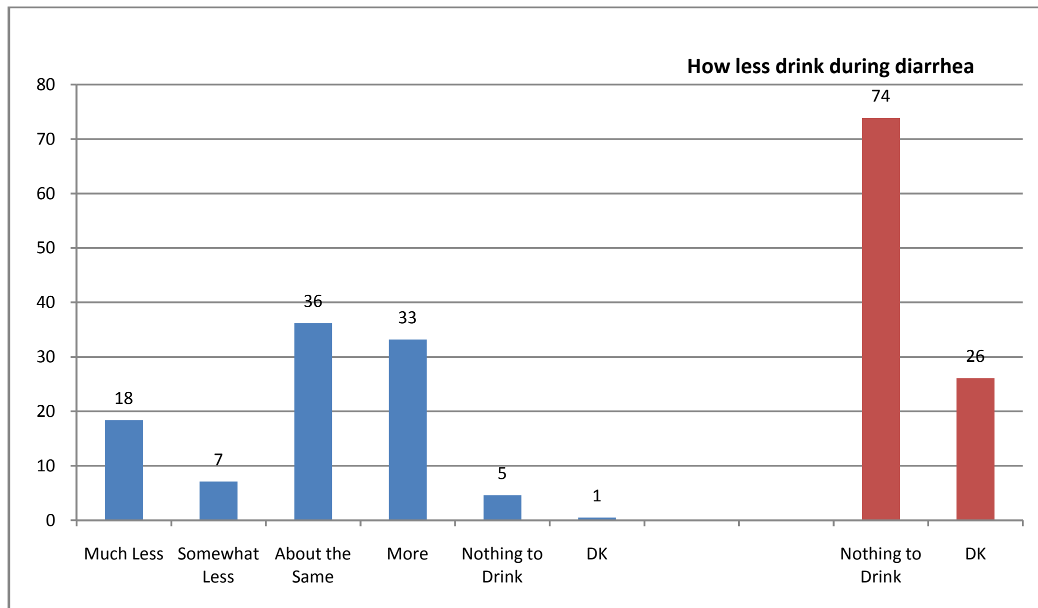
Respondents were further asked about the advice they received from the medical facility regarding intake of fluids and food. Figure 4.3.1b lists the responses. Around 32% were advised to keep the same food intake while 27% were asked to reduce it. 5% were advised to stop food intake altogether. These findings highlight the need to advocate best practices for diarrheal treatment in the intervention areas focusing on women as well as health care providers.

Figure 4.3.1.b: Details of the advice received from medical facilities for solid intake



Regarding fluids, around 32% were advised to increase fluid intake while 35% were asked to keep the fluid intake constant. Please refer to Figure 4.3.1.c

Figure 4.3.1.c: Details of the advice received from medical facilities for fluid intake



When asked how about the fluids that were given to children with diarrhea, 49% reported taking ORS or similar commercial fluids while 21% took home-made fluids.

4.3.2 – ARI/Pneumonia

In the CCSP baseline survey, the prevalence of ARI was estimated by asking mothers whether their children under age 2 had been ill with a cough accompanied by short, rapid breathing in the two weeks preceding the survey. These symptoms are consistent with ARI. It should be noted that the morbidity data collected are subjective in the sense that they are based on mother's perception of illness without validation by medical personnel. At the baseline stage, the incidence of pneumonia was 16 percent. However, when the end line survey was conducted, the results were captured on various indicators and suggest an improvement in case reporting for all.

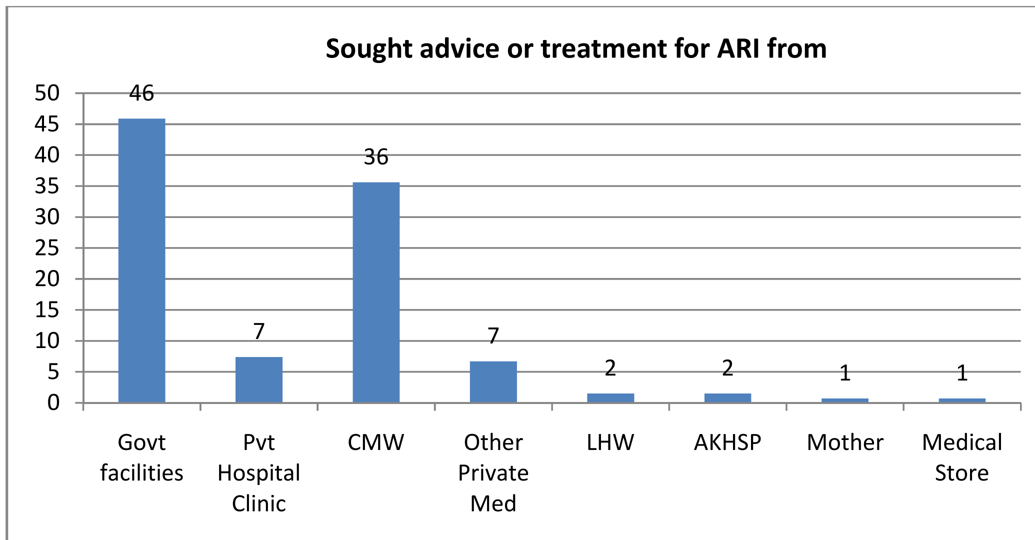
For example, 25% mothers reported fever in the last two weeks, 26% reported cough in the last two weeks and 88% reported difficulty in breathing at chest and nose. This exhibits an improved awareness in the intervention area to understand and report the symptoms of ARI compared to a mere 16% at the time of the baseline survey.

Table 4.3.2.a: Details of detection of ARI by mothers

Indicators		Yes	No
Ill with a fever at any time in the last 2 weeks?		24.7	75.3
Illness with a cough at any time in the last 2 weeks?		25.8	74.2
Had difficulty in breathing		88.4	11.6
Breathing problems were	Chest only	25.0	
	Nose only	74.0	
	Both	1.0	
Did you seek any treatment		73.0	27

With regards to seeking treatment, baseline findings show that among those children who experienced symptoms of ARI, appropriate treatment was sought from health care provider for two-thirds (65%) of patients. This percentage has gone up to 73% in the end line findings showing an improvement of 8%. A possible explanation could be the use of health awareness messages imparted under the CCSP BCC strategy. The end line survey also provides a breakdown of the type of intervention sought including top three sources such as 46% using government hospital, 36% using community midwives and 7% from other private hospitals or clinics.

Figure 4.3.2.a: Mothers who sought advice or treatment for ARI/Pneumonia



* Government facilities include DHQ, RHC, BHU

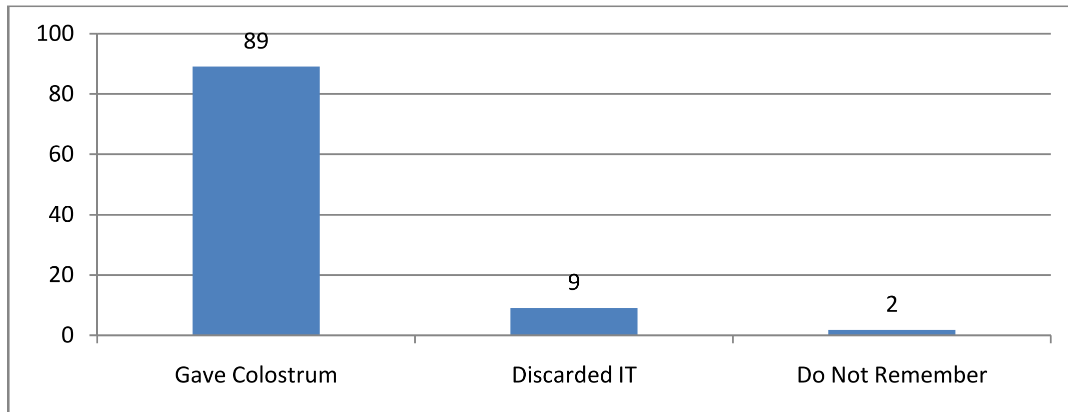
4.4. Nutrition

4.4.1. Breastfeeding

The survey has studied three key indicators including the trends amongst Chitrali women; i) breastfeed their children with normal milk and colostrum, ii) provide new-borns with other liquids before breastfeeding and iii) characteristics of mothers that breastfeed their new-borns.

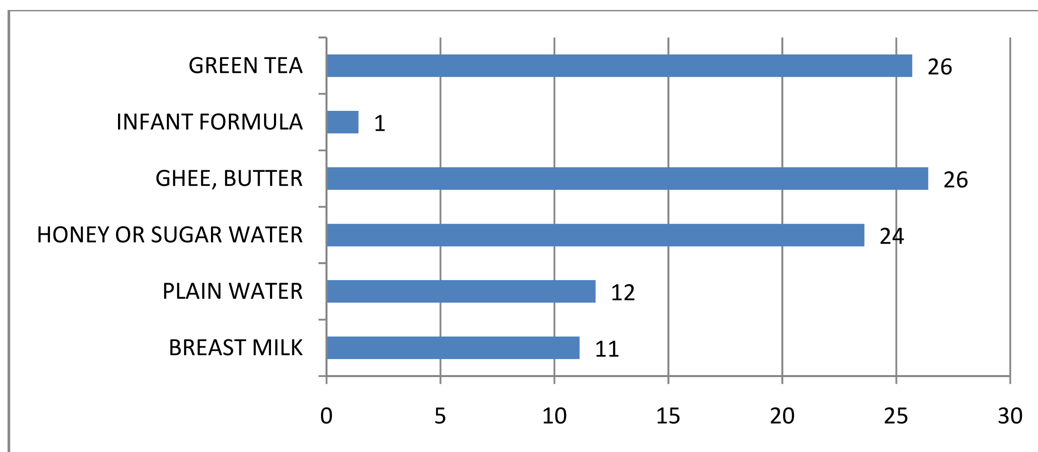
The baseline findings had suggested that nearly all Chitrali women (99%) breastfed their children and that feeding of colostrums was also common (94%). At the end of the intervention, the endline findings suggest that 90% of mothers continue to give their children colostrum. Although statistically it exhibits a decline of 4%, the trend can still be marked as universal.

Figure 4.4.1.a: Percentage of children who were ever breast fed, were given colostrum or not given colostrum



Another area of investigation in the study was an analysis of one of the oldest but most dangerous tradition of giving other liquids to new born before initiation of breastfeeding. According to the baseline findings, this was prevalent among one-fifth of the surveyed women. In terms of the split, these liquids included green tea (99%), ghutee (96%), ghee/butter (95%), honey/sugar water (89%), plain water (86%) and a combination of such liquids. The endline survey suggests that although this custom continues, the individual percentages have gone down with 25% women give their children green tea, 27% give ghee/butter, 23% give honey or sugar water and 12% give plain water.

Figure 4.4.1.b: Percentage of children who were given other liquids



Last but not the least, the baseline data had also shown that 95% of children 6-23 months of age who were still breastfed at the time of survey. After the intervention, the end line findings suggest that there has been a minor increase of 1% children who were breastfed during the age of 6-23 months.

The differentials on the basis of background characteristics were determined to be small during the baseline survey. This trend continues for the end line survey suggesting that breastfeeding is the highest for mothers between in the age bracket of 25 to 34 years (98%), mothers with 4-5 children (100%), women with education status above secondary (99 percent) and possessing middle income (99%). In addition, there is an overall average 2% increase in the number of children breastfed in all age groups. A similar trend was observed for women with varying number of children. However, the biggest differential was observed for mothers with 4-5 children where the percentage increased from 95% to 100%. For background characteristics of education and wealth, there has been a general overall increase – although the percentages are not very significant.

Table 4.4.1.a: Percentage of children who were ever breast fed, were given colostrum or not given colostrum by background characteristics

Background Characteristics		Percentage of children 6-23 months who are still breast fed
		Percentage
Age groups	<25	94.00
	25-34	97.50
	35+	96.20
Birth order	1	97.00
	2—3	95.20
	4—5	100.00
	6+	92.30
Education	No education	97.10
	Up to primary	95.80
	Middle	91.90
	Up to Secondary	92.60
	Secondary above	98.80
Wealth Index	Poorest	96.50
	Poor	97.90
	Middle	98.90
	Rich	93.50
	Richest	94.50
Total		96.30

4.4.2. Micronutrient

Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissues in the body. The baseline and end line findings provide a good analysis and comparison on indicators including trends on children 6-23 months of age ii) who ever received vitamin A-doze or had it during the past 06 months, and who had ii) differentials based on background characteristics.

In the intervention area, the baseline findings had suggested that 64% of children aged 6-23 months ever had a dose of vitamin-A supplement whereas 46% of the same age had vitamin-A supplement in the past six months. However, as per the end line findings, the percentages for both these categories have gone down. 43 percent of children aged 6-23 months ever had a dose of vitamin-A, whereas only 27% of the same age had vitamin-A supplement in the past six months.

Table 4.4.2.a: Percentage of children who received Vitamin-A doze within the last 06 months

Background Characteristics		Yes Within 6 Months	Yes Before 6 Months	Total
Age group	<25	21.1	15.2	36.3
	25-34	28.2	14.7	42.9
	35+	35.9	21.4	57.3
Birth order	1	24.9	14.7	39.6
	2—3	24.2	17.0	41.2
	4—5	35.1	16.0	51.1
	6+	32.2	15.3	47.5
Education	No education	29.2	17.8	47.0
	Up to primary	21.1	15.8	36.9
	Middle	30.2	13.2	43.4
	Up to Secondary	28.3	16.3	44.6
	Secondary and above	21.8	12.9	34.7
Wealth Index	Poorest	22.7	12.1	34.8
	Poor	29.0	18.3	47.3
	Middle	32.8	9.90	42.7
	Rich	32.3	15.4	47.7
	Richest	20.0	24.6	44.6
Total		27.2	15.9	43.1

Baseline findings also suggested that overall, women aged 25-34 years (67%); those with 2-5 children (69%); those with education up to secondary or above secondary education (78%) and are in higher wealth quintiles (78%) are more likely to give vitamin supplements to their children compared with those who are less than 25 years of age (60%); having single child (56%), who are poor (57%) and have no or only up to primary level education (61%).

The end line findings reflect the same overall trends. Provision of vitamin-A doze is the highest for women above 35 years of age (57%), having 4-5 children (51%), education status up to secondary (45%) and rich wealth index (48%). The provision has been the lowest for women less than 25 years of age (36%), having just one kid (40%), education status of up to primary (37%) and belonging to the poorest income bracket (35%).

Chapter 5

CONTRACEPTION

Contraception is an important predictor of fertility rates of an area. The family planning programme was started in the district of Chitral almost simultaneously with other districts in the country. The baseline survey had collected information on knowledge, ever use of family planning methods, current use of methods by age and parity, sources of family planning methods, and women's perception of reasonable spacing time between two births. After implementation of the CCSP to assess its impact on fertility and contraception similar questions were asked in the end line survey. This chapter illustrates findings of the end line survey and does a trend analysis and a comparative pre-post analysis.

5.1. Knowledge of family planning methods

Knowledge leads to practice and hence knowledge about contraception methods is important in assessing its use. Family planning surveys ask about knowledge and ever use of family planning methods from ever-married women of reproductive age. Whereas information on current use and related topics is asked of currently married women of age 15-49 years. Similar procedure was adopted in this end line survey as well.

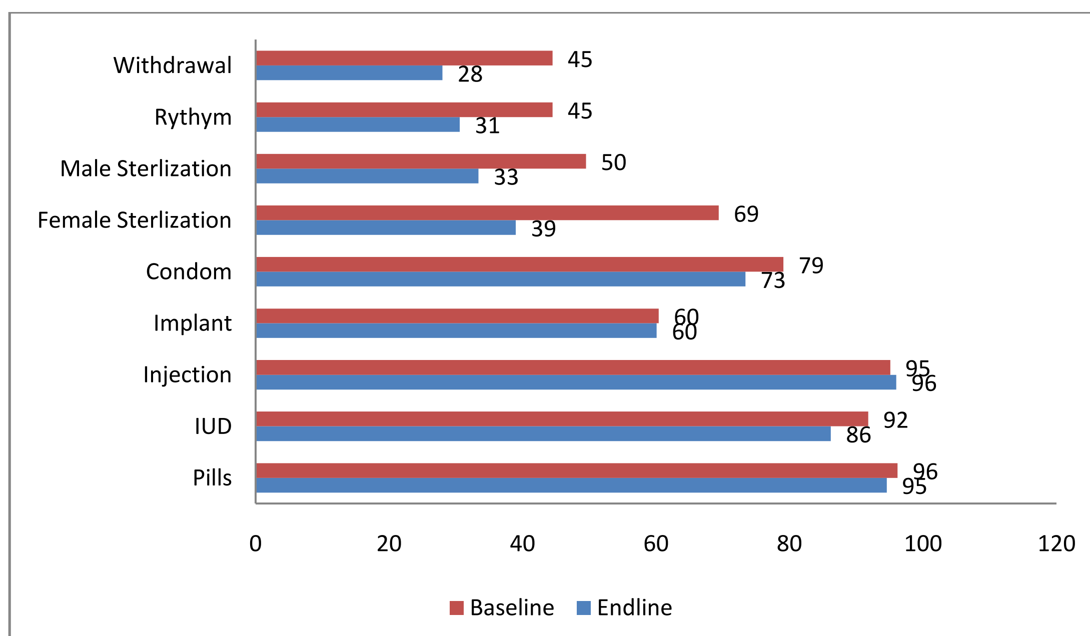
In this survey, the question was asked the way its asked in all DHS surveys 'Now I would like to talk about family planning-the various ways or methods that a couple can use to delay or avoid a pregnancy. Which ways or methods have you heard about? Methods not mentioned spontaneously were described by the interviewer and the respondents were asked again whether or not they had heard about the methods. The survey provides both prompted and unprompted knowledge about family planning methods as shown in Table 5.1.Maximum knowledge was on pills and injections (unprompted 75%)followed by IUDs and condoms. Least unprompted knowledge was on natural methods. When prompted, the knowledge of participants seems to increase on all contraception methods, especially more so for condoms, followed by implants. An interesting finding is that when prompted the knowledge on natural methods increases by 15 times for withdrawal method and 9 times for rhythm method.

Figures 5.1a and 5.1b show a comparison of end line and baseline on knowledge of contraceptive methods (blue for end line and red for baseline). The survey shows that injection is the most known (96%) method in Chitral followed by pill (94.6%), IUD (86%) and condom (73%). Traditional methods of contraception are the least known methods. A similar trend was seen in the baseline survey.

Table 5.1: Distribution of knowledge about family planning methods

Methods	Unprompted	Prompted	Total
Pills	75.0	19.6	94.6
IUD	54.5	31.7	86.2
Injection	75.0	21.0	96.0
Implant	22.0	38.1	60.1
Condom	27.6	45.8	73.4
Female Sterilization	5.2	33.8	39.0
Male Sterilization	2.9	30.5	33.4
Rhythm	3.0	27.6	30.6
Withdrawal	1.7	26.3	28.0

Figure 5.1.a: Knowledge about family planning methods - endline and baseline



5.2. Ever-use of contraception

The respondents were then asked whether they were currently using any method. If they were not currently using any method, they were asked, if they had ever used a method in the past. Based on responses to these questions, Table 5.2 shows that almost all women (98.2%) had heard about at least one method of contraception, which increased from 97% at baseline. Knowledge on at least one method of contraception was uniform across age groups, birth order, and education and wealth index.

Table 5.2 also shows ever use of contraception compared across baseline factors. On average 48.5% currently married women with children 0-23 months of age reported to have ever-used a contraceptive method, which has increased from 36.8% at baseline. Ever use increases with age, parity, education and wealth quintiles. Ever use of contraception in the end line CCSP survey, is more than that of the national average of 47.7% (PDHS 2006-07).

Table 5.2: Percentage distribution of women ever heard of and used a family planning method

Background Characteristics		Percentage of women who have heard at least one method of contraception	Percentage of women who had ever used a FP method in past	Number of women
Age groups	<25	98.00	34.50	200
	25-34	99.10	53.30	334
	35+	95.80	59.30	118
Birth order	1	97.90	27.20	195
	2--3	98.90	57.60	264
	4--5	97.00	61.40	132
	6+	98.30	50.80	59
Education	No education	97.40	43.30	344
	Up to primary	100.00	45.70	35
	Middle	98.10	54.70	53
	Up to Secondary	97.80	54.90	91
	Secondary+	100.00	56.00	125
Wealth Index	Poorest	95.40	48.90	131
	Poor	99.20	45.70	129
	Middle	98.50	47.30	131
	Rich	98.50	43.80	130
	Richest	99.20	57.30	131
Total		98.2	48.5	653

5.3. Knowledge of sources of contraceptives

Knowledge of a source of contraceptive methods is important for its use and continuation. Table 5.3 shows that an the majority of Chitrali women know about contraceptive methods as well as where to obtain them from (87.7%).On the whole, nine out of ten Chitrali women knew the source of contraceptive methods and this is the same as was in baseline. Women who are less than 25 years of age know about the source the most. There is no difference in knowledge on source of contraception according to birth order. Differentials on the basis of education and wealth quintiles are also minimal.

Table 5.3: Women's knowledge about source of family planning methods

Background characteristics		**Percentage of women who knows source of method**	**Number of women**
Age groups	<25	80.0	205
	25-34	76.1	335
	35+	73.7	118
Birth order	1	76.6	197
	2—3	75.0	268
	4—5	76.5	132
	6+	78.0	59
Education	No education	75.1	345
	Up to primary	78.9	38
	Middle	69.8	53
	Up to Secondary	79.6	93
	Secondary+	83.2	125
Wealth Index	Poorest	75.8	132
	Poor	76.3	131
	Middle	75.8	132
	Rich	80.9	131
	Richest	75.8	132
Total		87.8	719

5.4. Current use of contraception

Chitrali women are aware of family planning methods and their sources, the use rate of contraceptives which was 25.4% at baseline, picked up significantly after implementation of the CCSP and rose to 39.7%. Table 5.4 shows that current use of contraceptives is the same for all contraceptives as well as modern contraceptives, leading us to an interesting conclusion that hardly any woman reported to have been currently using these traditional methods. **The current use level is far higher by 10% points than the national average of 30% current contraception users.**

Women who are 25-34 years of age use contraceptives more as compared to older women above 35 years of age. This has seen a transition from the baseline survey where women of <25 years of age used contraceptives the most.

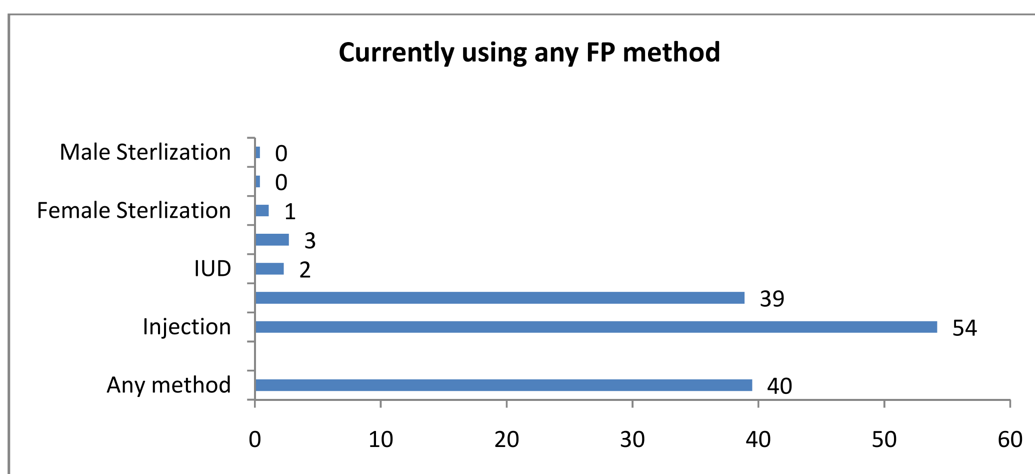
Low parity women and women who have more than 6 children are currently using contraceptives the lowest, where as women with 2-5 children are the highest users of contraceptives. The influence of education is quite visible on the current use of contraceptives, illiterate women have the lowest rates of current use of contraceptives, with a 10% difference between the highest educated compared to no education. A similar trend was seen in the baseline survey.

The current gap in the usage between the poorest (35%) and the richest (45%) is notable, but this bridge has narrowed significantly since the baseline survey. At baseline one in five poor women are also using contraceptives at end line over one third of women are using contraceptives. This is majorly due to increased awareness among the low socioeconomic class.

Table 5.4: Percentage of women with 0-23 month's children currently using method and modern method

Background Characteristics		Currently using a method	Currently using a modern method	Number of women
Age groups	<25	39.80	39.80	201
	25-34	42.40	42.40	335
	35+	31.40	31.40	118
Birth Order	1	35.40	35.40	195
	2--3	43.60	43.60	266
	4--5	40.20	40.20	132
	6+	33.90	33.90	59
Education	No education	36.90	36.90	344
	Up to primary	43.20	43.20	37
	Middle	41.20	41.20	51
	Up to Secondary	37.60	37.60	93
	Secondary+	47.20	47.20	125
Wealth Index	Poorest	35.90	35.90	131
	Poor	38.90	38.90	131
	Middle	40.80	40.80	130
	Rich	38.50	38.50	130
	Richest	44.70	44.70	132
Total		39.70	39.70	655

Figure 5.4.a: Current use of family planning methods



The baseline survey had revealed that Chitrali women either use injections (12.5 percent) or pills (9.4 percent). The use of all other methods was just nominal. At end line the use of injections increased to an overwhelming 54% followed by pills at 39%.This provision of injectable contraceptives supported by the AKHSP can largely explain the increase in contraceptive use in the intervention areas, while increase use of injectables may be attributed

to the need for privacy of the recipients. This is different in practice from national data, which show that the most common method of contraceptive is female sterilization (8.8%) followed by condoms (8.8%) (PDHS 2012-13). The national data also indicate that traditional contraceptive method use has doubled (PDHS 2012-13).

5.5. Birth spacing

Women were asked about reasonable spacing time between two births. Table 5.5 shows that 60 percent reported that in their opinion the difference between the two births should be 2-3 years, while one third said it should be more than 4 years, which has risen from 25% at baseline. Those who reported the duration to be two years or less were 5 percent. Women who thought the gap should be less than 2 years were generally older in age >35years and had 4-5 children. This shows that focusing on the particular age group of high parity and older age women is needed to increase the time duration between two children.

Chitrali women universally (97%) thought that birth spacing of less than 2 years had side effects, one third tough it is detrimental to both the mother's health and child's health whereas 25% thought it was harmful for the mother (Table 5.6).

Table 5.5: Percentage distribution of women with 0-23 month's children by knowledge of birth spacing

Background Characteristics		Birth spacing				Number of women
		<2years	2-3years	4+	Don't know	
Age group	<25	5.40	57.40	33.70	3.50	202
	25-34	4.20	62.90	30.80	2.10	334
	35+	7.60	53.40	37.30	1.70	118
Birth order	1	3.60	65.00	29.90	1.50	197
	2—3	6.00	60.00	30.60	3.40	265
	4--5	7.60	56.10	35.60	0.80	132
	6+	1.70	46.60	46.60	5.20	58
Education	No education	5.60	58.10	33.10	3.20	341
	Up to primary	7.90	63.20	28.90	0.00	38
	Middle	0.00	66.00	30.20	3.80	53
	Up to Secondary	7.50	57.00	33.30	2.20	93
	Secondary+	4.00	60.00	35.20	0.80	125
Wealth Index	Poorest	3.10	55.70	37.40	3.80	131
	Poor	3.80	60.30	32.10	3.80	131
	Middle	8.40	60.30	29.00	2.30	131
	Rich	4.60	71.50	22.30	1.50	130
	Richest	6.10	49.60	43.50	0.80	131
Total		5.10	59.5	32.8	2.60	670

Table 5.6: Knowledge of risks associated with birth spacing of less than 2 years

Background Characteristics	Percentage of women	Frequency
Hurt mother	4.2	28
Growth children	14.9	98
Mother Health	24.1	159
Baby Health	17.0	112
Both Health	29.1	192
Child upset stomach	0.2	1
No Problem	1.7	11
Blood problem for mother	1.2	8
HH Expenses	1.1	7
various diseases	0.2	1
Domestic work	1.2	8
Feeding will be difficult	0.2	1
Children's mental imbalance	0.2	1
NR	1.5	10
DK	0.5	3
Total	97.1	640
Missing system	2.9	19
Total	100	659

Chapter 6

KNOWLEDGE OF HIV/AIDS AND OTHER DISEASES

Pakistan is committed to attaining the health related Millennium Development Goals (MDGs) on all health aspects including i) HIV/AIDS, ii) Tuberculosis (TB) and iii) Hepatitis B&C. Improvements in awareness of the population with respect to these diseases can result in improvements in prevention programmes that specifically target them. Baseline knowledge of HIV/AIDS, tuberculosis and hepatitis B&C in the study population was document via a survey prior to proceeding with the awareness interventions through the CCSP. Based on the information received through the end line survey, this chapter examines the change in status of knowledge about these three diseases in the intervention areas of Chitral. The analysis has been done on the basis of pre-determined indicators such as aggregate level of knowledge, age groups, number of children, education and wealth. Targeted women were classified in the following categories.

1- Age*:* less than 25 years of age, between 25 and 34 years of age and 35 years and above
2- Number of Children:1, 2-3, 4-5, 6 and above
3- Education: No education, primarily, middle, up to secondary, secondary, secondary and above
4- Wealth: Poorest, Second, Middle, Fourth and Richest

As part of the baseline evidence, it was established that in general, younger women with fewer children, higher education and wealth are more likely to be aware of the three diseases. Conversely, older women with more children, no education and wealth are likely to be less aware of the three diseases discussed in this chapter.

6.1. Knowledge about HIV/AIDS

In the baseline survey, it was revealed that only 11 percent women surveyed in the intervention areas had heard of AIDS. However, as a result of the intervention, the knowledge went up to nearly 13 percent – marking a moderate increase of 2 percent.

At the onset of the project, the baseline study had concluded that awareness about AIDS was comparatively higher amongst younger women (less than 25 years of age). Comparison of the baseline and end line findings shows, the evidence shows that the percentage of women with knowledge of HIV/AIDS went up the most for age group 25 to 34 from 10% to 14% points (increase of 3%). Similarly, the percentage for the age group 35 years and also went up from roughly 7% to 9% (a 2% increase). However, there was no significant change in the knowledge of younger women of less than 25 years of age. This implies that the intervention was more successful with women over 25 years of age and hence provided better results for the most vulnerable age group. Given that the success rates are higher for vulnerable age group, it can be concluded that the intervention yielded moderately successful results.

Before beginning the intervention, education was found to be strongly related with acquiring knowledge about AIDS. It was recorded that 39% of the women with secondary and above education had knowledge about HIV/AIDS compared with only 5% who had no education. However, post-intervention, there has been no significant improvement in any education classification.

Pre-intervention, women in the highest wealth quintile were also more knowledgeable (21 percent) compared with those who were in the first income quintile (4%). In case of intervention areas, these percentages were much lower at 19% and 3% respectively. The end line survey reveals that the knowledge amongst the poorest has jumped up from 3% to 4.5 %. The biggest increase has been recorded for the middle wealth quintile whereby the percentage has gone up from 8% to 14%. This proves that the intervention was able to capitalize on the findings of the baseline survey and therefore focussed its efforts on poor to middle wealth quintile which is reflected through improvement of results.

Table 6.1: Percentage of women with youngest child age 0-23 months who have heard of AIDS

Background Characteristics		Heard about AIDS (Percent)	Number of women
Age groups	<25	11.70	205
	25-34	14.00	335
	35+	8.50	118
Birth order	1	13.20	197
	2—3	14.20	268
	4—5	8.30	132
	6+	10.20	59
Education	No education	4.90	345
	Up to primary	5.30	38
	Middle	11.30	53
	Up to Secondary	17.20	93
	Secondary+	32.0	125
Wealth Index	Poorest	4.50	132
	Second	8.40	131
	Middle	14.40	132
	Fourth	16.0	131
	Richest	18.20	132
Total		12.30	659

Overall, the end line survey provides moderate evidence of improvements in the knowledge of HIV/AIDS amongst women. The biggest achievements have been recorded with women aged 35 years and above and those falling between poor to middle wealth quintile.

6.2. Knowledge about Tuberculosis (TB)

Though knowledge about Tuberculosis (TB) amongst women with children less than two years of age is much higher than HIV/AIDS, yet the baseline survey had evidenced that only 44% women interviewed in the sample areas of Chitral had heard about TB at the aggregate level. However, as a result of the intervention, this aggregate level knowledge has gone up to 68% marking significant success for the project.

The baseline results had also suggested that younger women with one child were more likely to know about TB (48%) compared to older women with six or more children (31%). However, according to the end line findings, the percentages have gone up for both these

categories with 70% women with one child and 65% women with six children and above knowing about TB. In order words, the disparity of knowledge between these two groups has gone down to 5% compared to 17% before the intervention.

Table 6.2: Percentage distribution according to knowledge about TB

Background Characteristics		Ever heard about TB (Percent)	Number of women
Age groups	<25	69.60	204
	25-34	71.00	335
	35+	55.90	118
Birth order	1	69.50	197
	2—3	70.00	267
	4—5	62.90	132
	6+	64.40	59
Education	No education	56.70	344
	Up to primary	60.50	38
	Middle	79.20	53
	Up to Secondary	73.10	93
	Secondary+	92.00	125
Wealth Index	Poorest	55.70	131
	Poor	63.40	131
	Middle	74.20	132
	Rich	65.60	131
	Richest	80.30	132
Total		67.70	659

Women with above secondary education were twice more likely (74%) to know about TB compared to those who have no education (35%). This suggests a disparity of 35% between these two extreme classifications on access to education. However, post-intervention, the endline survey provides evidence that the knowledge of TB between these two groups has gone up to 92% and 72%, respectively. Not only has this increase the average knowledge of TB amongst women with varying education level, it has also reduced the disparity between the two extreme education level groups to 20%, hence, providing strong evidence in success of the intervention.

During the baseline phase, it was determined that women who were economically better off were also twice more likely (63%) to have heard about TB than those who are poor (29%). Based on the analysis of the end line findings, the same relationship still exists. However, the

average knowledge of TB has gone up for women belonging to all wealth quintiles. 80 percent richest women and 56% poorest women now know about the disease. This also brings down the disparity of knowledge between these two extreme wealth classifications from 34% to 26%.

6.3. Knowledge about Hepatitis B&C

During the baseline, the survey findings showed that only 16% women in the intervention area had heard of hepatitis B&C. However, as a result of the intervention, the knowledge went up to nearly 35% – marking an increase of 19%. This has been recorded the highest level of aggregate increase in knowledge amongst HIV/AIDS, TB and Hepatitis B&C.

Baseline study had also concluded that awareness about Hepatitis B&C was higher amongst younger women. Before the intervention, only 15% women over 35 years of age knew about the disease compared to 21% falling in the age group of 25 years or less. As a result of the intervention, the end line results show that the percentage of women with knowledge of Hepatitis B&C went up to 29% for women aged 35 years and above. This shows an increase of 14%. Similarly, the percentage for women 25 year of age or less went up to 35%, also marking an increase of 14%. There was also a significant up in the knowledge of women between 25 and 35 years of age with the percentage going up from 13 to 38 with an increase of 25 percentage points. This proves that the intervention was targeted aptly at women with the best results achieved for middle aged women falling between 25 and 35 years of age.

Following a similar trend, the baseline results had suggested that younger women with one child were more likely to know about Hepatitis B&C (19%) compared to older women and those having six or more children (10%). According to the end line findings, the percentages have gone up for both these categories with 32% women with one child and 36% women with six children and above knowing about Hepatitis B&C. Moreover, the disparity of knowledge between these two groups has also gone down to 4 percentage points compared to 9 before the intervention.

Table 6.3: Percentage distribution according to knowledge about Hepatitis B&C

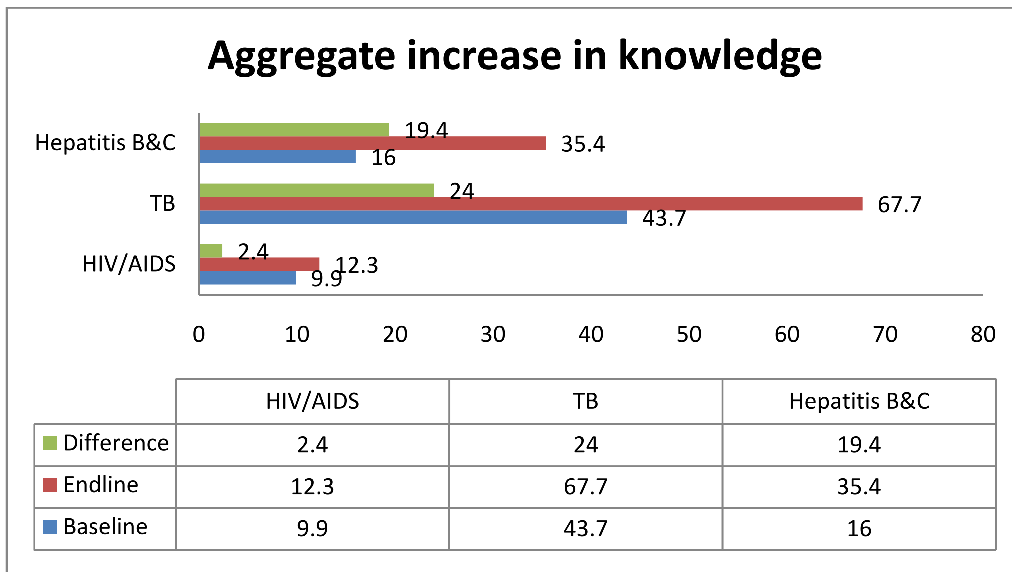
Background Characteristics		Ever heard about Hepatitis (B&C)	Number of women
		Yes	No. of women
Age groups	<25	34.60	205
	25-34	38.10	333
	35+	28.80	118
Birth order	1	32.10	196
	2—3	36.70	267
	4—5	38.60	132
	6+	35.60	59
Education	No education	32.00	344.00
	Up to primary	36.80	38.00
	Middle	34.00	53.00
	Up to Secondary	32.60	92.00
	Secondary+	48.00	125.00
Wealth Index	Poorest	33.60	131
	Poor	27.50	131
	Middle	34.80	132
	Rich	36.90	130
	Richest	44.70	132
Total		35.40	657

Women with above secondary level education were more likely (25%) to know about Hepatitis B&C compared to those who have no education (14%). This suggested a disparity of 35% between these two extreme classifications on access to education. However, post-intervention, the end line survey provides evidence that the knowledge of Hepatitis B&C between these two groups has gone up to 48% and 32%, respectively. This has increased the average knowledge of Hepatitis B&C amongst women with varying education level.

6.4. Key Findings

The end line survey reveals that the project intervention was most successful in increasing knowledge of TB in the targeted communities (24%), followed by Hepatitis B&C (19.4%) and HIV/AIDS (2.4%).

Figure 6.1: Aggregate increase in knowledge for HIV/AIDS, TB and Hepatitis B&C



	HIV/AIDS	TB	Hepatitis B&C
Difference	2.4	24	19.4
Endline	12.3	67.7	35.4
Baseline	9.9	43.7	16

CHAPTER 7

DISCUSSION AND RECOMMENDATIONS

The Chitral Child Survival Program (CCSP), was a 5 year USAID funded project that aimed to reduce maternal and neonatal mortality and morbidity in the district of Chitral. The interventions employed were strengthened community mid wife (CMW) referral linkages with TBAs and LHWs, awareness campaigns by BCC strategy and its key messages for enhanced knowledge on neonatal and maternal complications and birth preparedness plans, increased availability of skilled birth attendants at the community level, and increased financial access by formation of village bodies and Community Based Saving Groups (CBSGs).

The baseline survey was conducted to measure important project indicators for evaluation. The baseline survey collected information on household related indicators to assess the overall socioeconomic situation of the project area; availability, accessibility, affordability and acceptability of maternal and neonatal health services; health seeking behavior of the people especially with respect to women and children; and to determine the prevalence of health indicators to set the target for the CCSP and investigate factors that affect maternal, neonatal, infant and child health in the project area. The end line survey gauged the success of the intervention by asking the same set of questions as the baseline survey to assess the changes in knowledge, attitude and practices of the respondents after the implementation of the program. The intervention sought to increase awareness on MNCH indicators, use of FP by improving the quality of services provided by CMWs. No additional supplies – beyond the usual stock – were provided in the intervention. This is the report of the end-line survey, conducted after approximately five years of the start of the intervention. The following salient findings were found and are presented with key recommendations based on the inferences of these findings.

1. Knowledge of respondents related to pregnancy and birth preparedness

There was a mixed response to knowledge provision. The most remarkable change was seen in two sets of indicators, both of which showed a doubling up from baseline. Percentage of mothers of children 0-23 months who know at least two danger signs in newborns soon after birth that indicate the need for treatment and percentage of mothers of children 0-23 months who know at least two danger signs during pregnancy that indicate the need for treatment. It was also reassuring to observe that knowledge of danger signs at seven days of birth in the neonate, and knowledge of danger signs of child birth was universal at end line improving significantly from baseline.

Issues such as the post partum period pregnancy are culturally nuanced and influenced by traditions. In these, the understanding of respondents changed from baseline, but to a lesser extent, as compared to other indicators of knowledge uptake. Strata wise analysis revealed no specific pattern emerging regarding knowledge about danger signs by age, parity, education or economic well being. In general, respondents' knowledge regarding the need to identify and respond to danger is fairly high.

Previously in a study done in an urban setting by private providers knowledge regarding danger signs during pregnancy and delivery has been reported to be low in Pakistan (Haq Z ul, et al 2009). In the study by Haq et al, lack of preparation in terms of transport was reported in 83% cases. In another Ethiopian study, among 743 pregnant women only a quarter (20.5%) of pregnant women identified skilled provider before delivery. Only 8.1% identified health facility for delivery and/or for obstetric emergencies. Preparedness for transportation was found to be very low (7.7%). Considerable (34.5%) number of families saved money for incurred costs of delivery and emergency if needed. Only few (2.3%) identified potential blood donor in case of emergency (Hailu M, et al 2011). Our findings are different from both these studies, as introduction of a new cadre of workers, the CMWs in the private sector, seems to have shown a positive impact in raising awareness of women regarding danger signs during pregnancy and also at delivery. Similarly in our study women prepare for birth by arranging clothes, transport, funds and select a service provider for birth.

Recommendation

- Generally women and their families are not sensitized to prepare for safe deliveries, but for areas where there is marginalized population with less knowledge, CWMs as private skilled workers are a good way to impart knowledge on these critical pregnancy and delivery aspects

2. Improvements in health seeking behaviors

Overall due to the CCSP, the attitude and practices of health seeking behavior changed among Chitrali women. There was an overwhelming increase in women whose delivery was attended by Skilled Birth Attendants (SBAs). This increase is largely attributed to the training and deployment of CMWs in the community and increasing their referral linkages. At baseline, majority of women of all categories were primarily assisted by traditional birth attendants but at end line it decreased to half for Dai /TBA. Only 29 percent women were assisted by a doctor/nurse during their last pregnancy at baseline, whereas at the end line this increased two fold. This is because a quarter of births at end line were by CMWs, being only the second choice of clients after LHV/nurse assisted deliveries. The proportion of mothers who were assisted by a health professionals were generally younger in age, had higher education and were economically well off. Literature suggests that several socio-economic factors, play a significant role in the use of Skilled Birth Attendance for delivery. Overall the status of women in society; women's involvement in decision making; and women's autonomy and place of residence have been reported as significant contributing factors for uptake of Skilled Birth Attendance for delivery in Nepal (Baral YR, et al 2010). It appears that the CCSP project was successful in providing women enhanced awareness as well as communications skills besides a chance to be part of decision making concerning their access to ANC services and delivery. More women appeared to have had inter spousal communication with their husbands resulting in husband/in laws consent for deliveries assisted by SBAs.

Perhaps for future scaling up of this project, married women who are older in age, with high parity and economically disadvantaged should be specifically targeted and their awareness increased regarding the importance of skilled birth deliveries. As highlighted in the literature, one of the proxy indicators employed to assess Pakistan’s progress towards

decreasing the national MMR is the percentage of deliveries conducted by SBAs. Further to that, the number of SBA-handled deliveries in Pakistan has risen from 20% in 2000 to the current of 40%, but it remains far less than the MDG target of 90% safe delivery coverage. By relation, the current study's findings provide strong evidence of the potential to rapidly accelerate Pakistan's progress toward meeting its MDG commitments. This could be accomplished through integrated interventions which deploy and establish CMWs in communities reducing huge degree of gender inequality, social exclusion and poverty; factors which also contribute to high maternal and neonatal morbidity and mortality rates.

Only about one fifth of the study's participants sought PNC services from skilled healthcare providers, while 19.3% of women in KPK and 26.7% at the national level had similar such use of skilled providers. Moreover, the current study indicates an improvement in the number of women's visits to skilled providers for PNC services from the 17.5% found by the CCSP baseline study, even though there is large room for improvement. Compared to the more traditional and less contentious issues, the respondents' attitudes and practices regarding post partum care for mothers is still quite low and needs attention. This could be because generally PNC may not taken as a serious matter by traditional Chitrali families. The particular gaps in respondents' practices should be taken into account. In further scaling up of interventions focus should be on all weak areas of women's knowledge and practices. Media campaigns can also supplement the work of CMWs particularly through frequently watched media channels. The communication strategies should be strong to enhance women's knowledge so that they could be able to translate their knowledge into practice.

Similarly as is the case with PNC of mothers, the percentage of children aged 0-23 months who received postpartum visit within 2 days after birth by a health professional is also quite low, however it change significantly from the baseline. Here awareness campaigns are needed so women along with their children are mobilized to seek PNC.

Women who availed ANC services recorded a two fold increase. It was noted in baseline that 24 percent women had their first antenatal check-up in the first trimester, 31 percent in the second trimester and 15 percent in the third trimester. At end line 46 percent women had their first antenatal check-up in the first trimester, 25 percent in the second trimester and 12 percent in the third trimester. The improvements in health seeking behaviours can be

attributed to the success of the CCSP project. It shows an overall improvement as more women are making more number of ANC visits as compared to baseline and also as now more women are aware of the right time to seek ANC care (earlier in pregnancy rather than later).

Recommendation

- For future scaling up of the project, married women who are older in age, with high parity and economically disadvantaged should be specifically targeted and their awareness increased regarding the importance of skilled birth deliveries
- Building on the improvements in ANC health seeking behaviors awareness campaigns should also mobilize women to seek PNC along with their children

3. Components of ANC visits

The components of ANC are important in assessing the quality of prenatal care services. Among women with a child less than 24 months age, 59 percent had taken iron tablets during their last pregnancy in the baseline survey and this rose to 76 percent at end line, while 26 percent continued the use of iron tablets for at least two months at baseline and this doubled at the end line evaluation. The quality of prenatal care is particularly related to mother's age, education, wealth status and parity. Women who were younger in age, low parity, more educated and economically better off were more likely to be aware and take iron supplements during pregnancy.

At baseline only four out of ten women used Calcium tablets in the study areas and 14 percent continued its use for two or more months. At end line this improved to two thirds of the women taking calcium supplements and more than one third of these women continued it for more than two months. The pattern of calcium tablet use has changed significantly through the course of the project while age and birth order were are found to be important determinants for the increased calcium use.

This is generally because newly married younger women who are more educated are more open to change. Future interventions should give special attention to groups of women who

are more persistent in their views and present a greater challenge. Also future scaling up of these interventions should be focused differently for different strata of clients depending on their educational and economic categories. Women belonging to marginalized strata should be imparted knowledge through different channels as compared to women who are generally more aware because of their enhanced education. Street theatres, role modelling and storytelling could be some potential ways in which one can reach out to the more difficult strata of people and increase their knowledge and awareness. Also strategies other than iron tablets need to be introduced among marginalised women. Literature suggests the use of fortifying wheat with iron and similar programmes like GAIN can be employed (GAIN health project). There is promising evidence from studies whereby iron cooking pots are introduced at the community level. Cooking in iron pots has led to significant increase in hemoglobin concentrations, especially among adults (Geerligs PP et al 2003), but there are problems of acceptability as pots are heavy and can rust easily when not dried properly (Geerligs PP et al 2002). The cost effectiveness of such an intervention would also be a matter of concern, whether households would be able to afford such interventions.

Recommendation

- Future ANC interventions should focus on women from marginalized strata and should be imparted health education through different channels
- Street theatres, role modeling and storytelling, for women of higher age and parity as well as low education and socio-economic standing, are some of the potential approaches through which knowledge and awareness interventions can be implemented.
- Additional strategies for interventions focusing on iron are needed besides iron tablets. Introduction of iron cooking pots in communities is one such intervention that merits consideration due to the success demonstrated in other parts of the world.

4. Better vaccination coverage

Vaccination coverage for the mother and child seems to be following a mixed trend. Percentage of mothers with children 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child increased from 63 percent to 83 percent. Children who received a measles vaccination decreased from 81 percent to 68 percent,

however this can largely be attributed to the non availability of measles vaccine generally in the rest of the country during the project period. In PDHS 2012-13 the percentage of children vaccinated against measles was 61 percent, so Chitral vaccinations is fairly consistent, even slightly better than the national figures (PDHS 2012-13).

Children who received DPT1 fell from 95 percent at baseline to 80 percent, almost at a universal coverage. Children who got DPT3 decreased from 90.3 percent at baseline to 86 percent at end line, however the national figures for DPT3 are reported to be around 65 percent. The programme intervention areas in Chitral are therefore performing better than the rest of the country in terms of some measles and DPT3.

Recommendation

- More effort needs to be made in future interventions to ensure that all children are universally vaccinated
- Future interventions such as sending SMS messages through mobile phone reminders to mothers who have delivered at facilities or their homes are one mechanism to increase participation in vaccination.

5. Overall Increase in CPR

Contraception is an important predictor of fertility rates of an area. The family planning programme was started in the district of Chitral almost simultaneously with other districts in the country. The overall CPR rose in the program area from 25% to 40%, a 15% increase. The survey shows that injection is the most known (96 percent) method in Chitral followed by pill (94.6percent), IUD (86 percent) and condom (73 percent). Traditional methods of contraception are the least known methods. This happened while the overall knowledge and attitudes of the community remained more or less unchanged. Previous successful FP interventions have largely been those that increased availability of supplies rather than the quality of services. In this regard, this intervention suggests that a well orchestrated intervention that increases service quality and counselling through better networks of CMWs and their referral linkages with other key actors in the area can be at least as effective as a supply side intervention. A salient finding is that while FP use increased, the majority of Chitrali women also knew about contraceptive methods as well as where to obtain them from

(87.7%). On the whole, nine out of ten Chitrali women knew the source of contraceptive methods and this is the same as was in baseline. Women who are less than 25 years of age know about the source the most. There is no difference in knowledge on source of contraception according to birth order. Differentials on the basis of education and wealth quintiles are also minimal. All together, it suggests that the engagement of CMWs with a new training regime and the attention they gave to the community was the more important determinant of FP use than the actual supply of commodities.

Recommendation

- Interventions that train health workers to enhance their interaction with potential clients are needed
- Interactions of health workers with women should focus on counseling and appropriate referrals to have a positive impact on the uptake of contraceptives in a community

6. Limitations

This end line survey used pre and post intervention design for evaluation. Pre-post intervention research designs are internationally accredited for use in situations where controlled trials are not feasible due to logistic, financial or other ethical reasons. One advantage offered by pre-post analysis is that an outcome can be shown to vary statistically with the intervention and causality can be suggested since the intervention precedes the measurement of the outcome. A limitation in this analysis is that in the absence of a measurement of the outcome from control areas, despite a statistical difference in the intervention area, it is difficult to conclude how much of a change observed in outcome indicators is attributable to the intervention. In the present study the changes in key outcome indicators may be due to project interventions. In the absence of a comparable group it is difficult to say with certainty whether the impact on the outcomes was due to this project. However, if national figures for measles vaccination are taken as a comparator, it shows that measles vaccination is higher in the intervention areas of the project compared to national figures (PDHS 2012-13). Similarly current use of contraceptives is also about 10 percentage points higher than the national average. The better performance of key indicators in the project intervention areas compared to national figures points towards a positive impact of project interventions on the outcomes.

7. Conclusions

Overall it appears that the intervention increased MNCH knowledge, CMW skilled delivery and FP use substantially. It is less clear if the specific effect can be attributed to individual components of the intervention since there is no control area analyzed and time trends could have brought about a change. However, for most cases, especially regarding views and knowledge of the respondents leading to major practice shifts like CMW deliveries can largely be attributed to the intervention. A possibly explanation by is that the CMWs, who were trained, provided better services and captured some of the unmet need for FP as well as tapped the women who were never before approached for or counselled on an SBA delivery. That they did so without providing additional supplies is a major finding, along with the fact that they were able to become the major healthcare provider for these communities. This demonstrates that provision of relevant service delivery can have a positive impact on key reproductive and child health outcomes.

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APPENDICES

Appendix 1: Names of the team member

NAMES OF TEAM MEMBER IN CCSP ENDLINE SURVEY (SEDCO ASSOCIATES)		
S.NO	**NAME**	**DESIGNATION**
1	UZMA ATHAR	PRINCIPLE INVESTIGATOR
2	HASSAN BIN HAMZA	SENIOR TECHNICAL ADVISOR
3	MUHAMMAD ALI	PROJECT MANAGER
4	HUMA BINTE NAYYER	RESEARCH OFFICER
5	AZHAR ULLAH	COORDINATOR & MONITOR
6	IMRAN DASTAGIR	MONITOR
7	SEHAR SHAH	SUPERVISOR
8	JAHAN ARA	SUPERVISOR
9	SURAYA BIBI	SUPERVISOR
10	BENAZIR	ENUMERATOR
11	MAHTAB MULUK	ENUMERATOR
12	FARHANDA JAN	ENUMERATOR
13	SHABNUM SARDAR	ENUMERATOR
14	SALIMA KHANUM	ENUMERATOR
15	NUSRAT	ENUMERATOR
16	YASMEEN BIBI	ENUMERATOR
17	HALIMA AKHTAR	ENUMERATOR
18	ZUBAIDA	ENUMERATOR

Appendix 2: End line CCSP household characteristics questionnaire

End line Household survey

District Chitral

(ESC-2013)

Household Questionnaire

August 2013

SEDCO Associates

Islamabad

ENDLINE HOUSEHOLD SURVEY, DISTRICT CHITRAL (ESC - 2013)

HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION

TEHSIL (CHITRAL=1; DROSH=2; LOTKOH=3; MASTUJ=4; MULKOH=5; TORKOH=6) ....

.............CLUSTERNUMBER ....

..............HOUSEHOLDNUMBER ....

NAME OF HOUSEHOLD HEAD ______________________________

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	________	________	________	DAY
				MONTH
				YEAR 2 0 1 3
INTERVIEWER'S NAME	________	________	________	INT. NUMBER
RESULT*	________	________	________	RESULT
NEXT VISIT: DATE TIME	________ ________	________ ________		TOTAL NUMBER OF VISITS

*RESULT CODES:
1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4 POSTPONED
5 REFUSED
6 DWELLING VACANT OR ADDRESS NOT A DWELLING
7 DWELLING DESTROYED
8 DWELLING NOT FOUND
9 OTHER ______________________________ (SPECIFY)

TOTAL PERSONS IN HOUSEHOLD

TOTAL ELIGIBLE WOMEN

TOTAL CHILDREN UNDER AGE-2

LINE NO. OF RESPONDENT

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME ________ DATE ________	NAME ________ DATE ________		

اسلام علیکم!

میرا نام .... ہے۔ اور میں (SEDCO, ISLAMABAD)میں کام کرتی ہوں۔ ہم صحت کے مختلف مسائل سے متعلق چترال ایریا میں سروے کر رہے ہیں۔ اگر آپ اس سروے میں شریک ہو کر ہماری مدد کرینگے تو ہم آپ کے بڑے شکر گزار ہونگے۔ اس سروے میں سب سے پہلے آپ کے کنبے کے بارے میں چندایک سوال پوچھتے ہیں۔ ہم آپ کو یقین دلاتے ہیں کہ آپ کے جوابات صیغہ راز میں رہیں گے۔ اس سروے میں آپ کی شرکت کلی طور پر رضاکارانہ ہے۔ اگر آپ کسی سوال کا جواب نہیں دینا چاہتے تو آپ مجھے بتا دیں، میں آپ سے اگلا سوال پوچھ لوں گی۔ آپ یہ انٹریو کسی وقت بھی ختم کر سکتی ہیں لیکن ہم اُمید کرتے ہیں کہ آپ اس سروے میں شریک ہونگے کیونکہ آپ کے خیالات اس وقت ہمارے لیے بڑی اہمیت رکھتے ہیں۔ اب کیا آپ اس سروے کے بارے میں مجھ سے کچھ پوچھنا پسند کریں گی؟ کیا میں اب آپ کا انٹرویو لینا شروع کروں؟

Signature of interviewer: ______________________ Date: ____________

RESPONDENT AGREES TO BE INTERVIEWED .... 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .... 2 → END

HOUSEHOLD SCHEDULE

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	AGE 12 OR OLDER	IF AGE 5 YEARS OR OLDER EDUCATION	
	Please give me the names of the persons who usually live in your household, starting with the head of the household. عام طور پر رہنے والے افراد کے نام بتائیں۔ گھرانے کے سربراہ سے شروع کریں AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, THEN ASK QUESTIONS IN COLUMNS 5-9 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? (نام) کا گھر کے سربراہ سے کیا رشتہ ہے؟ **(SEE CODES) (BELOW)**	Is (NAME) male or female? (نام) مرد ہے یا عورت؟	How old is (NAME)? (نام) کی عمر کتنی ہے؟ IF LESS THAN 1 YEAR, WRITE 00'. IF AGE 96 YEARS OR MORE, WRITE '96'.	MARITAL STATUS What is (NAME'S) current marital status? ازدواجی حیثیت کیا ہے؟ **(SEE CODES) (BELOW)**	Has (NAME) ever attended school? کیا (نام) کبھی اسکول گیا ہے؟	What is the highest class of school (NAME) **completed?** سب سے بڑی کونسی جماعت پاس کی ہے؟ **(SEE CODES) BELOW)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			M F	IN YEARS	M W D/S N	YES NO	CLASS
01			1 2		1 2 3 4	1 2 GO TO 10↓	
02			1 2		1 2 3 4	1 2 GO TO 10↓	
03			1 2		1 2 3 4	1 2 GO TO 10↓	
04			1 2		1 2 3 4	1 2 GO TO 10↓	
05			1 2		1 2 3 4	1 2 GO TO 10↓	
06			1 2		1 2 3 4	1 2 GO TO 10↓	
07			1 2		1 2 3 4	1 2 GO TO 10↓	
08			1 2		1 2 3 4	1 2 GO TO 10↓	
09			1 2		1 2 3 4	1 2 GO TO 10↓	
10			1 2		1 2 3 4	1 2 GO TO 10↓	
11			1 2		1 2 3 4	1 2 GO TO 10↓	
12			1 2		1 2 3 4	1 2 GO TO 10↓	

CODES FOR Q. 3
RELATIONSHIP TO HEAD OF HOUSEHOLD:
01 = HEAD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 =BROTHER/SISTER IN LAW
10 = NIECE/NEPHEW
11 = GRAND PARENTS
12 =AUNTS/UNCLE
13 = OTHER RELATIVE
14 = ADOPTED/FOSTER/STEPCHILD
15 = NOT RELATED
16= DOMESTIC SERVANT
98 = DON'T KNOW

CODES FOR Q. 6
MARITAL STATUS
1 = **M**ARRIED
2 = **W**IDOWED
3 = DIVORCED/ SEPARATED
4 = **N**EVER MARRIED

CODES FOR Q. 8
EDUCATION CLASS:
00 = LESS THAN 1 YEAR COMPLETED
01 = CLASS 1;
02 = CLASS 2
. . .
10 = MATRIC, CLASS 10
11 = CLASS 11
. . . .
16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)
98 = DON'T KNOW

ELIGIBILITY	ILLNESS HISTORY DURING LAST ONE-MONTH							
CIRCLE LINE NUMBER OF ALL **WOMEN** AGE 15-49 WHO ARE MARRIED, WIDOWED OR DIVORCED OR SEPARATED AND CHILD < 2-YEARS	Has (NAME) been ill during last month? کیا (نام) پچھلے ایک ماہ میں بیمار ہوا ہے؟	Did (NAME) seek any treatment for illness? کیا (نام) نے علاج کروایا ہے؟	Place from where treatment received? علاج کہاں سے کروایا گیا؟ **(SEE CODES BELOW)**	Expenditure incurred on:				
				Transportation سواری پر کتنے روپے خرچ ہوئے؟	Consultation ڈاکٹر وغیرہ کی فیس پر	Medicine دوائی پر	Lab Test ٹیسٹ کروانے پر	Misc ان کے علاوہ متفرق اخراجات
(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
	YES NO	YES NO	CLASS					
01	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
02	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
03	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
04	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
05	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
06	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
07	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
08	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
09	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
10	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
11	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					
12	1 2 ↓ GO TO NEXT	1 2 ↓ GO TO NEXT	☐☐					

CODE FOR Q.12

01-DHQ HOSPITAL
02-THQ HOSPITAL
03-MCH CENTRE
04-RHC
05-BHU
06-AKHS HOSPITAL
07-PRIVATE CLINIC / HOSPITAL
08-DAI / BIRTH ATTENDANT
09-LADY HEALTH WORKER
96-OTHER

INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 4 YEARS

18 Now I would like to ask you about all the births that occurred in this household **in the last 4 years**, whether they were born alive or dead. Since January 2009, did any woman who was a usual resident of this household at that time give birth? I am interested in any birth, even stillbirths and children who did not survive.

YES ..1
NO ... 2 → 27

جنورری 2009 سے لے کر اب تک اس گھرانے میں کتنے بچے پیدا ہوئے۔
ایسے بچے بھی بتائیں جو مردہ پیدا ہوئے یا بعد میں فوت ہوئے۔

19 Total births occurred in this household in the last 4 year? ☐

NO	What are the names of the babies born in the last 4 years? IF STILL BORN, WRITE 'BABY' پچھلے 4 سال میں پیدا ہونے والے بچوں کے نام کیا ہیں؟	Is (NAME) a boy or a girl? کیا (نام) لڑکا تھا یا لڑکی؟	In what month and year was (NAME) born? (نام) کس ماہ اور سال میں پیدا ہوا/ہوئی؟ **IF MONTH NOT KNOWN RECORD '98'**	Was (NAME) born alive? کیا (---) زندہ پیدا ہوا تھا/ہوئی تھی؟	Is (NAME) still alive? ماشاء اللہ کیا (نام) ابھی زندہ ہے؟	LINE NUMBER FROM HOUSEHOLD ROSTER (RECORD '00' IF CHILD NOT LISTED IN HH ROSTER)
20	21	22	23	24	25	26
01	______	BOY 1 GIRL 2	MONTH ☐☐ YR 2 0 ☐☐	YES 1 NO 2 NEXT ↵	YES 1 NO 2 NEXT ↵	☐☐ NEXT ↵
02	______	BOY 1 GIRL 2	MONTH ☐☐ YR 2 0 ☐☐	YES 1 NO 2 NEXT ↵	YES 1 NO 2 NEXT ↵	☐☐ NEXT ↵
03	______	BOY 1 GIRL 2	MONTH ☐☐ YR 2 0 ☐☐	YES 1 NO 2 NEXT ↵	YES 1 NO 2 NEXT ↵	☐☐ NEXT ↵

27 Now I would like to ask you about any deaths that occurred in this household **in the last 4 year**. Since January **2009**, God forbid, has any usual member of this household died?

YES ..1
NO ...2 → 101

خدانخواستہ **January 2009** سے لیکر اب تک اس گھر میں سے اگر کسی کی موت واقع ہوئی تو
انکے نام لکھوائیں۔

28 Total deaths occurred to usual residents in this household in the last 4 year? ☐

NO	What were the names of the people who died in the last 4 years? پچھلے 4 برس میں فوت ہونے والے افراد کا نام بتائیں؟	Was (NAME) male or female? مرنے والا مرد/عورت/بچہ/بچی تھی؟	In what month and year did (NAME) die? اس کی وفات کس ماہ اور سال میں ہوئی؟ **IF MONTH NOT KNOWN RECORD 98**	How old was (NAME) when he/she died? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN 2 YEARS; OR YEARS وفات کے وقت اس کی عمر کیا تھی؟	**CHECK 31 AND 33:** WAS THIS A WOMAN AGE 12-49 WHEN SHE DIED?	**Female, 12-49 years old** Was (NAME) pregnant when she died? کیا (نام) وفات کے وقت حاملہ تھی؟	Did (NAME) die during childbirth? کیا (نام) زچگی کے دوران فوت ہوئی؟	Did (NAME) die within 6 weeks after delivery? کیا (نام) بچے کی پیدائش کے 6 ہفتہ کے اندر فوت ہوئی؟	Did (NAME) die because of complication during pregnancy or in delivery? کیا (نام) کی وفات حمل یا بچے کی پیدائش میں پیچیدگی سے ہوئی یا اور وجہ ہے۔
29	30	31	32	33	34	35	36	37	38
01	______	MALE 1 FEMALE 2	MONTH ☐☐ YR 2 0 ☐☐	DAYS 1 ☐☐ MONTHS 2 ☐☐ YEARS 3 ☐☐	YES 1 NO 2 NEXT ↵	YES 1 Q38 ↵ NO 2	YES 1 Q38 ↵ NO 2	YES 1 NO 2 NEXT ↵	YES 1 NO 2 NEXT ↵
02	______	MALE 1 FEMALE 2	MONTH ☐☐ YR 2 0 ☐☐	DAYS 1 ☐☐ MONTHS 2 ☐☐ YEARS 3 ☐☐	YES 1 NO 2 NEXT ↵	YES 1 Q38 ↵ NO 2	YES 1 Q38 ↵ NO 2	YES 1 NO 2 NEXT ↵	YES 1 NO 2 NEXT ↵

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
101	What is the main source of drinking water for members of your household? اس گھر کے افراد کےلیے پینے کے پانی کا سب سے بڑا ذریعہ کونسا ہے؟	**PIPED WATER**		
		PIPED INTO DWELLING	01	
		PIPED TO YARD/PLOT	02	103
		PUBLIC TAP	03	
		TUBE WELL OR BOREHOLE	04	
		HAND PUMP	05	
		WELL IN RESIDENCE/YARD/PLOT		
		COVERED WELL	06	
		UNCOVERED WELL	07	
		PUBLIC WELL		
		COVERED WELL	08	
		UNCOVERED WELL	09	
		SURFACE WATER		
		SPRING	10	
		RIVER/STREAM	11	
		POND/LAKE	12	
		DAM	13	
		RAIN WATER	14	
		CART WITH SMALL TANK	15	
		WATER TANKER TRUCK	16	
		BOTTLED WATER	17	
		OTHER ______ (SPECIFY)	96	
102	How long does it take to go there, get water, and come back? وہاں تک جانے، پانی لینے اور واپس آنے میں کتنا وقت لگتا ہے؟	MINUTES		
		ON PREMISES	99	
		DON'T KNOW	98	
103	How many rooms in this house and how many of them are used for sleeping? اس گھر میں کل کتنے کمرے ہیں؟ اور ان میں سے کتنے کمرے سونے کے لیے استعمال ہوتے ہیں؟	TOTAL ROOMS		
		USED FOR SLEEPING		
104	What kind of toilet facility do members of your household usually use? آپ کے کنبے کے افراد عام طور پر رفع حاجت /پاخانے کے لیے کس قسم کی سہولت کا استعمال کرتے ہیں؟	**FLUSH OR POUR FLUSH TOILET**		
		FLUSH TO SEWER SYSTEM	01	
		FLUSH TO SEPTIC TANK	02	
		FLUSH TO SOMEWHERE ELSE	03	
		FLUSH, DON'T KNOW WHERE	04	
		PIT LATRINE		
		VENTILATED IMPROVED PIT LATRINE (VIP)	05	
		PIT LATRINE WITH SLAB	06	
		PIT LATRINE WITHOUT SLAB/ OPEN PIT	07	
		BUCKET TOILET	08	
		NO FACILITY/BUSH/FIELD	09	
		OTHER ______ (SPECIFY)	96	

ESC - 2013 5 HH Questionnaire

No	QUESTIONS AND FILTERS		CODING CATEGORIES			SKIP
105	Does your household have:	کیا آپ کے گھر مں یہ چیزیں موجود ہیں		Yes	No	
	Electricity	بجلی	Electricity	1	2	
	Radio	ریڈیو	Radio	1	2	
	Television	ٹیلی ویژن	Television	1	2	
	Refrigerator	ریفریجریٹر	Refrigerator	1	2	
	Mobile telephone or land line telephone	موبائل فون یا لائن فون	Mobile telephone or land line telephone	1	2	
	Heater	ہیٹر	Heater	1	2	
	Washing Machine	واشنگ مشین	Washing Machine	1	2	
	Water Pump	واٹر پمپ	Water Pump	1	2	
	Bed	پلنگ	Bed	1	2	
	Chairs	کرسیاں	Chairs	1	2	
	Almirah/Cabinet	الماری	Almirah/Cabinet	1	2	
	Clock	گھڑی	Clock	1	2	
	Sofa	صوفہ	Sofa	1	2	
	Sewing Machine	سلائی مشین	Sewing Machine	1	2	
	Camera	کیمرہ	Camera	1	2	
	Personal Computer	کمپیوٹر	Personal Computer	1	2	
106	Does any member of this household own:	کیا گھرانے کی کسی فرد کے پاس یہ چیزیں ہیں؟		**Yes**	**No**	
	A Watch	گھڑی	A Watch	1	2	
	A Bicycle	سائیکل	A Bicycle	1	2	
	A Motorcycle or motor Scooter	موٹر سائیکل یا سکوٹر	A Motorcycle or motor Scooter	1	2	
	A Car or Truck or Tractor	کار یا ٹرک یا ٹریکٹر	A Car or Truck or Tractor	1	2	
107	Which is more frequently used medium used in your household?	آپ کے گھر میں ذرائع ابلاغ (ٹی وی۔ ریڈیو۔ اخبار) کا کونسا ذریعہ زیادہ تر استعمال ہوتا ہے؟	TELEVISION	1		
			RADIO...............	2		
			NEWSPAPER	3		
			NONE OFABOVE......	4		

6

No	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
105	Does your household have: کیا آپ کے گھر میں یہ چیزیں موجود ہیں		Yes	No	
	Electricity بجلی	Electricity	1	2	
	Radio ریڈیو	Radio	1	2	
	Television ٹیلی ویژن	Television	1	2	
	Refrigerator ریفریجریٹر	Refrigerator	1	2	
	Mobile telephone or land موبائل فون یا	Mobile telephone or land	1	2	
	line telephone لائن فون	line telephone	1	2	
	Heater ہیٹر	Heater	1	2	
	Washing Machine واشنگ مشین	Washing Machine	1	2	
	Water Pump واٹر پمپ	Water Pump	1	2	
	Bed پلنگ	Bed	1	2	
	Chairs کرسیاں	Chairs	1	2	
	Almirah/Cabinet الماری	Almirah/Cabinet	1	2	
	Clock گھڑی	Clock	1	2	
	Sofa صوفہ	Sofa	1	2	
	Sewing Machine سلائی مشین	Sewing Machine	1	2	
	Camera کیمرہ	Camera	1	2	
	Personal Computer کمپیوٹر	Personal Computer	1	2	
106	Does any member of this household own: کیا گھرانے کی کسی فرد کے پاس یہ چیزیں ہیں؟		**Yes**	**No**	
	A Watch گھڑی	A Watch	1	2	
	A Bicycle سائیکل	A Bicycle	1	2	
	A Motorcycle or motor Scooter موٹر سائیکل یا سکوٹر	A Motorcycle or motor Scooter	1	2	
	A Car or Truck or Tractor کار یا ٹرک یا ٹریکٹر	A Car or Truck or Tractor	1	2	
107	Which is more frequently used medium used in your household? آپ کے گھر میں ذرائع ابلاغ (ٹی وی۔ ریڈیو۔ اخبار) کا کونسا ذریعہ زیادہ تر استعمال ہوتا ہے؟	TELEVISION		1	
		RADIO...............		2	
		NEWSPAPER		3	
		NONE OFABOVE......		4	

6

108	Is this house rented, rent-free, mortgaged or owned by a member of the household? کیا یہ گھر کرائے کا ہے، بغیر کرائے کا ہے، رہن رکھا گیا ہے یا گھرانے کے کسی فرد کی ملکیت ہے؟	RENTED 1 RENT-FREE 2 MORTGAGED 3 OWNED 4 OTHERS 6	
109	Main source of Energy for Cooking آپ کا گھرانہ کھانا پکانے کے لیے زیادہ تر کون سا ایندھن استعمال کرتا ہے؟	WOOD 11 ELECTRICITY 12 CYLINDER GAS 13 KEROSENE 14 STRAW/SHRUBS/GASS 16 COW DUNG 16 OTHERS (Specify) 96	
110	What type of salt are you sing for cooking? آپ کھانے میں کون سا نمک استعمال کرتے ہیں؟	ROCK SALT 1 IODIZED SALT 2 NON-IODIZED REFINED SALT 3 OTHER (Specify) 6	
111	Does any member of this household own any land that can be used for agriculture? کیا گھرانے کے کسی فرد کے پاس ایسی کوئی زمین ہے جسے وہ زراعت کے لیے استعمال کرتا ہو؟	Yes 1 No 2	→113
112	Please tell the total cultivated land (in Kanals) کتنی زمین پر کاشت ہوتی ہے؟	LAND [ ][ ][ ]	
113	How many of the following animals does this household own? اس گھرانے کے پاس مندرجہ ذیل جانوروں میں سے کتنے ہیں؟ Bulls بیل Cows گائے Donkeys or mules or horses اونٹ Goats بکریاں Sheep بھیڑیں Chickens مرغیاں IF NONE, WIRT '00'. IF>95, WRITE '95' IF UNKNOWN, WRITE '98'	Bulls [ ][ ] Cows [ ][ ] Donkeys or mules or horses [ ][ ] Goats [ ][ ] Sheep [ ][ ] Chickens [ ][ ]	

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114	HOUSING STRUCTURE **(RECORD OBSERVATION)** مکان کی ساخت	KATCHA 1 SEMI-PACCA 2 PACCA 3 FLAT 4 CONSTRUCTED HOUSEH/ BUNGALOW 5	

		OTHER (Specify)	6
115	MAIN MATERIAL OF THE ROOF **(RECORD OBSERVATION)** چھت کا خاص میٹریل کیا ہے؟	**NATURAL ROOFING** THATCH/BAMBOO/WOOD/MUD **RUDMINTARY ROOFING** CARDBOARD/PLASTIC **FINISHED ROOFING** IRON SHEETS/ABSESTOS T-IRON/WOOD/BRICK REINFORCED BRICK CHEMENT/ RCC............ OTHER (Specify)	1 2 3 4 5 6
116	MAIN MATERIAL OF THE WALLS **(RECORD OBSERVATION)** دیواروں کا خاص میٹریل کیا ہے؟	**NATURAL WALLS** MUD/STONES BAMBOO/ STICKS/ MUD **RUDMINTARY WALLS** UNBAKED BRICKS/ MUD PLYWOOD SHEETS **FINISHED WALLS** STONE BLOCKS BAKED BRICKS CEMENT BLOCKS/ CEMENT TENT/ CLOTH OTHER (Specify)	 01 02 03 04 05 06 07 08 96

		YES	NO	DK
117	Questions to be asked from Head of the Household یہ سوالات گھر کے سربراہ سے پوچھیں؟			
	Do you support that every village should have arrangements for کیا آپ اس حق میں ہیں کہ اس گاؤں میں ایسے انتظامات ہوں جیسے	1	2	8
	a- Funds for hiring transport for taking pregnant women to a health facility گاؤں کے لوگ پیسے جمع کریں جو حاملہ خاتون کو ہسپتال لے جانے میں خرچ ہوں			
	b- Identification of Female doctor (Gynecologist) گاؤں کے لوگ کسی ماہر خاتون ڈاکٹر کاپتہ کریں	1	2	8
	c- Listing Blood donors خون دینے والوں کی پہچان کریں تا کہ ضرورت پڑنے پر مریض کو خون دیا جاسکے	1	2	8

8

		Imp	Not Imp.	No Opinion
118	Do you think it is important for the health of mother and child کیا آپ ماں اور بچے کی صحت کے لیے ان چیزوں کو اہمیت دیتے ہیں یا اہمیت نہیں دیتے؟			
	a To space birth for more than 2 years دو بچوں کے پیدائش کے درمیان دو سال سے زائد وقفہ ہونا چاہیے	1	2	3
	b To seek antenatal care from health حاملہ ماں کو ڈاکٹر یا صحت کے کسی	1	2	3

	professional	عملے سے چیک کرنا چاہیے			
c	To deliver at a health facility	بچے کی پیدائش ہسپتال میں کروائی جائے	1	2	3
d	To seek potential care from health professional	پیدائش کے بعد ماں کا ڈاکٹر یا صحت کے کسی عملے سے چیک اپ کروانا چاہیے	1	2	3
e	To Check-up neonat by a health professional	بچے کی پیدائش کے بعد ڈاکٹر یا صحت کے عملے سے چیک اپ کروانا چاہیے	1	2	3

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Appendix 3: End line CCSP Women questionnaire

End line Household survey

District Chitral

(ESC-2013)

Women Questionnaire

August 19, 2013

SEDCO Associates

Islamabad

ESC 2013

ENDLINE SURVEY IN DISTRICT CHITRAL (ESC) - 2013

EVER-MARRIED WOMAN'S QUESTIONNAIRE

IDENTIFICATION	
TEHSIL (CHITRAL=1; DROSH=2; LOTKOH=3; MASTUJ=4; MULKOH=5; TORKOH=6)	.... [ ]
CLUSTER NUMBER	.... [ ][ ]
HOUSEHOLD NUMBER	.... [ ][ ]
NAME OF HOUSEHOLD HEAD ________________	
NAME AND LINE NUMBER OF WOMAN ________________	.... [ ][ ]

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	________	________	________	DAY [ ][ ] MONTH [ ][ ] YEAR [2][0][1][3]
INTERVIEWER'S NAME	________	________	________	INT. NUMBER [ ][ ]
RESULT*	________	________	________	RESULT * [ ]
NEXT VISIT: DATE TIME	________ ________	________ ________		TOTAL NUMBER OF VISITS [ ]

*RESULT CODES:
1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 INCAPACITATED
7 OTHER ________ (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME ________ DATE ________ [ ][ ]	NAME ________ DATE ________ [ ][ ]	[ ][ ]	[ ][ ]

تعارف اور رائے   السلام علیم!

میرا نام ________ ہے، اور میں (SEDCO, ISLAMABAD)میں کام کرتی ہوں. ہم صحت کے مختلف مسائل سے متعلق چترال ایریا میں سروے کررہے ہیں. اگر آپ اس سروے میں شریک ہو کر ہماری مدد کریں گے تو ہم آپ کے بڑے شکرگزار ہوں گے. اس سروے میں ہم خاص طور پر آپ کی اور بچوں کی صحت کے بارے میں چند سوالات پوچھیں گے. ہم آپ کو یقین دلاتے ہیں کہ آپ کے جوابات صیغہ راز میں رہیں گے. اس سروے میں آپ کی شرکت کلی طور پر رضاکارانہ ہے. اگر آپ کسی سوال کا جواب نہیں دینا چاہتے تو آپ مجھے بتا دیں، میں آپ سے اگلا سوال پوچھ لوں گی. آپ یہ انٹرویو کسی وقت بھی ختم کرسکتی ہیں لیکن ہم امید کرتے ہیں کہ آپ اس سروے میں شریک ہوں گی کیونکہ آپ کےخیالات اس وقت ہمارے لیے بڑی اہمیت رکھتے ہیں. اب کیا آپ اس سروے کے بارے میں مجھ سے کچھ پوچھنا پسند کریں گی؟ کیا میں اب آپ کا انٹرویو لینا شروع کروں؟

Signature of interviewer: ________________ Date: ________________

RESPONDENT AGREES TO BE INTERVIEWED 1
RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .... 2 → END

SECTION 1. RESPONDENT'S INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	**RECORD THE TIME.**	HOUR ... ..[ ][ ] ....MINUTES ......[ ][ ]	
102	In what month and year were you born? آپ کس مہینے اور سال میں پیدا ہوئیں؟	MONTH ....[ ][ ] DON'T KNOW MONTH .... 98 ....YEAR [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
103	آپ کی عمر کیا ہے؟ How old are you? **COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT**	AGE IN COMPLETED YEARS [ ][ ]	
104	What is your current marital status? Are you married, God forbid Widowed, divorced, or separated? آپ کی موجودہ ازدواجی حیثیت کیا ہے؟ کیا آپ شادی شدہ، خدانخواستہ بیوہ، طلاق یافتہ یا آپ کی علیحدگی تو نہیں ہوچکی ہے؟	MARRIED .... 1 WIDOWED .... 2 DIVORCED .... 3 SEPARATED 4	→
105	Were you related to your husband before marriage? If yes, what was the relation? کیا آپ اور آپ کے شوہر کے درمیان خون کا کوئی رشتہ ہے/تھا؟ اور وہ کیا رشتہ ہے/تھا	NOT RELATED .... 1 FIRST COUSIN ON FATHER'S SIDE . 2 FIRST COUSIN ON MOTHER'S SIDE . 3 SECOND COUSIN .... 4 OTHER RELATIONSHIP.	
106	What was your age at first marriage? پہلی شادی کے وقت آپ کی عمر کیا تھی؟	AGE ....[ ][ ]	→
107	Have you ever attended school? کیا آپ نے کبھی سکول میں پڑھا ہے؟	YES.................. .... 1 NO 2	111
108	What is the highest class you passed? آپ نے آخری کون سی جماعت پاس کی ہے؟ **WRITE '00' IF LESS THAN CLASS ONE;** **WRITE '16' = IF MA, MPHIL, PHD, MBBS, BSC/4YEARS**	CLASS ....[ ][ ]	
109	**CHECK 109:** CLASS 00 – 08 [ ] ↓ CLASS 09 OR HIGHER [ ] →		112
110	How old is/was your husband? آپ کے شوہر کی کتنی عمر ہے/تھی؟	AGE IN COMPLETED YEARS [ ][ ]	
111	Did your husband ever attend school? کیا آپ کے (پچھلے) شوہر نے کبھی سکول میں تعلیم حاصل کی	YES.................. .... 1 NO 2	→ 116

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
112	What was the highest class he passed? انہوں نے آخری کون سی جماعت پاس کی تھی؟ **WRITE '00' IF LESS THAN CLASS ONE;** **WRITE '16' = IF MA,MPHIL,PHD, MBBS, BSC(4 YEARS)**	CLASS .... ☐☐ DON'T KNOW 98	
113	**CHECK 114 :** CLASS 00 - 08 ☐ ↓ CLASS 09 OR HIGHER ☐ →		**117**
114	Now I would like to ask about all the births you have had during your life. Have you ever given live birth? Please tell their number اب میں ان تمام بچوں کے بارے میں پوچھنا چاہوں گی جن کو آپ نے اپنی تمام زندگی میں جنم دیا۔ کیا آپ نے کبھی کسی زندہ بچے	Number of live births	→
115	Do you have any sons or daughters to whom you have given birth who are now living with you? آپ کے بیٹے یا بیٹیوں میں سے کوئی اس وقت آپ کے ساتھ رہ رہا / رہی ہے؟	YES .... 1. NO .... 2.	**120** →
116	آپ کے ساتھ کتنے بیٹے رہتے ہیں How many sons live with you? And how many daughters live with you? **IF NONE, RECORD '00'.** آپ کے ساتھ کتنی بیٹیاں رہتی ہیں	SONS AT HOME ☐☐ DAUGHTERSATHOME ☐☐	
117	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you? کیا آپ کے ایسے کوئی بیٹے اور بیٹیاں ہیں جن کو اور وہ حیات بھی ہوں لیکن آپ کے ساتھ نہ رہتے ہوں؟	YES .... 1. NO .... 2.	 → 119
118	کتنے بیٹے حیات ہیں جو آپ کے ساتھ نہیں رہتے؟ How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? کتنی بیٹیاں حیات ہیں جو آپ کے ساتھ نہیں رہتیں؟ **IF NONE, RECORD '00'.**	SONS ELSEWHERE ☐☐ DAUGHTERS ELSEWHERE ☐☐	
119	Have you ever given birth to a boy or girl who was born alive but later died? کیا آپ نے کبھی ایسے لڑکے یا لڑکی کو جنم دیا ہے جو زندہ پیدا ہو/ہوئی لیکن بعد میں فوت ہوگیا /ہوگئی ہو **IF NO, PROBE:** Any baby who cried or showed signs of life but did not survive? کیا کوئی ایسا بچہ/بچی جو پیدا ہونے کے بعد رویا/روئی ہو یا زندگی کی کوئی علامت ظاہر کی ہو لیکن زندہ نہ بچ سکا/سکی ہو؟	YES .... 1. NO .... 2.	 → 122

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
120	How many boys have died? آپ کے کتنے لڑکے فوت ہوئے؟ And how many girls have died? اور کتنی لڑکیاں فوت ہوئیں؟ **IF NONE, RECORD '00'.**	BOYS DEAD .... ☐☐ GIRLS DEAD .... ☐☐	
121	SUM ANSWERS TO 116, 118, 120 **ENTER TOTAL. IF NONE, RECORD '00'.**	TOTAL .... ☐☐	
122	Are/were any of your children suffering mental or physical disability at birth? کیا آپ کی اولاد میں سے کوئی خدانخواستہ پیدائشی طور پر ذہنی یا جسمانی معذور ہے یا تھا؟	YES .... 1 NO 2	

SECTION 2. DANGER SIGNS DURING AND AFTER PREGNANCY

NO.	QUESTIONS AND FILTERS		CODING CATEGORIES			SKIP
201	What illnesses or symptoms can be dangerous during Pregnancy?	اب میں آپ سے حمل سے متعلق کچھ سوالات کروں گی۔ حمل کے دوران کون سی بیماریاں یا علامات خطرناک ہوسکتی ہیں؟	Spontaneous	Prompted,Yes	No	
	a Severe Vomiting	بہت زیادہ قے آنا	1	2	3	
	b Shortness of Breath	سانس لینے میں دشواری	1	2	3	
	c Pallor, Weakness and Fatigue	پیلاہٹ، کمزوری اور تھکاوٹ	1	2	3	
	d Severe Headache	سرمیں شدید درد	1	2	3	
	e Blurring of Vision	نظر دھند لانا	1	2	3	
	f Swelling Over Ankles	ٹخنوں پر سوجن	1	2	3	
	g Swelling Over Face	چہرے پر سوجن	1	2	3	
	h Severe Lower Abdominal Pain	جسم کے نچلے حصے میں شدید درد	1	2	3	
	i Spotting (Minimal Vaginal Bleeding)	خون کے دھبے لگنا	1	2	3	
	j Frank Vaginal Bleeding	نیچے سے بہت زیادہ خون آنا	1	2	3	
	k Jaundice	پیلا یرقان	1	2	3	
	l High Fever With or Without Rigors	سردی یا بغیر سردی لگے تیز بخار ہونا	1	2	3	
	m Diagnosed High Blood Pressure	تشخیص شدہ بلڈ پریشر	1	2	3	
	n Fits or Convulsions	دورے یا جھٹکے لگنا	1	2	3	
	o Unconsciousness	بیہوشی / غشی آنا	1	2	3	
	p Anemia	خون کی کمی	1	2	3	
	q Burning Urine	پیشاب جلنا	1	2	3	
	r Other ____________ (SPECIFY)	اس کے علاوہ کوئی علامت	1	2	3	
202	What problems or complications could be dangerous on the day of delivery/abortion (before delivery/abortion, during Delivery/abortion or immediately afterwards)?	زچگی کے دن کون سے مسائل یا پیچیدگیاں خطرناک ہوسکتی ہیں (زچگی سے پہلے، زچگی کے دوران یا اس کے فوراً بعد)؟	Spontaneous	Prompted, Yes	No	
	a Prolonged Labor	زچگی کا لمبا دورانیہ	1	2	3	
	b Obstructed Labor	آڑھا/ٹیڑھا بچہ ہونا	1	2	3	
	c Bleeding Before Labor Began	دردزہ سے پہلے خون آنا	1	2	3	
	d. Excruciating Abnormal Pain	بہت زیادہ ٹیسیں مارنے والا درد	1	2	3	
	e Premature Rupture of Membranes	وقت سے پہلے پانی کی تھیلی کا پھٹنا	1	2	3	
	f Delay in Delivery of Placenta	آنول کا دیر سے آنا	1	2	3	
	g Retained Placenta	آنول کا ٹکڑا اندر رہ جانا	1	2	3	
	h Excessively Abnormal Postpartum Bleeding on Day of Delivery/Abortion	زچگی کے دن پیدائش کے بعد بہت زیادہ خون آنا	1	2	3	
	i Tear in Vagina	اندام نہانی کا پھٹ جانا	1	2	3	
	j Tear in Cervix or Uterus	بچہ دانی کا پھٹ جانا	1	2	3	
	k Prolapse of the Uterus	بچہ دانی باہر آنا	1	2	3	
	l Malposition of Fetus	بچہ الٹا ہونا	1	2	3	
	m Other ____________ (SPECIFY)	دیگر (تحریرکریں)	1	2	3	

NO.	QUESTIONS AND FILTERS		CODING CATEGORIES		
203	Do you know during postpartum period, for which danger signs, it is necessary to seek medical advice/treatment? کیا آپ جانتی ہیں کہ چھلے میں کن خطرناک علامات کے لیے طبی مشورہ یا علاج ضروری ہیں؟		Spontaneous	Prompted, Yes	No
	a Excessive Vaginal Bleeding	بہت دنوں تک بہت زیادہ خون آنا	1	2	3
	b Fits Or Convulsions	جھٹکے لگنا/دورے پڑنا	1	2	3
	c Unconsciousness	بیہوشی یا غشی	1	2	3
	d Prolapsed Uterus	بچہ دانی کا نیچے آنا	1	2	3
	e Offensive (Foul) Discharge From Vagina	بدبودار پانی کا اخراج	1	2	3
	fHigh Fever With Or Without Rigors	سردی یا بغیر سردی تیز بخار	1	2	3
	g Lower Abdominal Pain	جسم کے نچلے حصے میں درد	1	2	3
	h Extreme Weakness, Pallor And Fatigue	بہت زیادہ کمزوری، پیلاہٹ اور اکتاہٹ	1	2	3
	i Anxiety, Nervousness Or Depression	سخت بیچینی اور گھبراہٹ	1	2	3
	j Difficulty, Pain Or Burning While Passing Urine	پیشاب جلنا یا تکلیف سے ہونا	1	2	3
	k Kidney Pain	گردوں کا درد	1	2	3
	l Leaking Of Urine From Vagina	پیشاب رسنا	1	2	3
	m Other ____________ (SPECIFY)	دیگر(تحریر کریں)	1	2	3
204	Do you know soon after birth, for which danger signs in newborns, it is necessary to seek medical advice/treatment? کیا آپ جانتی ہیں کہ بچے کی پیدائش کے فوراً بعد نوزائیدہ بچے میں کون سی خطرناک علامات کے لیے طبی مشورہ یا علاج ضروری ہوتا ہے		Spontaneous	Prompted, Yes	No
	a Baby won't cry/weak cry	بچے کا نہ رونا	1	2	3
	b Difficult breathing	سانس لینے میں دشواری	1	2	3
	c Difficult fast breathing	تیز تیز دشواری سے سانس لینا	1	2	3
	d Yellow skin color (Jaundice)	پیلا یرقان	1	2	3
	e Blue skin color	جسم نیلا پڑ جانا	1	2	3
	f Baby is very cold/shivering (hypothermia)	سردی سے کپکپانا	1	2	3
	g Unable to suck/poor sucking	ماں کا دودھ نہ پی سکنا	1	2	3
	h Skin lesion (or blisters)	جسم پردانے یا خراش	1	2	3
	i Fits/Abnormal/Jerky movement	جھٹکے لگنا، دورے پڑنا	1	2	3
	j Red swollen eyes	آنکھیں سوج کر سرخ ہوجانا	1	2	3
	k Fever/High fever with or without rigors	سردی یا سردی کے بغیر تیز بخار	1	2	3
	Others (specify)	دیگر (تحریرکریں)	1	2	3

NO.	QUESTIONS AND FILTERS		CODING CATEGORIES			SKIP
205	Do you know within 7 days after birth, for which danger signs in newborn, it is necessary to seek medical advice/treatment? کیا آپ جانتی ہیں کہ نوزائیدہ بچے کے پہلے 7 دنوں میں کن خطرناک علامات کے لیے طبی مشورہ یا علاج ضروری ہوتا ہے؟		Spontaneous	Prompted, Yes	No	
	a Difficult fast breathing	تیز تیز دشواری سے سانس لینا	1	2	3	
	b Yellow Skin color (Jaundice)	پیلا یرقان	1	2	3	
	c Blue skin color	جسم نیلا پڑ جانا	1	2	3	
	d Baby is very cold/shivering (hypothermia)	سردی سے کپکپانا	1	2	3	
	e Unable to suck/poor suck	ماں کا دودھ نہ پی سکنا	1	2	3	
	f Skin lesion (or blisters)	جسم پر دانے یا خراش	1	2	3	
	g Fits/Abnormal/Jerky movement	جھٹکے لگنا، دورے پڑنا	1	2	3	
	h Red swollen eyes with discharge	سرخ سوجی ہوئی آنکھیں جن سے پانی نکلے	1	2	3	
	i Failure to pass urine/stool	پیشاب/پاخانہ نہ کرسکنا	1	2	3	
	j Frequent watery stools/stools with blood or mucus	پانی جیسے پاخانہ جس میں خون جھاگ ہو	1	2	3	
	k Rigidity	جسم کا سخت ہونا	1	2	3	
	l High fever with or without rigors	سردی یا بغیر سردی تیز بخار	1	2	3	
	m Others (specify)	دیگر (تحریرکریں)	1	2	3	

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SECTION 3. PREGNANCY, LABOUR/DELIVERY AND POSTNATAL CARE

MATERNAL AND NEW BORN CARE

No.	Question	Coding categories
301	What is the name, sex, date of birth of your youngest child that you gave birth to and that is still alive? آپ کے آخری زندہ بچے کا نام جنس اور تاریخ پیداش کیا ہے؟	YOUNGEST CHILD NAME ____________ SEX MALE..............1 FEMALE...........2 DATE OF BIRTH DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐
302	When you were pregnant with (NAME), did you see anyone for antenatal care? جب آپ (نام) کی امید سے تھیں، تو کیا آپ نے کسی سے معائنہ کروایا تھا؟	YES .... 1 NO .... 2 (SKIP TO 310) DON'T KNOW 8
303	Whom did you see for ANC for this pregnancy? آپ اس حمل کے دوران چیک اپ کے لیے کس کے پاس گئی تھیں Anyone else? کسی اور کے پاس بھی گئی تھیں؟ **PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.**	**HEALTH PERSON** DOCTOR........ A NURSE/LHV .... B CMW...... C **OTHER PERSON** DAI-TBA...... D LADY H. WORKER E FWC......... F AKHS G OTHER X (SPECIFY)
304	Did you receive ANC Card for this pregnancy? کیا آپ کے پاس حمل کے معائنہ کا کارڈ ہے؟	YES .... 1 NO .... 2 DON'T KNOW 8
305	Where did you receive antenatal care for this pregnancy? آپ نے اپنے حمل کے دوران چیک اپ کہاں کروایا تھا؟ Anywhere else? کسی اور جگہ سے بھی چیک اپ کروایا تھا **FOR ANY HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE.** ____________ (NAME OF PLACE(S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**HOME** YOUR HOME .... A OTHER HOME .... B **PUBLIC SECTOR** GOVT. HOSPITAL.. C RHC/MCH ...... D BHU .... E FWC. .... F OTHER PUBLIC G (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC . H AKHSP .... I CMW.............. J OTHER PRIVATEMED. X **(SPECIFY)**

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________
306	The <u>first time</u> you went for antenatal care did you go For a pregnancy related problem or did you go just for a check-up? جب آپ پہلی بار اپنے حمل کا چیک اپ کروانے گئی تھیں تو کیا آپ کو زچگی سے متعلق کوئی مسئلہ پیش تھا یا پھر آپ صرف اپنا چیک اپ کرانے گئی تھی؟	FOR pregnancy PROBLEM ..... 1 FOR CHECK-UP ONLY 2
307	How many months pregnant were you when you first received antenatal care for <u>this</u> pregnancy? جب آپ نے اپنے اس حمل کا چیک اپ کروایا تھا تو اس وقت آپ کو کتنے ماہ کا حمل تھا؟	MONTHS . . . [ ][ ] DON'T KNOW 98
308	How many times did you receive antenatal care during this pregnancy? اس حمل کے دوران آپ نے کتنی بار اپنا چیک اپ کروایا تھا؟	NUMBER OF TIMES .. [ ][ ] DON'T KNOW 98
309	As part of your antenatal care during this pregnancy, were any of the following measures taken اس حمل کے دوران آپ کے چیک اپ کے وقت **IF YES:** Were you weighed? کیا آپ کا وزن کیا گیا تھا؟ (کتنی مرتبہ) Was your blood pressure measured? کیا آپکا بلڈ پریشر دیکھا گیا تھا؟ (کتنی مرتبہ) Did you get a urine test? کیا آپ نے پیشاب کا ٹیسٹ کروایا تھا؟ (کتنی مرتبہ) Did you get a blood test? کیا آپ نے خون کا ٹیسٹ کروایا تھا؟ (کتنی مرتبہ Did you have an ultrasound exam? کیا آپ نے اپنا الٹراساؤنڈ کروایا تھا؟ (کتنی مرتبہ)	**NO YES TIMES** WEIGHT ... 2 1 [ ][ ] B.PRESSURE 2 1 [ ][ ] URINE ..... 2 1 [ ][ ] BLOOD ... 2 1 [ ][ ] U/S EXAM 2 1 [ ][ ] **(SKIP TO 311)**
310	Why didn't you see anyone for an antenatal check-up? آپ اپنے حمل کا چیک اپ کروانے کے لیے کسی کے پاس کیوں نہیں گئی تھیں؟ ضروری نہیں تھا/کوئی مسئلہ نہیں خرچہ بہت زیادہ تھا بہت زیادہ دور تھا کوئی سواری نہیں تھی ساتھ جانے والا کوئی نہیں تھا سروس اچھی نہیں تھی جانے کے لیے وقت نہیں تھا معلوم نہیں تھا کہ کہاں جانا ہے کسی مرد ڈاکٹر کو دکھانا نہیں چاہتی تھی بہت زیادہ انتظار کرنا پڑتا تھا جوانے کی جازت نہیں تھی دیگر (تحریرکریں) **CIRCLE CODES ALL MENTIONED.**	NOT NECESSARY/ NO PROBLEM....... A COSTS TOO MUCH .... B TOO FAR........ C NO TRANSPORT .... D NO ONE TO GO WITH ..... E SERVICE NOT GOOD..... F NO TIME TO GO .... G DID NOT KNOW WHERE TO GO ..... H DID NOT WANT TO SEE A MALE DOCTOR ..... I LONG WAITING TIME.... J NOT ALLOWED TOGO. . . . K OTHER ________ X
311	Do you know your blood group? کیا آپ کو اپنا بلڈ گروپ معلوم ہے؟	YES . . . . 1 NO 2
312	When you were pregnant with (NAME), did anyone talk to you about how to have a safe delivery? I mean things like using a safe delivery kit or a clean blade to cut the baby's cord or asking the person who helps you to wash their hands? جب آپ (نام۔۔۔۔) سے حاملہ تھیں تو کسی نے آپ کو یہ مشورہ دیا تھا کہ کس طرح محفوظ زچگی ہوسکتی ہے، جیسے زچگی کے لیے صاف کٹ کا استعمال یا ناڑو کاٹنے کے لیے صاف بلیڈ کا استعمال یا زچگی کروانے والی خاتون کو ہاتھ دھونے کا کہنا؟	YES . . . . 1 NO . . . . 2 DON'T KNOW 8

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NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________
313	During your pregnancy with (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is convulsions after birth? جب آپ (نام ـــــ) کی امید سے تھیں تو آپ نے بازویا کولہے میں ایسا انجکشن لگایا تھا جس سے بچہ پیدائش کے بعد جھٹکوں کی بیماری سے محفوظ رہتا ہے	YES . . . . 1 NO . . . . 2 (SKIP TO 317) DON'T KNOW 8
314	While pregnant with (NAME), how many times did you receive such an injection? ایسا انجکشن اس حمل کے دوران کتنی مرتبہ لگایا تھا؟	TIMES . . . . [ ] DON'T KNOW 8
315	Did you receive any tetanus toxoid injection at any time before that pregnancy, including during a previous pregnancy or between pregnancies? جھٹکوں سے محفوظ رکھنے والا انجیکشن کیا اس حمل سے پہلے بھی لگوایا تھا؟ **IF YES:** پچھلے حمل کے دوران یا دونوں حملوں کے درمیانی عرصہ میں If Yes, how many years ago?	YES . . . . .1 NO . . . . 2 YEARS AGO . . . . [ ][ ]
316	Before the pregnancy with (NAME), how many times did you receive a tetanus injection? آخری حمل سے پہلے آپ نے جھٹکوں سے محفوظ رکھنے والے انجکشن کتنی مرتبہ لگوائے تھے؟	ONE. . . . . 1 TWO.. . . . . 2 THREE OR MORE . . . 3 DON'T KNOW 8
317	During this pregnancy, were you given or did you buy any iron tablets or iron syrup? اس حمل کے دوران کیا آپ کو فولاد کی گولیاں یا شربت دیا گیا تھا یا آپ نے انہیں خود خریدا تھا **SHOW TABLETS/SYRUP.**	YES . . . . 1 NO . . . . 2 (SKIP TO 319) DON'T KNOW 8
318	During the whole pregnancy, for how many days did you take the tablets or syrup? حمل کے تمام عرصہ کے دوران آپ نے کتنے دن گولیاں یا شربت استعمال کیا تھا؟ **IF ANSWER NOT NUMERIC, ASK FOR APPROXIMATE NUMBER.**	DAYS .. [ ][ ][ ] DIDN'T TAKE . . . 997 DON'T KNOW . . . 998
319	During this pregnancy, were you given or did you buy calcium tablets? اس حمل کے دوران کیا آپ کو کیلشیم کی گولیاں دی گئیں یا آپ نے انہیں خریدا تھا؟	YES . . . . 1 NO . . . . 2→ 31 (SKIP TO 321) DON'T KNOW 8
320	During the whole pregnancy for how many days did you buy the calcium tablets? حمل کے تمام عرصہ کے دوران آپ نے کتنے دن گولیوں کا استعمال کیا تھا؟	DAYS .. [ ][ ][ ] DIDN'T TAKE . . . 997 DON'T KNOW . . . 998

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NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________________
321	Where did you give birth to (NAME)? (نام ــــ) کہاں پیدا ہوا تھا/ہوئی تھی؟ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** ________________ (NAME OF PLACE	**HOME** YOUR HOME ... 11 OTHER HOME .... 12 **PUBLIC SECTOR** GOVT. HOSPITA .. 13 RHC/MCH ...... 14 BHU .... 15 FWC .... 16 OTHER PUBLIC 17 (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC ... 18 AKHSP .... 19 CMW .... 20 OTHER PRIVATEMED. 96 **(SPECIFY)**
322	Who assisted with the delivery of (NAME)? (نام ــــ) کی پیدائش میں کس نے مدد کی تھی اس کے علاوہ کوئی اور تھا Anyone else? **PROBE FOR THE TYPE OF PERSON AND RECORD ALL MENTIONED.** **IF RESPONDENT SAYS NO ONE ASSISTED, ASK IF ANY ADULTS WERE PRESENT AT THE DELIVERY.**	**HEALTH PERSON** DOCTOR .... A NURSE/LHV .... B MIDWIFE. ..... C **OTHER PERSON** DAI-TBA. ..... D LADY H. WORKER E FWW .... F CMW .... G OTHER X (SPECIFY)
323	Was the child weighed at the time of birth? کیا پیدائش کے وقت بچے کا وزن کیا گیا تھا؟	YES .... 1 NO .... 2 **(SKIP TO 325)** ←
324	What was his/her weight? بچے کا وزن کتنا تھا؟ 1. **In Kilograms** 2. **In Pounds**	1 [ ] [ ][ ] 2
325	When (NAME) was born, was he/she very large, larger than average, average, smaller than average, or very small? جب (نامـــــ) پیدا ہوا/ہوئی تو کیا یہ بہت بڑا تھا/تھی، اوسط سے بڑا تھا/تھی، اوسط درجے کا تھا/تھی، اوسط سے چھوٹا تھا/تھی یا بہت چھوٹا تھا/تھی؟	VERY LARGE ...... 1 LARGER THAN AVERAGE ...... 2 AVERAGE .... 3 SMALLER THAN AVERAGE ...... 4 VERY SMALL ...... 5 DON'T KNOW 8
326	In total, how much did you pay for the delivery? آپ نے آخری زچگی کے لیے کتنی رقم ادا کی ؟ **RECORD '00000' IF NOTHING PAID**	**In Rs.** [ ][ ][ ][ ][ ]
327	**CHECK 321:** CHILD BORN AT HEALTH FACILITY [ ] ↓ CHILD BORN AT HOME [ ] →	332
328	Before you were discharged after (NAME) was born, did any health personnel check on your health? (نامـــــ) کی پیدائش کے بعد اور ہسپتال سے چھٹی سے پہلے کیا صحت کے کسی عملہ نے آپ کا چیک اپ کیا تھا	YES .... 1 NO .... 2 **(SKIP TO 331)** ←

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________
329	How many hours, days or weeks after delivery did the first check take place? زچگی کےکتنے گھنٹے، دن یا ہفتے بعد آپ کا پہلا چیک اپ ہوا تھا؟ **IF LESS THAN ONE DAY, RECORD HOURS.** **IF LESS THAN ONE WEEK, RECORD DAYS.** **IF MORE THAN ONE WEEK, RECORD WEEKS.**	HOURS 1 [ ][ ] DAYS 2 [ ][ ] WEEKS 3 [ ][ ] DON'T KNOW . . . 998
330	Who checked on your health at that time? اُس وقت آپ کی صحت کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR . . . . 11 NURSE/LHV 12 MIDWIFE. . . . . 13 **OTHER PERSON** DAI- TBA . . . . 14 LADY H.WORKER 15 FWW . . . . 16 OTHER 96 (SPECIFY)
331	After you were discharged, did you go again to any health care provider or a trained birth attendant to check on your health? ہسپتال سے ڈسچارج ہونے کے بعد کیا آپ نے دوبارہ طبی عملے یا تربیت یافتہ دائی سے چیک اپ کروایا، اگر ہاں تو ڈسچارج ہونے کے کتنے دن بعد کروایا؟ IF yes: After how many days:	YES . . . . 1 DAYS.... [ ][ ] **(SKIP TO 338)** NO . . . . 2 **(SKIP TO 340)**
332	Why didn't you deliver in a health facility? آپ نےکسی ہسپتال یا کلینک وغیرہ میں بچے کو جنم کیوں نہیں دیا؟ خرچہ بہت زیادہ ہے سہولت میسر نہیں بہت دور ہے/سواری کا انتظام نہیں تھا سہولت /ناقص معیار کی خدمت کوئی عورت سہولت مہیا کرنے والی نہیں خاوند/خاندان والوں کی اجازت نہیں تھی ضرورت نہیں تھی روایت نہیں ہے جانے کا وقت نہیں ملا / بے بی کی پیدائش بہت جلدی ہوگئی کوئی اور وجہ (تحریرکریں؟ **PROBE:** Any other reason? **RECORD ALL MENTIONED.**	COST TOO MUCH . . A FACILITY NOT OPEN......... B TOO FAR/ NO TRANS-PORTATION...... C DON'T TRUST FACILITY/POOR QUALITY SERVICE D NO FEMALE PROVID-ER AT FACILITY . . E HUSBAND/FAMILY DID NOT ALLOW . . F NOT NECESSARY . . G NOT CUSTOMARY . . H NO TIME/ BABY CAME TOO FAST . . I OTHER(SPECIFY) X
333	What was used to TIE the umbilical cord? ناڑ (نال) باندھنے کےلیے کیا چیز استعمال کی گئی؟	UNBOILED THREAD . . 1 BOILED THREAD . . . . 2 WASHED CLAMPS .... 3 UNWASHED CLAMPS 4 HAIR . . . . 5 OTHER ________ 6
334	What was used to CUT the umbilical cord? ناڑ (نال) کاٹنے کے لیے کیاچیز استعمال کی گئی؟	NEW RAZOR BLADE 1 OLD RAZOR BLADE 2 SCISSORS . . . . 3 KNIFE . . . . 4 TOKA, CHOPPER . . . . 5 OTHER__________ 6

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ______________
335	Was the instrument boiled before using or not boiled? اس اوزار کو استعمال سے پہلے اُبالا گیا تھا یا نہیں اُبالا گیا تھا؟	BOILED .... 1 NOT BOILED ...... 2 DON'T KNOW 8
336	After (NAME) was born, did any health care provider or a traditional birth attendant check on your health? (نام۔۔) کی پیدائش کے بعد کیا کسی طبی عملے یا روایتی دائی نے آپ کی صحت کا چیک اپ کیا تھا؟	YES .... 1 NO .... 2 (SKIP TO 340)
337	How many hours, days or weeks after delivery did the first check take place? زچگی سے کتنے گھنٹے، دن یا ہفتوں بعد آپ کا پہلا چیک اپ ہوا تھا؟ **IF LESS THAN 1 DAY, RECORD HOURS. IF LESS THAN 1 WEEK, RECORD DAYS; IF ONE WEEK OR MORE, RECORD WEEKS.**	HOURS .. 1 [ ][ ] DAYS ... 2 [ ][ ] WEEKS .. 3 [ ][ ] DON'T KNOW ... 998
338	Who checked on your health at that time? اس وقت آپ کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR .... 11 CMW .... 12 NURSE/LHV ..... 13 **OTHER PERSON** DAI- TBA .... 14 LADY H.WORKER 15 FWW .... 16 CMW 17 OTHER 96 (SPECIFY)
339	Where did this first check take place? سب سے پہلے چیک اپ کہاں ہوا تھا؟ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** ______________ (NAME OF PLACES)	**HOME** YOUR HOME .... A OTHER HOME .... B **PUBLIC SECTOR** GOVT. HOSPITA .. C RHC/MCH ...... D BHU .... E FWC .... F CMW G OTHER PUBLIC H (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC .. I AKHSP .... J CMW Home .... K OTHER PRIVATEMED. X **(SPECIFY)**
340	In the two months after (NAME) was born, did any health care provider check-up the child? (نام۔۔) کی پیدائش کے دو مہینے تک کیا صحت کے عطے میں سے کسی نے بچہ/بچی کی صحت کا چیک اپ کیا تھا؟	YES .... 1 NO .... 2 (SKIP TO 344) DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________________
341	How many hours, days or weeks after the birth of (NAME) did the first check take place? کتنے گھنٹے، دن یا ہفتے بعد (نام۔۔۔) کا پہلا چیک اپ ہوا تھا **IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS. IF ONE WEEK OR MORE, RECORD WEEKS.**	HOUR .. 1 DAYS .. 2 WEEK .. 3 DON'T KNOW ... 998
342	Who checked on (NAME)'s health at that time? اس وقت (نام۔۔۔) کی صحت کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR .... 11 CMW .... 12 NURSE/LHV ..... 13 **OTHER PERSON** DAI- TBA .... 14 LADY H.WORKER 15 FWW.......... 16 HAKIM .... 17 CMW .... 18 OTHER 96 (SPECIFY)
343	Where did this first check-up of (NAME) take place? (نام۔۔۔) کا سب سے پہلا چیک اپ کہاں ہوا تھا؟ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** ________________ (NAME OF PLACE)	**HOME** YOUR HOME.... A OTHER HOME .... B **PUBLIC SECTOR**GOVT. HOSPITAL.. C RHC/MCH ...... D BHU.......... E FWC.......... F OTHER PUBLIC G (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC ... H AKHSP........ I CMW .... J OTHER PRIVATEMED. X **(SPECIFY)**
344	What precautions did you take immediately after the birth of last child? بچے کی پیدائش کے فوراً بعد آپ نے کون سی احتیاطی تدابیر اختیار کیں؟	Y N DK
	نوزائیدہ کی لخشک تھی a NEW BORN'S BODY DRIED.	1 2 8
	ماں کے ساتھ جلد سے جلد رابطہ کریں b SKIN-TO-SKIN CONTACT WITH MOTHER	1 2 8
	PUT ANTISEPTIC ON THE CORD c PUT ANTISEPTIC ON THE CORD	1 2 8
	کپڑے میں لپیٹا d WRAPPED IN CLOTH	1 2 8
	آنکھیں صاف کیں e CLEANED EYES	1 2 8
	UTEROTONIC دیا f RECEIVED UTEROTONIC.......	1 2 8
	یوٹرن مساج کیا g UTERINE MASSAGE	1 2 8
	کارڈ ٹریکشن h CORD TRACTION	1 2 8
	دیگر (تحریرکریں) i OTHERS ________________ .... SPECIFY	1 2 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________
345	Now I will talk to you about the preparation that you had made before your last delivery? اب میں آپ سے یہ پوچھنا چاہوں گی کہ زچگی کی تیاری کے لیے آپ نے کون سے اقدامات کئے	
a	Did you know about the location of the nearest hospital? (a hospital which remains open 24 hours and has facilities for pregnant women in case of emergency) کیا آپ جانتی تھی کہ نزدیک ترین ہسپتال کہاں ہے (جہاں حاملہ عورتوں کو دیکھا جاسکے اور وہ 24 گھنٹے کھلا ہو)	YES .... 1 NO 2
b	Had you enquired about the fee of the doctor for delivery services? کیا آپ نے معلوم کیا کہ زچگی کے لیے ڈاکٹر کی فیس کتنی ہے	YES... .... 1. NO... .... 2.
c	Had you arranged transport to that hospital? کیا آپ نے ہسپتال کے لیے پیسوں کا بندوبست کیا تھا؟	YES... .... 1. NO... .... 2.
d	Had you arranged money for the delivery? کیا آپ نے زچگی کے لیے پیسوں کا بندوبست کیا تھا؟	YES... .... 1. NO... .... 2.
e	Had you arranged for money in case for emergency? کیا ایمرجنسی کے لیے رقم کا بندوبست کیا تھا؟	YES... .... 1. NO... .... 2.
f	Had you prepared clothes for the baby? کیا آپ نے بچے کے لیے کپڑے بنوائے تھے؟	YES... .... 1. NO... .... 2.
g	Had you talked to the doctor that you would like her to assist the delivery? کیا آپ نے ڈاکٹر سے طے کیا تھا کہ وہ آپ کی زچگی کروائے؟	YES... .... 1. NO... .... 2.
h	Had you taken consent of the household members that you would like to deliver at hospital? کیا آپ نے گھر والوں سےمشورہ کیا تھا کہ آپ زچگی ہسپتال میں کروانا چاہیں گی	YES... .... 1. NO... .... 2.
i	Blood donor arranged for emergency? کیا آپ نے خون کا بندوبست کیا تھا کہ ضرورت پڑ سکتی ہے؟	YES... .... 1. NO 2
346	In the first two months after delivery, did you receive a vitamin A capsule like this? زچگی کے پہلے دو ماہ میں کیا آپ نے وٹا من اے کے اس طرح کے کیپسول (دوائی لی تھی؟ **SHOW AMPULES/CAPSULE/SYRUP.**	YES .... 1.. NO 2 ....

BREAST FEEDING/INFANT AND YOUNG CHILD FEEDING

347	Did you ever breastfeed (NAME)? کیا (نام۔۔۔) کو آپ نے کبھی اپنا دودھ پلایا؟	YES .... 1.. NO .... 2.. **(SKIP TO 355)** ←
348	How long after birth did you first put (NAME) to the breast? **IF LESS THAN 1 HOUR,** **RECORD '00' HOURS.** **IF LESS THAN 23 HOURS,** **RECORD HOURS.** **OTHERWISE, RECORD DAYS.** (نام۔۔) کی پیدائش کے کتنی دیر بعد آپ نے پہلی بار اُسے اپنا دودھ پلایا تھا؟	IMMEDIATELY ... 000 HOURS 1 [ ][ ] DAYS 2 [ ][ ]

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NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ______________
349	Did you give the (NAME) the thick milk (colostrum) that comes first or did you discard it? کیا آپ نے (نام ـــــ) کو وہ گاڑھا دودھ جو سب سے پہلے نکلتا ہے پلایا تھا یا آپ نے اسے ضائع کر دیا تھا؟	GAVE COLOSTRUM 1 DISCARDED IT .... 2 DO NOT REMEMBER 8
350	In the first three days after delivery, was (NAME) given anything to drink other than breast milk? پیدائش کے بعد پہلے 3 دنوں میں (نام ـــــ) کو ماں کے دودھ کے علاوہ کچھ اور پینے کو دیا تھا؟	YES .... 1 NO .... 2 **(SKIP TO 352)**
351	What was (NAME) given to drink? (نام ـــــ) کو پینے کے لیے کیا دیا تھا؟ Anything else? دودھ (چھاتی کے دودھ کے علاوہ) سادہ پانی شہد یا میٹھا پانی گھی، مکھن پھلوں کا جوس INFANT FORMULA گھٹی سبز قہوہ دیگر (تحریر کریں) **RECORD ALL LIQUIDS MENTIONED.**	MILK (OTHER THAN BREAST MILK) .. A PLAIN WATER .... B HONEY OR SUGAR WATER ... . C GHEE, BUTTER .... D FRUIT JUICE .... E INFANT FORMULA .. F GHUTEE .... G GREEN TEA .... H OTHER X (SPECIFY)
352	Are you still breastfeeding (NAME)? کیا آپ اب بھی (نام ـــــ) کو اپنا دودھ پلا رہی ہیں؟	YES .... 1 **(SKIP TO 354)** NO 2
353	For how many months did you breastfeed (NAME)? آپ نے کتنے مہینے (نام ـــــ) کو اپنا دودھ پلایا تھا؟ **IF LESS THAN ONE MONTH, RECORD '00'**	MONTHS ... [ ][ ] DON'T KNOW ...98

354	Yesterday or last night, did (NAME) drink or eat: پچھلے 24 گھنٹوں میں (نام ـــــ) نے کیا اِن میں سے کوئی چیز پی یا کھائی؟		YES	NO	DK	IF YES TIMES
	a Breast milk?	ماں کا دودھ پیا	1	2	8	☐
	b Baby Infant formula milk?	بچوں کا ڈبے والا دودھ پیا	1	2	8	☐
	c Animal milk?	جانور (بھینس/گائے/بکری) کا دودھ پیا	1	2	8	☐
	d Cheese, yogurt or other milk products?	پنیر، دہی یا دودھ سے بنی دوسری چیزیں	1	2	8	☐
	e Plain water?	سادہ پانی پیا	1	2	8	☐
	f Juice, soda, tea, rice water?	جوس، شربت، چائے، چاول کی پیچ	1	2	8	☐
	g Cerelac?	سیریلیک	1	2	8	☐
	h Mash grain (Rice, wheat, bread)?	نرم کی ہوئی روٹی/چاول	1	2	8	☐
	i Potato, carrots, pumpkin?	اُبلے ہوئے آلو، گاجر، کدو وغیرہ	1	2	8	☐
	j Fresh green vegetables?	تازہ سبزیاں	1	2	8	☐
	k Fresh local fruit?	چترال کے تازہ پھل	1	2	8	☐
	l Egg?	انڈا	1	2	8	☐
	m Meat (fish, cow, etc.)?	گوشت	1	2	8	☐
	n Butter?	مکھن	1	2	8	☐
	o Other foods?	دیگر (تحریر کریں)	1	2	8	☐

NO.	QUESTIONS AND FILTERS				LAST BIRTH NAME ________			
355	Did (NAME) drink anything from a bottle or with nipple yesterday or last night? کیا (نام....) نے کل دن یا پچھلی رات نپل والی بوتل سے کچھ پیا تھا؟				YES .... 1 NO .... 2 DON'T KNOW 8			
356	Who has the final say in your home on the following: you, your husband, both of you or someone else?							
					R	H	B	E
		a WHEN TO HAVE A NEXT CHILD	اگلا بچہ کب ہونا چاہیے		1	2	3	4
	Coding Categories:	b GET ANTENATAL CHECKUP FROM A HEALTH PROFESSIONAL	حمل کے دوران صحت کے عملے سے معائنہ کروایا جائے		1	2	3	4
	Respondent (R) 1							
	Husband (H) 2	c DELIVERY AT HOSPITAL (NORMAL CASE)	زچگی ہسپتال میں ہو (نارمل حالات میں)		1	2	3	4
	Both (B) 3	d DELIVER AT HOSPITAL (IN EMERGENCY)	زچگی ہسپتال میں ہو (ایمرجنسی میں)		1	2	3	4
	Else (E) 4							
		e MAKE NECESSARY PREPARATIONS FOR EMERGRNCIES	ایمرجنسی کے لیے تیاری ہو		1	2	3	4
		f PREPARE CLOTHES FOR THE BABY	آنے والے بچے کے لیے کپڑے بنانا		1	2	3	4
		g GET POSTNATAL CHECKUP FROM A HEALTH PROFESSIONAL	زچگی کے بعد طبی عملے سے		1	2	3	4

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SECTION 4. CHILD VACCINATION, HEALTH AND NUTRITION

	CHILD IMMUNIZATION	
401	Do you have a card where (NAME'S) vaccinations are written down? کیا آپ کے پاس کوئی ایسا کارڈ ہے جس میں (نام ---) کو لگائے گئے حفاظتی ٹیکوں کا اندراج ہو؟ IF YES: May I see it please? کیا میں میں اسے دیکھ سکتی ہوں؟	YES, SEEN .... 1 YES, NOT SEEN .... 2 (SKIP TO 404) NO CARD 3
402	(1) COPY DATE OF BIRTH IF GIVEN. IF NOT ON CARD, LEAVE IT BLANK. (2) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD. (3) WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE IS RECORDED.	

LAST BIRTH	DAY	MONTH	YEAR
BIRTH			
BCG			
POLIO 0 (POLIO GIVEN AT BIRTH)			
POLIO 1			
POLIO 2			
POLIO 3			
DPT 1			
DPT 2			
DPT 3			
HBV 1			
HBV 2			
HBV 3			
MEASLES			

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ______
403	Has (NAME) received any vaccinations that are not recorded on this card including vaccinations received in national immunization day campaign **RECORD 'YES' ONLY IF RESPONDENT MENTIONS BCG, POLIO 0-3, DPT 1-3, HBV 1-3 , OR MEASLES VACCINES.** کیا (نام۔۔۔) کو کوئی ایسا حفاظتی ٹیکہ لگوایا گیا ہے یا قطرے پلائے گئے جس کا اس کارڈ پر اندراج نہیں کیا گیا ہو۔ اس میں حفاظتی ٹیکوں یا قطرے پلانے کی قومی مہم میں لگائے ٹیکے یا قطرے شامل ہیں۔	YES .... 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 402) **(SKIP TO 406)** NO .... 2 **(SKIP TO 406)** DON'T KNOW 8
404	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization campaign? کیا (نام۔۔۔) نے بیماریوں سے بچاؤ کے لیےکبھی کوئی ٹیکہ لگوایا یا قطرے پیئے۔ اس میں حفاظتی ٹیکوں کی قومی مہم میں لگائے گئے ٹیکے یا قطرے بھی شامل ہیں؟	YES .... 1 NO .... 2 **(SKIP TO 407)** DON'T KNOW 8
405	Please tell me if (NAME) received any of the following vaccinations: کیا (نام۔۔۔) نے ان میں سےکوئی ٹیکے لگوائے یا قطرے پیے ہوں تو مہربانی کر کےمجھے	
405A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar? ٹی بی سے بچاؤ کے لیے بی سی جی کا ٹیکہ لگوایا تھا جس سے بازو یا کولہے میں لگوانے سے عام طور پر ایک نشان پڑ جاتا ہے	YES .... 1 NO .... 2 DON'T KNOW 8
405B	Polio vaccine, that is, drops in the mouth? کیا پولیو کی دوا کے قطرے پلائے گئے تھے؟	YES .... 1 NO .... 2 **(SKIP TO 405E)** DON'T KNOW 8
405C	Was the first time polio drops were received in the first 2 weeks after birth or later? کیا پہلی بار پولیو کے قطرے پیدائش کے بعد پہلے دو ہفتوں میں پلائے گئے یا دو ہفتوں کے بعد؟	FIRST 2 WEEKS ..... 1 LATER 2
405D	How many times was the polio vaccine received? پولیو کی دوا کے قطرے کتنی بار پلائے گے تھے؟ **IF 7 OR MORE TIMES RECORD 7**	NUMBER OF TIMES .... ☐
405E	A DPT vaccination, that is, an injection given in the thigh or buttocks,(sometimes at the same time as polio drops)? کیا ڈی پی ٹی کا ٹیکہ لگوایا تھا جو ران یا کولہے میں لگایا جاتا ہے (بعض اوقات اُسی وقت پولیو سے بچاؤ کے قطرے بھی پلادیئے جاتے ہیں)	YES .... 1 NO .... 2 **(SKIP TO 405G)** DON'T KNOW 8
405F	How many times was a DPT vaccination received? ڈی پی ٹی (DPT)کا حفاظتی ٹیکہ کتنی بار لگایا گیا تھا؟	NUMBER OF TIMES .... ☐

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ______________
405G	A hepatitis HBV vaccination, that is an injection given in the thigh or Buttocks, sometimes at the same time as polio drops? کالا یرقان (ہیپاٹائٹس)، ایچ بی وی HBVکے بچاؤ کے لیے کیا ران یا کولہوں میں ٹیکہ لگایا گیا تھا۔ بعض اوقات پولیو سے بچاؤ کے قطرے بھی پلائے جاتے ہیں؟	YES .... 1 NO .... 2 (SKIP TO 405I) ← DON'T KNOW 8
405H	How many times was an HBV vaccination received? ایچ بی وی HBV یعنی کالا یرقان سے بچاؤ کا حفاظتی ٹیکہ کتنی بار لگایا گیا تھا؟	NUMBER OF TIMES ..... [ ]
405 I	An injection to prevent measles? کیا خسرہ سے بچاؤ کے لیے ٹیکہ لگوایا گیا تھا؟	YES .... 1 NO .... 2 DON'T KNOW 8
406	Did (NAME) ever receive a polio vaccine (drops in the mouth) during a national immunization day campaign? کیا (نام ....) نے کبھی پولیو سے بچاؤ کی قومی مہم کے دوران پولیو کی دوا کے قطرے (جو منہ میں ڈالے جاتے ہیں) لیے تھے؟ **IF YES, CHECK 402 OR 405D IS 1 OR MORE.**	YES .... 1 NO 2
407	Has (NAME) ever received a vitamin A dose like this? کیا (نام ....) نے کبھی وٹا من اے کے اس طرح کے کیپسول کھائے ہیں؟ **SHOW VIT.A CAPSULES.**	YES, WITHIN 6-MONTHS ... 1 YES, BEFORE 6-MONTHS ... 2 NO .... 3 AKHS .... 4 DON'T KNOW 8
	CONTROL OF DIARRHEA	
408	Has (NAME) had diarrhea in the last 2 weeks? کیا (نام ....) کو پچھلے 2 ہفتوں میں دست آئے تھے؟	YES .... 1 NO .... 2 (SKIP TO 414) ← DON'T KNOW 8
409	Now I would like to know how much (NAME) was given to drink during the diarrhea. اب میں جاننا چاہوں گی کہ دستوں کے دوران (نام ....) کو پینے کے لیے کتنا کچھ دیا گیا تھا؟ Was he/she given less than usual to drink, about the same amount, or more than usual to drink? کیا (نام ....) کو عام دنوں کے مقابلے میں پینے کے لیے کم دیا گیا تھا، وہی مقدار دی گئی تھی یا عام دنوں سے بھی زیادہ دی گیا تھا؟ **IF LESS, PROBE:** Was he/she given much less than usual to drink or somewhat less? کیا اُسے عام دنوں کے مقابلے میں پینے کے لیے بہت کم دیا گیا تھا یا تھوڑا سا کم دیا گیا تھا؟	MUCH LESS .... 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE .... 4 NOTHING TO DRINK .. 5 DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________________
410	When (NAME) had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? جب (نام ....) کو دست آئے تھے تو کیا اُسے عام دنوں کے مقابلے میں کھانے کے لیے کم دیا گیا تھا، وہی مقدار دی گئی تھی، زیادہ دی گئی تھی یا پھر کھانے کے لیے کچھ بھی نہیں دیا گیا تھا؟ **IF LESS, PROBE:** Was he/she given much less than usual to eat or somewhat less? کیا اُسے عام دنوں کےمقابلے میں کھانے کو بہت کم دیا گیا تھا یا تھوڑا سا کم دیا گیا تھا؟	MUCH LESS .... 1 SOMEWHAT LESS. 2 ABOUT THE SAME. 3 MORE .... 4 STOPPED FOOD. 5 NEVER GAVE FOOD 6 DON'T KNOW 8
411	Did you seek advice or treatment for the diarrhea from any source? کیا آپ نے کسی سے دست کے بارے میں مشورہ لیا تھا یا علام کرایا تھا؟	YES.............. .. 1 NO .... 2 (SKIP TO 413)
412	Where did you seek advice or treatment? آپ نے کہاں سے مشورہ لیا تھا یا علاج کروایا تھا؟ Anywhere else? اس کے علاوہ کسی اور جگہ سے؟ **FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE.** ________________ (NAME OF PLACE-S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**PUBLIC SECTOR** GOVT. HOSPITAL A RHC/MCH .... B OTHER PUBLIC C (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC.. .... D CMW .... E OTHER PRIVATEMED. F (SPECIFY)
413	Was he/she given any of the following to drink at any time since he/she started having the diarrhea: دست شروع ہونے کے بعد کیا کسی وقت (نام ....) کو پینے کے لیے:	**YES NO DK**
413A	A fluid made from a special packet called ORS or Nimkol? ایک خصوصی پیکٹ سے تیار کردہ محلول دیا گیا تھا یعنی نمکول یا ORS؟	FLUID FROM ORS PKT 1 2 8
413B	A drink made at home with sugar, salt and water? چینی، نمک اور پانی سے گھر میں تیار کردہ محلول دیا گیا تھا؟	HOMEMADE FLUID 1 2 8
	ARI/ PNEUMONIA	
414	Has (NAME) been ill with a fever at any time in the last 2 weeks? کیا (نام ....) کو پچھلے 2 ہفتوں میں کسی وقت بخار ہوا تھا؟	YES.............. .. 1 NO .... 2 DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________	
415	Has (NAME) had an illness with a cough at any time in the last 2 weeks? کیا آپ (نام ـــ) کو پچھلے 2 ہفتوں میں کسی وقت کھانسی کے ساتھ طبیعت خراب ہوئی تھی؟	YES................ NO .... (SKIP TO 417A) DON'T KNOW	1 2 8
416	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing? جب (نام ـــــ) کو کھانسی تھی تو کیا وہ عام دنوں کےمقابلے میں تیز تیز سانس لیتا تھا/لیتی تھی	YES................ NO .... (SKIP TO 417A) DON'T KNOW	1 2 8
417	Were these breathing symptoms due to a problem in the chest or to a blocked or runny nose? کیا سانس کی یہ علامات سینے میں تکلیف کی وجہ سے یا ناک کے بند یا بہنے کی وجہ سے ہوئی تھی؟	CHEST ONLY..... NOSE ONLY........ BOTH .... OTHER ________ (SPECIFY) DON'T KNOW	1 2 3 6 8
417a	**CHECK 414 and 415:** IF ANY YES ☐ ↓	NOT A SINGLE YES: ☐ →	420
418	Did you seek advice or treatment for these illnesses from any source? کیا آپ نے کسی سے اس بیماری کے بارے میں مشورہ لیا یا علاج کرایا تھا؟	YES................ NO (SKIP TO 420)	1 2
419	Where did you seek advice or treatment? آپ نے کہاں سے مشورہ لیا یا علاج کرایا تھا؟ Anywhere else? اس کے علاوہ کسی اور جگہ سے؟ FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. ________ (NAME OF PLACE(S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**PUBLIC SECTOR** GOVT. HOSPITAL RHC/MCH .... OTHER PUBLIC (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/CLINIC CMW .... OTHER PRIVATEMED. (SPECIFY)	 A B C D E F
	WATER AND SANITATION		
420	Do you treat water in any way to make it safe for drinking? کیا آپ کسی طریقے سے پینے کے پانی کو محفوظ بناتی ہیں؟ (یعنی پینے کے قابل بناتی ہیں)	.... YES NO................ (SKIP TO 422)	.....1 ...2 → 422

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME ________________	
421	How do you treat the water to make it safer for drinking? آپ پینے کے پانی کو کیسے محفوظ بناتی ہیں؟ **ONLY CHECK MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND CHLORINE.** (آپ پانی کو پینے کے قابل کیسے بناتی ہیں؟)	LET IT STAND ANDSETTLE/ SEDMEMTATION ..... STRAIN IT THROUGH CLOTH... BOIL.................. ADDBLEACH/CHLORINE .... WATER FILTER (CERAMIC, SAND, COMPOSITE) SOLAR DISINFECTION .... OTHER .... DON'T KNOW	 A B C D E F X Z
422	**INTERVIEWER: PLEASE OBSERVE:** **INTERVIEWER SHOULD OBSERVE WHERE THE RESPONDENT DOES WASH HER HANDS** خود مشاہدہ کریں اور دائرہ لگائیں؟	INSIDE/NEAR TOILET FACLITY .. INSIDE/NEAR KITCHEN/COOKING PLACE .... ELSEWHERE IN YARD .... OUT SIDE YARD .... NO SPECIFIC PLACE NO PERMISSION TO SEE	1 2 3 4 5 8
423	OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANSING AGENT? خود مشاہدہ کریں اور دائرہ لگائیں؟ THIS ITEM SHOULD BE EITHER IN PLACE OR BROUGHT BY THE INTERVIEWEE WITHIN ONE MINUTE. IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE CHECK NONE, EVEN IF BROUGHT OUT LATER.	SOAP .... DETERGENT ASH .... MUD/SAND .... NONE	1 2 3 4 5
	ANTHROMETRICS		
424	May I weigh (NAME)? کیا میں (نام ــــ) کا وزن کرسکتی ہوں۔ ہاں نہیں مشین نہیں ہے	YES.................... NO	. 1. 2 → 501
425	Weight of Child بچے کا وزن	IN KILOGRAM ... ☐☐.☐	

SECTION 5. CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. اب میں خاندانی منصوبہ بندی کے بارے میں بات کرنا چاہوں گا۔ یعنی حمل میں تاخیر کرنے یا اس سے بچنے کے مختلف طریقے یا ذرائع جنہیں میاں بیوی Which ways or methods have you heard about? آپ نے کن ذرائع یا طریقوں کے بارے میں سنا ہے؟ **U= UNPROMPT** **P= PROMPT** **N= NO** **ANY OTHER METHOD** **[IF NO KNOWLEDGE SKIP TO Q506]**	U P N PILLS.............. 1 2 3 IUD...................... 1 2 3 INJECTIONS .... 1 2 3 IMPLANTS .... 1 2 3 CONDOM .... 1 2 3 FEMALE STERILIZATION.. 1 2 3 MALE STERILIZATION........ 1 2 3 RHYTHM/PERIODIC ABSTINENCE 1 2 3 WITHDRAWAL........... 1 2 3 OHTERS ________ 1 2 3 (SPECIFY)	
502	Are you currently using any family planning methods? کیا آپ آج کل کوئی طریقہ استعمال کررہی ہے؟	YES........................ 1 NO 2	→504
503	Which method are you using? آپ کون سا طریقہ استعمال کررہی ہیں؟ عورتوں کی نس بندی مردوں کی نس بندی گولیاں آئی یو ڈی انجیکشن ایمپلانٹس کنڈم Rhythm Withdrawal	FEMALE STERILISATION...... 01 MALE STERILISATION........ 02 PILL.......................... 03 IUD .... 04 INJECTABLES.............. 05 IMPLANTS .... 06 CONDOM .... 07 RHYTHM.................. 08 WITHDRAWAL............. 09 OTHER ________ 96 (SPECIFY)	
504	Have you used any family planning methods in the past? کیا آپ نے پہلے کبھی طریقہ استعمال کیا ہے؟	YES.......................... 1 NO 2	
505	Do you know the place from where you can get the methods of family planning? کیا آپ جانتی ہیں کہ خاندانی منصوبہ بندی کے طریقے کہاں سے حاصل کیے جاسکتے ہیں؟	HOSPITAL .... A RHC/BHU/MCH CENTRE .... B FAMILY WELFARE CENTRE..... C AKHSP .... D PRIVATE HOSPITAL CLINIC..... E NGO CENTRE................ F DRUG STORE/SHOP .... G CMW .... H OTHER((SPECIFY) I DON'T KNOW. .... Z	
506	In your opinion, what should be the reasonable spacing between two births? آپ کے خیال میں دو بچوں کے درمیان کتنا وقفہ مناسب ہوگا؟	NUMBER OF MONTHS ☐☐ DON'T KNOW 98	
507	What can be the consequences/risks associated with birth spacing of less than 2-years? بچوں کے درمیان 2 سال سے کم وقفے کے کیا نتائج یا نقصانات ________ ________	☐☐ ☐☐	

SECTION 6. HIV/AIDS AND OTHER HEALTH DISEASES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Now I would like to talk about other diseases. Have you ever heard of an illness called AIDS? کیا آپ نے ایڈز کی بیماری کے بارے میں کبھی کچھ سنا ہے؟	YES . . . . 1 NO 2	 → 603
602	How does HIV/AIDS transmits from one person to another? ایڈز کیسے پھیلتا ہے؟ **PROBE:** Any other ways? **RECORD ALL MENTIONED.** ہوا کے ذریعے: کھانسی یا چھینکے سے ایڈز والے کسی دوسرے شخص کے چھونے سے غذا کے اشتراک سے جنسی روابط سے مچھر کے کاٹنے سے ماں سے اس کے ہونے والے بچے سے	THROUGH THE AIR WHEN COUGHING OR SNEEZING . . . . A BY SHARING UTENSILS . . . . B BY TOUCHING A PERSON WITH AIDS C THROUGH SHARING FOOD . . . . D THROUGH SEXUAL CONTACT E THROUGH MOSQUITO BITES . . . . F THROUGH MOTHER-TO-CHILD . . . . . . G OTHER ____________ X (SPECIFY) DON'T KNOW . . . . Z	
603	Have you ever heard of an illness called tuberculosis or TB? کیا آپ نے تپ دق یا ٹی بی کے بارے میں کبھی سنا ہے؟	YES . . . . 1 NO 2	 → 605
604	How does tuberculosis spread from one person to another? تپ دق ایک شخص سے دوسرے شخص کو کیسے لگتی ہے: **PROBE:** Any other ways? **RECORD ALL MENTIONED.** ہوا کے ذریعے: کھانسی یا چھینکے سے برتنوں کے اشتراک سے ٹی بی والے کسی دوسرے شخص کے چھونے سے غذا کے اشتراک سے جنسی روابط سے مچھر کے کاٹنے سے اس کے علاوہ کسی اور طریقے سے؟	THROUGH THE AIR WHEN COUGHING OR SNEEZING . . . . A BY SHARING UTENSILS . . . . B BY TOUCHING A PERSON WITH TB . C THROUGH SHARING FOOD . . . . D THROUGH SEXUAL CONTACT E THROUGH MOSQUITO BITES . . . . F OTHER ____________ X (SPECIFY) DON'T KNOW . . . . Z	
605	Have you ever heard about Hepatitis (B&C)? کیا آپ نے کالے یرقان کے بارے میں کبھی سنا ہے؟	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	 ┐ ┘→ 607
606	How does Hepatitis spread from one person to another? کالا یرقان کیسے پھیلتا ہے: **PROBE:** Any other ways? **RECORD ALL MENTIONED.** ہوا کے ذریعے: کھانسی یا چھینکے سے برتنوں کے اشتراک سے کالے یرقان والے کسی دوسرے شخص کے چھونے سے غذا کے اشتراک سے جنسی روابط سے مچھر کے کاٹنے سے	THROUGH THE AIR WHEN COUGHING OR SNEEZING . . . . A BY SHARING UTENSILS . . . . B BY TOUCHING A PERSON WITH HEP. C THROUGH SHARING FOOD . . . . D THROUGH SEXUAL CONTACT . . . . . . E THROUGH MOSQUITO BITES . . . . F OTHER ____________ X (SPECIFY) DON'T KNOW . . . . Z	
607	RECORD THE TIME.	HOUR [ ][ ] . . . . MINUTES [ ][ ]	

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: ____________ DATE: ____________

EDITOR'S OBSERVATIONS

NAME OF EDITOR: ____________ DATE: ____________

27 Woman Questionnaire

Appendix4: End line CCSP Community questionnaire

End line Household survey

District Chitral

(ESC-2013)

Community Questionnaire

August 2013

SEDCO Associates

Islamabad

ENDLINE HOUSEHOLD SURVEY, DISTRICT CHITRAL (ESC - 2013)

COMMUNITY QUESTIONNAIRE

IDENTIFICATION	
TEHSIL (CHITRAL=1; DROSH=2; LOTKOH=3; MASTUJ=4; MULKOH=5; TORKOH=6) ________ CLUSTER NUMBER	
INFORMATION ABOUT THE PARTICIPANTS	**DATE / RESULT**
PEOPLE WHO PARTICIPATED TO PROVIDE INFORMATION(WRITE NAME AND POSITION, E.G., VILLAGE LEADER, NAZIM, COUNCILLOR, RELIGIOUS LEADER, CHOWKIDAR, LOCAL FEMALE OR MALE TEACHER, LHV OR LHW) 1 ________ 2 ________ 3 ________ 4 ________ 5 ________ 6 ________ 7 ________ 8 ________	DAY MONTH YEAR 2 0 1 3 INT. NUMBER RESULT *
*RESULT CODES: 1 COMPLETED 2 UNABLE TO FIND SUITABLE RESPONDENTS 9 OTHER ________ (SPECIFY)	

INTERVIEWER/SUPERVISOR	OFFICE EDITOR	KEYED BY
NAME ________ DATE ________		

1. GENERAL DESCRIPTION

NO.	QUESTIONS	CODING CATEGORIES	SKIP
101	How far is the district headquarters from this village? اس گاؤں سے چترال شہر کتنا دور ہے ASK FROM THE CENTER OF THE LARGEST VILLAGE	KILOMETERS .... [ ][ ] 95 KMS. OR MORE 95	
102	Is the road to the district headquarters **mainly** a katcha road or a pukka road? چترال شہر تک سڑک زیادہ تر کچی ہے یا پکی؟	MAINLY KATCHA .... 1 MAINLY PUKKA 2	
103	How far is it from this village to the road that goes to the district headquarters? یہاں سے بڑی سڑک جو چترال شہر جاتی ہے، کتنی دور ہے؟ ASK FROM THE CENTER OF THE LARGEST SAMPLE VILLAGE	LESS THAN 1 KM. .... 00 ....KILOMETERS [ ][ ] 95 KMS. OR MORE 95	
104	How do most people get from this village to the road? یہاں سے بڑی سڑک تک زیادہ تر لوگ کیسے جاتے ہیں؟	WALK .. .. 01 BICYCLE .... 02 MOTORBIK .... 03 PRIVATE CAR / TAXI / SUZUKI VAN TRACTOR TROLLY .... 04 HORSE/DONKEY .... 05 COASTER .... 06 OTHER ________________ 96 (SPECIFY)	
105	If a woman in this village has a serious problem with her pregnancy, where would she go for treatment? اس گاؤں کی کسی خاتون کو حمل سے متعلق کوئی خطرناک مسئلہ ہو تو وہ علاج کے لیے کہاں جاسکتی ہے ________________ (NAME OF PLACE)	DHQ HOSPITAL .... 01 THQ HOSPITAL .... 02 MCH CENTRE .... 03 RHC .. .. 04 BHU ... . 05 AKHS HOSPITAL 06 PRIVATE CLINIC / HOSPITAL . ..... 07 LADY HEALTH WORKER .... 08 DAI/TRADITIONAL BIRTH ATTENDANT................. . 09 CMW 10 OTHER ________________ 96 (SPECIFY)	
106	How long would it take to reach the facility? وہاں (ہسپتال وغیرہ) تک پہنچنے میں کتنا وقت لگے گا؟	MINUTES ....[ ][ ][ ] DON'T KNOW 998	
107	How much would it cost? وہاں تک پہنچنے پر کتنی رقم لگےگی؟	Rs. .... [ ][ ][ ] DON'T KNOW 998	
108	Where do community people usually go for minor ailment? یہاں کے لوگ معمولی بیماری کے علاج کے لیے عام طور پر کہاں جاتے ہیں؟	DHQ HOSPITAL .... 01 THQ HOSPITAL .... 02 MCH CENTRE .... 03 RHC ... . 04 BHU ... . 05 AKHS HOSPITAL .... 06 PRIVATE CLINIC / HOSPITAL . ..... 07 LADY HEALTH WORKER .... 08 DAI/TRADITIONAL BIRTH ATTENDANT................. . 09 CMW...10 .OTHER ________________ 96 (SPECIFY)	

2. AVAILABILITY OF FACILITIES AND SERVICES

Now I would like to ask you about facilities and other services that may be in this village or at some distance.

	Type of facility/service کیا یہاں پر یہ سہولیات موجود ہیں؟ اگر نہیں تو یہاں سے کتنی دور ہیں؟ (ہر ایک کے بارے میں پوچھیں)	201 Is the (FACILITY / SERVICE) available in this village? کیا اس گاؤں میں یہ سہولیات موجود ہیں؟	202 How far away is (FACILITY/ SERVICE) from this village? **IF DK, WRITE 98.** **IF >95 KMS, WRITE 95.** یہ سہولیات اس گاؤں سے کتنی دور ہیں؟
a.	Medical store?	YES . 1 NO 2→	KMS. ....
b.	General store or shop?	YES . 1 NO 2→	KMS. ....
c.	Public/Private transport?	YES . 1 NO 2→	KMS. ....
d.	Post office?	YES . 1 NO 2→	KMS. ....
e.	Bank?	YES . 1 NO 2→	KMS. ....
f.	Primary school for **boys**?	YES . 1 NO 2→	KMS. ....
g.	Primary school for **girls**?	YES . 1 NO 2→	KMS. ....
h.	Secondary school for **boys**?	YES . 1 NO 2→	KMS. ....
i.	Secondary school for **girls**?	YES . 1 NO 2→	KMS. ....
j	Any ambulance service?	YES . 1 NO 2→	KMS. ....
k.	Television service?	YES . 1 NO 2	
l	Radio services	YES . 1 NO 2	
m	Cable television connection	YES . 1 NO 2	
n	Land-line telephone service?	YES . 1 NO 2	
o	Wireless Telephone Services?	YES . 1 NO 2	
p	Mobile telephone coverage?	YES . 1 NO 2	
q	Any public call office (PCO)?	YES . 1 NO 2	

3. AVAILABILITY OF HEALTH FACILITIES

NO.	QUESTIONS	CODING CATEGORIES	SKIP
301	Please tell me how far away each of the following facilities are from here? یہ سہولیات یہاں سے کتنی دور ہیں؟ **ASK FROM THE CENTER OF THE (LARGEST) VILLAGE**	**IF WITHIN VILLAGE OR LESS THAN 1 KM PUT 00 IF 95 KMS. OR MORE PUT 95 IF DK, WRITE 98**	
	a. Dai?	KILOMETERS ☐☐	
	b. **Functioning*** Basic Health Unit (BHU)?	KILOMETERS ☐☐	
	c. Rural Health Center (RHC)?	KILOMETERS ☐☐	
	d. Government dispensary.	KILOMETERS ☐☐	
	e. **Functioning*** Maternal and Child Health Centre.	KILOMETERS ☐☐	
	f. Private male doctor.	KILOMETERS ☐☐	
	g. Private female doctor	KILOMETERS ☐☐	
	h. Dispenser or a compounder.	KILOMETERS ☐☐	
	i Family Welfare Center (FWC)	KILOMETERS ☐☐	
	j. Lady Health Worker	KILOMETERS ☐☐	
	k. Community Midwife (CMW)	KILOMETERS ☐☐	
	l. Trained Birth Attendant (TBA)	KILOMETERS ☐☐	
	m. Hakeem or Homeopath.	KILOMETERS ☐☐	
	n. Tehsil HQ hospital.	KILOMETERS ☐☐	
	o. District HQ hospital	KILOMETERS ☐☐	
	p. Traditional healer	KILOMETERS ☐☐	
	q. Laboratory services (for blood test, urine test etc.)	KILOMETERS ☐☐	

* **Functioning**facility: Presence of Doctor/ LHV to provide required services on regular basis.

Annex VII. Training Matrix

Year	Training	Duration	Participants	Total participants		
				Male	Female	Total
2009	• Classroom training for CMWs	12 months	CMWs	0	28	28
2010	• Practical Training at referral facilities for CMWs	6 months	CMWs	0	28	28
2011	• Internship training at First Level Health Care facilities of AKHS,P	6 months	CMWs	0	28	28
	• Training on BCC and Social Mobilization	4 days	CMWs	0	28	28
	• Additional training	1 month	CMWs	0	28	28
	• Training on BCC & Social Mobilization	2 days	TBAs	0	42	42
	• Training on BCC & Social Mobilization for Change agents	2 days	Member VHCs ,religious leaders and activists	85	59	144
	• Training on BCC & Social Mobilization	2 days	Community Health workers (CHWs)	16	0	16
	• Refresher Training	11 days	CMWs	0	28	28
2012	• Training on BCC & Social Mobilization	5 days	Male motivators, Members of VHCs and CMWs	22	28	50
	• Training on BCC & Social Mobilization	1 day	Women volunteers	0	279	279
	• Training on BCC & Social Mobilization	5 days	CBSG supervisors	0	20	20
	• Refresher Training	11 days	Refresher training	0	28	28
2013	• Training on BCC & social mobilization	5 days	Lady Health Supervisors (LHS)	0	20	20
	• Training on BCC & Social Mobilization	3 days	Lady Health Workers (LHWs)	0	63	63
	• Refresher Training	11 days	CMWs	0	28	28
Total				**123**	**735**	**858**

ANNEX VIII. EVALUATION SCOPE OF WORK

Scope of Work for the Evaluation Team Leader:

Review project documents and resources to understand the project
Refine the evaluation objectives and key questions based on the CSHGP guidelines in coordination with the AKFP team and its partners
Develop the field evaluation schedule and assessment tools
Train enumerators and team members on objective and process of the evaluation including evaluation tools
Lead the team to complete the collection, analysis, and synthesis of supplemental information regarding the program performance
Analyze and interpret project HMIS data to draw lessons and conclusion
Analyze and Inter qualitative data and draw conclusions, lessons learned, and recommendations regarding project outcome
Lead an in-country debriefing meeting with key stakeholders, with a PowerPoint slideshow deliverable, no longer than 20 slides (with USAID/Washington, DC, participation remotely)
Prepare draft report in line with the CSHGP guidelines and submit to CSHGP and AKFP simultaneously on November 14th
Prepare and submit the final report, which is due at the USAID CSHGP GH/HIDN/NUT office on or before December 1, 2013.

***Note: Technical Support Consultant**
The FE Team Leader will coordinate with and receive support from another external consultant who will also support this process. The Technical Support Consultant will dedicate 10 days of his/her time and provide technical support and guidance for the development of the field assessment evaluation tools, questionnaires, and strategies, as well as provide editing, review, and revision support for the development of the final reports and in –country briefing presentation to AKF and USAID. The chart below outlines the specific tasks of each consultant, and clarifies areas of coordination.

Tasks and coordination between FE Team Leader Consultant and Technical Support Consultant

FE Team Leader	Technical Support Consultant
1) Development of field evaluation assessment tools:	
Provide input to the Technical Support Consultant for the development of the field evaluation assessment tools. *Finalize (translate, fine tune) the field evaluation assessment tools to ensure field ready* *Train enumerators and team members on evaluation tools*	• *In consultation with the FE Team Leader, design the field evaluation assessment tools* • *Provide technical guidance to the FE Team Leader for use and management of the assessment tools*
2) Collection of data from field sites in Chitral	
• *FE Team Leader will be responsible for the collection of all data from field sites in Chitral using the assessment tools.*	• *Technical Support Consultant will be available via skype to help answer any questions that may arise during the collection of data from field sites in Chitral.*
3) FE report and presentation to USAID	
• *Develop first draft of final report to share with*	• *Review, edit, and provide feedback to FE Team*

FE Team Leader	Technical Support Consultant
AKF and USAID according to timeline • *Develop Power Point presentation for the in-country briefing with USAID and other stakeholders* • *Using feedback from AKF and USAID complete and submit Final Evaluation Report to USAID and AKF.*	*Leader on the first draft of the final report; including review of presented data and interpretation, review and where necessary and appropriate revision of content, and identifying gaps to improve product.* • *Support and provide guidance to the FE Team Leader for the development of the in-country briefing presentation to USAID and AKF.* • *Support the FE Team Leader to incorporate feedback from the first draft of the final report, and revise to produce the final product.*

Composition of Evaluation Team:

The Evaluation Team Leader for the FE will conduct a participatory assessment of the program with support from a FE Team. The FE Team will include local external support personnel contracted to support this exercise, as well as support where appropriate from relevant AKDN staff and representatives from other partner organizations. In addition, the FE Team Leader will coordinate and work closely with an External Technical Advisor, based from the USA, who as an independent consultant will provide support for the development of qualitative data collection tools, methods, and strategies on the front end of the evaluation, and provide technical review, editing, and revisions for finalizing the report on the back end of the evaluation. The FE Team Leader will also have access to an independent consultant who developed the final report on the CBSG component of the project, as well as the consultant who finalized the OR for the CMW component.

Proposed Timeline:

Activity	Number of days	Dates
Document review, development of tools, and meeting/orientation with AKFP team in Islamabad, finalize travel and methodologies	5 days	October 28-November 1
Travel to project site	1 day	November 2
Field visit for site observation and qualitative data collection	7 days	November 3 – 9
Travel back to Islamabad	1 day	November 10
Preparation for analysis workshop	2 days	November 11-12
Analysis workshop with project team	2 days	November 13-14
Produce first draft of report in coordination with external consultant review	6 days	Nov. 15-20
Power point presentation to AKF team - morning, and USAID Islamabad – afternoon and submit first draft to AKF and USAID	1 day	Nov. 21
After feedback from USAID and AKFP finalize and submit final report	5 days	TBD
Total	**30 days**	

Final Evaluation Report

The FE report should follow the outline in USAID CSHGP's Guidelines for Final Evaluations. A draft and final report, written by the final evaluator, must be submitted directly to the CSHGP. Draft and final reports should be submitted according to the submission instructions as indicated in the guidelines.

ANNEX IX. EVALUATION METHODS AND LIMITATIONS

Final Evaluation Methods and Limitations

FE Approach and Design

The final evaluation approach consisted of a participatory mixed-methods approach using both quantitative and qualitative data. It was quasi-experimental design comprised both a desk review of secondary data sources and the collection of qualitative data to complement existing data. Upon signing of a formal contract, an inception meeting was held between the consultant and key representatives of AKF/AKHS (P). This opportunity was used to identify further key areas for investigation during field activities. Based on the information gathered and scope agreed upon, finalized methodology and work plan was mutually agreed to carry out the task.

Design and FE Questions

Review of literature and documents

The project documents and relevant studies carried out during the project life were reviewed and collated information guided to design data collection tools and instruments. The following documents were reviewed and utilized to synthesize FE report:

- Three phases of Operational Researches on CMWs,
- Work plans, and other relevant documents recommended by AKF team
- CCSP end line survey
- CCSP baseline report
- Midterm Evaluation Report
- CBSG final report
- RAF Research report
- CCSP final annual report
- Project Detailed Implementation Plan (DIP).
- Results Framework and CSHGP proposal
- CCSP M&E reports and tables

The study objectives were achieved by answering key questions and sub-questions set specifically in the **'Evaluation Design Matrix (EDM).** The types of questions identified were normative, descriptive and cause & effect and meant to capture information on various dimensions of program performance. Based on the TORs, following final evaluation key and sub-questions were identified and agreed with AKF focal staff.

1 To what extent did the project accomplish and/or contribute to the results (goals and objectives) stated in the DIP?
   a. Did the CCSP structure and functions (interventions) relevant to achieve project results?
   b. Are the beneficiaries satisfied by quality of healthcare services?
   c. What is the contribution of project interventions in terms of service delivery and utilization performance?

2 Do CBSGs reduce the economic barriers to health care?
   d. Does membership in a CBSG impact health care seeking behavior, especially use of CMW services?
   e. Does CBSG increased community KPC, access and utilization of health care services?

3 What are the key factors for sustainable CMW uptake within the MOH and community (VHC, LHW, TBA) health care provider's structures and referrals, etc?
   f. Did the CCSP strategies and interventions influence the uptake of the CMW services?
   g. What were the factors (social contexts, challenges, facilitators) that impacted?
   h. What are the lessons learned around gender equity and gender outcomes that facilitate program success – male involvement, women empowerment?

Qualitative Data Collection Methods:
A variety of qualitative methodologies were used for final evaluation of CCSP including field observations, informal discussions with stakeholders in terms of performance on key result indicators, availability of resources, knowledge of service providers, equipment and supplies, accessibility and coverage, management and organization of service delivery. This part of the study was essentially based on secondary data review, M&E reports, project progress reports and previous research studies and surveys carried out during various stages of CCSP implementation. Furthermore, in-depth inquiry through key informants was another key component of methodology and therefore information was collected mainly through in-depth interviews with the government health authorities both at district and provincial levels, AKDN staff at project and country office level. Finally, focus group discussions were carried out with community level service providers, beneficiaries and other relevant stakeholders under various thematic areas. The study team specifically explored replicability and sustainability of CCSP CMW model. Finally lesson learned were explored and recommended for future use by decision-makers. Thus, primary qualitative data collection was carried out as follow:

At Community Level: Five Focus Group Discussions (FGDs) were carried out separately with Project deployed CMWs (1), Other community health workers like LHWs, LHSs, LHVs (1), and male (1) and female beneficiaries (1), and Community Based Saving Group (CBSG) members (1) respectively. The FGDs were specifically designed to further explore bottlenecks and constraints in continuation of community based services delivery by CMWs and acceptability and satisfaction of communities with the services.

At District Level: Semi-structured interviews with key informants, i.e. District Health Officer (DHO), District LHW Program Coordinator, MNCH PMU focal person and Medical Superintendent (MS) of secondary hospital were carried out. The questionnaire was specifically developed to focus on in-depth inquiry in which the program services operated, how useful the program interventions were in meeting the needs of the communities. It will also look into strengths and weaknesses of the program to cater to the needs of the communities.

Furthermore, AKHS (P) General Manager, CCSP Coordinator, M&E Manager, CMW field monitors and AKRSP (P) focal staff were also interviewed to learn project progress on results, issues and gaps in implementation and coordination facilitation among government and AKDN internal partnership experience.

At Provincial level: Director General Health Services (DGHS), Executive Director Health Sector Reforms and Research Unit (HSRRU), Provincial Coordinators of LHW and MNCH Programs were interviewed to capture their views in terms of CCSP services, effectiveness of coordination mechanisms and sustainability of CCSP CMW model.

At AKF Country level: the study team also interviewed Chief Executive Officer AKF, Director Health and Built Environment, Program Manager, and Senior Program Officer to learn how successful were

CCSP strategies and interventions, coordination efforts, strengths and weaknesses in terms of sustainability of CCSP CMW model.

Limitations

The project communities were already over researched due to various studies carried out during project life, and therefore limiting further in-depth research for primary data collection from communities except FGDs. The Evaluator could not able to interview with district and provincial MNCH Program focal persons due to their frequent transfers and unavailability. The weather conditions and long distances in District Chitral hampered access to non-traditional communities. Furthermore, government deployed CMWs could not managed to gather for FGD at CCSP arranged venue.

Ethical Considerations

Evaluator made clear to all participating stakeholders that they would be under no obligation to participate in the evaluation study and assured their anonymity and confidentiality. Informed consent from the participants was obtained. In case of language barrier during FGDs in Chitral communities, an interpreter/s. was engaged to assist evaluator. Furthermore, evaluator received prior permission for taking photographs for evaluation report and presentations.

Data Analysis

The information collected from key informants was compiled and tabulated using MS Office software for each question, and inputs were organized by themes and dimensions of program intervention. Important quotes and observations were identified and used to build the analysis. Data emerging from interviews was validated internally through triangulation with information from documentary, routine, and other sources gathered prior to and during the fieldwork. The interpretations of triangulated thematic data were discussed with AKF district and country office teams for further modification and amendment. Information was synthesized by creating matrices around identified themes, and findings organized. The output of in-depth inquiry was integrated with secondary information for presentation in the report.

ANNEX X. DATA COLLECTION INSTRUMENTS

Semi-structured questionnaires for Key informants

Key Informant: AKF, AKHSP and AKRSP Managers

Reason for Interview: Learn overall impact, effectiveness, sustainability and replicability of CCSP Model in terms of service delivery and utilization by the target communities. Learn what the key bottlenecks, are and lesson learned in terms of implementation, coordination and collaboration for way forward

Instructions for the Interviewer:

Before the interview:

Make an appointment with the AKDN Managers through CCSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

a) Felicitate the AKDN Managers and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the AKDN Managers to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.

b) Ask the questions one by one and note down the replies clearly. If the AKDN Managers seem not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.

c) Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the AKDN Managers that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: AKF, AKHSP and AKRSP Managers

I CCSP Strategies, Interventions and Results:

1. *How do you rate success and progress of CCSP (in terms of overall goal, objectives, outputs, outcomes and impact)*

a. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity?*

b. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*

c. *In your opinion, can CMWs play an important role in reducing maternal morbidity and mortality?*

2. *What has been the community's response in terms of satisfaction, acceptability, utilization, CBSG membership, VHCs etc*

2. *Impact, Effectiveness, Sustainability and Replicability of CCSP Model*

6 *What are your views on CCSP CMW model?*

a. *What are strengths and weaknesses of CCSP model?*

b. *Do you recommend CCSP model to replicate in other districts of KPK and Pakistan?*

c. *What are various challenges linked with such replication? How can these be minimized/ addressed?*

3. *Coordination and Collaboration among Stakeholders*

Coordination and Collaboration within AKDN

3. *How has been the experience of working as AKDN for the project*

a. *AKF in TA/ M&E role,*

b. *AKHSP in Service delivery, and*

c. *AKRSP in community mobilization role*

Coordination and Collaboration with Govt. Stakeholders

d. *How has been the coordination with EDO (H), District MNCH & LHW Coordinators, DHMT*

e. *How has been the support from DoH KPK*

f. *How instrumental has been the advisory committee of CCSP*

2. *Monitoring and Supervision*

CMW Monitoring and Supportive supervision

4. *Do you have regular supervision of CMWs?*

a. *Who is directly responsible for Administrative and Technical monitoring of CMWs?*

b. *How often are CMWs supervised?*

c. *Do you allocate resources for CMW monitoring? Are the resources sufficient?*

d. *Do you get feedback on CMW's administrative and technical monitoring from her respective monitors*

e. *Do you collect data from the CMW on numbers of antenatal contacts, deliveries attended and referrals made? Is the data compiled and how do you use it? Can you show me the numbers?*

Semi-structured questionnaires for Key informants

Key Informants: District Coordinators LHW and MNCH Programs Chitral

Reason for Interview: Learn overall MNCH services management responsibilities of District Coordinators. Learn how monitoring information is used in making management decisions and performance measurement. Learn how District Coordinators ensure coordination mechanisms among various service providers and role of CCSP in provision of MNCH services at community level.

Instructions for the Interviewer:

Before the interview:

Make an appointment with the District Coordinators through CCSP/AKHSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

a. Felicitate the District Coordinators and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the District Coordinators to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.
b. Ask the questions one by one and note down the replies clearly. If the District Coordinators seem not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.
c. Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the District Coordinators that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: District Coordinator LHW and MNCH Programs Chitral

I Community Based MNCH Services Management:

Coordination of MNCH Services

5. *How do you ensure coordination of your Program with other Program Service Providers in organizing MNCH healthcare services in the district?*
    a. *How do you ensure coordination of LHW/ (MNCH) Program and other private MNCH service providers in your district? e.g. CCSP, Nutrition program, AKHSP?*

b. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*

c. *In your opinion, can CMWs play an important role in reducing maternal morbidity and mortality?*

Emergency Referral/Transportation of Maternity

6. *Does your district health system have an operational referral system in place for complicated maternity referral from primary and community based service outlets? Is it effective?*

   a. *Does LHW/CMW coordinate to manage referral cases?*

   b. *Do you get feedback on outcome of maternal referral cases from your program staff? If so, what is the source of information?*

   c. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity? Probe for community based transportation mechanisms!*

District Health Performance Review

7. *Do you have a District Health Management Team? If so, who are its members?*

   a. *Do you have local level Health Committee? If so, what is its role in health services management?*

8. *Do you conduct district performance review of your program services? If so, where do you get the data? How often? Monthly or quarterly?*

   a. *Do you make strategies or plans to address performance gaps?*

   b. *How do you measure community satisfaction in terms of service delivery, and quality of care?*

2. Monitoring and Supervision

CMW Monitoring and Supportive supervision

9. *Do you have regular supervision of outreach staff, especially CMWs?*

   a. *Who is directly responsible for Administrative and Technical monitoring of CMWs?*

   b. *Do you have resources for CMW monitoring?*

   c. *Do you get feedback on CMW's administrative and technical monitoring from her respective monitors*

   d. *Do you collect data from the CMW on numbers of antenatal contacts, deliveries attended and referrals made? Is the data compiled and how do you use it? Can you show me the numbers?*

3. Sustainability and Replicability of CCSP Model

6 *What are your views on CCSP CMW model?*

   d. *What are strengths and weaknesses of CCSP model?*

   e. *Do you recommend CCSP model to replicate in other districts of KPK and Pakistan?*

   f. *What are various challenges linked with such replication? How can these be minimized?*

Semi-structured questionnaires for Key informants

Key Informant: DGHS

Reason for Interview: Learn overall MNCH services management responsibilities of DGHS. Learn how monitoring information is used in making management decisions and performance measurement. Learn how DGHS ensure coordination mechanisms among various service providers and role of CCSP in provision of MNCH services at community level.

Instructions for the Interviewer:

Before the interview:

Make an appointment with the *DGHS* through CCSP/AKHSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

d) Felicitate the *DGHS* and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the *DGHS* to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.

e) Ask the questions one by one and note down the replies clearly. If the *DGHS* seems not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.

f) Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the *DGHS* that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: DGHS

1 MNCH Services Management:

Coordination of MNCH Services

10. *How do you ensure coordination among various National Program Service Providers in organizing MNCH healthcare services in your province?*
    a. *How do you see the role of AKHSP/CCSP in district Chitral in improving MNCH outcomes?*
    b. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*
    c. *Can CMW initiative of NMNCH Program play important role in reducing maternal morbidity and mortality?*

Emergency Referral/Transportation of Maternity

11. *Does your provincial health system have an operational referral system in place for complicated maternity referral from primary and community based service outlets? Is it effective?*
    a. *Do you have enough resources to manage referral cases? Probe for transportation mechanisms!*
    b. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity?*

Health Performance Review

12. *Do you conduct provincial performance review? If so, where do you get the data? How often? Monthly or quarterly?*
    a. *Do you make strategies or plans to address performance gaps?*
    b. *How do you measure community satisfaction in terms of service delivery, and quality of care?*

2. Monitoring and Supervision

CMW Monitoring and Supportive supervision

13. *Do you know monitoring system for CMWs?*
    a. *Who is directly responsible for Administrative and Technical monitoring of CMWs?*
    b. *Do you get feedback on CMW's administrative and technical monitoring from districts?*

3. Sustainability and Replicability of CCSP Model

6 What are your views on CCSP CMW model?
   g. *What are strengths and weaknesses of CCSP model?*
   h. *Do you recommend CCSP model to replicate in other districts of KPK and Pakistan?*

i. *What are various challenges linked with such replication? How can these be minimized?*

Semi-structured questionnaires for Key informants

Key Informant: District Health Officer Chitral (DHO)

Reason for Interview: Learn overall MNCH services management responsibilities of EDOH. Learn how monitoring information is used in making management decisions and performance measurement. Learn how EDOH ensure coordination mechanisms among various service providers and role of CCSP in provision of MNCH services at community level.

Instructions for the Interviewer:

Before the interview:

Make an appointment with the DHO through CCSP/AKHSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

g) Felicitate the DHO and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the DHO to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.

h) Ask the questions one by one and note down the replies clearly. If the DHO seems not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.

i) Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the DHO that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: DHO Chitral

1 MNCH Services Management:

Coordination of MNCH Services

14. *How do you ensure coordination among various National Program Service Providers in organizing MNCH healthcare services in your district?*
    a. *How do you work with AKHSP and other private MNCH service providers in your district? e.g. CCSP, Nutrition programs, CCSP, AKHSP?*
    b. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*
    c. *In your opinion, can CMWs play an important role in reducing maternal morbidity and mortality?*

Emergency Referral/Transportation of Maternity

15. *Does your district health system have an operational referral system in place for complicated maternity referral from primary and community based service outlets? Is it effective?*
    a. *Do you have enough resources to manage referral cases? Probe for transportation mechanisms!*
    b. *Do you get feedback on outcome of maternal referral cases from your healthcare outlets? If so, what is the source of information?*
    c. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity?*

District Health Performance Review

16. *Do you have a District Health Management Team? If so, who are its members?*
    a. *Do you have local level Health Committee? If so, what is its role in health services management?*
17. *Do you conduct district performance review? If so, where do you get the data? How often? Monthly or quarterly?*
    a. *Do you make strategies or plans to address performance gaps?*
    b. *How do you measure community satisfaction in terms of service delivery, and quality of care?*

2. Monitoring and Supervision

CMW Monitoring and Supportive supervision

18. *Do you have regular supervision of outreach staff, especially CMWs?*
    a. *Who is directly responsible for Administrative and Technical monitoring of CMWs?*

b. How often are CMWs supervised? Other outreach staff?

c. Do you allocate resources for CMW monitoring? Are the resources sufficient?

d. Do you get feedback on CMW's administrative and technical monitoring from her respective monitors

e. Do you collect data from the CMWs on numbers of antenatal contacts, deliveries attended, and/or referrals made? How is this data used?

3. Sustainability and Replicability of CCSP Model

a. What are your views on CCSP CMW model?

b. What are strengths and weaknesses of CCSP CMW model?

c. Do you recommend CCSP CMW model to replicate in other districts of KPK and Pakistan?

d. What are various challenges linked with such replication? How can these be minimized?

e. Semi-structured questionnaires for Key informants

Key Informant: Medical Superintendent DHQ Hospital Chitral

Reason for Interview: Learn overall MNCH services management responsibilities of Medical Superintendent (MS) of secondary hospital. Learn how Secondary hospital MS ensure coordination mechanisms among various service providers and role of CCSP in provision of MNCH services at community level.

Instructions for the Interviewer:

Before the interview:

Make an appointment with the *Secondary hospital* through CCSP/AKHSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

j) Felicitate the hospital MS and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the hospital MS to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.

k) Ask the questions one by one and note down the replies clearly. If the *Secondary hospital* seems not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.

l) Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the hospital MS that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: MS Hospital Chitral

1 MNCH Services Management:

Coordination of MNCH Services

19. *How do you ensure coordination among various National Program Service Providers in organizing MNCH healthcare services in your district?*
    a. *How do you work with AKHSP and other private MNCH service providers in your district? e.g. CCSP, AKHSP?*
    b. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*
    c. *In your opinion, can CMWs play an important role in reducing maternal morbidity and mortality?*

Emergency Referral/Transportation of Maternity

20. *Does your hospital have an operational referral system in place for complicated maternity referral from primary and community based service outlets? Is it effective?*
    a. *Do you have enough resources to manage referral cases? Probe for transportation mechanisms!*
    b. *Do you get feedback on outcome of maternal referral cases from your hospital service providers? If so, what is the source of information?*
    c. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity?*

District Health Performance Review

21. *Do you have a District Health Management Team? If so, who are its members?*
    a. *Do you regularly participate in performance review meetings?*
22. *Do you conduct hospital performance review? If so, where do you get the data? How often? Monthly or quarterly?*
    a. *Do you make strategies or plans to address performance gaps?*
    b. *How do you measure community satisfaction in terms of service delivery, and quality of care?*

2. Sustainability and Replicability of CCSP Model

6 *What are your views on CCSP CMW model?*

j. *What are strengths and weaknesses of CCSP model?*
k. *Do you recommend CCSP model to replicate in other districts of KP and Pakistan?*
l. *What are various challenges linked with such replication? How can these be minimized?*

Semi-structured questionnaires for Key informants

Key Informant: ED Health Sector Reform Unit (HSRU) KPK

Reason for Interview: Learn how does HSRU see role of AKHSP and CCSP in terms of provision of MNCH services in district Chitral? Learn about sustainability and replicability of CCSP CMW model in provision of MNCH services at community level.

Instructions for the Interviewer:

Before the interview:

Make an appointment with the *ED HSRU* through CCSP/AKHSP Managers and explaining him/her the objective of the Study and the reason for doing the interview.

At the time of interview:

m) Felicitate the *ED HSRU* and introduce yourself. Clearly explain him/her the objective of the Study and the reason for doing the interview with him/her. Explain how he/she was selected for the interview. Also, request the *ED HSRU* to allow you enough time for conducting the interview highlighting the importance of the views expressed him/her. Discourage prompting by other people in the room if their presence there is unavoidable.

n) Ask the questions one by one and note down the replies clearly. If the *ED HSRU* seems not to clearly understand the question, explain him/her further but avoid putting any leading question that suggests answer in itself. Facilitate discussion, if any, to remain within the context of the interview. If you are not clear about the answer provided to you, request the respondent to repeat his/her view on that particular question.

o) Before ending the interview session, reconfirm that all questions have been asked. Thank the respondent at the end of the session.

After the interview:

Organize the answers according to the questions. Collate all other views expressed by the *ED HSRU* that do not fall directly under any question in a separate section. Prepare a summary of the interview session with each respondent.

Key informants: ED HSRU KPK

1 MNCH Services Coordination

23. *How do you see the role of AKHSP/CCSP in district Chitral in improving MNCH outcomes?*
    a. *What are various difficulties and constraints faced in ensuring coordination among various service providers?*
    b. *Can CMW initiative of NMNCH Program play important role in reducing maternal morbidity and mortality?*

Emergency Referral/Transportation of Maternity

24. *Does your provincial health system have an operational referral system in place for complicated maternity referral from primary and community based service outlets? Is it effective?*
    a. *Do you have enough resources to manage referral cases? Probe for transportation mechanisms!*
    b. *How do you see role of CCSP strategies and interventions in improving timely referral and transportation of complicated maternity?*

2. Sustainability and Replicability of CCSP Model

3 *What are your views on CCSP CMW model?*

m. *What are strengths and weaknesses of CCSP model?*

n. *Do you recommend CCSP model to replicate in other districts of KPK and Pakistan?*

o. *What are various challenges linked with such replication? How can these be minimized?*

FINAL EVALUATION OF CHITRAL CHILD SURVIVAL PROJECT

FOCUS GROUP DISCUSSION WITH COMMUNITY MIDWIVES

(At Community level)

FGD Study ID Number ___________________

Date of FGD: ____/_____/____ Address: _______________________________________

Start time: _________ _______________________________________

Finish time: _________ District: _______________________________________

Language(s) of interview: ________________________________

Place of FGD: Health facility, Other; specify:______________

FGD Facilitator's Name: ______________________________________

(Suggested participants of FGD: CMWs from six project locations (ensure 6-8 participants)

(for office use only)

Reviewed by: ________________________

Date of review: _____/_____/_____

Date of data entry: ____/____/_____

Data entered by: ______________________

The discussion will take about two hours. [FACILITATOR NOTE: If you don't understand a question, please tell me. If you don't know the answer to a question, tell me and we will go on to the next one. If you don't want to answer a question, we will skip it. Is it OK to begin now? Please confirm your consent to participate in this interview.

Attach List of Participants: *Yes* ☐ *No* ☐

OVERALL QUESTIONS TO ANSWER IN FOCUS GROUP DISCUSSION:

Reminder to moderator:

The purpose of this focus group is to determine the following:

- *What were the factors (social contexts, perceptions, socio-cultural barriers and obstacles, challenges, enablers) that impacted CMW uptake and performance in the target communities?*
- *What were the challenges and barriers to set up CMW workstations/service outlets faced by CMWs and to learn about local solutions?*
- *Does the project strategies and interventions help improve coordination mechanisms among various local MNCH service providers?*
- *What is the contribution of project interventions in terms of improved service delivery by CMWs and timely referral of complicated maternity?*

PART ONE: INTRODUCTION

1. Good Morning. My name is ________ and member of the study team to guide this discussion. First, I want to thank you all for taking the time to be with us today.
2. We will be discussing your thoughts and ideas about maternal and child health in general and perception about MNCH services in your community. We are learning about CMWs and other service provider's role in provision of these services. Our discussion will provide us with information that will help us improve these services.
3. Before we begin, I'd like to explain what a focus group is and then give you some information about this specific focus group. A focus group is like a discussion group. It's a way of listening to people

and learning from them. In a focus group, people are asked to talk with others about their thoughts and ideas about a subject. We are interested in hearing what you think and feel about each topic. There is no right or wrong answer. We expect that many of you will have different points of view.

4. Our discussion today will be about two hours. We'll take a ten-minute break about halfway through. I'd like the discussion to be informal, so there's no need to wait for me to call on you to respond. In fact, I encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. I am here to ask questions, listen and make sure everyone has a chance to share.
5. We are interested in hearing from each of you, so if we seem to be stuck on a topic, I may interrupt you. If I do, please don't feel bad about it, it's just my way of making sure we get through all of the questions and everyone has a chance to talk.
6. We will be tape recording this discussion, because we don't want to miss any of your comments. None outside of this room will have access to these tapes. No names will be included in any reports. Your comments are confidential.
7. We are also requesting that you make sure your personal comments don't leave the room. I hope you'll feel free to speak openly and honestly.

Helping me is my assistant ____________. He/She will be taking notes and be here to assist me.

May we turn on the tape recorder?

Let's begin. I want to find out some more about each of you, so let's introduce ourselves and tell us your favorite food and sports/games. I'll start.

Note to Moderator: *Do not correct misinformation about maternal and child health during the focus group. Tell participants that they will have the opportunity to have all of their questions answered at the end of our discussion.*

PART TWO: DISCUSSION QUESTIONS

1. ***Cultural Perceptions of communities about MNCH Issues and CMW Services & Barriers to Health Seeking.***

[Approx. 20 min.]

Q1. What do you know about maternal and child health problems in your community?

Q2. What are various perceptions, practices and barriers to seek a medical help or treatment for maternal and child health problems in your community?

- ⇒ *PROBE: Personal physician, CMW, Govt. health facility, Private hospital, Hakeem, Local TBA? Etc*
- ⇒ *PROBE: What kind of important barriers to seek medical help exists in the community? please elaborate*
- ⇒ *PROBE: Why do pregnant women prefer to go to one type of provider as compare to others. What prevented them from seeing the doctor, CMW or other medical practitioner?*

2. ***Accessibility, Availability and Acceptability of CMW Services***

[Approx 30 min]

Q 3. What are the challenges faced by CMW in setting up their services the community? Please elaborate?

- ⇒ *PROBE: What are major difficulties encountered in attending deliveries or referral to secondary health facilities?*

Q. 4 Where do CMWs receive referral from local MNCH service providers?

- ⇒ *PROBE: Do LHWs or local TBAs refer cases? If not why?*
- ⇒ *PROBE: How CMWs coordinate for referral with local and secondary level service providers?*
- ⇒ *PROBE: Do CMWs get regular support and supervision from District Health Department to strengthen coordination with local health workers or hospitals to ensure service delivery?*

Q. 5 Do you get regular supervision and monitoring?

- ⇒ *PROBE: Technical and Administrative Monitoring mechanisms and responsible supervisors*
- ⇒ *PROBE: Do you get feedback from monitors/supervisors? How often?*

Q. 6 In case of emergency, how do you transfer maternity or sick child to bigger health facility (hospital)?

- ⇒ *PROBE: Availability of ambulance/transportation service*
- ⇒ *PROBE: Challenges and obstacles in transportation*
- ⇒ *PROBE: Barriers and constraints related to treatment in hospital, in case of financial constraints, how do you support the client to overcome?*
- ⇒ *PROBE: Are CBSGs helpful to facilitate on financial support?*

3. <u>Community Participation in Health Management</u>

[Approx 20 min.]

Q. 7. Do you know what is the role of VHCs and CBSGs in management of CBSG and CMW's work, Would you be able to give some recommendations to improve their work?

Q. 8. Have you ever been able to give this kind of feedback to the CBSG and VHCs?

- ⇒ *PROBE: Any example, which helped to improve VHC's work?*
- ⇒ *PROBE: Any example, which helped to improve services by CBSG?*

4. <u>Trainings and Skill Development</u>

[Approx 20 min.]

Q. 9. Do CMWs receive further refresher training or skill development opportunity after deployment? If so,

- ⇒ *PROBE: What were the topics of refresher courses or skill development? Does these refresher courses or skill development help improve your daily work?*
- ⇒ *PROBE: Do you think, you need other trainings or skill development particular to the local community needs?*

5. <u>Question and Answer about Health Educational Materials</u>

[Approx. 30 min.]

As you know, we are having a discussion to improve MNCH services to the communities and to learn of new ways we help people understand the importance of utilizing these services. For our final discussion of today, we would like to talk about ways in which community prefer to receive information.

Q 10. How do you provide information about child health in general and maternal health particularly related to pregnancy and delivery to the community?

⇒PROBE: e.g. verbal group discussions with clients, discussion with other people, video, television, radio, newspapers, other written information (Pamphlets/brochures),

⇒PROBE: Of all of the ways you have provided maternal and child health information, what was the most helpful?

Q 11. How does community prefer to receive information especially related to maternal and child health problems and treatment?

⇒PROBE: Pamphlets/brochures, Charts, TV messages and dramas, Radio Programs, Health Mela, Putali Tamasha (play), Debates, Discussions with health staff, etc

Q. 12. Finally, please tell us, how we can we further improve our MNCH related services in your community?

Acknowledgements

Thank you very much for coming here today. We appreciate your thoughts and ideas. They will be very helpful.

Name	***Occupation***	***Education***	***Address***	***Signature***

FINAL EVALUATION OF CHITRAL CHILD SURVIVAL PROJECT

FOCUS GROUP DISCUSSION WITH FEMALE COMMUNITY MEMBERS AND SERVICE USERS

(At Community level)

FGD Study ID Number ___________________

Date of FGD: _____/______/_____ Address: _______________________________________

Start time: _________ _______________________________________

Finish time: _________ District: _______________________________________

Language(s) of interview: ________________________________

Place of FGD: Health facility, Other; specify:_______________

FGD Facilitator's Name: _____________________________________

(Suggested participants of FGD: CMW service user, Local female social worker/activist, CBSG member, Female School Teacher, Local CBO/NGO female Representative, Female Community elders, (Ensure any 6-7 participants)

(for office use only)

Reviewed by: ________________________

Date of review: ______/______/______

Date of data entry: ____/____/_____   Data entered by: ______________________
The discussion will take about two hours. [FACILITATOR NOTE: If you don't understand a question, please tell me. If you don't know the answer to a question, tell me and we will go on to the next one. If you don't want to answer a question, we will skip it. Is it OK to begin now? Please confirm your consent to participate in this interview.

Attach List of Participants: *Yes* ☐ *No* ☐

OVERALL QUESTIONS TO ANSWER IN FOCUS GROUP DISCUSSION:

Reminder to moderator:

The purpose of this focus group is to determine the following:

- *What were the factors (social contexts, perceptions, socio-cultural barriers and obstacles, challenges, facilitators) that impacted CMW uptake and performance in the target communities?*
- *Does membership in a CBSG impact health care seeking behavior, especially use of CMW services?*
- *What is the contribution of project interventions in terms of service delivery and utilization of MNCH services by the community?*
- *Are the beneficiaries satisfied by quality of healthcare services?*

PART ONE: INTRODUCTION

8. Good Morning. My name is _________ and member of the study team to guide this discussion. First, I want to thank you all for taking the time to be with us today.
9. We will be discussing your thoughts and ideas about maternal and child health in general and perception about MNCH services in your community. We are learning about CMWs role in provision of these services. Our discussion will provide us with information that will help us improve these services.
10. Before we begin, I'd like to explain what a focus group is and then give you some information about this specific focus group. A focus group is like a discussion group. It's a way of listening to people and learning from them. In a focus group, people are asked to talk with others about their thoughts

and ideas about a subject. We are interested in hearing what you think and feel about each topic. There is no right or wrong answer. We expect that many of you will have different points of view.

11. Our discussion today will be about two hours. We'll take a ten-minute break about halfway through. I'd like the discussion to be informal, so there's no need to wait for me to call on you to respond. In fact, I encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. I am here to ask questions, listen and make sure everyone has a chance to share.
12. We are interested in hearing from each of you, so if we seem to be stuck on a topic, I may interrupt you. If I do, please don't feel bad about it, it's just my way of making sure we get through all of the questions and everyone has a chance to talk.
13. We will be tape recording this discussion, because we don't want to miss any of your comments. None outside of this room will have access to these tapes. No names will be included in any reports. Your comments are confidential.
14. We are also requesting that you make sure your personal comments don't leave the room. I hope you'll feel free to speak openly and honestly.

Helping me is my assistant ____________. He/She will be taking notes and be here to assist me.

May we turn on the tape recorder?

Let's begin. I want to find out some more about each of you, so let's introduce ourselves and tell us your favorite food and sports/games. I'll start.

Note to Moderator: *Do not correct misinformation about maternal and child health during the focus group. Tell participants that they will have the opportunity to have all of their questions answered at the end of our discussion.*

PART TWO: DISCUSSION QUESTIONS

1. ***Cultural Perceptions about MNCH Issues and Services & Barriers to Health/ Treatment Seeking.***

[Approx. 40 min.]

Q1. What kind of maternal and child health problems are common in this community?

⇒ PROBE: What are common maternal and newborn complications in your community?

Q2. Where would you go to see a medical help or treatment for maternal and child health problems?

⇒PROBE: Personal physician, CMW, Govt. health facility, Private hospital, Hakeem, Local TBA? Etc

Q3. Why do you prefer to go to one type of provider as compare to others

⇒ PROBE: What prevented you from seeing CMW or other medical practitioner? Probe for treatment cost, travel or else

⇒ PROBE: Are there some women in the community who do not want to go to the CMW? And why?

2. ***Accessibility, Availability and Acceptability of MNCH Services***

[Approx 30 min]

Q 6. Have you or anyone in your family received antenatal or delivery care from a CMW?

⇒ PROBE: CMW is available, whenever you or your family members in need to visit her?

Q 8 What do you think of the services of CMW?

⇒ PROBE: Acceptability of waiting time

⇒ PROBE: Remuneration for the CMW?

⇒ PROBE: Provision of care by CMW

⇒ PROBE: Confidence in her skills

Q. 9 In case of emergency, how do you transfer maternity or sick child to bigger health facility (hospital)?

⇒ PROBE: Availability of ambulance/transportation service

⇒ PROBE: Challenges and obstacles in transportation

⇒ PROBE: Barriers and constraints related to treatment in hospital, in case of financial constraints, how do you overcome?

⇒ PROBE: Are CBSGs helpful to facilitate on financial support?

3. Community Participation in Health Management

[Approx 20 min.]

Q. 10. Do you participate or play any role in management of CBSG and CMW's work, If so, how do you participate and support to CBSG and CMW? Would you be able to give some recommendations to improve their work?

Q. 11. Have you ever been able to give this kind of feedback to the CMW and CBSG?

⇒ PROBE: Any example, which helped to improve service delivery by CMW?

⇒ PROBE: Any example, which helped to improve services by CBSG?

4. Question and Answer about Health Educational Materials

[Approx. 30 min.]

As you know, we are having a discussion to try to improve MNCH services and to learn of new ways we help people understand the importance of utilizing these services. For our final discussion of today, we would like to talk about ways in which you prefer to receive information.

Q 12.Have you ever received any information about your child health in general and maternal health particularly related to pregnancy and delivery?

⇒PROBE: e.g. verbal group discussions with health staff (CMW, LHW), discussion with other people, video, television, radio, newspapers, other written information (Pamphlets/brochures),

⇒PROBE: Of all of the ways you have received maternal and child health information, what was the most helpful?

Q 13.How do you prefer to receive information especially related to maternal and child health problems and treatment?

⇒PROBE: Pamphlets/brochures, Charts, TV messages and dramas, Radio Programs, Health Mela, Putali Tamasha (play), Debates, Discussions with health staff, etc

Q. 14. Finally, please tell us, how we can further improve our MNCH related services in your community?

Acknowledgements

Thank you very much for coming here today. We appreciate your thoughts and ideas. They will be very helpful.

Name	**Age**	**Occupation**	**Education**	**Address**	**Signature**

FINAL EVALUATION OF CHITRAL CHILD SURVIVAL PROJECT

FOCUS GROUP DISCUSSION WITH COMMUNITY BASED SERVICE PROVIDERS (OTHER THAN CMWS)

(At Community level)

FGD Study ID Number ___________________

Date of FGD: ____/_____/____ Address: _______________________________________

Start time: _________ _______________________________________

Finish time: _________ District: _______________________________________

Language(s) of interview: ________________________________

Place of FGD: Health facility, Other; specify:______________

FGD Facilitator's Name: ______________________________________

(Suggested participants of FGD: LHSs, LHWs, LHVs, TBAs (from six project locations (ensure 7-8 participants)

(for office use only)

Reviewed by: ________________________

Date of review: _____/_____/_____

Date of data entry: ____/____/_____

Data entered by: ______________________

The discussion will take about two hours.* [FACILITATOR NOTE:** ***If you don't understand a question, please tell me. If you don't know the answer to a question, tell me and we will go on to the next one. If you don't want to answer a question, we will skip it. Is it OK to begin now? Please confirm your consent to participate in this interview.

Attach List of Participants: *Yes* ☐ *No* ☐

OVERALL QUESTIONS TO ANSWER IN FOCUS GROUP DISCUSSION:

Reminder to moderator:

The purpose of this focus group is to determine the following:

- *What were the factors (social contexts, perceptions, socio-cultural barriers and obstacles, challenges, enablers) that impacted CMW uptake and performance in the target communities?*
- *What were the challenges and barriers to set up CMW workstations/service outlets faced by CMWs and to learn about local solutions?*
- *Does the project strategies and interventions help improve coordination mechanisms among various local MNCH service providers?*
- *What is the contribution of project interventions in terms of improved service delivery by CMWs and timely referral of complicated maternity?*
- *Are the project beneficiaries satisfied with quality of care and MNCH services?*

PART ONE: INTRODUCTION

15. Good Morning. My name is _________ and member of the study team to guide this discussion. First, I want to thank you all for taking the time to be with us today.
16. We will be discussing your thoughts and ideas about maternal and child health in general and perception about MNCH services in your community. We are learning about CMWs and other service provider's role in provision of these services. Our discussion will provide us with information that will help us improve these services.

17. Before we begin, I'd like to explain what a focus group is and then give you some information about this specific focus group. A focus group is like a discussion group. It's a way of listening to people and learning from them. In a focus group, people are asked to talk with others about their thoughts and ideas about a subject. We are interested in hearing what you think and feel about each topic. There is no right or wrong answer. We expect that many of you will have different points of view.
18. Our discussion today will be about two hours. We'll take a ten-minute break about halfway through. I'd like the discussion to be informal, so there's no need to wait for me to call on you to respond. In fact, I encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. I am here to ask questions, listen and make sure everyone has a chance to share.
19. We are interested in hearing from each of you, so if we seem to be stuck on a topic, I may interrupt you. If I do, please don't feel bad about it, it's just my way of making sure we get through all of the questions and everyone has a chance to talk.
20. We will be tape recording this discussion, because we don't want to miss any of your comments. None outside of this room will have access to these tapes. No names will be included in any reports. Your comments are confidential.
21. We are also requesting that you make sure your personal comments don't leave the room. I hope you'll feel free to speak openly and honestly.

Helping me is my assistant ____________. He/She will be taking notes and be here to assist me.

May we turn on the tape recorder?

Let's begin. I want to find out some more about each of you, so let's introduce ourselves and tell us your favorite food and sports/games. I'll start.

Note to Moderator: *Do not correct misinformation about maternal and child health during the focus group. Tell participants that they will have the opportunity to have all of their questions answered at the end of our discussion.*

PART TWO: DISCUSSION QUESTIONS

5. *Cultural Perceptions of communities about MNCH Issues and Services & Barriers to Health Seeking.*

[Approx. 20 min.]

Q4. What do you know about maternal and child health problems in your community?

Q5. What are various perceptions, practices and barriers to seek a medical help or treatment for maternal and child health problems in your community?

⇒ *PROBE: Personal physician, CMW, LHW, Govt. health facility, Private hospital, Hakeem, Local TBA? Etc*

⇒ *PROBE: What kind of important barriers to seek medical help exists in the community? please elaborate*

⇒ *PROBE: Why do pregnant women prefer to go to one type of provider as compare to others. What prevented them from seeing the doctor, CMW or other medical practitioner?*

6. ***Accessibility, Availability and Acceptability of MNCH Services***

[Approx 30 min]

Q 3. What are the challenges faced by communities in accessing and utilization of MNCH services? Please elaborate?

⇒ *PROBE: What are major difficulties encountered in attending deliveries by CMWs/ other private service providers or referral to secondary health facilities?*

Q. 4 How do CMWs receive referral from local MNCH service providers?

⇒ *PROBE: Do LHWs or local TBAs refer cases? If not why?*

⇒ *PROBE: How LHWs/TBAs coordinate with CMWs for referral?*

⇒ *PROBE: Do CMWs provide feedback on outcome of referral?*

Q. 5 In your opinion, who is responsible for CMW's monitoring?

⇒ *PROBE: Technical and Administrative Monitoring mechanisms and responsible supervisors*

Q. 6 In case of emergency, how do family transfer maternity or sick child to bigger health facility (hospital)?

⇒ *PROBE: Availability of ambulance/transportation service*

⇒ *PROBE: Challenges and obstacles in transportation*

⇒ *PROBE: Barriers and constraints related to treatment in hospital, in case of financial constraints, how do you support the client to overcome?*

⇒ *PROBE: Are CBSGs helpful to facilitate on financial support?*

Q.7 Are communities satisfied by the CMW's services in terms of?

⇒ *PROBE: Trust in handling complicated maternity*

⇒ *PROBE: Understanding of health messages*

⇒ *PROBE: Confidence in handling sick children*

⇒ *PROBE: Fee for service*

7. ***Community Participation in Health Management***

[Approx 20 min.]

Q. 8. Do you know what is the role of VHCs and CBSGs in management CMW's work, Would you be able to give some recommendations to improve their work?

8. ***Question and Answer about Health Educational Materials***

[Approx. 30 min.]

As you know, we are having a discussion to improve MNCH services to the communities and to learn of new ways we help people understand the importance of utilizing these services. For our final discussion of today, we would like to talk about ways in which community prefer to receive information.

Q 9. How does community prefer to receive information about child health in general and maternal health particularly related to pregnancy and delivery to the community?

⇒PROBE: e.g. verbal group discussions with clients, discussion with other people, video, television, radio, newspapers, Charts, other written information (Pamphlets/brochures), Health Mela, Putali Tamasha (play), debates, discussions with health staff, etc which one is the most helpful?

Acknowledgements

Thank you very much for coming here today. We appreciate your thoughts and ideas. They will be very helpful.

Name	**Occupation**	**Education**	**Address**	**Signature**

FINAL EVALUATION OF CHITRAL CHILD SURVIVAL PROJECT

FOCUS GROUP DISCUSSION WITH MALE COMMUNITY LEADERS AND MEMBERS (SERVICE USERS)

(At Community level)

FGD Study ID Number ___________________

Date of FGD: ____/_____/____ Address: _______________________________________

Start time: _________ _______________________________________

Finish time: _________ District: _______________________________________

Language(s) of interview: ________________________________

Place of FGD: Health facility, Other; specify:______________

FGD Facilitator's Name: _____________________________________

(Suggested participants of FGD: Imam Masjid, UC Councilor, School Teacher, Local Social Worker, Local CBO/NGO Representative, Community elders, Male beneficiaries, Ensure any 5-6 participants)

(for office use only)

Reviewed by: ________________________

Date of review: _____/_____/_____

Date of data entry: ____/____/_____   Data entered by: _____________________
The discussion will take about two hours. [FACILITATOR NOTE: If you don't understand a question, please tell me. If you don't know the answer to a question, tell me and we will go on to the next one. If you don't want to answer a question, we will skip it. Is it OK to begin now? Please confirm your consent to participate in this interview.

Attach List of Participants: *Yes* ☐ *No* ☐

OVERALL QUESTIONS TO ANSWER IN FOCUS GROUP DISCUSSION:

Reminder to moderator:

The purpose of this focus group is to determine the following:

- *What were the factors (social contexts, perceptions, socio-cultural barriers and obstacles, challenges, enabling factors) that impacted CMW uptake and performance in the target communities?*
- *Does membership in a CBSG impact health care seeking behavior, especially use of CMW services?*
- *What is the contribution of project interventions in terms of service delivery and utilization of MNCH services by the community?*
- *Are the beneficiaries satisfied by quality of healthcare services?*

PART ONE: INTRODUCTION

22. Good Morning. My name is _________ and member of the study team to guide this discussion. First, I want to thank you all for taking the time to be with us today.
23. We will be discussing your thoughts and ideas about maternal and child health in general and perception about MNCH services in your community. We are learning about CMWs role in provision of these services. Our discussion will provide us with information that will help us improve these services.
24. Before we begin, I'd like to explain what a focus group is and then give you some information about this specific focus group. A focus group is like a discussion group. It's a way of listening to people and learning from them. In a focus group, people are asked to talk with others about their thoughts

and ideas about a subject. We are interested in hearing what you think and feel about each topic. There is no right or wrong answer. We expect that many of you will have different points of view.

25. Our discussion today will be about two hours. We'll take a ten-minute break about halfway through. I'd like the discussion to be informal, so there's no need to wait for me to call on you to respond. In fact, I encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. I am here to ask questions, listen and make sure everyone has a chance to share.
26. We are interested in hearing from each of you, so if we seem to be stuck on a topic, I may interrupt you. If I do, please don't feel bad about it, it's just my way of making sure we get through all of the questions and everyone has a chance to talk.
27. We will be tape recording this discussion, because we don't want to miss any of your comments. None outside of this room will have access to these tapes. No names will be included in any reports. Your comments are confidential.
28. We are also requesting that you make sure your personal comments don't leave the room. I hope you'll feel free to speak openly and honestly.

Helping me is my assistant ____________. He/She will be taking notes and be here to assist me.

May we turn on the tape recorder?

Let's begin. I want to find out some more about each of you, so let's introduce ourselves and tell us your favorite food and sports/games. I'll start.

Note to Moderator: *Do not correct misinformation about maternal and child health during the focus group. Tell participants that they will have the opportunity to have all of their questions answered at the end of our discussion.*

PART TWO: DISCUSSION QUESTIONS

9. ***Cultural Perceptions about MNCH Issues and Services & Barriers to Health/ Treatment Seeking.***

[Approx. 40 min.]

Q6. What do you know about maternal and child health problems?

Q7. Where would you want your wife and children to go to see a medical help or treatment for maternal and child health problems?

⇒PROBE: Personal physician, CMW, LHW, Govt. health facility, Private hospital, Hakeem, Local TBA? Etc

Q8. Where do you want your female family members to go to deliver or receive antenatal care and why?

⇒PROBE: Do you prefer to take your family member to CMW? If not,

⇒PROBE: What prevented you from seeing CMW? Treatment Cost, travel, lack of confidence on CMW etc

10. *Accessibility, Availability and Acceptability of MNCH Services*

[Approx 30 min]

Q 4. Has anyone in your family ever sought services from a CMW?

⇒PROBE: Was CMW available, whenever your family members visit her?

Q 5 Are you satisfied by the services of CMW?

⇒ PROBE: Acceptability of waiting time

⇒ PROBE: Remuneration for the CMW?

⇒ PROBE: Provision of care by CMW

Q. 6 In case of emergency, how do people transfer maternity or sick child to bigger health facility (hospital)?

⇒ PROBE: Availability of ambulance/transportation service

⇒ PROBE: Challenges and obstacles in transportation

⇒ PROBE: Barriers and constraints related to treatment in hospital, in case of financial constraints, how do you overcome?

⇒ PROBE: Are CBSGs helpful to facilitate on financial support?

11. *Community Participation in Health Management*

[Approx 20 min.]

Q. 7. Do you participate or play any role in management of CBSG and CMW's work, If so, how do you participate and support to CBSG and CMW? Would you be able to give some recommendations to improve their work?

Q. 8. Have you ever been able to give this kind of feedback to the CMW and CBSG?

⇒ PROBE: Any example, which helped to improve service delivery by CMW?

⇒ PROBE: Any example, which helped to improve services by CBSG?

12. *Question and Answer about Health Educational Materials*

[Approx. 30 min.]

As you know, we are having a discussion to try to improve MNCH services and to learn of new ways we help people understand the importance of utilizing these services. For our final discussion of today, we would like to talk about ways in which you prefer to receive information.

Q 9.Have you ever received any information about your health in general and maternal health particularly related to pregnancy and delivery?

⇒PROBE: e.g. verbal group discussions with health staff (CMW, LHW), discussion with other people, video, television, radio, newspapers, other written information (Pamphlets/brochures),

⇒PROBE: Of all of the ways you have received maternal and child health information, what was the most helpful?

Q. 10. Finally, please tell us, how we can further improve our MNCH related services in your community?

Acknowledgements

Thank you very much for coming here today. We appreciate your thoughts and ideas. They will be very helpful.

Name	***Age***	***Occupation***	***Education***	***Address***	***Signature***

ANNEX XI. SOURCES OF INFORMATION

List of Key Informant Interview Participants

S #	Name	Designation	Organization
1	Mr. Jim C. Meyers	CEO	AKHS, P
2	Dr. Babar T. Shaikh	Director Health & Built Environment	AKF, P
3	Dr. Qayoom Noorani	Program Manager	AKF, P
4	Dr. Sharifullah Khan	Senior Program Officer	AKF, P
5	Dr. Shazia Abbas	Ex. Program Officer AKF, P	AKF, P
7	Dr. Zafar Ahmed	GM Chitral & Punjab	AKHSP
8	Farid Ahmed	Manager CBSG	AKRSP Chitral
9	Sardar Ayub	Regional Program Manager	AKRSP Chitral
10	Aisha Bibi	Program Coordinator CCSP Chitral	AKHS Chitral
11	Mubarek Bibi	Filed Supervisor	AKHS Chitral
12	Jamila Bibi	Filed Supervisor	AKHS Chitral
13	Dr. Nazir Ahmad	DHO Chitral	Govt. Health Department, Chitral
14	Dr. Ibrahim	Coordinator LHW Program	Govt. Health Department, Chitral
15	Dr. Noorul Islam	MS DHQ Chitral	Govt. Health Department, Chitral
16	Dr. Zafar	Director General Health Services,	Govt. Health Department, KPK
17	Dr. Ghafoor	Director Public Health	Govt. Health Department, KPK
18	Dr Shabina Raza	Chief HSRU	Govt. Health Department, KPK
19	Dr Tahir Nadeem	Provincial Coordinator LHW Program	Govt. Health Department, KPK

Focus Group Discussion with Female Community Members Service Users

S #	Name	Place	S #	Name	Place
1	Mas Begum	Oragh	9	Khuban	Gree
2	Samina	Oragh	10	Pacha Gul	Gree
3	Rashida	Oragh	11	Lalihoor	Gree
4	Gul Nama	Oragh	12	Chust	Gree
5	Khanjar	Oragh	13	Khonza Nisa	Gree
6	Sharima	Gree	14	Khonza Begum	Gree
7	Bibi Nan	Gree	15	Mehraj Gul	Gree
8	Zarin Taj	Gree			

Focus Group Discussion with Male Community Members

S #	Name	Place
1	Shujauddin member CBSG	Loligram
2	Mohd Akbar Shah	Tashqar
3	Shahabuddin	Ajarandeh
4	Sher Doom	Gree
5	Sardar Murad	Gree
6	Sher Khan	Oragh

Focus Group Discussion with Service Providers other than CMWs

S #	Name	Designation	Place
1	Najma Anwar	SLHV	RHC
2	Zahida Muzafar	LHV	Chitral
3	Mumtaz	LHW	Loligram
4	Sharifa	LHW	Madashil
5	Samina	LHW	Oragh
6	Zohra	LHW	Gree
7	Hashida	LHW	Shoghor

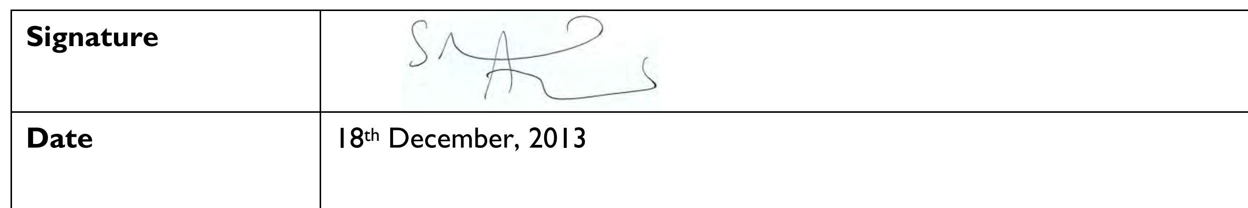
Focus Group Discussion with CMWs

S#	Name	Place	# of deliveries attended
1	Mehnaz	Lot Ovir Payeen	25
2	Farida	Parsan	23
3	Yuhanat	Barenis Bala	13
4	Shahida	Bomborat	12
5	Saifoora	Kushum	22
6	Zohra	Shoonjuran	43
7	Saeda	Awi	20

ANNEX XII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Dr. Sohail Amjad
Title	Senior Public Health and M&E Specialist
Organization	Consultant
Evaluation Position	☐ Team Leader
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	
I have real or potential conflicts of interest to disclose.	No

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.



Signature	
Date	18th December, 2013

ANNEX XIII. STATEMENT OF DIFFERENCES

At the time the project proposal and DIP were written, it was apparent that the national MNCH program was not going to continue after the 18th amendment was approved, therefore, it was difficult to spell out plans for transition and sustainability not knowing what the situation would look like after devolution of the health services to the provincial level. In the succeeding years, the provincial government has been absorbed in devising their policies and programs and working out financing for supporting health service delivery in one of the most geographically challenging provinces in Pakistan. During this time AKF,P and AKHS,P worked closely with the District Office of Health, but decisions about absorbing the CMWs into the government system and assuming the financial responsibility rested with provincial authorities, who had competing priorities. Engagement in constructive dialogue became more possible towards the end of CCSP when the provincial health system plans were less in flux.

AKF received a no-cost extension from October 1, 2013 to May, 31, 2014 and devoted this time to strengthening sustainability and transition of the CMWs to KPK Provincial Health Department support. The following has been achieved:

1. AKHSP has signed a MoU with DKT International in Pakistan to continue technical support, refresher courses and provision of FP supplies to the CMWs. In addition, the DKT will also do maintenance work on CMWs working stations.
2.
3. Dialogues with DOH KPK have been continued to absorb all the deployed CMWs in the mainstream provincial health system.
4. A meeting was held recently with Provincial Health Secretary and Provincial MNCH Coordinator in this regard where they reassured the visiting team of AKF, Pakistan about the absorption of CMWs.
5. The field team of AKHSP is currently doing supervision of CMWs on quarterly basis and the CMWs have been linked with local quality assured drug suppliers for replenishing their drug stocks.

The consultant questioned sustainability of some CBSGs. The underpinning concept for CBSGs sustainability is a simple one, they would be continued by the communities themselves based on their needs and the groups have been trained and taught in that way by the AKRSP. CBSGs do not need long-term support from outside the community.

ANNEX XIV. EVALUATION TEAM MEMBERS, ROLES, AND THEIR TITLES

Dr. Sohail Amjad, Lead Evaluation Consultant in Pakistan, qualitative field work, report

Judiann McNulty, DrPH, Senior Technical Consultant in U.S., data analysis, evaluation design and report writing assistance

David Hintch, MPH, Senior Program Officer, Aga Khan Foundation, USA

Dr. Sharifullah Khan, Senior Program Officer - Health, Aga Khan Foundation Pakistan

Field team participants:

1. Aisha Maab, Program Coordinator Chitral Child Survival Program
2. Mirajuddin, Manager Monitoring and Evaluation CCSP
3. Farid Ahmed, Manager CBSG Program, Aga Khan Rural Support Program

ANNEX XV

Operations Research

Chitral Child Survival Project (CCSP) 2011 - 2013

Operations Research

Prepared by: Rafat Jan PhD, RN, RM, Professor Midwifery
President, Midwifery Association of Pakistan (MAP)
Aga Khan University
School of Nursing and Midwifery
Stadium Road, P. O. Box 3500
Karachi, Pakistan, 74800

November 2013

The Chitral Child Survival Project (CCSP) in Chitral, Khyber Pakhtunkhwa, Pakistan is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Chitral Child Survival Project is managed by Aga Khan Foundation under Cooperative Agreement No. GHN-A-00-08-00010-00. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

Introduction

Annually, four million newborns die in the first week of life, and about half million mothers perish due to pregnancy-related causes which are preventable[i,ii]. Pakistan is among the few countries in South Asia that continues to have dismal maternal and child health indicators. In Pakistan, Maternal Mortality Ratios (MMR) is high, ranging from 240 to 700 per 100,000 live births. The top three causes of maternal death are postpartum hemorrhage, eclampsia and sepsis[iii]. According to PDHS 2012-13, infant mortality rate is 74/1000 live births, whereas under-five mortality rate is 89/1000 live births[iv]. While some maternity care indicators appear to have improved over the last two decades, according to the PDHS 2006-7, women's access to prenatal health care continues to be low in Pakistan. Approximately two-thirds of all births (61%) take place at home due to limited access to health facilities.

Home based unskilled deliveries being the main contributor to these deaths are predominant in the developing countries including Pakistan[v]. This has raised serious concern over the years in rural communities to ensure availability and accessibility of skilled care. Evidence suggests that around 20-30% of neonatal mortality could be averted with implementation of skilled birth care services. Uniform availability and distribution of skilled birth attendants is critical to consider for the attainment of MDG- 4 and 5a& b.

Realizing the need for community health work force, Government of Pakistan launched the national MNCH program in 2006 to help the rural women deliver safely[vi]. Although the program has been successful in countries such as Malaysia and Indonesia, challenges faced by the CMW program of Pakistan are multifaceted. The Program is supported by the Government of Pakistan with development partners that include UN agencies (UNFPA, UNICEF), DFID, and AUS-AID. The major components of NMNCH Programme include a) Comprehensive and integrated MNCH services at the district level, b) Community-based skilled birth attendants through Community Midwifery (CMW's) Program, c) Comprehensive Family Planning Services, and d) Advocacy and Demand Creation. This program is in line with Islamabad Declaration on Strengthening Nursing and Midwifery and was a response to the World Health Resolution passed in 2006a promoting scaling up of midwifery services to promote efficiency and effectiveness.

Project Overview: Problem to be addressed and proposed solution

In the northwest district of Khyber Pakhthunkhwa (KPK) Province of Pakistan, bordering Afghanistan, Chitral District is a high-altitude and geographically remote district, the largest district in the province, with the lowest population density and an area of approximately 14,850 km². It is located in the Pamir and Hindu Kush mountain ranges.

In KPK the MMR is 275/100,000 whereas under five mortality is 75/1000 live births[iii]. Chitral has some of the highest levels of maternal and infant mortality and morbidity in the country. Restricted access to health services due to poor roads and the high cost of transport through extremely rugged terrain, extreme weather condition resulting in inaccessibility to health care services during winter months, cultural restrictions on women's movement outside the home, high female illiteracy, and lack of preparation for emergency deliveries, all increase the vulnerability of expectant mothers and newborns.

In some areas 44.5% of the households are classified as poor or extremely poor. In Chitral, maternal and infant mortality rates remain persistently high due to barriers in accessing medical services. The lack of transportation, significant distances and travel time between women's homes and available health facilities, and the high costs associated with reaching and using medical care constitute the primary obstacles to women's access to and use of medical services.

Department of Health (DoH) and AKHSP are the two primary formal public and private health sector who are healthcare services providers in Chitral, ensuring equitable coverage throughout the district. The public-sector healthcare infrastructure in the district includes 22 civil dispensaries, 21 basic health units, three tehsil headquarters, and one district headquarter hospital[vii]. AKHSP operates 32 health facilities in Chitral which include 17 health centers, eight family health centers, four dispensaries, and three secondary care facilities, covering 60% of

Chitral district. Despite the presence of skilled birth attendants under MNCH program, deliveries in Chitral district are still attended by TBAs.

Eighty-two percent of deliveries in Chitral take place at home as compared to the national average of 65%[1], and only 20% are assisted by a skilled birth attendant. While a home delivery is a financial choice, it is also linked to cultural preference for the supportive presence of other female members of the family, special traditional foods prepared for the new mother, and the tradition of keeping the mother and new born in the home for the first 40 days after delivery.

In an attempt to increase use of maternal and child health (MCH) services and to remove access barriers to those services, the Aga Khan Foundation, Pakistan (AKFP), along with the Aga Khan Health Service, Pakistan (AKHSP) and the Aga Khan Rural Support Program, Pakistan (AKRSP) implemented the Chitral Child Survival Program (CCSP). In order to reduce maternal and neonatal mortality and morbidity in Chitral, the CCSP introduced two key interventions i.e. training community midwives (CMWs) and community based saving groups (CBSG). The main goal of the project was to upgrade the quality of services offered to women during Labour and Delivery through early detection of risk situations and early referral to decrease MMR and NNR and achieve MDG 4 and 5 targets According to the proposal document:

> ”The two key innovations—training and deploying CMWs and implementing a community financing initiative—address the primary barriers to accessing skilled care by 1) bringing the services to the home…….and 2) providing some financial cover for maternity care for families who would otherwise not be able to pay for EmONC services”. (Proposal Narrative; p.1)

Community Midwives

The candidates were selected according to criteria given in box 1. To deploy 28 Community midwives in Chitral, CCSP collaborated with the government to establish the first Midwifery School in Chitral, accredited by the Pakistan Nursing Council (PNC) in February 2010. The PNC's

Box # 1: Criteria for Community Midwives:

- female
- age 18-35
- grade 10 education
- preferably married
- resident in the location from which she is applying

[1] Pakistan Demographic and Health Survey, 2006-2007

standard 18-month curriculum was followed by 6 months of practical training that introduced CMW candidates to health facilities to which they would be referring patients once deployed and helped them develop additional skills.

Once they were deployed (July - September, 2011), CCSP supported the CMWs in several important ways.

- The project equipped CMWs with a delivery station, toolkit, and a monthly stipend for their first year of deployment, with the expectation that they would sustain themselves with user fees after that. AKFP provided them with about $250 (USD equivalent) to furnish their "Safe Maternity Centres" -- mini clinics with basic equipment and supplies.
- It formed Village Health Committees (VHCs) to set a fee structure for the CMW's services (posted in her delivery station), mobilize resources for emergency transportation to a health center[2], and conduct health events. More broadly, the purpose of the VHC was to ground improved MNCH services in the community, and ensure they continue after the CCSP closed.
- A significant Behavior Change Communication (BCC) component produced illustrated flipcharts and pamphlets covering danger signs of pregnancy, delivery, post-partum and newborn care, and trained dozens of local change agents to use them in the communities.
- For pregnancies requiring specialized or emergency treatment, CCSP strengthened the linkages between the community based care and more specialized health facilities for easy and prompt referral and treatment.

Trained Community Midwives and Community Mobilization

[2] The project's geographic area consists of all villages within a two-hour driving radius of any one of the three tertiary care facilities offering Comprehensive Emergency Obstetric and Neonatal Care to ensure realistic referral linkages for the CMWs. VHCs identified emergency transport options and negotiated prices in anticipation of emergencies.

To significantly improve home delivery, the project put in place a cadre of 28 trained Community Midwives (CMWs) who offered a comprehensive package of maternal and newborn services locally. The project trained the CMWs and paid them a monthly stipend of $ 20 in the first year and $ 50 in second year. All the CMWs were provided with equipped and well maintained workstations as well as medicines for MNCH services.

The project also formed village health committees (VHCs) to support the midwives, help cost their services, organize emergency transport for pregnant women experiencing complications, and motivate villagers to utilize CMWs' services.

Under a significant Behavior Change Communication component, health education sessions were conducted firstly, to introduce CMWs and motivate villagers to utilize their services; and secondly to create awareness on danger signs of pregnancy, delivery, post-partum and newborn care. Dozens of local change agents were trained to conduct BCC. For pregnancies requiring specialized or emergency treatment, CCSP strengthened the linkages between the community based care and more specialized health facilities.

Community-based Savings Groups

Cost is one of the most serious barriers to access skilled obstetric and neonatal care. According to data collected at the beginning of the project, 26% of women who did not access antenatal care during their last pregnancy stated that they did not do so because the cost was too high. Aside from the price of the service itself, women must pay travel and other costs associated with the journey to care. About half of women pay the equivalent of US $2.50 for a delivery, but about 10% pay more than $37 in cases of high travel costs and complicated deliveries.

Further, families also pay provider's fees and bed charges for inpatient stay, as well as for medicines and other supplies. And, while CCSP was putting the infrastructure in place to encourage safe, at-home deliveries, its community midwife model could only be sustained over the long term with user fees. Although significantly less expensive than a hospital, CMW fees were higher than the traditional birth attendants, presenting extra cost to the patient.

CCSP decided to test if a savings mechanism would increase utilization of services. CBSGs were established to determine if they could overcome some of the financial and cultural accessibility issues constraining women's use of services. CBSGs are intended to facilitate community members' access to safe delivery services by enabling women and their families to more easily pay for CMWs' services and by also assisting CMWs to better establish their practices, as the groups serve as a venue to promote their services and for talks and other health education related activities.

To ease financial barriers to MNCH services, whether at-home deliveries attended by a skilled birth attendant or transport for emergency care, the CCSP strategy included a community financing mechanism. After considering several options to operationalize this strategy, including an informal insurance scheme, the project team opted for CBSGs, an approach new to Pakistan, but promoted by AKF in six other countries.

While the CMW candidates were in training (the first years of the project), the AKF laid the groundwork for CBSGs. It recruited and trained two field supervisors and a cadre of 27 village agents who assumed responsibility for CBSG formation and training in group policies and procedures, and supervised each group regularly for the duration of the first 12-month cycle of weekly saving and borrowing.

CCSP formed the first groups in March, 2010. Despite some resistance –husbands' refusal to allow their wives to leave the house to attend meetings, objections to interest payments, and fear of committing to a weekly savings deposit --- by the time the project stopped forming new groups in September, 2013, there were 421 CBSGs with 7,988 members.

The operational research

Operational research was conducted to evaluate the outcomes of the interventions implemented during the project.

Theoretical Model

The theoretical framework (figure 1) utilized in this operational research is based on six factors associated with CMW utilization in relation to the four objectives of the CCSP. Following in the description of each factor:

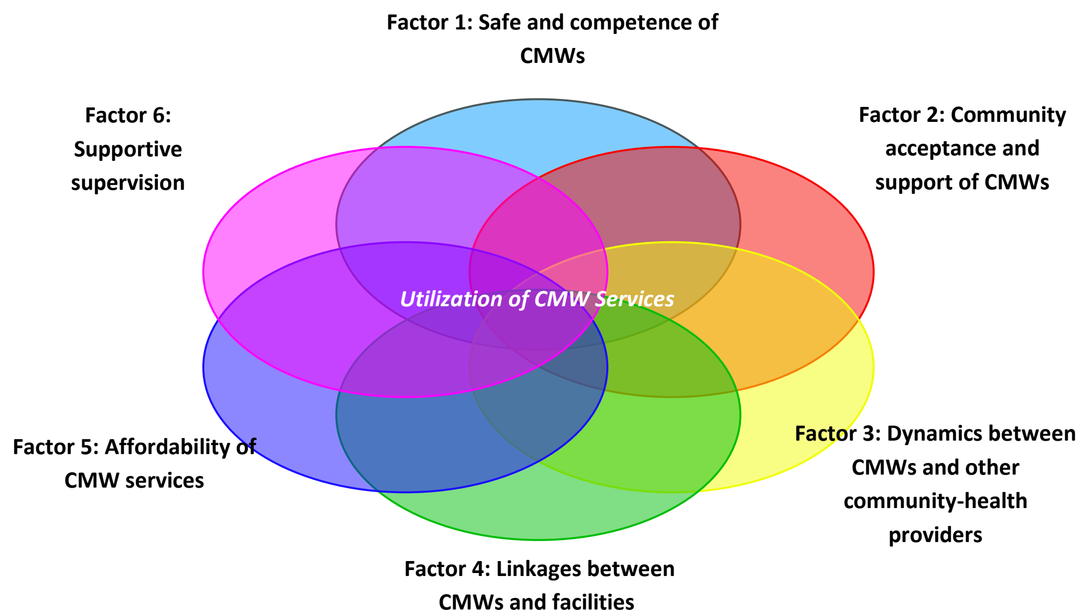


Figure 1. Six factors of CMW Service Utilization

1) *Quality of CMW training:* All CMWs must complete an 18-month training course approved by the Pakistan Nursing Council (PNC); this includes classroom training and hospital and community-based practical training. The quality of these courses varies across the country.[15, 16] Thus, the clinical competencies of CMWs and their level of confidence and comfort to work as independent providers within communities also varied. The literature indicates that the development of competencies during training is essential. In addition, maintaining and advancing the competencies of midwives through further training/education is highly important. This is one of the core factors in promoting the utilization of CMW services.

2) *Community perceptions of CMWs:* The community's perception of the quality of the midwife's practice is an important gauge of her acceptance and relative success in the community. This factor looks at how the community views and uses the CMW's services, and whether clients refer their relatives to the midwife, allowing her to increase her clientele and earn more income. It also assesses whether clients pay for services in cash or in kind. Many CMWs have reported that a low level of community acceptance reduces utilization.[21]

3) *Dynamics between CMWs and other community-health providers:* CMWs are a relatively new cadre of health care provider working at the community level while TBAs, LHWs, and Community Health Workers (CHWs) are well established.[24] The responsibilities of the CMW are both distinct from and overlap with other community health providers. As such, CMWs are often in competitive rather than collaborative relationships with other community-health providers. Some CMWs in Pakistan have reported problematic relationships with TBAs/*dais*, LHWs and obstetricians. The PAIMAN project and other CMW initiatives found that CMWs were able to gain the respect and acceptance by the community more readily when a mother, grandmother or other family member had served as a TBA.[28] The dynamics with other healthcare providers can have both positive and negative impacts; the image of the CMW within this network of community healthcare providers can link influence the level of utilization of the CMW's services. This factor assesses the CMW's relationships with other health professionals who work in the community, and documents whether she has some sort of income-sharing agreement with them, either in cash or in kind.

4) *Linkages between CMWs and facilities:* A key role of the CMW is to provide timely referral for obstetric and newborn complications that she cannot manage. [29] This factor looks at the availability and accessibility of referral services. It assesses the number of referral facilities accessible, the basis on which a facility permits the CMW to refer her clients and looks at other elements such as referral facility timings, the available mode of transport and its reliability, and the fees charged by the facility. It also looks at the midwife's record-keeping habits with regard to referrals, examines how well the referrals are followed up, and reviews the type of cases that are generally referred. It gauges the interpersonal relationships between the CMW and the referral service personnel – including but not limited to drivers, paramedics, nurses and doctors – and assesses the satisfaction of the community with these referral services.

5) *Affordability of CMW services:* Evidence to date suggests that financial remuneration of CMWs is a challenge. Most CMWs belong to relatively poor families resident in poor communities and do have a source of income other than their practice. In one study, the cost of care was identified as the principal reason why communities preferred TBA services.[21] Faisal et al. [24] found that the availability of free services in the community, the inability of women to pay for what are perceived to be higher-priced CMW services, family restrictions on the mobility of CMWs and low motivation to practice due to low financial returns are factors that influence the CMW's level of remuneration. TBA services, by and

large, are more affordable to low-income clients and payment terms are more flexible, e.g. TBAs often accept in-kind contributions as payment. As a result, affordability of the CMW's services is a major influence on the financial viability of her practice.

6) *Supportive supervision:* Supportive supervision is critical to ensuring the delivery of high quality services. [24] It provides confidence to the CMW and to the community, and also identifies needs for further training to maintain the quality of care provided by the CMW. This factor examines the CMW's access to supervision, the manner in which supervision is provided, the preparation of the supervisor and criteria for her selection, her role in handling any problems/grievances, and the supervisor's relationship with CMWs. It also looks at the CMWs' access to in-service education.

Research Questions

1. How do the following six factors influence CMW utilization and retention: [a] training competencies of CMWs, [b] client/community satisfaction, [c] perceptions of the CMW by TBAs/LHWs & LHVs [d] market share of the CMW, [e] CMW turnover, and [f] adequate remuneration to CMWs?
2. What are other push (facilitating) and pull (hindering) factors – not included in the six factors listed above – that have an impact on the CMW's service utilization by the communities?

Research Methodology and Modifications

The first year of the project, completed in 2011, assessed the competency, quality and readiness of CMWs of MNCH as well as CCSP, to perform in the community before their deployment. In the two remaining years, the research was to follow up these two groups of CMW and assess the constraining and facilitating factors, in terms of their contributions to supporting the uptake, utilization and effectiveness of CMW services. Due to non- deployment of MNCH CMWs only the CCSP's CMWs were tracked in the second and third year of OR. Refer to table 1 for details.

Table 1: Study Methodology and Its Description

	Phase I (2011)	Phase II (2012)	Phase III (2013)
Study design	Prospective, longitudinal comparative with quantitative and qualitative component (Mixed	Prospective, longitudinal cohort with quantitative and qualitative component (Mixed method)	Prospective, longitudinal cohort with quantitative and qualitative component (Mixed method)

	Phase I (2011)	Phase II (2012)	Phase III (2013)
	method)		
Instrument	**Quantitative**: Steven Harvey tool[3] pilot tested in Africa for Knowledge and skills Assessment of midwives **Qualitative:** Self developed pilot tested interview guides for CMWs	**Quantitative: Same** **Qualitative:** Self developed pilot tested interview guides for CMWs, VHC, Women utilizing and not utilizing services, other healthcare professionals (TBAs, LHVs & LHWs) community leaders and key informants including, programme manager, programme coordinator, supervisors, manager CBSG, and manager BCC.	**Same**
Study location	Chitral District of Khyber Pakhtunkhwa Province. 50% of the villages according to the Paul Rippey's categorization of 'green', 'yellow' and 'red' villages[4].	**Same**	**Same**
Study population, sampling and data collection procedure	1) Focus group discussion of CMWs from CCSP and MNCH(two each) comprising of 6-8 midwives in each group 2) Theory and OSCE Skills Test of all the	Individual in-depth interviews of all CCSP CMWs Theory and OSCE Skills Test of all the CCSP CMWs Following data was collected from the 14 villages (50%) for:	**Same**

[3] *S. A. Harvey et al. "Are skilled birth attendants really skilled? A measurement method, some disturbing results and a potential way forward," Bulletin of the World Health Organization, October 2007, 85 (10)*
[4] *From Paul Rippley's report*

	Phase I (2011)	Phase II (2012)	Phase III (2013)
	CCSP and MNCH CMWs	a) On-site observation of each CMW's workstation and routine. b) All TBAs and LHWs operating– Focus Group Discussions c) Village health committee members and community leaders d) Community Women who have utilized CMW services – Focus Group Discussions (6 to 8 women) e) Community woman who have not utilized the CMW services– Focus Group Discussions (6 to 8 women) f) key informant interviews including Program Manager for CCSP, Supervisors, EDO, Manager CBSG, Project Coordinator, Manager MIS – individual in-	

	Phase I (2011)	Phase II (2012)	Phase III (2013)
		depth interviews g) House hold survey from all stakeholder for CBSG and CMWs	
Ethical Review	Approval received from the Ethics Review Committee (ERC) at AKU, Pakistan	Renewal received from ERC, AKU	Renewal received from ERC, AKU

FINDINGS ACCORDING TO RESEARCH QUESTIONS:

1A: Competencies of CMWs

The three year quantitative assessment showed a progressive advancement in overall scores of the CCSP's CMWs. Although the theoretical cumulative score was 58% in 2013, there has been vast improvement from the cumulative score of first year that was 38% (figure 2). The CMWs were able to score better in practical exams (figure 3) as compared to paper based exam. This discrepancy may reflect a possible lack of conceptual clarity corresponding to practical skills,

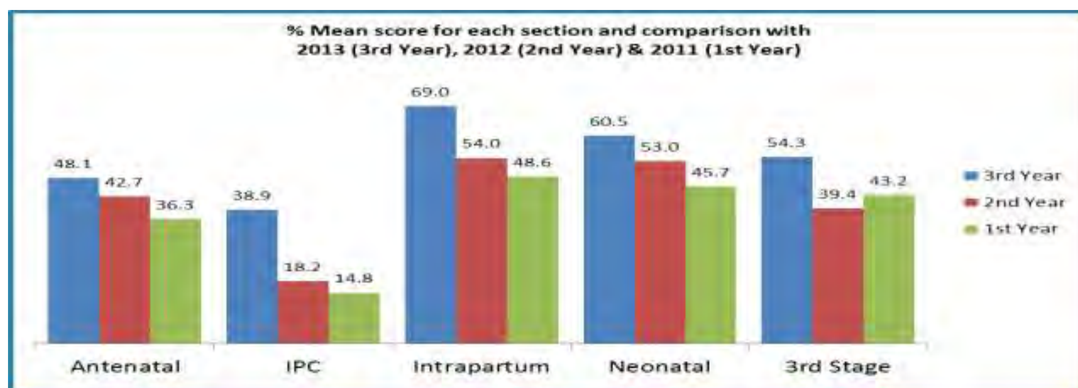


Figure 2: Percentage of mean scores in theoretical testing (2011, 2012 and 2013)

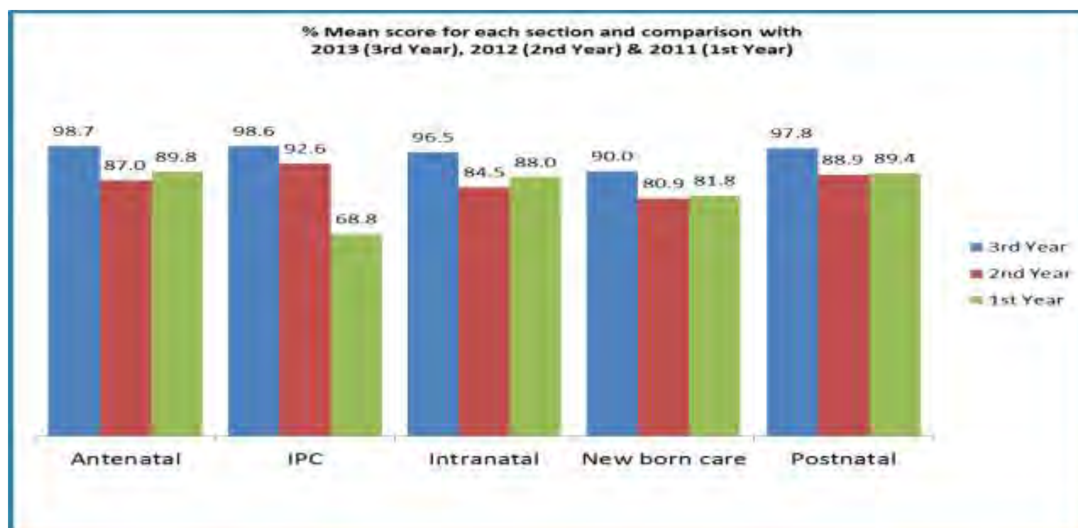


Figure 3: Percentages of mean scores in skills assessment (2011, 2012 and 2013)

possibly knowledge forgotten or never quite grasped. An overall increase gives a positive indication that the work experience post-deployment has improved the knowledge and the skills of CMWs over the period of two years.

All the CMWs felt that they were very well trained through their 18-month course and considered their 6-month attachments to have been an invaluable practical experience. During the training, lack of community component in the clinical practicum was a source of high anxiety for CMWs; however, working autonomously in remote and isolated areas, has enhanced the CMW's self-reliance expertise in caring for women during normal deliveries. The CMWs confidently shared numerous examples where they were able to manage difficult cases of MNCH as well as other health issues, through their knowledge and competence. Ongoing assessments and on-job trainings and refresher courses by AKHS, P has played a major role in improving CMWs' hands-on skills and practice.

You can see their competency level in the beginning it was not there. This came from the need assessment, we organized refresher training…. We see the change because during the refresher training we take pre posttest and we compare this test with previous pre posttest. So is the way we have found the change.(key informant)

(in the past) 2 adult and approximately 8 children died in a year… there are no deaths since I have started the practice. Now people come to me on time; so no misshapes happens…they call me doctor and avail benefits of the services that I offer. I am confident now. (CMW)

The CMWs were appreciated unanimously by all stakeholders, for their critical thinking, assessment and prompt referral of complicated cases, including cases related to MNCH and other health issues (hypertension, stroke, urinary retention, cardiac problems etc.).

1B: Community's satisfaction and acceptance of CMWs' services:

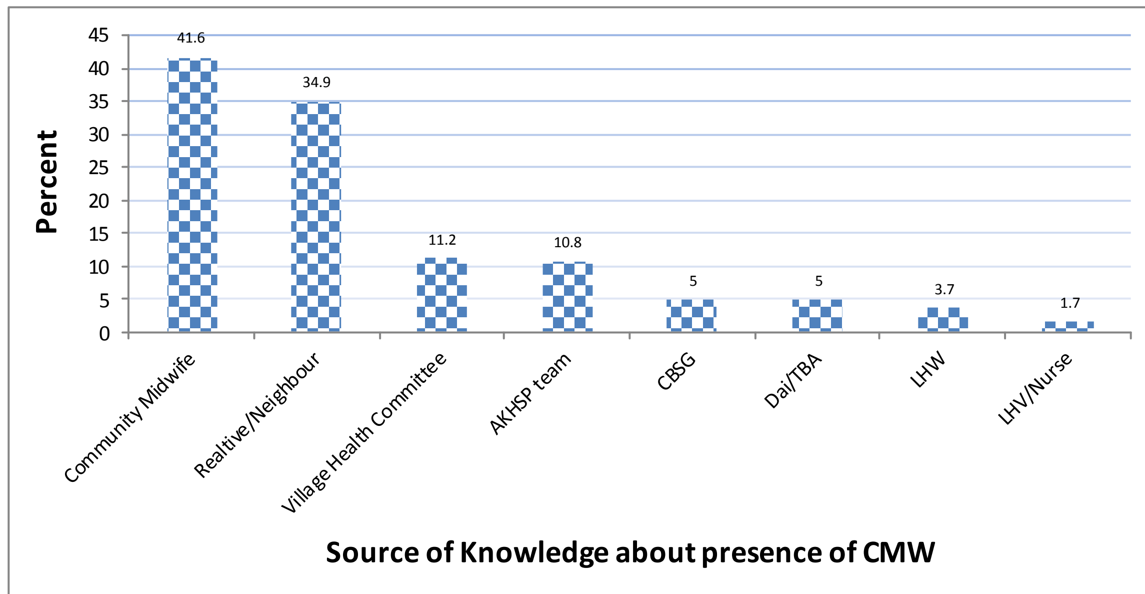
The surveys and FGDs revealed the following results in regard to communities where the CMWs were deployed:

Socio-demographic characteristics of women survey respondents: The mean age of all respondents was 27 and virtually all were currently married. Mean number of living children was 2.8. About 55% of women interviewed were illiterate.

Community knowledge of CMWs: All community members were asked about their knowledge and utilization of CMWs. About 59% of respondents knew that CMWs were in their

communities. CMWs themselves were the major source of respondent's knowledge followed by relatives/neighbors and village health committees (Figure 1).

Figure 4: Source of knowledge about the presence of CMWs in the area



Information about the acceptability of CMWs to community members was obtained from FGDs. Community members were appreciative of the fact that a CMW had been deployed to their area. Communities who accepted CMWs' services praised them highly for their competence, the health education sessions they provided and their attitude. Having CMW in their area was labeled as 'God's Blessing'. Availability of CMW at all times even in inclement weather made this cadre acceptable by majority of area people. Even in inclement weather the CMWs have travelled on foot in order to reach client's home for delivery.

> **She takes care of us throughout pregnancy till after the delivery… There are many benefits of CMW like saving of time and money and we receive quality treatment while sitting at home… In winter there is heavy snowfall in this area and we are disconnected from other areas. If there is any patient we cannot take them to hospital therefore it is good to have CMW in our area that is available and accessible at all times. (Community woman)**

Community support for CMWs is also evident by the fact that VHCs in a few cases have arranged CMWs' marriages or have looked for jobs for their future husbands so that the CMW will remain in the community.

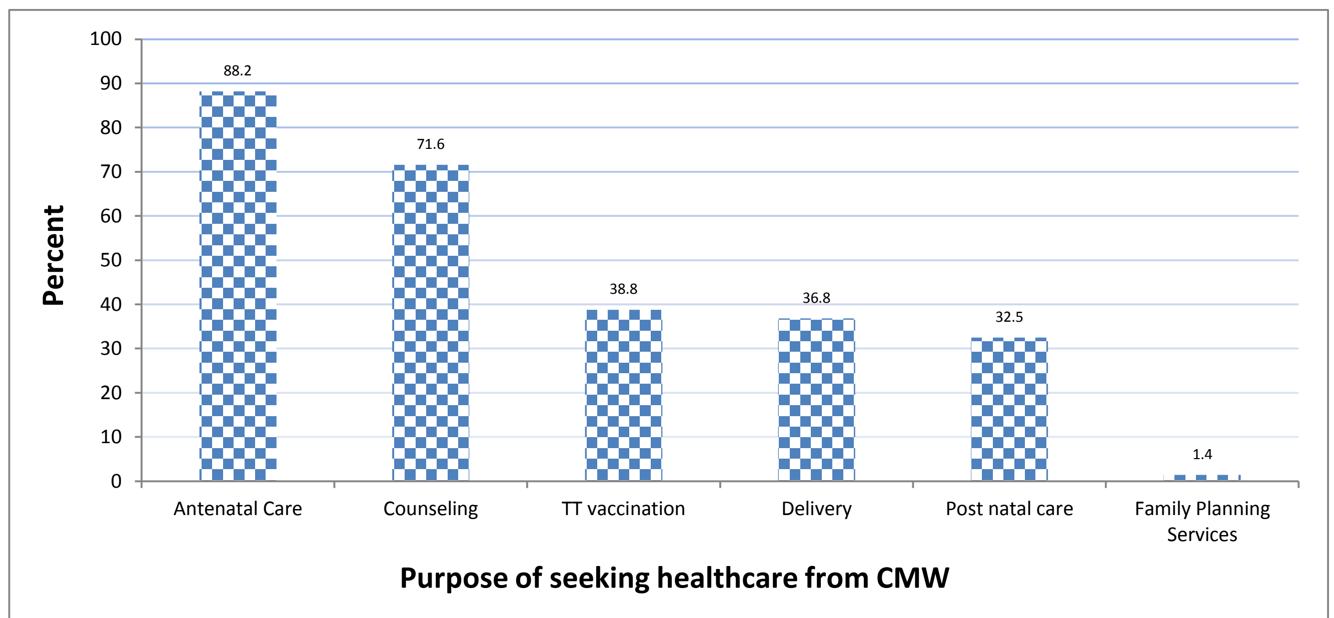
The FGDs revealed that women preferred higher level (especially doctors) providers to less trained providers. The lack of doctors required communities to use the less skilled trained birth

attendants (TBAs). CMWs were recognized as being better trained and more skilled than TBAs, and women began making more use of the CMWs. **'Care for woman by woman'** came up frequently in the discussions whereby most of the participants felt it easier to share female related issues with the CMW who understood their problems and managed the case accordingly.

There are instances where CMWs were still struggling for recognition in their community. Limited acceptability was most likely to occur in the most conservative villages with the highest levels of female illiteracy and the lowest levels of female autonomy. The presence of easily accessible free health care in the vicinity also reduced women's use of CMWs.

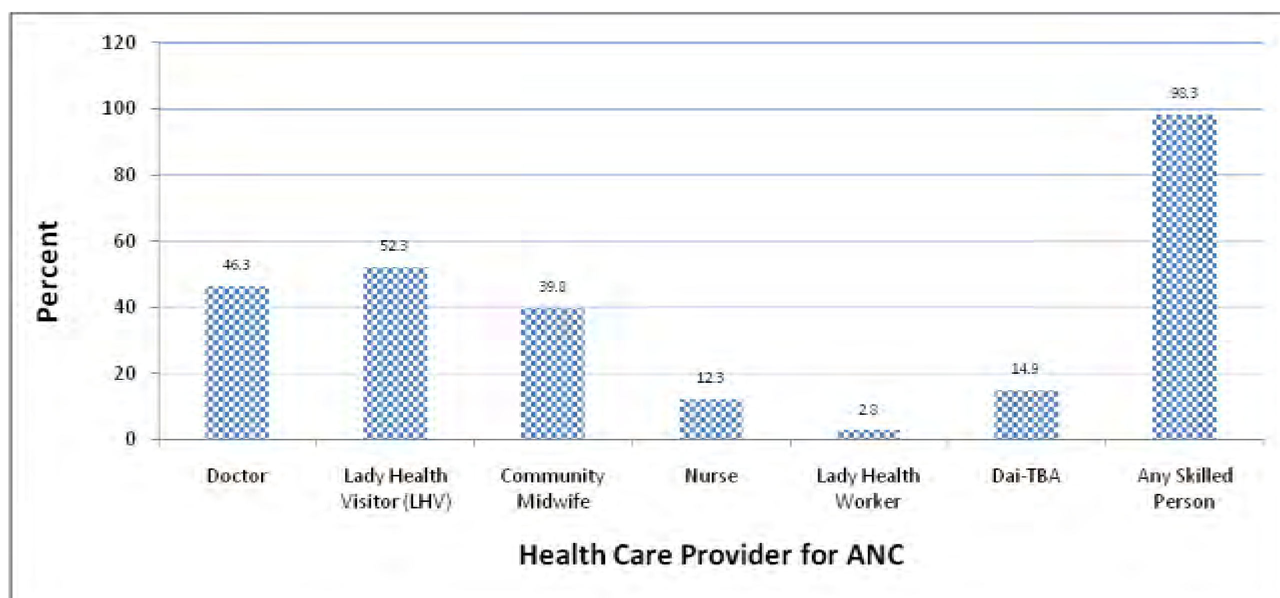
Utilization of CMWs: Among those who knew of the presence of CMWs in their areas, 53% attended educational sessions conducted by CMWs. Most respondents said that the information received at the sessions influenced their decision about seeking healthcare during pregnancy (Very much 46.3%, somewhat 30.9%, not at all 17.5%, non-response 5.4 %,). Additionally about 65% received healthcare from a CMW during their previous pregnancy. The most commonly provided service was antenatal care (Figure 2).

Figure 5: Respondent's purpose for seeking healthcare from CMWs



Antenatal Care: Women made an average of 3.7 ANC visits during their last pregnancy and many used more than one type of provider for the service. As shown in Figure 3, CMWs provided ANC services to 40% of women in the program villages.

Figure 6: ANC care provided by CMWs and other providers



Delivery during last pregnancy: As seen in Table 1 very few deliveries were attended at CMW posts, with most women delivering at home. However, CMWs did account for about a third of all birth assistance furnished by skilled attendants, and about 14% of all births.

Table 2: Location of last birth and person assisting last birth

Characteristics	N	%
Place of Delivery		
Home	643	70.8%
CMW working station	7	0.8%
BHU	17	1.9%
RHC	4	0.4%
Hospital/Clinic	101	11.1%
AKHSP	124	13.7%
Bashaleni	11	1.2%
On the way	1	0.1%
Delivery assisted by		
Doctor	119	13.1%

Lady Health Visitor	181	19.9%
Community Midwife	128	14.1%
Nurse/Midwife	49	5.4%
Dai-TBA	153	16.9%
Relative/Family Member	273	30.1%
LHW	2	0.2%
Self	3	.3%

In addition to assisting normal deliveries, CMWs also provided care at about 13% of complicated deliveries. Among skilled providers this number was third after the services provided by LHVs (37%) and doctors (30%).

CMW referral: An important part of CMW activity was referring complicated cases to higher level health facilities. CMWs increased the number of referrals they made over time. The CMWs have become more confident and competent in referring emergency as well as presumptive cases related to MNCH, on timely basis. So far approximately 50% of the CMWs have referred cases.

Yes we have transport issue mostly (for referral). In mornings the car goes to Chitral and comes back in afternoon…. (Transport is) not available, we have to call to Chitral for car. Many times due to transport crisis we also have to manage complicated cases (instead of sending them for referral) (CMW)

Barriers to completing referrals including lack of funds for transportation of the women in need of referral, lack of CMW funds for accompanying referred women, and a lack of accommodations for family members at the referral sites. Lack of CMW knowledge did not appear to be a referral barrier. Due to high cost related to referral most of the FGD participants wanted CMWs to be further trained in managing complicated cases in their own work stations.

Post-natal care: One third of study participants reported receiving PNC after their last delivery. Among women receiving PNC, The CMW was the most frequently cited source of care (37%) followed by doctors (29%) and LHVs (24%).

CMW availability and care seeking behaviour: Focus group results suggest that the presence of CMWs in the community allowed residents to act on their desire for skilled MCH care. Women at the FGDs said that they realised that appropriate care is essential to ensuring healthy pregnancies and safe deliveries and that, even if other healthcare providers are

unavailable or inaccessible, they felt they must consult the TBA. Since the arrival of the relatively better trained and experienced CMWs, community members have begun to alter their health decision-making and usage patterns and made greater use of CMWs. The majority of women expressed the desire for regular check-ups, and stated that these consultations were important so that women would face decreased risks of poor outcomes.

1C: CMWs' perception by TBAs/LHWs/LHVs

The CMWs, despite being considered private providers were expected to fit into the public health system worker cadres. Their relationship with LHWs and LHVs was generally found to be reciprocal. Most of the LHWs and LHVs acknowledged the expertise of CMWs. It was felt that CMWs have brought positive changes in their respective areas in terms of health management of women and children. However, In case of TBA, the relationship was either good or no relationship at all. Initially some TBAs were reluctant to accept CMWs and discouraged client to visit them. AKHS, P has worked on improving the CMWs' and TBAs' relationship by introducing monetary incentives for TBAs for referring clients to CMWs as well as having regular meetings with CMWs and TBAs. However, there were still TBAs who resented the competition of CMWs for clients and fees.

> **She also behaves well with the village people and has a good relationship with them…During delivery she is very careful about the cleanliness and nurse mother very well. If there are any complications then she refers her to the hospital…. We give medicines on the basis of our experience but she gives after complete checkup (TBA)**

> **We give fee referral of RS. 200 as an incentive to the TBAs, some are accepting this and some think that the money is less because when they used to do delivery they used to get more. They are working as a competitor now days so they don't accept this. Other than that they take CMW as a threat.(key informant)**

1D: CMWs' turnover

As of July 2013, all the 28 CMWs were working in their respective areas. This was likely due to the continued and organized support of AKHS,P which was provided to these CMWs, in form of material, human and financial resources.

However, most of the CMWs argued that after September 2013 they will continue working only if their monthly stipend is continued and increased by AKHS-P. Most of the CMWs who didn't earn well felt that financial survival with the closure of the project will be next to impossible. Although majority of the study participants wanted to retain the CMWs' services, they needed external financial support since the communities could not afford to do so. They also added that the project should continue to support the CMWs for a few years to help ensure their work continues and their services are sustained.

1E: Market share of CMWs

In terms of finances, the CMWs were sharing their income with TBAs who were referring clients or were assisting CMWs in deliveries. The CMWs paid TBAs for patient referral as well as for their assistance during delivery. For patient referral the CMWs gave $ 2 -$ 3 equivalent and half of their earning, approximately $ 5 equivalent for assistance during deliveries. On the other hand, CMWs were not being paid for referring clients to other health facilities.

> **… like every health provider is given objective and exact target that they have to achieve. obviously if CMW has come there, that CMW is very active and she sees every patient and covers her area so less patients go to the doctors and their target is not achieved like there are this much percent of deliveries and half of it is done by CMW and half of it is left for them, so that is why (issues have occurred) (key informant)**

In terms of patient volume, it was found that 26% of CBSG members and 18% of non CBSG members have utilized CMWs' services. Few FGDs revealed that in some areas the CMWs are catering to more MNCH clients than the other health care professionals of those areas.

Realities of underutilization of CMW services:

There are instances where CMWs are still struggling for recognition in their community. Some of the reasons highlighted during the interviews were a) illiteracy, b) decreased female mobility due to traditional restrictions,

> **In this village there is no acceptance of AKDN, there is no female mobility so they can't go outside…. Even there are many patients or clients that when CMW goes to their house they refuse them and they don't let them do their checkup… (VHC)**

c) presence of free health care services in the vicinity d) misconceptions about AKHS-P, e) people being stubborn and not ready to change practices. The above mentioned problems were identified by AKHS-P who vigorously addressed the issues on individual case to case basis.

1F: CMW remuneration and fee for service

Majority of the CMWs have voiced their dissatisfaction in regards to their remuneration. As per GOP's pay scale for the CMWs, AKHSP has increased CMWs' stipend from rupees 2000 to 5000 (from $ 20 to $ 50 equivalent) in the mid of 2012; however in comparison to the rising country's inflation this monthly payment was found to be inadequate by all stakeholders.

Although the CMWs' service fees were minimal in most of the areas, as per MIS data and CMWs' interviews (delivery package 500-1000 rupees ($5- 10), 20-50 rupees for ANC and no charge for postnatal care in majority of the areas), majority of the people in the villages still did not pay CMWs' fee. The reasons quoted were a) poverty, b) joblessness c) lack of education and awareness, d) lack of inclination to pay due to relationship with CMW, e) expectation of free health care services, and d) presence of free health care services within the vicinity. Most of the CMWs were found to be 'too humble' to ask for their services' fee from the people.

> **…. most (CMW's) services are given free. We call meeting and tell people that she has given many free services and now she should get her fees. These people are illiterate they do not agree to this. (VHC)**

CBSG and finances for MNCH services:

Characteristics of CBSG members and non-members: A total of 892 women provided information about their membership in CBSGs. About 35% of all women interviewed were members and 65% were non-members. Women who were CBSG members were younger (p<.02), more literate (p<.001), and had slightly fewer children than non-members (p<.001).

There were no statistically significant differences in household size, or in household monthly per-capita income.

CMW utilization among CBSG members and non-members: Table 3 compares CMW services accessed by members and non-members. In all cases except ANC, members used more services than non-members. Although more members than non-members received the "continuum of care" (ANC, Delivery and PNC care) the number receiving such care was quite small.

Table 3: Use of CMW services by CBSG members and non-members

CMW Service at last pregnancy	CBSG member	CBSG non-member
Received any type of care from CMW	75% (N=258)	55% (N=280)
Received antenatal care from CMW	39% (N=290)	40% (N=481)
Received MCH education from CMW	56% (N=262)	28% (N=331)
Delivery attended by CMW	26% (N=303)	18% (N=605)
Received postpartum care from CMW	54% (N=132)	24% (N=171)
Continuum of care from CMW	13% (N=303)	3% (N=605)

The difference in the number of ANC visits received by CBSG members and non-members was small. Members made a mean of 4.4 visits, compared to 3.3 for non-members.

CBSG loans: At the time of the survey about 16% of members had received loans from their CBSG for MCH purposes. The mean value of the loans was about $22. Most loans were used to cover the cost of factors related to obtaining child birth care in the case of complicated deliveries. Table 3 shows the purposes that loans were used for.

Table 4: Use of MCH related loans obtained from CBSGs*

Loan Use	Number of Responses	%
Transportation	14	30%

Mother's treatment cost	10	21%
Child's treatment cost	25	53%
Vaccination	16	34%
Medication	25	53%

*Multiple responses, table does not sum to 100%.

About 24% of members received loans for non-pregnancy related reasons. The mean value of these loans was approximately $27, which is somewhat higher than loans to cover costs related to complicated pregnancies. Table 4 shows the purposes these loans were used for.

Table 5: Use of non MCH related loans obtained from CBSGs*

Loan Use	Number of Responses	%
Purchase of household items	41	55%
School fees/books	23	31%
Non-pregnancy related health care	7	10%
Wedding	4	5%
Funeral	2	3%
Others	5	7%

*Multiple responses, table does not sum to 100%.

The most important reasons for taking a loan for non-pregnancy related reasons were to purchase household items, pay school fees and purchase textbooks, and for non-pregnancy related health care.

The FGDs revealed similar data on CBSG loan utilization for purposes other than MNCH. It was found that a very small amount of the saved money is being used for maternal health, as was the sole purpose of establishing these groups. The participants shared that initially the saving group were active but when the members were told to use this loan for maternal health only, the community's interest dwindled and very few groups survived; therefore, AKHS-P changed the approach to 'save for the purpose of saving only'. It was felt that at least this way the

women will be empowered to have financial accessibility and will be able to utilize money when required. This strategy helped in revitalizing the dormant CBSGs in majority of the areas.

2: Constraints and enabling factors for CMWs

The push and pull factors which affected CMWs' service provision are listed in table 6. These factors have been compiled from findings of the surveys and FGDs.

Table 6: the push and pull factors for CMWs' service utilization

Push factors	Pull factors
Strong supportive system by AKHSP e.g. Supportive supervision, coordinator, supervisors, BCC officer, female volunteers and male mobilizers	Low stipend even after increase in remuneration
Continuous quality assurance checks, on the job training, ongoing practical training through clinical mentorship at health centers	People unable or not willing to pay CMWs' fee
Collaborative relationship with LHWs, LHVs and TBAs. In some cases good working relationship with doctors and dispensers of the area	In few cases families of CMWs not allowing them to go for home visits
Stronger and active support from VHCs in motivating villagers, arranging transport for referral and home deliveries, monitoring CMWs'	Female mobility restrictions in few nontraditional areas
Active support and utilization of CMW's services by community	In few communities resistance against CMWs due to traditions, illiteracy, misconceptions against AKDN
Increased CMWs' families support due to increase in remuneration of CMWs	Referral issues due to transportation unavailability and affordability,
Increased status in the community, high self-motivation and positive changes within CMW's personality	Physical conditions: inclement weather, broken or blocked roads and far flung areas
Care of woman by a woman increased CMWs' service utilization	Few TBAs find CMWs as competitors and a threat and so discourage clients to go to CMWs
Few CMWs getting paid by area people for their services as evident by earning of 15000-20000 per month ($ 150-200 equivalent)	Future sustainability of CMWs after the closure of CCSP in 2013.

What worked well in CCSP Project

Social Solidarity and Empowerment

Through this project, the CMWs became empowered females who gained respect and positive status in their communities. When they joined the project, the CMWs were mere females who didn't have confidence to talk to anyone in their village, especially males; however, after 2 years they were confidently making home visits, motivating males and females to bring positive change in their health.

Supporting their own families financially has empowered these CMWs to have a say in family decision making process- a huge change where a female is not even allowed to step outside their home with the permission of their male family members.

In keeping with Saving Group experience globally, CBSG members experienced development that is both financial and personal -- a mixture of the pride in their accomplishments, solidarity with their friends, and confidence that comes with success. In addition to being member-run financial institutions, CBSGs were women's groups with an internal social dynamic of mutual support, and a strong common desire to improve their lives. Seen in that light, the role of CBSGs in education, self-improvement and mutual support seemed inevitable.

A Mutually Supportive Relationship – CMW & CBSG

The CBSGs were a logical target for the CMW. Members were a receptive audience, open to learning about how to care for themselves during pregnancy. By design, the CMWs and the CBSGs had a mutually beneficial relationship that advanced project goals. These intersecting dimensions of the CBSG/CMW relationship made it a privileged one that facilitated another aspect of the CMW's job – to market her services. Under pressure to replace her first-year salary with fees-for-service, the CMW had market herself. CBSGs were an important marketing channel for her; they were easy to use because she was already attending meetings in her role as educator. That the CMW targeted her marketing to CBSGs helps to explain how CBSG membership surfaced as a significant variable in the decision to use CMW services.

Support to sustain the CMW services

Interventions in this project like supportive supervision, CMWs' advocacy through VHCs, community mobilizers, other human resources, and CBSGs are unique measures that are comparatively new in Pakistani context. These actions led to community involvement and ownership from selection to CMWs till to date when these midwives are providing services. the positive role of AKHS-P in providing strong structural, administrative, and in field support in order to ensure the maximum utilization of CMWs' services in their respective areas. Keeping in view the cultural and traditional beliefs of those areas, a new cadre of 'helpers' i.e. male mobilizers were selected and trained. The main aim was order to create awareness and support for CMWs' services as well as address religious and cultural misconceptions against the project and AKDN-P in the non-traditional areas. Engagement of male motivators and religious leaders to facilitate CMW uptake in conservative communities have increased the utilization of CMWs' services.

BCC and Health Education information dissemination through VHC and CBSG

Initially VHCs platform was utilized for BCC, marketing of CMW services including her roles and responsibilities, and community mobilization. However, in long run, the CBSG platform served the purpose of BCC, uptake of CMW service, health education for the community and empowerment of CMWs and community woman. And because the CBSG membership is a family affair, BCC sessions reached beyond those in attendance. Older women often sent younger daughters or daughters in law to join and represent them in the group. Thus, educational messages and information disseminated to group members reached their extended families, especially the all-important mother-in-law who is the household administrator and

decision-maker regarding care for pregnant daughters-in-law. The CBSGs were instrumental to sensitizing the older generation to the importance of safe delivery.

What did not worked well in CCSP

Though there are so many interventions that worked well in the project; there are still grey areas that requires some more additional steps to be implemented and need further in-depth analysis of the overall situation.

Home births versus birthing station

The preference of CMWs and community female to deliver at home rather than a birthing station. The birth station was used for antenatal assessments, checking vital signs and treating minor illnesses. The reasons were expecting mothers felt more comfortable and stress free in their known surroundings; the whole family of the expectant mother would be present for continued support during delivery to the pregnant female and the CMW, pregnant woman would not have to travel through inclement weather or difficult roads, and the presence of male family members in the home were helpful in case of emergency referral. Hence, there was overall lack of utilization of the birthing station.

Referral and follow-up

Referring of cases by CMWs was working well and they were applauded by their community for their prompt assessment and immediate management. However, the follow-up of referred cases was to some extent done by CMWs but they were not receiving complete status. At times both CMW and community faced difficulty in referring the client due to a) transportation unavailability especially during inclement weather and damaged roads and b) very expensive transport in remote areas (For community people the expense of transportation was the top

most concern) c) non availability of accommodation for the referred patients' relatives near the referral site.

Utilization of CBSG

Mixed responses were elicited as far as CBSG activities and utilization is concerned. Although the saving groups have become more active in few areas, they have disintegrated or non-functional in some areas. Although majority of the saving groups are led by women, they are being used more for paying school fees, wedding, business, etc. CBSG is still underutilized for financing maternal and newborn health. Therefore, the CBSG has limited success and impact as mechanism to overcome financial barriers to health care seeking behavior.

As the end of the pilot project approaches, its future may be in jeopardy due to the Pakistan Government's decentralizing its health system which means that expanding the project depends on obtaining provincial funding. Existing CMWs may find that they cannot make a living in impoverished communities and may migrate to relatively better off areas or cease working in health altogether.

DISCUSSION

The information available for this synthesis indicates that CMW services enjoyed strong uptake during their first year of deployment. About 40% of women used CMWs for ANC during their last pregnancy, 14% for delivery, and 37% of PNC visits. Focus group reports suggest that CMWs made appropriate referrals, but that the number of completed referrals was constrained by the poverty of the target population who could not afford the travel and lodging costs involved in seeking care from clinics and hospitals. The CMW was also perceived as fitting in well with the government health providers in the district. The only problems appeared to be with TBAs who saw the midwives as a threat to incomes obtained from the provision of birthing services.

CBSGs were popular; approximately 100 groups with almost 1,900 members were established during an eight month period during 2010. Approximately 40% of all surveyed members had received loans by the third quarter of 2012. Most loans were used to finance the purchase of household items, school fees and textbooks, weddings and burials. Only 16% used loans for MCH purposes and about 40% of these were used to meet the costs of complicated deliveries. CBSGs also served as a venue for CMWs to give talks on maternal and child health and to promote their services. In a conservative culture, the CBSGs also provided women with access to money, and with experience in participating in and organizing group activities. The availability of the CBSG as a venue for health and other types of education along with the empowerment of women may prove to be at least, if not more important than, its role in providing money for MCH care.

Under the CCSP project AKHSP has put in a lot of efforts in order to bring a positive change in maternal and neonatal health. It is important to note that AKHSP has worked in those areas where no government or AKDN or any other health care facilities were available- the non-traditional areas. The goal of the CCSP is to develop a CMW Model that enhances utilization of CMW services and can be replicated in other parts of Pakistan. Though the overall funding was limited , CCSP not only effectively implemented the deployment guidelines laid down by the GOP it had also executed an additional set of targeted activities that aim to improve the uptake of CMW services and foster sustainability over time. For sustainability of CMWs, AKHS, P has signed MOU with DKT Pakistan to continue to provide technical support, refresher courses, and provision of family planning supplies. In addition, there is a communication with DOH KPK to absorb all the deployed CMWs in the mainstream provincial health system.

As the end of the pilot project approaches, its future may be in jeopardy due to the Pakistan Government's decentralizing its health system which means that expanding the project depends on obtaining provincial funding. Existing CMWs may find that they cannot make a living in impoverished communities and may migrate to relatively better off areas or cease working in health altogether.

Way forward – AKDN as a learning Agency

The CCSP ended with the strong probability that most of the Savings Groups, and most of the CMW's, would continue functioning past the end of the project. This is an impressive accomplishment in an area so remote, so poor, and in some places, so conservative. It alone is worth replicating. Indeed, informed by these lessons learned, AKDN plans to replicate the CCSP strategy integrating community health and finance. The CCSP experience serves to guide others as well -- health ministries, peer organizations, and other civil society organizations seeking more robust results from their MNCH programs.

However, In order to sustain the CMWs and their services, AKHS, P has done meeting with the provincial health secretary and provincial MNCH for absorbing the CMWs. This notion of future sustainability was widely echoed by the CMWs who reported they would quit the work when the project closed down in 2013 and this is congruent with the philosophy of the AKDN i.e. exit at appropriate time with empowered communities.

A health care system of 'health for communities by the communities' and in specifically 'care by the women for the women' has evolved in this project. It is a unique system which has been initiated and managed by AKHSP for CCSP. It is recommended that the system with its learnt experience should be shared and disseminate at national and international for future replication of this successful venture. This evolving model of supportive measures for CMWs is commendable and should be disseminated widely through print media and online blogs etc. This itself, if disseminated to various stakeholders, can serve as a model which could be replicated for achieving goals of decreasing MMR and NMR in the country.

End Notes

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ANNEX XVI

Operations Research Brief

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Community Midwifes, Aga Khan Foundation

Key Findings:

- Competencies of CMW
- Client/community satisfaction
- Perceptions of the CMW by other providers
- Market share of the CMW
- CMW turnover
- Remuneration to CMWs
- Other facilitating and hindering factors

"Final Evaluation Report of Chitral Child Survival Project"

EXECUTIVE SUMMARY

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

Background

In Pakistan, four million newborns die annually in the first week of life, and about half million mothers perish due to preventable pregnancy-related causes, such as postpartum hemorrhage, eclampsia, and sepsis. In Chitral District, a geographically remote area of northwest Pakistan bordering Afghanistan, maternal and infant mortality rates remain persistently high due to barriers in accessing medical services, such as a lack of transportation, significant distances and travel time between women's homes and available health facilities, and the high costs associated with reaching and using medical care. Not surprisingly, 82 percent of deliveries in Chitral take place at home, compared to 65 percent nationally, with only 20 percent assisted by a skilled birth attendant.

In 2005, the Government of Pakistan created the National Maternal, Newborn, and Child Health Program (NMNCHP). At that time, the NMNCHP was the custodian of the already established national Community Midwifery Initiative that aimed to train and deploy 12,000 skilled birth attendants at the community level around the country to support pregnancies and births and to stem thousands of preventable maternal, neonatal, and child deaths. Devolution occurred in June 2011 in Pakistan, transitioning the responsibility for the program to provinces. At this time, there are no accurate figures on the actual number of community midwives (CMWs) deployed and active in the field. Anecdotal information indicates that only 50% of CMWs are active in their communities. Hence, the Chitral Child Survival Program (CCSP) was initiated in 2009 as a pilot project to increase the competence and utilization of Community Midwives. The goal of the CCSP is to develop a CMW model that enhances utilization of CMW services and can be replicated in other parts of Pakistan. CCSP implemented deployment guidelines as they were documented in the government papers through set of targeted activities that aim to improve the uptake of CMW services over time.

OPERATIONS RESEARCH BRIEF

June 2014

Intervention Design and Implementation

In 2010, the Aga Khan Foundation, in collaboration with the government, established the first Midwifery School in Chitral, which was accredited by the Pakistan Nursing Council (PNC). The school trained 28 CMWs using the PNC's 18-month curriculum, plus six months of practical training, which has not been a component of the standard PNC curriculum). Once deployed (mid 2011), CCSP equipped the CMWs with a delivery station, toolkit, and a monthly stipend for their first year of deployment, with the expectation that they would sustain themselves with user fees after the first year. The CCSP also formed Village Health Committees (VHCs) in the communities where the CMWs were deployed to set a fee structure for the CMW's services, mobilize resources for emergency transportation to a health center, and conduct health events. The VHC was also designed to support ongoing maternal, neonatal, and child health (MNCH) services and ensure they continue after the CCSP ended. Additionally, the VHC served as a way to improve acceptance of CMW services, particularly among other providers like the Lady Health Workers. The CCSP trained local change agents to use behavior change communication (BCC) materials on maternal and newborn care issues. For pregnancies requiring specialized or emergency treatment, the CCSP strengthened the linkages between the community based care and more specialized health facilities for easy and prompt referral and treatment.

Devolution has had impacts on the project implementation over time, as previous agreements for support to CMWs after the end of the project with the national level MOH were no longer in place. In addition, the government was unable to deploy their own midwives during the project time period for comparison of CCSP supported midwives to this cadre.

The CCSP also established community based savings groups (CBSGs) to test if a savings mechanism would facilitate community members' access to safe delivery services by enabling women and their families to more easily pay for CMWs' services. CBSGs also served as a channel for CMWs to promote their services.

Methodology

The operations research component of the project sought to determine the effects of six factors known to affect CMW utilization and retention: (1) training competencies of CMWs, (2) client/community satisfaction, (3) perceptions of the CMW by other providers such as traditional birth attendants (TBAs), (4) market share of the CMW, (5) CMW turnover, and (6) adequate remuneration to CMWs. The project also investigated other facilitating and hindering factors that affected the community utilization of CMW's services.

In 2011, the project assessed the competency, quality, and readiness of CMWs to perform in the community. In 2012-2013, the project assessed the uptake, utilization, and effectiveness of CMW services. The researchers used quantitative and qualitative methods of data collection, including key informant interviews, on site observations, and focus groups with various stakeholder groups as well as a household survey of more than 900 community women who were members and non-menbers of CBSGs.

Findings

The key findings, grouped by the six factors listed above are:

Competencies of CMWs. The CMWs rated their competencies as high, as did various stakeholders. The CMWs scored higher in practical exams compared to paper-based exams. The CMWs said the practice aspects of the training were essential. Qualitative data suggest that CMWs made appropriate referrals to higher level facilities, when needed.

Client/community satisfaction. The research measured multiple aspects of this factor including community knowledge of CMWs, utilization of CMWs, and delivery during last pregnancy. About six of 10 female community members surveyed knew about the CMWs. Yet, CMWs were underutilized for delivery, accounting for 14 percent of all recent births. CMW utilization was higher for antenatal care (40 percent) and postnatal care (37 percent).

Perceptions of the CMW by other providers. Even though the CMWs were considered private providers, they were expected to fit into the public health system worker cadres. Their relationship with TBAs, Lady Health Workers (LHW), and Lady Health Visitors (LHVs) was generally found to be reciprocal. Most of the LHWs and LHVs acknowledged the expertise of the CWMs. However, some TBAs in particular resented the competition of CMWs for clients and fees.

Market share of the CMW. In terms of finances, the CMWs were sharing their income with TBAs who were referring clients or were assisting CMWs in deliveries. On the other hand, CMWs were not being paid for referring clients to other health facilities. Also, CMWs struggled for recognition in some communities. Reasons highlighted during the interviews for non-use of the CMWs were limited female mobility due to traditional restrictions and nearby free health care services.

CMW turnover. All 28 trained CMWs continued through the project, likely due to the continued and organized support of the project and government, provided in material, human, and financial resources. However, most of the CMWs indicated that they will continue working after September 2013 (the end of the project) only if their monthly stipend is continued and increased.

Remuneration to CMWs. A majority of the CMWs voiced dissatisfaction with their remuneration, likely because a majority of the people in the villages did not pay CMWs' fee. The reasons given for not paying included poverty, joblessness, expectation of free health care services, and presence of free health care services in the vicinity. Also, most CMWs were found to be 'too humble' to ask for their services' fee from the people.

Other facilitating and hindering factors. The project found additional factors that facilitated the uptake, utilization and effectiveness of CMW services, including strong supportive supervision, regular quality assurance checks, support from VHCs in motivating villagers to use their services, and care of a woman by a woman. Among the hindering factors found were female mobility restrictions, people unable or not willing to pay CMWs' fee, sustainability concerns, and others.

Research concerning the impact and use of the CBSG and finance services included several findings. Overall, the CBSGs worked well, with about 100 groups with almost 1,900 members established during an eight month period during 2010. About three of four CBSG members surveyed used some type of CMW services compared to just over half of non-members. Yet at the time of the survey, only about 16 percent of members had received loans from their CBSG for MCH purposes. The mean value of the loans was about $22. Most loans were used to cover the cost of factors related to obtaining child birth care in the case of complicated deliveries. It was more common to use loans for non-pregnancy related reasons: about 24 percent of members received loans for this purpose. The mean value of these loans was approximately $27 and most often went for household items and school fees.

Conclusions and Lessons Learned

Several aspects of the project worked particularly well. The CMWs became empowered females, gaining respect and status in their families and communities. Supporting their own families financially helped them to have a say in family decision-making, a huge change in a male dominated culture. Second, the CBSG platform provided a marketing channel for the CMWs and BCC for the community, thus supporting uptake of CMW services. In fact, membership in a CBSG emerged as a significant variable in the decision to use CMW services. Third, supportive community members, male motivators, and government representatives helped gain additional support for CMW services from their peers.

Despite these achievements, ccommunity women preferred delivering at home rather than at a birthing station, resulting in an overall lack of utilization of the birthing station. The CBSG was underutilized for financing maternal health care and thus had limited success as a mechanism to overcome financial barriers to health care seeking behavior.

The CMW was perceived as fitting in well with the other government health providers in the district. While the CMWs made appropriate referrals to higher level health facilities when needed, the number of completed referrals was constrained by the poverty of the target population who could not afford the travel and lodging costs involved in seeking care from clinics and hospitals.

Recommendations and Use of Findings

Since the CCSP ended, savings groups continue to meet regularly and 27 of the 28 CCSP supported CMWs have continued to function in Chitral, though support is still needed. Recent talks with provincial and district MNCH staff have reaffirmed commitment from the government to absorb the CCSP trained CMWs in the Khyber Pakhtunkhwa system. Even after the end of the project, AKF is committed to and is participating in ongoing discussions with the district and provincial Ministry of Health to ensure that support CMWs trained and deployed by CCSP is transferred to the ministries. AKF is discussing four key issues with the district and provincial Ministry of Health around absorption of CMWs: 1) recognizing the CMWs as a formal cadre of health professionals in the government health system; 2) establishing a service structure including a monthly salary or stipend for CMWs; 3) provision of technical and administrative supervision; and 4) ensuring provision of essential medicines and commodities through the district and provincial logistics system.

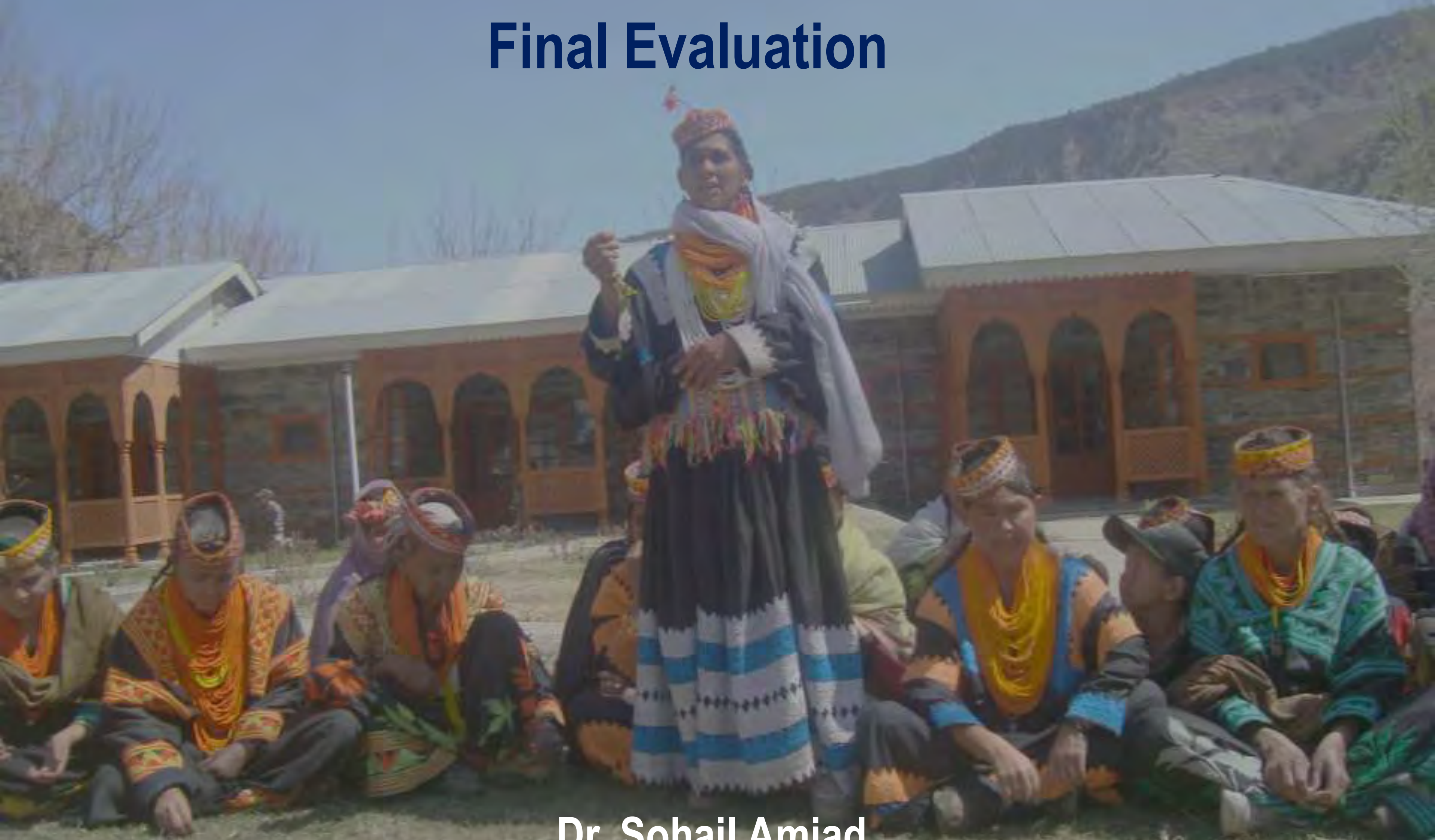
The Chitral Child Survival Project (CCSP) in Chitral, Khyber Pakhtunkhwa, Pakistan is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Chitral Child Survival Project (CCSP) is managed by Aga Khan Foundation under Cooperative Agreement No. GHN-A-00-08-00010-00.
The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

ANNEX XVII

Stakeholder Debrief PowerPoint Presentation

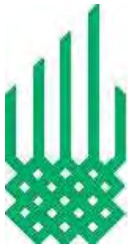
Chitral Child Survival Project

Final Evaluation



Dr. Sohail Amjad

November 2013



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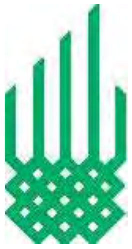
PRESENTATION CONTENTS

1. Background and Outcomes/Results of CCSP
2. Objectives of Final Evaluation (FE)
3. Evaluation Design, Methods and Key Questions
4. Stakeholders Consulted, Other Data Sources
5. FE Findings and Results
   a) Qualitative Research Quotes and Verbatim
   b) Project Accomplishments
   c) Summary of Findings, Conclusions and Recommendations
6. Lesson Learned and The Way Forward



BACKGROUND AND RESULTS OF CCSP

Chitral Child Survival Project (CCSP) was implemented in 28 remote community clusters in Chitral District

Strategic Objective: Increased utilization of obstetric and neonatal continuum of care

Intermediate Result 1:

Increased awareness of obstetric and neonatal complications and informed demand for SBA, community financing, community-based transportation, and birth preparedness and complication readiness plans

Intermediate Result 2:

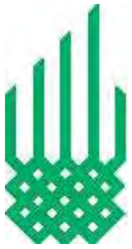
Strengthened CMW referral linkages for obstetric and neonatal care

Intermediate Result 3:

Increased availability of trained community midwives

Intermediate Result 4:

Increased financial access to emergency obstetric and neonatal care



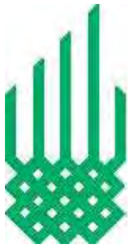
PURPOSE AND OBJECTIVES OF FE

Purpose of FE

"To conduct performance evaluation of CCSP and its contribution towards achieving key results"

FE Findings and Results would be broadly accessible to:

a) Ministries of Health (MOHs), Policy makers,
b) Provincial and District Health Departments
c) Provide evidence to global initiatives like the Global Health Initiative and Feed the Future
d) An opportunity for all project stakeholders to take stock of accomplishments
e) Project beneficiaries at all levels, local partners,
f) CSHGP grantees, donors and international global health community.



FE Design, Methods and Evaluation Questions

Quasi-experimental with Participatory Approach

Quantitative

Secondary Data (Project MIS), PSLM (2008, 2011), PDHS, MICS 2009

Qualitative

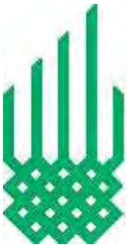
- KII: AKF, AKHSP, AKRSP, CCSP Staff
- KII: DGHS, DHO, LHW, MS DHQH, HSRRU , MNCH
- FGDs: CMWs, Non-CMWs CHWs, Male & Female Beneficiaries

Mixed Methods

Observations and Informal Discussions

Desk Review

- 3 OR Studies, MTE, DIP, Annual Progress Reports, RAF Report
- Baseline & End line Surveys, CBSG Assessment,

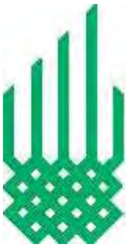


FE Design, Methods and Evaluation Questions (Cont:)

- **To what extent did the project accomplish and/or contribute to the results (goals and objectives) stated in the DIP?**
  - **Did the CCSP structure and functions (interventions) relevant?**
  - **Are the beneficiaries satisfied by quality of healthcare services?**
  - **What is the contribution of project interventions on service delivery and utilization?**

- **Do CBSGs reduce the financial barriers to health care?**
  - **Does membership in a CBSG impact health care seeking behavior?**
  - **Does CBSG increased community KPC, access and utilization services?**

- **What are the key factors for sustainable CMW uptake within the MOH and community (VHC, LHW, TBA) health care provider's structures and referrals?**
  - **Did the CCSP strategies and interventions influence uptake of the CMW services?**
  - **What were the factors (social contexts, challenges, facilitators) that impacted?**
  - **What are the lessons learned around gender equity and gender outcomes that facilitate program success – male involvement, women empowerment?**



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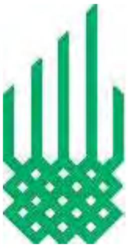


Findings and Results

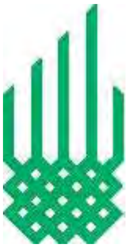
Qualitative Research Quotes and Verbatim

It is a good program, CMWs received quality training and they were timely deployed." (KII-DHO Chitral)

"Transport is a problem, when there is a referral case. Local transport is used to transfer maternity and or sick child to the hospital. CBSG is helpful in providing financial support". (FGD-CMWs)

"Referral system is improved under CCSP but no proper referral system in place. CMWs don't receive proper feedback on referral cases". (KII-DHO, Chitral)

"CBSGs have been proven to be an effective platform for communicating messages, ownership, decision making, and empowerment of women along with financial services". (KII-Manager, AKHSP, Karachi, and AKRSP Chitral)



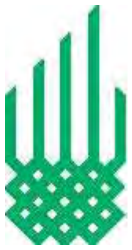
Qualitative Research Quotes and Verbatim (Cont:)

We always find CMW's present at her work station." (FGD-Male Community Leaders and Members, Chitral)

"In many areas in Chitral people don't have easy access to health facilities. CMW provides health service at their door step." (KII- Manger CBSG, AKRSP, Chitral)

CBSG empowers women and they utilize its saving for getting health facilities. Women utilize their saving whenever they needed without going through long process." (KII-Regional Program Manager, AKRSP, Chitral)

"This is a very well designed model to serve the women of reproductive age living in fragile living conditions and where there are seldom any trained birth attendants. Maternal morbidity and mortality is quite high just due to pregnancy related reasons." (KII-Director Health and Built Environment, AKFP, Islamabad)



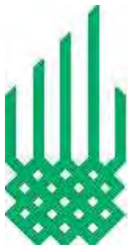
Qualitative Research Quotes and Verbatim (Cont:)

"CMWs who have been trained under MNCH program are not well trained; they have not been provided opportunities to conduct the required number of deliveries during the practical training". (KII- Provincial LHW Coordinator, Department of Health, KPK, Peshawar)

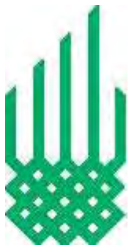
Role of Advisory Committee, "Not very effective, in fact it was the most important element for promoting CCSP model and ensuring its sustainability" (KII- Program manager, AKHSP, Karachi)

"Top level commitment, funding, coordination among different cadre of health workforce, quality and supervision is needed for replication" (KII-Program Manager, AKHSP, Karachi)

"DOH has been supportive but the AKHSP and AKFP didn't develop formal understanding with provincial health authorities regarding sustainability of the program." (KII-Program manager, AKHSP, Karachi)

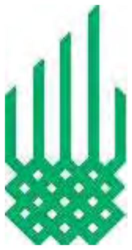


CMWs At Their Work Stations



Project Outcome Area 1: Increased awareness of obstetric and neonatal complications, increased utilization of birth preparedness and complications readiness (BPCR) plans, and an improved enabling environment for maternal, neonatal, and child health (MNCH)

Project Inputs	Outputs	Outcome
•Formative research •IEC and BCC Materials •Trainers •BCC & Community Mobilization strategy	✓ Households reached by BCC campaigns ✓ Village Health Committees active in all 28 communities	✓ Financial arrangements for delivery: 59% ✓ Transport arrangements for delivery 51% ✓ Blood donor arrangements for delivery 49% ✓ Utilization of VHC transportation plan 38%



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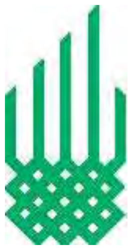
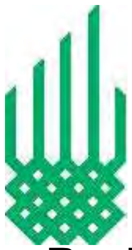
Project Outcome Area 2: Strengthened CMW referral linkages for obstetric and neonatal services

Project Inputs	Outputs	Outcome
• Formative work & situation analysis to develop referral protocol and guidelines • Referral tools and protocols •Referral strategy	✓CMWs linked with other community health workers (LHW, TBAs, or CHWs) – several referrals made by TBAs ✓CMWs linked with nearby health facilities (no referrals made to date)	✓ Client compliance with CMW presumptive shifting 80% ✓ Presumptive shifting feedback from facility to CMW 9.1% ✓ Client compliance with CMW emergency referral to health facility 97% ✓ Emergency referral feedback from facility to CMW 10% ✓ Referral from community-level health workers to CMW 38%



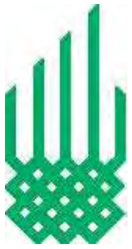
Project Outcome Area 3: Increase availability of trained community midwives

Project Inputs	Outputs	Outcome
• CMW curriculum from PNC • CMW tutors • Government public health building for Midwifery school • CMW Supervisors • IMNCI, family planning, etc. curriculum for additional training	✓28 CMWs received licenses and registration from PNC to work as CMW ✓28 CMWs active within communities ✓Supervisors recruited and trained to supervise CMWs ✓CMW birthing stations functioning in 28 community clusters	✓ Deliveries attended by CMW 17% ✓ Antenatal care provided by CMWs 24% ✓ Postnatal care provided by CMWs 24% ✓ Completion of continuum of care provided by CMWs 4% ✓ Completion of maternal care cycle provided by CMWs 14% ✓ Initial breastfeeding in CMW deliveries 100%

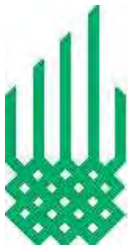


Project Outcome Area 4: Reduced financial barriers to the obstetric and neonatal continuum of care

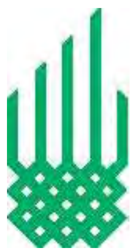
Project Inputs	Outputs	Outcome
• Formative work/ research analysis for intervention design	✓ 421 CBSGs established and active ✓ Loans made for health purposes	✓ Delivery coverage by Community Based Savings Groups ✓ Utilization of CBSG funds for maternal health ✓ Average monthly CMW income from service fees It varies from month to month ranging from 1000PKR to 2000PKR



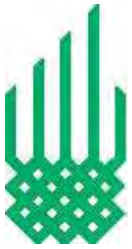
Finding	Conclusion	Recommendation	Action	Who Is Responsible
Deployment of 28 CMWs under CCSP 17% Skilled Deliveries, 24% ANC 24 % PNC by CMWs	CMWs contributed in birth preparedness, Access and Knowledge, Continuum of Care	Retention of 28 CMWs by DOH	Supervision and required support for CMWs by DOH	MNCH Program, District and Provincial Health Department
Establishment of VHCs in 28 communities	VHCs provided ownership and support to CMWs and communities	Sustainability and pro-active involvement of VHCs in MNCH care and management	CMWs presence in the VHCs must be ensured	AKRSP and District Health Department



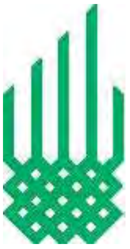
Finding	Conclusion	Recommendation	Action	Who Is Responsible
5186 health sessions 847 counseling sessions held for 63922 beneficiaries	BCC strategy implemented effectively Linked with utilization of social development fund for seeking maternal care	Continuation of BCC messages within structures of AKDN and DOH	Ensure availability of existing BCC materials and interventions with health workers	AKDN and District Health Department
38% referral from community-level health workers to CMW	Presence of CMWs in VHCs was meaningful to develop referral linkages	Involvement of LHWs, TBAs and CMWs in the referral linkages	Strengthen referrals thru TBAs and incentivized them for each referral	Provincial Health Department



Finding	Conclusion	Recommendation	Action	Who Is Responsible
421 CBSGs established and active Utilization of CBSG funds for maternal health Women having CBSGs membership are 4 times more likely to avail CMWs services	Social development fund not only influenced behavior change but also augmented skilled care	Sustainability and Replicability of CBSGs model	Continuous supervision, motivation and TA Linked with LSOs (registered with government)	AKRSP
Gender equality led to women empowerment and more utilization of MNCH services	Establishment of VHCs and CBSGs ensured GE/ Gender Empowerment	Gender equality must be ensured in VHCs and DHMTs	Social mobilization & communication strategy to ensure GE Role of VHCs in management	District Health Department and AKRSP



Finding	Conclusion	Recommendation	Action	Who Is Responsible
Close Monitoring and Supervision of CMWs by AKHSP Supervisors for Quality Control and Assurance	Poor supervision & monitoring mechanism within DOH However, under CCSP, it was strengthened	LHS of LHW program is responsible for administrative LHV of FLCF for technical monitoring of CMWs.	Government must play pivotal role in monitoring and supervision of CMWs	Provincial and District Health Department
Lack of project exit and sustainability strategy	CMWs are concerned about their future support and assistance after project completion	DOH should absorb CCSP deployed CMWs thru integrated PC 1 During interim period, AKHSP to continue supervision and support to CMWs	AKHSP must continue its support to CMWs, particularly in non-traditional communities.	AKHSP during interim phase and Department of Health



Lessons Learned and Way Forward

1. **A locally trained health care provider is more acceptable and accessible to the poverty struck communities for MNCH services in the geographically remote habitats of Chitral, thus facilitating the appropriate and timely utilization of MNCH services.**

2. **Women saving groups proved instrumental in many ways: women's exposure & social mobility, freedom of speech, exchange of ideas, social interaction, knowledge hub, sensitization to health issues, and of course financial aid; hence addressing different facets of women's empowerment.**

3. **A unique model of partnership: USAID & AKDN; within AKDN (AKF, AKHSP, AKRSP); between AKDN and DoH-KPK; and above all with scores of communities; narrating many stories of success.**

4. **Sustainability of both CBSGs and CMWs remains a question, where all stakeholders have a definitive role.**

THANKS FOR YOUR ATTENTION !

ANNEX XVIII

Project Data Form

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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | Partners | Project Details | Locations & Sub-Areas | Target Beneficiaries | Rapid CATCH...

Form Summary - CSHGP Project Data

The CSHGP project data form is used to capture critical project information to make CSHGP reporting easier at both the project and portfolio levels.

Form Completion Status

- ✔ Project Information
- ✔ Partners
- ✔ Project Details
  - ✔ Strategies
  - ✔ Capacity Building
  - ✔ Interventions & Components
  - ✔ Operational Plan Indicators
- ✔ Locations/Sub-Areas
- ✔ Target Beneficiaries
- ✔ Rapid CATCH Indicators
  - ✔ DIP Submission
  - ☐ Mid-term (Optional)
  - ✔ Final Evaluation

LEGEND
☐ = Please Complete ⚠ = Please Review
✔ = OK ✖ = Please Correct

Enter the project location or sub-areas on the Locations/Sub-Areas tab in order to enter "Target Beneficiaries" and "Rapid CATCH Indicators" data.

You may print the data entered for this project or download it as a PDF file. *(Note: PDF files require the free Adobe Reader for viewing.)*

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CHIP Maternal and Child Health Integrated Program
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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | Partners | Project Details | Locations & Sub-Areas | Target Beneficiaries | Rapid CATCH...

Project Information

Status: ✓ OK
Date Last Updated: 2013-09-18 09:42:09.43

Instructions: Click on each heading name to enter data for that heading.

✓ General Project Information

Cooperative Agreement Number:	GHN-A-00-08-00010-00
AKF Headquarters Technical Backstop:	David Hintch
AKF Headquarters Technical Backup Backstop:	David Hintch
Field Program Manager:	Dr. Zafar Ahmed
Midterm Evaluator:	David Pyle
Final Evaluator:	Sohail Amjad
Headquarter Financial Contact:	Innocent Manishimwe
Project Fiscal Year:	FY2008
Project Start Date:	9/30/2008
Project End Date:	3/31/2014
USAID Mission Contact Person:	Randolph Augustin
Project Web Site:	www.akdn.org

✓ Project Field Contact Information

Field Program Manager

First Name: Dr. Zafar
Last Name: Ahmed

Title: General Manager
Email: zafar.ahmed@akhsp.org

Address Line 1:
Address Line 2:

City: Chitral
State or Province: KP

Postal Code:
Country: Pakistan

Telephone: +92 (300) 858 8119
Fax:

Skype Name:

Alternate field contact

First Name: Dr. Qayyum
Last Name: Noorani
Title: Health and Built Environment P
Email: qayyum.noorani@akdn.org
Address Line 1: Level Nine, Serena Business Compl
Address Line 2: Khayaban e Suharwardy, G-5/1,
City: Islamabad
State or Province:
Postal Code: 44000
Country: Pakistan
Telephone: +92 (51) 111-253-254
Fax:
Skype Name:

✓ Grant Funding Information

USAID Funding: (US $) 1,599,176

PVO Match: (US $) 809,385

✓ General Project Description

Format Font Size

Aga Khan Foundation (AKF), a 2008 Innovation category grantee, is implementing the *Chitral Child Survival Program* (CCSP) in Chitral, a remote and isolated district in Khyber Pakhtunkhwa (KP) Province, Pakistan. The project goal is to contribute toward reduced maternal and neonatal mortality and morbidity by improving utilization of the continuum of care among the target population. Through a public-private partnership with the government's Maternal, Newborn, and Child Health (MNCH) Program, the CSSP is training and deploying community midwives (CMWs) into some of the most remote areas of the district to improve access to critical health services. CCSP aims to strengthen Pakistan's CMW model by introducing additional activities and interventions – including the program's primary innovation of Community Based Savings Groups – that will embed the CMWs into their communities, improve uptake of their services, and foster sustainability of this new cadre of community health providers.

✓ Project Location

Latitude: 35.8477

Longitude: 71.7814

Project Location Types (check all that apply):
- [ ] Urban
- [ ] Peri-urban
- [x] Rural

Levels of Intervention (check all that apply):
- [x] District Hospital
- [x] Health Center
- [ ] Health Post Level
- [x] Home
- [x] Community
- [ ] Other - Please specify:

Province(s):

Khyber Pakhtunkhhwa Province

District(s):

Chitral District

Sub-district(s):

✔ Operations Research Information

Is there an Operations Research (OR) component for this Project?

(•) Yes ( ) No

OR Project Title:

Operations Research for the Chitral Child Survival Program (2010-2013): Will women utilize the services of the Community Midwife?

Cost of OR Activities:

$ 40,000

Research Partner(s):

Aga Khan University (Karachi, Pakistan)

OR Project Description:

Format Font Size

Pakistan's Community Midwifery (CMW) strategy, a part of the government's Maternal, Neonatal and Child Health Program, was initiated in 2006 to improve skilled intra-partum care for women in remote and underserved communities. Assessments of the roll out of the CMW strategy to date have highlighted major bottlenecks in both the uptake of services provided by community midwives as well retention, as indicated by high drop-out rates.

The Aga Khan Foundation, in collaboration with the Aga Khan University (School of Nursing and Department of Community Health Sciences), is testing a new package for strengthening training, deploying, and incentivizing the new cadre of Community Midwives (CMW) as well as addressing barriers to utilization through introduction of approaches such as community-based savings groups and engaging village health committees in supporting and managing CMWs. The operations research will strengthen Pakistan's evidence base by examining the factors that affected the effectiveness of the proejct supported model, so that the lessons-learned from the CCSP approach can complement the Government model in training and managing the CMWs and achieve sustainability.

Save Project Information

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Maternal and Child Health Integrated Program

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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | **Partners** | Project Details | Locations & Sub-Areas | Target Beneficiaries | Rapid CATCH...

Partners

Status: ✓ OK
Date Last Updated: 2011-10-15 11:36:09.837

Instructions: Enter each partner organization and partner type below. Please spell out all acronyms. For subgrantees, enter the amount of USAID grant money allocated to the partner.

Partner Organization Name	Partner Type	USAID $ Allocated	Delete
Aga Khan Foundation, Pakistan	Collaborating Partner	$	☐
Aga Khan Health Services, Pakistan	Collaborating Partner	$	☐
Aga Khan Rural Support Program	Collaborating Partner	$	☐
Aga Khan University	Collaborating Partner	$	☐
District MNCH Program	Collaborating Partner	$	☐
		$	☐

Add a local partner organization

Save Partners Information

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Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Project Details: Strategies

Status: ✔ OK
Date Last Updated: 2011-10-15 11:38:31.49

Instructions: Listed on this page are different kinds of strategies that could be implemented during the life of this CSHGP project. Please check those boxes for the strategies planned for this project.

Social and Behavioral Change Strategies

- [x] Community Mobilization
- [x] Group interventions
- [x] Interpersonal Communication
- [ ] Social Marketing
- [x] Mass media and small media

Health Services Access Strategies

- [x] Emergency Transport Planning/Financing
- [x] Addressing social barriers (i.e. gender, socio-cultural, etc)
- [x] Community-based health insurance scheme/Community financing mechanisms
- [ ] Client sensitization on eligibility for incentives (i.e. voucher schemes/waivers to user fees/sliding fee scales/cash transfers)
- [x] Implementation with a sub-population that the government has identified as poor and underserved
- [x] Implementation in a geographic area that the government has identified as poor and underserved

Health Systems Strengthening

- [x] Quality Assurance
- [ ] Conducting capacity assessment of local partners
- [x] Supportive Supervision
- [x] Task Shifting
- [x] Developing/Helping to develop clinical protocols, procedures, case management guidelines
- [x] Developing/Helping to develop job aids
- [ ] Monitoring health facility worker adherence with evidence-based guidelines
- [x] Providing feedback on health worker performance
- [x] Monitoring CHW adherence with evidence-based guidelines
- [x] Referral-counterreferral system development for CHWs
- [x] Community role in supervision of CHWs
- [x] Community role in recruitment of CHWs
- [x] Development of clinical record forms
- [x] Review of clinical records (for quality assessment/feedback)
- [x] Coordinating existing HMIS with community level data
- [ ] Pharmaceutical management and logistics
- [x] Community input on quality improvement
- [ ] Performance-based incentives or contracts for health facility workers

Strategies for Enabling Environment

- [ ] Create/Update national guidelines/protocols
- [x] Advocacy for revisions to national guidelines/protocols

- [x] Stakeholder engagement and policy dialogue (local/state or national)
- [x] Advocacy for policy change or resource mobilization
- [x] Building capacity of communities/CBOs to advocate to leaders for health

Tools/Methodologies

- [x] BEHAVE Framework
- [ ] Sustainability Framework (CSSA)
- [ ] Rapid Health Facility Assessment
- [x] Community-based Monitoring of Vital Events
- [ ] TB Cohort Analysis (if applicable)
- [ ] LQAS
- [ ] Participatory Rapid/Rural Appraisal
- [ ] Mobile Devices for Data Collection
- [x] MAMAN Framework
- [ ] Lives Saved Calculator

Save Strategies Data

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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | Partners | Project Details | **Locations & Sub-Areas** | Target Beneficiaries | Rapid CATCH...

Locations/Sub-Areas

Status: ✓ OK
Date Last Updated: 2011-10-16 13:02:57.787

Instructions: Indicate whether this project collects, monitors and reports on Rapid CATCH data for one project location or different *geographic* project sub-areas:

- One project location
- (◉) Multiple geographic project sub-areas

Data for Multiple Geographic Project Sub-Areas

Enter data for each distinct sub-area below.

	Sub-Area Name	Population	Delete
Sub-Area	Intervention Area	88,889	☐
Sub-Area	Comparison Area	55,146	☐
Sub-Area			☐
Sub-Area			☐
	Population Total [Calculated]:	144,035	

Add a new sub-area

Note: the Locations/Sub-Areas form must be completed in order to enter "Target Beneficiaries" and "Rapid CATCH Indicators" data.

Save Locations/Sub-Areas information

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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | Partners | Project Details | Locations & Sub-Areas | **Target Beneficiaries** | Rapid CATCH...

Target Beneficiaries

Status: ✔ OK
Date Last Updated: 2011-10-15 11:48:16.47

Instructions: Enter the number of target beneficiaries for each location or sub-area.

	Intervention Area	Comparison Area	Beneficiaries Total [Calculated]
Children 0-59 months	16,001		16,001
Women 15-49 years	24,000		24,000
Beneficiaries Total [Calculated]:	40,001	0	40,001

Save Target Beneficiaries information

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CHIP | Maternal and Child Health Integrated Program

PVO NGO Support

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Project Reporting Home | Project Data Form | Reports

Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Form Summary | Project Information | Partners | Project Details | Locations & Sub-Areas | Target Beneficiaries | **Rapid CATCH...**

Rapid CATCH Summary | DIP Submission | Mid Term | Final Evaluation

Rapid CATCH Indicators

Status: ✔ OK

Instructions: Click on the appropriate tab or link in the 'Stage' column to view and update Rapid CATCH data for that phase of the project.

CSHGP grantees are required to update Rapid CATCH project data and submit this online form twice during the life of the project, first at the time of the DIP submission, and again at the time of the final evaluation.

PVOs and NGOs are encouraged to also enter Rapid CATCH data at the time of the mid-term evaluation; however, this is not a requirement.

Stage	Completion Status	Current Sample Type
DIP Submission	✔	(●) 30 Cluster ( ) LQAS
Mid-term (Optional)	☐	( ) 30 Cluster ( ) LQAS
Final Evaluation	✔	(●) 30 Cluster ( ) LQAS

Save Sample Types

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Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Rapid CATCH Indicators: DIP Submission

Status: ✓ OK
Date Last Updated: 2010-07-05 14:41:59.26

Current Sample Type: 30 Cluster
Current Location Type: Disaggregated
Change the sample and location types on the Rapid CATCH Summary tab.

Instructions: Click on each indicator name to enter data for that indicator. Enter numerator and denominator only.
Percent and confidence interval will be automatically calculated.

Display All

Antenatal Care

Description: Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child

Numerator: Enter the number of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

DIP Submission Indicator Table for Antenatal Care

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	145	657	22.1	± 4.8 %
Comparison Area				± %

Maternal TT Vaccination

Description: Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child

Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

DIP Submission Indicator Table for Maternal TT Vaccination

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	411	657	62.6	± 7.1 %
Comparison Area				± %

Skilled Birth Attendant

Description: Percentage of children age 0-23 months whose births were attended by skilled personnel

Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary

midwife, or other personnel with midwifery skills

Denominator: Enter the total number of children age 0-23 months in the survey

DIP Submission Indicator Table for Skilled Birth Attendant

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	217	657	33.0	± 5.7 %
Comparison Area				± %

Current Contraceptive Use Among Mothers of Young Children

Description: Percentage of mothers of children age 0-23 months who are using a modern contraceptive method

Numerator: Enter the number of mothers with children age 0-23 months who are using a modern contraceptive method

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

DIP Submission Indicator Table for Current Contraceptive Use Among Mothers of Young Children

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	166	657	25.3	± 5.1 %
Comparison Area				± %

Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Description: Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth

Numerator: Enter the number of children age 0-23 months who received a post-natal visit within two days after birth by an appropriate health worker

Denominator: Enter the total number of children age 0-23 months in the survey

DIP Submission Indicator Table for Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	115	657	17.5	± 4.3 %
Comparison Area				± %

Exclusive Breastfeeding

Description: Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours

Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours

Denominator: Enter the total number of children age 0-5 months in the survey

DIP Submission Indicator Table for Exclusive Breastfeeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	84	139	60.4	± 15.3 %
Comparison Area				± %

Infant and Young Child Feeding

Description: Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Denominator: Enter the total number of children age 6-23 months in the survey

DIP Submission Indicator Table for Infant and Young Child Feeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	518	1,288	40.2	± 4.4 %
Comparison Area				± %

Vitamin A Supplementation in the Last 6 Months

Description: Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall

Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)

Denominator: Enter the total number of children age 6-23 months in the survey

DIP Submission Indicator Table for Vitamin A Supplementation in the Last 6 Months

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	240	518	46.3	± 7.3 %
Comparison Area				± %

Measles Vaccination

Description: Percentage of children age 12-23 months who received a measles vaccination

Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother

Denominator: Enter the total number of children age 12-23 months in the survey

DIP Submission Indicator Table for Measles Vaccination

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	261	320	81.6	± 10.8 %
Comparison Area				± %

Access to Immunization Services

Description: Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

DIP Submission Indicator Table for Access to Immunization Services

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	304	320	95.0	± 10.9 %
Comparison Area				± %

Health System Performance Regarding Immunization Services

Description: Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

DIP Submission Indicator Table for Health System Performance Regarding Immunization Services

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	289	320	90.3	± 10.9 %
Comparison Area				± %

Treatment of Fever in Malarious Zones

Description: Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began

Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug

Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

DIP Submission Indicator Table for Treatment of Fever in Malarious Zones

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	0	0	0.0	± 0.0 %
Comparison Area				± %

ORT Use

Description: Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids

Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids

Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

DIP Submission Indicator Table for ORT Use

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	26	67	38.8	± 18.9 %
Comparison Area				± %

Appropriate Care Seeking for Pneumonia

Description: Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

DIP Submission Indicator Table for Appropriate Care Seeking for Pneumonia

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	66	102	64.7	± 18.2 %
Comparison Area				± %

Point of Use (POU)

Description: Percentage of households of children age 0-23 months that treat water effectively

Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively

Denominator: Enter the total number of households of children age 0-23 months in the survey

DIP Submission Indicator Table for Point of Use (POU)

Sub Area Name	Numerator	Denominator	Percent [Calculated]		Confidence Interval [Calculated]
Intervention Area	166	657	25.3	±	5.1 %
Comparison Area				±	%

Appropriate Hand Washing Practices

Description: Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing

Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

DIP Submission Indicator Table for Appropriate Hand Washing Practices

Sub Area Name	Numerator	Denominator	Percent [Calculated]		Confidence Interval [Calculated]
Intervention Area	442	657	67.3	±	7.2 %
Comparison Area				±	%

Child Sleeps Under an Insecticide-Treated Bednet

Description: Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night

Numerator: Enter the number of children age 0-23 months who slept under an insecticide-treated bednet the previous night

Denominator: Enter the total number of children age 0-23 months in the survey

DIP Submission Indicator Table for Child Sleeps Under an Insecticide-Treated Bednet

Sub Area Name	Numerator	Denominator	Percent [Calculated]		Confidence Interval [Calculated]
Intervention Area	0	0	0.0	±	0.0 %
Comparison Area				±	%

Underweight

Description: Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)

Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population

Denominator: Enter the total number of children age 0-23 months in the survey

DIP Submission Indicator Table for Underweight

Sub Area Name	Numerator	Denominator	Percent [Calculated]		Confidence Interval [Calculated]
Intervention Area	90	505	17.8	±	5.0 %
Comparison Area				±	%

Enter comments:
Please enter any comments you have regarding your Rapid CATCH Indicator data, and include any information or variation from the standard definition of the indicator, such as different age cohort or denominator, and the reasons for the variation:

Format Font Size

Information was not collected for Malaria indicators as Chitral is not a Malaria-Endemic Zone.

As stated in our First Annual Report, changes in senior level management of NIPS over the past 6 months caused substantial delays in finalizing the analysis and report and handing over the raw data set, which was outside the control of CCSP. The final report was received on November 12, 2009 and data was subsequently updated in the CSHGP Project Data Form.

Save Rapid CATCH Indicator Data

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Project: Pakistan - AKF - FY2008 (2008-2014)

Innovation

Rapid CATCH Indicators: Final Evaluation

Status: ✔ OK
Date Last Updated: 2014-08-25 15:06:02.46

Current Sample Type: 30 Cluster
Current Location Type: Disaggregated
Change the sample and location types on the Rapid CATCH Summary tab.

Instructions: Click on each indicator name to enter data for that indicator. Enter numerator and denominator only.
Percent and confidence interval will be automatically calculated.

Display All

✔ Antenatal Care

Description: Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child

Numerator: Enter the number of mothers with children age 0-23 months who had at least four antenatal visits while pregnant with their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Antenatal Care

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	296	659	44.9	± 5.4 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Maternal TT Vaccination

Description: Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child

Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Maternal TT Vaccination

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	544	659	82.5	± 4.1 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Skilled Birth Attendant

Description: Percentage of children age 0-23 months whose births were attended by skilled personnel

Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary

midwife, or other personnel with midwifery skills

Denominator: Enter the total number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Skilled Birth Attendant

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	494	603	81.9	± 4.3 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Current Contraceptive Use Among Mothers of Young Children

Description: Percentage of mothers of children age 0-23 months who are using a modern contraceptive method

Numerator: Enter the number of mothers with children age 0-23 months who are using a modern contraceptive method

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Current Contraceptive Use Among Mothers of Young Children

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	260	655	39.7	± 5.3 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Description: Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth

Numerator: Enter the number of children age 0-23 months who received a post-natal visit within two days after birth by an appropriate health worker

Denominator: Enter the total number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Post-Natal Visit to Check on Newborn Within the First 2 Days After Birth

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	74	670	11.0	± 3.4 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Exclusive Breastfeeding

Description: Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours

Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours

Denominator: Enter the total number of children age 0-5 months in the survey

Final Evaluation Indicator Table for Exclusive Breastfeeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	149	159	93.7	± 5.3 %
Comparison Area	0	0	0.0	± 0.0 %

☐ Infant and Young Child Feeding

Description: Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices

Denominator: Enter the total number of children age 6-23 months in the survey

Final Evaluation Indicator Table for Infant and Young Child Feeding

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area				± %
Comparison Area				± %

✔ Vitamin A Supplementation in the Last 6 Months

Description: Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall

Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)

Denominator: Enter the total number of children age 6-23 months in the survey

Final Evaluation Indicator Table for Vitamin A Supplementation in the Last 6 Months

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	143	460	31.1	± 6.0 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Measles Vaccination

Description: Percentage of children age 12-23 months who received a measles vaccination

Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother

Denominator: Enter the total number of children age 12-23 months in the survey

Final Evaluation Indicator Table for Measles Vaccination

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	186	272	68.4	± 7.8 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Access to Immunization Services

Description: Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Final Evaluation Indicator Table for Access to Immunization Services

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	218	272	80.1	± 6.7 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Health System Performance Regarding Immunization Services

Description: Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey

Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Final Evaluation Indicator Table for Health System Performance Regarding Immunization Services

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	224	272	82.4	± 6.4 %
Comparison Area	0	0	0.0	± 0.0 %

☐ Treatment of Fever in Malarious Zones

Description: Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began

Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug

Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Final Evaluation Indicator Table for Treatment of Fever In Malarious Zones

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area				± %
Comparison Area				± %

✔ ORT Use

Description: Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids

Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids

Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Final Evaluation Indicator Table for ORT Use

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	114	196	58.2	± 9.8 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Appropriate Care Seeking for Pneumonia

Description: Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Final Evaluation Indicator Table for Appropriate Care Seeking for Pneumonia

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	103	130	79.2	± 9.9 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Point of Use (POU)

Description: Percentage of households of children age 0-23 months that treat water effectively

Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively

Denominator: Enter the total number of households of children age 0-23 months in the survey

Final Evaluation Indicator Table for Point of Use (POU)

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	31	628	4.9	± 2.4 %
Comparison Area	0	0	0.0	± 0.0 %

✔ Appropriate Hand Washing Practices

Description: Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing

Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing

Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Final Evaluation Indicator Table for Appropriate Hand Washing Practices

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	591	669	88.3	± 3.4 %
Comparison Area	0	0	0.0	± 0.0 %

☐ Child Sleeps Under an Insecticide-Treated Bednet

Description: Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night

Numerator: Enter the number of children age 0-23 months who slept under an insecticide-treated bednet the previous night

Denominator: Enter the total number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Child Sleeps Under an Insecticide-Treated Bednet

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area				± %
Comparison Area				± %

✔ Underweight

Description: Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)

Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population

Denominator: Enter the total number of children age 0-23 months in the survey

Final Evaluation Indicator Table for Underweight

Sub Area Name	Numerator	Denominator	Percent [Calculated]	Confidence Interval [Calculated]
Intervention Area	103	309	33.3	± 7.4 %
Comparison Area	0	0	0.0	± 0.0 %

Enter comments:
Please enter any comments you have regarding your Rapid CATCH Indicator data, and include any information or variation from the standard definition of the indicator, such as different age cohort or denominator, and the reasons for the variation:

Format Font Size

Information was not collected for Malaria indicators as Chitral is not a Malaria-Endemic Zone.

As stated in our First Annual Report, changes in senior level management of NIPS over the past 6 months caused substantial delays in finalizing the analysis and report and handing over the raw data set, which was outside the control of CCSP. The final report was received on November 12, 2009 and data was subsequently updated in the CSHGP Project Data Form.

Save Rapid CATCH Indicator Data

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ANNEX XIX

Final Assessment of Community Based Savings Groups

Connections and Support: An Assessment of the CBSG Component of the Chitral Child Survival Project

Prepared for

Aga Khan Foundation (US)

Aga Khan Foundation (Pakistan)

Aga Khan Rural Support Programme, Pakistan

Aga Khan Health Service, Pakistan

October 2013

Paul Rippey

Consultant

Connections and Support:
An Assessment of the CBSG Component of the
Chitral Child Survival Project

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II. Abbreviations

AKF	Aga Khan Foundation
AKFP	Aga Khan Foundation Pakistan
AKHS	Aga Khan Health Services
AKRSP	Aga Khan Rural Support Programme
CBSG	Community Based Savings Group, the term used by AKDN to refer to Savings Groups
CCSP	Chitral Child Survival Project
EELY	Enhancing Employability and Leadership for Youth, a seven-year project of AKRSP/Pakistan with a youth CBSG component beginning in the third year.
SG	Savings Group, the generic term for groups savings-led, member-managed groups which typically return the savings of members after a year, and then begin another cycle.
VHC	Village Health Committee
CMW	Community Midwife
ANC	Ante Natal Care
PNC	Post Natal Care
BCC	Behavioural Change Communication
LHW	Lady Health Worker
TBA	Trained Birth Attendant
MNCH	Maternal, neonatal and child health
RAF	Research and Advocacy Fund of DFID
MTR	Mid-term review
MIAD	Multi-Input Area Development
CSHGP	Child Survival and Health Grants Program
BCC	Behavioural Change Communication
AKDN	Aga Khan Development Network
NT	"Non-Traditional" – refers to villages where AKDN has not recently worked.

III. Acknowledgements

Many people contributed to this report, and I hope it will be obvious to the reader the extent to which this draws on the good work of other people. I will not be able to name them all here but some people must be mentioned here:

Dr. Sharif Ullah Khan, the Senior Programme officer for Health at Aga Khan Foundation (Pakistan), has directed the CCSP, concentrating on health outcomes while appreciating the contribution of the CBSGs. He provided invaluable input into this report and support to my consultancy.

Mr. Tanvir Hussain was drafted into helping with data analysis for this study, and took on a large task that I know required many hours of evening work.

The field work for the Verification and Deepening Exercise was ably led by Mr. Asif Ali Shah, who also helped with the presentation of the analysis of the RAF data.

This report draws heavily on the RAF study, carried out under the direction of Dr Qayyum Noorani.

Farid Ahmad, the CBSG manager for AKRSP, and the CCSP field team provided great insight into the project, before, during and after the Islamabad workshop, and were thoughtful guides to the social dynamics of CBSGs.

Before the fieldwork, I had informative discussions with Dr. Rafat Jan of Aga Khan University, and Shireen Issa of AKF. Finally, David Hinch, John Tomaro, and Mark Staehle all provided useful detailed feedback on a draft of this report.

Thank you all immensely.

Paul Rippey

Connections and Support: An Assessment of the CBSG Component of the Chitral Child Survival Project

IV. Summary

The Chitral Child Survival Project (CCSP) is a four-year project (September 2009 to August 2013, plus a six-month no-cost extension), co-funded by USAIDs Child Survival and Health Grants Program (CSHGP) and AKF USA. Implementation is a joint effort of Aga Khan Health Service (Pakistan), Aga Khan Rural Support Programme/Pakistan, Aga Khan Foundation/Pakistan, and Aga Khan Foundation/USA. The objective of the CCSP is to contribute to sustained improvements in maternal and child survival and health.

The CCSP delivered two complementary services: selecting, training and placing Community Midwives (CMWs) within twenty-eight villages in the remote valleys of Chitral District and supporting them in becoming viable service providers; and creating Community Based Savings Groups (CBSGs) in the villages served by the midwives. The CBSGs were intended to help ease financial barriers to accessing health care for pregnant women. As the project comes to an end, it has formed and trained 421 CBSGs against the original target of 400, with 7,988 members, against an original target of 10,000.

The project participated in an exhaustive and rigorous study in 2011-12 funded by DFID's Research and Advocacy Fund (RAF), which looked at the correlations between CBSG membership and use of Community Midwives. It found that women with a family member in a CBSG were four times as likely to use the entire "continuum of care" (pre-natal, delivery, and post-natal) as women with no family membership. Some

of this difference is due to the availability of finance, and, at the time of the RAF, 15% of women with family members in a CBSG had taken some financing from the group for health care related to pregnancies. However, the difference cannot all be due to finance, since – again, at the time of the RAF – the difference in use of the continuum of care is greater than the use of CBSG financing for care. And, the amount of money taken from CBSGs is often quite small, and only a small part of the total financing, with the remainder most often coming from the family.

A verification and deepening exercise in August and September of 2013 looked at ten factors, spelled out in this report, that might go beyond finance to explain the high correlation between CBSG membership and use of CMWs, and probe more deeply into some of the RAF findings. The exercise found that members frequently funded health services from multiple sources in addition to the CBSG; that group members supported and encouraged other members in taking risks and trying new behaviours, though often in areas other than acquiring health care; and that group members were recipients of Behavioural Change Communication (BCC) more than non-members. The three factors – finance, social support, and information – worked together in complex ways to encourage and facilitate women in adopting new behaviours, including midwifery services.

The study noted differences between the health service uptake and the performance of CBSGs in "traditional" villages, that is, villages where AKDN has a recent history of interventions, and "non-traditional" villages, where AKDN is less well known. In non-traditional villages, women were less likely to use CMW services, and much less likely to take money from the group for their pregnancy (though the AKRSP staff argue that the gap has likely closed substantially since the RAF field work was done, about halfway through the project, at a time when

they were beginning to concentrate additional resources on NT villages). Also, CBSGs in traditional villages on average had more members at formation, and added members since formation, while those in non-traditional villages had fewer members to begin with, and lost some members.

Despite these differences, overall, the CBSGs appear to be in good health and likely to endure, with a few exceptions. The CCSP is preparing its exit strategy late in the project life cycle. The strategy involves relying largely on intrinsic motivation to keep the trainers in the field, and to have groups support each other. AKRSP tends not to leave an area it has worked in, and in fact it will continue to form CBSGs in Chitral (mostly in new areas) under the Enhancing Employability and Leadership for Youth (EELY) project, and is conducting a sustainability evaluation in March of 2014. It will continue to have a voice in the future of the CBSGs, and some influence over the groups.

In its remaining time with access to the CBSGs AKRSP plans to encourage groups to take responsibility for the ultra poor in their villages, those who are simply unable to save for various reasons. In many cases, CBSGs already support the ultra poor by using their social funds to support very needy people.

The CCSP did many things well, starting with having the discipline to keep the procedures simple and transparent. The remarkable extent to which the family as a whole is considered the group member can be useful in Pakistan and other countries when considering the degree of inclusion of a Savings Group project. The CCSP demonstrated clearly that Savings Groups make excellent platforms for the transmission of information. The project used multiple delivery channels (called *linked*, *parallel*, and *unified*) to bring BCC messages to CBSG members; this suggests that rather than look for the best delivery channel, it is more

effective to work to get everyone delivering the same messages. The project did an admirable job of learning as it went forward, in some cases making judicious adaptations to its programme. Finally, the project taught the value of patience: the complex change processes underway should not end with the close of the project, as the people of Chitral continue to talk to and learn from each other.

V. The Chitral Child Survival Project in brief

A. Rationale and Design

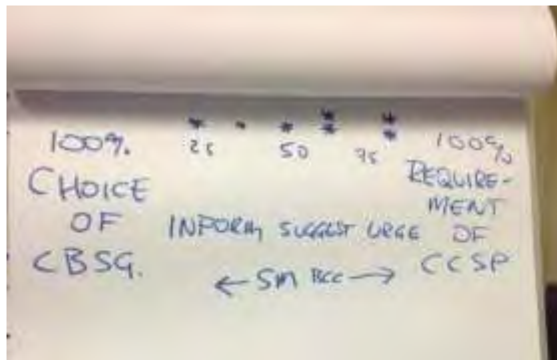
The Chitral Child Survival Project (CCSP) is a four-year program (September 2009 to August 2013, plus a four-month no-cost extension), co-funded by USAID's Child Survival and Health Grants Program (CSHGP) and AKF USA. Implementation is a joint effort of Aga Khan Health Service, Pakistan, Aga Khan Rural Support Programme/Pakistan, Aga Khan Foundation/Pakistan, and Aga Khan Foundation/USA.

The overarching objective of CCSP, and of CSHGP, is to contribute to sustained improvements in maternal and child survival and health. In particular, women giving birth in Chitral have seldom been assisted by a skilled health provider, and have typically delivered at home with a local birth attendant. Even when modern health care is available, many factors have mediated against its widespread acceptance and use, including the often great distances to health care facilities, cultural practices and traditions which limit a woman's ability to travel outside her home, and even more so outside her village, and poverty: costs of delivery with a skilled birth attendant may include transportation, bed charges for inpatient care, and the cost of medicines and other supplies.

To address these constraints the CCSP delivered two complementary services: placing Community Midwives (CMWs) within 28 villages in the remote valleys of Chitral District; and creating Community Based Savings Groups (CBSGs) in the villages served by the midwives.

The inclusion of CBSGs in a child and maternal health project stemmed from the realisation that one of the barriers to improved MNHC was the extreme poverty of the region, which has constrained the ability of families to pay not only for the direct costs of health services, but even more important, the costs involved in evacuating women with high-risk pregnancies to health centres capable of providing emergency obstetric care if necessary. Therefore, the agencies promised in their proposal to put in place a mechanism to reduce financial barriers to acquiring health care.

CBSGs were introduced to the agencies by a consultant recruited by AKF/Geneva in 2009. Because the savings groups were to be formed within the context of a health project, there was a creative tension between the health professionals and the CBSG team, with the health professionals arguing that the groups should be essentially health savings groups in which women were urged to save for their health needs. While the groups always had the freedom to save for whatever they liked, after the mid-term evaluation, the project readjusted its messaging to make it clearer that members could save for any need they had identified, or just save to build up their assets as protection against shocks. In parallel, all parties agreed that the CBSGs should receive behavioural change communication (BCC) health messages, and be invited, even urged, to use the services of the CMW. Some difference in emphasis between the health team and the CBSG team continued during the entire project, but in the end both sides were happy with the outcome, which included both increased use of modern health services, and the creation of a network of CBSGs. (In fact, whether or not trainers prioritize health care in CBSGs, members make it a priority anyway. The woman in labour is not thinking of school fees. Health brings its own urgency.)



Participants in the August 2013 workshop were asked where the messages that were given to groups about use of health services fell on the continuum of choice. They were asked to indicate whether CBSGs were *informed* of the option of using CMWs, or if using them was *suggested* to them, or *urged*, or *required*. The stars on the flipchart shows

The CBSGs were trained by 28 "CBSG Supervisors", women recruited in the villages and given training in CBSG methodology and a modest stipend. The Supervisors were trained, supported and supervised by four "Social Mobilisers" (initially two, and then four after the mid-term evaluation found that the Social Mobilisers' work load was unsustainably great), and the Social Mobilisers reported to the CBSG Manager. All of the CBSG activities were carried out by AKRSP. In parallel, AKHS/P provided support to the CMWs. As will be seen, there was generally good coordination between the health and CBSG teams, and the agencies harmonized messages, eventually involving a large number of actors, some already existing and some created by the project; these included the CMWs themselves; the CBSG supervisors; Village Health Committees created by the project charged with delivering messages, recommending fees for the CMW, and working creatively with villagers to help them put together financing in case obstetric evacuation was recommended; BCC agents sent by the project; Male Motivators, selected and trained in some villages in which it was socially difficult for women to give health messages to men; and existing structures and people including Lady Health Workers, Trained Birth Attendants, Community Health Workers, and Local Service Organisations which are community run enterprises formed by AKRSP. Coordinating all the entities required countless meetings and workshops, but the result was

wide understanding of the role both of the CBSG, and of the CMW. Having everyone deliver the same message proved important for introducing new ideas and services into traditional villages.

B. Milestones and modifications

The project conception evolved during implementation, and some of the major milestones, including modifications to design and procedures, follow:

Date	Milestone	Description
2009	Safe delivery fund replaced by CBSGs	The partner agencies first considered a "safe delivery fund", essentially a non-regulated insurance scheme, but such a plan would have involved large numbers of small payments and claims, which would have been expensive to administer, vulnerable to co-variant and other risks, and might have partially duplicated other insurance initiatives within the Aga Khan Development Network (AKDN). After much discussion and consideration, and encouraged by AKF, the project opted for an approach that was largely unknown in Pakistan, and relatively new within the AKDN, that of creating CBSGs.
15 March 2010	First CBSG	The first CBSG was formed in Karimabad.
June 2010	MIS	The project started collecting and entering data into the MIS.
2010	VHCs	The project systematically organized Village Health Committees in each village.
2010	Floods	Floods in Booni and elsewhere hampered project implementation.
2011	Change agents trained	The project systematically invested in training a wide variety of change agents, including village notables, the LHWs, LSOs, and the VHCs.
2011-12	Male motivators	AKHS/P hired 9 male "motivators" for non-traditional areas.

Date	Milestone	Description
2011	More staff hired	As work progressed, it became clear that the travel and work load of the Social Mobilisers was excessive. After the mid-term evaluation, AKRSP doubled the number of "Social mobilisers" (field supervisors) and increased the number of "CBSG Supervisors" (volunteer trainers).
2011	MIS changes	At the advice of the mid-term evaluation, the project completely re-designed and re-translated the data collection form, facilitating data collection and entry.
Sept 2011	Group tracking begins	AKRSP selected 54 CBSGs that would be visited twice yearly for three years to assess group performance and sustainability post graduation and then post-project.
Sept 2011	Savings Group Summit	AKRSP and AKHS/P staff attended the First Savings Group Summit in Arusha, Tanzania
June-July 2012	Exchange visits	AKRSP staff members carried out exchange learning visits to visit AKF CBSG projects in Afghanistan and Tajikistan
2011-2012	RAF Field work	The field work for the Research and Advocacy Fund study was carried out.
2013	Floods, elections	Floods and national elections hampered project implementation
August 2013	Deepening exercise field work	The field work for the "verification and deepening" exercise was carried out.
September 2013	Conference	AKRSP invites key stakeholders for an all-valley close-out conference, to discuss the way forward, post project.

C. Quantitative CBSG Outcomes

The project reports that it trained 7,988 group members, against a target of 10,000. The original target of 10,000 was determined based on what proved to be a faulty estimate of the population covered by the project. Once the project was launched, more accurate, and lower,

population data became available[1]. Nonetheless, ten thousand members remained the target, and the project exceeded the target for CBSGs formed but fell short of the target for membership.

	Target	Result
Number of groups	400	421
Number of members	10,000	7,988
Average group size	25	19

In fact, it is reasonable to consider that the quantitative outputs of the CCSP are a bit better than what has been reported. First, CCSP staff report that after they stopped forming new groups late in 2012, but before the end of the project, some villagers have formed their own groups, and CCSP knows of five groups that were formed in this manner, although these are not included in the MIS. Also, there has been growth in membership in tracked groups, and therefore, presumably, on average in all groups; this growth is also not reported.

These comments are not intended to suggest that CCSP reporting is incorrect, but simply that the conservative reporting approach of the CCSP should be taken into account when considering their reported outputs v. targets.

[1] The original figure of 112,406 was based on Pakistan's Federal Bureau of Statistics 1998 Census Report, assuming an annual growth rate of 2.4%. In late 2010, the CCSP team visited each CMW area to define a realistic boundary for her coverage area and the population for each village was taken from the Benazir Income Support Program census report. This exercise resulted in an estimate of the population in the area covered of 88,889. This decrease in the target population by 21% corresponds closely with the shortfall reported in number of members, with the final result reported (7988) being 20% less than the target of 100,000.

VI. Research and findings on CBSG impact on use of health services

A. Research conducted

The CCSP has been the object of a number of studies and evaluations. One of them, the Research and Advocacy Fund Study is of particular relevance to the present report. Others – the Operations Research, and the Mid-Term Evaluation - are less immediately germane.

Operations Research: The Aga Khan University (AKU) has been conducting a three-year operations research with three rounds of field work (in 2011, 2012 and 2013). Initially the OR was to compare the effectiveness of government and CCSP-trained CMWs in Chitral District to determine whether CCSP can provide lessons learned to replicate in other parts of Pakistan and to assess health outcomes, although the OR had to modified when the government-trained midwives were not deployed. While the Operations Research has looked at the role of CBSGs in supporting access to health care, its primary focus is on the CMWs and health outcomes.

Mid-Term Evaluation: In November 2011, an outside contractor conducted a mid-term evaluation of the CCSP, focusing on "process and qualitative aspects of the project, especially the training of the CMWs, the mobilization of the communities and the formation of the CBSGs". The report included a number of recommendations for strengthening the program but did not attempt to produce definitive conclusions on the link between CBSG membership and use of health services.

More relevant to an assessment of the CBSG component are two other studies, the Research and Advocacy Fund (RAF) Study, and the August-September 2013 Verification and Deepening exercise.

The RAF study[2] was an exhaustive and rigorous study involving a literature review, interviews with 908 women having given birth, as well as CMWs, VHCs and others, and focus groups with CBSGs, all designed to test whether and how membership in CBSGs by women and their family members is associated with utilisation of MNCH services provided by skilled providers, particularly CMWs.

The literature review, encompassing numerous studies concerning health and BCC, pointed to the usefulness of group membership in transmitting health messages and in determining health outcomes. For instance, a 2010 randomized control trial (RCT) in Bangladesh showed a reduction in neonatal mortality in children born to members of women's groups, compared to control groups, and a 2004 RCT from Nepal showed a very significant drop in neo-natal mortality. Note that in both of these cases, the groups were created for the purpose of health education, and did not have a financial services component.

The RAF study documented the poverty of the region, noting that about a quarter of respondents belonged to households with incomes below the poverty line. The study discovered that women who were CBSG members were, to a statistically significant extent, somewhat younger, better educated, and had fewer children than non-members. The study

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[2] *Role of Community Based Savings Groups (CBSGs) in enabling greater utilization of Community Midwives in Chitral District of Pakistan*, funded by DFID's Maternal and Newborn Health Programme – Research and Advocacy Fund (RAF), and implemented by Aga Khan Foundation Pakistan. The principal investigator was Dr. Qayyum Noorani.

looked at correlations between, on the one hand, a range of socio-economic variables, including education of the woman and the husband, occupations, age, income, and family size, and, on the other hand, the use of modern health services for MNCH. Remarkably, the study found that, after the final multivariable analysis, only two variables were statistically correlated with use of the complete continuum of care (antenatal care, assisted delivery, and post-natal care). The two factors were, first, CBSG membership of a family member, and second, the mother-in-law being the principal decision maker around use of health services in the family.

One of the most telling statistics to come out of the RAF study concerned the percentage of women who used the continuum of care offered by the CMW, which varied dramatically with family membership in a CBSG:

- For women with a family member in a CBSG, 12.9% availed themselves of the continuum of care.
- For those without a family member in a CBSG, only 3.1% did so.

It is important to note that the impact on use of MNCH services appears to be greatest not when the pregnant woman is a CBSG member, but when some other member of the family is. In fact, certain decisions are made by the family, not by the woman, and she often is not the principal decider around health or expenditure decisions, even when she is directly concerned.

Equally remarkable is the importance that the mother-in-law plays in the family. Note that many mothers-in-law are already group members. As focus groups showed and as noted below, older women may consider themselves represented in the group, even if they do not

formally join themselves, but only urge their daughters or daughters-in-law to join.

Finally, the RAF study, and much anecdotal evidence, strongly suggested that the correlation of CBSG membership with use of MNCH services could not be fully explained simply by the role of the CBSG as a financing mechanism. In fact, only about 15% of RAF respondents (that is, women who had recently delivered) with a family member in a CBSG used money from the CBSG for their last pregnancy, mainly for ANC and delivery, or for transportation[3]. And, in many of those cases, the loan or savings taken from the CBSG was only a small part of the cost of the health services. This finding raised the question, which will be examined below, of why there was such a telling correlation between CBSG membership and use of health services, if only a small percentage of members were taking money for health care.

RAF also revealed some surprising statistics: fewer than half of the respondents knew about the CBSG in their village. The workshop participants commented that the RAF fieldwork occurred about halfway through the study, at a time when the project was still making itself known in some villages; they were confident that if the study had been conducted at the end of the project, awareness of CBSGs would be much higher. Interestingly, among those who knew about CBSGs, three-quarters (303/404) reported having a family member with

Not just remote, but very remote…

The survey team for the August 2013 study, pictured here, struggled to reach

[3] It is perhaps good to remind the reader that the RAF fieldwork occurred approximately half-way through the project, and that the field staff argue convincingly that the statistics reported in the RAF would be much higher were the same questionnaire to be administered today.

CBSG membership; said another way, the take-up of CBSGs was quite high among those who knew about them.

Yet one more pertinent statistic from the RAF suggests one way that CBSG membership supports use of MNCH services: 67% of women-who-delivered and had a family member in a CBSG attended at least one session with a CMW, as opposed to 41% of women with no family member in a CBSG, a 26% percent differential. The significance of that finding will be developed in later sections.

Verification and deepening exercise: As the project was coming to a close, AKF USA commissioned a review and evaluation of the CCSP CBSG component. The review and evaluation were intended to complement and supplement information collected from the RAF report. In particular, the review and evaluation was to probe a bit more deeply into the extensive RAF data base to examine the manner in which the correlation between CBSG family membership and use of health services might have occurred, to assess the health and future prospects of the CBSGs, and to capture lessons learned that could be useful for other projects. Much of the present report is based on that exercise, which was sometimes referred to as a "Verification and Deepening Exercise".

The exercise developed nine tools to test ten hypotheses about what might have led to the correlations noted between CBSG membership and use of MNCH services. A local consultant was engaged to visit a random sample of villages. It had been projected that he should visit "up to" nine villages; in fact, within the time allotted, he was only able to visit eight. Within each, he interviewed the VHC, the CBSG Supervisor, two women who had recently delivered, and the CMW. He also conducted two focus groups with CBSGs that had been selected

randomly in advance remotely by the chief researcher, and finally collected basic information indicating the health of the CBSGs from ten CBSGs selected, randomly, to fall into three categories of approximately equal number:

- active groups, that is, first cycle groups that had not yet shared out;
- tracked groups, or groups from a sample of 54 groups that are being followed up on by AKRSP; and
- graduated groups, or those which have shared out and are having no formal visits from AKRSP.

The consultant engaged two women researchers to assist him with the workload, and to ease the social constraints in interviewing women. The reports are contained in annexes to this report.

In parallel, a skilled analyst at AKHS/P kindly assisted by looking more deeply into certain questions around the RAF data set, including differences between traditional and non-traditional villages (that is, villages with a recent history of AKDN involvement so that most adult villagers are familiar with AKDN and generally understand its role in bringing developmental benefits to villages, and those without that recent history).

Finally, the chief consultant for the study led a three-day workshop for AKRSP staff from 9-11 September 2013 to review project accomplishment, look at the way forward, and invite them to validate or comment on data from the field work. The present report seeks to present the most pertinent parts of the mass of information that was provided by RAF and by the 2013 Verification and Deepening Exercise.

B. Theories of change, and Connections and Support

In designing the Verification and Deepening Exercise, the researcher proposed ten factors for further investigation, which are presented in the following table.

- The first seven factors concern ways that CBSG membership might cause greater MNCH uptake.
- Factor 8 concerns a way that membership and uptake might be correlated without a causal relationship.
- Factor 9 concerns the likelihood of continued post-project impact. w
- Finally, Factor 10 is simply a reminder to look for "other causes" of the correlation.

For each factor, the researcher proposed assessment techniques that it was hoped would be able to illuminate the contribution it made to using health services. The different factors constitute elements of a theory of change. It is possible that each of these contributed to some extent to the higher take-up of midwifery services by CBSG members. Brief summaries of findings are also given in the table below, and the most significant findings are described in later sections.

	Factor	Description	Summary of findings	Assessment technique(s)
CBSG funding of MNCH services				

	Factor	Description	Summary of findings	Assessment technique(s)
1	Funding from CBSG	Loans, savings, or social fund contributions from CBSGs of members or of members' families finance MNCH services.	There were multiple documented cases of money from CBSGs supporting ANC, deliveries and PNC.	2
2	Multiple funding sources including CBSG	Studies also have argued that partial funding for a needed product or service often incites a person to put together a package of funding sources to top up the amount available. (This question would deepen Q 25, 48, 53, in RAF)	Funding from CBSGs was most often combined with funding from other sources, typically the husband or other family members. Often the CBSG contribution was a relatively minor part of the entire funding package.	1,4,7
3	Leverage funding due to CBSG	Portfolios of the Poor and other sources have argued that people who have access to finance from formal or semi-formal sources are more likely to call on funds reserved for emergencies for non-urgent uses since they know that if necessary they can take a loan.	No respondents reported this taking place. If it occurred, it happened at a low level of respondent awareness.	1,2,7
Social support				

	Factor	Description	Summary of findings	Assessment technique(s)
4	Social support	Sources cited in the literature review suggest that belonging to a CBSG empowers members. This means in part that they have the confidence to try new things and to take risks.	There were multiple documented cases of group members encouraging other members to take risks and try new activities. Sometimes this decisions around health care, but most often it concerned other areas of women's life.	1,4,5,6,7,
Differential uptake of messages and marketing				
5	Greater reception of BCC messages by CBSG members	Reports suggest that CBSG members were more likely to receive BCC messages than non-members.	There was strong evidence that this was the case. CBSG members were reported to be more receptive to messages by CMWs and VHCs, and at least in some villages, they received messages more frequently. CBSGs were seen as a way of transmitting messages to non-CBSG members also, particularly to family members.	3,6,7,8
6	Greater CMW marketing to CBSG members than non members	Reports suggest that CMWs preferentially marketed their services to CBSGs.	As with the previous factor, many of the CMWs visited the CBSGs regularly, and were well known to them. Others did not, almost certainly to their detriment.	1,4
Diverse other factors				

	Factor	Description	Summary of findings	Assessment technique(s)
7	Halo Effect – Knock-on effect	If members of CBSGs have positive attitudes towards the CBSGs, those feelings may transmit to CMWs through a "halo effect" (A halo effect is the transferral of attitudes towards one thing to another thing with which observers associate it)	In one village, Raman, the CBSG reported that they felt "llinked" to the CMW. Generally, it was difficult to document the transferral of attitudes from CBSG to CMW, although the absence of evidence that the halo effect exists should not be mistaken for evidence of absence.	1,4,7
8	Differences in populations of CBSGs members and non-CBSG members	RAF study showed that CBSG members in the sample were younger, had more education, and fewer children than non members. These factors may have influenced use of MNCH services.	This plausible hypothesis was not backed up by the data. In fact, family size, education and age did not have any strong correlations with use of MNCH services.[4]	3

[4] It seems very likely that better educated, younger women would be more likely to use CMW services, but the RAF data were unambiguous: "The association of study participants' socio-demographic characteristics including age of the participant, level of education of couples, occupation of women, number of alive children and household size by continuum of care through CMWs were found to be insignificant", RAF, p. 53.

	Factor	Description	Summary of findings	Assessment technique(s)
9	Viability of CBSGs	The usefulness of CBSGs for facilitating uptake of MNCH depends on the continued existence and health of CBSGs.	As argued in this report, there is good reason to believe that the majority of the CBSGs created by the CCSP will be durable, although the study encountered a few that are not strong and quite possibly will fail.	1,5,7,9
10	Other	Other factors that have not now been identified may have contributed to the greater uptake of MNCH by CBSG members.	This wide-open question did not lead to any unanticipated findings.	1,4,5,6,7,8

The fourth column above, "Assessment techniques", refers to the different instruments that it was thought might provide relevant information in each area. These are included in Annex C.

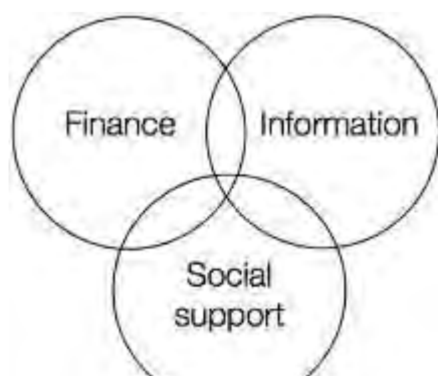
Instrument number	Designation
1	CBSG Focus Group Guide
2	Interview guide for women having delivered
3	Queries for the RAF data base
4	Interview guide for Community Midwives
5	Interview guide for CCSP management
6	Interview guide for BCC agents
7	Interview guide for Chitral AKRSP staff
8	Interview guide for Village Health Committee
9	CBSG Data Collection Form

Forms 5, 6 and 7 were not used, as the relevant people participated in the three-day Islamabad workshop.

As discussed above, all of the factors may have had some impact on the correlation between CBSG membership and use of MNCH services, but the Verification and Deepening Exercise found substantial anecdotal evidence primarily of financial support, differential uptake of messages, and social support.

In fact, of the three, the financial factors were perhaps not the most important contributions of CBSGs to increasing access of MNCH services. In fact, the use of the CBSG for the transmission of information, and the moral and social support that CBSG members give to each other, may have played greater roles. The qualitative work revealed many instances in which CBSGs worked through each of these pathways. While the RAF study and the Deepening Exercise produced quantitative data that is presented throughout this report, it is also useful to take a moment to let anecdotal data make the reality of life for villagers a bit more present, so the following three sections – on financial support, the platform for information dissemination, and social support – give brief vignettes collected during the field study of August 2013.

Three mutually supporting pathways by which CBSGs support the uptake of MNCH services



Financial support

Sometimes members used the CBSG to finance all their MNCH services. Ms. G. in Nargis reported, "I took a loan of Rs. 2500 from CBSG and spent Rs. 1,000 for ANC and Rs. 1500 on delivery".

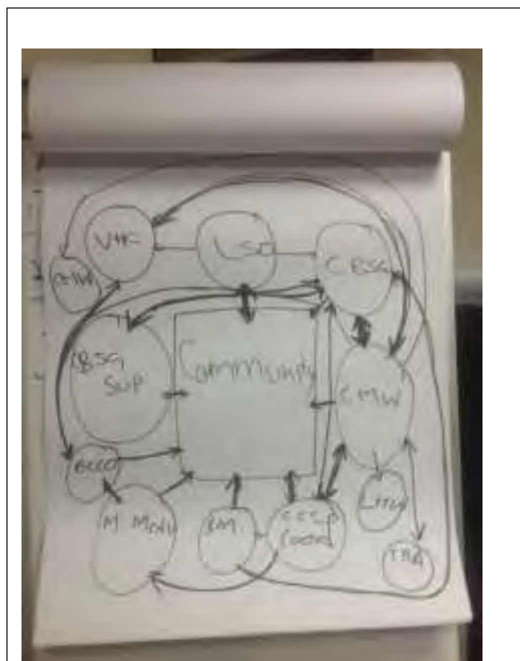
Very often, however, CBSG members used multiple sources of finance to pay for MNCH services. Ms. S. in Soni CBSG in Morder says she took Rs. 2500 from her CBSG and Rs. 6500 from her husband and paid her delivery expenses at the AKSH,P maternity facility in Booni. A member of Mori CBSG in Sultankhail reported that she paid for her antenatal care from the CMW "from her husband's pocket", then took Rs. 4000 from CBSG for her delivery.

Mori CBSG in Sultankhail is also thinking outside the CBSG box in relation to health services. The group reports that they are planning to increase the monthly saving from Rs. 10 to Rs. 50 and they will use the savings to attempt to attract funds from other organization to extend the village link road to facilitate access to their village in winter. There is a history of matching grants in the area, and it is possible that they will be able to find support to construct the road. When asked about why they wanted to build the road, they mentioned having year-round access to health facilities as an important reason.

Field research, notably the financial diary studies reported on in *Portfolios of the Poor*, has shown that people in informal groups seek lump sums for three purposes: life cycle predictable events, like weddings, births, funerals; investments and opportunities, like expanding a business or buying a house; and emergencies, most often health related. The CCSP field work demonstrated how well the CBSGs of Chitral conformed to that pattern. For instance, in Chashmebddur CBSG in Morder, it was reported that the majority of women took loans for their children's education. Some of them took loans and bought food. One lady reported that she took Rs. 2,000 and bought fodder for

her livestock. One of the ladies reported that she took Rs. 30,000 from the CBSG and constructed her home. And, another lady said that she took a Rs. 13,000 loan from the CBSG and spent it on her son's wedding.

It was also suggested by one of the reviewers of this report[5] that the fact of being in a CBSG might have led to increased CMW use by a more circuitous route. The simple fact of being a CBSG member makes it more likely the midwife will be 'paid,' at some time, by some family member, in kind or in cash. While it's difficult to conceive that any of the midwives would have consciously formulated a marketing strategy that targets some villagers and excludes others, it's also quite possible that on some less-than-fully-realized level, the CMWs might have seen the CBSG members as a market from which they were most likely to be paid.



A Complex Web of Communication
As a workshop exercise, participants were asked to map how the various actors in a village delivered messages about health care. The flip chart

Platform for Information

CBSGs also served as a locus for the transmission of information to all villagers, and especially to members. In the complex web of communication of health and saving messages that the CCSP used,

[5] Thanks to Mark Staehle for that observation.

CBSGs played one of the central roles both for members and non-members alike. In fact, CMWs urged women to join CBSGs, and CBSGs supported their members in using the CMWs.

For instance, the CMW in Terich says she does not have access to enough clients. She is aware of eight CBSGs in the village and she feels CBSGs are a very important source of referral and clients. She reported that CBSG members market her services as she could not go and talk to people door to door due to the mountainous terrain. She said that it is different working with women who are CBSG members because they are sensitized towards health issues and also they know that they have to pay for her services. It should be noted that other midwives are still struggling to get payment for services, as villagers do not have a habit of paying other villagers for services[6].

The VHC in Terich believes that the principal difference between CBSG members and non-members is that CBSG members are more aware and easily understand their message while with non-members they have to start from zero. For instance, members already have a basic understanding of health and hygiene, from the BCC agents and the CMW. However, the CBSG supervisor in the same village does not agree: she says that the women whose homes are near to CMW office are more likely to use CMW services whether they are CBSG members or not.

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[6] The culture of "Shukria" – giving thanks, but nothing more, for services rendered – is widespread in Pakistan. A workshop participant told of seeing an auto-repair shop whose owner received more thanks than money for repairing vehicles; when his business finally failed, he posted a sign on his empty shop saying, "Closed for Shukria".

The various actors in Morder village had positive impressions of the CBSGs as a means of delivering MNCH messages. The VHC, like VHCs in other villages, holds meetings with CBSGs to deliver health messages. They say that the CBSG members pass on the messages to those women who miss the meetings, and to other women in the village[7]. The CBSG supervisor in Morder agrees; she says that, all things being equal, CBSG members are more likely to use CMW services than non-members because they have attended so many awareness sessions and are more aware than non-members. The CMW in the same village says that she is aware of 10 CBSGs in Morder and she feels that they are a very important source of referrals and clients. She reported that she tries to find new clients first by going to CBSGs to talk to them; then going door to door; and finally through working with the VHC. She says that about 60% of her clients are CBSG members and she feels that it is different working with CBSG members than non-members because CBSG members give her their full attention and are "more aware".

CBSGs in Raman reported that they feel they are "linked" with the CMW. They have been told by SM's to use the services of CMWs. In other cases, it was reported that CMWs urge their clients to join CBSGs. In Khuz, Nighatat CBSG says that the CMW comes regularly to their meetings, checks the blood pressure of the members and charges Rs. 10 per head. The group pays the cost from their respective savings in their CBSG.

Again in Khuz, it was reported that only a few women are not members of CBSGs because they are aged and are not of child-bearing age; also

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[7] Interestingly, the VHC in Morder thought that "The principal difference between CBSG members and non members is that CBSG members are more mature, responsible and aged ladies." In fact, it is not statistically true overall that CBSG members are relatively aged; at least in the RAF study, they were younger than non members, though Morder may be an exception.

they are less likely to travel out of their homes. However, it was also reported that those non CBSGs members have encouraged their daughters, granddaughters, sisters and daughters-in-law to become CBSG members and to attend the regular monthly group meetings. The elderly ladies feel themselves to be part of the CBSG.

Social support

CBSG members provide other members with social support to try new things, to take risks, and to continue on new initiatives even when it is difficult. Most of the reported cases of this happening concern other areas of life besides childbirth. Still, in one clear case from Raman village, a member reported that she discussed her pregnancy with the CBSG members and the members advised her to visit the CMW or the nearest health centre and to take a loan from the CBSG for her delivery. She accepted the advice and borrowed Rs. 4,000 for her delivery.

Many other cases show social support in action, but in non-health areas. In K3 CBSG in Mori, Mrs. A reported that she was confused and remained undecided whether to continue her studies or not. She discussed her situation with the CBSG members during the monthly meeting. All the members urged her to continue studies. She took a Rs. 1,000 loan from the CBSG and enrolled in a college. She feels that the group gave her courage, and otherwise she could have given up her studies.

In Gobore, Nargis CBSG told the story of Mrs. S. who discussed the issue of her daughter’s continuing education with the CBSG members. She did not have the money to pay her daughter’s admission fees for the 11th year of school, and planned to stop her education. The CBSG members encouraged her to continue her daughter’s education; Mrs. S. took a loan for Rs. 3,000 and her daughter is in school.

A final example comes from Nighatat CBSG: One of the members was running a small business selling embroidery products. She decided to give up the business as she was short of money for further investment. She discussed her issue with other members in the CBSGs and the group encouraged her to take a loan from the CBSG and re-start the business. She borrowed Rs. 3,000 from the CBSG and is now running her business. She applauded the CBSG members for encouraging her.

Cases of group moral support were so common that it is difficult to imagine that they do not extend frequently to the use of health services, even if most of the documented cases were in other areas.

C. Traditional and non-traditional villages

The CCSP increased AKDN's outreach in some areas of Chitral where it had little presence. AKDN has been working in Chitral since 1983, organising men and women's groups for saving and lending, microcredit, electrification, health, education, and community infrastructure. CCSP expanded AKDN into some non-traditional areas where AKDN had been less present. The "non-traditional" (NT) areas are often relatively more socially conservative, making the introduction of both CBSGs and CMWs difficult.

It is not surprising that the program found easier success in its traditional valleys. In fact, what is remarkable is that the difference in performance was as little as it is. That the difference is not greater is probably due to intense efforts by the BCC campaigns to reach the NT villages.

The following table shows principal differences from the RAF data between traditional and non traditional villages. Other differences in

CBSG health, gathered in the August study, are discussed in the following section.

Differences between the performance of CBSGs in the traditional and

Variable	Traditional AKRSP villages	Non-traditional AKRSP villages
From RAF study		
Attend any session with the CMW	61.3% of respondents	40.5%
Received ANC by a skilled person	99.2%	06.8%
Post-natal care obtained from a hospital	16.3%	23.4%
Used money from a CBSG for pregnancy	8.7%	0.8%

non-traditional villages are discussed in the following section.

Some data in the above table are worthy of mention. The workshop participants insist that the performance gap between traditional and NT villages will have narrowed between when the RAF fieldwork was carried out, and the present, because of the on-going sensitisation efforts in NT areas. Also, note that the percentages of "Post-natal care obtained from a hospital" is higher in NT villages than in traditional villages; workshop participants said that this was due to the proximity of some of the NT villages in the RAF study to hospitals. If this is so, then the project has been successful in increasing use of CMWs, while not necessarily decreasing use of hospitals when they are available.

Finally, there may have been feedback loops that occurred in traditional and NT villages, that magnified outcomes. The supposition is this: CMWs assigned to traditional villages would find a warm welcome, and rapid acceptance, and therefore would bring more enthusiasm and confidence to their jobs, including marketing, and so would have more

business, which would in turn increase their enthusiasm and confidence further, and so on. CMWs in NT villages might have had a different loop, in which suspicion and wariness bred discouragement, leading to less business, and more discouragement. It’s interesting to compare the experience in a traditional village like Khuz, where nearly household has a CBSG member, even the men are requesting training in the CBSG methodology, and the CMW regularly attends CBSG meetings; and an NT village like Bombarate, where many women are not group members because they cannot leave their houses, the men of the Village Health Committee are not allowed to meet the women of the CBSGs, the villagers have confused “graduation” with “ending the group”, and the midwife reports she cannot grow her business, and is demoralized, because the women she delivers won’t pay her. The differences between the two populations of villages are more complex than this simple analysis suggests. However, a relationship between the existing expectations and familiarity of the population with AKDN, and the attitudes and performance of the CMWs assigned to them, is very probable.

VII. Way forward for sustainable CBSGs

A. Health of groups

The CBSGs in Chitral are generally healthy, and most can be expected to continue after the project closes. Still, it is generally difficult to know what happens to Savings Groups once they have shared-out once. In most projects, the data from the time of the share-out is recorded, but then the groups go into an "archive" section of the standard MIS, and no further data are collected. The CCSP is in better condition than many projects to assess the performance of graduated SGs for two reasons.

- First, it follows standard AKF practice of choosing a sample of CBSGs, in this case, 54 groups, to track post project, and visits them every six months for a three-year period to collect the standard MIS data.
- Second, as part of the Verification and Deepening exercise, the consultants chose a sample of 75 groups to visit; these included many graduated groups.

The tracked groups show the following data as of March, 2013:

Groups at time of formation	54
Groups at time of last visit	54
Members at time of formation	1102
Members at time of last visit	1120
Change in membership	+18
Attendance	94.4%
Dropouts	104
Dropout rate	8.5%
Loans outstanding as % of total assets	82.4%
Annualized return on equity	11.3%

NB: Dropouts are members who have left the CBSG definitively, because of death, ill health, moving away, or in rare cases, from being expelled from the group. The gain in membership of 18 is net of dropouts; in other words, the groups added 108 people (replacing the dropouts) plus 18 (the net gain), or a total of 126 new members.

The drop-out rate, 8.5%, is within industry norms[8]. Note that the number of new members joining the CBSGs is slightly more than the number of drop-outs, which justifies the claim for the general well-being of Chitral CBSGs. However, the good news is not evenly distributed. In fact, of the 54 groups, 21 had gained members and 18 had lost members. Two groups had gained ten or more members, while two had lost ten or more members. It must be noted that a certain amount of change in group membership is inevitable. The fact that overall the Chitral tracked group sample has had a small increase in membership is encouraging.

Exit surveys in Savings Group programmes are regrettably rare. During the August field work, we were able to interview 10 people who had left CBSGs. The results are illuminating:

Reason for leaving the group since share out:		
Responses	Freq	%
Moved	3	30%
Death	1	10%

[8] In fact, industry norms are just developing. VSL Associates has been following a cohort of 331 groups from six countries over four years, with one more year left in the study. The study has found that the survival rate of groups was 98% after one year, 95% after two years, and unexpectedly dropped to 89% after three years. Total membership was 7,256 at the beginning, rose to 7,621 after one year, dropped back to 7,333 after two (still higher than the initial number) and dropped below the initial number, down to 6,953, after three years.

Illness	0	0%
Lost interest	3	30%
Forced out by group	0	0%
Issue around service charge	1	10%
Group divided into two groups	1	10%
Change in membership policies	1	10%
Total	10	100%

Only three members had left for lack of interest, and none had been forced out. Three had moved, and one had died. The last three categories of response are notable, in part because they represent a technical loss of membership, but not a real decrease in ability to save:

- In the first case ("Issue around service charge"), three members had left a group because it was not taking a service charge on loans; the members joined another CBSG that was taking a service charge.
- In the next case ("Group divided into two groups") the membership had grown to 33 people and the group split into two. In the database, the member had technically left her group, because she ended up in the group with a new name and number.
- In the third case ("Change in membership policies"), after the group's second share-out, members decided to give membership to one member only from each household, to reduce the group size to a more manageable number; to compensate for the reduced saving opportunity for families who had had multiple members before, the group raised the share size from Rs.10 to Rs.20. The member left, but her family stayed in the group.

The attendance figure is quite high, but for a number of reasons not particularly informative, as women in Chitral do not have a lot of other scheduled events that would vie for their meeting time. The annualized return on equity is relatively quite low; the SAVIX database of 176 projects around the world gives an average return on equity of 35% compared to 11.3% in the tracked groups; this simply reflects the low level of borrowing in most Chitral CBSGs, and to the practice, reported by the CCSP, of groups re-investing their share-out because they do not have immediate needs for the cash, and value the security that comes with saving.

The Verification and Deepening Exercise in August 2013 showed results that are largely consistent with the results in the tracked groups. The sample of villages was segmented to include approximately equal numbers in traditional villages, those where AKRSP had a long and continuous presence, and non-traditional (NT) villages, that is, villages where AKRSP was not as widely known by the population. Because of constraints in the amount of time available for the study, only data were collected that could be gathered without reviewing the passbooks. Results for key variables follow:

	Traditional AKRSP villages	Non-traditional AKRSP villages
Number of groups in the sample	35	40
Members at time of formation	20.3	17.5
Change in membership from date of group formation to date of field survey in August 2013.	+2.0	–0.4

Membership change is a good indicator of group health. If new members join the group, existing members are expressing some level of satisfaction to their neighbours, friends and family. Again, these totals and averages by themselves hide important details at the level of the

individual CBSG. Small changes in membership can be due to any number of factors; larger changes are much more strongly suggestive of either robust, or failing, group health. Therefore it is useful to look at the number of CBSG’ s with double-digit membership changes.

In the traditional villages, six of the 35 groups in the study had gained ten or more members, while one had lost ten or more. The non-traditional villages had three CBSGs that had lost ten members, and two that had gained ten or more.

	Traditional AKDN villages (n=35)	Non-traditional AKDN villages (n=40)
Gained ten or more members	6 (17%)	2 (5%)
Lost ten or more members	1 (3%)	3 (8%)

In summary, eight of the 75 groups are showing particular robustness, while four are showing ill health. The robust groups are found much more in the traditional villages, while the ailing groups are found more in non-traditional villages. If the four ailing groups all fail, that will amount to 5.3% of the CBSGs in the sample. This failure rate would be within the normal range of CBSG durability.

Overall, it should be noted that the groups in the August 2013 Deepening Study had gained a total of 65 members.

B. Ultra-Poor and inclusive messaging

The workshop participants raised the issue of including the ultra-poor. That is to say, AKRSP has proposed (an ideal) that the CBSG programme should be of benefit to everyone in a village, and not only to the members. Participants pointed out that each CBSG is exclusive, by virtue

of having a fixed and determinate number of members; while recognizing that, they still hoped for a CBSG project that would be inclusive of everyone, with no one left out. They pointed out that Chitrali culture is inclusive – people in villages work to assure the well being of everyone.

While Savings Groups are reputed to be appropriate for the very poor, many people believe there is a level of poverty below which people simply cannot join the group. There is no single definition of "ultra poor" across Chitral, since every village has a different definition of poverty, different resources and different constraints. Participants pointed out that in some villages, almost every household was represented in a CBSG; the few people who were not included were those with such economic or physical disadvantages that they were legitimately the objects of charity. In some cases, groups had banded together and regularly used their social fund to support these ultra poor.

As one story among several, the CBSG Supervisor in Bombarate told about a 45 year old woman who suddenly became paralyzed on one side; she took Rs. 600 from the social fund of a CBSG Pehla Qadam and received her treatment. This is a fairly large contribution in Chitral where the average savings per member in the tracked groups is Rs. 1500; the generosity of the group is not an isolated case. In Raman, where there is perhaps the highest saturation of CBSGs - an estimated 98% of households have a family member in a CBSG. Many of the very poor are included, as the share value in some CBSGs is only Rs. 10, about nine US cents. Workshop participants knew of only one family that was not included. In this unfortunate family all the members suffer from congenital abnormalities. In this case, four other CBSGs are directly supporting the family through their social funds. The family receives about Rs. 300 (USD 2.80) per month from the four CBSGs; this

is said to be a useful contribution, but not enough to live on, and the family continues to live in difficult circumstances. Their poverty has been eased, though not eliminated.

CBSGs not only support their own members and needy non-members, but also are reported to support other CBSGs. Nighatat CBSG in Khuz reported that it is aware of ten other CBSGs in their village and they have held meetings with other groups whenever a loan request within a group exceeds the funds available in group savings. They report that lending outside the group to other groups is common, and they said that they "feel the village is a group". Workshop participants said such practices are common.

These examples demonstrate what is possible. The initiative to include everyone must come from the groups themselves, because of their autonomous nature. However, workshop participants believed that simply giving messages that CBSGs should be inclusive of everyone in the village would be enough to nudge members in the direction of finding their own solutions to including the ultra poor in the benefits of a CBSG programme.

C. Exit strategy and way forward

The conception of CBSGs has changed since program inception. In 2009, it was widely thought that CBSGs could be trained during a year; at the end of the year, they would share-out, or graduate from the programme, and they could then be left completely alone. It was thought that they would generally continue to save and share out indefinitely.

While this is true for some groups, experience has shown that it is far from true for all groups. Almost every group quickly learns the simple process of recording savings with stamps. Managing credit using the

processes presented in the CBSG manual on the other hand requires some numeracy, at least the ability to add and subtract sometimes quite long columns of figures. But compared to recording savings and loans, share-out is substantially more difficult, involving these four steps: first, adding up the total number of shares purchased by all of the members by adding up all the shares in all of the passbooks; second, counting all of the cash in the group fund; third, dividing the shares by the cash to get a new-value-of-share; and fourth, multiplying the new-value-of-share by the number of each member's shares. These calculations are not difficult to someone who has done them several times, unless there is missing information, or other complications. But they can be quite difficult for a group with low numeracy that only gets to participate in a share-out calculation once a year.

While many groups master the administration and record keeping associated with a CBSG, many others do not, especially not the share-out. As the realization has become more widespread that not all groups achieve mastery of all procedures during the first cycle, facilitating agencies have looked for ways to assure technical support post-project. This usually involves leaving behind trainers, variously motivated by intrinsic or extrinsic incentives[9].

One simple step that the CCSP can do in the remaining time with the CBSGs is invite those that wish to do so to use "flat" distribution instead of proportional. In flat distribution, each member receives an equal share of any money earned by the group, plus the member's

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[9] Motivation is *extrinsic*, when someone else wants the work done, and incentivizes the worker, usually with money. Motivation is *intrinsic* when the person wants to do something for its own value, for the pleasure or other perceived benefits that come from doing the work. Intrinsic factors might include the contribution one makes to the community, the satisfaction of doing a job well, improved standing in the community, future opportunities that may come through the work, and networking.

saving. For many groups, proportional is more desirable, but other groups deliberately opt for flat, thinking it is not only much easier, but also somewhat inclusive of the poorest members of the group, since they can save less, and therefore receive less under proportional distribution.

The CCSP CBSGs are not yet fully prepared for the post-project period. Some reported that they do not expect to continue after the end of the project, which betrays a fundamental lapse in training. A greater number said they expected to continue. At the workshop in Islamabad, the senior CCSP staff said they were holding an all-valley close-out conference in September, just before the end of the project, to discuss the way forward with relevant parties. The conference would announce its objective, which is to assure that going forward there would be continued demand for CMWs, sustainable CBSGs, that the Local Service Organisations (LSOs)[10] would step forward and take an ownership role, and that the CBSGs would support the CMWs, and vice versa. At the conference, the CBSG manager planned to say, "For us, this is the end. For you, it is the beginning", and continue to make a plea for both fee for service and volunteerism. In some cases, groups will be asked to pay for their training, and capable groups will be asked to train and support other groups. The conference is intended to be an opportunity to brainstorm on how to maintain and expand CBSGs post-project.

The approach is the correct one. Experience shows now that it is important to enter an area announcing and beginning to implement the

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[10] The LSOs are a key part of AKRSP's outreach strategy. Each LSO is an independent development organization, which frequently contracts with AKRSP or other members of AKDN, and of course is also free to contract with other development organisations and donors as the need and opportunities arise. The LSOs did not play a large role in the CCSP, but are slated to be the implementers of CBSGs in AKRSP's EELY project, starting to form youth CBSGs as CCSP ends.

exit strategy; four years ago, our understanding of the situation of post-project groups was not as clear and this was not done in the case of CCSP. However, this is perhaps not as great an oversight as it might appear. AKRSP does not usually abandon areas where it has worked, although its activity may rise and fall in any particular valley or village based on its strategy, activities and resources of the moment. In the case of Chitral, it will continue to form CBSGs (mostly in new areas) under the Enhancing Employability and Leadership for Youth (EELY) project, and AKDN is conducting a sustainability evaluation in March of 2014 to look at many issues around the way forward, including how CBSGs can be incorporated into the AKDN Multi-Input Area Development (MIAD) strategy. AKRSP will continue to have a voice in the future of the CBSGs, and some influence over the groups.The CBSG approach is well established in the minds of many of the people in the area, and the tradition of volunteerism may be enough to keep CBSGs forming and finding the support they need.

D. Further Study

While reports such as the present study typically conclude with recommendations for further study, in the present case we are discussing a project that has been studied more than most, and one which has perhaps already revealed most of its secrets. Beyond the final project evaluation, there is perhaps not a strong need for further research in Chitral. Nonetheless, writing this report made it clear how much is not known about Savings Groups in general, and about their interaction with other activities. The CCSP experience points to four areas where further study help decision makers understand the possible gains, possible risks and best strategies in using CBSGs as an adjunct to MNCH programmes, or programmes in other areas.

Household-based outreach measurement: The CCSP seems to have shown that the gains from CBSG membership accrue at the household level. Yet, most SG projects use total membership as the principal indicator of outreach. What are the marginal gains in increasing membership, once most households are included in a SG project?

Measuring SGs as social entities: Most SG projects use financial outcomes, like total amount saved or borrowed, as principal indicators of success. While few would argue that these are irrelevant indicators, the social impact of getting women to leave their homes and talk together about health services, starting businesses, and no doubt many other things, is likely as important, or more important, an outcome, as the financial results. How can social empowerment be easily and reliably measured?

Long term (>five year) follow up: Most early SG projects followed methodologies that by now are considered outmoded, so retrospective looks at the outcomes in these projects would be of little use in predicting the future of more modern groups. However, the CCSP and other projects started within the last five years follow methodologies that are mature and widespread. It would be very interesting to follow up on projects after five or more years.

Post-project tracking at the member level: AKF admirably tracks a sample of its CBSGs in most of its projects. Such studies, however, by their design always show the number of groups as static or declining, because they do not make any effort to find new groups that are formed, and they fail to show why members leave groups, and if they join other groups when they leave. While it would be costly to carry out the exercise, might it be possible to track a cohort of SG members over time?

VIII. Lessons learned and Good Practices

A. Keeping it simple

One of the most important things that the CCSP did, is, in fact, something that it did not do: it did not complicate the basic savings group model that they began with. In particular, they did not add any complications to the bookkeeping by adding ledgers or other additional accounting, and they did not try to change the nature of the groups by limiting their purpose to health financing. These decisions seem simple, but in fact many SG projects have yielded to the temptation to compromise the simplicity of SGs.

The basic simplicity has allowed the groups to spread widely, with some spontaneous growth, as discussed above.

B. Family as member

The CCSP was a striking demonstration of how CBSG membership is a family activity. This was true for the financial aspect, as well as the communication and social aspects. There were reported cases of members borrowing for family expenses, and cases like the older women in Khuz who considered themselves members of a CBSG because they had urged their younger family members to join. And of course, there is the remarkable correlation between family membership and increased use of the continuum of care.

There is an opportunity for further research into the impact of family membership, and perhaps *family membership* could be a new metric for SG outreach. Measurement of coverage of a Savings Group programme should perhaps not focus on the number of members in a village, but on the number of households having a member.

Trainers might do well to concentrate on family benefits as well as individual benefits when publicising a Savings Group project.

C. CBSGs as a platform

The field research showed clearly that CBSGs in Chitral were a privileged platform for transmission of information, and indeed Savings Groups are increasingly being recognized around the world as a platform for BCC, training and social marketing.

The workshop in Islamabad returned repeatedly to the subject of "other messages", or delivering messages beyond what is contained in the standard CBSG training manual. The CCSP field staff delivered many messages, sometimes deliberately, and sometimes simply in the course of speaking with villagers and reflecting their own values and ideas. The messages were usually positive, but sometimes negative. Messages around MNCH were clearly positive and very useful. The project staff in some cases may have missed opportunities to present CBSGs as a community resource that will continue after the end of the project, and one that the group members themselves can manage: for instance, in Bombarate, some members reported that women did not join CBSGs because they expected them to end with the close of CCSP. This misinformation was a rare exception and most groups seemed to understand the nature of CBSGs and said they planned to continue indefinitely. The idea that the CBSG should be inclusive of the entire community is another one that goes beyond what is found in standard manuals, that AKRSP plans to include in future trainings and messages.

While women's groups of other sorts might have been a good focal point for health messages, and might have provided moral support to women to access health services, non-financial groups often do not endure as well as CBSGs. CBSGs have a high survival rate, because the shared funds, access to finance, and opportunity to save provide a sort

of social and economic glue that keeps groups together, often for many years.

D. Choice of Delivery Channel

The CCSP facilitated the transmission of information, and helped assure consistency of message, by preparing and using

Delivery of the "other activity" in Savings Group projects has been classified as being through one of three channels[11]. In "linked delivery", one organisation forms and trains the SGs, and another organisation altogether delivers the other activity – in the instance, BCC. In "parallel delivery", different people from the same organisation visit the SGs to deliver both the SG training on the one hand, and the other services on the other. Finally, in "unified deliver", the same person delivers the CBSG training and the other activity.

This neat way of classifying delivery channels breaks down in the case of the CCSP, and this suggests that rather than look for the *best* delivery channel, it is more effective to work to get everyone delivering the same messages. In fact, the CBSG Supervisors supported members in using the CMWs, and thus the delivery was unified. Other people from within AKDN, including the BCC agent working for AKHS/P, also delivered parallel messages, and so the project used parallel delivery. Finally, the project facilitated access by the CMWs and VHCs, the Lady Health Workers, and the Trained Birth Attendants, who are not technically part of AKDN, and thus the delivery was linked. AKDN

[11] See *Beyond Financial Services: A Synthesis of Studies on the Integration of Savings Groups and Other Developmental Activities*, Aga Khan Foundation, April, 2011. Paul Rippey and Ben Fowler.

carried out a large number of meetings, and used various printed materials, to assure that the diverse actors all delivered the same messages.

There have been discussions about the advantages of using one or another of the delivery channels when other activities are added to Savings Groups; the lesson learned from the CCSP is about the advantage of using as many channels as possible to assure the maximum uptake of messages.

E. Learning

The project showed admirable openness to new inputs, and a good ability to adapt to feedback from the field. The following is a list of some of the changes made during implementation:

- After questions were raised about the precision of some of the MIS data, they shifted the task of data collection for the MIS from the CBSG Supervisors to the Social Mobiliser.
- When it became apparent how much family membership was important, and in the face of requests from some men to joining CBSGs, they began forming groups for men.
- In parallel, they created the new staff position of "male motivator" to reach men who for social or religious reasons were difficult to reach with health messages through the predominantly female field staff.
- When it became apparent that the acceptance of the CMWs and the CBSGs differed significantly between traditional and non traditional villages, they shifted resources to the latter.
- After the mid-term evaluation, CCSP shifted their encouragement of using CBSGs more towards *suggestion*, and away from *urging*.

Every project learns in the field, but only the wise project acts on what it learns. It is fair to say that the CCSP showed considerable wisdom in being flexible and adaptive in its approach.

F. Exit, embedding and patience

The title of this study, Connections and Support, was chosen to underline the defining element of the CCSP: a complex set of actors and activities combined and are changing deeply embedded attitudes and practices. Cultures that are hundreds of years old can change quickly, as telephones, roads and media introduce new ideas, goods and practices, but an end-of-project assessment of a four-year project, like the present document, is unlikely to capture all the changes that may happen in future.

Women in Chitral continue to talk with each other in their CBSGs about things that matter. Young people are growing up and taking on more important roles in their families, while older people are fading out of the key positions they once held. Assessing a Savings Group project requires a long view, as they should have a continual effect in areas where they have become embedded in the culture. This is apparently the case in some of the villages where almost every family is included and where there is frequent communication among the VHC, the CNM, the CBSGs and other actors.

However, in a few other villages, especially those that have seen CBSGs lose many members, it is less clear what the future will be. But even in the more difficult villages one can permit oneself some optimism. Two anecdotes demonstrate the power of demonstration, the need for patience and consistency, and the unpredictable ways that change occurs. They are perhaps a good way to end this section of the report.

In Terich Bala, the local mullah told people not to use the CMW, and preached that AKDN was not acceptable. He said that they "operated like an NGO", referring among other things to the fact that men and women travelled together in vehicles to the village. However, his wife got pregnant and had a difficult pregnancy; she was in labour for two days but not progressing. As a last resort he went to the midwife, who came to the mullah's home. Soon after the midwife came, his wife had a good, safe delivery. Now he preaches in the Friday prayer that it is part of Islam to use the midwife since she can deliver at home.

The CMW in Gabore told how she was called from Killich for an urgent delivery of Mrs. R. in Killich, a village that shares a border with Afghanistan and is the most distant village in the project area. It was a long way to go, and she took along her in-laws and her daughter. She said that it was snowing at the time, but she set off on foot anyway in light of the urgency of the call. On the way she experienced an avalanche and had a narrow escape but she still continued her journey, thinking she might save the life of Mrs. R. She finally reached the village and delivered the lady. The family had no one in a CBSG and could not afford to pay the midwife's fees. After some time, the new mother became a member of a CBSG, took a Rs. 1200 loan, and paid back the CMW.

IX. Annexes

A. Terms of reference (relevant sections)

B. Instruments used in the August field work

C. Field Reports

D. Headline statistics from "Instrument 9 – Data collection form"

ANNEXES of ANNEX XIX

Final Assessment of Community Based Savings Groups

Annex A: Terms of Reference (relevant sections)

Review and evaluation of the CCSP CBSG Component
Technical Support Consultancy
Terms of Reference (ToR)

Purpose: The purpose of the 'Review and Evaluation of the CCSP CBSG Component Consultancy' is to contract an individual to support AKF's CCSP Child Survival program in Pakistan. The consultant will lead a process for the review of the community based saving group (CBSG) component as it pertains to the impact on reducing barriers to key health seeking behaviors in Chitral, and guide the development of a final report that will inform the final evaluation of the CBSG component of the project.

AKF USA is seeking an experienced professional with extensive experience and knowledge of CBSG programs, especially as they relate to health outcomes. The consultant will provide support to AKDN internal partners in Pakistan to assess the achievements and lessons from the CBSG component, provide technical guidance for the collection of key data, and develop a report and recommendations that will inform the final evaluation of the CBSG component as it relates to the project objectives.

Background:
The Chitral Child Survival Program (CCSP) works towards improved maternal and child health in Chitral District, Pakistan. The program is a joint effort of USAID and several Aga Khan Development Network agencies: the Aga Khan Foundation USA (AKF USA), Aga Khan Health Services, Pakistan (AKHS, P), Aga Khan Rural Support Program, Pakistan (AKRSP) and the Aga Khan Foundation, Pakistan (AKF,P). AKF USA manages the grant and AKHS, P, AKRSP and AKFP implement the program.

This five year program (September 2009 to August 2013) is co-funded by AKF USA and USAID's Child Survival and Health Grants Program (CSHGP). The objective of CSHGP is to contribute toward sustained improvements in maternal and child survival and health, a value which the CCSP is designed to promote.
Few deliveries in Chitral (13%) are attended by a skilled health provider[1]. Women in Chitral face many barriers to accessing health services. Barriers include high levels of poverty and female illiteracy, cultural practices favouring childbirth at home, women's limited mobility outside of the home, and many hours and sometimes days

of travel required to reach a health facility. One of the major obstacles in accessing skilled care in Chitral, both for normal deliveries and for those requiring emergency interventions, is the inability to pay all the fees associated with utilizing health care services. Fees may include transportation to the provider, bed charges for inpatient care, as well as the cost of medicines and other supplies.

Specifically, CCSP is designed to:

1.) Increase the availability of skilled birth attendants at the community level;
2.) Increase financial access to Emergency Obstetric and neonatal care (EmONC) services.

Community Based Savings Groups (CBSGs) were introduced into the program as a potential mechanism to address financial barriers to accessing the obstetric and neonatal continuum of care. Studies undertaken in the project's year 1 found that Community-Based Savings Groups (CBSGs) were a potential mechanism for improving financial access for women for obstetric and neonatal services. Lessons from other countries have supported this hypothesis as CBSGs have shown to be relatively low cost and financially sustainable, and can contribute to health-seeking behaviors among women.

Groups are established according to the standard VSLA methodology and are encouraged, but not forced or required, to use savings, loans, and the social fund to cover some of the costs associated with maternal and newborn care, particularly those delivered by the community supported mid-wife (CMW).

The recent Research and Advocacy Fund (RAF) study demonstrated a statistical correlation between CBSG membership and use of health services, and created a statistical base from which it may be possible to define the connections between CBSG membership and use of health services.

Specific Objectives: In collaboration with AKF (USA and Pakistan the specific objectives of the consultancy include:

Part 1: (4 days working remotely – July 1-4, 2103)

1. Upon review of the recent RAF study, design a CBSG program assessment package (strategy, tools, and protocol) that will complement and supplement information collected from the RAF report. The assessment package will collect critical information from key stakeholders and target communities on the actual uptake, roles, and impact of the CBSG component in mitigating financial barriers to health care seeking behavior for women in Chitral. The

assessment tool will be designed so that it can be implemented by a local consultant over a two or three week period, produce information that complements the RAF Report and other project information, and helps produces information that will inform the final CBSG final evaluation. The consultant will develop this tool remotely after review of the RAF report, and coordinate with the AKFP project team in Pakistan and the local consultant to ensure that it is understood and implemented as per instructed.

Part 2: (12 days in Pakistan – 10 working days and 2 days travel – September 1-12, 2013)

1. Lead a workshop with the CCSP project team to:
   a. Identify and detail strategies and approaches that will facilitate community uptake and sustainability post project of the CBSG component;

b. With project staff conduct an overall review of the CBSG component and develop clear
descriptive overview and timeline of the CBSG component over the life of the project
– including barriers, costs, facilitating factors, outcomes, etc.

c. In conjunction with the project team identify lessons learned from the CBSG component that could be utilized by the project team for dissemination purposes.

2. Use information collected from the RAF report, project MIS, assessment package, workshop products, and data collected in the field to develop a final report of the CBSG
component as it relates to the project objectives of reducing barriers to key health seeking
behaviors for women/families in Chitral.

a. This will include travel to the Chitral region to collect pertinent data.

b. The final report will be due by the end of the consultancy.

Duration and Timeline of the Consultant: The duration and timing of this consultancy is highly dependent on when AKF will receive the consultant's Visa for travel to Pakistan.

Approximate itinerary for the consultancy is as follows:

Activity	Location	Days
1. Review RAF report, development of Assessment Package, and coordination with AKFP team and local consultant -	USA	4

July1-4		
2. Conduct CBSG workshop and develop final CBSG report September 2-11	Islamabad and/or Chitral Pakistan	10
3. Travel September 1 and September 12		2
Total		16

Terms of Engagement: The contract will be signed between the consultant and AKF USA.
The consultant will report directly to David Hintch, Senior Program Officer – Health - AKF USA, and Dr. Sharif Khan AKF Pakistan. While in Pakistan AKF P will provide logistical support and guidance.

Other potential contacts for this assignment include:

- Dr. Qayyum Noorani, AKF Pakistan
- Dr. Babar Shaikh, AKF Pakistan
- Shahbaz Latif, AKF Pakistan
- Frederick Kellett: AKF USA
- Caryn Sweeney, AKF USA

Deliverables: Payments will be subject to the satisfactory completion of the activities described above and the deliverable listed below:
The following deliverables are contingent upon internal consensus and deadline of submission.

- CBSG Assessment Package (as described above): Prepared in consultation with the CCSP team;
- CBSG final report containing:
    - Identified actions for CBSG sustainability;
    - Complete review and description of CBSG component
    - Complete description of lessons learned and best practices for program replication
    - Analysis and description of CBSG impact on health care seeking behavior for women in Chitral as outlined in the project objectives.

Minimum qualifications:

- At least 5 years' experience working with and/or supporting CBSG programming

- Extensive knowledge of CBSG programs, especially as they relate to health and/or other development programs
- Knowledge of Pakistan environment, preferably knowledge of CCSP project
- Ability to travel to Pakistan
- Fluency in written and spoken English
- Knowledge of the AKDN networks would be an advantage
- Some technical knowledge of maternal and newborn health desired, but not mandatory

Annex B: Instruments used in the August field work

Instrument 1: CBSG Focus Group discussion guide

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

Special Instructions: Discussion should have from five to eight participants. Use tape recorder or computer to record Focus Group Discussion. Be aware of the possibility of members deferring to leaders, and use probes to assure participation of everyone: "I haven't heard from you. What do you think?" "Do you agree?" "Thank you. Can I have another opinion on that?" Notice people's expressions especially of non agreement: "You look like you might have something to add to that..." Keep discussion moving, and finish within 30 minutes if possible. Record specific anecdotes and accompany them by photographs. In particular, look for cases where CBSG members were empowered or encouraged to use MNCH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MCNH services.

"I am ______. I am doing some research with the Aga Khan Foundation about how CBSG members use maternal and child health services. I'd like to hear from you about this. I want to record this so I can be certain I don't miss anything. Your remarks are confidential, and your names will not be used. [Ascertain if anyone in CBSG participated in RAF study. If so, tell them you want to share some of the results with them and ask if we got the information right.] May I begin?
We'd like to hear from everyone so if someone isn't talking, I may call on you!"

Would you please tell me the history of this group?

[Record date founded, changes in membership, salient events in group history]

I'd like to hear from you about CBSGs here in [name of village].

How many groups besides your own are you aware of?1
Do you ever meet with the other groups?
IF SO: why? What do you do together?
Are there women here in [name of village] who are not members?
IF SO: Why is that?
What sort of women are not members?
[Determine if it is because they haven’t been asked, don’t choose to join, or are thought to be unable to join. If some women are unable to join, determine why.]

I’d like to talk to you about how you finance personal expenses. How many of you have ever taken a loan from this group? I’d like to ask some of you about that...
[ASSUMING YOU ARE A 6 O’CLOCK, CHOOSE RESPONDENTS WITH HANDS RAISED CLOSEST TO 3 O’CLOCK, 9 O’CLOCK, AND NOON, IN THAT ORDER]

ASK 3 O’CLOCK
What did you purchase or pay with your most recent loan?
What was the cost?
How much was the loan?
IF LOAN < COST: How did you finance the difference?
Would you have purchased/paid without the loan?
RECORD ANY COMMENTS:

ASK 9 O’CLOCK
What did you purchase or pay with your most recent loan?
What was the cost?
How much was the loan?
IF LOAN < COST: How did you finance the difference?
Would you have purchased/paid without the loan?
RECORD ANY COMMENTS:

ASK NOON
What did you purchase or pay with your most recent loan?
What was the cost?
How much was the loan?
IF LOAN < COST: How did you finance the difference?
Would you have purchased/paid without the loan?
RECORD ANY COMMENTS:

Sometimes it is said that if people have access to savings or credit through a CBSG, they will make purchases out of funds they have been saving at home, because they know they can get a loan if they need it. Have any of you ever purchased something with your own money at home, because you know you have the group to fall back on in an emergency?

IF YES, RECORD UP TO THREE CASES

	Case 1	Case 2	Case 3
What was purchased?			
Amount			
Month and year			

IF YES: Other members, is this common?
GROUP COMMENTS:

Sometimes it is said that if women are members of a group where they meet regularly and can discuss things themselves, they learn about new things that they would not know about otherwise. Have any of you ever undertaken a project because you learned about the idea from the other members of your group?

IF YES, RECORD UP TO THREE CASES

	Case 1	Case 2	Case 3
Project			
Month and year			

IF YES: Other members, is this common?
GROUP COMMENTS:

Sometimes it is said that if women are members of a group where they meet regularly and can discuss things themselves, they will have the courage to do things that they could not do otherwise. Have any of you ever undertaken a project or done something you had wanted to do because the other members of the group supported you or encouraged you?

IF YES, RECORD UP TO THREE CASES

	Case 1	Case 2	Case 3
Project or action			
Month and year			

IF YES: Other members, is this common?
GROUP COMMENTS:

HAVE MEMBERS RAISE THEIR HANDS TO THE FOLLOWING QUESTIONS AND RECORD NUMBER OF HANDS RAISED FOR EACH QUESTION.

Are you aware of a community midwife here in _______________?
IF YES: Do you know what services she offers?
IF YES: Do you know what she charges for these services?
IF AWARE OF MIDWIFE: Do you know where she lives?
Do you know where her office is?
Have you visited her office?
Have you met her?
Do you know her name?
Has she ever visited your CBSG?

Are women in CBSGs more likely to use the CMW than women not in CBSGs?

IF YES: Conduct a ranking exercise.

Tell the women you would like to have all the reasons why CBSG members are more likely to use CMW than non members. Write down all reasons on cards. If more than four, write down all answers, and ask the members to choose the top four reasons. Help them combine similar answers. Give the members the cards with the top four answers, and ask them to put them in order from the most important reason why CBSG members are more likely to use CMWs than non members. Give them two to three minutes to arrange cards, and step away from the group.

On return, ask them what they decided, and ask them why.

Is there anything else you think I should know about CBSGs and MNCH?

Thank you very much for your time.
REMEMBER TO RECORD TIME FGD ENDED

NB: If it was not possible to contact the group, or if the group no longer exists, is no longer meeting, or never existed, it is important to record the following details:

CBSG that could not be contacted.
Reason (check all that apply)

- Could not be located
- Group no longer exists
- Members had all traveled
- Group never existed/No one has heard of it
- Members refuse to meet with interviewer

Please list all steps taken to locate and interview the group.

Ascertain if possible from any reliable source the existence and present functioning of the group and give what information you are able to acquire here:

Instrument 2 - Interview with women having delivered

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

Special Instructions: Interview women who have delivered in the last two months, both CBSG members and non-members. Record specific anecdotes and accompany them by photographs. In particular, look for cases where CBSG members were empowered or encouraged to use MNCH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MNCH services. Also record any interesting comments on CBGS by non-members.

"I am _____. I am doing some research with the Aga Khan Foundation about how women use maternal and child health services. I' d like to ask you a few questions about this. Your remarks are confidential, and your names will not be used. May I begin?

Are you a member of a CBSG? Y/N
IF NO: Are you aware of CBSGs here in [name of village]?
IF NON-MEMBER AND AWARE: Have you ever been invited to join one?
IF YES: What happened? [record reason she did not join]

Are you aware of a community midwife here in _______________?
IF YES: Do you know what services she offers? (Yes/partially/no/no answer)
IF YES: Do you know what she charges for these services? (Yes/partially/no/no answer)

IF AWARE OF MIDWIFE: Do you know where she lives?
Do you know where her office is? ? (Yes/partially/no/no answer)
Have you visited her office? ? (Yes/no/no answer)
Have you met her? ? (Yes/no/no answer)
Do you know her name? (Ask name, and verify) ? (Yes/partially/no/no answer)

I' d like to know what health services you used during your pregnancy and delivery. Please tell me if you used any of the following? [Once you have asked about services used, ask for all questions that were answered "Yes", "How much in total did you pay for these services?" Then, after she gives each amount, ask, "And where did you get those funds?" [do not read list of sources of funds] Record multiple sources if she gives them.

		Source of funds					
	Am t.	Self	Husban d	CBSG	Other loan	Other s	No respons
Antenatal care during most	Yes No						
Antenatal care							
Antenatal care							
Delivery	Yes No						

		Source of funds					
	Amt. Pai	Self	Husband	CBSG	Other loan	Others	No respons
Delivery Assisted by CMW							
Delivery assisted by other source							
Post natal care after most recent delivery	Yes No						
Post natal care provided by CMW							
Post natal care from other source							
TOTALS							

During or after your last pregnancy, did you visit any health facility for MNCH? Y/N

IF YES: Who referred you?

Referred by:	Self-referred	CMW	Other (specify
ANC			
Delivery			
PNC			

Did you discuss with CMW, VHC, or BCC person? Yes No
IF YES With whom?

Did they give you advice?

IF YES: Did you follow the advice?

IF NO, OR PARTIALLY: Why not?

IF RESPONDENT DID NOT USE CMW SERVICES

Why didn’t you use the services of the CMW? DO NOT READ LIST. MULTIPLE ANSWERS POSSIBLE

Husband or family member wouldn’t let me/ pressured me not to	Yes	No
I prefer not to / don’t trust CMW / didn’t know enough about her	Yes	No
Don’t have money / too expensive	Yes	No
Other (specify:	Yes	No

IF RESPONDENT BOTH DID NOT USE CMW SERVICES BECAUSE “DON’T HAVE MONEY / TOO EXPENSIVE”, AND IS AWARE OF CBSG:

Did you know that some women save in the CBSG and use that money, or a loan from the CBSG, to finance health care services around their pregnancy and delivery?
Yes No

Do you believe that is possible for someone like yourself? Yes No

IF CBSG MEMBER:
Did you discuss your pregnancy or PNC with any members of your CBSG?

Did you discuss what services to use?
Did you discuss that with individual members privately, or at the CBSG meeting?
What did the members say to you? [Record exact response]

Did you discuss how to finance it?
Did you discuss that with individual members privately, or at the CBSG meeting?
What did the members say to you? [Record exact response]

Did speaking to other members influence your decisions about health care during your pregnancy or after delivery?

IF YES: How?
Thank you very much for your time.

THANK RESPONDENT AND END INTERVIEW
Remember to record time ended

Instrument 3 – Queries of RAF Data base

A statistician should query to data to test the extent to which different factors vary with use of MCH services, and rank them from most determinant to least determinant.

Use of services
Attend session 14
Seek healthcare 16
Number of ANC visits 20
ANC from CMW 21
PNC 50
PNC from CMW 51
Use CBSG money for pregnancy 58

Age 01
Education 04
Education of Husband 06
Occupation 07
Husband occupation 08
Number of children 10
Monthly income 11
Decision maker 18
CBSG family 56
CBSG member herself 56
Ever taken CBSG loan 62

Instrument 4 – Interview with Community Midwives

Researcher(s)	
Respondent(s)	
Location	

Date	
Time begun	
Time ended	

Special Instructions: Record specific anecdotes and accompany them by photographs. In particular, look for cases that the CMW may know of where CBSG members were empowered or encouraged to use MNCH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MNCH services. Also record any interesting comments on CBGS by CMWs.

"I am _____. I am doing some research with the Aga Khan Foundation about how women use maternal and child health services. I' d like to ask you a few questions about this. Your remarks are confidential, and your name will not be used. May I begin?

Could you please tell me how long you have been working as a CMW in [name of village]?

During that time, how many deliveries have you had?

How many women have used ANC and PNC?

How many women did not take your services for maternity but come for other services?

In terms of you expectations, would you say that the amount of deliveries and other clients you have had…

Exceeded your expectations
Was about what you expected
Was less than you expected

Would you say that the number of deliveries and other clients you have is:

Increasing
Staying about the same
Decreasing

In terms of you expectations, would you say that the amount of payments you have received…

Exceeded your expectations
Was about what you expected
Was less than you expected

Would you say that the amount of the payments you are receiving is:

Increasing
Staying about the same
Decreasing

What kind of services other than maternity you provide?

Do people pay for those services? Yes No Sometimes

Do you have plans for increasing the use of your services? Yes No?
IF YES: Please describe.

Are you optimistic or pessimistic about the future? Optimistic Pessimistic

Why is that?

Are you aware of any Community Based Savings Groups in [name of village]?

How many?

How do you perceive the CBSGs as a source of referrals and clients?
Very important
A little important
Not important

How do you try to find new clients? [Do not read list – check all that apply]

Talk to people door to door
Go to the CBSGs and talk to them
Work with/ or rely on VHC.

Work with/ or rely on BCC officers
Media
Signage
Other (specify)

Are you a member of a CBSG?
Do you ever attend visit CBSGs of which you are not a member to talk about your services?

We are asking women how they finance MNCH services. I would also like to get your point of view.

What do you think are the sources that women use to finance services they get from you? (Give them cards. Take back any that don't apply. Have them put them in order, from most important source to least.)

	Rank
Self	
Husband	
CBSG	
Other loan	
Others	

Have any of your clients told you of strategies they used to find the money to pay you? What do you think your clients do when they don't have enough money to pay your fees?

About what percentage of your clients are CBSG members? % OR Don't know

Is it different working with women who are CBSG members, than women who are not members of CBSGs?

IF YES: How is it different?

All things being equal, is a CBSG member more likely to use your services than a non member?
IF YES: Why is that?

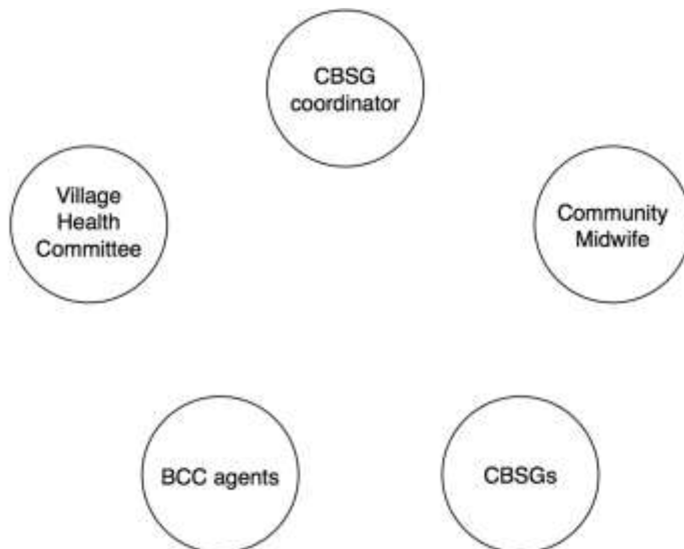
Have you made special efforts to attract CBSG members as clients?

IF YES: What did you do?

Our earlier research showed that CBSG members were more likely to use CMW services than non members. We have talked about some of the reasons why that might be so. Can you think of any other reasons why that might be so? PROBE. RECORD EXACT WORDS WHEN APPROPRIATE. LOOK FOR ANECDOTES.

We would like to understand how you and the different entities communicate and work together...

USE SMALL OBJECTS, OR DRAW ON A PIECE OF PAPER, TO REPRESENT THE DIFFERENT ACTORS IN THE COMMUNITY:



Are there any other key actors that should be represented? IF SO ADD THEM. Please think about the amount of time you spend talking, writing, phoning or otherwise communicating directly with these different entities.

Among all these entities, which one do you communicate with the most? ________ And how do you communicate with them?

And the second most? ________________
And how do you communicate with them?

And the third most? ________________
And how do you communicate with the them?

Can you tell me one or two success stories, good things for maternal and child health that would not have happened before the CCSP that have happened because of it? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

Thank you for your time.
Remember to record time interview ended

Instrument 5 – Interview with CCSP management and staff

To be conducted by principal researcher

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

Our earlier research showed that CBSG members were more likely to use CMW services than non members. There seem to be a number of reasons why this might be the case. I would like to hear any ideas you might have about these.

Factor	Description
Funding from CBSG	**The project assumed that loans, savings, or social fund contributions from CBSGs of members or of members' families would finance MNCH services. This has happened. Their absolute importance and importance relative to other factors are the subject of this research**
Differences in populations of CBSGs members and non-CBSG members	**RAF study showed that CBSG members in the sample were younger, had more education, and fewer children than non members. These factors may have influenced use of MNCH services.**
Leverage funding due to CBSG	**Portfolios of the Poor and other sources have argued that people who have access to finance from formal or semi-formal sources are more likely to call on funds reserved for emergencies for non urgent uses, since they know that if necessary they can take a loan.**
Multiple funding sources including CBSG	**Sources also have argued that partial funding for a needed product of service often incites a person to put together a package of funding sources to top up the amount available.**
Social empowerment	**Sources cited in the literature review suggest that belonging to a group encourages people to try new things and to take risks.**

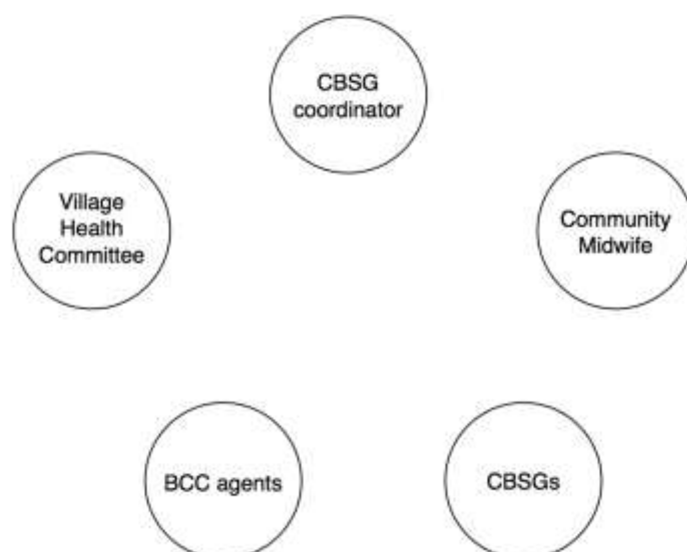
Factor	Description
Greater reception of BCC messages by CBSG members	**Reports suggest that CBSG members were more likely to receive BCC messages than non members.**
Greater CMW marketing to CBSG members than non members	**Reports suggest that CMWs preferentially marketed their services to CBSGs.**
"Halo Effect"	**If members of CBSGs have positive attitudes towards the CBSGs, those feelings may transmit to CMWs through a "halo effect"**
Other	**Other factors that have not now been identified may have contributed to the greater uptake of MNCH services by CBSG members.**

What is your general impression of the health and viability of the CBSGs?

And why do you say that?

We would like to understand how you and the different entities communicate and work together…

USE SMALL OBJECTS, OR DRAW ON A PIECE OF PAPER, TO REPRESENT THE DIFFERENT ACTORS IN THE COMMUNITY:



Are there any other key actors that should be represented? IF SO ADD THEM. Please think about the amount of time you spend talking, writing, phoning or otherwise communicating directly with these different entities.

Among all these entities, which one do you communicate with the most? __________ And how do you communicate with them?

And the second most? ____________________
And how do you communicate with them?

And the third most? ____________________
And how do you communicate with the them?

Can you tell me one or two success stories, good things for maternal and child health that would not have happened before the CCSP that have happened because of it? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

How can you build on and replicate that success?

How has the mindset of the community changed, if at all, around the use of CBSGs to support maternal and child health? Can you give us a specific example? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

Thank you for your time.
TIME ENDED.

Instrument 6 – Interview with BCC Agents

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

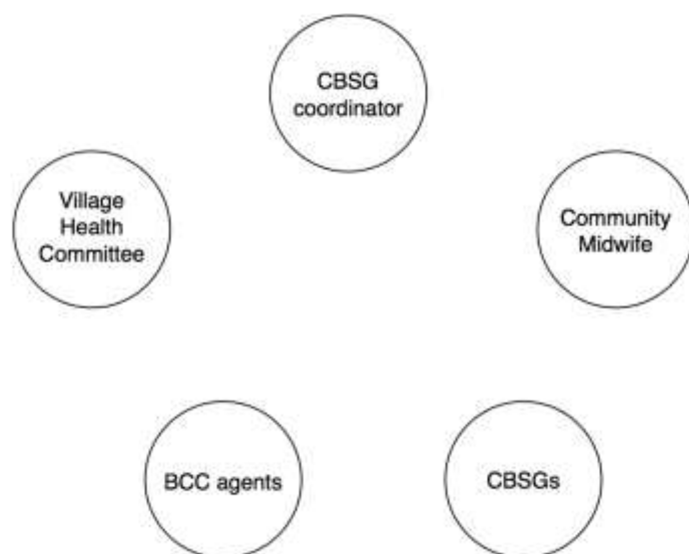
Special Instructions: Record specific anecdotes and accompany them by photographs. In particular, look for cases where CBSG members were empowered or encouraged to use MCNH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MCNH services. Also record any interesting comments about differing perceptions of members and non-members of CBSGs by the BCC agents.

"I am _____. I am doing some research with the Aga Khan Foundation about how women use maternal and child health services. I'd like to ask you a few questions about this. May I begin?

Please tell me how you carry out your BCC campaign.

We would like to understand how you and the different entities communicate and work together…

USE SMALL OBJECTS, OR DRAW ON A PIECE OF PAPER, TO REPRESENT THE DIFFERENT ACTORS IN THE COMMUNITY:



Are there any other key actors that should be represented? IF SO ADD THEM. Please think about the amount of time you spend talking, writing, phoning or otherwise communicating directly with these different entities.

Among all these entities, which one do you communicate with the most? ________ And how do you communicate with them?

And the second most? ________________
And how do you communicate with them?

And the third most? ________________
And how do you communicate with the them?

Can you tell me one or two success stories, good things for maternal and child health that would not have happened before the CCSP that have happened because of it? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

Is it different working with women who are CBSG members, than women who are not members of CBSGs?

IF YES: How is it different?

All things being equal, is a CBSG member more likely to use the services of a CMW than a non member?
IF YES: Why is that?

Have you made special efforts to deliver messages to CBSG members?
IF YES: What did you do?

Our earlier research showed that CBSG members were more likely to use CMW services than non members. We have talked about some of the reasons why that might be so. Can you think of any other reasons why that might be so?

Thank you for your time.
END INTERVIEW. RECORD TIME.

Instrument 7 – Interview CBSG Chitral staff – Draft

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

Special Instructions: Record specific anecdotes and accompany them by photographs if possible. In particular, look for cases where CBSG members were empowered or encouraged to use MNCH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MCNH services.

"I am _____. I am doing helping to deepen some of the research done earlier by the Aga Khan Foundation about how women use maternal and child health services and how that relates to CBSG membership. I' d like to ask you a few questions about this. May I begin?

Why are many women not members of CBSGs?

What sort of women are not members?
[Determine if it is because they haven’ t been asked, don’ t choose to join, or are thought to be unable to join. If some women are unable to join, determine why.]

What do you think is the principal difference between women who are CBSG members, than women who are not members of CBSGs?

Can non members eventually become members?

All things being equal, is a CBSG member more likely to use CMW services than a non member?
IF YES: Why is that?

We have talked to some CBSG members about how they finance MNCH services, and we’ d like to hear your point of view also. The RAF research identified these sources of finance:

Husband, Self, CBSG, other loan, Other sources

Hand cards to respondent. Would you please put these in order from what you think is the most important source to the least important source?

Some sources suggest that belonging to a group encourages people to try new things and to take risks. Have you ever experienced cases where women were encouraged or supported by their groups to try new things that they would not have done otherwise? (Record up to three things)

1
2
3
Reports suggest that CBSG members were more likely to receive BCC messages than non members. Do you think that is so?
Why is that?

When you talk to CBSGs, do you mention CMWs?

A lot
Some
Rarely or never

Are there other reasons that you know of why CBSG members would be more likely to use CMWs?

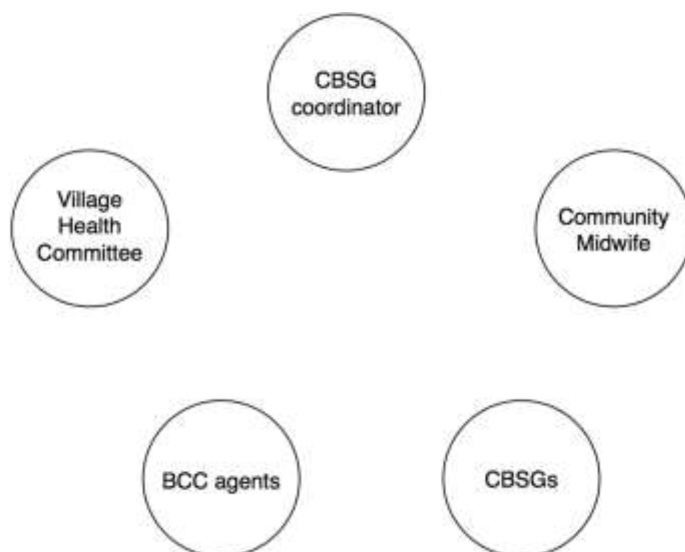
What is your opinion of the general health of the CBSGs? Please provide reasons for that opinion.

According to you, what percentage of the CBSGs do you think are:

Strong and growing
Essentially stable
Losing members, or in difficulty?
Inactive

We would like to understand how you and the different entities communicate and work together…

USE SMALL OBJECTS, OR DRAW ON A PIECE OF PAPER, TO REPRESENT THE DIFFERENT ACTORS IN THE COMMUNITY:



Are there any other key actors that should be represented? IF SO ADD THEM. Please think about the amount of time you spend talking, writing, phoning or otherwise communicating directly with these different entities.

Among all these entities, which one do you communicate with the most? ________ And how do you communicate with them?

And the second most? ________________
And how do you communicate with them?

And the third most? ________________
And how do you communicate with the them?

Can you tell me one or two success stories, good things for maternal and child health that would not have happened before the CCSP that have happened because of it? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

Thank you for your time.
REMEMBER TO RECORD TIME ENDED.

Instrument 8 – Interview Village Health Committees

Researcher(s)	
Respondent(s)	
Location	
Date	
Time begun	
Time ended	

Special Instructions: Record specific anecdotes and accompany them by photographs if possible. In particular, look for cases where CBSG members were empowered or encouraged to use MNCH services because they were members of the group, where members got information or tips about MNCH from other members, and where being in a CBSG enabled members to find or use other financing for MCNH services. Look for remarks that illustrate different attitudes towards CBSG members and non-members.

"I am _____. I am doing helping to deepen some of the research done earlier by the Aga Khan Foundation about how women use maternal and child health services and how that relates to CBSG membership. I' d like to ask you a few questions about this. May I begin?

Would you please tell me the history of your committee?
[record date of creation, changes in membership, salient events in the VHC' s history]

Would you please review for me the responsibilities and activities of the Village Health Committee?

We are interested in hearing your point of view on CBSGs and CMWs. To begin with, why are many women not members of CBSGs?

What sort of women are not members?
[Determine if it is because they haven' t been asked, don' t choose to join, or are thought to be unable to join. If some women are unable to join, determine why.]

What do you think is the principal difference between women who are CBSG members, than women who are not members of CBSGs?

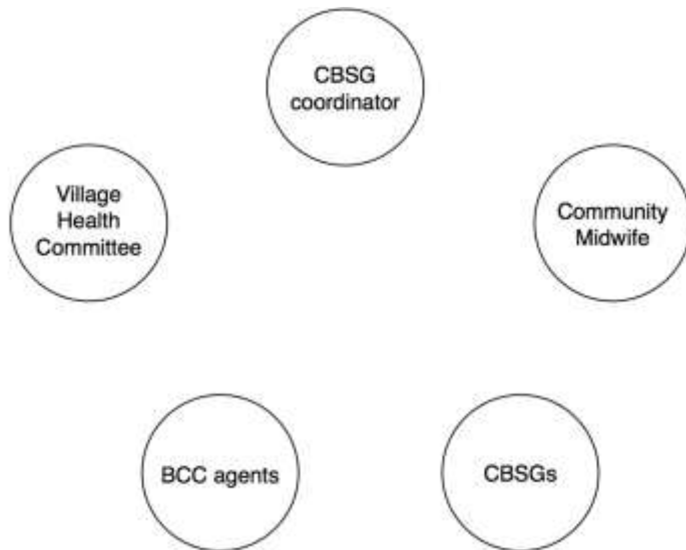
Is it different working with women who are CBSG members, than women who are not members of CBSGs?

IF YES: How is it different?

All things being equal, is a CBSG member more likely to use CMW services than a non member?
IF YES: Why is that?

We would like to understand how you and the different entities communicate and work together...

USE SMALL OBJECTS, OR DRAW ON A PIECE OF PAPER, TO REPRESENT THE DIFFERENT ACTORS IN THE COMMUNITY:



Are there any other key actors who should be represented? IF SO ADD THEM. Please think about the amount of time you spend talking, writing, phoning or otherwise communicating directly with these different entities.

Among all these entities, which one do you communicate with the most? ________ And how do you communicate with them?

And the second most? ________________
And how do you communicate with them?

And the third most? ________________
And how do you communicate with the them?

Can you tell me one or two success stories, good things for maternal and child health that would not have happened before the CCSP that have happened because of it? [DOCUMENT THIS, AND TAKE PHOTO IF POSSIBLE]

And how can you build on these successes?

Have you made special efforts to deliver messages to CBSG members?
IF YES: What did you do?

Reports suggest that CBSG members were more likely to receive BCC messages than non members. Do you think that is so?
Why is that?

Are there other reasons that you know of why CBSG members would be more likely to use CMWs?

Thank you for your time.
END INTERVIEW. RECORD TIME.

Instrument 9 – CBSG Data Collection Form

<table>
<tr><td>Researcher(s)</td><td colspan="2"></td></tr>
<tr><td colspan="3">How were data collected? Specify how many people, and positions</td></tr>
<tr><td></td><td>Attended group meeting</td><td>Yes No</td></tr>
<tr><td></td><td>Spoke with group officers (specify)</td><td>Yes No</td></tr>
<tr><td></td><td>Spoke with group members (specify)</td><td>Yes No</td></tr>
<tr><td></td><td>Spoke with third parties (specify)</td><td>Yes No</td></tr>
<tr><td>Location</td><td colspan="2"></td></tr>
<tr><td>Date</td><td colspan="2"></td></tr>
<tr><td>Time begun</td><td colspan="2"></td></tr>
<tr><td>Time ended</td><td colspan="2"></td></tr>
</table>

1	Name of Group (Verify that this is a group in the MIS for the village in question, and if not, please resolve)	
2	Group Number (Group may not know. If not, take from MIS)	
3	Does this group have a savings account in the group's name?	Yes No
4	When was the group formed? (date)	
5	Have you shared out?	Yes No
6	IF YES: How many times in all, since you first started saving?	
7	IF YES: When was your **most recent** share out? (date)	

8	Please tell me the total amount that the group shared out at the most recent share out.	
9	How many members did you have at the time of the most recent share out?	
10	How many members are there today?	
11	…Of those, how many are women?	
12	…And how many are men [verify that totals agree]	
13	[If group has not shared out within the preceding 12 months, ask:] I notice that it is over a year since you last shared out. Why is this?	
14	Thinking back to the **most recent meeting** of the CBSG, when was that? (date)	
15	And thinking back to that meeting, how many people were physically present?	
16	And how many people saved, including people who were not present but who sent their savings in to the group?	
17	And have any members left the group since the share out? How many? Reasons? [For each member who has left, specify reason: moved, death, illness, lost interest, forced out by group, other	
18	Do you know how many loans for Maternal, Newborn and Child Health there are outstanding?	
19	Does your group have a social fund?	Yes No
20	IF YES: And could you tell me how many members are using the social fund for Maternal, Newborn and Child Health?	
21	Other information about group health. Important events if any.	

Annex C: Field reports

A. Barum

Summary	
Social Mobiliser	Hajia Hussain
CBSG Supervisor	Tajun Nisa
Status	Non-Traditional
CBSGs	6

1.1 CBSG Aghyun

The group was formed in June 24, 2011 with an initial membership of 19 ladies. Now the membership reduced to 10 as three of the members got married and moved to other villages while the others were not regular to meeting and could not afford the monthly savings. No such events were organized by the group.

The group is aware of only two CBSGs in the village and this group did not meet with other groups. It was reported that there are women in the village who are not members of CBSG because they could not afford the monthly savings. They have been asked to join but they told that whenever they would be able to afford the monthly saving they will join the CBSG.

No case reported for any loan taking among the group.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group reported this CBSG is a new concept in this village and no one has asked for any loan yet. The group reported that they do not know how to utilize the CBSG savings.

The group is full aware of the CMW and her services. They all have visited her office and know where she lives.

The group reported almost all the women in the village are likely to avail the CMW services. It was reported that CMW have visited this CBSG so many time.

It was observed that the concept of CBSG and its purpose is not clear to the members. They feel that they cannot increase the monthly savings from Rs. 50 and they do not know how to utilize the savings. It was also reported that these 10 members are relatively better off than other women in the villages that's why this could also be the factor that no one has yet taken loan from the CBSG.

1.1.1 CBSG Dowlasht

The group was formed in June 04, 2011 with an initial membership of 16. Current membership of group is 14 (one got married and another women was not regular in meetings). The group did not organize any salient event.

The group is aware of four CBSGs in the village. The group claimed to meet other CBSGs sometimes and updates each other about the status of their savings.

It was reported that there are women in the village who are not members of CBSGs. Those women were asked to join CBSGs but they said that they are not allowed to go out of their homes from their family/husbands.

The group was organized into sub groups and asked individually if they have taken loan. The responses are as follows:

"I was sick and planned to visit a doctor in District headquarter hospital Chitral. I was having Rs. 3000 in my pocket but it was not enough to cover the transport expense and my treatment. I took Rs. 1000 loan from CBSG and went to Chitral town for treatment", Ms. Zaina.

"I took Rs. 600 loan from CBSG and Rs. 500 from my father and paid my admission fees for class 10", Ms. Nazia, a young CBSG member.

"I took Rs. 4,000 loan from CBSG and spent in my brother's marriage", Ms. Sakina.

"I took Rs. 4,000 loan from CBSG and spent Rs. 2,000 for my treatment as I was suffering from Malaria. I spent Rs. 2000 to buy shoes for my children". Ms. Fatikha.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group is fully aware of the CMW and her services. They all met her in her office and knew her name. It was reported that CMW regularly visits this CBSG.

It was reported that all women whether CBSG member or non-member are likely to use CMW services.

It was reported that CMW is the only service provider in the village and she is accessible to them at any time. The members reported that she never denies coming at their door steps even if she is called at mid night.

It was observed that CBSG members seemed quite happy about the CMW services.

1.2 CBSG Dashmanandeh

The group was formed in November 2012 with an initial membership of 18 women. The current membership is 16 as two of the women dropped out with a reason that they were being superstitious that working with this CBSG increased illness in their family. No such event organized by this CBSG. The group is aware of four other CBSGs in the village but this group did not met with any of the other CBSGs.

It was reported that there are women in the village who are not members of CBSG and they were asked to join but they refused by giving the reason that they are not allowed by their parents/husbands to go out of their homes. The group believes that the women are willing to join but they could get permission from their homes.

The group was further divided into sub group and asked individually if they have taken loans. Only one members, Ms. Zulhaja reported that she took Rs. 1000 loan from CBSG and helped her husband to promote his business.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group is fully aware of the CMW and her services and every member has visited her office. They all know where she lives and what her name is. The group reported that CMW has never visited this CBSG.

It was reported that all the women (CBSG members and non-member) are likely to use CMW services.

1.4 Village Health Committee

The VHC was formed in April 2012 with an initial membership of four men. It was reported that after sometime VHC noticed that there should be a women member in the committee so that she can have better access to the women. VHC included on Lady Health Worker in the committee and the current membership is five (one women). VHC claimed to organize awareness program in the village with the support of AKRSP. VHC feel itself responsible for the following:

- Mobilize community on MNCH and CMW services
- Facilitates refers MNCH cases by CMW

It was reported that there are women who are not member of CBSG. Those women are either culturally bound to go out of their homes or there is less acceptance of AKDN in that area.

The principal difference between CBSG members and non-members is that CBSG members have access to saving and they get chance to discuss so many things during CBSG meeting. CBSG members are more sensitized towards MNCH cases and other health issues.

VHC believes that it is different working with CBSG members than nonmembers because it becomes easy for deliver message to CBSG members as they are more sensitized.

All things being equal CBSG member are more likely to use CMW services than non-members because they are linked with each other and VHC regularly tells CBSG members about CMW services.

Among all entities VHC mostly communicate with CBSGs via meeting about their savings status and CMW services. At the second most, VHC communicates with CMW via meeting about MNCH cases in the village. At third most, VHC communicates with

CBSG supervisor via meeting about CBSG savings status and mobilizing members on MNCH cases.

"Mrs. Wiqar was referred by CMW to hospital for delivery. Her case was complicated. CMW called the VHC and one of the VHC member drove her to AKSHP maternity home Booni with free of cost. It could have been disaster if there had not been CMW and VHC in the village", Mr. Nasir, VHC Chairman.

VHC believes that CBSG members were more likely to receive BCC messages and use CMW services because CBSG members feels themselves responsible and majority of the CBSG members are educated. VHC also believes that CBSG provides a plate form to sensitize women on MNCH cases.

VHC suggest AKDN to support the CMW in terms of more advanced training and continuation of her salary. It was also suggested to increase the salary of the CBSG supervisor as she plays a vital role in mobilizing CBSG members and other women in the village.

1.5 CBSG supervisor

CBSG supervisor was not available in the village during the study.

1.6 CMW

It was reported that CMW recently got married out of the village and the villagers are doubt if she will carry her services in the village or not.

1.7 Delivered lady, Shahre Gul

She reported that she was a member of CBSG but she moved to her father's home and lived there for a long time that's why she did not continue her membership in the CBSG. She also reported that she heard that the CBSG discontinued for after sometime it was restarted but no one asked her to join the group.

She is aware of the CMW in the village and fully aware of her services. She has visited her office once after delivery. She reported that CMW registers every pregnant lady in her register and regular visits them. She reported that CMW also came to visit her when she was pregnant but told her that she should regularly come to CMW office for ANC.

Ms. Shahregul reported that during pregnancy she moved to her father’ s home which is away from Barum and got delivered over there without any assistance of any health service provider. She did not visit any health facility for PNC.

She said that she is planning to join CBSG because she feels that she can have access to CBSG finance at the time of emergency.

1.8 Delivered lady, Ms. Zulhaja

She is member of CBSG and fully aware of CMW and her services. She has met the CMW when she got pregnant. The CMW asked her that she needs regular check and she should come to her office for ANC but she could not get permission from her husband to go out of home and avail CMW services. She reported that she got delivered at home without any assistance of CMW or other health service provider because her husband is very conservative and does not allow her to avail any services regarding delivery.

She reported that CMW did visit her during pregnancy and she shared her plan with CMW to visit any health facility but was not able to get permission from her husband to go out and meet any service provider.

B. Morder

Summary	
Social Mobiliser	Hajia Hussain
CBSG Supervisor	Sifat Bibi
Status	Traditional
CBSGs	11

1.3 CBSG Chashmebddur

The group was formed in September 2010 with an initial membership of 16 and now the members have reduced to 10 (3 died, 2 got married and moved to other village and one migrated to another village). No such salient event organized by the group. The group is aware five other CBSGs in Morder but did not meet with other CBSG because they did not feel any need to them. It was reported that there are women in the village who are not members of CBSG because majority of them are members in

other AKDN supported WOs (women organization) and cannot afford savings in two groups.

The group was divided into sub group and asked them about if they have taken loan from CBSG. Three of the members told that they have taken loan ranging from Rs. 1500 to 3000 for their children school fees.

One case reported for a member who was encouraged to by the group to open a ladies shop. The group reported that she discussed with the group members that she planned to open a ladies shop. All the members encouraged her and told her that she must start the business. It was reported that she started that business two months ago and now she is earning good profit. It was reported that following that member there are other members who are planning to start business.

It was reported that all the members are fully aware of the CMW in Morder and they know about her services. They all have visited her office and CMW has also visit this CBSG.

The group believes that CBSG members are more likely to use CMW member than women not in CBSG because of the following reason:

- She is the nearest health facility in Morder.
- She is easily accessible without any transportation cost.

The members are more optimistic about their CBSGs future. It was reported that now they are well managing their savings and they are planning to increase their monthly savings.

1.4 CBSG Khushal

The group was formed inJune 07, 2010 with an initial membership of 18 and the membership increased to 33 after sometime. It was reported that with the passage of time the membership again reduced to 18 from 33. The reason for decrease was reported that the women were busy in household chores and could give time to CBSG. No such salient event organized by the group. The group is aware of five other groups in Morder but did not meet with other CBSG without any reason.

It was reported that there are women who are not members of CBSG because they gave the reason that interest on loan is forbidden in Islam that's why they do not want to be part of a group which works on interest.

The group was organized into sub groups and asked if they have taken loan from CBSGs. Majority of the women reported that they took loan for their children education. Some of them took loan and bought food items for home. One lady reported that she took Rs. 2000 and bought fodder for their livestock. One of the lady among the group reported that she took Rs. 30,000 from CBSG and constructed her home. Another lady told that she took Rs. 13,000 loan from CBSG and spent on her son's wedding.

"I feel secure that I can have access to CBSG finance at any time", Ms. Shahpari, CBSG member.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

It was reported that one of the member gave an idea to give the savings to a shopkeeper so that he can invest on business on profit/loss basis. The idea is under consideration but the group has not come to a conclusion yet.

The group is aware of the CMW and her services. They all claimed to meet her in her office and know her name. It was also reported that CMW did visits their CBSG.

It was reported that not only CBSG member, other women in the village are likely to use the CMW services and the reason is given below:

- Travel cost reduced as compared to other health facility
- Easily accessible and near to their homes
- She provides services on credit

The members of this CBSG are very optimistic about their CBSG future. They reported that they saved Rs. 100,000 in 2012 and did share out.

1.5 CBSG Soni

The group was formed in September 2011with an initial membership of 25 women. Now the membership reduced to 21because three of the ladies could not afford the savings in two groups as they are part of WOs No salient event organized reported by the group. The group is ware of six other CBSGs in Morder but did not meet with other CBSGs without any reason. It was reported that there are women who are not members of CBSG and majority of them are illiterate and aged women.

The group was divided into sub groups and asked if they have taken loan. The responses were as follows:

Two of the women reported that they took loan worth Rs. 2000-2500 from CBSG and paid their children education. One woman reported that she took Rs. 2,000 and paid her children school fee. One of the lady reported that she took loan worth Rs. 7000 in 2012 and bought food stock for winter.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group is fully aware of the CMW in Morder and every one reported that they have visited her office and met her. They also reported that CMW visits their CBSG.

The group reported that CBSGs members are more like to use CMW services because of the following reason:

- CBSGs are well aware of health issues.
- CBSG are well aware of CMW services.

The group is optimistic about their CBSG future. They compare their group with WO and feels that CBSG finance is very easily accessible than WO finance.

Funding from CBSG	Ms. Saira took Rs. 2500 from CBSG and 6500 from her husband and paid her delivery expenses to AKSHP maternity home Booni. Ms. Shamim took Rs. 4,000 from CBSG and paid CMW ANC fee and also went to AKHSP maternity home Booni for delivery (referred by CMW) "I took Rs. 4,000 loan from CBSG and paid ANC fees

Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.5 Village Health Committee

The committee was formed in August, 2011 with an initial membership of nine. Now the membership has increased to 10. No such salient event organized by this VHC. This VHC feels itself responsible for:

- Supporting CMW in smooth implementation of her activities
- Health awareness to women
- Monitoring the performance of the CMW

It was reported that there are women who are not member of the CBSG and mostly they are not that social and mostly busy in household chores. They were asked to join CBSG but they denied with a reason that they would not be able to give time to CBSG.

The principal difference between CBSG members and no member is that CBSG members are more matured, responsible and age ladies.

VHC believes that not only CBSG members but other women in the village are likely to use CMW service. "Before this program we have to walk two hours to reach health facility especially for MNCH cases and now it is at our door step in form this CMW", Ms. Bibi Hawa, VHC member.

Among all entities, VHC communicates mostly with CMW via meeting about her performance and CBSG savings. At second most, VHC communicates with CBSG supervisor via meeting about CBSG savings. At third most, VHC communicates with CBSG via meeting about their status if they are functioning well and also facilitates them to promote those CBSGs who are struggling.

VHC told that holding meeting with CBSG is a special effort to deliver message to CBSG members. This helps to disseminate the message quickly within the village. The CBSG members also disseminate the message to those women who miss the meetings.

VHC believes that it is not necessary that only CBSG members were more likely to receive BCC message rather VHC believes that all the women who attend the awareness program are likely to receive BCC messages.

This VHC is more optimistic about the future of CBSG. It was reported that CBSG members can have access to finance at any time. They share out and can see their money visually.

1.7 CBSG supervisor

She report that there are women who are not member of CBSG and among them majority are illiterate and they feel that interest is forbidden in Islam. She also reported that some of the non-members had worse experience in saving money in

former Women Organizations that's why they do not want to take risk while working with CBSG. She reported that these members have been asked to join CBSG but they refused with the aforementioned reasons and she also feels that they would eventually become members by observing the good work of CBSGs.

All things being equal, she believes that CBSG members are more likely to use CMW services than non-members because they have attended so many awareness sessions and are more aware than non-members.

According to her, the most important source of CBSG members to finance MNCH cases is as follows (starting from the most important to least important):

1. Husband
2. CBSG
3. Self

No case reported for getting encouragement from the group to try new things and to take risks. She believes that CBSG members are more likely to receive BCC messages than non-members as they attend CBSG meeting and gets opportunity to educate themselves.

She said that she talks a lot about CMW when she meets with CBSGs. She believes that CBSG members have an easy access to CMW that's why they are more likely use CMW services.

According to her CBSG are in good health and she rated the CBSG bellows:

1. Strong and growing: 54%
2. Essentially stable: 23%
3. Losing members, or in difficulty: 23%

Among all entities, CBSG supervisor mostly communicates with CBSGs via meeting about their savings status. At second most, she communicates with AKRSP social mobilizer via telephone about CBSG health and at third most, she communicates with VHC via meeting about CMW services and about her clients (MNCH).

Funding from CBSG	Ms. Gulshan took Rs. 5,000 and went to AKSHP maternity home Booni and got delivered.

Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.6 CMW

She started working in Morder in June 2011 and handled the following case so fare:

- Deliveries: 20
- ANC: 45
- PNC: 250

She also reported that there are many case other than maternity she has handled e.g women and children come to avail her services for pharmacy, fewer, disease specific to women, headache etc. She does not remember the exact amount of those clients.

She said that the amount of deliveries and other clients have exceeded her expectation and their number is increasing. She said that the amount of payment she has received was less than what she has expected and the amount of the payment she is receiving is staying about the same.

The services she offers other than maternity is pharmacy, blood pressure checkup, general checkup, etc. She reported that people pay for her services and she is optimistic about her future. She feels that she needs some more advanced training so that she can promote her work.

She is aware of 10 CBSGs in Morder and she feels that CBSG are very important source of referrals and clients. She reported that she tried to find new clients through:

- Going to CBSGs and talk to them
- Talk to people door to door
- Work with/or rely on VHC

She reported that she is a member of CBSG and attends other CBSGs meeting and tell them about her services. According to her women finance MNCH services from the following sources (form most important source to least):

1. CBSG
2. Self
3. Husband

She reported that no one among her clients have told her about their strategies to find money to pay her when they do not have enough money.

She said that about 60% of her clients are CBSG members and she feels that it is different working with CBSG members than non-members because CBSG members give full attention and are fully aware, and CBSG members are more likely to avail her services.

Among all entities, she communicates with VHC via phone and meeting about her clients and also recovery of her dues from CBSG members. At second most, she

communicates with CBSG supervisor via meeting/phone for linking her clients with her and at third most, she communicate with CBSGs via meeting about their saving status and also conducts session with them on health education.

1.9 Delivered lady, Nusrat

She is not member of CBSG but aware of only one CBSG in the village. She reported that no one has ever invited her to join any CBSG. She is fully aware of the CMW and her services. She has spent Rs. 900 for ANC from other health service provider out of the village and paid Rs. 2000 to this CMW for delivery. All the expenses were covered by her husband. She did not meet any health facility for PNC and nor discussed with any one.

1.10 Delivered lady, Sajida

She reported that she is not member of CBSG but her mother in law is CBSG member and she is aware of CBSGs in the Morder. She reported that she is fully aware of the CMW and knew where her office is located. She reported that she does not have a chance to meet the CMW as Ms. Sajida mostly spent time in her mother' s home in Torkhow valley which is out of the village Morder. She reported that she use to avail ANC services in AKHSP health centre Torkhow (Shahgram) and was delivered in AKHSP maternity home Booni and spent lump sum amount of Rs. 10,000 which was paid by her father in law. She did not avail any health facility for PNC.

C. Mori

Summary	
Social Mobiliser	Sartaj Gul
CBSG Supervisor	Samina +Madiha
Status	Non-Traditional
CBSGs	26

1.6 CBSG Pehchan

The group was formed in October 25, 2012 with an initial membership of 15 women. Three members were dropped out (one member got married and moved to another village and two members did not attend any meeting since they registered). The group has not organized any salient event. The members did not know or aware of

any other CBSGs in their village Mori. It was reported that aged women are not members of CBSG and those nonmembers have never been invited to join the CBSG.

During the discussion, only two members in the group reported that they have taken loan. One member reported that she took loan for PNC while another woman said that she took Rs. 500 from CBSG and took her child to nearest BHU when her child suffered from Diarrhea.

No case reported for any new project undertaken by CBSG members by learning from other members or any encouragement from the group to initiate any new project.

The group is aware of the CMW but no one has visited her office because she lives far away from this CBSG. They reported that her office and home is far away from the village and she had never come to their meetings. It was reported that she invited this CBSG members once to her village in an event on Health education.

Funding from CBSG	Rashida took Rs. 1000 loan from CBSG and spent the money on PNC.
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	

Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.7 CBSG K-3

This group was formed in May 25, 2010 with an initial membership of 18 and now it has reduced to 12 members (mostly young girls under age of 25). Among the dropped out women, some of them got married out of the village while other members were aged and they were not interested to continue without any reason. The group reported that they have not organized any event.

It was reported that the group is not aware of any other CBSG in the village.
There are women who are not members of this CBSG and majority of them are aged ladies. Those ladies were asked to join but they refused. From the discussion it was observed that the concept and objective of a CBSG was not clear to them and those nonmembers were expecting some incentives from AKRSP in terms of money.

ASK 3 O' CLOCK

One of the young CBSG members reported that she took Rs. 1000 loan from CBSG and paid her college fees.

ASK 9 O' CLOCK

One young lady reported that she took Rs. 1000 loan from CBSG and bought new shoes for Eid occasion.

ASK NOON

One case reported that she took Rs.1000 loan from CBSG and paid her college admission fees.

No case reported for any purchases out of fund from their home saving by knowing the group to fall back on in an emergency or taking any new project by learning from CBSG members.

Ms. Azra reported that she was confused and remained undecided whether to continue her studies or not. She discussed with the CBSG members during the monthly meeting. All the members suggested her to continue studies. She took Rs. 1000 loan from the CBSG and did her admission in a college. She feels that the group gave her courage and influences her decision otherwise she could have given up her studies.

The group is aware of the CMW and knows where she lives and what services she provides but reported that no one from the group has ever visited CMW officer and she does not have bothered to visit this CBSG. The reason for not visiting her office is that most of the girls are young and unmarried.

The group plans to increase its monthly saving from Rs. 10 to Rs. 20 and reported that in this way they could have access to more finance and can get benefited from the group.

Funding from CBSG	
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	

Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	The group is planning to increase its monthly saving per member from Rs. 10 to Rs. 20.
Other	

1.3 CBSG Sultankhail

The group was formed in March 2011 with an initial membership of 12 and now it has reduced to 11 (one member got married out of village). No such event was organized by the group. This is group is not aware of any other CBSGS in the surrounding/village.

The group believes that almost all the women in the village are members of the CBSG.

ASK 3 O' CLOCK

One of the lady reported that she took Rs. 3000 for her children education.

ASK 9 O' CLOCK

One lady said that she took Rs. 1000 loan from CBSG for her son college fee. The total fee was Rs. 2000 and she was short of money that' s why she took Rs. 1000 from CBSG. She said that she cannot ask any shopkeeper for loan as she feels it is not culturally look good.

The other group members said that they have not taken loan but they will take from CBSG if required.

No case reported for any purchases out of fund from their home saving by knowing the group to fall back on in an emergency or taking any new project by learning from CBSG members.

The group reported that everyone is aware of the CMW and they know about her services. They reported that she has come to visit the CBSG member and told everyone about her services and welcomed them to her office for any MNCH and other health related services. The group says that she has offered her services in office as well as door to door if she is called for maternity or other health related services. The group reported that majority of the members are in mid age and have stopped giving birth to babies that why they have not gone to CMW office. The group believes that they have noticed that women from other villages access to CMW for MNCH cases no matter if they are CBSG members or not.

The group reported that they are planning to increase the monthly saving from Rs. 10 to Rs. 50 and they will use the savings to attract funds from other organization to extend the village jeep able link road.

1.4 Village Health Committee

The Village committee was formed in 2009 with an initial membership of 7 men and currently there are 17 members. The reason for increase in membership was to give more coverage to different villages. This VHC has not conducted any event. The VHC feels its self-responsible to facilitate any MNCH cases in the village and to solve other health related issues in the village.

The VHC members are all men and they cannot have access to women CBSGs as it is not culturally acceptable in their area that' s why VHC does not access to CBSG members or meeting.

VHC mostly communicate with CMW via meeting for MNCH cases in the area and also for any disease outbreak. In the second most, VHV communicates with CBSG supervisor via meeting about CMW services. VHC only gets updates about the CBSGs from CBSG supervisor. At third most VHC communicates with BCC agent/male motivator via meeting about MNCH cases. It was reported that BCC agent gets help from VHC to meet the husband of pregnant ladies in the village to make them aware.

VHC reported that there have not been any complication with women on MNCH and this credits goes to CCSP. Before this program, a lady in the village died because her blood pressure shot up and there was no one to give her first aid. She was taken to

District Headquarter Hospital Chitral but she expired on half way before reaching to hospital.

1.8 CBSG supervisor

She reported that conservative and illiterate women are not members of CBSGs. They always believe that working with AKDN is not acceptable religiously. She believes that not only CBSG members but almost every lady is like to use CMW services if required any health services. From the supervisor' s point of view, CBSG members finance MNCH cases in the following order:

1. Husband
2. Self

She said that the CBSGs are newly formed (one year ago) and their savings are not that much that they use them for MNCH cases.

She is not aware of any case where a CBSG member encouraged people to try now things or risks. She strongly believes that CBSG are more likely to receive BCC messages than non members because CBSG members are part of the program and very well aware. She claims to mention CMW a lot when she meets with CBSGs. She believes that CBSG members are likely to use CMW services because CBSG members own the Program and feel CMW as part of them.

She said that CBSGs are in good health. Almost 38% are strong and growing and 38% are essentially stable and 25% are losing members, or in difficulty. No case reported for any inactive CBSGs.

CBSG supervisor claims that she communicates with CMW at most via meeting about CBSGs memberships and savings. At second most she meets with CBSGs about their savings and at third most she communicates with AKRSP social mobilizer about the status of CBSGs in her area.

No success story was reported about MNCH case.

1.6 CMW

It was reported that CMW has been working in Mori in July 24, 2011 and delivered 12 ladies until now. She has provided services to 21 ladies on ANC and 32 ladies for PNC. Apart from that, she has provided services to 670 ladies related to other health services.

She said that the amount of deliveries and clients are less than what she has expected because there is AKSHP health center, government Rural Health center and basic health unit in Mori that' s why only she has been able to attract few clients. Apart from that she said that there are other service providers (medical technicians) in the village as well. She also believes that her clients and deliveries are increasing with the passage of time. She claims to gain the trust of people as she feels that in the beginning people thought that she is young and inexperienced but now their perception is changing. She said that apart from diarrhea and deliveries cases only few clients pay for her services as there is no culture of paying to local service providers in the area. She reported that the amount of payment she had received was less than her expectation. "Women do not pay for ANC, PNC and blood pressure check-up. They say that I am local and their daughter", and she accepts this as it is the culture. She provides services on MNCH cases, first aid to diarrhea, blood pressure checkup, handle and referrers pneumonia cases. She reported that she is pessimistic about her future. AKHSP did not pay her salary for some time as she did not perform well in the beginning. This could also be the reason that she reported that she is pessimistic and she was expecting financial benefit from AKHSP. She claimed that she is aware of 10 CBSGs in Mori but It was noticed that CMW is only aware of the CBSGs which are near to her home but geographical Mori is scattered area and it takes at least two hour for women to walk across the river and reach other villages.

She said that she use to talk to people door to door to find new clients and also goes to CBSG meetings. She also talks to religious leaders and asks them to motivate people to be conscious about MNCH cases.

CMW is a member CBSG and attends nearby CBSGs meetings to talk about her services. She has observed that for majority MNCH cases the expenditure is covered in the following order:

1. Husbands
2. Self
3. CBSG

She reported that her clients avails her services on credit when they do not have enough money to pay her fees and pay backs to her after two months. 15% percent of her clients were CBSG members. The reason for low turnover was that majority of CBSG members are both young and unmarried or have stopped giving birth to children.

She reported that the CBSGs who are near to her home are more likely to use her services while others prefer to access AKSHP health center or RHC/BHU which are

nearer to them. The reason for CBSGs members are more likely to come to CMW is that they are more aware.

CMW communicates with VHC via meeting about MNCH cases in the village who do not come to her office to avail her services. At second most she communicates with CBSG supervisor via meeting and telephonic on health education to CBSG members. At third most, she communicates with CBSGs via meeting on health awareness education.

1.5 Delivered lady, Qanita bibi

She is not member of any CBSG but she is aware of the CBSGs. She said that she has not been invited from any CBSG because the group members know that her husband will not allow her to go out of her home for any meetings. She also said that she does not need any loan from anywhere that why she does not want to join CBSG.

She reported that she knows the CMW very well and whenever she needs her services she calls her. She said that she has not been to CMW office because her husband does not allow her to go out. She has availed CMW services for ANC, PNC and she was delivered by her. She paid Rs. 1700 to CMW for delivery and Rs. 260 for PNC. She said that she has also consulted a lady doctor during pregnancy referred by the CMW.

1.6 Delivered lady, Zuhra Bano

Ms. Zuhra is not a member of CBSG but she knows CMW very well and fully aware of her services and the charges. She claims that she has visit her office and delivered by her. She has availed ANC, delivery and PNC services of the CMW and paid her Rs. 600 in total.

She reported that her family keeps enough money at home for any emergency that's why she does not need to join any CBSG and does not have any plan to join CBSG in future.

D. Gobore

Summary	
Social Mobiliser	Sartaj Gul
CBSG Supervisor	Shazia Raheem
Status	Non-Traditional

CBSGs	11

1.8 CBSG Chambeli

The group was formed in 2010 with an initial membership of 25 ladies. It was reported that the current membership is 30 and the reason for increasing membership is that the more the membership is the more benefit they get from the CBSG. "This CBSG is our local bank in our village", Ms Mirza, CBSG member. The group did not organize any salient event in its history.

The group was aware of three other CBSGs in the village but they did not meet with other CBSGs as there had been no need rise to meet them. The group reported that almost all the women in the village are members of the CBSG accept 1% women who not in child bearing age (either old or young and unmarried). These ladies were asked to join the group but in the beginning they denied to join and now this group reported that now they are getting verbal applications to join the group.

Majority of the women reported that they took loan from CBSG ranging from 1,000 to 3,000 and bought wool to make yarn for business purpose. Some of the ladies in the group reported that they took Rs. 1000 loan from CBSG to see the CMW for ANC and general checkup.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or any encouragement from the group members.

The group reported that every member in the CBSG is aware of the CMW, her services, charges and they all have visited her office. The group reported that CBSG members are more likely to use CMW services because of the following reasons in order below:

1. CBSG members are more literate towards health and MNCH cases
2. They trust the CMW skills and expertise
3. They have access to CBSG finance

The group also reported that apart from CBSG members, almost every women in the village or outside the village are likely to use CMW services as she is the only service provider who give services at door step whenever called.

Funding from CBSG	"I took loan Rs. 1000 from CBSG and regularly visiting CMW for ANC" , Ms. Misrat, CBSG members
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.9 CBSG Nargis

The group was formed in August 08, 2012 with an initial membership of 24 members and remained the same since the time of formation. The group reported that they are not aware of the any other CBSGs in the village (which is the most remote village with a CBSG in Chitral). It was reported that there are women in the village who are not member of CBSG and the reason for them not being member was reported that they are busy at household chores. The group has attended AKSHP organized events in the village but it has not organized any event.

During the discussion, the group was organized into three groups and asked if they have taken loan. Only one lady among the group reported that she took loan Rs. 10,000 for house construction.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or any encouragement from the group members.

The group is fully aware of the CMW and her services. It was reported that they all have met her but never visited her office as she lives far away from this village, Gobore Bakh (which is one of the remote villages of Chitral sharing borders with Badakshan province of Afghanistan). The group also reported that mostly pregnant ladies in the village have visited her office.

It was reported that CBSG members as well as other women in the village are likely to use CMW services. Every pregnant women in the village calls her services for ANC and delivery.

1.10CBSG Thufan/Shaheen

It was reported that the old name of this CBSG was Thufan and now they members have changed its name to Shaheen.

The group was formed in May 2012 with membership of 20 ladies. The current membership is still 20. The group did not report any salient events organized by the group. It was reported that the group is aware of nine CBSGs in the village. This group claims to meet other two groups who are geographically near to this village. The groups mostly share their experiences about the benefits they take from CBSGs.

It was reported that only two women in the villages are not member of the CBSG. These non-members asked to join but they refused that they do not need any finance as they are well off to afford their health expenditures.

The group was organized into three sub groups and asked about if they have taken loan. Different responses are recorded below:

"I took loan Rs. 2500 from CBSG and spent 1,000 for ANC and Rs. 1500 on delivery", Ms. Gulnazir

"I took loan Rs. 1,000 from CBSG and did treatment for kidney pain", Ms. Bibi jan

"I took loan Rs. 1500 from CBSG and did my treatment for joints pain from District Headquarter Hospital Chitral", Ms. Zainab

"I took Rs. 1500 and paid my son's school fees", Ms. Gulthan

I took Rs. 1,000 and paid my son's school fees", Ms. Jamal

"I took Rs. 800 and paid my daughter's school fees", Ms. Zarnisa

"I took Rs. 1500 and to bear the expenses of my mother in law eye diseases treatment", Ms. Karima

"I took Rs. 1,000 from CBSG and paid my daughter's school fees", Ms. Fatima

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members.

The group told the story of Ms.Samina whose mother discussed the issue of her admission with the CBSG members. She was not having money to pay her admission fees for 11 class and planned to stop her education. The CBSG members encouraged her to continue her daughter's education and also facilitated her in getting loan worth Rs. 3,000.

The group is fully aware of the CMW and her services and everyone has visited her office and met her. The group reported that not only CBSG members, almost every woman in the village is likely use CMW services.

Funding from CBSG	"I took loan Rs. 2500 from CBSG and spent 1,000 for ANC and Rs. 1500 on delivery" , Ms. Gulnazir, CBSG member
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	

Other	

1.6 Village Health Committee

It was reported that this VHC was formed in 2010 with an initial membership of eight. The membership increased to twelve as the number of CBSG increased and it was being difficult to cover the villages with eight members. This VHC claims to organize an event on health education for the CBSGs and other villagers. The group feels itself responsible for:

- Door to door awareness about CMW services and MNCH cases
- Uses Mosques/Jamatkhanas for to educate people on MNCH
- Linked women with CMW

The VHC believes that only few women in the village are not members of CBSG and majority among them are uneducated. Those women were asked to join the CBSG but they do not trust any group because they had bad experience working in other groups prior to CBSGs.

VHC believes that it is different working with CBSG members than non CBSG members. CBSG members are united and they make decision based on their discussion with other women.

VHC notices that the reason for CBSG members more likely to use CMW services is that CBSG members are more aware and they got more opportunities to educate themselves in on health and MNCH cases.

Among all entities, VHC mostly communicates with CBSGs via meeting about their savings status. At second most VHC communicates with CMW via telephone and get updates about MNCH cases and her clients. At third most, VHC communicates with CBSG supervisor about forming new CBSGs in the area and linking them with CMW.

VHC uses CBSG meeting to deliver message to CBSG members and also try to bring simple examples in local context to make them understand fully.

VHC agrees about the reports which suggested that CBSG member were more likely to receive BCC messages than nonmembers and the reason is that CBSG members are more aware than nonmembers.

1.6 CMW

She started her work in July, 2011 and since then, she has handled the following number of cases

1. Deliveries: 19
2. ANC: 29
3. PNC: 25
4. Women took her services other than maternity: 150

In terms of her expectation, the amount of deliveries, other clients and the payments she get against her services exceeded her expectation. She also said that the amount of payments which she is receiving is increasing.

She reported that she provides the following services:

- General check up of children and adults
- Blood pressure checkup
- Blood group checkup
- Health education to women

She does not have any such plan to increase her services but she is optimistic about her future. She reported that in the beginning there were few clients of her but now they have increased.

She is aware of five CBSGs in the village and she feels CBSGs as an important source of referrals and clients.

She reported that she talk to people door to door politely to find new clients. She claims that she is also member of a CBSG (Chambeli) and she visits CBSG meetings where she is not a member. According to her women uses the following source in order for MNCH finance:

1. Husband
2. CBSG
3. Self

She thinks that her clients take loan from CBSG whenever they don’t have enough money to pay her fees. She believes that 80% of her clients are CBSG members.

According to her the principal difference between CBSG members and non-members is that CBSG members are fully aware of health issues and they share with each other if they hear new things about MNCH.

She reported that CBSG members are more likely to use her services than non-members because CBSG members are more aware and have access to CBSG finance.

She feels that attending CBSG meetings and educating women about her services is a special effort to attract CBSG members as clients.

Among all entities, she communicates with CBSGs via meeting and educates them on ANC, PNC and MNCH. At second most, she communicates with VHC about updates them about her work. At third most, she communicates with CBSG supervisor via meeting and updates her about her plan to visit new client mostly related to ANC.

CMW told about her story that she was called from the last village of Gobore, Killich (sharing border with Afghanistan) for delivery services. (Taking along her in-laws and her daughter) She said that it was snowing at that day but she went by foot to save the life of the pregnant lady, Ms. Raheema. On the way, she experienced with an avalanche and her daughter had a narrow escape but she still continued her journey with an aim to save the life of the pregnant lady. She reached to the village and delivered the lady. The family could not afford to pay her fees and were also not member of CBSG. After sometime the delivered lady (Ms. Raheema) became member of CBSG and took Rs. 1200 loan from CBSG and paid back the CMW service charges.

1.7 CBSG supervisor

She reported that there are women who are not member of CBSG because they do not afford to pay monthly saving or some of them are willing to be part of CBSG but they do not get permission from their husband to go out of home for attending CBSG meetings. Those non-members were asked to join but they refused. CBSG members believe that with the passage of time those non-members would be part of the CBSGs soon.

The principal difference CBSG members and non members are that they are more literate about health issues and more aware. She believes that CBSG members feel more confident that they have access to CBSG finance at any time.

She believes that CBSG members are more likely to use CMW services than non-members. CBSG members visit CMW regularly for general check-up and pregnancy while non-members do not know much about CMW services.

In CBSG supervisor's point of view, CBSG members source of finance for MNCH cases are in the following order:

1. CBSG
2. Husband
3. Self
4. Other sources (selling assets)
5. Other loan (from relatives or family members)

No case reported where women were encouraged or supported by their groups to try new things that they would not have done otherwise.

She agrees about the reports that suggest CBSG members are likely to receive BCC messages than non-members because they are more aware about health and MNCH. She claimed that she talks a lot about CMW when meets CBSGs.

Another reason she mentioned about CBSG members likely to use CMW services is that they trust the CMW skills and expertise.

According the CBSG member, the status of the CBSGs in her jurisdiction are as follow:

- Strong and growing (36%)
- Essentially stable (64%)

CSGS supervisor mostly communicates with CBSG via meeting about their saving, health and general issues in the group. At second most, she communicates with VHC via meeting about CBSGs and health related issues among women in the village. At third most, she communicates with CMW via meeting about liking women with CMW.

1.8 Delivered lady, Ms. Gul Nazir

She is a member of CBSG and she is fully aware of her CMW in her village and knows about her services. She claims that she has visited her office and met her personally. She said that CMW has charged her Rs. 100 for ANC, Rs. 1000 for delivery and Rs. 15 for PNC.

She said that she did not visit any health facility other than CMW.

She reported that she took loan Rs. 1000 for delivery and paid CMW service charges. She said that she also took Rs. 2,000 and did treatment of her daughter and herself in different occasions.

1.9 Delivered lady, Ms. Shazia Rahim

She is not a member of CBSG but she told that she use to visit CMW for ANC and she is delivered by her. It was reported that she paid Rs. 800 to CMW for ANC and Rs. 600 for delivery services. She is fully aware of the CMW services. She told that all the expenditures were paid by her husband. She said that she did not visit any other health facility for MNCH.

E. Bomborate

Summary	
Social Mobiliser	Farhana Kanwal
CBSG Supervisor	Gumaira +Shamshira
Status	Traditional
CBSGs	13

1.11CBSG Muslimabad

The group was formed in October 01, 2012 with an initial membership of 12 ladies. Now the membership has reduced to 10 members. Two members withdrew their savings with a reason that they cannot continue to afford the monthly savings. The group has not organized any salient event.

The group is not aware of any CBSGs in Bomborate and there are women who are not members of CBSG. Those women were asked to join CBSG but they refused saying that they do not have time to come to CBSG meeting and they are busy in farming. The group also told that they are also not being regular in monthly meetings because they are busy in farming.

The group was divided into three sub group and asked if they have taken loan from CBSG but only one lady (Ms. Rehana Naz) told that she took Rs. 1500 for treatment of her son who suffered from Pneumonia. She also took Rs. 2700 for his brother's marriage.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or any project undertaken by encouraging each other.

Majority of the group members are not aware of the CMW working in Bomborate and they have not availed her services and no one has been to her office. It was reported that the CMW use to come to CBSG meeting last year but this year no one has met her. The group reported that for health and MNCH purpose they approach to nearest hospital funded by Red Crescent. The group told that they get free treatment and medicines from that hospital.

The group reported that we want to improve this CBSG by increasing our saving and being regular to the meeting but now they stated that this CBSG is not functioning well (not regular in meetings and saving is very low).

1.12CBSG Pehla Qadam/Shaheen

Note: The new name of the CBSG is Shaheen.

The group was formed in March 08, 2011 with an initial membership of 17 ladies. Now the membership has reduced to 10 with a drop out of seven women. The group reported that even some more women are not willing to continue their membership because their homes are far away and they use to go to pastures in summer time. Some of the member reported that they will continue this CBSG even after the Program withdraw its support. They feel that CBSG is very much helpful in terms of access to finance. The group did not organize any salient event.

The group is aware of four other CBSGs in Bomborate but they did not have chance to meet with them. It was reported that there are women in the village who are not members of CBSGs. Those women are asked to join but they refused that they are busy in farming and they use to move to pastures in summer.

The group was divided into three sub group and each individual was asked if they have taken loan. The responses are given below:

"I took Rs. 2000 loan from CBSG for ANC", Ms. Mussarat Nazir

"I took Rs. 7,000 loan from CBSG and did shopping for my Children on Eid", Ms. Sultana

“I spent 12,000 in ANC (Rs. 6000 from CBSG and Rs. 6,000 from herself). I was hospitalized in District Headquarter Hospital Chitral for some days before pregnancy. I was delivered in my home without any health facility”. Ms. Sultana

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or any project undertaken by encouraging each other.

The group is aware of the CMW and fully aware of her services and where she lives. It was reported that only two members in this CBSG have been to her office but she use to come to CBSG meeting and check blood pressure/general checkup of the members. The group reported that she also give health education to CBSG members.

The group believes that CBSG members are more likely to use CMW than non-members as she use to come to CBSG meetings and provides health education.

It was observed that the members feel that the period of the CBSGs ends when it gets graduated. It was also reported that some of the women are willing to join the CBSG but they feel that it will going to end once it gets graduated. The word “graduated” has been wrongly interpreted to the members or it has been misperceived by them. This misperception or misconception could affect the sustainability of the CBSG.

Funding from CBSG	“ I took Rs. 2000 loan from CBSG for ANC”, Ms. Mussarat Nazir
Multiple funding sources including CBSG	“I spent 12,000 in ANC (Rs. 6000 from CBSG and Rs. 6,000 from herself). I was hospitalized in District Headquarter Hospital Chitral for some days before pregnancy. I was delivered in my home without any health facility”, Ms. Sultana
Leverage funding due to CBSG	

CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.13CBSG Sarukjal

The group does not exist anymore. The group shared out and did not continue. It was reported that they members were not regular in meetings and the area is scattered. Due to natural disasters the road and bridges were washed out that' s why the members could not get together for meeting and decided to finish the CBSG.

1.7 Village Health Committee

The VHC was formed in 2011 with an initial membership of 12 individuals. The VHC feels itself responsible for:

- Facilitating CMW
- If any delivery case referred by CMW to Chitral town hospital then VHC is responsible in facilitating the case in terms vehicle arrangement.

- Health awareness to CBSG

It was observed that VHC is mostly connected to CMW and less aware of the CBSG. Due to cultural constrains the VHC could not access to the CBSGs as they are women CBSGs and the VHC members are all men.

Among all entities, VHC communicates mostly with CBSG supervisor via meeting about the CMW services and linking MNCH cases with the CMW. At second most, VHC communicates with CMW about her performance. At third most, VHC communicates with male community via meeting in Mosques about health education and MNCH.

VHC told that VHC is playing its role in educating the men community about MNCH and general health using religious places like mosques.

It was reported that CBSG members get opportunity to get aware about MNCH and other case that' s why they are like to receive BCC messages and more likely to use CMW services. It was also reported that whenever need arise than every women is likely to avail CMW services.

VHC reported that there had been no cases recorded in ANC, delivery, PNC deaths in this area within the time period of this Program.

"Before this program, a lady became serious when got delivered. As usual the road was blocked and there were no such service provider to save her life. The villagers carried the lady on a cart and started their journey towards Chitral town. On half way, she got expired. The incident would not have happened if we have any trained CMW in our village at that time". Mr. Lal, secretary, VHC.

VHC suggested the AKDN should link CMW with pharmacy suppliers in order to ensure the quality of medicines.

1.9 CBSG supervisor

It was reported that there are women in the village who are not members of CBSG because they are not allowed from their husbands to go out thier homes for meeting. She reported that this case is specific to Muslim community while others (Muslim+Kalash) could not afford the monthly savings. All the women are dependent on their husband' s income so every time they have to ask their husband for money. CBSG supervisor believes that eventually those nonmembers will get membership soon. She believes that in this season majority of the women are planning to sell fruits and earn money to pay the monthly saving of the CBSG.

CBSG supervisor believes that CBSG members are more likely to use CMW services than nonmembers because CBSG members feels CMW as part of the CCSP program and they want to promote her business.

According to CBSG supervisor, CBSG members finance MNCH cases are given below following the order from most important source to the least important:

1. CBSG
2. Husband
3. Self
4. Other sources (selling assets)

She reported that Ms. Mussarat Nazir was encouraged by the CBSG members to set up a general store. In the beginning she was scared that she would not earn profit but the members encouraged her to start the business as they thought it would be lucrative. She started her business by taking loan from CBSG and running her business successfully. Her decision was influenced by CBSG members suggestion.

She reported that Mother of Ms. Yasmin took Rs. 2,000 and continued the education of her daughter for a year. She also reported that Ms. Sultana suffered from typhoid and gastric problem. She took Rs. 14,000 from CBSG in different quantum and did her treatment. She also told about the story of Ms. Wazir Gul, a 45 years old lady whose one side got paralyzed. She took Rs. 600 from social fund of CBSG Pehla Qadam and did her treatment.

"I was sick and my father was not at home at that time to finance my treatment. I took Rs. 11,300 loan from CBSG and went to Chitral town and did my treatment". Ms. Gumera, CBSG supervisor.

Among all entities, CBSG supervisor communicates mostly with CBSGs via meeting about their saving status. At second most, she communicates with CMW via meeting about plans to visit CBSGs. At third most, she communicates with AKRSP social mobilizer via meeting and telephonic.

1.6 CMW

She started her work in July 2011 in a sub village Ahmadabad of Bomborate. She has handled 11 cases of delivery, 30 ANC and 30 PNC. She reported that there are many women who have taken her services other than maternity. She does not remember the exact amount. She reported that the amount of deliveries exceeded her expectation

and the number of deliveries and other client is increasing. She also reported that the amount of payment she has received was less than her expectation because in the beginning people did not pay her for her services especially for general check, blood pressure checks up, etc. She said the amount of payment she is receiving is staying about the same. She offers services on the following:

- Delievery
- Blood group check up
- Blood pressure check up
- Pharmacy

She reported that people mostly pay her for delivery services only while for general check/blood pressure checkup no one has paid her.

She does not have any plan to increase her services. She said that her moral is low because women are not paying her for most of her services. She is optimistic about her future and feels that may be in future the women will pay her for her services.

She is aware of four CBSGs in the village and she feels CBSG as an important source of referrals and clients. She reported that she tries to find new clients through the strategies below:

- Go to CBSG and talk to them
- Talk to people door to door
- Work with or rely on VHC

She claimed that she was a member of CBSG but the group no more exits so far. She said that she attends other CBSG meetings. According to her the source the women use to finance her services are given below in order from most important to least important source:

1. CBSG
2. Husband
3. Other (sell assets)
4. Self

She reported that majority of clients avail her services on credit if they do not have money to pay her services. She claimed that 80% of her clients are CBSG members.

She said that CBSG members are more aware as they get opportunity to interact with her and other stakeholders (VHC, CBSG supervisor) than nonmembers.

All things being equal, CMW believes that not only CBSG member but also other women in the village are likely to avail her services. She told that she does not have to make any special efforts to attract CBSG members as a client.

Among all entities, she communicates mostly with VHC via meeting about MNCH cases and her clients. At second most, she meets CBSG supervisor via telephone about health issue in the village and her services. At third most, she communicates with CBSG members via meeting and telephone about health education and her services.

1.11 Delivered lady, Yasmin

She is member of CBSG and she if fully aware of CMW, her services and the about the charges. She was delivered by the CMW and paid her Rs. 500. For ANC she consulted lady doctor in Chitral and spent Rs. 1000. For PNC she did not visited any health facility.

She said that she discussed her plan with CMW to visit a lady doctor for ANC. She advised her to visit the lady doctor and following her advised she visited the doctor. Note: Only one delivered lady was available in the village.

F. Raman

Summary	
Social Mobiliser	Shagufta Noor
CBSG Supervisor	Sabiha
Status	Traditional
CBSGs	27

1.14CBSG Tholandeh

The group was formed in April 27, 2012 with an initial membership of 20 women. The members increased to 25 in order to increase the group savings. The group has not conducted a salient event and claim to organized small awareness session via CBSG meetings.

The group claimed to be aware of 29 other CBSGs in Raman but did not have met any others groups because there has not been such need arise to meet other groups.

There are other ladies, especially young school going age girls are in the village who are not CBSG members but it was reported that these ladies are willing to be member but this group feels that a group of more than 25 women is not manageable. This decision was taken in a CBSG meeting with mutual consultation.

The group reported that majority of the members have taken loan for their children education and MNCH cases. Apart from that they have purchased grain. Majority of the group took Rs. 3000 and bought wheat as food stock for winter. They have not taken other loan apart from CBSG.

"My savings in CBSG and access to CBSG loan is just like that I have money at my home. I can access to CBSG money at any time", Ms. Zarin Jamal, CBSG member.

One of the member reported that she took Rs. 15,000 loan from CBSG and went to see her parents after a long time (2 years) who live in Gilgit. She took gifts for her family and bear transportation cost from that CBSG loan. She claims that she has paid back to CBSG her debt along with profit.

The group reported that by know that they have access to CBSG saving or credits they have not purchased anything but have given loan to other village neighbors considering that they can use CBSG fund. One of the lady said that she gave Rs. 1500 loan to her neighbor out of her pocket which she saved to buy a bride dress for her daughter. Meanwhile her neighbor was not able to pay back the loan at the time of wedding. Therefore she took Rs. 1500 from CBSG and bought a bride dress for her daughter. They group reported that such type of activity is very common in their CBSG.

No case reported for taking an initiative in the group by hearing from each other or supported/encouraged by a group.

The group is aware of the CMW and better knows what services she offers and the charges. They have all met her in her office and she visits the CBSG regularly. Majority of the women in this village are CBSG members and they are more likely to avail CMW services. The reason was reported as follows:

1. CMW is linked with CBSG
2. CMW is easily accessible; her office is near to their homes. "We don't have to pay for any transportation cost to reach her", CBSG members.

3. She even give services on credit

The group reported that they are very optimistic about the future of the CBSG. They reported that in future they are planning to increase the savings.

"We will increase our savings in future and we will carry CBSG in long run even after this project". CBSG members

"We feel happy since we have formed this CBSG".CBSG member

"Now we can even have access to finance at any time, no matter day time or night, whenever we need money". CBSG member

Funding from CBSG	The group stated that one of the lady in the village, namely Marjan, took Rs. 15000 loan from CBSG and went to AKHSP maternity home Booni for delivery.
Multiple funding sources including CBSG	Sharifa: "I did my treatment worth Rs. 115000. My husband paid Rs. 100,000 and the remaining cost was covered by taking loan of worth Rs. 15,000 from CBSG". Note: The lady did not want to mention the disease name but told that that disease was specific to women.
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	

“Halo Effect”	After assessing the performance of this CBSG, AKRSP brought the members of Meragram CBSG on exposure visit. The members belonging to both CBSG shared their experiences.
Viability of CBSGs	“We are planning to increase our CBSG savings in future and we will promote our CBSG activities even after the AKRSP ends this project”.
Other	

1.15CBSG Shahri Phorth

The group was formed in June 02, 2011 with an initial membership of 25. The membership increased from 25 to 31 in order to increase the savings of the group. The group is aware of four other CBSGs in the village but the members have not met other CBSGs members without any reason.

It was reported that there are women who are not members of CBSG though they have been asked to join but they refused by giving the reason that they cannot afford the monthly savings. Those ladies who are not member of the CBSG are mostly old women.

Majority of the ladies reported that they have taken loan from CBSG to pay their children school fees while some of the ladies reported that they have taken loans buy food stuff for home e.g ghee, tea, sugar, beans, etc. The loan amount ranges from 2,000 to 3,000. The group also reported that majority of pregnant members have taken loans for maternity cases. The group reported that the loan taken for MNCH case were Rs. 3,000 to 4,000.

Ms. Saina gul took Rs. 6,000 from her CBSG and Rs. 6,000 from the men CBSG for her father’s treatment who suffered from kidney failure.

The group reported that there are three ladies who were pregnant and their husbands use to work in Gilgit. By knowing that their husbands will not be able to send money at the time of their delivery, the group decided to provide them loan for delivery. They

took Rs. 4000 loan each and paid their delivery charges. Among them, one of the ladies went to nearest health center while the other two were delivered by the CMW.

The group reported that before this CBSG the women use to take loan from local shopkeepers to pay their MNCH costs and education fees in case of short of funds and now they reported that they take loan from CBSG.

Funding from CBSG	"I took Rs. 4000 loan from CBSG and went to nearest health center for delivery", Ms. Shaheensha. This lady was referred by the CMW.
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	"My date of delivery was over and I discussed this issue with CBSG members in monthly meeting", Ms. Shaheensha. All of them suggested her to meet the CMW. She met the CMW and she was referred by the CMW to the nearest health facility.
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	

Viability of CBSGs	"We are planning to charge a penalty for those members who do not come to meeting without any solid reason. " Bibi Ashraf
Other	

1.3 CBSG Baghebostan

The group was formed in August 12, 2012 with an initial membership of 32. No such salient event organized by this CBSG. It was reported that the membership remained the same since then. The group is aware of five other CBSGs in the village Raman but they have never met.

The group reported that there are four women in their sub village who are not members of the CBSG. They have been invited to join the group but they have refused because they could not afford the monthly saving.

During the discussion, it was reported that majority of the members took loans from ranging to Rs. 500 to Rs. 3000 for their child health.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or any project undertaken by encouraging each other.

The group is fully aware of the CMW and her services and all of them have visited her office but she has never visited the CBSG. Not only the CBSG members but also other women are likely to visit the CMW.

1.8 Village Health Committee

The VHC was formed in March 2011 with an initial membership of three women and three men. Now they have increased the membership to nine by adding two women and one man.

VHC has organized three awareness events on VHC and MNCH cases. The VHC feels it' s self-responsible for the followings:

- Selection of office for CMW
- Vehicle arrangement for MNCH cases referred by CMW to hospital
- Awareness on MNCH cases and motivate women to avail MNCH services
- Set charges for CMW services by assessing the affordability of the people.

Mostly old ladies are not members of CBSG who are not in child bearing age. These ladies are asked by CBSG as well as CBSG supervisor to join CBSG but they denied. These ladies are very conservative and do not believe in modern practices on MNCH. It was reported that those ladies give example of their selves that they have gave birth to their children without consulting any health service provider.

CBSG members are more aware and get motivated quickly than those women who are not members of CBSG. CBSG provides them a platform to discuss things which other women that' s why the VHC feels that the CBSG members get motivated quickly.

Among the different entities, VHC communicates with CBSG supervisor at most via meeting on health education to CBSG members and their savings. At second most, VHC communicates with CMW via meeting on health education. At third most, VHC communicates with CBSGs via meeting about their savings and any MNCH cases. VHC claims that it utilizes the plate form of CBSGs monthly meeting to deliver message to CBSG members.

The reason for CBSG members to more likely use CMW services because they are more aware than other women. Secondly CMW services are cheap and easy to access. CBSG feels more confident about her skills and services.

Case studies were reported below:

Mr. Wazir is young unemployed guy. He planned to go abroad for work but he was not having money to bear the travel cost. He took Rs.150,000 from different CBSGs in Raman and went to Dubai for work.

Ms. Masgul, a 32 years lady having four kids. She took Rs.10,000 from CBSG and went to the province capital for her stomach operation.

Funding from CBSG	1. Wife of Mohammad took Rs. 20,000 and went to AKSHP maternity home Booni and got delivered. 2. Wife of Zar Mohammad took Rs. 15,000 and went to Karachi for ANC

Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	"I would have not even listen to my husband on MNCH but being CBSG member I got more aware and conscious about MNCH" . Ms. Workhot, VHC and CBSG member.
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.10 CBSG supervisor

She reported that women who could not afford to monthly saving or old women (non child bearing age) are not members of CBSGs. Those ladies are asked to join CBSGs by the supervisor but no willingness was observed. The principal difference between

women who are CBSG members, than women who are not members is that CBSG members are more aware on health and other MNCH issues. The reason for CBSG members to be more likely to use CMW services than non-members is that CBSG members get opportunity to educate themselves on health and MNCH through this CCSP. But this does not mean that other members are not likely to avail CMW services. It was reported that every women in the village avail her services in case of emergency but CBSG members are more regular and come to her frequently for general checkup, e.g blood pressure checkup, pharmacy services, etc. She also claims that salient events organized by VHC played vital role to motivate CBSG members to use CMW services.

According to CBSG supervisor, the sources of finance for women on MNCH services are in the following order:

1. CBSG
2. Husband
3. Other sources (by selling their assets)
4. Self
5. Other loan (from relatives or neighbors)

She reported that not only CBSG members but nonmembers in the village also take loan from CBSGs for MNCH services.

CBSG Supervisor claims that she talks a lot about CMW when she meets CBSGs. According to the CBSG supervisor the status of the CBSGs are as follows:

- Strong and growing: 28%
- Essentially stable: 66%
- Losing members, or in difficulty: 7%

Among all entities, CBSG supervisor communicates with CBSG at most via meeting on health education on MNCH. At second most, she communicates with CMW via meeting on MNCH cases in the village. At third most, she communicates with VHC via meeting on CMW.

1.6 CMW

CMW started her work in October 2011 with handled 15 cases of deliveries. She reported that all these 15 women has availed ANC and PNC. For PNC she reported that she has went to check them four times each. She reported that almost all the women in the village come for other than maternity services. She reported that the women come to check their blood pressure, injuries, and headache and pharmacy services.

The amount of deliveries and other clients exceeded the CMW expectation. In the beginning she thought that there would be less clients and her moral was low as well. With the passage of time her clients increased which has increased her motivation level. She reported that her clients (deliveries and others) are increasing day by day.

"I started given health awareness door to door and built the confidence of the women, which resulted increase in my clients. In the beginning the average clients per month was 30 and now it has increased. Recently, there were 250 clients in one day which was the maximum amount of clients ever I had."

The payment she received was about what she expected. She reported that the amount of the payments she is receiving is increasing but she decided to charge less than what VHC has fixed the rates because she got complaints from women that the rates were high – charging Rs 700 for delivery instead of Rs 800.

The services she offered other than maternity are BP check, pharmacy, injection, family planning, general checkup, blood test, etc.

She reported that she to enhance her skills more by acquiring trainings and extending her services to other villages as well. She is very optimistic about her future.

She is aware of 33 CBSG in Raman and she perceives the CBSGS as a source of referral and clients. She reported that she tried to find new client by going to CBSGs meetings and also talking to people door to door.

She claimed to be member of CBSG and she attends CBSGs meeting regularly and enjoys the plate form to market her services.

The sources that women use to finance services they get from CMW are in the following order:

1. CBSG
2. Husband
3. Self

She reported that majority of the clients avail her services on credit if they do not have enough money to pay their fees.

She claimed that 80% of her clients are CBSG members and CBSG members are more aware of her services. They come for CBSG meetings which gives them an opportunity

to educate their self about MNCH and other health facilities. She reported that It is easy to work with CBSG members. They have access to CMW flyers and presentations.

"CBSG members are likely to use my services but non-members also avails my services but CBSG members are more aware and it is easy to make them understand about any cases" .

Among all entities, CMW communicate mostly with CBSG supervisor via meeting about MNCH cases. CMW uses CBSG supervisor as a bridge between her and CBSG members. In second most, she communicates with VHC via meeting about pregnant ladies in the village which do not come for ANC. At third most, she communicates with BCC agents via meeting about educating women on MNCH cases.

1.5 Delivered lady, Nasima

She is not a member of CBSG but she did not mention any reason for not being member of a CBSG. She reported that she has been invited to join CBSG but she did not join without any reason. She is aware of the community Midwife and she is fully aware of her services and the charges. She has visited her office and knows her very well. For ANC she accessed to the nearest AKHSP health center and paid Rs. 1200 from her husband pocket. She was delivered by the CMW at her home and paid Rs. 1900 to her. For PNC, the CMW came to check her but did not charge her.

She reported that for ANC, she was self-referred to AKHSP health center but for delivery she preferred the CCSP trained CMW.

1.11 Delivered lady, Sheensha

She is member of CBSG and she is aware of two CBSGs in the village. She is fully aware of the CMW in Raman and she has visited her office and fully knows her. She reported that she is fully aware of the CMW services and the charges for her services. She availed the CMW services for ANC and paid her Rs. 600 to her from her husband pocket. She was delivered by local tradition birth attend (TBA) in the village. The reason she told for not asking CMW services in the time of delivery was that delivery happened so quickly that she could not contacted the CMW and called the local TBA, who lives near to her home. She paid Rs. 4000 to TBA which was covered by the loan she took from CBSG. For PNC, she accessed the AKHSP health center and paid Rs. 600.

She reported that she discussed her pregnancy with the CBSG members and the members advised her to visit the CMW or the nearest health center and take loan from the CBSG for her delivery. She was happy to hear about the CBSG advise and took Rs. 4000 for her delivery.

G. Terich Payeen

Farhana Kanwal	
Social Mobiliser	Sartaj Gul
CBSG Supervisor	Shahina
Status	Non-Traditional
CBSGs	9

1.16CBSG Torphot

The group does not exist anymore. Initially there were 13 members but seven members dropped out while the other six members joined another CBSG, Mulphot.

1.17CBSG Mushich

The group was formed in May 12, 2012 with a membership of 12. The members are still 12 now. The group is aware of other CBSGs in the village but do not know the exact number of CBSGs in the village. It was reported that this group did not meet any other group the area is scattered and it is difficult to access other sub villages.

It was reported that there are women in the village who are not member of CBSG because they do not give importance to CBSG and are not interested. Some of the women do not get permission from their homes to join CBSG.

No one reported that they have taken loan form CBSG.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group is fully aware of the CMW and her services. They all have visited her office and met her individually. It was reported that the CMW has never visit this CBSG.

The group believe that every women in the village is likely to use CMW services whether she belongs to CBSG or not.

1.18CBSG Smitch

The group was formed in December 17, 2012 with an initial membership of 19. Now it has reduced to 15 members. The group is aware of only one CBSG in the village but never met the group. It was reported that there are women in the village who are not members of CBSG because they feel that this CBSG is not that much beneficial and secondly they cannot spare time to give CBSG from their household chores. They have been asked to join but they denied by giving the aforementioned reasons.

No one reported that they have taken loan form CBSG.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraged by other members.

The group knows the CMW in the village and every claimed that they have met her in her office individually. It was reported that the CMW never visited their CBSG.

It was reported that both CBSG members and nonmembers are equally likely to use CMW services. In the beginning, women were preferred to go to RHC Shagram but now no one by pass her until and unless she refers them to RHC.

1.9 Village Health Committee

The committee was formed in 2012 with initial membership of six. The membership increased with the increase of CBSGs in the area. This VHC claims that it has organized a mega event on awareness on MNCH cases. It also claims that it organizes small events in Mosques after Friday prayers.

It was reported that there are women who are not member of CBSGs because the area is scattered and it is difficult for women to get together for a meeting. VHC feels itself

responsible for the conducting awareness session with community on MNCH issues and CMW services.

VHC believes that the principal difference working with CBSG members than non-members is that CBSG members are more aware and easily understand their message while with non-members they have to start from zero. For instance, members already have basic notions health and hygiene, from BCC and CMW.

It was reported that CBSG members as well as other women in the village are likely to use CMW services whoever have better access to her office.

VHC communicates mostly with BCC agent via meeting about the improvement of CMW services. At second most, VHC communicates with CBSG supervisor via meeting about CBSG savings, CMW issues related to transportation and accessibility to women. At third most, VHC communicates with CMW via meeting about her performance and any issues if she comes across.

VHC reported that it holds meeting with CBSG members to deliver its message to them.

VHC agrees that CBSG members were more likely to receive BCC messages as they are more aware and sensitized toward MNCH issues.

1.12 CBSG supervisor

She reported that there are women who are not member of CBSG due to religious factor. Those women believe that interest on loan is forbidden in Islam and they do not want to be part of any group which provides loan on interest while other women does not like NGO culture (by which is meant such things as men and women riding in the same vehicle) that's why they do not want to be part of CBSG. CBSG supervisor told that those women could not be easily sensitized and they are lesser chances that they will eventually become CBSG member.

CBSG supervisor does not agree that CBSG members more likely to use CMW services. She believes that the women near whose homes are near to CMW office are more likely to use her services whether they are CBSG members or not. The women whom homes are far away from CMW services prefer to access RHC Shahgram.

No case reported for group members encouraging each other to try new things.

She reported that she talks a lot about CMW when she meets CBSGs. According to her the status of the CBSGs in her area as follows:

- Strong and growing: 56%
- Essentially stable: 11%
- Losing membership, or in difficulty: 0%
- Inactive: 33%

Among all entities, she communicates mostly with CBSGs via meeting about their status. At second most, she communicates with BCC agent via meeting about CBSGs health. At third most, she communicates with CMW via meeting about MNCH cases.

1.13 CMW

She started working in Terich Payeen in July 2011 and handled the following cases until now:

- ANC: 32
- Delivery: 18
- PNC: 18
- Clients other than maternity: 300

She reported that the amount of deliveries and other clients she had exceeded her expectation and are increasing. The amount of payment she has received was about what she expected and is increasing. She told that she provides the following services:

- Health education
- Blood pressure checkup
- Pharmacy
- General check-up for headaches, diarrhea, fever etc

She reported that women do not pay every time for her services, like blood pressure check, general check, etc. She reported that her father is a dispenser in government dispensary and provides free health facility to villagers which has spoiled the habit of the villagers to avail free treatment. She reported that majority of women were expected free services from her as well. She does not have plan to for increasing her services as she told that most of the women demanded that she should shift her office to middle of Terich Payeen so that every could have better access to her office. She told that she is pessimist about her future because of geographical constrains and transportation of women she does not have access to enough clients. She is aware of eight CBSGs in the village and she feels CBSGs as a very important source of referral and clients. She reported that CBSG members market her services as she could not go

and talk to people door to door due to scarceness of the village and mobility constrains due to geography (hilly area).

CMW reported that she is not a member of any CBSG as there is no CBSG in her sub village. She also reported that she has visited only two CBSGs and attend their meetings but she said that 80% of her clients are CBSG members.

According to her women finance MNCH cases from the following sources (starting from the most to the least)"

1. CBSG
2. Self
3. Husband
4. Other loan
5. Other sources (e.g father in law or brother in law supports)

She said that it is different working with women who are CBSG members because they are sensitized towards health issues and also they know that they have to pay her for services while with non-members she has to tell them that they have to pay her.

She reported that she does not have to make any special efforts to attract CBSG members as clients. She agreed that CBSG members were more likely to use CMW services than non-members because CBSG supervisors have marketed her services to the CBSG members.

Among all entities, CMW mostly communicates with BCC agent via meeting tells him about her performance. At second most, she communicates with VHC via meeting and updates them about her clients. At third most, she communicates with CBSG supervisor via meeting about CBSG meetings.

She told a story about Ms. Zahira, a 29 year old lady. She was poor and could not afford her fees. She was pregnant and had labour pain for 2 days. She heard about Zahira and went for her checkup and found that the baby was dead inside. She delivered her and save Ms. Zahira' s life and did not charge her.

Funding from CBSG	"I refferd Ms. Zubaid to Rural Health Centre Shahgram for delivery as her case was complicated. She did not have money to afford the expenses but I heard that she took loan from CBSG and got delivered in Rural Health Centre Shahgram" Ms. Najmun Nisa, CMW Terich Payeen.

Multiple funding sources including CBSG	"Ms. Farigah took Rs. 600 from CBSG and Rs. 600 from her own and paid my fee for delivery" , " Ms. Najmun Nisa, CMW Terich Payeen.
Leverage funding due to CBSG	
CBSG population s different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	
Other	

1.12 Delivered lady, Ms. Gulnar

She is not a member of a CBSG but she is aware of CBSG in her sub village. She reported that she has never been asked to join the group. She is fully aware of the CMW in the village and knows where she lives and runs her office. She told that she

has met the CMW in her office and knew her name. She reported that she went to visit her for ANC and paid her Rs. 60 (paid by father in law). She reported that she was delivered by the CMW and paid her Rs. 1,000 which was covered by her father in law. She reported that she did not avail any health facility for PNC.

1.13 Delivered lady, Ms. Fatima

Ms. Fatima is not a member of CBSG but she is knows that there is a CBSG in her village but she has never been invited to join.

She is fully aware of the CMW and her services. She knows her name and also knew where she lives and runs her office. She told that she has availed CMW services for ANC and paid her Rs. 25. She said that she was referred by the CMW to RHC Shagram where she got delivered as well. In RHC Shagram she paid Rs. 1300 of ANC and Rs. 4000 for delivery. She reported that all the expenditure was paid by her father in law.

H. Khuz

Summary	
Social Mobiliser	Shagufta Noor
CBSG Supervisor	Sakina Bibi
Status	Traditional
CBSGs	7

1.19CBSG Nighatat

The group was formed in January 15, 2011 with an initial membership of 16 members. In the second year of the formation, the membership increased to 21 and currently there are 30 members. The reason reported for increase in membership is the financial benefit inform of savings and access to CBSG loan. The group reported that no such events have been organized by the group itself but they have participated in health awareness events organized by AKDN organizations. The group claims to hold regular meetings of the CBSG and they regularly call the CMW to check the group members' blood pressure after the meeting ends. They pay Rs. 10 per head to the CMW for blood pressure check. This group is aware of 10 other CBSGs in their respective village and the group reported that they have held meeting with other groups whenever the

loan request from its members has exceeded their group savings. This reflects that the CBSG members have not only access to their own CBSG finance but also to other CBSGs in the area/village as well. The have reported few cases in this regards.

The group reported that all most all the women in the village are members of CBSG except from few ladies (belonging to two households). They were asked to join the CBSG but they denied by saying that they do not trust any savings groups as they have had worse experience in previous groups (WOs) priors to CBSG. One of the member in the group claimed that she is neighbor of those two households who are not member of the CBSG. She believes that their perception has changed by observing the benefits of the CBSG and now they have showed willingness to join CBSG. She claims that they have realized its benefits in the form of quick access CBSG finance than acquiring loan from any bank. The group feels that the procedure in acquiring loan from CBSGs is easy and cheap. They do not have to pay any service charges or transportation cost for taking loan from CBSGs as compared to accessing any financial institution or a bank.

The group was organized into three groups and asked individually about their loans taken from CBSG. Every said that they have taken loans and majority of them claimed that they have taken loans to pay their children school fees ranging from 4,000 to 10,000. They said that they would have sold their livestock to pay their children school fees if they would not have access to CBSG finance. One of the lady in the group reported that she took Rs. 30,000 loan from CBSG and spent the money in her brother in-law marriage ceremony. Few of the ladies said that they have taken small loans for daily household expenditure. One of the lady reported that she took loan and went AKHSP maternity Booni for delivery.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members.

One of the lady reported that she was running a small business of embroidery products. She decided to give up the business as she was short of money for further investment. She discussed her issue with other members in the CBSGs and the group motivated her and advised her to take loan from the CBSG and re-start the business. She said that she has taken loan worth Rs. 3000 from CBSG and now running her small embroidery business. She applauded the CBSG members for encouraging her. There are similar cases for women’s education.

	Case 1	Case 2	Case 3
Project or action	Embroidery business		
Month and year	2013		

The group reported that they are aware of the community midwife (CMW) in Khuz and they said that she offer her services for MNCH cases, blood pressure check-up, general check-up, pharmacy, etc. Everyone is aware of her service charges, her home, office, and claimed that they have met her and know her name. It was reported that the CMW comes CBSG meeting regularly, checks blood pressure of the members and charges Rs. 10 per head. The group pays the cost from their respective savings in CBSG.
She charges Rs. 1000 for delivery services.

The group reported that every women in the village whether CBSG member or non CBSG member are more likely to use the CMW services.

The group is very optimist about its CBSGs future. They feel that this is a very quick access to finance. They group is planning to set salaries to the CBSG office bearer from the CBSG savings or the profit which CBSG earns from loaning in order to run the group activities smoothly.

Respondent: CBSG Nigahat Khuz Date: August 01, 2013

Funding from CBSG	Mrs. Ghulam ud din took 10,000 from the CBSG and did treatment for his son who suffered from Jaundice
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	One of the CBSGs members did not gave up her embroidery business because the group encouraged her not to give up and also suggested her to get loan. Her decision was influenced by the group and she took Rs. 3000 loan and re-started her business.
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	Men CBSG formed by seeing the good work of the women CBSGs. Men felt that this is very quick access to finance with low cost. Otherwise they have to go Mastuj and spend money on travelling to have access to finance from the bank. The requirement of the bank for getting loan is very much complicated then getting loan from CBSG.
Viability of CBSGs	"we are planning to set monthly salary for the officer bearers of the CBSG from the CBSG savings so that they should carry their job as efficiently as they are doing now" Shahnaz, CBSG member.

Other	

1.20CBSG Islah

The group is formed in May 21, 2013. In the beginning, the membership was 8 and now it has increased to 30. The group reported that the membership has increased by experiencing the benefits of the group.

This group is aware of 18 CBSGs in the village and it claims that this group meets whenever there is a special event organized by AKDN organizations. For loan purpose, the office bearers of this CBSG had held meetings with other CBSGs and presented their proposal for loans. The group claims that they have succeeded in getting loans from other CBSGs.

The group claims that all the women are members of CBSG. The reason for all women being members is that they have realized the benefit of the group and also more membership leads to more savings and it gives more opportunity for members to have access to large amount of finance.

During the FGD, the group was distributed into three groups and were asked about the loan which they have acquired and its purpose.

ASK 3 O' CLOCK
Majority of the women belonging mentioned that they have taken loan for their children education. One of the lady mentioned that she took loan to pay his son and daughter in-law college fees. Another lady (Xhur bas, a 40 years old lady) said that there was an urgent need of 10,000 for his two sons whom schools fees was due and they were not allowed to appear in the annual examination until and unless their fees are paid. She went around the village and asked three shopkeepers for loan but all of them denied. Finally she remembered that she can have access to the CBSG savings. She took 10,000 loan from the CBSG and paid their fees and they were able to get their examination roll numbers and appeared in the annual examination. Another lady mentioned that she has taken loan to afford the transportation cost of his son who is planning to go abroad.

ASK 9 O' CLOCK
Majority of the participants mentioned that they have taken loan for their children education. One of the lady bought goods for her shop worth Rs. 15,000. She took 10,000 loan from CBSG and 5,000 from her savings at home. She says that she would not have been uplifted her business if she has not taken loan from CBSG.

ASK NOON

Majority of the participants mentioned that they have taken loan for their children education. One lady bought goods for her shop worth Rs. 20,000. She took 5,000 loan from CBSG. Now she is running her business smoothly.

No case reported for purchases out of funds they have been saving at home by know that they could have access to CBSG in an emergency.

No case reported for undertaking project by learning about the idea from other group members or encouraging one another to initiate any project.

The group reported that they are aware of the community midwife (CMW) in Khuz and her services for MNCH, blood pressure check-up, general check-up, pharmacy, etc. All of them said that they know her name and visited her office. It was reported that the CMW comes to CBSG meeting regularly, checks blood pressure of the members and charges Rs. 10 per head. The group pays the cost from their respective savings in CBSG. She charges Rs. 1000 for delivery services.

The group reported that it is not necessary that only CBSG members are likely to use CMW services. They believe that all the women in the village are likely to use the CMW and the reason is that she is the only service provider in the village with regard to MNCH cases and other health services. They believe that CMW is very social and interacts with women freely. The group also reported that she is linked with their CBSG through CCSP and they also wanted to promote her and encourage her services. One member said, "We are linked together. We are in the same programme."

The group reported that through CBSG they have easy access to finance and through the CMW they have access to health facility.

Respondent: CBSG Islah Date: July 31, 2013

Funding from CBSG	
Multiple funding sources including CBSG	Ms. Fatima Afro took Rs. 10,000 loan from CBSG and Rs. 5000 from her pocket established a ladies shop. Ms. Marjina took loan Rs. 5000 from CBSG and Rs. 10,000 from selling her oxen and invested to promote her businesses.

Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	The women encouraged each other to be part of CBSG by telling them the benefit of savings in CBSG.
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	The membership increased as other women saw that the CBSG members have an access to quick finance.
Viability of CBSGs	
Other	

1.3 Village Health Committee

The committee was formed in October 2011 with an initial membership of 9. Two of them dropped out because they have not been able to give time to the VHC and play their active role. VHC has organized four mega events at the village level on health and hygiene focused on MNCH. Apart from that it has organizes small events in Jammat Khan on MNCH. VHC also claims to facilitate CMW to organize its events/meetings with the CBSGs. The events are in fact organized by AKDN along with the VHC: everyone is invited, there is a stage show, and themes like "Breast feeding

day" and "Mother's day". In many cases, the VHC has to mobilize men to reach women.

The committee reported that it is responsible for health education, awareness among community about CMW and building confidence of community towards CMW through endorsing that CMW is well trained and she has reliable instruments for patient's check-up. VHC also claims to connect the women in the villages with the CMW for MNCH and other health facilities.

The group reported that majority of the women even all young girls (school going age) are members of CBSGs. The reason for all the women and girls to be member of CBSG is a quick access to their savings and finance especially related to health issues and education. It provides a best financial support to everyone. The destitute get benefit from social funds. "It is a well-established bank for us", CBSG member.

The VHC said that few aged ladies (approximately 1%), who do not go out of their homes are not part of this CBSG but they have encouraged their daughters and daughters in laws to be members of this CBSG and attend the meetings regularly.

There was one household in the village, where the women were not part of the CBSG without any reason, though they were asked several time by the group. But recently one of the lady from that household approached CBSG for loan and she was granted worth Rs.10,000. While seeing the benefit of the CBSG she is a member now.

It was reported that the principal difference between CBSG members and non-members is that CBSGs women are more aware, organized, follow rules and regulations, united and more social than non CBSG members. It is because of the CBSGs meeting they get more updates about their villagers.

VHC reported that CBSG members feel themselves more responsible and take ownership than non-members. They follow the messages given to them by VHC, CMW and BCC quickly than non-members.

VHC believes that CBSG members and non CBSG members both are likely to use CMW services as there is no other health facility in Khuz.

VHC communicates mostly with CBSG supervisor through meetings about health related messages and CBSG savings.

In the second most, VHC communicate with CMW through meetings about MNCH services.

And the third most, VHC communicates with CBSG through meeting about CBSG's loan status, e.g how many loans have been granted, how many has been paid back, what amount is due, any defaults, etc.

Rukhsana, over 20 years old lady, is a CBSG member, she was referred to hospital by the CMW due to complication in her delivery. She took 20,000 loan from the CBSG, 10,000 from her father in-law and some money from her husband. She went to Tehsil headquarter hospital for delivery. The delivery was so complicated that baby did not survive but her life was saved.

Izat Bibi, a destitute and widow who does not have any son and a bread earner. One side her arm and leg is paralyzed. She gets regular benefit from the social fund of the CBSGs and does buy medicines for herself on regular basis.

VHC uses the platform of CBSGs meetings to deliver messages. Apart from that VHC makes telephone call to deliver messages to CBSG members.

The reason stated by VHC for CBSG members being more likely to receive BCC messages than non members is that the CBSG members feel themselves more responsible than other women and also BCC presentation technique is interesting and according to the education level of the community which helps the group to better understand her/his message. Apart from that interaction of CBSG members with each other through the CBSG meetings give them opportunity to hear and learn from each other. This factor influences their decisions to be more likely to use CMW services.

The men in the village observed the performance of the CBSGs and approached it for loan. The women CBSGs denied giving them loan by justifying that the main purpose of the saving is for MNCH, but still that men insisted. Only one men member of the village succeeded in getting 10,000 loans from CBSGs. The woman CBSGs advised the men in the village to form men CBSGs so that they could start their own savings and have an easy access to their savings and loan. Following the women CBSGs the men formed man CBSGs in the village and enjoying loan benefits.

Suggestion from the VHC: AKHSP should link the CMW with suppliers of medicines. CMW asks the local drivers to buy and bring medicines from Chitral towns. As there is no proper arrangement with the local drivers to keep medicines in dry and cool place

so sometimes the medicines get expire by travelling halfway to Khuz. AKHSP should support the CMW in proper carriage of medicines from Chitral market to Khuz.

Funding from CBSG	Ms. Izat Bibi, a destitute and widow who does not have any son and a bread earner. One side her arm and leg is paralyzed. She gets benefit from the social fund of the CBSGs and does buy medicines for herself on regular basis.
Multiple funding sources including CBSG	Ms. Rukhsana, over 20 years old lady, is a CBSG member, she was referred to hospital by the CMW due to complication in her delivery. She took 20,000 loan from the CBSG, 10,000 from her father in-law and some money from her husband. She went to Tehsil headquarter hospital for delivery. The delivery was so complicated that baby did not survive but her life was saved.
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	
Viability of CBSGs	

Other	

1.21CBSG supervisor

It was reported that only few women are not members of CBSGs because they are aged and are in non-child bearing age and they are less likely to travel out of their homes but it was also reported that those non CBSGs members have encouraged their daughters, granddaughters, sisters and daughter in laws to become CBSG member and be regular in monthly group meetings. These ladies feel themselves as part of the CBSG.

Keeping all things equal, it was true that CBSG members are more likely to use CMW services than non-members because they are more aware and they get regular health education from CMW and CBSG supervisor.

According to the CBSG supervisor point of view the most and the least important source how CBSG members finance MNCH services are as follows:

1. CBSG
2. Husband
3. Other source (family members such as father in-law, brother in-law, etc)
4. Self (mostly who run businesses or daily wagers/jobs)
5. Other loans (mostly from local shop keepers)

As mentioned in the FGD, CBSG supervisor also told the story of Xhurbas, as she was short of money to pay her sons' fees and she went to all the local village shopkeepers for loan but no one gave her any credit. She met some of the CBSG members where they told her that she can have access to CBSG fund. She got loan from CBSG and paid her sons' fees in time other while her sons' would not able to appear in the annual examination.

CBSG supervisor claims that she mentions CMW a lot when she talks to CBSG members.

It was reported that it is because of VHC and CBSG supervisor that CBSG members are more like to use CMW services as they play their role in mobilizing them.

CBSG supervisor feels that the CBSGs in her area are in good health. The members are regular in meetings and they have good access to CBSG finance. Majority of them

have taken loans and paid back the actual amount as well as the profit on that loan. She claims that 88% of the CBSGs are strong and growing while 22% are in difficulty. They are not regular in their meetings.

Among all entities, CBSG supervisor claims to communicate with:

1. Mostly with CBSGs via meeting on savings, social funds and CMW services
2. Second most with CMW via meeting on Health education.
3. Third most with VHC via meeting mostly on CMW performance.

Funding from CBSG	Hassena, a 20 years young lady was referred by CMW to Mastuj Hospital. She was not having money at that time but luckily she took Rs. 4000 from CBSG and went to Mastuj for her MNCH treatment.
Multiple funding sources including CBSG	
Leverage funding due to CBSG	
CBSG populations different	
Social empower-ment	
Greater reception of BCC by CBSG	
Greater CMW marketing to CBSG s	
"Halo Effect"	

Viability of CBSGs	
Other	

1.22Delivered lady, Ms. Zuhri

Ms. Zuhri is a CBSG member and she was delivered by the CMW. She is fully aware of her services. She visited the CMW office for ANC and paid her Rs. 85. She says that her delivery expenses paid to CMW were covered by her husband which was worth Rs. 1500. When she was asked about PNC , she said that she did not consulted any one for PNC and she feels healthy. She is fully aware of the CBSG finance and the reason why she did not take loan from CBSG was that the delivery cost was affordable to her husband and she says that she has kept her CBSG savings for any emergency in future. Mr. Bashir, husband of Ms. Zuhri, who works in Punjab province and sends remittances on monthly basis. He says that he felt so a good when he heard about CBSG. "I feel so secure that CBSG is here to support my wife in any emergency. Sometime I would not be able to send money on time and now I feel that in that case my wife and my family could take money from CBSG. Now I do not have to worry about my family regarding money in any emergency".

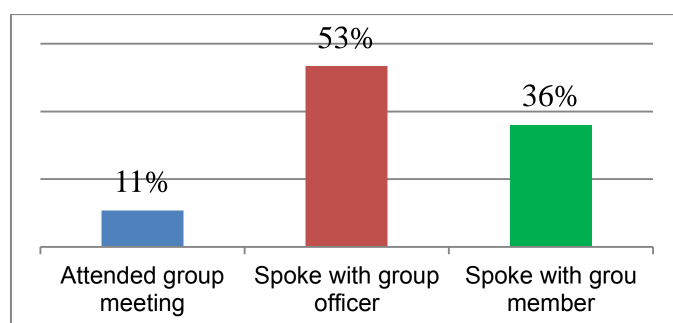
1.23Delivered lady, Ms. Sabiha.

Ms. Sabiha is not a member of any CBSG as she is newly married in this village. She is fully aware of the CMW and visited her for ANC on regular and paid Rs. 500 in total. For delivery, she was referred by CMW to a hospital in Mastuj. Her ANC and delivery expenses were paid by her husband. She said that she did not visit any service provider for PNC.

Annex D: Headline statistics from "Instrument 9 – Data collection form"

How were data collected?

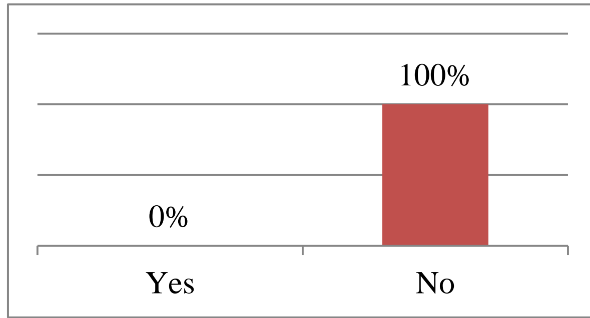
Responses	Freq	%
Attended group meeting	8	11%
Spoke with group officer	40	53%
Spoke with grou member	27	36%
Total	75	100%



Does this group have savings account in the group's name?

Responses	Freq	%
Yes	0	0%
No	75	100%

Total	75	100%

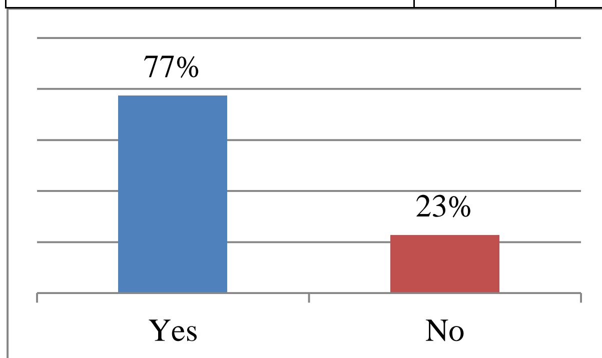


Name of Group	Village/valley	Group formed
Gul Bahar	Khuz	5-Mar-12
Benazir	Khuz	17-Jan-11
Education Welfare	Khuz	1-Dec-12
Islah	Khuz	10-Apr-10
Nigahat	Khuz	15-Jan-13
Shaheen	Khuz	4-Mar-10
Roshan	Khuz	12-Jan-11
Masha Allah	Khuz	25-Dec-12
Muskan	Khuz	15-Apr-10
Insaf	Khuz	12-Dec-12
Tholandeh	Raman	5-May-10
Aliabad	Raman	13-Sep-10
Saif brothers	Raman	30-Jun-12
Syed Saadat	Raman	21-Nov-12
shahri phorth	Raman	2-Jun-12
Rahimabad	Raman	6-Apr-12
Guchgal	Raman	7-May-10
Alkhidmat organization	Raman	25-Dec-12
Kochdur	Raman	9-May-10
Baghe Bustan	Raman	12-Aug-12
Muzhodur	Morder	15-Feb-12
Golook	Morder	20-Jan-11
Chashme bd dur	Morder	1-May-10
Mirzalandeh	Morder	17-May-12
Sada bahar	Morder	7-Apr-10
Chilesh	Morder	18-Oct-11
Khushal	Morder	2-Dec-10
Soni	Morder	10-Mar-10
Dilshadkham	Morder	25-Dec-11
Shamma	Morder	25-May-10
K-2	Bomborate	1-Mar-12
Muslimabad	Bomborate	23-Oct-12
Sarukjal	Bomborate	12-Apr-12
Dryanabad	Bomborate	10-Nov-11
Pehla qadam	Bomborate	28-Mar-11
Hamdard	Bomborate	18-Jun-11
Rishi	Bomborate	20-Jun-12
Superstar	Bomborate	22-Aug-10
Broon	Bomborate	17-Aug-10
K-2	Bomborate	17-May-10

Gulsamber	Gobore	25-May-12
Gulab	Gobore	20-May-10
Nurgis	Gobore	13-Jul-12
insaf society	Gobore	1-Jul-12
Uqab	Gobore	19-May-10
Bahar	Gobore	17-Mar-10
chambeli	Gobore	20-May-10
Shaheen	Gobore	19-May-10
Tufan	Gobore	18-Sep-10
Sahar	Gobore	25-May-10
Gulshan(Men)	Mori	27-Jul-12
Global	Mori	5-Dec-12
Parwaz	Mori	20-Jul-12
Middle	Mori	12-Jan-12
Parwana	Mori	27-Feb-12
behrawan	Mori	25-Mar-12
Pehchan	Mori	15-Nov-12
Mayun	Mori	5-May-10
Shotaar	Mori	22-Aug-10
Usan	Barum	10-Jun-12
Dawlasht	Barum	1-Jun-11
Barum	Barum	12-Aug-11
Aghyone	Barum	24-Jun-11
Dashmanandeh	Barum	25-Nov-12
Ishpemuli	Barum	20-Nov-12
Torpoht	Terich	10-Apr-12
Roy koth	Terich	13-Jul-12
Mushich	Terich	17-Jul-12
Inqilab	Terich	10-Nov-12
Bagh gole	Terich	10-Nov-12
Junali nichagh	Terich	12-Dec-12
Mulpoht	Terich	25-Jan-12
Simtich 1	Terich	15-Dec-12
Simtich 2	Terich	24-Nov-12
Gulshan	Terich	28-Jul-13

Have you shared out?

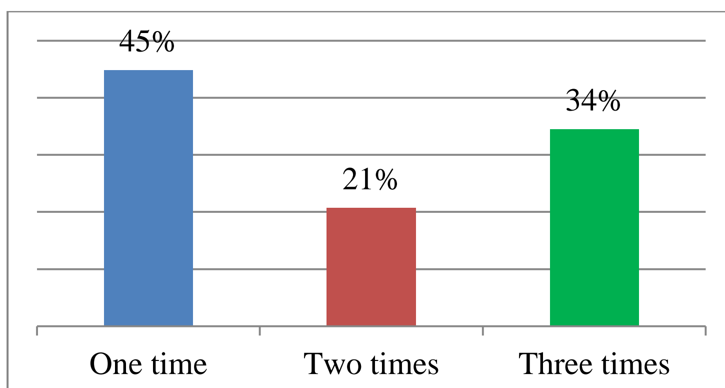
Responses	Freq	%
Yes	58	77%
No	17	23%
Total	75	100%



If yes (share out), how many times in all, since you first started saving?

Responses	Freq	%
One time	26	45%
Two times	12	21%
Three times	20	34%
Total	58	100%

Not applicable 17



Please tell me the total amount that the group shared out at the most recent share

out					
CBSGs	Minimum	Maximum	Mean	Std. Deviation	
58	1,380	96,010	19,784	20,732	
How many members did you have at the time of the most recent share out?					
CBSGs	Minimum	Maximum	Mean	Std. Deviation	
58	10	36	19.39	6.497	
How many members are there today?					
CBSGs	Minimum	Maximum	Mean	Std. Deviation	
75	0	40	19	8	
Note: The membership of Sehar, Gobore is zero and Insaf society, Gobore is 40 . The average could be different if exclude outliers					
Among the 75 groups only one CBSG was mixed (2 women and 14 men). The name of the CBSG is Education Welfare and it is in Khuz					
Thinking back to the most recent meeting, how many people were physically present					
CBSGs	Minimum	Maximum	Mean	Std. Deviation	
75	8	38	17.39	7.43	
And have any members left the group since the share out? How many?					
CBSGs	Minimum	Maximum	Mean	Std. Deviation	
59	0	20	1.46	3.88	

Comparison: Membership at the time of recent share out VS membership at the time of visit/data collection				
Name of Group	Village/valley	Membership at the time of most recent share out (A)	Membership at the time of the visit/data collection (B)	Change in membership (B-A)
Gul Bahar	Khuz	20	17	-3
Benazir	Khuz	15	12	-3
Islah	Khuz	30	30	0
Nigahat	Khuz	21	30	9
Shaheen	Khuz	20	20	0
Roshan	Khuz	23	25	2

Muskan	Khuz	17	22	5
Tholandeh	Raman	25	25	0
Aliabad	Raman	32	32	0
Saif brothers	Raman	36	36	0
shahri phorth	Raman	30	31	1
Rahimabad	Raman	30	30	0
Guchgal	Raman	24	35	11
Kochdur	Raman	21	21	0
Muzhodur	Morder	20	20	0
Golook	Morder	28	29	1
Chashme bd dur	Morder	15	10	-5
Mirzalandeh	Morder	17	15	-2
Sada bahar	Morder	15	17	2
Chilesh	Morder	34	34	0
Khushal	Morder	33	18	-15
Soni	Morder	25	21	-4
Dilshadkham	Morder	14	14	0
Shamma	Morder	21	25	4
K-2	Bomborate	17	17	0
Sarukjal	Bomborate	14	14	0
Dryanabad	Bomborate	12	12	0
Pehla qadam	Bomborate	18	16	-2
Hamdard	Bomborate	10	10	0
Rishi	Bomborate	14	14	0
Superstar	Bomborate	16	16	0
Broon	Bomborate	20	20	0
K-2	Bomborate	22	22	0
Gulsamber	Gobore	23	23	0
Gulab	Gobore	22	22	0
Uqab	Gobore	17	17	0
Bahar	Gobore	20	20	0
chambeli	Gobore	25	25	0
Shaheen	Gobore	30	30	0
Tufan	Gobore	15	15	0
Sahar	Gobore	20	0	-20
Gulshan(Men)	Mori	12	12	0
Global	Mori	16	16	0
Parwaz	Mori	15	15	0
Middle	Mori	14	14	0
Parwana	Mori	15	15	0
Behrawan	Mori	12	12	0
Mayun	Mori	15	15	0
Shotaar	Mori	12	12	0

Usan	Barum	18	18	0
Dawlasht	Barum	17	17	0
Barum	Barum	16	16	0
Aghyone	Barum	17	17	0
Torpoht	Terich	12	12	0
Roy koth	Terich	12	12	0
Mushich	Terich	12	12	0
mulpoht	Terich	12	16	4
Gulshan	Mori	12	12	0
Total		1,120	1,105	(15)
Average		19	19	0

Comparison: Membership at the time of formation VS membership at the time of recent data collection					
Name of Group	Village / valley	Group number	Membership at the time of formation (from MIS) (A)	Membership at the time of the visit/data collection (B)	Change in membership (B-A)
Gul Bahar	Khuz	2006	17	17	0
Benazir	Khuz	711	15	12	-3
Education Welfare	Khuz	2077	16	16	0
Islah	Khuz	704	20	30	10
Nigahat	Khuz	709	16	30	14
Shaheen	Khuz	602	20	20	0
Roshan	Khuz	708	18	25	7
Masha Allah	Khuz	2080	15	26	11
Muskan	Khuz	706	15	22	7
Insaf	Khuz	2079	21	29	8
Tholandeh	Raman	504	20	25	5
Aliabad	Raman	509	20	32	12
Saif brothers	Raman	2037	20	36	16
Syed Saadat	Raman	2055	30	25	-5
shahri phorth	Raman	2039	30	31	1
Rahimabad	Raman	2017	30	30	0
Guchgal	Raman	508	15	35	20
Alkhidmat organization	Raman	2072	37	37	0

Comparison: Membership at the time of formation VS membership at the time of recent data collection					
Name of Group	Village / valley	Group number	Membership at the time of formation (from MIS) (A)	Membership at the time of the visit/data collection (B)	Change in membership (B-A)
Kochdur	Raman	507	30	21	-9
Baghe Bustan	Raman	2044	31	30	-1
Muzhodur	Morder	23334	20	20	0
Golook	Morder	2318	27	29	2
Chashmebad dur	Morder	1002	15	10	-5
Mirzalandeh	Morder	2344	14	15	1
Sada bahar	Morder	1001	26	17	-9
Chilesh	Morder	2314	30	34	4
Khushal	Morder	1005	16	18	2
Soni	Morder	1004	Not found in MIS	21	21
Dilshadkham	Morder	2331	14	14	0
Shamma	Morder	1106	25	25	0
K-2	Bombo rate	1907	16	17	1
Muslimabad	Bombo rate	2735	13	12	-1
Sarukjal	Bombo rate	2710	14	14	0
Dryanabad	Bombo rate	1247	12	12	0
Pehla qadam	Bombo rate	1505	20	16	-4
Hamdard	Bombo rate	1506	12	10	-2
Rishi	Bombo rate	2711	25	14	-11
Superstar	Bombo rate	1503	16	16	0
Broon	Bombo rate	1502	16	20	4
K-2	Bombo rate	1501	22	22	0
Gulsamber	Gobore	1283	23	23	0
Gulab	Gobore	1405	36	22	-14

Comparison: Membership at the time of formation VS membership at the time of recent data collection					
Name of Group	Village / valley	Group number	Membership at the time of formation (from MIS) (A)	Membership at the time of the visit/data collection (B)	Change in membership (B-A)
Nurgis	Gobore	1282	24	24	0
Itifaq society	Gobore	1290	30	40	10
Uqab	Gobore	1302	17	17	0
Bahar	Gobore	1401	30	20	-10
Chambeli	Gobore	1303	22	25	3
Shaheen	Gobore	1301	20	30	10
Tufan	Gobore	1306	12	15	3
Sahar	Gobore	1305	20	0	-20
Gulshan(Men)	Mori	1287	12	12	0
Global	Mori	1294	16	16	0
Parwaz	Mori	1265	15	15	0
Middle	Mori	1275	14	14	0
Parwana	Mori	1267	15	15	0
Behrawan	Mori	1264	12	12	0
Pehchan	Mori	1305	20	12	-8
Mayun	Mori	1202	20	15	-5
Shotaar	Mori	1206	15	12	-3
Usan	Barum	2356	18	18	0
Dawlasht	Barum	2201	15	17	2
Barum	Barum	2329	16	16	0
Aghyone	Barum	2328	17	17	0
Dashmanandeh	Barum	2360	15	15	0
Ishpemuli	Barum	2361	25	25	0
Torpoht	Terich	1912	14	12	-2
Roy koth	Terich	2718	12	12	0
Mushich	Terich	2719	12	12	0
Inqilab	Terich	2720	15	15	0
Bagh gole	Terich	2721	12	12	0
Junali nichagh	Terich	2722	12	12	0
Mulpoht	Terich	1911	12	16	4
Simtich 1	Terich	2723	20	20	0
Simtich 2	Terich	2724	12	31	19
Gulshan	Mori	1273	12	12	0
Total			1,401	1,486	85
Average			19	20	1

Reason for leaving:

Reason for leaving the group since share out:

Responses	Freq	%
Moved	3	30%
Death	1	10%
Illness	0	0%
lost interest*	3	30%
Force out by group	0	0%
Other	3	30%
Total	10	100%

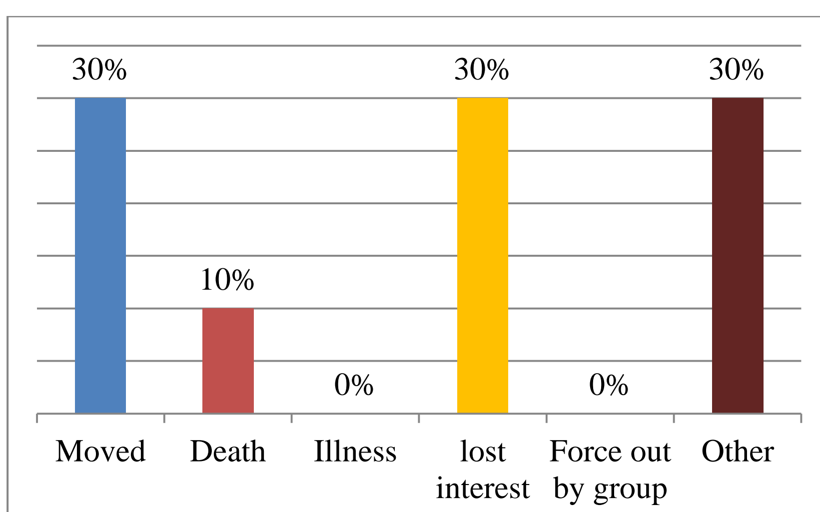
Not applicable 65

Others:

* 3 members left one group because the group did not allow to take service charge on loan and they joined another CBSG where service charge is being taken

In the beginning the group comprised of 33 members, after first share out the members divided into two groups

After second share-out members decided to give membership to one member from each households because they could not easily manage large group size but they decided to increase share value from 10-20 rupees



Annex XX: CCSP Package for Replication and Lessons Learned

The package From CCSP for Replication

- **a. Steering /Advisory committee** comprised of representatives of DoH KPK and AKDN (AKF-P, AKHSP, and AKRSP) proved to be instrumental in providing the oversight and technical inputs in the implementation of the project.
- b. **Village Health Committees** formed and comprised of equal number of men and women, particularly gate-keepers. Roles are to participate is selection of CMW candidates, introduce the CMW in the community and also help in all stages of her deployment, providing some supervision and helping her to build rapport within the catchment population**.** VHCs are responsible for organizing an emergency transportation system and promoting good maternal newborn health practices.
- c. **Behavior Change Strategy based on Formative Research** to raise awareness of maternal, newborn, and child health, to promote appropriate MNCH practices including use of CMW services, and positively change social norms to benefit the health or women and children. The BC strategy is gender specific and uses multiple channels to reach opinion leaders, family decision-makers and women.
- d. **Formation of CBSGs** as a means of enabling women to have savings for MCHN services, to empower women to manage money and make decisions, to serve as a platform for social development and for learning about MCHN.
- e. **Selection, training and deployment of CMWs** who were local women, trained according to the national program guidelines and deployed back in their respective communities with support to equip birth stations**.** They receive on-going periodic training which should include business skills.
- **f. Referral system** within the community from other community health workers to CMWs for delivery; and then cases which are complicated and the CMWs are not able to handle are referred to higher level of facilities with EmOC**.**
- **g. Supervision and monitoring** of the CMWs by the LHVs and the LHSs for competency, logistics, administrative tasks, MIS, quality of care etc.

Lessons Learned and Learning for Replication/Scale up of CCSP Model

1. Networking through grassroots level among service providers and local health teams proved to facilitate communication among them, minimize competition, and lead to collaboration and referrals.
2. CBSGs are powerful interventions and therefore should be replicated mainly around empowerment, social mobilization, BCC and access to social funds.
   - a. CBSGs are not able to protect ultra-poor and other marginalized population,
   - b. There should be an alternate mechanism to include the ultra-poor as they are unable to be part of the CBSG due to lack of money for savings. The program should have another strategy for the ultra-poor, to access loans, and to benefit from social mobilization and BCC.
   - c. CBSGs should not be limited to women of reproductive age. Results show that having any family member, such as a mother o mother-in-law, had a positive impact on seeing continuum of care for maternal and newborn health.
3. Community led program - their views are important that is how the program will be successful and program will be owned (VHCs).

a. Strong involvement of community gatekeepers
b. VHC should be further strengthened to participate/have role in CMWs, transport and HF management

4 CMW is a full package, with timely referral mechanism and continuum of care.
   a. Carefully selected CMWs and provide quality training—extra six months practicum with close supervision is important
   b. CMWs have a work station and also are mobile in the community
   c. Need to have post training and continuous support to assure CMW skills.
   d. Well thought out CMW sustainability strategy should be in place
5 Clear framework of working relationship with AKDN agencies and government departments and communities.
   a. Continuous advocacy with MOH on Replicable Package
   b. Ownership of program with government counterpart at all stages
   c. Advocate for recruitment of CMWs where they are not working,
   d. Take up the point of success stories and get support.
   e. Clarification of terms of engagement with district and provincial health department
   f. Dissemination and sharing with partners and other peer organization
6 Social mobilization with religious leaders and community leaders to penetrate traditional areas.
7 Framework of evaluations to make adjustments to overcome barriers, and flexibility of the program.
   a. Strengthened regular M&E system and mechanisms should be in place
   b. Data Analysis for Decision Making (DAD) and learning
8 Continuous refresher courses for CMWs, VHC members and CBSGs.
   a. Build business skills of CMWs
   b. Build BCC and supervision skills of VHC members.
9 Community Voice and Accountability mechanisms along with system of redressing complaints would be useful.