Mid-Term Evaluation of the National Maternal and Child Health Programme in Pakistan

Findings and Recommendations
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Acknowledgements

Review Team Acknowledgements
The evaluation team acknowledges the Planning & Development Division / Planning Commission, Provincial and District Health Departments, Maternal Newborn and Child Health Programme teams, Community Midwives, Lady Health Workers, Lady Health Supervisors and the Community. The team would like to acknowledge the Technical input of Dr. Raza Zaidi, Health and population Advisor from DFID, Dr. Qaiser Pasha, Senior Health Advisor from AusAID and Ms. Pamela Sequeira, from TRF. Your patience, understanding and feedback were appreciated and have shaped this document.

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Islamabad
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<th>Full Form</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AJK</td>
<td>Azad Jammu Kashmir</td>
</tr>
<tr>
<td>AKU</td>
<td>Aga Khan University</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Aid Agency</td>
</tr>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>BHU</td>
<td>Basic Health Unit</td>
</tr>
<tr>
<td>CCI</td>
<td>Council of Common Interest</td>
</tr>
<tr>
<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>CMW</td>
<td>Community Midwife</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>DAC</td>
<td>Development Assistance Committee</td>
</tr>
<tr>
<td>DDOH</td>
<td>District Department of Health</td>
</tr>
<tr>
<td>DG-Health</td>
<td>Director General Health</td>
</tr>
<tr>
<td>DHQ</td>
<td>District Headquarter Hospital</td>
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<tr>
<td>DHIS</td>
<td>District Health Information System</td>
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<tr>
<td>DHS</td>
<td>Department of Health Services</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DfID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>EAD</td>
<td>Economic Affairs Division</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
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<tr>
<td>ENC</td>
<td>Essential Newborn Care</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunisation</td>
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<tr>
<td>ET</td>
<td>Evaluation Team</td>
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<tr>
<td>FATA</td>
<td>Federally Administered Tribal Areas</td>
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<td>FANA</td>
<td>Federally Administered Northern Areas</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GB</td>
<td>Gilgit Baltistan</td>
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<td>GOP</td>
<td>Government of Pakistan</td>
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<td>GRD</td>
<td>Government Rural Dispensaries</td>
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<td>HFA</td>
<td>Health Facility Assessment</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population &amp; Development</td>
</tr>
<tr>
<td>IDI</td>
<td>In Depth Interviews</td>
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<tr>
<td>IHP</td>
<td>International Health Partnership</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>IMNCCI</td>
<td>Integrated Management of Newborn and Child Health Illness</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
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<td>LWHP</td>
<td>Lady Health Worker Programme</td>
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<tr>
<td>LHWP-MIS</td>
<td>Lady Health Worker – Management Information System</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NFC</td>
<td>National Finance Commission</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal Newborn Health</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
</tr>
<tr>
<td>NMNCH</td>
<td>National Maternal, Newborn and Child Health Programme</td>
</tr>
<tr>
<td>NNP</td>
<td>National Nutrition Programme</td>
</tr>
<tr>
<td>NP-FP&amp;PHC</td>
<td>National Programme for Family Planning and Primary Health Care</td>
</tr>
<tr>
<td>NPPI</td>
<td>Norway Pakistan Partnership Initiative</td>
</tr>
<tr>
<td>NWFP</td>
<td>North West Frontier Province</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
</tr>
<tr>
<td>OPD</td>
<td>Outpatients Department</td>
</tr>
<tr>
<td>PAIMAN</td>
<td>Pakistan Initiative for Mothers and Newborns</td>
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<tr>
<td>PC-1</td>
<td>Planning Commission Performa 1</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PHD</td>
<td>Provincial Health Department</td>
</tr>
<tr>
<td>PKR</td>
<td>Pakistan Rupee</td>
</tr>
<tr>
<td>PMRC</td>
<td>Pakistan Medical Research Council</td>
</tr>
<tr>
<td>PNC</td>
<td>Pakistan Nursing Council</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>PDHS</td>
<td>Pakistan Demographic and Health Survey</td>
</tr>
<tr>
<td>PPHI</td>
<td>People’s Primary Health Care Imitative</td>
</tr>
<tr>
<td>PRS</td>
<td>Poverty Reduction Strategy</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>PRISM</td>
<td>Promoting Initiatives for Safe Motherhood</td>
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<tr>
<td>PSLM</td>
<td>Pakistan Social and Living Standards Measurement Survey</td>
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<tr>
<td>PWD</td>
<td>Population Welfare Department</td>
</tr>
<tr>
<td>RAF</td>
<td>Research and Advocacy Fund</td>
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<tr>
<td>RHC</td>
<td>Rural Health Centre</td>
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<tr>
<td>RBM</td>
<td>Results Based Management</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Groups</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>THQ</td>
<td>Tehsil Headquarter</td>
</tr>
<tr>
<td>ToRs</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>TRF</td>
<td>Technical Resource Facility</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development/Pakistan</td>
</tr>
<tr>
<td>WMO</td>
<td>Women Medical Officers</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
General Definitions

Functional Health Facilities
A functional Health facility refers to the level of infrastructure, human resources, equipment, drugs and supplies to support a health service.

Functioning Emergency Obstetric and Newborn Care (EmONC) Facilities
According to the United Nations (UN) standards and the international standards referred to in the PC-1, a Basic Emergency and Obstetric Newborn Care (BEmONC) facility is functioning if it has provided all the basic interventions in Definitions 1-1 in the three months prior to the assessment. A Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facility is functioning if it has provided all the basic and comprehensive interventions in the three months prior to the assessment.

### Definitions 1-1: Signal Functions for Basic and Comprehensive EmONC Facilities

<table>
<thead>
<tr>
<th>Basic EmONC services</th>
<th>Comprehensive EmONC services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administer parenteral antibiotics</td>
<td>Perform signal functions 1-7, plus:</td>
</tr>
<tr>
<td>2. Administer uterotonic drugs (parenteral oxytocin, parenteral ergometrine, misoprostol)</td>
<td>1. Perform surgery (caesarean section)</td>
</tr>
<tr>
<td>3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia (magnesium sulphate, diazepam)</td>
<td>2. Perform blood transfusion</td>
</tr>
<tr>
<td>4. Perform manual removal of placenta</td>
<td></td>
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<tr>
<td>5. Perform removal of retained products (MVA, misoprostol, dilatation and curettage)</td>
<td></td>
</tr>
<tr>
<td>6. Perform assisted vaginal delivery (vacuum extractor, forceps)</td>
<td></td>
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<tr>
<td>7. Perform neonatal resuscitation (with bag and mask)</td>
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</tr>
</tbody>
</table>

A Basic EmONC facility is one that performs all functions 1-7.
A Comprehensive EmONC facility is one that performs all functions 1-9

** Parenteral administration of drugs means by injection or intravenous infusion.

Skilled Birth Attendant
The PC-1 defines a Skilled Birth Attendant (SBA) as a professionally trained health worker with the skills necessary to manage a normal delivery and diagnose and refer

---

1 Adapted from The Indicators for Monitoring the Availability and Use of Obstetric Services: A Handbook UNICEF, UNFPA, WHO, 1997 p 26 [5]
obstetric complications. They are trained in accredited institutions and are examined and licensed under a recognised national regulatory authority. A SBA must be able to manage labour and delivery, recognise complications early on and perform any essential interventions, start treatment and supervise the referral of mother and baby to the next level of care if necessary. The Community Midwives (CMW) are specially trained SBAs who are equipped to conduct a normal home delivery under safe and clean conditions.

**Functional Integration**
The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.

It is a programmatic reform instituted in an environment where universal maternal and child health services are carried out separately by different ministries and/or Programmes — services are integrated and jointly delivered without embarking on any significant structural adjustment or allowing existing management systems to disrupt this essential undertaking.

**Alignment, Harmonisation and Streamlining**
The term ‘alignment’ is sometimes confused with ‘harmonisation’ and ‘streamlining’. They are related but not synonymous.

**Alignment**
Broadly speaking, MCH strategy alignment refers to the fit of donor and other stakeholder policies, procedures and practices with national strategies, institutions and processes.

**Harmonisation**
Harmonisation, in contrast, refers to the unification of donor procedures and practices between donors in constituting a common approach.

**Streamlining**
Streamlining is a subset of harmonisation, and refers to the simplification and reduction in the number of donor procedures, indicators, missions etc. These distinctions serve to highlight that harmonisation and simplification could proceed without alignment.
Executive Summary

• This report presents the findings of an Independent Evaluation of the Government of Pakistan’s National Maternal, Newborn and Child Health (MNCH) Programme. The period covered by the evaluation in 2006/7-2010/2011. The Programme is in its fifth year and should be completed in June 2012; however limited federal government funding will be available until 2014.

• The MNCH Programme was designed to achieve MDGs 4 and 5 by “filling gaps” in the health system – primarily through emergency obstetric and newborn services and the development of a new cadre of community midwife, operating at the community level. The Programme has a strong focus on capacity building and institutional strengthening to support district management and targeting the poor.

• This report has 5 main sections. After the introduction and background Section 3 includes an evaluation of the design and implementation and overall management of the Programme. Section 4 provides a Value for Money Analyses (VfM). Section 5 reviews the impact of the current devolution scenario on the MNCH Programme. Section 6 summarises the findings against DAC criteria while the final section provides an overall assessment and recommendations.

CONTEXT AND LIMITATIONS

• Since commencing five years ago, the context in which the Programme is being implemented has been slowly changing. Under the 18th Constitutional Amendment of the GOP, the constitutional responsibility for the delivery of health services was devolved to the provincial departments of health and lower levels of the health system on the 1st July 2011. This has resulted in uncertainty regarding Programme implementation, delivery and strategic directions for MCH at national and sub-national levels. It is against this changing context, its challenges, funding constraints and a maternal, newborn and child mortality and morbidity that the MNCH Programme is being implemented.

Limitations

• Limitations included and discussed further in this report included include:
  - Lack of relevant baseline i.e. data such as complications of pregnancy, which is used internationally to monitor Emergency Obstetric and Newborn Care (EmONC), is available but not regularly collected or monitored even though the PC-1 defines³ the use of these indicator as a baseline.
  - In the absence of a strong baseline and EmONC indicators, data related to EmONC signal functions were extracted from a Health Facility Assessment (HFA), to assess the functioning of facilities which was conducted in 2010. This

³ Refer to Page 99 PC-1 National Maternal and Child Health Programme 2006-2012
is indicative only, as the process used to review the signal functions did not comply with international standards or best practice.\(^4\)

- The Federal MNCH cell closed in June 2011, following devolution. Access to management, administration and planning documents were not available to inform an understanding of how the Programme has been implemented.

- There are multiple partners and MNCH projects operating at all levels, implementing a broad range of MCH interventions with no central coordinating mechanism. Thus, attribution of individual achievements, lost opportunities, or value addition is difficult to determine.

- Catchment populations to calculate service coverage were neither used nor known in either District Departments of Health (DDOH) and health facilities visited. Without population denominators, it is hard to assess if services delivered were high or low in relation to each health facility, since catchment populations vary considerably.

- Unlike random sample surveys, case studies are not representative of entire populations, nor do they claim to be. However the multiple case study approach is an attempt to match results and strengthen findings.

### REVIEW FINDINGS

**Relevance of Design and Formulation**

- The design and formulation of the MNCH Programme is highly relevant in a context where maternal, newborn and child mortality is one of the highest in the region and where government policies, plans and strategies are focused on addressing the problems and the inequities between the rich and the poor.

- The Programme aligns with the MCH Policy and Strategic Framework which provides overall direction for the Programme. It is also relevant to the GoP Poverty Reduction Strategy (PRS), which is the foremost and most detailed policy paper of the government.

- Community-level review and national data and research\(^5\) confirms that the MNCH Programme is relevant to the realities of the main beneficiaries, who are women of reproductive age, newborns, and their children, especially the poorest and most marginalised. However because of trust issues the role of the CMW has not been fully accepted by the community – this will take time and effort to address.

- Case study analysis confirms that the Programme is valued by the district managers and facility staff; particularly in the context of limited resources. However, lack of funds and capacity building has hampered support to districts, the focal point for strengthening MNCH services.

- In the absence of a coordinating mechanism donors have designed projects based on their own country’s priorities for attainment of MDG 4 and 5. These projects align with government policy and plans but not always with government systems.

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\(^4\) This requires reviewing hospital records for the six months prior to an assessment and using a more comprehensive data set.

(e.g. GoP budget and assessment processes). As a result there are overlaps and duplication of interventions and in some cases donor projects have evolved as parallel projects to the health system. The overlap is discussed further in the MNCH Review document.

- Technically, the Programme adequately enables a reduction of maternal, newborn and child mortality, but the capacity needed to implement a highly ambitious Programme has been underestimated. In the absence of strong leadership, Provinces had problems taking the design forward on their own accord.

- Furthermore the broad scope of the Programme, changes in the design, inherent turf battle between Provincial Health Departments and Departments of Population Welfare, lack of incentives for staff, verticality of Programmes with little integration, bottle necks in funding, duplication of efforts, poor donor coordination and political interference has further weakened the intent of the original design.

- Thus; while highly relevant to the context; issues such as lack of leadership, poor planning and management, limited coordination between donors and other stakeholders and constant design changes has eroded the relevance of the Programme.

Programme Achievements and Outcome

- While it is too soon to detect changes in the overall objectives of the Programme, there have been positive gains in selected MCH indicators such as antenatal, post-natal and skilled birth attendance. What contribution the Programme has made to these changes is difficult to determine, as reporting systems are still being established. In time, the evidence for such changes should strengthen.

- The Programme is unlikely to achieve the outcome of reaching the “poor and marginalised” in its current form. Inputs have focused more on the secondary rather than primary health care level. Although progressing well, the coverage of upgraded facilities falls short of international standards referred to in the PC-1. There is a shortfall of at least 123 CEmONC facilities and 790 BEmONC at the primary health care level where the poor and marginalised live and work.

Programme Outputs

- In summary the Programme has made substantial progress toward the upgrade of facilities and the development of a new cadre of midwife. Management structures have not been strengthened as was envisaged in the PC-1 and the Programme has failed in achieving outputs supporting Component 3, the provision of Comprehensive Family Planning Services, and Component 4, Communication for MNCH Care.

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6 There was criticism of donors during the evaluation and review. For example; feedback was that the PAIMAN project was parallel to the system. On the other hand DFID has worked through government. However it is difficult to understand how support could be provided to a programme that has no baseline and “gap filling” is focussed more on infrastructure and human resources with little consideration of prioritising needs according to where women and children are dying and what they are dying of.

7 Refer to Page 99 of the PC-1 under monitoring and evaluation
Component 1: Integrated delivery of MNCH services at district level

- Upgrade of facilities at three levels of service delivery has been impressive. 88% of facilities targeted for upgrade to provide Basic or Comprehensive EmONC have been completed. A further 71% of targeted BHUs have been upgraded to provide MNCH services. The following areas need to be addressed: poor coverage and quality of services, gaps in services, integration and health systems strengthening.

Component 2: Training and deployment of a community midwives.

- Steady progress is being made towards the introduction of a cadre of community midwives. 45% of the targeted 12,000 midwives have been recruited and trained, with another 30% enrolled for training. Nursing schools have been upgraded to support training. 68 of these have been approved by the Pakistan Nursing Council (PNC). Ongoing challenges include: deployment, support, acceptance by the community, linkages with the LHW and more.


- Few interventions have been undertaken to improve the FP services at health facilities. There is neither IEC/BCC material related to the promotion and choice for family planning services at the DHQs and RHCs, or contraceptive supplies available at government administered public health facilities, whereas the PPHI run BHUs have the contraceptive supplies on a more regular basis. The Department of population welfare was to provide contraceptives to MNCH Programme. There was no formal agreement/or MoU signed between MNCH Programme and Population Welfare Department which could validate this commitment on ground.

Component 4: Strategic Communication and MNCH Care:

- The PC-1 identified advocacy and demand creation as a key implementation strategy. The focus is on improving health service utilisation and safe childbearing and child rearing practices. LHWs and CMWs were to undertake these activities, as well as a limited use of social mobilisers. A well laid out communication mobilisation strategy was developed, but has not been achieved, because of bottlenecks in funding.

Component 5: Strengthening Programme Management

- The Federal MNCH cell closed in June 2011, following devolution to provinces. Access to information about the overall management and oversight of policy committees such as steering committees at the federal level and technical coordination at a national level was limited. Feedback from the field was that oversight committees did not provide strategic guidance. Federal and Provincial Steering Committees were operational to some extent but the Provincial MNCH Coordinating Committees and technical coordination committees never took off.

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8 Annual Review Monitoring Data updated by the evaluation see Annex 8.13
9 Data collected from Provincial Records through feedback and Pakistan Nursing Council data during the evaluation.
District Health and Management Committees are operational in some districts but they are not MNCH specific.

- Recording and reporting tools were available and maintained in evaluated facilities. However, recording of obstetric complications or the treatment provided was deficient, with the exception of Caesarean section. Such reporting should have contributed to the baseline of this Programme. No such baseline was developed – therefore how the Programme has strengthened EmONC services and targeted the poor is difficult to determine.

- Feedback from provinces is that Programme Management Units are fully functional in 134 districts. However most provinces reported a shortage of staff in District Management Units.

**Effectiveness and Efficiency**

- It is too early to assess the effectiveness of specific interventions supported by the Programme, as there are extensive time lags in changes in the maternal mortality ratio, infant mortality rate, fertility rate, and other international comparable indicators which are not in place\(^\text{10}\). However inefficiencies caused by bottlenecks in funding, lack of leadership at a federal level, poor coverage of services, overlapping programmatic roles and failure to bridge service delivery gaps which target the beneficiaries of the programme have undermined the efficiency and effectiveness and overall relevance of the programme.

**Management**

- The MNCH Programme was not implemented as per the design (i.e. under the direction of the Director General Health). Instead; the federal MNCH cell became the implementer through the provincial Management Units and district management units, bypassing the provincial Departments of Health and operating as a vertical Programme. In addition, there was limited ownership of the provincial Departments of Health towards the Programme. The verticality also caused limited coordination and collaboration with other mainstream and vertical Programmes – thus the vision of integration was compromised.

- Throughout the Evaluation and Review this lack of coordination and integration was reflected in certain aspects of the Programme: ranging from non-availability/retention of staff, necessary equipment, essential medicine, poor coordination and linkages with other Programmes, retention and tracking of trained non-deployed CMWs and poor monitoring and supervision etc.

**Value for Money Analyses**

- A Value for Money analyses found that:
  - Budget allocations were less than envisaged in the PC-1.\(^\text{11}\) Since the Programme has only released 37% of committed funds but has provided

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\(^{10}\) Refer to page 99 of the PC-1

\(^{11}\) Feedback was that because of this the programme focused on component 1 and 2 and as a result other components which were to complement the program lost attention.
training to about half the CMW trainees, and upgraded more than 75% of targeted facilities it could be said these interventions are relatively successful.

- Allocation of funds to the provinces has contributed to an equalizing effect, improving the equity of the system. However there is insufficient evidence that these resources are being used to deliver the right services.
- The cost of caesarean section is being delivered at a comparative price to similar countries suggesting the Programme is financially efficient.
- A further study will be required to investigate this more.

- The findings of the VfM are inconclusive and it is too early to assess the Programme’s internal and external efficiency.

Sustainability

- The MNCH Programme is not sustainable in its current form. There is a strong focus on infrastructure and human resources with little targeting or prioritising needs according to where and why women and children are dying then; filling gaps to support these needs. If over time the programme is reorientated to be more responsive and issues raised in this report are addressed the sustainability of the programme would be strengthened.

- Sustainability will also depend on the availability of resources, institutional capacity and linkages with other Programmes; particularly links to the Lady Health Worker Programme. The availability of financial resources depends largely on the government’s commitment to MNCH, and the continued support of development partners.

- While such commitment is there, public sector financing is likely to remain constrained until the current fiscal challenges are fully addressed. A key determining factor will be the future of planning, to support implementation of MNCH in the provinces in the post 18th Amendment scenario.

- Provincial health sector strategies will be the driver pushing for adequate allocations for the health sectors, particularly the delivery of MNCH services. Specific to MNCH, the scope of MNCH services could be significantly expanded if provinces adopt a single operational MNCH plan, integrated into the government system.

Reaching the Poor and Marginalised

- Targeting the poor and marginalised is enshrined in the MNCH Programme mandate. Poor planning has led to poor results in this area – this is reiterated throughout the report and needs to be addressed.

OVERALL ASSESSMENT

- Despite alignment with Government Policies, Plans and Strategies, the MNCH Programme is yet to be translated into an effective MNCH Programme. In its current form the Programme is rated partly successful (Annex 7). It is partly relevant, ineffective, inefficient, and unlikely to be sustained. The relevance of the programme has been eroded by poor planning, lack of leadership, poor
management. It has performed poorly in Component 3, the provision of Comprehensive Family Planning Services and Component 4, Communication for MNCH Care.

- Unless changed significantly it will fail to translate into a Programme which can significantly accelerate progress towards the achievement of MDG 4 and MDG 5. The current Post 18th Amendment Scenario provides an opportunity to make the much needed changes.

EXAMPLES OF LESSONS

- A well thought out conceptual design is central to the success of any Programme.
- A baseline which focuses on the needs of the beneficiaries is required to plan and implement a Programme which targets the poor and marginalised. This should have been done prior to the programme.
- Inconsistencies between different versions of a design results in confusion and slows the pace of Programme implementation.
- Without sustained stewardship, leadership and good management the relevance, efficiency and effectiveness of a programme/project is undermined.
- Institutional capacity is a vital ingredient in translating the MNCH Programme into effective services.
- Functional integration has the comparative advantage of delivering MCH essential services packages, under the same roof and improving the scope and the quality of performance of the health workforce.

KEY RECOMMENDATIONS

Policy and Planning

- Provincial Health Sector strategies should guide MNCH and address gaps in the Strategic Framework through a succinct log-frame including: (i) access to quality EmONC and referral services; (ii) unified policy on child health through an integrated Programme; (iii) behaviour change interventions for reducing population growth and safer sex and; (iv) interventions to address nutritional deficiencies;
- Future plans should be (a) based needs of beneficiaries; (b) include strategic areas of intervention that are cost-effective and prioritised; (c) encourage partnerships between the public and private sector, that have been shown to work; (d) support a multisectoral approach and functional integration; and (d) include indicators which regularly measure progress towards of reduction of MCH mortality and morbidity.\(^\text{12}\)
- The current MNCH Programme should be integrated into provincial health sector strategies under the direction of the DG – Health, and be phased out by the end of the Programme (after final funds are transferred).
- Engage in federal - provincial level advocacy activities with key stakeholders, as they examine the findings of the Review of the MCH Strategic Framework and

\[^{12}\text{The approach based on UN indicators outlined in the PC-1; p. 99 is such an approach}\]
Evaluation of the MNCH Programme. Review implications for the economic and health challenges that lie ahead and endorse sound MCH related health policies.

- To assist in making strategic decisions and as per the PC-1, monitor international comparable indicators such as the UN process EmONC indicators.

Intuitional Mechanisms
- The institutional framework under which the MNCH Programme is being implemented should be strengthened. It is unlikely major restructuring will be undertaken in the near future, as it will take time for provinces to adapt to their new found responsibilities. Nonetheless consider institutional strengthening. Linkages to be strengthened are outlined in this report.

Essential Health Services Package at Facility and Community Levels
- Prioritise funding around a package of essential MNCH interventions with a strong focus on the district level and below. Only support simple highly cost-effective packages which have been show to save lives of mothers, babies, and children.
- To support the package there should be a strong focus on strengthening linkages between the community and first level of referral, functional integration of the roles of LHW and CMW and targeting the poorest and marginalised.
- Undertake a rapid mapping of all Population Welfare, Department of Health (DoH) and private service outlets to develop an Emergency and Obstetric Newborn Care coverage plan, which includes public and private facilities and BHUS. This could be done as part of an EmONC needs assessment; or simply through a series of workshops in provinces.
- The contractual terms of the nationwide outsourced and vertically managed BHUs—through the People’s Primary Health Care Initiative (PPHI)—need to be revisited, to formally guarantee comprehensive delivery of MNCH services, both at the facility and community levels. In addition, 24/7 EmONC or obstetric First Aid should be available in selected BHUs, to ensure coverage of services according to international or comparable standards – this could be achieved through “task shifting”; i.e. expanding the role of a front line workers where access and resources are a problem.  

Linkages with LHW, CMW and Referral
- A district control room be operationalised 24/7 to monitor and fill in gaps where required and communities be mobilised to share fuel cost for referrals.
- Improve LHW skills in ANC, FP and child health, while working as a team with CMW, who is competent enough to conduct safe delivery and make timely referral to BUH and/or RHC, through well connected operational ambulance system.
- Institutionalise the role of the CMW into the first level of referral in the catchment area where she is working, by reinforcing referral to the closest facility in her area

13 PNC and UNFPA have already trialled tasking shifting with the role of the LHW
and providing clinical support and training by the same facility on a rotation basis. Preferably this should be in partnership with the LHW in the same community.

- Strengthen the working relationship between LHWs and CMWs through regular supervision and support by the LHS. Ensure a uniform policy is in place to support this supervision and role of the LHS. Where required, provide capacity building support for the LHS.
- Ensure the policy for providing monetary incentives to CMW is fully operationalised and implemented uniformly across the country.

**Deployment, Nursing Council and Quality**
- Deployment guidelines being used to deploy CMWs should be finalised in line with the PC-1, and CMWs deployed in a timely manner in order to retain their skills and knowledge, which can be compromised by long delays in deployment.
- A uniform CMW retention policy needs to be approved by the appropriate body and implemented so there is uniformity in deployment and retention across provinces and regions as per the PC-1.
- Provide capacity building of PNC, to support standardised examinations and develop additional resources to support the development and maintenance of examination boards, and review of Nursing Schools training CMWs.
- Ensure competency, clinical and service standards are in place and are implemented and monitored.\(^{14}\)

**Integration and Linkages with Population Welfare**
- Ensure commitments around discussions made at federal level (pre devolution) are followed through and the health system is strengthened to address challenges facing implementation of an integrated MNCH Programme. These include: inter-ministerial coordination, provincial and district level management, commodity pricing, contraceptives, vaccines and essential medicines supply chain, human resource training and motivation, services provided by frontline workers, and expanding the promotion and advocacy and network for MCH services

**Public Private Partnerships for Services and Community Mobilisation**
- That various options for strengthening organisational and management systems, outlined in the PC-1 be tested and implemented where successful, e.g. contracting out, contracting in technical assistance, community management and franchising model, private sector provision of MNCH services and performance based incentives for district and health care providers.
- To match demand with supply, community mobilisation should have been undertaken early in the Programme. There is a need to start implementing the communication strategy, which outlines who does what and why.

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\(^{14}\) Most standards are in place but are not being implemented or monitored
Capacity Building

- DDOH staff should acquire further competence in performance monitoring, and be provided with technical support to become competent managers. DDOH managers and administrators should be rewarded for their success, first in completing their training and subsequently for performance in public health indicators, thus encouraging them to get good results from service providers.

- Provinces should now develop basic training and continued support packages for district and facility level staff, and ensure these are rolled out across the MCH network.

- Upscale the rotation of post graduate trainees from tertiary to district hospitals and institutionalise this best practice into the health system. Coordination for this would be the responsibility of the provincial health department. In time this will lead to health system strengthening.

Donor Harmonisation

- The GoP needs to proactively harmonise donor activities and harness incoming finances. This can be done by developing clear policy guidelines, whereby donor support and loans are governed by a common agenda. Financial inputs from donors should be considered a long term investment in strategic MCH areas, and must not be used to complement public financing of health services.

- Donors should re-strategise the way they fund provinces, to ensure a district focus as proposed in the PC-1.

- External donor partners should consider performance based financing for delivering an essential health care package of MCH services at the first level of referral and below. In other words, the greater the performance orientation of the PHC network, the more attractive it will be for donors, particularly large donors supporting the principles of Results based Aid (RBA).
1 INTRODUCTION AND BACKGROUND

This document presents the findings of a mid-term evaluation of the Pakistan National Maternal and Child Health (MNCH) Programme. The evaluation was undertaken by a team of independent consultants between October 2011 and June 2012. The consultants were subcontracted by HLSP / Technical Resource Facility (TRF) at the request of the Government of Pakistan (GOP). The period covered by the evaluation in 2006/7-2010/2011. Terms of Reference (TOR) are Annex 1

1.1 Purpose and Objectives of the Evaluation

The purpose of the evaluation was to:

1. Assess the achievements of the National MNCH Programme and the factors that have facilitated or hampered achievements
2. Compile lessons learned and recommendations that will inform the future direction of the MNCH Programme across Pakistan.

The main objective was to evaluate progress against Development Assistance Criteria (DAC) in achieving the Programme objectives, at a component level and provide recommendations at programmatic levels. The specific objectives were:

- To evaluate if the overall National MNCH Programme is aligned to the Maternal and Child Health (MCH) strategic framework (2005-2015)
- To track progress towards achieving planned objectives as per the Planning Commission Performa (PC-1)
- To evaluate if the Programme has been able to meet its specific targets including integration and linkages with other Programmes a) upwards in line with the MCH Strategic Framework and b) downwards at Programme implementation levels
- To analyse the management and governance mechanisms put in place for the implementation of the MNCH Programme at federal, provincial and district levels and identify gaps and challenges
- To assess the value for money of the MNCH Programme and its components and Review the unit costs in the PC-1
- To assess the overall changes in institutional framework and its challenges for the MNCH Programme, such as the post 18th amendment National Finance Commission (NFC) scenario, in the context of transferring of federal health Programmes to the provinces and its implications for the MNCH Programme.

To deliver these objectives, the key outputs of the evaluation were the:

- Contribution of the MNCH Programme in line with the MCH Strategic Framework (2005-2015)

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15 TRF was established by the UK’s Department for International Development (DfID) and the Australian Aid Agency AusAID. The TRF is a five year project managed by the firm HLSP, in partnership with John Snow Inc. (JSI) and Semiotics. The TRF is mandated to support improvements in policy, strategies and systems and help build the capacity of government functionaries at federal, provincial and district levels by providing strategic technical assistance.
• Overall Programme achievements in progress in improving MNCH/FP services at the facility and community levels
• Provincial specific achievement, highlighting differences/similarities across provinces in implementation of the MNCH Programme objectives
• Analysis of the organisational and management structure at all levels, for the effectiveness in meeting Programme objectives
• Value for money and cost analysis
• Lessons learnt for provincial departments and districts
• Recommendations on the implementation of the MNCH Programme
• Dissemination workshop on lessons learnt and recommendations

1.2 Approach and Methodology
The evaluation was undertaken in parallel with a review of the MCH Strategic Framework. To ensure comparability the methodology included:

1. A review of relevant literature including Programme and project documents, and annual reviews See Annex 2 for documents reviewed.
2. Interviews with key stakeholders and beneficiaries to gather information relating to the implementation of the National MNCH Programme at all levels of service delivery. See Annex 3 for a list of people consulted.
3. To gain a sharpened understanding of the context and activities being implemented by the MNCH Programme, case studies were undertaken in 3 districts of 3 provinces. Annex 4 provides more information on this approach.
4. Field visits (see Annex 5 for schedule) were made to observe how the National MNCH Programme was being implemented and to discuss the benefits, challenges and issues related to implementation. Of interest was the impact of devolution on MCH policy and planning across Pakistan.

Development Assistance Criteria (DAC)
Throughout the evaluation, the team kept in focus the key DAC criteria for reviewing the relevance, effectiveness, efficiency, impact and sustainability of the MCH Strategic Framework. The DAC Evaluation Matrix and Assessment Criteria are in Annex 6 and 7.

Data Analysis
Data was analysed from multiple sources including routine information systems (HMIS\textsuperscript{16}, DHIS\textsuperscript{17}, LHW-MIS\textsuperscript{18} and MNCH Programme-MIS) and specific studies undertaken by the TRF and other agencies. For higher level indicators – national databases such as Pakistan Demographic and Health Survey (PDHS), and Pakistan Living Standards Measurement Survey (PSLM) were used.

\textsuperscript{16} Health Management Information System
\textsuperscript{17} District Health Information System
\textsuperscript{18} Lady Health Worker – Management Information System
Analysis of the data occurred on an ongoing basis. The use of mixed methods assisted with triangulating data, thus strengthening the findings. Four types of triangulation were used; i.e. the use of a variety of sources, different evaluators, multiple perspectives to interpret data, and multiple methods and samples. Summary case study and provincial field notes are in Annex 8 and 10 of this report; while Annex 9 provides quantitative data to support the case studies.

**Draft Report and Time Schedule**

A draft report was prepared based on the primary and secondary data collection. A validation meeting was held to gain consensus and feedback on preliminary findings from GoP and donors before submitting the report. A dissemination workshop was held where findings were presented to stakeholders at federal and provincial levels.

The team has endeavoured to maintain high ethical standards and has tried to verify, when needed, its findings during discussion with multiple stakeholders. In drafting and finalising the report, the team has kept the sources of feedback confidential except in a couple of instances, where attribution was considered appropriate. Table 1-1 outlines the schedule of main activities.

<table>
<thead>
<tr>
<th>Process</th>
<th>Date</th>
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<tbody>
<tr>
<td>Finalisation of the Inception Report</td>
<td>October 2011 – February 2012</td>
</tr>
<tr>
<td>Review of the literature</td>
<td>December 2011– January 2012</td>
</tr>
<tr>
<td>Secondary data analysis</td>
<td>February – March 2012</td>
</tr>
<tr>
<td>Fieldwork and primary data analysis</td>
<td>February– March 2012</td>
</tr>
<tr>
<td>Preparation of draft report</td>
<td>March – April 2012</td>
</tr>
<tr>
<td>Feedback meeting before submission of final report</td>
<td>June 2012</td>
</tr>
</tbody>
</table>

**Limitations**

The following is a summary of the limitations of this evaluation

- **Changing scenario** devolution of vertical programmes from National to provincial levels. Caped funding by federal government to vertical programmes

- **Data indicative only**: In the absence of a strong baseline and EmONC indicators, data related to EmONC signal functions were extracted from a Health Facility Assessment (HFA), to assess the functioning of facilities which was conducted in 2010. This is indicative only, as the process used to review the signal functions did not comply with international standards or best practice.\(^{19}\)

- **Closure of the Federal MNCH cell**: The Federal MNCH cell closed in June 2011, following devolution of responsibilities to provinces. Access to management,

\(^{19}\) This requires reviewing hospital records for the six months prior to an assessment and using a more comprehensive data set.
administration and planning documents were not available to inform an understanding of how the Programme has been implemented.

- **Broad scope of the MNCH Programme:** There are multiple partners and MNCH projects operating at all levels, implementing a broad range of MCH interventions with no central coordinating mechanism. Thus, attribution of individual achievements, lost opportunities, or value addition is difficult to determine.

- **Reliability of data, particularly HMIS data:** Different Health Management Information System (HMIS) data compilation and storage practices were observed in provinces and districts. A general absence of data quality effects HMIS data. The evaluation/review team believes that these factors are responsible for a number of unexplained inconsistencies in recorded services.

- **Difficulty to establish population denominators:** Catchment populations to calculate service coverage were neither used nor known in either District Departments of Health (DDOH) and health facilities visited. Without population denominators, it is hard to assess if services delivered were high or low in relation to each health facility, since catchment populations vary considerably.

- **Lack of relevant baseline:** The baseline for the Programme was informed by a situational analysis of gaps in the health system, rather than the needs of women and children and gaps in the health system to address those needs. Data, such as complications of pregnancy, which is used internationally to monitor Emergency Obstetric and Newborn Care (EmONC), is available but not regularly collected or monitored even though the PC-1 defines the use of these indicators.

- **Case study approach:** Unlike random sample surveys, case studies are not representative of entire populations, nor do they claim to be. However the multiple case study approach is an attempt to match results and strengthen findings.

- **Value for money** analysis could not be completed as envisaged due to lack of data. The international comparable EmONC indicators referred to in the PC-1 which was needed for the analysis were not available.

### 1.3 Organisation of the Report

The Evaluation was done, parallel with a Review of the MCH Strategic Framework. Thus there is overlap between the two reports. In essence, the difference in the reports is that the evaluation focuses on the implementation of the MCH Policy and Strategic Framework by the MNCH Programme at a component level, whereas the Review focuses the overall “Framework”. There are 7 sections in this report:

- Section 1, this section provides an overview of the approach to the evaluation.
- Section 2 describes the context in which the MNCH Programme is implemented
- Section 3 evaluates design, implementation and management of the Programme.
- Section 4 presents a value for analyses of the Programme
- Section 5 provides a description and analysis of devolution scenario

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20 Refer to Page 99 PC-1 National Maternal and Child Health Programme 2006-2012
21 See page 99 under monitoring
• Section 6 summarises the evaluation findings against DAC criteria.
• Section 7 includes an overall assessment, lessons learned and recommendations.
2 CONTEXT AND MNCH PROGRAMME DESCRIPTION

2.1 Background and Context
Pakistan will have an uphill task in meeting the 2015 targets set for attainment of Millennium Development Goals (MDGs) 4 and 5. The current Infant Mortality Rate (IMR) of 78 per 1000 live births is lagging behind the MDG target of 40 per 1,000 live births, while the Maternal Mortality Ratio (MMR) of 276 per 100,000 live births is higher than the MDG target of 140 per 100,000 live births. Similarly, the current Contraceptive Prevalence Rate (CPR) level of 30% is below the 60% target set for 2020 and the current Total Fertility Rate (TFR), estimated at 4, is higher than the set target of 2.1. Reducing the current population growth rate from about 1.7% to 1.3%, in the limited timeframe is unlikely. \(^\text{22}\)

This situation is complicated by the growing number of married women of reproductive age and a high population growth rate leading to unprecedented population doubling in 40 years and approaching 460 million by 2060. High maternal, neonatal and child mortality are attributed to: high fertility rate, lack of appropriate prenatal care, low skilled birth attendance rate, low levels of female literacy, poverty, malnutrition, communicable diseases and inadequate and unreliable access to EmONC and other MCH services.

Since the commencement of the Programme five years ago, the context in which the Programme is being implemented has been changing. Under the 18th Constitutional Amendment of the GOP, the constitutional responsibility for the delivery of health services has been devolved to the provincial departments of health and lower levels of the health system. This has resulted in uncertainty regarding Programme implementation and the strategic directions for MCH at national and sub-national levels. It is against this changing context, its challenges and funding constraints that the MNCH Programme is being implemented.

2.2 National MCH Policy and Strategic Framework
The overall direction for the Programme is provided by the MCH Strategic Framework. The development of the National MCH Policy and Strategic Framework demonstrates the commitment of the GoP to improve the health and mortality status of mothers, newborns and children across Pakistan and accelerate progress towards the achievement of the MDGs. Prepared in consultation with provinces, areas, academics, professional bodies and other development partners, the Framework was launched by the Prime Minister to support the Islamabad Declaration in 2005.

The Strategic Framework provides a roadmap for the implementation of MCH across Pakistan. The strategy pledges to ensure availability of all levels of high quality MNCH services to the population, especially for the poor and disadvantaged. To this end the

overarching goal is to improve maternal and neonatal health status particularly among the poor and marginalised.

### 2.3 National MNCH Programme Description

To translate the MCH Strategic Framework into action, a National MNCH Programme was developed in 2006. The overall vision of the Programme is to ensure “health for all”, with attention directed towards the primary and secondary levels of the health care system, coupled with community outreach services through integrated system-wide approaches. The Programme goal is to improve accessibility of quality MNCH services, through development and implementation of an integrated and sustainable MNCH programme, at all levels of the health care delivery system. There are five specific Programme objectives and 11 outputs, spread across five components, which include comprehensive lists of activities Figure 2-3.

#### Figure 2-1: Programme Goal, Outcome and Structure

<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcome</th>
<th>Components</th>
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| To reduce maternal and child death and illnesses by improving the health status of all, particularly of the poor and marginalised | To improve the accessibility of high quality and effective MCH services for all, particularly the poor and the disadvantaged, through development and implementation of sustainable MCH Programme at all levels of health care delivery system | 1. Integrated Delivery of MNCH Services at District Level  
2. Training and Deployment of Community Midwives  
3. Provision of Comprehensive Family Planning Services  
4. Strategic Communication for MNCH Care  
5. Strengthening Programme Management |

The MNCH Programme includes the provision of Basic and Comprehensive Emergency Obstetric, and Neonatal care (Basic EmONC), assistance of normal delivery by a qualified midwife at the community level, and prenatal and postnatal care at a health facility.

The Programme supports the following strategies:

- Strengthening district health systems through improvement in technical and managerial capacity at all levels, and upgrading institutions and facilities
- Streamlining and strengthening services for provision of basic and comprehensive emergency obstetric and newborn care (Comprehensive EmONC)
• Integrating all services related with MNCH at the district level
• Introducing a cadre of community-based skilled birth attendants
• Increasing demand for health services through targeted, socially acceptable communication strategies.

At the time of design, it was envisaged that the Programme, with federal, provincial and district buy-in, would support MNCH interventions for the provision of an essential MNCH service package. This would include: the introduction of community skilled birth attendants, strengthening provision of a 24/7 basic and comprehensive EmONC services, child and neonatal health interventions, comprehensive family planning services, creating demand for MNCH services, improvement of planning and management of MNCH services and establishing an effective M&E mechanism.

The programme aims at functional integration of the ongoing maternal programs i.e. National Program for Family Planning, Primary Health Care, better known as the Lady Health Worker Programme (LHWP), Expanded Programme on Immunisation (EPI), Nutrition, and National AIDS Control Programme.

A salient feature of the Programme is that it adds on to what is already being done to achieve the MDGs. It acts as a catalyst to assist the ongoing initiative to fulfil the health related MDGs. The aim is not to displace or replace the current resources available for MNCH, but to fill in the resource gaps where ever possible, without duplicating inputs or activities.

The National MNCH Programme is being implemented in 134 districts across 4 provinces. It is also being implemented in Azad Jammu Kashmir (AJK), Northern areas, Federally Administered Northern Areas (FANA) and Federally Administered Tribal Areas (FATA).

The PC-1 for the Programme was approved by the Executive Committee of the National Economic Council on 7 March 2007. Thus, the Programme is currently in its fifth year of implementation and is due for completion in June 2012; however funding will be available until 2014.
3 EVALUATION OF DESIGN AND IMPLEMENTATION

3.1 Relevance of Design and Formulation

3.1.1 Government Plans, Policies and Strategies
The Programme aligns with the MCH Policy and Strategic Framework, which provides overall direction. It is also relevant to the Poverty Reduction Strategy (PRS), which is the foremost detailed policy paper of the government. This identifies revival of economic growth and reduction of poverty as the twin challenges for Pakistan. The Poverty Reduction Strategy goes beyond the National Health Policy, in important areas of reproductive health, maternal and child health and nutrition, outlining interventions like community midwifery, improvement of emergency obstetric care and behaviour change communication which are gaps filled by the MNCH Programme.

The Programme demonstrates the GoP commitment to internationally agreed frameworks and initiatives. These include the International Conference on Population and Development (ICPD), the Convention for the Global rights of the Children, the Global Strategy for Women’s and Children’s Health and alliances such as the Partnership for Maternal and Child Health, which supports over 400 partners. All desire to achieve universal access to comprehensive, high-quality MCH care.

3.1.2 Best Practice and International Evidence
The MNCH Programme is based on international evidence and best practice. The “Three Delays Model”\(^ {23} \), the delivery of an integrated package of services across a continuum of maternal and child care, supported by organisational and management of reforms, has been shown to work in a number of countries\(^ {24} \). Studies suggest that high coverage and quality of essential packages of care can avert maternal, neonatal and child deaths.\(^ {25} \) Coverage, accessibility, availability and quality of services were to be monitored using reliable, timely and internationally comparable data\(^ {26} \). These indicators have not been used, so the relevance of the evidence on which the Programme was designed has been undermined.

3.1.3 Context and Needs of the Beneficiaries
The MNCH Programme is highly relevant in a context where maternal, newborn and child health mortality is one of the highest in the region, and where government policies, plans and strategies are focused on addressing the problems and the inequities between the rich and the poor.


Community-level interviews by the evaluation team also confirm the Programme is relevant to the realities of the main beneficiaries (women and children). However there are factors further erode the relevance:

1. The role of the CMW as yet is not widely accepted in the community. Unless functional integration of the roles of the LHW and CMW is achieved, then the relevance of the service provided is under threat (see below).

Relevance of the Service Provided by CMWs

Community perceptions of BHUs/ RHCs/DHQs suggest women go to public sector health facilities for antenatal, tetanus toxoid, immunization for children and general laboratory tests. It is important to mention that most of these visits are because of the motivation of the LHWs. Most of the cases of deliveries assisted by CMWs were supported by the LHW. In view of this scenario, it is envisaged that unless functional integration of the roles of the LHW and CMW is achieved the relevance of the service provided by the CMW will lost in the “eyes of the community” *(Feedback—MNCH Programme Evaluation)*

2. The needs of the beneficiaries were not prioritised adequately when the Programme was initiated. A situational analysis was undertaken to identify gaps in the health system, rather than first identifying the needs of the beneficiaries, then strengthening the health system to meet those needs.

3.1.4 Donor Alignment with Government Policies, Plans and Strategies

- Donor projects are considered relevant to the goals and activities of the Programme. In the absence of a steering and coordinating mechanism, and a clear plan of action, a number of donors have designed their own MCH projects. These are relevant to government policies, plans and strategies, but based on their own country priorities. As a result some donor initiatives have evolved as parallel projects, with a lack of synergy with the MNCH Programme. The overlap is discussed further in the MNCH Review document*27*

- In the absence of a coordinating mechanism donors have designed projects based on their own country’s priorities for attainment of MDG 4 and 5. These projects align with government policy and plans but not always with government systems (e.g. GoP budget and assessment processes). As a result there are overlaps and duplication of interventions and in some cases donor projects have evolved as parallel projects to the health system. The overlap is discussed further in the MNCH Review document*28*.

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*27* There was criticism of donors during the evaluation and review. For example; feedback was that the PAIMAN project was parallel to the system. On the other hand DFID has worked through government. However it is difficult to understand how support could be provided to a programme that has no baseline and “gap filling” is focussed more on infrastructure and human resources with little consideration of prioritising needs according to where women and children are dying and what they are dying of.

*28* There was criticism of donors during the evaluation and review. For example; feedback was that the PAIMAN project was parallel to the system. On the other hand DFID has worked through government. However it is difficult to understand how support could be provided to a programme that has no baseline and “gap filling” is focussed more on infrastructure and human resources with little consideration of prioritising needs according to where women and children are dying and what they are dying of.
3.1.5 Design Formulation
The goal of the Programme is commendable. Yet the following factors impacted on the implementation and relevance of the MNCH Programme. Specifically:

1. With a large number of entities involved in the Programme, feedback from provinces was that it was difficult to take the Programme forward. Reasons for this included bottle necks in funding, and lack of leadership and capacity at all levels of government.

2. Weak coordination between Federal and Provincial health departments (PHDs); and confusion concerning responsibility for family planning activities and oversight committees did not provide the strategic guidance.

3. The provincial Departments of Health and Departments of Population Welfare failed to coordinate themselves effectively, to ensure integration of MCH, RH and family planning across the health system.

4. Ineffective coordination and the number of activities to be integrated into the Programme, has made it difficult for contributory Programmes such as LHW, EPI nutrition and Population Welfare Department to implement the Programme, in partnership with many entities.

5. Failure of donors to coordinate effectively among themselves, so inputs could be harmonised and aligned with government systems, policies, plans and strategies.

The design also expected each PMU to be staffed with a full-time Programme Manager/deputy, training experts, admin officers, monitoring officers, data analysts and more. However, it is only in the last 12 months that most PMUs have the prescribed staff strength to implement the Programme.

Furthermore, since the Programme commenced, governance structures have changed substantially as a result of devolution, Pakistan’s Ministry of Health was abolished on the 30th June 2011. Responsibility for public health care has been transferred from the federal to provincial level. The implications of the post 18th Amendment scenario for the Programme are discussed in section 5 of this report.

3.2 Achievement of Objectives
The overarching goal is to improve accessibility of quality MNCH services, through an integrated and sustainable MNCH Programme, at all levels of the health care delivery system. The Programme objectives are to ensure progress toward achieving the Millennium Development Goals (MDGs) in MCH. Specific objectives are:

1. To reduce the Under Five Mortality Rate to less than 65 per 1000 live births by the year 2013 (Target 2015: 45/1000)

2. To reduce the Newborn Mortality Rate to less than 40 per 1000 live births by the year 2013 (Target 2015: 25/1000)

3. To reduce the Infant Mortality Rate to less than 55 per 1000 live births by the year 2013 (Target 2015: 40/1000)

4. To reduce Maternal Mortality ratio to 200 per 100,000 live births by the year 2013 (Target 2015: 140/100,000)
5. To increase the proportion of deliveries attended by skilled birth attendants at home or in health facilities to 90%. (Target 2015: >90%)

It is too soon to assess the internal and external efficiency of specific Programme interventions. There are excessive time lags in changes to the maternal, newborn and under five mortality rates (indicators supporting objectives). Deliveries by the new cadre of community midwife are only now beginning to be recorded. Nonetheless while maternal and child mortality is possibly decreasing, the status and rate of change indicate that Pakistan will have an uphill task in meeting the 2015 MDG targets. Four fundamental observations are made:

- **Observation 1**: Improvement – though steady – is slower than in neighbouring countries and considering the country’s levels of economic development the level of IMR is lower than expected

- **Observation 2**: Variations between provinces and districts are very large for both maternal and newborn mortality. As can be seen by Table 3-1 the provincial indicators show a vast disproportion. While the national indicators show a better rate of maternal and neonatal mortality rates, the provinces of Balochistan and GB are so far behind that it seems an impossible task to bring them close to the national indicators. However, no province is close to achieving the MDGs targets that the Government aspires to achieve.

### Table 3-1: Summary of Provincial MNH Health Indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio/100000 live births</td>
<td>140</td>
<td>276</td>
<td>*201</td>
<td>785</td>
<td>400</td>
<td>275</td>
<td>227</td>
<td>314</td>
<td>*380</td>
</tr>
<tr>
<td>Infant mortality rate /1000 live births</td>
<td>-</td>
<td>78</td>
<td>*58</td>
<td>*72</td>
<td>81</td>
<td>63</td>
<td>81</td>
<td>81</td>
<td>*78</td>
</tr>
<tr>
<td>Child mortality rate /1000 live births</td>
<td>52</td>
<td>94</td>
<td>*88</td>
<td>*89</td>
<td>-</td>
<td>75</td>
<td>97</td>
<td>101</td>
<td>*104</td>
</tr>
<tr>
<td>Total fertility rate children per woman</td>
<td>2.1</td>
<td>4.1</td>
<td>*3.6</td>
<td>4.1</td>
<td>4.1</td>
<td>4.3</td>
<td>3.9</td>
<td>4.3</td>
<td>*4.3</td>
</tr>
</tbody>
</table>

Reference: PDHS 2006-2007 and MICS 2008 (all MICS marked with *)

- **Observation 3**: Women living in rural areas are at double the risk of dying of maternal causes than women living in urban areas – a maternal mortality rate of

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29 Mortality in Balochistan is an estimate by the Planning Commission
30 Millennium development goals targets 2015. Islamabad September 2005
319 and 175 deaths per 100,000 live births respectively. Likewise infant, neonatal and child mortality is higher in rural areas. Refer to Figure 3-1 below.

**Figure 3-1: Where Do Women and Newborns Die and who is at the Greatest Risk**

![Maternal Mortality vs Neonatal, Infant and Under 5 Mortality](image)

Data Source: PDHS 2006-2007

- **Observation 4:** While the long term development as presented in Figure 3-2 is – although slow – clearly positive, observations from the Pakistan Demography and Health survey 2006-2007 indicate absence of improvement.

**Figure 3-2: Infant Mortality Rate and Economic Development in Four Countries (1960 – 2008)**

![Infant Mortality Rate and Economic Development](image)

Source: Grapminder.com

This is a concern because history shows that since 1992 child and neonatal mortality rates have been stagnant. Refer to Table 3.1. Yet feedback to the team was that Pakistan did not have problems with newborn mortality.

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31 National Institute of Population Studies (NIPS) 2008:Pakistan Demographic and Health Survey 2006-07
32 National Institute of Population Studies (NIPS) 2008:Pakistan Demographic and Health Survey 2006-07:
### Table 3-2: Child Mortality Rates in Pakistan Demographic and Health Surveys (1992-2006)

<table>
<thead>
<tr>
<th>Year</th>
<th>Neonatal Mortality</th>
<th>Post Neonatal Mortality</th>
<th>Infant Mortality Rate</th>
<th>Child Mortality Rate</th>
<th>Under 5 Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-2006</td>
<td>0-4</td>
<td>54</td>
<td>24</td>
<td>78</td>
<td>18</td>
</tr>
<tr>
<td>1997-2001</td>
<td>5-9</td>
<td>52</td>
<td>24</td>
<td>76</td>
<td>18</td>
</tr>
<tr>
<td>1992-1996</td>
<td>10-14</td>
<td>56</td>
<td>30</td>
<td>86</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: WHO health statistics database on the web (WHO International June 10, 2009)

### 3.3 Achievement of Programme Outcome

If the Programme stayed on its present course, it is unlikely the outcome of “reaching the poor and marginalised” will be achieved. To date, physical inputs have focused more on upgrading facilities at the secondary level of health care rather than the primary health care level. A new cadre of community midwife has been developed, but linkages to the system are weak and social mobilisation component has been neglected. Coverage of EmONC does not meet international comparable standards.

Table 3-3 provides an estimate of coverage according to these standards. There is a shortfall of at least 123 CEmONC and 790 BEmONC facilities across Pakistan. Most BEmONC facilities are at the primary health care level, where the poor and marginalised live and the community midwife works.

### Table 3-3: Coverage of EmONC Facilities According to the International UN Standard

<table>
<thead>
<tr>
<th>Province</th>
<th>Projected Population for 2009-10 Based on 1998 Census</th>
<th># of Facilities Upgraded for CEmONC (Targets)</th>
<th># of Facilities Upgraded for BEmONC (Targets)</th>
<th>Coverage of CEmONC per 500,000 Population</th>
<th>Coverage of BEmONC per 500,000 Population</th>
<th>CEmONC Met/Not Met</th>
<th>BEmONC Met/Not Met**</th>
</tr>
</thead>
<tbody>
<tr>
<td>AJK</td>
<td>3,234,832</td>
<td>11</td>
<td>35</td>
<td>1.7</td>
<td>5.4</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Balochistan</td>
<td>8,979,385</td>
<td>28</td>
<td>88</td>
<td>1.6</td>
<td>4.9</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>FATA</td>
<td>3,998,958</td>
<td>7</td>
<td>7</td>
<td>0.9</td>
<td>0.9</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Gilgit Baltistan</td>
<td>1,145,433</td>
<td>5</td>
<td>15</td>
<td>2.2</td>
<td>6.5</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>KPK</td>
<td>24,233,623</td>
<td>25</td>
<td>106</td>
<td>0.5</td>
<td>2.2</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Punjab</td>
<td>97,916,452</td>
<td>114</td>
<td>291</td>
<td>0.6</td>
<td>1.5</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>SINDH</td>
<td>36,476,889</td>
<td>43</td>
<td>121</td>
<td>0.6</td>
<td>1.7</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>All Pakistan</td>
<td>177,394,210</td>
<td>233</td>
<td>663</td>
<td>0.7</td>
<td>1.9</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

** Where standards are met; coverage may still be a problem because geographical distribution is not known – there may be enough facilities but they may not be in the right place to ensure equitable access to services

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33 Based on a projected population of 178 million and assuming facilities are geographically and equitably distributed
3.4 Delivery of a Minimum Package

The MNCH Programme supports the delivery of a minimum package of services across a continuum of care delivered at 3 levels of care. Figure 3-3 shows that the package includes: preventive MNCH services at BHUs, Basic EmONC services at RHCs and Basic and Comprehensive EmONC services at DHQ/THQ hospitals.

Figure 3-3: Package of Care at three Levels

Progress of Selected Indicators

There have been some positive gains against selected MCH package indicators, such as antenatal care, postnatal care, skilled attendance and DPT3 immunisation). Figure 3-4 indicates that Antenatal Care (ANC) has increased from 84 to 91% and Postnatal Care (PNC) increased from 84 to 85% in 2011. Similarly, skilled birth attendance has increased from 32% to 41% during the last five years. The percentage of mothers immunised for TT-1, and children 12-23 months fully immunised, and children less than 5 years treated for diarrhoea, have also increased:

Progress of Selected Indicators in Public and Private Sectors

(All Pakistan: 2006-7 and 2010-11)

Data Source: PSLM Data 2006-2007 and 2010-2011
WHO recommends at least 4 ANC visits during pregnancy, to minimise the chances of complications at the onset delivery and to ensure a healthy pregnancy. Data from the National Nutrition Survey shows that in the public and private sectors combined, 49.9% women have 4 ANC visits.

Figure 3-5 shows that when selected interventions from the minimum package supported by the MNCH Programme, are viewed along a continuum, women from rural areas have the lowest coverage of care for both the mother and baby around birth.

**Figure 3-5: MNCH Care across a Continuum of Care**
*(All Pakistan: 2010-2011)*

![Graph showing MNCH care across a continuum of care](image)


When just the public sector is considered, skilled attendance falls from 41% to 12 percent, antenatal care drops significantly from 91% to 40 percent. A similar picture emerges for PNC for all Pakistan (See Figure 3.6) and Provinces (Figure 3-7).

**Figure 3-6: Continuum of Natal Care in the Public Sector**
*(All Pakistan 2011 - Includes LHWs and LHV)*

![Graph showing continuum of Natal Care in Public Sector](image)

Data Source: PSLM Data 2010-2011
3.5 Delivery at Different Levels of Service Delivery

Case study analyses were used to verify Health Facility Assessment data for gaps in services delivery. Significant gaps which warrant attention are summarised below.

Basic Health Units

- Around 11% facilities were providing all preventive service components and only 15 BHUs provided any kind of emergency obstetric care.
- Punjab had the highest proportion (17.8%) of facilities designated fully functional for preventive MNCH services, followed by GB and Sindh at 14.3% and 7.9%.
- Of the 992 BHUs assessed, more than 80% failed to provide one or more service components of the MNCH package and were thus termed as ‘non-functional’.
- Lack of laboratory services and nutrition counselling in 71% of facilities, followed by no growth monitoring in 57% of facilities, were the most common services preventing many facilities from attaining full functionality for preventive services.

Rural Health Centres

- More than 95% of 638 facilities across Pakistan failed to provide one or more service components of the MNCH package so were termed as ‘non-functional’.
- Lack of three essential drugs i.e. IMI ampicillin, oxytocin & magnesium sulphate was the main reason preventing delivery of BEmONC services.
- Magnesium sulphate injection was the least available component of the BEmONC.

Tehsil Headquarter Hospital

- Magnesium sulphate injections were available in less than 5% of facilities. Removal of retained products was the next service missing from BEmONC.
• More than 95% of the 280 THQs assessed, failed to provide one or more service components of the CEmONC package and were thus termed as ‘Non-functional’.
• Laboratory services were available at 75.5% of the DHQs.
• Oxytocin and magnesium sulphate was the only factor preventing 70% facilities from being designated as fully functional for the BEmONC services.

District Head Quarter Hospitals
• 86% of the DHQs assessed, failed to provide one or more of the service components of BEmONC and were thus termed as ‘Non-functional’ for BEmONC.
• Magnesium sulphate injections were the least available BEmONC intervention.
• 85% were DHQ hospitals were not providing a full package of CEmONC services. C-Section and blood transfusion were mostly unavailable

3.6 Achievement of Programme Outputs
Achievement of PC-1 log-frame outputs are described below. Annex 11 provides a narrative summary of log-frame components. Annex 12 provides a summary of progress against targets, reported in annual assessments since 2009. From this Annex it can be seen there are large numbers of activities which have not been undertaken. The reason for this is unknown.

3.6.1 COMPONENT 1: Integrated Delivery of Comprehensive MNCH Services

Outputs: Outputs are designed to strengthen integrated delivery of MNCH services at district level including: 1) Provision of 24/7 Comprehensive EmONC; 2) Provision of 24/7 Basic EmONC; 3) Provision of 8/6 preventive obstetric and child health including newborn care; 4) Establishment of newborn care units in THQ and DHQ hospitals and Well Baby Clinics in all DHQ, THQ, RHC and BHUs; and 5) Training of public and private facility staff at all levels on child survival and newborn care.

Activities: To achieve these outputs, activities include: increasing staff and facility coverage, upgrading facilities, ensuring the availability of equipment and supplies, strengthening referral, capacity building and training of 15,000 staff on child survival and newborn care in both the public and private sector, putting in place standards and protocols, support mechanisms, student rotations, performance incentives and more. See Annex 11 for PC-1 log-frame narrative summary.

Targets: Table 3-4 shows achievement of targets and completion rates for different types of facilities were between 71% and 88 percent. Considering budget constraints, these rates are impressive. A total of 93 out of 112 (83%) DHQ and 106 out of 122 (87%) THQ hospitals were upgraded to provide 24 hour care 7 days a week. A further 584 of a targeted 663 (88%) health facilities have been upgraded to provide BEmONC services. However, as already discussed targets do not meet international standards aspired to in the PC-1. See Annex 12 for more information.
Table 3-4: Targets for Upgrade of Health Facilities to Provide EmONC**

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Targets</th>
<th>Achievement</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All EmONC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health facilities Strengthening for EmONC</td>
<td>885</td>
<td>783</td>
<td>88%</td>
</tr>
<tr>
<td><strong>CEmONC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upgraded to Provided 24 Hour EmONC Facilities</td>
<td>233</td>
<td>199</td>
<td>74%</td>
</tr>
<tr>
<td>DHQs Upgraded to Provide CEmONC</td>
<td>112</td>
<td>93</td>
<td>83%</td>
</tr>
<tr>
<td>THQs Upgraded to Provide CEmONC</td>
<td>122</td>
<td>106</td>
<td>87%</td>
</tr>
<tr>
<td><strong>BEmONC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upgraded to Provide BEmONC</td>
<td>663</td>
<td>584</td>
<td>88%</td>
</tr>
<tr>
<td><strong>MNCH Package</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health facilities Strengthened for MNCH</td>
<td>4650</td>
<td>3319</td>
<td>71%</td>
</tr>
</tbody>
</table>

** Annual Review Monitoring Data

Target completion rates vary between provinces (Figure 3-8). For example; due to parallel donor funded projects and humanitarian assistance (Earthquake and war affected region) AJK has more than met the targets for upgrade of BEmONC facilities, similarly FATA for 8/6 preventative services. Punjab shows consistency in meeting nearly 100% of targets for all three types of facilities while Balochistan has met less than 40% of the EmONC targets but 77% of 8/6 preventative care targets. Feedback from the province was the reason for this was lack of funds. Nonetheless care needs to be taken when interpreting this table as the targets do not take into consideration the quality or delivery of services.

Figure 3-8: Province Completion Rate for Targets for Upgrade of Facilities To Provide EmONC and Preventative MNCH Care

Source: Target Data: from Annual monitoring and self reported from provinces/areas
OUTPUTS 1 & 2: PROVISION OF 24/7 BASIC\textsuperscript{34} AND COMPREHENSIVE\textsuperscript{35} EMONC:

Staff coverage increased, facilities upgraded, supplies and equipment, increase staff capabilities, standards and protocols, support mechanisms, student rotations, imprest money and Category III powers

Table 3-5 presents random results of 3 cases studies undertaken districts to better understand the functioning of upgraded EmONC facilities. The results are against international standards referred to in the PC-1; See Annexes 8 and 9 for more results.

- There are not enough facilities providing EmONC. There is a shortfall of at least 123 CEmONC and 790 BEmONC facilities across Pakistan. The shortfall is mainly at the primary health care level close to where most of the population live.

- While targeted facilities appear to be geographically distributed across the country, there is only about half the total number of facilities required to support a network of services which meet international standards. There needs to be more facilities providing EmONC and they need to be geographically and equitably distributed across the country. For more information on this refer to Tables 3-3.

- Case study analysis shows that there are not enough women using the upgraded facilities and the expected number life saving procedure for the number of expected pregnancy complications in the catchment area are not being performed. This is reflected in the met need (see table 3.5).

<table>
<thead>
<tr>
<th>EmONC Process Indicators (MNCH PC-1)</th>
<th>Standard</th>
<th>Current Status/Value</th>
<th>Met/Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 EmONC Facilities in district</td>
<td>≥ 5 per 500,000 population</td>
<td>2.3</td>
<td>Not Met</td>
</tr>
<tr>
<td>24/7 CEmONC Facilities in the district (At least 1 CEmONC)</td>
<td>≥ 1 per 500,000 population</td>
<td>0.2%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Geographical Distribution of BEmONC facilities</td>
<td>Well distributed facilities ensuring equitable access and availability</td>
<td>Urban well distributed - rural distribution poor</td>
<td>Partially Met</td>
</tr>
<tr>
<td>Proportion of all births at all EmONC facilities</td>
<td>15%</td>
<td>13%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Met need for EmONC at DHQ Hospital\textsuperscript{36}</td>
<td>100%</td>
<td>1%</td>
<td>Not Met</td>
</tr>
<tr>
<td>C-Section at DHQ Hospital as a proportion of all births\textsuperscript{37}</td>
<td>5% -15%</td>
<td>1%</td>
<td>Not Met</td>
</tr>
</tbody>
</table>

\textsuperscript{34} Basic EmONC services: Performed in health centre – IV/IM antibiotics, IV/IM oxytocics, IV/IM anticonvulsants, Manual removal of placenta, assisted vaginal delivery, Removal of retained products.

\textsuperscript{35} Comprehensive EMONC services: All six EMOC functions plus Caesarean section and blood transfusion

\textsuperscript{36} EmOC Data is not available for THQs and RHcs

\textsuperscript{37} C/section data is not available for THQs
• For all case studies, the met need for EmONC was around 1%. This falls short of the international standard of 100%. National evidence supports this finding\textsuperscript{38,39,40,41}.

• Critical services, such as C-Sections are not being performed. C-Section rates for different facilities in case study districts suggest this could be as low as 1%, which falls short of the international standard of 5-15%.

• Quality is often measured at a facility level in terms of case fatality rate. Data to support this indicator was not available. However observations from the case study suggest that quality is poor.

OUTPUT 1.3: PROVISION OF 8/6 PREVENTIVE MNCH AND FUNCTIONING CHILD HEALTH CARE SERVICES IN 5000 BHUs

Strengthened BHU coverage, performance incentives, strengthens referral, upgrade facilities, equipment and supplies, standards and protocols

Tokens: 3119 BHUs upgraded to provide 8/6 preventive MNCH services. This represents 71% of the target of 4650 (Refer to Table 3-4 and Figure 3-8). Although progress is apparent, feedback from the field is that results were less than intended, due to lack of funds and contracting out of BHUs under People’s Primary Health Care Initiative (PPHI).

Upgrade of Facilities: support for BHUs has been limited to outpatients departments (OPD), labour rooms and a residence of LHV. Feedback from District Health Management reported that most of this infrastructure was in place (81% on average) and was both available as well as functional at BHUs. Gaps exist in the availability of sub-components like scrub areas in labour rooms, hand washing facilities in OPDs and LHV residences.

Normal Deliveries: Feedback from facility staff is that delivery services are not encouraged or provided in BHUs, and the number of normal deliveries in BHU is variable. In the case study districts, 87.5% of BHUs in District Kasur provide normal deliveries, while less than 20% of BHUs provide deliveries in the other two districts. To provide the coverage required to meet international standards, selected BHUs will need to provide at least Obstetric Emergency First Aid. This could be delivered by a LHV but would need to be available 24 hours a day. There are 20 BHUs providing BEmONC in AJK – so there is a precedent for doing this.

\textsuperscript{38} Paxton, A; Maine, D; Freedman, L; Fry, D; Lobis S (2005). International Journal of Gynaecology & Obs, 88, 181-193
\textsuperscript{39} Moazzam, A; Mohammad, A; Humayun, R; Saima, H; and Chushi, K; (2006). Emergency Obstetric Care Availability, Accessibility and Utilization in Eight Districts of Pakistan’s North West Frontier Province, J Ayub Med Coll Abbottabad 2006: 18(4)
\textsuperscript{40} Moazzam, A; Mohammad A.B; and Chushi, K; (2008). Challenges in Access to and Utilisation of Reproductive Health Care in Pakistan, J Ayub Med Coll Abbottabad 2008: 20(4).
\textsuperscript{41} Fariyal, F; Fikree, A; Ali, M. Mir; Inaam-ul Haq (2006). She may reach a Facility but will still die! An Analysis of quality of public sector maternal health services, District Multan, Pakistan, Journal Pakistan Medical Association, Vol. 56, No. 4. April 2008.
Well Baby Clinics: In case study districts well baby clinics are available in less 10% of BHUs. In RHCs, DHQ and THQ availability ranges from 33.3% to 66% of facilities. Growth monitoring is more the norm at BHU level with 70—100% of facilities providing the service, and other levels of facilities not providing a service at all. Nutrition counselling also seemed to be the norm for BHUs, with over 90% of facilities providing the service; and higher level facilities not providing nutrition services at all.

OUTPUT 1.4 ESTABLISHMENT OF NEWBORN CARE UNIT IN THQ AND DHQ HOSPITALS AND WELL BABY CLINIC IN ALL DHQ, THQ, RHC AND BHUS

Newborn care units established, IMNCI, well baby clinics, nutrition, Epi-plus, community child survival

Newborn Care Units: Most upgrades for essential newborn care have been through mixed donor and UN support. In District Badin there have been significant numbers of infant deaths (248 in Y2010) and 48 newborn deaths were recorded and reported at the DHQ during Y2011. However, the district has not been able to mobilise adequate support, even though it is a Norway Pakistan Partnership Initiative (NPPI) district. When raised with donors, the response was that there was hesitation to provide such support when government has limited capacity to sustain efforts. On the other hand PAIMAN has made significant contributions to the establishment of newborn care units, and has been criticised for providing inappropriate technologies.

Only gynaecologists at DHQs are authorized to provide newborn care. If newborn care units are to be established in the future then a broad range of trained staff with resuscitation skills will be required.

IMNCI: The main support from IMNCI has come from WHO and donors. There is little evidence to support that anything other than training has been implemented. The government has developed partnerships with a number of different projects and donor agencies to support the scale-up of IMNCI across Pakistan. The JSI/PAIMAN project, before it closed, scaled up IMNCI to 22 districts with USAID support. NPPI has scaled up IMNCI in 10 districts. Save the Children US is supporting IMNCI scaling up in all the Tribal areas of FATA region.

Evidence of IMNCI “on the ground” was lacking. In the case study districts, IMNCI medicines were not available and protocols were available but not being used. The lists of essential medicines and equipment in health facilities were standard WHO lists, but not adapted to local context, training had been provided but had not been evaluated and clinics (such as well baby clinics, as already discussed) to support IMNCI were hardly functioning.

Nutrition: New interventions, like the introduction of low osmolality ORS, Zinc in the management of diarrhoea, micro-nutrient supplementation/ sprinkles etc were to be implemented on a large scale. However this has not eventuated. A National Nutrition Survey has recently been completed to assess the situation and establish benchmarks.
for a new Programme. A new Nutrition Programme is being developed with a focus on the poor and improving the nutrition status of women of child-bearing age.

Feedback from Focus Group Discussions (FGDs) and interviews (See Annexes 8 and 10 for more information) is:

- LHWs are referring women and children to BHU for routine MNCH, antenatal care and FP services. It is too soon to know the referral pattern of CMWs. For natal care and management of complications, LHV and Female Medical Officers refer cases to RHC and DHQ hospitals – rarely are services provided BHU level.
- Feedback was “Well baby clinics were imposed on Pakistan by a donor agency”. It is not clear if that was the case. However overlapping services such as “Well Baby Clinics” and “Growth Monitoring” need to be rationalised.
- Linkage to EPI and Nutrition Programmes, child survival interventions, including IMCI, is through the role of the CMWs and LHW. This role needs to be strengthened. There is little evidence to suggest CMWs are involved in child survival and IMNCI.
- Performance-based incentives for LHVs, midwives and dispensers are not in place and health facilities are not regularly monitored by provincial or district health services.

OUTPUT 1.5 TRAINING OF 15,000 HEALTH FACILITY STAFF FROM ALL LEVELS

Activities: Training was to include; attachments at tertiary hospitals for WMOs/MOs from DHQ/THQs, rotation of PG students, management training, post-graduate training for nurses, essential newborn care, and competency based training on emergency obstetric care, trainings on IMNCI

Training contributed significantly to all components of the Programme. For this reason training is addressed in a separate section of this report (Section 3-8).

CROSS CUTTING ISSUES

Quality of Services
The major issues faced with regard to continuous and quality service delivery is the acute shortage of human resource, lack of competency and motivation among service providers, frequent stock outs of essential medicines and supplies and low levels of conformance to the required infrastructure for providing 24/7 EmONC services.

Observation made during field visits to case study districts.

- Service delivery protocols were not widely available in health facilities visited. When available, they were not displayed correctly or adapted to the local context. When staff were asked if they had training in their use they “did not know”
- Best Practices, such as the use of the partograph during labour, and active management of third stage labour, were not in use.
• A significant proportion of the marginalised population, suffering from Hepatitis B and C, are deprived of EmONC services – when seeking help they are transferred on to the next facility before help is offered.

• Branding of health facilities was to make the health services more client-friendly. There is limited evidence of this except in 11 UNFPA supported districts, where recommendations have been made for a scale-up following a trial.

• Under the MNCH Programme, it was proposed to establish an accreditation system for all health facilities under the ISO 9000 management guidelines. There is little evidence to suggest this has been undertaken at any scale.

Infection Control

• Infection control practices were found to be inadequate. Gaps in infection control practices were mainly due to lack of training, materials and equipment required for waste collection, personal protection and waste treatment.

From the Field - Infection Control

Due to a lack of staff training and essential supplies at DHQ Mardan, used equipment is cleaned with tap water and re-used to manage 500-600 deliveries and 50-60 complications/month.

Considering the high risk of infection transmission through instruments used during labour, there is need to follow and practice infection prevention standards and protocols, as more than 50% of operated cases reported back with infection at DHQ Mardan.

(Feedback—MNCH Programme Evaluation Case Study Districts)

Human Resource Issues:
Minimum staff deployment quotas are not being met at almost all health facilities. WMO are particularly in short supply. Basic and Comprehensive EmONC services, which should be available 24/7, are hampered by lack of staff. At the DHQ and THQ Hospitals, the availability of specialists including Gynaecologists, Anaesthetists and Paediatricians is an issue.

Although there is a visible increase in the number of institutional deliveries at MNCH supported facilities, there is a high dropout rate among facility staff. This is due to delayed or non-payment of salaries, and lack of essential medicines and supplies adversely affecting the continuity and quality of services. One of the major factors hampering the retention of female staff at RHCs is the lack of an enabling working environment and an adequate, secure residential facility.

Key observations and feedback from FGDs include:

• Positions supported by the Programme are mostly short term contracts, often paid at a higher rate than government staff. An example District Badin, where short-term staff are being paid a salary three times higher than government staff. Sanctioned positions remain either unfilled or designated staff is not available.

• Not all available staff can provide 24/7 coverage; e.g. in the Mardan district in KP, there is only one WMO available in RHC-Takht Bhai, but not available after
the morning shift, leaving LHV's and staff nurses to provide coverage. Alternative solutions such as task-shifting may need to be considered.

- Human resources issues could be addressed more effectively by utilizing the incentive mechanism as given in PC-1, and provincial advocacy for filling up regular posts of OBGYN staff.

**Infrastructure and Renovations**

The majority of infrastructure components were both available as well as functional in BHUs and RHCs. However, gaps existed in availability areas, such as scrub areas in labour rooms; hand washing facilities in OPDs and LHV residences. For DHQHs gaps included availability of Paediatric ward and Nurseries, blood banks and residences for Gynaecologists, Anaesthetists and Paediatricians.

As discussed earlier, provision was made under the MNCH Programme for the repair of LHV residences at BHUs. The quality of construction also needs improving.

**Drugs, Supplies and Equipment**

Availability of medicines, supplies and functional equipment was a frequent barrier for the surveyed health facilities to deliver high quality MNCH services, with the notable exception of vaccines which were almost always available at all facilities.

At the time of evaluation, no health facility was provided with a complete range of items required to perform EmONC signal functions. It should be noted, that not all items (equipment, drugs and supplies) required for operating theatre and blood bank were fully available at any of the DHQ and THQ Hospitals.

It was observed during field visits that:

- Significant quantities of non-functional equipment, not repaired due to proper maintenance and/or budgetary constraints, were identified during field visits.
- Facility managers reported frequent stock-outs of essential drugs, supplies, vaccines and FP commodities.
- New drugs and equipment proposed by the Programmes have not been procured. For example, a vacuum extractor was included in the standard equipment list for RHCs; yet most facilities did not have this equipment.
- New equipment is not being utilised. In the district of Mardan, equipment provided to the DHQ hospital by USAID-funded PAIMAN project (2006-2010) and UNICEF, was still lying unpacked due to staff shortages. Similarly in Sindh, newborn care equipment provided by NPPI is not in use.

**Are Upgrades Working? – Targets Vs Results**

Figure 3-9 shows that even though nearly 900 facilities have been upgraded to provide either Comprehensive EmONC or Basic EmONC (81% of targeted facilities), only a small number of facilities are delivering a full package of Basic or Comprehensive services, according to international standards.
The delivery of a package of Basic and Comprehensive EmONC interventions is seen to increase progressively at the secondary and tertiary levels; it is at the highest in the DHQs surveyed (14.8% and 15.7% respectively). The THQs show an identical trend to DHQs; with BEmONC and CEmONC services available at 4.3% and 4.6% facilities respectively. At the primary level of care (RHCs and BHUs) the delivery of the basic package of EmONC services is almost negligible - RHCs 1.6% while EmONC is not available in BHUs despite being the first level of referral to most of the population.

The reason for this could be attributed to lack of staff, motivation and/or even women not accessing services. Case study analyses suggest it is more a quality issue and that services are planned poorly. This is reflected in the lack of Basic EmONC services at a primary health care level (less than 1.6%) closer to where 75% of the population lives.
3.6.2 COMPONENT 2: Training and Deployment of Community Midwives

**Output:** The output for this component focuses on the training and deployment of 12,000 community midwives by the end of 2012.

**Activities:** Activities include; development of a CMW curriculum, strengthening midwifery schools, training and deployment of midwifery tutors, equipment and teaching aids, transport to support training, accreditation and registration, deployment of LHV/nurses and midwives as CMWs, TA and capacity building, monitoring and support, promotion of SBAs, clean delivery kits. See Annex 12 for PC-1 log-frame narrative summary. See Annex 11 for PC-1 log-frame narrative summary.

**Targets:** Table 3-6 outlines selected targets which support the introduction of the new cadre of community midwife. Targets include training and deployment of CMWs and upgrade/construction of midwifery training schools. See Annex 12 for more information.

<table>
<thead>
<tr>
<th>Table 3-6: Targets for Training and Deployment of Community Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Midwives</strong></td>
</tr>
<tr>
<td>Functional midwifery schools</td>
</tr>
<tr>
<td>Approved by PNC</td>
</tr>
<tr>
<td>Renovations against target completed</td>
</tr>
<tr>
<td>New schools constructed</td>
</tr>
<tr>
<td><strong>Community midwife training</strong></td>
</tr>
<tr>
<td>Trained</td>
</tr>
<tr>
<td>Deployed out of total trained</td>
</tr>
</tbody>
</table>

**Community based Skilled Birth Attendants**

Under the MNCH Programme, a cadre of 12,000 Community based Skilled Birth Attendants (SBAs), known as community midwives, were to be trained and deployed nation-wide over a 5 year period. One SBA was to serve an estimated population of 10,000. To support the training of these workers 68 midwifery/ LHV schools have been up-graded and trainers have been developed to meet this demand.

In 2010-2011 58% of deliveries were at home. This is a decrease from 68% in 2006-2007. Of these deliveries 42% are conducted by SBAs (doctor, nurse, LHV, midwife) in 2010-2011 compared with 33% in 2006-2007. As reporting by CMWs is newly established contribution to this decrease cannot be attributed to CMWs as yet.

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42 Annual Review documents and from the Pakistan Nursing Council
43 An accredited health professional – such as a midwife, LHV, nurse or doctor – who has been trained to proficiency in skills needed to manage normal pregnancies, childbirth, and the identification, management or referral of complications.
44 Pakistan Bureau of Statistics, Pakistan Social And Living Standards Measurement 2010-2011
At the time of evaluation, a total of 5345 CMWs (45% of CMWs trained) had been deployed in the community. In terms of effectiveness of the CMWs, the following observations can be made from Table 3-7:

- The MNCH Programme Punjab has deployed the maximum number of CMWs (90.1%) followed by AJK (58.3%), KPK (36.6%), Balochistan (33.6%) and Sindh (32.9%). No deployment has taken place in GB and FATA.
- The Programme has achieved 75.3% target to enrol CMWs, of whom 45% had completed the training. Of those who have completed the training, 60.4% have been registered with PNC and 63.9% have been deployed.

Table 3-7: Status of CMWs’ Training and Deployment MNCH Programme (July 2012)\

<table>
<thead>
<tr>
<th>Provinces/Regions</th>
<th>Programme Target</th>
<th>Total Trained</th>
<th>% Trained out of Total Target</th>
<th>Total Enrolled (Trained+under-training)</th>
<th>% Enrolled out of Total Target</th>
<th>Total Deployed out of Total Trained</th>
<th>% Deployed out of Total Trained</th>
<th>Registered by PNC out of Total Trained</th>
<th>% Registered out of Total Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punjab</td>
<td>6346</td>
<td>2900</td>
<td>46%</td>
<td>4800</td>
<td>75.6%</td>
<td>2613</td>
<td>90.1%</td>
<td>1860</td>
<td>64.1%</td>
</tr>
<tr>
<td>Sindh</td>
<td>1960</td>
<td>1015</td>
<td>52%</td>
<td>1400</td>
<td>71.4%</td>
<td>334</td>
<td>32.9%</td>
<td>294</td>
<td>29.0%</td>
</tr>
<tr>
<td>Khyber Pakhtunkhwa</td>
<td>1810</td>
<td>837</td>
<td>46%</td>
<td>1676</td>
<td>92.6%</td>
<td>306</td>
<td>36.6%</td>
<td>784</td>
<td>93.7%</td>
</tr>
<tr>
<td>Balochistan</td>
<td>1200</td>
<td>286</td>
<td>24%</td>
<td>670</td>
<td>55.8%</td>
<td>96</td>
<td>33.6%</td>
<td>181</td>
<td>63.3%</td>
</tr>
<tr>
<td>Gilgit Baltistan</td>
<td>140</td>
<td>122</td>
<td>87%</td>
<td>136</td>
<td>97.1%</td>
<td>0</td>
<td>0.0%</td>
<td>12</td>
<td>9.8%</td>
</tr>
<tr>
<td>Azad Jammu &amp; Kashmir</td>
<td>285</td>
<td>115</td>
<td>40%</td>
<td>210</td>
<td>73.7%</td>
<td>67</td>
<td>58.3%</td>
<td>96</td>
<td>83.5%</td>
</tr>
<tr>
<td>Federally Assisted Tribal Area</td>
<td>255</td>
<td>70</td>
<td>27%</td>
<td>137</td>
<td>53.7%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>11996</td>
<td>5345</td>
<td>45%</td>
<td>9029</td>
<td>75.3%</td>
<td>3416</td>
<td>63.9%</td>
<td>3227</td>
<td>60.4%</td>
</tr>
</tbody>
</table>

Observations
Observations relating to the effectiveness of trained CMWs are summarised below:

1. The provinces and regions have not followed any uniform process and selection criteria as outlined in the PC-1.

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45 Annual Review reports, feedback from field work and the Pakistan Nursing Council
2. The verification process of candidates (spot verification) has not been undertaken systematically or rigorously. Feedback from the field is that family members are not given a proper orientation on the scope of work of the CMW.

3. Regarding service coverage, the CMW Deployment Guidelines proposes a catchment area of 5000 population for one CMW. The CMWs interviewed were not clear on this, the scope of work and range of services. Reported catchment population ranged from 4,000 to 10,000.
   - CMWs report also providing clinical services beyond their technical capability (e.g. treatment of common ailments, first aid, immunization etc)
   - There is a huge variation in the performance of CMWs; such as the number of registered pregnant women, ANCs, deliveries. None reported providing post natal care (PNC) services and most confirmed that they perform deliveries at their work-stations/clinics and not home-based, as proposed by the CMW Deployment Guidelines.

3. Service charges: there is a wide discrepancy; a uniform policy for service charge has not been possible as CMW Deployment Guidelines have not been approved by provinces.

4. Supervision: not being undertaken as per recommendations of the CMW Deployment Guidelines. Punjab has involved CMWs’ tutors. PHS has also been doing supervision of CMWs.

5. Deployment process: across provinces and regions, deployment has not been consistent with the guidelines in the PC-1 and the CMW Deployment Guidelines.

Quality of Training

CMW training commenced in 2007-2008 and has made good progress in terms of numbers enrolled and trained. Results of theoretical knowledge testing of CMWs are encouraging and show commitment of CMW training schools and MNCH Programmes, at provincial level.

A Review\textsuperscript{46} of the quality of CMW training found that the majority of graduates lack competence to practice due to an inability to think critically, problem solve and manage maternal and neonatal complications independently and refer in a timely manner. The review also notes limited clinical learning opportunities in a clinical and community setting.

Since this review the curriculum and training process has undergone a major revision in an effort to improve the quality of clinical training and achieve a level of competency and proficiency, which will allow CMW to practice safely, as an effective member of the primary level team.

Success of the cadre will depend on those involved in the Programme, the public health system, training and examination institutes, to address the gaps identified. It is

\textsuperscript{46}A Review of the Quality of Training of Community Midwives in Pakistan, TRF (2010)
vital to ensure that essential selection criteria are met, robust training and exam systems are further strengthened and adhered to, a coordinated system is functional among institutions and actors are involved in training process. At the forefront of these developments is the Pakistan Nursing Council who is to be commended for their efforts. However their capacity is limited and their ability to advocate for and ensure quality training will be dependent on the support they are given.

Feedback from the Field
The CMWs represent a large investment for the MNCH Programme. By and large, provinces and regions overlooked the introduction of CMWs to the communities and did not invest in establishing good working relationship with LHWs and TBAs.

Observations and Feedback from Stakeholders
Feedback from students was that MNCH has spent a lot of money on vehicles. According to the students these vehicles should be used to support community attachments.

Teachers of CMWs feel that there are not enough tutors. One of the problems is there is very little motivation to take on the role. They are getting 1,000 Rs over their basic salary – this is not enough to attract good tutors.

One CMW in Badin City is conducting 25 deliveries a month. She was to work in the community, however set up a private business, due to non acceptance by community and unable to get payment for services – feedback is that this is becoming the norm for CMWs.

CMW training schools believe that the PNC should be providing more support. Due to limited capacity they are accrediting schools without a full inspection. There need to keep the PNC engaged so they can advocate for CMW nursing schools. Feedback is there are cases where once a school has been approved CMWs have been moved from an approved building to an unapproved building. The approved building is used for other purposes not relating to the training of CMWs.

An inspection of the CMW kit found that there was no newborn resuscitation equipment in kit – these needs to be addressed.

(Case Study – MNCH Programme Evaluation Case Study Districts)

CASE STUDIES
In all three districts, 58% (282/485) of the CMWs have been trained while only 20% (98/485) have been deployed out of the total target. The MNCH Programme has completed or nearly completed the construction of a new CMW school and hostel in each of the surveyed districts. An appropriate system, however, needs to be defined and implemented to operationalise these structures, including provision of all essential amenities including electricity, gas and furniture etc. Below are analyses of CMW service delivery for two districts; District Kasur (Punjab) and District Badin (Sindh).

Case Study 1 - District Kasur: Punjab Province
Table 3-8 gives an analysis of CMW service delivery data for District Kasur (Punjab) just after their reporting to the DMU. During Aug-Oct 2011, out of total deliveries conducted through skilled birth attendants in district, deployed CMWs (46) conducted 2% deliveries (526/23521 all births).
Table 3-8: CMW Services Feb 2012 District Kasur  
(N=46 Deployed CMWs)  
CMW total covered Population (average) 460,000 (14% of district population)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>% ANC of expected pregnancies (829/1303)</td>
<td>64%</td>
</tr>
<tr>
<td>% PNC1 of expected pregnancies (183/1303)</td>
<td>14%</td>
</tr>
<tr>
<td>% deliveries of expected births (183/1112)</td>
<td>16%</td>
</tr>
<tr>
<td>% FP clients of expected eligible women (15-49 yrs.) (470/5942)</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: District MNCH office Kasur

Figure 3-10 shows performance categories of deployed CMWs by average monthly deliveries during Aug–Oct 2011 with reporting compliance of almost 99%. Major proportion (29/46) is conducting less than 4 deliveries per month; however 4 or more than 4 deliveries per month through 32% of deployed CMWs is positive and reflects the potential of the CMW cohort developed through the MNCH Programme. However as case study approach was taken it is unclear if this is the same across all Pakistan.

**Figure 3-10: Performance Categories of Deployed CMWs District Kasur**  
(by average monthly deliveries between Aug-Oct 2011 n=46 CMWs, reporting compliance = 98.5%)

- Conducting 4 or more than 4 deliveries/month (n=14)
- Conducting less than 4 deliveries/month (n=29)
- Conducting Zero deliveries/month (n=2)

Case Study 2 - District Badin (Sindh Province)

Table 3-9 gives an analysis of CMW service delivery data, just after their deployment in May 2011. A total 13 out of 60 trained CMWs are deployed so far. Of this number, 6 CMWs are deployed in the catchment area of the DHQ, 1 at THQ Golarchi, 4 at the district RHCs including RHC Talhar, 1 at BHU Abdullah Shah and 1 at the government dispensary in Sorhadi. A total of 413 deliveries were conducted by CMWs during June through November 2011 and constituted 3% of the total expected pregnancies in their catchment population.

Table 3-9: CMW Services June-Nov 2011 District Badin  
(N=13 Deployed CMWs)  
CMW total covered Population (average) 93,807 (6% of district population)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>% Expected Pregnancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC1</td>
<td>452</td>
<td>28</td>
</tr>
<tr>
<td>ANC2</td>
<td>367</td>
<td>23</td>
</tr>
<tr>
<td>ANC3</td>
<td>214</td>
<td>13</td>
</tr>
</tbody>
</table>
### Indicator Table

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>% Expected Pregnancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT vaccination</td>
<td>482</td>
<td>30</td>
</tr>
<tr>
<td>Deliveries</td>
<td>413</td>
<td>3</td>
</tr>
<tr>
<td>% of expected births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNC</td>
<td>279</td>
<td>17</td>
</tr>
<tr>
<td>BCG</td>
<td>338</td>
<td>82</td>
</tr>
<tr>
<td>LBW</td>
<td>62</td>
<td>15</td>
</tr>
<tr>
<td>Referrals to health facility</td>
<td>06</td>
<td></td>
</tr>
<tr>
<td>Maternal Deaths (July &amp; Oct)</td>
<td>02</td>
<td></td>
</tr>
</tbody>
</table>

206 out of a total 413 deliveries (50%) were conducted by only one CMW, deployed around the DHQ hospital (range 20-minimum to 43 maximum deliveries per month). The CMW conducted 43 deliveries during the month of June 2011, just after her deployment in May 2011. The remaining 50% of the deliveries have been conducted by the other 12 deployed CMWs (range 0 minimum to 20 maximum deliveries per month) at an average of 3-4 deliveries/month/CMW. One of the deployed CMW conducted 34 deliveries and reported 2 maternal deaths during months of July and October (See Figure 3-11). The number of reported maternal deaths in this case seems to be quite significant and needs further evaluation through a proper EmONC assessment.47

### Figure 3-11: Performance Categories of Deployed CMWs District Badin

(Minimum –Maximum monthly deliveries between June-Nov 2011 n=13 CMWs)

- 20-43 deliveries per month (1/13 CMWs) average 34 deliveries/month
- 0-20 deliveries per month (12/13 CMWs) average 3-4 deliveries/CMW/Month

Due to frequent delays in stipend disbursements, lack of continuity of supplies and a lack of clear policy on CMW retention and user fees, frustration among trained CMWs is rife, resulting in a significant drop-out rate. Payments to 13 community midwives are still pending since 19th May 2011 even though CMWs are regularly submitting their monthly report. Out of seven CMWs attached to RHC Talhar, four dropped out after training due to delayed deployment.

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47 As referred to on Page 99 of the PC-1
Provinces/Region Snapshot
Table 3-10 provides a summary of progress with the development of CMWs across Pakistan.

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>STATUS</th>
</tr>
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</table>
| Punjab          | • So far, 2800 CMWs have been deployed, 1300 have sat the examination and the successful candidates will be deployed in December 2012 on a three year security bond and will receive an Rs.2000/- retention fee.  
• All deployed CMWs were provided with CMW kits as per PC-1 and a two year supply of disposable safe delivery kits. Refresher courses are carried out annually, appraisals of the deployed CMWs will be carried out in Dec 2012 and a new batch of 1200-1300 candidates is in the process of being identified for 2015.  
• There are 22 Midwifery Schools in the province, fully equipped with registered and certified tutors. Currently, the MNCH Programme is managing these schools. A decision to hand them over to the Pakistan Nursing Council is pending.  
• New reporting tools of the CMW have been printed and training has been completed so CMWs can start reporting their activities. |
| AJK             | • 115 CMWs have been trained from a target of 285 and 43 are under training. 65 of the CMWs have been deployed and the remaining will be deployed by the time this report is published.  
• The normal cost for kits and deployment ceremony of the CMWs supported by UNICEF and UNFPA was approximately Rs.70,000/- per CMW.  
• A total of four midwifery schools are operational in AJK. Tutors are trained and registered, clinical instructors are female medical officers. |
| Sindh           | • The recruitment target for CMWs was 1960. 334 have been deployed as per the prescribed guidelines after proper registration; the registration cost was paid by Pakistan Initiative for Mothers and Newborns (PAIMAN) Project. Equipment and medicines provided through UNFPA and NPPI. 1400 CMWs have been inducted so far and a fourth batch is being trained in the 25 Midwifery schools across the province.  
• As per PC-1 guidelines, the CMWs were given a retainer of Rs 2000/- for a period of two years. After this they would sustain themselves. No sustainability strategy is in place. Deployed CMWs are charging individually. Weak monitoring aspect of CMWs. |
| Khyber Pakhtunkhwa (KPK) | • The target for recruitment of CMWs was 3000 and 1810 have been deployed after proper registration. MNCH Programme needs the prescribed guidelines. The selection criterion for CMWs was made 10-15% flexible in terms of age and level of education in the province in order to be able to meet the recruitment target.  
• A total of 230 CMWs were deployed with help from UNICEF, UNFPA and the USAID-funded PAIMAN Project. One-off equipment and medicines are also being provided through UNICEF. 300 additional CMWs to be deployed. Last batches of the CMWs are being trained at the Midwifery schools across the province.  
• The CMWs were to be given a retainer fee of Rs 2000/- for two years, then must sustain themselves. With no retention or sustainability strategy, shortage of funds, this stipend is not being paid. PNC certified un-deployed CMWs are being absorbed by other agencies at higher salaries. |
| Balochistan     | • The Balochistan MNCH Programme had a target of 1200 CMWs. 650 have been trained and 88 deployed so far, though the registration process with the PNC is taking longer than expected. 15 Midwifery Schools and hostels were also constructed in two schools with donor support. |
## Table 3-10: Progress with Development of Community Midwives

<table>
<thead>
<tr>
<th>Location</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Gilgit Baltistan (GB)** | • As regards CMWs, against a target of 140, 160 CMWs have been trained, with an additional 2 trained as volunteers. None have been deployed due to funds shortage. It was decided to adjust these trained CMWs against the vacant posts in health facilities so they are not lost but become part of the health system.  
• There are two Midwifery Schools in GB, one in Gilgit and the other in Skardu. Currently they are housed in a government building but custom built buildings are in the process of being constructed. In Gilgit, the Midwifery School building is 90% complete. In the case of Skardu, the construction has been stalled due to lack of funds. |
| **FATA**          | • FATA had a target of 225 CMWs. 70 have been trained so far in D.I. Khan and at the Hayatabad Midwifery School, Peshawar. No CMW has been deployed so far. UNICEF has committed itself to providing 120 kits for the CMWs. A batch of 61 CMWs is currently being trained. In order to achieve targets, extensive social mobilization was undertaken to attract people. 25 have already registered with PNC and registration for the remaining 45 is still awaited. The registration of 25 CMWs was processed through the Federal MNCH Cell but getting them others registered with the PNC is proving a challenge. |
3.6.3 COMPONENT 3: Provision of Comprehensive Family Planning Services

Outputs: This component includes increased availability of comprehensive family planning services.

Activities: Availability of LHV, training, strengthen contraceptive, procurement and logistic system counselling, links with Department of Population Welfare, and CSM, move FWC to BHUs and RHCs. See Annex 11 for PC-1 log-frame narrative summary.

Targets: Targets for this component were hardly achieved. Refer to Annex 12.

Approach to Comprehensive Family Planning Services
Efforts were to be made to ensure that preferably all (at least 7,000) health facilities would be providing a maximum range of family planning services for optimal birth spacing. The family planning package was to be achieved through making LHV available at all health facilities, training them on FP counselling and contraceptive technology, including Optimal Birth Spacing Initiative and Elective Contraception, strengthening of the contraceptive procurement and logistic system, provision of IEC material, surgical contraceptive training and services, FP counselling and linkages between the Department of Population Welfare and Greenstar, for the marketing for free contraceptive (policy, move FWC to BHU and RHC). There was no formal agreement/or MoU signed between MNCH programme and Population Welfare Department which could validate this commitment on ground.

HFA data shows that 58% of BHUS, 50% of RHC, 71% of THQ and 100% of DHQs and are providing at least 3 Family Planning (FP) methods and the MNCH Programme target for family planning training was only 6% achieved. Services are being implemented as parallel projects. Overcoming this is one of the biggest challenges for the MNCH Programme.

Lack of Progress
Few interventions have been undertaken to improve the FP services at health facilities. There is neither IEC/BCC material related to the promotion and choice for family planning services at the DHQs and RHCs, or contraceptive supplies available at government administered public health facilities, whereas the PPHI run BHUs have the contraceptive supplies on a more regular basis. According to Provincial Managers in case study districts no significant activity took place for skill development of facility staff in the district, as “family planning is third in the list of priorities”.

In District Badin, Sindh the DHQ offers only elective surgical contraception services during caesarean section procedures, and 50 elective tubal ligations were also performed during Jan-Dec 2011. Contraceptives are not available at the DHQ hospital pharmacy or Labour Room to cater for OPD or postpartum and post abortion clients,

48 FGD Provincial Managers / MNCH Programme
and CMWs and LHWs at RHC Talhar do not have supplies of contraceptive, whereas the PPHI-run BHU (BHU GM Nizamani) is well supplied.

**Links between Provincial Departments**
The failure to provide Comprehensive Family Planning Services is complex. In essence it relates to discussions, to merge the two Ministries into one Ministry of Health and Population Welfare, never being realised due to the changing context. Now, in the Post 18th Amendment Scenario, functional integration between Provincial Health Departments and Departments of Family Welfare still has not materialised in most provinces. This has affected the working relationship of health and family planning staff at all levels of service delivery, so the effectiveness of an integrated approach has been compromised – with little achievements of targets or integration.

Although at the federal level, the two ministries had stipulated their solid commitment to functional integration of MCH services there are challenges to be addressed. These include: inter-ministerial coordination, provincial and district level management, commodity pricing, contraceptives, vaccines and essential medicines supply chain, human resource training and motivation, services provided by frontline workers at community level, health system strengthening and enlarging the promotion and advocacy and network for MCH services.

**Progress in Provinces**
Despite coordination challenges; progress is being made with integration in some provinces. In Punjab, the MNCH Programme is leading the coordination efforts with Department of Population Welfare for ensuring availability of contraceptives at all levels in the public sector health facilities.

**Coordination at a District Level**
In Punjab formal coordination exists at district level between the PWD and health department through district technical and coordination committees (DTC & DCC). The DTC is chaired by EDO (H) in relation to coordination and joint activities for FP services through facilities and outreach. The DCC is chaired by district coordination officer (DCO - executive head of the district) and works to streamline coordination between all FP stakeholders (including NGOs). Minutes of the meetings are developed and disseminated; however, follow-up on decisions and agreed steps needs to be strengthened. It is worth mentioning that as per Punjab government policy, nine out of 12 Family Welfare Centres (FWCs) have been recently shifted to RHCs.

(Feedback–MNCH Programme Evaluation Case Study Districts)

In Sindh and Gilgit Baltistan, at the provincial level there is a good coordination between the MNCH Programme, DoH and the Department of Population Welfare for ensuring availability of contraceptives and training of health workforce but it gets weaker at the district level as there is very limited interaction between the two departments.

In Balochistan, there is no coordination of the MNCH Programme, DoH and the PWD. The Programme is not receiving contraceptives from the PWD as they charge for
supplies and there is no provision under the programme to pay for these. In Khyber Pakhtunkhwa, Azad State of Jammu and Kashmir, and FATA there is no coordination of the MNCH Programme, DoH and the Department of Population Welfare for ensuring availability of contraceptives and training of health workforce.

Focus Group Discussions
Feedback from FGDs and Interviews (See Annexes 8 and 10 for more information) is:

- In Punjab provincial steering committee met regularly and a lot of issues were sorted out by them. The Director of Population Welfare Department was participating in meetings, but the issue of family planning and provision of contraceptives were not given a focus.

- Supplies are not managed well. BHU are adequately stocked; CMW have limited supplies, LHV's buy from market and sell for profit. Have constant supply at the right time.

- Contraceptive are not available at the labour room in ward areas and even at pharmacy. This is a missed opportunity.

- The Programme has not capitalised on the opportunities to increase the coverage and availability of the Programme. According to secretary PWD Punjab, although defined in PC-1, roles and responsibilities were neither formalized nor shifted towards PWD.

- Training has not happened. – Need for Minilap training.
3.6.4 COMPONENT 4: Strengthen Communication for MNCH

**Output:** The only output in this component is - effective and broad based demand for MNCH services generated and better reproductive health behaviour adopted.

**Activities:** Activities include: Formative research, communication messages, national BCC strategy, advocacy, demand creation, community mobilization, capacity building, monitoring and evaluation. See Annex 11 for PC-1 log-frame narrative summary.

**Targets:** Nil specific targets have been monitored to support this output. Refer to Annex 12 for more information.

**Community Mobilisation**

The PC-1 identifies advocacy and demand creation as a key implementation strategy for the Programme. The focus is on inculcating socially acceptable and technically correct messages to improve health service utilisation and foster safe childbearing and child rearing practices. These activities were to be undertaken mainly through LHWs and CMWs and social mobilisers.

According to Programme staff in Sindh and KPK, community mobilisation initiative suffered due to political interference in the recruitment of social mobilisers. LHWs could have helped in taking forward the key MNCH messages but feedback was that negativity between the MNCH and LHW Programmes impacted adversely on activities. However the evaluation team was unable to substantiate this feedback.

In other provinces such as Punjab, feedback was that funds were channelled into more tangible outputs such as CMWs, midwifery schools and EmONC services, thus the communication component was not achieved. The political interference and bottlenecks in funding impacted on the whole demand creation component of the Programme. As a consequence, the well laid out communication strategy has not been implemented in most provinces – in other words little has been achieved in this component.

AJK reported that all 10 districts in the province have social mobilisers trained by UNFPA and PAIMAN. Their salary is at par with Grade-17 government employees plus a Rs.50,000/- project allowance. They work in collaboration with LHWs and are monitored by the provincial Communication Officer. Targeted MNCH related messages as per the communication strategy are channelled to the community through events organised by LHW Programme. The Coordinator LHW Programme is part of the Steering Committee. However it is not clear if this is the current situation as the PAIMAN project has been completed.

**Community Perceptions**

During FGDs it was evident that the community believes that the LHWs are doing all the motivational work and educating the

“We went to the DHQ for my last delivery and it was a bad experience as the doctor was not there even at 7:00 PM and thus an LHV delivered my baby. He was so small and she did not take care of him and he died. I will never go to that hospital again. My previous three babies were delivered by Baji (a local private doctor) and all are well and healthy.”
women. They accompany the women while referring them to private and public sector facilities, so it would be beneficial if they could also conduct deliveries. It is evident that it will take time for CMWs to gain the confidence of the community, as women are apprehensive about the young age of CMWs and their abilities. Some CMWs have managed to create a good impression by working closely with the LHW, and having her constantly at her side to influence household decision makers.

In District Kasur, Punjab the Women’s Committees for the LHW Programme complemented CMWs on being a positive influence in the community, regarding the work they are doing ante-natal care and delivery. The fee for service by CMWs is around Rs. 500, but it was observed during the field visit and interview that there is reluctance by the community members to pay for fees, medicines and other essential materials.

**Box 3-1: Community Perceptions – Cost and CMWs - Emerging Issues**

Women feel that private doctors inform them of the total one-time costs. This allows families to plan for this cost. At government facilities women report they are spending money constantly on supplies. This becomes very cumbersome for the family and overall they report that private facilities cost them no more than public facilities.

CMWs are few and not present in most of the communities but even if they are there, confidence level of the community is yet to be gained and it will take time. Most of the cases of deliveries assisted by CMWs were supported by the LHW. In view of this scenario, unless sound policies are backed by well-functioning Programmes, the CMWs are likely to become a victim of poor implementation.

A summary of barriers and underlying causes to reaching and working with communities identified during focus group discussion, field visits and interviews are summarised in Table 3-11 below.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Underlying Causes</th>
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<tbody>
<tr>
<td>Social determinants of health, barriers to health service use, inadequate information regarding healthy home behaviours and care seeking</td>
<td>Failure to implement a well laid out community mobilisation strategy as a result there is a lack of mechanisms for community participation, irrelevant or inappropriate messages; poor dissemination strategies; harmful cultural practices; lack of legal framework for gender equality and status of women</td>
</tr>
<tr>
<td>Lack of community frontline workers, and/or lack of effective linkages to the health system</td>
<td>Inconsistent policies for MNCH at a primary health care level – BHUs not operating as part of the network to support emergency care for MNCH Poorly defined roles and lack of supervision involving LHW, CMW and LHV</td>
</tr>
<tr>
<td>Low quality of care</td>
<td>Lack of standards for care, existing global guidelines (e.g. IMNCI) not known or adapted to the local context; poor supervision and support, infection control practices</td>
</tr>
</tbody>
</table>
Table 3-11: Barriers to Reaching Communities

<table>
<thead>
<tr>
<th>Barriers to Reaching Communities</th>
<th>Poor and discriminates again poor.</th>
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</table>
| **Erratic supply of essential commodities and diagnostics** | Poor management of supply chain  
Lack of integration between different provincial departments |
| **Low demand for care, late use and poor compliance** | Lack of information, negative experiences with health system, distance and cost – Feedback from the community was they prefer local traditional providers “as they are safer” |
| **Lack of skilled personnel, particularly in hard to serve areas** | Inadequate human resource policies; limited training and little focus on management, employment outside the system on higher rates, incentives not provided as promised; skilled staff not available for lower levels of the health system, absenteeism; poor accommodation, salaries not paid |
| **Poor quality of care in public and private sector** | Lack of or unknown standards for care; low sense of urgency for emergencies; training often not skills based; low accountability and motivation of health staff; lack of basic supplies and drugs |
| **Services of CMWs not used** | Not trusted by the community or community unaware of existence, lack of transportation; social and cultural gap between CMW and clients, especially poor, cost of services, rivalry between LHWs and CMWs – working relationship not always good |
| **Affordability barriers for the poor** | Low income/resources, lack of social security systems  
Corrupt practices by public sector providers  
High cost of private sector care |
3.6.5 COMPONENT 5: Strengthen Programme Management

**Outputs:** Outputs in this component include a strengthened (i) monitoring and evaluation system (2) management and support system

**Activities:** Monitoring system, supervision and support, evaluations, establishment of MNCH cells, provincial MNCH cells, district MNCH Units, national and provincial steering committee, TAG at federal and provincial levels partnerships. See Annex 11 for PC-1 log-frame narrative summary.

**Targets:** Relate to the establishment of Programme Management Units (PMU) in all Provinces, areas and districts. Feedback is that all PMU are established and functioning however PMUs in the 134 districts are having problems with staffing (Refer to Annex 12).

3.6.6 Programme Initiation

The PC-1 was approved by the Executive Committee of the National Economic Council on 7 March 2007. Thus, the Programme is currently in its fifth year of implementation and is due for completion in June 2012; however funding will be available until 2014.

It is difficult to determine when the Programme formally commenced operation and who was providing leadership. The July-August 2009 annual Review reports that the Federal MNCH cell had been established and functional. However, the National Programme Manager had not been appointed on full time basis.

Feedback was that positions for deputy Programme managers and other key positions were filled on a deputation basis. Full time, technical assistance was provided by UNFPA (Technical Advisor and Finance Manager) and UNICEF (M&E and BCC consultant). WHO provided technical assistance for IMNCI; however little more is known about these positions and what was accomplished.

In July 2011, it was reported that the Federal MNCH Cell was fully established and functional. A National Programme Manager was hired on full time basis – yet in October 2011, the same time the evaluation commenced the Federal MNCH cell stopped functioning, following devolution of powers to the provinces in June 2011.

3.6.7 Programme Management Structures and Processes

A national level federal MNCH Programme Management Unit (PMU) was to be established and led by national Programme manager. The federal level MNCH cell was to facilitate and monitor the Programme’s implementation, by providing assistance to provinces and districts. This role was the basis of the Federal MNCH Cell.

Every province was to establish its own provincial setup. The Programme was to provide some technical posts to assist implementation by regular provincial health staff. The provincial health departments, through the Provincial Directorate of Health, were responsible for ensuring implementation of the Programme.
The Executive District Officer, Health (EDO) was to be empowered to have ultimate responsibility for the implementation of this Programme. Each district was to have a public health specialist, working under the guidance of the EDO-H. These structures are reflected in Figure 3-12 below.

**Figure 3-12: Proposed Management Structure as Described in PC-1**

To provide a systematic assessment of what is required at each level of health care, a basic services package was proposed. The package comprised two parts. A minimum (core) component needed to reduce morbidity and mortality and a second component to suit local requirements and priorities.

**Provincial Steering Committee**

All the provinces were to establish a Provincial Steering Committee for Programme oversight. These would be chaired by the provincial health minister and have representation from the line departments. The committee had to meet half yearly to review progress and achievements of the Programmes. The Provincial Steering Committees would propose innovative strategies for pilot testing and oversee their implementation. The Provincial Steering Committees were also authorised to approve the ranking of the districts, according to performance for bonuses and incentives.

**Provincial MNCH Coordination Committee**

A number of key positions and partners in MNCH related activities report to the Secretary Health. The Provincial MNCH Coordination Committee was to be constituted at the provincial level, to foster coordination, and chaired by the DG Health. No new implementation structure was to be created for this Programme. Provincial health departments were to rearrange existing structures/positions responsible for MCH to form MNCH directorates/cells, with additional technical posts. They were to implement the MNCH activities, with other related Programmes/projects in the province, whether government or donor funded.

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49 MNCH ProgrammePC-1 Pages 11-12
In the spirit of partnership, a well-coordinated National MNCH Programme was to be implemented, with specific prescribed roles for federal, provincial and districts. All and development partners were to align their activities under the Programme.

3.6.8 Programme Implementation - Current Status

The MNCH Programme was not implemented as per the original design, under the direction of the DG Health. The federal MNCH cell became the implementer through provincial MNCH Programmes and Public Health Specialist, totally bypassing the provincial Departments of Health, operating as a vertical Programme. This situation was further exacerbated by low funding in every financial year from 2006-2010-11. The provincial Departments of Health had limited ownership in this Programme and there was limited coordination and collaboration with other mainstream and vertical Programmes.

The Provincial Steering Committee, chaired by the Special Secretary Health, was only operational in some provinces. The Provincial MNCH Coordination Committee, chaired by Director General (DG-Health) was never formed. This further led to lack of ownership by the DG-Health. This has since been confirmed; so the team stands by this statement.

It is worth mentioning that the majority of components and interventions of MNCH Programme were related to district based health facilities. The Provincial Directorate of Health needed to co-ordinate other Programmes, to maximise results. Limited collaborative efforts were made by the Federal and the Provincial MNCH PMU towards the Provincial Department or Directorate of Health.

![Figure 3-13: Management Failure in Key Areas Shown](image)

As can be seen from Figure 3-13 above this lack of coordination is reflected in all aspects of the Programme: non-availability/retention of staff, necessary equipment,
essential medicine, poor coordination and linkages with other Programmes, retention and tracking of trained non-deployed CMWs, poor monitoring and supervision. Thus the Programme entered into a vicious cycle of management failure for key areas.

Fragmentation and duplication in service delivery, pose a grave threat to achieving overarching targets. Certain RH and FP and limited MNCH Programme components are managed by the Population Welfare, with a mandate for the delivery of RH and FP services. The Programme itself is under the Department of Provincial Departments of Health. The overlapping programmatic roles, and service delivery gaps, are causing inefficiencies and disorganization in achieving the MDGs.\(^5^0\)

### 3.6.9 Monitoring and Evaluation

Quantitative and qualitative reporting is not a regular or strong feature of the Programme. The project M&E systems need to be strengthened to shift its focus to analysis and use of output and outcome data to assist in strategic decisions, rather than tracking activities. In addition inconsistent software is being used across the provinces for data collection and dissemination.

In Punjab, the MNCH Programme is collecting the facility level information from DHIS reports from all the districts, but in 11 districts of Sindh and 14 districts of Balochistan, there are issues as HMIS/DHIS is dysfunctional and segregated and data is not used for making decisions at the policy or operational level. The same is the case in Gilgit Baltistan. In Khyber Pakhtunkhwa, Azad State of Jammu and Kashmir and FATA, the PHS is sending monitoring reports to the PMU but the findings and recommendations are not being communicated to the service delivery sites for correction or improvement.

### 3.6.10 Management Information Systems

The current Health Management Information System does not provide a platform from which data can be collated and converted into information for decision making. Furthermore the EPI programme, LHW programme, TB control programme and teaching hospitals maintain their separate MIS thus excluding a wealth of information. Accurate and timely statistics on basic demographic event (vital statistics) and inclusion of private sector data and strengthening of vital statistics registration as per PC1 are foundation of rational public health planning, policy making and Programme, and basis for monitoring progress in reducing infant and maternal mortality. HMIS and MIS data linkage and collection is fragmented and cannot be used for timely decision making.

### 3.6.11 Public Private Partnerships

No mechanisms for public/private partnership, outlined in the PC-1, were developed. Districts were not encouraged to involve the private sector in improving quality health care. Private clinics, after quality audits (protocols to be developed by the EDO-H), were to be included in the MNCH capacity building Programme of health care providers.

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Unfortunately this never happened and an opportunity was missed, to include private sector in overall health network.

3.7 Efficiency Shortcomings – Management and Implementation
A summary of prioritized management issues are concerns are in Table 3-12 below.

<table>
<thead>
<tr>
<th>Major Management Concerns</th>
<th>Impact</th>
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<tbody>
<tr>
<td>• Inefficient planning and no baseline</td>
<td>• Poor coverage of services not targeting the poor</td>
</tr>
<tr>
<td>• Absence of minimum essential package of services including EmONC as proposed in PC1</td>
<td>• Poor treatment outcomes and pregnancy outcomes, and lack of patient satisfaction</td>
</tr>
<tr>
<td>• Lack of efforts to rationalize staff and match staff and skill mix with the current MNCH service delivery and management needs</td>
<td>• Low quality of services and poor treatment outcomes; poor Programme management</td>
</tr>
<tr>
<td>• Non integration with the provincial and district health system</td>
<td>• Mal-governance, and management</td>
</tr>
<tr>
<td>• Absence of efforts for public-private partnership</td>
<td>• Difficulties in expanding essential pro-poor services e.g. midwifery care and newborn care</td>
</tr>
<tr>
<td>• Inadequately functioning information system and limited use</td>
<td>• Poor planning resulting in inefficiency and ineffectiveness</td>
</tr>
<tr>
<td>• Weak monitoring and evaluation system</td>
<td>• Difficulty to measure performance of services in terms of outputs and outcomes</td>
</tr>
<tr>
<td>• Disconnect between management staff and their skills and programmatic services</td>
<td>• Poor educative supervision and less likelihood of measuring the outputs</td>
</tr>
<tr>
<td>• Absence of protocols and SOPs even for the currently offered services</td>
<td>• Mal-governance and difficult to measure quality of services</td>
</tr>
<tr>
<td>• Absence of 24/7 Basic and Comprehensive EmONC&amp; Obstetric emergency services at hospitals</td>
<td>• High IMR, under 5 mortality, MMR and maternal morbidity</td>
</tr>
<tr>
<td>• Non-use of essential drugs list at health facility and erratic supply of drugs</td>
<td>• Low level of patients attendance, inadequate use of fixed costs resulting in high unit cost of services</td>
</tr>
<tr>
<td>• No retention policy for CMWs</td>
<td>• Loss of trained un-deployed CMWs</td>
</tr>
<tr>
<td>• Lack of linkages with other Programmes</td>
<td>• Piecemeal services , lack of patient satisfaction</td>
</tr>
<tr>
<td>• Lack of clear policy and strategic direction in the development of human resource for MCH services and poor personnel management practices</td>
<td>• A major contributor to poor performance.</td>
</tr>
<tr>
<td>• In the absence of a clear policy and regulatory framework for the for-profit sector, commercial interests are taking priority over social goals.</td>
<td>• Coverage by NGOs is too small to have any significant impact on the MCH services.</td>
</tr>
</tbody>
</table>
3.8 Capacity Building of Staff

Training contributes significantly to all components of the MNCH Programme. Staff in both the Public and Private sectors from all levels of service delivery and management was to benefit from both management and technical training. Training was to focus on developing competencies and capacity building through a range of training experiences.

Activities: Training was to include; attachments at tertiary hospitals for WMOs/MOs from DHQ/THQs, rotation of PG students, management training, post-graduate training for nurses, essential newborn care, competency based training on emergency obstetric care, trainings on IMNCI, family planning - counselling and technical skills and more.

Capacity Building and Management

The 2011 annual review reveals that the capacity development initiatives undertaken by the Programme did not address capacity development requirements of the managers in a holistic manner. The need to introduce Information technology as an aid to Programme management was not met. Weak coordination and communication within Programme staff was an issue. High staff turnover is an on-going problem. Delay in the decision making for recruitment of the higher staff improper job description and unclear roles and responsibilities were found to be major management gaps.

Training needs of the finance staff were not assessed regularly nor were trainings provided to cater to their needs. Insufficient human resources in health sector (particularly female doctors, LHVs, community skilled birth attendants and LHWs) remain an unresolved issue.

Records of Training

It is difficult to know who benefited from training as there is no centralised database. Where data is available it is inconsistent, incomplete and cannot be validated.

Inconsistent Training Records

WHO reported that by the end of 2009 a total of 2542 health care providers from 996 had been trained in IMNCI by the National MNCH Programme; in 2010-2011 the Health Facility Assessment reported that 1978 health providers from 325 facilities had been trained in IMNCI. WHO also reported that Pakistan has been able to train 9700 LHWs on a new IMNCI curriculum and refers to a commitment of 25 medical and paramedical institutions to IMNCI.

(Feedback–MNCH Programme Evaluation Case Study Districts)

- A database was being kept by the Federal MNCH cell. This ceased to be maintained when the office closed in 2011. The HFA\(^{51}\) (2010-2011) reported more than 5228\(^{52}\) staff as having benefited from a range of trainings including: EMONC,

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\(^{51}\) The HFA in 2011, reported more than 5228 staff as having benefited from a range of training including, EMONC, ENC, IMNCI, IMPAC, FP Surgical, FP counselling and Client-Centred Behaviour.

\(^{52}\) The HFA 2010 included all DHQs, THQs and RHCs while 20% sample of BHUs was taken. Therefore the number of staff trained 5228 does include all BHUs.
ENC, IMNCI, IMPAC, FP Surgical, FP counselling and Client-Centred behaviour skills

- TRF has monitored training since 2009. Data is inconsistent and does not seem to capture all donor trainings – a self reporting questionnaire was sent to provinces to try and reconcile training data however feedback reinforced the inconsistencies. Number trained according to yearly assessments are available in Annex 11.

- Some provinces record donor training in a separate database or not at all. An attempt was made to triangulate data from provinces but this was unsuccessful, e.g. some provinces reported training provided by UNICEF, but this could not be verified by UNICEF at a central level.

**Approach to Training**

The PC-1 presents a well laid out 4 step plan to support training of 15,000 health facility staff, from all levels on child survival and newborn care. The phased plan is as follows:

- Year 1: Preparatory phase of trainings. Implementation of the EmONC and IMNCI trainings up to the provincial level. Management trainings for doctors and postgraduate trainings for nurses to commence.

- Year 2: Attachments at Teaching hospitals for WMOs/MDs to start, EmONC trainings implemented in 70% of the districts, IMNCI trainings conducted in 50% of the districts, ENC trainings conducted for identified staff and First phase of IMPAC trainings conducted up to District Master trainer level

- Year 3: Attachments at Teaching hospitals for WMOs/MDs to be continued, rotation of PG students started in facilities offering comprehensive EmONC, completion of EmONC trainings cascade in all the districts, IMNCI trainings conducted in rest of districts, IMPAC trainings conducted in 70% of districts.

- Year 4: Completion of IMPAC trainings, Refresher courses for EmONC and IMNCI

There is little evidence to suggest this plan was followed or teaching institutions strengthened to support training.

**Evidence of Training and/or Capacity Building**

What is known, from available data, is that a lot of training has taken place and not been recorded. However reviewing incomplete databases and reports it would seem that the focus of most training has been IMNCI followed by EmONC and Emergency Newborn Care (ENC). Hardly any family planning or management training is recorded. Feedback from District managers is that capacity building to support their role was not considered.

Standardised WHO curricular was used for the three clinical trainings (IMNCI, EmONC and ENC); however there is no evidence of adaption to the local context. An assessment of IMNCI and EmONC trainings is currently being undertaken by TRF.

According to the HFA; staff at 60% of facilities, have not received any MNCH-related training. This is reflected in Table 3-13. From this table it can be seen that training focused more on secondary and tertiary level facilities and decreased at the primary health care level.
Table 3-13: Percent of Health Facilities Receiving MNCH Training

<table>
<thead>
<tr>
<th>MNCH Staff</th>
<th>% or Number of HFs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DHQHs</td>
</tr>
<tr>
<td>EmONC</td>
<td>36.11%</td>
</tr>
<tr>
<td>ENC</td>
<td>23.15%</td>
</tr>
<tr>
<td>IMNCI</td>
<td>25.93%</td>
</tr>
<tr>
<td>IMPAC</td>
<td>12.04%</td>
</tr>
<tr>
<td>FP surgical</td>
<td>18.52%</td>
</tr>
<tr>
<td>FP Counselling</td>
<td>29.63%</td>
</tr>
<tr>
<td>Client centeredness</td>
<td>10.19%</td>
</tr>
</tbody>
</table>

Source: Aggregated data from Health Facility Assessment 2010-2011

Table 3-14 suggests that the main beneficiaries were LHV, Medical Officers, Nurses and Women Medical Officers (WMOs). However how this training has been translated into good practice is unclear as protocols were not available or displayed for most procedures which were the focus of training.

Table 3-14: Number of Staff Trained in Delivery MNCH Services

<table>
<thead>
<tr>
<th>MNCH Staff</th>
<th>EmONC</th>
<th>ENC</th>
<th>IMNCI</th>
<th>IMPAC</th>
<th>FP Surgical</th>
<th>FP Counselling</th>
<th>Client Centred</th>
<th>Total Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetists</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>64</td>
<td>17</td>
<td>31</td>
<td>2</td>
<td>8</td>
<td>36</td>
<td>15</td>
<td>173</td>
</tr>
<tr>
<td>LHV</td>
<td>604</td>
<td>242</td>
<td>493</td>
<td>21</td>
<td>48</td>
<td>332</td>
<td>87</td>
<td>1827</td>
</tr>
<tr>
<td>MO</td>
<td>182</td>
<td>76</td>
<td>772</td>
<td>0</td>
<td>39</td>
<td>118</td>
<td>96</td>
<td>1283</td>
</tr>
<tr>
<td>Nurse</td>
<td>245</td>
<td>152</td>
<td>215</td>
<td>8</td>
<td>12</td>
<td>60</td>
<td>49</td>
<td>741</td>
</tr>
<tr>
<td>OT Technician</td>
<td>29</td>
<td>3</td>
<td>22</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>23</td>
<td>19</td>
<td>53</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>111</td>
</tr>
<tr>
<td>WMO</td>
<td>358</td>
<td>88</td>
<td>388</td>
<td>5</td>
<td>23</td>
<td>83</td>
<td>63</td>
<td>1008</td>
</tr>
<tr>
<td>Total</td>
<td>1515</td>
<td>600</td>
<td>1978</td>
<td>38</td>
<td>136</td>
<td>641</td>
<td>320</td>
<td>5228 *</td>
</tr>
</tbody>
</table>

Source: Aggregated data from Health Facility Assessment 2010-2011. Only 20% BHUs were covered. Actual number of staff trained will be higher

Training in Case Study Districts

In the district of Badin, 8 facility staff have been trained on EmONC, but when asked about the training details, staff could not recall what they learnt or how their skills were tested. Facility staff were also trained in IMNCI (59 in the district), but, there was no proper follow up and continuity in supplies.

(Feedback–MNCH Programme Evaluation Case Study Districts)
Attachments and Rotations
Clinical support by teaching hospitals has not been developed as envisaged; the reason given was lack of funds. WHO states that they have recently begun working with teaching hospitals to set up a system of clinical support; however details are “scratchy”.

Rotation of postgraduate students at DHQ hospitals has been introduced in a limited number of districts. In Kasur, PG rotation from teaching hospitals in Lahore has been successfully implemented by the Programme to support 24/7 CEmONC services. These rotations should be encouraged and the number of medical colleges participating in the postgraduate rotation Programme monitored.

Evidence of Filling “A Gap”
In the RHCs, THQ and DHQ Hospitals, 80% of staff were not performing assisted vaginal deliveries. To address this issue, the National MNCH Programme has trained 2,421 MNCH related staff, through skill development in standards of service provision, counselling techniques and client centred behaviour. How these skills are monitored and/or updated is unclear.

Feedback from FGDs and interviews (See Annexes 8 and 10 for more information) is:
• There was little commitment to clinical training and professional development evident in the public sector, unless specifically funded by external donors – management training was almost totally ignored.
• A limited number of clinical specialists have benefited from competency based training in special areas; e.g. in district Kasur, one medical officer undertook a 2-year course in anaesthesia with the MNCH Programme.
• No specific strengthening pre-service trainings on EmONC in collaboration with Pakistan Medical and Dental Council, College of Physicians and Surgeons Pakistan and the Pakistan Nursing Council was reported during the evaluation as was proposed in the PC-1.

3.9 Programme Linkages
The PC-1 details close cooperation and linkages between the various Programmes. Besides the MNCH Programme, the most notable Programme implementing the MCH Strategic Framework is the National Programme for Family Planning and Primary Health Care (NP-FP&PHC) better known as the LHW Programme (employing more than 100,000 lady health workers), the Expanded Programme on Immunization EPI, and the National Nutrition Programme.

Other related initiatives include disease specific Programmes, which focus on HIV/AIDS, malaria, tuberculosis, non-communicable diseases and hepatitis. The Review of the MCH Policy and Strategic Framework provides more information on this.

53 Punjab Health Facility Assessment (2010-2011)
54 Health Facility Assessment (2010-2011)
Annex 13 provides a summary of National Programmes who contribute to the implementation of the MNCH Programme. The summary includes notes on recent assessments and their contribution to the MCH Strategic Framework.

3.10 Support by Development Partners
While a significant amount of financing in health systems development comes from multilateral and bilateral donors, there is limited coordination between donor agencies and government departments. Most donors have their own priorities governing their financing strategies. As a result, there is duplication of efforts, lack of sustainability of interventions and poor documentation of results of MNCH Programmes and projects.

Nonetheless development partners including UNICEF, WHO, UNFPA, USAID, GIZ, NORAD, MSF, Mercy Corps International through their development projects have contributed in filling up the gaps to the MNCH Programme. These included trainings to strengthen managerial staff, provision of technical assistance, development of service delivery standards, procurement of delivery kits, providing equipment to the health facilities, renovation of health facility, printing of CMW training curriculum and payment of fee necessary for registration of CMWs to Pakistan Nursing Council.

A summary of current and recent projects supported by major donors is in Annex 14. More information on support by development partners can be found in the Review of the MCH Policy and Strategic Framework.

3.11 Programme Monitoring and Evaluation
The only access the team had to monitoring and evaluation undertaken by or for the Programme was through TRF. The quality of Annual Reviews was disappointing as findings were not used to realign the Programme with the MCH Strategic Framework or make changes which would strengthen the Programme.

TRF has supported the government with annual reviews since 2009 and has provided technical support for a numbers of reviews and evaluations to support the Programme; including an assessment of quality of CMW training (2010), a rapid Assessment of the status of Community Midwifery in Pakistan, Health Facility Assessment 2010-11 and more.
4 VALUE FOR MONEY (VfM)

4.1 Background

There are several Programmes supporting the delivery of MNCH interventions across Pakistan. In order of importance, the National Programme for Family Planning and Primary Health Care (employing more than 100,000 Lady Health Workers), the Population Welfare Programme for family planning, the Expanded Programme on Immunization, and the MNCH Programme (Figure 4-1). The combined funding of the Programmes delivering MNCH services reached around Rs 83 billion in the period 2006-2012, from the total around 12% corresponds to the MNCH Programme.

Figure 4-1: MCH Programmes: Actual & Estimated Expenditures 2006-2012
(Millions PKR adjusted for inflation to 2006)

![Chart showing expenditures]

Source: Situation Analysis Punjab 2012

The MNCH Programme was designed to support MDGs 4 and 5 primarily through filling the gap in emergency services. At the time, emergency services were not a priority for any other vertical Programme. The MNCH Programme included the provision of Basic and Comprehensive Emergency Obstetric, and Neonatal care (EmONC), assistance of normal delivery by a qualified midwife at the community level, and prenatal and postnatal care at a health facility.

The objective of the service delivery component of the MNCH Programme was to provide 24/7 Comprehensive EmONC services in 234 district hospitals (DHQ) and tehsil headquarter hospitals (THQ), basic emergency services (BEmONC) in 599 rural health centres (RHCs) and in 15 DHQ and 48 THQs and provision of 8/6 preventive maternal and child health including newborn care in 4650 basic health units (BHUs). Table 4-1 shows all services supported by the Programme. Additionally, another new component of
the MNCH Programme was the training of CMWs and their deployment at the community level.

Table 4-1: MCH Services Supported by the MNCH Programme (Shaded Area)

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>Preventive</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N&lt;sup&gt;55&lt;/sup&gt;</td>
<td>Family Planning</td>
</tr>
<tr>
<td>Community Midwives</td>
<td>3416 deployed</td>
<td></td>
</tr>
<tr>
<td>Basic Health Units</td>
<td>4650</td>
<td></td>
</tr>
<tr>
<td>Rural Health Centres</td>
<td>599</td>
<td></td>
</tr>
<tr>
<td>District and Tensil Hospitals</td>
<td>127/170</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Tetanus toxoid vaccine, iron folate, screening and management of UTI, screening and treatment for severe hypertension.

<sup>b</sup> Newborn and child interventions, breastfeeding, interventions for low birth weight (LBW) infants.

<sup>2</sup> Cord care and clean delivery kit

4.2 Value for Money Methodology (VfM)

The underlying objective of the VfM analysis is to offer insight into how input resources, provided by MNCH project, are successfully transformed into outputs or MNCH services; prenatal care, assisted normal deliveries, and EmONC and later on outcomes for better quality and extension of life. As we measure how inputs are transformed into outputs, we estimate efficiency, and as we measure how outputs are transformed into outcomes, we can measure the effectiveness of the Programme.

Inputs represent the ‘money’ component of the VfM analysis and services such as EmONC, and years of life extended represent the “value” component.

First, the MNCH Programme is one of several Programmes delivering maternal and child services to this target population, so it is not the only intervention that impacts outputs and outcomes. There are two components where the Programme is the main supporter; EmONC services, and the CMW training and deployment. However, no baseline information is available on the number of EmONC beneficiaries, so it is not possible to measure the impact of the Programme on outcomes, but it is possible to evaluate economies and efficiency (Figure 4-2).

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<sup>55</sup> Source: current targets for Programme

<sup>56</sup> BHUs support Normal deliveries – According to the HFA It varies across provinces – With the average number of BHUs providing support for normal deliveries being 67%. Punjab has the highest number of BHUs providing deliveries (87.5%) and the lowest being Sindh (40.4%)
Second, the Programme implementation started only in the fiscal year 2008-2009, and has not spent more than 37% of total committed budget. Therefore, measures of how well the inputs are affecting the quality of service delivery are not included.

In order to estimate VfM, it is possible to use total and partial measures, of the whole or part of the Programme as described in Table 4-2. This exercise favours partial measures as there are some clear data limitations for this evaluation.\(^\text{57}\)

**Table 4-2: Measures of VfM**

<table>
<thead>
<tr>
<th></th>
<th>Comprehensive Indicators VfM</th>
<th>Partial Indicators VfM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Programme</td>
<td>Case 1 – Allocative Equity Is the Programme directing funds and services to the right groups? Using actual expenditure per children under 1 year old or per pregnant women by province against corresponding Maternal Mortality Rates.</td>
<td>Case 2 – Allocative Efficiency Is the right mix of inputs in place for providing MNCH services at the facility level?</td>
</tr>
<tr>
<td>Part of Programme i.e., case studies</td>
<td>Case 3 - Economies and Efficiency What are the actual costs of training and deploying CMW by province? What has been their productivity?</td>
<td>Case 4 – Economies. Comparing unit costs of EmOC episodes against international unit costs</td>
</tr>
</tbody>
</table>

Considering these limitations the following dimensions are used for evaluating VfM

- Budget expenditure execution and the allocation of resources to the target beneficiary groups; children under 1 and pregnant women, across provinces
- The extent to which the right mix of inputs is supported by the MNCH Programme
- Estimating the economy of training and deploying CMW by province
- Estimating the economy at which inputs are purchased for EmONC services

\(^{57}\)The last constraint has been that in all of the Provincial Programme Units (PMUs) data is NOT available in consolidated or summary form. Programme management is not trained in maintaining data, its analysis or monitoring it against outputs. This has led to data being scarce, un-reliable and at times not available.
4.3 Evaluating MNCH Total Expenditures 2006-2012

CASE 1: For a long time, several other Programmes have been delivering maternal and child health intervention in Pakistan but none of them has targeted Emergency Obstetrics services (Figure 4-1). The MNCH Programme was designed for six years, beginning at the end of 2006 and finishing in 2012. It was intended as a centralised Programme, with funding the responsibility of the federal government\(^58\) but this was distributed to all provinces across the country.

The financial targets of the Programme were defined in the PC-1 document of 2006 and amounted to about PKR 20 billion, divided into two main sources of funding, the GoP contributing with Rs. 12,404.871 million and DFID with Rs. 7,590 million. According to available information, the GoP and DFID have released a total of 4.55 million and 2,835 million respectively during the period 2006-2012, or around 37% of the pledge each made. Regarding the proportion of actual expenditures, over government released funds; this reaches 87%, during the period 2006-2012.

<table>
<thead>
<tr>
<th></th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-1 bid</td>
<td>131.0</td>
<td>2,970.7</td>
<td>5,788.5</td>
<td>4,231.3</td>
<td>3,526.8</td>
<td>3,346.6</td>
<td>19,994.9</td>
</tr>
<tr>
<td>Funds released GoP</td>
<td>40.0</td>
<td>185.0</td>
<td>1,716.6</td>
<td>1,090.2</td>
<td>1,523.1</td>
<td>1,523.0</td>
<td>4,554.9</td>
</tr>
<tr>
<td>Funds spend GoP</td>
<td>11.6</td>
<td>156.9</td>
<td>1,488.7</td>
<td>1,210.2</td>
<td>1,081.1</td>
<td>1,081.1**</td>
<td>3,948.4</td>
</tr>
<tr>
<td>Funds released &amp; spend DFID</td>
<td>0.0</td>
<td>660.0</td>
<td>1,479.1</td>
<td>0.0</td>
<td>696.1</td>
<td>1,594.4**</td>
<td>2,835.2</td>
</tr>
<tr>
<td>% Released of PC-1 bid</td>
<td>40.0</td>
<td>845.0</td>
<td>3,195.7</td>
<td>1,090.2</td>
<td>2,219.2</td>
<td>3,117.4</td>
<td>7,390.1</td>
</tr>
</tbody>
</table>

Source: DFID Pakistan **Notes: Assuming funds equal last year

Therefore, the annual allocations by GoP and DFID to the Programme have been below the targets, as shown in Table 4-3. The Programme was slow to get off the ground. The release of funds was around 30% of total committed resources, during the first two years but improved to more than 63% in the last two years of the Programme. During the first year of the Programme, the GoP made available funds just to GB and FATA, whereas DFID initiated its contribution the second year and disbursed to Punjab, Sindh, KP and Balochistan\(^59\). As a result the releases of funds during the first two years amount to less

\(^{58}\) At the time of launching the program a strong government was in place with a more centralised approach of governance. It was during this regime that many other federal health initiatives were launched with nationwide presence. The President’s Primary Health Initiative (PPHI) was another such program under which the Basic Health Units (BHUs) were taken from the district/provincial government and brought under the umbrella of the PPHI.

\(^{59}\) The MNCH Programme commenced toward the end of FY2006/07 and was meant to move forward quickly and substantially in 2007/08. The first release from the Federal Ministry of Health, however, did not take place until 51 days into the financial year, with a further release of funds not taking place until six days before the end of the financial year. Similarly, in FY2008/09, the first release to the Federal Ministry of Health for the Programme did not take place until 88 days into the financial year. Whilst it should be emphasized that some of the responsibility for these failings are attributable to Programme management, the fact remains that the very substantial delays in the process of making funds available for
than 13% of Programme total expenditures. The second main obstacle -- provoking DFID to delay funding during the fiscal year 2009-10, was the devolution policy introduced by the government. This was one of the biggest policy shifts in the country\textsuperscript{60}, as 18 Federal ministries, including health, were gradually abolished from the federal government and transferred to the administration of the respective provinces.\textsuperscript{61} As a consequence, only during the last two years has the Programme reached its financial target.

In addition to the funds allocated through MNCH Programme, other donors have also contributed significantly to maternal and neo-natal health care. The collective contribution of four major donors i.e. USAID, UNFPA, UNICEF and NORAD was approximately USD 125 million. USAID and NORAD’s share was 64% and 32% respectively\textsuperscript{62}. It is not evident where and how these funds were utilised but various assessments and reviews of the MNCH Programme show that the impact of these funds is hard to measure.

4.4 Evaluation of Allocative Equity\textsuperscript{63}

The Programme goals are bringing down basic indicators such as the maternal mortality ratio. The PC 1 envisaged the Programme to be implemented across the country. The allocative efficiency of the Programme is evaluated, comparing real Programme expenditures per capita with outcome measures like maternal mortality rate. Maternal mortality by province was available from the Demographic Health Survey 2007, and is compared against real expenditure per child under 1 year old. See Figure 4.3.

**Figure 4-3: GoP and DFID Annual per Child Under 1 MNCH Spending vs Maternal Mortality Rate (Rs adjusted for inflation)**

- DFID: Exp per child under 1
- GoP Exp per child under 1
- MMR per 100,000 - 2007-2008

expenditure has had the net effect of making de facto in-year ceilings highly opaque, with detrimental effects on the ability to plan and carry out expenditures in practice.

\textsuperscript{60} From mid-2011, the 7th NFC Award and 18th amendment to the Constitution changed the manner in which the Federation and provinces interact. There was now increased responsibility for provinces for service delivery in the devolved areas of health, education and social services, and development of new budgetary and governance frameworks and mechanisms to increase implementation capacity.

\textsuperscript{61} The health facilities should be left to the provincial governments as they come under their administrative control and jurisdiction. There is no justification to undertake sporadic and small interventions in large facilities like the DHQs, THQs, RHCs if the budgets and proper oversight mechanisms are not in place.

\textsuperscript{62} NORAD contribution of USD 40 million was for Sindh only.

\textsuperscript{63} In the case of the MNCH Programme, DFID has aligned with the health system and most other donors have opted for parallel financing. Thus, there are other donors who could contribute to changes in MMR.
Two provinces, FATA and Sindh, are not benefiting as others from the equalizing component of the Programme. FATA had suffered from political violence that probably had hindered the implementation efforts. In the case of Sindh, other reasons may explain the issue. Since DFID uses government systems to channel the aid resources, its performance relies on the government administrative capacity to reach the provinces. In Sindh, where most of the health care system administration is in private hands, the Programme has not had much capability to channel the available resources.

### 4.5 Costs and Efficiency of Newly Trained and Deployed CMWs

**CASE 2:** Obstetric emergencies can occur with any delivery, so attendants need to know how to recognize and respond to danger signs. Assisted delivery and referral to facilities that can manage complications, such as haemorrhage, and sepsis, is also required. Lack of Obstetric and Newborn Care (EmONC) services within reasonable travel distance, and poor ability of traditional birth attendants (TBA), in responding appropriately to trouble signs, are still important contributors to excessive maternal and neonatal morbidity and mortality in Pakistan.

One of the key interventions of the MNCH Programme was to train and deploy Community Midwives (CMWs) for ensuring that every delivery is attended by a trained midwife/health worker. The objective of training and deploying CMW, is to improve the performance of health care providers by replacing the TBA cohort with a well trained group of CMW. CMWs are being trained in home-based deliveries and they meet the international definition of skilled birth attendants.

This intervention is below its original target. The CMW cadre was introduced in 2007. The CMW initiative has suffered from significant problems due to slow fund disbursement. Originally the Programme had planned to train 10,000 midwives. This was upgraded to 11,996 CMWs, but only 5,345 (45%) of these have now been trained and out of those CMWs trained, only 3,416 (63.9%) have been deployed. The 63.9% deployment is because Punjab has a very high deployment rate, of approximately 90%, which has positively affected the overall deployment rate.

Deployment of the CMWs was substantially delayed in Sindh – just started in mid May 2011; however in Punjab the first batch was deployed in 2009, the second in 2010 and the third in 2011. In Sindh, KP and Balochistan the deployment rate has been 33%, 36% and 33% respectively. AJK has shown relatively better results with 58% CMWs deployed. In Gilgit-Baltistan, of the target of 140 CMWs, 122 have been trained but none have been deployed so far.

Full and effective deployment of all trained CMWs would require budgetary support, greater ownership from the respective health departments, proper monitoring and supervision at district level. This would only be possible if their role is institutionalised in the health system and is integrated with the health facilities at every level.
Under the proposed institutional framework, CMWs need to be supervised and owned by
district governments, and not through a vertical Programme or directly through the
provincial health department. The provincial health department can, however, be
involved in the overall oversight of provincial level performance and receive monitoring
results from each district. Performance of CMWs could also form part of the district
health information system. For practical purposes, CMWs need to be reporting to a
dedicated officer through the office of the Executive District Officer (EDO) Health. Since
they will work in communities, there needs to be a linkage with the EDO Community
Development and other related district departments. This service has to be devolved
further to achieve results. The institutionalisation has to keep in view the local
government structure and how both can complement each other.

The philosophy to "fill the gaps" in the MNCH Programme has not worked efficiently,
primarily because it was functioning as a parallel Programme within the overall health
system of the provinces - working more as a "stand alone" rather than integrated in the
health system to complement the care of mothers, newborns and children. The
Programme needs to work closely with district and provincial health officers rather than
through a separate Programme Management Unit in each province.

Regarding efficiency, according to a recent study, the utilisation of CMWs for conducting
delivery was very low; in Punjab about 1.8 deliveries per CMW in one year (See Table 4-4).
Most pregnant women use the CMW for antenatal care and go elsewhere for
delivery. The same study identified key factors inhibiting CMWs from conducting
deliveries. First, pregnant women were unable to pay CMW’s fee. The CMWs are
allowed to charge US$5.5 per delivery, but further discussions with deployed CMWs
revealed that their charges range from US$11 to US$66 (accepting only cash). Second,
pregnant women do not trust CMWs because they are a new cadre, made up of mostly
young women in their 20s (mean age 26). However, the cost-effectiveness ratio of CMW
will improve across Pakistan as more and more are deployed and function effectively in
their role.

<table>
<thead>
<tr>
<th>Table 4-4: Training CMW by Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of training CMW</td>
</tr>
<tr>
<td>N graduated CMW</td>
</tr>
<tr>
<td>Unit costs of training</td>
</tr>
<tr>
<td>N deployed CMW in public facilities</td>
</tr>
<tr>
<td>% Deployed out of Total</td>
</tr>
</tbody>
</table>

Arjumand and Associates. January 2012 Are Community Midwives Accessible in Punjab & Sindh?* funded by the Maternal and Newborn Health Research and Advocacy Fund
4.5.1 Calculating Per-Unit Costs and measuring Efficiency

Various permutations from data from district Kasur were used to calculate the VfM per-unit cost of the CMW See Table 4-5. The per-unit cost is only an approximate calculation since permutations can vary depending on the inputs. The per-unit cost of the CMW was calculated for two different categories: those trained and deployed and those trained but not deployed.

- The per unit cost for those trained is PKR 200,000
- The per unit cost for those trained and Deployed is PKR 270,000 (as this cost includes stipend, delivery kits and Programme cost for monitoring etc)

<table>
<thead>
<tr>
<th>Time-Line</th>
<th>Cost per deployed/trained</th>
<th>Trained</th>
<th>Deployed</th>
<th>Total Cost Deployed</th>
<th>Total Cost Deployed &amp; Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>270,000/200,000</td>
<td>144</td>
<td>44</td>
<td>11,880,000</td>
<td>31,880,000</td>
</tr>
<tr>
<td>24 months</td>
<td>3168</td>
<td>44</td>
<td>72</td>
<td>3,750.00</td>
<td>10,063.13</td>
</tr>
</tbody>
</table>

In district Kasur the data available for the last three months of CMW performance is 526 deliveries by 44 CMW deployed. This is approximately 12 deliveries by one CMW or 4 deliveries per month. Extrapolating this data over a period of two years; the period during which a CMW receives a monthly stipend of PKR 2000 results in 3168 deliveries.

The results shows that if calculations are made for those deployed, per delivery costs PKR 3,750/- and if cost of those trained is included then the per delivery cost is PKR 10,063/- The PC-1 had envisaged this cost to be PKR 400/ delivery. The cost per delivery will go down once more when more CMWs are deployed and their services are utilised.
The PC-1 had envisaged this cost to be PKR 400/ delivery. The cost per delivery will go down once more and more CMWs are deployed and their services are utilised in the community.

After accounting for inflation over the last 6 years (2006-2012) the PC-1 cost of PKR 400/delivery is PKR 914/delivery- approximately. This is around three times the cost calculated in the PC-1. In order to get to achieve this cost per delivery each CMW would need to conduct approximately 12 deliveries per month. Health policy makers may need to re-evaluate the costs defined in the PC-1 which seem under-inflated given the rising cost of living in Pakistan and inflationary pressures on the Consumer Price Index (CPI).

4.6 Allocative Efficiency: Extent to which Facilities have an Optimal Mix of Inputs

CASE 3: The analysis of the optimal mix of inputs is a partial VfM measure and could offer useful insights, especially when seeking to diagnose and improve the Programme’s performance in the next phase.

Allocative efficiency indicates the extent to which limited funds are directed towards supporting and purchasing the correct mix of inputs: human resources, drugs and consumables and the rehabilitation of key facilities. The presence of a right mix of inputs is the first indispensable step in producing the required MNCH services, but their presence does not guarantee success. There are other factors, such as governance and leadership, or the simple fact that today’s endeavours affect outcomes in following years.

The analysis of the optimal mix of inputs is based on the Health Facility Assessment Survey conducted in all provinces and regions of Pakistan during October 2010 to May 2011. The survey included District Headquarter Hospitals (DHQ), Tehsil Headquarter Hospitals (THQ) assessed for provision of 24/7 Comprehensive EmONC services; Rural Health Centres (RHCs) assessed for the provision of 24/7 Basic EmONC services and Basic Health Units (BHUs) assessed for availability of 8/6 preventive MNCH services.

PC-1 goal was to strengthen all the four health facilities in the province – District Headquarter Hospital (DHQ); Tehsil/Taluka Headquarter Hospitals (THQs), the Rural Health Centres (RHCs). These facilities were intended to provide basic and comprehensive EmONC facilities.

Figure 4-4 presents aggregated data of availability of key inputs for all Pakistan, to deliver Basic EmONC services at RHC level. Estimations are based on ‘average availability of inputs; these include infrastructure, human resources, equipment, drugs and supplies, and support services. Human resources present the major availability gap, [65]

\[65\] Note: this cost is taken from the PC-1 page XVI.

\[66\] Ibid

\[67\] Inflation is calculated on the rates from 2006-12. The inflation rates are: 7.9%, 7.6%, 20.3%,13.6%,13.4%,12.6% and 12.9% respectively.
pointing to issues of governance and disrupted allocation of funding to support salaries, during the devolution process.

**Figure 4-4: Average Availability of Key Health Inputs at RHCs for all Pakistan**

![Figure 4-4](image)

Since Figure 4-4 presents the country average, the following analysis is broken down by provinces. Table 4-6 presents the proportion of facilities with the best performance or appropriate staffing, essential drugs and supporting services for the provision of preventive, basic and comprehensive emergency obstetrics.

**Table 4-6: Provinces with Higher% of Facilities with Right Mix of Inputs for Providing MNCH Services**

<table>
<thead>
<tr>
<th>Facilities</th>
<th>8/6 Preventive MNCH1</th>
<th>24/7 Basic EmONC2</th>
<th>24/7 Comprehensive EmONC2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Health Unit</td>
<td>&gt; 80% Punjab and GB</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others &gt; = 55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Health Centre</td>
<td>&gt; 40% Punjab and AJK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THQ hospital</td>
<td>&gt; 60% Punjab</td>
<td>&gt; 40% Punjab</td>
<td></td>
</tr>
<tr>
<td>DHQ hospital</td>
<td></td>
<td>&gt; 60% Punjab and AJK KPK</td>
<td>&gt; 50% FATA GB</td>
</tr>
</tbody>
</table>

Source: Health Facility Assessment Survey 2010-2011. 1Only human resources, 2Human resources, drugs, supplies and support services - No EmONC is undertaken in BHUs

The main findings are summarised in the following points:

- Most provinces have the needed human resources available for the BHU level, with Punjab and GB over 80%. This is indicative that the BHU has received long term support from all other Programmes identified earlier in Figure 1. According to field visits by the team members at the BHUs level, there is no evidence of referrals to the tertiary level. This is because BHU do not provide emergency care and the role of the CMW is not institutionalised into the referral chain.

- Regarding basic EmONC – the focus of the MNCH Programme: only Punjab has the right mix of inputs for Basic EMOC at Tensil hospital level, demonstrating that it has benefited from the flow of funding support. In contrast, DHQ has not received much support.
• Concerning comprehensive EmONC at DHQ hospitals – also MNCH main Programme sponsor; Punjab, AJK, KPK, Fata and GB performed quite well, suggesting that this intervention was so far the real priority of the MNCH Programme at the delivery level.
• Punjab can be distinguished from the rest of the country in the better availability of inputs for the provision of all MNCH services at all levels; at the BHU and at the THQ and DHQ hospitals.

4.7 The Economy at Which Services are Delivered

CASE 4: A basic EmONC is expected to provide the following critical lifesaving services for the following conditions: pre-eclampsia; manual removal of retained placenta; removal of retained products of conception; assisted vaginal delivery; and basic neonatal resuscitation. A comprehensive EmONC offers, in addition to these, blood transfusion and caesarean delivery.

An international comparison of some selected Emergency Obstetric Neonatal Services is shown in Table 4-7. The information has been extracted from articles published in the scientific literature. Pakistan unit cost per caesarean section aligns well to the unit costs of similar services in countries like India, and Thailand.

<table>
<thead>
<tr>
<th></th>
<th>Low range</th>
<th>High range</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>US$154</td>
<td></td>
<td>Alkire et al, 2012</td>
</tr>
<tr>
<td></td>
<td>Caesarean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>US$ 133.29</td>
<td></td>
<td>Singha et al 2009</td>
</tr>
<tr>
<td></td>
<td>(caesarean section)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>US$ 116</td>
<td></td>
<td>Thinkamrop et al 2000</td>
</tr>
<tr>
<td></td>
<td>(caesarean section)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>US$100.61 (public hospital)</td>
<td>US$118.53 (mission hospital)</td>
<td>Disease Control Project 2006</td>
</tr>
<tr>
<td>Mexico</td>
<td>US$282.76 (postpartum haemorrhage)</td>
<td>US$ 746.36 (severe eclampsia)</td>
<td>Hu et al 2007</td>
</tr>
<tr>
<td></td>
<td>US$337.76 (obstructed labour)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

However, a real cost study to calculate unit cost per episode of EmONC care using the methodology known as the “ingredients” approach (quantity x price), or bottom-up costing method, is recommended to complete the VfM analysis in the future. This has to be a standalone exercise and will require a team of 2 accountants and 2 PFM experts. Under this methodology we calculate costs of each and every input from every HR cost, every medicine cost, all operation cost both inside and outside MNCH.

4.8 VfM Conclusions

Budget analysis of the Programme indicates that allocations were much less than envisaged per PC-1. The amount committed to the Programme in 2006 was around PKR 20 billion; from this total only 37% was released during 2006-2012. The “devolution” process certainly explains some of the Programme under spending. This would have been around 50%. There are many reasons to be taken into account: political violence, initial uncertainty, the inadequate federal capacity to reach provincial health systems such as Sindh. The low budget allocations and releases have impaired the implementation of the Programme and consequently the Programme health indicators.

Since the Programme has released only 37% of the committed funds and the CMW component has funded the training of about half its target trainees, it could be said that this component has been relatively successful. Still, the earlier cohorts face huge challenges such as the acceptance by other health professionals and the community.

The allocation of funds to the provinces has contributed to an equalizing effect, improving the allocative equity of the system. On the other hand, there is evidence that the Programme has been supporting the right mix of inputs for the delivery of Comprehensive EmONC services at the district hospital level in provinces like Punjab, AJK, KPK, FATA and GB. However, there is not enough evidence that these resources actually are being used to deliver the right services (or allocative efficiency). Finally, according to a new study, the cost of C-Section a comprehensive EmONC service, is being delivery at a price comparative to similar countries, suggesting that the Programme functions under an acceptable efficiency level.

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73 Under this methodology the cost of one episode is calculated. The following steps are performed: (a) identifying all inputs that are used for treatment; drugs, supplies, equipment, personnel and facilities for one episode of the chosen service, (b) determining quantities and proportions used of each input; (c) valuing the inputs at local purchased prices and (d) summing these values.
5 DEVOLUTION AND THE 18th Amendment

- From mid-2011, the 7th NFC Award and 18th Amendment to the Constitution changed the manner in which the Federation and provinces interact. There was now increased responsibility for provinces, for service delivery in the devolved areas of health, education and social services, and development of new budgetary and governance frameworks and mechanisms to increase implementation capacity. 18 Federal ministries including health and population welfare were gradually abolished from the federal government. This was one of the biggest policy shifts in the country.

5.1.1 Impact on MNCH Programme

- The 18th Amendment alone will not have any adverse financial impact on the Programme, as even prior to the 18th Amendment, releases were not being made as per PC-1 allocations. There has been an assurance from the Federal Government that the Programme will continue until at least 2014, and funds will be transferred from the Planning and Development Division, but there has been no official notification.

- Post devolution, authority for release of funds has shifted from the Ministry of Health to the Planning Commission. The MNCH will be relying on the respective DoHs for procurement of medicines and medical equipment, governed by the provincial/special areas respective regulation. Feedback during field visits was that procurement systems and regulations are not working.

- The provinces/regions will take time to draw up their respective PC-1s so the Programme PC-1 is currently being followed. Different perceptions and levels of preparedness exist in the provinces, but the priorities of the Federal Government, and push from the Programme, will play a key role in financial distribution.

5.1.2 Impact on Vertical Programmes

- It is clear that a majority of the vertical Programmes run by the Federal Ministry of Health will be devolved to the Provinces. These include the LHW Programme, EPI Programme, MNCH Programme, National AIDS/HIV Programme, Stop Tuberculosis, Malaria Rollback Programme, National Nutrition, National Blindness Prevention Programme, National Hepatitis Programme, etc.

- In the immediate future, the policies and Programme cycles already in place will most likely continue. However the Provinces may find difficulties in allocating budgets for these Programmes in the long run. The vertical Programme expenditures for the remainder of this financial year and next financial year (ending June 30 2012) will be borne by the Federal Government. When the review team visited, Provincial Governments raised concerns over their ability to provide budget allocations for the next year. It remains to be seen how the Federal Government will respond to the provinces’ demand for finances.
5.1.3 Opportunities and Challenges of Devolution

- Devolving power to the district has brought major changes in the structure of governance, impacting on provinces and areas in different ways. However, several transitional challenges need to be addressed, specifically the following:

- Budgetary transfers to districts are uncertain and unpredictable and do not always follow the agreed formula. Feedback from the districts is that they are severely handicapped, due to limited capability and autonomy in preparing their budgets.

- Confusion remains due to overlap between federal, provincial and district in terms of authority and functions. Selected vertical and provincial Programmes – with varying degrees of district involvement – restrict the district’s ability to allocate resources according to local priorities. Key decisions related to such Programmes rest with the provincial governments, restricting the role of district governments.

- The federal-province-district relationship has been generally hostile, where the political affiliation of the provincial government differs from that of the district government. This antagonism is reflected in difficulties and delays in fiscal transfers and manipulation of appointments and transfer of personnel.

- District authorities lack the capacity in planning and financial management. Lack of experience and political expediencies result in planning that is not evidence-based, even where relevant data is available and accessible. Adequate institutional, administrative, management, and technical capacities are critical to improve the quality of health services provision. If this capacity is not provided, there is a danger that the quality of decentralized services may further deteriorate.
6 OVERALL EVALUATION OF PERFORMANCE

6.1 Programme Relevance

- The goal of the Programme — “to reduce maternal and child deaths and illnesses by improving their health status particularly of the poor and marginalised”; is highly relevant in a context where maternal and child mortality is among the highest in the region.

- Although the technical design of the Programme adequately provides an approach for reducing maternal, newborn and child mortality, it has not assessed the capacity required to plan and implement a highly ambitious design. This requires leadership and strategic decision-making, based on available budgets and the needs of beneficiaries.

- The intent of the original design has been further weakened by: the broad scope of the Programme, changes in the design, if these aspects can be addressed properly in a more realistic design, the Programme has the potential to be rated relevant. However, because of the many weaknesses, it has been rated partly relevant. The design / Programme is highly relevant as stated by you earlier at the start of the report— how it was implemented is another issue.

6.2 Effectiveness in Outputs and Outcomes

- The Programme has limited achievements in Programme outcome and outputs supporting Component 3, the provision of Comprehensive Family Planning Services, and Component 4 Communication for MNCH Care. There is some achievements in FP components

- With the Programme outcome, inputs have focused more on the secondary rather than primary health care level. While well on the way to achieving the Programme targets, the coverage of upgraded facilities falls short of international standards referred to in the PC-1\textsuperscript{74}. There is a shortfall of at least 123 CEmONC facilities and 790 BEmONC. Most BEmONC facilities, at the primary health care level, where the poor and marginalised live and work.

- Although a well laid out communication mobilisation strategy was developed it has not been taken forward because of bottlenecks in funding. The shortcoming to provide Comprehensive Family Planning Services is a more complex matter. The government’s restructuring agenda to integrate Reproductive Health, Family Planning and MCH, did not take off because of political exigencies this has compromised the working relationship of health and family planning staff at all levels of service delivery. The project is therefore rated partially effective. (They have achieved most of the targets – except in component 4 and 5)

\textsuperscript{74} Refer to Page 99 of the PC-1 under monitoring and evaluation
6.3 Efficiency in Achieving the Programme Goal and Objectives

- Although costs were considered, no financial or economic analyses were undertaken when the MNCH Programme was designed. A Value for Money analyses was undertaken as part of current evaluation. The analyses found that:
  - Budget allocations were less than envisaged in the PC-1; since the Programme has only released 37% of committed funds but has provided training to about half the CMW trainees, and upgraded more than 75% of targeted facilities it could be said these interventions are relatively successful.
  - The cost of C-Section is being delivered at a price comparable to similar countries. This suggests the Programme functioning under an acceptable efficient level.
- A further study will be required to investigate this more. To complete future VfM analysis, a real cost study to calculate unit cost per episode of EmONC should use “ingredients” approach (quantity x price), or bottom-up costing method.
- The findings of the VfM are inconclusive and it is too early to assess the Programme’s internal and external efficiency, as there are extensive time lags in changes in the maternal mortality ratio, infant mortality rate, fertility rate, and other indicators.
- However, given the significant delays caused by inefficient Programme management; limited use of Programme funds earmarked for its different components; unsatisfactory monitoring; no appropriate baseline; and continued bifurcation of maternal and newborn services between other vertical Programmes; the MNCH Programme inefficient.

6.4 Preliminary Assessment of Sustainability

- The sustainability of the Programme will depend on the availability of resources and the institutional capacity and linkages within the government, in particular the links to the Lady Health Worker Programme. The availability of financial resources depends largely on the government’s commitment to MNCH and the continued support of development partners and donor agencies.
- While such commitment is there, public sector financing is likely to remain constrained, until the current fiscal challenges are fully addressed. A key determining factor will be the future of planning, to support implementation of MNCH in the provinces in the post 18th Amendment scenario.
- The health sector strategies put in place by the provinces will be the driver pushing for adequate allocations for the health sectors, and in particular, the delivery of MNCH services.
- The prospects seem uncertain for sustaining the limited benefits achieved by the strategic approach over the medium to long term: so the sustainability of strategic

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75 Under this methodology the cost of one episode is calculated. The following steps are performed: (a) identifying all inputs that are used for treatment; drugs, supplies, equipment, personnel and facilities for one episode of the chosen service, (b) determining quantities and proportions used of each input; (c) valuing the inputs at local purchased prices and (d) summing these values.
approach as currently implemented is rated *unlikely*. Unless issues raised in report are addressed.

### 6.5 Socio-cultural, and Other Impacts

- Although poverty remains a major factor underlying poor maternal, newborn and child morbidity and mortality, poor planning and poor coverage of services has limited the potential impact the Programme could have on the poor and marginalised. A Programme component relating to demand creation was grossly neglected; despite having a well laid out community mobilisation strategy. It is yet to be seen how the Programme will impact on the knowledge and attitudes of beneficiaries and communities, in terms of good maternal newborn and child health practices.

- There is a lack of attention paid to the broader social, cultural and political factors which affect women’s access to health services. This is a significant barrier to reducing maternal, newborn and child mortality rates in Pakistan. MNCH should make these considerations a central issue.
7 OVERALL ASSESSMENT AND RECOMMENDATIONS

7.1 Overall Assessment
Despite alignment with Government Policies, Plans and Strategies, the MNCH Programme is yet to be translated into an effective MNCH Programme. In its current form the Programme is rated partly successful (Annex 7). It is partly relevant, ineffective, inefficient, and unlikely to be sustained. The relevance of the programme has been eroded by poor planning, lack of leadership, poor management. It has performed poorly in Component 3, the provision of Comprehensive Family Planning Services and Component 4, Communication for MNCH Care.

Unless changed significantly to reflect the needs of the beneficiaries, it will fail to translate into a Programme which can significantly accelerate progress towards the achievement of MDG 4 and MDG 5. The current Post 18th Amendment Scenario provides provinces and areas with an opportunity to address issues raised in this report.

7.2 Lessons
• All Programmes delivering MCH services need to create a solid commitment for achieving MDGs 4 and 5, through the delivery of an essential package that is universally accessible, acceptable and affordable by the target population.

• The process of functional integration can facilitate the availability and use of a wide range of MCH services as a socially acceptable practice. This should be based on the effective role exerted by the LHWs, CMWs and other DHS service providers, and supported by aggressive community mobilisation and social marketing interventions.

• Functional integration has the comparative advantage of delivering MCH essential services packages, under the same roof and improving the scope and the quality of performance of the health workforce. However, the entrenched protective attitude among the health workforce, and their desire to maintain vertical operational accountability, may pose a direct challenge to functional integration.

• A well thought out conceptual design is a key to the success of any Programme. In this case, the Programme design had commendable objectives, but it seems to have overestimated the capacity of the provinces and special areas to implement the Programme. It has relied heavily on development partners to carry out social mobilisation and training in a system where implementation is a parallel project.

• Before commencing a Programme, an objective assessment should always be made of the readiness and capacity of the government, particularly of Programme Implementation Units and provinces, for implementing the Programme.

• Inadequate review by the GoP and donors, of Programme documents and inconsistencies between different versions of the PC-1 is a problem. This creates confusion and the pace of Programme implementation is slowed. Implementation could be facilitated by: a thorough review of documentation by the GoP and donors; a statement identifying both the similarities and differences between different versions; advising the PMUs on corrective measures.
• The Programme had too many activities under each component. As a result, the resources were too thinly spread. This made implementation difficult for the PMU and provinces and had the potential to dilute the impact of the Programme in the communities.

7.3 Options Considered

7.3.1 Options for Donors
The team has considered 5 broad options for the future of the MNCH Programme.

<table>
<thead>
<tr>
<th>Table 7-1: Options and Rationale for Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Do nothing for the MNCH Programme</strong></td>
</tr>
<tr>
<td>Engaging with the Health Departments and Population Welfare Departments across the country is too risky in the context of devolution. Donor involvement could require a level of engagement that would be problematic given the uncertainly of the current Post 18th Amendment Scenario. Donors should focus their support on other priority areas in other sectors.</td>
</tr>
<tr>
<td><strong>B. Continue Direct Budget support as limited number donors are doing</strong></td>
</tr>
<tr>
<td>Continue to fund the national MNCH Programme as is. It is delivering some results.</td>
</tr>
<tr>
<td><strong>C. Fund as a Parallel Project as a limited number of donors are doing:</strong></td>
</tr>
<tr>
<td>Continue to fund the national MNCH Programme as is. It is delivering some results.</td>
</tr>
<tr>
<td><strong>D. Re-orientate what Donors funds within the MNCH Programme</strong></td>
</tr>
<tr>
<td>Fund provinces directly. Use the MNCH Programme to focus on key districts, key MNCH services and interventions, and key reforms. Use this experience of supporting the current Programme to better align with government priorities and realities of the new Post 18th Amendment Scenario.</td>
</tr>
<tr>
<td><strong>E Stop support to MNCH Programme and design new Programme in specific provinces.</strong></td>
</tr>
</tbody>
</table>

- We do not recommend options A and B because this could negatively affect Pakistan improving on MDGs 4 and 5, and the current status of key health partners, supporting the Programme. We also do not recommend option C, as funding parallel projects to the system has resulted in duplication and fragmentation of the MNCH Programme.
- In the short term we recommend option D, but recognise that the feasibility of this option is currently being tested by some donors, who are trying to engage with provincial governments in the Post 18th Amendment Scenario. Ideally, Option D should help donors move towards option E. If Option D proves unfeasible, then we recommend donors design a new Programme of support, with individual provinces where they work. This would have high focus on MNCH outputs and outcomes.

7.3.2 Options for Government

<table>
<thead>
<tr>
<th>Table 7-2: Options and Rationale for Government</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Leave the Programme as is – Considering the Programme is showing some results</strong></td>
</tr>
<tr>
<td>The Programme is highly relevant to a context where maternal and child mortality is one of the highest in the</td>
</tr>
</tbody>
</table>
Table 7-2: Options and Rationale for Government

<table>
<thead>
<tr>
<th>Option</th>
<th>Rationale and Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Continue as is Implement as a Vertical Programme</strong></td>
<td>Vertical Programmes are disease specific; the MNCH Programme is a Holistic Programme which provides a broad package of interventions in different service packages along a continuum of care. An analysis of relevant vertical health Programmes for links to the MNCH Programme found that the most overlap was in interventions being delivered by the LHW and CMW; followed by the Nutrition Programme – All Holistic Programmes. <strong>This option was rejected.</strong></td>
</tr>
<tr>
<td><strong>B. Continue the Programme as is; but integrate into Provincial Plans</strong></td>
<td>This makes sense; however in the current Post 18th Amendment Scenario Provinces are not in a position to accommodate drastic changes. So phase out by the completion of the Programme and use an operational plan under the DG Health to integrate into the provincial health system. However in the meantime focus on some of the issues raised in this report. This is the preferred options</td>
</tr>
<tr>
<td><strong>C. Stop support to MNCH Programme and design new Programme in specific provinces.</strong></td>
<td>Because of the rationale given in C this is not recommended. However provinces may decide to do this when they are in a position to do this. However some provinces and areas may consider this in the future.</td>
</tr>
</tbody>
</table>

**What?**

We suggest approaches which will work with, rather than just through, Government to enable other stakeholders to complement and strengthen government services. For example, national or international NGOs might be contracted in certain districts by the provincial governments, to help the latter deliver more and better MNCH service and strengthen referral from the community to health facilities.

Lessons from Batagram district and experience from other parts of Pakistan (the Aga Khan Health Services network) and from the rest of the world (Cambodia, Nepal, India and many more) suggest that as the contracting capabilities of the DDOH are improved then coverage and quality of service improve. However feedback from the field is that there are weak linkages between PPHI and the DDOH. DDOH has limited capacity to manage a sub-contract, but the delivery of emergency services for women and children is complex. It will require certain services like (BEmONC) or obstetric first aid to be contracted in and out to ensure the synergy between MNCH RH and FP.

Furthermore Demand creation, a significant component of the MNCH Programme, has been grossly neglected, despite having a comprehensive community mobilisation strategy. The sub-contract of a local NGO under the DDHO could be used to address this issue. The picture right now is that the MNCH network misses most opportunities to deliver EmONC services, and the same can be said about missed opportunities among other MNCH services.

**How?**

Despite substantial fiduciary risks, donors should continue to try and make maximum use of government systems. Public/private partnerships are already in place and it is in the
interest of the Pakistan health sector to strengthen existing channels. Donors should investigate channels for providing earmarked budget support at the district level and below. The performance of district donor engagement could be just against a relatively short set of key indicators, such as key service outputs and/or specific reform milestones. These could relate to bottlenecks in the system e.g. building a regulatory framework; and capacity for contracting in or out to allow oversight; identifying and financing a basic service package; and adopting effective service delivery strategies.

From feedback in the field, this arrangement could be quite attractive to provincial governments, given the uncertainty surrounding future funding of MCH in the provinces, given the Post 18th Amendment Scenario. We also expect it to work well for donors, as this approach would enable increased focus on MNCH outcomes and PHC level.

Why?
The proposed approach focuses on improving access to key services, especially for the poor and marginalised in target areas. It encourages the adoption of innovative but evidence-based models, including public/private partnerships, and support for joint demand/supply models. It aims to protect access to emergency maternal newborn and child health services for the poor and marginalised. In an uncertain reform environment, there is a real risk that urgent funding for MNCH will be interrupted during the current Post 18th Amendment Scenario.

Implications for Donors and Government
The approach will require sustained presence and engagement by donors and government at provincial and district levels. At a provincial level, the focus should be on providing TA to support MNCH planning in the Post 18th Amendment Scenario.

At a district level, funding could be channelled directly through provincial governments to districts. This would support building the capacity of DDOH to implement a basic package of MNCH directly or through a sub-contractor. The package should be aligned with a province with an MCH operational plan and include:

- Simple highly cost-effective packages which have been show to save lives of mothers, babies, and children

Funding through certain local NGOs should not be discarded, particularly in areas like community mobilisation, where they would add value.

Alignment with provincial operation plans and government and donor priorities could be through annual monitoring, involving both government donors and stakeholders.
7.4 Recommendations

7.4.1 Policy and Planning

- For all documentation and implementation purposes terminology be standardised between Maternal and Child Health (MCH) and Maternal Newborn and Child Health (MNCH) to Maternal Newborn and Child Health (MNCH)

- Provincial Health Sector strategies should guide MNCH and address gaps in the Strategic Framework through a succinct log-frame including: (i) access to quality EmONC and referral services; (ii) unified policy on child health through an integrated Programme; (iii) behaviour change interventions, targeting men and women for reducing population growth and safer sex and; (iv) interventions to address nutritional deficiencies;

- Future plans should be (a) based needs of beneficiaries; (b) include strategic areas of intervention that are cost-effective and prioritised; (c) encourage partnerships between the public and private sector, that have been shown to work; (d) support a multisectoral approach and functional integration including attention to adolescent health; and (d) include indicators which regularly measure progress towards of reduction of MCH mortality and morbidity.\(^76\)

- The current MNCH Programme should be integrated into provincial health sector strategies under the direction of the DG – Health, and be phased out by the end of the Programme (after final funds are transferred).

- Engage in federal - provincial level advocacy activities with key stakeholders, as they examine the findings of the Review of the MCH Strategic Framework and Evaluation of the MNCH Programme. Review implications for the economic and health challenges that lie ahead and endorse sound MCH related health policies.

- To assist in making strategic decisions and as per the PC-1, monitor international comparable indicators such as the UN process EmONC indicators.

- As per PC1, put in place systems for seeking feedback from target groups and stakeholders to inform planning processes.

- As per the PC-1, put in place a database of health facilities providing EmONC services, certification and service statistics. This should form the basis of “reliable, timely and comparable data” for monitoring of standardised indicators agreed by the National HMIS Program\(^77\). An EmONC assessment may be required for this.

7.4.2 Intuitional Mechanisms

- The institutional framework under which the MNCH Programme is being implemented should be strengthened. It is unlikely major restructuring will be undertaken in the near future, as it will take time for provinces to adapt to their new found responsibilities. Nonetheless consider institutional strengthening.

- Linkages to be strengthened are shown in Figure 7-1 and described below.

\(^76\) The approach based on UN indicators outlined in the PC-1; p. 99 is such an approach

\(^77\) Ibid
Figure 7-1: Management and Health Service Delivery Network Showing Institutional Links

FEDERAL LEVEL
- PNC
- DONORS
- PLANNING COMMISSION

PROVINCIAL LEVEL
- PROVINCIAL PLANNING & DEVELOPMENT DEPARTMENT
- PROVINCIAL DEPARTMENT OF HEALTH
- PROVINCIAL POPULATION WELFARE DEPARTMENT
- PROVINCIAL AND REGIONAL TRAINING INSTITUTES

DISTRICT LEVEL
- DISTRICT DEPARTMENT OF HEALTH (EDO-Health)
  (Coordinator-same person for MNCH and LHW Programme)
  (Punjab Model)
- DISTRICT POPULATION WELFARE OFFICER (DPWO)
- REPRODUCTIVE HEALTH SERVICES CENTRE RHS-A
- FAMILY WELFARE CENTRES WITH FAMILY WELFARE WORKER (FWW)
- DHQ
- THQ
- RHCs
- BHUs
- MCH CENTRES

COMMUNITY LEVEL
- CMW TRAINING SCHOOLS
- RHCs
- BHUs
- MCH CENTRES
- Harmonization between LHSs/LHWs/CMWs
  CMW Role not integrated into system but need to be

Functional Integration through the roles of the front line workers; in particular CMW and LHW interacting with community and community groups
Provincial and District Departments of Health

- Provincial and District Departments of Health to prepare an operational plan (or similar) which is aligned to the provincial health strategy but under MCH. Interventions should focus on prioritised needs of beneficiaries.

Provincial Department of Health and Population Welfare Department

- Strengthen the link between the Provincial Department of Health and Population Welfare. The regional training school could be a nexus for integration between the Provincial Health and Population Welfare Departments, for strengthening of family planning components of MNCH and functional integration at the first level of referral and community.

Pakistan Nursing Schools and CMW Training Schools

- The link needs to be strengthened through accreditation of Nursing Schools and licensing of the CMWs. Currently there is no regular system in place for assessing Nursing Schools providing training to CMWs. Regular inspections need to be undertaken to ensure training is being strengthened.

CMW Training Schools and Other Clinical Training Facilities

- This linkage needs to be strengthened through innovations to regular supervision and support. This could include integrated supervision by Nursing Schools and clinical facilities providing for CMWs and LHW in the community. There was very little evidence this is happening. So, engage Female Medical staff of DHQ/RHQ to promote interaction and communication.

Functional Integration of Roles at First Level of Referral and in Communities

- Functional integration of the LHW and CMW at a community level and a strengthened partnership with the TBA, through integrated working relationships, supervision and support and reporting.

- Institutionallise the role of the CMW into the first level of referral in the catchment area where she practises, by reinforcing referral to the closest facility in her area and providing clinical support and training by the same facility on a rotation basis. Preferably this should be in partnership with the LHW in the same community.

Donor and Provinces – Donors and Districts

- Donors should interact with the MNCH Coordinators at a provincial level, and Public Health Specialist at District level. This could be done annually as a monitoring exercise with the District Health Management Team. Through this linkage, donors would be better placed to monitor Programme performance.

7.4.3 Essential Health Services Package at Facility and Community Levels

- Prioritise funding around a package of essential MNCH interventions with a strong focus on the district level and below. Only support simple highly cost-effective packages which have been show to save lives of mothers, babies, and children.
• To support the package there should be a strong focus on strengthening linkages between the community and first level of referral, functional integration of the roles of LHW and CMW and targeting the poorest and marginalised.

• Undertake a rapid mapping of all Population Welfare, Department of Health (DoH) and private service outlets to develop an Emergency and Obstetric Newborn Care coverage plan, which includes public and private facilities and BHUS. This could be done as part of an EmONC needs assessment; or simply through a series of workshops in provinces. Every women or child in Pakistan is within 2 hours of emergency care. (See page 99 of PC-1)

• The contractual terms of the nationwide outsourced and vertically managed BHUs—through the People’s Primary Health Care Initiative (PPHI)—need to be revisited, to formally guarantee comprehensive delivery of MNCH services, both at the facility and community levels. In addition, 24/7 EmONC or obstetric First Aid should be available in selected BHUs, to ensure coverage of services according to international or comparable standards – this could be achieved through task-shifting i.e. expanding the role of a front line workers where access and resources are a problem.78

7.4.4 Linkages with LHW, CMW and Referral

• A district control room be operationalised 24/7 to monitor and fill in gaps where required and communities be mobilised to share fuel cost for referrals.

• Consider building accountability and reliability into the referral system by introducing a centralised system, whereby facility readiness and referral transport can be mobilised and ensured 24 hours a days. An example of such a system would be ringing a emergency response number; the operator could facilitate the referral process.

• Improve LHW skills in ANC, FP and child health, while working as a team with CMW, who is competent enough to conduct safe delivery and make timely referral to BHU and/or RHC, through well connected operational ambulance system.

• Institutionalise the role of the CMW into the first level of referral in the catchment area where she is working, by reinforcing referral to the closest facility in her area and providing clinical support and training by the same facility on a rotation basis. Preferably this should be in partnership with the LHW in the same community.

• Consider retaining CMWs in the public sector health system, through revised salary structure (equivalent to Lady Health Workers) and job description (decreasing the catchment population from 10,000 to 5,000).

• Consider paying a stipend which is competitive with the LHW Programme and provide incentives which will retain her in the system; e.g. the Pakistan Nursing Council (PNC) could consider developing a career ladder for CMW. A scholarship could be provided after 3 years of service.

78 PNC and UNFPA have already trialled tasking shifting with the role of the LHW
• Strengthen the working relationship between LHWs and CMWs through regular supervision and support by the LHS. Ensure a uniform policy is in place to support this supervision and role of the LHS. Where required, provide capacity building support for the LHS.

• Ensure the policy for providing monetary incentives to CMW is fully operationalised and implemented uniformly across the country.

7.4.5 Deployment Nursing Council and Quality

• Deployment guidelines being used to deploy CMWs should be finalised in line with the PC-1, and CMWs deployed in a timely manner in order to retain their skills and knowledge, which can be compromised by long delays in deployment.

• Deployment should include introduction to the community, and working relationships with other frontline workers and TBAs.

• A uniform CMW retention policy needs to be approved by the appropriate body and implemented so there is uniformity in deployment and retention across provinces and regions as per the PC-1.

• Provide capacity building of PNC, to support standardised examinations and develop additional resources to support the development and maintenance of examination boards, and review of Nursing Schools training CMWs.

• Ensure competency, clinical and service standards are in place and are implemented and monitored. ⁷⁹

7.4.6 Integration and Linkages with Population Welfare

• Consider establishing a management coordination taskforce at provincial and district levels, with a mandate to establish joint monitoring and evaluation instruments, and assume shared accountability in achieving the MDGs.

• Ensure commitments around discussions made at federal level (pre devolution) are followed through and the health system is strengthened to address challenges facing implementation of an integrated MNCH Programme. These include: inter-ministerial coordination, provincial and district level management, commodity pricing, contraceptives, vaccines and essential medicines supply chain, human resource training and motivation, services provided by frontline workers, and expanding the promotion and advocacy and network for MCH services.

7.4.7 Public Private Partnerships for Services and Community Mobilisation

• That various options for strengthening organisational and management systems, outlined in the PC-1 be tested and implemented where successful, e.g. contracting out, contracting in technical assistance, community management and franchising model, private sector provision of MNCH services and performance based incentives for district and health care providers.

⁷⁹ Most standards are in place but are not being implemented or monitored
To match demand with supply, community mobilisation should have been undertaken early in the Programme. There is a need to start implementing the communication strategy, which outlines who does what and why.

Social mobilisation should have been one of the initial activities, in order to get maximum mileage from other activities, such as utilisation of facility level services, acceptability of CMWs etc. Social mobilisation should be undertaken in collaboration with the existing community institutions.

7.4.8 Capacity Building

- DDOH staff should acquire further competence in performance monitoring, and be provided with technical support to become competent managers. DDOH managers and administrators should be rewarded for their success, first in completing their training and subsequently for performance in public health indicators, thus encouraging them to get good results from service providers.
- Provinces should now develop basic training and continued support packages for district and facility level staff, and ensure these are rolled out across the MCH network.
- Upscale the rotation of post graduate trainees from tertiary to district hospitals and institutionalise this best practice into the health system. Coordination for this would be the responsibility of the provincial health department. In time this will lead to health system strengthening.

7.4.9 Donor Harmonisation

- The GoP needs to proactively harmonise donor activities and harness incoming finances. This can be done by developing clear policy guidelines, whereby donor support and loans are governed by a common agenda. Financial inputs from donors should be considered a long term investment in strategic MCH areas, and must not be used to complement public financing of health services.
- External donor partners should consider performance based financing for delivering an essential health care package of MCH services at the first level of referral and below. In other words, the greater the performance orientation of the PHC network, the more attractive it will be for donors, particularly large donors supporting the principles of Results based Aid (RBA).
- Donors should re-strategise the way they fund provinces, to ensure a district focus as proposed in the PC-1. Move funds directly to a MNCH designated account that operates as a sub account to the overall account. This arrangement will ensure necessary facilitation/collaboration from the mainstream health Programmes. See Figure 7-2 and Annex 16 for a rationale for the proposed model.
A scaled-up response, after re-strategising, will require increase in funding for health but also strong commitment by Provincial and District Governments for specific actions for reducing MMR and IMR through cost-effective interventions.

Consider developing a framework to align and coordinate donor support with government systems. Key characteristics of the framework could be:

- A single MCH strategy-led reform agenda with clear opportunities around a Technical Advisory Group (TAG) and Annual Progress Report to discuss areas of policy difference/overall progress towards targets and any change in policy direction. Preferably ‘framework’ and/or ‘strategic policy’ discussions, at other points of the MCH implementation cycle, should be avoided.

- A transparent system for assessing performance, with clear benchmarks and actions, setting out what happens when things go well and things go wrong.

- Clearly identified processes for dispute resolution, including the possible involvement of an independent third-party if necessary.

- Government transparency and openness to internal scrutiny (Auditor General/Parliamentary Budget Committees) re: abiding by budget rules/MTEF discipline etc within a given year. If these forms of scrutiny are sufficiently strong, and credible, donors should rely on them as far as possible.

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80 This diagram was developed based on feedback and advice from senior managers during field visits
8 ANNEXES

8.1 Terms of Reference

8.2 List of Documents Reviewed

8.3 List of People Consulted

8.4 Case Study Approach

8.5 Field Schedule

8.6 Evaluation Matrix against DAC Criteria

8.7 DAC Assessment Criteria

8.8 Field Notes – Cases Study Analyses

8.9 Quantitative Data to Support Case Study Analyses

8.10 Field Notes - Provincial Visits

8.11 Narrative Summary Supporting PC-1 Log-Frame

8.12 Targets and Indicators Since 2009

8.13 Summary of Contributory Programmes

8.14 Summary of Current and Recent MCH Programmes

8.15 Data to Support VFM Analysis

8.16 Rationale for Funding Model