report

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END OF PROJECT EVALUATION

NORWAY-PAKISTAN PARTNERSHIP INITIATIVE (NPPI)

OCTOBER 2014

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Table of Contents

List of Tables

List of Figures

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List of Acronyms

ANC	Antenatal Care
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
BHU	Basic Health Unit
CBA	Child Bearing Agency
CDK	Clean Delivery Kit
CEA	Cost Effective Analysis
CEmOC	Comprehensive Emergency Obstetric Care
CER	Cost Effective Ratio
CI	Contracting In
CMW	Community Midwives
CS	Cesarean Section
DEWS	Disease Early Warning System
DHIS	District Health Information System
DHO	District Health Officer
DHQ	District Headquarters
ENC	Emergency Neonatal care
EPE	End of Project Evaluation
ET	Evaluation Team
ETAT	Emergency Triage Assessment and Treatment
FGD	Focus Group Discussion
FFs	Focal Families
FP	Family Planning
GSM	Greenstar Social Marketing
HANDS	Health & Nutrition Development Society
HF	Health Facility
HSDC	Health Services Delivery Contracting-Out
HSS	Health System Strengthening
HSRU	Health System Strengthening and Reforms Unit
HRDC	Human Resource Development Cell
HQ	Head Quarter
ICER	Incremental Cost-effective Ratios
IDI	In-depth Interviews
IHS	Integrated Health Services
IEC	Information, Education, Communication
IHSAS	Integrated Health System Strengthening Alliance
IMNCI	Integrated Management of Neonatal and Childhood illness
IMR	Infant Mortality rate
IRB	Institutional Review Board
IUCD	Intra Uterine Contraceptive Device
KPIs	Key Performance Indicators
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMIS	Logistics Management Information System
LOA	Letter of Agreement
LUMHS	Liaquat University of Medical and Health Sciences
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MNCH	Maternal Neonatal and Child Health
MOU	Memorandum of Understanding
MSDS	Minimum Service Delivery Standards
MTR	Mid Term Report/Review
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development Cooperation
NMR	Neonatal Mortality Rate
NPPI	Norway-Pakistan Partnership Initiative
OOP	Out Of Pocket
OPD	Outpatient Department
OT	Operation Theater
OR	Operation Research
P4P	Pay-for-Performance
PC	Population Council
PCPNC	Pregnancy Childbirth and Postnatal Care
PDHS	Pakistan Demographic and Health Survey
PGS	Post Graduate Students
PI	Principal Investigator
PNC	Pakistan Nursing Council
PPHI	Peoples Primary Healthcare Initiative
PSLMS	Pakistan Social and Living Standards Measurement
PUMHSFW	Peoples University of Medical and Health Sciences for Women
PWD	Population Welfare Department
RHC	Rural Health Centre
SBA	Skilled Birth Attendants
SDG	Sustainable Development Goals

SMP	Standard Management Protocols
SMBBMU	Shaheed Mohtarma Benazir Bhutto Medical University
SNC	Sick Newborn Care
SRSO	Sindh Rural Support Program
THQ	Tehsil Headquarters
TPM	Third Party Monitoring
TRDP	Thardeep Rural Development Program
TT	Tetanus Toxoid
UN	United Nations
UNEG	United Nation Ethical Guidelines
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VC	Vice Chancellor
VPs	Voucher Promoters
VS	Voucher Scheme
VMA	Voucher Management Agency
WHO	World Health Organization

Executive Summary

Project Description

The Norwegian Pakistan Partnership Initiative (NPPI) project was implemented for six years—from 2009 through 2014—and aimed to reduce maternal, neonatal, and child mortality through increased coverage of quality maternal, newborn and child health (MNCH) and family planning (FP) services, along with improved MNCH and FP self-care as well as care seeking behavior within families and communities. After deciding to support Pakistan in its efforts to improve its MNCH indicators, the Royal Norwegian Government decided to focus its funding on Sindh province because of its weak MNCH and FP health indicators. It was decided that Norway would support the concept of ONE UN, and project implementation would be through multiple UN agencies in closely collaboration. Norwegian experts were involved from the beginning, designing the project.

The project was implemented in 10 rural districts of Sindh, namely Kambar Shahdadkot, Ghotki, Kashmore, Badin, Jamshoro, UmerKot, Tharparkar, Larkana, Shaheed Benazirabad and Shikarpur, for reaching the most vulnerable populations. The UN collaborating agencies in this initiative were UNICEF, as convener and implementer, with WHO and UNFPA as the other major implementers. UNDP, as administrative agent, was responsible for funds disbursement. As ONE UN, they implemented a range of health interventions with their respective implementing partners, through several innovative approaches to improve MNCH in Sindh.

NPPI assisted with key challenges to health care access in rural Sindh including financial barriers, women's low status[1], abject poverty, a sub-optimal health system[2], and poor quality of care[3], which affect both health care seeking and non-existent or extremely weak service delivery in most areas.

Each UN agency undertook responsibility for a distinct set of interventions, based on their expertise, which, for the most part, were implemented in distinct geographic areas. The project experienced setbacks due to natural disaster, specifically devastating floods in 2010 and 2011, which affected project momentum and early project gains due to diversions of health and development resources, management, and oversight to emergency relief and rehabilitation. After the mid-term review (MTR), the project focused on phase out planning and a road map for its exit strategy ending in December 2014.

Evaluation Objectives and Scope

Objectives

The End of Project Evaluation's key objectives are:

- Documenting and disseminating NPPI's results and achievements;
- Generating knowledge of evidence-based best practices for program approaches, cost effectiveness, and sustainability.

Scope

This End of Project Evaluation (EPE) is based on a desk review, qualitative interviews with key informants, field visits verifying activities, as well as a review of District Health Information System (DHIS) statistics and other survey findings. This information was triangulated and utilized for analysis.

For the four principles of relevance, effectiveness, efficiency, and sustainability, the EPE's focus is on reviewing individual interventions though a general assessment of the project is also included.

This EPE assesses how the interventions addressed gender equality and equity, while recognizing that it was too close to activities' end to measure impact. While there was a baseline evaluation, an in-depth end line was not conducted; consequently, we analyzed the outcomes of various interventions using statistics from DHIS and other large surveys such as the Pakistan Social and Living Standards Measurement Survey (PSLMS). Furthermore, there were limitations to assigning improvement and impact attributions due to the interventions' uneven geographical spread in addition to data limitations.

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[1] Mir AM, Rashida G. 2007. Challenging the Gender Paradigm in Rural Pakistan: A Case Study of Empowered Lady Health Workers in Reichenbach L. (Ed). Exploring the Gender Dimensions of the Global Health Workforce: Harvard Global Equity Initiative, Harvard University, Cambridge.

[2] Mir AM, et al: 2013. Final Report "Assessing Retention And Motivation Of Public Health-Care Providers (Particularly Female Providers) In Rural Pakistan". Population Council, Islamabad.

[3] Key priority areas-Health Sector Strategy Sindh 2012-20: district health system strengthening: PHC, PPP, HR, MNCH, Governance and accountability

The EPE team attempted to document the entire project period of 2009 to 2014, with particular attention to progress after the MTR, as it comprehensively evaluated the project's earlier implementation and made clear recommendations for phase out. One of the MTR's key recommendations was for redesigning the project, which was not totally feasible. Hence, the Norwegian Government decided to curtail funding from 245 million kroners to 145 million kroners. Post MTR, an exit strategy and road map was developed jointly by three implementing agencies (UNICEF, UNFPA, WHO), the donor and the Sindh government. The focus on the exit strategy and improved coordination did increase the momentum of NPPI project implementation.

Findings

Relevance

Project relevance is demonstrated, in part, by its alignment with MNCH program objectives and the draft national health policy of 2009.[4] The project clearly set out to address the most important impediments to achieving MDGs 4 and 5 by 2015 in Sindh province. NPPI implemented innovative approaches to improve and enhance health-seeking behaviors for better MNCH outcomes by reaching out to the most vulnerable communities. At the same time, it also endeavored to strengthen and maximize the health sector's responsiveness in delivering those services, and improve service quality. Without exception, each NPPI intervention was relevant for tackling the range of impediments for improving MNCH outcomes.

This evaluation identified many important lessons for the provincial government, health department, UN agencies, as well as other development partners commencing new programs in Sindh's health sector. Improved synergy and coordination among the UN agencies supporting NPPI interventions, in a well-defined geographic area, for a full health service package (uniformly in all 10 districts) would have potentially led to greater impact. As NPPI interventions were dispersed across districts, however, they were generally implemented in relative isolation. A full package of interventions tested jointly in one district would have enabled a more comprehensive evaluation of their relevance and impact.

Effectiveness

In the absence of an end line survey enabling comparisons, the EPE took advantage of the availability of district data from the PSLMS surveys of 2008-2009 and 2012-2013 to gauge changes in NPPI MNCH indicators for skilled birth attendance, institutional delivery, antenatal care visits, and immunization rates for children under the age of two. These were compared with two districts with comparable development indicators as well as Sindh province overall. The intervention districts, which started at much lower levels for indicators than provincial averages, in fact caught up and, in many instances, improved more rapidly than Sindh indicators overall as well as the two comparison districts. According to the PSLMS 2012-2013, institutional deliveries in NPPI districts increased from 20.4 percent to 36.8 percent between 2009 and 2013 compared to 35.5 percent to 43.1 percent in the neighboring comparison districts. Postnatal care rose from 31.1 percent to 48.2 percent in NPPI districts compared to 48.3 to 49.3 percent in the comparison districts. Antenatal care showed only a one percent change, with comparison districts showing an even smaller, 0.2 percent, difference.

DHIS data from 2012 through June 2014 also show an 11.7 percent annual rise in deliveries by skilled birth attendants; a 36.7 percent rise in FP visits and a 13 percent rise in postnatal and 24 percent rise in antenatal visits at health facilities in NPPI districts. Generally, indicator improvement measures suggest the project districts did experience the catalytic and positive effects of special attention and focus by the health system on MNCH services, despite the interventions' inconsistent and patchy coverage.

The project suffered from some key design flaws, particularly management and coordination. The NPPI had to take a corrective course after the MTR and contend with the Norwegian Government's decision to curtail funding. It revised its work plans for the project's remainder through an Exit Strategy focusing on the program's 'best and most promising elements' for sustainability and likelihood for utilization by the Sindh Government.

[4] Draft Document National Health Policy, July 2009. Ministry of Health, Government of Pakistan

The EPE team's field visits were particularly useful for identifying whether project partners collectively, and each agency individually, made marked efforts to focus on program key elements. Interventions comprised three broad categories. The first set—Sick Newborn Units, pre-service training, community midwifery training and deployment, establishment of skill labs equipment and health facility equipment provision—are seen as a natural, long term investment for improving Sindh's health sector.

The second set of interventions tried to address health care financing for increasing access by the poorest and redressing the shortages of human resources for health in the public sector. These activities were more difficult to implement and evaluate. They also suffered especially from the decision to halt activities by June 2014.

The Voucher Scheme, which had a very slow start, had begun to show an impact in changes in the poor's health seeking behaviors through facility use. The intervention may have produced fuller voucher redemption already distributed if the scheme had continued until the end of the project period.

The 'Contracting Out' intervention demonstrated that facilities operating all day, seven days a week and providing services at a small markup cost can operate in difficult and remote areas, and can improve service utilization and health outcomes.

The focal family scheme is a potential complement to the Lady Health Worker program by enhancing critical communication and mobilization activities that increase health seeking knowledge and behavior. It also demonstrated, successfully, a community approach to pooling resources for emergencies in birth preparedness.

These schemes require additional financial support to go beyond demonstration activities before scale up. Many senior Government officials are receptive to these three health financing interventions.

The third set of interventions, such as 'Contracting In', are ongoing, and the operations research study report is still pending, making evaluation difficult. Interventions such as the DHIS strengthening, which require changes in the orientation of personnel values and behavior, are critical for improving health systems. They are difficult to implement, however, and real change in coverage of health statistics and monitoring systems will require years to change.

The lack of visible leadership initially, which was subsequently filled by a high level professional coordinator for the project, did clearly make a difference. The project may have suffered because of the absence of a strong leadership working closely with provincial government, and regularly convening the relevant partners. A strong leadership structure is still required to show case the positive effects of the demonstration interventions.

The ONE UN concept may have suffered from development problems that adversely affected NPPI's full coordination, with each UN agency operating independently with its own remittance, reporting and financial systems, and not overly concerned with synergies with other UN agencies. As clearly documented in the MTR, NPPI faced challenges from its onset in part due to the complex management structure under the ONE UN approach, and implementation was delayed due to a variety of inherent weaknesses in program management. There was weak coordination between the UN agencies and interagency communication channels were not clearly identified. During the various annual meetings and steering committee meetings, weaknesses and delays in implementation were pointed out, but remediation was not initiated promptly. Stronger coordination and cohesion would have been beneficial for the project.

Efficiency

Overall utilization of the grants by the three UN agencies and UNDP'S costs of disbursement have been analyzed; they are available through UNDP. The burn rate of the grant was very slow in the first and second years (2009–2011), as can be expected in the life of any project, and picked up in 2012 and 2013 when it was at its highest level. The effect of the 2010 floods led to a diversion of efforts. Among the UN agencies, UNFPA had the most efficient burn rate followed by UNICEF, with WHO trailing substantively. The expectation is that the project will expend all funds by December 2014.

The multiple tiers of distribution of funds and related management costs would imply high project management costs. In spite of this structure, however, direct project management costs are less than 15 percent of overall costs, reflecting efficiency by UN partners responsible for managing large proportions of the project budget. Two of the major implementing partners, Greenstar Social Marketing

(GSM) and Integrated Health Services (HIS), also maintained low management costs, keeping the bulk of funds available for intervention implementation.

We have analyzed the efficiency of the major interventions and found that the Sick Newborn units are extremely efficient in terms of the cost per admission of each newborn. In terms of sustainability, running costs are low after the one-time establishment cost of US$ 90,000 per unit is incurred. Their attachment to teaching hospitals is a major factor in their efficiency and likely sustainability. The pre-medical training intervention is also an efficient investment, as training additional students requires minimal marginal costs, as the initial investments in developing teaching resources are already made.

The voucher scheme would have showed greater efficiency if there had been a longer period for the fuller redemption of the vouchers distributed. However, vouchers costed at US$134 were effective for critical ANC, delivery, FP, and postnatal care service use. The Contracting Out mechanisms were the most costly for putting in place incentives to ensure 24/7 availability of services at public facilities. These services are critical for dealing with maternal and child health emergencies, however, especially for poor women and children who use public facilities. Fuller and better maintained data records by each implementing agency could also have produced better cost efficiency computations.

Sustainability

There is a huge opportunity for scaling up the NPPI interventions, as they are so closely aligned with the Government of Sindh's objectives for reducing maternal and infant mortality and raising contraceptive prevalence in a short period of time. While there is general awareness of NPPI and a clear desire by project managers to sustain and scale up components, the process could have been taken further. A more conducive program implementation environment of working with government has been reported, but, at times, it appears project implementers acted independently as did each of the agencies. Greater engagement with the district and provincial governments should have been assigned greater priority by the implementing agencies right from the inception of the project, until its end.

The pre-medical training intervention is likely to be continued as the initial investments have already been made. Processes that need more time to reach fruition include fine-tuning of the deployment of community midwives (CMWs). While the MNCH program definitely envisages scaling up this cadre, there is no costed financial plan for how this will happen after the project ends. Similarly, negotiations for the government to make financial provisions for the additional proportion of human resource and related expenses for maintaining facilities such as the Sick New Born Units and in-service training have to be worked out in greater detail within a hand-over plan.

Clear costing exercises showing the additional costs required to retain effectiveness achieved during the project are required. We found that the data to construct such plans was incomplete and would require a longer effort (that were available to the evaluation team) to probe and analyze. Data for this exercise was found to be incomplete but may well be available with the partners if they apply further efforts to produce it. We have tried to do such an exercise for the Sick Newborn Unit for as an illustration of what we would like the project to complete for all its components.

Negotiation of a handing over of financial and administrative processes can be lengthy and will require persistent leadership and advocacy by the NPPI project and engagement with the government during the last stage of the project. The project should use this final evaluation and other evidence to organize a focused discussion of each of the interventions and about the design of a good 'package of interventions for rural Sindh' going forward. With the stronger coordination now between the UN agencies, the relative clout of a one UN advocacy with government would make up for some of the earlier lost opportunities. Further dialogue must take place with all three major implementing UN agencies on the table with Government.

Recommendations

In conclusion, had NPPI interventions been implemented simultaneously and allowed a greater implementation timeframe the project would have produced more tangible results. It is recommended that innovative schemes such as the following pro-poor initiatives be implemented fully in the poorest ten districts of Sind in line with the health sector strategy:

- Maintaining sick newborn care units and expanding them throughout Sindh;
- Pre-medical training sustained and expanded to other universities in Sindh;
- Replication and expansion of 24/7 EmOC services province wide;
- Upscale of the voucher scheme;
- Scale up of behavior change strategies such as the development of focal families.

The Government of Sindh, while investing its own resources must also actively seek the assistance of Pakistan's development partners to build on the NPPI experience in continuing effort to reach MGDs 4 and 5.

An advantage in terms of upscale of some key interventions is that there was close coordination of the NPPI with the MNCH program and to quite a degree with PPHI. These two programs that are most closely engaged with NPPI can really benefit directly from the contracting out and contracting in experiences. In particular the availability of the 24/7 CEmONC and BEmOC facilities is something that has to be institutionalized. Similar engagement with medical and public health schools and the department of health is required for the continuation of the Sick New Born Units, an excellent intervention for reducing the unusually high NMR in rural Sindh. The DHIS system is critical for all partners for routine monitoring and accountability systems that ensure mandated services are actually assessed and accounted.

It is recommended that the project holds intensive one-day sessions with the government of Sindh, key stakeholders, and development partners to assess the major components of the NPPI program and their impact. Such initiatives should focus on the successes that have been achieved as well as the challenges that confront the implementation of the interventions. The evidence emerging from these interactions---from components such as eyewitness accounts, beneficiaries' statements—would be useful to the government and the stakeholders to design similar initiatives in the future. It is suggested that such meetings modeled on the meeting in March 2014 should be conducted prior to closing the project to ensure the legacy of this precious partnership of investment of efforts and funds.

Chapter 1
Introduction

The Norway-Pakistan Partnership Initiative (NPPI) was launched in 2009 to address urgent maternal and child health needs in the Sindh province of Pakistan. Undertaken jointly by the Government of Norway and Government of Pakistan and implemented through ONE UN system, the multi-pronged project was aimed at assisting Pakistan in meeting Millennium Development Goals 4 (Improve Maternal Health) and 5 (Reduce Child Mortality).

NPPI was completed in mid-2014. This end of project evaluation report by Population Council considers project relevance, effectiveness, efficiency, and sustainability of key interventions. (See Annex 1 for the terms of reference of the evaluation).

CONTEXT AND BACKGROUND

Pakistan faces large economic, health, and development challenges that are compounded by a rapidly growing population, rising poverty, widespread political instability, and security concerns. While the country has seen significant economic progress over the past decade, no notable improvements have occurred in its maternal and child health indicators. Given its poor progress in reducing under-five and maternal mortality, it appears unlikely that the country will achieve United Nations (UN) Millennium Development Goals (MDGs) 4 (maternal care) and 5 (child care).[5]

Pakistan's health sector has historically remained under-resourced, with the least priority being accorded to primary healthcare initiatives.[6] This is a major factor underlying the country's poor reproductive health indicators. Among South Asian countries, Pakistan has one of highest infant mortality rates at 74 per 1,000 births. Its maternal mortality ratio is 276 deaths per 100,000 live births. Pakistan is in fact one of six countries that account for more than 50 percent of the world's maternal deaths.[7] Neonatal mortality has actually risen in the last five years to the current rate of 55 per 1,000 live births. Pakistan has the highest rate of first day deaths and still births at 40.7 per 1,000 births and is ranked 26th of countries with the world's highest infant mortality rates.[8]

MAIN CHALLENGES OF MCH SECTOR

In the province of Sindh, healthcare coverage, availability, and accessibility are below the national averages. Maternal, neonatal and child health (MNCH) indicators are alarming, especially in rural areas of the province. Sindh's maternal mortality ratio, measured directly in 2006-07, was 314 per 100,000. According to the Pakistan Demographic and Health Survey (PDHS) 2012-13, the infant mortality rate in rural Sindh is 86 per 1,000 live births; the neonatal mortality rate is 62 per 1,000 live births; and antenatal care (ANC) coverage is only 68 percent. While Sindh has the highest level of skilled birth attendance, stark urban and rural disparities exist: only 46.5 percent of births take place at a health facility in rural Sindh.[9]

Sindh is also confronted with additional vulnerabilities that have caused a major shift of focus in its health care priorities, most important are the province's natural disasters that lead to large-scale emergencies. Annual floods devastated areas of Sindh in 2010 and 2011 and were followed by periods of famine. The most recent project area affected was Tharparkar. These natural disasters also result in displacements of large populations, including health workers; they also damaged health facilities and led to loss of medical supplies and equipment.

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[5] B.T. Shaikh and A. Mazhar, "Reforms in Pakistan: Decisive Times for Improving Maternal and Child Health," *Healthcare Policy* 8(1): 24-32, doi:10.12927/ hcpol.2012.23015.

[6] Ministry of Finance, Government of Pakistan, *Poverty Reduction Strategy Paper 2011- 2012*. Islamabad: Ministry of Finance, 2012.

[7] Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, et al: Maternal mortality for 181 countries,1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet* 2010, 375(9726):1609-23.

[8] Report "Ending Newborn Deaths: Ensuring Every Baby Survives". Save the Children. 2014.

[9] National Institute of Population Studies (NIPS) [Pakistan] and ICF International, *Pakistan Demographic and Health Survey 2012-13*. Islamabad, Pakistan, and Calverton, Maryland: NIPS and ICF International, 2013.

Chapter 2
Project Overview

Recognizing the urgent need for improving the health of the most vulnerable communities in rural Sindh, particularly for women and children and in an effort to contribute towards the global effort to attain MDGs 4 and 5 and save lives, the Government of Norway and the Government of Pakistan jointly initiated the Norway-Pakistan Partnership Initiative (NPPI), implemented from 2009 to 2014. The UN agencies collaborating in NPPI included the United Nations Children's Fund (UNICEF) as convener, United Nations Population Fund (UNFPA), and the World Health Organization (WHO). The three agencies coordinated their efforts as ONE UN. The United Nations Development Programme (UNDP) was the administrative agent for the project, through which funds were disbursed. Each UN agency ensured NPPI project implementation through their respective implementing partners.[10]

PROJECT OBJECTIVES

The fundamental aim of NPPI was to reduce maternal, neonatal and child mortality in Sindh by accelerating activities under national MNCH policies, plans and strategies. The project's specific objectives were to:

- Increase coverage of quality MNCH and family planning (FP) services; and
- Improve MNCH and FP self-care and care-seeking behavior among families and communities.

PROJECT COMPONENTS AND LOGIC MODEL/THEORY OF CHANGE

The project design and implementation plans were based on a theory of change which hypothesized that the project's two objectives would be achieved through effective implementation of project activities geared towards the following seven key outputs:

- Integrated MNCH and FP care made available through contracting (including public-private partnerships);
- Strengthened community-based and outreach MNCH and FP care services;
- Improved governance and results-based management of health delivery system;
- Voucher/Incentive schemes implemented to increase demand and utilization of MNCH and FP services;
- Operational research conducted to produce knowledge and improve future decision-making related to increasing MNCH and FP coverage and self-care; and
- Community networks for MNCH and FP advocacy and mobilization established, and behavior change communication (BCC) and awareness raising program implemented.
- Establishment of Sick Newborn Units to address neonatal mortality.

The assumption was that the different strands of these major interventions would contribute collectively to improvements in health-seeking behaviors and coverage of MNCH services. The theory is illustrated in Figure 1.

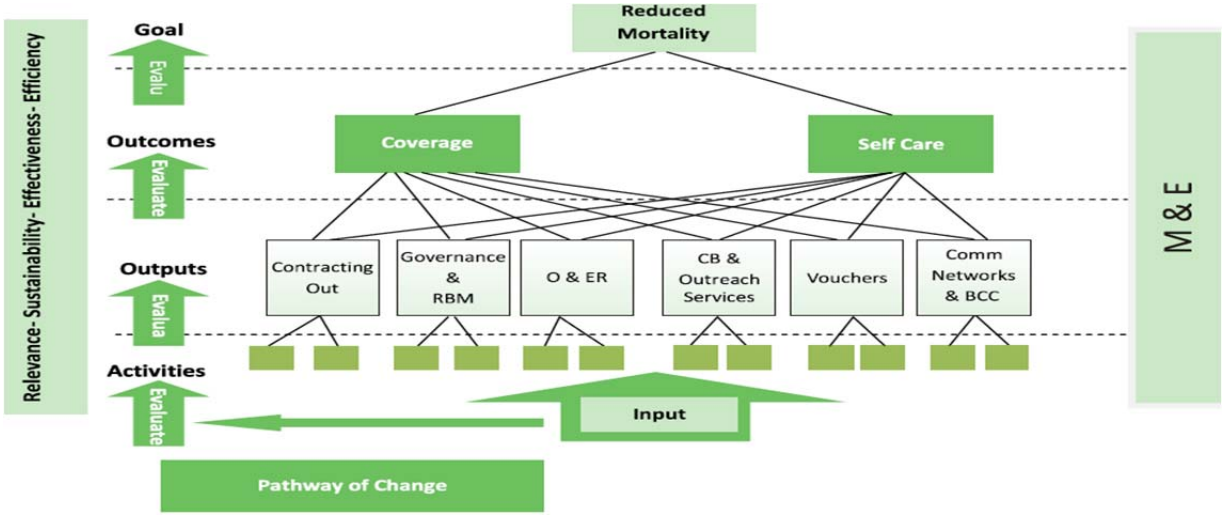
NPPI's seven components were carefully selected to support national MNCH policies, plans and strategies[11] aimed at reducing maternal, neonatal and child mortality by catalyzing, accelerating and demonstrating the effectiveness of envisaged activities. In particular, NPPI was designed to:

- Provide catalytic and strategic support to strengthening health systems efforts (e.g. human resources, referral system, etc.); and
- Use innovative and flexible result-based financing approaches to improve the effectiveness and productivity of quality MNCH care provision, and increase demand for and utilization of care.

[10] Greenstar Social Marketing, Integrated Health Services, Thardeep Rural Development Programme, Oxford Policy Management, Mustashaar, and Health and Nutrition Development Society.

[11] Logical Framework Document, National Programme for Maternal. Newborn and Child Health, Department of Health, Sindh

Figure 1: Theory of Change



EXPECTED RESULTS

The expected outcomes of the NPPI project, designed to reduce maternal, neonatal and child mortality, were:

- Increased coverage of quality MNCH/FP services; and
- Improved MNCH/FP self-care and care seeking behavior among families and communities.

Table 1: Expected Outcomes

Outcome 1: MNCH and Family Planning (FP) care coverage	Outcome 2: MNCH and Family Planning (FP) self-care and care seeking behavior
Output 1.1 Integrated MNCH and FP care made available through contracting (including public-private partnerships)	**Output 2.1** Strengthened community-based and Outreach MNCH and FP Care services
Output 1.2 Improved governance and results-based management	**Output 2.2** Voucher/incentive schemes implemented to increase demand and service utilization
Output 1.3 Operational research conducted to produce knowledge and improve future decision making related to increasing MNCH and FP coverage and self-care	**Output 2.3** Community networks for MNCH and FP advocacy and mobilization established and behavior change communication (BCC) and awareness raising program implemented

PROJECT SCOPE

Geographic Focus

Ten Sindh districts—Kambar Shahdadkot, Larkana, Shikarpur, Kashmore, Ghotki, Shaheed Benazirabad, Jamshoro, Badin, UmerKot and Tharparkar—were selected due to their vulnerability in terms of maternal, newborn, and under five mortality, and poor functioning health systems.[12]

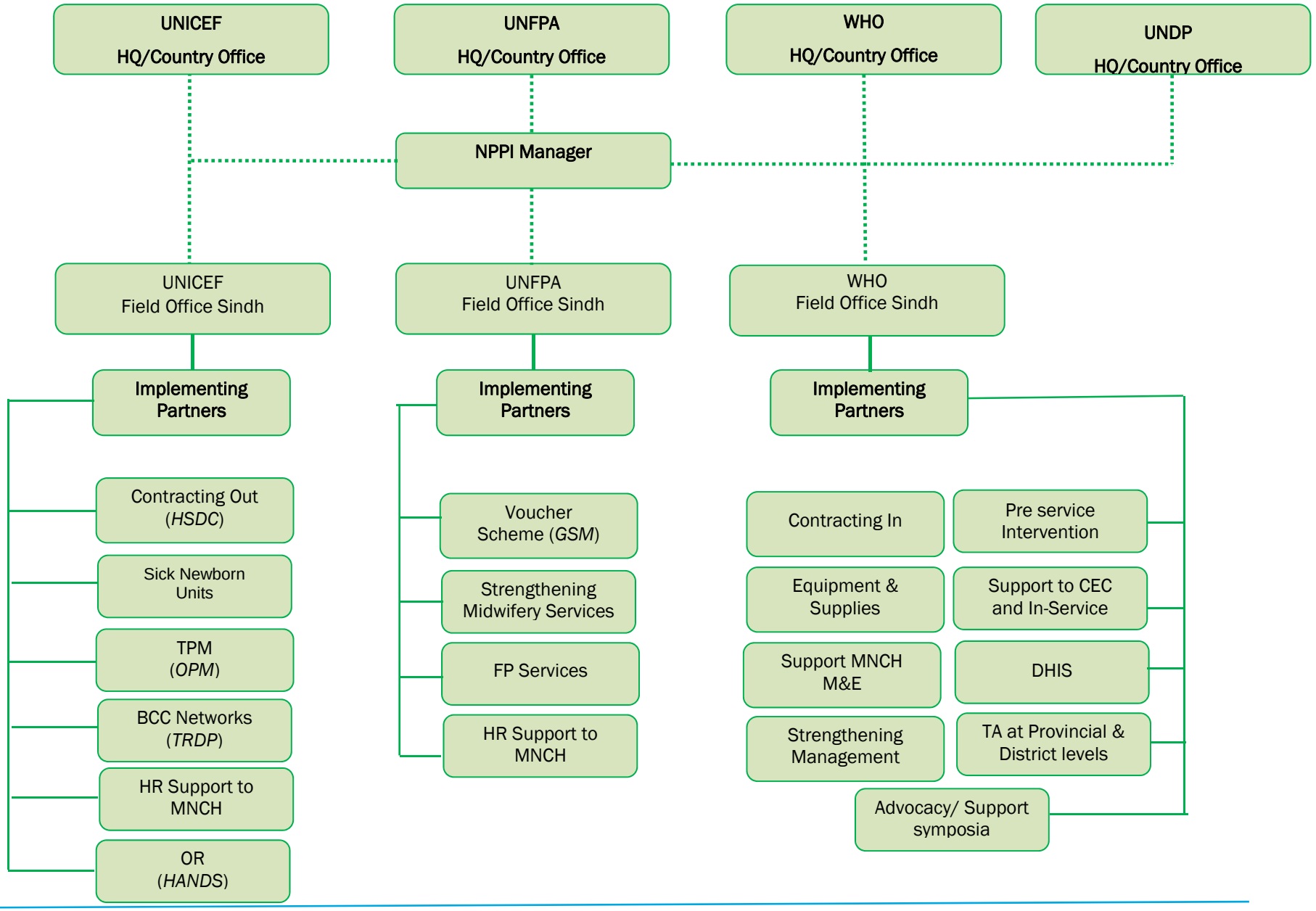
Project Resources and Management Structure

The Norwegian government initially approved a grant of 285.4 million Norwegian kroners to be spent in a period of five years to accelerate the efforts of the Government of Pakistan to implement the national MNCH program. The national MNCH program was approved in February 2007, in line with the support planned from the UN Joint Programme and Gavi under the Health System Strengthening (HSS) Proposal 2008-2010.

The NPPI project incorporated recommendations from the mid-term review, which included a project manager role for NPPI. This role is responsible for the overall management and administration in the development, planning, implementation, monitoring and evaluation of the NPPI project during the phase out, including team work and capacity building in Sindh. This role was also responsible for coordination among ONE UN agencies. The management structure of ONE UN is given in Figure 2.

[12] MICS 2003-04 Sindh

Figure 2: Management structure for ONE UN agencies



Key Stakeholders

Several stakeholders were involved in developing and implementing NPPI in the 10 target districts of Sindh. Broadly, the support was received under the umbrella of the Government of Sindh including the Department of Health, the district health authorities; ONE UN agencies, the Royal Norwegian Embassy, the Royal Ministry of Foreign Affairs, Norway, NORAD, the (federal) Ministry of National Health Services Regulation and Coordination, implementing partners, including Integrated Health Services (IHS), Health and Nutrition Development Society (HANDS), Thardeep Rural Development Programme (TRDP), Greenstar, health service providers, and beneficiaries. A complete list of stakeholders is provided in Annex 2.

Project Beneficiaries

- Men and Women
- Newborn and Children
- Health Care Providers
- Medical and Paramedical Students

MAIN PROJECT ACTIVITIES

Contracting Out of Health Service Delivery (HSDC)

Under NPPI Maternal, Neonatal and Child Health Service Delivery Contracting Out (HSDC) was implemented in the districts of Shaheed Benazirabad and Larkana from January 2012 to June 2014. The purpose of this contracting out arrangement was to ensure the delivery of quality maternal, newborn, child healthcare and family planning services under a pay for performance (P4P) model at 22 public facilities in the two districts (see Annex 3 for the complete list of facilities).

UNICEF was responsible for financing, technical support and monitoring. Implementing partners for the intervention included Integrated Health Services (IHS), Ibn-e-Sina Afghanistan, and the Sindh Rural Support Program (SRSO). The consortium of these implementing partners was called IHSAS, and was led by IHS, which had been selected through a transparent bidding process by UNICEF.

The project's logic model may be summarized according to its primary activities proposed:

- Upgrading of selected health facilities based on population coverage;
- Deployment of human resources (HRs), including service providers;
- Capacity building and training;
- Pay for performance scheme for facility and community based staff;
- Infrastructure repair and renovation, including heating and cooling arrangements;
- Electricity back up provision;
- Transportation, pick and drop services for staff with security arrangements;
- Equipment, drug, and other supply provision; and
- BCC interventions.

Establishing Centre of Excellence for Sick New Born

The centers were established at three medical universities to provide services for newborns based on nationally recommended practices and standard procedures for Essential Newborn Care (ENC) including Integrated Management of Neonatal and Childhood Illnesses (IMNCI). They are also functioning as a resource facility for training and mentoring pediatricians and medical officers, post-graduates and undergraduate medical students. The UN agency responsible was UNICEF.

Pre-Service Trainings

Pre-service training was designed to ensure Sindh's public sector medical colleges, universities, and public health schools incorporate Integrated Management of Neonatal and Childhood Illness (IMNCI), Essential Newborn Care (ENC), and related national strategies into their curricula, teaching, and exams systems. WHO was the responsible agency. The intervention targeted three medical universities and all five public health schools.

In-Service Training

The objective of NPPI's in-service training initiative was to scale up trainings on ENC, IMNCI, EmONC, emergency triage assessment and treatment (ETAT), and pregnancy, childbirth and postpartum care (PCPNC) for healthcare providers at primary healthcare and referral facilities. The training was conducted by the department of Pediatrics with technical assistance from WHO.

Contracting In

The goal of the contracting in (CI) model was to bring improvements in MNCH service delivery and outcomes, particularly in the context of basic and comprehensive EmONC, in the secondary care public sector health facilities of two districts, Ghotki and Jamshoro. In each of the districts, 3 THQ hospitals were to be upgraded to provide CEmONC services technically supported by WHO.

Strengthening District Health Information System (DHIS)

The strengthening of the DHIS was completed in all 10 NPPI districts with technical support from WHO. The intervention aimed to train provincial, district, and facility staff (healthcare providers responsible for reporting and maintaining DHIS). Strengthening included provision of equipment (desktops, laptops, UPS, printers) and DHIS data collection tools for a strong reporting and feedback system in all health facilities of the 10 identified districts.

Operations Research

NPPI's Operations Research (OR) was aimed at testing interventions for improving the nutritional status of mothers and newborns, and focused on the "Reduction of Low Birth Weight and Maternal Anemia." This component was led by UNICEF, who awarded the contract to a national research organization, Mustashaar, which provided the technical design (a case-control design) and supervision. The Health and Nutrition Development Society (HANDS) was sub-contracted to deliver interventions at the field level.

Two poor and food-insecure districts, UmerKot and Tharparkar, were identified for conducting the operations research study. The control group formed for the study included pregnant women from both districts living in areas not visited by Lady Health Workers ('non-LHW areas') who receive no intervention packages. The intervention group formed comprised pregnant women in UmerKot and Tharparkar who did receive intervention packages and resided in areas covered by LHWs ('LHW areas'). The final results and report of OR is due by the end of October 2014.

Strengthening Community Midwifery

Strengthening midwifery services for improved community based and outreach MNCH within the 10 NPPI districts was one of UNFPA's responsibilities.

UNFPA conducted two activities in this component:

Strengthening midwifery schools: UNFPA provided equipment for skills lab, furniture and other material for midwifery schools and student resident housing in 10 midwifery schools of the selected NPPI districts. Training of trainers was also provided to improve teaching skills as well as technical knowledge.

CHW deployment: In addition to the skilled based training the UNFPA provided equipment, furniture, one time drug supply, FP commodities and materials for setting up CMW work stations to ensure deployment within intervention districts.

Voucher Scheme

The NPPI voucher scheme was aimed at improving maternal and neonatal health among vulnerable communities by improving their access to public and private health facilities through an innovative financing approach. The initiative was financed through UNFPA, which selected Greenstar Social Marketing (GSM) as its implementing partner through competitive bidding. The program was implemented in two districts, Shikarpur and Badin.

Voucher promoters (VPs) were recruited to distribute vouchers and were overseen by supervisors, also appointed by Greenstar. In addition, UNFPA appointed its own supervisors, one for Shikarpur and the other for Badin. VPs had to work in close collaboration with Lady Health Workers (LHWs); few VPs were, in fact, LHWs. Trainings were conducted for identification of beneficiaries using the standard poverty score card, refer to Annex 4, distribution of voucher booklets, and for motivating women to deliver in health facilities.

Behavior Change Communication and Focal Families

The aim of the "Advocacy, Behavior Change Communication and Social Mobilization" intervention was to improve MNCH self-care and care-seeking behaviors by establishing community networks of 'focal families' (FFs) for MNCH advocacy and mobilization, and a behavior change communication (BCC) and awareness raising program. This NPPI intervention was targeted at marginalized communities in the poorer districts of UmerKot. TRDP was implementing partner for the initiative supported by UNICEF.

The initiative was implemented in 140 villages (with village health committees) in 14 union councils of the UmerKot district in areas that were not served by lady health workers. (LHW-catered areas were included in the original plan and LHWs were trained for the purpose, but it was later decided that the focus would be on areas that were not reached by LHWs). IEC material, deworming tablets and clean delivery kits (CDKs) were provided to the FFs. No intervention was conducted at the health facility level.

Chapter 3
Evaluation Objectives and Methodology: An Overview

EVALUATION OBJECTIVES

The end of project evaluation's main objectives are:

- Documenting and disseminating results and achievements of the NPPI program; and
- Generating knowledge on evidence-based best practices related to approaches, cost effectiveness, and sustainability.

Broadly, the evaluation considered four dimensions of the NPPI project: relevance, sustainability, effectiveness, and efficiency, focusing on the project's approach, planning, design, implementation, management, effect, and specifically the potential for scale up and replication of the innovative approaches and financing schemes in an effort toward equitable access to health care services for the most vulnerable in Sindh districts where these key interventions were implemented.

The evaluation process included review of secondary data through a comprehensive desk review, direct observations in the field, and interviews with key stakeholders. The information was triangulated and analyzed with an emphasis on the specific evaluation questions within each dimension.

EVALUATION SCOPE

While this evaluation covers aspects of the entire project period from its inception in 2009 to its completion in 2014, the focus in this report is on assessing progress achieved against the results set out in the exit strategy and road map developed after the project's Mid-Term Review (MTR)[13] in May 2013. NPPI's progress and performance prior to mid-2013 was comprehensively assessed and documented by the MTR process. This evaluation has also reviewed the innovative financing schemes such as voucher scheme, contracting in and out, and paying for performance to inform on whether they supported equitable access to health care services.

NPPI's MTR was mainly focused on overall project design, strategy and management. The report admitted to dwelling less on operational aspects and field implementation of innovative interventions. In light of this observation, and the short interval between the MTR and EPE, it was concluded that the end of project evaluation would focus on the road map implementation and innovations.

The EPE team also aims to compare health related changes achieved in the project's target districts with trends in comparable districts in Sindh province (where neither NPPI nor other similar interventions were carried out during the project period).

Geographic Focus

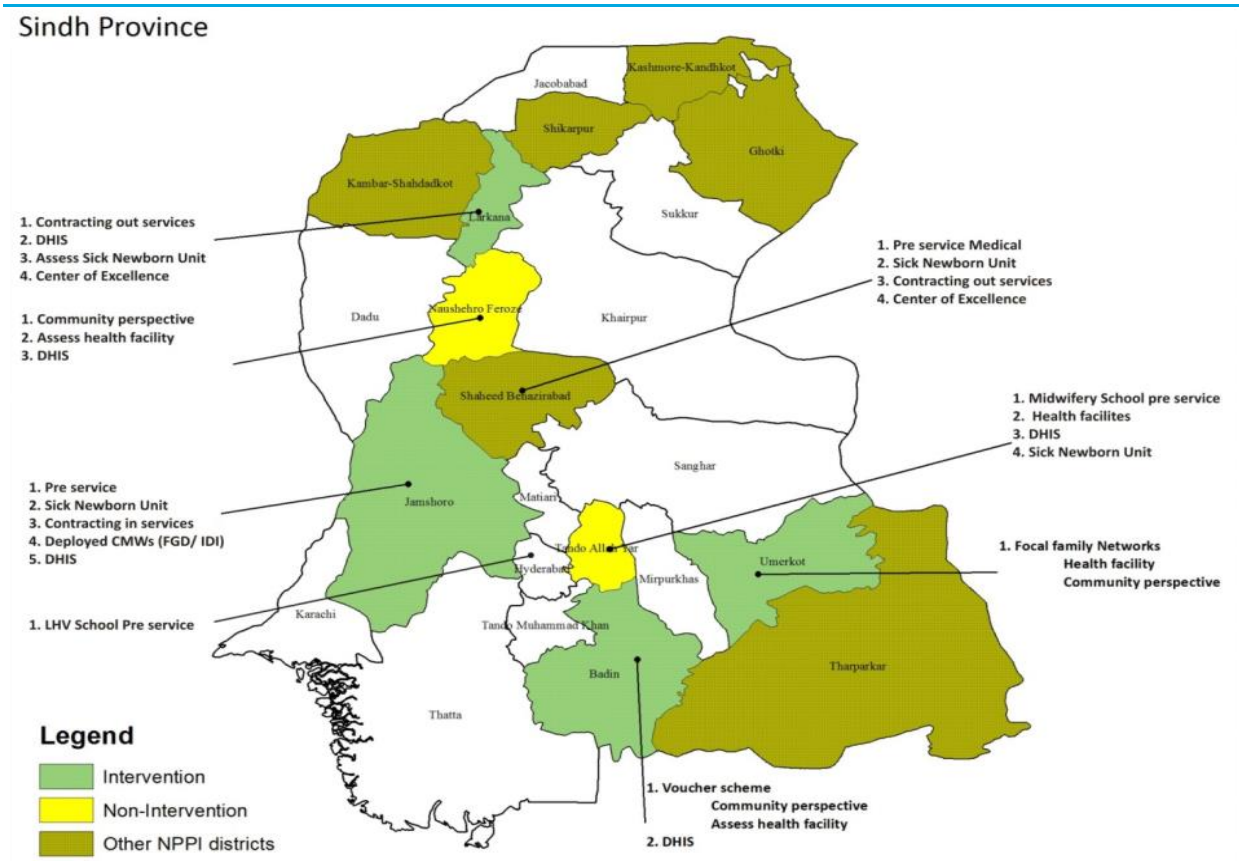
To evaluate the maximum number of NPPI project interventions given the agreed timeframe, and with an emphasis on the innovative approaches, the evaluation study concentrated efforts in four of the 10 Sindh districts where the project was implemented. The following criteria were used for district selection:

- Districts with multiple project interventions;
- Review of all three UN agency activity areas; and
- The security environment in each district.

Field work for the evaluation was carried out from September 2 to 13, 2014, in the four districts that fulfilled the criteria: Larkana, Jamshoro, UmerKot, and Badin. These intervention districts, as well as the specific interventions reviewed in each, are marked in the map in Figure 3. In addition, the evaluation team visited Benazirabad, to assess pre-service medical and sick newborn care unit interventions, as well as Hyderabad, to assess a public health school where NPPI pre-service intervention was implemented.

13 Mid Term Review Report | Norway-Pakistan Partnership Initiative, Sindh. April-May 2013

Figure 3: Geographic Coverage of the End Evaluation



Two additional 'non-intervention' districts, Naushehro Feroze and Tando Allahyar, served as comparisons for NPPI's impact and effect.

The districts were selected on the basis that no large-scale health interventions comparable to NPPI had been implemented in the geographic area, which could affect the results.

METHODOLOGY AND DATA SOURCES

The evaluation focused on exploring in-depth answers to the four critical evaluation questions identified: 1) Relevance, 2) Effectiveness, 3) Efficiency, and 4) Sustainability. The EPE utilized a mixed method approach (desk review, questionnaires, face-to-face, open-ended interviews, and direct observations) with a range of stakeholders.

The evaluation specifically employed open-ended, unstructured in-depth interviews with key provincial and district stakeholders, as well as officials from teaching and training institutes. Focus group discussions (FGDs) and in-depth interviews (IDIs) with women, CMWs, and providers and promoters allowed for qualitative assessment. A specially designed structured questionnaire assessed health facilities (Annex 5).

A total of 46 face-to-face interviews were conducted with program managers and policymakers; 13 facilities and seven teaching institutions were visited and assessed; nine FGDs were held with community members and beneficiaries (with 43 individuals); and four IDIs were conducted with community midwives, their tutors, and trainers.

A detailed methodology for this EPE, including its approach, instruments, district selection, and lists of respondents, is documented in the NPPI Inception Report submitted in August 2014 (Annex 6).

During data collection, an effort was made to identify whether the system was mindful of observing gender sensitivities during service delivery, particularly FP, and what policies or activities were introduced to ensure the most vulnerable and marginalized receive care with an aim of universal access to care.

EVALUATION LIMITATIONS

Due to unforeseen delays, the NPPI project evaluation was implemented approximately two months after the majority of key interventions had ended. This created limitations for the EPE team to assess full project effect or results. Moreover, the duration noted in the Terms of Reference and RFP for NPPI end project evaluation limited evaluation interventions at field level, for example there was not sufficient time to conduct a comprehensive evaluation based on the representative household sample, by way of survey. Each UN agency had a distinct financial process, meaning there was not one standardized and/or uniform financial procedure for the project, which made it challenging in accessing financial data. Moreover financial data from WHO was not made available for purposes of this evaluation. Staff transfers and attrition of staff created challenges in locating staff for who had been involved with the project from its inception.

ETHICAL ISSUES

As part of its policies and procedures, Population Council requires all studies involving human subjects be reviewed by its Institutional Review Board (IRB) before the activity is initiated. Ethical approval for this evaluation was obtained from IRB at the onset before the start of field activities. To have an orientation on UNEG ethical guidelines, a meeting with UNICEF staff was held on August 25, 2014 at the Population Council Office. To ensure discharge of obligations to participants, informed consent was obtained in advance from all the respondents. The informed consent form essentially covered the information on rights of respondents for their participation in the evaluation; ensuring voluntarism, confidentiality of information and avoidance of any harm. The Informed Consent Form used during the evaluation is attached as Annex 7.

Data collection teams were predominantly Sindhi and were well versed with the local culture, customs, and beliefs. UNEG ethical guidelines were followed as guiding ethical principles. Additionally, UNEG norms and standards of evaluation were also considered throughout the evaluation—honesty, integrity, independence, impartiality and credibility. The evaluation team is glad that no incident has been reported during the evaluation that compromised the mandatory obligations of evaluators as set forth in UNEG ethical guidelines and UNEG norms and standards of evaluation.[14]

Moreover face to face interviews with different stakeholders were conducted in a private setting and were kept as brief as possible.

PARTICIPATORY APPROACH

The involvement of the ONE UN agencies was taken into account from the onset of the evaluation.

Initially a draft inception report was prepared and shared with each NPPI ONE UN agency focal point, as well as reference group members (Annex 8). The final inception report was finalized after the incorporation of comments from all NPPI reference group members. Similarly the draft comprehensive report was also shared with the relevant stakeholders and the reference group and finalization was completed only after addressing their specific comments adequately.

[14] www.unevaluation.org

Chapter 4
Findings

This EPE's findings are based on primary and secondary data collected during the evaluation, which were triangulated and analyzed with an emphasis on addressing the specific evaluation questions within each dimension: relevance, effectiveness, efficiency, and sustainability. Findings focus on the project's approach, planning, design, implementation, management, effect, and specifically, potential for scale up and replication to ensure more equitable access to health care services for the most vulnerable in Sindh districts where these key interventions were implemented.

This section presents findings for the overall NPPI project as well as the six individual project interventions, primarily at district level.

RELEVANCE

Overall NPPI Project

Evaluation questions:

Were the strategies or approaches realistic, appropriate, and adequate to achieve results?

National and provincial goals, policies, and strategies are important resources in determining whether NPPI's strategies or approaches were realistic, appropriate, and adequate. NPPI's roadmap key interventions, expected results, and expected milestones were compared with the draft National Health Policy 2009, the Sindh Health Sector Strategy 2012-2020, and the Provincial MNCH Program, Sindh 2006 (revised in 2012). The comparison is outlined in Table 2.

A Provincial Manager stated, "NPPI interventions were very relevant to the needs of communities of selective districts. However, targets were overambitious." Similarly, one District Manager stated, "overall, the project was extremely relevant, yet targets were very ambitious." One Provincial Manager observed, "the project was relevant… but the targets were overambitious… [targets] should be realistic, keeping in view the current situation of the health system…"

While the draft National Health Policy and Sindh's Health Sector Strategy have broader health-related goals for the population as a whole, Sindh's Provincial MNCH Program focuses specifically on MNCH priorities addressed by NPPI, namely:

- Strengthening district health systems through capacity building and upgrading institutions and facilities;
- Strengthening and integrating MNCH services for provision of Basic and CEmONC;
- Introducing a cadre of community-based SBAs;
- Increasing health service demand with targeted, socially acceptable communication strategies.

NPPI's core objectives for target populations, as outlined in the project's baseline study, were in line with the objectives of the Provincial MNCH Program.

The **objectives** outlined in the National Health Policy and the Provincial Health Strategy broadly include welfare and healthcare for all, including women and children. The Provincial MNCH Program and NPPI, however, intend to improve MNCH access, coverage, and healthy behaviors in Sindh districts. This concurrence of aims and objectives for the Provincial MNCH Program and NPPI was confirmed in interviews with most provincial and district stakeholders. The Provincial Manager, MNCH, also stated that NPPI's overall objectives were in accordance with Sindh's MNCH program.

Several **strategic actions** by NPPI were similar to those proposed by the draft National Health Policy, the provincial Health Sector Strategy, and Sindh's Provincial MNCH Program. There was agreement on implementing financial schemes and mechanisms; strengthening provincial and district stewardship, governance and managerial capacity; and improving health service access and coverage, particularly MNCH. Strengthened skilled birth attendants (SBAs), through training and deployment, were another common strategic action for NPPI and the Provincial MNCH Program. Notably, the draft National Health Policy and provincial Health Sector Strategy propose only 'supply side' actions, while the Provincial MNCH Program and NPPI's strategies also included interventions to strengthen 'demand side' such as BCC and community mobilization for MNCH advocacy.

Table 2: Comparison of NPPI with Health Sector Policies and Strategies

	National Health Policy 2009 (Draft)	*Health Sector Strategy Sindh*	*MNCH Program Sindh*	*NPPI*
Goal	To remove barriers to access to affordable, essential health services for every Pakistani	Maximizing efforts to improve health status of the people in Sindh in congruence with international & national commitments & in response to the province's needs Focusing on: Concerted action on MNCH, nutrition & polio eradication, with special focus on control of key communicable diseases, occupational health & disaster management	To improve health status of mothers, newborn & children especially of poor and marginalized	Reduction of maternal, new born and child mortality
Objectives	-To provide and Deliver a basic package of quality Essential Health Care Services -To develop and manage competent and committed health care providers -To generate reliable health information to manage and evaluate health services -To adopt appropriate health technology to deliver quality services -To finance the costs of providing basic health care to all Pakistanis -To reform the health administration to make it accountable to the public	To provide a strategic direction aligned with evidence-based prioritized needs which, in turn, will be a basis for detailed operational planning.	To improve access to maternal and newborn health services promoting healthy MNCH behavior, especially among the poor and most marginalized	-Coverage of MNCH services (Maternal, Neonatal & under 5) increased. -Improvement of MNCH health self-care and care-seeking behavior among families and communities
Core Objectives/Priority Actions	-To develop & implement a nationally agreed package for primary care outlets including outreach services, referrals and emergencies -Federal & provincial health authorities to direct & facilitate teaching institutions in reorienting their curricula & competency based trainings -To make DHIS operational & integrate to all national programs -Provincial health authorities will provide the required health technologies according to national package of essential health services. -To develop financing schemes to ensure equitable access of health care services to vulnerable -Outsourcing management of health services -Paying for performance -Enhance quality & coverage of services	-Enhance health outcomes in the province while improving cost efficiency & quality of service delivery -Enhance stewardship role of DoH for steering public & private sector towards desired health outcomes -Harmonize the strategy plan with national policies & international commitments while maintaining strong contextual relevance for Sindh Provide a Financial Framework for investment by government, private sector, UN agencies & international partners -Provide a broad M&E framework for monitoring of sector strategy by DoH & partners	-Strengthen district health systems through improvement in technical & managerial capacity at all levels & upgrading institutions & facilities -Streamline & strengthen services for provision of Basic & CEmONC -Integrate all services related with MNCH at the district level Introduce a cadre of community-based SBAs -Increase demand for health services through targeted, socially acceptable communication strategies	-Integrated MNCH Care available through contracting out services -Improved governance & results based management -Operational & evaluation research conducted to produce knowledge & improved future decision making related to increased coverage & self-care for MNCH -Strengthened community based & Outreach MNCH Care services -Voucher/ incentive schemes implemented to increase demand & service utilization -Community networks for MNCH advocacy & mobilization established & BCC & awareness raising programme implemented
Targets and expected outcomes	-Implement package of essential services for PHC outlets -Appointment & retention of relevant staff esp.at PHC outlets -Operational efficient DHIS & Health Information Resource Center, capacity building for evidence based decision making -Provision/ replacement of required drugs, diagnostics, equipment etc. to facilities according to EHP -Birth spacing programs through health outlets & FP supply -Budget allocated as per capita costs for PHC package & financing schemes for equitable access of poor/vulnerable -Effective delivery of health services free of political interference & accountable to communities	-Strengthening district health system -Urban primary health care -Regulate private sector -Streamlining human resource -*Special areas of emphasis (polio, nutrition, MNCH, FP,* NCDs, communicable diseases, disaster management) -Integrated action on drugs -Improving governance and accountability and increased & efficient funding	To reduce: - <5 Mortality Rate to < 65 / 1000 live births by 2011 & 45 by 2015 -NMR to < 40 / 1000 live births by 2011 & 25 by 2015 - IMR to < 55/ 1000 live births by 2011 & 40 by 2015 - MMR to 200/ 100,000 live births by 2011& 140 by 2015 To increase: -The proportion of deliveries attended by SBA at home or in HFs to 90%. (Target 2015: >90%) -CPR to 55	To reduce: - <5 Mortality Rate to < 65 / 1000 live births -NMR to 36 / 1000 live births - IMR to < 55/ 1000 live births - MMR to 200/ 100,000 live births To increase: - Proportion of 12 to 23 months old children immunized for six immunizable childhood diseases – 90% -The proportion of deliveries attended by SBA at home or in HFs to 60%. -CPR to 60% - women receiving at least 1 ANC by a SBA 95% - proportion of new mothers receiving post-partum care – 60%

The comparison revealed that NPPI's interventions, expected **results and milestones** were relevant to the Health Sector Strategy in general and the MNCH Program in particular. NPPI and the MNCH program were in complete agreement in their prioritization of people's health related problems and needs in the target districts, including lack of access to maternal, neonatal and child health knowledge and services.

Innovative Approaches

Contracting Out of Health Service Delivery (HSDC)

The contracting out model was highly relevant to the needs of underprivileged communities of the selected districts. In the predominant rural environment of Larkana and Shaheed Benazirabad, HSDC was able to provide innovative solutions ensuring 24/7 availability of female service providers at upgraded facilities. Target facility health care providers received provision of pick and drop services, security arrangements, and the creation of a conducive environment at health facilities, particularly for female staff and availing the services of post graduate students where specialists were not available.

Establishing Center of Excellence for Sick Newborns: A Timely Intervention

Under this NPPI intervention, three Sick Newborn Care (SNC) Centers of Excellence were established, with the support of UNICEF, at three teaching hospitals affiliated with the Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro; Shaheed Mohtarma Benazir Bhutto Medical University (SMBBMU), Larkana; and the People's University of Medical and Health Sciences for Women (PUMHSW), Benazirabad.

All interviewed stakeholders concurred that the SNC units were most needed especially given the high neonate mortality rate (NMR) and infant mortality rate (IMR) in rural Sindh. The upgrading and establishment of SNC units was a priority intervention due to the burden of newborn admissions and outpatient department (OPD) load was being dealt at the selected hospitals by single, poorly equipped units that lacked proper infrastructure and trained human resources. The centers are designed to respond to primary causes of newborn morbidity and mortality, and also to act as a referral centers for complicated cases being sent from primary and secondary care health facilities.[15] Additionally they are functioning as Centers of Excellence to train healthcare providers from primary and secondary care health facilities of nearby districts.

According to the Head of Pediatrics Unit, Benazirabad: "The sick newborn unit is very relevant and is catering to the needs of newborns of 3-4 districts as this is the only center providing comprehensive emergency neonatal care. Moreover, this center helps the undergraduates and postgraduates in getting hands-on training for management of newborns." Similar views were expressed by the pediatrics head at children hospital Larkana.

The Head of the Pediatrics Department at the hospital in Jamshoro remarked: "In the wake of challenges related to lowering IMR, this unit is extremely relevant as it is catering to the needs of newborns of the surrounding districts. Equipment and trained HR has been provided according to the need of our hospital."

Improving Pre-Service Trainings: Focusing on MNCH

A large number of students graduate from public health and medical schools each year in Sindh and join primary health facilities or establish their own private practices. Most of them are unaware of the national protocols pertaining to neonatal and childhood diseases, and have an inadequate skills-set to provide quality services in this regard. In this context, the inclusion of IMNCI in undergraduate curriculum is highly relevant. Analysis of primary data also indicates that pre-service training is highly relevant to the MNCH requirements of rural Sindh. If the essential trainings and modules on maternal and child health are incorporated in the curriculum, they will ensure an improved and relevant skill set which has the potential to improve health indicators in the province.[16]

[15] Pakistan accounts for 7% of global neonatal deaths. Infection (36%), preterm birth (28%) and birth asphyxia (23%) account for 87% of neonatal deaths worldwide.1-6

[16] LUMHS. Teacher's Manual, Department of Pediatrics, 2010-11

One of Provincial Manager said, "Doctors and Lady Health Visitors are mostly the main health care providers for maternal, neonatal and child care in primary health facilities (especially rural areas) in both public and private health facilities. Improving the teaching of undergraduates during their basic training in this component is very relevant because once they pass out they are independent to work in any sector and most of them may not have an opportunity to improve their skills through refresher trainings."

In-Service Training: Enhancing Provider Competence to Deal with MNCH Cases

In-service trainings were conducted at centers of excellence developed under NPPI at three medical universities, Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro, Shaheed Mohtarma Benazir Bhutto Medical University (SMBBMU) Larkana and People's University of Medical and Health Sciences for Women (PUMHSFW) Shaheed Benazirabad. Skills laboratories, seminar rooms and equipment were also provided through the initiative. Training materials and guidelines were printed and disseminated as resources. The centers are not only being utilized for in-service training but also for training of undergraduate students and postgraduate students at the institutions.

A review of documents and primary data indicate clearly that in-service training is already part of the MNCH strategy for Sindh, and highly relevant. During an interview, a manager stated, "The training of healthcare providers on IMNCI, ENC, and PCPNC are highly relevant to the needs of these professionals regarding their knowledge and skill enhancement." Likewise, another trained healthcare provider pointed stated, "The recent PDHS has shown that the neonatal mortality has not reduced during these 5 years. Hence, this intervention is highly relevant because the providers at the facilities who are dealing with the newborns and childhood diseases are not aware of the latest national protocols."

It is essential that the competencies of healthcare providers be enhanced, as studies show service providers working in primary and referral facilities generally have sub-adequate knowledge and skills for managing newborn, childhood diseases and PCPNC. The in-service trainings initiative is highly relevant for meeting the objectives of healthcare professional trainings to improve MNCH outcomes.

Contracting In

This innovation was implemented by WHO, which aimed to provide specialized staff and renovate6 health facilities. The specific activities undertaken in the development of the model included assessment of secondary care health facilities in terms of infrastructure, equipment, supplies, availability of staff and consultative meetings with all relevant stakeholders at provincial and district level.

CI was intended to improve service delivery, equity, access, quality, and efficiency in the delivery of MNCH and family planning services in the target districts.

"The objectives of the Contracting In model were very relevant and as per the need of this area. Up gradation of THQ Thana Bola Khan in district Jamshoro for CEmONC services is extremely good as this will provide the services to people of remote and hard to reach areas." *District Manager*

"The contracting in highly relevant intervention because of up gradation of secondary care facilities and provision of specialist staff who can provide quality MNCH care to the poor people of the community." *Service Provider, THQ Kotri*

Strengthening District Health Information System (DHIS)

DHIS is a crucial tool for assessing progress of health facilities and observing trends in health indicators. The accuracy of data compilation and management is therefore very critical. In this context, strengthening of DHIS cells through the provision of equipment, reporting tools and training of staff maintaining DHIS was completed through this project.

"DHIS training was relevant to the needs of all DHIS staff as it was the need of time to enhance their knowledge and skill in data storing, maintaining, management and retrieval." *Provincial Manager*

Strengthening Midwifery Schools to Improve Quality of Care

CMWs are the main skilled birth attendants in the community and have to work independently for provision of maternal and child care services. Increasing coverage of CMWs is expected to lead to a rise in skilled birth attendance it is therefore very important that quality training be provided to the CMWs to build their competence and confidence in delivering services independently. In this context this intervention is highly relevant.

"The CMW School has been provided equipment, furniture and teaching aids through NPPI which will improve the training of CMWs." ***District Manager***

Deployment of CMWs: Enhancing Access

In addition to the skilled based training the UNFPA provided equipment, furniture, one time medicine, FP commodities and materials for setting up the work stations of CMWs to ensure their deployment in the intervention districts. A total 486 CMWs were deployed by NPPI in 10 districts (See Annex 9).

The deployment of the CMWs was appreciated by Government's Provincial and district managers and according to them they are the only skilled birth attendants available at grass root level, especially critical, in hard to reach areas. The provision of equipment and necessary support for setting up work station was regarded as an intervention that was highly relevant to meet the needs of rural women.

"Very relevant, because they are the only skilled birth attendants in the community for providing MNCH services including FP." ***District Manager***

Voucher Scheme: Reaching out to the poor

NPPI's voucher scheme was highly relevant in rural Sindh, where it targeted a population of very poor people who cannot afford institutional deliveries. The scheme has a relevance to the health system in general and the provincial MNCH program specifically.

The main objective of voucher financing scheme was to enable those who could not access services due to financial barriers through increasing demand and utilization of services. According to the proposed plan, a voucher entitled its bearer to four antenatal care visits, obstetric care and essential newborn care (either normal delivery or basic/comprehensive emergency obstetric and neonatal care, as needed), a postnatal visit, key vaccinations, FP, and transportation costs.

Behavior Change Communication and Focal Families

Interviews with community beneficiaries show that, before this intervention, communities in UmerKot were unaware of MNCH care and had deficient knowledge and access to services. They benefitted greatly from focal families. At FGD, beneficiaries of FFs informed the evaluation team: *"We had no knowledge and awareness of the advantages of MNCH but due to this FF project we have come to know about the dangers of neglecting problems related to MNCH. Now we have knowledge about ANC, child care, FP and having our deliveries at health facilities."*

"This intervention was very relevant because it was empowering women from the underserved and marginalized … in non-LHW areas through community mobilization." ***District Manager***

EFFECTIVENESS

Overall NPPI Project

This section evaluates the program's effectiveness by looking at project outputs, reviewed along with the project's outcomes, which are reflected in various sources of information. The findings indicate that NPPI's effectiveness was not uniform but varied by strategy, innovation, and district.

Evaluation Questions:

- To what extent did the project achieve its overall objectives?
- What are the key project achievements?
- How effective were the 'innovative approaches',
- What results were achieved, are they replicable within the Sindh context?
- Were the UN agencies effective in delivering as one? What are the good practices and/ or shortfall in delivering as 'one'?
- What are main lessons that have emerged?

A unique opportunity was available in the form of the Pakistan Standard of Living Measurement Surveys for 2009 and 2012-2013 to compare the situation in the intervention (NPPI target) districts with the two comparison (no-intervention) districts and with Sindh as a whole. Comparison of key indicators for the first three years of the project shows that NPPI intervention districts experienced a 4.2 percent annual rise in child immunization compared to 0.0 percent in comparison districts and 1.8 percent in Sindh. Similarly, skilled birth attendance rose 16 percent annually in NPPI districts compared to 7.8 percent in non-intervention areas and 6.4 percent in Sindh. The percentage of institutional deliveries rose an impressive 20.1 percent annually in intervention districts, compared to 5.4 percent in comparison districts, and 8.1 percent in Sindh. There is also a 13.7 percent point increase in postnatal care in NPPI districts, which is commonly neglected indicator. ANC increased by only 1.0 percent (and mainly in the private sector), however, in NPPI districts compared to an even lower increase of 0.1 percent for Sindh and 0.2 percent for comparison districts. Pregnant women receiving tetanus toxoid vaccination did rise 13.7 percent annually in NPPI target districts, compared to only 0.5 percent in non-intervention districts, and 5.7 percent in Sindh. Further details are provided in Table 3.

Table 3: Change in Key MNCH Indicators in NPPI Districts, Comparison Districts and Sindh, 2009-2013

		Pakistan Social and Living Standards Measurement Survey (PSLMS)		Annual change (2009 to 2013)	
Indicator	**Region**	**2008-09 (%)**	**2012-13 (%)**	**Absolute**	**Percent**
Percentage of children aged 12-23 months that have been immunized	Sindh	69.0	74.0	1.3	1.8
	Non-intervention areas	79.0	79.0	0.0	0.0
	NPPI Districts	**60.0**	**70.0**	**2.5**	**4.2**
Percentage of deliveries, assisted by Skilled Birth Attendant (SBA)	Sindh	42.4	53.3	2.7	6.4
	Non-intervention areas	39.3	51.6	3.1	7.8
	NPPI Districts	**22.8**	**37.4**	**3.7**	**16.0**
Percentage of Institutional Deliveries - Public & Private	Sindh	39.0	51.7	3.2	8.1
	Non-intervention areas	35.5	43.1	1.9	5.4
	NPPI Districts	**20.4**	**36.8**	**4.1**	**20.1**
ANC from Public & Private health institutions	Sindh	90.4	90.7	0.1	0.1
	Non-intervention areas	93.4	94.2	0.2	0.2
	NPPI Districts	**83.7**	**87.6**	**1.0**	**1.2**
Pregnant women that have received tetanus toxoid injection	Sindh	57.0	63.0	1.5	2.6
	Non-intervention areas	55.0	45.0	-2.5	-4.5
	NPPI Districts	**42.0**	**54.0**	**3.0**	**7.1**
Post Natal Care (included mothers with institutional deliveries)	Sindh	48.5	59.5	2.8	5.7
	Non-intervention areas	48.3	49.3	0.3	0.5
	NPPI Districts	**31.1**	**48.2**	**4.3**	**13.7**

Sources: Pakistan Standard of Living Measurement Surveys for 2008-09 and 2012-13.

Table 4: Changes in Average Number of Monthly Clients Visiting Health Facilities, NPPI Districts 2012-2014

Indicator	2012	2014	Annual change (2012 to 2014 June) Absolute	Percent
Full immunization coverage [a]	2269	2180	-44	-2.0
Antenatal Care (ANC-1) coverage [b]	2009	2976	483	24.0
First Postnatal Care visit (PNC-1) in the facility	537	680	72	13.3
Delivery by skilled persons reported [c]	630	777	74	11.7
Total Family Planning Visits	948	1644	348	36.7
Total Normal Vaginal Deliveries (NVDs)	305	371	33	10.9
Cesarean Sections	10	23	6	61.0

[a] Proportion of children aged 12-23 months who are fully vaccinated against Expanded Programme on Immunization (EPI) target diseases

b Proportion of women (15-49) who delivered during the last 3 years and received at least one antenatal care session during their pregnancy period from either public/private care providers

c Proportion of deliveries attended by skilled health personnel (medical officers, midwives, lady health visitors)

Source: DHIS data

Change in Key Indicators

Given the significant constraints that interventions were implemented with, to varying degrees in intervention districts, this improvement is quite remarkable. It appears to reflect the overarching attention MNCH received as a priority in the intervention districts, which was missing earlier. Some interventions that focused on governance, policy reform, and the general partnership between district governments and NPPI may have had an independent effect beyond the individual interventions. It is possible, to some extent, that observed improvements reflect the diffusion effects of overall efforts to improve management, to draw attention to maternal and child health as a priority for the intervention districts and the diffusion of some of the innovative models fielded by the project.

NPPI has successfully demonstrated the efficacy of several innovative models in improving MNCH care and practices in a challenging environment. It provided stakeholders an opportunity to learn from the experience of diverse project interventions and their management. The different partners brought unique strengths and expertise that enriched this opportunity. The challenging socio-political context of deprived Sindhi districts and the multiple facets of partnerships and coordination added further dimensions for improvement and continuity.

The District Health Information System (DHIS) is another independent source of data that indicates an overall rise in the utilization rates of public health facilities in the NPPI districts between 2012 and (June) 2014, especially for deliveries, and, most encouragingly, FP visits. Table 4 shows the annual change (percent and absolute) in the average number of clients who visited health facilities in a month in nine NPPI districts, including Badin, Ghotki, Jamshoro, Kambar Shahdadkot, Kashmore, Larkana, Shikarpur, UmerKot, and Shaheed Benazirabad. (Average data for the nine districts is presented; DHIS data for the Tharparkar district was not available.)

At the strategic level, the NPPI project was implemented by ONE UN involving three UN agencies, UNICEF, UNFPA and WHO. The advantage in this situation was that the project could deliver diverse interventions, with each UN agency implementing its chosen intervention based on its strengths and comparative advantage. However, the advantage of

having the best expertise available to lead each intervention was, to an extent, counterbalanced by the absence of a central point of convergence for project management, liaison with stakeholders, effective coordination, reporting and decision making, which hindered effective project implementation and realizing the full potential of the project.

There are well-established examples of relatively successful national and provincial initiatives where a lead partner, Principal Investigator (PI), or Chief of Party serves as the face of the project leadership and takes responsibility for coordination and compliance.

In the case of NPPI, although the ONE UN established a coordination mechanism and position, timely actions were delayed and lacked strong coherence primarily due to the following:

- Unique set of policies and procedures of each UN agency;
- Diversity of interventions and project geographic scope; and
- Absence of local, unified branding of the project for purposes of identification

This resulted in clear coordination gaps and, ultimately, unwanted delays in result-based implementation. Regarding this issue, a Provincial Managers, observed:

"WHO, UNFPA and UNICEF were working but no oversight committee was formed at provincial level. Though these agencies were working together, no one endeavored to bring together all activities under one umbrella. The convergence point was lacking as there was no one strong leadership at the top." He was further of the opinion that *"only one agency should implement the project in which all important partners, including government—the Director-General Health—should play a strong role."*

The Provincial Manager further recommended:

"To bring about improvement in related future interventions, it will be feasible to have separate grant and different strategy for funding. There should be a separate team leader and stakeholders should be involved from the very initial planning phase. Targets should be realistic and should be ensured adequate staffing in the facilities. Moreover the volatile security situation of the country should also be given prime focus under assumptions."

The importance of such coordination is evident from the visible improvement in project implementation observed after 2013, when, following the project's MTR, a central project coordinator was hired. This addressed many issues: Overall coordination among implementing partners improved, and project efforts were effectively channelized to achieve the results set in the exit strategy and roadmap. Consequently, much better progress was recorded after 2013 for financial flows and achieving objectives of the phase out period.

From these observations, it may be inferred that the ONE UN strategy in itself was a good step, but providing the related requisites of a central coordination body or office for NPPI from the outset could have been more effective in tapping potential synergies among the UN agencies and facilitating decision making.

Operational records of the implementing UN agencies, such as the following checklists, also provide evidence of significant progress against all actions envisaged in the exit strategy. The extent of progress varied for different actions as shown in Table 5 (also refer to Annex 10).

Contracting Out of Health Service Delivery (HSDC)

The findings of the Mid-Term Review and Third Party Monitoring indicate that contracting out accomplished tangible improvement in the quality of services available. An analysis of interviews with provincial managers, district managers, facility staff and secondary data[17] shows that the majority of the inputs were in place in two intervention districts. As a result, coverage of MNCH services improved in the intervention districts and **data from the DHIS shows that utilization of MNCH services increased from January 2012 to December 2013.** This is indicated by the increase in antenatal care, postnatal visits, normal deliveries and caesarian sections, immunization and FP visits.

[17] End of project report and NPPI Third Party Monitoring Report for HSDC, February 2010

Table 5: Activities Implemented vs Activities Proposed in Exit Strategy

UNICEF	
Contracting Out	
28 health facilities providing 24/7 MNCH service in two Districts	22 Health Facilities functional instead of 28.
Establishing 3 Centers of Excellence For Sick New Born Care	Centers are established
Third Party Monitoring	Monitoring of Contracting Out and VS done
Behavior Change Communication Network- Implemented	Implemented in Umerkot only
HR Support To MNCH-Technical assistance for communication, admin & finance(2 posts)	Support was provided but not sustained
Final Evaluation	In process
Support for NPPI Coordinator to be one UN Joint Programme Focal Person	Support provided
UNFPA	
Voucher Scheme-39,000 Vouchers were distributed by the Greenstar	Done
Strengthening of Midwifery Services	
* Midwifery Schools- Provision of equipment, furniture, teaching aids	Done
* Deployment Of CMW's- Midwifery kits provided	486/532 CMW's in 10 NPPI districts
6 weeks Clinical Attachment of passed out CMWs at Midwifery Institute	Trainings conducted
Family Planning Services- Enhance skills of 200 service providers in FP	2 batches conducted by UNFPA. Now taken up by MCHIP
Human Support To MNCH Programme -Technical assistance (two posts)	One person retained
WHO	
Contracting In -Implemented in Jamshoro and Ghotki Districts	This activity was delayed and not fully functional
Pre-Service Intervention (IMNCI part of curriculum)	Done in 3 Medical Universities and 5 PHS
Pre-service committee formed	Committee formed. Secretariat of Pre-Service located in DG office
Scaling up of In-Service Training-of SPs in IMNCI, ENC, PCPNC and ETAT	Done
Support to 3 Centers of Excellence-Establishment as resource facility	Done
Equipment Supplies- provided at HFs in 10 districts	Equipment provided
DHIS-Training of staff and provision of equipment/tools	Done
Support MNCH Monitoring and Supervision	Done, MNCH program has taken it up according to WHO
Technical Support, Supportive Supervision And Policy Guidance at Provincial and District Level-10 district units establishment	Done
Sindh Government has appointed Focal Persons MNCH in all Districts	Done
Strengthening Management	Done
16 Mid-Level Managers trained at AKU in Health System Management	Activity conducted
3 Members from each District will be trained in PM from COMSATS Institute	Activity not conducted
Implement SAAVY (Sample Vital Registration With Verbal Autopsy)	Activity not conducted.
Advocacy/ Support Symposia	Done

"The NPPI project had done a great deal in improving community health as some of the BEmONC Centers which remained closed before the projects are now open. The project had provided them with supplies and HR and enabled them to provide 24/7 services to the catchment population. In the rest of the NPPI supported facilities also, staff was available for 24/7. This has enabled the community to avail specialized services for children and newborns even at the THQ/RHC level." *Medical Officer, Benazirabad*

During the FGD with community women in a district where contracting out was implemented, they expressed satisfaction with the services and concern regarding project closure.

"For the last one and a half year, facilities in Government hospital had improved. There were 24/7 services and doctor was available. Lab services, ultrasound, surgery and C-section were also provided free of cost at these health facilities. Moreover, family planning products were also available there. After closure of project, we again have to go to the civil hospital in the main city for these services." *FGD*

The project experienced challenges such as significant delays in implementation due to floods in 2010 and 2011, wreaking havoc in Nawabshah (Shaheed Benazirabad) and causing partial damage in Larkana. This delay in project implementation led to delays in fund release.

Furthermore, under the contracting out arrangements, management powers for the health facilities were retained with the district health departments instead of being transferred to implementing partners. This lack of management control proved to be a significant challenge and constraint for HSDC in smooth implementation of their respective interventions.

There were also significant delays in implementing the third party monitoring (TPM) for HSDC, which only began after the fifth quarter. This caused further delays in release of funds. TPM revealed some positive outcomes as well as gaps and under-achievements. For instance, OPM reported 100-percent client satisfaction with regard to effective antenatal, postnatal, and neonatal care services; however, effective care was available at only 50 percent of upgraded facilities. It was also reported that all upgraded facilities were functional for comprehensive emergency obstetric and neonatal care (CEmONC), basic emergency obstetric and neonatal care (BEmONC), and sub-BEmONC according to plan. With reference to effective care, it was reported that partographs were correctly filled for 94 percent of deliveries, and case recording forms were correctly filled in 91 percent of IMNCI cases. The project scored 81 percent, 83 percent, and 89 percent, respectively, in the last three quarterly monitoring rounds[18].

Situation at Two Public Health Facilities visited by the End of Project Evaluation Team: A Rural Health Center (RHC) and a Taluqa Headquarters Hospital (THQ) in Larkana

The visit established that these facilities had been providing CEmoNC services during the NPPI project period. However, at the time of the visit, three months after the end of these facilities were not even providing full BEmONC services. The RHC was still providing 24/7 delivery services (though not the full EmONC services), but the THQ was conducting deliveries only during the daytime. At the time, specialized pediatric services were not being provided. Full laboratory services and blood transfusion services were available in the daytime only at the RHC. Both institutions had fully equipped Operation Theater which was nonfunctional because of shortage of staff. The providers had received training in IMNCI, ENC PCPNC and infection prevention. The main problem was that all the staff appointed through NPPI had left after the project ended. Due to the shortage of staff (both technical and support), the facilities were not able to provide 24/7 services. One of the managers pointed out that, apart from the problem of payment, the special pick and drop services with security arrangements provided for staff provided had also been a very important factor in the provision of 24/7 services.

Despite several challenges and constraints, such as delays in funds release, and even without management control of health facilities, which was retained by District Health Officers (DHOs),

[18] NPPI Third Party Monitoring Report for HSDC, February 2010

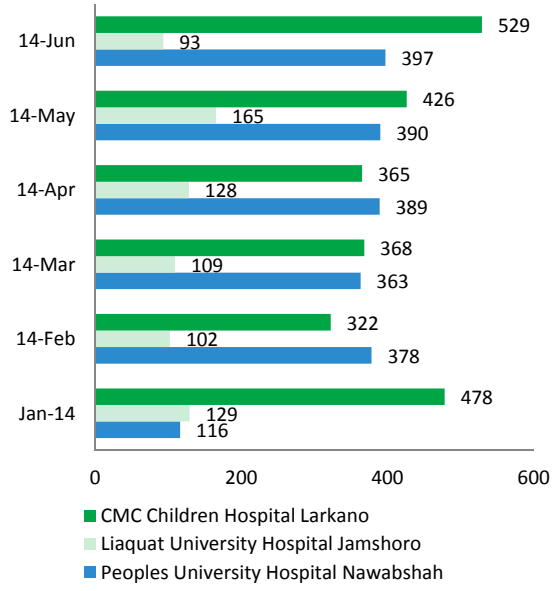
contracting out led to improved performance in health service delivery, as measured by outputs and progress towards intended outcomes. The intervention only had 30 months for implementation, but even in this short period of time, the upgraded facilities attracted an increased number of MNCH clients (according to DHIS records for the districts). Community sensitization with SRSO also helped in improving MNCH behaviors through involvement of religious leaders for male participation, radio messages and street theatres for pregnant mothers and elderly female decision makers of the families.

Establishing Centers of Excellence for Sick Newborns

The evaluation team found during its visits to Shaheed Benazirabad, Jamshoro, and Larkana that the SNC Centers of Excellence are fully equipped to cater to the needs of newborns. There were different sections, including a Newborn Unit, Under-Five Clinic, and a Nutrition Clinic. NPPI has provided all the essential equipment according to the needs of each institution, which were available and recorded. NPPI had also provided trained technical and support staff. On the day of visits, all the wards were more than fully occupied with two or more children in the incubators, cots and phototherapy units. Hospital authorities reported that the centers were providing care to newborns from neighboring districts as well.

Undergraduate students, house officers, and postgraduate students were all receiving hands-on training in neonatal care according to the latest WHO protocols on safe newborn management.

Figure 4: Number of Admissions in Sick Newborn Units



A review of service statistics showed that the number of admissions and cases of management of newborns with complications have progressively increased after the refurbishment or establishment of these units. Figure 4 provides the number of admissions for the three centers.

NPPI support ended in June 2014 but the institutions continued to provide services through their regular budgets. Each institution had retained some of the staff provided by NPPI to continue providing quality services. All the three Heads of the departments of Pediatrics informed that although they were trying their best to manage, they needed more support staff to avoid deterioration of the quality of services. The centers can be sustained with provision of some trained technical and supportive staff.

"This unit is one of the key successes of NPPI project because this is an important intervention which would help in improving neonatal mortality. This institution will also help the future graduates to improve their skills in managing newborns which would help them later in their practices." *Provincial Manager*

Pre-Service Trainings

The inclusion of the IMNCI module in the regular curriculum of pre-service medical and public health schools is a big achievement. The log books and case books are the first of their kind in the province, according to a provincial manager. The evaluation team visited three universities (Benazirabad, LUMHS, Larkana) where IMNCI training was incorporated in the undergraduate curriculum. Department heads stated that the intervention constituted a big step in undergraduate instruction, and would help future doctors in applying protocols in their practices. NPPI organized training of trainers and also set up skills laboratories for practical training. Moreover, the Sick Newborn Units established within the pediatric wards were very useful for hands-on training in managing childhood diseases. Trainers at the institutions considered the intervention a very good initiative that had made teaching easier and more effective.

This curriculum has also become part of the examination system and is accorded 30 percent weight. The head of Benazirabad University informed the team that training is according to the new modules, but the university awaits approval of its Academic Council.

All five public health schools of Sindh have incorporated IMNCI guidelines in their training. However, they have not yet received approval from the Nursing Council. According to the records, all five institutions had received trainer's manuals and equipment for skills laboratory. The tutors have also received training of trainers in teaching methodologies and in IMNCI protocols.

The evaluation team also visited one public health (LHV) school in Hyderabad. The principal informed the team that her staff had received 11 days' training in IMNCI protocols and two of her staff had also been provided training of trainers in implementing this curriculum. In addition, they had received equipment and teaching aides for demonstration at a skills laboratory. The trainers were very happy with the training and found it very easy and practical.

The Pre-service Secretary, Government of Sindh informed the team that he was in the process of arranging funds for translation of IMNCI modules in Urdu for LHVs and midwives, which would improve the teaching.

CASE STUDY

An evaluation of IMNCI pre-service education at LUMHS by regional team from WHO termed the teaching of IMNCI consistent with traditional, classic pediatric teaching and well integrated throughout the curriculum and materials. The inclusion of IMNCI in teaching at graduate levels makes the intervention self-sustaining; however, a continuous support is required to keep the teaching facilities and teaching sites fully functional and operational.

Liaquat University of Medical and Health Sciences, Jamshoro is the Asia's first university to incorporate IMNCI into the undergraduate teaching and examination system.

One of the major reasons for the poor maternal neonatal and child health indicators in Sindh is under performance of public sector health facilities essentially due to shortage of human resources, inadequate supplies and equipment and low capacity of health care providers. To address these gaps, The Norway-Pakistan Partnership Initiative pledged establishment of **Centre of Excellence** in three teaching hospitals in Sindh including Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro.

The initial discussions and preparatory work on establishing a Center of Excellence at Liaquat University Hospital (LUH) started in 2009. LUH in collaboration with MNCH Programmed and NPPI developed and printed several teaching tools (log books, case books, trainees manual etc.) and finalized arrangements for revisions in under graduate curriculum. The project has really been instrumental to complete this lengthy and cumbersome process in a timely and dependable manner. First IMNCI training course for faculty members was conducted in April 2010 in LUMHS. Thus far, the center has trained a total of 385 participants from NPPI districts in IMNCI; 351 participants in ENC and 113 participants in PCPNC.

The Centre of Excellence is equipped with state of the art teaching aids and other facilities. Pediatric OPD and Obstetric Services have been reorganized to compliment training of providers as well as teaching at undergraduate levels. IMNCI has been included in the University's examination system, with 30% of total marks assigned to IMNCI. Another major landmark of the NPPI project was establishment of a Sick Newborn Care Unit at the LUH that has been operational since January 2014. This unit provides an opportunity to students to practice their skills of actual clients

The successful intervention of pre-service teaching/ training serves as a model for other institutes providing medical education. There have been two study visits conducted by the faculty of public medical colleges and universities of Balochistan, Punjab, KPK and Afghanistan to learn from this experience and to potentially replicate it.

In-Service Training

Under this intervention, training was provided to in-service medical officers, in-charges of health facilities, pediatricians, Lady Health Visitors, and health technicians. According to the database provided, 1,006 healthcare providers received training in IMNCI[19]; 705 received training in ENC[20]; and 310 were trained in PCPNC.[21]

The evaluation team's visits confirmed that the in-service trainings were implemented according to plan. On visits to the three centers of excellence, it was observed that the seminar rooms and skill laboratories were very well set up with the latest equipment; mannequins and models were available to enable training participants to understand, learn and practice labor room procedures and IMNCI and PCPNC protocols. The skills laboratory was also being used for practice by students enrolled at the universities.

All three centers of excellence have conducted a number of training courses. Field visits to primary, secondary and tertiary healthcare facilities found that the trained providers were highly appreciative of the training they had received, which had provided them the necessary skills to diagnose and manage common neonatal and childhood illnesses through a methodology they found easy to use.

"If anyone takes the 11 days IMNCI course then they would not need a doctor to manage a newborn and childhood problem and they would know when to refer the client to an appropriate facility." ***Healthcare Provider***

"The project was effective in building the capacity of doctors, LHVs and midwives in MNCH care." ***District Manager***

However, one of the provincial mangers commented that not all standards were met: "The result of Centers for Excellence was good. The staff of the Directorate of health had also received trainings. However the mechanism of implementation of this initiative in the field was not proper. Though the trained staff was working in the field there was no reporting mechanism in place to ensure that they were following the protocols."

Furthermore, one of the Dean suggested, "The follow up of the providers at their respective health facilities would be very beneficial to demonstrate the extent to which training has improved the quality of MNCH related services being delivered and its impact on the overall MNCH indicators."

Contracting In Faced Implementation Delays

An analysis of secondary data and interviews with provincial and district health managers and observation of evaluation team during field visits revealed that, due to unanticipated delays in finalization and non-availability of specialized staff, it was hard to achieve the desired outcomes from CI.

The evaluation team visited two secondary care facilities, THQ Thana Bhula Khan and THQ Kotri in Jamshoro district. Both the facilities were designated to provide CEmONC services but it was observed that THQ Thana Bhula Khan was providing BEmONC services only, while THQ Kotri provided 24/7 CEmONC services. Both the facilities were renovated and equipped with all necessary equipment including anesthesia machines, resuscitation sets, warmers and baby cots were provided. Essential medicines were also provided as per requirements. Ambulance was available and functional at both the facilities. Keeping in view, the gender sensitivity of the women wanting to be seen separately, the facilities were offering proper seating arrangements with a separate examination room and toilet for women. The gap of human resource was filled to an extent to provide the CEmONC services in both facilities and they had received IMNCI and PCPNC trainings.

However, as mentioned earlier, THQ Thana Bhula Khan was only providing BEmONC services and no C-Section or other surgical procedure were being performed even in the presence of trained female Ob/Gyn and anesthetist. Despite the availability of pediatrician in THQ Kotri, there was no separate neonatal care unit. All laboratory tests were performed in THQ Kotri but in Thana Bola Khan, urine RE and complete blood picture tests were not offered. Blood transfusion services were available. However, in both THQs, infection prevention practices for sterilization of equipment and safe disposal of sharps and syringes, the standard protocols were being followed.

[19] List of IMNCI Trained Persons

[20] List of ENC Trained Human Resources Sindh

[21] List of PCPNC Trained Human Resources Sindh

The Provincial Manager, MNCH has now informed NPPI that four THQs (2 in Ghotki and 2 in Jamshoro) have begun providing CEmONC services.

Strengthening District Health Information System (DHIS)

Equipment and data collection instruments were available, functional, and properly recorded in stock registers in all 11 health facilities visited, and reporting tools were adequate for one additional year.

During the field visits and interviews with provincial and district level managers it was found that twenty six district level facilitators were trained, with the target to train health care providers from 644 facilities. A total of 1,089 personnel (provincial/ district and facility)[22] were trained in filling out forms, and managing and reporting data. One provincial manager stated that the use of information for DHIS management still remains a weak area, although there have been significant improvements and changes recently because of this intervention.

"Trainings in DHIS for staff of the provincial and district offices and health facility staff were effective as it helped to fill the gaps. Provision of instruments [tools] was also very help full." **Provincial Manager**

"Reporting has improved after training and regular feedback is being received from provincial DHIS office to ensure correct filling of the reports." **District Manager**

Some provincial managers were of the opinion that these trainings were less effective. Much more is required and they suggested that stress should be given on monitoring and accountability to achieve timely and accurate information.

"Monitoring and supervision is missing at district level to ensure the reporting and feedback mechanism for DHIS. There is no mobility for data validation at the district level. There are certain limitations of the DHIS data quality and it rarely helps in decision-making. Accurate data needs close supervision but due to lack of mobility on account of budget constraints monitoring was usually not being done". *Provincial Manager*

[22] List of Health Care Providers trained in DHIS Sindh

Operations Research

The activity has been completed and report is to be shared by end of October 2014. If the results are positive, this intervention could have a profound effect on MNCH strategy, lead to a decline in pregnancy-related complications, and improve MNCH outcomes**. It remains to be seen how the researchers will navigate the complexities of comparing results from two intrinsically different intervention and control populations;** as mentioned earlier, the LHW areas are better in most respects than non-LHW areas.

Strengthening Community Midwifery

Strengthening Midwifery Schools

Interviews with the trainers revealed that the training provided to them was highly effective and now they are using participatory techniques (role plays, group discussions and case studies etc.) while teaching the students instead of didactic lectures only. They were also utilizing the skills labs for practical training.

The Evaluation team visited two out of the total 10 schools strengthened by NPPI)—one each in Badin and UmerKot and one in non-intervention district where the school was not strengthened. The schools were assessed by using the pre structured checklist (Annex 5). It was observed that the equipment was entered in a stock register. In district Badin, because the school was under construction, the skills lab was not established. CMWs were practicing by using the skills lab of the nearby nursing school, however. In UmerKot, the equipment for teaching, furniture, and other necessary equipment were being used by the students. In the comparison district of Tando Allahyar, similar furniture and material were provided by MNCH and was found properly recorded in stock register. No similar equipment was provided for skills lab, however. The hostels of all three schools were equipped in terms of furniture and other materials but were not being utilized due to shortage of staff and security concerns.

Face-to-face interviews with students showed that they were confident and knowledgeable about the common maternal and neonatal problems. Students being trained in the intervention schools had more knowledge of ANC, management of common problems during childbirth, as well as postpartum, compared to the non-intervention area.

"Training on IMNCI should be provided to tutors so that they can provide training to students on the new protocols."

Principal, Midwifery School, Non-intervention Area

However, additionally in Tando Allahyar, another USAID project, MCHIP, appointed one female doctor and one paramedic to supervise pupils in the hospitals for "hands on" training, a very good step for improving clinical skills training.

CMW Deployment

The field visits found many positive outcomes of this intervention. A total of 486 out of 532 CMWs trained were deployed (Jamshoro 40/43, Badin 87/88, UmerKot 55/61, Tharparkar 37/37, Nawabshah 62/64, Larkana 70/70, Kambar Shahdadkot 45/51, Shikarpur 42/46, Ghotki 24/48 and Kashmore 24/24) in the 10 NPPI districts. The intervention is highly successful in utilizing the services of trained CMWs, which at times, are known to not find suitable employment.

Work Stations Established

The evaluation team also elicited community midwives' views through two FGDs and two IDIs with the deployed CMWs. A Focus Group discussion with CMWs who had benefitted from this intervention revealed that seven out of nine participants had established their health house in a room attached with their houses. Most of them were conducting two to three deliveries on an average in a month and some were conducting five to seven deliveries in a month while two participants were conducting 10 to 11 deliveries in a month because there was no health facility or even a Dai or LHW in their area. They had also received refresher trainings in BEmONC (3 CMWs) and FP (4 CMWs and they had also received IUD kits). Six CMWs had attended training in Agha Khan Hospital Hyderabad for midwifery practice. Three CMWs had been given Oxygen cylinders by MNCH because there were no health services in their area, not even the LHW. All reported that they receive regular and quality monitoring and supervision from their supervisors.

All CMWs interviewed were knowledgeable regarding MNCH issues and their management, confident and happy with the services they were providing.

"I have one room house and a very small store, I have setup my work station in the store room where I have put the delivery table and there is no space even to sit. Last night I conducted a delivery, I was standing by the woman for four hours and she had a baby boy, I am so excited and proud about it that although I have not slept the whole night and have been standing but I don't feel tired at all." *CMW who had delivered a child the night before*

The FGD with six CMWs from the non-intervention area revealed that they were also knowledgeable. Four of them had setup their work stations and doing practice (one was conducting eight to 10 while the other three had three to four deliveries per month). Two CMWs were working in private clinics because they did not have space in their home for establishing work station. They were also confident to provide the services.

Voucher Scheme

The Voucher Scheme was evidently implemented with great commitment at the outset and distribution and redemption initially remained on track. Unfortunately, the promising early performance of the project was interrupted by implementation challenges. This section first evaluates the effectiveness of the project on the basis of service statistics; client satisfaction and empowerment; behavior change for MNCH care; and comparison with non-intervention areas. It then explores the challenges that compromised its later performance and their implications.

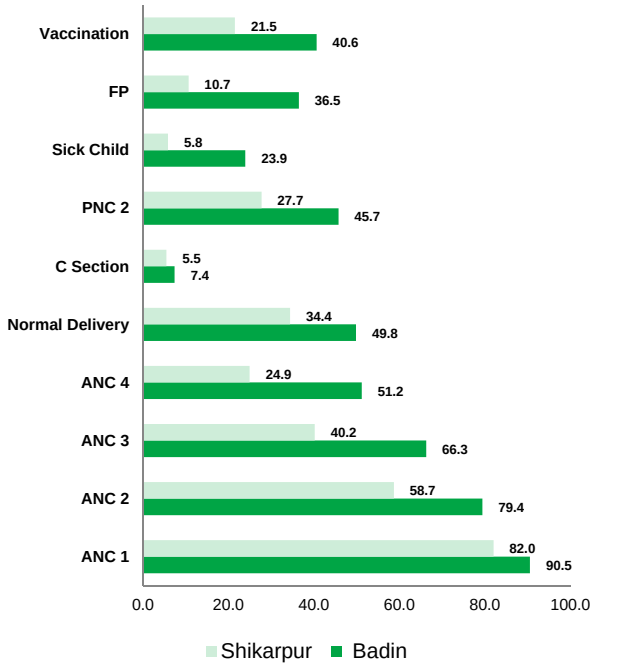
Service Statistics

Around 40,000 women were registered for voucher distribution and 164,981 vouchers had been redeemed up to the time of this evaluation. (Details of voucher redemption for various purposes are in Annex 11). The record shows that 19844 deliveries took place over two years at the intervention facilities in the intervention areas. According to our estimates, there are about 40,000 births in each of the districts annually, and therefore 25 percent of deliveries were in intervention facilities. No maternal or infant deaths were reported during the intervention in areas covered by the scheme. In view of the prevailing high maternal and infant mortality in the province, progress report claims that NPPI averted many deaths of expecting mothers and newborns.

After the introduction of the VS, clients were more inclined to seek MNCH care. ANC, PNC, deliveries by SBAs, immunization and FP counseling and practices improved. Service providers, and provincial and district stakeholders agreed that the voucher scheme was successfully initiated to improve the MNCH status of the poorest of the poor. Despite many implementation issues, that, for the pregnant women in the most vulnerable groups and poorest households, the voucher scheme provided the only real opportunity to obtain proper antenatal checkups, delivery care, postnatal checkups, and FP services from qualified healthcare providers.

In all, 39,923 vouchers booklets were distributed (22,481 in Badin and 17,442 in Shikarpur), of which 41 percent were redeemed (Figure 5). **Based on the expected births in Badin and Shikarpur, it is estimated that almost 25 percent of births (normal deliveries and C sections) were facilitated through the Voucher Scheme.** The average cost per voucher booklet was Rs. 13,776, almost 9.5 percent higher than the proposed cost. However it was lower than the cost package of Rs. 14,314 (for ANC, normal delivery, C-section and child illness) based on the lower range of willingness to pay, as per feasibility study[23] for financing interventions under NPPI.

Figure 5: Percent of Vouchers Redeemed of Total Disbursed



Client Satisfaction and Empowerment

TPM reports show that clients were satisfied with the voucher scheme and services provided. Respondents from the community and service providers also reported that awareness and utilization of ANC, skilled delivery, PNC, neonatal care, FP, exclusive breastfeeding, complementary feeding, nutrition, vaccination and child care by the beneficiaries had improved. Findings from FGDs with community beneficiaries revealed that vouchers had helped poor women and families to avail MNCH services and laboratory tests free of cost.

Women (beneficiaries) of voucher scheme at a FGD in Badin reported: *"We were satisfied with the services of private hospitals through VS as the providers were giving special attention and providing medicines and facilities for treatment. We were getting ANC, skilled delivery, PNC, infant care, vaccination and family planning services there."*

A VP narrated the striking experience of Razia, a woman in the project area married to Karim Baksh, who, before the scheme, had delivered four babies, none of whom had survived: *"All her deliveries had been conducted at home as she could not afford to go to the hospital. This time when she was pregnant, she was given voucher booklet. She had 4 antenatal checkups during this pregnancy and the doctor informed her that she would need a C section and a blood transfusion. At the time of delivery, the condition of the patient was very critical and needed blood otherwise her operation could not be performed. We arranged blood, the doctor performed CS and mother and baby are both healthy. The doctor inserted an IUCD for five years for spacing."*

[23] Aga Khan University, *Result Based Financial Mechanisms for Improving Maternal, Newborn and Child Health Outputs: A Feasibility Study for 10 Selected Districts of Rural Sindh* (Karachi: AKU, 2009).

Behavior Change for MNCH Care

According to the community respondents and voucher promoters, the project was effective in the most important and difficult task of changing the behavior of communities towards MNCH. During the project, the ratio of institutional deliveries went up because of the increase in community awareness and affordability. Clients also expressed satisfaction and appreciated the scheme. They claimed unanimously that their awareness of the importance and utilization of services related to MNCH had improved. A 20-year-old uneducated mother of two told the evaluation team in Badin: "Now, due to voucher scheme, women have knowledge related to family planning. Now, health seeking behavior has also changed and women prefer to go to hospital for checkup of their problems and children."

Comparison with Adjacent Districts

Evaluation team visits to the comparison districts (where no Voucher Scheme was being implemented), during the FGD, it was found that understanding and importance of MNCH care in general and PNC in particular was deficient. There were also problems in seeking ANC, deliveries by skilled birth attendants and C-Sections because of distance from the facilities and costs. Moreover the services for X-ray, blood tests and emergency new born/child care were missing in public facilities. This meant that people had to visit distant facilities and incur heavy transport costs. Some women were visiting community midwives (CMWs) who charged up to Rs. 2000 per delivery. The majority of women went to health facilities only in case of serious complications as they could not afford the cost. However, according to the women the facilities were not meeting standards due to insufficient staff, hygiene and cleanliness issues, and shortage of medicines, and lack of infection prevention supplies for labor rooms.

"For normal delivery, we go to *Dai* (a traditional birth attendant) or to a private facility. A private car charges Rs. 1000 and a rickshaw takes Rs. 200 for the trip. For complicated cases, we have to travel up to the main city of Naushehro Feroze." *FGD Participant*

Implementation Challenges

The Voucher Scheme was evidently implemented with great commitment at the outset and distribution and redemption initially remained on track. However, performance began to decline during the intervention's fifth quarter. Through a careful review of various project documents and, in particular, interactions during field visits, it was evident that the scheme was halted due to its faltering performance and was unable to complete its course.[24]

It is important to understand the reasons and issues that led to slow progress and low utilization of the services of this apparently beneficial and relevant financial scheme. Keeping the performance of the voucher management agency, GSM, in view, and in fulfillment of the agreed roadmap and exit strategy for NPPI activities, the contract with the implementing partner was revised and GSM was directed to redeem only those vouchers which had already been distributed (about 40,000) for MNCH services in the two districts, instead of the originally planned 55,000.

Some implementation problems that arose included inadequate support for the implementation team and weak quality assurance mechanisms. From the perspective of GSM, the implementing partner, the main reason for this low performance was delay in payments and in the setting up of mechanisms of monitoring.

From the point of view of the service providers, the scheme was considered effective, although there were some delays in the release of funds from VMA after April 2013, following the decisions taken after the MTR. As a result of the decision to halt the scheme mid-way, health facilities included in the scheme faced delays in reimbursements from GSM. The Voucher Scheme could have performed better had these issues been addressed in a systematic way as outlined in the project proposal.

Notwithstanding these shortcomings, providers were generally positive about the scheme.

[24] Documents reviewed included monthly and quarterly reports, District Shikarpur-UNFPA_26, District Badin-UNFPA_37, Monthly reports-UNFPA_35, third party monitoring reports, Midterm Review, Exit Strategy and primary data from in-depth interviews and focus group discussions.

Furthermore, while quality assurance mechanisms were in place, they required more emphasis. There was also room for improvement in waste disposal and infection control arrangements. Some facilities lacked lifesaving equipment for newborns, such as ambu bags, suction machines and baby warmers. Blood testing and transfusion services and kits were not available at some private BEmONC units.

Nevertheless, despite all the issues and challenges, NPPI achieved several positive outcomes from the voucher scheme intervention. It is likely that the innovation could have achieved its desired outcomes if internal and external challenges had been addressed.

Behavior Change Communication and Focal Families

Focal families played an important role in registering and referring pregnant women to nearby health facilities. TRDP's final report shows that during the project period (April 2012 to March 2014) and after implementation of the intervention, 12,286 pregnant women were registered and referred to health facilities and 2,648 women delivered their babies through skilled birth attendants. Community mobilizers and focal families promoted key health messages and practices, raising awareness; changing the behavior of the community in terms of improving recognition of danger signs in newborns and children under-five, and seeking timely and appropriate care; and bringing issues related to health in the community to the VHCs. The TRDP report claimed that EPI coverage in the intervention areas also improved during this period.

Discussions with community women in Umerkot reinforced the effectiveness of the initiative. An uneducated 30 year old mother of five told the evaluation team in UmerKot: *"There is a change in the last three years. Previously women used to have their deliveries conducted by the village* Dai (Ram Payeri)*. But now women go to hospital for delivery and TT. They have their antenatal care check ups four times in a pregnancy, ultrasound, and after delivery go to facility for adopting family planning. Now women are also careful for their personal and child hygiene."*

A female FGD participant claimed: "Our knowledge has improved regarding all the MNCH issues including FP and we have started availing the services at health facilities."

The district health management, again, had positive comments about the intervention's effectiveness: *"The Focal Families intervention was beneficial in mobilization of communities to avail health services. The awareness of communities has increased and ANC and vaccination indictors have improved."*

Health facility staff observed that FF has been beneficial in mobilization of communities to avail nearby health services. Awareness of community has increased and ANC and vaccination indictors have improved. A nearby basic health unit run by People's Primary Health Initiative (PPHI) in Umerkot was visited by the evaluation team and even though there was no NPPI intervention in the facility, clients from the nearby catchment area where focal families were functioning were utilizing the facility. This BHU was functional only until 2 pm, but a male and a female doctor and a midwife and nurse were appointed and present. All the providers had received training in IMNCI and DHIS. According to the facility in-charge, the coverage of ANC, facility based deliveries and immunization had increased due to the focal family intervention.

In our evaluation we assessed that the provision of **referral fund enabled focal families to mobilize pregnant women.** Deliveries by TBAs were discouraged and immunization, hygiene and hand washing practices were improving in the intervention communities. The community led activities by focal families resulted in their greater acceptance and respect at household level and in the community.

FFs were also responsible for maintaining documentation of such cases at village level. The referral fund which was given to FFs produced positive changes in health seeking behaviors in the intervention communities. **The District Manager and the implementing partner both pointed out that the VHCs had played a vital role in reducing deliveries by TBAs and generating and maintaining the referral fund.** According to TRDP member, *"People have started seeking care in health facilities. Antenatal care registration, number of institutional deliveries, and immunization increased."*

The final narrative report on focal families concludes that due to the active role played and thorough awareness sessions delivered by focal families, newborn babies and mothers were given appropriate care and survived the postnatal period. Table 6 given below presents Pakistan Social and Living Standard Measurement Survey data for 2008 and 2012, showing an improvement in key RH seeking behaviors.

Table 6: MNCH Indicators of District Umerkot, 2008-2013

Indicators	2008-09	2012-13
Percentage of children aged 12-23 months that have been immunized	33	84
Percentage of deliveries, assisted by Skilled Birth Attendant (SBA*)	8.3	27.9
Percentage of Institutional Deliveries in NPPI Districts - Public	2.1	8.9
Percentage of Institutional Delivers in NPPI Districts - Private	4.5	18.3
Percentage of Institutional Deliveries in NPPI Districts - Public & Private	6.6	27.2
ANC from Public institutions (%)	49.0	50.7
ANC from Private health institutions (%)	45.1	44.5
ANC from Public & Private health institutions (%)	94.1	95.2
Pregnant women that have received tetanus toxoid injection (%)	20	32
Post Natal Check-up (%)	13.5	56.2

Source: *Pakistan Social and Living Standard Measurement Survey 2008-9* and *2012-13*.

Success Story

Focal Families:

About the village

Karan saran is a village 48 kilometers away from Umerkot. The road going to the village is made of bricks and it takes about one and a half hour to reach Umerkot. There are no basic amenities of life - electricity, school, health facilities etc.

Before Project –Challenge

Focal Family XX informed that in this village there are no health services for females. Women had never gone to health facility for ANC nor for delivery because it was very expensive. Moreover there is no proper transport system.

Women usually have their deliveries conducted at home by family elders or a dai and sometimes women or her baby have died. Children were also not vaccinated. There was no concept of cleanliness.

Activity conducted under the project

Thardeep introduced the concept of focal families and I was selected as a focal family with one male member and they also selected a facilitator. We are all from this village.

We were provided training on maternal and neonatal health and family planning. Thardeep also provided Rs. 5000/- as emergency fund for using it for transport or hospital expenditures. This was to be refunded by the family within two to three days till one month depending on the economic situation of the family. After training I identified women and conducted group meetings to make them aware of pregnancy related problems, danger signs, advantages of ANC, immunization, TT vaccination, and FP.

We also arrange for transport in case of emergency and I have cell numbers of two to three drivers.

Output

The community realizing the importance of emergency fund they on their own collected Rs. 5000/- more and now the fund is Rs. 10,000/-.

In my village, there is a woman Nagoo w/o Dasir Magowed, aged about 33 years. She has six children. Her last delivery had been very difficult which was conducted by her mother in law. She did not have any antenatal checkups. During delivery, the duration of her labour was prolonged, mother in law tried hard and bleeding started. At last the baby was born but it was a stillbirth and Nagoo was very sick afterwards.

After the start of this project, she was again pregnant, she had attended my group meetings and I had also tried to motivate her. During this pregnancy, she had 4 antenatal checkups and two TT vaccinations. When her labor started, it was 5 pm and her mother in law tried to examine her but the water bag ruptured.

I arranged for the transport, which took me about half an hour, I gave Rs. 2000/- to the driver and Rs. 3000/- to the family. The husband had already arranged Rs.10, 000/- as a loan against his working in the field. The facilitator accompanied them and they went to a private hospital Mehran clinic in Umerkot. Baby girl was born and both the mother and child are well. The name of the child is Shanti and now she is three months old.

If the transport had not been arranged in time and if they did not have the money for emergency, the life of mother and child both would have been in danger.

This was the first time Nagoo had her delivery conducted in a hospital and had TT vaccinations.

The family soon returned their loan to me.

Outcome

Now in this village:

- There is a trend of women going for antenatal checkups
- If there is any problem they prefer going to hospital for delivery
- I have the phone numbers of drivers so transport can be arranged.
- At the time of emergency, funds can be made available, which the families return later.

Note:

FF XX informed that being inspired by the project, women have started a committee system in their village.

Every month each family contributes money (first we started with Rs. 20/- month, then Rs. 50/- and now Rs. 100/-). This money is given to the woman whose name is randomly picked. She keeps the money and if anyone needs this money for delivery, operation, dowry or wedding it is given to them, which they return later. This money is only kept with the members of the committee.

EFFICIENCY

Overall

Evaluation Questions:

Analyzing the financial data and change in service statistics

- Was the project cost-efficient? Did the actual or expected results justify the cost incurred for the innovative approaches?
- Did the approaches that were utilized produce expected results?

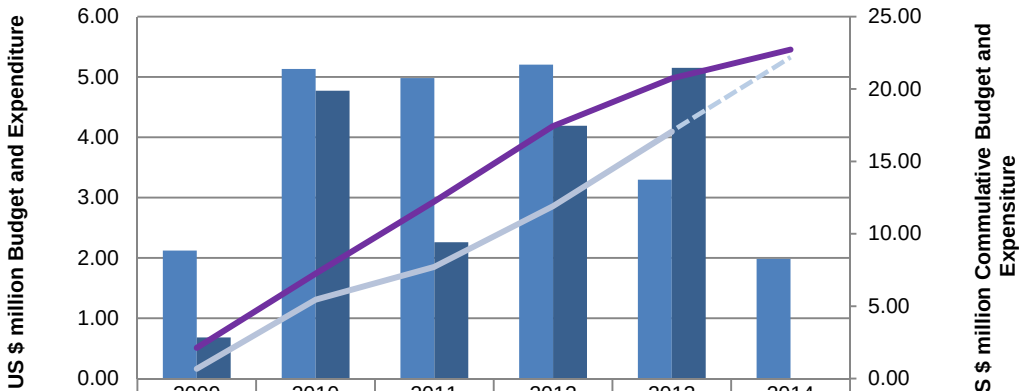
NPPI's initial funding was for 245,400,000 Norwegian kroners, of which 105,400,000 was disbursed by 2011. The 2013 Mid Term Review (MTR) highlighted issues such as lack of strategic leadership, management and quality control leading to insufficient monitoring, low efficiency and effectiveness of investment, and lack of accountable reporting which led to the phase-out of the project. One UN Pakistan and the Norwegian government reached an agreement post the MTR recommendations, that 40,000,000 kroners would be disbursed for 2013 and 2014 (20,000,000 for each year) to implement the exit strategy and activities would phase out by June 30, 2014.

According to its original plan, NPPI was gearing up to escalate efforts to utilize the remaining funding and suddenly found itself 100,000,000 kroners short of the pledged amount. As Figure 6 shows, although disbursement and utilization of funds was slow in the initial years of the project, both had taken off by 2012 and were rising sharply hence. In 2013, the gap between funding disbursed and expenditure had narrowed considerably. Since there is no data for 2014, it can only be speculated based on 2013 trends that funds will be fully utilized as budgeted.

The efficiency analysis relied mainly on secondary data from the UN agencies and their implementing partners and district Government. Data was not sufficient for the estimation of full service costs or efficiency analysis. The lack of full data also limited a detailed cost analysis (unit costs estimates or per service or per beneficiary costs, etc.). Standardized guidelines for data recording and keeping would have made the efficiency analysis much more meaningful in comparing across interventions. Each organization maintained their own system of record keeping in its own format and level of detail. In the absence of a comprehensive database base it has been a challenge to conduct cost efficiency analysis. We have tried to present an overall analysis based on the data available and made some assumptions later for the individual interventions.

NPPI fund distribution to the four major UN agencies is illustrated in Figure 7. Data on the funds utilization shows UNFPA as the highest, followed by UNICEF and then WHO until 2013, with almost complete funds utilization by December 2014, based on the trajectory of spending in Table 7.

Figure 6: NPPI Budget and Expenditure



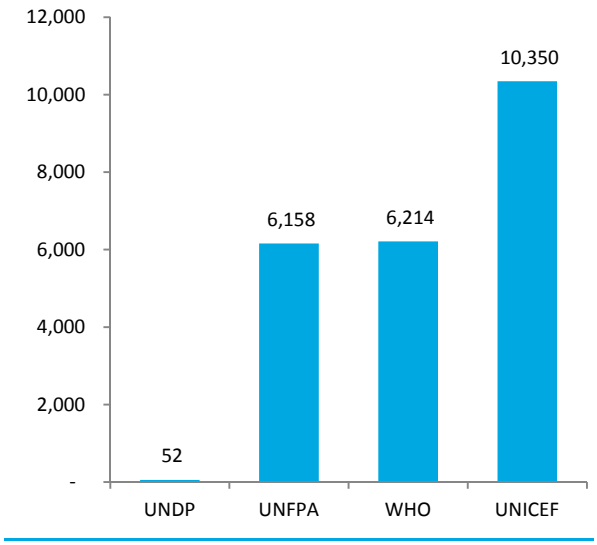
	2009	2010	2011	2012	2013	2014
Net Funded Amount	2.12	5.13	4.98	5.21	3.30	1.98
Expenditure	0.68	4.77	2.26	4.19	5.15	0.00
Cumulative Funded amount	2.12	7.25	12.24	17.44	20.74	22.72
Cumulative Expenditure	0.68	5.45	7.72	11.91	17.06	

Table 7: NPPI Funds Utilization (US$)

Agencies	UNFPA		WHO		UNICEF		Total	
Years	**Expenditure**	**% utilization**	**Expenditure**	**% utilization**	**Expenditure**	**% utilization**	**Expenditure**	**% utilization**
2009	4679.9	0.8	247273.6	32.8	430372.7	56.7	682326.2	32.1
2010	2542823.0	172.7	720718.1	39.5	1508172.4	82.2	4771713.5	93.0
2011	1371618.2	96.0	489444.0	27.6	400150.2	22.5	2261212.3	45.4
2012	2638.0	0.2	694717.5	37.3	3492733.6	186.4	4190089.1	80.5
2013	1294826.6	132.5	1799807.1		2055672.0	88.6	5150305.7	156.2
Total	5216585.7	84.7	3951960.3	63.6	7887100.9	76.2	17055646.9	75.1

Source: MPTF

Figure 7: Total Budget by Agencies (US$)



NPPI involved considerable administrative expenditures as part of the program design. UNDP, the administrative agent used to deduct a one percent administrative cost and then disburse the net funding amount to the headquarters of the implementing agencies namely UNFPA, UNICEF and WHO. These UN agency headquarters deduct an averaged seven percent administrative or management cost and then disburse remaining amount to their country offices in Pakistan. Country offices then disburse the funds to implementing partners (IHS, GSM, TRDP etc.). Management costs are incurred by implementing partners which vary from organization to organization and averaged almost 4%. The remainder amount was spent on providing MNCH services in NPPI districts through different interventions.

Table 8: Estimated Administrative Costs within UN System

Administrative Cost Unit	Amount US$ (000)	Effective Percentage
Headquarters		
UNDP (1%)	228	1.0%
UNFPA (7%)	415	1.8%
UNICEF (7%)	709	3.1%
WHO (7%)	709	3.1%
Subtotal for HQ Administrative Cost	2,061	9.1%

Figure 8 presents the relative spending on each of the major interventions. As can be seen the major portion of the NPPI funding has gone to the contracting out of services followed by the Voucher scheme. Other interventions had much smaller outlays such as the focal families and Sick new born care units at a one tenth of the voucher scheme costs. Despite these rather elaborate funding flows, the overall estimated management costs for the main agencies, including GSM, HIS and TRDP, were still at a reasonable level (Figure 9).

Figure 8: Spending on each of the major interventions

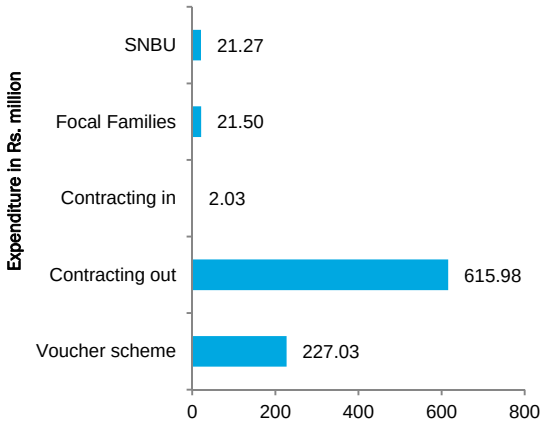
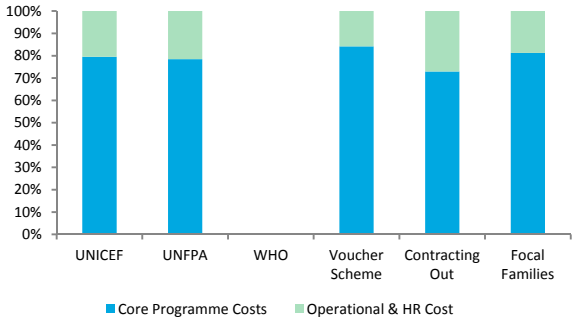


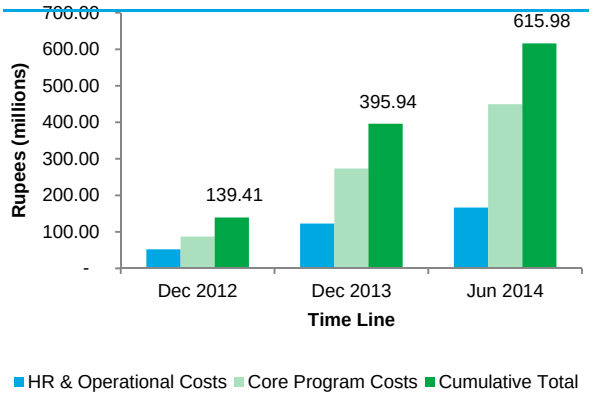
Figure 9: Operation and HR Costs Versus Core Program Costs for UNICEF, UNFPA, IHS, GSM and TRDP



Contracting Out of Health Service Delivery (HSDC)

The initial budget for the contracting out intervention, per the project contract signed in November 2011, was Rs. 769.7 million, including a four percent management cost. In June 2013, there was a reduction in the number of facilities covered, from 28 to 22, because of the PPHI takeover of BHUs in the HSDC intervention districts. The budget was accordingly revised to Rs. 618.6 million. According to IHS, due to delays in the first tranche of payment to IHS, compounded by delays and issues in TPM—there was lack of clarity on performance indicators. This may have contributed to earlier low ratings of performance, and further delays in funding. Expenditure from 2011 to December 2012 was as low as 22 percent of the total expenditure; however almost 42 percent of the budget was spent by 2013, while the remaining 36 percent was spent in 2014. This is shown in the Figure 10.

Figure 10: Cumulative Expenditure Summary – Contracting Out



The project had a one line budget giving the implementing partner flexibility to divert funds as needed, with the main aim of ensuring 24/7 availability of MNCH services that is why the expenditures cannot be compared with budgeted figures. However, we can analyze overall expenditures provided by IHS (Figure 11): 29 percent of the intervention's costs are being spent on deployment of human resources, and an additional five percent on the pay-for-performance scheme. The rest of the operational and establishment costs represent around 12.6 percent, equipment and supplies 19.8 percent.

Figure 11: Expense Distribution – Contracting Out

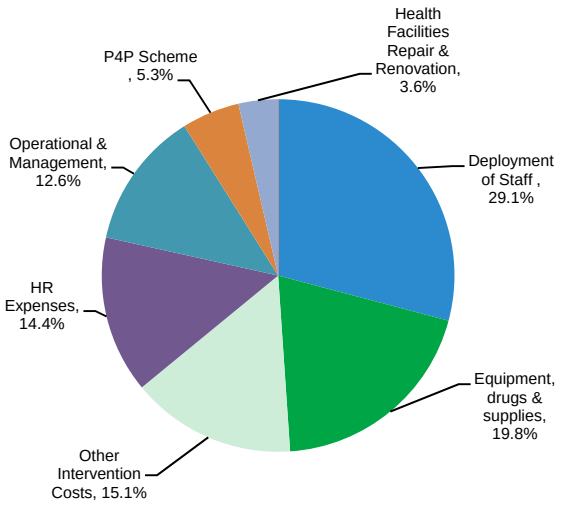
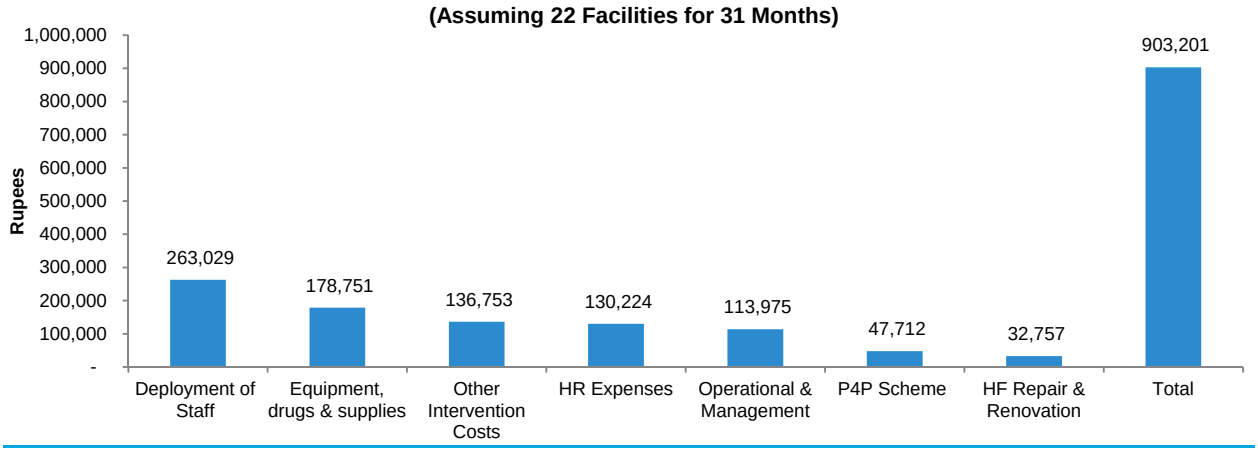


Figure 12: Monthly Average Cost of Facilities – Contracting Out



The total expenditure from 2011 to 2014 was Rs. 616 million. On the basis of 600,000 beneficiaries, (as provided by IHS) the cost per beneficiary comes to Rs. 1,027, against the proposed cost of Rs. 111. However, we think that it is more meaningful to derive the unit average cost of setting up and then running each of the 22 facilities. Analysis of IHS data shows that the initial setting up costs for 22 round the clock 24/7 facilities were 61 million (averaging 2.7 million rupees per facility). In addition, to be fully functional, facility running costs for 22 units are shown to be 554.9 million. Since these costs were for 31 months of actual implementation, we estimate the annual cost of each facility to be Rs. 9.7 million. The average monthly cost (including setting up) is presented in Figure 12.

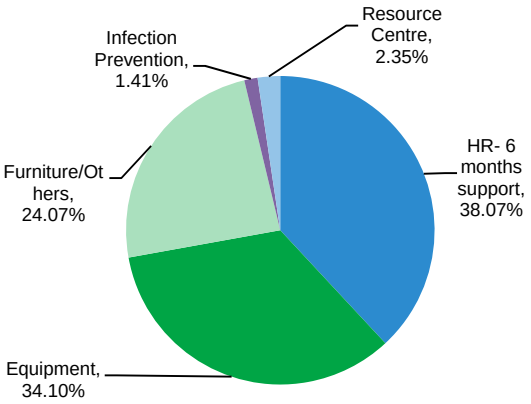
We also present the breakdown of these costs into various broad items in the figure below. This will make it easier for the upscale and continuity of the intervention from the point of view of PPHI and Government to see that the additional costs of maintaining HR for 24/7 in the payments to deploy staff and the P4P. Expenditures by facility and by service were not recorded, which makes it difficult to compare efficiency across units run by IHS.

The improvement in utilization of services was observed in Larkana and to a lesser extent in Shaheed Benazirabad according to the DHIS.

Establishing Sick Newborn Centre of Excellence

The three Sick Newborn units established are, by all accounts, being heavily utilized and likely to retain their clientele if they continue to function as effectively as they are doing so now. This intervention had a one-time cost of Rs. 13.17 million, and an additional human resource support for six months costed at Rs. 8.10 million, coming to Rs. 1.35 million per month. The contracts with the hospitals were from January through May 2014. The highest expenditures were made at the PMC hospital in Shaheed Benazirabad (36%), followed by LUMHS, Jamshoro (33%) and CMC Children's Hospital, Larkana (31%). Figure 13 shows that about 38 percent of the cost was related to human resource; 34 percent, to equipment; 24 percent, to furniture and other supplies. Their current monthly load is 272 admissions on average varying from 117 in Jamshoro to 389 in Larkana.

Figure 13: Sick Newborn Unit Expenditure Summary



The cost efficiency of these units can be measured by unit cost per admission. The highest cost per admission Rs. 9,943 was from LUMHS Jamshoro while CMC Children Hospital Larkana was most cost efficient at Rs. 2,823 per admission (Figure 14). A major reason for the lower efficiency seen in Jamshoro is the smaller number of children admitted mainly because the unit was located separately from the teaching hospital. Average cost per admission was Rs. 5,631. Applying some assumptions about future and current case loads and about recurring 10 percent inflation and other additional recurrent costs, we demonstrate the long term costs in five years will by Rs. 2,179 per admission compared to Rs. 1,785 in 2014[25] (Figure 15).

Figure 14: Sick New Born Unit – Cost per admission

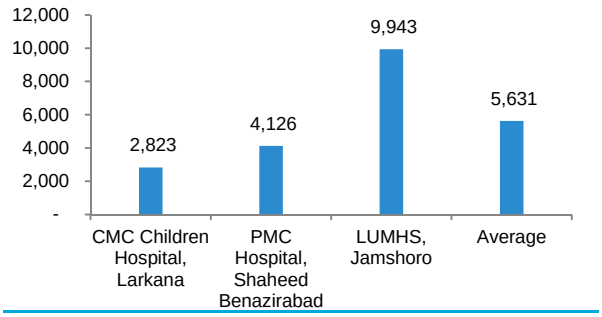
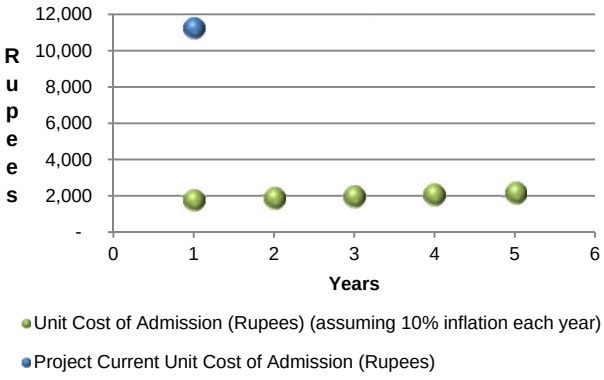


Figure 15: Sick New Born Unit – First & subsequent year admission cost



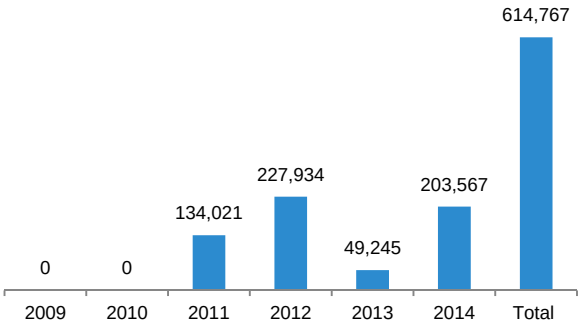
[25] Average HR Cost for 6 months is approx. Rs. 2.7m and yearly cost is twice the amount I.e. Rs.5.39 per month. Estimated maintenance cost per year is assumed to 10% of the fixed costs, therefore the total yearly cost of running the unit for base year1 is Rs.5.83 and the total cost of admission is arrived by dividing this cost with average number of admission i.e. Rs.1785 per admission. Inflation factor is 10% per year while number of admission likely to remain constant.

Strengthening Community Midwifery

Strengthening Midwifery Schools

Out of the total expenditure by UNFPA under various NPPI interventions, US$ 600,000 was utilized for strengthening MNCH Midwifery Services (Figure 16). A considerable portion was also spent of strengthening family planning services among CMWs. The midwifery schools were upgraded and a portion was set aside for their deployment in the community setting.

Figure 16: Funding utilized for MNCH Midwifery by year (in US$)



CMW Deployment

MNCH sources reported that an estimated amount of Rs. 450,000 to 500,000 is required to provide the 18 months training and deployment of each additional CMW through this intervention model. This seems very cost effective for the Government to maintain and upscale. The UNFPA spent US$ 1,200 per CMW based on their model which included deployment of CMW schools and the additional elements of strengthening CMW schools.

Voucher Scheme

Funding for the voucher scheme initially came through both UNICEF and UNFPA but after the phase-out decision in 2013, UNFPA took full management responsibility. The voucher scheme was implemented by Greenstar Social Marketing. The initial budget as per the contract signed in November 2011 was Rs. 692 million. However, 60 percent of the amount was utilized in 2013.

Human resources accounted for almost 17 percent of the project cost; administration and operational costs, for 12 percent; and vouchers, for 71 percent.

The proposed cost per voucher was Rs. 10,159; after including a management cost of Rs. 2,424, the total per voucher cost came to Rs. 12,583 based on a an expected distribution of vouchers to 55,000 pregnant women. The proposed share of management cost per voucher was 19 percent but actually came to 29 percent (including salaries, operational expenses, fee).

Project expenditures commenced slowly: In 2011, they were at 0.11 percent; in 2012 it was 36 percent, while the bulk of the expenditure, 60 percent, was incurred in 2013. According to GSM, third party monitoring started in the project's fifth quarter and, due to lack of clarity on targets achieved or to be measured, and delay in preparation of progress assessment tools, performance was rated as low. This resulted in delayed payments which adversely affected implementation. However, the scheme was in full gear by 2013.

The redemption of services and their cost give valuable information for refining the voucher scheme and its costs implications for future interventions.

The voucher scheme implemented in two districts, involved more private providers than public providers: 20 private providers and seven public providers participated in Badin, while there were 15 private providers and four government providers in Shikarpur. Payments to private sector providers accounted for 92 percent and public providers for eight percent of the payments (Figure 17). The per voucher payment to private providers was Rs. 1,020 as compared to Rs. 670 to public providers for the same set of services. Almost 89 percent of vouchers were redeemed through private facilities as compare to the 11 percent through public facilities. Although the ratio of private to public providers enlisted for the program was a 76: 24 ratio of vouchers redeemed, almost 89 percent were redeemed through private facilities and 11 percent through public facilities.

Figure 17: Voucher Payments by Type of Services

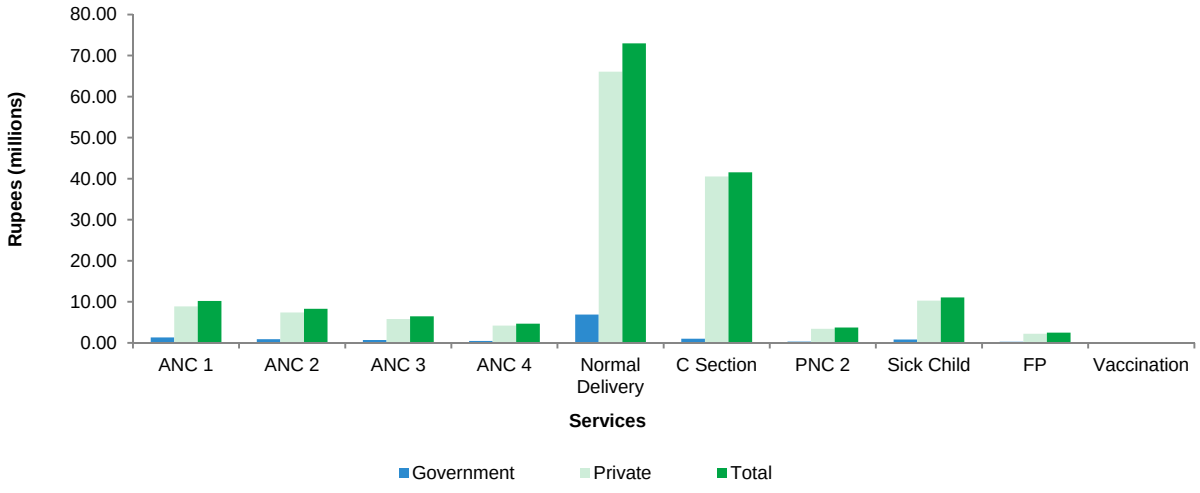
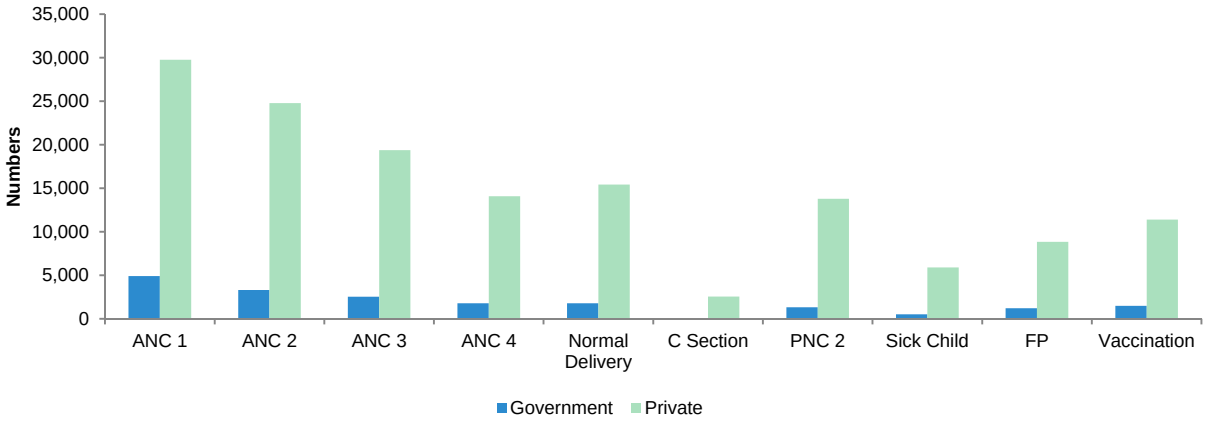


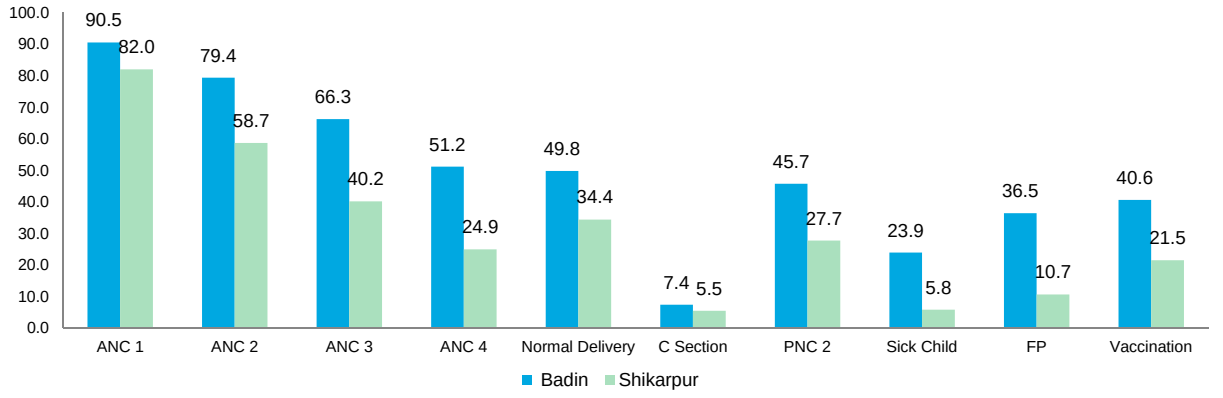
Figure 18: Voucher Redemption by Services



The total vouchers booklets distributed were 39,923 out of which 41 percent were redeemed. Based on the expected births in Badin and Shikarpur it is estimated that almost 25 percent of births (normal deliveries and caesarian sections) were facilitated through voucher scheme (Figure 19). Average cost per voucher booklet was Rs. 13,776 which is almost 9.5 percent higher than the proposed cost[26], but lower than the cost package of Rs. 14,314 (includes ANC, normal delivery, caesarian and child illness) based on the lower range of willingness to pay per feasibility study[27] for financing interventions under NPPI. In terms of cost per type of service, delivery charges (normal and caesarian) account for around 72 percent of the total payments. ANC visits (1 to 4) accounted for only 18 percent of the total payments, which is expected because NVD charges were Rs. 3,500 or less, and caesarian sections were Rs. 15,000 or less, while ANC was Rs. 250 or less.

The expenditure of Rs. 227 million led to improvement in the health utilization coverage and in the two and half year period from 2012 to 2014[28] there was increase in monthly ANC1 visits by 38.7 percent, PNC1 visits by 21.4 percent, deliveries by skilled persons by 10.7 percent, total FP visits by 194 percent, and normal deliveries by 25.6 percent and c sections by 92.6 percent. In Shikarpur the indicators improved from 2012 to 2014 as well—ANC1 visits by 97 percent, PNC1 by 23.7 percent, total FP visits by 28 percent, and normal deliveries by 26.7 percent, and c sections by 14.2 percent (DIHS).

Figure 19: Percent of Vouchers Redeemed out of total Disbursed



[26] The cost per voucher booklet as per proposal was Rs. 12,583 based on the 55,000 target population.

[27] Result Based Financial Mechanisms for Improving Maternal, Newborn and Child Health Outputs: A Feasibility Study for 10 Selected Districts of Rural Sindh, prepared by AKU, Karachi, 2009

[28] Data only available for six months for 2014

Behavior Change Communication and Focal Families

The total budget for this intervention by contract was approximately Rs. 29.89 million, with Rs. 21.57 million spent to date. About Rs. 6,923 was spent to train each focal family, comprised of a man and a woman mobilizer. The cost per woman registered and mobilized was almost Rs. 1,750 (mobilization services include pregnant women registered and referred to health facilities, pregnant women mobilized to deliver their babies by skilled birth attendants, newborn babies to be given colostrum and exclusive breast feeding, couples mobilized to adopt FP methods, women mobilized for second PNC contact within 40 days of delivery, pregnant women identified and mobilized for ANCs, etc.).

Almost 42 percent of expenditures were made by 2012; 45 percent, in 2013; and 11 percent, in 2014. As per expenditures detail almost 52 percent of expenditures were incurred on human resource whereas 13 percent were spent on trainings, 19 percent on transport, and indirect program costs constitute up to seven percent of total cost (Figure 20).

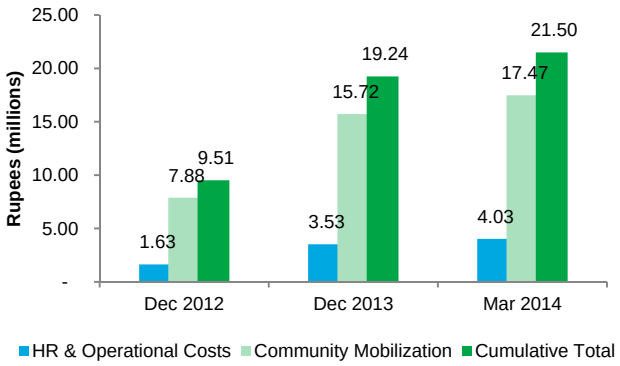
The beneficiaries are quite widely spread in terms of types of services for which they were mobilized and a particular beneficiary may have been contacted several times. The initiative was able to register and referred 12,286 pregnant women to health facilities. About 2,648 of these women delivered their babies through skilled birth attendants; 2648 new born babies were given colostrum and exclusive breast feeding. Further 5087 out of 15611 couples identified adopted family planning methods. An additional, 4500 babies were delivered at home by using clean delivery kits, pregnant ladies vaccinated through crush program were 2321 and 6871 households mobilized by focal families and constructed latrines at their homes (TRDP Report).

We propose that it may be more useful to calculate the unit cost per village in which the intervention was implemented and we arrive at an average cost of Rs. 153,570 per focal family. As can be seen in the service statistics for Umerkot where this intervention was tested, utilization rates went up substantially demonstrating that this intervention is particularly suited to mobilize communities in non-LHW covered areas (Table 9).

Table 9: Unit Cost per Village of Focal Families Component

Cost Item	Total (Rupees)	Unit Cost per village (total 140 villages)
Operational & HR	4,026,201	28,759
Community Mobilization	17,473,547	124,811
Total	**21,499,748**	**153,570**

Figure 20: Cumulative Expenditure Summary - Focal Families



Contracting In

The contracting in model has been introduced recently and expenditures are available only for June and July 2014 for the human resources component. Of the total human resource cost, 45 percent was incurred in Jamshoro, 37 percent in Ghotki, and 18 percent in the Karachi office. The average human resource cost per month was Rs. 35,000. The total expenditure on Contracting In was Rs. 2.03 million.

Operations Research

The results of the operational research are yet to be disseminated. The original estimated cost for OR was approximately US$ 300,000 (approximately Rs. 30 million) and the budget for operational research was sufficient. The intervention would be a cost efficient way to improve MNCH indicators.

SUSTAINABILITY

Overall NPPI Project

Evaluation Questions:

- To what extent are the benefits of the project likely to be sustained after project completion?
- 3.2 What has been done to ensure linkages with other relevant MNCH initiatives that may strengthen the sustainability of the program?
- What is required to ensure prospects of sustainability of project outcomes and the potential for replication or scale up of good practices and/ or innovative approaches?

The sustainability of the NPPI project is vital to properly address MDGs 4 and 5 in Sindh, positively impacting the health of women and children. The full, comprehensive sustainability of NPPI is influenced by the following challenges:

- Limited commitment by government with NPPI on sustainability (i.e. to develop a clear sustainability roadmap for the government);
- Governance, leadership, and capacity issues for effective and sustained initiatives;
- Potential for insufficient financing or government investment to financially support and prioritize key initiatives to reach the most vulnerable;
- Limited efforts by NPPI ONE UN agencies to ensure the interventions were owned by the government and continued after the end of the project.

Several NPPI project initiatives have a real potential for continuity through existing government programs, for example, the achievements of pre-service, contracting out of MNCH and FP services, establishment of units for sick newborn care, strengthening of focal families for BCC and community outreach, capacity building, and strengthening skills of CMWs and the District Health Information System can be sustained with available r provincial and district Health department resources. The provincial MNCH office has ensured the sustainability of distinct interventions, for example, integrated management of neonatal and childhood illness (IMNCI) strategy are now part of undergraduate curriculum and in-service trainings; trained CMWs will continue providing services to their communities; teaching and midwifery schools are likely to continue to promote MNCH and FP long after the NPPI project ends.

While overall coordination with various tiers of the government may have been patchy, there was close coordination with the MNCH program and, to some degree, with the PPHI throughout the life of the project, both whom have similar objectives to NPPI. NPPI could have worked more closely with the LHW program to capitalize on their potential in tackling maternal and child health and family planning; however, NPPI collaborated and utilized LHW Program in contracting out districts for social mobilization.

The two programs (PPHI and MNCH) that are most closely engaged however can really benefit directly from the contracting out experience (PPHI) and MNCH from the CMW training and deployment experience and of course the 24/7 CEmONC facilities. It is the Department of Health that is more directly involved in the Sick Newborn Units, an excellent intervention for reducing the unusually high NMR in rural Sindh and the Pre service training. The DHIS system is critical for all partners in terms of having the routine monitoring and accountability systems in place which ensure that mandated services are actually assessed and accounted.

Contracting Out Health Service Delivery (HSDC)

Project documents reflect that 22 facilities were upgraded to provide BEmONC and CEmONC with all the qualified human resources, equipment and adequate supplies, 24/7 services, institutional deliveries and caesarian sections, refresher trainings, provision of free services, ensuring quality assurance mechanisms for infection prevention and hospital waste management. According to district health office, most of the service providers hired under NPPI in Larkana district, stopped working after June 30, 2014. However, nine LHVs have been retained by the MNCH Program in Shaheed Benazirabad district to provide MNCH services. District Health offices reported that interventions were efficient but unfortunately, due to staff shortage after NPPI ceased funding, the contracted out facilities no longer provided the services to earlier standards. This created a negative impact on the community's earlier gains in health seeking behavior.

"To make the MNCH services available 24/7 at THQ/RHC level, it is required that not only the providers and support staff be appointed but arrangements for their security be made and also pick and drop services be provided to the staff." **District Manager, Benazirabad**

IHS made efforts to advocate for stronger government ownership and buy in of the intervention towards the end of the project to ensure sustainability. For example, the training strategy was revised in 2013 and only government employees were trained thereafter. **To ensure continuity of service delivery after NPPI support, the Department of Health has advertised posts for healthcare providers.** "Interviews have been conducted and appointments will be made soon," and efforts will be made to hire staff already trained under NPPI.

A more cost efficient approach for 24/7 facilities is outlined in the efficiency section.[29]

Establishing Centre of Excellence for Sick Newborns

This institution-based intervention is most likely to produce future graduates with improved skills in managing newborns, which would help them provide better quality services. It is also a part of the overall WHO agenda of capacity building and institutionalization of interventions. While supplies were provided on a one time basis, there will be some maintenance and running costs in the future. **However, teaching universities can bear these recurrent costs from their own resources to sustain this activity in the future after the end of the project.** As reported by the Registrar of SMBBMU, Larkana:

> **"The department of pediatrics is developing a PC-1 to sustain this intervention after the end of the project." Likewise, the head of the pediatrics department at LUMHS informed the evaluation team that "The department has retained some of the essential staff through the trust funds of the university."**

The pediatric department heads at all three teaching hospitals were of the view that the sick newborn units are highly relevant and effective and should be sustained and replicated at other public and private teaching institutions.

Pre-Service Trainings Will Continue

In the opinion of the Head of the Department of LUMHS and Pre-service Secretary, the Pre-Service Training intervention is a self-sustaining activity as no major cost will be involved in future. Manuals and log books will be purchased by students just as they purchase their other books and reference materials. Sustainability can be further ensured by setting up government monitoring and on-job training systems.

According to the Pre-service Secretary, the cost of in-service training for 24 participants for 11 days is approximately Rs. 2 to 3 million. The inclusion of IMNCI guidelines in pre-service training at the undergraduate level will therefore prove highly cost-effective.

During discussions and review of records, we found that the pediatric department staff from colleges and universities in Punjab, Khyber Pakhtunkhwa and Afghanistan had visited LUMHS to observe the teaching/trainings, manuals, reference materials, and log books developed with the aim of replicating this component.

In-Service Training

The training provided to the healthcare providers will continue to benefit the women and children utilizing the health facilities for MNCH related health issues. However, even though it is essential to address inadequate capacities among healthcare providers, this training may not be sustained as it is costly. In the words of a District Manager, "*This is a very important component but it cannot be sustained without allocating special funds to conduct trainings and is quite expensive.*"

The availability of training manuals, teaching aides is an asset that will be used in future.

Encouragingly, the Provincial Manager MNCH has pledged that the MNCH Program will continue this activity from the regular budget of MNCH until 2015.

The Head of PUMHSFW's Pediatrics department recommended that the Centers of Excellence be established at all institutions for training undergraduate, postgraduate, and in-service providers, as it is very useful for improving their skills.

Strengthening District Health Information System (DHIS)

The Provincial DHIS Coordinator, during his interview, stated that NPPI successfully trained district staff (including PPHI) in both software and hardware. He emphasized the online dashboard system is also underway in collaboration with JSI supports MNCH

[29] Introduction of a set of critical interventions

data management. The Exit strategy conferred that Government of Sindh has approved PC-1 of DHIS as part of budget 2013-14 and will take over responsibilities of human resource development, supply of DHIS tools and district MIS cells as part of the regular public sector activities.

The provincial managers suggested, "In order to ensure sustainability and accuracy of data, regular monitoring and accountability mechanism should be formulated and executed in letter and spirit so that accurate and timely reporting is materialized. Moreover, feedback structure should be set up and executed from provincial level. Data should physically be validated to make it useful in decision making."

Strengthening Community Midwifery

Strengthening Midwifery Schools

The provision of equipment and development of skills labs in intervention area was a onetime investment that can be sustained beyond the project period, at least for five years duration. Moreover the capacity building of the teaching faculty on new and advanced teaching methodologies will benefit the target population in future.

The principal of CMW schools and district managers of MNCH said that the provision of equipment to strengthen the teaching institutes and training of trainers are both sustainable.

Most importantly, the Provincial MNCH manager has committed that the training of CMWs will be continued after the phase out of the project under regular budget of MNCH program.

Furthermore based on the success of the intervention, UNFPA has continued its support in two non-intervention districts (Naushehro Feroze and Tando Mohd. Khan) through its core funding which includes Technical Assistance, training, equipment and clinical attachment.

CMW Deployment to be Expanded

CMW training and deployment is part of the MNCH strategy and they are committed to invest in strengthening this component of the MNCH program.

According to the CMWs, there has been a positive change in health seeking behaviors of the women in their respective communities. Women are now visiting CMW work stations for ANC and deliveries. Presently there is a system of refresher trainings and continued technical support and supportive supervision, the impact would therefore continue beyond the life of NPPI project.

The principal of CMW schools and district managers of MNCH said that the provision of equipment to strengthen the teaching institutes and training of trainers are both sustainable.

Voucher Scheme

The NPPI Project has built the case for Voucher Schemes as a lifesaving intervention and also a health financing model to be promoted in Sindh and across Pakistan poorest areas. The positive outcomes of the intervention should not be overlooked on account of implementation problems faced by the NPPI team.

The provincial MNCH office has stated emphatically that the initiative helped in empowering marginalized population to seek facility-based services for MNCH. The Chief Secretary Sindh conveyed his intentions and assurances to continue some aspects of the voucher scheme after the phase out of NPPI. It is important that planners realize the potential of the voucher scheme model to address the MNCH problems of the poorest communities, and the Sindh government will attempt to find the best methods to incorporate this approach in its MNCH program. However, at present, there is no mechanism or strategy to sustain the voucher scheme launched by NPPI. Since the Sindh government lacks adequate funds and the initiative is expensive, it may be hard to sustain the voucher scheme despite its recognized benefits.

Behavior Change Communication and Focal Families

The implementing agency, TRDP, was of the view that FFs were not self-sustainable; this initiative will need continued follow-up for sustainability. TRDP is pursuing other donors to continue this initiative.

The In-charge of a BHU in the project area was of the opinion that *"The change in the behavior would continue even after the closure of the project. This is a good intervention and should not be stopped."*

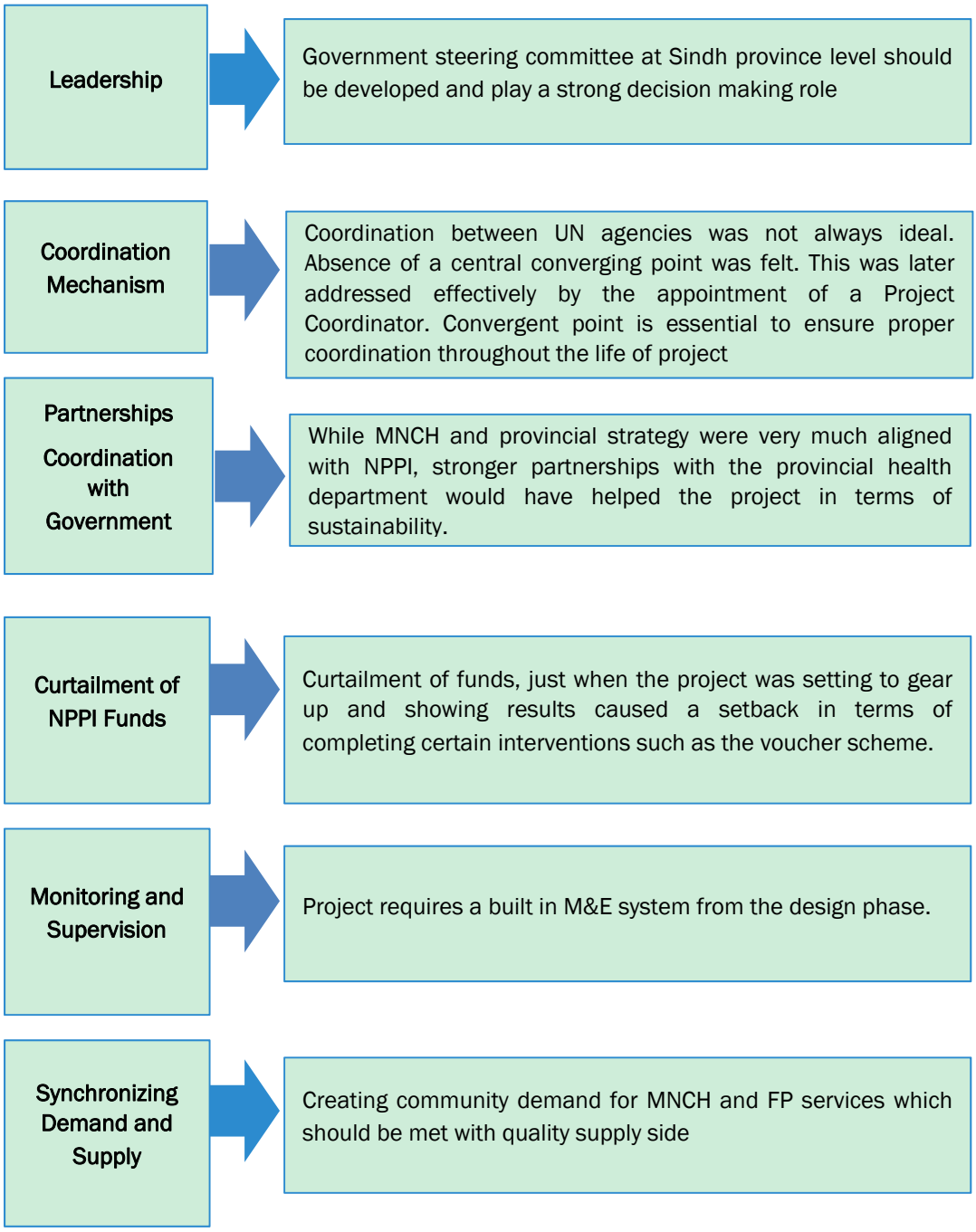
The evaluation team conducted FGDs with community beneficiaries three months after the closure of the project. It was observed that women were still seeking care at the health facilities, which did not exist before the intervention began. Focal Families presently continue to conduct advocacy activities with motivation and interest. When asked during the focus group with Focal Families why they were functioning after the closure of project, one of the participants of a FGD with FFs in UmerKot said: *"Good deeds are always rewarded in the Hereafter. Moreover we were doing nothing at home previously, but now we have something to do."*

CHALLENGES AND LESSONS

This section outlines the main lessons learned that should be considered for forthcoming relevant projects with the same scope and objectives:

- Expected outcomes can only be seen if the project completes its life. The project activities were curtailed after the MTR and could not be completed within the original stipulated time.
- Special mechanisms are required to enable a consortium of partners to vision and plan a project as challenging as the NPPI.
- Foreign development assistance has a significant role for the implementation on high risk initiatives such as the ones taken up by NPPI but the involvement of Government at all levels ensures effective implementation and sustainability.
- One UN is a good initiative because one organization does not have full technical capacity to perform all tasks. However, there were issues and challenges in management and coordination. A strong central leadership and neutral point person or unit was missing initially. All the three UN agencies involved in the project had their own methods of functioning, protocols and procurement procedures which caused delays.
- Shortage of skilled human resource in primary and secondary health facilities is a perennial problem all across Pakistan, but the project interventions show that with the right incentives and conditions this can be tackled.
- Frequent changes and high turnover in the Sindh government has been a challenge in decision making.
- Creating demand and changing behaviors in the community are critical for bringing women and children to facilities but this has to be matched with health facility up gradation and 24/7 functionality.
- Once communities learn about fully functional CEMOC and Newborn services they do come to these facilities, but if this is not well known then utilization would be lower, furthermore vouchers can play a positive role in overcoming out of pocket and transport costs for the poorest families
- Monitoring and supervision is the integral part of the information system. To ensure the reporting and feedback mechanism for DHIS, direct data validation at district level has to be provisioned.
- Public private partnership is feasible to implement in rural Sindh context for the improvement of MNCH service delivery.
- The innovative community mobilization interventions, such as creation of focal families, can help support demand creation in non-LHW areas
- Lower cadre health care workers can be trained to perform multiple tasks, through task sharing and task shifting, to fill the gaps in human resource for specialized staff.
- Local unified branding would have enhanced identification and ownership of the project

Figure 21: Challenges and lessons



Chapter 5
Conclusions and Recommendations

There are a host of factors that have challenged the NPPI project, both internally and externally. At the same time the project has shown that due to its intrinsically strong relevance to addressing the maternal and child health outcomes needed in Sindh, it made a strong contribution in the latter years especially. Effectiveness and efficiency has really picked up after 2012 and remarkable progress was made in the short period after the MTR on developing the exit strategy. In order to redeem the potential of opportunities lost earlier, the project should focus on pointing out the importance of the individual interventions and work hard with Government and partners to ensure its upscale and sustainability.

We can say that the main legacy of the NPPI project has been to demonstrate the functionality of different (already tried and tested) models within the context of Sindh province. These interventions are relevant not only for Sindh but for the other provinces as well. If these could be scaled up they could result in dramatically improving the health indicators of the province and the country as a whole.

CONCLUSIONS

The NPPI Project as designed was highly relevant to the needs of marginalized communities as it was envisioned. It supported the Provincial MNCH program through the ONE UN system to address the major determinants of maternal and child health, including poverty, gender discrimination, socioeconomic inequalities, and care seeking behavior, maternal under nutrition, high fertility, lack of adequate basic health services, trained staff, adequate medical supplies and incomplete reporting systems. The project was closely aligned to the Sindh Provincial MNCH program and aims, and more broadly to the National Health Policy 2009. Though initially well-funded, the project was compromised by a sluggish start, ambitious targets, and a lack of attention to a unified strong leadership structure and effective coordination of an extensive set of interventions. Furthermore, the interventions were assigned to three different agencies of the ONE UN program with their diverse financial and management structures.

The evaluation has endeavored to highlight all the major factors that influenced the project directly or indirectly, the challenges and some of the major achievements and shortfalls of the project. The floods in 2010-11 were a major external challenge resulting in internal displacement of facilities and staff. The interventions under the NPPI started late in the first two years, partly due to delays in the release of funds. There were breaches in implementation and provision of effective services through certain interventions. Activities and expenditures accelerated in 2012 as demonstrated in the rise in expenditures against releases of budget going up from 62 percent in 2011, 68 percent in 2012, and 82 percent in 2013.

The 2013 midterm review, which pointed out the weaknesses of the slow progress both on the part of the UN agencies and their implementing partners, had both positive and negative effects. The negative effect was the drastic cut in the overall funding of the project and a decision to restrict all activities after June 2014, which did decelerate the pace of progress that started in 2012. The positive effect was that the project went through a major corrective restructuring coming back with very clear objectives for the exit strategy for 2013-2014 and a much stronger management structure through the appointment of a national coordination unit for the NPPI.

This evaluation shows substantial progress in a one year period and improvements in both health seeking behavior and service utilization in the NPPI districts. In particular, interventions like BCC and Focal families, pre-service and in-service trainings, strengthening CMW training and deployment, sick units for newborns, have shown real progress in this period. Some activities may have suffered the most as they were making significant progress by the time of the MTR in achieving planned output. Progress against outcome indicators of the project is shown in Table 10.

Even in these circumstances, the overall effectiveness of the project is visible especially in the post 2012 period. Some interventions tackled sensitive gender issues which plague most of our health outcomes, by providing special attention to issues of mobility and purdah in the environment at health facilities and also transport and security to female health providers. A few interventions will continue to have long term sustainability and benefits for Sindh such as the Sick Newborn units, capacity building of healthcare providers, building up of the DHIS system, the pre-service training and the specialized training.

Table 10: Outcome Indicators for NPPI

Outcome Indicators	Baseline Indicators 2009	Target to be achieved by 2012**	Achieved 2012-13***
Proportion of 12-23 month old children immunized against six immunizable childhood diseases	37	90	70
Proportion of births attended by a skilled health personnel (SBA)	29	60	37.4
Proportion of pregnant women receiving at least 1 ANC by a skilled birth attendant	53	95	87.6
Proportion of new mothers receiving postpartum care (included mothers with institutional deliveries)	15	60	48.2

Sources:

**Base line is taken from MICS 2004 data*

** *Project Document- NPPI, Reducing Maternal, Neonatal & Child Mortality in Sindh- Government of Pakistan, Ministry of Health*

*** *Pakistan Social and Living Standards Measurement (PSLM) 2012-13*

Undoubtedly much more could have been accomplished if the initial impetus had been similar to the remediation efforts after 2012. While time consuming, the project should have devoted much more time and efforts to engage Government in all its initiatives which would have ensured a smoother transfer of some key interventions to the Government and would have led to a higher degree of ownership.

The NPPI has demonstrated that private and public partnerships can work. The MTR recommended building partnerships with PPHI, which ought to be fully addressed by the project. For the overall design, it is concluded that the interventions would have been more effective and easier to implement if they had been all implemented together in the districts. The current design may have seen a diluted impact due to the geographical spread of the interventions.

Above all, strong determination is required from all stakeholders including government, donors, implementing partners, health care providers (public or private), and communities to make a project as complex and challenging as NPPI a success. This evaluation concludes that the performance of the NPPI project was held back by a multitude of factors. Despite all the setbacks NPPI has gained some profound lessons to share with the Government and its major partners. These are worth showcasing in greater detail and to a wider audience of stakeholders to ensure sustainability and expansion.

RECOMMENDATIONS

One of the most important recommendation is that Sindh province must increase funding and improve the efficiency of current spending on the public health system to effectively improve services for maternal and child health for its poorest populations.

Within NPPI's selected districts, the most important recommendation is that health outcomes for women, neonates and children can improve through clearly designed and focused interventions which address and respond to the root causes of poor health in rural Sindh. Poverty and lack of knowledge prevent millions of families from utilizing health services. There are also crippling effects of ineffectual health facilities that do not operate round the clock, are understaffed or have under qualified staff, and under equipped to deal with maternal and neonatal emergencies.

Several NPPI interventions have proven effective to addressing these challenges and would require further funding or a shift in the focus regarding how existing funds are spent, or perhaps most importantly shifts in the way services are delivered, with additional financial mechanisms in place. NPPI has also demonstrated that Public Private Partnership is a realistic and required approach for Health System strengthening in Pakistan, and is already a part of the Sindh health sector strategy[30]. Here we put forward some key recommendations for future consideration by the government, UN agencies, other development partners, potential implementers and supporters of programs such as NPPI.

Institutional Recommendations

- **A provincial coordination cell should be set up** by the Sindh Government that works towards increasing coordination and develop synergy among all donor funded and private sector programs working with the government. The coordination cell can also provide periodic monitoring of interventions and assist in ensuring the sustainability of the project activities. It will help to prevent duplication of efforts thereby enhancing efficiency and effectiveness.
- **Public-private partnerships and contracting out mechanisms should be scaled up at the provincial level.** However, concurrently a Health Commission on the pattern of Punjab could be created that would regulate the private sector and ensure that minimum quality standards are being met by private providers. The Sindh government has already passed a "Healthcare Bill"[31] that should be enforced.
- **The Human Resource Development Cell (HRDC) established at the provincial level should be empowered** so it works toward improving and strengthening the health service delivery system by ensuring human resource availability, capacity development, efficient placement of staff and enhancing staff motivation. The cell should also examine the possibility of entrusting the roles and responsibilities of post-graduate trainees (PGs) and lower cadre staff LHVs, LHSs, etc. to perform functions traditionally reserved for mid- or high-level cadres of health workers as a means of optimizing the number and capacity of available providers. Through this process of "task-sharing" or "task-shifting," lower level cadre staff and PGs can be trained on specific areas to increase health care access.
- **A Performance Based Accountability Mechanism (PBAM) should be introduced,** with strong commitment and political will, within each district for identifying specific key performance indicators (KPIs) and linking it to a functional DHIS. The KPIs must derive information that can measure changes in the MNCH and FP situation at the district and provincial level and making decisions accordingly. This will ensure DHIS data are used for district planning, implementation, and monitoring on major indicators of disease pattern, preventive services and physical resources.

Programmatic Recommendations

Based on the lessons of the NPPI project, we are recommending the following interventions which should continue as an essential component for improving MNCH service provision in rural Sindh:

[30] Health Sector Strategy Sindh, 2012-20

[31] The Sindh Healthcare Commission Ordinance, 2013

- **Pre- and in-service training components** have had a meaningful impact on enhancing medical students' understanding and management of MNCH issues. The pre-service component needs to be expanded to include all medical and para-medical schools and institutions in the province. Existing programs may continue to operate without major inputs from the Government.
- The Government must **build upon Sick Newborn Care Units established** by the NPPI at pediatric Departments of the teaching institutions and upscale this innovative intervention. This need is substantiated by the evidence of the high utilization and case load of these units. The units are having an immediate and visible impact in saving lives of neonates that would otherwise suffer ill health or perish. The cost of setting up a unit in an existing hospital is only 9.8 Million Pakistan rupees ($98,000) in the first year and a lower 5.7 Million (57,000$) in the next year (Details are provided in Annex 12)
- The **CMW program should be regularized**. There are about 1,500 CMWs in Sindh and there is a need to induct more CMWs to ensure the presence of skilled birth attendance at all deliveries. But at the same time there has to be greater emphasis on providing them with competency based skill development trainings and proper supervision. Deployment requirements must also be adhered to properly. The work stations of these workers also need to be established and more equipment and supplies provided to them. Community integration through effective referral mechanisms and supervision of CMWs are necessary for better uptake. The NPPI model shows that with an additional $1,200 per CMW there can be better training and deployment of the CMWs.
- **Pro-poor financing mechanisms that favor the vulnerable and poor, such as the voucher scheme, that have shown some real potential and success in terms of empowering poor communities to seek maternal and child healthcare facilities, must be scaled up.** These interventions can serve as model for the provincial government to increase equitable coverage of MNCH services. With a full voucher cost of Rs. 13,647 ($136), the poorest pregnant women did redeem vouchers for ANC, delivery (both normal and caesarean), PNC, and FP. Utilization rates of facilities for deliveries, especially private sector, went up substantially.
- **The WHO prescribed number of CEmOC and BEmOC facilities must be made available at quality standards and operational 24/7 to deal with maternal obstetric emergencies and deliveries.** NPPPI, through its contracting out mechanisms, did show that barriers can be broken to provide round the clock services in public facilities through appropriate incentives of security and monetary advantages. The first year cost of setting up and running a facility is Rs. 12.5 million, falling to less than Rs. 10 million in subsequent years.
- **Community mobilization interventions such as focal families are ideal for Non-LHW rural areas**, as they represent a sustainable model of communication, information sharing and organizing maternal and child health seeking strategies for poor families that otherwise have no link to the formal health care system. The cost of a focal family which can cater to about 200 to 300 households is only Rs. 93,000 ($930 per year).
- **Projects must have a built in M&E Plan.** Similar projects in the future must be designed purposively with strong management structures and with improved monitoring and evaluation systems built in. Management and M&E structures should focus on the following elements:

  For project initiatives comprised of multiple partners, such as NPPI, central leadership is essential. This central leadership role will support the enhancement of coordination among stakeholders, improve accountability and synchronize implementation of initiatives.

  A strong M&E plan and a uniform reporting mechanism (quarterly and annually) should be part of the strategic project plan from the onset.

  Long term projects, such as NPPI, should have clearly defined realistic project targets both for the individual interventions and geographic areas such as districts. NPPI project targets were overly ambitious and were not measured periodically. Ideally, progress ought to be measured in regular periodic assessments or process evaluations, as well as midterm and final evaluations.

Strategic Recommendations for Scaling Up

Focus on the Poorest of the Poor

The final recommendation is for the Sindh Government to focus on its poorest ten districts, and within them on the poorest population which will benefit most from MNCH interventions. Provincial budgets will have to increase their outlay for districts, allocating more funds to the most vulnerable districts. Poverty score cards can be used to target the poorest for financial support schemes like vouchers. Improvement of 24/7 services in remote areas by focusing on RHCs and BHUs, and on providing services through alternate models in areas (with no LHWs) will improve the health outcomes of the poorest populations. Some of this has to been done through public private partnerships which place the stewardship with the Government and implementation with the private partners and can work to strengthen and optimize health systems.

The Government of Sindh spent Rs. 53,210 million in 2013-2014 on health as compares to Rs. 42,805 million in 2012-2013, showing an increase of 24.3 percent over a year. The budget allocated for 2014-2015 is Rs. 56,807 million (current budget Rs. 43,583 million and development budget Rs. 13,224 million)[32] which is almost 8.7 percent of the total Sindh Government budget. Most of the NPPI expenditure incurred in 2012 and 2013 which averaged US$ 4.67 million almost Rs. 467 million (1$=Rs.100) per year. Putting it into perspective, the NPPI expenditure in ten districts was a mere 1.09 percent of the government expenditures on health. Focusing on targeted communities and innovative interventions, this led to the notable improvement in utilization of health services in those 10 districts according to the combined DHIS data for those districts.

An analysis of out of pocket (OOP) expenditures in Sindh according to the NHA report 2011[33]-12, is 61.3 percent compared to the expenditures by provincial and district governments at 22 percent and NGOs are contributing about 12 percent of the total health outlay. It is widely argued that OOP are disproportionately high for the poor. To reduce the burden of the OOP expenditures for the poorest of the poor, it is critical to provide quality services at affordable prices and to protect the poor through some additional financial mechanisms. On the basis of the NPPI experience in Sindh, we propose that the tested innovations which have been addressed by the project are up scaled.

Applying some assumptions, we have costed what it would take to provide the financial mechanisms for a typical district in Sindh. We have selected the combination of interventions which would provide financial cover to the targeted poor population of the poorest ten districts of Sindh.

The two options suggested differ mainly with regard to the Voucher Scheme. The first option recommends a VS that offers a full package of 10 services and the second option includes a reduced package of services, covering ANC, PNC and deliveries, which will reduce costs. The costs computed for these two options are:

Table 11: Cost assumptions to test a package of pro-poor interventions

Option 1	Cost (Rs.)
Cost of 24/7 health facility (including BCC and FF component)	62,350,000
Cost of providing vouchers to poor women (full package)	316,371,936
Cost of CMWs (57)	25,564,500
Cost of focal families to register and mobilize women in non LHW area (based on per woman cost)	20,041,176
Total Cost	**424,327,612**
Rs. Million	**424.33**
Option 2	**Cost (Rs.)**
Cost of 24/7 health facility (excluding BCC and FF component)	60,950,000
Cost of providing vouchers to poor women (reduced package)	206,766,146
Cost of CMW s(57)	25,564,500
Cost of 200 focal families to register and mobilize women (based on per FF cost)	18658280
Total in Rs.	**311,938,926**
Rs. Million	**311.94**

[32] Source: Budget analysis 2014-15, Department of Finance, Government of Sindh, http://fdsindh.gov.pk/site/userfiles/BUDGET%20ANALYSIS%202014-15.pdf

[33] Pakistan National Health Accounts 2011-12, Pakistan Bureau of Statistics, Statistics Division, Government of Pakistan, 2014

The two alternative options cost Rs. 424 million and Rs. 311 million, respectively, per district to introduce a set of critical interventions in Sindh's poorest districts. We are proposing that 10 of the poorest districts be selected for these interventions. These interventions can significantly increase the utilization rates and improve the health status in these selected districts. Information on district health expenditures was not available. One assumption was that 20 percent of the health budget is being spent in the districts which come to Rs. 473 million. The second assumption is that based on NHA 2007-08 data district expenditure in Sindh was Rs. 255 million. Looking at the increase in health budget over the years we can assume that the district expenditure will be in the range of Rs. 350 to 400 million.

The first option will cost 0.74 percent of the existing health budget to implement in one district and implementation of Option 2 will cost 0.54 percent of the health budget. Doubling the district budget would improve utilization of health facilities for MNCH care and improve reproductive health outcomes among women and children in the poorest districts in Sindh.

Furthermore, these costs refer to the first year, during which many of the systems will have to be set up. Therefore annual costs will go down in subsequent years as the capital establishment costs will be incurred in the first year and only running and maintenance costs will be required thereafter. Many schemes may change behaviors that would make them more cost effective. For example, the GSM vouchers have mainly been redeemed through the private sector and costs in the private sector are higher as compared to the public sector.

Annexes

Annex 1: Terms of Reference of the Evaluation

Annex 2: List of Stakeholders

Annex 3: List of Facilities upgraded Under Contracting Out

Annex 4: Poverty Assessment Scorecard

Annex 5: Tools for Data Collection

Annex 6: Evaluation Methodology

Annex 7: Informed Consent Form

Annex 8: Reference Group Composition and Responsibilities

Annex 9: Breakup of Deployed CMWs in NPPI Districts

Annex 10: Activities Implemented Versus Activities Proposed in Exit Strategy

Annex 11: Details of Voucher Redemption

Annex 12: Scaling Up Key NPPI Interventions

ANNEX 1: TERMS OF REFERENCE OF THE EVALUATION

United Nation Children's Fund

Terms of Reference for Institutional Consultancy

Norway-Pakistan Partnership Initiative (NPPI) End of Project Evaluation

1. Programme Information:

Norway Pakistan Partnership Initiative, Sindh Province, Pakistan

2. Purpose of Assignment/Objective:

The NPPI project has been implemented for six years (2009-2014). The overall objective of the end of project evaluation is to document and disseminate results and achievements, as well as to generate knowledge on evidence-based best practices related to approaches, cost effectiveness and sustainability. The independent, end of project evaluation will be undertaken during the months of May, June and July 2014, and the publication and dissemination of the evaluation findings are scheduled for the third quarter of 2014.

3. Background

Pakistan lags behind most developing nations in its MNCH indicators. According to the Lancet's 'Reproductive, maternal, newborn, and child health in Pakistan: challenges and opportunities' published May 17, 2013, globally Pakistan has the third highest burden of maternal, fetal and child mortality. The province of Sindh in particular faces enormous health sector challenges, with the most vulnerable 10 districts of Sindh highlighted here: Kashmore, Badin, Tharparkar, Ghotki, Jamshoro, Umerkot, Qambar/ Shahdadkot, Shaheed Benazirabad, Larkana and Shikarpur. Service coverage for ante-natal care, skilled birth attendants, post-natal care and contraceptive prevalence rate (CPR) is very low; BEmONC and CEmONC access is limited, and social and economic barriers make it difficult for poor women to make healthy choices in these districts. The health system remains weak and in some areas non-functional at district level.

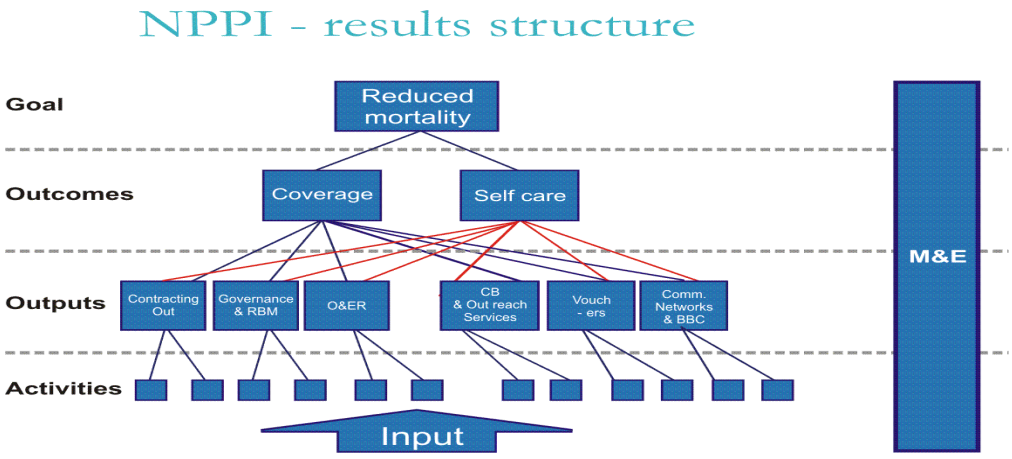
The goal of the Norway-Pakistan Partnership Initiative (NPPI) is to reduce maternal, newborn and under-five mortality in 10 selected districts in Sindh province in Pakistan. The NPPI project was intended to support maternal, neonatal and child health (MNCH) interventions and to empower women to take care of themselves by seeking healthcare in 10 under-served rural districts of Sindh. The districts selected were those that had the highest maternal mortality, newborn mortality, and under-five child mortality rates, and poorly functioning health systems.

NPPI demonstrates the commitment of the governments of Norway and Pakistan to contribute to the global effort to achieve the targets of the Millennium Development Goals 4 (child health) and 5 (maternal health). The NPPI grant is in line with the Global Campaign for Health MDGs that aim to provide political impetus at the highest level to facilitate country-led action directed toward attaining MDGs 4 and 5; in accordance with the principles of the Performance-Based Catalytic Initiative to Save a Million Lives. The 5 year initiative focuses on improving access to quality maternal, neonatal, and child health services while generating demand for services, increasing their utilization and developing sustainable health sector policies.

The underlying principles of NPPI are:

a) Provide catalytic and strategic support to strengthening health system efforts (aimed at accelerating activities under national MNCH policies, plans and strategies);

b) The logical model used in the project to achieve its intended results is the theory of change. The theory of change promotes social change, defining long-term goals and mapping backward to outline outcomes.



The expected outcomes of NPPI, designed to reduce maternal, neo-natal and child mortality, are:

- Increased coverage of quality MNCH/FP service
- Improved MNCH/FP self-care and care-seeking behavior among families and communities.

The related outputs are as follows:

Outcome 1: MNCH and Family Planning (FP) care coverage	Outcome 2: MNCH and Family Planning (FP) self-care and care seeking behavior
Output 1.1 Integrated MNCH and FP care made available through contracting (incl. public private partnerships).	Output 2.1 Strengthened community-based and Outreach MNCH and FP Care services.
Output 1.2 Improved governance and results-based management.	Output 2.2 Voucher/incentive schemes implemented to increase demand and service utilization.
Output 1.3 Operational research conducted to produce knowledge and improve future decision making related to increasing MNCH and FP coverage and self-care.	Output 2.3 Community networks for MNCH and FP advocacy and mobilization established and Behaviour Change Communication (BCC) and awareness raising program implemented.

Based on the progress made and lessons learned during project implementation, and the 2013 Mid-Term Review, an exit strategy for NPPI was developed to identify priority activities to be carried forward during the phase-out of the project, ending June 2014. The activities identified for continuation during phase out were based on sustainability criteria which include both financial sustainability through Sindh Government's commitment to further continue activities with their respective resources, and the demonstration of "best practice models" for further replication in Sindh and across Pakistan.

All activities will end by June 2014, with the exception of the operational research and the end of project evaluation to be finalized during the third quarter of 2014. Payments, accounting, and submission of final report will be completed before 31 December 2014, on which date the grant will expire.

4. Scope of Work:

Purpose: The NPPI project has been implemented for six years (2009-2014). The overall objective of the end of project evaluation is to document and disseminate results and achievements, as well as to generate knowledge on evidence-based best practices related to approaches, cost effectiveness and sustainability. The independent, end of project evaluation will be undertaken during the months of May, June and July 2014, and the publication and dissemination of the evaluation findings are scheduled for the third quarter of 2014.

Target Audience/Recipients of the end of Project Evaluation: This end of project evaluation primary reader group will be the Department of Health Government of Sindh, the District Health Authorities, the One UN, the Royal Norwegian Embassy, the Royal Ministry of Foreign Affairs, NORAD, implementing partners, service providers, beneficiaries, and the global health community.

UNICEF intends to hire an institution to conduct an end of project evaluation for the Norwegian Pakistan Partnership Initiative (NPPI). The institution conducting the end of project evaluation will look at the following areas: project approach, planning, design, implementation, management, cost effectiveness, sustainability, and impact. It will address, document & disseminate results and achievements, as well as to generate knowledge on evidence-based best practices related to approaches for replication and scale up. The evaluation will reflect upon risks and what role they played in achieving results, and with the benefit of hindsight, what mitigating actions (including monitoring and follow-up) could have been taken by whom at what point in time.

Evaluation Questions:

1. RELEVANCE: To take stock of what has been achieved by the project from the baseline, in select project areas. Particular emphasis will be placed on coverage of maternal, newborn and child health services in intervention districts compared to non-intervention districts to assess the contribution of NPPI specific interventions and the feasibility to maintain these.

1.1. To what extent did the project achieve its overall objectives?

1.2. What are the key project achievements?

1.3. Were the strategies or approaches realistic, appropriate, and adequate to achieve results?

2. SUSTAINABILITY: The evaluation will address sustainability factors including an analysis of commitment and capacity of management structures of government, implementing institutions, and target communities to continue implementing project activities, including the monitoring and evaluation capacity in the system. The analysis will also conclude whether a conducive program environment was created in relation to NPPI project implementation, with supporting policies, strategies, resource allocations, coordination and partnerships to ensure access to quality MNCH services with improved outcomes for children and women.

2.1. To what extent are the benefits of the project likely to be sustained after project completion?

2.2. What has been done to ensure linkages with other relevant MNCH initiatives that may strengthen the sustainability of the program?

2.3. Is it likely there will be a continuation of sustainability of project benefits after completion of project?

2.4. What is required to ensure prospects of sustainability of project outcomes and the potential for replication or scale up of good practices and/or innovative approaches?

2.5. What main lessons have emerged?

2.6. To what extent has NPPI contributed to broader health sector reform in Sindh?

2.7. What are the good practices and shortfalls of UN agencies towards 'delivering as one'?

3. EFFECTIVENESS: The evaluation will review management processes, appropriateness and effectiveness.

3.1. Were the UN agencies effective in 'delivering as one'?

3.2. How effective where the 'innovative approaches', what results were achieved, are they replicable within the Sindh context?

4. EFFICIENCY: The evaluation team will review the efficiency of project implementation.

4.1. Was the project cost-efficient? Did the actual or expected results justify the cost incurred?

4.2. Did the approaches utilized produce expected results?

4.3. Was the project implemented in the most efficient way?

Geographic Area of Evaluation: 10 Districts (Qambar/Shahdadkot, Larkana, Shikarpur, Kashmore, Ghotki, Shaheed Benazirabad, Jamshoro, Badin, Umerkot, Tharparkar) in Sindh Province where NPPI is implemented.

5. Duty Station:

UNICEF Karachi, Pakistan with travel throughout Sindh Province as required to complete duties of TOR. Cost for travel, transport, lodging, food will be paid directly to the institution by UNICEF.

6. Supervisor:

NPPI Project Manager, Michele Roessler

7. Major tasks to be accomplished (after selection of the firm):

Desk review; qualitative and quantitative evaluation activities including, but not limited to, consultation with stakeholders in the form of key information interviews & focus group discussions; assessment; survey; draft and final inception reports, including table of contents; draft comprehensive report; final end of project evaluation report; presentation.

Suggested Methodology:

Desk review of project related documents and secondary data:

The evaluation team is expected to do a comprehensive desk review of external and internal documents that are relevant to meet the objectives of the evaluation. Some of the documents recommended are listed below:

1. NPPI Project Document
2. NPPI annual plans
3. NPPI Exit Strategy/ Phase out June 2013-June 2014
4. Roadmap and milestones for implementation during the phase out
5. NPPI baseline studies reports
6. NPPI end line study
7. Reports/data generated from the government and NPPI partners monitoring system including DHIS reports
8. Reports or draft reports of any recent assessments, NPPI funded or others carried out in Sindh such as Human resources needs assessment (WHO);
9. NPPI case studies, operational research, and other publications describing and/ or documenting NPPI approaches, experiences, and lessons learned prepared by One UN or under the auspices of NPPI implementers.
10. Norwegian Partnership Assessment Report and Royal Norwegian Embassy Gender Review Report;
11. Midterm review report

12. Partnership agreements and contract/ procurement process related documents
13. Performance reports of implementing partners
14. Reports and relevant records of major initiatives conducted through the government, such as training of health care providers, mother and child week
15. Reports of district MNCH officers, field trip reports of NPPI staff and Norwegian missions
16. Communications related to and minutes/action points of NPPI Steering Committee Meetings, NPPI provincial Coordination Committee meetings, planning meetings, inter-agency meetings, quarterly reviews, and annual reviews and activity/initiative specific meetings
17. Policy, strategy and programme document of Federal MNCH programme and Provincial MNCH programme and provincial health sector reform and health system improvement initiative documents of DoH Sindh
18. Reports of flood impact assessment and interventions in Sindh from NDMA, PDMA, UN and other partners
19. Periodic reports sent by UN to Royal Norwegian Embassy
20. Monthly progress reports of roadmap and milestones implementation during the phase out
21. Concept notes, terms of reference, implementation plans, operational plans/guidelines of key initiatives, and any One UN final assessments of contractors relating to how well contractors have performed and delivered in relation to expectations.
22. Any survey reports, administrative report, or other document that the evaluation team considers necessary to meet the objective of the evaluation
23. RAF and TRF reports for MNCH Sindh during NPPI

Consultation with Stakeholders:

An initial briefing meeting will take place with RNE, Department of Health and UN agencies, to highlight aspects of the project they would like the final evaluation process to capture. Using the inputs provided in the initial briefing the evaluation team will prepare a work-plan to achieve the objectives of the final evaluation.

Based on the desk review, the team will prepare an inception report.

The team is expected to conduct an extensive round of key informant interviews and focus group discussions with key stakeholders. The key stakeholders include the following:

1. Relevant representatives of Provincial Department of Health, specifically, the Provincial Maternal New-born and Child Health Programme team, Provincial and District Program for Family Planning and Primary Health Care (Lady Health Worker) Programme Team, District Health Officers, District MNCH teams of the NPPI districts (District Focal Points MNCH and District MNCH Officers NPPI/ WHO), relevant representatives of the Population Welfare Department Sindh, the Provincial and district DHIS teams, Provincial Manager Child Health/ Secretary Pre-Service Sindh, Focal Person Pre-Service Singh, DG Health, and the DoH staff working on Health Sector Reform Process
2. Relevant representatives in the UNFPA, UNICEF, WHO, UNDP and RC offices (National, Provincial and District Levels)
3. Representatives of partner NGOs, academia, others institutions/civil society organizations working in this area such as Sindh Rural Support Organization, HANDS, TRDP, BDN, PPHI, Agha Khan University Karachi, Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro Shaheed Mohtarma Benazir Bhutto Medical University (SMBBMU), Peoples University of Medical and Health Sciences for Women (PUMHSFW), etc.
4. Representatives of private sector organizations working in health sector
5. Representatives of the beneficiaries of the project

Field Visits and Interviews of Executing Agency Staff, MNCH Programme Managers, Local Stakeholders, Services Providers and Beneficiaries:

The review team is expected to visit the offices of the UN agencies and provincial MNCH Cell Sindh to carry out in depth interviews, inspection, and analysis of the project activities and:

a. Conduct interviews with Department of Health MNCH staff and UN agency who participated in the program design and execution.

b. Conduct interview with local stakeholders (DHO, DHMTs, private sector representatives, and beneficiaries);

c. Conduct interviews with focal persons at LUMHS, SMBBMU, PUMHSFW;

d. Conduct interviews with a sample of technical assistance providers of the project;

e. Conduct interviews with Principals of CMW schools in NPPI districts;

f. Conduct field visit to see universities, midwifery schools, district, Union Council, health facility and community level services facilities and interact with health care providers, medical students and beneficiaries to get first- hand information and to assess the progress of MNCH activities carried out under this project (including service provision, trainings, service access, pre-service intervention). During these visits the team is expected to speak to health providers as well as with women who use the services about the specific NPPI interventions in the geographic areas. The selection of sites for field visits are expected to be inspired by one or more of the following criteria:

   i. Maturity of the activity;

   ii. Wealth of experiences and the chances of their generating interesting lessons;

   iii. Strategic interest of the project or activity;

   iv. Interest of the experiences in the context of the inter-agency collaboration

Note: For each of these interviews, the review team is expected to design tools for capturing information, administering interview and documenting results.

Other methods as deemed appropriate:

The team may carry out any other feasible and relevant activities, including assessments and surveys, utilizing these methods to generate insights into end of project evaluation process and outputs. The evaluation will specifically address gender and equality concerns related to the project.

End Products/Deliverable/Work plan

1. **Draft inception report**: A draft inception report will be produced and submitted within 10 days of commencing the consultancy. The draft inception report will be presented to the implementing partners of NPPI and the Norwegian Embassy, for feedback and finalization within 5 working days from draft submission. The draft inception will contain the following elements:

a. A scope of work which will include a work-plan listing activities, deliverables, and who is accountable for each task or product;;

b. A clear description of the proposed approach, methodology, sources of data, data collection procedures, and tools that will be employed to conduct the evaluation;

c. An outline of the end of project evaluation report, including table of contents;

d. Analysis based on desk review, demonstrating an understanding of end evaluation objectives, processes and outputs

2. **Inception report**: Evaluation team will produce a final inception report, integrating feedback and suggestions from draft review, within 5 days from submission of draft, and present to the implementing partners of NPPI and the Norwegian Embassy as final

3. **Draft comprehensive report**: The evaluation team will produce a draft comprehensive report in English, including an appendix identifying and explaining any deviations in method/approach from the inception, and present to implementing partners of NPPI and the Norwegian Embassy for input and comments, by 15th July 2014.

4. **Final evaluation report**: The team will produce a final end of project evaluation report outlining processes, findings, lessons learned including examples of best practice models demonstrated through NPPI project implementation, conclusions and recommendations. The findings should clearly describe expectations outlined in the scope of the evaluation. The main text of the report should not exceed 30 pages, plus an executive summary of no more than 5 pages, with fully cross-referenced findings and recommendations. It should include at least one case study or success story. The report shall essentially follow the structure e of the table of contents outlined in the inception report, and detailed materials shall be attached as appendix.

   The report will have one appendix elaborating on any differences or disagreements between the findings of the evaluation team and opinions/inputs of any stakeholders involved, and an appendix that explains how comments received from stakeholders on draft comprehensive report have been incorporated.

5. **Presentation**: The team will produce a power point brief, summarizing findings, and present to key stakeholders upon submission of final end of project evaluation report.

Reports/documents noted above will be submitted in bound hard copy as well as soft copy, and fully compatible with MS Office application.

9. Responsibilities

Responsibilities of the institution: desk review; qualitative and quantitative evaluation activities including, but not limited to, consultation with stakeholders in the form of key information interviews & focus group discussions; assessment; end-line survey; draft and final inception reports, including table of contents; draft comprehensive report; final end of project evaluation report; presentation

Responsibilities of UNICEF: committee support in selection of institution, induction of institution, participation in interviews if required, and all other obligations as noted in the final contract.

10. Reporting Requirement

Please refer to deliverables in section 8.

11. Duration:

The end of project evaluation process is expected to take 48 working days (eight weeks including Saturdays, which are government working days, but excluding Sundays) and two calendar months in total. The consultants will be hired for the duration. Please see the below table for deliverable details:

Deliverable/Responsible	Number of Days
D1: Draft inception report/Institution	**10 days**
Review of draft inception report/UNICEF	3 days
D2: Inception report/Institution	**3 days**
D3: Draft comprehensive report/Institution	**28 days**
Review of draft comprehensive report/UNICEF	7 days
D4: Final end of project evaluation report/Institution	**7 days**

ANNEX 2: LIST OF STAKEHOLDERS

Provincial Level

- Secretary Health
- Former Secretary Health (Capt. Majid)
- Secretary Pre-service
- Provincial MNCH Manager
- Director General Health and other relevant staff
- Provincial Incharge DHIS
- Provincial Coordinator for the LHW program
- Feasibility Study Team (Aga Khan University)
- Representatives of OPM
- UN Agency staff (UNICEF, UNFPA, WHO)
- Representatives of implementing NGOs

District Level

- District Health officers
- MNCH Focal Person
- LHW Coordinator
- District Coordinator DHIS
- DHIS Incharge in health facility
- District Focal person NPPI (If Any)
- Representatives of implementing NGOs
- Health Care Providers
- Targeted Communities/ beneficiaries

Teaching/Training Institutions:

- Vice Chancellor of People's University of Medical & Health Science
- Pre-service Administrators
- Principals of midwifery and LHV schools
- Faculty members and students of medical, LHV and midwifery schools

ANNEX 3: LIST OF INTERVENTION HEALTH FACILITIES IN SHAHEED BENAZIRABAD AND LARKANA

Shaheed Benazirabad

1. THQ Sakrand CEmONC
2. BHU Gupchani FCLF
3. RHC Mehrabpur BEmONC
4. BHU Punhal Khan Chandio FCLF
5. RHC Mehar ali jamali BEmONC
6. RHC Qazi Ahmed CEmONC
7. BHU Badho Mehr FCLF
8. RHC Dolat Pur BEmONC
9. RHC Shah pur jahania BEmONC
10. RHC Bandhi CEmONC
11. BHU 60 Mile FCLF
12. BHU Jam Sahib FCLF
13. RHC Chak 3 BEmONC
14. BHU GM Jamali FCLF

Larkana

1. THQ Dhokri CEmONC
2. RHC Badeh BEmONC
3. THQ Areeja/Bakrani CEmONC
4. RHC Garello BEmONC
5. THQ Rato Dero BEmONC
6. RHC Naudero CEmONC
7. RHC Bangal dero BEmONC
8. RHC Garhi Khuda Bux BEmONC

ANNEX 4: POVERTY ASSESSMENT SCORE CARD

	غربت کی علامات	
۱	گھرانے کے کتنے افراد عموماً کھٹے رہتے ہیں اور کھانا کھاتے ہیں (مہمانوں اور ملاقاتیوں کو شامل نہ کریں)	
۲	گھرانے کے کتنے افراد کی عمر 18 سال سے کم اور 65 سال سے زیادہ ہے	☐ 0-2 15 ☐ 3-4 10 ☐ 5-6 5 ☐ 7 سے زیادہ 0
۳	گھرانے کے سربراہ کی تعلیمی قابلیت کیا ہے	☐ کبھی سکول نہیں گیا 0 ☐ پرائمری پاس یا اس سے کم 1 ☐ کلاس 6 سے میٹرک تک 3 ☐ کلاس 11 / کالج یا اس سے زیادہ 10
۴	گھرانے کے 5 سے 16 سال کی عمر کے کتنے بچے سکول جاتے ہیں	☐ گھرانے میں 5-16 سال کا کوئی بچہ نہیں 4 ☐ 5-16 سال کی عمر کے تمام بچے سکول جاتے ہیں 4 ☐ 5-16 سال کی عمر کے کچھ بچے سکول جاتے ہیں 3 ☐ 5-16 سال کی عمر کا کوئی بچہ سکول نہیں جاتا 0
۵	گھرانہ کتنے کمروں میں رہائش پزیر ہے (ہر فرد کے لیے کمروں کا تناسب معلوم کریں، کمروں کی کل تعداد کو گھرانے کے کل افراد سے تقسیم کر کے)	☐ >=0- <=0.2 0 ☐ >0.2-<=0.3 2 ☐ >0.3-<=0.4 4 ☐ >0.4 12
۶	گھرانہ کس قسم کا لیٹرین استعمال کرتا ہے	☐ لیٹرین کی نکاسی آب پکا، سیوریج، گڑھے/گٹر یا کھلی نالیوں سے منسلک ہے 3 ☐ شنک، اونچی زمین یا زمین گڑھا 2 ☐ گھرانے میں لیٹرین نہیں ہے 0
۷	کیا گھرانے کی ملکیت میں کم از کم ایک ریفریجریٹر، فریزر یا واشنگ مشین ہے	☐ ہاں 3 ☐ نہیں 0
۸	کیا گھرانے کی ملکیت میں کم از کم ایک ائیر کنڈیشنر، ائیر کولر، یا ہیٹر ہے	☐ ہاں 9 ☐ نہیں 0
۹	کیا گھرانے کی ملکیت میں کم از کم ایک چولہا، کوکنگ رینج یا مائیکرو ویو اوون ہے	☐ ہاں 5 ☐ نہیں 0
۱۰	کیا گھرانہ انجن سے چلنے والی درج ذیل سواریوں کی ملکیت رکھتا ہے	☐ کم از کم ایک کار/ٹریکٹر اور ایک سکوٹر یا موٹر سائیکل ہے 24 ☐ کم از کم ایک کار/ٹریکٹر ہے مگر سکوٹر یا موٹر سائیکل نہیں ہے 24 ☐ کار/ٹریکٹر نہیں مگر کم از کم ایک موٹر سائیکل یا سکوٹر ہے 7 ☐ نہ کار/ٹریکٹر ہے نہ موٹر سائیکل یا سکوٹر ہے 0
۱۱	کیا گھرانے کی ملکیت میں کم از کم ایک ٹی وی ہے	☐ ہاں 2 ☐ نہیں 0
۱۲	کیا گھرانے کی زیر ملکیت میں درج ذیل مال مویشی ہیں	☐ کم از کم ایک بھینس/بھینسا ہے اور کم از کم ایک گائے/اکری/بھیڑ 6 ☐ کم از کم ایک بھینس/بھینسا ہے اور کم از کم ایک گائے/اکری/بھیڑ نہیں ہے 6 ☐ بھینس/بھینسا نہیں ہے لیکن کم از کم ایک گائے/اکری/بھیڑ موجود ہے 2 ☐ نہ بھینس/بھینسا ہے نہ گائے/اکری/بھیڑ ہے 0
۱۳	گھرانے کی زیر ملکیت زرعی زمین کا رقبہ درج کریں (ایکڑ میں تبدیل کر کے لکھیں)	☐ 0 رقبہ 0 ☐ >0-<12.5 4 ☐ >12.5 7

ANNEX 5: TOOLS FOR DATA COLLECTION

Guidelines for Provincial Managers/ Focal Persons

1. Have you been involved in the NPPI project and in as was what capacity?
2. What do you know about the NPPI project being implemented in the province of Sindh?

First provide an opportunity to the policy makers to narrate unprompted his/her response. Once the response has been completed and if some interventions have not been described, please specifically ask about these by naming them

Description	When was it started and ended	Was it a relevant required at that time(Responsive to the needs/ priorities and circumstances of the health department and the people in general (Relevance)	Did it serve the intended purpose (Effectiveness)	Was the amount spent on it appropriate (Efficiency) -Less -More	Will the activities be continued in future (Sustainability)
Voucher Scheme					
Contracting out					
Community Mobilization through Focal Families					
Pre-service intervention					
In-service Training					
Establishment of Center of Excellence					
Contracting In					
Support for monitoring and supervision to MNCH program Sindh					
Strengthening district health information system (DHIS)					
Sick New Born Care Units					
Support to MNCH in Strengthening the Midwifery Education					

3. Don't you think that the NPPI project was implemented effectively? If yes, how?
4. Do you think the project has been able to achieve any success? Narrate an example to what extent?
5. If not, what could have been done in a better way or what are the reasons for under achievement?
6. Can you narrate a few major achievements of the project?
7. Do you think any of the interventions (best practices) could be scaled up and is there any plan to do so? i.e. allocation of funds inclusion in PC-1.
8. In different districts, NPPI implemented different activities; do you think the scale, design and implementation approach was relevant to the situation obtaining in the districts?
9. How could have the NPPI project implementation been improved?
10. What is your opinion regarding the way the project was implemented by the UN agencies?
11. How did you experience the coordination among the UN agencies?
12. To what extent do you think the managerial capacity of the NPPI staff was effective in implementation of the project?
13. How would you describe the NPPI leadership within One UN?
14. In your opinion, were there any gaps/deficiencies in implementation and how these could have been improved?
15. The project was reviewed in 2013, it highlighted some deficiencies and as a result a corrective strategy was developed. Do you think that some improvements were made in the implementation of project since then? If yes, could you please describe them?

Guidelines for District Managers

Basic Information

- How long have you been involved in the NPPI project and in what capacity?
- What types of interventions have been implemented within your district to improve the MNCH services under NPPI project and by whom:
  - UNICEF
  - UNFPA
  - WHO
  - Local NGO partners
  - Health department/PWD
- Do you think the activities/interventions which were implemented in your district were relevant for improving MNCH situation by the NPPI project
- How far do you think that these interventions have been successful? And why do you think so?
- What were the key highlights of the successful interventions?
- In your opinion, what do you think are the major achievements/success stories of the project?
- What were the major challenges/barriers faced by the implementing agencies in carrying out the interventions in your district
- How are the NPPI interventions different from the existing interventions being implemented by the government for improving the MNCH situation?
- Do you think that if the NPPI interventions had not been implemented, the situation would not have improved? And why?
- With regards to the interventions of NPPI project implemented in your district, were there any indicators that were established to monitor the progress? What were those performance indicators?
- What was the mechanism of following/monitoring those indicators?
- How often were the indicators followed up?
  - Is there any change (improvement) in the service statistics related to MNCH care and to what extent (could we get a copy of the yearly DHIS for the past 3 years)?
- Do you think NPPI interventions in your district are sustainable
  - Which of the interventions are sustainable and how?
  - Which of the interventions are not sustainable and why not?
- Have any special actions been taken to make the interventions sustainable?
- Do you think any of the interventions (best practices) in terms of the government continuing with its own funds could be scaled up and is there any plan to do them?
- In your opinion, what were the major gaps or deficiencies of the project and what could have been done differently to avoid them?
- Will you face any problems after the end of the project and what?
- What is the cost of the intervention (depending what intervention was implemented in the district) and how you see the progress in health outcomes in relation to cost?
- In case of contracting in or contracting out what is the difference of cost which government was bearing before these interventions or whether the amount was same as before contracting?
- Assume there is no donor funding then how much money would be required to provide the same level of services with the same level of quality in your district?
- Any lessons learnt and suggestions for future directions?

- **If relevant ask the following questions:**
- Can you please provide the detailed cost over the year against the different interventions tested in your district?
- Can you please provide the details of costs government is bearing other than the donor funding, to provide the MNCH services? (facility wise cost/ budget)

Guidelines for Health Facility In-charge

Basic Information

- How long have you been working in this facility?
- Do you know about the NPPI project?
- How many of your staff (providers) have received training in (list of trainings) in MNCH through NPPI?
- What interventions have been implemented in your facility?

Voucher Scheme

- What is this Voucher scheme and what is your opinion regarding it (advantages, limitations, issues)?
- What is your role?
- Do you think this is a good method of improving MNCH indicators?
- How many vouchers have been distributed from your facility and by type?
- About what percentage has been redeemed?
- Do you keep record of the vouchers? (See the records)
- What is the procedure of payment and keeping of financial records?
- Do you have any problems or issues regarding the financial disbursements? If yes, please specify.t
- In your opinion what is reaction of the communities (women and men) regarding the voucher scheme?
- Do you think this is a sustainable activity? How and if no why not?
- Has the attendance for MNCH services increased because of this intervention? See records.
- What are the main achievements of this intervention?
- Do you think there is any long term advantage of this activity?
- What is your opinion about the value of continuing this activity?
- In your opinion how could we improve the implementation of this scheme in future?

Contracting Out/In Facilities

- What is the Contract Out/In Facility?
- What is the difference in the services under this activity as compared to a normal government model?
- Do you /staff get any allowance for working in this facility and what are key highlights of this intervention?
- Do you think this has improved the provision of the care and how with regard to quality of services, gender perspective and to the poorest of the poor?
- Do you think this model is sustainable and how what issues do you envisage after the close of NPPI Project?
- Has the attendance increased because of this? See records
- In your opinion what were the gaps and how it could have been improved?
- Do you think this intervention should be continued?
- What actions will be needed by the government to continue this?
- What would you suggest to improve the implementation of the intervention?

Note:

This questionnaire will be filled with the Ms/In charge of the health facilities. She/he can provide information herself/himself or can refer to a relevant person for specific details

Now I would like to ask about the Infrastructure of this facility.		
B1	Was this facility renovated or constructed by NPPI?	Yes .....1 No.....2
B2	If yes When?	Year: __|__|__|__
B3	What type of services does your facility provide? [Multiple responses allowed; Prompt if needed]	<u>Basic EmONC</u>.....01 1. Parenteral antibiotics 2. Parenteral oxytocic 3. Parenteral anti-convulsants and anti-hypertensive 4. Manual removal of placenta 5. Removal of retained products (MVA) 6. Assisted vaginal delivery (forceps, vacuum extraction) <u>Comprehensive EmONC</u>.....02 1. All 6 basic functions plus: 2. Blood transfusion 3. Cesarean section Surgery .....03 FP services(either temporary or permanent).....04 Radiology/ U- Sound .....05 Anesthesia.....06 Pediatrics 07
B4	Is there a proper seating arrangement for patients? **(observation of interviewer)**	Yes .....1 No.....2
B5	Are there separate space/ room to examine/consultation of patients? **(observation of interviewer)**	Yes .....1 No.....2
B6	Was health reproductive/ maternal health material was displayed? **(observation of interviewer)**	Yes .....1 No.....2
B8	Are their separate M/F toilets for staff and patients?	Yes .....1 No.....2
B9	Are there proper arrangements for safe disposal of syringes/ sharps?	Yes .....1 No.....2
B10	What are the opening and closing timings of this facility?	a. Opening timings: ___ ___ ___ ___ b. Closing timings: ___ ___ ___ ___ C: 24 hours..... 1

I would like to ask some questions about the facilities available at your facility

C1	Essential medicines for MNCH	Yes .....1 No.....2	
C2	Blood bank	Yes .....1 No.....2	Yes .....1 No.....2
C3	Laboratory	Yes 1	Yes 1

		No.....2	No.....2
C4	Hep-B, C Screening	Yes .....1 No.....2	
C5	HIV Screening	Yes .....1 No.....2	
C6	CBC	Yes .....1 No.....2	
C7	Urine R/E	Yes .....1 No.....2	
C8	Blood transfusion facility	Yes .....1 No.....2	Yes .....1 No.....2
C9	Operation theatre	Yes .....1 No.....2	Yes .....1 No.....2
C10	Chlorine solution	Yes .....1 No.....2	Yes .....1 No.....2
C11	Sterilizer	Yes .....1 No.....2	Yes .....1 No.....2
C12	Autoclave	Yes .....1 No.....2	Yes .....1 No.....2
C13	Ambulance	Yes .....1 No.....2	Yes .....1 No.....2
	D1 **Staff**	**D2** **Availability**	
S. No	**Post**	**Sanctioned posts**	**Currently appointed**
01	Gynaecologist		
02	Doctor (MBBS)		
03	Anesthetist		
04	Lab Technician		
05	X-Ray Technician		
06	OT Technician		
07	Nurse		

Note: Please verify the entry of following equipment in the inventory list/ stock register and spot check essential equipment for MNCH care.

Guidelines for Interview with the Health Care Providers

Basic Information

Do you know about the NPPI project?

What are its objectives?

- How long have you been working in this facility?
- Were you recruited through NPPI or you were already an employee of Sindh Health Department?
- What is the status of your job (if recruited through NPPI)?

Training and Capacity Building:

What type of trainings have you received in MNCH through NPPI and

- When
- For how long
- Where

How has this training helped you in providing MNCH services? Do you think you would like to have more training to further improve your skills? If so, please specify.

Voucher Scheme provider

- What is this Voucher scheme?
- What is your opinion regarding it (advantages, limitations, issues, other)?
- What was your role?
- Do you think this is a good method of improving MNCH indicators?
- How many vouchers have been distributed from your facility and by type?
- What percentage has been redeemed?
- Do you keep record of the vouchers? (See the records)
- What is the procedure of payment and keeping of financial records?
- What problems or issues do you have regarding the financial disbursements? Were you paid for the services redeemed through vouchers? Any delays in payments? What was the mechanism of payment-through DHOs? Were there any irregularities?
- In your opinion what is perception of the communities (women and men) regarding the voucher scheme?
- Do you think this is a sustainable activity, How and if no why not?
- Has attendance for MNCH services increased because of this intervention (See records)?
- After the end of the project, do think the community women will continue to use these services?

Contract Out/In Facilities

- What is the Contract Out Facility?
- What is the difference in the services under this model as compared to a normal government services?
- What interventions were made to upgrade your facility to CEmOc or BEmOC?
- Do you think this has improved the provision of the care and how with regards to quality of services, gender and to the poorest of the poor?
- Do you think this model is sustainable and how?
- What issues do you envisage after the close of NPPI Project?
- Has the attendance increased because of this?
    - **P4P:**
- What was the procedure of pay for performance (P4P) under NPPI?
- Did you/your facility was awarded P4P? How many times? If not why not?
- What were the key performance indicators for P4P?
- Do you get any special allowance for working in this facility?
- After the end of the project, what issues/problems can arise?
- In your opinion, what actions are needed by the government to sustain this activity?

Referral Facility of Community Networks (Add some questions for this)

- What interventions were implemented by NPPI to improve the demand side? E.g. community mobilization, focal families, volunteers, CMWs, LHWs?
- Was there any improvement in referral of MNCH/FP clients from the community?
- Who were the main players in referral (Women themselves, LHWs, CMWs, focal families, volunteers, others)?

Guidelines for Interview with In-charge Center of Excellence / Sick Newborn Unit

Basic Information

- What do you know about the NPPI Project?
- What interventions they have implemented in your institution and through which agency (WHO, UNICEF, UNFPA).
- Do you think setting up of Sick New Born Units is relevant and need of the area?
- What types of services are being provided by this unit?
  - Neonatal Intensive care
  - Well Baby Clinic
  - Lactation Management
  - Immunization
- After the establishment of this unit to what extent newborn health indicators have been improved? (See records)
- No. of admissions
  - Complication management,
- Mortality
- Referral
- What type of training do you conduct and for whom?
- Is there any specific curricula for these trainings (See the curriculum)?
- 7What practical skills are provided to the trainees?
- Do you have record of these trainings? (See Record)
  - Type of training
  - Number of participants by gender and facility
- Do you give any support to your trainees and if so what type of support?
- What type of HR support you have received under this project?
- Do you think this is a sustainable activity? If yes, how?
- After the end of the project, how will you maintain this unit?
- Have any special efforts been made to make it sustainable?
- Will you be able to conduct trainings after the end of the project?
- What are your recommendations for the future?
- Are there any lessons learnt?

Note: Please verify the equipment from Stock register/ Inventory and spot check the equipment. (Below is the list of equipment and Supplies

Supplies

S. No.	Item	Quantity Available	Status	
			Functional	
			Yes	No
A) Equipment				
	Incubator			
	Photo Therapy Unit			
	Flow Splitter for Oxygen Concentrator			
	Pulse Oxygen Meter			
	Vital Sign Monitor			
	Baby Warner			
	Suction Machine (foot operated)			
	Infusion Pumps			
	CP Analyser			
	Chemical Analyser			
B) Furniture / Others				
	Baby cart for Roaming Inn			
	Mother Beds with mattress / side table for Roaming Inn			
	Bed side Benches			
	Benches for Waiting Area			
	Baby Blankets with hoods			
	Baby Cart linen			
	White Board			
	Flip Chart with Stand			
C) Infection Prevention				
	Autoclave			
	Surgical Drums			
	Disposable Surgical Gloves (Pair)			
	Disposable had and face masks (Each)			
	Apron			
D) HR Support				
	Medical Officer			
	Staff Nurse / LHV			
	Nursing Aid / Peads technician for SNCU			
	Nursing Aid / Peads technician for Rooming In			
	Aya			
	Private Security Guards			
	Sweepers			
	Receptionist /Record Keeper			
	MIS Officer			
E) Resource Center				
	Chairs			
	White Board			
	Multimedia with Sound System			
	Computer with Printer			
	Flip Chart with Stand			

Guidelines for Principal of Midwifery/LHV Schools

Basic Information

- Do you know about the NPPI Project?
- What intervention has NPPI implemented in your school?
  - Training materials
  - Equipment models (Established any skills lab)
  - Student Logbooks.
- Has any specific curricula been prepared under NPPI project (CMWs, LHVs)?
  - Is it competency based?
  - What skills are required to be developed among the trainees
- Have any practical sites been developed for hands on training?
- Any training of trainers conducted
  - If Yes Who conducted
  - By Whom
  - How many have attended the training
  - What skills are required to be developed of the trainees?
- Do you have any manuals based on the new curricula?
- Do you give away the manuals to students?
- Has your institution been provided with any teaching aids and what kind? (Observe at site)
- Are the teaching aids being used?
- Are specific questions included or are being included in the examinations?
- Has the curricula helped in improving the teaching of MNCH to students?
- After end of the project, will you get these manuals printed?
- Do you think this is a sustainable activity and why?
- What more would be needed to improve the teaching?
- Will you have any problems/issues after the end of project? If yes what are those?
- Is the equipment provided sufficient for your institute?
- Are all these items entered in your stock register? (See the register}
- What else would you need to improve the functioning?
- Will you be able to maintain the functioning of the institute?

List of Equipment for Paramedic Schools					
Items	Quantity Provided		Quantity Available	Status	
				Functional	
				Yes	No
	CMW School	Hostel			
Air conditioners	1	0			
UPS and Battery	0	1			
Generator	1	0			
Water dispenser	0	1			
Refrigerator 14"	0	1			
Ceiling fan	0	2			
Geyser (Gas)	0	1			
LED TV 32"	0	1			
Water pump with motor	0	1			
portable rechargeable light	1	1			
Galli pot	1	0			
Instrument tray with lid	1	0			
Drape sheet	5	0			
White Lab coat	5	0			
Mask	10	0			
Close toes shoes	5	0			
Gown	5	0			
waste bin	1	1			
Stethoscope	1	0			
Weighing scale baby	1	0			
Plastic apron	5	0			
Suction catheter	5	0			
Printers hp	1	0			
Multimedia	1	0			
Projector screen	1	0			
Fax machine	1	0			
Forceps, artary mixter 14cm	2	0			

List of Equipment for Paramedic Schools					
Items	Quantity Provided		Quantity Available	Status	
				Functional	
				Yes	No
	CMW School	Hostel			
Forceps, sponge holding 24cm	1	0			
Scissors	1	0			
Sphygmomanoter, anerial adult	1	0			
Mucus extractor	5	0			
Surgical gloves	5	0			
Class rooms Chairs					
Table for tutors (CR)	2				
Office chairs	10				
Office almirah	1				
Notice board	1				
White board	1				
Book shelves (Lib)	3				
Central library table	1				
Chairs (Library)	0				
Sofas (Principal office)	0				
Single Bed		10			
Almirah Single		10			
Writing/study table		10			
Study chairs		10			
Dining table		1			
Dining Chairs		6			
Chairs for common hall		10			

Guidelines for Faculty of Teaching Institutions

Basic Information

- Do you know about the NPPI Project?
- What curricula have been specifically prepared under NPPI project (CMWs, LHVs)?
  - Is it competency based?
  - What skills are required to be developed in the students during this training?
  - Is it now a part of the regular course content?
  - Do you have the copy of the curricula/training manual?
- Have you received any training of trainers?
  - By: Whom and when
- Has the training helped you improve your teaching skills and how?
- What teaching methodology do you use while teaching?
- Are specific questions being included in the examinations?
- What methods do you use for assessing student knowledge and skills?
- Has the curricula helped in improving the teaching of MNCH to students?
- What is the main achievement of NPPI project?
- What else do you think would be needed from the project to further improve the teaching?

Guidelines for Students

Basic Information

- In which year are you studying?
- How many sessions have you attended on Maternal, Newborn and Child Care?
- What specific skills have you been taught for providing MNCH services?
- In your opinion, what are the main problems associated with the poor MNCH indicators and how they can be improved?
- What are the methodologies being used for teaching? (Group discussion, demonstration technique, role plays, case studies and actual practice in clinics/community)
- Have you had any experience of working in the communities for providing MNCH care? (CMWs)
- What are the advantages of skills lab as a teaching methodology?
    - Do you use it and how?
- According to your Log Books, one of the assignments is a research work. Have you done any? If yes, on what topics? (Medical Students)
- Are you satisfied that the knowledge and skills you have acquired are sufficient to enable you to provide MNCH services?
- Do you think keeping the log books/case studies are useful for you and how?
- In your opinion what else would you need to improve your skills for providing MNCH services?

Guideline for FGDs with Deployed CMWs.

Profile:

Name, Age, Education, Marital status, Number of children, Community name, working experience, Population served/ population attached**,** Training duration, PCPNC registration number, year of registration with PNC

Project information

- Do you know about NPPI (Norway-Pakistan Partnership Initiative) Project?
- When did you join this project?
- What type of training did you receive after joining this project?
- Was this training beneficial for you and how?
- Are you receiving any stipend /allowances for your work and how much?

CMW Work

- Who has established your health house Government/WHO/UNFPA/UNICEF?
- What type of facilities have they provided for your health house? (General medicines, equipment, safe delivery kits, others)
- What is the system of replenishment of supplies (Medicines, Contraceptives, Delivery kits, equipment)

Referral

- In the case of emergency where do you refer clients?
- Do you have link/ relationship with the doctor / LHV/ health facility where you can refer clients?
- What are the improvements in referral services due to NPPI project?
- Do you get proper support and priority at the referral facility?

Supervision

- Who provides the technical support /supervision to you? Are you satisfied?
- What is the mechanism of feedback by supervisor?

Challenges

- What type of challenges/ Problems/ issues you face in performing your responsibilities?
  - (Community, linkages, supply, equipment, supervision)
- After the end of the project what problems do you envisage in your work?
- Is there any efforts being made by the MNCH program for your retention?

Guideline for FGDs with Promoters for Voucher Scheme

Profile:

Name, Age, Education, Marital status, Number of children, Community name, working experience, Population served/ population attached**,** Training duration

Project information

- What do you know about NPPI project and how?
- When did you join this project?
- Do you receive allowance given to you for this work, how much?

Voucher's Scheme

- What is the voucher scheme?
- What is your opinion regarding it?
  (Advantages, Issues, Challenges)
- Did you receive any training related to it?
- If yes, duration
- Was it useful and how?
- Is it sufficient for you to enable you to perform your work?
- If no, what type of training do you need?
- In your view, is voucher scheme beneficial for the community, if yes how?
- How many vouchers have you distributed and to whom. What were the criteria?
- In your opinion, what is the response of communities (women, men) regarding this scheme?
- Are they using the vouchers?

Linkages with health facility (Referral)

- Where do your commonly refer your community women for voucher redemption?
- Do you get full cooperation and priority for your clients in this facility?
  - If no, why
  - If yes, how
- In your opinion, are women of your community availing services from this facility?
- Are they satisfied?
- If no, what are the problems
- In your opinion, has attendance for MNCH services increased because of this intervention?

Record keeping /Issues/

- Do you keep record of the vouchers distributed and redeemed?
- What is the procedure of payment to clients?
- Do the women face problems at the facility to receive the payment against voucher?

Challenges and recommendations

- What type of challenges/ problems/ issues you face in performing your responsibilities?
- In your opinion, what are few key achievements of this scheme (Any success stories)?
- After the end of the project, what will be your role and how will you sustain this activity?
- After the end of the project, do you think the community women will continue using the health services for MNCH care?
- Do you feel that there is change in the health seeking behavior of the community people within last 2 years, if yes what and why?
    - What are your recommendations for future?

Guide line for FGDs with Focal Family/ Community Mobilizers

Profile:

Name, Age, Education, Marital status, Number of children, Community name, working experience, Population served/ population attached**,** Training duration

Project information

- What do you know about NPPI project?
- When did you join this project?
- Is any allowance given to you for this work, how much?

Training

- Did you receive any training related to your work?
- What was the duration of the training
- Topics covered

Probes:

- ANC, Delivery, PNC, FP, Newborn and Childcare
- Do you think that knowledge and skills you have are sufficient for you to perform your work?
- If No, what type of training do you need?
- In your opinion, what is the response of community (women, men) regarding your work?
- What is your opinion about this approach, do you think it is beneficial for the community and how?

Referral

- Where do you commonly refer your client for MNCH services?
  (Public, private)
- Do you have any referral slips?
- Do you get full cooperation and priority for your clients from referral facility?
- If no, why
- If yes, how
- In your opinion, do women of your community availing services from referral facility?
- Are they satisfied
- If no, what problems
- Do you have any arrangements for emergency cases?
  (Transport, Funds)

Supervision/ Record keeping

- If you have any problem related to your work, from whom do you get guidance / instructions? (Technical , administrative)
- What type of records do you maintain?
  - Map of community
  - Family register

- Community chart
- Treatment and family planning register
- Diary
- Mother and child health card
- Referral slip
- Monthly report of FF

- Do you feel that there is change in the health seeking behavior of the community people within last 2 years? I if yes what and why?

<u>Challenges & Recommendations</u>

- What type of challenges/ problems/ issues you face in performing your responsibilities?
    - (Community, linkages, supervision, allowances)
- In your opinion, what are few key achievements of this initiative (Any success stories)?
- After the end of the project, what will be your role and how will you sustain this activity?
- What are your recommendations for future?

Guidelines for FGDs with beneficiaries (Community Women)

General

- What are the common problems of health in your area?
- Where do you normally go for treatment? (ANC, Delivery, Post natal, Child health, Family planning)
- Do you prefer public or private health facilities/provider for MNCH/FP services and why?

Voucher Scheme

Instructions: (Ask these questions from women in the district where voucher scheme is implemented)

- Are you aware of any voucher scheme implemented in your area?
- What do you know about the voucher scheme?
- Have you received any vouchers for MNCH services?

  Probes:

  - By whom
  - How were they distributed
- What information was provided to you regarding this?
- Have you availed these services?
  - If no, why not
  - If yes, where do you go for receiving these services
  - Which facilities (public, private)
- Are you satisfied with the services provided to you under this scheme?
  - Why
  - What are the benefits
- Were there any problems in accessing care on these vouchers and what?
- What problems do you envisage when you will not have any vouchers?
- In future when you do not have these vouchers will you continue going to health facilities availing MNCH services and why?
- Do you feel that there is change in health seeking behavior of the people in last 2 years, if yes, what and why do you think so?

Focal family

Instructions: (ask these questions from women in the district where Focal Family Scheme is implanted)

- Are you aware of the focal family scheme in your area what do you know about it?
- What information do they provide for maternal care?

Probes:

- Counseling on ANC, delivery, nutrition , vaccination during pregnancy, recognize danger sign during pregnancy, skilled birth attendant, use of clean delivery kit in case of home delivery, post-natal care and Family Planning
- What information do they provide to a mother for care of newborn and child health?

Probes:

- (Umbilical cord care, colostrum, breast feeding up to six months, danger signs during the childhood illness, immunization, growth monitoring)
- What are the benefits of the focal families?

- Do you go to the health facility for availing the MNCH services?
  - Which facilities (public, private)
  - How far is it?
- Are you satisfied with the services provided at the facility?
  - If yes, why
  - If not, why not
- What are the benefits of availing MNCH services at a health facility?
- In health related emergency is there any arrangement for referral? (Where and how)
- What is the role of social mobilizers/ focal family? Are you satisfied?
- What is the help you receive for community network?
  - Arranging transport for emergency care
  - Arranging money for emergency care
  - Referral facility location, distance, services available
- In the future when you do not have this focal family will you continue going to health facilities for availing MNCH services and why?
- Do you feel that there is change in health seeking behavior of the community people in last 2 years? If yes, what and why do you think so?

Guidelines for FGDs community women (Non -Intervention Area)

General

- What are the common problems of health in your area?
- Where do you normally go for treatment? (ANC, Delivery, Post natal, Child health, Family planning)
- What do you know about?

(ANC, nutrition, vaccination during pregnancy, danger sign during pregnancy, delivery, skilled birth attendant, use clean delivery kit in case of home delivery, post-natal care, (baby cord care, colostrum , breast feeding up to six months, danger signs in the baby, vaccination, growth monitoring)

- Do you need information on these issue and why?
- Who should provide information with this knowledge?
- What type of maternal and child health services available in your community?
    - **Probes:**
    - Availability of female service provide
    - Full range of services available
    - Attitude of providers
    - Environment
    - **Probes:**
        - (ANC, Natal, Postnatal, child health, Immunization, general health, counseling and family planning services)
- Do you have any problems in accessing at the health facility and why?

Probes:

- Distance
- Cost
- Transport

- How these problems can be solved?

In an emergency do you have any arrangement for reaching health facility?

- If yes, what
- If no, why

ANNEX 6: EVALUATION METHODOLOGY

PURPOSE OF THE EVALUATION

The NPPI project has been implemented for six years (2009-2014). The main objective of the end of project evaluation was:

- To document and disseminate results and achievements of the NPPI programme
- To generate knowledge on evidence-based best practices related to approaches, cost effectiveness and sustainability.

1. TARGET AUDIENCE:

The primary reader group of the end of project evaluation will be the Department of Health Government of Sindh, the District Health Authorities, the ONE UN, the Royal Norwegian Embassy, the Royal Ministry of Foreign Affairs Norway, NORAD, the federal Ministry of National Health Services Regulation and Co-ordination, civil society organizations implementing partners, service providers, beneficiaries, and the global health community.

2. DATA COLLECTION AND ANALYSIS:

The evaluation has focused on exploring in-depth answers to the four critical evaluation questions that have been identified as: i) Relevance; ii) Effectiveness; iii) Efficiency; and iv) Sustainability. The end evaluation has been conducted through a mixed method approach i.e. Structured questionnaires, face-to-face open ended interviews with different stakeholders and direct observations. While the project was implemented in 10 districts of Sind, but we have evaluated the project field activities in 4 sample districts due to time constraints. As the spread of interventions in all districts was uneven and therefore we purposively selected those 4 districts which had the maximum number of interventions.

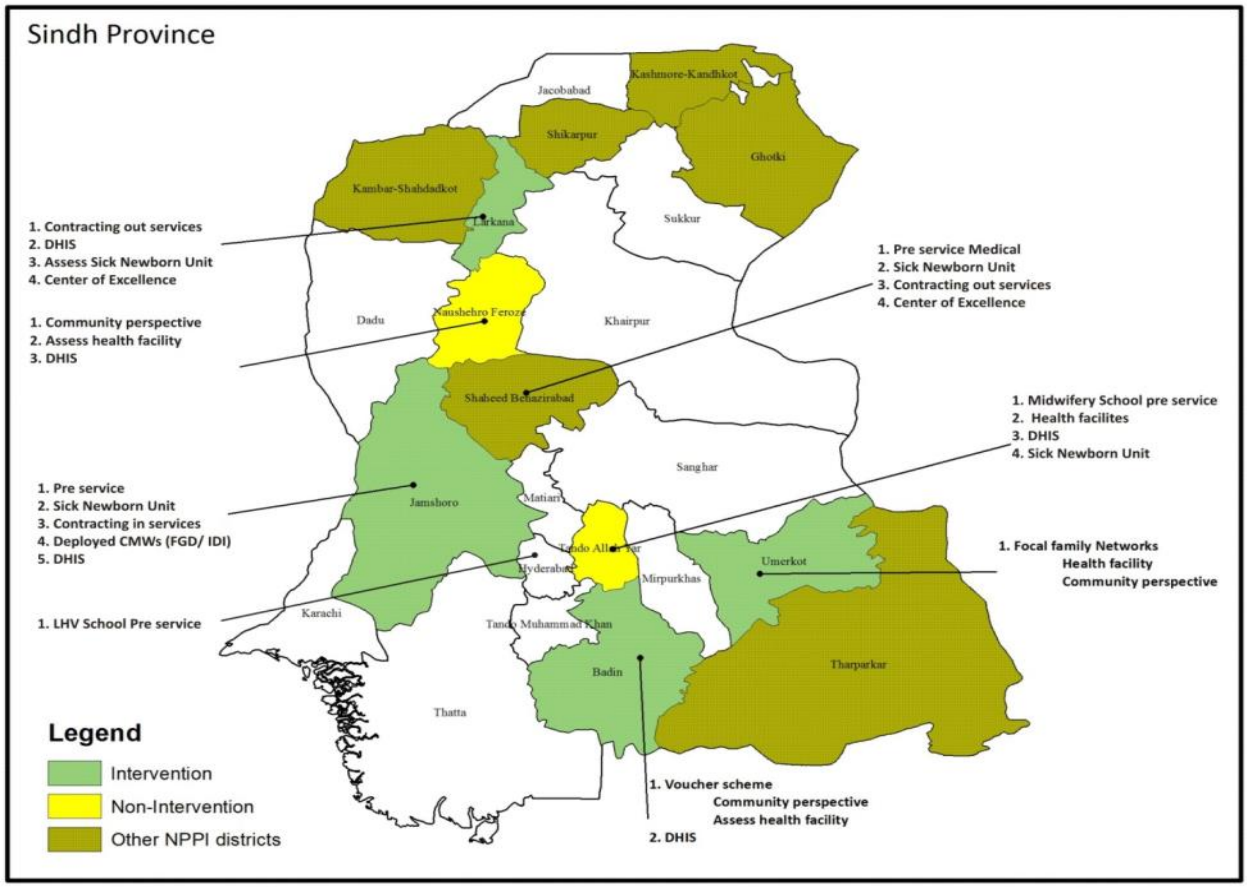
While the evaluation was for the entire project period since its inception in 2009, the major focus, however, was on assessing the progress towards the results set out in the Exit Strategy/ road map that were developed post Mid-Term Review (MTR) 2013. This is because this review comprehensively assessed the earlier period of the project. Therefore we have focused on the latter and final period of the project. Furthermore, we have also focused on the actual field situation in terms of how project interventions impacted upon the health seeking behaviors of the beneficiaries compared to those areas where the project was not implemented as a final reality check. In view of the time constraints, and in order to evaluate the maximum number of interventions, especially all the innovative approaches of the NPPI project, we adopted the following criteria to select the districts for our field visits.

- Districts where more than one intervention was implemented.
- Ensure that Interventions of all three UN agencies are covered.
- Security Concerns: relatively better law and order situation.

Four districts fulfilling the abovementioned criteria were identified; namely Larkana, Jamshoro, Umerkot and Badin were identified where the field work was carried out. In addition, we also visited Benazirabad to assess the pre-service medical interventions and Hyderabad to assess the LHV School.

The map given below shows the selected districts, those with interventions and those with no NPPI interventions, specifying the type of interventions and activities we conducted.

Figure 1: Geographic Coverage of the End Evaluation:



In order to draw a comparison, two additional districts (Nausheroferoze and Tando Allahyar) were selected as a comparison point against which the impact of the NPPI was assessed. These districts were selected on the basis that no large scale interventions comparable to NPPI were being implemented in these districts by other organizations that could confound the results. These comparison districts were similar in all other respects to the districts chosen for our field evaluation i.e. socio demographic characteristics of the people and availability of health facilities. The comparison districts were being included to help in establishing that the reported outputs/ outcomes were indeed attributed to the implemented interventions and not due to external factors. We have objectively evaluated the impact of these interventions and compared the results with the realities in comparison districts, based on the following:

- Service Statistics in relation to changes in specific MNCH indicators (Immunization coverage, ANC, PNC, Facility based deliveries and FP) within last two years.
- Human resource availability
- Impact of Capacity Building Initiatives such changes in providers' perspective on MNCH services and training of CMWs.
- Institutional Strengthening: Readiness of health facilities for providing MNCH services- (infrastructure, supplies, trained staff and appropriate referral mechanisms; adherence to the human rights principles; measures instituted to overcome gender discrimination and reaching out to underserved vulnerable and marginalized groups).

Evaluation Process:

The evaluation process is structured in two phases, inception and implementation. During the inception phase, the evaluation team conducted a desk review and produced inception report. The final end evaluation included review of secondary data and field evaluation. The field evaluation was based on planned and actual outcomes of the project. It also took stock of inputs and their comparison with processes and outputs in the nonintervention districts. Field Evaluation established how the project activities led to the outputs that in turn contributed to the expected outcomes. To assess that programmatic objectives and results derived through interventions have been achieved, we defined:

Inputs:

- Human resource capacity development
- Infrastructure placement
- Introduction of innovations such as :
  - o Contracting out
  - o voucher scheme
  - o Pre-Service Intervention
  - o Sick newborn units

Outputs:

- No. of trained persons
- No. of facilities upgraded / equipped as a result of contracting out
- Curricula developed
- Number of beneficiaries
- Voucher Scheme in place (vouchers distributed and redeemed)
- No. of Community networks in place

Impact Sustainability:

- Intervention to be taken forward in terms of Government commitment to scale-up
- Evidence of financial outlay to sustain existing interventions

Outcomes:

Changes in;

- Health seeking Behavior (Self Care)
- Policy Environment
- Coverage of services
- Quality of service statistics

3. EVALUATION QUESTIONS:

Relevance:

1: Were the strategies or approaches realistic, appropriate, and adequate to achieve results?

Efficiency:

1. Was the project cost-efficient? Did the actual or expected results justify the cost incurred for the innovative approaches?
2. Did the approaches that were utilized produce expected results?

Effectiveness:

1: To what extent did the project achieve its overall objectives?

2: What were the key project achievements?

3: How effective were the 'innovative approaches', what results were achieved, are they replicable within the Sindh context?

4: Were the UN agencies effective in delivering as one? What are the good practices and/ or shortfall in delivering as 'one'?

5: What were the main lessons emerged?

Sustainability:

1: To what extent are the benefits of the project likely to be sustained after project completion?

2: What was done to ensure linkages with other relevant MNCH initiatives that strengthened the sustainability of the program?

3: What was required to ensure prospects of sustainability of project outcomes and the potential for replication or scale up of good practices and/ or innovative approaches?

4. DATA COLLECTION METHODS

The evaluation employed open ended unstructured In-depth interviews with the key stakeholders at provincial and district levels and officials from teaching/training institutes. Focus Group Discussions and In-depth interviews were also conducted with women, CMWs and providers/promoters for qualitative assessment. Structured questionnaire was designed especially for Health Facilities assessment.

During the data collection process an all-out effort was made to identify if the system is mindful of basic human rights and that they are being observed by providers while delivering services and what steps were introduced that directed towards reaching out to the most vulnerable and marginalized people in a non-discriminatory manner. The methodological approach followed during the evaluation is illustrated in figure-2.

Figure-2: Evaluation Methodological Framework

Data collection exercise was designed on following five methods:

a: Documents Review:

The Evaluation Team (ET) conducted desk review of the available documents from UNFPA, UNICEF and WHO monthly and quarterly reports for NPPI Project. Mid Term Review, Exit Strategy and Roadmap were also appraised. The inputs and outputs were defined on the basis of an analysis of the secondary information and data made available through these reports, project documents, correspondence, letters of agreement and strategy documents (list of documents attached as Annex-10.

b: Consultation with stakeholders

Senior evaluation team members were responsible for meetings with various public and private stakeholders in the selected districts. Similar to the interviews with provincial managers/stake holders, district interviews were also conducted face to face, using specific guidelines. Research team visited the teaching Institutes and discussed the impact of the interventions with focal persons, relevant teaching staff and students to assess the curricula incorporated into the main syllabus, in particular if it has helped to improve the teaching and its use in future (list of key stakeholders attached as Annex-2).

Table 1: Number of IDIs conducted With Managers

In-depth Interviews	#
Implementing Partners	9
Provincial Managers	6
District Managers	11
Teaching Institutions	7
Facility Incharge	13
Total	**46**

c: Field visits to health facilities and interviews with implementers/executing agency staff

Health facilities of different levels in both intervention and comparison districts were also visited to assess their readiness and ability for providing MNCH services through an assessment (using a standard checklist), and through direct observations and provider interviews. Indicators set in Phase-out strategy) were taken as reference point to gauge the progress because this was the period when different interventions were implemented according to revised work plan.

Table 2: Total Number of Facilities visited

	Districts								
Health Facilities	Umer Kot	Larkana	Badin	Tando Allahyar	Naushahrof eroze	Hyderabad	Jamshoro	Shaheed Benazirabad	Total
BHUs	1								1
RHCs		1	1	1	1				4
THQs		1	1				2		4
Civil Hospital				1	1				2
Private hospital			2						2
Total	**1**	**2**	**4**	**2**	**2**	**0**	**2**	**0**	**13**
Teaching Institutions	1	1	1	1		1	1	1	7
Total	**2**	**3**	**5**	**3**	**2**	**1**	**3**	**1**	**20**

d: Qualitative assessment of Community Perspectives

To assess the community perspective on various community and facility based interventions implemented by NPPI, In-depth interviews and FGDs with beneficiaries were conducted. The purpose of this exercise was to evaluate the project interventions on women and their families and to assess the change in health seeking behaviors as to how well they were implemented and how they benefited the community.

Table 3: Number of Focus Group Discussions (FGDs) conducted

Beneficiaries	Districts						
	Badin	UmerKot	Larkana	Naushefro Feroze	Jamshoro	Tando Allahyar	Total
Community Women	2	1	1	1			5
Focal Families		1					1
Deployed CMWs					1	1	2
Promoters of Voucher Scheme	1						1
Total	**3**	**2**	**1**	**1**	**1**		**9**

Table 4: Number of IDIs with Beneficiaries

Beneficiaries	Districts			
	Hyderabad	Benazirabad	Jamshoro	Total
Tutors – Public Health Schools	1			1
Trainers – Medical Institutions		1		1
CMWs			2	2
Total	**1**	**1**	**2**	**4**

e: Financial assessment of the project inputs

Financial Assessment of the project inputs was performed to explain the program implementation costs and to articulate the costs of different interventions under NPPI.

5. ANALYSIS STRATEGY

We defined the inputs and outputs on the basis of secondary information and review of data available through reports, project documents, and letters of agreement and strategy documents. On the basis of site visits and direct observation of facilities and institutions, the approach was further complemented through quantifiable observations and indicators. The overall expected outcomes have been measured in terms of perceptions and behavior of intended beneficiaries i.e. community representatives, providers, students and policy makers obtained through open ended In-depth interviews, focus group discussions and observations. The more qualitative component of the evaluation has provided deeper insights into identifying the risks, obstacles and the external and internal factors that either facilitated or hampered programmatic implementation. The analysis is based on measuring overall change in the policy environment, health seeking behavior, increase in coverage and sustainability of the intervention in terms of how managers and policy makers view the interventions and the government's commitment to take forward and scale up the interventions.

The field evaluation was based on selecting the interventions districts and their comparison with processes and outputs in the nonintervention districts. In addition, the role of the various UN agencies independently and as a whole (One UN) was also assessed in terms of their ability to coordinate efforts, avoid duplication; provide managerial assistance and effective use of resources; and to identify the stewardship and leadership role of the NPPI management team and the efforts made to ensure financial and programmatic sustainability.

6. LIMITATIONS OF THE EVALUATION METHODOLOGY

The evaluation has taken place two months after the interventions have ended. This has prevented us from being able to measure full impact. Moreover, the time duration stipulated for the end evaluation was not sufficient to conduct a comprehensive evaluation based on the representative household sample. Frequent transfers and attrition of staff meant that we could not interview staff who had been involved with the project from its inception.

7. ETHICAL CONSIDERATIONS

As part of its policies and procedures, the Population Council requires all studies involving human subjects be reviewed by its Institutional Review Board (IRB) before the activity is initiated. Ethical approval for this evaluation was obtained from IRB at the onset before the start of field activities. To have an orientation on UNEG ethical guidelines, a meeting with UNICEF staff was held on August 25, 2014 at the Population Council Office. One of the agenda item was to discuss UNEG ethical guidelines for evaluation. To ensure discharge of obligations to participants, informed consent was obtained in advance from all the respondents. The informed consent form essentially covered the information on rights of respondents for their participation in the evaluation; ensuring confidentiality of information and avoidance of any harm. Informed Consent form used during the evaluation is attached as Annex-11. Data collection teams were predominantly Sindhi and were well versed with the local culture, customs and beliefs. UNEG ethical guidelines that have been followed as guiding ethical principles[34]. Additionally, UNEG norms and standards of evaluation were also considered throughout the evaluation i.e. honesty, integrity, independence, impartiality and credibility. The evaluation team is glad that no incident has been reported during the evaluation that compromised the mandatory obligations of evaluators as set forth in UNEG ethical guidelines and UNEG norms and standards of evaluation.

8. QUALITY ASSURANCE MECHANISMS

Evaluation design, planning and implementation processes have been clearly defined that are inherently quality oriented, covering appropriate methodologies for data-collection, analysis and interpretation. The evidence, findings, conclusions and recommendations have been clearly defined. We have clearly explained the methodology followed; highlighted the methodological limitations of the evaluation, key concerns and evidenced-based findings, nonconforming views and significant deductions, recommendations and lessons.

[34] UNEG Ethical Guidelines for Evaluation

UNEG, March 2008

ANNEX 7: INFORMED CONSENT FORM

PURPOSE OF THIS RESEARCH STUDY

The purpose of this study is to conduct a NPPI End of Project Evaluation which has been implemented by UN One organizations in Pakistan. Your answers are very important to us and will help us find ways in improving Maternal, Neonatal and Child Care services in Pakistan.

1. PROCEDURES

My name is _____ and I am from the Population Council, which is a research organization with an office in Islamabad. We are conducting an End of project Evaluation funded by UNICEF to assess the different interventions with regards to its relevance, effectiveness, efficiency and sustainability. We would like to seek your cooperation in getting a better understanding of the different interventions implemented by NPPI in Sindh.

You will participate in interview/ discussion. Your responses will be completely confidential and will be used for research purposes only. No personal reference will be made to your participation in this survey. We will combine your responses with those of other participants in a report. The interview will take 60-90 minutes to complete. The duration of the entire study is 20 days. We may need to contact you again to clarify a point made earlier, but you may agree or disagree to this.

2. POSSIBLE RISKS OR DISCOMFORT

If this is not a convenient time for you, we can come back later. You may end the interview at any time without penalty or loss, and you don't have to answer any questions that you do not want to answer.

3. POSSIBLE BENEFITS

There are no direct benefits to you for participating in the study. You may find an indirect benefit in knowing that you have participated in an important study that could help others in the future.

4. VOLUNTARINESS

Your participation in this study is purely voluntary and you will not be paid for participating in this study. There is no penalty for refusing to take part. If you agree to participate in this study, you may end your participation at any time without penalty or loss of existing benefits to which you are entitled.

5. CONFIDENTIALITY

Your responses to this questionnaire will be completely confidential and will be used for research purposes only. No personal reference will be made to your participation in this study. We will combine your responses with those of other participants to describe the general picture in Pakistan. This information will only be accessible to the study team.

6. TERMINATION OF RESEARCH STUDY

If you decide to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with the interviewing team.

7. AVAILABLE SOURCES OF INFORMATION

The results of the study will be published in a report. If you have a concern about any aspect of the study, you should ask to speak to the researchers who will do their best to answer your questions. Any complaint about the way you have been treated during the study or in case of violation of rights you may call Mr. Noushad Mehmood at this number 0092-51-8445566 Ext. 112. For information about the study, your rights or any possible harm you might suffer you may contact Dr. Saleem Shaikh at this number 0092-51-8445566 Ext. 195.

8. AUTHORIZATION

I have read / heard the Informed Consent for this study. I have received an explanation of the planned interview and its procedure, risks and benefits, and privacy of my personal information. I agree to take part in this study. I understand that my participation in this study is voluntary. I understand that information obtained in this study will be transmitted only in a form that cannot be identified with me.

Your name:_____

Your signature:_____**Date:**_____

Investigator or person who conducted Informed Consent discussion: I confirm that I have personally explained the nature and extent of the planned research, study, procedures, potential risks and benefits, and confidentiality of personal information.

Name of person obtaining consent:_____

Signature of person obtaining consent: _____**Date:**_____

ANNEX 8: REFERENCE GROUP COMPOSITION AND RESPONSIBILITIES

Objective: To ensure evaluation quality, independence and credibility.

Reference Group Members:

1. MNCH Sindh NPPI focal point & chair
2. NPPI Project Manager & co-chair
3. UNICEF NPPI focal point
4. UNFPA NPPI focal point
5. WHO NPPI focal point
6. Additional members may support the forum for the duration of the NPPI end of project evaluation, which will/may include the following:
    a. PME to ensure essential work processes of convening agency are adhered to (as Pop Council administratively procured through convening agency)
    b. Other 'one UN' agency technical team members as required, including RCs office and UNDP as AA
    c. RNE and technical consultants/advisors from NORAD as required

Key Tasks: taking into account UNEG (United Nations Evaluation Guideline) norms, standards and ethical guidelines, our forum is committed to:

1. Reviewing and commenting on ToRs for NPPI end of project evaluation (completed)
2. Reviewing and commenting on draft inception report including the following:
    a. Work plan
    b. Table of contents
    c. Methodology proposed
    d. Assurance that key evaluation questions are included & addressed:
        i. Relevance
        ii. Sustainability
        iii. Effectiveness, including innovative approaches
        iv. Efficiency, including cost-efficiency
3. Reviewing and commenting on draft comprehensive report, providing constructive and detailed feedback

ANNEX 9: BREAKUP OF DEPLOYED CMWS IN NPPI DISTRICTS

District	CMWs Deployed
Jamshoro	40
Badin	87
Umerkot	55
Tharparkar	37
Nawabshah	62
Larkano	70
Kambar Shahdadkot	45
Shikarpur	42
Ghotki	24
Kashmore	24
Total	**486**

ANNEX 10: ACTIVITIES IMPLEMENTED VS ACTIVITIES PROPOSED IN EXIT STRATEGY

United Nations International Children's Emergency Fund (UNICEF)

Contracting Out

Health Financing with relevance to Scale Up and Sustainability.	Implemented for 30 months.
• 28 health facilities providing 24/7 MNCH service in two Districts---Larkana and Benazirabad.	22 Health Facilities functional instead of 28.
Improving Health Facilities • Provision of HR. • Improved infra-structure. • Provided equipment	Both technical and support staff provided Infra-structure was improved. Equipment was received in health facilities and was recorded in stocks register.
• Build Capacity of Health Care Providers.	Training in IMNCI, ENC, PCPNC, FP and Infection prevention was provided. Trained staff seen in health facilities.
• P4P to Health Care Providers and Staff.	P4P was provided.
Chief Secretary expressed strong commitment to maintain 24/7 facilities.	
Community based activities to be implemented for demand creation.	Activities were conducted to create demand (community mobilization through LHWs, and Focal families in non LHW areas, involvement of religious leaders and conduction of street theatres).

Establishing 3 Centers of Excellence for Sick New Born Care.

To establish Centers of Excellence for Sick New born in 3 Medical Universities.	Centres are established and on direct observation were functioning extremely well.
Larkana	
PC-1 approved.	But at the time of visit there was shortage of HR especially support staff therefore quality of care was suffering.
Benazirabad	Functioning efficiently, maintaining some staff from their own funds, but still facing problems. They need support.
Liaquat University	Functioning extremely well, but still needs staff.

INPUTS • Provision of HR---both Technical and Support. • Provide Equipment.	Staff was provided and verified the payment of salaries. Equipment available and entered in the stocks registers.

Third Party Monitoring

OPM awarded contract to conduct Third Party Monitoring.	OPM functioned to conduct TMP of Voucher Scheme and Contracting Out Health Financing Models Reports verified.

Behavior Change Communication Network

Implemented in districts UmerKot and Tharparkar.	Implemented in UmerKot only
Train 140 Focal Families from 14 villages in 14 Union Councils in LHW in uncovered area.	FF have been trained and conducting social mobilization activities.
140 Health Committees and 560 Women Groups formed.	Evidence in report seen. (Thardeep close out report) and by conducting focal groups and discussions with focal families and beneficiaries.
Trained LHV's (488) to conduct similar activity.	LHW's were trained. (Record and IDI with manager). But activity not implemented for conducting social mobilization on forming of family networks.
Communication Model shared with DC and HSRU	Current DG not aware.

Human Resource Support to MNCH

Technical assistance to MNCH for Communication and Administration and Finance.	Support was provided.
Commitment of Sindh Government to continue these posts from their own funds.	Not sustained.
Final Evaluation	In process.
Support for NPPI Coordinator to be one UN Joint Programme Focal Person.	Support provided.

United Nation Population Fund (UNFPA)

Voucher Scheme Innovative Health Financing Scheme with the aim to increase demand and utilization of maternal and child health as well as family planning by removing financial barriers in accessing services (eliminating out of pocket expenses). 39,000 Vouchers were distributed by Greenstar	39,000vouchers were distributed and ---redeemed. Report of Greenstar. Focus Groups conducted with Voucher promoters and beneficiaries both confirmed the distribution and redemption of voucher.

Strengthening of Midwifery Services

Midwifery Schools. Provision of equipment, furniture, teaching aids to Midwifery Schools and Hostels.	The equipment, furniture and teaching aids have been received by the Midwifery Schools and entered in the stocks register. Physically verified in 2 Midwifery Schools of NPPI districts. However, hostels were non- functional due to shortage of support staff. Two more Midwifery Schools were visited, one had similar furniture for hostel but skills labs were not established.
Development of CMW's Trained CMW's will be provided with Midwifery kits containing equipment, medicines, family planning commodities and consumable items. Six week Clinical Attachment of passed out CMW's at Midwifery Institute Hyderabad in 3 batches.	486/532 CMW's in 10 NPPI districts have been deployed for setting up of their work stations. Interviews with deployed CMW's confirmed receiving of the material and setting up of work stations. Interviews with CMW's of Non-intervention districts (Tando Allahyar) also revealed that they had received similar kits to set-up their work stations through MNCH programme. Trainings conducted

Family Planning Services

Enhance skills of 200 service providers working in BHU's and Rural Health Centres in FP counseling and intrauterine contraceptive device in coordination with health department and PPHI.	Two batches conducted by UNFPA. This activity is now taken over by MCHIP.

Human Resource Support to MNCH

Technical Assistance to MNCH Programme for Midwifery, Administration and Procurement by providing two posts to MNCH Programme. Government of Sindh expressed commitment to further support these posts from their own resources.	According to MNCH manager , support was provided but after close of the project , they have retained only one person

World Health Organization (WHO)

Contracting In	
The intervention was implemented in Jamshoro and Ghotki Districts and is part of on-going activity of MNCH Programme.	This activity was delayed and not fully functional as yet. According to Managers, these facilities are non-functional as 24/7.
All District and Taluka Hospitals are operational and providing 24/7 integrated MNCH/FP Services.	Two THQ's visited. One was providing CEmONC service 24/7, while the other was conducting only deliveries with no C section. In both facilities there was shortage of staff. According to the MNCH manager, now 2 THQs in Jamshoro and 2 in Ghotki have started providing 24/7 CEmONC services
Pre-Service Intervention	
Adaption of IMNCI, ENC and District Health Information System and other national strategies in:	
Medical	
• 4 Medical Institutions	IMNCI, ENC part of 3 Medical Universities of which one still needs approval from Academic Council. Visited all 3 Institutions and observed the intervention. Functioning extremely well. DHIS not included in pre-service curriculum
5 Public Health Schools.	Public Health Schools--- Trainers are trained in IMNCI.

Teaching aid provided for skills lab. Pre-service committee formed by Govt. and secretariat at DG office.	Visited one PHS: Teaching aids have been received and entered in stocks register. Skills lab not properly established so probably not used for teaching. Committee is formed. Secretary Pre- Service located in DG office. Held meeting with him.

Scaling up of In-Service training

Train service providers on IMNCI, ENC, PCPNC and ETAT. From primary health <u>Support to 3 Centers of Excellence</u> Establish fully functional Centers of Excellence as a resource facility / training site for training and mentoring of medical pediatricians and Obstetrician and gynecologist.	Training has been provided. Verified lists. Interviewed providers in the districts. All six health facilities in intervention area had trained providers. Centers of Excellence are established. Seminar rooms and skills lab were observed in all 3 universities. According to MNCH manager, they will continue this activity through the funds of MNCH program However the skills lab will be used for training of undergraduates and postgraduates

Equipment Supplies

To strengthen the integrated MNCH Services at Public Health Facilities in 10 Districts to ensure 24/7 coverage of facilities and BEmONC facilities CEmONC Equipment (medical and general), medicines and other supplies sent. Minor repair to Labour Rooms in 10 Districts.	Equipment has been provided and entered in stocks register. Verified at the time of visit in the facilities.

District Health Information System (DHIS)

Training of Trainers of 10 NPPI Districts conducted.	List of providers trained available. In the facilities we visited, trained personnel were available.
Training of health care providers of health facilities conducted.	In all 4 Districts visited, equipment was available and entered in the Stocks Register.
Equipment (One desk-top computer, one lap-top computer, one printer and one UPS) provided to District Offices.	Tools were available even in Non-NPPI districts but proper training was not conducted.
Data Collection tools provided.	

Support MNCH Monitoring and Supervision

Objective to ensure quality supervision of NPPI operations by MNCH Programme.	
Travel for Supervisors financed.	
Monitoring will be structured using MNCH MIS tools and reports will be shared.	MNCH program has taken it up according to WHO
Government of Sindh will continue this activity as part of regular services using the MIS tolls and Reporting System tested under NPPI.	

Technical Support, Supportive Supervision and Policy Guidance at provincial and District Level

10 Districts Technical Units were established in NPPI Districts staffed with Technical Officer and driver, equipment with IT, Energy and Support equipment and a 4x4 Double Cabin vehicle.	
District Officer responsible for Monitoring of DHMT and DTC and MMC.	
Sindh Government has appointed Focal Persons MNCH in all Districts to take over the District Support Unit at end of NPPI with own resources.	Focal Persons of MNCH program are in the districts

Strengthening Management

16 MID-Level Managers trained at Aga Khan University in Health System Management.	Activity conducted
3 Members from each District will be trained in Project Management from COMSATS Institute.	Activity not conducted
Implement SAAVY (Sample Vital Registration With Verbal Autopsy)	Activity not conducted.

Advocacy / Support Symposia

This activity was to sensitize the policy makers, general masses, health care providers and future health professionals.	
Symposia, workshops and seminars planned under NPPI.	Symposia have been conducted in Medical Universities. Reports available.
Symposia added to University events calendar.	

ANNEX 11: DETAILS OF VOUCHER REDEMPTION

Type of Voucher	Badin	Shikarpur	All
Registration	22,481	17,442	**39,923**
ANC 1	20,376	14,311	**34,687**
ANC 2	17,873	10,242	**28,115**
ANC 3	14,912	7,009	**21,921**
ANC 4	11,520	4,352	**15,872**
Normal Delivery	11,266	6,004	**17,270**
C Section	1,662	952	**2,614**
PNC 2	10,300	4,840	**15,140**
Sick Child	5,384	1,017	**6,401**
FP	8,208	1,860	**10,068**
Vaccination	9,142	3,751	**12,893**

ANNEX 12: SCALING UP KEY NPPI INTERVENTIONS

1. Cost Assumptions

Costing of a Typical District in Sindh

Following is the detail of the costing of an ideal district.

2. Demographic and Health provision related Assumptions

Demographic information	No./ %	Comments/ Sources
Target average population size	1,300,000	based on the 2011 population in NPPI districts
Urban	390,000	30 %
Rural	910,000	70 %
Female population	617,500	47 .5%
Reproductive age	284,050	15-49 years old (46%) out of female population
Ever married women	218,719	77% are ever married
Pregnant women	30,621	14% of ever married are assumed to be pregnant
Poor pregnant women	75%	75 % in NPPI districts are considered as poor according to the SPDC *Research Report No.82 DISTRICTS' INDICES OF MULTIPLE DEPRIVATIONS FOR PAKISTAN, 2011 by Social Policy and Development Centre* *Total Number of Districts counted in Sindh as 23, considering Karachi as one district,*
Total poor women	22,965	
Total New borns	30,000	Estimated on the basis of NPPI district data
Population not covered by LHW	44%	Average based on Sindh Statistics
Pregnant women not covered by LHW	13,473	
urban population	15%	
Total pregnant women not covered by LHW and not urban	11,452	Total not covered – 15 % urban = total not covered in rural area
FF required according to 200-300 households covered by LHWs	200	Woman mobilized per FF are 88 according to the TRDP data

3. Cost for Establishing a Sick New Born Unit

The following cost would incur to Establish and run the SNBU in a district:

Cost for establishing a SNBU	Rs. 9,790,000
Cost for SNBU for next year	Rs. 5,707,000
Average monthly admission	272
Yearly admission	3264
Cost per admission 1st year	Rs. 3,000
Cost per admission 2nd year	Rs. 1,749

Cost SNBU Rs. Million	Rs. 9.8
Cost for 10 Districts	Rs. 98
Cost as % of provincial budget	0.02 %
Cost % of health budget	0.17 %

The costs show that it will be only 0.17 % additional amount to existing health budget to establish a SNBU in 10 districts and the cost would go down substantially in next years as the capital cost has already incurred in first year. In fact the admission rate may rise in subsequent years if they provide quality services. That is why this is really a cost effective intervention to save the lives of many children in those poor districts.

4.

Interventions/ Cost Units	Rs.	Comments
Cost for mobilizing a woman by FF- Cost per woman	1,750	Estimated on the basis of 12286 registered woman - TRDP data
Cost for mobilizing a woman by FF – Cost per FF per year	93,291	Estimated on the basis of 140 FF- TRDP data (including fund for emergencies)
Next year running cost per FF	6,0278	Including HR and operational expenses
Cost per voucher booklet (package of 10 services)	13,776	Estimated from VS scheme in NPPI districts
Per Voucher booklet cost (partial)	9,003	Based on assumption of 100 % redemption
First year's running and establishment cost of 24/7 facility including BCC and FF	12,470,000	Estimated from IHS data for Contracting out model in NPPI districts
First year's running and establishment cost of 24/7 facility excluding BCC and FF	12,190,000	Estimated from IHS data for Contracting out model in NPPI districts
Cost per SNBU- yearly	9,790,000	Estimated from SNBU data
Running cost of SNBU for next year	5,707,000	Estimated from SNBU data – includes HR cost and 7 % operational/ maintenance cost
Cost of training & deployment of CMW	450000	Govt . provided estimates
Provided Running cost for CMW for next year	1,363,440	Estimated on the basis of Rs. 2000/month stipend

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