FIGO SAVING MOTHERS AND NEWBORNS PROJECT IN PAKISTAN

Community Based Interventions to Reduce Maternal and Perinatal Mortality and Morbidity in Rural Sindh Pakistan

FINAL EVALUATION

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ACRONYMS

AJK	Azad Jammu and Kashmir
BHU	Basic Health Unit
CME	Continuing Medical Education
CMW	Community Midwife
EDO	Executive District Officer
EmONC	Emergency Obstetric and Newborn Care
FIGO	International Federation of Gynaecology and Obstetrics
HMIS	Health Management Information System
IEC	Information, Education and Communication
MAP	Midwifery Association of Pakistan
MDG	Millennium Development Goals
MVA	Manual Vacuum Aspiration
NCMNC	National Committee on Maternal and New-born Care
NGO	Non -Governmental Organisation
PMA	Pakistan Medical Association
PPH	Post Partum Haemorrhage
RHC	Rural Health Centre
SOGC	Society of Obstetricians and Gynaecologists of Canada
SOGP	Society of Obstetricians and Gynaecologists of Pakistan
SZMC	Sheikh Zayed Medical Centre
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nation Population Fund
WMO	Woman Medical Officer
WRLH	Women's Right to Life and Health

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EXECUTIVE SUMMARY

This project was very successful and achieved commendable results in the provision of EmONC services in the project area. Despite the challenges encountered due to the humanitarian crisis because of major flooding in August 2010 and political instability, the project made substantial achievements in providing basic and comprehensive EmONC services and raising awareness of reproductive health issues within the community.

The core Project team, with the support of the Society of Obstetricians and Gynaecologists of Pakistan (SOGP), has successfully implemented the project activities in three health facilities of Thatta District. There has been an enormous positive impact on the availability of quality emergency obstetric and neonatal care. This is evident by the increased utilization of services, and increase in the number of women receiving antenatal, intra-natal and postnatal care. The project has pioneered various innovative approaches to finding solutions to issues of access to quality care. Collaboration with the local ambulance service to provide subsidized transport for the timely referral of women in the community is one such success story.

The relationship with and confidence building of traditional birth attendants, and their training has been extremely helpful, as TBAs are increasingly referring complicated cases to the facilities in time. The use of emergency obstetric care protocols, at the facilities along with training of the health care staff also clearly contributed to improving the quality of services.

The project team also tried hard to engage with numerous stakeholders at various levels and was successful the majority of the time. The involvement of local political figures and government health officials proved very helpful in the implementation process. The collaboration with the National Committee on Maternal and New-born Care (NCMNC), the Midwifery Association of Pakistan (MAP) and United Nation Population Fund (UNFPA) helped them achieve their objectives. The capacity building and training of local women as midwives will substantially strengthen efforts to make service improvements to the community sustainable beyond the life of the project. The twinning society involvement has also added value to the project although it is felt that this could have been increased if they had been involved in training of midwives.

There were enormous challenges, some of which were successfully tackled, others have found no solution. The biggest challenge is the issue of sustainability, especially the costly human resource component. If the staff are not maintained after the end of the project it is highly unlikely that many of the project's very substantial achievements will be sustained.

Key lessons learned from the project are:

- The issue of sustainability has to be critically thought over, analysed and the possible challenges and solutions identified both before the start of any project and as it progresses, so that project efforts do not go to waste. In order to resolve challenges appropriate advocacy pathways should be identified i.e. identifying whom to target, when, the strategy or method to be used, and who should facilitate on-going action. Identifying this step-wise approach and making it clear to the team is important, together with advocacy training. Formal government commitment to take over the project activities after its external funding has ended should be raised at a very early stage and efforts should continue to achieve a formal commitment before the end of the project.

- The development of the logical framework needs to be a process that allows for changing circumstances to be incorporated into a living project management tool. Project teams need to be supported to identify indicators that are appropriate measures of success and for these to be adapted at regular points throughout the project cycle.

- Developing strategic partnerships with the help of the twining society to strengthen midwifery as a profession and the capacity of midwives to teach, manage and lead is important and more support is likely to be needed to enable the MAP to take on a greater leadership role.

- There is a need to provide appropriate and on-going support to new cadres of community midwives who have the potential to increase coverage of Emergency Obstetric and Newborn Care (EmONC) in areas where services are currently unavailable.

1. INTRODUCTION

This end line evaluation assesses the achievements reached during the implementation of the "Community Based Interventions to Reduce Maternal and Perinatal Mortality and Morbidity in Rural Sindh Pakistan" from its inception in November 2006 till 2010.

Situated in the Thatta District of Sindh Province, Pakistan, the project is one of ten International Federation of Gynaecology and Obstetrics (FIGO) projects that are part of the "Saving Mothers and Newborns Initiative". Other participating countries are Haiti, Kenya, Kosovo, Moldova, Nigeria, Ukraine, Peru, Uganda and Uruguay.

The report is structured into the following sections (Box 1):

Box 1: Signposts for Report Sections

Section 2	Sets out the ***background*** to the Saving Mothers and Newborns Initiative
Section 3	Outlines the evaluation ***methodology***
Section 4	Summarises the ***project achievements***
Section 5	Summarises the ***project challenges***
Section 6	Reviews ***project management***, including relationships between FIGO and the Pakistani project team.
Section 7	Lists the ***lessons learnt***
Section 8	Provides the ***conclusion*** and ***recommendations***

2. BACKGROUND

2.1 FIGO

FIGO brings together professional societies of obstetricians and gynaecologists on a global basis in order to promote the well-being of women and their children and to raise standards of practice in obstetrics and gynaecology. The Saving Mothers and Newborns Initiative is the successor to FIGO's Save the Mothers Initiative.

The Saving Mothers and Newborns Initiative was launched in 2006 with the goal of reducing maternal and newborn morbidity and mortality, and to contribute to the achievement of Millennium Development Goals (MDG) 4 and 5 (Box 2).

Box 2: Millennium Development Goals

MDG 4: Between 1990 and 2015 reduce by two thirds the mortality rate among children under five.
MDG 5: Between 1990 and 2015 reduce by three quarters the maternal mortality ratio

The Initiative aims to build and sustain the capacity of obstetrics, gynaecology and midwifery societies in participating developing countries to conduct essential projects relevant to the promotion of safe motherhood and the improvement of neonatal health.

Two key features of the initiative are:

1) North-south partnerships through the establishment of twinning mechanisms between obstetrics, gynaecology and midwifery societies in developed and in the implementing countries.
2) Increasing women's access to new, cost-effective and evidence-based technology for the reduction of maternal and newborn mortality.

2.2 The Pakistan Context

Pakistan has a high maternal mortality ratio (276/ 100,000). When compared with 55 other low-income countries it ranks in the bottom five (5). Every 20 minutes, a Pakistani woman dies due to complications of pregnancy. Over 60% of newborn deaths occur within the first week of life. The majority of these maternal and newborn deaths occur at home.

The poor state of maternal and newborn care in Pakistan is primarily due to:

- Poor availability of, and access to, Basic and Comprehensive Emergency Obstetric and Newborn Care (Basic EmONC and Comprehensive EmONC)
- Poor community awareness regarding safe motherhood, newborn and child care
- Lack of skilled care/ human resources
- Social and economic barriers that make it difficult for poor women to make health changes
- Lack of continuing professional education such updating obstetricians and midwives' knowledge and skills in emergency obstetric care.

2.3 Saving Mothers and Newborns Project in Thatta District, Pakistan

Box 3 below sets out the Project Objectives:

Box 3: PROJECT OBJECTIVES & OUTPUTS

Project Goal:
To contribute to the reduction of maternal and perinatal mortality and morbidity in Thatta District.

Purpose:
To improve the provision of emergency obstetric and newborn care in the community and health care facilities in Thatta District

Output 1:
Effective 24/7 essential obstetric basic and comprehensive EmOC services established in the Project area

Output 2:
Increased awareness and demand in communities regarding maternal and child health care and survival especially awareness of pregnancy and related complications

Output 3:
Project data effectively used for making decisions and informing policy

Source: Project log frame

- The Project commenced in November 2006. Health facilities were chosen in consultation with the District Health Office and a Memorandum of Understanding (MoU) was signed between District Health, UNFPA and the Project team in February 2007. The initial MoU listed seven facilities to be upgraded over two Phases but the revised Project Proposal targeting three of the seven facilities was submitted to and approved by FIGO in May 2007. The reduction in facilities reflected the project team's perception of what they felt was achievable over the funding period.

- The project area is in District Thatta and in the sub-district Mirpur Sakro.[1] The approximate population covered by the project is 150,000. The growth rate is 2.2% and female literacy rate is 11%. The Project in Pakistan was implemented by the Society of Obstetricians and Gynaecologists of Pakistan (SOGP). The President of SOGP is Dr Sheershah Syed and General Secretary is Dr Aisha Nasir.

- **The Project mentor** was Dr Bo Möller from Sweden.

- **The twinning societies** were;
  The Swedish Association of Obstetrics and Gynaecology – contact person Dr Charlotta Grunewald; and The Swedish Association of Midwifery – contact person Dr Ingela Wiklund.

[1] Project documentation states that the project took place in two sub-districts in District Thatta. It has been confirmed, however, with the project team that the location of the project and the three facilities is in the sub-district Mirpur Sakro as well as in the main District Thatta itself.

- **Project Team (SOGP)**
  Manager: Dr Razia Korejo
  Coordinator: Dr Habib-Ur-Rehman Soomro
  Computer Operator: Mr Adeel Afzail
  Accountant: Mr Bashir
  Principal Investigator: Dr Shershah Syed

- **Partners**
  National Committee for Maternal and Neonatal Health (NCMNH)
  Midwifery Association of Pakistan (MAP)
  Pakistan Nurses Federation (PNF)
  Pakistan Medical Association (PMA)
  Pakistan Paediatric Association (PPA)
  WRLH Project of UNICEF
  UNFPA
  Health Department, Government of Sindh
  District Government, District Thatta
  Beneficiaries of training/Project activities
  Community members /Clients

- The Project is located in the office of the SOGP at Jinnah Postgraduate Medical Centre Karachi; one of the largest and most respected public health facilities in Pakistan. SOGP had the overall responsibility for implementation of the Project. Prof Shereen Bhutta (SOGP member and FIGO Safe Motherhood and Newborn Health Committee member) monitored progress against the work plan and provided support and encouragement as needed. The mentor, twinning societies and key partners related directly to the SOGP Secretariat and Project Team. The Project Team had direct responsibility for managing and implementing Project sites including project employed full-time staff.

  The project health facilities were:
  - Chari Wah Basic Health Unit (BHU)
  - Gharo Rural Health Centre (RHC)
  - Sheikh Zayed Medical Centre (SZMC)

3. EVALUATION METHOD

3.1 Process

- The evaluation took place in Pakistan from 22nd – 30th November 2010.

- Desk Review; The consultant reviewed project documentation provided by FIGO and the project team and spent time reviewing progress, achievements and challenges. The modified log-frame tool shared by the team was reviewed. Unfortunately the final project report was only received after the evaluation had been completed and the draft evaluation report received by FIGO. As a result it was not possible to review the final project report and incorporate any new information it contained within this evaluation report.

- *In Depth Interviews*; The evaluator met with members of SOGP, the Project Coordinator, and Project Manager (as a group and separately) to discuss:
    - Project activities
    - Project management
    - Project log-frame
    - Reporting
    - Communication
    - Roles and responsibilities

- *Focus Group Discussion;* A stakeholder meeting was held for discussion and feedback. Participation was encouraged at all times throughout the process.

- *Field Survey*; the consultant then visited the following sites with the country team
- Chari Wah Basic Health Unit (BHU)
- Gharo Rural Health Centre (RHC)
- Sheikh Zayed Medical Centre (SZMC)
- SOGP Office at Jinnah Postgraduate Medical Centre Karachi
- Communities: Chari Wah and Gharo

- The evaluator talked with the staff including chief of hospital, chief Obstetrician/Gynaecologist, paediatrician, midwives and women from the village (a list of interviewees is provided in Annex 1)

- *Interviews via e-mail*; the mentors in Sweden were approached through emails and a formal questionnaire provided by Options, and approved by FIGO, was sent to them for their feedback to better understand roles, responsibilities and lines of communication.

3.2 Tools

- Discussions and questions were guided by formats developed and provided by Options and FIGO for:
    - The Project Team
    - Twinning societies
    - Mentor
    - External stakeholder groups, and
    - Community.

4. PROJECT ACHIEVEMENTS

The results show that the Project team has been able to meet their objectives which aim to improve the availability of quality maternal and newborn health services in the Thatta District of Pakistan. The achievements are specified below.

4.1 Provision of quality EmONC Services in Thatta District

- The major achievement of the project has been the provision of basic and comprehensive EmONC services in the project area. This occurred through strengthening three Health facilities (Table 1).

Table 1. List of health facilities upgraded in the project area

Serial No	**Health Facility**	**EmNOC Level**
1	Sheikh Zayed Medical Centre	Comprehensive EmONC
2	RHC Gharo	Basic EmONC
3	BHU Ghari Wha	Ante and postnatal and newborn care and emergency referrals

- The infrastructure of the health facilities did not require major contributions from the project; however the operating theater and the labour room of Sheikh Zayed Medical Centre were renovated. The necessary equipment, furniture and supplies were provided by the project.

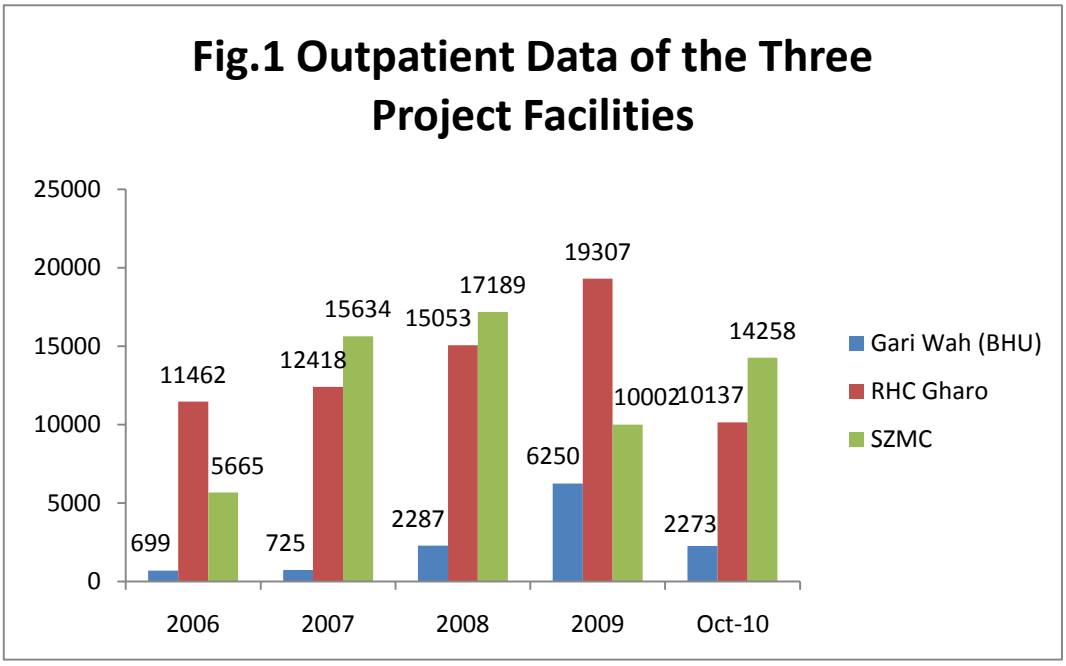
- Technical human resources were made available at the three facilities. These included contracting one doctor and one midwife at RHC for four years, together with one consultant gynaecologist contracted for six months to increase outpatient department capacity. One midwife was contracted for four years at BHU. Detailed information on the number of staff recruited at SZMC is provided in Table 2. Although total numbers of staff varied during the four years of the project, the core staff provided uninterrupted antenatal, postnatal and new born care.

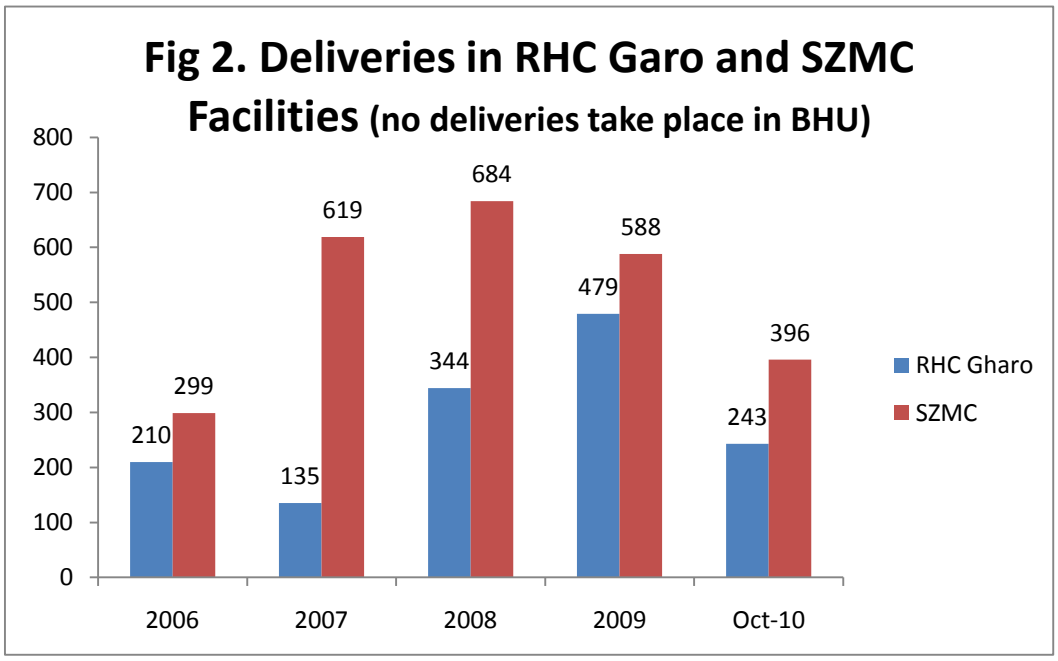
Table 2. Staff recruited at SZMC, Mirpur Sakro for Comprehensive EmNOC

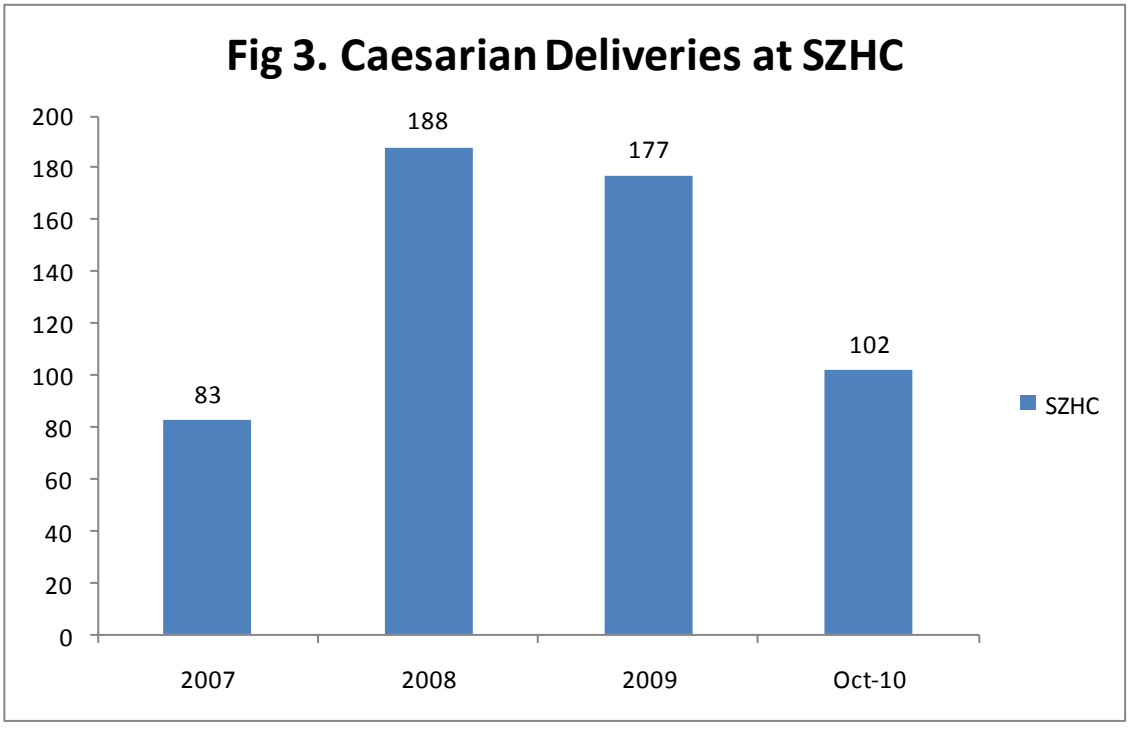
Staff Recruited	FIGO- SOGP	UNFPA	Government
Obstetrician	2	1 (withdrawn after one year as UNFPA narrowed its scope in this area).	1
WMO	2	1	
Anaesthetist	2		
Paediatrician	1		
Staff Nurse	1		1
Midwives	2		

Focal person	1		
Operating Theater technician	1		
Generator Operator	1		
Lady cleaner	1		
Total	14		

- The protocols for patient care are in use and displayed at all the three facilities. In spite of substantial baseline obstacles for all activities in Pakistan (see baseline report) the team managed to establish cooperation with the local (health) authorities and numerous UN and NGO actors in the area. Antenatal attendance, number of deliveries and number of caesarean-sections increased over time even though there were periods with great political tension in Pakistan and Sindh/Karachi (see Figures 1, 2 and 3).







- The utilization of the facilities increased substantially during the life of the project. The baseline data was very deficient and forceps, vacuum, Manual Vacuum Aspiration (MVA) and caesarean-sections were not being performed before the project. With improved documentation and the availability of services, the project has demonstrated increased utilization of the facilities. It is also heartening to note that life-saving obstetric surgeries like obstetric hysterectomy for post partum haemorrhage (PPH) and laparotomy for ruptured ectopic pregnancy is also being performed.

- Another indirect benefit of facility up-grading is utilization for general surgery as well as gynecological surgery.

Table 3. Objectively Verifiable Indicators for SZMC and RHC Facilities	**2006(Baseline)**	**2009**
No of maternal deaths	11	2
Perinatal Mortality Rate	88/1000	25.05/1000(Gharo) 22.10/1000(SZMC)
Delivery by vacuum extraction (No)	-	27
Delivery by forceps(NO)	-	13
Delivery by caesarean section%	-	10.3%
Post partum haemorrhage(No)	-	22
MVA (No)	-	33
Blood transfusion (No)	-	42

There was no evidence of uniject or temponade being used.

4.2 Clinical Supervision & Training

The training of all in-service staff involved in deliveries (e.g. midwives, doctors, and obstetricians) included antenatal, perinatal and postnatal care, first aid and basic EmONC and referral of mothers and newborns with complications. The Project has successfully initiated "on-the-job" clinical supervision and training of health service personnel. With support of local partners the following training has been completed:

- Infection Prevention (2 workshops) by the Pakistan Medical Association (PMA) at SZMC and at RHC Gharo
- 5 Orientation (7-day) workshops for 25 TBAs each by MAP at SZMC
- 2 Appreciative Inquiry Workshops by the Women's Right to Life and Health (WRLH) project at SZMC and RHC Gharo (Appreciative Inquiry is an organizational development process that engages individuals within an organizational system in its renewal, change and focused performance)
- 2 MVA workshops at Jinnah Postgraduate Medical Centre by NCMNH
- EmONC workshop of doctors by UNFPA
- Competency Based Trainings by PMA

4.3 Community Sensitization and liaising with Community Leaders

- Community awareness programmes were held periodically throughout the four years of the project. These programmes targeted both women and men within the community. These activities included community meetings, viewing a movie (Mamta ki hifazat), information, education and communication (IEC) materials e.g. leaflets and posters in local language and radio (FM98) transmissions that discussed the availability of 24 hour EmONC services, danger signs in pregnancy, and promoted the use of health care facilities. Other public health issues pertaining to pregnancy, childbirth and newborns were also included.

Box 4: Examples of increased uptake of services

"We are happy with the facilities in Gharo and I bring my daughter in law here". (Khaira Village woman and a mother in law)

"All of my eleven children were born at home but this time I chose the hospital as the midwife advised me to." (Shahida Village woman)

- The political leaders in the community were approached and involved in the process of community sensitization. This inculcated a sense of ownership in the local leaders. Through these channels it was possible to reach and get acceptance from the local communities and health workers.

- The increase in the awareness cannot be totally attributed to the project as the community workers called lady health workers (LHW) are also promoting the same messages as the project. Unfortunately no community survey was undertaken to quantify the level of change, however there is indirect evidence through increased attendance of pregnant women and their awareness of services provided. During interviews with village women, they were able to identify to the Options reviewer the LHW who had sent them to the facility. These women also expressed satisfaction of the up-graded services (a key project effort). The results do, however, demonstrate the impact that project efforts can have, especially when undertaken in conjunction with other initiatives e.g. LHW, which are also conveying the same message.

4.4 Sustainable Transport System

- Collaboration was established with the local Edhi ambulance welfare service to provide subsidized transport services (50% subsidy), for the patients needing referrals. This welfare service by Edhi will continue and is sustainable.

- Communities also used local self-hiring of transport to enable joint visits to the facility. Unfortunately no data exist to be able to ascertain the increased number of referrals resulting from improved transport systems.

4.5 Health Management Information System

- Prior to the project there was no system of record keeping in these health facilities and an HMIS was initiated by the project in all three health facilities with monthly reporting to the central office. However there was a lack of available staff within the project with the abilities and time to compile, analyze and report on the vast amount of data amassed (see Project Challenges below).

4.6 Training of TBAs and Confidence building

In collaboration with the Midwifery Association of Pakistan (MAP), training to improve knowledge and skills of TBAs was conducted (20-25 TBAs per group for seven days). TBAs were trained to provide misoprostol in the prevention of postpartum haemorrhage and were provided with delivery kits.

Box 5: Changing attitudes of TBAs

"Initially the TBAs were scared that they will be held responsible for the complication if they brought the complicated patients to the health facilities". (Dr Razia Korejo Project Director)

"'The project helped them get the credit for saving a life by bringing a woman to the facility timely". (Dr Habib Somroo Project Co-ordinator)

- TBAs were encouraged to bring women to the hospitals in case of danger signs and were offered a minimal financial incentive. There is anecdotal evidence (but no documentation) that this increased referral rates, particularly in the case of complicated deliveries, however, no data were collected by the project to enable this increase to be quantified. This

helped TBAs develop trust in the health facility where the doctors received these patients without being judgmental (Box 5).

- Refresher training sessions were also held. Unfortunately, due to lack of evaluation data it is not possible to assess the levels of knowledge and skills retention. The project team is highly appreciative of the co-operation of MAP in these activities.

4.7 Training of local Community Midwives

- Nine local women were identified and trained as midwives. They have started providing services in the area and on average deliver 20 patients a month. This initiative will go a long way in serving the community due to sustainability as far as the basic EmONC is concerned.

4.8 Cohesive Project team & partners

- The project team made strong links with other partners which added value to the success. UNFPA had provided support in human resource for the first eighteen months and conducted various EmONC trainings for the staff. MAP conducted the trainings of TBAs and PMA conducted various workshops for the health workers.

4.9 Summary of key project achievements

Upgrading of local facilities • One facility upgraded to Comprehensive EmONC • One facility upgraded to Basic EmONC • One facility upgraded for ante and postnatal and newborn care and emergency referrals	**Increased recruitment and training of staff** • A total of 17 staff recruited to ensure fully functioning Comprehensive EmONC services. • Nine local young women recruited and trained as midwives. • Local TBAs (approximately 100 in total) provided with training on when and why to refer women to health facilities.
Increased utilization of local facilities • Substantial increased utilization of facilities for routine deliveries. • Life-saving obstetric surgery such as obstetric hysterectomy for PPH and laparotomy for ruptured ectopic pregnancy being performed. • Increased utilization of facilities for general surgery as well as gynecological surgery.	**Increased community satisfaction with services provided** • Local women reporting increased satisfaction with services. • Increased willingness to deliver at facilities among women who previously used TBAs. • Men in the community showing greater acceptance of the need for facility-based deliveries and to train local young women as midwives.

5. PROJECT CHALLENGES

Whilst the project has made many significant achievements, it has also encountered challenges during its implementation phase. In some instances the project has been able to find creative solutions; other challenges however have been more difficult to overcome.

5.1 Sustainability

- The major challenge is the sustainability of the project. Since the human resources, drugs and supplies in the three health facilities were provided by the project, their sustainability needs resources and ownership. The increase in the utilization of services in the health centers is because of the availability of expert human resources and it is felt that with the end of the project the whole system might collapse. There has been no progress in finding the solution to this issue.

- The local team has tried to talk to the political leaders, government officials and international donors, but have not been promised any tangible solutions.

- This being said, SOGP has developed a proposal in October 2010 explaining the results achieved by the project team and the needs for 2011 and onwards. The proposal explains what should to be done to maintain the higher level of health services achieved, given the impacts of the flood in August 2010. Dr. André Lalonde, Executive Vice-President of the Society of Obstetricians and Gynaecologists of Canada (SOGC) strongly advocated for this project to UNFPA for their support.

5.2 Round the clock availability of human resources

- The government-sanctioned posts for obstetricians are still lying vacant. The probable reasons are mismanagement of human resources, complex hiring mechanisms of the government, low salaries, lack of quality education in the geographical area and lack of persistent demand (Box 6).

Box 6: Human Resource Challenges
"I have talked to the EDOs (Executive District Officer) and they promise as well but nothing has been done" (Chief of Hospital, when asked about demand for an obstetrician)

- The project obstetrician running the department for four years could have been absorbed into the government post, but there is no support from the government quarters yet. There is one obstetrician posted by the government, however she is not providing the surgical services needed for comprehensive EmNOC.

- Moreover, the recruitment also meant that salaries above the government rate were paid to newly employed staff. Such conditions create envy among regular staff; however it was not possible to recruit new staff at the government rates.

5.3 Availability of local women for midwifery training

- The project team had great difficulty convincing and enticing local women into training for midwifery as there was dearth of educated young women and the parents refused to send their daughters for the training. However the project was successful in training nine young women who are now providing services. The community is now more receptive to the idea as the women have earned respect and money.

Box 7: Recruiting local women as midwives
"My brother had a lot of resistance against my induction as a midwife but now he is very happy" (Local Midwife)

5.4 Security and Political Situation

- There were security issues for women staff living alone and it was difficult to hire and retain women staff for services. The political turmoil resulted in blocked roads and instability which affected the functioning of local midwives.

5.5 Floods and poor resources

- The floods not only devastated the local population, it shifted the focus of the government away from strengthening the health facility. Resources were reduced despite high demand (Box 8).

Box 8: Lack of local government commitment
"The government felt that since the project is taking care of these facilities, it should focus to other areas and hence neglected the facilities" (Prof Shereen Bhutta)

5.6 Advocacy and Government Commitment

- A lack of commitment from the government in the sustenance of the project cannot be ignored. There was strong resistance to the project in the beginning but with the continuous efforts of the project team, EDOs were involved and a working relationship was established. There was a rapid changeover of the local EDOs, which did not help the advocacy process.

- While talking to the government MNCH representative the evaluator felt that the possible avenues of funding have not been pushed for as strongly as they might have been; the government is also too slow to respond. When asked whether when making the annual plan, MNCH can get funding allocation from UNFPA, the answer was "yes we can do that". There is, therefore, a need for a strong advocacy process when engaging with government.

5.7 Poor Local Baseline Data and Log Frame

- The indicators initially developed in the project were modified as local data on key indicators were either not available or were not accurate due to poor reporting mechanisms (Box 9). This created difficulty in calculating the MMR or PMR and the filling of the initial log frame and hence the indicators had to be modified.

Box 9: Poor Baseline data
"The LHW data showed no death in the area whereas I had confirmed evidence of a local maternal death in year 2007" (Dr Habib Somroo project Co-ordinator)

5.8 Involvement of the Midwifery Association of Pakistan

- The President of the midwifery association of Pakistan has been very supportive of the project and attended various meetings. The TBA training was also conducted by the MAP. However it was felt by the mentors and MAP that a deeper involvement of midwives is needed in the planning, implementation and evaluation of the project (Box 10).

Box 10: Need to encourage greater involvement by midwives

"'The MAP is actually a one woman show. Midwives are scared of voicing themselves" (Imtiaz Kamal President of MAP)

6. PROJECT MANAGEMENT

6.1 Project Team

- The project team has worked passionately for the project. The Pakistan team comprised of senior, capable professionals and who were passionate about maternal and child health.

- Team members were able to provide documentation and evidence in support of the annual reports even though the computer and IT services in the Centre are not up to the mark.

- With financial record keeping and reporting the Project has been diligent in ensuring all funds are being accounted for.

6.2 The Log Frame

- The Project Team found the log frame activity confusing and difficult, though they were helped by the twining society during their visits. This resulted in frequent changes in the log frame and its indicators.

6.3 Relationship with FIGO team

- The FIGO coordinating office in London was in contact with the project team/ mentors through e-mails. The communication was mostly general clarifying the scope of the projects and the limits for funding. The frequent change of the co-ordinators at FIGO was considered disappointing by the mentors as they hardly had started to get connected to the various teams, mentors and twinning partners before they were replaced. Intended field visits never took place due to difficulties in obtaining visas and other challenges.

6.4 Twining Mentors and Twinning Society

- The project team felt that the involvement of the twinned society was useful and a strong professionally supportive relationship was formed between the Project Director and mentors from Sweden. The role of the international mentors has been widely appreciated by the project team who gained from their experience and guidance.

- The team made 4 visits to the project area over the four year period. They took part in the reports and gave their points of view when visiting Pakistan as well as by e-mail. The progress reports were discussed, and the project sites in the Thatta region of Sindh were visited to see how the project evolved. Due to limited financial resources and the security situation in the country mentors were not able to participate in the training of midwives, and could not give feedback about the quality of the training, standards and quality.

- The twining society participated in the initial meeting in London where they had talks with Pakistani partners and a considerable amount of time was spent on logframe formatting issues. In an attempt to be able to have a uniform format Options instructed the teams on how to use their log frames.

- The twinning society had written two editorials in Acta Obstet Gynecol Scand, and also various reports in the SFOG bulletin.

- The Nordic Federation (NFOG) had given support to the twinning-project by financing the participation to the FIGO world congress in Cape Town to two Obstetricians from Pakistan. Dr Shershah Syed was invited by the SFOG to participate in the annual national SFOG conference in Sweden 2008.

- The role of the mentors as described by FIGO was considered to be vague from the onset and some of the mentors felt that they had not been able to contribute substantially to this project.

7. LESSONS LEARNT

7.1 For FIGO

- Advocacy training for the project team to address the sustainability issues could have been useful. Effective advocacy has an important part to play in strengthening opportunities for both financial sustainability of projects but also in ensuring that important findings are disseminated to key stakeholders including policy makers. Few health professionals, however, have any formal training in advocacy and have limited time to engage in advocacy efforts. For example, the SOGP members as well as the Project Director were busy practitioners with little time to give to concerted advocacy efforts. Strengthening their skills in this area would increase the likelihood of optimising what can be achieved with limited resources and time.

- The development of the logical framework should be in line with the local situation and should allow for changing circumstances to be incorporated into a living project management tool. Project teams need to be supported to identify indicators that are appropriate measures of success and for these to be adapted at regular points throughout the project cycle.

- Twinning is a successful support mechanism, but deeper involvement to suggest solutions and provide training is needed. The extent to which the twinning societies and mentor are able to provide support is limited by time and distance.

- Development and support of MAP to enhance the leadership and training capabilities of midwives, and their involvement in the training of local midwives can go a long way in achieving the MDG targets.

7.2 For the Project Team

- There is a need to explore possible national avenues of funding support initiatives beyond the period of FIGO funding. This activity should be written into project activity annual plans.

- Routine data collection at regular intervals during the life time of the project is essential in order to be able to demonstrate progress towards achieving the outputs and outcomes of the project.

- It is extremely important to inculcate mechanisms from the start that lead to sustainability of the projects. The interventions which are sustainable should be given more importance and weight.

8. CONCLUSIONS

- The project managed to achieve the main objectives of increasing services and awareness within the local community. There is no doubt about the increased availability and utilization of comprehensive and basic EmNOC as well as the ante and postnatal care, newborn care and emergency referrals services at the three facilities. Community awareness has also increased and ambulance services are both available and improved. A long term benefit of the project is the availability of the community midwives for basic and emergency EmNOC. On-the-job clinical supervision and training of health service providers was done. Unfortunately no formal evaluation of changes to the quality of care provided was undertaken, however, health workers reported anecdotally that this had improved. A facility based health management information system is in place and data is being collected and submitted to the local District Health Office.

- The challenges have been many, sustainability being the major one, as there is no formal commitment from the government or international donors. UNFPA had initially co-ordinated and provided some human resource, but decided to move out in the early years of the project. The difficulty in finding local women for midwifery, the engagement of politicians, and poor baseline data were some other challenges which were faced. While the issue of sustainability was not resolved, and the poor level of baseline data meant that many project outcomes were difficult to quantify, the project team managed to successfully address many other important challenges such as community attitudes to young women training as midwives.

- Lessons can be learnt from the project particularly with regards to providing support to develop mechanisms for sustainability. However, overall, this FIGO project has made substantial progress towards improving the quality of obstetric care in Thatta District of Pakistan.

9. RECOMMENDATIONS

9.1 For FIGO

- The Midwifery Association of Pakistan is young and needs to build its capacity in training and leadership, for which leadership and technical training should be organized for this organization. The younger cadre should be encouraged to become involved in MAP activities and increase their capacity as future leaders of midwifery in Pakistan.

- Seeking government commitment at the start of the project for sustainability is vital and project teams should be supported to do so. There are local examples of maternal health projects where memorandum of understanding with the government included retention and absorption of human resources in the government system (Pride project in Mansehra and Bagh, Azad Jamu and Kashmir, Pakistan)

- Provision of advocacy training for team members would support efforts to ensure financial sustainability for the project and enable stakeholders, including government, to be informed about the achievements of the project.

- FIGO should engage with project teams to ensure awareness that project funds that are spent on drug purchases should comply with WHO recommendations.

- The concept of twinning (i.e. mutual strengthening by sharing ideas and competences between professional organisations) is good and it is viewed that strong professional organisations are crucial for improvements in reproductive health. Some of the mentors, however, felt that they had not been able to contribute substantially to this project through capacity strengthening and training. Greater emphasis should be placed in supporting effective twinning and optimising the value to be gained from mentoring visits and on-going communication between mentors and the project team.

9.2 For the Project Team

- Quality training and investment in the new cadre of community midwives will ensure easier access and availability of basic and emergency obstetric services.

- A focussed, targeted and persistent approach is needed for advocacy with the government.

- Midwives should be fully involved in the planning, implementation and evaluation of the project.

Annex 1: Interviewees

Project Role	Name / Position	Title	Country
Mentor	Dr Bo Möller	Swedish Society of Obstetrics & Gynaecology	Sweden
Midwife mentors	Dr Charlotta Grunewald	President, Swedish Society of Obstetric & Gynaecology (SFOG)*	Sweden
	Ms Anna Nordfjell	President, Swedish Association of Midwives (SMA)	Sweden
	Ms Ingela Wiklund	Member, Swedish Association of Midwives	Sweden
26th-29th Nov 2010 Pakistan			
Project Manager	Ms Razia Korejo	Project Manager	Pakistan
Project Coordinator	Dr Habib Soomro	Project Coordinator	Pakistan
Collaborating Partner	Prof Sadiqa Jaffery	President NCMNH	Pakistan
Stakeholder	Prof Shireen Bhutta	Vice President , Sindh SOGP	Pakistan
Stake holder	Dr Nighat Shah	General secretary SOGP	Pakistan
Stake holdr	Dr Rukhsana	SOGP	Pakistan
Stakeholder	Dr Mohammad Yakoob Khushk	Medical Supretendant, SZMC	Pakistan
Project team	Dr Murad Baloch	Focal Person	Pakistan
Stakeholder	Dr Rehana Yaseen	WMO, FIGO, RHC, Tharo	Pakistan
Trainer / Obstetrician	Dr Shugafta Khero	Consultant Gynaecologist	Pakistan
Trainer/Obstetrician	Dr Almas Fatimah	Consultant Gynaecologist	Pakistan
Anaesthetist	Dr Ayaz Hussain	Anaesthetist	Pakistan
Paediatrician	Dr Jhamandas	Paediatrician	Pakistan
Beneficiaries	Ms Anum Sarfraz	CMW	Pakistan
Beneficiaries	Ms Sughra M. Ilyas	CMW	Pakistan
Beneficiaries	Ms Tehmina Alludin	CMW	Pakistan
Beneficiaries	Ms Rehana Abid Majid	CMW	Pakistan
Beneficiaries	Ms Rozina Sakro	Staff Nurse	Pakistan
Beneficiaries	Ms Fareha Salongi	LHV/ midwife	Pakistan
Beneficiaries	Ms Samina Moiz	LHV/ midwife	Pakistan
Beneficiaries	Ms Rehana Amin	LHV/ midwife	Pakistan
Beneficiaries	Yasmeen	Village woman	Pakistan
Beneficiaries	khaira	Village woman	Pakistan
Beneficiaries	shahida	Village woman	Pakistan
Stakeholder	Imtiaz kamal	President Midwifery association of Pakistan(MAP)	Pakistan
Government Stakeholder	Sahib Jan	MNCH program manager Sindh	Pakistan

Annex 2

Community Based Interventions to Reduce Maternal and Perinatal Mortality and Morbidity in Thatta District of Sindh, Pakistan
July 2006 - June 2010
Society of Obstetricians and Gynaecologists of Pakistan

Dr. Razia Korejo, Research Manager
E-mail: razia_korejo2000@yahoo.co.in. If difficult to reach, send e-mail to Shereen Bhutta shereen_bhutta@yahoo.com

LOGICAL FRAMEWORK

OBJECTIVES	OVI – objectively verifiable indicators (process and outcome)	MOV – means of verification	Important Risks/Assumptions
GOAL To contribute to the reduction of maternal and perinatal mortality and morbidity in Taluka Mir Pur Sakro of Thatta district.	Functional services for Basic EmONC (in RHC Gharo), and comprehensive EmNOC (in tertiary care Shaikh Zayed Medical Center Mir Pur Sakro), and for referrals and antenatal care (in BHU Ghari wah) available in catchments area of Taluka Mir Pur Sakro of Thatta District by the project.	1. Post-project Evaluation Report (Comparison with initial needs assessment) 2. Number & distribution of Basic and CEmONC services / population 3. proportion of all births in Basic and CEmONC facilities 4. Number of C/S as a percentage of all births in population 5. Signal Function of EmONC 6. Annual narrative reports	

PURPOSE To improve provision of emergency obstetric and newborn care in the community and health care facilities in Thaluka Mir Pur Sakro of Thatta District.	1. Three facilities (one BHU, one RHC, and a Tertiary Facility) are staffed with qualified and trained health providers [3 midwives (one in BHU and two in Tertiary) and 1 Staff Nurse & 2 Obstetricians (in Tertiary), and 1 LMO (in RHC) and 1 lady RMO round the clock, and 1 Pediatrician (in Tertiary)]; and have necessary equipment and supplies to provide basic EmONC (RHC), and comprehensive EmONC (in tertiary facility), and antenatal care /referrals (in BHU). 2. 10% increase in number of cases delivered in each facility each year (2007, 2008, 2009, 2010)	1. Annual narrative reports 2. Facility Upgradation Report incorporating list of equipments/supplies provided (comparison with initial facility needs assessment report). 3. Training Workshop reports for SBAs at facility 4. Orientation Training Workshop reports for clean and safe delivery for TBAs 5. Facility service statistics 6. Scientific publications based on data collected	1. Provided the communities remain intact and are willing to be part of the scheme. 2. That the health care facilities and care giver are still running and ready to be part of the project.

OUTPUT 1 Effective 24/7 essential obstetric, and basic and comprehensive EmOC services established in the project area	1.1 By the end of first year, one facility is providing Basic, and one facility is providing comprehensive EmONC services to communities in the catchments area 1.2 Over all Increase in antenatal clinic visit 1.3 10% increase in number of women using essential obstetric or EmOC services reporting being satisfied with the service 1.4 By the end of project, 10 trained community midwives are working effectively in the community and are able to correctly report warning signs of eclampsia	1.1 Signal function of EmONC 1.2 Facility readiness reports 1.3. Health facilities' data - Number of pregnant women booked. - Number of deliveries conducted - Number of complicated cases received - Number of C/S performed 1.2.1 ANC Register 1.3.1 Client exit interview/ facility users' satisfaction survey (successive comparison) 1.4.1 Midwives' Training Assessment Report 1.4.2 KAP of trained midwives	1. The health care systems will continue to function

OUTPUT 2 Increased awareness and demand in communities regarding maternal and child health care and survival, especially awareness of pregnancy related complications	2.1. By the end of project, 1,000 women trained to recognize danger signs in pregnancy and labor 2.2. One thousand (1,000) mothers trained to provide basic newborn care to their children	2.1.1 Reports on the community awareness raising sessions/workshops (successive comparison)	2. The target groups are willing to adopt new habits in respect of health seeking behavior in pregnancy, labor and delivery
OUTPUT 3 Project data is effectively used for making decisions and informing policy.	3.1. Periodic HMIS Reports are used in decision making and performance monitoring	3.1.1 HMIS Reports 3.1.2 Yearly report from EDO Office	

ACTIVITIES: 1.1 Conduct needs assessment survey at the start of project 1.2 Hold one appreciative inquiry and on-site infection prevention workshops per facility every year	Deliverables Facility up gradation report. Workshop Report per facility Facility Status Report		

1.3 Conduct facility readiness exercise in each facility every Year 1.4 Purchase of necessary equipment in Year 1	List of Equipment purchased		
ACTIVITIES: 2.1 Ten (10) Community Sensitization Meetings in Year 1, and six (6) meetings in Year 2 and Year 3 each, and two (2) meetings in year 4 2.2 Two (2) Community socio-cultural enlightenment activities such as theater Plays, puppet shows, interactive theater and film shows every year 2.3 Production and dissemination of IEC Materials in Sindhi	Community Meeting Reports Activity/Event Report List of IEC Material disseminated		
ACTIVITIES: 3.1 Training of 10local women as community midwifes by the end of project	Training Assessment Report		

ACTIVITIES: 4.1 One CBT (Competency based training) of skilled births attendants in safe delivery, basic newborn resuscitation, and appropriate after-care every year in all three facilities	CBT Assessment Report		
ACTIVITIES: 5.1 Training of staff in using and updating health management information system	Training Report		
ACTIVITIES: 6.1 One annual workshop with key stakeholders to share lessons learned	Workshop Proceedings/Report		
INPUTS **Human Resources** 1 Project Manager – Full Time 1 Project Coordinator – Full Time 1 OBGY Consultant – Full Time (also on call in night) 3 Lady Medical Officer – Full Time for three shifts on rotation 4 Midwives – Full Time for three shifts on rotation.	**Cost/ Resources** US$ 64,000 77,540 29,234 104,486 86,000 63,760 US$ 425,020		

1 Staff Nurse – Full Time (also on call in night) 1 Focal Person – Full Time (at SZMC Mirpursakro) 1 Computer Operator – Full Time 1 Accountant – Full Time 1 Anesthetist – On SOS call 1 OT Technician – On SOS call … **Project Office Support** 1 Computer 2 Printers 1 Fax Machine 1 Scanner 1 USB 1 UPS 1 Digital Camera 1 Telephone 1 Water Dispenser 1 Split AC Furniture … **Equipment & Supplies** Multi-parameter Monitors Diathermy Oxygen Cylinders Supporting Surgical Instruments Anesthetic Drugs Repair/Maintenance of OT Machines **Local Workshops and IEC**			

Orientation Workshop for TBAs Community Sensitization/ Mobilization/ awareness workshops/Seminars IEC Material in Sindhi **Local M&E** One fulltime focal person for monitoring and evolution **FIGO Admin. Fee**			