MID TERM REVIEW
IMPROVED SEXUAL AND REPRODUCTIVE HEALTH STATUS OF WOMEN, MEN, YOUTH AND ADOLESCENTS IN PAKISTAN

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The European Commission (EC) and Balochistan Rural Support Programme (BRSP) co-financed project "Improved Sexual and Reproductive Health Status of Women, Men, Youth and Adolescents in Pakistan" is being implemented by BRSP in Pishin and Mastung districts of Balochistan. The 42-months project started on 1st January 2009 and will end on 1st July 2012. The total anticipated cost of the project is €1,111,111 out of which €1,000,000 (90%) is financed by the European Commission and the remaining €111,111 (10%) is financed by BRSP.

The overall objective of the project is to improve the reproductive health status and overall well-being of women, men, youth and adolescents in Balochistan Province. Specific Objectives of the project are: 1) to mobilize the communities for increased demand of and use of reproductive health services, including ante-natal and post-natal care, family planning services, STI management, safe delivery practices and referral of complicated pregnancies and deliveries through Community Organizations (COs), Lady Health Workers (LHWs), TBAs and Community Health Educators (CHEs), and 2) to strengthen governance and management of health sector by expanding and improving the quality and accessibility of emergency obstetric care (EmOC), RH services, Adolescent RH services and family planning services within Government health facilities: two Tehsil Headquarters (THQ) Hospital, and six Rural Health Centres (RHCs).

This Mid-term Review of the Project was commissioned with an overall objective to assess the relevance and progress of the intervention and efficiency of the approaches and resources used towards the achievement of estimated results and to contribute towards improving the approaches, pace and effectiveness of the project interventions. More specifically, the MTR was undertaken to: take stock of current program activities, problems and opportunities; verify the continued relevance and pertinence of the project as well as the related sustainability; identify the necessary adjustments, if any, in project design, objectives, strategies and implementation arrangements in consideration of the implementation environment, make recommendations on how to improve performance of the project, and to identify areas which the program management should pay specific attention to in order to achieve project objectives. The evaluation was mandated to focus the **DAC evaluation criteria of Relevance, Effectiveness, Efficiency, Sustainability and Impact.** Given the stage of the project at mid-term the focus of the review was in particular on effectiveness of the project and its various components. The review further looks at process issues, including project management.

Relevance: The project, with all good intentions, has special significance to the people of the area owing to prevalent low level of health and socio-economic indicators such as high maternal mortality, poverty, illiteracy and low status accorded to women and girl child. The relevance of the intervention stems from a logical and convincing problem analysis and is anticipated to contribute to addressing the needs and constraints of the target groups and the final beneficiaries. The emphasis of the project on targeting poor communities in rural areas that lack access to basic social services is coherent with strategic objectives for poverty alleviation. Therefore, the project subscribed to national and the European Commission's goals for poverty reduction.

The project continues to be highly relevant to the Government of Pakistan's objective of poverty reduction and the maternal and child health and HIV/AIDS MDGs. The project compliments the GoP's aims of Health Sector Strategy to improve the quality of health and population services provision. Similarly the project supports the objectives of the Population Policy of Pakistan in its goals and strategies. The project also works towards the objectives expressed in the Pakistan Poverty Reduction Strategy Paper and the European Commission's 2007-2013 Country Strategy Paper for

Pakistan, and the objectives and priorities of the Call for Proposals under which this project was awarded.

The achievements of the project so far indicate that the project is well designed and despite implementation issues due to exogenous factors responds to the needs and constraints of the target groups and its ultimate beneficiaries. The design has sound vertical and horizontal intervention logic and the objectives and the range of its pro-poor activities to address the needs of beneficiaries are highly relevant to the RH needs of beneficiaries exemplified by the range of dire social indicators. The results framework of the project needs to be reviewed to look into the relevance and measurability of some of the indicators.

Effectiveness: The project is anticipated to contribute to its overall objective to a greater extent. Given the short time span of the project, extremely fragile and volatile operating environment, and above all, the difficult intervention theme and context, the project's contribution are expected to lead to increased accessibility to, and utilisation of affordable, high quality S&RH services and information among underserved and marginalized people of the targeted areas. The project's completed, ongoing and planned processes are expected to make a modification towards positive health seeking behaviours. Availability of staff (with some exceptions), equipment and supplies is leading to an increased utilization of health services. However, BCC activities need to be implemented more strategically.

The project M&E systems need to be strengthened to shift its focus to analysis and use of output and outcome data to assist in strategic decisions, rather than tracking activities. There is also a need for more in-depth analysis of data for informed planning. Though the project has three levels of indicators (outcome, output, and activity level), it primarily uses activity data for monitoring progress and reporting. The team believes that too much emphasis has been put on monitoring activities without sufficient analysis of output and outcome data to strategically guide the program. Coordination and communication internally within project staff and BRSP, and between BRSP and the Department of Health needs improvement. High staff turnover is an on-going problem and BRSP management needs to respond to this issue in consultation with the Balochistan Department of Health.

Efficiency: In general, the project is on track in successfully, efficiently and economically converting the resources/inputs (funds, expertise, time, etc) to outcomes/results. Despite a number of challenges including extremely fragile and volatile operating environment, high staff turnover and above all, the difficult intervention theme and context, the project is assessed to be able complete the anticipated processes. It is anticipated that most of the planned targets will be met. The project management need to have alternate strategies ready and implied efficiently to tackle with any unforeseen situation in the aftermath of the security situations. The M&E system and the reporting mechanism is in place, however, in general, the aspects of analytical depth and reporting on outputs and impact need to be strengthened. In addition, the project needs to put in place systems for seeking feedback from target groups and stakeholders to inform planning processes. Sharing of the findings of monitoring and evaluation exercises, and periodic reports with different stakeholders including the Department of Health and other organisations could foster support for the project and will lead to improved communications and coordination. The role of the DAGs and the PAB shall be transformed into a more strategic role.

Impact and Sustainability: The project aims to increase utilisation of affordable, high quality and sustainable maternal and reproductive health services among low-income socio-economic groups in the two targeted districts of Balochistan. Interventions based on identified unmet need and coherency

with national and international health strategies in Pakistan are being undertaken to improve the Reproductive Health status and overall well being of women, men, youth and adolescents in Balochistan Province. An increased number of deliveries are being attended by a skilled provider resulting in safer births. Since complications are often not predictable in advance, and since roughly 15% of deliveries have some complication, centre-based births with a skilled provider on hand are much safer. During FGDs with beneficiaries, stakeholders, service providers, and project management, and from the monitoring data available to the MTR Team, it is concluded that there has been increased attendance by women at three ante-natal visits that has allowed for an increased detection of some early warning signs that are detectable in advance, such as raised blood pressure that has assisted in screening high risk women for delivery in a hospital. As a result of project interventions awareness of family planning methods along with CPR in the targeted areas have increased resulting in reduction in absolute number of pregnancies and therefore reduction in absolute numbers of pregnancy related complications. In particular, use of family planning reduces the number of unwanted pregnancies, which carry even higher risk given the prevalence of recourse to induced abortions that are often unsafe. The services utilisation trend in the targeted areas has gradually increased which also includes treatment of incomplete abortion or miscarriage that reduces the risk of death or injury through complications such as infection or haemorrhage.

Benefits are being diffused to community, village and household level. Lower incidence of complicated deliveries and the resulting deaths from improved and continuous services and improved maternal and child health by use of trained service providers (including TBAs) is seen by the stakeholders as positively impacting on sustainable livelihoods.

While the disseminated information has enabled the women to make informed choices, the affordable services via clinic services and mobile outreach services have increased their access to quality services. It was assessed that enabling women in the target areas to improve their SRH and health, had positively impacted the capacity they then have to contribute to their productive and community roles.

The GoP has made a commitment to provide SRH services to the citizens of Pakistan. However, the overburdened and under-funded Pakistani public health system is incapable to adequately respond to the SRH needs of the population, especially those living in remote rural locations, for whom there is consequently high opportunity costs to seeking services to improve their SRH. This is particularly relevant for the populations of the target areas. Through this project the need for SRH service and information provision among these groups has been accepted by community and gatekeepers. This in turn has enabled BRSP and other service providers' access to these communities through mobile outreach services. By bringing the services and information to them, this project is contributing to helping direct beneficiaries help themselves out of poverty and to ensure that they are not excluded from experiencing a better quality of life due to their location.

The project approach to build links and local capacity over a long period of time is expected to lead to more sustainable outputs. The creation of networks and community-based oversight and advocacy structures can increase the potential sustainability of community groups and their initiatives, as well as specific outcomes for capacity building. The CBOs/VDOs/LSOs, established under the project, are gaining improved capacity for self- help and to undertake local advocacy and development initiatives to address the needs of their respective communities. Yet, social and political constraints can mitigate that potential. This is part of a wider process to create an enabling environment for civil society and influence the policy dialogue on the development scene. Activities under the project and the strengthening of such institutions shall improve the capacity of communities and other stakeholders to contribute to social sector development and the social transformation process, albeit

in the long-term. Involvement of all stakeholders in implementation is more likely to sustain project outputs. Nonetheless, the MTR recommends that capacity building efforts need to be focused and further consolidated and that inter-linkages among similar structures in other areas could be useful.

Chapter 1
Introduction

Background

BRSP in partnership with Government of Balochistan- Department of Health is implementing the European Commission co-financed project "Improved Sexual and Reproductive Health Status of Women, Men, Youth and Adolescents in Pakistan" since 1st January 2009. This project was awarded to BRSP through a competitive Call for Proposals process under the European Commission's "Non-state Actors and Local Authorities (Actions in Pakistan) Thematic Budget Line. NSA-LA Thematic Programme falls within the general framework of the European Union's (EU) commitment to combating poverty and promoting the rule of law and adherence to fundamental freedoms set out in Article 177 (former Article 130u) of the European Community Treaty. The project objectives are in line with the principal aims of the Millennium Development Goals (MDGs). The project also seeks to tackle some of the major goals for maternal health that are outlined in the Pakistan Poverty Reduction Strategy such as lowering of maternal mortality, decreasing fertility in the coverage area of village based Lady Health Worker. The project is also consistent with the European Commission's (EC) three Programme Objectives as outlined in Regulation No 1567/2003: 1) Secure the right of women, men and adolescents to good reproductive and sexual health: 2) Enable women, men and adolescents to have access to a comprehensive range of safe and reliable reproductive and sexual health care services and products: and 3) Improve access of women to basic and comprehensive essential/emergency obstetric care, including skilled birth attendants, and thereby, in the long run, contribute to a reduction of maternal mortality rates in countries and populations where these are highest.

The project addresses the EC's objective of poverty reduction. Good health is both an end and a means to reducing poverty. Illness causes suffering and pain, which poor people identify as a key aspect of being poor. Perhaps the largest cost is when a household income earner or economic contributor is unable to pursue his or her livelihood. Illness or death of a family member also causes poverty through loss of the income-earning capacity of the deceased. This lost income and associated cost of treatment can push people further into poverty. Poor households often build up debts, sell land, or reduce spending on other items to pay for health care. For those who lack material and other productive assets, labour power and a healthy body are the core components of their livelihood and even survival strategy.

The project is also in line with the EC's policies on RH and the goals outlined in the 1994 International Conference on Population and Development's (ICPD) "Programme of Action" (specifically: decreasing maternal mortality and; improving universal access to a full range of reproductive and sexual health services including FP) and the new benchmarks set out during the ICPD+5 session in 1999 (specifically the need for greater urgency in: improving reproductive health care and unmet need for contraception; reducing maternal mortality; and reducing HIV/AIDS). The proposed interventions will be implemented according to the recently established National Maternal, Newborn and Child Health (MNCH) Programme's policies/frameworks to address gaps in RH and safe motherhood. The Government of Pakistan (GoP) is signatory to the Millennium Development Goals (MDGs); therefore the proposed Action will help the GoP in undertaking their responsibilities towards achievement of the MDGs, specifically: promoting gender equality (goal 3); improving maternal health (goal 5); and preventing the spread of HIV/AIDS (goal 6).

The **overall objective** of the project is to improve the Reproductive Health status and overall well being of women, men, youth and adolescents in Balochistan Province. **Specific Objectives** of the project are: 1) to mobilize the communities for increased demand of and use of reproductive health services, including ante-natal and post-natal care, family planning services, STI management, safe delivery practices and referral of complicated pregnancies and deliveries through Community Organizations (COs), Lady Health Workers (LHWs), TBAs and Community Health Educators (CHEs), and 2) to strengthen governance and management of health sector by expanding and improving the quality and accessibility of emergency obstetric care (EmOC), RH services, Adolescent RH services and family planning services within Government health facilities: two Tehsil Headquarters (THQ) Hospital, and 6 Rural Health Centres (RHCs).

The project rationale is based on the locally established needs and constraints of the most vulnerable populations. BRSP initiated this project on the basis of local knowledge of the persistent high unmet SRH need within the target groups/areas. Degree of vulnerability and marginalized status through unmet need for SRH services and information directed the selection of the direct beneficiaries, whilst the capacity building and information needs of indirect beneficiaries directed their selection. The reasons and criteria used included incidence of poverty, lack of technical capacity, access to SRH services, information and skills, and gender analyses. The populations of Pishin and Mastung in general are targeted because the incidence of poverty in these areas is extensive and pervasive. The populations are underdeveloped with low literacy rates and poor SRH status. The target areas in Pishin and Mastung were selected because of their low safe motherhood indicators and poor availability of services. This intervention is anticipated to address the identified gaps in both the supply and demand for RH services, such as: inadequately equipped and functioning 24/7 EmOC facilities; weak referral systems; poor access to EmOC services; poor Health Service Providers' knowledge of modern contraceptive methods, safe sex promotion, STIs and HIV/AIDS transmission; limited access to safe blood transfusions; absence of addressing GBV; lack of male involvement in RH issues; limited decision-making power of women; lack of adolescent RH services; lack of infection prevention protocols; and low community awareness of RH services.

Description of the Project

The overall objective of the project is to improve the Reproductive Health status and overall well-being of women, men, youth and adolescents in Balochistan Province.

BRSP is working in direct partnership with the Government of Balochistan to upgrade eight government owned facilities in Pishin and Mastung districts. These facilities include two District Head Quarter Hospitals (DHQs) and six Rural Health Centres/Basic Health Units (RHCs/BHUs). Capacity building intervention both for the services providers and community-based structures (CBOs/VDOs/LSOs), and awareness raising and social mobilisation interventions are also being implemented. Strengthening of the RH services in 2 target districts is expected to enable 8 government health facilities to offer quality RH services, including B-EmOC. Out of the identified 8 health facilities, 2 government referral hospitals are being strengthened to provide quality C-EmOC services, HIV VCT services and safe blood transfusions.

Expected Results:

1. Community Mobilization at the village level carried out through COs (Community Organizations), LSOs (local Support Organizations) resulting in increased community awareness about RH issues including maternal/neonatal health and family planning issues, HIV/AIDS, STIs, GBV and improved health seeking behaviours at the time of delivery.

2. A new cadre of Community Health Educators (CHEs) and also the existing LHWs identified, trained on RH issues including STIs, HIV/AIDS, GBV, FP, Adolescent and Youth Issues, sexual harassment and the Counselling and Communication and working in the project area to provide community-based awareness about RH, and facilitate referral.
3. Increased support of the government for the project interventions at district and provincial level
4. Management capacity of district health managers enhanced through providing them necessary equipment and training in health system analysis, quality of care, planning, monitoring and evaluation.
5. Accessibility and availability of RH services including comprehensive family planning services, surgical contraception, STI management, HIV/AIDS testing Emergency Obstetric Care services within government health facilities in the project area with: 24l7 Comprehensive EmOC facility at the two THQ Hospitals and 24/7Basic EmOC facilities in 6 RHCs in the project area
6. Referral system for FP, STI Management, HIV/AIDS Testing and EmOC developed and strengthened
7. TBAs identified, trained in danger signs recognition, use of clean delivery kits, infection prevention and referral of complicated pregnancies and deliveries for facility-based care.

Objectives of the Evaluation

This Mid-term Review of the Project was commissioned with an overall objective to assess the relevance and progress of the intervention and efficiency of the approaches and resources used towards the achievement of estimated results and to contribute towards improving the approaches, pace and effectiveness of the project interventions. More specifically, the MTR was undertaken to: take stock of current program activities, problems and opportunities; verify the continued relevance and pertinence of the project as well as the related sustainability; identify the necessary adjustments, if any, in project design, objectives, strategies and implementation arrangements in consideration of the implementation environment, make recommendations on how to improve performance of the project, and to identify areas which the program management should pay specific attention to in order to achieve project objectives.

Evaluation Methodology

The propose evaluation methodology encompassed an analysis of the primary and secondary data to answer the evaluation questions of the project's **relevance**, **effectiveness**, **efficiency**, **sustainability** and **impact** in line with the standard DAC evaluation guidelines. This analysis was derived from the data consulted through:

- Desk review of the provided project related documents;
- Analysis of trends from the statistics provided by BRSP;
- Briefing meetings with the project staff and management;
- FDGs and in-depth interviews with key informants such as community leaders, project management staff, and service providers;
- Client Exit interviews records
- Focus groups discussions with beneficiaries
- Facility based staff interviews

Thematic Areas for In-depth interviews, Exit Interviews and Focus Group Discussions was:

- Socio-Demographic profile of the targeted community
- Intervention relevance and design
- Clientele, Requirements and Resources
- Project Management
- Utilization of services including immunization, treatment, contraceptives utilization, deliveries, ANC and PNC
- Extent of satisfaction with the services

Other supportive observations included:

- Facility based record review and data extraction, (e.g. treatment records, family planning records, antenatal and postnatal records)
- Inspection of equipment, drugs, supplies (availability, condition etc.)

Focus Groups Discussions and In-depth Interviews

FGDs & IDIs were held in the target area with community leaders, women, and men, RHVs, CHWs, LHVs and TBAs, and staff of the service centres. The Principal Investigator prepared questionnaires and FGDs Guidelines and implemented data collection, entry and analysis and report writing.

Data Limitations

The major shortcoming of the mid-term evaluation was inaccessibility of the project sites in Mastung district due to security concerns. The MTR Team could not visit Mastung district. Nevertheless, District Health Authorities and in-charges of the targeted health facilities in Mastung were invited for meetings in Quetta and the MTR Team was able to hold quality discussions with them on various aspects of project implementation. Some key informants from Mastung like the facility staff and beneficiaries were not interviewed. Other important Mastung district officials and representatives of Health Committees and District Advisory Group were not met. Another important set of key informants not interviewed were BRSP peer organizations such as UNFPA, Mercy Corps, PAIMAN Project, etc and other organizations working on same issues.

Chapter 2
Review of Literature

The population of Pakistan is estimated around 160 million and is growing at1.9 percent per annum (Government of Pakistan, 2007). The population growth rate has receded from a record high of 3.7 percent per year in the 1960s. About two-thirds of the population is rural. Pakistan is the sixth most populous country in the world (PRB, 2007) and is adding around three million persons per year (NIPS, 2007b). Forty-one percent of its population is below 15 years of age, which is indicative of high fertility in the past. Women of reproductive age constitute almost one quarter of the total population. Marriage is universal and the fertility rate is far above replacement level. The government's population policy, promulgated in 2002, aims to reduce fertility to replacement level by 2020 (MOPW, 2002). However, population stabilization would still be two generations away even if replacement-level fertility were attained by that date. The rapid increase in population has resulted in a quadrupling of the population over the past five decades. This has jeopardized economic gains; in spite of a 327-fold increase in the national GDP between 1960 and 2006, the per capita income has increased only nine-fold. Although the literacy rate has increased since the early 1960s, illiterates number more than 52 million. Unemployment has grown by 11 times in the past 35 years, per capita availability of water has declined to below 1,200 cubic meters per year, and an investment of over 7.4 billion US dollars is required to keep the 2006 level of per capita income of US$847 (NIPS, 2006). The rapid increase in population is also adversely affecting health indicators. Huge funds are required to maintain the existing ratio of population per health facility. At present, there is only one hospital available for over 170,000 persons; one rural health centre available for more than 184,000 persons living in rural areas; one basic health unit available for more than 19,000 persons in rural areas; and one maternal and child health centre available for more than 4,400 expecting mothers and newborns. There is only one doctor available for over 1,300 people and one nurse for 4,600 persons. The rapid increase in population constrains economic gains and stretches the already overburdened health facilities (Government of Pakistan, 2007).

The population welfare programme has taken a number of initiatives to reduce the rapid increase in population. The programme has been in the process of engaging different stakeholders in the public, private, and nongovernmental sectors to cater to the family planning and reproductive health needs of men and women across Pakistan. The programme aims to provide universal access to modern contraceptive methods by 2010 and reduce the unmet need for family planning.

Data show that only one-third (35 percent) of ever-married women age 15-49 in Pakistan are literate. The level of literacy increases from 32 percent among women age 15-19 to 45 percent among those age 25-29 and thereafter decreases substantially to 22 percent among women 45-49. Urban women are much more likely to be literate than rural women (58 and 24 percent, respectively), with the highest level of literacy being among women residing in a major city (66 percent). Provincial differences in literacy are marked, with literacy being highest among women in the predominantly urban Punjab province (41 percent) and lowest in the predominantly rural Balochistan province (15 percent). There is also a marked difference in literacy levels by women's wealth status, ranging from a low of 6 percent among women in the lowest wealth quintile to a high of 75 percent among women in the highest wealth quintile. By work status, the highest level of literacy is found among ever-married women who worked only before marriage (49 percent), while the lowest is among those who worked before and after marriage (26 percent) and those who are currently working (27 percent).

Fertility in Pakistan

Fertility is one of the three principal components of population dynamics, the others being mortality and migration. In view of the fast growing population of Pakistan, the government has been trying since the 1960s to reduce the fertility rate through implementation of various population policies. However, the fertility transition in this country only started about two decades ago. Fertility levels that remained more or less constant at more than six children per woman from the 1960s to the mid-1980s started to decline in the late 1980s (Feeney and Alam, 2003; Arnold and Sultan, 1992). Total Fertility Rate (TFR) declined slowly during the last 15 years of the 20th century, changing from a high of 6.0 children per woman in 1984 to 5.4 children in 1992-96. However, fertility began declining quickly after 1992-96 to reach 4.1 children per woman in 2004-06 (Population Welfare Division, 1986; Hakim et al., 1998). Overall, the TFR declined from 5.4 children per woman in the six years before the 1990-91 PDHS to 4.1 in the three years before the 2006-07 PDHS. Fertility decreased in all four provinces. By place of residence, the decrease in fertility is more conspicuous in urban than rural areas (decline of 33 percent and 20 percent, respectively).

Among women age 15-19, 94 percent have never given birth. However, this proportion declines rapidly to 12 percent for women age 30-34 years; only 4 percent of women at the end of their reproductive age remain childless, indicating that childbearing among Pakistani women is nearly universal. On average, Pakistani women attain a parity of 6.3 children per woman at the end of their childbearing. This number is more than two (2.2) children above the TFR (4.1 children per woman), a discrepancy that is attributable to the decline in fertility. Cumulative fertility for currently married women has shown a decline since the 1994-95 Pakistan Contraceptive Prevalence Survey (PCPS) in almost all age groups of women. The overall mean number of children ever born declined from 4.5 in 1994-95 to 3.9 in 2006-07. Interestingly, the declining trend in the mean number of living children is not as sharp as in the case of children ever born. This trend reflects improvement in child survival because of the improvements in the associated socio-economic indicators that affect the child survival. There has been a modest but steady downward trend since 1990-91 in the mean number of children ever born among all women by age group. Overall, the mean has declined from 3.0 children born per woman in 1990-91 to 2.5 in 2006-07[1].

Family Planning

To attain a balance between resources and population, the Population Policy of Pakistan seeks to promote family planning as an entitlement based on informed and voluntary choice by motivating couples to adopt a family planning method through improved access to quality of reproductive health services. In this context, the level of knowledge about family planning methods is important because adequate information about the available methods of contraception enable couples to develop a rational approach to planning their families. Knowledge of family planning in Pakistan is nearly universal; 96 percent of ever-married and currently married women age 15-49 know of at least one method of family planning. Modern methods are more widely known than traditional methods. For example, 96 percent of currently married women have heard of at least one modern method, while only 64 percent have heard of a traditional method. Among currently married women, pills (92 percent), injectables (90 percent), female sterilization (87 percent), IUD (75 percent), and condoms (68 percent) are the most widely known methods of family planning. The least widely known methods are emergency contraception (18 percent), implants (32 percent), and male sterilization (41 percent). About half of currently married women have heard of the rhythm method (49 percent) and withdrawal (49 percent). The mean number of methods known by ever-married as well as currently

[1] Pakistan Demographic and Health Survey; June 2008

married women is six. Differences in the level of contraceptive knowledge between urban and rural areas are minimal. Among provinces, women in Punjab and Sindh report the highest levels of knowledge (97 percent each), followed by KP (92 percent) and Balochistan (88 percent). The level of contraceptive knowledge increases slightly with education and wealth quintile.

The latest trends indicate that that the proportion of married women who had heard of a contraceptive method increased substantially in the late 1980s and early 1990s, from 62 percent in 1984-85 to 94 percent in 1996-97. Because of the high levels reached, there has been a plateau in this figure over the past decade. The same pattern—large increases in the late 1980s and early 1990s with little change since then—generally holds for knowledge of specific methods, with a few exceptions. Knowledge of male sterilization and implants has continued to increase since 2000-01, while knowledge of the IUD appears to have declined since 2000-01, particularly in the past few years. Knowledge of the rhythm method and withdrawal has increased substantially over time, although the trends for both methods are somewhat erratic.

There has been a substantial increase in contraceptive use since the mid-1980s, with some indication of a possible plateau in recent years. This plateau in contraceptive use could be due to various factors, including non-devolution of the programme from central control, thus leading to lack of ownership of the programme at provincial and district levels; lack of support from the health sector, especially its Lady Health Workers programme; and a disconnect between the community and facilities providing services, caused by abolishing the Village Based Family Planning Worker component.

Informed Choices

Current users of modern methods who are informed about the side effects and problems associated with methods and know of a range of method options are better placed to make an informed choice about the method they would like to use. Current users of various modern contraceptive methods who started the last episode of use within the five years preceding the survey were asked whether, at the time they were adopting the particular method, they were informed about side effects or problems that they might have with the method and what to do if they experienced side effects or if they were informed about other methods that they could use. Latest figures indicate that that 33 percent of modern method users were informed about the side effects or problems of the method and 29 percent were informed about what to do if they experienced side effects. Thirty-eight percent of users were informed of other methods available. The results indicate that IUD users are more likely than users of other methods to be informed about side effects, what to do if they experience side effects, and about other methods available. These data imply that there is considerable room for improvement in terms of providing women with information about family planning methods. With regard to the source of supply, users who obtain their methods from Lady Health
Workers are more likely to be informed about side effects and other methods than users who obtain their methods from other sources.

Need for Family Planning

One of the major concerns of family planning programmes and maternal health care services is to define the size of the potential demand for contraception and to identify women who are in need of contraceptive services. According to the latest data available the total unmet need for contraceptives in Pakistan is 25 percent; there is a greater need for limiting births than for spacing future births (14 percent and 11 percent, respectively). The total met need for family planning (i.e., current use) is 30 percent of currently married women; among these, a large majority are using contraception because

they do not want more children, with only one in five users reporting a desire to delay the next birth for two or more years. As expected, unmet need for spacing purposes is higher among younger women, while unmet need for limiting childbearing is higher among older women. Women living in rural areas tend to have greater unmet need than women in urban areas (26 percent and 22 percent, respectively). By region, Punjab has the lowest unmet need (23 percent) and Balochistan and KP have the highest (31 percent).

Overall, the total demand for family planning comprises 55 percent of currently married women. Nevertheless, over half of the demand for contraception is satisfied. Looking at variations in the total demand by background characteristics, demand for family planning services remains around 50-60 percent of married women in almost all subgroups; however, the percentage of those whose family planning demand is satisfied ranges from 25 percent at age 15-19 to 70 percent for those who have attained higher level of education. It is estimated that the unmet need has increased from 33 percent in 2003 to 37 percent in 2006-07. It is clear that urgent attention of policymakers is required to minimize unmet need by transforming it into met need.

Reproductive Health

In Pakistan, the National Health Policy was promulgated in June 2001. The policy provides an overall national vision for the health sector based on a "health of all" approach (Pakistan, 2001). It aims to implement the strategy of protecting people against hazardous diseases of promoting public health, and of upgrading curative health care facilities. The policy identifies a series of measures, programmes, and projects as the means for enhancing equity, efficiency, and effectiveness in the health sector through focused interventions. Improved safe motherhood services and focused reproductive health services through a life cycle approach are aimed to be provided at the doorstep. Promotion of maternal and child health has been one of the most important objectives of the health programme in Pakistan. Primary health care services are also extended through the Lady Health Worker (LHW) programme, which provides services through home visits especially in rural areas. LHWs are contributing directly to improved hygiene and higher levels of contraceptive use, iron supplementation, growth monitoring and vaccinations.

Prenatal Care

Three out of five Pakistani women receive some prenatal care from a medical professional, most commonly from a doctor (56 percent). Only one-third of women had a prenatal care visit by their fourth month of pregnancy, as recommended. Even among those who receive prenatal care, many important components are often missing. According to the 2006-07 PDHS, only 25 percent of women were informed of signs of pregnancy complications during prenatal care. Only 43 percent took iron tablets or syrup. Blood pressure was measured in 80 percent of women, but less than half of women who received prenatal care were weighed, or had a urine or blood sample taken. Two-thirds, however, received an ultrasound. Sixty percent of births were protected against neonatal tetanus. Prenatal care is highest among women with higher levels of education, those living in the wealthiest households, and those in urban areas. Seventy percent of women in Sindh receive prenatal care compared to only 41 percent in Balochistan. Thirty-five percent of women received no prenatal care at all. The most common reason for not getting prenatal care was because women believed it was not necessary (73 percent); 30 percent cited cost as the primary deterrent.

Delivery and Postnatal Care

One-third of Pakistan's births occur in health facilities—11 percent in the public sector and 23 percent in private sector facilities. Two-thirds of births occur at home. Home births are more common in rural areas (74 percent) than urban areas (43 percent). One third of home births used a

safe delivery kit, but the majority (79 percent) used an un-boiled thread to tie the cord and 28 percent used scissors to cut the cord. Thirty-nine percent of births are assisted by a skilled provider (doctor, nurse/midwife, or Lady Health Visitor). Half are assisted by a DAI or Traditional Birth Attendant. Postnatal care helps prevent complications after childbirth. Less than half of women (43 percent) had a postnatal checkup. Only 27 percent, however, had a check up within 4 hours of birth, as recommended.

Maternal Mortality

Pakistan's national health policy emphasizes the need to improve quality and accessibility of maternal health services, particularly in the rural areas. All national programs on primary health care have included maternal health as a core component. The country's first maternal and child health program was launched in the early 1950s. In the 1990s, the Lady Health Worker program was introduced, which has a major emphasis on maternal health. In spite of these efforts, progress in maternal health indicators has remained slow in comparison with other health and population indicators. About 40 percent of pregnant women do not receive skilled prenatal care or full protection against tetanus (Chapter 9). Moreover, almost two in three births occur at home and 60 percent of births are not assisted by skilled medical attendants. Delays in seeking medical care for obstetric complications are common. Pakistan is a signatory to the Millennium Declaration and is committed to achieve the Millennium Development Goals (MDGs). The country's targets for MDG-5 are to reduce the MMR to less than 140, and to increase skilled birth attendance to 90 percent by the year 2015 (Ministry of Health, 2005). To achieve these targets, the Government has recently launched a large-scale national maternal, neonatal and child health program. The major emphasis of the program is on improving the quality and accessibility of emergency obstetric and neonatal care and increasing the use of skilled birth attendance by introducing a new cadre of health workers—community midwives—along the same lines as the Lady Health Worker program. The community midwives will be fully trained health professionals who will gradually replace the traditional birth attendants in the rural areas of Pakistan. Most data on the MMR are based on local or sub-national data. No reliable MMR data are available at the national level, with the exception of an indirect estimate arising from a national survey conducted in 2001. Several local and national studies have reported widely different values for MMR, from a low of 279 maternal deaths per 100,000 births to a high of 533. Most international sources prior to 2000 reported an estimated MMR of 500 per 100,000 live births. The government currently uses a working range of 350 to 400 (Planning Commission of Pakistan, 2002).

Community-based studies of maternal mortality (e.g., the Maternal and Infant Mortality Survey—MIMS) have estimated large variations in MMR by urban and rural areas, provinces and more and less developed districts. Based on statistical models, the government has classified districts into low, medium and high MMR categories (Ministry of Health, 2005). In general, Balochistan has the highest average MMR and Punjab has the lowest. The most important cause of the divergence is differences in access to emergency obstetric and neonatal care services (Midhet et al., 1998). Hospital-based studies of maternal mortality report much higher MMRs because of the selection bias (more high-risk pregnancies being referred to hospitals). The studies conducted in the large teaching hospitals in the public sector typically report MMRs that are exponentially higher than the community-based studies (Jafarey, 2002; Jafarey and Korejo, 1993; Qureshi and Qazi, 2003). Previous studies have identified postpartum haemorrhage, antepartum haemorrhage, puerperal sepsis, obstructed labour, eclampsia, and complications of abortions as the leading direct causes of maternal deaths, accounting for approximately 70 percent of all maternal deaths, both occurring in the community and in hospitals (Jafarey, 2002) Unfortunately, these causes are neither preventable nor predictable. A woman having a normal pregnancy can suddenly develop any of these complications.

However, all of these causes are treatable at a modestly staffed and adequately equipped secondary care hospital, provided that the mother arrives at the hospital relatively early in the course of the complication. Because of the paucity of data on MMR and the desire to measure progress towards meeting the MDG-5 goal, the need for a national study to estimate the MMR was felt among public health professionals and government circles for a long time. It was decided that the scope of Pakistan's 2007 Demographic and Health Survey could be expanded to measure MMR using verbal autopsies. Besides estimating the MMR, the 2007 PDHS provides valuable data on the causes and risk factors of maternal mortality, as well as on a number of process indicators, which will be of great help in programme development and monitoring and evaluation.

The overall pregnancy-related mortality ratio (PRMRatio) for Pakistan is 297 pregnancy-related deaths per 100,000 live births. As expected, the overall maternal mortality ratio (MMR) is slightly lower (since it excludes non-maternal deaths occurring during pregnancy and 6 weeks postpartum) at 276 maternal deaths per 100,000 live births. Nevertheless, the two rates are very close and compare plausibly with previous estimates. The overall pregnancy-related mortality rate and the maternal mortality rate are the same at 0.4 per 1,000 woman years. The data imply that approximately 1 in 89 women in Pakistan will die of maternal causes during her lifetime (lifetime risk).

The 2006-07 PDHS indicates that 20 percent of female deaths are attributed to maternal causes (complications of pregnancy, childbirth, and the six weeks post childbirth). More than one-third of deaths to women age 25-29 were due to maternal causes. Maternal deaths are more common in rural areas than in urban areas (22 versus 14 percent of adult women deaths). Maternal deaths vary dramatically by region. In Punjab, only 16 percent of adult women deaths were due to complications of pregnancy, childbirth and the 6 weeks postpartum compared to 35 percent in Balochistan.

The maternal mortality ratio is 276 deaths per 100,000 live births, which means that approximately one in every 89 women in Pakistan will die of maternal causes during her lifetime. The maternal mortality ratio is almost twice as high in rural than urban areas (319 versus 175), and is highest in Balochistan (785) compared to only 227 in Punjab. The most common direct causes of maternal deaths are postpartum hemorrhage (27 percent), puerperal sepsis (14 percent), and eclampsia/toxemia of pregnancy (10 percent). An additional 13 percent of maternal deaths are due to indirect causes, such as hepatitis, cancer, and gastrointestinal disorders.

Knowledge of Other Sexually Transmitted Infections

The importance of STIs is two-fold. Besides imposing a significant disease burden, they also represent a marker for HIV transmission (which is also transmitted sexually). The 2006-07 PDHS collected information on respondents' awareness about other STIs and women were also asked about their knowledge of the symptoms of STIs. Only one in ten ever-married women age 15-49 years reports having ever heard about other infections that can be transmitted through sexual contact. Knowledge about STIs varies only slightly by background characteristics. Women in the older age groups are slightly more likely to know about other STIs than younger women, i.e., more than 10 percent of women 40-49 years are aware of other STIs compared with 5 percent of women age 15-19 years. Education has a positive relationship, i.e., as education an increase, knowledge of other STIs also increases.

HIV/AIDS Knowledge and Attitudes

Less than half of ever-married women (44 percent) have heard of AIDS. Knowledge of AIDS is lowest in Balochistan, where only 24 percent have heard of AIDS. Few women know the major HIV

prevention methods. Only 20 percent know that HIV can be prevented by using condoms, 31 percent know that it can be prevented by having sex with only one uninfected partner, and 24 percent know that abstaining from sexual intercourse will prevent AIDS transmission. Prevention knowledge is twice as high in urban areas as in rural areas, and increases dramatically with women's education. Half of women with higher education, for example, know that using condoms and limiting sex to one uninfected partner prevents HIV, compared to only 8 percent of women with no education. Prevention knowledge is highest in Punjab and lowest in Balochistan. Only about one quarter of women know that HIV can be transmitted by breastfeeding. There are many myths about HIV/AIDS in Pakistan. Only 18 percent of ever-married women know that AIDS cannot be transmitted by mosquito bites, and only 28 percent know that a healthy-looking person can have the AIDS virus. Less than one in four women know that they will not get AIDS by sharing food with someone who has AIDS.

Chapter 3
Overall Assessment

3.1 Relevance

Pakistan is a country with a high Maternal Mortality Rate, high Fertility and low Contraceptive Prevalence Rate (CPR). A high percentage of women are illiterate, and the latest (June 2008) results from Pakistan Demographic and Health Survey indicate poor knowledge of the young population about Sexual Reproductive Health (SRH) issues like Puberty, Family Planning (FP) and Sexually Transmitted Infections (STIs) including HIV/AIDS. The project, with all good intentions, has special significance to the people of the area owing to prevalent low level of health and socio-economic indicators such as high maternal mortality, poverty, illiteracy and low status accorded to women and girl child. The objectives of the intervention are fully consistent with the beneficiaries' requirements, country needs, global priorities and the European Commission's and Pakistan's policies. The targeted districts of Mastung and Pishin, and their surrounding areas are among the most deprived areas of the country, with a high unmet need in SRH service provision and information. Evidence (Chapter 3, Section 3.2) indicates that the project is contributing to addressing the SRH information and service delivery needs of the targeted underserved and marginalized population. A comprehensive range of SRH and primary health care (PHC) services are being provided through static centres, mobile outreach units and community-based interventions. Community based advocacy and information activities reached the most isolated communities, empowering them as information resources and advocates for their own SRH and rights. The emphasis of the project on targeting poor communities in rural and peri-urban areas that lacked access to basic social services with a multi-pronged approach to needs is coherent with strategic objectives for poverty alleviation.

The project was awarded under the European Commission's Thematic Budget Line "Non-state Actors and Local Authorities in Development" with an overall objective of poverty reduction through support for disadvantaged people in developing countries designed to meet their basic needs, to improve the quality of their lives and to reinforce their own development capacities. The project is fully in accordance with the objectives and priorities of the Call for Proposals. In particular the project is contributing to increasing the utilisation of preventative health care among rural populations. It also promotes gender equity, through improving the S&RH of women, including their maternal mortality/morbidity status. It additionally compliments the EC's stated aim to co-operate with civil society in the field of population. As prioritised by the EC, through awareness-raising of SRH issues and collaboration and capacity building activities with existing public/private health providers, the project also contributes to increasing the use of existing SRH services. Evidence (Chapter 3, Section 3.2) demonstrates that the project is increasing access to quality S&RH services and information for those who have difficulty accessing existing facilities. Formation and strengthening of the community-based structures is the particular civil society strengthening and participatory development promotion element addressed by the intervention. The action is also consistent with the European Community's development policy framework by virtue of its contribution to the achievement of the Millennium Development Goals.

The project is highly relevant to the Government of Pakistan's objective of poverty reduction and the maternal and child health and HIV/AIDS MDGs. This project aims at contributing to improving the SRH of underserved and marginalized populations in Mastung and Pishin districts of Balochistan. The emphasis of the project on targeting poor communities in rural and peri-urban areas that lacked access to basic social services is coherent with strategic objectives for poverty alleviation shared by both Pakistan and the European Union. Pakistan's 2003 PRSP identifies delivery of basic services

such as maternal care and reproductive health as one of the 4 'pillars' of poverty reduction, although Pakistan is very far from reaching the MDG target of a 75% reduction in maternal mortality from the 1990 baseline. The quality of poor people's lives will be improved through a reduction in maternal deaths, which when they occur, destabilise a family and render it economically and socially vulnerable. The project compliments the GoP's aims of Health Sector Strategy to improve the quality of health and population services provision. Similarly the project supports the objectives of the Population Policy of Pakistan in its goals and strategies to: promote family planning (FP) as an entitlement based on informed and voluntary choice; reduce fertility through improving access to, and quality of, reproductive health (RH) services; launch advocacy campaigns to address special groups such as youth and adolescents; strengthen the participation of stakeholders in service delivery and programme design; and ensure availability in the prioritised areas of FP, safe motherhood, infant health and sexually transmitted infections (STIs)/reproductive tract infections (RTIs).

The achievements so far (Chapter 3, Section 3.2) indicate that the project is well designed and despite minor effectiveness & efficiency issues, primarily due to security concerns and staff turnover, responds to the needs and constraints of the target groups and its ultimate beneficiaries. The design has sound vertical and horizontal intervention logic and the objectives and the range of its pro-poor activities to address the needs of beneficiaries are highly relevant to the RH needs of beneficiaries exemplified by the range of dire social indicators. The project was designed in 2008; however, the project environment did not necessitate a re-interpretation of the initial objectives. The scope of activities was highly relevant, the vertical logic was consistent and the log frame as a whole was appropriately designed, and includes adequate indicators. Most indicators are measurable and can be used easily and regularly. Nevertheless, project management shall review the relevance and scope of some of the indicators to judge if they fulfil the definition of SMART indicators. The project envisaged a set of relevant and interrelated results in order to increase access to essential maternal and reproductive health care and more specifically to help deliver high-quality Emergency Obstetric Care (EOC). The project is also building the capacity of local community-based structures, Ministry of Health at the District level (through staff training and enhanced facilities), BRSP (through strategic linkages with the Ministry of Health) and community health agents like LHWs, LHVs, TBAs, CHEs etc (through training and equipment).

3.2 Effectiveness

In terms of Overall Effectiveness the project has started to produce important outputs in the various outcome areas that the project works on. Moreover, some of the outcomes start to be realised across the various outcome areas. Given the timing of the review at mid-term of the project, outcomes cannot yet be expected to have been fully realized. The project so far has focused more on putting requirements in place for changes to happen and shall now put more emphasis on providing support to the transition process itself for stakeholders concerned, supporting the change process from the present to the required stage. The project will need to enhance its focus in these areas in the next stage of the project, in order to facilitate change processes and to capitalize on the work done so far.

In order to enhance effectiveness, in particular on outcome level changes, there is a need to establish a results based monitoring system which includes regular assessment of outcome level changes in the various outcome areas of the project. This information needs to be used to inform project decision-making as well as inform the approach on BCC and capacity development, in particular the balance between the various levels of capacity development interventions and various aspects of change management.

Given the limited time span of the project, extremely fragile and volatile operating environment, and above all, the difficult intervention theme and context, the project's contribution is leading to increased accessibility to, and utilisation of affordable, high quality S&RH services and information among underserved people of the targeted areas, and to the creation of an enabling environment. The project, with a few exceptions, is on track and is anticipated to complete most of its foreseen processes. Despite frequent staff turnovers, availability of staff, equipment and supplies has led to an increased utilization of health services. However, advocacy and capacity building components could have been implemented more strategically.

The project has successfully established the three-tier service delivery model consisting of strengthening of static clinics, Community-based Interventions and outreach, and is carrying out awareness raising and capacity building interventions targeting the community, service providers and stakeholders.

Result 1: Community Mobilization at the village level carried out through COs (Community Organizations), LSOs (local Support Organizations) resulting in increased community awareness about RH issues including maternal/neonatal health and family planning issues, HIV/AIDS, STIs, GBV and improved health seeking behaviours at the time of delivery

Like all the RSPs, social mobilisation is also BRSP's strength. In order to achieve this result, the project is undertaking multi-pronged social mobilisation interventions. These include sensitisation meetings. 451 sensitisation sessions (126 Mastung and 325 in Pishin were held with already existing COs. In these sessions 10,286 CO members (5121 men, 5165women) were sensitized through group meetings.) with the existing COs that were previously established by BRSP or other projects in Pishin and Mastung. An important element was the development BBC strategy and culturally sensitive IEC material that was widely shared among stakeholders and communities to enhance the awareness on RH. A wide range of IEC material is developed in the project that includes: Booklet on Islam and Reproductive health, Maun ko marnay say bachain, (Save Mothers from dying), Training manual for CHEs and LHWs, Peer Educators' manual, Adolescent Reproductive health and Islam, RH posters (Immunization, TT vaccine, danger signs in Pregnancy), leaflets on unified health messages, booklet on the status of women in Islam, and booklets on gender based violence and promoting male involvement. These IEC materials have helped to enhance the understanding of reproductive health in a cultural context. This material was developed in consultation with various stakeholders and experts under a comprehensive social mobilisation and BCC strategy. Under a coherent BCC approach, BRSP has advocated 15 key project messages in consultation with other MNCH partners as well the provincial advisory group. These 15 messages have also been endorsed by the provincial health department. BRSP has already incorporated the 15 messages in its orientation package developed in the start of the project. BRSP in collaboration with National MNCH program, Mercy Corps, and provincial health department organised dissemination workshop of 15 key messages.

BRSP organised a consultative workshop with a group of 36 renowned religious leaders of the province to review and finalize the booklet "Status of women in Islam". Maulana Mateen Akhunzada (President Inter Religious Council for Health-IRCH), Mr. Nadir Gul Barech (CEO-BRSP), Mr. Sardar Naseer Tareen (Chairman BRSP), Mr. Tahir Rasheed (Member BRSP board of Directors), and prominent scholars i.e. Maulana Anwar-ul-Haq Haqani, Qari Abdul Rasheed Al-Azhari and Maulana Atta-ur-Rehman addressed the participants and highlighted the importance of "Status of women in Islam". The participants approved the contents in the context of Balochistan for wider sharing. The workshop concluded with the decision on the constitution of a five member committee

comprising Maulana Mateen Akhunzada, Maulana Anwar-ul-Haq Haqani, Qari Abdul Rasheed Al-Azhari, Maulana Abdul Ali and Maulana Atta-ur-Rehman. It was decided that the booklets on GBV and male involvement will be reviewed by the five member committee. Later, all the three booklets were reviewed and finalised by the committee and the head of the committee drafted the preface with his name for the booklets.

Following IEC material has been produced by the project:

Name of publication	Quantity	Distributed	Target Audience
Booklet on Islam and Reproductive Health	7000	3365	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials
Maun ko Mernay say Bachayen (Save Mothers from dying)	10,000	4500	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials
Training manual for CHEs and LHWs/RH Sensitization session package	1000	550	LHWs, CHEs, CO members, project staff, NGOs, Govt officials
RH Posters on the topics (importance of immunization, Danger signs of pregnancy, Doses of Tetanus in pregnancy	1500 (500 each)	1100	LMOs, LHVs, Nurses, paramedics, CO members, media, NGOs, govt offices
Peer Educator's Manual	1000	530	Youth, CO members, religious leaders, community gatekeepers, media, project staff, NGOs, Govt officials, volunteers
Adolescent Reproductive Health and Islam	10000	5560	Adolescents, Youth, CO members, religious leaders, community gatekeepers, media, project staff, NGOs, Govt officials
Islam mein Aurat ka maqam	5000	280	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials
IEC material on GBV	10000	3200	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials
Promoting male involvement for RH	10000	1150	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials
Leaflets on 15 key RH messages	10000	8590	CO members, religious leaders, community gatekeepers, media, project staff, NGOs, youth, Govt officials

In addition to the existing COs, BRSP formed 286 new community organizations and involved them in project activities. The COs are involved in all the project activities. The Cos takes lead in organizing infotainment activities at the village level. The COs members are also part of the Village Health committees formed around each facility. The COs are engaged in identifying groups including TBAs, peer educators, CHEs etc.). In the first two yeas of the project, 451 sensitisation sessions (126 in Mastung and 325 in Pishin) were carried out with these COs. In these sessions, 10,286 CO members (5,121 men, 5,165 women) were sensitised. he COs are sensitized on RH related issues including maternal and child health, HIV/AIDS, three delays esp. focusing on 1st delay where the household decide to seek to seek services. This sensitisation has generated demand for RH services and as a result the demand for RH services has considerably increased by 44% in Mastung and 39% in Pishin. The targeted audience of the sensitisation includes; married couples, youth and adolescents, tribal leaders, religious leaders, teachers and students.

The project has formed 16 Village Health Committees (VHCs), 8 male and 8 female in both districts. The role of the VHCs is social mobilization, ownership for project activities, involvement of local tribal elders for effective and efficient result oriented project outputs and impact of the project and for the sustainability of project interventions. These Committees are strengthened through regular monthly meetings. The VHCs are strengthened through regular monthly meetings where they discuss the issues of the facility, issues of staff in the facility, logistics issues including water, overall hygiene conditions in the facility. They also discuss the emergency transport system for referral of complicated cases.. These VHCs have been formed with the involvement of COs. 33 follow up meetings have been conducted with the VHCs so far. Regular interaction with these VHCs have resulted in the arrangement of emergency transport systems and savings through COs and Village Organizations. The male VHC in Karbala Pishin have contributed Rs. 0.5 million for the repair and renovation of the RHC. The VHC has a separate bank account where they pool donations from the communities for emergency RH services and requirements in the community. The VHC members have been mobilized to take ownership of their facility. The members of the VHCs have also been engaged in monitoring, repair and renovation of their facility which has ensured greater community ownership.

In addition, 150 Community Resource Persons (CRPs) have been identified and trained (in 10 training events) on the project sensitisation methodology to further sensitise their communities.

As per the adolescents and youth indicators of the project baseline in July 2009, 72% youth in Pishin and 81% in Mastung had no idea about STIs. Among youth 79% of the youth had never heard about Sexual and reproductive health. During the first half of the project, BRSP completed the identification of 400 Peer educators in the age bracket of 15-25 years in both the districts. Peer youth include school and college students, out of school adolescents and working adolescents and youth. As a result of the initial interaction with young people, most of them were found very enthusiastic to learn about the RH and its issues. The manual for youth peer educators training has been reviewed, finalized and printed. Training on Peer Education was organized for the project staff and peer educators to equip them to effectively and efficiently trickle down the delivery at district level. A ToT was organised from 12-14 March 2010 where 30 master trainers participated including project staff and community youth trainers in order to train a pool of 30 Master trainers to conduct onward peer educators trainings in the districts. The trainings for peer educators are also being arranged. In district Mastung 73 (68 boys, 5 girls) peer educators have been trained while Pishin has trained 120 (88 boys and 32 girls). According to the results almost 30% of adolescents and youth can now explain the symptoms of major STIs i.e. HIV, Hepatitis etc. Above 70% are aware that how an STI (including HIV) is transmitted and how to avoid transmission of these STIs.

BRSP has organized 481 RH focused events i.e. football and cricket matches, speech competitions, Naatkhuwani competitions, tug of war, wrestling, debate contests, and other local games. In these events 6,1317 people participated (4,8064 Pishin, 13,253 Mastung). Among them 340 events were organized in Pishin and 141 were organized in district Mastung. In these events 57 events in Pishin (participated by 1183) were organised for young girls whereas 19 girls events (participated by 1,727) were organised in Mastung. At the end of each event, adolescents and youth have been sensitised on RH issues prevailing in the districts and highlighted their role in addressing these issues. Key messages on ARH were displayed in the playgrounds where youth were sensitised on issues pertaining to their sexual and reproductive health. Trained Peer educators in the districts were also given opportunities to organise infotainment events and sensitise youth on key messages of ARH.

Project data trends indicate that the number of prenatal and postnatal visits to the facilities have increased manifold.

GBV is a cross cutting theme of all the interventions in the project. The project focuses on enhancing awareness on GBV through meetings with Cos, community based trainings including peer educators training and CHEs training. A major indicator of the maternal deaths in the communities was refusal to seek services. The monthly data from the facilities have proven that the households are more inclined to conduct deliveries in the project target facilities.

Result 2: A new cadre of Community Health Educators (CHEs) and also the existing LHWs identified, trained on RH issues including STIs, HIV/AIDS, GBV, FP, Adolescent and Youth Issues, sexual harassment and the Counselling and Communication and working in the project area to provide community-based awareness about RH, and facilitate referral

According to the baseline survey results, 66% children in Pishin whereas 64% children in Mastung were not vaccinated. Majority of mothers 78% in Pishin and 77% in Mastung had never used any family planning method. As per the data available with National Program for Family Planning and Primary Healthcare, approximately 30% population of both Pishin and Mastung is covered by LHWs. BRSP has identified 100 LHWs in each district in order to organize refresher trainings for them on the manual developed by BRSP under this project. So far, 185 LHWs have been trained in both districts (87 Pishin, 98 Mastung).

In addition, BRSP has also identified a cadre 150 volunteer CHEs in each district particularly in the areas that have not been covered by LHWs. Under the project, 101 CHEs have been trained including 79 in Mastung and 22 in Pishin. BRSP has also devised a mechanism for the follow-ups of CHEs. Each CHE has been assigned a cluster of 200 population (20-25 households) where they will deliver the key RH messages within their catchments. According to the follow up data, in Mastung a population of 15,800 while in Pishin 4,400 population have been accessed through the messages delivered by CHEs.

The CHEs and LHWs have been educated on important key action messages of Safe motherhood including; the importance of seeking antenatal visits, proper maternal nutrition, immunisation, the importance of a skilled attendant at delivery, Danger signs of pregnancy and labour requiring immediate medical attention, the nearest health facility offering relevant services, the importance of early inclination of breast feeding and exclusive breast feeding (EBF) for the first six months of age,

the importance of Postnatal (PN) care, and dangers signs in the PN period, importance of FP and STI symptoms etc.

During the FGDs and IDIs, many stakeholders and beneficiaries confirmed that the CHEs and LHWs are providing very valuable RH information to the communities and that the quality and range of information is of a very good quality.

Result 3: Increased support of the government for the project interventions at district and provincial level

The project has so far undertaken several advocacy events to create an enabling environment both at provincial and district levels. These include major advocacy events; the Provincial Project Launching Ceremony, Religious Leaders Seminar at Provincial level, celebration of World Population Day, International Women Days, and World Health Day.

The efforts and series of advocacy meetings at provincial level through the Project Provincial Advisory Group have been meaningful and as a result the Balochistan Provincial Assembly passed a unanimous resolution "Resolution on Preventable Maternal Mortality" on October 14, 2010. The Provincial Advisory Group of the project had been toiling and consistently persisting for the recognition of the UN resolution on "Preventable Maternal Mortality and Morbidity and Human Rights" resolution at provincial level. The members of the Balochistan Assembly in Balochistan i.e. Provincial Minister Health Ainullah Shams, Molvi Mohammed Sarwar, Ms. Raheela Durrani, Mr. Asfandyar Kakar and Chairman Senate Standing Committee for Health Ms. Kalsoom Parveen were approached and invited to different events organized under the EC-RH project. The support and pursuance of all these MPAs and Ministers have triggered this major achievement towards promoting safe motherhood in Balochistan; it also implies concrete policy reforms and appropriate resource allocation to prevent maternal mortality in Balochistan.

One of the most prominent advocacy events that will have far-reaching results is the inauguration of BRSP-EC project's MSU by the Balochistan Chief Minister in Kardigap, Mastung on 5 June 2010. He appreciated the idea and termed it the right approach for the scattered population in Balochistan. He said that the approach will ensure access to Reproductive Health and Primary Healthcare services for women, men and children living in isolated settlements and scattered terrain. He emphasized the need for similar strategy for the rest of the province. The Provincial Finance Minister Mir Asim Kurd Gilo and Minister for Works and Services Mir Sadiq Imrani also accompanied the Chief Minister. Appreciating the efforts of BRSP and funding from the European Commission, Mr. Raisani subsequently invited the BRSP Board of Directors to further discuss the possibility of up-scaling the interventions in Balochistan.

The workshop on "Islam and Reproductive Health" was another very important advocacy and support and enabling environment event held in collaboration with "Inter Religious Council for Health (IRCH)", on 26 March 2009. This workshop was participated by 16 prominent religious leaders from all over Balochistan. The religious leaders were oriented with the abysmal RH indicators. Opinions of the religious leaders were unanimous with regard to the RH rights of women, men, youth and adolescents. A six point declaration at the end of the workshop was signed by all the religious leaders elaborated their commitment by acknowledging the dismal state of health in the province and assuming it as their social responsibility to sensitise the masses about RH issue in light of true education and teaching of Quran and Hadith. Declaration to support the objectives of project

was signed by all participants on the letterhead of "Interfaith Religious Council for Health, Balochistan". Similar events were also organised at the district level that were participated by more than 20 religious leaders in each event. During the orientation workshops, the religious leaders were oriented on the importance of reproductive health and mother and child health. The IEC material developed under the project has also been shared with the religious leaders. The religious leaders pledged to circulate key messages of RH in their spheres. They expressed concern over the high rate of maternal mortality in the province and expressed their commitment to raise their voices for reproductive health.

Similarly, the project identified and engaged gatekeepers for each district (221 Pishin, 265 Mastung) and are regularly being sensitised through advocacy meetings. The project has regular interaction with these gatekeepers in order to ensure levelling off the smooth ground for project implementation at district level.

In addition, the project also celebrated a number of international events to express solidarity, create an enabling environment, awareness-raising, EU-BRSP visibility, and to muster support for the project. These events included: celebration World Health Days, World Population Days, and International Women Days etc. These events were participated by a range of stakeholders including provincial ministers, district authorities, religious and tribal leaders, media representatives, national and international NGOs, partner organisations (CBOs, VDOs, LSOs, VHCs), students, UN organisations, district, tehsil and union council nazims, civil society representatives, intellectuals, academia, Provincial Advisory Board and District Advisory Group members, and a good number of masses.

Launching of the results of the base-line survey has also been a successful evidence-based advocacy event as it revealed alarming RH indicators for the targeted districts.

These events were widely covered by the media is helping the project in mustering support for its objectives and considerably contributed to the BRSP-EU visibility.

Such advocacy has also resulted in additional resource allocations by the Government for RH interventions e.g. provision of seven ambulances for the targeted health facilities and a financial grant of Rs. 8.5 million by district government. In case of Khanozai, 50% extra medicines are provided in the facility by the District Health Department. Similarly, the EDO has specially focused the BRSP target facilities in the allocation of resources. On part of the communities in-kind and cash resources have also been mobilised e.g. in case of RHC Karballa in Pishin, the communities have contributed Rs. 400,000 cash to strengthen the RHC.

BRSP is a major recipient of the GoB development assistance. Allowing the nature of the intervention and where feasible, BRSP has a policy of working and collaboration with state institutions. This project has not been an exception and being associates of the project, the health department has been involved in the project activities right from start of the project in January 2009. Health department has appointed Deputy EDO Health as the focal person for this project who pays regular visits to the project targeted facilities and monitor the project progress and to address any implementation issues. So far DDHO and EDO Health, Pishin have paid 229 visits to health facilities in district Pishin while EDO health Mastung had 122 visits of the target facilities. The project has ensured the participation of the GoB staff involvement in the project. In district Pishin, The deputy DHO is the project focal person on behalf of the district health department. He pays 15-20

monitoring visits of the target facilities and comes up with the recommendations to improve the delivery of work at the facility level. He also lobby with other organizations working in the area to pool their resources to improve the situation in the project target facilities. He works as a bridge between the district health department and BRSP.

In district Mastung, The DHO has been engaged in the project monitoring activities. He pays visits per month to monitor the progress at the facilities. The GoB staff is also engaged in the capacity building activities. They have been invited to take sessions as resource persons in the project training events.

BRSP is in negotiation both with provincial and district health department to absorb the project staff into Govt structure. BRSP is in consultation with health department to absorb the project staff in the target facilities on their regular payroll. Similarly, efforts have been carried out for joint interventions with National MNCH program. The national MNCH program has consented to continue the staff after the project life.

Result 4: Management capacity of district health managers enhanced through providing them necessary equipment and training in health system analysis, quality of care, planning, monitoring and evaluation

Details on Trainings and Capacity Building:

Staff Category	Type of Training	Training Events	Trainees
Health Managers	Health management	One (1) in Agha Khan Karachi	Dr. Abdullah Nashnas (deputy DHO Pishin)
Medical Officers	B-EmOC C-EMOC	2 event	All the LMOs trained on B-EmOC working in the project (total 4) Gynecologist of Pishin Dr. Farah Naz trained on C-E-EmOC in Qatar hospital Karachi by Dr, Sher Shah)
Paramedical Staff	2 Training for Health care providers 1 in Pishin and 1 in Mastung	2 events	25 paramedics
LHVs	1 B-EmOC training	1 event	11 LHVs/nurses
LHWs	Refresher Training for	8 events	185 LHWs provided with

	LHWs		refresher trainings
CHEs	Training for CHEs	4 events in both districts	101 CHEs trained up to December 2010
Total		18	328

The target groups trained under the project have yielded positive results and the impact has been encouraging. BRSP trained the facility-based staff on B-EmOC which resulted in enhancing their capacity to deliver the delivery cases at the first level facility.

The CHEs trained under the project has resulted increased RH messages at the community level as performed by LHWs. In total, 185 LHWs and 101 CHEs have been trained. The trained CHEs have been assigned a population cluster of 200 populations per CHE (20-25 households) to deliver the key RH messages and according to the follow up data, in Mastung a population of 15,800 by 79 CHEs while in Pishin 4,400 population by 22 CHEs have been accessed through the messages delivered by trained CHEs.

As a major target group, BRSP also engaged youth and adolescents in RH focused infotainment activities and as peer educators. 481 infotainments events conducted and 193 peer educators (37 girls) have been trained in both districts. As per results shared by peer leaders in the quarterly meetings, almost 30% of adolescents and youth can now explain the symptoms of major STIs i.e. HIV, Hepatitis etc and above 70% are aware that how an STI (including HIV) is transmitted and how to avoid transmission of these STIs.

Training of TBAs in better delivery practices did result a significant improvement in their practices because TBAs were sensitized on danger signs of pregnancy. The quarterly follow ups of trained TBAs revealed that almost 9% increase in referrals of complicated cases have been reported by TBAs. TBAs were assigned the role of monitoring pregnant mothers in the community and following these women to ensure that each expectant mother received immunization and attended at least three antenatal visits. The transformed role of TBAs have resulted an increase in facility based deliveries resulting in significant reductions in stillbirths, birth-related complications and maternal mortality. 94% TBAs in Pishin and 81% in Mastung have used clean delivery kits since they are trained under the EC-RH project, according to TBAs follow up data.

After a needs assessment exercise in the targeted 8 facilities, pooling of equipment from the health department, PPHI and MPAs was worked out and materialised. Equipment and MSUs were handed over to the district health department. Through its concreted efforts and advocacy, the project was successful in acquiring 7 ambulances for the targeted health facilities in Mastung i.e. for RHC Kanak, BHU Ashqan Rodhini, RHC Splingi and district head quarter Hospital with POL and drivers. Moreover, district health department has allocated Rs. 1 million for the boundary wall of RHC Splingi and PPHI has allocated around 6 million for the equipments and repair form the district government and health department to strengthen services in the target health facilities. In district Pishin communities have contributed Rs. 1.5 million for the RHC equipment.

In addition to the normal project operations and without suffering of the normal operations in the targeted districts, the project technical staff i.e. doctors and LHVs and MSUs contributed

significantly in responding to the emergency situation in the aftermath of the August 2010 floods and treated 4,823 flood affectees through organising 23 MSUs.

The project refurbished the labour rooms of RHC Karbala, Splingi, DHQ Pishin and Mastung and RHC Gangalzai. The equipment for the labour rooms was also provided under the project. In district Pishin, the village health committee of RHC Karbala has generously contributed Rs. 550,000 for the repair and renovation of RHC and accommodation of LMO/LHV. The project renovated and provided equipment for the labour room. Upon completion of the labour room, Provincial Health Minister Mr. Ainullah Shams formally inaugurated the labor room on 30th July 2010. The event was attended by prominent stakeholders comprising Director General Health, EDO health, District Advisory Board members, VHC members, local elites, media and civil society representatives. The Provincial Minister for health appreciated the efforts of community and acknowledged the EU support for sophisticatedly equipped labour rooms in far flung areas of Pishin and Mastung.

In both the districts 50 private and public health practitioners have been trained in the provision of standardized B-EmOC, C-EmOC and HIV/AIDS services. These include gynaecologists, paediatricians, lady medical officers, male medical officers, lady health visitors and female medical technicians. Trainings for 50 HCPs in both the districts is planned for 2011.

Deputy District Health Officer (Curative), district Pishin was facilitated by BRSP to attend a 19 training at Agha Khan University, Karachi on Health System Management (HSM) including leadership and teamwork, health planning, monitoring tools and systems, financial planning, quality tools and mechanism and advocacy tools. It is anticipated that the training will contribute to enhancing the management capacity of the Health Officer.

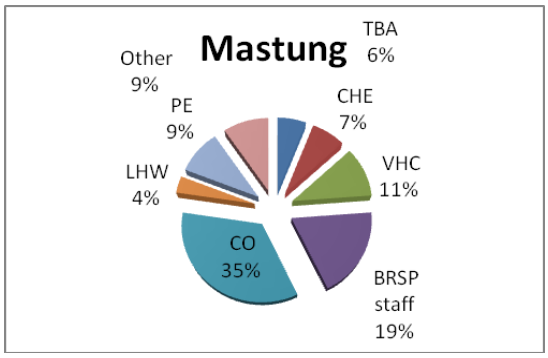
BRSP in consultation with Peoples Primary Healthcare Initiatives (PPHI), district Heath departments and department of population welfare planned to put in-place medications and supplies flow to the target health facilities. It was decided that the above organizations will pool medicines and shortfalls will be met by BRSP. To promote safe delivery and help victims of earthquake affected areas 10000 clean delivery kits, and at the request of Health Department 2200 health and hygiene kits were procured and distributed through health service providers, LHWs, Mobile Support Units and TBAs.

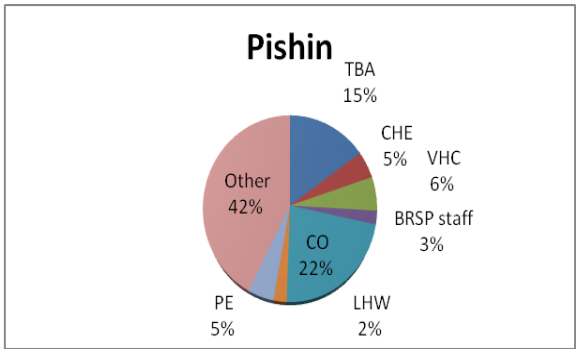
The availability of technical staff has been ensured 24/7 by the recruitment of LMOs and LHVs in the target facilities. Similarly, the strengthening of referral system has also been considered in the quality care protocols.

As per data collected in the project baseline, 76% respondents in Mastung and 78% in Pishin expressed dissatisfaction with the services at Govt facilities. According to the results of the Client/patient Exit Interview in November 2010, 73% in Mastung and 71% in Pishin of clients/patients expressed their satisfaction over the services provided in the target facilities whereas 23% in Mastung and 27% in Pishin termed the services as reasonable.

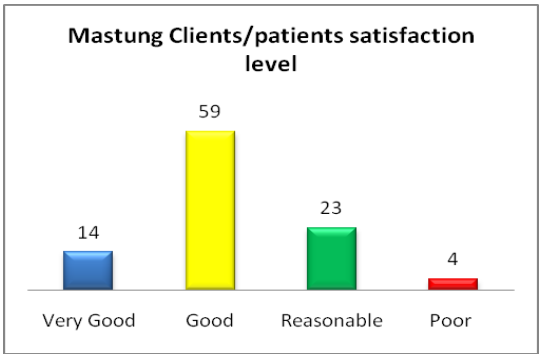
In total, 74% of the clients interviewed were referred by the project groups. 58% in Pishin and 90% in Mastung have either been referred by COs, CHEs, Peer educators, LHWs and TBAs.

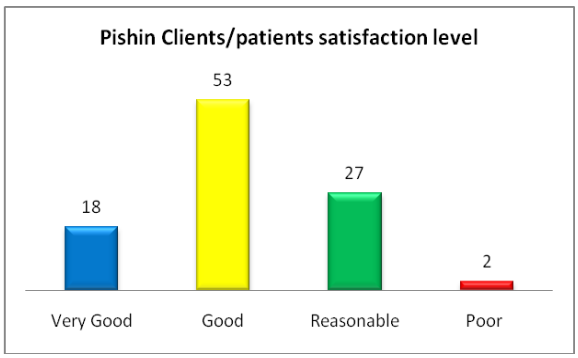
Clients/patients referred to facilities by:





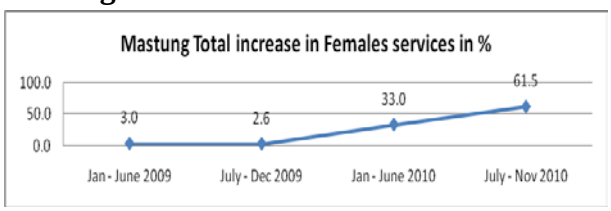
Results of the clients' satisfaction level

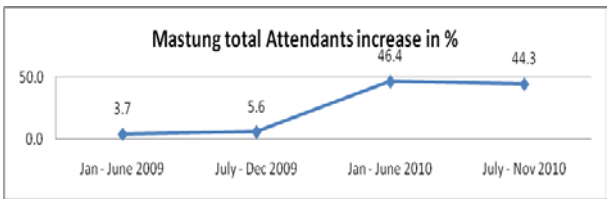


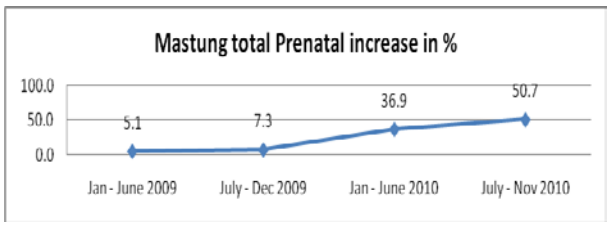


According to the monthly data received from the facilities in Mastung, 61% increase in women seeking services, 50% increase in prenatal visits, and 44% increase in the overall facilities' attendance have been observed. In Pishin, 40% increase women seeking services, 34% increase in prenatal visits, and 39% increase in the overall facilities' attendance have been observed since the start of project in January 2009.

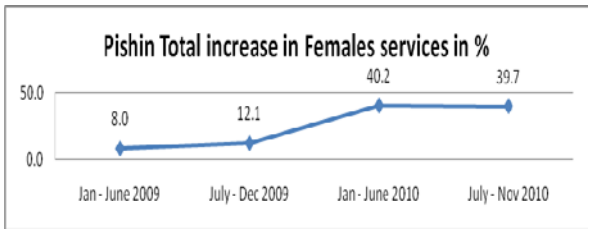
Mastung

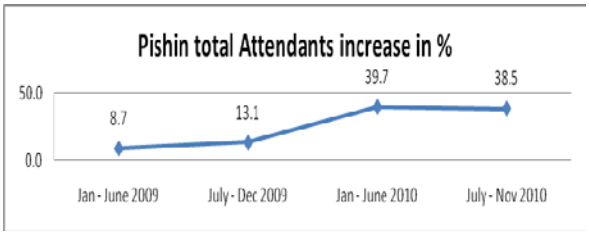


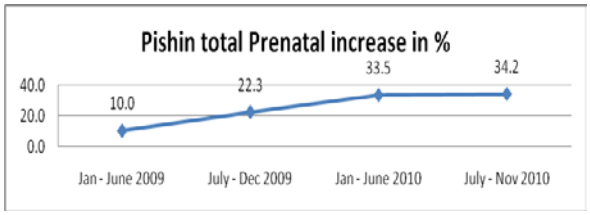


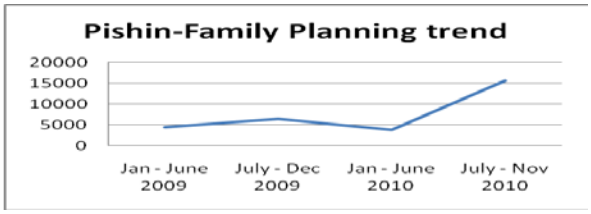


Pishin









Meetings have been held with EDOs and Coordinator, National Program for Primary Healthcare and Family Planning for effective role of LHWs in both the districts. The mechanisms for monitoring of LHWs activities have also been devised during the meetings. DDHO and EDO Health, Pishin have so far, paid 229 visits to health facilities in district Pishin during the reporting period. EDO health Mastung has, so far, had 122 visits of the target facilities.

The availability of technical staff has been ensured 24/7 by the recruitment of LMOs and LHVs in the target facilities. Similarly, the strengthening of referral system has also been considered in the quality care protocols. The capacity of the staff has been developed on quality care protocols which resulted in following standard referral protocols in BRSP model facilities.

Result 5: Accessibility and availability of RH services including comprehensive family planning services, surgical contraception, STI management, HIV/AIDS testing Emergency Obstetric Care services within government health facilities in the project area with: 24l7 Comprehensive EmOC facility at the two THQ Hospitals and 24/7Basic EmOC facilities in 6 RHCs in the project area

Two Gynaecologists, three Lady Medical Officers (LMOs) and 8 Lady Health visitors (LHVs) are appointed in the health facilities. These facilities include; DHQ Mastung, RHC Barshore, RHC Karbala, RHC Gangalzai, RHC Splingi and RHC Kanak. Currently, there is one Gynaecologist (Pishin) and one Medical Officer (Mastung) is providing services in the facilities. With the Gynaecologists coming on board in 2010, the CEmOC services have started in two DHQs. The complicated pregnancies are referred from first level to DHQ. The caesarean cases are being managed in the DHQs by the Gynaecologists.

The residence for Lady Medical Officer (LMO) in Barshore, Kanak, Karbala, Gangalzai and Splinji were in miserable condition. The required repair and renovation has been done in the target facilities and accommodations. In connection with this, BRSP EC-RH project staff has had a meeting with the Provincial Coordinator of National MNCH program. MNCH has formally agreed to work with BRSP.

The action points of the signed and agreed collaboration on 7th June 2010 between BRSP and National MNCH program are as under:

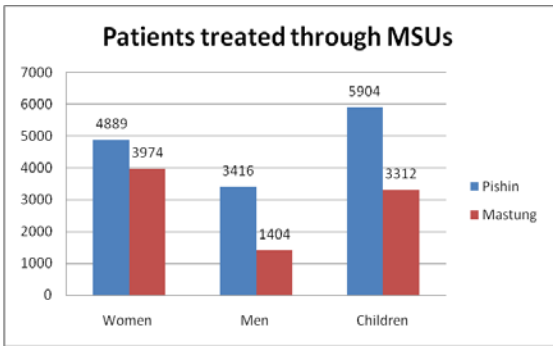
- BRSP will bear the on-air cost of the drama produced by MNCH in three languages i.e. Pashto, Brahvi and Balochi;
- MNCH to bear the cost of renovation at both DHQs of Pishin and Mastung. MNCH will bear the salary cost of Anesthetist upto Rs. 30,000+Government salary while BRSP will pay the salary of Gynaclogists.
- For RHC Kanak, MNCH will repair the labor room where the equipment for labor room is already provided by BRSP.
- Similarly, MNCH will also repair the labor room of RHC Splingi. The equipment for labor room has already been provided by BRSP.
- MNCH will provide the cost of accommodation for RHC Karbala Pishin and BRSP will cover the cost of establishing labor room. The cost can be shared vice versa considering the budget limitations of both MNCH and BRSP.
- For RHC Gangalzai Pishin, MNCH will bear the cost of labor room repair and renovation while BRSP will renovate the accommodation for LMO/LHV.
- BRSP will initiate organizing District Health Management Team meetings in each district where BRSP has presence in the health sector. The DHMT is proposed to be chaired by DC.
- MNCH will share with BRSP the standard EmOC protocols that BRSP will print onwards for display in health facilities.

Efforts have been carried out for accessibility and availability of RH services; including emergency Obstetric Care in the government health facilities in the project area with 24/7 EmOC (basic for RHCs and comprehensive for district HQ hospitals) facilities in 6 RHC and 2 district HO hospital. After the deployment of Gynaecologist is in Pishin, C-section has been started in the DHQ. Almost 30 c-section cases were delivered by the Gynaecologist.

The B-EmOC services are also available in the target RHCs 24/7. In facilities, where LMO is not available, the combination of LHV and Nurse is dealing the cases of normal deliveries.

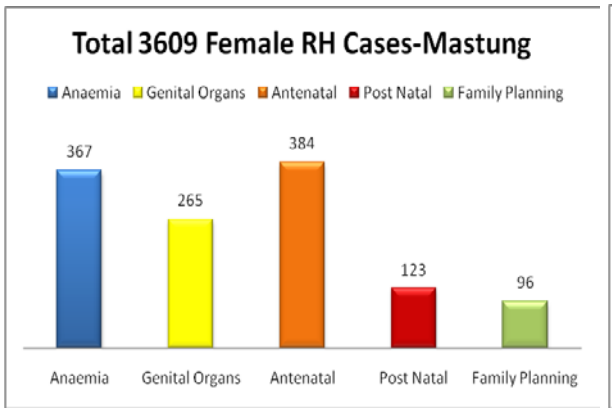
In both the districts 50 private and public and private health practitioners have been trained in the provision of standardized B-EmOC, C-EmOC and HIV/AIDS services. These include gynaecologists, paediatricians, lady medical officers, male medical officers and lady health visitors and female medical technicians.

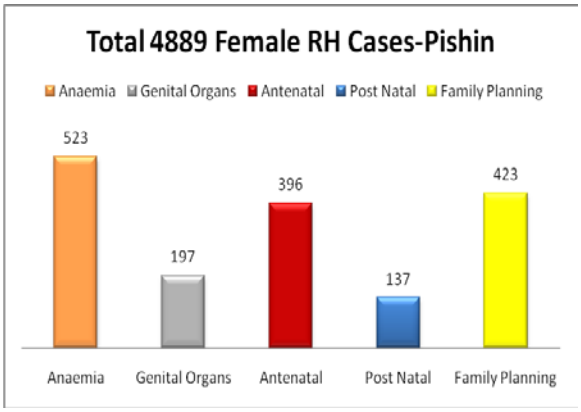
Since the start of the project, 121 MSUs have been organized (84 in district Pishin and 37 in Mastung) where in Pishin total 14,219 patients (3,416 men, 4,889 women, 5,904 children/adolescents) while in Mastung total patients 8,690 (1,404 men, 3,974 women, 3,312 children/adolescents) were provided with PHC and RH services in the districts.



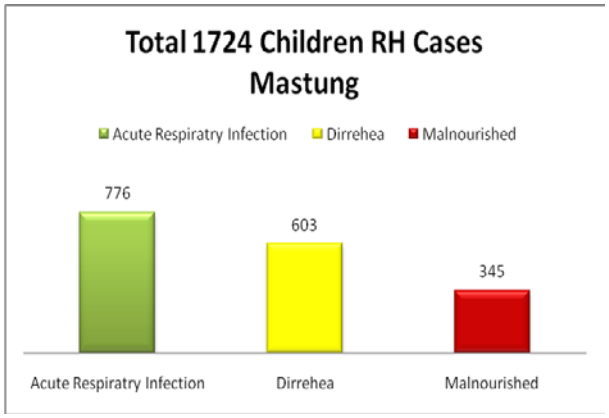
In these MSUs, almost 30-40% OPD of was related to reproductive health. In the cases of women, anaemia and antenatal visits were reported to be high in the MSUs patients' analysis.

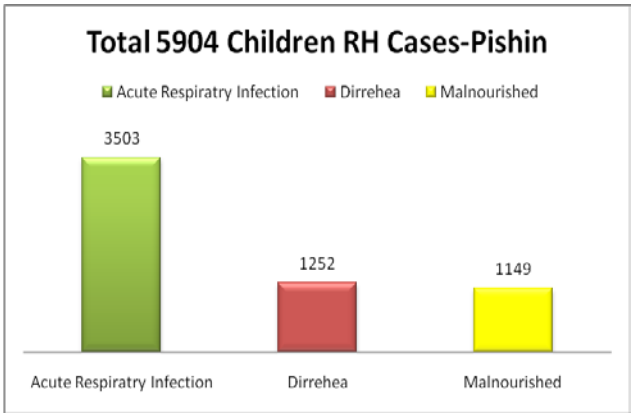
Women RH diseases trend in MSUs





Children diseases trend in MSUs





Result 6: Referral system for FP, STI Management, HIV/AIDS Testing and EmOC developed and strengthened

The existing EmOC referral protocols have been refined and shared with district health department. Referral system has been developed and reviewed by the DDHOs of both the districts. These EmOC protocols have been printed and dispatched for display in health facilities.

Community based referral system is further strengthened over the time that was piloted in July 2009. Inception plan had been developed while Emergency transport system for the communities between two of the target facilities linking it to the first level facility is operative. The project will review the system for its effectiveness and affordability to the communities, and if found feasible will gradually be replicated in the rest of the target areas.

Training TBAs in better delivery practices did result in an improvement in their practices because TBAs were sensitised on danger signs of pregnancy. Attempts at educating mothers and sensitisation of mothers against delivering at home and about the danger signs yielded considerable results. The follow ups of trained TBAs revealed that almost 10% increase in referrals of complicated cases have been reported. However, with support from the European Commission, the BRSP trained TBAs were integrated into the health system where their role was transformed from assisting with home deliveries to linking the health facility with the community. TBAs were assigned the role of

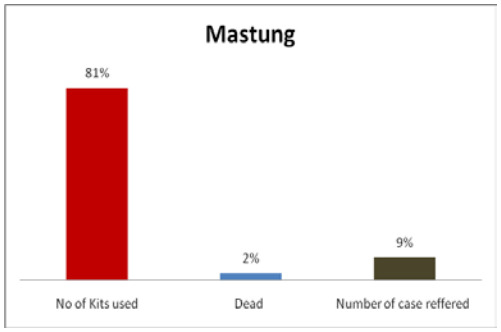
monitoring pregnant mothers in the community and following these women to ensure that each expectant mother received immunization and attended at least three antenatal visits. TBAs were also allowed to refer their clients in labour and to deliver them in the hospital under supervision of a trained midwife.

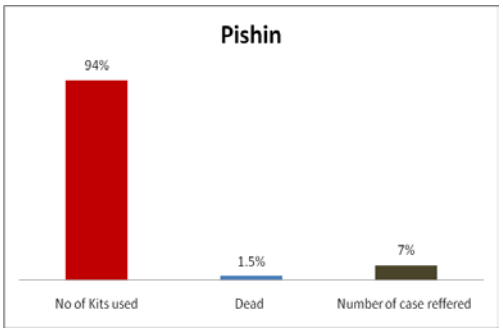
The transformed role of TBAs has resulted in an increase in facility-based deliveries resulting in significant reductions in stillbirths, birth-related complications and maternal mortality.

Result 7: TBAs identified, trained in danger signs recognition, use of clean delivery kits, infection prevention and referral of complicated pregnancies and deliveries for facility-based care.

The identification of 500 TBAs has been completed and a total of 368 TBAs have been trained (202 in Pishin and 166 in Mastung). These TBAs have been trained on danger signs recognition, use of clean delivery kits, infection prevention and referral of complicated pregnancies and deliveries for facility-based care. The trainings also included on how to create awareness among pregnant women on the need and importance of regular ante-natal checkups, advantages of TT vaccine during pregnancy as well as creating awareness about cleanliness and use of Clean Delivery Kits.

Quarterly follow up data is collected from the trained TBAs in order to gauge their effectiveness in terms of referrals and hygienic deliveries. The TBAs have also been provided with delivery kits in order to ensure safe births at the community level. The following analysis highlights the results of the TBAs follow-ups:





3.3 Efficiency of implementation

At the mid-term of the project it is not possible to make an objective and comprehensive assessment of efficiency of implementation. However, the MTR here has attempted to assess the efficiency of the project activities undertaken in order to yield the expected results in accordance with its overall goal and purpose. Attention was paid to the means and resources, organisation and management, participation of beneficiaries in project implementation, and capacity of the associate partner. How well activities are transforming resources into results were examined. The role of interventions in achieving the expected results, constraints faced and how they are being overcome were considered. The extent to which the project and beneficiaries are responding to the unforeseen external factors was examined as part of the analysis.

On the basis of its findings, the MTR concludes that the project is facing challenges that could potentially hinder in successfully, efficiently and economically converting the resources/inputs

(funds, expertise, time, etc) to outcomes/results. A number of exogenous factors including deteriorating security situation, unavailability of appropriately skilled staff in Balochistan, and high staff turnover have, and will continue to pose challenges to the efficiency of implementation. From the analysis presented in Section 3.2, the indications are that the project has initiated and has made significant progress on intervention processes and it is anticipated, provided the status of external risk factors and the assumption made at the time of project formulation, does not change so much, that the project shall be able to complete its processes and is more likely to deliver the expected results. The project management so far has been able to imply alternate strategies to address such situations. The M&E system and the reporting mechanism is in place but is still evolving and, in general, lacks analytical depth and reporting on outputs and outcomes.

In general, the mechanism for implementation of the project is working efficiently; however, there is further room for improvement. Timely and close follow-up by the senior management will be instrumental in guiding the project more strategically. The original grant application included a work plan that listed each project activity by month in year one and by semester in years two and three. This was a very general plan as it did not explain who was responsible and what steps were required for completing each activity, which is the level of detail necessary for managing the day-to-day operations of a project of this size and complexity. Planning and execution of activities at the field level need to be undertaken more in compliance with the overall project implementation plan with a more concerted strategy and in compliance with the overall theme of the project and not in isolated manner losing the depth.

Organisation and management

Assessment of organisation and management was made by way of key respondent interviews with the BRSP Senior Management, Managers of the Department of Health, BRSP Regional Managers, Senior Project Manager and other key staff of the project, and by looking at the decision-making and managerial leadership processes. The status of five management functions, as assessed for the project, is summarized below:

Planning: The planning of the project initiates from the level of the senior project management team comprising Project Director, Project Manager, and District Project Managers. The implementation authority of the project lies with the Project Director and Project Manager in close consultation with District Project Managers. Funding, targets as well as activities under the project are determined on the basis of the project's global work plan that is part of the project framework grant agreement with the European Commission. Planning and scheduling at the field operation level were frail. There is, in general, a satisfactory level of planning but implementation follow-up needs to be more rigorous.

Organizing Project organigramme is well prepared and job descriptions and work procedures are found to be well defined. Project office facilities and vehicles have been sufficient. Buildings and facilities at the offices and health facilities are appropriate. Budgets are centralized with BRSP HQs in Quetta. There have been delays with regard to releases, in some cases salaries, to the field, which the management is addressing.

Staffing: Staffing is probably the weakest link during the entire implementation period. The project is facing a high turnover of staff. BRSP, like many other similar organisations, is facing challenges in replacing the departing staff. Particularly, in the vague of the current security situation in Balochistan where non-local qualified people are leaving the province and there are not many local qualified human resources, the key technical positions e.g. gynaecologists, female doctors, and paramedics,

who are critical for the success of the project, have remained vacant often. All staff members received training. Nevertheless, the project shall continuously provide refreshers. Recruitment policy and procedures are found to be well defined and consistent.

Delegating: Delegation of authority and responsibility has been an informal feature of the project management structure. The Project Manager responsible for implementation enjoyed freedom to manage the centrally approved project activities without undue inspection and hindrance. Professional staff such as the doctors was, however, found to depend heavily on day-to-day support from the District Office and Head Office indicating a highly centralized management.

Controlling: Controlling and monitoring function has typically been not up to the mark. This is reflected also in the data collection and its quality. Supervision of staff at times was found to be weak. Nevertheless, BRSP senior management is cognizant of this issue and is evolving a strategy to strengthen the project M&E.

Project Monitoring, Evaluation and Reporting

M&E is a key element for efficient programme management. For this project, the management shall put in place a monitoring mechanism that, in addition to other regular monitoring function, shall consider an assessment of the inputs and outputs contribution. A weakness of the project is that output based monitoring needs to be strengthened to be systematic and purposeful. Such a system will enhance programme delivery and management. It is essential part of PCM and shall be realised to the detriment of programme implementation.

Participation of beneficiaries and local stakeholders in project implementation

Involvement of key local stakeholders in the implementation is satisfactory but has further room for improvement. Coordination and communication with the DoH, and DoSW needs to be improved. The strengths of DAG and the PAB shall be enhanced to leverage support and ownership of the project. BRSP also needs to beef up negotiations with DoH for absorption of the project technical staff into the DoH. Project shall also put in place feedback monitoring mechanisms to seek feedback from the beneficiaries for informed decision-making.

The project is providing ample training opportunities for both its own personnel, Department of Health staff, and for capacity building of the community-based institutions. External technical assistance for strengthening M&E and reporting and data quality assurance can be of great utility in this project. With the aim of strengthening grassroots capacity and strengthening the civil society and improving access to SRH services, the project has so far organised 115 capacity building and orientation events, which were attended by xxxxxx participants. In total, capacity of xxxx service providers was built through xxxx training events. The EDOH, health facility staff and other service providers including RHV, LHWs, CHEs, and TBAs were consistent in stating that the project trainings were one of the project's most valuable contributions and that they were well planned and administered.

Networking and Alliances

The project has generated a sound momentum among the stakeholders, national and international actors, religious leadership, tribal elders, state institutions and others involved in support of the reproductive health theme in Balochistan. DAGs and PAB have been quite instrumental in this

regard. However, it is recommended that further regular efforts shall be made to lobby the improvement of RH situation in Pakistan.

Information and dissemination as a means to BCC and Awareness Raising

A diverse and professional range of information of a high standard was produced as a means to provide information and to increase awareness on S&RH topics. In both quantity and quality this was directly relevant to the main purpose of the project. It was an efficient deployment of resources to enhance both the visibility of both BRSP and the EU as the donor, as well as informed a wider audience than immediate beneficiaries. Nevertheless, there was no overall BCC strategic policy for dissemination of such information and training materials and a more overall strategic approach on BCC/IEC might have enhanced more efficient deployment of resources for information production and dissemination.

3.4 Impact and Sustainability

It is also relatively early to look at impact level changes after a period of a little bit more than two year. There is a need to further refining the results framework of the project, particularly the relevance of some of the indicators, and increasing M&E capacities. In this way the evaluability of the project would also be enhanced.

Despite all the challenges, considering the processes initiated and completed, the project is likely to significantly contribute to its overall objective**.** The project, within its geographic and thematic scopes and the targeted communities, is effectively contributing towards Pakistan meeting the Millennium Development Goals of reducing child mortality, improving maternal health, promoting gender equality and empowering women.

The project aims to increase utilisation of affordable, high quality and sustainable maternal and reproductive health services among low-income socio-economic groups in Balochistan. Interventions based on identified unmet need and coherency with national and international health strategies in Pakistan are being undertaken for increasing utilisation of maternal and RH services to reduce maternal mortality. An increased number of deliveries were attended by a skilled provider resulting in safer births. Since complications are often not predictable in advance, and since roughly 15% of deliveries have some complication, centre-based births with a skilled provider on hand are much safer. Initial data trends indicate that there has been increased attendance by women at ante-natal visits that has allowed for an increased detection of some early warning signs that are detectable in advance, such as raised blood pressure that has assisted in screening high risk women for delivery in a hospital. As a result of project interventions awareness of family planning methods in the targeted areas are gradually increasing resulting in reduction in absolute number of pregnancies and therefore reduction in absolute numbers of pregnancy related complications. In particular, use of family planning reduces the number of unwanted pregnancies that carry even higher risk given the prevalence of recourse to induced abortions that are often unsafe. The services utilisation trend in the targeted areas is gradually increasing which also includes treatment of incomplete abortion or miscarriage that reduces the risk of death or injury through complications such as infection or haemorrhage.

The project is on track to have measurable impact in the key areas the European Union, and BRSP planned to make: widespread modern contraceptive use; progress in gender equality, and dramatic gains in reproductive health KAP, including HIV/AIDS and STI's. The project on track in successfully strengthening and reviving eight health facilities in the targeted districts for managing

basic and comprehensive S&RH needs of the targeted communities. This is being made possible by ensuring presence of trained health care providers and the availability of medicine and supplies, equipment, and through building the capacities of the service providers, supporting community structures, Community-based Interventions, and finally through extensive awareness-raising among the targeted communities. All these interventions shall potentially orchestrate to build the confidence of the most vulnerable targeted populations to seek institutionalised, affordable, accessible and quality health care.

The experience of BRSP is being used to identify activities that demonstrate a significant impact on improving the SRH situation and knowledge of the target groups and overcoming barriers to access. Barriers to access were determined taking into account physical (convenience), economic (affordability) and socio-cultural (appropriate) aspects. Working in partnership with existing providers, activities have also been selected to demonstrate the impact of an integrated service delivery model. The commitment of local government at the district level and below is vital for poverty-focused development; therefore this project focuses all services (clinical, outreach, and community-based behaviour change communication (BCC) activities) at the district level and below. The acceptable high quality of care is the result of the effective and impactful training and capacity building activities. Community and volunteers provide a channel for community feedback on training and advocacy through to clinical services. Analysis of data trend and the MTR meetings, IDIs, and FDGs with the project stakeholders, including sate and non-state service provides, local Department of Health Officials, other NGO/CBOs, and the beneficiaries confirmed the contributions of the project.

While the disseminated information has enabled the women to make informed choices, the affordable services via static clinic services and mobile outreach services are increasing their access to quality services. It was assessed that enabling women in the target areas to improve their SRH and health, shall positively impact the capacity they then have to contribute to their productive and community roles.

The project approach to build links and local capacity over a long period of time shall lead to more sustainable outputs. The creation of networks and community-based oversight and advocacy structures can increase the potential sustainability of community groups and their initiatives, as well as specific outcomes for capacity building. The VHC and Cos, VDOs and LSOs being established/strengthened under this project, shall improve capacity for self- help and to undertake local advocacy and development initiatives to address the needs of their respective communities. This is part of a wider process to create an enabling environment for civil society and influence the policy dialogue on the development scene. Activities under the project and the strengthening of community-based institutions is expected to improve the capacity of communities and other stakeholders to contribute to social sector development and the social transformation process, albeit in the long-term. Involvement of all stakeholders in implementation is more likely to sustain project outputs.
As indicated by the various trends, while the project is expected to have very good impact, the project needs to pay also attention to collections and dissemination of good practice, experience sand lessons. This shall lead for NGOs and other stakeholders to have the opportunity to learn from each other's successes or struggles.

Advocacy is a relatively new concept in a country where the relationship between government and civil society is uneasy and often extremely tense. It takes time to establish good working methodologies, identify entry points, and build up trust within government and communities. BRSP needs to increase its capacity for evidence-based advocacy with regard to the sexual and reproductive

rights (S&RHR) of vulnerable groups. It needs to strengthen its collection and management of data from field to review the constraints faced by vulnerable populations, interventions that can support them and policy changes that are required to provide an enabling, rather than disabling environment.

Visibility

All the material and takeaways developed under the project have been displayed with EU logo. EU visibility guidelines have been considered in all activities. EU logos have been applied to all equipment purchased under this project, and acknowledgement and logos have been provided in printed materials. EU funding has been widely discussed with health authorities. Similarly, EU support is also acknowledged in the project communication with stakeholders including, federal, provincial and local governments; international, national and local NGOs; and local influential. Media, both at provincial and district level have provided remarkable coverage. All internal and external project related communication and all project related documentations e.g., presentations, reports, IEC material, news letters, brochures, attendance sheets, manuals, minutes of the meetings, internal and external advertisements etc display EU logo. BRSP has also displayed signboards with EU logo at the district offices and on the highways, and 6 RHCs and 2 DHQ hospitals. BRSP has developed various takeaways and gift items including 300 P-caps, 150 gift packs, 3000 wooden key chains, 4000 pens, 11000 pencils, 120 leather gift packs, 5000 writing pads, 5000 file folders, 250 wall clocks and 1000 brochures for distribution among the relevant stakeholders and officials for publicity campaign of the project. All such materials were marked with EU standardized logo and nametag.

Chapter 4
Conclusions and Recommendation

- Despite the challenges, the project is on track to a greater extent to be able to achieve its objectives. Once completed, it more likely to have measurable impact in the key areas the European Union and planned to make: widespread modern contraceptive use; progress in gender equality, and gains in reproductive health KAP, including HIV/AIDS and STI's.

- The Community-based and Outreach interventions, despite facing extremely difficult context, have contributed significantly towards a positive behaviour change for seeking health care.

- While the processes have started to contribute to the outcomes, there has been little documentation and dissemination of good practices, experiences and lessons. If this aspect is not paid attention, it will mean that NGOs and other stakeholders may not have the opportunity to learn from each other's successes or struggles.

- Under this project the need for SRH services and information provision has been accepted by the targeted community and community gatekeepers, particularly the religious leaders. This in turn has enabled BRSP and other service providers' access to these communities. By bringing the services and information to them, this project is contributed to helping direct beneficiaries help themselves out of poverty and to ensure that they are not excluded from experiencing a better quality of life due to their location.

- The continuation of processes, the outputs, and their contribution to the expected outcomes indicate that the project was well designed and despite minor effectiveness & efficiency exogenous issues, is responding to the needs and constraints of the target groups and its ultimate beneficiaries. The design had sound vertical and horizontal intervention logic and the objectives and the range of its pro-poor activities to address the needs of beneficiaries are highly relevant to the RH needs of beneficiaries exemplified by the range of dire social indicators. The project design was well informed by the experience of BRSP in working with the communities. The BRSP knowledgebase was used to identify activities that are demonstrating good impact on improving the SRH situation and knowledge of the target groups and overcoming barriers to access.

- The project BCC interventions are empowering the targeted beneficiaries, particularly women, to enhance the quality of their lives through behaviour change. The awareness raising is encouraging encouraged translating into behaviour change through the provision of a comprehensive service delivery network. Women are particularly being enabled to make informed choices to improve their health and quality of their lives. The project interventions are likely to contribute to enabling women to act upon their SRH choices through provision of authentic information and provision of affordable services via static clinic services, community-based interventions and mobile outreach. On the basis of FGDs and IDIs with visiting clients and community gatekeepers, it is concluded that enabling women in the target areas to improve their SRH and health, will positively impact the capacity they then have to contribute to their productive and community roles.

- Poor SRH is inextricably linked to poverty. Ill health is not simply a consequence of poverty; it is an aspect of it, which can be seen explicitly in the impact maternal mortality has on the welfare of family members. By providing beneficiaries with the knowledge and means to improve their

SRH, the project shall contribute to alleviating the extent and intensity of poverty experienced in the target areas.

- The project is demonstrating an impact of the capacity building activities and particularly of the training, which are designed to be replicated through the cascade process. Improved and acceptable quality of services both by the state and non-state service providers and the targeted beneficiaries is an example of the impact.

- A participatory, holistic, bottom-up approach is the key characteristic of the project the validity of which shall be demonstrated through the project results. It is replicable for a future intervention but with minor adaptation to its implementation mechanisms and methodology such as a comprehensive involvement of the stakeholders e.g. other actors active in the field, traditional service providers etc.

- The socio-economic profile of the targeted area and that of the communities clearly indicate that the targeted population has a very low socio-economic status and that most of the clients availing the project would be the most vulnerable populations.

- The project successfully established and is demonstrating the usefulness of the "three-tier service delivery model" consisting of static clinics, community-based interventions, and outreach, and is carrying out awareness raising and capacity building interventions targeting the community, service providers and stakeholders.

- The "gender" aspect of the project is not well addressed. Gender disaggregated data is not available. Such project interventions must address the gender issues in a comprehensive way and shall be gender sensitive in their approach and scope of services; by gender one should not talk about women only. Gender shall be a definite focus in any future interventions. Addressing the needs of women as well as men and ensuring their participation and ownership in development strategies and projects is essential. The participation of men in accessing the clinical services is to be ascertained.

- With regard to the expected strategic outcomes aspects, the overall concept of the project has to be very well understood and strategically directed at the operational level. The scope of the project interventions shall not primarily be limited to the service delivery aspects. For example the idea of establishment of the VHCs as a public oversight body and the expected strategic and policy level outcomes that should have had far-reaching policy and strategic learning providing critical impetus for formulation of future interventions are to be well understood and hence addressed comprehensively. The role of the VHCs and CBOs has to be strengthened as a public oversight body. The senior management staff of BRSP shall organise periodic (may be quarterly) strategic review exercises with the operational staff to follow-up on the strategic aspects of the project and to make them realise the importance of the theme and idea of the overall concept and not just concentrating on service delivery.

- Staff turnover within both the Departments of Health and the project could jeopardize the potential impact of this project. Projects focused on building capacity in partners tend to succeed based on the strength and continuity of person-to-person relationships. When a key individual leaves, a project can lose momentum that can be difficult to recover from, especially in shorter projects. The main reasons for staff turnover include primarily lesser than market salaries, and due to concerns about the deteriorating security situation. Maintaining an acceptable level of quality through times of high turnover is a challenge for any project, especially for one in a high-risk

setting. Staff turn-over issue is not a unique to this project, it is a well known issue for areas like Balochistan, and strategies shall be placed in advance to address this issue; innovative budgeting and contracting capacity building is required to negotiate clauses in contractual arrangements with the donors to allow for a flexible and dynamic indexation of staff salaries staff for their retention and motivation.

- In Balochistan, an intervention in health sector, and particularly on S&RH issues, is a very sensitive task, and building a trustworthy working relation with sate authorities is the key to the success of any intervention in health sector. Program partnerships ultimately succeed or fail primarily due to the quality and trust in the relationships that exist between the individuals involved. Effective and efficient communication and coordination are very important measures in building a fruitful partnership. The project needs to further improve its coordination and communication with the DoH. For sustainability of the project, it is of utmost importance that BRSP senior management intervenes and take confidence-building measures to address this issue. It is very important the project is fully integrated/embeded into the state structures.

- A project tailored frail monitoring and information system has been put in place for the project, it was, nevertheless, noted that overall data collection, its quality, and reporting are inconsistent. In addition, the frequent turnover of the staff also posed problems in terms of understanding the monitoring system. Moreover, monitoring function also suffered particularly due to law-and-order situation. A future intervention needs an output- based M&E system as part of its strategic framework, with defined indicators for measurement of quality. It should be set up at the start of implementation. Such a system is essential if accurate assessments are to be made of outputs in relation to objectives and their impact.

- The project shall already start preparing an exit strategy for the project.

- A more proactive and frequent interaction and follow-up by the project manager is mandatory for such types of projects.

- Tailor made training for project management and professional staff shall be undertaken after a TNA exercise. Skill training may be need based, locally planned and implemented, and formally linked with project interventions and services.

- TBAs', LHWs', and CHEs' links with Service Centres should be further strengthened for sustainability of the Centres. In this regard coordination and linkages with the local health authorities shall be effectively continued.

- GBV interventions shall be strengthened and GBV shall be treated a a cross cutting theme in the project;

- Networking and functional coordination with NGOs/CBOs shall continuously be strengthened to ensure sustainability of the Centres and project impact in the long-term. NGOs/CBOs expressed their commitment in the FGDs in this regard.

- BRSP needs to enhance its capacity for evidence-based advocacy with regard to the sexual and reproductive rights (S&RHR) of vulnerable groups. Training in this aspect would have enhanced the impact. Only anecdotic evidence was found that any such activities were undertaken.

- Engaging religious leaders in disseminating key RH messages needs to be more structured; BRSP needs to engage religious leaders, orient them on key RH messages and then engage their services to disseminate these messages in Friday speeches so that maximum population in the catchment area is covered through these messages.

- Youth has been an important target group of the project. Besides, infotainment activities youth should be provided with sports and entertainment items printed with project Logo and messages.

- Considering the volatile security situation in the province, BRSP needs to beef up the security of the district offices as observed by the interviews of some of the staff members.

- According to some of the Government and other staff, technical knowledge regarding HIV/AIDS esp. testing and counselling should be incorporated in the trainings imparted to the health care professionals.

- The active and dynamic youth trained in peer education trainings should also be given opportunities to attend policy level events conducted at provincial and national level. This will enable them to be acquainted with national youth policy, build their capacity on areas of leadership and youth empowerment.

- The Village health committees formed around each health facility should be rigorously followed up. Their ownership can play a vital role in the sustainability of the BRSP model health facilities. Their role should further be diversified in fund raising, community transport system, monitoring and utilization of funds.

- For enhanced 24/7 C-EmOC services in DHQ, BRSP needs to hire the services of a trained and qualified Anaesthetist who can provide on call services in DHQ along with the Gynaecologist.