FINAL PROJECT REPORT

PREPARED FOR THE JAVED FIYAZ CHARITABLE TRUST

Save the Children

YOUR PROJECT SUMMARY: **SAVING CHILDREN'S LIVES** IN UMERKOT DISTRICT, SINDH PROVINCE, **PAKISTAN**

THE **NEED**

Every year, 432,000 children under-five die in Pakistan, over two thirds of whom die within their first month of life. Access to healthcare varies dramatically; the risk of a newborn baby from one of the poorest families dying (63 per 1,000) is almost double the rate from the richest families (38 per 1,000).

Two thirds of the population live in rural areas where neonatal mortality is twice as high as in urban areas. Just 1% of government spending was allocated for healthcare in 2009, whist the country's private healthcare system is beyond the reach of the majority of Pakistani families.

A typical district health infrastructure in rural Pakistan comprises of basic health units, rural health centres and a referral hospital. In rural settings, staffing levels are inadequate and referral systems function poorly. 70% of births take place inside the home, as basic health units are closed after 2pm and many lack trained medical staff.

THE **LOCATIONS**

The Umerkot Child Survial Project focused on three Union Councils in rural Sindh province. In these locations:

- preventable and treatable diseases such as pneumonia, tuberculosis and malaria are the main cause of child deaths
- only 37% of infants are fully immunised
- only 4% of pregnant women receive antenatal care at a health facility
- 70% of births take place in the community, overseen by an unskilled birth attendant.

THE **DATES**

- **Year one:** April 2010 – March 2011
- **Year two:** August 2011 – July 2012
- **Year three:** August 2012 – July 2013

The project was interrupted between years one and two due to the devastating flooding that affected thousands of families in Sindh province in 2010.

WHAT WE **AIMED TO ACHIEVE**

Thanks to your support, over the past three years we have worked hard to reach:

- 17,330 children under the age of five
- 19,048 women of reproductive age.

Through our advocacy activities, we anticipated that district level authorities would replicate activities profiled by our work, reaching a further estimated 203,848 women of reproductive age, 145,606 children under the age of five and 400 Female Health Workers.

The main aim of the project was **to reduce child mortality by 30% in the target areas**. We planned to achieve this through three objectives:

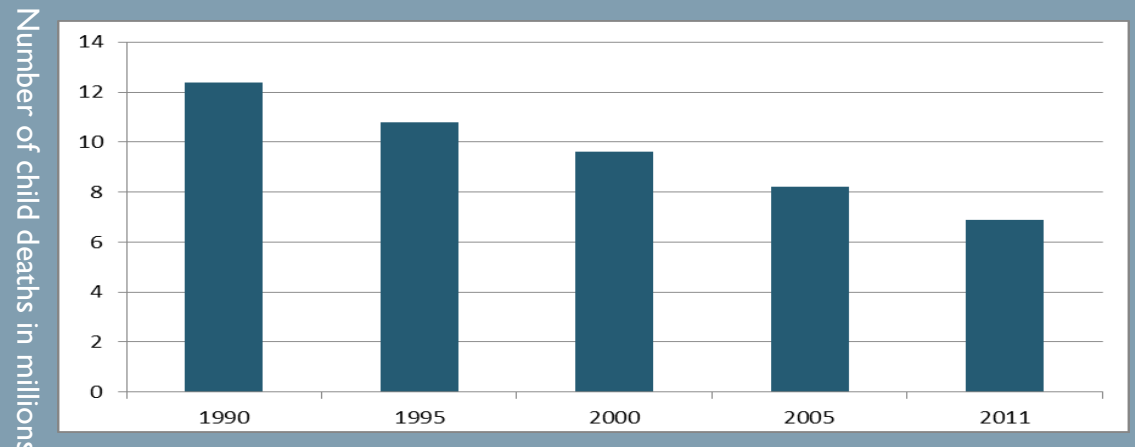
- Increasing the utilisation of maternal, newborn and child health services by 30%.
- Improving the knowledge and practice of mothers and primary carers on key maternal, newborn and child health practices and danger signs of life-threatening childhood illnesses.
- Advocating for the placement of key health staff and availability of essential lifesaving supplies and equipment at all target public healthcare facilities in Umerkot.

NO CHILD **BORN TO DIE**

In 1990, 12.4 million children under-five died each year from easily preventable or treatable diseases. In 2000, as part of the Millennium Development Goals, the world pledged to reduce child mortality rates by two thirds by 2015.

Save the Children has remained committed to tackling the injustice that prevents children from reaching their fifth birthday. Over the years, our work (including your project in Pakistan) has contributed to the significant decrease in child mortality rates.

Trend of global child mortality rates since 1990



THANK YOU FOR BEING PART OF SOMETHING SPECIAL

THE **DIFFERENCE** YOU'VE MADE

KEY **ACHIEVEMENTS**

Over the three year project, dramatic progress has been made to transform healthcare in Umerkot and we are exceptionally pleased with the results:

- The project directly **reached over 18,500 children**, exceeding its target.
- Estimates suggest that we directly **reached over 60,000 women** – significantly more than the 19,048 initially planned.
- Our final assessment shows very promising progress, including: a 19% increase in antenatal visits; 46% of women visiting public sector facilities compared to 16% in the baseline study; 89% of women being vaccinated twice against tetanus compared to 64% during the baseline study; and a 38% increase in patients visiting public health facilities in project intervention areas. This progress should have a **long lasting effect on health services and the lives of mothers and children** in the district.

Highlights for achieving the above indicators include:

- training over 200 Traditional Health Attendants and Community Health Workers and providing refresher training throughout the project
- providing training for Female Health Workers who gave on-going care to over 2,800 babies and mothers during the first month after birth
- surpassing our target of increasing the skills and knowledge of 20 facility-based health staff. The training covered a range of topics, including: counselling skills; antenatal care; and the causes of (and precautionary measures around) vaginal bleeding
- distributing 3,527 clean delivery kits to Traditional Health Attendants and Female Heath Workers in the district. These will help provide a clean, safe environment in which mothers can give birth
- providing essential emergency drugs and equipment to five health facilities in the district
- supporting women's support groups and Village Health Committees who in turn, reached over 10,000 people each year with messages around positive health
- producing a range of local language materials to promote healthy practices in the district
- engaging key stakeholders at various levels (both from government and other organisations) with the project.

OUR PROGRESS AGAINST OBJECTIVES

OBJECTIVE ONE

Increasing the utilisation of maternal, newborn and child health services by 30%.

Planned activities	Achievements
1.1 Carry out a baseline, mid-term and end of project facility assessment survey to assess utilisation levels.	**Year one:** in April – June 2010 (the first quarter of the project), a baseline study was completed which confirmed alarming statistics, such as: an illiteracy rate of 81.4%; a low rate of antenatal care visits (21%); and minimal usage of safe delivery kits (just 9% of births). **Year two:** with a partner organisation, we carried a mid-term evaluation in May 2012. The findings were shared with representatives from other NGOs, government contacts in Umerkot, national level health authorities and with the Director of General Health in Sindh province. **Year three:** the final assessment was conducted in July 2013 and will be available in late September. **The final assessment shows significant improvements as outlined in the 'key achievements' section.**
1.2 Orientation and capacity building for project partners. *Introduced in year two.*	**Year two:** over 12 months, we trained 35 project staff on our Partnership Development Quality (PDQ) approach. This was subsequently rolled out to additional participants. **Year three:** we worked with the Norway-Pakistan Partnership Initiative to train over 34 participants on how to support Female Health Workers. Most recently, six project staff members received training on how to effectively carry out postnatal check-ups and child assessments. **Amongst other benefits, this activity improved our project partners' knowledge of maternal and newborn care techniques.**
1.3 Train 10-15 Traditional Birth Attendants to use clean delivery kits and identify danger signs of illnesses in children and refer these to health facilities. We will also provide refresher training.	**Year one:** we exceeded our proposed reach by training 96 Traditional Birth Attendants and 44 Community Based Workers on safe delivery, newborn care and resuscitation techniques (an assessment had identified these as skills that needed improving). **Year two:** we repeated the training for an additional 78 Tradition Birth Attendants and carried out refresher training for 153 participants (the refresher training was tailored around gaps in knowledge). **Year three:** we held a further two refresher training sessions with 94 participants. Follow-up meetings were held to encourage continued development.

	In total, we trained significantly more Traditional Birth Attendants than anticipated. They now have the knowledge to deliver babies in a safe environment and provide care for newborns.
1.4 Train 100 Female Health Workers on essential newborn and child care, and provide biannual refresher training.	**Year one:** 96 Female Health Workers received training in collaboration with district health officials. In total, Female Health Workers visited 809 newborns on the 1st, 3rd and 7th day following birth, and examined babies for signs of illness or complications. **Year two:** we provided refresher training for 58 Female Health Workers who in total, visited 704 newborn babies, providing advice throughout the first month of each baby's life. When appropriate, they referred children to the necessary care. **Year three:** we held follow-up meetings with Female Health Workers trained in years one and two, and conducted refresher training on essential newborn and child care with 48 participants. We also conducted refresher training for 116 Female Health Workers and male volunteers on support group methodology. In total, the Female Health Workers provided vital support and assistance to 1,319 newborn babies. **Training included topics like treatment of severe pneumonia and diarrhoea among neonates. As a result of this activity, more Female Health Workers in Umerkot have the skills to offer appropriate care to babies after birth, benefiting thousands of children. Participants in the training reported an increased confidence in their abilities.** **See the following case study, 'Zamin Ali's story' to learn more about the difference that Female Health Workers make.**
1.5 Train 20 facility-based healthcare staff, including doctors and paramedics in essential maternal and newborn care, and provide biannual refresher training.	**Year one:** in collaboration with district health officials, 25 heath facility staff completed the training. **Year two:** we continued to work with the 25 staff previously trained to maintain their knowledge and skills. In February 2012, 17 health facility staff received refresher training in Essential Maternal and Neonatal (EMNC) skills. **Year three:** In June 2013, 20 facility-based healthcare staff completed EMNC training. Two obstetricians facilitated the first three days of training, ensuring participants were skilled in maternal care, while two paediatricians covered neonatal care in the final three days. **We delivered training to more staff than expected. Strengthening the skills and knowledge of facility-based staff in Umerkot was vital for improving the quality of healthcare in the district. The training**

	covered a range of topics, including: counselling skills; antenatal care; and the causes of (and precautionary measures around) vaginal bleeding.
1.6 Provide 500 clean delivery kits to Female Health Workers and Traditional Birth Attendants.	**Year one:** 1,302 clean delivery kits were distributed and utilised. They contained a sterilised blade for cutting the umbilical cord, a sanitary pad, soap, cotton, plastic sheeting, bandages, hand gloves, and pictorial guidelines for delivery and hygiene. **Year two:** 1,175 clean delivery kits were distributed and utilised. In addition, 500 insecticide-treated mosquito nets were distributed for the use of mothers and babies in malaria prevalent areas. **Year three:** 1,050 clean delivery kits were distributed and utilised. **In total, we distributed 3,527 clean delivery kits (3,027 more than expected). These gave Female Health Workers and Traditional Birth Attendants the tools needed for safe deliveries.**
1.7 Provide essential emergency drugs and supplies to health facilities.	**Year one:** this activity was completed in year one so facilities could take immediate advantage of the life-saving equipment. The following items were supplied to five health facilities: • resuscitation trolley with heater • phototherapy light • delivery table with heavy duty cushions • instrument tray • drip stand • nebulizer • weight machine • baby cart • ambo bag • screen sheet • curtains for labour rooms.
1.8 Hold quarterly monitoring meetings among our partner organisations and the Department of Health.	**Year one:** we undertook quarterly visits with Female Health Workers, Community Based Workers, and staff at the five basic facilities in Umerkot. **Year two:** due to the flooding in Sindh, these meetings were postponed until July 2012, when Umerkot's District Health Officer visited our programme work to see its impact. **Year three:** meetings with programme staff, partner organisations and district officials continued throughout the

	year. **These meetings ensured that the skills of health staff and volunteers in the district were regularly reviewed and gaps in knowledge addressed as appropriate. They gave participants the opportunity to comment on their experiences and the project's progress.**

CASE STUDY – **ZAMIN ALI'S STORY**

Gulnaz lives in the village of Khan Banglani, which is situated in the west of Umerkot. Gulnaz gave birth to a premature baby, Zamin Ali, who, at the time of birth, was dangerously underweight, weighing less than 2lbs.

Thankfully, because of your project, Female Health Worker Farzana visited mother and baby on a regular basis and gave life-saving advice on how to care for a Zamin.

Fazana advised Gulnaz on breast feeding, keeping the baby warm, delayed bathing and skin-to-skin contact.

Zamin is now slowly gaining weight and his mother is delighted with progress.

"My son has only survived thanks to the support and education provided by Farzana."

OBJECTIVE TWO:

Improving the knowledge and practice of mothers and primary carers on key maternal, newborn and child health practices, and danger signs of life-threatening childhood illnesses.

Planned activities	Achievements
2.1 Train 60 women's support groups and 60 Village Health Committees to promote healthy practices, such as exclusive breastfeeding, from birth.	**Year one:** in total, we worked in 96 villages where support groups and health committees were created for 1,925 female and 836 male community members. The groups were supervised by Female Health Workers. 96 'breakout' groups were held, raising awareness about positive health practices among a further 14,000 women. **Year two:** we continued to support groups and committees in 82 villages as well as the 'breakout' groups which reached 14,542 women. We also trained 58 Female Health Workers in how to lead groups to ensure they were as effective as possible. **Year three:** the support groups promoted healthy practices to 9,380 women through 1,378 support group meetings. We also held 684 Village Health Committee meetings in which 1,240 members participated.

	We have exceeded expectations in this activity, implementing support groups and Village Health Committees in more villages than anticipated. Thousands of women have received information on health and hygiene practices to keep them and their children healthy, and these have started to be integrated into communities.
2.2 Develop Information, Education and Communication (IEC) materials to promote better health practices.	**Year one:** this activity was completed in year one so communities could take immediate advantage of them. We created and printed posters and manuals in regional languages and dialects. These were distributed by our Female Health Workers and Community Based Workers. The materials were approved by the National Programme for Family Planning and Healthcare. **These materials were used throughout the project as training materials. Throughout years two and three, we identified shortages and replenished as necessary.**
2.3 Village Health Committees hold quarterly sessions to help parents recognise danger signs and symptoms of childhood diseases.	**Throughout the programme, regular sessions were held across Umerkot. These were facilitated by Female Health Workers and Community Based Workers and focused on the danger signs of, and preventative measures for, illnesses such as pneumonia, diarrhoea and measles.**

CASE STUDY – **AKHERAJ VILLAGE**

Akheraj village is situated in the north of Umerkot and has a mixed population of Hindu and Muslim communities living together.

Before your project, there was little knowledge of child health practices in the village and no health promotion.

Thanks to you, Female Health Worker Dhapoo helped men in the village create a health committee. Dhapoo worked with the committee to ensure they were aware of health issues and had the knowledge to take action and promote good practices in their village. The committee has now assisted with a polio awareness campaign and delivers health sessions in the village. They meet regularly and have referred mothers and children to correct health facilities when necessary.

OBJECTIVE THREE:

Advocating for the placement of key health staff and availability of essential lifesaving supplies and equipment at all target public healthcare facilities in Umerkot.

Planned activities	Achievements
3.1 Form a coalition of district level civil society organisations to advocate for improved availability and quality of Maternal and Neonatal Child Health services.	**Year one:** in collaboration with our district partner, HANDS, we formed a coalition of government and non-government organisations. Regular district meetings were held and the project received media coverage in local newspapers and Sindhi news channels. **Year two:** the coalition was successfully restructured to include: members of the District Health Management Team; representatives of national family planning and reproductive healthcare programmes; Department of Health contacts; and civil society organisations. **Year three:** the frequency of coalition meetings was increased to once per month to expand the opportunity for awareness raising and promoting good health practices. The project's coordinator also attended seven District Health Management Team meetings, during which progress and health related issues were discussed in detail. On 30th July 2013, a seminar took place where we shared final project findings with the authorities and stakeholders that are essential to the continued provision of quality healthcare in Umerkot and beyond. **Thanks in part to the project's advocacy work the District Health Department has agreed to scale up awareness raising activities. Other activities are also being continued. Our implementing partners have agreed to provide technical assistance to district and the Civil Society Coalition continues to function.**
3.2 Celebrate mewborn and child health weeks annually to highlight maternal, newborn and child health issues.	**Twice in the project (November 2012 and May 2013), a 'newborn and child health week' was ran in collaboration with all stakeholders (such as the District Health Department). These weeks covered the areas of nutrition, hygiene, immunization, antenatal care, postnatal care and more. A total of 3,709 community members from 53 villages attended sessions in the awareness weeks.**

CHALLENGES AND LEARNING

A number of challenges were faced throughout the project. Our community work created a higher demand for mother, newborn and child healthcare, and we reached more people than expected. However, the prevailing lack of skilled health workers resulted in a wide gap between the demand for and supply of basic healthcare.

We addressed this by the continuous training of health workers to improve their skills. The number of health workers was also a problem. Recruitment in remote districts is difficult as there is a lack of political commitment to investing in salaries in rural areas. We are advocating at all levels to ensure that remuneration is smooth and fair for all health workers in Sindh province but this is a slow process.

FINANCIAL UPDATE

Please note, the budget below is based on the original total project budget submitted to The Javed Fiyaz Charitable Trust in January 2010. Over the course of the project, minor changes were made to annual budgets and outlined in previous reports. The expenditure outlined is for the duration of the entire project. For details of annual spending and budgets, please see previous reports or contact us.

All costs in £ GBP			
Summary budget line	**Original budget**	**Complete spend**	**Balance**
Objective one			
Training for facility-based healthcare staff	30,000	11,195	18,805
Training for Female Health Workers	9,000	12,864	(3,864)
Transport for Female Health Workers to visit newborns in the first 24 hours	6,750	8,716	(1,966)
Training for Traditional Birth Attendants	2,700	3,487	(787)
Clean delivery kits, essential drugs and supplies	10,275	11,002	(727)
Objective two			
Quarterly community awareness sessions / materials	15,400	16,215	(815)
Supporting women's support groups	14,400	20,153	(5,753)
Supporting Community Health Committees	17,280	18,410	(1,130)
Training Community Health Volunteers	4,500	5,011	(511)
Objective three			
Overseeing coalition of district level organisations	4,000	3,079	921
Celebrating newborn and child health weeks	3,000	4,117	(1,117)
Partner coordination, monitoring and evaluation			
Field visits, surveys and partner meetings	19,800	29,960	(10,160)
Health Programme Manager (10%)	7,011	6,798	213
Project Coordinator (100%)	31,471	28,651	2820
Project support staff costs	40,730	43,602	(2,872)
Operational costs			
Rent, communication and utilities	22,495	29,247	(6,752)

Transportation	38,145	25,871	12,274
Subtotal	**276,957**	**278,375**	**(1,418)**
Supervisory and programme support (10%)	27,696	27,837	(141)
TOTAL	**304,653**	**306,212**	**(1,559)**

In total, the project cost £1,559 above budget. The majority of overspends and underspends were relatively small except for: training for facility-based health staff; field visits, surveys and partner meetings; and transportation.

THANK YOU FOR MAKING A DIFFERENCE

Your support has helped transform access to and the quality of health services in Umerkot, benefiting thousands of families. We've heard many stories of how the project has provided help and hope to people across the district; people like Karman.

Karman lives in Arz Mohammad Banglani, a village in Umerkot, with her husband, Bhoomon. The pair married ten years ago and both are employed in low paid, agricultural work.

Karman had been pregnant eight times but knew nothing of antenatal care or immunisations during pregnancy. Sadly, six of Karman's pregnancies failed to reach full-term and the two babies that were delivered alive, died soon after birth.

After failing to give birth to a healthy baby eight consecutive times, Karman's mother-in-law advised her son to divorce her and marry another woman. Bhomoon refused but, despite their happy marriage, they desperately wanted a child.

Shortly after her eighth pregnancy, Female Health Worker Parveen started visiting the village and invited Karman to participate in support group meetings. At the meetings, Karman received advice on antenatal care, postnatal care, vaccinations and more. When she became pregnant for ninth time, she applied all the knowledge and skills she'd learnt and gave birth in a local health facility.

Karman now has two healthy daughters who are properly immunised and cared for.

Karman's happiness would not have been possible without your generosity so once again, thank you.