FINAL EVALUATION REPORT

Access to Primary Healthcare for the Most Vulnerable Among the Crises Affected Population in KP/FATA, Pakistan

December 2020

RBC
CONTRIBUTING FOR DEVELOPMENT RESULTS

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Acknowledgements

The Result Based Consulting (RBC), The Team Leader and research team extends profound gratitude to the focal team of Medecins Du Monde, Pakistan, in particular to Ms. Marie Reissi, (Grant Manager), Mr. Waqas Ahmad (General Coordinator MdM) and Dr. Adil (Medical Coordinator MdM), and Mr. Saeed Gul (Field Coordinator, MdM) for their guidance and support to execute this formative research and vision to benefit from the evaluation outcomes.

RBC is grateful to the government authorities of the districts for sparing time for discussion. We highly appreciate the coordination efforts of both base managers at Kohat and Dera Ismail Khan to organize and support field meetings with health care providers and communities.

We are thankful to the whole research team including our core consultants especially Dr. Ali Yawar Alam and Mr. Mata Ur Rehman their untiring efforts and dedication to complete the task in the given timeline. Thanks, are also due to Ms. Saniya Khan and Ms. Shahnaz Akhter for their tremendous assistance to collect field data.

Médecins du Monde, France, Pakistan Office

Global website:	https://www.medecinsdumonde.org/en
Project funded by:	German Federal Foreign Office (GFFO)
Date:	December 2020
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List of abbreviations

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
BHU	Basic Health Unit
DAC	Development Assistance Committee
DHO	District Health Officer
DoH	Department of Health
DRR	Disaster Risk Reduction
ECM	Extended Coordination Meeting
FGD	Focus Group Discussion
FMO	Female Medical Officer
HF	Health Facility
HQ	Head Quarter
HR	Human Resource
JD	Job Description
KII	Key Informant Interview
LHVs	Lady Health Visitors
MdM	Medecins du Monde
MEAL	Monitoring, Evaluation, Accountability & Learning
MoH	Ministry of Health
MSDS	Minimum Service Delivery Standards
PHC	Primary Health Care
PNC	Postnatal Care
QOC	Quality of Care
RHC	Rural Health Center
SOPs	Standard Operating Procedures
THQH	Tehsil Headquarter Hospital
TNA	Training Need Assessment
VHC	Village Health Committee

Executive summary

MdM in consultation with department of health, introduced 24/7 Basic Emergency Obstetric and Newborn Care (BEmONC) services in select three RHCs and one THQH in Dera Ismail Khan, Tank and Hangu districts in KP province of Pakistan between 2018 and 2020. The MdM BEmONC project introduced an innovative mechanism to reduce health inequities, which included health system strengthening through professional development, enhancing quality service delivery capacities, use of modern medical equipment for diagnostic and treatment modalities, change in knowledge, attitudes and practices (KAP) of both service providers and beneficiaries through awareness, building health facility management capacities, village health committees, and sensitization of community to create demand for BEmONC services.

The objectives of this evaluation done in December 2020 are to review the overall relevance, coverage, efficiency, effectiveness, coherence, impact and sustainability of MdM interventions during the years 2018 to 2020, focusing on the key components of Basic Emergency Obstetrics and Neonatal Care (BEmONC), and social mobilization. A participatory mixed-methods (MM) approach was applied, for this evaluation utilizing review of project documents including log-framework, primary collected quantitative and qualitative data and secondary quantitative data. Quantitative data was collected by client exit interviews and quality-of-care assessment checklist. Qualitative data was collected through key informant interviews of service providers, Project Managers, DHOs and focus group discussions with women beneficiaries and community-based Village health committees. Cross-analysis of all sources of data was done for triangulation and formulation of results.

Findings and Results

The BEmONC services were being provided to local women, IDPs and refugee women without any discrimination and free of cost. These services including (health staff, BEmONC equipment and medicines, ANC, patient triage /screening, facility-based normal deliveries, assisted vaginal delivery, PNC, basic lab services, FP counseling) were available 24/7 in the MdM supported facilities. Further, 24/7 electricity supported by solar panels was also available in MdM supported facilities.

A number of capacity building initiatives and trainings were carried out by MdM for strengthening BEmONC quality service delivery as well as Infection prevention and control with particular reference to COVID-19. Though COVID-19 epidemic did slow down BEmONC services utilization yet MdM ensured 24/7 services availability in the designated health facilities.

The MdM project strategies and interventions including social mobilization and village health committees truly influenced the uptake of the BEmONC services by the local communities and therefore, overall beneficiary's satisfaction for the care provided in the BEmONC healthcare facilities was 85.7%. 82% of the clients reported that they got the medicines free prescribed by their doctor. The high-risk pregnancies were being referred to higher level facilities transported by an ambulance along with LHV for close monitoring; a strong evidence of continuity of care. Cash payment was being provided to families for arranging transport to reach higher level healthcare facility in non-emergency obstetric cases.

An average of 50-60 deliveries per month per facility were presently being carried out as compared to 3-4 deliveries per month per facility at the base-line. The ANC, deliveries, PNC, new-born care and immunization services were provided under one roof and ANC target of 70% coverage in three years' time was well achieved. It was learned that 5827 deliveries in 3 years' time surpassed the set project target of 5272 deliveries (100% achievement). There was 41.7% increase in PNC

services utilization from 2018 to the year 2019. Though FP services uptake was 34% during the project life against the target of 40%, yet FP material availability was 100% across all the facilities.

Six dimensions of quality of care were mostly met except some safety standards which were not met: e.g. in RHC Band Korai sharps and needles were not being collected in dedicacted, closable, puncture proof containers, in RHC Gomal and Band Korai safe disposal of sharps, needles, infectious and biological wastes was not in place. In all the four BEmONC facilities, there were no fire alarms system or fire extinguishers available.

Eight components of patient centred care were mostly met except that there was no system of feedback received on the patient outcome from the referred facility. This does not meet one of the standards of Transition & continuity of care.

Infection prevention & control measures: SOPs were there to guide the infection prevention and control measures. The staff was trained on case definition, screening for covid-19, and general cleanliness & aseptic measures in the labor rooms were optimal. Personal protective equipment (PPE) including gloves, masks, eye protection goggles, gowns, other protective equipment, soap, hand sanitizer and disinfectants were available and were being used appropriately.

The project was specifically evaluated and assessed based for DAC criteria as follow:

Relevance: The MdM's project was highly relevant to meet the need of humanitarian assistance in the remote villages of Hangu, DI Khan and Tank districts of KP province. MdM fortified the efforts of district health department in the provision of BEmONC services in these areas. Therefore, **coverage** expanded to include 24/7 functional BEmONC health facilities to the communities living in remote and far-flung areas. The project immediate and intermediate results are completely in line and **Coherent** with KP's health sector strategy 2010-17, health sector strategic plan (HSSP 2019-25), National SDGs 2 targets addressing reproductive health and reduction in maternal and neonatal morbidity and mortality. This is also in line with the DoH recent notification to functionalize 200 BHUs and 50 RHCs for providing 24/7 MNCH services across KP. The services utilization pattern and increased monthly institutional deliveries clearly reflected **efficient** use and deployment of resources. **Effectiveness**: The BEmONC services were well organized and effective to cater the needs of the vulnerable communities especially women and children, which is evidenced by 50-60 deliveries per month per project facility. Though at the early stage, it is difficult to measure project **impact**, yet robust result chain assures ultimate achievement of impact. Thus, theory of change and result chain of MdM BEmONC project is sound. The immediate and intermediate results are contributing towards end outcome and thus to the impact.

Sustainability & Replicability

There was high willingness and acceptance by provincial and district health departments with special reference to the DHOs. The mix HR model with a mix of FMOs, LHVs, Dais from MdM and DoH has higher probability of sustainability in case of MdM pull-out. There was high level of acceptance and satisfaction by the community leaders and women beneficiaries. Though the project did not have an approved exit strategy or sustainability plan, yet MdM remained engaged in advocacy with DHO for reformulation of HR strategy and availability for BEmONC service delivery in the designated health facilities. Additionally, recent efforts made by MdM head office and field managers to sustain the project interventions beyond project end point are commendable.

Conclusions and Recommendations: The MdM BEmONC project introduced an innovative mechanism to reduce health inequities, which included health system strengthening through professional development, enhancing quality service delivery capacities, use of modern medical equipment for diagnostic and treatment modalities, change in knowledge, attitudes and practices

(KAP) of both service providers and beneficiaries through awareness, village health committees, and sensitization of community to create demand for BEmONC services. The MdM project strategies and interventions truly influenced the uptake of the BEmONC services by the local communities. The key strengths of the MdM project were; adoption of an integrated approach under one roof in collaboration with DoH to provide quality BEmONC services through reasonably well-equipped health facilities and capacitated health professionals after creating demand for health services through VHCs and other awareness activities. Therefore, it is **recommended,**

i) to consider BEmONC model as an opportunity due to availability of trained staff in remote regions and all efforts must be made to retain this asset and use them to the best of their knowledge and skills. This is also in line with the recent notification by DoH KP to functionalize 200 BHUs and 50 RHCs for 24/7 MNCH services provision, and therefore MdM may advocate to DoH for replication of its model at the notified health facilities.

ii) Health Facility Assessments (HFA) and quality audits should be more objectively focused than subjective assessment and HFA should be made part of annual appraisal of health managers and healthcare providers. Monthly supervision -using Minimum Service Delivery Standards (MSDS) be introduced in BEmONC facilities, which is also in line with the DoH initiatives for ensuring patient safety and enhancing quality of care standards. KPIs should be broadened to include obstetric mortality rate, perinatal mortality rate, patient satisfaction rate, number of patient complains and number resolved, number of medication errors and lab report turn around time.

iii) Monitoring, Supervisory and Feedback Practices must be strengthened and designated staff must be trained to carry out M&E activities especially data analysis for decision making in healthcare setting.

iv) Monthly Clinical Audit program, may be introduced in these facilities in order to monitor all the BEmONC KPIs. This will introduce continuous quality improvement (CQI) in health facilities and enhance the effectiveness of the BEmONC services.

v) A mechanism needs to be developed to monitor the effectiveness of the training programs by developing on-job supervisory checklists. Further, the health managers must provide both vertical and horizontal feedback at all levels.

vi) The gap between LHWs, CMWs of MNCH program and BEmONC health facilities for case referral needs to be bridged. The PNC volume can be significantly enhanced by promoting home-based PNC visits by collaborating with CMWs and LHWs of the MNCH program.

vii) Finally, institutionalized Village Health Committees, strengthened awareness campaign, and improved meaningful coordination with district health department would be pivotal for continuity and sustainability of BEmONC services.