Sehat Sahulat Card Scheme

Partnering for saving the lives of mothers by providing quality MNCH services

DISTRICT GOVERNMENT KASUR

CONTECH INTERNATIONAL
Health Consultants

ACKNOWLEDGEMENTS

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Public Private Partnership Initiatives Team
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Foreword

Pakistan has lagged behind many of it neighbors regarding health and population outcomes. Although it has substantially reduced its MMR and IMR in the past decades but compared to other neighboring countries like Srilanka, China and Bangladesh, these reductions are so long-drawn. Pakistan is a signatory to the eight Millennium Development Goals, of which 3rd, 4th, 5th and 6th are directly related to children and women's health and status. The global focus of MDGs and insistence on tracking their progress in every part of the world has changed the nature of priority status of maternal and neonatal child health from a technical concern to a moral and political imperative. Reducing high tolls of IMR and MMR in line with the MDGs, depend largely on every mother and child having the right to access to health care. While the mothers and children constitute 69% of our total population, focusing our interventions to this vulnerable group will provide us with an opportunity to fulfill our MDGs commitment.

Interagency estimates show that of urban dwellers, 99 percent had access to health care, 96 percent to safe water, and 62 percent to sanitation, while of rural dwellers, only 35 percent had access to health care, 71 percent to safe water, and 19 percent to sanitation. These inequities have implications for the population that is economically vulnerable and face a lot of social hardships. Dwindling financial allocations with less focused investment in health of rural population, inadequate antenatal care at public facilities without any back up of skilled birth attendance, poor accountability system for staff, fragmentation of care and lack of referral system, and issues of accessibility and affordability are major hinderances in delivery of healthcare services in rural and remote areas. Under the Punjab health policy context, for reaching these vulnerable communities with essential healthcare services, an innovative strategy – dubbed the 'Sehat Sahulat Card Scheme' – was initiated through a public private partnership. Such partnerships are being promoted by the World Bank, UN leaders and number of influential governments, as the innovative policy of the New Millennium. Undoubtedly, states and institutions can both benefit from interaction and collaboration with the private for-profit sector. It is a powerful and a novel mechanism for leveraging the strengths of both the public and private partners and letting them both contribute to achieve the same goal. Overall results of this scheme in a nutshell have been very encouraging and it has proved to be a forerunner for initiating similar schemes to provide social safety net for vulnerable communities. Most importantly government should scale up this intervention to ensure appropriate maternal and newborn care where it matters the most: among the rural and urban poor.

Dr. Naeem uddin Mian
Health Specialist & CEO - Contech International

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Acronyms

ADB	**A**sian **D**evelopment **B**ank
BHU	**B**asic **H**ealth **U**nit
BITH	**B**hatti **I**nternational **T**eaching **H**ospital
DCO	**D**istrict **C**oordination **O**fficer
DGHS	**D**irector **G**eneral **H**ealth **S**ervices
ECCD	**E**arly **C**hildhood **C**are and **D**evelopment
EDO	**E**xecutive **D**istrict **O**fficer
EmONC	**Em**ergency **O**bstetric and **N**eonatal **C**are
FCPS	**F**ellow **C**ollege of **P**hysicians and **S**urgeons
FRCOG	**F**ellow **R**oyal **C**ollege of **O**bstetrics and **G**ynecology
HP	**H**ealth **P**rovider
LHV	**L**ady **H**ealth **V**isitor
M&E	**M**onitoring and **E**valuation
MBBS	**B**achelor of **M**edicine, **B**achelor of **S**urgery
MCPS	**M**ember **C**ollege of **P**hysicians and **S**urgeons
MDGs	**M**illennium **D**evelopment **G**oals
MIS	**M**anagement **I**nformation **S**ystem
MNCH	**M**aternal and **C**hild **H**ealth
MSDS	**M**inimum **S**ervice **D**elivery **S**tandards
PAC	**P**reschool **A**ge **C**hildren
PDSSP	**P**unjab **D**evolved **S**ocial **S**ervices **P**rogram
PPP	**P**ublic **P**rivate **P**artnership
SAC	**S**chool-going **A**ge **C**hildren
SHSP	**S**chool **H**ealth and **S**creening **P**rogram
SOP	**S**tandard **O**perating **P**rocedure
SSC	**S**ehat **S**ahulat **C**ard
STH	**S**oil **T**ransmitted **H**elminth
UC	**U**nion **C**ouncil
UN	**U**nited **N**ations

Executive Summary

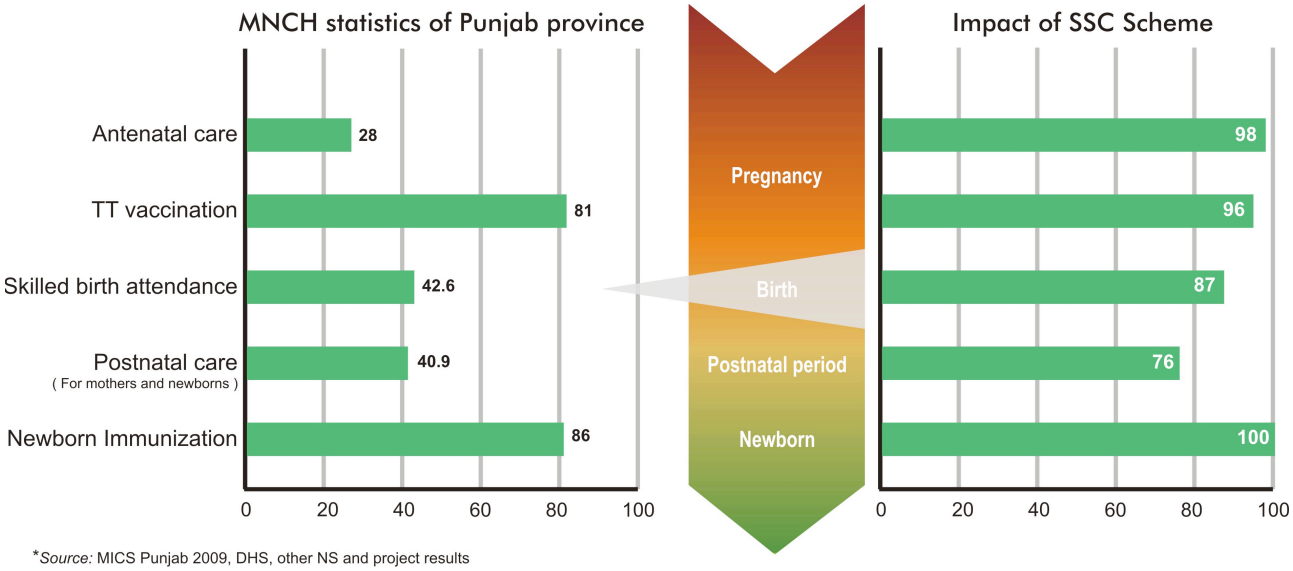
Poor mothers and children are undeserved along whole continuum of care because the poor are more likely to live in rural and remote areas with little access to healthcare services. Although public health services aim to make health care accessible and affordable for the poor and marginalized, but it has largely failed to do so. Barriers such as distance, transportation cost, problems with supplies of medicines and poor staff attitudes hold back mothers from seeking care in public sector hospitals, whereas high out of pocket payments in private sector health facilities have limited their access among the poor. These women are taken care by local TBAs who are unskillful to identify danger signs or to deal with complications arising during birth hence increasing risk of death for them. Such inequitable patterns of healthcare provision both reflect and entrench the social exclusion faced by the poorest and the most marginalized groups and help explain why maternal, neonatal and child mortality show marked socioeconomic variations.

SSC Scheme, an innovative model public private partnership, was implemented in districts of Kasur and Rawalpindi as an operational research to test out strategies that could bring improvements in the indicators of maternal and neonatal deaths. Given the limited resources and inefficiencies of the public sector, such PPPs were thought to be a straightforward solution to address the growing healthcare inefficiencies. Punjab Devolved Social Services Program initiated the whole process of building up this PPP model and acted as a catalyst between both parties. Contech International (private partners) contributed its share in the form of providing technical and management assistance for the scheme whereas district governments (public partners) provided financial resources for implementation of project activities and were also responsible for supervision of these activities.

SSC Scheme focused below poverty line pregnant women from rural areas, who were at most risk of suffering from problems related to pregnancy and childbirth due to little access to quality healthcare. One union council in Kasur and two union councils in Rawalpindi were selected to carry out the scheme. Private healthcare providers were selected for providing both basic and comprehensive EmONC services to the beneficiaries because government and other supervising agencies could not ensure proper functioning of public facilities. Involving private providers also enhanced coverage of skilled care and utilization of quality care.

Pregnant mothers were enlisted through purposive sampling of the catchment area and final selection was made using a '*poverty index*' that included income thresholds and social indicators of the households. SSC package included free antenatal care services, skilled birth attendance, postnatal and newborn care by qualified medical personnel. Providing free transport, medicines and supplements to the beneficiaries

enhanced their confidence and compliance. BCC was an integral part of this scheme and community awareness was enhanced through series of communication sessions with the beneficiaries. The results of this scheme proved to be very encouraging as depicted in the following graph.



Source: MICS Punjab 2009, DHS, other NS and project results

SSC Scheme proved to diminish inequities in access to maternal and neonatal healthcare and made it possible to deliver health interventions to those that had often been forgotten or omitted. It also addressed the challenge of saving those households that are harmed by catastrophic healthcare payments through provision of free and quality MNCH services. The experiences and challenges faced during the implementation of this scheme shall be helpful for upscaling this model. Results of this intervention should serve as a source of inspiration for some to initiate similar intervention in their setting for improving indicators of maternal and neonatal health and survival.

1.

Overview

Pregnancy and childbirth are generally times of joy for parents and families but mothers risk death to give life. Limited education, early marriage, premature pregnancy, difficult labors, poor diet, anemia and lack of primary health care all conspire against mothers of developing world. The most recent UN inter-agency estimates suggest that 536,000 women died from causes related to pregnancy and childbirth in 2005. Although the number of under-five deaths has fallen consistently worldwide - from around 13 million in 1990 to 9.2 million in 2007 - maternal deaths have remained stubbornly intractable. Globally, efforts to reduce deaths among women from complications related to pregnancy and childbirth have been less successful than other areas of human development; with the result that having a child remains among the most serious health risks for women.

On average, each day around 1,500 women die from complications related to pregnancy and childbirth, most of them in sub-Saharan Africa and South Asia.

Many women in the developing world and most women in the world's least developed countries, give birth at home without skilled attendants, yet their newborns are usually healthy and survive past their first few weeks of life until their fifth birthday and beyond. Despite the multitude of risks associated with pregnancy and childbirth, the majority of mothers also survive. But the health risks associated with pregnancy and childbirth are far greater in developing countries than in industrialized ones. They are especially prevalent in the least developed and lowest-income countries, and among less affluent and marginalized families and communities. On average, each day around 1,500 women die from complications related to pregnancy and childbirth, most of them in sub-Saharan Africa and South Asia. The divide between industrialized countries and developing regions is perhaps greater on maternal mortality than on almost any other issue as the average lifetime risk of a woman in a least developed country

dying from complications related to pregnancy and childbirth is more than 300 times greater for a women living in an industrialized country.[1] No other mortality rate is so unequal.

The maternal death... root cause may lie in women's disadvantaged position in the society.

Improving women's health is pivotal to fulfilling the rights of girls and women under CEADAW,[2] the Convention on the Rights of Child and achieving the Millennium Development Goals. In addition to meeting MDG 5, enhancing reproductive and maternal services will also contribute to attaining MDG 4, which seeks to reduce the under-five mortality by two thirds between 1990 and 2015. While targets for reproductive health were not initially included in the MDGs, at the World Summit in September 2005 the decision was taken to achieve universal access to reproductive health by 2015. Subsequently, a new MDG framework was adopted and the revised goals of January 2008 include a reproductive health target. Maternal health, however, goes beyond the survival of pregnant women and mothers. For every woman who dies from causes related to pregnancy and childbirth, it is estimated that there are 20 others who suffer pregnancy-related illness or experience other severe consequences. Millions of women who survive childbirth suffer from pregnancy- related injuries, infections, diseases and disabilities, often with lifelong consequences. The number is quite striking as an estimated 10 million women annually who survive their pregnancies experience such adverse outcomes. The truth is that most of these deaths and conditions are preventable as research has shown that approximately 80 percent of maternal deaths could be averted if women had access to essential maternity and basic health-care services.[3]

1.1 Current situation of maternal and neonatal health

In Pakistan, more than 320 in every 100,000 mothers die during pregnancy, childbirth or soon after, leaving behind devastated families. With skilled and responsive care, at and after birth, nearly all fatal outcomes and disabling sequelae can be averted and much of the suffering can be eased. The maternal death - as epitomized by the risk of death and disability from causes related to pregnancy and childbirth - has scarcely reduced in decades is result of multiple underlying causes. The root cause may lie in women's disadvantaged position in the society

[1] Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World Bank, WHO, Geneva, 2007: 29-35.

[2] The Convention on Elimination of All Forms of Discrimination against Women (CEDAW), 1979. Article No 12.2.

3 Ronsmans, Carine, Graham W. Maternal Mortality: Who, when, where and why, The Lancet. 2006; 368(9542):1193

and cultural barriers towards seeking facility-based healthcare. The health of mothers and newborns is intricately related, so preventing deaths requires, in many cases, implementing the same interventions. These

Fig 1.1

Millennium Development Goals on maternal and child health

MDG 4: Reduce child mortality	
Targets	Indicators
4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1-year-old children immunized against measles
MDG 5: Improve maternal health	
Targets	Indicators
5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

**Source:* UNICEF. The State Of The World's Children; Maternal and Newborn health. 2009.

include such essential measures as antenatal care, skilled attendance at birth, access to emergency obstetric care when necessary, adequate nutrition, post-partum care, newborn care and education to improve health, infant feeding and care, and hygiene behaviors. To be truly effective and sustainable, however, these interventions must take place within a development framework that strives to strengthen and integrate programmes with health systems and an environment supportive of women's rights. A human rights-based approach to improve maternal and neonatal health focuses on enhancing healthcare provision, addressing gender discrimination and inequities in society through cultural, social and behavioral changes, among other means, and targeting those communities who are most at risk.

1.2 Developing a healthcare model for quality MNCH services

In developing countries, routinely recommended obstetric care programs are often poorly implemented and clinical visits can be irregular, with long waiting times and poor feedback to the women. Most of the MNCH care models currently in use around the world have not been subjected to rigorous scientific evaluation to determine their effectiveness. Despite a widespread desire to improve maternal healthcare services, this lack of "hard" evidence has impeded the identification of effective interventions and thus the optimal allocation of resources. A human rights-based approach to improving maternal and neonatal health focuses on enhancing healthcare provision, addressing gender discrimination and inequities in society through cultural,

social and behavioral changes, among other means, and targeting those countries and communities most at risk. To be truly effective and sustainable, however, these interventions must take place within a development framework that strives to strengthen and integrate programs with health systems and an environment supportive of women's rights.

Financing quality healthcare is a global challenge for industrialized and developing countries alike.

Financing quality health care is a global challenge for industrialized and developing countries alike. Although there are no internationally agreed thresholds on minimum per capita total spending, the Countdown to 2015 initiative has estimated that per capita spending of less than US$45 is insufficient to provide quality basic health care services. Among the 68 priority countries for maternal, newborn and child health identified by the Countdown to 2015 initiative (including Pakistan), 21 have spending of less than US$45 per capita.[4] Public expenditure on health can be a key determinant of health system capacity. Countries with low rates of spending per capita may be associated with poor health outcomes, gaps in staffing, and weak investment in healthcare infrastructure and logistics. In 2004, the average expenditure on public health was just 2.6 percent of gross domestic product for low- and middle-income countries as a whole, in sharp contrast to the near 7 per cent of GDP spent by high-income countries. South Asia had among the lowest rate of spending, at just 1.1 per cent of gross domestic product.

Countries and donors are increasingly recognizing the pivotal importance of maternal and newborn health care in equitable social and economic development. Many governments, even in low-resource areas, are exploring different strategies for helping families manage the costs of routine and emergency obstetric and newborn care. Various options are possible, including reducing or eliminating direct user charges; implementing social protection initiatives such as cash transfers and vouchers on either a conditional or unconditional basis; and introducing national or community health insurance or subsidizing private provision of health care for poor households.[5]

1.2.1 Eliminating user charges

A key area of debate in health financing is direct user charges, which are an important barrier to accessing health services, particularly for poor people.

4 Bryce, Jennifer, Requejo J. H. Tracking Progress in Maternal, Newborn & Child Survival: The 2008 report, Countdown to 2015, United Nations Children's Fund, New York.

5 Borghi J.O. Mobilizing Financial Resources for Maternal Health. The Lancet, 2006; 368(21):1457-1465.

Removing user fees has the potential to improve access to health services, especially for the poverty-stricken. Several countries across the developing world have already abolished, or are in the process of eliminating, some or all direct charges and it is often with encouraging increases in access to healthcare services. No systematic evaluation of user fee removal across developing countries has taken place so far. Preliminary evidence suggests that in countries where user fee removal was not supported by other policy measures, such as increased national budgets for health care or careful planning and deliberate implementation strategies, health system problems tended to increase and performance weakened. In countries where fee removal was carefully planned and managed, however, there are signs of increased utilization of services and indications that the poor may have benefited most, although the incidence of catastrophic expenditures among the poor did not fall.[6]

National health insurance schemes... are hard to expand in countries with limited formal sector employment and low incomes.

It should be emphasized that user fees are not the only barrier that the poor face. Other cost barriers include informal fees; the cost of medicines, laboratory and radiology tests not supplied in public health facilities; travel, food and accommodation; and charges in private health-care facilities. These costs generally make up a significant proportion of the total costs that households face and disproportionately affect the poor. In addition, cultural barriers must also be overcome before the poor can access adequate health services. The evidence indicates that the poor are disproportionately affected by these non-barriers. Although user fees are only one of many barriers facing the poor, they are among the most amenable areas for policy action. As the recent experience from Uganda has shown, the policy process of fee elimination can have a catalytic effect in allowing governments to confront other issues, such as drug supply and procurement, budget allocation or financial management, which pose further barriers to progress. Clearly, removing user fees is not a simple exercise. Countries that seek to move in this direction re- quire sup- port in planning and implementing this policy change, and need to link the removal of direct user charges to broader measures for strengthening health systems. It should be noted that the context for user fee removal is critical, and no blanket policy is likely to address the needs of each country. Careful analysis of the country-specific situation, the equity implications of alternative financing and delivery strategies and the multiple financial and non-financial barriers to access is required to support decisions on the most appropriate course of action.

6 Gilson, Lucy, McIntyre D. Removing Fees for Primary Care in Africa: The need for careful action. British Medical Journal, 2005; 331:762–765

1.2.2 Insurance and cash transfers/cost-sharing

Effective improvements in maternal health outcomes may not be realized without concomitant improvement in quality of services.

National health insurance schemes such as Bolivia's social insurance for maternal and child healthcare services can increase access for the poorest women to antenatal and delivery care. Yet these forms of financing are hard to expand in countries with limited formal sector employment and low incomes. Community health insurance schemes, which operate more informally and on a smaller scale than social insurance schemes, have increased institutional delivery rates by 45 per cent in Rwanda and by 12 per cent in the Gambia. A cost-sharing scheme in an urban district of Burkina Faso increased the number of emergency referrals from 84 to 683 in a year.[7] It may be difficult to expand such schemes for wider coverage as they require government or donor support because they may not be self- financed and are dependent on effective community mobilization.

Conditional cash transfers and voucher schemes are being piloted to generate demand for specific services among the poor. Cash transfers have increased antenatal care during the first trimester among poorer women in Mexico by 8 per cent and in Honduras by 15–20 per cent.[8] India has provided financial incentives for deliveries in facilities for women from marginalized groups in priority districts of Gujrat province. While these initiatives have increased access to healthcare services, effective improvements in maternal health outcomes may not be realized without concomitant improvements in quality of services. Continued monitoring and evaluation of these financing innovations are required to inform appropriate scale-up by policymakers.

1.2.3 Providing safety net through Sehat Sahulat Card Scheme

The Sehat Sahulat Card Scheme is an innovative intervention to provide a social safety mechanism for pregnant ladies living below poverty line for ensuring free and quality MNCH services. The effectiveness of providing such health vouchers to improve utilization among vulnerable population is evident from national and international practices. Contech International and District Governments of districts Kasur and Rawalpindi implemented this project on pilot basis for one year. In Kasur, UC Matta was selected and more than 125 Sehat Sahulat Cards were distributed to pregnant women. The selection of beneficiaries was made on the

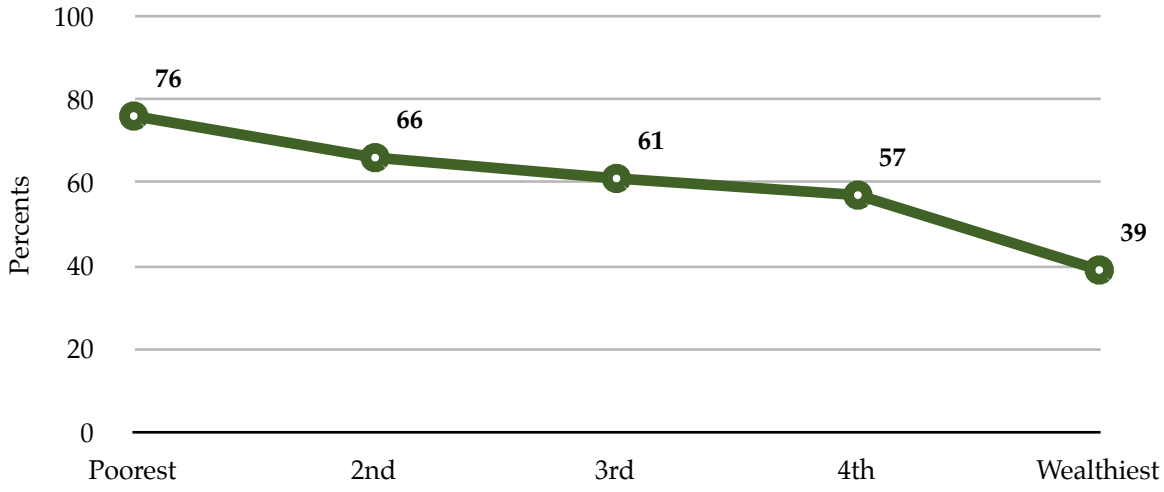
7 Richard F. Reducing Financial Barriers to Emergency Obstetric Care: Experience of cost- sharing mechanism in a district hospital in Burkina Faso. Tropical Medicine and International Health. 2007; 12(8):972-981.

8 Morris S.S. Monetary Incentives in Primary Health Care and Effects on Use and Coverage of Preventive Health Care Interventions in Rural Honduras: A cluster randomized trial. The Lancet, 2004; 364(9450):30–37.

basis of poverty scoring of these pregnant ladies. Beside providing the resources, community awareness was also emphasized in this program as in Pakistan, particularly in the rural areas, women are constrained in seeking healthcare for themselves and their children on account of low mobility and restrictions imposed in the name of religion or culture.[9] It further enhanced the equity in population by overcoming the coverage gap for the poorest, as in Pakistan the coverage gap between the poorest and the wealthiest exceeds 37%.

Fig 1.2

Coverage gap of healthcare services by wealth quintile in Pakistan



**Source*: UNICEF, Countdown to 2015. Tracking Progress in Maternal, Newborn and Child Survival. The 2008 Report.

1.3 Objective of the scheme

To develop and implement a model for improving coverage of quality MNCH services through a social safety mechanism for mothers and newborns, living below poverty line in the selected union cou ncils of Rawalpindi and Kasur.

1.4 Composition of the report

This report is generated at the completion of project and all the activities conducted during the project cycle are explained and have also been supported with literature review of best practices from countries of similar backgrounds. It is subdivided into five sections; implementation of the scheme is given in the second section, explaining the methodologies for selecting the catchment areas, healthcare providers, beneficiaries and set of services, and also the tools developed for monitoring of the scheme. Targets achieved through this innovative scheme are highlighted in the third section of this report, whereas the fourth section discusses the scope of upscaling of this scheme. Relevant information is annexed as at the end of the report.

9 Aslam A. Health-Related Millennium Development Goals: policy challenges for Pakistan. Journal of Pakistan Medical Association. 2004; 54(4):175:81.

2.

Implementation of SSC Scheme

SSC Scheme was implemented on pilot basis under Public Private Partnership between the District Government and Contech International. The main novelty of PPP is the framework of thought underlying the approach. A key feature distinguishing partnerships from other interactions with the private for-profit sector is shared process of decision making.[10] The term partnership covers a multitude of activities and relationships, perhaps best conceptualized as a special case of 'close' rather than 'arm-length' relationships between government and business.

The term partnership... best conceptualized as a special case of 'close' rather than 'arm-length' relationship between government and business.

The scheme was implemented within the ambit of Punjab Devolved Social Services Program (PDSSP), through a Public Private Partnership between the District Government of Kasur and Contech International Health Consultants. Activities conducted during implementation of the SSC Scheme are explained in the following segments.

2.1 Establishing a PPP Cell

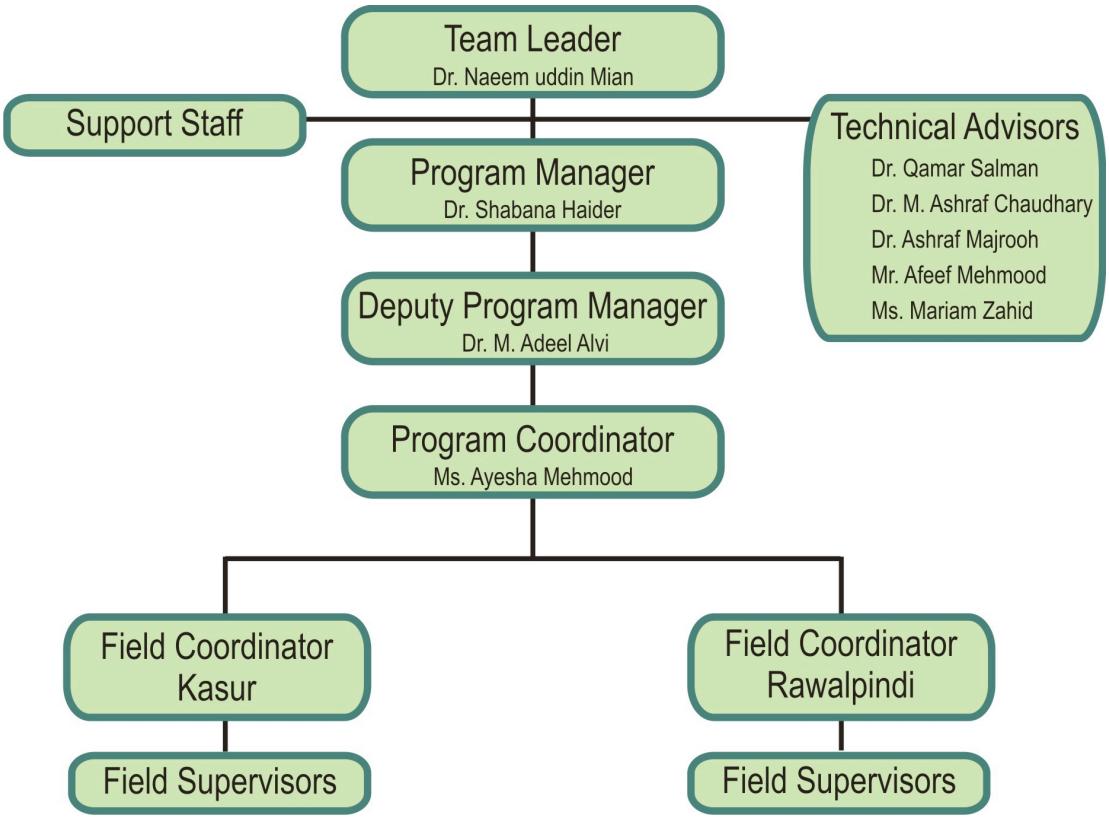
A PPP cell was established at Contech head office for centralized and uniform technical expertise and smooth implementation of PPP Initiatives. Under supervision of Team Leader, the PPP cell comprised of a Program Manager, a Program Officer, a Coordinator and support staff (including statistician, data operators). Field team was also recruited comprising of a District/ Field Coordinator and Field Supervisors. They were involved in the mapping and baseline assessments, and implementation of field activities. Training material was formulated for field staff to train them with required skills and competencies for implementation of field activities, monitoring, recording and reporting through MIS tools to achieve uniform standards and quality assurance. Field office was also established in Ramthaman, which is one of eight villages of UC

[10] Zammit A. Development at risk: Re-thinking UN-business partnerships Geneva. 2003. UNRISD in collaboration with South Centre. Available at www.unrisd.org. Assessed on 11th August 2009.

Matta. It had a central location in the UC for convenience of field team to conduct their daily meetings after completion of field work.

Fig 2.1

Organizational structure of PPP Cell and Field Teams



2.2 Inception meeting with District Administrative Authorities

An inception meeting was held on 17th November 2008 at the District Coordination Officer's office attended by District Administrative Authorities, PDSSP officials and Contech team (Minutes of meeting is attached as 'Annex I'). The purpose of the meeting was to introduce the participants about the program, its operational modalities and expected outcomes. It concluded with assurance of strong collaboration between Contech Team and the district administrative authorities, particularly the departments of education and health. An MOU was also signed between the DCO of Kasur and the CEO of Contech International. Although the inception meeting was held in November 2008 but project was delayed due to certain problems and the project was formally signed and initiated in February 2009.

2.3 Selection of Union Council

Union Council Matta was selected from Kasur through pre-decided criteria, in consensus with District Administrative Authorities of district Kasur and officials of PDSSP. It was a rural UC, comprising of eight villages and most of its population belonged to low socio-economic group . It further lacked functional and ac-

cessible healthcare facilities both in public as well as private sector. Its neighboring location from Contech's head office provided an opportunity for enhanced interaction of technical team with the field.

2.4 Baseline survey of selected UC

Statistical data was archived from the latest census results available from District Census Report (DCR) - Kasur, prepared by Population Census Organization in 1998 and Pakistan Demographic Survey (PDS) - 2005. A baseline survey was conducted to gather the required information about the area and target population. All the healthcare facilities were also enlisted both from public as well as private sector. The information gathered about the Union Council Matta is presented in Fig. 2.3.

2.5 Set of services under SSC Scheme

Recently, quality care has expanded from an exclusive focus on biomedical outcomes to a more inclusive approach that also takes into consideration patient rights and satisfaction, standards, equity, and the responsibilities and rights of healthcare facilities and their workforce.

The prime objective of SSC was to provide quality maternity and neonatal care to communities living in straitened circumstances. Providing a good quality care to all the beneficiaries of SSC Scheme included a minimum level of care to all pregnant and intrapartum women and neonates, with capacity of attending to those requiring emergency or more specialized services. It was aimed to obtain the best possible medical outcome; satisfy providers, patients, and families; maintain sound managerial and financial performance; and developing linkage with the beneficiaries for brining a change in their behavior. The novelty of SSC was the set of services covered under this social safety mechanism, which also encompassed provision of transportation and micronutrient supplements

Fig 2.2

Union Council Matta; at a glance...

beside the clinical checkups and medical procedures, hence providing a greater opportunity for investment to save lives of mothers and children.

Fig 2.3

General information about the Union Council Matta, Kasur

SERIAL NO.	INFORMATION	MATTA - KASUR
1	Type of region	Rural
2	Population	30,645
3	Male to female ratio	107
4	Number of annual pregnancy	1,200
5	Crude Birth Rate	27.4
6	IMR	81
7	Literacy rate	53
8	Public healthcare facilities	3 BHUs
9	Private healthcare facilities	Nil
10	Private schools	13

Complete list of set of services provided under this scheme is as follows:

- Transportation services (for Kasur only)
- Antenatal care
  - Maximum 4 visits: 1st during the first trimester, 2nd close to 26th week, 3rd at 32nd week and 4th visit between 36th to 38th week of pregnancy[11]
  - Baseline investigation on first antenatal checkup including Ultrasound Examination, Complete Blood Examination, Urine Examination, Blood grouping, Screening for Hepatitis B and C, Blood Sugar Level. At the subsequent visits, investigations are performed on the recommendation of gynecologist.
  - One to two doses of TT vaccination on basis of month of pregnancy (first dose on confirmation of pregnancy, second till 8 weeks after first dose).
  - Medicines for any complication/health problem
  - Micronutrient supplements of iron (Tablets or Injectable Venofer), Vitamins (Folic acid and B complex), Zinc and Calcium
- Natal care
  - Delivery services (Normal, Episiotomy or C-Section)

[11] WHO Antenatal Care Trial, conducted by UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Assessed on 23rd April 2009.

- Medicines and equipment for procedures
- Hospital stay
- Newborn care and vaccination

* Postnatal care
  - Clinical examination
  - Medicines, Micronutrient supplements (if required)
  - Counseling on breast-feeding
  - Counseling on FP
* Behavior Change Communication

2.6 Development of tools for monitoring and reporting

MIS Tools for efficient recording and reporting were devised to index all the activities of the program. A sample copy of all these forms/tools is attached as Annex II.

2.6.1 Mother's Sehat Sahulat Card

Sehat Sahulat Card is a small booklet accompanied by a small identity card. It was used by the healthcare provider to store information about every visit of the mother for MNCH services.

2.6.2 Mother Database Register

It was used by the Field Supervisors and detail of all type of services provided to each of the beneficiary was entered in this register.

2.6.3 Reimbursement Register

It was be used to file reimbursements for services provided by the health provider to the beneficiaries of SSCs. The Field Coordinator was responsible for verification and submission of monthly reimbursement to head office.

2.6.4 Monitoring tools

Monitoring tools were prepared for recording and reporting of activities of field staff (Annex III). They were modified after field testing and included the following:

- Daily Log Book
- Weekly Monitoring Performa
- Monthly Monitoring Performa

•Monthly Report

• Daily Telephonic Record-keeping Performa

Monitoring Performa and Activity Logbook were used by field staff for recording and reporting their activities on daily, weekly and monthly basis.

2.7 Poverty scoring of the pregnant ladies

Poverty Index, comprising of questions regarding income thresholds and social indicators, was used to select the beneficiaries of SSC Scheme.

Sehat Sahulat Card was focused on the households where catastrophic health expenditure had proved to be a big hinderance in utilization of maternal and child healthcare services by qualified health personnel. A *Poverty Index* was formulated to select poorest of the poor mothers of the community.

2.7.1 Poverty Index

Poverty Index was designed to measure the prevalence of poverty by determining a threshold against which the living standards of a family or household were measured. Poverty Index, comprising of questions regarding income thresholds and social indicators, was used to select the beneficiaries of SSC Scheme. It was prepared with help of annual income and growth statistics of Pakistan, publications of Department of Statistics, UNDP and World Bank's guidelines. The value of foreign currency was adjusted for Purchasing Power Parity (PPP) by using *International Dollar* to set income thresholds . The questionnaire contained nine questions and a household can score from 0 to 20 (20 indicates the poorest whereas 0 denotes least poverty according to selected indicators). It was provided in the vernacular for convenience of field staff and a sample of translated Poverty Index Questionnaire is attached as 'Annex IV'.

During the baseline assessment, field team enlisted all the pregnant ladies from selected UCs by gathering information from LHWs and LHV, and also through *purposive sampling* by door-to-door survey in the catchment area. Field Supervisors completed the poverty scoring by visiting the houses of all enlisted pregnant ladies from the selected UCs. In the Union Council Matta, 314 pregnant ladies were assessed for their level of poverty using this index. After completion of poverty scoring, the data was explored and analyzed for the selection of the beneficiaries.

2.8 Selection of beneficiaries

After the completion of the poverty scoring and analysis of the results, a cut-off value was set to select the desired number of beneficiaries. These selected mothers

were issued the Sehat Sahulat Cards. In the Union Council Matta, 125 pregnant ladies were issued the Sehat Sahulat Cards in the start but due to various reasons (like migration, family pressure, unwillingness), 23 mothers left the scheme, 12 of them left after availing antenatal care. Therefore new mothers were selected and by the end of the project number of valid cards was 103 (List of beneficiaries is attached as 'Annex V').

The Sehat Sahulat Card consists of an ID card and an obstetric record booklet. The field team visited the houses of selected mothers and handed over the ID cards bearing their photographs and required details, signed by the Program Manager. National Identity Cards were used for those beneficiaries who did not allow to take their photographs due to religious or cultural reservations.

2.9 Service deliverance

2.9.1 Selection of healthcare provider

The private sector has become an important healthcare provider, particularly in Asia, but the evidence base to measure its effectiveness is still limited. Attention to public private mix in health system is urgently required as public sector alone is not adequate for provision of healthcare services, particularly for the rural communities. The original concept of SSC Scheme involved both public and private sector healthcare providers. However, in the selected UC, private providers were selected at all levels of care, as the public facilities were found non-functional and inaccessible, and where functional they were lacking qualified staff and equipment.

The original SSC model planned to contract local LHVs for provision of antenatal care and basic EmONC. In UC Matta, only one LHV was working at BHU Ramthaman and she was available only in the morning hours. The BHU was not selected because it was unable to provide

Fig 2.4
BIT Hospital's laboratory

Fig 2.5
BIT Hospital's NRU

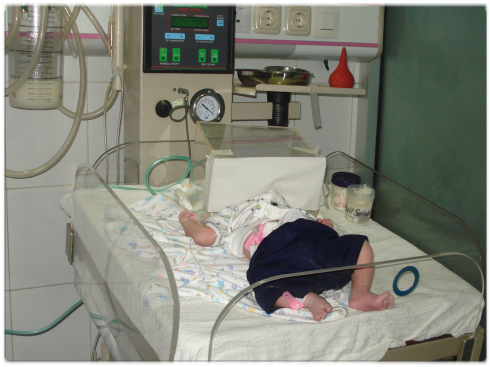
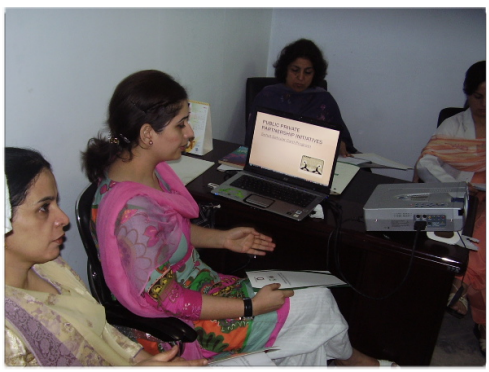


Fig 2.6
Doctors' training at BIT Hospital



required set of services like functional laboratory, medicines and referral linkages. Further, referral linkages had to be developed with DHQ Hospital but there was no obstetrician available at the DHQ Hospital Kasur at inception of the project. Therefore private facilities were contracted to provide both Basic and Comprehensive EmONC services to the beneficiaries. Public and Private healthcare facilities in the selected union council were evaluated for provision of Basic and Comprehensive EmONC. A comparison of available facilities is given in the following figure.

Fig 2.7

Comparison of healthcare facilities available for SSC beneficiaries in Kasur

Information	BHU Matta	Walli Clinic Kasur	Saif Clinic, Kasur	BITH
Type of facility	Primary	Secondary	Secondary	Tertiary, Teaching
Distance from Catchment area	0Kms	22Kms	23Kms	18Kms
Transport available	Yes	Yes	Yes	Yes
Basic EmONC	Only in the morning hours	Yes	Yes	Yes
Comprehensive EmONC	No	Referral for surgical procedures	Yes	Yes
HPs' profile	LHV, MBBS	MBBS	MBBS	FCPS, MCPS
Facility assessment	Very poor	Poor	Fair	Very Good

2.9.2 Bhatti International Teaching Hospital (BITH)

Due to unavailability of skillful healthcare provider 24/7 in the union council, Bhatti International Teaching Hospital (BITH) was selected to provide both basic and comprehensive EmONC services. It is a teaching hospital associated with Central Park Medical College and is well equipped to provide both basic and comprehensive EmONC as well as newborn care. It's department of Obstetrics and Gynecology is being run by a dedicated and competent team of fellow gynecologists including a Professor, an Assistant Professor and four Senior Registrars. A team of trained staff and qualified gynecologist was present round the clock to ensure timely and effective management of obstetric care as well as emergencies. An MOU was signed between Contech International and BITH and cost of agreed set of services was negotiated with the hospital administration.

2.9.3 Training of BIT Hospital's staff

A training was conducted for the doctors regarding SSC. They were made familiar with the program concept and service delivery protocols. They were trained on reporting mechanisms and on filing monthly reimbursements of expenses incurred. Further, continuous support was provided to the hospital staff through monthly meetings for ensuring quality of care to SSC beneficiaries.

2.9.4 Monthly reimbursement plan

Reimbursements were being made on monthly basis to the hospital. Claims including the hospital charges (from department of OBGYN and department of Pediatrics), laboratory cost and pharmacy bills were received by the Field Coordinator on the last working day of every month. After filling in the reimbursement register, all the entries were verified by cross-checking from Mother Database Register, Sehat Sahulat Card and medical records of the mothers and the infants. After verification, Field Coordinator used to send claims to head office for financial approval and release of payments. Payments were usually made to the hospital by the 10th of every month to maintain confidence and trust.

2.9.5 Conducting a hospital visit

Some of the selected beneficiaries were initially unwilling to go to the hospital for MNCH related services because of lack of trust in the beginning which was successfully dealt by the field teams. It was the responsibility of Field Supervisors to motivate the beneficiary and take them for a hospital visit for utilization of services. For an antenatal visit, the Field Supervisor first used to visit the houses of the beneficiaries to plan the visit and they were trained on enhancing awareness among the beneficiaries through BCC. These women were then clustered together on the basis of their location (Fig 2.8).

Fig 2.8

Clustering of villages of UC Matta, Kasur

Serial No.	Name of village	Number of beneficiaries
1	Ramthaman	24
2	Kalukhara	4
3	Theh Rossa	3
4	Matta, Beron Matta	40
5	Saharan	12
6	Sherokana	4
7	Kahn Singh Wala	6
8	Maluke	8

On each antenatal care day, 5 to 8 mothers were brought to the hospital for the checkup. After the checkup, the same ambulance was used to take mothers from hospital back to their homes. On each visit, beneficiaries were provided with supplements' doses sufficient till their subsequent visit. Upon confinement, the family of the beneficiary was orientated to call the ambulance and the Field Supervisor was always accompanying the mother to the hospital. Once delivered, the neonate was also taken care of in the neonatal nursery.

2.10 Provision of transportation

Reducing the time between arising of complications and getting women to facility is often critical for her survival.

Plans for health infrastructure development should consider the best means of improving transportation systems to aid women and children in accessing routine and emergency care. Lack of transport for shifting obstetric and neonatal emergencies is one of the reasons for 1st and second level delay. Reducing the time between arising of complication and getting woman to facility is often critical for her survival. Incentives have been used to finance transportation for pregnant women in India (Chiranjeevi Yojana) and Nepal (Safe Motherhood Program).[12] In a study in rural west Maharashtra, India, the distance to reach appropriate treatment for birth complications was 63.5 km for women who died and 39.3 km for women who survived.[13] Healthcare facility closest to UC Matta where skills and resources were available to deal with obstetric and neonatal emergencies was BIT Hospital It was situated 16 Kilometers from the catchment area and this distance was a big hindrance for timely transportation of beneficiaries. There was no direct public transport facility available from UC Matta to BIT Hospital. It was countered by providing transport services to the SSC beneficiaries through an existing ambulance service in the UC. This ambulance service was provided under Community Emergency Ambulance Services (CEAS) Initiative of Zahanat Foundation, which is a non-governmental and non-profit organization. The average time taken by the ambulance to bring the beneficiary to the BIT Hospital was about half hour and this timely arrival helped saving the avoidable maternal deaths.

2.11 Fostering social mobilization

In rural communities of Pakistan, entrenched cultural attitudes and beliefs often surround pregnancy and childbirth, and women are often blamed for their ill

[12] Carol B. Support to the Safe Motherhood Program in Nepal: An Integrated approach. Reproductive Health Matters, 2007; 15(30):5.

[13] B. R. Ganatra, Coyaji K. J., Rao V.N. Bulletin of the World Health Organization Too Far, Too Little, Too Late: A community-based, case-control study of maternal mortality in rural west Maharashtra, India, 1998; 76(6):591-598.

health and disease, and the mortality and morbidity of newborns. Supply-side measures cannot be successful without strengthening demand for quality healthcare at the level of households and communities. Social inclusion must be prioritized and individual families - particularly women - and communities must be included and treated as partners in healthcare provision. In Mali, for example, the involvement of grand-mothers in community education led to increased awareness of good nutrition for mothers and babies and the detrimental effects of heavy work for mothers as well as greater involvement by fathers in the care of their partners and newborns. The program also improved relations between women and their mothers-in-law, reducing shame and mistrust that had created distances between them.[14] Unconventionality of SSC Scheme was to enlist communities through inclusion rather than coercion. Field Supervisors under SSC Scheme were instructed through series of informal training sessions about raising community awareness by BCC. The achievement of service deliverance targets can be much attributed to these awareness strategies.

All technical and financial records were maintained by Contech International and are available for inspections

2.11.1 Engaging men and other family members - Friends of SSC

The goal of greater unity requires not just inclusion of more women but of men as well. Studies suggest that men perceive a myriad of complications that result in maternal mortality, yet they do not always recognize their own roles in preventing these deaths. In the target community of SSC Scheme, it was noticed that extended kin live in close proximity therefore, besides both parents, in-laws particularly mother-in-law and other older relatives were also approached through Friends of SSC for influencing their healthcare decision making.

2.12 Maintenance of technical and financial record

All the technical records related to services availed by the beneficiaries were properly organized and cataloged by the implementing agency. Individual file of each beneficiary was prepared and it included SSC booklet providing information about services utilized by the beneficiary, reports of laboratory investigations, details about mode of delivery and its outcome, prescribed medicines and supplements, and record of reimbursement. All technical and financial records were maintained by Contech International and are available for inspection at the head office, if and when required.

[14] Joe E., Lawn, Kerber J. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Partnership for Maternal, Newborn and Child Health, Cape Town, 2006:87.

3.

Accomplishments

3.1 Extending Antenatal care

Much ill health among pregnant women is preventable, detectable or treatable through antenatal visits. Antenatal care provides an opportunity to reach pregnant women with multiple interventions that could be vital to their well-being and that of their babies. In three regions - Latin America and the Caribbean, Central and Eastern Europe and the Commonwealth of Independent States, and East Asia and the Pacific - around 9 out of every 10 pregnant women receive antenatal visits one or more times. These percentages are far lower in the Middle East and North Africa, sub-Saharan Africa (both 72 per cent) and South Asia (68 per cent). The minimum number of antenatal care visits during pregnancy recommended by UNICEF and WHO is four (1st during the first trimester or 12 weeks, 2nd close to 26th week, 3rd at 32nd week and 4th visit between 36th to 38th week of pregnancy).[15]

Antenatal care coverage is relatively low in Pakistan, representing a significant opportunity to reach a large proportion of pregnant women with essential interventions. These visits help provide key services to pregnant women, including measures to detect and treat anaemia and nutritional deficiencies; tetanus immunization; management of other illnesses like infections; and provision of vital information to pregnant women on risks during the antenatal period and also during delivery.[16] Antenatal target of each beneficiary was calculated individually

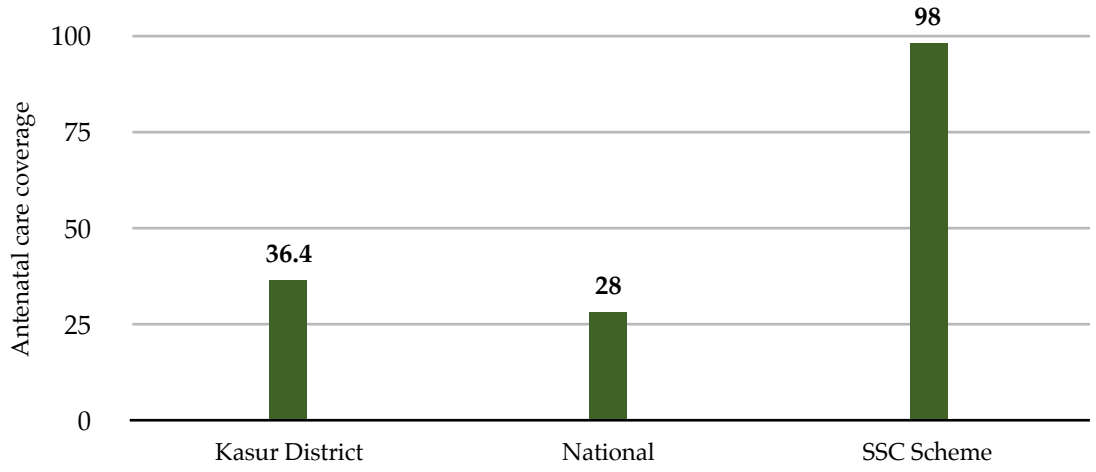
[15] WHO Antenatal Care Trial, conducted by UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Assessed on 23rd April 2009.

[16] United Nations Children's Fund. Progress for Children: A report card on maternal mortality. UNICEF. 2008; 7:44.

depending upon her month of enrollment in the scheme. Comparing the unsatisfactory national statistics of antenatal coverage (28%[17]) with that of Kasur district (36.4%[18]), it was quite remarkable to achieve more

Fig 3.1

Comparison of antenatal care coverage

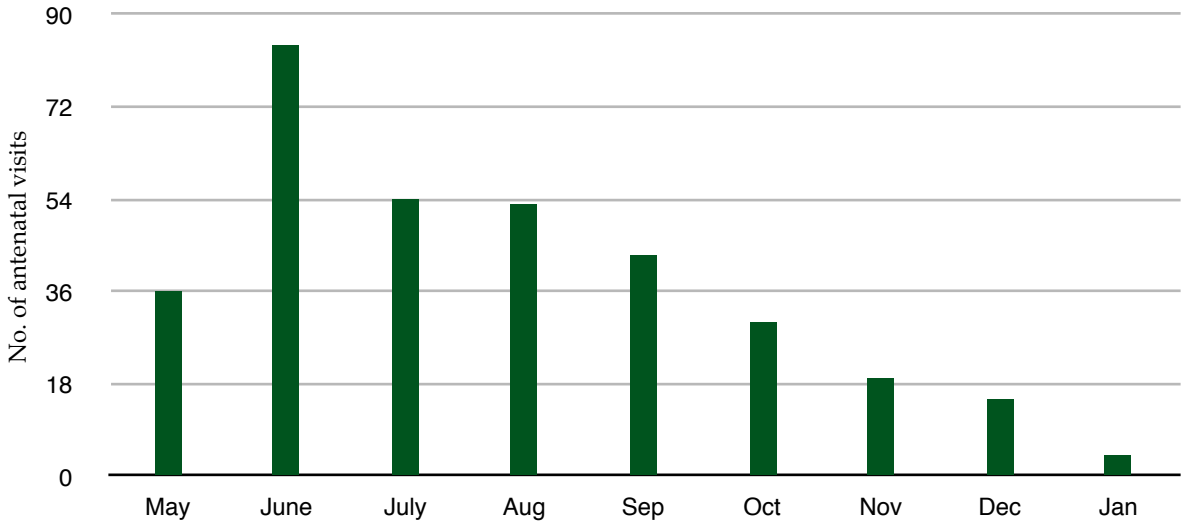


*_Source_: MICS, PDS, MCW - 2009, other NS

than 98% of antenatal care targets among SSCs' beneficiaries (according to month of registration; 4 if beneficiary is registered in first trimester, 3 visits for mother registered during second trimester, 2 visits if registered during the 7th or 8th month and one visit if registered during the 9th month of pregnancy.

Fig 3.2

Monthly record of antenatal care coverage in Matta Kasur



17 UNICEF, Geneva. The State of the World's Children Report, 2009. Statistical Tables; 149.

18 Government of the Punjab, Planning and Development Department; Bureau of Statistics. MICS - Punjab 2007-2008.

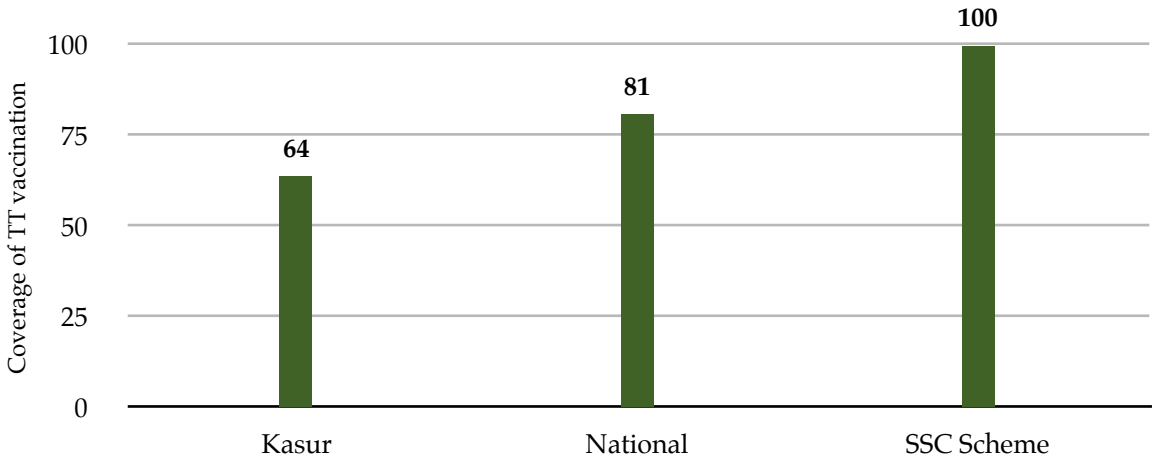
3.1.1 Immunization against Tetanus

Tetanus remains a significant cause of maternal and neonatal deaths, taking the lives of more than 180,000 newborns and between 15,000 and 30,000 mothers in 2002. The condition develops when a bacterium, Clostridium tetani, infects a cut or wound. Unclean delivery or abortion practices can result in maternal tetanus, while neonatal tetanus is caused by the unhygienic care of the umbilical cord or umbilical stump in babies. In the absence of intensive hospital care, neonatal tetanus is nearly always fatal. As with other causes of maternal and neonatal deaths, most of the fatalities from tetanus take place in sub-Saharan Africa and South Asia, especially in poor and marginalized communities where women have limited or no access to quality health care and little knowledge of safe delivery practices.[19] Tetanus is readily preventable through the vaccination of adult women and through hygienic delivery practices. Immunization has been among the most significant counter-actions against maternal and neonatal tetanus. The global rate of vaccination against neonatal tetanus for pregnant women has risen sharply since 1980, when it stood at just 9 per cent, to 81 per cent in 2007. Nonetheless, this still leaves almost 1 in every 5 newborns without protection.

Under SSC Scheme, all the beneficiaries selected from UC Matta received TT (Tetanus Toxoid) vaccination during the antenatal care. In Pakistan only 81% of newborns were protected from tetanus, therefore providing TT vaccination to 100% of the beneficiaries helped reduce the incidence of neonatal tetanus.

Fig 3.3

Comparison of T T vaccination coverage



**Source:* MICS, PDS, MCW - 2009, other NS

3.1.2 Supplements and micro-nutrients

Nutritional supplements including iron, folic acid and calcium provided during the antenatal period are beneficial for reducing the likelihood of under-nutrition and anaemia in the mother, and low birthweight in the newborn. Maternal anaemia affects about half of all pregnant women and it contributes to the risk of

19 World Health Organization, Geneva. Beyond the Numbers: Reviewing maternal deaths and complications to make pregnancy safer, 2004.

death in case of hemorrhage. It is also associated with poor fetal growth, fetal distress; and if mother has to be delivered by C-Section, it is an indication for blood transfusion. A low body mass index (less than18.5 kg/m2) for pregnant women increases the risk of both maternal and neonatal mortality; the same applies if a mother is stunted. Low body mass can restrict the growth of the fetus, which is a risk factor for neonatal complications such as low birthweight. Enhancing maternal nutrition also brings benefits for the achievement of Millennium Development Goal 1, which seeks to eradicate extreme poverty and hunger by 2015. Undernutrition is a process which often starts in-utero and may last, particularly for girls and women, throughout the life cycle. A stunted baby girl is likely to become a stunted adolescent and later a stunted woman.

Worldwide, birth in urban areas are twice likely to be attended by skilled healthcare personnel as those in rural areas.

Analysis of maternity records of SSC beneficiaries showed a high prevalence of anemia among them but through provision of micronutrient supplements including iron and folic acid, their hemoglobin reservoirs were built for safer pregnancy and confinement. While injection Venofer and Jectosol were provided to those beneficiaries whose hemoglobin level had to be built in short span of time. Provision of micronutrient supplementation to the SSC beneficiaries was found to be useful for gaining confidence of these mothers and it also encouraged them for continued adherence to MNCH services. Beside clinical advantage of improving risks by providing these supplements, it also had cut down the costs and risks associated with blood transfusion.

3.2 Natal care

Three quarters of all maternal deaths occur from complications either during delivery or in the immediate post-partum period. These complications include: hemorrhage (25 per cent of maternal deaths); infections (15 per cent); complications of abortion (13 per cent); eclampsia or related hypertensive disorders (12 per cent); and obstructed labour (8 per cent).[20] Factors hindering the provision of emergency obstetric care include distance, direct user charges, transportation and accommodation costs, knowledge and cultural barriers. Furthermore, the quality of care offered may also prove a deterrent, as shown in a study in northern United Republic of Tanzania, which indicated that the poor quality of care in facilities was the main barrier to access.[21]

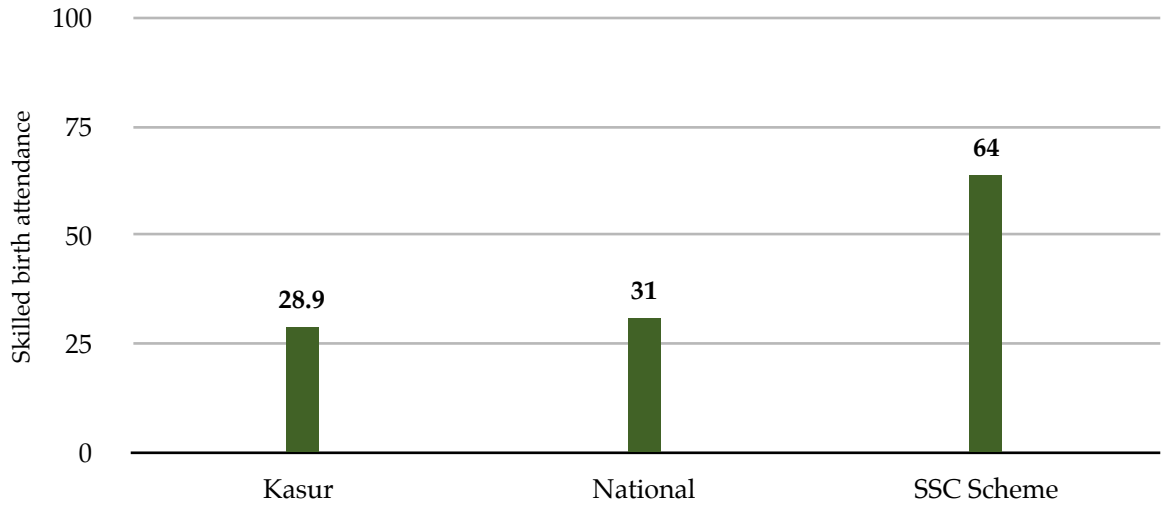
[20] Khan K. S. WHO Analysis of Causes of Maternal Death: A systematic review. The Lancet, 2006; 367(9516):1069.

[21] Even O, Nordheim N. Availability, distribution and use of emergency obstetric care in northern Tanzania. Health Policy and Planning, 2005; 20(3):171-173.

Worldwide, births in urban areas are twice as likely to be attended by skilled healthcare personnel as those in rural areas. Reducing maternal deaths from birth complications is possible through increasing the number of births attended by a skilled health worker who can be a doctor, LHV or trained midwife. Timely care in a medical facility is often necessary to save the life of a woman experiencing birth complications. The quality of care delivered by the facility is also critical. SSC Scheme provided opportunity for skilled birth attendance and in the selected facilities, trained health personnel were not only available to assist with a normal delivery or delivery with moderate complications, they were also competent to recognize serious complications for providing more specialized emergency care. Required essential drugs, supplies and equipment was also provided free of cost under this social safety net. The healthcare providers under SSC Scheme followed several recommendations of the WHO for saving the lives of mothers with complicated deliveries. Post-partum bleeding or hemorrhage, a leading cause of maternal death, was managed through active management of third stage of labor which is most widely accepted method of intervention. Active management involves administering a uterotonic to facilitate contractions for delivery of the placenta and delayed clamping, cutting and traction of the umbilical cord. These protocols were followed in the selected facilities to ensure quality MNCH services. Similarly, beneficiaries suffering from pre-eclampsia, eclampsia were hospitalized prior to delivery for observation and magnesium sulfate therapy.

Fig 3.4

Comparison of skilled birth attendance



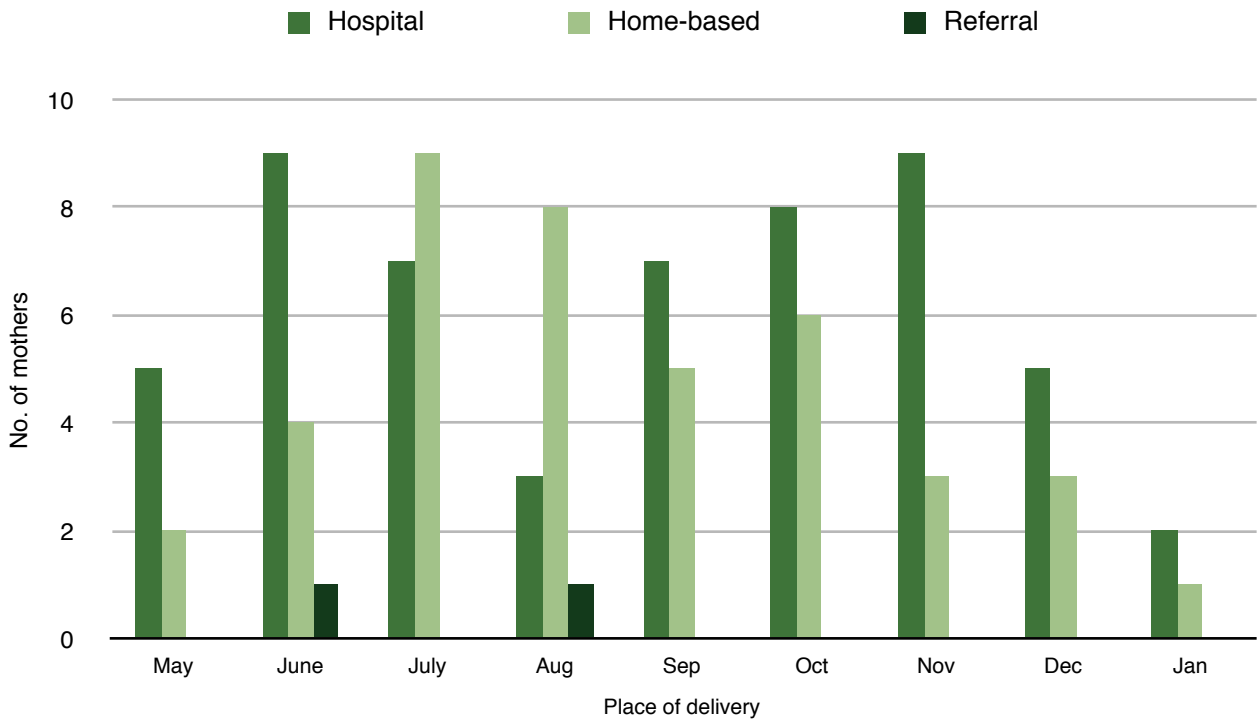
**Source:* MICS, PDS, MCW - 2009, other NS

Most of the beneficiaries of SSC preferred to deliver at the selected facility (58%). Two beneficiaries were referred to Lahore General Hospital due to unavailability of blood in the blood banks of Kasur city. Those who delivered at BIT Hospital, 37 of them were delivered by NVD whereas 18 beneficiaries were delivered by Cesarean Section. More than 90% of the primigravida ladies have delivered at the selected facility by qualified personnel. The number of deliveries occurring at other facilities (including referral) or home accounted for account for 41% of total deliveries. The TBAs in the catchment area were also trained by

Contech under the "Initiative of Capacity building of TBAs" regarding safe and clean delivery practices. Clean Delivery Kits (CDKs) were provided to these TBAs for practicing safe measures of delivery. Further, risk assessment of the pregnancy was done during the antenatal checkups by health provider for planning future interventions. It was in accordance with the WHO guidelines *'if the course of pregnancy was normal and mother was multigravida too and had previously delivered at home, then she should be delivered at home by a trained birth attendant'.*

Fig 3.5

Preference for place of delivery among beneficiaries in Matta Kasur

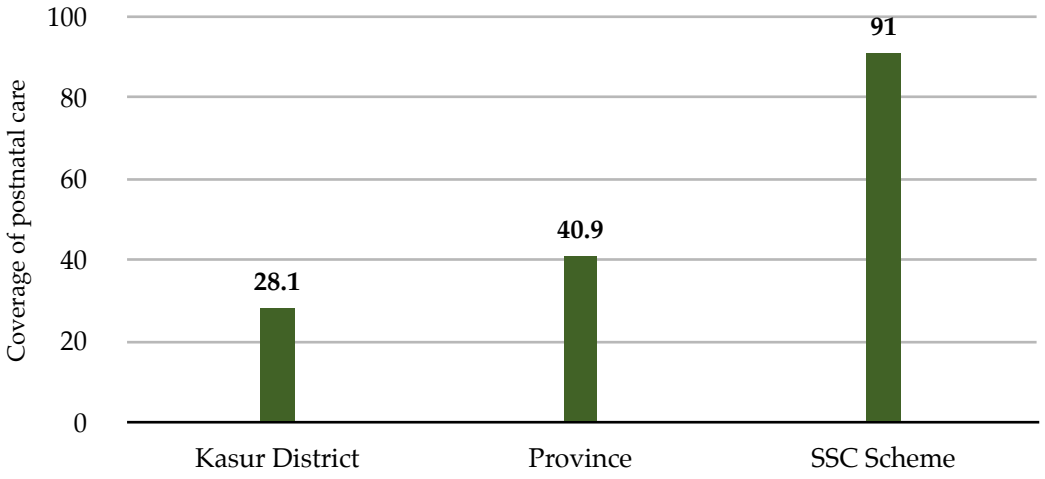


3.3 Post-natal care

The determinants of some pregnancy outcomes and the benefits of antenatal care may be seen only when they are part of a comprehensive program for the postnatal period which includes a postnatal visit. Providing effective care for mothers and newborns during the early postnatal period has the potential to generate the greatest gains in survival and health of any period in the continuum of care. It has long been neglected in developing countries including Pakistan where postnatal care is not provided to half of the mothers. Effective postnatal care requires care and attention during the immediate post-partum period and also several follow-up visits. Enabling mothers to return to health facilities in the days and weeks following childbirth, was very challenging. In addition to lack of healthcare facilities or difficulties in arranging transport, postnatal check-ups are seldom done due to certain cultural barriers and taboos. Under SSC Scheme, these cultural barriers were addressed by enhancing awareness about importance of postnatal visit among beneficiaries. Besides the counseling done by Field Supervisors, the importance of this visit was also stressed during the antenatal and natal visits by healthcare provider.

Fig 3.6

Comparison of postnatal care



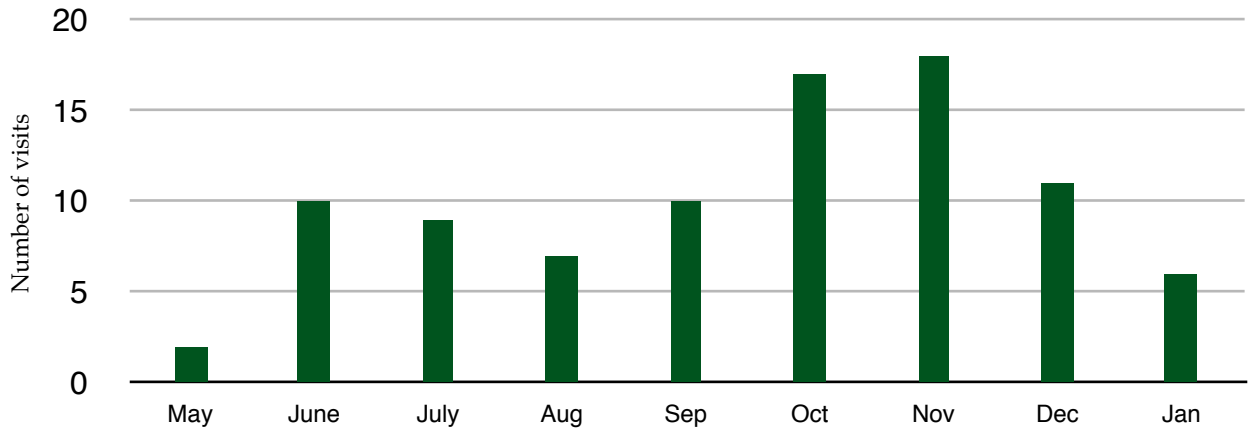
**Source:* MICS, PDS, MCW - 2009, other NS

3.3.1 Saving mothers and newborn lives – the crucial first days after birth

During postnatal visit, both mother and newborn were examined by the qualified gynecologist and it was aimed at the prevention of future unplanned pregnancies, reinforcement of breast-feeding, complete tetanus immunization for late attendants to antenatal care, folate supplementation for women with previous neuro-tubal defective infants, continuation of iron supplementation for women who are anaemic or with heavy blood loss in labor, prevention of infection and finally planning any continued postnatal surveillance, if required.

Fig 3.7

Monthly record of postnatal care visits in Matta Kasur



For mothers who were delivered through Cesarean Section, their stitches were also removed during postnatal visit. Transportation was also provided to the beneficiaries and in UC Matta Kasur, 91% of beneficiaries had a postnatal visit at the BIT Hospital.

3.4 Newborn care

Across the human lifespan, an individual faces the greatest risk of mortality during birth and the first 28 days of life, which is the neonatal period. Each year, nearly 4 million newborns die during this period. Three quarters of these deaths take place within one week of birth, and 1–2 million die during the first day following birth. Most of these deaths occur at home, are unrecorded, and remain invisible to all but their families. Millions more suffer severe illness each year, and an unknown number are affected with lifelong disabilities. The divide in neonatal deaths between the industrialized countries and developing regions is also wide. Based on 2004 data, a child born in a least developed country is almost 14 times more likely to die during the first 28 days of life than one born in an industrialized country.[22] The major causes of these deaths are serious infections (36 percent), prematurity (27 percent), birth asphyxia (23 percent) and congenital malformations (7 percent); whereas intrauterine complications and asphyxia are responsible for additional 3 million stillbirths.[23] These deaths can be prevented with provision of skilled care rather than technological advancements. These deaths can be averted by practices that do not incur high costs on the health system such as clean delivery practices, promotion of early and exclusive breast-feeding and ensuring mother's good health at delivery. Newborn care was provided under this scheme for first one month of life and was of great help in improving the infant mortality and immunization coverage. Immediate newborn care was provided to all the deliveries conducted in the selected facilities. BITH is associated with a medical college, therefore, department of Pediatrics was also available at the selected facility to provide specialized care for neonatal complications.. Every baby delivered through Cesarean Section was kept in neo-natal resuscitation unit for 24 hours. Babies of mothers delivering at home were brought to hospital for pediatric consultation at their postnatal visit. Key recommendations were followed during provision of care, such as hygienic cord care and keeping the baby warm, especially the low birth weight newborns. Infec-tions - a major cause of death among neonates - were timely identified during postnatal visits. Lives of these newborns were saved through active case manage-ment of neonatal sepsis by qualified healthcare personnel.

A child born in a least developed country is almost 14 times more likely to die during the first 28 days of life than one born in an industrialized country.

[22] Lawn J E., Simon C., Jelka Z., 4 million neonatal deaths: When? Where? Why?, The Lancet 2005; 365(9462):891–900.

[23] Bhutta Z. A. The first 28 days of life. The State Of World's Children, UNICEF 2009. Accessed 8 March 2010.

3.5 Success stories

I had one miscarriage a few years back and that too because of lack of proper antenatal care. There was no doctor or any qualified health personnel in our village and not even in the adjoining villages to provide care during my pregnancy. Through Sehat Sahulat program I not only availed quality healthcare services throughout my pregnancy by a lady doctor but also got free medicines, laboratory tests and healthcare services for me and my newborn.

MUKHTARAN BIBI
Ramthaman, Kasur

I was struck by polio in childhood. All my life I suffered because of my disability. All the more poverty added to this like a curse. I got married a few years back and when I got pregnant and came to know about Sehat Sahulat program through a neighbor I decided that if I get enrolled in this program, I could avail the best health services which I cannot even afford in my dreams. And seeing my poverty conditions and disability this would be a great blessing.....and I am so happy that it proved like a true blessing.

REHANA SADIQ
Matta, Kasur

In my 12 years of marriage I have had three abortions, one baby died in my womb and now I have only one alive baby boy who is one and a half years old. I realized that maybe this is due to lack of proper healthcare services and personnel available in our village as a result, going to local Dais is the only option left for poor people like us.

Sehat Sahulat program was like a breath of fresh air, a fresh beginning for me. With my bad experiences I could not rely once again on the untrained Dai. So I got enrolled in this program and delivered a healthy baby boy....a long awaited companion for my elder son.

NAJMA ARSHAD
Matta, Kasur

I am a mother of four children. When I got pregnant for the fifth time I was very weak physically. I would feel breathless after doing small household chores. Then I got enrolled in Sehat Sahulat Card program. I availed all their services. Through the blood tests I came to know that my Hb level was very low. The doctor said it could prove dangerous if the Hb levels were not raised. So she gave me a number of injections to treat it and that too all free of cost. I felt better and had a smooth delivery in the end.

SEEMA TALIB
Maluke, Kasur.

4.

Conclusion

SSC Scheme is an innovative social safety mechanism for pregnant mothers living in destitution. It thus diminished inequities in access to maternal and neonatal healthcare and made it possible to deliver health interventions to populations that had often been forgotten or omitted. Very high out-of-pocket payments prevent many people from seeking care and in Pakistan; a large number of households are harmed by catastrophic healthcare payments, particularly in rural community. SSC Scheme addressed these challenges by providing free and quality (timely, effective and accessible) MNCH services to the selected beneficiaries. The project successfully achieved its targets, providing sound basis for future up scaling. This pilot program helped identify the snags that should be dealt effectively at the larger scale.

✴ Pregnant mothers were very receptive and they understood well the importance of MNCH care for safe motherhood. BCC campaign played a vital role in enhancing the opinions of these women and just as parents were mobilized, so, too, were other family members to enhance the acceptance of such initiatives. Good patient-provider relationship and community linkage of SSC's field team contributed to better compliance.

✴ There are number of ancillary benefits associated with the SSC Scheme. During hospital visits, the beneficiaries from same village were grouped together for hospital visits and it enhanced their confidence and also provided an opportunity to socialize with other mothers, eventually enhancing compliance to care.

✴ Providing transport facility was the mainstay of high utilization of healthcare services. Public sector referral linkages were not up to the mark, therefore, improving transportation infrastructure should also incorporate strengthening referral process therewithal, which is also a crucial element for the survival of

mothers and newborns.

✳ While selecting the healthcare facility for SSC Scheme it was mandatory for the facility to have adequate medicines, supplies, equipment and personnel, besides its ability to perform potentially life-saving functions such as Caesarean sections, blood transfusions and newborn resuscitation. Though, best available healthcare facilities were selected but it was found important to select multiple healthcare facilities for providing choice of selection to the beneficiary.

✳ It may sound like a cliché but TBA is a reality that is deeply intertwined in the customs of rural communities of Pakistan. SSC promoted and facilitated skilled birth attendance; therefore the local TBAs of UC Matta started lobbying against this program and misguided the beneficiaries. It started to increase the number of home-based deliveries and two infant deaths were reported among these TBA-delivered mothers. Field Supervisors countered this problem by relationship building with TBAs and also by counseling the mothers about the benefits of being delivered by a skilled birth attendant. While up scaling, TBAs should also be involved, as it is inevitable to run such a program without their support. Capacity building of TBAs should be incorporated in project design and they should be utilized according to their capability to assist in providing care to pregnant women.

✳ Financial issues, like delayed release of payments by district government could pose a big hindrance if the project has to be upscaled. This is also detrimental for fostering such partnerships, which are based on trust and timely release of payments.

✳ SSC has been documented as one of the best practices in GPLP documentation of the UNICEF.

✳ Duration of SSC Scheme was one year and objective of this scheme was to test a model that could be scaled up for brining a difference in maternal and neonatal health. A third party evaluation was required to validate outcomes and also to provide sound basis for scaling up. This task was assigned to Punjab Economic Research Institute (PERI), a subsidiary of Planning And Development Department of Government of the Punjab. They randomly selected 25% of total beneficiaries and interviewed them about service deliverance and quality of care. In addition to these beneficiaries, they also involved healthcare providers and implementing agency in the evaluation process for formulating concrete recommendations. These recommendations should be taken up for scaling up the scheme to a wider audience for meeting our MDGs commitment.

Annexes

Annex I

Minutes of the Inception Meeting with District Administrative Authorities, Kasur.

Date and Time:

17th November 2008 at10 am.

Venue:

Office of the District Coordination Officer, Kasur.

Participants:

- District Government Officials:
  - District Coordination Officer.
  - Executive District Officer (Health).
- PDSSP Representatives:
  - Mr. Abdullah Khan Sumbal
  - Mr. Qurban Shah
  - Ms. Uzma Hussain
- Contech International
  - Dr. Naeem uddin Mian
  - Dr. Shabana Haider
  - Dr. Muhammad Adeel Alvi

Minutes Briefing:

- ➡ Meeting started with a brief introduction of the participants.
- ➡ It was decided by the district administration authorities that the verbal communication of the project modalities is better than a projector based presentation.
- ➡ Dr. Naeem explained the concept of Public Private Partnership Initiative and its projects in the Kasur District, the Sehat Sahulat Cards (SSCs) Scheme and School Health Screening Program (SHSP).
- ➡ The concerns regarding the Maternal and Neonatal Health were shared, explaining the alarming figures of IMR and MMR in Pakistan. Through SSCs, subsidized health care services will be provided to the pregnant ladies of the selected union council, who are living below the poverty line.

- Question was raised by the DCO regarding the selection of beneficiaries as if there are more than 400 pregnant females in the selected union council, then why only 100 will be catered under SSCs Scheme.
- Dr. Naeem explained the circumstances as it is a pilot project, therefore it is limited to a sample of only 100, and when it would have been implemented successfully then it can be scaled up to involve whole of the district.
- It was suggested by the DCO that instead of Zakat Office, cross-verification should be done by the Patwaris.
- In the end, financials were discussed apropos to the cost of the project and cost of the management. MR. Sumbal described the procedure for financial procurements. The 15% of the total amount will be released at the start of the project as mobilization advance. The remainder will be provided in quarterly installments.

The meeting concluded with assurance of strong collaboration between the Contech Team and the district administrative authorities. EDOs of Health and Education Department will provide the team with their valuable support.

A copy of this report is forwarded to:

1. Mr. Abdul Jabbar Shaheen, DCO Kasur
2. Mr. Abdullah Khan Sumbal, Program Director - PDSSP
3. Dr. Muhammad Aslam Randhawa, EDO Health Kasur
4. Dr. Naeem udDin Mian, CEO - Contech International

Annex II

Tools for MIS: Reimbursement Register for SSC

Reimbursement Register for SSC

Sr.No	Patient's Name	Patient's ID No.	Date	Charges of Services Provided						Total Amount	Verified by
				Antenatal	Lab Investigations	USG	Delivery	Post-Natal	Newborn	Medicines		
Grand Total												

ID. NO: KS-

Mother's name (ماں کا نام): _____ Husband's name (خاوند کا نام): _____

Address (گھر کا پتہ): _____ Month of Enrollment (اندراج کا مہینہ): _____

L.M.P (آخری ماہواری کی تاریخ): _____ E.D.D (ڈلیوری کی تاریخ): _____

Trimester(سہ ماہی): _____

Ante-Natal (AN) (دوران حمل)

VISIT # وزٹ نمبر	Date تاریخ	TT Vaccine ٹی ٹی ویکسین	Lab Investigations لیبارٹری کے ٹیسٹس: Hb/CBC ہیموگلوبن/بلڈ کمپلیٹ	Blood Sugar بلڈ شوگر	Hepatitis B&C ہیپاٹائٹس بی اور سی	Urine پیشاب	USG الٹراساؤنڈ	Others دیگر	Medication ادویات	AN-Complications دوران حمل پیچیدگیاں
I										
II										
III										
IV										

Natal (زچگی)

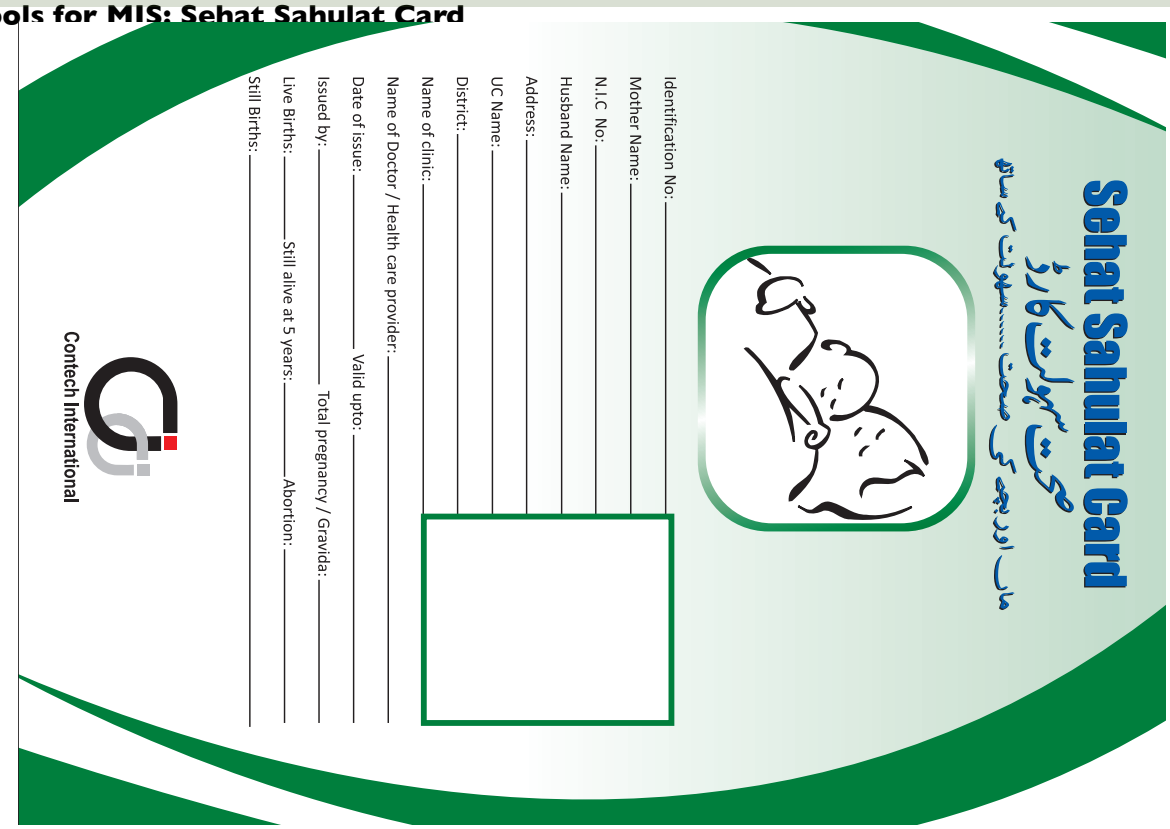
Date تاریخ	Outcome بچے کی جنس (لڑکا/لڑکی)	Type of delivery ڈلیوری کی قسم: NVD /SVD نارمل	Episiotomy چھوٹا آپریشن	C-Section بڑا آپریشن	Natal Complications زچگی کے دوران پیچیدگیاں

Post-Natal (PN) (زچگی کے بعد)

Date تاریخ	Findings: Mother ماں	New-born نوزائیدہ بچہ	Medication ادویات	PN-Complications زچگی کے بعد کی پیچیدگیاں

Annex II

Tools for MIS: Sehat Sahulat Card



Antenatal Visits

Last Menstrual Period (LMP) _____ Expected Date of Delivery (EDD) _____

Date of First Visit: _____

VISIT SUMMARY			
Complaints	BP	Pulse	
Weight	Height	Ab girth	
Anemia	Fundal Ht	Position	
Fetal heart rate	P/V bleeding	P/V discharge	
Breast examination	Urine test findings	Ultra sound	
Any other lab test		Associated illness	
Pregnancy status			
Normal / High risk (give detail)			

ACTION TAKEN			
Treatment/advice		TT vaccine	
Follow-up/Referral		Date of next visit	
Comments		Signature	

Date of Second Visit: _____

VISIT SUMMARY			
Complaints	BP	Pulse	
Weight	Height	Ab girth	
Anemia	Fundal Ht	Position	
Fetal heart rate	P/V bleeding	P/V discharge	
Breast examination	Urine test findings	Ultra sound	

Any other lab test		Associated illness	
Pregnancy status Normal / High risk (give detail)			
Action Taken			
Treatment/advice		TT vaccine	
Follow-up/Referral		Date of next visit	
Comments		Signature	

ANTENATAL VISITS

Last Menstrual Period (LMP) _____ Expected Date of Delivery (EDD) _____

Date of third Visit: _____

VISIT SUMMARY					
Complaints		BP		Pulse	
Weight		Height		Ab girth	
Anemia		Fundal Ht		Position	
Fetal heart rate		P/V bleeding		P/V discharge	
Breast examination		Urine test findings		Ultra sound	
Any other lab test				Associated illness	
Pregnancy status Normal / High risk (give detail)					
ACTION TAKEN					
Treatment/advice				TT vaccine	
Follow-up/Referral				Date of next visit	
Comments				Signature	

Date of fourth Visit: _____

VISIT SUMMARY					
Complaints		BP		Pulse	
Weight		Height		Ab girth	
Anemia		Fundal Ht		Position	
Fetal heart rate		P/V bleeding		P/V discharge	
Breast examination		Urine test findings		Ultra sound	
Any other lab test				Associated illness	
Pregnancy status Normal / High risk (give detail)					
ACTION TAKEN					
Treatment/advice				TT vaccine	
Follow-up/Referral				Date of next visit	
Comments				Signature	

LABOR AND DELIVERY

Duration of Labor pains		Expected complications	
Delivered in the center Y / N	Referred Y / N	Place of referral	
Date of referral		Reason for referral	

Type of delivery		SVD/Instrumental	Date of delivery	
Maternal complication during delivery		Neonatal complication		
Mother referred after delivery Y / N	Place of referral		Date of referral	
Baby referred Y / N	Place of referral		Date of referral	
Date of PNC follow-up			Date of ischarge	
Follow Instructions			Signature	

REFERRAL HOSPITAL MANAGEMENT (Only for referred complicated births)

Name of the hospital		Date/time of Admission	
Services provided		Date of discharge	
Name of the health			
	ACTION TAKEN		
Treatment/advice		TT vaccine	
Follow-up/Referral		Date of next visit	
Comments		Signature	

A Project of Contech International and District Governments of Kasur and Rawalpindi.

Contech International
2-G Model Town Lahore, Pakistan.
Email: contech@brain.net.pk,web: www.contech.org.pk

Annex III

Tools for M&E: Daily Logbook

Sehat Sahulat Card Scheme

Daily Logbook

Name of the Field Worker:

Union Council:

District:

Month: **Year:** **Date:** **Day:**

S.No	Activity	Purpose of Activity	Issues/Constraints	Remarks

Points for follow up:

1

2

3

4

Annex III

Tools for M&E: Weekly Monitoring Performa

Sehat Sahulat Card Scheme

Weekly Monitoring Performa

Name of the Field Coordinator conducting the meeting:

Names of the field staff present:

1

2

3

Date of the meeting:

Venue of the meeting:

Main Discussion points	Program updates	Weekly Targets	Issues/constraints	Points for follow up

Remarks:

……
……
……
……
……
……
……
……
……

Annex III

Tools for M&E: Monthly Monitoring Performa

Sehat Sahulat Card Scheme

Monthly Monitoring Performa

Date: **Time:** **Venue:**

Names of the Participants attending the monthly meeting:

1
2
3
4
5
6

Main Issues:

Service Delivery

No of pregnant women evaluated for poverty scoring	
No of SSC cards issued to the beneficiaries	
No of ante- natal visits	
No of deliveries carried out at the selected health facility	
No of home deliveries	
No of post natal visits	
TT coverage	

Health Facility

<table>
<tr><td>Medicines</td><td colspan="3">Total expenditure:

Verification of medical prescriptions: Authentic Fake

(Check the relevant box)

Are medicines over prescribed: Yes No

(Tick the appropriate one)</td></tr>
<tr><td rowspan="3">Investigations</td><td colspan="3">Total Expenditure:

Special investigations if any done:</td></tr>
<tr><td>Name</td><td>ID No of beneficiary</td><td>Name of the Test done</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Reimbursements</td><td colspan="3"></td></tr>
<tr><td>No of NVDs</td><td>No of Episiotomies</td><td>No of C-sections</td><td>No of abortions</td></tr>
<tr><td colspan="2">No of Maternal Deaths (if any)</td><td colspan="2">No of Neonatal Deaths (if any)</td></tr>
</table>

Logistics

1 2 3

Problems /Constraints

At the beneficiary level	
At the facility level	
Others	

Decisions Taken

Decisions	Responsibility	Deadline
1 2 3 4		

Annex IV

Poverty Index

اس سوالنامے کا مقصد صحت سہولت کارڈ سکیم سے فائدہ اٹھانے والی خواتین کو منتخب کرنا ہے۔ کمیونٹی سے غریب ترین گھرانوں کے چناؤ کیلئے معاشی اور اقتصادی مظاہر کا انتخاب کیا گیا ہے۔

فارم نمبر:----------

نام----------خاوند کا نام----------عمر----------

کنبہ کے افراد----------پتہ----------

یونین کونسل----------ضلع----------فارم مکمل کرنے والے کا نام----------

حمل کا مہینہ----------تاریخ----------

نمبر شمار	سوال نمبر	جواب	سکور
1	کنبہ کے تمام افراد کی مجموعی ماہانہ آمدنی کتنی ہے؟	1. 4000 روپے فی مہینہ سے کم (3 سکور) 2. 4000 سے 6000 روپے فی مہینہ (2 سکور) 3. 6000 روپے سے زائد (0 سکور)	
2	کیا رہائش کی جگہ ذاتی ملکیت ہے یا کرائے پر ہے؟	1. کرائے پر (1 سکور) 2. ذاتی (0 سکور)	
3	رہائش گاہ کی تعمیر کیسی ہے؟	1. کچی (3 سکور) 2. نیم پختہ (2 سکور) 3. پختہ (0 سکور)	
4	خاندان کے افراد کیلئے کیا ذاتی ذرائع آمدورفت مہیا ہیں؟	1. کوئی نہیں (2 سکور) 2. بائیسکل (1 سکور) 3. موٹر سائیکل۔کار۔جیپ۔ٹریکٹر۔وین (0 سکور)	
5	کیا گھر کے بچے پڑھنے کیلئے سکول جاتے ہیں؟	1. نہیں (3 سکور) 2. ہاں (0 سکور)	

6	کیا خاندان کی ملکیت میں کوئی مویشی (بھینس، گائے وغیرہ) ہیں؟	1. نہیں 2. ہاں	(3 سکور) (0 سکور)	
7	کیا خاندان کی ملکیت میں کوئی زرعی اراضی ہے؟	1. نہیں 2. ہاں۔ 2 ایکٹر یا اس سے کم 3. ہاں۔ 2 ایکٹر سے زیادہ	(2 سکور) (1 سکور) (0 سکور)	
8	کیا گھر میں بجلی کی سہولت میسر ہے؟	1. نہیں 2. ہاں	(2 سکور) (0 سکور)	
9	کیا گھر میں قدرتی گیس کی سہولت میسر ہے؟	1. نہیں 2. ہاں	(1 سکور) (0 سکور)	
	ٹوٹل سکور			

ایک گھرانہ زیادہ سے زیادہ 20 سکور حاصل کر سکتا ہے۔غریب خواتین کو اس سہولت سے فائدہ اٹھانے کیلئے کم از کم ۔۔۔ اسکور درکار ہے۔

تبصرہ:

Annex V

List of beneficiaries, Matta Kasur

Sr. No.	Codes	Name of female	Husband Name	Address	Age	Month	Score
1	KS-001	Shahnaz	Salamat	Matta	23	8	14
2	KS-002	Seema	Talib Hussain	Maluke	35	7	15
3	KS-003	Nusrat	Zia Shahid	Theh Saharan	27	7	17
4	KS-004	Irshad	Sardar	Theh Saharan	31	7	15
5	KS-005	Nabeela	Ramzan	Theh Saharan	28	7	14
6	KS-006	Nusrat	Rafique	Ramthaman	30	8	14
7	KS-007	Ghurria	Khushi Muhammad	Matta	25	7	14
8	KS-008	Shakeela	Arif	Matta	19	7	16
9	KS-009	Fouzia	Ilyas	Matta	20	7	14
10	KS-010	Yasmeen	Ghulam Mustafa	Matta	23	8	14
11	KS-011	Salma	Basharat	Matta	28	5	13
12	KS-012	Yaqeenan Bibi	Rafique	Ramthaman	35	8	15
13	KS-013	Kousar Abbas	Muhammad Abbas	Near Jamia Masjid Noor, Matta	25	8	16
14	KS-014	Rubina	Jameel	Near Dera Saleem Gujjar, Ram Thaman	25	8	15
15	KS-015	Asghari	Sarwar	Ram Thaman	30	6	15
16	KS-016	Mukhtaran Liaqat	Liaqat Shah	Near LHS Shameem	23	5	13
17	KS-017	Abida	Majeed	Kahan Singh Wala	26	6	17
18	KS-018	Rehana Sadiq	Sadiq	Near Raza Foundation School, Matta	18	7	15
19	KS-019	Sajida	Allah Ditta	Matta	32	6	15
20	KS-020	Fouzia	Mukhtar	Theh Saharan	30	6	16
21	KS-021	Najma	Muhammad Aslam	Matta	21	6	16
22	KS-022	Razia	Yousaf Maseeh	Near church, Maluke	30	7	20

23	KS-023	Rani	Amanat Ali	Beron Matta	30	6	14
24	KS-024	Zaib-un-Nisa	Alamgheer	Near Jamia Masjid, Theh Rosa	33	4	12
25	KS-025	Sumera	Intizar	Ram Thaman	25	5	16
26	KS-026	Jamila	Mustafa	Saharan	25	8	10
27	KS-027	Salma	Latif	Ram Thaman	35	8	15
28	KS-028	Azra	Basheer	Ram Thaman	22	5	11
29	KS-029	Akhtari Musarrat	Musarrat Ali	Govt. boys school Matta	30	8	16
30	KS-030	Safia	Rasheed	Ram Thaman	25	5	15
31	KS-031	Yasmeen Younas					
32	KS-032	Nasreen	Waqas Ali	Ram Thaman	24	4	16
33	KS-033	Zakia	Anwar	Ram Thaman	37	7	11
34	KS-034	Shahida	Muhammad Ali	Kalu Khara	30	4	15
35	KS-035	Muqaddas		Near Imam Masjid house, theh Saharan	28	4	18
36	KS-036	Mumtaz	Ghulam Qadir	Near Bus Stop, Maluke	25	7	12
37	KS-037	Aisha	Arif	Near Govt. Middle School, Matta	19	7	12
38	KS-038	Rukhsana	Mushtaq	Ram Thaman	24	4	18
39	KS-039	Perveen	Ghulam Mustafa	Theh Saharan	28	4	15
40	KS-040	Shahnaz	Akram	Matta	22	5	13
41	KS-041	Aasia	Shahzad	Matta	25	4	17
42	KS-042	Bushra	Salamat	Theh Saharan	32	3	15
43	KS-043	Aasia	Khalil Ahmad	Kahan Singh Wala	20	3	14
44	KS-044	Nasreen	Anwar	Matta	35	3	14
45	KS-045	Perveen	Muhammad Ramzan	Matta	25	3	15
46	KS-046	Ishrat	Rafeeq	Ram Thaman	30	3	14
47	KS-047	Kalsoom	Yousaf	Near Raza Foundation School, Matta	24	2	16
48	KS-048	Razia	Saleem	Matta	26	3	15
49	KS-049	Safia	Faqeer Hussain	Matta	20	3	16

50	KS-050	Shameem	Shabbir	Near LHW Shameem, Matta	30	3	14
51	KS-051	Saba	Riffayat	Beron Matta	18	3	14
52	KS-052	Aasia	Allah Ditta	Matta	25	3	16
53	KS-053	Najma Ramzan	Ramzan	Maluke	32	4	12
54	KS-054	Azra	Latif	Near Jamia Masjid Noor, Matta	22	3	12
55	KS-055	Naseem Akhter	Mashooq	Matta	27	2	15
56	KS-056	Zahida	Mansha	Theh Saharan	26	2	14
57	KS-057	Nazeeran	Razzaq	Ram Thaman	35	2	16
58	KS-058	Zohra	Muhammad Hafeez	Matta	25	2	15
59	KS-059	Nusrat	Sharafat	Saharan	22	3	17
60	KS-060	Najma	Arshad	Matta	22	3	11
61	KS-061	Nadia	Muneer	Sherokana	18	2	19
62	KS-062	Safina	Mukhtar	Near LHW Shameem, Matta	27	3	16
63	KS-063	Farzana	Jameel	Near Khajoor Wali Masjid, Ramthaman	33	3	13
64	KS-064	Hameeda	Salana Maseeh	Maluke	35	4	19
65	KS-065	Najma	Asghar	Near Syed Yousaf Shah, Sherokana	22	4	15
66	KS-066	Rukhsana	Muhammad Ahmad	Saharan	22	5	12
67	KS-067	Hameeda	Rasheed Maseeh	Near Rikshaw Stop, Matta	38	4	18
68	KS-068	Sakeena	Arif	Near Arif Tailor, Matta	17	4	16
69	KS-069	Naseem Abbas	Abbas	Maluke	35	6	14
70	KS-070	Tahira	Allah Ditta	Near Anjum Grammer School, Matta	20	6	14
71	KS-071	Hafeeza	Liaqat	Near Arif's Shop, Sherokana	20	6	15
72	KS-072	Aneesa	Mumtaz	Near Main Adda, Rosa	22	6	18
73	KS-073	Kousar	Siddique	Near Pakistan Model School, Ram Thaman	20	7	15

74	KS-074	Khalida Liaqat	Liaqat	Kahan Singh Wala	25	3 ½	14
75	KS-075	Sakeena	Shoukat	Near Kumhari Wali Gali,Ram Thaman	33	8	12
76	KS-076	Bushra	Ramzan	Ramthaman	25	4	13
77	KS-077	Mukhtaran	Ramzan	Ram Thaman	25	7	13
78	KS-078	Mumtaz	Ramzan	Ram Thaman	28	3	13
79	KS-079	Zubaida	Ashraf	Maluke	26	5	13
80	KS-080	Yasmeen	Shafiq	Theh Saharan	23	5	13
81	KS-081	Zahida Perveen	Abdul Jabbar	Near Anwar's shop, Matta	20	4	13
82	KS-082	Allah Rakhi	Arshad	Near Khajoor wali Masjid, Ramthaman	20	6	17
83	KS-083	Azra	Nazeer	Matta	30	3	13
84	KS-084	Sajida	Haneef	Matta	24	3	13
85	KS-085	Razia Liaqat	Liaqat Ali	Jinnah Public School, Matta	25	8	17
86	KS-086	Rukhsana Sabir	Sabir	Matta	25	7	17
87	KS-087	Nasreen Irfan	Irfan	Near Masjid Noor	25	4	16
88	KS-088	Asifa Tanveer	Muhammad Tanveer	Near Masjid Noor	20	4	16
89	KS-089	Shamim	Shoukat	Ram Thaman	32	6	13
90	KS-090	Sugra Taj					
91	KS-091	Sughran Bibi	Sattar	Maluke	35	5	13
92	KS-092	Shazia Bibi	Tufail	Sherokana	22	7	13
93	KS-093	Anwari	Abdul Majeed	Beron Matta	30	6	12
94	KS-094	Bushra					
95	KS-095	Shabana	Aashiq Maseeh	Near Church, Theh Rosa	23	3	13
96	KS-096	Maqbool Bibi	Aslam	Kahan Singh Wala	25	2	12
97	KS-097	Nazeeran	Fareed	Ram Thaman	35	6	12
98	KS-098	Jameela	Nisar	Maluke	33	7	12
99	KS-099	Irshad Bibi	Muhammad Anwar	Near Govt. Girls High School, Matta	35	3	11
100	KS-101	Safia	Shoukat	Near Govt. Girls School, Matta	22	4	11

101	KS-103	Sajida	Arshad	Kahan Singh Wala	20	2	10
102	KS-105	Shazia	Liaqat	Theh Saharan	35	1	10
103	KS-107	Tasleem	Jameel (Amb. Driver)	Kalu Khara			
104	KS-108	Kalsoom	Iftikhar	Theh Saharan	27	3	15
105	KS-109	Bushra	Younas	Ramthaman	22	5	14
106	KS-110	Irum Nadeem	Nadeem				
107	KS-111	Asia Yaseen	Muhammad Yaseen				
Sr.#	**Codes**	**Name of female**	**Husband Name**	**Address**	**Age**	**Month**	**Score**
1	KS-069	Tahira	Maqsood	Near LHW Shameem, Matta	16	5	16
2	KS-055	Naseem Akhter	Mashooq	Matta	27	2	15
3	KS-053	Nazia	Zulfiqar	Near Haji Khushi Muhammad, Ram Thaman	27	3	16
4	KS-049	Safia	Faqeer Hussain	Matta	20	3	16
5							
6							
7	KS-013	Rukhsana	Saleem	Near U fone, Anari Wala, Matta	22	7	16
8	KS-016	Abida	Shahid	Maluke	30	6	15
9	KS-074	Kalsoom	Sharif	Kalu Khara	30	7	12
10	KS-085	Sajida Bibi	Abdul Jabbar	Theh Saharan	33	8	13
11	KS-090	Sughran	Taj	Kalu Khara	16	2	13
		Jameela	Aslam	Theh Saharan	32	8	11
		Shumaila	Hashim	Maluke	25	8	11
		Gull Naz	Riaz	Ram Thaman	18	8	11