

**International Rescue Committee and PRIDE  
Request for Proposal – Health Communication Strategy Contractor**

A. Summary

The **P**rimarily Healthcare **R**evitalization, **I**ntegration and **D**ecentralization in **E**arthquake-affected areas (**PRIDE**) project is designed to improve primary health care (PHC) services and health outcomes for the nearly two million people of Mansehra and Bagh Districts in northern Pakistan—two of the districts most affected by the massive earthquake in October 2005. Over a four-year period beginning in August 2006, PRIDE seeks to address the ongoing tragedy of some of the worst maternal, newborn and child health indicators in the South Asia region through the following project components:

- *Improved performance of public health services and management*
- *Improved access to and quality of primary health care services*
- *Healthier behaviors and institutionalized community participation in health services*

PRIDE is a four-year project, with a budget of \$30 million. It is implemented by a consortium headed by the International Rescue Committee (IRC), with international partners including Management Sciences for Health (MSH), JHPIEGO – an affiliate of Johns Hopkins University – and the Population Council.

B. Project Summary/Scope of Work

PRIDE/IRC seeks to recruit a consultant/contractor to design a health communication strategy and implementation plan that will result in measurable improvements in specific health behaviors in keeping with project objectives.

The consultant/contractor will preferably have prior experience in Pakistan and the South Asia Region with similar relevant tasks that have demonstrated success. This includes designing and facilitating implementation of primary healthcare behavior change communication strategies in low resource, low literacy settings that have resulted in measurable improvements in health behaviors.

**Scope of Work:**

The consultant/contractor will design the project's behavior change communication (BCC) strategy to improve specified health behaviors of the people in Bagh and Mansehra districts. Behavior change must be consistent with project objectives and indicators; and must be measurable within a 2-3 year period in keeping with the life of the project.

The strategy will improve access to quality health services for the most vulnerable populations; and will specifically address gender issues and the need for women to not only practice healthier behaviors but achieve healthier outcomes.

The strategy will include:

- the purpose, objectives, results and impact to be achieved based on the results indicators already developed by PRIDE (with additional indicators if required);
- how the strategy will build upon, relate to and complement other health related information and campaigns already being conducted in each district;
- the health issues to be addressed and the population segments to be targeted;
- the key messages for each target population;

- the mix of media and interpersonal channels of communication that will be used to deliver the targeted messages;
- a draft plan and schedule for production of any materials and/or media productions required to implement the strategy;
- a detailed implementation plan and schedule for implementing the strategy, with clearly defined roles and responsibilities;
- the required resources (human, material and financial) for implementing the strategy;
- a management and monitoring plan for implementation.

The strategy should involve multiple communication channels relevant to the local setting. PRIDE anticipates that multiple partners may be involved in various aspects of design and implementation, including a locally-based design and marketing firm; local communities; and existing public health workers.

The contractor is expected to begin work no later than early January 2008 in Pakistan; and to complete the assignment within an approximate 6 month period.

#### C. Administrative Information

1. Bids shall be received by December 14, 2007. Bids may be submitted at anytime prior to the due date.
2. Bidders shall submit sealed bids to [Alex.Bornstein@theirc.org](mailto:Alex.Bornstein@theirc.org)
3. The submitted proposal shall include:
  - a. Written answers to the questions in Sections D and E.
4. The bidder's responses shall be evaluated by a committee of no less than four IRC/PRIDE employees. Selection criteria will include:
  - a. Soundness of methodology, approaches and overall design.
  - b. Clear articulation of how results shall be achieved.
  - c. Clear understanding of cultural issues that need to be taken under consideration for success.
  - d. Qualifications, skills and experience of proposed personnel.
  - e. Demonstrated capability to design, plan and scale-up a BCC strategy.
  - f. Demonstrated experience in core aspects of PHC.
  - g. Cost.
5. The consultant selection process shall be conducted as follows:
  - a. RFP released to selected contractors and posted on selected websites.
  - b. Responses received by the IRC by submission due date.
  - c. IRC evaluation committee evaluates proposals and notifies finalists via email. IRC will discuss proposals with the finalists. Bidders not invited are informed at this time.
  - d. After discussing the proposals with the finalists the IRC will inform the winning bidder and the other remaining bidders, if applicable, within ten (10) working days of the finalist notification.

6. The IRC reserves the right to accept or reject any or all bids and to accept the bid deemed to be in the best interest of the IRC and is not bound to accept the lowest price bid submitted.

7. Bidders shall direct questions to:

Alex Bornstein, C.P.M., Director of Contracting and Procurement  
[Alex.Bornstein@theirc.org](mailto:Alex.Bornstein@theirc.org)

#### **D. Requirements**

The bidder shall provide detailed responses to the following questions.

1. Previous Pakistan and/or South Asia Region or equivalent (Sub-Saharan Africa) experience in designing, implementing and scaling up a BCC strategy for populations of a similar size as the one to be targeted by PRIDE.
2. Detail BCC experience related to core aspects of PHC including maternal, newborn and child health utilizing grass-roots approaches in low-literate, low-tech and low – resource settings.
3. Provide description of methodology to be used and steps to be followed for the development of the strategy.
4. Provide brief discussion of cultural issues that will require particular consideration when working in this context.
5. Provide detail of proposed project pricing.
6. Provide proposed project timeline.

#### **E. Bidder Qualifications and References**

The bidder shall provide detailed responses to the following questions.

1. Name of primary owners (to be checked against anti-terrorism databases).
2. Length of ownership.
3. Number of staff.
4. Summary of technical qualifications of staff.
5. Brief overview/history of company.
6. Bidder shall provide three client references, preferably non-profit clients, with email addresses if available.

#### **F. Reference Documents**

1. PRIDE Annual Report
2. PRIDE's list of indicators



Toward  
**BETTER  
HEALTH**

**PRIDE Project  
Annual Report 2007**

Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected Areas

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Cover: A mother cradles her newborn baby as a proud health worker looks on. Healthy pregnancy, delivery and postnatal care are vital outcomes supported by PRIDE.

Cover photo : Chantelle Allen

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Photo: Chantelle Allen

## Introducing PRIDE

### How we began

Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected Areas (PRIDE) is a USAID-funded project to improve primary healthcare services and health outcomes in Bagh and Mansehra districts.

PRIDE came into being in the aftermath of the earthquake that struck northern Pakistan on 8 October 2005, bringing devastation to a 30,000 sq. km. area, killing 75,000 people and leaving 3.5 million homeless. Loss of habitat and infrastructure was enormous: 600,000 homes, 6,000 schools, and nearly 800 health facilities were destroyed.

The U.S. Agency for International Development (USAID) played a major role in response to the emergency, immediately providing supplies, personnel and funds. In fact the national and international response to the tragedy was quick, comprehensive and effective, despite the extreme conditions posed by mountainous terrain and poor socioeconomic conditions. This was particularly visible in the health sector: a network of field hospitals and primary health care facilities was quickly functioning at a level surpassing what existed before the earthquake.

In January 2006 the governments of the United States and Pakistan signed a bilateral agreement under which USAID would provide at least \$200 million for reconstruction and revitalization in the earthquake-affected area over the next five years. This agreement includes commitments to construct schools and health facilities, to revitalize health and education programs, and to support economic activities in two of the worst-affected districts, Mansehra in Northwest Frontier

Province (NWFP) and Bagh in Azad Jammu and Kashmir (AJ&K).

PRIDE's mandate is the health component of USAID's reconstruction and revitalization program. PRIDE is a four-year project, with a budget of \$30 million. It is implemented by a consortium headed by the International Rescue Committee (IRC), with international partners including Management Sciences for Health (MSH), JHPIEGO an affiliate of Johns Hopkins University and the Population Council.

### Our scope of work

The earthquake tragically took the lives of 16,000 people in Mansehra district, 5,000 of them in the town of Balakot alone. In Bagh district, 7,500 people died. In both districts, about 80 percent of the primary healthcare infrastructure was destroyed or severely damaged.

There is another ongoing tragedy that, somewhat less dramatically but perhaps more importantly, plays itself out each year in Mansehra and Bagh districts. Every year around 60,000 babies are born in these two districts. Unfortunately, two-thirds of their mothers do not receive adequate antenatal care during pregnancy, and a similar proportion deliver their babies at home without the assistance of a skilled birth attendant. Only one in five mothers and their newborns receive basic postnatal care.

It is not surprising, then, that each year in these two districts, approximately 1,500 babies die within 24 hours of birth and another 2,100 newborns die within the first month. Each year, nearly 6,000 children (99 per 1,000 live births, according to a recent study conducted by PRIDE) do not live to their fifth birthday.

During the coming years, PRIDE is committed to improving health outcomes for the people of Mansehra and Bagh, especially mothers, newborns and children. PRIDE will accomplish this by improving the health system, strengthening health services and increasing community participation in managing healthcare.



**PRIDE is committed to better health for the nearly two million people living in two of the districts most affected by the massive earthquake of October 2005, Mansehra and Bagh.**

**PRIDE seeks to address the ongoing tragedy of some of the worst maternal, newborn and child health indicators in South Asia.**

**PRIDE's mission is to achieve better health through improved health systems, health services and community participation.**

## The First Year: Findings and Achievements

### Setting the stage for better health

#### BEGINNING THE PROJECT

Certain start-up activities are necessary precursors to project implementation. PRIDE's start-up accomplishments during the first year include:

- Established offices in Islamabad, Mansehra and Bagh.
- Recruited around 70 professional and support staff.
- Put effective financial and administrative systems in place.
- Formulated an initial annual implementation plan.
- Consolidated a performance monitoring plan.
- Introduced the project to a wide spectrum of government counterparts and beneficiary communities.

As these start-up activities were taking place, PRIDE also began the process of building an evidence base and developing standards, strategies and guidelines for the project.

#### BUILDING AN EVIDENCE BASE

In order to ensure more effective planning, management, monitoring and evaluation, a number of data-gathering and analysis exercises were undertaken. These activities are described in the following paragraphs.

#### Rapid district health services assessment (RDHSA)

This rapid survey was conducted in December 2006 in all 22 Rural Health Centers (RHCs) across both districts and a random sample of about half (53) of the Basic Health Units (BHUs). Data were collected by a team of PRIDE staff, along with interviewers recruited and trained from Ayub Medical College, Abbottabad. Over 20 indicators of the basic functioning of the health system and health facilities were measured, providing valuable information to be used for project planning and as baseline data for follow-up monitoring and evaluation. Preliminary results were shared and discussed with the respective district health offices. Findings and main discussion points were published in January 2007.

#### Drug supply management (DSM) survey

The RDHSA highlighted that the drug management system in both districts is largely dysfunctional, with heavy dependence on external agencies to supply and distribute drugs. In April-May 2007, a more detailed assessment was done in collaboration with WHO and the respective district health offices. Recommendations from this assessment include formulating essential drug lists and basic operational protocols for use of drugs in BHUs and RHCs; training health staff in drug supply management; and providing adequate shelving for storing drugs in health facilities.

#### Baseline assessment of service standards in 30 health facilities

The quality of health service performance was assessed using a detailed check-list of over 200 standards covering 14 key service areas that are expected to be provided in health facilities. Out of approximately 120 RHCs and BHUs in the two districts, 30 were selected for assessment and intervention in the first phase. Service areas include various aspects of maternal and child health; treatment of diseases, such as tuberculosis and malaria; and cross-cutting areas, such as infection prevention and physical resources. The average performance score for facilities in Mansehra district was 12 percent, and in Bagh district was 18 percent.

**In the two years since the earthquake, more children between the ages of 0 and 5 years have died in Mansehra and Bagh from preventable causes than were killed in the earthquake.**



Rapid assessment team at RHC Dhirkot in Bagh district, December 2006  
Photo: Steve Sapirie

*Just one outcome of the baseline assessment of service standards...*

### Water for Khawari RHC

*The power of a champion for change*

Mr. Basit is a medical technician at Khawari RHC. When he participated in initial PRIDE activities, in preparation for the performance improvement process in Mansehra, he learned about the process and how to develop action plans.

The baseline assessment of service performance resulted in an overall score of 32 percent for Khawari RHC – the highest score achieved by any of the 30 facilities assessed. The 92 percent achievement in the management of sick infants was particularly pleasing to Mr. Basit.

When the Khawari RHC team began developing action plans to address gaps identified by the assessment, Mr. Basit was enthusiastic and took the lead, encouraging his team to develop a plan to affect real changes at their facility. For many actions he took personal responsibility.

The biggest problem identified by the Khawari RHC team was water. The facility's earthquake-damaged water supply had not been repaired. When Mr. Basit approached the EDO Health and UNFPA for assistance, he was assured the water supply would be repaired. But Mr. Basit decided he could not wait: he paid for pipeline repairs himself!

Through his positive example and encouragement, Mr. Basit has been important to the development of a dedicated team at his facility. Achieving health service standards and improving the quality of care provided by the Khawari RHC are no longer just the dream of Mr. Basit; these are now the goals of every member of the facility team.

The PRIDE team is excited by the progress and motivation of the Khawari RHC team and wants to develop this RHC into a model health facility. Other health facility teams will visit and see how, in Khawari, they work together to solve problems and achieve standards.

As for Mr. Basit, he will be a champion for change by encouraging and motivating other facility teams in the coming year.



Mr. Basit discusses service standards with a PRIDE public health officer  
Photo: Chantelle Allen



A KPC survey team visiting households in Bagh district, May 2007  
Photo: Saman Naz

## Knowledge, practice and coverage survey (KPC)

Household surveys were carried out in Mansehra and Bagh districts to gather baseline demographic and health data. Information on health knowledge and practices of ever-married women of reproductive ages included pregnancy and childbirth, child health, family planning, as well as community involvement in health. Results show that mothers, newborns and children are especially vulnerable and require more access to better health services in order to survive and thrive. Highlights from the KPC surveys are provided below.

### Knowledge, Practice and Coverage Survey 2007

Selected findings based on interviews with ever-married women of childbearing age (1,496 in Mansehra and 1,473 in Bagh)

Indicator	District	
	Mansehra	Bagh
<b>Maternal and newborn health</b>		
■ Antenatal visits (at least 4) (%)	35.0	26.7
■ Tetanus toxoid injection during pregnancy (2 or more) (%)	48.3	44.2
■ Skilled attendant at delivery (%)	34.4	36.3
■ Delivery in a health facility (%)	31.3	37.1
■ One or more postnatal visits (%)	22.6	24.6
■ Contraceptive prevalence rate for modern methods (%)	23.3	18.2
■ Female literacy (%)	44.0	54.7
<b>Child health</b>		
■ Child (under five years) mortality rate per 1,000 live births	99*	99*
■ Infant mortality rate per 1,000 live births	81*	81*
■ Fully immunized children 12-23 months (%)	39.4	45.9
■ Measles immunization, children 12-23 months (%)	52.0	62.9
■ Last diarrhea treated with ORT, children 0-23 months (%)	54.6	54.2

\*For Mansehra and Bagh combined.

## SETTING STANDARDS, CLARIFYING STRATEGIES AND PREPARING TRAINING MODULES

In consultation with stakeholders representing communities, the district health system and other health-focused agencies, PRIDE produced the following key documents to guide project implementation:

### Performance standards for public health, primary healthcare facilities, and community mobilization

PRIDE assembled an experienced group of national and district health managers, health care service providers from both districts, and international experts to review and set performance standards for each of the three project components. Special emphasis was placed on working within existing national policies and guidelines. A compendium of 279 standards in the three areas was developed: 47 public health management standards, 219 standards for clinical services in primary health care facilities and 13 community participation standards. Clinical standards include infection prevention,

physical resources, family planning, maternal health, child health, and TB and malaria management.

Following the 5-day standard setting workshop, draft standards were field tested and modified, then translated into Urdu. Service providers throughout the two districts were given copies of the performance standards, which serve as a guide to specific performance improvement processes facilitated by PRIDE.

### Guidelines for sub-district performance improvement process for public health (PIP-PH)

These guidelines are used by PRIDE staff and district health office managers to facilitate teams of sub-district health facility managers to analyze current public health service performance, identify priority needs for performance improvement, and then design and plan interventions for improving service performance utilizing existing resources. The process focuses on use of existing data for analysis, planning and monitoring.

### On-the-job training modules for maternal and newborn health

In order to minimize trainings that require facility staff to leave their workplace, PRIDE has developed learning modules on maternal and newborn health for on-the-job training of BHU and RHC staff (see box). Each module consists of a session outline, pre-test, presentation, small group activity (case study, role play, practice with models, etc.), and a post-test. The length of the modules varies from 1.5 to 3.5 hours. When health facility staff complete all 10 modules they will receive a certificate of acknowledgement jointly issued from the district health office and PRIDE.

*A success story from the sub-district performance improvement process for public health*

#### Taking responsibility for health

PRIDE stopped using the term catchment area and instead began using responsibility area to underscore the broader scope of provider outreach responsibility. PRIDE instills this way of thinking in facility managers through the performance improvement process for public health (PIP PH) workshops, which emphasize improving health outcomes in an entire population area.

In one of these workshops, which included participants from two sub-districts of Balakot tehsil, responsibility areas were mapped for each facility. Participants transferred these individual facility responsibility area maps onto one combined map. This exercise had interesting results: there were areas where the facilities overlapped and areas where no facility provided any coverage.

Once the mapping exercise made facility representatives aware of the problems, they addressed these immediately, deciding how best to modify their responsibility areas to ensure that quality services reached everyone.

Because facility representatives were willing to take responsibility for better health for their communities, all mothers, infants, children and other vulnerable populations in these sub-districts now have better access to services. And better access leads directly to better health outcomes.

#### Training Modules for maternal and newborn health

Module 1	Rapid initial assessment and shock
Module 2	Antenatal care: history and physical exam
Module 3	Vaginal bleeding in pregnancy
Module 4	Management of pre-eclampsia and eclampsia
Module 5	Birth preparedness and complication readiness
Module 6	Use of the partograph
Module 7	Normal childbirth: beneficial process
Module 8	Preventing postpartum hemorrhage
Module 9	Active management of the third stage of labor
Module 10	Normal newborn care

## Community mobilization strategy

This strategy is a comprehensive approach to constructively involving communities in supporting better health services. It includes village organizations helping to identify health issues, making plans to address those issues and facilitating effective implementation of actions to improve health outcomes. At the health facility level, Health Management Committees (HMCs) will bring together community and local government representatives, alongside health care providers, to support improvement of health services. Similar committees at tehsil and district levels will contribute to an overall network of participatory forums that together will be an integral, institutionalized part of the district health system, helping to ensure better access to quality health services.



Health facility managers develop action plans for improving public health outreach  
Photo: Steve Sapirie

## Guidelines for HMCs

These guidelines lay out the objectives, principles and methods of operation for Health Management Committees that will be formulated for each BHU and RHC. The project aims to have HMCs notified by the district administration and reporting to the district health officer (DHO in Bagh or the executive district officer health (EDOH) in Mansehra. HMCs will develop and implement annual plans for improving services at each health facility.

## Project implementation

In accordance with a work plan formulated during the initial months of the project, the following activities were achieved under each of the main components of PRIDE during the project's first year.

During initial discussions, the project team made a strategic decision to focus on quality improvement processes designed to engage health care providers in practical skills development in real-life situations as close to their work settings as possible. This is in contrast to conducting classroom-based trainings that remove staff from their work context, thus making the problem of under-staffed health facilities worse.

## 1. Improved performance of public health services and management systems

### 1.1. Improved planning and budgeting

Initial assessment and planning for these key aspects of health service management were included in the rapid district health services assessment (RDHSA). Neither district has a very meaningful institutionalized approach to annual planning and budgeting, though assistance from international agencies is sometimes available. PRIDE is promoting an approach to planning and budgeting that builds on the health facility and sub-district action plans.

### 1.2. Improved human resource management

The RDHSA also confirmed that there are enormous gaps in staff allocation and management. At times these gaps are partly filled by external assistance, particularly after the earthquake. There is an urgent need to more comprehensively address the health sector's critical human resource (HR) requirements in a sustainable manner. In the coming year, PRIDE will help to assess HR management processes, constraints and opportunities, and will support the respective health departments in implementing sustainable improvements.

### 1.3. Improved drug supply management

The following story demonstrates the power of facilitation to improve drug supply management in one RHC.

*The power of facilitation*

**Improved drug storage at RHC Chatter No. 2**

One of the findings of the baseline assessment of health service standards, conducted at RHC Chatter No. 2 in Bagh district, was that the achievement of the standards for maintenance of drug stores was very low.

During follow-up visits, Ms Farida Shah, one of PRIDE's public health officers in Bagh, discussed the baseline results with the staff, outlining basic actions that would easily lead to achieving standards for maintenance of drugs.\* However, staff members were reluctant to start on the outlined tasks.

Ms. Shah decided to lead by example. She asked Mr. Hanif Shah, a medical technician, to open the drug storage room. When he had done so, Ms. Shah started cleaning the storage area and rearranging the drug stock on her own. Staff members were clearly surprised, but immediately began to assist Ms Shah. On her visit to the RHC the next day, Ms Shah found that the facility team had cleaned the storage area and rearranged the medicines on beds (an improvement from the floor).

Working with the facility team a few days later, Ms. Shah assisted as they identified unused shelves and cabinets in the health facility that could be used to store drug supplies. The facility team, led by Mr. Hanif Shah and Ms Naheed Perveen , a Lady Health Visitor (LHV), took charge, moving storage units to the storeroom and rearranging the drugs, while adhering to the “first expired, first out” standards.

Now the drug stores at RHC Chatter No. 2 are well organized, and the facility team is proud of their achievement. This experience also encouraged the PRIDE team by demonstrating how facilitation and leading by example can be powerful initiators of change.

\*This strategy, referred to as *reaching for low hanging fruit* by the facilitation team, allows for quick progress on easy targets, resulting in improved morale and motivation that positively influences work on more difficult goals.



Photos: Shabana Zaeem

**1.4. Improved data use and public health service performance**

PRIDE's approach to PIP-PH engages sub-district teams of health managers in a structured process of assembling information, analyzing the current service operating situation, and choosing and planning interventions for improving the performance of priority public health services in order to improve selected health problems. In the first year, 48 health managers, out of approximately 120, have participated in a series of workshops on performance improvement.

The goal of this process is to improve the health of the population in the two districts through increased use of effective public health interventions to prevent and control diseases. By engaging in the process, health managers and sub-district teams of managers will achieve the following:

- Define the population catchment and responsibility areas of their respective health facilities.
- Create and put into practice a “health watch” mechanism, which prioritizes public health problems and activates a set of responsibilities and procedures for disease notification and investigation.
- Select one or two priority public health problems and related services and prepare an implementation plan for performance improvement.
- Establish the procedures, skills and discipline to maintain and use the health watch mechanism, and to implement progress monitoring tools.
- Establish a quarterly review process in which each facility's health watch framework is consolidated into a sub-district summary; progress and problems are discussed; and implementation plans revised.

### 1.5. Strengthened health service partnerships with communities, elected representatives and private sector healthcare providers

Work began during the first year on partnerships with communities and elected representatives, including establishing HMCs for each health facility. In addition, initial discussions have taken place regarding how to mobilize private providers in support of the health watch framework. This work is ongoing.

## 2. Improved access to and quality of primary health care services

### 2.1. Health service standards set and implemented in primary healthcare facilities using standards based management and recognition (SBMR)

A comprehensive set of health service standards for BHUs and RHCs was discussed and agreed upon by a wide spectrum of stakeholders during a workshop in March 2007. These standards form the basis for a process that empowers health facility staff to improve the performance of their facility. PRIDE initially selected 30 health facilities, 19 in Mansehra and 11 in Bagh, in which to implement the process. A baseline assessment was conducted at each facility in May and June 2007, with immediate feedback to the facility staff. The assessment process included a facilitated discussion that highlighted key findings and prioritized immediate action steps to address gaps.

Performance against standards was found to be very low, with an average score for health facilities in Mansehra of 12 percent and in Bagh of 18 percent. Out of 14 areas of service performance, the score for infection prevention was particularly low; therefore, initial action plans have focused on infection prevention, along with some aspects of physical resources.

Following the assessment, PRIDE public health officers have regularly visited each of the 30 health facilities to further facilitate and support each of their improvement action plans. PRIDE is in the process of supplying a range of simple equipment to improve infection prevention and to support other basic functions in these facilities. Equipment includes: plastic buckets and basins for storing chlorine solution, water storage containers, dustbins, dispensers for alcohol hand cleanser, small electric sterilizers, waste disposal units, cupboards and footstools for easy access, and simple equipment for physical examinations, such as sphygmomanometers, stethoscopes and fetoscopes.

### 2.2. Improved skills and service delivery capacity of primary healthcare providers

Through the health facility baseline assessments described above, skills requiring additional training were identified and prioritized by the service providers themselves. These included: infection prevention; family planning, particularly hormonal contraceptives; and antenatal care. Initial training in both districts began in August 2007; by the end of September, a total of 124 mostly female service providers were trained in infection prevention and family planning, and 44 female providers were trained in antenatal care.

Training sessions are highly interactive and practical. For infection prevention, special focus is given to practice in making chlorine solution, proper cleaning and sterilization of instruments and making inexpensive alcohol hand cleanser. Family planning training sessions focus on counseling skills and the use of WHO medical eligibility criteria for hormonal contraceptives.

To ensure ongoing implementation of skills, PRIDE public health officers conduct regular follow-up visits to each facility to further mentor staff. The performance standards are used as job aids and monitoring tools for these coaching sessions.



A PRIDE public health officer facilitates hands-on delivery skills training  
Photo: Chantelle Allen

### 2.3. Improved referral mechanisms

Work on this task, which includes decision making, communication, transportation and feedback, will begin in year two.

## 3. Healthier behaviors and institutionalized community participation in health services

### 3.1. Improved health knowledge and behaviors at household and community levels

During the first project year quantitative and qualitative data have been collected, and a better understanding of the dynamics of district health systems has been gained. Based on this PRIDE will design and implement a large-scale behavior change communication (BCC) strategy to improve health knowledge and behaviors beginning in year two. The strategy will utilize multiple channels of communication and be targeted to a variety of people who influence health behaviors.

### 3.2. Institutionalized community participation in health services

In the first year of operation, PRIDE formulated its community mobilization strategy and set standards for institutionalized community participation in the health system. The project built working relationships with, and introduced its program to, the local administration and political set-up in both Mansehra and Bagh. This includes two district set-ups, five tehsil units and 86 union councils. PRIDE compiled basic demographic, political

and social profiles of each union council. Four HMCs were set up in Bagh, in collaboration with the health department and another USAID-funded project focusing on construction.

## 4. Highlights of support activities

### 4.1 Construction of district health office in Bagh

Following the earthquake, staff of the district health office in Bagh were working in tents and temporary containers. Early in the project, USAID encouraged PRIDE to provide a more adequate temporary building to accommodate the district health office staff. Construction of a 3,000+ sq. ft, well-insulated, fully furnished building was completed and handed over to the district health office in July 2007. A memorandum of understanding was signed between the district health office and PRIDE clarifying the relevant terms and conditions.



The Prime Minister AJ&K inaugurates the District Health Office, Bagh  
Photo: Rashid Mehmood

### 4.2 Recruitment of a network of implementing partners to support the community mobilization strategy

Scale-up of activities at the community level requires extensive on-the-ground presence. For this, PRIDE invited proposals from NGOs active in Bagh and Mansehra to partner in implementing the community mobilization strategy. Five partners were competitively selected: National Rural Support Program (NRSP) and American Refugee Committee (ARC) in Bagh district; and Sarhad Rural Support Program (SRSP), HealthNet TPO and ACTED in Mansehra district.

## How PRIDE is improving health outcomes for the people of Mansehra and Bagh districts

HEALTH SYSTEMS	HEALTH SERVICES	COMMUNITY PARTICIPATION
<b>Performance of public health services and management systems</b> <ul style="list-style-type: none"> <li>Improved planning and budgeting.</li> <li>Improved human resource management.</li> <li>Improved drug supply management.</li> <li>Improved data use and public health service performance.</li> <li>Strengthened health service partnerships with communities, elected representatives and private sector healthcare providers.</li> </ul>	<b>Access to and quality of primary health care services</b> <ul style="list-style-type: none"> <li>Set and implement service standards in all primary healthcare facilities.<sup>1</sup></li> <li>Improved skills and service delivery capacity of primary health care providers.</li> <li>Improved referral mechanisms.</li> </ul> <p><sup>1</sup>Using the standards based management and recognition approach (SBMR).</p>	<b>Healthy behaviors and community participation in health</b> <ul style="list-style-type: none"> <li>Improved health knowledge and behaviors within households and communities.</li> <li>Institutionalized community participation in health services.</li> </ul>

## Strategic Directions: Year Two and Beyond

During the coming years, PRIDE faces challenges and opportunities to revitalize health systems decimated by the earthquake of 2005. However, revitalizing primary healthcare services alone is not PRIDE's goal. Even before the earthquake the health system was not adequately addressing the health needs of the people due to basic underlying weaknesses and gaps. PRIDE aims to comprehensively address these gaps in partnership with communities, the government and other key partners.

PRIDE will help individuals and communities to take charge of their health, through improved health behaviors and participation in decision making in the health system. During its first year PRIDE has been impressed by the hope of the people of Mansehra and Bagh districts for a better quality of life. Their hope is the best possible opportunity for change to achieve better health.

Following are some highlights of work planned for the coming year and beyond in order for PRIDE to achieve better health outcomes for the people of Mansehra and Bagh.

- **Support district planning, budgeting, human resource management and drug supply management.**
- **Continue performance improvement process for public health (PIP-PH)** to cover all of the managers of more than 120 BHUs and RHCs. This includes regular follow-up visits by PRIDE staff to individual health facilities to assist and assess progress on maintaining the health watch framework.



Hope for the future...

Photo: Colin Rasmussen

- **Ongoing implementation of standards-based approach (SBMR)** to improve service quality in 30 phase 1 health facilities, with trainings on various aspects of maternal, newborn and child health. Scale-up of this approach to another 45 facilities will begin in year two, followed by coverage of all 120 health facilities by year three.
- **Provision of basic infection-prevention equipment** to health facilities and establishment of infection-prevention practices with regular support from PRIDE's public health officers.
- **Develop a project strategy to increase births assisted by a skilled attendant** based on the global best practice that now focuses on "health-center intrapartum care." PRIDE will focus on ways to substantially increase the proportion of births in health facilities from the current low level of about one-third.
- **Develop a project strategy for improving health referral mechanisms** through a coordinated approach that more effectively links communities and health care providers.
- **Roll out implementation of the community mobilization strategy** through newly recruited implementing partners. This includes forming and strengthening village, union, tehsil and district health forums, and facility HMCs.
- **Build the capacity of HMCs and other health forums** in close collaboration with the departments of health.
- **Develop and implement an extensive BCC strategy** to increase awareness and bring about healthier behaviors, including increased demand for health services.
- **Develop a partnership with the national Lady Health Worker (LHW) program** to increase access to LHWs and improve the quality of their work in the target districts.

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Despite relative economic prosperity our country still has frightening levels of maternal and infant mortality... There is a clear need of not only improved health infrastructure but for improved health systems and for such care to be sustainable... The PRIDE project rightly envisions a revitalized primary health care program providing affordable, sustainable, replicable and quality health services...

Ali Muhammad Jan Orakzai, Governor, NWFP  
on the occasion of launching PRIDE in Mansehra district

Effective development isn't just about money. It's also about integrating lessons learned and applying them to program design. In that regard, I'm particularly proud of what USAID and PRIDE are doing.

Peter Bodde, Deputy Chief of Mission  
United States Embassy, Islamabad

Basic health indicators related to disease and death of children and mothers remain unacceptably high in Pakistan – mostly due to factors that are preventable. PRIDE intends to change this by working with communities and the health system to achieve better health outcomes in Bagh and Mansehra districts.

Bruce Rasmussen, Chief of Party  
PRIDE Project

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## List of Indicators for PRIDE Project Performance Management Plan

Revised June 15, 2007

### Key:

B/E	Baseline/End of project	PIP	Performance Improvement Process
B/M/E	Baseline/Mid-term/End of project	RDHSA	Rapid District Health Services Assessment
CBDB	Capacity Building Database	TBD	To be determined after baseline KPC survey
DEWS	Disease Early Warning System	KPC-HH Survey	Knowledge, Practice, Coverage- Household Survey
ERP	USAID Earthquake Reconstruction Program	OP	USAID Annual Operating Plan
HF records	Health Facility records	TIMS	Training Information Monitoring System
LHW MIS	Lady Health Worker Management Information System	Red Highlight	Minimum Indicators to be reported to USAID Quarter
HMS	Health Management Information System		

No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
<b>Joint IR Indicators</b>							
1	OP	Under-5 mortality rate (individual maternal, infant and child deaths will also be tracked and investigated at the health facility level)	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
2	OP	% of births attended by a skilled birth attendant	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
3	ERP	Contraceptive prevalence rate (modern methods, all women 15-49 years)	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
4		% of mothers having at least one post-natal visit within 40 days of delivery	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
5		% of mothers with at least two tetanus toxoid injections during last pregnancy	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E

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No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
6		% of mothers attended antenatal consultations at a health facility during her last pregnancy (disaggregated by number of visits, 4 visits optimal)	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
7		% of children 12-23 months fully immunized	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
8	ERP	% of facilities with measles vaccination coverage rate in their catchment area >80%	HMIS	HF record	TBD	80%	Quarterly and B/M/E
9	ERP	Health facility daily headcount - total visits (number of patients per day all services and disaggregated for selected PHC services)	RDHSA, HMIS	HF records	TBD	TBD	Quarterly and B/M/E

No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
<b>IR 1: Improved performance of public health services and management system</b>							
<b>1.1: Improved planning and budgeting</b>							
10		# of districts with an annual district health plan	RDHSA	HF (district) records	Bgh-Yes Mns-No	100%	B/M/E
11		% of BHUs and RHCs that provide timely data for decision making	RDHSA, HMIS	HF records, HMIS reports	92%	98%	Quarterly and B/M/E
<b>1.2: Improved human resource management</b>							
12	ERP	% of health facilities which meet minimum staffing requirements for the implementation of the essential PHC package	RDHSA, HMIS	HF records	8%	80%	B/M/E
13		Absenteeism rate: % of posted health workers absent from their posts	RDHSA, CBDB	HF records, Observation	30%	5%	B/M/E
14		% of staff aware of their roles and having up to date written job descriptions	RDHSA	HF records	1%	80%	B/M/E
15	ERP	% of PHC staff that are women – by function	RDHSA, HMIS	HF records	42%	TBD	Quarterly and B/M/E
16		% of supervision visits that address more than one program	RDHSA	HF records	M:49% B:35%	80%	B/M/E

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No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
17		% of administrators trained in select management topics by gender (supervision, financial management, HMIS, DEWS, planning, HR management)	RDHSA,CBDB	HF records, CBDB reports	Planning & Monitoring (3%), HMIS (58%)	50%	Quarterly and B/M/E
18		% of health facilities that apply performance appraisal system	RDHSA	HF records	16%	80%	B/M/E
		<b>1.3: Improved drug supply management</b>					
19		% of facilities with a functional drug management system (DMS): have essential drug list, stock cards up to date, conduct periodic inventory, staff able to calculate use rate and practice FIFO	RDHSA	HF records	drug list (15%), calculate use rate (41%)	80%	B/M/E
20	ERP	% of facilities with zero stockouts of tracer essential drugs over past 3 months	RDHSA,HMIS	HF records	37%	80%	Quarterly and B/M/E
		<b>1.4: Improved data use and public health service performance</b>					
21	ERP	% of facilities maintaining Health Watch disease and service monitoring framework	RDHSA, DEWS	HF records	0%	80%	Quarterly and B/M/E
22		% of facilities that know their current coverage of measles immunizations	RDHSA	HF records	21%	80%	B/M/E
		<b>1.5: Strengthened health service partnership with communities, elected representatives and private sector health care providers</b>					

No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency

No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
IR 2: Improved access to and quality of primary health care services							
2.1: Health service standards set and implemented in all PHC facilities using Standards Based Management and Recognition (SBM-R)							
23		% of health facilities providing essential package of primary health care services: - family planning - immunization - antenatal care - delivery care - TB case management - postnatal care - newborn care - IMCI - Malaria	RDHSA	HF records	79%	80%	B/F
24	OP	Number of health facilities providing family planning services	RDHSA	HF records	TBD	FY07=25	Annual
25	ERP	% of assisted facilities actively implementing clinical performance improvement process for each of 9 PHC components (antenatal care, postnatal care, delivery care, family planning, new born care, EPI, IMCI, TB, and malaria)  <i>(Note: Actively implementing is defined as completing at least two internal assessments.)</i>	PIP	PIP database	0%	80%	Annual

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No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
26	ERP	Average % of performance standard met by assisted facilities	PIP	PIP database	TBD	TBD	Annual
27		% of assisted facilities achieving 80% performance standards for AMSTL	PIP	PIP database	TBD	TBD	Annual
28		% of assisted facilities achieving 80% performance standards for newborn care	PIP	PIP database	TBD	TBD	Annual
29		% of assisted facilities achieving 80% performance standards for immediate post partum care	PIP	PIP database	TBD	TBD	Annual
30		% of health facilities with PHC related standards, guidelines, or protocols	RDHSA	HF records	EPI: 46%, TB: 31%, FP:39%, GM: 28%	60%	B/F
31		% of assisted facilities achieving 80% performance standards for infection prevention	PIP	PIP database	TBD	TBD	Annual
32		% of ANC clients in the last six months who received at least two tetanus toxoid injections	KPC-HH Survey	Survey Respondents	TBD	TBD	Annual
33		TB cure rate: proportion of new cases of smear-positive TB that were cured through treatment	RDHSA, HMIS	HF records, HMIS reports	36%	TBD	Quarterly
34		TB case detection rate: number of reported new cases per 100,000 persons per year divided by the estimated incidence rate per 100,000 per year	RDHSA, HMIS	HF records, HMIS reports	40%	TBD	Quarterly
		<b>Sub-IR2.2: Improved Skills and Service delivery capacity of primary health care providers</b>					

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No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
35		Number and % of government service providers in assisted facilities trained in PHC related standards, guidelines, or protocols (By Gender)	TIMS	Training records	TBD, TBD	FY07=50, 80%	Quarterly
36	OP	Number of people trained in child health care and child nutrition	TIMS	Training records	TBD	FY07=50	Quarterly
37	OP	Number of people trained in maternal and/or newborn health and nutrition	TIMS	Training records	TBD	FY07=50	Quarterly
		<b>Sub-IR2.3: Improved referral mechanism including decision making, communication, transportation and feedback</b>					
38	ERP	% of health facilities that have a referral system in place (standard procedures, referral protocols/checklists and referral feedback)	RDHSA	HF records	25%	60%	B/F

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No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
IR 3: Healthier behaviors and institionized community participation in health services							
3.1: Improved health knowledge and behavior at household and community level							
39		% of community based organizations (CBO) health grant proposals funded, (# of CBO Proposals funded/# received)	project grants records	Project documents	0%	TBD	Quarterly
40		% of mothers of 0-23 months children who can cite at least 3 newborn danger signs that require immediate treatment	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
41		% of children 0-23 months whose last bout of diarrhea was treated with ORS	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
42		% of women who can identify pneumonia symptoms in their children and seek appropriate care.	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
43		% of mothers of 0-23 months children who cite at least one danger sign of diarrhea that require immediate treatment at health facility	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
44		% of mothers of 0-23 months children who cite rapid or difficult breathing as a cause of immediate treatment at health facility	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
45		% of house holds using Iodized salt	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
46		% of mothers household who can cite at least two key	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E

No.	Type	Indicator	Data Collection Method	Source	Baseline	End of Proj. Target	Frequency
		<b>3.2: Institutionalized community participation in health services</b>					
47		LHW population coverage rate ((Population/# of LHW)/(1000/1))x100	LHWMIS	LHW records	TBD	80%	B/M/E
48		% of LHW with functional village health committees	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
49		% of union councils with functional village committees engaged in health promotion	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
50		% of villages engaged in community mobilization process	CBDB	CBDB reports	TBD	TBD	Annual
51		% of union and district councils with mechanism and procedures for the participation of citizens to address health management issues	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
52		% of health facility/district plans designed with input from community representatives	KPC-HH Survey	Survey Respondents	TBD	TBD	B/E
53	ERP	% of facilities with a regularly functioning Health Committee.	RDHSA, Community project record	HF Records	TBD	TBD	B/M/E