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Sida Review

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Strengthening Midwifery and Emergency Obstetric Care (EmOC) Services in India

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List of Abbreviations

ANM	Auxiliary Nurse Midwife
ANS	Academy of Nursing Studies
CAMT	Centre of Advance Midwifery Training
EmOC	Emergency Obstetric Care
FHW	Female Health Workers
FIGO	International Federation of Gynecology and Obstetrics
FRU	First Referral Unit
Gol	Government of India
ICM	International Confederation of Midwives
IIM A	Indian Institute of Management Ahmedabad
IMR	Infant Mortality Ratio
KI	Karolinska Institute
LF	Logical Framework
LFA	Logical Framework Approach
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MTR	Mid-Term Review
MyTRI	Midwifery Training and Research Institution
NGO	Non-Government Organization
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NTP	National Training Programme
PHC	Primary Health Centre
PIP	Project Implementation Plans
SA	Situational Analysis
SAM	Swedish Association of Midwives
SEK	Swedish Krona
SBA	Skilled Birth Attendant
Sida	Swedish International Development Cooperation Agency
SOMI	Society of Midwives in India
SRHR	Sexual and Reproductive Health and Rights
TBA	Traditional Birth Attendant
TNAI	Trained Nurses Association of India
ToR	Terms of Reference
ToT	Training of Trainers (in this report trained Nursing Tutors at CAMT)
WRAI	White Ribbon Alliance for Safe Motherhood, India
WHO	World Health Organization

Executive Summary

The Project

The overall development goal of the Sida funded project, *“Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India”*, was to contribute to the national efforts to reduce the maternal morbidity and mortality, through strengthening midwifery and Emergency Obstetric Care (EmOC) services in the public and private health systems in India. The project started in December 2005 and during four years it has progressed through three phases; (1) a planning and preparation phase, (2) an implementation phase and finally (3) a phasing out period. The Swedish International Development Cooperation Agency (Sida) disbursed a total of 20 million Swedish Krona (SEK) to a number of different project activities that together form the current project.

Inter-Institutional Collaboration

The key component of this project was to develop an inter-institutional network consisting of collaborating organizations, academic institutions, professional bodies and other non-governmental organizations (NGOs) in India which would be linked with their counterparts in Sweden and could carry out capacity building, research, advocacy and monitoring to support improvement of maternal health services in India. This project was implemented by a Core Group consisting of the Academy for Nursing Studies (ANS), Society of Midwives in India (SOMI), Trained Nurses' Association of India (TNAI), White Ribbon Alliance for Safe Motherhood, India (WRAI) and Indian Institute of Management, Ahmedabad (IIM A), as the overall coordinating partner in India. In addition, on the Swedish side, Karolinska Institute (KI) and the Swedish Association of Midwives (SAM) were engaged in the Core Group to provide additional technical support.

Evaluation

The present evaluation appears at the end of the project and it is above all a summative evaluation, meaning to recapitulate the results and discuss what forms of cooperation may follow in the new strategy for development cooperation between Sweden and India. The current evaluation was undertaken during the months of November and December 2009. The evaluation assignment is structured around six clusters of issues: 1) Effectiveness and efficiency, 2) Impact, 3) Gender Equality, 4) Equity, 5) Sustainability and 6) Relevance.

Effectiveness and Efficiency

The project consisted of five objectives and nine outcomes. Of the nine outcomes the project has produced three outcomes, while five have been reached to some extent and one not at all. The project has succeeded in getting the attention of top decision-makers in India. Maternal mortality reduction and the importance of midwifery care have become a national priority as well as a priority in at least five states. The Government's commitment is reflected in the contribution towards the Centers of Advanced Midwifery Training (CAMTs) as well as incorporating work on midwifery in the state Project Implementation Plans (PIPs) for National Rural Health Mission (NRHM). These developments are positive and in line with the project objective, however, it is difficult to attribute these results to the project alone as other actors and activities have also been working towards the same goals.

Impact and Sustainability

The impact of its activities is significant and there are results at different levels. The project has contributed to increasing visibility of midwifery at the policy level and also among the nursing profession. The central and the state governments own the agenda of midwifery and are committing resources within their annual plans for continuation of the CAMTs. Empowerment has resulted in a cadre of nurse-midwife leaders. Partnerships have been forged between Swedish and Indian organizations – these have potential for continuing. The research done under this project has resulted in a consolidated body of knowledge related to nursing and midwifery.

Gender Equality

Strengthening midwifery services is in line with goals of gender equality. This project has worked on capacity building and empowering female master trainers and trainers of nurses and midwives. This approach has definitely empowered the direct beneficiaries. However, the evaluation team could identify gaps in the area of gender mainstreaming. Gender equality was not incorporated in the project in a systematic manner.

Equity

Equity is a significant issue for the midwifery occupation in India. Culturally, birthing is surrounded by a host of pollution taboos. Those who have traditionally been birth attendants have been from the 'lower' castes. In this context enhancing the status of midwifery as a profession is an equity measure. However, there is no evidence of how an equity perspective was incorporated into this project.

Relevance

This project has been highly relevant for India given the fact that one fifth of all global maternal mortality occurs in India. The project has been congruent with the health policy focus in India, Sida's previous as well as current strategy for India 2009–2013 and the Memorandum of Understanding (MoU) signed between Sweden and India which includes maternal health.

Working for the survival of mothers is a human rights imperative. It also has enormous socio-economic consequences – and is a crucial international development priority. When midwifery is strengthened, midwifery and EmOC services are improved and enhanced; fewer women's and newborn's lives are lost. Thus, strengthening of midwifery and EmOC services in India are fundamental strategies for reducing maternal and newborn morbidity and mortality.

Major Challenges and Constraints

- National confusion of the expressions Skilled Birth Attendant (SBA) midwife and midwifery;
- The Indian Government has amended the international definition of SBA¹ and includes Auxiliary Nurse Midwives (ANM);
- Advocacy was done by each core group member, however, collective, systematic and strategic advocacy was missing in the project;
- Insufficient communication between the Core Group members;

¹ "A skilled attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period, and in the identification, management and referral of complications in women and newborns." (WHO, 2004).

- The opportunity to develop strong alliances and partnerships was not maximized;
- Project coordinator (IIM A) was overburdened with responsibilities;
- Monitoring at several levels was weak;
- No mid-term review was conducted;
- Fundraising was never built into the project and therefore at the end of the four years some partners in the Core Group are not able to continue the required activities;
- Partner-driven cooperation is a new programme adopted by Sida and it will take time to further develop the strategy.

Lessons Learned

- Resources, including time, for partnership building should be consciously built in the project;
- Good quality training has to be matched with attention to health systems changes that will be required to implement the training;
- Conceptual issues around midwives, nursing, midwifery and SBA as well as Traditional Birth Attendants (TBAs) need to be mapped out in a coherent form.

Recommendations in Brief

Future Sida funded midwifery projects in India could focus on:

- Support a partnership of naturally interested stakeholders in midwifery;
- National Training Programmes (NTP);
- Strengthening of CAMTs;
- Strengthening of SOMI;
- Research cooperation.

1 Introduction

1.1 The Project Objectives

The present project, *“Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India”*, has been supported by Sida since the 16th of December 2005. The agreement was signed between Sida, IIM A and KI covering the period 16th of December 2005 to 16th of June 2009. The first six months, December 2005 to June 2006 were formative and considered as the planning and preparation phase. The implementation phase lasted from July 2006 to June 2009. In May 2009, during the annual review of the project, the agreement period was extended to December 2009, to give time for a phasing out period. In January 2010 the period was granted a no-cost extension to the end of March 2010.

The overall goal was to contribute to the national efforts to reduce the maternal morbidity and mortality in India, through strengthening midwifery and EmOC services in the public and private health systems in India. During a Logical Framework Approach (LFA) Workshop, for project development and stakeholder participation, five major problems were identified as the cause of inadequate maternal health services in India and consequently high Maternal Mortality Ratio (MMR). The problems identified are:

- i Under developed policy for maternal health, poor management of programmes and weak implementation.
- ii Lack of development of midwifery profession due to inadequate training.
- iii Weak knowledge base about the situation of midwifery and maternal health care including EmOC as well as inadequate analysis of problems.
- iv Weak professional capacities of midwifery and maternal care organizations and lack of networking among institutions.

The current project tries to address the key problems by five broad interventions of capacity building, research and advocacy, pilot testing, policy analysis and networking. Each of the five above mentioned strategies has its own specific objective and the evaluation addresses the objectives of each intervention. However, during the desk review the evaluation team noticed that the objectives and outcomes in the project document and the Logical Framework (LF) were stated differently.

The specific objectives according to the project document are:

- 1 Capacity building for midwifery skills for safe motherhood services to women
- 2 Develop a body of shared knowledge and understanding on current status of midwifery and EmOC services in India through situational analysis to adapt Swedish midwifery and maternal health services in Indian situation. Understand how lessons from organizations of midwifery and maternal health services in Sweden as well as other countries can be adapted and applied in Indian situation.
- 3 Develop a midwifery focused model of maternal care and to test feasibility of implementation of new guidelines for ANMs for SBA/EmOC and to develop suitable management models to monitor these new interventions.
- 4 Conduct policy analysis and management studies for policy advocacy to key decision makers in state and central governments and professional organizations for improving status of midwifery and maternal health services and improve resource allocation in the country.

- 5 Develop an active network of organizations including academic institutions, professional bodies, government agencies, women's groups and other civil society organizations which can carry out key facilitating functions such as research, pilot testing, advocacy and monitoring to support improvement of maternal health services.

The objectives according to the LF are:

- 1 *Capacity Building*; Improve midwifery skills among midwifery care providers (midwives, nurses, doctors).
- 2 *Research and Advocacy*; Effective advocacy for maternal health based on situational analysis (SA) and research evidence.
- 3 *Pilot testing*; Improve maternal health services by development of midwifery focused model of care for mothers.
- 4 *Policy Analysis*; Necessary tools and skills provided to Government Health departments for effective management of maternal health.
- 5 *Networking*; Strengthen institutions and network organizations of maternal health sector.

After informing IIM A and Sida/Delhi about the difference in objectives in two basic project documents, it was decided by Sida/Delhi and IIM A that the evaluation team would use the objectives in the LF as these were most recently designed and accurate. The LF objectives are interconnected but not overlapping. Each of the objectives is unique and different from the others and therefore involves different activities.

The key element of this project was to develop a inter-institutional network consisting of collaborating organizations, academic institutions, professional bodies, government agencies, women's groups and other NGOs in India, which will be linked with their counterparts in Sweden and can carry out research, pilot testing, advocacy and monitoring to support improvement of maternal health services in India. Hence, this project was implemented by a Core Group consisting of:

- Centre for Management of Health Services at the Indian Institute of Management, Ahmedabad (IIM A)
- Academy for Nursing Studies (ANS),
- Society of Midwives in India (SOMI),
- Trained Nurses' Association of India (TNAI),
- White Ribbon Alliance India (WRAI)
- Karolinska Institute (KI) and
- Swedish Association of Midwives (SAM)

1.2 Roles and Responsibilities

The IIM A was chosen as the overall coordinator of the project and KI as the coordinating institution in Sweden, whereas the whole Core Group was the collaborating and implementing body. IIM A had the facilitating role and was supposed to arrange regular meetings and workshops with the partner organizations. In addition, IIM A was responsible to monitor the project process and document the findings.

Each of the Indian Core Group members was responsible for one specific objective and the related interventions see table 1.

Table 1. Summary of the roles played by the Core Group members

Responsibilities	IIM A	ANS	SOMI	TNAI	WRAI	KI	SAM
Project Coordinator	✓					✓	
Developing/running the Centre for Advanced Midwifery Training (CAMT)		✓				✓	
Situation Analysis (SA)			✓	✓			
Pilot testing of new guidelines					✓	✓	
Research	✓					✓	
Networking and institutional support	✓					✓	✓

1.3 Monitoring and Evaluation

The Core Group members were responsible for monitoring individual interventions while IIM A was responsible for Monitoring and Evaluation (M&E) at the overall level. It was planned that the Core Group would meet on a quarterly basis with the objective of monitoring the project performance and progress towards outputs. In addition, a Mid-Term Review (MTR) was planned to be conducted.

The Core Group has submitted three Annual Project Reports and minutes from eight Core Group meetings. For some reason the Core Group met on average twice a year instead of four times a year as agreed upon. The minutes indicate that the meetings were valuable in terms of sharing of experiences and suggestions for each other. The M&E function has somehow “fallen between the cracks”.

The quality of the information produced is fragile and the Core Group is reporting activities instead of achievements and outcomes which were pointed out at each annual meeting by KI. Furthermore, the MTR was not carried out. The evaluation team could not find any documented reasons for not carrying out the MTR.

In general, the project overlooks structured and systematic M&E efforts. It appears that the Core Group ignored the LF for systematic monitoring. Furthermore, there is lack of a practical and collective data collection. The evaluation team struggled to collect data from the different Core Group members as no complete, common data archive existed.

The only other evaluation efforts, made by the Core Group, were pre and post tests of the CAMT training. However, research indicates that the pre/post-test concept has inherent problems. This test concentrates on value-added rather than outcomes assessment. Evaluation of the SBA training in the Haryana pilot project is under process as writing this report.

1.4 End-term Evaluation Purpose

In accordance with the agreement, an end of project evaluation was to be carried out during October–November 2009 to assess the overall quality, functioning and achievements and to formulate specific recommendations for the rest of the agreement term and for future direction in accordance with the new country strategy i.e partnership driven cooperation between Sweden and India.

The overarching objective of this summative evaluation is to carefully, objectively and systematically assess the overall quality, functioning and results of the project and to formulate specific recommendations for future direction in accordance with Sweden’s new strategy mentioned above.

The specific objectives of the evaluation are:

- To collect data the effectiveness, efficiency, impacts, gender equality, equity, sustainability and relevance of the interventions.
- To review initiatives and strategies with a view to providing recommendations for future initiatives.
- To provide Sida and its partners with lessons learned that can be used in policy work or when designing new programmes and projects.

The results are analyzed in terms of whether they have been generated effectively and efficiently, whether the expected impact has been achieved, whether the project was gender-blind, gender-specific or gender-transformative, whether the project was equitable and finally whether the project was relevant and the impact sustainable.

The evaluation assignment is structured around six clusters of issues: 1) Effectiveness and efficiency, 2) Impact, 3) Gender Equality, 4) Equity, 5) Sustainability and 6) Relevance.

2 Terms of Reference

2.1 Evaluation Questions

The Terms of Reference (ToR) directed the evaluation team to use the objectives stated in the project proposal. However, after discussions with IIM A and Sida/Delhi we were asked to use the LE. As earlier, mentioned the objectives in the two documents are stated differently.

The evaluation team was asked to address the following issues:

- The project outcome with regard to the expected end results and the effectiveness of the approach/strategy used to achieve the project outcome.
- The efficiency of project management and the cost-effectiveness of the resources/inputs used.
- The outcome in relation to the efforts put in for capacity building, including internal control routines, and institutional development and the development of networking and coordination.
- Gender equality and social equity concerns at various levels of project implementation.
- The qualitative outcome of the project implementation in general, and in particular the midwife training component in Sweden and the study visits by decision-makers in Sweden.
- The institutional collaboration and partnership between the key partners and clarity in roles and responsibilities.
- Signs of potential impact at policy and implementation levels and sustainability of results, including the sustainability of the partnership between the collaborating organizations.
- The continued relevance of the collaboration in relation to Sida's new Country Strategy for India 2009–13 and scope of the project to move towards Partner Driven Cooperation mechanism.

2.2 Evaluation Team

The evaluation team consisted of two experts from India and one from Sweden. Between them, they have many years experience in project management, research, midwifery and sexual and reproductive health and rights (SRHR). In addition, all of them have many years experience of working in developing countries.

2.3 Work plan and schedule

The evaluation was carried out during three weeks in November–December 2009. The following schedule was followed during the evaluation:

23 November	Accomplish the Scope of Work
23–25 November	Stakeholder Analysis: Major stakeholders will be informed about the evaluation initiative and meetings will be scheduled with key informants in Sweden and India. Desk review: All project documents, written evaluations and published materials relevant for the programme were to have been reviewed by all team members.
26 November	Data collection: Interviews with Sida Team India staff in Stockholm, KI and the Swedish Association of Midwives in Stockholm
30 November	Meetings with IIM A, collection of remaining project documents.
2–10 December	Field trips
11 December	Interview with Yasmin Sida/New Delhi
11–14 December	Data analysis: Meetings between the Evaluation team, analyzing information, preparing for the Dissemination Workshop
14 December	Briefing and debriefing with the Core Group and the Sida personnel in New Delhi
15–16 December	Dissemination Workshop in New Delhi and presentation of preliminary findings of the evaluation
17 December	Last meetings with the Evaluation team
4 January 2010	Draft report to Sida/DCS Stockholm and New Delhi, IIM A, KI and the Swedish Association of Midwives.
25 January	Final day for the Stakeholders to comment on the draft report
1 February	Final Report

2.4 Reporting

The evaluation team provided an oral briefing of its preliminary findings and recommendations to the Core Group during a meeting in New Delhi and alike to Sida/New Delhi prior to the dissemination workshop in New Delhi on the 15th and 16th of December 2009. In addition, the evaluation team presented a draft report in English of its findings and recommendations to Sida and the partner organizations for comments before the Final Report was submitted. Annex 1 shows the ToR for the current end-term evaluation.

3 Methodology

The project's LF Matrix was used as the basis for the summative project evaluation.

3.1 Stakeholder Analysis – Sampling

In order to achieve the aims of the evaluation the team first identified and categorized the major stakeholders, beneficiaries and target groups with different characteristics in different institutions.

The four broad groups were:

- 1 Collaborating and implementing agencies (Core Group),
- 2 Beneficiaries of the project activities,
- 3 State Governments where the project had been executed, and
- 4 Sida/New Delhi and Sida/Stockholm.

Subsequently the evaluation team selected a purposive sample. Key persons were selected in a deliberative and non-random fashion to achieve the evaluation objectives. The evaluation team has interviewed a total of 90 persons; 26 Core Group members, 53 beneficiaries, 8 Government personnel and 3 Sida staff, which represents a small sample of the whole study population.

3.2 Qualitative Data collection

All project documents, written evaluations and its published materials provided prior to and during the site visits were reviewed. Annex 2 presents the list of documents reviewed.

The team developed consent forms, and interview guidelines and conducted semi-structured interviews in English with key informants. On-sight observations and group discussions were carried out in Haryana, Uttarakhand, Ahmadabad, Hyderabad, Kolkata, Chennai and New Delhi. In addition, the team conducted interviews with representatives from KI, Swedish Association of Midwives and Sida Team India staff in Stockholm. The interviews were the main evaluation instrument. Annex 3 presents a list of all persons interviewed.

Observation data were used to assess the physical and visible aspects of the project activities, such as the CAMTs and interactions between the network members, as well as advocacy work, contacts with the government agencies and development partners.

3.3 Data analysis

After collecting data, the information was analyzed and interpreted by the evaluation team in order to answer the evaluation's priority questions. Through a series of meetings in India, the team dialogued and analyzed the preliminary results of the interviews. Finally a judgment was made about the meaning of the findings in the context of the project.

3.4 Limitations, Reliability and Validity

This project is complex and several factors make it extremely difficult to reach valid and reliable conclusions about the achievements and the impact. Sida and the Core Group have pointed out that this project should be perceived as a programme rather than a project because of its complexity.

First of all, the major difficulty is timing. The research efforts made by IIM A and TNAI have just recently finished and it is too soon to evaluate its impact. The core group members were busy getting ready for the dissemination workshop and for ANS, especially, it was a difficult time since a major conference had just finished, the project coordinators were also trying to get commitments from the four states for continuation of the activities. In Hyderabad political conflict and unrest was responsible for the planned activities not taken up according to the schedule when the evaluator visited ANS and SOMI.

Secondly, the evaluation team met only a sample of the whole study population. A total of 90 core group members, beneficiaries and other stakeholders were interviewed but this is just a small proportion of people involved in the project. In addition, the team only saw a small part of the field activities.

Thirdly, the multi-location of the implementation, geographically dispersed and difficult-to-access sites was a limitation for the evaluators within the given time. Additionally, as mentioned above, all the necessary documents were not available during the time allotted for the desk review.

Finally, the evaluation team could have interviewed more beneficiaries and perhaps assessed more technical components. The Training of Trainers (ToT) programme through the CAMTs could have been analyzed at more depth as well as conducting additional interviews with the ToTs. Although, the evaluators intended to interview a large number of ToTs, it was not possible to reach the TOTs due to lack of follow-up by the CAMTs. The overall picture of the impact of this project might have been different if there were more such interviews. However, the evaluation team considers their answers to the questions stated in the ToR to be valid and reliable due to a representative sample and a triangulation approach (i.e. data gathered from several different sources).

4 Findings

The overall development goal of the partnership project was to *“Contribute to national efforts to reduce maternal morbidity and mortality through strengthening of midwifery and EmOC services in the public and private health system in India.”* Technically it is difficult to measure MMR, which makes it problematic to measure progress and to evaluate impact of projects focusing on MMR reduction. Has this project contributed to the MMR reduction in India? To reduce MMR is a long term goal; therefore this evaluation has focused on the specific objectives and the linked outcomes.

When development projects are evaluated it is generally assumed that the goal and the expected impact are understood by all stakeholders in more or less the same way. Do all stakeholders have the same understanding of midwifery in India? Is the definition of midwifery the same for the stakeholders? It is worth mentioning that in India there is no separate training or registration for midwives, all general nurses are registered as nurses and as midwives, even if their basic midwifery competencies might not be standardized according to the “Essential Competencies for Basic Midwifery Practice²” developed by the International Confederation of Midwives (ICM).

² ICM, Essential competencies for basic midwifery practice, 2002

India earlier had ANMs, who were trained mainly to provide family planning services, antenatal care and immunization in addition to midwifery. The earlier ANM training was for two years but this was reduced to eighteen months and led to a reduction in the number of hours in midwifery. These workers are now called Multi Purpose Workers (Female) or Female Health Workers (FHW) and have weak midwifery skills³. In addition, over time, medical doctors have taken over the conducting of deliveries in India. Within the larger environment, different stakeholders are using different terms often synonymously – nurse midwife, ANM, FHW, SBA, qualified midwife, independent midwife, professional midwife. The Government of India (GoI) has amended the WHO definition of SBA and includes ANM/FHW as SBA. In this context, is the goal well formulated and easily understood by all stakeholders? During the interviews, the evaluation team noticed that there was a lot of confusion about the concept of midwifery in India and the internationally recognized midwifery definitions⁴ and competencies⁵ by ICM are not used.

Why is this of importance? A recent study by Fauveau et al. has shown that a great deal of unsuccessful maternal health programmes are the effect of “confusion and careless choices in scaling up between a limited number of SBAs and large quantities of multi-purpose workers with short training, fewer skills, limited authority and no career pathways.” Fauveau et al. argue that no significant progress in MMR reduction can be achieved without a strong political will to empower skilled midwives and simultaneously strengthening of health systems. An adequate number of highly skilled professionals are preferred to a high number of “multi-purpose workers” based in rural areas without support⁶

4.1 Effectiveness – outcomes

In this section we are looking at the specific objectives and the expected outcomes. According to the Sida Evaluation Manual, the definition of outcome is “The likely or achieved short-term and medium-term effects of an intervention’s outputs.”

As mentioned before the evaluation team used the LF for evaluating the project, however, it was noticed that the LF was not identical to the objectives and outcomes in the project document or the ToR for the evaluation team. After discussions with IIM A and Sida/New Delhi it was decided that the objectives and outcomes declared in the LF would be used, although verifiable indicators were missing for most of the project results.

Outcome one, “*Provided life saving skills to midwifery and nursing students at established three CAMTs*” has been achieved. During the field trips it was recognized that all five CAMTs have advance skill laboratories, training equipments, models for practicing birth procedures, audio-visual teaching aids and a well equipped library. However, at present time, 12 of 15 master trainers have been shifted out from the CAMTs. They were sent back to their places of work prior to their training; some of them not even teaching midwifery. Their skills have not been harnessed to the fullest. The CAMTs have not yet been able to reach their envisaged role of resource centers for midwifery research, policy influence etc.

The CAMTs have designed and implemented a curriculum for midwifery tutor training. All CAMTs are using the same curriculum of three months training. This curriculum is strong in modern pedagogies but weaker in family planning, abortion, gender perspectives, equity and current policy issues relating to maternal health and SRHR. Generally, the curriculum is divided into two blocks, where the first part is concentrating on theory (antenatal, intranatal and postnatal care). The second part is focusing

³ ANS, Situational Analysis of Public Health Nursing Personnel in India; based on national review and consultations in six states. Training Division, Ministry of Health and Family Welfare, Government of India with support from UNFPA, Hyderabad – India, 2005

⁴ ICM, Definition of the Midwife, Australia, 2005

⁵ ICM, Essential competencies for basic midwifery practice, 2002

⁶ Fauveau, V. et al., Human resources for maternal health: multi-purpose or specialists? Human Resources for Health 2008, 6:21

on the practical skills. All CAMTs have conducted training for midwifery tutors. However, none of them have been able to evaluate the curriculum. According to this evaluation the ToTs felt they forgotten a large part of the theory when it came to the practical session. In our opinion, it was not efficient to divide the theory and practical into two blocks, it would have been more feasible to first give the students the theory in one subject and immediately have the practical for that subject.

Approximately 143 staff nurses, clinical instructors and nursing tutors have completed the three months ToT midwifery training at the CAMTs. Not all of the participants were tutors and not all tutors were teaching midwifery after the training at the CAMT due to lack of midwifery tutors in India. Furthermore, a systematic method for follow-up and mentoring was not developed. The CAMTs could have established a training attendance data base which captures information about each participant tutor for follow-up and mentoring.

Discussions with students of the nursing tutors trained at the Chennai CAMT indicate that students are noticing a positive change in the midwifery training after the Nursing Tutors' training at the CAMT. There are also changes reported in the labour room practices, such as increased quality of care and a more humanized care during labour and delivery.

The state governments have invested in the CAMTs during the project period by contributing with infrastructure for the training and human resources for project activities. Three CAMTs have conducted two batches of ToT training, but since 2008 there has not been any ToT training at the mentioned CAMTs. Unfortunately the CAMTs were unutilized when the evaluation team visited them. Table 2 presents the achievements in respect to Project Purpose one and Project Results one, as presented in the LF.

Table 2. Achievements in respect to capacity building

1. Project Purpose	Assessment
Improved midwifery skills among midwifery care providers (midwives, nurses, doctors).	
1. Project Results	
Provide life saving skills to midwifery and nursing students at established three CAMTs.	In total five CAMTs were established (1 in Ahmedabad, 2 in Hyderabad, 1 in Kolkata and 1 in Chennai) in collaboration with respective state government and the ANS. Fifteen master trainers (9 in 1st batch and 6 in 2nd batch), nominated by the state governments, have concluded a three months training, part of which was in Sweden. All centers, except Chennai centre have conducted two batches of midwifery tutor training. Chennai has conducted one batch of tutor training. Approximately 143 staff nurses, clinical instructors and nursing tutors have undertaken a three months refresher course in midwifery at the five CAMTs. However, there are no data of the actual midwifery competencies of the trainees.

Outcome two and three, “2. *Strengthened capacities of key stakeholders for effective advocacy* and 3. *Decreased policy barriers and improved resources allocation to maternal health through evidence based advocacy.*”, lack verifiable indicators in the LF matrix. Without indicators it is difficult to measure outputs. The evaluation team was informed two Situation Analysis (SA) have been finalized and are at the final stage of reporting. The SAs have yet not been cast in a suitable form for the Government. The Core Group is aiming to publish a book, “*Midwifery and Maternal Health in India: Situation Analysis and lessons from the field*”, where these SA will be included as chapters. In the Monograph, with the same name as the planned book, the SAs were not included as the editor thought they needed enhancement before publishing. Although attempts were made to develop advocacy plans based on the research studies and situational analysis,

systematic, collective advocacy has not resulted during the project period. In conclusion, outcome two and three were partially achieved. Table 3 presents the achievements in respect to Project Purpose two and Project Results two and three, as presented in the LF.

Table 3. Achievements in respect to research and advocacy

2. Project Purpose	Assessment
Effective advocacy for maternal health based on SA and research evidence.	A collective, strategic and effective advocacy was not seen.
2. and 3. Project Results	
Strengthened capacities of key stakeholders for effective advocacy	At the beginning of the third year two SA were completed. These studies will be included as chapters in a book "Midwifery and Maternal Health in India: Situation Analysis and lessons from the field" . However, this book has yet not been published nor has the SA been used systematically for advocacy.
Decreased policy barriers and improved resources allocation to maternal health through evidence based advocacy.	

Outcome four, *"A new model of maternal care evolved/based on government's new guidelines for ANMs and this model tested in selected districts with help of NGOs and Research training institutes"*. Although there were missing verifiable indicators for this project result, the evaluation team concluded that this outcome was achieved. WRAI/CEDPA pilot tested SBA guidelines by the GoI and the ANS developed a model to improve midwifery led maternal health services at the Primary Health Centers (PHC) in the Medak district of Andhra Pradesh. This model focused on the health personnel and the quality of care at the PHC. The interventions within the model were to improve the quality of the labour rooms as well as the skills of the ANMs and Nurse-Midwives. The Government of Andhra Pradesh will implement the model in other districts in the state during 2010, although, the Medak model has yet not been evaluated and documented.

The GoI's guidelines are being pilot tested in three districts-Gandhinagar in Gujarat, Karnal in Haryana, and Almora in Uttarakhand by WRAI/CEDPA. As part of this the following activities have been done:

- Clinical sites in district hospitals have been upgraded for training ANMs and Staff Nurses in terms of providing teaching aids, ensuring supplies of labour room equipments and drugs etc. However, doctors are conducting the deliveries in these clinical training sites; they are still performing episiotomies and not using the partographs. There is need to shift the training to sites where nurses do the deliveries, to have consistency between the teaching and the practice.
- To date about 148 ANMs and Staff Nurses have been trained for three weeks by the lead trainers in the three states. In Uttarakhand a meeting with Hawalbag ANMs shows that trained ANMs practicing improved/new skills in their field areas even in home deliveries. However, no systematic monitoring and follow-up of the training in the field – Lady Health Workers are not oriented to supervise the trained ANMs. Only around 50% of the trained ANMs reported doing partographs for every delivery.

The national maternal health policy in India is to encourage women to deliver in public or private institutions. This has led to a decreasing need of ANMs conducting deliveries in the communities. Some states like Gujarat have reached a high coverage of institutional deliveries and the relevance of training ANMs in midwifery services is questioned. Table 4 presents the achievements in respect to Project Purpose four and Project Results four, as presented in the LF.

Table 4. Achievements in respect to pilot testing

4. Project Purpose	Assessment
Improved maternal health services by development of midwifery focused model of care for mothers.	
4. Project Results	
A new model of maternal care evolved/based on government's new guidelines for ANMs and this model tested in selected districts with help of NGOs and Research training institutes.	The developed guidelines have been pilot tested in three selected project districts in three states – Haryana, Gujarat and Uttarakhand. The results of this piloting are reflected in the form of encouragement from the State governments in Haryana and Uttarakhand to replicate this in other districts. However, a technical evaluation of the interventions is in process.

Outcome five, six and seven, “5. *Strengthened management capacities for maternal health at national and state level.* 6. *Models of improved management of maternal health services including First Referral Units (FRUs) in selected districts.* 7. *A system developed to record and investigates and maternal and neonatal deaths.*” There were no indicators for this project purpose or the project results. Outcome six have not been reached but outcome five and seven has been achieved to some extent.

Due to lack of capacity, overburdening of IIM A and inability to mobilize other partners from out of this network, six studies were done and most of them in Gujarat. At the time of the evaluation, the studies have just been completed and they need to undergo peer review to bring them up to publishable quality. Table 5 presents the achievements in respect to Project Purpose five and Project Results five, six and seven, as presented in the LF.

Table 5. Achievements in respect to policy analysis

5. Project Purpose	Assessment
Necessary tools and skills provided to Government Health departments for effective management of maternal health.	
5., 6., 7. Project Results	
5. Strengthened management capacities for maternal health at national and state level.	IIM A provided management and leadership training to senior nurses. Concrete results of this training at the state and national level are not yet evident.
6. Models of improved management of maternal health services including FRUs in selected districts.	This was not seen by the evaluation team.
7. A system developed to record and investigate all maternal and neonatal deaths.	In one district a system was developed to record all maternal deaths.

Outcome eight and nine, “*Evidence based midwifery methods introduced in India through a strong network of institutions.* 9. *Raised professional capacity of relevant midwifery and maternal health institutions.*” These two outcomes have partially been achieved. Table 6 presents the achievements in respect to Project Purpose eight and Project Results eight and nine, as presented in the LF.

Table 6. Achievements in respect to networking

8. Project Purpose	Assessment
Strengthened institutions and network organizations of maternal health sector.	
8. and 9. Project Results	
8. Evidence based midwifery methods introduced in India through a strong network of institutions.	The fullest benefits of the partnership and networking were not leveraged amongst the Indian partners. Each partner largely did their own intervention independently, without the benefit of other partners' experiences and expertise. The synergy of diverse competent partners' efforts is not seen at the end of the project. SOMI as a professional organization has grown in numbers. During the project period SOMI has organized several national conferences and an international midwifery conference.
9. Raised professional capacity of relevant midwifery and maternal health institutions.	

4.1.1 Analysis

- Reasons for achievement of the objectives:
 - The most important single factor is commitment from all the Core Group Members to improve maternal and newborn health in India.
 - Very conscious focus on the deliverables promised in the Project Application.
 - Important contribution from the Swedish stakeholders, KI and SAM.
 - State governments' involvement.
- Reasons for 'non achievement' of objectives in terms of quality:
 - Mismatching of responsibilities with partners' competence/expertise. E.g. research cannot be done by every organization.
 - For advocacy on identified issues, the strength of the associations – WRAI, TNAI – perhaps not fully leveraged.
 - Nature of the project – 'true' partnership is very tough given the pressure of fulfillment of own objectives. Partnership building requires processes which are time consuming.
 - Working together and coordination wanting at various levels: among national partners, among state partners, between the coordinating organizations and the state partners.
 - A MTR would have helped in identifying mid course corrections consolidation in the second half. Internal collective reviews-e.g. All CAMTs, all district pilot projects, all in charge of research studies-may have enhanced the quality of the interventions.

4.2 Cost effectiveness

Analyses of cost-effectiveness are an important part of end-term evaluations. In general, cost-effectiveness analyses of projects are methodologically weak. They often suffer from lack of comparative data, and they rarely contribute to the assessment of the project in question. This is certainly the case with evaluations of social sectors and of research. This project is first of its kind, with the objective to strengthening midwifery services in India. The evaluation team was not able to conduct a cost-effectiveness analysis as there were no comparative data.

A few observations on cost effectiveness however, can be made. The positive aspect is that the state governments contributed around 60% to match what the project spent in the first two years of the project period⁷. On the other hand, the selection of the participating districts, for example in Gandhinagar 93%

⁷ Source: Annual Report for 3rd year-15.6.09

of all deliveries are institutional and selection of trainees (only 3 out of 16 trained FHWs in Gandhinagar were conducting deliveries before and after the training and similar impressions were obtained in field visit to Hawalbag PHC in Almora.) is perhaps an indication that cost effectiveness was jeopardized⁸.

The cost effectiveness of taking 56 persons to Sweden, for exposure visits and training, with a substantial portion of the Indian and Swedish budgets can be questioned. However, as a result of the exposure visits, the Gujarat state developed a plan to create an Independent Midwifery cadre. The project management reported that after the exposure visits and participation in various project activities there was a substantial increase in nursing/midwifery leadership in the capacity in the officers involved in the activities in the states.

Furthermore, the positive aspects are that the visits to Sweden by the Government and nursing personnel served to increase their ownership of the midwifery agenda in India. The result was the commitment of many of them to take the agenda forward whatever their office/position. The possibilities and scope of the midwifery profession were a new and crucial learning for them, where they realized the high value and position professional midwives are accorded in Sweden, as well as women in general. They also learned about ethical aspects, SRHR, alternative ways of taking care of the woman during labour and delivery and men's important role in reducing MMR.

4.3 Efficiency

Efficiency is a measure of how economically resources/inputs are converted to results/outputs. It describes the ratio of the value of the achievements of an intervention to the value of the resources used to produce them. An intervention is optimally efficient if its value is greater than the value of any alternative use of the resources. As mentioned above the evaluation team has not been able to do an economic evaluation of this project. However, we have looked at allocation of resources.

Investment in the health and rights of women is smart economics. It is not meaningful to put a value on the achievements this project has reached. Overall, the project has reached a large amount of people, and the achievements seen are all much more valuable than the monetary contribution from Sida. Nevertheless could the same efforts been produced at a lower cost? In the process of cooperation, there have been unnecessarily high budget for some of the interventions. Such as:

- The training of SBAs through the district projects was costly and we are not convinced the outputs justify the inputs considering the selection of the SBAs as well as the districts, as discussed earlier.
- The CAMTs have cost significant amounts of money. However, since 2008 most of the CAMTs have not been used due to lack of funding.
- Some training material at the CAMTs seemed to be unnecessary, e.g. the pregnancy profile vest, which replicates the visual appearance and actual feel of the third trimester of pregnancy.
- The training of the first batch of master trainers in Sweden during one month was ambitious and the time could have been used for hands-on training in India. However, this was recognized by the Swedish counterparts and changes were made for the second batch of master trainers.

The evaluation team is also concerned about processes which have just been initiated but need further handholding otherwise they will collapse. E.g. Tamil Nadu needs some facilitation between Nursing Education and the Public Health side to pull together lessons learnt and work further. Tamil Nadu needs facilitation even among the CAMT resources created to plan and execute further advocacy. Uttarakhand needs facilitation and technical assistance at the state level to move towards systematic capacity building for programme management.

⁸ Source: Monitoring Visit Report March 17–18, 2008

4.4 Impact

The project has contributed to increasing visibility of midwifery in India at several levels – among health policy makers, development partners, health officers, as well within the nursing profession itself. There is an increasing realization of the need to strengthen the midwifery component within nursing both in terms of longer duration in the curriculum and also in terms of methods of teaching specifically more hands on, skill based training.

Another significant impact is that many individuals are emerging as leaders in the nursing and midwifery professions. There is a sense of personal transformation in terms of empowerment and self determination amongst many women whom we met during this review. SOMI is increasing in membership – the conferences are helping increase professional commitment, pride, articulation of issues and agendas. Concepts, positions and issues are being unpacked and discussions about midwifery as an independent profession are becoming more visible in India.

Furthermore, national and state governments are taking ownership of the agenda, giving space and human resources for the CAMTs, starting one year post basic programme – Independent Nurse Practitioner in Midwifery – and committing money in their state PIPs. Partnerships between Swedish and Indian institutes have been forged – KI with IIM A and ANS, Swedish Midwifery Association with SOMI and Midwifery Training and Research Institution (MyTri).

The research intervention under this project has led to the creation of a body of knowledge which needs to be utilized effectively for advocacy towards systemic improvements and enhancing the status/practice of the nursing and midwifery profession.

Finally, in several states there are reports of safe deliveries coming closer to women – at homes in Uttarakhand, in PHCs in Gujarat. A systematic evaluation of this aspect would be very helpful.

4.5 Gender Equality

Gender mainstreaming is the process of assessing the implications for women and men of any planned intervention – policy development, research, advocacy, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects. Mainstreaming is not an end in itself but a strategy, an approach. The ultimate goal is to achieve gender equality. Experience has shown that addressing women's empowerment and gender equality requires strategic and systematic integrations at all phases of the project cycle.

The agenda of the project is gender specific for improvement in women's health mainly. There are a whole host of gender issues at two levels: women's access to safe deliveries and gender issues around those, and gender issues that affect midwives and nurses.

Midwives and nurses in India have the same regulatory body and same registration which hamper the midwives to participate effectively in policy planning. Midwives in India are excluded from policymaking, overshadowed by adjacent professions such as nursing, and obstetrics. This exclusion is evident in regulatory bodies, professional associations, government ministries, maternity hospitals, university faculties, and in health and other agencies. As a primarily female workforce, working with and for women, midwives face many difficulties that their male colleagues do not because of their sex and associated cultural issues, and also because of their area of work. In India midwifery is not yet recognized as an independent profession. Lack of professional recognition for midwifery in India is directly a reflection of the widespread inequalities associated with gender and social status. Therefore, strengthening midwifery services in India is in line with women's empowerment and gender equality. This project has worked on capacity building and empowering female midwifery teachers. This approach has definitely empowered the direct beneficiaries.

However, the evaluation team could identify gaps. Gender equality was not incorporated in the project in a systematic manner. In our opinion, a project has mainstreamed gender into its implementation when the following happen:

- Collective analysis and perspective building on gender issues
- Setting indicators for gender mainstreaming
- Planning strategies, monitoring methods for this aspect
- Resource allocation for gender mainstreaming including designating a Gender Focal Person

Some indicators of gender mainstreaming could be:

- Nurses/midwives have a collective analysis and understanding of structural power imbalances between doctors and nurses, between nurses and ANMs, between ANMs and community women.
- Nurses/midwives collectively work out strategies to address these power imbalances and to implement these strategies.
- Gender issues in maternal health and related barriers for women's access to safe deliveries and SRHR are a part of the curriculum and nurse midwives are evaluated on this component.
- Addressing productive and reproductive health concerns of nurses/midwives – working conditions and issues of safety in an organised and systematic way through the project.

The project could have started with a common understanding, amongst the Core Group members, of gender dimensions related to midwifery, this project could directly and indirectly address. With an appropriate and common understanding of which gender issues related to midwifery (i.e. a “gender analysis”), the network could have been better able to promote and mainstream gender issues.

Although the midwifery training in Sweden and at the CAMTs addressed gender concerns, the gender analysis amongst those whom we interviewed is very uneven. However, a few respondents referred to men's politicking and fight for control within the nursing profession in India. They referred to the fact that powerful positions within the nursing management structures are occupied by men who are actually fewer in number. Many also spoke about the marginalization of midwifery within the nursing profession. They see this as an issue of power relations. One person interviewed pointed to the gender issues within medicine and nursing, compounded by the fact that the two professions are gendered also in terms of gender stereotypes – men as doctors, women as nurses. Most frequent responses to gender issues within midwifery referred to sexual harassment and exploitation that midwives face out in the field and the absence of grievance and redressal measures.

4.6 Equity

Equity comes from the idea of moral equality; all people should be treated as equals. There is growing recognition that equity is important for development. Even today there are disparities in access to maternal health care in India. In the rural area access to high quality maternal health care is limited in comparison to the urban areas. The important role of human resources for equity and improved quality in health is known and this project focuses on strengthening human resources for maternal health.

Equity is a significant issue for the midwifery occupation in India. Culturally birthing is surrounded by a host of pollution taboos. And those who have traditionally been birth attendants have been from the 'lower' castes. In this context enhancing the status of midwifery as a profession is an equity measure.

Thus, the training of midwives for deliveries has a larger equity goal. However, there is no evidence of how an equity perspective was incorporated into this project. Master trainers were selected on the basis of their potential to perform not on the basis of equity. The selection of states, Uttarakhand and Haryana may have been based on some sort of equity consideration. Gandhinagar was suggested by Government of Gujarat, secondly this was pilot project so taking up a difficult or needier district may reduce the chances of success.

4.7 Sustainability

The term sustainability describes the extent to which the positive effects of the development intervention continue after the external assistance has come to an end. The assessment of sustainability is looking at the long-term effects of the development process.

The key component of this project was to develop an inter-institutional network. The fundamental question is if this network can be sustained after the end of the Sida funded project. If the Core Group members are willing to sustain it and if there are resources for the network to continue its collaboration in strengthening midwifery and EmOC, it can be kept alive. However, the absence of sustainability planning in the design and development of the network puts it all at risk. During the project period there were limited joint arrangements for leveraging coordinated activities to achieve the project outcomes. Each Core Group member was occupied with multiple activities outside the project and modest time was prioritized for the actual networking.

During the evaluation it was obvious that the Core Group members were not sufficiently motivated to continue with the network as planned. Most of the organisations perceived the network to be only for the project, and not intended to continue after the end of the project. On the other hand, Core Group members have indicated that they will independently continue to work for improving maternal and newborn health in India. For example, the Government of Uttarakhand has endorsed the efforts of SBA training through a written commitment to CEDPA. The state government has already incorporated the cost of scaling up these interventions in the state to two additional districts in the state's current PIP.

The partnership between KI and IIM A ; SOMI and the Swedish Association of Midwives can of course be sustained for as long as they both benefit from it but if they are to engage in activities that require resources it will require a stronger effort to solicit funds from external organisations.

4.8 Relevance

This project has been highly relevant for India given the fact one fifth of all global maternal mortality occurs in India. The project has been congruent with the health policy focus in India – the Reproductive and Child Health programme Phase II, the National Rural Health Mission and the 10th and 11th Five Year Plans have a special focus on maternal health and reduction of the MMR. Working for the survival of mothers is a human rights imperative, safe deliveries are a matter of women's right to life. The target for the fifth MDG set by 189 countries in 2000, including the state of India, is to reduce the MMR by three-quarters by 2015. Over the last 50 years India has made progress in public health. However, the progress in maternal health has been very slow and the MMR remains high. Because maternal mortality is intrinsically hard to measure, estimates vary widely: The GoI estimates that 254 maternal deaths occur per 100,000 live births, whereas the World Health Organization (WHO) puts the estimate at 450. Nonetheless, available data suggest that maternal mortality is gradually decreasing.

Professional midwives offer evidence-based, cost-effective, high impact health care. As competent health care providers, midwives can early detect complications in births, take immediately appropriate life-saving actions and refer where appropriate. Midwives' critical thinking and competencies contribute to the saving of women's and newborn's lives. When midwifery is strengthened, midwifery and EmOC services are improved and enhanced; fewer women's and newborn's lives are lost.

Deliveries closer to home by skilled personnel is compatible with cultural condition of beneficiaries. Normal deliveries conducted by nurses and midwives, who are competent and skilled, is a part of task shifting, and bringing down costs of health service provision. The project has been consistent with Sida's previous as well as the new country strategy for India 2009–2013 and the MoU signed between Sweden and India which includes maternal health.

All stakeholders whom we interviewed (government representatives as well as representatives of the nursing and midwifery community) were unanimous that the project goal, objectives and strategy of strengthening midwifery is very relevant. The implementation of the project – selection of research topics, selection of states (Uttarakhand, Haryana) and districts (Almora) for testing of SBA guidelines – also has inbuilt relevance. Thus, strengthening of midwifery and EmOC services in India are fundamental strategies for reducing maternal and newborn morbidity and mortality, as severe shortages of trained health providers with midwifery skills are holding back progress.

4.9 Major challenges and constraints

During the desk review and by interviewing stakeholders the evaluation team could recognize a confusion of the expressions SBA, ANM, midwife and midwifery care. The international definition of SBA by WHO, ICM and International Federation of Gynecology and Obstetrics (FIGO)⁹ is not used by the GoI, as a substitute they have included ANM defined as SBA. This creates uncertainty and makes it hard to come to a consensus. This could have been one of the reasons why collective, systematic and strategic advocacy were missing in the project and why respondents reported insufficient communication between the Core Group members. Furthermore, not enough activities for relationship-building took place to strengthen the Core Group. The opportunity to develop strong alliances and partnerships was not maximized.

The coordinator of this project was IIM A; in addition they were responsible for networking, implementation, research and programming. This was too much for one organization and led to overburden, slow progress with the research component and weaknesses in project management. In actual fact, IIM A became the secretariat for coordination and financial management. Network building should be done by all partners from the network, not only by one organization. Other core group members have mainly been concentrating on their individual responsibilities. Collective strength and complementarity of individual partners was not optimally leveraged in this project.

Monitoring at several levels was weak. The monitoring indicators in terms of outcomes and achievements were not clearly spelt out in the original project proposal as well as in the LF. This is a complex developmental project and evolved over time so developing very clear indicators was seen as impossible by IIM A. Support in monitoring and evaluation to develop clear indicators was needed from the beginning. Also the MTR that was planned to be conducted was not done; which could have led to strategic corrections during the process. Trainees from the CAMT and SBA-training were not adequately followed-up and monitored. A number of trained SBAs and ToTs pointed out the lack of opportunities for review and refresher sessions as constraining the effectiveness of the training.

The title of this project includes strengthening of EmOC services; EmOC skills were incorporated in the project, however EmOC service is not only skilled personnel. EmOC services address a part of what is referred to as *“the enabling environment”*. The enabling environment refers to the working environment of midwives and other health personnel. It includes ensuring there are sufficient drugs, supplies, and that equipment are available, but also that the maternal health services are welcoming and friendly, both for clients, midwifery students and for the midwives. The evaluation team interpreted EmOC

⁹ “A skilled attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period, and in the identification, management and referral of complications in women and newborns.” (WHO, 2004).

services as a part of the “the enabling environment”. Apart from the one study done by IIM A, there does not appear to be much else as an EmOC services outcome of this project. When planning for scaling-up human resources for maternal health, through midwifery, substantial strengthening of the health system with a focus on quality of care and enabling environment for midwifery is fundamental.

Finally, ensuring continuous funding from diversified sources was identified as an obstacle for the sustainability of the project. For example, none of the CAMTs were able to conduct a third batch of ToTs due to funding crisis. The project period, including the phasing out phase was not long enough. The states are expressing need for additional technical support and hand-holding. Unfortunately, a financial plan was never built into the project and therefore at the end of the four years some partners in the Core Group are not able to continue the required activities.

5 Lessons Learned

Networking and partnerships require time for partnership building processes which will ultimately enhance the effects and impact of the project. Partnership building processes were required at several levels in this project – some examples are: better quality of CAMT training and its cascading effects, more effective strategic advocacy on collectively decided issues. In projects of such significance, resources including time for partnership building should be consciously built in. An important dimension of the partnerships is the one with the Government both at the national and state levels. Working closely with the Government, first in alignment with their goals and later in a way that nudges them along to the network’s way of thinking is crucial for sustainability as well as for policy change.

Strengthening midwifery capacity requires hands-on skills training as well as improvements in labour room practices. It is important to involve labour room personnel directly as partners. There is need for close collaboration between the midwifery teaching and practice/services. Good quality training has to be matched with attention to systemic changes that will be required to implement the training. There is a whole host of systemic issues that need to be sorted out and improved for effectiveness: midwifery tutors should be posted in positions where they will teach midwifery only (and not be posted back to their positions if these are not related to midwifery teaching); midwifery should be taught where practice is consistent with what is being taught; follow-up in the field is extremely important so supervisors have to be oriented and trained too and some system for field mentoring and monitoring has to be thought out and followed. If equipment and supplies are not provided regularly to the trainees after the training, they will not be able to fully implement what they have learned.

There are several conceptual issues around midwifery, midwives, nursing, SBAs as well as TBAs in India – these needs to be put out in a coherent form. Resolution may not be possible but broad consensus on short and medium term action plans to consolidate on the achievements thus far can be reached. This project has led to a quantum leap in the production of body of knowledge related to midwifery in India. The volume of papers that is being planned will be a definite asset. However, a systematic evaluation of the CAMTs and the district pilot projects on piloting SBA guidelines, (including an evaluation of field practices and skills) will also add to the body of knowledge.

M&E should be more integrated into future projects. This allows information to be continuously fed back to the organisations as it works through the various stages of implementation. Even though the Core Group and Sida had annual reviews it seems like there was need of a more continuing function that used systematic collection of data on specific process indicators, an internal monitoring system where the quality of the interventions were tracked from the inside. Developing a monitoring system which involves input from various stakeholders at critical points in the project can generate valuable information and establish a constant improvement of the project management cycle.

6 Conclusions and Recommendations

Overall, the project has been relevant and it has had impact in various ways. There are many reasons for Sida to continue funding future partnerships in midwifery between Indian and Swedish organizations.

- The relevance of strengthening midwifery and EmOC services in India is high in terms of the MDGs, the Indian national policies, MoU signed between Sweden and India and Sida's country strategy for India 2009–2013.
- The need to reduce the IMR and MMR in India is immense and more efforts are required.
- Swedish universities have high-quality knowledge base in midwifery training and few international cooperation agencies work in India in this field.

a Midwifery in India – partner driven cooperation

Sida's country strategy for 2009–2013 defines the general approach to partnership. However, before planning for a next phase or continuation of cooperation, the CAMTs training need to be technically evaluated. The evaluation needs to concentrate on: (1) the capacity of the CAMTs to produce an adequate and sustained supply of ToTs with the ability to offer skilled birth attendance, (2) review the capacity, quality, and appropriateness of clinical practice sites to create the enabling environment necessary for learning and support ToTs during their practice, (3) review the current knowledge, skills, confidence and practices of the ToTs.

Future Sida funded Midwifery Projects in India could focus on

- **Support a partnership of naturally interested stakeholders in midwifery**, to promote and influence political and legislative action for professional midwifery in India; to develop capacity of professional councils for instituting a process of effective accreditation system in order to ensure quality of care and to promote evidence-based standards for midwifery education programmes and institutions, such as the 11-month course, Independent Nurse Practitioner in Midwifery. These partnerships should be built on mutual respect, genuine interest and include community participation, civil society groups, from the beginning of the project.
- **National Training Programmes (NTP)** in professional midwifery that follow the International Confederation of Midwives' (ICM) recommendations for midwifery training and with strong gender and SRHR components – through a train-the-trainers programme. There is a need to build the capacity of the maternity workforce in terms of quantity in order to reach out to all communities, but it must not be forgotten that it is even more important to consider quality. Therefore, highly qualified midwifery teachers with strong clinical skills are needed in India. Several Swedish universities have long experience of midwifery training in Sweden and gradually more Swedish midwives are getting interested in development efforts but lack field experience, consequently it would be advantageous for both Indian and Swedish partners to establish a NTP in professional midwifery with technical support from Swedish Universities.
- **Strengthening of CAMTs** by conducting technical, action research to bring about curriculum improvement. Factors which influence curriculum effectiveness and need to be assessed are: ToT recruitment and selection, curriculum structure, curriculum contents, appropriateness and robustness of assessment schemes, the preparation of evaluations, and the role of the master trainers in assessment in practice settings. The follow-up done by the CAMTs also needs to be strengthened – follow-up of the training in terms of advocacy for implementation, further research and becoming hubs of technical expertise on midwifery.

- **Strengthening of SOMI** to enhance the ability of Indian midwives to contribute to the reduction of maternal and newborn morbidity and mortality. Midwives in India need the united power of their profession to reach both their individual and collective goals. Well organised midwives can become a voice for healthy families. The Swedish Association of Midwives is a strong professional association and has experience and interest in mentoring SOMI. A formal and substantive collaboration between two organizations is often called a twinning approach. This is a recommended, two-way, mutually beneficial exchange between two midwifery associations by the ICM for strengthening midwifery.
- **Research cooperation**, where Swedish universities and Indian partners have complementary skills. Subjects to investigate are total quality care improvements, quality circles, as well as needs assessments, clinical audits, community surveys, confidential enquiries into maternal deaths, investigations of near-miss cases: all can be used as means of improving quality of care.

b Organisations growth

- The problem of the continuing shortage of nursing and midwifery personnel needs to be urgently addressed.
- Clarification of confusions around SBA, midwife and midwifery in India are fundamental for future HR planning.
- Strategic planning for human resources for maternal health in India, scaling-up and skilling up of female multi-purpose health workers and/or scaling-up of professional midwives.
- Discussion and advocacy about the values, possible contributions and impacts of the Midwives' work and role in development needs to be kept alive.
- Legislative and regulatory environment is needed to allow midwives to deliver life-saving interventions
- Develop professional roles and further strengthen leadership in midwifery.
- Extend adequate working environment for midwives and midwifery students.
- Introduce in-service training for midwifery personnel.
- Enhance M&E system with focus on effects, outputs and outcomes within all midwifery projects. How to report on achievements should be subject to further clarification. Records on results should be substituted with indicators of outcomes and effects adequate support and mentoring to be provided.
- Ensuring equity by improving the quality of maternal-, SRHR- and EmOC-services for poor and marginalized people.

Annex 1 Terms of Reference

End-term Evaluation of the project “Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India” – a collaboration between Indian and Swedish institutions

1 Evaluation purpose

An end of Agreement evaluation is planned to be carried out during October–November 2009 to assess the overall quality, functioning and success to date and to formulate specific recommendations for the rest of the agreement term and for future direction in accordance with the country strategy India i.e. partnership driven cooperation between Sweden and India.

2 Intervention background

Sida has been supporting the project “Developing inter-institutional collaboration between institutions in India and Sweden for improving midwifery and EmOC services in India” covering the period December 2005–end June 2009. The agreement period was extended to December 2009 to complete the project activities.

The project, based on developing partnership between Indian and Swedish actors, is implemented through a core group of institutions viz. the Academy of Nursing Services (ANS), Trained Nurses Association of India (TNAI), Society of Midwives in India (SoMI), the White Ribbon Alliance India (WRAI) and coordinated by The Centre for Management of Health Services at the Indian Institute of Management, Ahmedabad (IIMA), while Karolinska Institute (KI), is coordinating from the Swedish side and works closely with the Swedish Association of Midwives.

The overall goal of the collaborative project is to contribute to the national efforts for reduction in maternal and neonatal mortality and morbidity through strengthening midwifery and EmOC (Emergency Obstetric Care) services in the public and private health system in India. The key strategy of this effort would be to develop a network of collaborating institutions in India and in Sweden that will provide technical expertise to central/state governments, midwifery training institutions, professional organisations and other stakeholders, and closely support the maternal health policy under the Government of India’s National Rural Health Mission (NRHM) and the Reproductive and Child Health (RCH) programme.

The specific objectives are:

- 1 Capacity building for midwifery skills for safe motherhood services to women
- 2 Develop a body of shared knowledge and understanding on current status of midwifery and EmOC services in India through situational analysis to adapt Swedish midwifery and maternal health services in Indian situation. Understand how lessons from organizations of midwifery and maternal health services in Sweden as well as other countries can be adapted and applied in Indian situation.
- 3 Develop a midwifery focused model of maternal care and to test feasibility of implementation of new guidelines for Auxiliary Nurse Midwives (ANMs) for Skilled Birth Attendant (SBA)/EmOC and to develop suitable management models to monitor these new interventions.
- 4 Conduct policy analysis and management studies for policy advocacy to key decision makers in state and central governments and professional organizations for improving status of midwifery and maternal health services and improve resource allocation in the country.

- 5 Develop an active network of organizations including academic institutions, professional bodies, government agencies, women's groups and other civil society organizations which can carry out key facilitating functions such as research, pilot testing, advocacy and monitoring to support improvement of maternal health services.

Key Activities and achievements within the project

A: Strengthening pre-service training in midwifery:

The following activities were taken up to improve in-service training in midwifery:

- Five Centres for Advanced Midwifery Training (CAMT) were established at nursing colleges in Ahmedabad, Hyderabad, Kolkata and Chennai (in collaboration with respective state governments) and MyTRI Institute of the Academy for Nursing Studies. The Centres have advance training equipment such as skill laboratories having models for practicing normal birth procedures, other teaching aids and a well equipped library.
- Fifteen senior faculty members (9 in 1st batch and 6 in 2nd batch) teaching midwifery and maternal health related subjects have been nominated by the state governments and been given 3 months training, part of which was in Sweden. These are the “master trainers”.
- The master trainers have in turn trained about 119 tutors from the ANM and GNM schools in the three project states for 3 months each. The project has helped improve quality of midwifery training in 100 nursing institutions in the country. Each CAMT has adopted one district in the state and strengthened the labor room in the district hospital and also strengthened the field practices of the students of ANM and GNM schools.
- One district (Medak in Andhra Pradesh) has been adopted for designing and implementing a mid-wifery model of care in the periphery.

B: Pilot testing of Government of India guidelines for Skilled Birth Attendants (SBA):

The Government of India's guidelines are being pilot tested in three districts- Gandhinagar in Gujarat, Karnal in Haryana, and Almora in Uttarakhand by WRAI/CEDPA. As part of this the following activities have been done:

- Clinical sites in district hospitals have been upgraded for training ANMs and Staff Nurses in terms of providing teaching aids, ensuring supplies of labour room equipments and drugs etc.
- Lead trainers were trained at the CAMT.
- Till date about 148 ANMs and Staff nurses have been trained for 3 weeks by the lead trainers in the three states.
- Based on this experience the modules for training are being revised.

C: Management studies and situation analysis for nursing and midwifery:

The project has taken up a number of small scale studies to understand and document key issues related to maternal health. Since midwives are crucial for reducing MMR, some studies have also looked at issues in midwifery and nursing. The following studies have been undertaken:

- State and district capacities for Operationalizing First Referral Units in Gujarat
- Referral System Analysis for providing Emergency Obstetric Care
- Work Load analysis of Auxiliary Nurse Midwife (ANM), Public Health Nurse (PHN) at Primary Health Centre & Community Health Centre (IIM A)
- Study of the Nursing Management Capacity in Gujarat, West Bengal, Uttar Pradesh and Tamil Nadu

- Professional Autonomy of Nurses and ANMs and its effect on motivation

Most of these studies were carried out by IIM Ahmedabad team. Results from these studies point out clearly that there is a dearth of midwifery personnel in the field and the management capacity at the state level for nursing is also very weak. The other situational analysis studies conducted by TNAI show the similar result. The following situational analysis studies were undertaken:

- History of midwifery and nursing in India
- “Commissions’ Reports, Policies-finished, unfinished agenda of various committees”, appointed by the Government of India for nursing and midwifery
- Role of regulatory bodies in nursing and midwifery

All these studies point out that there was a strong midwifery cadre in India in the past (before independence) which got diluted over a period of time.

Institutional strengthening and advocacy:

As part of the institutional strengthening various officers from central and state Government dealing with maternal health and midwives from nursing schools and colleges visited Sweden as the part of the exposure visit organized by the project. They have submitted their observations and suggestions for improving midwife’s role in maternal health which will be taken forward. As a result of these visits there has been lot of interest in improving midwifery services, for example in Gujarat the government has taken initiative to start a 1 year course approved by Indian Nursing Council on independent nurse practitioners in midwifery. Andhra Pradesh and West Bengal are also making efforts to strengthen midwifery services in rural areas through training of the ANMs and Staff nurses.

Contribution of state governments to the Midwifery project

The government contribution has been in the form of funds, infrastructure and human resource support. The government contribution/support has been for the following activities:

- 1 Establishment of the Centre for Advanced Midwifery Training (CAMT) in Gujarat, Andhra Pradesh and West Bengal being coordinated by the Academy of Nursing Studies (ANS, Hyderabad) lead by Dr. Prakasamma.
- 2 Supporting the pilot testing of the Government of India Skilled Birth Attendants guidelines in Gujarat, Uttarakhand and Haryana being coordinated by the White Ribbon Alliance of India/ CEDPA lead by Dr. Bulbul Sood.

It was difficult to estimate the government contributions separately for the two years of project implementation because some activities were delayed and also the contributions should be seen as continuous throughout the project period and beyond. The total project expenditure for the last two years (January 2006–March 2008) was around Rs 3,54,93,965 and the government contribution to the two components were around Rs 2,23,66,000, which means government’s contribution is around 63% of Sida project expenditure.

Challenges for future:

- The maternal health programmes are rapidly encouraging women to deliver in institutions through JSY program thus role for institution based midwives is increasing.
- The fact that midwifery is not recognized as a separate profession in India. It is seen as part of nursing, and midwifery skills of ANMs are lost as she has been converted into Multi-Purpose Worker, MPW, (Female). India needs to develop strong separate midwifery cadre in rural areas.

- There is increasing interest in states to develop midwifery cadre and to ensure that all births are attended by qualified mid-wives/nurses. This needs substantial efforts to develop good quality training programs for midwives.
- High level political and administrative commitment is required for maternal health which should be backed up by resources and monitoring.
- All maternal and neonatal deaths are still not recorded and investigated – this is urgently needed to improve the health care for mothers.
- Management capacity in maternal health care needs to be improved at state and national level. There are only 2 national maternal health managers/officers and in many states one officer is singularly responsible for maternal health.

3 Stakeholder Involvement

The main stakeholders of this evaluation are the collaborating and implementing agencies mentioned above, the State Governments where project has been executed, the Development Co-operation Section (DCS) of the Embassy of Sweden in New Delhi and Sida in Stockholm.

4 Evaluation questions

The external evaluation will cover all important aspects and components of the project as outlined in the project document taking into account developments since the signing of the agreement between IIMA, KI and Sida to date.

The evaluation team shall particularly address the following issues:

- The project outcome with regard to the expected end results and the effectiveness of the approach/strategy being used to achieve the project outcome.
- The efficiency of project management and the cost-effectiveness of the resources/inputs used.
- The outcome in relation to the efforts put in for capacity building, including internal control routines, and institutional development and the development of networking and coordination.
- Gender equality and social equity concerns at various levels of project implementation.
- The qualitative outcome of the project implementation in general, and in particular the midwife training component in Sweden and the study visits by decision-makers in Sweden.
- The institutional collaboration and partnership between the key partners and clarity in roles and responsibilities.
- Signs of potential impact at policy and implementation levels and sustainability of results, including the sustainability of the partnership between the collaborating organizations.
- The continued relevance of the collaboration project in relation to Sida's new Country Strategy for India 2009–13 and scope of the project to move towards Partner Driven Cooperation mechanism.

5 Recommendations and lessons

On the basis of this assessment, the evaluation team should identify problems and constraints, if any, and lessons learned, and propose recommendations for future. A number of generic recommendations should also be made that have bearing beyond the project.

6 Methodology

The evaluation team will, in consultation with the project organisations and Sida/DCS prepare a detailed scope of work and time schedule reflecting this ToR and present it to Sida/DCS for approval.

The evaluation team will review all relevant documentation, including the original project document, the project progress reports, review minutes and other relevant documents or reports.

The team will visit the project offices/sites in India and conduct interviews with relevant staff in the Sida/DCS, project partners in India and Sweden, the relevant Government officials at state and central level as well as other stakeholders in the activities undertaken.

7 Work plan and schedule

The evaluation will be carried out during three weeks in November/December 2009. It is proposed that the evaluation be carried out as follows:

- Documentation review and preliminary consultations with the Sida/DCS and IIMA/KI, including the development of a work plan;
- Visit to project sites, including collection of relevant written material as well as interviews with the staff of IIMA/KI including their collaboration partners, and concerned Embassy/Sida staff;
- Analysis of the information collected and preparation of a first draft of the report;
- Debriefing, information validation and preparation of the final version of the report.
- Logistical arrangements for the project visit will be decided upon once a detailed work plan has been developed.

8 Reporting

The evaluation team will produce an evaluation report of not more than 20–25 pages, apart from relevant annexes, containing the following sections:

- Cover page with date of version and name of consultants;
- List of contents;
- Executive summary – with particular emphasis on main findings, conclusions, lessons learned and recommendations;
- Introduction – presentation of the evaluation's purpose, questions and main findings;
- The evaluated intervention – description of the evaluated intervention and its purpose, logic, history, organization and stakeholders;
- Findings – factual evidence, data and observations that are relevant to the specific questions asked by the evaluation;
- Evaluative conclusions – assessment of the intervention and its results against given evaluation criteria, standards of performance and policy issues;
- Lessons learned;
- Recommendations;

- Annexes – terms of reference, methodology of data gathering and analysis, list of people interviewed, references, etc.

The findings and recommendations should also be verbally presented to IIMA/KI and partners, and the Sida/DCS. A draft version of the evaluation report will be shared with the partner organisations for comments at least two days before the presentation/s. The final evaluation report will be submitted to the Sida/DCS in 4 bound hard copies and one electronic copy (in MS Word or compatible software).

9 Evaluation team

The evaluation team will be consisting of two-three members (Swedish and Indian) designated by Sida/DCS.

The team should possess demonstrable skills in evaluating capacity development of organization as well as substantive experience from dealing with programmes for maternal and child health, gender issues and management/networking procedures. Excellent (English) oral and writing skills are essential. Work experience in India/South-Asia is of advantage and good knowledge and ability to apply Sida's goals and policies in carrying out the evaluation is needed.

The team leader is responsible for the conduct of the evaluation team, for ensuring that the ToR is fully understood by all the team members, and for ensuring that the evaluation report is completed in accordance with this ToR.

Annex 2 Reviewed Project Documents

A Study of Referral System for EmOC in Gujarat, Mona Gupta, Dileep Mavalankar, Poonam Trivedi, June 2009

Agreed Minutes from the Annual Review of the Project ‘Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India’ for the year 2006

Agreement between Sida, IIM A and KI on Financing of “Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC in India” during 2005–2009

Aktörssamverkan för global utveckling – policy för aktörssamverkan inom utvecklingssamarbetet, Sida 2007

Amendment to the specific agreement on “Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC in India” Between Sida, IIM A and KI 2005–2010

Assessing the Regional and District Capacity for Operationalizing Emergency Obstetric Care through First Referral Units in Gujarat, Parvathy Sankara Raman, Bharati Sharma, Dileep Mavalankar, Mudita Upadhyaya, April 2009

Assessment of Academy of Nursing Studies (ANS), Kyllike Christensson, Eva Johansson, 2003 02 20

Auxiliary Nurse Midwife’s (ANM) changing role in India: Policy issues for Reproductive and child health. By Dr. Dileep Mavalankar IIM A Ahmedabad

Beslut KI 2005

Decision on Contribution

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, First Core Group Meeting 27–29 March 2006

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Minutes of the 2nd Core Group Meeting 21st of September 2006

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Minutes of the 3rd Core Group Meeting 28th of January 2007

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Minutes of the 4th Core Group Meeting 4th of March 2007

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Minutes of the 5th Core Group Meeting 8th and 9th of October 2007

Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Annual Review Meeting of Midwifery Project Supported by Sida, 5th and 6th of May, 2009 at IIMA and May 9th at Sweden Embassy, New Delhi

Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC services in India, Annual Project Report, Submitted to Sida for the period of January 2006–March 2007

Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC services in India, Annual Project Report for 2nd year Submitted to Sida for the period of January 2007–March 2008

Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC services in India, Annual Project Report for 3rd year Submitted to Sida for the period of April 2008–March 2009

Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India, Visit of the Core group representatives to Netherlands and Sweden, 16–22nd October 2006. Dileep Mavalankar, Amarjit Singh, SR Patel, Ajesh Desai, Prabal V Singh

Final Overall Work plan for no cost extension period

Final proposal for the midwifery project 12[1].12.05

Final work plan March 2007 April 08– final–14-12-07

Government of India Guideline on Training for SBAs, MOHFW, 2009

Historical perspective of Nursing and Midwifery Training, education and Practice in India, Arvin Kulkarni, Anita Deodhar, Mudita Upadhyaya, Parvathy Raman, Dileep Mavalankar.

Historical perspective of Nursing and Midwifery: Training, Education and Practice in India – By Parvathy Raman, Dileep Mavalankar, Arvind Kulkarni, Mudita Upadhyaya, Anita Deodhar, 2009

HR Practices and Legal Issues in Nursing in India, Arvind Kulkarni, Anita Deodhar, Jyotsna Pandit, Reshma Padekar. 2008

Log Frame for Midwifery Project

Midwifery and maternal health in India: Situation Analysis and lessons from the field, Monograph by Center for Management in Health Services, Indian Institute of Management, developed as part of MEDP, Project supported by Sida, 2009

Minutes from the 2nd Annual Review of the Project “Developing Inter Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India” for the year 2007, 22–24 April 2007, Hyderabad

Minutes of the meeting of GoI officials and Midwifery and EmOC development project core group supported by Sida held on 7th of July 2008

Principles guiding the assessment and decisions regarding bilateral contributions within the framework of Partner Driven Cooperation, Sida 2009

Project Application

Proposal on Developing Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC services in India, IIM A, KI Sweden November 2005

Report of the activities Conducted by the TNAI June 2006–March 2007

Report of the activities during: March–December 2008 TNAI

Report of ToT CAMT, College of Nursing, Civil Hospital Ahmedabad

Review Meeting for II ToT Participants, From 19th to 21st of March, 2009 at CAMT centre Hyderabad

Revised Annual report 2009 for sharing

Revised Work plan April 2008–June 2009 as on June 8

Role of Nursing Councils in regulating nursing and midwifery education, training and practice in India – By Bharti Sharma, Dileep Mavalankar, Arvind Kulkarni, Anita Deodhar and Jasu Patidar, 2009

Role of Regulatory Bodies in regulating nursing and midwifery training and practice in India. Bharati Sharma, Dileep Mavalankar, Arvind Kulkarni, Anita Deodhar, Jyotsna Pandit. 2008

Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjeevi scheme of Gujarat, India

Saving mothers and newborns through an innovative partnership with private sector obstetricians: Chiranjivi scheme of Gujarat, India – By Dileep Mavalankar, Amarjit Singh, Sureshchandra R. Patel, Ajesh Desai, Prabal V. Singh, 2009

Sida India Evaluation Plan 2009-12-09

Situational Analysis of Reporting and Recording of Maternal Deaths in Gandhinagar District, Gujarat State, Tapasvi I. Puwar, Parvathy S Raman, Dileep V. Mavalankar

Situational Analysis, Research and Advocacy by TNAI, New Delhi, 2008

Special Bulletin on Maternal Mortality in India 2004–06, Sample Registration System Office of Registrar General, India

Strengthening Midwifery practices for Safe Motherhood in India, August 25–30, 2008 Workshop Report. TNAI New Delhi

Strengthening Midwifery practices for Safe Motherhood in India, October 5–9, 2009 Workshop Proceedings. TNAI Meghalaya State Branch

Strengthening Midwifery practices for Safe Motherhood in India, September 22–27, 2008 Workshop Proceedings. Adhiparasakthi College of Nursing

Strengthening Midwifery practices for Safe Motherhood in India, September 7–12, 2009 Workshop Proceedings. TNAI Maharashtra State Branch

Sweden Report, TNAI

Towards Midwifery based maternal Care: A road map for India – by Bharti Sharma, Dileep Mavalankar, 2009

Training of ANMs, Lady Health Visitors and Staff Nurses as SBAs – By Medha Gandhi and Manju Chuggani, 2009

Women and Work. Nurses/Midwives Working in Difficult/Discriminatory Environment in Gujarat State, Jyoti Gade, Bharti Sharma, Dileep Mavalankar, Prabal Singh

Women's perspective on Midwifery in India – a literature review, Arvind Kulkarni, et al. 2008.

Annex 3 List of Persons Interviewed

Date	Key Informant	Organisation	Location
Sweden – Stockholm			
26.11.09	Gunilla Essner	Sida/Stockholm	Stockholm
27.11.09	Ms Bharati Sharma	IIM A	Stockholm
27.11.09	Anna Nordfjell	Swedish Association of Midwives	Stockholm
India – Ahmedabad			
30.11.09	Dileep Mavalankar	IIM A	Ahmedabad
30.11.09	Prof. K V Ramani	IIM A	Ahmedabad
30.11.09	Parvathy S Raman	IIM A	Ahmedabad
30.11.09	Poonam Trivedy	IIM A	Ahmedabad
30.11.09	Dr. Viru Budhiya	IIM A	Ahmedabad
02.12.09	Lekha Nair	IIM A	Ahmedabad
02.12.09	Ms. Jyoti Gade	IIM A	Ahmedabad
02.12.09	Parvathy S Raman	IIM A	Ahmedabad
02.12.09	Ms. Anandi Chauhan	CAMT, Collage of Nursing Master Trainers	Ahmedabad
02.12.09	Ms. Manhar Tande	CAMT, Collage of Nursing	Ahmedabad
02.12.09	Dr. Ajesh Desai	CAMT, Collage of Nursing	Ahmedabad
02.12.09	Ms. Alice Fernadez	State Government	Ahmedabad
02.12.09	Ms. Kankben Solanki	School of Nursing	Ahmedabad
02.12.09	Ms. Jyotsana Pandya	School of Nursing	Ahmedabad
02.12.09	Ms. Parfulla Butani	School of Nursing	Ahmedabad
02.12.09	Ms. Poagna Dabhi	School of Nursing	Ahmedabad
02.12.09	Ms. Kamal Jadhav	School of Nursing	Ahmedabad
02.12.09	Ms. Rekha Barot	School of Nursing	Ahmedabad
02.12.09	Ms. Alita Amdekar	Trainees	Ahmedabad
02.12.09	Ms. Rekhu Barot	Trainees	Ahmedabad
India – Gandhinagar			
01.12.09	Ms. Giraben Solanki	SBA Trainer, SBA Training Centre	Gandhinagar
01.12.09	Dr. Jaldhara	Gynecologist, Dist.Hospital	Gandhinagar
01.12.09	Dr. Devang B.Shah		Gandhinagar
01.12.09	Dr. Vijay Patel	Adalaj PHC	Gandhinagar
01.12.09	Dr. Jodha		Gandhinagar
01.12.09	Dr. Seema Shah	Pediatrician, District Hospital	Gandhinagar
01.12.09	Sangita Makvana	SBA Trainee	Gandhinagar
01.12.09	Saroj Patel	SBA Trainee	Gandhinagar
01.12.09	SonalThaker	SBA Trainee	Gandhinagar
01.12.09	Kanta Chauhan	SBA Trainee	Gandhinagar
India – Kolkata			
04.12.09	Mr. Namit Biswas	Special Secretary Nursing, Govt of WB	Kolkata
04.12.09	Samar Ghose	Additional Chief Secretary – Govt. of WB	Kolkata
03.12.09	Manimala Ghose	Sister Tutor, CAMT, West Bengal	Kolkata
04.12.09	Madhavi Das	Director Nursing WB-Nursing Department	Kolkata
03.12.09	Ms. Bandana Das	Principal College of Nursing, West Bengal	Kolkata

Date	Key Informant	Organisation	Location
04.12.09	Chameli Roy	Principal Nursing Officer, School of Nursing,	Kolkata
5.12.09	Kalyani Kala	Principal, RG Kar Medical College,	Kolkata
5.12.09	Mousimi Hembrom	Clinical Instructor WB District Training Centre	24 South Pragana
5.12.09	Smita Bhuyan	Sister Tutor, WB	Kolkata
3.12.09	Mitali Adhikari	Faculty College of Nursing Medical College Hospital	Kolkata
5.12.09	Kaya Samanta	Nursing Superintendent WB	Kolkata
5.12.09	Pratima Chatterjee	Registrar WB Nursing Council	Kolkata
5.12.09	Kalpana Mozumdar	Senior Sister Tutor, District School of Nursing	South 24 Pragana
5.12.09	Shipra Dey	Senior Sister Tutor, WB	South 24 Pragana
India – Baroda			
01.12.09	Aditi Desai	Nursing college	Baroda
India – Haryana			
8.12.09	Dr. Vandana Agarwal	MO Civil Hospital, Nilokhedi	Haryana
8.12.09	Dr. Naresh Saini	CMO, Karnal	Haryana
8.12.09	Ms. Mridula Dhiman	DPM Karnal	Haryana
8.12.09	Ms. Niru Dhir, Lead	SBA Master Trainer	Haryana
8.12.09	Dr. Seema Sharma	Lady Medical Officer District Hospital, Karnal	Haryana
8.12.09	Ms. Lotesch	ANM Beyana Delivery Hut, Sub Center	Haryana
8.12.09	Ms. Anita	ANM Beyana Delivery Hut, Sub Center	Haryana
12.12.09	Dr. Narveer Singh	Director Health Department of Health, Government of Haryana	Haryana
8.12.09	Dr. Manju Chugani	Training Consultant	Haryana
India – Chennai			
02.12.09	Dr. Elango	Director, Preventive medicine	Chennai
02.12.09	Dr. Jaya	Coordinator CAMT	Chennai
02.12.09	Ms. Kumari	Master trainer	Chennai
02.12.09	Narmada	Master trainer	Chennai
India – Hyderabad			
03.12.09	Dr. M. Parkasamma	SOMI HQ	Hyderabad
03.09.15	Shanthi Videtnani	SOMI Hyderabad	Hyderabad
04.12.09	Ms. Radha Ramanashree	Master trainer CAMT Hyderabad	Hyderabad
04.12.09	Sandhya Rani	CAMT Coordinator	Hyderabad
04.09.09	Salver Sujatha	Master trainer CAMT Hyderabad	Hyderabad
04.09.09	Anil Chandra Punetha	Commissioner of Family Welfare, Gov. of AP	Hyderabad
05.12.09	Santhi Videtnani	ToT at CAMT Hyderabad	Hyderabad
05.12.09	B. Prameela	ToT at CAMT Hyderabad	Hyderabad
08.12.09	Olivia Benjamin	ANS – Medak model	Hyderabad
08.12.09	Dr. Govardham Reddy	District Medical Health Officer	Hyderabad
India – New Delhi			
06.12.09	Dr. Manchanda	IIC Delhi	New Delhi
06.12.09	Medha Gandhi	WRAI/CEDPA	New Delhi
09.12.09	Manju Chuggani	WRAI/CEDPA New Delhi	New Delhi
11.12.09	Dr. Bulbul Sood	WRAI	New Delhi
10.12.09	Dr. Manmeet Kaur	WRAI	New Delhi
09.12.09	Dr. Aparajitha Gogi	Country Director, CEDPA	New Delhi
14.12.09	Prof. Kyllike Christenson	KI	New Delhi

Date	Key Informant	Organisation	Location
10.12.09	Sheela Sheda	TNAI	New Delhi
11.12.09	Ms. Anita Deodhar,	TNAI	New Delhi
10.12.09	Evelyn	TNAI	New Delhi
14.12.09	Mr. Arvind Kulkarni	TNAI	New Delhi
10.12.09	Dr. Amarjit Singh	Ex. Health commissioner, Government of Gujarat	New Delhi
14.12.09	Dr. Dilip Kumar	President, Indian Nursing Council Ministry of Health, Government of India	New Delhi
09.12.09	Dr. H. Bhusan	Commissioner, Maternal Health Ministry of Health, Government of India	New Delhi
11.12.09	Ms. Bandana Bhattacharya	President, SOMI	New Delhi
11.12.09	Claes Leijon	Sida/New Delhi	New Delhi
11.12.09	Yasmin Zaveri-Roy	Sida/New Delhi	New Delhi
09.12.09	Leila Varkey	WRAI	New Delhi
10.12.09	Dr. Manmeet Kaur	PGI Chandigarh, Focal Point & Chapter President, WRAI, Chandigarh for Punjab	New Delhi

Recent Sida Reviews

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2009:30 Programme for Democratic Policing (PDP) between the Rwanda National Police (RNP), the Swedish National Police Board (SNPB) and the South African Police Service (SAPS)

Birgit Lindsnaes, Piet van Reenen

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2010:01 Review of Impact of Sida's Microfinance Support in Bosnia and Herzegovina

Monica Lindh de Montoya, Aida Selimić

Sida

2010:02 External Assessment of the Sida Supported Research Cooperation Project within Information Communication Technology (ICT) at Universidad Mayor de San Andres, UMSA, La Paz, Bolivia

F F Tusubira, Nora Mulira, Ali Ndwelana

Sida

2010:03 Cooperation Programme between the Ministry of Agriculture and Rural Development of Vietnam and the Swedish International Development Cooperation Agency – MSCP 2005–2009

John Markie, Nguyen Tu Sien

Sida

2010:04 Working beyond the grassroots:

An Evaluation of the Chia Se Poverty Alleviation Programme 2003 to 2008

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STRENGTHENING MIDWIFERY AND EMERGENCY OBSTETRIC CARE (EMOC) SERVICES IN INDIA

The overall development goal of the Sida funded project, "Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and EmOC Services in India", was to contribute to the national efforts to reduce the maternal morbidity and mortality, through strengthening midwifery and Emergency Obstetric Care (EmOC) services in the public and private health systems in India. The present evaluation appears at the end of the project and it is above all a summative evaluation, meaning to recapitulate the results and discuss what forms of cooperation may follow in the new strategy for development cooperation between Sweden and India. The current evaluation was undertaken during the months of November and December 2009. The evaluation assignment is structured around six clusters of issues: 1) Effectiveness and efficiency, 2) Impact, 3) Gender Equality, 4) Equity, 5) Sustainability and 6) Relevance.

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