

United Nations Children's Fund (UNICEF)

Report on Evaluation of Humanitarian Actions -  
Nutrition Emergency Response in District  
Tharparkar, Sindh, Pakistan

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### Abbreviations / Acronyms

BHU	Basic Health Unit
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMAM	Community Based Management of Acute Malnutrition
DDMA	District Management Authority
DHQ	District Headquarter
EHA	Evaluation of Humanitarian Action
EMOC	Emergency Obstetric Care
GAM	Global Acute Malnutrition
HRGE	Human Rights and Gender Equality
IYCF	Infant and Young Child Feeding
LHW	Lady Health Worker
MAM	Moderate Acute Malnourishment
MMN	Multi-Micro-nutrients
MNCH	Maternal, Newborn and Child Health
MUAC	Mid-upper Arm Circumference
NIS	Nutrition Information System
OTP	Outpatient Therapeutic Programme
P&D	Planning and Development
PCA	Project Cooperation Agreement
PDMA	Provincial Disaster Management Authority
PLWs	Pregnant and Lactating Women
PPHI	People's Primary Health Initiative
ROSA	Regional Office for South Asia
RUTF	Ready to Use Therapeutic Food

SAM	Severe Acute Malnourishment
SC	Stabilization Centre
SPA	Strategic Priority Area
THQ	Tehsil Headquarter
TPFM	Third Party Field Monitoring
TTSFP	Targeted Supplementary Feeding Programme
UC	Union Councils
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WFP	World Food Programme
WHO	World Health Organization

## EXECUTIVE SUMMARY

This document presents the real-time evaluation of UNICEF's Nutrition Emergency Response in drought-affected district Tharparkar in Sindh province, Pakistan. The Nutrition Emergency Response was implemented by UNICEF Pakistan in partnership with two national Non-Governmental Organizations, Shifa Foundation and HANDS, between January 2014 and March 31, 2016. The overarching purpose of the response was to address emergency nutrition needs of children in the age group of six months to two years (6-59 months) and Pregnant and Lactating Women (PLWs).

The overall goal of UNICEF's response was: "strengthened capacity for reducing risks, as well as planning, preparing, and effectively responding to disasters in accordance with UNICEF Core Commitments to Children in Humanitarian action."

The purpose of the evaluation was to help improve the effectiveness and quality of UNICEF's nutrition response and learn lessons for similar future emergencies in Tharparkar or in other districts of Pakistan. The evaluation analyzed both the processes and outcomes of the intervention.

The main users of the evaluation are UNICEF's Pakistan Country Office, the Regional Office for South Asia (ROSA) and the Global Emergency Unit. Intended users also include key government agencies, including the National Disaster Management Authority, the District Disaster Management Authority, the Provincial Disaster Management Authority, Sindh, the Provincial Department of Health, Sindh, and the Provincial Nutrition Cell and Planning and Development Department, Government of Sindh. The implementing partners of UNICEF and the implementing partners of the Department of Health, Sindh, could also benefit from the findings and recommendations for implementation of the nutrition strategy.

The objective of the evaluation was to assess UNICEF's humanitarian response in Tharparkar, using standard criteria for evaluation of humanitarian action, such as relevance, efficiency, effectiveness, coverage, connectedness, coordination and coherence. The evaluation was also expected to assess crosscutting issues such as coordination, management and the inclusion of gender equity and human rights and to identify challenges and lessons for implementation of multi-sectoral nutrition interventions.

### Methodology

The methodology adopted was primarily qualitative and the bulk of the data was collected using qualitative methods. A mini-survey with structured, open-ended questions was administered to 60 households. An observation checklist complemented the data. Both secondary and primary data were collected. Documents related to design, implementation and monitoring were reviewed. Data on coverage from the Nutrition Information System (NIS) were also analyzed. Primary data was collected in Focus Group Discussions, Key informant interviews, the observation checklist and the mini-survey. During the field investigation the evaluation team visited 10 out of 44 static sites established by the implementing partners in four Talukas of Tharparkar. At least two sites from each of four Taluka and five OTP sites for each partner, Shifa and HANDS, were visited by the evaluation team.

An inception meeting with the UNICEF Nutrition team was held in Islamabad on January 19, 2016. In light of discussions with UNICEF Nutrition team the evaluations questions given in the TOR were further developed and refined. The required inception report was submitted on March 1, 2016 and approved in March 18, 2016.

Fieldwork took place between March 26 and March 31, 2016. Data was analysed using content analysis and inductive analysis methods. OECD/Development Assistance Committee (DAC) criteria for evaluation of humanitarian interventions were used to organize and analyze the findings. Gender Equity and Human

Rights were additional dimensions used for analysis, based on UNICEF's evaluation standards for equity-focused and gender responsive evaluations. The evaluation combined elements of an end-of-project and a formative evaluation. UNICEF Procedure on Ethical Standards in Research and Evaluation were followed.

## **Key Findings**

The following four results were identified in the Project Cooperation Agreements:<sup>1</sup>

### **Result 1: CMAM services remain functional in static and mobile nutrition sites for the management of identified acute malnourished children and PLWs**

Both of UNICEF's implementing partners successfully set up static Outpatient Therapeutic Programme sites in each of the 44 target Union Councils to provide nutrition services. Each partner also established two mobile teams to deliver services to remote villages. In addition, both partners used all the teams deployed in the static OTP sites as static-cum-mobile teams, with the exception of teams deployed at static sites in District Headquarter (DHQ) and Tehsil Headquarter (THQ) hospitals. The evaluation found that CMAM services remain functional in static and mobile sites, although OTP sites closer to the center were better equipped and more organized than the ones located farther from the center.

### **Result 2: Healthy nutrition behaviors promoted at facility and community level to prevent malnutrition in early childhood.**

The partners were notably effective in increasing awareness among women community members, particularly among PLWs, about the causes of malnutrition, ways to prevent, and increasing women's knowledge of good feeding practices. However, they were far less effective in reaching out to male community members, in general, and in particular to fathers of children 6 to 59 months old. Widespread behavioural changes will take some time to become evident although there are some reports of this already.

Lack of standardization of messages for IYCF and hygiene promotion emerged as an important issue. HANDS was using a training manual designed for an African context; Shifa was using its own material. Limited technical capacity among the field staff of implementing partners to implement nutrition interventions were noted as important reasons for some field staff delivering mixed messages.

### **Result 3: Micronutrient deficiencies disorders in children and women prevented / treated in the target population.**

The targets for all of the project services were exceeded: the over-achievements were: 214% in screening children aged 0-59 months; (294,232 vs 93,600); 51.6% in screening PLWs (97,582 vs 62,400); 63.77% in registering SAM children (18,508 vs 7,207), 238% in MAM children registered and treated (40,407 vs 11,957) and 100% in PLWs registered and treated in TSFP program (21,833 vs 10,920). In addition 28,538 children were de-wormed (no target had been set) and there was a 76% over-achievement in reaching women for promotion of IYCF practices (109,779 vs 62,400).

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<sup>1</sup> Annex C: Programme Document, UNICEF, Shifa Foundation, 30<sup>th</sup> June 2015.

The partners were successful in screening both girls and boys and PLWs to identify SAM and MAM cases and providing treatment through mobile and static OTP and TSFP sites. They also succeeded in identifying cases of SAM with complications and referring those cases to the stabilization center. The partners provided transportation costs for children referred to stabilization centers, but were not able to ensure that all cases referred to the stabilization center were admitted. However, data compiled by NIS shows significant untraceable gaps between: (i) those identified as malnourished (SAM and MAM) and those admitted to OTP and TSFP and (ii) those admitted to OTP and TSFP and those who were discharged.<sup>2</sup>

#### **Result 4: Sustainability of CMAM interventions ensured by strengthening local technical capacity for integration of CMAM into Primary Health Care system.**

The Nutrition Cell conducted two five-day Training of Trainers workshops on CMAM for the representatives of the Provincial Health Department, District Health Departments, representatives of relevant civil society organizations and its two implementing partners. As a result, HANDS and Shifa now have sufficient in-house capacity for training on CMAM and strengthened capacity for implementing nutrition projects. The provincial and District Health Departments, civil society organizations have enhanced expertise to implement and monitor nutrition interventions. It was expected that they would act as Masters Trainers when the World Bank-supported Nutrition Support Programme is implemented, in terms of the Provincial government's commitment to maintain the initiative.

A major limitation is the disjuncture between OTP sites and BHUs and the government dispensaries run by the People's Primary Health Initiative (PPHI). The effectiveness of the nutrition emergency response was somewhat compromised because PPHI did not allow the implementing partners to set up OTP sites within the BHUs or the government dispensaries under its control. Conclusive evidence as to why PPHI did not allow the partners to setup OTP sites within BHUs could not be found.

In terms of HRGE, the project design significantly contributes to the promotion of the rights of the most vulnerable segments of the population, *i.e.* children and women, including those living in remote villages. The project can be rated 2A on the IASC Gender Marker<sup>3</sup>, because it promoted the rights and met the needs of the most vulnerable segments of the population: PLWs and malnourished children aged 0-59 months.

Although HRGE concerns were recognized as important in the PCAs, the requirements for sufficiently addressing HRGE were not defined, except for an output indicator in the project LFA related to hiring 40% women. As a result, HRGE concerns did not receive sufficient attention in either implementing or monitoring project activities.

The nutrition emergency response was directly relevant to identified practical needs in the drought-like situation in Tharparkar, but it was not necessarily the most appropriate response for addressing the high number of child deaths from other causes, as nine (3%) of the 326 child deaths recorded in Tharparkar in 2014 were caused by malnutrition.<sup>4</sup> The main reasons for the child deaths were lack of access to and

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<sup>2</sup> Data extracted from Nutrition Information System (NIS) provided by UNICEF

<sup>3</sup> The project are rated 2A on IASC Gender Marker if "the project is designed to contribute significantly to gender equality. The different needs of women/girls and men/boys have been analyzed and integrated well in all three essential components: the needs assessment activities and outcomes." See

[http://floods2010.pakresponse.info/gender/Guidance\\_Note\\_for\\_Clusters\\_to\\_implement\\_the\\_IASC\\_Gender\\_Marker.pdf](http://floods2010.pakresponse.info/gender/Guidance_Note_for_Clusters_to_implement_the_IASC_Gender_Marker.pdf)

<sup>4</sup> Data was provided to UNICEF from Department of Health, Government of Sindh

poor quality of Maternal, Newborn and Child Health (MNCH) services, particularly Emergency Obstetric Care services.

The intervention is well aligned with the policies and priorities of the UN, UNICEF and the Sindh government. It addresses the Common Country Programme of Action (2013-2017) of the Government of the Islamic Republic of Pakistan, UNDP, UNFPA and UNICEF. It particularly addresses Strategic Priority Area 6 of the Common Country Programme related to food nutrition security for the most vulnerable groups. It also addresses UNICEF's aim to achieve "improved and equitable use of nutritional support and improved nutrition and care practices."<sup>5</sup> The Sindh government's health strategy for 2012-20 has also identified nutrition as one of the special areas of emphasis.

Broadly speaking, the response addressed the Universal Declaration of Human Rights (UDHR) and the Principles of The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). However, although gender equity was identified as a priority area in the Project Cooperation Agreements, the response did not benefit from any intervention-specific analysis of or planning for Human Rights and Gender Equality.

Cost per beneficiary was found to be relatively high compared to the average cost per beneficiary of USD145 assessed by an evaluation of 45 CMAM projects implemented by UNICEF in Khyber Pakhtunkhwa province of Pakistan. (See Section 2.4 for intervention-specific cost details.) The biggest source of high costs was the short duration of projects and the resultant need to re-start projects that had been closed.

Although the evaluation found that UNICEF has been successful in meeting its objectives and programmatic and operational commitments, both efficiency and effectiveness were compromised because the intervention was implemented in short spurts, with unnecessary gaps between different projects.

The monitoring framework is insufficiently developed. The monitoring reports developed by UNICEF Sindh were of poor quality. Third party monitoring reports focus narrowly on availability of equipment, supplies and availability of staff at OTP sites: they do not address the causes and consequences of either positive or negative findings.

## **Conclusions**

Widely-scattered populations, high levels of poverty and illiteracy, as well as entrenched cultural beliefs and practices about childbirth and infant feeding practices were context-specific challenges that made adoption of practices promoted by the project difficult and less effective than it might have been. Some of the limitations of the outreach activities, such as inadequate focus on hygiene promotion, can possibly be traced to overburdened IYCF Counselors. The inability to effectively engage with male community members is another example.

The partners' outreach to men was largely ineffective, beyond creating awareness about the project. The outreach did not explore the potential of using *Otaqs* (traditional gathering place for men) or the possibility of modifying the organizations' own systems to accommodate community needs.

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<sup>5</sup> UNICEF Strategic Plan, 2014-2017

The challenging geographic context was also a factor in high costs per beneficiary. More significant, however, were the frequent interruptions in project implementation. Each time a project was closed, human and financial resources had to be demobilized with attendant costs, and when new projects were initiated, these required new resource mobilization.

Overall, the emergency response is seen by most respondents representing UNICEF, WFP, NDMA, PDMA, district government and local NGOs as one of the better coordinated emergency responses, although a few representatives viewed the overall approach as piecemeal and lacking integration.

The intervention would have been stronger if it had been integrated with Health and possibly with WASH. This would also be in line with UNICEF's institutional priorities for integrated programming and its understanding of the causes of malnutrition, as reflected in its framework for understanding malnutrition.

Limited technical capacity of field staff, including coordinators and supervisors, and lack of standardized messages were two important limitations that sometimes led to contradictory messages being conveyed to women. This limited the effectiveness of the nutrition intervention.

The partners were successful in taking into account military policies which required the partners to follow security restrictions, seek NOCs for visits and regularly share information about project activities, particularly in areas closer to the Indian border. The partners maintained good relations with security agencies and regularly shared information with them to ensure increased access to the project areas. Being cooperative and transparent in sharing information was key to ensure relatively better access to the target areas.

Although some in UNICEF saw the nutrition emergency intervention as a life-saving intervention implemented with a particular focus on saving lives, rather than with an eye on integration with long-term food-security needs, there is ample evidence to suggest that the intervention was originally designed as a precursor to the World Bank-funded Nutrition Support Programme in Sindh. The choice of partners (specifically the non-selection of PPHI as a partner) may have led to the disconnect between OTP sites and BHUs. However, the emergency nutrition intervention has contributed to shaping the implementation strategy for the World Bank-funded nutrition support programme, which was one of the underlying expectations of nutrition emergency response.

## **Lessons Learnt**

- ▶ UNICEF' organizational systems have yet to catch-up with changed institutional priorities. As a result, as shown by the experience of the project shared by UNICEF representatives, integrated programming did not receive sufficient attention and projects were formulated in department-specific silos. Unless concerted efforts are made to harmonize organizational systems with changing institutional priorities, it takes more time for systems to catch up with institutional priorities.
- ▶ Terrain, the quality of roads and the quality of communications technologies are critical factors in successfully implementing programmes of this nature. In areas where the population is scattered and access to service delivery points is limited by long distances, lack of transport and poor road infrastructure, mobiles team work best, provided they are well equipped and have appropriate vehicles and communications technologies.
- ▶ For this project, the relevance of static sites was strong, but it also shows that in areas where the population is scattered and access to OTP sites is limited by long distances, lack of transport and poor road infrastructure, mobiles team work best, provided they are well equipped and have appropriate vehicles and communications technologies.

- ▶ Partners have found through experience that they can use their visits to communities to support EPI coverage. They have frequently encouraged EPI extension workers to accompany them for this purpose. Where possible, this sharing of local resources and knowledge should be integrated into implementation plans.
- ▶ Government records including items as basic as a list of villages do not always catch-up with the changing reality (e.g. shifts in population, demographic trends, the state of local water supplies) on the ground, underlining the need to augment government records with local knowledge.

## Recommendations

- ▶ In line with UNICEF's institutional priorities for integrated programming, and UNICEF's understanding of the multi-faceted nature of the causes of malnutrition, UNICEF should design and implement integrated and multi-faceted programs to address malnutrition in children and adults. Government Departments and Government Health Facilities should be involved in planning these programmes. The Province's Health Strategy, as it relates to treating and reducing malnutrition, should be analysed, and new UNICEF and World Bank initiatives should take into account how to support the Provincial and District Health Departments.
- ▶ Strategies must be generated to ensure consistent and long-term implementation: this requires, inter alia, that projects and services are not shut down and re-opened, that staff members are assured of long-term employment and that community members know that staff are engaged with them in the long term.
- ▶ Future projects should develop and use project-specific HRGE analyses, strategies and implementation plans to inform context-specific actions. These should be integrated into monitoring and evaluation plans and into reporting requirements. Reaching men, especially fathers, and also men who may serve as 'champions', such as school teachers and religious leaders, must be part of the HRGE. An HRGE Specialist should be recruited to ensure that this process is institutionalized and mainstreamed. Sufficient funds must be allocated to ensure that this happens.
- ▶ The implementing partners' approach to community outreach focused almost exclusively on verbal communication and written messages placed on the walls of OTP sites. The partners should ensure that messages are delivered 'deeply' into communities, and that the reasons for present ideas and practices on childbirth and infant and child nutrition are thoroughly understood, so that messages on new practices can address those. UNICEF and the implementing partners should use more creative media with a strong emphasis on visual media (especially for non-literate community members and older children) such as puppet shows, street theatre and videos, where possible. FM radio should also be used for developing and conveying nutrition-related and 'healthy child' messages. It would be useful to recruit a Communications and Behaviour Change expert for at least the start-up phase of the World Bank initiative. Again, sufficient funds must be allocated.
- ▶ Access to high quality MNCH services, particularly EMOC services, should be increased. Comprehensive EMOC service is only available at the DHQ hospital in Mithi. Because of long distance and high travel costs, people tend to avoid using these services, often to the detriment of women's and children's health. The Government should provide comprehensive EMOC services at the THQ level.
- ▶ Skilled human resource scarce in contexts like Tharparkar, and it can be difficult to attract skilled staff, particularly women, from outside the area to work in challenging contexts. In such cases,

UNICEF should encourage partners to develop monetary as well as non-monetary incentives (e.g. housing facilities, regular leave and higher salaries) to attract and retain skilled female workers, including medical and para-medical staff.

- ▶ A results-based monitoring framework should be developed, incorporating ultimate, intermediate and immediate outcomes, specific targets and key performance indicators for each activity, including training events, and a target and strategy for HRGE and for links to WASH. It should also include follow up on children, who have been treated, both in BHUs and at the community-level.

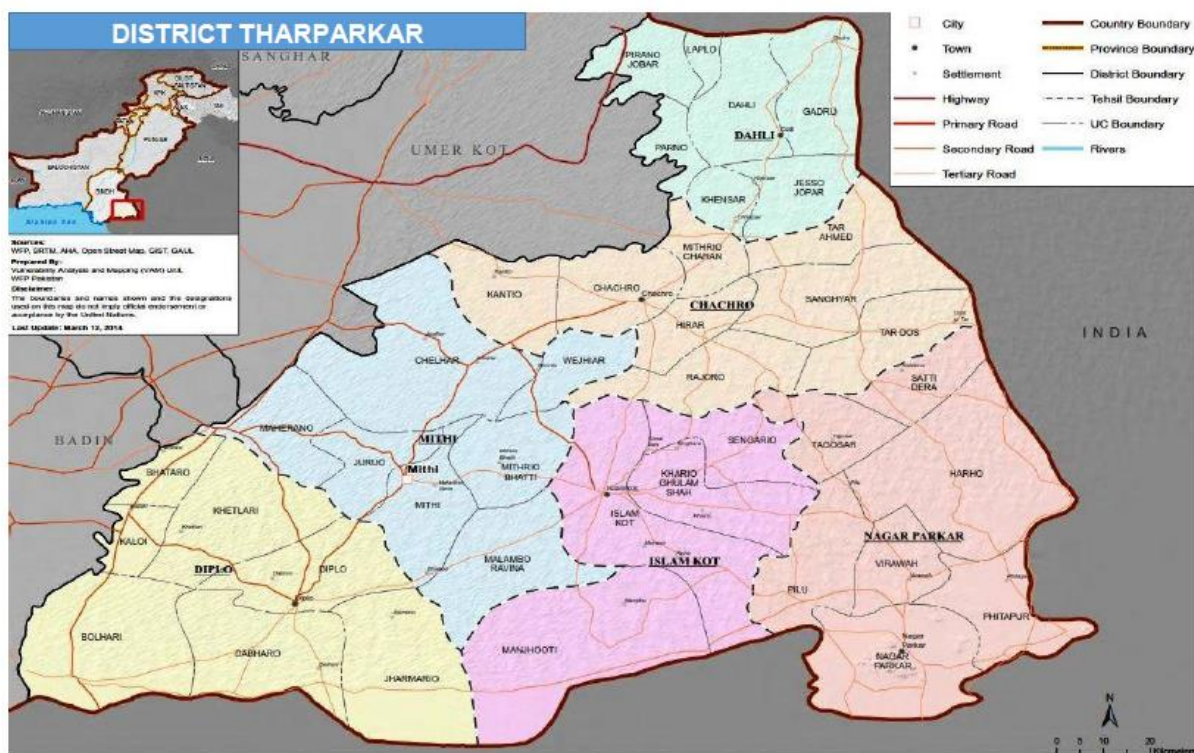
## 1 Introduction

This document presents the evaluation of UNICEF Pakistan's Nutrition Emergency Response in the drought-affected District Tharparkar, of Sindh province in Pakistan. The evaluation was conducted by a team of independent evaluators representing EY. The evaluation covers six projects implemented by UNICEF Pakistan in partnership with two national NGOs, Shifa Foundation and HANDS, from January 2014 to March 31, 2016. The report provides a critical assessment of the Nutrition Emergency Response and presents findings highlighting the extent to which the response was relevant, effective and efficient. It also shows how well coordinated the response was and to what extent longer-term problems were taken into account. The report also presents lessons learnt and recommendations for improving the quality and effectiveness of future actions of this nature.

### 1.1 Background and context

Tharparkar is one of the 29 districts of Sindh province in Pakistan. It covers an area of 19,638 square Km.<sup>6</sup> It is part of the great Thar Desert, which is spread over parts of NW India and SE Pakistan. In Pakistan, the Thar desert includes districts Umerkot, Sanghar, Khairpur and Sukkur. District Tharparkar borders the Indian states of Rajasthan and Gujarat in the East, the Arabian Sea in the South, and Pakistan's Districts Mirpur Khas to the North and Badin to the west.<sup>7</sup>

Figure 1.1: Map of district Tharparkar



<sup>6</sup> Pakistan Bureau of Statistics. <http://www.pbs.gov.pk/sites/default/files/tables/District%20at%20a%20glance%20Tharparkar.pdf>  
<sup>7</sup> [https://en.wikipedia.org/wiki/Thar\\_Desert](https://en.wikipedia.org/wiki/Thar_Desert) accessed on May 10, 2014

Source: *reliefweb.int*

Tharparkar remains one of the most disadvantaged districts in Pakistan in number of ways. Sporadic and scant rainfall, limited ground water resources and transient are the permanent features of Thari livelihoods. Limited rainfall in a particular year often leads to drought. For example, district only received 124mm of rainfall in 2014 as compared to 190mm and 220mm in 2012 and 2013 respectively<sup>8</sup>. Poor roads and communication are systemic challenges. As a result, except for livestock farming, there are limited opportunities for income generation, excluding a few occupations such as handicraft and carpet production that are more beneficial for middlemen than producers. Because there are no viable economic alternatives, people migrate to irrigated areas of nearby districts to work as farm laborers or in brick kilns at very low wages. The majority of men usually look for livelihood opportunities in cities especially Karachi.<sup>9</sup>

Sindh has the highest food insecurity rate in the country (72%). According to National Nutrition Survey 2011, an estimated 17.5% and 49.8 % children were wasted and stunted respectively in Sindh province. This means more than a million children were acutely malnourished. Among the districts of Sindh Tharparkar is one the most affected districts by malnutrition, where GAM rates exceed 20%, which is far above World Health Organization's (WHO) emergency threshold of 15%. According to SMART surveys conducted in district Tharparkar in 2013 and 2014 by UNICEF, 22.7% and 45.9% children are reported as wasted and stunted respectively.

The hardships are further exacerbated by the drought situation in Tharparkar in 2014 taking the situation of malnutrition from bad to worse. The problem of malnutrition was further compounded by poor access to clean drinking water and sanitation and unavailability of staff and medicine at health care facilities. Maternal malnutrition is another compounding factor, which contributes to the high prevalence of low birth weight leading to neonatal and infant infections. In the wake of drought, Provincial Disaster Management Authority (PDMA) reported 305 deaths resulting from malnutrition among children between December 2013 and November 2014. According to the health department, approximately, 70 to 80% of deaths were in the age group 0-6 months.

## 1.2 Object of the evaluation

The United Nations (UN) initiated its response to drought and malnutrition in 2013. Initially, the response was implemented in eight Union Councils (UCs) of Tharparkar in partnership with Merlin. Later on UNICEF engaged HANDS and Provincial Nutrition Cell of DOH, for the implementation. DOH in turn contracted out implementation of the project to People's Primary Health Initiative (PPHI)<sup>10</sup>, a government sponsored NGO established for "contracted out" management of primary healthcare.

Keeping in view prevalence of malnutrition in Tharparkar the UN response was scaled up in 2014 to all 44 UCs of Tharparkar. HANDS continued to work with UNICEF as an implementing partner, but partnership with DOH through which PPHI engaged was ended.<sup>11</sup> PPHI was replaced by Shifa Foundation, an affiliate

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<sup>8</sup> Pakistan meteorological Department, <http://www.pmd.gov.pk>, Accessed January 2016

<sup>9</sup> *Migration and small Towns in Pakistan. IIED Working Paper Series on Rural-Urban Interaction. Working Paper 15. Arif Hasan and Mansoor Raza. 2009. IIED.*

<sup>10</sup> *PPHI was inspired by the success of "contracted out" management of primary health in the Punjab province. It was established in 2005 as the President's Primary Healthcare Initiative. Although the model retained the acronym, in 2008 its name was changed to People's Primary Healthcare Initiative*

<sup>11</sup> *The documents do not spell out the reasons. Individuals interviewed for the evaluation also did not dilate on the reasons. Rather they preferred to sidestep the question.*

of Shifa family, which had successfully implemented emergency nutrition interventions in partnership with UNICEF in other districts of Sindh (Benazirabad, Umerkot and Sanghar).

As per the approved TORs for the evaluation and discussions held with UNICEF team, it was decided that the evaluation would focus on projects implemented by UNICEF in Tharparkar in partnership with Shifa Foundation and HANDS since 2014.

The overall objective of the response UNICEF intended to achieve was “strengthened capacity for reducing risks, as well as planning, preparing, and effectively responding to disasters in accordance with UNICEF Core Commitments to Children in Humanitarian action.”

### 1.2.1 Project’s Theory of Change

The project documents did not have any Theory of Change recorded anywhere. Due to being a short-term emergency project, UNICEF documentation on the project did not have any thing on to elaborate its logical framework and indicators for progress monitoring. However, some elements of a theory of change are present in the associated documents under which this project was developed that somewhat explained the link between the activities undertaken and the expected results of the programme. A summary of overall understanding achieved on Theory of Change through discussions and document review is as follows.

Broadly speaking, there are two approaches to addressing malnutrition: one is a nutrition sensitive approach, which is a long- term and integrated approach that focuses on identifying the underlying causes of malnutrition and addressing them; the second is a nutrition specific approach that is typically used in nutrition emergencies. The second approach is necessitated when Global Acute Malnutrition (GAM) rate reaches 15% or more, which according to WHO Crisis Classification is suggest critical situation<sup>12</sup>.

UNICEF’s emergency nutrition intervention in Tharparkar is an example of second of approach. It addresses malnutrition in the context of an emergency using the Community Based Management of Acute Malnutrition (CMAM) approach. Assessments conducted by UNICEF and other international NGOs identified the GAM rate in Tharparkar in excess of 20 percent. The situation was further complicated by a drought like situation in Tharparkar in 2013 and 2014, which caused the deaths of many children and threatened to kill many more.

As per CMAM guidelines the target groups interventions addressed:

- ▶ Severe Acute and Moderately malnourished children aged 6 month to 5 years and
- ▶ Acutely malnourished pregnant and lactating women (PLW).

The CMAM approach has four components that can help reduce general acute malnutrition in a cost effective way.

The first component of the programme is community outreach for the purposes of detecting cases of Acute Malnutrition, sensitizing community members following up of cases, as and when required. As a first step, children aged 6-59 months are screened to identify those with acute malnutrition . Acutely malnourished children are then sub-divided into Severely Acute Malnourished (SAM) and ) Moderately

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<sup>12</sup> *Acute Nutrition Summary Sheet. Save the Children.* <http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/Acute-Malnutrition-Summary-Sheet.pdf>

Acute Malnourished (MAM). . SAM children are further divided into: SAM without complications and SAM without appetite or complications. Complications include either bilateral pitting edema or Marasmic-Kwashiorkor (MUAC) with any of the following conditions: Anorexia, no appetite for RUTF, vomits everything, hypothermia  $\leq 35.5^{\circ}\text{C}$ , fever  $\geq 38.5^{\circ}\text{C}$ , severe pneumonia, severe dehydration, severe anemia, not alert (very weak, lethargic, unconscious, fits or convulsions), conditions requiring IV infusion or NG tube feeding.<sup>13</sup>

The second programme component is Outpatient Therapeutic Programme (OTP). SAM children without complications are admitted to OTP and receive Ready to Use Therapeutic Food (RUTF) and routine medications. They require regular visits to the health facility or OTP site. It is found by UNICEF that more than 85% of children with SAM without complications can be successfully treated at home with RUTF.

Targeted Supplementary Feeding Programme (TTSFP) is the third component. Children with MAM and pregnant and lactating women with acute malnutrition are given dry take home rations every two weeks or every month (guidelines for CMAM were revised duration was increased from 15 days to one month). TTSFP also includes children discharged from OTP. Moderately acutely malnourished children with complications are admitted to the TTSFP but referred for medical treatment and return when medical complications have been resolved.

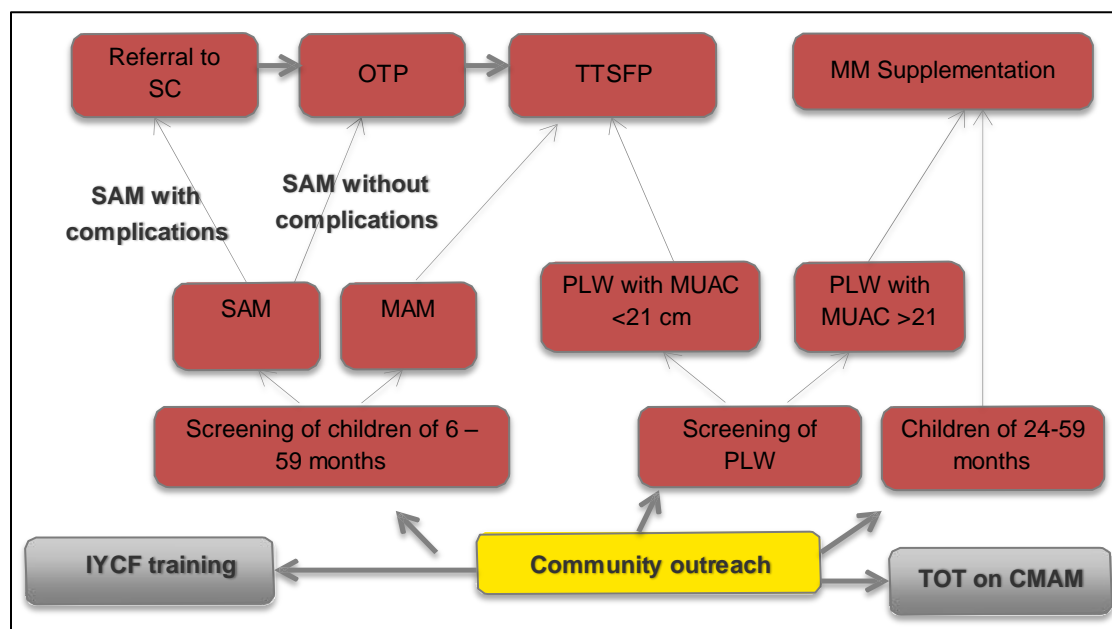
The Fourth component is the Stabilization Center (SC). The purpose of the SC is to provide in-patient care to SAM Children without appetite or / and with medical complications until they are stabilized or their appetite is restored and medical complications they suffer from are restored. SAM children once identified are referred to stabilization centers. These centers are setup by government health department in a tertiary care hospital and run with the technical support of UNICEF and the World Health Organization (WHO). Children are released from the SC when the staff evaluate them as stable (out of danger), after which they return OTP. The role of the implementing partners was to refer SAM with complications to the SC.

The intervention also included 1) training trainers for doctors and nutrition officers of government health facilities and staff of NGOs implementing nutrition projects; 2) training PLWs on IYCF.

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<sup>13</sup> *How to use National Guidelines on CMAM*,  
[http://www.unicef.org/videoaudio/PDFs/national\\_guidelines\\_on\\_CMAM\\_Pakistan.pdf](http://www.unicef.org/videoaudio/PDFs/national_guidelines_on_CMAM_Pakistan.pdf). UNICEF

**Figure 1.2: Schematic Representation of CMAM Model**



### 1.2.2 Results

The nutrition emergency intervention aimed at the following four results:

- R 1: CMAM services remain functional in static and mobile nutrition sites for the management of identified acute malnourished children and PLWs;
- R 2: Healthy nutrition behaviors promoted at facility and community level to prevent malnutrition in early childhood;
- R 3: Micronutrient deficiencies disorders in children and women prevented / treated in the target population
- R 4: Sustainability of CMAM interventions ensured by strengthening local technical capacity for integration of CMAM into primary health Care system

To achieve these results, UNICEF supported HANDS and Shifa Foundation to implement nutrition interventions in Tharparkar. Between January 2014 and March 31, 2016, UNICEF in partnership with HANDS and Shifa Foundation implemented six different projects. The table below shows beginning and end dates and duration of these projects.

**Table 1-1: Projects implemented by Implementing Partners in Tharparkar, 20 September 2014 to 31 March 2016**

Implementing Partner	From	To	Duration
HANDS	20-Sep-2014	4-Apr-2015	6.5 months
HANDS	5-Apr-2015	21-Jul-2015	3 months
HANDS	15-Sep-2015	14-Feb-2016	6 Months

Shifa Foundation	Jan-2015	Jun-15	5 Months
Shifa Foundation	1-Aug-2015	30-Nov-15	4 months
Shifa Foundation	1-Feb-2016	31-March 2016	3 Months

The intervention covered all the 44 UCs of Tharparkar. The table below shows names of *Talukas* (a sub-district administrative unit) and the number of UCs in each *Taluka* covered by each implementing partner.

**Table 1-2: Geographic Coverage of Implementing Partners in District Tharparkar**

HANDS		Shifa Foundation	
Talukas	Number of UCs	Talukas	Number of UCS
Mithi	13	Nagarparkar	7
Diplo	7	Chachro	17
Sub-total	<b>20</b>		<b>24</b>

Table 2.2 shows that HANDs provided emergency nutrition services in 20 UCs of two Talukas, Mithi and Diplo and Shifa Foundation provided services in 24 UCs in Nagarparkar and Chachro. Each implementing partner implemented the three interventions in the same UCs.

### 1.2.3 Services provided by the projects

The services provided by the projects were:

- i. Community outreach activities, including social mobilization to build support and demand for other project activities
- ii. Screening of children of 6-59 months of age
- iii. Targeted supplementary feeding programme (TTSFP) to treat children (6-59 months) with moderate acute malnutrition (MAM), implemented with the support of World Food Programme (WFP)
- iv. Out Patient Therapeutic Programme (OTP) to treat children (6-59 months) with severe acute malnutrition
- v. Referral of acutely malnourished children with medical complications to stabilization center (SC) for in-patient care with support in the form of supplies from UNICEF and technical support from World Health Organization (WHO). After June 2015 the SC was supported by Concern Worldwide with funding from ECHO
- vi. Deworming of children between 24-59 months of age
- vii. Multi-micro-nutrients supplementation for children of 6-23 months of age
- viii. Multi-Micro-nutrients supplementation for PLWs
- ix. Targeted supplementary feeding programme (TTSFP) to treat acutely malnourished pregnant and lactating women (MUAC < 21 cm)
- x. Promotion of Infant and Young Child Feeding (IYCF)
- xi. Formation of mother support groups

A total of forty four OTP/TTSFP sites were established in partnership with the WFP: 44 static sites, one in each UC, and four mobile teams providing services to communities in remote villages who could not access the static OTP/TTSFP sites. .

Stabilization Centers (SCs), a hospital based facility to which SAM children with complications are referred to for in-patient treatment were run with material support of UNICEF and technical support of WHO. Support provided by UNICEF included supplies, anthropometric equipment and lump sum amount of PKR 2,000/child paid to mothers / caretakers of SAM children for food and transportation. After June 2015 SC was supported by Concern Worldwide with funding from ECHO.

#### 1.2.4 Targets

Overall, UNICEF and its implementing partners targeted to reach 60% of the 1.3 million population of Tharparkar, which makes 780,000<sup>14</sup>. The table below presents comparison of targets versus achievements for key indicators (see section 3.3.5 for more detail presentation of coverage). The targets for different indicators represent estimated share of different groups in the target population. Data for achievements are drawn from Nutrition Information System (NIS). Achievements appear to exceed the target largely because of double counting. Part of it could well be the result of over achievement, but this cannot be definitively established because NIS did not track individual cases.

**Table 1-3 Targets Vs Achievement**

Services	Target	Achievements
Screening of children of 6-59 months-- 12% of the target population (780,000)	93,600	294,232
Screening of pregnant and lactating mothers-- 8% of the target population	62,400	97,582
Registration of SAM children-- 6.6% of children of 6-59 months	7207	18,508
MAM Children registered and treated—10.95% of children of 6-59 months	11957	40,407
PLWs are registered and treated in TSFP program	10,920	21,833
Deworming of children	Not defined	28,538
Women reached for promotion of IYCF practices	62,400	109,779

#### 1.2.5 Importance of the Project

The nutrition emergency intervention was important on the following counts:

- ▶ It represented scaling-up of emergency response implemented in 2013 after the drought like situation arose in Tharparkar in 2014.
- ▶ It was seen as a precursor to World-Bank-funded nutrition support programme or, alternatively, a stop-gap arrangement pending the implementing of the World-Bank- supported programme.
- ▶ Since malnutrition was perceived as one of the main reasons for large number of deaths among children in Tharparkar, the projects contributed to addressing these concerns.

<sup>14</sup> According to 1998 Census in Pakistan, population of Tharparkar was 914,291. According to estimates, current population of Tharparkar is 1.3 million. For reference see <http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Tharparkar-Sindh.pdf>

### 1.2.6 Stakeholders

Stakeholders of the project included UNICEF, WFP, WHO, Department of Health, Government of Sindh, PDMA, the implementing partners (HANDS and Shifa Foundation), the District Health Department, District Disaster Management Authority (DDMA), and elected representatives from Tharparkar and communities living in Tharparkar. PPHI was also an important stakeholder with considerable influence because it manages primary healthcare facilities in Sindh under the “contracted out” management arrangement with the government of Sindh (see Annex 3 for stakeholders map).

UNICEF was the prime mover of the nutrition emergency response. It was responsible for designing and implementing the projects under the nutrition emergency response, with the exception of the TSFP component which was implemented by WFP in partnership with two other implementing partners. UNICEF’s specific contribution to the projects included funding, technical support for designing projects, identification of partners, oversight of implementation and monitoring and evaluation.

WFP was primarily responsible for implementation of TSFP. WFP and UNICEF have a global partnership for implementing CMAM programmes. WFP engaged the implementing partners through field level agreements for the implementation of TSFP. WFP provided supplementary food (oil, WSB and RUSF) for treatment of MAM children and PLWs. The role of WHO was to provide technical assistance for running Stabilization Center.

The two implementing partners, Shifa Foundation and HANDS, were responsible for implementation of project activities in the field. They participated with UNICEF in designing the projects, hired project teams, set up project offices and implemented projects activities as per the agreed plan. Provincial and district offices of implementing partners also monitored project activities and reported on the progress of the project.

The Provincial Department of Health (DOH), Sindh has the mandate to approve implementation of health projects in the province. Provincial Nutrition Cell as a sub-agency of DOH is dedicated to oversee implementation of nutrition related interventions in the province. Provincial Nutrition Cell was one agency of the provincial government that UNICEF more closely worked with in relation to nutrition emergency response. UNICEF designed the intervention in consultation with the Provincial Nutrition Cell, which was also involved in monitoring project activities. District Health Department Tharparkar was also an important stakeholder, but the department did not play an active role in implementation of the project: nor did the department actively monitor project activities. Limited resources and capacities and lack of political will were cited as reasons as to why of District Health Department did not actively monitor project activities.

The Nutrition Working Group was another stakeholder: it played a role in coordination of emergency nutrition intervention. It provided technical support to partners and played a role in organizing regular review meetings, updating the 3W matrix, capacity assessment, situation review and gap analysis report and dissemination of quarterly bulletin. The role of the Nutrition Working Group did not come to fore in the interviews with the implementing partners.

Concern Worldwide partially took over responsibility of supporting Stabilization Center from UNICEF from June 2015 onwards, while UNICEF continued to provide supplies and cash support for mothers/care takers. Concern Worldwide provided technical and material support to the SC with the funding from ECHO.

PPHI was the only stakeholder whose influence can be counted as somewhat negative. PPHI manages most of the BHUs and government dispensaries in Tharparkar as part of the “contracted-out management” of primary healthcare services in Sindh. PPHI did not allow the implementing partners to use BHUs under its jurisdiction for setting-up OTP sites, with significant implications for the effectiveness of the projects. Some respondents believed that PPHI did not allow it because UNICEF had not extended

the contract with the Department of Health (DOH) under which PPHI had implemented nutrition activities prior to agreement with Shifa Foundation. UNICEF representatives did not agree with the assessment but did not offer a plausible alternative explanation.

NDMA, PDMA and DDMA represent three-tiers of the government’s institutional infrastructure for disaster management in Pakistan. The three tiers are national, provincial and district levels. . DDMA does not have an independent presence at the district level. Instead, the Deputy Commissioner (DC), who is the administrative head of the district, serves as ex-officio head of DDMA. NDMA, PDMA and DDMA. The Pakistan army played an important role in coordinating emergency response operations in Tharparkar. The DC or head of DDMA also held regular meetings with NGOs to acquire updates on emergency response operations. UNICEF’s implementing partners actively took part in meetings organized by DDMA and provided regular updates on progress. They occasionally responded to requests for support from the DC e.g. for transporting sick children from remote areas to District Headquarter Hospital (DHQ).

As noted, the Pakistan army was another important stakeholder on two important counts: Firstly, Tharparkar being a border district is considered a sensitive area from a security standpoint. Therefore, all the agencies working in Tharparkar, especially those which operate in UCs located near the international border, are required to seek security clearance from the Army. Second, the Army plays a lead role in large-scale relief operations in Pakistan. At the height of the emergency in Tharparkar, the Army together with NDMA, PDMA and DDMA led the coordination of emergency response operations. As the intensity of the emergency decreased, this coordinating role subsided, but the role of providing security clearance remained relevant and intact. Implementing partners were required to share their field plans with the military for security clearance.

### 1.2.7 Budget

Table 2.4 below provides details of the budgets for each of the six projects implemented under nutrition emergency response. It shows that total budget for six projects was PKR 307,008,360 (USD 2,969,420), of which PKR 296,292,926 (USD 2,865,779) was contributed by UNICEF and PKR 10,715, 434 was contributed by implementing partners (USD 103,641).<sup>15</sup> This cost, however, does not reflect UNICEF’s direct spending on the project and indirect spending through Nutrition cell of DOH.

**Table 1-4: Project details with funding allocations, by partner**

Partner	Project Code	Duration (Months)	From	To	Partner's Contributions (PKR)	UNICEF Contributions (PKR)	Total Budget (PKR)
HANDS	PAK 14-004	6.3	10-Feb-14	20-Aug-14	1,386,415	48,810,373	50,196,788
	PAK-14-120	10	20-Sep-14	21-Jul-15	1,934,550	62,817,335	64,751,885
	PAK-15-111	6.5	15-Sep-15	31-Mar-16	1,402,500	59,985,856	61,388,356

<sup>15</sup> Equivalent in USD is calculated based on the conversion rate on November 13, 2016

Partner	Project Code	Duration (Months)	From	To	Partner's Contributions (PKR)	UNICEF Contributions (PKR)	Total Budget (PKR)
Shifa Foundation	PAK-14-149	6.5	10-Dec-14	25-Jun-15	2,083,500	65,414,041	67,497,541
	PAK-15-154	4	1-Aug-15	30-Nov-15	1,836,069	46,330,602	48,166,671
	PAK-16-02	2	1-Feb-16	31-Mar-16	2,072,400	12,934,719	15,007,119
Total					<b>10,715,434</b>	<b>296,292,926</b>	<b>307,008,360</b>

### 1.2.8 Human Resources

UNICEF supported the following positions, with some variations, for the implementation of the six emergency nutrition projects:

- ▶ Project Coordinator
- ▶ Nutrition Assistant
- ▶ Male and Female Community Mobilizers
- ▶ Project MEAL Officer / Monitoring Officer
- ▶ IYCF Counselor
- ▶ Nutrition Assistant / OTP Nurse
- ▶ Distribution Assistant
- ▶ Monitoring and Evaluation Officer
- ▶ Logistic Assistant
- ▶ MIS Assistant

### 1.2.9 Monitoring Mechanisms

A number of monitoring mechanisms were put in place to monitor project activities. These include:

- ▶ Monitoring by Nutrition Officer, UNICEF Sindh
- ▶ Monitoring by representatives of UNICEF Country Office
- ▶ Third party field monitoring
- ▶ Internal monitoring system of partner organizations
- ▶ Monitoring by Provincial Nutrition Cell
- ▶ Monitoring by the Nutrition Working Group.

UNICEF performed monthly monitoring visits. Nutrition Cell and Nutrition Working Group monitored field activities on quarterly basis. Third party monitoring was done on monthly basis. The implementing partners claimed that they also performed monitoring regularly. Monitoring reports produced by UNICEF Sindh and third party monitoring reports were available for analysis. Other monitoring reports, including monitoring reports by Nutrition Cell, Nutrition Working Group and implementing partners were not available for the evaluation.

## 2 Evaluation Framework

### 2.1 Evaluation Purpose

As per the approved Terms of Reference (Annex 1) and discussions with relevant UNICEF staff, the real-time evaluation of the nutrition emergency response was formative and forward-looking to help improve the effectiveness and quality of UNICEF's nutrition response and learn lessons for similar future emergencies in Tharparkar or other districts of Pakistan, where applicable. The evaluation identified lessons and provides UNICEF with actionable recommendations for improving the current response as well as future actions.

In addition, the evaluation examined the benefits, issues and challenges around implementation of the integrated nutrition strategy in Sindh that has been finalized by the Government of Sindh in August 2013, to achieve improvements in access to health care for the affected population, especially for children aged 6 to 59 months and pregnant and lactating women.

The evaluation drew on lessons regarding coordination and working in partnership with national and local authorities and with other UN agencies under the UN Delivering as One program in Pakistan.

At the country level, the evaluation of nutrition emergency response will help UNICEF understand which aspects of its response to the emergency have been working well and those which have not, in relation to established benchmarks and existing guidelines and standards.

The main users of the evaluation intended to be UNICEF's Pakistan Country Office, the Regional Office for South Asia (ROSA) and the Global Emergency Unit. Intended users also include key government agencies: the National Disaster Management Authority (NDMA); the provincial health department of Sindh, the Nutrition Cell of the Sindh Health Department, the Provincial Disaster Management Authority in Sindh and the Sindh Planning and Development Department. The District Health Department and the District Disaster Management Authority could also benefit from key recommendations, as could UNICEF's implementing partners and the potential implementing partners of the health department for future implementation of the integrated nutrition strategy.

### 2.2 Evaluation objectives

- ▶ To assess UNICEF's humanitarian response in Tharparkar using OECD criteria for evaluation of humanitarian action such as relevance, efficiency, effectiveness, coverage, connectedness, coordination and coherence.
- ▶ To assess the extent to which cross-cutting issues such as coordination, management and gender and equity and have been addressed.
- ▶ To identify challenges and lessons for implementation of multi-sectoral nutrition interventions.
- ▶ To draw lessons and recommendations for improving current response and possible future response in Tharparkar and in other districts of Pakistan.

### 2.3 Evaluation Scope

The main focus of the evaluation as per the approved TORs is on assessing UNICEF's emergency nutrition projects implemented in 44 UCs of Tharparkar in partnership with HANDS and Shifa Foundation and in collaboration with WFP and the Department of Health. The evaluation does not cover the initial phase of the emergency in 2103 when UNICEF implemented emergency nutrition projects in a smaller number of UCs in partnership with HANDS and DOH. Although the main focus was on the emergency

nutrition projects implemented in 44 UCs, the evaluation was also expected to assess the extent to which UNICEF was able to address the felt-need within UNICEF of a multi-sectoral response.

## 2.4 Evaluation Criteria

The project has been evaluated against the OECD criteria for evaluation of humanitarian action in complex emergencies. These criteria include appropriateness, effectiveness, efficiency, connectedness, coverage, coherence, and coordination. However, there is a slight variation in content and emphasis between criteria provided in technical TORs for the EHA and OECD-DAC criteria provided in a pilot guide developed by ALNAP for evaluation of humanitarian action<sup>16</sup>. The TOR identified service quality as a criterion to be assessed; this does not appear in ALNAP (probably quality of services can be addressed under effectiveness). The other difference is that the TOR advises EHA to mainly focus on coherence, coverage, coordination and connectedness of relief activities. The criteria for evaluation as described in the pilot guide developed by ALNAP appears to be more appropriate, so was used instead of using standard DAC criteria which do not address coordination, connectedness and coherence. However, instead of addressing coherence, which looks at policy level alignment, coherence is addressed in the relevance section in this report.

Compliance with UNICEF's evaluation standards for equity-focused and gender responsive evaluations has also been ensured.

## 2.5 Evaluation Questions

As advised in the TOR the evaluation questions given in the TOR were further developed by the consultants. The key evaluation questions, listed below, are derived from the evaluation objectives and purpose and are based on the evaluation criteria mentioned above:

- ▶ How relevant and appropriate was UNICEF's emergency response to the needs and concerns of local people across various socio-economic groups and minorities in Tharparkar?
- ▶ How well did humanitarian action reached target population groups?
- ▶ How well have UNICEF's resources, both human and financial, been managed to ensure the most timely, cost-effective and efficient response to emergency in Tharparkar?
- ▶ How successful has UNICEF been in delivering objectives vis-à-vis its programmatic and operational commitments in the Tharparkar emergency response?
- ▶ To what extent did the UNICEF response support longer-term goals and what is the likelihood that eventually such needs will be addressed without UNICEF's intervention?
- ▶ To what extent are the policies and practices of different actors involved in the emergency complementary or contradictory to each other? Do politics foster continuation of the emergency?
- ▶ What are the lessons learnt and recommendations for course corrections in the current programme and enhancing effectiveness of other potential similar emergencies in future?
- ▶ To what extent were crosscutting issues such as gender, equity and the Human Rights Based Approach (HRBA), as well as climate change, incorporated at various levels of planning and implementation of the response?

Evaluation questions and sub-questions, judgment criteria and sources of information and proposed methods are included in the Evaluation Matrix given in Annex 2.

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<sup>16</sup> Evaluation of humanitarian actions: Pilot Guide", ALNAP, 2013  
<http://www.alnap.org/resource/8229>

## **2.6 Evaluation Team**

Evaluation was conducted by a senior evaluation specialist and a nutrition specialist. They were assisted in the field for data collection by six field researchers, including three male and female members.

## **2.7 Evaluation Methodology**

Since the evaluation was formative in nature in consultation with UNICEF it was decided that qualitative methods would yield the best results. To ensure triangulation or cross verification of data from multiple sources, different qualitative data collection methods were used. The data was also augmented by a quantitative observation checklist and a survey questionnaire. The evaluation did not attempt to create counterfactual evidence because it was intended to be a performance, summative evaluation. Moreover, there was no reliable and appropriate baseline available to design a counterfactual design as well.

Methods used for data collections are described below:

### **2.7.1 Data collection methods**

#### **2.7.1.1 Desk review**

Available documents related to design; implementation and ongoing monitoring of emergency nutrition projects were reviewed covering the period from January 2014 to March 31, 2015. Data on coverage from the Nutrition Information System (NIS) was also reviewed and analyzed. Key project documents reviewed included following:

- ▶ Project Cooperation Agreements
- ▶ Third party monitoring reports
- ▶ Selected field trip reports
- ▶ Reports on Training of Trainers (TOT)
- ▶ Survey reports
- ▶ Project progress / completion reports
- ▶ Multiple indicator survey reports
- ▶ Mid-year review report

#### **2.7.1.2 Key informants interviews**

Greater in-depth information about certain aspects can be derived by talking to a few key people who have insight and knowledge about a particular aspect of human activity. Key informants were identified in consultation with the UNICEF nutrition team and representatives of the implementing partners. Key informants were selected using purposive sampling. In all, 73 key informants were interviewed. Of those, 56 were interviewed individually and the remaining 17 in seven group interviews. Key informants comprised 35 individuals representing the UNICEF Country Office, UNICEF Sindh, the WFP, the National Disaster Management Authority, the Planning and Development Department, Government of Sindh, the District Disaster Management Authority, the District Health Department, PPHI, senior management and districts heads of HANDS and Shifa Foundation, and the staff of the stabilization center. The remaining key informants were: 38 field staff posted at OTP sites, including OTP nurses, 18 social mobilizers (7 female and 11 male) and 10 IYCF counselors (see Annex 5 for lists of key informants identified by their position, organizational association and location).

#### **2.7.1.3 Focus Group Discussions**

In order have a closer look at the knowledge, attitudes, practices related to nutrition and to triangulate information collected through key informant interviews and mini survey, FGDs were held with community members. Keeping in view the focus of the interventions, FGDs were held with the following groups:

- ▶ Pregnant and lactating mothers (PLWs)
- ▶ Mother support groups
- ▶ FGD with male community members

PLWs were selected for FGDs because PLWs and their children were direct beneficiaries of the response. Since direct interviews could not be held with targeted children about feeding practices, outpatient therapeutic care, and in-patient care at stabilization center, it was important to interview mothers to learn about knowledge, attitudes and practices related to nutrition and how the intervention helped children.

FGDs with women support groups were important because of the role of these groups promoting key messages and creating an enabling environment at village level.

Although the projects did not directly focus on male community members, they remain key decision-makers at community level as well as at the household level. Community's relations with external agencies are typically mediated through male community members. Since they earn an income for their households, they tend to have a big say in choices regarding nutrition.

One FGD of each type was conducted in each of the 10 sampled UCs, resulting in a total of 30 FGDs. Table below provides distribution of FGDs by partner and geographical location.

**Table 2-1: Number of FGDs by Type of Respondent and Location**

Target Groups	Shifa Foundation		HANDS		Total
	Chachro	Nagarparkar	Mithi	Diplo	
FGDs with Pregnant and Lactating Mothers	3	2	3	2	10
FGDs with mothers support group	3	2	3	2	10
FGDs with male community members	3	2	3	2	10
<b>Total</b>	<b>9</b>	<b>6</b>	<b>9</b>	<b>6</b>	<b>30</b>

#### 2.7.1.4 Observation Visits

Observation checklists were used to assess OTP sites for availability and functionality of equipment and availability of supplies and presence of essential staff. In all 10 OTP sites were visited and observation checklists were filled. Since there was one OTP site in each UC, selection of OTP site was determined by selection of UC (explained in section 3.5 on sampling strategy). The evaluation team had planned to visit four mobile teams as well, but it turned that all the teams work as static-cum mobile teams.

. Observation visit checklists were prepared for:

- ▶ OTP Sites (General)
- ▶ OTP site for SAM
- ▶ OTP site for MAM
- ▶ the Stabilization Center

In all, 10 static OTP sites (out of 44 OTP sites established by partners) and the stabilization center were assessed to check completeness and functionality of equipment, availability and regularity of supplies, and availability and quality of staff.

### **2.7.1.5 Mini Surveys**

Since a large representative survey was beyond the scope of evaluation, to complement and triangulate data collected using FGDs, key informant interviews and observation checklists, a mini-survey was conducted to assess the knowledge and practices of mothers and caretakers regarding use of RUTF, RUSF, IYCF and hygiene practices. The mini-survey involved interviewing mothers/care takers using a set of standardized open-ended questions, most of which required short answers.

Keeping in view time constraints and resource limitations, a sample of 60 was agreed with UNICEF. The findings of the survey are illustrative, rather than statistically generalizable.

From each of the 10 target villages, six respondents were selected for the mini-survey. They were selected using a mix of random and convenience sampling. Respondents were selected from women accessible at the time of the field visit for the evaluation. In cases where women gathered at one place, every second or third woman (depending on the number of women gathered) was chosen for the interview.

### **2.7.1.6 Sampling strategy**

At the first stage a sample of 10 UCs was selected for field investigations. The sample included five UCs for each partner, and two to three UCs from each of the four *Talukas*. Key considerations for selection of sample were distance from *Taluka* headquarter and security clearance. UCs with no security clearance were excluded from the list. The list was divided into three categories: UCs close to *Taluka* headquarter *Taluka*, one moderately remote and one remote UC. Then from each category UCs were randomly selected for field investigations. At the second stage, specific villages were selected, using a mix of random and convenience sampling in consultation with the partners.

### **2.7.1.7 Analytical approaches**

Formal analysis was carried out at the end of the data collection process. Responses to different questions were entered in an Excel sheet under each question by the field researchers. Next, answers to each question were reviewed carefully and coded. Answers to each question given by different respondents were read to identify variations among responses. Interviews transcripts were also read as whole to ensure that context of specific answers was retained.

Similar themes were grouped together and assigned to categories. Categories in this case were determined by research questions for the evaluation. Overarching categories for organizing the findings were provided by OECD Criteria for the evaluation of complex emergencies i.e. appropriateness, effectiveness, efficiency, connectedness, coverage, coherence, and coordination.

Findings were used to draw a set of conclusions. Based on the conclusions a set of recommendations were drawn and presented in the report. Some early findings and recommendations were shared with implementing partners and UNICEF country office staff. An early draft of the report was also shared with UNICEF Country office for comments and feedback. Their feedback is incorporated in this report. Some recommendations which surfaced during preliminary analysis in field were also shared with other stakeholders for verification e.g. implementing partners appreciated the recommendation to use *Otaq* for more effectively engaging with male community members. Similarly, staff of Nutrition Cell verified the need to develop standardized messages for IYCF. The recommendations were further refined in the light of discussions held with UNICEF country office staff.

Throughout the process, gender and equity were used as the crosscutting themes. Data collected from available reports were gender-disaggregated to assess whether specific needs of men and women were appropriately addressed.

## 2.8 Ethical considerations

The evaluation followed the UNEG Norms and Standards<sup>17</sup> as well as the UNEG Ethical Guidelines for Evaluation<sup>18</sup>. The evaluation process strictly adhered to *UNICEF Procedure for Ethical Standards in Research, Evaluations and data Collection and Analysis*<sup>19</sup>. Children were not interviewed for this evaluation. More specifically, the consultants followed the following ethical guidelines.

- ▶ Before seeking information from the participants of the evaluation, the consultants informed them about the purpose of the evaluation and sought their consent for participation.
- ▶ The consultant respected the right of institutions and individuals to provide information in confidence and safeguard that sensitive data cannot be traced to its sources. In order to do so the consultant removed any identifying information shared by the respondents.
- ▶ During the evaluation the consultants were sensitive to beliefs, manners and customs of social cultural environments in which the consultant were expected to function for the purpose of the evaluation.
- ▶ The consultants were sensitive to the issues of discrimination and gender inequality. The Consultant has identified one such issue and highlighted it in this report.
- ▶ It was understood that that evaluation was not supposed to evaluate the personal performance of individuals involved in the project.
- ▶ To minimize the risk of missed livelihood opportunities for beneficiaries, consultants did not conduct unnecessarily long interviews.

To ensure that all the community members had an equal chance of participating in the evaluation, the villages were selected using random sampling. However, villages located close to the border were excluded because of security restrictions. Male community members who were at work at time of fieldwork for evaluation could not participate in the evaluation.

Cost of to community members for participation in the evaluation was time they spared to participate in the interviews. Benefits included the opportunity to participate in the assessment of relevance and performance of the intervention and to recommend improvements. Community members actively participated in the meetings and eagerly shared their views about the response. They appreciated the opportunity of sharing their views about the project. Their eagerness to share their views and their appreciation of opportunity suggested that they willingly spared their time to participate in the evaluation. This appears to suggest on balance, the benefits outweighed the costs.

## 2.9 Limitations

- ▶ Security restrictions prevented the consultants and the team of field researchers from visiting UCs and villages closer to the border. As a result, it was not possible to document performance of the project in areas with security restrictions. It was not possible to interview project beneficiaries in these areas, but project implementers were interviewed about performance of the project in areas with security restrictions.
- ▶ Ensuring meetings with NDMA and PDMA was challenging due to their busy schedules. Finally, in May 2016 meeting was held with NDMA, but meeting with PDMA could not be held. Since NDMA was

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<sup>17</sup> UNEG. *Norms for Evaluation in the UN System*. April 2005

<sup>18</sup> UNEG. *Ethical Guidelines for Evaluations*. March 2008

<sup>19</sup> *UNICEF Procedure for Ethical Standards in Research, Evaluations and data Collection and Analysis*, April 2015

directly engaged in field operations along PDMA, PDMA representatives were able to provide necessary information about the role played by NDMA and PDMA in organizing government's response to drought like situation in Tharparkar in 2014.

- ▶ The project is poorly documented. Although, it was mentioned that monitoring visits were conducted by UNICEF Country Office, UNICEF programme office in Sindh, implementing partners, Provincial Nutrition Cell and Nutrition Cluster. However, no reports were available from these visits except for the monitoring reports by UNICEF. Moreover, the quality of monitoring reports developed by UNICEF Sindh was low. It took a long time to obtain documents from implementing partners, making data analysis challenging. The information gaps in secondary data were partly bridged by interviewing a large number of key informants.
- ▶ Third party monitoring reports had a very narrow focus on availability of equipment, supplies and availability of staff at OTP sites. They do not delve into investigation of causes and consequences. If reports had a broader focus and had delved into causes and consequence, the evaluation could more beneficially draw findings of third party monitoring reports. This limitation was partly addressed by gathering a large volume of primary data through FGDs, key informant interviews and small group interviews.

## 3 Major Findings

### 3.1 Relevance

#### 3.1.1 Relevance to the community needs

Nutrition emergency response was a relevant intervention in the context of drought-like situation in Tharparkar and high number of child deaths. According to data collected by DOH, between January to December 2014, 543 children died in Tharparkar, including 326 children under the age of 5 and 217 children above 5 years of age<sup>20</sup>. A Rapid needs assessment carried out by HANDS with the technical assistance of United Nations Office for Coordination of Humanitarian (UNOCHA) in March 2014 found nutrition of vulnerable segments of the population, such as children and PLWs was affected by the drought<sup>21</sup>. For example, survey found that percentage of women exclusively breastfeeding had decreased from 39% before drought to 28% after drought. The survey recommended a nutrition intervention<sup>22</sup>.

There was considerable agreement among a range of stakeholders interviewed for the evaluation that the nutrition intervention on its own was not sufficient to respond to emergency in Tharparkar. According to the respondents, including UNICEF nutrition team, despite media hype, which identified malnutrition as the main cause for child deaths, the real cause of high number of child deaths was not malnutrition. This is borne out by child mortality data collected by DOH. It shows that 9 (3%) out of 326 children under five had died as a result of malnutrition. Main reasons for child deaths were pre-term/low birth weight (26%), Birth Asphyxia (18%), Severe Pneumonia (16%), neonatal sepsis (13%) and sepsis (6%).

There was also agreement among various stakeholders that poor access to MNCH services, particularly EMONC, was the most important reason for child deaths. NDMA officials, who carried out a survey immediately after the drought-like situation arose, came to the same conclusion, as did officials of the District Health Department in Tharparkar.

It would be fair to say that although nutrition was relevant in the context of drought, it was not sufficient on its own to address the issue of high number of child deaths. So where does the relevance for the intervention come from? There were three sources of relevance: 1) Nutrition intervention addressed the perception promoted by the media that underlying cause of death was malnutrition; 2) Tharparkar was among districts with very high Global Acute Malnutrition (GAM), that exceeded 20%<sup>23</sup>; 3) even before the drought hit Tharparkar. UNICEF with the advice of the Provincial Nutrition Cell was planning to implement an emergency nutrition project as a precursor or as a stop-gap arrangement before the implementation of the World Bank supported nutrition support programme. In other words, the emergency nutrition intervention would have been implemented anyway.

The intervention may not have addressed the direct causes of child deaths, but a nutrition specific intervention to address nutrition needs was highly relevant to the context of Sindh province which lags behind the rest of Pakistan in terms of nutrition related outcomes. According to the National Nutrition Survey conducted in 2011, Sindh province had the highest rate of child under-nutrition (40%), maternal malnutrition (62%) and child anemia (73%) and food insecurity (72%). The survey results also showed that Sindh lagged

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<sup>20</sup> Mortality report developed by DOH

<sup>21</sup> First Situational Analysis Report, District Tharparkar, March 2014, HANDS

<sup>22</sup> *ibid*

<sup>23</sup> Project documents

behind national average regarding all aspects of child nutrition (i.e. underweight, stunting and wasting), and child and maternal micronutrient deficiencies (vitamin A deficiency, anemia, and zinc deficiency).<sup>24</sup>

Tharparkar, according to the National Nutrition Survey, was among the more severely affected districts of Sindh province. In terms of wasting differentials, it was among the most severely affected districts of Sindh with wasting rates in the range of 26.09% to 42.01%.<sup>25</sup> In terms of stunting and underweight, Tharparkar was better off than some of other districts, but it still had high stunting and underweight rates with highly unenviable rates of 50.96% to 54.95% for stunting and 35.51% to 44.17% for underweight. The SMART surveys conducted by UNICEF in district Tharparkar in 2013 and 2014 also showed that 22.7% of children were wasted and 45.9% children were stunted.

Even if malnutrition were a direct cause of deaths, keeping in view UNICEF's own understanding of the causes of malnutrition<sup>26</sup>, a multi-sectoral response would be more relevant than the approach followed in the response. The review of documents and discussions with UNICEF staff showed that a multi-sectoral response was not discussed or considered as an option. The immediate reaction of UNICEF was to launch a nutrition project, even though in 2013 UNICEF had implemented a WASH project in Tharparkar and UNICEF was aware of huge WASH related needs. Perhaps this was because UNICEF was mindful of potential duplications in WASH and health and consciously focused on nutrition as one of the pieces in a complex puzzle. Neither the review of documents nor discussions with UNICEF staff showed that the decision to focus on nutrition was strategic. In fact, UNICEF staff cited two different reasons for why a multi-sector response was not considered. According to a senior UNICEF staff member, four types of considerations prevented a multi-sectoral approach:

- i. Humanitarian considerations (need to respond to emergency immediately)
- ii. Administrative challenges (coordination for multi-sectoral programmes consume a lot of time and is administratively challenging)
- iii. Time constraints (response time was short).
- iv. Financial constraints (one can do so much within a given budget).

Another perspective shared by a group of UNICEF staff members was that the multi-sectoral approach is a new "mantra" in UNICEF: that is, it is too recent to have been integrated into planning. According to them, until recently various departments within UNICEF were working in department-specific silos. Therefore, they said, it was not surprising that a multi-sectoral response was not considered or adopted. As an example, they mentioned that when the nutrition intervention was being designed, the WASH team in Sindh province was not consulted at all.

### 3.1.2 Alignment to Project Goal and Objectives

The overall objective of the intervention, as stated in various PCAs signed by UNICEF with its partners, was "by 2017 public and civil society duty bearers with strengthened capacity are reducing disaster risks as well as planning, preparing and effectively responding to disasters in accordance with UNICEF'S core

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<sup>24</sup> National Nutrition Survey cited in Sindh Province Report: Nutrition Political Economy, Pakistan. Shela Zaidi et al. 2013. The Aga Khan University and Institute for Development Studies.

<https://www.aku.edu/mcpk/Documents/Political%20Economy%20UnderNutrition%20Sindh%20Report.pdf>

<sup>25</sup> *ibid*

<sup>26</sup> UNICEF's Framework for Understanding Malnutrition

*commitments to children in Humanitarian action.*” The overall objective of the intervention was reproduction of intermediate Result 4 (IR4) of UNICEF’s Programme Framework<sup>27</sup>.

While the overall objective is framed in terms of capacity strengthening, the first three outcomes of the nutrition emergency response (i.e. provision of CMAM services, promotion of healthy nutrition behaviours, prevention and treatment of micronutrient deficiencies) are expressed in terms of increasing access to quality nutrition services for children and women. If viewed in isolation, these outcomes are not quite consistent with the overall objective. The fourth outcome (increasing local technical capacities for integration of CMAM into the primary healthcare system) is, however, directly aligned with overall objective of the intervention or IR4.

Upon closer scrutiny this lack of alignment appears to be the result of an internal inconsistency in UNICEF’s programme of work. Although three out of four outcomes of the emergency nutrition intervention are aligned with IR2<sup>28</sup> (except that it only mentions public duty bearers and makes no reference to civil society duty bearers), there are no activities identified under IR2 to match project outcomes. Although IR4 is framed in terms of strengthening capacities, activity 1.4 (respond to health and ongoing and current emergencies based on CCC and guided ERPs) in UNICEF’s programme framework is what the intervention directly addressed.

### 3.1.3 Alignment with Policies and Priorities of Government, UN and UNICEF

The nutrition emergency response is in line with Common Country Programme of Action of Government of the Islamic Republic of Pakistan, UNDP, UNFPA and UNICEF 2013-2017. The project directly addressed strategic priority area 6 (SPA 6) of the Common Country Programme, which is related to food nutrition security for the most vulnerable groups. Under SPA 6, among other things, UNICEF has committed to “strengthen capacity to design, manage and implement nutrition-specific interventions, including maternal nutrition, infant and young child feeding promotion and micronutrient interventions for prevention of malnutrition” and “facilitate mainstreaming of awareness, referral, screening and treatment of malnutrition into public health programmes, including through the Community Management of Acute Malnutrition (CMAM) approach<sup>29</sup>. The emergency nutrition response under review included nutrition-specific interventions for maternal and child nutrition, infant and young child feeding promotion and micronutrient interventions. The nutrition emergency response, together with similar interventions in other parts of Sindh, has also paved the way for mainstreaming nutrition into public health programmes, as will be noted in section 4.3 on effectiveness. It is also aligned with Humanitarian Strategic Plan which plans to target most pressing needs of 3.6 million people, including 0.3 million children and women who are malnourished and disaster affected<sup>30</sup>.

The intervention is also aligned with SPA 1 and SPA 2 of Common Country Programme and with UNICEF’s Programme of Cooperation Work Plan for nutrition signed by UNICEF and the Government of Sindh on March 12, 2013. UNICEF’s Programme of Cooperation Work Plan specifically identifies SPA 1,

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<sup>27</sup> UNICEF’s Programme Framework

<sup>28</sup> IR2 is “by 2017, public duty bearers with strengthened capacity are delivering quality integrated health and nutrition services in communities and facilities reached by the most disadvantaged mothers and children.”

<sup>29</sup> Common Country Programme Action Plan of Government of Islamic Republic of Pakistan and UNDP, UNFPA and UNICEF 2013-2017

<sup>30</sup> Pakistan Humanitarian Response Plan Overview.

[http://reliefweb.int/sites/reliefweb.int/files/resources/201603\\_snapshot\\_2016\\_hsp\\_overview.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/201603_snapshot_2016_hsp_overview.pdf)

SPA 2 and SPA 6 as being the relevant strategic priorities identified in the CCP for nutrition related interventions.

UNICEF's emergency nutrition intervention also addressed one of the outcomes UNICEF intends to achieve during the period 2014-2017 i.e. "Improved and equitable use of nutritional support and improved nutrition and care practices."<sup>31</sup> The emergency nutrition intervention addressed four of the five results areas, including infant and young child nutrition, micronutrients, CMAM and nutrition in humanitarian situations.

The intervention was aligned with the priorities of the Sindh Government's Health Strategy for 2012-20, which identified nutrition as one of the special areas of emphasis along with Polio Plus, MNCH, Family Planning, NCDs, Communicable Diseases and Disasters. The intervention also speaks to the Health Strategy's focus on strengthening district health systems, particularly in the most under-developed districts of Sindh. <sup>32</sup>In addition, it was aligned with the Nutrition Policy guidance note and the Sindh integrated nutrition strategy.

#### 3.1.4 Relevance to Implementing Partners

Intervention was also relevant to partners' experience. Shifa Foundation began implementing nutrition related projects since 2011 with a programme in Nawabshah in partnership with UNICEF. Shifa Foundation also implemented projects in Umarkot and Sanghar in partnership with UNICEF as well as independently. Nutrition remains one of the strategic priorities for Shifa for the next five years, other being poverty, WASH, education, livelihood and health.

HANDS is one the largest NGOs in Pakistan with its roots in Sindh. HANDS has been partnering with UNICEF for nutrition interventions for the past three years. Although its partnership with UNICEF goes back to 2008, their interest in nutrition stems from their longstanding interest in health sector. They have been part of the RAPID assessment survey conducted with the technical assistance of UNOCHA following the drought situation in Sindh in 2014.

#### 3.1.5 Concerns for HRGE

The intervention broadly addresses the Universal Declaration of Human Rights (UDHR) <sup>33</sup>, and the Principles of The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)<sup>34</sup>. The intervention speaks to the CEDAW principle of non-discrimination by recognizing health needs specific to PLWs and by providing services, such as provision of micronutrients and awareness raising sessions on nutrition, health and hygiene. The intervention also addressed "the right to life, and to live in freedom and safety" as the services provided by the project reduced the risk of maternal and child morbidity and mortality.

In addition to broad alignment with CEDAW principles and UNDHR, the PCAs commit partners to consider gender and equity in all planned activities. The partners committed to achieve at least the 2A marker on IASC Gender Marker<sup>35</sup>. As well, there was a specific indicator used in project Log Frames

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<sup>31</sup> UNICEF Strategic Plan, 2014-2017

<sup>32</sup> *ibid*

<sup>33</sup> <http://www.un.org/en/universal-declaration-human-rights/>

<sup>34</sup> <http://www.unwomen-eseasia.org/projects/Cedaw/principlescedaw.html>

<sup>35</sup> The project are rated 2A on IASC Gender Marker if "the project is designed to contribute significantly to gender equality. The different needs of women/girls and men/boys have been analyzed and integrated well in all three essential components: the needs assessment activities and outcomes." See [http://floods2010.pakresponse.info/gender/Guidance\\_Note\\_for\\_Clusters\\_to\\_implement\\_the\\_IASC\\_Gender\\_Marker.pdf](http://floods2010.pakresponse.info/gender/Guidance_Note_for_Clusters_to_implement_the_IASC_Gender_Marker.pdf)

included in the PCAs that required project implementers to hire at least 40% women. However, the project was not informed by any tailor-made HRGE analysis. As a result, HRGE matters were not clearly reflected in intervention design (log frame, indicators, activities, M&E systems, reporting mechanisms). The intervention design also did not benefit from an inclusive stakeholders analysis and analysis of context to assess whether it was conducive to HRGE.

### 3.2 Efficiency

The table below shows cost per beneficiary for different projects based on SAM admissions. It shows that cost per beneficiary for different projects ranged from USD 131.91 per beneficiary to USD 255.41 per beneficiary (see table below). The highest cost per beneficiary for a single project was for a project implemented by HANDS (PAK-15-111), with USD 255.14 per beneficiary. The lowest cost per beneficiary for a single project was for a project implemented by Shifa Foundation (PAK-14-149) with USD 131.80 per beneficiary.

Based on this analysis cost per beneficiary appears to be relatively high compared to average cost per beneficiary of USD145 assessed by an evaluation of 45 CMAM projects implemented by UNICEF in KP province in Pakistan<sup>36</sup>. The average cost per beneficiary for the 45 CMAM projects ranged between USD 123 and USD 275. The range is not dissimilar to the cost per beneficiary range for the projects implemented in Tharparkar. However, the highest cost per beneficiary for the projects implemented in Tharparkar was somewhat lower than the highest cost per beneficiary for one the 45 projects implemented in KP.<sup>37</sup>

**Table 3-1: Comparison of cost per beneficiary for different projects, by implementing partner**

Partner	Project Code	SAM Admissions	Total Budget (PKR)	Cost per Beneficiary (PKR)	Cost per Beneficiary (USD)*
HANDS	PAK 14-004	3,118	50,196,788	16,099	152.55
	PAK-14-120	3,323	64,751,885	19,486	184.65
	PAK-15-111	2,280	61,388,356	26,925	255.14
Shifa	PAK-14-149	3,571	67,497,541	18,902	179.11
	PAK-15-154	2,442	48,166,671	19,724	186.91
	PAK-16-02	1,079	15,007,119	13,908	131.80

<sup>36</sup> Evaluation of Community Management of Acute Malnutrition (CMAM): Pakistan Country Case Study. P. 52.

[http://www.unicef.org/evaluation/files/Pakistan\\_CMAM\\_final\\_report\\_11oct2012.pdf](http://www.unicef.org/evaluation/files/Pakistan_CMAM_final_report_11oct2012.pdf)

<sup>37</sup> *ibid*

Total	15,813	307,008,360	19,415	183.98
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\* The current PKR to USD conversion rate has been taken i.e. 1 USD = 105.532

According to the implementing partners, during the projects implemented in 2014 and earlier parts of 2015, their efficiency was compromised because of the limited number of vehicles. One vehicle was provided to cover two UCs. Therefore, the OTP teams in each UC could only provide mobile services on alternate days. For projects implemented in the later part of 2015 and early part of 2016, the number of vehicles was increased and one vehicle per OTP site was given, allowing OTP teams to visits villages on a daily basis.

The biggest source of inefficiency was the short duration of the projects, which were implemented in short spurts. There was a one-month break between the first and second projects and a two-month break between the second and third projects implemented by HANDS. Similarly, there was a one-month break between the first and second projects and a two month break between the second and third projects implemented by Shifa Foundation. Implementing projects in short spurts tends to increase costs, because fresh hiring and relocation of existing employees consumes a lot of time and money. It is understood that funding constraints prevented UNICEF from supporting longer-term projects, but this had consequences for efficiency.

Implementing projects in short spurts with uncertainty surrounding start of new projects had many negative implications. Delay in approval of the projects caused a number of children under treatment to relapse, requiring a fresh cycle of treatment. According to a UNICEF representatives, delay in signing of PCAs was caused by delays in approval from the Provincial Nutrition Cell owing to uncertainties regarding implementation of PC1. Even though children were provided stock of RUFT as part of the exit plan, the delays caused children to default, requiring fresh enrolment. More than being inefficient, it compromised the recovery of children from malnutrition. The short duration of the projects and uncertainty surrounding continuation also compromises partners' relationship with the target communities. It can potentially reduce levels of trust and confidence. It also affects motivation of project staff, as they remain unsure about continuation of their employment with the partner.

In the case of HANDs, not being able to hire enough female community mobilizers affected efficiency because female IYCF Counsellors were overburdened with dual responsibilities: their own responsibilities as well as responsibilities of those of female social mobilizers. On the other hand, the time of male social mobilizers was somewhat underutilized.

The partners leveraged their resources in two different ways to achieve more with existing resources. Shifa transported over 700 children needing urgent treatment to DHQ hospital in Mithi. They also encouraged Polio extension workers to travel with them in their vehicles to provide EPI services in the remote areas, something they might not otherwise be able to do because of lack of transportation.

PPHI's refusal to allow the partners to establish OTP sites in BHUs also compromised efficiency as partners had to identify alternate locations. It was also inefficient for community members as it reduced their ability to benefit from referral services and obtain medicines.

During the most recent project implemented by HANDs (PAK-15-111), one and half months was wasted in the bidding process for car rental. Until the bidding process was completed, there were only two cars for project activities, which clearly reduced the project's efficiency and effectiveness

### 3.3 Effectiveness

UNICEF has been successful in delivering its objectives vis-à-vis its programmatic and operational commitments in Tharparkar emergency response, although with two important caveats:

- ▶ Viewed in Isolation, the nutrition emergency intervention was effective. However, it was less than what UNICEF could have done to respond to the emergency in Tharparkar e.g. in addition to addressing nutrition-specific needs, UNICEF could have contributed to addressing health and WASH needs.
- ▶ The emergency nutrition intervention was implemented in short spurts with unnecessary gaps in between different projects which compromised the effectiveness of the programme.

Aside from these caveats, which point to larger gaps in UNICEF's response, the assessment of effectiveness involves assessment of the emergency nutrition intervention implemented by UNICEF with its partners. The assessment of the effectiveness of each component of the nutrition emergency response with associated outcomes is given below:

### 3.3.1 CMAM Services at Static and Mobile Sites

#### Outcome 1: CMAM services remains functional in static and mobile nutrition sites for the management of identified acutely malnourished children and PLWs

Both implementing partners of UNICEF, Shifa Foundation and HANDS, successfully set up static OTP sites in each of the 44 target UCs to provide nutrition services to the target population. As stipulated in the PCAs, Shifa Foundation setup 24 static sites and HANDS setup of 20 static sites. Static sites were established, where possible, in government health facilities, such as District Head Quarter hospital (DHQs), Tehsil Head Quarter hospitals (THQs), Government dispensaries and Basic Health Units (BHUs). Where it was not possible to use government health facilities, static sites were established in spaces provided by the community. In areas where BHUs and government dispensaries were run by PPHI under the contracted-out management of primary health services, the partners were not allowed to setup static OTP sites<sup>38</sup>.

As per the agreement with UNICEF, the partners were expected to constitute two mobile teams each to cover target populations in remote villages. In practice, keeping in view the context of Tharparkar, in addition to two mobile teams, the partners also used all the teams deployed in the static OTP sites as static-cum-mobile teams, with the exception of teams deployed at static sites in DHQ and THQ Hospitals. The static-cum-mobile teams worked at static sites till 12.00 p.m. After that they went on an agreed schedule to different villages to provide mobile services in their defined catchment areas. Closing static sites housed in BHUs and government dispensaries was also necessitated because they closed at 12.00 pm, while DHQ and THQ hospitals remain open throughout the day. In short, with the exception of teams deployed in DHQ and THQ hospitals, all the teams deployed in static sites functioned as static-cum mobile teams.

During the field investigation for the evaluation, the evaluation team visited 10 static sites, five belonging to Shifa and five to HANDs, and found all of them functional. Those were open and OTP staff were examining and treating patients. However, it was observed that OTP sites closer to the district centre were better equipped and organized than the ones located farther from the centre. Results of observation check-lists at ten OTP sites showed that following facilities were available in all OTP sites:

- ▶ separate shelter for weighing and consultation,
- ▶ breastfeeding corner,

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<sup>38</sup> PPHI run 31 BHUs and 18 government dispensaries in Tharparkar under contracted out management of primary health services in Sindh Province.

- ▶ sheltered waiting area,
- ▶ adequate number of staff,
- ▶ IEC material,
- ▶ necessary formats,
- ▶ enough supplies of RUFT and RUSF.

The biggest gap, however, was waste collection. Five out of ten sites did not have appropriate waste collection arrangement for medical and non-medical waste. The other major gap observed was non-availability of washing area for mothers in four OTP sites, and non-availability of a washing area for staff at three sites. Safe drinking water was not available at two sites.

Interviews conducted with OTP nurses revealed that they were well aware about their responsibilities. They were knowledgeable about the enrolment and exit criteria for OTP and TSFP and referral to stabilization centre, appetite test, and composition and use of RUFT.

Interviews with IYCF counsellors also showed that 8 out of 10 were quite knowledgeable about exclusive breastfeeding, complementary feeding, and early initiation of breastfeeding and attachment positions. IYCF counsellor said they visited each of the target villages every 15 days and visited two to three villages per day (this was verified by community members). IYCF counsellors working with HANDS had double roles. Since HANDS was not able to hire female social mobilizers, IYCF counsellor also handled responsibilities typically associated with female social mobilizer, such as organizing meetings with women and screening girls and women.

A major limitation observed was the disconnect between OTP/TSFP sites and the BHUs and government dispensaries run by PPHI. According to the Shifa and HANDS teams, despite several attempts by the Nutrition Cell at the provincial level, they were not able reach an agreement with PPHI to use BHUs and government dispensaries under their jurisdiction to set up OTP/TSFP sites. Even though most respondents preferred not to comment on the subject, sensitivities may have stemmed from the fact that in 2014 UNICEF had ended a contract with the Department of Health under which PPHI was implementing the nutrition emergency response in Tharparkar with UNICEF's support. During this evaluation, the UNICEF team did not agree with the assessment that non-cooperation on the part of PPHI might have been the result of UNICEF's decision to end the contract with DOH, which effectively excluded PPHI as an implementer of nutrition response. According UNICEF staff they did not extend the contract because of they did not have funds available.

Even in BHUs where the project was able to set up OTP sites (those which were not run by PPHI), BHU staff were found to be non-cooperative. One reason cited by some of the field staff for this lack of cooperation was the sudden surge in demand for services at the BHUs caused by the demand for OTP and TSFP services. Although no numbers were available to support such an assertion, it does seem to make intuitive sense that OTP/TSFP sites, if established within BHUs, could lead to a surge in demand for ANC immunization and MNCH services: more women would visit BHUs to benefit from OTP and TSFP services, and particularly to receive food support given to PLWs. Since referrals would be easy, more people would be referred to BHUs and most of those referred would tend to benefit from the services.

The effectiveness of the nutrition emergency response was somewhat compromised because the implementing partners were not allowed by PPHI to set-up OTP sites within BHUs and the government dispensaries under its control. This meant it was time consuming for community members to access the BHUs and dispensaries in case where women and children were referred to BHUs for medical examination or for medicines not available at the OTP sites. As a result, not all women referred to BHUs

were able to benefit from referrals. Referral was also challenging because a number of dispensaries set up on political grounds (without necessary budgetary allocations) were non-functional.

Implementing partners were able to deploy adequate number of staff for static and mobile OTP/TSFP sites. The staff hired for OTP/TSFP sites included OTP nurses, two social mobilizers and female IYCF counsellor. However, partners, particularly HANDS was not able to hire sufficient number of female community mobilizers. Staffing patterns observed at sampled sites and interviews with partner staff showed that HANDS, instead of hiring one male and one female social mobilizer, only hired a male community mobilizer. According to HANDS' representatives, hiring women to work in Tharparkar, even from outside the district, was challenging. Shifa, on the other hand, was notably successful in hiring a significant number of female community mobilizers. Besides, the fact that both Shifa and HANDS were able to hire female IYCF Counsellors and that Shifa was also able to hire female community mobilizers and even women OTP nurses shows that this challenge was not insurmountable.

Not being able to hire or not hiring female community mobilizers had important implications related to HRGE. One implication was overburdened female IYCF counsellors. In the absence of female community mobilizers, female IYCF counsellors had to play both roles: 1) the role of IYCF counsellor for which they were hired and 2) to bridge the gap left by absence of female community mobilizers. Male community mobilizers were considerably underutilized because most of the project activities focused on women, While male community mobilizer was mainly responsible for mobilizing male community members and screening boys, female community mobilizers, mobilized female community members, screened girls and PLWs, organized mother support groups and conducted sessions on IYCF.

The majority of the mothers whose children were admitted to OTP learned about their children being *kamzoor* (malnourished) when the partners' team screened them (i.e. did MUAC), highlighting a serious lack of knowledge regarding malnutrition on one hand and effectiveness of intervention on the other. Few said they learnt about it when they took the child to the doctor.

Women mostly heard about the services provided by the project when implementing partners' teams visited their village, which highlights importance of mobile visits. In some cases, they learnt about it through community representatives or a representative of the mothers' support group. Friends, neighbours, husbands, and mothers' support group were other sources through which women learnt about static sites and mobile teams. Women had learnt that Shifa and HANDS were providing treatment for weak (*kamzoori*) children and mothers and were providing food. According to women, concern for the health of their children was the major reason for visiting OTP sites. Occasionally, food was also mentioned as a reason for visiting OTP sites or receiving service from mobile teams. However, partners have learnt through experience that the TSFP programme, particularly the provision of oil, serves as an important incentive for the mothers.

When women were asked if they knew any women whose children were assessed as weak, but preferred not to benefit from the service, only one respondent out of 60 said she knew one family who did not visit OTP site because of distance. All others said they did not know any such case.

### 3.3.2 Promoting Healthy Nutrition Behaviours

#### Outcome 2: Healthy nutrition behaviours promoted at community and facility level for prevention of malnutrition in early childhood

The partners were notably effective in increasing awareness among community members, particularly among PLWs, about the causes of malnutrition and ways to prevent it in early childhood. They were very

effective in reaching out to male community members in general and to fathers of children aged 6-59 months.

The strategies adopted to increase awareness were: sessions conducted by IYCF counsellors at the community level, messages disseminated through mother support groups and one to one counselling sessions during their visit to OTP sites.

Key messages PLWs seem to have retained are the importance of giving colostrum to babies (i.e. feeding them within 30 minutes of the birth), exclusive breastfeeding till six months, identifying cues for hunger, the need to feed the babies more frequently, importance of complementary feeding using a soft diet after six months, correct breastfeeding methods, and the importance of breast feeding till children are two years old and eating for two during pregnancy and lactating period.

The importance of antenatal check-ups was also mentioned by some PLWs, showing that there is an increase in awareness about the importance of antenatal care as well. Knowledge regarding antenatal care was not as pervasive as messages regarding early childhood feeding practices.

There has been a notable increase in knowledge about the importance of feeding the newborn within 30 minutes of the birth. Not only PLWs recognizes the importance, but at least some PLWs appeared to know the rationale for why babies should be fed within thirty minutes of the birth, as evidenced by the following quote from two PLWs, one of whom had received services from HANDS and the other from Shifa Foundation:

*“After half hour of delivery we should feed our children, because first milk is full of vitamins and it’s a blessing of almighty Allah. It protects children from many diseases like malnourishment.”*

*“We give milk after half hour of delivery because Shifa team told us that it is very important for infant. It has many nutrients which protect a child from many diseases.”*

Increased knowledge about importance of colostrum can be appreciated more if this is put into the perspective of many myths that exist in some of the communities of Tharparkar. For example, in some communities mothers express colostrum and throw it because it is considered smelly and useless. In some Hindu tribes in Tharparkar mothers do not feed their babies until they seek permission from religious leader (Pinday Maharaj). In some communities, mothers did not feed the babies until three days after birth.

Increases in knowledge about exclusive breastfeeding was also notable. Most women who participated in the FGDs said they learnt from Shifa and HANDS teams that women should exclusively breastfeed their children until 6 months of age. One woman said that she had learnt from sessions that babies should not be even a single drop of water until they are six months of age. PLWs also shared that they also learnt that mothers should start giving a soft diet to babies after six months as a complementary feed. Although exclusive breastfeeding was not non-existent in Tharparkar, the practice of giving goat or cow milk to babies before six months is very common.

There is an increase in awareness about the importance of feeding babies every two hours (10-12 times in a single day), instead of waiting for the baby to cry. PLWs confirmed that they had recognized the importance of identifying cues other than crying to feed their babies.

Increased awareness was also visible regarding the importance of breastfeeding babies until they are two years. Some mothers did feed their babies for two years, but there are cultural practices and beliefs in some communities in Tharparkar that discouraged mothers from feeding babies for this long. For

example, in some communities it is believed that milk becomes poisonous once the mother is pregnant. Some believe that giving milk to babies reduces nutrition to babies who are not yet born. As a result of these beliefs, mothers in such communities would stop feeding their children as soon as they became pregnant. Against this backdrop, increased awareness that children should be fed until two years is an important step forward.

Increased knowledge about the importance of antenatal check-ups was also noted, but it did not surface as much as messages regarding child-feeding practices. Some women said they learnt from Shifa and HANDS teams that pregnant women should go for antenatal check-ups. Most PLWs who participated in FGDs said they go for antenatal check-ups although a few did not. One of them said she did not go for antenatal check-up because she did not feel like it, indicating that some women may still be treating antenatal check-ups rather casually.

Another area where some increase in awareness was noted was the concept of extra meals for women during pregnancy. Some women who participated in FGDs said they have learnt from Shifa and HANDS teams that pregnant mothers should “eat for two”. They said, they had learn that they should eat fruits, milk, buttermilk and vegetables for the sake of children, infants being breastfed and those who are yet to be born.

Some confusion was noted regarding the initiation of breastfeeding and the length of exclusive breastfeeding. Although most PLWs who participated in FGDs appeared to know that babies should be fed within 30 minutes after birth, a few said babies should be fed within an hour. Similarly, most PLWs knew exclusive breastfeeding should be done for six months; a few thought babies should be fed until three months. Some confusion also existed regarding strategies for feeding the babies when they are sick and unable to suckle. One woman said they had learnt from IYCF counsellor that in case mothers could latch the baby with breast, she should express her milk, then dip a clean cloth in the milk and squeeze it in baby’s mouth. Some said they should use a cup or teaspoon to feed. These are indications of mixed messages given to communities by few IYCF counsellors.

Interviews with IYCF counsellors revealed that some mixed messages given to women were the result of confusion on the part of IYCF counsellors. This appraisal is strongly supported by assessment of UNICEF staff, nutrition cell staff and district health department regarding the technical capacity of implementing partners. As per their assessment, the partners’ technical capacity was not quite strong enough, particularly related to outreach activities. According to a representative of the Nutrition Cell some of the field staff did not have sufficient knowledge of the messages they were promoting.

There were claims made by women community members about changes in practice. For example, a vast majority of PLWs (54 out of 60) said they followed the advice of partners and introduced complementary feeding after 6 months. Four women said they started complementary feeding earlier than 6 months. Similarly, majority of PLWs said they fed soft diet to their children as part of complementary feeding. In the same vain, most of the lactating mothers who participated in the FGDs said they fed their children within 30 minutes of the birth. All PLWs who claimed to follow positive practices credited the partners for influencing their practices. However, seven out of 60 (11.66 percent) PLWs also reported that they gave goat milk to their babies, something the project advised against.

However, claims made by women about changes in practices did not match the assessment of other stakeholders, including UNICEF staff, the Nutrition cell and District Health Department Officials. They, endorsed changes at knowledge level, but said the changes in practices were not quite visible. The partner staff also claimed change at knowledge level, but did not made tall claims about changes in practices. There were no pre-KAP and post-KAP surveys. Also, the evaluators were not able to directly

observe the practices claimed by women. Keeping in view factors such as, assessment of key stakeholders and proverbial lesson that cultural practices do not change overnight and that change is not simply a function of awareness or knowledge, claims regarding changes in practices should be treated with a considerable degree of caution. Such changes should be confirmed by participant observation.

There was strong ownership of the intervention at community level. Both male and female community members appreciated the intervention and support provided by the partners in the form of supplies and information. Women appreciated the fact that they not only received information, but also received in kind support from partners such as Acha Mum, WSB and OIL. They also confirmed receiving tablets (folic acid and iron) from implementing partners. Some women said they received tablets because these were good for health during pregnancy. Some were more specific about the reasons for receiving tablets and said that tablets increases blood, increases blood bonding, relieves pain in legs and increases milk.

There was strong ownership of the intervention among male community members as well, but there was no parallel increase in awareness among male community members about child feeding practices and specific health needs of PLWs. Male community members knew about the purpose of the intervention and its activities in general terms, but their knowledge regarding IYCF messages was very limited compared to women's. The men knew the interventions aimed to address malnutrition among children and PLWs. They also knew about supplies provided by the project. But when it came to any substantive increase in knowledge regarding key nutrition messages given by the partners, they were not quite knowledgeable about it. Limited knowledge among male community members of IYCF is understandable (though not desirable) because the partners did not focus on increasing knowledge of male community members on these issues. They did not work intensively with the male community members to increase their knowledge. So long as there was "buy in" from the male community for implementation of the project activities, partners were satisfied with their participation.

One of the reasons partner staff cited for not being able to reach out to male community members effectively was that male community members generally remain at work during the day time. Some of them even work in cities. When community mobilizers visit villages, they do not find male community members in the village to engage with. This was confirmed by both male community members interviewed for the evaluation and also partner staff. However, some of the male community members during interviews suggested that if partner staff had wished to engage with male community members, they should either visit them in the evening or on Sundays. This option was apparently not discussed or considered by the partners, possibly because reaching out to male community members was not one of their key priorities.

Lack of standardization of messages for IYCF and hygiene promotion emerged as an important issue. One of the partners (HANDS) was using a training manual designed for an African context. A related issue mentioned earlier was the limited capacity of staff responsible for implementing the project activities. Some of the staff interviewed for the evaluation identified limited training opportunities as a reason for capacity related issues. They found the trainings they attended useful but said it was not sufficient to build their capacity. They said they needed refreshers trainings to discuss and resolve issues they faced in the field.

Lack of standardization of messages and limited capacity of staff were noted as two important reasons for some of mixed messages given to women. For example, differing messages were given regarding initiation of breastfeeding, and strategies for feeding children when child is sick and how to latch the baby to the breast for feeding. Discussions with PLWs showed that some of them had received differing messages regarding initiation of breast-feeding. Similarly, interviews with IYCF counsellors also revealed that understanding of issues and topics also differed in some cases.

Community outreach activities were rather one-dimensional. The partners did not use creative strategies to promote nutrition related messages. Messages were mostly conveyed verbally during community meetings or during one to one interactions. Other medium used by the project was staff written messages displayed at OTP sites. The partners did not make use of creative strategies such as street theatres or radio dramas or messages to convey their messages.

### 3.3.3 Hygiene Promotion

The partners aimed to promote key hygiene behaviours such as washing hands with soap, treating and drinking safe water and keeping the household environment clean. Hygiene promotion did not appear to receive sufficient attention. When women were asked what they learnt from the partners, hygiene promotion did not surface as a theme. Even interviews with IYCF counsellor showed that communication primarily focused on IYCF practices. Absence of waste bins for medical and non-medical supplies in half of the OTP sites and absence of hand washing areas for women in three out of 10 sites also indicates relatively less importance given to hygiene promotion compared to IYCF messages.

### 3.3.4 Mother support groups

Mother support groups were loosely formed structures formed by the implementing partners to promote IYCF and hygiene related messages in the target communities. Mother support group appeared to be an effective tool for promoting nutrition and hygiene related messages in the community. Size and constitution of group differed from place to place. Size of the group ranged between eight to fifteen women. Where available, Lady Health Workers (LHWs) were selected as heads of the mother support groups because they were considered the most appropriately qualified persons to do this job. In places where LHWs were not available, literate women with interest in promoting messages were selected to lead the groups.

Not all mother support groups were active. Most claimed that they met regularly, roughly every two weeks. Others met less frequently. Some said they only met whenever they are asked to meet or whenever *Baji* (the IYCF counsellor) visited them (they typically visited them once every two weeks). Some even conflate mother support group meeting with community meetings held whenever project staff visited the village. Some mother support groups were well-established: The oldest group the evaluation team met was two years old and the youngest was only 15 days old.

According to members of mother support groups, they meet to discuss issues related to IYCF. They said they try to convey these messages to PLWs. They appeared considerably knowledgeable about key messages, although some were more knowledgeable than others. It also included members who probably have a token presence. But overall, the group appeared to have important practical and symbolic value as a standard bearer for promoting nutrition related messages. They do seem to offer advice to other women (claimed by mother support group heads and verified by other women). PLWs regarded the head of the mother support group as an important individual who interacted with partner staff and gathered women at her own house. Since being head of the group and member of the group gave them recognition, they have an interest in promoting messages.

According to members of mother support groups, they drew a lot benefits from participating in the groups. They identified key benefits to be: increased knowledge regarding breastfeeding practices, antenatal check-up, and nutrition of children and nutrition of mothers during pregnancy and vaccination. This is highlighted by following quote from a member of mother support group:

*“We are getting a lot of knowledge by participating in this group. Earlier we were unaware about importance of breastfeeding, antenatal check-ups. We did not know that during pregnancy woman need more food, but now we are well aware of this and try to follow what we have learnt.”*

### 3.3.5 Screening, Admission and Treatment of SAM and MAM Cases

The partners have been successful in screening children (both girls and boys) and PLWs to identify SAM and MAM case and providing treatment through OTP and TSFP. The partners have also been successful in identifying cases of SAM with complications and referring them to the Stabilization Centre. The partners also supported children referred to stabilization centre with transportation costs; however they have not been able to ensure that all cases referred to stabilization centre are admitted to the Stabilization Centre.

Since a representative survey was not part of the design, coverage data reported here is provided by UNICEF. It is drawn from Nutrition Information System of UNICEF, which in draws on the data collected and provided by implementing partners from the field.

#### Number of Children Screened with Results and Yearly Distribution

As shown in table 4.2, between 2014 and 2016 the implementing partners screened 294, 232 children, of which 148,944 (51%) were boys and 145,288 (49%) were girls, indicating that the partners were successful in maintaining a gender-balance in screening process. The majority of children (62.92%) were screened in 2015 (27.78 percent and 9.30 percent of children were screened in 2014 and 2016 respectively). The data presented in the table also shows that of the 294, 232 children screened, 18,508 (6%) were identified as severely acute malnourished or SAM and those who were identified as moderately malnourished or MAM were 65,822 (22%).

**Table 3-2: Number of Children Screened with Results and Yearly Distribution**

Children Screened	2014	2015	2016	Total
Total Screening-Children	81,743	185,127	27,362	294,232
Total SAM Identified	3,018	14021	1469	18,508
Total MAM Identified	6,552	54,086	5184	65,822

Source: UNICEF Nutrition Information System

#### **Number of SAM children identified with gender-wise breakup**

As shown in the table 4.3 below, of the 18,508 SAM children, 10,076 (54%) were girls and 8,432 (46%) were boys. In line with the screening process, the majority SAM children were identified during 2015. Even though there was no significant difference in number of girls and boys screened, presence of higher number of girls identified with SAM children indicates that girls are more vulnerable of being malnourished compared to boys.

**Table 3-3: Number of SAM Children Identified with Gender Breakup**

Children Identified	2014	2015	2016	Total
Male	1,465	6,376	591	8,432

Female	1,553	7,645	878	10,076
Total	3,018	14,021	1,469	18,508

Source: UNICEF Nutrition Information System

### Number of children admitted with in OTP with Gender Distribution

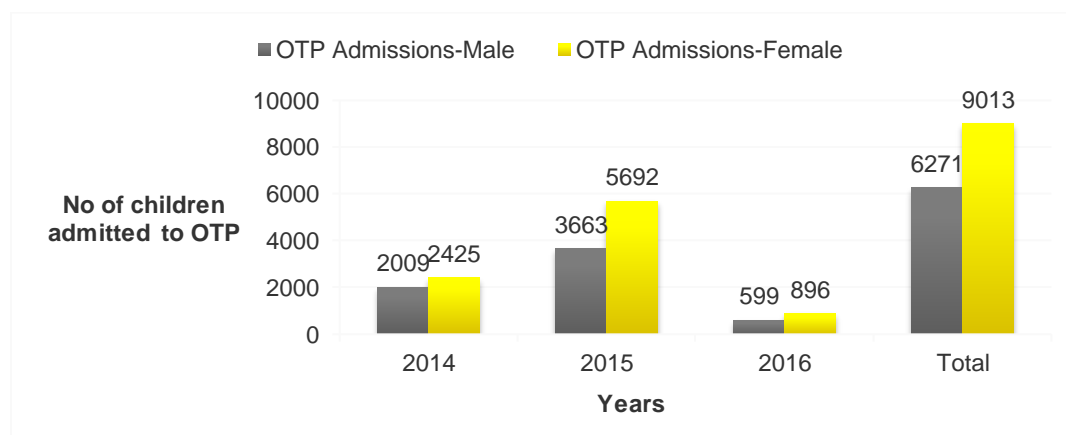
In all, 15,284 children (6,271 girls and 9,013 girls) were admitted to OTP by the implementing partners during the three-year period. Those who were admitted to OTP make 82.56 percent of children identified SAM children. In other words, 17.44 percent children who were identified as SAM did not benefit from the programme. According to a UNICEF representative dealing with NIS the difference between number of screened children and number of children admitted can occur owing to following reasons:

- ▶ Since TSFP did not suffer a break, the way OTP did, screening continued even if there was a break in PCAs. As a result, number of children identified can be greater than children admitted, as was the case here.
- ▶ Some parents bring their children to OTP site immediately after identification, others take time. During this time three things can happen:
  - Children could get cured on their own possibly owing to improvement in food (possibly influenced by initial assessment)
  - SAM can become MAM (MAM could also become SAM as well)
  - Parents may take their children to a doctor instead of taking the child to OTP (more admission for girls in OTP is apparently an indication of this factor)

The figure also provides yearly and gender-wise breakup of children admitted to OTP. It shows that of the 15,284 children admitted to OTP, majority were 9,013 (59%) were girls and 6,271 (41%) were boys.

Interestingly, proportionately many more girls were admitted to the OTP than boys: 89.45 percent of girls identified as severely malnourished were admitted to the programme compared to 74.37 percent for boys. Given gender preferences in the community, it is possible that boys are taken to a doctor to treatment and girls are taken to OTP site. As indicated above UNICEF also believes that one the reasons why there is difference in number of identified children and those admitted in OTP is because parents take their children to a doctor. This data indicates that perhaps boys are more likely to be taken a doctor than girl.

**Figure 3.1: Number of children admitted to OTP with Gender Distribution**



### Number of Children Discharged from OTP

Table 4.4 shows the number of children discharged from OTP between 2014 and March 2016 and the nature of discharged with yearly distribution. It shows that over the three year period 10,229 children were discharged, of which 9,847 (96.27%) were cured, 331 (3.24%) defaulted and 0.5% died.

To understand the difference between the number of children admitted to OTP and those who are labeled as discharged (cured, default, death), it is important to note that NIS only measures these three performance indicators. There are other possibilities as well which are not captured in NIS. These include medical transfers, non-recovered, relapses, transfer to TSFP, transferred to other OTP, moved out (outer district or seasonal migration). Besides, when PCAs ended, enrolled beneficiaries were moved out instead of being discharged as cured, defaulter or death – so, these other indicators/reasons created gaps among admissions and performance indicators.<sup>39</sup>

**Table 3-4: Number of Children Discharged from OTP**

Type of Discharge	2014	2015	2016	Total
Cured	2,067	6,763	1,017	9,847
Defaulters	166	117	48	331
Deaths	9	38	4	51
Total Discharged	2,242	6,918	1,069	10,229

Source: UNICEF Nutrition Information System

### Number of MAM Children Admitted to TSFP, Treatment and Results

In all 53,628 children (25,564 boys and 28,064 girls) were admitted to the TSFP programme. Of those, 40,407 (75.35%) were cured, 0.70 percent defaulted, 0.04 percent died. Remaining 23.90 percent medical transfers, non-recovered, relapses, transferred to OTP, transferred to other OTP, moved out (outer district or seasonal migration). There is no record of remaining. Default rate of less than 1% is quite remarkable.

**Table 3-5: Number of MAM Children Admitted to TSFP and Results**

Children	2014	2015	2016	Total
Admission Male - TSFP	5,280	17,352	2,932	25,564
Admission Female - TSFP	5,775	18,898	3,391	28,064
Cured - TSFP	4,521	26,128	9,758	40,407

<sup>39</sup> A written explanation provided in an email by a representative of UNICEF's Information Management System in Sindh Programme Office

Defaulters - TSFP	64	191	118	373
Deaths - TSFP	0	17	5	22

Source: UNICEF Nutrition Information System

#### Number of PLWs Screened, Admitted to TSFP and Results

As shown by the table 4.6, in all 97,582 pregnant women were screened by the partners between January 2014 to March 2016. Of the total screened 75,417 (77%) were identified as malnourished. Of those, 36,496 (48% of the identified) were admitted to the TSFP programme. Of these 21,833 (59.82 percent of those admitted) were cured. Percentage of women who defaulted was high, with 8,804 (24 % of admitted). As noted earlier, high default rate may be an indication that oil was provided upfront reducing the incentive to revisit TTSFP site for treatment.

**Table 3-6: Number of PLWS Screened, Admitted to TSFP and Results**

PLWs	2014	2015	2016	Total
Screened	39,951	39,808	17,823	97,582
Identified	5,037	67,138	3,242	75,417
Admissions	9,065	23,621	3,810	36,496
Cured - PLW	3,426	15,343	3,064	21,833
Defaulters - PLW	27	8,125	652	8,804
Deaths - PLW	0	8,263	6	8,269

Source: UNICEF Nutrition Information System

During the interviews conducted in the field project staff of Shifa Foundation and HANDS also claimed that they reached out to 60% of the target population in the target UCs. They also claimed that even though they target 60% of the population or villages, some of the villagers served under previous PCAs also visit OTP sites and benefited from the services of the project.

#### **3.3.6 Treatment of Micro Nutrient Deficiency**

##### R3: Micronutrient deficiencies disorders in children and women prevented / treated in the target population:

Both women and children received multi-micronutrient supplements. Women confirmed receiving tablets (folic acid and iron) at OTP sites. Some women said, they received tablets because these were good for health during pregnancy. Some were more specific about the reasons for receiving tablets and said that tablets increases blood, increases blood bonding, relieves pain in legs and increases milk. At the OTP sites visited by the evaluation team micronutrient supplements were available. 28,538 children received deworming treatment. Respondents confirmed using micronutrient supplements, but it was not possible for the evaluation to assess to what extent micronutrient deficiencies were prevented or treated.

### 3.3.7 Strengthening Local Capacity

#### R 4: Sustainability of CMAM interventions ensured by strengthening local technical capacity for integration of CMAM into primary health Care system.

In order to strengthen local capacity UNICEF supported Nutrition Cell to conduct two five-day Training of Trainers (TOT) workshops on CMAM for the representatives of Provincial Health Department, District Health Departments and representatives of various civil society organizations, including Shifa Foundation and HANDS. This allowed HANDS and Shifa to develop in house capacity for training on CMAM. Individuals representing HANDS and Shifa in turn conducted trainings on CMAM for staff members involved in implementation of emergency nutrition interventions. Senior management of HANDS and Shifa appreciated the opportunities for training of master trainers. They believe that trainings have significantly strengthened their organizations' capacity to implement nutrition projects. They said they no longer need to look elsewhere to train their staff on CMAM because they have internal capacity to do so. UNICEF through the nutrition cell also conducted a Training of Trainers (TOT) staff of DOH. They included three officials of the District Health Department in Tharparkar, including District Coordinator of Lady Health Workers (LHW) programme and a pediatrician deployed in the stabilization center in DHQ hospital Mithi. Even though they did not use their skills as Master Trainers when they were interviewed, it was expected that they would act as Masters Trainers when the Nutrition Support Programme is implemented.

### 3.3.8 Human Rights and Gender analysis (HRGE)

Although a tailor made Human Rights and Gender analysis was not done by the UNICEF and its partners, the project can be rated 2A on IASC Gender Marker<sup>40</sup>, because the projects' design significantly contributed to gender equality by promoting of rights of most vulnerable segments of the population such as, women and children (both girls and boys). Even among women, the emergency intervention focused on differentiated needs of PLWs and children suffering from malnutrition. However, absence HRGE analysis allowed certain undesirable practices to go unnoticed e.g. mostly hiring of male community mobilizers and payment of higher salaries to male community mobilizer as compared to IYCF counselor (even though later was playing dual roles). Some of limitations of outreach activities, for example, inadequate focus on hygiene promotion, can possibly be traced to overburdened IYCF Counselors. Similarly, not being able to effectively engage with male community members is another example. A tailor-made HGRE analysis would put a spotlight on such practices.

### 3.3.9 Security Considerations

Tharparkar being a border district is considered a sensitive area from security standpoint, particularly villages located closer to international border. Depending on military's assessment of security situation, access to areas closer to border was either permitted or restricted. Sometimes partners were able to operate up to eight kilometers from the international border. However, when security concerns were heightened, movement was restricted upto 15 kilometers from the international border. Restrictions on movement had implications for the implementation of the project. Given these restrictions, the partners

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<sup>40</sup> The project are rated 2A on IASC Gender Marker if "the project is designed to contribute significantly to gender equality. The different needs of women/girls and men/boys have been analyzed and integrated well in all three essential components: the needs assessment activities and outcomes." See [http://floods2010.pakresponse.info/gender/Guidance\\_Note\\_for\\_Clusters\\_to\\_implement\\_the\\_IASC\\_Gender\\_Marker.pdf](http://floods2010.pakresponse.info/gender/Guidance_Note_for_Clusters_to_implement_the_IASC_Gender_Marker.pdf)

relied on good will of CRPs to bring children and PLWs for screening. It was not possible to verify this, but the partners claimed that CRPs did bring children and women for screening and treatment from some of the border areas.

Partners maintained good relations with security agencies and regularly shared information about field plans and movement of staff. Regular information sharing allowed them to earn trust and they were allowed to work without raising any concerns.

### 3.3.10 Monitoring

Intervention was monitored at multiple levels:

- ▶ Monitoring by partner organizations' staff representing their head offices, district offices and M&E officers hired for the project.
- ▶ Monitoring by UNICEF Sindh team (on average one visit per month).
- ▶ Third party monitoring (TPFMs) conducted by an external agency, Apex Consulting
- ▶ Monitoring by Provincial Nutrition Cell
- ▶ Monitoring by Nutrition cluster

Monitoring reports developed by UNICEF do not appear to be of sufficiently high quality. The reports remain short on analytical insights and focus on describing the field visits. The reports are not sufficiently informative about the performance of the project. However, tools or formats for collecting quantitative data regarding screening, admissions, treatment, discharge and referral were of high quality. The formats were consistently used at all OTP sites to collect information. This information was shared with UNICEF on monthly basis. This information was captured in NIS.

According to implementing partner staff, monitoring conducted by UNICEF was of supportive nature. According to them, UNICEF Sindh representatives provided on spot verbal feedback and helped to rectify problems.

Third party monitoring reports had a narrow scope. The focus was more availability of physical facilities, presence of staff and availability of supplies. They do not provide any information about process and quality of implementation and achievement of results. Implementing partner staff also viewed third party monitoring beneficial in that it always kept the project staff on the toes and they always felt monitored. However, they contended that third party monitoring at times made them feel uncomfortable, because, third party monitoring team silently observed and took notes without asking clarification questions and never offered any suggestions for improvement or never shared feedback directly. They also observed that third party monitors themselves were not trained and knowledgeable. They also identified an issue of bias in monitoring. According to one of the respondents some of the third party monitors had previously worked with the partner organizations. Therefore, at times an element of bias for or against could not be ruled out, depending the persons experience with the organization.

UNICEF monitoring team developed monitoring reports, decisions were mostly influenced through on-spot feedback given to partner staff. Partner staff also confirmed that UNICEF staff followed-up with them on points raised in Third Party Monitoring reports. According to partner staff in most cases they would provide clarifications for absence of staff or absence of medicines. These clarifications could have been provided to third party monitors had they asked why questions. Since third party monitors only relied on silent observation, they had to provide clarifications and when UNICEF after reviewing the third party monitoring reports sent them queries. Even though projects were monitored at multiple levels, quality of monitoring needed improvement. This need is highlighted by quality of available monitoring reports. Besides monitoring reports developed by the implementing partners were not provided.

UNICEF team did use monitoring results to follow-up on project achievements and make operational decisions. An important example of using monitoring information is allowing the partners to use majority of OTP teams as static-cum-mobile team, without formally changing the design of the project. However, monitoring reports produced by UNICEF Sindh team did not systematically follow project indicators. While third party monitoring, as indicated above, had a much narrower focus and indicators used for third party monitoring were not appropriate to follow the achievement of the project.

### 3.3.11 Effectiveness and Relevance of Accountability Mechanisms

One aspect of upward accountability—accountability of partners to UNICEF—ensured by monitoring performed by UNICEF’s own staff, the third party and reports submitted by the partners, appeared to be strong. A reasonable assessment of effectiveness of accountability of UNICEF and its partners to Department of Health via Provincial Nutrition Cell cannot be made in the absence of monitoring reports produced by Nutrition Cell and Nutrition Working Group. To ensure accountability to District Health Department, the partners submitted monthly progress reports, but District Health Department did not appear to make use of those reports.

Incentives for accountability of the partners to UNICEF were strong because UNICEF had the authority to extend or not to extend the projects. Incentives for downward accountability were rather weak largely because the implementing partners did not draw their mandate from beneficiaries.<sup>41</sup> The key mechanism for downward accountability (partners to community) was community meetings. To some extent community meetings did create a sense of accountability, as partners felt obliged to fulfill their promises to community, but community meetings mostly served as mechanism for information sharing from partners to communities. Similarly, accountability of UNICEF to implementing partners was not strong either because the partners depended UNICEF good will for continuation of the projects rather than vice versa.

### 3.3.12 Unexpected Outcomes

An unintended outcome reported by members of mother support group was increased confidence and ability to talk in front of others. They said through participation in meetings of mother support group they have learnt to speak in front of others. Earlier they would not dare to do so.

### 3.3.13 Challenges Faced

Lack of standardized messages was a big challenge, sometimes resulting in mixed messages and use of out of context training material. Absence of training material in Urdu and Sindhi was identified as an issue that compromised capacity building of partners, which in turn affected awareness raising activities. A number of organizations, including USAID, MCHIP and WFP have developed training material in Sindhi, but according to a UNICEF representative, these guidelines were organization specific. It is understood that both UNICEF and Nutrition cell were cognizant of this limitation. UNICEF is already taking a lead in reviewing previously produced material to develop standardized messages. If the standardized messages are developed then this limitation would be addressed in future projects. In case, efforts to develop standardized messages do not come to fruition, quality of future projects will also be compromised.

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<sup>41</sup> *NGDOs as international advocates: The challenge of downward accountability.* <http://www.gdrc.org/ngo/downward-account.html>

- ▶ Limited technical capacity of implementing partners was identified by representatives of UNICEF and Nutrition Cell as a challenge for effective implementation of the interventions. Capacity was noted to be limited, particularly, with respect to outreach activities. According to UNICEF Sindh representatives, partners were not able to hire the competent staff. As a result, there were errors and delays in reports submitted by on-field staff. From partners' standpoint, since projects were of short-term nature, hiring competent staff and retention was a big challenge. Since project staff would not be sure about continuation of the project, they would leave the project as soon as they saw another opportunity. While working with the implementing partners UNICEF should be cognizant of this limitation and should work with the partners and develop strategies for capacity building and retention of trained staff.
- ▶ Access to border areas was a big challenge. Challenge was overcome to some extent by asking community resource persons to bring people to the nearest OTP sites. This is likely to remain a challenge for projects implemented in security-sensitive areas. UNICEF and its partners should devise better ways of addressing this issue e.g. developing local capacities or providing free of cost transportation.
- ▶ Counseling illiterate women was identified by some of IYCF counselors as a challenge. This challenge was compounded by language barrier as people of Tharparkar speak their own local language. It shows even though Tharparkar is part of Sindh, competency in Sindhi is not sufficient to engage with communities, particularly illiterate women,
- ▶ Scattered population, long distances and transportation costs presents huge challenges. Long distance reduces accessibility of people to health facilities and also makes it challenging for service providers to offer services closer to doorsteps. Issue of access to OTP sites was addressed through mobile service, access to stabilization center was compromised by transportation costs. It prevented some parents from taking their children to stabilization centers.
- ▶ Many cultural practices militate against promotion of nutrition and health for PLWs and children. There are serious gender disparities rooted in local cultural practices. The workload at household level is disproportionately divided. Women bear most of the work burden, even when they are pregnant. But males receive preferential treatment at home. Lack of food diversity and unhealthy eating habits are also deeply rooted in cultural practices. Practice of throwing colostrum, because it is considered dirty and smelly, and not initiating breastfeeding until women have permission from religious leaders or until few days from birth are practices with deep cultural roots. These beliefs and practices present huge challenges for initiatives aimed at promoting health and nutrition for children and PLWs.
- ▶ In some communities, for example, Lund community in Diplo, there is a tradition that all support received from outside should be distributed equally. Another community, Kathari community, thought of services provided by the partner as un-Islamic and unacceptable. This made targeting very challenging for the partners. Such challenges may compromise effectiveness of future projects as well. Therefore, such challenges should be documented and context sensitive strategies should be devised to address these challenges. These strategies should be made part of training package for project staff.
- ▶ High poverty levels and unemployment are an ever-present challenge with many negative implications: e.g. people cannot take children to hospitals as advised as they cannot bear the cost of transport. They cannot buy medicines or eat required type and amount of food. They cannot diversify their food even if they wish to.

### **3.4 Coordination**

Emergency response organized in the context of drought-like situation in Tharparkar is viewed by many important stakeholders, including NDMA representatives, as one of the better coordinated operations. When the issue of drought and deaths were highlighted in the media, a number of agencies moved into Tharparkar to respond to the emergency. These agencies, among others, included National Disaster Management Authority (NDMA), Provincial Disaster Management Authority (PDMA), Pakistan Army, WFP, UNICEF, some international NGOs, a number of local NGOs and private foundations. A Joint Coordination Cell was established in Commissioner's office representing Pakistan army, NDMA, PDMA and district government to organize and plan emergency response operation. Daily meetings were held and attended by many agencies involved in response activities to discuss the situation on the ground and coordinate response operations.

Some key informants in the government as well as individuals with knowledge of situation on the ground do not agree with the assessment of response being a well-coordinated operation. They saw big gaps in the operation. Some of them pointed out that even though there was a Joint Coordination Cell, not many agencies participating in response operation actively took part in the meetings. According to them even if they took part in the meeting they did not coordinate their activities on the ground to remove duplications and create synergies.

Both Shifa Foundation and HANDS also took part in coordination meetings held at Commissioner's Office during the height of emergency. At the request of district government, they also provided logistical support to transport children needing urgent medical attention to DHQ Mithi. Shifa alone claims to have transported 700 children to Mithi.

Partners view coordination with UNICEF in a positive light and appreciate the support provided by UNICEF, particularly UNICEF Sindh with whom they had a regular contact. They also appreciated the support and feedback they received from UNICEF country office during monitoring visits. They appreciated the prompt responses they received from UNICEF to their queries, be they programme related or any financial matter. Both implementing partners and UNICEF closely worked with Nutrition Cell. Nutrition cell also took part in monitoring missions.

UNICEF, WFP and WHO have a history of implementing Global model of CMAM. They continued this coordination in Tharparkar well. WFP through field level agreements with implementing partners provided supplies for TSFP. Since WFP deploys monitors at field level, they received daily monitoring reports. According to WFP representatives, knowing that UNICEF does not have its own monitors on the ground, they shared the information received from the field with UNICEF. WHO provided technical support for stabilization center.

UNICEF also supported district nutrition review meeting. In addition to HANDS and Shifa, TRDP and Sukhar also participated in the nutrition meeting. But according to project staff of partner organizations, expectations were not fulfilled.

Emergency nutrition intervention was also coordinated by nutrition cluster. They provided technical support to partners, organized review meetings, updated 3W matrix, conducted capacity assessment and gap analysis, and developed and disseminated quarterly bulletin.

### **3.5 Connectedness**

There are two differing perspectives held within UNICEF as to whether UNICEF's emergency nutrition intervention took into account longer-term needs. One perspective holds that purpose of emergency nutrition intervention was to save lives in the context of drought like situation in Tharparkar. Therefore, it was argued, long-term needs and integrated approach were not quite considered. In fact, it is also

argued, that keeping in view challenges involved in coordinating a multi-sectoral response and funding constraints, it was only realistic to implement a nutrition intervention. Another perspective is that intervention was already at the design stage when emergency situation occurred. Therefore, implementing a nutrition response was logical next step. Those who held later perspective argued that the intervention was designed with the knowledge that Tharparkar is among the nine “PC-1 districts” selected for implementation of World Bank-supported, three-year-long Nutrition Support project. Therefore, it was designed as forerunner for the World Bank supported project.

Apparently, plan to implement an emergency nutrition project coincided with an emergency situation in Tharparkar. The view that project was originally conceived as a precursor to Nutrition Support Programme is given credence by PCAs for the project. PCAs specifically identified linkages with Nutrition Support Programme as an exit strategy. So an exit strategy did exit and it was the right one.

In practical terms as well, government of Sindh, particularly Nutrition cell, has benefited from experience of the nutrition emergency response while designing an implementation strategy for Nutrition Support Programme. Even though PPHI has been identified as the lead agency for the implementation of the project, role of NGOs like Shifa Foundation and HANDS is also recognized by the government. PPHI is selected to manage facility-based OTP sites in all the UCs where it is managing BHUs and other dispensaries. In areas where PPHI is not operating OTP sites, community outreach will be done via LHWs. In Tharparkar HANDS will be responsible for managing OTP sites in areas not covered by PPHI (areas where PPHI is not responsible for managing BHUs) and also for implementing community outreach component in areas where there no LHWs (same role will be played by Shifa in Umarkot). This decision was taken keeping in view partners experience of successfully implementing community outreach programme.

With the hindsight, UNICEF was not strategic enough in ending its contract with provincial Department of Health through which PPHI was implementing nutrition emergency response in parts of Tharparkar. The contract with provincial Department of Health was not extended by UNICEF owing to some concerns (not explained) and PPHI ceased to be an implementer of the project. This may have been one of the reasons why PPHI did not allow Shifa Foundation and HANDS to use BHUs and Dispensaries under its management.

In short, emergency nutrition intervention was implemented in a context where long-term needs were considered, although UNICEF missed the opportunity to continue work to with or engage with PPHI and build its capacity for the implementation of Nutrition Support Programme. Apparently, UNICEF was not able to anticipate selection of PPHI as the lead agency for Nutrition Support Programme.

As for the overall emergency response some important stakeholders believe that overall approach was piecemeal with little connectedness and sustainability. According to them, although there was a veneer of coordination, in reality approach was fragmentary. Another example of fragmentation was lack of continuity in projects implemented by UNICEF with its partners, which according to UNICEF was the result of uncertainties surrounding the implementation of Nutrition Support Programme.

## 4 Conclusions

Although the nutrition emergency intervention was relevant to address long-standing issue of malnutrition in Tharparkar, which was worsened by drought-like situation in Tharparkar in 2014, in and of itself the nutrition emergency response was not sufficient to address the issue of malnutrition. Most of the stakeholders agreed that the main cause of the high number of deaths among children was poor access to MNCH services rather than malnutrition.

The intervention would be stronger if it were integrated with Health and possibly with WASH as well. This would also be in line with UNICEF's institutional priorities for integrated programming and its understanding of the causes of malnutrition, as reflected in its framework for understanding malnutrition.

The project did not benefit from a tailored-made HRGE analysis. Although HRGE concerns were recognized as important in the PCAs, the requirements for sufficiently addressing HRGE were not defined, except for an output indicator in the project LFAs related to hiring 40% women. As a result, HRGE concerns did not receive sufficient attention in the implementation of project activities as well as monitoring e.g. not enough women were hired by HANDS. Some women staff, despite bearing greater workloads than their male colleagues were paid lower salaries than men.

Costs per beneficiary for all the projects in the nutrition emergency response were higher than USD 145, the average cost per beneficiary assessed by an evaluation 45 CMAM projects implemented by UNICEF in Pakistan's KP province. The only exception was the most recent project implemented by Shifa Foundation, for which the cost per beneficiary was USD 131.80. Although the challenging geographic context was a reason for higher cost per beneficiary, frequent interruptions or gaps in projects appeared to be the most important reason for higher cost per beneficiary. Each time a project was closed, resources (human and capital) had to be demobilized with attendant costs, and when new projects were initiated, those required new resource mobilization.

Aside from the caveats related to lack of integrated programming and frequent gaps in the projects, UNICEF and its implementing partners were considerably effective in delivering specific project outcomes: setting up static and mobile OTP sites in all the 44 UCs of Tharparkar. UNICEF was quick to identify the need to deploy additional of mobile teams than they had committed and successfully turned most of the teams into static-cum-mobile teams to provide services to communities living far from OTP sites.

Implementing partners were also notably effective in increasing awareness about infant and young child feeding among PLWs. The key messages retained by PLWs include: the importance of initiating feeding within 30 minutes of the birth, exclusive breastfeeding till six months, identifying cues for hunger; the need to feed babies more frequently, importance of complementary feeding using soft diet after six months, correct breastfeeding methods, and importance of breastfeeding until children are two years old.

The partners have been effective in reaching out to women, but their outreach to men was much less effective, beyond creating awareness about the project.

Limited technical capacity of field staff, including coordinators and supervisors, and lack of standardized messages were two important limitations that sometimes led to contradictory messages being conveyed to women. This limited the effectiveness of the nutrition intervention. The partners were not inventive enough in communicating with communities, and relied on traditional methods such as sharing information in community meetings, one to one meetings with PLWs during their visits to OTP sites and written material displayed at OTP sites. They overlooked the role of visual media such as street theatre

and, video documentaries. Nor did the outreach to men explore the potential of *Otaq* (traditional gathering place for men) or the possibility of modifying organizations' own systems to accommodate community need.

The partners have been successful in screening and identifying malnourished children and PLWs and treating them through mobile and static OTP and TSFP sites. However, data compiled by NIS shows significant untraceable gaps between:

- ▶ Those identified as malnourished (SAM and MAM) and those admitted to OTP and TSFP
- ▶ Those admitted to OTP and TSFP and those who were discharged.

These gaps exist because the NIS does not include information on children and PLWs who were identified as malnourished but chose not to visit OTP (either because they saw a doctor or chose not to go anywhere), and those who were admitted but dropped out for various reasons and were not identified again.

Widely-scattered populations, high-poverty levels, high levels of illiteracy and entrenched cultural practices were context-specific challenges that made adoption of practices promoted by the project difficult and less effective than it might have been.

Overall, the emergency response to the drought-like situation in Tharparkar is seen by most respondents representing UNICEF, WFP, NDMA, PDMA, district government and local NGOs as one of the better coordinated emergency responses, although a few representatives viewed the overall approach as piecemeal and lacking in integration.

The partners were successful in taking into account military policies which required the partners to follow security restrictions, seek NOCs for visits and regularly share information about project activities, particularly in areas closer to the Indian border. The partners maintained good relations with security agencies and regularly shared information with them to ensure increased access to the target areas. Being cooperative and transparent in sharing information was key to ensure relatively better access to the target areas.

Although some in UNICEF saw the nutrition emergency intervention as a life-saving intervention implemented with a particular focus on saving lives, rather than with an eye on integration with long-term food-security needs, there is ample evidence to suggest that the intervention was originally designed as a precursor to the World Bank-funded Nutrition Support Programme in Sindh. Although the choice of partners (specifically the non-selection of PPHI as partner) may have led to a disconnect between OTP sites and BHUs. However, the emergency nutrition intervention has contributed to shaping the implementation strategy for the World Bank-funded nutrition support programme, which was one of the underlying expectations of nutrition emergency response.

## 5 Lessons Learnt

The following lessons have been captured by evaluation team that may be useful for UNICEF for broader application to different contexts and programmes beyond the object of this evaluation (i.e. nutrition emergency work in Tharparkar).

- UNICEF' organizational systems have yet to catch-up with changed institutional priorities. As a result, integrated programming did not receive sufficient attention and projects were formulated in department-specific silos. Unless concerted efforts are made to harmonize organizational systems with changing institutional priorities, it would take more time for systems to catch up with institutional priorities. Hence, the lacunas in application of integrated approach would keep hampering achievements of results for UNICEF programmes. This is a lesson needs that attention at broader organizational level than just by the nutrition programme
- HRGE concerns remained unaddressed because a tailor-made analysis of HRGE was not conducted. These concerns, when they did arise, remained outside the bounds of planning, implementation, monitoring and learning. UNICEF has broad commitments to HRGE, and it seemed self-evident that conducting an emergency nutrition response is addressing HRGE. However, the evaluation found that these concerns were not operationalized, making it difficult to understand what it means to fulfill these commitments for project implementers and UNICEF. It seems pertinent to develop context specific analysis of HRGE issues and integrate them into programme results for all UNICEF programmes.
- For TSFP, two alternative methods were followed for provision of cooking oil. Recipients either received one instalment of 4.5 litres, or three installments of 1.5 litres. The lesson learned from this programme is that smaller amounts of oil serve as an important incentive for PLWs to return to TSFP sites. Conversely, receiving a single large amount increases the probability of PLWs not returning for subsequent visits and thus not receiving necessary diagnoses and care. In similar, future projects of this kind, it would be useful to consult PLWs and their families to learn their perceptions of the costs and benefits of both options and monitor carefully the follow up visits of PLWs after delivery of food commodities. Other UN Agencies such as the World Food Programme (WFP) could also be consulted, to plan optimal ways of ensuring that PLWs and their children are best served and programme objectives are met. A better coordinated approach among UN agencies could have served better.
- For this project, the relevance of static sites was strong. However, terrain, the quality of roads and the quality of communications technologies are critical factors in successfully implementing programmes of this nature. In areas where the population is scattered and access to service delivery points is limited by long distances, lack of transport and poor road infrastructure, mobile teams could work better, provided they are well equipped and have appropriate vehicles and communications technologies. All future programmes of UNICEF in Tharparkar must learn from this experience and carefully consider using most-suitable strategies to reach communities.
- In areas where skilled human resource (e.g. female and male community mobilizers and health care providers, and administration and logistics experts) are scarce, UNICEF future programmes in Tharparkar should consider providing residential facilities to staff, particularly to women, as a useful strategy to attract and retain staff.
- Involving LHWs for community outreach is a potentially effective strategy, but the lack of a monitoring system compromises this strategy. Using existing community based structures could be useful, if members were trained in basic monitoring. Where there are gaps in the existing system, instead of opting for a less sustainable alternate system, weaknesses in existing systems should be addressed.

Overall, in all its work, UNICEF can focus on strengthening its Communication for Development work, as it is the key strategy being used in behavior change and awareness raising in various programmes.

- Partners have found through experience that they can use their visits to communities to support EPI coverage. They have frequently encouraged EPI extension workers to accompany them for this purpose. Where possible, this sharing of local resources and knowledge should be integrated into implementation plans of future programmes.
- In this intervention's community outreach activities, it was much more useful to use the list of villages obtained from polio workers than the lists maintained by the land revenue department. The latter lists were found to be incomprehensible and outdated. Nor did they identify new settlements that have sprung up owing to increases in population, or villages that have been renamed for one reason or another. Government records including items as basic as a list of villages do not always catch-up with the changing reality (e.g. shifts in population, demographic trends, the state of local water supplies) on the ground, underlining the need to augment government records with local knowledge. Thus, using more updated polio lists (endorsed by government) can be a time saving strategy for other baselines and fieldwork.
- For cases of SAM children with complications, PKR 2,000 was given to their families to meet the cost of transportation to the stabilization center in Mithi. This practice was not planned or budgeted, initially, but it proved to be beneficial and successful. However, if SAM-with-complications cases were from remote areas, then PKR 2,000 was not a sufficient incentive, as it costs PKR 8,000 to 10,000 to hire emergency transportation to Mithi DHQ. As a result, not all children identified as SAM with complications were admitted to the stabilization center. Incentives provided to improve service utilization (in this case provision of cost of transportation to reach stabilization centers should be commensurate with the need. Incentives need to be customized to context and wholesome solutions instead of piecemeal approach can work more effectively.
- Partner staff noted that until few years ago the WFP experienced gaps in supplies. After 2013 WFP resolved to remove the gap and adopted a performance indicator to this effect. For UNICEF, stock-out was not an issue, but there were time lags between two PCAs, arising from delays in signing new PCAs. Although UNICEF did provide RUFT for one month (instead of 15 days as in the past) to under treatment SAM children, delays in signing new PCAs caused some children to relapse, requiring a fresh cycle of treatment for those children when the new PCA was signed. The partners advise that even though reasons for gaps experienced by UNICEF and WFP were different, UNICEF can still adopt a strategy similar to that of WFP to remove gaps in supplies in future interventions where supplies are involved. Gaps in PCAs present a huge challenge. This challenge can possibly be addressed by adopting a performance indicator related to gaps.

## 6 Recommendations

Recommendation	Priority	Responsibility
1. In line with UNICEF's institutional priorities for integrated programming and its understanding of the multi-faceted nature of the causes of malnutrition, UNICEF should design and implement integrated programs to address malnutrition. For the context of Tharparkar integrating nutrition-specific intervention with WASH and health is recommended. UNICEF could also explore option of integrating Education because the state of education in Tharparkar is poor, especially for girls, and education as an underlying factor can have a long-term impact.	High	UNICEF
2. A multi-pronged monitoring mechanism was in place, but quality of monitoring reports and document management was an issue: monitoring reports produced by UNICEF Sindh office were not of high quality; reports of monitoring visits by Nutrition Cell and Nutrition Working Group were not available; while third party monitoring had a narrow focus. To address these concerns UNICEF should develop rigorous results-based monitoring mechanism that address quality issues as well as issues related to document management. The monitoring framework should identify ultimate, intermediate and immediate outcomes, and establish specific targets and key performance indicators for each activity, including training events. It should also have a target and strategy for HRGE. It should include follow up on children who have been treated at BHUs and in communities.	High	UNICEF
3. The absence of a tailor-made HRGE analysis and lack of operationalization of commitment to address HRGE concerns was an important weakness. Future projects would do well to conduct an E analysis to inform context-specific actions for addressing HRGE concerns.	High	UNICEF and Partners
4. For future programming related to nutrition, UNICEF should build on its experience of using mobile teams to provide OTP services in remote areas in Tharparkar. UNICEF should use these as a preferred strategy for implementing nutrition projects in areas where population is scattered and distances are long.	Medium term	UNICEF Nutrition Cell Implementing partners
5. How and what messages are delivered to community is partly a function of type and quality of IEC material and partly a function of knowledge and understanding of field staff responsible for delivering these messages. Most of field staff of the implementing partners, if not all, had received training on CMAM and some had also received refresher trainings. However, one-off training and one refresher training not sufficient to build the capacity of field staff. Therefore, more	Medium term	Implementing Partners

Recommendation	Priority	Responsibility
intensive training should be imparted to project staff responsible for directly working with the communities.		
6. Effectiveness of awareness raising activities also depends on methods used for conveying the messages. Implementing partners' approach to community outreach was rather one-dimensional. It almost exclusively focused on verbal communication and written messages placed on the walls of OTP sites. The partners should use more creative media with a strong emphasis on visual media, such as puppet shows, street theatres, videos (at least where possible). FM radio is another medium that partners should use for developing and conveying nutrition related messages.	Medium Term	Nutrition Cell UNICEF Implementing Partners
7. To engage with male community members more effectively and increase their awareness about nutrition, health and hygiene, implementing partners should consider introducing flexi-hours for male social mobilizers. Knowing that it is easy to access male community members in the evening or on a Sunday, working hours of male social mobilizers could be modified to include evening hours and Sunday. For example, social mobilizers can work in the morning, take a longer break in the afternoon and conduct community meetings in the evening. Special incentives should be given for working in evenings and on Sundays e.g. those who work on Sundays can be given one or two extra days off in a month. This uld mean moulding organizations policies and systems to suit community needs rather than expecting male community members to make themselves available for meetings as per the working hours of the partner organizations.	Medium Term	Implementing partners
8. The institution of <i>Otaq</i> (a meeting place) has very deep roots in the culture of Sindh. It offers an excellent venue for engaging with male community members. What is discussed in a meeting in <i>Otaq</i> acquires the potential to become the 'talk of the town'. Somehow this opportunity has been missed. UNICEF and implementing partners should explore ways to use <i>Otaqs</i> for awareness raising activities. Owners of <i>Otaqs</i> in Tharparkar are relatively speaking economically better off and socially-minded people. If they are engaged as focal persons, they can influence many other people who visit their <i>Otaqs</i> .	Medium term	Implementing partners
9. The disconnect between OTP sites and BHUs operated by PPHI is of great concern. It appears that as a result of implementation of the World Bank supported Nutrition Support Project the disconnect between OTP sites and BHUs would be removed, as emergency nutrition support would be	Immediate	UNICEF

Recommendation	Priority	Responsibility
<p>mainstreamed within the primary health system. This would address a major gap identified in the project.</p> <p>10. UNICEF should promote mainstreaming of nutrition services in the primary healthcare system.</p>		
<p>11. Access to and quality of MNCH services needs to be increased. Comprehensive EMOC service is only available at the DHQ hospital in Mithi. Because of long distance and high travel costs, people find it challenging to use MNCH and tend to avoid using these services as far as they can, to the detriment of the health of women and young children. The Government should provide comprehensive EMOC services at the THQ level</p>	Long-term	<p>Provincial Department of Health</p> <p>UNICEF and partners for advocacy</p>
<p>12. Training of staff on CMAM is important to give them an orientation and initial training should be augmented by refresher trainings. This would allow staff to reflect on their experience, share their experience with others and seek solutions for practical problems they face during the implementation. Further capacity building of partner staff is required for more effectively implementing nutrition projects. Capacity building of partners' staff should be emphasized to ensure intervention activities are effective.</p>	Medium term	<p>UNICEF Nutrition Cell</p> <p>Implementing partners</p>
<p>13. It is recognized that skilled human resource can be scarce in contexts like Tharparkar, and it could also be difficult to attract skilled individuals, particularly women, from outside to work in challenging contexts. In such cases, UNICEF should encourage partners to develop monetary as well as non-monetary incentives to attract and retain skilled female workers, both community mobilisers and health care providers.</p>	Medium terms	Implementing pat
<p>14. In addition to mother support groups, father support groups should also be formed to involve fathers and engage them in discussions regarding child health and women health, particularly health of PLWs.</p>	Immediate/ Medium Term	<p>UNICEF Nutrition Cell</p> <p>Implementing partners</p>
<p>15. Transportation costs given to cases of SAM with complications should be commensurate with the distance between home and stabilization centre. PKR 2,000 was not a sufficient incentive for families living in remote areas. Higher amounts should be paid to those who travel long distances. Possibility of conditional cash transfers can be explored.</p>	Medium term	<p>UNICEF Partners</p> <p>Nutrition Cell</p>

## 7 Evaluation Team Statement

We have carried out our procedures and developed this evaluation report as per the scope of work mentioned under contract number 43191417, dated 21 December 2015. This report, solely for the purpose of the Evaluation Humanitarian Action (EHA) is formative and forward-looking to help improve the effectiveness and quality of UNICEF's nutrition response in Tharparkar.

Our report to you is based on the information provided, discussion with management personnel, interviews of UNICEF's Implementing Partners i.e. HANDS and Shifa Foundation and representatives of UNICEF and work steps performed. We have not, except to such extent as you requested and we agreed to undertake sought to verify the accuracy of the data or the information and explanations provided by management. There is an inherent risk involved in deriving factually incorrect information from these sources; accordingly, the correctness of information contained therein cannot be ensured.

The findings in our report are based on our fieldwork from 20 January 2016 to 30 May 2016. We have not undertaken to update our report for events or circumstances arising after that date.

In accordance with our policy, neither EYFRSH nor any Partners or employees undertakes responsibility arising in any way whatsoever, to any person other than the management of UNICEF or any of its implementing partners in respect of the matters dealt with in this report, including any errors or omissions therein, arising through negligence. All analyses in this report, conclusions or assessments have inherent limitations, failure of essential purpose or otherwise. The preceding limitation shall not apply to liability that has been finally determined to have resulted from the fraud or other willful misconduct by or on behalf of EYFRSH.

UNICEF shall not bring any claim relating to the Services or otherwise under this Agreement after 12 months of the act or omission alleged to have caused this claim.

This report discharges of our obligations under the said assignment. Furthermore, any queries in respect of this assignment and the report will be responded to by us if inquired within a period of 3 weeks from the date of this report.

## 8 Annexes

### 8.1 Annex 1: Terms of reference of the evaluation

Object of the evaluation:

The UN initiated response to drought and malnutrition in 2013. With the above backdrop, this was scaled up in 2014 to all 44 Union Councils to effectively address the nutrition needs of most vulnerable populations. The nutrition response is implemented through NGOs, where HANDS and SHIFA Foundation are working in 22 UCs separately – altogether

44 UCs. Both NGOs are helping in implementing nutrition program in district Tharparkar with following services.

- a) Community outreach, including community mobilization, screening of children and pregnant and lactating women for acute malnutrition, promotion of infant, young child feeding, formation of mother to mother support groups;
- b) Targeted supplementary feeding programme (TSFP) to treat children (6-59 months) with moderate acute malnutrition (MAM) and acutely malnourished pregnant and lactating women;
- c) Out Patient Therapeutic Programme (OTP) to treat children (6-59 months) with severe acute malnutrition;
- d) Referral and treatment of acutely malnourished children with medical complications to stabilization center (SC);
- e) Provision of multi-micro-nutrients for prevention and treatment of micronutrient deficiencies among children (6 < 24 month) and pregnant and lactating women and deworming.

UNICEF and WFP have established OTP/TSFP sites in all 44 union councils (UCs) in the district for treatment of severely acute malnourished and moderately acute malnourished children and pregnant and lactating women.

In addition, WHO was supporting the inpatient treatment through technical support to stabilization center.

- ▶ Till date, 177,194 children (6-59 months) and 74,267 pregnant and lactating women are screened at health facilities and community level using MUAC. Among them, 10,495 severely acute malnourished children, 26,370 moderately acute malnourished children are registered and treated in OTP and SFP respectively. Furthermore, 17,370 PLWs are registered and treated in TSFP program
- ▶ A total of 28,538 children are dewormed as part of services package
- ▶ A total of 109,779 pregnant and lactating women are reached for promotion of infant and young child feeding practices.

Furthermore, in addition to the direct nutrition intervention under emergency, UNICEF has also supported the provincial government, mainly Planning and Development Department (P&DD) of Sindh in developing and endorsing a multi-sectoral nutrition strategy in 2013. The nutrition strategy focuses on an integrated approach and takes into account all other relevant sectors that are needed to help address the malnutrition crisis in Sindh.

The planned implementation (as the PC 1 - Government of Pakistan's official document narrating project details) has been approved by the Government in 2015. The approved program, with its proposed components already reviewed by UNICEF, will pave the way and have direct impact through implementation of nutrition specific and nutrition sensitive interventions to address the scale of malnutrition crisis by addressing the immediate, underlying and basic causes effectively. Since Tharparkar is one of the districts included in the approved PC1, hence the nutrition intervention under PC1 will be having the effect of continuity and sustainability of interventions.

#### Purpose of assignment:

The evaluation purpose is evidence generation for humanitarian action through formative and forward-looking evaluation to help improve the effectiveness and quality of UNICEF's nutrition response in Tharparkar and learn lessons for similar future emergencies in Tharparkar or other districts, where applicable. It shall also be reviewing plans and performance in order to provide impartial evidence on how UNICEF has been responding in the initial phase of the emergency operationally and implementation wise. By drawing lessons, the EHA will provide UNICEF with actionable recommendations to facilitate operational and implementation improvements to strengthen the response and the transition to implementation of the integrated approach toward addressing emergency through nutrition multi-sectorial strategy.

The Evaluation will have a strong utilization focus. The main users of the evaluation will be the Pakistan Country Office, the Regional Office and the Global Emergency Unit. At the country level, the EHA will help UNICEF understand which aspects of UNICEF's response to the emergency have been working well and those which are not in relation to established benchmarks and existing guidelines and standards. The EH will also consider how well the response has addressed issues of accountability to the affected population.

Under Delivering as One, UNICEF works in collaboration with other UN agencies, especially during emergencies. The evidence and analysis provided by this Evaluation will also inform other UN agencies as well as the members of the clusters where UNICEF serves as cluster member or lead agency. Moreover, other partners in Sindh in provincial and local governments (e.g., National and Provincial Disaster Management Authorities; Health and P&DD, other departments and other local authorities) participating in the response will also be part of the evaluation and would receive recommendations to improve their work for the emergency in Tharparkar.

At the regional and global level, the EHA is intended to inform both regional and HQ concerned staff to learn from this evaluation and use it for improvement in their work.

#### Evaluation Objectives:

- ▶ To undertake analytical assessment of the progress achieved in implementing nutrition interventions in Tharparkar to identify key achievements, good practices; factors leading toward success or failure of interventions; and gaps / constraints that need to be addressed.
- ▶ To examine performance using standard criteria of EHA such as relevance / appropriateness; efficiency and quality of services; effectiveness, (potential for sustainability and scalability).
- ▶ To examine the use and effectiveness of related cross-cutting issues such as coordination and management; gender and other dimensions of equity.
- ▶ To document good practices and generate evidence-based lessons and recommendations to strengthen multi-sectoral nutrition interventions in Pakistan.

- ▶ To identify the factors (boosters and barriers) in implementing multi-sectoral interventions as per multi-sectoral strategy to address the emergency in Tharparkar.
- ▶ To assess the factors affecting transition to early recovery or linking it with developmental prospective of nutrition.

#### Evaluation Criteria and questions:

The project will be evaluated against the humanitarian evaluation criteria of relevance / appropriateness, efficiency and quality of interventions, effectiveness including coherence, coverage, coordination and connectedness of relief activities. The effectiveness of longer-term programme objectives under the integrated nutrition strategy will also be used. Compliance with UNICEF's evaluation standards shall also be maintained.

The evaluation would like to ask the following main questions to inform the key stakeholders for course correction and future improvement. Based on these, a few sub-questions have been provided in the evaluation matrix to guide further discussion. The given questions and sub-questions should be refined / further developed by the consultants in consultation with UNICEF and key stakeholders during inception phase:

- a) How relevant and appropriate was UNICEF's emergency response to the needs and concerns of local people across various socio-economic groups and minorities in Tharparkar?
- b) How well have UNICEF's resources, both human and financial, been managed to ensure the most timely, cost-effective and efficient response to emergency in Tharparkar?
- c) How successful has UNICEF been in delivering objectives vis-à-vis its programmatic and operational commitments in Tharparkar emergency response?
- d) What are the lessons learnt and recommendations for course corrections in the current programme and enhancing effectiveness of other potential similar emergencies in future?
- e) To what extent cross-cutting issues such as gender, equity, HRBA and climate change were incorporated at various levels of planning and implementation of the response?

#### Evaluation Ethics:

The evaluation will adhere to UNICEF's ethical guidelines. The UNICEF Procedure on ethics will be shared with the evaluation team by UNICEF Evaluation Unit. To confirm informed consent, the consultant will be expected to annex sample consent forms for various types of respondents.

#### Methodology:

In order to help UNICEF gather as much insight as possible with a light footprint on the PCO and UNICEF's partners, the EHA will follow a phased approach, which also allows time for reflection and real-time feedback. The Evaluation will be participatory in its approach, so as to maintain ownership and promote interaction with, and feedback from, the UNICEF response team in country, personnel in the Regional Office and HQ, and from UNICEF's partners. In keeping with the IASC Transformative Agenda, the evaluation will make special efforts to consult the affected population, notably children and women, to help inform the on-going response, and promote accountability. In the same way, it is essential that the evaluation process is rigorous and evidence based. It will employ mixed-methods to triangulate qualitative and quantitative data and reach findings and conclusions in each phase, as outlined in the enclosed evaluation matrix (please see Annex. 1). Furthermore, the evaluation will be participatory in approach – including vulnerable groups, utilization focused, gender and human rights response and equity focused. Lastly, the evaluation will follow UNEG Norms and Standards and UNEG Ethical Guidance.

## 8.2 Annex 2: Evaluation matrix

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
1. How relevant and appropriate was UNICEF's emergency response to the needs and concerns of local people across various socio-economic groups and minorities in Tharparkar?	<p>i) How well consultations with the local communities (including men, women, elderly, adolescents and children) across various socio-economic groups and minorities were carried out and addressed / incorporated their concerns / needs during the design, implementation and monitoring of UNICEF's response?</p> <p>ii) How closely UNICEF's emergency response is aligned with the provincial disaster risk reduction and response plan?</p> <p>iii) How closely UNICEF's programmatic and operational response is aligned with key sources of guidance and normative standards, including the CCCs?</p>	<ul style="list-style-type: none"> <li>- Women, elderly, adolescents and children across various socio-economic groups confirm that they were consulted and their needs and concerns were addressed.</li> <li>- Comparison of UNICEF's emergency response and PDMA response plan shows a close alignment.</li> <li>- A comparison of UNICEF's programme and operational response with key guidance documents including CCCs show that the UNICEF's and its partners have taken the guidance in consideration while designing it.</li> </ul>	<ul style="list-style-type: none"> <li>- health facility / govt. records</li> <li>- MIRA reports</li> <li>- UNICEF monitoring reports</li> <li>- partner NGOs' reports</li> <li>- HMIS / NIS data for the district</li> <li>- LHW reports</li> <li>- Qualitative data from:                             <ul style="list-style-type: none"> <li>o beneficiaries</li> <li>o government partners / officials</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Document review</li> <li>- Recall method with beneficiaries</li> <li>- Key informant Interviews and FGDs with partners, government, and beneficiaries</li> <li>- Before and after comparison (primary and secondary data) of areas where project was implemented and where it was not</li> </ul>

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
2. How well humanitarian action reached target population groups?	<ul style="list-style-type: none"> <li>How many UCs in the district were covered?</li> <li>What percentage of villages were covered?</li> <li>What percentage of population were covered?</li> <li>How many children were screened?</li> <li>How many PLWs were screened?</li> <li>How many children received OTP treatment?</li> <li>How many PLWS benefited from supplementary feeding programme?</li> </ul>	<ul style="list-style-type: none"> <li>Number of UCs covered out of total UCs</li> <li>Percentage of villages where children and PLWs were screened</li> <li>Number of children screened</li> <li>Number of children receiving treatment through OTP</li> <li>Number of children who received supplementary feeding</li> <li>Number of children who benefited from supplementary feeding programme</li> </ul>	<ul style="list-style-type: none"> <li>MIS Data maintained by UNICEF</li> <li>HMIS / NIS data for the district</li> <li>LHW reports</li> <li>Qualitative data from: <ul style="list-style-type: none"> <li>o beneficiaries</li> <li>o government partners / officials</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Review of project progress reports and project completion report</li> <li>Key informant interviews</li> <li>FGDs with beneficiaries</li> </ul>
3. How well have UNICEF's resources, both human and financial, been managed to ensure the most timely, cost-effective and efficient response to emergency in Tharparkar?	<p>iv) To what extent has government / UNICEF's investment in preparedness prior to the emergency resulted in a more timely, cost-effective and efficient response?</p> <p>v) What has supported and / or constrained the efficiency of the response?</p>	<ul style="list-style-type: none"> <li>Cost / beneficiaries analysis</li> <li>HR available for delivering the cost efficient services</li> </ul>	<p>Program document (PCAs)</p> <p>Budget / Financial documents</p>	<ul style="list-style-type: none"> <li>Document review (Work plan, budget, progress report)</li> <li>Interviews with program people.</li> <li>Review of project budgets</li> </ul>

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
<p>4. How successful has UNICEF been in delivering objectives vis-à-vis its programmatic and operational commitments in Tharparkar emergency response?</p>	<p>vi) How well has organization / sector-wide mobilization under the emergency response contributed toward achieving the planned objectives?</p> <p>vii) To what extent has the affected population been properly targeted and reached by UNICEF and its partners?</p> <p>viii) How well various stages (during planning and implementation) of the emergency response were coordinated at district, provincial and national level and among sectors and partners?</p> <p>ix) To what extent nutrition response was integrated with other sectors in addressing the emergency situation?</p> <p>x) To what extent UNICEF's nutrition-specific response was successful in contributing to decrease the child mortality among the children age group (6 to 59 months) in the district Tharparkar?</p>	<p>Analysis of:</p> <ul style="list-style-type: none"> <li>- multi-sectoral response or its absence</li> <li>- Government buy-in</li> <li>- UN coordination</li> <li>- Timeliness</li> <li>- Quality of response</li> <li>- Fund raising</li> </ul>	<ul style="list-style-type: none"> <li>- Provincial departments</li> <li>- (P&amp;DD, Health, Nutrition, Education, WASH, Agriculture, Food Security, Livestock)</li> <li>- UN agencies (WFP, WHO, nutrition working group)Beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>- Key informant Interviews and FGDs with partners, government, beneficiaries</li> <li>- Document review (departmental work plans, meeting minutes, reports etc.)</li> <li>- Project documents</li> </ul>

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
5. To what extent UNICEF response support longer-term goals, what is the likelihood that eventually such needs will be addressed without UNICEF's intervention?	XI) Is UNICEF response aligned with longer term goals of UNICEF and government? XII) How does nutrition intervention fit within UNICEF conceptual framework for nutrition?	- Comparison of intervention objectives with long-term goals of UNICEF and provincial government show that objectives contribute to long-term goal - Comparison with UNICEF's conceptual framework for understanding malnutrition	- Primary data collected using qualitative methods - Review of secondary data	Key informant interviews (with UNICEF, PDMA, P&D, Health Department) Desk review of key documents (e.g. nutrition strategy)
6. To what extent are policies and practices of different actors involved in emergency are complementary or contradictory or whether politics fosters	xiii) What are policies of and practices of different actors related to emergency response? xiv) How do these policies related to each other?	- Analysis of policies and practices of different actors (UNICEF, other NGOs, PDMA, Provincial Government)	- Policy documents - Key informant interviews	Desk review of key policy documents Interviews with key informants representing key actors (e.g. UNICEF, other NGOs, PDMA, Provincial Government)

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
7. What are the lessons learnt and recommendations for course corrections in the current programme and enhancing effectiveness of other potential similar emergencies in future?	xi) What other strategies/ interventions from sectors other than nutrition could have been employed to better achieve the results planned under the emergency response? xii) How effectively has UNICEF fulfilled its cluster leadership/ coordination obligations? xiii) How effectively UNICEF's emergency response could have integrated with other sectors at various stages of emergency response for achieving better results?	- Identification of barriers and boosters in the project / program. - Cluster mechanism (frequency of coordination, partners involve in coordination) - Multi-sectoral partners involvement into emergency response at district level - Analysis of current situation and recommendations of the integrated nutrition strategy	Periodic progress report Cluster bulleting Cluster meeting minutes SitREPs4 W matrix. Multi-sector partners mapping Provincial departments (P&DD, Health, Nutrition, Education, WASH, Agriculture, Food Security, Livestock)	Key informant interview ( Health department both provincial and district level) Documents review

Questions	Sub-Questions	Judgment Criteria	Expected Sources	Method
8. To what extent cross-cutting issues such as gender, equity, HRBA and climate change were incorporated at various levels of planning and implementation of the response?	xiv) How successful has UNICEF been in reaching the most vulnerable groups in the most affected geographic areas? xv) Have data been disaggregated by sex, age, disability status, and ethnicity? xvi) To what extent has equity based approach contributed to better results for children and young people?	Geographical selection based on equity. Gender disaggregated data collected and analysed Data on disability - Analysis of current situation and recommendations of the integrated nutrition strategy - Identification of bottlenecks / gaps - Recommendations on removal of bottlenecks / gaps	Program information data (NIS) Progress reports Rapid assessment / other baseline document on situation Provincial departments (P&DD, Health, Nutrition, Agriculture, Food Security, Livestock) UN agencies (WFP, WHO and others) Beneficiaries	NIS data review Other program progress report review Beneficiaries interview - Interviews and FGDs with partners, government, beneficiaries - Document review (meeting minutes, reports etc.) - Program

### 8.3 Annex 3: Stakeholder map

Stakeholders	Interests	Likely impact interventions
<p><b>Primary stakeholders</b></p> <p>UNICEF</p> <p>IPs (HANDS and Shifa Foundation) Government Health Department, Sindh Nutrition Cell</p> <p>Communities in Tharparkar District Health Department World Food Programme (WFP)</p> <p>World Health Organization (WHO)</p>	<p>Reducing child mortality and morbidity is its core mandate of UNICEF</p> <p>Contributing to improve health. Partnership with a reputed agency like UNICEF. Earning a reputation for good work.</p> <p>Improving situation of health in Sindh</p> <p>Core mandate of nutrition cell to improve nutrition and monitor nutrition related projects in Sindh</p> <p>Reducing child mortality and morbidity and improving health of women</p> <p>Improving situation of health in Tharparkar</p> <p>Improving food security in the country</p> <p>Improving health in the country</p>	<p>+</p> <p>+</p> <p>+</p> <p>+</p>
<p><b>Secondary Stakeholders</b></p> <p>Provincial Disaster Management Authority (PDMA)</p>	<p>Responding to emergency and reducing disaster risks in the province of Sindh</p> <p>Responding to emergency and reducing disaster</p>	<p>+</p>

Stakeholders	Interests	Likely impact interventions
District Disaster Management Authority, Tharparkar	risks in the province of Sindh	+
Local Politicians	They have interest in improving health situation, otherwise they could earn a bad name	
Peoples Primary Health Initiative (PPHI)	As manager of “contracted out” primary healthcare services they have interest in managing health services in the province.	+

#### 8.4 Annex 4: List of documents consulted / References

- ▶ ALNAP Pilot Guide for Evaluation of Humanitarian Action, 2013, <http://www.alnap.org/what-we-do/evaluation/eha>
- ▶ Annual Work Plan, Midyear Review 2014, Nutrition Sindh, UNICEF, 17-Jun-14
- ▶ An extract from a document that appears to describe an M&E plan (no reference is given to document)
- ▶ Community Based, Sentinel Site Surveillance (CSSS), Dera Ismail Khan and Tank, Districts Of Kp, Pakistan (Draft Report), Apr-2014
- ▶ Consolidated Coverage Investigation Report for Three Districts Of Khyber Pakhtunkhwa Province (draft), Pakistan (Apr-14)
- ▶ Ethical Guidelines for Evaluation, UNEG, March 2008, <http://www.uneval.org/document/download/548>
- ▶ District Tharparkar Geography with Nutrition Data Glimpse, Sindh, Pakistan
- ▶ Multiple Indicator Cluster Survey, UNICEF, January, 2015
- ▶ Integrating Human Rights and Gender Equality in Evaluation -- Towards UNEG Guidance, UNG, 2011, <http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/IOS/temp/HRGE%20Handbook.pdf>
- ▶ Integrated nutrition interventions for conflict and flood affected children and women in Pakistan- (Jan-12)
- ▶ Multiple Indicator Cluster Survey (MICS), Sindh 2014, Sindh
- ▶ Norms for Evaluation in the UN System, UNEG, April 2005, <file:///Users/Aslam/Downloads/Revision%20of%20UNEG%20Norms%20and%20Standards-March%2019.pdf>
- ▶ Nutritional Anthropometry Survey Report, Kohat, Hangu, Di Khan, Peshawar, Nowshera, Tank Districts
- ▶ Nutrition and Mortality Survey Tharparkar, Sanghar and Kamber Shahdadkhot districts of Sindh Province, Pakistan, 18-25 March, 2014)
- ▶ Need Assessment Report 2013 (tables in an excel sheet in draft form)
- ▶ Needs and Gaps Analysis District: Kashmore, Sindh May-13
- ▶ Nutrition Bulletin Jan-July 2014 Nutrition Working Group –Sindh (Aug-14)
- ▶ Nutrition Technical Update – UNICEF, January to December 2013
- ▶ Nutrition Transition Plan, Sindh Province, Pakistan, from Emergency to Development. Nutrition (Nov-13)
- ▶ Nutrition Response in Pakistan, UNICEF, January 2011
- ▶ Research Ethics Training Curriculum (2nd Ed). Roberto Rivera, David Borasky. 2009
- ▶ Semi Quantitative Evaluation of Access and Coverage (SQUEAC), Nutrition Cluster, Sindh, (April 2013)
- ▶ Situation of Infant and Young Child feeding Practices Umerkot District, Sindh, Pakistan, January 2 – 10, 2014
- ▶ Single Form for Humanitarian Aid Action submitted to ECHO for the project “ Nutrition interventions for emergency affected children and women in Pakistan”, 1 July 2013.
- ▶ Single Form for Humanitarian Aid Action submitted to ECHO for the project “Integrated nutrition interventions for conflict and flood affected children and women in Pakistan”. 1 July 2012
- ▶ Single Form for Humanitarian Aid Action submitted to ECHO for the project, “ Nutrition Response in Pakistan, 1 September 2011, UNICEF
- ▶ Single Form for Humanitarian Aid Action submitted to ECHO for the project, “Strengthening support to nutritional interventions for flood- affected populations in Sindh and Punjab Provinces of Pakistan 1 December 2010
- ▶ Training of Trainers (TOT) Report. Five days training of trainers on infant young child feeding (IYCF)
- ▶ Training Report on Five Day TOT on CMAM 20-May-14

- ▶ Third Party Field Monitoring Report – UNICEF Regular Program (16-May-15)
- ▶ Third Party Field Monitoring Report – UNICEF Regular Programme (1-Jun-15)
- ▶ Third Party Field Monitoring Report – UNICEF Regular Programme (1-Jul-15)
- ▶ Third Party Field Monitoring Report – UNICEF Regular Program (1-Aug-15)
- ▶ Third Party Field Monitoring Report – UNICEF Regular Program (1-Sep-15)
- ▶ Third Party Field Monitoring Report – UNICEF Regular Program (1-Oct-15)
- ▶ Third Party Field Monitoring- Final Field Monitoring Project completion Report (17- Mar-14)
- ▶ *UNEG. Norms for Evaluation in the UN System. April 2005* *UNEG. Ethical Guidelines for Evaluations. March 2008*
- ▶ UNICEF Procedure for Ethical Standards in Research, Evaluations and data Collection and Analysis, April 2015

## 8.5 Annex 5: List of key informants consulted

### 5 A: List of Key Informants Interviewed

S.No.	Name	Designation	Institutional Affiliation	Method
1	Dr. Umar Khan	Project Officer, Nutrition	UNICEF, Country Office	KII
2	Saeed	Project Officer, Nutrition	UNICEF, Country Office	KII
3	Masooma	Project Officer, Humanitarian	UNICEF, Country Office	KII
4	Presia	Humanitarian Programme Specialist	UNICEF, ROSA	Telephonic interview
5	Mussarrat Yousuf	Evaluation Specialist	UNICEF, Country Office	KII
6	Dr. Shehla	Nutrition Officer	UNICEF, Sindh	Group Interview
7	Dr. Ayaz	Nutrition and Health Specialist	UNICEF, Sindh	Group Interview
8	Dr. Naila	Nutrition Cluster Coordinator	UNICEF, Sindh	Group Interview
9	Mubashira Irum	WASH Officer	UNICEF, Sindh	Group Interview
11	Dr. Kamran	Programme Manager	Shifa Foundation	KII
12	Zia Ur Rehman	District Project Manager	Shifa Foundation	Group Interview
13	Ghulam Ali	District Project Manager	Shifa Foundation	Group Interview
14	Dr. Salman	Senior Programme Manager	HANDS	KII
15	Dr. Satram	District Manager	HANDS	KII
16	Umair Soomro	District Project Manager	HANDS	KII
17	Baharat Maharaj	Taluka Coordinator (Diplo)	HANDS	KII
18	Dr. Sikandar	Pediatrician	Stabilization Center, DHQ	Group Interview

S.No.	Name	Designation	Institutional Affiliation	Method
19	Dr. Bawan	Pediatrician	Stabilization Center, DHQ	Group Interview
20	Dr. Rabael	NDS	Concern Worldwide	Group Interview
21	Dr. Shehzad	District Commissioner	PDMA	KII
22	Dr. Arjun Kumar	District Health Officer (DHO)	District Health Department, Tharparkar	KII
23	Dr. Bansi Dor	Coordinator LHW Programme	District Health Department, Tharparkar	KII
24	Khalil Ahmed	District Manager	PPHI	KII
25	Dr. Yasir	Nutrition Officer	WFP	Group Interview
26	Dua	Programme Officer	WFP	Group Interview
27	Irfan Malik	Head Officer	WFP	Group Interview
28	Dr. Mazhar Alik Kashani	Chief of Party	Nutrition Support Programme	Group Interview
29	Dr. Suhail		Nutrition Support Programme	Group Interview
30	Dr. Fawad Shaikh	Chief Planning Officer, P&D	P&D	KII
31	Dr. Jeerat Rai	Planning Officer, P&D	P&D	KII
32	Zarina Fazle Illahi	Community Member	West Color Colony	KII
33	Rupa	Community Member	village Mehwath, UC Jorio, Mithi	KII
34	Hanifa	Community Member	Mithio Bhatti, UC Loondar, Mithi	KII
35	Lakshmi	Community Member	Sabhusan	KII

### 5 B: List of Partner Field Staff Interviewed

S.No.	Name	Designation	Institutional Affiliation	UC
1	Liaquar Faqeer	Interview with DA	Shifa	Chachro
2	Niaz Muhammad	Interview with DA	Shifa	Chellar
3	Zulifquar Ali	Interview with DA	Shifa	Daheli
4	Imran Ali	Interview with DA	Shifa	Nagarparkar
5	Adnan Khalid	Interview with DA	Shifa	Warewah
6	Aqsa	Interview with IYCF	Shifa	Chachro
7	Moomal Kumari	Interview with IYCF	Shifa	Chellar
8	Saira younus	Interview with IYCF	Shifa	Daheli
9	Mehwish ali syed	Interview with IYCF	Shifa	Nagarparkar
10	Jamila Nizamani	Interview with IYCF	Shifa	Warewah
11	Kishore kumar	Interview with OTP Nurse	Shifa	Chachro
12	Qudoos Ahmed	Interview with OTP Nurse	Shifa	Daheli
13	Rashid	Interview with OTP Nurse	Shifa	Nagarparkar
14	Aneela	Interview with OTP Nurse	Shifa	Warewah
15	1-Zakia khoso 2-Basheer Ahmed	Interview with community mobilizer	Shifa	Nagarparkar
16	1) Satram Das 2) Shazia Junejo	Interview with community mobilizer	Shifa	Chachro
17	1-Lajpat Rai 2-Jalal din Nohri 3-Rukhsana Umrani	Interview with community mobilizer	Shifa	Daheli
18	Peero mal	Interview with community mobilizer	Shifa	Warewah
19	Shahmeer	Interview with DA	HANDS	Diplo
20	Suresh Vallasai	Interview with DA	HANDS	Jhirmrio

S.No.	Name	Designation	Institutional Affiliation	UC
21	Shankar lal	Interview with DA	HANDS	Mathiro Bhatti
22	Kamlesh Kumar	Interview with DA	HANDS	Sonal Bah
23	Allah Nawaz	Interview with Community mobilizer	HANDS	Diplo
24	Ishwar Singh	Interview with Community mobilizer	HANDS	Jhirmrio
25	Predan	Interview with Community mobilizer	HANDS	Mathiro Bhatti
26	Abdul Mutlab	Interview with Community mobilizer	HANDS	Sonal Bah
27	Afshan Ali Solangi	Interview with IYCF	HANDS	Mithi
28	Pashmina solangi	Interview with IYCF	HANDS	Jhirmrio
29	Sumand Pehwal	Interview with IYCF	HANDS	Mathiro Bhatti
30	Nusrat Rehman	Interview with IYCF	HANDS	Sonal Bah
31	Dilber	OTP nurse Interview	HANDS	Diplo
32	Mashoque Ahmed	OTP nurse Interview	HANDS	Jhirmrio
33	Pervez ahmed	OTP nurse Interview	HANDS	Mathiro Bhatti
34	khesingh	OTP nurse Interview	HANDS	Sonal Bah

## 8.6 Annex 6: List of OTP Sites Visited by Evaluation Team

### 8.7

S#	Name of village/ OTP site	Taluka	UC	Implementing partner
1	Chelar	Chahro	chelar	Shifa foundation
2	Badha sandha GD	Chahro	Chachro	Shifa foundation
3	Kethe jo tar GD	Chahro	Dahli	Shifa foundation
4	Mokhae	Nagarparkar	werawah	Shifa foundation
5	THQ mithi	Nagarparkar	Nagarparkar	Shifa foundation
6	Goddar	Mithi	Mithrio bhatti	Hands
7	THQ Diplo	Diplo	Diplo	Hands
8	Arnaryo	Islamkot	Sonal Bah	Hands
9	DHQ mithi	Mithi	Mithi DHQ mithi	Hands
10	Sar Junejo GD	Diplo	Jhirmiryo	Hands

## 8.8 Annex 7: Tools for FGD

### Guidelines for FGDs

#### Instructions for Moderators of FGDs

##### Instructions for Moderators

Greet the participants make them comfortable by talking about weather then clearly state the purpose of the FGD

Inform the group about the purpose of the interview

Specifically seek consent for the participation in interview

This is not a question answer session probing is an essential skill you have been oriented on in the training so probe ask any other sub question that comes to your mind after the respondents answer – but probing should be done after they themselves answer don't put words in their mouth by probing first

Be respectful let people speak their minds – do not interrupt

If elderly are participating pay special attention to hear them out pay attention to their needs and specific problems they share

Make sure persons with disabilities inform on the specific problems they face and the causes of these problems same is with elderly and their members who are more likely to face discrimination and injustice for example members of religious or ethnic minorities

In all instances don't stop at asking about issues and confirm that the causes of these issues are discussed and properly documented Maintain privacy, confidentiality

Note taker must ensure that following items are noted on the notebook: Names of Taluka, UC and Village Names of Moderator and Note Taker

Names of participants

##### Indicative Template for Introduction

Good morning and welcome. Thanks for taking the time to join our discussion about malnutrition among children and women and some of the work that may have been done in your area to address this issue. My name is \_\_\_\_\_, and I will serve as the facilitator for today's Focus Group Discussion. Assisting me is \_\_\_\_\_ and \_\_\_\_\_. The purpose of today's discussion is to get information from you about prevalence of malnutrition in your area and initiatives to address this issue. Please note that there are no right or wrong answers to the questions I am about to ask. I understand that you - can have differing points of view. Please feel free to share your point of view even if it is different from what others may say. If you want to follow up on something that someone has said, you want to agree, disagree, or give an example, please feel free to do that. Don't feel like you have to respond to me all the time. Feel free to have a conversation with one another about these questions.

I am here to ask questions, listening, and make sure everyone has a chance to share. We're interested in hearing from each of you. So if you're talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you. We just want to make sure we hear from all of you. We will be taking notes to help us remember what is said. (We are also recording this session because we don't want to miss any of your comments.) Let's begin by having each person in the room tell us their name and a little bit about themselves, your role in the community, what do you do for livelihood and anything else you'd like to share.

The facilitator starts with question once participants finish introducing themselves.

#### 8.8.1 Guiding Questions for FGDs with Mother Support Group

1. What is the purpose of the group?
2. How was it established?
3. Who established? Who is included in it? When was it established?
4. How often do you meet?
5. How many times have you met so far?
6. When you meet what do you discuss in the group?
7. How long does the meeting typically last?
8. Who participates?
9. How many participate?
10. Where is meeting held?
11. Who organizes it?
12. Do you keep record of attendance?
13. When did you the group meet last time? Who participated in it? What was discussed? Where was the meeting held? How many women participate?
14. What benefits did you gain from participating in the group?
15. What did you learn?
16. How does you participation in the group help you?
17. What would you lose or if you had not participated in the support group? Do women need to eat more during pregnancy? What nutritious is food required for pregnant women?
18. What type of support or advice do you give when women become pregnant?
19. Who is responsible to look after the new-born baby especially during the first day/s?
20. As a member of mother support group how you advice to mother regarding the care to new- born baby?

21. What lessons did you learn as a result of your participation in the project activities?
22. What are your commendations for improvement?

#### 8.8.2 Guiding Questions for FGDs with Pregnant and Lactating Women (PLW)

1. Do / Did you receive antenatal check-ups / Visits (at least 4 during pregnancy)?
2. Are you pregnant or giving milk to your child?
3. How many children do you have? How old is the youngest one?
4. How are you feeding your baby?
5. How many hours after the child was born did have had his/her first feed?
6. Are you giving him any other food or drink in first 6 months? What made you decide to do that? (Mixed Feeding)
7. What is exclusive breast-feeding means? (Not even giving them water)
8. What are signs that your baby is hungry?
9. What is the concept of "extra meal" during pregnancy?
10. What type of support did you receive?
11. Did you receive any tablets (Iron, Folic acid and Vitamin A)? How are those tablets given to you? How often?
12. Why are those given to you? What is the reason for giving tablets to you?
13. How regular are you in eating tablets?
14. Did they always breastfeed their babies (ones born earlier). If they did not have babies earlier ask why they did breast fed their babies?
15. Would they breast feed their babies anyway?
16. Where they learn about importance of breast feeding?
17. What infant and young and child feeling messages did you receive from project team? What do you remember? Which one do you practice? Which one cannot practice? Why not?
18. Did you children receive any nutritional services (SFP, OTP and services at stabilization centre, micronutrient supplementation)?
19. Did you receive any nutritional support?

### **Guiding Questions for FGDs with Male Community Members**

#### **Knowledge of CMAM**

1. Are you aware of any nutrition service at your local clinic?
2. Who told you about it?
3. When did you hear about it?
4. What do you know about it?
  - a) Target children?
  - b) Admission criteria?
  - c) Treatment given?
  - d) Free treatment?
  - e) What days is treatment available?
  - f) Identification of children?

#### **Role / Sensitization**

5. Have you told others about the service? How? When?
  - a) Usual channels / message dissemination? Barriers
6. Are you aware of any children who need treatment but are unable to access services?
  - a) What stops them coming? (distance / family / beliefs / other)
  - b) How could we reach these children / encourage them to attend?

#### **Knowledge of Cases**

7. Do you know any children receiving treatment?
  - a) What can you tell me about them?
8. Do you know any children who have defaulted / stopped coming?
  - a) Why is that?
  - b) How can we encourage them to return for treatment?

#### **Communications**

9. Do you know who the volunteer is for this service?
  - a) When did you last see them?
  - b) What do they do? (frequency and organization of activities)

10. Have you had any feedback from the volunteer / clinic staff / Government Health officials about the service?

a) Do you know what the results are?

**Perceptions of CMAM**

11. What are people saying about intervention to prevent malnutrition in your area?

a) Do you think most people are aware of it?

b) What do they understand about it?

12. What do you think of the service?

a) What do other key community figures think of it?

**Improvements**

13. How can we improve the service?

14. Do you have any messages for those running the service?

15. What could have been done differently?

## 8.9 Annex 8: Tools for key informant interviews

### Semi-Structured Interview Guides for Key Informant Interviews

#### Questions for Interview with Nutrition Specialist - UNICEF

1. What is the history of involvement of UNICEF in Nutrition in Sindh? What about current involvement? How is it decided to intervene?
2. What is / was the broader involvement of UNICEF? What is emergency related involvement of UNICEF?
3. What are the linkages between nutrition related intervention and emergency programme?
4. How were needs identified? Who identified them?
5. Drought being a slow-onset hazard agencies involved in providing nutrition should have been able to plan much ahead based on the early warning system? Why it could not be done?
6. Does UNICEF always work with local implementing partners?
7. How were partners chosen? Why were Shifa and HANDS chosen?
8. What else was considered?
9. How much nutrition related PCAs have you signed? With how many partners? How happy are you with your choice of partners?
10. How many UCs did you cover? (Apparently 24 with Shifa Foundation and 20 with HANDS)
11. What kind of activities do you do? Screening (SFP, STP, SC, micronutrient support for children and mothers, support group for mothers)
12. Where are nutrition sites typically established? How are sites chosen?
13. How are nutrition's sites chosen? UCs a large area? How is access ensured to remote villages?
14. One LFA mentions OTP sites re-established, while HANDS proposals mentions additional sites established? Similarly, it says teams are re-hired? Why is this?
15. Who does the screening? Are they doctors? Who supervises them? How is the quality of work on the ground ensured?
16. How are mothers for support group identified? How is the number of mothers in each support group determined? What is the purpose of establishing women's group? What do they do on a day to day basis?
17. What is the relationship with UNICEF? What is the role of UNICEF? What is the role of nutrition cell? What is the relationship with WFP?
18. What differences was there between different PCAs? What changes were introduced, if any, and why?

19. What were your expectations of the project?
20. Which expectations were filled and which expectations were not fulfilled?
21. What challenges did you face in implementing the programme?
22. How did you address the challenges?
23. What could have been done differently?
24. Part of your project was to develop capacities of NGOs and government agencies and IP itself? How were these capacities built?
25. What capacities of government agencies built and what capacities of NGOs and IPs built?
26. What local capacities have been built? [building capacity of both governmental health system and NGOs staff to prevent, identify and treat malnutrition]
27. What role did UNICEF play in inter-agency coordination, collaboration with government stakeholders at design, implementation and phase over stages?
28. As a result of increased capacities what could happen in future that does not happen now? What limitations would be addressed?
29. What are context specific practices that UNICEF has learnt as it result of its experience?
30. What is your assessment of environment of CMAM? Is the environment for CMAM enabling?
31. What is your assessment of role of national and provincial leadership?
32. What is your assessment of monitoring mechanisms in place?
33. What about record keeping?
34. How accessible are CMAM Supplies? What are issues related to procurement of CMAM supplies? Did these issues also affect the current projects? [review of external monitoring show that occasionally some supplies were not available at OTP sites?]
35. What systems are in place for management of CMAM equipment supplies (distribution ad storage and stock management)? Does this have any implication for how projects are managed on the ground? I understand that signing of PCA with Shifa

**Questions for Meeting with Humanitarian Programme Expert - UNICEF**

1. What is UNICEF emergency programme?
2. What are the focus areas for emergency?
3. What are focus geographic areas?
4. How a decision to intervene is taken? What is the threshold for intervention in case of an emergency? What factors contribute to decision?
5. How does Nutrition programme fit in emergency?
6. Why should nutrition become an emergency when NNS established that nutrition is a big problem and food insecurity can be predicted through early warning system?
7. How did nutrition interventions in Tharparkar fit in overall emergency programme?
8. It appears that it has been conceptualized separately from other emergency interventions?
9. What is the on ground links with the emergency interventions?
10. What are your observations of nutrition programme on the ground?
11. What did you see?
12. What are strengths of the nutrition intervention
13. What are some of the weaknesses?

### **Questions for Interview with Senior Management of Shifa Foundation**

1. Tell me something about Shifa Foundation? What is your mandate? What types of activities do you do? How big is Shifa Foundation, number of staff members? Offices? Yearly budget?
2. What are your target geographic areas? How do you finance your projects?
3. What other agencies donor agencies do you work with? UN or other agencies?
4. What is the history of involvement of Shifa with UNICEF? What projects did you do with UNICEF? How about involvement of Shifa in nutrition? How about involvement of in nutrition projects with UNICEF?
5. Involvement in Tharparkar?
6. How many PCAs have you implemented? I have document for one, but it also mentions another one? Are you still implementing the Nutrition activities?
7. How many UCs do you cover?
8. What kind of activities do you do? Screening (SFP, STP, SC, micronutrient support for children and mothers, support group for mothers)
9. Where are nutrition sites typically established? How are sites chosen?
10. How are nutrition's sites chosen? UCs a large area? How is access ensured?
11. LFA mentions OTP sites re-established, while HANDS proposals mentions additional sites established? Similarly, it says teams are re-hired? Why is this?
12. Who does the screening? Are they doctors? Who supervises them? How is the quality of work on the ground ensured?
13. How are mothers for support group identified? How is the number of mothers in each support group determined? What is the purpose of establishing women's group? What do they do on a day to day basis?
14. What is the relationship with UNICEF?
15. What is the relationship with WFP?
16. What is the role of nutrition cell? What is the role of UNICEF? What are your linkages and relationships to WFP?
17. What differences was there between different PCAs? What changes were introduced, if any, and why?
18. What were your expectations of the project?
19. Which expectations were filled and which expectations were not fulfilled?
20. What challenges did you face in implementing the programme?
21. How did you address the challenges ?

22. What could have been done differently?
23. Part of your project was to develop capacities of NGOs and government agencies and IP itself?  
How were these capacities built?
24. How were Shifa foundations capacities built?

### **Questions for Interview with Management of HANDS**

1. What is history of your involvement with nutrition projects and with emergency nutrition projects?
2. What are your target geographic areas? How do you finance your projects?
3. What other agencies donor agencies do you work with? UN or other agencies?
4. What is the history of involvement of Shifa with UNICEF? What projects did you do with UNICEF? How about involvement of Shifa in nutrition? How about involvement of in nutrition projects with UNICEF?
5. Involvement in Tharparkar?
6. How many PCAs have you implemented? I have document for one, but it also mentions another one? Are you still implementing the Nutrition activities?
7. How many UCs do you cover?
8. What kind of activities do you do? Screening (SFP, STP, SC, micronutrient support for children and mothers, support group for mothers)
9. Where are nutrition sites typically established? How are sites chosen?
10. How are nutrition's sites chosen? UCs a large area? How is access ensured?
11. LFA mentions OTP sites re-established, while HANDS proposals mentions additional sites established? Similarly, it says teams are re-hired? Why is this?
12. Who does the screening? Are they doctors? Who supervises them? How is the quality of work on the ground ensured?
13. How are mothers for support group identified? How is the number of mothers in each support group determined? What is the purpose of establishing women's group? What do they do on a day to day basis?
14. What is the relationship with UNICEF?
15. What is the relationship with WFP?
16. What is the role of nutrition cell? What is the role of UNICEF? What are your linkages and relationships to WFP?
17. What differences was there between different PCAs? What changes were introduced, if any, and why?
18. What were your expectations of the project?
19. Which expectations were filled and which expectations were not fulfilled?
20. What challenges did you face in implementing the programme?
21. How did you address the challenges?

22. What could have been done differently?
23. Part of your project was to develop capacities of NGOs and government agencies and IP itself?  
How were these capacities built?
24. How were HANDS capacities built?

### **Questions for Interviews with OTP Nurse**

1. What are the Key Messages for OTP?
2. What are the enrolment procedures and criteria for admission in OTP and action / medical protocol for OTP?
3. How to maintain the ration of RUTF? What is RUTF / compositions?
4. How to calculate that how much RUTF is needed per month assuming that imported RUTF is packed in cartons of 150 sachets?
5. What is iron and folic acid protocol for OTP?
6. What is referral protocol from Supplementary Feeding Program (SFP) to OTP?
7. What is the exit / Referral procedure and criteria for OTP to SPF or SC?
8. How to do the appetite test? How to take the follow up history and do examination?
9. How the links between health facility and community is established? How to do a follow up for absent or defaulted child in the community?
10. How you manage to avoid break in supplies? How the stocks are stored? What is the necessary equipment and supplies available for OTP / SFP?

### **8.10 Questions for Interview with IYCF Counsellor**

1. What key messages of Infant, young and child-feeding (IYCF) message did you convey to caregivers?
2. What is early initiation of Breast Feeding?
3. What is "Exclusive Breast Feeding"?
4. What is "Foremilk" (has more water and satisfy the baby's thirst) and the "Hindmilk" (The nutritious part which has more fats and satisfy baby hunger)?
5. How to feed the sick baby aged less than six months?
6. What is complimentary feeding? What should be the frequency, variety and amount?
7. What messages do you expect them to remember? Why?
8. Which messages do you not expect them to remember? Why not?
9. When should the baby be breastfed after delivery? (Check for colostrum's feeding as well),
10. What are mothers given to eat after the delivery?
11. Do mothers need any extra food after delivery? What?
12. After what age should children be given complementary food?

13. What complementary food is actually given to children to eat?

### **Questions In-Depth Interviews with Community mobilizers**

1. How long have you been working as community mobilizer?
2. Why did you become community mobilizer?
3. What your responsibilities as community mobilizer?
4. What is your coverage area? How many households?
5. How did you identify malnourished children?
6. What methods do you use?
7. How often did you visit households?
8. How do you start the community Dialogue with community regarding nutrition?
9. What are the basic causes, identification criteria and treatment options of malnutrition? How do you do case finding exercise? How you do the case referral? What type of Health and nutrition education (prevention) do you impart at community level?
10. How many active cases (malnourished children) did you identify?
11. How you measures MUAC (Mid Upper Arm Circumference (MUAC), measuring weight, taking height and length and how to use the weight / height ratio tables?
12. How you check for edema in Children? What are the criteria for admission / referral in OTP or SC?
13. How you sensitize the community leaders understand purpose of the program?
14. How you follow up absent and defaulted children?

### **Questions for Interview with Distribution Assistant**

1. How long have you been working as distribution assistant?
2. What are your main responsibilities?
3. What are the enrolment procedures and criteria for SFP?
4. What are SFP routine supplies / medicines?
5. What are MMS? How you do registration in SFP?
6. How you fill SFP ration card?
7. What is the exit procedure and criteria for SPF?
8. What are the Key messages for SFP?

### **8.11 Annex 9: Questionnaire for Mini-Survey**

For mothers / care takers about CMAM & use of RUTF/RUSF & IYCF

#### **Understanding of Malnutrition**

1. When did you first notice that your child was unwell?
  - a) What was wrong with them?
  - b) What symptoms did they have?
  - c) What did you do?

#### **Outreach**

2. How did you first hear about the service?
  - a) Who told you?
  - b) Have you heard about it from any other source since?
  - c) Who is telling people about it in your settlement / area?
3. What did you hear about it?
4. What made you go to OTP site?

#### **Time**

5. How long has your child been attending the clinic?

#### **Explanation from Nurse**

6. What did the clinic staff tell you about your child's condition?
7. What were you told about the treatment?
8. What do the staff call the treatment?
  - a) What do you call the treatment?

#### **Other Cases / Case Referral**

9. Do you know of other children who have the same problem but who are not attending the clinic?
  - a) If yes, why not?
10. Have you told anyone else to bring their child to the clinic?
  - a) Why / why not?

#### **Distance**

11. How far is it from your home to the clinic?

- a) How do you get here? Walk / transport?
  - b) How long does it take?
  - c) Determine the farthest distance travelled
12. Do you have any other reason to come to this clinic / this place?

**Standard of Service**

13. What do you think of the service?
- a) What are the strengths / good things?
  - b) What are the weaknesses?
  - c) What could be improved?
14. How long do you usually wait before the nurse sees you?
15. How much time do you spend with the nurse?
- a) How do the staff treat you?
  - b) Have you ever been scolded? Why?
16. Have you always received the correct supply of treatment sachets (RUTF / RUSF?)
- a) Have there been any shortages of RUTF / RUSF on any week?
  - b) Have you ever not received the full amount / or received something else instead?

**Infant, Young and Child Feeding (IYCF)**

17. What key messages of Infant, young and child feeding (IYCF) message did you receive you're your caregivers?
18. When should breast feeding should start? Till what time should they be exclusively breast fed? What complementary feeding practices do you follow?
19. What else do you feed your children apart from you your own milk? What has changed?
- Has it always being so? What other things are fed traditionally? When should complementary feed begin? When did you start?

**Absence / Defaulting**

20. How easy is it for you to come every week?
- a) What makes it difficult for you to come / what stops you from coming sometimes?
21. Do you know of any children who have stopped coming?
- a) Why is that?

b) How can we encourage these children to return and continue the treatment?

**Perception of CMAM / Feedback**

22. What are people saying about the service in your settlement / area?

23. Have you any messages you want us to give to the people running the service?

## 8.12 Annex 10: Observations Checklist

### Performance Checklist for OTP Site

Questions	Means of Verification	Remarks
<b>Infrastructure: Are the following facilities available?</b>		
Shelter for weighing and consultation		<input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting area or covered shelter		<input type="checkbox"/> Yes <input type="checkbox"/> No
Breastfeeding corners available?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Water and Sanitation: Are the following services present?</b>		
Safe drinking water availability		<input type="checkbox"/> Yes <input type="checkbox"/> No
Waste collection system for empty RUTF / RUSF and non- medical waste		<input type="checkbox"/> Yes <input type="checkbox"/> No
Waste collection system for and medical waste		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Staff: Are the following HR elements present?</b>		
OTP Staff		<input type="checkbox"/> Yes <input type="checkbox"/> No
Job description		<input type="checkbox"/> Yes <input type="checkbox"/> No
Ongoing staff training		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Material: Are the following printed material present?</b>		
OTP/SFP ration cards for all beneficiaries		<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard CMAM protocol available on site?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Stock control of following items in place?</b>		
RUTF / RUSF		<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicines		<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-food items		<input type="checkbox"/> Yes <input type="checkbox"/> No

## Performance Checklist for SAM

Monitoring Checklist for Outpatient Department (OTP) of Severe Acute Malnutrition (SAM)

Date \_\_\_\_\_

Location \_\_\_\_\_

Health Facility Type \_\_\_\_\_

	Questions	Means of Verification	Remarks
<b>Input Indicators</b>			
1	Are there adequate staff at the OTP site? Dose clear job description available for each staff member?	Community Mobilizers,	<input type="checkbox"/> Yes <input type="checkbox"/> No
		OTP Nurse	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Distribution assistant	<input type="checkbox"/> Yes <input type="checkbox"/> No
		IYCF Counsellor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Others	
2	Have OTP staff received training on management of severe acute malnutrition?	One week standard training according to MoH guidelines	No <input type="checkbox"/> Yes, but not Certificate <input type="checkbox"/> Yes, Certificate
3	Are there guidelines on management of severe acute malnutrition (SAM)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Are there IEC materials (posters, take home-brochures, flipcharts) on management of severe malnutrition available in the OTP?	Appropriate: Visible, readable, Adequate: enough for distribution	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate/complete <input type="checkbox"/> Yes, adequate/complete
5	Are there adequate number of forms and formats necessary for OTP?	Home treatment card, Follow-up card, Register book, W/H table (z- score)	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate/complete <input type="checkbox"/> Yes, adequate/complete
6	Is there the flow chart of operational guideline visible in the wall? IYCF Session Plan, BF Session Plan?	Appropriate: Visible, readable	<input type="checkbox"/> No <input type="checkbox"/> Yes, but not appropriate <input type="checkbox"/> Yes, Yes appropriately visible

	Questions	Means of Verification	Remarks
7	Is there adequate equipment for the centre?	Baby scale Measuring board Salter scale MUAC tape Others	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Not Functional
8	Are there enough supplies for management of severe malnutrition available in the health facility according monthly caseload?	RUTF	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate /complete <input type="checkbox"/> Yes, adequate /complete
9	Are there enough pharmaceuticals available to treat severe malnutrition according monthly caseload?	Antibiotics and other necessary drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate /complete <input type="checkbox"/> Yes, adequate /complete
10	Are the admission criteria followed correctly according to the protocol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Are the discharge criteria followed correctly according to the protocol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
12	<b>Does the OTP Nurse:</b>		
	a) Make good interview of the mothers		<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Make complete clinical examination		<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Write the complete feeding prescription		<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Assess the appetite of the child correctly		<input type="checkbox"/> Yes <input type="checkbox"/> No
	e) Provide counselling		<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Are children weight and height measured and interpreted correctly?		<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Are the staffs able to wash their hands with soap and water?		<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Are mothers able to wash their hands with soap and water?		<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Are children referred correctly to SC?		<input type="checkbox"/> Yes <input type="checkbox"/> No

	Questions	Means of Verification	Remarks
<b>Output</b>			
17	Check there register for:		
	a) Average number of admission / day		<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Correct registration of clients according to the standard format.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Cure rate:		<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Defaulter rate		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Are children's filing completed correctly?		<input type="checkbox"/> Yes <input type="checkbox"/> No

## Performance Checklist for MAM

Performance checklist for Outpatient Department (OTP) of MAM

Date \_\_\_\_\_

Location \_\_\_\_\_

Health Facility Type \_\_\_\_\_

S. No.	Questions	Means of Verification	Remarks
<b>Input Indicators</b>			
1	Are there adequate staffs at the MAM-OTP site?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have OTP staff received training on management of moderate acute malnutrition?	One week standard training according to MoH guidelines	No <input type="checkbox"/> Yes, but not Certificate <input type="checkbox"/> Yes, Certificate
3	Are there guidelines on management of moderate acute malnutrition (MAM)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Are feeding centre register book maintained properly and regularly?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Does HF staff review data and take action in weekly and monthly meeting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Is there water available for staff, beneficiaries and caretakers		<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Is soap and water available for hand washing		<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Are SFP rooms and courtyard clean (no litter, faces)		<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Are sufficient space and equipment available for efficient food preparation (including cleaning)		<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Are shelves and floor free of food scraps / refuse		<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Are measuring equipment accurate and checked daily		<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Are equipment / utensils washed and dried properly, and stored in clean, dry place		<input type="checkbox"/> Yes <input type="checkbox"/> No

S. No.	Questions	Means of Verification	Remarks
<b>Process</b>			
13	Do weight and height measure correctly		<input type="checkbox"/> Yes <input type="checkbox"/> No
14	Is anthropometric index calculated correctly and nutrition status correctly assessed		<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Are admission and discharge criteria applied correctly		<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Are routine medical administered on admission (clinical exam, vitamin A, measles vaccination, Iron and folic acid, mebendazole)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Is ration size meets CMAM protocol (nutrient quality and quantity)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Are food commodities stored in Clean, controlled area?		<input type="checkbox"/> Yes <input type="checkbox"/> No
19	Are mothers able to wash their hands with soap and water?		<input type="checkbox"/> Yes <input type="checkbox"/> No
20	Are children referred correctly to SAM?		<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Are children received properly from SAM?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Output</b>			
22	Is released ration appropriate according to the ration size and number of beneficiaries monthly?		<input type="checkbox"/> Yes <input type="checkbox"/> No
23	Are community agree with objectives / purpose / design of OTP-MAM		<input type="checkbox"/> Yes <input type="checkbox"/> No

## Performance Checklist for Stabilization Centre (SC)

Date \_\_\_\_\_

Location \_\_\_\_\_

Health Facility Type \_\_\_\_\_

S. No.	Questions	Means of Verification	Remarks
Input Indicators			
1	Are there adequate staff at the Stabilization Centre? Dose clear job description available for each staff member?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Have SC staff received training on management of severe acute malnutrition?	One week standard training according to MoH guidelines	No <input type="checkbox"/> Yes, but not Certificate <input type="checkbox"/> Yes, Certificate
3	Are there guidelines on management of severe acute malnutrition (SAM)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Are there IEC materials (posters, take home-brochures, flipcharts) on management of severe malnutrition available in the SC?	Appropriate: Visible, readable, Adequate: enough for distribution	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate /complete <input type="checkbox"/> Yes, adequate/complete
5	Are there adequate number of forms and formats necessary for SC?	Hospital Charts, Home treatment card, Follow-up card, Register book, W/H table(z- score)	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate /complete <input type="checkbox"/> Yes, adequate/complete
6	Is there the flow chart of operational guideline visible in the wall?	Appropriate: Visible, readable	<input type="checkbox"/> No <input type="checkbox"/> Yes, but not appropriate <input type="checkbox"/> Yes, Yes appropriately visible
7	Is there adequate equipment for the centre?	Baby scale Measuring board Salter scale MUAC tape, Beds, toys Others	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Not Functional

S. No.	Questions	Means of Verification	Remarks
8	Are there enough supplies for management of severe malnutrition available in the health facility according monthly case load?	F75, F100, RUTF, CMV, Resomal (at least for one month)	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate/complete <input type="checkbox"/> Yes, adequate/complete
9	Are there enough pharmaceuticals available to treat severe malnutrition?	Regular drug supply, Antibiotics 1st and 2nd line, (based on monthly case load), Vit A, Iron, Folic acid	<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate/complete <input type="checkbox"/> Yes, adequate/complete
10	Are there enough utensils to prepare food for children?		<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Are the discharge and discharge criteria followed correctly according to the protocol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Are there appropriate facilities for mothers to bath and do laundry?		<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Are transfers of patients from phase I to phase II and so on done correctly according to the protocol?		<input type="checkbox"/> No <input type="checkbox"/> Yes, not adequate/complete <input type="checkbox"/> Yes, adequate/complete
14	Does the health staff provide counselling to the clients		
15	Does the doctor: Make good interview of the mothers Make complete clinical examination Write the complete feeding prescription		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Are the rooms' temperatures adequate for malnourished children?		<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Are children weight and height measured and interpreted		<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Is therapeutic milk prepared properly (based on protocol)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
19	Are children fed according to the schedule and recorded correctly?		<input type="checkbox"/> Yes <input type="checkbox"/> No
20	Are the staff able to wash their hands with water and soap?		<input type="checkbox"/> Yes <input type="checkbox"/> No

S. No.	Questions	Means of Verification	Remarks
21	Do the children have access to adequately equipped play room?		<input type="checkbox"/> Yes <input type="checkbox"/> No
22	Are mothers able to wash their hands with soap and water?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Output</b>			
23	Check the registers for:		
	a) Average number of admission / day during the last month:		
	b) Correct registration of clients according to the		
	c) Cure rate:		
	d) Length of stay		
	e) Defaulter rate		
24	Are children's filing system completed correctly?		<input type="checkbox"/> Yes <input type="checkbox"/> No