End Project Evaluation of GAVI Supported CSOs Project to Strengthen CSO Involvement in Immunisation and Maternal-Child Health Services in Pakistan

Final Report

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By

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This report is the product of a summative end project evaluation of the GAVI supported "CSOs Project to Strengthen the Involvement of CSOs in Immunisation and Related Health Services in Pakistan" (2009-2015). The evaluation was commissioned by UNCEF Pakistan country office and was an inclusive and participatory process involving key stakeholders – EPI and Health, CSOs, outreach, LHWS and vaccinators, district partners, and community beneficiaries.

The evaluation report has been prepared by the consultant Dr. Ayesha Khan with assistance from research associates for data collection.

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The opinions expressed in this document do not necessarily reflect the policies or views of UNICEF.

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ACRONYMS

AKHSP	Aga Khan Health Services, Pakistan
AKU	Aga Khan University
BCC	Behaviour Change Communication
BCG	Bacillus Calmette–Guérin (tuberculosis vaccine)
BDN	Basic Development Needs Program
BHUs	Basic Health Unit
CBOs	Community Based Organizations
CBBA	Community Based Birth Attendants
CDC	Centres for Disease Control
CHIP	Civil Society Human and Institutional Program
CHW	Community Health Workers
CMAM	Circumference Mid-Arm Measurement
CRS	Catholic Relief Services
CSF	Cerebrospinal Fluid
CSO	Civil Society Organizations
DHIS	District Health Information System
DHMT	District Health Management Team
EDO	Executive District Officer
EIA	Enzyme Immunoassay
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunisation
FLCF	First Level Care Facility
FP&PHC	Family Planning and Primary Health Care Program
GAVI	Global Alliance for Vaccine and Immunisation
GB	Gilgit-Baltistan
GoP	Government of Pakistan
HACT	Harmonized Approach to Cash Transfer
HANDS	Health and Nutrition Development Society
HBIG	Hepatitis Immune Globulin
HBV	Hepatitis B Virus
HELP	Health, Education, Literacy Program
IEC	Information, Education and Communication
IRC	Independent Review Committee
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health

NHSCC	National Health Sector Coordination Committee
NHSRC	Ministry of National Health Services, Regulation and Coordination
MoU	Memorandum of Understanding
NICC	National Inter-agency Coordination Committee
NIDs	National Immunisation Days
NRSP	National Rural Support Program
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PCAs	Project Cooperation Agreements
PPHI	People's Primary Health Care Initiative
PVDP	Participatory Village Development Program
RACI	Responsible, Accountable, Consulted, Informed
SBA	Skilled Birth Attendants
SCI	Save the Children International
SES	Socio-Economic Status
SNIDs	Sub-National Immunisation Days
SOP	Standard Operating Procedures
SSFA	Small Scale Funding Agreement
THF	The Health Foundation
THO	Taluka Health Office
THQ	Taluka/Tehsil Headquarter Hospital
TT	Tetanus Toxoid
UC	Union Council
UNICEF	United Nation's Children Fund
VHC	Village Health Committee
WB	World Bank
WHO	World Health Organization
WIW	World Immunisation Week

EXECUTIVE SUMMARY

THE CONTEXT AND BACKGROUND

Pakistan is the sixth most populous country in the world with maternal-child health indicators that lag behind its regional neighbours. Pakistan's public sector spending on health is approximately 1% of its GDP US $ 234 billion[2] with the cost of immunisation activities (routine and campaigns by the EPI[1] program) ranging from USD 47 -175 million per year. The goals of the EPI program are to achieve immunisation coverage of at least 80% across all districts of Pakistan against eight vaccine preventable diseases (DPT, measles, Hepatitis B, BCG, polio, and pneumococcal) and mothers with tetanus.

Despite high level government support Pakistan's full immunisation coverage is low at 54% and polio, measles cases continue to emerge across the country. In 2008, as part of enhancing immunisation outcomes in hard to reach areas, Government of Pakistan requested GAVI support for pilot testing an innovative model of CSO-Government partnership to facilitate immunisation and MCH service delivery, demand creation, and engagement of CSOs to expedite policy and practice change.

GAVI UNICEF CSOs PROJECT

UNICEF-EPI -Government of Pakistan was successfully awarded a Type B US $ 7.5 million (after the initial US $ 100,000 mapping Type A grant) by GAVI in partnership with the core group of 14 CSOs to work on improving immunisation and MCH outcomes in 21 districts across all 4 provinces, AJK and GB. The GAVI CSOs project was managed and supervised by UNICEF and the CSO Monitoring Unit (M&E and coordination role) and implementation activities were carried out by the CSOs.

EVALUATION DESIGN AND METHODOLOGY

In June 2015, the CSO project reached its final conclusion and UNICEF Pakistan commissioned an end project evaluation to review project outcomes, lessons learned, and recommendations for future CSO-Government partnership model. The current summative evaluation has used a mixed method of 1) desk review and secondary data analysis (CSOs progress and monitoring reports) plus 2) the baseline report 2014, along with 3) primary interviews/FGDs with all relevant stakeholder categories – community, local LHW/vaccinators, district and provincial EPI/Health staff, Federal EPI, CSOs, CSO Monitoring unit, and UNICEF team to compile an overview of the findings, lessons learned and recommendations. As per UNICEF TORs the main thrust of the evaluation methodology was qualitative. The evaluation used desk review, data triangulation, interviews with key stakeholders, site visits and observations to formulate this evaluation report. An inception report was shared and approved by the UNICEF Pakistan and ROSA team, and field work was initiated in July 2015. Data was analyzed using content analysis and thematic analysis, using, OECD/Development Assistance Committee (DAC) criteria of Relevance, Effectiveness, Efficiency, and Sustainability with the addition of Gender Equity and Human Rights dimensions.

Key Findings of the evaluation are:

RELEVANCE

- **Alignment** – the CSOs project activities were well aligned with the original proposal and the national EPI priorities, UNICEF and GAVI mandates. Original proposal documents do not specify how the CSOs project design and selection was responsive to specific immunisation and MNCH needs of the selected areas.
- **Need Responsive and Flexible –** a key strength of the GAVI CSOs project was flexibility and agility in meeting community needs. However, there is lack of clarity on how the project design took into account the baseline needs assessment of the community and baseline capacities of the implementing CSOs. Furthermore, this approach lacked systematic planning and documentation of course corrections during the process.
- **Reaching the Poorest Populations –** It appears that CSOs for most parts did reach poor and vulnerable populations. CSOs except for a few, lacked objective tools for poverty assessment or documentation on the socio-economic demographics of their beneficiaries.
- **Demand Creation –** was actively done and showed results (>85% uptake of messages and services) according to the CSOs progress reports. Independent verification is only available through Baseline study (2014) and it supports the overall claim that immunisation and MNCH uptake improved in the intervention areas (keeping in mind the

[1] Expanded Immunisation Program established in 1978

limitations to the conclusions drawn from this data). However the broader effects of demand creation were undermined by low absolute numbers and absence of independent verification of the results during the project life from district or UC level.

- **Federal and Provincial EPI Engagement –** even in the backdrop of devolution the CSOs project still continued with a centralized operational model of decision making and this was noticed (and criticized) by provincial counterparts.

EFFECTIVENESS AND PERFORMANCE

- **Performance –** in nearly 90% CSOs achieved their stated targets and results. Considerable improvements (15% points increase in immunisation coverage), TT and HBV vaccination, rehabilitation of severely malnourished children, reduction in default and refusal rates, and increased SBA were some of the salient achievements.
- **Difficult to Accurately Assign Causation and Attribution –**many of the CSOs achievements cannot be confidently attributed due to the project due to weak or absence of good (rigorous) documentation, measurable indicators, and limited understanding of the importance for good documentation.
- **Enabling the Community as Active Partners –** a more participatory engagement and proactive "partner role" for the community would have strengthened the CSOs effectiveness and empowered the communities. Our findings highlight that communities do not fully understand the greater role of seeking preventive services as primarily their responsibility (and their benefits) and to collectively negotiate with public sector providers.
- **Institutional Relationships and Challenges –** relationship and coordination were best at the Federal and local level. Although provincial EPI recognized the importance of CSOs there was a more distant and at times tense association between the CSOs-provincial partners. Local district relationships were often informal and support was not fully institutionalized and transparent.
- **Delays Due to Devolution and System Changes** – CSOs performance was adversely affected by the periods of uncertainty of grant extensions and delays (no funds released) during the devolution transition and when UNICEF transitioned to the HACT reporting system (2012).
- **Communication Strategy and Issues –** there was an absence of a clear communication channel (in practice) and many partners defined their own informal mechanisms. There were a few incidents where this deficiency led to miscommunication, by-passing of proper channels and generated a sense of unfair advantage.
- **Representation of CSOs –** there was a wide variation of CSOs capacities from some grass-roots to large national CSOs. The perception among the smaller CSOs was that selection and representation on national forums was not fairly balanced and needs to be significantly improved. By giving only large more mature CSOs the opportunity to represent CSOs limited the diversity and capacity building of smaller CSOs to learn from the exposure/experience.

EFFICIENCY

- **Costing of the Model –** accurate costing of the CSOs project is not possible due to absence of disaggregated UNICEF cost data prior to 2012.-13 With limited information provided to the evaluation team the CSOs project appears to be a moderately high cost model that may not be sustainable in its current form. CSOs provided immunisation services at approximately USD 19.2 per child immunized (without including the cost of immunisation supplies), and MNCH services are estimated to be in the range of USD 15-25. Costing of implementation models by areas and activities was not possible due to lack of data.

- **Local Models –** during grant funding CSOs did not pursue testing out potential lower cost models or documentation of local lessons learned. These are great opportunities missed.

SUSTAINABILITY

- **Exit Strategy –** a well-planned or clear exit strategy was not present in the CSO project design. Individual CSOs did have some have level of planning however for most CSOs project activities closed as of June 2015.

MANAGEMENT MODEL AND M&E

- **Human Resource Limitations at UNICEF –** a project of this size and complex nature would have benefitted from full time staff/teams to focus on project nuances and regular review of the data. This was not done during the 6 year project life.

- **Output Based Monitoring –** monitoring was regularly undertaken and an extremely challenging task for a project of this scope. The CSO Monitoring Unit (M&E officer and Coordinator) had to undertake potentially 280+ visits over the project life of 6 years. Given the large M&E reporting scope, the main focus was on input-output based monitoring; informal guidance, and many important lessons and learning were not documented. Having clear results framework and a monitoring plan would have likely improved project outcomes even more.

GENDER, EQUITY AND HUMAN RIGHTS

- **Primary Beneficiaries were Women and Children –** the primary beneficiaries of CSO project and activities were mainly women and children. Indirectly the project activities increased women's access to information and services, thereby improved gender equity, and potentially empowerment of women through regular engagement at the community level. However the project design did not have a clear strategy for gender mainstreaming within the CSOs implementation processes, M&E policies, and institutional structures to address socio-cultural inequities in health care access and outcomes.

ADVOCACY AND REPRESENTATION

- **Participation in Policy and Practice forums –** due to project support CSOs have been actively and consistently engaged in influencing immunisation and MCH on to the national (and possibly provincial) agenda. It is hard to comment on concrete achievements in terms of budget or coverage increases in immunisation and MNCH services as a direct result of the CSO project (based on poor documentation of independent verification). However, the Pakistan CSOs Coalition is a concrete outcome of the initial GAVI support and has potential to enhance advocacy and make service delivery changes.

KEY LESSONS

1. **Project Design: Balance of Clarity and Flexibility** the lesson learned is that CSOs project flexibility while a positive strength should have been coupled with self-derived but clearly articulated (and documented) results.

2. Project Design: Course Corrections and Feedback

Course corrections are a necessary part of responsive and accountable programming. Having regular and specific issue directed feedback sessions between UNICEF and the CSOs and/or directly with the communities (without the presence of CSOs) would promote a more open environment of information sharing and program responsiveness. This aspect was lacking in the current CSO project.

3. Mapping and Broadening CSOs Selection

Pakistan has a moderate sized and vibrant body of CSOs approx 3000+ or so in different categories and sectors. In future GAVI funding calls new CSOs with strong provincial and district roots should be actively recruited to expand the pool of eligible partners and to build lasting social capital.

4. Focusing Activities and Results one District at a Time

The scale (i.e. absolute numbers) of project activities and beneficiaries influences outcomes on health and immunisation coverage. While CSOs were providing a comprehensive spectrum of activities within health and MCH, their geographic reach and target beneficiaries were a very small percentage of the UC or sub-district population to make a significant impact on the indicators. Enhancing the scale of CSOs reach and using a more focused approach would be beneficial in improving health indicators.

5. Participatory Monitoring

Output based monitoring was deployed in the project throughout the project via the CSO Monitoring Unit and the GAVI missions. The lesson learned is to engage in actual participatory monitoring along with provincial partners (both within and outside of routine scheduled visits) and to think of monitoring as a change enabling incremental process.

6. Government Co-Sharing and Resource Contribution

The government is strongly committed to achieving 90% immunisation coverage and eliminating polio, measles and other VPDs. A lot of public sector human resource and effort (i.e. demand creation, advocacy) can be more effectively channelled if some of the tasks were co-shared and duplication in human resources is reduced.

7. Use of Evidence and Knowledge Management

Best practices and good evidence can guide public sector programming and potentially reduce wastage of critical resources. However, despite the initial key objective of knowledge management in the CSOs project design the CSOs lacked ability to keep or use data and this was a major deficiency that needs to be addressed in future programming.

8. Gender Equity and Mainstreaming in Project Activities

The CSOs project activities focused on immunisation and MCH, which predominantly affects the well-being of women and children. One project design limitation was the lack of integration of gender equity and rights within the project activities with the result that the implementing CSOs did not fully avail the opportunity to address issues of harmful gender roles, teach men and women about their gender rights, maintain disaggregated sex data on utilization of services, document (or research) challenges faced by women in access and uptake of services, promote women in decision making and representation etc..

9. Advocacy Forums and Representation of CSOs

Advocacy was a key objective of the CSO project and CSOs through one-one, at policy and practice forums, with donors including GAVI missions and meetings did considerable amount of advocacy to highlight challenges of MCH and immunisation. The feedback on and perception of representation demonstrates that larger, donor savvy CSOs had a disproportionate control on the representation process.

10. Peer-Peer Learning

The project did make special efforts to promote CSO-CSO learning (i.e. horizontal learning). The lesson learned was the learning process has to continuously evolve with project specific circumstances and that pairing a mature CSO with a grass-root CSO for practical advice on work planning, monitoring activities, documenting lessons would have been an innovative way of addressing the learning challenge.

11. Provincial Autonomy and Division of the Roles

Post devolution the landscape of health responsibilities and autonomy changed. However, the GAVI CSOs project continued to function in the old paradigm of centralized "Federal" direction with passive involvement of the provincial partners. This created internal resentments and affected provincial-CSOs uptake and ownership. Going forward with the upcoming local bodies and district government's representations and elections – the additional autonomy aspects and decentralization of the CSOs project design and implementation will need to be taken into account to create equitable distribution of responsibility and authority.

RECOMMENDATIONS

1. CSOs-Government Model and Project Design

1.1 Continue to support the CSOs-Government partnership model with modifications/changes as learned through six years of on-ground program implementation. Performance monitoring and work plans should be routine part of the initial project design.

1.2 M&E - should include CSOs driven frameworks and feedback from communities and district governments on how CSOs work is affecting district/sub-district indicators.

1.3 Efficiency – a proper costing exercise with disaggregation by geographical challenges and looking at inputs versus outputs and alternative scenarios should be undertaken.

1.4 The project design should be of long term duration (5 years or more), focused on specific key indicators, cover complete UCs in order to enable and measure change

2. Partner Selection and Capacity Building

2.1 Revisit and expand the partner mapping exercise with goal of expanding the pool of eligible CSOs and building social capital in small-medium size CSOs at the grass-roots in Pakistan.

2.2 Prolong mapping to include capacity building and mentoring of smaller, less skilled CSOs with more able and adept partners. Local lessons and organic models of participatory development should be encouraged to flourish.

2.3 Encourage competitive bidding between CSOs for taking local know-how and testing out low cost innovative models of service delivery in immunisation and MCH. Program effectiveness should be optimally linked with efficiency to move beyond the "project approach" which is expensive and short term.

3. Implementation and Results

3.1 Baseline measurements should be a mandatory part of program design and implementation.

3.2 Objective and measurable indicators of progress should be a routine part of work plans and progress reports.

3.3 Quarterly dissemination of progress reports with key partners and local communities to ensure that information sharing and verification of findings is being done throughout the project implementation phase.

4. Monitoring and Evaluation

4.1 Outcome and participatory monitoring to enable real time learning for the CSOs and course corrections in the project activities

4.2 Annual value for money exercise to see which CSO models are cost-effective and how they can be best scaled up

5. Management Model and Coordination

5.1 Test out different models of fund management such as 1) province or district specific stand alone management by a large CSO(with 2 co-signatories), 2) CSO-Provincial agreements with supervision by district governments model, 3) CSO coalition with supervision by Government in a combined HSS model, and 4) Externally managed UNICEF or any other large donor agency model. The advantages and disadvantages of each model can be carefully reviewed in terms of costs, long term social capital, accountability and ownership of the key partners.

5.2 Manage conflict of interest through diversity of roles and stakeholder responsibilities to maintain ownership and accountability

6. Research and Evidence Use

6.1 Independent research and involvement of academic institutions Baseline measurements should be a mandatory part of program design and implementation.

6.2 Peer reviewed papers and knowledge management beyond the project period

CHAPTER 1: INTRODUCTION

COUNTRY SITUATION: IMMUNISATION AND MATERNAL-CHILD HEALTH (MCH)

Background

Pakistan is the sixth most populous country with an estimated population of 186 million[2]. The country consists of six provinces and administrative units (Punjab, Sindh, Khyber Pakhtunkhwa, Balochistan and Gilgit-Baltistan, AJK) and 145 districts/or agencies. Although classified as a lower middle income country (GDP per capita is USD 1275)[3], there are significant access and income inequities with 60% of the population living on under USD 2 per day[4].

Pakistan's public sector spending on health is 1% of its GDP USD 234 billion[2] with the cost of immunisation activities (routine and campaigns by the EPI[5] program) ranging from USD 47 -175 million per year. The average cost per child vaccinated is varied between USD 10-20[6].

The Expanded Immunisation Program (EPI)

Immunisation services in Pakistan are primarily offered through the government's Expanded Program on Immunisation (EPI)[7]. Approximately 80% of traditional vaccine costs are supported by the Government of Pakistan (GoP)[8].In late 2008, GAVI supported the introduction of pentavalent DTP-Hepatitis B-Hib, with co-financing by the government.

The goals of the EPI program (since 2009) are to immunize children (0-12 months) against eight vaccine preventable diseases (DPT, measles, Hepatitis B, BCG, polio, and pneumococcal) and mothers with tetanus. The annual targets are approximately 5.9 million children and 6 million pregnant women to reach approximately 90% overall, and at least 80% coverage across all districts of Pakistan.

Immunisation delivery in Pakistan is undertaken by 10,000 vaccinators and 6,000 Lady Health Visitors (LHVs) and other paramedics. More than 100,000 Lady Health Workers (LHWs) assist in this process primarily by social mobilisation and defaulter tracing. There are 6,000 fixed EPI centres, approximately one for about 27,000 population, though there is wide variation in coverage from district to district, and even at sub-district levels[9]. The cost of vaccination per child in Pakistan is reported to US $ 24 of which $ 14 is covered by government and US $ 10 by GAVI. Breakdown of immunisation expenditures and other costs by GoP are shown in Figure 2-4.

Various supplementary immunisation activities, such as National Immunisation Days (NIDs) for polio and vaccine specific mop-up campaigns, are organized in order to increase immunisation coverage among high-risk populations.

Apart from Government of Pakistan, a number of donor agencies are providing technical and financial assistance to the EPI program. The main partners are WHO, UNICEF, GAVI, World Bank, JICA, USAID, DFID, the Bill and Melinda Gates Foundation, and CDC.

Figure 1. Incidence of Vaccine Preventable Diseases

Indicators	2008	2012
Polio	117	74
Measles (lab confirmed)	1,129	8,046
Tetanus Neonatal	320	809
Diphtheria	32	98
Rota		1,692
Rubella		483
Pertussis	169	60

Figure 1 shows the number of cases across Pakistan between 2008 and 2012, with some higher numbers seen in measles and rota virus detection representing better availability of surveillance and diagnostic testing in 2012. In Figure 3 – the cost breakdown shows that of

Figure 2. ImmunisationExpenditures

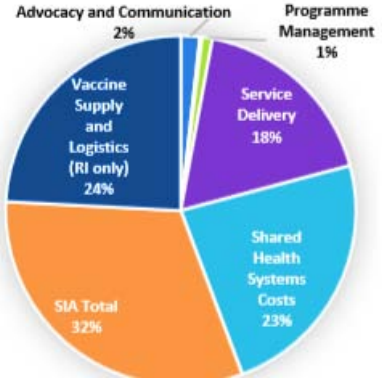
Total Immunization Expenditures	$180,793,176
Campaigns	$75,301,701
Routine Immunization only	$105,491,475
Per Capita (Routine Only)	$0.60
Per DTP3 child (Routine Only)	$29
% Vaccines and supplies (RI)	46.5%
% Government Funding	57%
% THE	2.0%
% GHE	19.9%
% GDP	0.048%
Total Shared Costs	$54,662,109
% Shared health systems cost	23%
Total Immunization system costs	$235,455,285

the US 238 million in immunisation program

[2] Economic Affairs Division Report Pakistan 2013
[3] World Bank South Asia Pakistan 2013
[4] Human Development Index 2014
[5] Expanded Immunisation Program established in 1978
[6] PILDAT Working Paper on Immunisation2010
[7] Hassan Q et al. A review of the EPI progress in Pakistan towards achieving coverage targets: present situation and the way forward. East Mediterr Health J Vol 16
[8] UNICEF Pakistan www.unicef.org /infobycountry/pakistan
[9] Government of Pakistan statistics 2012

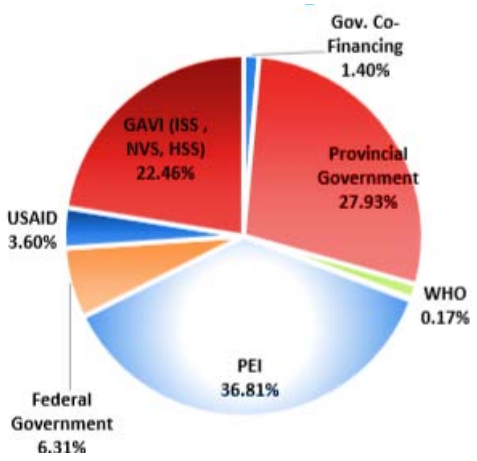
expenditures 24% goes to routine immunisation logistics and vaccine supply ($ 57 million) and 32% ($ 75.3 million) is for SIA of which 98% is spent on polio campaigns.

Figure 3. Baseline Costing Profile



In Figure 4 which shows immunisation financing without shared health system costs, the major contributors are polio eradication initiative (36%) and the provincial governments (27%) followed by GAVI (22%). If shared HSS costs are taken into consideration, provincial governments were the major source of financing with 44.29% share followed by PEI (28.19%). Federal government's share was 5.36% plus 1.08% accounting for co-financing of GAVI supported vaccine (Pentavalent).

Figure 4. Immunisation Financing



Governance and Administration of the EPI Program at the Federal Level

The administration and oversight of the EPI progress is done by the following bodies:

- National Interagency Coordination Committee (NICC)
- National Steering Committee for EPI (NSC EPI)
- National Immunisation Technical Advisory Group (NITAG)
- Impact Assessment Committee

There appears to be some overlap of functions and responsibilities between the governance entities (except NITAG).

Child Health - Immunisation

Health is one of the foremost indicators that define the well-being of a country and childhood immunisation coverage often represents the ability and functioning of the country's healthcare system to deliver these results. Pakistan has some of the highest rates of deaths among children in the world. One child in every 11 (87 per 1000 live births) dies before turning 5 years old and nearly half of all deaths in Pakistan are among children less than 5 year old, compared with 8-10% of all deaths in developed countries[10].

Although the rates of child death have been falling steadily over years, however, progress has been slow and Pakistan has missed it's Millennium Development Goals (MDGs) 2015 target of reducing under-5 deaths to 52/ 1000 live births[11]. Pakistan remains one of the 3 countries where polio transmission is still endemic and new cases continue to arise[12]. Around a third of these child deaths are due to vaccine preventable diseases[3]. Since vaccine preventable diseases contribute so much to morbidity and mortality rates, prevention programs, particularly immunisation are critical to improve the long term child health indicators.

The 2012-13 Pakistan Demographic Health Survey shows that 54% of children ages 12-23 months were fully immunized (16% Balochistan, 29% Sindh, 52% KPK, and 66% in Punjab). Children from rural areas, having a high birth order, belonging to the lower wealth quintile and with illiterate mothers were less likely to be immunized[13]. While undoubtedly, the trends in immunisation coverage are encouraging i.e. nearly 20% in 2 decades, the rate has been slower than regional neighbors, and there have been recalcitrant pockets due to growing security concerns and exploitation by religious ideology[14] which limits Pakistan's progress in achieving 90% vaccination coverage[15].

Maternal Health

The importance of maternal health is globally recognized[16] and affirmed by country commitments and

[10] UNICEF Report State of Children 2012
[11] MDG Report 2013
[12] WHO Polio Report 2014
[13] PDHS 2012-13
[14] Lorenz C et al. Influencing Factors on Vaccination in Pakistan. JPMA Vol 62, January 2012
[15] WHO recommendation reference 12
[16] International Conference on Safe Motherhood 1987

goals (including Pakistan's) through the ICPD[17] and MDGs 2015. Unfortunately, despite extensive resource investments[18] and high-level commitments by the Government of Pakistan, the MMR in Pakistan is 276/100,000 live births, and will miss the country target of reducing maternal mortality to 140/100,000 live births[19].

Maternal deaths contribute to an estimated 13% of all deaths in married women of reproductive age (MWRA)[20], and generally occur around the time of delivery and are attributed to lack of skilled birth attendance. In Pakistan only 48% of women delivered in health facilities and 52% were delivered by a skilled birth attendant (SBA)[4]. Various studies[21] have shown that reproductive and maternal healthcare uptake and practices are shaped by the woman's level of education, place of residence, wealth status, occupation, mobility, and religious belief. On a positive note, more than 7 out of 10 mothers receive ante-natal care from a skilled provider and nearly 64% had received tetanus vaccination in the last 5 years[4].

Nutrition of Women and Children

Under-nutrition is a significant public health problem in Pakistan. Stunting, low birth weight, vitamin and mineral deficiencies, perinatal mortality, poor pregnancy outcomes, and cognitive impairments[22] are direct consequences of malnutrition or under-nutrition. Malnutrition is specifically defined as lack of proper nutrition and includes either under- or over-nutrition. However, under-nutrition is far more prevalent in developing societies.

In Pakistan, an alarming 45% of children under-5 years are stunted, 11% have wasting, and 30% are underweight. For women the PDHS showed that 14% of the women were undernourished (BMI[23]<18.5) and 40% are overweight or obese (>25), with the iron and iodine deficiencies being the most common[4].

CHALLENGES IN IMMUNISATION

Low Routine Immunisation Coverage

There exist many population pockets of unimmunised children that go undetected due to access and mobility issues of the public sector vaccinators and outreach workers (Lady Health Workers). This problem is further compounded by growing threats and security concerns for vaccinators and LHWS. Targeted approaches are needed to identify and gain access into these hard to reach areas.

The Missed Link Community as an Active Partner

The EPI program is mainly focusing its efforts on supply-side inputs without truly utilizing communities and local community based organizations (CBOs) to help create immunisation as a "gain and loss framing"[24]that benefits the families themselves make them partners in the solution process and dispelling of myths.

Lack of Private Sector Models and Involvement in Vaccination

With its wide geographic spread and diverse populations it's difficult for the government/EPI program alone to effectively reach the millions of children and families with childhood vaccination. Therefore, it is very important to explore innovative ways to partner with and incentivize the private sector to provide preventive services like vaccinations, ante-natal care and family planning etc..

Attitude and Referrals between Health Facilities and Vaccinators

Providers at health facilities do not regularly inquire about the vaccination status or refer eligible children to local vaccinators, with many missed opportunities. There is also a common complaint that paediatricians have no coordination and/or referral mechanism with EPI centres.

Ineffective Record Keeping and Documentation

Across all provinces we found that less than one-third of mothers or vaccinators had accurate records (i.e. vaccination cards) of child being immunized. Repeatedly the complaint was voiced that paper records are tedious and therefore skipped by the providers and easily misplaced by the families/mothers. Even when completed by the vaccinators and LHWs paper records are seldom reviewed by the local district authorities to guide them in planning or special campaign positioning.

Political Interference

Political interference in the selection, postings and support of absenteeism of vaccinators and LHWs is a serious concern and limits the accountability of staff to conduct their assigned duties.

[17] International Conference on Population and Development Action Program

[18] Large scale MCH programs through USAID, DFID etc.

[19] MDG 2015 Pakistan

[20] Interagency (WHO, UNICEF, WB, UNFPA) 2012 Pakistan Statistics

[21] Maqsood 2009, Midhet and Becker 2010, Yasir et al 2009

[22] McCann JC et al. An overview of evidence for casual relationship between iron deficiency during development and cognitive or behavioral deficits. Am J of Nutri 2007:85: 931-45.

[23] BMI expressed as the ratio of weight in kilograms to the square of height in meters.

[24] Prospect Theory on gain and loss of not getting immunisation.

Lack of District Autonomy and Evidence Use in Planning

Even in the post-devolution scenario, district and sub-district involvement and responsibility for increasing coverage is limited with a greater "hands on" approach by the provincial EPI programs. This lack of local ownership in the planning stage limits accountability of poor performance later on.

Interrupted Cold Storage and Management of Distribution Chain

There have been reported cases in some districts of the effectiveness of the cold chain in storing and transporting the vaccines resulting in loss of vaccine efficacy, wastage of vaccines, and unnecessary disruptions in supply continuity. Better stock management and reduced stock wastage would save lives and scarce financial resources.

CHAPTER 2: OVERVIEWOF THE GAVI SUPPORTED CSO PROJECT

OVERVIEW

The Government of Pakistan (GOP) recognizes health and wellbeing of women and children as a key priority for national prosperity and achievement of human development indicators. To expand its efforts in reaching the most vulnerable populations with critical services of immunisation and MCH and piloting the public-private partnership model, GOP requested Global Alliance for Vaccines and Immunisation (GAVI) support to fund Civil Society Organizations (CSO) under a joint arrangement with the Expanded Program on Immunisation (EPI) and UNICEF Pakistan.

The original Type B funding was initiated in July 2009 and provided support to 19 CSOs[25] to increase their involvement in strengthening health systems and improving CSO engagement in policy and strategic planning. The original funding was for USD 4.5 million followed by two additional extensions of USD 1.5 million each bringing the grant total to USD 7.5 million (2009-2015). CSOs worked in the areas of immunisation and maternal and child health, with a particular focus on hard-to-reach communities in 34 districts from all four provinces, as well as Azad Jammu and Kashmir (AJK) and Gilgit-Baltistan (GB). Specifically the CSOs goals were to strengthen and complement immunisation and maternal-child health service delivery, demand creation, advocacy, and evidence generation along with close coordination with local government counterparts.

In Pakistan there is a vibrant base of CSOs working in public health and development particularly in complementing (and at time singularly offering) service delivery activities to the most marginalized communities. During the last decade the role of CSOs has grown in Pakistan's health sector response, particularly in service delivery activities such as conducting vaccine campaigns, awareness camps, training, providing equipment and supplies, and is now well recognized by the public and private sector as a critical element for improving service coverage[26].

Type A Funding

GAVI's initial Type A[27] support (US $ 100,000) enabled the mapping, consultations and eventual final formation of a consortium of 14 CSOs. The Type A funding was aimed at strengthening the role and the participation of Pakistan civil society within the health system for achieving MDGs in the areas of immunisation and child health services. In the initial mapping phase 23 CSOs were invited to submit expression of interests outlining their comparative advantage and presence. Of the 23, 15 CSOs were then selected and facilitated for proposal development under the GAVI CSO funding stream by UNICEF and a core group of consultants.

Type B Funding

The consortium participated with the government, UNICEF and WHO in the development of the country proposal for CSO Type B funding (USD 7.5 million). The grant awarding in March 2008 was followed by signing of MoUs between the EPI program and CSOs. Two series of capacity building workshops were conducted for CSOs to enable them to understand the GAVI funding and reporting mechanisms, monitoring. 141 representatives from 14 CSOs participated in these workshops.

Program activities were coordinated and monitored by a small CSO Monitoring Unit set and physically housed in UNICEF and later on (2013) in the Ministry of Health. Funds were channelled through UNICEF office to the CSOs with co-signatory on behalf of the GoP/EPI program until the time of devolution. After 2013, UNICEF introduced a new financial and reporting system (HACT) and directly released funds to CSOs without GoP signatures.

CSOs underwent a risk assessment for financial management skills by the UNICEF office and each CSO was graded high, medium or low risk. High risk CSOs worked on the re-imbursement modality where the funds were reimbursed to the CSO (post-expenditure and after activity verification) while low risk CSOs worked on the advance modality i.e. received advance fund release.

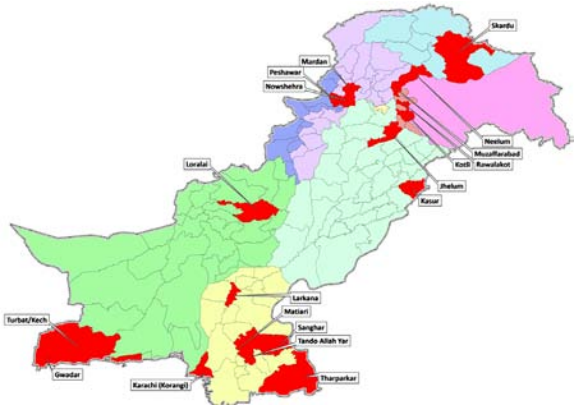
Quarterly monitoring was conducted by the CSO Monitoring Unit and the M&E report shared with UNICEF and GOP for release of payments. Documentation of the initial monitoring reports 2009-2012 did not have a standardised format and this was partially rectified in the 2013 onwards time period.

[25] Attrition of CSOs to the final 14 that were part of this evaluation

[26] Overview of CSOs in Pakistan May 2009. ADB working paper

[27] Type A support of USD 100,000 was for initial mapping, basic capacity building and identification of potential CSOs working in Pakistan.

Figure 5. Geographic Distribution of CSOs



OBJECTIVES

The basic idea was to use CSOs to expand services and address gaps in public sector service delivery in key areas of delivering maternal and child health services; strengthening health systems through training of primary health care providers at the community level to deliver MNCH care and immunisation and revitalizing and establishing community based health clinics; providing technical assistance to national immunisation and child health services; designing and implementing operational research on causes of disease, community disease burden, and improving health systems; and community awareness raising and advocacy to influence decision-makers and policy.

The primary objective defined in the country proposal for the 14 CSOs working in 21 districts of Pakistan in all 4 provinces[28], plus AJK and GB are:

1. To strengthen and institutionalize meaningful participation of CSOs in national and provincial health strategy development and its implementation;
2. To advocate for increasing coverage of EPI vaccines to marginalized children of selected 'hard to reach' districts;
3. To encourage knowledge development for overcoming the operational issues of vaccinators (EPI program), lady health workers (FP & PHC program), and community midwives (MNCH program) and generate best practices at all levels.
4. Partnership building with provincial governments and
5. Advocate for CSOs' involvement at policy level.

GEOGRAPHIC SCOPE AND PARTNERS

The coverage area of the CSOs in the GAVI grant was across all 4 provinces, GB and AJK (Table 1) in the following districts and union councils:

[28] There is a greater clustering of CSOs and districts in Sindh compared to other provinces

Table 1: CSOs and Target Population

CSO	Location	Target Population*
Sindh		
AKHSP	TAR (4UCs)	65,660
AKU	Karachi (18 UCs), Matiari and Hala DHQ	-
HANDs	Matiari (18UCs)	252,107
HELP	Sanghar (2UCs)	14,212
PVDP	Sanghar (1UC), Tharparkar (2UCs)	139,211
PAVHNA	Larkana (8UCs)	233,921
THF	Karachi (9UCs)	546,444
Punjab and GB		
CHIP	Jhelum (4UCs) Skardu (1UC)	219,093
BDN-K	Kasur (15UCs)	357,796
KPK		
BDN-N	Nowshera(8UCs)	219, 093
SABAWON	Mardan (6UCs), Peshawar (12UCs)	83,098
Balochistan and AJK		
LIFE	Muzaffarabad(6UCs)	134,150
BDN-M	Muzaffarabad (6UCs), Neelam (4UCS)	190,782
NRSP	Rawalakot(7UCs), Kech (7UCs), Gwader (7UCs)	334,381

*Estimated UC population by the CSOs. The CSO - AKU is not included in the table as it's a research partner.

CSO PROJECT ACTIVITIES AND INDICATORS

The Project activities and key indicators by CSOs are briefly summarized below (Annex: Detailed Activities)

1. AKHSP

- Increase immunisation by 20% for children up to 23 months.
- Ensure 80% of expectant mothers avail antenatal services.

2. AKU

- To collect evidence based information for assessing the impact of GAVI-supported new vaccines (Pneumococcal vaccine and Rotavirus vaccine) in Pakistan.
- To estimate the burden of severe rotavirus gastroenteritis in children at a rural district hospital in Matiari.

3. BDN Kasur, Muzaffarabad, and Nowshera

- To increase/maintain TT vaccination among childbearing age and pregnant women up to 80%
- To support 13 MCH centres

4. CHIP

- 80% increase in number of health facilities in target UCs with functional health committees for extending quality health services, particularly for child vaccination, TT vaccination and safe deliveries.
- Equip 70% of FLCFs to deliver immunisation and safe delivery services to improve the quality of maternal and child health services.
- Increase awareness among communities: 30% increase in those with knowledge of the danger signs related to illness in children under five, and 30% increase in those delivered who have increased knowledge about danger signs of pregnancy

5. HANDS

- Maintain EPI coverage (children under 23 months) at 90%, a 10% increase in TT coverage and 10% increase in safe deliveries from existing evaluation.

6. HELP

- Increase TT vaccination coverage to 80% among childbearing age women in the target area.
- Increase routine immunisation coverage to 80% children less than two years of age
- Equip over 80% government health facilities in the target area for nutrition screening and counselling.
- Identify 70% severely malnourished children less than two years of age and rehabilitate over 90% of such children.

7. LIFE

- 25% decrease in unsafe injection use
- 25% increase in use of AD syringes
- 35% increase in general community levels of awareness are reached

8. NRSP

- Increase coverage of routine immunisation in children up to 23 months of age in target area by 15-20%.
- Increase coverage of TT vaccination in pregnant women by 10% and in childbearing age women.
- Increase safe deliveries by SBAs by 35%.

9. PAVHNA

- Provide maternal and child health care services to 70,000 people through community based clinics.
- Increase immunisation coverage by 10%.
- Increase TT coverage and ratio of safe deliveries by 10%

10. PVDP

- Increase coverage of routine immunisation in children less than two years of age in target area by 85%.
- Increase coverage of TT in pregnant women 80% and in women of childbearing age by 60%.
- Increase number of trained community based birth attendants (CBBA) by 80% in target areas.

11. SABAWON

- Improve community awareness on mother and child health issues to 50% of the target population.
- Through social mobilisation, raise EPI coverage of the target union councils by 20%, TT by 25% and safe deliveries by 20%

12. THF

- Catch up vaccination of Hepatitis B - Vaccinate 48,627 children with three doses of Hepatitis B vaccines.
- Develop a referral system for HBIG and Hepatitis B vaccination of babies born to Hepatitis B positive mothers and to vaccinate mothers with Hepatitis B vaccination.
- Sharp Waste Management - Provide a needle remover and 50 gallon plastic barrel for sharp waste disposal at community health care facility.

EXPERIENCE OF CSOs- INDIA AND BANGLADESH

South Asian countries, particularly India, Nepal, Pakistan and Bangladesh have seen commendable progress in several sectors – agriculture, industry, health, education, and technology. However, overall improving poverty indicators and outcomes remains a daunting challenge with 34% in India, 53% in Nepal, 37% in Pakistan, and 48% in Bangladesh still living below the poverty line[29]. In the context of improving health, education and development indicators it is now realized that governments in collaboration with civil society organizations can achieve greater mobilisation of communities to improve outcomes.

CSO-Government partnerships in numerous developing countries have demonstrated that an active civil society and a well-informed and socially mobilized citizenry can initiate the processes of responsible and effective governance and yield results.There are many explanations for this. The vast majority of the poor have no organizational structure to represent them. Unorganized, isolated, uneducated and vulnerable, they often depend on the elite for their livelihood and security. They lack the wherewithal to act as countervailing power to the socio-economic forces that they face; however, it is now recognized that if the poor are not given an opportunity to participate fully in the development process, they will continue to be excluded from its

[29]World Bank Poverty Assessment 2013

benefits. This realization is evoking new interest of several alternative strategies emerging from the grass roots[30]. The key element in all these strategies is people's participation and engagement of civil society organizations from the grassroots to help (not replace) government in improving outreach and social mobilisation efficiency.

The search for solutions to problems of the overextended, overloaded and over-centralized government role necessitated the search for a 'third sector'. This includes varied local and community institutions and CSOs collectively distinguished by their non-governmental status. In 2006, with a budget of US $ 29 million, GAVI initiated the CSOs program, first as a pilot in 2007-2009 in Indonesia, Ethiopia, Pakistan, DRC, and Afghanistan, and then extending it to other countries[31]. Since then CSOs have a proven track record for working in partnership with governments in a number of GAVI-eligible countries to ensure the delivery of vaccines. This is also true in extending healthcare services to marginalized communities, particularly in remote areas that are difficult to reach.

In many GAVI-eligible countries, CSOs provide a large proportion of health services. For example, CSOs provide 43% of medical services in Tanzania, 40% in Malawi, 34% in Ghana, 15% in India (which has over 200 CSO hospitals), 13% in Bangladesh, 12% in Indonesia, and 9% in the Democratic Republic of Congo. CSOs are also instrumental in vaccine delivery, providing up to 60% of immunisation services in some countries.

In July 2011, the GAVI Board decided to consolidate all GAVI cash-based support under the Health Systems Funding Platform (HSFP). GAVI's support to civil society organisations was restructured as part of a single funding stream for health systems strengthening; allowing countries to better define the role of civil society within national health strategies. This model promotes a more harmonized, country-driven approach and avoids fragmenting support to countries through multiple support windows. The 2012 GAVI Evaluation reinforced the need for CSO support to be tailored to each country's context, national EPI situation and CSO roles in order to maximize the value of the program.

Some reported experiences and benefits from the GAVI support in Bangladesh and India are:

1) **The Immunisation Platform of Civil Society in Bangladesh (IPCSB)** was formed in late 2014 with the specific vision to have improved immunisation coverage in Bangladesh; it aimed to bring this about through a joint effort with the Government of Bangladesh and the Civil Society Organization (CSO) platform.[32] The objective of IPCSB involves increasing the contribution of the Civil Society platform in raising awareness and basic knowledge of immunisation from 78% to 90% by 2016. In achieving this target the IPCSB has conducted trainings and workshops on advocacy strategy of CSO platform.

2) **The Alliance for Immunisation in India (Aii)** is another body of 19 CSOs, comprising 19 established in December 2013.[33] Its chief purpose was to increase immunisation awareness and coverage in India and its method of achieving this target was to build social capital through its CSO members. CSOs with their direct links into the communities were able to promote equitable access, and have helped India achieve immunisation coverage in remote areas. Aii makes a special effort to address prevalent misconceptions and engage the community in promoting their message too, so that the impact is more sustained and long lasting and the importance of vaccines becomes internalized within the minds of the locals.

3) **The Core Group Polio Project (CGPP) India** has been working specifically with regards to the eradication of polio and has been working with local communities to create awareness and to this effect has displayed immunisation messages on water tanks, as they are a permanent visible feature in houses and communities. The messages are informative and brief and in local languages so as to achieve their purpose and be understood by the target audience[34]. Discussions with government officials identified micro-planning and due list tracking as the two areas CSOs can support the government to achieve better immunisation coverage.

[30] Using the approaches of 1) Decentralization governance, 2) democratization, 3) delegation, 4) devolution, and 5) deconcentration

[31] www.gavi.org/results/evaluations

[32] www.ipcsb.org

[33] www.aii-india.org

[34] ibid

CHAPTER 3: EVALUATION PURPOSE, OBJECTIVES AND METHODOLOGY

OVERVIEW

This report is the end project evaluation of GAVI support to CSOs for strengthening the involvement of CSOs in immunisation and related health services in Pakistan. This is a summative End Project Evaluation as per UNICEF TORs and covers the entire GAVI funding period (2009-2015). The evaluation includes a detailed review of policy, programmatic and management aspects – GAVI CSO program design, mapping and selection of CSOs, management at UNICEF, EPI cell (national and provincial), GAVI CSO M&E unit and on ground CSOs, coordination between the different partners, and the functioning of the feedback loop for course corrections.

The evaluation methodology triangulates findings from CSOs progress reports, M&E reports, the Baseline study (2014), along with qualitative interviews from the key stakeholders of this program- Federal EPI and provincial counterparts, Ministry of Health Services, Coordination and Regulation, provincial departments of Health, district partners, UNICEF, WHO, the advisory group, CSOs, and most importantly the end beneficiaries i.e. the communities served (or not served) throughout the process. The evaluation has tried to cover management and outreach staff of all 14 CSOs and randomly selected one intervention area to have in-depth or focus group discussions with community beneficiaries and local partners (LHWs, vaccinators and local health officials). The evaluation also attempted to review the CSO programme and activities in the light of Evaluability design. In specific the evaluation team looked at whether the original programme design and implementation was designed to be evaluated in "a reliable and credible fashion[35]"

For this summative evaluation, individual CSOs were considered as a group working towards 2-3 common objectives of 1) improving immunisation coverage, 2) improving MCH services coverage, 3) policy and practice advocacy and engagement. The report for most part does not individually list the CSOs strengths or shortcomings but highlights the issues in a non-judgemental manner as a group.

The timeline for this summative Evaluation was 8 weeks, which is a relatively short duration, given the geographic spread of the CSOs, complexity of program activities and multiple partners involved. However, additional time was obtained after consultation with the RG to better manage the time constraints[36] and to enable quality assurance in data collection and analysis process.

The end project evaluation looks in comprehensive details at the processes, contextualization to ground realities and CSOs capacities, and outcomes. However, it is emphasised that due to initial design limitations this is a summative evaluation[37] (not an impact evaluation per se). Even in situations where the term impact is mentioned, the reference is to what the CSOs interventions achieved in the immediate period and potentially for the long term in improving immunisation(or other agreed upon) MCH outcomes.

OBJECTIVES

The main objectives of the Evaluation are:

1. Review whether the project interventions were aligned with the objectives of the GAVI CSOs grant.
2. Assess the extent to which this project has been able to strengthen and institutionalise meaningful participation of CSOs in national and provincial health strategy development and its implementation.
3. Assess whether CSOs supported by GAVI have been able to advocate for increasing coverage of EPI vaccines to marginalised children of selected hard to reach intervention districts.
4. Evaluate to what extent the resources/inputs (funds, experts, time, etc..) used by the programme were converted to results across genders and various socio-economic groups.
5. Determine whether the CSOs have been able to build strong CSOs coalition and linkage with the provincial health department and advocacy for CSOs engagement at policy level.
6. Identify lessons learned and formulate recommendations on how to best engage CSOs in future Health Systems Strengthening projects and enhance equitable results.

PURPOSE AND TARGET AUDIENCE

The main purpose of the End Project Evaluation is to assess the extent to which the CSOs activities and

[35] Planning Evaluability Assessment DFID 2013 Working Paper 30

[36] Shorter working hours in Ramazan June 2015 and Eid holidays July 2015

[37] Summative evaluation is defined as intervention's efficacy i.e. its ability to do what it was designed to do. Summative evaluation judges the worth, or value, of an intervention at its conclusion and in its intended context.

involvement has brought (or started bringing) about anticipated changes in immunisation and MCH outcomes in these hard to reach communities, examine which factors were critical in helping or hindering change and draw lessons for future programming. The findings of this evaluation will help key stakeholders in understanding potential models of service delivery, limitations of the current approach, and identify existing capacity gaps that need to be addressed for effective program implementation and policy change.

The primary audience for the evaluation are Government of Pakistan (EPI and Health Departments) and GAVI. The secondary audience includes CSOs, local partners, other donors/partners/ NGOs and community beneficiaries. The evaluation findings in section 4 will bring out the process and performance of different CSOs, their effectiveness, efficiency and equity in reaching the most marginalized and vulnerable populations. In Section 5 there is a discussion on the lessons learned followed by Section 6 on recommendations for further improvements.

SCOPE OF THE EVALUATION

The evaluation covered entire GAVI supported CSOs program from 2009 – 2015 and all of its phases in all four provinces as well as two areas of GB and AJK.

Using a participatory approach the evaluation included key stakeholders such as the Federal EPI cell, Ministry of National Health Services Coordination and Regulation, Provincial and district EPI, provincial Department of Health of all four provinces and two areas, UNICEF, WHO and Civil Society Organizations implementing partners. Although all stakeholders are expected to benefit, however, the Department of Health, EPI and CSOs will benefit the most from the evaluation findings not merely because of direct involvement in GAVI CSOs implementation processes but also because the evaluation is expected to determine the future role of CSOs in GAVI supported Health System Strengthening (HSS) grant.

Evaluation Criteria and Questions

The criteria used for the evaluation was UNICEF adapted OECD/Development Assistance Committee (DAC) criteria for evaluations that include Relevance, Effectiveness, Efficiency, Impact (long term outcomes) and Sustainability. In addition, as per UNICEF's guidance, the evaluation particularly focused on using the Equity, Gender and Human Rights lenses to ensure that evaluation tools are equity-focused and gender responsive and the findings are presented accordingly. Although the OECD/DAC criteria includes impact, for the purpose of this evaluation, we have only looked at the long term outcomes of the project under impact. By design, this evaluation does not entail any experimental methods or counterfactuals and therefore is not an impact evaluation as per the definition of the impact evaluation. The Evaluation questions are:

Relevance

i. To what extent the project design and implementation were relevant to the needs of men and women beneficiaries across all socio cultural groups including the marginalized and vulnerable in the targeted communities in terms of achieving expected results?

ii. To what extent the project objectives relevant to UNICEF's mandate on health/immunisation and are aligned with national EPI policy and provincial EPI strategies?

Effectiveness

i. To what extent were project implementation strategies effective and successful in achieving the planned outcomes/results for women and men beneficiaries across all socio-cultural groups including the marginalized and vulnerable in the targeted communities?

ii. To what extent the programme was able to achieve its outcomes in strengthening and institutionalizing meaningful participation of CSOs in national and provincial health strategy development and its implementation?

iii. To what extent the equity principles were integrated in various components of the project during implementation such as social mobilisation, BCC, supplies facilitation, and were substantiated by project results?

Efficiency

i. To what extent have the outputs delivered within the allocated resources/inputs such as funds, expertise, time, etc. to women and men beneficiaries across all socio cultural groups including the marginalized and vulnerable in the targeted communities?

ii. To what extent the resources/inputs used by the programme were converted to results addressing the needs of women and men beneficiaries across all socio cultural groups including the marginalized and vulnerable in the targeted communities?

Outcomes

i. To what extent the GAVI funded CSO support was able to help improve immunisation coverage for girls and boys, especially among those belonging to the most marginalized socio-economic groups in the targeted communities?

ii. To what extent the project was able to create the supportive environment and mechanisms for

CSOs to play effective role in service delivery, evidence generation and informing policy and practice?

Sustainability

i. How far and in which ways the programme benefits will be able to continue for women and men, especially from the most vulnerable groups, after the culmination of UNICEF support?

ii. Whether and in which ways the government will be able to sustain the momentum built by CSO project and its benefits for the disadvantaged women without GAVI support?

THEORY OF CHANGE (TOC)

For the GAVI CSOs project, there was no defined Theory of Change[38] (TOC). However, for the evaluation after consulting the UNICEF team and Evaluation Reference group, we proposed to test the evaluation hypothesis that working together CSOs and government can strengthen and improve immunisation outcomes in hard to reach communities. Therefore the Theory of Change in this CSOs-centred, Government-CSO partnership model assumes that working through CSOs would 1) complement and mitigate public sector gaps leading to low immunisation coverage (service side intervention), 2) local CSOs as part of the communities they live in would generate demand for immunisation/other MNCH services (demand side intervention) in a cost-effective manner, and 3) CSOs-based interventions would connect different stakeholders in immunisation i.e. critical pre-conditions in order to achieve desired goals (i.e. immunisation coverage). The original project design it appears assumed that the selected 14 CSOs spread across 21 districts of Pakistan would be able to complement gaps in government immunisation coverage in their intervention areas. From review of the background documents, the rationale for selecting intervention districts/union councils appears to be based on the presence and/or prior work of the selected CSOs rather than a needs assessment of immunisation or MNCH service delivery gaps.

To overcome the limitation of considerably different activities and indicators between the 14 CSOs including changes in activities within CSOs over the funding period/years the evaluation used 10 relevant immunisation, MCH and social mobilisation indicators (from the baseline study 2014) to assess outcome(These are 5 immunisation, 3 MCH, and 2 demand creation/information indicators Table 5 and 6).

[38]As per the TORs from UNICEF and review of initial country proposal.

For example, to provide summative interpretations the evaluation process took CSO outputs/outcomes and used backward mapping to review how the GAVI support to CSOs achieved the stated objectives using relevance, effectiveness, efficiency, results, and sustainability as the main criteria. These results and percentage achievement by CSOs are shown in Section 4 (Effectiveness and Achievement) and in Table 5 and 6.

EVALUATION PROCESS

The evaluation was implemented in three phases between June – August 2015:

Phase 1: Design Phase (June 2015) – the Evaluation Team conducted a desk review and prepared a detailed evaluation design in consultation with the UNICEF team and study Reference Group (RG) that included stakeholder mapping (list of interviews), evaluation and analytical framework, interview and focus group discussion (FGD) guides and tools, introduction to the CSOs, and data collection plans. Starting June 2015 the CSOs were also asked by written and phone communication to share all their progress reports from 2010 onwards to compile a performance review of CSO achievements to stated targets. For CSOs that failed to share the reports a second and third reminder were given 4 days apart and assistance from UNICEF office was also sought to encourage CSOs information sharing. Monitoring reports and other relevant documents were shared by the UNICEF team.

Phase 2: Data Collection Phase (July 2015) - during this phase the Consultant and team pre-tested the evaluation questionnaires with staff members from NGOs and in a nearby local community to ensure fluency in the interview process and to identify underlying issues in the understanding of the questions. The team then conducted semi-structured interviews with UNICEF team, CSO Monitoring Unit, government EPI partners, CSO management and staff, and GAVI secretariat to understand the project design from conception phase to implementation, its achievements and challenges, and coordination between different partners.

The team then scheduled field visits (July 2015)through direct coordination with UNICEF team and the CSOs head offices to visit selected intervention areas (1 from each CSO) and conducted FGDs with community beneficiaries (women and men), government outreach workers such as LHWs and vaccinators, and with district or local health officials on their perceptions on the relevance of CSO interventions, access to services, use of services, coordination and communication, gaps, and implementation challenges.

Beneficiaries were specifically asked to give examples of the CSOs role in improving immunisation, MCH or other health-related services in the area and give recommendations for any shortcomings. By using semi-structured interviews and FGDs, along with direct observations the team was able to assess changes in access and equity of services, demand creation, facilitation, working partnerships, and estimations of changes in immunisation or MCH coverage in the CSOs intervention areas. While CSO staff were informed and aware of the dates of visits they were specifically requested not be present during the discussions with the community and local partners to minimize risks of bias and influence.

Phase 3: Analysis and Reporting Phase (August 2015)–in this phase the evaluation team transcribed and thematically analyzed (content analysis) the qualitative data from the different stakeholder categories following the evaluation framework and TOR questions using the OECD/DAC areas of relevance, effectiveness, efficiency, outcomes and sustainability. As a priority area, the evaluation also analyzed gender equity and human rights perspective of the initial design and subsequent implementation process.

Data from CSO progress reports was tabulated into yearly grids for 10 initially selected targets/indicators (5 immunisation, 3 MCH, and 2 demand creation/information) with 1) work plan targets stated (A), and 2) targets achieved (B) comparisons. The difference between A and B was reported as % variance (positive or negative) and helped to categorize the CSO's performance through the grant period (Table 4 and Table 5).

The final report then compiled findings by triangulation of results from 1) Baseline study report (2014) in which quantitative data was collected from randomly selected 3600 households in the 21 project districts of 12 CSOs on key immunisation and MNCH indicators, 2) CSOs performance variance based on their own reporting and the GAVI CSO M&E unit monitoring reports, and qualitative information from stakeholder interviews and FGDs to depict an overall picture.

The final report and presentation of findings were shared with the study RG and ROSA for their feedback and comments.

METHODOLOGY AND DATA COLLECTION

As described above the methodology comprised a mix of primary and secondary data compilation and interviews/FGDs with stakeholders, field visits to project intervention areas, desk-based review of research and documents. The five main sources of data that were used during the evaluation are:

- Stakeholders – interviews with UNICEF team, CSO Monitoring Unit, Government EPI (federal and provincial) partners, CSOs, and local partners (LHWs or vaccinators) and health officials.
- Direct Beneficiaries - (community women, men and children) – FGDs
- Intervention Area Visits – direct observation of health practices and perceptions
- Monitoring and CSOs Progress Reports – compilation of performance grading
- Strategic Documents and Research –for triangulation of information and contextualization of the findings

Evaluation Tools by Stakeholder Category

1. **CSO Questionnaire** (semi-structured).The CSO tool captured information on CSOs' access to target populations, the mobilisation approaches used, type of services provided, costs of CSO services, barriers and facilitation perspectives, and their perceptions on the outcome and experience with UNICEF, CSO Monitoring Unit, local partners, government officials and communities. CSOs were also asked about their role in policy or advocacy changes for immunisation and/or MCH.

2. **Community Beneficiary Questionnaire (**FGD)- For communities information was collected on uptake and acceptance of services, awareness and dissemination of information including changes in practices, barriers to access of services, and perceptions on the importance of continuing the CSO services.

3. **Government Partners Questionnaire** - With government officials from EPI (provincial and federal) we asked about coordination with UNICEF, CSOs and the CSO Monitoring Unit, approval processes, governance, value added and oversight mechanisms that this project enabled (or did not).

With LHWs and vaccinators we explored how linkages and partnerships affected their service delivery, communication and referrals with CSOs, and the perceived outcomes and value additions of the CSOs presence in their local communities.

4. **CSO Monitoring Unit Questionnaire** – we reviewed the implementation and monitoring mechanisms for CSOs, the coordination with UNICEF, GAVI and Government partners, capacity to respond to changing needs (feedback), and sharing of the know-how and lessons learned.

5. **UNICEF Management Questionnaire –** in this we enquired about the project design, responsiveness, management and governance including technical guidance approach used by UNICEF and GAVI representation in Pakistan. The tool used guidance from the **RACI matrix**[39] (Responsible, Accountable, Consulted and Informed) which is a simple analytical tool that helps identify the extent to which roles and responsibilities are understood and agreed within the organization and with government partners. The guide helped us categorize whether within UNICEF management and coordination there was responsible, accountable, consultative, and informed decision making systems and processes.
6. **Baseline Study (2014) –** we used data from the baseline survey done in 2014 as independent means of verification/attribution to validate the achievements/outcomes of the CSOs (Table 4-6) Out of 14 CSOs, 12 were included in the baseline survey as AKU was already implementing a research project in selected UCs of Karachi while one of the CSOs namely PAVHNA signed its PCA in June 2014 when the survey had already started. Thus, a total of 14 CSO projects in 19 districts were covered (2 projects overlapped in Muzaffarabad and Sanghar districts). Though it is not exactly the baseline as CSOs has been working on ground for more than five years however this survey gives a quantifiable measure of the work of the CSOs. However, the findings cannot be generalised to the district as the CSOs in question worked only in few villages of the selected UCs of a district.

The survey collected data against agreed indicators of maternal and child health from 3512 households, 34 FGDs and 8 in-depth interviews between May – June 2014.

Table 2: Interviews and FGDs by Stakeholder Category

Group	FGDs	IDI
Community	12	
LHWs/Vaccinators	-	10
District/local officials (health)		8
CSOs Management/Outreach workers		16
Federal/Provincial EPI/Health Officials		6
CSO Monitoring Unit		1
UNICEF/WHO		3
Total	12	44

[39] www.responsibilityassignment matrix.com

LIMITATIONS OF THE EVALUATION

Absence of Baseline - The major limitations of the evaluation were the absence of an actual baseline from the start of the CSOs project period (2009). To some extent the evaluation team tried to overcome this deficiency by using the 2014 baseline study indicators and CSOs individual baselines and/or progress reports. However, it is hard to draw direct cause-effect relationships between the interventions and the achieved outcomes in the absence of a credible baseline.

Government or Independent UC level Data - In addition, the absence of accurate government data on immunisation(EPI data from UCs) made it difficult to objectively measure (quantify) and attribute the extent to which the CSOs activities had improved immunisation coverage. However, this information as discussed with the study RG and EPI officials is 1) not available, and 2) not accurate to draw meaningful conclusions. The evaluation team had to at times use baseline and interim data provided by individual CSOs with the subsequent potential risk of "reporting bias".

Modification of the TORs - the original UNICEF TORs had suggested a quantitative survey of the CSOs end line indicators. However, in consultation with the RG consensus was that a more effective strategy would be to triangulate qualitative information with monitoring reports and with the recently conducted Baseline Study (2014) along with independent indicators from the districts. The RG and Consultant noted that the 14 CSOs have different activities and indicators across the 21 intervention areas and many of these activities and indicators are not measurable or comparable within the same survey.

Lack of Work Plans and Monitoring Framework - An inherent gap in the GAVI CSOs project design was the absence of proper work plans (prior to 2013) M&E framework and varied activities/indicators approved in the CSOs proposal. While recognizing the programmatic advantage of having such a flexible approach, it makes measurement of results extremely challenging during and at the conclusion of the project.

Inconsistent Documentation and Information Sharing - Sub-optimal documentation mechanisms and lack of timely sharing of progress reports by the CSOs including missing quarterly reports, lack of cumulative annual reports made the data compilation process extremely tedious for the evaluation team. The reluctance to share information may reflect the perceived negative fears about evaluations in general or may simply be a lack of capacity gaps regarding data collection and reporting formats within some CSOs. In some situations till the end the CSOs was unable to share completed progress reports due to staff turnover (i.e. initial staff prior to 2012 was no longer working

there and there were no records prior to 2012 available) and there were substantial missing quarters.

CSO Issues and Interactions - Some CSOs were extremely reluctant to have the evaluation teams interact directly with the community beneficiaries or their former outreach staff and repeatedly insisted on having their staff accompany the evaluation team. When this offer was politely refused in order to maintain ethical and professional integrity of the evaluation, some CSOs management became accusatory, inappropriate, hostile and defensive with the evaluation team members. These incidents were formally conveyed to the UNICEF team. However, the consultant is confident that data collected is accurate and unbiased to the best possible efforts due to the multiple levels of validation and triangulation.

Time Constraints - Another limitation that affected the evaluation is the short time span for field data collection and analysis (4 weeks). With diverse CSOs to evaluate and the geographic spread, effectively interviewing 14 CSOs and the communities in intervention areas requires a longer period of time i.e. 6-8 weeks. To some extent we were able to overcome the time constraint by using trained research assistants for data collection in field sites.

PARTICIPATORY APPROACH

In order to develop ownership and engagement of stakeholders for accepting the evaluation findings and thereby taking action on the proposed recommendation, the evaluation process has used an inclusive and participatory approach. During the study RG meeting the evaluation design was shared with the members and UNICEF team for inputs and corrections. RG members include representatives from government, WHO, Polio, and UNICEF MER experts. Once a design was agreed upon the Inception Report was formally circulated to the RG, government health officials from EPI, and to UNICEF ROSA for their suggestions.

With CSOs, the evaluation objectives and process was individually explained to each CSO and their written (email communication) permission was obtained prior to any of the field visits.

An initial presentation of findings of the evaluation has been shared with UNICEF and GAVI mission, and their feedback has been incorporated into the final report.

ETHICAL ISSUES

The evaluation followed ethical guidelines from UNICEF's procedure on Ethics and UNEG's ethical guideline[40]s and ensured that participation in the evaluation process (i.e. primary data collection and stakeholder interviews/FGDs/questionnaires) was voluntary and with informed consent.

To safeguard rights, dignity, and privacy all unique individual identifiers were removed from the data collected and responses to protect individuals, institutions or CSOs confidentiality unless permission was obtained explicitly from the participants to list their name with the responses. Even in situations where quotes are given, the names of the individual have been removed to maintain anonymity. Particular attention has been paid not to individually single out CSOs for criticism or praise since the evaluation focus is of the entirety of the CSOs project (not specific CSOs).

Through the evaluation, the team was polite, sensitive to cultural beliefs, manners and customs, aware of gender equity and inclusion, and human rights of the participants and general research principles. Views of all stakeholders were recorded (unless not permitted by the respondent) and reported verbatim in the transcriptions.

The evaluation itself is independent, impartial, and rigorous and conducted with professional integrity and no conflict of interest. The goal of the Consultant is to provide UNICEF Pakistan and GAVI a credible document that can contribute to the learning of CSO funded support and guide future programming.

[40] UNEGs Ethical Guidelines March 2008

CHAPTER 4: EVALUATION FINDINGS

RELEVANCE

This section examines the relevance of the GAVI CSOs project design and implementation to address the immunisation and MCH service delivery gaps[41], advocacy, and engagement of CSOs in policy and strategy formation to improve coverage outcomes in Pakistan.

The information presented compares and summarises findings from the desk review, baseline study, CSOs progress and monitoring reports, and stakeholder interviews/FGDs. The results are reported according to the key evaluation questions (Box 1).

BOX 1: RELEVANCE

1. To what extent was the program design and implementation relevant to the needs of community and vulnerable populations?
2. Were the objectives of the GAVI CSO project consistent with the approved grant proposal?
3. Is the project scope aligned with UNICEF and EPI program policies and national priorities in immunisation in Pakistan?

Alignment of CSOs Project Activities with Approved GAVI CSOs Grant Proposal and National EPI Priorities

The CSOs project activities and scope of work were consistent and aligned (> 90%) with the original GAVI CSO grant proposal. Comparison of the original grant proposal and CSO activities over the project life noted minor changes in some CSOs program activities and were a "responsive change" to natural disasters (i.e. floods, and local displacements) and identification of newly emerged needs. Discussions with stakeholders involved in the initial proposal development and program design reported that unlike traditional donor programs, the flexibility of the GAVI CSO funding allowed the selected CSOs to continue and build on their existing activities mostly in the same geographical locations. For example, CSOs were selected mainly based on their presence and access into hard to reach communities with ongoing immunisation, maternal-child, or health related activities, and then most of those activities were scaled up in the GAVI CSO project. This approach capitalized on the strengths of CSOs and their well-established presence in local communities.

Review of GAVI CSO proposal and background documents does not clearly shed light on the original decision making processes. For example, the evaluation team could not clearly understand 1) whether there had been a needs assessment of project intervention areas or discussions with provincial government counterparts for interventions in those particular areas, 2) rationale for clustering of CSOs in Sindh compared to other provinces, 3)evaluation (and documentation) of baseline capacity of the selected CSOs for service delivery and responsiveness to the community needs, and 4) effectiveness of the CSOs in delivering these activities. While many of these questions were certainly present in the minds of the original planners – the documentation to support the stepwise progression of how the GAVI CSO proposal was designed was not clear.

Most stakeholders particularly UNICEF, CSO Monitoring Unit and EPI stakeholders strongly agreed that the project activities supported the Comprehensive Multi-Year Plan (CMYP of Immunisation) as depicted below:

Table 3.CMYP Activities

National Priorities and EPI objectives	Compatibility with CSO Activities
The EPI program's overall aim is to reduce mortality and morbidity resulting from the eight EPI target diseases by immunizing children aged from 0 to 11 months and pregnant women.	CSOs facilitated demand creation, for vaccination in local communities, provided vaccinations, and linked up with LHWs and/or vaccinators identifying and reaching eligible children 0-23 months.
Increase routine immunisation coverage to 90%	Identification of children for vaccination
Interruption of polio virus by 2012	Facilitation in local SIAs at the local level
Elimination of neonatal tetanus and measles by 2015	Assistance of LHWS and vaccinators Vaccination of pregnant women/mothers with TT and HBV
Reduction of diphtheria, pertussis and childhood tuberculosis to a minimum level so that they do become a public health problem	Increase in routine immunisation in local communities (no TB related activities)
Control of other diseases by	Evidence-based research - 1

[41] As applicable to their proposal targets/indicators

introducing new vaccines in EPI as and when they become available.	CSO conducted research on the burden of disease and potential savings through new vaccines
Using EPI as a spearhead for promoting other primary health care activities integrating EPI into primary health care	CSOs used "routine interactions" with local communities on immunisation to also encourage and promote positive maternal-child and health practices and awareness.

Engagement Gap between Federal and Provincial EPI Involvement

The 18th amendment and devolution of Health (June 2011)to provinces happened at the midway point of the CSOs project and did not significantly change the operational model or decision making processes of the project – which were more Federal centred.

Provincial EPI stakeholders reported a conflict between the letter and spirit of devolution and the centralized involvement of the Federal EPI via the project even in the in the post-devolution period. There was an unrealized expectation on part of the provincial EPI program that post-devolution consultations with provinces (particularly the more ready ones) should have been undertaken with suggestions as to how the project needed to be adapted in light of devolution. Provincial stakeholders strongly expressed some concerns that in often in GFATM and GAVI proposals their involvement is limited to final endorsement of the Pakistan proposal.

"GAVI CSOs project continued to function mostly unchanged with all decision making powers at the UNICEF and Federal level and minimal inputs or control of the provincial EPI on CSOs functioning. We met some of the CSOs at national meetings only". *District Health/ EPI Staff*

Discussions with Federal EPI management highlight the uncertainty and prolonged duration (i.e. 6-9 months approximately) where internal programmatic roles and autonomy, signing authority, and decision-making were unclear, and the CSOs project suffered due to lack of attention and budgetary delays. Our discussions also highlighted challenges of frequent Health Department changes in designated and focal EPI staff (at the provincial level) which made relationship building and understanding of the GAVI CSOs project difficult for the newcomers and for all involved stakeholders.

Close to Local Communities and Vulnerable Populations

A key outcome of the CSOs project that emerged in discussions with community beneficiaries is the appreciation of "personal approach" that CSO workers used in highlighting the importance of immunisation and health. Because many of the CSOs had been operational in the area (for other donor projects and in some cases self-funding) and their workers themselves lived in these communities, there was a long-term relationship between the outreach providers and those they served. These long-term relationships built on a sense of mutual trust – of giving good guidance, having credibility and personal camaraderie, and therefore the advice given was more likely to be followed.

Community members shared stories where outreach workers were present socially for the birth of their child and immediately encouraged them to get vaccination early on. Comparisons were made between short visits of LHWs and other health staff (from other ongoing local area interventions) and how the CSO project workers spent time explaining and listening.

Women in the communities appreciated the CSOs emphasis (and importance) on their well-being, advice on maternal-child health topics, accompanying them for immunisation, coordination with vaccinator visits, and health camps. Community women reported on receiving timely information and how this information helped them make good decisions to seek care for maternal or child health issues which they otherwise would not have done. Some women reported assistance in monetary terms for transport costs as well.

"Apa cares a lot for my family and this neighborhood, when there are health events or the vaccinator is coming she arranges for all our neighborhood sisters/mothers to be present. We laugh and have an enjoyable time, and our children get shots and checked-up for growth". *Community woman Sindh*

One limitation of this "personal approach" or informal outreach worker driven approach was the variation seen within the CSOs in achieving targets (quarterly targets). We observed that CSOs were extremely dependent on the motivation of the outreach workers, and the capacities of different CSOs to effectively deliver results, with smaller CSOs often reported struggling to develop a systematic approach to target setting. For example, there were some CSOs where management and outreach workers did not regularly communicate or consult each other for target planning or sharing of community feedback. On the other hand there were CSOs with well developed targets and monthly planning meetings. The broad and often large number of targets and indicators also at times made it difficult for out-reach workers to fully understand what they were trying to accomplish.

Smaller CSOs while closer to the community lacked the "know how" or importance of documenting the processes of success stories along the six years, and thus missed opportunity to build on this learning. For

example, communities shared stories of "mohallas" village women pooling individual resources for purchasing a weight machine so that they could monitor their children's growth, helping each other about the safekeeping of vaccination cards, encouraging men to participate in health camps, or referring family members for Hepatitis B vaccination. These stories can potentially provide important lessons on "best practices" for reaching communities and be inspirational models of change.

Potentially Missing the Poorest

The GAVI CSOs project design did not clearly define the objective of equitable access or the requirement of having a poverty scoring criteria with the CSOs. With the result that most CSOs did not assess beneficiary socio-economic demographics or scoring during the project duration. Since most of the areas in the project are in the poorest and least well performing districts it is possible to assume that those served were most likely poor. However, this assumption cannot be claimed with certainty. It would have been useful to have a Pakistan standardized[42] or even locally adapted (and validated) criteria for the CSOs to self-assess and periodically review the socio-economic categories of beneficiaries they were reaching. We found through our discussions, that in the six years of project interventions very few CSOs formally reassessed changing community needs or had documented SOPs for SES categories.

All CSOs were internally cognizant of reaching the most vulnerable in their project vision and implementation activities. However, this assessment of the poorest and most vulnerable was subjective (except for three CSOs) and not an institutionalized and documented process (i.e. conducted on an ad hoc basis).

Discussions with community beneficiaries and local government partners, affirmed that for most part the recipients of CSOs services were poor in terms of access and opportunities to availing services.

"We walked miles for health services and then we gave up. CSO A brought the service to my home area. Now when I need help I am able to easily go there". Community woman KPK

"These refusal families were not convinced that immunisation for small children is important and when we told them they did not believe me. When a few local area CSO B workers told them the same thing, then these families came back to me" LHW Punjab.

Demand Creation for Change in Immunisation and Health Related Practices

CSOs were successful in reaching the communities with their messages and increasing uptake of key services. Using CSOs reports, M&E reports, and the Baseline performance data in the selected areas we see >85% achievement of targets and results and an average of 15% increase in immunisation coverage[43]. The limitation to fully attributing this to CSOs efforts that this did not take into account other local NGOs working in the area including government services through other donor sources.

The projects' demand creation was deemed effective as per the results observed at 14 field sites and community discussions during the evaluation process. The results were consistent with the Baseline 2014 report of increased community's immunisation uptake, TT vaccination[44] rates were higher, antenatal care seeking, and recall of 3 vaccine preventable diseases was comparable to national averages (PDHS 2012) etc. even in these hard to reach, impoverished areas.

However, several factors limited the effects and scale of demand creation in having a greater impact:

1. **1. Low numbers -** Demand creation was limited to low numbers and narrowly targeted in some areas (i.e. villages within UCs) and missed out greater than half the population of the UC. According to government, EPI stakeholders' coverage must be at least 80% of UC population to have a significant impact on the immunisation outcome. The evaluation team was unable to identify monitoring or CSO level internal check mechanisms that could have addressed this gap early on during the grant implementation period. CSOs worked only in their designated areas and did not take into account the eligible population in the surrounding villages of the UC.

2. **2. Absence of denominators/mapping** of target populations and/or making social mobilisation plans[45] based on "educated estimates" with the communities. Most CSOs have listed the UC population as the target population covered via the CSOs project. However, there is little objective evidence to support whether the project activities covered full UC versus selected villages/geographic areas and/or what clusters of populations. Except for 2-3 CSOs, an initial mapping exercise of eligible population target are not available.

3. **3. Independent Measurement and Improvement Of UC Level Coverage** – one key objective of the CSOs project was to assist district/local health officials in improving ways for collecting "reliable" immunisation data recording and management from sub-areas in UCs/UC. The evaluation team did not find any evidence in discussion with local health officials or CSOs that this

[42] BISP criteria

[43] CSOs reported data and from Baseline Report 2014

[44] For selected CSOs indicator only

[45] Only 2 CSOs documented conducting the planning exercise

Table 4. Performance Ranking of CSOs

	1st	2nd	3rd	Overall Score
AKHSP	-	-	-	
HANDs	2	2	1	11
HELP	-	-	-	
CHIP	4	-	-	12
BDN Muzaffarabad	-	-	-	
BDN Kasur	-	7	1	15
BDN Nowshera	-	1	2	4
THF	-	-	-	
PVDP	-	-	1	1
LIFE	-	3	1	7
NRSP Rawalakot	3	2	2	15
NRSP Gwadar	-	1	-	2
NRSP Kec.h	2	2	-	10
SABAWON Peshawar	2	1	4	12
SABAWON Mardan	1	-	2	5

task was undertaken. District and local health officials continue to relay on LHWS and vaccinators records for estimating immunisation coverage and no role of CSOs was not reported. In fact provincial EPI officials reported a few outbreaks of measles and polio cases in CSO areas with no "red flagging" from the CSOs.

In Table 4 we have summarised the performance ranking of CSOs (2012-2014 data mainly) for the 10 selected indicators using their own progress reports.

For example in the 1st -3rd column the number denotes how many times the CSO achieved 1st, 2nd or 3rdposition in the six years (or when CSO data was available). Therefore a cumulative high score of 15 is 1st, followed by 2nd = 12, and thereafter. A (-) in the column indicates that the CSO did not achieve 1st, 2nd or 3rd performance scoring in that category. The indicators that formed the basis for compiling this ranking are shown in Table 5 and 6 with the detailed achievements by individual CSOs.

EFFECTIVENESS, PERFORMANCE AND OUTCOMES

This section focuses on the effectiveness of the GAVI CSOs project in achieving planned outputs in the given timeframe and the effect of those outputs on the broader community, stakeholders and immunisation/MCH coverage in the intervention areas.

In order to assess effectiveness and outcomes the evaluation team carefully assessed the achievements of each CSO, monitoring and accountability systems in place, validation of the findings from the community beneficiaries and partners, as well as the project contribution to initiating policy or practice change in the country.

QUESTIONS ON EFFECTIVENESS

Was UNICEF's role clear in project guidance, partner selection, and achieving results?

1. How effective were project activities in achieving planned results? What were the most effective outputs?
2. Did the project achieve its outcomes in strengthening and institutionalizing participation of CSOs in national/provincial health policies and development?
3. To what extent did the CSOs advocate for increased immunisation coverage in hard to reach communities?
4. Was equity embedded in project activities?

CSOs Project Results and Outcomes and Measurement Challenges

In terms of measuring results, there is some evidence to document the achievements of the CSOs project (i.e. APRs, progress and monitoring reports, mid-term evaluation report, discussions with stakeholders at all levels, government publications etc.). However, there are major gaps (i.e. objective measures) in placing direct attribution of the claimed results to the CSOs efforts alone.

Presented below are some salient outputs (additional details shown in Table 5 and 6).

1. Immunising Children and Reduced Default Rates– according to the CSOs (and listed in the mid-term evaluation 2012) an estimated >162,000 children in collaboration with government services were vaccinated in CSOs project areas during 2010-2014. These best available estimates are based on the CSOs figures of demand creation and facilitation for

vaccination through home visits and camps, and were confirmed by the GAVI M&E unit and EPI programme. CSOs facilitated in SIAs, assisted in demand creation and uptake of services for 8714+ mothers with TT vaccination.

2. Mother-Child Health Sessions and Awareness Camps – 12094 sessions, reached 500,000 individuals with information and IEC materials, trained 1000+ health and mid-level providers, strengthened FLHF (55), supported 13 MCH centres with resources and equipment, and 100 public sector facilities (CSOs reporting and verified by CSO Monitoring Unit M&E).

3. Formation of Local Village and Health Committees – 2638 committees, CBOs, social organizers were established and trained to continue promoting health issues

4. Testing of innovative models - CSOs experimented with pay for performance, tele-messaging, puppet shows to varying levels of success. Unfortunately many of these lessons were not rigorously captured through documentation to draw meaningful conclusion on what worked and how.

5. Established district level surveillance model for rotavirus in public sector hospital – Matiari. This model however is not sustainable without external support due to lack of dedicated government human resource and space limitations.

6. Rehabilitated severe malnourished children with services provision to 800 children

7. Hepatitis B vaccination was provided to 58,000 individuals

8. CSO Coalition (Initiation stage) and Engagement in National Policy and Practice - for the first time CSOs were organized and have a platform for a united "voice" and representation in national decision-making forums. At this time, it is too early to see what the CSO coalition has achieved but there is a potential of 1) advocacy, 2) greater expansion into service delivery complementing government gaps in services, and 3) influencing policy focus to immunisation and MNCH.

"Women were trained who then came to our houses and told us about the project. Our children were also given vaccination. This was something….a concept that was never practiced, prior to this project, in our area."

Community man, Kharmang Tolti District Baltistan

"Community attitude about health, informal care seeking, and traditional practices are embedded into people. New ideas must not be forced but will be slowly accepted"

Health Official, Gwader Balochistan.

"People see and follow their neighbors"

LHW Larkana Sindh

The most visible strength of the CSO project at the community level is the prominence that it gave to bringing immunisation and maternal-child health as a priority agenda in these difficult to reach communities.

By working together with local CBOs and government partners, the GAVI CSOs model was able to combine the complementary strength of local trust (i.e. access) with scale (government resources) to better meet national and provincial priorities. Active mobility of outreach and mixing of awareness with service delivery facilitation was another factor that increased the project effectiveness. Although in discussions with CSOs we did not always see how outreach mobility was decided on a daily or weekly basis – for example many CSOs lacked a "systematic planning of clusters or targeted areas within the UCs" but in principle this was the general approach that most CSOs were implementing.

Table 5. CSOs Performance Indicators (Baseline 2014 Report)

Performance Indicators (Coverage achieved in %)		AHKSP	HANDS	HELP	CHIP	BDN M	BDN K	BDN N	THF	PVDP	LIFE M	NRSP R	NRSP G	NRSP K	SABAWON P	SABAWON M
Immunisation Coverage:	BCG	75	81	78	96	69	89	84	-	58	75	81	70	79	88	85
	Penta 3	36	56	24	69	66	74	65	-	13	65	76	49	74	68	71
	PCV	27	56	19	64	55	72	62	-	8	47	64	51	74	68	71
	Measles	72	72	77	83	67	78	73	-	63	69	74	58	75	77	73
	Children never vaccinated	20	18	15	2	30	9	16	-	26	25	19	28	19	13	15
Knowledge Level of respondents regarding childhood vaccination	Knowledge about 3 or more childhood vaccine preventable diseases	36	80	46	24	34	68	49	28	52	54	62	14	62	48	50
	Respondents with Knowledge about childhood vaccine schedule	1	37	3	37	41	61	45	-	5	30	73	8	27	32	44
Maternal Health	ANC by skilled provider	55	86	-	58	50	82	89	-	50	90	90	62	78	92	84
	Pregnant Women TT coverage	53	60	59	75	42	84	53	-	33	80	89	87	68	65	65
	Pregnant Women receiving all 4 contents of ANC	8	45	-	18	29	16	47	-	14	59	59	31	66	54	22
Delivery by Place and Type of Provider	Deliveries at Health facilities	61	73	-	12	27	47	58	-	64	56	67	37	61	71	56
	Deliveries attended by skilled providers	71	73	-	22	31	50	65	-	63	75	72	46	75	78	69
Sources of information and Knowledge Level regarding Safe Motherhood	Danger signs during pregnancy or delivery (at least 3)	20	73	-	52	36	55	73	-	48	62	39	12	58	57	78
	Information From NGO	2	12	4	30	2	1	0	-	3	1	1	2	2	0	0

The relatively longer project duration of nearly 6 years (despite the intermittent periods of uncertainty to grant continuation and changes in some CSOs partners) was noted by the evaluation team to be instrumental in enabling community change in health behaviors and practices. Communities with CSOs presence were more informed about health information, when to seek care, and reported higher levels of preventive health (compared to their own pre-project behaviours).

CSOs also reported the detrimental effects of uncertainty but were overall appreciative that GAVI

UNICEF funding was longer than their usual projects durations of 1-3 years.

Although it's difficult to assign direct attribution, the trends of improvements in immunisation, MCH services and general awareness amongst intervention communities (compared to their own baselines and some government reported data of similar communities), does show a positive impact of CSOs on the communities. While undoubtedly, a more rigorous measurement of baseline and project related changes, would have been preferred – the evaluation team observations do provide moderate evidence of improvements. It is however, hard to state whether with the same funding alternative options (i.e. capacity building or performance incentives for government vaccinators) could have achieved greater results.

For one CSO the target was Hepatitis B immunisation for mothers and children and they were well able to accomplish that. Some unintended consequences that were observed are:

- **Passive Expectations by the Community to Receive Continuous Support from CSOs -** except for one CSO, most of the CSOs provided free or mostly subsidized services. Undoubtedly, in the short term this may be a good approach in demand creation, however it has to be complemented with empowering people/communities to understand that preventive services are for their own well-being and benefit (Prospect Theory Gain Framing). Like in developed countries, government of Pakistan must ensure that people/communities have access to services but the eventual responsibility should belong to the people.
- **Failure by CSOs to develop or test out lower cost outreach models during GAVI CSO project support** – since costs were not an issue during the GAVI funding period, few to none CSOs were pushed to develop lower cost models of outreach, service delivery or advocacy. Despite an extensive geographic footprint and contexts, few rigorous models of best practices have emerged to guide future programming. In addition, at these costs many of these activities are unlikely to be sustainable. Many of the CSOs admitted that they had not focused on seeking out alternative models during the funding period and were now not in a position to continue the activities (i.e. many CSO field offices were already closed at the time of this assessment). This also identifies the issue that while CSOs worked with local CBOs many of the CSOs in the consortia were not local but large scale organizations who piloted the CSO project as a "project".

Regardless of gender, CSOs were able to package the messages and negotiate change in ways that were locally appropriate and resonated with the population. The evaluation team was not able to identify any hostilities and/or complaints of immunisation as a "Western agenda" or any other culturally inappropriate materials.

Delays in Budget Release and Program Activities

Throughout the grant funding period 2009-2015 there were two periods of funding interruptions and programming delays. One during, the devolution of the Health Ministry and the interim period of uncertainty that resulted in 2-3 months of delay as the MoH was the signing authority to release funds. In the second, change in UNICEF leadership and initiation of a new financial system (HACT[46]) led to 3-4 months delay in late 2013. More grass-root and smaller CSOs were seriously affected and had to suspend activities until the time funds were released.

Adaptation to UNICEF's new financial system (HACT) was a considerable challenge for some CSOs with limited finance staff and capacities to implement the stringent new reporting requirements and this adversely impacted the pace of activities. As part of HACT, UNICEF also introduced new Project Cooperation Agreement (PCA) documents that were contractual agreements between CSOs and UNICEF to meet the target and funding requirements. CSOs focused on learning the new system with its exact requirements, which was markedly different from the previous flexible reporting without any standard formats. For some CSOs acceptance of this new system was harder and some CSOs perceived the newly revised reporting and documentation system as lack of trust, micro-management, and intrusiveness on the part of UNICEF into the way they did things.

The UNICEF team conducted several sessions with the CSOs finance staff along with extending ongoing support in refreshing their knowledge, however despite these bridge building efforts many CSOs felt that the "post 2013" approach by UNICEF was rigid, less trusting and therefore less conducive to effective performance. Complaints were also made to GAVI HQ and the Board into UNICEF's procedural delays and its larger impacts on mothers and children in Pakistan. Direct communication between GAVI HQ and UNICEF senior management in New York followed by instructions to management in the UNICEF Pakistan office helped resolve the matter on a priority basis – but this whole process of "direct communications" created feelings of undue pressure and uncertainty for all parties involved.

Another consequence of this delay was that larger more established CSOs (3-4) took the opportunity to actively lobby and even presented to the GAVI mission that GAVI funding should come directly through CSOs.

[46] Harmonized Approach to Cash Transfer

Favorable factors to support this model were reduced management costs, prevention of time delays and further building the CSOs capacity at the national level to manage programming and funds. The GAVI secretariat has carefully noted this proposed management model for future consideration and will review its feasibility in terms of internal controls and safeguards.

Table 6. CSOs Targets and Achievements[47]

CSO Name	Work plan Activities/Target (2013-2015)	Targets Achieved (as reported by CSOs)[48]
AKHSP Tando Allah Yar (TAR)	Increase immunisation by 20% (children 0-23 months). Ensure 80% of pregnant women avail antenatal services. Organizing vaccine campaigns (36) Registration of women (2405) and children (4560) Organize social mobilisation activities (176)	The immunisation coverage increased to 96.5% (2013) from 40% in 2009 (AHKSP baseline). Tetanus Toxoid (TT) coverage increased to 78% in from 35% in 2009. Achieved 33 vaccine campaigns (2015) Registered 2398 women (100%) and 4552 children for? Achieved 184 social mobilisation activities
AKU Matiari	To assess the impact of Pneumococcal vaccine and Rotavirus vaccine in Pakistan. To estimate the burden of severe rotavirus gastroenteritis in children at a rural district hospital in Matiari.	Overall, rotavirus is responsible for one third of all hospitalization in young children with severe gastroenteritis in rural settings. The burden of confirmed pneumonia in young children (aged < 2 years) is 18% in the urban and rural population in Pakistan. The burden of bacterial meningitis has been decreasing after the introduction of Pentavalent (containing Hib) vaccine in Pakistan. Published findings and disseminated information to government of Sindh health officials, UNICEF, and GAVI.
BDN Kasur Nowshera Muzaffar-abad	Support to 13 Maternal and Child Health Care Centres and introduction of 24/7 services To increase/maintain TT vaccination among childbearing age and pregnant women up to 80% (Data source would be district health department) Income support for safe deliveries (40) Arrange community sessions	The 13 centres established and operationalized through GAVI CSO Funds provided vaccination, maternal care and child health care facilities in far flung areas of Muzaffarabad, Kasur, and Nowshera. The ratio of deliveries through SBA increased from 35% to 75%. 24/7 services available in 5 centres. Increase in EPI coverage 54% to 72%[49] in Muzaffarabad, TT coverage increased from 40% to 85% and ANC visits increased from 20% to 70% in BDN areas. Income support to 40 deliveries (100%) Reached 2000 people with community sessions
CHIP Jhelum Skardu	80% increase in number of health facilities in target UCs with functional health committees for extending quality health services for child vaccination, TT vaccination and safe deliveries. Equip 70% of FLCFs to deliver immunisationand safe delivery services to improve the quality of maternal and child health services. Increase awareness among communities: 30% increase in those with knowledge of the danger signs related to illness in children under five, and 30% increase in those delivered who have increased knowledge about danger signs of pregnancy.	100 % health facilities in the target UCs have functional health committees for extending quality health services (particularly for children vaccination, TT vaccination and safe deliveries) 80% FLCF in Jhelum and 48% FLCF in Skardu are equipped for delivering immunisationand safe delivery services 93% and 70% (Jhelum and Skardu respectively) increase in number of mothers having knowledge of danger signs related to illness in children under five years of age. 93% and 70% (Jhelum and Skardu respectively) increase in numbers of mothers delivered who have increase knowledge about danger signs of pregnancy.
HANDS	Maintain EPI coverage (children under 23 months) at 90%	EPI coverage raised to 85.1%[50] against the baseline 48.1% in 2009. In the reporting period, all efforts helped to sustain this coverage

[47] Triangulation of data from CSOs reports, monitoring reports and government/independent data
[48] All achieved targets are drawn from project reports by partner CSOs and surveillance data.
[49] Based on an internal assessment carried out by BDN in the Union Councils in which it is working.

Matiari	10% increase in TT coverage 10% increase in safe deliveries from existing evaluation. Training of 25 health care providers	at 85%. 10% increase in safe deliveries recorded by HANDS team in the intervention period. Training of providers not documented
HELP Sanghar	Increase TT vaccination coverage to 80% among childbearing age women in the target area. Increase routine immunisation coverage to 80% children less than two years of age Equip over 80% government health facilities in the target area for nutrition screening and counselling. Identify 70% severely malnourished children less than two years of age and rehabilitate over 90% of such children.	68% TT coverage among childbearing age women. Routine immunisation coverage in target UCs in children under 2 years is 68% complete and 32% in process. 74% of identified severely malnourished children rehabilitated. 100% facilities trained on nutrition screening and counselling (Two government health facilities equipped and 52 health care professionals trained).
NRSP Gwadar Kech Rawalakot	Increase coverage of routine immunisation by 20% in children up to 23 months of age Increase coverage of TT vaccination in pregnant women by 10% and in childbearing age women. Increase safe deliveries by SBAs by 35%. Sessions with religious leaders (40) Awareness sessions on MNCH (200)	EPI coverage of the target UC and villages of Kotli, Rawalakot, Turbat and Gwadar has increased to more than 20% (average) through various interventions carried out for this purpose[51]. TT vaccination among pregnant ladies increase by 10% in the target areas Safe deliveries ratio increased by 35% Completed 36 meetings with religious leaders Completed 256 awareness sessions
PAVHNA Larkana	Provide maternal and child health care services to 70,000 people through community based clinics. Increase immunisation coverage by 10%. Increase TT coverage and ratio of safe deliveries by 10%	Two maternal and child health centres catered population of 70,000 19% increase in routine immunisation (from 61 % to 80%). Data source is project impact assessment conducted internally by PAVHNA to assess the immunisation coverage in project targeted area
PVDP Tharparkar Sanghar	Increase coverage of routine immunisation in children less than two years of age in target area by 85%. Increase coverage of TT in pregnant women 80% and in women of childbearing age by 60%. Increase number of trained community based birth attendants (CBBA) by 80% in target areas.	Cumulative EPI coverage of target UCs in children under 2 years is more than 86%[52]. TT Coverage in pregnant women is 92% while in women of childbearing age it is 54%. 90% of villages have at least one trained CBBA.
SABAWON Peshawar Mardan	Improve community awareness on mother and child health issues to 50% of the target population. Through social mobilisation, raise EPI coverage of the target union councils by 20%, TT by 25% and safe deliveries by 20%.	50% population reached within project communities of 18 union councils in two districts. 20% increase recorded in immunisation coverage in various villages of 18 Union Councils of two districts. The 20% increase in immunisation coverage has been recorded as per increase in immunisation ratio at local health facilities
THF Karachi	Vaccinate 48,627 children with three doses of Hepatitis B vaccines. Develop a referral system for HBIG and Hepatitis B vaccination of babies born to HBV+ mothers Provide a needle remover and 50 gallon plastic	1st dose (Hep B) given (to children 5-15 years of age) 27,649 (96%) 2nd dose (Hep B) given to children 5-15 years of age) --- 26,260 (91%) 3rd dose (Hep B) ongoing to children 5-15 years of age) ----

[50] HANDS carried out an endline survey to ascertain the percentage increase.
[51] NRSP field data report
[52] Reported by PVDP – no supporting evidence from UC records in Tharparkar and Sanghar

	barrel for sharp waste disposal at community health care facility.	19,426 (67%) 100% of neonates born immunized with HBV[53]

[53] Reported by THF – no documentary evidence shared with assessment team of denominator estimations or independent measurement of eligible children and proof of vaccination.

Institutional Challenges and Informal Relationships with Local Health Officials

The GAVI CSO project (Type B proposal) was developed mainly with engagement of Federal EPI (early 2008), UNICEF, a small core of CSOs, and a consultant. Documentation on the early project inception phase and decision-making are scarce.

Inputs from the provincial governments were taken but because of tight submission deadlines and small group meetings (in Islamabad), the full consultative process of inclusion was not perceived to be "inclusive" by provincial EPI and Health Department counterparts. District stakeholders (health) were not involved in the proposal design or development process at all.

Provincial stakeholders voiced concerns that their involvement remained minimal until the end, with no real say on the CSO activities or decision-making process. Punjab and KP (provincial officials) in particular felt that the CSOs did not add much value to their immunisation activities. Some provincial stakeholders went on to say that during the entire project period they had met CSOs representatives for less than half a dozen times only and that too at meetings in Islamabad.

CSOs reported that with frequent staff turnovers, transitions of authority at the Ministry of Health to the National Health Services, Regulation and Coordination, delayed or missed sending out the formal notifications to provincial departments about the CSO project activities. With the result that provincial counterparts were openly "hostile or bureaucratic" leading to delays.

UNICEF and CSO Monitoring Unit facilitated the liaison to bridge Federal-Provincial, and even district level communication and coordination in many instances including memoranda of agreements with CSOs. However, a clear coordination strategy that all partners were aware of was lacking in the project design and implementation process.

At the local level CSOs formed good "working relationships" with district and UC officials. CSOs and local officials met on a regular basis and closely coordinated immunisation activities and campaigns including CSOs providing support to transportation, linkages with identified households and eligible children, recognition/media interviews of officials, holding health camps etc.. These relationships were mostly informal (no MoUs) and while critical to implementation of the CSOs activities, did not enable the proposed institutional changes at the district or provincial level. For example, in most cases provincial departments were not aware of the activities supported and in some cases duplication of support may have been present at the district level. This is an unintended consequence and has the potential of aggravating poor accountability and "rent seeking" at the district level.

CSOs Representation and Transparency Mechanisms

Objective 5 of the CSOs project was to advocate for increased CSO engagement and involvement in policy and practice for improving immunisation and mother-child health coverage outcomes. Through the project funding, CSOs were involved and represented in the policy and strategy making processes (i.e. participation in NICC, meetings with EPI, UNICEF and GAVI mission teams, inputs at the GAVI Board, etc.). Several issues were highlighted in discussions with CSOs and other country stakeholders

Representation – CSOs in the project had varying levels of capacities with some grass-roots to national and/or international organizations with expertise in research, presentation of content and high-level access to GAVI leadership and other key forums. This capacity imbalance frequently translated into selection and positioning of the "same group" of technically mature CSOs in representing all the other partners in key forums. One critical purpose of CSOs engagement is to rotate and engage even those CSOs that are "less ready" so as to build indigent capacity (more broadly) and allow a newer perspective of ground realities to be heard in these forums. Smaller CSOs reported the selection process and requirements more attuned in favor of recognized CSOs and they felt helpless in influencing change without openly antagonizing the CSO consortia.

Future programming may need to take into account a well-defined and equitable representation process right at the project design phase. In addition, there may be provisions for capacity building for identified gaps, limiting the duration of terms and positions one CSO can be selected for in order to allow a wider number of partners to participate in the process.

Communication Channel and Access– as expected communication channels and expectations between UNICEF, EPI, CSO Monitoring Unit and CSOs changed and evolved over the project life. Given the initial very flexible nature of the project, partners reported occasional lack of clarity in duties, communication channels and lines of authority. Partners used "individual level" informal arrangements to best resolve these issues. However, this lack of a clear communication strategy and channel between GAVI secretariat, UNICEF, EPI, CSO Monitoring Unit and CSOs resulted in a number of avoidable incidents where miscommunication, premature information sharing, or one-sided communication occurred with subsequent perceptions of "unfairness" and "bias" being exercised in favor of the more influential party being felt by the aggrieved party.

Documentation of Learning and System Approach

Knowledge management and learning from the rich experience of the UNICEF-CSOs-government partnership pilot model – in terms of what worked, the processes and strategies for overcoming challenges, and synthesizing best practices was envisioned in objective 3 of the CSOs project. Individual CSOs (5-6) did produce commendable informational materials (beyond just progress or IEC materials) and few case studies during the project to showcase this learning.

Embedding good documentation and operational research as part of the project design (or implementation period) would be useful in preventing this rich learning from being dissipated as the project concludes. These materials can then be displayed from UNICEF or GAVI platforms to increase the knowledge base from Pakistan and globally.

The evaluation team was unable to find conclusive evidence to suggest that after project conclusion information on the CSOs project, experiences and case studies (or working papers) would be available on any UNICEF or GAVI website to inform future donors or organizations about the scope and lessons of the CSOs project. Neither the government partners nor UNICEF team or the CSOs were able to provide information on whether the original project design had planned for continuation of such a knowledge management site beyond the project duration.

Pakistan CSOs Coalition

GAVI Alliance, in partnership with Catholic Relief Services (CRS), initiated the process of strengthening engagement by CSOs in providing health services and immunisation in 14 countries, including Pakistan, during 2012.

The Civil Society Human and Institutional Development Programme (CHIP), one of the CSOs implementing GAVI Alliance's Type B support since 2009, has also been assigned responsibility for facilitating the process of strengthening the engagement of CSOs in providing health services, with the aim of contributing to the increase in immunisation coverage in support of the efforts of Government of Pakistan. With joint efforts through GAVI CSO Support and CRS-CHIP, the coalition has been planning to penetrate at provincial level for policy, planning and implementation in a more formalized way. It is envisioned that the coalition, in future, will engage with government at different levels for immunisation and health system delivery, simultaneously working with the Government on HSFP. The coalition members in Sindh have already signed a formal Memorandum of Understanding (MoU) with the Sindh Provincial Government for engaging CSOs for immunisation.

To date the coalition has enrolled 56 CSO members and is expanding.

EFFICIENCY

This section examines whether GAVI CSOs grant resources were used efficiently to achieve project results. The evaluation team carefully assessed the activities and the costs incurred, and conducted basic comparative cost assumptions (on Pakistan government or local NGO costs) as to what other alternate options may have resulted in better or more outputs. However, it is important to note that cost data shared by UNICEF team was mainly from 2013 onwards and many costs were not disaggregated by activities and management costs.

QUESTIONS ON EFFICIENCY

1. To what extent were the outputs/results delivered with the available resources?
2. Were the resources adequate to meet the project activities and objectives?
3. Whether an efficient M&E mechanism existed during the project life

Cost-Efficiency of the CSOs Project Model

The total GAVI CSOs project funding was US $ 7.5 million over 6 years (i.e. approx Pak Rupees 675 million)[54]. From the partial financial data shared with the evaluation team the breakdown is:

Table 7.Budget Categories

Allocation Head	Amount US $	%
UNICEF Administrative	750,000	10%
M&E supervision	525,000	7%
CSOs Activities	6,225,000	83%
Total	7,500,000	100%

According to the 2010 PILDAT working paper that immunisation in Pakistan[5], the per cost child of vaccination is $24 (Table 8) inclusive of vaccination supplies.

This $ 24 estimate is inclusive of vaccination and supplies $ 16 procured by the government. However, the CSOs project did not purchase any vaccinations or

[54] Adjusting for average US $ 1 = Rs 90 for the varied conversion rate 2009-2014

direct immunisation related supplies so their costs were adjusted accordingly.

Table 8. Costs of Vaccination per Child

Area	Cost (USD)
Vaccine (Traditional: BCG, OPV, Measles, TT)	2.63
Vaccine (Pentavalent)	10.93
Injection and equipment	0.91
Other Logistics	0.42
Advocacy and Communication	0.47
Service Delivery	6.46
Monitoring and Disease Surveillance	0.94
Programme Management	1.75
Total	24.51
Source: PILDAT 2010	

One major limitation in drawing accurate conclusions on the efficiency of the CSOs project is the absence of financial data from the start 2009-2012 period. For example, many CSOs in the GAVI CSO project were also recipients of UNICEF funding under other programme heads/activities.

Prior to 2013, neither UNICEF nor the CSO Monitoring Unit have financial records to disaggregate funding streams to CSOs. In addition, matching of financial inputs to results is made difficult by inconsistent documentation (both in terms of absolute beneficiaries and lack of denominators of eligible beneficiaries) by the CSOs including what percentage were management or advocacy costs. Nonetheless Table 9 shows the funded amount versus utilisation as shared (2014)

Table 9.CSO Budget Allocation and Utilisation

CSO Name	Allocated Funds[55]	Fund Utilization	Variance*
BDN-M	6,451,350	6,319,350	132,000
THF	5,242,639	5,503,316	(260,677)
AKHSP	12,904,260	11,998,728	905,532
HANDS	5,414,285	5,046,455	367,830
SABAWON	7,982,940	7,839,782	143,158
CHIP	13,241,311	11,995,676	1,245,635
AKU	3,293,486	3,293,486	-
HELP	5,360,584	4,508,757	851,827
NRSP	9,215,750	9,215,750	-
PVDP	8,043,568	7,821,510	222,058
LIFE	6,582,219	4,653,738	1,928,481
BDN-N	5,700,220	5,700,220	-
BDN-K	4,416,340	4,416,340	-

***returned to UNICEF. Generally percentage utilization was > 85% across the CSOs.**

The Table 9 shows that majority of CSOs were able to utilize > 80% of their financial budget for the year 2014, and under-utilization did not exceed 15% (one exception 30% due to security and staff issues). For project activities the variation was <10%.

An encouraging trend noted by the UNICEF team and CSOs staff was progressive improvements of risk ratings of some initially high risk CSOs to medium or lower risk categories during the project. By CSO-CSO interactions and capacity building through UNICEF and CSO Monitoring Unit guidance, CSOs reported enhanced staff capacity to handle finances, budget forecasting, and management skills.

Cost-Effective Scenarios

The costing exercise shown below is an attempt to understand how the GAVI CSOs project performed on value for money. Due to the limited cost data available, this costing is not complete. However, UNICEF and GAVI would be well served to review the value for money in this project through a proper costing exercise.

For Estimating Effectiveness of Child Immunisation Services- assuming that 50% of the CSO grant funds were used for immunisation activities (i.e. USD 3,112,500 over 6 years). Since CSOs were not purchasing vaccinations their cost of demand creation/social mobilisation per child vaccinated (matched to government efficiency would be USD 8 per child or less). A crude analysis shows that would come out to be 389,062 children immunised over 6 years. However, the actual number of children immunised/facilitated by the CSOs is 162,000 at approximately USD 19.2 per child immunised. This cost of identification, social mobilisation and facilitation is higher than government costs and regional averages. In addition, there were missed opportunities in facilitating or reaching 227,000 children with services.

Maternal And Reproductive Health Services – if on average 25% of the CSO funds were used for maternal health services (USD 1,556,250 over 6 years) for awareness raising, ante and post natal visits, delivery care and TT vaccination.

Using the international standard of USD 25 (Report 2014 by Guttmacher Institute[56] the per woman costs of delivering an essential package of maternal-reproductive health) that includes contraceptive services, pregnancy

[55] Financial data available for only 2014

[56] Adding it Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014. www.who.int/pmnch/media

and newborn care, services for pregnant women living with HIV, including prevention of mother-to-child transmission of the virus, and treatment for four other sexually transmitted infections. Transport costs amount to an additional $ 4.61 per women accessing health service. Considering that CSOs were facilitating and complementing government services and providing basic maternal health services the cost of services should not exceed $ 15 per woman. Based on that assumption, CSOs should have provided coverage to 103,750 women – however there are no clear documentation of how many women were served with CSOs MNCH service delivery. Costs per woman served through the CSOs project cannot be calculated.

Cost Savings for the Community

The CSO project provided cost savings for both community beneficiaries and government partners – allowing them to perhaps divert the disposable income/savings for other health priorities. For communities, we estimate that the time savings, greater health and wellbeing, receiving free preventive services and facilitation, linkages to other providers, referrals, and general capacity building all amounted to a substantial amount in monetary and indirect benefits that otherwise would not have happened.

For government partners (local officials, LHWS and vaccinators), the supplemental support in terms of honorarium, petrol and transport facilitation, capacity building and skill development, and professional acknowledgement led to increased work performance, greater job satisfaction, motivation, and perhaps improved overall district outcomes (cannot validate as there are no district level data available).

"CSO worker Baji motivated me to do a better job. She showed me how to organize my time and earn extra income as well." LHW Sindh

Monitoring Mechanisms

7% of GAVI CSO budget was allocated to monitoring and supervision by the CSO Monitoring Unit. Initially housed in UNICEF and later on in the EPI offices, the CSO Monitoring Unit was staffed by a 3 member team (1 Project Manager, 1 M&E officer, and 1 finance officer). The unit functioned as a monitoring, liaison, coordination, and supervision/guidance resource for the GAVI secretariat, UNICEF, EPI and CSOs depending on the issues at hand.

The CSO Monitoring Unit conducted regular monitoring visits every quarter (approximately 4 visits per CSO per year, total of 280+ visits during the 5 year project duration for these 14 CSOs). UNICEF team conducted monitoring in the final year 2014. With regular monitoring the CSO Monitoring Unit was able to timely identify problems and work with the CSOs to find solutions, as well as offer technical guidance, facilitate resource mobilisation from GAVI, UNICEF or other partners, and advocate for CSOs in different forums. However, the documentation of these course corrections and informal guidance mechanisms are not present in the written monitoring records and are only discerned through discussions with the CSOs and the CSO Monitoring Unit. This reflects a lack of understanding on part of the monitoring team and the CSOs on the importance of documentation and learning aspect of the M&E process.

The CSO Monitoring Unit maintained friendly working relationships with CSOs while at the same time managing the difficult tasks of enforcing necessary corrective actions (when needed) and providing a trusted advisory guidance resource. Our discussions with CSOs all strongly endorsed the positive and encouraging role played by the CSO Monitoring Unit.

While the evaluation team recognizes the immense challenge of monitoring such a large CSOs portfolio with only a 3-member team, some key actions taken during the project life could have helped improve the efficiency and results of monitoring process. For example, building the capacity of some CSOs to do self-monitoring between monitoring visits, documenting trend comparisons between quarter to quarter on the monitoring reports would have helped to better see the progress on the ground, or linking recommendations to objective measures would have helped maximize quality and results more effectively.

The CSOs and the monitoring team both simply relied and used basic "inputs and outputs" monitoring with little comparison as to how the outputs were influencing broader change in immunisation coverage, MNCH services uptake or policy/practice engagement.

The key gap noted in both in the CSOs progress reports and the CSO Monitoring Units monitoring reports was that the targets, indicators and visit observations are difficult to cross compare within the CSOs and between CSOs, and there is no annual cumulative performance overview. Furthermore, the evaluation team was not able to obtain an overall results framework for the CSOs project with planned and/or updated project achievements and measurable indicators to monitor progress (what was available were outputs mainly).

SUSTAINABILITY

This section reviews the sustainability of the GAVI CSOs-UNICEF investment in continuing beyond the conclusion of the grant funding. The sustainability aspect looks at whether project activities, advocacy changes, and influence on national or provincial decision making will have a lasting effect on GOP or UNICEF practices.

QUESTIONS ON SUSTAINABILITY

1. How far and long will the program benefits continue after the conclusion of UNICEF support?
2. Whether the project design had an exit strategy? Other alternatives
3. Level of commitment and ownership amongst stakeholders particularly GOP?

Institutionalization of Model and Process

Despite its long duration, the GAVI UNICEF CSO project was considered a pilot initiative with much instructive learning that now needs to be reviewed (interim learning is not available other than a mid-term review 2012) in its entirety – successes and limitations as part of the overall package. Some changes in the business paradigm and behaviors as a result of this pilot that are visible are:

CSOs are Collectively Organized and have a Functional platform in Pakistan– GAVI UNICEF support to CSOs enabled CSOs to collectively organize and recognize their far lasting potential and role in improving health outcomes working with donors and government.

The formation of Pakistan CSOs Coalition for Health and Immunisation[57]is the first concrete step to work together with government and other donors for reaching the unreached populations with services – and it was jumpstarted with GAVI endorsement of CSOs potential in Pakistan and other countries like India and Bangladesh (Example 1 India: The Alliance for Immunisation in India (AII) is another body of CSOs, comprising 19 in total established in December 2013.[58] Its chief purpose was to increase immunisation awareness and coverage in India and its chief method of achieving this target was to engage Social capital through its CSO members. Thanks to their direct links to the community, CSOs can contribute to promotion of equitable access to vaccines by informing families about outreach immunisation facilities.[59] Capitalizing on this benefit of CSOs has helped India increase immunisation in remote areas.

Example 2 Bangladesh: The Immunisation Platform of Civil Society in Bangladesh (IPCSB) was formed in Dec 2014 with the specific vision to have the highest level of immunisation coverage in Bangladesh; it aimed to bring this about through a joint effort with the Government of Bangladesh and the Civil Society Organization (CSO) platform.[60] The objective of IPCSB involves increasing the contribution of the Civil Society platform in raising awareness and basic knowledge of immunisation from 78% to 90% by 2016.[61] In achieving this target the IPCSB has conducted trainings and workshops on advocacy strategy of CSO platform.[62]

Government Appreciation and Acknowledgement in the Process –government stakeholders on the whole recognized and appreciated the GAVI CSO project's efforts and its contribution to increasing coverage of immunisation and MCH services. While firm commitment of support are yet not present, the debate is being slowly generated at the Federal and Provincial levels asking about 1) which hard to reach areas and populations can best be served by CSOs, 2) effectiveness of the model given its small scale, and 3) whether a wider pool of CSOs can (and should) be gathered together to induce grassroot mass change.

At the policy and practice level, CSOs were able to highlight both the importance of the immunisation and MCH agenda, and their own capacities to be credible partners in service delivery, demand creation and advocacy.

Communities are Receptive to Changing Practices –this pilot has once again demonstrated that communities are ready and can be mobilized to accept demand creation and health practices – providing that they packaged in a way to gain trust and credibility.

With CSOs we learnt that local ownership through their workers and using "market based" worker incentives to meet targets improves performance and is mutually beneficial. Government policy and compensation to reward good performance and hold accountable poor performers would improve many of current "implementation issues" that undermine immunisation coverage. Weak governance more than anything seems to be undermining immunisation and health outcomes, and CSOs can be used as a modality

[57] January 2011
[58] www.aii.org
[59] India GAVI 56 Ref
[60] Bangladesh 34
[61]
[62]

for bringing reform and competition to de-motivated public sector workers and bureaucratic hurdles in the public sector.

While the project had no clear defined or documented exit strategy, a few CSOs have devised their scaled back versions of continuing some of the activities from their own or other funding sources. Most CSOs however, acknowledged that they do not have the funds to continue working on these activities unless additional funding from GAVI UNICEF becomes available.

GENDER, EQUITY AND HUMAN RIGHTS (HR) PERSPECTIVE

Although the CSOs project was broadly aligned with the mandate of UNICEF, CEDAW[63] and CRC[64] to protect and support the rights and health of children and women to reach their full opportunities, it was not informed by tailor-made human rights and gender analysis or frameworks. While the CSOs activities and project objectives implemented broadly address gender, equity and HR, but individual CSOs work plans (and results frameworks in some cases) do not clearly state these objectives and indicators.

While women and children were the prime beneficiaries (>60%) in majority of the CSO activities, and many of the activities did potentially contribute to increased realization of GE. The CSO project design and the implementation processes themselves did not directly address causes of gender inequality in access to health care, decision making, discrimination, rights of women and men, gender roles, maintaining of sex disaggregated data on services uptake, and representation of women etc..

It is not possible to conclusively comment on how equitable CSO activities and implementation processes were for the most marginalized populations. Except for a rare few CSOs there were no clear criteria for inclusion or targeting of the poorest beneficiaries by most of the CSOs. Generally work plans did not explicitly mention gender mainstreaming or human rights as a clear target in their targets.

MANAGEMENT ISSUES AND MODEL

The GAVI CSO project was designed and implemented with active participation of government EPI partners (mainly Federal EPI but also provincial involvement), the CSOs selected in the Type A mapping exercise (2008), CSO Monitoring Unit team, UNICEF and WHO. The UNICEF Islamabad office played a central role in proposal development, providing technical guidance and coordination, channeling of funds, and supervision of CSOs (particularly during 2014 last year of funding). Funds were released with the co-signatory by the Ministry of Health (until 2012).

A number of strengths of UNICEF management were highlighted by the CSOs, CSO Monitoring Unit and government partners – mainly a very consultative and participatory approach to working with CSOs in meeting the immunisation and MCH needs in their respective geographic areas. CSOs mentioned that UNICEF team was always available and receptive to their issues and accepted reasonable justifications for any delays in completion of activities. Except for rare 2-3 incidents of delay in fund releases, explained by extraordinary external circumstances, CSOs did not have any complaints on the timely and efficiency of UNICEF management.

The project management design used in GAVI UNICEF CSO project i.e. contracting out a UN Agency to manage and channel funds to local NGOs/CSOs has been widely tested in different public health scenarios in many developing country settings. This model has shown good results in situations where 1) absence of in-country CSOs with governance and accountability mechanisms to administer large funds, 2) reduces corruption risks, 3) managing partner needs to have standard capacity for international procurement, and 4) a neutral partner is required. The limitations of the model are: 1) higher cost implications than hiring local partners, 2) lack of in-country development of social capital, and 3) lack of sustainability and building CSOs maturity to handle risks and funds.

Project staffing at UNICEF level was a weakness in this spread out diverse CSOs project. During the project life there was at most 1-2 UNICEF staff that were assigned to manage the CSOs' project in addition to being assigned to handle and/or be responsible for other projects as well. This is a difficult expectation given the pilot design, the number of partners involved, and the geographic spread. Even with the coordination and support of the fully dedicated CSO Monitoring Unit housed in UNICEF, it was not effective to expect that 1-2 team members would be able to devote full efforts (while also overseeing other simultaneous UNICEF projects). For example, the nuanced tasks of technical guidance and supervision such as quarterly adjustments, review of data from CSOs and their activities, pushing for greater social mobilisation etc. would perhaps have been better accomplished if UNICEF team members and CSO Monitoring Unit had "time" to give to these less urgent matters. For such a fairly time-intense and large scale project dedicated full time staff should have been hired.

Discussions with UNICEF team and the CSO Monitoring Unit highlight the project design limitation

[63] Convention on the Elimination of All Forms of Discrimination Against Women

[64] Convention on the Rights of Children

of division of clear roles and responsibilities between the two partners.

Fund effectiveness and channeling was raised as a controversial issue by both CSOs and government officials. CSOs were keen to propose an independent of UNICEF (or other donors) mechanism that would allow funding to directly come to CSOs (or to the newly established CSO coalition, and managed by the consortia). CSOs were reluctant to hand over full or partial control to government for release of their funds citing fears of government preference for certain CSOs, unpredictability of compliance, political interference and no oversight etc..

Government stakeholders on the other hand were skeptical of exerting authority over CSOs work and activities without financial controls. It was felt that in this CSO project government supervisory role in oversight of actual activities and the results was weak and needs to strengthen. It was proposed that monitoring teams should preferably include government district officials from neighboring districts to one promote inter-district learning, and two ensure that activities are meaningful (without self-interest or influence) from the district perspective.

CONCLUSION

It is evident from the evaluation that the relevance of the GAVI CSOs project was very high and well aligned with country policies and priorities in improving immunisation and MCH outcomes particularly in hard to reach and marginalized populations. The project was able to demonstrate successfully that CSOs-government partnership, though not an easy collaboration has the potential for achieving significant improvements for maternal-child health and full immunisation coverage in Pakistan. Learning from other similar countries, India and Bangladesh, show some encouraging results as well.

To achieve more effective implementation outcomes and results, the CSOs project design needs to be improved and focused. The project design and implementation were undermined by the absence of a clear theory of change and lack of a results framework with measurable results. Though the objectives were need responsive and broad, the guidance to CSOs to actively (and objectively) conduct strategic planning and regularly measure outcomes of their activities/efforts was not explicit in the project life.

The project has been relatively effective and has been able to bring about outcome level changes. In particular increases in immunisation coverage, TT and HBV vaccination, access and uptake of maternal health services, rehabilitation of severely malnourished children and support to MCH centres are commendable achievements. Project effectiveness was largely undermined by minimal use of data (neither by the CSOs nor government partners) to guide year by year planning, output based monitoring, and too broad variations in activities within CSOs. The focus was on too many things and thus no one thing improved to full coverage or maximum excellence.

In terms of efficiency the management model was consistent and worked well. CSOs demonstrated good models of active outreach, market and non-monetary incentives to enhance the performance of their own workers and local government partners, and practice changes in communities. However, project efficiency cannot be accurately documented and thus appears to be moderately high cost due to absence of measured outputs for individual CSOs. Documentation of type and category of support through institutional MoUs with provincial and district governments would have helped quantify and made the process more transparent.

In terms of gender equity and human rights perspective, the CSOs project mainly affected women and children. However, the project design and the implementation of activities did not clearly state or take into consideration critical steps of gender mainstreaming and ensuring awareness of human rights within the communities. The monitoring processes also did not explicitly specify how gender and human rights was being ensured in the project implementation process.

Coordination and partnerships were well established and functional at the Federal level with some gaps in communication and timely engagement seen at the provincial level that should be addressed.

Sustainability remains a weak link with the challenges of limited government and/or provincial resources to continue the project in its current design. Even for GAVI UNICEF careful attention to the cost-effectiveness of the CSOs project should focus on encouraging active roles for smaller CSOs (most of the CSOs in this project were large-medium sized), engaging communities beyond mere passive recipients of services, and piloting out smaller but direct funding mechanisms to CBOs tied to UC level health indicators improvements. CSOs in the next phase of funding should be encouraged to identify value for money within their own project activities and not operate in "donor funding mode" (i.e. plenty of resources).

The project was instrumental in building national ownership of CSOs as credible partners in advancing the immunisation and MCH agenda, and this initiative needs to be improved and carried forward with enhancements from six years of learning.

CHAPTER 5: LESSONS LEARNED

This section of the report outlines the main lessons learned for future program design and planning.

1. Project Design: Balance of Clarity and Flexibility

The GAVI CSOs project was extremely flexible in its project design. The advantage of giving CSOs flexibility enabled them to be responsive to the local context and ground realities of how immunisation and MCH activities can be undertaken and was a major strength. By allowing the CSOs to work in their areas of expertise, with small populations, and to use local knowledge and expertise desired outcomes in a personalised manner built trust and credibility within the communities – perhaps even induced long term practice change (compared to a more directed external approach). However, one key lesson learned was that this flexibility needed to have been more effectively managed with CSO-UNICEF planning to develop clearly stated (and documented) results, systematic work plans, and regular meeting to follow progress.

CSO-UNICEF meetings could have helped develop mutually agreed upon surrogate indicators of measurement/progress. This way CSOs and all key partners know of the expectations, self-monitor their results, and these results are well documented. In the current project flexibility led to compromised effectiveness and lost opportunities to reach a wider target population.

2. Project Design: Course Corrections and Feedback

Course corrections are a necessary part of responsive and accountable programming. In the current project design some grass-root CSOs had the implicit fear that suggesting course corrections would be considered poor performance on their part. Some simply perceived the formal mechanisms to request changes and give constructive feedback to the relevant UNICEF or CSO Monitoring Unit team as tedious. This reduced the real time course corrections and program effectiveness over the project duration. The project would likely have achieved better results if the CSOs and supervising management could have shared vision and progress updates in a learning setting.

3. Mapping and Broadening CSOs Selection Base

Pakistan has a moderate sized and vibrant body of CSOs approx 3000+ or so in different categories and sectors. The initial mapping exercise (Type A in 2008) was helpful in establishing a baseline but 6 years of CSO project implementation shows that its critical to expand the mapping exercise, include national and provincial mapping strategy based on priorities and geographic needs and presence, type of work, capacities etc..

One lesson learned is the disproportionate advantage/selection that large and international CSOs have in the current selection process that has to be better addressed and made more "level" so as to allow grass-root organizations to be a meaningful part of the process.

4. Focusing Activities and Results one District at a Time

The scale (i.e. absolute numbers) of project activities and beneficiaries influences outcomes on health and immunisation coverage. The CSOs project experience shows that while CSOs provided a comprehensive spectrum of activities within health and MCH, their geographic reach and target beneficiaries were a very small percentage of the UC or sub-district population and did not make a significant impact on the indicators. Consideration for reaching a critical number per UC or district is essential if the goals are to measure change and this was missed in the current programming.

5. Participatory Monitoring

The project used Output based monitoring was throughout the project design via the CSO Monitoring Unit and the GAVI missions. While monitoring was regular and identified structural issues such as missed or delayed activities but it failed to enable collective learning of the CSOs to recognize their own strengths and weaknesses, wider implications of the activities/results in the intervention areas, and greater engagement of community as "active partners". The lesson learned was that monitoring cannot be narrowly focused and should not miss encouraging a broader social change through the project activities.

The lesson learned is to engage a wider participation of partners and the community feedback should be a vital part of the monitoring process. M&E (both internal and external) should be considered as an incremental process to enable change.

6. Government Co-Sharing and Resource Contribution

The government is strongly committed to achieving 90% immunisation coverage and eliminating polio, measles and other VPDs. A lot of duplication of public

sector human resource and efforts (i.e. demand creation, advocacy) can be more effectively channelled if some of the tasks were co-shared. This did not happen during the CSOs project (was not part of the CSOs project design) and missed the opportunity to reduce costs and get value for money.

The CSO model presented an opportunity to experiment with alternative scenarios of 1) task sharing of immunisation activities to CSOs with government rigorously supervising the results, 2) using a combination of salary plus performance based incentives to motivate well performing workers and weed out underperformers in the public sector, and 3) supervision of immunisation campaigns by local CBOs/activists communities (like in Bangladesh and India) and these should be carefully studied by the Federal and Provincial governments to see how best they can be applied to their local contexts.

7. Use of Evidence and Knowledge Management

Without accurate data and using the data to guide programming, Pakistan will continue to blindly waste critical resources without good value for money. While it's understandable that punitive consequences make districts reluctant to collect accurate data particularly when political or bureaucratic interferences limits firing of poor workers. However the CSOs project did not avail or improve data documentation or recording skills of UCs or district officials (and most CSOs themselves lacked the know-how of good data management).

The lesson learned is that foremost CSOs themselves must first learn and develop the ability to keep or use data and this is a major deficiency that should be addressed. Much of the rich contextual learning of the project was not captured and there are no platforms to display this learning after project conclusion (lost learning opportunity).

8. Gender Equity and Mainstreaming in Project Activities

The CSOs project activities focused on immunisation and MCH, which predominantly improves the lives of women and children. However, the project design was flawed in terms of lack of integration of gender equity and rights within the project activities themselves and CSOs understanding of gender equity. The missed opportunities were addressing issues of harmful gender roles, teaching men and women about their gender rights, maintain disaggregated sex data on utilization of services, document (or research) challenges faced by women in access and uptake of services, promote women in decision making and representation etc.

9. Advocacy Forums and Representation of CSOs

Advocacy was a key objective of the CSO project and CSOs through one-one, at policy and practice forums, with donors including GAVI missions and meetings did considerable amount of advocacy to highlight challenges of MCH and immunisation. This process has been institutionalised through the representation of CSOs in policy forums and formation of the CSOs Coalition. The feedback on and perception of representation demonstrates that larger, donor savvy CSOs had a disproportionate control on the representation process. This defeats the spirit of "free voice" and fair representation.

10. Peer-Peer Learning

The project made special efforts to promote CSO-CSO learning (i.e. horizontal learning). One CSO was entrusted with the task of building capacity, trainings, refreshers etc. and put in considerable efforts that were appreciated by the CSO participants. However, to be fully effective the process of information sharing and mentoring has to be embedded and internalised throughout the project design and implementation process – not as one off activity.

11. Provincial Autonomy and Division of the Roles

Post devolution the landscape of health responsibilities and autonomy have completely changed. While devolution occurred well after the initiation of the GAVI CSOs project funding some changes in increasing provincial autonomy and project design could have been undertaken in the phase 2 and 3 funding tranches (2012 onwards).

Going forward with the potential of local bodies and district government's representations and elections – the additional autonomy aspects and decentralization of the CSOs project design and implementation will have to be taken into account. Division of responsibilities (i.e. upward and downward supervision) and decentralized decision making will lead to greater accountability at the local level and likely improve outcomes.

CHAPTER 6: RECOMMENDATIONS

This section provides key recommendations based on the findings of the evaluation, triangulation of the available CSOs progress and monitoring data, discussions with stakeholders and suggests strategic interventions for UNICEF, GAVI, government and CSO partners in future programming.

The recommendations have been finalised after inputs from the study Reference Group and are based on and consistent with the findings and lessons learned during the evaluation process. The recommendations presented below are meant to be further discussed with a broader group of GAVI, government of Pakistan, UNICEF and CSO stakeholders for reaching consensus on the best approaches.

Recommendation	Priority	Responsibility
1. CSOs-Government Model and Project Design		
1.1 Continue CSOs-Government partnership model with necessary adjustments in program design, theory of change and definition of results in consultation with local communities, clearly defined results framework, work planning, and documentation of indicators to improve program effectiveness and efficiency. **1.2 Heterogeneity of Provincial Health System Capacities and Needs** - GAVI support should take into account heterogeneity of provincial needs and immunisation and health systems in the project design. A one design fit all across the provinces may not be the most optimal approach. **1.3 Synergy with the Health System Country Proposals** – future GAVI CSO support should be in alignment with country HSS proposals to improve and implement immunisation goals according to the cMYPs, and reduce duplication of funding support. There is currently no coordination noted, and thus considerable opportunity for improvement in coordination between GAVI CSO support and HSS grant funding. **1.4 Performance measurement tools** such as a Rubric[65] can be potentially adapted (and piloted) and used to quantify even qualitative results	Medium-High	Government GAVI UNICEF
1.5 M&E - Yearly monitoring frameworks and sessions with district government should review how CSO inputs are affecting district indicators and mechanisms for documented evidence of the results should be part of the program design. **1.6 Restructuring of Country APRs and M&E Reports -** to collect vital activity based reports and analysis on the budget utilization by the CSOs.	High	UNICEF CSOs
1.7 Efficiency - there needs to disaggregation of input costs by project activities and matched to outputs (along with costing exercise) to CSO and area specific costs. For example, costs of the same CSOs activities in Balochistan UCs cannot be the same for densely populated UCs in Punjab. Value for money needs to be a strict criterion for CSO selection. **1.8 Breakdown of management, administrative and service delivery costs** -would help in understanding the efficiency of activities and implementation. **1.9 Efficiency in Management Fees –** 7% management fee by UNICEF for just routing the funds is high and may need to be reviewed in the light of other developing countries, the advantages offered and whether local capacity can be developed to handle financial arrangements at lowered costs.	Medium-High	GAVI

[65] www.gavi.org Fact sheet CSO Project (November 2014) – Measuring Performance

2. Partner Selection and Capacity Building		
2.1 Strengthen Partner mapping exercise with reassessment of CSO criteria looking at ground strengths vs. technical application ability, capacity building phase of CSOs, technical facilitation for CSOs with weak technical or financial management abilities, and ability to do low cost local models of service delivery.	High	UNICEF Government
2.2 Lengthen Mapping Phase and Budgets - to include capacity building and mentoring as part of the process– develop multi stage partner selection. **2.3 Preference Should Be Given To Smaller CSOs** or partnering of smaller-large CSOs. Learning from the India and Bangladesh experience would be useful for Pakistan where mid-small size CSOs were encouraged in the GAVI CSOs initiative.	Medium	GAVI UNICEF
2.4 Competitive Low Cost Grants And Bidding Between CSOs to promote and encourage lower cost immunisation and MCH service delivery and advocacy models. Current individual CSO models were relatively higher costs and did not fully build on the strength of local presence and efficiency.	Medium	GAVI UNICEF
3. Implementation and Results		
3.1 Baseline Measurements need to be a mandatory part of program design and implementation.	High	Government UNICEF
3.2 Objective Measures should go into work plans and activities and some level of cross-comparison between CSO performance trends should be built into progress report.	High	UNICEF GAVI
3.3 Quarterly Progress Reports should be routinely shared and disseminated with government partners and local communities to ensure information sharing and verification of the findings.	Medium	CSOs UNICEF
4. Monitoring and Evaluation		
4.1 Outcome and Participatory Monitoring to enable learning and incremental improvement in performance during the project life	Medium-High	UNICEF
4.2 Annual value for money exercise should objectively review how and which CSOs-government partnership models are most cost effective and need further scaling up	Medium	GAVI
5. Management Model		
6.1.1 Test out new models of fund management such as 1) province or district specific standalone management by a large CSO(with 2 co-signatories), 2) CSO-Provincial agreements with supervision by district governments model, 3) CSO coalition with supervision by Government in a combined HSS model, and 4) Externally managed UNICEF or any other large donor agency model. The advantages and disadvantages of each model can be reviewed. **Caution needs to be exercised to ensure that conflict of interest is managed and supervision and financial control are split between partners**	Medium	UNICEF Government
5.2 Distribution of Different Responsibilities between partners to create ownership and accountability.	Medium	UNICEF
6. Research and Evidence Use		
6.1 **Independent Operational Research and Involvement of Credible Research Institutions** for case studies and learning of lessons should be part of the overall program design and budget. As seen in the current project CSOs tend be favorably biased on self-accomplishments/progress and having independent documentations would help increase credibility of	High	GAVI

findings.		
6.2 Peer Reviewed Papers And Publications for increasing the knowledge base from Pakistan	Medium	UNICEF

ANNEXE

ANNEX 1. LIST OF WEBSITES AND DOCUMENTS REVIEWED

1. GAVI strategy 2007 – 2020 (Phase 2, 3, and 4)
2. Country Proposal (Type A and B)
3. Pakistan CSOs APR Reports 2009-2014
4. UNICEF progress and management reports
5. CSO Unit M&E reports 2009-2014
6. Baseline Report (2014)
7. Independent Review by CEPA (2012)
8. Donors Report 2012
9. CSOs MoUs and/or agreement documents, project work plans (2013-2014)
10. CSOs quarterly progress reports (2010-2014)
11. PDHS 2012-13
12. PSLM 2012
13. MICs 2013 (not available)
14. UNICEF guidelines on Evaluation 2011
15. UNICEF Survey Methods- Innocenti Working Paper 2007
16. UNEG Ethical Guidelines
17. UNODC Guidelines on Inception Report
18. HACT system
19. UNICEF Pakistan strategy documents, priorities and mission documents 2010-2014
20. Independent research on CSOs in the region, Pakistan, and developing world experiences from GAVI and other sources
21. Word Bank Statistics on Pakistan 2014
22. UNICEF statistics on Pakistan 2014
23. Government of Pakistan and provincial statistics 2014
24. Comprehensive Multi-Year Planning Document 2013
25. MDG Report 2013
26. www.gavi.org
27. www.unicef.org
28. www.who.org
29. www.nhsrc.org

ANNEX 2: LIST OF KEY INFORMANTS

Stakeholder /Category	Management (IDI)	Outreach worker (IDI)	Community (FGD)	LHW/Vaccinators (FGD)
Government				
Ministry of National Health Services, Regulation and Coordination/Federal EPI program	2	-	-	-
Punjab Health Department/EPI program	2	-	-	-
District EPI (Kasur)	1	-	-	-
KPK Health Department/EPI program	1	-	-	-
District EPI (Mardan)	1	-	-	-
District EPI (Nowshera)	1	-	-	-
Sindh Health Department/EPI program	2	-	-	-
District EPI (Sanghar)	1	-	-	-
Balochistan Health Department/EPI program	1	-	-	-
Total	**12**	-	-	-
GAVI and UN Agencies		-	-	-
UNICEF	2	-	-	-
CSO Monitoring Unit	1	-	-	-
WHO	1	-	-	-
GAVI Secretariat	1	-	-	-
Total	**5**	-	-	-
CSOs				
1. AKHSP	1	-	1	1
2. AKU	1	-	-	-
3. HANDs	1	1	1	1
4. HELP	1	-	1	1
5. CHIP	1	1	1	1
6. BDN-Muzaffarabad	1	-	1	-
7. LIFE	1	1	1	1
8. BDN-Kasur	1	-	1	1
9. NRSP	1	-	1	1
10. SABAWON	1		1	1
11. THF	1	-	-	-
12. BDN-Nowshera	1	-	-	1
13. PVDP	-	1	1	1
14. PAVHNA	1	-	1	1
Total	**13**	**4**	**11**	**11**

ANNEX 3: EVALUATION MATRIX

Evaluation Questions	Data Sources	Data Collection Tools	Indicators of Success	Analysis
Area: Relevance				
1.How does GAVI support for CSOs fit into its overall objectives – global and Pakistan specific				
1.1To what extent is the CSOs programme design and implementation relevant to the needs of men and women beneficiaries in terms of expected results across all socio-cultural groups including vulnerable in the targeted communities?	GAVI strategy documents 2007-2020 Pakistan documents – UNICEF, GAVI, Research papers/Reviews District immunisation coverage	Desk review CSOs monitoring reports Stakeholder perspectives	GAVI vision is aligned with GAVI support to CSOs in Pakistan % improvement in Immunisation coverage in intervention areas MCH services are accessible to poor women and men in the communities	Narrative - Situation analysis and contextualisation according to local needs
1.2 To what extent are the objectives of the GAVI CSO project consistent with the scope of work delineated in the approved project proposal (i.e. coordination MOH-CSOs, supportive environment for CSOs, work closely with government in enhancing MNCH and immunisation coverage)	Review of federal and provincial documents on immunisation and MNCH priorities 2009-2015 Policy documents Budget allocations	Desk review Record of Meetings between CSOs-MOH/EPI	Alignment of CSOs project document and country or provincial priorities	Funding to priorities match Project and country priorities matched
1.3 Whether the scope is relevant to UNICEF's mandate on health and immunisation and is aligned with national EPI policy and provincial strategies	UNICEF mandate EPI policy and strategies	Desk review	Alignment with EPI/provincial EPI strategy	Narrative – Theme analysis
Area: Effectiveness				
2. To what extent were the GAVI funded CSOs able to implement/achieve the programme design goals				
Evaluation Questions	Data Sources	Data Collection Tools	Indicators of Success	Analysis
2.1 To what extent were the GAVI funded CSOs able to effectively achieve and implement the programme for all rich and poor men and women across socio-economic groups and marginalised and vulnerable groups	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.)	Qualitative – FGDs/IDIs with stakeholders Quantitative data from CSOs progress reports	% achievement of stated indicators and targets Number of Linkages formed % of users who were in the lower socio-economic categories (equitable access) % of female	Theme analysis Quantitative – comparison to trends

			users of services from the total (high utilisation by women compared	
2.2 To what extent was the programme able to achieve its outcome in strengthening and institutionalising meaningful participation of CSOs in national and provincial health strategy development and its implementation?	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.)	Qualitative – FGDs/IDIs Meeting minutes of NHSCC and others	Policy and or planning Meetings with CSOs participation (national or provincial level disaggregation) CSO representation in meetings	Measure what policy, planning or implementation changes occurred due to CSOs influence and participation
2.3 To what extent was the CSO able to advocate for increasing EPI vaccine marginalised children of selected hard to reach districts reference to the project proposal	CSO progress reports Community perceptions (qualitative interviews) Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.)	Qualitative – FGDs/IDIs with stakeholders Quantitative data from CSOs progress reports	% improvement in Immunisation coverage (independent data) % improvement in uptake of MCH services >80% CSOs met their 100% stated targets	Theme analysis - Reasons for performance categories i.e. target achievement (as matched by their own programme data) Deciphering UC level challenges (local officials/outreach workers LHWs, vaccinators) in improving immunisation and MCH services and coverage.
2.4 What were the most effective outputs within the overall programme which contributed to the desired outcomes and why?	Discussions with stakeholders Policy documents	Qualitative – FGDs/IDIs with stakeholders Quantitative data from CSOs progress reports Policy documents	% improvement in Immunisation coverage (independent data) % improvement in uptake of MCH services >80% CSOs met their 100% stated targets	Narrative – Theme analysis Evidence on what outputs were most effective in bringing about a policy or practice change
Evaluation Questions	Data Sources	Data Collection Tools	Indicators of Success	Analysis
Area: Efficiency				
3. Was the GAVI supported CSOs project design and implementation good value for money?				
To what extent have the outputs delivered and outcomes of the project been achieved (in terms of quality and quantity) with the allocated resources/inputs (such as funds, time, and procedures)?	Perceptions of all stakeholders – community, local partners, district and provincial government, and Federal EPI CSOs reports	Qualitative – FGDs/IDIs with stakeholders Quantitative data from CSOs progress reports	number of children immunised number of women availed MCH services	Approximate - Matching of inputs (resources, funds) to outputs and results Comparison of input costs to outputs in terms of costs and matching to other alternative options.
Whether an efficient and robust M&E	M&E reports CSO	M&E reports	Number of M&E	Review the output of

plan is in place and has been fully operational during the project life.	Unit		visits and reports per CSO during project life	the M&E visits and reports and feedback to CSOs (how did it improve programming)
To what extent the resources/inputs (funds, experts, time, etc..) used by the programme were converted to results, i.e., increased awareness about the importance of vaccinating children against vaccine preventable disease? Were the resources allocated adequate in terms of quantity to help achieve project objectives?	Perceptions of all stakeholders – community, local partners, district and provincial government, and Federal EPI CSOs reports	FGDs/IDIs with stakeholders	% improvement in Immunisation coverage (independent data) % improvement in uptake of MCH services >80% CSOs met their 100% stated targets	Approximate - Matching of inputs (resources, funds) to outputs and results
How much clarity was offered by UNICEF in partner selection guidelines about the capacities required for project implementation? To what extent were these adhered to? Whether these helped in achieving results effectively and in time?	UNICEF management interviews CSOs management interviews Perceptions of all stakeholders – community, local partners, district and provincial government, and Federal EPI	Review of the partner selection process (desk review of documents)	Clearly stated partner selection criteria % of CSOs selected that met the selection criteria	Theme analysis - CSOs selection process was need responsive to GAVI, UNICEF and country priorities Selection of geographic areas was need responsive UNICEF role in the process
What areas can be improved for partners' selection in future programmes?	Feedback from stakeholders Review of other best practices and CSO models (regionally or globally)	Desk review FGDs/IDIs	Revised model proposed for partner selection	Recommendations based on the data analysis
Areas: Sustainability and Impact				
4. **Was the GAVI supported CSOs project sustainable and what impact did it have on the country goals vis-a vis the change in practice/uptake of immunisation and MCH services in the communities?**				
4.1 Was there a UNICEF or CSOs Exit strategy	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.)	Qualitative – FGDs/IDIs with stakeholders	UNICEF exit strategy present CSOs project design has an exit strategy	Narrative– implications of an exit strategy in the project design
4.2 Government ownership for continuation	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.) Government PC 1	Qualitative – FGDs/IDIs with stakeholders	Federal and provincial EPI strategies have embedded CSOs-government partnership	Narrative – examples of ownership and buy in
4.3 What impact did this 4 year GAVI funded CSO project have on the communities they served 1) Service provision changes, 2) Improved health outcomes, 3) Better linkages with local partners, 4) Rights of communities at the policy level, and 5) Institutionalised local	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.) Community	Qualitative – FGDs/IDIs with stakeholders	% improvement in Immunisation coverage (independent data) % improvement in uptake of	Triangulation of data sources – CSOs reports, qualitative data and independent area data on short and intermediate outcomes

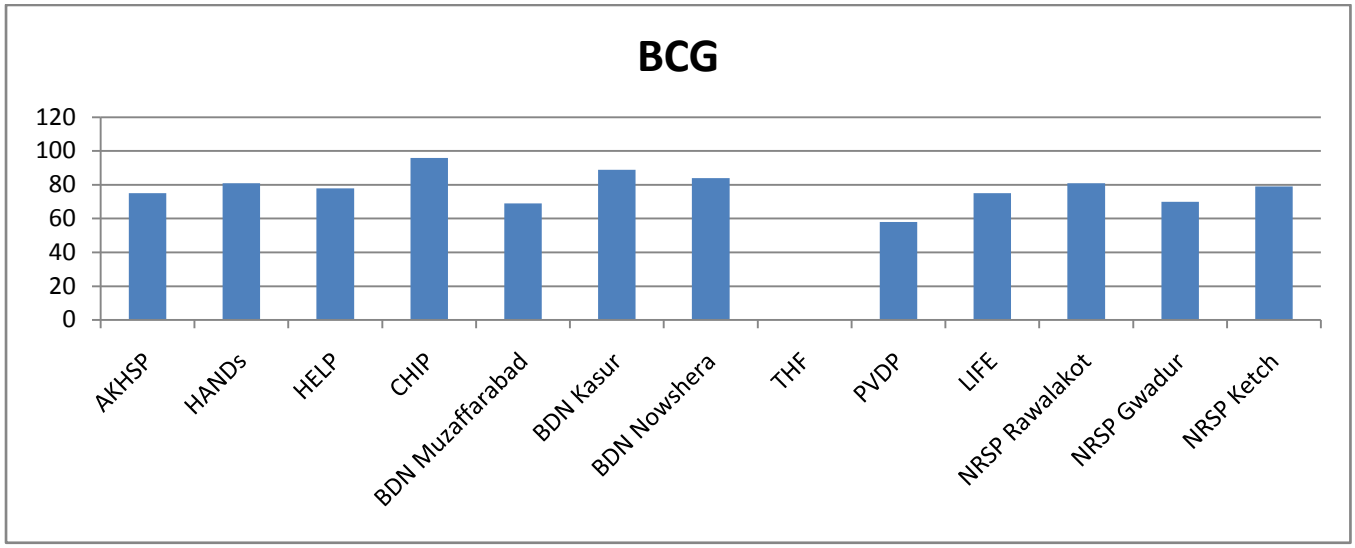
knowledge?	perceptions (qualitative interviews)		MCH services >80% CSOs met their 100% stated targets	
4.4 Lessons learned for the next level of planning and support (if applicable) GAVI UNICEF Government CSOs Communities The Evaluation will address how in the post-devolution scenario GAVI support to CSOs and the management mechanisms may need to be reviewed	Discussions with stakeholders (CSOs, community, LHWs, vaccinators, CSO unit, UNICEF GoP partners etc.)	Qualitative – FGDs/IDIs with stakeholders	Changes and benefits attributable to the CSOs interventions	Discussion of the context and actionable recommendations

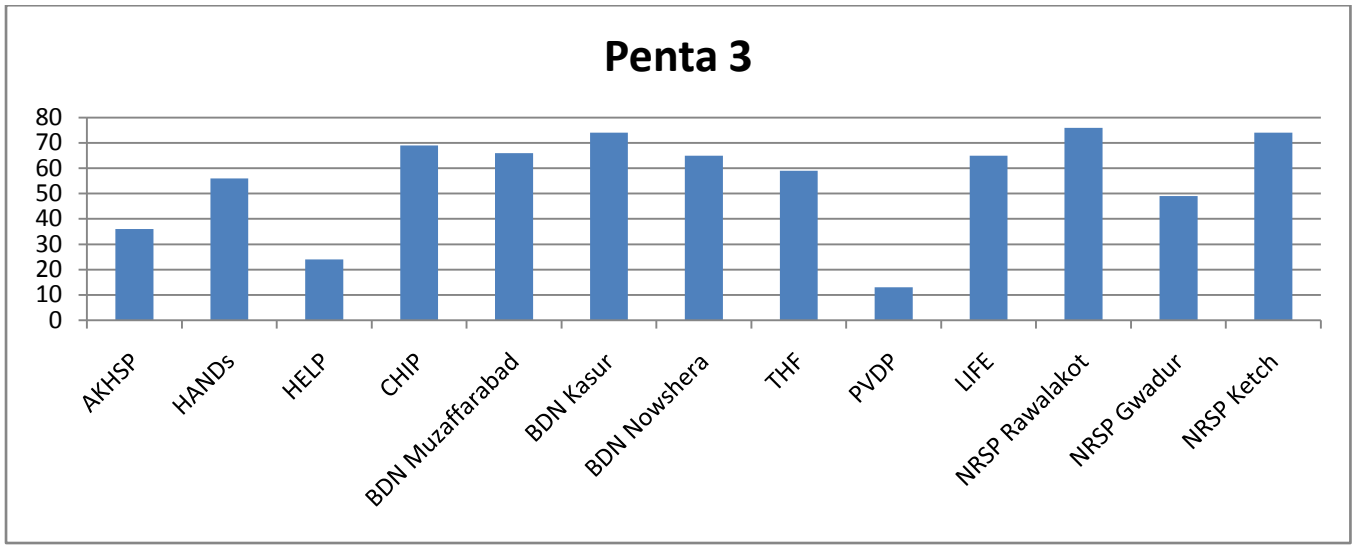
ANNEX 4: CSO PERFORMANCE GRADING CRITERIA

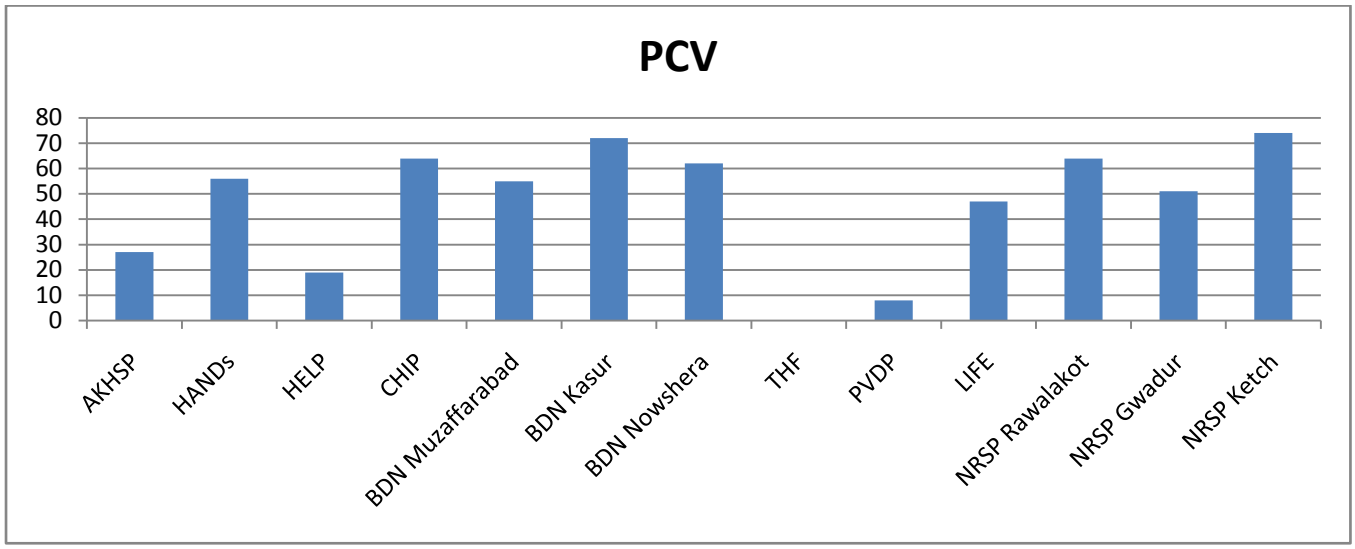
Performance Table for CSOs

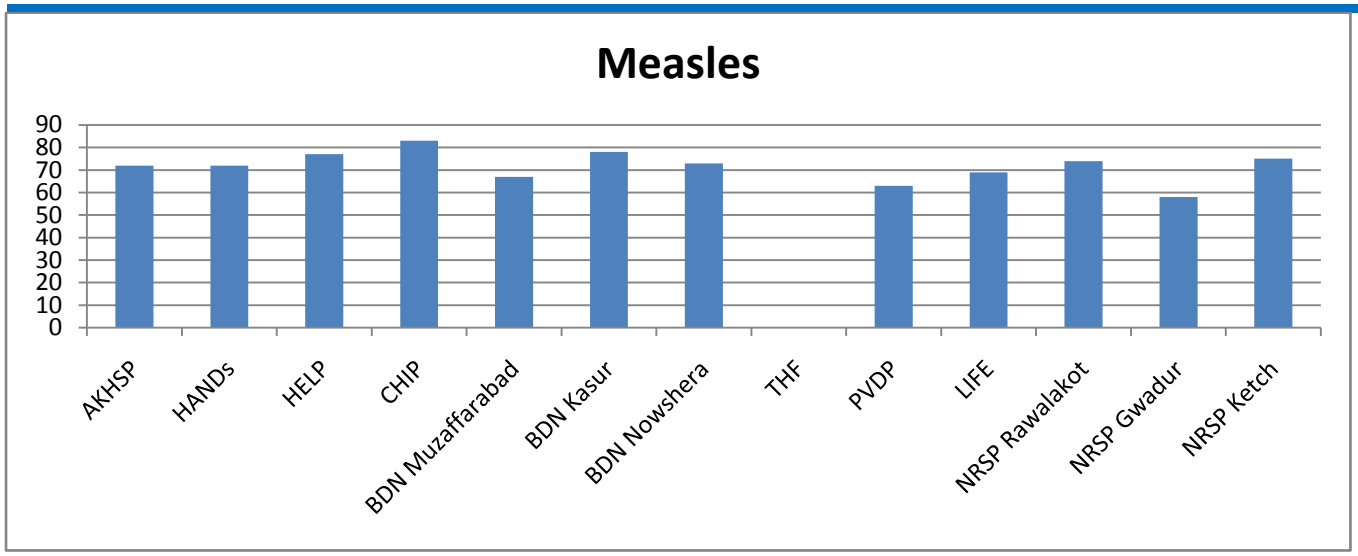
Performance Indicators		AHKSP	HANDS	HELP	CHIP	BDN M	BDN K	BDN N	THF	PVDP	LIFE M	NRSP R	NRSP G	NRSP K	SABAWON P	SABAWON M
ImmunisationCoverage:	BCG	75	81	78	96	69	89	84	-	58	75	81	70	79	88	85
	Penta 3	36	56	24	69	66	74	65	59	13	65	76	49	74	68	71
	PCV	27	56	19	64	55	72	62	-	8	47	64	51	74	68	71
	Measles	72	72	77	83	67	78	73	-	63	69	74	58	75	77	73
	Children never vaccinated	20	18	15	2	30	9	16	-	26	25	19	28	19	13	15
Knowledge Level of respondents regarding childhood vaccination	Knowledge about 3 or more childhood vaccine preventable diseases	36	80	46	24	34	68	49	28	52	54	62	14	62	48	50
	Knowledge about childhood vaccine schedule	1	37	3	37	41	61	45	-	5	30	73	8	27	32	44
Maternal Health	ANC by skilled provider	55	86	-	58	50	82	89	-	50	90	90	62	78	92	84
	Pregnant Women TT	53	60	59	75	42	84	53	-	33	80	89	87	68	65	65
	Pregnant Women receiving all 4 contents of ANC	8	45	-	18	29	16	47	-	14	59	59	31	66	54	22
Delivery by Place and Type of Provider	Deliveries at Health facilities	61	73	-	12	27	47	58	-	64	56	67	37	61	71	56
	Deliveries attended by skilled providers	71	73	-	22	31	50	65	-	63	75	72	46	75	78	69
Sources of information and Knowledge Level regarding Safe Motherhood	Danger signs during pregnancy or delivery (at least 3)	20	73	-	52	36	55	73	-	48	62	39	12	58	57	78
	Information From NGO	2	12	4	30	2	1	0	-	3	1	1	2	2	0	0

ANNEX 5 PERFORMANCE COMPARISON OF CSO FOR EACH INDICATOR








Measles
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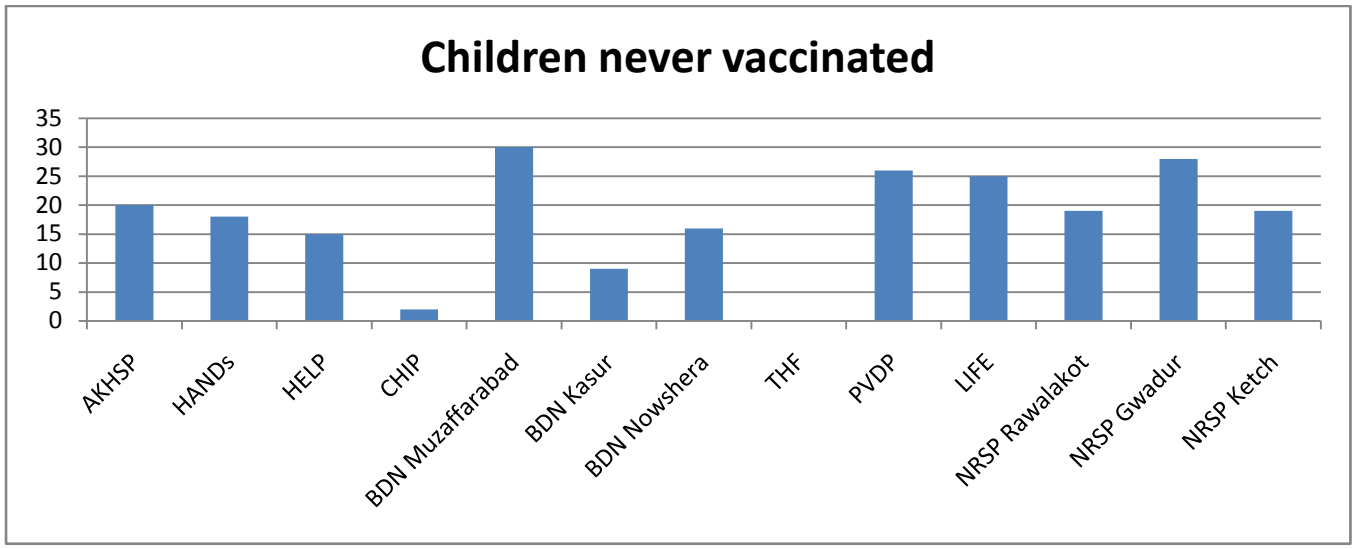
Children never vaccinated
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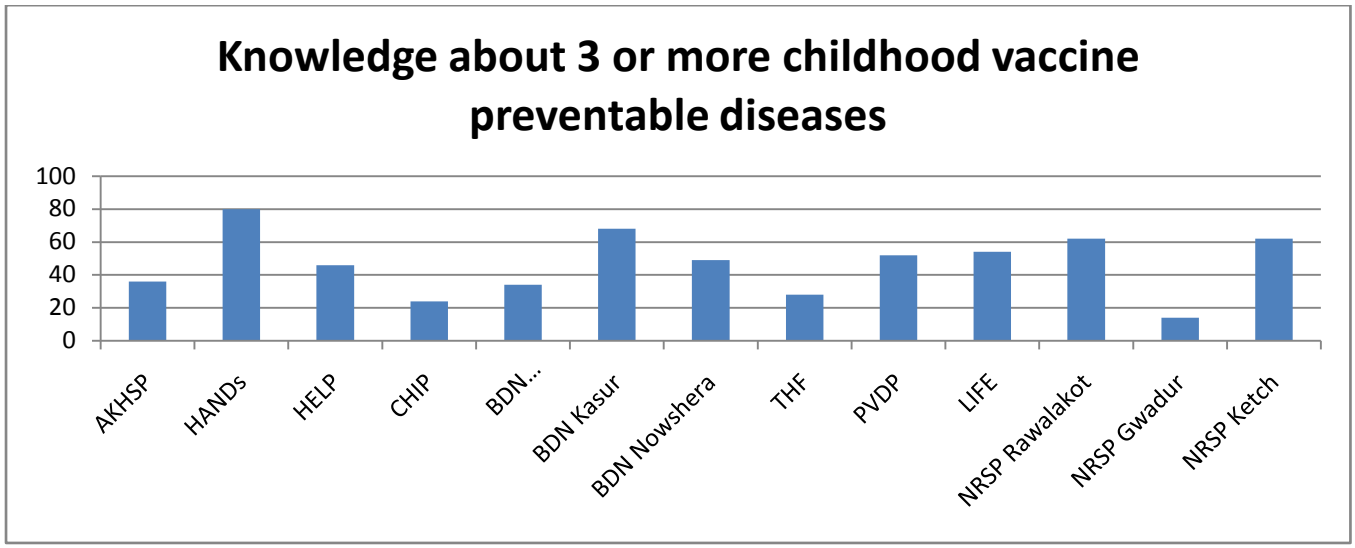
Knowledge about 3 or more childhood vaccine preventable diseases
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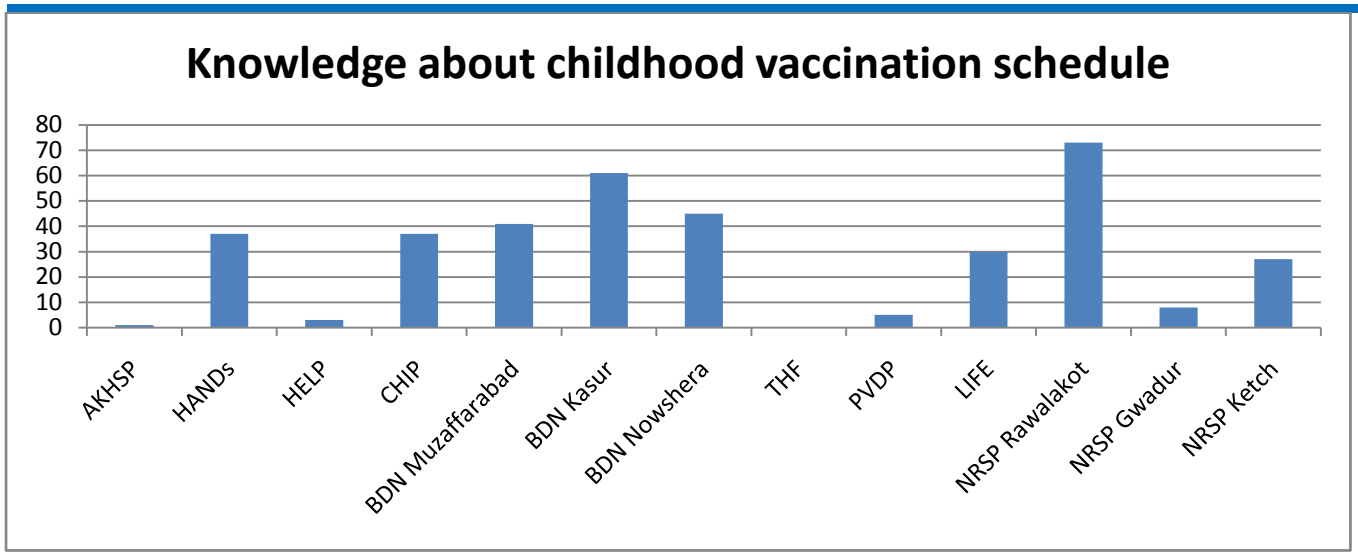
Knowledge about childhood vaccination schedule
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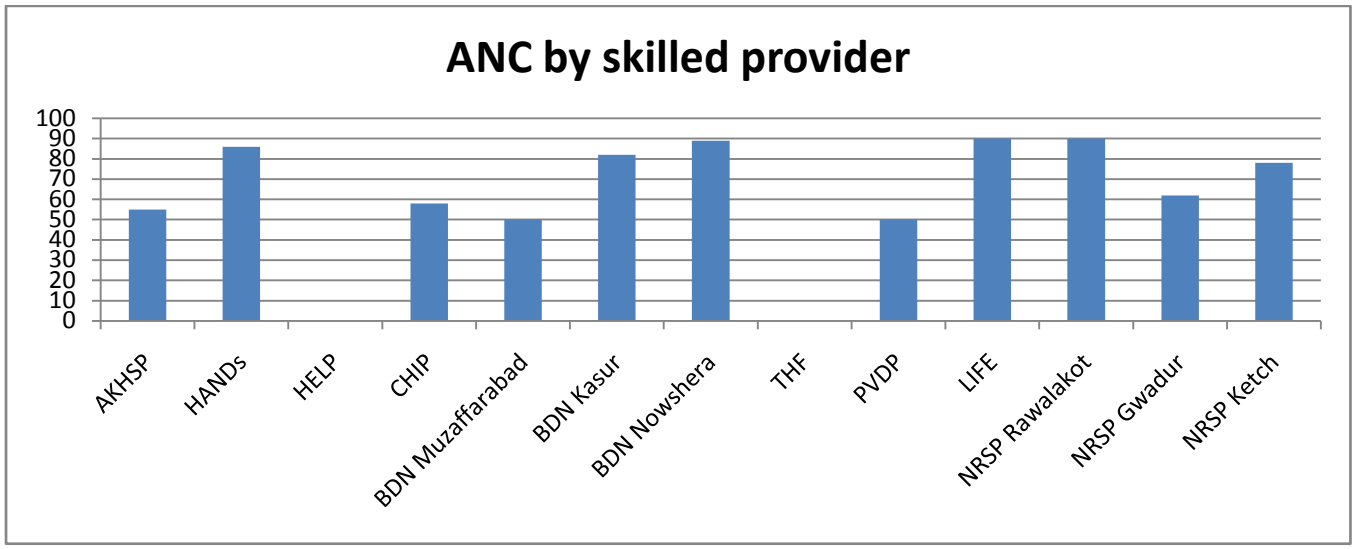
ANC by skilled provider
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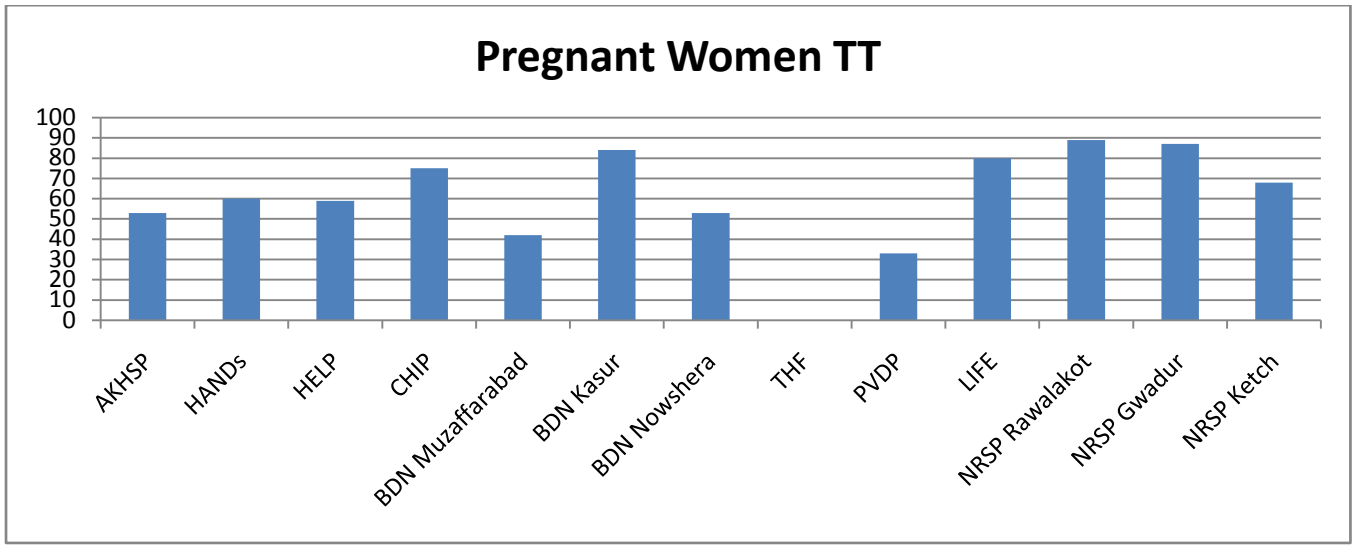
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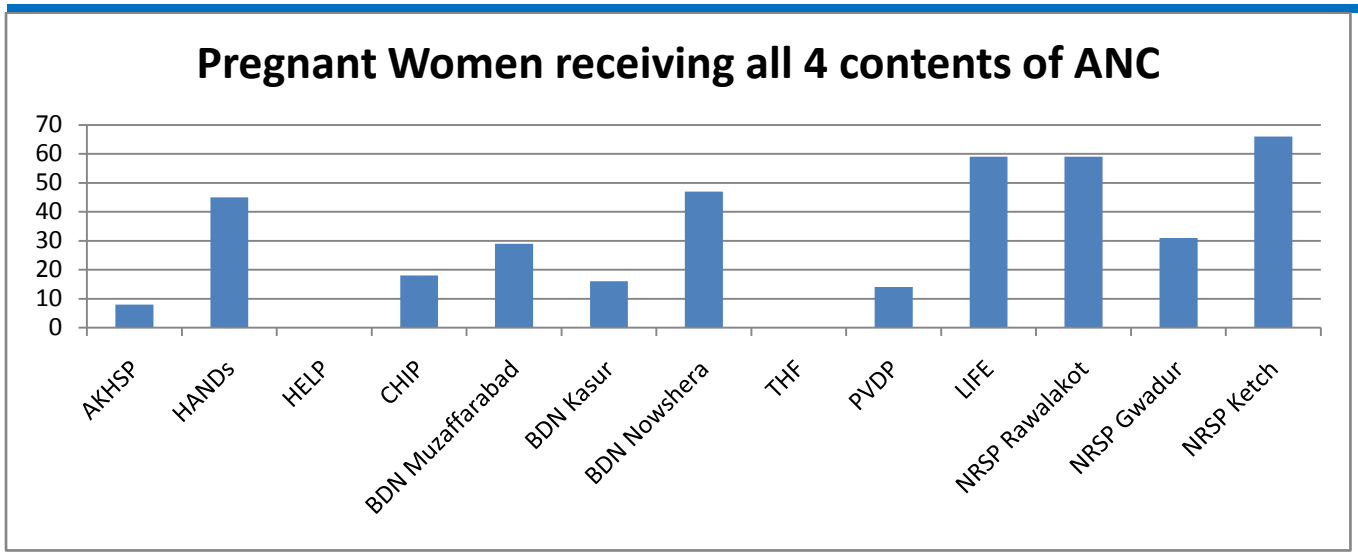
Pregnant Women receiving all 4 contents of ANC
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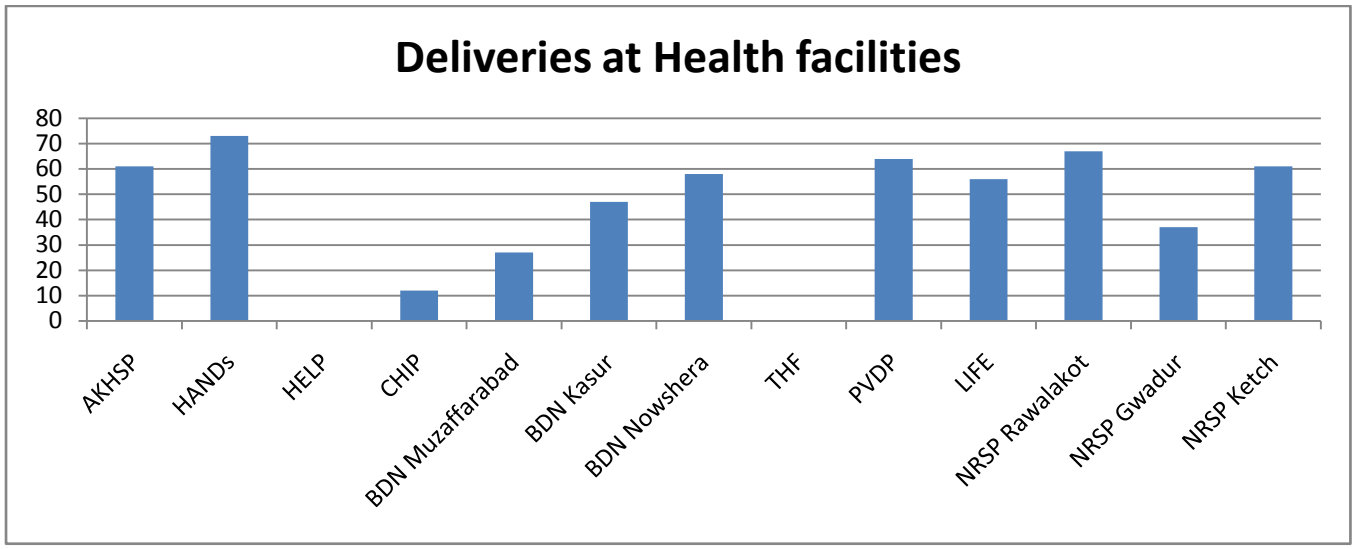
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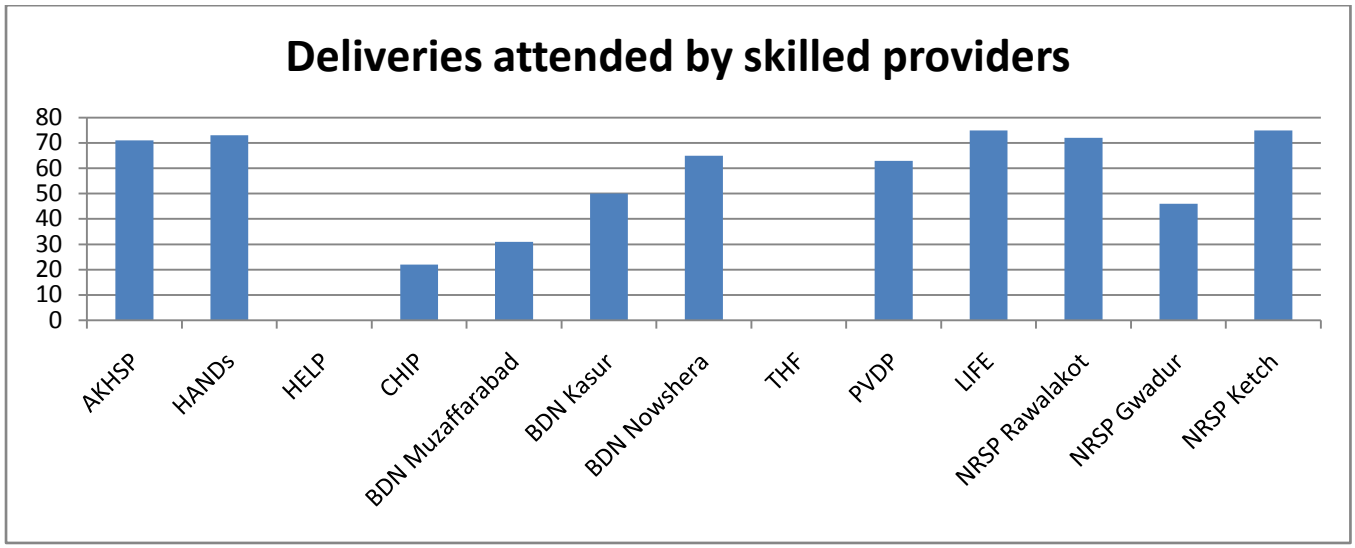
Deliveries attended by skilled providers
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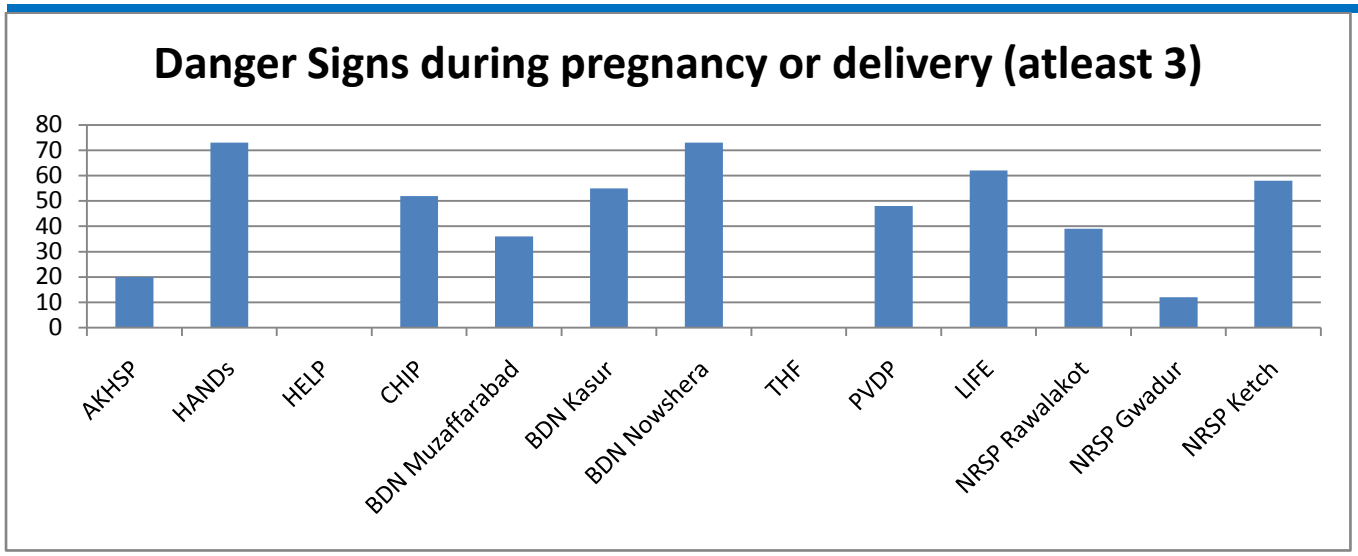
Danger Signs during pregnancy or delivery (atleast 3)
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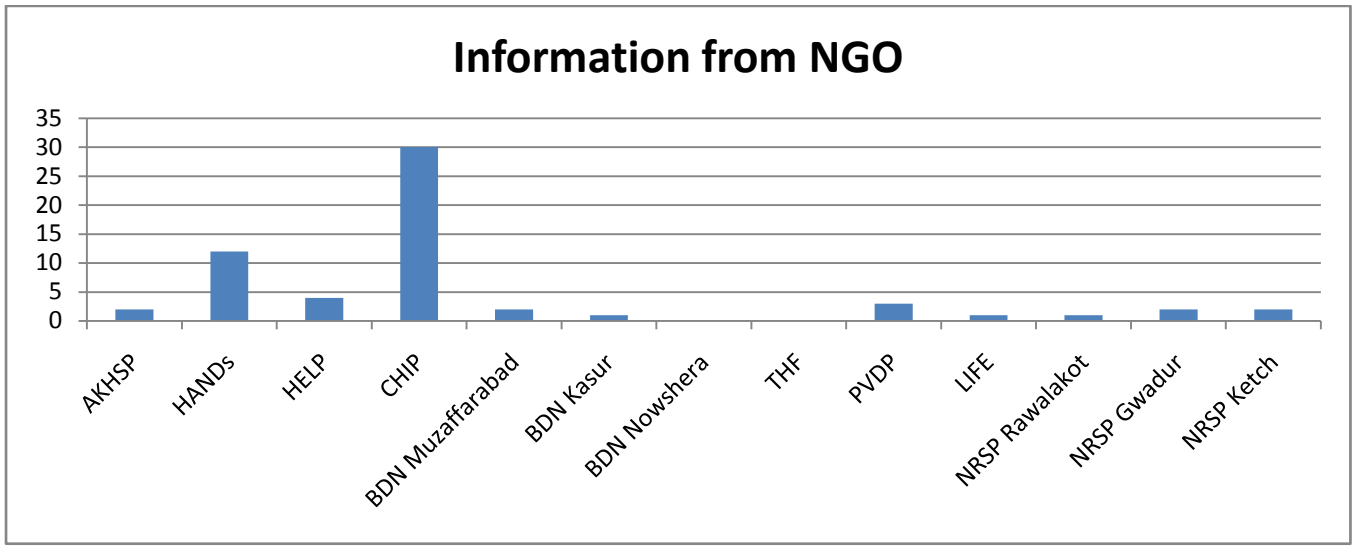
Information from NGO
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ANNEX 6 TERMS OF REFERENCE

Terms of Reference (UNICEF): Evaluation of the GAVI supported CSO project to strengthen the involvement of CSOs in immunisationand related health services in Pakistan

1. Programme Background

Pakistan's population exceeds 180 million people makes it the sixth most populous country in the world with one fifth of the total population living below the poverty line and housing the fifth largest number of un immunized U5 children. The population is growing fast (pop growth rate 1.55%) and will likely to exceed 210 million by 2020. The birth rate is estimated to be 24.3/1,000 population.

Pakistan's Federal Ministry of Health was abolished in 2011 as an aftermath of implementation 18th constitutional amendment by virtue of which the autonomy was devolved to the provinces. In the wake of this decision resulting in fragmentation of Health, there was lack of clarity & coordination between the federal & provincial levels. Interagency turf tensions disconnect between information & policy & lack of clarity about responsibilities vs countries public health priorities, created difficulty for international partners and created more challenges for health services at all levels.

In Pakistan, nearly one in ten children dies before her/ his fifth birthday in Pakistan (**U5M 89/1000 live births**). Most of these children do not even reach one year (**IMR: 74/1000 live births**). They are particularly vulnerable in their first month of life and new born mortality accounts for over half of all under-five deaths in the country1 (**Neonatal Mortality: 55/1000 Live Births**). **The neonatal mortality has remained stagnant for the last decade.** Each day 618 new borns die and in 2009 Pakistan accounted for 6.9% of global new born deaths, ranking 191 out of 193 countries in total number of new born deaths worldwide.2

1 Pakistan Demographic and Health Survey (PDHS) 2012/13.

2 Oestergaard et al, 2011, Neonatal Mortality Levels for 193 Countries in 2009 with trends since 1990: A Systematic Analysis of Progress, Projections, and Priorities, PLoS Medicine , August 2011, Volume 8, Issue 8.

3 Pakistan Demographic and Health Survey (PDHS) 2012/13.

Contributing to these worrisome infant and child mortality rates is low immunisationcoverage (**only 54% children 12-23 months fully immunized**). Pakistan has the fifth largest number of unimmunised children in the world, and provinces like Balochistan and the Federally Administered Tribal Areas (FATA) have much lower coverage than the rest of the country. The percentage of fully immunized children ranges from as low as 16% in Baluchistan compared to Punjab having the highest coverage at 66%.3 There is **significant inequity** (by socio-economic status, Rural/Urban, education, gender) **in service access and utilization**, with little change since the 1990s. Due to deteriorating routine immunisation(RI) coverage all over Pakistan, numerous measles outbreaks with thousands of cases and hundreds of deaths have occurred since 2012. Most of the cases were aged bellow 10 years and about two-third were reported unvaccinated. A nationwide Supplementary ImmunisationActivity (Measles SIA) was started in 2014 to be finalized by mid-2015, as part of strengthening of the RI.

In recent years, GoP began tapping into the potential of civil society organizations for availing benefits of working together for health system strengthening. To enable the country to address the emerging opportunities and challenges associated with the 18th Constitutional Amendment, after which a number of health related functions were transferred from the federal to provincial governments, it is essential to further augment the role of CSOs and build alliances with professional networks and associations. Therefore, continued support is required to strengthen CSO Government partnership until it is institutionalized. The Global Alliance for Vaccine and Immunisation(GAVI Alliance) is supporting Civil Society Organization (CSOs) for increasing their involvement for health system strengthening towards achieving Millennium Development Goals (MDGs) 4 & 5. GAVI Alliance funding was the first of its kind that particularly focused on bridging the gap and strengthening relations between CSOs and the government. There were two types of funding. Type A funding constructively addressed various challenges ranging from weak communication and collaboration between CSOs and government and occasional misunderstandings. Until that time, a common platform did not exist for interaction between government and CSOs at all levels. The 15 member consortium of CSOs, mapped under Type A fund, has established a national coalition of CSOs in Pakistan to interact with government on public health sector issues at a number of levels, including policy and service delivery. Progress and achievement by CSO Pakistan under Type A include mapping, capacity building and declaration of partnership between CSOs and GoP, and proposal development processes to secure funding for Type B among others. These Type A CSOs are working in areas of immunisationand maternal and child health with particular focus on hard to reach communities. Later on CSO Type "B" funding came in and initiated support for 14 CSOs throughout Pakistan in selected locations of 21 districts strengthening of routine immunisation. The main focus of their activities is in service delivery, with an emphasis on social mobilisation by Lady Health Workers and community-based support. These districts are located in all four provinces, Azad Jammu and Kashmir (AJ&K) and Gilgit-Baltistan (GB). With the continuation of Type A funds, the government and CSOs envisage working towards achieving the following objectives:

1. To strengthen and institutionalize meaningful participation of CSOs in national and provincial health strategy development and its implementation;

2. To advocate for increasing coverage of EPI vaccines to marginalized children of selected 'hard to reach' districts;

3. To encourage knowledge development for overcoming the operational issues of vaccinators (EPI programme), lady health workers (FP&PHC programme), and community midwives (MNCH programme) and generate best practices at all levels.

Two more objectives were added to the already existing three objectives in 2013 seek to address the changing environment brought into being by decentralization and are as follows:

4. Partnership building with provincial governments and

5. Advocate for CSOs' involvement at policy level.

Monitoring was a very strong component to enable integration within the existing structures. Vigorous M&E process were proposed to verify actual progress against stated objectives. CSO Monitoring Unit comprising of three members was expected to play a vital role to ensure effective and transparent utilization of funds, monitoring and reporting to MoH. The overall management of this continued Type A, over a period of two years, was through Federal EPI Cell, Ministry of Health and UNICEF Country Office did the funds management on behalf of the government. 3

In April 2013, the Independent Review Committee (IRC) of GAVI stressed on having a coherent and focused CSO Type B programme using the existing M&E Framework with clear baselines and targets, so that progress over time and for 2013/14 can be monitored. Though CSOs have been working on ground since 2009 and no baseline was undertaken to measure the progress of work. So the baseline survey was completed out in 19 districts during the second quarter of 2014 to establish baseline for immunisationand maternal, newborn and child health projects implemented by 12 CSOs. The project documents do not present a clear theory of change for this project. Lack of a clear theory of change or logic framework has been a big challenge for the project and would also confront the evaluation team.

2. Evaluation Purpose

The purpose of this assignment is to evaluate the impact of the GAVI funded CSO support on advocacy, policy engagement, networks and impact on immunisationand to determine the extent to which the programme has been able to deliver on these aspects. The evaluation findings will be shared with the Government and are expected to help improve programme efficiency as well as enhance equity aspects of various interventions in future.

3. Objectives

1. Review whether the project interventions were aligned with the objectives of the GAVI CSOs grant.

2. Assess the extent to which this project has been able to strengthen and institutionalize meaningful participation of CSOs in national and provincial health strategy development and its implementation.

3. Assess whether CSOs supported by GAVI have been able to advocate for increasing coverage of EPI vaccines to marginalized children of selected hard to reach intervention districts.

4. Evaluate to what extent the resources/inputs (funds, experts, time, etc..) used by the programme were converted to results across genders and various socio-economic groups.

5. Determine whether the CSOs have been able to build strong CSOs coalition and linkage with the provincial health department and advocacy for CSOs engagement at policy level.

6. Identify lessons learned and formulate recommendations on how to best engage CSOs in future Health Systems Strengthening projects and enhance equitable results.

4. Scope

a. The evaluation will cover the entire programme and all its phases. The overall time frame of the programme covered by the evaluation will be from 2009 to 2015. It would cover all four provinces as well as two areas namely Gilgit Baltistan (GB) and Azad Jammu and Kashmir (AJK).

b. Main stakeholders of this programme are Federal EPI cell, Ministry of National Health Services Coordination and Regulation (MoNHSR&C), Provincial and district EPI, provincial Department of Health of all four provinces and two areas, UNICEF, WHO and Civil Society Organizations; all of these will be involved in the process of evaluation. Although all stakeholders are expected to benefit, however, the Department of Health, EPI and CSOs will benefit the most from the evaluation findings not merely because of direct 4 involvement in GAVI CSOs implementation process but also because the evaluation is expected to determine the future role of CSOs in GAVI supported Health System Strengthening (HSS) grant.

***5.* Evaluation Criteria and Questions**

The evaluation will use UNICEF and UNEG's recommended OECD/DAC criteria covering aspects of relevance, efficiency, effectiveness, impact and sustainability (explained in detail below). It would also use equity and human rights lenses for analysis and recommendations. It is not an impact evaluation with a counterfactual requirement. However, the phrase 'impact' and the questions underneath address the aspects related to impact as part of the standard OECD/DAC criteria to measure any long term outcomes:

Some proposed evaluation questions related to these criteria are given in the following. These will be finalized by the evaluator during inception meeting:

5.1. Relevance

i. To what extent the programme design and implementation was relevant to needs of men and women beneficiaries in terms of achieving expected results across all sociocultural groups including the vulnerable in the targeted communities?

ii. To what extent the objectives of the GAVI CSOs project are consistent with the scope of the work delineated in the approved project proposal (i.e. to improve coordination between the MoH and CSOs, create supportive environment for CSOs to play an active role in health programme delivery, work closely with the government in enhancing MNCH and immunisationcoverage).

iii. Whether the scope of work is relevant to UNICEF's mandate on health/immunisationand is aligned with national EPI policy and provincial EPI strategies.

5.2. Effectiveness

i. To what extent were project implementation strategies effective and successful in achieving the planned outcomes/results for rich and poor men and women across all sociocultural groups including the most marginalized and vulnerable in the targeted communities?

ii. To what extent the programme was able to achieve its outcomes in strengthening and institutionalizing meaningful participation of CSOs in national and provincial health strategy development and its implementation?
iii. To what extent CSOs were able advocate for increasing coverage of EPI vaccines to marginalized children of selected hard to reach districts reference to the project proposal?

iv. What were the most effective outputs within overall programme which contributed to desired outcomes and why?

v. To what extent the equity principles were integrated in the project implementation (social mobilisation, BCC, supplies facilitation, and others) and substantiated by project results?

vi. Whether the gender analysis carried out within the communities and was used to inform programme implementation? Can the results be gender disaggregated?
5 Some of the sub-questions are also suggested to probe further the effectiveness aspects. These can be integrated in the tools/questionnaires related to each aspect:
a. Whether CSOs have a strategy for seeking notification in favor of recognition of Gavi CSOs Coalition from Federal and provincial governments?
b. Whether CSOs were able to secure representation in the provincial health sector coordination forum?

c. Whether mapping of stakeholders engaged in MNCH in the selected districts to create synergies for developing coordinated strategies to improve RI.

d. What is the district level coordination mechanism in place; how effective it is and whether capacity building of selected stakeholders in establishing the coordination mechanism?

e. How effectively CSOs worked with district health department during Polio campaigns both NIDs and SNIDs, World ImmunisationWeek, Mother and Child Health weeks.

f. Whether database of research findings exist at CSO level to assist government to utilize for decision making.

g. Whether documentation of best practices (to increase accessibility in hard to reach areas for enabling partnerships and local communities) was undertaken and available.

h. Whether documentation of updates to share field issues ()to assist government for developing joint strategies aiming for strengthening health and immunisationsystems on a quarterly basis from each district was undertaken and now available?

i. What was the role of CSO unit?

5.3. Efficiency

i. To what extent have the outputs delivered and outcomes of the project been achieved (in terms of quality and quantity) with the allocated resources/inputs (such as funds, time, and procedures)?

ii. Whether an efficient and robust M&E plan is in place and has been fully operational during the project life.
iii. To what extent the resources/inputs (funds, experts, time, etc..) used by the programme were converted to results, i.e., increased awareness about the importance of vaccinating children against vaccine preventable disease?
iv. Were the resources allocated adequate in terms of quantity to help achieve project objectives?
v. How much clarity was offered by UNICEF in partner selection guidelines about the capacities required for project implementation? To what extent were these adhered to? Whether these helped in achieving results effectively and in time?
vi. What areas can be improved for partners' selection in future programmes? 6

5.4. Impact (long term outcomes)

i. To what extent the project was able to improve the coordination between departments of health and the CSOs both at the district and provincial levels.

ii. To what extent the project was able to create the supportive environment for CSOs to play an important role in service delivery, evidence generation and informing policy and practice.

iii. To what extent the GAVI funded CSO support was able to help improve immunisationcoverage for girls and boys, especially among those belonging to the most marginalized socio-economic groups.

5.5. Sustainability

i. How far and in which ways the programme benefits will be able to continue after the culmination of UNICEF support?
ii. Whether an exit strategy is available for the Gavi supported CSO project?
iii. Was sustainability aspect of the programme a part of the design from the outset?
iv. What is the level of commitment amongst stakeholders to sustain the current immunisationstatus or increase it further in project areas? Are there any challenges? Whether and in which ways the government will be able to sustain the momentum built by CSO project and its benefits for the disadvantaged women without Gavi support?
The above mentioned proposed evaluation questions will be further refined and finalized by the consultants in the inception report in consultation with the Reference Group and key stakeholders.

6. Methodology

This is a summative evaluation that will need to use mixed method approach (both Quantitative and qualitative methods). The overall methodology will include a thorough desk review of all the relevant key documents (a list will be prepared in consultation with the key stakeholders and provided to the consultant). Using quantitative method, a short survey of current usage of services from selected health centre supported by Gavi CSO project will be conducted. To help explore in depth findings, semi-structured interviews with key informants and focus group discussions both at national and provincial levels will be held to take advantage of the qualitative approaches for understanding the existing situation, gaps and suggestions

for ameliorative actions. The recommendations are also expected to help at the broader policy level.

Based on the above guidance, the consultant is expected to discuss the proposed methodology with the programme staff and key stakeholders during scoping discussions and inception meeting to agree on and finalize a detailed methodology that will be presented in the inception report. Since this project does not have a clear theory of change elaborated in the documents, therefore, finalization of the methodology will also include discussions with key stakeholders to derive an agreed theory of change for the project. The inception report will clearly lay down the agreed theory of change as well as the final evaluation questions derived out of the same. Throughout the evaluation process, UNICEF's quality standards for evaluation and ethical safeguards will be strictly followed.

7. 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 ensure informed consent, the consultant will be expected to annex sample consent forms for various types of respondents.

8. Deliverables

i. Inception report *(based on an outline/format to be provided by PMER) including a clear theory of change, evaluation matrix, interview protocols and other tools).*

ii. 1st draft report

iii. 2nd draft report (after incorporation of al comments from all respondents and audit trail)

iv. Presentation to stakeholders/Reference Group of main findings and recommendations and building consensus on major actionable recommendations.

v. Final report (and audit trail)

vi. Final debrief to UNICEF senior management (if required)

9. Timeframe

oTwo months and 20 days (May 10– July 30 2015), various outputs that need to be separately factored in by the consultant and included in the detailed work plan will include:

oDesk review

oBriefings of evaluator(s)

oPreparing and sharing the detailed inception report, incorporation of all feedback from UNICEF and other stakeholders in the revised inception report

oEvaluation mission (details of field work)

oPreparing the draft report

oIncorporation of all feedback from UNICEF and other stakeholders in the revised draft stakeholder meetings

oFinalization of report

oIncorporation of all feedback from UNICEF and other stakeholders (if any). Discussion of final findings and recommendations with stakeholders. Final debriefing to UNICEF senior management (if needed)

ANNEX 7: QUESTIONNAIRES / INTERVIEW GUIDES

Focus Group Discussions (FGDs): Community

Salaam Alikum!

I am _____ and I am working with a research organization working with the GAVI-UNICEF supported CSOs immunisation/MNCH/health program. I would appreciate some of your valuable time to go over issues (both strengths and limitations) regarding your experience.

Please be assured that this FGD is voluntary, and all your responses will be confidential. The interactive discussion will take 45 minutes and we will be taking notes and also recording in order not to miss any important issues that are discussed. If you have any questions please feel free to ask them any time.

Name		Gender	
Age group (Range)		Total no. of respondents	
District		UC Name	
Village name		FGD start time	
FGD end time		Date	

Themes	Probe
Socio- Demographic Characteristics of End Beneficiaries Observation – users of services. Ask community who were the users of services? Did the services successfully reach the most poor people/marginalized? Women and children – were they an equal part? How so?	Age group Education Occupation Marital status No. of children
Access and Availability of Health Services? (Access to Services) Which services did they mainly use – Immunisation, Maternal, other health related? Outreach (OR) access to their households? Facility access? Discrimination or barriers to access of services? Which GAVI supported CSOs? Other NGOs?	Importance of which services to them? Reasons? How frequently were they visited by OR Time and resources needed to access those services Perceptions and experience of the CSOs – both outreach and how the CSO staff helped them access services?
How did they learn of the CSOs or Health Services (those that they availed)? – (Access to Information) Was it early on? At a later stage of the CSO services How can it be done better Did their neighbours/family/others also use these services	Estimation of the coverage by the community perspective – was it commonly used, often, or rarely Dissemination of CSOs information in the community "spaces" – are there such spaces for women? Spaces for men?
Experience value to them – Outreach activities (Value Utility and Change of Practices Theory) Was it just a health visit or did they build rapport How was this interaction different from others? What changed for them – trainings, capacity building, cost savings, respect?	CSO outreach workers/name of CSO Examples of change in practice, understanding or approach?
Experience change of other Local Health Providers (Community Level Change in Health Provision) As a result of the CSOs efforts does the local LHW or vaccinator or other health provider – give them better services? What can be done differently?	Examples how CSO presence changed the community receptivity/acceptance to health services? Examples how other providers improved or remained unchanged?
Replacement and Continuity (Sustainability value) If the CSO is no longer there how will it affect your/child's well being/or family health/ life – health services What would you like to happen – How much can you contribute to its continuity?	Examples of loss of service Examples of support
Overall Perception and Suggestions What should the next type of support be for you? Do you have local self-institutions or organizations that you feel would be better for the neighbourhood? Others	Changes from this current model?

Focus Group Discussions (FGDs): LHW and Vaccinator

Name		Gender	
Age group (Range)		Total no. of respondents	
District		UC Name	
Village name		FGD start time	
FGD end time		Date	

Themes	Probe
Socio- Demographic Characteristics of Local Partners Who were the local partners – roles, capacity Who were the end users – women, marginalised populations? Were rights of the community a key priority in the approach of the CSOs?	Educational attainment Years in service, locals vs. outside UC Type of roles – current and past General experience of their work, expectations
Access and Availability of Health Services (Access to Services) How did the CSO presence improve access and availability of services to the community How did it influence the work/roles of the LHWS or vaccinators	Complementarity in tasks? Examples Facilitation roles – who did what Duplication of services? Frequency of visits to HHs – changes? Due to the CSO presence? Communication with CSOs – changes Communication with local officials – changes Communication with facilities – changes
3. Were the CSO objectives and activities clear to them (Access to Information) Did they understand, agree with the objectives/activities as the need of the community and area (relevance of activities) Was there flexibility to change activities and give feedback?	Their perceptions of community uptake Their general impressions of relevance and was the programming "needs based" – were they part of the CSOs planning processes? Did the activities evolve over time? For better or worse?
4. Experience value to them – Change in Their Capacities (Value Utility and Change of Practices Theory) Capacity building Why and how was this interaction different from others? What changed for them? Time period of change?	Which CSOs or outreach workers What type of capacity built – examples Examples of change in their practice, understanding or approach?
5. Experience change in the Community practices (Community Level Change in service uptake) As a result of the CSOs efforts has the community changed health seeking, importance of immunisation? What can be done differently?	Examples how CSO presence changed the community receptivity/acceptance to immunisation or other health services? Examples how other area providers improved or remained unchanged (Motivation, competition, incentives)?
6. Replacement and Continuity (Sustainability value) If the CSO is no longer there how will it affect your work? b. What would you like to happen –	Examples of loss of service Examples of support – time, resources, others?
7. Overall Perception and Suggestions What should the next type of support to CSOs be like? Do you have local institutions or organizations that you feel would be better for the neighborhood? Others	Changes from the current model?

In-depth Interviews (IDIs): CSO Management/Outreach Workers

Name		Gender	
Age group (Range)		Total no. of respondents	
District		UC Name	
Village name		FGD start time	
FGD end time		Date	

Themes	Probe
Socio- Demographic Characteristics of CSOs users? Who were the users CSO vision/mandate? Did the services successfully reach the most marginalised? Women and children – were they an equal part? How was that measured?	Age, education, SES, poverty scoring Distance from CSOs services
Access and Availability of Health Services? (Service Provision perspective) Which services did they mainly provide– Immunisation, Maternal, other health related? Outreach (OR) access to households? Facility access and linkages? Other NGOs present in the area? **Management perspective – what kind of support was there from UNICEF or CSO Monitoring Unit?**	Importance of services? Reasons? How frequently did you visit or engage with HHs? Time and resources needed Perceptions and experience CSOs – both outreach and how the CSO management helped them access services? Communication with district officials, UNICEF, LHWs/vaccinator
How did the CSOs create demand for services? – (Access to Information) Define the process- reaching out to communities, meetings? How can it be done better What services were popular? Role of management? Role of outreach workers- feedback into programming? Advocacy of immunisation? Representation of CSOs on policy forums? Where and how was it done?	Estimation of the coverage– was it commonly used, often, or rarely Dissemination of CSOs information in the community "spaces" – are there such spaces for women? Spaces for men? Local strategies that they tried?
Experience value to CSOs – Outreach activities (Value Utility and Change of Practices Theory) Community recognition, respect, appreciation? GAVI and UNICEF support – how was it different What changed for them – trainings, capacity building, cost savings, respect?	Examples of how GAVI support to the CSO enabled them to change community outcomes? Examples of change in practice, understanding or approach?
Experience change of other Local Health Providers (Community Level Change in Health Provision) As a result of the CSOs efforts have the local officials and services become more responsive to immunisation, MNCH or other health? What can be done differently?	Examples how CSO presence changed the community uptake of health services? Examples how providers improved or remained unchanged?
Replacement and Continuity (Sustainability Planning) If funding is no longer available how will the CSO continue? What would you like to happen – How can you contribute to its continuity?	Exit strategy or planning in anticipation Other examples of support
Overall Perception and Suggestions What should the next type of support be like? Do you think funding to community directly or grassroot CBOs would be better? Others	Changes from this model?

In-depth Interviews (IDIs): Provincial/Federal EPI and Health Department Officials

Name		Gender	
Age group (Range)		Total no. of respondents	
District		UC Name	
Village name		FGD start time	
FGD end time		Date	

Themes	Probe
Socio- Demographic Characteristics Government Partners Roles and understanding of their roles – with CSOs and with UNICEF? Expectations of the CSO project? Was it met? Priorities for marginalised population and health outcomes? Were they met through this project?	Age, background education, gender Years in service Province?
Access and Availability of Health Services? (Service Supervision perspective) Which services improved with GAVI supported CSOs activities? Facility access and linkages, data management, reporting etc.? Others? Other NGOs present in the area? Comparison with their performance? **Management perspective – what kind of support was there from UNICEF or CSO Monitoring Unit? Coordination and communication?**	Examples? Immunisation indicators Measures of tracking Community feedback LHW or vaccinator feedback? Time and resources needed Perceptions and experience
How did the CSOs create awareness and advocacy? – (Access to Information) Define the process- engagement with officials, meetings, working knowledge? How can it be done better What changes occurred – implementation or policy level? How did district or UC level changes happen? Advocacy of immunisation? Representation of CSOs on policy forums? Where and how was it done?	Estimation of the coverage– was it commonly used, often, or rarely Dissemination of CSOs information – formal forum or through informal channels? Which CSOs were better? Reasons Effect of devolution and changes?
Experience value to Government – (Value Utility and Change of Practices Theory) Improved outcomes? Partnerships? Knowledge base? GAVI and UNICEF support – was it useful and effective? What enabled change in you– trainings, capacity building, cost savings?	Examples of how GAVI support to the CSO enabled them to change outcomes? Examples of change in <u>your</u> practice, understanding or approach? Frequency of interactions with UNICEF, CSO Unit and CSOs
Experience change of other Local Health Providers (Community Level Change in Health Provision) As a result of the CSOs efforts have the local providers and services become more responsive to immunisation, MNCH or other health? What can be done differently?	Examples how CSOs model in different areas has worked or not? Examples how providers improved or remained unchanged? Reasons Provincial differences?
Replacement and Continuity (Sustainability Planning) Once GAVI funding not available will Government support CSOs in this same manner? What would you like to happen – How can you contribute to its continuity? Is UNICEF the best management partner or can it be different?	Exit strategy or planning in anticipation Other examples of support
Overall Perception and Suggestions What should the next type of support be like? Do you think funding to community directly or grassroots CBOs would be better? Others	Changes from this model?

In-depth Interviews (IDIs): UNICEF, CSO Monitoring Unit and GAVI Representation

Themes	Probe
Management Characteristics Roles and understanding of their roles – GAVI CSO strategy expectations and clarity Country expectations and priority – alignment?	Age, background education, gender Years in service Position at organisation
Access and Availability of Project Activities (Service Supervision and Management perspective) Management processes – programmatic, financial, logistics Facilitation and linkages, review of data Disbursements – ease, transparency, timeliness? **Management perspective – what kind of support is there between UNICEF or CSO Monitoring Unit to each other and to Government partners, CSOs? Coordination and communication?**	Examples? PCAs with CSOs – issues? Measures of tracking Community feedback mechanisms? LHW or vaccinator feedback? Time and resources needed Perceptions and experience – by different categories of management
How did the CSOs create awareness and advocacy? – (Access to Information) Define the UNICEF (or CSO Monitoring Unit) role in the process- engagement with officials, meetings, working knowledge? How can it be done better What changes occurred – implementation or policy level? Advocacy of immunisation? Representation of CSOs on policy forums? Where and how was it done?	Dissemination of CSOs information – formal forum or through informal channels? Which CSOs were better? Reasons Estimations of coverage? Provincial facilitation factors? **Effect of devolution?**
Experience value of UNICEF Management – (Value Utility and Change of Practices Theory) To government To GAVI To CSOs What enabled change the most– meetings, trainings, capacity building, cost savings, technical assistance? What other models are possible?	Examples of how UNICEF coordinated and translated GAVI vision into the CSOs project? Examples of UNICEF change in practice, understanding or approach 2009 to 2015? Pre-and post HACT issues? Frequency of interactions with UNICEF, CSO Monitoring Unit and CSOs
Experience change in Government Practices (Community Level Change in Health Provision) As a result of UNICEF management government partners were more responsive to immunisation, MNCH or other health? What can be done differently?	Examples how UNICEF guided change different areas what worked or not? **Provincial differences?** Examples how providers improved or remained unchanged? Reasons
Replacement and Continuity (Sustainability Planning) Once GAVI ceases will Government support CSOs in this same manner? What would you like to happen – UNICEF lessons and learning How can you contribute to its continuity? Is UNICEF the best management partner or should it be different?	Exit strategy or planning in anticipation Other examples of support
Overall Perception and Suggestions What should the next type of CSO support be like? Do you think funding to community directly or grassroot CBOs would be better compared to the current models? Others	Changes from this model?