Evaluation Report

UNFPA COUNTRY PROGRAMME EVALUATION:

Pakistan (2013-2017)

December 2016

FINAL EVALUATION REPORT

Figure 1: Map of Pakistan with UNFPA Interventions in three Provinces (Punjab, Sindh, and KP)

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Disclaimer

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Acknowledgements

The evaluation team for the UNFPA Country Programme 8 Assistance to the Government of Pakistan (2013-2016) is grateful to all stakeholders and partners who contributed their time, suggestions, feedback, and critical review throughout the evaluation process.

We would like to thank the UNFPA Country office led by Country Representative, Dr. Hassan Mohtashami and Deputy Representative, Ms. Sarah Masale for their on-going facilitation and assistance throughout the evaluation process. We specially appreciate the constant coordination undertaken by Ms. Khadija Zeeshan during the field/site visits and the excellent arrangements made by the Provincial officers of UNFPA.

Special thanks are due to the implementing partners, government and civil society stakeholders, beneficiaries, experts, UN Agencies, and donors who gave us their time and freely shared their honest opinions and experiences of the UNFPA Country 8 Programme and interventions.

Finally this report has benefitted greatly from the inputs of the Evaluation Reference Group and UNFPA Country and Regional Office team.

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Abbreviations and Acronyms

AKU	Aga Khan University
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BHUs	Basic Health Unit
CBOs	Community Based Organizations
CBBA	Community Based Birth Attendants
CCPD	Common Country Programme Document
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CHW	Community Health Workers
CMWs	Community Midwives
CO	Country Office of the UNFPA
COAR	Country Office Annual Report
CP	Country Programme of the UNFPA
CP7	The 7th Country Programme of the UNFPA
CP8	The 8th Country Programme of the UNFPA
CPE	Country Programme Evaluation
CPR	Contraception Prevalence Rate
CSO	Civil Society Organizations
DHIS	District Health Information System
DHMT	District Health Management Team
EDO	Executive District Officer
EmONC	Emergency Obstetric and Newborn Care
ERG	Evaluation Reference Group
FDMA	FATA Disaster Management Authority
FGD	Focus Group Discussion
FLCF	First Level Care Facility
FP	Family Planning
FP & PHC	Family Planning and Primary Health Care Programme
GB	Gilgit-Baltistan
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoP	Government of Pakistan
HACT	Harmonized Approaches to Cash Transfer
HANDS	Health and Nutrition Development Society
HBIG	Hepatitis Immune Globulin
HBV	Hepatitis B Virus
IEC	Information, Education and Communication
IP	Implementing Partners
IRC	Independent Review Committee
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDGs	Millennium Development Goals
MICS	Multi Indicator Cluster Survey
MISP	Minimal Initial Service Package
MNCH	Maternal, Newborn and Child Health

MSU	Mobile Service Unit
NHSRC	Ministry of National Health Services, Regulation and Coordination
MoU	Memorandum of Understanding
NDMA	National Disaster Management Authority
NGO	Non-Government Organization
NICC	National Inter-agency Coordination Committee
NRSP	National Rural Support Programme
PC	Population Council
PCAs	Project Cooperation Agreements
PDHS	Pakistan Demographic Health Survey
PDMA	Pakistan Disaster Management Authority
PLWH	People Living with HIV
PPHI	People's Primary Health Care Initiative
PTH	Pathfinder International
PWD	Population Welfare Department
RG	Reference Group
RSPN	Rural Support Programme Network
SBA	Skilled Birth Attendants
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
SSFA	Small Scale Funding Agreement
STI	Sexually Transmitted Infection
THQ	Taluka/Tehsil Headquarter Hospital
UC	Union Council
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
VAW	Violence Against Women
VHC	Village Health Committee
WHO	World Health Organization
WP	Work Plans

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Table 1: Pakistan: Facts and Figure

Key Facts and Figures		Source
Population:	191,715,847 (estimated 2015)	Pakistan Economic and Labour Survey 2014-15
Population Growth Rate	1.92 % (2015)	
Urban Population	74,987, 621	UN world Urbanisation Prospects 2014
Type of Government:	Democratic Parliamentary Federal Public	National Assembly 2016, FAFEN 2015[1], Aurat Foundation
Seats held by women in national assembly (%)	60/342 (17.2%) and 60/256 in Provincial Assembly (23.4%)	
Economy		
GDP per capita (PPP US$)	1512 (2014-15)	Pakistan Economic Survey 2014-15
GDP growth rate	4.2 % (2014-15)	
Main Industries:	Agricultural Sector: Crops, cotton ginning, livestock, forestry and fishing. Industry includes: mining and quarrying, manufacturing, electricity generation, gas distribution and construction. Service sector: wholesale and retail trade, transport, storage & communication, finance and insurance, housing services,	
Unemployment rates	5.32 % (2014-15) 8.95 % (15-19 years old) 9.88 % (20-24 years old)	Pakistan Economic and Labour Survey 2014-15
Labour force participation rates	50.46% (Total) 67.85% (Male): (82.41 for 20-24 years old) 32.58% (Female) : (37.04 for 20-24 years old)	
Social and Health Indicators		
Maternal Mortality ratio (maternal deaths per 100,000 live births):	Total: 276 (2006-07) Urban: 175 (2006-07) Rural: 319 (2006-07) Estimated 220 (2012) – Population Council	Pakistan Demographic and Health Survey 2006-07
Life expectancy at birth	65.1 (Male) (2015) 66.8 (Female) (2015)	
Infant Mortality rates (infant deaths per 1000 live births):	74	
Under 5 mortality (deaths of children <5years per 1000 live births):	89	
% of Skilled Birth Attendance:	52%	
Total Fertility rate	3.8%	
Net reproduction rate (NRR)	1.59	UN WPP 2015
Adolescent fertility rate (births per 1000 women aged 15-19)	44	Pakistan Demographic and Health Survey 20012-13
Contraception Prevalence Rate	35% (Any method) 26% (Modern method includes Lactation amenorrhea)	
Unmet need (married couples unable to access family planning):	20% (approximately 6 million married women of reproductive age) 14.9% (for 15-19 years) 20.6% (for 20-24 years)	
Number of people living with HIV	100,000	UNAIDS 2015

[1] Free and Fair Election Network www.fafen.org

Women aged 15 and over living with HIV	30,000	
Health expenditure as % of GDP	0.69 (2013-14)	Pakistan Economic and Labour Survey 2014-15
Education expenditure as % of GDP	2.14 (2013-14)	
Adult literacy rate (ages 15 and above)	57%	Pakistan Standards and Living Measures Survey 2014-15
Literacy rate (10+ years old)	60% (total) 49%(female) 70% (male)	
Net enrolment rate (primary level):	57% (total) 53% (female 60% (male)	
Net enrolment rate (Middle level):	22% (total) 21% (female) 23% (male)	
% of out of school children (primary level)	34.4% (Total) 38.9% (Girls) 30.2% (Boys) 22% (Urban) 39.5% (Rural) Punjab = 29.8% Sindh = 39.9% KP = 37% Balochistan = 47.8%	UNICEF 2013

EXECUTIVE SUMMARY

OBJECTIVES AND AUDIENCE OF THE COUNTRY PROGRAMME EVALUATION

The objectives of the CPE were to 1) provide an independent assessment of relevance and effectiveness (performance) of the Eighth Country Programme; 2) assess UNFPA's strategic positioning within the development and national partners, and contribution to the outcomes specified in the CPD; and 3) to draw lessons and recommendations from past and current cooperation as feedback to the design of the next programme cycle in Pakistan. The target audiences for the CPE were UNFPA Pakistan, UNFPA Asia Pacific Region (APRO) and Headquarters, and national/provincial government and non-government partners.

The UNFPA 8th Country Programme in Pakistan had a budget of $36 million and covered four programmatic areas: 1) Policy and Advocacy $2.86 million (10%), 2) Youth, Reproductive and Sexual Health $1.31 million (5%), 3) Family Planning and Maternal Health $20.83 million (72%) in development and humanitarian contexts, and 4) Population and Development $3.38 million (12%). An amount of $ 0.69 million (2%) were allocated to programme management, coordination and monitoring. There was no separate component for gender equality and it was considered cross cutting.

BACKGROUND CONTEXT OF THE EVALUATION

Pakistan is a low middle income country with an estimated population of 191 million with poor health and human development indicators. The key challenges faced by Pakistan for sustainable development include rapid population growth, with one of the highest fertility rates 3.8 in the region, low modern CPR 26%, and low empowerment of women in household and reproductive health decision making that limits the acceptance and uptake of RH/family planning services. Challenges for the health sector include weak governance and accountability, inadequate availability and distribution of human resource in remote rural areas, lack of strategic vision and planning by government planners as evidenced by inadequate use of evidence, weak implementation and oversight of programmes that has in turn limited the effectiveness of interventions and funding support. Discrimination and violence against women is an endemic social problem that directly and indirectly affects how sexual and reproductive health programming can be designed, and implemented.

EVALUATION METHODOLOGY

The evaluation was mixed methods and followed the OECD-DAC criteria. Primary data collection was mainly through semi-structured interviews/focus group discussions desk review and analysis of secondary data such as programmatic reports, M&E reports, and other independent data for triangulation of findings. The OECD-DAC evaluation criteria of relevance, effectiveness, sustainability and efficiency were expanded to include (i) the criteria of coordination and strategic positioning/added value based on UNFPA Evaluation Guidebook (2015), and ii) Humanitarian efforts were reviewed using the ALNAP-EHA[2] criteria for leadership, coherence, coordination from acute-recovery phase interventions. The evaluation team also looked at inclusion of women (specific strategies used by IPs), gender mainstreaming in the CP 8 design, and during the implementation process, and whether UNFPA CP 8 interventions enhanced gender equality and empowerment of women.

Between July – October 2016, the evaluation team conducted semi-structured interviews with 112 key informants; 8 focus groups discussions (FGDs) with training recipients (PBS, NIPS, PIDE, CMWs, LHWs, CMW Tutors) and beneficiaries of UNFPA supported interventions (ASRH counselling Youth, Fistula clients, Parliamentarians). The selection of the key informants/FGDs was

[2] OECD-DAC Active Learning Network for Accountability and Performance in Humanitarian Action (Guide 2006)

illustrative of all categories of UNFPA partners and stakeholders. The evaluation team made five site visits to Peshawar, Lahore, Karachi, and Islamabad. The selection of site visits was based on a predefined selection criteria using purposive sampling and were meant to illustrate the diverse portfolio of interventions supported by UNFPA in Pakistan.

Throughout the evaluation process, the evaluation team relied heavily on the evaluation matrix. Information collected was routinely validated through cross checking between the multi-categories of stakeholders and independent data, where available. The evaluation focused on the broader results/outcomes achieved (or not achieved) by the UNFPA CP 8, and less so on individual interventions. *While the evaluation has certainly captured lessons from individual interventions and programmatic components the focus has been to review whether and how UNFPA CP 8 support has led to (cause-effect) or influenced enhancements and created opportunities in RH, FP, MH and PD landscape in Pakistan.*

Evaluation Limitations – the quality of the evaluation has been affected by (i) weakness (or lack) of well documented baseline for many of the interventions, absence of disaggregated data by gender, provinces/areas, missing "*objective information*" in annual work plans, and low institutional memory of the CP 8 design process; ii) limited availability of monitoring data particularly at the level of outcomes, and especially for documentation of pilots and lessons learned, (iii) time and budget constraints limited the number of sites visited and end-beneficiaries consulted given the large scope of the CP 8. Mitigation Strategies: these limitations were addressed through cross-referencing data across multiple sources of information, ii) using an extended desk review of programmatic reports, and through additional interviews if needed, and ii) using expert opinion where evidence was lacking.

CONCLUSIONS

Strategic Level

Conclusion 1 (EQ 1, 2, 7, 8)**:** UNFPA CP8 design and interventions were relevant with national and UNDAF/OPII priorities. However design flaws such as lack of focus on strategic content, detailed planning on how the various programmatic interventions would be achieved, owned and scaled up by the government, and/or bring systems and institutional change undermined programmatic relevance, effectiveness and sustainability. CP8 was too ambitious in terms of what it aimed to achieve in a short span of time, too fragmented in its approach with many of the same traditional partners and exclusion of non-traditional and cross-sectoral partners, and did not fully take into account the importance (and necessity) of mitigation for weak accountability mechanisms in public sector. Finally the design and effectiveness would have benefitted from receiving inputs from end-beneficiaries.

CP8 was able to highlight the FP-RH and Population as an important priority in national discourse and policy documents. However, the sense of urgency and the connection between population growth and impact on macro-economic development did not fully get translated into strong cross-sectoral policies and actions.

Conclusion 2 (EQ 7 and 8): The CP8 design and country office management systems did not give priority to reviewing the effectiveness and value for money of the proposed interventions at the design phase and during implementation that affected the overall impact that the CP8 interventions could have achieved.

UNFPA's role in Pakistan is to assist (not substitute) the government in strengthening and enhancing its FP-RH and Population and Development agenda and outcomes by "*delivering thinking"* instead of delivering things. This conceptual clarity was not always apparent in CP8 design, the CO management approach, and by the government and NGO implementing partners. While internal transitions and re-structuring at UNFPA CO including long term vacancies of senior management and technical positions has affected overall efficiency. The main issues were weakly defined internal controls and guidance by the CO, low understanding of the importance of needs based planning, and absence of regular exercises in measuring impact and cost efficiencies of partners and programmes.

Conclusion 3 (EQ 8 and 9): Active engagement by UNFPA is widely recognised among traditional Health and Population partners as the lead technical and coordination agency in FP-RH and Population & Development. UNFPA now needs to expand this recognition with cross-sector partners and downstream district/sub-district leadership as part of its strategic positioning.

The ongoing SDGs 2030 planning presents an excellent opportunity for UNFPA to strategically position itself and the Population & Development agenda across sectors, with other UN agencies and in the provincial Planning & Development units for greater visibility and integration.

Conclusion 4 (EQ 1, 2, 8 and 9): The sustainability varied and would have been substantially improved with better exit strategy planning, and taking into account mitigation strategies for weak accountability in the public sector.

There is little evidence to suggest that measureable attitudinal or behavioural changes were achieved in policies, societal narrative or even a serious debate about obstacles women face in homes and outside, in accessing reproductive services, education or livelihood. Additionally, since many of the policymakers who participate in such sessions have already been convinced, in effect, these efforts became exercises in "*preaching to the choir".* The results did not clearly show how these initiatives would be sustained or expanded.

For sustainability to be ensured (right from the beginning) UNFPA must emphasise to the government that it is their responsibility to ensure commitment to FP-RH and Population & Development goal, help put in place strategies with the government that strengthen accountability for achieving pro-women friendly policies such as incentives for girls education and women's entry into the labour market, women's right to choose contraceptives without written spousal consent etc.

Programmatic Level

Conclusion 5 (EQ 3, 4, 5 and 6): UNFPA interventions were effective in putting FP-RH and Population & Development in policy and programmatic documents (i.e. rhetorical support and commitments) but did not significantly push for or measure the attitudinal, systems and institutional changes. Even in the constraints that these changes take decades, UNFPA interventions should strive to enable and promote that paradigm change. Decision making in government still remains ad hoc, driven by short-term political and bureaucratic interests with very little evidence-informed policy and practice changes.

Despite 90% successful completion of CP8 programmatic targets, the programme did not translate into national sense of urgency, and government ownership of actual results (beyond rhetorical commitments) i.e. outcome level changes such as macro-policies or actions with emphasis on population development, improved FP programme results, and cross-sectoral collaborations. Future programming must critically review and address the system flaws such as weak governance, political economy and incentives that are currently shaped to favour lack of accountability before enhanced programme results can be achieved.

RECOMMENDATIONS

Strategic Level

Recommendation1: *Develop a clear strategy note for UNFPAs support to FP-RH and Population & Development that responds to emerging needs such as provincial autonomy, mechanisms to measure and assess results right from the design phase and throughout.*

UNFPA should continue its focus on youth, FP-RH, and Population & Development but shift its approach to "outcome" oriented institutional and systems level changes. This can be achieved by greater provincial and district engagement, expand capacity of government partners to take leadership and bring accountability for results, expand access to non-traditional and cross-sectoral partners, support innovations, and have a clear handing over strategy right from the design phase.

Recommendation 2: *Support and promote efforts for reaching the poorest and most vulnerable populations, and establish institutional mechanisms for measuring outcomes of pro-poor policies and programmes interventions.*

CP9 should define clear strategy on what and where are the most marginalised target audiences that should be reached and how this would be achieved or measured. This would entail defining clear protocols and criteria for targeting the most vulnerable, measuring access, and including gender mainstreaming in all programmatic interventions and outcomes.

Recommendation 3: *Integrate FP-RH and Population within the ongoing SDGs 2030 national and provincial development and planning processes and mechanisms.*

This is the right time for UNFPA to assist the government in holistically looking at RH-FP-Population & Development within cross-sector policies and partners and in the broader SDG goals 1 (poverty), 3 (women's well- being), and 5 (gender equality) and including 4 (education), 8 (access to employment and skills), 11 (sustainable cities and communities) and 16 (inclusive institutions and justice) adapted to local capacities and ensuring effective implementation. UNFPA can support technical capacity building of local government staff in supervising effective implementation and monitoring of progress.

Recommendation 4: *UNFPA should explore innovative ways including demonstration pilots of engaging the private sector markets to complement public sector services and gaps in reaching a wider number of beneficiaries with FP-RH services.*

Going forward UNFPA should consider the vital role of private sector in delivery of health and FP, MH and RH services[3]. In CP 9, UNFPA should explore how to find cost-effective ways of engaging private sector partners to conduct certain tasks within the overall framework of public sector services, performance and quality. For example, UNFPA can support facilitation of the private sector in production of cheaper local products (i.e. contraceptives, commodities), technical assistance for quality and standardisation.

Recommendation 5: *Right from the design phase UNFPA should develop a detailed strategy for maximizing programmatic inputs (technical, financial, logistics, and human) to deliver sustainable outcome level results (not just outputs)*

UNFPA should develop a culture of cost-effectiveness through a well-designed interventions that match interventions to unit costs and impacts. Even for soft aid activities like seminars, advocacy and capacity building there is a need to consider the overall benefit, and monetize the outcome and impact.

Recommendation 6: Coordination and Strategic Positioning

UNFPA should strengthen its strategic positioning by working more closely with UN agencies and other donors in Pakistan for sharing resources, planning exercises, and strategic analyses to avoid duplication and increase effectiveness.

UNFPA should take a more active and consistent role in strategizing the FP-RH and Population & Development agenda with donors and UN partners, making women's reproductive health and access to services and information a central premise in all development and humanitarian interventions.

[3] PDHS 2012-2013 that over 80% of outpatient services are in the private sector and existing public sector system only reaches around 15% of MWRA with FP services and 52% of skilled births

In donor coordination for FP, UNFPA should help develop an overall FP-RH and Population Development Framework that is consistent (and agreed upon with government Planning and Development departments) whereby financial, technical and human resource inputs and supports by donors are considered long term investments in the provincial FP and Development agenda. There is a need to reduce dependency on short-term and ad hoc donor financing for health services that should be covered by government's own funding mechanisms and proper planning. Annual tracking of the Framework and activities should be routinely done as a joint UNFPA-Donors-Government exercise with performance monitoring and public sharing with civil society stakeholders and district representation.

Programmatic Level

Recommendation 7: *UNFPA should revise its current approach in Advocacy, Capacity Building and Knowledge Management by using available evidence and having a systematic plan of action that takes into account contextual realities such as weak governance.*

Past mistakes of having a long wish list and ad hoc interventions that do not contribute significantly to the overall FP-RH and Population outcome can be avoided by targeted formative research (i.e. what is needed and where), using evidence informed strategic content for programming, systematic plans for capacity building that are owned by the government, and credible Knowledge Management models that bring together public-private sector research organizations to achieve measurable results and changes.

Recommendation 8: *UNFPA should operationalize its monitoring framework to rigorously measure and monitor outcome level results rather than just outputs.*

Converting the Monitoring Framework into a corresponding *M&E plan/monitoring tool* is just as important to track the progress. Findings from the M&E should be used to inform collective learning of the implementing partners, government stakeholders, UNFPA management, and if applicable be shared with end-beneficiaries and with communities. M&E (both internal and external) should be considered as an incremental process to enable change. In the next phase of programming UNFPA should pay strong attention to developing a clear *Monitoring Framework* with well thought out monitoring strategies, and activities. The monitoring objectives should be classified in the short, intermediate and longer term horizons, with clarity on the associations between activities and external and internal factors in order to achieve results. Learning from CP8 the Monitoring Framework should be informed by a clearly analysed theory of change model for each of the interventions proposed and focus more on measuring outcomes (versus outputs).

Chapter 1: INTRODUCTION TO THE EVALUATION OF UNFPA EIGHTH COUNTRY PROGRAMME (2013-2016)

1.1 Purpose and Objectives of the Country Programme 8 Evaluation

The UNFPA Country Programme (2013-2017) of Assistance to the Government of Pakistan is nearing conclusion in 2017. UNFPA Pakistan Country Office has commissioned an independent evaluation team in line with the UNFPA Evaluation Policy. The objectives of the evaluation are:

1. To provide UNFPA, Government of Pakistan and other stakeholders an independent assessment of the contribution of the UNFPA 8th Country Programme (CP8)
2. To provide feedback to the design of the next CPD in the form evaluative evidence.

The evaluation followed UNFPA's Handbook on How to Conduct an Evaluation (2013)[4] and OECD-DAC Criteria for Evaluating Development Assistance[5] to look at relevance, effectiveness and outcomes, efficiency and sustainability of UNFPA programme activities. In addition, the evaluation team reviewed UNFPA response to Humanitarian crisis using the OECD criteria for Humanitarian Action (ALNAP-EHA explained in section 1.3 Methods), value added, strategic positioning and coordination in leading the population and reproductive health agenda in Pakistan.

The primary focus of CPE is to demonstrate performance and accountability of CP8 results achieved (or not), along with lessons learned. The evaluation seeks to measure outcomes and provide evidence on how to accelerate achieving the Sustainable Development Goals (SDGs) and implementation of the Programme of Action of the International Conference on Population and Development beyond 2015 (ICPDb2015) commitments and most importantly how best to reach Pakistan's RH and Population Development goals with UNFPA assistance in the CP9.

1.2 Scope and Audience of the Evaluation

The evaluation covered all activities (national and provincial) planned, implemented or supported by UNFPA under its CP8 development and humanitarian programming for the period 2013-2016. Though the CP8 period is from 2013-2017, the evaluation covers mainly activities on-going or completed up to 2016. The four main components of the CP8 that were evaluated are: i) Policy Advocacy, ii) Youth/Adolescent Sexual and Reproductive Health, iii) Family Planning and Maternal Health in both development and humanitarian settings, and iv) Population and Development.

The evaluation covered UNFPA initiatives in 3 provinces (Khyber Pakhtunkhwa, Punjab and Sindh) and at the Federal level including review of engagement (or indirect effects) in the province of Balochistan, AJK and Gilgit-Baltistan during the CP8 programme cycle. The evaluation duration was from July – October 2016 and included a broad range of stakeholders, implementing partners and site visits.

The main audience and primary users of the 8th Country Programme Evaluation (CPE) are the UNFPA Country Office, UNFPA Asia and Pacific Regional Office (APRO), and UNFPA Headquarters; which may all use evaluation findings to modify, enhance or re-align programme activities and to inform decisions.

The evaluation will also benefit government partners, donors, development partners and other UN Agencies, along with implementing partners, NGOs and civil society to review overall programmatic

[4] How to Design and Conduct a Country Programme Evaluation – Handbook. UNFPA 2013
[5] Development Assistance Committee (DAC) Principles for Evaluating Development Assistance (Paris 1991)

performance and outcomes in RH, ASRH, FP and PD by UNFPA CP8 Assistance and to adjust current or future programmes or resources accordingly.

1.3 Methods and Process

1.3.1 The Evaluation Process

The evaluation process was conducted in 4 phases from July – November 2016:

Phase 1: Design Phase (July 2016) – the design phase included preliminary meetings with UNFPA CO team (CT) to go over the evaluation TORs, expectations, share key documents, and overall planning for the country programme evaluation (CPE). The evaluation team conducted a desk review of relevant global and country documents and shared the Design Report.

The Design Report specified the purpose and scope of the evaluation, the context and background of the country programme, a reconstruction of the intervention logic of the programme, a stakeholder matrix, the structure of the evaluation matrix containing key evaluation questions, interview tools, and a detailed data collection plan, including proposed site visits. The Design Report was presented to the ERG and UNFPA APRO in late July 2016 and feedback/comments were incorporated into the evaluation methodology in early August 2016.

Phase 2: Data Collection Phase (August 2016) – the field phase (i.e. 3 weeks) covered mainly data collection through stakeholder interviews, consultations, and focus group discussions (FGDs) with programme staff, sample of selected stakeholders in government, donors, UN Agencies, IPs, and end-beneficiaries. The stakeholders were selected from a "Stakeholder Map" already compiled by the UNFPA CO in 2015 (described in section 1.3.5)

During this phase the evaluation team conducted 112 stakeholder interviews and discussions (List of Stakeholder Interviews and Field Visits) with government, IPs, UN Agencies, donors, recipients of trainings in FP, MH and RH clinical, midwifery curriculum and training outcomes review, capacity building in evidence use (Population and Development component) and most importantly a small number of end beneficiaries from marginalised and vulnerable communities where the UNFPA CP 8 activities were implemented.

In order to *ensure illustrative representation* of different categories of stakeholders and ownership for accepting the evaluation findings, the evaluation process used an inclusive and participatory approach of sharing the evaluation methods and preliminary findings with the UNFPA team, ERG and stakeholders for inputs. This phase concluded with a debriefing meeting to UNFPA country team in 3rd week of September 2016.

Phase 3: Analysis and Synthesis Phase (September 2016)–during this phase the evaluation team compiled the findings of the stakeholder interviews and site visits to analyse and draw context specific inferences of the evaluation findings, triangulate with desk review and independent data sources for an overall picture on the effectiveness and outcomes of the UNFPA CP8. Results were thematically analysed for coherence/alignment with the overall UNFPA global strategy (2010-2013, 2014-2017 etc.), national priorities, effectiveness, efficiency, and sustainability. As a key priority area the analysis particularly focused on UNFPA added value and coordination in Pakistan, and what were design, policy or implementation shortfalls that affected UNFPA's development and Humanitarian efforts.

The 1st Draft Final report was shared with UNFPA CO and ERG for their feedback and comments in 2nd week of October 2016.

Phase 4: Dissemination Phase (October 2016) – inputs from the UNFPA team and ERG meeting (14th October 2016) were incorporated in the Draft 1 including comments from the Stakeholder Validation meeting on 25th- 26th October 2016 shared with the UNFPA team on 31st October 2016. The Stakeholder Validation meeting including participation from all stakeholders at the national and

provincial level, and there were two days of reviewing the evaluation findings, the Population Situation and Geographic Situation Analysis Report presented by different consultants.

The Final revised report with comments from UNFPA APRO and HQ and other stakeholders will be finalised and shared in the UNFPA Evaluation Database in early-mid November 2016.

1.3.2 The Evaluation Questions

The evaluation questions correspond to the OECD/DAC Criteria for International Evaluations[6] of Relevance, Effectiveness, Efficiency and Sustainability. In addition, and following the UNFPA Evaluation Handbook, an additional criteria, Coordination/Strategic Positioning were added to assess UNFPA's strategic positioning in Pakistan for the RH, FP and PD landscape and partners. *The evaluation process mainly focused on the broader achievements of the CP 8 instead of individual level interventions keeping in mind the programme intervention logic.* Throughout the evaluation process the team kept the broader questions of i) how UNFPA CP 8 changed or influenced RH-FP and Population Development outcomes in Pakistan, and ii) what is the sustainability or longer term impacts of the development and humanitarian assistance in building the capacity, understanding and leadership of Government of Pakistan in the FP-RH and Population Development agenda.

For Humanitarian actions the evaluation team used OECD's ALNAP-EHA[3] criteria for leadership, coherence, coordination from acute-recovery phase interventions.

The evaluation Terms of Reference (ToR) identified the following nine Evaluation Questions (EQ) to correspond to the evaluation criteria (Table 2) listed above. The questions described below formed the basis for the development of the data collection tools and Evaluation Matrix and guided data collection and analysis throughout the evaluation process. The evaluation question (EQ) are:

Table 2: Evaluation Questions and Criteria

EQ	Criteria
EQ1	**Relevance** - To what extent are the objectives of the CP adapted to the needs of the population (including vulnerable and marginalised groups), and Aligned with the government and UNFPA priorities
EQ2	**Responsiveness -** To what extent was the Country Office able to respond to the changes in the national development context and in particular to emerging humanitarian context?
EQ3	**Effectiveness -** To what extent have the interventions supported by UNFPA in reproductive health contributed to an improved access to family planning, ASRH, and midwifery services at the community level?
EQ4	**Effectiveness** - To what extent have the intervention supported by UNFPA in population and development contributed to the availability and use of data on population issues both at the federal and provincial levels for informed decision making?
EQ5	**Effectiveness** - To what extent has UNFPA contributed to an improved humanitarian response in the area of sexual and reproductive health and addressing issues of Gender Based Violence (GBV) in emergencies?
EQ6	**Effectiveness** - To what extent were the principles of equitable access, right-based approach and gender-responsiveness integrated in UNFPA 8th country programme and its interventions/activities?
EQ7	**Efficiency -** To what extent has UNFPA made good use of its human, financial, and technical resources, and used appropriate combination of tools and approaches to pursue the outcomes defined in the country programme and its response to humanitarian crisis?

[6] The OECD/DAC Criteria for International Development Evaluations: An Assessment and Ideas for Improvement. Thomas Chianca. 2008 Journal of Multidisciplinary Evaluation, Volume 5, Number 9

EQ8	**Sustainability** - To what extent was the CP able to create a supportive environment in service delivery, evidence use, policy advocacy for RH, FP and Population Development in Pakistan?
EQ9	**Coordination and Strategic Positioning** - How far and in what ways have the partnerships established by UNFPA built capacities to respond to development and humanitarian needs and supported national ownership of interventions, programmes and policies? How has UNFPA added value and what was its strategic positioning in CP8?

Table 3: Association between Evaluation Questions and Analysis

Level of Analysis	Programme Phase	Evaluation Criteria	PA	RH-ASRH	MH-FP	PD	GBV and Humanitarian
			Evaluation Question				
Programmatic Analysis	Design	Relevance	EQ1	EQ1	EQ1	EQ1	EQ1
		Responsiveness	EQ2	EQ2	EQ2	EQ2	EQ2
	Process	Efficiency	EQ7	EQ7	EQ7	EQ7	EQ7
	Results	Effectiveness	EQ6	EQ3 & EQ6	EQ3&EQ6	EQ4&EQ6	EQ5&EQ6
		Sustainability	EQ8	EQ8	EQ8	EQ8	EQ8
Strategic Positioning	Sustainable Partnerships	Coordination	EQ9 & EQ6				
		Added Value					

1.3.3 Methods and Tools for Data Collection

The evaluation process used mixed methods with the greater emphasis on 1) qualitative data collection using semi-structure interviews or FGDs from key informants and end beneficiaries, supplemented with 2) desk review of documents, and 3) validation and triangulation with independent primary and secondary data (as available), and 4) site observations.

Desk Review of Documents – this included review of relevant UNFPA country programme documents such Country Programme Document (CPD, CPAP), Combined Country Programme of Action (CCPAP), One UN Programme II (OP II), annual reports, annual work plans, monitoring matrix, financial ATLAS lists, and IPs documents/agreements with UNFPA.

The evaluation team also reviewed UNFPA Global Documents (Strategy 2010-2013, 2014-2017, Status of the World Population Report 2015 etc.) along with national RH, MH and FP key documents to better understand country priorities, ground realities, and current country context. In addition, 3rd party assessments and evaluation reports by different donors or UN Agencies were also reviewed. During the evaluation process, the team also reviewed the Population Situation Analysis (October 2016, Gavin Jones) and used it for validation of some of the CPE findings.

Semi Structured Interviews – semi structured interviews were conducted with 112 key informants from UNFPA staff, government officials/focal persons, IPs management and focal persons, civil society experts, UN Agencies staff, and donors at the Federal and Provincial level.

The developed tools were thematically based on the evaluation questions and the evaluation matrix. The category of stakeholders and beneficiaries and the respective guidance for questions were as follows::

- **UNFPA Country/Provincial and Management –** the interview tool explores UNFPA CO's perspectives on CP8 design, relevance, responsiveness, management and governance including technical and coordination approach used by the country office team. The tool was simplified from

the standardised **RACI matrix**[7] (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 upon within the organisation, and with partners. Using this information the evaluation team categorised how UNFPA CO (by staff categories of senior and program management) processed management, oversight of partners, implementation of programmes, consultations, coordination, resource mobilisation, and informed decision making in their systems and interactions.

- **Government Partners and Academic Institutions** - With government partners from national and provincial/districts officials in Health (MNCH, LHW, PNC), Population Welfare, Finance, Planning and Development, NDMA/PDMA/FDMA, PIDE, PBS, Health Services Academy questions were about CP8 programme effectiveness – in terms of utility, strengths and gaps, achievements, coverage, barriers to uptake and access, quality, trainings, value added, and institutional strengthening that the CP8 enabled (or did not). The tool explored responsiveness to emerging needs (development and humanitarian emergencies) and gender equality approach in reaching marginalised populations – how those were undertaken and monitored.
- **Implementing Partners-NGOs** - NGO IPs were asked about CP8 programme effectiveness and performance – in terms of implementation, coverage, utility, strengths and gaps, achievements, barriers to uptake and access, quality, value added, and sustainability that the CP8 enabled (or did not). The tool explored how work plans were implemented, outcomes of policy advocacy, service delivery, and trainings. *The tool also asked on how targeting was done for gender and vulnerable populations in reaching populations and delivery of programming.*
- **Donors and UN Agencies Questionnaire –** donors (DFID, USAID, KFW, GIZ, Packard, Gates, WB) and UN Agencies (UNICEF, UNDP, UN Representative office, UNAIDS, WHO, UNOCHA and UN Women) were asked on UNFPA coordination, strategic positioning role in terms of defining the agenda in FP-RH and Population Development, mechanisms that enabled coordination, participatory and inclusiveness of the processes, stakeholder engagement, and limitations in the CP8 that can be addressed

Focus Group Discussions (FGDs) – Eight FGDs were used to collect information among programme' primary beneficiary / trainees of UNFPA capacity building interventions (government institutions and NGO partners). FGDs were assessed to be a quick and effective approach to gathering information from a large number of programme beneficiaries in youth counselling/ASRH centres, Population Development skills based trainings, Fistula recipients, rights based trainings on FP-RH for LHWs, CMWs, FWWs, and CMW curriculum improvisations*. The sample of beneficiaries was illustrative and rather than a statistically significant sample based on a pre-defined criteria and purposive sampling.* FGD tools were thematically based on the training category and included:

- **Community Beneficiary (**FGD)- from community beneficiaries information was collected on uptake and acceptance of ASRH, FP or MH services, awareness and dissemination of information including changes in behavioural practices, barriers to access of services, and perceptions on the importance of continuing the interventions.
- Beneficiary sample for FGDs were determined on the basis of convenience sampling approach namely that the IPs or Government partners identified local beneficiaries who were willing to participate and facilitated their participation (i.e. venue and arrangements) for the FGD.
- **Training Beneficiary Questionnaire (**FGD) - With training recipients such as LHWs, CMWs, CMW Tutors female doctors, statisticians and government staff in DoH, PWD, PIDE, PBS, NIPs etc we explored how the capacity building training affected their service delivery, counselling, skills and capacity, post –training utilisation, perceived outcomes and value additions in their local

[7] www.responsibilityassignment matrix.com

communities and jobs; asked about their assessment of outstanding gaps and needs in these training sessions.

Site Visits and Observations - Five field visits were conducted to selected youth and health counselling centres and hospitals, Regional Training Institutes (RTIs), disaster management/refuge sites, and other relevant facilities that received UNFPA CP 8 support. *Site visits were based on convenience i.e. ease of travel, availability of the management, and were illustrative of the wide diversity of UNFPA CP 8 interventions.*

Site visits aimed to observe and assess UNFPA assistance usage and effectiveness in the provision of services to community beneficiaries. Site visits also included interview with the facility managers, and where possible, an informal short interview of facility users (beneficiaries) present at the time of the visit.

1.3.4 Validity of Data

The evaluation team transcribed and analysed the data collected on a weekly basis by joint debriefing by the two consultants, and reviewing the information independently, and cross checking the validity with UNFPA programmatic documents. Data collected was also triangulated with other independent national data sources as relevant to each evaluation question for validation purposes including the Population Situation Assessment.

Secondary data obtained through the desk review was used to verify information shared by the IPs and programme activities. Data gathered was thematically categorised and inferences were drawn keeping in mind national and provincial capacities and contexts. Additionally, data validation was sought through regular exchanges with the UNFPA technical team and other civil society experts for an unbiased perspective. Following the completion of the data collection and validation exercises, a content analysis was performed. The information was further refined during the Stakeholders Validation Meeting in October 2016, where the findings were shared and reviewed by all stakeholders for accuracy and coherence.

In the final stage the evaluation matrix was used to ensure that a host of data sources had been cross referenced and considered and that the evaluation team had minimised reporting and recall bias to a minimum for each question.

1.3.5 Selection and Sampling of Stakeholders

During the Desk Review process the evaluation team in consultation with UNFPA CO team reviewed the UNFPA stakeholder mapping (2014) and selected the stakeholder's categories[8] to be interviewed and the site visits. Stakeholder mapping was done by UNFPA in 2014 and included all traditional stakeholders and partners.

Selection Criteria - Considering the large number of IPs and programme activities, the evaluation team prioritised the selection and sampling criteria on the following basis: *1) category of programming (ASRH and RH, FP and MH, PD, Policy Advocacy, and Humanitarian), 2) Federal and Provincial representation, 3) representation from public and private sector, and 4) level of engagement in UNFPA CP8 activities/interventions.* Special attention was given to get representation from pilots working with at risk, youth/adolescents, and marginalised, vulnerable populations, and in humanitarian settings.

The final sample size for key informant interviews/FGDs/site visits included stakeholders and beneficiaries from all 4 components of the CP 8 programme activities, geographic representation of

[8] UNFPA CO team, Government, IPs NGOs, Community Beneficiaries, Trainee Beneficiaries, and Donors/UN Agencies.

provinces, thematic areas and level of engagement. Field visits were selected on the basis of convenience, 1-2 sites for each component, and accessibility by air or ground transport and 5 sites were visited. A total 112 interviews and 8FGDs were conducted.

Table 4: Stakeholder Selection for Interviews and Focus Group Discussions

Category (National and Provincial)	ASRH	FP and MH	PD and Humanitarian	Total
UNFPA	Country Office Representative/Dep. Rep (2), Program officers (7), Provincial Coordinators (3), M&E (1)			13
Government (Ministries/Departments)	DG DoH (3), DG PWD(3), Programme Managers IRMNCH (3), Program Manager LHW (3), Program Manager PWD (3), EDO Health (3), DCO (2), NHSRC (2), Provincial Policy and M&E units (5), Finance (4), Planning & Development (3), Planning Commission (2), PBS (2), NIPS (2), NDMA (2), PDMA (3), SACP (2), PPW (1), provincial youth and sports departments, NACP, Federal Ministry of IPC			46
IPs/NGOs	Population Council (2-3), Pathfinder (2), Marie Stopes Society (3), Pakistan National Forum for Women Health (2), Pakistan Nursing Council (2), Muslim Aid (2), Bargad (2), Rozan (2), Aurat Foundation (2), Sarhad Rural Support Programme (1), Greenstar (2), FPAP-Rahnuma (2)			25
Donors/Un Agencies	USAID (1), DFID (1), GIZ/KFW (1), World Bank (1), ADB (1) Packard Foundation (1), Gates Foundation (1), DELIVER (1), UNDP (2), UNICEF (2), UNAIDS (1), UN Women (1), One UN Representative (2), WHO (1), UNOCHA (1)			12
Beneficiaries (Trainees of Capacity Building)	FGDs – LHWs (1), CMWs (1), WMOs (1), PBS (1), NIPS (1), GBV Coordinators (1), Civil Service (1), CMW Tutors (2), Y-PEERs			7
Community Beneficiaries- Users of Services	Intervention Field Site visits – Sindh (Karachi), Punjab (Lahore, Sargodha), KP (Peshawar) to see 1) ASRH counselling facilities, 2) FP voucher scheme, 3) GBV and Humanitarian, 4) Fistula prevention and referrals. FGDs with community beneficiaries. 5G) adolescents and youth			4 FGDs with 39 beneficiaries
Academic Institutions	PIDE (1), AKU (1), HSA(2-3)			4
Parliamentarians	National (5), Provincial (Sindh 2-4, Punjab 3-5, KP 2-3)			8-12
Media				2
Total				**112**

1.3.6 Limitations and Mitigation Strategies

This evaluation was constrained by several limitations:

- **Limited Time and Resources** – this CPE was limited by time (approximately 3 months) and expert' resources with only two experts tasked to collect data and analysis. UNFPA Pakistan Country Programme (2013-2016) is geographically spread and covers 30+ implementing government and

NGO partners, academic institutions, direct and indirect beneficiaries across 27 districts of Pakistan. The evaluation of such a large programme would have required a longer time period than has been allocated and / or team assistants specifically for data collection.

Mitigation - the tight timeline the evaluation team split into 2 with each expert undertaking data collection in the Federal and three provinces separately and simultaneously. This resulted in extra burden on the experts and at times delays in transcription of notes, sharing and validation of findings, and analysis for theme and content including the Final Report. To the best efforts the experts did not compromise on the integrity and quality of the data and analysis although there were time delays in the sharing of the Evaluation Report.

- **Absence of Objective Baseline and Tracking Data Including Disaggregated Data** – Review of documents, AWPs, UNFPA CPAP, and annual reports highlighted the lack or absence of objective baseline data and the source of information for many of the CP8 activities and interventions. For many of the interventions data was not disaggregated by gender, province, and this affected the credibility of the conclusions to be drawn. For example, in many advocacy seminars the number of participants were not disaggregated, or service beneficiaries which were mostly women were not disaggregated by the most marginalised or other poverty scoring etc.

  Mitigation- To some extent the evaluation team tried to overcome this deficiency by triangulating various programmatic information such as ATLAS spreadsheets, Country Office Annual Reports (COARs), and discussions with the UNFPA CO team. *However, it was challenging (and often improbable) to draw direct cause-effect relationships between UNFPA programme activities and outcomes in the absence of credible baselines, disaggregation of data and more quantitative objective measures.*

- **Methodological Constraints** included: i) the insufficient information provided by documents shared by country office regarding programme interventions (especially those relating to "soft aid activities" such as advocacy and policy dialogue); ii) a limited access to final beneficiaries within the time period allocated to the field phases of the evaluation, iii) informant bias: In several cases, information's provided by the stakeholders/key informants was evidently biased in either direction (too positive or too negative) and iv) In case of Pakistan, data at district level for demographic and reproductive health indicators are limited and time trends are not available for sub-district or union council level. The evaluation team repeatedly used triangulation, multi-category interviews and expert knowledge to draw inferences and reduce biases.

  Mitigation – the evaluation team used three strategies to address gaps in information namely i) cross validation between what different stakeholders reported and what the results showed, ii) focused on outcomes rather than just outputs of the intervention, iii) used expert opinions as unbiased when no objective evidence was available to deem the effectiveness of the intervention or not. The evaluation put as feasible all divergent views (with evaluation inferences) in the final report.

- **Government or Independent UC level Data on the Intervention Areas –**The absence of accurate and up to date government data on RH, FP and PD makes it difficult to objectively measure (quantify) and attribute the extent to which UNFPA programme activities influenced or improved RH or FP service utilisation, awareness, quality of trainings and their outcomes, effects of policy advocacy etc.

  Mitigation **-** For most part the evaluation team used stakeholder interviews, field visits, and secondary data triangulation to draw meaningful conclusions with the subsequent potential risks of "informant bias". However by using multiple informants from different categories including end beneficiaries the evaluation team was able to effectively minimise the risk. Even then this evaluation is about contribution and not attribution.

- **Weak Monitoring Framework and Indicators -** An inherent gap in the UNFPA CP8 activities and interventions appears to be the weak M&E framework and corresponding M&E plan. While recognising the programmatic advantage of having such a flexible and diverse intervention-based

approach, it makes measurement of results extremely challenging during and at the conclusion of the project.

Mitigation – to some extent 2015 onwards UNFPA CO strengthened and improved its monitoring mechanisms. The evaluation team was able to use data triangulation and informant discussions to piece together information that was missing.

- **Additional Research Queries** - some of the preliminary evaluation findings would have required additional assessment through quantitative surveys to confirm programme reported results such as deciphering CYPs in the Voucher scheme, ASRH counselling outcomes of providers trained through UNFPA, or outcomes of Policy Dialogue with Parliamentarians, Religious Leaders and Media.

  ***Mitigation* -** In light of TORs and current evaluation scope, the evaluation team would suggest that future end evaluations also include a component of in-depth quantitative verification specifically at the level of community beneficiaries/end recipients to enrich the quality of the final evaluation.

1.3.7 Ethical Considerations

The evaluation process followed ethical guidelines of UNEG [9] and ensured that participation in the evaluation process (i.e. selection of stakeholders, primary data collection and stakeholder interviews/FGDs) were voluntary and with informed consent.

To safeguard rights, dignity, and privacy particularly of youth, women and community beneficiaries or recipients of services all unique individual identifiers have been removed from the data collected and responses to protect the confidentiality of individuals and institutions unless permission was explicitly obtained to list names with responses.

In situations where quotes have been given, the names of individuals have been removed to maintain anonymity. Particular attention has been paid to ensure that no one institution, NGO or individual has been singled out for criticism or praise since the evaluation focus UNFPA Country Programme activities, learning, and lessons. Views of all stakeholders, regardless of favourable or not have been duly noted and included in the evaluation findings in an impartial manner. However, all information (positive and negative) is presented to provide learning for the future.

Throughout the evaluation process the evaluation team was professionally committed, impartial, independent and sensitive to the country context, gender and equity focus of UNFPA and research ethics. The goal of the evaluation team is to provide UNFPA Pakistan with a credible document that can contribute to programmatic learning and guide future programming.

[9] UNEGs Ethical Guidelines March 20087

Chapter 2: COUNTRY CONTEXT OF REPRODUCTIVE HEALTH AND POPULATION

2.1 The Development Challenges and National Strategies.

Pakistan is the sixth most populous country in the world, with an estimated population of 192 million that is growing at 1.92% annually.[10] Although the country has developed significantly in recent years, many macroeconomic stresses and a rapidly growing population curb its growth potential.[11] Key constraints include an inability to capitalise on a young population that is both under-educated and under-employed (high unemployment and lack of specialisation) which have contributed to Pakistan's low *human development index (HDI)* ranking of 146th among 187 countries. While poverty has decreased from 34% in 2001 to 13.6% in 2011;[12] these gains may be fragile as many households transitioning out of poverty – and constitute around 60% of all households (up from 53% in 1999)[13] - remain clustered near the poverty line. Poverty remains widespread in all provinces, and varies little across them.

2.1.1. Governance and the Political Context

Pakistan is a constitutional democracy that has progressively devolved powers to provinces over the years; most noticeably with the 18th Amendment to the Constitution in 2010. This made provinces directly responsible for strategizing and delivering social sector services such as health and education. While provinces initially struggled to meet the sudden demands of planning, budget allocations and management, recent anecdotal evidence suggests that they are now settling down with the processes and health indicators have begun to improve[14].

In May 2013, Pakistan successfully transitioned from one democratically elected government (Pakistan People's Party) to a new politically elected government (Pakistan Muslim League -Nawaz - PML-N). PML-N had a clear majority at the Federal level and in Punjab, with opposition party Pakistan Tehreek-e-Insaf wining in Khyber Pakhtunkhwa (KP) and the Pakistan People's Party in Sindh. Provincial autonomy became even more real following the 18th Constitutional Amendment (April 2010 by the National Assembly) which re-shaped Federal-Provincial dynamics and resource allocations. Even more recently in 2015, elections for local governments have further devolved the autonomy, responsibility and resources of development issues to sub-provincial levels (i.e. districts and union councils).

2.1.2. Poverty and its Gendered Context

Poverty reduction is a key guiding principle of development planning in Pakistan. World Bank (2015) estimates/simulations suggest that a moderate growth scenario (average GDP growth rate of 4.3%) would lead to Pakistan meeting its goal of reducing extreme poverty to 3% by 2030 and by 2020 with higher growth (7%). The latter scenario also reduces the population under the vulnerability threshold from 74% in 2011 to 64% in 2018 – a decline of 2% per year compared to 1% under the baseline.

Women in Pakistan have a disproportionately low labour force participation (LFP) in Pakistan.[4] Only around 22% of women participate in paid work and those that do work in agriculture (60%), unskilled informal (16%), professional (1.5%), and non-agricultural low skilled (20%) settings – nearly all of which

[10] Economic Survey of Pakistan 2014-15
[11] Nayyab D et al. Demographic Dividend or Demographic Threat in Pakistan. PIDE working papers 2006:10. www.pide.org.pk
[12] World Bank Report 2015 – Leveraging Urbanization in South Asia.
[13] World Development Indicators Report 2015: www.worldbank.org
[14] Discussions with Punjab and Khyber Pakhtunkhwa Health Policy Units (2015)

is non-specialised and therefore low-paying.[15] This massive under-utilisation of human resource leads to diminished social wellbeing and status of women in the society. Low LFP is due to socio-cultural restrictions on women's mobility, education and autonomy, which in turn sets up a vicious cycle where women have lower access to specialised jobs and therefore to specialisation training, leaving labour markets to be largely dominated by men; further limiting women's access to specialised and higher paying employment and imposing steep social costs on any women seeking to break this paradigm.

2.1.3. Managing the Demographic Transition

The demographic transition in Pakistan has lagged its neighbouring countries by a decade or more. Pakistan's fertility rate is 3.8, which is among the highest in the region; and around half of its population is 21 years or younger. The national labour force is increasing at 3.2% per annum and includes 55% of the total population; and is expected to increase to 67% by 2030. However, lack of access to formal education (Pakistan's total public sector education allocation in 2016 is USD 2.7 billion or 2.5% of GDP)[16] or vocational and life skills training along with centralised planning that is not sensitive to local problems or solutions in a country of nearly 200 million and a much marginalised private sector that produces too few opportunities or builds skills uncommonly are constraining Pakistan from achieving its demographic dividend due to an untrained or poorly equipped workforce. It is possible that Pakistan's *'youth bulge'* which should ideally become a *'demographic dividend'* may likely become a *'demographic threat'* from numerous, undereducated and frustrated youth and young adults.[17] For its part the public is responding to an extent to mitigate the effects of an overly controlling government. The government pays at least some attention to the issue, for e.g. the Government's Framework for Economic Growth (2011) sees opportunities to develop marketable skills among young people to increase their access to decent and productive employment.

2.1.4. Governance and Accountability in Health Systems

Despite considerable improvements, long standing health system, accountability and implementation problems continue to limit progress on sexual, reproductive and maternal health indicators.[18] For example, while Pakistan leads the region in median age at marriage for women at 19.5 years[9] (up from 18.5 years - PDHS 2006-7), this and other measures have not translated into a proportionate improvements in maternal, infant and child mortality. Maternal mortality – a key surrogate of health systems performance and gender equality in a society -was 276 deaths per 100,000 live births nationwide in 2007 (ranges from 319 in rural areas to 175 in urban areas and 227 in Punjab while 785 in Balochistan). Only 52% of births are assisted by skilled birth attendants (including 48% in a health facility) – mostly from the private sector. CPR has risen at <1% per annum to be 35% in 2012. The under-5 mortality rate in Pakistan is one of the highest in the South Asia region. Indeed, improvements have been too slow and likely reflect secular changes rather than results of intended programming.

2.1.5. Law and Security

Pakistan has faced many man-made crises and natural disasters lately. Insecurity, weak governance, underdevelopment and social inequity have driven man-made crises and limited effective responses to natural calamities. In turn emerging humanitarian situations exacerbate inequality; hamper poverty alleviation and strain individual and household coping mechanisms setting up a vicious cycle of poverty and deprivation. Recent government (national and provincial) efforts to strengthen National/Provincial

[15] Federal Bureau of Statistics. Pakistan Labour Force Survey 2014-15. http://www.pbs.gov.pk/content/labour-force-survey-2014-15-annual-report

[16] Naviwala N. Pakistan's Education Crisis: The Real Story. Wilson Centre Report 2016. https://www.wilsoncenter.org/event/pakistans-education-crisis-the-real-story

[17] Nayab D. Demographic Dividend or Demographic Threat in Pakistan. The Pakistan Development Review 47 : 1 (Spring 2008) pp. 1–26

[18] Pakistan Demographic Health Survey 2012-13

Disaster Management Authority (NDMA/PDMA) have met with mixed success and there is limited research on the outcomes of humanitarian assistance and transition.

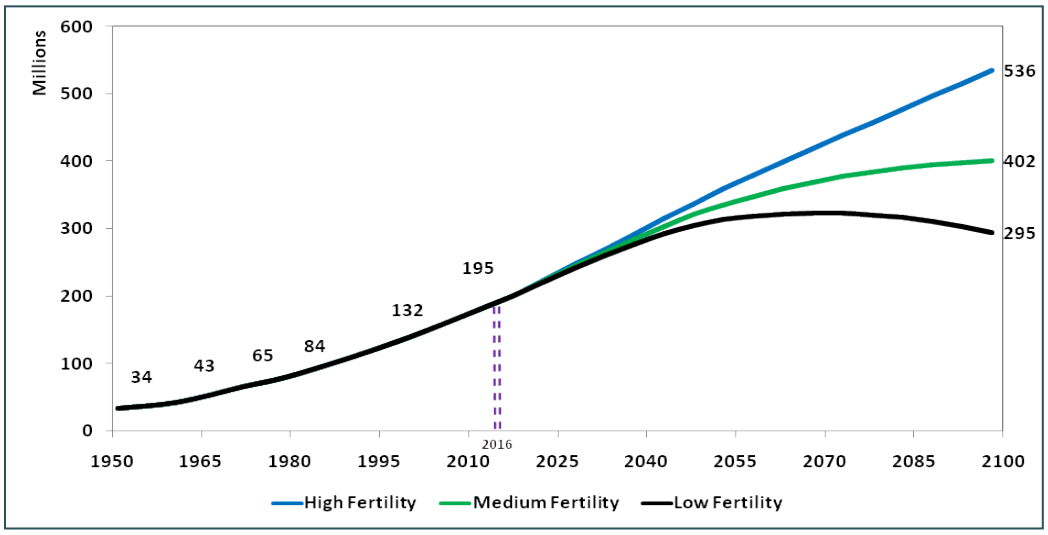
Pakistan's law and order situation remains volatile, with deepening security challenges, increasing militancy, sectarian and ethnic violence that result in rising human rights violations, gender based crimes and weakening of the State's writ and legitimacy. Such violence has caused a pervasive sense of insecurity among people, lack of foreign investment and uncertainty in the business community that have limited growth in economy and employment.

2.1.6. Population and Development

There are currently approximately around 68 million girls

/women aged 15 years or older in Pakistan of whom around 30 million are married women of reproductive age (MWRA) [14]. The 39 million children between ages 10-19 years and about 18 million youth population aged 20-24 years together, account for about 30% of total population. Teenage fertility is 8% among 15-19 year olds and use of any contraception is only 10% among married couples aged 15-19 years (PDHS 2012). Currently, the total youth population account for 45% of the total population, and is expected to grow an additional 10% by 2030.

Figure 2: Estimated and Projected Population Projects for Pakistan: 1951-2100



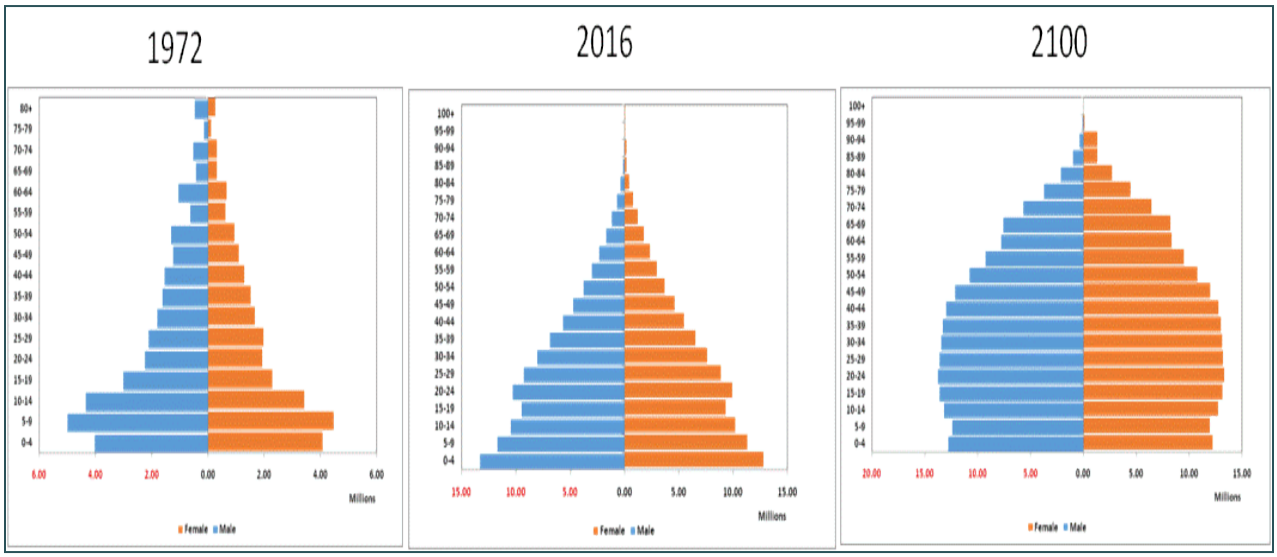
Source: UN WPP 2015; National Population Census 1972, 1981, 1998; and Wazir (2016)

Population dynamics are determined by three major demographic components: fertility, mortality, and migration. The population of Pakistan will continue to grow over the next few decades largely due to continued high levels of *fertility*. Figure 4 depicts the estimated and projected population of Pakistan from 1951 to 2100 according to three different fertility scenarios.[19] Declining mortality has resulted in longer life-spans so that life expectancy at birth has risen from 41.2 years in 1950-55 to 64.6 years in 2005-10. Fertility declines lagged declines in mortality and now continue to be the most important of the three major drivers of the population changes. The total population of Pakistan increased from 34 million in 1951 to 132 million in 1998, and is estimated at 195 million in 2016. Based on the medium fertility scenarios, which assumes that fertility will decline to reach replacement level by 2060, population could reach 402 million (range 295-535 million) by 2100. It is important to note that since fertility rate changes are translated only slowly into actual population sizes, investments in family planning take several decades to be realised.

[19] Wazir, MA (2016). The likelihood of Population Stabilization in Pakistan,

Consistent with the pattern of countries in the early to middle stages of the demographic transition, Pakistan has a very young population although as fertility declines; the population is beginning to age. In 1972, 43% of the total population was under the age of 15 while 49% was of working age (15-60). Under 15 population declined to 34% in 2016 and will decline further to 21% by 2100 due to anticipated fertility declines.

Figure 3: Age Structural Changes in Pakistan from 1972 to 2100



Source: Population Census 1972, and Wazir (2016)

Meanwhile, as is the rest of the World, Pakistan is seeing massive rural to urban migration at a rate of 2.8%. While the government data show that around 38% of Pakistani population is urban,[20] using more modern methods and definitions, a recent World Bank report classified around 55% of population as urban.[12] As residents shift to cities, their prosperity, adaptation to cities, attitudes and fertility will all change and these changes will have to be studied and accommodated in development planning and policies.

2.2 Overview of the Reproductive and Maternal Health Landscape in Pakistan

2.2.1. Sexual and Reproductive Health

Much of the discourse around reproductive health in Pakistan relates to family planning and birthing for couples married for 5+ years. Information and services are seldom available for unmarried adolescents or even newly married couples. Information about pregnancy and childbirth is acquired by women on average at the time of first pregnancy/ birth and about family planning around 9 years after marriage. Nearly all male or female adolescents describe being unable to approach to their parents information about puberty, sexuality, masturbation or sexually transmitted infections due to social unacceptability and often turn to siblings or peers.[21] Some seek healthcare for perceived ailments such as nocturnal emission among young men.[22] Most appreciate opportunities to learn more about these topics; such as

[20] Planning Commission of Pakistan. Vision 2025

[21] Khan et al. Understanding how Adolescent Girls and Women Learn, Process and Use RHMNH Information. RAF/ DFID October 2013.

[22] Situation Analysis of Adolescent Sexual and RH in Chakwal and Islamabad (RHIA Assessment). Research and Development Solutions for Plan International. 2010.

in the case of a project that informed adolescents about sexual health and had adult counsellors who addressed their questions and provided a safe place for them to "hang about".[23]

On the other hand around 6-11% of men in Pakistan engage in pre- or extramarital sex and only around half of these with a commercial sex worker,[24] suggesting that a significant minority of girls/women engage in non-marital consensual sex as well. These men are also not very informed about safe sex and took many unnecessary risks[24].

Much of this lack of openness and information sharing relates to pervasive patriarchal and conservative mores in the Pakistani society that preclude any discussion on reproductive health and sex for adolescents and youth particularly for girls. In fact government programmes (such as LHWs) deliberately exclude girls/youth from their household visits with women/families where RH is discussed. Thus, despite having one of the largest adolescents and youth populations in the world, little is known about their sexuality, behaviours and practices across socio-economic and geographic distributions in Pakistan.

2.2.2. Maternal Health

Formal planning in Pakistan recognises maternal health as a key developmental goal.[25] However, despite extensive resource investments[26] and high-level commitments by the Government of Pakistan, the MMR in Pakistan is 276/100,000 live births, and missed the country MDG target of reducing maternal mortality to 140/100,000 live births[27].

Maternal deaths contribute to an estimated 13% of all deaths in married women of reproductive age (MWRA).[28] Most occur around the delivery due to a lack of skilled birth attendance. In Pakistan only 52% of deliveries are with skilled birth attendants (SBA - 48% in health facilities and 4% by SBA at the woman's home).[9] Among facility births 23% happen in a private and 11% in a public facility.[18] Those delivering in a facility are urban, well off and more educated women.

Another consideration is that there are around 65 public sector medical colleges that manage around 5-10,000 deliveries each every year. That would come to around 350-400,000 deliveries (precise figures are not available) in public sector tertiary centres, leaving <100,000 for nearly 7,000 other public facilities that have been upgraded for this purpose. These facilities underperform due to a host of implementation (weak governance, staff absence, stock out of supplies and medicines) and quality of care issues.

Attempts at making home deliveries safe have been undermined by mixed messages about the particular cadre of trained providers. First traditional attendants were trained then abandoned in favour of community mid-wives (CMWs), without much impact.[29] Some provincial governments are also promoting a "basic minimum services package" to improve the quality of care that is delivered. Others have tried to expand their conventional 8am to 2pm working hours to 24/7 services by innovative approaches such as flexi-timings for female medical officers. The bigger question is: why is it that despite considerable investments by the Government of Pakistan (and donors) most women prefer private or home based birthing options; what is stopping women from taking up these "free" services.

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[23] Khan, A et al. Reproductive Health Initiative for Pakistan in Rawalpindi and Islamabad (Evaluation Report 2009) Plan Pakistan www.planpakistan.org

[24] National AIDS Control Programme, Population Council of Pakistan. Study of Sexually Transmitted Infections: Survey of the Bridging Population. 2007.

[25] International Conference on Population and Development Action Program

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

[27] Pakistan MDG Report 2015

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

[29] Research and Development Solutions Policy Brief Series #20. The Community Midwives Programme in Pakistan. 2012. http://resdev.org/files/policy_brief/20/20.pdf

Reproductive and maternal healthcare uptake and practices are shaped by woman's education, place of residence, wealth, occupation, mobility, and religious belief. It is well recognised that pervasive gender inequality, conservative practices and socio-cultural norms that restrict women's autonomy, and access to opportunities/resources all serve to undermine maternal health and wellbeing. However, the slow changes in uptake of reproductive behaviour may suggest avenues for interventions. For e.g. sustained information campaigns and behavioural interventions have resulted in 7 out of 10 mothers receiving ante-natal care from a skilled provider and nearly 64% receiving tetanus vaccination in the last 5 years.[30]

2.2.3. Nutrition of Women and Children

Under-nutrition is a significant public health problem in Pakistan: 18% of MWRA and 31% of children are underweight (24% are severely stunted); 51% of women and 62% of children are anaemic. These result in stunting of new-borns, low birth weight, vitamin and mineral deficiencies, perinatal mortality, poor pregnancy outcomes, and cognitive impairments.[31] Some of these reflect abject poverty of certain households, however the fact that women have lower status and have ever more restricted access to scarce resources such as food may be aggravating the situation.[32]

2.2.4. Family Planning

Pakistan was a regional pioneer for family planning programming in 1960s. However its contraceptive prevalence rate (CPR) has risen at <1% per annum to the current 35% (Figure 1).[18] Since 2008 considerable government and donor funding/ resources and programmatic approaches (i.e. public-private partnership models in FP service delivery) have sought to rectify this. Pakistan undertook at London FP2020 summit to increase its CPR to 55% by 2020 and more recently increased its annual PKR 6.5 billion funding to over 10 billion a year.[33]

Figure 4: Changes in CPR between 2006 and 2012

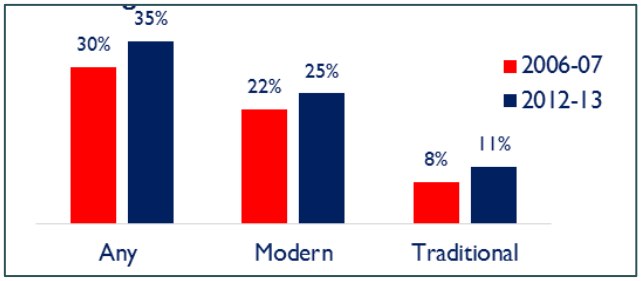


Figure 5: Changes in Method Mix between 2006 and 2012

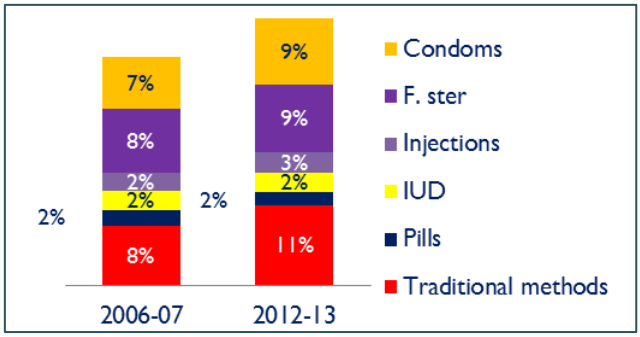
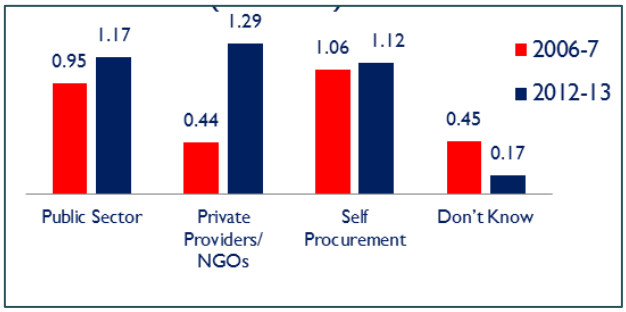


Figure 6: Changes in Service Providers between 2006 and 2012



From Research and Development Solutions Policy Brief Series#43

[30] Pakistan Economic Survey 2014-2015

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

[32] Gottret P et al. Protecting pro-poor health services during financial crises: lessons from experience. Washington DC, World Bank, 2009.

[33] Khan AA, Khan A, Javed W, Hamza HB, Orakzai M, Ansari and Abbas, K. Family Planning in Pakistan: Applying What We Have Learned. JPMA April 63 (4, Suppl 3) S3-10

Pakistan's current CPR is 35% having risen by only 5% since 2006-7 (Figure 1). Modern methods CPR (mCPR) has increased from 22% to 26% (although this included lactational amenorrhea as a modern method for the first time, without LAM mCPR drops to 24.6% or an increase of 2.5% in 6 years). This translates into an increase in the total number of FP users from 6.9 million to 8.9 million, modern method users from 5 million to 6 million.

Since Pakistan's method mix includes 37% of women that have had tubal ligation (and will continue to be counted among modern method users until they turn 50), it is more meaningful estimate the number of women that avail services each year. In 2006-7, this number was approximately 2.9 million women and increased to around 3.65 million by 2012.[34]

The contribution of modern methods to the overall CPR has decreased. Individual modern methods have largely remained unchanged (Figure 2) while the proportion of traditional methods has increased from 8% to 11%. DHS 2012 shows that condoms and traditional methods are the commonest "services" people avail, although self-procurement of FP supplies (essentially without a provider or counselling) accounts for 42% of such services with the public sector providing only 33% of FP services – or 1.17 million women that come to around 5% of MWRA.[34]

2.2.5. Abortions

One large national study an estimated 2.2 million induced abortions were performed in Pakistan in 2012.[35] Given an annual birth cohort of 3.7 million (UNICEF 2014, Pakistan) approximately 25% of all pregnancies end in abortion. Punjab and Sindh with the highest CPR have the lowest rates of abortions. Around 60-70% of women that sought abortions were using a modern method when they became pregnant,[36] suggesting contraception failure and the need for better counselling (particularly when nearly half of modern contraception users directly buy FP supplies directly from stores without counselling or a provider). However, there is also the possibility that the high number of abortions reflect the fact that abortions may be a used as the principle method of contraception.

2.2.6. Rights of Women and Youth

NGOs such as Aahung, FPAP, Shirkat Gah, Rozan, Plan Pakistan, Sachet, Rutgers, PAVHNA and Marie Stopes Society (and a host of their smaller and local partners) have pushed forth the public dialogue on SRH and adolescent rights including life skills curriculum pilots in private and public sector schools with varying degrees of success.

However, right to information is recognised and protected as a basic right in Article 19 A of Pakistan's constitution, right to sexual preference (Pakistan recently declared transgender as a legally accepted gender 2014, there are many on-going efforts for advocacy against early age and child marriages, and the awareness and right to seek treatment sexual and reproductive health issues particularly for unmarried girls/youth. These efforts have been mainly driven by civil society alliances and have met with mixed success.

There is a need to develop the ability of NGOs to assess the effectiveness of their rights promotion approaches, identify those among the gamut of their activities that works (and with which audience/ group), their cost effectiveness and general sustainability over time.

The Government of Pakistan has focused its attention on increasing protection for women and children from sexual harassment, abuse, exploitation and gender based violence. Important legislation have

[34] Research and Development Solutions Policy Brief Series #43. Changes in CPR between 2006 and 2012.

[35] Sattar Z et al. Induced Abortions and Unintended Pregnancies in Pakistan. Studies in Fam Planning 2014: 45(4) 471-491

[36] Sathar ZA, Singh S, Fikree FF. Estimating the incidence of abortion in Pakistan. *Stud Fam Plann* 2007;38:11-22.

been passed to stop honour killings, rape, domestic violence (bills), bonded labour, and increase accountability of the medico-legal criminal justice system[37].

2.2.7. The Role of Public Sector Academia and Teaching Hospitals in SRH

The 38 public sector medical colleges in Pakistan and their affiliated teaching hospitals handle approximately 80-90% of all public sector deliveries. These medical college are linked to facilities are where most of the gynaecologists and general practitioners receive their pre-service training (called house job, equivalent of an internship). For many future general practitioners this may be the last and only "hands on" educational training they will receive and habits/ practices ingrained during this period will be continue to be practiced for the rest of their professional careers. Discussions with Obstetrics-Gynaecology practitioners and experts in highlight that there is insufficient emphasis on SRH, FP and a public health perspective during the training phase of medical doctors that adversely influences their future counselling and practices in these areas. Correcting these gaps may yield high returns.

2.2.8 Analysis of Stakeholders

The main service provision and funding in RH, MH and FP can be broadly divided into three broad categories namely government (public sector - DoH, PWDs, and Federal level NHSRCC), NGOs including international INGOs (private sector implementers such as Greenstar, Marie Stopes Society, FPAP-Rahnuma, DKT International etc.), and donors (USAID, DFID, KFW, GIZ, WB, Packard Foundation etc). The recent devolution of Health and Population welfare Services from the Federal level (via vertical programs) to the Provinces has created new opportunities for integration, public-private partnerships, and debate on stagnant FP and RH outcomes – in short trying out innovative schemes to scale up. Private philanthropies are conspicuously absent.

The private sector is the main service provider for RH and FP services. It accounts for >90% part of the birthing market (although >60% of this component are traditional birth attendants), around 65% of family planning services and >80% of medical outpatient visits.[38] However, since it constitutes of thousands of private providers and stores with different characteristics and typology, its scope or role in the overall service delivery is not well understood by policy makers or even RH experts. In fact most policy discourse completely ignores the role of private sector.

Within the private sector, particularly since 2009 NGOs are playing an increasing role in FP, MH and RH service delivery to complement the central role they have played with promoting rights, advocacy and setting the tone for dialogue. This has prompted increases in donor funding to NGOs. In 2012 both USAID and the DFID entered into direct service delivery for FP via NGOs. Thus, MSS and Greenstar have received large grants (>USD 40 million a year) for providing FP services in communities with a special focus on longer term FP methods.

Within existing NGO actors, considerable re-alignment has been observed. MSS which was largely an advocacy organization that was famous for providing abortions, entered FP services in 2007 and is now the largest provider of these services in the country. New services providers such as DKT International, the Rural Support Programme Network – a large national NGO – have entered the service delivery arena. A major gap is the production of evidence for service delivery, planning and advocacy. For e.g. despite the large funding, there is no clear evidence to show impact, describe the various models for replication or measure their cost-effectiveness. Some analysis and advocacy has been done by the Population Council which has looked at unmet need for FP and abortions. Research and Development Solutions, a private research group, has taken a somewhat unique view of turning available data into "actionable knowledge" by connecting programming with survey data and identifying key gaps in

[37] Khan, A et al. National Study on the Medico-Legal Criminal Justice System from a Gender Perspective (2015 Research and Development Solutions). www.resdev.org

[38] Pakistan Bureau of Statistics. Pakistan Social and Living Measurements Survey 2014.

services and presenting this information in the form policy briefs, working papers and journal publications.[39]

Some work, especially on advocacy for RH and FP, has been done by civil society, NGOs, individual activists, journalists and philanthropic organizations. For example, the Alliance for MDG 5b that was heavily supported by NGOs (FPAP, Shirkat Gah etc) successfully lobbied to influence national and international policy, advocacy for the media. Moreover, the CSOs behind the "Karachi Declaration" - that seeks to ensure RH rights and services and was signed by CSOs and Government - play a minor role in the society. The effectiveness of their efforts has yet to be measured or scaled up on a national scale.

Journalists have highlighted the benefits of FP to the society particularly for younger couples. Many of these have worked in collaboration with NGOs – often on specific projects. However, much of this contribution is ad hoc and most the work by the civil society goes unrecorded, lacks proper documentation evidence in terms of the scale or quantum and is mostly in English language press.

2.2.9 Public Sector Institutional Capacity for Data Collection and Analysis

Population policies must be complemented by efforts to anticipate and plan for population changes. To this end, it is imperative to collect disaggregated population data on a regular basis and use this data for planning at national, provincial and urban/rural levels. The lack of timely availability of accurate data about trends in population growth, fertility and contraceptives prevalence undermines the effectiveness of the population policy.

While there is considerable capacity nationally to collect demographic data via National Institutes of Population Studies (NIPS), Pakistan Bureau of Statistics (PBS), Health Services Academy (Islamabad), and the Policy Units in DoH (Sindh, Punjab and KP). Nationally available data that inform about reproductive health include: the Demographic Health Survey (PDHS), the Social and Living Measurements Survey (PSLM), the Household Integrated Economic Survey (HIES), the National Health Accounts (NHA), supply record from the central warehouse, the Household Survey of the Pakistan Institute of Development Economics and the provincial versions of the MICS which all measure some aspects of RH and its funding. Few formal arrangements occur between these government entities and private sector or academia to analyse the data is collected.

A key issue has been that data from these surveys is not consistent. For e.g. PSLM from the year 2012 showed "full vaccination coverage" of children of around 82% whereas PDHS show the same indicator at 54%. MICS (for Punjab) shows slight variation from the preceding two as well. These variations stem from using slightly different methodology of approaching households and asking the question. There is a need for streamlining/ standardising the methodology of these surveys.

The last census was conducted in 1998 and planners have been using a standardised multiplier for estimating current population. Absent a recent census, vital demographic statistics such as period and cohort fertility, age specific deaths rates, and internal as well as international migration are all loose estimates. For e.g., given the very high rates of internal migration in Pakistan, these estimates can be erroneous. For e.g. the government estimates that 35% of population of Pakistan is urban while recent estimates suggest that this is closer to 55%.[40] This surely plays a role in how data from national surveys are interpreted (due to differences in how rural and urban samples are weighted) but the magnitude of this error remains unexplored. Finally, the quality of census data in Pakistan has been questioned. Issues include "over weighting" the young.[41] These issues must be addressed before the

[39] Research and Development Solutions. www.resdev.org/publications.html

[40] Ellis, Peter; Roberts, Mark. 2016. *Leveraging Urbanization in South Asia : Managing Spatial Transformation for Prosperity and Livability*. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/22549

[41] Ali, S. M., & Sultan, M. (2003). Age and sex distribution of 1998 census: An Evaluation. In Kemal, et al editors. *Population of Pakistan: An Analysis of 1998 Population and Housing Census* (pp. 95-119). Pakistan Institute of Development Economics.

next census is conducted. Even, once the data are collected, there is little capacity for evidence generation and analysis remain at sub-provincial, district or sub-district level, and therefore, data are rarely used for informed decision making.[42,33]

Beyond data quality, there is a need to re-address the focus of national and provincial data sources to go beyond interim indicators such as fertility, FP to include outcome/ impact measures. Infant and child mortality are usually measured (because they are prevalent enough to be measured at low sample sizes) but maternal mortality (and its causes) – which is also a good proxy for the effectiveness of health systems – was last measured in 2007. Such measurements must be systemised and built into routine surveys – or to be conducted as additional planned and routine surveys.

2.2.10 History of Population Policies

Concern over population growth in Pakistan was expressed as early as 1950s. This led to fund for NGOs in the first five-year plan of Pakistan (1955-60) and formulation of a population policy in 1965 that focused on population growth rate and restricting birth rate. The first government national family planning program was started in 1965 to address the rapidly growing population that was seen to be diluting economic gains. Fertility reduction has been a key policy goal in nearly subsequent governments, including the Population Policy 2002 that articulated the goal of population stabilization by 2020. A national population policy was developed but never finalised in 2010 as the Population Welfare Ministry was abolished following the 18th amendment to the Constitution. Despite these policy goals and considerable funding through the years, progress towards these goals has been slow; as seen by the fact that there has been little correlation between available data, policy goals, funding and achievements. [33,43]

More broadly, population policies and programmes have nearly exclusively focused on family planning – that too on supply side only - and paid little attention to building the human capital of the population with education, capacity building, infrastructural and environmental consequences or potentials, economy and their interface with a growing populace that is unable to contend with a changing world.[17,44] Any future policies – or provincial strategies given the devolution – would have to contend with not only family planning to reduce population growth but to do family planning to empower people (especially women), build their human capital with better and more effective investments into educations and skills and to allow economy to prosper. Furthermore, they must also reflect the understanding that in a resource controlled country, the government can't, and is not, doing everything and that the private and NGO sector already accounts for an overwhelming majority of services in health, family planning and skills building. The best role for the government would be to allow these to flourish by avoiding overregulation or crowd it out.

2.3 Role of External Development Assistance

Pakistan has received significant foreign aid in recent decades. Pakistan ranked eight on the list of top ten countries receiving the most foreign assistance in 2013-2014. During the past decade, Pakistan received significant official development assistance (ODA) from various bilateral and multilateral donors. Figure 7 depicts the total development assistance to Pakistan in 2013-14 and share of ODA in different development sectors. On average in 2013-2104, Pakistan received major share of the ODA from international development association (IDA)—950.9 USD million, followed by United States and

[42] Research Advocacy Fund Strategic Vision 2012– How Decisions are made in Public Sector MCH. www.raf.org

[43] Robinson WC, Shah MA, Shah NM. The Family Planning Program in Pakistan: What Went Wrong? Int.Fam.Planning Perspectives. 9/1981 1981;7(3):85-92.

[44] Research and Development Solutions Policy Brief Series #16. Can Pakistan Reap its Demographic Dividend. http://resdev.org/files/policy_brief/16/16.pdf

United Kingdom. About 31% of total ODA in 2013-14 was spent on economic infrastructure and services, followed by 17% on social infrastructure and services. Approximately, 8% of the ODA was spent on Health and Population and 16% on humanitarian assistance in 2013-2014.

Table 5 shows the trend of total ODA from 2011 to 2014 in constant of 2014 price, million USD. It would be interesting if the government budget figures is available to examine the share of the ODA as a percent of the government spending. However, it is not possible due to limited data availability particularly the distribution of the government spending in different sectors. In 2014, the total ODA disbursement was 4,499 million USD (constant of 2014), while UN contribution was 33.1 million USD (1% of the total ODA). Among the UN contribution, UNFPA contributed about 18 percent or 0.13% of ODA . The yearly variation is also depicted.

Figure 7: Overview of the Official development assistance in Pakistan: 2013-2014.

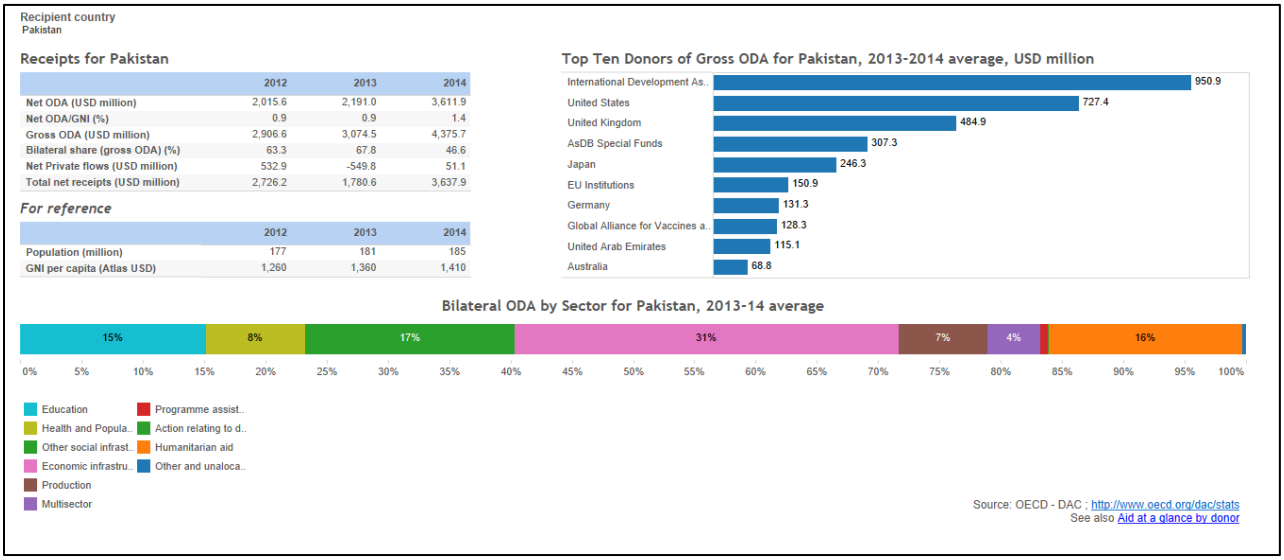


Table 5: Overview of the Official Development Assistance in Pakistan for all donors and UN: 2011-2015.

	2011	2012	2013	2014	2015
Commitment Total ODA (Million, Constant 2014, US$)	3,654.3	4,281.5	3,344.8	4,499.4	
Disbursement Total ODA(Million, Constant 2014, US$)	4,057.1	2,886.2	2,991.8	4,343.1	
UN Contribution (Million, US$) (%age of total ODA)	45.0 (1%)	38.1 (1%)	31.5 (1%)	33.1 (1%)	49.6
UNFPA Contribution (Million, US$) (%age of total UN contribution)	9.544 (21.2%)	6.717 (17.6%)	4.899 (15.5%)	5.766 (17.4%)	7.488 (15.1%)

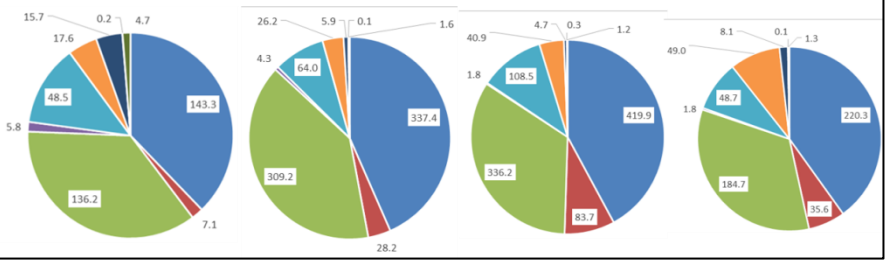
SOURCE: Creditor Reporting System (CRS), OECD - Statistics Department.

Table 6 depicts the disbursement of total official development assistant to Pakistan by all donor in Health sector. We have presented also the disbursement in different thematic areas under health sector. In 2014, the ODA disbursement in health was 5.1 percent (220.3 million USD) of the total ODA. The share of total health in ODA was reduce from 14 percent in 2013. Within health, major share was

spent on basic health (about 84% of the total ODA assistance in health was spent on basic health). RH and FP are the second most important areas where the ODA were disbursed.

Table 6: Overview of the Official Development Assistance in Pakistan by thematic areas: 2011-2014.

Disbursement (Million, Constant 2014, US$)	2011	2012	2013	2014
Health (Total)	143.3	337.4	419.9	220.3
Health General	7.1	28.2	83.7	35.6
Basic Health	136.2	309.2	336.2	184.7
Population Policies and Administrative Mang.	5.8	4.3	1.8	1.8
Reproductive Health	48.5	64.0	108.5	48.7
Family Planning	17.6	26.2	40.9	49.0
STD Control including HIV/AID	15.7	5.9	4.7	8.1
Capacity Building for Population & RH	0.2	0.1	0.3	0.1
Statistical Capacity Building	4.7	1.6	1.2	1.3



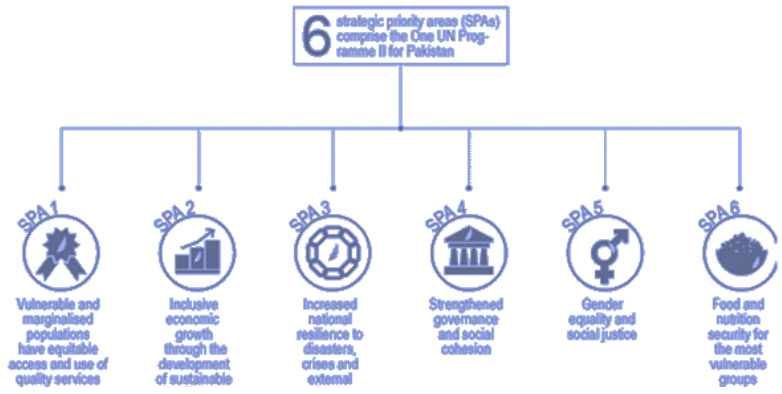
SOURCE: Creditor Reporting System (CRS), OECD - Statistics Department.

Chapter 3: UNFPA COUNTRY PROGRAMME AND RESPONSE

3.1 United Nations and UNFPA Response

In late 2012, UN in Pakistan signed a second generation of UNDAF/OPII (2013-2017) with the Government of Pakistan. The One UN Programme I (2009-2012) was initially signed in 2009 to align with the development plan cycle of the Government of Pakistan (2005-2010). It was based on Government of Pakistan's Framework for Economic Growth (FEG) which prioritises youth and vulnerable communities, urbanisation and population growth, governance reform, capacity development, sustainable livelihoods and industrial development. UNFPA contributes to OPII in Health and Population, Education, Disaster Risk Management, Agriculture, Rural Development & Poverty and Environment.

Figure 8: Six Strategic Priority Areas



The OPII (2013-2017) sets out results expected from UN and Government of Pakistan cooperation at the outcome level results within six Strategic Priority Areas (SPAs) (Figure 4). The cooperation between the GOP and the UN reflect the support for national priorities. For their work, individual UN agencies collaborated to develop the outputs for the OPII that were based on individual agency annual plans. These documents were developed in close collaboration with the Economic Affairs Division (EAD) and national, provincial/regional authorities.

Consistent with the OPII, UNDP, UNFPA and UNICEF developed a Common Country Programme Document (CCPD) 2013-2017 reflecting complementary agency specific results and resource

Figure 9: Medium Term Macro-Economic Framework of Pakistan

	Pillar	Links with MDGs	Links with SDGs
1.	**People First:** Developing social and human capital and empowering women	This pillar encompasses poverty eradication (MDG1), access to health and education services (MDGs 2, 4, 5, and 6), and gender empowerment (MDG 3).	SDGs 1 (poverty), 3, (health) 4 (education), and 5 (gender)
2.	**Growth:** Sustained, indigenous, and inclusive growth	While this was not an explicit goal, it was a key driver of MDGs, as well as being implicit in MDG 1 (equity, decent work), and MDG 6 (environmental sustainability).	The target is virtually identical to SDG 8, and also to SDGs 10, 12, 13, 14, 15
3.	**Governance:** Democratic governance: institutional reform and modernization of the public sector	Again, while not an explicit goal, there is abundant evidence that shows the positive impact of good governance on the human development goals.	Again, the language is similar to that of SDG 16
4.	**Security:** Energy, water, and food security	These are incorporated in MDG 1 (hunger), and MDG 6 (water)	Linked to SDG 2 (zero hunger), 6 (water security), 7 (energy security), and 11 (urban)
5.	**Entrepreneurship:** Private Sector and entrepreneurship-led growth		This is linked to SDG 9 (foster innovation)
6.	**Knowledge Economy:** Developing a competitive knowledge economy through value addition		SDG 9 (innovation), and 4 (education)
7.	**Connectivity:** Modernizing transport		SDG 9 (infrastructure), and

frameworks to maximize the comparative strengths of each UN agency. The CCPD has been developed in close collaboration with Government, development partners, and provincial governments, so that it is aligned with national and provincial priorities along with international commitments such as

the MDGs, and SDGs. On the basis of the CCPD, a Common Country Programme Action Plan (CCPAP) was developed, as a legal basis for implementation, by the three organisations and approved by EAD in October 2013.

UNFPA specific components of the CCPAP were then used to develop the CP8 Programme Strategies and Management Plan, with a Core Action Plan that form the basis of programme activities and evaluation described in this report.

3.2 UNFPA Pakistan's response through the 8th Country Programme (2013-2016)

3.2.1. Lessons learned from the 7th Country Programme (2007-2012)

In 2011, an independent assessment of UNFPA 7th Country Programme[45] highlighted the following issues and learning:

- **Lack of a Holistic RH Approach –** even though CP7 programme effectiveness and alignment was good, the efforts were narrowly focused on improving maternal health through public sector service delivery, equipment and human resource support, and often missed critical elements including engagement of men, lack of FP advocacy, and coordination. For example, impact, as assessed through the mini end line survey and other secondary data analysis shows encouraging results for maternal health and HIV/AIDS, however due to lack of priority given to FP related advocacy, its limited coverage of interventions and interpretation of RH into maternal health only through CP7, comprehensive changes in RH-outcome at district level, was not visible.
- **UNFPA Internal Management Challenges** – lack of technical staff and rapid staff turnover led to implementation delays, missed targets, and slow release of funds. The CP7 assessment of UNFPA programme management at the Country office level reveals that on a scale of 1 to 4 (4 as highest) the programme maturity has been rated (on an average) at level 2 for various dimensions of the management.
- **Good Pilots and Innovations but Lack of Uptake –** the report mentioned lack of timely planning and advocacy by UNFPA with government partners resulted in some successful initiatives failing to be adequately owned and assessed for scalability – leading to missed opportunity for learning and expansions. The CP7 has added value in furthering the maternal agenda at national level but continuity of all the efforts beyond the life of CP7 may not be necessarily ensured. The knowledge as well as evidence generated through all the three components have not been properly utilized for improved policy and planning at the country level.
- **Weak Monitoring and Progress Reporting -** The implementation process was reported by completion of activity and not according to output indicators. The monitoring and evaluation procedures were not adequate enough to assess cost-effectiveness, transaction costs with numerous IPs and efficiency of the use of financial and material resources.
- **Lack of Clarity of Gender in Mainstream Programming -** There is lack of clarity in defining the gender related outputs in the Country Programme Document (CPD), Country Programme Action Plan (CPAP) and the Country Office (CO). This lack of clarity contributes to the confusion shared by UNFPA staff about addressing and positioning gender equality issues within the mainstream programme. It also highlights the various shapes and dimensions that the 'gender component' has taken over the entire period of CP7. Due to an unclear design, monitoring mechanisms are also weak with no clear indicators and/or regular system for monitoring. Within the RH component, most

[45] Evaluation UNFPA 7th Country Programme (2011) Report

of the gender mainstreaming efforts was through national and UN system level advocacy, while some through direct work with youth (though limited in number).

3.2.2. Current Country Programme

The UNFPA 8th Country Programme was designed with the aim of helping Government of Pakistan accelerate its progress and achievement of MDG goal 5 (Improve Maternal Health) through revitalising FP and bringing a new emphasis on adolescent reproductive health (ASRH), pushing the FP 2020 country commitments by strengthening institutional capacity for improved service delivery and evidence use, and addressing gaps in humanitarian responses. The key partners involved with UNFPA in implementation of CP8 activities/interventions were approximately 32 with representation from government ministries/departments, NGOs/INGOs, academic institutions, parliamentarians, media, religious leaders, and donors/UN agencies across Pakistan.

Intervention Logic and Design

The UNFPA 8th Country Programme for Pakistan (2013-2017) design and activities are closely aligned with three key documents namely 1) UN Development Assessment Framework (UNDAF)/One United Nations Programme II (OPII), 2) Common Country Programme Document of UNICEF, UNDP and UNFPA (CCPD and CCPAP), and 3) Pakistan Framework for Economic Development (2011). From these three main documents, UNFPA CO developed the 8th Country Programme Strategies and Management Plan (2013-2017) which forms the basis of the intervention logic as derived by the evaluation team and illustrated in the Effects Diagram.

The main activities/interventions undertaken by the Country Office are in the areas of i) *Policy Advocacy*, ii) *Youth/Adolescent Sexual and Reproductive Health*, iii) *Family Planning and Maternal Health in development and humanitarian settings*, and iv) *Population and Development* with capacity building and knowledge management as a cross cutting component. The review of UNFPA CO programmatic documents does not clearly identify gender equality as a key intervention and seems to consider gender as a cross-cutting component, including using Gender Based Violence (GBV) prevention as a surrogate for addressing gender. During the evaluation the team tried to assess how gender equality was mainstreamed in programming – and noted down observations by interventions. *The UNFPA CPAP document shows that the interventions and activities undertaken between 2013 and 2016 aimed to contribute to two of six SPA's in OPII* - SPA 1 (Vulnerable and marginalised populations have equitable access and use of quality services) and SPA 2 (Inclusive economic growth through the development of sustainable livelihoods).

The intervention logic (re-constructed by the evaluation team) shows that CP 8 envisioned accelerating FP, MH and RH improvements through focusing on many *numerous* interventions such creating a policy enabling environment; service delivery pilots of voucher programmes for young and poor couples, reaching adolescents to reduce pregnancy and early age marriages; provision of fistula care, embedding reproductive health trainings and curriculum enhancements for wide cadre of service providers; and building long term institutional capacity for population development and disaster management. While a SWOT analysis informed CPAP and intervention logic – the risks identified do not appear to have been adjusted in the interventions and approach.

SPA 1: Access to Social Services

Output 1.1: Universal access to reproductive health integrated in provincial health policies, plans and budgetary frameworks

Policy Advocacy - Pre-CP8 in 2012 and 2013 (Election Year), UNFPA CO had made several advocacy efforts to raise the profile of population and FP issues. The most significant one was targeted towards political parties and Parliamentarians to create an enabling environment for pro-women, RH and FP favourable policies and programmes. Two partners, Population Council (PC) and Pathfinder

International (PTH) were engaged to do high-level advocacy with politicians, media, and religious groups including creating alliances with civil society stakeholders.

Advocacy with Provincial and National Bureaucracy to Increase Ownership and Prominence for FP, RH and Population – Complementary to the policy advocacy, this component of the CP8 activities focused on targeting government officials in the new provincial governments, such as Population/Health, advisors in Chief Minister's office, planners in the Provincial Planning Departments and Finance Departments, and MNCH, LHW managers in Population Welfare (PWD), Department of Health (DoH) and the Ministry of National Health Services, Regulation and Coordination (NHSRC) at the Federal level. This advocacy focused on i) initiating and sustaining provincial allocations to the procurement of contraceptives (an external donor funded programme DELIVER was phasing out in 2015), ii) ensuring timely release of budgets for MNCH/LHW programme which are critical for delivery of SRH services, and iii) piloting and implementing results-based performance monitoring mechanisms in selected districts.

UNFPA in its strategic positioning and coordination role established the Family Planning Donor Group, Country Engagement Group for FP 2020 Agenda, and several Provincial Technical Coordination and Steering Committees with representation from donors, government, and key experts to create a sustained platform for debate, planning, information sharing, and tracking of progress on RH, FP and Population.

Output 1.2: Adolescent and Youth, especially the most marginalised in selected districts, have access to integrated sexual and reproductive health information and services according to provincial standards and protocols on youth friendly services to address early marriage and early pregnancies

Consistent with UNFPA global mandate (2013), CP8 centred its activities to target adolescents and newlyweds as one of the often overlooked and neglected key groups. Under this output activities such as

1. **ASRH/Newlywed Counselling and Service Provision Mechanism in Public Sector Facilities** - in three pilot districts government service providers (male and female doctors) were trained on youth friendly services and newlywed counselling and ASRH. The pilot supported capacity development initiatives (in 3 districts), especially through development of training manuals and tools to provide counselling to newlyweds. To generate demand, the activity was linked to the FP voucher scheme being undertaken in these 3 districts by implementing partner Marie Stopes Society (MSS). Additional government partners were DoH and PWDs.
2. **Adolescents and Youth Friendly Reproductive Health Services**: Provision of sexual reproductive health is based on clinical and non-clinical services to adolescents and young people. The supply side component is with PWD and DOH, where as demand generation, capacity building and policy advocacy is with Pathfinder. To provide adolescents and youth friendly reproductive health services, the first adolescent counselling centre was established in the Family Health Clinic of Jinnah Hospital, Lahore in 2014. The partners were Population Welfare Department, Government of Punjab. Later on three more centres were established in ASRH focused districts Ghotki, Sargodha and DIK in collaboration with PWD and DOH in 2015. The component of ASRH services include counselling services through adolescent counselling centres setup in the Family Health Clinics, and provision of health/clinical services in the district hospitals. The other additional ASRH programme components implemented by pathfinder are capacity building of health care providers on the concept of adolescent and youth friendly sexual reproductive health issues and services, adolescent and youth engagement through peer educators, training of young people on peer education and ASRH, policy advocacy for the institutionalization of ASRH programme and adoption of protocols of adolescent friendly services, and also community sensitization programme for the acceptance and demand creation. The Population Welfare Department, Government of Punjab has scaled up adolescent counselling centres in 17 districts of Punjab and programme became part of Annual Development Plans in 2015. Recently PWD has also notified Adolescent RH Education Cell to be established under Family Health Clinics. It will complement adolescent counselling centres.

3. **Model On Elimination Of HIV/AIDS Transmission And Risk Behaviours Among At-Risk Young Populations –**the pilot was aimed to increase access for young MSM and TGS to SRH and HIV prevention services through coordination with Sindh AIDS Control Programme (SACP), UNAIDS, and DoHs. The intention was to also advocate for provision of contraceptives and condoms for sex workers. Two researches were conducted 1) Surveys on Sexual Behaviour and Health among Sex Workers in Karachi 2) Sexually Transmitted Infections (STIs) Testing among Hijra Sex Workers (HSWs) and Men who have Sex with Men (MSM) in Karachi. But later-on the project could not continue due to operational issues and lack of commitment from the Sindh AIDS Control Programme (SACP) level.

Output 1.3: Provincial health departments have the capacity to plan, implement and monitor universal access to Reproductive Health including in humanitarian settings.

This was the largest output of the CP8, which accounts for almost 72% of the total country programme resources. It aimed at building greater capacity of the health system (in particular, the Health and Population departments) at the provincial level after devolution to deliver integrated quality RH information and services with a focus on family planning. This output intended to address key barriers in the health system for RH/FP, namely lack of coverage and quality. The programme had the following key components, which are regarded as sub- outputs.

1. **Demand side FP Voucher Scheme in 11 Districts** – this pilot intervention was implemented by MSS, DoHs, and PWDs in the target districts of 3 provinces The intention was to enhance FP uptake and coverage in poor and marginalised populations through active outreach, demand generation/behaviour change, financing, and provision of high quality services. Started in July 2014 this intervention was terminated early in December 2015 due to issues of security clearance (i.e. NOC from government agencies), slow progress, and UNFPA budget cuts. Originally the intervention was envisioned to provide 500,000 CYPs (Couple Year of Protection). In 3 districts this pilot was linked with the ASRH counselling programme.
2. **Strengthen Capacity Of Female Service Providers To Deliver Quality RH/FP Information And Services** - Pakistan has an extensive basic health care infrastructure and outreach footprint in MNCH on the ground. These include CMWs, LHVs, nurse midwives, and FWWs. All these types of health professionals provide family planning services and the three different cadres of midwives: nurse/midwives, LHVs and CWMs all provide midwifery services although their training, employment settings and remuneration rates differ. This component of CP8 aimed to support training of these community level outreach health professionals in skills development, midwifery curriculum reforms (through implementing partner Pakistan Nursing Council), integration of RH and FP in a holistic demand and supply side approach. The programme activities supported the establishment of a question bank and an examination management system, advocated an adjustment of passing marks as well as an increasing in weightage of skills, business planning for CMWs, audit and assessed the quality of CMWs trainings[46].

   In addition, the programme supported provincial governments to establish appropriate, sustainable and quality-oriented in-service training system for FP. The programme assisted relevant provincial departments to strategically map training centres, integrate and share training resources, standardise training packages and training curriculums, enhance long term and short term training plans, advocate for sustained financing, support capacity development of faculties, and build capacity in performance assessment and evaluation. The programme also strengthened Regional Training Institutes (RTIs) in PWDs to enable long term institutional strengthening beyond the CP8 duration.

[46] CMWs programme activities according to CP8

3. **Pilot Integrated Service Delivery model for GBV and Fistula** - Building on the results achieved in the CP7, the CP8 promoted integration of GBV and Fistula services within RH services. Working through implementing partner Pakistan National Forum for Women's Health (PNFWH) and IRMNCH Programme Punjab, UNFPA provided gap funding for fistula treatment and reintegration and in the meantime shifted the focus to fistula prevention and capacity development to integrate Fistula in RH services. Focus was given to strengthening the fistula surveillance through LHWs and conducting community awareness campaigns on fistula. The programme also highlighted the challenges of "*iatrogenic fistula*" through training of WMOs and LHVs.

   The support to GBV focused on implementing a tailored stepping-up campaigns for the elimination of GBV in humanitarian, recovery and development settings. To ensure continuum of response on GBV, UNFPA CP8 activities supported National and Provincial Disaster Management Authority (NDMA/PDMA), DoH, PWDs by deployment of GBV coordinators, regular disaster preparedness committee meetings, devising a disaster management plan programme, especially in KP and Sindh

4. **Enhance Capacity Of Relevant Provincial Departments To Respond To Disasters In The Areas Of SRH –** CP8 incorporated the lessons from CP7 to strengthen provincial departments to manage disasters in a proactive and efficient manner. Working with PDMAs, NDMA and DOHs to integrate MISP (Minimum Initial Service Package) in the national and provincial contingency plans, UNFPA Humanitarian section worked closely with government counterparts for capacity building to lead, coordinate and implement MISP in humanitarian crisis. Training manuals, protocols and MSU (Mobile Service Units) in the most vulnerable districts were strengthened.

5. **Commodity Security -** USAID has been implementing a DELIVER project over the last 4 years. Through the project, USAID also supported the provision of contraceptives of around $ 10 million per annum. This more or less accounted for 100% need of the country to maintain a CPR at 23%. With USAID DELIVER programme phasing out in 2015 (this was communicated to GoP), there were gaps in capacity building for inventory, logistics, management, and procurement. Budgets for procurement (i.e. ensuring Reproductive Health Commodity Security RHCS) have been allocated by all 3 provinces (Balochistan is pending). UNFPA CP8 activities provided capacity building of government staff from DoH and PWDs to successfully manage procurement and inventory distribution, and has played an instrumental role in ensuring RHCS between government and donors. Institutional capacity both for management and administration of trainings (through implementing partner Health Services Academy) has further strengthened GoPs RHCS goal.

SPA2: Inclusive Economic Growth through Development of Sustainable Livelihood

The second component of CP8 contributed directly to Second One UN Programme (OPII) SPA2, Outcome 2.4 '*key causes and consequences of population addressed'*. It creates an enabling environment for the implementation of the SRH/FP programme with the broader goal of promoting economic growth through population management. It has two outputs.

Output 2.1: Planning and statistics departments at the national and provincial level have increased capacity to utilise research and data on population, reproductive health and gender research for evidence-based advocacy and policy reforms

1. **Enhancing Capacity Of Provincial Departments To Integrate PD In Provincial And District Sector Plans –** based on a mapping study by UNFPA (2012) that identified significant capacity limitations in civil servants a short term tailored population training programme in partnership with selected universities and other relevant national or provincial institutions on subjects such as population projection and use of statistics analysis tools was developed.

   Innovative approaches have been used to familiarise government officials with advancing knowledge, cost reductions, and importance of RH and FP. Government institutions like NIPS (National Institute of Policy Studies), PBS (Pakistan Bureau of Statistics) were assessed for RH and PD needs and as feasible institutional capacity was strengthened through hands-on training courses to their staff.

2. **Enhancing National and Provincial Capacity to Generate Evidence for Policy Advocacy** – research and academic institutions in the public sector are often weak in Pakistan with little evidence for policy being generated. CP8 addressed this gap through building capacity of public sector research institutions at the national and provincial level to generate evidence on population and SRH/FP with a youth/adolescence focus through provision of research grants, developing capacity of research staff, promoting research networks and facilitating knowledge sharing including support to dissemination of research findings. Focus of the assistance was towards adopting international best practices in research undertaking and uplift the research to high ethical and quality standards.

   The programme also aimed to facilitate management of research and to enable transfer of evidence to policy and practice. Results of research were supposed to be translated into advocacy and communication tools, such as policy briefs, and then to be timely disseminated towards the right audiences so as to influence the policy change. Findings were also consolidated in the form of a country population assessment to inform the programme direction for the next UNDAF and UNFPA CP9 planning.

3. **Supporting Renewed Efforts To Conduct A Census Of Population And Housing -** Since 2008, UNFPA has been leading the assistance to PBS to carry out a census with international standards and quality. However, for a variety of political and logistical reasons the census has been repeatedly postponed. The CP8 aimed to catalyse efforts through donor coordination, technical assistance and government advocacy to conduct the census in the CP8 time period. UNFPA role was to provide assistance in questionnaire development, methodology, analysis of the census data. Monographs in relevant areas, such as population dynamics, gender and migration will to be produced including helping PBS to digitize census maps and take over GIS labs established under CP7.

3.2.3 Financial structure of the 8th Country Programme

From the onset of the proposed 8th country program commitment from 2013-2016 was $36.2 million from both core and non-core resources—(24.2 million from core and 12 million from non-core resource). The distribution of the total budget among four programme areas were as follows: $3.4 million for Policy Advocacy (10% of the total allocation), $1.6 million for Adolescent and youth including adolescent reproductive health (5% of the total allocation) and $26.4 million for sexual reproductive health including FP and humanitarian (73% of the total allocation). Population and development consisted of the total $3.8 million (11% of the total allocation) and programme coordination was 2% ($0.7 million). The country financial programme is implemented as planned and no significant restructure of the programme is executed.

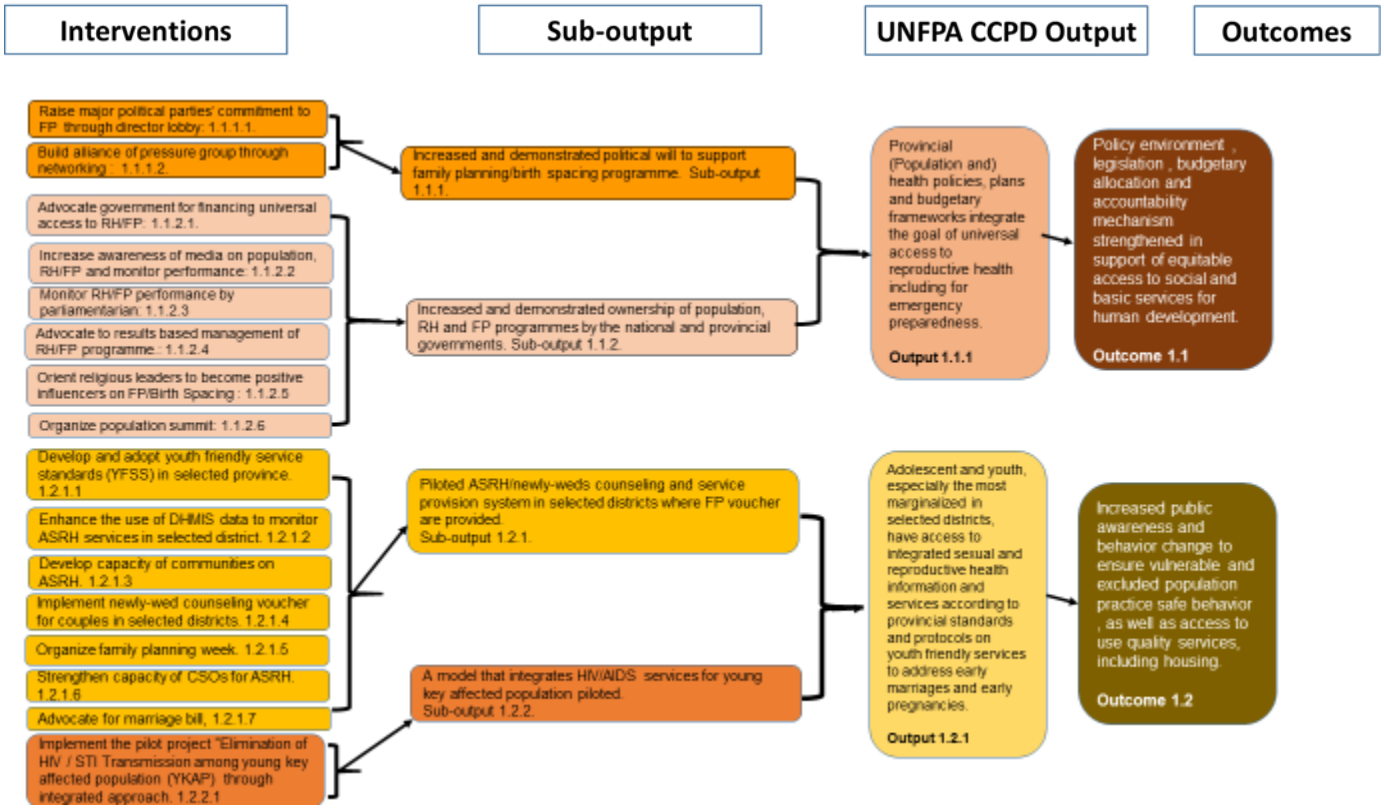
Because of the effective resource mobilization from the country office, donor has contributed significantly particularly in humanitarian assistance, RH including humanitarian. The overall donor assistance from 2013-2016 was $12 million (about 33% of the total budget of the program). Table 7 also illustrates the total allocations, expenditures and implementation rate from 2013 to 2016 for both core and non-core resources for four thematic areas. The implementation rate of each thematic programme areas is good. Implementation Rate for Policy advocacy was 82% from 2013 to 2016. While for adolescent and youth and RH including FP and humanitarian was 77% and 79% respectively over the same period. P&D is the most efficient thematic area in-term of the financial implementation, rate was 87%. Overall, the country office implementation rate was about 80% from 2013-2016.

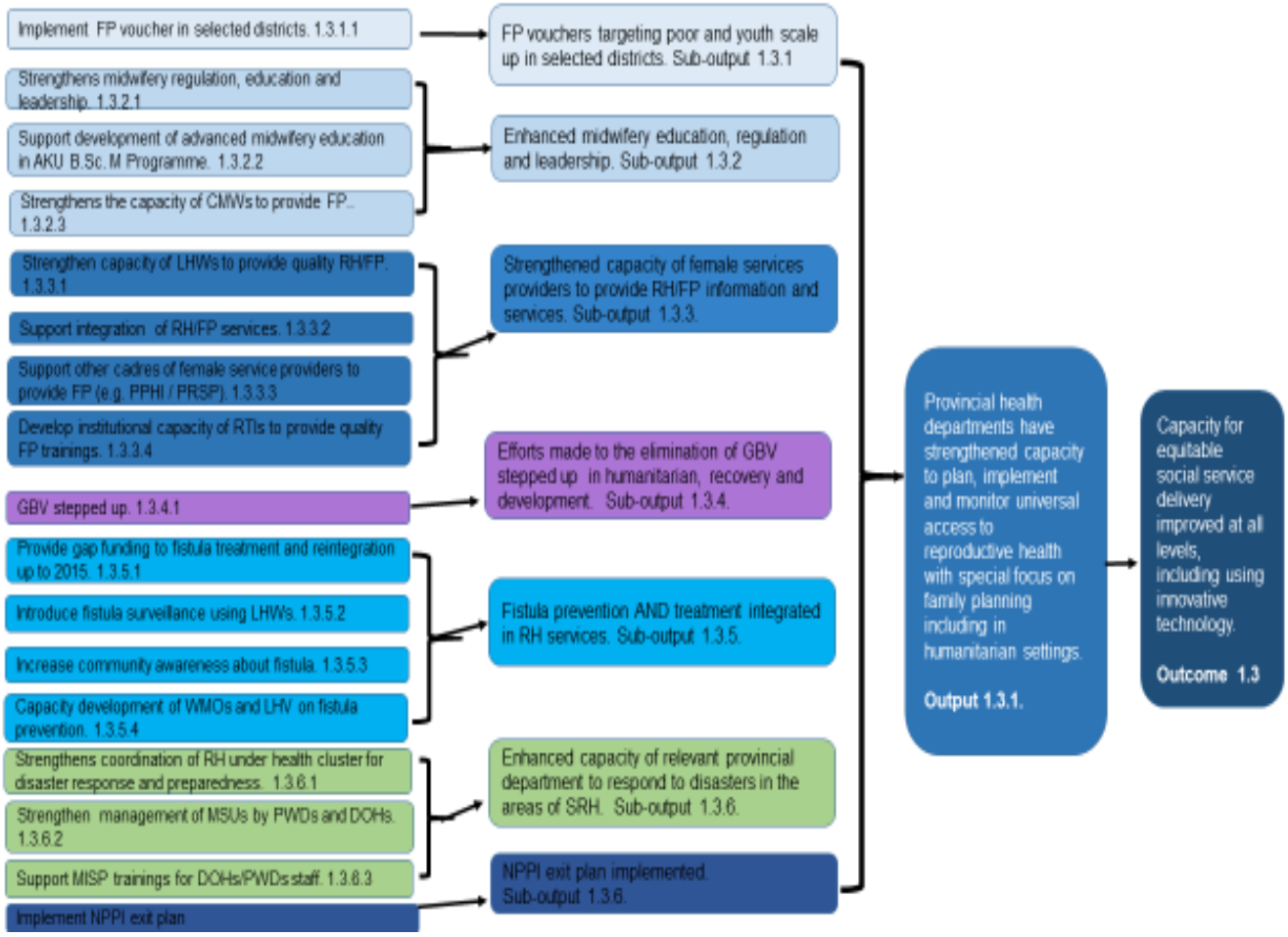
Table 7: Overview of the budget (Budget, expenditures and implementation rate) for four thematic areas of CP8-Pakistan: 2013-2016

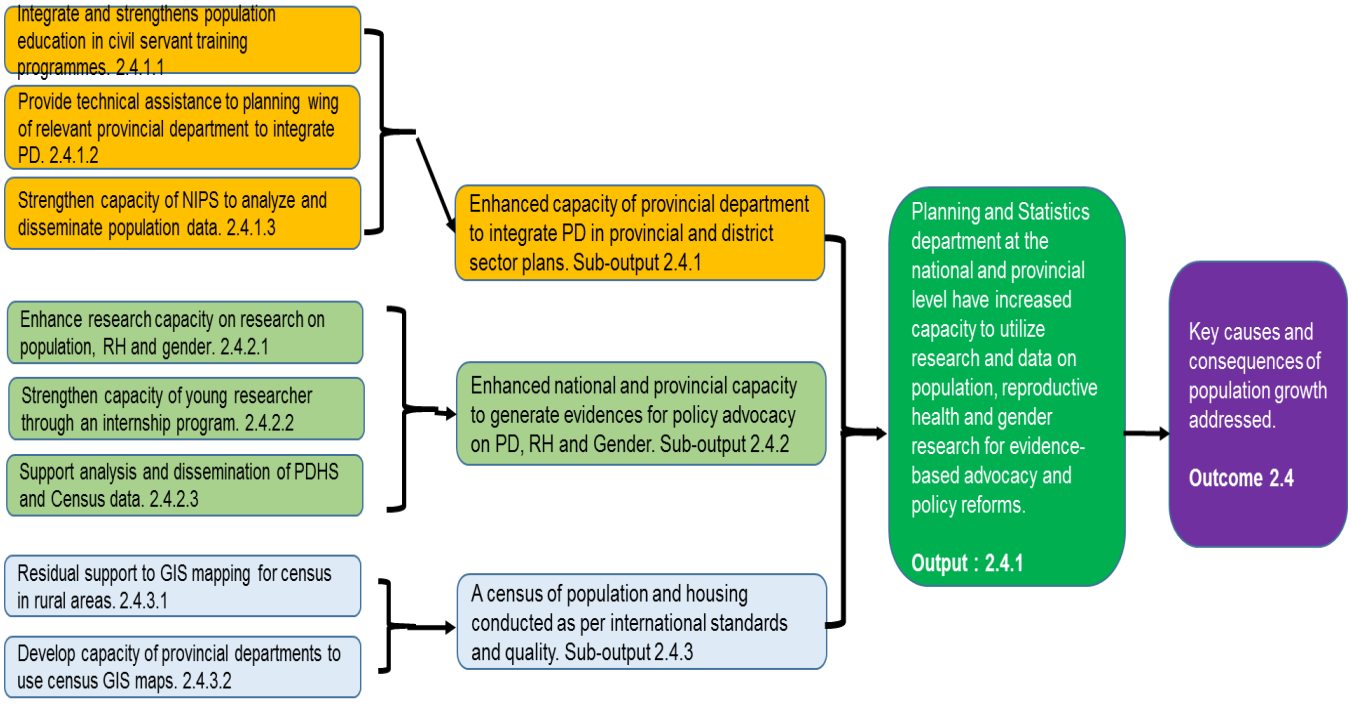
	2013	2014	2015	2016	Total
Policy Advocacy (CCPD Output 1.1.1)					
Allocations	1,250,103	836,328	919,641	474,126	3,480,198
Expenditures	1,030,131	742,350	812,034	283,946	2,868,461
Imp. Rate	82.4%	88.8%	88.3%	59.9%	82.4%
Adolescent and Youth including ASRH (CCPD Output 1.2.1)					
Allocations	84,866	791,515	431,181	391,910	1,699,472
Expenditures	68,447	721,650	292,111	233,899	1,316,107
Imp. Rate	80.7%	91.2%	67.7%	59.7%	77.4%
Sexual Reproductive Health including FP and Humanitarian (CCPD Output 1.3.1)					
Allocations	5,194,227	6,723,780	8,464,687	6,022,791	26,405,485
Expenditures	4,097,051	4,878,091	7,212,191	4,647,855	20,835,188
Imp. Rate	78.9%	72.5%	85.2%	77.2%	78.9%
Population and Development (CCPD Output 2.4.1)					
Allocations	906,733	735,761	837,840	1,391,429	3,871,763
Expenditures	872,347	746,998	729,580	1,032,427	3,381,352
Imp. Rate	96.2%	101.5%	87.1%	74.2%	87.3%
Programme Coordination					
Allocations	195,200	200,000	153,000	230,000	778,200
Expenditures	192,116	193,409	129,444	179,076	694,045
Imp. Rate	98.4%	96.7%	84.6%	77.9%	89.2%

Source: Cognos report from 2013-2016, provided by UNFPA country office. The budget for 2016 is up to September 2016. The details budget and expenditures by IPs from 2013-2016 can be found in the annex.

Figure 10: Effects Diagram




Implement FP voucher in selected districts. 1.3.1.1
FP vouchers targeting poor and youth scale up in selected districts. Sub-output 1.3.1
Strengthens midwifery regulation, education and leadership. 1.3.2.1
Support development of advanced midwifery education in AKU B.Sc. M Programme. 1.3.2.2
Strengthens the capacity of CMWs to provide FP.. 1.3.2.3
Enhanced midwifery education, regulation and leadership. Sub-output 1.3.2
Strengthen capacity of LHWs to provide quality RH/FP. 1.3.3.1
Support integration of RH/FP services. 1.3.3.2
Support other cadres of female service providers to provide FP (e.g. PPHI / PRSP). 1.3.3.3
Develop institutional capacity of RTIs to provide quality FP trainings. 1.3.3.4
Strengthened capacity of female services providers to provide RH/FP information and services. Sub-output 1.3.3.
GBV stepped up. 1.3.4.1
Efforts made to the elimination of GBV stepped up in humanitarian, recovery and development. Sub-output 1.3.4.
Provide gap funding to fistula treatment and reintegration up to 2015. 1.3.5.1
Introduce fistula surveillance using LHWs. 1.3.5.2
Increase community awareness about fistula. 1.3.5.3
Capacity development of WMOs and LHV on fistula prevention. 1.3.5.4
Fistula prevention AND treatment integrated in RH services. Sub-output 1.3.5.
Strengthens coordination of RH under health cluster for disaster response and preparedness. 1.3.6.1
Strengthen management of MSUs by PWDs and DOHs. 1.3.6.2
Support MISP trainings for DOHs/PWDs staff. 1.3.6.3
Enhanced capacity of relevant provincial department to respond to disasters in the areas of SRH. Sub-output 1.3.6.
Implement NPPI exit plan
NPPI exit plan implemented. Sub-output 1.3.6.
Provincial health departments have strengthened capacity to plan, implement and monitor universal access to reproductive health with special focus on family planning including in humanitarian settings.
Output 1.3.1.
Capacity for equitable social service delivery improved at all levels, including using innovative technology.
Outcome 1.3


Integrate and strengthens population education in civil servant training programmes. 2.4.1.1
Provide technical assistance to planning wing of relevant provincial department to integrate PD. 2.4.1.2
Strengthen capacity of NIPS to analyze and disseminate population data. 2.4.1.3
Enhanced capacity of provincial department to integrate PD in provincial and district sector plans. Sub-output 2.4.1
Enhance research capacity on research on population, RH and gender. 2.4.2.1
Strengthen capacity of young researcher through an internship program. 2.4.2.2
Support analysis and dissemination of PDHS and Census data. 2.4.2.3
Enhanced national and provincial capacity to generate evidences for policy advocacy on PD, RH and Gender. Sub-output 2.4.2
Residual support to GIS mapping for census in rural areas. 2.4.3.1
Develop capacity of provincial departments to use census GIS maps. 2.4.3.2
A census of population and housing conducted as per international standards and quality. Sub-output 2.4.3
Planning and Statistics department at the national and provincial level have increased capacity to utilize research and data on population, reproductive health and gender research for evidence-based advocacy and policy reforms.
Output : 2.4.1
Key causes and consequences of population growth addressed.
Outcome 2.4

Chapter 4: EVALUATION FINDINGS AND SITE OBSERVATIONS

This chapter presents the evaluation findings organised around the evaluation criteria and sub-questions within each criteria. Findings are thematically arranged starting from the Country Programme design process to eventual programmatic sustainability and intended and unintended influences on the larger national (and provincial) landscape.

4.1 Relevance and Responsiveness

EQ 1: To what extent are the objectives of the CP adapted to the needs of the population (including vulnerable and marginalised groups), and aligned with the government and UNFPA priorities

EQ 2: To what extent was the Country Office able to respond to the changes in the national development context and in particular to emerging humanitarian context?

EQ5: To what extent has UNFPA contributed to an improved humanitarian response in the area of sexual and reproductive health and addressing issues of Gender Based Violence (GBV) in emergencies?

SUMMARY

The CP8 design and objectives were relevant and aligned with Pakistan's national priorities and UNFPA mandate. The primary objective of CP8 was *revitalizing* Pakistan's stagnant family planning and population development agenda through a number of diverse interventions (i.e. there were 43 interventions under 15 outputs) in *Policy and Advocacy, Youth and RH/ASRH, FP and Maternal Health, and Population and Development.*

Designed in 2011-12, the relevance of CP8 design and implementation was affected by two major transitions: i) Devolution and early phase of transitioning of Health and Population responsibilities from the Federal level to the provinces with the subsequent challenges of provincial autonomy; lack of clarity of roles, resources and infrastructure; and available capacities. This had implications on government ownership of CP8 and overall performance outcomes in terms of a unified population vision, and/or available provincial capacities and commitments to properly dedicate resources, and to fully supervise progress; and ii) Management and organizational restructuring at UNFPA Country Office with periods of vacancy in senior management and technical staff positions that undermined the timely transition and understanding of CP8 goals and objectives into on-ground interventions. While the CP8 showed some responsive adaptations in programmatic activities many of these emerging "*new realities*" were not incorporated in re-structuring the programmatic approach.

The design process and implementation was inclusive, participatory and responsive to national and to a lesser extent provincial stakeholders. However, a major limitation in the design process was low attention to specifics and low inclusion of cross-sectoral partners, private sector actors, or inputs from end beneficiary on their needs and programmatic results. Stakeholder interviews revealed gaps in understanding of UNFPA role as complementary rather than substituting government, narrow focused, and limited to the short term objectives.

Most critically, UNFPA was less able to help the government and civil society partners find institutional ways of taking into account lessons from past FP-RH programming (by UNFPA and others) and the detrimental role that weak governance and accountability has played in undermining success. Evidence clearly shows that low accountability results in poor implementation and results, with few consequences for programme planners and often low evidence interventions are again funded by new donors in another funding cycle.

Marginalised and vulnerable population groups were a key target audience in the CP8 design. However an inherent design and implementation flaw was that it did not specify i) any clear methodology or strategies on how this would be achieved by partners; ii) how would targeting be

measured; iii) if targeting was not being achieved what corrective actions would be put in place to increase access to and for the most marginalised. The results were thus implementing partner dependent with missed opportunities and lack of evidence on changes in social-structural barriers that limit access for the most marginalised.

The CP8 did not specifically focus on gender equality as a programmatic area. So while women and girls were generally assumed to be the main beneficiaries of programme interventions there is lack of evidence on whether UNFPA support directly increased women's equality, inclusion, access to information, representation or decision making at the individual or induced institutional level change in behaviours towards women/girls.

LESSONS

Narrow Approach- While the design process of CP8 was inclusive it missed out engaging crucial partners in Ministries/Departments of Planning & Development, Finance, Education, Social Welfare, Labour, Law and Justice along with private sector providers and markets. This is a significant gap since broader national and provincial actors were not engaged to include FP-RH and Population Development in their policies and practices. Additionally over 80% of outpatient services are in the private sector and the public sector only reaches 15% of MWRA (married women of reproductive age) with FP services and 52% of skilled births. Document review also shows that these gaps were not recognised or corrected during the implementation process.

UNFPA's mandate goes well beyond FP and RH to include Population Development related priorities such as enhanced building social capital, demographic dividend, maximising capacities and well-being of youth/adolescents, urbanisation and mortality issues. *UNFPA's CP 8 strategic planning missed out on details of how results would be achieved and overall engaging and exploring many of these opportunities and alliances during the design and implementation process.*

Lack of Strategic Focus – CP8's ambitious design and implementation lacked the *strategic focus* to translate many of the innovative interventions into government practice changes, institutional reforms, or re-focusing of the societal barriers that curtail women's right to choose family planning and access reproductive health. Better results could perhaps been achieved with focusing on selected activities, detailed planning, measuring results, and making in time corrective changes to encourage government leadership and accountability to the Population agenda.

For example, many of the interventions started the process, *built momentum* but did not significantly change the *business as usual* model in partner institutions. A deeper analysis of why and what could be done differently shows that until awareness can be created in government partners for ownership and accountability, merit based recruitment, performance criteria and hiring-firing consequences for sub-optimal employees, UNFPA or other donors funding programme results are likely to remain below par for the resources invested.

Humanitarian Responsiveness - While considerable improvements have taken place in the capacity building, coordination and communication between UNFPA, government agencies, UN agencies and non-government partners', the overall relationship still is not smoothly organised. There are many issues of lack of clarity on roles and ongoing turf issues, absence of strategic planning (i.e. contingency plans or communication protocols) that require UNFPA's sustained efforts to continue.

UNFPA must try to encourage greater leadership from government partners e.g. encourage GoP leadership via DoH/PWD/government and abdicating responsibilities to UNFPA in disaster situations.

4.1.1 Alignment with National and UNFPA Priorities

The CP8 objectives are consistent with national priorities of the Government of Pakistan and contributes to two of six priority areas set by UNDAF/OPII (2013-2017). As an "orange country" (in

2014) UNFPA Pakistan focused on Policy Advocacy, Capacity Building and demand creation for Knowledge Management with some pilots of adolescent and maternal reproductive health service delivery.

CP8 was developed via cooperation and consultation between UNFPA, several UN agencies and the national and provincial governments with broad level of consultations starting in 2011-2012. The CP 8 design and planning closely followed the OPII and CCPAP (UNICEF and UNDP) and is reflective of close coordination with Government of Pakistan (through the Economic Affairs Division) and the One UN Programme in Pakistan. Being an orange country, UNFPA support in Pakistan focused on Policy Advocacy, on service delivery only through "*demonstration*" projects and building the Capacity to produce and use data.

4.1.2 Limitations in the Intervention Logic and Design

There are several inbuilt weakness in the CP8 design and intervention logic that overall affected programmatic relevance and performance effectiveness (Figure 11: Effects Diagram) and made it challenging to measure the outcomes. These deficiencies were highlighted during the desk review when trying to find the causal chain and later on in discussions with informants. First, the causal relationship and linkages between outputs, indicators, and interventions are not clear. For example, community sensitisation of ASRH leading to increased youth access to ASRH services; advocacy with religious leaders when PDHS 2006 clearly shows only 6 percent women reported religion as a barrier to FP use and religion does not play a significant role in individual RH care choices; Results based management leading to improved monitoring of FP-RH indicators that were never captured in the district health information systems etc.). Secondly, in some cases there is lack of clarity on the planning steps and how the stated interventions would result in the desired results i.e. Advocacy seminars with Parliamentarians or religious leaders leading to what specific outcomes are unclear. In other situations multiple partners (independent of UNFPA) worked towards a combined goal and UNFPA's role (i.e. contribution) to achieving results are difficult to decipher. For example, in passage of the early age marriage bill in Sindh and Punjab.

Frequently the indicators listed are subjective percentages without adequately documented baselines and at times the indicators are merely outputs. Therefore the evaluation has been able to mainly measure contribution. Perhaps future programme designs and evaluations would be better positioned to also measure attribution if monitoring and data disaggregation can be more rigorously applied.

4.1.3 Documentation of the Design Process Is Weak

Meeting reports do not provide adequate details on how strategic planning, thematic areas, risks and assumptions, activities, budget allocations and indicators were discussed during consultations or how local evidence informed decisions in finalising the Country Programme. For example, the pre-planning exercise of CP8 is not informed by any analysis reconciling the policies and programmes of different sectors or identification of potential entry points for Advocacy or interventions in FP and RH. Key questions like *how did the CP 8 build on achievements of CP 7 or previous work done by other organisations/donors/UN agencies were not addressed or not available in the official records. Questions on how accountability and weak governance would be mitigated were very superficially addressed and no suggestions provided in the SWOT analysis and risk matrix shared by UNFPA CO.*

Furthermore, the five fundamental programming principles for UNFPA support: the human rights-based approach, gender equality, environmental sustainability, results-based management, and capacity development exercises were not clearly described during the Country Programme formulation; nor were there available records of how the CP 8 was assessed prior to finalisation by the APRO or UNFPA HQ i.e. the internal UNFPA quality assurance mechanisms and what rating the design received.

The CP8 design process while participatory and inclusive of traditional health and population partners did not fully adjust for local evidence, risk management or intersectoral actors.

The CP8 was designed via an inclusive wide ranging process starting in late 2011-2012. The process focused on UNFPA global priorities, national (and provincial) priorities, built upon some of the lessons from CP7 (i.e. strengthen RH-FP focus, increase funding support for Population and Development) and sought to arrive at consensus on the CP8 through one national and 3 Provincial consultations. The process was led by UNFPA Country Team and included mainly traditional stakeholders from government ministries/departments, NGOs/INGOs, academic institutions, donors, UN Agencies, and civil society experts.

Consultation included mostly traditional actors. For example, from the government Ministries/Departments of Health and Population Welfare but not Ministries/Departments of Education, Youth, Women Development, Law Enforcement, Labour and Industries, National/Provincial Commission on the Status of Women, or Justice and Human Rights.

Well recognised and larger NGOs or those that had previously worked in CP7 interventions were invited, but the wider and more dispersed private sector that accounts for around 4/5th of all health services was also not included in consultations or implementation coverage. The debate and planning process was held while devolution following the 18th Constitutional Amendment and re-structuring at UNFPA management were going on and is likely to have limited how focused and committed provincial governments were in recognising and articulating their local priorities, or having capacities to implement and fully own the process. UNFPA CO did not re-visit the design gaps at a later stage with the provincial governments in 2013 onwards including adjustments according to provincial priorities.

4.1.4 Relevance by Programmatic Areas

POLICY AND ADVOCACY

UNFPA Country Programme 8 was a major shift from the activities and partnerships of CP7 with a predominant focus on FP-RH revitalisation.

The Policy Advocacy component (OPII outcome 1.1, UNFPA CCPD 1.1.1. and CPAP sub-outputs 1.1.1 and 1.1.2) targeted advocacy for building political will to support FP, healthy birth spacing and timing, and to increase its ownership by political or bureaucratic leadership to lead the population agenda. Given the recent elections (2013) and FP 2020 commitments, the CP8 activities targeted parliamentarians, provincial and national government, religious leaders, media and civil society pressure groups to raise awareness and address FP as a national priority and to play an instrumental role of "*positive influencers*".

Policy and Advocacy has primarily focused on two major areas i) enabling environment, and ii) enhancing funding for FP-RH. Momentum has certainly been built for an enabling environment through UNFPA interventions plus investments of other donors like USAID and DFID in large scale FP programmes, and the government's own focus on improving population indicators. The simplistic advocacy for increased funding as a solution to addressing low FP uptake contradicts national data (PDHS 2012 and NHA analysis) which shows that current public sector resources would be sufficient if public sector efficiency can be improved through reducing inactive workforce, re-strategizing on the number of health facilities by utilisation, and task shifting from doctor centred care provision to non-doctor or mid-level providers. Currently public sector FP service provision is nearly twice as expensive as NGO run models and the regional averages[47]

[47] Abbas K, Khan AA and Khan A. **Costs and Utilization of Public Sector Family Planning Services in Pakistan**. JPMA April 2013. 63 (4, Suppl 3) S33-39

Advocacy with government decision makers did not address issues of deriving better "*return on investment*" by making service delivery more accountable and improving performance. For example, government's claim on low numbers of LHWs (40%-60% non-coverage by LHWs in rural areas) can be *rationalised* through evidence on holding accountable under-performing LHWs[48] (25%-35%), redistributing of human resource and front line providers, and better coordination between DoH and PWD in the provinces. These are some of the challenging discussions which UNFPA should have highlighted for action by government planners to improve effective utilisation of available resources and infrastructure.

UNFPA CP 8 had a youth focus but discussions with informants identify how the *Policy Advocacy* component advocacy with parliamentarians, religious scholars and media did not sufficiently connect FP-RH opportunities and access to information and services for adolescents (particularly girls), youth and younger couples. For example, the paradigm shift to change the narrative from exclusion of young people to inclusion and empowering them was reported as a "*weak side note*" and not the main thrust of advocacy.

Provincial government officials of MNCH and LHW programme were also targeted to build their capacity for strengthening performance, integration, and supervision of RH, MH and FP services for the most marginalised and vulnerable populations. Nearly all of this focus was on public sector providers with some inclusion of NGO providers. One area of improvement that may have had a greater amplifier effect would have been to include private sector providers (in those localities) that were already providing FP-RH services in their communities – to build their quality, standardisation, and RH-FP awareness for universal access and rights based services.

YOUTH, RH and ASRH

In principle, the CP8 tried to 1) enhance universal access to affordable, quality integrated SRH services that meet human rights standards; 2) strengthen accountability by setting standards, training service providers, reaching out to marginalised groups (inclusion and empowerment), and supporting legislative protection like bills against child marriages; and 3) integration of RH and ASRH in humanitarian context and organise the rapid response.

These activities were aligned with rights based, poverty reduction and sustainable development goals of ICPD and now the SDGs, the provincial Population Policies (2012), provincial Youth Policies (Punjab-2012 and KP-2016) and the recently unveiled National Health Vision (2016), including inclusion in the 10 points RMNCAH that Pakistan has committed to in the Women's Deliver conference (May 2016). The CP8 addressed these through both its RH, Population and Development components in a mixed capacity building and innovative service delivery model approach.

In this component (OPII outcome 1.2, UNFPA CCPD 1.2.1 and CPAP sub-outputs 1.2.1 and 1.2.2) activities were geared towards ensuring equitable access (i.e. services, information, behavioural change) and quality for marginalised, under-reached adolescents/youth and high risk populations. The interventions were tests of innovative approaches for overcoming barriers to access or uptake of services in these sub-populations using a mix of public-private, outreach and health facilities models, training of first level female service providers for adolescent/ youth friendly reproductive health services, newly-wed counselling, setting up adolescent counselling centres, developing service protocols, promoting safe behaviours through peer education approaches, HIV/AIDS risk reduction and raising awareness of the civil society.

A positive outcome of the CP 8 interventions were that they addressed key deficiencies in the overall RH-FP health system landscape. The piloted Adolescent Counselling Centres, and development of protocols for health professionals etc. all of which are essential for addressing this key gap. Some of these *"innovations*" have been adapted by Punjab and (to some extent) Sindh government. While this is

[48] LHW Systems Review. Oxford Policy Management 2009-2010 Pakistan

a very positive sign it is important for sustainability purposes for the government implementers to also fully understand the rationale/reasons for doing so. The evaluation found that the expected outcomes are less well understood by many of the government informants consulted during the evaluation.

MH AND FP IN DEVELOPMENT AND HUMANITARIAN CONTEXTS

The FP and Maternal Health component (OPII outcome 1.3, UNFPA CCPD 1.3.1 and CPAP sub-outputs 1.3.1, 1.3.2, 1.3.3, 1.3.5, 1.3.7, and 1.3.8) constituted the largest output of CP8 (nearly 72% of Country Programme) and were focused on capacity building, piloting innovative models and removing barriers that undermine health system effectiveness in FP-MH. Programme activities in this component were demand side FP voucher scheme, capacity building of female doctors and mid-level providers (CMWs, LHWs, LHVs, and FWWs), fistula identification and treatment, trainings for procurement, inventory management and commodity security, and a holistic MNCH approach (NPPI).

Documentation of the interventions which would help in future scalability and advocacy of these interventions was repeatedly weak. Issues such as objective documentation of the results achieved, follow up on changes in practices (including quality) of the service providers trained, research on processes and what did not work and why at the community level were often missing or missed. *For example, in Fistula treatment interventions it would be helpful to map out most at risk districts and those providers and to target mitigation strategies at them through community awareness, negative incentives, and government regulations to prevent these providers from additional iatrogenic and new fistula cases. Or effectiveness of CMW training courses would be better assessed for success if reliable documentation is available to show increase in community uptake of SBA or FP, improved referrals and recognition of danger signals, and timely management.*

EVIDENCE USE FOR POPULATION AND DEVELOPMENT

The Population and Development component (OPII outcome 2.4, UNFPA CCPD output 2.4.1 and CPAP sub-outputs 2.4.1, 2.4.2 and 2.4.3) activities were mainly focused on capacity building and knowledge management. CP8 interventions supported provincial and national government departments/institutions for evidence generation for policy and planning, capacity building of government staff to use evidence for tracking progress and monitoring programmes and to facilitate GOP in conducting a population census and a development survey.

In CP8, the UNFPA sought to help the government institutions understand the key causes and consequences of population growth, rapid urbanisation, SRH needs of adolescents and youth, and develop relevant Health and Population specific policies and evidence. Most importantly UNFPA CP 8 spent a considerable effort in helping PBS prepare for the Population Census and post-census dissemination.

The logical assumption was that helping government planners to understand the link between sexual and reproductive health, gender and population dynamics would in turn feed into development objectives of the Economic Growth Framework (2011) including poverty reduction; employment; inequality and social protection; food, water and energy security; and with sustainable development, environmental impacts and climate change. Such population dynamics have a critical influence on, for example, each of the three (social, economic and environmental) pillars of sustainable development. *However, this broader alignment was never fully incorporated in the work plans or understanding of the government officials or institutions that UNFPA collaborated with and many of the activities under this component were limited to a number of trainings.*

HUMANITARIAN ASSISTANCE

These activities (OPII outcome 1.3, UNFPA CCPD 1.3.1 and CPAP sub-outputs 1.3.4 and 1.3.6) were important components of CP8 and were designed to respond to humanitarian crises in recurrent natural disasters (floods, drought), the growing challenges of internally displaced populations (IDPs) and the limited capacity of the government to respond to these emergencies. Programme activities focused on working with and through government institutions and departments aimed to strengthen contingency

planning, coordination, and response from the acute emergency needs to rehabilitation of IDPs and integrating SRH and GBV in overall government responsiveness.

The CP7 review had identified gaps in the government's lack of disaster preparedness particularly contingency planning and preparedness for RH and GBV and had suggested a potential entry point for UNFPA to coordinate humanitarian responses in the next programme cycle. The CP8 activities of coordination with government and UN agencies (Humanitarian cluster), developing a Minimal Initial Service package, GBV and SRH stepping up, and helping from acute to recovery phase are aligned with the UNFPA Humanitarian Strategy (2012)'s transformative agenda and Global Programme to enhance Reproductive Health Commodity Security (GPRHCS).

4.1.5 Systematic Approach to Humanitarian Efforts and Emerging Needs

From the devastating earthquake in 2005 and during the floods of 2010-11, UNFPA Pakistan has been involved in humanitarian programme efforts on a "*need basis*", mainly working through the UN Humanitarian Response Cluster and through NGOs/IPs to provide assistance. Despite substantial involvement, CP7 operational documents showed no dedicated Humanitarian section or assigned roles and responsibilities or a Humanitarian Response Strategy at the UNFPA CO management level.

In CP 8 there was a strategic shift to "*systematically*" work with government agencies such as NDMA, PDMA, FDMA and the DoH to re-direct attention on the sexual-reproductive-maternal health and violence prevention for women and girls in disaster or conflict affected areas. UNFPA signed a number of MoUs/LoA and revived the RH Working group in collaboration with the National Health Emergency Preparedness and Response Network (NHEPRN).

UNFPA effectively responded to emerging needs identified by government partners and to the humanitarian crises such as the 2014 floods in Sindh and massive crisis of displaced populations (IDPs) in KP/FATA in coordination with government agencies (NDMA/PDMA/FDMA/DoH-PWD) and UN Humanitarian Cluster Response partners (i.e. OCHA, UNICEF, WHO, WPF). The main reason for this rapid response was UNFPA's flexibility to mobilise resources and open communication with upstream and downstream partners.

Limitations included ongoing coordination issues with government partners, bureaucratic delays (beyond UNFPA control), limited on ground understanding and wide spread funding for newer approaches such as MISP and the very nature of emergencies where instincts for survival – with their attendant material needs - supersede any long term behaviour change. *A key lesson was that implementers need to learn to apply what they understand of local customs in the context of emergencies while using some level of standardised protocols for SRH-GBV, FP and MH. Generic emergency responses may not work well in the context of conservative societies where acceptance of, access to and opportunities for girls and women may be the lowest priorities even for local implementers.* Finally there was perceived need to identify how best to engage the government in leadership role, delivering of timely and quality services and owning new approaches in the context of large scale emergencies that are "*messy*"

Drawing on mapping from Humanitarian Needs Assessment,[49] UNFPA conducted humanitarian interventions in 3 districts. For preparedness the relevant government counterparts were engaged and UNFPA built capacities for contingency planning, introduced MISP, included family planning and brought together DoH and Disaster Management partners to the same table in Sindh, Punjab and KP/FATA. However, results were modest and partners do not fully understand the objectives of coordination and pooling resources.

[49] Identified 19 priority districts in KP (Peshawar, Charsadda, Nowshera, Buner, DI Khan, Fr. Tank, Tank,Kohat, Hangu, Swabi, Mardan and Lower Dir) and FATA (Bajur, Khyber Agency, Mohmand Agency, Kkurram Agency, North and South Wazirstan)

4.1.6 Contribution to Humanitarian Efforts

Figure 11. Disaster Management Cycle

In Pakistan, UNFPA has been involved in coordinated humanitarian response since the earthquake devastated northern parts of the country in 2005, the massive floods in 2010-11 and other recurrent disasters. In this time, UNFPA has provided substantial programming and coordination assistance for relief and recovery needs.

In 2010 floods, UNFPA initiated the first ever large scaled GBV project in Pakistan covering 4 provinces to enhance the capacity of GBV service providers to proactively prevent GBV and allow survivors access to quality, appropriate and relevant services. In 2013 RH Working Group was reactivated under leadership of the UNFPA and the National Health Emergency Preparedness and Response Network (NHEPRN). A major achievement of UNFPA is successfully integrated MISP into the Disaster Management Training's modules.

Common Observations and Findings

1. A number of areas for improvement have been identified during the CP 8 implementation: These included programming issues such as delayed identification of relevant partners to implement humanitarian projects due to non-availability of updated GBV and RH mapping, late disbursement of (CERF) fund to IPs, late distribution of RH and GBV Kits, non-availability of a humanitarian strategic document and a rigid management structure of the previous humanitarian programme.

2. Coordination issues such as non-updated versions of GBV and RH actors mapping, developing standardised SOPs, and avoiding overlap in joint-assessments and reporting between UN agencies were key challenges that the CP 8 faced in getting the programme off the ground.

3. Sub-cluster and working group's tools still are partially revised and have to finalise.

4. Humanitarian and Development aspects are interlinked. A better understanding of the disaster management cycle, with its four phases: Mitigation, Preparedness, Response and Recovery helps align key concepts. The Mitigation and Recovery are very much interlinked with development. For e.g. a large number of IDPs or refugees living temporarily/ permanently in Islamabad, Karachi or Peshawar, are a humanitarian issue inside a development phenomenon, and this interlinkage remains weak in the current Humanitarian and Development programming of UNFPA CP 8.

4.1.7 Enhancing SRH-GBV Responsiveness and Building Provincial Capacities

UNFPA Humanitarian interventions under two outputs 8 and 10 supported Government and partner humanitarian actors to decrease risks of GBV, address SRH and MH including exploitation and unwanted pregnancy through mitigation, preparedness, and response and recovery phases.

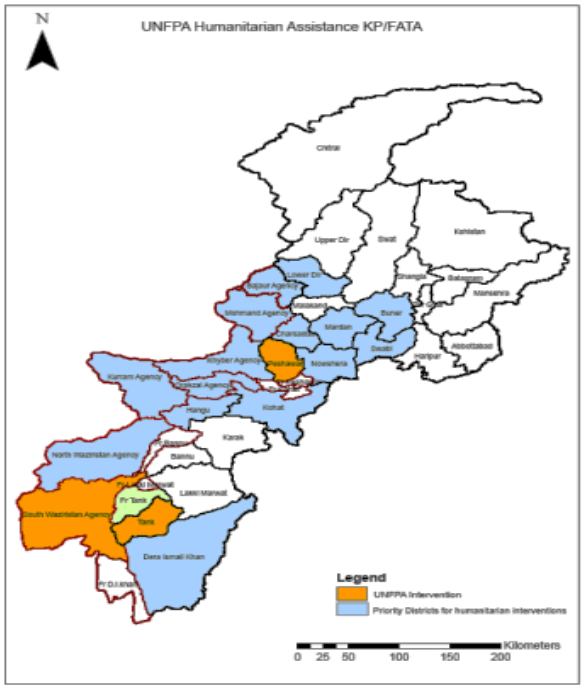
UNFPA has worked closely with government partners in health (DoH), population (PWDs), disaster management (NDMA, PDMA, FDMA), PNC, Health Services Academy, the NHEPRN (National Health Emergency Preparedness Response Network), NGOs (Muslim Aid, SRSP, FPAP, HHRD, NHSD etc), donors, and UN Humanitarian agencies (OCHA, UNICEF, UN Women, WHO, UNHCR) to improve disaster management and services in all 3 provinces and at the national level.

Key achievements are:

- Sectoral coordination meetings started at the provincial level including the RH working attended by UN, NGOs, PWD, DoH, and PDMA's – partners are sharing information.

- Coordination mechanism with NHEPRN is in place with coordination of several ongoing humanitarian responses in KP districts and FATA agencies.
- Shift from a completely UN centric humanitarian response effort to more visible level of leadership and coordination initiative by government institutions namely PDMAs/NDMA.
- Inclusion of MISP in disaster risk reduction (DRR) plans and responses along with trainings of government and NGO staff in implementation of MISP objectives[50] and services.
- UNFPA has supported development of training materials, trainings and clean delivery and new born kits.
- 169 health disaster management staff have been trained on the Minimum Initial Service Package for SRH in Crises in three provinces. Two provinces (Punjab and Sindh) developed the Provincial Action Plans for MISP implementation in their disaster prone areas. In addition, 17 Medical Officers and Field Technical Officer (FTO) from 10 disaster prone districts have been trained on emergency RH/ FP services including MISP.

Figure 12. UNFPA Humanitarian Assistance in KP and FATA



- Inputs into the Humanitarian Strategy and Multi-Hazard Contingency Plans
- Mapping and research into the RH needs of Health facilities in KP and FATA, GBV Standard Operating Procedures for roll out in 2016 have been developed.
- Inclusion of MISP, GBV-SRH into curriculum and trainings of LHWs, CMWs (limited success)
- In CP 8, UNFPA mobilized $ 375,000 (2014-2015) and $ 1.36 million (2016) from core programme and CERF/ERF, to support humanitarian efforts and pilot interventions with IDPs in Peshawar, Bannu, Kohat, Tank and North and South Waziristan.
- Through Muslim Aid, UNFPA has supported UNFPA the strengthening the emergency and service delivery at MCH centre Mamash Khel through a comprehensive RH package and distribution of 600 safe delivery kits to RHC Kakki and Mamashkel. . The efforts have been well placed in providing immediate services but the intervention design has lacked coordination with recovery and rehabilitation of IDPs and families.
- Through SRSP, UNFPA piloted “Ensuring Protection for Women” UNFPA supported establishing Women Friendly Health Spaces (WFHS) with provision of psychosocial support to girls/women, awareness raising for protection, legal rights and documentation, vocational trainings, GBV management, dignity kits, health facilitation and mobile vans for specialised services. The project served 15,343 women and approximately 4000 adolescent girls through the WFHS, awareness sessions to 7701 men on women’s rights and protection, and the two Women Protection Desks helped women 375 women get CNIC cards.

[50] 5 main objectives- lead organization, reduction and management of sexual and gender violence, prevention of HIV/STIs, reduction of maternal-newborn deaths, and a phase appropriate SRH plan.

Common Observations and Findings

- Informants highlighted that UNFPA successfully brought relevant actors to the table and helped increased the prominence of SRH-GBV issues in the overall response. However, the emergency responses by all the partners remain fragmented and on-ground coordination is still hindered by conflicting or overlapping bureaucratic rules. For example, DoH and PDMA's struggle to pool allocated financial and human resources due to procedural delays, and confusion on the duties and communication hierarchy. Contingency plans and work plans have not fully been developed or shared, and women's exploitation, SRH-GBV remain less prioritised than more immediate life threatening concerns. Progress on these fronts will take repeated discussions, advocacy and is anticipated to be a slow and organic process (especially in the more conservative areas), and cannot be externally imposed.
- MISP is still a fairly new approach and its actual understanding remains limited. Other constraints include the lack of a dedicated government budget and trained human resources to implement MISP services. There is a considerable lack of awareness, on the importance and the inclusion of Sexual Reproductive Health (SRH) in humanitarian settings at all tiers; communities, policymakers, decision-makers, emergency and health practitioners need to be sensitized in this regard.
- The SRSP project highlighted some key lessons: i) in complex conflict settings and working with very conservative social norms, many of the routinely accepted paradigms of rights, gender equality and access have to be tailored to acceptable social traditions and a flexible project approach is needed, ii) poverty induces people, men and women, to seek tangible (and at times) short term gains. With the result that Dignity kits and Male Awareness Kits were the most popular components of the project, more so than the "*theoretical knowledge*" that was imparted during the project, iii) despite showing preliminary successes these small scale pilots remain underutilised/ignored by the government. *There is a need going forward to critically re-examine how to make government engagement and handing over for these pilots more sustainable.*

4.2 Effectiveness and Sustainability

EQ3: To what extent have the interventions supported by UNFPA in reproductive health contributed to an improved access to family planning, ASRH, and midwifery services at the community level?

EQ4: To what extent have the intervention supported by UNFPA in population and development contributed to the availability and use of data on population issues both at the federal and provincial levels for informed decision making?

EQ6: To what extent were the principles of equitable access, right-based approach and gender-responsiveness integrated in UNFPA 8th country programme and its interventions/activities?

SUMMARY

The four main programmatic areas were mostly relevant and to a great extent effective in bringing forth on the national and provincial stage the FP-RH and Population agenda. ***The Policy Advocacy component*** led to a "*momentum*" starting from the inclusion of FP in the political party manifestos to development of provincial Health, Population and Youth Policies, and resulting in the nationally recognized and widely endorsed Population Summit. For the first time the Population agenda was openly recognized as a national (and provincial) priority and included in the broader development documents (Vision 2025, MTDF, and provincial Road Maps). While all of this attribution may not just be the result of direct UNFPA support, a considerable catalyst effect was achieved by the continuous engagement of and advocacy to different groups. On the other hand some interventions such as results based management, financing of RH-FP local allocations, and orientation of religious leaders to

become positive influences, while successfully completed (some cases) showed mixed results making it difficult to conclude direct cause-effect association.

Conspicuously absent in the Policy and Advocacy component were cross-sectoral partners and the wider debate on how Population is beyond just fertility and includes critical aspects of women's/girls rights and access to education, vocational training, economic opportunities, and safe societies, and these in turn positively affect fertility. The inclusion of men as partners, and role of restrictive social norms and changing the societal narrative were not addressed during CP 8 programs.

The Youth and ASRH component were innovative and relevant. By setting up ASRH counselling services within public sector facilities of PWD RHCs, UNFPA showed that uptake of innovative ideas is possible within the government departments (given the right mix of interest, advocacy, and resources). Similarly with newlywed counselling voucher scheme, the pilot was encouraging in terms of its strategic relevance. However, both these innovative ideas suffered as a result of weak documentation, low coverage, gaps in the implementation (some centres did not have community mobilisation and thus could not be cross-compared).

ASRH interventions to raise awareness of the community showed limited achievement mainly because of lack of proper planning for social mobilization expertise and the required time duration to induce behavioural change in conservative communities. On the other hand capacity building of nearly 22,000 female service providers in ASRH counselling, FP and MH will likely have some impact on their practices and access for young people (not measured at this time).

The FP and MH component focused heavily on building the capacity of public sector female and frontline service providers. However, PDHS 2012-13 shows that vast majority of deliveries take place in the private sector as do 65% of FP services.

UNFPA support to PNC, in improving the CMW curriculum and trainings were recognised as a very strong contribution in improving the effectiveness and quality of CMWs. However, this translation of training into improvements in practice i.e. safe deliveries and quality FP services needs to be evaluated in the near future. System changes are also needed to strengthen the linkages between CMWs and LHWs, LHVs, and FWW and to address duplication in roles and targets.

Fistula prevention, identification and treatment services have greatly benefited from UNFPA long term support. The next step now is to focus advocacy with provincial governments and other donors to adopt fistula management in their MNCH packages and for serious debate to centre on task shifting and human resource distribution in remote areas.

For Population and Development component UNFPA supported a host of critical interventions in evidence generation, promoting evidence use, and support to capacity development for public sector institutions in conducting much needed analysis on urbanisation, demographic dividend, country landscape in FP and Population, data management and PDHS reviews. The support to conducting the Population Census is an ongoing effort that has been delayed due to political expediency beyond UNFPA's control.

Unfortunately what the CP 8 interventions could not achieve were institutional changes or attitudinal changes in understanding the importance of data use and generation to guide decision making. In reality very little evidence supports actual decision making which remains based on political economy, short-term interests i.e. heavy focus on infrastructure and human resource, and trainings are considered "one offs" instead of a spectrum of skills and outcomes. The unintended consequence of UNFPA CP8 support for extensive capacity building has made the government (in some provinces) less responsible for budgeting capacity building in its own internal PC 1 budgets.

LESSONS

Policy Advocacy was particularly successful in some key measures such as promoting bills to raise age of marriage for girls, prevention of violence against women bills etc. where UNFPA and a number

of local and INGOs worked together over the last decade to accomplish results. *Enforcement and implementation remain constant challenges.* For example, less than 1% conviction rate for VAW is not because of absent laws but poor evidence gathering, social biases, and discrimination in the criminal justice system against women[51]. Going forward, there is a need to focus on enforcement, including grass-root advocacy and capacity building of frontline workers to change the discriminatory narrative.

In societies behaviour and attitudinal changes are complex processes and sustained advocacy, institutionalisation of the processes, and accountability will be required to achieve real success.

Youth, ASRH and RH - Lack of attention to details at the design and implementation phase including absence of baseline or end line indicators undermined the potential replicability and evidence based advocacy to government decision makers. Even though some pilots were taken up by government this reflects inadequate attention to building the evidence base for "good practices" and rationalisation of services.

Post-training follow up and feedback from district supervisors is necessary to understand how capacity building improved skills or practices.

In MH and FP interventions, UNFPA has leaned heavily only in public sector capacity development and engagement. The evidence suggests that there is a need to include private sector providers (beyond just NGOs), including pharmacies and low end factories/industries with the FP and MH messages.

Population and Development - A number of successes of the CP8 programme are evident in the policy arena. However, this enhanced capacity is also an opportunity to further advance the use of evidence generation and use. Areas for improvement include creation of demand for data by policy makers on a routine basis, use and triangulation of the multiple databases that are available in Pakistan, exploration of in depth themes (beyond the usual questions) that inform about actionable inferences, exploration of discrepancies between similar databases and strong advocacy to finally conduct the national census.

4.2.1 Contribution of ASRH Interventions for Increasing Access, Behavioural Change, and Awareness

4.2.1.1 Increasing Access to Youth Friendly Services and Rights Based Standards

In Pakistan, SRH information needs and access of the young people (10-24 year old) to friendly sexual reproductive health services remains neglected in the public sector. Barriers to access include both non-availability of these services and the lack of awareness about them.

[51] Assessment of the Criminal Justice System. Maliha Zia and Sarah Zaman 2012

Table 8: **Youth Friendly Services and Programmes**

Outcome	Output	Interventions	Indicators
Focused on Young People, ASRH and RH Outcome 2: Increased public awareness and behavioural change to ensure that vulnerable populations practice safe behaviours and access/use quality services	Output 3: ASRH/ newlywed counselling in FP voucher districts	7 interventions 1. Develop YFSS 2. Use of DHMIS data to monitor ASRH 3. Develop community capacity in ASRH 4. Implement newlywed counselling/vouchers 5. Organise FP week 6. Capacity building of CSOs in ASRH 7. Advocacy for marriage bill to prevent early age marriage	# of districts with newlywed counselling % of facilities providing YFSS # of districts with community sensitization to ASRH % of LHWs equipped with RH-FP and ASRH information # of provinces that have passed marriage bill
	Output 4: Integrating HIV prevention model (YKAP) for risk populations	1 intervention 1. Elimination/prevention of HIV in MARPs (YKAP)	Scaling up of the YKAP model to decision makers

Two UNFPA CCPD outputs addressing youth, adolescents and humanitarian emergencies were:

1.2.1: "*Adolescent and youth especially the most marginalised in selected districts have access to integrated sexual and reproductive health information and services according to provincial standards on youth friendly services to address early age marriages and pregnancy" and*

1.3.1: *Provincial health departments have strengthened capacity to plan, implement and monitor universal access to reproductive health with special focus on family planning, including in humanitarian settings"*

UNFPA implementation partners for this component were DoH and PWD in Punjab, Sindh, KPK, the MNCH and PHC Departments (Punjab, Sindh and KPK), PSPU Punjab, NDMA/PDMA/FDMA and UN Humanitarian Cluster, Pakistan Nursing Council, SACP, NGOs (MSS, Pathfinder, Bargad, PNFWH, MA, SRSP, SHED), and AKU

4.2.1.2 Establishment of ASRH and Newly Wed Counselling Centres in 3 Districts

Counselling centres were established in Ghotki (Sindh), Jinnah Hospital, Lahore, Sargodha (Punjab), and DI Khan (KPK) in collaboration with PWD, DoH In 2014 UNFPA established first ASRH centres in Family Health Clinics (Population Welfare Department) located in Tehsil Hospitals of the 3 selected districts. These ASRH centres were designed on the model of WHO YFRHS guidelines and provided counselling and clinical services for married and unmarried adolescents and young people. In addition, these centres were linked with the newly wed counselling programme (FP Voucher Programme MSS-PWD-DOH) where young couples (15-29 years of age) were provided counselling on FP. The intervention objectives were: 1) integration of youth specific information and services in routine health care services, 2) help provincial health and population departments develop and adopt province-wide YFRH protocols and standards, and 3) test the uptake of the ASRH centres and newlywed counselling lessons. Project activities included trainings of health providers on YFRHS including sensitization of LHWs/LHVs on referrals, IEC materials, support to clinical psychologists, formation of youth and peer groups, and sensitization of community to create an enabling environment for seeking SRH care services. Key achievements noted were:

4.2.1.3 Strengthening Capacity of CSOs For ASRH

Adolescents And Youth Friendly Reproductive Health Services Trainings - For quality youth friendly reproductive health services it is important that medical staff including doctors, para medics and MS to be trained on global youth friendly service standards to provide friendly services.

At the initiation of project, a cadre of health care providers were trained on International youth friendly RH service standards. Five days training were designed and the first batch of health care providers, male and female doctors were trained. Within two years 2015-2016, two rounds of training health care providers has been conducted in three project districts. Doctors from PPHI programme and PWD-FHCs from all three districts were also included in this training programme.

Table 9: Programme Coverage

	UC/Estimated Target Population	
Location	**YFRHS to young people**	**Newlywed counselling**
Ghotki (Sindh)	240	120
Sargodha (Punjab)	360	180
DI Khan (Punjab)	240	180
Key Achievements		
• Punjab has adopted the ASRH model and scaled it to 17 centres (one in each district) in their PC 1 (Annual Development Plan)		
• 100 health care providers from PWD, DoH and ASRH centres were trained in YFRHS and counselling		
• 142 health professionals (doctors and LHVs) trained on newlywed counselling techniques		
• Development and endorsing of the training manuals (YFRHS and Newlywed) by the provincial governments.		
• Nearly 75 boys and girls have been engaged in voluntary peer-peer SRH (Y-PEERS) education in their three		

Common Observations and Findings

- Advocacy for increasing the age of marriage has led to bills legislating increased age of marriage to 18 years for girls in Sindh, and 16 in Punjab province. UNFPA was part of a very active consortium of many civil society partners and provided the TA for drafting the bill. *It would be useful to describe this experience so that lessons, obstacles and means to overcome for other advocacy in the future. The learning is that numerous civil society partners, parliamentarians, organisations across provinces were able to overcome institutional differences and worked together over the last one decade to bring together this change. A useful addition to the knowledge base would be "How was this intervention "collaborative" while many others fail."*
- Protocols development for ASRH developed at a formal level, as were providers trained and their training was standardised all for the first time in Pakistan. These protocols should now be widely shared with provincial governments for final endorsement and inclusion in their trainings for front line workers in the future. Translation of these protocols in the local language is also important (Sindh and KP requested for Sindhi and Urdu respectively).
- Many of these pilot models built and on the concept of RHYIA initiated under CP7 by incorporating learnings from the problem of untrained providers identified during the review of CP7. Experience sharing and case study on how this model differed from RHYIA, provincial adaptations in the peer-peer learning, and acceptance among the youth. Our FGDs with youth highlighted high levels of acceptance (in Lahore) however there was a lack of clarity how this learning continues beyond the immediate project support period.
- Beneficiary targeting was neither well defined nor much considered: with the result that some key beneficiaries – i.e. the most vulnerable youth - were missed in the design. While youth were consulted the most marginalised may not have been systematically captured (or at least there is no documentation support). What was the criteria for selecting peer-peer volunteers, how did they

target their communities, what were strategies to reach those that refused are some of the questions that the pilot should have better captured.

- Even for pilot models, their scale was too small - sometimes as few as 30 youth per union council of around 25,000 (~3% of eligible population) - to draw any meaningful inferences. Why was this the case given the baseline study in these three districts showing a "high demand for services"? Qualitative research at endline is needed to explore reasons for low coverage and uptake.
- Even though these were pilot models, rigorous testing, cost effectiveness analysis, documentation of their implementation protocols or what issues were identified and overcome during implementation, making their replication or scale up difficult.
- Results (and therefore their effectiveness) were not measured rigorously. Even when adapting protocols from WHO guidelines, they must be locally contextualised and their effectiveness measured. Just as RHYIA lessons were never institutionalised, neither were new ideas/ best practices/ lessons from these pilots. Thus, it is unclear how well lessons from these pilots address ASRH needs of youth/ adolescents, how receptive would be beneficiaries to them and how well lessons from one part of Pakistan transplant to another.
- Punjab has scaled up to include 17 districts, however the concept of youth and universal RH is still not recognized at the programmatic level (it's a one off). For example, what is the expected outcome or benefit of the youth centred intervention and how will it tie in to the overall RH uptake – was not clearly articulated by informants in KP, Punjab. The basic conclusion was that its part of the expanded package of services that PWD is undertaking.

  The same is true of Sindh and KP. Moreover, this programming did not account for ground realities. For e.g. providers from the pilot were not hired on automatically during the scale up. New recruitments underwent usual "*government"* hiring process, resulting in delays and interruption of programming for 9-12 months and diminished trust among beneficiaries.
- Although the programme was originally linked to the Marie Stopes Society voucher programme (next section), the MSS programme did not fully take off, and there were little referrals. Since MSS Voucher programme did not target young couples and documentation was poor, actual number of referrals were not known.
- There were crucial gaps in programming. For e.g. district mechanism for supporting ASRH awareness and gatekeepers were conceived but not be formed due to ineffective coordination between and limited technical capacity of provincial and district personnel. Thus the proposed district steering committees on ASRH were not established.
- Some implementation was piecemeal. For e.g. the Youth Star KAP (YKAP) project could not be piloted due to the lack of commitment by Sindh Aids Control Program. In this instance the lack of commitment (i.e. on-going management and funding issues in SACP leading to disinterest) on the part of SACP was the main reason however some of the issues could have been anticipated with better pre-planning discussions. However, a behavioural study on incidence and prevalence of STIs among key at-risk population has been completed in three towns of Karachi ((Sindh).

4.2.2 Contribution of FP-MH Interventions in Enhancing Access, Service Delivery and Quality

UNFPA expanded public-private partnership to improve skill birth attendance, improve quality of service delivery by providers and the capacity of providers regarding FP and associated knowledge.

Table 10: Programmes in Reproductive Health, Family Planning and Maternal Health

Outcome	Output	Interventions	Indicators
Focused on FP and Maternal Health Outcome 3: Capacity for equitable social service delivery improved at all levels	Output 5: FP vouchers targeting the poor and youth	**18 interventions** 1. FP voucher scheme (11 districts)	# of districts with PPP # of trained CMWs deployed CMW workforce policies developed # of SDPs providing FP and RH % of LHWs trained in RH and FP # of GBV interventions Functioning inter-agency GBV coordination body # of fistula services and costs in PC 1 # of fistula repair surgeries per year # of provinces with a contingency plan, SOPs of MSUs
	Output 6: Enhanced midwifery curriculum	2. Support mid-wifery education and regulation 3. Pilot BSCM programme (AKU)	
	Output 7: strengthened capacity of female service providers in RH-FP	4. Strengthen CMWs for FP 5. Strengthen LHWs for FP 6. Integration of FP 7. Capacity of FWWs, WMOs 8. Strengthen capacity of RTIs	
	Output 8: Elimination of GBV in humanitarian settings	9. Develop GBV stepping up	
	Output 9: Fistula prevention and treatment	10. Gap funding for fistula 11. Fistula surveillance 12. Community awareness in fistula 13. Prevent iatrogenic fistula	
	Output 10: SRH capacity of provincial departments to respond to disasters	14. Strengthen coordination for SRH 15. Strengthen management of MSUs 16. Conduct MISP trainings	
	Output 11: NPPI exit plan implemented Output 12: Ensuring RHCS	17. Implement exit plan 18. Enable commodity security and coordination	

For enhancements in maternal health the focus was on increasing the quality and access to skilled care birthing services in partnership with MNCH programmes (DoH Punjab, Sindh, and Khyber Pakhtunkhwa), the Population Welfare Departments, HSA along with NGO partners MSS, Pathfinder, and MAP/PNC.

- Capacity building trainings of female service providers (doctors, LHWs, LHVs, CMWs, FWWs) to provide standardised FP/ RH information, counselling and services from public facilities.
- Skills based trainings of CMWs in SBA and FP
- Fistula surveillance (Punjab); prevention and availability of treatment of fistula in 3 provinces.
- Community awareness of fistula

4.2.2.1 Reaching the Poorest and Marginalised Couples for Family Planning

FP Voucher Programme in 11 Districts - Poverty and lack of women's empowerment/mobility limit access and uptake of FP services. Evidence supports that demand side financing (DSF) through voucher programmes can increase the uptake of FP and RH among poor and hard to reach populations.[52] In CP8 UNFPA supported a pilot DSF initiative lead by Marie Stopes Society (MSS – a social business) in collaboration with PWD in 11 selected districts to improve access to public sector health facilities through outreach and reimbursements for services with vouchers.

[52] Research and Development Solution Policy Brief Series #34. Using DSF in Reproductive Health. http://www.resdev.org/files/policy_brief/34/34.pdf

Table 11. The Pilot of Vouchers for FP and RH Services

Models	Location	Referral	Static Centre	Outreach
MSS only	Punjab: Attock and Sargodha KPK: DI Khan and Kohat Sindh: Ghotki	MSS' Field Health Educators (FHEs)	MSS Clinics (Behtar Zindagi Centres)	MSS outreach team and FHEs
PWD only	Punjab: DG Khan and Bahawalpur	MSS FHEs Government's Lady Health Worker (LHWs) Community Midwives (CMWs) Family Welfare Workers (FWWs)	Public Health Facility (PHF)	At PHFs through FHEs and government mobilisers
Mixed MSS + PWD	Punjab: Lodhran, Narrowal KPK: Malakand and Peshawar	MSS Field Health Educators (FHEs)	Public Health Facility (PHF)	MSS Outreach teams and FHEs

Demographic and Health Impact		
	2014	2015
Maternal Deaths averted	4	11
Unintended Pregnancies averted	2,783	10,952
Unsafe Abortions averted	303	3,330
Couple Year Protection (CYP)	5,961	32,269
Users of modern FP	3,487	20,701

Common Observations and Findings

> The pilot succeeded in operationalizing a working model between NGO-Government using DSF and community mobilisation and demonstrated that 90% of service users were from the poorest quintile; of which 22% were young couples. 46,000 vouchers were distributed resulting in uptake of 55% in services i.e. 25,814 clients served with FP services in 1 year at a cost of USD18 per CYP which is similar to (already very high) government cost of USD17 per CYP.[53]

Training and quality supervision of health care providers led to capacity building in public and private sector. However, despite being set up as a 3 arm trial, no comparisons are available between results of the three prongs of the project; neither is there information on challenges encountered, how they were overcome and what implementation modalities were employed. Unfortunately the intervention was prematurely ended due to issues of security clearances in KP, budget cuts in UNFPA funding, and management transitions and delays in MSS management. The lessons learned of how public-private collaboration worked, the challenges and how they were mitigated (even in the shortened duration) should have been captured for future learning.

4.2.2.2 Trainings of Female Service Providers

Learning from CP 7 and two detailed assessment funded by UNFPA[54] and TRF-DFID[55], the CP 8 focused heavily on improving the quality of RH, FP and MH service delivery through trainings of female service providers in public sector facilities (DoH and PWD) including outreach workers. Prior to

[53] Abbas K, Khan AA and Khan A. Costs and Utilization of Public Sector Family Planning Services in Pakistan. JPMA April 2013. 63 (4, Suppl 3) S33-39

[54] Family Planning In-Service Mechanisms. Contech International 2013.

[55] Assessment of Quality of Trainings of CMWs. TRF July 2010

programme initiation UNFPA conducted a SWOT analysis (Table 9) of the three components of the training system: i) pre-service education, ii) in-service training, and iii) continuing education. Together these three systems with appropriate monitoring form the basis of quality service provision. However in CP 8, UNFPA primarily focused on strengthening in-service trainings with some basic support to Regional Training Institutes (RTIs and Midwifery Schools- discussed later).

Table 12: SWOT Analysis of the Training System and Institutes in Sindh, KP and Punjab

Strengths	Weakness
▪ Available public sector infrastructure for training service providers. ▪ RTIs mandated to conduct pre-service and in-service trainings ▪ Pool of master trainers, facilitators and facility trainers available ▪ Training protocols developed ▪ Monitoring and quality assurance tools available ▪ FP training curriculum available ▪ FALAH/USAID training package on family planning and birth spacing available ▪ RTIs have the capacity to provide FP trainings to a range of cadres of health workers ▪ A large number of family welfare centre facilities are available across Pakistan. ▪ Revision of FWW curriculum ▪ FWWs are now registered by the PNC ▪ Accreditation of two RTIs	▪ Lack of strategic policy or planning direction ▪ Ambiguity of administrative procedures after devolution ▪ Financial constraints on the basic most equipment, learning aids and plans ▪ Lack of coordination among stakeholders ▪ Lack of inter-departmental and intra-departmental coordination ▪ Lack of linkages between institutes imparting theoretical and practical trainings ▪ Lack of formal mechanism for TNA ▪ Training plans developed top down rather than bottom up approach ▪ Old training modules for refresher and in-service trainings ▪ Lack of follow-up and supportive supervision ▪ Lack of training database ▪ Private sector managing public health facilities lacks capacity-building component ▪ A complete absence of focus on task-sharing in health facilities ▪ Weak family planning components of the LHV, CMW and nurse/midwife curricula ▪ Parallel roles of LHW and FWW ▪ Co-location of FWCs and BHUs with apparent duplication of FP services and clinical safety issues

Opportunities	Threats/Challenges
▪ TA from Donor and development partners ▪ Support from NGOs & Development Partners ▪ Provincial or regional specific approach for FP and RH trainings in devolved scenario ▪ Provincial governments of 2 provinces committed to providing refresher training courses for LHW cadre as per their PC1 ▪ Public-private partnership such as both the PPHI and PRSP desire to link with Population Departments to get their staff trained ▪ PWD commitment to increase trainings for healthcare cadre providing FP services thus increasing linkages ▪ Health sector strategies in three provinces (Punjab, KP, and Sindh) have accorded FP a priority ▪ Two provinces have already prioritized staff training as a basic need and modified their Essential Drug Lists to include contraceptives at all facilities ▪ Upgraded skills lab in 2 RTIs with well-equipped clinical practice apparatus. ▪ Recent arrangement between the Punjab DOH and DOPW for placement of trainee CMWs in RHS centres for one month to gain FP skills ▪ RTIs well placed to increase their role in FP training to other cadres of workers	▪ Lack of political commitment to improve the quality of trainings and service provision – changing political environment ▪ Donor shift to other areas ▪ Donor agenda is short term ▪ Provincial PWDs have limited role with DOH and vice versa ▪ Lack of international ease of learning and TA due to geo-political risk

▪ 2 provinces to integrate LHS and CMW by tasking LHS to manage performance of CMW and provide administrative oversight. ▪ The successful model of District-based Mobile Training and Supervisory units providing critical supportive supervisory role at facilities for OJT	

The training interventions of UNFPA were highly appreciated by government partners in all three provinces and was deemed relevant and a success in terms of meeting gaps in the government's budget to provide in-service trainings to a cadre of nearly 150,000 female service providers (DoH and PWD combined including PPHI centres). UNFPA support strengthened inclusion of practical counselling techniques for FP particularly longer acting reversible methods (LARCs), gender sensitive approach, GBV identification and referrals, rights based FP approach to patient care, and integration of universal access requisites into actual care provision. This UNFPA intervention directly benefited 22,000 (15%) of the on-ground frontline workforce (Table 10).

Table 13. UNFPA Trained Female Service Providers

	Punjab		Sindh		Khyber Pakhtunkhwa		
Category	Total	Trained (UNFPA)	Total	Trained (UNFPA)	Total	Trained (UNFPA)	UNFPA Contribution
LHW/LHS/LHV	47,975	5943 (12%)	23,549	7188 (30%)	13,136	7117(54%)	20248 (24%)
CMW	6,500	322 (5%)	3000	427 (14%)	1,200	260 (22%)	1009 (9%)
FWW/FWO		634	-	542	-	86	1262
WMO/MO	-	48	-	607	-	160	815

Common Observations and Findings

- FGD informants - The training content on FP and RH was too theoretical and could be improved through more practical (context specific skills) on counselling and patient care. Respondents said that one week for practical was too less and that their learning was the most during the practical sessions (i.e. 1 week).
- Trainings should include skills in i) business development how to keep inventory, tracking, ii) linkages with other cadres of providers such as LHVs, CMWs in line with the new changes that have taken place in Punjab, Sindh and KP. Participants said that they are unclear on how to coordinate with the multiple levels of supervision and reporting (Punjab), iii) provision of written reference material (translated in local language) should be part of the training packages, iv) a schedule of trainings every year instead of the ad hoc calls for trainings by their respective departments (or failure to follow through on the assigned schedule should be avoided), and v) teach skills of Ultrasound, better infection control practices and HIV case detection to increase their competence and business.
- The Duration of training and whether it was adequate or not was controversial depending on the baseline level of knowledge and years in service of the provider – for example respondents suggested that future trainings should be based on some level of pre-test assessment and having slightly different modules for different categories of providers would be useful
- Duplication of trainings – some providers have been repeatedly selected for similar type of trainings. Helping define a clear selection criteria and measuring the frequency and gaps of trainees would help prioritise trainings to be more useful. Training selection is currently a "favour" by the nominating authority and may miss out on those most in-need, and is biased. Discussions with DFID and USAID highlighted that they are also conducting widespread trainings and many of these are duplicated in similar geographic areas.

- UNFPA should propose to the government to develop a training needs assessment that should be institutionalised as part of the annual review by respective departments to better understand "overall training needs and deficiencies" instead of ad hoc estimations of the gaps.
- Review from TRF Report 2013-14 – "What is known, from available data, is that a lot of trainings have taken place and there is not sufficient information (i.e. Feedback from supervisors or district managers) on how this training has improved performance or results. Past reviews are also consistent with this findings that for government departments trainings while much needed are often "an easy activity to conduct" and does not necessarily benefit the overall system or recipient in changing practice.
- *In conclusion for UNFPA when focusing on Capacity Building it is extremely importantly to follow up of training outcomes and the inclusion of trainings in the overall government plan is critical for UNFPA support to have a long lasting and substantial impact – not be a one off.*

4.2.2.3 Fistula Prevention and Treatment Intervention

UNFPA has been the global champion for "End Fistula Restore Dignity" through its three-pronged strategy of prevention, treatment and social reintegration. From CP7 onwards, UNFPA has supported partners (PNFWH, SOGP, DoH) through seven regional and seven referral centres in Karachi, Hyderabad, Multan. Lahore, Peshawar, Quetta, and Islamabad. Nearly 4,100 fistula cases have been surgically repaired and 550 women rehabilitated, along with 1000 healthcare providers trained to treat and manage fistula complications in the last 9 years.

With CP8 support a series of advocacy (national/provincial) events plus direct lobbying with government counterparts in DoH has been undertaken. The priority has been to engage provincial MNCH/PHC/DoH decision makers and civil society activists to recognise, address and devise strategies for fistula risk reduction (i.e. iatrogenic fistula), management and rehabilitation. It is encouraging to note that fistula surveillance has been initiated (2016 early stages) through capacity building of LHWs and CMWs identification and referral trainings, by the Punjab government in 36 districts through their MNCH PC 1. Community level advocacy to reduce stigmatization and increase awareness of fistula centres was also conducted. However the 40 sessions conducted dwarf against wide national scope of the problem in terms of impact.

Common Observations and Findings

Despite its longevity (dating back to CP7), a number of limitations have (and continue to) undermine the effectiveness of UNFPA support for this much needed intervention:

- **Lack of Institutionalisation** (or recognition of this as an important priority) in the action agenda by medical colleges, PMDC, the Nursing Council or DoH's of Sindh, KP and Punjab in their core health professional training and monitoring of providers. Fistula care is not embedded in the surgical practice training of providers or reporting protocols of outreach workers such as LHWs in remote health facilities and is therefore cases are overlooked and not captured. In other words much of advocacy for fistula prevention is standalone and does not cut across the health system. This has also meant that advocacy has not prioritised expanding the base of engaged CSOs and targeting health care providers (public and private). For example, fistula care or prevention are not viewed as a part of the package of safe and quality MNCH services by government, donors supporting MNCH interventions or even by recipients of UNFPA programmatic support.
- **Absence of good data** - data on fistula incidence, profiling providers at risk of iatrogenic fistula, mapping of high and intermediate prevalence locations and oversight regulations to reduce incidence and provide recourse for fistula affectee's are not institutionalised; nor are there any institutional measures to record and report the annual incidence of new cases

- **Policy Level Advocacy for Task Shifting** - Need to consider policy level advocacy for task shifting to develop "Non-Physician Clinicians (NPCs) – to take on the role of providing surgical repairs and management in remote areas where doctors/surgeons are least likely to practice/be available.[56] Some debate has been initiated but this is yet not mainstreamed in government departments (Health and PWD) planning and decision making processes.

4.2.2.4 Contribution to Enhancing Midwifery Curriculum, Leadership and Regulations

Nearly 48% of all births in Pakistan are conducted by unskilled birth attendants (PDHS 2012-13). These unskilled deliveries are a major contributor to the high maternal mortality rate (276/100,000) in the country. Evidence shows that up to 90% of maternal deaths could be prevented by universal access to adequate reproductive health services, required equipment, supplies and skilled healthcare workers - a 10% increase in skilled health workers leads to a 5 percent decline in maternal mortality. Thus, regional countries Bangladesh, India, Sri Lanka) have managed to halve heir MMR within 10 years by increasing the number of midwives deployed thereby increasing their SBA rate.

In Pakistan, training of CMWs was started by the MNCH programme (2007) with support from USAID, DFID, UNICEF and technical support to curriculum development by UNFPA and PNC to provide frontline workers in rural areas. These were rural women from the same community as their clients. They were given 18 month of training in antenatal, intra- partum, postnatal and newborn care. The program aimed to train and deploy around 12,000 CMWs nationwide.

In 2010, a comprehensive assessment of CMW Training and Competencies[57] revealed significant gaps: i) PNC approved training curriculum was available yet not being used by clinical trainers and theory teachers lacked capacity to translate these into teaching activities, academic calendars, and session plans, ii) there was a mismatch between theory and practice with inadequate time being dedicated to practice, iii) Community rotations lacked structure and organization. There was no coordination between the CMW School and other clinical training institutions such as hospitals, health facilities and the district health system. As a result clinical training was extremely deficient both at the facility and in community settings; 16% of CMW graduates had not conducted a single delivery in the hospital or community (46%) independently. Supervision and monitoring was unrealistic and there were no deployment plans.

Based on the gaps identified in this assessment and another independent assessment supported by UNFPA, "***Workforce Analysis of CMWs in 3 Provinces"*** (2014), the CP8 midwifery interventions adopted a holistic approach to curriculum improvements, enabling environment and addressing structural deficiencies in the business model. Future assessments of how CMWs are performing (i.e. quality of services, increased monthly deliveries) and tying in changes in trainings and curriculum will help provide convincing evidence to support the claim of effectiveness and full success.

Some key achievements and activities through UNFPA interventions are:

- In collaboration with PNC and MAP UNFPA supported revisions in the 18 month curriculum to two year midwifery curriculum in line with International Confederation of Midwives (ICM) midwifery education guidelines. The contents (obstetric fistula, gender based violence, misoprostol, PPFP, and concept of respective maternity care) have been incorporated in the revised two years midwifery curriculum. Furthermore, centralized examination centre was strengthened which enhanced the efficiency of PNC to process examinations and maintain central questionnaire bank and timely management of examination results.

[56] Chu K et al. Surgical task shifting in Sub-Saharan Africa. PLOS May 2009

[57] Assessment of CMW Training and Programme (TRF-DFID) 2010

- Training of Midwifery Tutors - 62 midwifery tutors (Punjab, KP and Sindh) were trained in WHO core competencies of midwifery educator and teaching methodologies.
- An online Nursing Management Information System has been developed to facilitate and expedite of registration and issuance of license to midwives and nurses and generating and tracking data on midwifery workforce availability, distribution and retention.
- Support to Bachelors of Science Midwifery (AKU Programme) – 2 batches of 18 and 12 each are enrolled in the programme trainings. Some of these graduates have been recruited as midwifery and nursing teachers. This intervention has helped address the nationwide shortage of qualified midwifery tutors. Detailed FGDs with CMWs and midwifery tutors highlighted how the new curriculum is 70% practice and 30% theory, and its effects on CMW learning and confidence.
- Adaptation of the "Midwifery Work Force Plan Report58" recommendations by the three provinces in their PC 1 or action plans.
- Uptake of Practices and Innovations - IRMNCH Program Punjab has introduced performance based incentives for CMWs to improve quality and access of midwifery services. MNCH Program Sindh has included the position of provincial midwifery specialist for MNCH and clinical supervisors (for technical supervision of deployed CMWs) for each district in their budgets. All Provincial Directors of MNCH Program have agreed to review deployment guidelines and adopt a uniform approach across the country.
- UNFPA Sindh is supporting a pilot in 4 districts using clinical supervisors and clinical attachments of 48 days in DHQ/THQ for practical trainings in clinical skills, marketing, business model etc. (results yet not available).
- 550 CMWs have been trained on FP counselling and have according to UNFPA progress reports and discussions with MNCH programme contributed towards increasing their business viability, number of deliveries per month, and FP service provision to couples. trained on family planning counselling in the three provinces have contributed towards increasing the number of women attended by skilled attendants, postnatal visits and utilization of family planning services. Review of provincial (Punjab and KP) monitoring dashboard on CMW performance shows on average 2-6 deliveries per month per CMWs (2015 data). There is no follow up comparison of those CMWs trained via UNFPA support and those yet to receive skill building training.
- Support to five midwifery schools in terms of learning aids, equipment, books, infrastructure, and technical assistance that has helped in providing conducive teaching and learning environment for midwifery teachers and students (FGD Lahore with CMWs).
- Midwifery work force policy developed on ICM/WHO standards
- Institutional strengthening of MAP to become autonomous – still not completely done

Common Observations and Findings

Within these encouraging developments some common operational and structural issues were identified through interviews/FGDs with CMWs, MNCH programme, and MNCH experts that need attention for future programming:

- There is a need to integrate and link CMWs within communities – with both community representation and engagement (end users) and existing agents such as LHWs, LHS, LHVs, dais and other healthcare providers in the community. While CMWs form these collaborations

[58] Development of the Work Force Plan to Match Demand to Supply of CMWs in Pakistan. UNFPA 2014 December (AAA Associates)

individually there is no formal mechanism for this and in many situations, things are actually counter-productive, competitive and hostile. For example, LHWs, LHVs and CMWs are competing for the same deliveries and clients.

- There is a need for clarity on Job Descriptions and Coordination between LHVs, LHWs and CMWs. Currently significant overlap in duties and number of deliveries are tied to the financial incentives. Similar there is a need to develop viable business model(s) for CMW.
- Expand on Need Appropriate Business Skills Training – some CMWs flourish while others are unable to do. Preliminary research shows that business skills, competencies, family support in the management model etc. play a role and needs to be better understood.[59] In addition to clinical skills aspiring CMWs must also receive appropriate business skills training to allow them to become better entrepreneurs (perhaps consider the potential as an entrepreneur as a criterion for admittance into the program) and to manage their practice.
- Right sizing – is dependent on the area and cannot be generically determined as 1/10,000 or 1/5000. Some rationalization and good estimations are needed and technical assistance by UNFPA and donors can help government better rationalise its work force planning and distribution.

4.2.2.5 Contribution to Building Provincial Capacity to Plan, Implement And Monitor Universal Access To RH-FP And Decision Making

Pakistan's weak health indicators (maternal mortality: 276/ 100,000 live births; child mortality: 78 per 1000 live births) are perhaps a result of relatively low spending on health of around 3.36% of the total GDP, with the result that the poorest populations end up spending 70% of the health expenditure from out of pocket. Even among the PKR 82.5 billion (USD825m) annually (or around RPKR 450 - USD4.50 per capita) of government spending most (81%) is spent on tertiary care.[60] These modest allocations for preventive and promotive health are further compromised by lack of evidence informed planning, mismanagement of funds and inefficient implementation – all due to a lack of accountability to end beneficiaries.[61] This sets a downward cycle of underperformance at public facilities, with majority of the people seeking care in the private sector, and thereby rendering the very large network of government clinics and hospitals underutilized and costly. UNFPA support included an extensive array of technical assistance for improving the accountability infrastructure including:

- A long term consultant to work within the PSPU and Management Information System (MIS).
- Technical resource M&E provided to IRMNCH Punjab, KP and Sindh
- Results-Based Management (RBM) introduced to monitor and evaluate family planning programmes in Pakistan and was initially piloted in seven districts of three Provinces to help Provincial Governments replicate the model and apply RBM tools at district level.
- A centralized database established and operationalized in KP, linking all administrative districts through a web-based platform. The database will enable the users to access updated districts profiles on population related indicators. All relevant trainings have been completed to ensure efficient analysis and use of data. The first-ever comprehensive research on "Internal Migration and Urbanization in Pakistan" has been completed to provide data on internal migration and urbanization and its linkages to, and impact on human development. The study findings were disseminated during the launch of SOWP. Five evidence-based policy briefs (for each of the four provinces and federal) have been developed to supplement the report as an advocacy tool

[59] Mumtaz Z et al. Successful CMWs in Pakistan: an asset Based Approach. PLOS September 2015.
[60] National Health Accounts 2007. Pakistan Bureau of Statistics
[61] Making Decisions Using Information in Population and Health in Pakistan. July 2013 Policy Brief # 39 http://resdev.org/files/policy_brief/39/Policy%20Brief%2039%20-%20Making%20RH%20Decisions.pdf

- UNFPA and TRF+ has funded a long term consultant to work on Management Information Systems (MIS) and validation. However many of the lessons and issues highlighted in the assessment are still not addressed (3 years later).
- Technical support has been provided towards drafting and finalizing evidence based Provincial Youth Policies of KP, Sindh, AJK, Baluchistan and GB. The drafts are awaiting approval. Key components such as ASRH, rights of young people and life skills have been successfully integrated into Provincial Youth Policies. A National Forum on Provincial Youth Policies attended by 1036 youth delegates, NGOs, UN agencies and senior officials from federal and provincial youth departments has further motivated the Provincial Governments to accelerate the policy process in their respective provinces.

Table 14. Allocated Budget and Expenditure of Population and Development (in USD)

Year	Allocated Budget	Expenditure	%age of PD budget*	Implementation rate
2013	906,733	872,347	19%	96%
2014	735,761	746,998	11%	102%
2015	837,840	729,580	12%	87%
2016	1,391,429	1,032,427	25%	74%
Total	3,871,763	3,381,352	16%	87%

All funds in USD
Expenditure of 2016 is as of 30th Sept 2016
* Percentage of PD budget to the overall country office budget in each year.

Common Observations and Findings

- The support by UNFPA (and collaborators has provided considerable infrastructure and capacity building that is foundational towards building accountable public sector systems. It remains to be seen how these are operationalized and put to use; and how (if they do) they serve to improve the effectiveness and efficiency of these systems. *However this evaluation and discussions with informants repeatedly highlighted the fact that within the government, national and provincial there is no comprehensive Population Development policy and strategy which takes into account how all these activities and various donor supported interventions will come together.*

4.2.3 Profile of the Population Development Interventions

The PD component of the programme contributed technical and financial support to the planning and preparation of the 6th population and housing census, building capacity of public departments on research and analysis, and raised awareness of the government and UN agencies on Population, Reproductive health and gender equality.

Key lessons from CP7 were 1) CP7 had prioritised RH over PD and even within RH primary focus was improving obstetric care rather than including family planning.[62] 2) There was a lack of a focus on measuring results and lessons from the various pilots. 3) There was insufficient strategic investment in institutional capacity. These lessons were internalised in CP8 and led to a strengthened PD component and focus on the institutional capacity. This is reflected in CP8 Output 2.4.1: "Planning and Statistics Departments at the national and provincial level have increased capacity to utilize policy research and data on population, RH and gender equality for evidence-based advocacy and policy reforms."

UNFPA collaborated with Provincial Population Welfare Department (PWDs) and INGOs/NGOs (Pathfinder International, Population Council and Bargad) to provide technical assistance in formulating population dynamics in sector plans, for developing population policies in the provinces and financially

[62] UNFPA 8th Country Programme: Programme Strategies and Management Plan 2013-2017 Pakistan

supported the National Institute of Population Studies (NIPS) for research and analysis using PDHS. This support is intended to both enhance local capacity and to generate evidence for policy advocacy on PD, RH and Gender and to disseminate research findings using international best practices.

UNFPA has provided assistance to PBS for carrying out the next census with international standards and quality and to digitise census maps by a UNFPA supported GIS laboratory. Capacity building in GIS will be extended to the PBS, other line ministries and provincial department such a DOH, PDMA in utilisation of GIS sectoral plans and establish an inter-government department mechanism to share GIS and mapping resources, for example in developing disaster preparedness plan.

Several internal factors contributed to delays of population and development interventions of CP8. These included the frequent changes of the management of UNFPA country office Pakistan. From 2013 to 2016, two country representative had been changed with more than six month the position was vacant. These changes have negative impact on the overall implementation of the policy advocacy activities.

4.2.3.1 Contribution to the Capacity Strengthening of Provincial Departments

During CP8 (Sub-output 4.2.1), UNFPA cooperated with Population Welfare Department and Youth departments of provinces, National Institute of Population Studies and INGOs/NGOs to better integrate and mainstream population and development linkages into the **national development plans and sector policies and strategies**. The “Pakistan Vision 2025” endorsed the linkage between population, development and population dynamics. Other examples of UNFPA support to PWDs and Youth departments from Sindh, Punjab and KP has resulted in various policy dialogues on population and development linkages, reproductive health and rights and youth. These contributed to supporting actions for ICPD beyond 2014 and post MDGs advocacy (2015); and provided evidence base for provincial policy documents. The population policies have been approved and adopted in two provinces (KP and Sindh) and is awaiting final approval in Punjab. Furthermore, youth policy in KP has also been approved; thus successfully achieving the target for the CPAP PD Output 2.4.1.

Capacity building included Planning and Population Welfare Departments of Punjab, Sindh and KP. District level demographers were excluded due to time constraints. Training content included demographic projections, connecting these with needs and gap identification and to conduct surveys.

UNFPA support includes the development of **material for advocacy** such as knowledge products aimed at parliamentarians and senior government officials. Their acceptance is mixed. Some officials feel that the government does not own these UNFPA driven products while others feel that the capacity for producing such analysis is essential and should be internalised within government departments.

Most existing surveys are powered to only inform at the provincial level (PDHS, LFS and Pakistan Economic Survey) except the sporadic MICS and biennial rounds of PSLM. Following the 18th constitutional amendment and increasing devolution, there is a need to be able to draw district level inferences. Recognizing this need, UNFPA is helping establish a **Demographic Cell** in each province. The first such demographic cell was established in KP and coordinates with district administrations to supply district level data. The Cell also conducts surveys and shares data via web-based interface.

4.2.3.2 Capacity Building for Evidence Generation

UNFPA has supported (Sub-output: 4.2.2) production of **information pieces and material for advocacy**. These include: “Capturing the Demographic Dividend in Pakistan” (Sathar Z, editor. 2013), other research studies that link family planning and achievement of the MDGs goals 4 and 5 of infant, child and maternal health (Population Council 2014), studies on internal migration (“The state of internal migration, Urbanization: Trends and Consequences in Pakistan”, Migration Research Group Trust 2015) and other studies to link population and SDGs (2015).

These publications have been used as references for planning by specialized NGOs working in population and development, public institutions such as Planning and Development Department Punjab in developing the Punjab Growth Strategy 2018; Population Welfare Department developing its Costed implementation plan (CIP) of FP for Sindh 2015; and PWDs of provinces in their population policies.

The National Institute of Population Studies is a leading organisation for research in population issues and conducts the Pakistan DHS. In the CP8, NIPS was supported with capacity building of their personnel in data analysis and modelling and in dissemination. NIPS was also supported to conduct secondary analysis on DHS data on women and child health and presented these in seven monographs such as "factor affecting perinatal mortality in Pakistan", Risks and Exposures of VAW in Pakistan" and "use of maternal health care and post-partum contraception in Pakistan".

National Transfer of Accounts (NTA) is another project funded by UNFPA and implemented by the Pakistan Institute of Development Economics (PIDE). NTA maps causes and consequences of demographic dividend in order to understand how does population growth and changing age structure influences economic growth, gender and generational equity, public finances and other important features of the macroeconomics. The project has several policy implications: these include the evaluation of intergenerational transfer system, public policy with respect to pension, health care, education, reproductive health and social institutions, such as the extended family and social political and economic implications of population ageing. Project is currently ongoing and will be completed in December 2016.

4.2.3.3 Efforts towards Population Census

Both CP7 and CP8 (Sub-output 4.2.3) supported the strengthening the national capacity (at the Pakistan Bureau of Statistics – PBS) to collect census data. This included a state of the art geographical information systems (GIS) laboratory, other high end equipment (high speed computers, scanners, printers etc.), up to date software (ArcGIS, high resolution scanning of the maps, ICR), capacity building trainings. With this technology, PBS completed digitization of almost 94 percent of the urban area across Pakistan but has yet to publish the results. UNFPA has also supported PBS to establish a Data Centre to digitise its data.

Common Observations and Findings

- Follow up interviews after capacity building of data analysis personnel of PBS, NIPs suggest that these new skills were only partially applied. Trained personnel returned to their departments where there is little demand for their skills – since decision makers don't often ask for data for decision making - and over time these are lost. Others reported they had attended these training sessions as mandated by their departments but were unsure how to apply these skills to their routine work. It would be useful if the use of evidence in policy and programming is institutionalised and routinized so that all actors know what to expect and are able to meet anticipated demands effectively.
- While the publications by the NIPS (and others produced through UNFPA support) are of very useful, many are aimed at a technical audience. It would be useful if the more technical analyses could be produced for the less technical decision makers, including some that are produced in Urdu.
- They also limit themselves to data from PDHS and not contend with issues of reconciling discrepancies with other data sets. Moreover, the questions addressed are conventional such as CPR, unmet need etc. In depth analyses such who are the users of FP, age specific and location specific differences, other factors that lead to FP use or discontinuation are seldom addressed.
- While PSLM and PDHS both use the same sampling frame (provided by the PBS), they yield widely different results for the same indicators for the same year. For e.g. PDHS showed CPR to be 35% in 2012 while PSLM showed it to be 29%. Despite such crucial differences, no stakeholders –

researchers or decision makers have sought to clarify the source of these discrepancies. While understandably this is beyond the realm of UNFPA control – some level of technical discourse on this would be helpful for improving country level compatibility of data sets.

- Much of analysis for policy purpose is driven by the need for short term goals such as budgeting and grant writing for donors. Long term goals or in depth analyses for context specific nuances of FP, RH and related behaviours are seldom done.
- Despite nearly a decade of support for census, there is little progress in conducting the survey. This stems from political reasons that are beyond UNFPA's control. However, given this ongoing delay, perhaps this support may be rationalised or supplemented with higher level advocacy to finally move on with the census. Alternatives would be to explore in smaller scale pilots innovative techniques that can reliably provide at least some of the data that are produced in census.
- While PSLM and PDHS are two of the mostly commonly cited surveys, other sources of data, for e.g. contraceptives commodity supply report by the PBS is also available. There are groups that have triangulated these with survey data to develop a deeper understanding of FP related behaviours and to track resources,[63,64] these analyses should be mainstreamed for use in policy and decision making.

4.2.4 Creation of Enabling Environment for MH and RH

EQ 8: To what extent was the CP able to create a supportive environment in service delivery, evidence use, policy advocacy for RH, FP and Population Development in Pakistan?

SUMMARY

Compared to previous efforts, CP8 appears to have been more effective in bringing to the attention of political leadership and government decision makers the importance for the need to stabilise population growth. UNFPA advocacy and support has contributed to this recognition in various official documents, with growing voiced commitments from national and provincial leadership. However, the key need is to move from words to action. According to the recent situation assessment report (Gavin Jones 2016 Pakistan) *"there has been a remarkable lack of urgency in official circles with regard to health issues in general, and to family planning in particular."*

So while UNFPA support started a promising momentum in terms of the official population policies and documents all now recognise population development as a priority area there is insufficient recognition and a "*planning disconnect*" of the ways in which rapid population growth has held back economic development, and in particular, human development, in Pakistan. For example, while the need to raise health and education budgets to at least 3% is clear and recognised by government planners, the political or bureaucratic will to address fundamental issues of inefficiency, weak governance, demand generation, and supply side quality deficiencies is less evident in many of these discussions and strategies.

Another example is how policies in labour and economic development have failed to analyse how Pakistan's international (and local) competiveness has been directly influenced by its population and human development situation such as failing to integrate women into the workforce compared to a number of neighbouring Muslim-majority countries which have benefitted from slower population

[63] Research and Development Solutions Policy Brief #13. FP Services Uptake and Trends over time. http://resdev.org/files/policy_brief/13/13.pdf

[64] Research and Development Solutions Policy Brief #33. Do More Supplies Increase FP Use in Pakistan. http://resdev.org/files/policy_brief/33/33.pdf

growth and demographic dividend. These cross-sectoral areas are where UNFPA can play a greater role in expanding the understanding and impact of population and development relationship.

UNFPA support to the development of provincial Population Policies and joint collaborations with other donors (USAID, Packard, Gates Foundation) on the preparation of costed implementation plans and commodity security has been instrumental in starting the process of enhanced FP-RH and ASRH planning at the provincial and is now moving to the district levels to ensure continuity of the chain of supplies and services.

In evidence generation UNFPA support has certainly strengthened analysis of population and development relationships in public sector institutions focusing on topics of urbanization, migration, fertility rate associations with mortality rates. UNFPA support has prepared the PBS to conduct analysis of the upcoming Population Census data and digitise maps once it is conducted. But despite these strengthened capacities there are still substantial gaps in the understanding macro-economic effects, adolescent and youth social capital development, research and interconnectedness of women's mobility and educational empowerment with fertility rate.

Repeatedly the message from informants is that UNFPA should focus on the big picture and strategically advocate to all government departments, donors and civil society partners the importance of population–development relationships. UNFPA itself should be looking at the big picture instead of just 4 year programme cycles, assisting the national and provincial governments in strengthening their capacity for policy formulation in the area of population and development.

Key Results were:

- Advocacy with Religious Leaders was undertaken to mobilize their support for family planning as a pillar of population and development. The Religious Leaders signed a Declaration titled "Improving Family Health and Wellbeing with focus on Birth Spacing", hence pledging their support for FP.
- Parliamentarians from all major political parties were also engaged on issues related to population and development. The sensitized leaders became advocates for FP within their respective Assemblies and Parliamentary Committees. A joint statement was signed by more than 30 legislators supporting family planning.
- A national summit titled "Population Summit 2015; Putting People First in Pakistan's Development Agenda" was held on 5-6 November 2015 to build consensus for to prioritize population issues in Pakistan's development agenda. The Summit was officially opened by the President of Pakistan and attended by the UNFPA Regional Director and other dignitaries.
- Population Studies was incorporated as a Master's degree subject in the syllabus of the Mass Communications Department, University of Punjab.
- The Media has been extensively engaged to play an effective role in population issues and several media networks have been formed to raise the issues of FP-RH and Population at the national and provincial levels beyond UNFPA support period through their own resource generation.

Table 15. Population and Youth Policies Priority Focus

Area	Current Status (approved yes/no, year)	Comments/Observations
Population Policy (year)		Priority areas
National		
Punjab	No, draft version	Ensure universal coverage and improve access to safe and quality FP and RH by 2025.

	prepared (2016)	Raise CPR to 60% by 2030. Lower want family size to 2.5 by 2020 through an effective population communication and education program Achieve fertility level of 3.3 by 2020 and attain replacement level fertility of 2.1 by 2030.
Sindh	Yes (2016)	Enhance CPR from 30% in 2015 to 45% by 2020. Decrease in fertility level from 3.9 in 2013 to 3 births per woman by 2020 and attained replacement level fertility (i.e. 2.1) by 2035. Achieve universal access to safe and quality RH/FP services by 2020. Increase efforts to reduce unmet need for FP from 21 to 14% by 2020.
Khyber Pakhtunkhwa	Yes (2015)	Achieve universal access to safe and quality RH/FP services by 2020. Increase CPR from 28% to 42% by 2020 and to 55% by 2032. Raise modern CPR from 20% to 28% by 2020. Reduce unmet need for FP from 26% to 15% by 2020. Decrease TFR from 3.9 to 3.3 by 2020 and attain replacement level fertility (i.e. 2.1) by 2032. Reduce annual population growth rate from 2.2% in 2013 t0 1.3% by 2032. Encourage increased investment for acceleration of female education and empowerment to facilitate attainment of population sector related objectives.
Balochistan	No	
Youth Policy (year)		Is ASRH addressed in the policy?
Punjab	Yes (2012)	Launch of Youth Venture Capital fund & Punjab Internship program by public-private partnership; 5% quota to youth under Local government; promote technical education in south Punjab; Established youth helpline for counselling of adolescent on their health and reproductive issues; Implement laws against early and forced marriages; Education and communication of activities in RH rights at school level
Sindh	No, draft version prepared	Economic Empowerment of Youth: Stimulation of Employment and Livelihood Opportunities; Promotion of Entrepreneurship Skills and Opportunities; Skill Development and Vocational Training Social Empowerment of Youth: Education for youth development; Youth Population and Health for a Better Youth Future; Promotion of Youth Volunteerism and Community Service; Promotion of Sustainable Peace and Development Political Empowerment of Youth: Political Participation and Engagement of Youth
Khyber Pakhtunkhwa	Yes (2016)	Youth in KP is economically active. Youth in KP possesses economic and social competencies for their future market and social roles through quality education. Youth in KP is socially empowered, progress, egalitarian, tolerant, non-violent, peaceful, having positive self-image and health and hopeful of their own future contributing to family and social well-being. (Adolescence and youth health rights) Youth in KP is politically dynamic and engaged in decision making process and civic activities. Youth in KP can efficiently govern the multi-sectoral field of youth development.
Balochistan	No, draft version prepared	Create an enabling environment for sustainable, rightful and gainful employment, livelihood, training, financial credit and other services. To promote a youth that is socially sensitive, egalitarian, pro-peace and gender-friendly. To promote education as a vehicle for youth development inculcating social and economic competencies for future roles in youth. To facilitate integrated healthcare ensuring reproductive health programming and services and to groom a generation that is committed to gender equality.

		To promote healthy lifestyle and mobility through sports and tourism and engage youth in preservation and promotion of art, culture and heritage.

Common Observations and Findings

- Lessons Learnt: Sustained advocacy with key stakeholders including the media has been instrumental in raising the profile of population issues in the country. This needs to be sustained, and backed by technical support to assist in translating commitments into plan of actions both at federal and provincial levels.
- A robust and formal advocacy strategy is required to support Advocacy going forward.

- Advocacy has to expand to new actors and local level for greater accountability and results - The focus of advocacy remains upon the *"usual" subjects and with the "usual" actors*. Given the very low penetration of FP (15% of MWRA avail FP services in a given year) and MH (52%) services among the population suggests the need for engaging communities and particularly with local leaders that were recently elected during local body elections and are closer to the people than members of senate or assemblies.
- Advocacy has to be measured otherwise a lot of resources (time and money) is going into "preaching to the converted" with little translation into concrete actions – the time to move "beyond rhetorical commitments" (Civil society expert in Sindh).
- UNFPA does not have an in-house Advocacy specialist with formal training in Advocacy and Communications which is a critical gap given the level of advocacy work that UNFPA undertakes and wishes to expand in.

4.3 Efficiency

EQ 7: To what extent has UNFPA made good use of its human financial and technical resources and used appropriate combination of tools and approaches to pursue the outcomes defined in the country programme and its response to humanitarian crisis?

SUMMARY

UNFPA CO was partly efficient (75%) in resource mobilisation, disbursements and overall utilisation mainly due to a late start (2014) of the Country Programme activities. UNFPA raised approximately one-third of its total $ 36.23 million from co-financing or non-core resource mobilisation through the RMNCH Trust Fund and Humanitarian Emergency Fund.

At the time of the evaluation the programme utilisation rate was 75% (mid-cycle) and expected to increase by 10-12% by year end. Disbursements to the IPs were in compliance of the AWPs and IP contracts with records maintained in the Atlas system. For CP 8 UNFPA did not undertake any Programme Efficiency reviews at the design or implementation stage. The internal management systems do not easily allow (disaggregate financial data) to see unit cost of activities or efficiency of the interventions.

During the CP 8 programme duration, there were increases (10%-25%) noted in Federal PSDP (2012-2015) budget allocations to provincial Population Welfare programmes including the vertical MNCH and PHC programme; and budgets of the three provincial Health Departments that could be reflective of UNFPA's advocacy and capacity building efforts for RH and FP. While it is cautioned that the bulk of increased budget allocations went to support administrative costs of tertiary care hospitals and salary expenditures, the overall increase for FP and RMNCH support has been estimated to be $126 million in the last 4 years (i.e. $ 30 million per year).

Though there was no direct cost share by government in UNFPA interventions there were salient examples of contributions in kind through availability of office space, staff deputations, and co-sharing of transport and logistics costs that increased programme efficiency

LESSONS

UNFPA business model of public-private partners effectively reached small scale coverage of underserved and remote populations via NGOs. IPs demonstrated diverse models of innovation, capacity building and integration within public sector services that may potentially be scaled up. However, programme efficiency is hard to accurately ascertain due to absence of validated outcomes and tracking of end-beneficiary benefits, unit costs etc.

UNFPA IP assessments showed some IPs had expensive management structures that reduced the efficiency of the programmatic results. It is possible that transactions costs may actually increase rather than decrease if the models were to be scaled up in their current form.

4.3.1 Financial Resource Management

Review of UNFPA Country Programme documents such as the Office Management Plan, ATLAS system and management and IP interviews highlight the following:

- Clear steps were taken by the Country Office Management and Finance team (2015-16) to improve budget control, financial procedures, bank reconciliations, updating of ATLAS activities and allocations, direct financing measures, and accounting liquidation of cash. This was done through monthly review meetings with the management and technical team, utilisation and IP reports review, and presentation to senior management on bottlenecks.
- Some good practice noted since 2015 are the matching of planned resources to planned results by outputs and IPs. Compliance with monthly and year end closure activities and deadlines. Clean audit report for 2015.

- UNFPA CO was less efficient in disbursing annual programme budgets to support implementation of AWPs (Table 12). One concern raised by IPs was that in 2014 and 2015, the funds released for that fiscal year were delayed till nearly March (instead of January) which resulted in delayed start of activities.
- IPs reported issues of delays in release of quarterly payments and significant (30%) funding cuts from the initial planned AWPs allocations during 2014-2016 that has affected partner's capacity for continuation and timely completion of activities. Delay in quarterly funds transfer to some IPs is also partly due to IPs non-conformity with all of UNFPA financial and reporting procedures. According to UNFPA management procedures, IPs need to provide progress reports and financial documentation to evidence at least 75 percent disbursement of the previous quarter budget before the next quarter budget can be transferred. Hence delays when IPs supporting documentation are not in conformity with UNFPA management and financial procedures.

Table 16. Funds Planned (Core and Non-Core) to Expenditure

2013 + 2014		2015		2016	
Funds Planned (% Non-Core)	Expenditure (%)	Funds Planned (% Non-Core)	Expenditure (%)	Funds Planned (% Non-Core)	Expenditure (%)
16,918,513 (32%)	13,542,590 (80%)	10,806,349 (33%)	9,175,360 (85%)	8,510,256 (34%)	6,377,203 (75%)
Total (2013 – 2016 September)				36,235,118 (33%)	4,309,193.00 (67%)

4.3.2 Technical Resource Management

In terms of human resource the CP 8 has faced serious technical and senior management staffing challenges during 2012-2014, and has now only filled all of its key positions since December 2015. The core UNFPA technical positions are: 1) 5 Programme specialists in Youth and RH, FP-MH, Population and Data, Gender and Humanitarian, and 2) Monitoring and Evaluation specialist (1). This early period also coincided with restructuring of the UNFPA approach in Pakistan. Common reasons for delayed recruitments cited by UNFPA management and document review were organisational restructuring, finalisation of the terms of references, delayed (central) approval processes for senior and/or international positions by UNFPA Headquarters, and challenges in finding in-country technical expertise for the required positions. For example, the hiring of Country Representative and Deputy Country Representative took 9 – 15 months respectively. Till date the post for communications specialist remains vacant.

Furthermore, many responsibilities of technical staff incorporate the "soft interventions" which may not be specifically described or budgeted in the annual work plans, yet require a great deal of staff time. Soft interventions, particularly coordinating with government partners, involves continuously encouraging progress toward planned results and joint problem-solving. The positioning of UNFPA staff in government departments i.e. MNCH advisor (Sindh), CMW tutors, Research Advisor (PSPU Punjab), has promoted timely implementation but may not be long term sustainable.

In addition, to the CO (Federal capital) in 2013, UNFPA established provincial offices in 3 provinces (Lahore, Karachi and Peshawar) with 1 technical specialist and 1-2 support assistants to serve as liaisons between the CO and provincial governments on a routine basis. The provincial offices are functional and vary in their level of effective engagement with the provincial governments and IPs. The salient findings of the provincial offices and management are:

- Provincial offices (all three provinces) do not have defined (written) Terms of Reference and there is substantial possibility of misinterpretation error on the specified duties, frequency of tasks, roles and expectations with government partners and private IPs, and overlap with the CO team and provincial staff supervision and monitoring. The provincial staff felt that in several instances

IPs/NGOs bypassed them in routine information sharing, invitation to provincial consultations, and general supervisory authority.

- There are no formal business plans. Provincial offices have individually designed their work plans in collaboration with the CO and government partners (mainly DoH and PWD). Budget allocations are from the CO and dependent on need identification based on the CP 8 planned activities and in turn contingent on how "proactive" the provincial office and the respective government counterparts in DoH or PWD are in that province. For example, Punjab DoH directly communicates with CO and often leaves the provincial office outside of the communication channel. DoH KP has lengthy approval processes, and UNFPA provincial office directly interacts with MNCH programme to hasten short term programme activities such as trainings of CMWs, LHWs to avoid lapse of funds allocated. Provincial officers expressed frustration at the lack of clarity with managing bureaucracy at two levels – UNFPA CO and IPs.
- Coordination between CO and provincial offices is good. Routine monthly meetings have recently started (2016) to discuss provincial work plans and progress updates between UNFPA CO and provincial teams. The IPs are not invited to these UNFPA team meetings. Schedule for quarterly or biannual meetings would additionally strengthen information sharing (IP-IP learning) and coordination, and ensure a greater sense of ownership.

Since mid-late 2015, UNFPA has been systematically reviewing its functional organogram and capacity, staffing distribution, staff roles with the objective of better delivering the remaining CP 8 outcomes, as well as strengthening programmatic capacity for delivering CP 9.

4.3.3 Cost Efficiency and Partner Selection

In CP 8 there were approximately 32 partners (public sector 19 ministries/departments/academic institutions, and 13 NGOs/INGOs). Partner selection has followed the UNFPA defined process[65] as per global UNFPA rules of recruitment and is centralised mainly at the UNFPA CO with less inputs or representation from the provincial offices. Issues identified during stakeholder and UNFPA management interviews and review of recruitment documents are:

- For CP 8 the rapid expansion in the number of partners made monitoring of programme activities and coordination very challenging for UNFPA staff particularly for government partners.
- The CP 8 Management Plan had envisioned that selection of the same, large, nationally recognised IPs for different thematic areas and interventions would results in cost efficiencies i.e. some shared management and personnel costs. Review of the CP 8 programme documents including IPACT assessments does not validate this assumption.

4.3.4 Leveraging Resources for Government Ownership

UNFPA support (financial and technical) in highlighting the priority and urgency of RH and FP has directly and indirectly influenced increased financial resources commitments by national government/provincial and donors during 2010-2018.

Leverage effect of resources provided by UNFPA soft and financial resources have triggered provision of other resources from donors namely DFID and USAID, government at the national and provincial governments as seen in budget allocation increases of 15%-25%.

[65] Advertisement, competitive bidding, selection criteria and partner capacity assessment tool (IPCAT)

4.4 Coordination, Partnerships and Value Added

EQ 9: How far and in what ways have the partnerships established by UNFPA built capacities to respond to development and humanitarian needs and supported national ownership of interventions, programmes and policies? How has UNFPA added value and what was its strategic positioning in CP8?

SUMMARY

UNFPA has been actively involved since 2014 in coordinating and leading the development partners/donor group (FP Donors Core Group), along with the national/provincial country engagement FP group (FP 2020 Working Groups National and Provincial chapters), plus multi-layered coordination with UN partners in Humanitarian efforts, national and provincial technical committees (PTCCs). There are also district level Technical Steering Committees (DTCs) that have been activated with UNFPA support but many of them are not yet fully cognizant of their true roles. Each of these groups/ committees and coordination forums have defined objectives and meet regularly and are making progress in improving overall coordination and addressing RH-FP issues in development and Humanitarian contexts.

UNFPA supported and/ or led coordination mechanisms have for most part been effective in harmonising the efforts of development partners and with UN agencies to achieve RH and FP objectives, share information on progress, avoid duplication of technical and financial resources and geographic locations, and improve overall complementarity. There are however several challenges as identified in the OPII midterm review and in discussion with donors/stakeholders in terms of i) improving coordination between the interventions of UN agencies. For example, multiple UN agencies typically work on particular interventions in separate geographic areas. Coordination should be strengthened so the full range of interventions i.e. skills development combined with social mobilization of the households for maternal health, immunization, and diarrhea etc. can be carried out within a single area, so as to generate the full benefits, ii) Convergent programming is an effective approach to address needs in different sectors (e.g. health, education, WASH, child protection); by tackling these together at the same time, positive impacts are amplified, and iii) Donors are still concentrating in certain geographic areas and missing out other high need provinces (i.e. Balochistan) and districts (southern Punjab, FATA etc.)

UNFPA is now being recognised as the "***lead agency***" in FP-RH and Population issues. This technical expertise and particularly competitive advantage over other donors and UN agencies in having a clearly defined women centred population mandate needs to be further strengthened through expansion of partnerships at the provincial, district and sub-district levels (local engagement), knowledge management, and local strategic positioning via advocacy and capacity building. One major opportunity for UNFPA is to help government partners implement the SDGs in their development activities. UNFPA is not recognised by non-Health and Population actors and this gap needs to be addressed in the next programme cycle.

4.4.1 Contribution to Enhancing Coordination and Strategic Positioning

UNFPA has progressively strengthened its coordination role during CP 8 and is now well recognised amongst the traditional health and population partners and stakeholders as the lead agency in coordinating RH and FP, less so in maternal health, Population Development sector (where UNICEF for maternal child health and UNDP is more associated with development and growth specific interventions).

During CP 8 UNFPA established and revived several instrumental groups:

- FP Donor Group – which brings together key donors (USAID, DFID, KFW-GIZ, Aus Aid, World Bank, UNICEF) to regularly review and harmonise their funding, interventions, and support to RH, MH and FP issues.
- FP 2020 Country Engagement Group – with national and provincial working groups with membership from government, donors, NGOs, and civil society experts to monitor and plan the progress on achieving the FP 2020 commitments including synergies with the SDGs and beyond ICPD agenda.
- Coordination between Provincial DoH and PWDs through Provincial Technical Coordination Committee (PTCC) – and bringing structural and functional coordination in the activities, planning and policies of Health and Population (first time initiative by UNFPA)
- Revitalised the RH Working Group – to address coordination, leadership and preparedness for addressing RH, GBV and MH within the context of Humanitarian settings. Provincial DoH, PWD, and PDMA's as well as NGOs are part of this forum.
- UNFPA also provides strong financial and technical assistance to NHEPRN and has coordinated efforts through the network and partner NGOs.
- Leads the UN Humanitarian GBV Sub-Cluster with regular reporting, trainings in MISP, and moving forward of the Humanitarian agenda.
- UNFPA coordinates directly with Ministry of National Health Services Regulation and Coordination (Population Wing), Economic Affairs Division, UN Representative Office and the Provincial DOH and PWDs to further align and coordinate country needs to the UN mandate and support.

Common Observations and Findings

First provincial devolution (2011) and now devolving of the power to the district (2015) has brought new challenges and structural changes particularly in how coordination governance will need to be managed. These transitional challenges are and will play a tremendous role in future programming and have to be considered right from the beginning:

- Within the donors and government stakeholders, UNFPA's strategic positioning is still not fully conceptualised in terms of role as an Advocacy and Knowledge Management versus a more of Capacity Building and Service delivery organisation role. This is due to past inconsistencies and trying to achieve too many objectives with absence of strategic focus
- The relationship between Federal-Provincial-District governments is generally hostile particularly across political parties, international commitments, resource allocations, autonomy of authority over budgets, human resources, and planning. The antagonism is reflected in inconsistencies between national and provincial plans and strategies (absence of district inclusion or feedback is obvious) with the result that donors and UNFPA face a daunting task in choosing the lead partner and effective implementation.
- Confusion remains due to overlap between federal, provincial and district in terms of authority and functions. Selected vertical and provincial Programmes – with varying degrees of district involvement – restrict or ignore the district's ability to allocate resources according to local priorities. Key decisions related to such Programmes rest with the provincial governments, restricting the role of district governments.
- Participation and partnerships in the various working groups are limited to selected invited "recognised" partners that have been working in RH and FP for decades. This exclusion of new ways of thinking, evidence perspectives through diversity of participants, and questioning the same old approach to "business as usual" is needed if Pakistan is to slowly move on its FP and Development Agenda.

- Coordination meetings should have some type of standardised reporting format to objectively capture the progress made from the last meeting. Often incremental “agenda points” are not followed up or are interrupted by more urgent but less important issues.
- Though there are District Technical Committees (DTCs) there role in supervision and accountability is limited. Feedback from the districts is that they are severely handicapped, due to limited capability and autonomy. UNFPA future programme attention in terms of capacity building and advocacy should focus on district level engagements.
- Feedback from donor partners and UNFPA Country and Provincial staff summarises that UNFPA CP 8 engaged in too many activities under each component. As a result, the resources were too thinly spread. This made ***strategic positioning*** and implementation difficult for the staff and potentially diluted what UNFPA could have achieved with fewer interventions but greater focus on quality, scale and measuring. Learning lessons from other strategic donors like David and Lucille Packard Foundation where funding and coordination has been very strategically positioned would be useful for UNFPA.
- To enhance its strategic positioning UNFPA management has to prioritise ***what will work approach and in what context*** instead of the generic through government or public-private models For example, private sector providers are part of the FP and RH ecosystem and can be engaged through market or social entrepreneurship models to complement and support mutually beneficial service delivery, capacity building, cost efficiencies referrals and learning.
- Assessments of the health systems and end beneficiary needs would make UNFPA more strategically placed to deliver within its mandate. The CP 8 mainly addressed health system deficiencies and did not adjust for benefits or coverage or outcomes for the end beneficiaries.

CHAPTER 5: CONCLUSIONS

Strategic Level

Conclusion 1 (EQ 1, 2, 7 and 8) – UNFPA CP8 design was relevant with national priorities, and UNDAF/OPII priorities. However, design flaws such as lack of focus on strategic content, detailed planning on how the interventions would be achieved, owned and scaled up by the government, and/or bring systems and institutional change undermined the programmatic relevance, effectiveness and sustainability.

In theory CP8 was relevant and well aligned to national priorities. What undermined the Country Programme from achieving its full potential of institutional and practice changes and outcomes (rather than immediate-short term outputs) can be directly attributed to limitations in the design and implementation approach. Design flaws such as lack of programmatic focus and setting out to accomplish too ambitious an agenda in a limited time; lack of specifics by the CO in guiding IPs on targeting the most marginalised populations; low attention to known inherent risks and mitigation strategies to address weak governance and accountability that has undermined previous Population and Health programming; and weak objective measuring of progress and timely course corrections all affected the overall programmatic results, efficiency and sustainability. In addition, absence of engagement with non-traditional partners and feedback of end beneficiaries' feedback which are instrumental in improving service delivery mechanisms, oversight and/or sustainability were critically overlooked.

Conclusion 2 (EQ 7 and 8) – The CP8 design and CO management systems did not give priority to reviewing effectiveness and value for money of the proposed interventions at the design phase and during implementation which limited the overall impact that CP8 interventions could have achieved.

UNFPA's role in Pakistan is to assist (not substitute) the government in strengthening and enhancing its FP-RH and Population Development agenda and outcomes by "*delivering thinking"* instead of delivering things. This conceptual clarity was not always apparent in CP8 design, the CO management approach, and by the government and NGO implementing partners. While internal transitions and re-structuring at UNFPA CO including long term vacancies of senior management and technical positions has affected overall efficiency the main issues were weakly defined internal controls and guidance by the CO, low understanding of the importance of needs based planning, and absence of regular exercises in measuring cost efficiencies of partners and programmes.

Efficiency was also compromised by engaging a large numbers and different types of IPs (government, INGOs, NGOs) and by spreading out geographic coverage of interventions with higher transaction costs, monitoring and management challenges for UNFPA. So while innovative models of public-private partnerships were tested, there was no emphasis on achieving maximum value for money and reaching better cost-efficiencies through low cost management models, and monetizing results.

The current Country Office management team has systematically incorporated routine reviews, needs based resource planning, improved business plans, results and budgetary matching, monthly coordination meetings with provincial offices, and streamlined guidance for IPs on contract delivery. Gaps in CP8 design that need to be further addressed in the next phase of programming are:

measuring cost-efficiencies of programme interventions, monetising soft aid activities, lowering transaction costs, strengthening the resource mobilisation planning and tapping into private sector/corporate funding sources

Conclusion 3 (EQ 8) – Active engagement by UNFPA is widely recognised among traditional Health and Population partners (government, donors, NGOs, UN agencies) as the lead technical and coordination agency in FP-RH and Population Development. UNFPA now needs to expand this recognition with cross-sector partners and downstream district/sub-district leadership as part of its strategic positioning.

UNFPA is now recognised as the "*lead agency*" in FP-RH and Population issues. Its strategic advantage now lies in maintaining this credibility and advocating a focused FP-RH-Population Development agenda. This may be translated through technical expertise to the government to achieve results in RH by specifically focusing its advocacy at key upstream and downstream personnel to achieve accountability; expanding engagements and partnerships at the provincial, district and sub-district levels (local engagement); offering need responsive knowledge management (for evidence based advocacy) and strategic capacity building (to achieve results) in accordance to a long term plan that is owned by the government. Other major opportunities that exist include helping the government integrate population planning and implementation into its SDG agenda; incorporating non-Health and Population actors, policies and programmes into the of Health and Population Departments and helping address gaps in district capacities (where much of public sector implementation happens) through government owned initiatives.

UNFPA coordination has been largely effective in harmonising the work of development partners and UN agencies to achieve RH and FP objectives, share information on progress, avoid duplication of technical and financial resources to the Government and distribute geographic locations, and improve overall complementarity. These groups have subtly influenced government/provincial leadership in addressing their FP-RH commitments seriously and understanding the need to "own" the response. However, the transition from a "*UNFPA/ donor led agenda to a government owned and led agenda is not yet complete*". This evaluation shows that while crucial structures have been constituted, they have yet to recognise or achieve their true role. For example District Technical Coordination Committees (DTCC) have been activated with UNFPA support but many of them are not yet fully functional or even aware of their potential role. Similarly in Humanitarian coordination there remains variation in the level of ownership and understanding of how FP-RH embed within the response and their importance.

This evaluation and the OPII midterm review identified several challenges in UN harmonisation in terms of i) coordination between the interventions of different UN agencies. For example, multiple UN agencies typically work on similar interventions in separate geographic areas. Cross-agency coordination may be strengthened so the full range of interventions i.e. skills development combined with social mobilisation of the households for maternal health, immunization, and diarrhoea etc. can be carried out within a single area, to maximise benefits. ii) Convergent programming is an effective approach to address needs in different sectors (example health, education, WASH, child protection). By tackling these problems simultaneously, positive impacts can be amplified. iii) Finally donors continue to concentrate on certain geographic areas while missing out on other high-need provinces (e.g. Balochistan) and districts (southern Punjab, FATA, etc.)

Conclusion 4 (EQ 1, 2, 8 and 9) – The sustainability of CP8 varied and would have been substantially improved with better exit strategy planning, and taking into account mitigation strategies for weak accountability in the public sector.

An enabling environment for sustainability was mixed in CP8; which had a number of advocacy initiatives with government officials, parliamentarians and religious leaders, encouraging them to transcend sociocultural/ traditional inhibitions and accept women's/ couples FP choices and RH rights as emergent need. With government decision makers positive changes were seen in development of Health, Youth and Population policies, that highlight RH and FP and to increase budgetary support (although most went towards infrastructure, tertiary care facilities, and salaries). UNFPA's strategic ASRH and FP counselling via capacity building interventions with LHWs, CMWs, FWWs and other public sector providers and ASRH centres (Punjab and Sindh) have been strongly taken up in government PC 1's (Punjab, KP, Sindh) and will be replicated on a large scale (i.e. the trainings component), and is a positive accomplishment. Similarly the FP Voucher initiative has been taken up by large donors (DFID and USAID) in nationwide interventions and is showing moderate success in adding new users.

While successful in some aspects, lack of measurement of results often meant that only token/ nominal endorsement by religious leaders or parliamentarians were obtained and construed as substantial successes. Little evidence suggest that measureable changes were achieved in policies, societal narrative or even a serious debate about obstacles women face in homes and outside, in accessing services, education or livelihood and perniciousness of gender violence regardless of its historic or cultural roots. Additionally, since policymakers that participate in such sessions have already been convinced, in effect, these efforts become exercises in "*preaching to the choir".* Even at this level, it is unclear how these initiatives would be sustained.

For sustainability to be ensured (right from the beginning) UNFPA CO must emphasise to the government that it is their responsibility to ensure commitment to FP-RH and Population Development goal, help put in place strategies with the government that strengthen accountability and provide technical assistance within the government's own defined institutional plan of action.

Interventions targeting community demand creation were not undertaken in CP8. UNFPA could have directed their advocacy (or supported such advocacy by community or civil society groups that work on these issues) for changing the societal narrative by working with men and husbands who exert a strong influence on women's RH-FP choices today and play a critical role in perpetuating gender discrimination and violence against women, restrictions on women's mobility and their access to education, employment and skills; and with boys, who will grow into men with such control over women of tomorrow. This would have meant a grassroots sustainability mechanism to the advocacy work of UNFPA. Furthermore discussions with experts reveal that since grass-root level community level support is perceived by politicians as the "*will and mores*" of their constituents, UNFPA could have achieved a greater and wider leverage among the policy makers with its efforts.

For Population and Development, the outputs (i.e. number of personnel trained in particular skills) should not be confused with the desired outcomes that should have been achieved as a result of these newly acquired capacities. In short, to achieve the real results of trainings and capacity building the advocacy should target relevant government decision makers on how evidence is important, and how it can help in better decision making.

In Humanitarian efforts, still in the early stages of UNFPA led coordination and GBV/SRH focus, show promise but were challenged by frequent staff transfers in government and NGOs, involvement of and turf tussles among multiple government and UN agencies, and security-accessibility concerns in conflict affected areas. UNFPA has had limited success in shifting responsibility and ownership to government

partners (PDMA/NDMA) and for them to effectively recognise SRH-MH as a necessary continuum of services for women in conflict and transition situations.

Programmatic Level

Conclusion 5(EQ 3, 4, 5 and 6) – UNFPA interventions were effective in putting FP-RH and Population & Development in policy and programmatic documents (i.e. rhetorical support and commitments) but did not significantly push for or measure the attitudinal, systems and institutional changes. Recognizing the constraints that these changes take decades, UNFPA CO through its support and interventions, and technical leadership must still strive to enable and promote the paradigm change

UNFPA CP8 interventions led to a momentum and recognition of FP and Population Development as a important national priority with some very positive proposed actions. However, these UNFPA efforts, to institutionalise evidence generation or attitudinal changes towards programming, which understandably takes decades, still remain weak. Perhaps the UNFPA CO could focus on studying and understanding the political economy that heavily favours low accountability, short term interests, and advocate the FP-RH message to Government in such a way that it is more likely to be taken up, and hence improve programme results.

This would require the deeper understanding of why despite achieving 90% + delivery of programmatic inputs and outputs, the outcome level changes in decision making, macro-level planning, inclusion of key cross-sector partners did not happen. This would require UNFPA to work with government decision makers and advocate to change the political incentives that are holding Population Development and FP down.

CHAPTER 6: RECOMMENDATIONS

Strategic Level

Recommendation 1 *(Conclusion 1,4, and 5)*

Develop a clear strategy note for UNFPAs support to FP-RH and Population & Development that responds to emerging needs such as provincial autonomy, mechanisms to measure and assess results right from the design phase and throughout.

Priority Level – High
Responsibility – UNFPA Country Office

Action Points

UNFPA should continue its focus on youth, FP-RH, and Population Development but shift its approach to "outcome" oriented institutional and systems level changes. This can be achieved by

- **Enhance Mechanisms for Provincial Engagement** - In light of the growing provincial autonomy, and emerging leadership, UNFPA CO should establish mechanisms for formal engagement with provinces including inputs from the districts for defining the final shape of CP9 design and interventions. National level planning and programming will no longer be sufficient and might even be counterintuitive for strengthening provincial and eventually district autonomy and accountability for long term results.

  Another strategic question that UNFPA will also need to ask is at what level of government it would be ideal to engage in. The answer realistically depends on the type of intervention planned and will require a mapping of the context and impact to be achieved, and the transaction costs vs. benefits.

- **Support/ contribute Capacity of Government Partners**- The UNFPA should continue to strategically support the government in improving FP-RH and Population & Development outcomes through targeted advocacy, technical assistance (or expertise) to generate credible evidence and build the capacity of government to implement its own vision and strategic plans. *For example, what is the Government's Population Plan? How does it address other cross-sector policies and interventions? Does it include women/girls as part of national development? Policy and practice coherence between Education, Labour and Justice Interventions?*

- **Expand Partnerships to Non-Traditional and Cross Sector Partners** – CP9 planning, design, and implementation should include cross-sectoral partners (including non-health and population ministries or departments such as Education, Law and Justice, Interior etc.), private sector actors (NGOs and the for profit sector) or inputs from end beneficiary on their needs and programmatic results. In addition, when addressing health system gaps, the Country Program should clearly specify mitigation mechanisms for weak governance and accountability that have undermined the FP-RH and Population outcomes for the past several decades.

- **Support Innovation Outside of Government Partners** – Support to government should be supplemented with UNFPA's role in supporting innovation and piloting new approaches; with consideration of how these will fit in, strengthen or complement existing government policies and programmes and what will be the added value to the overall health system. For example, where can advocacy be most effective in improving programme performance – at the provincial or district level – learning how to make district supervision most accountable and identify the best measures of this accountability. *Key questions to specifically ask and institutionalise in the design and implementation are i) is government truly committed to and leading/ owning the response, and ii) what mechanisms are (or need to be) in place to ensure that targets and results are measured and achieved as planned.*

- **Clear Exit Strategy –** beginning from the programme design UNFPA should have a well-documented and clear exit (i.e. handing over) strategy in place. This strategy can be modified later with new information but it should be part of the design conception.

Recommendation 2 *(Conclusion 1)*

Support and promote efforts for reaching the poorest and most vulnerable populations, and support institutional mechanisms for measuring outcomes of pro-poor policy and programme interventions.

Priority Level – High
Responsibility – UNFPA Country Office, Government or Implementing partners

Action Points

- **Define Criteria and Protocols** – CP9 should define clear strategy on what and where are the most marginalised target audiences that should be reached and how this would be achieved or measured.
- **Gender Mainstreaming -** UNFPA should identify how gender and rights based equitable targeting will be done in the CP9 design and implementation, and secondly, how will the designed interventions in *Policy Advocacy*, *Capacity Building* and *Knowledge Management* incorporate gender equity, inclusion, gender mainstreaming indicators, and measurements of progress in their plans and practices.

Recommendation 3 *(Conclusion 3, 4 and 5)*

Integrate FP-RH and Population within the ongoing SDGs 2030 national/provincial development and planning processes and mechanisms to achieve wider influence of the advocacy and interventions.

Priority Level – High
Responsibility – UNFPA Country Office, along with UN Agencies, Government

Action Points

This is the right time for UNFPA to assist the government in holistically looking at RH-FP-Population & Development within cross-sector policies and partners and in the broader SDG goals 1 (poverty), 3 (women's well- being), and 5 (gender equality) and including 4 (education), 8 (access to employment and skills), 11 (sustainable cities and communities) and 16 (inclusive institutions and justice) adapted to local capacities and ensuring effective implementation. UNFPA can support technical capacity building of local government staff in supervising effective implementation and monitoring of progress through:

- **SDG Advocacy and Grassroots Support Strategy -** One limitation that was commonly identified during implementation of the MDGs and is often a recurring theme in public or private sector programming in Pakistan is the lack of engagement of communities in planning, participating or supporting programmes. For the SDGs, UNFPA can assist the government in helping devise an SDG Popularisation and Advocacy Road Map Strategy to gain public awareness and support for reaching the beneficial goals.

  K*ey clarifications to address* are i) placement of overall responsibility for coordinating the implementation of SDGs in Pakistan with provinces, ii) monitoring and reporting, iii) coordination mechanisms, and iv) advocacy that links civil society and communities in the process of change.
- **Provincial Planning through Planning and Development Departments** - Possibilities to consider by UNFPA and government decision makers are placement of the SDG coordination units in provincial Departments of Planning and Development with province specific

targets/goals, and sector specific responsibilities given to Health, Population Welfare, Education, Economic Development and Labour etc. for aligning with the overall and cross-sectoral development goals. For example, Uganda has addressed this through assigning responsibilities to each ministry and agency; i.e. the Ministry of Finance, Planning and Economic Development is responsible for financing the SDGs, the National Planning Authority takes the lead for integrating the SDGs into national, sector and local government planning frameworks, and the Uganda Bureau of Statistics deals with data generation, analysis and dissemination.

- **Developing Consensus on Monitoring of Progress** – This is going to be a key issue. Discussions with stakeholders and past programming experience highlight that there are currently no "single" consensus or mutually compatible instruments to monitor and report on the SDGs in Pakistan. More importantly, many of the indicators have not been clearly identified or have available data or baselines to monitor progress. UNFPA can advocate for and support the government's efforts to improve the availability of data to monitor progress and report accurately.
- **Reinforce Accountability Mechanisms** - Strategize Policy and Advocacy to specifically promote means to improve accountability. Without accountability and improved governance, the yield of efforts are likely to be sub-optimal (as seen in previous and other donor programming evaluation reports example MNCH Programme Review 2014 DFID Pakistan).

Recommendation 4 *(Conclusion 4, 5)*

UNFPA should explore innovative ways including demonstration pilots of engaging the private sector markets to complement public sector services and gaps in reaching a wider number of beneficiaries with FP-RH services.

Priority Level – Moderate to High
Responsibility – UNFPA Country Office, Private sector representation, Government

Action Points

- **Identify Opportunities for Collaboration -** Going forward UNFPA should consider the vital role of private sector in delivery of health and FP, MH and RH services[66]. In CP 9, UNFPA should explore how to find cost-effective ways of engaging private sector partners to conduct certain tasks within the overall framework of public sector services, performance and quality.

  For example, UNFPA can support facilitation of the private sector in production of cheaper local products (i.e. contraceptives, commodities), technical assistance for quality and standardisation, working in remote areas where public sector service provision can be supplemented or alternatively have private sector deliver services in inner cities while public sector serving the remote poor where private sector models are too expensive (i.e. private sector to complement public sector gaps).

Recommendation 5 *(Conclusion 2, 4, and 5)*

Right from the design phase UNFPA should develop a detailed strategy for maximizing programmatic inputs (technical, financial, logistics, and human) to deliver sustainable outcome level results.

[66] PDHS 2012-2013 that over 80% of outpatient services are in the private sector and existing public sector system only reaches around 15% of MWRA with FP services and 52% of skilled births

Priority Level –Moderate to High
Responsibility – UNFPA Country Office, UNFPA APRO and HQ

Action Points

UNFPA should conduct a detailed cost-efficiency exercise looking at i) ***Allocative Equity*** - Is the Programme directing funds and services to the most marginalised or poorest groups as per programme design, ii) ***Allocative Efficiency*** – are the optimal mix of inputs/resources in place for providing the necessary programmatic interventions, iii) ***Economies and Efficiency*** - What are the actual costs of delivering interventions (including advocacy interventions), and what are the outcomes achieved, and iv) training and deploying CMW by province? What has been their productivity and iv) ***Economies*** – what are the compared unit costs local, national, and regional levels.

- **Strengthening Internal Financial Controls and Review Systems** – ongoing capacity building of financial and management staff should be done to ensure that UNFPA internal controls are accountable, transparent, and clearly understood and followed to avoid disbursement delays and gain cost savings.
- **Review and Revise the Resource Mobilisation Plan –** UNFPA will need to review and revise its current RMP in the light of including new partners, dedicated funding for Humanitarian efforts, and expanding on the mobilisation strategies. Considerations should also be given to co-sharing of financing with other UN agencies and complementary donors, including provincial governments and corporate sector for achieving cost-savings and efficiency.
- **Promote an Efficiency Culture** – Accountability for programme efficiency and effectiveness should be part of the reporting frameworks and results culture within the organisation. Senior management should routinely review efficiency savings and improve the overall transparency of programme results and contribution to results.
- Periodic reviews should be conducted during the CP9 implementation to monitor cost-efficiencies.

Recommendation 6 *(Conclusion 1, 4 and 5)*

UNFPA should strengthen its strategic positioning by working more closely with UN agencies and other donors in Pakistan for sharing resources, planning exercises, and strategic analyses to avoid duplication and increase effectiveness.

Priority Level – Moderate
Responsibility – UNFPA Country Office, UN agencies, Donors

Action Points

- **Develop a Donor Development Coordination Framework -** UNFPA should help lead the development of a combined ***FP-RH and Population Development Framework*** in collaboration with the Planning and Development departments (including central Planning Commission at the Federal level) to document and streamline effectiveness of external donor assistance, reduce duplications, and enable greater performance and monitoring of results. This Framework can be jointly reviewed in the light of Costed Implementation Plans (developed by some provinces) and will help governments to better prioritise and rationalise what the long term FP-RH and Population goals and activities are and distribute internal and external resources accordingly.
- **Logistics and Coordination with UN Agencies -** For example, this might include UNICEF and UNDP for youth focused advocacy, skills development and empowerment, USAID and DFID for Maternal-RH programming including CMWs and trainings of front line service providers and

fistula management, and UN OCHA for humanitarian efforts. Between UN agencies the possibility of convergence programming should be discussed as part of the One UN initiative.

For Humanitarian efforts UNFPA can increase its leadership role in UN joint assessments and response and ensure that emergency preparedness and responses by government and implementing partners are SRH and gender sensitive. UNFPA should build further on its current communications and coordination strategy with government and UN agencies to institutionalise the processes of responsiveness, timeliness, uptake of MISP, and incorporation of GBV prevention within all contingency plans and responses.

- **Reassessing UNFPA Strategic Positioning in CP9 -** UNFPA has the opportunity to clearly redefine its approach and comparative advantage within the context of UN agencies, national (and provincial) priorities, and the SDGs. Most importantly the understanding that *UNFPA's programme of support to Pakistan does not and should not be misconstrued as the national population programme*.

  UNFPA should build on its strategic advantage to play a ***stewardship*** role in bringing together different actors in population development. UNFPA can particularly assist the government and relevant stakeholders to address the broad and multiple dimensions of population that require urgent attention such as interrelationships between population, sustained economic growth and development; gender equality and empowerment of women in achieving sustainable development; RH and population growth, distribution, migration, urbanisation, mortality, rights; technology, research (using population data, census, demographic dividend, youth, social capital development), and integrated population and development planning across sectors (education, labour, economic growth, justice).

  Within the One UN system, UNFPA can advocate for ways of overcoming the fragmentation of the UN "*so that the system can deliver as one*" – at least in RH. The process would build on UNDAF as a common platform for UN agencies to provide their support to governments; but the full institutional reforms process has been slower and less "unified" (Pakistan OPII mid-term evaluation report 2016). At the root of the challenge of "delivering as one" are resources: the lack of a common resource mobilisation strategy, differences in agency regulations, and the imperative of agency allegiance to their respective bodies and offices at the headquarters, all of which set a limit on agency collaboration. The One UN system is expected to work as one at country level, but the agencies represented at the headquarters remain separate and operate independently, guided by their own regulations. These are challenges that UNFPA in partnerships with other UN agencies can start addressing in Pakistan.

Programmatic Level

Recommendation 7

UNFPA should revise its current approach in Advocacy, Capacity Building and Knowledge Management by using available evidence and having a systematic plan of action that takes into account contextual realities such as weak governance.

Priority Level – High
Responsibility – UNFPA Country Office, with inputs from youth, Government, NGOs, Donors

Action Points

Past mistakes of having a long wish list and ad hoc interventions that do not contribute significantly to the overall FP-RH and Population agenda can be avoided by:

- **Using Evidence to Guide Programming and Planning** – Going forward UNFPA has a large body of evidence available to help rationalise and guide its future Country Programming. The key learning from past programming should be to focus on i) strategic areas likely to yield maximum impact, ii) selectively focus on doing well in rather than too many or too much, iii) conducting realistic stakeholder, policies and systems needs mapping focusing on who the key actors are across sectors, what messages would resonate with them, what are existing capacities, what interventions/efforts have been tried and worked (or did not work) in the past, and why things did not work, and iv) ensuring that the feedback or accountability loop is present and functioning.

- **Targeted Advocacy and Measuring -** Advocacy for policy or practice change is a complex process and in order to be effective must have clear advocacy objectives, target audiences, expected outcomes and specific interim milestones clearly identified. Regardless of what picture emerges, whether UNFPA will focus on upstream and/or downstream advocacy, it is crucial to i) have an in-house trained *Advocacy* expertise who can strategically guide and advise on results that are being achieved, review and develop advocacy pieces, work with communication experts on how to package the messages for different audiences, ii) routinely monitor the progress, and iii) provide feedback to partners on corrective changes during the process.

  Advocacy must also take into consideration the need for demand creation i.e. community level to increase the uptake of FP and RH services and create a wider grass-root support. Possible ways are to engage community based civil society organisations – either directly, but preferably via larger national NGOs – to understand the variable local context in communities across Pakistan and then to identify locally nuanced solutions in RH, FP or rights. For example this may include working with elected district officials in one community and directly with families in another.

- **Capacity Building as Part of a Holistic Capacity Building Programme, not Ad Hoc Activities** – For capacity building to be fully effective and achieve the desired results i.e. increased capacity of government and non-government partners to design, implement and supervise programmes and interventions, leading to supportive environments and healthier behaviours, reducing the impoverishing effects of poor RH, and improving overall RH and Population outcomes it must be part of an overall strategic plan.

  UNFPA in collaboration with partners should develop a "***Capacity Building Programme***" with several dimensions such as i) longer term support to academic institutions to conduct technical analysis, in areas that are critical but deficient in Pakistan such as economic demography, statistical demography, and anthropology, ii) support management and supervision skill development in RH-FP and Population issues across cross-sector departments/line ministries so as to embed population as a central issue in planning and implementation, iii) support the government's plans in training front line providers in delivering quality of services and following up on the outcomes, iv) support to operations research leading to the development of cost-effective interventions and protocols; and (v) support to organisations active in technology and information transfer to community levels for building community awareness and reducing information asymmetry, in order to complete the feedback and accountability loop between planners, implementers and beneficiaries of programmes.

  The Capacity Building Programme should have a well-articulated programme logic for each category of support, M&E framework, exit strategy and measurable performance indicators that are routinely (i.e. six monthly) reviewed and incorporated into programme adjustments.

- **Knowledge Management Sustainability and Utility -** Knowledge management is a powerful tool that UNFPA can strategically use to improve the generation of knowledge in FP-RH and Population Development research, share and manage the information, and take it one step further to use it for advocacy and for improvement in best practices in Pakistan. There are several Knowledge Management models that UNFPA can draw upon such as i) UNDP/UNFPA/WHO/World Bank

Special Programme of Research, Development and Research Training in Human Reproduction (HRP) that seeks to strengthen research capacity and use in developing countries through Long Term Institutional Development Grants (LID), ii) UNFPA Innovation Accelerator (East and Southern Africa Regional Office UNFPA) funded by DFID to reduce maternal deaths and increase innovative ways of enhancing the SRHR body of knowledge through social entrepreneurship, and iii) UNFPA Thailand – MDF Asia model that is working with private research institutions to develop, organize and share the evidence and best practices, and iv) Local Consortia and Models such as linking data producing government entities such as the Pakistan Bureau of Statistics with the many semi government entities (example the National Institute of Population Studies - NIPS), academia (Lahore University of Management Sciences – LUMS) and local private think tanks (Research and Development Solutions – RADS, Population Council etc.) to identify the strengths of each partner to analyse existing data (according to their strengths and mandates), produce different aspects of evidence and provide feedback on quality of data and other information needs.

This latter function is much needed to improve the quality of data from national surveys. For example there are marked variations in CPR and full immunization rates from DHS and PSLM data from the same year, despite both surveys sharing the rationale for their sampling frames. Additionally, different national surveys have elements that are pertinent for RH but use these effectively would require triangulating these surveys with programming results, demographic projections or other streams of information to yield high quality of actionable information at relatively low costs.[Error! Bookmark not defined.] The consortium can introduce these skills into the newly forming programming support units within provincial health departments (although a private core must be maintained as interest and political will to use evidence varies at times within the public sector). UNFPA can both support the work and also help to connect it with different stakeholders within government and beyond. *UNFPA must both promote the use of evidence to government decision makers and help identify means and avenues to ensure this use.*

- Develop an open access website for Knowledge Management and Information Sharing which presents the best practices, lessons learned and also transparently shares the progress on various policies and interventions.

Recommendation 8

UNFPA should operationalize its monitoring framework to rigorously measure and monitor outcome level results rather than just outputs.

Priority Level – High
Responsibility – UNFPA Country Office, Government

Operational Implications

- **Monitoring Framework and Tools –** In the next phase of programming UNFPA should pay strong attention to developing a clear *Monitoring Framework* with well thought out programmatic strategies, objectives and planned activities. The programme objectives should be classified in the short (i.e. <1 year), intermediate (1-2 years) and longer term horizons (by 4 years), with clarity on the associations between activities and external and internal factors in order to achieve results. Learning from CP8, the Monitoring Framework should be informed by a clearly analysed theory of change model for each of the interventions proposed and focus more on measuring outcomes (versus outputs).

  Converting the Monitoring Framework into a corresponding *M&E plan/monitoring tool* is just as important to track the progress. Findings from the M&E should be used to inform collective learning of the implementing partners, government stakeholders, UNFPA management, and if applicable be

shared with end-beneficiaries and with communities. M&E (both internal and external) should be considered as an incremental process to enable change.

Annexes

Annex 1: Pakistan 8th Country programme evaluation terms of reference

OBJECTIVE OF THE EVALUATION
The objectives of the independent evaluation of the UNFPA 8th country programme for Pakistan are:

1. To provide the UNFPA, Government of Pakistan and other stakeholders with an independent assessment of the relevance and performance of the UNFPA 8th country programme;
2. To provide an analysis of how UNFPA has positioned itself within the development community and national partners with a view to adding value to the country development results;
3. To draw a focused set of strategic and actionable recommendations that serve as a foundation to inform the development of the next programming cycle in terms of strategic content as well as in terms of implementation issues.
4. To draw key lessons from past and current cooperation and provide a set of clear and forward- looking options as well as strategic and actionable recommendations for the next programming- cycle.

Besides the assessment of the intended effects of the country programme, the evaluation also aims at identifying potential unintended effects.

SCOPE OF THE EVALUATION
Country Programme Evaluation (CPE) will focus on i) an independent assessment of progress of the programme towards expected outputs and outcomes and ii) provide key inputs for the development of the next Country Programme (CP9) which will be submitted to UNFPA's Executive Board for consideration in 2017. It will also provide an assessment of UNFPA's strategic positioning within the development efforts in-country.
Thus the evaluation of 8th Country Programme should assess UNFPA's comparative advantage in the field of Policy Advocacy, Youth/ASRH, RH in regular and humanitarian settings and population and development as outlined in the programme outputs.
The evaluation will cover all activities planned and/or implemented during the period 2013-2016, under both the development programme of assistance and the humanitarian programme.
The evaluation exercise will cover the national as well as the provincial level initiatives of the country programme thus covering 4 geographical locations (1 federal and 3 provincial) and include the programmatic focus of both development work and humanitarian assistance.

EVALUATION CRITERIA AND EVALUATION QUESTIONS
In accordance with the methodology for CPEs as set out in the Evaluation Office Handbook on How to Design and Conduct Country Programme Evaluations (2013)6, the evaluation will be based on a number of questions (limited to a maximum of ten) covering four main evaluation components. The evaluators will assess the relevance of the UNFPA country programme including the capacity of the CO to respond to the country needs and challenges. The evaluators will also assess progress in the achievement of outputs and outcomes against what was planned (effectiveness) in the country programme action plan (CPAP) as well as efficiency of interventions and sustainability of effects. The indicative questions based on the above four main components are given below:
RELEVANCE
1. To what extent are the objectives of the programme (i) adapted to the needs of the population (including needs of vulnerable groups), (ii) aligned with government priorities (iii) as well as with policies and strategies of UNFPA?
EFFECTIVENESS
2. To what extent have the interventions supported by UNFPA in the field of reproductive health contributed to an improved access to family planning, ASRH, and midwifery services at community level?
3. To what extent have the interventions supported by UNFPA in the field of population and development contributed to the availability and use of data on population issues both at federal and provincial levels for informed decision making?
4. To what extent has UNFPA contributed to an improved humanitarian response in the area of sexual and reproductive health and addressing issues of Gender Based Violence in emergencies?
EFFICIENCY

5. To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the outcomes defined in the UNFPA country programme and in its response to humanitarian crisis?

SUSTAINABILITY

6. To what extent have the partnerships established by UNFPA built capacities to respond to development and humanitarian needs and promoted national ownership of supported interventions, programmes and policies?

Besides the above standard evaluation criteria, the programme will also be assessed against the following specific criterion, with a view to characterizing the strategic positioning of UNFPA within the UN system in Pakistan:

ADDED VALUE

i. What are the main comparative strengths of UNFPA in Pakistan – particularly in comparison to other UN agencies?

The questions listed above are only indicative; the final set of evaluation questions will be determined during the design phase, after a discussion with the evaluation reference group.

EVALUATION METHODOLOGICAL APPROACH

The evaluation team will use a mixed method approach, including qualitative as well as quantitative data gathering. The results framework will guide the assessment of results achieved. The evaluation will make use of participatory approach, including a wide range of relevant stakeholders in the various stages of the evaluation process. The use of multiple-methods and the involvement of a variety of stakeholders will be used in data triangulation and will reduce the reliance on the single source data and enhance the validity of the data.

Methods for Data Collection

The evaluation will use a variety of data gathering methods including document review, group and individual semi-structured interviews, focus group discussions and observations. Since each method has its unique strengths and weaknesses, the evaluators will combine them in a way that uses the comparative strengths of one approach to correct for the relative weaknesses of others. The triangulation techniques should be systematically applied throughout the evaluation process which means the evaluators must double or triple check the results of the data gathering by way of cross-comparing the information obtained via each data collection method (documentary review, individual interviews, group discussions, focus groups) and through different data sources (e.g. compare results obtained through interviews with government staff with those obtained from statistical data). Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with UNFPA programme officers and the evaluation reference group members. The evaluation process will include meetings with UNFPA country office staff, government agencies and other stakeholders in Islamabad with field visits to selected provinces at the sub-national level. Details of the methodology will be finalized during the design phase and will be specified by the evaluation team in the design report.

Methods for Data analysis and validation

The use of variety of methods by the Evaluation Team will ensure that the results of the data gathering process are credible and the analysis is evidence-based. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers and presenting and discussing preliminary findings with the CO and the reference group. The analysis will be made at the level of programme outputs and corresponding components and their contribution to outcome level changes as well as in terms of cross cutting issues such as gender, partnerships etc. The analysis will also address the managerial aspects of programme design and implementation.

Sampling of stakeholders and project locations

Considering the large geographic coverage and the wide range of stakeholders of UNFPA CP8, Country Office will provide an initial overview of stakeholders. This stakeholders mapping will reflect the variety of interventions in terms of programme components and region. Based on this initial stakeholder map, and informed by the desk review, the evaluation team will select a sample of stakeholders for data collection clearly identifying the selection criteria applied. Stakeholders will be selected from National as well as provincial level (Khyber Pakhtunkhwa, Sindh and Punjab provinces). Field locations within selected provinces will be selected based on the initiatives of programme components within the province.

Stakeholder participation
An inclusive approach, involving a broad range of partners and other stakeholders, will be taken. The evaluation team will further develop the initial stakeholder mapping provided by the country office, including both UNFPA direct as well as indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). Stakeholders include representatives from National and sub-national Government agencies, civil-society organizations, the private-sector, other UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.
Limitations to the methodology and constraints to the data collection process
Certain constraints have been identified during the preparatory phase that may impact the data collection process. These include:
 Unavailability of key government officials and other stakeholders for data collection. Lack of robust population data mainly due to postponement of the census and other key surveys. Other constraints such as security situation, extreme weather conditions and occurrence of natural disasters may also affect the data collection process.
The evaluation team will assess the limitations and conclude with a clear description of mitigating measures such as triangulation and validation in the design report.
Ethical Considerations The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG) (Ref: Annex 2). The evaluation process should conform to the relevant ethical standards in line with UN Ethical Guidelines for Evaluation, including but not limited to informed consent of participants, privacy, and confidentiality considerations. Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

EVALUATION PROCESS
The evaluation will unfold in five phases, each of them including several steps:
i. Preparatory process This phase will include: drafting of terms of reference for the evaluation; gathering of initial documentation regarding the country programme (including a list of Atlas projects); selection and recruitment of the external evaluation team; constitution of an evaluation reference group; orientation of UNFPA main national partners to the evaluation process; refining the scope of the evaluation (and the formulation of evaluation questions);
ii. Design Phase This phase will include: documentary review of all relevant documents available at UNFPA Country Office and Sub office level regarding the 8th Country Programme 2013-2017 for the period under assessment; Stakeholder mapping – The evaluation team will develop a mapping of stakeholders relevant to the evaluation making use of an initial overview provided by the country office. The mapping exercise will include state, civil-society and other relevant stakeholders and will indicate the relationships between different sets of stakeholders; assess limitations to the data collection process and mitigation measures. a review of UNFPA specific results matrix from CCPD and the intervention logic of the programme that leads from planned activities to the intended results of the programme; the finalization of the list of evaluation questions; the preparation of the evaluation matrix the development of a data collection and analysis strategy as well as a concrete work plan for the field phase.
At the end of the design phase, the evaluation team will produce a design report (Ref: Annex 3), displaying the results of the above-listed steps and tasks.
iii. Field Phase After the design phase, the evaluation team will undertake a three week in-country mission to collect and analyze the data required in order to answer the evaluation questions as agreed upon at the design phase.
At the end of the field phase, the evaluation team will provide the CO with a debriefing presentation on the preliminary results of the evaluation and will hold a validation meeting, with a view to present the findings, preliminary conclusions and recommendation and validating preliminary findings and testing tentative conclusions and recommendations.
iv. Reporting Phase During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a first draft of the evaluation report, taking into account comments made by the CO at the field phase debriefing meeting. This first draft report will be submitted to the evaluation reference group and APRO regional advisor for comments (in writing). Comments made by the reference group will then allow the evaluation team to prepare a second draft evaluation report. The second draft of the evaluation report will undergo an evaluation quality assessment by the country office evaluation manager with support from M & E Advisor from UNFPA Regional Office.

This second draft final report will form the basis for an in-country stakeholder workshop, which should be attended by the CO as well as all the key national programme stakeholders. The final report (Ref: Annex 4) will be drafted shortly after the workshop, taking into account comments made by the participants.
v. Management response and dissemination phase During this phase, the country and regional office as well as relevant division at UNFPA headquarters will be informed of the results of the evaluation. A response will be prepared on the recommendations and once finalized; this document will become the management response to the evaluation (Annex II).
The evaluation report, along with the management response, will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

Annex 2: List of persons/institutions met

Province/Location	Organization	Stakeholder
Federal		
Islamabad	UNFPA	Country Rep Dep. Country Rep Programme Specialist M&E
Government	Planning Commission	Member Social Sector
	Population Welfare Wing	DG
	NHSRC	Secretary or DG
	EAD	UN Agencies/WB Coordination
	PBS	Secretary or DG
		Focal person for census
		Training Recipient (2-3)
	NIPS	ED or DG
		Training Recipient (2-3)
		Focal person for Research and Policy
	Health Services Academy	DG
		Focal person for UNFPA Coordination and Research
	PIDE	Focal person for Research and Policy
	Pakistan Red Crescent Society	ED or Focal Person for Disaster Relief
	NDMA	ED or DG
IP's	Population Council	GBV Coordinator
		Country Rep
		Programme Manager
	Pakistan Nursing Council	Manager Programmes
	Pathfinder	Country Rep + Programme Manager for UNFPA
	Muslim Aid	Programme Manager
	Rozan	Programme Manager
	Rutgers WPF Pakistan	Head of Program
		Parliamentarians - Perspectives
	Aurat	Programme Manager
UN/Donors	UNICEF	MCH Focal person
	UNDP	Development and Humanitarian Focal person
	UNAIDS	HIV Focal Person
	UNOCHA	Humanitarian and UNFPA Focal person
	UN Women	Country Rep
	One UN	Country Rep
		M& E Focal Person
	WHO	MCH, RH and HIV Focal Person
	USAID	Health Focal
	DFID	Health Focal
	World Bank	Health Focal
	ADB	Social Service Focal Person

	GIZ	Health Focal person
Sindh		
	UNFPA	Provincial Coordinator
Government	Planning and Development	Focal for Social Sector or Health
	PWD	Secretary or DG
		Focal Person for UNFPA programming
		Visit RTI (Asif)
		Visit Fistula Clinic (Ayesha)
	DoH	DG or Secretary
		Focal Person for MCH
		Focal Person for LHW
		FGD with 6-8 LHWs or CMWs on youth and ASRH trainings
	SACP	Programme Manager
	PDMA	Focal Person for UNFPA
IP's	MSS	Programme Manager
	Pakistan National Forum for Women's	
	AKU	Mid-Wifery Coordinator and Training Programme
	Greenstar	Programme Manager
Donors	Packard-Gates	Country Rep.
Punjab		
	UNFPA	Provincial Coordinator
Government	Planning and Development	Focal for Social Sector or Health
	PWD	Secretary or DG
		Focal Person for UNFPA programming
	DoH	DG or Secretary
		Focal Person for IRMNCH
		Focal person for PSPU
		LHW Focal person
		UNFPA Research Coordinator
	Ministry of Youth Affairs	Secretary or DG
		Visit RTI Lahore
		Visit FP voucher & Newly Wed counciling center (Sargodha)
		FGD with 6-8 LHWs or CMWs on youth and ASRH trainings
	PDMA	Focal Person for UNFPA
IP's	FPAP-Rahunuma	Programme Manager
	Contech International	Head of Programme
	Bargad	Head of Programme
Khyber Pakhtunkhwa		
	UNFPA	Provincial Coordinator
Government	Planning and Development	Focal for Social Sector or Health
	PWD	Secretary or DG,
		Focal Person for UNFPA programming,
		Focal person for Demographic cell
	DoH	DG or Secretary,
		Focal Person for IRMNCH
		Focal person for HSPU
		LHW Focal person
	PDMA	Focal Person for UNFPA
	FDMA	Focal Person for UNFPA
IP's	Sarhad Rural Support programme	Focal Person for UNFPA
	Bente Hawa Peace & Development Organization - BPDO	Programme Manager or Focal Person for UNFPA
	Society for Human and Environment Development	Programme Manager or Focal Person for UNFPA
		Visit RTI Peshawar
		Visit Humanitarian Camp, IDPs visit

Annex 3: List of Documents Reviewed

1. UNFPA Strategic Plan 2010 – 2013, and 2014-2017. UNFPA
2. UNFPA PAK CP8 CPAP Core Action Plan 2013-2017 – Aligned with UNDAF/OPII
3. CPAP Core Action Plan Aligned with UNFPA Strategic Plan 2014-2017 (Programme Management Plan)
4. Final Common Country Programme Document for Pakistan 2013
5. UNFPA Results and Monitoring Matrix 2013-2016
6. UNFPA 8th CPAP: Programme Management and Operational Strategies
7. UNFPA 8th CPAP: Resource and Business Plan
8. SWOT Analysis Of Key Partners at the Design of CP8
9. Stakeholder Mapping UNFPA (2012-2016)
10. MTDF Government of Pakistan
11. Vision 2025 Government of Pakistan
12. OP II 2013-2017
13. OP II Mid-term Evaluation Report (2016)
14. Population Situation Analysis (Gavin Jones) 2016 UNFPA
15. Landscape Analysis of Family Planning in Pakistan. Population Council 2016
16. Country Office Annual and General Reports 2013-2016
17. Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA, UNFPA Independent Evaluation Office, October 2013.
18. Progress Reports of Implementing Partners in RH, ASRH and FP (2013-2016)
19. Pakistan Demographic Health Survey 2006 and 2012
20. Pakistan Social and Living Standards Measurement Survey 2014-15. Pakistan Bureau of Statistics
21. Pakistan Economic Survey 2014-15
22. Multi-Indicator Cluster Survey 2014 Pakistan. UNICEF
23. Vision 2020 Government of Pakistan. Planning Commission
24. Provincial Health Sector Strategies for Punjab, Khyber Pakhtunkhwa and Sindh. Department of Health website (download 2016)
25. Pakistan Framework for Economic Growth (2011) Sectoral Strategies for the 10th 5 year Plan. Planning Commission
26. Leveraging Urbanisation in South Asia. World Bank 2015
27. Pakistan's Post-2015 Development Framework Report On Consultative Process with CSOs, Experts and Marginalised People. Awaz 2015
28. Population and SDGs Relevance for Pakistan. Sajjid Akhtar 2015
29. Status of World Population UNFPA 2015
30. Pakistan-Country Partnership Strategy. World Bank 2015
31. UNFPA Country Evaluation Reports of Bangladesh (2015) and Turkey (2011)
32. UNICEF Ethical Guidelines for Evaluation 2013.

Annex 4: Evaluation Matrix

Evaluation Assumptions	Indicators	Sources of Information	Methods and Tools for Data Collection
Relevance **EQ1: To what extent are the objectives of the UNFPA 8th CP adapted to the needs of the population (including vulnerable and marginalised groups), and 2) Aligned with the government and UNFPA priorities**			
1.1 The CP8 took into account the evolving needs of vulnerable and marginalised populations particularly women (including in humanitarian settings) during the design and implementation processes.	▪ Documentary evidence of needs assessments, alignment of CP with UNDAF, OPII, and national documents prior to CP8 design and development ▪ Extent to which the programmes and interventions had flexibility to meet changing needs i.e. re-targeting ▪ Extent to which target beneficiaries were consulted and had access to feedback on services, policies and programmes.	OPII, CCPD (Comon Country Programme Document,, Second One UN Programme OPII, UNFPA 8th CPAP AWPs National/provincial documents and strategies 3rd party independent surveys (PDHS, MICS, PSLM etc) Interviews with key stakeholders – government, donors, civil society, NGOs, academia, and end beneficiaries	Semi-structured IDIs with UNFPA CO, implementing partners, donors, government partners, beneficiaries in communities, NGOs M&E reports – annual reports Triangulation of district data on gender, humanitarian outcomes, budgets and plans.
1.2 The objectives, strategies and interventions of the CP8 are consistent with government policies and priorities (national and provincial) and are planned with evidence-based knowledge of sub-national structures in the selected components (i.e. RH, MH, PD, and capacity building)	▪ Review consistency of 8th CP activities with government and UNFPA and OPII documents ▪ Extent to which the interventions and activities were participatory, inclusive, relevant and timely ▪ The 8th CP set out relevant goals (and measured) to increase national and provincial capacities ▪ Evidence of UNFPAs contribution to Government policies and plans		Review of global UNFPA mandate in RH, MH, PD, humanitarian, GBV and gender equality, capacity building, knowledge management, and policy advocacy – country specific needs and comparisons Field visits to intervention areas and IPs IDIs and FGDs with stakeholders (stakeholder mapping) Triangulation of independent data
Responsiveness **EQ2: To what extent was the Country Office able to respond to the changes in the national development context and in particular to emerging humanitarian contexts?**			
2.1 UNFPA 8 CP activities were responsive and flexible to emerging county needs particularly unforeseen emergencies or humanitarian crises	▪ Timeliness of response ▪ Inclusiveness and coordination with other development partners ▪ Support from UNFPA regional and global office ▪ Level of staff capacity and resources to meet the new requirements ▪ Relevant adjustments in the AWPs/Country Plan of Action	▪ Document review of Atlas projects, staffing, and funding budgets ▪ Independent reviews and monitoring reports (UNFPA, others) ▪ Interviews with government, UNFPA, donors, NGOs	Semi-structured IDIs with UNFPA CO, implementing partners, donors, government partners, beneficiaries in communities, NGOs M&E reports – annual reports
2.2 UNFPA country office was appropriately responsive to emerging development priorities (i.e. capacity building, resources, or others)	▪ Type of the response ▪ Reallocation of funds, human resource, to new activities		
Effectiveness **EQ 3: To what extent have the interventions supported by UNFPA in reproductive health contributed to an improved access to family planning, ASRH, and midwifery services at the community level?**			
3.1 The CP8 activities have contributed to increased demand, access and utilisation including enhanced service delivery in family planning, ASRH and	Intervention districts have higher (comparison from baseline): ▪ CPR ▪ No. (%) Trained female	▪ Provincial-district data (PDHS 2012, MICS, DHIS, planning and monitoring units data) ▪ IP partner reports	▪ Documents review and comparison ▪ Meetings with government, donors, NGOs, district

community midwives (CMWs) or skilled female providers at the community level (CPAP output 1.1 and 1.2).	service providers in SBA and FP counselling-services ▪ No. (%) Facilities with newlywed counselling ▪ Midwifery curriculum improvements and trainings ▪ No. (%) of government (DoH and PWD) that have protocols for YFSS	▪ UNFPA Annual reports (2013-2016) ▪ Health system staff and care providers ▪ Women/service recipients in communities	authorities, ▪ FGDs with end beneficiaries and service users ▪ Interviews with IPs, academia, and trainees ▪ Observation from field visits ▪ Review of training documents and 3rd party findings
3.2 The activities implemented to enhance adolescent and youth friendly behavioural change information and services in RH and FP have reduced early age marriages, early pregnancies and HIV/AIDS (CPAP sub-output 1.2.1 and 1.2.2)	▪ No.(%) of youth friendly services delivery points in districts ▪ No. of CYPs from voucher programme ▪ % of LHWs with knowledge skills in ASRH, FP and MH ▪ % of gatekeepers with accurate knowledge-skills in FP, RH and ASRH ▪ Provincial bills on early age marriage – passed and implemented ▪ Number of youth policies ▪ District or programmatic data on reductions in early age marriages and pregnancies	▪ Baseline data – PDHS, MICS and district level (3rd party) ▪ IPs coverage and out-reach data ▪ Provider and service recipients in communities	▪ Document review ▪ Data analysis – triangulation ▪ Stakeholders interviews and FGDs as per stakeholder mapping ▪ Field visit and observations ▪ Discussions with NGOs (MSS, Pathfinder, PC, SACP, Impact Development) on implementation processes and outcomes
3.3 FP voucher Interventions targeted at the poorest, marginalised and youth populations have increased access, uptake and utilisation of FP services in selected districts (CPAP output 1.3.1)	▪ No. of FP users have increased in poor and marginalised populations (subjective perception of providers through clinic traffic, uptake etc)	▪ ▪ ▪ ▪ Data triangulation – comparison baseline and current ▪ Utilisation (DHIS, IP coverage data) ▪ Interviews with government and IPs ▪ Training assessments	▪ FGDs with end beneficiaries of services ▪ Data analysis
3.4 The activities to improve education, leadership capacity and quality in service delivery of female providers (nurse midwives, CMWs, LHWs, LHVs, FWWs) has contributed to increased access to maternal health, delivery and FP services (CPAP output 1.3.2 and 1.3.3)	▪ No.(%) of government facilities (BHUs, RHCs, FWCs) that have trained service providers – comparison baseline to current (2016) ▪ Utilisation trends in maternal health and FP services 2013-2016		▪ FGDs with community beneficiaries and training recipients ▪ Interviews with government and IPs implementers on service changes ▪ Data analysis
3.5 High level political will and alliances to support FP have translated into a supportive policy or programme environment to benefit end beneficiaries (CPAP sub-output 1.1.1)	▪ % Representation level of political commitment by provinces and national ▪ No. of FP targeted Conferences ▪ % actions committed or completed on FP outcomes ▪ % media engagement and articles on FP specific topics in local press or forums	▪ Meeting reports and actions ▪ Attendance records ▪ Signed provincial policies and strategies supporting FP2020 commitment ▪ IP and UNFPA Annual reports	▪ Document review on the situation analysis – political and media support ▪ Outcomes of actions – what actions were taken? ▪ Interviews with NGOs, donors, government ▪ Analysis of provincial budget allocations and costed plans implementation plans on FP
EQ4: To what extent have the intervention supported by UNFPA in population and development contributed to the availability and use of data on population issues both at the federal and provincial levels for informed decision making?			
4.1 Programme activities have contributed to increasing data use, analysis and information at the national, provincial and district level for policies and plans (CPAP output 2.1)	▪ ▪ ▪ No. of government staff trained in RH, PD, and gender issues ▪ No. of national or provincial plans or documents with	▪ ▪ ▪ Training reports ▪ Attendance records ▪ Type of participants and nomination or selection criteria	▪ ▪ ▪ Document review ▪ Relevance and selection of participants ▪ Analysis of use of training – post training
4.2 Programme activities have			

contributed to building capacity in government partners to analyse data on RH, PD and gender and use (CPAP sub-output 2.4.1)	emphasis on RH, PD and gender issues during the CP8 period ▪ No. of institutions with increased capacity for use of evidence	process ▪ Provincial and national plans	actions? ▪ Interviews with trainees, government, academic institutions (PBS, PIDE) , donors, NGOs
4.3 Capacity building activities have led to improved outcomes in evidence generation, use and policy reforms (CPAP sub-output 2.4.2)	▪ No. of provincial strategies/policies that have evidence-based planning, design or learning (documented) ▪ No. of policy papers or documents with evidence base	▪ Provincial and district documents ▪ Policy papers or documents	▪ Interviews with government, donors and UNFPA on policy changes or reforms ▪ Document review
4.4 UNFPA has been able to coordinate efforts to conduct a national census of population and housing (CPAP sub-output 2.4.3).	▪ Progress on national census on population and housing	▪ Process documents – advocacy, meetings, resource mobilisation, future plans for census survey	▪ Interviews with government, donors and UNFPA on progress of census survey ▪ Document review
EQ5: To what extent has UNFPA contributed to an improved humanitarian response in the area of sexual and reproductive health and addressing issues of Gender Based Violence (GBV) in emergencies?			
5.1 Programme activities have helped government partners (provincial and national health and population welfare departments) develop capacities to plan, implement and monitor universal access to RH including in humanitarian settings (CPAP out 1.3)	▪ No. and presence of Disaster preparedness committee's – inter agency GBV coordination ▪ Clear TORs for management of SRH, GBV and MH by provincial institutions ▪ No. of provincial plans with SRH and GBV	▪ Disaster management plans ▪ Committee meetings – minutes ▪ Prioritisation of RH and GBV	▪ IDIs with PDMA/NDMA and government on plans and planning exercise ▪ Document review for relevance to RH, GBV activities
5.2 UNFPA has been able to support partners in elimination of GBV and SRH in humanitarian, transition and recovery settings in an integrated disaster management approach (CPAP output 1.3.4 and 1.3.6)	▪ Support level and duration – acute, transition or rehabilitative ▪ Exit strategy ▪ No. of humanitarian activities supported	▪ Process documents and interviews to review level of advocacy, meetings, resource mobilisation, future plans for government ownership	▪ Document review ▪ Interviews with government, IPs and UNFPA on the plan, implementation and challenges
5.3 UNFPA support has enabled integration of fistula prevention, treatment and reintegration in RH services by provinces (CPAP output 1.3.5)	▪ No. of recipients that received treatment or referrals ▪ Institutionalisation of the process – what stage	IP and monitoring reports	
5.4 Programme interventions including joint programme activities set in place mechanisms that improved MNCH and FP ownership and durability of the effects (CPAP output 1.3.7 and 1.3.8)	▪ Documentation of ownership by the government (provincial and national level)	▪ Document review – PC1 ▪ Provincial and national plans ▪ Interviews with stakeholders in government, donors, UN agencies	▪ Interviews with government, donors and UNFPA on mechanisms and ownership through budget allocations, PC 1s ▪ Document review
EQ 6: To what extent were the principles of equitable access, right-based approach and gender-responsiveness integrated in UNFPA 8th country programme and its interventions/activities?			
6.1 CP8 programme activities, UNFPA management and engagement with partners adhered to gender equality and rights based approach that promoted gender equality (cross-cutting)	▪ Gender equality in mainstream programme activities (observations and documented) ▪ Number of documents (IPs and partners) that have gender and rights based strategies in their plans, design, or implementation	▪ Document review ▪ Interviews with stakeholders in government, donors, UN agencies	▪ Interviews of stakeholders and observations by the evaluation team in review of the documents/discussions.
<u>Efficiency</u> EQ7: To what extent has UNFPA made good use of its human, financial, and technical resources, and used appropriate combination of tools and approaches to pursue the outcomes defined in the country programme and its response to humanitarian crisis?			
7.1 Beneficiaries of UNFPA	▪ Beneficiaries received	▪ Partner discussions	▪ Interviews with UNFPA

support received the committed resources as per approved budget and work plans in a timely manner	support as per AWPs ▪ The resources were timely and appropriate ▪ Budgets disbursement have clear policies (documented ▪ Inefficiencies were identified and corrected in a timely manner	and interviews ▪ Audit and monitoring reports ▪ COARs	administrative staff, government and NGOs, donors on the coordination, complementarity of implementation ▪ Review of financial documents ▪ Discussions with end-beneficiaries
7.2 UNFPA was successful in leveraging its resources and position to meet CPAP objectives and emerging needs particularly in humanitarian settings	▪ Evidence that UNFPA was able to mobilise or leverage appropriate funds- from government, donors, other sources etc. ▪ Evidence that the resources provided by UNFPA triggered the provision of additional resources from other partners	▪ UNFPA CO staff finance, admin ▪ Partners (implementers and direct beneficiaries) ▪ COARs and monitoring reports.	
7.3 UNFPA's administrative, financial, and technical and implementation modalities are transparent, timely, and facilitate smooth execution of the programme activities.	▪ Review on the appropriateness of the administrative, financial, partner selection criteria by CP8 management. ▪ Adequacy of the mechanisms to implement an integrated approach.		
Sustainability, Outcomes and Impact **EQ8: To what extent was the 8th CP able to create a supportive environment for and strengthen service delivery access, evidence use, policy advocacy for RH, FP and Population Development in Pakistan?**			
8.1 UNFPA CP8 programme design, activities and implementation added value to the RH, FP, ASRH, PD, evidence use and policy advocacy landscape in Pakistan	▪ Evidence of changes in the national landscape for RH, ASRH, FP and MH, and PD – possibly attributable to UNFPA direct activities or through advocacy effects.	▪ Document review of changes 2013 onwards – comparison ▪ Indicators or trends	▪ Document review on the situation analysis ▪ Interviews with NGOs, donors, government ▪ Analysis of provincial budget allocations and costed plans implementation plans in the 4 components
Partnerships and Coordination **EQ9: How far and in what ways have the partnerships established by UNFPA built capacities to respond to development and humanitarian needs and supported national ownership of interventions, programmes and policies?**			
9.1 The UNFPA country office has actively contributed to improved coordination and partnership mechanisms between government, civil society, donors, and other UN agencies for improved performance	▪ ▪ Evidence of participation or lead in donor working group, UN Agencies, provincial steering committees. ▪ Evidence of exchanges of information between UN agencies ▪ Evidence of joint programming initiatives (planning) ▪ Evidence of joint programming ▪ Evidence of mapping to avoid duplication	▪ Meeting reports ▪ Documents review ▪ Discussions with stakeholders- government, partners, UNFPA, UN Agencies	▪ Document review ▪ Interviews with NGOs, donors, government ▪ FGDs with end-beneficiaries
9.2 UNFPA country office has avoided duplications and overlaps in the CP8 programme activities and built synergies among the various interventions and stakeholders	▪ Evidence of coordination and information sharing with other donors, stakeholders	▪ Document review ▪ Discussions with stakeholders	
9.3 The main comparative strengths of UNFPA have been identified and built upon in designing and implementing the	▪ UNFPA comparative strength has been fully identified and built upon in public, private and with	▪ CPAP, CCPD, OPII, and country strategy for external assistance or donors	

CP8	other donors and UN Agencies. ▪ Partners' views on UNFPA's added value have been captured.	▪ Data sharing – databases with other donors	

Annex 5: Interview Guidelines

QUESTIONNAIRES / INTERVIEW GUIDES

Focus Group Discussions (FGDs): Community Beneficiaries (Development and Humanitarian Settings)

Salaam Alikum!
I am _____ and we are conducting an evaluation of the UNFPA 8th Country Programme activities and services – some of which you may have participated in or used. I would appreciate if you can kindly share your experiences and perceptions of these services, information or trainings.
Please be assured that this interview/FGD is voluntary, and all your responses will be confidential. The discussion will take 1 hour or so, and we will be taking notes. If you have any questions please feel free to ask them any time. Do you agree to participate (yes or no).

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

Themes	Probe
1. **Equity and Gender Equality - Socio- Demographic Characteristics of End Beneficiaries** a. Observation – users of services. Ask who were the users of services? b. Did the services successfully reach the poorest, women and girls, youth, newly married couples, people/marginalised? c. Women, girls and children – were they an equal part? How so? d. **Note down if the settings are humanitarian – displaced populations**	Age group Education Occupation Marital status
2. **Relevance, Access, Availability, Reach of Services or Information (SPA 1, Equity, Quality, Coverage, Relevance)** a. Type of service? – Importance, what do they think? Which services did they mainly use? b. How did they learn of the programme? c. Duration of involvement or engagement with the programme? How long was the service available to the community for? d. Barriers to access? Difficulties or challenges met in accessing services? At what level – how was it overcome? e. Did their neighbours and other community also use the service? f. How was feedback on the use of services or information generated by IP or UNFPA?	Importance of which services to them? Reasons for use? How frequently were they visited by outreach? Perceptions and experience of both outreach and fixed facilities (public and private) Examples of feedback and programme change?
3. **Effectiveness - Experience value and (Behavioural Change) (Value added, Sustainability, Behavioural change)** a. Can you please describe your relationship with service provider? b. What was the extent of support provided? c. How will these services or practices be useful in the future?	Examples of support Examples of communication channels – is there a feedback loop? Examples of how their health behaviours have changed? Why? What are the concrete gains in their life because of the programme activities?
4. **Overall Perception and Suggestions**	Changes from this current model?

a. Suggestions for future programming? b. Strengths and weaknesses?

Focus Group Discussions (FGDs): Capacity Building of Training Recipients/Service Providers

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

Themes	Probe
1. **Equity, Rights-Based Approach Socio-Demographic Characteristics Recipients** a. Who were the recipients – roles, capacity b. How were they selected/identified? Was there personal interest or commitment to participate? c. Gender disaggregation?	Educational attainment Years in service, locals vs. outside General experience of their work, expectations of the trainings Department of affiliation? Changes/transfers
2. **Relevance/Effectiveness of the Type of Capacity Building (SPA 1 and 2, Effectiveness, Performance, Quality)** a. How did the training help you? b. What were the limitations and strengths of the training/programme? Were you able to give feedback or suggest changes? c. How/what did you learn of the programme/training? d. Have you received similar trainings before?	Type Their perceptions on utility Relevance of training Effectiveness Responsiveness of training to participant needs?
3. **Sustainability - Utility and Plan of Action for the Capacity Building (Sustainability, Effectiveness, Outcomes, Value Added)** a. What did you plan to do with the training? b. do you anticipate changes/transfers in the next 1 year?	Were the recipients/participants partners and included in deciding how the training would be used or useful to them (external imposition vs, internal engagement) Was there any re-entry planning during the last day of the training to enable you plan how to apply the training
4. **Behavioural or Practice Change (Institutional Capacity Building, Value Added)** **a.** How will you or how did you use this training? b. What changed for them? Time period of change? c. How is there institutional strengthening? Long term change?	Examples of change in their practice, understanding or approach? Evidence use, counselling, quality etc? Long term change?
5. **Overall Perception and Suggestions** Suggestions for future programming? Strengths and weaknesses?	Changes from this current model?

In-depth Interviews (IDIs): IPs/NGOs in Development and Humanitarian Settings

Evaluation Areas/Themes	Probe
1. **Equity, Rights-Based Approach - Socio- Demographic Characteristics of service/programme users? (Equity, Relevance, needs assessment, targeting of the most vulnerable, gender)** a. Who were the users b. IPs vision/mandate? c. Did the services successfully reach the most marginalised? d. Women and children – were they an equal part? How was that measured? (please be careful in localising these questions with respect to the SH and Context. E.g how will you ask this question from SH of PD	How was the programme design and implementation undertaken? What was the consultation process? Partners? **Identify type of project/intervention – 1) Policy advocacy, 2) ASRH, 3) FP and MH, 4) PD, and whether it was development or humanitarian context**
2. **Relevance of the intervention/activities to UNFPA and Pakistan's priorities?** a. How well is the alignment? To what b. How well does the intervention support relevant provincial priorities? (list which one) c. How well was the IP able to respond to emerging needs or changes (note down examples and communication with UNFPA/process of change)	Examples of alignment, relevance, responsiveness to emerging needs Country- national or provincial context, structures, ground realities Adaptation of programming? Feedback mechanisms – between end users-IP, IP to UNFPA Timeliness of response
3. **Effectiveness – in terms of access and quality of RH, ASRH, FP and MH, use of evidence, and response to disasters.** a. How was the IP selected? What is the significance of asking this question from IP b. Examples of the intervention is working? c. Objective measures – were they kept and available to verify progress (performance, results, M&E) d. What were the implementation challenges, barriers? (intervention specific) – how were they addressed? e. Who provided support – how? f. Can the capacities/services function without UNFPA support? g. Is there ownership? Who? Exit strategy h. What was UNFPA's value added?	Record numbers (coverage), quality, scale, targeting, utilisation, Increases in skills, capacity, service delivery, knowledge management, disaster preparedness, coordination Documented exit strategy or planning
4. **Efficiency – was UNFPA resources invested well** a. Examples how so – by category or type of support b. Duration of support c. Institutional mechanisms/other collaborations? Give examples d. Costs incurred vs. achievements - results	Details of human resource, technical assistance, financial, others What could have been alternate options? What existed before (and after) UNFPA support
5. **Functioning, Coordination and Value Added** a. General experience of working with UNFPA? b. Experience of working with other UN Agencies or donors? – ease, timeliness, responsiveness, c. Gaps that were missed or wrongly identified in the intervention? d. How did UNFPA support make a difference	Concrete examples of coordination Functioning of management processes – UNFPA-IP, other donors etc Examples of value added – note down.
6. **Other Issues or Recommendations for Future Programming?**	

In-depth Interviews (IDIs): Academic and Government Institutions in Evidence Use

Evaluation Areas/Themes	Probe
1. **Equity, Rights-Based Approach - Socio- Demographic Characteristics of service/programme users? (Equity, Relevance, needs assessment, targeting of the most vulnerable, gender)** **a.** The vision/mandate of the capacity building or training? **b.** Did the training intervention/design ensure that it would benefit the marginalised?	How was the intervention design and implementation undertaken? What was the consultation process? Partners? Institutional concurrence? (individual vs. institutional) **Identify type of project/intervention – 1) Policy advocacy, 2) ASRH, 3) FP and MH, 4) PD, 5) Capacity Building and whether it was development or humanitarian context**
2. **Relevance of the intervention/activities to UNFPA and Pakistan's priorities?** a. How well is the alignment? b. How well does the intervention support relevant CP8 outcomes and outputs? (list which one) need to check relevance with Government and UNFPA global priorities rather than only focusing on CP8 c. How well was the IP/institution able to respond to emerging needs or changes (note down examples and communication with UNFPA/process of change)	Examples of alignment, relevance, responsiveness to emerging needs Country- national or provincial context, structures, ground realities Adaptation of programming? Feedback mechanisms – between end users-IP, IP to UNFPA Timeliness of response
3. **Effectiveness – in terms of access and quality of RH, ASRH, FP and MH, use of evidence, and response to disasters.** a. How was the IP selected? What is the significance of asking this question from IP b. Examples of how the intervention is working? c. Objective measures – were they kept and available to verify progress (performance, results, M&E) d. What were the implementation challenges, barriers? (intervention specific) – how were they addressed? e. Who provided support – how? You mean other than UNFPA ? or who---- need explanation f. Can the capacities/services function without UNFPA support? g. Is there ownership? Who? Exit strategy h. What was UNFPA's value added?	Record numbers (coverage), quality, scale, targeting, utilisation, people trained. Increases in staff skills, capacity, service delivery, knowledge management, disaster preparedness, coordination Documented exit strategy or planning
4. **Efficiency – was UNFPA resources invested well** e. Examples how so – by category or type of support f. Duration of support g. Institutional mechanisms/arrangements or other collaborations that were enabled as a result? h. Costs incurred vs. achievements - results	Details of human resource, technical assistance, financial, others What could have been alternate options? What existed before (and after) UNFPA support
5. **Functioning, Coordination and Value Added** e. General experience of working with UNFPA? f. Experience of working with other UN Agencies or donors? – ease, timeliness, responsiveness, g. Gaps that were missed or wrongly identified in the intervention? h. How did UNFPA support make a difference	Concrete examples of coordination Functioning of management processes – UNFPA-IP, other donors etc Examples of value added – note down.
6. **Other Issues or Recommendations for Future Programming?**	

In-depth Interviews (IDIs): Government Ministries and Departments

	Evaluation Areas/Themes	Probe
1.	**Equity, Rights-Based Approach - Socio- Demographic Characteristics of service/programme users? (Decision making by Government, Equity, Relevance, needs assessment, targeting of the most vulnerable, gender)** a. Who did the intervention most support? Pro-poor? b. Who made the decision for supporting or requesting this specific intervention or programming? c. Did the intervention successfully reach the most marginalised? What were the safeguards at the planning or policy stage?	Government involvement in the design, planning and implementation processes? What was the consultation process? Partners? Institutional concurrence? (individual vs. institutional) **Identify type of government partner – Type of programming/project**
2.	**Relevance of the intervention/activities to Pakistan's priorities (provincial and national)?** a. How well is the alignment? b. GoP/partner role? Duration? c. How well does CP8/intervention support government priorities?? (list which one) d. Public-private partnerships – examples? e. How well was UNFPA able to respond to your emerging needs or changes (note down examples and communication with UNFPA/process of change)	Examples of provincial or national alignment, relevance, responsiveness to emerging needs Country- national or provincial context, structures, ground realities Adaptation of programming? Feedback mechanisms – between end users-IP, IP to UNFPA, Government-UNFPA? Timeliness of response
3.	**Effectiveness – in terms of access and quality of RH, ASRH, FP and MH, use of evidence, and response to disasters.** a. Examples of how UNFPA programming/interventions worked? b. Objective measures – were they kept and available to verify progress (performance, results, M&E) c. What were the challenges, barriers? – how were they addressed? d. Can the capacities/services function without UNFPA support? e. Is there government ownership?/ scaling up of intervention Examples? PC 1? f. What was UNFPA's value added?	Record numbers (coverage), quality, scale, targeting, utilisation, people trained. Increases in staff skills, capacity, service delivery, knowledge management, disaster preparedness, coordination Documented PC 1, budgetary inclusions, district planning etc
4.	**Efficiency – was UNFPA resources invested well** a. Examples how so – by category or type of support b. Duration of support c. Institutional mechanisms/ arrangements or other collaborations that were enabled as a result? d. Costs incurred vs. achievements – results compared to other donors support?	Details of human resource, technical assistance, financial, others What could have been alternate options? What existed before (and after) UNFPA support
5.	**Functioning, Coordination and Value Added** a. General experience of working with UNFPA? b. Experience of working with other UN Agencies or donors? – ease, timeliness, responsiveness, c. Gaps that were missed or wrongly identified in the intervention? d. How did UNFPA support make a difference in government agenda, service delivery, capacities, others?	Concrete examples of coordination Functioning of management processes – UNFPA-government, other donors etc Examples of value added – note down.
6.	**Sustainability and Institutional Strengthening** a. How will you sustain the gains (or not) supported by the CP8 or intervention? b. What else could be done differently? Is some other donor doing that?	Ownership Value added, synergy with activities and programming
7.	**Other Issues or Recommendations for Future Programming?**	

In-depth Interviews (IDIs): UNFPA Management and Country Office

Evaluation Areas/Themes	Probe
1. **Equity, Rights-Based Approach - (Decision making by UNFPA, Equity, Relevance, needs assessment, targeting of the most vulnerable, gender)** a. Comprehensive strategic vision? Was it a pro-poor? b. Did the CP8 successfully reach the most marginalised? What were the safeguards at the planning or policy stage? c. Did women, girls, children, at risk, youth populations benefit?	Processes of needs assessment, CP8 design and consultations? Documentation Transparency Gender sensitivity and mainstream Monitoring Learning from CP 7 incorporated
2. **Relevance of the intervention/activities to UNFPA's mandate and Pakistan's priorities (provincial and national)?** a. How well is the alignment? b. GoP/partner role? Stage at which engagement started? c. How well does CP8/intervention support government priorities? d. Public-private partnerships – examples? e. How well was UNFPA able to respond to emerging needs or changes of the country(note down examples and communication with partners/process of change)	Examples of OPII, UNFPA, provincial or national alignment, relevance, responsiveness to emerging needs Country- national or provincial context, structures, ground realities Adaptation of programming? Feedback mechanisms? Ad hoc or systematic? Timeliness of response
3. **Effectiveness – in terms of management and programme implementation, supervision?** a. Examples of how UNFPA administrative management worked for the intervention? b. Examples of how CP8 activities made a difference? c. Objective measures – were they kept and available to verify progress (performance, results, M&E) d. What were the challenges, barriers? – how were they addressed? Staff turnover, skills? e. Gaps in management capacities – staff, senior and field level? f. What was UNFPA's value added?	Record management performance – administrative, financial, and technical achievements Documents and protocols Flexibility and feedback mechanisms – examples
4. **Efficiency – were UNFPA resources invested well** a. Examples how so – by category or type of support b. Institutional mechanisms/arrangements or other collaborations that were enabled as a result? c. Costs incurred vs. achievements – results compared to other donors support?	Details of human resource, technical assistance, financial, others What could have been alternate options? What existed before (and after) UNFPA support
5. **Functioning, Coordination and Value Added** a. General experience of working with government? Provinces? b. Experience of working with other UN Agencies or donors? – ease, timeliness, responsiveness, c. Gaps that were missed or wrongly identified in the CP8 intervention?	Concrete examples of coordination Functioning of management processes – UNFPA-government, other donors etc

d. How did UNFPA support make a difference in government agenda, service delivery, capacities, others?	Examples of value added – note down.
6. **Sustainability and Institutional Strengthening** a. How will CP8 gains (or not) provided by UNFPA continue? b. What else could be done differently? Is some other donor doing that?	Ownership Value added, synergy with activities and programming
7. **Other Issues or Recommendations for Future Programming?**	

In-depth Interviews (IDIs): Donors and UN Agencies

Evaluation Areas/Themes	Probe
1. **Equity, Rights-Based Approach - Socio- Demographic Characteristics of service/programme users? (Equity, Relevance, needs assessment, targeting of the most vulnerable, gender)** a. How relevant do you perceive UNFPA's interventions for Pakistan? b. Is it gender and rights equitable? How so?	Government involvement in the design, planning and implementation processes? What was the consultation process? Partners? **Identify type of type of donor or UN Agency – and whether directly involved in what activity or coordination?**
2. **Relevance of the intervention/activities to Pakistan's priorities (provincial and national)?** a. How well is the alignment? b. How well does CP8/intervention support government or UN priorities? (list which one) c. Public-private partnerships – examples? d. How well was UNFPA able to respond to country emerging needs or changes (note down examples and communication with UNFPA/process of change)	Examples of provincial or national alignment, relevance, responsiveness to emerging needs Country- national or provincial context, structures, ground realities Adaptation of programming? Feedback mechanisms – between donors and UN agencies? Timeliness of response
3. **Effectiveness – in terms of access and quality of RH, ASRH, FP and MH, use of evidence, and response to disasters.** a. Examples of how UNFPA programming worked? b. Objective measures – were they shared and available? c. Is UNFPA a leader in the population and RH arena? d. Can the capacities/services function without UNFPA support? e. Is there government ownership? Examples? PC 1? f. What was UNFPA's value added?	Examples of effectiveness – regular meetings, information sharing, learning Increases in staff skills, capacity, service delivery, knowledge management, disaster preparedness, coordination Documented PC 1, budgetary inclusions, district planning etc

4.	**Efficiency – was UNFPA resources invested well** a. Examples how so – by category or type of support b. Institutional mechanisms or other collaborations that were enabled as a result? c. Costs incurred vs. achievements – results compared to other donors support?	Details of human resource, technical assistance, financial, others What could have been alternate options? What existed before (and after) UNFPA support?
5.	**Functioning, Coordination and Value Added** a. General experience of working with UNFPA? b. Challenges and barriers c. Experience of working with other UN Agencies or donors? – ease, timeliness, responsiveness, d. Gaps that were missed or wrongly identified by UNFPA? e. How did UNFPA support make a difference in donor agenda? In the government agenda?, service delivery, capacities, others?	Concrete examples of coordination Functioning of management processes – UNFPA-government, other donors etc Examples of value added – note down. How does your organisation complement or compete with UNFPA?
6.	**Other Issues or Recommendations for Future Programming**	

Annex 6: UNFPA CP 8 Interventions and Indicators List

Outcome	Outputs	Interventions	Indicators
Outcome 1: Policy environment, legislation, budgetary and accountability mechanisms strengthened in support of social and equitable basic services for human development	Output 1: Increased political will to support FP	**2 interventions** 1. Political party lobbying 2. Civil society pressure groups	FP in party manifestos
	Output 2: Increased population and RH ownership by provincial/national governments	**6 interventions** 1. Advocacy government for financing universal RH/FP access 2. Media awareness of FP and RH 3. Parliamentarian Monitor RH-FP performance 4. RBM in pilot districts 5. Religious leaders as positive influencers 6. Population summit	# of Costed plans % increase in media reports dedicated provincial budgets for SRH commodities Allocated release of LHW salary
Outcome 2: Increased public awareness and behavioural change to ensure that vulnerable populations practice safe behaviours and access/use quality services	Output 3: ASRH/newly wed counselling in FP voucher districts	**7 interventions** 8. Develop YFSS 9. Use of DHMIS data to monitor ASRH 10. Develop community capacity in ASRH 11. Implement newlywed counselling/vouchers 12. Organise FP week 13. Capacity building of CSOs in ASRH 14. Advocacy for marriage bill to prevent early age marriage	# of districts with newlywed counselling % of facilities providing YFSS # of districts with community sensitization to ASRH % of LHWs equipped with RH-FP and ASRH information # of provinces that have passed marriage bill Scaling up of the YKAP model to decision makers
	Output 4: Integrating HIV prevention model (YKAP) for risk populations	**1 intervention** 2. Elimination/prevention of HIV in MARPs (YKAP)	
Outcome 3: Capacity for equitable social service delivery improved at all levels	Output 5: FP vouchers targeting the poor and youth	**18 interventions** 19. FP voucher scheme (11 districts)	# of districts with PPP # of trained CMWs deployed CMW workforce policies developed # of SDPs providing FP and RH % of LHWs trained in RH and FP # of GBV interventions Functioning inter-agency GBV coordination body # of fistula services and costs in PC 1 # of fistula repair surgeries per year # of provinces with a contingency plan, SOPs of MSUs
	Output 6: enhanced midwifery curriculum	20. Support mid-wifery education and regulation 21. Pilot BSCM programme (AKU)	
	Output 7: strengthened capacity of female service providers in RH-FP	22. Strengthen CMWs for FP 23. Strengthen LHWs for FP 24. Integration of FP 25. Capacity of FWWs, WMOs 26. Strengthen capacity of RTIs	
	Output 8: elimination of GBV in humanitarian settings	27. Develop GBV stepping up	
	Output 9: fistula prevention and treatment	28. Gap funding for fistula 29. Fistula surveillance 30. Community awareness in fistula 31. Prevent iatrogenic fistula	
	Output 10: SRH capacity of provincial departments to respond to disasters	32. Strengthen coordination for SRH 33. Strengthen management of MSUs 34. Conduct MISP trainings	
	Output 11: NPPI exit plan implemented	35. Implement exit plan 36. Enable commodity security and coordination	

	Output 12: ensuring RHCS		
Outcome 4: Key causes and consequences of population growth addressed	Output 13: enhanced capacity of provincial departments to integrate PD in district plans	**9 Interventions** 1. Strengthen population education for civil servants 2. TA to provincial departments in PD 3. Strengthen NIPs	# of government officials trained in RH, FP and PD # of institutions supported to conduct census
	Output 14: enhanced national and provincial capacity to generate evidence for policy advocacy, RH and PD, gender	4. Enhance research on PD, FP and RH 5. Strengthen capacity of young researchers internship programme 6. Strengthen analysis and use of population data	# of peer reviewed papers published # of students completing internship # of monographs on PDHS data published
	Output 15: census for population	7. Support census 8. Digitize census map 9. Develop capacity to use census GIS maps	% of census maps digitized

Annex 7: Overview of budget versus expenditures by IPs from 2013-2016

UNFPA: Annual Budget and expenditure by IP from 2013 to 2016

IP		2013			2014			2015			2016			Total (2013-2016)		Overall (2013-2016) Imp. Ratre
		Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure	
Policy Advocacy (CCPD Output 1.1.1)																
PGPK11	Population Welfare Department - Punjab				43,792	34,811	79.5%	35,388	31,160	88.1%	33828	11580	34.2%	113,008	77,551	68.6%
PGPK13	National Progamme - Punjab				75,323	75,323	100.0%							75,323	75,323	100.0%
PGPK23	Population Welfare Department - Sindh				22,088	20,838	94.3%	27,209	14,599	53.7%	4,991	1	0.0%	54,288	35,438	65.3%
PGPK31	Population Welfare Department - KPK				22,139	3,850	17.4%	22,994	3,531	15.4%	2,000	1	0.1%	47,133	7,382	15.7%
PGPK32	Director General Health Services - KPK							16,946	161	1.0%	9,185	134	1.5%	26,131	295	1.1%
PGPK41	PSPU, Punjab				13,626	13,153	96.5%	14,598	12,834	87.9%	6,353	1	0.0%	34,577	25,988	75.2%
PGPK42	Population Programme Wing - PPW				38,096	9,324	24.5%	59,501	49,243	82.8%	36,680	3,544	9.7%	134,277	62,111	46.3%
PGPK44	Director General Health Services - Sindh							20,153	9,658	47.9%	20,850	6,975	33.5%	41,003	16,633	40.6%
PGPK47	National Ministry of Health							17,500	100	0.6%	30,000	5,742	19.1%	47,500	5,842	12.3%
PN4598	Population Council	470,772	453,136	96.3%	401,349	394,332	98.3%	484,341	480,543	99.2%	177,173	16,376	9.2%	1,533,635	1,344,387	87.7%
PN5105	Bargad							48,171	47,995	99.6%	31,888	12,786	40.1%	80,059	60,781	75.9%
PN5632	Pathfinder	32,896	31,767	96.6%	131,995	119,862	90.8%	123,243	122,867	99.7%	140,870	39,062	27.7%	429,004	313,558	73.1%
PN5886	Contech International	314,351	250,272	79.6%										314,351	250,272	79.6%
PU0074	UNFPA	296,717	283,640	95.6%	188,408	156,474	83.1%	354,867	319,246	90.0%	50,380	34,420	68%	890,372	793,779	89.2%
Sub-Total (Policy Advocacy)		1,114,736	1,018,815	91.4%	936,816	827,967	88.4%	1,224,911	1,091,937	89.1%	544,198	130,622	24.0%	3,820,661	3,069,340	80.3%
Adolescent and Youth including ASRH (CCPD Output 1.2.1)																
PGPK11	Population Welfare Department - Punjab				21,767	20,433	93.9%	32,045	11,390	35.5%	104,530	2,589	2.5%	158,342	34,412	21.7%
PGPK13	National Progamme - Punjab				97,798	93,455	95.6%							97,798	93,455	95.6%
PKPK18	National Programme - Sindh				40,560	40,477	99.8%							40,560	40,477	99.8%
PGPK23	Population Welfare Department - Sindh				25,616	25,614	100.0%	33,652	12,483	37.1%	43,622	14,225	32.6%	102,890	52,322	50.9%
PGPK31	Population Welfare Department - KPK							36,874	10,078	27.3%	37,000	3,057	8.3%	73,874	13,135	17.8%
PGPK32	Director General Health Services - KPK							4,030	2,893	71.8%				4,030	2,893	71.8%
PGPK35	Sindh Aids Control Programme - SACP	37,353	17,478	46.8%	16,712	9,258	55.4%	23,927	6,655	27.8%				77,992	33,391	42.8%
PGPK41	PSPU, Punjab				11,229	9,134	81.3%	12,032	7,030	58.4%				23,261	16,164	69.5%
PGPK44	Director General Health Services - Sindh							27,500	8,189	29.8%	8,992	546	6.1%	36,492	8,735	23.9%
PN5105	Bargad				63,949	63,608	99.5%							63,949	63,608	99.5%
PN5632	Pathfinder										166,367	30,092	18%	166,367	30,092	18.1%
PU0074	UNFPA	54,258	40,464	74.6%	114,662	109,948	95.9%	119,735	96,464	80.6%	9,050	4,091	45.2%	297,705	250,967	84.3%
Sub-Total (Adolescent & ASRH)		91,611	57,942	63.2%	392,293	371,927	94.8%	289,795	155,182	53.5%	369,561	54,600	14.8%	1,143,260	639,650	55.9%
Sexual Reproductive Health including FP and Humanitarian (CCPD Output 1.3.1)																
PGPK11	Population Welfare Department - Punjab	75,882	61,726	81.3%	213,248	202,883	95.1%	245,394	161,343	65.7%	126,314	10,074	8.0%	660,838	436,026	66.0%
PGPK13	National Progamme - Punjab	342,731	291,184	85.0%	41,797	36,379	87.0%							384,528	327,563	85.2%
PKPK15	Lady Health Worker Programme - KPK				20,140	16,182	80.3%							20,140	16,182	80.3%
PKPK18	National Programme - Sindh				54,747	1,608	2.9%	305,554	105,963					360,301	107,571	29.9%
PGPK20	MNCH - Sindh	14,157	27,535		107,235	85,484	79.7%	273,103	272,975	100.0%	219,802	79,320	36.1%	614,297	465,314	75.7%
PGPK22	Pakistan Nursing Council	146,635	143,443	97.8%	163,560	162,937	99.6%	204,153	202,619	99.2%	117,442	84,752	72.2%	631,790	593,751	94.0%
PGPK23	Population Welfare Department - Sindh	165,941	165,290	99.6%	82,875	72,500	87.5%	194,563	182,090	93.6%	174,283	120,207	69.0%	617,662	540,087	87.4%
PGPK25	Director General Health Services - Balochistan							18,270	4,018	22.0%	83,779	83,506	99.7%	102,049	87,524	85.8%
PGPK27	Population Welfare Deparmtne - Balochistan							26,000	18,364	70.6%	14,090	14,101	100.1%	40,090	32,466	81.0%
PGPK31	Population Welfare Department - KPK	58,754	54,672	93.1%	19,675	11,041	56.1%	67,722	22,811	33.7%	18,200	15,409	84.7%	164,351	103,933	63.2%
PGPK32	Director General Health Services - KPK							137,445	85,877	62.5%	332,361	154,727	47%	469,806	240,604	51.2%
PGPK36	Punjab MNCH				73,891	67,051	90.7%							73,891	67,051	90.7%
PGPK41	PSPU, Punjab							24,011	23,487	97.8%	29,014	10,859	37%	53,025	34,346	64.8%
PGPK43	Health Services Academy							77,351	76,804	99.3%	45,511	45,507	100%	122,862	122,311	99.6%
PGPK44	Director General Health Services - Sindh										155,364	133,630	86%	155,364	133,630	86.0%
PGPK46	Integ. RMN & Child Health, Punjab							240,230	213,800	89.0%	236,199	65,393	28%	476,429	279,193	58.6%
PGPK47	National Ministry of Health							165,500	56,679	34.2%	238,500	164,914	69%	404,000	221,593	54.8%
PN4465	Marie Stopes Society - MSS				489,132	355,166	72.6%	556,578	554,697	99.7%				1,045,710	909,863	87.0%
PN4534	Pakistan National Forum on Women Health - PNFWH	169,074	226,153	133.8%	163,231	162,292	99.4%	290,076	289,988	100.0%	133,067	65,310	49.1%	755,448	743,743	98.5%
PN4741	Merlin	261,180	163,073	62.4%										261,180	163,073	62.4%
PN5190	Support With working Solutions - SWWS				193,935	174,653	90.1%							193,935	174,653	90.1%
PN5525	Rozan							24,338	24,289	99.8%				24,338	24,289	99.8%
PN5632	Pathfinder				13,740	13,206	96.1%	14,415	14,237	98.8%	12,748	9,153	71.8%	40,903	36,596	89.5%
PN5764	BPDO	148,737	120,704	81.2%	77,924	77,354	99.3%							226,661	198,058	87.4%
PN5765	EHSAR, Foundation				127,981	119,426	93.3%							127,981	119,426	93.3%
PN6209	Agha Khan University				61,280	57,102	93.2%							61,280	57,102	93.2%
PN6256	Muslim Aid				141,425	131,449	92.9%	617,734	600,925	97.3%	111,160	40,997	37%	870,319	773,371	88.9%
PN6259	Sarhad Rural Support Programme - SRSP				94,119	73,653	78.3%	524,219	410,185	78.2%	209,805	170,193	81%	828,143	654,031	79.0%
PN6382	Aurat Foundation							65,834	61,778	93.8%				65,834	61,778	93.8%
PN6507	Foundation for Rural Developmet - FRD										93,383	91,340	98%	93,383	91,340	97.8%
PN6514	Society for Human and Enviornment Development										90,617	88,125	97%	90,617	88,125	97.2%
PU0074	UNFPA	2,899,321	2,096,269	72.3%	3,530,829	1,884,945	53.4%	1,752,899	1,483,195	84.6%	1,171,920	558,840	48%	9,354,969	6,023,248	64.4%
Sub-Total (RH-FP)		4,282,412	3,350,049	78.2%	5,670,765	3,705,311	65.3%	5,825,389	4,866,124	83.5%	3,613,559	2,006,357	55.5%	19,392,125	13,927,841	71.8%
Population and Development (CCPD Output 2.4.1)																
PGPK06	NIPS				22,949	22,949	100.0%	47,667	43,928	92.2%	64,840	13,286	20%	135,456	80,163	59.2%
PGPK11	Population Welfare Department - Punjab				6,663	1,508	22.6%	21,179	14,908	70.4%				27,842	16,416	59.0%
PGPK23	Population Welfare Department - Sindh				24,211	20,122	83.1%	38,315	35,846	93.6%	14,748	2,985	20%	77,274	58,953	76.3%
PGPK31	Population Welfare Department - KPK				29,072	25,031	86.1%	26,610	24,767	93.1%	24,000	5,655	24%	79,682	55,453	69.6%
PGPK40	Pakistan Bureaue of Statistics -PBS				108,730	108,730	100.0%	128,629	127,690	99.3%				237,359	236,420	99.6%
PGPK45	Pakistan Institute of Development Economics - PIDE							7,364	7,286	98.9%	6,986	956	14%	14,350	8,242	57.4%
PN5105	Bargad							92,142	71,440	77.5%				92,142	71,440	77.5%
PN5632	Pathfinder	21,401	19,235	89.9%	42,624	24,516	57.5%	33,018	31,016	93.9%				97,043	74,767	77.0%
PU0074	UNFPA	221,371	205,546	92.9%	367,075	390,277	106.3%	193,798	174,549	90.1%	267,970	63,395	24%	1,050,214	833,766	79.4%
Sub-Total (P&D)		242,772	224,781	92.6%	601,324	593,133	98.6%	588,722	531,430	90.3%	378,544	86,276	22.8%	1,811,362	1,435,620	79.3%
Programme Coordination Assistance		195,200	192,116	98.4%	200,000	193,409	96.7%	153,000	129,444	84.6%	230,000	179,076	77.9%	778,200	694,045	89.2%
Country Programm Total		5,926,731	4,843,701	81.7%	7,801,198	5,691,747	73.0%	8,081,817	6,774,117	83.8%	5,135,862	2,456,932	47.8%	25,802,347	19,126,846	74.1%

Annex 8: Results Matrix

ASRH Counselling

Models	Indicator	Location	Indicators (Achieved)	Budget & Partner
Sub-output 1.2.1: Piloted ASRH/newly-weds counseling and service provision system in selected districts where FP voucher are provided.	Develop and adopt youth friendly service standards (YFSS) in selected province.	Punjab: Sargodha KPK: DI Khan Sindh: Ghotki	Three districts supported that introduced newly-weds counselling services.	US$ 69,276 (UNFPA) US$ 13,135 (PWD-K) US$ 2,893 (DG Health-K) US$ 26,708(PWD-S) US$ 8,735 (DG Health-S)
	Develop capacity of community workers on ASRH	Punjab, Sindh and KP	Punjab = 48 WMO, 1679 (LHW& & LHV) Sindh = 206 (LHS/FWW/WMO) KP = 74	US$ 2,484 (PWD-P) US$ 30,092 (Pathfinder) US$ 64,85(UNFPA)
	Organize family planning week	Punjab, Sindh, KP		US$ 9,935 (PWD-K) US$ 93,455 (LHW Program-P) US$ 40,477 (LHW Program-S)
	Strengthen capacity of CSOs for ASRH		Provincial youth policies	US$ 22,261 (PWD-P) US$ 63,605 (Bargad) US$ 64,530 (UNFPA)

RBM in Districts

Models	Indicator	Location	Indicators (Achieved)	Budget & Partner
Sub-output 1.1.2: Increased and demonstrated ownership of population, RH and FP programmes by the national and provincial governments.	Advocate RBM of RH/FP (1.1.2.4):	Punjab = Sargodha and Gujrat KPK = Peshawar and Mardan AJK = Muzaffarabad		US$ 2,281 (PWD-S) US$ 5,120 (PPW) US$ 16,633 (DG-Health Sindh) US$ 155,745 (Pathfinder) US$ 14,859 (UNFPA)

Population and Development Indicators

Models	Indicator	Location	Indicators (Achieved)	Budget & Partner
Sub-output 2.4.1: Strengthen capacity to integrate PD into provincial policies	# of key government officials trained to incorporate population, reproductive health and gender issues in national plans and programmes	Federal and four provinces	181 officials trained across country	US$ 18,241 (PWD-P) US$ 55,968 (PWD-S) US$ 71,440 (Bargad) US$ 10,71 (Pathfinder) US$ 46,597 (UNFPA) US$ 31,548 (NIPS)

Sub-output 2.4.2: Generate evidence on PD, RH and Gender **Sub-output 2.4.3:** Support Census operation	# of institutions supported by UNFPA to incorporate results of the population census and surveys in selected national and provincial policies and plans	Punjab, Sindh and KP	Three Population Policies Four Youth Policies	US$ 55,453 (PWD-K) US$ 51,612 (NIPS) US$ 44,815 (Pathfinder) US$ 8,242 (PIDE) US$ 256,392 (UNFPA)
	# of research report and Monograph published.	National	9	
	% of census maps digitized using GIS technology	National and provincial level	**94% of the urban areas maps digitized.** **Rural areas work in Progress.**	US$ 318,590 (UNFPA) US$ 236,419 (PBS)