REPORT

Evaluation of Mother and Child Weeks

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ACRONYMS

AJK	Azad Jammu and Kashmir
ANC	Antenatal care
BHUs	Basic Health Units
CRC	United Nations Conventions on the Rights of the Child
CSOs	Civil society organizations
DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
DG	Director General
DHQ	District headquarter
DQRC	Data Quality Review Committee
EDM	Evaluation Design Matrix
EPI	Expanded Programme on Immunization
FATA	Federally Administered Tribal Areas
FGDs	Focus Group Discussions
GB	Gilgit-Baltistan
IRB	Institutional Review Board
ICT	Information and communications technology
ISCS	Institute of Social and Cultural Studies
KIIs	Key Informant Interviews
KP	Khyber Pakhtunkhwa
LHS	Leady Health Supervisor
LHW	Leady Health Worker
MCW	Mother and Child Health Week
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, neonatal and child health
NOC	No Objection Certificate
NPFP&PHC	National Programme for Family Planning and Primary Health Care
OECD	Organisation for Economic Cooperation and Development
PDHS	Pakistan Demographic Health Survey
PNC	Postnatal care
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Science
SSRC	Social Science Research Center
TBA	Traditional birth attendant
TOC	Theory of Change
UC	Union Council
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

Overview of the initiative

Pakistan has the third highest burden of maternal and child mortality in the world. Hence, improving maternal and child health is an integral part of the country's national development plan, *Vision 2025*, and its *National Health Vision 2016-2025*. To about bring positive change in the health of mothers and children in Pakistan, several international organizations, including UNICEF, are playing a significant role – especially in areas that lack basic health services. To support efforts to translate Pakistan's National Health Vision into action, UNICEF developed a Mother and Child Health Week (MCW) Strategy which aims to help the Government to deliver maternal and child health services to communities' doorsteps.

The MCW initiative was launched as a pilot project in 2007 in three districts of Punjab by the National Programme for Family Planning (FP) & Primary Health Care (PHC) and the Expanded Programme on Immunization (EPI), with UNICEF's technical and financial support. The initiative was later scaled up to six districts – three in Punjab and one each in Khyber Pakhtunkhwa (KP), Sindh and Balochistan. In April 2009, the MCW was expanded to 29 districts – nine districts in Punjab, eleven in Sindh, three in Balochistan, four in KP and two in Azad Jammu and Kashmir (AJK). Based on the pre- and post-MCW assessment of 2008, the Ministry of Health decided to scale up the programme to the national level. As of April 2012, ten rounds of Mother and Child Weeks have been completed.

The MCW package includes:

i. Immunization of children between 0-2 years of age;
ii. Tetanus Toxoid (TT) vaccinations for all pregnant women;
iii. Deworming of all children between 2-5 years old; and
iv. Raising awareness of health.

OBJECTIVES OF THE EVALUATION

This evaluation aimed to achieve the following objectives:

1. To assess the extent to which the MCWs' implementation followed its intended plan (i.e. to strengthen existing MNCH services and enhance access to these services for potential beneficiaries);
2. To analyse synchronization between national/provincial policies/priorities on maternal, neonatal and child health (MNCH) and the MCW initiative's goals and objectives;
3. To understand the process and lessons learned during the 2007-2011 period, when MCW implementation transitioned from small-scale piloting to nationwide implementation in 2012 and thereafter;
4. To assess the extent to which the MCW met the basic health needs and rights of women, girls and boys – the intended primary beneficiaries of the initiative – and whether there were any unintended outcomes;
5. To determine the extent to which the MCW helped to mobilize communities to utilize and strengthen routine health services;
6. To explore the extent to which the MCW addressed the needs of marginalized, excluded, crisis and disaster-affected populations;
7. To provide a descriptive cost analysis of the MCW initiative;
8. To identify lessons learned, exploring what has worked well and what has not worked;
9. To determine the sustainability of the MCW and to look into possibilities for the Government taking over its activities in the future; and
10. To offer recommendations on institutionalization, gender programming, equity and child rights.

The intended users of this evaluation include government institutions and officials, international organizations, donors and other partners working in the field of maternal and child health.

EVALUATION APPROACH

In order to address the complex, wide-ranging set of research questions for this evaluation, a systematic and scientifically sound methodology was adopted. The evaluation followed the widely used criteria developed by the Development Assistance Committee (DAC) of the

Organization for Economic Cooperation and Development (OECD). A household survey of programme beneficiaries was conducted to identify the extent of the MCW initiative's coverage and efficiency. To explore the initiative's relevance, efficiency, effectiveness, outcome and sustainability, qualitative research methods were employed with different stakeholders. The evaluation followed the United Nations Evaluation Group's (UNEG) standards for evaluation (2005), including professional integrity, absence of bias, behavioural and organizational independence, honesty, anonymity and confidentiality of individual information, impartiality and the participation of stakeholders throughout the evaluation process.

EVALUATION METHODOLOGY

An analytical approach to contribution analysis was adopted to provide a credible assessment of cause and effect. Contribution analysis helped the evaluation team to verify the theory of change upon which the MCW initiative was based and to examine whether the MCW contributed to achieving its intended outcomes.

Target population: The target population was identified in accordance with the evaluation's objectives and scope, and on the basis of a review of secondary data. Thus, the target population encompassed (i) potential beneficiaries of the MCW and (ii) stakeholders involved in MCW planning, implementation and monitoring processes.

Potential beneficiaries are women of reproductive age (i.e. between 15 and 49 years old) who had at least one child under the age of 5 at the time of the survey. For stakeholders, data collection was limited to the most relevant informants at the federal, provincial and district levels. At the federal level, informants included the Federal Director General of Health, the National Auditor, UNICEF's Health Chief, the National Coordinator of Lady Health Worker (LHW) Programme and the National Programme Manager of the EPI. At the provincial level, key informants included each provincial Director General of Health Services, the Provincial Coordinator of the LHW Programme, the Provincial Coordinator of the EPI Programme, UNICEF's Provincial Health Specialist and the Provincial Coordinator of the MNCH Programme. Stakeholders contacted at the district level encompassed specifically District Health Officers, District Coordinators of the LHW Programme, District Coordinators of the EPI Programme and District Coordinators of the MNCH Programme. Health care providers at the

sub-district Union Council (UC) level, and representatives of NGOs working on MNCH on the ground, were also part of the evaluation, as were community health care workers – i.e. LHWs, Lady Health Supervisors (LHS) and vaccinators.

Nature of the data: The evaluation design comprised both primary and secondary data. Primary data consisted of qualitative and quantitative data, while secondary data included a desk review of academic articles and UNICEF reports. The primary quantitative data was based on a household survey of 1,540 mothers of reproductive age and 220 Lady Health Workers. Survey respondents reside in six districts of Punjab, four districts of Sindh, four districts of KP and two districts each in Balochistan, AJK, Gilgit-Baltistan (GB) and the Federally Administered Tribal Areas (FATA). The districts were selected on the basis of their performance – i.e. they encompass the best and worst performing districts with respect to different health indicators. For quantitative data collection, two union councils in each district were selected randomly. Qualitative data was based on 22 case studies of mothers, 172 Key Informants Interviews with federal, provincial, district and union council level health mangers and 66 Focus Group Discussions (FGDs) with community health workers (LHWs, LHS and vaccinators).

Data analysis: Quantitative and qualitative data was analysed separately at the initial stage of the evaluation. After compiling the initial findings, drawn from both quantitative and qualitative data, the data was compared and combined. The qualitative data was analysed by using themes based on evaluation criteria. The quantitative data was processed by using the Statistical Package for Social Sciences (SPSS, vs. 22). Univariate and bivariate tables/graphs were created to present the data. In order to interpret the data, descriptive statistics were applied. For the purposes of analysis and inferences, quantitative and qualitative data were used to complement each other.

FINDINGS

Considering the objectives of the MCW initiative, this evaluation followed OECD DAC criteria.

Its key findings are presented below in accordance with these criteria.

RELEVANCE

- The evaluation's qualitative findings reveal that the MCW Strategy was devised to assist the Government and provincial/regional health departments to effectively utilize existing public

health networks, with a focus on improved, cost-effective and accessible health care services at the grassroots level for mothers and children, as outlined in health policies and plans.

- The qualitative findings highlight the alignment of the MCW initiative with health priorities defined at different levels, including within the framework of the international Sustainable Development Goals (SDGs), Pakistan's National Health Vision and all provincial/regional health policies.
- The qualitative findings affirm that the MCW Strategy is highly relevant to national and provincial/regional health strategies and plans, in terms of achieving improved MNCH services.
- The qualitative data found that the provision of high priority MNCH interventions through the MCW Strategy helped to reduce the maternal mortality ratio (MMR), the infant mortality rate (IMR) and under-five mortality and morbidity in Pakistan.
- The qualitative data show that health managers and service providers are in agreement about how relevant MCW activities are to national and provincial/regional health priorities related to addressing community health needs and improving services, particularly for mothers and children.
- The qualitative data substantiates the fact that MCW Strategy was designed to meet the health needs of communities in general and of marginalized and vulnerable populations in particular. Analysis of quantitative data indicated that, overall, 78.5 per cent of mothers reported benefitting from MCW activities.
- The qualitative findings demonstrate that MCW events were organized biannually, following careful analysis of the existing state of MNCH indicators at the district level, coupled with an analysis of community health needs and consultations with concerned health authorities. During qualitative interviews, most study participants affirmed that areas covered by LHWs were selected after thorough planning which prioritized poor and underserved communities in order to bridge gaps in access to, the availability of and the affordability of MNCH services.
- The quantitative findings substantiated this by showing that nearly two-thirds of mothers surveyed (69.2 per cent) identified the availability of free health services as the major driving force behind their participation in MCW activities.

- The qualitative data confirm that MCW implementation was aligned with already defined roles and responsibilities of federal, provincial/regional and district level health managers and health care providers. These health mangers had broad responsibility for planning, coordinating, managing and monitoring MCW events. Health care providers played an active role in advocacy and delivering MCW initiatives in the field.
- As noted above, the MCW initiative reinforced existing maternal and child health care service delivery components in a 'campaign mode' twice a year (biannually). However, findings also suggest that certain improvements are required in the MCW initiative, especially in terms of devising selection criteria for areas in which MCW activities are undertaken; giving equal opportunities to areas that are not covered by LHWs in order to maintain equity; and organizing MCWs more frequently to strengthen MNCH services.

EFFECTIVENESS

- The qualitative and quantitative data reveal the MCW initiative's strong performance overall, affirming that the initiative was very good at achieving its intended goals. Stakeholders at the federal, provincial and district levels acknowledged that the MCW raised knowledge of health among mothers.
- Both qualitative and quantitative data confirms that the effective MCW awareness campaign equipped mothers with better knowledge of health care, especially in terms of preventing diarrhoea and pneumonia. Greater awareness also led to an increased number of deliveries in hospitals, dispelled various cultural misconceptions about vaccines and encouraged women to get TT shots. The quantitative findings reveal that 67.4 per cent of births were attended by doctors and 12.2 per cent of deliveries were attended by LHWs. Similarly, 87.1 per cent of mothers reported that they did not have any fear of immunization. The quantitative data further showed that 91.9 per cent of mothers received TT vaccination during their last pregnancy and 77.5 per cent acknowledged that the benefits of TT vaccinations were properly explained to them. The MCW initiative similarly raised women's knowledge of deworming tablets – 77.7 per cent of mothers reported that deworming tablets were provided to their children during the MCWs.

- All informants during the qualitative interviews reported that the MCW field plan was largely chalked out by Health Departments, whereas UNICEF largely undertook budgetary/fiscal planning.
- During the qualitative interviews, informants from southern Punjab, FATA, GB and Balochistan reported that the MCW initiative's implementation was often halted due to various petty logistical gaps and geo-cultural limitations, such as harsh weather or commutes through hilly/hard/far flung areas, religious and social misconceptions regarding vaccinations and the iatrogenic implications of the interventions used.
- During the FGDs, community health care workers highlighted some of the bottlenecks which affected the MCWs' implementation, such as an absence of transport and six day-long unpaid laborious work.
- Overall, the qualitative and quantitative findings reveal that the MCW initiative followed an efficient multi-level monitoring and reporting mechanism at the federal, provincial, district and field levels.

EFFICIENCY

- The qualitative data indicates that available human, financial resources and supplies were used quite efficiently. The MCW was considered cost-efficient as it utilized most existing programme resources.
- However, data from Balochistan, FATA and GB show that the MCW initiative's overall efficiency was undermined as resources did not reach society's marginalized or poorest groups. The qualitative data also reveals that health workers lacked motivation in the absence of monetary compensation for additional work. This had a negative impact on their efficiency and job productivity.
- During the qualitative interviews, some participants criticized MCW-led trainings of LHWs as not being long enough to share extensive information/knowledge in the most effective manner possible. Despite some participants' reservations, stakeholders' overall opinion was that MCW activities were synchronized with existing field work, which improved LHWs' reporting and communication skills when engaging with beneficiaries. On the whole, MCW-led trainings improved the overall competencies of health staff.

- In short, the data affirms that MCW activities were carried out efficiently at various levels. Considerable support was provided by stakeholders to enhance and upgrade MNCH services across Pakistan's provinces. However, the initiative's efficiency would be further enhanced by supporting human resources, adding monetary incentives for community health workers and increasing logistical supplies.

SUSTAINABILITY

- Sustainability constitutes the continuation of benefits from an intervention after major development assistance has been withdrawn. The qualitative findings indicate that most key informants agreed to the continuation of the MCW initiative's benefits for beneficiaries after UNICEF's sponsorship of the initiative comes to an end.
- The qualitative data demonstrates that Punjab ran the MCW initiative successfully and independently. During the Key Informant Interviews, most informants – from almost all provinces – suggested that provincial health departments may earmark a greater share of their finances for this initiative, so the MCWs' outreach can be extended to the most marginalized segments of society.
- The qualitative data shows that some management and capacity issues hindered the sustainability of the MCW initiative. These included the scarcity of financial and human resources, the exclusion of areas that are not covered by LHWS and flaws in micro-planning.
- A few informants noted that the active role of civil society in maintaining the MCW initiative will be a crucial component of the initiative's future outlook.

LONG-TERM OUTCOMES

- The qualitative findings reveal that MCWs were an effective approach for improving MNCH indicators, strengthening the service delivery system and raising awareness among communities by using Pakistan's existing network of outreach workers. Similarly, the MCW accelerated progress on priority health indicators, such as immunization coverage, antenatal and postnatal care, and deliveries assisted by skilled birth attendants.
- The qualitative findings showed that the MCW is a beneficial and effective initiative that helped to achieve vaccination targets and to provide deworming tablets. During qualitative

interviews, community health workers reported that the MCW was beneficial in terms of helping them achieve their vaccination targets and reach 'unreached' children.

- The qualitative data found that certain constraints and challenges hindered the smooth implementation of the MCW initiative. These included irregular logistical supplies, limited coordination at the service provider level, a weak monitoring mechanism, a lack of financial incentives, a lack of resources, and poor law and order situations.

CROSS-CUTTING ISSUES

- One of the MCW initiative's core objectives is to address cross-cutting issues – such as gender, disaster risk and security – while providing services to mothers and children. The qualitative data shows that the MCW did not address these cross-cutting issues.
- The qualitative data also reveals that the planning of the overall initiative and its activities did not account for engaging with, and raising awareness among, men. Nevertheless, most informants from GB reported that men also participated in health sessions, as men are also connected with reproductive, maternal and child health.
- The important cross-cutting issue of disaster-affected areas remained unaddressed. It was not prioritized in the MCW initiative, except in FATA and GB, where key representatives reported that efforts were made to cover disaster-affected areas.
- Some informants – particularly from KP, FATA, Balochistan and AJK – reported that religious misconceptions restricted communities' receptiveness towards vaccinations, which were perceived to contain prohibited (*haram*) ingredients/chemicals. Nonetheless, there was a silver lining, as most religious leaders did not support such perceptions and had a positive opinion of vaccinations.

CONCLUSIONS

The evaluation concludes that the MCW initiative effectively provided MNCH services to targeted populations. However, variations are apparent across regions. Some regions experienced better results, such as Punjab, Sindh, AJK and KP. Others performed relatively poorly with regard to the efficiency of the MCW, such as GB, FATA and Balochistan. However, the MCW initiative has the potential to increase health coverage by enhancing community participation through community mobilization. The initiative can be further improved through effective

participation of civil society and communities, the adequate and timely provision of logistical supplies, and by enhancing financial incentives for field teams.

RECOMMENDATIONS

Recommendations were devised in line with the MCW's theory of change, which prioritizes the involvement of multiple stakeholders. As such, recommendations are provided for each stakeholder involved in the process of planning and implementing the MCW initiative.

UNICEF LEVEL

- UNICEF should continue its technical support of the MCW initiative.
- The establishment of MCW Secretariats at the federal and provincial levels would support the effective planning and implementation of MCW activities.
- The advocacy component of the MCW initiative needs to be strengthened by properly using information, education and communication (IEC) materials.
- The MCW initiative's monitoring and evaluation system needs to be strengthened. Information and communications technology (ICT) may be extensively used to make the monitoring and evaluation system more efficient, cost-effective, and user-friendly.
- An operational guide should be developed, outlining the explicit responsibilities of each stakeholder at district, provincial and federal levels.

POLICY LEVEL

- To address provincial and regional disparities in socio-economic and health profiles, each province's/region's health care legislation should be in line with its specific socio-economic realities.
- There is a need to adopt an approach centred around learning and building on experiences. Attention should be paid to identifying risks and planning mitigation measures. Before planning a new phase of the MCW initiative, previously identified risks and shortcomings must be analysed, and mitigation measures adopted accordingly.
- There is also a need for an approach grounded in learning from best practices. For example, the MCW initiative's planning and implementation could be improved by learning from best

practices in other countries, where similar interventions are working more effectively and efficiently.

- The MCW initiative's implementation should be embedded in the health sector's action-planning documents.
- To maintain health equity and address issues of accessibility and affordability, the MCW initiative should be scaled up in areas that are not covered by LHWs.
- The MCW initiative should become part of the health care delivery system, rather than a random or added-on activity.
- As maternal and child health is intimately linked with gender equality and gender mainstreaming, there is a need to include a gender component in the MCW activities by involving both women and men.
- The service package for outreach workers should be reviewed and customized as a smart, uniform package.

OPERATIONAL LEVEL

- The MCW initiative's social mobilization strategy should be made more effective by increasing the participation of all stakeholders.
- Using mobile phone technology, specific applications and software to monitor MCW activities can increase the initiative's effectiveness.
- As the MCW's narrow focus on reproductive health may not be helpful in winning communities' trust and confidence, efforts are needed to make the MCW initiative more relevant to people's day-to-day health needs. Medicines for common illnesses could also be provided during MCWs, such as antipyretic medicines, allergy treatments, cough syrup or multivitamins.
- Health managers and health care providers must be provided with financial incentives for participating in MCW activities.
- MCW activities should be conducted every three months so that communities' receive maximum benefits from the initiative.
- The planning of MCW activities should be initiated in good time by involving all relevant stakeholders.

- Local NGOs can be actively involved in raising awareness among mothers of upcoming rounds of MCWs.
- There is a need to increase human resources by recruiting more LHWs, particularly for areas that are not currently covered by these health workers and far flung areas in AJK and Balochistan.
- There is a need to strengthen the MCW initiative's community-specific communications and awareness components to reach Pakistan's most underserved and marginalized populations.
- Effective awareness creating campaigns must include culturally and locality-specific information to meet the communications needs of end users.
- To build awareness and disseminate information sustainably, all stakeholders must be kept on board. The collective power of communities will help people to receive information and translate their new knowledge into action.

  The costs of the MCW initiative should be documented and continuously updated so that cost-related data is readily available for analysis.

1. INTRODUCTION

1.1. BACKGROUND AND CONTEXT

Improving maternal and child health is a fundamental developmental goal for the United Nations (UN) and UN agencies, particularly the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). Improving the health status of mothers and children is a significant indicator for measuring the effectiveness of health services in a country (WHO, 2004; WHO, 2011). It is the state's prime responsibility to ensure the provision of health services and facilities for mothers and children (Thomas, 2007).

The right to health is an important component of each individual's basic human rights. This basic right can only be ensured if there is a tangible improvement in reproductive health, maternal health and child health. Furthermore, to ensure this basic right, improving health care systems is not enough. Mothers and children must also have decent living standards and a good quality of life (WHO, 2010 & 2011). At present, health care systems experience significant challenges in terms of the provision of universal maternal and child health care. This especially true in developing countries, given a high rates of poverty, low rates of education and limited infrastructural development (Black, 2008; Brown, 2003; Marmot et al., 2008).

Pakistan has the third highest burden of maternal and child mortality in the world (Bhutta et al., 2013). The status of maternal and child health in Pakistan is ranked the lowest among countries in the region (UNICEF, 2016). One in every 14 children in Pakistan dies before their first birthday and one in 11 do not reach the age of 5 (NIPS, 2013). Among the total number of deaths of children under five years of age, two-thirds are newborn deaths (NIPS, 2013). Moreover, the 2015 *Maternal Mortality Ratio Index* ranked Pakistan 149th of 179 countries, with 178 maternal deaths per 100,000 live births (UNICEF, 2015).

The gravity of this situation belies the urgent need to improve maternal and child health indicators. Improving maternal and child health is also an integral part of Pakistan's national development plan, *Vision 2025*, and its *National Health Vision 2016-2025*. This is reinforced by Pakistan's international commitments, including its ratification of the United Nations Convention on the Rights of the Child; its commitment to achieving the Sustainable

Development Goals (SDGs) by 2030; its approval of the One UN Programme I for Pakistan (2009-2012), the One UN Programme II (2013-2017) and One UN Programme III (2018-2022); and its acknowledgement of UNICEF's Strategic Plans for 2006-2013 and 2014-2017.

Although substantive improvements in maternal and child health have yet to be achieved, the aim of improving health indicators among mothers and children are central to several national programmes in Pakistan. These include the National Programme for Family Planning (FP) and Primary Health Care (PHC), the Expanded Programme on Immunization (EPI), the National Maternal, Newborn and Child Health (MNCH) Programme, and the National Nutrition Programme. To bring about positive change in terms of maternal and child health in Pakistan, a range of entities are working in collaboration with the Government. These encompass non-governmental organizations (NGOs), UN agencies – such as WHO, UNICEF and the United Nations Population Fund (UNFPA) – and donors – including the United States Agency for International Development (USAID) and the United Kingdom's Department for International Development (DFID). UNICEF's role is especially significant, as it has taken on responsibility for improving maternal and child health in all provinces and in areas which lack basic health services. To support efforts to translate Pakistan's National Health Vision into practice, UNICEF developed a *Mother and Child Weeks (MCW) Strategy* to support the Federal Government, provincial departments of health and development partners to enhance the delivery of maternal and child health services at the grassroots level.

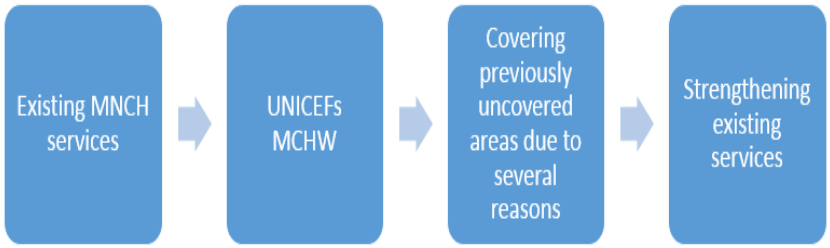
In countries with resource constraints, such as Pakistan, government interventions alone are often unable to attain the desired levels of maternal and child health indicators. Seeking technical support from international organizations, such as WHO and UNICEF, paired with social support and political clout from civil society organizations (CSOs) tends to prove effective in bringing about desired improvements in MNCH indicators. For example, this approach has been successful in other developing countries, including Nigeria (UNICEF, 2016; Gotsadze, Zanetti, & Makharashvili, 2011) with similar levels of socio-economic development and poor performance in terms of attaining SDG 3. The schematic presentation of this approach is depicted in Figure 1 (UNICEF, 2011).

Figure 1: Approach of seeking technical support from international organizations to improve MNCH indicators

1.2. OBJECT OF THE EVALUATION (INITIATIVE EVALUATED)

The MCW initiative was introduced to effectively utilize existing public health services with a focus on greater cost effectiveness and enhanced accessibility of health care services, in order to improve health care seeking practices among mothers and children. The MCW initiative was primarily delivered by using the existing network of Pakistan's Lady Health Workers (LHWs) Programme and the Expanded Programme on Immunization (EPI). In Pakistan, the MCW initiative aims to strengthen existing maternal and child health services so as to attain the desired level of maternal and child health indicators as articulated in SDG 3. This rationale is presented in Figure 2 (UNICEF, 2012).

Figure 2: Rationale for MCW operations



The MCW package includes:

i. Immunization of children between 0-2 years of age;
ii. Tetanus Toxoid (TT) vaccinations for all pregnant women;
iii. Deworming of all children between 2-5 years old; and
iv. Raising awareness of health.

1.2.1. Immunization of children 0-2 years of age

Immunization is a key tool for preventing and eliminating life-threatening diseases among children. It is a part of the global transformation of the health sector from a curative regime to a preventative regime which is much more effective, both socially and economically. A comprehensive immunization programme is a cornerstone of good public health and can reduce inequities and poverty (Schmitt, 2006). However, its significance is not well-recognized among parents in Pakistan because of a lack of awareness, the absence of trust and little confidence in the health care system which relies heavily on biomedical notions of disease causation. Against this backdrop, the MCW initiative's chief components include the immunization of children, raising awareness of immunization and particularly targeting children who have missed regular vaccinations.

1.2.2. Tetanus Toxoid vaccination for pregnant women

Tetanus is one of the most serious ailments among children and mothers. It causes an estimated 58,000 neonatal deaths and an unknown number of maternal deaths every year worldwide (Thwaites, Beeching & Newton, 2015). The prevalence of tetanus is especially pronounced among least developed countries, where health infrastructure is less developed and the provision of health care services is scarce (Vandelaer et al., 2003). Neonatal tetanus remains a public health concern in Pakistan, where it is estimated that the current reporting system captures less than 10 per cent of cases. Thus, it is imperative to ensure children's immunity against tetanus to reduce maternal and under-five mortality rates (Thwaites, Beeching, & Newton, 2015). A lack of education, limited knowledge of free vaccinations and little understanding of tetanus/vaccinations are core reasons that tetanus often goes untreated (Zeb, Zaidi & Jehan, 2006). Thus, the MCW initiative aims to counter tetanus and bring about positive changes in maternal, neonatal and child health in Pakistan.

1.2.3. Deworming of children 2-5 years of age

Deworming is a practice adopted by the international health community as a part of routine health interventions (Olds, 2013) to prevent intestinal parasitic infections. Such infections are endemic worldwide and produce severe adverse effects on child health (Baired et al., 2011; Mehraj et al., 2008). While infections affected most regions in the world, sub-Saharan Africa and

South Asia are the regions most affected (Bundy et al, 2009). In Pakistan, the burden of disease due to intestinal worms is not known. However, some small scale studies have highlighted it as a major public health problem, estimating that 52 per cent of pre-school and school-aged children are affected by it (Ensink et al., 2005; Mehraj et al., 2008). A lack of sanitation facilities and poor hygiene are the prime causes of the high prevalence of worm infections in Pakistan (Ahmed et al., 2003; Mehraj et al., 2008). In order to reduce the worm-associated burden of disease WHO recommends annual deworming in countries where the prevalence rate for intestinal parasites is above 20 per cent and biannual deworming where the rate is above 50 per cent (WHO, 2017).

Empirical evidence suggests that efficient and continuous deworming should be an integral part of health programmes for school children at high risk of intestinal worms in Pakistan (Akhter et al., 2013). As such, deworming – that is, the regular, scheduled treatment of preventive medicine against parasitic worms – was included in the MCW initiative's activities for children between the ages of 2-5. Its aim is to improve children health, nutritional status and school attendance.

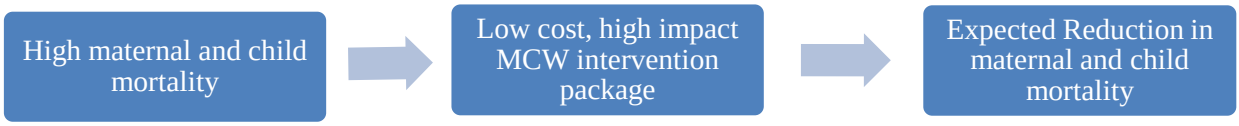
One of the most significant components of the MCW initiative is raising awareness among mothers on maternal, neonatal and child (MNCH). The significance of awareness through education is well established in almost all spheres of modern society, as awareness leads to understanding, which is frequently followed by changes in perceptions that are considered crucial for transforming health-related practices. Awareness is also necessary for mothers' to take appropriate decisions regarding their own, and their families', health, including in terms of their utilization of timely, professional health care services (Abraham & Sheeran, 2015; Yousuf, 2011).

During Mother and Child Weeks, mothers acquired knowledge and awareness on MNCH and related issues, including the significance of deworming, immunization, pre-natal, delivery and postnatal care, and recognizing the danger signs of diarrhoea and pneumonia. Information was also provided on sanitation and hygiene, birth spacing and the importance of iodized salt by using information, education and communications (IEC) materials.

Each of the three sets of interventions described above is significant in attaining the desired level of maternal and child health indicators. The underlying rationale for the MCW initiative was to provide a package of low cost, high impact interventions designed to improve maternal and child

health indicators, particularly in the worst performing areas of Pakistan. This rationale is illustrated as a logic model in Figure 3.

Figure 3: Indicators to improve maternal and child health



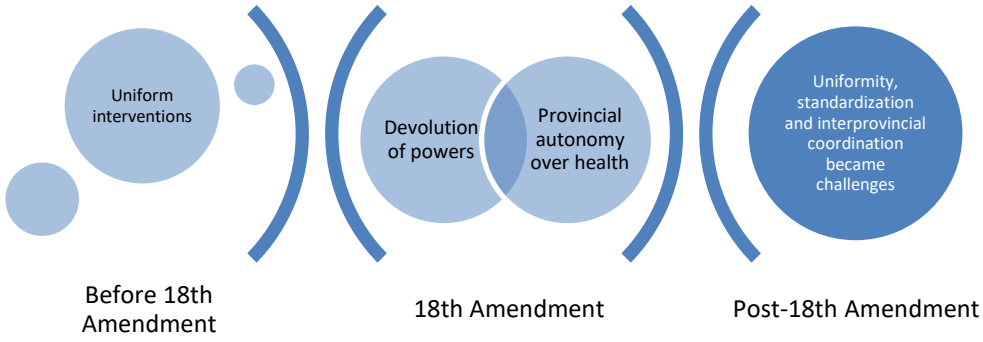
1.2.4. Mother and Child Weeks

The MCW initiative was launched as a pilot project in 2007 in three districts of Punjab by National Programme for Family Planning & Primary Health Care and the EPI, with UNICEF's technical and financial support. The intervention was scaled up to six districts – three in Punjab and one each in KP, Sindh and Balochistan. In April 2009, the MCW was expanded to 29 districts – nine districts in Punjab, eleven in Sindh, three in Balochistan, four in KP and two in Azad Jammu and Kashmir (AJK).

Based on the pre- and post MCW assessment of 2008, the Ministry of Health decided to scale up the programme to the national level. As of April 2012, a total of ten rounds of MCWs had been completed. After the implementation of this initiative for over ten years, UNICEF commissioned an evaluation of the MCW initiative. This evaluation sought to evaluate MCW interventions from 2007 to 2017 to attain a holistic picture of its achievements and challenges. Such evidence is crucial for planning future decisions, particularly at the managerial level.

Several crucial factors had to be accounted for during the evaluation process. The most significant is the 18th Constitutional Amendment (2010), which devolved significant responsibility for health care to the provincial level. Following this amendment, the MCW initiative was entrusted to Pakistan's provincial governments. This shift of responsibility posed challenges for the initiative's implementation. Notable challenges included a lack of coordination among provincial governments and the provinces' inability to handle complex legal and procedural matters. This led to non-uniform evolution of health programmes across provinces (Review and Planning Meeting, 2011), as portrayed in Figure 4.

Figure 4: Effects of devolution



Furthermore, evidence from the high-risk countries, including Pakistan, demonstrates that maternal and child mortality is characterized by significant disparities between the rich and the poor, urban and rural areas, places of residence and levels of education, particularly among women (Hancioglu & Arnold, 2013). These disparities are reflected in data on provincial EPI coverage, which shows that the proportion of full immunization coverage for all basic vaccinations is as high as 79.9 per cent and as low as 28.8 per cent in Balochistan (NIPS, 2018). Such factors that affect the evaluation of initiatives have been duly considered within the MCW evaluation process, in order to ensure that the evaluation is as objective and unbiased as possible.

1.3. KEY STAKEHOLDERS

The MCW initiative is implemented by Pakistan's federal and provincial Governments, in collaboration with UNICEF. Key stakeholders include the Federal Director General of Health; the Director of Programmes; the National Programme Manager of the National Polio Emergency Operation Centre (EOC); and the Directors/Coordinators of respective provincial and district Departments of Health, and of NGOs working on MNCH. Key partners include WHO, UNFPA and the donor community, represented within the Health, Population and Nutrition Donor Coordination Forum. All of these stakholders are the intended users of this evaluation. Drwaing on evaluation's findings and implementing its recemndations would significantly enhance their approach to improving maternal and child health indicators across Pakistan.

Pakistan's government institutions are responsible for planning, implementing, training, monitoring and the overall coordination of different MCW activities. Partners and donors, meanwhile, are responsible for resource mobilization. UNICEF's role in the MCW initiative is significant, involving technical support, social mobilization, financial support for the procurement of supplies and resource mobilization.

1.4. PROGRAMME LOGIC MODEL/THEORY OF CHANGE

To fully understand the effectiveness and efficiency of the MCW initiative, this evaluation employed a theory of change (TOC) model. A TOC is a comprehensive explanation of how and why a desired change is expected to happen in a particular context. (Center for TOC, 2018).

The MCW intuitive did not have a TOC model, so it was conceptualized by the evaluation team retrospectively, after reviewing and analysing programme documents provided by UNICEF, coupled with research papers using linguistic analysis. The TOC model was refined after various consultations with provincial health mangers, with UNICEF's reference group and after field visits. The TOC model is explained in the section 5 of this report.

1.5. EVALUATION PURPOSE AND SIGNIFICANCE

The purpose of the evaluation was to assess the extent to which the MCW initiative has been successful in achieving its intended objective of strengthening the delivery of routine maternal and child health services while simultaneously improving access to services for marginalized, excluded, crisis and disaster-affected populations. To fulfil this purpose, the evaluation documented the process, strengths, weaknesses and challenges observed during implementation of the MCW initiative between 2007 and 2017. Based on the evidence gathered, the evaluation assessed the efficacy and efficiency of the MCW initiative developed by UNICEF.

The evaluation also focused on the differences, if any, in the execution of the MCW initiative before 2011 – when it was managed nationally – and in the period after the 18th Amendment, when MCWs became a provincial subject. The evaluation also looked at provincial and geographical disparities, if any, in the implementation of the MCW initiative. Provincial and regional disparities fuelled by socio-cultural factors like gender (i.e. cultural differences in

powers vested in gender roles) and equity (i.e. the uniform provision of services across provinces and regions, with special reference to vulnerable and marginalized populations) were accounted for in the evaluation, as they might have a bearing on the achievement of intended objectives. Insights related to the MCW initiative's institutionalization, challenges in its implementation, its potential for sustainability and expected benefit-value are also included in the evaluation. Furthermore, the evaluation illustrates the extent to which its findings would be beneficial to implementing agencies in terms of increasing the MCW initiative's coverage to a larger number of areas.

As explained above, the evaluation provided a holistic overall picture of the MCW initiative's achievements, in keeping with SDG targets for the delivery of health services for mothers and children. It also helped to understand the initiative's scalability in different provinces without UNICEF's support. In addition, this evaluation helped relevant federal and provincial government personnel to decide about investing in the MCW in terms of future planning and policy making. The evidence generated further helped to define UNICEF's position and programming for the MCW initiative, along with other development partners who aim to undertake similar interventions of their own.

The evaluation is valuable for government and partner organizations working on MNCH, as its evidence will enable stakeholders to learn lessons and replicate interventions with improved planning and designs in the future. The evaluation provides in-depth insights about the MCW initiative's effectiveness, efficiency, long-term outcomes and sustainability; alongside insights on differences in implementation strategies among Pakistan's provinces and regions, including the Federally Administered Tribal Areas (FATA), Gilgit-Baltistan (GB) and AJK. As such, the evaluation's findings can be used to inform federal and provincial government decisions on investing in the MCW initiative.

1.6. OBJECTIVES OF THE EVALUATION

This evaluation aimed to address the following objectives:

1. To assess the extent to which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services and enhancing access to these services for potential beneficiaries);

2. To analyse the synchronization between national and provincial policies/priorities regarding maternal, neonatal and child health (MNCH) and the MCW initiative's goals and objectives;
3. To better understand the MCW process and lessons learned during the 2007-2011 period, when the MCW initiative's implementation transitioned from small-scale piloting to nationwide implementation in 2012 and thereafter;
4. To assess the extent to which the MCW initiative met the basic health needs and rights of women, girls and boys – the intended primary beneficiaries – and whether there were any unintended outcomes;
5. To determine the extent to which the MCW initiative helped to mobilize communities to utilize and strengthen routine health services;
6. To explore the extent to which the MCW initiative addressed the needs of marginalized, excluded, crisis and disaster-affected populations;
7. To provide a descriptive cost analysis for the MCW initiative;
8. To identify lessons learned, exploring what has worked well and what has not worked;
9. To determine sustainability of the MCW initiative and look into the possibilities for the Government taking over its activities in the future; and
10. To offer recommendations regarding institutionalization, gender programming, equity and child rights.

1.7. SCOPE OF THE EVALUATION

This evaluation was designed to cover the 11 year period (2007-2017) of the MCW initiative's implementation across Pakistan. The aim was to deliver a national evaluation with clear provincial/area differentiation. To this end, data was collected in sample districts/areas of all four of Pakistan's provinces and in the Federally Administered Tribal Areas (FATA), Gilgit-Baltistan (GB) and Azad Jammu and Kashmir (AJK). As noted above, the 2007-2011 period mainly involved piloting the MCW initiative in a few districts of Punjab, before its national scale implementation from 2012 onward.

The evaluation team analysed lists of districts in all provinces and administrative areas, whereupon it selected target areas for the evaluation through simple random sampling to ensure an unbiased, representative sample. As the scope of the present evaluation was not restricted to assessing coverage, a relatively small sample size was deemed to suffice (details on the sample

size, proceedures and limitations of this evaluation are discussed in Section 3). The evaluation also entailed evaluating the managerial aspects of the MCW initiative in the context of 18th Constitutional Amendment (2010), which devolved primary responsibility for health care to Pakistan's provinces.

2. EVALUATION CRITERIA AND QUESTIONS

To assess the MCW initiative, the evaluation followed the criteria formulated by the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD, 2010). These widely used DAC criteria are considered a strong foundation for programme evaluation (Chianca, 2008). The criteria include relevance, effectiveness, efficiency, sustainability and impact. It is important note that the MCW evaluation measured the 'impact' criterion by looking at long-term outcomes, as the assessment was not intended to be an experimental or impact evaluation. Cross cutting issues – such as equity, gender and human rights – were also included as part of the evaluation criteria in this assessment.

The evaluation also employed the United Nations Evaluation Group's (UNEG) standards for an impartial, coherent and effective evaluation. As per UNEG standards, a set of key questions and relevant sub-questions were devised. Based on these questions, separate data collection tools were developed for different stakeholders, in accordance with their roles and responsibilities in the MCW initiative, as elaborated by UNICEF's referral guide. These tools were finalized in consultation with key stakeholders during consultative meetings. A detailed Evaluation Design Matrix (EDM) was developed in line with UNEG standards and the OECD DAC evaluation criteria, as stipulated in the ToR (see Annex 2). The Evaluation Design Matrix explains how the evaluation questions were addressed, the types of data source used, data collection and analysis methods, and relevant stakeholders for each specific type of question. Table 1 summarizes the criteria and evaluation questions.

Table 1: Evaluation criteria and key evaluation questions

Criteria	Key evaluation questions
Relevance	• How relevant and meaningful are the MCW initiative's objectives and activities in terms of addressing the needs and priorities of marginalized/vulnerable children and mothers in the intervention areas? • To what extent are the strategies used by the MCW initiative relevant to the national priorities and policies related to MNCH addressed by this initiative? • How relevant is the selection of project areas (districts and villages) with reference to the MCW initiative's objectives?
Effectiveness	• To what extent has the implementation of MCW strategies worked as intended? • Were the strategies appropriately designed and properly delivered?

	• How successfully did the MCW initiative reach intended target groups in the areas covered? • What major changes have occurred as a result of the implementation of the MCW initiative over the past ten years?
Efficiency	• How efficiently have UNICEF and its implementation partners managed resources (both human and financial) to ensure timely, cost-effective and efficient attainment of results?
Long-term outcomes	• To what extent has the MCW initiative achieved its objectives and what were the major factors that affected its achievement of, and its inability to achieve, intended objectives/outcomes? • What lessons were learned during implementation of the MCW initiative and what other more cost-effective options were available, if any?
Sustainability	• To what extent are provincial governments willing to continue the MCW initiative if UNICEF itself pulls out of the initiative? • To what extent has the MCW contributed to strengthening the capacity of maternal and child health providers/duty bearers? • What were the enablers and drivers (internal and external) that contributed to, or hindered, the sustainability of the MCW initiative?
Cross-cutting issues	• To what extent were cross-cutting issues – such as gender, equity, a human rights-based approach and disaster risk reduction – incorporated at various levels of the MCW initiative's planning and implementation?

2.1. EVALUATION APPROACH

To address the complex, wide-ranging set of research questions for this evaluation, a systematic and scientifically sound methodology was adopted. A social system-based approach was used to understand Pakistan's health care system and its intricate relationship with the inputs, activities and outcomes of the MCW initiative. To identify the extent of coverage and efficiency of the MCW initiative, a household survey was conducted with programme beneficiaries. To explore the initiative's relevance, efficiency, effectiveness, outcomes and sustainability, qualitative research methods were employed to engage different stakeholders. As explained above, the evaluation followed the UNEG (2005) standards for evaluation, including professional integrity, absence of bias, behavioural and organizational independence and impartiality, stakeholders' participation throughout the evaluation process, honesty, anonymity and confidentiality of individual information. In keeping with the evaluation's focus on cross-cutting issues, the

evaluation team strove to integrate gender equality and human rights principles throughout the evaluation process.

3. EVALUATION METHODOLOGY

3.1. DESIGN

In general, the evaluation of a programme uses quasi-experimental design. However, as baseline data was not available, it was neither feasible nor practical for the present evaluation to adopt this form of evaluation design. Instead, an analytical approach was adopted – in the form of contribution analysis – to provide a credible assessment of cause and effect (Mayne, 2008). Contribution analysis helped the evaluation team to verify the theory of change upon which the MCW initiative is based and to examine whether the initiative contributed to achieving its intended outcomes, specifically improvements in maternal and child health across Pakistan.

Contribution analysis *"explores attribution through assessing the contribution a programme is making to observed results"* (Mayne, 2008, p. 1). According to contribution analysis, causality in the context of the MCW initiative can be inferred from the following evidence:

1. The MCW initiative is based on a credible theory of change;
2. MCW activities are carried out as planned;
3. The initiative's theory of change can be verified by current evidence, that is, the fact that the chain of expected results has been achieved; and
4. The contribution of other influencing factors, if any, is clearly acknowledged.

To validate the contribution story, the evaluation team designed a mixed-method approach to gather evidence-based data for the summative evaluation of the MCW initiative.

3.2. TARGET POPULATION FOR THE EVALUATION

The evaluation's target population was identified in accordance with the evaluation's objectives and scope, and based on a review of secondary data. Thus, the target population encompassed (i) potential beneficiaries of the MCW initiative and (ii) stakeholders involved in planning, implementation and monitoring processes.

The potential beneficiaries are women of reproductive age (i.e. between the ages of 15 and 49) who had at least one child under the age of 5 at the time of the survey. For other stakeholders,

data collection was limited to the most relevant informants at the federal, provincial and district levels. At the federal level, stakeholders included the Federal Director General of Health, the National Auditor, UNICEF's Chief of Health, the National Coordinator Lady Health Worker (LHW) Programme and the National Programme Manager of the Expanded Programme on Immunization (EPI). At the provincial level, key stakeholders included each Provincial Director General of Health, the Provincial Coordinator of the LHW Programme, the Provincial Coordinator of the EPI Programme, UNICEF's Provincial Health Specialist and the Provincial Coordinator of the MNCH Programme.

Stakeholders at the district level encompassed District Health Officers and the District Coordinators of the LHW, EPI and MNCH programmes. Health care providers at the sub-district Union Council (UC) level were also contacted, as were representatives of any NGOs working on MNCH in these areas. Community health workers – including LHWs, Lady Health Supervisors (LHS) and vaccinators – were also part of the evaluation. A list of all stakeholders included in the MCW initiative's evaluation is presented in Annex 3.

3.3. METHODS OF DATA COLLECTION

The evaluation used both primary and secondary data, as described below.

3.3.1. Primary data

The primary data used for this evaluation was collected by using the following data collection techniques:

- Quantitative data was collected by using a face-to-face survey technique at the household level. This enabled the evaluation team to assess the coverage of the MCW initiative and to examine the knowledge, attitude and practices (KAP) of potential MCW beneficiaries regarding different maternal and child health issues. These women were selected on the assumption that, as they have at least one child under the age of 5, they have participated in at least one or two rounds of MCW activities. Based on this data, the team was able to infer how effective the MCW initiative has been.
- Both quantitative and qualitative data was collected from LHWs who had attended at least two rounds of Mother and Child Weeks. Quantitative data provided by LHWS included, for

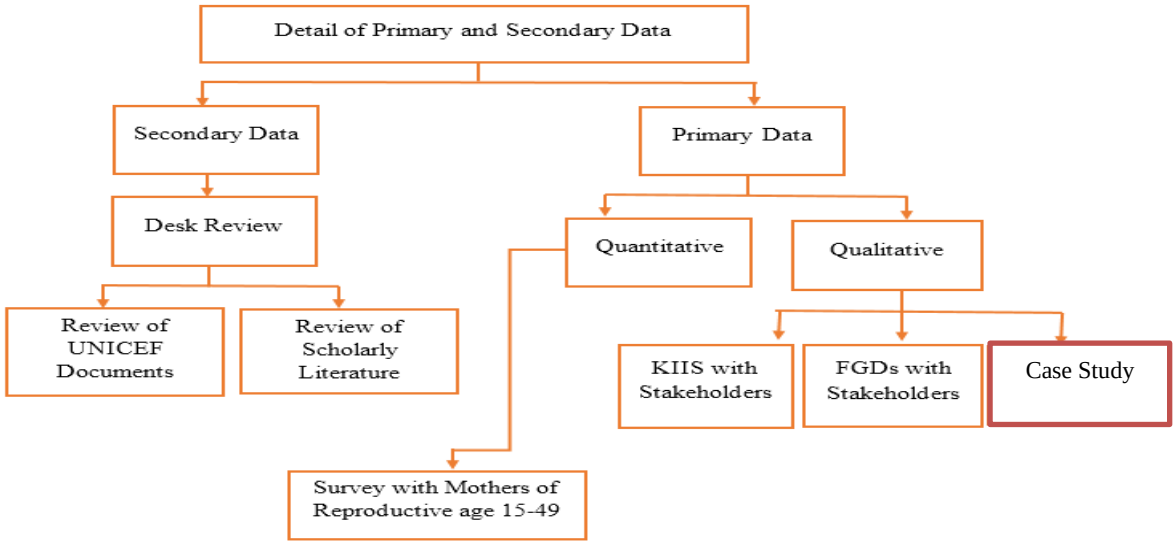
instance, their KAP regarding maternal and child health issues and their experiences of delivering training in the context of MCWs.

- Qualitative data was collected through Focus Group Discussions (FGDs) with LHWs, LHS and vaccinators who had attended at least two rounds of MCW activities. In this way, the evaluation collated data on their perceptions and views regarding the MCW initiative.
- Key Informant Interviews (KIIs) were conducted with health managers at the federal, provincial and district levels, as were KIIs with health care providers at the basic health unit (BHU) level, such as doctors, dispensers, LHVs or other officials responsible for managing a BHU. A list of stakeholders engaged through KIIs is included in Annex 3.
- A case study technique was also used to collect information, explore successes/failures and identify positive/negative experiences of the MCW initiative's potential beneficiaries. This enabled the evaluation to identify particular instances of success/failure and consider how successes may be replicated. Case studies are considered helpful for explaining how change comes about (i.e. processes and causal mechanisms) and when (i.e. in what situations and contexts) change can be useful. The case study approach recorded household level personal accounts of change (i.e. accounts from mothers in this evaluation), determined which of these accounts are especially significant and explored why change came about in these instances.
- To undertake a descriptive cost analysis, complete data would have been required on the MCW initiative's inputs (i.e. financial and intellectual capital) and outputs (i.e. the total number of beneficiaries reached) during the past ten years. As complete data was not available for all years (specifically for 2007-2014 and 2017), the evaluation team could not conduct a detailed descriptive cost analysis. Nonetheless, as data for two years (2015 and 2016) were provided by UNICEF, a descriptive cost analysis was undertaken for these years. The total cost of two rounds of Mother and Child Weeks in 2015 and 2016 was calculated by adding the costs spent (i.e. on human resources, vaccination, deworming, IEC materials, monitoring and supervision activities) divided by the total number of MCW beneficiaries (see Annex 9 for details). The total cost is presented as the cost per beneficiary, in terms of the share provided by both the Government and UNICEF. The Government's share is presented as the costs incurred in terms of human resources and vaccination. UNICEF's share, meanwhile, was spent on IEC materials, deworming, monitoring and supervision.

3.3.2. Secondary data

The secondary data used for this evaluation comprised relevant documents, including reports of national surveys – specifically, the *Multiple Indicator Cluster Surveys* (MICS) and the *Pakistan Demographic and Health Surveys* (PDHS) – review and planning reports of the MCW initiative, reports of provincial annual health sector reviews and provincial health sector stocktaking reports. The literature review also included information, education and communications (IEC) materials, training manuals, reports provided by UNICEF, MCW progress reports and academic literature. The details of the primary and secondary data sources used are illustrated in Figure 5.

Figure 5: Data sources



3.4. EVALUATION SETTING AND SAMPLING PROCEDURE

The sampling procedure[1] for this evaluation was adapted from the immunization coverage cluster survey (WHO, 2005) which, in turn, followed the precedent set by the 30-cluster survey to assess immunization coverage. As the scope of the present evaluation was not restricted to assessing coverage, a smaller sample size was deemed to suffice. In addition, the target population for this evaluation is considerably smaller than that of the immunization coverage survey. Therefore, the evaluation team, in consultation with a senior statistician, adapted 30-cluster survey's technique

[1] The sampling procedure and selection of districts were approved by all implementation partners during consultative meetings with the Provincial Coordinators of the LHW, Nutrition, EPI and MNCH programmes.

and selected 10 clusters from each district. The following sections explain the quantitative sampling procedure used for this evaluation in greater detail.

3.4.1. Selection of districts

Districts were selected in each of Pakistan's provinces and regions on the basis of health indicators. A list of health indicators was developed on the basis of MCW coverage indicators. The indicators include the infant mortality rate (IMR), the under-five mortality rate (U5MR), immunization coverage, stunting, wasting, the prevalence of children under the age of five being underweight, episodes of diarrhoea and fever among children under the age of five, recognized symptoms of acute respiratory infections (ARI) and an unmet need for family planning (as outlined in Table 2).

These health indicators were discussed during all provincial consultative meetings with health managers, who approved and accepted them as the means of selecting districts for the MCW initiative's evaluation. The selection of districts was also discussed with representatives of UNICEF, and the EPI, MNCH, Nutrition and LHW Programmes. Data for the health indicators was retrieved from the latest available Multiple Indicator Cluster Survey (MICS) in each province (Punjab MICS, 2014; Sindh MICS, 2014; Balochistan MICS, 2011; GB MICS, 2016-17; FATA MICS, 2009; KP MICS, 2008).

Table 2: Health indicators from MICS reports used for district selection

Positive indicators			**Negative indicators**	
Early initiation of breastfeeding	Exclusive breastfeeding	Four and above number of antenatal care visits	IMR	U5MR
Minimum dietary diversity	Salt iodization	Use of antenatal care services (checkups for anaemia, blood pressure, blood sugar)	Underweight	Stunting
Fully immunized children	Weight at birth	Skilled birth attendant	Wasting	Bottle feeding
Recognition of ARI	Use of contraceptives	Institutional deliveries	Overweight	Episodes of diarrhoea/fever

symptoms				
Use of oral rehydration salts (ORS) and zinc during episodes of diarrhoea	Protection against tetanus	Postnatal health checkups for mothers and children	Low birth weight	Unmet need for family planning

Based on these indicators, districts were ranked in terms of their performance – from the best performing to those which perform poorly. Ranking involved calculating separate cumulative scores for the indicators used – one score for negative indicators (i.e. the lower the score on negative indicators, the higher a district's performance) and a second score for positive indicators (i.e. the higher the score on positive indicators, the better a district's performance). To attain cumulative scores on negative indicators, lower than average values were coded green (i.e. for good performance) and higher than average scored were coded red (i.e. for poor performance). For cumulative scores on positive indicators, the reverse is true (i.e. green for higher than average scores and red for scores that are lower than average).

The best preforming districts were selected by taking the lowest value from the cumulative scores of negative indicators and the highest value from cumulative scores of positive indicators. The selection of districts that perform poorly involved taking the highest value from cumulative scores of negative indicators and the lowest value from the cumulative scores of positive indicators. In most cases, values were coherent – i.e. district with the lowest value on negative indicators have the highest value in positive indicators and vice versa. In the case of incoherence between values, districts with the lowest difference between their cumulative score of negative indicators and their cumulative score of positive indicators were selected.

Table 3: Distribution of selected districts by province/region

Provinces and regions	No. of districts
Punjab	6
Sindh	4
KP	4
Balochistan	2
GB	2
AJK	2

FATA	2
Total	**22**

As Table 3 shows, the evaluation focused on 22 districts in Pakistan's four provinces and three regions/administrative areas, selected on basis of their maternal and child health indicators. Despite the uniform criteria, certain provincial and regional disparities had to be taken into account during the sampling procedure. For instance, as Punjab is Pakistan's most densely populated province, it naturally has a greater number of both beneficiaries and primary health care providers (LHWs and LHS). To account for this disparity, two districts from each geographic region of Punjab (i.e. north, central and south Punjab) were selected. Thus, six districts in the province were selected.

For Sindh and KP, two districts from each of these provinces' two geographic regions were selected (i.e. the northern and southern parts of each province), totalling four districts in each province. MICS data on Balochistan comprises six divisions rather than districts. Thus, two divisions in Balochistan were selected – i.e. the best and the worst performing divisions – and one district from each of these selected divisions was randomly chosen. The three regions of GB, AJK and FATA were not subdivided. As such, two districts – i.e. the districts with the best and the poorest performance – were selected in each of these regions.

3.4.2. Selection of *tehsils*, union councils and households

One *tehsil* (administrative division) in each of the 22 selected districts was randomly drawn and two union councils (UCs) in each of these *tehsils* were randomly selected. A list of LHWs working in different union councils was obtained from respective health departments. A cluster of 10 LHWs was randomly selected from the list of LHWs working in these union councils (i.e. five LHWs in each union council). Each selected LHW assisted the field research team to approach seven households in their union council. Each LHW also facilitated the quantitative household survey, undertaken by employing a simple random sampling technique. As discussed above, the survey focused on women of reproductive age with at least one child under the age of five.

As it was difficult to find a prepared list of all households in each union council, methods employed by the EPI coverage survey were used (WHO, 2005). This technique involved

identifying the central point of a village or town. From this point, the field research team randomly picked a direction. Once they began walking in this direction, the team began counting houses. A random household from among these houses was selected for survey. If the household met the inclusion criteria, the survey was conducted; if not, another household was randomly selected. Details on this sampling are presented in Table 4 below.

3.4.3. Sampling procedure for the qualitative study

The sampling procedure used for Key Informant Interviews (KIIs) was purposive. Only data-rich informants who were directly involved in the MCW initiative's planning and implementation were selected at all four levels – i.e. federal, provincial, district and union council (BHU health managers). Details of these informants are presented in Annex 3.

A 10-cluster sampling technique was used as the sampling procedure for Focus Group Discussions (FGDs) with LHWs. Once 10 LHWs were selected from each of the two union councils (five LHWs from each union), they participated in the evaluation's FGDs. The sampling procedure for the FGDs with LHS and vaccinators was based on convenient sampling. Thus, lists of LHS and vaccinators were procured from district health managers. From these lists, ten LHS and ten vaccinators were selected for FGDs, based on their willingness to participate.

3.5. SAMPLE SIZE

The sample size was finalized in accordance with the 10-cluster sampling strategy, adapted from 30-cluster technique developed by WHO and used for the EPI coverage survey (WHO, 2005). This was done in consultation with a statistician from the College of Statistical and Actuarial Sciences of the University of the Punjab in Lahore. As discussed above, 10 LHWs were selected randomly in each selected district. Each LHW, in term, helped the team to approach seven households for the evaluation. The sample size for the household survey with the MCW initiative's beneficiaries was 1,540 (10x7x22=1540) and included 220 (10x22=220) LHWs. The sample size for the qualitative study included 22 case studies of potential MCW beneficiaries[2], 172 Key Informant Interviews (KIIs) with identified stakeholders at the federal,

[2] One case study from each selected district.

[3.1] In some areas, the evaluation team did not find NGOs working on MNCH. Thus, a total of 164 KIIs were conducted.

provincial, district and union council levels, and 66 FGDs with LHWs, LHS and vaccinators (see Table 4).

Table 4: Sample size for the evaluation

Data collection technique	Punjab	Sindh	KP	Balochistan	GB	FATA	AJK	Federal	Total
Survey with potential beneficiaries	10x7x6= 420	10x7x4= 280	10x7x4= 280	10x7x4= 140	10x7x4= 140	10x7x4= 140	10x7x4= 140	0	**1540**
Key Informant Interviews	41	29	29	17	17	17	17	5	**172** 3.1
Survey with LHWs	60	40	40	20	20	20	20	0	**220**
Focus Group Discussions	18	12	12	6	6ss	6	6	0	**66**
Case studies	6	4	4	2	2	2	2	0	**22**

Table 5 presents the details of different research techniques and the sample size for the evaluation by province/region.

Table 5: Sample size for the evaluation

Province	Region	District	Tehsil	Union council	Performance	Qualitative					Quantitative
						Provincial KIIs	KIIs	FGDs	Survey with LHWs	Case study	Survey with potential beneficiaries
Punjab/ ICT	North	Chakwal	Kallar Kahar	Buchal Kalan Bhaun	Best	5	6	3	10	1	70
		Mandi Bahauddin	Phalia	Duggal Qadirabad	Worst		6	3	10	1	70
	Central	Lahore	Raiwind	Jia Bagg Arayan	Best		6	3	10	1	70

		Kasur	Kot Radha Kishan	Zafar kay Handal	Worst		6	3	10	1	70
	South	Vehari	Mailsi	Alam Pur Sandal	Best		6	3	10	1	70
		Muzaffargarh	Kot Addu	Budh Ahsan Pur	Worst		6	3	10	1	70
Federal	N/A	N/A	N/A	N/A	--		5	N/A		N/A	0
Sindh	North	Naushahro Feroze	Moro	Lalia Fatoo balal	Best	5	6	3	10	1	70
		Shikarpur	Khanpur	Zarkhel Mian Sahib	Worst		6	3	10	1	70
	South	Karachi (south)	Sadar	Clifton Old Haji Camp	Best		6	3	10	1	70
		Dadu	Johi	Phulji Kamal Khan	Worst		6	3	10	1	70
KP	North	Peshawar	Peshawar	Faqirabad Shaheen Town	Best	5	6	3	10	1	70
		Lakki Marwat	Lakki Marwat	Dara Tang Mama Khel	Worst		6	3	10	1	70
	South	Lower Dir	Timergara	Bandagai Noora Khel	Best		6	3	10	1	70
		Swabi	Topi	Kotha Kabgani	Worst		6	3	10	1	70
Balochistan	N/A	Makran (Kech)	Turbat	Malikabad [3]	Best	5	6	3	10	1	70
	N/A	Zhob	Zhob	Islamyar zhob Appozai	Worst		6	3	10	1	70
G.B	N/A	Hunza	Gojal	Gojal I Gojal II	Best	5	6	3	10	1	70

[3] During the training sessions, the team of enumerators from Balochistan explained that the selected union council of Pidark in Kech is considered a 'no go' area. It was recommended that evaluation team should revisit the selection of union councils, and instead select a more accessible union council in Kech. After consultation with UNICEF, the selected union council was changed.

	N/A	Gilgit[4]	Gilgit[6]	Amphray Nagral	Worst		6	3	10	1	70
AJK	N/A	Mirpur	Mirpur	Khari Khas Pindi Sabarwal	Best	5	6	3	10	1	70
	N/A	Muzaffarabad	Muzaffarabad	Panjkot Chatter Domel	Worst		6	3	10	1	70
FATA	N/A	Khyber	Jamrud	Jamrud	Best	5[5]	6	3	10	1	70
	N/A	Orakzai	Lower Orakzai	Lower Orakzai	Worst		6	3	10	1	70
						35	**137**	**66**	**220**	**22**	**1540**

3.6. DATA COLLECTION TOOLS

As discussed above, the evaluation's key questions were elaborated in accordance with OECD DAC criteria (2005). Thus, they include questions to gauge the MCW initiative's relevance, efficiency, effectiveness, impact (long-term outcomes) and sustainability. The sub-questions were developed in line with the aforementioned criteria and stakeholders' roles and responsibilities in the MCW initiative. Different data collection tools were developed for each category of the target population.

- For the quantitative survey, an interview schedule was developed on the basis of the evaluation's objectives and scope, alongside an extensive review of available literature. A separate set of interview schedules was developed for both potential beneficiaries and LHWs on the basis of their job descriptions, roles and responsibilities in the MCW initiative (see the Annexes for more details).
- For the KIIs, a semi-structured interview guide was developed for stakeholders from all four levels (i.e. federal, provincial, district and union council level) based on a deductive and inductive approach.

[4] During the training sessions and consultative meetings, the team of enumerators and UNICEF's representatives noted that data collection in Nagar could be very challenging due to cultural and structural barriers. Therefore, after consulting with the team, the selected district of Nagar was changed in favour of the district of Gilgit.
[5] Initially five provincial KIIs were proposed in FATA.

- For the FGDs, a FGD guide was developed using the same approach used for the KIIs, to be conducted in each selected district (see Annex 4).
- For the case studies, a list of key questions was finalized (see Annex 4.4 for details).

The indicators used to developing data collection tools are presented in Table 6.

Table 6: Indicators related to the MCW initiative's evaluation

List of indicators
• Needs and priority assessment of potential beneficiaries • Extent to which the MCW initiative fulfilled its intended objectives • The MCW initiative's alignment with national/provincial policies and priorities • Aptness of the selection of areas for MCW interventions • Design of the MCW initiative's strategies • Implementation of the MCW initiative's strategies • Efficacy of the MCW initiative's strategies • Coverage of the MCW initiative • Contribution of the MCW initiative, since its inception, to maternal and child health indicators • Efficient resource utilization • Factors affecting the achievement of intended objectives • Lessons learned from the MCW initiative • Administrative will to continue the MCW initiative • Factors that affect the sustainability of the MCW initiative • Cross-cutting issues

3.7. PRE-TESTING

The pilot testing of data collection tools was undertaken prior to the actual process of data collection for the MCW evaluation. The purpose of this pilot testing was to check the validity and reliability of each data collection tool, while assessing the evaluation's design and fieldwork arrangements. The pre-testing of the FGD guide was conducted with one group of LHWs, LHS and vaccinators. To test the KIIs guide, interviews were conducted with at least two selected stakeholders at all four levels (i.e. federal, provincial, district and union council levels). To pilot test the surveys for potential beneficiaries and LHWs, respondents were selected from one district of central Punjab (Kasur). The findings of the pilot evaluation were included in the final data analysis. Lessons learned from the pilot testing of tools were incorporated into the process of finalizing the evaluation's design, instruments and arrangements.

3.8. TRAINING TEAMS FOR FIELD RESEARCH

Separate teams of field researchers and enumerators were hired for each district. In May 2018, the evaluation team arranged a three-day field training workshop in Lahore for enumerators from Punjab and KP. Separate training workshops were arranged for field research teams from Balochistan and Sindh, held in Karachi, and those from AJK and GB, which were held in in Muzaffarabad and GB, respectively, in August 2018.

The main purpose of the workshops was to ensure the uniform application of the evaluation's methodology, to raise enumerators' awareness of the theoretical and practical aspects of the MCW initiative, and to ensure that they understood the evaluation's rationale and objectives. All field research teams were also trained to administer the survey tools and qualitative interview guides through mock exercises during the workshops. In tandem, participants were trained to make audio recordings of interviews/discussions. Representatives of UNICEF's reference group also participated in, and contributed to, the training workshops, thereby contributing to the participatory nature of the evaluation process. The robust, rigorous training workshops greatly enhanced the data collection process in the field.

3.9. FIELD OPERATIONS

To supervise the data collection process, highly qualified and experienced field researchers were recruited, generally with MPhil or Master's degrees in public health or a related social sciences field. They received extensive training on the study tools and field settings. Each supervisor was responsible for supervising and monitoring the process of data collection in two specified areas. They were also responsible for validating and verifying the data collected by field research teams.

For primary data collection in the four provinces and three administrative areas/regions, 22 teams of enumerators were recruited, comprising 66 qualified, experienced field researchers. Three enumerators made up each team – one man and two women. These researchers each had a

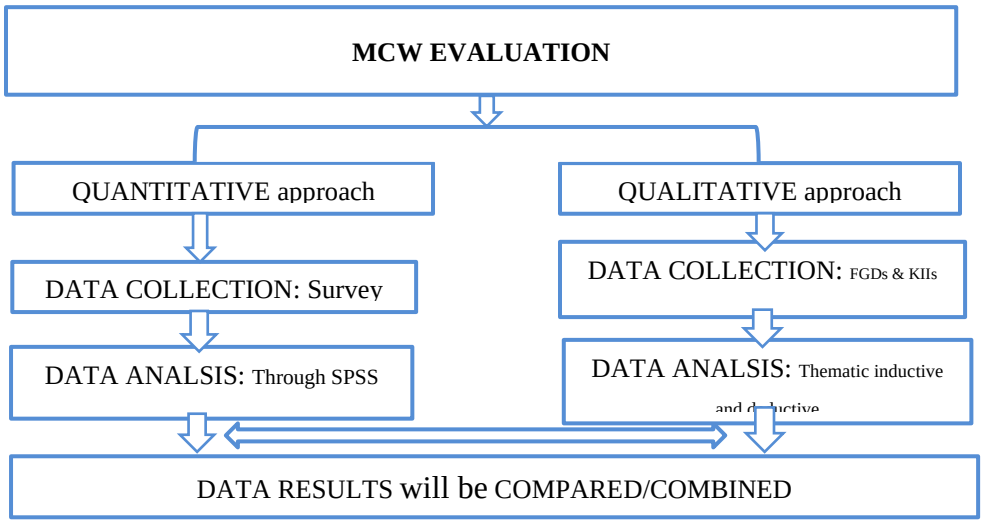
Master's degree in a field of social sciences. To assist the field research teams during the data collection process, a focal person was hired for each district – an individual who was well-versed on the area, its culture, language, the local health care system and stakeholders involved in the evaluation. These focal persons helped the evaluation team to make arrangements for field work in each respective district and to make appointments with stakeholders for interviews. Three field supervisors were designated from the core research team at the Institute of Social & Cultural Studies at the University of the Punjab (ISCS). Each supervisor was responsible for monitoring and data validation for two provinces/regions.

Data collection was completed in June 2018 in Lahore and Kasur. Data was collected in all other districts between the 15th of August and the 30th of September, 2018. The trained field research teams carried out interviews as per the interviewee's convenience. Observations and written field notes were also taken during the interviews. Where possible, interviews and discussions were recorded via audio recordings, with the permission of the individuals' interviewed. The research teams arranged de-briefing sessions after the FGDs to identify gaps, which the teams strove to overcome in successive interviews.

3.10. ANALYTICAL APPROACHES

Different analytical techniques were employed to analyse the quantitative and qualitative data collected during the initial stages of the evaluation. After compiling the initial findings drawn from this data, all of the data was compared and triangulated.

Figure 6: Data analysis strategy



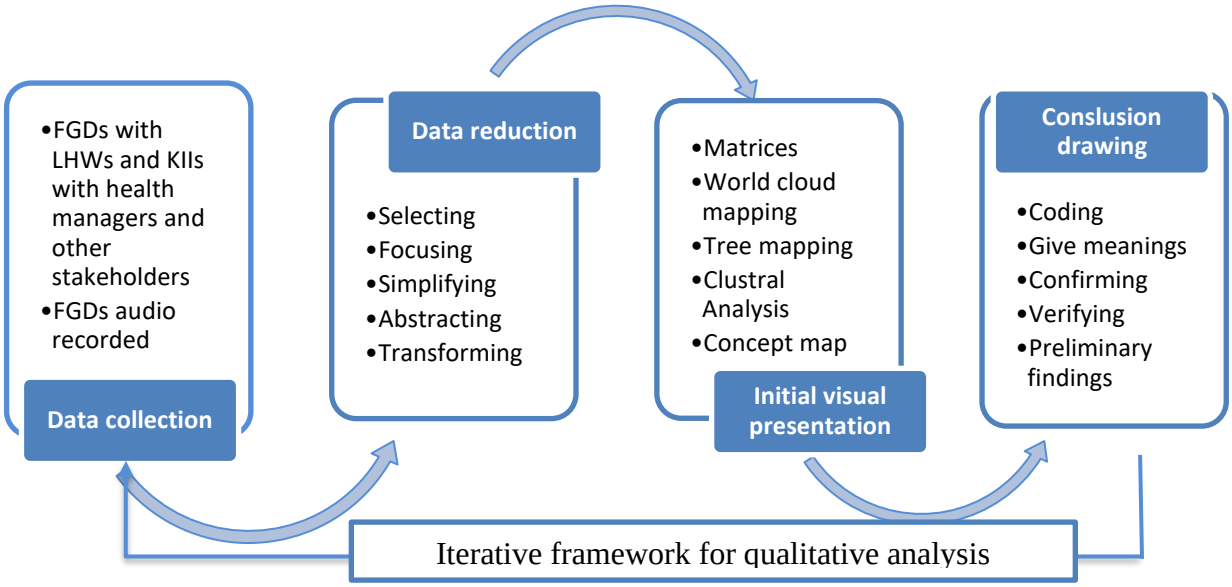
3.10.1. Qualitative data analysis

The qualitative data gathered through KIIs, FGDs and case studies was transcribed verbatim in Urdu (when these were originally in Punjabi, Sindhi, Balochi, Saraiki and Pashto), before being translated into English. During the process of verbatim translation, the colloquial style of the participants' verbal and non-verbal communication was included in the transcriptions. Attempts were also made to capture the intended context of participants' expressions. The anonymity of the interviewees and discussion participants was duly considered during the transcription process through the use of pseudonyms in place of the actual names and places mentioned by the participants.

An iterative framework for data analysis was used. This included a loop-like pattern of multiple rounds of revisiting the data as additional questions emerged. At the second stage, the data was analysed by initiating the process of coding and assigning categories. All data reduction techniques were considered – including selecting, focusing, simplifying, abstracting and transforming –during the data cleaning process, in order to generate themes from the data. At this stage, both an inductive and a deductive codes approach was employed. Deductive codes were derived from the review of available literature, material and MCW reports provided by UNICEF, reviewed in accordance with DAC criteria. Inductive codes emerged directly from the data collected. The research team analysed the complete coded and categorized data to identify and remove discrepancies, which may arise as a result of cross validating data.

The third stage involved analysing the inductive themes derived from the collected data. At the final stage of qualitative data analysis, the evaluation team's salient findings were discussed in light of the themes inferred from data collected and the themes derived from secondary sources. A schematic diagram of the iterative framework used for data analysis is depicted in Figure 7 below.

Figure 7: Steps for qualitative data analysis



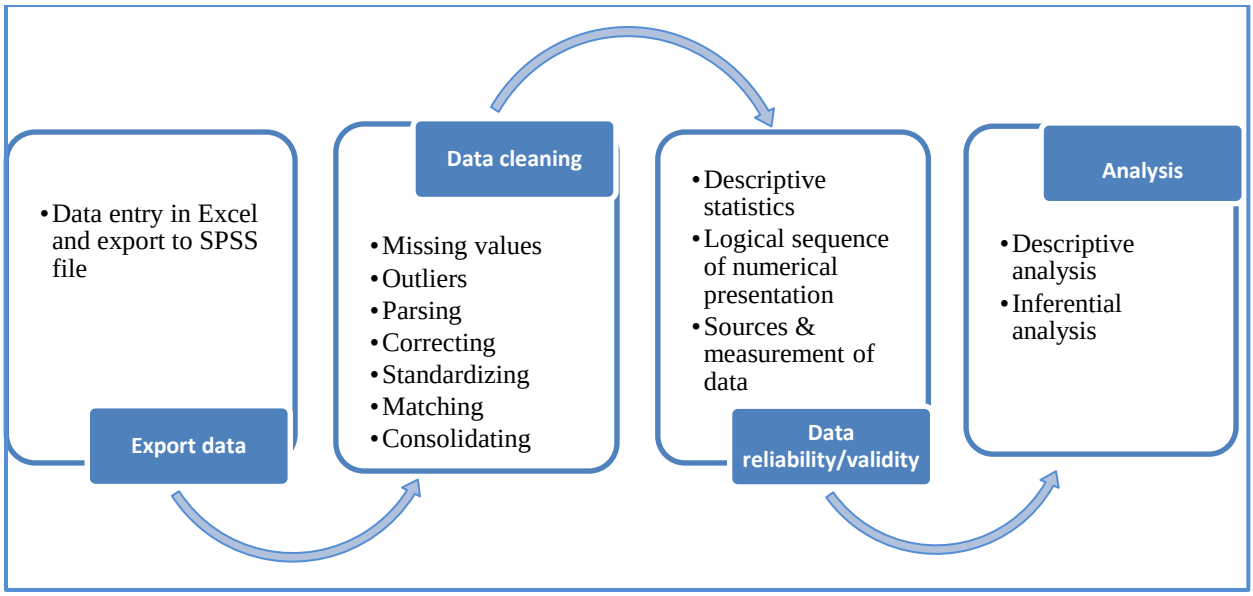
3.10.2. Quantitative data analysis

The quantitative data was processed using software, specifically the Statistical Package for Social Sciences (SPSS, vs. 22). Univariate and bivariate tables/graphs were created to present the results of the quantitative data. For the purposes of data analysis, descriptive statistics were applied. This process is portrayed in Figure 8 below.

3.10.3. Triangulation

The findings of the quantitative analysis were triangulated with the findings of nationally representative surveys such as the PDHS, MICS and baseline indicator surveys. For the purposes of analysis and inferences, quantitative and qualitative data were used to complement one another. Findings from similar reports available were also consulted and included in the discussion. Based on this process, conclusions were drawn.

Figure 8: Steps for quantitative data analysis



3.11. STAKEHOLDER CONSULTATIONS

To develop a robust methodology and data collection tools, stakeholders were thoroughly involved throughout the evaluation. At the beginning of the evaluation process, an inception meeting was held at the Marriot hotel in Islamabad on the 9th of March, 2018. Afterwards, consultative meetings were held with the Provincial Coordinators of the LHW, EPI, MNCH, UNICEF and Nutrition programmes at the provincial and regional levels, between the 20th and 30th of March, 2018. These consultative meetings helped the evaluation team finalize the evaluation's methodology and data collection tools. Details on each meeting are included in Annex 6. Throughout the evaluation process, the team maintained contact with the UNICEF

Reference Group, which consistently provided technical support. The findings and recommendations of evaluation were shared with stakeholders during the final MCW evaluation dissemination in January 2019.

3.12. ETHICAL STANDARDS AND COMPLIANCE

As outlined above, the evaluation strove to uphold UNEG's (2005) ethical standards, including respondents' anonymity, the confidentiality of information and the principle of doing no harm to all those involved in the interviews (UKaid, 2015). The information provided by the participants was used solely for research and academic purposes. All of the participants were informed about these ethical considerations. All interviews, FGDs and KIIs were conducted with the participants' complete, freely given consent.

The Institutional Review Board (IRB) of the University of the Punjab thoroughly reviewed the evaluation's protocols. Based on its examination, it issued a letter of approval, affirming that the evaluation does not contradict any ethical considerations. Given the evaluation's countrywide scope, the evaluation team also contacted the Director General Health in each province/region to obtain 'No Objection Certificates' (NOC) for the purposes of travel and data collection. Furthermore, the District Health Officials in the selected districts were approached through the proper channels and the District Coordination Officers of each district were also informed of the MCW evaluation and its objectives. All of these measures were taken to ensure that research ethics were applied, in letter and spirit, throughout the evaluation process.

3.13. QUALITY ASSURANCE

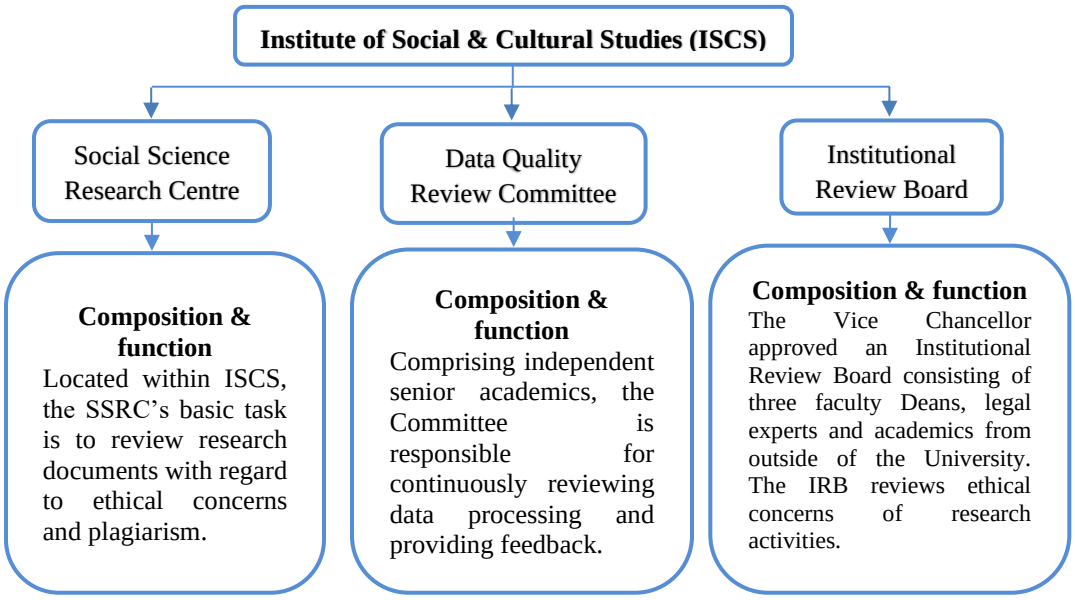
The Institute of Social and Cultural Studies (ISCS) has installed a built-in mechanism of quality assurance and cross verification to ensure the reliability and validity of all data collected. This mechanism ensures respect for the aforementioned ethical consideration of confidentiality, anonymity and effective neutrality. Any breach of these principles is not tolerated. The Institute has its own Data Quality Review Committee (DQRC) and a Social Science Research Centre (SSRC). The functions of the IRB, DQRC and SSRC are presented in Figure 9, reflecting the ISCS' longstanding commitment to the quality of data and its accurate, scientific interpretation.

The ISCS is mandated to develop and enhance the capabilities of young researchers by engaging them in the entire process of research; starting from the conceptualization of the topic to framing

methodology and planning to collect data, its analysis and interpretation. Through this evaluation, the young researchers were engaged in learning sophisticated skills and technical competence in collecting and analyzing data. The project team at ISCS continuously strived to nurture a culture of excellence by revising and reviewing the already documented ideas. By undergoing rigorous review and supervision, the young researchers learnt the value of truth, scientific neutrality and scholarly objectivity. In this environment, the young researchers at ISCS are professionally groomed and socialized to carry out research activities that meet the highest standards of research ethics and integrity.

As discussed above, the entire research process for the MCW initiative's evaluation was based on a participatory approach, which served as an important element for quality assurance. During the evaluation's initial stages, the evaluation's methodology and data collection tools were finalized in consultation with the UNICEF Reference Group, taking into account the contributions of different stakeholders during consultative meetings. The aforementioned robust, rigorous training workshops, delivered by the evaluation team for the field research team, greatly enhanced the data collection process in the field. Most of the interviews were audio recorded; written field notes were also taken during the interviews. The research teams arranged de-briefing sessions after the FGDs to identify gaps, which the team strove to overcome in successive interviews.

Figure 9: Quality assurance



Throughout, the evaluation team supervised and monitored the data collection process in all selected districts. After receiving data from the field, the evaluation team verified and validated its authenticity through random calls to study participants. All of the data (both written hard copies and recorded audio/video recordings) were organized and arranged by region/province. Reports on provincial findings were later shared with the respective field research teams and local stakeholders so that they could confirm the evidence drawn from the data.

3.14. CHALLENGES/LIMITATIONS AND MITIGATION STRATEGIES

The evaluation team experienced certain challenges and limitations during the course of the evaluation process. Table 7 presents these limitations, while explaining how the team addressed and managed these limitations.

Table 7: Limitations and mitigation strategies

Limitations	Description	Mitigation strategies
Attribution	• As neither baseline data nor cross-sectional research design were available, it was not possible to determine cause and effect relationships. • Due to the nature of the initiative under evaluation, there were several other governmental and non-governmental factors that affected maternal and child health indicators. Hence, isolating the impact of the MCW initiative and evaluating these impacts independently was a major challenge. • This could also lead to the false attribution of outcomes to the initiative under evaluation.	• To mitigate this limitation, the evaluation team employed contribution analysis. This form of analysis helps to draw robust conclusions about the contribution made by a specific programme/initiative to an observed result through both a quantitative and qualitative evaluation of the initiative.
Quality and availability of secondary data	• Detailed information on the costs of the MCW initiative was not available. • Baseline data on the initiative was not available. • The latest disaggregated data for all	• The quality and availability of secondary data is beyond the reach of the evaluation team. However, the team tried their level best to triangulate the information from different

	provinces/areas was not available.	secondary sources to ensure the quality of the information used for the MCW evaluation.
Field research arrangements	• It proved challenging to obtain NOCs for the purposes of travel and data collection for some provinces. This also delayed the data collection process in some areas.	• With UNICEF's support, the process of obtaining NOCs was successfully completed, even for the provinces/regions where difficulties were experienced.
Selection of districts and union councils	• It was not possible to collect data in certain regions due to security concerns or their geographical location.	• Access constraints were highlighted during the field research training workshops. Following deliberation and discussions with UNICEF's Reference Group, alternative districts/union councils were selected in place of less accessible areas.
Field work	• Completing the data collection process within a short period of time proved extremely challenging. Despite the evaluation team's best efforts, process could not be completed within stipulated time period. The reasons for this delay are described in the following points. • The extensive scope of the evaluation – which covered almost all of Pakistan's territory – made it highly time consuming to recruit the best field research team in each province/region. • Pakistan's geographic diversity made it necessary for the evaluation team to arrange four separate training workshops for different field research team. This took up considerable time. • The busy schedule of federal, provincial and district level health managers caused appointments for interviews to be rescheduled several times in some provinces/regions. • In a few cases, departments restricted health managers from	• The evaluation team ensured data quality by approaching relevant stakeholders with UNICEF's cooperation. • Through coordinated team efforts and the support of UNICEF's Reference Group, data completion was ultimately completed. • To overcome constraints, a wide range of stakeholders were included in the evaluation process. • During field work, the research team sought to assure stakeholders that their anonymity would be preserved and the information they provided would be treated as entirely confidential. Interviews began by building rapport with participants so that the interviews were able to provide candid responses. • Rigorous training for research teams, robust supervision of these teams and the evaluation team's monitoring of field

	providing information to the research teams without the prior approval of their District Health Offices. They feared that health mangers may disclose sensitive information, with problematic implications for the administration. As a result, approaching stakeholders and arranging interviews was challenging. • In some areas, harsh weather – particularly the scorching heat in July, August and September – proved challenging for field teams. • Most stakeholders are dispersed over a wide geographic area; thus, high communication and travel costs were incurred, particularly in GB, FATA and AJK. • Time consuming official procedures and tiring security checks took up significant time when field teams approached certain types of participants, especially in FATA, Sindh and GB. Although field teams were issued NOCs by the Directorate General of Health in each province/region, in some cases, researchers had to seek the consent of local administrations or authorities to conduct interviews. It is likely that this was due to the law and order situation in certain areas, especially in FATA. In some instances, participants expected stipends or compensation in exchange for interviews; however, there was no such provision for such remuneration included in the budget for field work. • The observance of Eid-al-fitr, Eid al-Adha, the month of Muharram, many other public holidays and general elections considerably delayed the process of data collection.	work greatly helped the field teams to overcome challenges. For example, as discussed above, four 3-day training workshops were arranged for field teams from different provinces, in which representatives of UNICEF's Reference Group also participated. Moreover, the entire data collection process in each district was monitored by field supervisors/coordinators from the evaluation team.

	• During the FGDs, peer pressure/group influence caused most participants to exclusively share positive experiences. They sought to give socially desirable responses and were reluctant to discuss any negative feedback regarding the MCW initiative because of their job obligations.	
KIIs	• The evaluation initially planned to conduct one KII in each district with the representatives of an NGO that works on MNCH issues. However, in most districts, no NGOs working on these issues could be identified worked; thus, these interviews could not be held.	
Household survey	• Many mothers who participated in the survey were not aware of the term 'Maternal and Child Health Week', although they were aware of the MCW initiative's activities. This lack of familiarity with certain terms sometimes confused the interviewers when recording participants' responses. • Due to time and financial constraints, it was not possible to use a large sample size for the evaluation. This makes it difficult to 'generalize' – or draw general conclusions – about the evaluation's quantitative findings, which represents a notable limitation.	• During the field research training workshops, researchers received extensive information on the MCW. Mock exercises were arranged so that interviewers would be able to address confusion among participants, or other similar limitations, during their field work. • The triangulation of the quantitative data collected was conducted vis-à-vis the qualitative data collected and with the secondary data analysed by the research team. This ensured the reliability of the evaluation's results, despite its relatively small sample size for data collection.
Gender inclusion	• The MCW initiative ignored men in education health sessions.	• Given men's important role in health care decision-making, engaging them in health education sessions and other MCW activities (e.g. social mobilization) is one of the principle recommendations of this evaluation.

Cost analysis	• It was difficult for the evaluation team to undertake a descriptive cost analysis for the last 10 years because the relevant documents were not available.	• The evaluators tried to acquire cost-related data during the evaluation's field work phase and by telephoning health managers. Nevertheless, the evaluation team was not able to access the relevant data and an overall descriptive cost analysis for the MCW initiative's entire ten year period proved impossible. As UNICEF representatives from Punjab and Islamabad shared cost-related data for 2015 and 2016, a descriptive cost analysis was undertaken for these two years.

4. FINDINGS

This section of the report provides the evaluation's key findings on the relevance, effectiveness, efficiency, long-term outcomes and sustainability of the MCW initiative, which aims to address pressing challenges related to maternal, newborn and child health in Pakistan. As discussed above, the MCW initiative was designed to address gaps in the provision of quality MNCH services, especially for poor and marginalized communities. It focused on preventive and promotive health care by providing health education and raising awareness among communities to promote safer, healthier practices that lead to better health among mothers and children.

4.1. RELEVANCE

The DAC criterion of relevance was one of the key areas of this evaluation. The MCW initiative's relevance was explored with a view to answering three evaluation questions:

- To what extent were the strategies used by the MCW initiative relevant to national priorities and policies related to MNCH?
- How relevant and meaningful were the MCW initiative's objectives and activities in terms of addressing the needs and priorities of marginalized, vulnerable mothers and children in the areas in which the MCW initiative was implemented?
- How relevant was the selection of areas (districts and villages) covered by the MCW initiative with reference to its objectives?

The MCW initiative's relevance for this evaluation parameter was determined through two primary components. First, from the perspective of health care supply, the MCW initiative's alignment with national and provincial/regional health policies and priorities was examined. Second, the MCW initiative's role was investigated in terms of addressing the health needs and demands of both the general and especially vulnerable populations, from a demand side perspective.

To assess the synchronization of the MCW concept with national and provincial/regional health policies, and their translation into implementation/actions to address the health needs of poor and marginalized communities which remain deprived of routine government health services, this evaluation ascertained the perspectives of different stakeholders. These included (a) health managers involved in the policy, planning and management of the MCW initiative, (b) health

care providers responsible for advocacy and service delivery in the context of the MCW initiative and (c) beneficiaries who accessed MCW services. Overall, the findings presented a macro to micro level analysis of the MCW initiative. Therein, most participants acknowledged the importance of the MCW initiative's efforts and their relevance vis-à-vis health policies. They also agreed that the MCW initiative brought about positive changes to improve MNCH indicators across Pakistan.

4.1.1. Relevance of the MCW initiative for national and provincial policies

The findings of the evaluation's qualitative data analysis affirmed that the MCW initiative was devised to assist the Government and provincial/regional health departments to effectively utilize existing public health networks. It focused on improved, cost-effective and accessible health care services at the grassroots level for mothers and children, including a focus on expanding immunization coverage and preventing diarrhoea and pneumonia, as outlined in health policies and plans.

Findings from the review of policy documents/literature

The evaluation team thoroughly reviewed relevant policy and strategy documents, including Pakistan's *National Health Vision* (2016-2025), provincial/regional health sector strategies, development and nutrition strategies/policies, and MCW-related planning and review documents. The findings of this review of policy documents offers a holistic picture of the MCW initiative's for national and provincial/regional health priorities. The review's findings showed that all policies/strategies including *National Health Vision Pakistan*, 2016-2025 primarily focus on improving the health status of mothers and children by providing universal access to affordable and quality health services. These policies place primary health care and essential health services for mothers and children centre stage.

The findings of the review also affirmed that achieving health targets – highlighted in the Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs) – is always a top priority for Pakistan. According to national and sub-national policies, all of its provinces/regions are striving to deliver quality services to accelerate progress on maternal and child health care services.

Once responsibility for the health sector was devolved to the provinces following the 18th Amendment, the review found that valid efforts to reorient the health system have been made by provinces. These include drafting health policies, aspiring to achieve the SDGs, strengthening vertical programmes, initiating public-private partnerships (PPPs) and reforming human resource development and infrastructure.

Provincial health documents were also comprehensively reviewed, all of which highlight maternal and child health. The analysis of Punjab's *Health Sector Strategy* (2013) reveals that the province aims to enhance its institutional capacities for health service delivery and plans to increase budget allocations. Most importantly, this document highlights the importance of reducing Punjab's child mortality rate, largely caused by poor nutrition and anaemia. The policy focuses on strengthening maternal and child health by improving nutrition among mothers and children, and by controlling infectious and non-infectious diseases.

Sindh's *Health Sector Strategy* (2012) highly recommends interventions to improve maternal and child health, including the integrated management of childhood illnesses, childhood vaccination, the control of parasitic infections, micro-nutrient supplementation, the treatment of moderately malnourished children, nutrition counselling and integrating contraception into pregnancy services. After the 18th Amendment, the Government of Balochistan formulated a comprehensive multi-year plan to increase the proportion of fully immunized children. The plan also explicitly aims to reduce deaths caused by Tetanus from 0.6 to 0.3 per 10,000 newborns by 2018.

KP has also expressed a commitment to improving health services for mothers and children. According to KP's *Health Sector Strategy* (2010), the province's neonatal mortality rate is 41 newborn deaths per 1,000 live births, the infant mortality rate is 63 infant deaths and the under-five mortality rate is 75 deaths per 1,000 live births. Thus, the provincial administration planned and approved a nutrition programme which includes interventions to improve nutrition, especially among women and children. It also encompasses identifying cases of vaccine defaulter children and also strengthening the existing pattern of nutrition services.

Overall, the findings of the literature review revealed that all national and provincial health policies emphasize achieving improved MNCH outcomes. The MCW initiative has supported the

Government to deliver a complete package of MNCH services across the country, while simultaneously helping communities to cope effectively and efficiently during emergency situations in terms of attaining health goals. Most significantly, the coordinated efforts of the MCW initiative are the key to success for other MNCH-related programmes such as the EPI, MNCH and Population Welfare Departments.

Findings from the primary data

The qualitative findings highlighted the alignment of the MCW initiative with health priorities defined at all levels. These include, for instance, within the international framework of the SDGs, Pakistan's *National Health Vision* and all provincial/regional health policies. Qualitative interviews with health managers affirmed that the MCW initiative is highly relevant to national and provincial/regional health strategies and plans which aim to achieve improved MNCH services. All the key stakeholders engaged during the evaluation were in agreement, recognizing the MCW initiative's significance for achieving national and provincial/regional health targets. The qualitative data also found that the provision of high priority MNCH interventions through the MCW initiative helped to reduce maternal mortality, infant mortality, and under-five mortality and morbidity.

Qualitative findings from the KIIs with policy makers and planners at the federal level confirmed that the MCW initiative is relevant for Pakistan's national health vision and priorities. One key informant stated, *"Our global and national priorities are to improve health indicators and keep mothers and children healthy. MCW helps in achieving progress against MNCH indicators, as its basic principle is to facilitate mothers and children."* Another informant remarked, "*MCW addresses the issues of accessibility and enhances the coverage, especially in rural areas. MCW supports the government health departments to fulfill local community needs and achieve SDGs targets."* An NGO representative also noted, "*MCW, with its prime focus on maternal and children health, is fully aligned with national health priorities and our health goals as well."*

The qualitative data specifically confirms that the MCW initiative is in harmony with the goals of national and provincial/regional health policies. As one informant put it, *"The goals and strategy of MCW are aligned with national and provincial health priorities."* Another key informant from Punjab remarked:

> *Technically speaking, the concept of MCW is in alignment with national health needs and provincial policies, as our national vision and provincial health sector strategy focus on reduction of maternal and infant mortality, and the provision of treatment to children under five years old against pneumonia and diarrhoea. Overall, all these services are covered under MCW package, making it more appropriate to address local health needs.*

Another key informant agreed, *"Our health priorities (both national and provincial) emphasize the need to reduce maternal and infant mortality, which is addressed through MCW, targeting mothers and children health."* An informant from Balochistan noted, *"Both are aligned, as national/provincial MNCH policies and MCW are aimed to ensure the healthy mothers and children."*

During the qualitative interviews, some provincial/regional health managers considered that the MCW initiative significantly contributed to improving MNCH services by enhancing accessibility, vaccination coverage and community awareness. A key informant from Sindh observed, *"A special emphasis has been given on deliverance of national and provincial MNCH priorities into MCW, to achieve good health for all."* In the same vein, a health manager from AJK stated, "*MCW is aligned with improving MNCH indicators, creating community' demands for contraceptives and safe deliveries, and minimizing MMR and IMR in the region and country as well."*

Qualitative interviews with UNICEF officials further endorsed the view that the MCW initiative is in accordance with the objectives outlined in the health policy documents that define national and provincial MNCH-related strategic priorities. One key informant noted:

> *MCW addresses the national and provincial health priorities and the objectives of UNICEF in improving mothers and children's health. Our priorities are to reduce maternal, infant and under-five child mortality and morbidity in Pakistan and provide quality health services. Therefore, the component of nutrition benefits has also been added in MCW along with MNCH services to enhance health education and hygienic practices amongst community to achieve improved health.*

Another key informant observed:

> *National and Provincial MNCH priorities focus on addressing the gaps in health services, which result in maternal, neonatal and infant mortality. Though Government' infrastructure and outreach network is available, but MCW aims to provide services at such communities, where health facilities are either inaccessible or unavailable. Therefore, in my opinion, MCW is fully aligned with MNCH priorities.*

A different informant explained that:

> *MCW is organized for LHWs coverage areas in Sindh, striving to prevent the under-5 child mortality. In the summer season (April), MCW focuses on prevention of diarrhoea and promoting hygienic practices, whereas in the winter season (October), awareness is raised for pneumonia prevention. Moreover, defaulter children of immunization and vaccination are also identified and vaccinated along with provision of tablets for deworming.*

Most district-level stakeholders (118 of 124) across all provinces/regions expressed the similar views. As one key informant put it, *"MCW objectives are aligned with our health policies to improve MNCH services and strive for prevention of malnutrition, prevalence of pneumonia and diarrhoea, and the promotion of healthy breastfeeding practices and birth spacing."* Speaking of the initiative's contributions, a key informant from Sindh noted, *"MCW key feature is to identify the children, who missed vaccination during regular services. This initiative helps in accessing the missed-out cases and increasing immunization coverage, which has resulted in improved MNCH services within the community."*

Another health manager from Sindh explained, *"National as well as provincial health priorities emphasize on the strengthening of MNCH service delivery through improved service utilization and health education, these issues are addressed during MCW."* An informant from Balochistan highlighted the MCW initiative's relevance for enhancing the coverage of MNCH services. He added, "*Our health policies focus to maximize the coverage of MNCH programme and improve the immunization and deworming services, which are the principle objectives of MCW as well."* A health manager from AJK also commented, *"Our national health policy is aimed to expand coverage and acceleration of the progress of MCNH indicators through health seminars and health weeks. Similarly, the MCW is being organized twice in a year to improve health of*

mothers and children." Another key informant from AJK remarked, *"The prime focus of MCW activities as well as national and regional health policies is to increase safe deliveries and EPI coverage, enhance trained workforce and MNCH service utilization."*

Findings from KIIs with health managers in Punjab linked the MCW initiative's achievement of targets with the attainment of targets under the SDGs and MDGs. He observed, *"I consider MCW, having prime focus to improve health indicators, particularly related to MNCH services, to attain the targets outlined in SDG 3 (and previously MDGs 4 and 5)."* A key informant from KP also highlighted, "*MCW emphasis on preventive and promotive health care services and helps in achieving SDG 3 and national targets, through reducing MMR and IMR."* As the key informant from KP explained:

> *MCW objectives are quite aligned with national/provincial health policies, as MCW ensures to provide immunization and deworming services for children, TT vaccination to all pregnant females and health awareness campaign for mothers and communities at large. These interventions pave the way to enhance MNCH service utilization and achieve national and provincial health targets.*

During the KIIs, other district health managers also acknowledged the relevance and alignment of MCW with the national health indicators. *"MCW has improved and antenatal and postnatal service utilization, accelerated the immunization coverage, promoted hygienic practices and brought a positive change in the community behaviour towards mothers and children health related issues"* affirmed by key informant from Punjab. Further, key informant from Balochistan remarked, *"MCW bridges the gaps in MNCH service utilization, through behaviour change communication strategy, focusing on health education and health promotion. All these efforts are linked to accelerate the progress against our national and provincial health priority areas."*

The qualitative findings revealed that all the federal, provincial/regional and district level health managers and service providers – including NGO representatives/focal points and FGD participants (LHS, LHWs and vaccinators) – agreed that the MCW initiative is relevant for national and provincial/regional health priorities to address the community health needs and improve MNCH services. Health care providers, agreed about the MCW initiative's relevance for attaining national and provincial MNCH health targets. A key informant from Punjab

explained that *"Our focused health priorities are to reduce burden of disease in community and raise awareness against danger signs of diarrhoea, pneumonia and malnutrition amongst children. These are catered adequately in-service package of MCW."*

It may be concluded that overarching policy documents such as the *National Health Vision* (2016-2025), provincial health sector strategies and health plans all highlight the importance of MNCH indicators and that MCW was specifically designed to fit within this broader national and provincial/regional health vision to contribute to strengthening MNCH services and community health.

4.1.2. Relevance of the MCW initiative for marginalized populations

The qualitative data substantiates the fact that MCW initiative was designed to cater to the health needs of both communities in general, and marginalized and vulnerable population in particular. MCW activities are planned biannually, which requires extensive planning and a methodological approach that analyses the existing situation and identifies potential beneficiaries and marginalized populations.

Considering this a prime focus of the MCW initiative, the evaluation team sought to understand the relevance of the initiative by asking key stakeholders at all levels (federal, provincial/regional and district) whether any baseline or needs assessment survey was conducted with potential beneficiaries, prior to or during the MCW initiative. Most stakeholders were unaware of such baseline or needs assessment analysis at the MCW initiative's planning or implementation stage. One key informant stated, "*I don't know about any survey conducted from MCW perspective. However, regular data is collected for vaccination to identify the potential beneficiaries and prioritize the areas, having poor MNCH indicators."* One key informant considered the absence of baseline assessments as a gap in planning. He noted, *"The non-availability of real time data or assessment indicates the lack of proper planning for MCW at macro or micro level. Such data is required to see the impact of MCW, in bridging the gap of MNCH services for the potential beneficiaries.* Another informant was similarly unaware of any such survey. He explained, "*I don't know about it, as we are working only in the selected districts of Punjab."*

The qualitative findings of interviews with provincial/regional health managers presented critical and varied opinions regarding such baseline surveys. Some health managers reported that needs

assessment had not been conducted. As one key informant from Balochistan remarked, "S*pecific base line study or needs assessment was not conducted to reach the potential beneficiaries in MCW campaign".* An informant from GB also held "*No such study was held at any time of MCW".* However, some provincial/regional stakeholders equated baseline surveys with routine data collection or studies conducted with the support of development partners, including UNICEF. One key informant from Punjab explained, *"No such assessments were done in the past. However, UNICEF has conducted a study in uncovered areas regarding MNCH services."*

By contrast, some provincial/regional stakeholders engaged through KIIs reported that baseline/needs assessments for the MCW initiative were carried out. A key informant from Sindh reported that "*A needs assessment survey with community and health care providers was conducted initially to plan MCW for the specific rural or hard to reach areas."* Another key informant from KP said, "*We have done a baseline study, because planning of MCW targets and their achievement is not possible without any prior assessment."*

However, another key informant from KP contradicted this statement, noting that *"As far as I know, some assessment was conducted to set targets, but, how and when this assessment was conducted, it's not in my knowledge. However, I strongly feel that such assessments are mandatory to systematically plan any programme."* Similarly, a key informant from AJK stated, *"There is no need of any assessment, as this programme is funded by UNICEF and launched in national programme covered areas through LHWs, who have complete list of target population, which is also used as a baseline."* This key informant also observed that *"Needs assessment is conducted through LHW programme's regular reports/statistics, provided to DOH. LHWs' and vaccinators' data is used for baseline, highlighting defaulter children, who missed vaccination and pregnant and lactating mothers, who need services."*

The findings of the KIIs showed that the opinions of key informants varied. The key informant from Sindh doubted whether any baseline assessment has been undertaken. As he put it, "*UNICEF is not aware of any baseline surveys activities, conducted prior or during MCW."* The key informant from KP explained, *"No such assessment has been conducted so far. However, UNICEF collects data for assessments of stocks including supplies and medicines, consumed during the last MCW and required for the upcoming MCW. After assessment, stock is provided to all concerned to execute MCW smoothly."* The key informant from Balochistan remarked,

"*Baseline survey was conducted to validate the LHWs' data of their respective areas at union council level."*

The qualitative findings reveal that most district level health managers also gave conflicting statements about whether a needs assessment survey was conducted before or during the MCW initiative. A few of the health managers (20 of 124) said that baseline assessments were undertaken. However, the majority (104 of 124) stated that they were not. A key informant from Punjab reported, *"Yes, baseline and needs assessment studies were conducted during MCW, using existing data for identification of potential beneficiaries".* The key informant from Sindh also said, *"Needs assessment survey was conducted by LHW programme, where DHO office collected relevant data and information on health indicators, mainly to identify the missed cases of vaccinations to prioritize and plan MCW activities."*

The findings of the KIIs indicated that some district officials linked this needs assessment with data collected by the LHW and EPI programmes. As a key informant from KP explained, *"LHWs conduct assessment surveys within their catchment area before MCW. They collect necessary information to identify target groups (mothers and defaulter children), inform them about MCW' event and share the information further to plan health sessions and immunization."* A key informant from Punjab similarly noted, *"LHWs collect needs assessment data from fields, such as number of clients received family planning services, to get a fair idea for organizing MCW."*

A key informant from GB expressed the same view, "Before MCW, LHWs complete the assessment through registration of target population, including pregnant and lactating women and defaulter children, who missed vaccination. Moreover, a list of children between 2-5 years is also prepared for deworming." The key informant from AJK concurred:

> *We have existing data for baseline and target settings. However, in case of any seasonal outbreak before the start of MCW, we arrange a consultative meeting for situation assessment, based on burden of diseases or cases reported from a particular area and treatment provided to potential beneficiaries.*

This reflects the view of the key informant from Punjab, who stated, *"Needs assessment is done based on the lists of all excluded or defaulter children for immunization. These lists are developed by LHWs and handed over to the vaccinators to plan MCW activities."*

Some key informants commented upon the type of data collected for assessment, with regard to the MCW initiative's micro-level planning. The key informant from Punjab noted, *"Baseline studies include accurate registration of target population, information of burden of diseases and logistic requirement according to the needs of MCW."* Nevertheless, some officials erroneously linked the baseline survey with other similar studies, as the key informant from KP reported, "A *study on nutrition was conducted during MCW by LHWs, where they filled a Performa for each house to assess status of malnutrition."*

It may be reasonably concluded that a specific baseline or needs assessment survey was not conducted prior to the initiation of the MCW initiative. Some participants erroneously conflated similar health studies by UNICEF or routine data collection as this baseline assessment. The findings also reveal that routine data collected by the LHW and EPI programmes were usually utilized to inform the planning of the MCW initiative. It appears that such data was particularly used to analyse the existing situation of MNCH indicators at the district level, to identify target beneficiaries and to prioritize MCW activities for poor and marginalized populations.

4.1.3. Selection of areas for organizing MCW activities

The qualitative data revealed that MCW events were organized following careful analysis of MNCH indicators, community health needs and consultations with the concerned health authorities. The evaluation team sought to assess the rationale behind the selection of areas (district and village) in which MCW activities were organized. The team also aimed to determine the alignment of this selection process with the initiative's objectives. The qualitative findings from the KIIs at the federal, provincial/regional and district level with health managers held that the selection of areas was fully aligned with efforts to address the initiative's objectives. They highlighted a focus on improved MNCH services in neglected, remote, impoverished areas and slums. The key informants all confirmed that areas covered by LHWs were selected after thorough planning, prioritizing poor and underserved communities to bridge gaps in the accessibility, availability and affordability of MNCH services.

One key informant explained, *"The selection of specific area for organizing MCW is as per the health needs of mothers and children determine, with the involvement of local officials."* The informant went on to say, *"We plan MCW activities according to the requirements of community, to address the issues of accessibility and availability of health services. We intend to cover all segments of society, particularly deprived and marginalized areas to maximize coverage of MNCH services."*

Similar views were expressed during KIIs with most provincial/regional level health managers. The key informant from KP explained, "*MCW is a cost-effective intervention, where existing networker of outreach workers, e.g., LHWs is used. Therefore, LHWs covered areas are chosen, to maximize the coverage for underprivileged and deprived communities."* The key informant from AJK also noted that "*Area is selected through national programme. Only LHWs' covered areas are selected for MCW, because we lack human or financial resource to introduce such interventions in uncovered population."* The key informant from Sindh remarked:

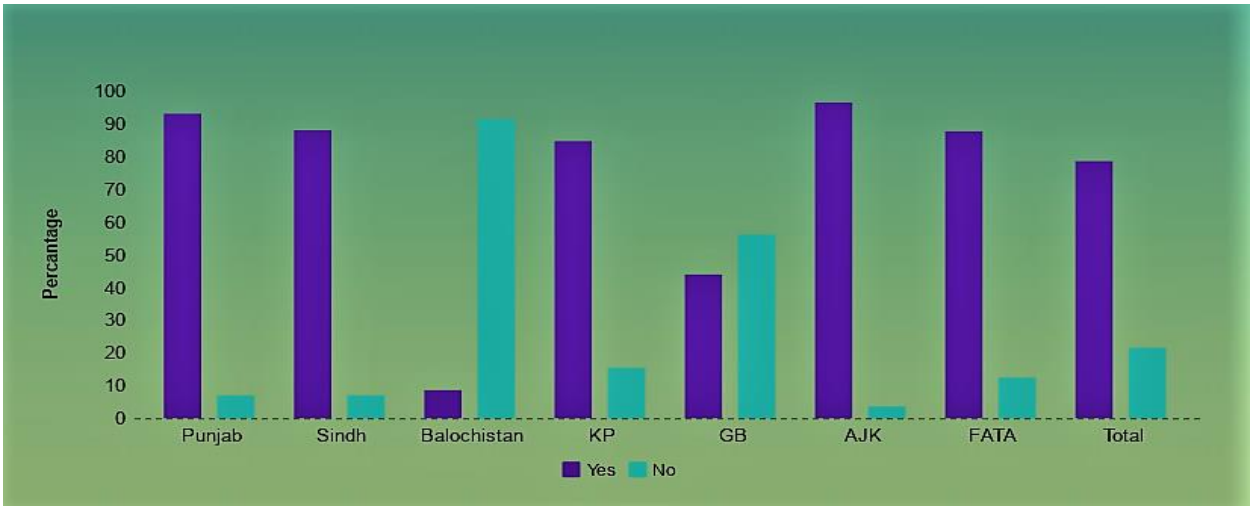
> *Currently, we have 48 per cent covered areas and we have achieved our goal through proper planning. We prioritize those villages with poor MNCH indicators, especially those children who missed the scheduled vaccination from the list of registered households. After identification of areas, we plan MCW and provide services, such as provide vaccination to the defaulters and deworm children.*

Nonetheless, during the KIIs, the key informant from Punjab reported that certain components – such as deworming and immunization – were conducted in both areas covered by LHWs and areas that are 'uncovered'. He stated, "*MCW is planned for underprivileged, deprived and marginalized communities, particularly for needy or disaster-affected areas. MCW activities are preferred mainly for LHWs covered and uncovered areas."*

The findings of the KIIs with district level key informants also highlighted the MCW initiative's prioritization of less developed areas with low levels of health services' coverage. The key informant from Balochistan stated, *"Poor and marginalized communities, as well as LHWs' covered and uncovered areas are the priority of MCW to enhance the coverage and service utilization."* The key informant from AJK pointed out that *"Focus is given to remote and underprivileged communities living in LHWs covered areas to attain 100 per cent coverage."*

Similarly, the key informant from Balochistan commented, *"Yes, we select those areas for MCW, which have the low coverage and worst health indicators."* The key informant from KP agreed, *"Remote areas with LHWs coverage are selected for MCW, where MNCH service utilization is poor."* The key informant from AJK also commented on the involvement of LHS and LHWs in decision-making, observing that "*The matter of prioritizing areas for MCW activities is discussed during monthly meetings of LHWs and LHS. In these meetings, gaps are identified based on monthly reports and thus area is selected."*

Figure 10: Mothers who benefitted from the MCW initiative in the last 10 years

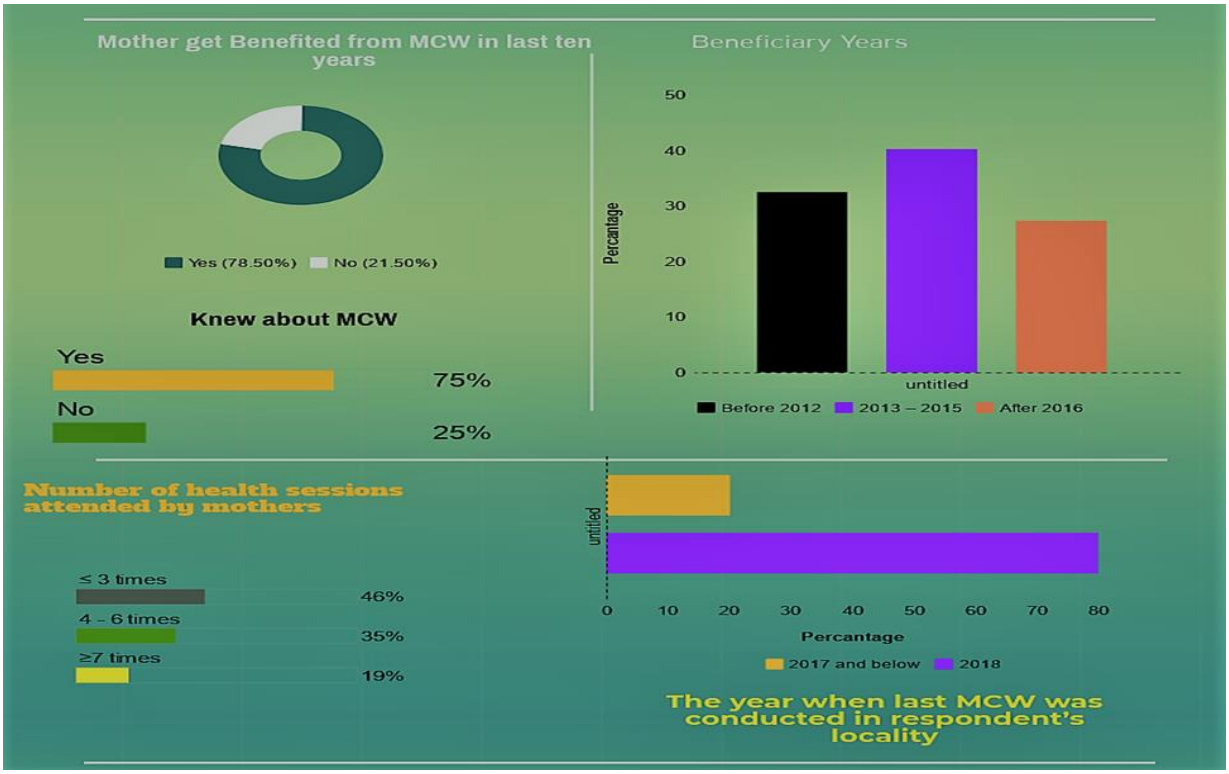


Both quantitative and qualitative data showed that MCW interventions reached mothers across Pakistan. The quantitative findings indicated that, overall, 78.5 per cent of mothers surveyed reported benefitting from MCW activities (see Figure 10). Figure 11 illustrates the women's awareness and utilization of MCW activities for the entire evaluation sample. Nearly three-quarters (74.5 per cent) of the mothers were familiar with the term 'maternal and child health week'; only 25.5 per cent were not familiar with it. Considering that 78.5 per cent of women reported benefitting from MCW activities, this implies that while some women were not familiar with the term 'MCW', they nevertheless accessed MCW services – such as immunization, deworming or other health care awareness raising materials.

Comparing the provincial trends reveals that the highest proportion of women who reported benefitting from MCW activities is in AJK (96.5 per cent), followed by Punjab (93 per cent) as illustrated in Figure 10. It is important to note that only 8.6 per cent of the mothers surveyed in

Balochistan reported benefitting from MCW activities, as did 43 per cent of the women surveyed in GB. This shows that the MCW initiative's performance is inconsistent across different regions of the country. However, the fact that the lowest number of beneficiaries in Balochistan reported benefited from MC activities may not necessarily be considered a reflection of inefficiency in terms of the MCW initiative's management. This low level of achievement may be contingent upon various systemic and structural factors, such as the volatile security and law and order situation in parts of the province, the threats of violent attacks on health care workers, geographically disperse populations and poor infrastructural development.

Figure 11: Percentage distribution of mothers' responses on MCW participation



Similarly, while 29.4 per cent of mothers surveyed benefitted from MCW activities for the first time after 2016, 40.2 per cent benefitted between 2013 and 2015. This implies that, although MCW activities began before 2012, they gained popularity after 2013. The fact that 79.9 per cent of women surveyed reported that the last MCW session was held in their locality in 2018 shows the MCW initiative's sustained progress (see Figure 11).

The quantitative data also revealed information on participation levels in MCW sessions. This was measured by the number of sessions attended by the women surveyed. Fewer than half (45.8 per cent) of those surveyed reported attending three or fewer session, while over one-third (35.4 per cent) reported attending between four and six sessions. Almost one-fifth of the mothers surveyed (18.8 per cent) attended over seven sessions. This indicates that women participated in MCW sessions frequently, implying that they found them significantly useful (see Figure 11).

District level qualitative data from health managers similarly noted that MCW activities were arranged in remote, poor and deprived areas, where health facilities are unavailable. They stated that these areas were prioritized by the MCW initiative, enabling a high level of outreach to marginalized communities. However, the opinions of district level key informants differed in some important respects. Most reported that MCW activities were organized in areas covered by LHWs. Others indicated that both areas covered by LHWs and those not covered by these health workers were chosen for MCW activities, based on which areas had poor health indicators. As the key informant from Punjab explained, *"We cover the whole district, including LHWs covered and uncovered areas to access the defaulters within poor and marginalized population and vaccinate them free-of-cost for improving health services utilization."*

The key informant from AJK was of a similar view, *"MCW is organized at the district level, prioritizing the disaster risk areas. During seven days of MCW, both LHWs covered and uncovered areas are catered, where initially LHWs covered areas are served during the first four days of MCW, followed by the uncovered areas in the last three days."* The key informant from KP pointed out, *"Those areas for MCW are selected, where health facilities are either inaccessible or health activities are very slow."* A key informant from Balochistan indicated that *"We simply select the nearest areas for coverage."*

While one key informant from AJK stated that *"Villages are selected according to the recruitment of LHWs", another key informant in AJK held that "Those areas are preferred for MCW where immunization coverage remains low."* Similar views were given by the key informant from Punjab, *"MCW is organized to target the children, missed during routine vaccinations and other services. MCW provides opportunities to cover all the defaulters."* Another informant from Punjab remarked, *"We prefer to organize MCW in rural areas, where deprived and excluded groups, belonging to lower socio-economic background are residing,*

while in urban areas, we focus on slums." The key informant from Punjab added that *"Mostly, thickly populated areas and slums are selected for organizing MCW, to reach out the unreached."*

By contrast, some district/agency level key informants indicated that they were not aware of the basis on which areas were selected for MCW activities. The key informant from FATA remarked, *"I have no clear idea about MCW and its selection criteria."* The key informant from Sindh felt that "*Selection of area lacks rationalization and highlighting gaps of proper planning."*

The FGDs also stressed the importance of MCW interventions for addressing the health needs of deprived and marginalized populations. Most LHS, LHWs and vaccinators considered that MCW activities have been effective, in terms of promoting health education and the utilization of MNCH services. They remarked that women living in areas that are not covered by LHWs, particularly refugees, were more motivated to participate in Mother and Child Weeks. They also noted that MCWs helped build communities' trust in service providers. The LHS from Punjab recommended enhancing the MCW initiative's coverage, noting:

> *MCW must not be planned at the time of crop harvesting, when women, belonging to backward areas and lower socio-economic groups, remain busy in labour. Due to this reason they ignore their health needs, which make them more vulnerable and at risk of various health issues. So, if MCW is organized just after that time period it will be greatly beneficial for this segment of women's population.*

Overall, the qualitative findings affirmed that MCW activities reached out to 'unreached' marginalized women and children. Nevertheless, one of the health manager remarked, *"There is a huge variation in terms of socio-economic background and intensity of the social exclusion of the marginalized sections. So, there is no one-size-fit-for-all formula to reach out to the marginalized children and women."* Some service providers indicated that approaching marginalized families remains a challenge. Despite working in the field for 10 years, one participant in Sindh explained that *"Marginalized community is still not aware of MCW. Even one of our union council, named Raheem Abad, is still not covered in it. It shows less option for marginalized women and children to avail services*." Another LHS from Balochistan observed

that *"The issues addressed by the MCW were not the priority areas of the local population, because their problems were not preventive health but food and security.*"

The case studies revealed a dismal picture of the inaccessibility of MNCH services for impoverished women. One poor, marginalized married woman, living in a part of Sindh that is not covered by LHWs stated:

> *This is the first time that I have heard the name of LHW. She never visited our villages, comprising 25 houses. However, vaccinators have visited us for polio drops. We are not aware about the concept of family planning or nutrition. The Government should think of our health as well, providing free facilities at our doorsteps.*

Overall, therefore, the qualitative findings indicate that MCW activities were arranged in poor and deprived areas, where access to health facilities remains is a challenge. The qualitative data also suggests that marginalized communities in areas covered by LHWs were prioritized by the MCW initiative. In response to the constraints these communities experienced – in terms of the accessibility, availability and affordability of health services – the MCW initiative focused on improving their health status and maximizes the coverage of MNCH services. The quantitative data substantiated this finding, as nearly two-third of the mothers surveyed (69.2 per cent) reported that the availability of free health services was the major driving force behind their participation in MCW activities. During the qualitative interviews, participants suggested that the local, culture/context-specific needs of marginalized communities must be explored in future planning to gain more inclusive participation on the behalf of community. They recommended that staff should be trained accordingly in order to provide effective service.

4.1.4. Awareness and service delivery during the MCW initiative

As integral members of the health system, all of the health managers and services providers engaged during the evaluation were aware of services provided during Mother and Child Weeks. Most federal, provincial/regional and district health managers were aware that the MCW package included immunization for children under the age of two, deworming for children under the age of five, TT vaccinations for pregnant women and awareness raising sessions for pregnant women, mothers and communities. One key informant pointed out that *"MCW is an innovative and holistic approach to deliver service package and health awareness for immunization,*

deworming, breastfeeding promotion and control of pneumonia and diarrhoea. Key health messages are delivered through IEC material and interactive sessions." Another key informant added:

> *MCW is multi-intervention initiative focusing on improving MNCH services, such as antenatal and postnatal check-ups, use of contraceptives, exclusive breastfeeding, deworming, immunization and promoting general health awareness. Through the involvement of outreach workers like LHWs and vaccinators, missing cases are particularly identified to ensure that every mother and child in the area is immunized against vaccine-preventable diseases.*

During the qualitative interviews, all key informants agreed that the MCW initiative has increased health awareness, especially of children's and women's health. In their view, MCW activities have positively changed community health seeking practices and behaviour towards service providers. As one LHS from AJK put it, *"MCWs promote education on maternal and children health issues, such as perinatal care, vaccination, prevention and treatment of diarrhoea, pneumonia and deworming."* They also commented upon the significance of MCW health sessions on exclusive breastfeeding, complementary feeding and birth spacing, which raised community awareness. A LHS from Punjab felt:

> *MCW is very effective, where we provide health education, which increased community awareness on children' complementary feeding practices, recognition of danger signs of diarrhoea and pneumonia, promotion of hygiene and sanitation. One of the key features of MCW is provision of deworming tablets, which is highly beneficial and well-accepted in the community.*

The qualitative findings highlight the efficacy of health education and the dissemination of IEC materials. In order to attract a wider audience, a LHS from Punjab explained, *"We use audio-visuals aids to gauge the demotivated and disinterested people and also provide them a copy of a CD, having video of health awareness messages. These help us in changing community behaviour for good health practices."* According to a vaccinator from Balochistan, *"People are more aware now about the MCW interventions and bring other people with them to avail themselves of MNCH services."*

The qualitative data also revealed that greater awareness among women – both in general and among marginalized groups – led them to seek MNCH services. This is reflected in the case studies, which reflect the experiences of women from different socio-economic backgrounds. One mother of three children in Punjab confirmed the relevance of MCW activities for addressing her family's health needs. She explained:

> *I have been participating in MCW since 2016 and found service very beneficial, especially for poor people like us. Before MCW, I had faced multiple complications during my pregnancies and gave births to unhealthy children. Earlier, I was not convinced for using such services. During my recent pregnancy, I was seriously ill, I followed the advice of LHV and LHWs, attended MCW sessions, got medicines and supplements like folic acid and iron tablets. All these services and timely advice improved my health and I was able to give birth to a healthy baby.*

Another case study highlighted the experience of an illiterate mother of four in AJK, from a poor nomadic family who works as a maid. She stated:

> *I never got a chance to visit MCW event untill local LHW informed me about the benefits of MCW. I took permission from my husband and mother-in-law and attended MCW, where doctors and other staff educated me on good hygienic health practices and raised my awareness on maternal and health issues. MCW also informed me advice on the use of family planning.*

MCW activities used IEC materials at the grassroots level to enhance health education for mothers and children. A mother of two from an underprivileged family in Sindh appreciated the MCW initiatives efforts to deworm children and promote health education through IEC materials. She shared her experience of attending MCWs and seeking treatment for her 3-year-old son:

> *My younger son had complained of abdominal pain, swelled stomach and over-eating. I had consulted many doctors, but his condition didn't improve. Then, a local LHW informed me about MCW and its services. I attended MCW and get my boy examined. The doctors gave deworming tablets, free-of-cost and, Alhamdulillah he improved in*

three to four days. I really appreciate this initiative, especially for poor and illiterate people like us.

A mother of two children in KP similarly reported:

In the past, I had never felt the need to visit any health facility for my delivery as I believe in traditional birth attendants. Once LHW of my area informed me about MCW event and its services, I visited the place and found it very relevant. Now, I am fully aware of whom and when to contact in case of any emergency.

Another impoverished mother in FATA noted, *"There is no hospital nearby, from where we may avail health services. We are grateful to MCW and LHWs for educating us on how to remain safe from diseases."*

Overall, the qualitative findings revealed that health managers and service providers were well-informed regarding the MCW service package and its positive impacts on community health awareness. They believe that the MCW constitutes a multi-dimensional approach that bridged gaps in MNCH service utilization, by enhancing service delivery and promoting health education. Moreover, greater levels of awareness among beneficiaries increased their utilization of health services.

4.1.5. Alignment of MCW strategies with health managers' and service providers' activities

The alignment of the MCW's strategies with health managers' and service providers' activities is of the utmost importance, given the leading role which the Government and its existing network of outreach workers play in delivering MCW activities. The qualitative data showed that the MCW initiative's execution was aligned with previously defined roles and responsibilities of federal, provincial/regional and district level health managers and health care providers. Health managers had broad responsibility for planning, coordinating, managing and monitoring MCW events. Health care providers, meanwhile, play an active role in advocacy and delivering MCW activities in the field. In this regard, one key informant stated, "*It's a social event, so there is no additional role, which I have to perform during MCW. I support the planning process and ensure*

to create awareness amongst people (especially women) on health preventive measures." Another key informant explained:

> *My basic responsibilities during MCW include the overall planning and coordinating with the provinces/regions, receiving material from UNICEF and providing all relevant supplies and commodities to the provinces/regions as per requirements. Besides that, I also review the micro plan, visit different areas to monitor implementation and receive feedback from our field officers.*

During the KIIs, provincial/regional and district level key informants outlined their key role in the MCW initiative's planning, implementation and quality assurance, and in terms of taking all districts on board and assigning roles and responsibilities to relevant individuals. The key informant from Punjab stated:

> *We organize orientation meetings on planning with the health officials from all 36 districts of Punjab, including district coordinators and monitoring officers. All districts bring their micro-planning sheets, based on the already shared planning template. Main agenda of the meeting is to review and finalize the micro-planning of MCW. These meetings serve a purpose of refreshers or orientation for newly inducted officials.*

Other health managers shared this view. As an informant from AJK put it, *"I have prime responsibility in planning and oversight of MCW management."* Another key informant from KP stated, *"My responsibility is to organize the planning meetings with EPI staff and discuss the targets and strategy for MCW implementation."* The key informant from Sindh noted:

> *Planning and orientation meetings for MCW are held at my office with the concerned provincial and district focal points to discuss roles and responsibilities of team members and implementation challenges. During meetings, we work on micro-planning of MCW activities and devise strategy for monitoring. Later, we share our plan with the Secretariat, DGH and UNICEF.*

According to the key informant from AJK:

> *In our office, we hold planning and coordination meetings, where all district EPI coordinators and other vaccination staff plan, discuss and share the strategy, of accessing the missed vaccination children during MCW. List of such defaulters as well as required supplies and vaccine is also developed for further approval.*

When speaking of his department's role, the key informant explained: *"EPI programme has major role during MCW, for instance, in the timely provision of vaccinations for pregnant women and children. We supply these on the direction of the Secretary (Health)."*

One UNICEF provincial level representative highlighted the organization's role in planning and coordinating the MCW initiative. As the key informant from Punjab noted, *"I have advisory role in all MCW planning meetings, where I share the objectives of MCW and ensure the quality in achieving the defined targets."* An informant from KP elaborated:

> *My responsibility starts even before planning meetings, where I ensure pre-planning arrangements, for instance, the positioning of UNICEF staff in field, provision of requisite material and funds. Besides the programme, vendors and many others are also involved in these processes. After pre-planning, I have a meeting with Department of Health for detailed micro-planning at provincial and district level, where I (on the behalf of UNICEF) remain 100 per cent involved in each step of planning and the implementation of MCW.*

Like provincial/regional key informants, district health managers also outlined their responsibilities within the MCW initiative. These were aligned to their routine tasks and similar to those of provincial/regional health managers. However, the role of district health managers is more closely resembled to macro to micro level management. For instance, it involves organizing and participating in planning meetings with LHWs and staff members of the MNCH and EPI programmes; developing schedules/micro-planning; managing logistics, supplies and medicines; delivering training/orientation for field teams; coordinating with other line departments; monitoring and supervising field teams; and disseminating IEC materials for advocacy purposes. As an informant from Punjab mentioned, "*I direct and guide MCW-related staff, review the progress and also monitor MCW activities for quality assurance."* An informant from AJK explained:

> *My responsibility is to focus and monitor the primary health care component. I am also responsible for micro-planning, team deployment and logistic support. All the field staff of the national programme is invited for meeting at district health officer's office, where we conduct micro-planning, make list of defaulter children and demand for medicine and vaccines. We also impart trainings to LHS, who further train LHWs.*

Similarly, the key informant from KP stated, "*I mainly coordinate with LHW focal person and LHS for identification of areas and assigning the areas to LHWs. I also review the quantity of medicine, ensure the availability of stocks and physically verify the distributed banners at the UC level."* The key informant from AJK noted, *"My responsibility is to arrange seminar, brief press/media and coordinate with partners."* Another key informant indicated that, as the MCW is *"a component of a national programme, so my main responsibility is monitoring and evaluation of MCWs' planning, coordination and implementation processes."*

However, a select few district/agency level key informants denied any involvement in the MCW initiative. A key informant from Balochistan said, "*I have no role in the MCW",* while other informants from Balochistan and KP stated that they had never participated in the MCW initiative and were unaware of planning meetings. One key informant observed, "*Basically, I am not involved in planning process. I prepare schedule only, which have to follow."* Another key informant from KP explained, *"I am not involved in planning; it's mainly the responsibility of LHW Coordinator. I only have role to ensure vaccination during MCW and confirm EPI staff."* Yet another KP key informant remarked, *"Personally I have less involvement in MCW's activities. LHS and LHWs have main role and coordinate with us for my support."*

During the FGDs, participants discussed their roles and responsibilities in the MCW initiative, noting MCW activities' alignment with their routine tasks. Most Lady Health Supervisors confirmed that they were involved in training/orientations sessions, the micro-planning of activities, managing logistics, transporting supplies and medicines, and the monitoring and evaluation of MCW activities. LHWs and vaccinators said that their role involved identifying target populations, developing lists of defaulters, arranging public announcements in mosques about MCW events, advocating with communities, providing vaccinations, covering defaulters/children who have missed vaccinations, supplying deworming tablets and delivering

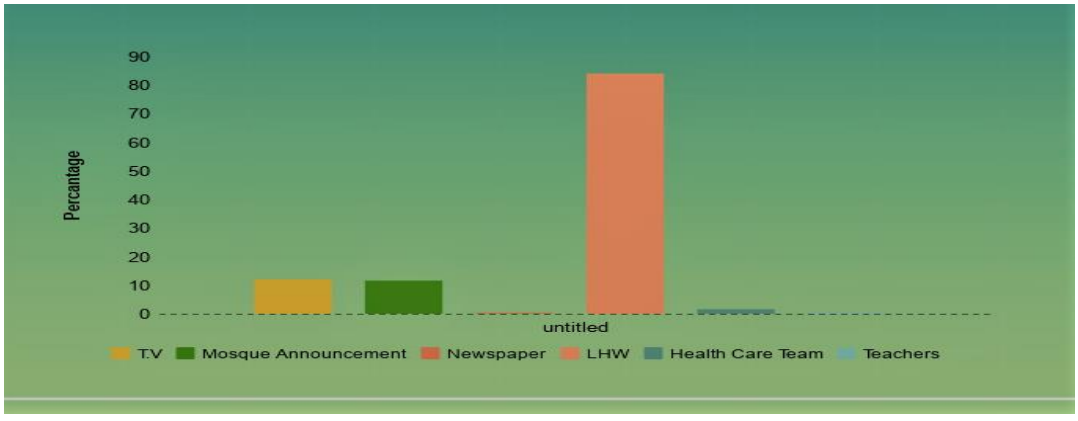
health education on hygiene, sanitation, nutrition and the prevention of diarrhoea and pneumonia.

The qualitative data indicates that these service providers successfully micro-managed the delivering of MNCH services and ensured community participation in MCW events. The key informant from KP explained, "*Our role is related to the implementation of MCW events and to ensure the availability of supplies and logistics, and conduct monitoring. We have been assigned these roles during training session of 4-5 hours."* By contrast, a key informant from Punjab denied a major role in MCW planning by stating, *"We have just been called for 1-2 hours training session, as a refresher, before commencement of MCW. We have not been involved in proper planning."*

In the FGDs, LHWs and vaccinators highlighted the role they played in changing communities' behaviour through health awareness sessions and social mobilization. They believe that the MCW initiative's targets were aligned with community needs, with an emphasis on improving health education and MNCH services, particularly the provision of deworming tablets. However, one vaccinator from Punjab disagreed, arguing that:

> *The MCW' interventions are not as per requirements of community; rather it is just a formality. Community needs are not prioritized, as lots of activities are already part of routine health care system. So, what is special for this week?*

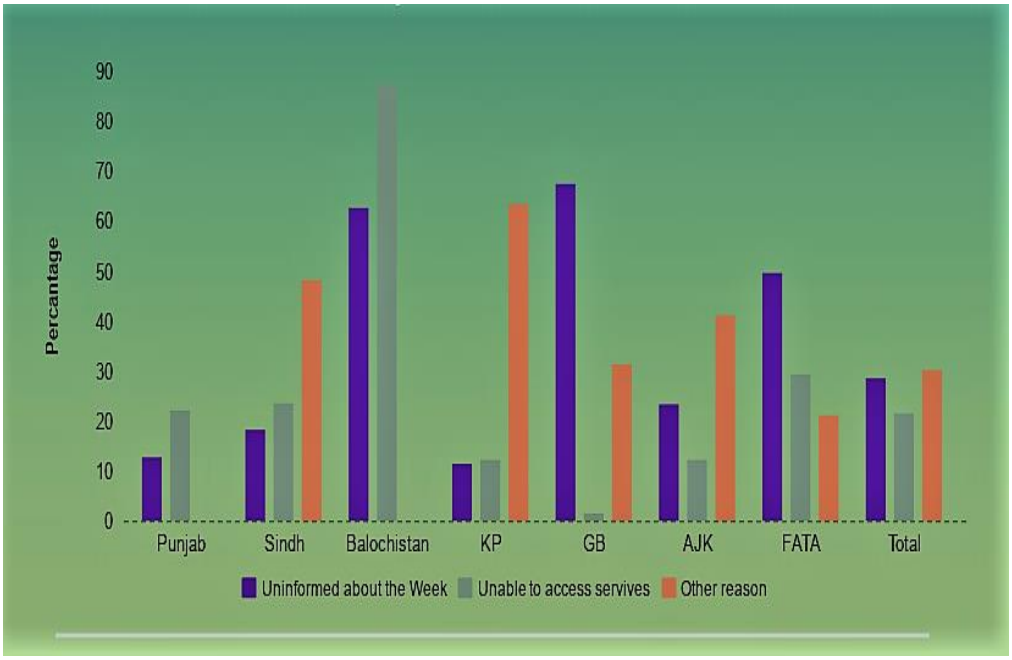
Figure 12: Source of information for upcoming MCW round



The quantitative data points to LHWs as the most significant source of information on planned MCW rounds. As Figure 12 illustrates, 84 per cent of the mothers surveyed became aware of upcoming MCW sessions because LHWs informed them of these.

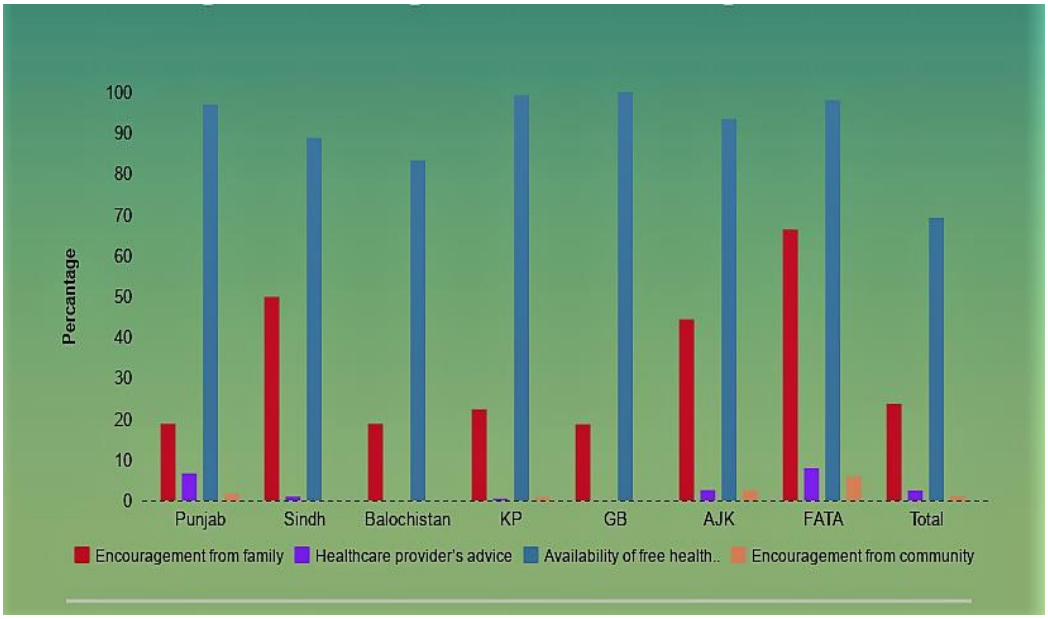
In Sindh, 97.8 per cent of mothers credited LHWs as their main source of information on MCW sessions, as did 93.3 per cent of women in KP. This suggests that LHWs were the main source of information about MCW activities across regions/provinces. Overall, 11.6 per cent of women stated that mosque announcements were their main source of information about MCW activities. About 28.5 per cent of respondents said that they were unable to attend MCWs due to a lack of information on upcoming sessions. While 30 per cent of those surveyed did not specify reasons for missing a round of MCW activities (Figure 13). The exception to this general trend is Balochistan, where 62.6 per cent of mothers reported that they were not informed about the upcoming rounds of MCW. This indicates that awareness of MCW activities is relatively weak in Balochistan. This may be due to fact that the province's population is thinly distributed across an immense geographical area. As a result, information providers' access to target populations is limited, particularly by poor infrastructural development and a lack of transportation facilities.

Figure 13: Reasons for not participating in MCWs in any particular round



Nearly two-thirds of the mothers surveyed (69.2 per cent) cited the availability of free health services as the main reason for their participation in MCW activities. One-quarter (24 per cent) identified family encouragement as the driving force behind their utilization of MCW services, as illustrated in Figure 14.

Figure 14: Driving force behind women's utilization of MCW services



In sum, it appears that the routine roles and responsibilities of health managers and service providers were aligned with the MCW initiative. As a result, they were fully capable of delivering services effectively to improve MNCH indicators, particularly in rural and less developed areas.

Overall, the qualitative findings demonstrate that the MCW initiative's objectives remain valid and highly relevant to the global, national and provincial/regional MNCH context. While implementing the MCW initiative, there is a need to accelerate progress on MNCH targets. The findings affirm that the MCW initiative bridged gaps in quality MNCH service provision for poor and marginalized communities. As a result, there has been a gradual improvement in indicators related to MNCH service utilization.

It may be concluded that MCW reinforced existing maternal and child health care service delivery components in a campaign mode twice a year. The MCW initiative was fully aligned

with Pakistan's national and provincial/regional health priorities and policies. The evaluation also found strong evidence of the valuable contribution made by health managers and service providers, who enhanced awareness – both among communities in general and women in particular – while strengthening their confidence in government services and outreach workers.

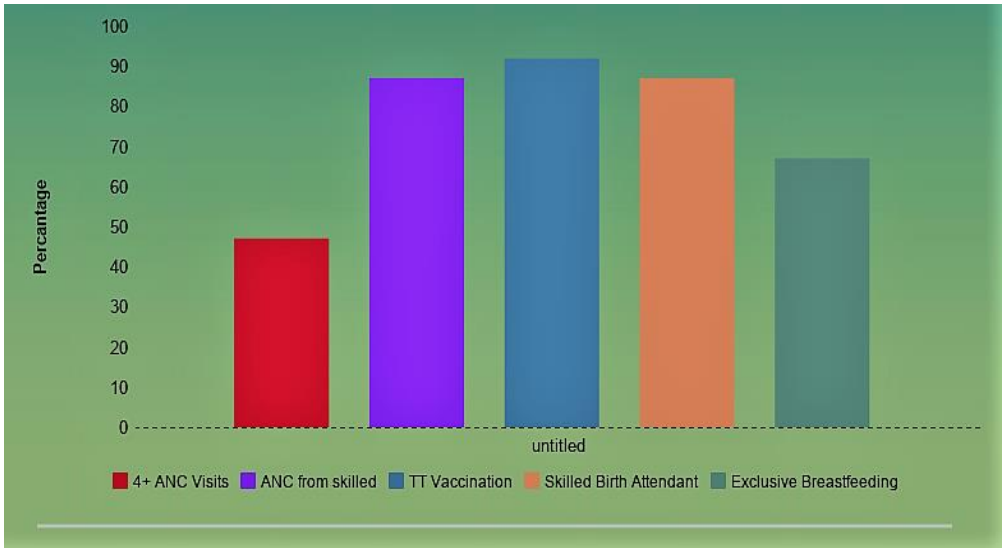
The women who participated in MCW activities are aware of its benefits, affirming that they learned a great deal from the health education provided. Surveyed beneficiaries expressed their satisfaction with, and trust in, health care providers when seeking services directly through MCW activities. However, the data also suggests that certain improvements are required in the MCW initiative, especially in terms of devising selection criteria to ensure the rational selection of areas in which to conduct MCW opportunities. For instance, offering equal opportunities to areas that are not covered by LHWs in order to maintain equity and organize activities more frequently to strengthen MNCH services. The timing of MCW activities is also important to bear in mind, so that sessions do not clash with the harvest period in rural areas, when women are too busy working in the fields to attend. A multi-sectoral approach would help to make MCW initiative more relevant and more effective for the marginalized communities.

4.2. EFFECTIVENESS OF THE MCW INITIATIVE

4.2.1 Changes prompted by the MCW initiative's implementation, 2007-2017

The MCW initiative's effectiveness was determined by analysing its performance over the past decade. Qualitative data from federal, provincial and regional stakeholders provided multiple contrasting views on the initiative's performance and implementation. Distinctions are evident between socio-economically and geo-culturally distinct areas. Nonetheless, significant commonalities exist in the data, pointing to the overall effective performance of the MCW initiative. Most research participants consider that the initiative considerably improved health standards – both in general among communities and specifically among mothers and children.

Figure 15: Mothers' practices regarding different health issues



According to the quantitative data, 47 per cent of the mothers surveyed had four or more antenatal care (ANC) checkups during their last pregnancy. As Figure 15 shows, 87 per cent received ANC from a skilled health care provider, 91.9 per cent reported receiving TT vaccinations, 87 per cent had a skilled birth attendant and 67 per cent exclusively breastfed their last child. These findings suggest that, due to the MCW initiative, maternal, infant and child mortality rates have decreased; skilled antenatal and postnatal health care seeking behaviours have emerged and been strengthened; and an increasing number of women received a complete course of TT vaccinations. The MCW initiative also appears to have led to greater value accorded to breastfeeding, a reduction in malnutrition following the expansion of deworming, increased vaccine coverage, and changes in expecting mothers' lifestyles, dietary habits and exercise routines.

Figure 16: Trends of different health indicators, 2007-2018 (PDHS & NNS)

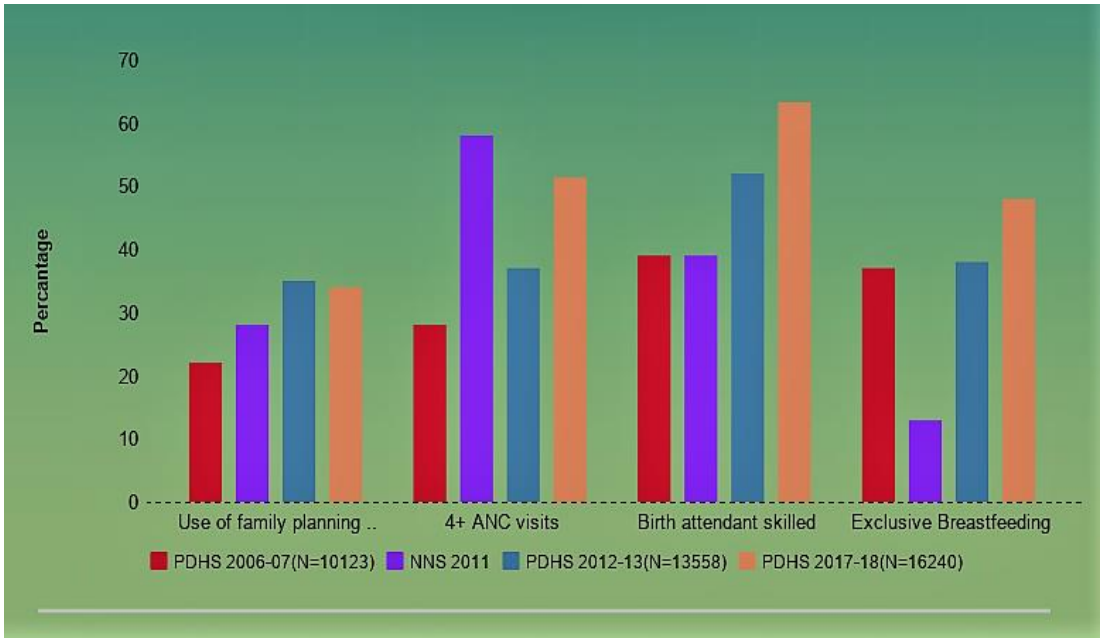
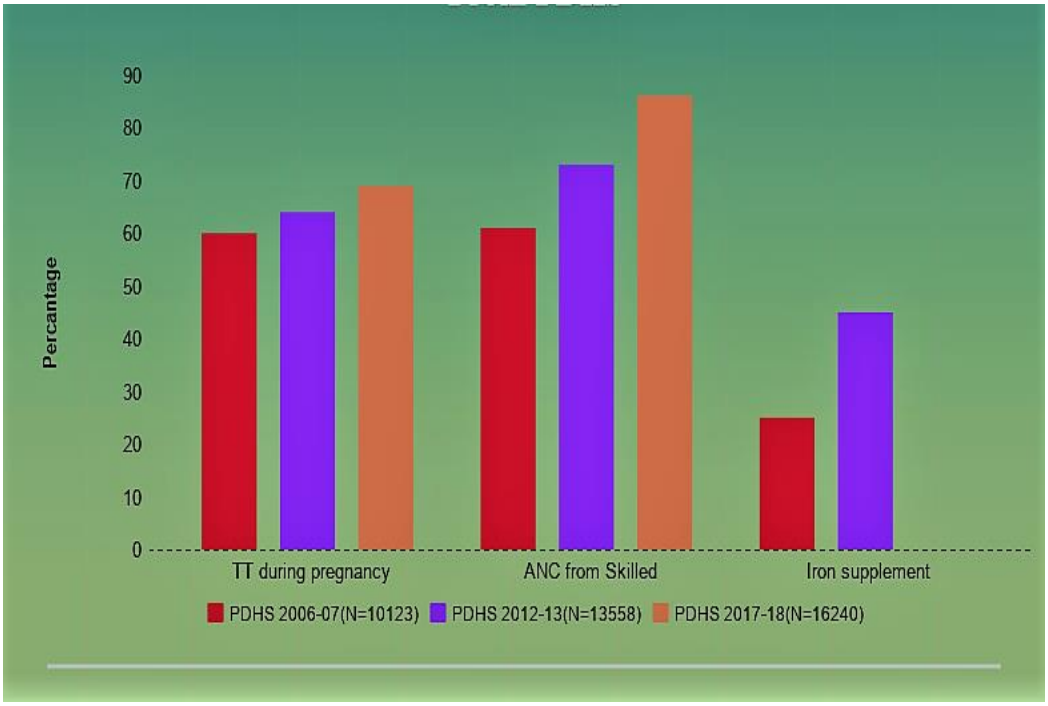


Figure 17: Trends of different health issues, 2007-2018 (PDHS)



These findings are also supported by the results of the *Pakistan Demographic and Health Surveys* (PDHS 2007-2018). Surveys from 2006 (before the MCW initiative) to 2018 reveal that the number of women's ANC visits increased from 28 to 51.4 per cent. Over the same period, the proportion of ANC services received from skilled health care providers rose from 61 to 86.2 per cent, while deliveries assisted by skilled birth attendants shot up from 39 to 69.3 per cent. The use of iron supplements during pregnancy rose from 25 to 45 per cent and exclusive breastfeeding increased from 37 to 48 per cent (NIPS, 2007 & NIPS, 2018). These trends are illustrated in Figures 16 and 17.

The cumulative effect of multiple awareness campaigns and other MCW activities includes women's enhanced disease prevention capacities. One key informant reported:

> *The programme has been successful in awareness raising; reducing maternal and infant mortality as outcome of improved knowledge in women about antenatal, postnatal and child health care; and increasing overall coverage of vaccination among women and children under the age of five.*

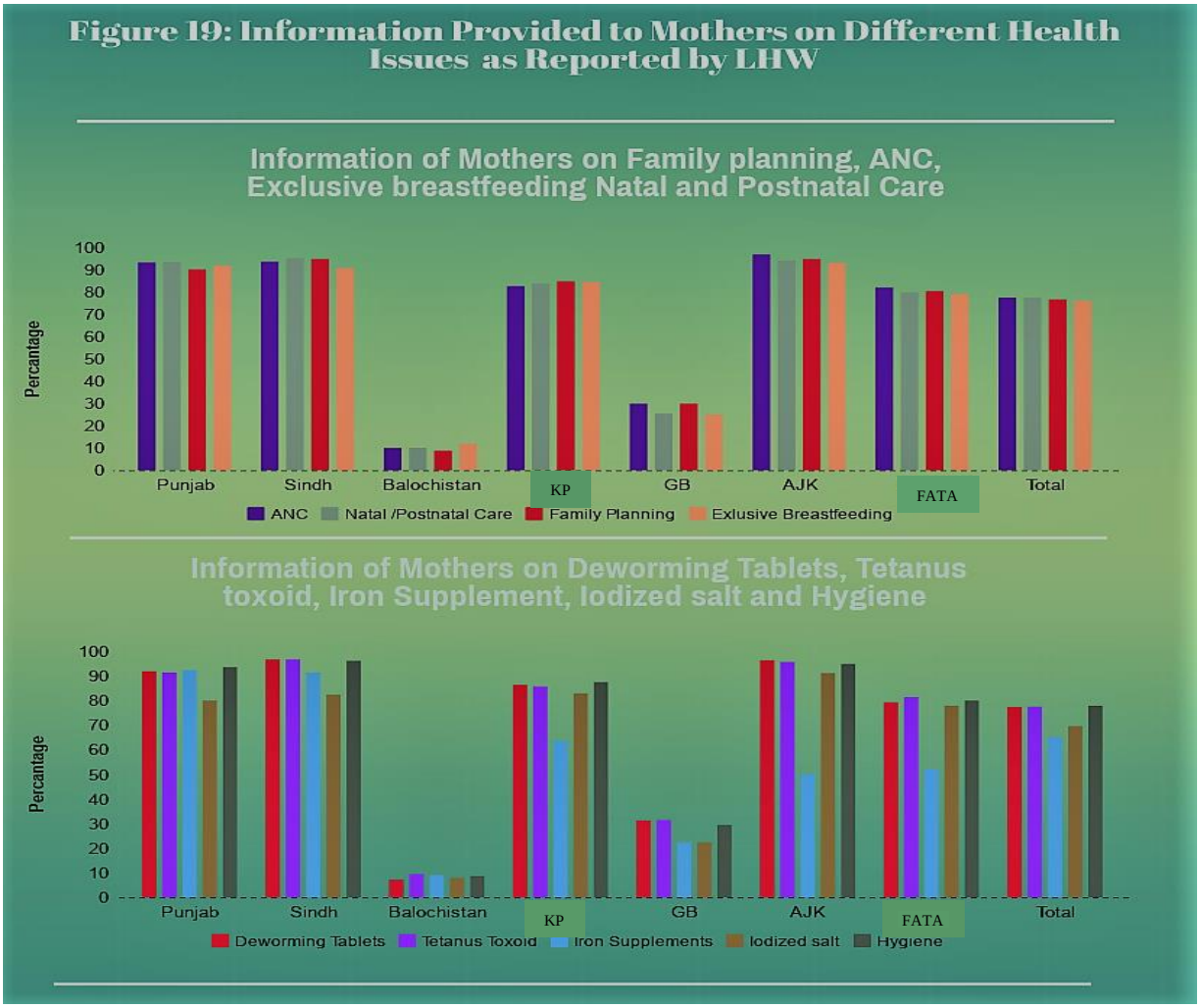
Alongside the qualitative findings, the quantitative data reveals that mothers received information on different health issues from LHWs during MCW activities. Figure 18 reflects the fact that LHWs in Punjab reported conveying information to mothers on health-related issues –

such as deworming, family planning, iron supplements, ANC visits, breastfeeding, danger signs during pregnancy, and hygiene and sanitation. Some disparities exist among provinces/regions. For instance, less health information appears to have been conveyed in Balochistan than other areas. Overall, the findings show that information provided by LHW was optimal with respect to different health indicators.

One key informant from Punjab spoke of the effects of MCW activities:

> *As a result of ten-year service of MCW, now people know that this activity is launched twice a year; once in summer with focus on diarrhoea and in winter with pneumonia. They know that we deworm children in this programme. People also know that defaulter children are vaccinated in this programme... Furthermore, due to frequent health sessions, behavioural changes have occurred in the community. Women now do not shy away in going to someone else's house to attend health session and ask questions regarding mother and child health. They are now more confident and better aware.*

Figure 18: Information provided to mothers on different health issues during MCWs, as reported by LHWs



During the KIIs, almost all of the informants considered that the MCW initiative had emerged well from its envisaged plan and reached its target population effectively. Most informants highlighted vaccinations and deworming as the anchors of the initiative's success. A LHW from Sindh stated, "*Deworming tablets are the lineament of MCW; being that, it can exclusively rationalize the cause of its continuation".* It is important to highlight that mothers – particularly in KP and AJK – understood the benefits of deworming. Some demanded tablets for themselves and for their children who were between 5-11 years old. A LHW from AJK pointed out that "*Mothers are fascinated by the results of deworming tablets and they, regardless of us telling them otherwise, keep on insisting for receiving a stock of tablets for themselves and their children more than five years in age.*"

While they appreciated the effectiveness of deworming tablets, some mothers, LHS and LHWs in Punjab felt that tablets (in general) are not child-friendly and that deworming syrups would be preferable. Similarly, a LHW from AJK indicated, "M*others often ask if we have deworming syrup instead of tablets. They argue that children take sweet syrups much more easily than taking tablets.*" Nonetheless, overall, it may be concluded that deworming is perceived as highly beneficial for children.

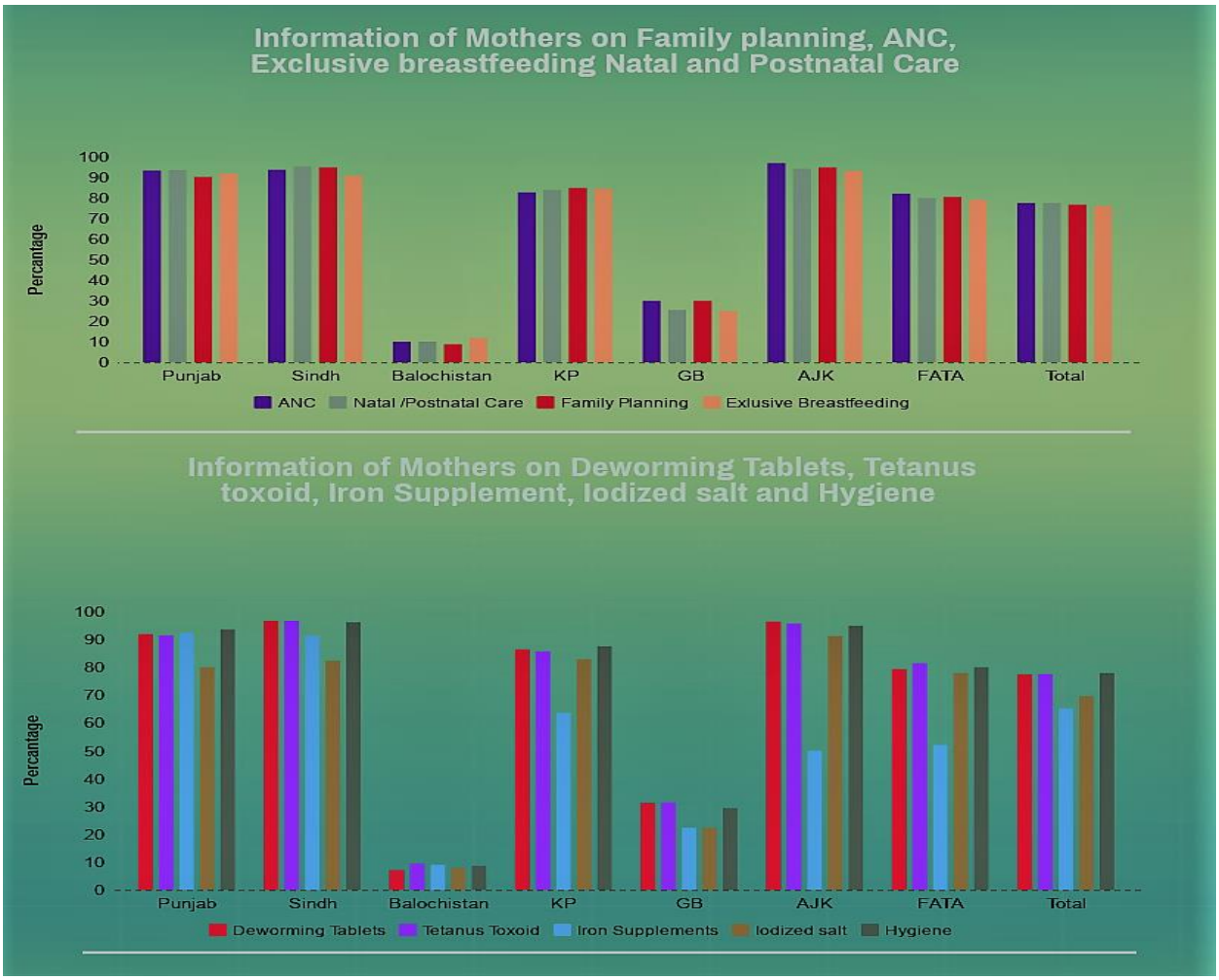
Analysis of the qualitative data affirmed that, alongside deworming, life-saving vaccines have been the backbone of the MCW initiative. Almost all informants considered that vaccine coverage had increased since the initiative began. They also felt that the MCW initiative's prime feature is its coverage of defaulter children and the provision of life-saving vaccines for children and TT vaccinations for women. Informants from Balochistan, KP and AJK explicitly stated that educating the community on the importance of vaccines was an extremely arduous task from the very beginning of the MCW initiative. Some argued that it was difficult to change cultural myths and socio-religious misconceptions that have existed for decades. These created an environment of mistrust among communities, who were suspicious about the chemical composition of vaccines and often held other negative beliefs about exclusive breastfeeding and antenatal care. Gradually, LHWs managed to dispel damaging cultural beliefs in communities and convince women to seek professional medical health care for themselves and their children.

In line with the discussion above, the quantitative data also provide evidences that the MCW initiative provided mothers with information on different health issues. Figure 19 illustrates the information which women received from LHWs during MCW activities across all provinces/regions. Despite some regional disparities, most mothers reported receiving significant health information from LHWs during MCW sessions.

Qualitative findings from interviews with health care providers suggest that the MCW initiative helped them to build strong relationships of mutual trust and respect with communities. A LHS from AJK contented that "*Our relationship has become quite friendly with the community. They treat us like their family members.*" A vaccinator in AJK agreed, *"I cover an area of seventeen to eighteen thousand people in which I found only seven to eight children vaccine defaulters during my last MCW. We have their parents contact numbers through which we l contacted them."* According to most informants (105 of 124), enhanced community cooperation and trust is an

indication of the MCW initiative's effectiveness and marks the achievement of an important milestone.

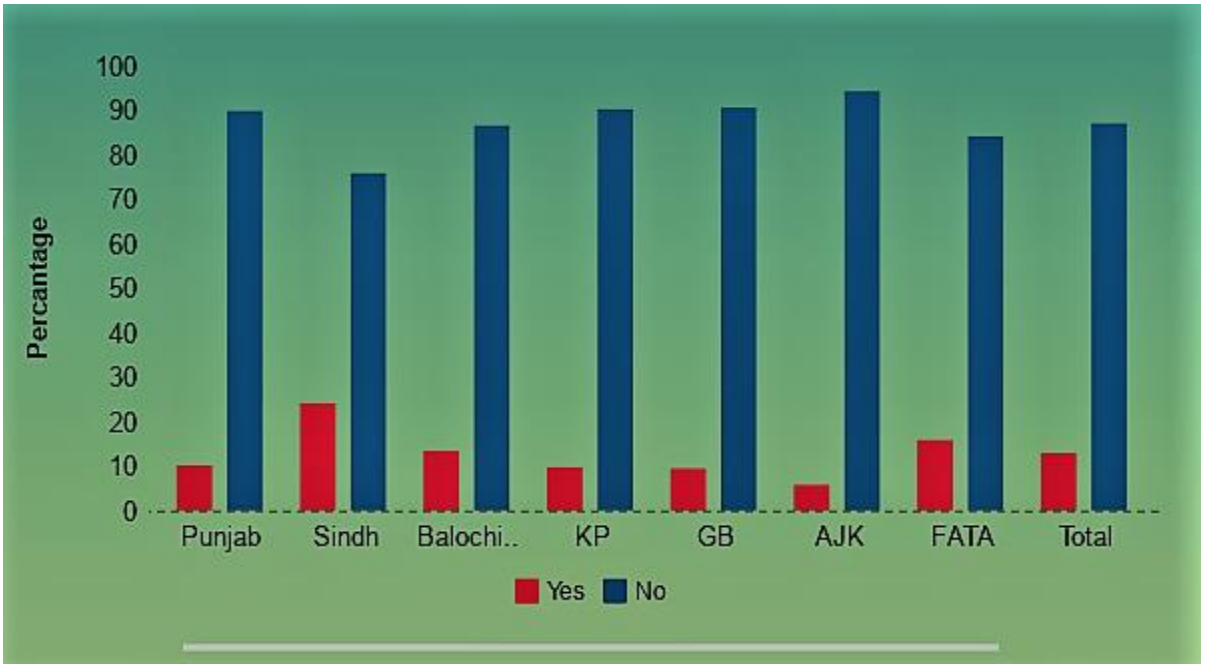
Figure 19: Information provided to mothers by LHW on different health issues during MCWs, as reported by mothers



However, qualitative findings from Balochistan, FATA and KP found a considerable proportion of people who were concerned that the contents of vaccines may be subject to religious prohibition. Figure 20 shows that, although MCW awareness campaigns helped to minimize such (unfounded) misconceptions, 13 per cent of the mothers surveyed still feared vaccinations, with some regional variations. Informants from KP, FATA and Balochistan reported that awareness campaigns to address misconceptions were *"on the swing"* and that *Imam Masjids* (religious clerics) had joined hands with health departments to help the MCW initiative with this important issue. A LHW from Balochistan reported:

Religious misconceptions are still a big factor compromising full vaccine coverage. I must appreciate the efforts of Imam Masjids who have joined hands with us for spreading awareness regarding the importance of immunization and changing people's religious misconceptions about polio vaccination. Their kind words, approving vaccinations and stressing their importance has had utmost impact on community and days are not far when MCW would be administering full vaccine coverage.

Figure 20: Mothers' fears concerning immunization



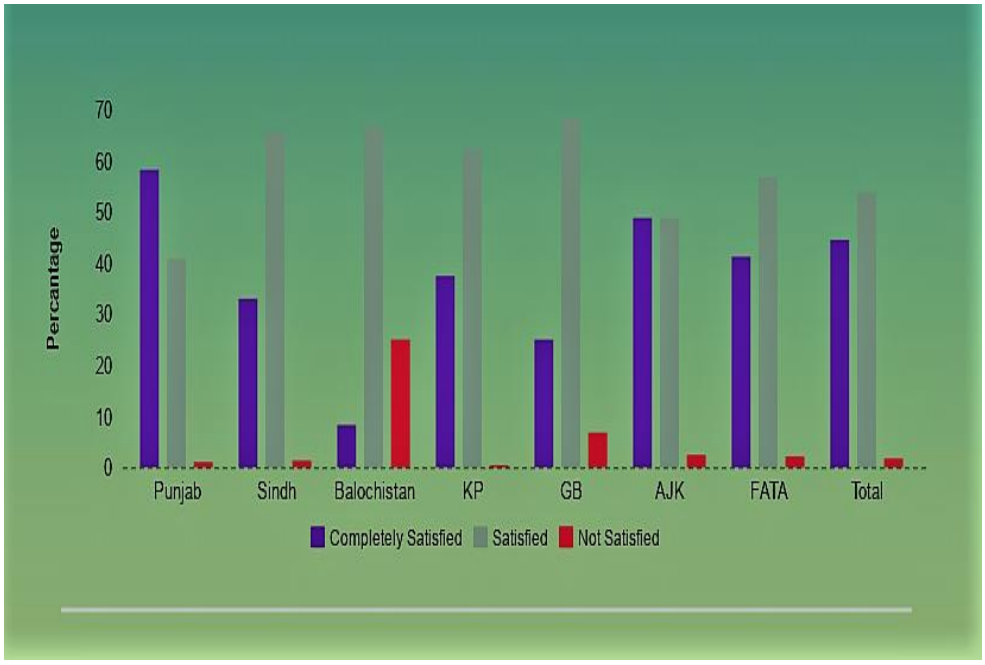
Alongside health care practitioners, beneficiaries from across the country praised the MCW initiative when they were asked about changes in their personal health as a result of MCW activities. One 32-year-old mother of four in Punjab stated:

My first premature baby, on utter insistence of my mother-in-law, and against the guidance of local LHWs, was delivered by a family Dai [traditional birth attendant]. The newborn died of birth shock soon after delivery. The awareness we got through MCW guided my family for my next pregnancy. My mother-in-law herself took me to the hospital for check-ups and delivery. Alhamdulillah, now all of my four children born at the hospital have good health.

Another beneficiary in FATA said that the MCW initiative's doorstep services were the most suitable in the secluded patriarchal culture of her town, which curtails women's mobility. She explained:

> *In 2015, my first pregnancy ended in stillbirth for staying too long in labour as hospital was far away from our home. This happened also due to the fact that my family never took me for regular check-ups at hospital. Now by the grace of God and advice of my neighbour LHW, I took proper care during pregnancy. I also received TT shots for my baby's good health. I delivered my baby by LHV at the hospital. I am so grateful for the good work that MCW and LHWs do to protect and save us.*

Figure 21: Experience of using MCW services



Considering informants' responses, the MCW initiative is considered to have contributed to strengthening existing MNCH services over the past decade. It appears to have had fruitful results by providing health care services at communities' doorsteps throughout the country. The quantitative data reveals that most mothers surveyed, from all regions/provinces, are satisfied with MCW services. As Figure 21 shows, only 1.7 per cent of mothers were not satisfied with MCW activities. By contrast, 53.8 per cent were 'satisfied' and 44.5 per cent were 'completely

satisfied' with the MCW initiative. This reinforces the fact that MCW activities are considered extremely useful by mothers nationwide.

The FGDs with health care providers revealed that some areas/regions encountered greater geo-cultural and infrastructural challenges to the MCW initiative's implementation when compared with the rest of the country. In KP, AJK, FATA and Balochistan, cultural and religious misconceptions around vaccines and family planning persist; vaccines are (erroneously) perceived to be iatrogenic or prohibited on religious grounds.

In many parts of Pakistan, patriarchal mindsets lead to women's seclusion, restricting women's mobility even in terms of seeking health services. This challenge is compounded by a lack of sufficient medical facilities, particularly in FATA, Balochistan, AJK and GB. Hence, MNCH and MCW planning may focus more on awareness raising in order to do away with cultural myths that limit optimal outreach. Given feedback on deworming tablets, the MCW initiative might want to introduce syrups for children under the age of five, while extending deworming interventions to cater to the needs of adults and children over the age of five.

4.2.2. MCW initiative's planning, implementation and monitoring

4.2.2.1. Reviews and planning

The qualitative data affirmed that the MCW initiative was reasonably well-planned, encompassing planning and reviews at the federal, provincial, district and union council levels. It involved backwards and forward planning. That is, LHWs mapped out their target beneficiaries through registration sheets and shared these with LHS who, in turn, discussed plans with district representatives – plans included the total number of registered beneficiaries, schedules for health sessions and a plethora of details, such as the number of defaulter children, reasons for defaulting and how to cover them. District representatives then shared these plans with provincial representatives, who reviewed them, suggested changes – if any – and developed their own plans for arranging the required logistics and supplies.

As the key informant from AJK explained, *"If micro-planning is good enough then we get best output. In this regard, if we do not know the size of our target audience we cannot work out an effective and efficient programme."* The key informant from KP pointed out that *"The review mechanism is very strong. Estimates of expected beneficiaries for cover and required supplies*

first prepared by LHWs are sent to LHS, then to medical officers and DPIU for review." Commenting on the overall significance of micro-planning, the key informant from GB stated:

> *Whole operational side of MCW is based upon micro-planning as this gives us ground statistics. After reviewing these, we can amend changes, if any, and arrange for required supplies/logistics. As far as Gilgit-Baltistan is concerned, we are getting best reports from LHWs, which we draw a calculated and well-devised operational plan from.*

All relevant informants confirmed that field plans were largely elaborated by health departments, while UNICEF was responsible for budgeting/fiscal planning. The key informant from KP noted that "*Micro-planning for on field operations is mainly the responsibility of the health department while UNICEF micro-planning is limited to calculation of targets and expenses.*"

On the other hand, commenting on the mismanagement of scheduling reviews and planning meetings, a key informant from Punjab noted, "*Reviews and planning meetings are sometimes called at a very short notice. In such a short time, it is not possible to develop good reports for review and extrapolate plan."* Regarding the MCW initiative's drawbacks, a key informant from Punjab suggested that *"MCW can use polio planning as a yardstick to improve performance."* Some district level informants from FATA felt that the MCW initiative's planning was held back because LHWs could not provide accurate accounts of registration. The key informant from FATA stated, "*Planning is weak as LHWs do not provide the true account of beneficiaries and we cannot work out the supplies subsequently."*

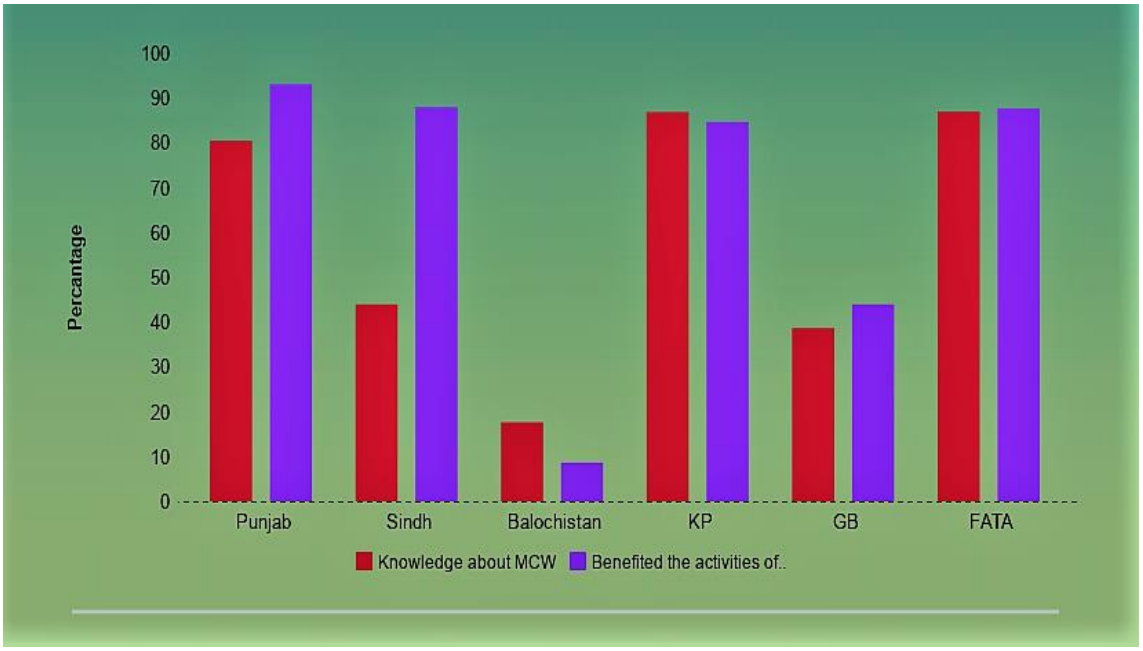
Overall, the MCW initiative's planning and reviews appear to be conducted well in all provinces and regions, with exception of FATA. There is a need to enhance the capacities of LHWs in this region, to motivate them to ensure accurate accounts of registration. There is also a need for a comprehensive and timely review and planning at the district level to ensure that desired results are attained.

4.2.2.2. Implementation

The qualitative data reveals strong disagreement on the effective implementation of MCW initiative, with marked differences in opinion between informants in different provinces and regions. Informants from AJK, Sindh and KP were largely optimistic, while those in Punjab,

FATA, GB and Balochistan highlighted a number of bottlenecks that constrain the MCW initiative's effective implementation. Identified challenges to its implementation principally concern logistics and geo-cultural constraints. As discussed above, beneficiaries in some regions engaged in MCW activities but were not aware of the term 'Mother and Child Week'. This reflects some of the weaknesses in terms of the initiative's ability to advertise the term MCW efficiently (see Figure 22).

Figure 22: Mothers' knowledge about the terminology of 'MCW'



Nonetheless, the qualitative findings reveal that community health workers generally consider that the MCW initiative has been effectively implemented. LHWs, LHS and vaccinators from AJK, KP and Sindh pointed to the initiative's effective implementation and confirmed that logistical needs were provided in due time and in sufficient quantity. A LHW from Sindh explained that "*We do not face any problem in getting the right quantity of required supplies at the right time. The programme is implemented in best possible way and it has proven to be very beneficial for the community.*"

LHWs in AJK, KP and Sindh reported displaying banners on roadsides, in public places and at schools, in addition to distributing pamphlets, to inform the community of MCW activities and their significance. A LHW from AJK said, "*We place banners and distribute pamphlets to raise*

awareness among community about the importance of mother and child health care." Most LHWs (105 of 116) felt that the response of communities is improving as a result of the MCW initiative's improved implementation over the past ten years. A LHW from AJK observed, "*Community's reaction towards MCW is very supportive and women feel extremely satisfied after attending health sessions.*"

Similarly, the FGDs showed that vaccinators from AJK, KP and Sindh appeared satisfied by the MCW initiative's implementation. They noted that LHWs, community volunteers and FM radio made announcements and circulated information about their visits one week before MCW sessions were held. One vaccinator from KP stated:

> *Community is informed by the vaccinators, LHWs and various other community volunteers, such as molvis [religious leaders] and school teachers, before MCW starts. Then the beneficiaries are gathered and vaccinated according to the mentioned date and time and especially defaulters are vaccinated during MCW*.

Informants from Punjab, FATA, GB and Balochistan complained that the MCW initiative's implementation was often halted as a result of various petty logistical gaps and geo-cultural limitations. Informants from KP, FATA, AJK and GB also highlighted certain geo-cultural constraints. These included commutes through hilly/difficult/remote areas, coupled with religious and social misconceptions around vaccinations, as discussed above, and myths about the iatrogenic implications of the interventions. A LHS from FATA explained:

> *Initially, women were reluctant to receive TT shots as they believed this would damage the health of their unborn. Some even believed that injections might lead towards abortion. I must say the present understanding of most of the women is not that adverse yet some women still are not getting TT shots afraid of perceived harmful consequences. This is affecting good implementation of the programme*.

By the same token, some informants in KP and AJK cited patriarchal mindsets as major constraints for the initiative's implementation. They noted that some community members were not cooperative and did not allow women from their households to participate in MCW activities. They were also skeptical about the authenticity and chemistry of MCW interventions, particularly vaccines. As a LHW form KP remarked:

> *Programme implementation suffers because women are not allowed mobility. Similarly, to ensure privacy of household, women are not even given liberty to talk to us. Moreover, people sometimes are not that too kind and welcoming. They do not trust the vaccine – owing to religious misconceptions – and medicine provided by the Government.*

Qualitative data from interviews with LHS, LHWs and vaccinators from AJK, GB, KP and Balochistan also highlighted the difficulties of commuting through hilly/difficult/remote areas, citing this as a constraint for the MCW initiative's effective implementation. As a LHW from KP put it, "*We find it quite difficult to travel through hilly areas, so provision of conveyance can actually ease things up and make implementation of MCW more effective.*" Another LHW from AJK concurred, "*Sometimes we have to commute through forests, lowly populated and unsafe areas, and this is not feasible for a woman at all. We must be provided suitable conveyance so we may travel without security risk and fear."*

Commenting on the difficulties of covering remote areas with limited time and resources, a LHS from GB stated:

> *For monitoring purpose, it is necessary that we should go to the field, but for that we do not have fuel and funds There are 22 LHWs working under a single LHS and we have to visit to 22 different locations, which is quite difficult in the absence of funds and conveyance. Despite these difficulties we are trying to do our work most effectively.*

The qualitative findings reveal that the absence of transportation is as one of the most persistent complaints by community health care workers. They also pointed to six-day-long unpaid laborious work as reducing their motivation. As a LHS from KP said, "*LHWs and we are not paid at all for the laborious work that we do. Whereas additional incentives given can boost up the staff members and have them work harder to further the effectiveness of the whole programme.*"

While participants in Sindh were satisfied with the initiative's implementation, some highlighted weakness in the implementation system. One key informant from Sindh observed:

District health officers have limited capacity to implement MCW campaigns. Frequent transfer posting of officers is a major constraint, hinders the smooth implementation of MCW. Moreover, other health priorities such as polio campaigns or routine immunization also hamper this MCW as LHWs remain engaged in the campaigns which delay the celebration of MCW in some localities.

Thus, to maximize the MCW initiative's implementation, it will be necessary to raise awareness in KP, FATA, Balochistan and AJK to overcome cultural/religious misconceptions surrounding MCW-related interventions. It is equally essential to address challenges posed by arduous commutes through difficult terrain in parts of KP, FATA, Balochistan, AJK and GB. A proper strategy is needed in this regard, one which includes providing adequate transport for field workers, or limiting the expanse of the areas they cover. Necessary supplies must be provided to LHWs in good time and in sufficient quantity so that they can use these to full effect.

4.2.2.3. Monitoring and reporting

The qualitative data indicates that the MCW initiative followed an efficient multi-level monitoring and reporting mechanism at the federal, provincial, district and field levels. During the KIIs, informants from district and provincial administrations outlined the initiative's monitoring and reporting processes. First, concerned health officials devised a well-engineered plan to ensure effective field monitoring able to accurately capture results. These officials included LHS in particular, alongside various district representatives/inspectors, including District Coordinators, Assistant District Coordinators and District Health Officers. The key informant from KP explained:

The programme features *monitoring of each and every activity as planned, at various levels starting as low as from UC and BHU to as high as the federal level. One copy of LHWs six-day plan is kept at thethe UC office so we exactly know where and what an LHW might be up to. This helps us keep a close watch on the field team.*

Another key informant from Punjab stated, *"District management takes detailed report of everyday on-field activity from LHS."* One health manager noted, *"For reporting and monitoring purposes, our different provincial officers' conduct inspections of District Coordinators and LHS*

to ensure effective reporting mechanism." Describing the MCW initiative's monitoring arrangements as effective, the key informant from AJK noted:

> *We follow a tour programme in which we visit all UCs of Muzaffarabad. We attend health sessions to oversee them properly. We validate all the finding through our community visits. We review reports submitted by LHS. We process data at district level and forward to the provincial level.*

Regarding the proper handling and transportation of vaccines, informants from across the country reported that the cold chain was well-maintained and monitored. A vaccinator from FATA stated, "*Required temperatures and environment for vaccines is closely and carefully monitored. Vaccinators are advised and monitored for maintaining a perfect cold chain.*"

Overall, the qualitative data revealed that the MCW initiative's reporting arrangements for community health workers were simple and convenient, thereby responding to the fact that LHWs may not have a high level of education. According to informants in Balochistan, LHW reporting was not difficult and only involved marked/signed registration sheets and pictures of their daily activities. The key informant from Balochistan observed, "*There is no formal mechanism for reporting of MCW. A simple registration sheet and pictures of the activity are used for evidence of the MCW campaign.*"

Despite the convenience of reporting procedures, some LHS and LHWs – generally from KP and Punjab – complained that reporting was difficult due to LHWs' often low levels of education. A fair number of LHWs were concerned about the short, over-simplified training sessions they received before having to manage *"complex reporting"*. They recommended robust and effective trainings to strengthen LHWs' capacities for better, more efficient reporting. One LHW from southern KP suggested that "*Better and effective trainings can contribute towards appropriate reporting by LHWs.*"

In the light of the evidence, it may be concluded that the MCW initiative had a robust, effective system of monitoring and reporting in place at multiple levels. Nevertheless, rigorous training to develop LHWs' monitoring and reporting skills, coupled with monetary incentives for community health workers, would further improve the effectiveness of monitoring and reporting.

4.3. EFFICIENCY OF THE MCW INITIATIVE

Overall, the qualitative findings indicate that available human and financial resources were used quite efficiently by the MCW initiative. This was attributed to the fact that most field staff are passionate, vigilant about their tasks and perform their duties efficiently. Available supplies/interventions were also well-utilized. As an informant from KP stated:

> *All the activities were conducted within available resources and we well utilized all resources including human and logistical – none of the supplies were wasted. I must say that efficient use of resources has made MCW a success since community has eventually gotten benefit.*

An informant from FATA concurred, "The available resources are off course well utilized and community has been getting a lot of health care benefits. Our field staff members are motivated and they understand that they are doing a great service to the community".

Almost all informants nationwide felt that the MCW initiative was cost-efficient, as it used the existing resources of the EPI and LHW programmes. One key informant from Sindh noted, "*The programme is cost effective since it's in alignment with already existing programmes*". A key informant from Punjab observed that *"medicines and vaccinations used during MCW are high quality yet low in cost, while on the other hand, MCW itself is a cost-efficient programme as it is aligned with the existing MNCH and EPI programmes."*

Some participants, however, considered that the MCW initiative's overall efficiency was undermined by inadequate financial and human resources. This dearth of resources, they held, prevented the MCW initiative from extending support to marginalized/socially excluded populations, particularly nomadic groups. This view was held by some informants at the federal level and in AJK, Balochistan, Punjab and Sindh. They cited insufficient resources and mismanaged planning as barriers to efficiently pursuing health care objectives, particularly the priority of reaching out to marginalized groups. As the key informant from AJK explained:

> *If health care promotion is the main target of MCW then the priority must be addressing marginalized and uncovered such as nomadic settlements, disaster-affected*

and kiln workers. As these folks are not being targeted properly, I would doubt to say if resources are most efficiently being utilized.

An informant from GB noted, *"We try to utilize the resources in the best possible way but there should be more resources so that we can outreach to our remote and marginalized areas."* By the same token, federal informants observed that the MCW initiative requires more planning to achieve its targets of reaching out to 'uncovered' urban slums and nomadic settlements. One key informant suggested that the *"MCW can be improved with well-thought out fiscal and programme planning that may ensure greater coverage and efficiency."* The National Programme Manager of the EPI agreed that the MCW initiative *"is prone to be inefficient in outreach to most marginalized areas as job of LHWs is restricted to their localities."*

The data revealed that LHWs met MCW targets within the scope of their daily routines. As such, they were not entitled to any additional payment. One key informant explained:

During the MCWs, LHWs are provided brochures, pamphlets, deworming tablets for the target population. So, the resources provided are always efficiently utilized and the beauty of this programme is its cost-effectiveness that LHWs carry out MCW activities in their catchment areas without any extra benefits. We give no extra benefits to LHWs and LHS but they include the MCWs targets in their routine schedule. It will require a large number of human resources if MCWs interventions are planned without the LHWs support.

However, this lack of monetary compensation for additional work has been a blow to workers' motivation, with dire implication for the MCW initiative's efficiency. As a key informant from AJK explained, the lack of additional salaries for LHWs, LHS and vaccinators – who performed an additional six days' worth of laborious work – demotivated staff and, consequently, undermined the overall efficiency of the MCW initiative. As he put it:

Field workers do not get any extra incentive for their work. This subdues their level of dedication whereas additional incentive can heighten their motivation and uplift the efficiency of their work in particular and of the whole programme in general.

Some LHWs (19 of 116) – particularly from Punjab and KP – highlighted a shortage of medicines as a factor that reduced the MCW initiative's efficiency. They suggested increasing the supply of medicines and recruiting more LHWs in order to expand the initiative outreach, coverage and – ultimately – its efficiency.

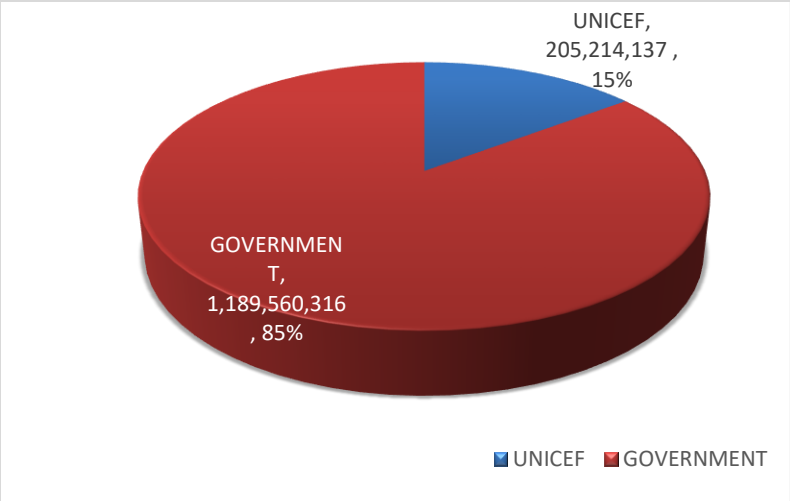
4.3.1. Descriptive cost analysis

As explained above, a descriptive cost analysis could only be undertaken for two years (2015 and 2016) for which data was provided by UNICEF, rather than the entire ten year period of the MCW initiative's implementation for which complete data was unavailable. The total cost spent in 2015 and 2016 on two rounds of MCWs per year is presented as the cost per beneficiary, in terms of the share spent by both the Government and UNICEF. The Government's share is presented as the costs incurred for human resources and vaccination, while UNICEF's share was spent on IEC materials, deworming, monitoring and supervision activities.

Cost per beneficiary

According to the data provided by the Government and UNICEF, the cost per beneficiary (i.e. per person) for service delivery in terms of the provision of health education for behaviour change during both MCW rounds in 2015 was PKR 41 million, while in 2016 it was PKR 51 million. Segregating the costs of health education reveals that the total spent in 2015 was PKR 96.3 million per beneficiary and in 2016 it was PKR 104.6 million per beneficiary solely for service delivery (see Annex 9 for details).

Figure 23: Total MCW costs and distribution in 2015

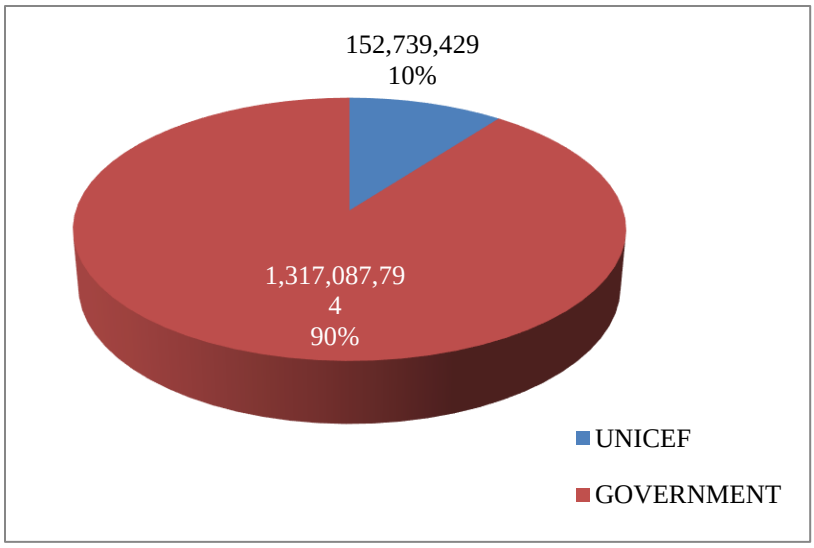


Total costs and distribution

The total cost of the MCW initiative in 2015 was PKR 1,394.8 million. Of this, 85 per cent (PKR 1,189.6 million) was borne by the Government of Pakistan, including its national programme for Family Planning

& Primary Health Care and the Expanded Programme on Immunization. The remaining 15 per cent (PKR 205.2 million PKR) was contributed by UNICEF (see Figure 23).

Figure 24: Total MCW costs and distribution in 2016



The total cost of the MCW initiative in 2016 was PKR 1,469.8 million. The breakdown of these costs reveals that 90 per cent (PKR 1,317.1 million) were spent on human resources and vaccination. This sum was contributed by the Government, including by the national programme for FP & PHC and the EPI. The remaining 10 per cent (PKR 152.7 million) were provided by UNICEF in the form of Mebendazole tablets for deworming, IEC materials, logistical arrangements for training, and travel for monitoring and supervision (see Figure 24 and Annex 9 for details).

Thus, it can be concluded that the MCW initiative utilized available funds efficiency, while bearing in mind that the absence of additional pay for field staff is a double edged sword. While, on the one hand, it plays a role in cost efficiency (as additional staff costs are not incurred), it simultaneously harmed worker motivation, dealing a severe blow to the overall efficiency of the initiative. While health care improved in 'covered' areas, the MCW may consider according a greater share of resources/services for marginalized populations – especially in slums and nomadic settlements – to enhance the efficient utilization of resources and better meet its objectives.

Thus far, this section has focused on a macro understanding of efficiency in terms of resources, their utilization and cost efficiency. To better understand operational efficiency, the following sections offer a microanalysis of two key components of the MCW initiative – capacity building and programme operations.

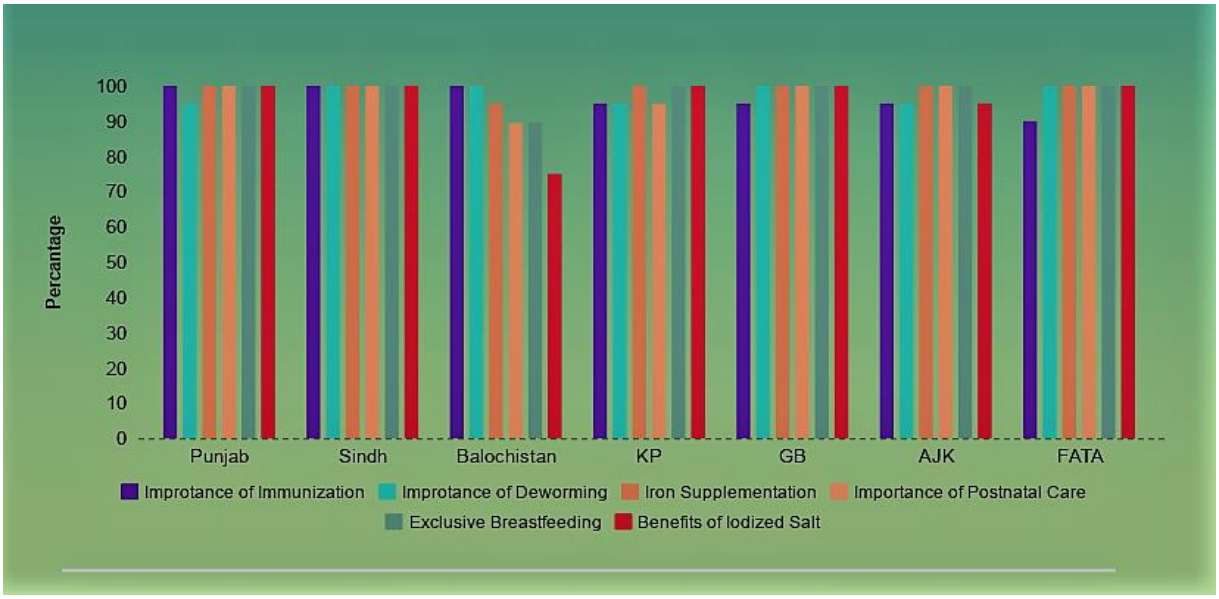
4.3.2. Capacity building

The document review found that the MCW initiative relied heavily on the training and capacity building of field teams, especially LHWs and LHS. Before each round of MCWs, a one-day training was conducted for LHS and LHWs on: (a) MDGs 4 and 5 and SDG 3 after 2015 (b) primary health care, (c) service delivery, specifically the immunization of children aged 0-2 to protect them from five major deadly diseases, TT vaccinations for women of reproductive age and deworming for children between two and five years old, and (d) health education. Training on health education encompassed discussions of how to change behaviours that have a bearing on serious diseases among children; social mobilization through community awareness on essential newborn care, exclusive breastfeeding and complementary feeding; immunization; recognizing the danger signs of pneumonia and diarrhoea; the basic principles of hygiene, sanitation and deworming; and psycho-social support and development (MCW Report, 2011). Training programmes varied for each phase and for each province, depending on the planning of MCW activities by the concerned district and provincial management (ibid).

The qualitative data found that skilled, well-trained and dedicated teams were the backbone of the MCW initiative. The initiative's biannual time schedule meant that it involved long enough intervals for staff skills to potentially wane. As such, the MCW initiative used a range of training materials and, sometimes, literature. Trainings equipped field staff with relevant knowledge and upgraded/refreshed their skills set, thereby enhancing their operational efficiency. Qualitative data revealed that the MCW initiative employed a multilevel, trickle-down form of training. This followed the training of LHS by District Health Officers, and then of LHWs by LHS. Lady Health Supervisors sought training for between two and three days before delivering one-day intensive training to LHWs. Overall, participants from various provinces and regions agreed that these trainings were useful for enhancing efficiency in the field. As one LHS in Punjab put it, *"We are now more informed about mother and child health care after receiving training. Our overall knowledge has multiplied over the course of past ten years"*.

The quantitative data also confirms that LHWs' knowledge of different MNCH-related issues were quite strong. This reflects the benefits of capacity building delivered in the context of the MCW initiative (see Figure 25).

Figure 25: LHWs' knowledge of different health-related issues



Commenting on the usefulness of the trainings, one LHW from KP stated:

> Y*es, we get proper training. Our Baji [LHS] give us training. Training duration is one day and all of the field interventions are briefed properly. In training, we are told about the content and distribution of materials and targets of health.*

The key informant from KP noted, *"Our health care provider's professional competence has increased owing to the additional assignments during MCW."* A LHS from FATA concurred, *"Yes, our capacity is enhanced, especially communication skills. We also remain updated and get new information, such as on hygiene and sanitation and dengue prevention."* According to the key informant from Punjab, *"Trainings for the MCW service providers have really been helpful in uplifting their operational skills, particularly reporting skills."*

Despite the general positive opinion of training among participants across the county, LHS and LHWs in AJK and FATA reported that they were not given proper training. They stated that they were only provided with supplies at the District Coordinator's Office. One LHS from AJK explained: *"We did not receive regular trainings. Just before the MCW, we go to district office with our data, and staff there just ask us about the needed supplies and issue the supplies accordingly.*" Similarly, a LHS from FATA complained, "*We are not given proper trainings.*

Most of the trainers are not capable enough to guide us in best possible ways." Another LHW from AJK noted:

> *There should be one proper training session before this week that would make this more efficient and productive. But due to lack of proper training sessions, lots of new things remain unknown. During polio trainings, we are also provided with refresher sessions, but there is no such thing during MCW programme.*

It is worth noting that trainings were criticized for not being long enough to share considerable information/knowledge efficiently. Participants also felt that trainings could not have a wide-ranging impact because of trainees' relative lack of education. Some LHWs and LHS – mainly from Sindh and Punjab – did not feel that trainings were especially helpful. As the training sessions only lasted for one day, they argued that the immense scale of information shared could not be fully grasped in such a short period of time. One LHW from Punjab stated, *"MCW training is too short and it is not possible to learn a lot of stuff in given time."* A LHW from KP noted, "*LHWs have limited educational capacity, so trainings must be made straightforward and easier to understand. Furthermore, duration of the trainings must be increased to have the effect come out better.*"

On the whole, MCW-led trainings have improved overall staff competencies. However, some field staff did not receive sufficient training to learn how to perform their duties to the best of their abilities.

4.3.3. MCW operations

Most provincial/regional informants believe that the MCW initiative's operations were performed efficiently. As noted above, the qualitative findings reveal that logistical supplies were provided in due time and in sufficient quantity. Most LHS reported that they usually received supplies one week before MCW sessions. While supplies for LHS were provided at their respective District Coordinator's Office, LHWs tended to collect their supplies from basic health units. LHWs then displayed the aforementioned promotional banners in crowded public places – especially schools and mosques – and distributed pamphlets among the community.

As a LHW from AJK explained, *"We get all the supplies from either District Coordinator's Office or from basic health unit in the vicinity. We have to collect the supplies on our own*

conveyance." A LHS from KP said, *"All the supplies are provided to us on time and we are provided with vaccination cards, registration cards, banners, TT injections, vaccines, deworming tablets and other relevant medicines. The provided supplies are quite sufficient for MCW."* A LHW from Sindh concurred, *"The logistic supply was efficient and we were provided with the IEC material and other supportive things well in time. This really helped us in executing the project activities within the given timeframe."*

Some informants disagreed, stating that supplies were insufficient and did not cover the target population efficiently. One LHW form Balochistan stated:

> *We require more quantity of various supplies and interventions. Due to large area and population, provided supplies do not cover the whole area. Similarly, community demands more medicines such as Panadol, antibiotics, blood pressure tablets [anti-hypertensive medicines], folic acid and tonics.*

Vaccinators, like most LHS and LHWs, generally reported that the MCW initiative's operations were well-managed, leading to effective vaccine outreach. They noted that LHWs' efficiently shared vaccinations schedules with the communities. LHWs also kept a record of defaulter children, enabling the initiative to address their vaccination needs. According to a vaccinator from KP:

> *During the MCWs, the community was priory informed; they were told about the venue and time by the LHWs. Besides LHWs, we made on-the-spot announcements that the EPI team has reached and the community people need to come to the specified home or hujra [reception area]. If the campaign is going on in the nearby area, then we call them to gather in the health house.*

Participants from KP and GB said that community volunteers made announcements about upcoming vaccination drives. These volunteers included teachers and *Imam Masjids* (religious clerics), whose announcements were made through mosques. Roadside banners were also used to promote vaccination schedules and sensitize communities on the important of immunization. By contrast, informants from Balochistan reported that no announcements of vaccinations were made in their areas. As one vaccinator explained:

No announcements are being made on [the] loud speaker in mosques. The message has only been sent out by using banners, which is not sufficient because of low literacy. So, for ensuring efficiency with greater number of children showing up for vaccination, proper and frequent announcements are required.

Vaccinators from FATA indicated that security concerns sometimes prevented them from making announcements. One vaccinator from FATA observed:

FATA is a tribal area and a lot of security issues exist there. Some religious folks here consider vaccines haram (forbidden), so sometimes it's not very easy to campaign about these wide-open. Not just that, FATA is unstable anyhow, so we have to act extremely cautiously.

Overall, the qualitative findings confirm that MCW activities were carried out efficiently at various levels and the stakeholders provided considerable support for enhancing MNCH services across the provinces. The findings indicate that available resources were utilized efficiently, well within the scope of health service providers' capacities. The initiative's operations were also considered efficient, due in large part to capacity building for health workers. Nevertheless, some constraints were identified – such as a lack of motivation among service providers in the absence of monetary compensation for extra work. The MCW initiative's efficiency would be further enhanced by better supporting its human resources, introducing monetary incentives for community health workers and increasing logistical supplies.

4.4. SUSTAINABILITY OF THE MCW INITIATIVE

Sustainability denotes the continued benefits from a programme/initiative after major development assistance has been terminated (IFAD, 2007). It implies that an initiative's benefits continue to reach target populations even after project interventions have ended. Therefore, the sustainability of MCW activities requires efforts to ensure the initiative's ownership by key stakeholders and to guarantee that its benefits continue to improve the lives of the target population, even if the initiative itself comes to an end.

4.4.1. Stakeholders perspectives and disposition towards the MCW's continuation

As discussed in detail above, although the MCW initiative began as a federal project in 2007, it fell under the remit of provincial administrations after the 18th Constitutional Amendment (2010)

accorded them primary responsibility for health care. The Amendment has precipitated both positive changes, such as greater power at the district level, and multiple challenges in terms of standardization, the uniformity of interventions and inter-provincial coordination (Review and Coordination meeting MCW, 2011). After 2010, MCW activities have been supervised by provincial health managers, although they are also monitored by federal authorities. Provincial and district authorities, therefore, are primarily responsible for ensuring the MCW initiative's sustainability.

As the qualitative data demonstrates, informants unanimously agreed that the MCW initiative has led to beneficial health care outcomes and that the initiative needs to be sustained. A few informants questioned the prospects of the initiative being sustained once external funding is withdrawn. They argued that its sustainability is uncertain given the challenges that provincial governments are likely to face in terms of financial and operational arrangements, especially considering Pakistan's stagnant health care budget. Some informants felt that civil society would need to play a crucial role in sustaining the MCW initiative. As the key informant from Punjab put it, "*The stakeholders' ownership like civil society is very important for continuity and sustainability of the programme."*

Most informants, however, maintained that financial challenges to the MCW initiative's sustainability were being blown out of proportion since the initiative is largely cost-effective. They pointed out that provincial governments are aware of the initiative's benefits for community health and might be willingly to continue the initiative – either in its current form or by incorporating its features into broader MNCH programmes. According to the key informant from KP, "*Yes, MCW programme is beneficial. In my view, we must continue it and our staff is committed to sustain this initiative for betterment of the community."*

During the KIIs, participants argued that the MCW initiative's sustainability can be ensured with the support of government health policies. One key informant explained:

> *MCW is cost-effective and must easily be continued under the umbrella of MNCH. In this regard, we have got human resource and most of the supplies/interventions already covered through MNCH. For its continuation, we are not talking a very huge amount of finances, especially considering the kind of results we might expect to get.*

Many informants suggested that the MCW initiative could be integrated into existing MNCH services, pointing out that Punjab has been running the initiative successfully and independently. According to the key informant from Punjab, "*We have pulled out our financial support from this programme, since the last two years the Government is managing all on its own. We just provide support in monitoring of MCW activities. Our health system should sustain such projects."*

Another informant echoed this view, *"I think this programme has been successfully sustained in Punjab province, where LHWs play an active role in its sustainability."* Nonetheless, the key informant from Punjab acknowledged that the provincial *"Government has taken over the responsibility of MCW to address the issue of sustainability; however, the cost of supplies, medicines and monitoring may affect its sustainability."*

It is worth noting that Punjab accounts for over half of the country's population. Therefore, half of the MCW initiative – in in terms of the number of its beneficiaries – is already internally sustained by a provincial government. Nonetheless, immense efforts by other provincial/regional governments will be needed to sustain the initiative without UNICEF's support. Speaking of ways forward, one key informant observed that "*The sustainability of this project lies in its integration into family practice model and health insurance programme, engaging public and private health care professionals to serve the community, ensuring the health of all."*

KIIs suggested that provincial health departments should allocate a greater proportion of their budgets to the MCW initiative in order to extended outreach to the most marginalized segments of society. As discussed above, budgets must be expanded to remunerate field staff for the additional work they perform in the context of MCWs. This is vital for the initiative's efficiency and sustainability, which ultimately relies on motivated field workers. According to the key informant from Balochistan:

> *The most important factor in sustaining of the programme is motivation of field staff as they are the service providers. They should be given extra financial benefits for extra work that they do, to make endow the programme with greater sustainability.*

In conclusion, a considerable part of the MCW initiative is already sustained by the Government of Punjab. Most health administrations in other provinces/regions appear dedicated to ensuring

the initiative's sustainability. While the prospects for sustaining the initiative appear promising, judging from discussions with health officials, there is no denying that less than one per cent of Pakistan's fiscal budget is allocated to health care. The fact that health care in the country relies on development assistance, coupled with extremely low national expenditure on health and the stagnant health budget, are likely to negatively affect the MCW initiative's sustainability once development support is withdrawn.

This is the case for health-related projects in most developing countries. However, donor agencies tend to continue to provide technical support even after withdrawing financial assistance. Their technical assistance enables governments and other stakeholders to ensure that initiatives continue benefit it target population (USAID, 2015). In Pakistan's case, it may be better for external funding to decrease in order to prompt an increase in national/provincial budgetary health allocations, thereby obliging the country to sustain initiatives like MCWs internally.

4.4.2. Strengthening the capacity of MNCH service providers

As discussed above, both secondary data and primary qualitative data confirm that the MCW initiative gave community health workers the opportunity to strengthen their professional capacities, which contributed to the initiative's efficiency. By raising women's awareness of health care, the initiative led to an overall improvement in community health. As a key informant from Balochistan remarked, "*MCW increased mothers' knowledge on prevention and treatment of pneumonia and diarrhoea. Now she is capable to give immediate care to their children, such as preparing home-made ORS, if sachet is not available and save the children from dehydration."* Overall, stakeholders agreed that the MCW initiative – and its capacity building component –should be sustained to promote better health services and improve MNCH service utilization.

4.4.3. Factors affecting the MCW's sustainability (contributing or limiting factors, internal or external)

The qualitative findings identified various management and capacity issues, including limited financial and human resources in Balochistan, KP and some parts of southern Punjab, which hindered the MCW initiative's sustainability. While most informants considered micro-planning to have been acceptable, they stressed that it must be improved to ensure the sustainability of the

initiative. One informant from Balochistan observed, "*If you don't plan things properly, it leads to wastage of resources and lowers the morale of the workers. It damages [the] programme's efficiency and reputation."* Another informant from KP added, *"There is no uniform method or formula for micro-planning; it should be done according to local needs and efficiency of the system."*

Other challenges for the MCW initiative's sustainability included a lack of transportation for field workers. As viable public transport systems do not exist in most rural areas, health workers' mobility proved a major challenge. The vast majority of informants linked the initiative's sustainability with the provision of transportation. Some informants also linked transportation with supplies and logistical management. As one informant from Balochistan put it, *"If the population is geographically dispersed and health workers have to travel miles to reach beneficiaries, how could one expect that supplies will be in time and logistical management will be proper*?" According to an informant from Punjab, *"Local community ownership and their active involvement is key issue for sustainability."* The key informant from Balochistan observed, *"factors like unavailability of supplies and transportation system affects the sustainability."*

The key informant from FATA argued that *"Lack of funding from development partners and non-availability of financial incentives for service providers are major hindrances."* Service providers cited factors that affect field workers motivation as barriers to sustainability. A LHS from Punjab's capital city, Lahore, said that *"improper supplies and no financial incentive demotivate us and the programme exploits us."* Another LHS from Punjab stated, *"We need more facilities, volunteers and enough supplies of deworming tablets, medicines and supplements according to the population's needs. Incentives should be provided to LHWs when going in uncovered areas, so that we remain motivated and work more efficiently."*

One key informant from KP felt that the MCW can be sustained by partnerships between local NGOs active in the field of health care. He observed, "*If UNICEF pulls itself out sooner or later from this programme, DoH must identify potential NGOs in his areas and CBOs [community-based organizations] who are willing to work for the promotion of health care to keep the MCW cause alive and well going."*

Despite the MCW initiative's positive results, the documentary review found that questions of sustainability remained unanswered. The review noted that government ownership appeared declined over time and that the MCW initiative was increasingly referred to as exclusively a UNICEF undertaking. The results of the review also suggest incorporating the MCW initiative into integrated Planning Commission documents (PC-1) to ensure sustainability.

As the qualitative data shows, most stakeholders agree that the MCW initiative should be sustained to benefit communities in general and marginalized populations in particular. Health managers and service providers, especially from Punjab, concurred that the initiative can further strengthen their capacities if training and refresher courses are arranged more frequently. There is a need to overcome constraints related to the timely logistical arrangements and the provision of supplies, coupled with more effective and frequent training for field workers and additional financial benefits for LHWs. The engagement of both health workers and community stakeholders will ensure the MCW initiative's sustainability and, thereby, support progress on MNCH indicators.

4.5. LONG-TERM OUTCOMES

As discussed above, this evaluation assessed the MCW initiative's long-term outcomes in order to gauge its impacts between 2007 and 2017, in line with DAC evaluation criteria. To assess these long-term outcomes, the evaluation sought to answer two key questions:

- To what extent has the MCW initiative achieved its objectives and what were the major factors that affected the achievement of – and/or the inability to achieve – intended objectives/outcomes?
- What lessons were learned during the implementation of the MCW initiative and what other cost-effective options were available, if any?

Therefore, the evaluation assessed the MCW initiative's contribution to fulfilling the basic health needs of its intended beneficiaries, including pregnant and lactating mothers, adolescent girls and children. The evaluation also looked at unintended outcomes, if any, with a special emphasis on provincial and regional disparities. It determined the main factors and challenges that affected whether the initiative's objectives were achieved or not achieved, while highlighting lessons learned from the initiative's implementation.

As discussed above, the MCW initiative's ultimate objective was to deliver a comprehensive package of integrated, high-impact, low-cost MNCH interventions with the highest possible coverage. The evaluation found that health managers', service providers' and beneficiaries' perceptions differed on the question of whether the initiative achieved its objectives. Some participants believe that the MCW initiative helped to mobilize communities to utilize and strengthen the routine health services, with an added dimension of scalability. Others felt that the MCW succeeded in addressing the needs of marginalized, excluded, crisis and disaster-affected populations in terms of improved maternal and children health. These findings are discussed in detail in the following sections.

4.5.1. Achievement of the MCW initiative's intended objectives

The qualitative findings revealed that the MCW initiative proved an effective approach for improving MNCH indicators, strengthening the service delivery system and raising awareness by utilizing Pakistan's existing network of outreach workers. The concept of 'achieving objectives' was interpreted differently by stakeholders at different levels. Health managers considered that it refers to a shift in policy and pointed to a progressive improvement in MNCH indicators at the national and provincial/regional levels. Service providers valued the initiative for strengthening their routine tasks and capacities to improve MNCH service utilization and increase community participation. Beneficiaries equated the MCW initiative's achievements with service utilization and awareness raising, which had a positive impact on maternal and child health.

The qualitative data found that many stakeholders considered the MCW initiative's prime achievement to be its strengthening of the health service delivery system. They indicated that the initiative accelerated progress on priority health indicators, such as immunization coverage, antenatal and postnatal care, and deliveries assisted by skilled birth attendants. As one key informant put it, *"I consider efficacy of the vaccines, as an achievement of MCW, which ensures to access the missed children and provide them vaccination."* The key informant referred to the successful example of Punjab, indicating that "*This intervention highlights the policy shift and very successful in case of Punjab, where, in my opinion, around 50 per cent of the population has been benefited from MCW. Now, Punjab province celebrates this week as 'health mela' [health fair]."* Another key informant from Punjab observed, "*If you compare the existing*

MNCH indicators with previous years, you will see a progressive improvement in these indicators. MCW campaign has bridged the gap of quality services."

A key informant from Balochistan was of a similar view, noting that *"MCW services and health sessions improved the maternal and children health."* A key informant from AJK said, *"Most of the desired outcomes have been achieved with the help of MCW, such as AJK ranked second in completing targets, after Punjab province."* According to one key informant from KP, *"The desired outcomes of MCW in terms of improved MNCH services have been achieved at large. Though, 100 per cent achievement of targets is not possible, but it has strengthened the MNCH services, and IMR and MMR reduced to an extent."*

Some health managers considered that the MCW initiative's greatest achievement was increased community participation and their growing trust in service providers. As one observed, "*MCW enhanced the participation of communities, it projected positive image of LHWs. Overall, trust of people on provision of health services has increased. Though, we still lack budget for preventive health services, but MCW is a successful programme."* Some provincial level key informants, however, were more critical of the MCW initiative's achievements. They stressed the need for further improvements. As one key informant from Punjab stated, "*This* intervention *has not achieved 100 per cent of targets. Although maternal and children health improved to some extent, but more has to be done yet."* Another key informant from KP stressed the need to conduct an impact assessment to examine real-time changes brought about by the MCW initiative. In his view, "*Though maternal and children health improved to some extent, but more has to be done yet. Therefore, an impact assessment is required."*

District level health managers highlighted the MCW initiative's achievements in terms of improving the accessibility and availability of MNCH services for poor and under-served people, creating health awareness and building community trust. They reported that the initiative successfully enhanced coverage and improved MNCH indicators – including deliveries in hospitals, child immunization, TT vaccinations for pregnant women, the contraceptive prevalence rate and the provision of deworming tablets. They felt that these services, coupled with health education sessions, reduced the risks of maternal and infant mortality. One key informant from KP explained that *"MCWs has brought behavioural changes within illiterate and poor mothers. Now, they continue their regular checkup during pregnancy and after delivery,*

which was not their practice previously." Another key informant from AJK noted, "*AJK region has reduced MMR and IMR. Since last 10 years, not a single case of infant or under-five child mortality has been reported from the LHW covered areas. In my opinion, it's because of full immunization coverage and MCW in AJK."* Another informant agreed:

> *Yes, MCW has improved the health of mothers, children and general community. A number of health services are provided during MCW to different age groups, such as screening for non-communicable diseases (e.g. diabetes, hypertension) and measurement of weight, height and BMI [body mass index], along with counselling and health sessions, making it a success.*

Other key informants stressed the MCW's achievements in terms of community ownership and awareness raising. As one informant put it, *"MCWs' ownership by community is an achievement. It has improved the overall health and nutrition status of children and mothers."* A key informant from Punjab explained:

> *MCW's continuous efforts and health education sessions (rallies) have changed the behaviour of community. MCW improved the access of mothers and children, especially in the areas, where women are not allowed to visit health facility alone, LHWs accompany them for seeking MNCH health care services*

During the KIIs, some district managers quantified the MCW initiative's achievements. A key informant from AJK held that *"We have achieved 90 per cent MNCH coverage with the support of MCW in the district."* Similar statements were given by an NGO representative, who said:

> *Through MCW, 80 per cent of intended outcomes have been achieved."* Other key informants claimed, *"We have achieved 70 per cent MNCH coverage, with the support of MCW"* and "*In overall coverage areas, 60 per cent improvement has been witnessed.*

However, a few key informants disagreed. An informant from KP stated, *"No, MCWs' intended objectives have not been 100 per cent achieved yet. Though MNCH services are strengthened in LHWs' covered areas, but uncovered areas are still deprived of such services."* An informant from Punjab pointed out, *"We are still lagging behind the stated objectives of MCW. Such kind of programmes is also required in uncovered and slum areas to improve services."*

FGD participants pointed to the MCW initiative's achievements in terms of strengthening services and serving the community efficiently. One LHS from KP contented that *"MCW initiative is effective in improving health of mothers, newborn, children and general community."* Another LHS from Punjab said, *"Yes, MCW is a good initiative, providing us the opportunity to interact with all management. Overall it enhances our capacity."* A LHS from Balochistan claimed that "*MCW has proved to be a backbone for improving health of mothers and children."* A LHW from AJK concurred, *"Exactly, MCW has achieved their goals/targets and reduced MMR, which is the success of MCW."* So did a LHS from GB, who stated, "*I find this programme successful, inviting more mothers, children and even adolescent girls and provide them services and health education."*

A select few service providers were less effusive when speaking of the MCW initiative's achievements. According to a LHW from Balochistan, "*Through MCW, 98 per cent of its objectives in covered area have been achieved and remaining 2 per cent is still to be achieved, targeting those women, who are not ready to leave their homes to attend health sessions."* A vaccinator from KP was more critical, "*MCW did not achieve its intended objectives due to its short span and lack of human resources."*

Overall, the qualitative findings suggest that most key informants consider the MCW initiative a success, considering that it achieved its intended objectives. While a few participants disagreed, most linked the overall achievements of the MCW initiative with improved coverage, health service utilization and community ownership.

4.5.2. Awareness and utilization of MNCH services

As discussed above, one of the MCW initiative's key objectives was to raise awareness of health care – particularly MNCH – among local communities, while improving women's utilization of MNCH services. Health managers and service providers generally commended the initiative for raising community awareness – particularly the awareness of pregnant and lactating women and adolescent girls – prompting them to approach qualified health care providers and health facilities. As one key informant from KP remarked, "*MCW is achieving its results, through creating awareness amongst adolescent girls, pregnant and lactating mothers and also increasing the number of safe deliveries conducted. Now, women are aware and prefer to deliver child by skilled birth attendants."* Another key informant from KP said, *"MCW is a good*

initiative, increasing community awareness and trust in health care services. It has changed the behaviour of the community in seeking MNCH services, such as antenatal and postnatal care and family planning."

Similar views were expressed by a key informant from GB, *"Mothers' awareness has upgraded and instilled practices seeking for antenatal checkups, postnatal care, safe delivery practices and birth spacing through different health sessions held by LHWs."* A key informant from AJK noted, *"MCW provide skilled birth attendants and maternal health care utilization at the doorstep of community, and I think, its achievement of MCW."* Another key informant said:

> *Since the day MCW has been launched, the awareness among women for maternal health issues has greatly increased. People themselves come in the centre to take information about it. In our area, there has been a lot of betterment in child and maternal health.*

All of the FGDs participants unanimously agreed that the MCW initiative successfully raised community awareness and increased the utilization of MNCH services. They regarded the MCW as a useful initiative for expanding MNCH services for all communities and particularly for women in marginalized communities. A LHS from Sindh explained, *"For me, MCW interventions are really useful for raising awareness and social mobilization among local people. Because of this awareness, I observe significant behaviour change among community about maternal health care services."* A LHS from Punjab observed that *"MCWs enhance the health awareness of women and children belonging to backward or marginalized community."*

Another LHS from Punjab stated, *"Due to MCW' initiative, health of mothers and adolescent girls have gradually improved. We provide them necessary services and medicines such as folic acid and iron tablets."* A LHS from Balochistan reported that *"Mothers now visit BHU for routine checkup and seek medical advice. Problems of pregnant women have been addressed in MCW."* According to a vaccinator from GB, *"MCW has been very effective in changing the mindset of the community to seek maternal health care services from skilled providers or health facilities, rather than visiting traditional birth attendants and adopting traditional methods."* Thus, service providers highlighted community awareness and changes in attitudes, behaviours and practices as some of the MCW initiative's most important achievements.

Beneficiaries agreed that the MCW initiative enhanced their awareness of MNCH. In Sindh, an illiterate, but not impoverished, house-wife with two children in Sindh described how her attitudes and behaviour changed after attending MCW sessions in 2015. She explained:

> *My elder son is disabled as he was not vaccinated against polio. Earlier we [my family and I] were not convinced for child immunization. Once, a LHW visited my house and I requested her for my son's treatment. She advised me to attend MCW. I participated in this programme, where a doctor told us the importance of vaccination during pregnancy and also for children. At the end of the session, I was fully motivated for vaccination. Later on, I took proper vaccination for my daughter as advised by doctor. Now, I am volunteer community worker, who convinces other mothers to participate and avail benefits from MCW services.*

An under-privileged mother of two in KP praised the initiative's achievements:

> *I never faced any difficulty in availing MCW services. I think it's a great success of MCW that we get deworming tablets for children on time and these tablets are given to us after every six months. Health session during MCW convinced me to continue breastfeeding to my children for two years and start complementary feeding practices after 6 months of birth for healthier children.*

Similarly, an impoverished mother of three children from Punjab said of her experience:

> *I was getting weaker, conceiving my first baby when an LHW visited our home in 2009. She told me I had blood deficiency and gave me folic acid and iron tablets. Since then I have been availing the health care services from LHWs and MCW. Masha Allah, now I am healthy and given births to three healthy babies.*

An illiterate mother of four in AJK, from a nomadic family and employed as a domestic worker, stated:

> *I am thankful to MCW, as it dealt with my misconceptions regarding maternal health care services. It's very difficult for us to visit private doctors, while this week is free of cost so it provides us supplements and tablets, which helped a lot during my pregnancy.*

A beneficiary in AJK from a middle income household spoke of her increased awareness:

> *When local LHW informed me about MCW activities and its benefits, I was really impressed and was in favour to avail such services provided by the Government at our doorstep. But my husband is very religious and opposed the family planning methods and services utilization. Due to my repeated requests and insistence, he agreed and we both visited together. I took advice from qualified medical professionals on family planning and birth-spacing to ensure good health.*

Overall, all the health managers interviewed – at all levels – and all service providers and beneficiaries were in agreement that the MCW initiative achieved its objectives. Specifically, they highlighted that it successfully raised community awareness of MNCH issues and prompted increased MNCH service utilization by women, thus contributing to its overall goals of healthy mothers and children in Pakistan.

4.5.3. Deworming, Tetanus Toxoid and immunization

The qualitative findings reveal that all key stakeholders credit the MCW initiative with strengthening progress on deworming services and vaccinations for children and women. All of the participants believed that the MCW initiative's focus on deworming and immunization differentiated it from other health activities. As one key informant said, *"In the MCW service package, the deworming of children and adolescent girls is a highly significant feature. With the exception of deworming, the other interventions are the same, being delivered in existing government programmes."*

Another key informant observed, *"Vaccination and deworming are imperative and cost-effective aspects of this intervention and MCW enhanced the service utilization for immunization and deworming."* A key informant from Punjab agreed, *"The success of MCW is to provide deworming services, which is recommended once in every six months. Alongside, it also helps in identify the children, who are not routinely vaccinated due to some reasons and vaccinate them accordingly."* A key informant from KP remarked:

> *I personally feel MCW as a success. The provision of deworming tablets, vaccination to the defaulters, prevention of pneumonia and diarrhoea, and health education to mothers*

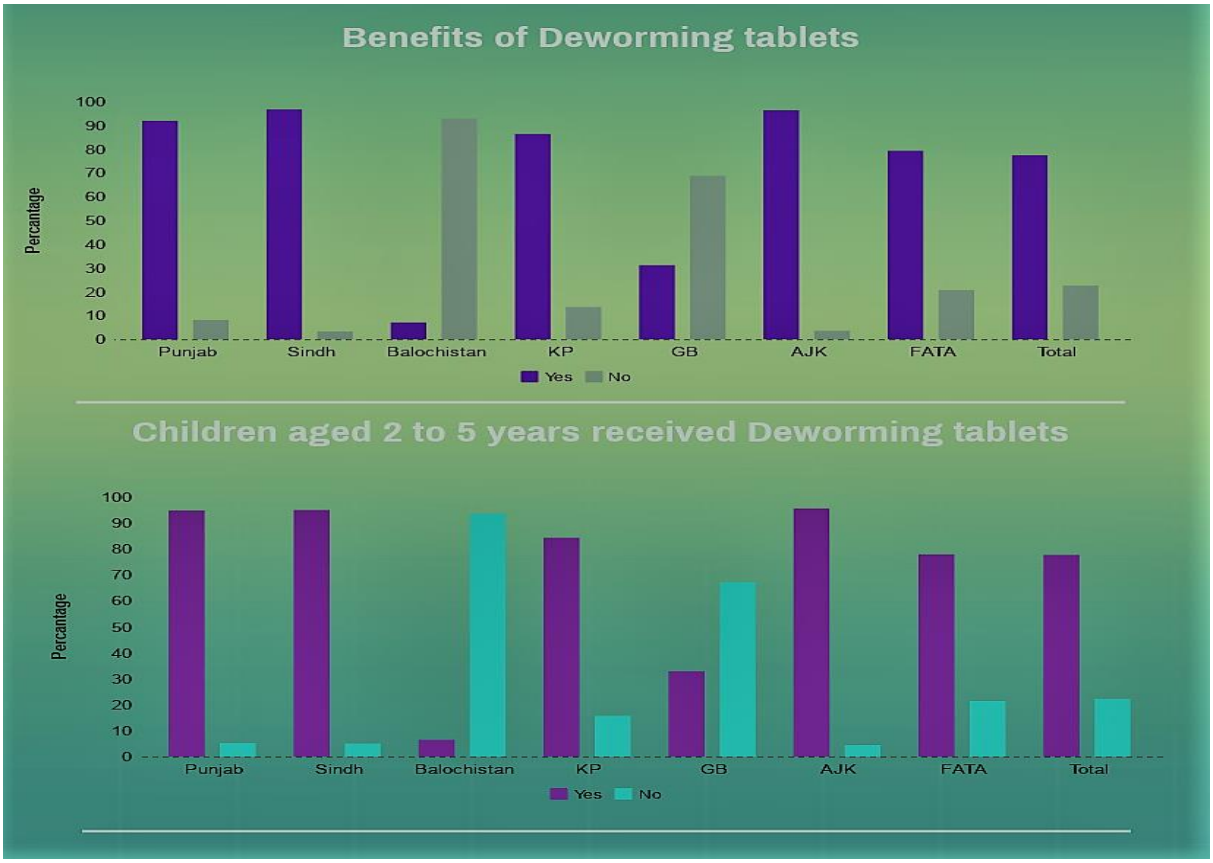
are the salient feature of this campaign. In a nutshell, it has supported the LHW and EPI programmes' staff to perform their tasks efficiently.

FGDs also credited the MCW initiative with helping to achieve vaccination targets and provide deworming tablets. They felt that, the MCW initiative's support had helped to resolve the problem of intestinal parasites among children. One LHW explained that the initiative resolved this issue by adopting a two-pronged strategy – providing deworming tablets, on the one hand, and improving hygienic practices, on the other. A LHS from AJK stated, "*This week has improved the maternal and children health, particularly related to deworming tablets. Earlier, most of the children had complaint of loss of appetite, but now they have started eating properly."* A LHS from Sindh stressed, *"If the provision of deworming tablets would stop, then the concept of MCW would collapse."* A LHW in Sindh said, "*MCW interventions must continue, especially the provision of deworming tablets, which are useful and its absence will negatively affect child health."*

A LHS in Punjab highlighted the significance of the MCW initiative for marginalized communities. She noted, *"MCWs enhance the health awareness of women and children belonging to backward or marginalized community. The knowledge of community on vaccination have increased due to the MCW health sessions."* A LHW in FATA remarked, *"MCW intervention such as provision of medicines, especially deworming tablets, counseling and health education are the success factors."* A participant from Lahore explained that *"Initially, women were unaware about the benefits of deworming tablets, however, after proper counselling and treatment of children, now they are fully convinced."*

The quantitative findings affirmed that LHWs explained the benefits of deworming tablets to mothers during MCW sessions. Similar numbers of mothers across provinces reported receiving deworming tablets during MCW activities (see Figure 26).

Figure 26: Mothers' knowledge of deworming tablets



In Sindh, 96.7 per cent of surveyed women confirmed that the benefits of deworming were explained, as did 91 per cent of women in Punjab 91 per cent and 91.9 per cent in AJK. In Punjab, 94.8 per cent of children received deworming tables, as did 95.7 per cent of children in AJK and 95 per cent in Sindh. However, only 6.4 per cent of the mothers surveyed in Balochistan, and 32.8 per cent of those in GB, reported receiving deworming tablets. This demonstrates that the MCW initiative's deworming component was performed exceptionally well in all provinces/regions, except Balochistan and GB (Figure 26).

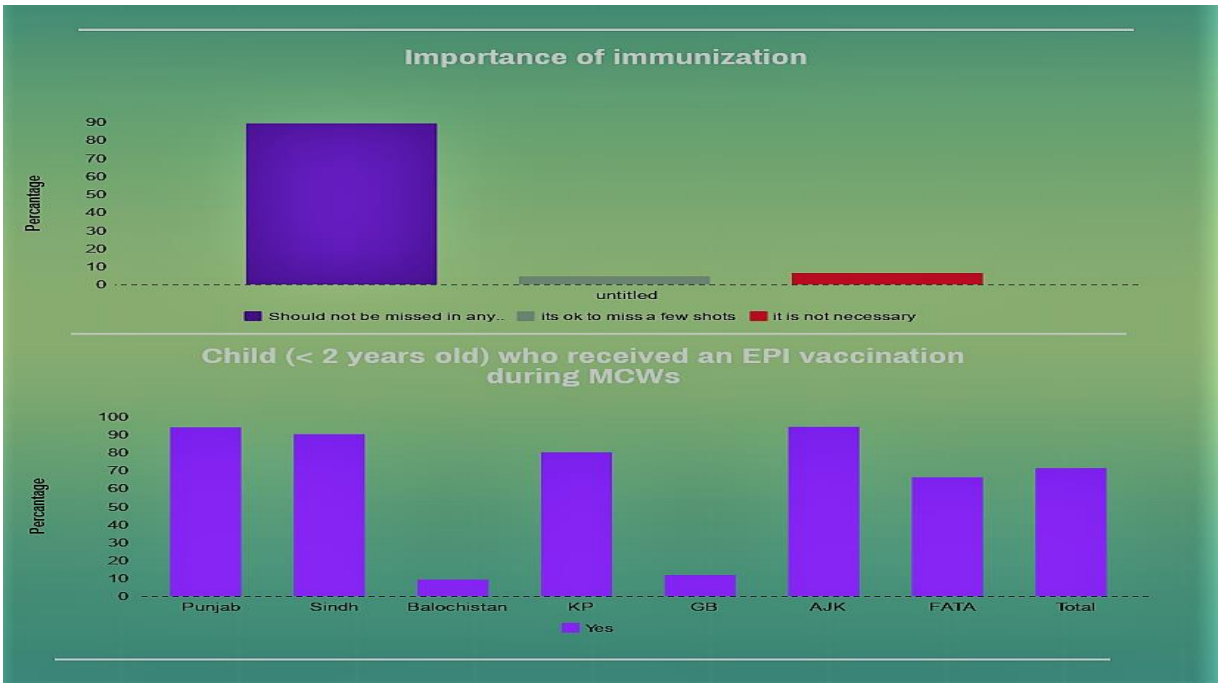
During the KIIs, health managers and service providers generally highlighted the MCW initiative's role in strengthening MNCH services and achieving immunization targets. An informant from AJK remarked, "*Definitely MCW helped a lot in strengthening existing MNCH services in terms of improved health education, increased immunization and TT vaccination coverage."* Another key informant in AJK stated, "*AJK has achieved its immunization targets*

with the support of Government and MCW." Yet another key informant held that "*Through MCW programme, immunization services have improved. Now women visit our EPI centres and health facilities regularly to get themselves and their children vaccinated"*. One key informant from GB said that:

> *Due to MCW, the motivated people now prefer to visit EPI centres and health facilities to get their children vaccinated on regular basis. However, there is a group in society, having limited financial capacity and poor roads to access health facilities. Such communities rely on MCW only for vaccination and deworming services.*

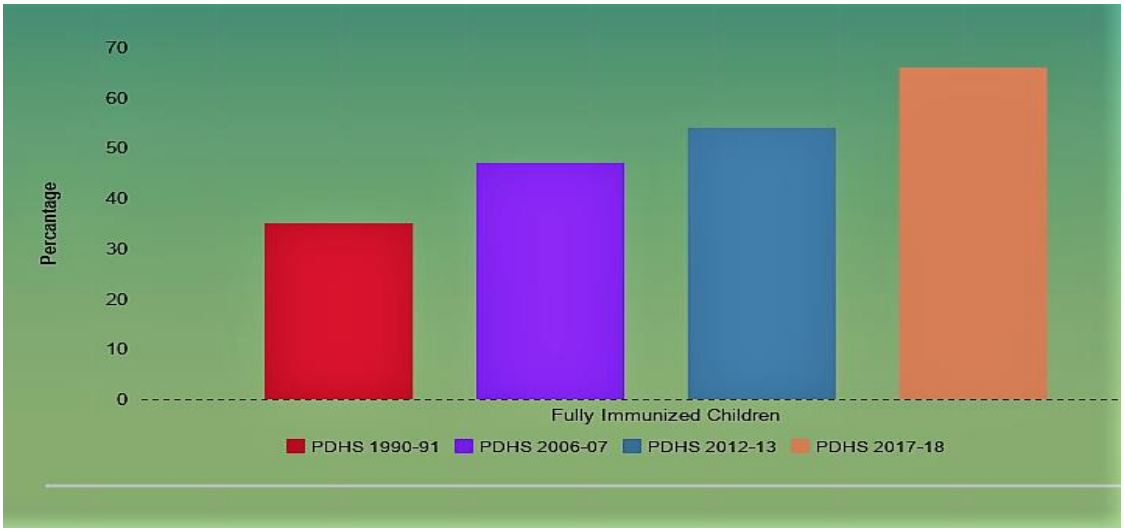
The quantitative findings affirm that MCW activities helped dispel fears regarding immunization, as 87.1 per cent of respondents reported having 'no fears' concerning immunization. The vast majority (89.2 per cent) considered that immunization should not be missed in any case (Figure 27). This reflects strong knowledge among MCW beneficiaries about the importance of immunization. Over half (71.4 per cent) of respondents reported that one or more of their children, under the age of two, was vaccinated during a MCW session. However, provincial disparities are apparent. Only 11.7 per cent of respondents in Balochistan reported such vaccinations during MCWs, compared to 66 per cent of respondents in FATA. Figures for child vaccinations during MCWs were even higher in other areas, reaching 94.5 per cent in Punjab, 94.3 per cent in AJK and 90.2 per cent in Sindh. This demonstrates that the MCW initiative's performance with regard to vaccinations was not consistent across provinces (see Figure 27).

Figure 27: Mothers' knowledge of the importance of immunization and vaccinations received for children during MCWs



The trends in fully immunized children between 12-23 months old in Pakistan also show that the proportion of fully immunized children in the country increased form 47 per cent in 2007 to 66 per cent in 2018 (see Figure 28). In 2018, children in Punjab were more likely (80 per cent) to receive all of their basic vaccinations compared to children in Balochistan (29 per cent) and FATA (30 per cent) (NIPS, 2018). This reveals that the number of fully immunized children in Pakistan is increasing and that the MCW is playing a major role in identifying and immunizing defaulter children under the age of two.

Figure 28: Trends in childhood immunization in Pakistan, 2007-2018 (PDHS)



Most vaccination team members agreed that the MCW initiative helped them achieve their vaccination targets and reach 'unreached' children. With LHWs' support, they received lists of defaulter children missed by routine vaccination drives, enabling them to target such children. However, some vaccinators felt that enhanced immunization coverage cannot be linked solely with the MCW. As one vaccinator from KP said, "*MCW is conducted once after six months, while we visit the community on a weekly basis, so how can we give whole credit to MCW for enhancing immunization coverage."* Service providers also suggested including other medicines in MCW activities to make them more effective, such as antibiotics and syrups.

As noted above, beneficiaries acknowledged that the MCW initiative improved the health status of mothers and children. An educated mother of two daughters in AJK highlighted the benefits of deworming:

> *MCW has changed my behaviour towards my daughters' diet and health. My elder daughter had complaint of loss of appetite, which I ignored. I preferred home remedies but they were of no use. Once, I saw a banner of MCW and took my daughter there. Doctors completely examined my daughter and prescribed deworming tablets. Now she is cured and enjoying her life.*

A mother of two in a remote part of KP stated:

> *MCW proved a blessing in disguise for me, because it cured the unknown disease of my son. My son was suffering from abdominal pain and become weak. I got him examined at local dispensary, where doctors prescribed different medicines and syrup, but he didn't improve. It worried me a lot and I discussed this with our area LHW, who advised me to visit a MCW event. During the MCW, the doctor not only informed me about his diseases and its reasons, but also provided deworming tablets to my son. The doctor also advised to monitor his routine and stools. Second day, my son passed stool and I found that there are many worms in his stools which frightened me. I contacted LHW, who told me don't worry. Alhamdulillah, now my son is healthy. I am thankful to MCW.*

A woman of reproductive age, living in Punjab with her husband and two children, credited LHWs with enhancing her awareness of MNCH services and motivating her to seek out vaccinations. She explained:

> *My mother-in-law was very rigid and believed in traditional birth attendance. She was against LHWs and MCW, likewise, never permitted me to attend any doctor. However, during my pregnancy, local LHW visited my house several times and motivated my mother-in-law to visit MCW and attend health sessions. Once we both visited MCW, where doctors and other staff treated us very well, examined me and gave me medicines. I was also educated about mother and child health care, particularly immunization, supplementary and deworming pills.*

One government employee in Punjab with two children remarked:

> *I have been attending MCW session for the last six years and it has given me a new perspective on mother and child health care. I was not aware of postnatal services, malnourished and premature baby's conditions but through this programme I got a lot of information regarding TT vaccinations for mother and routine immunization for babies.*

An illiterate mother from FATA explained that:

> *My family was against vaccination due to a lack of finances, knowledge and different myths. Local area LHW visited me and informed about the benefits of regular*

immunization to protect children from multiple diseases. She also told me about MCW opportunity at my doorstep, who provide immunization to missed children. I listened to her and vaccinated my children during MCW. I am thankful to MCW for providing free of cost services for the poor people like us. Now my children will live healthy lives.

Both the qualitative and quantitative findings revealed that, due to an effective awareness raising campaign by the MCW initiative, family planning became an important topic of discussion for married couples. As women were equipped with better knowledge of health care, they were able to prevent their children from contracting diarrhoea or pneumonia and vigilantly treated these ailments when they arose. Raising awareness and promoting better practices in response to the danger signs of pneumonia and diarrhoea were found to be the two major components of the MCW initiative, as both diseases pose a primary threat to child health. The fact that MCW sessions were held twice a year, with focused messages on pneumonia or diarrhoea according to the seasonality of these diseases, proved highly useful for beneficiaries.

The evaluation also found that MCW helped to improve knowledge and practices among mothers with respect to pneumonia and diarrhoea. The vast majority of mothers surveyed (92.4 per cent) reported that they are aware of the danger signs of diarrhoea. This marks a significant increase from an estimated 67.4 per cent of women, according to studies conducted in 2010 and 2015 (UNICEF, 2015). Awareness of the danger signs of diarrhoea was apparent among 98 per cent of mothers surveyed in KP, 97 per cent in AJK and Sindh, 90 per cent in Punjab and 94 per cent in Balochistan (see Figure 29). About 70 per cent of these women reported receiving information on the danger signs of diarrhoea during MCW health sessions (see Figure 30).

Figure 29: Mothers' knowledge of the danger signs of diarrhoea

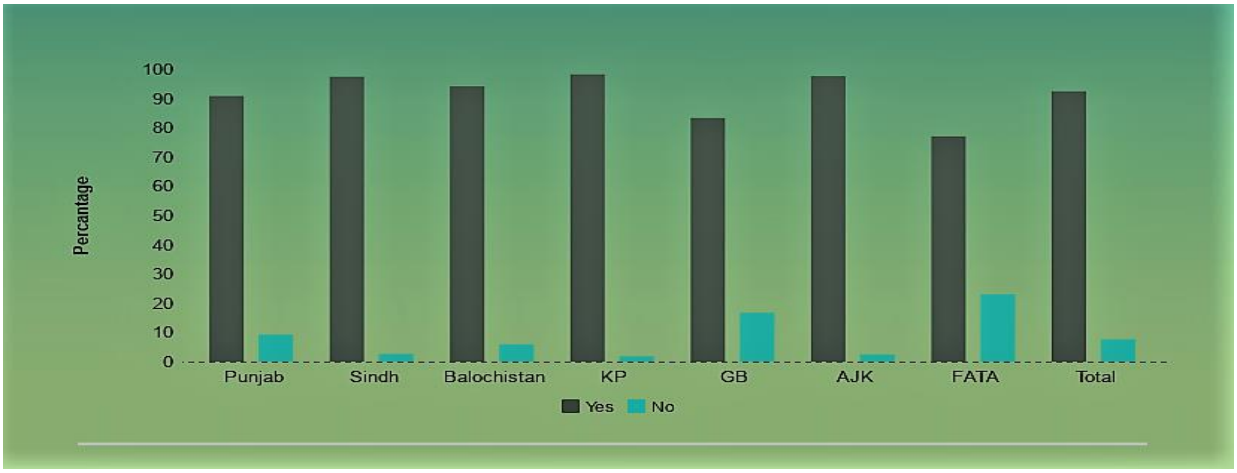
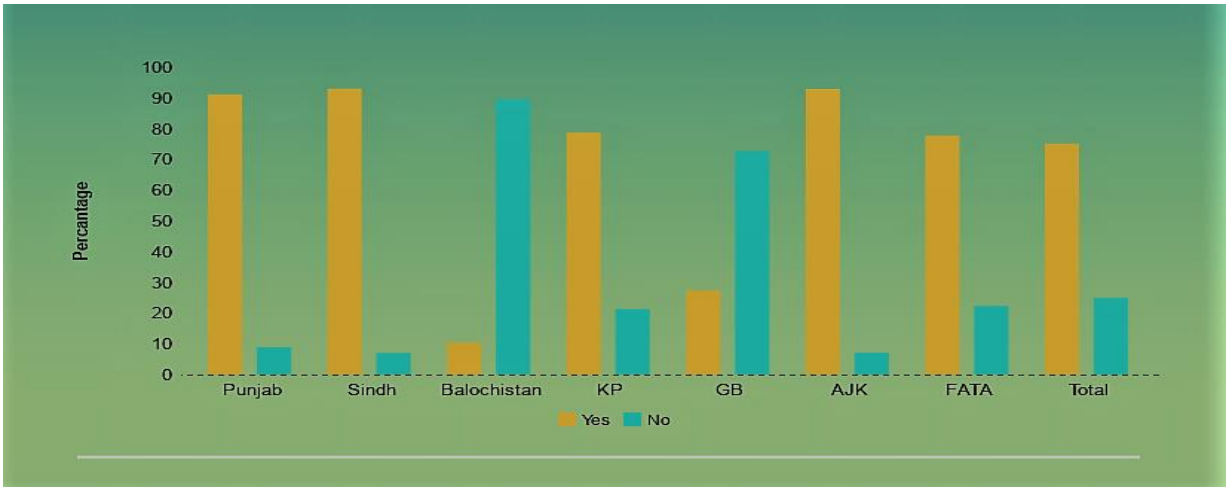


Figure 30: Mothers who received information on diarrhoea danger signs during MCW rounds



More than two-third of the mothers (69.3 per cent) reported administering oral rehydration salts (ORS) to their children in order to manage diarrhoea. This was true for almost all of the mothers (99 per cent) in AJK, GB and Sindh, 94 per cent in KP, 93 per cent in Balochistan and 96 percent in Punjab (see Figure 31). As Figure 32 shows, trends in the use of oral rehydration therapy to treat child diarrhoea improved from 55 per cent in 2017 to 58 per cent in 2018. Hence, the MCW initiative proved especially important for improving knowledge and practices regarding the danger signs and management of diarrhoea and pneumonia in children.

Figure 31: Mothers' knowledge of preventing dehydration caused by diarrhoea

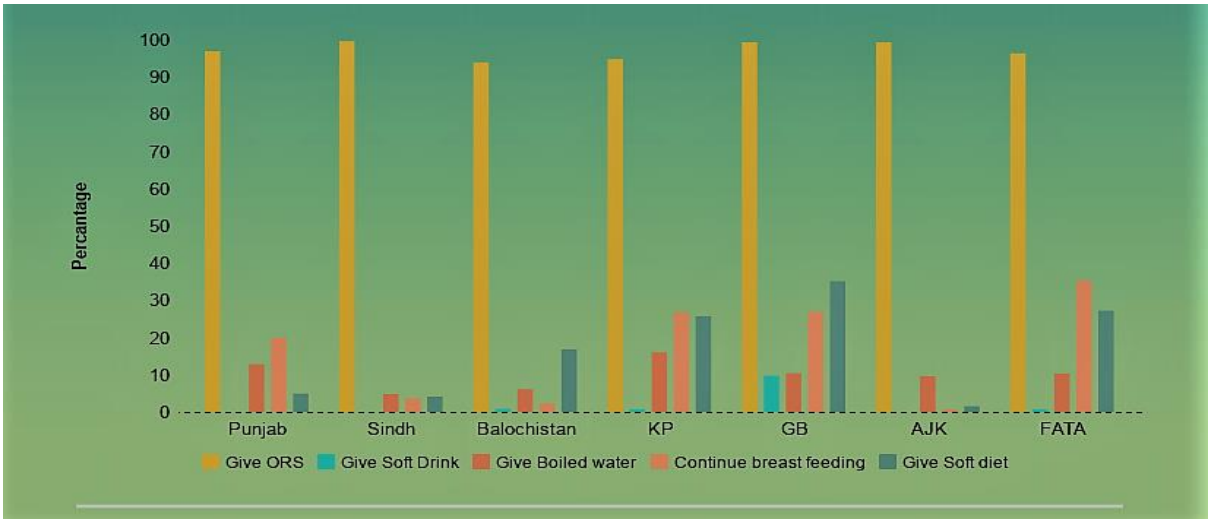
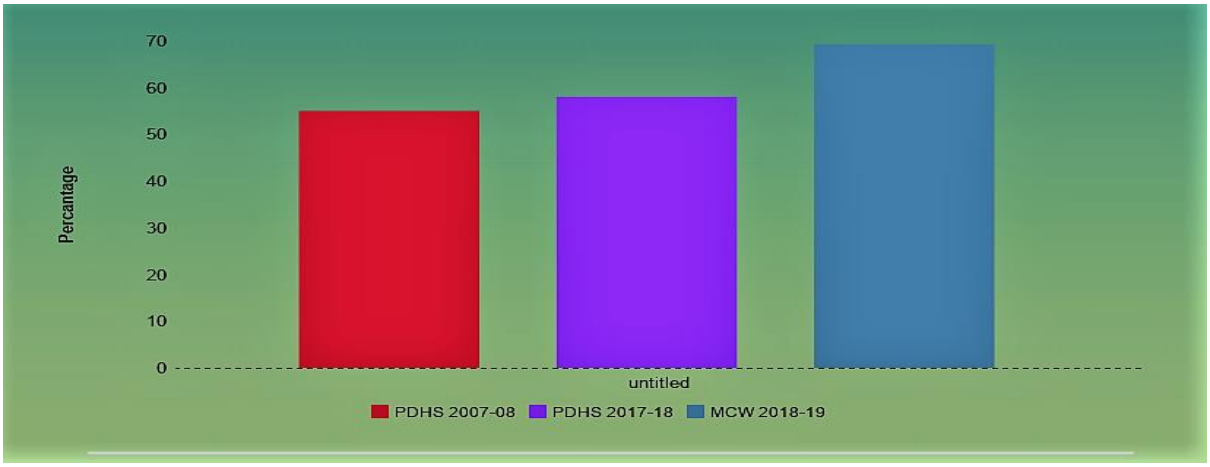
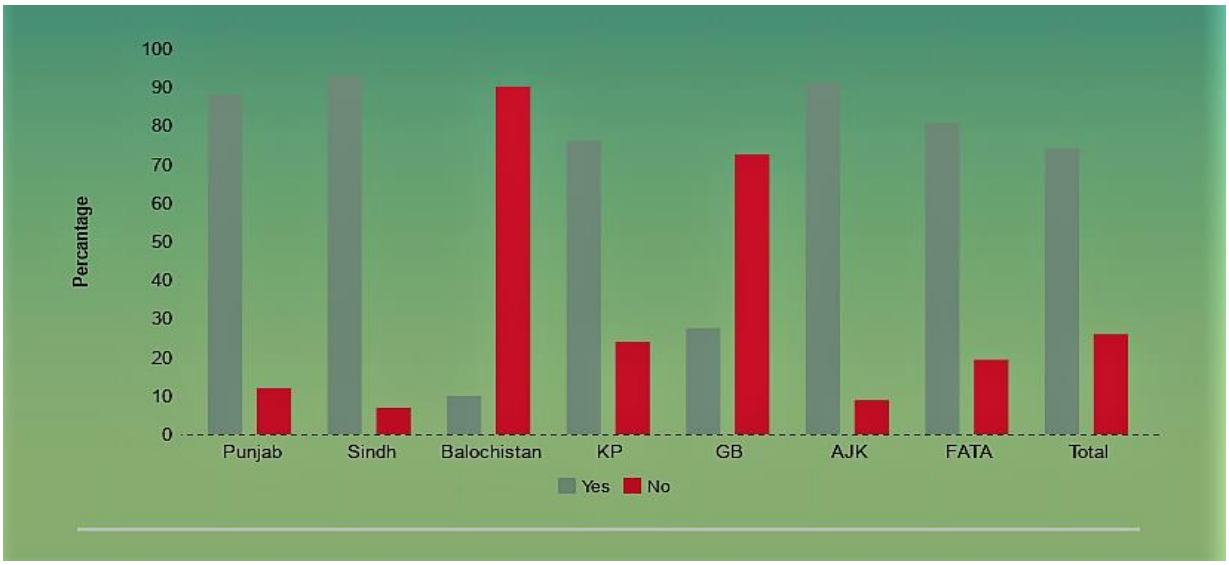


Figure 32: Trends in the use of oral rehydration therapy to treat diarrhoea in children, 2007-2018 (PDHS)



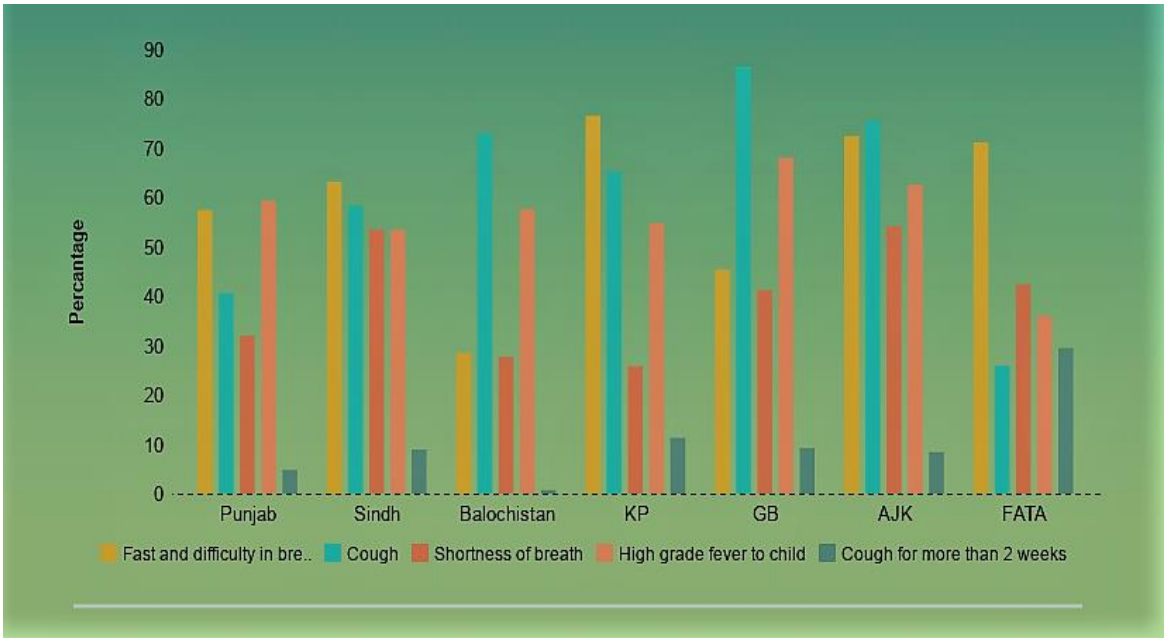
Similarly, most of the mothers surveyed (92.4 per cent) reported having knowledge of the danger signs of pneumonia in children (see Figure 33). Nearly three-quarters (74.1 per cent) credited MCW sessions with boosting their knowledge of these danger signs of pneumonia (Figure 34). Thus, overall, the MCW successfully raised awareness of the danger signs of pneumonia among children.

Figure 33: Mothers who received information on the danger signs of pneumonia during MCW rounds



However, regional disparities exist. Most respondents in Sindh (93.2 per cent) stated that MCW sessions sensitized them on the signs of pneumonia, as did mothers in AJK (91.3 per cent) and Punjab (88.1 per cent). By contrast, MCW activities were only cited as having raised awareness of danger signs of pneumonia by 27.5 per cent of the women surveyed in GB and 9.9 per cent in Balochistan (Figure 34). Table 18 affirms the vast majority (94.6 per cent) of respondents were aware that they should visit a doctor if their child exhibits signs of pneumonia. However, once more, some regional disparities are apparent. All (100 per cent) of mothers in GB and Balochistan knew that they should visit or consult a doctor when a child shows signs of pneumonia, compared to 96.8 per cent in Sindh, 91.4 per cent in Punjab and 92.6 per cent in KP.

Figure 34: Mothers knowledge and recognition of the danger signs of pneumonia



Overall, it may be concluded that the MCW initiative successfully provided vaccination and deworming services, raised health awareness among communities, increased service utilization and achieved immunization targets necessary for improving maternal and children health.

4.5.4. Constraints, challenges and lessons learned from the MCW initiative's implementation

The qualitative data suggests that certain constraints and challenges hindered the MCW initiative's implementation. The opinions of key stakeholders varied. Some health managers felt that there were no constraints or challenges to the initiative's implementation, while others disagreed. According to one key informant from KP:

> *No significant challenge has been faced so far, because the staff (LHWs and vaccinators) is already trained and serving communities through social mobilization and counselling. The area is well-known to the staff and target beneficiaries need no introduction to seek service.*

By contrast, a key informant from Punjab highlighted the MCW initiative's planning phase as a challenge. He remarked, *"MCW planning is always a challenge, which requires multiple and*

extensive meetings with key stakeholders, at least two months prior to MCW [sessions], to ensure effective implementation." A key informant from KP stated:

> *I don't think so about any hindrance in MCW implementation, however, this programme is not yet expanded to the uncovered areas, which could be its limitation. It's a policy level decision, which could be because of the fact that Department of Health and LHWs programme protocols don't allow them to intervene in the uncovered areas, while UNICEF has sufficient capacity to provide all the logistics even for uncovered areas, subject to the agreement of DoH.*

During the KIIs, some health managers spoke of the MCW initiative's complexities. As one key informant from Punjab put it, *"The implementation of a long-term programme, such as MCW, is full of bottlenecks and complexities which need timely solutions."* The most common challenges identified by key informants included the difficulties of ensuring robust monitoring at all levels, the availability of sufficient resources and trained human resources to implement MCW activities effectively. One key informant observed, *"MCW requires more resources and an effective monitoring mechanism."* Another said that the *"lack of trained outreach staff with insufficient communication skills hinders the smooth implementation of MCW."*

Some key informants pointed to other constraints, including insufficient numbers of LHWs, cultural barriers and the fact that areas not covered by LHWs are not included in the MCW initiative. According to one key informant from AJK, *"MCW has made significant progress, but we can't achieve health goals and targets fully till uncovered areas would not remain underserved."* Another key informant from AJK indicated that cultural practices affect the initiative's achievements, observing "*Cultural male domination, other social factors like a lack of family support and decision-making power are the key challenges for MCW achievement."* Key informants from FATA echoed this sentiment, pinpointing socio-cultural practices and deeply embedded myths as barriers to the MCW initiative's effective implementation in the region.

Some key informants from Balochistan, GB and south Punjab reported irregular supplies, a lack of coordination at the service provider level, weak monitoring mechanisms, poor human resources, inadequate logistical arrangements, insufficient financial incentives and a lack of

resources. Other constraints cited included poor law and order situations, particularly in parts of Sindh, Balochistan and FATA regions, which posed access challenge for service providers. One key informant from Balochistan noted, *"Limited resources and weak accountability are the major constraints of MCW campaigns. There is no check and balance on logistics and supplies management, resulting in unsatisfactory results of MCW."* An informant from FATA stated, "*Security issues and less number of staff are the hurdles for MCW."* Another key informant from FATA explained that *"Due to security threats, our two tehsils are not completely covered."* The review of programme documents and periodic reviews also indicated management issues. These included delays in the delivery of supplies, low budgetary provisions for provincial and district monitors, the absence of incentives for LHWs/LHS, the fact that petrol for vehicles was unavailable and time constraints that affected the preparation of MCW activities.

In the qualitative data, some key informants suggested necessary elements to effectively and efficiently manage the MCW initiative. These included community participation, political will, coordination and departmental support. One key informant from AJK observed, "*Lack of strong political will and commitment with efficient human resources hamper MCW success."* Another from Balochistan said, "*Due to lack of ownership, the targeted outcomes of MCW are not achieved."* District level key informants highlighted the challenges posed by the climate, especially in AJK. As one key informant explained, *"uncertain weather conditions and other calamities also affect the efficiency and achievements of MCW."*

As discussed above, several key informants pointed to a lack of monetary compensation for LHWs as a major constraint. One informant from AJK pointed out that:

> *Lack of financial incentives for community health workers and unqualified outreach workers hinder the MCW success. Government should grant us sufficient funds to recruit qualified LHWs in required areas and provide them allowances, so that all communities may benefit from this programme.*

Another key informant in AJK said*, "Contributing factors in non-achievement of MCW could be no provision of travel allowance/daily allowance to outreach workers."* An informant from KP concurred, *"Irregular supplies, along with less number of LHWs and absence of financial resources during MCW, limit the interest of outreach workers and their performance."*

Some participants felt that the MCW initiative's achievements were affected by the schedules of national immunization days (NIDs), sub-national immunization days (SNIDs) and other campaigns. A key informant from KP stated, "*Overlapping of regular NIDs and measles campaigns with MCW' event affect the results of MCW."* Another informant from KP pointed to the challenges posed by religious taboos/cultural myths associated with health services:

> *Security and religious taboos are affecting MCWs outcome in our district. Since this is located near to the tribal areas, highly populated by Taliban, hence vaccination and other MNCH services are considered anti-Islamic activities. Therefore, common people are frightened to avail themselves of health services.*

Constraints identified by FGD participants included the lack of transportation for field workers, insufficient or irregular supplies and medicines to meet community needs, too few LHWs, the increased workload of outreach workers, a lack of financial rewards for these workers and a lack of community cooperation. A key informant from AJK stated, "*Vehicles are neither functional, nor repaired and no financial incentives are given."* As a LHS in AJK explained:

> *We face problems in travelling in field, because all LHS don't have proper vehicles or provision of travel allowance/daily allowance to travel. Private cars are expensive, which we cannot afford. We don't even get our monthly salary on time. In such situations, it is so difficult for us and also for LHWs to visit all of the community's houses and perform their jobs.*

A LHS in Sindh experienced similar challenges, *"We usually face difficulty in mobility because many areas are very far off where we can't reach without transportation. Moreover, the situation is worse in Karachi due to security, law and order crisis."*

An informant from Punjab commented on financial constraints, *"I think LHWs' salary is the main issue. If their salary would be raised, they will perform more effectively."* A LHW agreed, *"During MCWs, we have been assigned additional tasks but no extra payment is given which is embarrassing."* A LHS from AJK spoke of similar logistical challenges, *"There is no mechanism for transportation of logistics from District Health Office to the MCW centre. Hence, we ourselves have to commute to different centres using automobile rickshaws or sometimes by foot."*

LHWs from AJK complained of weak administrative support and insufficient medicines. One stated "Weaknesses of MCW are the less administrative support and an absence of medicine. Sometimes we have to provide medicine of our own from medical store." Another LHW from AJK was critical of the short notice they received before MCW sessions, "Sometimes, we have our own schedule but suddenly we are informed that doctor is visiting to brief us about MCW, so it becomes quite tough for us to manage our routine tasks."

Some LHWs pointed to challenges of community passivity, indifference, a lack of cooperation, a dearth of trust and negative perceptions of health interventions. A LHW in Sindh explained: *"Lack of educated people, especially the parents and their minimal interest in health seeking is the main problem of our area."* A LHS from GB said that, *"at times, people behaviours hurt us; they don't give us respect being a service provider."* A LHW in Punjab reported, *"We face issues in building people' trust in us and our services; if there is no trust, then the service is useless."*

During the KIIs, key informants commented on issues of micro-panning and a lack of coordination. An informant from AJK claimed, *"Poor micro-planning and improper logistics distribution hamper the execution of MCW."* A key informant from Punjab pointed to limited coordination and cooperation within health teams, *"The non-cooperation and lack of commitment of staff could be the major constraint. During MCW, all workers should perform their duty as per defined roles."*

Other challenges highlighted by the qualitative data include a lack of IEC materials for MCW activities and the need for a more robust monitoring system. One key informant in Punjab said, "*We don't have enough IEC material to disseminate and inform the community about MCW."*

In terms of lessons learned, stakeholders highlighted the cost-effectiveness of the MCW initiative, given its linkages with existing EPI, LHW and MNCH programmes. To ensure the MCW initiative's long-term impacts, they pointed to the importance of actively seeking the support of local political leaders, community gate-keepers – such as *Imam Masjids* (religious clerics and school teachers – social workers/volunteers and civil society organizations. Without the support of such influential key players, it will not be possible to secure community ownership – the cornerstone of sustainable, long-lasting impacts. Stakeholders also stressed the need for

rigorous monitoring, periodic evaluations and more comprehensive training for service providers to bridge gaps in quality and strengthen MCW services.

In conclusion, the stakeholders were positive about the MCW initiative's achievements in terms of improving MNCH services. The data collected for the evaluation revealed a holistic picture of the initiative's achievements, alongside certain challenges to attaining its intended objectives. Most participants agreed that the MCW initiative served as an excellent platform for raising community awareness and promoting health education. However, bottlenecks sometimes hampered the initiative's implementation. These require the immediate attention of government counterparts and other managers. Overall, the data found that the MCW initiative significantly increased women's awareness of maternal and child health, while promoting positive health seeking behaviours among beneficiaries. The utilization of key MNCH services – including deworming, immunization and TT vaccinations – has improved, due in large part to the contributions of the MCW initiative.

Thus, it may be concluded that MCW activities produced the initiative's intended outcomes. However, in some cases, hurdles prevented the full achievement of its objectives. Major constraints included a lack of financial remuneration for community health workers and logistical issues, such as the absence of transportation for field workers. Overall, the MCW proved to be a highly beneficial, cost-effective option for providing preventive and promotive health care services to improve MNCH – rendered all the most efficient by its alignment with existing routine health services.

4.6. CROSS-CUTTING ISSUES

As noted above, one of the MCW initiative's core objectives was to address cross-cutting issues while strengthening MNCH services. The document review and qualitative data from federal and provincial/regional stakeholders indicated that the initiative did not address adequately the cross-cutting issues of gender, disaster risk, outreach to marginalized groups/areas and security.

The planning of the MCW initiative and its activities did not account for engaging and raising awareness among men across all provinces and regions, with the exception of GB. Given the initiative's focus on maternal and child health, its activities nationwide engaged mothers as primary beneficiaries. However, the initiative focused solely on women's roles and

responsibilities, while completely ignoring the importance of involving fathers and other men. A key informant from KP argued that "*This programme only focused on female fraternity and children in covered areas and males were ignored. So, the crosscutting issues were not fully addressed*". A key informant from Sindh stressed the importance of engaging men, observing that *"Mother and child health care awareness sessions must be conducted with males, as women and children can seek the best medical health care with their support only."*

The exceptional case of GB may be held up as a good practice of addressing cross-cutting issues by engaging both women and men. Most key informants from GB reported that during their MCW activities, men participated alongside women in health sessions, as they are too are intimately implicated in maternal and child health. One key informant from GB explained:

> W*e do not restrict health sessions to females only, and community males and females also do not feel any sense of discomfort attending health sessions together. As a result of males receiving health awareness, the overall mother and child health care surely has improved.*

The pivotal cross-cutting issue of disaster risk remained unaddressed by the MCW initiative, which failed to prioritize disaster-affected areas in most parts of Pakistan. One key informant in Sindh noted that *"Disaster-affected areas remained uncovered",* while a health manager from Balochistan observed, *"Disaster areas should be considered as a top priority for needs based MCW interventions."* FATA and GB proved to be exceptional, as most informants reported that disaster-affected areas were well addressed by the initiative. A key informant from FATA observed:

> *Disaster-affected areas get well covered through MCW programme. Furthermore, we have reached to the IDPs [internally displaced persons] who probably need our help the most. So, I can say that the programme has been able to reach marginalized and disaster-affected areas quite sufficiently.*

Similarly, a key informant from GB stated:

> *Yes, MCW has covered disaster-affected people quite nicely. It was back in 2010 when destabilization in a chasm in mountain caused a massive land slide in which a lot of*

people died and many got displaced from their homes. It was then and afterwards, through active participation of GBDMA [the GB Disaster Management Authority], MCW and MNCH programmes that disaster affectees were specially considered in health care activities.

Thus, the qualitative findings indicate that disaster-affected areas were not prioritized for needs-based interventions, except in some parts of FATA and GB. It is also important to highlight that efficient disaster management – particularly in GB – owed a great deal to the work of its Disaster Management Authority.

The review of programme documents highlighted the importance of MCW activities during natural disasters, crises, and emergency situations. The evidence affirmed that the MCW initiative helped the Government and communities to cope effectively and efficiently during natural disasters, crisis and emergency situations.

Nationwide qualitative data indicates that marginalized groups – particularly nomadic people, slum settlements and bonded labourers working in brick kilns – were not well incorporated into the MCW initiative. One key informant from Sindh pointed out that *"Marginalized groups and nomads in particular are not covered, while coming from 'equity' principle, they should be involved. Awareness raising campaigns were not targeted to these marginalized groups."*

Key informants from Punjab reported that the MCW initiative strived to address the needs of marginalized communities in the province. However, service delivery was hampered by time constraints. Only a few days were allotted to MCW activities, including outreach to marginalized communities, such as nomadic groups, slum settlements and bonded labourers in brick kilns. In such a short space of time, they could achieve relatively little. Most informants from Punjab agreed that more needs to be done to address the health care needs of marginalized communities. Their needs are particularly important as they are highly prone to health risks, have extremely limited health care knowledge and tend not to understand that they have a human right to health. According to one key informant from Punjab:

MCW is good as it reaches to areas previously not covered through MNCH programmes. However, we are understaffed to effectively cover these excluded areas with given time

and human resources. In this regard, coverage must [be] enhance[d] through mainstreaming MNCH programme.

In the same vein, another key informant stated:

Socially excluded groups such as nomads and displaced populations do not even understand the notion of human rights, hence they are in dire need of human rights-based action interventions. In this regard, they should be covered through MNCH and made aware of the health rights they are entitled to and responsibilities that they share.

The cross-cutting issue of security was not adequately addressed by the MCW initiative. Health care providers – particularly in KP, AJK, FATA and Balochistan – reported having to commute through dense forests and sparsely populated, uninhabited and remote areas. This is especially dangerous for women, who run the risk of being mugged, raped or killed. Bearing in mind that the community health workers who implemented MCW activities are almost all women, this lack of attention to security issues – and the gendered dimensions of security challenges – further reinforces the fact that the MCW initiative did not sufficiently consider gender concerns. As a LHW from AJK explained, "W*e have to travel long distances to cover beneficiaries. Sometimes we have to take routes from within the dense forest which is highly unsafe. We do not only have imminent threat only from muggers but also animals like stray/wild dogs can attack us.*" A LHW from Balochistan stated, "*Balochistan is very lowly populated area and sometimes we have to travel from uninhabited to lowly populated areas. This is very dangerous and a permanent security threat for us."*

To a certain extent, security challenges were lessened by the MCW initiative addressing cultural/religious misconceptions and seeking the support of local religious leaders. As discussed above, informants from KP, FATA, Balochistan and AJK reported that religious misconceptions had negatively affected community response. Vaccinations were particularly affected, as these were erroneously believed to contain prohibited (*haram*) ingredients/chemicals. Involving religious clerics in awareness raising drives helped to convince many community members that the vaccines contents are not dangerous or prohibited on religious grounds. Nonetheless, vaccinators were still perpetually at risk of being attacked by religiously motivated mobs. As one vaccinator form FATA put it, *"sometimes we do not make announcements for vaccinations on*

loudspeaker. People here have a lot of religious misconceptions about vaccines and they pose us a potential threat sometimes." Another key informant from KP explained:

> *People did not trust the chemistry of vaccines and medicines early on. Now as the religious clerics also are involved in making announcements regarding vaccination, the community's repose has been changing. Yet there remain people who are still not convinced. They pose a certain threat as well, but our resolve is unshaken and we will keep on trying to convince all the people. So MCW awareness must go on to fully eliminate religious misconceptions regarding the use of various vaccinations and medicines.*

In conclusion, the MCW initiative failed to adequately address a number of cross-cutting issues. It did not cover disaster-affected communities, marginalized areas and nomads in most provinces/regions. Only representatives from FATA and GB reported that the initiative catered to the needs of disaster-affected and/or marginalized groups. Similarly, only in GB were gender issues addressed by engaging both women and men in MCW activities. In all other parts of the country, the initiative did not engage men, thereby limiting the scope and benefits of MCW activities. The very real security threats faced by health workers, particularly vaccinators, were not sufficiently tackled. In order to maximize the MCW initiative's impact and ensure its sustainability, cross-cutting issues must be addressed. By strengthening men's involvement, focusing on marginalized, nomadic and disaster-affected groups, and mitigating security threads, the MCW initiative would improve its ability to enhance MNCH services.

5. THEORY OF CHANGE MODEL

The evaluation used a Theory of Change (TOC) model to guide its assessment of the MCW initiative. As discussed in section 1.4, a Theory of Change explains how and why a desired change is expected to occur in a particular context. It focuses on identifying what type of activity or intervention will lead to the outcomes identified as pre-conditions for achieving a long-term goal. Through this TOC model, the precise link between activities and the achievement of long-term goals are clearly understood (Center for TOC, 2018). TOC is a multi-sectoral approach that has been widely used to addressing MNCH issues.

As explained above, the TOC model for the MCW initiative was conceptualized by the evaluation team after reviewing and analysing documents provided by UNICEF and other research papers. The model was refined further following field work and consultations with provincial health mangers and the UNICEF Reference Group. This TOC model is presented schematically in Figure 35 and Table 8.

The preceding chapters have explained that the MCW initiative's core objective was to improve the health status of women and their children by changing the health seeking behaviour of mothers, their family members and the community at large. In essence, the MCW initiative is a targeted activity to prompt desirable behavioural change in Pakistan's society, specifically in the sphere of maternal and child health. To introduce this change, the MCW was designed to (1) raise awareness of good health, particularly immunization, deworming, antenatal care, delivery care, postnatal care, family planning, exclusive breastfeeding, the danger signs of pneumonia and diarrhoea, iodized salt, hygiene and sanitation. In tandem, it was designed to (2) provide services/interventions to prevent and treat health situations that undermine maternal and child health (e.g. immunization for children aged 0-2, TT vaccinations for pregnant women and deworming for children under the age of five). Thus, for example, before offering TT

vaccinations, pregnant women are informed of the risks of disease and learn how vaccination can protect them from ailments like tetanus.

The first step taken to introduce this change was local priority setting, involving raising awareness among communities about maternal and child health. Logically, this awareness could only be raised through local stakeholders, both professionals and non-professionals. These professionals include community health workers such as LHWs, LHS, vaccinators, health care providers at health facilities and health managers. Non-professionals include local representatives, community leaders, volunteers and community influencers, such as teachers, *molvis* (religious leaders), NGO activists and other notable member of the community.

The basic assumption of the MCW initiative's activities is that awareness can be raised, and behaviours changed, by creating synergies – i.e. connecting material and non-material resources at the community level. Material resources include health care infrastructure, medicines, vaccinations and other logistical arrangements. Non-material resources include the social capital of LHWs within the community, which endows them with the capacity to raise awareness among women about risks and opportunities related to their reproductive health and child health.

In light of the TOC's basic assumption, behavioural change could not occur without changing individuals' underlying system of understanding diseases and health practices. Every culture has its own health-related belief system, which provides a framework to understand the causes of a particular disease. For instance, vaccinating a mother against TT is a bio-medical model of disease causation. Indigenous belief systems may not share this model. Therefore, if we want a mother to agree to be vaccinated against TT, we need to raise her awareness of the bio-medical model. It should be noted here that awareness alone is not enough; there is also a need to neutralize negative perceptions and debunk conspiracy theories that surround diseases and prevention/treatment strategies in Pakistan (e.g. negative perceptions about polio vaccination).

As the MCW initiative's prime focus was to improve MNCH indicators, integrated, comprehensive and concerted social action was needed. This starts by providing relevant, understandable and useable health-related information. This information needs to be disseminated by motivated and well-informed health care professionals who have good communication skills and cultural understanding, while being adept at engaging target

populations. This is not just a matter of “feeding beneficiaries certain pieces of information” at one time; instead it implies a continuous, two-way process of changing behaviours through inculcation of a new health belief system among beneficiaries.

All of these activities and inputs (advocacy, social mobilization, management and technical assistance) are meant to lead to the increased utilization of MNCH services, the improved capacity of health workers to deliver MNCH interventions, greater knowledge of health practices, and improved health seeking attitudes, behaviours and practices. These outputs are meant to ultimately strengthen existing MNCH services and, thereby, improve maternal and child health indicators in Pakistan.

Figure 35: Theory of Change model for the MCW initiative (developed on the basis of the literature review and the evaluation's findings)

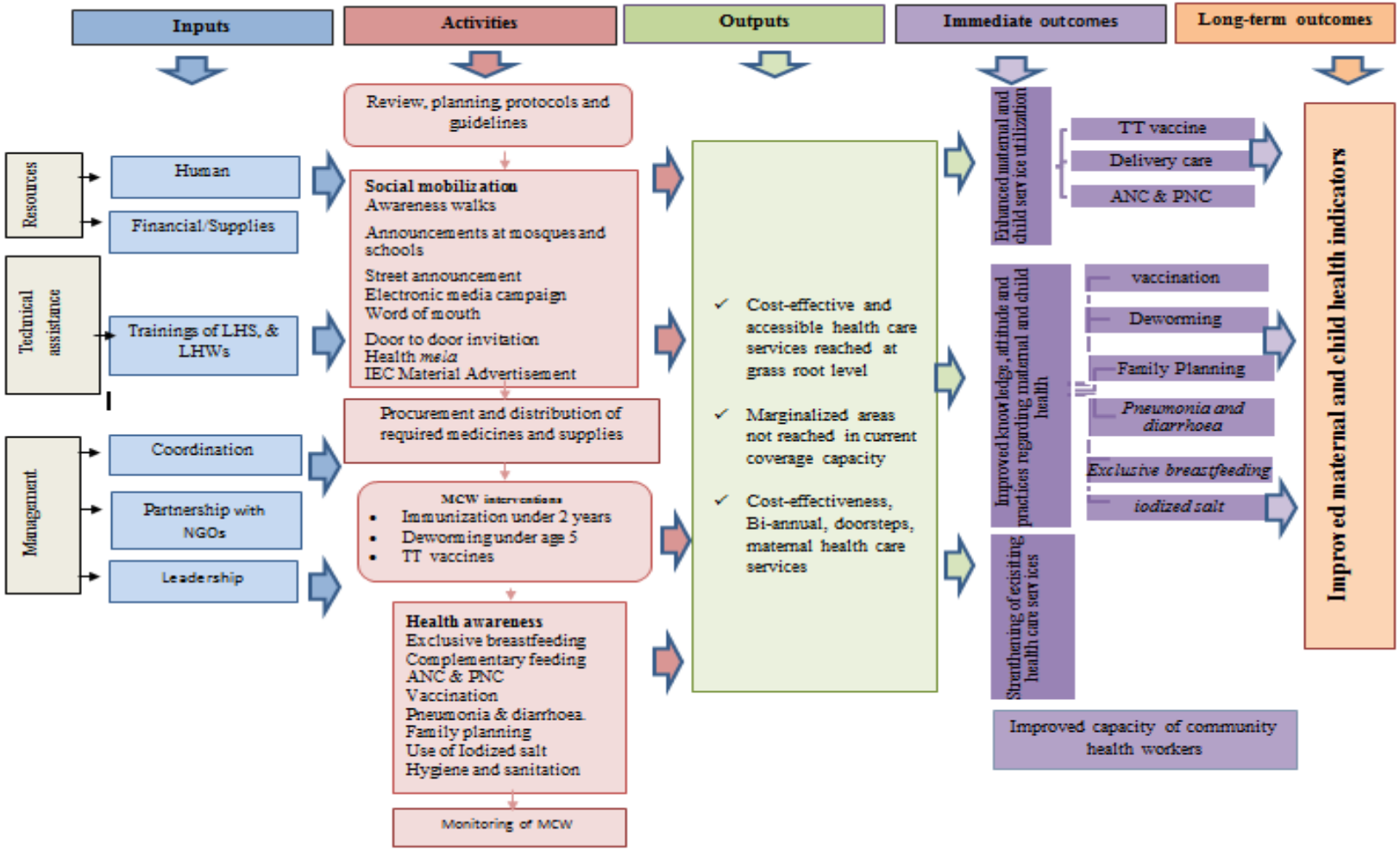


Table 8: Explanation of the Theory of Change model of the MCW initiative

			Worked well	Challenges/did not work well	Recommendations
Inputs	Resources	*Human*	Human resources – particularly LHWs, LHS and vaccinators contributed to the best of their ability and potential 90,000 LHWs and 3,500 LHS covered over 17 million beneficiaries in MCW rounds in 2009 (UNICEF, 2009) Satisfactory *stocktaking* was done to estimate beneficiaries and supplies	Human resources did not have the capacities/support needed to extend MCW coverage to most marginalized areas	Policy level direction is required to scale up the MCW initiative to include areas that are not covered by LHWs. This will help to maintain equity and address issues of the accessibility, affordability and availability of MNCH services Monetary incentives should be introduced for LHWs to compensate them for additional work; transport facilities should also be considered to enable LHWs to reach out to remote areas
		Financial / supplies	*Cost-effective* initiative The initiative was aligned with the health priorities and provincial/regional health policies; therefore it utilized the existing MNCH service delivery system	No transparent and comprehensive details are available on budgetary allocations to assess macro-costing Supply utilization was moderately satisfactory; delayed supplies and procurement challenges were a prominent issue	There is a need to keep records of cost related-data; these records should be maintained and easily available Greater allocations of funds are required for supplies and medicines
	Technical assistance	*Training for LHS and LHWs*	Satisfactory staff *capacitation* trainings increased resource *efficiency*	The limited duration of training sessions and a lack of trainer capacity were significant bottlenecks	Robust, regular refresher and skills development trainings are needed health care providers, particularly community health workers and

					trainers
	Management	*Team coordination*	The initiative involved satisfactory coordination at various levels – from the federal to the provincial, district and health facility levels Multiple programmes – such as the EPI and MNCH – and various NGOs worked together in collaboration to deliver various MCW interventions	In some areas, there were a lack of coordination between different stakeholders	A MCW secretariat (systematic centralized system for coordination between stakeholders) would help to create a culture of planning, assistance in designing and executing MCW activities, and measuring success against needs
		Partnerships	Human resource inputs were marked by collaborative efforts through public-private partnership NGOs and UNICEF play a significant role in the initiative	The initiative lacked a monitoring system for on-going partnerships	Public-private partnerships and the greater involvement of civil society is needed to enhance the initiative's coverage, scope and funding There is a need to engage national and provincial/regional governments, the private sector, NGOs, CBOs and international donors to mobilize resources to fill financing gaps
		Leadership	The initiative's leadership showed a sense of ownership and supportive environment. This appears promising for	There was a lack of ownership and leadership at different management levels	A supportive management system should be strengthened at each level

			improving the initiative's inputs for effective implementation and the achievement of its outcomes		
MCW activities Initial phase/ desk activities	Review, planning, protocols and guidelines	*Review and planning*	The MCW initiative is highly *relevant* in the context of international and national frameworks – e.g. the SDGs and Pakistan's – and all provincial/regional health policies Micro-planning was undertaken after the needs assessment to ensure effective implementation	Baseline data was missing *Focus on marginalized groups and addressing gender* was not reflected satisfactorily in the MCW initiative's planning	The initiative should be scaled up to areas that are not covered by LHWs to maintain equity and address MNCH services' accessibility, affordability and availability
		Protocols and guidelines	The initiative was aligned with health priorities and provincial/regional health policies The initiative was relevant to national and international guidelines Guidelines for codes of conduct, programme operations and implementation were devised and shared Protocols and guidelines were shared with partners	In some cases, there was a minor disconnect between larger frameworks and micro-planning and implementation In some regions/provinces, health managers were not sufficiently aware of guidelines and protocols In some cases, protocols were perceived to be unnecessarily long and were not taken seriously	An operational guideline should be developed, which explicitly delineates the responsibilities of each stakeholder at the district, provincial and federal levels An accountability framework should be developed, defining the roles and responsibilities of all key stakeholders and departments, to address the challenges of a deficit of accountability. This framework would also help to provide clarity for target setting, to measure progress in each intervention area and define reporting channels

Field activities	Social mobilization /advocacy events	*Awareness walks*	Awareness walks were planned and were successful in some areas. Such walks increased the visibility of the MCW initiative	Awareness walks on highways and roads was included in the initiative's plans but, in general, they were not carried out satisfactorily	Awareness walks, seminars at the district level and school sessions are a good way of disseminating information. These activities can be incorporated in future plans and initiatives to enhance field activities, especially in underdeveloped areas Engaging men is essential for improving reproductive health and family planning-related behaviours
		Mosque announcements	MCW announcements, particularly for vaccinations, were made at mosques and effectively mobilized communities		Community volunteers – such as teachers and *molvis* (religious leaders) – can be engaged as a valuable resource to educate communities about health-related issues They can also be engaged for community mobilization Street and school announcements should be improved, as these are considered useful channels of communication
		Street and school announcements	Announcements were made in schools and on streets using loudspeakers Community volunteers and field staff made announcements Social mobilization through LHWs was a very effective way of disseminating information		
		Door-to-door invitations	Door to door invitations to health sessions were extended to women by LHWs Men also participated in	Men were not involved in health sessions in almost all areas except GB	Men's involvement is essential for improving reproductive health and family planning-related behaviours

			health sessions, albeit only in *GB*		
		Distribution of IEC materials and 'health melas' (health fairs/carnivals)	Banners were displayed on roadsides Pamphlets were distributed to communities community, sharing information on health care and the significance of MCW activities *Health melas* (fairs) were organized through public-private partnerships; they advertised and raised awareness of the MCW initiative for *community mobilization*	The procurement of sufficient IEC materials was hampered by transportation challenges In some areas, IEC materials were delivered late IEC materials contained standardized, uniform information for all sections of society, rather than more useful context-specific information	A system should be developed to ensure the regular and timely supply of IEC materials in remote or hard-to-reach areas IEC materials should be designed to feature locality-specific information and meet the identified communication needs of local populations
	Interventions	*Immunization of children aged 0-2*	Children under the age of two were *immunized,* with a focus on vaccine defaulters 89.2% of women in MCW-targeted communities came to understand the importance of vaccinations At least 61.8% of children were immunized during different MCW rounds	An understanding of communities' underlying health belief system was not incorporated in behaviour change communications. As a result, behaviour change could not occur effectively, as this depends on changing underlying understandings of health and diseases	The MCW initiative should include continuous, two-way processes to evoke behaviour change. Information needs to be disseminated by motivated, well-informed health care professionals with strong communication skills Health care workers must be trained to understand the mind-sets and worldview of local populations. Effective awareness campaigns must address locality-specific information and the communication needs of local

					populations
		Deworming for children aged 2-5	*Deworming* tablets were distributed for children between the ages of two and five Communities considered deworming a prime feature of the MCW initiative and commended deworming efforts	The involvement of communities, community influencers and religious leaders was weak in some areas Deworming interventions are not provided for children over the age of five or for adults, despite the fact that these are in demand by communities Deworming syrups are required by the community for children under the age of five	Deworming for children over the age of five and for adults might be included in the initiative As syrups are considered more child-friendly, deworming syrups might be used rather than tablets The involvement of communities, community influences and religious leaders should be increased, particularly in FATA, GB and Balochistan
		TT vaccines for women	*TT vaccinations* were administered to women by LHWs *91.1% of women* received the TT vaccination during their last pregnancy	Women from FATA believed that TT shots would harm the health of their child 8.1% of women did not get the TT vaccination during their last pregnancy	MCW must continue to ensure that women receive TT vaccinations during pregnancy More awareness raising is required, especially by religious authorities. It is essential to get them on board and involve them in the initiative's activities
	Health awareness sessions	*Breastfeeding*	Women in communities were educated about the importance of *exclusive breastfeeding*.	Social ecology and local people's mindsets were ignored in awareness campaigns regarding breastfeeding	Awareness raising needs to be sustained and strengthened so that women understand the complete concept of exclusive

			99% of women became aware of the need to breastfeed exclusively 68.3% of the women knew the optimal duration (6 months) of exclusive breastfeeding Women were educated on *complementary feeding* for children		breastfeeding MCW should strengthen iron supplementation interventions to benefit more women
		Antenatal, delivery and postnatal care	The initiative informed women of the significance of iron supplements during pregnancy Women were educated about ANC and PNC 65.2% of the women received iron supplements through MCW activities		
		Vaccination	Women's and community knowledge was increased regarding the significance of childhood immunization and TT vaccination	The need to debunk conspiracy theories opposed to vaccinations was not well addressed in awareness campaigns in some areas, such as Balochistan, FATA and AJK 13% mothers remained afraid of vaccination	More awareness raising is required on the importance of immunization, especially by religious authorities, with a focus on dispelling misconceptions
		Dangerous signs of childhood	Women were educated about the dangers, etiology, prevention and treatment of *pneumonia and diarrhoea*	Some women still did not understand how to make oral rehydration salts for children suffering from diarrhoea	More awareness needs to be raised to overcome deadly diseases among children. MCW should continue equip women to address diarrhoea

		diarrhoea and pneumonia			and pneumonia in their children
		Family planning	Women were educated about *family planning, optimal birth spacing and the use of contraceptives* *45% of respondents* became aware of about ideal birth spacing through MCW activities 67.3% reported using contraceptives, far higher than the average of 35% across Pakistan (UNICEF, 2010-2015)	Pakistan still faces a high fertility rate (TFR) in many regions, especially FATA, Balochistan and Sindh	MCW must continue to enhance capacities and innovations to reach out to the people of FATA, Balochistan and Sindh – areas with extremely high fertility rates and which extremely challenging to work in
		Iodized salt	Women were made aware of the significance of *iodized salt* 69% women used iodized salt at home	Misconceptions continue regarding the use of idolized salt in some areas	Awareness raising must be continued to ensure that more households use iodized salt, the simplest and safest means of preventing serious iodine deficiency disorders
		Hygiene and sanitation	Mothers were educated about personal and child hygiene	Awareness raising did not discuss environmental factors and communicable diseases	Environmental factors and communicable disease prevention should also be included in the MCW agenda
	Monitoring	*Real time monitoring/supervision*	MCW followed a multi-level monitoring and reporting mechanism at the federal, provincial, district and field levels Monitoring was undertaken	In Balochistan, there was no formal mechanism for LHW reporting. Instead, a simple registration sheet and pictures of the activity were used as evidence of MCW activities	The MCW initiative's reporting, monitoring and evaluation system needs to be strengthened by involving all provincial and regional stakeholders/departments

			through field inspections by various provincial and district representatives, particularly LHS and health managers On-file plans was largely mechanized by health departments Community health workers considered reporting to be simple and well-suited to their educational background		
		Review	Monitoring was undertaken through the review of daily progress reports	There were some claims that the scheduling of review and planning meetings were mismanaged in FATA and Balochistan LHS and LHWs from Punjab and KP felt the reporting mechanism was complex. They also complained that short and over-simplified training sessions were not sufficient to understand the reporting mechanism	Capacity building and efforts to motivate LHWs is required through robust and skill-development trainings. These will contribute to improved reporting by LHWs
	Procurement and distribution of required medicines and		On the whole, supplies were delivered in due time and in sufficient quantity, although medicines were sometimes in short supply and the delivery of supplies was sometimes delayed Difficulties were faced by	In FATA, LHWs did not provide a true account of beneficiaries which resulted in weak planning and the inadequate provision of supplies Medicines were sometimes in short supply and the delivery of supplies was delayed in some	Improvements are needed in planning and reporting to ensure the timely arrangement of supplies

	supplies		health care providers in terms of the procurement of supplies without proper transportation	areas	
Outputs		A week-long, biannual, free-of-cost, mother and child health care service week was provided at communities' doorsteps, particularly in rural and disadvantaged areas	MCW outcomes are *relevant* for international frameworks, national frameworks (National Health Vision) and all provincial/regional health policies The MCW initiative is successfully improving preventive and promotive MNCH health care The initiative effectively utilized existing public health networks to deliver accessible MNCH health services in a cost-effective manner at the grassroots level	The initiative could not reach most marginalized communities given its current coverage capacity. *Disaster risk management, a human-rights based approach/equity, a focus on marginalized groups and due consideration of gender* issues are not satisfactorily reflected in the initiative's planning and implementation 25.5% of mothers were not familiar with the term 'Mother and Child Week"; however they were aware of, and many participated in, MCW activities	The MCW initiative's coverage must be extended through public-private partnerships Disaster-affected areas must be prioritized, as should marginalized communities, nomadic groups and slums More awareness should be raised of the MCW initiative and the importance of maternal and child health care, particularly through the involvement of community volunteers (e.g. religious leaders and schoolteachers) Information communication technologies can be used to a greater extent to increase the dissemination of information
Outcomes	Improved knowledge, attitudes and	*Overall health care system*	A huge number of people benefitted from quality health care services through MCW activities during the last ten years. Existing MNCH services are	The initiative could not reach most marginalized communities given its current coverage capacity	The initiative should be extended to cover more marginalized communities, including urban slums, bonded labourers, disaster-affected areas and nomadic groups

	practices around maternal and child health		being strengthened Community health care indicators are improving Change are afoot in terms of *community capacity*, prompting a culture of openness and learning, while building relationships of trust		
		vaccination	Women knowledge of vaccinations increased as a result of MCW activities 89.2% women are now fully aware of the importance of vaccinations for children 61.8% of children were immunized during MCWs	13% of women feared that vaccines would have undesirable side effects that could harm their child's health	As immunization levels are not yet extremely high among children under the age of two, the MCW initiative must sustain its efforts towards universal immunization Awareness needs to be raised further to dispel cultural misconceptions about vaccinations
		Deworming	77.4% of women became aware of deworming through MCW activities Communities appreciated deworming and believed this had improved child health	The MCW initiative does not offer deworming for children over the age of five, or for adults Deworming tablets are not considered child-friendly	Deworming for persons over the age of five, and deworming syrups for children under the age of five, should be introduced Awareness raising should continue to increase the number of deworming beneficiaries
		Birth spacing	76.7% women gained knowledge of optimal birth spacing exclusively through MCW activities	Women in tribal areas of FATA, Balochistan and Sindh do not practice family planning or optimal birth spacing	Awareness must continue to be raised about family planning Community volunteers should be engaged – such as teachers and religious leaders – to educate communities about

					family planning
		Pneumonia and diarrhoea	74.1% of women gained awareness about pneumonia during MCW health sessions 94.6% of women reported taking preventive measures against pneumonia and confirmed that they consult doctors if they observe any signs of pneumonia in their children This figure is far higher than the national average of 64% of pneumonia cases being treated by health professionals (UNICEF, 2010-2015) Women became aware of diarrhoea risks, danger signs, prevention and treatment. They were also trained to make oral rehydration salts at home		Diarrhoea and pneumonia must continue to be dealt with vigilantly by the MCW initiative Awareness should be enhanced among women, particularly on hygiene and the importance of purified drinking water Women should be more thoroughly trained how to prepare oral rehydration salts at home
		Exclusive breastfeeding	94.7% of women became aware of the importance of exclusive breastfeeding and appropriate durations (six months) recommended by WHO		The initiative should continue to raise awareness to ensure that women understand the whole concept of exclusive breastfeeding, the reasoning behind the practice and practical details, such as its appropriate duration

		Use of iodized salt	70.7% of the women reported using iodized salt at home and 69.9% confirmed that they became aware of its benefits during MCW activities This proportion is slightly higher than the national average of 69% for iodized salt consumption (UNICEF, 2013)	29.3% women do not use iodized salt	The initiative must continue to raise awareness of the importance of using iodized salt
	Enhanced maternal and child service utilization	*TT vaccines*	*91.1% of the women* received the TT vaccination during their last pregnancy, significantly higher than the national average of 75% estimated by UNICEF in 2014 So, receipt of TT shots among pregnant women was quite higher in MCW intervened areas.	As noted above, some women in FATA are reluctant to receive the TT vaccine as they believe it is forbidden on religious grounds and/or that it will harm their child's health	More awareness raising is required to dispel myths surrounding vaccines especially by religious authorities
		Delivery care	67.4% of the women surveyed sought professional treatment from doctors/health professionals in the wake of MCWs, significant higher than the national average of 52% (UNICEF, 2010-15) Only 7.5% of deliverers were overseen by traditional birth attendants	Women from FATA and Balochistan reported that patriarchal culture restricted their mobility to such an extent that they were unable to visit health facilities. In many cases, facilities were unavailable in their areas given their lack of basic health infrastructure. Thus, they were obliged to rely on traditional birth attendants as their best possible	There is an urgent to improve overall health infrastructure in Pakistan in general and in Balochistan and FATA in particular Awareness should be raised, especially among men, so that they facilitate adequate delivery care for women at medical facilities

				option 7.5% deliveries are still overseen by untrained traditional birth attendants (*Dai*)	
		Antenatal care	47.7% of MCW participants sought over four check-ups at hospitals during their last pregnancy – considerably higher than the national average of 37% (UNICEF, 2010-2015) 86% of women took iron supplements during their last pregnancy Thus, beneficiaries of the MCW initiative have sought better antenatal care	52.3% of women still do not seek over four antenatal check-ups at hospitals Patriarchal culture that prescribes women's seclusion and restricts their mobility – particularly in FATA, Balochistan, KP and AJK – prevents women from seeking antenatal care at hospitals. A lack of health care facilities in remote areas also hampers antenatal care.	Communities in general, and men in particular, should be sensitized about the importance of antenatal/postnatal care and how they can support such care Policy level changes are needed in school/college curricula to educate students on health care issues and, thereby, evoke overall improvements in health care seeking behaviours Influential community volunteers should be engaged to educate communities about importance of health care in general and specifically antenatal/postnatal care
		Postnatal care	84.9% of women sought postnatal care for their newborns, almost twice the national average of 43% (UNICEF, 2010-15). 90.2% of women sought skilled postnatal care at government or private hospitals, remarkably higher than the national average of 60% (UNICEF, 2010-15)		
	Enhanced staff competency		Health care providers' professional competencies increased, particularly LHWs' reporting capacities	MCW trainings for LHWs were only one-day long, a duration many felt was too short to absorb extensive, complex information Trainers sometimes lacked	Durable and robust trainings are required to further enhance staff competencies Training and reporting must be tailored to LHWs needs,

				sufficient capacity to deliver effective training	contexts and academic qualifications

6. LESSONS LEARNED AND CONCLUSIONS

6.1. LESSONS LEARNED

This evaluation's findings provide evidence that, overall, the MCW initiative was implemented efficiently, successfully strengthening existing MNCH services and raising health awareness among communities in Pakistan. Nevertheless, a lack of human and financial resources in some areas, coupled with weak micro-planning and coordination, limited its effectiveness. The following sections summarize lessons learned from the initiative's successes, challenges and policy directions. Based on these lessons learned, recommendations are offered to improve the MCW initiative.

Implementation of the MCW initiative as intended

Holding MCW events proved a culturally acceptable intervention for increasing access to MNCH services. The festive aspects of these events – in as much as they were often presented as health *melas* (fairs) – succeeded in attracting vulnerable groups. Health risks were prevented among beneficiaries through the provision of deworming tablets, immunization, TT vaccinations and health education. An important lesson learned from the MCW initiative's experience is that such events may usefully become part of routine MNCH services. Their experience also indicates that more rigorous micro-planning, coordination, trainings and effective monitoring is needed to ensure the best possible utilization of resources and to achieve better health outcomes among target populations.

Partnerships between the Government, donors and NGOs

High levels of UNICEF commitment contributed greatly to the prioritization of MNCH services and led to strengthened partnerships with Government counterparts and other key stakeholders. Thus, it is clear that collaboration between the Government, development partners, donors, NGOs and community-based organizations is vital for increasing the efficiency of the MCW initiative, while avoiding overlaps.

Improvements in micro-planning

Despite significant efforts, micro-planning did not improve sufficiently in some districts. This offers a strong lesson on the need for efficient micro-planning at the district level in all cases in order for MNCH interventions to be successful. In the MCW initiative's case, innovative strategies are required to improve micro-planning and coordination in these districts.

Political and policy level commitment

As it is aligned with the existing frameworks of federal and provincial health policies, the MCW initiative utilized existing health infrastructure and networks of outreach workers to address the health needs of mothers and children, with a focus on vulnerable populations. This alignment clearly contributed to the MCW initiative's sustainability, offering a pivotal lesson on the importance of linking interventions with existing national and sub-national frameworks. However, as the MCW initiative's experience makes clear, political and policy level commitment are needed to ensure that such initiatives can be sustained over time within the existing health system.

Training of service providers

Training and capacity building for community health workers proved one of the MCW initiative's greatest strengths. Nevertheless, trainings were not consistent in terms of their contents and duration. More extensive training, paired with hands-on exercises, may be useful for equipping service providers with innovative advocacy and communication strategies, while ensuring their continuous professional development. Longer training sessions that afford participants adequate time to reflect and absorb information are clearly useful for MNCH interventions. In the MCW initiative's case, the evaluation shows that longer training sessions are vital for enhancing health workers' social mobilization and reporting skills.

Participatory planning and coordination

The planning and tight schedule of MCWs – which were undertaken over a period of just six days each – overburdened health managers and outreach workers. This affected their routine tasks/operations and performance. A lack of monetary compensation for their extra work served to dampen their motivation. This is an important lesson for MNCH interventions which ultimately depend on the skills, motivation and abilities of community health workers to perform

their duties effectively. To ensure that quality services are delivered through the MCWs initiative, a strong coordination mechanism and participatory planning, involving all health managers and outreach workers, is essential. Financial incentives should also be introduced to reward LHWs for their additional work and dedication.

Deworming services and supplies

The provision of deworming tablets was one of the MCW initiative's major successes, lauded by communities and mothers' as having improved child health manifold. The significance of low-cost, high-impact interventions like deworming are important to bear in mind for MNCH interventions. However, sufficient supplies of deworming tablets are required to meet the needs of older children, adolescents, women and the general population. The significance of the overall MCW service package should not be underestimated; this should be promoted through continuous advocacy and social mobilization activities.

Use of routine data

A major gap in planning MCW activities occurred due to the absence of baseline or mid-term assessment data for the initiative. Instead, routine data collected under the EPI or LHW programmes was used to guide MCW planning. This limited target-setting for particular areas (districts/villages/towns). Bench-marking or baseline data is vital for measuring the specific impact of the MCW initiative over time – a key lesson to take into account for any MNCH intervention.

Lack of disaggregated data

The lack of appropriate disaggregated data on the MCW initiative's coverage posed serious challenges. The initiative's experience offers a number of lessons about the need to collect timely, accurate disaggregated data, with a focus on vulnerable groups. For instance, many disaster-affected areas, nomadic groups and other marginalized communities were not covered by the MCW initiative. These marginalized groups are usually excluded from routine health services; unless the MCW initiative covers their needs, they will be further relegated to social exclusion and deteriorating health outcomes. Moreover, MCW coverage data is not disaggregated by age or other socio-demographic parameters. This restricts its ability to present a holistic picture of specific community needs. The MCW platform may be used to ensure the

availability of up-to-date data on the utilization of MNCH services, which would improve the robustness and functionality of MCW activities.

Lack of financial data

The main challenge which the evaluation team encountered was the lack of available financial data and valid information – from a single source – on budgetary allocations for the MCW initiative over the past ten years. As such, a cost-benefit analysis of MCW activities could not be performed to determine the initiative's value for money. However, as information was provided by UNICEF for 2015 and 2016, a descriptive cost analysis was undertaken for these two years. This highlights the importance of collecting and making available complete financial data on MNCH initiatives in order to inform more effective evaluations.

Logistics and supply management

Challenges arose in terms of the MCW initiative's management of logistics and supplies. Delayed, irregular or insufficient supplies in some areas undermined health workers' motivation and meant that they were unable to cater to the needs of beneficiaries. Ensuring the timely provision of adequate supplies is a significant lesson for any health intervention. A strong logistical and supply management mechanism is needed to ensure the sufficient and timely provision of medicines and supplies – including vaccines and IEC materials (such as playing cards and banners) – to health workers engaged in the MCW initiative.

Engaging men and communities

The participation of diverse communities in MCW activities proved challenging due to their different backgrounds, socio-economic status and cultural practices. Nonetheless, the involvement of local women outreach workers enabled effective community engagement. They were able to engage women even in restrictive patriarchal environments, while changing community mind-sets and enhancing knowledge of MNCH issues through advocacy and behaviour change strategies. In Punjab and Sindh, the initiative succeeded in cementing community ownership of MCW activities. This offers a strong lesson on the importance of community health workers for ensuring community ownership.

However, another lesson learned points to the need to engage men in MNCH interventions. The fact that the MCW initiative's awareness raising campaigns and other activities focused solely on

women, while ignoring men, proved extremely problematic in a country where decision-making power at the household and community levels tends to lie with men. Its failure to engage men limited the MCW initiative's effectiveness. Involving men in MCW activities would accelerate progress on MCNH. Gender specific advocacy and communications are needed to enhance the initiative's effectiveness.

Role of the media and continuous advocacy

Information on the MCW initiative was generally disseminated through mosques and LHWs. Such limited channels prevented the dissemination of information to a wider audience. As a result, many women missed upcoming rounds of MCWs. As discussed throughout this report, in many areas, misconceptions and conspiracy theories abound with regard to vaccinations. More active involvement of the media (television, radio, newspapers) and local community leaders is needed to improve the initiative's implementation and debunk myths. Modern means of communication – such as text messages/SMS alerts – coupled with sustained advocacy would increase the MCW initiative's outreach and efficiency. Clearly, expanding outreach through a wider variety of communication channels – including ITC technologies – while engaging in continuous advaocy are pivotal lessons for all MNCH interventions at the grassroots level to take into account.

6.2. CONCLUSIONS

This section presents summarizes the conclusions which the evaluation arrived at, in line with DAC OECD criteria.

6.2.1. Relevance

Based on the evaluation's findings, it can safely be concluded that the MCW initiative was:

- Aligned with – and relevant to – health priorities defined at all levels, including the international framework of the SDGs, the national framework of Pakistan's National Health Vision and all provincial/regional health policies;
- Relevant to/in line with community health care needs;
- Aligned with the responsibilities and expertise of health managers and service providers; as a result, staff are well-trained, effective and efficient;

- Lacking in baseline data; in its absence, MCW needs assessments were informed by on registration data compiled by health care providers; and
- Not relevant for the objective of reaching marginalized communities/areas – especially urban slums, disaster-affected areas, bonded labourers in brick kilns and nomadic groups.

6.2.2. Effectiveness

Overall, the MCW was:

- Largely effective, since it improved child and maternal health indicators over the course of ten years;
- Well-coordinated from within and with programme partners;
- An effectively monitored imitative encompassing real-time monitoring and reviews of daily progress reports;
- Not effective in reaching out to marginalized groups/areas;
- Sometimes hampered by socio-cultural constraints, such as patriarchal restrictions on women's mobility and misconceptions about vaccine composition, especially in FATA, Balochistan and KP;
- Constrained by accessibility and mobility issues for health care providers in remote areas with difficult terrain in parts of KP, Balochistan, GB, AJK and FATA;
- Affected by inconsistent logistical support, particularly in FATA and Balochistan; and
- Held back in terms of effectiveness by a lack of health worker motivation, which is dampened by the lack of monetary incentives for service providers in exchange for their laborious extra MCW-related work.

6.2.3. Efficiency

Despite some gaps in programme efficiency, the MCW initiative may be considered efficient overall. In this regard, the MCW was:

- Adept at efficiently making the most of available human and financial resources;
- Cost-efficient, since MCW interventions were of good quality yet relatively inexpensive;
- Unable to efficiently address the needs of marginalized segments of society; and

- Limited in terms of its efficiency by a lack of motivation among health care providers, caused by the absence of additional remuneration for additional MCW-related work.

It is worth repeating that this evaluation lacked inputs on transparent and comprehensive budgetary details. Therefore, macro-costing or a descriptive cost-benefit analysis of the MCW initiative could not be undertaken for the entire ten year period. As UNICEF provided data for 2015 and 2016, a descriptive cost analysis was only undertaken for these two years of the MCW initiative's implementation.

6.2.4. Sustainability

In terms of sustainability, the evaluation found that:

- That the MCW initiative successfully increased the capacities of health workers, which bodes well for the initiative's sustainability;
- Stakeholders agree that the initiative should be sustained and that its coverage should be extended to marginalized areas;
- In Punjab, the MCW initiative is already being sustained without development assistance. Provincial authorities took over the initiative and have been running it successfully for years; and
- Withdrawing UNICEF funding might limit the sustainability of the MCW initiative. This makes it all the more important to engage civil society and public sector partners, both to expand outreach and to secure alternative financial and human resources.

6.2.5. Long-term outcomes

Overall, the MCW initiative successfully achieved many of its intended long-term outcomes, including:

- Improved MNCH service utilization and increased community participation;
- Greater awareness among communities on various maternal and child health issues;
- Strengthened community capacity around health issues, coupled with a growing culture of openness, learning and relationships of trust;
- Successful skills development among health service providers, particularly community health workers;

- Better maternal and child health indicators among targeted communities; and
- Dispelling cultural and religious misconceptions in many areas, thereby removing bottlenecks that had prevented the effective implementation of the MCW initiative.

6.2.6. Cross-cutting issues

The MCW initiative did not adequately address cross-cutting issues related to gender, equity, disaster risk and security. Most prominently:

- Men were not engaged in MCW activities in most provinces/regions; GB was the sole exception to this trend. Failing to engage men – the primary decision-makers at the household level – limited the initiative's impacts;
- Marginalized areas/groups – such as urban slums, bonded labourers and nomadic settlements – were largely uncovered by the MCW initiative, undermining health equity and the initiative's intended human rights-based approach; and
- Disaster-affected areas were not adequately covered by the initiative and were not addressed as a priority.

7. RECOMMENDATIONS

As maternal, neonatal and child health is a multi-dimensional issue, MNCH service provision involves a range of stakeholders. Their roles, responsibilities, capacities and the scope of their work differ considerably. As such, this section presents recommendations separately for different stakeholders.These recommendations are drawn from the evaluation's analysis of data collected from primary and secondary sources, and have been designed within the framework of the aforementioned Theory of Change (TOC) model. As discussed earlier in this report, the principles of a TOC model are (HFRP, 2014):

- Change cannot come alone, there is a need to work together and 'build a movement' to improve maternal and child health;
- Change comes from identifying and addressing underlying causes;
- Different approaches are needed to create change at the individual, community and institutional levels;
- A multi-faceted, long-term programme – with activities that reinforce each other – will maximize change;
- Work needs to be done across the entire population, with tailored approaches for different groups; and
- There is a need to continually test and evaluate existing approaches and to undertake further research in order to refine strategies.

The evaluation's findings provide insights that contribute to mapping out the pathway for the change required to improve MNCH services in Pakistan. The following recommendations, therefore, are guided by a TOC model and seek to include all stakeholders involved in the provision and utilization of health care services for mothers and children.

7.1. UNICEF level recommendations

- It is recommended that UNICEF continues its technical support for the MCW initiative, given the organization's leading role in promoting MNCH and its capacity and credibility to undertake work in this field.
- Setting up a MCW secretariat at the federal and provincial levels would assist the proper planning, design, implementation and monitoring of MCW activities. A centralized system,

capable of facilitating coordination between stakeholders, would improve the initiative's efficiency and achievement of its objectives/outcomes.

- At the policy level, the advocacy component of the MCW needs to be strengthened. This is important for eliciting political commitment, engaging communities and securing sufficient resource allocations. Properly utilizing IEC materials is especially important. Extremely marginalized, socially excluded groups require special attention in advocacy efforts, given their limited knowledge of MNCH.
- The MCW initiative's monitoring and evaluation system needs to be strengthened by involving all provincial/regional stakeholders and departments. Information and communications technologies should be used to make this monitoring and evaluation system more efficient, cost-effective and user-friendly.
- Cross-cutting issues – including gender, equity, disaster risk and security – must be adequately addressed by the MCW initiative. Special efforts are required to extent the initiative's coverage of marginalized and disaster-affected areas across the country and to mainstream gender, engage both women and men in activities.
- While four major MCW activities are carried out nationwide, data reveals that different areas have different health needs. It is recommended that certain customized activities be added to cater to the context-specific needs of particular areas.
- There is a need to develop operational guidelines which explicitly delineate the responsibilities of each stakeholder at the district, provincial and federal levels.
- System capacities should be enhanced in terms of designing tools to identify health needs, selecting the most appropriate solution from among different options, formulating strategies, and planning interventions and activities.
- A framework for accountability should be developed to define the roles and responsibilities of all key stakeholders and departments. This will address the challenges of the MCW initiative's accountability deficit. Such a framework would also help efforts to set targets, measure progress in intervention areas and define reporting channels.

7.2. Recommendations for policy reforms

- Given the Government's responsibility for formulating and implementing health policies, its representatives should analyse existing health-related legislation, with a particular focus on

MNCH. It is recommended that health care legislation in each province/region is brought in line with the province's/region's socio-economic context.

- The provision of MNCH services is a long-term undertaking that requires the sustained provision of up-to-date, multi-sectoral information and awareness raising campaigns. All stakeholders must be taken on board. The collective power of communities will enable them to not only receive information, but also to adopt improved health seeking practices.
- Longer, more comprehensive training should be delivered for community health workers. They also require continuous professional training, which could be delivered online to keep them abreast of the latest information related to MNCH and the MCW initiative. Adapting the Australian model could be one way forward – therein, doctors and health professionals working in remote areas participate in online training courses to update their knowledge and technical competencies.
- While planning and executing MCW rounds, holistic approach that involves multiple components – such as regular training for health care professionals and the provision of medicines, vaccines and other supplies must be taken into consideration.
- The MCW initiative's implementation should be embedded in health sector action-planning documents, bearing in mind that all stakeholders involved in the evaluation agreed on the initiative's relevance for national health plans and provincial/regional health strategies.
- Policy level directions are required to scale up the MCW initiative to areas that are covered by LHWs to ensure equity and addressing issues of the accessibility, affordability and availability of MNCH services for marginalized groups. This would ultimately contribute to achieving global, national and provincial/regional MNCH targets.
- The Government should offer public institutions at the provincial and district levels the opportunity to hire temporary technical services from private sector organizations and academic institutions. Such technical support will help them overcome the administrative, managerial and service provision-related challenges identified by this evaluation.
- The service package for outreach workers must be reviewed and customized as a smart, uniform package which addresses specific local needs related to health seeking behaviours and healthy life styles.

- Given the patriarchal structure of Pakistani society, men must be actively engaged in MCW activities in order to change reproductive health and family planning-related behaviours. Men's involvement will also help MCW interventions to reach end users efficiently.

7.3. Recommendations for the MCW initiative's sustainability and institutionalization

- Successful interventions like the MCW initiative must become part of Pakistan's regular health service delivery system.
- There is a need for continued performance reviews, both in terms of the functioning of health systems and human resources. These should identify gaps and weaknesses, before using this analysis to design and implement measures to improve the performance of health systems and human resources.
- To mobilize the resources needed to address shortages of supplies, equipment and personnel, it is essential to engage national and provincial/regional governments, the private sector, NGOs, CBOs and international donors.
- It is essential to mobilize and engage local political elites to secure the political commitment required for the MCW initiative's sustainability. Their participation and cooperation is key to evoking meaningful, durable behaviour change at the community level.
- Efforts to cement community ownership are vital for ensuring the MCW initiative's sustainability**.** To create a sense of ownership, communities must be actively involved and made aware that the MCW initiative is a community-based intervention that takes place in the community, for the community's benefit, with the community's help.
- Internal community resources or assets should be organized to strategically focus on context-specific health issues. This can be achieved by strengthening neighbourhood organizations and promoting networks/linkages between individuals and community organizations.
- Interventions that seek to improve MNCH should be integrated, such as the MCW initiative and the National Programme for Family Planning Primary Health Care, the LHW Programme, the EPI and the MNCH Programme. One programme cannot succeed without the success of the other. Dedicated awareness raising is required to ensure that health care professionals and end users understand the linkages between these initiatives.
- As health care provision and utilization is not uniform across Pakistan, regions with extremely poor health indicators and social disparities require special attention from health

care professionals. MCW initiative planners should bear this in mind and capacities should be built for needs based planning at the district level. These plans should then be consolidated into provincial plans that address broader health sector strategies.

- The MCW initiative largely depends on UNICEF in terms of planning and various technical tasks. To ensure the initiative's sustainability, health departments should take on primary responsibility for planning and implementing MCW activities. Districts should be empowered to prepare MCW plans and submit budgetary requests, which should be fulfilled appropriately.
- The MCW initiative must learn from best practices identified over the course of its implementation. Punjab offers a strong example, as MCW activities have been fully integrated into existing MNCH services and made an integral part of the Integrated Reproductive Maternal Neonatal Child Health & Nutrition (IRMNCH&N) Programme. It is recommended that other provincial/regional governments to take on the MCW initiative within the scope of their own MNCH programmes by learning from the experience of Punjab.

7.4. Operational level recommendations

- In some areas, community involvement was limited – end users did not own the MCW initiative and it was perceived as a 'government or UNICEF's programme'. The initiative's social mobilization strategy must be made more effective to increase community engagement.
- Cost-related data on the MCW initiative should be documented, continually updated and readily available for analysis. This will enhance sustainability and course correction by informing cost-benefit analyses.
- An ICT-driven monitoring and evaluation (M&E) system would help to overcome infrastructural and geographical barriers in order to rapidly identify and address the MCW initiative's operational bottlenecks. Intelligently using modern technologies for M&E purposes would increase the effectiveness of the initiative.
- The MCW initiative's narrow focus on reproductive health may not help it to win communities' trust. To make the initiative more relevant to people's daily needs, medicines for common illnesses – such as antipyretic medicines, allergy treatments, cough syrup or

multivitamins – should be provided to participants during MCWs. This would increase their motivation to participate in MCW activities, since most mothers reported a need for such medicines.

- Health managers and community workers/service providers must be provided with financial incentives to remunerate them for the additional work they perform in the MCW initiative. This will increase their motivation and efficiency.
- The MCW initiative should be made more transparent in order to increase public trust. For instance, programme documents must be simpler and less cumbersome. Reports should be submitted in a timely fashion and summaries should be available as open access documents.
- Information on environmental factors, communicable disease prevention and hygiene issues should be included in the MCW initiative's agenda and outreach materials, given their bearing on maternal and child health.
- The provision of information and facilities to women in GB and Balochistan must be urgently improved. A focus on these areas is needed to enhance the initiative's effectiveness.
- MCW activities should be conducted every three months – rather than every six months – so that more mothers and children can benefit from the initiative.
- To enhance the initiative's effectiveness, both men and women, particularly LHWs, should be engaged as social mobilizers to reach out to under-served, under-developed areas – including parts of Balochistan, southern Punjab and Sindh.
- The fact that some meetings were conducted hastily, without prior planning, negatively affected the MCW initiative's implementation. Planning meetings should be organized well in advance, so that partners can participate easily. All meetings should be evaluated against a set of criteria for effective meetings by the provincial/district health departments. There is also a need to work out the resources required for MCW activities, in terms of logistical arrangements, supplies and transportation. This is vital to avoid administrative and management challenges in the field.
- Proper planning is also required to avoid overlaps between MCW activities and National/Sub-national Immunization Days, as overlapping schedules can hamper effectiveness. Similarly, MCW sessions must be organized so that they do not clash with the harvest season in rural areas, when many women may be too busy to participate.

- Local NGOs/CBOs should be more involved in the programme, with clearly defined terms of reference. As they are familiar with local characteristics, customs, attitudes, practices, problems and particularities, they are ideally placed to raise awareness among women on MCW sessions, to facilitate operations and to add to the initiative's credibility.
- As all areas in Balochistan and AJK are not covered by LHWs, more LHWs should be recruited to provide services in remote areas. Other resources/logistical supplies should also be provided. As a stop gap solution, local NGOs could be encouraged to perform the role of LHWs temporarily. Such efforts will help to address the initiative's sustainability issues.
- Data on cases of defaulter children (i.e. who have missed vaccinations) must be maintained to ensure optimal coverage of relevant areas and cases. A data management system needs to be developed based on mobile technology.
- During the planning phase, MCW activities should synchronize with existing government programmes on MNCH in different provinces. This is vital to avoid duplication.
- Periodic assessments should be undertaken to document best practices, verify which targets have been achieved by the MCW initiative and pinpoint challenges/constraints hampering the initiative's success.
- Standardized, uniform information is often not useful for raising awareness of issues like high-risk pregnancies and delivery, or addressing culturally embedded health belief systems surrounding pregnancy. Health workers should be trained to understand local mind-sets and worldviews in order to engage with community members and promote positive health seeking behaviours. Effective awareness raising campaigns must address local context-specific information and communication needs.
- Media stakeholders should be engaged to sensitize policy-makers, implementers, health managers, service providers and communities on MNCH issues. By using their 'privileged access', major national and local media groups can raise awareness among political actors, communities and households, while identifying and promoting MCW-related success stories to showcase the initiative's positive impacts.

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Annex 1. Phases of work

Month	Weeks	Description of activities
1st	1-2	Introductory meeting and facilitation of required data to the evaluation team by UNICEF
	Inception phase	
	3-4	Preparation and submission of the first draft of the inception report
2& 3rd	5	Review and evaluation of the inception report by UNICEF
	6	Meeting on inception feedback and comments by UNICEF
	7-8	Consultative meetings and revised inception report
	Data collection phase	
4th	9-10	Finalizing the methodology (data collection methodology & sampling)
	11-12	Selection of data collection areas, teams and the preparation of training guides
4th	2 days	Training sessions and pilot testing
4th & 5th	15-17	Data collection duration and managing record
	Data analysis and evaluation report	
	19-21	Data analysis
6th	22-23	Preparation of the draft evaluation report
6th + 7th	24-25	Review by UNICEF and feedback on the draft evaluation report
8th	26-27	Revision and submission of the final evaluation report

Annex 2. Evaluation design matrix (EDM)

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
#1 Assess the extent to which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)	***Relevance***	How relevant and meaningful are the MCW initiative's objectives and activities in terms of addressing the needs and priorities of marginalized /vulnerable mothers and children in the intervention areas?	Are the MCW initiative's objectives clearly relevant to the needs of potential beneficiaries – as identified by any form of situation analysis, baseline evaluation, or other evidence and/or arguments?	Primary and secondary data	Key Informant Interviews (KIIs) were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) Focus Group Discussions (FGDs) were conducted with service providers A survey was conducted with end users/benefici	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	**The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme	Theory of change of the MCW initiative developed by UNICEF and/or implementing partners (not available (NA)) Baseline study or other evidence and/or arguments for the initiative's implementation by UNICEF or implementing	Thematic analysis was applied to data collected through KIIs, FGDs and case studies by using NVIVO software Quantitative data was analysed by using SPSS

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					aries and service providers (LHWs)		**District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)	partners Inception documents for the MCW initiative prior to its inception in 2007 (NA) Needs assessment documents prior to, or during, the MCW initiative's implementation by UNICEF and/or implementing partners (NA)	
#1 Assess the extent to which the	***Relevance***	How relevant and meaningful are the MCW	To what extent did the MCW initiative	Primary and secondary data	KIIs were conducted with health managers	KII guide **(see Annexes 4.3, 4.3.1,**	The target population for the survey were potential beneficiaries – i.e. women of	Documents containing data on	Thematic analysis was applied to on data collected

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)		initiative's objectives and activities in terms of addressing the needs and priorities of marginalized /vulnerable mothers and children in the intervention areas?	reach potential beneficiaries and meet their needs – especially marginalized/excluded under the age of five and pregnant women?		identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	**4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	reproductive age (15-49 years) with one or more child under the age of five The target population for the FGDs included all LHWs and LHS The target population for the in-depth interviews include beneficiaries with significant stories identified through surveys and LHWs' input	the total number of potential beneficiaries in selected districts **(NA)** Lists of the number of beneficiaries in selected districts covered by the MCW initiative **(NA)** Lists of marginalized and excluded potential beneficiaries **(NA)** Lists of	through FGDs and KIIs by using NVIVO software Quantitative analysis was done using SPSS

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
								areas covered that were previously uncovered **(NA)**	
# 2 Analyse the synchronization between national MNCH policies/priorities and the MCW initiative's goals and objectives	***Relevance***	To what extent were the strategies used in the MCW initiative relevant to the national priorities and policies related to MNCH addressed under by this initiative?	Are the MCW initiative's goals and objectives aligned with national priorities and policies related to MNCH service provision for potential beneficiaries ?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	**Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the	Documents containing national MNCH policies **(NA)** Documents outlining the MCW initiative's goals and objectives **(Available)**	

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					users/beneficiaries and service providers (LHWs)		MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#1 Assess the extent to which the MCW initiative's implementation	***Relevance***	How relevant was the selection of covered areas (districts and villages) with	Was the selection of areas for MCW activities aligned with the initiative''	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii)	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs	The target population for the FGDs included all LHWs and LHS **The target population for the KIIs included:** **Federal level** ○ Federal Director	Documents containing the MCW initiative's goals and objectives **(Availabl**	Data analysis was undertaken by using NVIVO Secondary data was analysed

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and access to these services for potential beneficiaries)		reference to the MCW initiative's objectives?	stated objectives?		provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the	**e)**	through linguistics analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW		
#1 Assess the extent to which the MCWs implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential	***Effectiveness***	Were the initiative's strategies appropriately designed and properly delivered?	What was the rationale behind the MCW initiative's strategy design and how effective was it?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)**	The target population for the FGDs included all LHWs and LHS **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers) **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director	Theory of Change of the MCW initiative developed by UNICEF and/or implementing partners **(NA)** Inception documents for the initiative prior to its commencement in 2007	Thematic analysis was applied to data collected through KIIs by using NVIVO software Secondary data was analysed through linguistics analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
beneficiaries)					A survey was conducted with end users/beneficiaries and service providers (LHWs)	Case studies (**see Annex 4.4)**	○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme	**(NA)** All micro-planning reports and data (partially available, 5 out of 20)	

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							○ Representatives of NGOs involved in MNCH/MCW		
#1 Assess the extent to which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)	***Effectiveness***	Were the initiative's strategies appropriately designed and properly delivered?	What was the rationale behind the MCW initiative's implementation strategy and how effective was it?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	The target population for the FGDs included all LHWs and LHS **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme	Theory of Change of the MCW initiative developed by UNICEF and/or implementing partners **(NA)** Inception documents for the initiative prior to its commencement in 2007 **(NA)** All micro-planning reports and data **(partially available,**	

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					service providers (LHWs)		○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)	**5 out of 20)**	
#1 Assess the extent to which the	***Effectiveness***	To what extent did the implementation of the	How effectively did UNICEF engage with	Primary and secondary data	KIIs were conducted with health managers	KII guide **(see Annexes 4.3, 4.3.1,**	**The target population for the KIIs included:** **Federal level** ○ Federal Director	Review and planning documents	Data analysis was undertaken using NVIVO

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)		MCW initiative's programme strategies work as intended?	implementation partners to strengthen coordination for the achievement of the MCW initiative's desired results?		identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	**4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the	for all MCWs **(partially available, 5 out of 20 documents)**	software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#1 Assess the extent to which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in	***Effectiveness***	To what extent did the implementation of the MCW initiative's programme strategies work as intended?	How effective was the monitoring and evaluation of the MCW initiative?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey	The target population for the FGDs included LHS **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director	Monitoring and evaluation data on MCW activities **(NA)** Review and planning documents for all MCWs	Data analysis was undertaken using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
Pakistan and enhancing access to these services for potential beneficiaries)					managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme	**(partially available, 5 out of 20 documents)**	

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#5 Explore the extent to which the MCW initiative addressed the needs of marginalized, excluded, crisis and disaster-affected populations	***Effectiveness***	How successfully did the MCW initiative reach marginalized, excluded, crisis and disaster-affected populations in the areas it covered?	How successful was the MCW initiative in reaching marginalized, excluded, crisis and disaster-affected populations in the areas it covered?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case	The target population for the FGDs included all LHWs and LHS The target population for the in-depth interviews included beneficiaries with significant stories identified through surveys and LHWs' inputs **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH	List of all areas covered by the MCW initiative **(NA)** Documents containing data regarding the coverage of marginalized, excluded, crisis and disaster-affected	Data analysis was undertaken using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					A survey was conducted with end users/beneficiaries and service providers (LHWs)	studies (**see Annex 4.4)**	Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District	populations **(NA)**	

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#3 Assess the lessons learned during the 2007-2011 period, when MCW initiative's implementation transitioned from small-scale piloting to nationwide implementation in 2012 and thereafter	***Effectiveness***	What major changes have occurred because of the implementation of the MCW initiative over the past ten years?	What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of the MCW initiative over the past ten years?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)**	**The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme	Review and planning documents for all MCWs **(partially available, 5 out of 20)**	Data analysis was undertaken using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					A survey was conducted with end users/beneficiaries and service providers (LHWs)	Case studies (**see Annex 4.4)**	○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							The target population for the FGDs included all LHWs and LHS		
#9 Determine the extent to which resources allocated for the MCW initiative (both human and financial resources) were utilized efficiently	***Efficiency***	How efficiently have UNICEF and its implementing g partners managed their resources (both human and financial) to ensure the timely, cost-effective and efficient attainment of results?	How efficiently have UNICEF and its implementing g partners managed their resources (both human and financial) to ensure the timely, cost-effective and efficient attainment of results?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	The target population for the survey were potential benefits – i.e. women of reproductive age (15-49 years) with at least one child under the age of five The target population for the FGDs included all LHWs, LHS and vaccinators **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director	Documents containing complete data on resources (human and financial) allocated by all implementing partners **(NA)**	Opportunity cost analysis was used to gauge efficiency, alongside the application of appropriate statistical tools Data analysis was undertaken using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					service providers (LHWs)		**Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW		

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							Union council level Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#1 Assess the extent to which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)	**Long-term outcomes**	To what extent has the MCW initiative achieved its objectives and what were the major factors that affected its achievement of – and/or its inability to achieve – intended objectives	To what extent has the MCW initiative achieved its objectives?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/benefi	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	The target population for the FGDs included all LHWs, LHS and vaccinators **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI	Documents containing data collected for all of the indicators related to the MCW initiative's long-term outcomes **(NA)** Monitoring and evaluation data for all MCWs **(NA)**	Quantitative analysis was undertaken by using SPSS Data analysis undertaken done using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					ciaries and service providers (LHWs)		Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#1 Assess the extent to	**Long-term outcomes**	How far the MCW has achieved its	What were the major factors	Primary and seconda	KIIs were conducted with health	KII guide **(see Annexes**	The target population for the FGDs included all LHWs, LHS and	Review and planning	Thematic analysis was applied to data

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
which the MCW initiative's implementation followed its intended plan (i.e. strengthening existing MNCH services in Pakistan and enhancing access to these services for potential beneficiaries)		objectives and what were the major factors affecting the achievements and/or non-achievement of intended objectives.	affecting the achievements and/or non-achievement of intended objectives.	ry data	managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers) FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	**4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnaire (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	vaccinators **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level**	documents for all MCWs **(partially available, 5 out of 20)**	collected through the FGDs and KIIs, using NVIVO software Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
#8 Identify lessons learned, exploring what has worked well, and what has not worked as well,	**Long-term outcomes**	What lessons were learned in the implementation of the MCW initiative and what other more cost-effective options were	What lessons were learned in the implementation of the MCW initiative and what other more cost-	Primary and secondary data		KII guide was used to collect data **(see question # 15 in Annexes 4.3.1, 4.3.2 and 4.3.3)**	The target population for the FGDs included all LHWs, LHS and vaccinators **The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health,	Review and planning documents for all MCWs **(partially available, 5 out of 20)**	Thematic analysis was applied to data collected through the FGDs and KIIs, using NVIVO software Secondary

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
and offer recommendations – including to strengthen gender programming, equity and child rights		available, if any?	effective options were available, if any?			FGD guide was used to collect data from LHWs, LHS and vaccinators **(see to questions 17-19 in Annex 5.2)**	UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the		data was analysed using linguistics analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		
# 10 Determine the sustainability of the MCW initiative	***Sustainability***	To what extent are provincial governments/ regional administrations willing to continue the MCW in case UNICEF itself pulls out of the initiative?	To what extent is the Government willing to support the continuation of MCW activities if and when UNICEF pulls out>	Primary and Secondary data		KII guide was used to collect data **(see question # 16 in Annexes 4.3.1, 4.3.2 and 4.3.3)**	**The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial		Thematic analysis was applied to data collected through the FGDs and KIIs, using NVIVO software

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or		

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							dispensers)		
# 10 Determine the sustainability of the MCW initiative	***Sustainability***	To what extent has the MCW initiative contributed to strengthening the capacities of MNCH service providers/ duty bearers?	To what extent has the MCW initiative contributed to strengthening the capacities of health service providers/duty bearers?	Primary and Secondary data	FGDs were conducted with vaccinators, LHWs and LHS	FGD guide was used to collect data from LHWs, LHS and vaccinators	The target population for the FGDs included all LHWs, LHS and vaccinators		Thematic analysis was applied to data collected through the FGDs and KIIs, using NVIVO software
# 10 Determine the sustainability of the MCW initiative	***Sustainability***	What were the enablers and drivers (internal and external) that contributed to, or hindered, the sustainability of the MCW initiative?	What internal/external factors affected the sustainability of the MCW initiative, in which direction and to what extent?	Primary and Secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers)	KII guide **(see Annexes 4.3, 4.3.1, 4.3.2 and 4.3.3)** FGDs guide (**see Annexes 4.2, 4.2.1, 4.2.2 and 4.2.3)** Survey questionnai	**The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level**		Thematic analysis was applied to data collected through the FGDs and KIIs, using NVIVO software

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
					FGDs were conducted with service providers A survey was conducted with end users/beneficiaries and service providers (LHWs)	re (**see Annexes 4.1.1 and 4.1.2)** Case studies (**see Annex 4.4)**	○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level**		

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							Health managers at the basic health unit level (doctors, LHVs or dispensers)		
Make recommendations, including on institutionalization and the strengthening of gender programming, equity and child rights	***Cross-cutting issues***	To what extent are cross-cutting issues addressed in the MCW initiative?	To what extent are cross-cutting issues, such as gender, equity, a human rights-based approach (HRBA) and disaster risk reduction (DRR) incorporated at various levels of planning and implementation?	Primary and secondary data	KIIs were conducted with health managers identified at four levels – (i) federal, (ii) provincial (iii) district and (iv) union council level (basic health unit health managers)	Survey tools were used to collect data from mothers	**The target population for the KIIs included:** **Federal level** ○ Federal Director General Health ○ National Auditor ○ Chief of Health, UNICEF ○ National MNCH Programme Director ○ National EPI Programme Director **Provincial level** ○ Provincial Director General Health ○ Provincial Coordinator of the LHW Programme ○ Provincial Manager of the EPI Programme ○ UNICEF Provincial Health Specialist ○ Provincial Coordinator of the		Data analysis was conducted using NVIVO software and SPSS Documents containing secondary data were analysed by employing linguistic analysis

Objectives	DAC OECD criteria	Evaluation questions	Sub-questions	Type of data	Data collection methods	Data collection tools	Target population	Availability of secondary data	Data analysis method
							MNCH Programme **District level** ○ District Health Officer/Chief Executive Officer ○ District Coordinator of the LHW Programme ○ District Coordinator of the EPI Programme ○ District Coordinator of the MNCH Programme ○ Representatives of NGOs involved in MNCH/MCW **Union council level** Health managers at the basic health unit level (doctors, LHVs or dispensers)		

Annex 3. List of stakeholders

Key Informant Interview (KII) stakeholders	**Federal level** • Federal Director General Health • National Auditor • Chief Health, UNICEF • National MNCH Programme Director • National EPI Programme Director **Provincial level*** • Provincial Director General Health • Provincial Coordinator of the LHW Programme • Provincial Manager of the EPI Programme • UNICEF Provincial Health Specialist • Provincial Coordinator of the MNCH Programme **District level*** • District Health Officer/ Chief Executive Officer • District Coordinator of the LHW Programme • District Coordinator of the EPI Programme • District Coordinator of the MNCH Programme • Representatives of NGOs involved in MCW** **Union council level** • Health manager at the basic health unit level (doctor/LHVs/dispensers) ***
Focus Group Discussion (FGD) stakeholders	Lady Health Workers (LHWs), Lady Health Supervisors (LHS) and vaccinators
Household survey stakeholders	Potential beneficiaries – i.e. women of reproductive age (15-49 years old) with at least one child aged 0-5 years. LHWs who have been a part of at least two rounds of MCWs
Case study stakeholders	Potential beneficiaries – i.e. women of reproductive age (15-49 years old) with at least one child aged 0-5 years
*After consultation with Provincial Coordinators, it was found that provincial and district level nutrition programmes have no role in the MCW initiative's implementation. Hence, interviews were not included with representatives of the nutrition programme. ** During discussions in provincial consultative meetings, it was found that not many NGOs were involved in the implementation of the MCW initiative. Nevertheless, one KII was included from each district with an NGO representative involved in MCWs.	

***After discussions with UNICEF's Reference Group, it was decided that one KII would be conducted with a health manager at the basic health unit level – either a doctor, LHV or dispenser (depending on their availability) from one selected union council in each district. In total, 22 KIIs were planned with BHU level health managers.

Annex 3a: Consent Forms

Annex 3a.1: HOUSEHOLD QUESTIONNAIRE

HH Questionnaire ID	<WFP code/Serial Number>	Dated	____ /____ / 2018

Informed Consent

Assalam o Alaikum, my name is _____ and I am working with University of the Punjab and UNICEF Pakistan. We are conducting a survey that asks households about the initiative of Maternal and Child Week celebrated in your area twice a year. Additionally, we will be asking about your knowledge, attitude and practices pertaining to different maternal and child health related issues. Your house has been selected to do an interview for this survey.

We would very much appreciate your participation in this survey. This information will be used to help the Ministry of Health, Government of Pakistan, provincial governments and UNICEF to understand your problems and improve maternal, neonatal and child health services. The survey should take about 25-30 minutes to complete. The information you provide will be kept confidential and will not be shared with anyone other than members of our project team. Your responses will also be anonymous and not linked back to you in anyway.

Participation in the survey is voluntary. If we ask you any questions you don't want to answer, please feel free to let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will participate in this survey, as your input is important to us. I will be happy to answer any questions you may have about the survey now. Do you have any questions?

May I begin the interview now? Circle one option	(1) Verbal consent granted	(2) Verbal consent declined/refused

INSTRUCTIONS: If verbal consent is not granted then (a) politely thank the respondent for his/her time, (b) exit the interview and leave.

Annex 3a.2: FOCUS GROUP DISCUSSION (FGD)

Informed Consent

Assalam o Alaikum, my name is _____ and I am working with University of the Punjab and UNICEF Pakistan. We are conducting an evaluation of initiative of Maternal and Child Week undertaken by UNICEF twice a year. You have been identified as a participant of FGD for the evaluation.

We would very much appreciate your participation in this process. This information will be used to help the Ministry of Health, Government of Pakistan, provincial governments and UNICEF to understand the problems associated with this initiative. The interview should take about 45-60 minutes to complete. All information will be consolidated and presented in an evaluation report. Therefore, the information you provide will be kept confidential and will not be shared with anyone other than members of our evaluation team. Your responses will also be anonymous and not linked back to you in anyway.

Participation in the FGD is voluntary. If we ask you any questions you don't want to answer, please feel free to let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will participate in this evaluation, as your input is important to us. I will be happy to answer any questions you may have about it. Do you have any questions?

Name of participant:	
Designation:	Work experience:
District:	Date of Interview:

Annex 3a.3: KEY INFORMANT INTERVIEW (KII)

Informed Consent

Assalam o Alaikum, my name is _____ and I am working with University of the Punjab and UNICEF Pakistan. We are conducting an evaluation of initiative of Maternal and Child Week undertaken by UNICEF twice a year. You have been identified as a Key Informant for the evaluation.

We would very much appreciate your participation in this process. This information will be used to help the Ministry of Health, Government of Pakistan, provincial governments and UNICEF to understand the problems associated with this initiative. The interview should take about 45 minutes to an hour to complete. All information will be consolidated and presented in an evaluation report. Therefore, the information you provide will be kept confidential and will not be shared with anyone other than members of our evaluation team. Your responses will also be anonymous and not linked back to you in anyway.

Participation in the KII is voluntary. If we ask you any questions you don't want to answer, please feel free to let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will participate in this evaluation, as your input is important to us. I will be happy to answer any questions you may have about it. Do you have any questions?

Name of Key Informant:	
Designation:	Department:
District:	Date of Interview:

Annex 4. Data collection tools

Annex 4.1. Survey questionnaires

Annex 4.1.1. Survey with potential beneficiaries

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Mothers aged 15-49 years

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for mother and child health. This study is sponsored by UNICEF Pakistan. We are from the Institute of Social and Cultural Studies of the University of the Punjab. We are conducting an evaluation of Mother and Child Weeks. This survey is for households with at least one woman member of reproductive age [15–49 years] or at least one child aged 0-5 years. This survey will take approximately 25-30 minutes. We highly appreciate your participation in this interview. We ensure you that all information provided will be confidential, anonymous and used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

Survey with mothers

☐ Start the interview
☐ Permission not granted, quit

S No	HOUSEHOLD ID: District/Tehsil/UC/HH	__/__/__/__
1.	Province	1. Punjab 5. GB 2. Sindh 6. AJK 3. Balochistan 7. FATA 4. KP
2.	District Tehsil Basic Health Unit (BHU) Union Councils Village	_____ _____ _____ _____
3.	Date of interview	
4.	Name of interviewer	

Section 1- Demographics

Questions	Codes	Response
What is your age?	In complete years	
Have you had any formal schooling?	**1.** Yes **2.** No	
What is highest level of education you completed?	**1.** Less than primary **2.** Primary **3.** Middle **4.** Secondary **5.** Intermediate **6.** Graduate **7.** Post-graduate **8.** Other (please specify)	
How many children do you have?	Number	
How many of your children are 0-5 years old?	Number	
Type of family	**1.** Nuclear **2.** Joint	

1. Do you know about the MCW initiative? [Yes/No]
2. When was the first time you heard about it? State the year _____
3. Have you been a beneficiary of MCW in the past ten years? [Yes/No]

If the answer to question number 3 is 'No', then skip questions 4-13.

4. Please mention the period in which you were a beneficiary (years)_____
5. Number of health week sessions/activities you have attended _____
6. When was the last MCW conducted in your locality? State the year_____
7. How do you usually get information about upcoming MCW activities? State the source of information.
   a. TV b. Radio c. Mosque announcement d. Newspaper e. LHW f. Health care team g. Any other
8. On average, how far in advance do you get information about the upcoming MCW? State in days_____
9. Who encouraged you to use MCW services?
   a. Encouragement from community volunteers such as *Imam Masjid* or school teacher
   b. Encouragement from other families/family members [husband, father-in-law, mother-in-law]
   c. Health care provider's advice
   d. Free health care services
   e. Entertainment events accompanying MCWs
   f. Self-motivation
   g. Any other _____
10. What was your experience of using the services during MCWs?
    a. Completely satisfied
    b. Satisfied
    c. Not satisfied
    d. If satisfied, state the reason _____
    e. If not satisfied, state the reason _____
11. What were the factors that prevented/discouraged you from using MCW services in any particular round? State the reason
    a. We were not informed about the week
    b. Unable to access services. State the reason _____
    c. Opinion of others who dissuaded my use of MCW services. What were their opinions _____
    d. Other _____
12. What, if anything, would you suggest to improve the MCW campaign
    a. Contents (e.g. types of services provided)
       What?_____
    b. Format (e.g. frequency, organization)
       What?_____
    c. Communication (e.g. information on MCWs)
       What?_____
    d. How women are encouraged/motivated to participate in the MCWs
       What?_____
    e. Other
       What?_____
13. If you could pass on a message to the organizers of the MCWs, what would you like to tell them?

_____

_____

Immunization of children (0-2 years old)

Child immunization status (0-2 years) by type of vaccine

S No.	Sex	EPI card	BCG	Combo Penta Vaccine			Measles Vaccine	
	(M/F)	1. Yes 2. No		Penta 1	Penta 2	Penta 3	Measles 1	Measles 2
1.								
2.								

Questions	Codes	Response
In your view, how important it is to be immunized?	**1.** Should not be missed in any case **2.** It is ok to miss a few shots **3.** It is not necessary	
Do you have any fears concerning immunization? If 'Yes', please specify	**1.** Yes **2.** No	
Were there any issues regarding the availability of vaccines? If yes, what issues? Please specify	**1.** Yes **2.** No	
Did a child (< 2 years) receive an EPI vaccination during the MCW?	**1.** Yes **2.** No **3.** Don't Know	
Have your beliefs or practices regarding vaccination changed due to MCWs?	**1.** Yes **2.** No	

Deworming of children (2 – 5 years old)

S. No	Sex	Age (month)	Did your child receive drugs for intestinal worms during the MCW?	**1.** Yes **2.** No	
			During this pregnancy, did you take any medicine for intestinal worms through MCW? If yes, how many times?	**1.** Yes **2.** No **3.** Don't Know	

Health care utilization by pregnant women

Contraceptive use/birth spacing

Did you receive any counselling on the benefits of family planning and methods during the MCWs? In case of 'Yes', from whom did you receive FP counselling?	**1.** Yes **2.** No **1.** LHW **2.** LHV **3.** Doctor **4.** Other (specify)	
Do you have knowledge on the ideal spacing between two births?	**1.** One year **2.** Two years **3.** Three years **4.** Any other **5.** Don't Know	

Do you or your husband use any family planning method? If 'Yes', what method? If 'Yes', what is the source of your FP materials?	**1.** Yes **2.** No **1.** Condoms **2.** IUD **3.** Injections **4.** Pills **5.** Tube ligation **6.** Withdrawal **7.** Vasectomy **8.** Other (Specify) **1.** LHW **2.** Government health centre (BHU/RHC/THQ/DHQ) **3.** Private hospital/clinic **4.** Private pharmacy **5.** Local general store **6.** Other (specify)	
Have your belief or practices about birth spacing changed due to MCWs?	**1.** Yes **2.** No	

Tetanus Toxoid vaccination

Are you currently pregnant? If 'Yes', what month?	**1.** Yes **2.** No Months	
Did you receive a TT injection during your current pregnancy?	**1.** Yes **2.** No **3.** Not applicable	
Did you receive a TT injection during your last pregnancy? If 'Yes', how many? If 'Yes', then who recommended this TT vaccine?	**1.** Yes **2.** No **1.** 1st injection **2.** 2nd injection **1.** Doctor **2.** Nurse **3.** LHW **4.** Relatives **5.** Electronic media **6.** Other (specify)	

Antenatal care

How important do you think antenatal care is for your and your child's health?	**1.** Very important **2.** Important **3.** Not important	
Do you know how many antenatal visits are required during one pregnancy?	**1.** One **2.** Two **3.** Three **4.** Four **5.** Any other **6.** Don't know	
How many times did you have antenatal checkups during your last pregnancy?	**1.** No **2.** One **3.** Two **4.** Three **5.** More than three	
Which type of care provider did you consult?	**1.** Doctor **2.** Nurse **3.** LHW **4.** LHV **5.** TBA/*Dai* **6.** Community midwife **7.** Other (specify)	
Where did you receive antenatal care for your last pregnancy?	**1.** Home **2.** LHW **3.** Government hospital (BHU/RHC/THQ/DHQ) **4.** Private hospital/clinic **5.** Other (specify)	
Did you take iron supplements during you last pregnancy? If 'Yes', from whom did you receive the supplements?	**1.** Yes **2.** No **1.** LHW **2.** BHU **3.** RHC **4.** THQ **5.** DHQ **6.** Pharmacy **7.** Private clinic/hospital **8.** Other (Specify)	
Have your beliefs and/or practices about antenatal care changed due to MCWs?	**1.** Yes **2.** No	

Delivery/natal care and preparation for delivery

Who conducted your last delivery?	**1.** Doctor **2.** Nurse **3.** Family member/ relative **4.** LHV **5.** TBA/*Dai* **6.** Community midwife **7.** Other (specify)	
Where did your last delivery occur?	**1.** Home **2.** Government hospital/centre **3.** Private hospital/clinic **4.** Other (specify)	
Was a clean delivery kit used for your delivery?	**1.** Yes **2.** No	
Was the newborn weighed at birth?	**1.** Yes **2.** No	
When was the newborn baby given a bath after birth?	**1.** Immediately **2.** Within the first 6 hours **3.** After the first 6 hours **4.** After 1 day **5.** After the 2nd day **6.** Don't know **7.** Other (specify)	
Did you area LHW provide any advice during your pregnancy for the place of delivery? If 'Yes', what place/care was advised?	**1.** Yes **2.** No **1.** Doctor **2.** Nurse **3.** TBA/*Dai* **4.** LHV **5.** Community midwife **6.** Other (specify)	
Have your beliefs and/or practices about natal/delivery care and the place of delivery changed due to MCWs?	**1.** Yes **2.** No	

Postnatal and neonatal signs

How important do you think postnatal care is for your and your child's health?	**1.** Very important **2.** Important **3.** Not important	
After how many hours, days or weeks after birth, newborn had first checkup. In case of Yes, by whom newborn was examined	Specify number in hours, days or week **1.** Doctor **2.** Nurse **3.** Untrained TBA/Dai **4.** LHW **5.** LHV **6.** Other (specify)	
Did anyone check the mother's health after she gave birth? If 'yes', who?	**1.** Yes **2.** No **1.** Doctor **2.** Nurse **3.** Untrained TBA/Dai **4.** LHW **5.** LHV **6.** Other (specify)	
After how many hours, days or week after delivery mother's first checkup should take place?	Number in hours, days or weeks	
Where did this first checkup took place	**1.** Home **2.** Government hospital/centre **3.** Private Hospital/ Clinic **4.** Other (specify)	
Have your beliefs and/or practices about postnatal care changed due to MCWs?	**1.** Yes **2.** No	

Danger Signs for pregnant women and infants

Do you know any danger signs in mothers during pregnancy ?(mark all that apply)	**1.** Spotting/vaginal bleeding **2.** Swelling on the face and hands **3.** Blood pressure **4.** Low weight (45kg and less) **5.** History of still	

	birth/abortion **6.** Anaemia/pallor **7.** Fever and too weak to get out of bed **8.** Fits/convulsions **9.** Severe lower abdominal pain **10**. Fast and difficult breathing **11**. Any other **12.** Don't know	
What was the source of knowledge about danger signs?		
What are danger signs during the postpartum period? (Mark all that apply)	**1.** Excessive bleeding after birth **2.** Fever after delivery **3.** Non-involution of uterus **4.** Lower abdominal pain **5**.Urinary incontinence **6.** Fits **7.** Increased vaginal bleeding **8.** Fits **9.** Fast and difficult breathing **10.** Fever or too weak to get out of bed **11.** Severe headaches with blurred vision **12.** Don't know **13.** Other (specify)	
What was the source of your knowledge about these danger signs?		
Do you recognize the danger signs for newborns (0- 28 days) (Mark all that apply)	**1.** Low birth weight **2.** Difficulty breathing **3.** Fits **4**. Low body temperature **5** .Fever **6.** Difficulty in /stops feeding **7.**Feeds less than every 5 hours **8.** Pus from eyes **9.** Redness and pus around umbilical stump **10.** Yellow eyes and skin **11.** Don't know **12.** Any other	
What was the source of your knowledge about these danger signs?		

Exclusive breastfeeding practice

In your view how important is exclusive breastfeeding?	**1.** Very important **2.** Important **3.** Not important	
Have you given colostrum to the infant after birth?	**1.** Yes **2.** No	
Do you have knowledge about exclusive breastfeeding?	**1.** Yes **2.** No	
When breastfeeding was initiated after the delivery?	**1.** Within one hour **2.** Second hour **3.** 1 day **4.** Any other **5.** Don't know	
What, according to you, is exclusive breastfeeding?	**1.** Breastfeeding only, even no water (polio drops) **2.** Breastfeeding and water **3.** Breastfeeding and tea/*qahwa*/*sharbat* **4.** Breastfeeding and tetra-pack milk **5.** Breastfeeding and cow/goat milk **6.** Only breastmilk with ORS, vitamins, drops,	

	minerals, medicines **7.** Any other (specify)	
How long should mothers' exclusively breastfeed?	**1.** 1 month **2.** 4 months **3.** 6 months **4.** Any other **5.** Don't know	
For how much time have you exclusively breastfed your child?	**1.** 1 month **2.** 4 months **3.** 6 months **4.** Any other **5.** Don't know	
Are you breastfeeding with water/ cow milk/other? If 'Other', please specify	**1.** Yes **2.** No	
What is the starting age of complementary feeding for children?	**1.** 3 months **2.** 6 months **3.** 9 months **4.** 1 year **5.** Any other **6.** Don't know	
Have your beliefs and/or practices regarding breastfeeding changed due to MCWs?	**1.** Yes **2.** No	

Use of iodized salt

Do you use iodized salt at home for cooking?	**1.** Yes **2.** No **3.** Don't know	
Do you know why iodized salt should be used?	**1.** Improves intelligence **2.** Prevent cretinism **3.** Prevent goiter **4.** Prevent irritability **5.** Any other	
Have your beliefs and/or practices regarding the use of iodized salt changed due to MCWs?	**1.** Yes **2.** No	

Danger signs for children

Do you have knowledge about the danger signs of diarrhoea?	**1.** Yes **2.** No	
In which danger sign of diarrhoea should a child be taken to hospital	**1.** More episode of diarrhoea (3 per day with loose consistency with or without smelly stools) **2.** Skin pinch test **3.** Sunken eyes **4.** Sunken Fontanilla **5.** Stools with blood **6.** Very high fever **7.** Other (specify)	
If a child has diarrhoea, what will you do to prevent dehydration?	**1.** Give ORS **2.** Give soft drink **3.** Give boiled water **4.** Continue breastfeeding **5**. Give soft diet **6.** Other (Specify)	
Do you know how to prepare ORS at home when ORS packets are not available? If 'Yes', Please explain	**1.** 1 litre (4 glasses) of water boiled and cooled, 8 spoon sugar and 1 tea spoon salt **2.** Don't know **3.**Other, specify	
Do you know how to prepare ORS from a packet of ORS?	**1.** Yes **2.** No	
Do you know the causes of diarrhoea in children under 5 years old?	**1.** Poor diet **2.** Spoiled food **3.**Feeding with bottle **4.** Contaminated drinking water **5.** Flies **6.** Open defecation **7.** Unclean hands **8.** Change of weather **9.** Poor personal hygiene	

	10. Don't know **11.** Any other.	
What was the source of knowledge about the danger signs of diarrhoea?		
Do you have knowledge about the danger signs of pneumonia?	**1.** Yes **2.** No	
Can you recognize the danger signs of pneumonia?	**1.** Fast and difficulty breathing **2.** Cough **3.** Shortness of breath **4.** High grade fever **5.** Cough for more than 2 weeks **6.** Others (specify)	
Do you know where to go for treatment if your child shows danger signs of pneumonia? (Do not give any indication)	**1.** Doctor **2.** Nurse **3.** LHV **4.** LHW **5.** Compounder **6.** Other (specify)	
What was the source of your knowledge about these pneumonia danger signs?		

Water, sanitation and hygiene (WASH)

Do you purify your drinking water? If 'Yes', then how?	**1.** Yes **2.** No **1.** Boiling water **2.** Adding bleach **3.**Use of Tablets **4.**Use of sachets **5.**Use of Ceramic **6.** Use of filter **7.**Solar disinfection **8.** Sieving through cloth **9.** Other (specify)	
Under what conditions do you think you must wash your hands?	**1.** Before cooking **2.** Before eating **3.** After using the toilet **4.** After washing a child's bottom **5.** Before child feeding **6.** Any other	
Do you use soap for hands washing	**1.** Yes **2.** No	
Have your beliefs and/or practices about purifying water changed due to MCWs?	**1.** Yes **2.** No	

Annex 4.1.2. Survey with Lady Health Workers (LHWs)

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: LHWs

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. The survey will take approximately 25-30 minutes. We assure you that any information you provide will be kept strictly confidential and will be used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the survey will not be conducted).

S. No	**Vaccinators ID: District/Tehsil/UC/HH**	__/__/__/__
1.	Province/region	1. Punjab 5. G.B 2. Sindh 6. AJK 3. Balochistan 7. FATA 4. KP
2.	District Tehsil Basic Health Unit Union Council Village	_____ _____ _____ _____
3.	Date of survey	
4.	Name of enumerator	

Questions	**Codes**	**Response**
What is your age?	In complete years	
Have you had any formal schooling?	**1.** Yes **2.** No	
State your highest academic qualification	**1.** Primary **2.** Middle **3.** Secondary **4.** Intermediate **5.** Graduate **6.** Other (specify)	
How long have you been working as a LHW?	1. 0-2 years 2. 2-4 years 3. 4-6 years 4. More than 6 years	

How long have you been working in this specific area?	1. 0-2 years 2. 2-4 years 3. 2-6 years 4. More than 6 years	

Immunization

Questions	Codes	Response
In your view, how important is immunization?	1. Should not be missed in any case 2. It is ok to miss a few shots **3.** It is not necessary	
Do you have any fears concerning immunization? If 'yes', please specify	**1.** Yes **2.** No	
Were there any issues regarding the quality and/or availability of vaccines? If 'yes', what were they? Please specify	**1.** Yes **2.** No	
Have your beliefs or practices regarding vaccination changed because of the MCW initiative? If 'yes', please specify	**1.** Yes **2.** No	

Deworming

What is deworming?	
Why is deworming important?	
Who among a household should be dewormed during MCWs?	

Health care utilization by pregnant women

Birth spacing and contraceptive use

What is the ideal spacing between two births?	**1.** 1 year **2.** 2 years **3.** 3 years **4.** Any other **5.** Don't know	
Are you familiar with family planning methods? If 'yes', what methods?	**1.** Yes **2.** No **1.** Condoms **2.** IUD **3.** Injections **4.** Pills **5.** Tubal ligation **6.** Withdrawal **7.** Vasectomy **8.** Norplant **9.** Other (Specify)	

What are the benefits of family planning?	**1.** Ensures good maternal health **2.** Ensures good child health **3.** Other. specify	
Have your beliefs or practices about birth spacing changed due to the MCW initiative? If 'yes', please specify.	**1.** Yes **2.** No	

Tetanus Toxoid vaccination

What is tetanus toxoid vaccine?		
What are the benefits of tetanus toxoid vaccine?		
How many TT injections are necessary during pregnancy?	**1.** 1 injection **2.** 2 injections **3.** Three injections	

Antenatal care

In your view, how important is antenatal care?	**1.** Very important **2.** Important **3.** Not important	
Do you know how many antenatal visits are required during a pregnancy?	**1.** 1 visit **2.** 2 visits **3.** 3 visits **4.** 4 visits **5.** Any other **6.** Don't know	
What are the benefits of antenatal visits?		
Who should be consulted during antenatal visits?	**1.** Doctor **2.** Nurse **3.** LHW **4.** LHV **5.** TBA/*Dai* **6.** Community midwife **7.** Other (specify)	
Are iron supplements necessary during pregnancy? Were iron supplements provided during all MCWs?	**1.** Yes **2.** No **1.** Yes **2.** No	
Have your beliefs and/or practices about antenatal care changed due to the MCW initiative? If 'yes', please specify the change	**1.** Yes **2.** No	

Skilled Birth Attendance

Which health care providers are skilled birth attendants?	**1.** Doctor **2.** Nurse **3.** Family member/relative **4.** LHV **5.** TBA/*Dai* **6.** Community midwife **7.** Other (specify)	
Which place do you think is safe for delivery?	**1.** Home **2.** Government hospital/centre **3.** Private hospital/clinic **4.** Other (specify)	
How important is a clean delivery kit for childbirth?	**1.** Very important **2.** Important **3.** Not important **4.** Don't know	
When should a newborn baby be given a bath after birth?	**1.** Immediately **2.** Within the first 6 hours **3.** After the first 6 hours **4.** After 1 day **5.** After the 2nd day **6.** Don't know	

	7. Other (specify)	
Have your beliefs and/or practices about places of delivery changed due to the MCW initiative? If 'yes', please specify.	**1.** Yes **2.** No	

Postnatal and neonatal signs

In your view, how important is postnatal care?	**1.** Very important **2.** Important **3.** Not important	
How many hours, days or weeks after birth, should a newborn have their first postnatal checkup? If 'yes', by whom should the newborn be examined?	Specify number in hours, days or week **1.** Doctor **2.** Nurse **3.** Untrained TBA/*Dai* **4.** LHW **5.** LHV **6.** Other (specify)	
Is it important to gauge maternal health status after delivery? If 'yes', who should gauge it?	**1.** Yes **2.** No **1.** Doctor **2.** Nurse **3.** Untrained TBA/*Dai* **4.** LHW **5.** LHV **6.** Other (specify)	
How many hours, days or week after delivery, should a mother's first checkup be conducted?	Number in hours, days or weeks	
Have your beliefs and/or practices about postnatal care changed due to the MCW initiative? If 'yes', please specify.	**1.** Yes **2.** No	

Danger signs in pregnant women and infants

Do you know of any danger signs during pregnancy? (mark all that apply)	**1.** Spotting/vaginal bleeding **2.** Swelling of the face and hands **3.** Blood pressure **4.** Low weight (45kg and less) **5.** History of still birth/abortion **6.** Anaemia/pallor **7.** Fever and too weak to get out of bed **8.** Fits/convulsions **9.** Severe lower abdominal pain **10**. Fast and difficult breathing **11**. Any other **12.** Don't know	
What are the danger signs during the postpartum period? (mark all that apply)	**1.** Excessive bleeding after birth **2.** Fever after delivery **3.** Non-involution of uterus **4.** Lower abdominal pain **5**.Urinary incontinence **6.** Fits **7.** Increased vaginal bleeding **8.** Fast and difficult breathing 9**.** Fever or too weak to get out of bed **10.** Severe headaches with blurred vision **11.** Don't know **12.** Other (specify)	
Can you tell us the danger signs for newborns (0- 28	**1.** Low birth weight **2.** Difficulty breathing **3.**	

days)? (mark all that apply)	Fits **4**. Low body temperature **5** .Fever **6.** Difficulty in or stops feeding **7.** Feeds less than every 5 hours **8.** Pus from eyes **9.** Redness and pus around umbilical stump **10.** Yellow eyes and skin **11.** Don't know **12.** Any other	

Exclusive breastfeeding practices

In your view, how important is exclusive breastfeeding?	**1.** Very important **2.** Important **3.** Not important	
Is it important to give colostrum to the newborn soon after birth?	**1.** Yes **2.** No	
When should breastfeeding be initiated after delivery?	**1.** Within 1 hour **2.** 2nd hour **3.** 1 day **4.** Any other **5.** Don't know	
What, according to you, is exclusive breastfeeding?	**8.** Breastfeeding only, even no water (polio drops) **9.** Breastfeeding and water **10.** Breastfeeding and tea/*qahwa*/*sharbat* **11.** Breastfeeding and tetra-pack milk **12.** Breastfeeding and cow/goat milk **13.** Only breast milk with ORS, vitamins, drops, minerals, medicines **14.** Any other (specify)	
What is the optimal duration for exclusive breastfeeding?	**1.** 1 month **2.** 4 months **3.** 6 months **4.** Any other **5.** Don't know	
What is the starting age for complementary feeding for children?	**1.** 3 months **2.** 6 months **3.** 9 months **4.** 1 year **5.** Any other **6.** Don't know	
Have your beliefs and/or practices regarding breastfeeding changed due to the MCW initiative? If 'yes', please specify the change	**1.** Yes, **2.** No	

Use of Iodized salt

Do you know why iodized salt should be used?	**1.** Improves intelligence **2.** Prevents cretinism **3.** Prevents goiters **4.** Prevents irritability **5.** Any other	
Have your beliefs and/or practices regarding the use of iodized salt changed due to the MCW initiative? If 'yes', please specify the change	**1.** Yes **2.** No	

Danger signs for Pneumonia and diarrhoea

Upon which danger sign of diarrhoea should a child be	**3.** More episodes of diarrhoea (3 per day with loose consistency with or without smelly	

taken to hospital?	stools). **4.** Skin pinch test **3.** Sunken eyes **4.** Sunken Fontanilla **5.** Stools with blood **6.** Very high fever **7.** Other (specify),	
If a child has diarrhoea, what should you do to prevent dehydration?	**1.** Give ORS **2.** Give soft drink **3.** Give boiled water **4.** Continue breastfeeding **5**. Give soft diet **6.** Other (Specify)	
Do you know how to prepare ORS at home? If 'yes', please explain	**1.** 1 litre (4 glasses) of water boiled and cooled, 8 spoons of sugar and 1 teaspoon of salt **2.** Don't know **3.**Other, Specify	
Do you know how to prepare ORS from a packet of ORS? If 'yes', how?	**1.** Yes **2.** No	
Do you know the causes of diarrhoea in children under 5 years old?	**1.** Poor diet **2.** Spoiled food **3.** Bottle feeding **4.** Contaminated drinking water **5.** Flies **6.** Open defecation **7.** Unclean hands **8.** Changes in the weather **9.** Poor personal hygiene **10.** Don't know **11.** Any other.	
Can you recognize the danger signs of pneumonia?	**1.** Fast and difficult breathing **2.**Cough **3.** Shortness of breath **4.** High fever **5.** Cough for more than 2 weeks **6.** Others (Specify)	

Water, sanitation and hygiene

How should you purify drinking water?	**1.** Boiling water **2.** Adding bleach **3.**Using chlorine tablets **4.**Using sachets **5.**Using ceramic **6.** Using a filter **7.**Solar disinfection **8. S**ieving through a cloth **9.** Other (specify)	
When is it compulsory to wash your hands?	**1.** Before cooking **2.** Before eating **3.** After using the toilet **4.** After washing a child's bottom **5.** Before child feeding **6.** Any other	
Have your beliefs and/or practices about purifying water changed due to the MCW initiative? If 'yes', please specify the change	**1.** Yes **2.** No	

Annex 4.2. Focus Group Discussion (FGDs) guide

Annex 4.2.1. Focus Group Discussion guide for Lady Health Supervisors (LHS)

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: LHS

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This discussion will last approximately 45-60 minutes. We highly appreciate your participation in this discussion. We assure you that any information you provide will be kept strictly confidential and will be used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

General information

1. Respondent 's name		1. Coverage area	
2. Education		2. Union council	
3. Years of service		3. Interviewer 4. Date & time of FGD 5. Time ended	
4. District			
5. Respondent name		6. Coverage area	
6. Education		7. Union Council	
7. Years of service		8. Interviewer 9. Date & time of FGD 10. Time ended	
8. District			

1. What are your views regarding the MCW initiative's relevance to your community's needs and priorities? Probe for
    - To what extent have MCWs reached potential beneficiaries and met their needs, especially marginalized (i.e. socially and economically) and excluded (i.e. not covered by routine MNCH services) children under 5 and pregnant women?
    - Is the MCW initiative in line with your targets and activities?
    - Are the MCW initiative's goal and targets helping to achieve your goals and targets?
    - If 'yes', how?
    - If 'no', why not?

2. How is the MCW initiative implemented?
   Probes: How are logistics arranged? Who supervises them and how?
3. Please comment on your monitoring and reporting mechanism

   Probe: (What aspects are given special consideration during monitoring and reporting? [stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chains and other programme-relevant materials)]

4. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of this initiative over the past ten years?
   Probe for:
   - Specific examples
   - Supporting evidence (MSC can be recorded if available)
5. How has the MCW initiative affected your professional competences?
   Probe for:
   - Have your professional skills been enhanced? Provide examples
   - Have your knowledge, attitudes and/or practices changed as a result of this initiative? Provide examples
6. How efficient were the programme operations?
   Probe:
   - How efficiently were supplies provided? Were they provided in a timely fashion?
   - List the supplies provided to you
   - Were the provided supplies sufficient?
7. What are your opinions about training for MCWs?
   Probe for:
   - Comment about the duration and frequency of your training
   - Training according to your role in MCWs
8. State your opinion regarding immunization during MCWs
   Probe for:
   - Was the community informed of the date, time and venue where the vaccinator planned to arrive?
   - Were the identified beneficiaries gathered in the health house/place prior to the vaccinator's arrival?
   - Were due and defaulter children vaccinated during MCWs?
9. How was communication regarding the commencement of MCWs managed?
   Probe for:
   - On average, how far in advance were announcements made?
   - What mediums were used to make announcements regarding MCWs?
10. Comment on MCW health education sessions
    Probe for:
    - How many health education sessions were conducted during MCWs?
    - What supporting materials were used during these health education sessions?
    - What were the contents of these health education sessions?
    - Who were the intended beneficiaries of these health education sessions?
    - What was the community turnout during these health education sessions?
    - Provide details of attendees (i.e. their number, age groups, gender)
    - What was the response of the attendees to these health education sessions?
11. Comment on the efficacy of the MCW initiative's health education sessions
    Probe for:
    - Was there any particular health education session during any MCW (state the week and year) which was especially successful or unsuccessful?
    - If 'yes', provide detailed reasons for its success
    - In your opinion, are these health education sessions changing the lives of attendees?
    - Provide reasons and examples to support your opinion
12. Do you believe that the MCW initiative has achieved its intended objectives?
    Probe for:

- Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
- Has maternal and child health improved in your area?
- Do you think that maternal and child health might be affected if the MCW initiative is discontinued?

13. State any significant factors affecting the achievement of – and/or the inability to achieve – the MCW initiative's outcomes
14. Kindly state any difficulties you faced during the implementation of the MCW initiative
    Probe for:
    - Logistical challenges
    - Household accessibility
    - The community's lack of cooperation
    - Other
15. Comment about your fieldwork during the MCW initiative. Probe for specific reasons and examples, such as:
    - Were activities with complementary supplies conducted in your community during the entire week?
    - State the nature and severity of problems, if any, faced during the MCW initiative's work in your community

Annex 4.2.2. Focus Group Discussion guide for LHWs

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: LHWs

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This discussion will take approximately 45-60 minutes. We highly appreciate your participation in this discussion. We assure you that any information you provide will be kept strictly confidential and will be used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

1. Respondent's name		5. Tehsil	
2. Education		6. Union council	
3. Designation		6. Type of community a. Urban b. Rural	
4. District name			

1. Is the MCW initiative in line with your district's health goals and targets?
2. Are the MCW initiative's goal and targets helping to achieve these district goals and targets?
   - If 'yes', how? If 'no', why not?
3. What are your views regarding the MCW initiative's relevance to your community's needs and priorities?
4. Are MCW interventions consistent with LHWs' routine tasks?
5. What are the roles and responsibilities of LHWs during MCWs?
6. Do you believe that the MCW initiative has achieved its intended objectives?
   Probe for:
   - Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
   - Has maternal and child health improved in your area?
   - Do you think that maternal and child health might be affected if the MCW initiative is discontinued?
7. Please comment on your monitoring and reporting mechanism

   Probe: What aspects are given special consideration during monitoring and reporting? [stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chain and other programme-relevant materials)]?

8. How efficient were programme operations? Probe:
   - How efficiently were supplies provided? Were they provided in a timely fashion?
   - List the supplies provided to you

- Were provided supplies sufficient?

9. What are your opinions about training for MCWs? Probe for:
    - Comment about the duration and frequency of your training
    - Training according to your role in MCW
10. State your opinion regarding immunization during MCWs. Probe for:
    - Was the community informed of the date, time and venue where the vaccinator planned to arrive?
    - Were identified beneficiaries gathered in the health house/place prior to the vaccinator's arrival?
    - Were due and defaulter children vaccinated during MCWs?
11. How were communications regarding the commencement of MCWs managed? Probe for:
    - On average, how far in advance were announcements made?
    - What mediums were used to make announcements regarding MCWs?
12. Comment on the MCW initiative's health education sessions. Probe for:
    - How many health education sessions were conducted during MCWs?
    - What supporting materials were used during these health education sessions?
    - What were the contents of these health education sessions?
    - Who were the intended beneficiaries of these health education sessions?
    - What was the community turnout during these health education sessions?
    - Provide details of attendees (i.e. their number, age groups, gender).
    - What was the response of the attendees to these health education sessions?
13. Comment on the efficacy of the MCW initiative's health education sessions. Probe for:
    - Was any particular health education session during any MCW (state the week and year) especially successful or unsuccessful?
    - If 'yes', provide detailed reasons for its success
    - In your opinion, are these health education sessions changing the lives of attendees?
    - Provide reasons and examples to support your opinion
14. Kindly state any difficulties during the registration of pregnant women and children under 5 years old. Probe for:
    - Logistical challenges
    - Household accessibility
    - The community's lack of cooperation
    - Other
15. Comment about your fieldwork during MCWs. Probe for specific reasons and examples, such as:
    - Were activities with complementary supplies conducted in your community during the entire week?
    - State the nature and severity of problems, if any, faced during the MCWs in your community
16. How has the MCW initiative affected your professional competences? Probe for:
    - Have your professional skills been enhanced? Provide examples
    - Have your knowledge, attitudes and/or practices changed as a result of this initiative? Provide examples
17. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of this initiative over the past ten years in your area? Probe for:
    - Specific examples
    - Supporting evidence (MSC can be recorded if available)
18. What can be done to increase the efficiency of the MCW initiative?
    - **Supply-side**: Probe about planning, implementation, logistics, training, monitoring, human resource advocacy and demand creation
    - **Demand-side**: Probe about geographical, financial and cultural factors, information and awareness
19. State any significant factors that have affected the achievement of – and/or the inability to achieve the MCW initiative's outcomes

Annex 4.2.3. Focus Group Discussion guide for vaccinators

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Vaccinators

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This discussion will take approximately 45-60 minutes. We highly appreciate your active participation. We assure you that any information you provide will be kept strictly confidential and will be used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

1. Respondent's name		4.Tehsil	
2. Education		5.Union council	
3. District name			

Relevance:

[Addresses objective #1 and OECD/DAC Q#1]

1. Are the MCW initiative's objective in line with the district's health goals and targets? Provide specific examples
2. Are MCW interventions synchronized with your community's needs and priorities?
3. What are your roles and responsibilities during MCWs?
4. Did MCW interventions strengthen your routine vaccination tasks (with a special focus on coverage)?
5. Has the MCW initiative achieved its intended objectives?
   Probe:
   - Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
   - Would the immunization of mothers and children be affected if the MCW initiative were discontinued?
6. State your opinion regarding immunization during MCWs. Probe for:
   - Was the community informed of the date, time and venue where the vaccinator would arrive?
   - Were identified beneficiaries gathered in the health house/place prior to the vaccinator's arrival?
   - Were due and defaulter children vaccinated during MCWs?
7. How were communications regarding the commencement of MCWs managed? Probe for:
   - On average, how far in advance were announcements made?
   - What mediums were used to make announcements on MCWs?

8. How has the MCW initiative affected your professional competences? Probe for:
    - Have your professional skills been enhanced? Provide examples
    - Have your knowledge, attitudes and/or practices changed as a result of this initiative? Provide examples
9. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of this initiative over the last ten years in your area? Probe for:
    - Specific examples
    - Supporting evidence (MSC can be recorded if available)
10. What can be done to increase the efficiency of the MCW initiative?
    - **Supply-side**: Probe about planning, implementation, logistics, training, monitoring, human resource advocacy and demand creation
    - **Demand side**: Probe about geographical, financial and cultural factors, information and awareness
11. State any significant factors that have affected the achievement of – and/or the inability to achieve – the MCW initiative's objectives.
12. Please comment on your monitoring and reporting mechanism. Probe for:
    - What aspects are given special consideration during monitoring and reporting? [Stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chains and other programme-relevant materials]

Annex 4.3. Key Informant Interview (KII) guide

Annex 4.3.1. Key Informant Interview (KII) guide for federal stakeholders

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Key informants (federal stakeholders)

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This interview will take approximately 40-45 minutes. We highly appreciate your participation in this interview. We assure you that the information you provide will be kept entirely confidential and will be used for research purposes only. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

Name of the participant	
Education	
Designation	
Years in service in department	
Date of interview	
Duration of interview	

Federal level

1. How many MCWs have you been involved in?
2. What were your responsibilities in terms of organizing planning meetings for the MCW initiative?
3. Were any baseline studies, needs assessments and/or priority assessment surveys of potential beneficiaries conducted prior to, or during, the MCW initiative?
4. What are the national priorities and policies regarding MNCH service provision
   Probe for:
   - How are the MCW initiative's goals and objectives aligned with these priorities/policies

   Was the selection of areas for MCW activities aligned with the initiative's stated objectives?
   Probe for:
   - What was the MCW initiative's rationale for the selection of areas?
   - What are the reasons for alignment and/or non-alignment?
5. What was the rationale behind the MCW initiative's strategy design and how effective was it?
   Probe for:
   - Strengths
   - Weaknesses
   - Challenges
   - Effectiveness

6. What are your views regarding the micro-planning of MCWs? Probe for:

- Significance of micro-planning
- Review mechanism
- Effectiveness of micro-planning

7. How would you evaluate the MCW initiative's monitoring and reporting mechanism at the provincial/regional level?
   Probe for:
   - What is the monitoring mechanism?
   - What is the reporting mechanism?
   - What aspects are given special consideration during monitoring and reporting? [stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chains and other programme relevant materials)]
8. In your view, how successful was the MCW initiative in reaching marginalized, excluded, crisis and disaster-affected populations in the areas covered?
   Probe for:
   - How were these populations operationalized?
   - Strategies to approach these populations
   - What proportion (percentage) of these populations is covered up to now by the MCW initiative?
9. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of the MCW initiative over the past ten years?
   Probe for:
   - Specific examples
   - Supporting evidence
10. Do you believe that your organization's resources have been efficiently utilized in the MCW initiative?
    Probe for:
    - Were the programme interventions cost-effective?
    - Did the resources you contributed result in the attainment of desired results?
11. What are your views regarding the MCW initiative's achievement of its intended outcomes?
    Probe for:
    - Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
    - Has maternal and child health improved in areas under your jurisdiction?
    - Specify reasons and examples
12. State any significant factors affecting the achievement of – and/or the inability to achieve – the MCW initiative's outcomes.
13. What lessons were learned in the implementation of the MCW initiative and what other more cost-effective options were available, if any?
    Probe for:
    - Specific reasons and examples
14. What are your views regarding the sustainability of the MCW initiative?
    Probe for:
    - Beliefs about the MCW initiative's benefits
    - What is your organizations commitment to continuing this initiative?
    - What factors affect the sustainability of this initiative?
15. To what extent are cross-cutting issues – such as gender, equity, a human rights-based approach (HRBA) and disaster risk reduction (DRR) incorporated at various levels of planning and implementation? Probe for:
    - Specific reasons and examples

Annex 4.3.2. Key Informant Interview (KII) guide for provincial stakeholders

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Key informants (provincial stakeholders)

- Provincial Director General Health
- Provincial Coordinator National Programme
- Provincial Director General Family Planning
- Provincial Officer UNICEF
- Provincial Officer Pakistan Initiative for Mothers and Newborns (PAIMAN)
- Provincial Officer MNCH Programme
- Members of all governmental and non-government organizations involved

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This interview will take approximately 40-45 minutes. We highly appreciate your participation in this interview. We assure you that any information you provide will be kept strictly confidential and will only be used for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

Tool for KIIs with key stakeholders

Name of institution: _____ Position in institution: _____

Length of time in position: _____

1. How many MCWs have you been involved in?
2. What were your responsibilities in terms of organizing planning meetings for the MCW initiative?
3. Were any baseline studies, needs assessments and/or priority assessment surveys of potential beneficiaries conducted prior to, or during, the MCW initiative?
4. What are the national priorities and policies regarding MNCH service provision?
   Probe for:
   - How are the MCW initiative's goals and objectives aligned with these priorities/policies?
5. Was the selection of areas for MCW activities aligned with the initiative's stated objectives?
   Probe for:
   13. What was the MCW initiative's rationale for the selection of areas?
   14. Reasons for alignment and/or non-alignment
6. What was the rationale behind the MCW initiative's strategy design and how effective was it?
   Probe for:
   - Strengths
   - Weaknesses
   - Challenges
   - Effectiveness

- Effectiveness

7. What are your views regarding the micro-planning of MCWs?
   Probe for:
   - Significance of micro-planning
   - Review mechanism
   - Effectiveness of micro-planning
8. How would you evaluate the MCW initiative's monitoring and reporting mechanism at the provincial level?
   Probe for:
   - What is the monitoring mechanism?
   - What is the reporting mechanism?
   - What aspects are given special consideration during monitoring and reporting? [stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chain and other programme-relevant materials)]
9. In your view, how successful was the MCW initiative in reaching marginalized, excluded, crisis and disaster-affected populations in the areas it covered?
   Probe for:
   - How were these populations operationalized?
   - Strategies to approach these populations
   - What proportion (percentage) these populations is covered up to now by the MCW initiative?
10. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of the MCW initiative over the past ten years?
    Probe for:
    - Specific examples
    - Supporting evidence
11. Do you believe that your organization's resources have been efficiently utilized in the MCW initiative?
    Probe for:
    - Were the initiative's interventions cost-effective?
    - Did the resources you contributed result in the attainment of desired results?
12. What are your views regarding the MCW initiative's achievement of intended outcomes?
    Probe for:
    - Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
    - Has maternal and child health improved in areas under your jurisdiction?
    - Specify reasons and examples
13. State any significant factors affecting achievement and/or no achievement of MCW's outcomes.
14. What lessons were learned in the implementation of the MCW initiative and what other more cost-effective options were available, if any?
    Probe for:
    - Specific reasons and examples
15. What are your views regarding the sustainability of the MCW initiative?
    Probe for:
    - Beliefs about the initiative's benefits
    - What is your organizations commitment to continuing this initiative?
    - What factors affect the sustainability of this initiative?
16. To what extent are cross-cutting issues such as gender, equity, a human rights-based approach (HRBA) and disaster risk reduction (DRR) incorporated at various levels of planning and implementation? Probe for:
    - Specific reasons and examples

Annex 4.3.3. Key Informant Interview (KII) guide for district stakeholders

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Key informants (district level stakeholders)

Thank you very much for your time. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This interview will take approximately 40-45 minutes. We highly appreciate your participation in this interview. We assure you that any information you provide will be kept strictly confidential and will only be used for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

Tool for KIIs with key stakeholders

Name of institution: _____ Position in institution: _____

Length of time in position: _____

1. How many MCWs have you been involved in?
2. What were your responsibilities in terms of organizing planning meetings for MCWs?
3. Were any baseline studies, needs assessments and/or priority assessment surveys of potential beneficiaries conducted prior to, or during, the MCW initiative?
4. What are the national priorities and policies regarding MNCH service provision?
   Probe for:
   - How are the MCW initiative**'s** goals and objectives aligned with these priorities/policies?
5. Was the selection of areas for MCWs aligned with its stated objectives?
   Probe for:
   - What was the MCW initiative's rationale for the selection of areas?
   - Reasons for alignment and/or non-alignment

6. What was the rationale behind the MCW initiative's strategy design and how effective was it?
   Probe for:
   - Strengths
   - Weaknesses
   - Challenges
   - Effectiveness
7. What are your views regarding the micro-planning of MCWs?
   Probe for:
   - Significance of micro-planning
   - Review mechanism
   - Effectiveness of micro-planning
8. How would you evaluate the monitoring and reporting mechanism at the distrcit level?

Probe for:

- What is the monitoring mechanism?
- What is the reporting mechanism?
- What aspects are given special consideration during monitoring and reporting? [stocktaking system (vaccination, syringes, registration sheets, deworming tablets, maintenance of cold chains and other programme-relevant materials)]

9. In your view, how successful was the MCW initiative in reaching marginalized, excluded, crisis and disaster-affected populations in the areas covered?
   Probe for:
   - How were these populations operationalized?
   - Strategies to approach these populations
   - What proportion (percentage) of these populations is covered until now by the MCW initiative?
10. What major changes (positive/negative, direct/indirect, intended/unintended) have occurred because of this initiative over the past ten years?
    Probe for:
    - Specific examples
    - Supporting evidence
11. Do you believe that your organization's resources have been efficiently utilized in the MCW initiative?
    Probe for:
    - Were MCW interventions cost-effective?
    - Did the resources you contributed result in the attainment of desired results?
12. What are your views regarding the MCW initiative's achievement of intended outcomes?
    Probe for:
    - Achievement of stated objectives (i.e. strengthening existing MNCH services and increasing coverage).
    - Has maternal and child health improved in areas under your jurisdiction?
    - Specify reasons and examples
13. State any significant factors affecting the MCW initiative's achievement of – and/or its inability to achieve – intended outcomes
14. What lessons were learned during the MCW initiative's implementation and what other more cost-effective options were available, if any?
    Probe for:
    - Specific reasons and examples
15. What are your views regarding the sustainability of the MCW initiative
    Probe for:
    - Beliefs about the initiative's benefits
    - What is your organization's commitment to continue this initiative?
    - What factors affect the sustainability of this initiative?
16. To what extent are cross-cutting issues, such as gender, equity, a human rights-based approach (HRBA) and disaster risk reduction (DRR) incorporated at various levels of planning and implementation?
    Probe for:
    - Specific reasons and examples

Annex 4.4. In-depth interview guide with potential beneficiaries

INSTITUTE OF SOCIAL & CULTURAL STUDIES

University of the Punjab, Pakistan

Project Title: Evaluation of Mother and Child Health Weeks

Respondents: Mothers aged 15-49 years

Thank you very much for your time. We are from the Institute of Social and Cultural Studies of the University of the Punjab. We are conducting an evaluation of Mother and Child Weeks among households with at least one woman member of reproductive age (15-49 years) and/or at least one child between 0-5 years old. We are conducting an evaluation of initiatives undertaken by UNICEF for maternal and child health. This study is sponsored by UNICEF Pakistan. This in-depth interview will take approximately 40-45 minutes. We highly appreciate your participation in this interview. We assure you that any information you provide will be kept strictly confidential and will be used only for research purposes. If you give your consent, shall we proceed? (If consent is denied, the interview will not be conducted).

Case Study

☐ Start the interview

☐ Permission not granted, quit

1. District Name: _____ Tehsil: _____
2. Union Council: _____ Community address: _____
3. Type of community: Rural _____ Urban_____
4. Focus on field observations to gauge the respondent's health and hygiene practices, with a special focus on MCW interventions.
5. What is respondent's narrative?
6. Probe for:
   a. Since when are you a beneficiary of the MCW initiative?
   b. Why did you start using its services?
   c. What motivated you to avail yourself of these services?
   d. Were there any challenges in utilizing these services? What were they?
   e. Were you using such services before the MCW initiative?
   f. Through what channels were these services available?
   g. Has the MCW initiative exceptionally benefited you in terms of the provision of maternal and child health care services? Please provide reasons
   h. In your view, should this initiative be continued or not? Give reasons
   i. Other situational probes, if and where necessary.

Annex 5. Results framework matrix

The following Results Matrix was prepared by the evaluation team to facilitate rapid analysis of the evaluation's results.

Objective	Indicator	Means of verification	Findings	Target at the time of the MCW initiative's implementation	Result	Comment

Annex 6. List of reviewed documents

Sr. #	Author	Document
1	UNICEF & Government of the Pakistan, 2014	National Mother and Child Week April Round 2014 Report
2	UNICEF & Government of the Pakistan, 2013	Mother and Child Health Week, Punjab, November 2013
3	UNICEF & Planning Commission Government of the Pakistan, 2012	Mother and Child Week Review and Planning Meeting, 13th September 2012
4	UNICEF Pakistan, 2012	Celebrating mother and child week in Pakistan 2007-2012
5	UNICEF, 2015	UNICEF procedure for ethical standards in research, evaluation, data collection and analysis
6	UNICEF & Government of the Pakistan, 2015	National Mother and Child Week Report 2015
7	United Nations Evaluation Group, 2005	Standards for Evaluation in the UN System
8	UNICEF & Planning Commission Government of the Pakistan, 2011	Mother and Child Week 2011
9	United Nations Evaluation Group, 2005	Norms for Evaluation in the UN System
10	United Nations Evaluation Group, 2005	UNEG Ethical Guidelines for Evaluation
11	UNICEF Pakistan, 2014	Pakistan Annual Report 2013
12	UNICEF Pakistan, 2016	Pakistan Annual Report 2015
13	UNICEF, 2013	UN Joint Programme on Maternal, Newborn and Child Health (UN-JMNCH) in Myanmar
14	USAID, 2015	Strategies to Strengthen Community Maternal, Newborn and Child Health: Findings from a Cohort of Child Survival and Health Grants Ending in 2014
15	UNICEF, National EPI Programme, Ministry of	Child Health and Sanitation Week 2008

	Health Pakistan, 2008	
16	UNICEF, 2009	Mother Child Week Evaluation Report 2009
17	United Nations Pakistan, 2010	Stocktaking Report January 2009-April 2010 Pakistan

Documents received from implementing partners

Sr. #	**Author**	**Document**
1	LHW Programme Coordinator, Punjab	Information about areas covered by the MCW initiative and LHWs' within their respective areas
2	LHW Programme Coordinator, KP	Information about areas covered by the MCW initiative and LHWs' within their respective areas
3	LHW Programme Coordinator, Balochistan	Information about areas covered by the MCW initiative and LHWs' within their respective areas
4	LHW Programme Coordinator, GB	Information about areas covered by the MCW initiative and LHWs' within their respective areas
5	LHW Programme Coordinator, FATA	Information about areas covered by the MCW initiative and LHWs' within their respective areas
6	LHW Programme Coordinator, AJK	Information about areas covered by the MCW initiative and LHWs' within their respective areas

Documents reviewed by the evaluation team

Sr. #	**Author**	**Document**
	Government of Pakistan & USAID, 2012	Pakistan National Maternal and Child Health Programme Mid-Term Evaluation
	USAID Global Health Technical Assistance Project, 2013	USAID/Pakistan: Maternal Newborn and Child Health Programme Final Evaluation
	Tamar Gotsadze, Chiara Zanetti &	Formative Evaluation of Improvement of Mother and

	Maia Makharashvili, 2011	Child Health Services in Uzbekistan
	Zulfiqar A. Bhutta, Assad Hafeez, Arjumand Rizvi, Nabeela Ali, Amanullah Khan, Faatehuddin Ahmad, Shereen Bhutta, Tabish Hazir, Anita Zaidi & Sadequa N Jafarey, 2013	Reproductive, maternal, newborn and child health in Pakistan: Challenges and opportunities
	Pakistan Bureau of Statistics, 2016	Pakistan Economic Survey 2015-2016 (health and nutrition)
	DAC Network on Development Evaluation, 2006	DAC Evaluation Quality Standards
	T. Akhtar, Z. Khan & S. Raoof, 2014	Community participation eludes Pakistan's maternal, Newborn and child health programme.
	WHO & Agha Khan University Pakistan, 2011	Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health
	Jessica Davis, Joseph Vyankandondera , Stanley Luchters, David Simon & Wendy Holmes, 2016	Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific
	WHO, 2017	Ambition and action in nutrition 2016–2025
	Shabina Ariff, Sajid B. Soofi, Kamran Sadiq, Asher B. Feroze, Shuaib Khan, Sadiqua N. Jafarey, Nabeela Ali & Zulfiqar A. Bhutta, 2010	Evaluation of health workforce competence in maternal and neonatal issues in public health sector of Pakistan: an Assessment of their training needs
	Rural Support Programme Network (RSPN), 2014	The Role of Community Spaces and Mechanisms in Health Promotion amongst the Poor Communities in

		Rural Pakistan 2014
	Paulin Basinga, Paul Gertler, Agnes Binagwaho, Agnes Soucat, Jennifer Sturdy, Christel Vermeersch, 2011	Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation
	UNICEF & Government of the Pakistan, 2014	KAPB National 2014. A study to identify drivers of inequities and barriers to access and utilization of immunization services for improved immunization coverage and outcomes in Pakistan
	Bureau of Statistics, Planning & Development Department, Government of the Punjab, 2014	Multiple Indicator Cluster Survey Punjab2014
	Mobile Alliance for Maternal Action, 2012	Global Monitoring and Evaluation Framework
	Liverpool School of Tropical Medicine Centre for Maternal and Newborn Health, 2016	Independent Evaluation of the Health Transition Fund in Zimbabwe
	Musa Abubakar Kana, Henry Victor Doctor, Bárbara Peleteiro, Nuno Lunet & Henrique Barros, 2015	Maternal and child health interventions in Nigeria: a systematic review of published studies from 1990 to 2014
	Government of the Pakistan, 2014	National Health Vision Pakistan 2016-2025
	USAID, 2015	Strategies to Strengthen Community Maternal, Newborn and Child Health: Findings from a Cohort of Child Survival and Health Grants Ending in 2014
	Government of the Pakistan & UNICEF, 2012	Situational Analysis of children and women in Pakistan. National Report 2012
	UNICEF Nigeria, 2016	Evaluation of Maternal Newborn and Child Health Programme in Nigeria.

	Pakistan Bureau of Statistics Division Government of Pakistan, 2010	National Health Accounts Pakistan 2009-10
	Pakistan Bureau of Statistics Division Government of Pakistan, 2014	Pakistan national health accounts 2011-12
	Ferguson, Webster, Yohanna-Dzingina, Akinyele and Adeyemi, 2014	What are the barriers to attendance to the MNCHW and how can these be reduced?
	NIPS, USAID & Government of Pakistan, 2013	Pakistan Demographic and Health Survey 2012-2013
	USAID, n.d.	Building Capacity to Improve Maternal, Newborn, and Child Health and Family Planning Outcomes
	UNICEF Programme Division, 2015	UNICEF Strategy for Health 2016-2030
	UNICEF Pakistan, 2017	Pakistan Annual Report 2016
	Maternal and Newborn Child Health (MNCH) World Vision Australia's policy, 2017	World Vision Australia's position on maternal and newborn child health
	UNICEF, National EPI Programme, Ministry of Health Pakistan, 2008	Child health and sanitation week 2008

Annex 7. Terms of Reference (ToR)

unicef

Terms of Reference (ToR) for Consultancy Services

(Individual and Institutional)

Pakistan

Requesting Section/Field Office: Health/PMER, Islamabad

PROGRAMME AREA & SPECIFIC PROJECT INVOLVED: (Specify programme area and project activity under the approved Work Plan)

Output 1: Strengthened political commitment and national capacity to legislate, plan and budget for children.

Activity: FED-H-1.9: Provide Technical Assistance to government for a comprehensive review of Maternal Child Week intervention including an exit strategy for UNICEF support beyond 2017

NATURE & PURPOSE OF CONSULTANCY:

☐ Study ☐ Documentation ☐ Facilitation ☐ Technical ☒ Evaluation

☐ Clerical/Secretarial ☐ Others

Context and Description of Object of the Evaluation

In 2011, the 18th Amendment of Pakistan's constitution fully devolved the subject of health to its provincial governments. The then Ministry of Health, Pakistan was dissolved. Most of the previous national health programmes were re-established as provincial health department programmes. In the absence national coordination and faced with different and complex provincial realities, laws, and guidelines, many of these programmes evolved differently across the provinces. In 2013, the Ministry of National Health Services, Regulations and Coordination (MoNHSRC) was established. With that, the national health sector visioning, coordination, and regulation are strengthening. These political developments are relevant for the evaluation. The Maternal and Child Week (MCW) strategy was adopted in Pakistan in 2007 when the country had a national ministry of health. In 2011, the National Programme for Family Planning and Primary Health Care was devolved and the coordination of the MCW moved into the respective provincial and area departments of health.

The MCW was developed to help Governments, departments of health and development partners to fulfil the health related rights of children. In the case of Pakistan, the rights of children are embedded within the Articles of

the Convention on the Rights of the Child (CRC), ratified by Pakistan in 1990. The health-related CRC Articles include: Every child has a right to life (Articles 6, 23, 24); every child has the right to the highest attainable standard of health and medical care (Articles 3, 6, 17, 23, 24); and every child has the right to a standard of living adequate for her or his holistic development (Article 27). The rights are also embedded previously in the Millennium Development Goals (MDGs) and presently as part of the Sustainable Development Goals (SDGs); the country's Vision 2025; its National Health Vision 2016-2025; previously in the One UN Programme I (2009-2012) and presently in the One UN Programme II (2013-2017); and UNICEF strategic plans 2006-2013 and 2014-2017. Collectively, these instruments and as appropriately adapted for Pakistan define the country's social economic and political parameters. The adapted health sector related strategies and frameworks guide the country's response to the health outcomes in the country with a particular focus on women and children.

The survival of children in Pakistan is currently undermined by poor access to immunization services, as demonstrated by the statistic of 54 per cent of children aged 12-23 months being fully immunized nationally.[6] There are huge provincial and rural disparities by virtue of their geographic location and existence of other access barriers given their low social economic status. The disparities are reflected in the provincial EPI coverage data which shows that the proportion of full immunization coverage in Punjab stands at 65.6 per cent; whereas, while it is only 16.4 per cent in Balochistan. The survival of children and women is further undermined by poor access to and utilization of quality maternal and new-born care services. The skilled birth attendance rate is 52 per cent and the high national neonatal mortality rate is at 55 per 1,000 live births[7]. The limited access to these life-saving interventions is further complicated by huge disparities between provinces, income, rural/urban locations and level of education, particularly of mothers.

New-born girls and boys are dying of conditions that could be managed within households (low birth weight, hypothermia, sepsis) as well as other conditions that require interventions in health facilities (birth asphyxia, prematurity). Neonatal survival is further complicated by other poorly performing cross-sectoral family care practices and interventions, including sub-optimal breastfeeding, hygiene and sanitation. The net effect of the maternal and child survival dynamics is that each year an estimated 432,000 children under-five and 20,000 mothers die due to causes related to pregnancy and child birth. Among the under-five deaths, two-thirds are in the newborn period (first 28 days of life) and the remaining are largely due to diarrhoea (11 per cent) and pneumonia (13 per cent). In general, the number of cases of diarrhoea start rising in April and peak around July/August each year and for pneumonia, the cases start rising in October with a peak around November each year. About 70,000 children in Pakistan die due to diarrhoea, every year. Most of these precious lives can be saved by simple knowledge about prevention and promotion of some key measures at home and health care seeking practices.

[6] PDHS 2012-2013, op.cit.
[7] Ibid.

As a response to the adverse maternal, new-born and child health outcomes, the National Programme for Family Planning and Primary Health Care and the Expanded Programme of Immunization, Ministry of Health in collaboration with UNICEF initiated MCWs in three districts of Punjab in 2007. In 2008, the intervention was scaled up to six districts in Punjab, and In April round of 2009, 29 districts of the country were involved. Based on the results of the pre and post MCW assessment of April 2008 round, the decision to scale up the activity to a nation-wide scale was taken by the Ministry of Health. As at April 2012 a total of ten rounds of MCWs had been completed. The two week campaign is organized bi-annually, first week- round in the month of April and the other week-round in October of every year. Each of the rounds are focused on either diarrhoea or pneumonia. These are the two major killer diseases of under-five girls and boys in Pakistan.

Object of the evaluation

The evaluation seeks to assess the extent to which MCW strategy fulfilled its intended objective of strengthening the delivery of routine maternal and child health services while at the same time improving access to the services to marginalized, excluded, crisis and disaster-affected populations. The evaluation will seek to bring out any differences in the execution of the MCW strategy before 2011 when it was managed through a national programme and the period after 2011 when the MCW became a provincial subject. The evaluation also seeks to reveal insights into the institutionalization of MCW strategy by the provinces, if any, as well as its sustainability or potential for sustainability.

2.2.1. Interventions

The MCW strategy was established to mobilize existing public health service network to reach out to communities twice a year to provide opportunity for increasing coverage of health interventions and to promote appropriate evidence based cost effective family care and health care seeking practices. The MCW package include:

- Immunization for every child 0-2 years;
- Deworming for every child 2-5 years;
- Tetanus toxoid vaccination for all pregnant women
- Community/ mothers' awareness about exclusive breastfeeding, complementary feeding, immunization, recognition of danger signs of pneumonia and diarrhoea, hygiene and sanitation, birth spacing and use of Iodized salt.

The Mother and Child Week event utilizes primarily the existing network of Lady Health worker Programme and EPI Programme to deliver the interventions. With the exception of deworming of children, the interventions delivered are those that are already part of existing government programme. A modified version of Mother & Child Weeks were also implemented to deliver package of services in limited scale, initially to the crisis-affected population and then to the flood affected population. The coverage for each of the round is assessed using data from administrative reports and post campaign coverage done by the Health Management Information System of Ministry of Health.

2.2.2. Programme Logic Model/ Theory of Change

We do not have a record of the logic model or theory of change for the MCW strategy when originally conceived in 2007. The construction of the model retroactively will be included as part of the deliverable under these terms of reference. A desk review of any available secondary data sources and documents will be undertake to inform the construction of the model. Through a participatory process, the people who participated in the introduction of the MCWs in Pakistan will help to validate and finalize the modeling.

2.2.3. Key stakeholders

The key stakeholders include the Federal Director General of Health; Director of Programmes; National Immunization Programme; National Health Emergency Preparedness and Response Network; National Polio Emergency Operation Centre (EOC); and the respective Provincial, Area, District Departments of Health and Polio EOCs. The partners will include WHO, UNFPA and the donor community represented in the Health Population and Nutrition donor coordination forum.

The evaluation will be steered by a selected sub-committee of the national RMNCH taskforce, chaired by a representative of the DG-Health, Government Nutrition programme and with representation from UNICEF health, nutrition, WASH, social policy, C4D and PMER sections, WHO, and the provinces/areas. The TORs for the steering committee include, among others, the following responsibilities:

- Review and approve key deliverables of the evaluation, including the inception report, evaluation plan and final reports.
- Review plans for the data collection, instruments and tools as required and if needed.
- Provide timely feedback on draft reports, including comments from peer reviewers to the service provider or through any appropriate means as mutually agreed.
- Approval of the final report based on the fulfillment of quality standards/criteria agreed the inception report.
- Recommend approval/rejection of specific recommendations emerging from the report, and provide management response.
- Develop minutes of the meeting including all relevant decisions.

2.2.4. Purpose of Evaluation

The purpose of the evaluation is to assess the extent to which MCW strategy fulfilled its intended objective of strengthening the delivery of routine maternal and child health services while at the same time improving access to the services to marginalized, excluded, crisis and disaster-affected populations. The evaluation will document the process, strengths, weaknesses and challenges observed out of the implementation of the MCWs. The evidence from the implementation of the MCWs over the period of 10 years will used to inform Federal and

provincial Government decisions on investing in the MCWs. The Government audience for the evaluation will therefore include the federal DG Health as well as the provincial DGs including senior programme managers of the lady health workers programme, maternal child health, and the EPI programme. In addition, the evidence from the evaluation will help define UNICEF's position and ing for the MCWs. Other development partners are also likely to benefit from the evaluation findings in their programming.

2.2.5. Evaluation Objectives

Taking into account gender, equity, and child rights consideration, the summative evaluation seeks to:

- Assess the extent to which the MCWs implementation followed the intended plan.
- Assess the process and lessons learned during the period 2007-2011 when MCWs implementation transitioned from small scale piloting to nationwide implementation in 2012 and thereafter.
- Assess the extent to which the MCWs met the basic health needs and rights of women, girls and boys- they being the intended primary beneficiaries, and whether there were any unintended outcomes.
- Determine the extent to which the MCWs helped to mobilize communities to utilize and strengthen routine health services.
- Establish the extent to which the MCWs addressed the needs of marginalized, excluded, crisis and disaster-affected populations.
- Provide a descriptive cost analysis for the intervention.
- Identify lessons learned, exploring what has worked well, what has not worked as well and make recommendations including on the strengthening of gender programming, equity, and child rights.

2.2.6. Scope of Evaluation

The evaluation will cover the 11 years period 2007 to the end of 2017. The aim is to deliver a national evaluation but with clear provincial/ area differentiation.The evaluation will cover the period starting in 2007 when MCWs were first implemented in Pakistan to the end of 2017. It is noted that the period 2007-2011 was used mainly for piloting of the MCWs in a few districts in Punjab before its national scale implementation starting in 2012. The evaluation will therefore cover all the 4 provinces and 3 Areas.

2.2.7. Evaluation Criteria

The evaluation will use the UNEG standards for an impartial, coherent and effective evaluation. The OECD/DAC criteria - including relevance, efficiency, effectiveness, impact (long-term outcomes) and sustainability - will be used to assess the programme. The evaluation measures the criterion of impact as long term outcomes and is not intended as a counterfactual, experimental, impact evaluation. Additionally, cross cutting issues will also be used as part of the evaluation criteria in this exercise.

2.2.8. Major Evaluation Questions as per UNEG Criteria

All major evaluation questions are given in the following under the OECD/DAC criteria. Other key questions regarding evaluability and significant areas are provided in the enclosed matrix as Annex. 1 for the evaluation team to consider, use and refine.

2.2.8.1. RELEVANCE

How relevant and meaningful are the programme objectives and activities in terms of addressing the needs and priorities of marginalized and vulnerable children, men and women, in the programme areas?

To what extent the strategies used in this programme are relevant to national (Government of Pakistan) priorities and policies related to MNCH issues addressed under the programme?

How relevant is the selection and targeting of project areas (districts and villages) with regard to programme objectives?

2.2.8.2. EFFECTIVENESS

To what extent has the implementation of strategies and programme approaches worked as intended and whether they were appropriately designed and delivered?

How effectively UNICEF engaged with the Government to strengthen coordination and how far government leadership and political will influenced the achievement of results, or vice versa?

How effectively UNICEF engaged with relevant UN and CSO partners to strengthen coordination to align results with them and achievement of results, or vice versa?

How successful was UNICEF in reaching the most vulnerable groups in the target areas?

What other changes (positive/negative, direct/indirect, intended/unintended) have occurred as a result of this programme over the last ten years?

2.2.8.3. EFFICIENCY

How well have UNICEF's resources, both human and financial, been managed to ensure the timely, cost-effective and efficient attainment of results?

2.2.8.4. IMPACT (Long-term Outcomes)

To what extent has the programme achieved its objectives and what were the major factors influencing the achievement or non-achievement of the objectives/outcomes?

To what extent the programme learned and evolved over the years and whether there were other alternative, more cost-effective strategies available to reach intended results?

How successful was UNICEF in reaching the most vulnerable groups in the target areas?

2.2.8.5. SUSTAINABILITY

To what extent the government is willing to support the continuation of programme activities if and when

UNICEF funding stopped?

To what extent has the programme contributed to the strengthened capacity of duty bearers / service providers?

What internal/external factors and drivers contribute to or constrain the sustainability of the programme?

2.2.8.6. CROSS CUTTING AREAS (GENDER, EQUITY, HUMAN RIGHTS, DRR)

To what extent are cross-cutting issues such as gender, equity, HRBA and DRR incorporated at various levels of planning and implementation?

2.2.9. Evaluation Methodology

The overall research method will adopt mixed qualitative and quantitative inquiry and participatory in nature. During the Inception phase, an evaluability assessment will be conducted. The main objective of the evaluability assessment is to determine the best evaluation approach and design for the evaluation, considering the constraints of time, budget and methods. Also during the inception phase, the logical framework/ theory of change for the MCWs will be reconstructed retroactively. To the extent possible, the reconstruction will pull together the anticipated indicators, targets, outputs, and outcomes. And thereafter used to guide the rest of the evaluation process.

The third party consultants will develop the data collection and analysis strategies and plans for presentation and approval by the steering committee once the evaluability is concluded. This will include a data collection and analysis plan, in which the procedures related to the data to be analysed under the evaluation design will be described and detailed. The sources of information that will be used in the course of the evaluation are as follows:

- National surveys (MICS and PDHS)
- Reports of Reviews of the MCWs
- Report of provinces annual health sector reviews
- Provinces health sector stocktaking reports where they exist.
- Trip reports of personnel participated in monitoring and review of MCWs activities
- Key informant Interviews, focus group discussions
- Any other sources as advised by the steering committee and team of consultants.

The data analysis plan is integral part of evaluation plan. Data collection phase, during which the great majority of new data acquisition, aligned with the approved evaluation plan and design and the major analytic work is completed. This shall include sample size and selection; household survey, focus group, data collection at the community level and related field work, as relevant.

The consultants will draft a report for comments and approval by the steering committee. Then a final evaluation report addressing all comments should be submitted within a month to UNICEF and to the steering committee for approval. It is expected that the evaluation design will deal with the four dimensions of quality of impact

evaluation and the proposal will demonstrate how it will successfully address the following:

- Statistical conclusion validity;
- Construct validity;
- External and internal validity.

The evaluation might be limited for various reasons. There is no guarantee that all data concerning the MCWs will be retrievable since the inception of the strategy in 2007. The devolution of the Ministry of Health functions to provinces in 2011 might make it difficult to access the MCWs related data. The evaluation will be conducted in the absence of a baseline evaluation, formative evaluation, and evaluability assessment at its initiation. The logical framework and theory of change were also not designed before commencement of the implementation.

2.10. Presentation of data and report:

In preparing the results of the evaluation, the findings will be evidence-based and have clear references to respective sources. The structure and quality of the evaluation report must adhere to UNICEF quality standards, and include the following report structure:

- Title page
- Table of contents
- Executive Summary, including the purpose of the evaluation, key findings, conclusions and recommendations in priority order (3-4 pages)
- Background/context of the evaluation, including a description of project interventions, log frame/results matrix
- Purpose and objectives of the evaluation
- Scope of the evaluation
- Limitations and mitigation strategies
- Evaluation criteria and key questions
- Methodology
- Findings per criteria
- Conclusions and recommendations, explicitly linked to the findings
- Lessons learned

The final report should follow the UNICEF Evaluation Report Standards and will be reported on UNICEF's global reporting system known as GEROS. The selected evaluation team will receive these guidelines at the first meeting following issuance of the contract.

2.11. Evaluation Ethics

Children remain the most significant yet sensitive group of respondents to inform the evaluation, therefore, the evaluation team must use ethically sound, child sensitive methods when engaging with boys and girls.

Accordingly, *UNICEF's Protocol on Ethical Standards in Research and Data Collection* will be strictly adhered to during the entire process of evaluation and with regard to training the evaluation field teams. In addition, all participants in the study will be fully informed about the nature and purpose of the research and their requested involvement. Appropriate consent form will be used to elicit written consent from research participants. The *'Do no harm'* principle must also be applied throughout, especially when working with respondents. The Evaluation will follow Government of Pakistan and UNICEF guidelines on the ethical participation of children. Specific mechanisms for feeding back results of the evaluation to stakeholders will be included in the elaborated methodology.

All the documents, including data collection, entry and analysis tools, and all the data developed or collected for this study/consultancy are the intellectual property of the UNICEF. The Evaluation team members may not publish or disseminate the Evaluation Report, data collection tools, collected data or any other documents produced from this consultancy without the express permission of, and acknowledgement of UNICEF Pakistan.

2.12. Evaluation Management and Logistics

UNICEF's Programme Monitoring, Evaluation and Reporting (PMER) Section will be responsible for leading the evaluation process, with active support from Health Section to coordinate evaluation activities within the provinces. An evaluation Reference Group will be established including all key stakeholders to oversee and assure the quality of key deliverables. UNICEF's standard Terms of Reference for the said Reference Group will apply and participation will include representatives from UNICEF programmes, and key stakeholders. The selected evaluation team will be responsible for all aspects of the evaluation, including refining the sampling strategy, adapting and designing data collection tools, coordinating data collection in the field (including trainings for enumerators), ensuring quality of data, including managing enumerators and proper administration of the survey tools, data entry, and analysing quantitative and qualitative data. The evaluation team will also be responsible for all logistics, including field movements, local accommodation, vehicles etc. However field visits and data-collection will be facilitated by focal persons within the programme's provincial coordination teams, as nominated by UNICEF. PMER will also assure the quality of field work through field observations.

UNICEF's provincial PMER and focal points and relevant IPs (where applicable) will be identified to help organize the interaction with district stakeholders, including local communities. UNICEFs focal points will extend all reasonable support necessary to facilitate activities uninterrupted, including the provision of clear and unambiguous details of target villages in the cotton farming areas and linkages with relevant stakeholders. Throughout the delivery of field activities, the consultant will remain in constant communication with PMER, UNICEF-nominated focal points and field staff, as identified in due course.

2.12.1. Accountabilities

i. PCO-PMER and Health:

PMER will lead the evaluation process. Chief of Health and his team in Islamabad will provide all key documents, contact points and arrange meetings with government and other counterparts in Islamabad. They will ensure smooth coordination of activities throughout the evaluation process. A Reference Group (as mentioned above) will be established to oversee the evaluation process.

ii. Field Office:

The UNICEF Field Office PME Specialists will support PMER Islamabad as requested and the Health Specialists in all provinces will support the Health Section and serve as the primary contact persons with the evaluation team. They will provide the documents, necessary technical guidance and logistic support and serve as a link with PCO.

iii. Regional Office

The Regional Office will be invited to peer review the TORs and draft deliverables.

2.12.2. Evaluation team roles/responsibilities

The evaluation team should be composed of a team leader international or national and a team of national evaluators to assist him/her. The team leader will be responsible for the overall oversight of evaluation and quality issues while the team of evaluator shall assist the team leader in carrying out the assignment, including but not limited to facilitating logistics, meetings, interviews with stakeholders and identifying/accessing relevant data sources. Based on detailed roles and responsibilities, as will be mutually agreed and approved by the Approving Authority, detailed responsibilities of both parties will be further elucidated once selection is made.

The proposal should demonstrate a mixed team (international and national) composition with solid and relevant experience in both high quality evaluations and related sectors (Health, Immunization and nutrition).

2.12.3. Procedures and logistics:

The evaluator/evaluation firm will determine the logistics support required to execute the assignment. The requirements should be briefly outlined in the inception report and agreed to by UNICEF for inclusion in entitlements payable.

2.13. Proposed evaluation tasks:

The key evaluation tasks:

- To refine the theory of change and scope of the intervention;
- Develop an inception report containing a detailed Evaluation Plan and design that address the specific evaluation questions proposed here, relevant indicators, data collection methods and present evaluation design options to meet the quality expectation for approval by the Project Authority (UNICEF);
- Undertake a comprehensive desk review of the MCWs and similar approaches in Pakistan and other countries in the sub-region to establish a rich knowledge base to facilitate comparisons and proffering of solutions to identified shortcomings;
- Consult and work with stakeholders at the national, province and sub-province levels through all

available means (email, teleconference, in-person meetings, etc) to gather primary information/data and corroborate other information provided by stakeholders at other levels;

- Periodically review the evaluation plan and provide updates to ensure timely and transparent delivery.
- In good time, inform UNICEF of any significant modifications to the intervention/project that could affect the evaluation and any difficulties that may arise in implementing the approved evaluation design;
- Provide at least one progress report and prepare the evaluation report described in the agreed Deliverables.
- Undertake any reasonable task associated with the evaluation within the period of engagement.
- The evaluation plan will have to identify the project's capacity and determine whether the requirements/assumptions for cost-effectiveness analysis are present.
- Conduct a cost-effectiveness analysis if the requirements or assumptions are met.

2.14. Deliverables:

An inception report, detailing the evaluation design and detailed work plan and cost. Given the evaluation will be province/area specific, the evaluation design and detailed plan will reflect that.

Periodic updates and a final Evaluation by province/ area. Report, which should include:

- Executive summary
- Methodology: description of sampling and evaluation methodology used, assessment of methodology and its limitation, data collection instruments, and data processing (analysis methodology, and quality assurance)
- Findings;
- Conclusions;
- Recommendations;
- Lessons learned;
- Annexes: List of indictors, questionnaires, and if survey, table of sample size and sample site as appropriate

The report should be provided in both hard copy and electronic version in English in the required UNICEF format.

Completed data sets (filled out questionnaires, records of individual interviews and focus group discussion, etc.)

The evaluation report will be required to follow and will be rated in accordance with Government of Pakistan policy and "UNICEF Evaluation Report Standards" and UNICEF Evaluation Technical Notes.

- Estimate the cost and prepare a detailed budget. Note the source of funds. Link the budget to the key activities or phases in the work plan. Cost estimates may cover items including:
- Travel
- Team member cost: salaries, per diem, and expenses

- Payments for translators, interviewers, data processors, and secretarial services.
- Training cost and printing of material if relevant
- Estimate separately any expectations in terms of time costs for:
- Staff (before, during, after)
- Other stakeholders meetings, including for primary stakeholders.
- UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, not delivered or for failure to meet deadlines.

2.15. Most likely risks and mitigation measures

The evaluation proposal should provide information on how the team foresees numerous potential risks and constraints which may affect the evaluation and respective mitigation measures should also be provided to ensure a robust evaluation process and outcome e.g. data quality, consistency and others.

Timing presents a major risk for this evaluation. Time for data collection might be tight. Country office including Field offices support will be necessary to ensure that time spent in country is well used and documentation sharing happens well before arrival, so that consultants can quickly begin with data collection and logistical issues resolved prior to arrival. In addition, bidders are encouraged to be forthright about whether they recommend a longer period, or the compromises they project emerging if that duration is maintained.

REASONS WHY THE ASSIGNMENT CANNOT BE DONE BY A UNICEF STAFF MEMBER:

This is a complex assignment that require an institution with diverse technical capacity to undertake. The assignment require multiple data collection and analysis. The participatory nature of consultancy will involve concurrent meetings at the federal and in the provinces and areas. For all these, multiple skill sets are required and given that the assignment will be delivered in a period of 2-3 months, a UNICEF staff or team may not efficiently and effectively deliver on the assignment. Furthermore, the use of UNICEF staff members or team might call for additional recruitment of skill sets that normally do not sit in UNICEF. For this, more time will be needed. The 2-3 month deliver period might therefore not work with UNICEF staff direct execution.

WORK ASSIGNMENTS, DELIVERABLES & PAYMENT SCHEDULE

Task to be Performed (Indicate expected work to be performed.)	**DELIVERABLE(s)** *(Specify final outputs.)*	**WORK SCHEDULE** *(Month/period covered)*	**TERMS OF PAYMENT** *(No more than 30% advance/* ***Final payment no less than 10%)***
Inception mission and evaluability assessment	**D1:** Final Inception report including the evaluability assessment, logic model/ theory of change, the proposed approaches, methods, and tools	15 days	30%
All stakeholders' workshop to present the tools and incorporate comments of stakeholders on the inception report and tools Pre-test and finalize the tools.	**D2:** Final hard and soft copies of pre-tested tools and field guides for surveyors	10 days	30%
Train field survey teams to use the field guide and survey tools to conduct the survey	**D-4**: Survey team training report	5 days	
Conduct data collection	**D-5**: Data collection completion report	20 days	
Carry out data entry, data cleaning and data analysis	**D-6**: Cleaned data sheets in MS excel to be shared with FP & PHC and UNICEF	10 days	
Report writing and submission of draft report	**D-7:** First draft report, electronic copy in editable format	15 days	15%
Presentation of draft report to the MoNHSRC, UNICEF, and provincial Stakeholders	**D-8:** Draft report sharing seminar/workshop for approximately 40 participants	5 days	
Incorporation of comments of Stakeholders consultation	**D-9:** 2nd draft report submission, electronic copy in editable format and as hard copies	3 days	
Incorporation of comments of UNICEF Regional peer review. Incorporation of any final comments from the steering committee	**D-10:** End assignment report as specified below: Three signed hard copies Electronic copy in editable format and PDF format Cleaned raw data entered in MS excel or other format that can be transferred to other software	2 days	25%
	Total	**85 days**	100 %

TOR FOR STUDIES AND EVALUATIONS REVIEWED AND ENDORSED BY THE PROGRAMME MONITORING, EVALUATION AND RESULT (PMER) SPECIALIST: *(Please tick)* ☒ Yes ☐ No

ESTIMATED DURATION OF CONTRACT *(Indicate start of contract but not earlier than CRC: if CRC is required):*

Weeks	**Description of activities**
	Inception phase
1-3	Inception mission and evaluability assessment
4	Inception report the results of evaluability assessment and proposed approaches and methods
5	Review of the study plan, protocol, analytical framework and indicators by steering committee
6	Feedback and revision; acceptance of the inception report
	Data collection phase
7- 11	Data collection phase: preparation (conception of household survey, pilot the survey, training of enumerators, etc.) and execution. In the field.
	Data analysis and report
12-13	Preparation and submission of draft report
14	Steering committee/UNICEF peer review and feedback on draft report
15	Preparation and submission of final report

OFFICIAL TRAVEL INVOLVED *(Specify if international or domestic travel will be required of the consultant/contractor): N.A*

7.1 ☒ Local Travel ☐ International Travel

7.2 Anticipated Travel Itinerary (Annex 1 – Please complete Travel Plan template):

QUALIFICATIONS OR SPECIALIZED KNOWLEDGE/EXPERIENCE REQUIRED *(Indicate skills and qualifications requirement):*

The selected firm/consultant must possess the following qualifications, abilities and qualities:

At least a Ph. D or Master's degree or its equivalent in the field of public health, epidemiology, biostatistics or social sciences from a recognized institution;

Demonstrated experience in conducting high quality, UNEG standard evaluations

Excellent report writing and analytical skills

Previous experience in carrying out impact evaluations for MCW or similar public health interventions is an advantage;

Sound capacity and experience in planning and organizing evaluation logistics;

Strong capacity in data management and statistics;

Adequate background in microeconomics, statistics and econometrics;

Excellent track record in partnering with African survey or equivalent firm(s) to conduct field work or research;

Excellent track record of working with Sub-Saharan African clients, including Governments;

Good will be an added advantage

Additional requirements

Experience of working in and understanding of the Pakistan health care architecture and systems will be an added advantage

Ability to work in a multicultural environment and teamwork are also desirable

Relevant advanced Public health expertise for at least 10 years.

Experience of conducting trainings

Strong relevant analytical , oral and written communication skills

Understanding of UNICEF mandate and activities

Effective facilitator with proven ability to engage and train a group of individuals

Demonstrated ability to work in multi-cultural environment.

Knowledge and understanding of the manual on Care of the Newborns at home would be an added asset.

TECHNICAL EVALUATION CRITERIA AND WEIGHT ALLOCATION BETWEEN TECHNICAL AND PRICE PROPOSAL

Technical 70 per cent and Price 30 per cent.

Technical Proposal (70 per cent): Tender should be structured as per given details:

The criteria for evaluation shall include:

Proposed Technical Criteria		
S. No.	**Technical Evaluation Criteria**	**Max. Points**
1	**Overall Response** (e.g. the understanding of the assignment and the alignment of the proposal with the ToR)	**20**
1.1	Completeness of response	10
1.2	Overall concord between RFP requirements and proposal	10
2	**Company and Key Personnel**	**40**
2.1	Range and depth of organizational experience in evaluations (performance, impact, others) with similar projects in social sector (such as health, immunization, nutrition)	10
2.2	Specific work experience on evaluations in health sector under UNEG criteria with Government of Pakistan or UN agencies.	10
2.3	Key personnel's relevant experience and qualifications of the proposed team leader and other members in health and evaluations under UNEG criteria), report writing and	20

	facilitation skills)	
3	**Proposed Methodology and Approach** e.g. Work plan showing detail sampling methods, project implementation plan in line with the project	**40**
3.1	Proposed methodology, approach and work plan for the tasks as per the ToR	25
3.2	Implementation strategies, participation of key stakeholders, quality control mechanism	10
3.3	Innovative approach in addressing data gaps	5
TOTAL TECHNICAL SCORES		**100**
Minimum technical required score: 70		

Financial Proposal (30 per cent): Tender should be structured as per given UNICEF Pakistan Supply Section template.

SUPERVISION:

Name of Supervisor:

Mussarrat Youssuf, Research and Evaluation Specialist, PMER Section, Islamabad

Type of Supervision:

Close supervision for quality assurance for the evaluation process through provision of evaluation related guiding documents, reviews of deliverables, provision of detailed feedback and comments. Health Section will support in providing all key documents, contact details of key stakeholders and ensure smooth coordination of evaluation activities.

11. TOTAL ESTIMATED COST CONSULTANCY: USD ---- (including fee, logistics, travel and all costs related to evaluation).

11.1. Is funding available? ☒ Yes ☐ No

If yes please state grant/WBS (Funding Source): **Non grant**

11.2. Details of Costs for this Activity: *(Includes consultancy fee, travel & any other anticipated costs)*

Cost description	Estimated cost of contract in USD
13.3 Proposed level of assignment	
13.4 Proposed fee (daily/ 81 days -3 months)	
13.5 DSA /other travel allowances (confirmed by admin /BTC)	
13.6 Economy class air ticket (confirmed by admin /BTC)	
13.7 Total estimates cost of contract (fee only)	

NATURE OF PENALTY CLAUSE TO BE STIPULATED IN CONTRACT:

(The clause provided in the contract should apply)

A maximum of 5-10 per cent deduction from pending contract fee if deliverables are unreasonably delayed.

PROPOSED COMPETITIVE SELECTION:

☒ Web roster ☐ Local Advert ☐ Inter. Advert ☒ Internet ☐ RO/HQ identified ☐ others – specify:

Important: Write-up on the competitive selection process followed with at least 3 P11/CVs (Individual Service Contract) or bids (Institutional Service Contract) **and the respective submissions.**

SIGN OFF/VALIDATION REQUIREMENTS:

Prepared by (Name/Signature/date):	Certified by (Name/Signature/date):	*Reviewed by(Name/Signature/ date) – If applicable
_____ Samia Rizwan Health Specialist	_____ Kennedy Ongwae *Chief of Section, Health*	_____ Mussarrat Youssuf Research and Evaluation Specialist

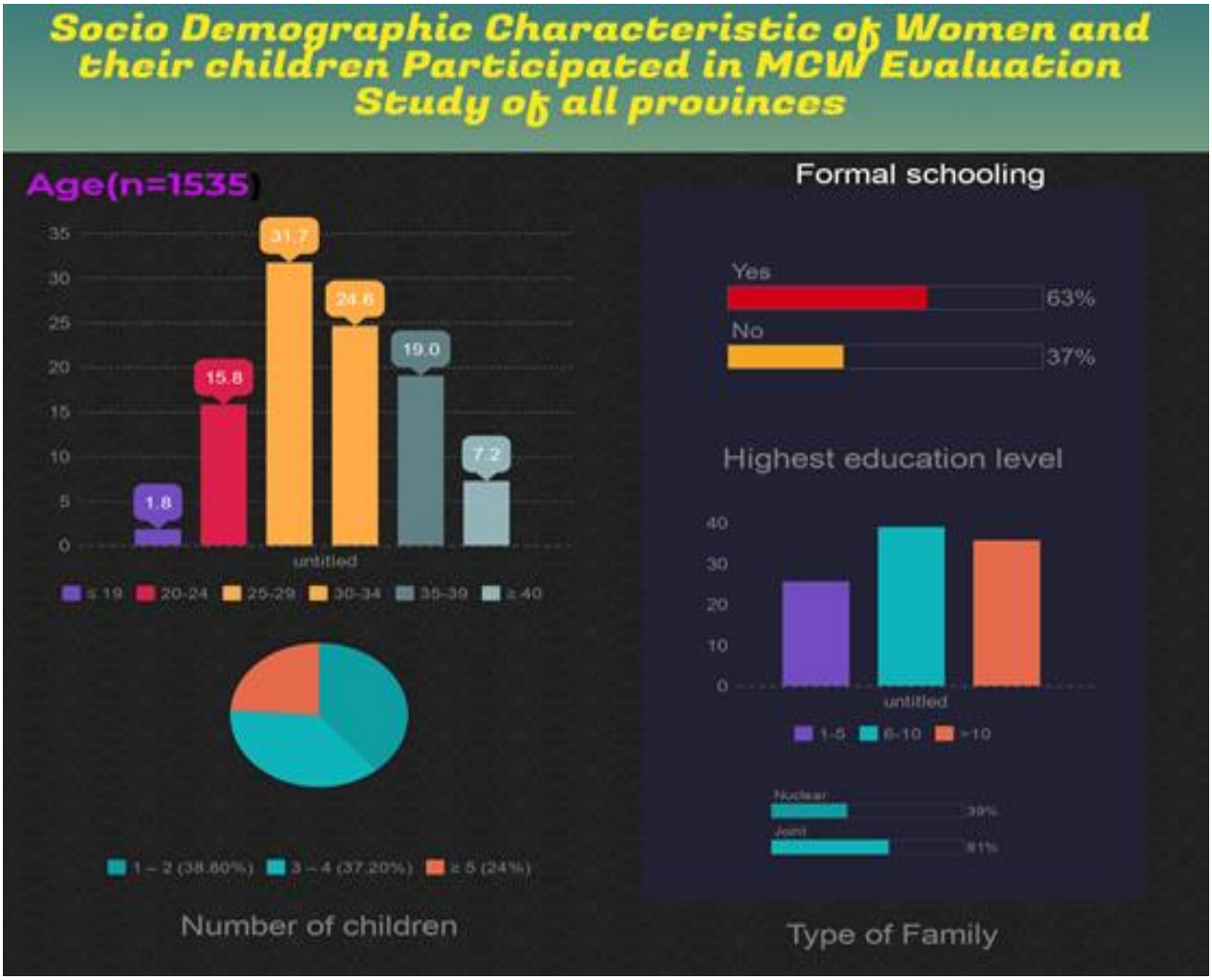
Recommended by (Name/Signature/date):	Authorized by (Name/Signature/date):
_____ ***Deputy Representative/Chief of Operations/ Chief of Field Operations*	_____ ****Representative/Deputy Representative*

Annex 8. Quantitative findings

This Annex presents the findings of the MCW evaluation's quantitative survey, which engaged women of reproductive age (15-49 years old) with at least one child under the age of five. Respondents were asked about their health seeking behaviours and utilization of MCW activities related to maternal, neonatal and child health. A total sample of 1,540 mothers participated in the survey.

Figure 36 shows the age and level of education of mothers for the entire sample. One-third (31.7 per cent) of respondents were between the ages of 25 and 29 years, while 1.8 per cent were under the age of 18. More than half (63.3 per cent) had some level of formal schooling.

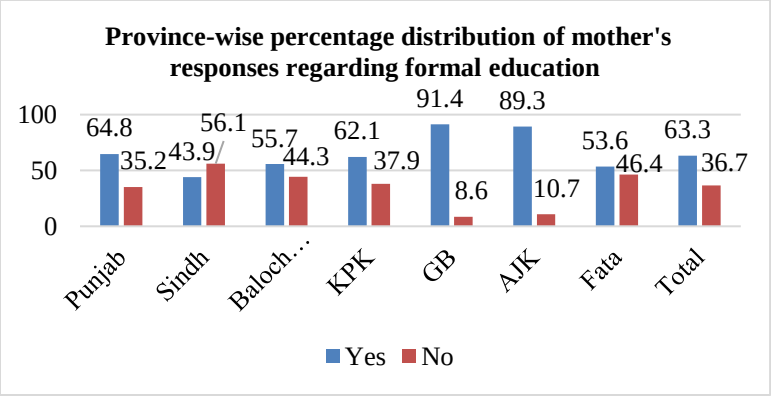
Figure 36: Mothers' socio-demographic characteristics



Trends across provinces reveal 91.4 per cent of respondents in GB were formally educated, followed by 89.4 per cent in AJK. Sindh had the fewest respondents (43.9 per cent) with a formal education (see Figure 37). One-quarter (25.5 per cent) of respondents had between one and five years of schooling, 38.9 per cent had between six and ten years of schooling, and 35.6 per cent were education past the 10th grade level. The highest proportion of respondents with over ten years of education was in GB (55.5 per cent), closely followed by AJK (50 per cent). FATA had the lowest proportion (9.3 per cent) of respondents with over ten years of formal education (Figure 37).

Data gathered on family size reveals that 38.8 per cent of respondents had one or two children, while 37.2 per cent had three to four children. More than half (60.8 per cent) of respondents live in a 'joint family system'.

Figure 37: Mothers' formal education by province/region



Alongside immunization, deworming was another key component of the MCW initiative. As discussed in the report, intestinal parasites are endemic worldwide (Mehraj et al., 2008), posing a major public health problem as 52 per cent of pre-school and schoolchildren are affected (Ensink et al, 2005). As Table 9 shows, 77.4 per cent of respondents reported that the benefits of deworming tablets were clearly explained to them during MCWs. A similar number reported receiving deworming tablets during MCW activities. Nonetheless, as with vaccinations, differences abound across provinces/regions. In almost all regions, except GB and Balochistan, the vast majority of respondents stated that both the benefits of deworming were clearly explained during MCW sessions and deworming tablets were provided. In Sindh, 96.7 per cent of mothers reported that the benefits of deworming were clearly explained, as did 91.9 per cent

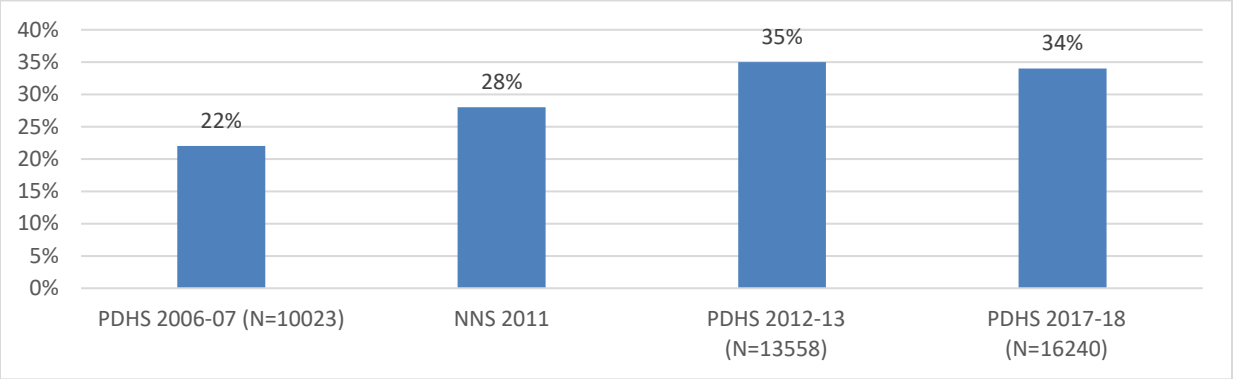
of respondents in AJK and Punjab. Similarly, 95 per cent of respondents' children in Sindh received deworming tables, as did 95.7 per cent in AJK and 94.8 per cent in Punjab. However, only 6.4 per cent of respondents in Balochistan and in 32.8 per cent in GB, reported receiving deworming tablets. This indicates that the deworming component of the MCW initiative was performed exceptionally well in all regions except GB and Balochistan.

Table 9: Mothers' knowledge of the use of deworming tablets (N=1540)

Characteristics	f	%
Benefits of deworming tablets explained during MCWs (N=1500) *		
Yes	1161	77.4
No	339	22.6
Children aged 2-5 years received deworming tablets in MCWs (N=1483)		
Yes	1153	77.7
No	329	22.2
Don't know	1	.1

Controlling unsustainably high birth rates is essential for ensuring better planning, resource sharing, maternal and child health, and development outcomes (Sami & Shaikh, 2012). The MCW initiative appears to have succeeded in raising awareness of family planning methods. Table 10 shows that 95 per cent of the respondents were aware of ideal birth spacing, although only 46 per cent could define what it means (i.e. 3-5 years). Over two-thirds (67 per cent) of respondents used contraceptives. The most commonly used contraceptives were condoms (48.3 per cent), injections (19.2 per cent) and birth control pills (16.5 per cent). Over three-quarters (76.7 per cent) of the women surveyed gained knowledge of family planning methods during MCW activities. Figure 38 depicts trends in the use of family planning methods across Pakistan between 2006 and 2017, indicating that their use gradually increased from 22 to 34 per cent. Among the survey sample, 67.3 per cent of respondents used family planning methods – roughly twice the national average.

Figure 38: Trends in the use of family planning methods, 2006-2018 (PDHS & NNS)



Nonetheless, significant provincial/regional variations exist. In some parts of the country, most respondents use family planning methods –85.7 per cent in AJK, 71.7 per cent in KP and 78.7 per cent in FATA – all far higher than the national average. However, performance was far poorer in other regions. Yet, overall, the MCW initiative proved successful in raising knowledge and eliciting positive practices related to family planning.

Table 10: Mothers' knowledge of family planning (N=1540)

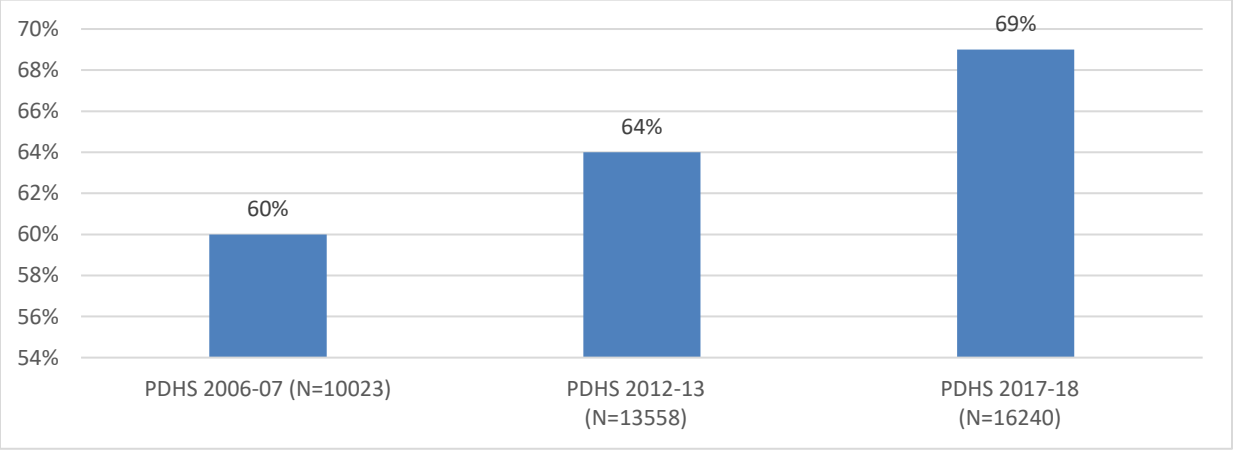
Characteristics	f	%
Knowledge about ideal birth spacing (N=1503) *		
Yes	1428	95.0
No	75	5.0
Ideal birth spacing (N=1432)		
1 year	68	4.7
2 years	663	46.3
3 years	628	43.9
5 years	34	2.4
More than 5 years	39	2.7
Use of contraceptives (N=1501) *		
Yes	1010	67.3
No	491	32.7
Type of contraceptives used (n=1010) *		
Condoms	488	48.3
IUD	55	5.4

Injections	194	19.2
Pills	167	16.5
Tubal ligation	23	2.3
Norplant	15	1.5
Withdrawal	38	3.8
Natural	19	1.9
None	11	.11
Information received on birth spacing practices during MCWs (N=1439) *		
Yes	1104	76.7
No	335	23.3

*The response is not 100% because of missing values.

The MCW initiative placed significant emphasis on TT vaccinations, while contribute to safe pregnancies and improved neonatal health outcomes worldwide (Park, 2009; Peeters et al., 2011). As Tetanus Toxoid is particularly prevalent in less developed countries (Vandelaer et al., 2003), WHO (2015) recommends a specific dose of TT vaccinations to prevent the infection. Table 11 shows that 77.5 per cent of the mothers reported that the benefits of TT vaccination were explained to them during MCW sessions and 91.9 per cent reported receiving the TT vaccination during their last pregnancy. As the figure below shows, Pakistan's *Demographic Health Survey (PDHS) 2017-18*, found that 69 per cent of mothers received TT vaccinations during pregnancy, a modest increase from 60 per cent in 2006 (see Figure 39). Hence, this points to the MCW initiative's success in providing women with access to TT vaccination.

Figure 39: Trends of TT vaccination during pregnancy, 2006-2018 (PDHS & NNS)



In most provinces/regions, survey respondents reported gaining knowledge about TT vaccinations during MCW sessions – 91.4 per cent in Punjab, 96.7 per cent in Sindh , 95.7 per cent in AJK and 85.7 per cent in KP. However, far fewer respondents in Balochistan (9.4 per cent) and GB (31.4 per cent) reported receiving knowledge about TT during MCW events. Thus, the MCW initiative performed well, overall, in terms of raising awareness of TT vaccinations, although it performed poorly in this regard in Balochistan and GB.

In Punjab, 96.7 per cent of survey respondents reported receiving the TT vaccination during their last pregnancy, as did 96.8 per cent in Sindh. Even in GB and Balochistan, where the MCW initiative did not perform well in terms of raising TT awareness, most respondents received the TT vaccination – 88.6 per cent in GB and 82.1 per cent in Balochistan. This reveals a disparity between knowledge and practices. It implies that the practice of seeking TT vaccinations in these areas can be attributed to other government interventions or the presence of other vertical programmes.

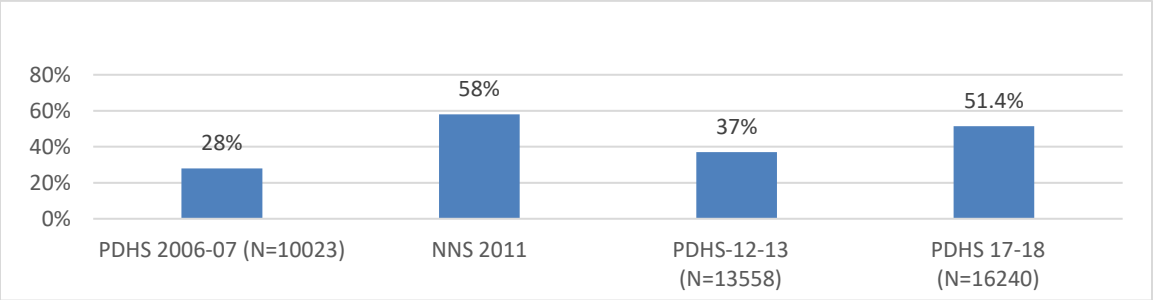
Table 11: Mothers' knowledge of Tetanus Toxoid vaccination (N=1540)

Characteristics	f	%
Benefits of Tetanus Toxoid vaccination explained during MCW sessions (N=1503) *		
Yes	1165	77.5
No	338	22.5
TT injection received during respondent's last pregnancy		
Yes	1415	91.9
No	125	8.1

While antenatal care (ANC) delivered by skilled health professionals is extremely important for the health of mothers and newborns (Darmstadt et al, 2015), only half (51 per cent) of pregnant women worldwide access the recommended number of four antenatal checkups during their pregnancies (WHO, 2011). The survey findings show that almost all mothers recognized the importance of ANC and 66.5 per cent knew that four or more ANC visits are required during pregnancy. This is well above the national average. Data from the PDHS 2017-

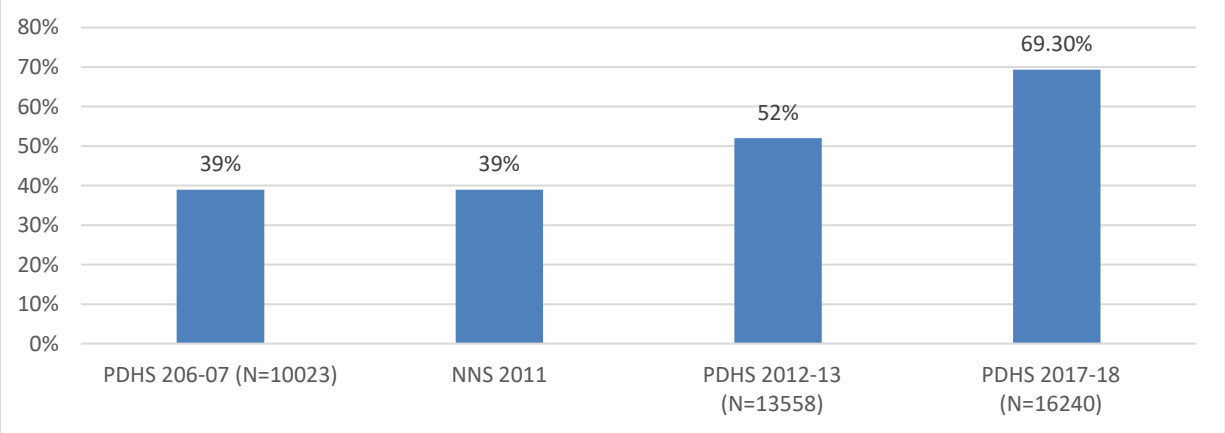
2018 shows that only half (51.4 per cent) of women in Pakistan access four or more ANC checkups (see Figure 40).

Figure 40: Trends in the number (4+) of antenatal care visits, 2006-2018 (PDHS & NNS)



Nearly half (49.9 per cent) of the survey respondents received ANC at government hospitals, 18.4 per cent at private hospitals/clinics, 15.7 per cent from LHW and the remaining 13.1 per cent in their homes. Most respondents (77.5 per cent) said that they received information on ANC during MCW activities. The MCW initiative clearly raised women's awareness of the importance of antenatal care. These findings are reinforced by the PDHS 2017-18, which found that most women (86 per cent) received ANC from a skilled health care provider (see Figure 41).

Figure 41: Trends in ANC by skilled health care providers, 2006-2018 (PDHS & NNS)



Results on antenatal care varied across provinces. Only 50.7 per cent of respondents in Sindh, and 55 per cent in Balochistan, acknowledged its importance. Far more respondents in other provinces/regions reported understanding the significance of antenatal care –95.7 per cent in AJK, 93.6 per cent in GB and 86.7 per cent in Punjab (see Table 12). While most respondents across all provinces/regions reported receiving information on antenatal care during MCW

sessions, this was not the case in GB and Balochistan. In GB, only 10 per cent of respondents said that they received information on ANC during MCW sessions, as did a mere 29.9 per cent of respondents in Balochistan. This indicates that the MCW initiative's provision of antenatal care information worked effectively across the country, but did not work efficiently in GB and Balochistan.

Table 12: Mothers' knowledge of antenatal care (N=1540)

Characteristics	f	%
Importance of ANC (N=1501) *		
Very important	1191	77.4
Important	328	21.3
Not important	20	1.3
Number of ANC visits required during pregnancy (1462) *		
1	82	5.6
2	117	8.0
3	291	19.9
4 or more	972	66.5
Number of antenatal checkups received during respondent's last pregnancy		
None	101	6.8
1	94	6.4
2	162	11.0
3	416	28.1
More than 3	705	47.7
Place where ANC was received (N=1442) *		
Home	189	13.1
LHV clinic	227	15.7
Government hospital	720	49.9
Private clinic/hospital	266	18.4
Home and government hospital	20	1.4
LHV and government hospital	20	1.4
Information on ANC received during MCWs (N=1396) *		
Yes	1082	77.5
No	314	22.5

*The response is not 100% because of missing values

WHO recommends daily iron supplements during pregnancy for better maternal and child health outcomes (WHO, 2012). Most (86 per cent) mothers surveyed used iron supplements during their last pregnancy and 65.2 per cent received iron supplements during MCWs. Findings from the PDHS 2017-18 (NIPS, 2018) indicate that the use of iron supplements by pregnant women has risen during the MCW initiative's implementation period – from 25 per cent in 2006 to 45 per cent in 2012 and 86 per cent in 2017-18.

Although women in most provinces/regions reported using iron supplements, this was true for only 39.6 per cent of survey respondents in Balochistan. Fewer women in Balochistan (9 per cent) and GB (22.3 per cent) reported receiving iron supplements during MCW sessions. This reinforces the disparities in the MCW's efficiency between different regions (see Table 13).

Table 13: Mothers' knowledge of iron supplements during pregnancy (N=1540)

Characteristics	f	%
Use of iron supplements during respondent's last pregnancy(N=1522) *		
Yes	1309	86.0
No	213	14.0
Received iron supplements during MCWs (N=1496) *		
Yes	975	65.2
No	521	34.8
Received information on place for delivery (N=1482) *		
Yes	1157	78.1
No	325	21.9

Overall, 78.1 per cent of respondents received guidance on places for delivery, while 80.5 per cent were advised to go to a government hospital for their child's birth. Table 14 shows that 77.5 per cent of respondents reported receiving information on places for delivery and skilled birth attendance during MCWs. Most noted that their last delivery was attended by a skilled birth attendant. This echoes trends noted by the PDHS 2017-18, which found that 69.3 per cent

of deliveries were attended by skilled health care providers in 2018, compared to just 39 per cent in 2006 (see Figure 42). This suggests that the MCW intervention successfully raised awareness and prompted behaviour change related to delivery care.

Table 14: Mothers' knowledge of delivery and postnatal care (N=1540)

Characteristics	f	%
Birth attendant for respondent's last delivery (N=1348)*		
Doctor	908	67.4
Nurse	118	8.8
LHV	164	12.2
Untrained TBA/*Dai*	102	7.5
LHW	56	4.2
Place of last delivery (N=1473)*		
Home	126	8.9
Government hospital	882	58.5
Private hospital	441	31.0
Any other	24	1.6
Newborn weighed at birth (N=1522) *		
Yes	1200	78.8
No	322	21.2
Newborn checkup after birth (N=1534) *		
Yes	1303	84.9
No	231	15.1
Time between birth and the newborn's first checkup		
As soon as possible	40	31
Within 1 hour	14	15.6
Within 2 hours	4	3.1
More than 1 day	78	46.6
No checkup	5	3.9
Place of first checkup after delivery (n=1423) *		
Home	126	8.9
Government hospital	832	58.5
Private hospital/clinic	441	31.7
Any other	24	1.0
Information received about delivery and postnatal care during MCWs (N=1461) *		
Yes	1133	77.5
No	328	22.5

Figure 42: Trends in deliveries by skilled birth attendants, 2006-2018 (PDHS & NNS)

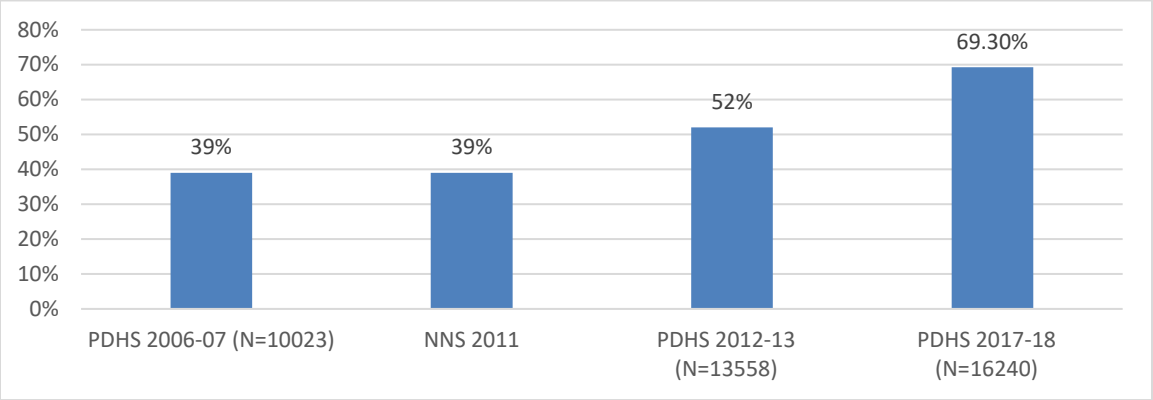


Table 15 illustrates respondents' knowledge and practices related to exclusive breastfeeding – which WHO recommends for the first six months of an infant's life, followed by breastfeeding coupled with complementary feeding until the child is at least two years old (WHO, 2011). Almost all (95 per cent) respondents were aware of the importance of exclusive breastfeeding. Overall, 67.7 per cent reported that they exclusively breastfed their child for 6 months, while 84.1 per cent began complementary feeding only once their child was 6 months old. Over three-quarters (76.1 per cent) reported receiving information on exclusive breastfeeding during MCW activities. Figure 43 reveals that exclusive breastfeeding rates rose from 37 per cent in 2006 to 48 per cent in 2017 nationwide (PDHS, 2017-18). This may be considered an encouraging sign with respect to the MCW initiative's performance – specifically its promotion of recommended breastfeeding and complementary feeding practices to improve child health and nutrition.

Figure 43: Trends of exclusive breastfeeding

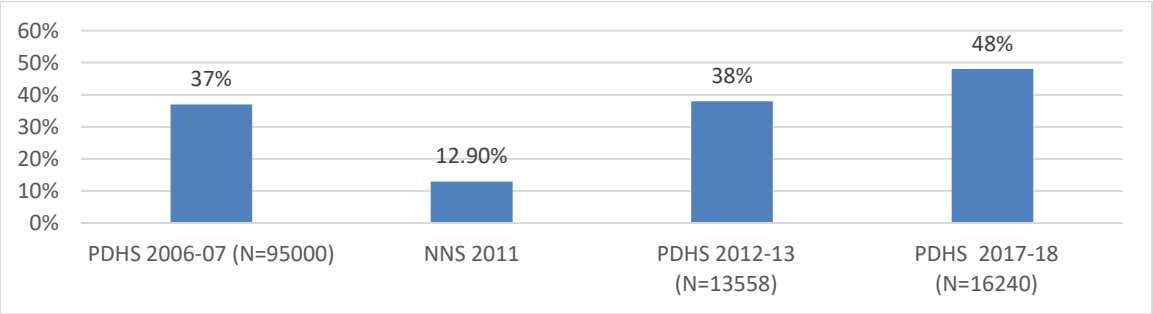


Table 15: Mothers' knowledge of exclusive breastfeeding (N=1540)

Characteristics	f	%
Importance of exclusive breastfeeding (N=1468) *		
Very important	1459	94.7
Important	79	5.1
Not important	2	1
Infant given colostrum after birth (N=1539) *		
Yes	1486	96.6
No	53	3.4
Knowledge about exclusive breastfeeding (N=1538)*		
Yes	1494	97.1
No	44	2.9
Time after delivery that breastfeeding was initiated (N=1524) *		
Within 1 hour	1269	83.3
Within 2nd hour	139	9.0
1 day	64	4.2
Any other	52	7.8
What is exclusive breastfeeding? (n=1519) *		
Breastfeeding only; even no water (only polio drops)	1328	87.4
Breastfeeding and water	66	4.3
Breastfeeding and tea/ *qehwa*/*sharbat*	65	4.3
Breastfeeding and Tetra-pack milk	25	1.6
Breastfeeding and cow/goat milk	29	1.9
Only breast milk with ORS, vitamins, drops, minerals, medicines	6	.4
Optimal duration of exclusive breastfeeding (N=1342) *		
1 month	14	1.0

4 months	58	4.3
6 months	916	68.3
2 years	154	10.0
Any other	160	10.4
Don't know	36	2.7
How long was the respondent's child exclusively breastfed?(N=1303) *		
1 month	15	1.2
4 months	91	7.0
6 months	882	67.7
2 years	58	4.5
Any other	257	19.7
Starting age of complementary feeding for children (N=1521) *		
3 months	29	1.9
6 months	1279	84.1
9 months	83	5.5
1 year	93	6.1
Any other	36	2.4
Knowledge received on breastfeeding during MCWs (N=1460) *		
Yes	1111	76.1
No	349	23.9

Table 16 shows that 70.7 per cent of surveyed mothers used iodized salt at home for cooking, while 69.6 per cent noted that information on the benefits of iodized salt was provided by MCW activities. Figures varied across provinces/regions. While 98.6 per cent of respondents in GB use iodized salt – as do 97.9 per cent in AJK, 78.3 per cent in Punjab and 81.8 per cent in KP – the figure falls to 20 per cent in Balochistan. Most (91.2 per cent) mothers in AJK confirmed that they gained knowledge on iodized salt during MCW sessions, as did those in Punjab (80 per cent). However, very few respondents in GB (23.3 per cent) and Balochistan (7.9 per cent) reported receiving information on iodized salt during MCWs. This finding shows that many women in GB were using iodized salt but were not sensitized on this issue during MCW sessions. The reason for this was that some NGOs in the region – such as the Agha

Khan Rural Support Programme – were active in disseminating information on healthy life styles, including the use of iodized salt among women and their families.

Table 16: Mothers' knowledge of iodized salt (N=1540)

Characteristics	F	%
Use of iodized salt at home (N=1539) *		
Yes	1088	70.7
No	451	29.3
Knowledge received on the benefits of iodized salt during MCWs (N=1494)*		
Yes	1040	69.6
No	454	30.4

In terms of health-related hygiene practices, Table 17 shows that 70 per cent of respondents use purified drinking water and 98.2 per cent gained knowledge of the importance of purifying drinking water during MCW sessions. Over half (57.6 per cent) boil water to purify it, while 22.9 per cent use filters. Far more survey respondents use purified drinking water in FATA (89.9 per cent), Punjab (82.1 per cent) and KP (87.5 per cent) than in Sindh (51.5 per cent) or Balochistan (20.4 per cent). Most respondents reported gaining knowledge of purified drinking water during MCW sessions – 93.6 per cent in Punjab, 96.2 per cent in Sindh, 94.9 per cent in AJK and 80 per cent in FATA. Although boiling water and using filters were the two main methods used by respondents to purify drinking water, 17.8 per cent of those in KP and 23 per cent in FATA purify drinking water by sieving it through a cloth.

Table 17: Mothers' knowledge of hygiene

Characteristics	F	%
Drinking water purified		
Yes	1062	70.0
No	456	30.0
Knowledge received on purifying water during MCWs (N=1533)*		

Yes	1505	98.2
No	28	1.8
Methods of purifying water used (multiple responses possible) (N=1277)*		
Boiling water	735	57.6
Adding chlorine	30	2.3
Using tablets	51	4.0
Using sachets	29	2.3
Using ceramics	21	1.6
Using filters	292	22.9
Sieving through a cloth	119	9.3

Annex 9. Descriptive cost analysis, 2015 and 2016

Pakistan		
Study period 2015 (April 2015-December 2015)		
Costs of National Programme, EPI and UNICEF		
LHWs	**Costs, when presented, are in PKR**	**Description**
Total number of LHWs who participated in a biannual activity	91608	
Number of days each LHW spent on MCW activities	12	
Estimated one week salary at for half a year (weekly stipend consisting of 6 working days)	3490	
Cost of LHWs in a biannual activity	319711920	
Total cost of LHWs during the whole year (2015)	**639423840**	
LHS		
Number of LHWs supervised by each Lady Health Supervisor	25	
Number of days each LHS spent on MCW activities	12	
Total number of LHS who participated in MCWs	3664	
Estimated one week salary for half a year (weekly stipend consisting of 6 working days)	3639	
Cost of LHS in a biannual activity	13333296	
Total cost of LHS during the whole year (2015)	**26666592**	
Vaccinators		
Number of vaccinators assigned to line-up his/her vaccination activities with LHWs	12	
Total number of vaccinators who participated in MCWs	9160	
Estimated one week salary for half a year (weekly stipend)	3490	

Cost of vaccinators in a biannual activity	31968400	
Total cost of vaccinators during the whole year (2015)	**63936800**	
District health personnel		
Total number of district health personnel who participated in MCWs	4	
Monthly stipend for each district health personnel member in PKR	45440	* assuming DHP is of grade 18 with 10+ years of experience
Number of days each district health personnel member spent per month in MCW activities	12	
Cost of an individual district health personnel member in PKR	18176	
Total cost of district health personnel in PKR	72704	
Total number of districts that implemented the MCW initiative	146	
Total cost of district health personnel during the whole year (2015)	**10614784**	
Other personnel		
Salary of the Provincial LHW Coordinator	77205	20 grade+ with 10+ years of experience
Number of days which the Provincial LHW Coordinator spent on MCW activities	15	
Total cost of the Provincial LHW Coordinator	38602	
Total number of regions/provinces involved in the MCW initiative	8	
Total cost of Provincial LHW Coordinators for the whole year (2015)	**308816**	
Salary of the provincial MCW Focal Persons	60905	19 grade+ with 10+ years of experience
Number of days which provincial MCW Focal Persons spent on MCW activities	30	
Total cost of provincial MCW Focal Persons	60905	
Total regions/provinces involved in the MCW initiative	8	
Total cost of Provincial MCW Coordinators for the whole year (2015)	**487240**	

Salary of other team members at the provincial level	28473	30 per cent of Provincial LHW Coordinators
Number of days which other team members at the provincial level spent on MCW activities	6	
Total cost of other team members in a province	**170838**	
Total number of regions/provinces involved in the MCW initiative	8	
Total costs of other team members for the whole year (2015)	**1366704**	
Salary of other team members at the district level	13632	30 per cent of Provincial LHW Coordinators
Number of days which other team members at the district level spent per month on MCW activities	6	
Total costs of the other team members at the district level	81792	
Total number of districts involved in the MCW initiative	146	
Total costs of other team members in all districts for the whole year (2015)	**11941632**	
Total cost of other personnel	**14104392**	
Total cost of the National Programme (2015)	**754746408**	
EPI		
TT vaccine cost per dose	7.79	Inflation adjusted
Number of pregnant women vaccinated for TT during half a year	970138	
Cost of TT vaccines for half a year		
Total cost of TT vaccines for the whole year (2015)	**7557375.02**	We are assuming that same number of women were vaccinated in the second session
Pentavalent/other vaccination costs per dose	409	Inflation adjusted
Number of children aged 0-2 vaccinated	1044637	
Cost of pentavalent/other vaccinations for half a year		
Total costs of child vaccination for the whole year (2015)	**427256533**	We are assuming that same number of children vaccinated in the second session

Total cost of EPI	**434813908**	
Total cost of service delivery	**1,189,560,316.02**	
Total cost (EPI + National Programmes + UNICEF)	**1394774453**	
Cost per person (service delivery + behaviour change)	**41.00455391**	The cost is calculated on the basis of total cost divided by the number of beneficiaries. As the number of beneficiaries included beneficiaries of service delivery and beneficiaries of the behaviour change campaign, the cost per beneficiary is less than the cost per beneficiary solely for service delivery
Cost per person (service delivery only)	**96.27025662**	

Total population covered during both MCW rounds		
Source	UNICEF provided the number of total beneficiaries for one round of MCW in all provinces except Punjab where the number of beneficiaries was retrieved from Punjab' Annual MCW Report 2015	
	Number of beneficiaries	
Service delivery		
Children under 2 years old vaccinated	1044637	
Pregnant women vaccinated for TT	970138	
Children dewormed	12473339	
Total	**14488114**	
Behaviour change		
Pregnant and lactating women (PLW)	**19526997**	
Total population covered		
Population covered for service delivery	14488114	
Population covered for behaviour change	19526997	
Total population covered	**34015111**	

Total cost		
Financial inputs by UNICEF		
Activities	**Inputs (PKR)**	**Inputs (USD)**
Developing and printing IEC materials	25298785	248539
Mebendazole tablets	119390204	1172907
Operational costs (cash transfer to MCW initiative for various activities + monitoring by UNICEF)	60525148	594608
Total	**205214137**	**2016054**
Conversion rate: PKR 101.79 = USD 1		
Total contribution by the Government	1,189,560,316.02	85.3%
Total contribution by UNICEF	205,214,136.66	14.7%
Total cost	1,394,774,453	

Pakistan		
Study period 2016 (April 2016-December 2016)		
Cost of the National Programme, EPI and UNICEF		
LHWs	**Costs, when presented, are in PKR**	
Total number of LHWs who participated in a biannual activity	91,227	
Number of days each LHW spent on MCW activities	12	
Estimated one week salary at for half a year (weekly stipend consisting of 6 working days)	3,625	
Cost of LHWs in a biannual activity	330,697,875	
Total cost of LHWs during the whole year (2016)	**661,395,750**	
LHS		
Number of LHWs supervised by each Lady Health Supervisor	25	
Number of days each LHS spent on MCW activities	12	
Total number of LHS who participated in MCWs	3,649	
Estimated one week salary for half a year (weekly stipend consisting of 6 working days)	3,875	
Cost of LHS in a biannual activity	14,140,185	

Total cost of LHS during the whole year (2016)	**28,280,370**	
Vaccinators		
Number of vaccinators assigned to line-up his/her vaccination activities with LHWs	10	
Total number of vaccinators who participated in MCWs	9,123	
Estimated one week salary for half a year (weekly stipend)	3,625	
Cost of vaccinators in a biannual activity	33,069,788	
Total cost of vaccinators during the whole year (2016)	**66,139,575**	
District health personnel		
Total number of district health personnel who participated in MCWs	4	
Monthly stipend for each district health personnel member in PKR	55,890	* assuming DHP is of grade 18 with 10+ years of experience
Number of days each district health personnel member spent per month in MCW activities	12	
Cost of an individual district health personnel member in PKR	22,356	
Total cost of district health personnel in PKR	89,424	
Total number of districts that implemented the MCW initiative	146	
Total cost of district health personnel during the whole year (2016)	**13,055,904**	
Other personnel		
Salary of the Provincial LHW Coordinator	94910	20 grade+ with 10+ years of experience
Number of days which the Provincial LHW Coordinator spent on MCW activities	15	
Total cost of the Provincial LHW Coordinator	47455	
Total number of regions/provinces involved in the MCW initiative	8	
Total cost of Provincial LHW Coordinators for the whole year (2016)	**379,640**	

Salary of the provincial MCW Focal Persons	74970	19 grade+ with 10+ years of experience
Number of days which provincial MCW Focal Persons spent on MCW activities	30	
Total cost of provincial MCW Focal Persons	74,970	
Total regions/provinces involved in the MCW initiative	8	
Total cost of Provincial MCW Coordinators for the whole year (2016)	**599,760**	
Salary of other team members at the provincial level	28,473	30 per cent of Provincial LHW Coordinators
Number of days which other team members at the provincial level spent on MCW activities	6	
Total cost of other team members in a province	170,838	
Total number of regions/provinces involved in the MCW initiative	8	
Total costs of other team members for the whole year (2016)	**1,366,704**	
Salary of other team members at the district level	28,473	30 per cent of Provincial LHW Coordinators
Number of days which other team members at the district level spent per month on MCW activities	6	
Total costs of the other team members at the district level	170,838	
Total number of districts involved in the MCW initiative	146	
Total costs of other team members in all districts for the whole year (2016)	**24,942,348**	
Total cost of other personnel	**27,288,452**	
Total cost of the National Programme (2016)	**796,160,051**	
EPI		
TT vaccine cost per dose	8.1	Inflation adjusted
Number of pregnant women vaccinated for TT during half a year	254,797	
Cost of TT vaccines for half a year	2,063,855.7	
Total cost of TT vaccines for the	**4,127,711.4**	We are assuming that

whole year (2016)		same number of women were vaccinated in the second session
Pentavalent/other vaccination costs per dose	424	Inflation adjusted
Number of children aged 0-2 vaccinated	609,434	
Cost of pentavalent/other vaccinations for half a year	258,400,016	
Total costs of childhood vaccination for the whole year (2016)	**516,800,032**	We are assuming that same number of children vaccinated in the second session
Total cost of EPI	**520,927,743**	
Total Cost of Service Delivery	**1,317,087,794**	
Total cost (EPI +National Programmes+ UNICEF)	**1,469,827,223**	
Cost per person (service delivery + behaviour change)	**51**	The cost is calculated on the basis of the total cost divided by the number of beneficiaries. As the number of beneficiaries included beneficiaries of service delivery and beneficiaries of the behaviour change campaign, the cost per beneficiary is less than the cost per beneficiary solely for service delivery
Cost per person (service delivery only)	**104.5973389**	

Total population covered during both rounds of MCW		
Source	UNICEF provided the number of total beneficiaries for one round of MCW in all provinces except Punjab where the number of beneficiaries were retrieved from Punjab' annual report of MCW, 2015	
	Number of beneficiaries	
Service Delivery		
Children under 2 years old vaccinated	1,218,868	
Pregnant women vaccinated for TT	509,594	

Children dewormed	12,323,781	
Total	**14,052,243**	
Behaviour change		
Pregnant and lactating women (PLW)	14,558,306	
Total population covered		
Population covered for service delivery	14,052,243	
Population covered for behaviour change	14,558,306	
Total population covered	**28,610,549**	
Total cost		
Financial inputs by UNICEF		
Activities	**Inputs (PKR)**	**Inputs (USD)**
Developing and printing IEC materials	32,294,331.82	308,243
Mebendazole tablets	58,456,282.63	557,954
Operational costs (cash transfer to MCW initiative for various activities + monitoring by UNICEF)	61,988,814.62	591,671
Total	**152,739,429.07**	**1,457,868.54**
Conversion rate: PKR 104.769 = USD 1		
Total contribution by the Government	1,317,087,794.40	89.6%
Total contribution by UNICEF	152,739,429.07	10.4%
Total cost	**1,469,827,223**	