

EVALUATION REPORT

UNITED NATIONS MATERNAL AND CHILD STUNTING REDUCTION PROGRAMME IN THREE TARGET DISTRICTS IN SINDH, PAKISTAN

November 2019



Prepared for UNICEF Pakistan's Country Office in Islamabad by:

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List of Acronyms

ABC: Actor-based Change	HH: Households	ORS: Oral Rehydration Solution
AAP: Accelerated Action Plan	HR: Human Resource	OTP: Outpatient Therapeutic Centre
ACF: Action Contre La Faim (ACF) in French (Action Against Hunger)	HRBA: Human Rights Based Approach	ODF: Open Defecation Free
ADC: Additional Deputy Commissioner	HF: Health Facilities	P&DB: Planning and Development Board
ADP: Annual Development Plan	HELP: Health Education Literacy Programme	PMP: Performance monitoring plan
ARI: Acute Respiratory Tract Infection	IDI: In-depth Interviews	PHE&RDD: Public Health Engineering and Rural Development Department
BCC: Behaviour Change Communication	IEC: Information Education and Communication	PATS: Pakistan Approach to Total Sanitation
CBA: Cost-Benefit Analysis	IP: Implementing Partner	PCA: Partnership Cooperation Agreement

CEA: Cost-Effectiveness Analysis	IAP: Integrated Action Plan	PSLM: Pakistan Social And Living Standards Measurement
CBA: Child Bearing Age	INGO: International Non-Government Organization	PPHI: People's Primary Healthcare Initiative
CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women	IYCF: Infant Young Child Feeding	PC-1: Planning Commission 1
ICESCR: International Covenant on Economic, Social and Cultural Rights	IR: Intermediate Result	PLW: Pregnant and Lactating Women
CIGs: Community Investment Grants	IT: Information Technology	PMER: Project Monitoring, Evaluation and Results
CHWs: Couple Health Workers	JMP: Joint Monitoring Programme	QDA Miner :Qualitative Data Analysis Miner
CMAM: Community Based Management of Acute Malnutrition	KAP: Knowledge Attitude Practice	QALY: Quality Adjusted Life Years
CRP: Community Resource Persons	LFA: Logical Framework Approach	RHC: Rural Health Centre
CSO: Civil Society Organization	LGD: Local Government Department	RNA: Rapid Needs Assessment
DALY: Disability Adjusted Life Years	LHW: Lady Health Worker	ROSA: Regional Office for South Asia
DAC: Development Assistance Committee	LHW-MIS: Lady Health Worker Management Information System	RUTF: Ready to Use therapeutic Food
DFID: Department for funding for International Development	LiST: Lives Save Tool	SAM: Severe Acute Malnutrition
DG: Director General	LMIS: Logistic Management Information system	SC: Stabilization Centre
DHMIS: District Health Management Information System	MAM: Moderate Acute Malnutrition	SACOSAN: South Asian Conference on Sanitation
DHQ: District Head Quarter	M&E: Monitoring and Evaluation	SAFWCO: Sindh Agricultural Forestry Workers & Coordinating Organization
DHS: Demographic Health Survey	MCH: Maternal Child Healthcare	SDGs: Sustainable Development Goals
DRR: Disaster Risk Reduction	MSP: Multi-sectoral Platform	SPO: Strengthening Participatory Organization
DSC: District Steering Committee	MIS: Management Information System	SR-ICG Stunting Reduction Interdisciplinary Coordination Group
DoH: Department of Health	MICS: Multiple Indicator Cluster Survey	SUN: Scaling up Nutrition
ESC: Evaluation Steering Committee	MMS: Multi Micronutrient Supplementation	ToC: Theory of change
ECHO: European Commission's Humanitarian Aid Office	MoNHSR&C: Ministry of National Health Service Regulation and Coordination	UN-MCSR: United Nations Maternal Child Stunting Reduction Programme
ET: Evaluation Team	MS: Medical Superintendent	UN-SWAP: UN System-Wide Action Plan
EU: European Union	MSGs: Mothers Support Groups	UNEG: United Nations Evaluation Group
EU-PINS: EU Programme for Improved Nutrition in Sindh	MTDF: Multi Donor Trust Fund	SAFWCO: Sindh Agricultural Forestry Workers & Coordinating Organization
FGD: Focus Group Discussion	MSAN: Multi-Sectoral Action for Nutrition	USD: United States Dollars
FACE: Funding Authorization and Certificate of Expenditure	NCE: No-Cost-Extension	VfM :Value for Money
FFP-USAID: Food for Peace-United State Agency for International Development	NGO: Non-Government Organization	VIP: Ventilated Improved Pit Latrine
FSGs: Father Support Groups	NIPS: National Institute of Population Studies (NIPS)	VWCs: Village WASH Committees
GDP: Gross Domestic Product	NMIS: Nutrition Management Information System	WASH-MIS: WASH Management Information System
GoS: Government of Sindh	NNS: National Nutrition Survey	WB: World Bank
GEEW: Gender Equality & Empowerment of Women	NOC :No Objection Certificate	WFP: World Food Programme
GRM: Grievance Redress Mechanism	NSP: Nutrition Support Programme	WHA: World Health Assembly
HACT: Harmonized Approach to Cash Transfer	NUST: National University of Sciences and Technology	
HANDS: Health and Nutrition Development Society	OECD: Organization for Economic Cooperation and Development	

I. EXECUTIVE SUMMARY

Childhood Stunting Causes and Consequences: Childhood stunting is the consequence of maternal and child inadequate dietary intake (poor maternal health and nutrition, inadequate infant and young child feeding practices, micronutrients deficiencies), repeated bouts of infections and/or combination of both. Underlying these immediate causes are socio-economic factors including poverty, gender inequalities, food insecurity, inadequate care of mothers and children, low women literacy and poor availability and quality of water, sanitation, hygiene and health services. The consequences of stunting are clear; however, its causes are more complex. It is one of the most significant impediments to human and economic development and accurate reflection of children's well-being and gender inequalities. It impacts quality of life through increased susceptibility to infections, reduced stature in adulthood, compromised physical growth, increased risk of maternal, perinatal, and neonatal mortality, and increased risk of chronic diseases in adulthood. Stunting is also associated with impaired cognitive development and school performances in children and reduced lifetime earnings. There is a general acceptance that stunting occurs in the first 1000 days of life, from conception till age 2, which is largely irreversible, hence, this period constitutes the key window of opportunity to reduce stunting. In addition to vulnerable points in the life-cycle, gender inequities substantially influence poor maternal and child feeding practices and under-nutrition. These inequities stem from inadequate attention to the needs and roles of women, resulting in inadequate care for pregnant and lactating women and other socio-economic gender disparities. This highlights the need that women and girls should be kept at the centre of the nutrition-specific interventions and nutrition-sensitive approaches and viewed them as the key agents in the fight against under-nutrition rather than passive victims of malnutrition who are in need of assistance. In order to unleash their potential as change agents, they need to be empowered so that they can make decisions about their own and their children health and wellbeing including participation in the community-led activities.

Programme (Object of Evaluation) Overview: The nutritional status of the children and women in Pakistan denotes both a chronic long-term problem and an acute on-going emergency. A large proportion of Pakistan's children are stunted (one in every three children), which represents an estimated 6% of the global stunting caseload. Sindh is the worst hit province in Pakistan in terms of malnutrition and food insecurity, with a prevalence of 49.9% for stunting, 16.1% for wasting and 4.4% for severe wasting. In the given context of Sindh province, UNICEF with support of USAID designed and implemented integrated nutrition-specific and nutrition-sensitive programme to complement Government of Sindh (GoS) efforts in stunting reduction. The programme implementation began in May 2016 and continued until December 2018 with a no cost extension for one year. UNICEF signed contracts with Implementing Partners (6 NGOs, one Government Line Department and a Consulting Firm) on varying dates. Hence, they became operational on ground on roll-on basis. USAID provided \$20 million while the 6 NGOs contributed \$1.1 million as part of the PCAs requirements.

The programme revolved around to address systemic, human and geographical needs and vulnerabilities through creating an enabling environment for the improved service provision and policy environment. To this end programme prioritized both upstream and downstream interventions to garner households, community, service delivery and policy/institutional level changes under a strategic objective and three intermediate results. In order to translate the programme theory of change (ToC) into action, the programme deployed gender-responsive integrated implementation approach to address the immediate and underlying causes of under-nutrition and preventing repeated bouts of infection in Ghotki, Khairpur and Nausheroferoz districts in Sindh province, Pakistan as:

- 🕒 **Nutrition-Specific Interventions:** The interventions focussed on improving the nutritional status of children from conception until age 2, pregnant & lactating women (PLW), adolescent girls and women of reproductive age. These preventative nutrition interventions covered aspects of improving exclusive breastfeeding practices, complementary feeding for children aged 6-23 months, micronutrient supplementation to address deficiencies among PLW & adolescent girls. Alongside preventative measures, the programme established mechanisms for early detection of under-nutrition in children through their MUAC screening at the community level and enrolling the severely malnourished children for treatment in OTPs and SC including referral for seeking additional health services such as vaccination and other ailments like diarrhoea.
- 🕒 **Nutrition-Sensitive Interventions:** The nutrition-sensitive interventions focussed in reducing incidence and severity of infection in children whilst controlling environmental enteropathy and its potential negative impact on children's linear growth through gender-responsive WASH services (clean water and ODF village status through construction of latrines, safe disposal of human excreta and triggering process for achieving ODF).
- 🕒 **Integrated Gender-Responsive SBCC:** The SBCC focused on improving infant and young child feeding (IYCF) practices, improving family and community hygiene knowledge/practices, creating demand for the use of micronutrient supplementation, reduction in open defecation, and promoting sick children care.
- 🕒 **Creating Enabling Environment:** The programme supported GoS in developing policies and M&E frameworks, building duty bearers and decision makers including LHWs capacities on integrated approaches, strengthening coordination mechanisms at provincial and district levels and rolling out web-based WASH and Nutrition Management Information System.

Additionally, the programme addressed inequities in reaching poor and marginalized communities by improving access to and availability of gender-responsive nutrition-specific and nutrition-sensitive services and supported the

poorest of poor through community investment grants (CIGs) to construct latrines. Moreover, the programme ensured women, girls, boys, men and marginalized groups participation in the community-led structures and community-based provider's network as: a) conducted pre and post KAP survey with 929 and 948 women respectively, b) established 2,288 gender mixed Village WASH Committees (10,926 males and 5,844 females members), c) established 605 School WASH Clubs (45,917 boys & 30,612 girls members), d) established 1,289 Father's/Mother's Groups with 7,981 men members and 8,089 women members, e) Recruited CRPs/Social Organizers (829 men and 720 women), f) trained 365 male Masson and 163 male Entrepreneurs, and g) recruited 72 female IYCF Counsellors' and 218 male CHWs and 219 female CHWs from the indigenous community.

Evaluation Purpose and Objectives: There exists a knowledge gap in Pakistan on how Nutrition-Specific interventions and Nutrition-Sensitive approaches can be integrated to combat the menace of stunting. Hence, the summative evaluation aimed to assess the effects of the integrated Nutrition-Specific and Nutrition-Sensitive programme and to gather evidence-based learning on how to design and implement such integrated programmes in future that may work more effectively.

The specific objectives of the evaluation were: a) to provide relevant key stakeholders with accurate, credible, and usable information on the performance of the UN Maternal and Child Stunting Reduction Programme against the DAC criteria for evaluation, b) to examine effects of integrated Nutrition-Specific and Nutrition-Sensitive interventions on the contribution toward reduction of stunting, c) to explore the determinants of good or poor performance (internal and external, such as the enabling environment) and the system support, d) to review and assess the benefits of the programme received by the entire health system in various ways, especially by various stakeholders for supporting their programmatic objectives such as assessing how it has contributed in shaping the planning and implementation within GoS and other public-sector stakeholders, and e) to elicit lessons learned and good practices for providing recommendations on strengthening future stunting reduction programs using convergence approaches and guide on-going projects line like AAP.

Intended Users of the Evaluation: The evaluation is expected to support advocacy purposes of adopting and refining further integrative Nutrition-Specific and Nutrition-Sensitive programme approaches and strategies. The primary expected audience of this evaluation are the Government, UNICEF Pakistan, ROSA, donors, policy makers, service providers, NGOs and academicians. Indirectly, the learning from this evaluation will support the women, children, families, communities and opinion leaders as secondary audiences of the evaluation.

Evaluation Methodology: The evaluation used mixed evaluation methods by employing both qualitative and quantitative methods. The evaluation was conducted in three phases as:

- 🕒 **Inception Phase:** The evaluation team held meetings with UNICEF and IPs to understand the programme and plan the evaluation based on the desk review of the programme documents. The evaluators developed the evaluation matrix to unpack the DAC criteria and cross-cutting themes of gender, HRBA, equity, DRR and participation that served as a guide to gather and analyse the data/information to answer the evaluation questions. Additionally, the evaluators developed the evaluation tool kit based on extensive review of the documents, scale and reach of the provided services at the community level, project implementation modalities, priorities & directions, pre and post KAP survey analysis, programme dataset analysis and roles/stakes of the rights holders (women, girls, boys, adolescents, men, marginalized groups) and duty bearers (male and female key informants from government, UNICEF and IPs).
- 🕒 **Data Collection and Field Work Phase:** The evaluators conducted IDIs with key informants, FGDs with communities, direct observations in the field and case studies. Additionally, the evaluators conducted scoping literature review and accessed national, regional and international reference documents from multiple sources including online scientific databases and grey literature, ran statistical analysis of the pre and post KAP surveys, undertook cost-effectiveness and cost-benefit analysis and conducted programme documents review including structured desk analysis of programme design, implementation approaches and analysis of programme and secondary data etc. In the process of primary data collection through FGDs, IDIs, Case Studies, Direct Observations including Pre and Post quantitative KAP Surveys, the **gender and equity** related aspects were addressed systematically as: a) evaluators used snowball methodology to reach vulnerable and marginalized individuals/groups at the village level. During the field work, the evaluators identified the destitute neighbourhoods within the villages. A team of the enumerators comprised of one male and female visited these identified areas in each of three districts to assess the extent to which the programme interventions reached these neglected communities. After identification, the enumerators who belonged to these districts and familiar with the local context conducted FGDs with vulnerable groups by ensuring that all the respondents felt safe and freely express their views. Moreover, the evaluators documented two case studies of the destitute families (one family received assistance from CIG while the other family malnourished child received services), b) enumerators conducted 31 FGDs with a total of 220 participants out of which more than half of the women and girls (114 out of 220) participated as FGD's respondents, c) evaluation deployed purposive sampling methods to interview key informants during IDIs at district, provincial and national levels based on the stakeholders mapping. The lead evaluators (two females and two males) conducted in-depth face-to-face interviews with the 49 key informants. The gender compositions of the key informants in the IDIs were as: 36% (4/11) female at the national level, 31% (5/16) female at provincial level, and 18% (4/22) female at district level, and 3) a total of 929 and 948 women with

a child less than two years were surveyed in the pre and post KAP surveys respectively to measure the change in knowledge, attitude and practices of them between the base and end line surveys.

- **Data Analysis and Reporting Phase:** The applied methodology ensured to collect primary and secondary data and use it in an integrated manner, combining different methods at different stages of the evaluation process to ensure complementarities between methods. This integrated data collection helped the evaluation team in gathering comprehensive information with the intent to draw impressions, expectations, experiences, reflections and learning of women, girls, boys, men and marginalized groups those who remained engaged directly or indirectly with the programme. Hence, the applied methodology ensured gathering of information needed to answer the evaluation questions and generated evidence and learning within the limits of the resources and the availability of data. The evaluators analysed the quantitative and qualitative data to assess the achievements, draw conclusions and recommendations against the DAC criteria of relevance, efficiency, effectiveness, impact and sustainability and cross-cutting themes of stakeholder participation, equity, HRBA, gender and DRR.

Evaluation Key Findings:

- The programme situated well within the larger landscape of addressing malnutrition in Sindh province. The programme objectives and delivery were consistent with the Sindh government strategies and priorities to address malnutrition and the perceived needs of the target communities. The programme was also fully aligned to the international commitments and directions.
- The programme achieved the status of “Complete Integrative Programming” as it considered all the five elements of integrative programming (joint programme design, one or merged budget, shared staffing, shared M&E, consolidated report). The evaluation found that iterative adaptive programme management and the joint programme frameworks played vital role in putting back the programme on track and to achieve the complete integrative programming status, after faltering from the integrative programming in the early phases of implementation. The complete integrative programming offers a number of lessons learned to government, UNICEF and integrative programming practitioners.
- Though the programme proposal and objectives didn’t articulate explicitly how to mainstream HRBA principles, equity, and gender aspects in practice in the programme delivery. Despite, the programme took a number of initiatives in the implementation of activities which were guided by the overarching principles of HRBA. To this end the evaluation found that the programme addressed HR&GE aspects as: a) gathered gender and age disaggregated data for all interventions, engaging and capacitating women, girls, boys, adolescents and marginalized groups in the community-led structures and the network of community-based providers, b) provided gender responsive nutrition and WASH services, and c) engaged men in the form of “Father’s Groups” to support mothers in improving maternal and child nutrition and adopting healthy behaviours. Similarly, in the given context to reduce stunting, the programme adopted various measures to reach disadvantaged, marginalized and hard to reach areas and groups in equitable manner as: a) established community-led structures and providers network with inclusion of women and members from marginalized groups, b) planned and implemented programme activities in hard to reach and neglected areas within the target districts, c) identified the poor HHs in the target villages to assist them with CIGs for construction of latrine, d) improved access to water sources, hence, reduced water fetching time that primarily is done by women and children in the community, and e) constructed latrines in schools and health facilities to accommodate the needs of persons living with disability.
- The cost-effective and cost-benefit analysis indicates that the programme saved 662 under five year’s children lives and averted 58,760 DALYs at cost of \$359 per averted DALY. Additionally, 596 children under the age of 5 were at the risk of stunted which were avoided due the implementation of the programme interventions. Based on the WHO criteria, the programme is classified as highly cost-effective, as the cost per DALY averted is lesser than 4.5 times as compared to the GDP per capita of Pakistan which is \$1,641 in 2018. The cost-benefit ratio stands at \$4.6 as a return on each \$ invested under the nutrition-sensitive and nutrition-specific interventions.
- Quantifiably the programme achieved most of the targets sets in the PMP under the specific objective (outcome) and three intermediate results (outputs). Similarly, the programme made a good progress in achieving the set targets in adaptation of healthy behaviours and influencing key family and community awareness with exception for fewer indicators with no change against the baseline values. Nevertheless the evaluation found issues related to the programme data such as possible double counting of beneficiaries and differences of the reported data in the programme datasheets and PMP that may put in question the fully achievements of the programme targets. The evaluation also found out issues related to Misaali Maan Campaign such as fragmented promotion of hand washing messages where the campaign focussed on two critical moments instead of five critical moments which were even wrongly worded. Additionally, the campaign used stylistic and most media watched simulated pictorial IEC materials that led to the misperceptions about the iron/folate supplementation.
- The programme put in place measures technically and operationally to sustain the intended results beyond the project lifespan as: a) the programme assisted GoS in developing policies and strategic frameworks for nutrition-sensitive and nutrition-specific interventions, namely, WASH Sector Master Plan, Safe Drinking Water Policy, Sanitation Policy, WASH BCC Strategy, Research, Monitoring and Evaluation Framework and Dashboard for AAP, IYCF Communication Strategy, Incorporation Nutrition-specific and Nutrition-Sensitive SBCC Approaches and Messages in LHW Manual, b) programme deployed a systemic approach to plan the programme exit in consultation and collaboration with GoS and agreed on the next steps for the continuum of services after the programme exit, c) The GoS under AAP initiative deployed PPHI to continue the nutrition-specific services with effect from April 2019 in the three target districts. The AAP is in process to deploy partners for nutrition-sensitive interventions, and d) even after the closure of the programme for a year, the community-led structures such as

VWCs, WASH clubs, Fathers and Mothers Groups are yet functional and motivated to sensitize and mobilize communities

Key Lessons Learned:

- 🕒 **Integrative Programming:** The deployed integrative approaches and how it sought to be adaptive draws out lessons that may be of interest to the government, UNICEF Pakistan, UNICEF Regional Office for South Asia (ROSA) and global integrative programme's practitioners. These lessons are related to iterative adaptive management processes and developing and rolling out frameworks to operationalize the UNICEF, WHO and USAID guidance on the integrative programming at the organizational, partners and programme interventions levels.
- 🕒 **Bottom-up Solutions:** The programme adjusted its approach and course in line with the understandings of context, political enablers and obstacles through seeking of bottom-up solutions to the problems it faced during the implementation. UNICEF and IPs developed frameworks to facilitate joint activities and established mechanisms for improved coordination and cooperation with authorities at the district level, namely District Steering Committees (DSCs). This bottom-up solution led to improved cooperation and synergies not only among the IPs to undertake joint activities but also with government authorities.
- 🕒 **Gender Sensitive and Responsive Programming:** The programme deployed gender-responsive approaches in the delivery of interventions to ensure women participation in the programme activities and empowering them to break the multifaceted circle of under-nutrition. This provide lessons to: a) scale-up such deployed approaches in future programming at the community level with clear articulation in the programme design including ToC, and b) influence changes in GoS policies and practices through direct advocacy for inclusion of gender-responsive approaches within the multi-sectoral stunting reduction programmes, AAP under Taskforce secretariat.

Recommendations: The recommendations are based on the findings, conclusions and lessons learned which were derived as: a) held in-depth discussion key informants during IDIs, b) brainstormed the preliminary findings in four presentations to the key stakeholders, c) received feedback on the possible recommendations from the key stakeholders in the draft report, and d) validation of recommendations in the revised report and endorsement of the recommendations in the UNICEF country office meeting that was participated by the senior management including UNICEF Country Representative and Deputy Country Representative and the programme staff from the four field offices. It is also planned that the key findings and recommendations will be widely disseminated to state and non-state actors. The recommendations are elaborated in section F of the report with defining characteristics to aid interpretation and support UNICEF in planning and execution either directly by themselves or advocating with concerned state and non-state actors for adopting in their programme which include:

- 🕒 Advocate with government and programme practitioners on the key elements of integrative programming and support them in adopting these elements in their existing and future sector-wide integrated programmes (intended users: GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD, UNICEF Pakistan, UNICEF ROSA, national and global Integrative Programme's Practitioners, Academia and CSOs/NGOs)
- 🕒 Advocate for adaptation and scale-up of the integrated Nutrition-Specific and Nutrition-Sensitive programme frameworks and mechanisms as best practices which were developed under the programme to support convergence of disciplines/sectors and integration of interventions (intended users: GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD, UNICEF Pakistan, UNICEF ROSA, national and global Integrative Programme's Practitioners, Academia and CSOs/NGOs)
- 🕒 Publish Key Findings and Lessons-learned of Integrative Programming and Develop Replicable Packages with Minimum Standards for Designing and Operationalizing Sector-wide Stunting Reduction Programme in Future
- 🕒 Scale-up the use of iterative adaptive management principles for improved and effective planning and execution of integrated programme (intended users: UNICEF & Taskforce Secretariat)
- 🕒 Advocate for integration of gender sensitive and responsive approaches within the sector-wide programme policies and practices (intended users: GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD, UNICEF Pakistan and CSOs/NGOs)
- 🕒 Consider changes in the PCA templates to allow UNICEF and IPs for incorporating aspects of integrative programming and cross-cutting themes of HRBA, Gender and Equity (intended users: UNICEF)
- 🕒 Articulate explicitly HRBA, gender and equity in the programme proposal, objectives and programme ToC to the donors in future programme proposals (intended users: UNICEF)
- 🕒 Establish Grievance Redress Mechanism (GRM) in future integrated programme to provide rights holders with opportunities to voice their concerns and share their feedback about the programme and hold duty bearers to account (intended user: UNICEF, IPs and Taskforce Secretariat)
- 🕒 Improve further integrated WASH & Nutrition programme data management by ensuring that critical programme data is gathered and used (intended users: UNICEF and IPs)
- 🕒 Advocate with donors for adequate programme's inception period and longer duration of the stunting reduction programme in future to allow UNICEF with optimal preparation and contribute in measurable way in stunting reduction (intended users: UNICEF)
- 🕒 Promote standardized messages and use of IEC materials for creating awareness and adaptation of healthy practices (intended users: UNICEF, IPs, NSP, LHW programme)
- 🕒 Engage LHWs adequately in service delivery at the community level (intended users: UNICEF, LHWs Programme and IPs)

- Consider placement of optimal number of implementing partners in the geographic co-locations in future integrated programmes (intended users: UNICEF)

A. BACKGROUND & PROGRAMME DESCRIPTION

A.1. Programme Introduction

Table 1 provides an overview of the key aspects of the programme at glance and definition of key terms is presented in Annex 1.

TABLE 1: PROGRAMME DESCRIPTION AT A GLANCE

Programme Aspect	Brief Description
Programme Donor	USAID
Programme Budget	USD 20 Million
Contribution from 6 Ngo's IPs under PCAs	USD 1.1 Million (IPs contributed in kind as management costs while one of the IP also contributed in cash in the development of WASH MIS)
Programme Duration	30 months (18 months at the design phase with 12 months no cost extension)
Programme Impact Areas	Programme implemented in three districts (167 UCs for Nutrition and 59 for WASH) of Nausheroferoz, Khairpur, and Ghotki, Sindh province, Pakistan
Geographic Locations Rural/Urban Split	The rural/urban split of the three districts is 68%, 75% and 76% for Khair Pur, Gotki and Nuashero Feroze respectively with 49% female and 51% male living in the target district
Programme Beneficiaries	Programme catered the needs of all population in the target districts with a focus on women, girls, boys, female adolescents and marginalized groups. The intended direct and indirect beneficiaries of the nutrition-specific interventions are over 5 million (indirect) and 646,590 (direct) while nutrition-sensitive over 1.8 million (indirect) and 1.2 million (direct).
Programme Timeframe and Activities Implementation	<p>The programme implementation began in May 2106 and continued until December 2018 with a no cost extension for one year. UNICEF signed contracts with Implementing Partners (6 NGOs, one Government Line Department and a Consulting Firm) on varying dates. Hence, they became operational on ground on roll-on basis as:</p> <ul style="list-style-type: none"> PCAs were signed with 4 WASH IPs (NGOs) in May 2016. They implemented programme activities for around 23.5 months until mid-April 2018 PCAs were signed with 2 Nutrition IPs (NGOs) in July 2016. They implemented programme activities for around 21 months until March 2018 Institutional Contract was signed with a Consulting Firm in December 2016 for undertaking formative research and SBCC campaign. The consulting firm implemented the activities for around 24 months until Mach 2018. The firm also evaluated the campaign between January 2019 and March 2019 Institutional contract was signed with Government Line Department (PHE&RDD) in January 2017. The PHE&RDD implemented activities of rehabilitation of water supply schemes until December 2017 Institutional contract of post service delivery consultancy was signed with an NGO in May 2018 to focus on continuum of services after the exit of other IPs (around 7 months of implementation until December 2018)
Programme Relative Importance for UNICEF	In Pakistan, UNICEF implemented an integrated stunting reduction programme for the first time. UNICEF will use the learning from this program in several ways as: to build further on the momentum of sector-wide and gender-responsive programming in Sindh by influencing government policies and practices of how nutrition specific and nutrition sensitive can be integrated efficiently and effectively to reduce stunting, to disseminate learning and best practices from the programme at regional and global level on integrative interventions and frameworks, and to position UNICEF Pakistan to set future integrated programme directions

A.2. Context of Evaluation

The nutritional status of the children in Pakistan denotes both a chronic long-term problem and an acute on-going emergency. A large proportion of Pakistan's children are stunted (one in every three children), which represents an estimated 6% of the global stunting caseload. The under-5 stunting rate in the country is as high as 38%, the third highest rate in the world (42%)¹. The high burden of under-nutrition has vast economic consequences in the form of 177, 000 child deaths annually, low educational attainment, reduced labour productivity and a high burden on the health system. As a result Pakistan is losing 3% of its GDP annually, which is being equal to about \$7.6 billion².

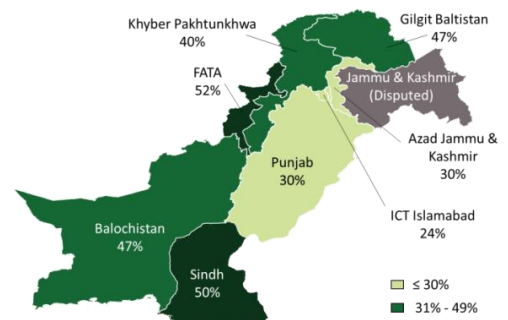


FIGURE 1: CHILD STUNTING IN PAKISTAN (PDHS 2017-18)

Sindh is the worst hit province in Pakistan in terms of malnutrition and food insecurity, with a prevalence of 49.9% for stunting, 16.1% for wasting and 4.4% for severe wasting. It is noteworthy that the percentage of severe wasting increased from 3.4% in 2013 to 4.4% in 2018 in Sindh province³. The programme target districts are part of the rural Sindh where situation is further deteriorated due to the prevailing socio economic and environmental challenges. Around 70% of population in these target districts live in rural areas⁴ which have limited access to basic healthcare and stuck in the vicious circle of poverty, gender discrimination and malnutrition. Rural Sindh suffers from chronic and widespread food insecurity where more than 70% of households are unable to afford an adequate nutritious diet. The agricultural output, rural incomes, rural poverty and social welfare indicators are considerably lower than the urban areas. The situation is further exacerbated by the frequent occurrence of natural disasters (floods and droughts), which have increased the vulnerabilities of the communities, depleted their savings, destroyed their source of earnings and negatively impacted their nutritional status. The following section presents socio-economic aspects of the target districts with generalization of certain aspects of rural Sindh where data is lacking in particular for the three programme target districts.

A.2.1. Stunting Causes and Socio-Economic Determinants

Childhood stunting is an accurate reflection of children's well-being, socio-economic and gender inequalities⁵. The consequences of stunting are clear; however, its causes are more complex. Childhood stunting happens due to maternal and child inadequate dietary intake (poor maternal health and nutrition, inadequate infant and young child feeding practices, micronutrients deficiencies), repeated bouts of infections and/or combination of both during the first 1000 days of life⁶, from conception till age 2. Underlying these immediate causes are socio-economic factors including poverty, gender inequalities which mean that adolescent girls and other WRA often fail to get the nutrition they need for a healthy pregnancy, food insecurity, inadequate care of mothers and children, low women literacy and poor availability and quality of water, sanitation and health services. These immediate and underlying causes are as:

Infant and Young Child Feeding (IYCF) Practices and Girls/Boys Under-Nutrition: Inadequate nutrition is the major reasons for stunting in Pakistan whereas only 12% of the girls and boys are fed in accordance with the criteria for a minimum acceptable diet. Pakistan is conspicuous for having the lowest rates for the early initiation of breastfeeding (18%) and exclusive breastfeeding rates (48%) for girls and boys. Similarly, Pakistan fares poorly in timely initiation of complementary feeding for both girls and boys. After the first six months of a child's life, appropriate complementary feeding of nutritious and safe foods is a cornerstone of adequate childhood nutrition. However, the general lack of awareness of optimal feeding practices and other social taboos, misconceptions (such as the concept of 'hot and cold foods' or inappropriateness of some foods for children, such as meats and fruits) and poverty further affects IYCF practices and girls/boys under-nutrition.

Adolescent Girls and Pregnant and Lactating Women (PLW) Under-Nutrition: Under-nutrition not only leads to increased risk of mortality among women but also contributes to foetal growth restriction (small size of the baby during pregnancy) that, in turn, multiplies the risk of growth faltering and stunting in childhood. Maternal under-nutrition is estimated to account for a fifth of childhood stunting. NNS 21011 indicates that 18% of the reproductive age women in Pakistan are thin or wasted and this prevalence is highest among households that are food insecure. The 2011 NNS also highlighted the prevalence of "Hidden Hunger" or micronutrient deficiency among adolescent girls and WRA as a major challenge for the country. Half of the women and adolescent girls (50%) suffer from anaemia, and 15% suffer from energy/caloric deficiency. NNS 2011 indicated that Vitamin A deficiency affects 37.1% of the population. Moreover, it has been demonstrated that women and adolescent girls are more vulnerable to micronutrient deficiencies like iron, vitamin A calcium, iodine and folic acid which are essential for normal growth and development.

¹ Poor sanitation and stunting children in Pakistan [https://blogs.worldbank.org/endpovertyinsouthasia/poor-sanitation-stunting-children-pakistan]

² Impact Evaluation of Sindh stunting Prevention Program implemented by WFP

³ Pakistan Demographic and Health Survey 2017-18

⁴ Government of Pakistan. District Wise Population By Sex and Rural / Urban. 2017;

⁵ de Onis M, Branca F. Childhood stunting: a global perspective. *Matern Child Nutr* [http://www.ncbi.nlm.nih.gov/pubmed/27187907]

⁶ WHO | Stunting in a nutshell. WHO: https://www.who.int/nutrition/healthygrowthproj_stunted_videos/en/

Infections: Diarrhoea and ARI are closely interlinked with malnutrition. PDHS 2017-2018 indicates that 14% of girls and boys under age 5 showed symptoms of ARI, 38% had a fever, and 19% experienced diarrhoea in Pakistan. Of these, care was sought for 84% and 81% girls and boys suffering from ARI and diarrhoea respectively. However, this reduced to 71% in case of diarrhoea and only 31% of these girls and boys received ORS and 12.5% were given Zinc.

Health Seeking Behaviours: Inadequate routine immunizations, weak antenatal, perinatal, post-natal care, and a myriad of health system gaps exacerbate the stunting in girls and boys. Gender bias exists in health-seeking behaviour for sick children. The parents who belong to low-income households in Pakistan have been more likely to seek health-care and better quality care for sick sons than sick daughters^{7,8}. Only 65% of children age 12-23 months received age appropriate vaccines. The basic vaccination status for 12-23 months in Sindh was 48.8% (Urban 62.9 and Rural 36.8). There also exists gender bias for vaccination of children where only 63 girls of 12-23 months received basic vaccination in comparison to 68 boys of same age. District Ghotki has been ranked 10th out of the 16 districts of Sindh where 48% male and 55% female children aged between 12-23 months have yet not been fully immunized. Less than half of urban and 1/4th of rural women can access a formal health facility for pre natal consultation in district Khairpur. In rural Sindh, only 1 in every 5 urban and 1 in every 10 women receives consult a formal health care facility and 36% rural women receive some kind of prenatal care from a formal health service. 83% deliveries in rural areas take place in homes normally in the presence of some relative/ neighbour women or traditional birth attendant and 23% rural women receive some kind of postnatal care from a formal health facility⁹.

Poverty: The most pervasive and dominant factor underlying women, girls, boys and adolescents under-nutrition is widespread poverty and food insecurity. Under-nutrition is the result of low income which reduces the capacity of households to purchase required caloric food¹⁰. The prevalence of multidimensional incidence of poverty in District Ghotki is 60-69.9%, Khairpur is 50-59.9% and Nowhero Feroze is 40-40.9%^{11,12}. Periodic or seasonal food insecurity is reported by almost 40-50% of families in rural Sindh. One of the studies found the positive association of household per-capita income, father's occupational status and number of rooms (one living room) in the household with malnutrition in girls than boys¹³. The global review indicates that underweight & stunting is inversely related with wealth quintile; 43% of girls and boys in the lowest wealth quintile are underweight and stunted, as compared with 11% of girls and boys in the highest wealth quintile. The PDHS 2017-18 provides a similar trend of childhood stunting by wealth in Pakistan. The income is purely related with gender aspect in the form that due to scarcity of resources, the male children are given the resources as required and the female children are ignored.

Geographic Disparity, Household Economic Status and Living Condition: There are evidences that children from low socioeconomic background living in poor houses with unhygienic standards, poor sanitary conditions, and unsafe drinking water are more prone to malnutrition. The PDHS (2017-18) notes that the proportion of children who are underweight is greater in rural areas (25%) than urban areas (19%). As for as the gender of child is concerned, it is hypothesized that rural areas aggravate the gender discrimination due to strong social and cultural norms. Moreover, the resource constraint led to gender discrimination where boys are fed better than girls. The access to media and literacy status is also low in rural areas which may enhance further the gender discrimination in rural households¹⁴.

Poor Sanitation and Hygiene and Safe Drinking Water: The World Bank (WB) estimates the economic cost of poor water and sanitation services to be around 4% of GDP of Pakistan¹⁵. In Pakistan, there is a statistically significant relationship existing between poor access to sanitation and high rates of stunting. Lack of sanitation, and particularly open defecation, contributes to the incidence of diarrhoea and to the spread of intestinal parasites, which in turn cause malnutrition (i.e. environmental enteropathy). Children are shorter, on average, in countries where they are exposed to more OD¹⁶. WHO/UNICEF Joint Monitoring Programme (JMP) reports that sanitation infrastructure in Pakistan improved considerably in the last two decades rising from 35% in year 2000 to 66% in 2017, however, there exists big disparities within the country (with 83% coverage in urban areas, while rural areas barely exceed 50% coverage). The population having no access to adequate sanitation is estimated to be 68 million people. Moreover, open defecation is still practiced in 21% of rural areas. In 2015, around 25 million people were still practicing open defecation in Pakistan¹⁷. Around 75% in poor rural communities have access to improved drinking water sources where women, girls and boys spend more than 30 minutes walking to reach a water source¹⁸.

⁷ Fakult W, Aus FL, Dc W. Development and Gender Inequality. 2011;

⁸ Gender Analysis of Malnutrition: A Case Study of School-Going Children in Bahawalpur. Asian Dev Policy Rev. 2016;3(2):29-48.

⁹ RDPI. Neighboring Risk-District Ghotki. and Khairpur

¹⁰ World Bank annual report 2002

¹¹ Multidimensional Poverty in Pakistan | UNDP in Pakistan

¹² (IRIS) IARAN. Stunting in Pakistan A Trends Analysis of Underlying Factors

¹³ Biswas S, Bose K. Sex differences in the effect of birth order and parents' educational status on stunting

¹⁴ Gender Analysis of Malnutrition: A Case Study of School-Going Children in Bahawalpur. Asian Dev Policy Rev. 2016;3(2):29-48.

¹⁵ World Bank. World development report. [Internet]. Oxford University Press; [cited 2019 Jun 26]. Available from:

<http://documents.worldbank.org/curated/en/435331468127174418/World-development-report-2006-equity-and-development>

¹⁶ Reframing undernutrition: faecally-transmitted infections and the 5 As Vol. 2014, IDS Working Paper. 2014.

¹⁷ UNICEF: Without toilets, childhood is even riskier due to malnutrition (https://www.unicef.org/media/media_86283.html)

¹⁸ Pakistan Demographic and Health Survey 2017-2018

Gender Inequality: In Pakistan, women accounts for 49% of the population, however, the colossal disparity in power dynamics between men and women has resulted lagging them behind from men in every sphere of life. Pakistan's ranks 133 out of 160 countries on UNDP's Gender Inequality Index and stands 148th out of 149th countries on gender gap. The gender inequalities contribute to underlying causes and often constitute to the cycle of vulnerability of under-nutrition and stunting. The studies found that more female children as compared to male children have been found stunted in households of poor socioeconomic status than in households of good socioeconomic status. Similarly, it has been found that female children were three times more likely to be stunted than male children in poor and rural families and households in Pakistan¹⁹. Another study noted that when there is more number of children in the household, the mothers prefer the nutritional needs of the sons over daughters.

Mother's Education: Global review highlights that children of women with no education are more likely to be underweight and stunted than children whose mothers are educated (32% versus 8%). In Pakistan bringing the mother's education up to primary level may reduce wasting by 6.8 %^{20,21}. There exists stark gender, urban, rural and intra district disparities in programme districts. In Ghotki, 15% rural women/girls are literate compared to 38% urban while in Khairpur 25% females are literate compared to 65% males, and 17% rural compared to 47% urban. The trend remains the same for District Nowsheroferoze where 32% of women in rural areas are literate as compared to 65% in urban areas and 67 % men in rural areas. Only 12% rural women have completed primary or higher levels of education in the target districts. Similarly, there are much lesser educational facilities for girls than those for boys in these districts²².

Women Empowerment: Women can directly affect their children's nutrition through child care practices, as well as indirectly through their own nutritional status. Several studies have shown the important linkages between women's empowerment dimensions and nutritional outcomes. Such studies indicate that higher female earnings and bargaining power turn into greater investment in children's education and health and nutrition, which leads to economic growth in the long terms. Women's participation in agriculture can also bring financial ease to families, allowing them to focus on health and education in a much better way. These immediate causes are influenced by a number of underlying socio-economic factors such as purchasing power, gender inequality, decision making power of women at family level, and investment in nutrition care of self, children and family. Similarly access to money and freedom to choose to go to market are also associated with lesser prevalence of stunting. An International Food Policy Research Institute study stated that as much as half of the reduction in hunger can be attributed to improvements in the societal status of women. Hence, it is vital to keep women at the centre of investment and intervention packages to break the cycle of malnutrition.

A.2.2. Need for Sector-wide Integrated Programming for Stunting Reduction

Since the adaptation of SDGs, the progress on addressing malnutrition remained slow globally and as well in Pakistan.²³ Despite slow progress, yet the opportunity to end malnutrition has never been greater, as the world has been better equipped than ever before with knowledge-base and understanding better the multifactorial aetiological factors and underlying causes of stunting. Considering the multifactorial aetiology nature of stunting and growing body of evidence-based interventions to address the basic and underlying causes and contextual factors, the global community strongly advocates and demands for the adaptation of sector-wide integrated programming (involving health, nutrition, agriculture, WASH, social policy and education) by deploying multi-sectoral approaches to combat the menace of stunting (refer to annex 2 for more details). In addition to these, stunting reduction programmes need to pay due considerations to cross-cutting themes, social determinants and confounding factors such as poverty, social differences and gender inequities to address stunting in a sustained manner. It is vital that the duty bearers may seize this window of opportunity to reach the SDG target of ending malnutrition in all its forms by 2030²⁴ through sector-wide and evidence based integrated programming.

A.2.3. Institutional Context

In order to combat the menace of high prevalence of stunting and under-nutrition, Government of Sindh (GoS) set its priorities and direction under an overarching strategy, namely, Sindh Vision 2025. Under this overarching strategy, the GoS with support of the developmental partners adopted several policy and practice reforms for creating enabling environment to support the implementation of nutrition-specific interventions and nutrition-sensitive approaches. These initiatives include but not limited to: Inter-sectoral Nutrition Strategy Sindh, Sindh Strategic Sector Plan 2016 – 2026, Sindh Drinking Water Supply Policy 2016, Sindh Sanitation Policy and Behavioural Change and Communication Strategy and SAAF SUTHRO Sindh Programme. In addition to GoS initiatives, the federal government has established a high-level task force in 2017 on early childhood development at the National Planning Commission. The federal government of Pakistan has also prioritized to: a) finalise Pakistan's Multi-Sectoral Nutrition Strategy, b) approve the Federal Nutrition Programme (PC-1), c) promulgate legislation on food fortification in the provinces, d)

¹⁹ Wamani H, Tylleskär T, Åström AN, Tumwine JK, Peterson S. Mothers' education b the best predictor of child health inequalities i. <http://equityhealth.biomedcentral.com/articles/10.1186/1475-9276-3-9>

²⁰ Alderman H, Garcia M. Food Security and Health Security(<https://www.journals.uchicago.edu/doi/10.1086/452099>)

²¹ Review AN. Gender Influences A Narrative Review on Child Survival , Health and Nutrition:

²² RDPI. Neighboring Risk-District Ghokti. and Khairpur

²³ Global Nutrition Report 2018

²⁴ Global Nutrition Report 2018

prepare operational guidelines for the enforcement of breastfeeding laws, and e) develop a SUN advocacy and communication strategy.²⁵

In addition to creating conducive policy and enabling environment, the GoS with support of World Bank developed an Accelerated Action Plan (AAP) for reduction of stunting and malnutrition, namely “Sehatmand Sindh”. AAP is a multi-year and multi-million dollar initiatives that aims to reduce stunting from 50% to 30% by 2021 and additional 15% by 2026 through multi-sectoral programming. AAP is a step forward to operationalize and achieve targets that have been set out in Sindh Vision 2025 and to contribute in reaching the SDGs targets by 2030. In order to operationalize AAP, the GoS established a Taskforce Secretariat, under the Planning and Development Board (P&DB). The Taskforce Secretariat worked directly with eight government line departments to plan, coordinate and oversees implementation of the sector-wide plan. In addition to sectoral collaboration, the Taskforce also works closely with developmental partners to foster new partnership with non-state actors for unleashing the developmental potential in a sustained manner. AAP focuses on first 1,000 days of child’s life, children of 24-59 months and the women of reproductive age with specific attention to adolescent girls.

A.3. Programme Description (Object of Evaluation and ToC)

Programme’s Interventions Description: The programme deployed integrated nutrition-specific interventions and gender-responsive nutrition-sensitive approaches to address the multifactorial aetiology of stunting as:

🕒 **Nutrition-Specific Interventions:** The intervention package aimed to address the immediate/basic causes of under-nutrition (inadequate dietary intake and infections or combination of both). To this end, the programme focussed on improving the nutritional status of children from conception until age 2, pregnant & lactating women (PLW), adolescent girls and women of reproductive age. These preventative interventions covered aspects of improving exclusive breastfeeding practices, complementary feeding for children aged 6-23 months, multi-micronutrient supplementation (vitamins and minerals) and provision of iron and folate to address deficiencies among PLW & adolescent girls. Alongside these preventative measures, the programme established mechanisms for early detection of under-nutrition in children through their MUAC screening at the community level and enrolling the malnourished children for treatment in OTPs and SC including referral for seeking additional health services such as vaccination and other ailments.

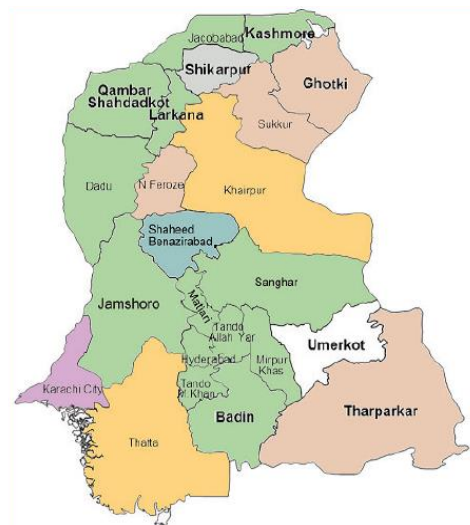


FIGURE 2: MAP OF SINDH DISTRICTS

🕒 **Nutrition-Sensitive Interventions:** The nutrition-specific interventions were coupled with gender-responsive WASH services to address the underlying causes of under-nutrition by improving access to and availability of water and sanitation services at the household and community level. The focus of the nutrition-sensitive approaches revolved around in reducing incidence and severity of infection in children while controlling environmental enteropathy and its potential negative impact on children’s linear growth. These interventions included: a) providing clean water through construction or rehabilitation of water supply schemes and installation of hand pumps, and b) providing sufficient means of sanitation to achieve ODF village status (construction of latrines, safe disposal of human excreta and triggering process at the community level for achieving ODF).

🕒 **Gender Responsive Integrated SBCC:** The programme adopted comprehensive and integrated SBCC activities for nutrition-specific interventions and nutrition-sensitive approaches. These interventions included: improving infant and young child feeding (IYCF) practices, improving family and community hygiene knowledge/practices, creating demand for the use of micronutrient supplementation, reducing in open defecation, and promoting sick children care and seeking care of sick children from the health facilities.

🕒 **Creating Enabling Environment:** The programme prioritized upstream and system strengthening actions by creating an enabling environment for the improved service provision and policy environment. The programme key contributions included: supporting GoS in developing policies and M&E frameworks, building duty bearers and decision makers capacities on integrated approaches, strengthening coordination mechanisms at provincial and district levels and rolling out web-based WASH and Nutrition Management Information System.

Additionally, the programme addressed inequities in reaching poor and marginalized communities by improving access to and availability of gender-responsive nutrition-specific and nutrition-sensitive services and supported the poorest of poor through community investment grants (CIGs) to construct latrines. Moreover, the programme ensured women, girls, boys, men and marginalized groups’ participation in the community-led structures and community-based provider’s network.

²⁵ Pakistan Institutional Transformations 2016-2017. <http://docs.scalingupnutrition.org/wp-content/uploads/2017/10/Pakistan-SUN-Movement-Annual-Progress-Report-2017.pdf>

Programme Result Framework and Theory of Change (ToC): The programme established and maintained a multi-faceted model to garner household, community, service delivery and policy/institutional level changes through the above stated intervention package. The programme interventions were organized under result framework²⁶ with a **strategic objective (goal)** of “Contribute towards Reduction in Childhood Stunting Prevalence in the Programme Target Districts of Sindh”. In order to translate the aim into action, the result chain was organized **under a specific objective (outcome)** of “Uptake of Nutrition and WASH Services and Practices Improved in the Programme Target Districts”. The specific objective was reached through **three intermediate results (outputs)** which included: a) Enabling Environment for Integrated Nutrition-Specific and Nutrition-Sensitive Services Improved at Provincial and District levels in Sindh, b) Access to WASH and Nutrition Services Strengthened in 3 Target Districts through Public and Civil Society Organization (CSO) partners, and c) WASH and Nutrition Awareness in Communities Improved.

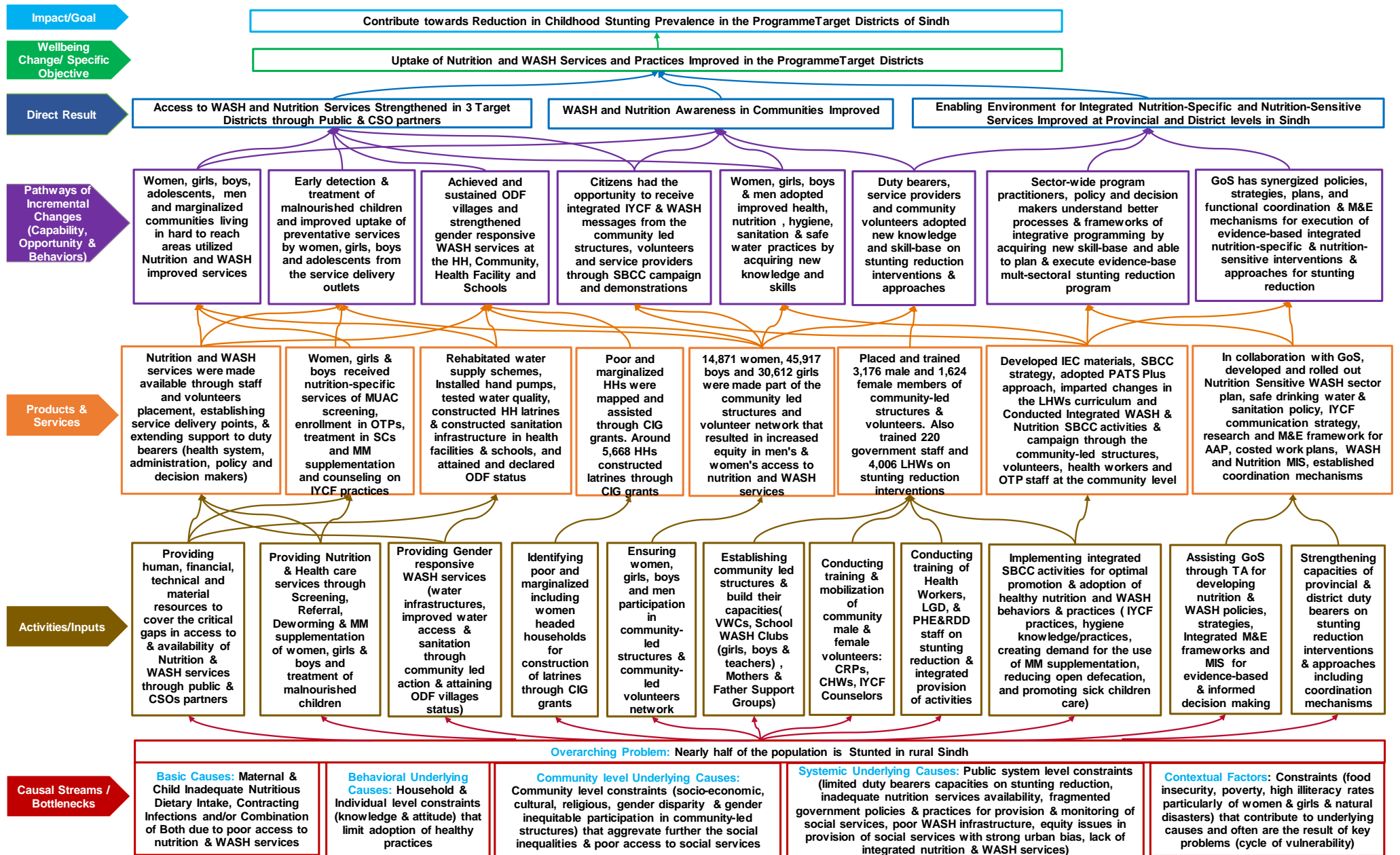
In line to the result framework the evaluators structured the programme ToC, as reflected in **figure 3**. The ToC provides an overview of the key programme aspects, ranging from inputs to impact level, and the intended population level changes. The ToC also demonstrates the causal links and the linear connect among the vertical hierarchy of the result framework, pathways of incremental changes and key assumptions²⁷. **Though objectives in the result framework didn't specify gender aspects per programme design (see PMP in Annex 3) which UNICEF needs to consider imparting in future programmes. Despite this limitation of lacking gender reflection in the result framework, the programme imparted gender-responsive activities in the programme delivery and implementation. Subsequently, the evaluators reflected these gender-responsive aspects in the restructured ToC** by stating how the programme effected change within a specified population including women, girls, boys participation and social inclusion of the poor and marginalized communities, and contributed in accomplishing the higher results in hierarchy of change such as intended outputs (intermediate results), outcome (specific objective) and impact. In order to translate the ToC into action, the programme deployed integrated implementation approach to effectively address the immediate, underlying and basic causes of under-nutrition through system strengthening actions, provision of comprehensive WASH and nutrition services and behavioural change communication to improve households and communities knowledge and practices. To this end, the programme deployed a phased implementation approach to operationalize the programme intervention package. The phasing in interventions is described in the PMP in Annex 3) and Integrated Action Plan (Annex 4).

Programme Beneficiaries: The programme addresses the needs of all population in the target districts with a focus on women, children, female adolescents and marginalized population. The intended **direct and indirect beneficiaries** of the nutrition-specific interventions are over 5 million (indirect) and 646,590 (direct) while nutrition-sensitive over 1.8 million (indirect) and 1.2 million (direct). In addition to the direct beneficiaries, the programme also worked with stakeholders and community-led structures to support the integrated activities. These **individuals, groups and institutions** included: a) Individuals, including Community Resource Persons (CRP), IYCF counsellors and Couple Health Workers, b) Communities, including village WASH committees, mother support groups and father support groups, c) Institutions, including health facilities and schools, and d) Stakeholders including provincial and district governments. Moreover, the programme also took in account to address the aspects of **gender, equity and social inclusion** through various measures among the programme beneficiaries such as: a) provision of CIGs to the poor and vulnerable including female headed households, b) improved sanitation facilities at the healthcare centres aimed to provide women the opportunity to use these with dignity and privacy, c) established community-based structures (e.g. Mother and Father Support Groups) resulted in greater participation of the local community (especially women). The members of mothers and father support groups were also part of the village WASH committees in their respective villages to increase ownership and enhance leadership of the women. The members of mothers and father support groups were also part of the village WASH committees in their respective villages to increase ownership and enhance leadership of the women, d) preventing and treating micronutrient deficiencies specifically such as children, adolescent girls and Pregnant and Lactating Women (PLW).

²⁶ The review of the program ToC given in the evaluation ToR and PMP highlighted disconnect in structuring “vertical hierarchy of the result framework”. The goal, outcome and outputs were presented in varying order in the vertical hierarchy of the result framework. The evaluators discussed this disconnect between the two documents with the UNICEF program team. After discussion, the evaluators and the UNICEF team agreed to revise the vertical hierarchy of the result framework for the evaluation purpose and to reword slightly to make them smarter without compromising on the intended outcomes per the program design

²⁷ The key assumptions are not depicted in the ToC diagram, however, these included: a) women, girls, boys, adolescents and men will be open to adopt new practices & knowledge, b) men and community influential will not prevent women and girls in participating in the program activities, c) citizen Committees will continue to function, d) District Authorities, DoH and School Administration will support the initiatives, e) Community-based Volunteers and Committees are sufficiently motivated to organize SBCC sessions and mobilize communities, f) Service delivery staff & community based volunteer network will use the newly acquired skills and knowledge in provision of services, community mobilization and creating awareness, and g) GoS supports the implementation of activities and commit resources to continue nutrition and WASH services after the program life span

FIGURE 3: PROGRAMME THEORY OF CHANGE



A.3.1. KEY STAKEHOLDERS

The programme engaged stakeholders from public institutions, rights holders (male and female services beneficiaries), community-led structures (male and female members), civil society organizations and male & female nutrition/WASH practitioners in technical working groups during the course of programme implementation as:

National Level Engagement with Key Stakeholders: UNICEF worked with the National Health Services Regulation and Coordination (MoNHSR&C) and male & female Nutrition Working Group's members to develop a web-based Nutrition Management Information System (NMIS). UNICEF also engaged NUST to develop WASH-MIS to support the PHE&RDD in managing data flow and feedback mechanisms. Similarly, UNICEF also coordinated with WFP and WHO on various aspects of the programme at national level.

Provincial and District Level Institutional Engagement with Key Stakeholders: Programme worked in close collaboration and partnership with the provincial departments of Health, PHE&RDD, LGD, Taskforce Secretariat, and PD&B. The role of these departments relates to policy and strategy formulation; avoid duplication of efforts, coordination with different partners, resource allocation and oversight of the programme implementation. Similarly, the programme involved all the key line departments at the district level. The programme established District Steering Committee (DSC) to coordinate among the implementing partners (NGOs) and government line departments to identify & address the bottlenecks in implementation and oversee the progress of the programme implementation. The programme was designed and implemented in consultation and collaboration with provincial and district authorities and institutions. The duty bearers' involvement in all phases of the programme from design until exit of the programme led to the ownership and buy-in of the government institutions which resulted in the allocation of resources and continuum of nutrition-specific and nutrition-sensitive services after the exit of the programme in a sustained manner. In the implementation phase, GoS assisted the programme through in-kind support that included: use of the GoS existing health workforce (particularly LHWs), use of health facilities, coordinate programme activities through DSCs in the target districts, conduct monitoring and supportive supervision visits, ODF verification and certification and commitments to allocate resources to ensure continuum of nutrition-specific and nutrition-sensitive services after the exit of the programme.

Community Level Engagement and Key Stakeholders: These key actors and stakeholders included:

- 🕒 **Institutions and staff at Service Delivery Points:** At the community level the programme worked in close collaboration with male and female health facility staff in the OTPs and SCs, medical superintendent of the DHQ/RHC, male and female school staff and male and female WASH club members. The programme built their capacities on provision of services and SBCC approaches. In turn, they extended their support in the implementation of the program activities. Programme worked with USAID's flagship MCH Programme that was geared towards improving maternal, New-born, and child health through 1,500 fully functional, standardized 24/7 MNCH Centres. The nutrition and WASH Programme developed linkage with USAID MCH program to leverage on on-going health interventions in the three targeted districts.
- 🕒 **Community-led Structures and Community-based Network of Service Providers:** The programme established mixed gender VWCs, Mother and Father Support Groups, female YCF Counsellors, male & female CHWs and Social Mobilizers. The programme built the capacities of the male and female members of the community-led structures and network of providers. They played a key role in undertaking the programme outreach activities including screening of patients, referral of patients, SBCC, triggering for ODF at the community and identification of poor and marginalized in allocation of CIGs.
- 🕒 **Rights Holder (Female and Male Direct or Indirect Services Beneficiaries):** The programme ensured access to and availability of improved WASH and Nutrition services and commodities at the community level to all, particularly women, girls, boys, adolescents and vulnerable population.

B. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

B.1. Evaluation Purpose

This summative evaluation is being planned after the implementation of the programme interventions. Currently, there exists a knowledge gap in Pakistan on how Nutrition and WASH programmes can be integrated to reduce stunting. Hence, the evaluation aims to assess the effects of the integrated WASH and Nutrition programme and to gather evidence-based learning on how to design and implement such integrated programme in future. The evaluation is expected to support advocacy purposes among Nutrition and WASH sectors for an integrated approach towards stunting reduction in future programmes. Moreover, the evaluation will contribute to improve the design and implementation as well as monitoring and evaluation of future integrated Nutrition and WASH interventions within UNICEF in Pakistan and globally. The primary expected users of this evaluation are the Government of Sindh, Government of Pakistan, UNICEF Pakistan and ROSA, donors, NGOs and academicians in the Nutrition and WASH sectors. Indirectly, the learning from this evaluation will also support the women, children, families, communities, health care providers, policy makers and opinion leaders as secondary audiences of this evaluation. Additionally, the GoS will use the learning from the evaluation in shaping the multi-sectoral programme strategies under AAP initiative for integration of nutrition-sensitive and nutrition-specific interventions and approaches in efficient and effective manner. The evaluation findings will also influence changes in the GoS and development partners programme

implementation practices and creating an enabling environment at institutional level to support the implementation of evidence-based integrated approaches to reduce stunting including refinement of the existing government policies and strategies.

B.2. Evaluation Objectives

The specific objectives of the evaluation are as: 1) to provide accurate, credible, and usable information on the performance of the Stunting Reduction Programme against the DAC criteria for evaluation, 2) to examine effects of integrated Nutrition and WASH interventions on the contribution toward reduction of stunting, 3) to explore the determinants of good or poor performance (internal and external, such as the enabling environment) and the system support, 4) to review and assess the benefits of the programme received by the entire health system in various ways, particularly, assessing how it has contributed in shaping the planning and implementation within GoS and other public-sector stakeholders, and 5) to elicit lessons learned and good practices for providing recommendations on strengthening future stunting reduction programs using convergence approaches.

B.3. Evaluation Scope

The evaluation covered the programme implementation period between May 2016 and December 2018 in the three target districts of Noushero Feroze, Ghotki and Khairpur in the Sindh province of Pakistan. The evaluation scope of work included: a) holding kick-off meeting and drafting evaluation inception report including evaluation matrix and evaluation tool kit, b) conducting extensive desk review of the key project documents and scoping literature review, b) mapping and listing of key stakeholders at the community, district, provincial and national levels and gathering information from them through IDIs and FGDs, b) gathering, analysing, interpreting, triangulating and synthesizing both primary and secondary qualitative and quantitative data and information including direct observations, cost-effectiveness and cost-benefit analysis and case studies, c) sharing preliminary findings of the evaluation and holding in-depth discussion with the UNICEF and Implementing Partners at Islamabad and Karachi Level, d) re-working on the preliminary findings in the light of held discussion with the UNICEF and IP staff and drafting recommendations, e) sharing draft evaluation report and incorporate feedback from the UNICEF in the revised evaluation report, and f) finalizing the report. Programmatically, the evaluation examined all programme aspects under UNEG/OECD-DAC evaluation criteria for the entire programme timeframe. The evaluation team used the OECD/DAC criteria to assess relevance, efficiency, effectiveness, impact and sustainability comprehensively, using mixed method approach. Additionally, the evaluation team also gathered information and ascertained the state of the cross-cutting themes of gender, rights, equity and DRR. Concerning the evaluation scope for more details refer Annex 5.

C. EVALUATION METHODOLOGY

C.1. Evaluation Criteria and Matrix

The listed objectives, including evaluation criteria based on the OECD- DAC/UNEG principles and cross-cutting themes (stakeholder participation, gender, equity, human rights and disaster risk reduction) made the overall scope of work of the intended program evaluation. The definitions used for each of the DAC criteria were drawn directly from the relevant OECD/DAC publication, the “Glossary of Key Terms in Evaluation and Results Based Management.”²⁸ For the non-DAC criteria, the United Nations Evaluation Group (UNEG) guidelines on “Integrating Human Rights and Gender Equality in Evaluations 2014”²⁹ were used. The Evaluation Matrix expands on the criteria and elements, discussed briefly below and presented in Annex 6. The standard evaluation criteria were approached as:

Relevance: The evaluation assessed the extent of the programme alignment with national and international commitments, beneficiaries’ perceived needs, and complementarities with key actors, and mainstreaming human rights commitments including synthesizing information on social difference and aspects of gender and equity considerations.

Efficiency: Under this criterion the evaluation examined how well the resources been utilized in the best possible way to transform inputs into results in efficient manner. The evaluation observed the adopted programme strategy of integration and convergence, capacities and synergies of the implementing partners, program timeframe and efficient attainment of results and cost-benefit analysis. The report also provides details on the measures of iterative programme adaptive management and its potential for scaling up.

Effectiveness: The evaluation assessed the extent to which the programme achieved the planned objectives of the programme, using ToC and PMP. Additionally, the evaluation examined the aspects of programme’s adaptation to constraints to help achieve the programme results and human rights, equity, gender and DRR dimensions.

²⁸ Organisation for Economic Coordination and Development – Development Assistance Committee (OECD DAC), 2010. *Glossary of Key Terms in Evaluation and Results Based Management*. [pdf] Paris: OECD DAC. Available at: <http://www.oecd.org/dac/evaluation/2754804.pdf> [Accessed: 12 January 2019].

²⁹ United Nations Evaluation Group (UNEG), 2014. *Integrating Human Rights and Gender Equality in Evaluations*. [pdf] New York: UNEG. Available at: <http://www.unevaluation.org/document/download/2107> [Accessed: 12 January 2019].

Impact: Under this criterion, the evaluation examined how well the programme contributed in achieving positive and lasting effects on individuals, households, communities and institutions. These aspects were covered through adaptation of healthy behaviours and key family practices, enabling environment for provision of improved services and programme un-intended effects. The evaluation couldn't ascertain the contribution of the programme in stunting reduction as the intended NNS was delayed and findings were not available to show the programme attribution in stunting reduction

Sustainability: The evaluation assessed the extent to which the positives effects of the programme are sustainable or likely to continue beyond the project life. The various aspects of sustainability were analysed against program exit strategy, continuum of services after the exit of the programme, institutionalization of policies and practices, lasting behaviour changes at household/community levels and key factors/drivers contribute to or constrain the program effects/interventions

The cross-cutting criteria of **gender, social differences, HRBA, equity, DRR, and stakeholder's participation** were referenced across all the evaluation criteria, particularly integrated under relevance and effectiveness sections of the finding section of the report. Moreover, parts of these cross-cutting themes are discussed throughout of the report from background until recommendations including presenting gender disaggregated data against the indicators, particularly within the finding section of the report.

Evaluation Matrix: The evaluation ToR listed DAC and non-DAC criteria-based questions (see annex 2A for the original ToR), which guided the formulation of Evaluation Matrix with few changes. In total there were 24 major questions in the ToR (2 in relevance, 6 in efficiency, 6 in effectiveness, 6 in impact, 2 in sustainability and 2 in cross-cutting themes). The evaluation team assessed all these 24 questions and noted that: a) some questions were repetitive and transversal in nature; hence, they were repeated with slight difference in wordings under more than one DAC criteria and regrouped several criteria, b) some of the questions were of loaded nature that were having more than one question to explore multiple aspects, c) parts of some questions were of probing nature which could be captured during interviews and FGDs with participants, and d) aspects of cross-cutting questions (gender, equity, human rights and DRR) were covered under two questions only in the ToR. In the inception phase, the evaluators modified a few of these listed questions in the ToR, which is being reflected in the evaluation matrix (please refer for the details of the modified questions and the evaluation matrix in Annex 6)

C.2. Data Collection Methods

The Evaluation Team used mixed evaluation methods by employing both qualitative and quantitative methods including scoping literature review, FGDs, IDIs, case studies and direct observations in the field. The deployed mixed evaluation methods for gathering information and data are described in the sub-sections below:

C.2.1. Desk Review and Analysis of the Secondary Sources of Information

The evaluation team undertook extensive desk and scoping literature review and analysis of the key documents and processes that include but not limited to: a) in-depth documentary review and structured desk analysis of programme design, implementation approaches, documenting of results and processes, structured desk analysis of policy documents and legislative frameworks, b) analysis of results from M&E systems, program and secondary data at national and provincial level (PDHS, PSLM, MICS), c) conduct scoping literature review and access reference documents from multiple sources including online scientific databases and grey literature, national & international key strategic and policy documents, and UNICEF evaluation documents standards etc., d) hold meetings with UNICEF and implementing partners, e) stakeholder listing, f) situational and contextual analyses to determine factors which promoted or impeded the progress against intended results, and g) mapping of risks analyses and mitigation measures, financial analysis, and systems analysis of management, monitoring, quality control and assurance strategies

C.2.2. Gathering & Synthesizing Quantitative Data & Information

UNICEF with the help of a consulting firm conducted baseline and end line KAP quantitative cross-sectional surveys to measure progress against the key indicators overtime. UNICEF agreed during the inception period to use the KAP end-line survey data for comparing and analysing the progress made against the baseline as a source of primary data. The pre and post cross-sectional surveys used 929 and 948 mothers with a child less than two years as a sample size (more than 300 women per districts) respectively that yielded weighted representation of the coverage estimates at the district and programme level. The evaluators conducted data cleaning and analyses, using the statistical software R Studio® (version 3.5.1)³⁰. Descriptive statistics were produced as frequencies, proportions and charts. The selected WASH and Nutrition programme indicators were calculated based on the standard WHO³¹ and UNICEF definitions. In the first stage of analysis, the evaluation team crosschecked the data for any inconsistencies and missing values. In the second stage, all the variables relevant for the programme were analysed to assess the impact of the interventions. Since the types of the samples were independent data samples and the indicators were calculated as

³⁰ R Studio, Inc., Boston, MA, USA

³¹ WHO (2010) Indicators for Assessing Infant and Young Child Feeding Practices, World Health Organization. doi: ISBN 978 92 4 159975 7.

proportions of the categorical variables, the evaluators used the chi-square test to determine the level of association or difference between the pre and post intervention values. For all the indicators, a p-value of <0.05 was considered for calculating statistically significant effect of the intervention and to measure change between end and baseline.

C.2.3. Cost-effectiveness and Cost-benefit Analysis

Evaluation calculated DALYs averted to evaluate the cost-effectiveness³² of nutrition-specific and nutrition-sensitive interventions. Evaluation carried out the cost-benefit analysis by monetizing the DALYs averted and calculating the return on investment. To calculate DALYs averted, evaluation team deployed the following process and methodology for measuring the improvements in the key outcomes of the programme interventions between end-line and baseline:

- **Cost Related Indicators:** a) Cost per capita, b) Cost per death averted of conceived or born children until age 5 years, and c) Cost per additional DALYs averted for overall programme, Nutrition-specific interventions and Nutrition-sensitive interventions
- **Estimating cost-effectiveness:** The key steps included:
 - **Develop Cost Sheet:** A cost sheet was developed where all the expenditures incurred during the project implementation period were analysed by each component i.e. Nutrition and WASH. The costs included UNICEF³³ and IPs contributions.
 - **Calculate Cost per Capita:** Cost per capita was calculated by adding all the costs obtained as above and dividing them by the total target population.
 - **Interventions selected:** These include: a) Nutrition-specific component: Exclusive breast feeding, Iron and folic acid supplementation for pregnant women, Treatment of Severe Acute Malnourished Children (SAM), Multi Micronutrient Supplementation (MMS), and b) Nutrition-sensitive component: Improved sanitation, Water connection in the home
- **Lives Saved Tool (LiST):** The evaluation team used LiST³⁴ (v5.73) to calculate the deaths averted and calculating DALYs averted by improvement in the key outcomes.

C.2.4. Gathering and Synthesizing Qualitative Data & Information

The evaluation team deployed mixed qualitative methods (IDIs, FGDs, Direct Observations and Case Studies) to gather evidence of the intended or unintended outcomes of the programme in a descriptive manner. The deployed methods also collated the stakeholders (male & female duty bearers and women, girls, boys, men and poor/marginalized segment of the population at the community level) views on the performance of the programme including lesson-learned and bottlenecks that they faced and/or mitigated in the implementation. Subsequently, these deployed methods also provided in-depth analysis and insight to the how and why aspects of the programme delivery in relation to macro and micro contextual factors and serve the purpose to triangulate the quantitative findings and results of the program. The human rights and gender equality (HR&GE) dimensions were integrated into all data collection methods and tools. The qualitative methods^{35 36} have been assigned to the Evaluation Questions in the Evaluation Matrix and the overview of these methods is presented in Annex 7.

Evaluation Tool Kit: Prior to begin the data collection and during the inception period, the evaluators developed the qualitative evaluation tool kit to facilitate FGDs, IDIs and direct observations with male, female and mixed groups that included: a) FGD's Topic guides for Natural Group such as Mothers Group, Fathers Group, ODF/WASH Committees (male and female), male Masons, male Entrepreneurs and School Children (boys and girls), b) FGDs Topic Guides for Expert Group such as female LHWs, male & female Social Mobilizers/CRP, School Teachers/WASH Club Members (male and female), c) IDIs Topic guides for male and female key informants such UNICEF and Implementing Partners, USAID, Provincial Officials, District Officials, and LGD and PHE&RDD Government Representatives. The evaluation tool kit of the topic guides for women, men, girls and boys or mixed groups are presented in Annex 8 and 8A and the related Informed Consent, Informed Assent and data protection guidelines in Annex Box 2 (Annexes A to I).

Placement and Training of Enumerators: Evaluation team recruited eight male and six female enumerators to implement the field work under the supervision of the evaluation team. The recruited enumerators were local, understood the cultural context and spoke the local language. They had a research background, experience of health, nutrition and WASH sectors, and worked with women, girls, boys, adolescents and marginalized segment of the population. Considering the evaluation needs, the evaluation team recruited two more male enumerators than female as the programme worked with only male masons and entrepreneurs, hence, the evaluation team deployed a specific team consisted of two male enumerators to reach the masons and entrepreneurs accordingly. Additionally, the same

³² Cost-effectiveness analysis (CEA) is a form of economic analysis that compares the relative costs and outcomes (effects) of course of action adopted. The CEA is expressed in terms of a ratio where the denominator is a gain in health from a measure (years of life, premature births averted, etc.) and the numerator is the cost associated with the health gain. Health gain is usually measured by calculating Disability Adjusted Life Years (DALYs) or Quality Adjusted Life Years (QALYs).

³³ Both cash and in-kind contributions

³⁴ This is a globally accepted tool and used by: Bill & Melinda Gates Foundation, Children's Investment Fund Foundation, DFID, USAID, Gavi, WHO, UNICEF, World Bank, JHPIEGO, PATH, PSI, Save the Children and World Vision.

³⁵ UNICEF. Equity-focused evaluations. 2014;

³⁶ Nick. Microsoft Word - IJQM 8.3 Onwuegbuzie. 2009;1–21. Available from:

http://research.apc.org/images/2/2f/A_Qualitative_Framework_for_Collecting_and_Analyzing_Data_in_Focus_Group_Research.pdf%5Cnpapers3://publication/uuid/97441C12-D3E5-4116-BE31-58D5E04A3915

team was assigned to undertake the community level direct observations whilst keeping in view the cultural sensitivities in the given communities. The senior evaluation team comprised of two female and two male lead evaluators, trained male and female enumerators on the FGDs topic guides, direct observations in the field sites and how to document case studies. The evaluators conducted the training for four days in Sukkar which covered aspects such as scope of the integrated Nutrition and WASH project, rationale of the evaluation, UNICEF ethical guidelines, characteristics and tools of qualitative methods, introduction of interview topic guides/tools; moderation or facilitation skills with an emphasis on asking the right question, constitution of groups with gender and power balance and the art of probing such as note-taking skills and checking information for correction. Considering the scale and complexity of the topics, evaluation team also grouped the enumerators in pairs for conducting FGDs on specific topics during the training so that they can gather the data on those topics with specificity. The enumerators practiced the relevant FGD topics including the related aspects of the direct observations through role plays during the training. They also practiced the tools in their neighbourhood to assess the flow of questions and understating of the respondents in their neighbourhood. The enumerators then reported back their experience of practicing the tools in the training which were discussed thoroughly in the plenary to develop shared understanding of asking questions from the FGDs respondents in a consistent manner in all sites.

Sampling Approach and Field Work: Non-probability sampling methodology was used, where sample were chosen purposely (criteria-based) within the sampled population at various levels (women, boys, girls and men at the community level and male & female service delivery staff, decision makers and key informants at district, provincial and national levels). Considering the complexity of the research topic, the respondents were selected deliberately based on features and characters that enable a detailed understanding of the research topics. Prior to the selection of units a mapping exercise was carried out in which all the respondents for FGDs and sites for direct observations were listed, based on the details provided by UNICEF and IPs. Out of the list, communities and sites were randomly identified for conducting FGDs, direct observations and case studies. Seven teams (6 female and 8 males) were deployed for data collection in the field, each team with a facilitator and a note-taker. The note takers also played the role of group organizer. The lead evaluators (two male and two female) directly supervised the survey teams in the field whilst they were collecting data. Additionally, the survey team including the lead evaluators conducted direct observations of ODF village status, OTP sites, stabilization centres, hand washing stations, water pumps and latrines in the field sites. The survey team and evaluators also gathered information on 3 case studies in the field and held interviews with concerned individuals, families and district authorities. In addition to direct supervision of survey team by the lead evaluators in the field, the evaluators also debriefed the enumerators on daily basis after their return from the field. In the debrief sessions, the lead evaluators and the enumerators discussed the field experiences, identified missing information, reviewed the recorded information, discussed challenges, sought solution and plan for the next day and took special measures to minimize the data collector's bias. In the process of data collection **for FGDs and IDIs including pre and post quantitative data, the gender and equity** related aspects were addressed systematically as:

- Equity Considerations in Data Collection:** The evaluators used snowball methodology to reach vulnerable and marginalized individuals/groups at the village level. During the FGDs at community level, the evaluators identified the destitute neighbourhoods within the villages. A team of the enumerators comprised of one male and female visited the identified areas in each of three districts to assess the extent to which the programme interventions reached the neglected communities. After identification, the enumerators who belonged to the target districts and were familiar with the local context conducted FGDs with vulnerable groups by ensuring that all the respondents felt safe and freely express their views. The evaluators randomly selected one household in all three target districts who received CIGs for direct observations and gathered data for the case studies. Additionally, the evaluation team ensured that FGDs with women are conducted in a convenient manner with them whilst keeping in view the cultural constraints. These measures included: a) selected convenient time for women so that FGDs may not hinder their household chores and responsibilities, b) identified FGD's locations within the community which is culturally appropriate for them to visit such as Basic Health Unit (BHU) or the house of a respected elderly female representatives etc. and c) facilitated the discussion in an environment where women expressed freely their views without fear of social reprisal such as expressing their opinions on matters related on children feeding practices and decision making dynamics in the households
- FGDs and Gender Composition of the Respondents:** The survey team conducted 31 FGDs with a total of 220 participants out of which more than half of the respondents were women and girls (114 out of 220). The gender composition per group included as: Mothers group (67 women), 25 school children (13 boys and 15 girls), 13 school teachers (7 male and 6 female), 19 CRP/social organizer (8 male and 11 female), 28 VWC members (all men)³⁷, and 4 male masons and 3 male entrepreneurs³⁸.
- IDIs and Gender Composition of the Key Informants:** Evaluation deployed purposive sampling methods to interview key informants at district, provincial and national levels based on the stakeholders mapping. The lead evaluators (two females and two males) conducted the in-depth face-to-face interviews with the key informants (except for two key informants with whom the evaluators held interview on phone and skype). In the process, the

³⁷ Though the VWCs have representation of female members, however, during the data collection in the field the evaluation team didn't able to locate and meet the female VWCs members.

³⁸ The program placed and trained only men as masons for constructing latrines and worked with men entrepreneurs for sanitary materials

evaluators focused to reach women serving at key positions to interview them as key informants, as fewer numbers of women are employed at key positions in the government at provincial and district levels. The evaluators conducted 49 IDIs with key informants at all levels using topic guides in line with the role and contributions of the key informants. The gender compositions of the key informants from government institutions, UNICEF, Programme Implementing Partners and USAID included as: 36% (4/11) female at the national level, 31% (5/16) female at provincial level, and 18% (4/22) female at district level. Please refer to annex 9 for the list of key informants who were interviewed during the evaluation.

- C **Gender Composition in the Pre and Post KAP Survey's Respondents:** A total of 929 and 948 women with a child less than two years were surveyed in the pre and post KAP surveys to measure the change in knowledge, attitude and practices of them with regard to IYCF, hygiene, human excreta disposal, sanitation facilities and water sources. Out of the interviewed women the majority (67% in pre & 59% in post) were illiterate and most of the households (61% in pre & 50% in post) live below the poverty line of having income less than PKR15,000 per month. Additional HHs (36% in pre & 47% in post) earning was between PKR 16,000 to 30,000. Hence, the very vast majority of the surveyed population belonged to destitute or extremely poor socio-economic background.

C.3. Analytical Approaches & Quality Assurance

The evaluation assessed the programme against DAC criteria of relevance, efficiency, effectiveness, impact and sustainability and non-DAC cross-cutting themes of stakeholder participation, equity, HRBA, gender and DRR as discussed in section C.1 above. The key elements of evaluation assessment included: programme design, programme reports, ToC, result framework, PMP, IAP and data used for monitoring performance and attainment of the results. Additionally, the evaluators used qualitative and quantitative data including scoping literature review to draw inferences against the DAC and non-DAC criteria. In order to operationalize the evaluation, the evaluators developed an evaluation matrix (section C.1 and annex 6) that served as a guide to gather and analyse the data/information to answer the evaluation questions. The evaluation matrix specified indicators, data collection methods and sources of information to answer the questions under each criterion. The key aspects of the analytical approaches and quality assurance included: a) Analysis of Quantitative Pre and Post KAP Surveys, b) Management and Analysis of Qualitative Data, c) Programme Data and Secondary Sources of Information, d) Data Validity and Reliability, e) Checklist for Conducting Field Work are discussed, f) Evaluation Reference Group (EVG), and g) Coordination and Meetings with UNICEF and IPs. All these aspects are presented in Annex 10.

C.4. Ethical Standards and Compliance and Approval

The evaluation religiously followed the ethical standards of "UNEG Norms and Standards of Evaluation 2017"³⁹ and the 2015 "UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis"⁴⁰. These standards included: independence of judgement, impartiality, honesty and integrity, accountability, respect and protection of the rights and welfare of human subjects and communities, confidentiality, avoidance of risks, harm to and burdens on those participating in the evaluation, accuracy, completeness, transparency and reliability of report. The Evaluators were cognizant of and committed to employ measures resulting in adherence to the relevant guidelines on evaluation norms and ethical considerations that included:

- C The evaluators requested ethics review approval from the HML Institutional Review Board. The ethical review board approved the evaluation tool kits including human subjects' protection protocols as detailed out in the inception report and the Annex Box 2 and Annex Box 1 (tools). Based on the review, the ethical review board granted ethical approval for the evaluation as presented in **the annex 10A**.
- C The evaluation team rigorously up-held the principles and ethics for **children under the age of 18 years** as spelled out in the UNICEF Research Ethics Procedure and in accordance with the ethical guidelines documented in UNICEF's Principles and Guidelines for Ethical reporting on Children and Young People under the age of 18 years⁴¹. A few key safeguards that were put in place while engaging school children included: a) Obtained informed Assent from all school children, b) obtained informed consent from the teachers on behalf of children, c) Informed school children on the purpose of their engagement in the evaluation including the reasons why they are being engaged, b) Educated the children about their rights of dissent or refuse to participate or not answering any question if they feel so, c) Conducted FGDs with girls by a pair of female enumerators and with boys by a pair of male enumerators in the school, and d) Respected children's rights to privacy and ensured that their information remains confidential
- C Evaluators **trained field teams/researchers on the ethical guidelines of UNICEF** which enabled them to place the priorities of protecting the evaluation participants, anticipating harms, avoiding undue intrusion, rights to confidentiality and anonymity, and intellectual property rights

³⁹ United Nations Evaluation Group (UNEG), 2016. *Norms and Standards for Evaluation*. [online] New York; UNEG. Available at: <http://www.uneval.org/document/download/2787> [Accessed: 12 January 2019].

⁴⁰ United Nations Children's Fund (UNICEF), 2015. *UNICEF PROCEDURE FOR ETHICAL STANDARDS IN RESEARCH, EVALUATION, DATA COLLECTION AND ANALYSIS*. [online] New York: UNICEF. Available at: https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF [Accessed: 26 April 2018].

⁴¹ www.unicef.org/eapro/Reporting_on_children_and_young_pp.pdf and www.childethics.com

- Evaluation methods and tools were applied using **cultural and group sensitive approaches** to collect information. For instance, female facilitators were recruited to conduct FGDs with female respondents. This was to overcome cultural barriers around differential gender access to men and women and to promote an enabling environment for women to speak openly about their experiences
- **During data collection**, evaluators ensured that participants express their opinions openly and maintained confidentiality of their answers. The evaluators were **sensitive to local beliefs, manners and customs** and protected the anonymity and confidentiality of participant's information.
- Evaluators obtained **informed consents** from all the participants of the FGDs, IDIs, Case Studies and Direct observations. Additionally, the evaluators obtained **Informed Assents** from children and Informed Consent from the teachers on their behalf. To this end the evaluation took several measures as: a) UNICEF informed the district authorities through a letter of introduction specifying the evaluation scope, process, protection of privacy, information confidentiality and FGDs sites, b) The FGDs, IDIs, Case Studies and Direct Observations respondents were informed about the evaluation and obtained their consent or assent to participate, c) Participation in the evaluation was voluntary and the respondents were educated and allowed to refrain from answering any question, if they felt uncomfortable to respond or they can withdraw from the discussion any time they wanted

C.5. Preliminary Analysis, Debriefing and Final Report

After completing the field work including data cleaning/validation, gathering and synthesizing quantitative and qualitative data, the evaluators ran analysis on the collated data. The preliminary findings were presented at three occasions (two times at Islamabad and one time at Karachi) to UNICEF and IPs (NGOs) to elicit discussion and clarifications. The draft report was shared with UNICEF for structured feedback. The institutional response received in writing including comments/opinions expressed in de-brief presentations formed the composite feedback on the evaluation report. In the de-brief presentations the recommendations were formulated jointly with the UNICEF and IP's programme teams. Based on composite feedback (written and verbal during debrief presentations) the draft report was modified by incorporating the required changes in the text of the revised report. The UNICEF and IPs programme staff reviewed the revised report and endorsed the findings and recommendations. The evaluators then presented the key conclusions and recommendations to all the UNICEF programme team which was attended by the senior management including Country Representative and staff from the four field offices. The final report was submitted to UNICEF Pakistan.

C.6. Evaluation Limitations

TABLE 2: EVALUATION LIMITATIONS AND RISKS/CHALLENGES

Limitations/Challenges	Mitigation Plan
In the pre and post KAP survey diarrhoea prevalence data was not gathered. This missed opportunity negatively impacted on calculating DALYs averted, cost-effective and cost benefit analysis	UNICEF and evaluation team discussed and explored alternative options such as to consider MICS 2014 and 2019 district disaggregated data; however, MICS also didn't collect such data for the comparable indicator. Hence, DALYs including cost-effectiveness and cost-benefit analysis was not calculated for the diarrhoeal prevalence. Instead, the evaluation assessed the cost-effectiveness and cost-benefit for the programme as whole than differentiated for nutrition-specific and nutrition-sensitive programme interventions in the report. This resulted in calculation of low-end estimates for cost-effectiveness and cost-benefit analysis
The evaluation didn't assess one of the evaluation objectives, "to examine effects of integrated Nutrition and WASH interventions on the contribution towards reduction of stunting".	In the evaluation inception phase (Jan-Feb 2019), UNICEF and evaluators discussed and agreed that the intended objective is beyond the scope of this evaluation. Prior to the circulation of the ToR for evaluation, UNICEF intended to undertake the RCT (Randomized Control Trial). However, the deployment of the RCT approach was not feasible to assess the effects of stunting reduction so it was dropped. Despite, it was kept as a part of the evaluation as UNICEF in collaboration with government initiated National Nutrition Survey (NNS) in 2018-19 and it was anticipated that the results would be available by April 2019. Hence, the evaluation will use the NNS findings in proxy to comment on the programme contribution in stunting reduction. The province-wide NNS survey results were published on 10 th June, however, district level disaggregated information has not yet been available until the write up of this report. It is anticipated that the NNS district level disaggregated data will be published in the last quarter of 2019. Hence the evaluation didn't comment on this objective of examining effects of integrated nutrition and WASH interventions contribution towards stunting reduction
At the district and provincial levels a few of the key government officials, who were engaged with the programme at different phases, were posted somewhere else	The Evaluators identified the government official who had been posted somewhere else with the support of the UNICEF and IPs and interviewed them. As a result in few instances, the evaluators ended up interviewing 2 to 3 different government officials who had worked on the same role

D. EVALUATION FINDINGS

D.1. Relevance

Several aspects of the integrated UN Maternal and Child Stunting Reduction programme were assessed to evaluate the relevance of the programme design and delivery through key questions that included:

- To what extent the program was in line to the government and international priorities and directions?
- Was the programme based on adequate needs assessment, analysis of the target communities (particularly to cater the needs of most vulnerable and marginalized groups) and relevant to the program objectives?
- Was information disaggregated according to gender and other relevant social differences (ethnicity, income levels, rural/urban split, DRR etc.) in the program design and delivery?
- How relevant the target communities perceived the programme in addressing their priority WASH and Nutrition needs including measures to protect the rights of access to services in non-discriminatory way?

D.1.1. Programme Alignment with International Impetus and Directions

Based on the review of the programme documents, scoping literature and interviews with key informants, the evaluators found that the **programme was consistent** with international aspirations and directions. The programme considered many aspects of the international impetus as summarized in table 3 and referenced in Annex 2.

TABLE 3: ALIGNMENT OF THE PROGRAM WITH INTERNATIONAL IMPETUS

International Priorities and Strategies	Programme Interventions Packages	Assessment
<p>UN Decade of Action on Nutrition (2016-2025): The World Health Assembly (WHA) adopted six⁴² global nutrition interventions and targets for addressing global burden of malnutrition</p>	<p>Out of the 6 interventions, 4 are related to stunting reduction which were all adopted by the programme that included: stunting reduction, anaemia, low birth weight, and exclusive breastfeeding</p>	Fully Aligned
<p>SDGs: The 17 SDGs are interconnected and far-reaching, ranging from gender equality and the fight against climate change to eradicating poverty and ensuring education for all. 12 out of 17 SDGs are related to end all forms of malnutrition through nutrition specific and nutrition sensitive intervention packages.</p>	<p>Programme covered nutrition-specific and nutrition-sensitive intervention packages which are contributing towards stunting reduction, ultimately leading to achieve SDGs targets.</p>	Fully Aligned
<p>Global Drive of sector-wide Integrated Programming: The global nutrition practitioners emphasize on the need of sector-wide integrated programming to combat the burden of malnutrition. The international impetus for sector-wide is evident from but not limited to: SUN movement, SDGs, UNICEF global strategy, UNICEF WASH strategy 2016-2030, Guidance from WHO, UNICEF and USAID for improving nutrition outcomes with better WASH, Lancet and WASH Plus Strategy.</p>	<p>The programme was designed on the growing evidence of the need for integrated Nutrition and WASH interventions. The programme is also situated well in the UNICEF Pakistan and regional direction and priorities for adopting and scaling-up integrated programming to improve nutrition outcomes with better WASH services.</p>	Fully Aligned
<p>Evidence-base and Evidence-led: Though, the global community has made significant progress to gather data and expand on evidence-base to tackle malnutrition. WHA has established a scorecard to measure progress towards the adoption of national level nutrition targets in 50 high burden countries including Pakistan. Among them only a third have integrated nutrition targets into their national policies and gathering the related data.</p>	<p>The programme established data flow and feedback mechanisms through Nutrition Management Information System (NMIS), WASH Management Information System (MIS). However⁴³, the review of the WHA scorecard reveals that Pakistan situation was not analysed due to unavailability of data for the priority indicators⁴⁴.</p>	Largely Aligned
<p>Fostering Partnership and Translate Countries Political Resolves into Action: The global impetus places better the global</p>	<p>The programme contributed in shaping policies and practices such as: Safe Drinking Water & Sanitation Policies, Nutrition-sensitive</p>	Fully Aligned

⁴² 40% reduction in stunting, 50% reduction of anaemia in women of reproductive age, 30% reduction of low birth weight, No increase in childhood overweight, 50% increase in the rate of exclusive breastfeeding, and Reduce and maintain childhood wasting to less than 5%

⁴³The comparability of the adopted targets and indicators for the various data flow and feedback mechanisms, developed under this program, against the UN Global indicator Framework was beyond the scope of this evaluation.

⁴⁴ http://scalingupnutrition.org/wp-content/uploads/2017/06/EXE_Black_SCORECARD-ACF_ENG.pdf

community and national stakeholders to deliver results, with improved governance, policies, actions, plans and targets by translating the country's political commitment and will into action.

Leaving No One Behind: The SDG 2030 Agenda promotes a set of overarching principles that include: non-discrimination, particular attention to girls and women, and leaving no one behind. These overarching principles are also part of the wider commitments of CRC, Universal Declaration of Human Rights (UDHR), Convention on the Rights of Persons with Disability (CRPD), UNICEF Core Commitments for Children (CCC).

WASH sector master plan, IYCF Communication Strategy, Multi-sectoral M&E framework & dashboard. This helped at large in translating Pakistan's political resolve into action.

The programme targeted women, girls, boys, men and marginalized groups in the programme delivery. The programme addressed the equity aspects through nutrition-sensitive and specific interventions to contribute in stunting reduction that primarily affect the poor and vulnerable population. It also assisted the poor through provision of CIGs to construct latrines. However, the programme didn't articulate well the approaches related to gender, equity, HRBA in the programme proposal & objectives.

Largely Aligned

D.1.2. Programme Alignment with National Strategies and Priorities

Cross-referencing to the IDIs with key informants and review of the key documents, the evaluation confirms that the **programme situated well within the larger landscape of addressing malnutrition in Sindh province**. The programme objectives are consistent with the Sindh government strategies and priorities to address malnutrition through adaptation of integrated and sector-wide approaches. To this end the programme contributed as:

- 🕒 **Accelerated Action Plan (2017-2026), Namely Sehtmand Sindh:** GoS is one of the first provincial governments in Pakistan to allocate financial resources for addressing stunting and malnutrition through multi-sectoral action. The evaluation confirms that programme **is fully aligned to the strategic direction of AAP**. UNICEF also extended technical support to AAP secretariat, AAP health and NSP in developing and rolling out the plan. Further to the on-going technical assistance and secondment of staff, UNICEF assisted AAP secretariat in developing M&E framework, multi-sectoral M&E dashboard, and WASH and Nutrition Management Information System for Sindh province.
- 🕒 **Sindh Multi Sectoral Action for Nutrition⁴⁵ (MSAN), Particularly Saaf Suthro Sindh:** Cross-referencing to MSAN project document review and IDIs with the key informants, the evaluation found that the programme is **fully aligned to the component 1 of Saaf Suthro Sindh⁴⁶**. The Saaf Suthro Sindh is the GoS approved plan aiming to make Sindh open defecation free and promoting hand washing in communities.
- 🕒 **Nutrition-Sensitive Programme Strategies:** To operationalize Sindh Vision 2025, the **programme supported the Sindh government in developing nutrition-sensitive WASH Sector Master Plan, Safe Drinking Water Policy, Sanitation Policy and WASH BCC Strategy**. The IDIs with local government and PHED department's staff considered this as a landmark achievement to operationalize nutrition-sensitive approaches and contribute towards the AAP in efficient and effective manner. Similarly, UNICEF under this programme also developed WASH MIS to support the PHED in gathering, analysing and interpreting WASH programme data.
- 🕒 **Nutrition Support Programme (NSP):** In 2013, the Sindh government initiated the programme to coordinate and implement nutrition programme activities⁴⁷. Over the years, particularly under this programme, UNICEF **extended technical support to NSP in adopting SBCC approaches**.

D.1.3. Stakeholder's Participation and Complementarities with Key Actors

Cross referencing to the IDIs with key informants, FGDs with community and review of the documents, the evaluation found that the programme **ensured the participation of the involved stakeholders at various levels and complemented the government's priorities and directions** in collaboration with state and non-state actors as:

- 🕒 **Government's Stakeholders Participation:** The evaluation confirms that the programme involved the key government male and female stakeholders at the provincial and districts levels. At the inception phase of the programme, UNICEF consulted duty bearers in P&DB, NSP, DG health, local government department, PHE&RDD, LHW programme, and nutrition/WASH working group at the provincial level. The programme also made an institutional contract with PHE&RDD to rehabilitate the water supply schemes in the target districts. During the implementation phase, the programme worked with the district governments and involved them in the delivery of the programme activities. At the district level, programme established DSCs comprising of 15% of female to coordinate and oversee the programme implementation. The programme also involved the provincial

⁴⁵ <http://documents.worldbank.org/curated/en/893571483783978617/pdf/ITM00194-P158769-01-07-2017-1483783975398.pdf>

⁴⁶ MSAN project is based on the learning's of a pilot conducted in three districts (Thatta, Umerkot and TM Khan) and supported by World Bank. The project comprises of three components as: Component 1: Support to Saaf Suthro Sindh, Component 2: Agriculture for Nutrition (A4N), Component 3. Project management, monitoring, and coordination

⁴⁷ NSP became operational under PC1 for three years (2013 to 2016) in 2013. In 2016 the PC1 was extended for another three years until 2019

and district male and female government officials in conducting supportive supervision and monitoring of the programme activities. Additionally, the district officials were kept involved in certification of the ODF villages in the target communities. This is noteworthy that women's employment rates in Pakistan are much lower than that of male with far fewer women employed in public institutions at key positions compared to men as office holders at provincial and district government levels. Despite this, the evaluators made special attention to interview 27% of women as key informants (13 out of 49).

- Rights Holder's Participation:** The programme involved the rights holders (women, girls, boys, adolescents, men and marginalized segment of the population) in the target communities in several ways to ensure access to and availability of the services at the community level. The various aspects of the community participation are discussed throughout this report which included but not limited to: a) undertook rapid needs assessment by involving 130 women and 130 men, b) conducted pre and post KAP survey with 929 and 948 women respectively, c) established community-led structures and community-based providers network of 2,288 gender mixed WVCs (10,926 males and 5,844 females members), 605 girls and boys School WASH Clubs (45,917 males & 30,612 females members), 1,289 Father's/Mother's Groups with 7,981 men members and 8,089 women members, CRPs/Social Organizers (829 men and 720 women), 365 male Masson, 163 male Entrepreneurs, 72 female IYCF Counsellors' and 218 male CHWs and 219 female CHWs), d) women, girls, boys and adolescents services utilization, and e) developed community-led action plans for attaining ODF villages status and supporting the poor in construction of latrines
- Complementarities with State and Non-state Actors:** UNICEF not only participated proactively in coordination platforms but also extended support to inter-sectoral coordination forums either through provision of technical assistance or secondment of staff. These inter-sectoral platforms were led by government and attended by all state and non-state actors which included: Mixed Gender Nutrition Working Group, Mixed Gender WASH Working Group, Mixed Gender IYCF Working Group, AAP health, NSP and AAP taskforce. The programme also worked with USAID supported MCH programme and the related implementing partners such as JSI, MSI, Save the Children and John Hopkins in the target districts for referral of patients to the related health facilities.

D.1.4. Programme Objectives Alignment with the Perceived Needs

Cross-referencing to the programme documents review, scoping literature review, district mapping⁴⁸, IDIs with the key informants, FGDs with communities and field sites visits, the **evaluation found that the programme objectives and ToC were consistent with the perceived needs of system strengthening and target communities as:**

- Systemic Needs and Vulnerabilities:** The programme prioritized "upstream" support through a specific result, "Enabling Environment for Integrated Nutrition-Specific and Nutrition-Sensitive Services Improved" that proved vital to tackle the gaps from policy environment to services availability at the community level. The evaluation confirms that the programme **contributed in several ways to address the systemic needs and vulnerabilities ranging from capacity building to gender-responsive service delivery and policies and strategies formulation**, which are discussed in various chapters of this report.
- Human Needs and Vulnerabilities:** Pakistan's high under 5 mortality and morbidity rates are directly related to malnutrition, lack of access to clean water and inadequate sanitation practices. The situation is further exacerbated in rural areas due to food insecurity, inequitable economic access by the poor, women and marginalized communities, gender disparity and low literacy of women. In the given context, **the evaluation confirms that the programme was fully consistent to address the human needs and vulnerabilities of the population, particularly women, girls, boys, adolescents and poor/marginalized.**
- Geographical Needs and Vulnerabilities:** The evaluation found that **UNICEF considered geographic needs and vulnerabilities in selection of districts** through: WASH exposure index, child well-being index, prevalence of stunting, gaps in service provision (ODF, OTPs, SCs, Water, Latrine) and presence of USAID's flagship maternal and child health programme, based on the districts mapping. Additionally, one of the NGO-IP (HANDS) conducted a Rapid Needs Assessment (RNA) with women and men in the three districts.

D.1.5. HRBA and Disaggregated Information on Gender & Social Differences

HRBA Principles and Leaving No One Behind: The HRBA's framework is based on international human rights standards to promote and protect human rights in the programme delivery⁴⁹. It seeks to analyse inequalities and redress discriminatory practices and unjust distributions of power that impede the provision of services in equitable manner. UNICEF is part of the global drive of HRBA and upholds the Convention on the Rights of the Child and works towards achieving SDGs which is being based on human rights based approaches to sustainable development. UNICEF is also part of the Global Movement for Children, a dedicated broad-based coalition that works to improving the life of every child by ensuring equality for those who are discriminated against, particularly girls and women and disadvantaged groups. From operational point, UNICEF's approach underpins the "equity agenda" of leaving no one behind to operationalize the HRBA principles in its programme design and delivery. This equity-based approach guides UNICEF's policies and programmes to better understand the underlying causes of inequity and take corrective

⁴⁸ Revised USAID district mapping, 19 August 2015

⁴⁹ Source: UNEG Integrating Human Rights and Gender Equality in Evaluations

measures so that all children and targeted beneficiaries, particularly those who suffer the worst deprivations in society including those living in fragile contexts and with disabilities, have access to education, healthcare, sanitation, clean water and protection services, required for survival, growth and development.

Cross-referencing to the UNICEF approaches of leaving no one behind and the review of the documents including IDIs with key informants and FGDs with communities, the evaluation found out that the **programme delivery was guided by HRBA principles. Nevertheless, the evaluation also noted that the programme proposal lacks cross-referencing and clear articulation of adopting HRBA principles in programme implementation except for UN Convention on the Rights of Persons with Disabilities Assistance. Similarly, the programme also didn't establish grievance redress mechanism (GRM) to provide the rights holders and the services beneficiaries with opportunities to share their voices and views on the provided services.** Despite these limitations, the programme upholds the overarching human rights principles of non-discrimination, equality and use of resources in the delivery of programme activities as: a) Developed strong partnership with government counterparts and communities to address systemic, human and geographical needs and vulnerabilities, as discussed above and in the other sections of this report, b) Ensured participation from the male and female duty bearers and rights holders in the programme delivery. At the rights holder level, the programme developed community-based structures with representation from women, girls, boys, men, marginalized groups which are discussed in section D.1.3 under rights holder participation above and in the various sections of the report below, c) Provided nutrition-specific services across the district to ensure equitable access to and availability of services across the board, including hard to reach areas through establishing satellite OTP centres and undertaking community outreach activities, d) Mapped the vulnerable and most disadvantaged individuals and assisted them with community investment grants (CIGs) including community-led self-help initiatives, e) Constructed latrines that also address the needs of persons with disabilities at the schools, hospitals and to a limited extent at the community level, and f) Improved access to water and reducing the water fetching time by women, girls and boys as discussed under effectiveness and impact sections of the report.

Gender Disaggregated Information: The HRBA underscores the need for gathering and synthesizing gender and age disaggregated data for taking informed and timely decisions by policy and decision makers. The evaluation found that the programme has gathered gender and age disaggregated data as:

- 🕒 **Programme Data:** Both Nutrition and WASH developed a data collection system to gather gender disaggregated data during programme implementation. For example 328,131 children (169,549 boys & 158,582 girls) less than two years screened for under-nutrition and reached 599,140 individuals (297,346 men & 323,909 women) with hygiene promotion activities. Similar disaggregated data has gathered for all other programme interventions.
- 🕒 **Baseline and End Line KAP Surveys:** In both surveys, the data was gathered from mothers (929 in pre KAP and 948 in post KAP) with age disaggregation of the respondents. The data for children less than two years in the respondents' household was also disaggregated for gender and age (480 boys and 447 girls in pre KAP and 491 boys and 457 girls in post KAP).
- 🕒 **Capacity-Building Data:** The data provides disaggregated information on gender and the type of staff or volunteers. The programme trained 9,944 (4,009 males and 6,155 females) community based providers and staff including government and NGOs-IPs
- 🕒 **Community-based Structures:** The programme gathered gender disaggregated information on VWC's members (8,008 males and 3,432 females), Fathers Groups (7,981 men members), Mothers Groups (8,089 women members), and CHWs (218 men and 218 women) etc.

Disaggregated Information on Social Differences: While the concept of equity is universal, the causes and consequences of inequity vary across cultures, countries, and communities. Inequity is rooted in a complex range of political, social, and economic factors that include but are by no means limited to: gender discrimination; ethnic, linguistic, minority, and religious discrimination; discrimination due to disability status; structural poverty; natural or man-made disasters; geographic isolation; cultural and social norms; and weak governance. Such analysis informs the design of programs and interventions that are tailored to address the local causes and consequences of inequity. Shifting to an equity-focused analysis will frequently identify groups who can be defined as vulnerable through one or more indicators⁵⁰. Cross-referencing to the UNICEF guidance on equity-based programming and evaluation, review of the programme documents and IDIs with the key informants, the **evaluation found limited evidence on gathering and synthesizing disaggregated information on social differences. The information on social differences under this program is limited to:** a) rural and urban split (more than 70% of the population live in rural areas in the target districts), b) geographical needs and vulnerabilities as discussed in D.1.4 above, c) identification of poor families with support of VWCs for the provision of community investment grants, and d) income level of families in pre and post KAP survey that reflects more than half of the population live below the poverty line with HH earning up to PKR15,000/month and the remainder earn up to PKR 30,000/month. This denotes that surveyed population belonged to destitute or extremely poor socio-economic background. **The programme would benefit at large, if data on other**

⁵⁰ Source UNICEF: Equity based Evaluation

social differences would have been gathered that would enable the programme to address the other aspects of social differences and consequences of inequity in systematic manner.

D.2. Efficiency

Several aspects of Efficiency were assessed to know the extent of implementing adopted programme strategies and managing efficiently the resources to achieve the intended objectives through key questions that included:

- 🕒 How well aligned were the multiple WASH and Nutrition partnerships and to what extent they supported programme convergence and integration?
- 🕒 How well the allocated resources were managed by partners to ensure timely, cost efficient attainment of results?
- 🕒 To what extent costs incurred can be justified by the results achieved?

D.2.1. Programme Implementation Strategy (Integration and Convergence)

According to UNICEF, WHO and USAID guidance on improving nutrition outcomes with better WASH⁵¹, the integration options and the associated delivery channels are varied, highly contextual and require joint planning. UNICEF, WHO and USAID consider integration of WASH into nutrition by including one or more WASH interventions within a nutrition policy or programmatic effort based on the needs and requirement of the context. The elements of the integration based on UNICEF, WHO and USAID guidance are reflected in table 4 and detailed out in Annex 11. Cross-referencing to the elements of integration, review of the programme key documents, IDIs with key stakeholders at all levels, field sites visits and FGDs with the community, **the evaluation found that the programme achieved the status of “Complete Integrative Programming” as it addressed all five elements of integration (3 fully and 2 partially) alongside implemented activities in 59 UCs out of 167 UCs in co-locations, hence, classified as “Complete Integrative Programming” by definition as reflected in Table 4.**

TABLE 4: PROGRAMME STATUS OF INTEGRATION OF INTERVENTIONS AND APPROACHES

Elements of Integration	Adapted Programme Aspects against the Elements of Integration	Assessment of Integration
Joint programme design and development	UNICEF Nutrition and WASH programme teams developed a joint programme proposal and implementation approach, which was agreed and supported by USAID	Completely
Single or multiple partners with one or merged budgets	The grant agreement (UNICEF and USAID) covered both sectors; however, UNICEF adapted varying approaches to implement the programme by signing standalone contracts with IPs (2 NGOs-IPs for Nutrition and 4 NGOs-IPs for WASH interventions implementation, a Consulting firm and PHE&RDD). In the exit phase, awarded contract to one IP (HANDS) to carryout follow-up activities for nutrition and WASH intervention after the exit of the remaining IPs for around 7 months	Partially
Shared staffing	The IPs had no shared staffing except for one staff at each district, recruited by PLAN International, to support the District Steering Committee (DSC).	Minimal
Shared M&E and Accountability Framework	The programme adopted several frameworks such as integrated programme ToC, joint performance monitoring plan (PMP), joint KAP baseline and end line surveys, integrated activities plans (IAP), integrated action plan, joint 3 rd party monitors, and joint periodic review meetings	Completely
One and Consolidated Report	UNICEF developed one consolidated report for USAID on periodic bases.	Completely

Bottlenecks and Mitigation Measures in Achieving Complete Integrative Programme Status: Despite achieving the complete integrative programming status, **the IDIs with key informants reveals mixed understanding of the staff with regard to integration processes.** Most of the key informants considered “geographical co-location” as an optimal form of integration only and were quite sceptical about the scale of integration under this programme. One of the key informants stated, *Integration is a buzzword and a jargon which all the developmental partners are using often and irrationally – you tell me, would you call it integration where services are jointly implemented only in 59 UCs and leaving behind 109 UCs in three districts.* Similarly another key informant stated, *I am wondering why so many partners were selected to implement activities. Would you call it integration where 8 IPs work in a small area?*

On-contrary, a few key informants were having better understanding of the integration processes and integrative programming. One of the key informants stated, *Integration has many forms and shapes, it is vital to think broadly as*

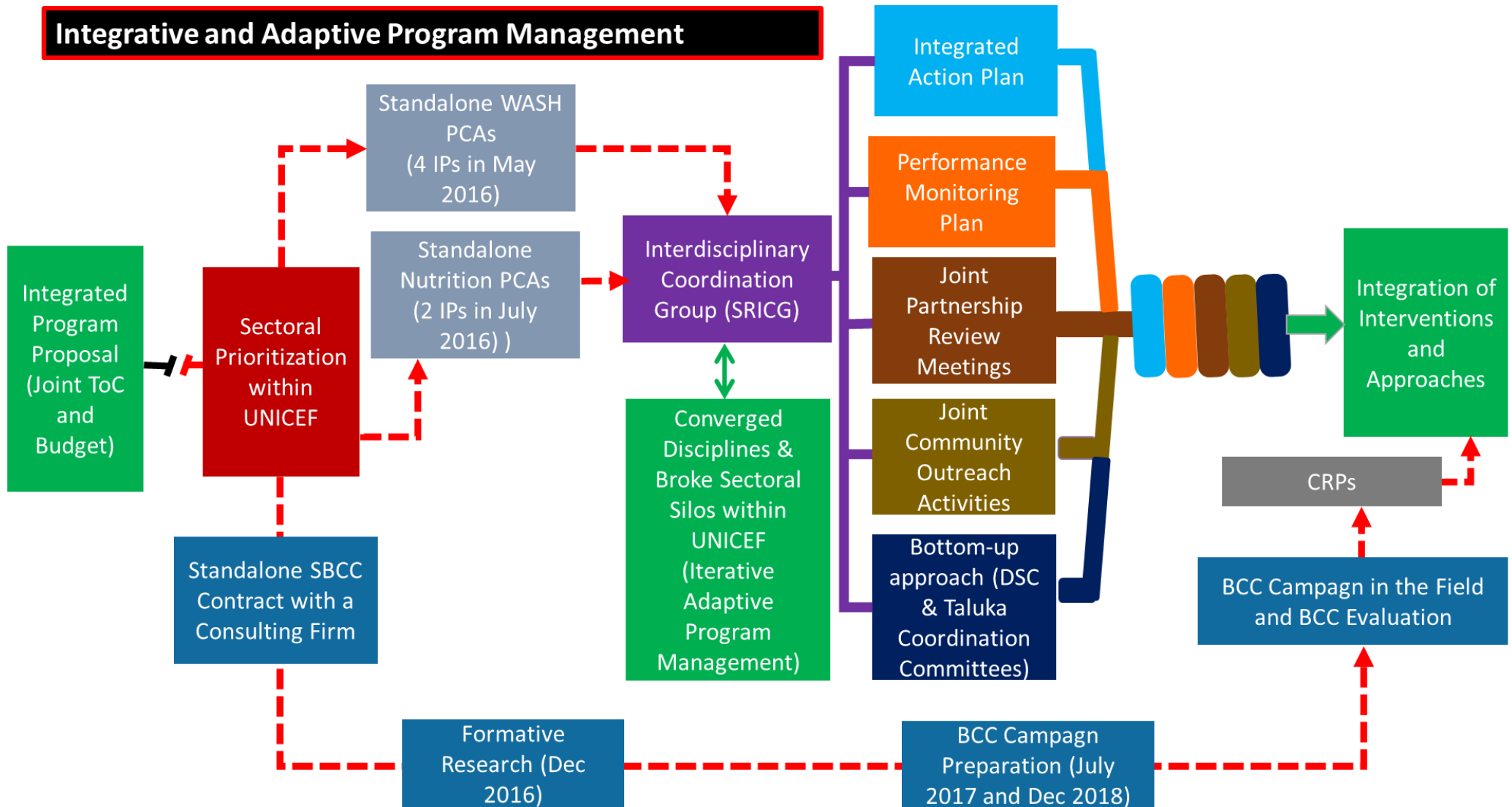
⁵¹ Source: UNICEF, WHO and USAID guidance on improving nutrition outcomes with better water, sanitation and hygiene: practical solutions for policies and programs: https://www.unicef.org/media/files/IntegratingWASHandNut_WHO_UNICEF_USAID_Nov2015.pdf

integration is not limited to implement joint activities at the same locations. In the given resources, programme has made strides in achieving integration within the Sindh context, as it influenced and shaped multi-sectoral policies and practices at institutional level. Another key informant shared his experiences about integrated programming as, Integration is a concept and translating it into action needs understanding, capacities and organization-wide structural reforms and commitment. This involves reflecting back and taking corrective measures and set and re-set directions.

This **mixed understanding of integration processes highlight the need to carefully consider the capacity building** of involved stakeholders on the processes and concept of integration before commencement of such programme. **Figure 4 provides schematic illustration of the programme journey of how it reached to the intended level of integration after faltering in the early phases of the programme implementation in integrated manner.** The journey was manifested with many challenges/bottlenecks but primarily the programme was put back on track by taking corrective measures through **iterative adaptive management**. The review of the documents and IDIs with key informants highlighted the bottlenecks and mitigation measures of the journey to achieve complete integrative programming status as below and reflected in figure 4.

- **Programme Kick Off:** After signing of the grant agreement with USAID, UNICEF awarded standalone PCAs and institutional contracts to the IPs (NGOs, PHE&RDD and a Consulting Firm) on-roll-on basis without any binding to implement programme activities in integrated manner, hence, resulted in the sectoral prioritization within UNICEF.
- **Adaptive Programme Management:** After 6-8 months of the implementation and faltering on many aspects of the integrative programming, UNICEF recognized the need to take corrective measures to support integration of interventions and approaches through iterative adaptive management, the examples of bottlenecks and mitigation measures which are addressed through adaptive management are presented in Annex 12. **The evaluation found out that iterative adaptive management played vital and central role in putting back the programme on track, after faltering on many aspects to kick off the program activities in a coherent and integrated manner in the early phase of implementation.** The evaluation also found out the following two aspects as key driving force behind the iterative adaptive management:
 - **UNICEF's Stunting Reduction Inter-disciplinary Coordination Group (SR-ICG):** Historically, UNICEF operations are organized under sectors (Health, WASH, Nutrition, Child Protection, and Education) and each sector independently manages its operation. After the inception of the programme activities, UNICEF realized that sectorial prioritization led to the fragmentation of the integration interventions and approaches. This realization started at the WASH and Nutrition's Chiefs which is steered and led by the UNICEF Deputy Representative. As a result, the Deputy Rep announced a SR-ICG (as reflected in figure 4) and made it mandatory for the WASH and Nutrition sectors to meet on periodic basis to address challenges and pave the way forward for integration of interventions. In the start, the Deputy Rep used to lead the coordination meeting on weekly basis and at latter stage on monthly basis. The coordination meetings were devolved to the Nutrition and WASH Chiefs to steer the process at latter stage. In order to support the members of SR-CIG's, a common email group was also established for on-going communication among the team members. One of the key informants from UNICEF stated, *after get-going SR-ICG, we felt so at ease to share updates in the group and ask the team members from other sectors without hesitation for an update and/or carrying out a required action. In reality, it never works like this in the UNICEF to ask a member of the team from other sector for an update and/or taking a required action. It was a huge step forward to break the silos within UNICEF.* The evaluation **found out that SR-CIG played the central role of converging Nutrition and WASH sectors.** The convergence of the programme, under the leadership of Deputy Rep, paved way for breaking the silos within UNICEF and achieving the intended results of integration of interventions. It also served as a driving force to implement iterative adaptive management and ensured the integration of activities.
 - **Joint Program Proposal and Frameworks:** As part of the iterative adaptive management, the Nutrition and WASH programme developed various frameworks that supported the integration of interventions and implementation of activities in coherent manner. Evaluation found out that the joint proposal and programme frameworks including DSC served as a mean to plan, implement and monitor the progress of both sectors. These frameworks are illustrated in the figure 4 and discussed further in the section D.2.3.

FIGURE 4: INTEGRATIVE AND ADAPTIVE PROGRAMME MANAGEMENT SCHEMATIC OVERVIEW



D.2.2. Adequacy and Synergies of Implementing Partners

Programme Inception Phase including Selection and Adequacy of Partners: In the inception phase, UNICEF coordinated with key government's stakeholders to identify the programme impact areas. At the design phase, it was jointly planned to implement activities in the southern parts of Sindh but Nutrition PC1 was already covering those districts, hence, with consultation P&DB and other partners the plan was changed to implement programme in three districts in north of Sindh. The new intervention districts were based on district mapping exercise as: USAID funded MCHIP presence, high stunting prevalence, poor sanitation and hygiene indicators and poor water quality. Additionally, at the programme design phase, UNICEF had discussion with WFP for joint venture; however, it was also not materialized due to varying preferences of geographic location. As a result of these efforts, **UNICEF lost considerable time in the programme inception phase.** The time constraint pushed UNICEF to speed up the processes of nutrition-specific and nutrition-sensitive NGOs Implementing Partners (IPs) selection and placement from a pool of pre-qualified firms. UNICEF placed two INGOs ACF and PLAN International strategically in two and three districts respectively so that they may work in conjunction with the national NGOs who may benefit of their expertise in the programme implementation. Though strategically, it was important to place international NGOs to tap-in their expertise, however, PLAN International implemented programme in 26 UCs out of 59 UCs in three districts while the additional three NGOs in 33 UCs in three districts. The IDIs with key informants also highlighted **low capacities of the IPs, particularly, limited understanding of stunting reduction approaches and integrated nutrition-specific and nutrition-sensitive interventions** which are reflected from their statements as: *UNICEF tried to bring on board international partners, aiming to tap-in their expertise so that all partners may take advantages of their skill-base. However, they didn't bring any added value as was expected from them.* Another key informant stated that *those who called themselves as sector specialist didn't prove themselves to be the experts.* Another key informant stated that *HANDS has good experience of implementing both WASH and Nutrition activities; it was a missed opportunity of not assigning them one district for both interventions and reduces the complexity of partnership management.*

Synergies and Cooperation of Implementing Partners and Government Stakeholders at District level: The placement of IPs on roll-on basis negatively impacted the synergies and cooperation among the IPs in the early phase of the programme. The IDIs indicated that even after the placement and commencement of activities both sectors were working on their own to establish community-based structures and conducting community outreach activities. **Despite, UNICEF and the IPs made strides to overcome these challenges which they faced in the early phase of the programme implementation** through iterative adaptive management and developing frameworks to facilitate joint activities. They also established mechanisms for improved coordination and cooperation with male and female authorities and partner's staff at the district level, namely District Steering Committees (DSCs). Considering the death of women as duty bearers, the DSC worked towards the inclusion of female members from the line departments and partner's organization, hence, 15% of the women participated in the DSC proceedings. The DSC proved vital in implementing integrated activities and addressing the challenges in implementation at the field level. The evaluation **documented the DSC approach and successes as case study which is presented in Box 1.** Additionally, at community level, the IPs held a total of 699 monthly joint coordination meetings among field staff, village WASH committees, mother to mother and father to father support groups, CRPs and CHWs in order to implement the joint activities in three districts.

BOX 1: CASE STUDY OF DISTRICT STEERING COMMITTEE

Bottom-up Solutions, a Case Study of District Steering Committee (DSC)

In order to achieve efficient, equitable and sustainable implementation of integrated programme, the programme promoted both top-down and bottom-up approaches to ensure engagement of duty bearers from Provincial level to District and Taluqa levels (D.1.3). To this end, the programme advocated and adopted measures for improved nutrition and WASH policies (D.3.1) and alignment with GoS strategies (D.1.2). Similarly programme worked on creating enabling environment through adaptation of bottom-up solutions by working with the District and Taluqa level stakeholders to ensure smooth implementation of the programme interventions and to generate their buy in and ownership. UNICEF and IPs in collaboration with district authorities established District Steering Committees (DSCs) in the three districts, led by DCs/ADCs with representatives from all line departments, UNICEF-IPs and other CSOs. The DSCs used to meet on periodic basis to oversee the progress of the programme implementation and address the challenges and bottlenecks faced by the NGO-IPs in implementation of programme activities. In the programme life span, the DSCs met 15 times (5 per each district) and played a vital role in improved coordination and better synergies among the IPs and district authorities. UNICEF with support of PLAN International also seconded a coordination officer for organizing DSC meetings and following up on the agreed actions points.

The evaluators met with chair and members of DSC and triangulated the findings with key programme documents and review of DSC meeting records to understand the impact of adopting bottom-up solution for better integration of activities. Some of the key areas of contributions and examples of the DSCs are below:

- **Ownership and accountability:** DSCs led to ownership of the programme interventions and created an environment for cross departmental accountability and joint working to address stunting. It brought all the involved stakeholder under one roof and paved the way for collaborative implementation of activities
- **Risk Management /Quality Safeguards:** The DSCs served as a watchdog to oversee the progress of the programme implementation, use of optimal resources and implemented quality safeguards. For example post water quality testing of the installed hand pumps was not budgeted. DSCs highlighted the need and requested IPs and UNICEF for re-appropriation of budget. As a result the post hand pumps installation water testing was made part of the work plan.
- **Re-allocation of Resources:** The programme initially planned to construct WASH facilities in basic health units (BHUs), however, PPHI constructed or renovated such facilities in the BHUs. Hence, the DSCs in collaboration with IPs re-allocated the resources to higher level of health facilities and schools
- **Equity:** DSC's member such as Social Welfare Board (SWB) and IPs worked together to identify the marginalized communities for provision of equitable services. Additionally, on the request of SWB, HANDS conducted hygiene promotion sessions for prisoners in Khairpur jail and constructed public latrines near a park
- **Enabling Environment:** The DSC's proactively supported the IPs in: a) issuing NOCs to the IPs for implementation of activities, b) extending administrative support to carry out the activities, c) certifying ODF status, d) joint planning and integration of activities at community level, and d) supportive supervision of activities in the field. The Taulqa Coordination Committees held 27 meetings to ensure joint implementation of the program interventions at the community level
- **Sustainability:** DSC's played as a catalyst in developing the exit strategy of the programme. Each IPs in its district prepared a clear and detailed exit strategy consultation with the members of DSC resulting in smooth handing over of the project activities and resources. Additionally, the DSC approach as a best practice was adopted by AAP and notified it with the name of District Coordination Committee (DCC) for replication across the province.
- **Women Representation:** Women representation in DSC remained a challenge and around 15% of them attended the DSC meetings. This is noteworthy that women's employment rates in Pakistan are much lower than that of male with far fewer women employed in public institutions at key positions compared to men as office holders at provincial and district government levels. It is suggested that the DCC may encourage more women representation from CSOs, NGOs and public departments to ensure the protection of Human rights, Gender and equity in the programmes

Concerning the role and effectiveness of the DSCs, a few of the key informants stated: a) *I'm responsible to organize resources to address the needs of the population in my district. The development of the district is close to my heart and my utmost priority. I know the needs of my districts and DSC provided an opportunity to work together with my team and decide the optimal use of resources (Chair of a DSC),* b) *we were struggling with processing NOC which was addressed by DSC in our district, (an IP representative),* c) *DSC members, particularly AC in Naushero Feroze was the champion for change and supported the interventions at all levels, (an IP representative),* d) *after notification of DCC based on the learning from DSC, AAP requested UNICEF to support them in adopting and scaling-up the approach across the province through capacity building initiative,* e) *the programme did a good job by establishing DSCs, we as Taskforce Secretariat notified it across the province and thanks to UNICEF for the initiative as we have not to start from the scratch rather building on the foundation that the programme has provided to us.*

D.2.3. Efficient Attainment of Programme Results

Programme Results Based Management: Cross-referencing to the review of the programme documents, reports, data and IDIs with key informants, the programme adopted various measures to carry out result-based managements in a structured manner. The key elements of the result-based management included:

- **Programme Operational Frameworks and Plans:** UNICEF and IPs established and rolled out the key operational frameworks and plans that served as a management tool that not only paved the way to integrate nutrition-specific interventions and nutrition-sensitive approaches but also served as a mean to track progress and take corrective measures in the course of implementation. These frameworks included:
 - **Integrated Action Plan (IAP):** The plan covered various aspects to ensure joint planning and integration of activities at the community level and coordination among the partners. The IDIs and review of the periodic meetings outcomes against the IAP revealed that the tool founded the basis of putting back the partners on track to implement activities and was used as a mean of iterative adaptive management.
 - **Performance Monitoring Plan (PMP):** The tool served as a management tool to assess technical and programmatic progress against planned activities, reaching set targets and intended outputs. The tool also served to hold each partner accountable for undertaking joint activities and report back to all partners on the agreed action points in the joint programme and partnership review meetings.

- **Joint Programme and Partnership Review Meetings:** On periodic basis the programme held joint programme & partnership review meetings. The review of the sample reports indicates that UNICEF and partners followed a structured process to identify challenges and way forward to mitigate those along with action planning for the next period.
- **Joint Community Outreach Activities:** WASH and Nutrition NGO's IPs planned and executed joint outreach activities for women, girls, boys, men and marginalized population through establishment and mobilization of community-based providers' network by involving CRPs, IYCF counsellors and CHWs, social mobilizers and members of the WVCs, WASH school clubs and father/mother groups. The programme also conducted SBCC campaign at the community level.
- **Interventions Monitoring System and Result Framework:** The review of the programme ToC in the evaluation ToR and PMP highlighted gaps and disconnect in structuring and presenting the "vertical hierarchy of the result framework". The goal (strategic objective), outcome (specific objective) and outputs (intermediate results) were presented in varying order (rather placed wrongly) in the vertical hierarchy of the result framework. For instance, both documents have different Specific Objective as: Programme ToC in the evaluation ToR stated Specific Objective as, "To contribute towards a reduction in stunting rates by focussing on the 1000 days critical window, through multi-sectoral approach in targeted districts of Sindh". Whilst the PMP stated Specific Objective as, "Enhanced Nutrition and WASH Practices contribute to a reduction in stunting by 2018 in three target districts of Sindh". Similarly, both documents have differently narrated the Outputs (Intermediate Results). The ToC stated them as outputs whilst the PMP stated them as outcomes (though PMP has also narrated them as intermediate results).

Moreover, the objectives in the vertical hierarchy of the result framework were having elements of the next level results and even goal was stated more as an activity. Consequently, the results statements did not convey clearly what the programme intervention set out to achieve. Considering these gaps, which were also noted by the evaluation reference group from UNICEF regional office, the evaluators in consultation with UNICEF Pakistan team agreed to reconstruct the vertical hierarchy of the result framework and elaborate on the ToC to reflect the programme scope of work in appropriate manner (refer to figure 3 for the revised result framework and ToC). Concerning indicators, the programme adopted mostly process and a few outcome indicators and established baseline and developed mechanism to gather data in an on-going basis or through KAP surveys. However, the programme didn't gather baseline and end line data for diarrhoea prevalence related indicator in pre and post KAP surveys which is a major missed opportunity of the programme, as discussed in Table 2.

Despite these limitations, **the evaluation found that the programme established and implemented efficiently a multi-layered data collection and monitoring mechanisms alongside the operational frameworks, particularly PMP that served as management tool.** The intervention monitoring system included:

- **Routine Programme Data:** Both WASH and Nutrition established data flow and feedback mechanisms and gathered on-going programme activities data against the indicators listed in the PMP. The analysis of the data for the selected indicators are presented in section D.3.1 and D.4.1
- **Programmatic visits:** UNICEF staff conducted periodic visits (35 during the program lifespan) to the field sites to review progress against planned results and support the partners in implementation
- **Third Party Monitoring:** UNICEF engaged third party monitors for verification of activities, using a checklist to track progress against intended outputs. The IPs were used to respond to the observations of the 3rd party monitors, using Action Points Matrix
- **Joint monitoring with government counterparts:** In the programme lifespan, UNICEF organized a total of 54 joint monitoring visits with provincial and district governments' officials to the field sites
- **Baseline and End Line KAP Surveys:** Programme gathered comparable data to measure change overtime in the knowledge-attitude-practice of the services recipients
- **Use of Programme and Monitoring Data in Decision Making:** The evaluation found that **intervention monitoring system and analysis of the programme data alongside the operational frameworks served as a management tool for taking informed and timely decisions to set programme directions and priorities. The programme in particularly used PMP, ToC and IAP to identify and rectify gaps in implementation.** To this end, 3rd party monitors were recruited to carry out programme sites monitoring and to gather data against the activities in work plan and set targets in the PMP. In turn, they compiled monitoring reports by flagging out issues in traffic light colour coded system to UNICEF management. For instance, in one of the 3rd party monitors reports, they identified delays in provision of materials and vouchers to the CIG grants recipients, lack of IEC materials in conducting nutrition and hygiene awareness session, MIS register and data was not updated, joint activities at the community levels were not implemented and less women participation in the WVCs etc. On receipt of the report from 3rd party monitors, UNICEF triangulated the report against the analysed programme data and observations from joint monitoring visits from government counterparts, using a checklist and structured template to track progress against intended outputs and assessed progress made on key programme deliverables. After the validation of the monitoring reports, UNICEF shared them with IPs' who in turn responded to the observations, using Action Points Matrix by specifying the time frame to rectify the gaps in implementation. Additionally, UNICEF held periodic joint programme and partnership review meetings with IPs to track the achievements of the key

results and ensured joint planning for cross-cutting activities among the partners, using a standardized checklist for planning of activities and tracking progress. The joint review meetings served the purpose of identifying gaps in the programme implementation and taking corrective measures including setting targets and action points for the next period of programme implementation phase until the joint programme review meeting. In addition to UNICEF and 3rd party monitors monitoring reports, the IP's also used to analyse the programme data and shared the feedback with the community-led structure and volunteers to organize joint activities at the community level. These measures proved vital in adopting iterative programme management and timely and informed joint decision making by UNICEF and IPs. Despite these stringent measures, the evaluation noted caveats in data management including the possibilities of double count of beneficiaries which are discussed in section D.3.1 under the sub-section of analysis and achievements of specific objective.

Timeline and Execution of Activities: USAID awarded the grant for 18 months; however, delays happened in the start-up of the programme activities that resulted in 12 months no cost extension. **The IDIs with UNICEF and IPs highlighted several reasons for the delay in kick off activities which included:** a) selection and placement of nutrition partners was delayed, hence, they became operational around 3 months later than the WASH partners, b) selection of district for nutrition-specific and nutrition-sensitive interventions took much longer than anticipated. Upon selection, the authorities took time in awarding the No Objection Certificates (NOC) to international organizations such as Plan International and ACF to commence the implementation of activities, and c) political influence from authorities to recruit staff and community-based workers on their reference also posed additional challenges, which further delayed implementation of activities. Cross-referencing to the periodic programme periodic reports, 3rd party monitoring reports and IDIs with key informants, **the evaluation found that activities against the work plan started getting back on track from the first quarter of 2017 after faltering on the timeline in the early stages of the programme.** Hence, programme built further on the momentum from the first quarter 2017 and implemented the programme activities in a coherent manner.

Flow of Funds and Financial Management: The review of the documents and IDIs with key informants revealed that UNICEF put in **place stringent measures to avoid misuse of funds and tracked them against standards** as:

- 🕒 **Spot checks for financial monitoring:** UNICEF staff undertook a total of 17 spot checks (eleven for WASH IPs and six for nutrition IPs) to review financial records related to this grant. These spot checks were carried out against UNICEF financial policy, standard procedures and Harmonized Approach for Cash Transfer (HACT) requirements.
- 🕒 **Scheduled audits:** UNICEF staff conducted schedule audits, as per HACT (Approach for Cash Transfer) guidelines of all implementing partners on yearly basis.

In addition to spot checks and scheduled audits, UNICEF disbursed funds through Funding Authorization and Certificate of Expenditure (FACE) on quarterly basis, where, IPs used to provide the details of their actual spending against each line of the approved budget. In turn, UNICEF programme team used to verify the activities against the claim made and the finance department authorized the disbursement.

Supply-chain Management: The evaluators were not able to review the UNICEF's Logistics and Inventory Management System (LMIS); however, the IDIs with IP's staff revealed **no or minimal gaps in provision of supplies from UNICEF.** Most of the IPs raised concerns about the delayed provision of IEC materials for undertaking SBCC activities which were delayed in the early stages of the programme.

D.2.4. Cost-Effectiveness and Cost-Benefit Analysis

Considering the data limitations of diarrhoea prevalence as discussed in section C.6 above, the evaluation carried out the cost-effectiveness and cost-benefit analysis for the programme as a whole instead of Nutrition and WASH programme components as:

Programme Implementation Costs: The total programme implementation cost was \$21.11 million (\$20 contributed by USAID and around \$1.1 million by IPs), spread over a period of 21 to 24 months. Out of the total cost 56% was used for implementing nutrition-sensitive interventions whereas 44% was used for implementing nutrition-specific interventions under the programme. Table 5 provides the breakdown of costs by components.

TABLE 5: COSTS BREAKDOWN BY COMPONENTS

Programme Budget Head	USD
Nutrition-Specific Component	
USAID contribution	7,680,862
IP's contribution	184,863
Local support – cross sector @ 9%	691,278
UNICEF cost recovery @ 8%	669,771
Sub Total Nutrition-Specific Component	9,226,774
Nutrition-Sensitive Component	
USAID contribution	9,308,605

IP's contribution	921,728
Local support – cross sector @ 9%	837,774
UNICEF cost recovery @ 8%	811,710
Sub Total Nutrition-Sensitive Component	11,879,817
Grand Total	21,106,591

Estimated Lives Saved: The evaluation used LiST to model impacts of the project interventions and calculate estimated number of under-five lives saved. The evaluation found that a total of 662 under five lives were saved as a result of implementing the nutrition-specific and nutrition-sensitive programme interventions. These averted lives were calculated against the programme interventions that included exclusive breastfeeding, multi-micro nutrient supplementations, folate/iron supplementation, SAM patients, improved sanitation, and improved water availability between the baseline and end lines estimates for these interventions. Additionally, 596 children under the age of 5 were at the risk of stunted which were avoided due the implementation of the programme interventions

Number of DALYs averted: The evaluation calculated the number of DALYs averted based on the number of lives saved by different interventions implemented under the programme as discussed above and in section C.2.3. The evaluation estimated that the programme averted a total of 58,760 DALYs by implementing the nutrition-specific and nutrition-sensitive interventions.

Cost per Capita and Cost per Averted Death: The nutrition-specific interventions were implemented across the three districts (167 UCs with total catchment population of over 5 million) by two NGO's IPs. On the other hand, the nutrition-sensitive interventions were implemented in 59 UCs in three districts (with a total catchment population of over 1.9 million) by 4 NGO's IPs and a government line department (PHE&RDD). Nutrition-specific interventions cost per capita is calculated as \$2.6 while the nutrition-sensitive as \$9.4 per capita. The programme average per capita cost is calculated as \$ 4.4. Hence, the cost per capita for nutrition-sensitive programme is almost four times higher than the nutrition-specific interventions. The reasons for the higher per capita cost for nutrition sensitive programme are: the implementation costs were much higher for the nutrition-sensitive component of the programme than the nutrition-specific component, and the catchment population was almost one third for nutrition-sensitive than nutrition-specific component. Hence higher costs and lesser target population made nutrition-sensitive interventions costly per capita in comparison to nutrition interventions. The evaluation also calculated that a life of less than five years child was saved at cost of \$ 32,000 (662 lives saved out \$21,106,591) by the programme interventions.

Cost-Effectiveness and Cost-Benefit Analysis: Cost-effectiveness analysis is a method for assessing the gains in health relative to the costs of the deployed interventions. The evaluation used WHO benchmark⁵² to assess the cost-effectiveness of the programme based on calculation of the cost per DALY averted by the programme. **The programme cost per DALY averted is calculated as \$359. Based on the WHO criteria, the programme is classified as highly cost-effective, as the cost per DALY averted is lesser than 4.5 times as compared to the GDP per capita of Pakistan which is \$1,641 in 2018.** The evaluation also assessed the **cost-benefit ratio which stands at \$4.6⁵³ as a return on each \$ invested** under the nutrition-sensitive and nutrition-specific interventions.

Sensitivity Analysis: The evaluators tested the robustness of the findings by carrying out a sensitivity analysis around the variables that could potentially change the findings. The purpose of this sensitivity analysis was to determine which variables could materially change the cost effectiveness reported in this study. To this end the evaluators developed a scenario with reduction in benefits from DALYs by 35%. The evaluators recalculated the results assuming a reduction in benefits by 35% as compared to what was calculated in the original case. This was intended to identify any overestimation in monetising DALYs. The results revealed that even then the programme remained highly cost-effective with a return of \$3 for every USD invested, as shown in table 6.

TABLE 6: RESULTS OF SCENARIO TESTING (SENSITIVITY ANALYSIS)

Details	Cost per DALY averted	Benefit to Cost Ratio – for each \$ invested	Cost-effectiveness
Original Case	USD 359	4.6	Highly cost effective (cost per DALY averted is 4.5 times lower than the GDP per capita of the Pakistan).

⁵² In order to assess cost-effectiveness of the program, the evaluation used the Commission on Macroeconomics & Health and the World Health Organization (WHO) recommendation. According to this recommendation an intervention is considered to be very cost-effective if the cost per Disability Adjusted Life Year (DALY) is less than per capita Gross Domestic Product (GDP) or between 1- and 3-times per capita GDP, respectively. If the cost per DALY is more than three times the GDP per capita, then the intervention is regarded as not cost-effective.

⁵³ Benefit to cost ratio is calculated on the statistical life years approach. Based on this, number of DALYs averted are multiplied with GDP per capita of Pakistan and divided by the total program cost to estimate the monetary value of lives saved and return on investment

35% reduction	USD 553	3	Highly cost effective (cost per DALY averted is 2.9 times lower than the GDP per capita of the Pakistan).
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E.3. Effectiveness

The effectiveness of the programme was examined through key questions as:

- To what extent the programme produced the intended outputs and outcomes per the ToC?
- To what extent has the application of integrated approach and implementation strategies worked as intended in influencing policies, strategies, plans, collaboration and integrated community engagements?
- To what extent and how well gender, HRBA, equity, DRR were mainstreamed in the programme delivery?

D.3.1. Programme Accomplishments at the Outcome and Output levels

Assessment of Strategic Objective (Goal): Section C.8 discusses the limitations of assessing one of the evaluation objectives of examining effects of integrated Nutrition and WASH interventions contribution towards stunting reduction. This evaluation objective relates to the goal or strategic objective of the programme. As indicated in section C.8, the assessment of the goal was beyond the scope of this evaluation, however, in the evaluation inception phase it was agreed upon to use the results of NNS-2018, which was anticipated to be published in April 2019, in proxy to comment on the programme contribution in stunting reduction. **The province-wide NNS survey results were published on 10th June, however, district level disaggregated information has not yet been published and the results are not available yet.** Hence, the evaluation couldn't assess the strategic objective.

Analysis and Achievements of Specific Objective (Outcome): Based on the analysis of the Pre and Post KAP surveys and programme data evaluation found that **quantifiably the specific objective was achieved largely, as presented in table 7. Nevertheless, the evaluation found out issues related to the programme data which may put in question the full achievements of the programme in quantifiable manner, under the specific objective or the output (intermediate results).** In addition to missing data for diarrhoea as discussed in section C.6, the reported data for number of people gaining access to an improved drinking water source doesn't match in PMP and the programme datasheet. The programme datasheet shows 326,262 as baseline for improved drinking water sources while the PMP states it as 480,000 for the baseline. Similarly the programme datasheet presents 409,523 end line status for improved drinking water sources and the PMP as 526,324.

Additionally, the Nutrition and WASH programme data reported the multiple interactions with women, girls, boys and men for Nutrition and WASH awareness and/or same beneficiaries were counted under different interventions. Hence, double count of the beneficiaries couldn't be excluded. For example, Nutrition programme datasheet states provision of MM supplementation to 107,340 to CBAs and 142,729 to lactating women whereas the lactating women fall within the CBA definition. Moreover, the Nutrition programme set a target of 49,999 for the CBAs who constitute 22% of the population while for lactating mothers it set a target of 133,778 who also constitutes 4% of the population. The Nutrition programme datasheet states to reach 363,936 individuals (280,653 females and 83,283 males) through 23,312 health and nutrition awareness sessions, with an average of 20 participants per session. This indicates that the programme recorded the interactions with individuals where same individuals might have attended the health and nutrition awareness sessions multiple times. The WASH datasheet also provided a similar picture where the programme has recorded the interactions on hygiene promotion activities in the same way as by the Nutrition programme. For instance the datasheet states 1,220,395 individuals (297,346 males, 323,909 females & 599,140 children) through community-based hygiene promotion activities, 987,793 (243,772 males, 269,123 females & 474,898 children) reached through WASH BCC campaign and 247,104 (86,487 males & 160,617 females) through Misaali Maan campaign. The FGDs with women, girls, boys and men also revealed their multiple interactions with service providers on the health, nutrition and hygiene promotion activities.

TABLE 7: STATUS OF ACHIEVEMENTS OF SPECIFIC OBJECTIVE (OUTCOME) RELATED INDICATORS

Specific Objective (Outcome): Uptake of Nutrition and WASH Services and Practices Improved in the Programme Target Districts					
Indicators	Baseline	Target	End Line Status	Source	Assessment
Percentage of women who initiated early breastfeeding within one hour of delivery	51.2%* (24.3% girls & 26.9% boys)	2% above from the baseline	51.4% (25.7% both boys & girls)	Pre & Post KAP Survey	No Change between baseline & end line
Exclusive breastfeeding rates of infants under 6 months of age	15.4%** (7.5% girls & 7.9% boys)	2% above the baseline	35.6% (13.5% girls & 22.1% boys)	Pre & Post KAP Survey	Exceeded
% of children(ages 6-24 months) receiving MM	200,666***	60% of the under two years children	106% (213,889 /200,666) - --- 114,470 boys & 99,419 girls	Program Data and PMP	Exceeded

Proportion of children under 5 years of age who had diarrhoea in the two weeks preceding the post KAP and WASH evaluation study	Not Available	60%	Not Available	No data	No Assessment
Number of water, sanitation and hygiene polices made "Nutrition Sensitive" and incorporated into WASH Programming	0	2	4	PMP	Exceeded
# of children with access to WASH facilities (toilets, group hand washing facilities & improved drinking water) in schools	52% sanitation coverage in schools 47% water coverage in schools	28,024	76,529 children (45,917 boys & 30,612 girls) in 605 Schools (276%)	PMP	Exceeded
Number of people gaining access to an improved drinking water source	Overall Sindh: 90.5%	480,000*** *	526,324**** (126,318 men, 136,844 women & 263,162 children)	PMP	Achieved
Number of communities certified as open defecation free as a result of USG assistance	0	114,285*** ** HHs and 800,000 population	96% (2,150 post ODF certified out of 2,196 ODF, hence, reached 1,192,425 individuals (286,182 men, 298,106 women, 608,137 children)	PMP	Exceeded

* KAP states 51.2% while the PMP states it as 20.7% for Sindh, in the evaluation we used KAP baseline as it is specific to the programme districts and assessed in the end line KAP survey as well, ** PMP states it as 28.9% for Sindh, however, in the evaluation we used pre KAP findings to compare it with baseline KAP, *** PMP doesn't states it so the evaluators took the figure from the Nutrition Program Data, ****Figures in PMP and Program Datasheet don't match, ***** The set target in the PMP is for households than villages, additionally the target in programme datasheet is 1,060,073 while in PMP it is 800,000 individuals living in ODF certified villages.

Analysis and Achievements of Intermediate Result 1 (Output 1): The programme has made strides in achieving the intermediate result of "Enabling Environment for Integrated Nutrition-Specific and Nutrition-Sensitive Services Improved at Provincial and District levels in Sindh" as:

- 🕒 **Nutrition-sensitive WASH Sector Master Plan, Safe Drinking Water Policy, Sanitation Policy and WASH BCC Strategy:** The programme developed these policies and strategies in close collaboration with provincial taskforce secretariat, technical working group under LGD and PHE&RDD and other non-state key actors. All these strategies and policies were endorsed by the government line departments and vetted by the provincial Law Department. The Safe Drinking Water and Sanitation Policies were also approved by the Chief Minister Sindh. These policies and strategies provided a strong foundation for setting the government priorities and directions to address stunting and adopting multi-sectoral programming in systematic manner under the multi-sectoral AAP.
- 🕒 **Research, Monitoring and Evaluation Framework and Dashboard for AAP:** The programme in consultation with line department/sectors, taskforce secretariat, development partners and donors developed the M&E including research framework for AAP which is currently in process of rolling out.
- 🕒 **WASH Management Information System (MIS):** Programme in close consultation with relevant line departments (PHE&RDD and LGD) developed WASH Management Information System. The MIS is operational and hosted in the PHE&RDD.
- 🕒 **IYCF Communication Strategy:** The programme also developed IYCF strategy to support the implementation of Infant and Young Child Feeding activities at the community level

The interviews with government line departments (LGD, PHE&RDD), AAP taskforce, AAP Health and NSP (13 females and 36 males key informants) not only confirmed their buy-in for all these initiatives but they also commended UNICEF for its generous support for taking ahead the provincial government priorities. One of the key informant stated, *the government of Sindh prioritized to address stunting with support of World Bank through sector-wide programming by modelling AAP, however, we were lacking behind on many aspects with regard to policies, strategies and M&E frameworks. Thanks to UNICEF who not only provided us with technical support but also worked on the missing areas to take ahead nutrition-specific interventions and nutrition-sensitive approaches. At least now we have tangible guidance on how to implement WASH and Nutrition sectors interventions in integrated manner.*

In addition to these commendable achievements, the programme also made a good progress on the two indicators in the PMP, under this intermediate result, as reflected in table 8.

TABLE 8: STATUS OF ACHIEVEMENTS OF INTERMEDIATE RESULT 1 (OUTPUT 1) RELATED INDICATORS

Intermediate Result 1 (Output 1): Enabling Environment for Integrated Nutrition-Specific and Nutrition-Sensitive Services Improved at Provincial and District levels in Sindh					
Indicators	Baseline	Target	End Line Status	Data Source	Assessment
Number of projects and interventions with resource allocations by Government of Sindh as a result of Nutrition sensitive WASH policies and specific action plans	0	20	GoS has listed 20 projects in the Draft Sector Development Plan; however, GoS has yet to allocate resources. This requires follow-up and advocacy with GoS UNICEF has also prioritized key interventions in the rolling work plan (2018-19)	PMP	Achieved Largely
Number of nutrition specific health programs reflected in the draft ADP scheme by P&DD, Sindh	0	1	UNICEF supported Taskforce Secretariat in the implementation of AA plan through capacity building on SBCC, development of M & E framework and Dashboard and strengthening of coordination mechanism. AAP is based on the multi-sectoral strategy which integrated eight sectors for nutrition specific and nutrition sensitive interventions	PMP	Achieved Largely

Analysis and Achievements of Intermediate Result 2 (Output 2): The programme has implemented effectively the envisaged programme implementation strategy under the intermediate result of “Access to WASH and Nutrition Services Strengthened in 3 Target Districts through Public & CSO partners”. Despite the caveats in programme data, stated above, the programme mostly exceeded quantifiably the set targets as in table 9 and below:

- 🕒 **Nutrition-Specific Interventions Coverage:** Programme established 148 Nutrition Sites and reached 788,610 (369,169 girls & 398,762 boys) and 473,601 PLWs and 83,934 Adolescent’s girls
- 🕒 **Nutrition-Sensitive Interventions Coverage:** The programme reached 1,192,425 people (298,106 women, 286,182 men and 608,137 children) with WASH interventions under PATS Plus approach.
- 🕒 **Breastfeeding Corners:** In all static and community-based nutrition sites, programme established breastfeeding corners to ensure privacy of lactating mothers whilst breastfeeding their children and/or going through physical Lactation Management Assessments (Simple Rapid Assessment or Fully Skilled Assessment)
- Management of Malnourished Children:** A total of 328,131 children (69,549 boys and 158,582 girls) were screened via door-to-door visits by community outreach teams, using mid-upper arm circumference measurements. Out of the total screened, 37,064 children (16,607 boys & 20,731 girls) were registered as SAM in OTP for minimum two months and treated through weekly/biweekly dosages of Ready to Use Therapeutic Food (RUTF) and antibiotics. Additionally, the programme also established two Stabilization Centres (SCs) in the district hospitals for inpatient care of SAM patients with medical complications. The programme didn’t establish SC in **Naushero Feroze district that impacted negatively over the SAM patient caseload management.** As a result the program treated only 3,668 children (1,700 boys & 1,968 girls) and reached 55% of the anticipated case load.
- 🕒 **Capacity Building:** The programme carried out an array of activities to train government staff and network of community-based providers which included: a) trained 220 male LGD union council secretaries, elected local government council representatives and PHE&RDD staff on nutrition sensitive PATS Plus interventions, b) trained 1,137 government education officials and teachers (612 men and 525 women) on Three Star Approach, c) trained 1,549 CRPs (829 men and 720 women) on social mobilization tools and PATS implementation processes, d) Trained 365 male masons and 163 male entrepreneurs on toilet construction and attaining the ODF status for villages, e) trained 38 female provincial and 350 female district master trainers to conduct trickle down trainings on Stunting Reduction (newly adopted manual for LHWs) to LHWs. In the programme target districts, the district master trainers conducted trickledown trainings, hence, trained 3,618 female LHWs (1,334 in Naushero Feroze, 694 in Ghotki and 1,590 in Khairpur), and f) trained 436 CHWs (218 male and 218 female) on community mobilization and conducting nutrition and sanitation awareness sessions at the community and household levels

Interviews with government staff revealed that the **government officials including females viewed these initiatives as to fill-in gaps in access to and availability of services in the given contexts of the three districts.** Despite, a few of the government officials at district levels remained sceptical about the way the programme began in a

fragmented manner. They also raised their concerns about the commencement of programme without formal MoUs with the line departments and their limited role in joint monitoring and supportive supervision of the activities. Once these concerns were discussed with the key informants from IPs, they pointed out that the district authorities used their position to influence staff recruitment based on their reference which IPs couldn't accommodate as they were following the organizational HR policies and procedures to recruit staff.

The FGDs with the women, girls, boys, men and marginalized segments of the population and the community-network of providers **confirmed that the programme provided an improved access to and availability of services and information.** One of the mother stated, *my daughter and a son both were too week and severely ill. I took them to the doctors, traditional healers and Mullahs in the village and nearby but they got worsen overtime. One day a girl and a man came to our village and they put a band around their arm. They referred me to the nearby clinic and I got some food materials. I started giving them to my children and they became well.* Similarly a man stated, *we never thought to build a latrine in our house. It was the programme who gave us some money for materials along with top-up from VWC and ourselves, hence, constructed the latrine in our house.*

TABLE 9: STATUS OF ACHIEVEMENTS OF INTERMEDIATE RESULT 2 (OUTPUT 2) RELATED INDICATORS

Intermediate Result 2 (Output 2): Access to WASH and Nutrition Services Strengthened in 3 Target Districts through Public & CSO partners					
Indicators	Baseline	Target	End Line Status	Data Source	Assessment
Number of households using an improved drinking water source	Overall Sindh: 90.5%	68,572* HHs (480,000)	75,189* HHs (526,324 individuals including 126,318 men, 136,844 women & 263,162 children)	PMP	Achieved
Number of communities certified as "open defecation free" as a result of USG assistance	0	114,285** HHs/ 800,000 people	96% (2,150 post ODF certified out of 2,196 ODF, hence, reached 1,192,425 individuals (298,106 women, 286,182 men & 608,137 children)	PMP	Exceeded
Number of children under five reached by USG-supported nutrition programme	200,666	60% of the under two years children	106% (213,889 /200,666) - --- 114,470 boys & 99,419 girls	PMP	Exceeded
Number of pregnant & Lactating women reached with nutrition interventions through USG-supported programs	0	133,778	142,729 women	PMP	Exceeded

*PMP and Program data doesn't match as discussed in table 12 and section on caveats related to data, ** Targets in PMP was for households instead of villages,

Analysis and Achievements of Intermediate Result 3 (Output 3): Under the intermediate result of "WASH and Nutrition Awareness in Communities Improved", the programme took a number of initiatives as:

- **Community-led Structures:** The programme established: a) gender mixed 2,288 VWCs (10,926 males & 5,844 females members), 1,289 Mothers Support Groups (MSGs), 1,289 Father Support Groups (FSGs) and 605 WASH clubs (45,917 males & 30,612 females). **These structures played a key role in community sensitization, awareness and mobilization alongside generating community buy-in and ownership of the program activities.**
- **Sanitation in Schools:** UNICEF supported construction of latrine, hand washing stations and provision of safe drinking waters in 605 schools (242 gender mixed schools, 151 boys schools and 91 girls schools). In order to promote healthy behaviours and maintain an enabling environment in the schools, the programme deployed a 3-star approach. **The FGDs girls, boys and male and female teachers and direct observations revealed that the WASH related infrastructure in schools was improved such as availability of hand washing stations, latrines and running water in the schools.** Despite the improvement in physical infrastructure, running water was not available in one of the observed school and the students were fetching water from the teacher's house who lived in the vicinity of the school. Similarly, the direct observations revealed that soap was lacking in the hand washing stations in the school on the day of observations. The FGDs revealed that in the past the schools used to practice hand washing demonstrations on periodic basis in both gender mixed or boys/girls schools, however, the demonstrations were not practiced anymore in the schools for the last many months. Despite these lags, the schools adopted good measures such as gender segregated sanitation facilities in mixed schools and using

LUDO game for promotion of hygiene messages and allocating a slot once a week in the morning's assemblies for health and hygiene messages dissemination and checking children's neatness.

- **Community-based Network of Service Providers:** The programme recruited and trained community-based network of providers to deliver programme interventions in integrated manner and reached girls, boys, women, men and marginalized groups for sensitization, awareness, mobilization screening, referral and follow-up. The community-based network of providers included: male and female Social Organizers/CRPs (829 males and 720 females), 72 female IYCF Counsellors, 436 CHWs (218 males & 218 females) and 365 male Masons
- **SBCC Strategy:** After the inception of the programme activities at the district and community level, UNICEF in collaborations with IPs, state and non-state actors adopted an integrated gender-responsive nutrition-sensitive and nutrition-specific SBCC strategy. The adopted strategy served twofold purposes: supported implementation of programme activities in the target districts, and complemented other sector-wide programs efforts in provision of standardized messages, using same IEC materials. Additionally, the programme incorporated the key aspects of the strategy in the LHWs curriculum manual to equip the largest network of community-based service providers with nutrition-specific and nutrition-sensitive SBCC approaches and standardized messages.
- **Misaali Maan (Ideal Mother) Campaign:** Despite adopting a comprehensive and gender-responsive SBCC strategy, as stated above, **UNICEF introduced a Misaali Maan Campaign in the later part of 2017, nearly two years after the start of the programme.** To this end UNICEF contracted a consulting firm to undertake a formative research, develop another set of IEC materials/products, and adopt new SBCC approaches to carry out the campaign including evaluation of the campaign. Cross-referencing to IDIs with key informants including consulting firm staff, FGDs with women and review of Misaali Maan Campaign reports/documents, **the evaluation noted concerns about the campaign** which included:
 - **Lags in Adopting IEC Materials and Standardization of Messages:** The formative research conducted by the firm found that females in the rural Sindh, particularly in the targeted districts, used to watch Indian movies and TV dramas. The rural women in these areas are fantasizing the famous Indian Actress, Madhuri Dixit. Hence, the firm simulated her in the IEC⁵⁴ pectoral messages (see annex 13) which had implications for the programme, as discussed under misperceptions below. Additionally, the IEC materials and campaign promoted only two critical moments (hand washing with soap before handling food and after using the toilet) instead of the global drive and evidence to promote 5 critical moments (see annex 13) which had also negative consequences, as discussed under fragmentation of messages below.
 - **Misperceptions:** The FGDs with female CRPs and mother groups revealed that the campaign has led to the creation of misperceptions at the community level such as taking Iron/folate tablets makes one "prettier", "treat infertility" and "helps families to have a male baby". One of the female CRP stated, *Madhuri simulated images led to the perception that taking iron/folate tablets will make one pretty like her.* Similarly, the FGDs with mothers revealed their perception that taking iron/folate helps mothers to treat infertility. In one of the FGD they narrated the story of a mother, *who was infertile for a long time. In quest of children, her husband got married to a second wife. By any chance she got pregnant which spread the misperception in the community that taking iron/folate tablets not only makes one pretty but it also helps treating infertility.* Similarly, the mothers in the FGDs also reported son births in multiple areas after taking iron/folate tablets. This created an additional misperception that iron/folate is a magic pill to help families in having male babies. In the interview with consulting firm, evaluators raised these misperceptions related to iron/folate tables with regard to treating infertility and son preferences. The key informants (a man and a woman) from the firm confirmed that they also heard about these during the impact evaluation phase of the campaign. The evaluators probed what the firm did to avoid such misperception, in turn they replied, *as we heard these in the evaluation phase so reported back to the IPs.*
 - **Fragmentation of Messages:** The campaign promoted **only two critical hand washing moments (hand washing with soap before handling food and after using the toilet) instead of the global drive and evidence to promote 5 critical moments**⁵⁵. The evaluators noted with a concern that even both the adopted messages were wrongly worded, particularly, there is no such critical moment to wash hands with soap "before handling food", which is much broader statement than promoting a peculiar moment for hand washing with soap to avoid contracting of diarrhoeal diseases. The messages are presented in Annex 13.
 - **CRPs Skill-base and Campaign Outreach Activities:** The campaign adopted an alternative health education and awareness methodology⁵⁶ of using interactive activities with the beneficiaries. **Though the adopted health education and awareness methodology is better than the traditional ones; however, it is resources intensive and required high skill-base of the providers.** The IDIs with male and female IPs' staff and FGDs with male and female CRPs revealed that the process of undertaking awareness sessions was cumbersome by implementing 6 planned visits for each mother with participatory activities which required high skill-base of the volunteers to implement such activities. The FGDs with male and female CRPs revealed

⁵⁴ The SBCC products include materials such as the flip book, Marvi's story, different posters and stickers, and wall chalking

⁵⁵ 5 critical moments of hand washing with soap include: after defecation/urination, after cleaning a child/changing nappy, before preparing food, before feeding a child/breastfeeding, and before eating

⁵⁶ The campaign used 6 visits to reach out to the intended beneficiaries with participatory activities with mothers such as: a) rapport building including identification of mothers and HHs problems and priorities, b) emo-demos, c) spot the difference, d) group sessions, and d) community sessions

that they faced challenges to conduct sessions by following all steps of the methodology and using the newly adopted materials. In the FGDs the male and female CRPs listed these challenges as: a) we were already overworked and doing a number of activities for the programme but we were asked to do this additional work, b) after training we were told to follow all the steps in conducting awareness sessions which we were not used to and even culturally difficult to implement such activities as role plays and demos, c) we were using different IEC materials in the past for undertaking sessions and the newly adopted IEC made us confused how to use them properly, and d) we were not offered additional incentives to carry out the campaign activities. The interview with the key informant from the firm also confirmed that the implementation of adopted methodology required optimal skill-base of the providers. One of the informants stated, *this approach is a way forward to replace the traditional health education and awareness methodology, however, it requires high skill-set of the first level workers and wider commitment from the organization to support the adaptation of such approach.*

Despite the highlighted issues related to Misaali Maan campaign, the programme established a multi-layered and well-connected community-led structures and network of community-based providers that led to the achievements of the intended targets in quantifiable manner mostly, as reflected in table 16.

TABLE 10: STATUS OF ACHIEVEMENTS OF INTERMEDIATE RESULT 3 (OUTPUT 3) RELATED INDICATORS

Intermediate Result 3 (Output 3): WASH and Nutrition Awareness in Communities Improved					
Indicators	Baseline	Target	End Line Status	Source	Assessment
Percentage of households with soap and water at a hand washing station commonly used by family members	50.1%	60 % of the targeted population	78.1%	Pre and Post KAP Surveys	Exceeded
Percentage of audience who recall hearing or seeing a specific USG-supported nutrition or WASH related message	0	60%	57% of surveyed population re-called nutrition or WASH related messages.	Pre and Post KAP survey	Achieved
Number of school children reached with specific hygiene related messages	0	24,000	76,529 (45,917 boys & 30,612 girls)	PMP	Exceeded
Number of Health care providers/IPs receiving nutrition related professional trainings through USG-supported programs	0	80%*	3,618 LHW trained on Stunting prevention 1,549 CRPs (829 men & 720 women) trained on SBCC	PMP	Achieved

* Target is based on % instead of number in the PMP

D.3.2. HR&GE, Equity & DRR Dimensions in the Programme Design & Delivery

Mainstreaming Human Rights and Gender Equality (HR&GE): Promoting gender equality and reducing gender-based discrimination are at the heart of HRBA⁵⁷ and are both central to sustainable economic and human development and to supporting women’s rights. To measure the progress, the UN-SWAP Evaluation Performance Indicator serves both as a reporting tool and a benchmark to help UN entities integrate Gender Equality and Empowerment of Women (GEEW) into programming and evaluations. The intent of all these initiatives revolves around promoting equality between girls and boys and women and men. Gender mainstreaming is a ‘twin track strategy’⁵⁸ that involves: a) integrating women and men’s needs and interests into all development policies and programs, and b) developing interventions oriented at empowering women. In order to operationalize the twin track strategy, UNICEF’s adopted a Gender Action Plan that emphasizes to integrate gender equality across all UNICEF Programmes under two major themes as: 1) Gender equality in life outcomes across the life cycle of girls and boys from 0-18 years of age, and 2) Gender equality in care and support of women and children.

Cross-referencing to the twin track strategy, UNICEF gender action plan, review of programme documents, IDIs with key informants and analysis of the programme data the **evaluation confirms that HR&GE dimensions were largely considered in the programme because of:** 1) HR&GE mainstreaming approaches were not clearly articulated in the programme proposal narrative and objectives on how to address them by bringing changes in the rights and equality situation in practice in the programme delivery at the design phase, and 2) undertook a number of initiatives during the programme implementation to provide an enabling environment for women, girls, boys and men to participate within the programme activities and ensured access to and availability of the gender responsive nutrition and WASH

⁵⁷ SIDA, WHO and OHCHR, ‘Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence’, WHO 2011, p. 15, <whqlibdoc.who.int/publications/2011/9789241564083_eng.pdf>.

⁵⁸ Caren Levy, ‘Gender Justice and Development Policy: Is “Gender Mainstreaming” Up To The Challenge?’ UCL Development Planning Unit, <[www.ucl.ac.uk/~ucugw3i/files/ISID6/ISID_Caren Levy_Gender Justice and Policy.pdf](http://www.ucl.ac.uk/~ucugw3i/files/ISID6/ISID_Caren%20Levy_Gender%20Justice%20and%20Policy.pdf)>.

services. Table 11 provides the extent to which the various aspects of HR&GE were mainstreamed in the programme design and delivery.

TABLE 11 MAINSTREAMING HR&GE IN THE PROGRAMME DESIGN AND DELIVERY

HR&GE Areas	HR&GE Aspects in the Programme	Assessment
HR&GE twin track strategy and UNICEF Gender Action Plan	The programme addressed the first component of the “twin track strategy” and both elements of “UNICEF’s Gender Action Plan” through implementation of activities based on: a) 1000 days window of opportunity based on the life cycle course by extending services to pregnant and lactating mothers, adolescents and girls & boys under two years of age, and b) gender-responsive WASH services such as gender appropriate access to safe water, latrines and hygiene including promotion of menstrual hygiene management contributed in achievement of results 8 under the second theme of UNICEF Gender Action Plan.	Largely Mainstreamed
HR&GE articulation in the programme proposal	HR&GE approaches were neither articulated in the programme proposal nor in the objectives and result framework.	Not Mainstreamed
Extent the programme engaged and capacitate women, in the community-led structures and the network of community-based providers including HE&GE in programme activities	<p>Although gender equality was not an explicit strategy pursued by the programme, however, there was a rather good gender balance among the beneficiary (girls, boys, adolescents, women, men), community-led structures and workers as:</p> <ul style="list-style-type: none"> ○ Programme ensured women, girls, boys and men participation in the community-led structures and community-based providers network as WVCs (10,926 males and 5,844 females members), School WASH Clubs (45,917 males & 30,612 females members), 1,289 Father’s/Mother’s Groups with 7,981 men members and 8,089 women members, CRPs/Social Organizers (829 men and 720 women), 365 male Masson, 163 male Entrepreneurs, 72 female IYCF Counsellors’ and 218 male CHWs and 218 female CHWs ○ Programme trained a total of 9,944 (6,155 females and 4,009 males) community-based providers network and staff including government and NGO-IPs ○ Screened 328,131 children (169,549 boys & 158, 582 girls), provided multi micronutrient supplementation to 274 pregnant and lactating and 83,934 adolescent girls and 1,192,425 (298,106 males, 286,182 females and 608,137 children) population live in ODF villages and provided MHM kits to adolescent girls in the schools 	Fully Mainstreamed
HR&GE articulation in the PMP	Though HR&GE specific indicators not clearly spelled out in the PMP, however, the programme indicators specified provision of nutrition-specific services to children, women and adolescents	Partially Mainstreamed
Gender and age Disaggregated Data	The programme has gathered gender and age disaggregated data such as children (boys and girls) under 5 years, primary school children (boys and girls), Adolescents girls, pregnant and lactating mothers, community-based providers (male and female), training data (male and female), and nutrition and hygiene awareness sessions data (male and female). Please refer for details to section D.1.5 above	Fully Mainstreamed
Men engagement to support mothers in improving maternal and child nutrition and adopting healthy behaviours	The programme worked with men through establishment of 1,289 Father’s Groups to improve maternal and child nutrition by promoting key healthy behaviours. The initiative also aimed to sensitize men for creating an enabling environment at HH to support pregnant and lactating women in taking care of children at home and seeking healthcare outside home when they are sick. More than half of the women respondents of the FGDs stated that they felt more comfortable to attend mother’s group meetings when their husbands were engaged in father’s group and other programme interventions. Similarly, FGDs with the father’s found that the majority of men knew about the importance of maternal health and nutrition for improved nutritional status of children. However, around half of men stated that mothers are solely responsible for taking care and feeding children per cultural norms. Similarly, the majority of mothers in FGDs also stated that children brought up and taking care of children nutritional needs is responsibility of mothers. This reflects that programme has taken a step forward by engaging men for creating an	Fully Mainstreamed

	enabling environment at HHs, however, it needs more time and continuous efforts to change the attitudes and practices at the HHs and community level	
Programme adoption of gender sensitive activities in the cultural context	The programme recruited 436 CHWs (a woman accompanied by her father, brother or husband—218 males and 218 females) to undertake community outreach activities in culturally accepted manner and to avoid any negative implications for the women whilst working in the conservative rural areas.	Fully Mainstreamed

Disaster Risk Reduction: PATS Plus advocates for the construction of water sources and latrines on principles of DRR. The programme employed DRR approaches and constructed a raised platform around the hand pumps and covered them properly to avoid water sources contamination during rain or flush floods. The programme also supported the re-invigoration of Nutrition Management Information System (NMIS) which has been linked to District Health Information System (DHIS) Dashboard. Similarly the programme supported the re-invigoration of District Health Management Information System (DHMIS) and Lady Health Worker Management Information System (LHW-MIS). The operationalization of these MISs will ensure to gather data on the diseases trends, patterns and thresholds which will serve to anticipate the potential risks and enable the duty bearers and decision makers in timely and informed decision making.

Equity: Article 24.2(c) of the Convention on the Rights of the Child, adopted by virtually all countries in the world, that urges states to ensure “adequate nutritious foods and clean drinking-water” to combat disease and malnutrition (UN1989) in equitable manner with a focus on vulnerable and marginalized groups. The programme addressed the aspects of equity by targeting the most vulnerable population such as women, girls, boys, poor and marginalized communities as:

- Programme addressed the multi-factorial aetiology human (basic, underlying and contextual causes and determinants, as discussed in section A.2 above) of stunting that is prevalent in higher instances in poor and marginalized segments of the population. The KAP surveys gathered insights on socio-economic status of the population living in the programme target district. The KAP survey revealed that more than half of the HHs income falls below PKR 15,000/month and they live below the poverty line. Almost another half of the HH income falls between PKR 16,000 to 30,000 per month (\$100 to 200/month) with overwhelming majority of them is illiterate. In order to address the high prevalence of stunting, the programme adopted various measures to reach disadvantaged, marginalized and hard to reach areas and groups in equitable manner through establishing community-led structures and providers network with inclusion of women and members from the marginalized groups, planned and implemented programme activities in hard to reach and neglected areas within the target districts and identified the poor HHs in the target villages to assist them with CIGs for construction of latrines and extended gender responsive nutrition and WASH services. The FGDs with mothers, men and family members of the malnourished and stunted children and direct observations in the field sites revealed that those who benefited from the programme represent the most vulnerable and marginalized segment of the population. The evaluators randomly picked a family from the OTP register in Khair Pur and visited the family who lived in a slum area in impoverished environment. The evaluation documented it as a case study as reflected in **box 2**. Similarly, the programme provided CIGs to the poor families to construct latrines, which is a step forward for equitable access to gender-responsive sanitation facilities. The evaluation also documented the processes and met with families who received assistance, as presented in **box 3**. These case studies provide further insight to socio-economic status and vulnerabilities of the programme beneficiaries, ultimately the endeavours of providing equitable services to the vulnerable and marginalized segment of the population.
- Though, Accessibility Code of Pakistan 2006 makes it mandatory to remove physical barriers in all public buildings and create an accessible physical environment to meet the needs of persons with disabilities (PWDs) and elderly, however, it still remains the most neglected aspects in construction of public buildings such as health facilities and schools etc. Hence, elderly and PWDs face challenges in accessing sanitation facilities in the public buildings. Considering these challenges, the programme developed a disability friendly design of latrine and ensured that all partners follow the specified design and accessibility code in construction of sanitation infrastructure in schools and health facilities, a step forward to protect the rights of PWDs and elderly. Additionally, the programme proactively sensitized communities for construction of disability friendly latrines in their households. During the field visits, the evaluators directly observed the constructed sanitation infrastructures in the health facilities and schools. The observation revealed that the programme constructed latrines by incorporating standards from the accessibility code such as raised accessible toilets, grab bars and enough space in toilets for turning wheel chair. In one of the health facility, the evaluators also observed an elderly woman on a wheel chair who attended the toilet with support of another woman easily by taking the wheel chair inside the toilet. In one of the school, a girl with physical disability also participated in the FGD who expressed her satisfaction to attend sanitation facilities easily due to presence of grab bar and raised toilet seat.
- Primarily women and children used to fetch water from the nearby sources. The installation and/or rehabilitation of hand pumps and water supply scheme minimized the walking distance and water fetching time, hence, reduced burden from them and avoid their vulnerabilities to physical assault.

Family who lived in impoverished slum and received assistance from the Programme

Sindh has the highest prevalence of stunting and under-nutrition in the Pakistan due to wide inequities in socioeconomic status, literacy and gender equality. The programme designed and implemented effective and scalable gender-responsive interventions in the given cultural context and contributed to improving the nutritional status of the population, especially the most affected and most vulnerable to under-nutrition in the three target districts. As access barriers do not affect all population groups alike and worst hit the destitute slums. The programme provided the nutrition specific intervention across the districts by establishing 148 OTP centres and established a network of community-led male and female providers and community-based structures for conducting outreach activities. The community network of providers reached women, men, girls and boys living in marginalized and neglected pockets of the districts to disseminate key behaviour change messages for better health and nutrition, MM supplementation to women and adolescent girls, screening of the girls and boys for malnutrition, identification of the malnourished children and referring them to the OTP and SC for treatment and following them up at the community level to assess the health status of the malnourished children including home care.

During the field work the Evaluation team visited an OTP centre in District Khairpur, found it functional even after 4 months of the closure of the programme assistance which was now supported by PPHI under AAP initiative. The Evaluators reviewed the facility records and randomly identified a boy named Bilawal, who was treated in the OTP centre by the programme around 8 months earlier. The child belonged to a family living in the destitute neighbourhood to the OTP centre. The Evaluators visited Bilawal family to verify the information and also to understand better how programme made the nutrition interventions accessible to those who needed it the most.

Bilawal is son of Husna a mother of 6 children and lives in a poor slum area in village Peerghot, District Khairpur, Sindh. The residents of the slum area live below the poverty line and most of the residents primarily earn through begging and daily wages. Husna Lives with her 6 children in a joint family of about 14 people in a two rooms house. She became pregnant when her son Bilawal was only 5 months old. As per local norms, the pregnant mother's breast milk become poisonous for the child, hence, she stopped breastfeeding her child when she came to know about her pregnancy. However, she was concerned and worried about Bilawal health as she felt that the breast milk that she fed Bilawal whilst being pregnant was poisonous and may have harmed him. Her concerns turned into reality when she started noticing that Bilawal is getting weaker day by day, had frequent episodes of diarrhoea and not growing well compared to the children of his age. This firmed her belief that Bilawal got sick due to her poisonous breast milk. Husna lives far from city and access to the formal healthcare services is challenging as they were very poor and did not afford the travel cost. Moreover, the social norms do not allow women to travel alone to distant places. She discussed about Bilawal's health with her husband who initially blamed her for the sickness of him but later agreed to take him to the traditional healers in nearby village for treatment. Husna and her husband arranged money for Bilawal's treatment by begging and taking loan. They took him a few times to the traditional healers but he got worsened instead of improving. Husna lost her hope and money; hence, she and her husband decided to leave his treatment as they had to feed their other children. Furthermore Husna felt very guilty when her relatives and neighbours accused her of the Bilawal's poor health and blamed her for feeding him with poisonous breast milk.

Meanwhile, the CHWs (a female and male) recruited by the programme, visited Husna's village. The female CHW gathered the women and conducted awareness session on nutrition and hygiene. They CHWs also screened all the boys and girls in that area to assess their health status for under-nutrition. When they measured Bilawal's arm circumference, the arm band indicated red colour. They informed Husna that her son is very weak and referred him to RHC in Peerghot Khair Pur (OTP site that programme established) for treatment. Husna stated "I became hopeful that my child can be treated but was also concerned about permission from husband to go there and about the associated travel costs. They also referred my neighbour's daughter to the same hospital and she was worried for the same reason. The girl (female CHW) realised our worry and they assured us that the man accompanying them will explain the same messages to men's group and he will also separately counsel the fathers' of the children identified who are malnourished if needed. She further explained that the OTP centre is not very far and has been established in the RHC near to our village. The girls also distributed Iron/folic acid tablets and MAM supplements to the pregnant and lactating women and adolescent girls in our village".

When Husna discussed about taking Bilawal to OTP centre with her husband, who was already sensitized by the male CHW, allowed her and also promised to arrange some money for the treatment. After a couple of days Husna went to the OTP centre along with her neighbour and her daughter. Husna told the Evaluation team that; "the doctors (common word for all healthcare providers) examined Bilawal and my neighbour's daughter and gave us chocolate sachet and explained how to use them and when to return. They also told us that we must wash our hands before eating /feeding the child and after defecation as it will prevent Bilawal from contracting diarrhoea. They didn't charge us and provided the medicines free of cost. I started using chocolate sachet; Bilawal's health started improving day by day and as well my neighbour's daughter. We went for a follow up every week and brought more chocolate sachet free of cost.

She further shared; I lost all my hopes but after treatment Bilawal, he is well and get sick less often. I'm thankful to the girl who came to our village and referred Bilawal to the hospital and the doctors who treated Bilawal free of cost. I am happy that now everyone in my village especially my husband and family members know that I was not responsible for ill health of my child. She also stated, we bring drinking water from a hand pump installed nearby and keep it covered. I do not have latrine at my house. After learning about its importance, I asked my husband to build it but he doesn't have money and also we don't have enough space in our house to build a latrine".

BOX 3: CASE STUDY OF COMMUNITY INVESTMENT GRANT

Community Investment Grant – A Step Forward for Equitable Access to WASH Facilities

Stunting and WASH interventions are intrinsically linked as unimproved sanitation is the second leading cause of stunting worldwide and 50% of under nutrition is associated with infections caused by poor WASH (source: WHO) . The situation is further exacerbated by the confounding factors such as poverty, mother's education, geographic disparities, gender's inequalities and women's empowerment. The programme implemented nutrition-specific and nutrition-sensitive interventions that primarily affect children and requires support across life cycle of girls, adolescents and mothers, particularly within the first 1000 days of life starting from conception until the second birthday of the child. The integrated nutrition and WASH programme to reduce stunting was guided by the HRBA principles that underpin the "equity agenda" of leaving no one behind. However, 'leaving no one behind' requires more efforts and also implies giving priority attention to the people in the direst circumstances who are hard to reach. These groups are very diverse in both their socio-demographic composition and their psychological and cognitive capacities. Extreme poverty and marginality not only denote a lack of income, but are also strongly linked to increased exposure to risk of natural and economic shocks, limited or no access to social and economic entitlements, and exclusion from mainstream development

The programme addressed the equity aspects as discussed in the report and the earlier case study. Moreover, it also reached vulnerable and marginalized including poorest of poor through Community Grant Investments (CIGs) and community-led self-help initiatives. The programme allocated CIGs, in phased manner as: a) established VWCs in the target villages to engage the local communities, b) undertook triggering process to mobilize and sensitize communities for attaining of ODF status, c) identified and listed the poor and most vulnerable families through the VWCs, d) held discussion with the poor families for their construction of latrines including their contributions in the form of in-kind or cash and involved community members to get additional support on the basis of community-led self-help initiatives, and e) allocation of grants to the identified poor families in coordination of VWCs.

To this end, programme supported 5,668 most vulnerable and poor families in the three districts through community investment grants (around PKR 8,000/family) for construction of latrines. The programme involved the VWC's members and CRPs in mapping and identification of the most vulnerable families in each village. The construction of 5,668 latrines facilitated 43,611 poorest individuals (22,232 children, 10,902 women and 10,477 men) in gaining access to improved sanitation facilities.

The evaluation team randomly selected Ms Sumia's family from the list who received CIG assistance and visited her family, met with CRPs, VWC members and the general community in the area to understand if the grants reached the poorest. Ms Sumia lives in Village Saif Mahgrio, UC Behlani, District Nuserofoze, Sindh. The Programme team established the VWC in this village and sensitized the members on the importance of improved nutrition and WASH conditions to address stunting. They further assigned a role to the VWC to support and oversee the programme implementation in their village including identification of the recipients for CIG assistance. The VWC's members recommended Sumia's family for the CIG who is a widow, mother of two daughters and two son and lives in one room house. Her eldest son is 12 years who works in local grocery shop and is the sole bread winner for the family. He earns less than 100 dollar/month which is barely enough to feed the family of 5 a single time a day. The other son is 8 years while daughters are 5 and 3 years of age. Sumia's stated that her youngest daughter often had recurrent diarrhoea episodes and was very weak. She was screened by a CHW almost one year back and enrolled for treatment of malnutrition and recovered after treatment.

The CRP and a VWCs member visited Sumia's house and explained the importance of hand washing, hygiene, the hazards associated with the open defecation and importance of constructing latrines in the house. Sumia and her family understood the message and agreed to construct latrines in their house. She stated that we wanted to have a latrine in the house as I and my elder daughter felt insecure to go for defecation in open fields. However, we couldn't afford to construct latrine in our house. The CRP informed her about the CIG where the family will receive PKR 8000 support in the form of materials. Sumia and her family became excited to know about the assistance, however, she became worried to contribute for construction of boundary wall for the latrine through self-help basis. Keeping in view her concerns, the CRP and VWC members found an alternative to support the family through community-led self-help by pooling additional money for the boundary wall of the latrine. As a result, the latrine was constructed in Sumia's house, using CIGs and community contribution. Sumia said," I'm thankful to my community and the programme for

helping me. Now my children get less sick and they also feel more secure. There are more mothers like me in my neighbourhood who are poor and vulnerable, and I hope that the programme will also help them some way". The VWC members also appreciated the programme but requested that duration, coverage and resources of the program shall be increased. They further said that there were too many families who were extremely poor and identifying only three for the grant was very challenging.

D.4. Impact

The impact of the programme was assessed through key questions as:

- Has programme contributed in adaptation of improved health, nutrition, sanitation and hygiene practices and behaviours both in men and women?
- Has any unintended or negative effects been observed as a result of the programme implementation?

D.4.1. Adaptation of Healthy Behaviours and Influencing Key Family and Community Awareness

The evaluators analysed pre and post KAP survey data, which was cross-referenced and triangulated with the field sites visits, direct observations and FGDs with women, boys, girls, men and network of male & female community-based providers to supplement the quantitative results with qualitative aspects. Based on the quantitative and qualitative analysis, **the evaluation found out that the programme has made a good progress in achieving the set targets in adaptation of healthy behaviours and influencing key family and community awareness with exception for fewer indicators with no change against the baseline values.**

Immediate Initiation of Breastfeeding after Delivery and Practices of Feeding New-borns: Early initiation of breastfeeding along with kangaroo mother care and avoiding pre-lacteal feeds are essential elements of the new-born care. The global evidence shows that initiation of early breastfeeding within first hour of birth could increase exclusive breastfeeding rates by 43%, while no breastfeeding at day one reduces the breastfeeding rates by 32%⁵⁹. The end & baseline surveys depict almost the same pattern with regard to immediate initiation of breastfeeding within one hour of delivery and as well maternal knowledge of early initiation and feeding colostrum, as reflected in figures 21 and 22. Additionally, figures 23 and 24 shows the practices of pre-lacteal feeding of new-borns. The FGDs with mother's revealed a mix of knowledge and practices of early initiation of breastfeeding. They stated their preferences of providing honey, guthi, fresh milk and warm water and continue feeding new-borns with breast milk until 3rd day. They also stated that usually the mothers didn't have sufficient breast milk to feed their children in the initial few days which lead them to feed their children with fresh milk or guthi. Figures 5 to 8 provide knowledge and practices of mothers regarding essential elements of new-born care in pre and post KAP surveys.

FIGURE 5: TRENDS OF IMMEDIATE BREASTFEEDING WITHIN ONE HOUR OF BIRTH

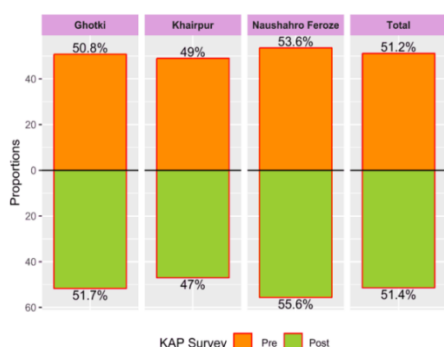


FIGURE 7: MATERNAL KNOWLEDGE OF GIVING FIRST MILK OR COLOSTRUM TO THE NEW-BORNS

FIGURE 6: TRENDS OF MATERNAL KNOWLEDGE ON IMMEDIATE BREASTFEEDING

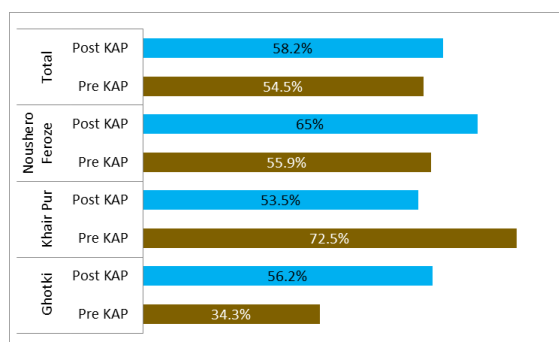
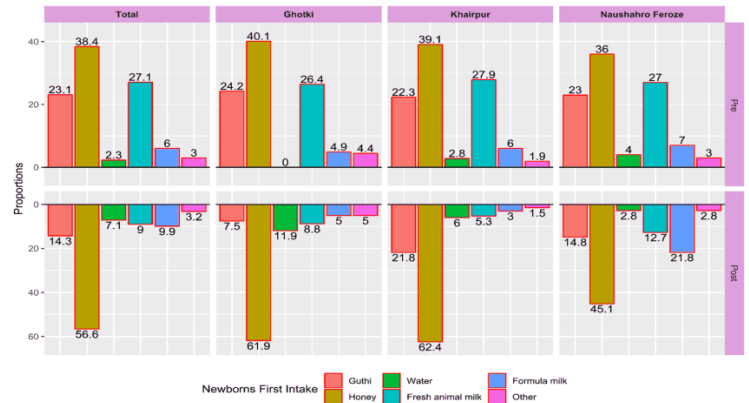
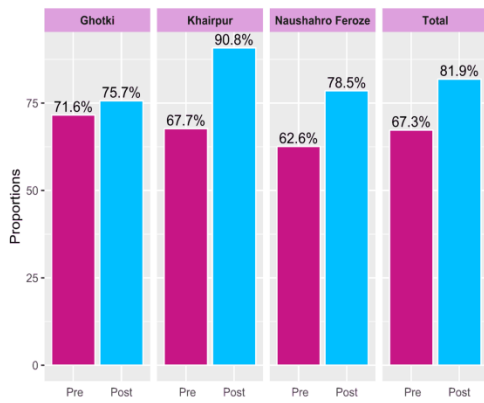


FIGURE 8: TRENDS OF NEW-BORNS FIRST INTAKE AFTER DELIVERY

⁵⁹ Source: Lancet Maternal and Child Under Nutrition, June 2013 <http://www.lancet-journals.com/NutritionSeries/files/assets/common/downloads/publication.pdf>



Exclusive Breastfeeding and Introduction of Complementary Feeding including Dietary Diversity:

Maternal practices of exclusive breastfeeding between base and end line KAP in two districts (Khair Pur and Naushero Feroze) increased substantially, however, a reverse trend is observed in Gotki districts. The exclusive breastfeeding rates are reflected in figure 9. The pre and post KAP analysis also indicates an increase in providing complementary feeding, as reflected in figure 10 with a substantial increase in two districts. Despite the substantial increase in initiation of complementary feeding beyond 6 month, a minor increase was noted in minimum dietary diversity as shown in figure 11. The KAP findings were also triangulated with the FGDs results with mothers that reflected the same pattern of mixed knowledge of the duration of how long a child should be breastfed exclusively during the initial six months. Concerning dietary diversity, the FGDs with mothers revealed that they wanted to feed their children with diverse foods; however, they feed them whatever is available in their household. One of the mother stated, *this is all about the money, if one has money will feed one's children with diverse food. We are poor and have to live with what is in our hand.* The FGDs with fathers remained aligned with the mother's one. They also highlighted the lack of opportunities to earn money. The majority of them said that they either work in the farms of Vaderas (Feudal Lords) or earning through daily wages, hence, living a hand to mouth life. One of the father stated, *we work hard all the day, even then can't meet the requirements of our households. If government wants to help so they should provide us with jobs and/or take care of the children and family food requirements. This won't work only to come and tell us to feed children with diverse food. We wanted it so by ourselves but we can't afford it.*

FIGURE 9: EXCLUSIVE BREASTFEEDING PRACTICES IN THE PROGRAM IMPACT AREAS

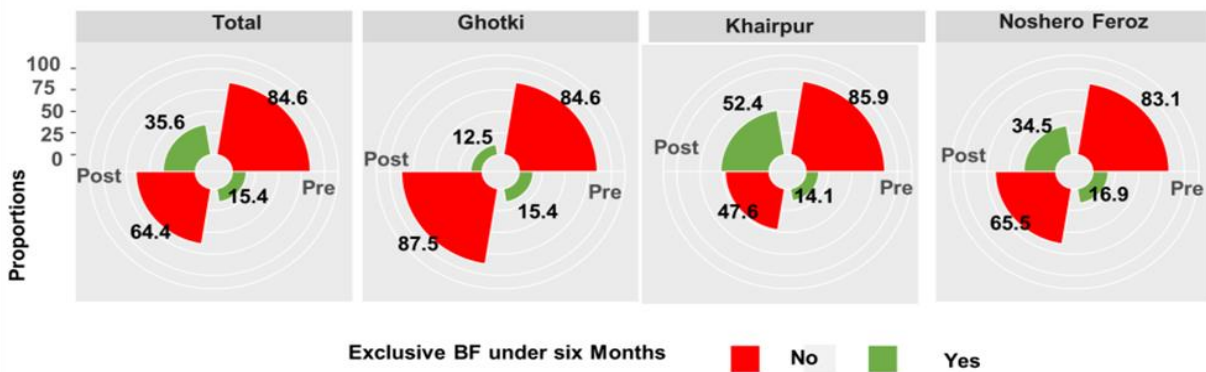
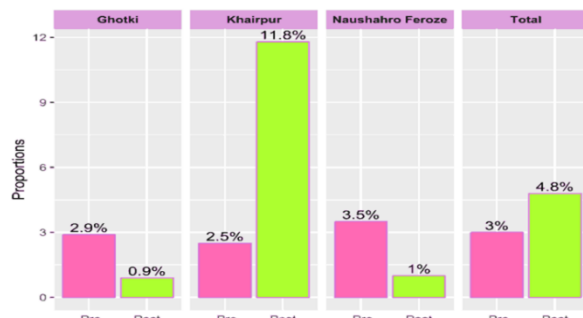
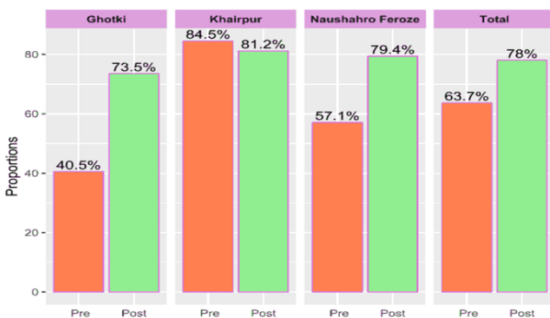


FIGURE 10: INTRODUCTION OF COMPLEMENTARY FEEDING

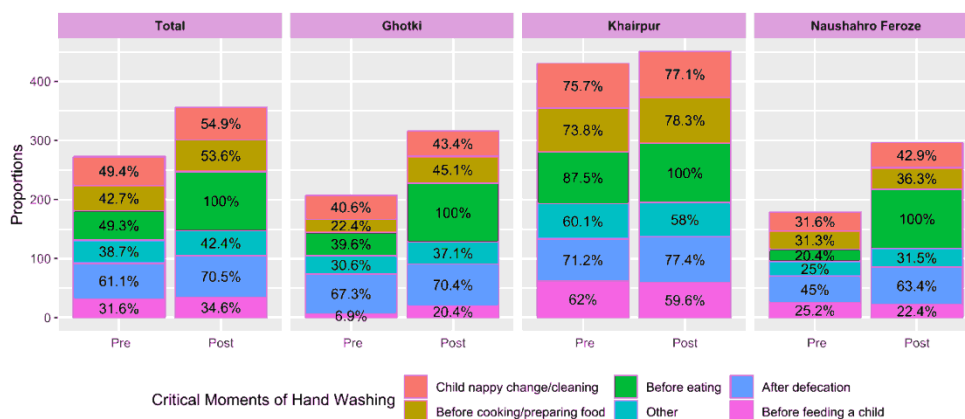
FIGURE 11: PATTERN OF MINIMUM DIETARY DIVERSITY



Hand Washing with Soap at Five Critical Moments: The analysis of pre and post KAP survey indicates that hand washing knowledge with soap at the five critical moments increased from the baseline values for all moments, particularly washing hands with soap “before eating” among women, as presented in figure 12. The FGDs with

mothers, fathers, male and female CRPs, VVCs members and WASH Club members (girls, boys, male & female teachers) revealed that an overwhelming majority of the respondents reported hand washing with soap before eating. Around two-third reported of hand washing with soap after defecation and one-third before preparing food. One of the respondent stated, *we know that washing hand with soap is only necessary before eating and rest of the times why one need to wash hands with soap, it's a waste of soap and we can't afford that.* Another respondent stated, *water alone is enough to wash hands for maintaining cleanliness, why should we use soap as we can hardly afford to buy soap for washing clothes with the money that we have in hand.* The FGDs also revealed a misperception about hand washing with soap, where a few fathers and teachers reported to wash hands “5 times a day” instead of 5 critical moments as reflected from a teacher statement, *we taught children to wash hands with soap 5 times a day.* In addition to the FGDs, the enumerators also visited the households to observe directly the hand washing stations for availability of soap and running water. In around half instances, the direct observation revealed that soap and/or running water was lacking at the designated area (within the toilets or nearby toilets) within the households. The evaluation found out that FGDs respondents were having a mixed understanding of the need for hand washing with soap at 5 critical moments except prior to eating, after defecation and before preparing food. Moreover, the programme disseminated fragmented hand washing messages (as discussed in section D.3.1, under intermediate result 3) to women, girls, boys and men by focussing only on two critical moments (even those were wrongly worded) instead of the five critical moments which might have contributed to the mixed level of knowledge on the hand washing. Similarly, the evaluation also noted that the FGDs participants’ knowledge was on higher end in the co-programme locations (integrated Nutrition & WASH) than the non-co-programme location.

FIGURE 12: HAND WASHING WITH SOAP AT 5 CRITICAL MOMENTS



Open Defecation Free (ODF) Status and Access to and Use of Latrines and Disposal of Human Excreta:

The KAP surveys analysis reflect increase in access to improved sanitation facilities (latrines) and preferred excreta disposal methods, particularly, rinsing stools into the latrines, as shown in figure 13 & 14. The FGDs with mothers, fathers, male & female CRPs, VVCs members and male masons/entrepreneurs and IDIs with key informants pointed out **mixed responses about sustaining ODF status** including access to and use of latrines, drainage/sewerage system, and disposal of human excreta. Around half of the FGDs respondents (male & female) reported that open defecation was declined in their communities due to construction of latrines and/or designated open defecation areas in their communities. One of the FGD’s respondent stated, *we sensitized and organized the communities and gathered donations to help poor households in construction of latrines”. Another respondent stated, latrines at households are not for men, they are only for women.* The IDIs with the male and female key informants (IPs and government officials) revealed that some of them remained quite sceptical about

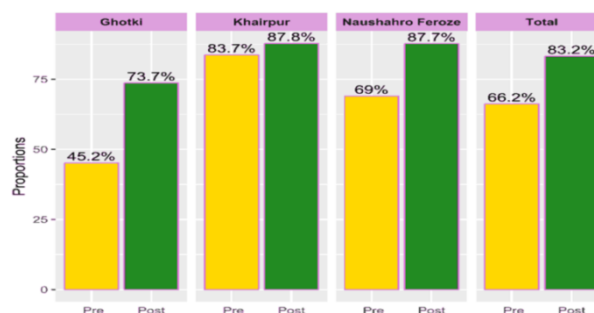


FIGURE 14: LATRINE COVERAGE TREND

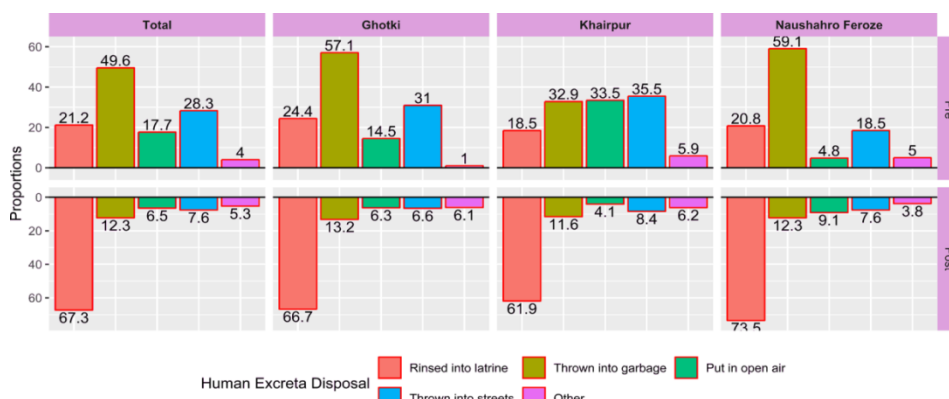


FIGURE 13: PRACTICES RELATED TO DISPOSAL OF CHILDREN EXCRETA

attaining and sustaining the ODF status. One of them stated, *the train track passes across the programme impact areas whereas the trains are having open toilets, hence, leading to faecal pollution of the area.* Another key informant from the government stated, *have a look at the pathetic and bizarre sewerage system with open drains and even then hoping to achieve ODF status is beyond understanding.* One of the district administration key informants reported, *I'm not an authority to question the mobilization or triggering process to attain ODF status. This might have worked for certain communities. However, this approach is not appropriate for rural Sindh as it is plagued by poverty, fragmented drainage system and cultural preferences for open defecation. As a duty bearer for this district, I appreciate the efforts of the developmental partners who followed the process of community mobilization and triggering, however, the certified ODF villages still have open defecation with children's excreta lying in the streets.* Upon exploration of children excreta disposal, the male and female FGD respondents reported that the children mostly defecate in open. One of the mothers stated, *our children used to walk and play in the streets, they defecate in the open and are happy to do it so instead of a latrine.* The direct observation of the field sites also revealed that in most instances the streets were having open drains and stagnant water along with children/human faeces lying in the streets. The evaluation found out that the programme has **mobilized the communities through triggering** process about declaring the villages as ODF status. **However, the debilitating sewerage infrastructure including the presence of open drains with cultural preferences for open defecation and poverty remained the key bottlenecks in maintaining and sustaining ODF village status.**

Improved Access to Water and Knowledge of how to make it Safer: The KAP analysis indicated a slight

increase in access to improved sources of water against the baseline, as depicted in figure 15. The FGDs with women, girls, boys and men revealed that the respondents had a limited understanding on the risks or health hazards associated with taking unsafe water. In around one-third instances the respondents reported diarrhoea (stomach problems, vomiting and loose motion) followed by one-fifth who stated skin diseases were associated with using unsafe water. A very few respondents also reported hepatitis. One of the mother stated, *I and my children walk a long way to fetch water. The water is Charra (heavy) but we have to use it even if it makes us sick.* Another respondent stated, *the water that we use is not clean that's why our family suffer often from stomach problems.*

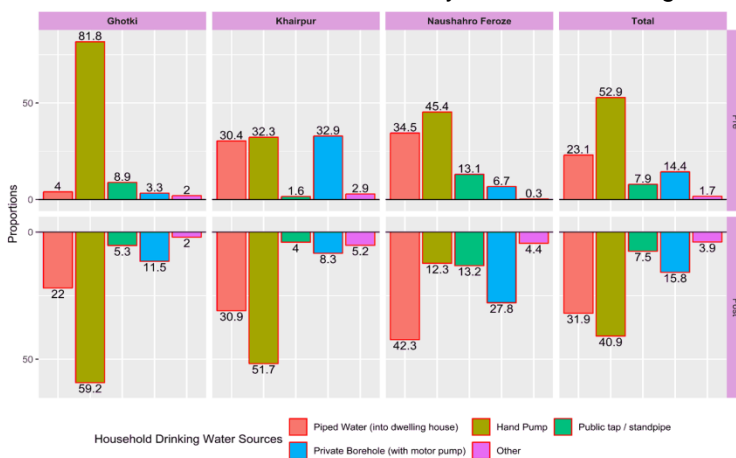


FIGURE 15: ACCESS TO IMPROVED WATER SOURCES

The FGDs with women and men also revealed limited understanding of the respondents with regard to treating water at home to make it safer. Around half of the respondents reported boiling as the preferred method to make water safer at home. In around one-third instances they reported of straining water through a cloth and storing it for some time to settle down the large particles. **The evaluation found out that the target communities have limited understanding and knowledge of the risks associated with use of unsafe water and to make it safer at homes.**

D.4.2. Programme Un-intended (Positive or Negative) Effects

The evaluation found out a few unplanned effects of the programme. In most instances these unplanned results were having positive effects except for one that have negative implications. The review of the key documents, interviews with key informants and FGDs with community revealed these positive and negative effects as:

- Nutrition Management Information System (NMIS):** UNICEF developed a web-based NMIS in consultation with Ministry of National Health Services Regulation and Coordination (MoNHSR&C), Nutrition Cluster/Working Group members and nutrition development partners. The web-based NMIS was launched at the federal level and it is now linked to the National District Health Information System (DHIS) Dashboard. Although, the NMIS was not supported directly under this program, however, it was inaugurated in 2017 in Sindh which will be rolled out across Sindh in 2019.
- Re-invigoration of District Health Management Information System (DHMIS) and Lady Health Worker Management Information System (LHW-MIS):** The existing District Health Management Information System and Lady Health Worker Management Information System were updated through inclusion of nutrition indicators. Under this programme UNICEF supported the roll out of updated MIS systems through printing of paper-based data collection and reporting tools which was not initially part of the programme design.
- Menstrual Hygiene Management and 16 days Gender Activism:** The programme promoted menstrual hygiene management through distribution of hygiene kits in the schools. The FGDs with the school WASH club members revealed that the distribution has positive impacts over the adolescent's girl's attendance and their self-esteem. One of the IP also proactively remained engaged in 16 days activism campaign in the community for gender promotion.
- Misperceptions and Fragmentation of Messages:** As discussed under IR3, section D.3.1, the FGDs with CRPs and mother groups revealed that the SBCC activities has led to the creation of misperceptions at the community

level such as taking Iron/folate tablets makes one “prettier”, “treat infertility” and “helps families to have a male baby”. Misperceptions have far negative consequences in adaptation of health behaviours.

In addition to the misperceptions, the SBCC activities promoted only two critical moments (hand washing with soap before handling food and after using the toilet) instead of the global drive and evidence to promote 5 critical moments to avoid contracting diarrhoeal diseases. Moreover, the evaluators noted with a concern that even both the adopted messages were wrongly phrased, particularly, there is no such critical moment to wash hands with soap “before handling food”, which is much broader statement than promoting a peculiar moment for hand washing with soap to avoid contracting of diarrhoeal diseases.

D.5. Sustainability

The sustainability aspects of the programme were assessed through key questions:

- What are the key factors and drivers (internal & external) that contribute to or constrain the continuity of the programme effects and interventions after the intervention period?
- What aspects of the programme activities and the induced behaviours would likely to continue and last beyond the project life?

The evaluation found that the programme put in place measures to sustain technically and operationally the intended results beyond the project lifespan. These measures included:

Exit Strategy and Continuum of Services after the Exit of the Programme: UNICEF and IPs deployed a four pronged approach to plan the programme exit as: 1) IPs developed an exit plan with a focus on finalizing the interventions packages at the community level including handover of assets and materials to the government counterparts at the district level, 2) In the first quarter of 2018, UNICEF held consultative meetings with the key state and non-state male and female stakeholders at the provincial level (NSP, AAP and other nutrition and WASH partners) to discuss the programme exit plan. In the meetings, GoS (AAP and NSP) committed to continue nutrition and WASH services, under the AAP initiatives in the target districts, 3) UNICEF placed an IP (after the exit of all others) with effect from June 18 until Dec 18 to ensure the continuum of key services including sustainability of the programme interventions at the district and community level, and 4) In December 2018, a round table conference was organized led by Taskforce Secretariat and attended by the representatives from P&DB, Departments of Health, Education, Agriculture and Livestock, Local Govt; and Social Welfare, Academia, Representatives of USAID, UNICEF, WFP, EU/PINS and nutrition stakeholders. The GoS re-iterated their commitment to continue nutrition-specific and nutrition-sensitive services in the target districts.

The IDIs with AAP secretariat, AAP Health and NSP staff revealed that they were in process to place nutrition and WASH implementing partners to continue with the services in the three target districts. **During the field visit of the evaluators in April 2019, the district health authorities confirmed the placement of an NGO (PPHI) to begin with the nutrition-specific interventions, under AAP initiative, in three districts with effect from March/April 2019.** In the field visit, the evaluators also met with the staff members of the OTP centres in district Khair Pur. These staff members were recruited by PPHI and in the past they worked with the UN Maternal and Child Stunting Programme. Though, GoS hasn't yet finalized and placed WASH implementing partners, however, the IDIs with AAP secretariat pointed out that the WASH partners will be also placed in the near future.

The evaluation found that the programme planned and executed well the exit plan which paved the way for the continuum of services beyond the project lifespan. The IDIs and direct observation confirmed that the community-led structures were in place, even after the exit of the IPs for more than a year. Similarly the GoS fulfilled its commitment to continue with provision of nutrition-specific services by placing PPHI, under AAP initiative. Additionally, the GoS is in process to identify WASH partner to fill-in the gap in provision of nutrition-sensitive services.

Institutionalization of Policies and Practices at Institutional Level: Cross-referencing to review of key programme documents and IDIs with male and female key informants, the programme has taken significant steps to better equip the provincial government and involved stakeholders to deliver results with improved governance, policies, evidence-led programming and plans for sector-wide nutrition specific interventions and nutrition sensitive approaches. These steps set the GoS directions of addressing stunting, operationalizing Sindh Vision 2025 and 10 Years AAP and paving way to reaching SDGs targets. To this end, the programme key contributions and achievements include: developing and rolling out of WASH Sector Master Plan, Safe Drinking Water Policy, Sanitation Policy, WASH BCC Strategy, APP M&E framework & Dashboard, WASH MIS, IYCF Communication Strategy, Incorporation of Nutrition-Sensitive and Nutrition Specific SBCC Approaches within LHWs Manual, Nutrition MIS and Re-invigoration of DHMIS and LHW-MIS by Linking Nutrition Program Data within these management information system.

Similarly, the programme established District Steering Committees (DSCs) to support joint planning, implementation and coordination of program activities with district authorities and line departments. As discussed in section D.2.2, under synergies and cooperation of IPs and Stakeholders) and text box 1, this bottom-approach served as best practice to operationalize sector-wide programming and addressed the bottlenecks in implementation at the district and community level. As a result of the lesson learned and efficacy of the DSC in implementation of multi-sectoral programming, AAP adopted and replicated this bottom-up approach across the province with the name of District Coordination Committee, hence, institutionalized this best practice.

Lasting Behaviour Changes at Household and Community Level: As discussed in section D.4.1, the evaluation found out a good progress of adaptation of healthy behaviours and influencing key family and community awareness. In general the programme influenced positively the knowledge and practices of the target communities (women, Girls, boys and men), however, there remain lags for a few aspects where the evaluation noted no change in knowledge or practices against the baseline values. The major aspects of improved knowledge and practices of the community include: giving colostrum to new-borns, exclusive breastfeeding, introduction of complementary feeding, reduction of open defecation, improved coverage and utilization of latrines and improved use of safe drinking water.

Additionally, the community-led structure and network of providers (male and female CRPs, male and female CHWs, gender mixed VWCs, male and female School WASH clubs, Father and Mother Groups etc.) are motivated and functional which will serve as agent of change to re-enforce the adaptation of knowledge and practices in the target communities.

Key Factors/Drivers Contribute to or Constrain the Program Effects/ Interventions: These factors included:

- **Alignment with International and National Priorities:** The programme was fully aligned to the international and national priorities. To this end programme considered and mainstreamed many aspects of SDGs, SUN movements, UN Decade of Action on Nutrition, Global Drive of Sector-wide integrated programming, AAP, NSP, Vision 2025, SAAF SUTHRO Sindh etc. (refer for details to section D.1.1 and D.1.2)
- **Political Resolve:** The high prevalence of stunting and huge gaps in access to and availability of services to combat the menace of stunting, having multifactorial aetiology, led to generate a political will at the provincial government level. Since 2012 onward, the government showed a strong political resolve which was translated into action under AAP initiative in 2017 to address stunting through sector-wide programming. The programme positioned itself well in this evolving context and contributed well in creating an enabling environment through improved service delivery, institutionalization of best practices and filling the policy vacuum to support the implementation of sector-wide programming.
- **Government Buy-in:** Joint planning with government counterparts and extension of technical support to the government and Nutrition/WASH technical working groups facilitated the buy-in and ownership of the programme. The programme team also worked with the government counterparts to plan the exit of UNICEF support and takeover by the government, under AAP, to continue the provision of services.
- **Complementarities with Key Actors:** The programme adopted a fill-in the gap approach and supported the implementation of services in areas to avoid overlap and duplication of efforts by the state and non-state actors.
- **Community Buy-in:** The programme ensured participation from the rights holders and developed structures with representation from women, girls, boys, men, marginalized groups such as: Village WASH Committees, Mother's Groups, Father's Group, School WASH Clubs, Couple Health Workers, and Community Resource Persons etc.
- **Services Demand Creation:** The programme created demand for the utilization of nutrition-specific and nutrition-sensitive services through improved access to and availability of services at the community level. As a result of the utilization of these services, the community is now more aware of their health rights and entitlements which will ultimately push back the government to ensure the continuum of services.
- **Poverty, Cultural Preferences and Debilitating Sewerage Infrastructure at the Community Level:** These factors/drivers constrained the programme effects at large at the community level. Even though, there had been an increase in the coverage of latrines including adequate disposal of human excreta and reduction in open defecation, as discussed in section D.4.1 above. Despite, the debilitating sewerage infrastructure with open drains across the villages and cultural preferences of children to defecate in streets and men to use open fields for defecation hindered to maintain ODF status of villages. Similarly, poverty restricts the community in construction of latrines at households which remains an obstacle in reaching the universal coverage of latrines in the community.
- **Misperceptions and Fragmented Messages:** As discussed in section D.3.1 (IR3), the SBCC activities led to the creation of misperceptions of the use of Iron/Folate and the fragmented promotion of hand washing with soap at critical moments impacted negatively over the programme interventions effects.
- **Limited Involvement of LHWs in Service Delivery at the Community Level:** LHWs is the largest community network of service providers in Pakistan. Though, programme made efforts to engage them such as making changes in the LHWs curriculum, provided training to LHWs and made them part of mothers support groups, however, the LHWs didn't participate in the delivery of the services at the community level. The IDs at the district level with LHW programme coordinator (woman) pointed out that every programme wanted to work through the network of LHWs, however, LHWs are already overburdened and they have to fulfil their obligations. Additionally, the

developmental partners shall sign MoUs with the LHW programme for undertaking their programme activities including incentivizing such services.

- ❉ **Missed Opportunity of Health Programme Exclusion from the Integrated Nutrition-Specific and Nutrition-Sensitive Programming:** Though in the programme design phase, UNICEF proposed to include health interventions as part of the integrated nutrition and WASH programme, however, USAID was supporting the health interventions through another funding stream, under the umbrella of MCH programme which was being implemented by consortium led by JSI through 1,500 functional 24/7 MNCH centres. Hence, it was agreed between USAID and UNICEF to design and implement the integrated nutrition and WASH programme in the districts where the USAID's Flagship MCH program has been operational. Although, UNICEF coordinated with the MCH flagship programme, however, lack of direct support and implementation of health services couldn't happen under this programme that hindered the effects of the integrated programme. This missed opportunity of direct support to build capacity of facility based health workers, who provide assistance to mothers during childbirth and immediate postpartum care, negatively impacted improvement in the early initiation of breastfeeding at facilities and care of sick children in general. In future, UNICEF may need to consider a minimum integrated services package for stunting reduction by combining interventions from nutrition, health and WASH sectors.

E. EVALUATION CONCLUSIONS & LESSONS LEARNED

E.1. Evaluation Conclusions

- ❉ The programme situated well within the larger landscape of addressing malnutrition in Sindh province. The programme objectives and delivery were consistent with GoS strategies and priorities to address malnutrition through adaptation of nutrition-specific interventions and nutrition-sensitive approaches. These strategies and priorities included AAP, MSAN (particularly to Saaf Suthro Sindh), NSP, Inter-sectoral Nutrition Strategy and Nutrition Sensitive Programme Strategies, as discussed in section D.1.2. Similarly the evaluation found that the programme interventions were fully aligned with the perceived needs of system strengthening and target communities. The programme addressed the health and well-being of all, particularly the most vulnerable such as women, girls, boys and poor/marginalized groups, as discussed in section D.1.4. The programme ensured participation of rights holders (women, girls, boys, adolescents, men and marginalized groups), duty bearers (male and female government officials), and UN agencies and complementarities with non-state actors in the design and delivery of the programme, as discussed in section D.1.3. Though programme engaged LHWs in the capacity building initiatives and brought changes in their curriculum, however, they didn't implement activities (D.5).
- ❉ The programme design was consistent and aligned to the international commitments and directions such as UN Decade of Action on Nutrition 2016–2025, Sustainable Development Goals (SDGs), SUN movement approaches, UNICEF global and regional strategies, UNICEF Core Commitments for Children, Lancet, and Global aspiration of adopting sector-wide and integrated programming. These aspects including findings of the programme are discussed in sections D.1.1, A.2.2 and Annex 2. Though, the programme remained fully aligned to the international impetus, however, the review of the WHA scorecard reveals that Pakistan's situation was not analysed due to unavailability of data for the priority WHA indicators (table 4). UNICEF programme team needs to consider the WHA scorecard indicators in the future programming to provide assessment of the progress against the UN Decade of Action on Nutrition.
- ❉ The programme proposal and objectives didn't articulate explicitly how to mainstream HRBA principles, equity, and gender aspects in practice in the programme delivery. The evaluation found that there was no customized channel established to allow beneficiaries /communities lodge their complaints and grievances if any. Hence, the programme didn't establish Grievance Redress Mechanism (GRM) to promote voices of the rights holders and to hold the service providers and duty bearers to account (D.1.5). Similarly, the programme didn't gather data on some aspects of the social differences such as deprivation, ethnicity, minority, geographic isolations (section D.1.6) during the programme implementation.

Despite these limitations, the programme took a number of initiatives in the implementation of activities which were guided by the overarching principles of HRBA. To this end the evaluation found that the programme addressed **HR&GE aspects** by gathering gender and age disaggregated data for all interventions including baseline and end line KAP surveys (D.1.5), engaging and capacitating women, girls, boys, adolescents and marginalized groups in the community-led structures and the network of community-based providers and providing gender responsive nutrition and WASH services (table 11 in D.3.2 and also in other sections of the report), engaging men in the form of "Father's Groups" to support mothers in improving maternal and child nutrition and adopting healthy behaviours (table 11 in D.3.2), adopting gender sensitive approaches in the given cultural context to facilitate women participation in the community-led structures and ensure their mobility without fear of reprisal (table 11 in D.3.2). Similarly, the programme contributed in addressing the multi-factorial aetiology human (basic, underlying and contextual causes and determinants (A.2) of stunting that is prevalent in higher instances in poor and marginalized segments of the population. The KAP surveys revealed that the target population live in abysmally low socio-economic conditions where more than half of the households' income is less than \$100/month and remainder HHs income ranges from \$100 to \$200/month (D.3.2 and other sections). In the given context to reduce stunting, the programme adopted **various measures to reach disadvantaged, marginalized and hard to reach areas and groups in equitable manner as:** a) established community-led structures and

providers network with inclusion of women and members from marginalized groups (D.3.2, and D.3.1), b) planned and implemented programme activities in hard to reach and neglected areas within the target districts (D.3.1 and D.4.1), c) identified the poor HHs in the target villages to assist them with CIGs for construction of latrine (D.3.2. including case study in Box 3 and D.1.5), d) improved access to water sources, hence, reduced water fetching time that primarily is done by women and children in the community (D.4.1), and e) constructed latrines in schools and health facilities to accommodate the needs of persons living with disability (D.3.2).

- The programme achieved the status of “Complete Integrative Programming” as it considered all the five elements of integrative programming with some missing aspects (D.2.1 and table 4). Figure 4 in section D.2.1 provides an overview how the programme achieved the complete integrative programming after faltering in the early phases of the programme to implement it in integrated manner. The evaluation found that iterative adaptive programme management and the joint programme frameworks played vital role in putting back the programme on track and to achieve the complete integrative programming status. These key frameworks to support the implementation of integrated programme included: IAP, PMP, Joint Partnership Review meetings, Joint Community Outreach Activities and Bottom-up Management (DSC), and Joint M&E and Policy frameworks (section D.2.3). These frameworks provide UNICEF with opportunities to advocate with GoS, particularly AAP, for adaptation to support the implementation of multi-sectoral programming.
- The cost-effective and cost-benefit analysis indicates that the programme saved 662 under five year’s children lives and averted 58,760 DALYs at cost of \$359 per averted DALY. Based on the WHO criteria, the programme is classified as highly cost-effective, as the cost per DALY averted is lesser than 4.5 times as compared to the GDP per capita of Pakistan which is \$1,641 in 2018. The cost-benefit ratio stands at \$4.6 as a return on each \$ invested under the nutrition-sensitive and nutrition-specific interventions (D.2.4). These are the lower end estimates as cost-effectiveness and cost-benefit analysis was not carried out for diarrhoea prevalence due to lack of data in the baseline and end line KAP survey (D.2.4 and C.6)
- Quantifiably the programme has achieved most of the targets sets in the PMP under the specific objective (outcome) and three intermediate results (outputs) and programme made a good progress in achieving the set targets in adaptation of healthy behaviours and influencing key family and community awareness with exception for fewer indicators with no change against the baseline values (D.3.1 and D.4.1). Nevertheless the evaluation found issues related to the programme data such as possible double counting of beneficiaries and differences of the reported data in the programme datasheets and PMP that may put in question the fully achievements of the programme targets (D.3.1). The evaluation also found out issues related to Misaali Maan Campaign such as fragmented promotion of hand washing messages where the campaign focussed on two critical moments instead of five critical moments which were even wrongly worded. Additionally, the campaign used stylistic and most media watched simulated pictorial IEC materials that led to the misperceptions about the iron/folate supplementation (D.3.1). The additional confounding factors that contribute to or constrain the programme effects and delivery of the interventions are discussed in section D.5.
- The programme put in place measures to sustain technically and operationally the intended results beyond the project lifespan. These measures included:
 - Programme made significant progress in influencing and developing policies and strategic frameworks for nutrition-sensitive and nutrition-specific interventions and integrated programming in collaboration with state and non-state actors such as WASH Sector Master Plan, Safe Drinking Water Policy, Sanitation Policy, WASH BCC Strategy, Research, Monitoring and Evaluation Framework and Dashboard for AAP, IYCF Communication Strategy, Incorporation Nutrition-specific and Nutrition-Sensitive SBCC Approaches and Messages in LHW Manual (D.3.1 and D.5). These commendable contributions from the programme set the directions of the multi-sectoral programme implementation in the given context of Sindh and complement the GoS efforts in reaching its intended objectives of reduction in stunting by 2026 and the SDG targets by 2030.
 - The programme deployed a systemic approach to plan the programme exit as: developed and implemented exit plan at the district level, held consultative meetings with the provincial government authorities and agreed on the next steps for the continuum of services after the programme exit, based on the agreement with the government extend the contract of one NGO-IP to continue with the services at the community level until December 2018, after the exit of other NGOs-IPs in March and April 2018, and held round table conference with involved stakeholders at the provincial level and reconfirmed the GoS commitment for the continuum of services (D.5).
 - The GoS under AAP initiative deployed PPHI to continue the nutrition-specific services from April 2019 in the three target districts. The AAP is in process to deploy partners for nutrition-sensitive interventions (D.5).
 - Even after the closure of the programme for a year, the community-led structures such as gender mixed VWCs, male and female WASH clubs, Fathers and Mothers Groups are yet functional and motivated to sensitize and mobilize communities (D.5).

E.2. Lessons Learned

- **Integrative Programming:** The deployed integrative approaches and how it sought to be adaptive draws out lessons that may be of interest to the government, UNICEF Pakistan, UNICEF Regional Office for South Asia (ROSA) and global integrative programme’s practitioners. As discussed in section D.2.1 and table 4 that the programme achieved the status of complete integrative programming. The assessment of integration was carried

out against the 5 pillars of integrative programming that UNICEF, WHO and USAID advocates to adopt for integrative programming (table 4 and Annex 11). Furthermore, figure 4 provides schematic illustration of the programme journey of how did it reach to the intended level of integration after faltering in the early phases of the programme implementation in integrated manner. The journey was manifested with many challenges/bottlenecks but primarily the programme was put back on track by the UNICEF commitment by taking corrective measures through iterative adaptive management and developing the key frameworks. The iterative programme management was led by the establishment of Stunting Reduction Interdisciplinary Coordination Group (SR-ICG) that paved the way of converging Nutrition and WASH disciplines and breaking the silos within the UNICEF. The SR-ICG provides an important lesson that convergence of discipline is vital for the integration of interventions which provides a platform to the teams for improved coordination and effective planning including joint and informed decision making and iterative adaptive programme management. The examples of iterative adaptive management are discussed in annex 12 while better planning and the rollout of the frameworks in section D.2.3. These provide lessons and best practices how to operationalize the UNICEF, WHO and USAID guidance at the organizational, partners and programme interventions level.

- Staff Understanding and Capacities on Stunting Reduction and Integrative Programming:** This was the first ever integrated stunting reduction programme that UNICEF implemented in collaboration with NGOs IPs and government in Pakistan. In the early phase of the programme, UNICEF and IP's staff were having a mixed understanding of the stunting interventions and approaches (D.2.1 and D.2.2). The nutrition-specific partners were more oriented towards CMAM approach as they had implemented such programmes in the past. Similarly, staff was having limited understanding of the integrative programming as most of them were considering geographic colocation the only and optimal form of the integration. During the course of implementation, UNICEF and IPs made significant progress to refine the stunting programme interventions such as they adopted PATS Plus approach and developed the joint frameworks by covering the common touch points to implement the programme activities in coherent manner. Hence, the programme offer lessons on the stunting intervention packages and integrative approaches to UNICEF, IPs and GoS. Additionally, the lessons from implementation and understanding of stunting and integrative programming provide UNICEF with opportunities how to influence government, particularly AAP, approaches of stunting reduction through multi-sectoral programming.
- Bottom-up Solutions:** The programme adjusted its approach and course in line with the understandings of context, and the political enablers and obstacles through seeking of bottom-up solutions to the problems it faced during the implementation. After the placement of the NGO's-IPs on-roll-on basis in the districts, the IP's faced challenges of working jointly among themselves and with the district administration and line departments. Some of these challenges included: a) IPs used to work on their own to establish male and female community-based structures and conduct community outreach activities, b) delays in placement of staff due to political influence from the district authorities to recruit them on their reference, and c) delays in signing MoUs of the international NGOs with government to begin the services. In order to address these bottlenecks in joint implementation and coordination, UNICEF and IPs developed frameworks to facilitate joint activities and established mechanisms for improved coordination and cooperation with authorities at the district level, namely District Steering Committees (DSCs). Based on the success of the DSC's approach, taskforce secretariat adopted its processes and scaled the approach across the province with the name of District Coordination Committee (DSC) to support the implementation of the multi-sectoral programme for the reduction of stunting in Sindh province (D.2.2 and box 1).
- Implementing Partners:** The multifaceted programme deployed 6 NGOs, PHE&RDD and a consulting firm to undertake activities in the target districts. Among them UNICEF also placed two international NGOs strategically with intention that the local NGOs will be benefited from their expertise. For example UNICEF placed four NGO's IPs to implement nutrition-sensitive programme in three districts. Among these four partners, PLAN International implemented nutrition-sensitive programmes in 26 UCs out of 59 UCs in three districts while the additional three NGOs in 33 UCs in three districts (D.2.2). The placement of four IPs had implications on the transaction costs where PLAN had to set-up operations in three districts. Similarly, the additional three IPs also established operations per each district. Contrary to this practice, UNICEF adopted a different model in the last phase of the programme implementation by placing one IP (HANDS), after the exit of all others NGO's partners, to continue the implementation of programme activities across the three district between June 18 and December 18, covering both nutrition-sensitive and nutrition-specific interventions. The deployments of these two approaches offer the lesson that UNICEF may consider the placement of IPs in the future programming by minimizing the number of partners to the extent possible. Subsequently, this will make the programme more efficient and effective in terms of coordination, implementation and transaction costs.
- Participation of Stakeholders and Rolling out Community-led Structures:** The programme ensured the participation of duty bearers, rights holders (women, girls, boys, men and marginalized groups), institutions, male and female staff at service delivery points (A.3.1 and D.1.3). Additionally, the programme developed multi-layered community-led structures and placed community-based service providers (D.3.1). These initiatives played a central role in generating ownership and buy-in of the programme at duty bearers and rights holder's levels. The male and female community-led structures bridged the gap between the service providers and the community they served including identification of the poor families for provision of CIGs. Even after the exit of the programme, these community-led structures are still in place and the members are motivated to continue their role of

community mobilization and sensitization about adaptation of health behaviours. These initiatives provide lessons on the importance of community engagement and replicating such approaches in the future UNICEF's initiatives.

- Gender Sensitive and Responsive Programming:** In addition to vulnerable points in the life-cycle, gender inequities substantially influence poor maternal and child feeding practices and under-nutrition. These inequities stem from inadequate attention to the needs and roles of women, resulting in inadequate care for pregnant and lactating women, lack of education and low economic status. Hence, it is vital to ensure women participation in the programme activities and empowering them to break the multifaceted circle of under-nutrition. To this end, the programme deployed gender-responsive approaches (D.3.2) in the delivery of interventions which were more pronounced at the community level than at the policy and enabling environment level at the district and provincial levels. This provide lessons to: a) scale-up such deployed approaches in future programming at the community level with clear articulation in the programme design including ToC, and b) influence changes in GoS policies and practices through direct advocacy for inclusion of gender-responsive approaches within the multi-sectoral stunting reduction programmes, AAP under Taskforce secretariat.

F. RECOMMENDATIONS

Process of Developing Recommendations: The summative evaluation recommendations are based on the findings, conclusions and lessons learned which were derived by following a structured process as: a) Held in-depth discussion with male and female key informants (UNICEF, IPs and government staff members) about the programme approaches, intervention packages, bottlenecks and how those were mitigated, lessons learned and what would they do differently in future alongside recommendations based on their experiential learning, gaps and strength of the programme. The evaluators then clubbed those insights under different themes and drew preliminary inferences based on the analysis and triangulation of the primary and secondary data as presented in the finding, conclusion and lessons-learned section of the report, b) Presented the preliminary findings and inferences in four meetings to the key stakeholders (UNICEF, IPs, GoS) at provincial and national levels. During the presentation, the participants brainstormed on the possible recommendations of the programme in the purview of the preliminary findings. The evaluators then processed the insights further and elaborated them as possible recommendations from the four sessions which were then shared with UNICEF for feedback, c) Received feedback on the possible recommendations which the evaluators refined further and shared with UNICEF in the draft report, d) UNICEF and key stakeholders provided a composite feedback on the draft report including findings, conclusions and recommendations which the evaluators incorporated in the revised report, e) the revised report was shared with UNICEF and IPs for their feedback and inputs which was incorporated in this version of the report, f) UNICEF and partners validated the findings and recommendations in the UNICEF programme meeting which was attended by the programme staff from all four field offices and senior management team including UNICEF's Country Representative and Deputy Country Representative which are presented in this version of the report, g) Presented findings and recommendations to USAID to elicit their feedback and validation of recommendation, and h) It is also planned that the key findings and recommendations will be widely disseminated to state and non-state actors.

Recommendations: The recommendations are elaborated with defining characteristics to aid interpretation and support UNICEF in planning and execution either directly by themselves or advocating with concerned state and non-state actors in their programme. The recommendations are addressed to UNICEF for considerations in their future programming and advocating with government, IPs, UNICEF regional office and global integrative programming practitioners. The recommendations are referenced with the related findings including conclusions and lessons learned and are ranked based on their prioritization level, as presented in table 12.

TABLE 12: PROGRAMME'S RECOMMENDATIONS

Recommendations	Level	Priority	Intended Users
<p>F.1. Advocate with Government and Programme Practitioners on the Key Elements of Integrative Programming and Support them in Adopting these Elements in their Existing and Future Sector-Wide Integrated Programmes</p> <p>Cross-referencing to sections D.2.1, E.1, E.2, and figures 4, the programme achieved the status of "Complete Integrative Programming" as it considered. In the process of achieving this status, the programme faced several challenges and bottlenecks which were addressed through iterative adaptive management. The process drew many lessons learned that may be of interest to:</p>	Strategic	High	<ul style="list-style-type: none"> GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD National: Ehasaas Program

- 🕒 **Government of Sindh (GoS):** under AAP initiative, GoS is implementing sector-wide programme through eight line departments and developmental partners. The programme offers lessons how it operationalized the integrative interventions that may help AAP to refine its strategic approach against the integrative programming conceptual framework and elements
- 🕒 **UNICEF Pakistan:** will use the learning in the design and delivery of the future integrative programming in a more structured manner
- 🕒 **UNICEF ROSA:** under Stop Stunting Strategy, ROSA advocates for integrated nutrition-specific and nutrition-sensitive programming. Hence, the programme provide example of actual implementation of integrative approaches.
- 🕒 **Integrative Programme's Practitioners:** the learning and best practices from this programme may be used as an example how to operationalize UNICEF, WHO and USAID recommended framework of 5 elements through integrative approaches

🕒 UNICEF Pakistan, UNICEF ROSA, national and global Integrative Programme's Practitioners, Academia and CSOs/NGOs

F.2. Advocate for Adaptation and Scale-up of the Integrated Nutrition-Specific and Nutrition-Sensitive Programme Frameworks and Mechanisms as Best Practices which were Developed under the Programme to Support Convergence of Disciplines/Sectors and Integration of Interventions

Cross-referencing to sections D.2.1, D.2.3, E.1 and figure 4, the integrative programme frameworks played vital role in implementation of the programme in an integrated manner. These frameworks provide a roadmap to guide integrative programme practitioners and government, particularly AAP, to adopt such frameworks for the implementation of sector-wide programmes. UNICEF may advocate proactively with GoS for adaptation and scale-up of these frameworks.

Cross-referencing to sections D.2.1, D.2.2, E.2 and box 1, the programme established mechanisms that played vital role in the convergence of disciplines/sectors and integration of interventions among government authorities and IPs. These initiatives led to the adjustment of the programme implementation approach in line with the evolving programme needs which included: a) SR-ICG, and b) Bottom-up Solutions through DSC. These best practices may need to be replicated in the future integrative programming at UNICEF and government level. The SR-ICG is at par with the AAP initiative that converge eight sectors to implement stunting reduction sector-wide programmes. UNICEF may share the best practices of the SR-ICG with Taskforce Secretariat for refining further the convergence of sectors. Though, AAP has already taken into account the replication of the DSC with the name DCC across the province, however, UNICEF may work further to refine the ToR of the DCC and advocate for measures to make it part of the government officials appraisal system in line with the Polio Eradication Programme in Pakistan.

Strategic

High

- 🕒 GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD
- 🕒 National: Ehasaas Program
- 🕒 UNICEF Pakistan, UNICEF ROSA, national and global Integrative Programme's Practitioners, Academia and CSOs/NGOs

F.3. Publish Key Findings and Lessons-learned of Integrative Programming and Develop Replicable Packages with Minimum Standards for Designing and Operationalizing Sector-wide Stunting Reduction Programme in Future

Cross-referencing to sections D.2.1, D.2.3, E.1, D.5 and discussion with UNICEF programme team including UNICEF's Country Representative and Deputy Country Representative; it was considered vital to invest further in knowledge management from this programme. It was suggested to define the minimum

Strategic

High

UNICEF

integrated stunting reduction intervention packages and cross-sectoral linkages among Nutrition, WASH, Health and Education to avoid missed opportunity in future integrated programme. The design and development of such replicable packages will not only guide UNICEF Pakistan integrated programme directions but will also help to share evidence, tools, and lessons within and across regions. Additionally, UNICEF may consider publishing the key findings and lessons-learned from this programme so that integrative programme practitioners and implementers may benefit from the experience and tools which played central in achieving the “complete integrative programming status”.

F.4. Scale-up the Use of Iterative Adaptive Management Principles for Improved and Effective Planning and Execution of Integrated Programme

Cross-referencing to sections D.2.1, E.1 and annex 11, the programme deployed iterative adaptive management to enable implementers to identify and address challenges in timely manner. The adaptive management is a process for continually improving decisions, management policies, and practices through learning by doing and from the outcomes of decisions made previously. As a result the programme developed a number of integrative programme frameworks and led the process to achieve the complete integrative programme status. Additionally, UNICEF may consider the capacity building of the staff on agile project management and scrum methodology to improve further on the iterative adaptive management principles and effective planning.

Operational

Medium

UNICEF & Taskforce Secretariat and Ehasaas Programme

F.5. Advocate for Integration of Gender Sensitive and Responsive Approaches within the Sector-wide Programme Policies and Practices

Gender equality is intrinsically linked to sustainable development and is vital to break the multifaceted circle of under-nutrition as gender inequities substantially influence poor maternal and child feeding practices and under-nutrition (E.2, E.1, D.3.2 and A.2.1). The women and girls should be viewed as the key agents in the fight against under-nutrition rather than passive victims of malnutrition in need of assistance. In order to unleash their potential as change agents, they need to be empowered so that they can make decisions about their own and their children health and wellbeing including participation in community-led activities. To this end, the programme deployed gender responsive Nutrition and WASH interventions in the implementation of activities that provide lessons learned how to integrate such approaches and interventions (D.3.2, E.1 and E.2). These lessons provide UNICEF with opportunities to advocate with GoS and non-state actors to: a) scale-up such deployed approaches in the delivery of programme activities, and b) influence changes in GoS policies and practices through direct advocacy for inclusion of gender-responsive approaches within the multi-sectoral stunting reduction programmes. The adaptation of these approaches will prove vital to break the logjam of addressing under-nutrition.

Strategic

High

- GoS including Taskforce Secretariat, AAP Health, NSP, PHE&RDD, LGD
- National: Ehasaas Programme
- UNICEF Pakistan and CSOs/NGOs

<p>F.6. Consider Changes in the PCA templates to allow UNICEF and IPs for Incorporation Aspects of Integrative Programming and Cross-cutting Themes of HRBA, Gender and Equity</p> <p>Cross-referencing to sections D.1.5 and D.3.2, there is a need of to make changes in the PCA templates to allow UNICEF and partners to cover aspects of the integrative programming and cross-cutting themes of HRBA, gender and equity. This will help UNICEF to mainstream these principles by articulating clearly the envisaged processes, ultimately leading to plan and execute these aspects better in the programme delivery. Additionally, UNICEF may need to consider the adaptation of Macro LFA for the sectors of interest for integrative programming. This will enable UNICEF to agree on the common objectives and the related indicators for tracking the progress in a coherent manner</p>	Operational	High	UNICEF
<p>F.7. Articulate Explicitly HRBA, Gender and Equity in the Programme Proposal, Objectives and Programme ToC</p> <p>Cross-referencing to sections D.1.5, D.3.2 and E.1, the programme proposal didn't articulate explicitly how to mainstream HRBA principles, equity, gender, and gathering data on social differences. Despite this, the programme delivery was guided by the HRBA principles where it has mainstreamed many aspects of these cross-cutting and overarching themes. Hence, this is recommended that UNICEF may ensure to cover these aspects in the programme proposals in future. To this end, UNICEF may build the capacity of the programme staff on these principles including guidance how to articulate these within the programme proposals, objectives and indicators.</p>	Operational	High	UNICEF
<p>F.8. Establish Grievance Redress Mechanism (GRM) in Future Integrated Programme to Provide Rights Holders with Opportunities to Voice their Concerns, and Share their Feedback about the Programme and Hold Duty Bearers to Account</p> <p>Cross-referencing to sections D.1.5 and D.3.2, though the programme was guided by HRBA principles, however, the programme didn't establish the GRM to promote voices of the rights holders, monitor the relevance of the provided services and to hold the service providers and duty bearers to account. GRM often include hotline numbers, help desks, and complaint boxes. However, it is suggested to promote multiple mechanisms in order to facilitate community members in filing complaints and/or suggestions to improve services. Importantly the system needs to take up the concerns or suggestions with provision of feedback to the complainants in timely manner. Hence, it is recommended that UNICEF and IPs may consider the establishment of the GRM in future programmes.</p>	Operational	High	UNICEF, IPs and Taskforce Secretariat
<p>F.9. Improve further the Integrated WASH & Nutrition Programme Data management by Ensuring that Critical Programme Data is Gathered and Used</p> <p>Cross-referencing to D.1.5, D.3.1 and E.1, the programme gathered gender disaggregated data; however, it didn't gather data on certain aspects of social differences. Similarly, the programme didn't gather data on diarrhoea episodes during pre and post KAP survey. Additionally, there were some issues in the programme data including double counting. The review of the WHA scorecard reveals that Pakistan situation was not analysed due to unavailability of data for the priority WHA indicators. UNICEF programme team need to consider the WHA scorecard indicators in the future programming to provide assessment of the progress against the UN Decade of Action on Nutrition. Considering these areas, it is recommended that UNICEF and</p>	Strategic	High	UNICEF and IPs

partners may consider these aspects to improve further the data collection and management in future.

F.10. Advocate with Donors for Adequate Programme’s Inception Period and Longer Duration of the Stunting Reduction Programme in Future to Allow UNICEF with Optimal Preparation and Contribute in Measurable way in Stunting Reduction (Intended Users: UNICEF)

Cross-referencing to sections D.2.2, UNICEF lost considerable time of the programme’s inception phase due to finalization of the programme impact areas, discussion with WFP for joint venture and inclusion of health sector within the programme. Similarly, the programme was implemented for around two years which is not enough timeframe to reduce stunting. This provides a lesson that UNICEF may engage the donor and request for the extension of the inception phase in future programming instead of kicking and advocate with them for longer duration of the programme activities implementation

Strategic

Medium

UNICEF and Donors

F.11. Promote Standardized Messages and Use of IEC Materials for Creating Awareness and Adaptation of Healthy Practices

Cross-referencing to sections D.3.1 and E.1, the Misaali Maan Campaign promoted two out of five critical moments of hand washing, even wrongly worded. Similarly, the campaign used simulated IEC pictorial messages by incorporating stylistic components of the most watched media into the illustration that created misperceptions about iron/folate supplementation. Additionally, the campaign was designed and conducted in silos and introduced in the last phase of the programme. This is recommended that UNICEF and partners may adopt in future standardized messages and materials which are aligned with national or provincial SBCC packages and contents. This is important as the communities will receive the same message from multiple point of contacts and communication channel to reinforce the adaptation of healthy behaviours

Operational

High

UNICEF and IPs

F.12. Engage LHWs adequately in Service Delivery at the Community Level

LHWs is the largest community-based network of service providers in Pakistan who can play critical role in creating awareness, screening and referral of malnourished children, adolescents and PLWs and adaptation of healthy behaviours. Though programme engaged LHWs in the capacity building initiatives and brought changes in their curriculum, however, they didn’t implement activities (D.5 and E.1). This warrants the need to advocate with LHWs programme at provincial and district levels for their adequate involvement including facilitating them in undertaking activities at the community level

Operational

High

UNICEF, LHWs Programme and IPs

F.13. Consider Placement of Optimal Number of Implementing Partners in the Geographic Co-Locations

The programme placed eight partners to implement programme activities (6 NGOs, PHE&RDD and a Consulting Firm) at the community level. Among them 6 partners implemented nutrition-sensitive activities, where one of the INGO was placed in three districts covering 26 UCs whilst the additional 3 NGOs implemented activities in 33 UCs in the same three districts. Contrary to this practice, UNICEF adopted a different model in the last phase of the programme implementation by placing one IP, after the exit of all others NGO’s partners, to continue the implementation of programme activities across the three district between, covering both nutrition-sensitive and nutrition-specific interventions (D.2.2 and E.1). The deployments of these two approaches offer lessons that UNICEF may consider the

Operational

Medium

UNICEF

placement of IPs in the future programming by minimizing the number of partners to the extent possible. Subsequently, this will make the programme more efficient and effective in terms of coordination, implementation and transaction costs.

G. ANNEXES

Annex Box 1:

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- 🕒 Annex 2: Global Impetus for Sector-wide Programming
- 🕒 Annex 2A: ToR of Evaluation
- 🕒 Annex 3: Performance Monitoring Plan (PMP)
- 🕒 Annex 4: Integrated Action Plan (IAP)
- 🕒 Annex 5: Evaluation Scope
- 🕒 Annex 6: Evaluation Matrix
- 🕒 Annex 7: Overview of Qualitative Methods
- 🕒 Annex 8: FGD and Observation Tool Kit
- 🕒 Annex 8A: IDI Topic Guide
- 🕒 Annex 9: List of Persons Interviewed and Area Visited
- 🕒 Annex 10A: Ethical Review Approval
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Annex Box 1:

- 🕒 Annex A: Case Study Guide
- 🕒 Annex B: Consent Form Case Study
- 🕒 Annex C: Guide of the Spot Checks & Observation
- 🕒 Annex D: Consent Form Spot Checks
- 🕒 Annex E: Data Protection Guidelines

- Annex F: Assent Form School Children
- Annex G: Consent Form School Teachers
- Annex H: Consent Form FGDs
- Annex I: Consent Form IDIs