Application Form B

For

GAVI Alliance CSO Support in 10 Pilot GAVI Eligible Countries

March 2008

Maternal & Neonatal Child Health (MNCH)
Ministry of Health, Government of Pakistan
National Institute of Health, Park Road, Chak Shahzad, Islamabad
Tel: 00 92 51 2271823 Fax: 0 92 51 9218019

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Abbreviations and Acronyms

AJK	Azad Jammu & Kashmir (,State of)
AKF, P	Aga Khan Foundation, Pakistan
AKHS, P	Aga Khan Health Service, Pakistan
AKU	Aga Khan University
APR	Annual Progress Report
APWA	All Pakistan Women's Association
BDN:	Basic Development Needs
BHU	Basic Health Unit
CES	Coverage Evaluation Survery
CHIP	Civil Society Human and Intuitional Development Programme
cMYP	Comprehensive Multi-Year Plan for Immunisation
CSO	Civil Society Organization
DHQ	District Headquarter
DTP	Diptheria / Tetanus / Pertussis
EmONC	Emergency Obstetric & Neonatal care
EPI	Expanded Program of Immunization
FLHF	First Level Health Facility
FP	Family Planning
GAVI	Global Alliance on Vaccines immunizations
GoP	Government of Pakistan
HANDS	Health and Nutrition Development Society
HELP	Health Education and Literacy Programme
HSS	Health System Strengthening
IMNCI	Integrated Management of neonatal and childhood illnesses
IMR	Infant Mortality Rate
IPs	Implementing Partners
LHWs	Lady Health Workers
LHVs	Lady Health Visitors
LIFE	Literacy/Information in Family Health and Environment
MoH	Ministry of Health, Govt of Pakistan
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MTDF	Mid Term Development Framework
NA	Northern Areas
NHSCC	National Health System Coordination Committee
NGOs	Non Governmental Organization
NRSP	National Rural Support Programme
NWFP	North West Frontier Province
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PHC	Primary Health Care
PRSP	Punjab Rural Support Programme
PSC	Project Support Cost

PVDP	Participatory Village Development Programme
RHC	Rural Health Centre
SABAWON	Social Action Bureau For Assistance in Welfare and Organisational Networking
SBA	Skilled Birth Attendant
TB	Tuberculosis
THF	The Health Foundation
TT:	Tetanus Toxoid
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UNICEF	United Nations Children Fund
UNFPA:	United Fund for population
USAID:	United States Agency for International Development
UC	Union Council
VHC	Village Health Committees
WHO	World Health Organization

Executive Summary

The Government of Pakistan recognizes improving the health and wellbeing of women and children as an essential element to achieving the social sector goals for poverty reduction and overall development. The Government of Pakistan, (GoP) in particular, acknowledges the need to strengthen maternal and child health and improving vaccination delivery, especially, to hard to reach population if the Millennium Development Goals 4&5 are to be achieved. Towards this goal an integrated Maternal, Neonatal, and Child Health (MNCH) program was developed in 2006 for implementation at all levels of the health care delivery system.

In 2007, the GAVI Health System Strengthening (HSS) proposal was conceived and prepared to seamlessly support and eventually build upon, in order to expand the efforts of the Government of Pakistan in reorganizing the health services and tailoring them to the socio economic context of the country and to the most vulnerable strata of the population. The government led National Health Sector Coordination Committee (NHSCC) has devised a phased strategy in support of the HSS efforts of the Ministry of Health (MoH). The HSS plan aims at correcting already identified bottlenecks that weaken the effective implementation of national health strategies and interventions.

The purpose of the GAVI HSS plan is to improve the capacity of district health management teams to effectively manage resources and plan strategically, through district health management training, provision of technical assistance and logistics support. It aims at improving the access to quality comprehensive MNCH services through improving skills of health workers and First Level Care Facilities, (FLCF) supplementing drugs and equipment, and introducing IMNCI and EmONC in training curricula. To enhance effective promotive and preventive MNCH outreach, the program is also providing training, equipment and supplies to LHWs who work at the village level in their own catchment areas. To successfully implement the HSS plan, the MoH recognises the need of public – private partnership to achieve the desired health outcomes. It is recognized that opportunities will have to be sought to deepen the engagement of and collaboration with private and civil society organizations.

Recognizing that: (a) working alone the public services would not be able to deliver the MNCH plan and reach desired results/health outcomes; (b) any investment in improving quality and accessibility of health services will have an impact only if similar skills and resources are made available to other service providers; and (c) that the proposed strategies will not achieve desired objectives until substantial improvement is made at the level of community engagement and involvement in planning and monitoring, the NHSCC and partners brought together a Technical Working Group (TWG) with representation from the Ministry of Health and UNICEF, to support the process of collaboration with civil society organizations.

To support the efforts of the GAVI HSS proposal and build and expand on the initiative by tailoring services to the needs of the most vulnerable strata of the population, the GAVI Alliance CSO Support proposal was conceived and prepared.

Over an 18 month period, the proposed implementation plan aims at effective delivery and strengthening of maternal and child health services and vaccination to the hard to reach urban and rural population.

The three objectives of the program are:

1. Improving the quality of MNCH services by : (a) equipping and revitalising FLCFs through the provision of drugs and equipment; (b) enhancing the effectiveness of preventive and promotive

MNCH outreach services through the provision of necessary equipment and supplies to LHWs, LHVs and SBAs;

2. Broadening the range of MNCH services being provided at various levels by improving, expanding and diversifying the skills of health workers in private sector at First Level Care Facility (FLCF), LHWs, LHVs and SBAs
3. Improving access to the above quality services by: (a) improving referral systems and providing referral support to CSOs, EPI vaccinators, and LHWs and LHVs for child health and maternal health related activities, and; (b) empowering communities and village based health committees to effectively participate in accessing and monitoring the quality of health service delivery vis-à-vis immunization and mother/child health care.

A multi-stakeholder informative meeting was held by the Federal Ministry of Health, the NHSCC together with, partners, GAVI Secretariat and CSOs, on September 4th, 2007, building on the same structure that had elaborated the HSS plan. Technical inputs and advice was provided by Ministry of Health, UNICEF and WHO. CSOs actively involved in health sector initiatives, national as well as international were identified and invited to the first meeting. This process led to the developing of 3 clusters as sub components of the overall CSO consortium. With support from the TWG, CSOs held further consultative and consensus building meetings to identify their comparative advantage and geographical presence, and form three clusters.

While the major role of CSOs is in provision of services where there are gaps, they have also established close linkages and trust in the remote and very poor communities where they work. CSOs have demonstrated strength in mobilising and organising village level health committees to plan for community health care and monitor services.

During the selection and proposal development process a total of 15 CSOs were selected as potential partners with GoP for the GAVI Alliance CSO support.

The CSOs were invited to a workshop on 29th January to agree on the way forward for: the formation of the consortium of CSOs working in the health sector; tapping their potential in complementing the government in health system strengthening; and initiating a consultative process for the development and submission of a funding proposal for GAVI Alliance CSO Support. Discussion focused on the thematic areas, HSS objectives, the purpose of GOP and CSO cooperation, and application process. A representative of GAVI secretariat was also present at the meeting and shared the progress by other pilot countries and further clarified that the CSO funding is a part of the HSS government initiative.

To take forward the proposal development process, two important decisions were made at the 29th January meeting: (a)TWG would circulate a matrix to the participating CSOs and (b) the CSOs would fill in the information details in the matrix and send it back with the proposals to the CSO Support Coordinator. The matrix asked the CSOs for the following information in light of GAVI Alliance CSO Support and included CSOs':

- Proposed objectives
- Comparative advantage
- Theme of interest (capacity building, service delivery, advocacy, community mobilisation)
- Geographical presence (by province and rural / urban)
- Funding required

The information from the CSOs was organised by the CSO Support coordinator to map the CSOs according to geographical presence and theme. The analysis of this information helped to organise the CSOs according to their comparative advantage, geographical focus, themes, and to avoid

duplication, while building on complementarities of proposed interventions. Three clusters emerged based on geographic diversity, focusing stronger organisations in geographic areas where service delivery is the weakest. This allowed for space to be created for some of the smaller organisations to also participate.

Cluster	***Geographical Area Coverage***	***CSOs***	***Rural/Urban***	***Presence***
Cluster 1	*Northern Areas, Punjab, NWFP*	*5 CSOs*	*R & U*	*Local*
Cluster 2	*Balochistan, AJK*	*4 CSOs*	*R & U*	*Local*
Cluster 3	*Sindh*	*7 CSOs*	*R & U*	*Local*

The clusters have held three meetings to draft consortium and cluster TORs and develop and submit proposals to the TWG. The proposal was then drafted based on the interest and comparative advantage of the participating CSOs and their contribution towards achieving the HSS goal. The proposal, costing and budgetary implications were reviewed and endorsed by the NHSCC and the Ministry of Health.

The management and monitoring mechanism will involve district, provincial and federal government health departments, NHSCC, TWG, and CSO consortium. GAVI funds will be channelled through UNICEF country office. CSOs will prepare quarterly progress and financial reports and submit to the TWG for review. After review, UNICEF will release funds to the CSO accounts.

Section 1: Application Development Process

Name of HSCC (or equivalent):
The National Health Sector Coordination Committee (NHSCC)

Date HSCC has been operational since
The NHSCC has been operational since 23rd August 2006

Frequency of meetings
The NHSCC meets every three months and whenever required.

Overall Role and Function of the NHSCC
a) Recommend the proposal for GAVI funds to Ministry of Health and Ministry of Finance for approval
b) Periodically monitor the utilization of GAVI HSS funds as per approved proposal and identified indicators.
c) Provide technical and administrative support, where needed, where for timely implementation of the planned activities under GAVI HSS.
d) Examine and approve the progress reports required by GAVI.

1.1 Application Development Process
The NHSCC is a stand-alone body, (List of members attached as Annex-A), comprising variety of partners, both government and non-government. CSOs are occasionally consulted in this process. It is recognized that the CSO network is an untapped resource and there is recognition of the strong utility of working collaboratively with the private sector in Pakistan, although there is currently limited participation and coordination of the CSOs to support HSS implementation. The three cluster heads will represent national CSOs of Pakistan on the NHSCC. However for the GAVI civil society meeting in Geneva, which took place earlier in 12-13 November 2007, three CSOs were recommended to the Ministry of Health by the NHSCC to represent the national CSOs. From amongst these one organisation was selected to represent Pakistan's evolving CSO consortium at the GAVI meeting.

In July 2006 the NHSCC was constituted as an overarching body to oversee HSS support for health system strengthening to achieve the Millennium Development Goals 4 & 5. The NHSCC provides support and management to the GAVI HSS project. On 4th September 2007, the NHSCC convened an informative meeting of civil society organisations to introduce the availability of new GAVI funding to strengthen the involvement of CSOs in immunization, maternal and child health and related health services, with a view to encourage cooperation between the public sector and civil society to help build sustainability in the planning and delivery of these services. Ministry of Health, its attached departments, WHO and UNICEF, identified CSOs in Pakistan who are involved in immunization and maternal and child health activities. The GAVI database was also tapped for CSO identification. In total 31 CSOs, both national and international, were invited to the 4th September meeting (Letter of Invitation attached as Annex-B) where the new GAVI funding for CSO Support was introduced by the visiting GAVI secretariat team.

The NHSCC extended invitation to 31 organisations and 7 partners, out of which 23 CSOs attended the first meeting for the GAVI Alliance CSO Support on 4th September 2007 (Minutes of Meeting attached as Annex C). At this meeting the two funding opportunities under the GAVI Alliance CSO Support and the HSS project were introduced by representative of GAVI secretariat team. The purpose of this meeting was to maximise learning and facilitate the government's successful

engagement with the CSOs for the new GAVI Alliance support to civil society and to provide proposal development assistance to selected CSOs. The CSOs were informed that the GAVI Alliance was investing in strengthening civil society organizations in providing immunization, child healthcare, and technical assistance, and increasing demand for services through social mobilization and advocacy, especially, in hard-to-reach populations in 10 pilot countries including Pakistan. It was also clarified that the CSOs present had been invited on the basis of their involvement in immunization, child healthcare and health system strengthening work and the purpose of the GAVI Alliance was to stimulate stronger CSO representation, improve CSO coordination, and facilitate effective partnerships between CSOs, governments and bilateral partners. The HSS and the Form A was also introduced, which includes the initiative of mapping of CSOs; facilitating CSOs' participation; sharing information between partners; and establishing a national and regional forum to discuss and share experiences. The GAVI representative also introduced the areas of immunization, injection safety, new vaccines, and health system strengthening. The areas introduced for the CSO support activities were immunization, child health, technical assistance to national immunization, teaching and training health professionals, and community mobilization and advocacy. It was also cleared that all GAVI Alliance CSO support activities were to be completed by October 2009. The CSOs were asked to develop their proposals and submit them to the NHSCC. The group was informed that a review of the activities would be carried out in late 2009 or early 2010 to draw lessons learnt from the implementation in the 10 pilot countries, which will inform the GAVI Alliance board's decision on whether to expand or reduce further support for civil society in GAVI-eligible countries.

At the end of the meeting the Ministry of Health provided the CSOs with information and supporting documents, including: HSS document, priority districts, studies on health systems barriers, PDHS, MNCH Strategic Framework, MTDF, and CES 2006.

1.2 The Technical Working Group

To support the GAVI Alliance CSO Support application and manage the implementation process a Technical Working Group (TWG) was formed by the NHSCC, comprising representatives from Government of Pakistan, Health Ministry and UNICEF. The GAVI Alliance CSO Support Coordinator in Pakistan is also a member of this team. The TWG is ultimately responsible to the NHSCC, which is still responsible for signing the overall application to the GAVI Alliance Secretariat. The TWG is responsible for all tasks related to applying for and managing the application process, including:

- Raising awareness among CSOs of the GAVI Alliance CSO support
- Identifying the key areas for CSO support to reflect the GAVI HSS proposal
- Sending out application forms to interested CSOs
- Providing assistance to CSOs in completing the application forms
- Developing a set of criteria and evaluating the completed application forms against them
- Making recommendations to the NHSCC on CSOs to be selected for support
- Preparing the overall application form to the GAVI Alliance Secretariat on behalf of the NHSCC
- Identifying the most appropriate route to channel the GAVI Alliance funds into the country
- Monitoring performance of the CSOs on a regular basis
- Reporting to the GAVI Alliance Secretariat

For the long term, the TWG will provide technical assistance to the functioning of the CSO consortium and its membership. TWG members provided CSOs with information on data on EPI coverage; target population; basic health facilities in the district; IMR and MMR data; LHWs catchments and number of LHWs available in target areas.

At the 4th September meeting, it was realised that this was the first time that the CSOs were being asked to engage in a proposal development process side by side with the government. The CSOs

were uncertain and unfamiliar with the process and thought that the government would tell them what to do as activities. On the other hand, the government wanted the CSOs to express their comparative advantage in developing their own project design and activities. In Pakistan there is an over all lack of coordination between the CSOs working in health as well as with the government. As this was a new process for both, the Ministry of Health along with the TWG recruited a consultant as Coordinator CSO Support to facilitate the process.

Out of those attending, 19 CSOs submitted their EOIs and profiles, which were reviewed by the TWG. The GAVI Alliance CSO Support Coordinator met with each organisation separately in January 2008 to answer questions related to the application process, provide support, and verify information regarding the existence and functioning of the CSOs provided in their profiles. This was an important step taken by the TWG as one CSO was found to be a ghost organisation.

1.3 Formation of Consortium

The remaining 18 CSOs were invited to a workshop on 29th January 2008 (Minutes of Meeting attached as Annex-D) to agree on the way forward for: the formation of the consortium of CSOs working in the health sector; tapping their potential in complementing the government in health system strengthening; and initiating a consultative process for the development and submission of a funding proposal for GAVI Alliance CSO Support. Thematic areas, HSS objectives, purpose of GoP and CSO cooperation, and application process, were discussed and clarified. GAVI representative, also present at the meeting, shared the progress by other pilot countries and further clarified that the CSO funding is a part of the HSS government initiative.

To take forward the proposal development process, two important decisions were made at the 29th January meeting: (a)TWG would circulate a matrix to the participating CSOs and (b) the CSOs would fill in the information details in the matrix and send it back with the proposals to the CSO Support Coordinator. The matrix asked the CSOs for the following information in light of GAVI Alliance CSO Support and included CSOs':

- Proposed objectives
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- Geographical presence (by province and rural / urban)
- Funding required

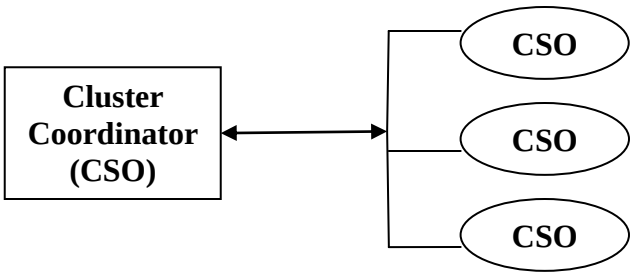
The information from the CSOs was organised by the CSO Support Coordinator to map the CSOs according to geographical presence and theme. The analysis of this information helped to organise the CSOs according to their comparative advantage, geographical need, and themes, and eliminate duplication while building on complementarities of proposed interventions (Matrix attached as Annex-E). Three clusters emerged based on geographic diversity, focusing stronger organisations in geographic areas where service delivery is the weakest. This allowed for space to be created for some of the smaller organisations to also participate.

Cluster	Geographical Area Coverage	CSOs	Rural/Urban	Presence
Cluster 1	Northern Areas, Punjab, NWFP	6 CSOs	R & U	Local
Cluster 2	Balochistan, AJK	3 CSOs	R & U	Local
Cluster 3	Sindh	7 CSOs	R & U	Local

In February 2008 three meetings were organised by TWG for each cluster in which cluster members discussed aims of the clusters including objectives, responsibilities, expected outputs, and coordination mechanism. Each cluster elected its cluster coordinator to represent the group, while all cluster members were identified as duty bearers (Cluster ToRs attached as Annex F). Depending on

the area of their work, two CSOs were part of more than one cluster. The structure of the cluster was proposed as follows:

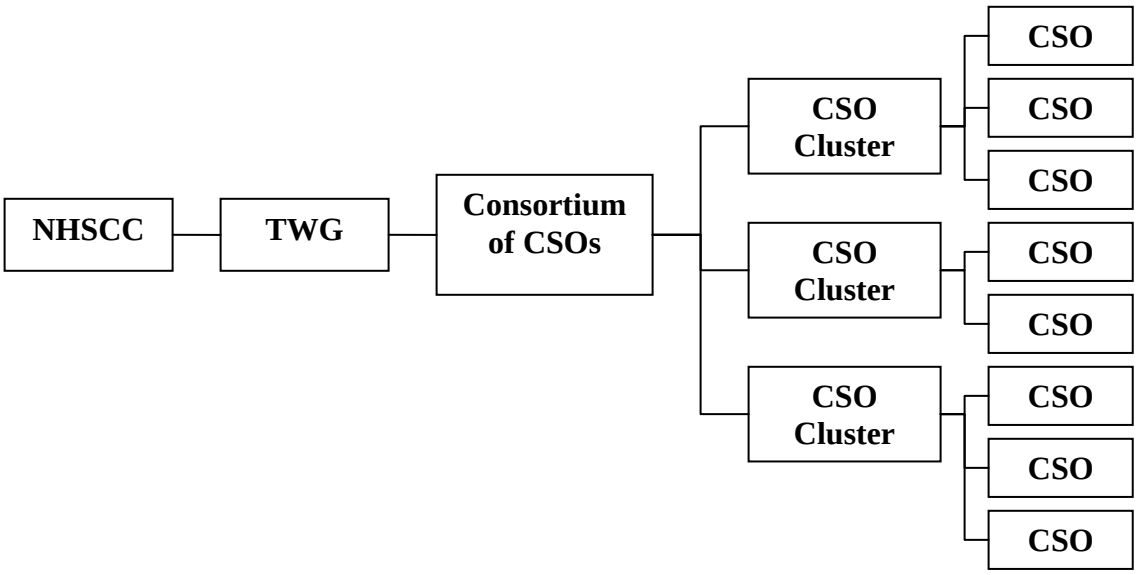
Cluster Structure



This also proved to be the opportunity for each cluster's members to introduce themselves to the group. Under the focus it was identified that the organisations were focusing on: (a) Social mobilisation and (b) Training of vaccinators, skilled birth attendants, health department, BHU staff, LHVs, and community volunteers. It was decided that during the next cluster meeting each organisation would share clear indication of project goal, purpose, results, geographical coverage, and objectively verifiable indicators. The members agreed that the protocol amongst cluster members would include: adoption of standardized formats for reporting; on time reports; focus on priority of community; and timely and open and honest sharing of information. The cluster members agreed not to duplicate activities or areas or pass judgements on other members. As the timeframe for the GAVI Alliance CSO Support was known, the CSOs agreed to develop performance measures for the clusters and discuss how to keep the clusters intact once the project finishes. The 3 cluster coordinators will become representatives of CSOs on NHSCC.

With the formation of the clusters, the structure of the Government - CSO alliance also emerged, which is represented here:

Government-CSO Alliance Structure



TWG assessed 18 CSO applications against the selection criteria and selected 15 final applications. All proposals were submitted to the GAVI CSO Support Secretariat housed at the EPI cell in the National Institute of Health (NIH). The CSO Support Coordinator, sitting in the NIH received the applications. TWG members reviewed the applications and collective feedback was provided to the CSOs to strengthen their applications. All proposal reviews and discussions were conducted jointly between each CSO and the CSO Support Coordinator, who also provided on-going support in developing and formatting proposals in Form C. Finalization of each CSO proposal was done by the TWG, which has been meeting every week for this purpose since 29th January 2008.

Who coordinated and provided oversight to the application development process?
TWG provided the oversight, support, and managed the development of the applications by CSOs.

Who led the drafting of the overall application and was any technical assistance provided?
TWG led the drafting of the overall application in consultation with the GOP Health Ministry. UNICEF and WHO provided technical assistance in developing the application.

What was the process for individual CSOs to submit their applications for support?
Individual CSOs submitted Expression of Interest and profiles to the TWG, after which they were invited to submit their application for support. The applications were reviewed by TWG members, including the Federal Ministry of Health, UNICEF, and the GAVI Alliance CSO Support Coordinator.

What mechanism was adopted for choosing which CSOs to put forward for support?
CSOs were assessed on their capacity, comparative advantage, relevance to GAVI HSS, registration status, past performance and financial systems. Preference was given to national CSOs over international NGOs registered in Pakistan.

1.4 Roles and responsibilities of key partners (HSCC / TWG members and others)

Title / Post	Organisation	HSCC / TWG member?	Roles in the development of the application for GAVI Alliance CSO support
Director General Health, Chair of NHSCC:	Ministry of Health	Yes/ No	• Over looking the NHSCC and TWG
Deputy Director General Health,	Planning & Development GoP	No/No	• Technical support to CSOs.
National Program Manager	MNCH Ministry of Health, GoP	Yes/Yes	• Identification of CSOs. • Facilitation in proposal development. • Review and selection of CSO applications.
Deputy National Program Manager	EPI/ Ministry of Health, GoP	Yes / Yes	• Mapping of existing CSOs • Technical support to CSOs.
Coordinator GAVI CSO Support	Ministry of Health, GoP	No/Yes	• Facilitation in proposal development. • Review and selection of CSO applications. • Support in proposal revisions and discussions • Coordination and networking and linkages development. • Development of clusters and cluster meetings
National Program Manager,	Family Planning & Primary Health Care Ministry of Health, GoP	No/Yes	• Coordination and Technical support
MCHC Head	UNICEF Country Office	Yes/Yes	• Identification of CSOs. • Review and selection of CSO applications. • Developing M&E Mechanism
Program Communication Specialist – Health	UNICEF Country	No/Yes	• Identification of CSOs. • Facilitation in proposal development.

	Office		• Review and selection of CSO applications.
National Professional Officer, Primary Health Care	WHO	No/No	• Technical support to CSOs in proposal development.
Technical Officers	EPI Team – GoP	No/No	• Identification of CSOs • Mapping process • Data access for baseline development • Debriefing
District EDOs – Health	GOP	No/No	• Facilitation to CSOs in accessing data for proposal development.

Section 2: Overview of GAVI Alliance CSO Support

2.1 Role of CSOs in Health Services

To achieve the Millennium Development Goals 4&5 in Pakistan, it is necessary to ensure access and demand for quality maternal and child health services and wider immunization coverage, especially in the marginalised and poor rural areas as well as urban slums, which covers well over 60% of the total population. Health needs of the community in Pakistan are provided by both public sector (over 30%) and by the private sector, including CSOs (nearly 70%). Rural and urban slum areas are mainly serviced by public services, though they are limited in their coverage, and are entirely absent from hard to reach areas. Where private facilities are present they are either not accessible by the poor, or simply unaffordable. They are then entirely dependent on traditional health care or poor public facilities.

CSOs' work in Pakistan has mainly focused on filling this gap in service provision. In Pakistan, work of most CSOs working in the health sector and those identified in this initiative, concentrated around three main areas of: delivering maternal and child health services; strengthening health systems through training of primary health care providers at the community level to deliver MNCH care and immunization and revitalising and establishing community based health clinics; providing technical assistance to national immunization and child health services; designing and implementing operational research on causes of disease, community disease burden, and improving health systems; and community awareness raising and advocacy to influence decision-makers and policy.

As the demand for availability of primary health workers at the community level is high CSOs also train a cadre of women health workers from the communities to be SBAs and LHVs to provide services of maternal and child care, prenatal and postnatal care, nutrition, hygiene, and vaccination for Tetanus Toxoid (TT). While the government has a strong LHW Program to provide MNCH and EPI services, they are presently unable to reach all areas. CSO managed health facilities and trained workers are positioned close to communities where no BHU or RHC is available. CSO trained and facilitated SBAs, LHVs, school teachers, and immunization teams continue to reach out to the communities.

While the major role of CSOs is in provision of services where there are gaps, they have also established close linkages and trust in the remote and very poor communities where they work. CSOs have demonstrated strength in mobilising and organising village level health committees to plan for community health care and monitor services. However generating demand for health services remains weak owing to insufficient information on government HSS programs and types of public services available. This has caused CSOs to do only limited work in developing referral systems, especially in timely access to secondary and tertiary public health facilities, especially those providing neonatal, EmONC and immunization.

2.2 Program Objectives

There are three consolidated objectives of the 15 CSO projects, which include:
1. Improving the quality of MNCH services by : (a) equipping and revitalising FLCFs through the provision of drugs and equipment; (b) enhancing the effectiveness of preventive and promotive MNCH outreach services through the provision of necessary equipment and supplies to LHVs, LHWs and SBAs;

2. Broadening the range of MNCH services being provided at various levels by improving, expanding and diversifying the skills of health workers in private sector at First Level Care Facility (FLCF), LHVs, LHWs and SBAs

3. Improving access to the above quality services by: (a) improving referral systems and providing referral support to CSOs, EPI vaccinators, and LHWs and LHVs for child health and maternal health related activities, and; (b) empowering communities and village based health committees to effectively participate in accessing and monitoring the quality of health service delivery vis-à-vis immunization and maternal/child health care

2.3 Participating CSOs

During the selection and proposal development process a total of 15 CSOs were selected as potential recipients of the GAVI Alliance CSO support, and include the following:

1. **Aga Khan Health Services** (Islamabad)
2. **Aga Khan University** (Karachi)
3. **APWA** - All Pakistan Women Association (Islamabad)
4. **BDN** - Basic Development Need (Nowshera)
5. **CHIP** - Civil Society Human and Institutional development Programme (Islamabad)
6. **HANDS** – Health and Nutrition Development Society (Karachi)
7. **HELP** – Health Education and Literacy Programme (Karachi)
8. **LIFE** – Literacy/Information in Family Health and Environment (Islamabad)
9. **NRSP** – National Rural Support Programme (Islamabad)
10. **PAVHNA** – Pakistan Voluntary Health and Nutrition Association (Karachi)
11. **PRSP** – Punjab Rural Support Programme (Lahore)
12. **PVDP** – Participatory Village Development Programme (Hyderabad)
13. **SABAWON** – Social Action Bureau for Assistance in Welfare and Organisational Networking (Peshawar)
14. **Save The Children UK** (Islamabad)
15. **The Health Foundation** (Karachi)

2.4 Major activities and outcomes for each CSO over the duration of the GAVI support

The activity sets listed below are in relation to the overall results framework included in Section 4, and correspond to the overall outcomes and outputs envisaged as result of GAVI support. Within these activity sets, various CSOs propose undertaking various sub-activities, depending on the present state and quality of related healthcare infrastructure in their respective geographical jurisdictions, and the corresponding localized healthcare needs for the project thereof. The activities and inputs proposed by the various CSOs in respect of each activity set listed below are therefore reproduced in their original form (Attached as Annex G), to allow room for local flexibility and adaptability. Consolidation of CSO proposals in this manner has two advantages: (a) the broad output and outcome framework and indicators remain the same for each CSO, and; (b) there is room for local adaptation with the broad overall approach and innovation at the CSO levels. It is however recommended that the various CSO activities are further attuned with the broad objectives of the project and made more inter-consistent through a consultative/feedback process after the first draft report.

Name of each CSO, type of organisation and their activities to be supported	Expected outcomes	
	2008	2009
Provision of essential equipment and drugs/supplies to FLCFs	For the corresponding outcome and output level indicators, please refer Section 4.	
Provision of essential equipment and drugs/supplies to LHVs, LHWs and SBAs	For the corresponding outcome and output level indicators, please refer Section 4.	
Training/Skills expansion and diversification of FLCF staff	For the corresponding outcome and output level indicators, please refer Section 4.	
Training/Skills expansion and diversification of SBAs, LHWs, LHVs, volunteers, and immunization teams	For the corresponding outcome and output level indicators, please refer Section 4.	
Awareness raising and sensitization campaigns at union council and community levels	For the corresponding outcome and output level indicators, please refer Section 4.	
Community mobilization through the reorganization of existing CBOs or formation of dedicated community health committees	For the corresponding outcome and output level indicators, please refer Section 4.	
Training and capacity building of community health committees for participation in healthcare management and monitoring	For the corresponding outcome and output level indicators, please refer Section 4.	
Strengthening referral systems, through increased and formalized interfacing, and development/improvement of referral procedures and communication links	For the corresponding outcome and output level indicators, please refer Section 4.	

2.5 Sustainability of Interventions

The sustainability of interventions that are included in this program has multiple dimensions ranging from financial through knowledge and skills to capacity and direct community involvement.

The sustainability of training has a different dimension as almost all the LHWs, LHVs, and STBs are local residents of the villages they serve. With some initial investment the training of these service providers in IMNCI, MNCH, vaccination and communication skills will not only permanently enhance their skills but the overall capacity of the villages they reside in with addition of permanent resource development at the village level. In this case the requirement is to sustain knowledge and skills learnt by the service providers, which is mostly sustainable in itself.

Similarly the MNCH training of health care providers from both the public and private sectors will lead to overall enhancement of health systems' capacity. This is again an initial investment with refreshers thereafter to further strengthen and retain the learnt skills. Furthermore, incorporating the IMNCI and EmONC training components in the curricula of government and private trainings will permanently resolve this issue.

While building on the existing capacities of CSOs their capacity building for working in a coordinated and complementary way will also occur as they engage in cluster formation, organizing interventions

and improving communications. This in itself is sustainable as CSOs will be able to use this capacity in other areas of their health programs.

The capacity building of community health committees will further enhance the village capacities to identify gaps and take corrective actions. This will have a lasting impact and is sustainable as empowered communities will be able to manage village resources, adequately plan for the village and implement actions.

The communities, being the sole beneficiaries of the health sector services, have the greater stakes. Once they are transformed into cohesively active groups to play their roles in the betterment of health systems they would not need additional resources on continuous basis but are expected to contribute many types of resources leading to further value addition to the system.

2.6 Financial Sustainability

The political commitment at the highest level is one of the major reasons to believe the financial viability of the GAVI Alliance CSO Support after completion of the program duration. The Ministry of Health, provincial departments, and donor organizations have remained keenly involved in the proposal development process, which is reflective of their ownership of such initiatives with an integrated approach to involve civil society organizations. The level of participation and involvement of partner organizations like UNICEF and WHO may also open more avenues of financial and technical assistance for health system strengthening through government and civil society alliance.

Section 3: Programme Implementation Plan (one – two pages)

3.1 Introduction

Progress in improving the health indicators in Pakistan has been slower than countries with equal or lower health expenditure and per capita income. The GAVI Alliance CSO Support program aims to contribute towards the MDGs 4&5 by increasing immunization coverage; reducing IMR; reducing MMR; and reducing U5MR by supporting and consolidating the efforts of actors involved in providing immunisation coverage and maternal and child health care.

The program builds coordination and cooperation between CSOs and government and strengthens their capacities for monitoring and information sharing to fully meet the following three objectives: 1)Improving the quality MNCH services; 2)Broadening the range of MNCH services ; and 3)Improving access to the above quality services.

3.2 Specific activities for implementing the project and implementation schedule

Major Activities	**2007**	**2008**				**2009**	
	Q0	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
Project Inception							
Attunement of CSO activities with project objectives	X						
Finalization of Baseline and targets	X						
Project launch with stakeholders	X						
Inputs/Activities							
Provision of essential equipment and drugs/supplies to FLCFs			X	X	X	X	
Provision of essential equipment and drugs/supplies to LHVs, LHWs, and SBAs			X	X	X	X	
Training/Skills expansion and diversification of FLCF staff		X	X	X	X	X	
Training/Skills expansion and diversification of SBAs, LHVs, LHWs, volunteers, and immunization teams		X	X	X	X	X	
Awareness raising and sensitization campaigns at union council and community levels		X	X	X	X		
Community mobilization through the reorganization of existing CBOs or formation of dedicated community health committees			X	X	X	X	
Training and capacity building of community health committees for participation in healthcare management and monitoring			X	X	X	X	
Strengthening referral systems, through increased and formalized interfacing, and development/improvement of referral procedures and communication links			X	X	X	X	X
Coordination and Information sharing							
Cluster meetings with TWG and district and provincial government			X		X		X
Network meeting with federal government and stakeholders				X			X
Monitoring							

Cluster level and TWG monitoring and field visits		X	X	X	X	X	X
District, Provincial, Federal government monitoring			X		X		X
Reporting							
Quarterly Reports		X	X	X		X	
Annual Report					X		
End of Project Report							X
Auditing							
Regular auditing of project			X	X	X	X	
Final project audit							X

3.3 Management of Program

The consolidated program will be managed by the Ministry of Health through the TWG to ensure that program objectives are met, while each CSO will be responsible for the management of its project activities, in compliance with the program objectives. As the program will be implemented in all four provinces, Northern Areas, (NA) and Azad Jammu & Kashmir (AJK), the number of CSOs involved is proposed to be fifteen. Management of such a large number of CSO covering a vast geographical spread is not plausible or effective from a single central location. For this purpose the participating CSOs have been organized into three clusters, based on geographic presence, and each cluster in represented by a cluster coordinator. The three cluster coordinators will be responsible for management of coordination, information sharing, and reporting between cluster members. The cluster coordinators will be the point of contact between the CSOs, TWG, and Ministry of Health and will report to the Ministry of Health and TWG. Coordination across clusters and with relevant stakeholders will also be managed by the cluster heads with support from the TWG.

3.4 Strategy to Achieve Results

To build consensus and commitment to achieving results the program implementation plan includes a three month inception period to allow CSOs to collect and share their project areas surveys/baseline data and finalize targets in coordination and consultation with the district governments, and to finalize their activities in discussion with the program team. This will allow for a joint development and finalization of the program monitoring plan for the outcomes and the outputs and ensure consistency, commitment, and shared accountability amongst all levels of program implementation and monitoring tiers, as well as between CSOs and the related government departments. To ensure the commitment by both CSOs and government towards achieving results the program ensures ample opportunities for district, provincial, and federal government and CSOs to not only meet, discuss and share information but for the government to be directly involved in the project through visit to the CSO project areas for learning and monitoring. The building of such an alliance focused on achieving the same results would enable actors working from different ends to assist and enable each other in contributing towards the shared outcomes.

3.5 Support to GAVI HSS Proposal

The program shares its results with the GAVI HSS proposal for Pakistan. It further intends to support and strengthen networking between relevant CSOs already engaged in providing community based maternal and child health service and immunization services, and develop coordination, support, and

consistency between CSOs and the government activities related to EmONC and Immunization, which will result in better and successful implementation of the GAVI HSS proposal and immunization plan.

3.6 Coordination with Others and Role of Key Stakeholders

Federal:

The Ministry of Health will coordinate the overall program activities with stakeholders at the district and federal level. The ministry will facilitate a project management and coordination structure. The PHC will provide monitoring support through its Federal and district level structure of field program officers and district PHC coordinators. EPI will provide technical support, policy, and implementation guidelines and monitoring. Logistics support will also be coordinated with provincial and district EPI.

Provincial:

Provincial health departments will provide leadership and policy guidelines for project implementation. The provincial governments will also ensure political support to the CSOs and will monitor activities and provide feedback to the national and district government.

District:

District committees headed by DCOs, elected district and union council members (*nazims* and *naib nazims*) will monitor and support program activities. The members of this steering committee will be from relevant district line departments. The district steering committee will provide support to program implementation by assigning roles to each department and will mobilize district resources to facilitate participatory process of planning and resource allocation. The district steering committee will also help to strengthen and coordinate inter sectoral support to the program.

CSOs:

Participating CSOs will be responsible for planning and implementation of the proposed activities. They will ensure community participation in mother and child health care interventions and help raise demand for utilization of services. CSOs will also coordinate with the provincial and district governments as well as elected representatives and other stakeholders through the clusters, and where required individually, to monitor, sustain and evaluate activities through community based interventions. The CSOs will report activities and provide regular feedback to all relevant stakeholders.

WHO, UNICEF and Other Partners:

Other partner organization will provide technical and planning support through provincial offices. The primary health care staff of the partner organizations at the national and provincial levels will remain engaged with the program to achieve the desired results.

Section 4: Monitoring and Evaluation (one page)

4.1 Indicators that will be used to monitor performance

Indicator	Estimate of baseline[1]	Data Source (if any)	Date of Baseline	Target	Date for Target
Outcome/Result Level:					
Enhanced DPT3 Coverage in project areas (% increase in communities with full DPT3 coverage)	% of project communities with full DPT3 coverage	EPI Coverage – Third party evaluation	2006	>80%	2009
IMR across project communities	Average IMR across project communities	Pakistan MDG Report 2005, Planning Commission, GOP	2005	<55	2009
MMR across project communities	Average MMR across project communities	Pakistan MDG Report 2005, Planning Commission, GOP	2005	200	2009
U5MR across project communities	Average U5MR across project communities	Pakistan MDG Report 2005, Planning Commission, GOP	2005	<65	2009
Output Level:					
Improving the quality MNCH services					
Increase in number (or %) of FLCF revitalized with essential equipment and drugs (In project communities)	Number of FLCF without essential equipment and drugs for MNCH an Immunization	MoH/ HMIS		100%	2009
Increase in number (or %) of LHVs, LHWs, and SBAs provided equipment and supplies (In project communities)	Number of LHVs, LHWs, and SBAs with required equipment and supplies to deliver basic health and immunization	MoH/ MIS LHWs		100%	2009
Increase in number (or %) of safe deliveries conducted at FLCFs and through outreach services (In project communities)	Number of safe deliveries conducted at FLCFs and through outreach services	HMIS		50%	2009
Increase in number(or %) of children vaccinated at FLCFs and through outreach services (In project communities)	Number of children vaccinated	EPI Country Survey / EPI MIS		60%	2009

Broadening the range of IMNCI and EmONC services					
Number (or %) of FLCFs receiving staff training (In project communities)	Number of FLCFs with trained staff	HMIS. MIS LHWs	100%		2009
Number (or %) of LHVs and LHWs receiving training (In project communities)	Number of trained LHVs and LHWs	HMIS. MIS LHWs	100%		2009
Number (or %) of SBAs receiving training (In project communities)	Number of trained SBAs	HMIS. MIS LHWs	100%		2009
Number (or %) of teams trained for immunization (In project communities)	Number of trained immunization teams	EPI/ MIS	100%		2009
Improving access to quality services					
Increase in number (or %) of communities with increased awareness and sensitization towards MNCH and immunization (In project communities)	Number of communities aware and sensitized towards MNCH and immunization	HMIS. MIS LHWs	100%		2009
Increase in number of referrals made for immunization at FLCFs (In project communities)	Number of referrals made for immunization at FLCFs	HMIS. MIS LHWs	100%		2009
Increase in number of referrals made at EmONC facilities (In project communities)	Number of referrals made at EmONC facilities	HMIS. MIS LHWs	100%		2009
Increase in number of target communities with functional health committees (In project communities)	Number of communities with functional health committees	LHWs Program Record	70%		2009

Baseline data including target will be finalized after consultative and coordination meetings between CSO clusters and the Ministry of Health and INE**.** While CSOs have presented some data related to their individual target area, where it is available, baselines and targets have to be finalized and agreed upon jointly in coordination meetings with the district government departments. This will be completed as a CSO clusters activity during the inception period of the project.

4.2 Monitoring Mechanism

Level	Tools	Frequency
Communities	Visits to health facilities included in referrals system; household visits; meetings with parents and potential clients for mother and child health	Monthly
CSOs	Reports; Site Visits; Meetings/FGDs with beneficiaries	Monthly
Cluster	Reports; Site Visits; Meetings/FGDs with beneficiaries	Quarterly

District	Reports; Site Visits; Meetings/FGDs with beneficiaries	Six monthly
Provincial	Reports; Site Visits; FGDs with beneficiaries	Six monthly
GAVI Alliance	Reports; Site Visits; FGDs with beneficiaries	Quarterly
Federal	Reports; Site Visits	Six monthly

Community members will be part of the project implementation process and follow up of the project activities, which will be through village health committees in Union Councils, health volunteers, and teachers. Village health committees will be directly accountable to the communities, who will take part in the monitoring of health facilities in their area. CSOs and village health committees will monitor the progress against the indicators.

Section 5: Implementation Arrangements

5.1 GAVI Alliance Support Management

Name of lead organisation responsible for managing implementation of the programmes
Ministry of Health, Government of Pakistan, will be the lead organisation responsible for managing the implementation of the programmes.

Name of lead organisation responsible for coordination, monitoring and quality control
TWG, on behalf of the Ministry of Health and in conjunction with partners, will be the lead organisation for coordination, monitoring, and quality control.

Role of HSCC (or equivalent) in implementation
The NHSCC will ensure that the programmes are in coordination and support of the HSS objectives and will advise corrective measures to HSS and Clusters to ensure HSS goals are achieved

Mechanism for coordinating GAVI Alliance CSO support
The Consortium will coordinate all GAVI Alliance CSO activities through cluster coordinators. The Consortium will also develop coordination with TWG, NHSCC, and the Ministry of Health through the CSO Support Coordinator.

5.2 Roles and responsibilities of key partners (HSCC / TWG members and others)

Title / Post	Organisation	HSCC / TWG member?	Roles in the implementation of the application for GAVI Alliance CSO support
Chair of NHSCC: Director General Health,	Ministry of Health	Yes/ No	• Over looking the NHSCC and TWG
Deputy Director General Health,	Planning & Development GoP	No/No	• Technical support to CSOs.
National Program Manager	MNCH MoH/ GoP	Yes/Yes	• Coordination with GOP and Ministry of Health. • Technical Assistance to programmes
Deputy National Program manager	EPI – MoH/ GoP	Yes/ Yes	• Overall management of program Focal person for information exchange between GOP and Clusters
GAVI CSO Support Coordinator	MoH/ GOP	No/Yes	• Coordinating intra cluster meetings • Overall coordination and management of consortium of CSOs • Coordination for information sharing and learning between consortium, GOP, wider civil society, and other

			stakeholders.
Chief of MCHC	UNICEF Country Office	Yes/Yes	• Technical Support • Monitoring
Program Communication Specialist – Health	UNICEF Country Office	No/Yes	• Technical Support • Monitoring
Cluster Coordinators	CSO Clusters	No/No	• Organize quarterly meetings for experience sharing and learning between CSOs. • Coordinate between Cluster members, GAVI Alliance, UNICEF, and Ministry of Health for information sharing. • Maintain and disseminate information resources for members. • Document cluster events • Compile six monthly progress and financial reports of cluster members.
Cluster Members	CSO Clusters	No/No	• Sharing and developing project learning across members. • Preparation of quarterly activity reports and submission to cluster coordinators. • Compliance to the GAVI Alliance formats. • Responding to queries and communication by cluster members and coordinators. • Nominate project focal person and backup for each CSO.

5.3 Financial Management Arrangements for the GAVI Alliance CSO support:

Mechanism for channelling GAVI Alliance CSO funds into the country
GAVI Alliance financial funds will be channelled through UNICEF Pakistan country office. UNICEF will develop a letter of agreement with each CSO.

Mechanism (and responsibility) for budget use and approval
The CSOs will prepare individual activity plans and cash advance requests and submit to the Ministry of Health for review. On approval from the Ministry of Health fund release requests of CSOs will be submitted to UNICEF. UNICEF will release funds in three instalments: 1st (40%) instalment on approval of proposal; 2nd instalment (30%) on approval of progress report; 3rd instalment (30%) on approval of progress report. Project Managers will be responsible for appropriate utilization of budgets at the CSO level.

Expected duration of the budget approval and transfer process
Expected one month following approval of detailed activity plan by the TWGs.

Mechanism for disbursement of GAVI Alliance CSO funds
Fund disbursement will be through bank accounts to CSOs into accounts established for the GAVI Alliance projects. All accounts will be operated with double signatures at all levels.

Auditing procedures (and details of auditors, if known)
Audits of each GAVI Alliance CSO project will be done by the CSO itself as a part of their regular auditing system (internal and/or external).

Justification of management fees (if applicable)
UNICEF will charge 7% Program Support Cost (PSC) as per rules and will go to the UNICEF headquarter. UNICEF country office will not be charging anything for their management and monitoring role, and technical support to the program.

5.4 Reporting

Progress and financial reports will be submitted by each CSO to its cluster head on a quarterly basis. The three cluster coordinators will compile six month, annual, and final progress and financial reports for their clusters and submit to TWG and Ministry of Health. Following reports will be produced by the project:

- Quarterly Progress and Financial Report
- Annual Progress and Financial Report
- Final Progress and Financial Report

Apart from systematic and timely reporting quarterly experience sharing meetings will be organised and coordinated by the cluster coordinators which will provide ample opportunities for data analysis and learning.

TWG will be the entity responsible for compiling and preparing the APR, which will be endorsed by the Ministry of Health.

Section 6: Costs and Funding for GAVI Alliance CSO Support

6.1 GAVI Alliance CSO Support Fund Available

Pakistan is included in the 10 pilot countries eligible for the CSO support. The following amount will be available to Pakistan up to 2009:

Country	Least Developed Country	Fragile state	Un-immunised infants (DTP 3)	Total Budget Available (US$)
Pakistan			1,529,00	4,587,000

6.2 Cost of implementing GAVI Alliance CSO support

Support for activities (for each CSO)	Cost per year in US$ (.000)			Total Costs
		2008	2009	
Project Inputs and Activity Cost (of all CSOs)		1,364,826	2,047,240	3,412,066
Management Costs (of all CSOs)		153,352	230,026	383,378
Management Costs (of HSCC / TWG)		-	-	-
Financial Auditing Costs (of all CSOs)		15,335	23,003	38,338
Consortium Management Cost - GOP		172,851	259,277	432,128
UNICEF PSC- 7% on gross		128,436	192,654	321,090
Total Costs		**1,834,800**	**2,752,200**	**4,587,000**

Section 7: Endorsement of the Application

Representatives of the Health Sector Coordinating Committee (HSCC), or equivalent, should endorse the application, and the Chair of the HSCC should sign the application on their behalf. All HSCC members (or equivalent) should sign the minutes of the meeting where the GAVI CSO application was endorsed. The minutes should be submitted with the application.

Please note that the signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.

The Health Sector Coordination Committee (HSCC) representing Government of Pakistan/ Ministry of Health and partners commits itself to providing support to the Civil Society Organisations in this application to implement the strategy. The HSCC further certifies that the CSOs are bona fide organisations with the expertise and management capacity to complete the work described successfully.

The HSCC requests that GAVI Alliance funding partners provide financial assistance to support CSOs that can contribute to the implementation of the GAVI HSS proposal and / or the cMYP as outlined in this application.

- **Chair of NHSCC:** Name, Post, Organisation, Date, Signature

Members of the HSCC (or equivalent) endorsed this application at a meeting on …….

Chair of NHSCC	Director General Health, Ministry of Health
Name	Maj.Gen (Retd) Shahida Malik
Post	Director General Health
Organization	Ministry of Health
Date	March 06, 2008-03-06
Signature	

The signed minutes to be attached.

This section should also include the name and contact details of the person for the GAVI Alliance Secretariat to contact in case of any queries. Please provide the following information:

- **Contact person:** Name, Post, Organisation, Tel No., Fax No., Address, Email

Contact person:

Name	Dr. Rehan. A. Hafiz
Post	National Programme Manager
Organization	Maternal Neonatal and Child Health
Tel/Fax:	0092-51- 2271823/ 9218019
Address	NPM Office, MNCH, National Institute of Health, Park Road, Chak Shahzad, Islamabad -- Pakistan
Email	drrehan@mail.comsats.net.pk
Phone	00 92- 51- 2271823
Fax	00 92- 51 -9218019

ANNEX Documents Submitted in Support of the GAVI CSO Support Application

Please submit the following documents with this application (in electronic copy if possible). Please number and list the documents in the table below:

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
Last CSO annual and audited report	Yes	2007	*
Registration document	Yes		
CSO constitution	Yes		
Strategic plan (if available)	Not Available		
Reports of recent similar projects completed (if any)	Not Available		
Reports of any external evaluations of the CSO (if any)	Yes		
Banking Form	Yes		

* Hard copies of all CSO Reports to be sent (as annex) with the Proposal by mail.

Response to Recommendations for Approval

For

GAVI Alliance CSO Support in 10 Pilot GAVI Eligible Countries

September 2008

Maternal & Neonatal Child Health (MNCH)
Ministry of Health, Government of Pakistan
National Institute of Health, Park Road, Chak Shahzad, Islamabad
Tel: 00 92 51 2271823 Fax: 0 92 51 9218019

Conditions Addressed

*** The contracting of CSO coordinator placed in EPI. Funding for this position is not mentioned (MOH?/ partner)**
The CSO Coordinator's position is budgeted under Form A – *GAVI Alliance Support to Strengthen Coordination and Representation of Civil Society Organisations,* funded by GAVI, and managed by UNICEF.

1. **Revise the overall monitoring framework by developing individual frameworks for each of the three clusters to help monitoring closer to the implementing levels.**

Monitoring Framework for Clusters:

Clusters	**Cluster 1** (Punjab, NWFP, Northern Areas)						**Cluster 2** (Balochistan, AJK)				**Cluster 3** (Sindh)						
	1	2	3	4	5	6	1	2	3	4	1	2	3	4	5	6	7
Monitoring Indicators	CHIP	PRSP	SABAWON	BDN	AKU	APWA	BDN	LIFE	PAVHNA	SCF-UK	HANDS	PAVHNA	HELP	AKHS	AKU	THF	PVDP
Outcome Indicators																	
1. Increase in immunization coverage (up to 23 months)	X	X	X	X	X		X	X	X	X	X	X	X	X	X		X
2. Decrease in children with moderate / severe malnutrition (less than 5 yrs)				X		X	X		X	X	X	X	X	X			
3. Decrease in low birth weight babies				X			X		X		X	X	X				
4. Increase in delivery by Skilled Birth Attendants	X			X		X	X		X	X	X	X	X	X			X
5. Increase in TT Coverage (pregnant mothers)	X	X		X			X	X	X		X	X	X	X			X
Additional Outcome Indicators																	
6. Increase in Hepatitis B vaccination of children (5-16 years)																X	
7. Increase in number of mothers vaccinated for Hepatitis B																X	
Output Indicators																	
Objective 1- Improving The Quality of MNCH Services																	
Ind. 1.1: 70% FLC facilities in target areas equipped to deliver immunization and safe service delivery	X		X	X	X		X	X	X	X	X	X	X	X	X		

Ind. 1.2: 70% increase in number of FLCF, LHVs, LHWs, and SBAs in project area who have equipment to provide basic health and immunization				X			X		X		X	X	X	X			X
Ind. 1.3: 20% increase in number of safe deliveries conducted at FLCF/other community health care providers and through outreach services in project area	X			X			X		X	X	X	X		X			X
Ind. 1.4: 50% increase in number of children vaccinated at FLCF/other community health care providers and through outreach services in project area		X	X	X	X		X	X	X		X	X	X	X	X		X
OBJECTIVE 2: Broadening the range of IMNCI and EmONC services																	
Ind. 2.1: 70% of FLCF in project area have trained staff		X		X			X	X	X	X	X	X	X	X			
Ind. 2.2: 50% increase in number of LHVs, LHWs and TBAs in project area who are trained in social mobilization	X		X	X			X	X	X		X	X	X	X			X
Ind 2.3: 50% increase in number of SBAs in project area who are trained in safe delivery practices	X			X			X		X		X	X					X
Ind. 2.4: 50% increase in number of teams in project area that are trained for immunization		X	X				X	X	X		X	X	X				X
OBJECTIVE 3: Improving Access to Quality Services																	
Ind. 3.1: 50% increase in number of mothers in project area with increased knowledge of preparation of ORS	X		X	X		X	X		X	X	X	X	X	X			
Ind. 3.2: 30% increase in number of mothers in project area who	X		X	X		X	X		X	X	X	X	X	X			X

have increased awareness about danger signs of illness in a child under 5 years																	
Ind. 3.3: 30% increase in number of delivered mothers in project area who have increased awareness about danger signs of pregnancy	X		X	X		X	X		X	X	X	X		X			X
Ind. 3.4: 30% increase in number of decision makers related to delivered mothers in project area who have increased awareness about danger signs of pregnancy	X		X	X		X	X		X	X	X	X		X			X
Ind. 3.5: 50% increase in number of referrals made for immunization to FLCF/other community health care providers in project area	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X
Ind. 3.6: 50% increase in number of referrals made at Comprehensive EmONC facilities in project area	X		X	X			X		X	X	X	X		X			X
Ind. 3.7: 80% increase in number of health facilities in project area with functional health committees	X		X	X			X		X	X	X	X	X	X			X
Additional Outcome Indicators																	
Ind. 3.8: 30% increase in parents awareness about Hepatitis B & C (disease, symptoms, diagnosis, and treatment advice for referral to health care providers/facilities)																X	
Ind. 3.9: 30% increase in teachers awareness about Hepatitis B & C (disease, symptoms, diagnosis, and treatment advice for referral to health care providers/facilities)																X	
Ind. 3.10: % increase in number of																X	

teams trained for vaccination against Hepatitis B																	
Ind. 3.11: % increase in facilitation of treatment for Hepatitis B & C – referrals and provision of treatment to community members in targeted school communities																x	
Ind. 3.12: 50% increase in vaccination against Hepatitis B to infants born to Hepatitis B positive mothers																x	

2. Provide all indicators with clear baselines and targets and where baselines are missing indicate when they will be established

Indicator	Estimate of baseline[1]	Data Source (if any)	Date of Baseline	Target	Date for Target
Outcome Level:					
1. Percentage of fully immunized (up to 23 months)	47 %	EPI MIS & Pakistan Demographic and Health Survey (PDHS) 2006-07	2007	80% increase in target area	End of 18 months
2. Percentage of TT Coverage of pregnant mothers	60%	Pakistan Demographic and Health Survey (PDHS) 2006-07	2007	85% increase in target area	End of 18 months
3. Percentage of delivery by Skilled birth attendant	39%	Pakistan Demographic and Health Survey (PDHS) 2006-07	2007	40% increase in target area	End of 18 months
4. Percentage of low birth weight babies	25%	Pakistan Demographic and Health Survey (PDHS) 2006-07	2007	20% decrease in target area	End of 18 months
5. Percentage of children with moderate and severe malnutrition (less than 5 yrs)	56%	Agha Khan HMIS data	2007	50 % decrease in target area	End of 18 months

[1] Baseline at outcome level indicators has been taken from PDHS-2006-2007 and other sources, while the baseline at output level will be collected by all CSOs during inception phase from project area.

Output Level:					
OBJECTIVE 1: Improving The Quality MNCH Services					
Indicator	**Estimate of baseline**	**Data Source (if any)**	**Date of Baseline**	**Target**	**Date for Target**
1.1 Number of First level care facility equipped to deliver immunization and safe service delivery	Number of FLCF/other community health care providers without essential equipment and drugs for MNCH an Immunization	Programme record of CSOs	Inception [2] Phase	70% increase	End of 18 months
1.2 Number of FLCF, LHVs, LHWs, and SBAs provided equipment and supplies (In project communities)	Number of FLCF, LHVs, LHWs, and SBAs with required equipment and supplies to deliver basic health and immunization	Programme record of CSOs	Inception Phase	70% increase	End of 18 months
1.3 Number of safe deliveries conducted at FLCF/other community health care providers and through outreach services (In project communities)	Number of safe deliveries conducted at FLCF/other community health care providers and through outreach services	Quarterly DHIS report of the district	Inception Phase	20% increase	End of 18 months
1.4 Percentage of children vaccinated at FLCF/other community health care providers and through outreach services (In project communities)	Number of children vaccinated	Quarterly EPI report of the district	Inception Phase	50% increase	End of 18 months
OBJECTIVE 2: Broadening the range of IMNCI and EmONC services					
2.1 Number of FLCF receiving staff training (In project communities)	Number of FLCF with untrained staff	Programme record of CSOs	Inception Phase	70%	End of 18 months
2.2 Number of LHVs, LHWs and TBAs receiving training in social mobilization (In project communities)	Number of LHVs and LHWs without required level of knowledge and skills	Programme record of CSOs	Inception Phase	50%	End of 18 months
2.3 Number of SBAs receiving training on safe delivery practices (In project communities)	Number of SBAs who do not meet the minimum level of knowledge and skills	Programme record of CSOs	Inception Phase	50%	End of 18 months

[2] All CSOs will conduct baseline study during the inception phase in their project districts.

2.4 Number of teams trained for immunization (In project communities)	Number of trained immunization teams	Programme record of CSOs	Inception Phase	50% increase	End of 18 months
OBJECTIVE 3: Improving access to quality services					
3.1 Percentage of mothers with increased knowledge of preparation of ORS (In project communities)	Percentage of mothers who know the preparation and administration of ORS during diarrhoea	KAP survey by CSOs	Inception Phase	50%	End of 18 months
3.2 Percentage of mothers with increased awareness about danger signs of illness in a child – under 5 years (In project communities)	Percentage of mothers of children under 5 who know the danger signs of illness	KAP survey by CSOs	Inception Phase	30%	End of 18 months
3.3 Percentage of delivered mothers with increased awareness about danger signs of pregnancy (In project communities)	Percentage of delivered mothers with awareness about danger signs of pregnancy (In project communities)	KAP survey by CSOs	Inception Phase	30%	End of 18 months
3.4 Percentage of decision makers of delivered mothers with increased awareness about danger signs of pregnancy (In project communities)	Percentage of decision makers of delivered mothers with awareness about danger signs of pregnancy (In project communities)	KAP survey by CSOs	Inception Phase	30%	End of 18 months
3.5 Number of referrals made for immunization to FLCF/other community health care providers (In project communities)	Number of referrals made for immunization at FLCF/other community health care providers	Programme record of CSOs	Inception Phase	50% increase	End of 18 months
3.6 Number of referrals made at Comprehensive EmONC facilities (In project communities)	Number of referrals made at EmONC facilities	Programme record of CSOs	Inception Phase	50% increase	End of 18 months
3.7 Number of health facilities with functional health committees (In project communities)	Number of communities with functional health committees	Programme record of CSOs	Inception Phase	80%	End of 18 months

3. Clarify how outcome indicators will be measured, in particular coverage across targeted communities. If this is not feasible, alternative indicators should be developed.

Overall Monitoring Plan						
Performance Indicator	**Unit of Measure**	**Information required**	**Data Source**	**Method of Collection**	**Schedule of Collection**	**Reporting responsibility**
Outcome Indicators						
1. 80% increase in fully immunized (up to 23 months)	Percentage	% of children immunized in project area	EPI MIS (for project districts)	Document review, site visits	Baseline 6 monthly Final Evaluation	CSOs Project Managers Cluster Heads
2. 85% increase in TT Coverage of pregnant mothers	Percentage	% of TT coverage of pregnant mothers in project area	EPI MIS (for project districts)	Document review, meeting with stakeholders	Baseline 6 monthly Final Evaluation	CSOs Project Managers Cluster Heads
3. 40% increase of delivery by Skilled Birth Attendant	Percentage	% of deliveries by skilled birth attendants	HMIS data (for project districts)	Document review, experience sharing meetings	Baseline 6 monthly Final Evaluation	CSOs Project Managers Cluster Heads
4. 20% decrease in low birth weight babies	Percentage	% of babies born with low birth weight	HMIS data (for project districts)	Document review, meeting with stakeholders	Baseline 6 monthly Final Evaluation	CSOs Project Managers Cluster Heads
5. 50% decrease in children with moderate and severe malnutrition (less than 5 yrs)	Percentage	% of children with moderate and severe malnutrition	HMIS data (for project districts)	Document review, site visits	Baseline 6 monthly Final Evaluation	CSOs Project Managers Cluster Heads
OBJECTIVE 1: Improving The Quality MNCH Services						
Ind. 1.1: 70% FLC facilities in target areas equipped to deliver immunization and safe service delivery	Number	Number of FLCF/other community health care providers receiving essential equipment and drugs for MNCH and Immunization	EPI, DMIS, FLCFs, community health care providers, project documents	Document review, interviews Document review, Data analysis of CSO reports	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads

Overall Monitoring Plan						
Performance Indicator	**Unit of Measure**	**Information required**	**Data Source**	**Method of Collection**	**Schedule of Collection**	**Reporting responsibility**
Ind. 1.2: 70% increase in number of FLCF, LHVs, LHWs, and SBAs in project area who have equipment to provide basic health and immunization	Number	Number of FLCF, LHVs, LHWs, and SBAs provided with equipment and supplies to deliver basic health and immunization	EPI, DMIS, FLCF, LHVs, LHWs, and SBAs, project documents	Document review, interviews Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 1.3: 20% increase in number of safe deliveries conducted at FLCF/other community health care providers and through outreach services in project area	Number	Number of safe deliveries conducted at FLCF/other community health care providers and through outreach services	DMIS, FLCF and other community health care providers	Document review, sample survey Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 1.4: 50% increase in number of children vaccinated at FLCF/other community health care providers and through outreach services in project area	Number	Number of children vaccinated	EPI, FLCF and other community health care providers	Records review, sample survey, focus group interviews Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
OBJECTIVE 2: Broadening the range of IMNCI and EmONC services						
Ind. 2.1: 70% of FLCF in project area have trained staff	Number	Number of FLCF participating and number of staff trained	FLCFs, FLCF staff, project documents	Document review, focus group interviews Data analysis of CSO reports, focus group interviews	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 2.2: 50% increase in number of LHVs, LHWs and TBAs in project area who are trained in social mobilization	Number	Number of LHVs and LHWs trained in social mobilisation	DHIS, LHVs, LHWs, TBAs, key community informants, project documents	Document review, sample survey, focus group interviews Data analysis of CSO reports, focus group interviews	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads

Overall Monitoring Plan						
Performance Indicator	**Unit of Measure**	**Information required**	**Data Source**	**Method of Collection**	**Schedule of Collection**	**Reporting responsibility**
Ind 2.3: 50% increase in number of SBAs in project area who are trained in safe delivery practices	Number	Number of SBAs trained in safe delivery	SBAs, key community informants, project documents	Document review, focus group interviews Data analysis of CSO reports, focus group interviews	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 2.4: 50% increase in number of teams in project area that are trained for immunization	Number	Number of immunization teams trained	DHIS, FLCFs, key informants, project documents	Document review, interviews Data analysis of CSO reports, document review	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
OBJECTIVE 3: Improving Access to Quality Services						
Ind. 3.1: 50% of mothers in project area with increased awareness and sensitization towards preparation of ORS	Number	Number of mothers trained in the preparation and administration of ORS during diarrhoea	Trainees, key informants, project documents	KAP survey, interviews Data analysis of CSO reports, focus group interview	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 3.2: 30% mothers in project area who have increased awareness about danger signs of illness in a child under 5 years	Number	Number of mothers of children under 5 who participate in awareness sessions about the danger signs of illness	Trainees, key informants, project documents	KAP survey, interviews Data analysis of CSO reports, focus group interview	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 3.3: 30% delivered mothers in project area who have increased awareness about danger signs of pregnancy	Number	Number of delivered mothers who participate in awareness sessions about danger signs of pregnancy	Trainees, key informants, project documents	KAP survey, interviews Data analysis of CSO reports, focus group interview	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 3.4: 30% decision makers related to delivered mothers in project area who have increased awareness about danger signs of pregnancy	Number	Number of decision makers related to delivered mothers who attend awareness sessions to recognise danger signs of pregnancy	Trainees, key informants, project documents	KAP survey, interviews Data analysis of CSO reports, focus group interview	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads

Overall Monitoring Plan						
Performance Indicator	**Unit of Measure**	**Information required**	**Data Source**	**Method of Collection**	**Schedule of Collection**	**Reporting responsibility**
Ind. 3.5: 50% increase in number of referrals made for immunization to FLCF/other community health care providers in project area	Number	Number of referrals made for immunization at FLCF or to other community health care providers	FLCFs, community health care providers, key community informants	Document review, interviews, sample survey Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 3.6: 50% increase in number of referrals made at Comprehensive EmONC facilities in project area	Number	Number of referrals made at EmONC facilities	EmONCs, community health care providers, key community informants	Document review, interviews, sample survey Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads
Ind. 3.7: 80% increase in number of health facilities in project area with functional health committees	Number	Number of communities health committees formed and/or made functional	Health committees, key community informants, FLCFs, project documents	Sample survey, focus group interviews Data analysis of CSO reports, sample survey	Baseline Monthly Quarterly Final Evaluation	CSOs Project Managers Cluster Heads

4. Revise implementation schedule and timelines to align with period available for implementation.

Major Activities	2008	2009				2010		
	Q0	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**
Project Inception								
Baseline and KAP survey in project target areas	**X**							
Project launch with stakeholders	**X**							
Inputs/Activities								
Provision of essential equipment and drugs/supplies to FLCFs			**X**	**X**	**X**	**X**		
Provision of essential equipment and drugs/supplies to LHVs, LHWs, and SBAs			**X**	**X**	**X**	**X**		

Training/Skills expansion and diversification of FLCF staff		X	X	X	X	X		
Training/Skills expansion and diversification of SBAs, LHVs, LHWs, volunteers, and immunization teams		X	X	X	X	X		
Awareness raising and sensitization campaigns at union council and community levels		X	X	X	X			
Community mobilization through the reorganization of existing CBOs or formation of dedicated community health committees			X	X	X	X		
Training and capacity building of community health committees for participation in healthcare management and monitoring			X	X	X	X		
Strengthening referral systems, through increased and formalized interfacing, and development/improvement of referral procedures and communication links			X	X	X	X	X	
Coordination and Information sharing								
Cluster meetings with TWG and district and provincial government			X		X		X	
Network meeting with federal government and stakeholders				X			X	
Monitoring								
CSO, Cluster level, and TWG monitoring and field visits		X	X	X	X	X	X	
District, Provincial government monitoring			X		X		X	
Final Evaluation								X
Reporting								
Quarterly Reports		X	X	X		X		
Annual Report					X			
End of Project Report							X	
Auditing								
Regular auditing of project			X	X	X	X		
Final project audit							X	

5. **The high administration cost with five budget lines – but only one for project activities - needs to be explained and justified.**

The program budget has been reviewed as follows:

Support for activities (for each CSO)	Cost per year in US$ (.000)			Total Costs
		1st Year	2nd Year	
DIRECT ACTIVITY COST				
CSO Project Activity Cost (of all CSOs)		2,530,296	1,265,148	3,795,444
Monitoring & Evaluation		100,000	80,000	180,000
CSO Coordination & Audit		193,644	96,822	290,466
MANAGEMENT COST				
UNICEF PSC (7% on gross)		214,060	107,030	321,090
Total Costs		**3,038,000**	**1,549,000**	**4,587,000**

NOTE: TWG and NHSCC management of program activities is their contribution to the CSO Support Program. The total management cost is 7% while total activity cost is 93% of budget.

6. **Missing details of eligibility of some participating CSOs (PRSP and PVDP) should be provided.**

Attached as Annex A are the titles of the previously missing CSO documents listed below:

a. Participatory Village Development Programme (PVDP):

- Registration Certificate,
- Last Audit Report --2007
- Five Year Strategy Plan 2006-2010
- Memorandum &Articles of Association of PVDP
- Similar Project Report --2007

b. Punjab Rural Support Programme (PRSP):

- Registration Certificate
- Last Audit Report-2007
- Similar Project Report-2008

Full documents have been sent as hard copies through courier to GAVI Alliance Secretariat, Geneva office.

7. **(to HSCC) Suggest reviewing administrative process to identify bottlenecks and procedures (e.g. fund release)**

To improve administrative processes and to remove possible bottlenecks the following section from the proposal is reviewed as below:

5.3 Financial Management Arrangements for the GAVI Alliance CSO support:

Mechanism for channelling GAVI Alliance CSO funds into the country

GAVI Alliance financial funds will be channelled through UNICEF Headquarter through a project budget allocation (PBA) to UNICEF country office.

Mechanism (and responsibility) for budget use and approval
The CSOs will prepare individual activity plans and cash advance requests and submit to TWG for review. On approval from TWG fund release requests of CSOs will be submitted to UNICEF. UNICEF will release funds in three instalments: 1st (40%) instalment on approval of proposal; 2nd instalment (30%) and 3rd instalment (30%) on verification through monitoring system as described in proposal document. CSOs will be responsible for appropriate utilization of budgets.

Expected duration of the budget approval and transfer process
Expected one month following approval of detailed activity plan by the TWGs.

Mechanism for disbursement of GAVI Alliance CSO funds

Fund disbursement mechanism will be initiated after approval of this proposal and subsequent letter of agreement between executing body of GoP and partner CSOs. Under the fund disbursement mechanism all funds will be transferred from UNICEF account to CSOs' bank accounts. All accounts will be operated with double signatures at all levels.

Auditing procedures (and details of auditors, if known)
Audits of each GAVI Alliance CSO project will be done by the CSO itself as a part of their regular auditing system (internal and/or external) and appropriate documents will be provided to GAVI on request. A final audit will be conducted at the end of program.

Justification of management fees (if applicable)
UNICEF will charge 7% Program Support Cost (PSC).