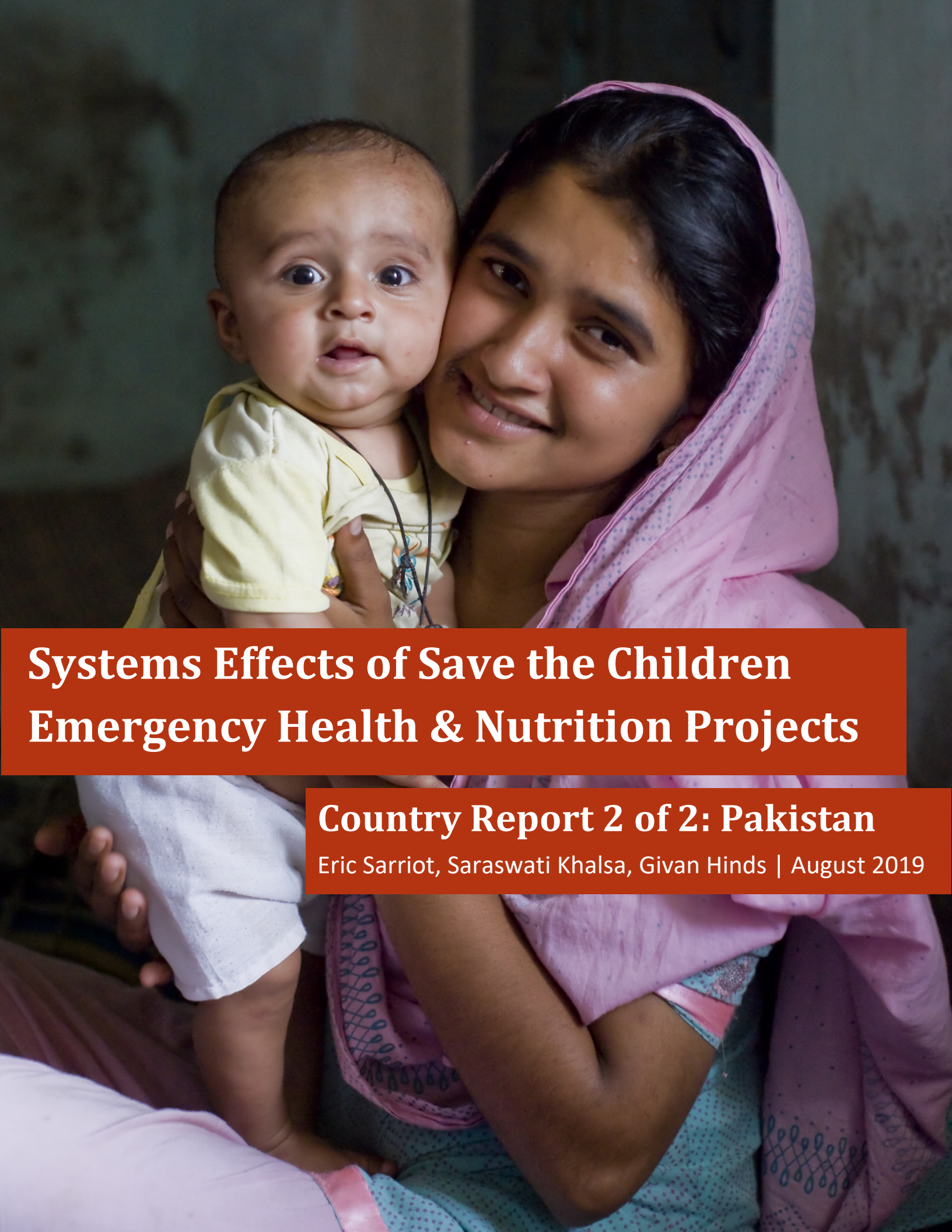

Systems Effects of Save the Children Emergency Health & Nutrition Projects

Country Report 2 of 2: Pakistan

Eric Sarriot, Saraswati Khalsa, Givan Hinds | August 2019

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The CORE Group Humanitarian-Development Task Force is a consortium-led effort to increase community health and nutrition program learning and augment the evidence for community based approaches in the humanitarian and development contexts; increase global participation, coordination, and organizational collaboration to improve knowledge and build strategic capacity of stakeholders at the global and country level; and share relevant learning with USAID Missions, host governments, implementing partners and other key stakeholders.

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Cover photo by: Ayesha Vellani/Save the Children

Abbreviations

CARE – Cooperative for Assistance and Relief Everywhere
CHV – Community Health Volunteer
CIP – Costed Implementation Plan
CM – Community Mobilization
CPR – Contraceptive Prevalence Rate
CSM – Creative Social Marketing
D&C – Dilation and Curettage
DHD – District Health Department
DHN – Department of Health and Nutrition
DHR – Division of Humanitarian Response
DoH – Department of Health
EHN – Emergency Health and Nutrition
FATA – Federally Administered Tribal Areas
FBR – Federal Board of Revenue
FGD – Focus Group Discussion
FHC – Family Health Center
FP – Family Planning
HH – Household
HSS – Health Systems Strengthening
HTSP – Healthy Timing and Spacing in Pregnancy
IDA – International Dispensary Association
IDI – In-depth Interview
IDPs – Internally Displaced Persons
IEC – Information, Education and Communication
IMNCH – Integrated Maternal, Newborn and Child Health (Project)
IMRES – International Medical Relief Emergency Service
INGO – International Non-Government Organizations
IRC – International Rescue Committee
IUCD – Intrauterine Contraceptive Device
IUD – Intrauterine Device
KPK – Khyber Pakhtunkhwa (Province in Pakistan)
LAPM – Long-Acting and Permanent Method (of Contraception)
LARC – Long Acting Reversible Contraceptives
LHS – Lady Health Supervisor
LHV – Lady Health Visitor
LHW – Lady Health Worker
LTPM – Long-term or Permanent Method (of Family Planning)
MEAL – Monitoring, Evaluation, Accountability & Learning
MERLIN – Medical Emergency Relief International
MNH – Maternal and Neonatal Health
MOH – Ministry of Health
MOI – Ministry of Interior
MOPW – Ministry of Population Welfare
MOU – Memorandum of Understanding
MSS – Marie Stopes Society
MVA – Manual Vacuum Aspiration
M&E – Monitoring and Evaluation
NGO – Non-government Organization
NSAG – Non-state Armed Group
ORW – Outreach Worker

PAC – Post-abortion Care
PIMS – Pakistan Institute of Medical Science
PPHI – People's Primary Healthcare Initiative
PPUID – Post-Partum Intrauterine Device
PWD – Population Welfare Department
QA – Quality Assurance
RAISE – Reproductive Health Access Information and Services in Emergencies (Initiative)
RHC – Rural Health Center
RH – Reproductive Health
SPA – Service Provision Assessment
SBC – Social Behavior Communication
SC – Save the Children
TNA – Training Need Assessment
TOT – Training of Trainers
WMO – Women Medical Officer

Contents

Abstract

We implemented an embedded case study of health systems effects of Save the Children projects in two countries, Sudan and Pakistan, to identify opportunities for emergency health programs to strengthen systems during their implementation. We examined systematically the interaction between project efforts and observed changes in critical health systems functions over time. This report covers Pakistan, where Save the Children implemented emergency programs to respond to the needs of some of the world's largest populations of refugees and internally displaced people following a series of large-scale natural disasters, and crises. From 2011 to 2018, an anonymous donor funded three phases of projects focused on integration of family planning (FP) and post abortion care (PAC) into the package of essential health services in Save the Children's emergency health programs.

Save the Children chose to initially work through its own systems (clinician recruitment, procurement) in order to ensure rapid expansion of quality services, and responsiveness to demand generation through the Pakistani LHW corps. Clinical staff had however transitioned back to government payroll to a large extent by Phase III. The most significant observed systems contributions were towards strengthening human and service capacity for high quality FP and PAC services. Supported facilities also benefitted from strengthened data collection processes, the practice of data use for decision-making and quality improvement in facilities. Save the Children coordinated with the government at all stages, but project alignment and contribution to systems strengthening, notably DOH and districts, benefited from the government itself re-emphasizing its own leadership. This required adaptation by the successive projects, increased contribution to systems strengthening, but also resulted in some tensions, with undetermined outcomes (positive or negative) by the end of the study.

While Save the Children expanded some efforts in evaluation, these took second stage to the primary program agenda of FP/PAC service introduction and expansion. Limitations and threats to health systems capacity and future performance come from the initial path taken by the project, gaps in information, and factors also commonly observed in non-emergency programming.

Introduction

This report is one of two case studies examining health systems effects of past Save the Children emergency health and nutrition (EHN) programs in Pakistan and Sudan. This document presents the findings from three cases studies in Pakistan—one from each phase of the program funded by an anonymous donor. The two country reports (Sudan and Pakistan) will be consolidated in a final crosscutting analytical publication as a next step.

Purpose

Since its origins, Save the Children has intervened in humanitarian crises, conflict areas, and provided response to disasters. This mission continues as more than 140 million people are in need of humanitarian assistance (UN OCHA), with 51% of refugees worldwide being children (UNICEF), and 93% of the highest neonatal mortality countries face chronic conflict or political instability. Save the Children International, Save the Children US and Global Emergency Health and Nutrition teams work in over 40 countries providing primary health care to mothers, newborns, and children, nutrition, and reproductive health services.

The global community has evolved to consider a 'nexus' between humanitarian and development work. This consideration has been central to the creation of the CORE Group Humanitarian-Development Task Force, which became a partner in this study with support from the U.S. Agency for International Development, Office of U.S. Foreign Disaster Assistance (OFDA).

While important differences can be identified between development and emergency assistance, we believe that "*there are important, systemic changes that can be made in international assistance efforts to meet and lessen the need for aid while also complementing local development efforts*"[1]. Concerns for 'transition' from emergency to development are also raising more questions on how to strengthen systems for the future while responding to immediate emergencies, which may have overtaken the capacity of these systems.

The undertaking of Save the Children's Emergency Health and Nutrition (EHN) projects and how they function are heavily determined by:

- Externally driven events and crises (political, economic, natural events and disasters);
- Multiplicity of actors from donors to implementers;
- National systems either weak, or lacking coherence, or both;
- Often large funding, coming in discrete short frames;

EHN projects also aim to take a development orientation at the design stage, and follow through on this design during life of project to improve sustainability. But while projects have their own M&E plans and account for delivery of outputs, and possibly outcomes, systems effects are far less documented.

Both implementation and evaluation of Health Systems Strengthening (HSS) are challenged by an afflux of resources and skilled labor into weak health ecosystems, and the pressing demands for rapid action and results called for by the emergency itself. EHN programs consequently only have "discrete" strategic options, skewed toward results. What systems effects they can and do have requires further examination.

[1] InterAction. (2016). Retrieved from: https://www.interaction.org/FABB2016/humanitarian-and-development-nexus

Save the Children launched a two-country case study (Sudan and Pakistan) to learn about both opportunities taken and opportunities lost for strengthening systems for health through EHN funding received over a substantial period of time. Evaluation and accountability to the original donor(s) are not the objective, as evaluation of the performance of projects should have been answered. The purpose of this study was to:

- Provide recommendations to Save the Children on the strategic space and opportunities for improving HSS in its emergency programs;
- Provide lessons learned and inform global development thinking on improving the strengthening of systems for health—capacity, sustainability, resilience—while responding to emergencies.

Method

We used a systematic, embedded, multiple case study design to examine the systems effects of EHN programs in two countries over the last decade. An embedded design allowed us to assess the impact of multiple EHN projects by collecting various forms of data for each case (i.e., project or phase), including annual reports, proposals, and key informant interviews. The multiple case study approach (rather than a single case study) allowed us to compare different projects within each country as well as across different country contexts. The purpose of this design was to generalize the lessons learned from the case studies through analytic generalization. The two countries were selected purposefully and opportunistically, based on expectations that documentation could be retrieved, that informants would be available, and that the experience of the projects was expected to provide lessons.
To develop our theoretical framework, we conducted an extensive literature review on the intersection between EHN programs and health systems strengthening, and summarized 36 peer-reviewed articles. Based on the evidence and questions from these previous studies, we developed a conceptual model, which evolved marginally over the study period (Figure 1). In the absence of universally recognized measures for the strengthening of health systems, we also developed a set of explanatory propositions about what a strengthened health system would demonstrate in different dimensions of its operations. These dimensions bear some resemblance to the traditional HSS 'building blocks' but include additional elements[2]. More importantly, our explanatory propositions sought to present dynamic 'dimensions' and relationships of systems strengthening.

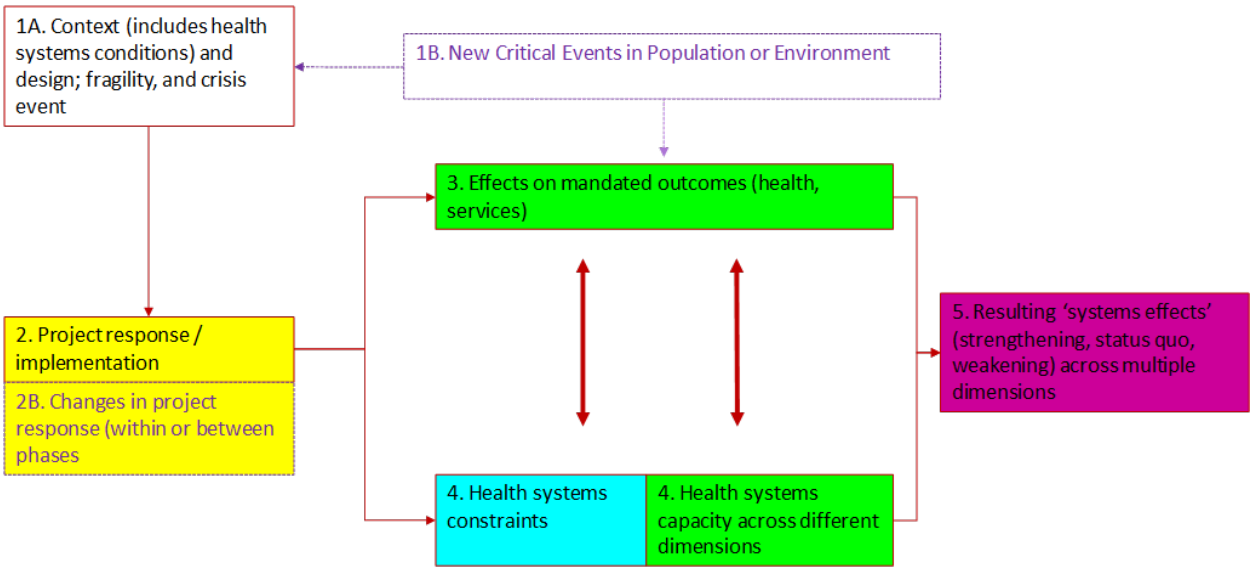
Our case study outline focused on the following three elements for each country: country profile, population health and health services achievements, and systems effects. The country profile included the country context (i.e., the history of the protracted conflict and the national response) and a description of each project's reach and implementation (i.e., including a timeline of events and the budget, duration, reach, and demographics of the target populations). The population health and health services achievements focused on the effects of each project on project-specific outcomes. The systems effects section seeks to provide a description of the interaction between project efforts, observed changes in health systems capacity over time, and the resulting changes in the overall health system 'strength' (i.e., explanatory propositions).

We consulted closely with a team of technical 'backstops' from Save the Children US and Save the Children International, previously involved in part or in whole of the projects included in the study. We requested documentation of projects from the technical team and country offices. This included: annual reports, final reports, proposal summaries and other relevant materials from each project (see Annex 1:

[2] See: Sacks Emma et al. *Beyond the building blocks: integrating community health into health systems frameworks to achieve health for all*. BMJ Global Health. In Press. 2019

List of Documents Reviewed). We created a codebook to conduct our documentation review, which consisted of eight themes, 20 sub-themes, and 19 explanatory propositions (Annex 2). For Pakistan, we reviewed over 50 documents from projects across three different regions: Haripur, Shikarpur and Jacobabad. Documents were uploaded into the qualitative software package NVivo 11.0 and analyzed according to the codebook in Annex 2. A case report was written for each period of implementation using the case study outline described above. We obtained written comments to fill information gaps from the documentation review, and then conducted a series of key informant interviews (see Annex 3: interview guide). We conducted three key informant interviews with individuals who were closely involved with the project during its implementation (technical backstop, senior in country health lead, and FP/PAC project coordinator). Interviews lasted 60-75 minutes and the information gleaned from each interview was incorporated into the final country report. The final review of the report suggested that our coding and extraction process may have missed information. We carried out a full second review of documents and interview notes section by section and revised the report, which was then discussed one last time with members of the technical team.

Figure 1: A Theory of Change for systems effects of EHN interventions



Background for the Pakistan Case Study

Country Profile

Pakistan's national history comes with a history of refugee migration and temporary displacement as a result of both natural disasters and conflict. This includes protracted crises' of Afghan refugees and a series of natural disasters. The scale of displaced peoples in the country, frequently evolving migration patterns, and limitations on IDP registration makes it difficult to quantify the cumulative number of displaced people at any given time, but a review of select data is useful to illustrate the scale of the issue. It is estimated that between 2008 and 2014, a cumulative total of 14.57 million people fled natural disasters in Pakistan; at the time this made it the fourth highest total in the world, though it reflects only those immediately displaced. Additionally, in 2014, approximately 1.5 million registered and an estimated 1.3 million unregistered Afghan refugees meant that Pakistan was carrying the world's largest and most protracted refugee caseload. Finally, the number of temporarily displaced persons was estimated at 1.8 million as of June 2015. [3]

Figure 2: Map of Pakistan with Provinces and Capital Cities

Timeline of Save the Children Projects

In 2011, Save the Children started receiving funds from an anonymous donor to integrate family planning (FP) and post-abortion care (PAC) into the package of essential health services its emergency health and nutrition (EHN) programs provided in countries facing emergency. Pakistan was one of these countries. At that point, Save the Children became the only organization providing emergency obstetric services with PAC in Pakistan.[4] While Save the Children had implemented reproductive health programs for emergency contexts, FP/PAC had not been provided in all emergency situations at the time.[5]
This led to three project phases, with the aim of providing FP and PAC services to Pakistan's vulnerable populations. The program—which was framed as aiming to 'scale up' FP and PAC services in the Pakistani health system--involved eight to 13 health facilities in 3 districts across 2 provinces (see Table 1), serving two populations, namely Afghan refugees in one regional area and IDPs affected by flooding in another area. In 2011, two of these health facilities were Save the Children health facilities—all others were government health facilities. Save the Children's staff number reached up to 30, not counting clinical staff discussed in the Human Resources section.

[3] Internal Displacement Monitoring Centre. (2015). Pakistan: Solutions to displacement elusive for both new and protracted IDP's. http://www.internal-displacement.org/
[4] Taussig, N. (2011).
[5] Taussig, N. (2011).

Table 1: Project phases and number of health facilities per district (province)

District (Province)	Phase I (2011-2012)	Phase II (2013-2016)	Phase III (2016-2018)
Haripur (KPK)	8	6	0
Shikarpur (Sindh)	5	5	6
Jacobabad (Sindh)	0	2	2

The project goals included: (1) systematically integrating FP and PAC in Save the Children agency systems at global and country levels and strengthening core capacity in FP and PAC service provision; (2) developing, implementing, and monitoring FP and PAC programs serving IDPs in Pakistan; and (3) initiating and implementing FP and PAC program in new emergencies which may occur in countries with a high IDP and refugee populations.[6]

These EHN projects were a capacity-building initiative to strengthen ability to respond to health and nutrition needs of women and children affected by emergencies, starting however with developing the capacity of Save the Children as an agency. This dual purpose (Save the Children systems and national systems) is reflected in our findings below. Each phase had objectives with specific target deliverables for service delivery, number of clients, quality of services, availability of trained providers (health facilities and community health workers), and use of information for management.

The emergency FP/PAC projects also took place against the backdrop of a changing national health system, in which a 2010 constitutional amendment – the 18th amendment – devolved critical health functions to provincial level health authorities, including policy-making, service delivery, and functions of service delivery such as the health information system and HR management. At the national level, the Ministry of National Health Services, Regulation, and Coordination (MNHSRC) maintains responsibility of regulation and coordination of health services and health development partners in the country. Because of the evolving governance landscape and the developing capacity of provincial governments to take on new functions, coordination with government entities also evolved over the course of implementation. This consisted of coordination at the implementation level with the provincial departments of health (provincial DOH's), the provincial-level Population Welfare Department (PWD), and relevant district departments of health (district DOH's), as well as coordination (to a lesser extent) with the national level MNHSRC, National Disaster Management Authority (NDMA) and National Health Emergency Preparedness and Response Network (NHEPRN).

Funding for Pakistan from the donor was respectively $2.9 million (Phase I),[7] $4.6 million (Phase II), and $3.4 million (Phase III).

[6] Taussig, N. (2011).
[7] Save the Children. (2011). Summary Budget Pakistan.

Population Health and Health Services Achievements

A strengthened health system would show:	Summary findings:
• **Health system includes host population (not just displaced) in improved services** • **Services delivered by the health system are responsive to community needs and adapted to context** • **Health system innovations for coverage of health services and preparedness for EHN needs**	The emergency health programs expanded services and supplies for FP/PAC to refugees. It supported facilities, which expanded services and uptake of FP/PAC to both displaced and host populations. Additional needs of the community identified by trends in facility reports were also regularly and formally communicated to the DOH and donors.

As already noted, service providers were initially employed by Save the Children. We focus here on the expansion of service availability and utilization, to address unmet needs.

Project performance indicators were service- not population-based. The three project phases were considered generally successful, based on service numbers, available method mix for FP, PAC services and FP adoption, training human resources, and for Phases II and III additional systems improvements (health information systems, and logistics management). Phase I showed increased availability of methods, presence of trained providers and number of women seeking FP methods in clinics, modern contraceptive use among Afghan refugees, and an increase in IUDs and implants (the most common FP method after PAC is the oral contraceptive pill). [8] The expansion of services continued in Phase II, while Phase III saw a plateau and even a slight reduction in FP acceptors and PAC clients as the program no longer operated in KPK and in Sindh a number of additional organizations also began offering FP services (Table 2). By Phase III, the Integrated Health Service (IHS) – a public/private entity contracted by the Sindh DOH to operate 111 primary care facilities in 20 districts – had taken over many of the health centers in Save the Children intervention districts using standards established through the FP/PAC emergency programs.[9] Save the Children had also expanded support to IHS in terms of capacity building in clinical services, supportive supervision and data management and other standards in other clinics that they are operating.

One key informant observed that the projects contributed key learning within the framework of FP 2020's efforts on FP/PAC in Pakistan, which helped "deepen the discussion and move the conversations forward." Initially, Save the Children was the only international partner working with the government for these services in program areas, but this landscape evolved by Phase III to include many FP service providers, first the Department of Health (DOH) supported by the Population Welfare Department (PWD), and also international implementing partners. When Save the Children observed a slight reduction in clients during Phase III (Table 2), it implemented a stakeholder mapping, which found that the crowded landscape of FP providers was creating a competitive environment for FP acceptors, with some clinics providing incentives of up to Rs1,000 (about $6.5) to attract clients, in support of Pakistan's targets and commitments for FP 2020, which received important resources in the Sindh province, where Save the Children's project was operating.

[8] Taussig, N. (2012).
[9] This information was absent from the document reviewed, but provided during the informant interviews, as a recent evolution.

Table 2: Service delivery indicators from Save the Children's FP/PAC emergency programs in Sindh and KPK provinces (number of clients accepting services)

Province	Sindh	KPK	Sindh	KPK	Sindh	KPK	Sindh	KPK	Sindh	KPK	Sindh	KPK	Sindh	KPK
Period / Indicators	**Gen FP: New acceptors (all)**		**Gen FP: LARC acceptors**		**Gen FP: Permanent method acceptors**		**IPPFP: New Acceptors (IUD, IMP, TL)**		**PAC: PAC clients (all)**		**PAC: FP acceptors**		**PAC: FP LARC acceptors**	
July 2011 to December 2012 (Phase I)	18,240	4,684	6,008	1,869	226	57	18	78	2,811	1,182	1,107	486	479	116
January 2013 to March 2016 (Phase II)	30,568	9,814	10,007	3,952	214	32	395	919	3,022	1,385	2,459	1,082	600	355
April 2016 to December 2018 (Phase III)	29,636	N/A	9,920	N/A	239	N/A	1,269	N/A	2,906	N/A	2,398	N/A	483	N/A
Total	**78,444**	**14,498**	**25,935**	**5,821**	**679**	**89**	**1,682**	**997**	**8,739**	**2,567**	**5,964**	**1,568**	**1,562**	**471**

System Effects

Service and health achievements, discussed above, are in part 'systems effects' of the projects themselves, according to our theory of change. In this section however, we focus on systems effects of the interventions beyond service expansion, in major domains or nodes in a network of interdependent sub-systems.

Coordination & Policy Setting

A strengthened health system would show:	Summary findings:
• **Evolution toward humanitarian and health policies in support of essential interventions at the national or regional level** • **Signs of ownership and commitment to the policy manifested through different levels of the health system**	Save the Children obtained approval for the project with central and provincial levels, but effectively coordinated primarily at district level in order to implement—with initially Save the Children-recruited clinicians—at frontline and community levels. For one informant, national policy alignment effectively took place through harmonization with FP2020 forums and guidelines, along with other international implementing partners of the MOH. Central level advocacy was a secondary priority compared to implementation, and was predominantly carried under the FP2020 movement. The main contribution of the projects to central policy and governance capacity was consequently indirect. Projects started in some ways as parallel structures, but may have served the role of innovator, demonstrating not only the value of, but also the possibility of expanding FP/PAC services within MOH structures, and indirectly attracting more implementing partners of reproductive health services to Pakistan.

Save the Children's coordination with health governance structures, at least at central levels, was initially limited to obtaining essential authorizations, as the priority was integration of FP/PAC into Save the Children's global strategies, and in the Pakistan emergency health response. Coordination took place primarily at district level, and increasingly with the provincial Department of Health (DOH) through a Save the Children Health Coordinator. The next section (decentralization) discusses the increasing role of the DOH.

Save the Children carried out central-level policy advocacy primarily under the umbrella of the global partnership Family Planning 2020 (FP2020). Coordination also took place with other external agencies such as the International Rescue Committee (IRC), the Cooperative for Assistance and Relief Everywhere

(CARE), Medical Emergency Relief International (Merlin)10, and Columbia University. As Pakistan was evolving in its policies and capacity, harmonization with the FP2020 agenda served as a reference point to the project. By 2016, the program considered the government strongly supportive of FP, with written commitments indicating substantial political ownership, and quarterly meetings held by the government to advance FP programs.

Save the Children's vision for the project in relation to the health system evolved over the three phases, with expansion into coordination and support of governance and management structures at district and provincial levels increasing over time. Phase I problems were anchored in emergency issues; one informant commented that issues during the last phase more closely resembled those of traditional development projects, but Save the Children project team could not relate and document these interventions as key steps towards health system strengthening due to lack of familiarity with the concept. Initial requirements from the donor to prioritize expanding services did not encourage systems strengthening efforts. An informant also explained that central coordination was also complicated by the fact that in Pakistan, the MOH is in charge of coordination of emergency responses, while FP services are under the responsibility of the Population Health Department. In the end, increased demands for engagement with health system governance certainly owed to the evolution of the national system itself (see next section). Informants felt that deeper engagement at all levels could have started earlier (for example with the Disaster Management Authority, which was not engaged by the project), if the values of HSS had been better internalized. In fact, a Phase III report noted as a lesson learned—maybe surprisingly late in the process--that coordination should take place with authorities at all levels, that they should be all be well-informed, and that district support should come from the provincial authorities.

The early focus on district level, as opposed to central coordination can be described with two lenses. On one hand, the district level experience effectively created misalignment with national policy. District health officers provided initial approval for Lady Health Visitors (LHV's) – a nurse-midwife level of clinician - to provide implants, manual vacuum aspiration (MVA), and dispense misoprostol after training, with the understanding that Save the Children would provide detailed and focused performance monitoring of providers and of health facilities. Districts also authorized an updated training curriculum. This type of task sharing was not yet provided for in provincial or national policy, thus leading to a misalignment once PWD and DOH took back central stage. On the other hand, for services initially lacking attention and availability, the work with districts—while showing a lack of central harmonization in the early phases—might be seen as a 'positive disruption', which may inform future useful policies. According to informants, documentation of the feasibility of this task sharing has been supporting advocacy conducted in formal forums with national leaders by reproductive health development partners. Pakistan will ultimately have to decide whether to adapt policy and treat this innovation as a positive disruption, or close the door on it.

[10] Merlin with Save the Children in July 2013.

As noted before, Save the Children was the sole implementer of FP/PAC services initially. By Phase III, a number of additional international agencies collaborated with the MOH to implement or support services. Informants considered, with reasonable plausibility, that Save the Children's projects had served a role of innovator, demonstrating not only the value of, but also the possibility of expanding services in partnership with the MOH. While projects' influence was not primarily or first at central level, their contribution to the capacity of the national health service to offer a broader range of reproductive health services was in the end substantial.Decentralization & Management Capacity

A strengthened health system would show:	Summary findings:
• **Decentralized MOH system[11] uses processes for program learning and management course correction based on information** • **Decentralized MOH system limits or corrects displacement of other essential routine services by emergency response**	District health departments were the natural operational counterparts of Save the Children during all three phases of implementation, but decentralized policies and national decisions in Phase II established the importance of working in closer coordination with the province's DOH and the PWD. This led to an increasing role of Save the Children in capacity building for training, supervision, and use of information for management decisions, albeit without explicit systematic design and evaluation. At least according to one informant, Save the Children staff did not see themselves, certainly initially, as major actors in systems strengthening. Addressing system management issues evolved from the basic coordination of emergency response in Phase I, to activities more typical of development by Phase III, with a greater articulation of 'transition' needs in 2018. The path of country and project decisions involved trial and error, or 'muddling through', with an overarching orientation toward capacity building. Without more explicit evaluation of system capacity and transition steps, it is difficult to assess whether Save the Children could have gone faster to strengthen the leadership of provinces' DOH and districts.

[11] That is the DOH in Pakistan, at provincial level

The country's own decentralization policies were the main factor in the evolution of Save the Children's engagement with decentralized management structures. The 18th constitutional amendment of Pakistan[12] gave a new and important role to provinces in overseeing districts and coordinating implementing partners of the government. After prioritizing districts for Phase I coordination, Save the Children adapted to align to the increased demands coming from operationalization of these policy, and work actively with provinces' DOH.

Effective coordination went through some 'muddling through' on the part of both project and government. The KPK Provincial Health Department revised policies and procedures in 2012 which led to restricted involvement of LHW's in the project's community outreach activities in Haripur. Other political events and donor policy shifts also prevented the program from obtaining an MOU for facilities in Haripur in 2013, which led to Phase II adjustments in selection of participating health centers and referral hospitals. As decentralization became operationalized, the government of Pakistan also became more forcefully explicit on the importance of aligning training to the Population Welfare Department (PWD) and its coordination structures in provinces. Save the Children signed an MOU with PWD in 2017. Delay in, or absence of, coordination with PWD during the first two phases, resulted in different sets of guidelines and checklists for service provider evaluation and training, and the need to standardize FP and PAC resources between the departments.

Project Phases II and III evolved not only in the locus of their coordination but in increasing support to management and decentralized governance. Project documents suggest a dominant component of 'learning by doing' in the capacity building provided by Save the Children to the DOH and districts. Progress reports feature "cross-sharing and learning" through regular monthly coordination meetings[13], joint visits to facilities, discussion of issues with district offices (and required decisions under district purview) ranging from training, IEC material, stock management, establishment of service targets, and site selection for surgical procedures (e.g. tubal ligations). Project and health facility teams attended monthly coordination meetings at the DOH. Although early phases privileged Save the Children's own staff, reports document a number of active steps of program learning through surveys, assessments, data reviews, quarterly meetings, data quality checks (inclusive of client interviews), technical and management supportive supervision visits that informed program course corrections during and between projects, with DOH and district staff. District staff were involved in on-the-job trainings and mentorship in facilities as part of supportive supervision. Data collection and management tools were reviewed and actions were identified with facility staff to improve processes and quality– for example updates to data flowcharts, data collection, and client follow-up mechanisms were reported in January 2012. Regular review and analysis of data were continued in facilities even after transfer of staff from Save the Children to the government, and were adopted in select facilities by the Integrated Health Service, a public-private organization that manages 119 health facilities on behalf of the DOH, according to an informant.

The projects also conducted training on supportive supervision, data management, and use of data for action for health providers and supervisors. Supportive supervision tools were revised to be more efficient, and to trigger the development of solutions for identified problems.

[12] Eighteenth Amendment to the Constitution of Pakistan. Retrieved from: https://en.wikipedia.org/wiki/Eighteenth_Amendment_to_the_Constitution_of_Pakistan

[13] Form A, Pakistan Narrative Report, The Susan Thompson Buffett Foundation (July to December 2016)

By Phase III, these more explicit efforts at building decentralized management capacity became articulated as 'transition', including a plan for decreased Save the Children staffing (see human resources section). At that point, Save the Children worked actively with the Joint Coordination Forum, which involved 85 members from two implementation districts, representatives from the DoH, district coordinators of the LHW program, PWD, members of district press club, and NGOs working on reproductive health services. This forum "strengthened liaison and improved coordination amongst all stakeholders,"[14] as a replicable structure beyond life of project, at least potentially. An informant explained that by 2018[15] (Phase III), transition efforts had become priorities. A series of meetings took place with PWD and DOH, with a costed implementation plan cell to discuss possibilities of handing over of clinical component to the existing system. An MoU was signed with the PWD to streamline provision of contraceptive supplies. This was followed by another agreement on task shifting to midlevel care providers with the aim of enhancing trained and competent human resources to provide quality FP and PAC services beyond project life. The Integrated Health Service (IHS) - a public-private institution contracted for service delivery by the Sindh DOH - planned to integrate FP and PAC services into existing MNCH services in rural health centers under their management, following the protocols set in place by Save the Children with PWD.

In conclusion, the activities described for program learning and management certainly had potential to build management capacity. On the other hand, one informant acknowledged that more could have been done to engage DOH staff in data reviews at the facility level as well as to strengthen DOH supervision, beyond cursory checks. Given that efforts started first with Save the Children staff and facilities, and that transition to government run services was progressive, the documentation is not always explicit about the extent to which these practices built decentralized capacity. **Without more explicit evaluation of system capacity and transition steps, it is difficult to assess whether Save the Children could have gone faster to yield leadership to provinces' DOH and districts.**

Engagement with Community Organizations & Societal Partnerships

A strengthened health system would show:	Summary findings:
• **MOH engages in effective societal partnerships and with community organizations to improve efficiency, and resilience of community systems and facility-based services** • **Health system stakeholders (MOH, non-health sectors, civil society, private sector) develop stronger accountability mechanisms** • **The health system shows improved engagement with community**	The central and fixed component of Save the Children's community engagement strategy was to work through the recognized government LHW's program. This is likely the clearest contribution to the community component of systems strengthening by the projects over the three phases. Implementation did not immediately follow the comprehensive vision of the project proposal for engaging LHWs along with communities themselves. Save the Children expanded the community approach only progressively, through training of its own outreach staff, and progressively more and more of national partners. This took place in parallel

[14] Save the Children. (n.d.). Form A Pakistan Narrative Report.
[15] This study started in 2017, before the end of Phase III.

organizations to design, implement, and evaluate community health work • **The health system has mechanisms in place to mobilize community volunteers during emergencies (in addition to paid CHWs)** • **There are signs of increased trust and social capital between community leaders/organizations and the health system**	with an increased involvement of the government in managing the LHW program, notably through the DOH and PWD for training. A redesign of the community approach was recommended as late as Phase III (2017). It is hard to discern how much these efforts will be maintained after end of project.

An initial knowledge attitudes and practices survey showed that Lady Health Workers (LHWs) were the primary source of FP information for one to two thirds of women, depending on the survey region. **The primary and central investments of the Save the Children projects in community engagement was the support to the national LHW program.**

The proposal had plans for engagement of community structures given the sensitivity of FP/PAC issues along with support to LHWs, referring to Save the Children's *"global reputation for innovative best practices in community mobilization and in behavior-centered approaches to programming*." Plans mentioned "*partnership defined quality*," as a Save the Children signature participatory dialogue and monitoring approach, on which LHWs and female community health workers were to be trained to build quality, inclusion, and social accountability. Surprisingly, there were "*no typical processes of community consultation and research*" at the beginning [beyond the LHW program], because the focus was on "*building up quality services and spreading the message in the communities that these services were available*."[16] Informants considered this an **unfortunate delay in community engagement and research, which might otherwise have helped the project find its footing more rapidly.**

Additionally, a community coverage analysis in 2014 revealed a large percent of uncovered households in each catchment population area of each facility due to limited coverage by LHWs.[17] A roundtable of health care providers in 2012 mentioned the need for behavioral efforts involving media, street theater (which was later implemented), integrating FP in MNCH services and "messages", engaging religious leaders to dispel misconceptions, involving men, reaching out to local NGOs, and activating health committees already established by LHWs. [18]

Greater community engagement came over time, in fact with greater involvement of the government through the policy of decentralization to DOH (provinces). The DOH increased its responsibility for the LHW program, and the increased transfer of costs to the government (see Financing section below), may have freed Save the Children to explore more innovations in community mobilization. Substantial efforts were then dedicated by the project to coaching and training Save the Children and DoH teams on community mobilization techniques, group communication, conflict management, and counseling of individuals or couples as well as supportive supervision of community sessions.

[16] Informant interview.
[17] Save the Children. (2014). Community Coverage and Mobilization Report No. 1.
[18] Yasmin, N. (2012)

Increased community outreach and engagement supported efforts to access remote isolated communities in LHWs covered and uncovered households (HHs). Save the Children's outreach team worked with both Community Health Volunteers (where LHWs were unavailable) and LHWs on a revised Community Coverage Plan, despite interruptions in service delivery as a result of political and local events. The outreach team organized local events, to help communities to access basic health information with focus on FP and PAC key messages and established referral linkage between community and targeted health facilities.[19] This reportedly increased the reach of the project, with for example 16,810 participants from community members in target districts reached by general outreach efforts followed by smaller group discussions with segmented groups of participants.[20] Save the Children organized street theatre with involvement and supervision District Health Department(s) on the importance of birth spacing & harms of early marriages.[21] Save the Children and the health departments jointly organized and shared credit in reports for 'client facilitation days' in targeted health facilities. For the first six months of 2015, the project attributed to these efforts 10,952 new clients enrolled in FP and 1,003 new PAC clients in program. (Of note, a 2016 evaluation report explored the coordination between LHWs, Save the Children outreach teams, community volunteers, as the perceptions of women and community members on the outreach about FP/PAC[22]). By Phase III (2017), the community mobilization strategy was revised to incorporate supportive supervision for community level activities, based on guidelines form Columbia University (CU) on message development, communication and follow up. Phase III reports indicate integration of a community mobilization component in the collaboration with, and capacity building of PWD in terms of capacity strengthening. As one possible indicator of some institutionalization, PWD provided a manual on male community mobilization for trainings carried out after April 2017, and 40 youth volunteers were trained jointly by Save the Children and the government as peer educators (later stationed at supported health facilities in order to facilitate youth access to reproductive health services.[23])

Costing & Financing

A strengthened health system would show:	Summary findings:
• **The national health system progressively increases domestic funding for services, seeks to reduce financial hardship on users, without displacement of resources from other essential public goods**	The project did not initially explicitly seek to address sustainability issues related to costing and financing. Progressively, by Phase III, government and project efforts in the context of the national devolution to provinces' policy started channeling more costs to PWD and DOH budget lines. This showed results in payment of salaries (which Save the Children phased out of to a large extent by Phase III), and training costs no longer requiring expert or international consultants. Some of these achievements have been substantial.

[19] Project Progress Summary from Jan 2015 – July 2015
[20] Project Progress Summary from Jan 2015 – July 2015
[21] Monitoring, Evaluation, Accountability & Learning (MEAL) Unit. (2014). Quarterly Review Report – MEAL Unit, Save the Children Pakistan Program.
[22] Save the Children. (2016). Client Validation Report.
[23] Flinn, L. (2017).

	Project activities also included a lot of small, even micro-costs, which were not integrated in devolution plans, and raise questions about post-project continued operations, given the risk of an end to emergency funding, with no simple coordination or transition to development funding.

The projects were not set to address domestic resource mobilization and health financing allocation for FP. However, efforts contributing toward financial sustainability can be found in operational and budgetary changes between the difference phases, as the cost of facility staff shifted substantially to the government payrolls over time (see Human Resources section). Health-financing issues were otherwise addressed, appropriately, between the government and FP2020, of which Save the Children is a partner. For example, the government (PWD) worked with FP2020 to develop a costed implementation plan (CIP) in the Sindh Province, to increase CPR by 2020,[24] and an FP2020 working group carried out a funding gap analysis.[25]

Documents and informants report clear signs of transition of staffing ('macro' HR costs) and operational costs to national structures. Decentralization increased budgetary requirements on provinces for essential services. In addition to the evolution of salary costs, Save the Children pulled out resources from procurement, and closed its project position for dispensers by Phase III. For training, use of consultants as trainers ended after Phase II, in favor of the PWD trainers. While Save the Children still provided an honorarium, the trainers' salary was covered by PWD, and this reduced projects' costs for trainers to 25% of the previous phases, in addition to reducing logistical requirements, also integrated under PWD responsibility (Save the Children still providing refreshments, per diems [as per policy], and certificates). One informant summarized, "*slowly and gradually, the training system has been incorporated into the government system.*" According to another informant, the government and Save the Children have been discussing long-term plans with full ownership of training by the government, but requiring a reduction in dosing, using a 'blended learning approach' – using observation and coaching rather than formal training, and maintaining just one formal budgeted training per year in each district action plan. The informant considered this achievable by 2019, or "it could be 2022."

There were however also a number of additional 'micro' costs incurred by the project to carry out its basic activities, which fall outside of the basket of 'macro' HR costs that the government is trying to integrate (salaries, training), but which may bear some weight in the future. While daily allowances were reduced to align with government policies, they were still paid by the project in Phase III. Other project-covered costs, common to development interventions and not specific to emergency programming, included per diems, performance based incentives for lady health supervisors, lady health workers, and community health volunteers for performance-based objectives like submission of monthly reports, client tracking, referrals, and education sessions. The projects also provided PKR 10,000 as a revolving fund to facilities to cover costs of local vehicles for the referral of clients, based on the distances travelled.

These observations suggest a few conclusions:

[24] Save the Children. (2017). Pakistan Program Narrative Report.; National Institute of Population Studies and ICF International, (2013).
[25] Save the Children. (n.d.). Form A Pakistan Narrative Report.

- Government leadership, and progressive adaptation of project designs both contributed to the opening space for sustainable health systems solution. Even under an initial emergency approach (marked by the choice to take on staffing costs through project funds), a transition to national (decentralized) budgets can take place over 4-6 years, if there is government commitment.
- Projects can benefit and work with larger national partnership programs, such as FP2020 in this case, to fit their contribution within a broader systems approach to health financing.
- Small, even 'micro' incentives, support project performance in emergency programming as they do in development projects. Alignment to national policy is a requirement, but alignment does not ensure their inclusion in governmental budgetary plans, or financial sustainability.

Informants differed on whether initial project choices could have been different, but remarked on the greater anchoring of the Save the Children team in HSS practice and culture by Phase III, while questioning the fragmentation between emergency and development programming, not only within the agency itself, but also within donor agencies, as questions about funding beyond Phase III loomed.

Human Resources

A strengthened health system would show:	Summary findings:
• **The health system is expanding its human resources for health through domestic resources, including through incorporation of CHWs** • **The health system appropriately uses task shifting to ensure a more efficient use of staff time and skills'**	Save the Children launched a broad human resources development strategy that focused on clinical service providers and LHWs. It also expanded beyond these cadres and addressed a number of supportive functions, notably use of information and supervision. In order to rapidly introduce new services (FP/PAC) and generate demand by both ensuring quality and reaching out to communities, Save the Children and its donor made the choice to recruit and train its own staff first, and progressively involved more MOH staff (who made up the majority of trainees by end of Phase III). This also fit the donor and organizational mandate to expand the capacity of the agency in a set of countries (not just Pakistan). National and provincial ownership and coordination were strengthened when the MOH required full PWD endorsement of trainings. Save the Children responded to these legitimate requests and thus positioned the project to better contribute to systems strengthening. The Phase II project also invested in a true systems effort - assessing the distribution of roles and improving the complementarity between community and facility staff (both Save the Children's and DOH's).

	The overall picture is one of progressive evolution toward systems strengthening, interdependent with leadership steps taken by the government itself. Both expected and unexpected tensions with a systems strengthening trajectory, however endured by the end of our study.

Development of technical human capacity for FP/PAC services was a central component of the projects. This in itself is an enduring contribution to HR capacity, even as implementation challenges and tensions were observed. At the facility level, the project worked with and trained women medical officers (WMO's), lady health volunteers (LHV's), and some male providers in rural health centers. At the community level, the projects worked with lady health workers (LHW's) and community health workers (CHW's). These efforts involved training on clinical skills and supervision, coordination of different types of cadres, evolution of coordination with government, with a progressive integration of staff within government payroll.

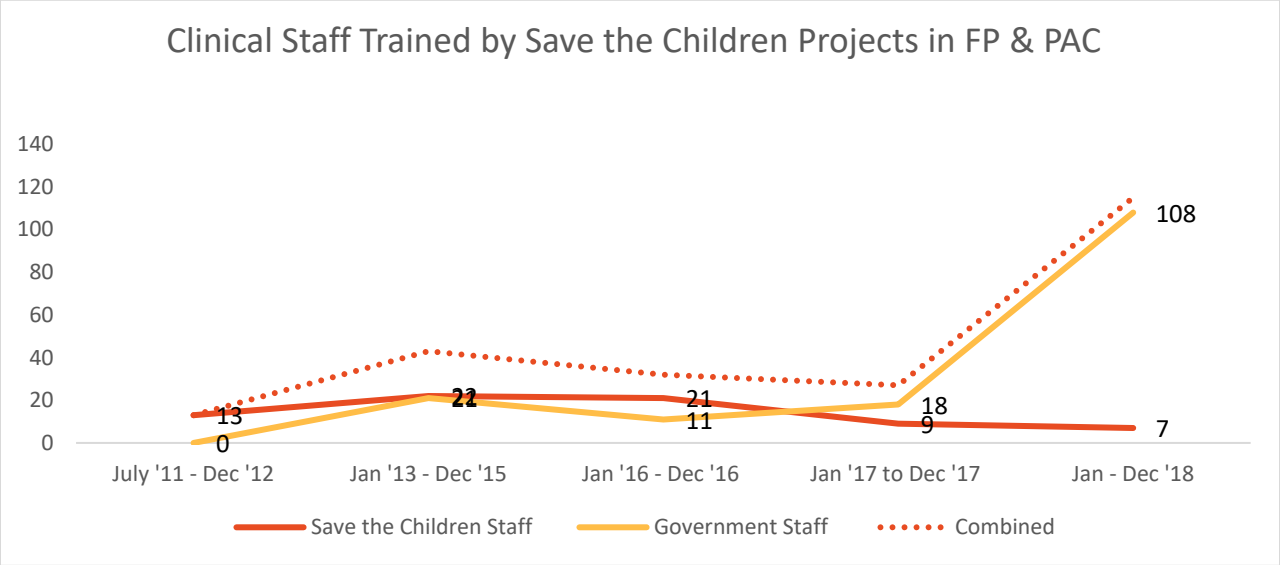
An informant added details to early phase project documents: initial attempts to provide services through government physicians and lady health visitors (LHV's) seemed slow to yield results. Given concerns about rapidly delivering quality services and stimulating demand, the project shifted strategy and recruited clinicians. This allowed the project to deliver, but then required a longer process of transferring staff onto government payroll.

Clinical Training and Supervision – Training involved multiple layers of health volunteers, personnel, and functions, to comprehensively address patient flow (demand generation, care seeking, referral, care delivery), and conditions for quality care. As noted throughout this report, Table 3 and Figure 2 illustrate the initial focus on building capacity for Save the Children-hired clinicians, and the evolution to HIS- and government-hired clinicians and staff under the oversight of the PWD and its regional training centers. Training manuals initially brought in by Save the Children partners became PWD-approved training manuals.

Table 3: Institutional affiliation of trainers over three project phases

	Phase I	Phase II	Phase III
Trainers	Save the Children and external consultant trainers	PWD/DOH staff and Save the Children staff trainers in equal distribution	All PWD/DOH trainers, no Save the Children trainers

Figure 3: Staff trained by FP/PAC projects, by provider type



In Phase I, training and follow-up facility supervision was initiated with 35 project providers and supervisors. Although this focused on staff hired by Save the Children, it was done in collaboration with the Pakistan Institute of Medical Science (PIMS), the Lahore Regional Training Institute and an international expert from Mary Stopes International (MSI) bringing international expertise. LHW's were also trained during this phase. Training on information systems also started in Phase I.

Training expanded during Phase II, as supervision tools and processes were developed. Participatory problem definition and solving emerged in trainings as illustrated in a 2015 report: *"group discussions were made on creating a more collaborative atmosphere for data verification by allowing supervisees to offer solutions to correct their own mistakes; emphasizing the 'supportive' aspects of supportive supervision, such as mentoring and discussing staff confidence, motivation, and problem solving, and promoting use of data and reports for decision making with active involvement of District Health Department(s)."*[26]

Training in FP/PAC service provision was followed with on-the-job training and rotations of government providers to emphasize performance improvement and monitoring. Rotations allowed for more supervised practice and support from Save the Children master trainers to address a reluctance among some MOH clinicians to perform FP/PAC procedures. A supportive supervision checklist introduced in 2015 provided a score of performance and ability to identify low and high performing providers. This guided 'attachment' of low performers to senior providers for on-the-job support and supervision. The checklist was used systematically every quarter after its introduction.

[26] Save the Children. (2015). Strengthening Save the Children's Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: Our Partnership with the Susan Thompson Buffett Foundation. (Progress Report).

In Phase III, training started including e-Learning modules. Data and health information training was a substantial topic with DOH staff and included use of DHIS2 (IMPACT); clinical and refresher training also took place.[27] At this stage, the role of Save the Children's clinical staff was limited to training service providers – both project and government (PWD/DOH) providers – and providing post training follow up and on-the-job support. Project documents only partially presented transition of these roles; clarification on how this transition took place came from study informants.

Coordination of HRH cadres **–** The project, notably in Phase II, also gave attention to the human resources architecture to support, deliver, and to some extent integrate services, with a mapping of differential and complementary roles of LHWs, CHVs, LHS' and community engagement staff and trainers from the project. CHVs were trained, but only where LHWs were unavailable, according to the same protocol as the LHWs, to allow future integration.

The consideration for staff relationships, collaboration, complementarity, and distribution of roles shows an overall systems orientation of project implementers, within the boundaries of the initial choices made by in a context of urgency. Coordination with volunteers was strengthened through regular interaction with project outreach workers in the community and in monthly meetings in health facilities.

HR challenges included management of staff movement during religious and political events and recruitment of female staff, which required proactive advertisement and even 'headhunting in the words of an informant. Safety of female staff was addressed through strong relationships with community stakeholders and religious leaders. 'No-go' areas were still reported.

Government Coordination - In 2017, the Secretary of the PWD instructed all private and public organizations to follow training guidelines endorsed by PWD. This required and led to strengthened collaboration with, and training oversight by the PWD.[28] In the absence of this identified lead central agency in early phases, Save the Children coordinated with decentralized structures (districts then DOH). The clear re-establishment of PWD leadership by the MOH was a clear signal for alignment across development partners. Documents and informant interviews show clear Save the Children alignment. By completion of this report, Save the Children remained engaged closely with PWD, for example, in monitoring the performance of LHVs in implant insertion, which was introduced by Save the Children but, as of yet, not permissible by provincial PWD guidelines. Reporting systems to PWD were being set in place, as well as concertation with FP2020 partners.

Systems-Related Capacity Building Challenges—Apart from the original choice to staff clinical positions directly (which had a rationale and justification, while creating a misalignment that was still being corrected by Phase III), elements above are mostly positive. Some tensions were however observed.

- The project introduced a new cadre of Community Outreach Workers (ORW's) to supervise CHVs in Phase II, creating a tension with the long-term prospect of a nationally-owned public health

[27] Save the Children. (2017). Pakistan Program Narrative Report.

[28] The Susan Thompson Buffett Foundation Pakistan Narrative Report. Form A. Reporting Period: July to December, 2016.

system, even though the project otherwise displayed a progressive transition to national staffing and structures that was accelerated in Phase III.

- Another tension existed with micro-incentives provided by the FP/PAC projects to LHS', LHW's, and CHV's up until Phase II for services provided, such as monitoring, supervision, education sessions, client tracking, and referrals.[29] [30] According to one informant, incentives were removed in Phase III and affected volunteer motivation and clientele referral to health facilities; particularly from far and isolated areas, where volunteers used to organize and lead group visits to facilities. So while the removal of project incentives sought to reduce a threat to sustainability from an external resourcing, it was not replaced by endogenous resources and appears to have negatively affected the performance of a reasonably cost-effective referral system. Reports on this issue are ambivalent: one states that there is strong coordination of LHWs, who show full commitment towards their work without receiving any incentive. Another states that volunteers and LHWs don't cooperate following the end of project incentives and because other organizations are providing transport costs and incentives. The same report also notes insufficient cooperation from government staff.[31]

- Informants provided two examples that exemplify how both alignment and non-alignment can present challenges. In an alignment-related challenge, the project's MOU with the Sindh PWD detailed project catchment areas. Increasing referrals and service utilization to fulfill program objectives would have required expansion into new facilities, something not permissible by the existing MOU. In a non-alignment challenge, the addition of new agencies providing FP services in Sind resulted in a crowded landscape of providers, and an inflation of volunteer incentives, which reportedly started affecting work in Shikarpur and Haripur.

Monitoring, Evaluation and Information Systems

A strengthened health system would show:	Summary findings:
• **Appropriate human resources are allocated to HMIS in the health system to inform decision makers** • **Data systems and information have been strengthened within the health system**	From the initial project proposal to the implementation of the three project phases, Save the Children placed important emphasis on data processes, reference to data for decision-making, use of special studies and evaluation. The projects operated on a trajectory toward progressively more systems strengthening. This involved training on data tools (registers, logbooks, reporting), ongoing joint reviews with facility staff,

[29] Save the Children. (n.d.). Guidelines for Community Mobilization FP PAC Project.
[30] Save the Children. (n.d.). Roles and Responsibilities of Volunteers.
Tasks for LHS included monitoring and supervision of LHWs (PKR 1,000/month). Tasks for LHWs included holding sessions (PKR 400/month), client tracking (PKR 300/month) and client referral (Rs. 200/client referral per LHW). Tasks for CHVs included holding sessions (PKR 400/month), tracking clients (PKR 300/month), and referral of 5-10 clients to health facility (PKR 1,000/month). In 2014 (Phase II), increased client utilization of services placed demands on additional budget allocation for clinical supervisors and service providers, which Save the Children accommodated for within the existing program budget.
[31] Save the Children. (2016). Client Validation Report.

	adaptation of DOH/PWD tools and introduction of new tools to support patient tracking, quality of care, or logistical flows, as well as repeated emphasis on use of information for decision-making. As in other areas, the primary beneficiaries of these efforts were Save the Children staff during Phase I, and in time included DOH facility staff as well. Coordination had started with DHOs, and then involved PWD. Capacity building was not a measured objective, but most likely happened and was reported, in good part from 'learning-by-doing'. The projects appear to have contributed to a number of necessary but not sufficient systems elements to establish sustainable information systems, and build a monitoring culture. The role of Save the Children on underlying systems issues that are dependent on DOH and higher levels remained limited.

Throughout the successive phases, Save the Children placed importance on the production, processing, and use of data for decision-making. Program design included plans to ensure data quality, align program data with national systems, regular analysis of data to understand program performance, and use of data for decision-making. This emphasis was reflected during implementation through the monitoring, evaluation, accountability, and learning activities carried out in the three project phases. The projects' invested in data accuracy of government health information systems and established a functional system for client based recording and tracking that improved on an existing system to coordinate follow up of clients by LHW's. When government tools existed, Save the Children built on those, but also introduced new tools and new energy in information systems, as government systems had "*a lot of gaps in reporting and documentation*." In addition to contributions for facility-level data collection and client tracking, the projects' undertook several surveys and assessments to understand and evaluate project contributions to elements of service delivery, this included:

- A facility readiness survey;
- A knowledge, attitude, and practice (KAP) survey;
- Client satisfaction surveys (in 2012 and another one in Phase III) through exit interviews (N=200), observation of provider-client interaction, focus groups;
- A program review conducted by Columbia University in 2014 on FP services, FP continuation monitoring system, PAC services, community outreach, supplies and equipment, waste management and infection prevention, staffing and training, supportive supervision, data use, and staff attitudes towards FP/PAC services.
- A 2017 study on effectiveness of community mobilization in the FP/PAC project
- Register data quality audits (Phase III)

One informant commented that facility staff *"were [over project implementation] much better in terms of analyzing data trends, using them and improving next month's planning*." Project site visit and supervision reports provided details about status of logbooks and registers in health facilities and reflected on health care providers' appreciation and use of facility logbooks and registers, as well as the chain of communication of service data and whom to reach to obtain needed information. Tools such as

facility reports benefited from small adaptations (e.g. adding a column to a report to comment on possible causes of a trend) to facilitate these processes. Providers used data for observing and analyzing trends in utilization of FP services and products; checking for defaulter FP clients; identifying and addressing gaps in services; preparing supply requisitions based on the trends in the adoption of FP methods; and preparing monthly reports for the head office.

As with technical capacity building, program reports show the progression over three phases from an emphasis on strengthening data collection and use by Save the Children staff (in liaison with the government) to strengthening the capacity of government staff in later phases for these functions.

Over Phases II and III, the focus on coordination with district and provincial systems increased. Joint reviews of data and problem solving, based on tools (for example checklists) and service reports appear to have taken place regularly with the PWD, which was involved in trainings along with the DOH. By Phase III, the Save the Children team visited and assessed government facilities for data use through joint supervision visits and one report noted "most of the standards were [put] in practice." During these visits, course corrections were identified and discussed with service providers along with agreed action points; these were quantified and tracked and the same report also indicated that "it's encouraging that almost all course corrections were completed within agreed deadlines." Another report found that "service providers regularly updated data tools and wall charts showing trends of clientele. There have also been quarterly review meetings with project stakeholders and joint field monitoring visits with the aim to keep them updated and gain their ownership for different project activities." Informants also comment on the substantial amount of human capacity development among government clinical staff.

The projects had implemented substantial efforts at capacity building implemented at facility and district levels with government staff. Training and mentoring capacity on information systems quality improvement and use of data remained, however, with Save the Children's M&E team. Informants willingly acknowledge that transfer to provincial [government] capacity should expand in in the future. One informant summarizes the progress: "*The data collected from the project intervention sites is regularly updated in the district health information system. There has been clear indication of positive progress in supported health facilities in both FP and PAC. However this area needs further work in terms of integrated use of the data collected for analysis and action purpose which is planned for Phase IV. Generally, the data analysis trend is missing in the government health system. The project observations and outcomes at the community and health facility levels were regularly shared with government officials, however it is important to develop ways of integrating best practices of data review and analysis in the government health system and involve them in surveys and client exit interviews from the beginning.*"

Retrospectively, an informant concluded that the measurement and evaluation focus of the successive projects had been placed on clinical performance areas, and getting essential data flowing and used, and that more could be done to strengthen underlying systems in a possible Phase IV.

In a comment, which will reflect on our summary findings, this informant also noted **that while the program was designed and activities were conducted to contribute to health systems strengthening at the health facility level up to the district level, these efforts [and their results] were not measured.** Again, reference was made to the donor's mandate for an emergency response. Evaluation of systems conditions to sustain gains may not have fit that mandate. The opinion of the informant was that in spite of the emergency context, projects could have been introduced to local partners (provinces, districts,

civil society) in a way to look at both systems conditions supporting facility and community work, and the population health outcomes of expanded services.

Quality of Health Services

A strengthened health system would show:	Summary findings:
• **Health system includes host population (not just displaced) in improved services** • **Services delivered by the health system are responsive to community needs and adapted to context** • **Health system innovations for coverage of health services and preparedness for EHN needs** • **Health system has the capacity to contribute to large EPI campaigns and outbreak responses**	Save the Children carried out determined FP/PAC health services development and were thorough in building the conditions for quality of services. This included the introduction of new care procedures and practices, extensive skills building of Save the Children and then government staff, training of national master trainers, collaboration with the PWD and institutionalization of standards, diffusion of learning and skills to support task shifting, attention to data and performance with remedial and adaptive steps, and measurement of client satisfaction. Positive client-provider interactions and quality of services supported by community engagement and demand generation drove the successful uptake of services in the eight target facilities. The projects progressively shifted to closer support of national structures through alignment to the PWD (now the authority for FP/PAC clinical training) and coordination with DHOs and provinces. By end of Phase III, Save the Children viewed a possible Phase IV as required for accelerating systems strengthening, integration of quality improvement across services, and conditions for sustainability. Reflections of key informants indicated the belief that deliberate engagement and operation through government structures may have fostered more systems strengthening and sustainability of project interventions, even if service delivery results took longer to reach target numbers. Assessing what Save the Children and its donor “should have done” given its resources and scope is beyond the reach of this study. We can only observe that the path chosen allowed a ‘successful’ project experience in terms of service expansion, and that the orientation toward systems strengthening progressed over time under strong government signaling.

From the beginning of the series of projects, the provision of quality services was a central focus, as it was understood that strong quality of service would ensure both client uptake and continuation of FP and PAC services in supported facilities.

On the achievements side, the projects introduced new clinical services delivered with quality in a challenging environment. As discussed in the HR section, Save the Children emphasized the development of a cadre of competency-based trained FP and PAC professionals through clinical training,[32] targeted first at Save the Children staff and later incorporating government staff (including District Health Officers) and also diffusing learning and skills to new cadres within the MOH structure. Training included clinical skills for FP/PAC procedures, counseling and client-provider interaction (including confidentiality and values clarification), contraceptive availability, mechanisms to promote continuation of services in clients including community and service provider partnerships, appropriate technology and availability of a referral mechanism for complications. Training Needs Assessment (TNA) were repeated –planned for every six months-- in order to stay informed of staff departures and shifts to different departments so that priority staff for training could be identified. The projects also trained national master trainers and developed and institutionalized clinical and training standards through collaboration with the PWD over progressive phases. In addition to training, clinical capacity and quality services were strengthened through the establishment of supportive supervision with the use of a supervisory checklist and logbooks in facilities for provider performance review and trainee follow-up,[33]and the introduction of rotations (in Phase II).

Having a project approach with different teams (community outreach, QA, program management) may have allowed to address complex issues where culture, law, staff confidence, and service delivery intersect. For example, conflicts – such as a client coming in for post abortion care and the husband coming later with the police and complaining to facility staff – created fear among FP/PAC providers. A Phase II workshop on supportive supervision and professional attitudes helped uncover cultural and religious issues such as this and develop remedial solutions which left providers with greater confidence in their ability to address them. Other contributions to quality included the establishment and strengthening of referral linkages from the community to the health centers for FP PAC services through client facilitation days jointly organized with strong coordination between the DOH and Save the Children.

Through all three project phases, capacity building for quality services was reinforced through the promotion and monitoring of determinants of quality: Save the Children's M&E team emphasized the use of data on clinical performance as well as measurement of client satisfaction, which was followed by remedial attention as needed. Through program data, assessments, and reviews, the project and providers were also able to unpack gaps for FP services and uptake, such as variances in utilization between specific ethnic groups, differences in referrals between districts,[34]youth friendliness of services, and uptake of specific PAC procedures. One review also covered details on data quality and reporting. For example, gaps in counselling and FP procedures reported by the Quality Assurance (QA) team led to

[32] Taussig, N. (2012). Save the Children's Expertise in, Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Request to Sustain Our Partnership with the Susan Thompson Buffett Foundation. Save the Children.

[33] Taussig, N. (2012). Save the Children's Expertise in, Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Request to Sustain Our Partnership with the Susan Thompson Buffett Foundation. Save the Children.

[34] Columbia University Mailman School of Public Health. (2014). Save the Children-Pakistan Family Planning Register Review Report. Save the Children.

development of performance improvement plans including for a high turnover facility. The QA team also coordinated directly with the Technical Director of PWD to review and revise the supervision QA checklists. Program monitoring efforts were noteworthy, but strongly Save the Children dependent, with a progressive and cautious evolution toward integration within national systems over time.

Even as early as Phase I, efforts to provide quality services yielded results in service uptake and positive perceptions of care. The reasons that Save the Children health service providers cited for the increase in FP utilization were ease of access to free FP products and services by skilled health providers, polite and professional provider attitudes, increased community awareness of FP, provider efforts to build and maintain client trust, and trust in the sustainability of FP services offered by Save the Children.[35] In Phase II, a register review report showed that the proportion of referred clients and total users was on an upward trend. Client satisfaction of FP services was assessed as early as Phase I through a client satisfaction survey (2012).[36] The results showed that overall, clients were satisfied with FP and PAC services in both Haripur and Shikarpur. By 2017, more than 96% of surveyed clients said that they would recommend the facility to a friend, although only 40% were examined in a private room. That survey found that providers were perceived as knowledgeable, proficient, and competent in FP and PAC provision of services. Clients reported satisfaction with services and counseling sessions, their understanding of the use of different FP methods and their problems/side effects, as well as their understanding of the need for follow-up visits to the health facility.

On the other hand, a lot of work and transition to national structures remained to be done by the end of Phase III. A lot of capacity and leadership for activities remained at least partly in the hands of Save the Children even by end of Phase III (for example the use of the QA checklist), and client preferences for Save the Children FP services providers puts a question mark on the level of sustainability achievable in the future.[37] No information was available on elements of financial sustainability or institutionalized systems for quality assurance / quality improvement. The projects' reports focused on the 'task at hand' and, while engaging with the MOH, did not analyze or report on integration within structures or care and management, or possible displacement effects on other services.

One informant stressed the essential coordination with the MOH at each step, first DOH and then PWD. Another informant described it differently. From her perspective, the project "started off on the right foot", building LHV and physicians' capacity [within the national system]. After six months, no results were observed as the DHO was still getting used to the project, which did not find momentum, meaning that women were not being served and the project failing to gain on its indicators, which naturally the donor wanted to see. At that point, Save the Children decided ("was pressured" for our informant) to hire physicians and LHVs to be seconded within the DOH facilities. For our informant, "this was not the right thing to do," although it helped "get our numbers", quality of care was being recognized and women started coming in. Accordingly, this had to do with the staff and their performance, as Save the Children was able to be assertive about quality benchmarks. Only the last phase of the projects saw the majority of staff return to DOH positions, and greater attention to building capacity at province level to affect a larger scale of services beyond the project supported facilities. This also involved local civil society partners, which –again for our informant—could have been involved earlier to strengthen the community component. This increased engagement of government and local CSOs is a different endeavor (from the Phase I direction) requiring more supervisory and management capacity inputs, but our informant felt that this was "*something we could have done from the beginning*," to avoid investing

[35] The Development Strategies Pakistan. (2013). KAP Survey for Family Planning and Post Abortion Care (PAC) Program, Haripur and Shikarpur. Save the Children.

[36] Spilotros, N. (2012). Measuring Client Satisfaction of Family Planning Services. Save the Children.

[37] Save the Children. (n.d.). Research Study on Family Planning and Post Abortion Care Project.

project energy on staff who may choose not to re-enter governmental services. We also observe two limiting factors to Save the Children's contribution to strengthening systems for quality of care: first, remaining dependence on project systems and staffing; and second, relatively limited scale of influence at the implementation level in a small number of facilities.

Assessing what Save the Children and its donor "should have done" given its resources and scope is beyond the reach of this study. On one hand, the strategy chosen allowed close attention to quality issues in supported facilities, which was a central factor in generating uptake of new and critical services. The long-term intentions of Save the Children leaders and national orientations (decentralization and clear communication on PWD's mandate) led to more coordination and orientation of project contributions toward systems strengthening. Those are significant contributions in a very troubled and challenging context. On the other hand, the informant cited above reported that Save the Children had chosen an approach more immediately integrated within government structures in another country, and been able to achieve results. In addition, discussions within the Humanitarian Development Task Force's Technical Committee, as part of the review of this study, indicated that the International Rescue Committee (IRC) started implementing PAC in Pakistan also in 2011 through the MOH from the onset, and had been able to go through a very slow start but grow steadily through capacity building efforts. We lack the data to make further comparisons between the two paths.

Supply Chain Management

A strengthened health system would show:	Summary findings:
• **There is increased capacity and autonomy of the health system to manage procurement and supply of commodities.**	The first order of priority for Save the Children was to build its own capacity across Pakistan and other countries funded through the same FP/PAC project funds, and to ensure commodity availability in order to make services viable. Because the government procurement and supply chain had many gaps, Save the Children developed its own procurement and supply chain for the projects that were in many regards "parallel" systems. At the same time, the projects did coordinate with the government and aligned with regulations on local procurement of medical supplies. Evolution in practice over the project phases led to clearer objectives in Phase III for capacity building, which increased the complexity of Save the Children's role. As the project transitioned functions to the government, it also worked to provide technical assistance and problem solving in a challenging implementation environment. By the end of this study (Phase III) the project approach had evolved to actively support

	government-operated FP/PAC procurement and supply chain management. At the same time, the project still provided key functions of gap filling, support (e.g., direct recruitment to operationalize the establishment of a pharmacovigilance system in Phase III), and strengthening of the supply management system to protect the ability to deliver services.

Procurement of commodities started as a gap-filling required measure to start delivering services. An initial health facility assessment observed limited distribution of FP commodities to facilities, with limited management support to expand and ensure the method mix. Independent procurement and supply management of FP commodities was consequently seen as essential to rapid and successful launch of the initial project. A Phase III report summarized, "The uninterrupted supply of FP commodities remained the most important factor in achievement of project deliverables since the start of the program."[38]

Phases I and II focused on Save the Children's own systems, with Pakistan one of three countries receiving support from the donor: FP commodities and PAC supplies were incorporated into Save the Children's procurement, grant management, monitoring and evaluation, and supply chain systems and the project built the capacity of the country office in tracking FP commodities. A cross-country initiative of the project that benefited Pakistan was to work with UNFPA and International Dispensary Association (IDA) Foundation and the Netherland-based International Medical Relief Emergency Service (IMRES) for drugs, contraceptives, and medical equipment.[39] A shadow stock of FP commodities and PAC supplies was established.[40] The Save the Children procurement teams also sought to identify *local* vendors for medical supplies for tubal ligation and vasectomy.[41] This suggests an order of priorities, which is nearly impossible to challenge retrospectively without questioning the time-sensitive nature of projects: first ensure the success of the program, and then build national systems as much as possible. According to our informants, the project initially first sought to "*fill community needs. Save the Children had its own supply chain management system under regular monitoring. The system was parallel but the focus was to provide immediate care because the MOH needed the help of multiple organizations working on health. The project coordinated with PWD on FP to provide for communities.*"

The projects set in place and supported supply management between facilities and management levels. At health facilities, a register was maintained on a daily basis, and an expense report was shared with a supply chain officer fortnightly. The supply chain officer communicated with the country office

[38] Save the Children. (2016). Pakistan Work Plan, Save the Children (July – December).
[39] Taussig, N. (2012). Strengthening Save the Children's Expertise, Commitment to, and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Partnership Between the Susan Thompson Buffett Foundation and Save the Children. (Semi-annual Progress Report). Save the Children.
[40] Taussig. N. (2011). Strengthening Save the Children's Expertise in, Commitment to, and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Partnership Between The Susan Thompson Buffet Foundation and Save the Children.
[41] Taussig, N. (2012). Strengthening Save the Children's Expertise, Commitment to, and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Partnership Between the Susan Thompson Buffett Foundation and Save the Children. (Semi-annual Progress Report). Save the Children.

team when needed, for example, in case of unavailability of supplies or a stock out. The warehouse where supplies and medication was kept was reported to have been well maintained.[42]

Training for supply chain management involved both national system and Save the Children staff (global and country health advisors and service delivery staff including nurses, midwives, medical doctors, health coordinators/supervisors, pharmacists, and logistics officers).[43] Training was done on product selection; quantification; forecasting; warehousing, distribution and inventory management, and tools for stock management, quantification, and forecasting as well as recording and reporting for commodities. On the job sessions helped managers shift from a supply-led to a need-led approach and ensure timely forecasting of supplies to avoid stock outs. M&E focused on the net results of these efforts (no stock outs), without seeking to discriminate between overall achieved capacity versus specific MOH capacity. Reports show capacity building 'spilling over' into national systems, rather than independently targeting national capacity, always with a focus on avoidance of stock outs. This focus showed positive achievements, with project reports demonstrating avoidance of stock rupture in health facilities and the existence of buffer stocks in health facilities.[44]

By Phase III, the work plan (April 2016 – December 2018) was strongly oriented toward capacity building, systems strengthening, and sustainability, with plans to reduce staffing and focus on quality assurance and supportive supervision. The evolution toward systems strengthening transpires from informant interviews and narratives in project documents, rather than formal capacity, readiness, or strength assessments. Substance about the plans is provided in a footnote of the work plan:

> "*Our plan is to gradually reduce staffing, with the aim of phasing-out direct service delivery by Save the Children staff by Dec. 2018. The new hires are for [a new health facility]. The basic role of these hires would be to support the DoH staff in managing FP and PAC services in Yr1, followed by gradual transition of supply chain and service provision; in Yr3, we propose one service provider budgeted for each health facility to provide ongoing supportive supervision. The main objective of Phase III is to enhance coordination with the DOH, in order to sustain FP / PAC services, while limiting Save the Children's role to Quality Assurance*."

The stated objectives included that "joint supportive supervision" should be carried out at least once a quarter, and further reports on commodity issues referred to a shared "sustainability plan"[45], describing a distribution infrastructure of warehouse and dispensers supporting facilities. One of our informants reports: *"[By Phase III in 2016], the team started educating government authorities that Save the Children had been procuring commodities for FP and PAC in the last two phases. They expressed the need to phase out and signed an MOU with the government in order to hand over the project. A subgroup of NGOs developed terms and conditions that they would provide commodities to health facilities. Since mid-2017, all commodities were being provided by the government whether short or long term. The FP system has been streamlined, but supplies are still being procured for PAC. The project is in the process of integrating with the government."*

[42] Yasmin, N. (2012). Field Visit Report Shikarpur

[43] Save the Children. (n.d.). Headquarter Training Matrix – Training Plans: (Headquarters, Democratic Republic of Congo and Pakistan). Annex E.

[44] Ashraf, S. (2011). Family Planning and Post-abortion Care for IDPs and conflict-affected women in Haripur & Shikarpur, Pakistan. Health Facility Assessment Report. Save the Children.

[45] "Sustainability plan" reflected the general intention of the project; it did not refer to any specific planning document.

Transition of supply chain management to the government in the last project phase was formally established in agreements and project reports, but came with ongoing operational challenges, adjustments, technical support, including new project recruitment.

Phase III still reported stockouts (notably clotrimazole, implants, and tranexamic acid), including due to "security challenges reported in certain villages", a noted competition between MOH facilities, and an increasing number of NGOs and local agencies in demand of commodities. Save the Children continued to support problem solving in noted coordination with PWD, with which an MOU was signed on streamlining availability of contraceptives. Problems included shortage of implants, from the prequalified suppliers and consequently from the local market. Coordination with PWD reportedly helped address some of the problems in both districts and the JIMS hospital in Jacobabad.

In this last phase, Save the Children even created and resourced a new position, aiming to build capacity to operationalize an existing national policy. As reported, "*There will also be addition of a new position to establish and maintain pharmacovigilance system which has never been done in Pakistan, though there is clear policy mentioned in Drug Regulatory Authority Pakistan. This would be supported by FP and PAC and Integrated Maternal, Neonate and Child Health (IMNCH) projects in technical collaboration with the concerned authority*." This fits the pattern of using project resources to follow a policy, but anticipate on the government's capacity to operationalize (and resource) it.

An informant summarizes the evolution toward incrementally orienting project efforts toward systems strengthening. "*Over time the team tried to integrate this process into the district health system. They managed to integrate the supply chain, however the information system required such detailed and complicated reporting (for donors) that it required extra staff at the health facility who could keep and enter data. The system is still trying to be integrated. PWD is managing at the provincial level, and has asked to share, simplify and upgrade the system into something that works.*"

Discussion

Methodological caveat and limitations

The caveat of this country report (and the overall case study design) is a restatement of its premise: this is not a project evaluation, but an examination of health systems effects of successive projects, which already carried out their donor-mandated objectives. This distinction is a perilous exercise: pointing to unsatisfactory or negative system evolutions can lead the reader to reflexive responses such as: "the project should have… the project failed to…" This is not the object of the study. The study remains a natural baseline of sorts on how system effects manifest themselves, and both influence and are influenced by projects. The tension between "doing" and "strengthening" is a constant tension in development and emergency assistance. There's an ongoing questioning of HSS approaches vis-à-vis the achievements of results at population level. We reversed the question—what are systems effects of projects designed to achieve results—in order to discover possible adjustments to a results-first strategy from a country systems and sustainability perspective. We will expand on this in our cross-country analysis, but acknowledge the inherent challenge of the method.

We discovered that gathering all documentation about projects implemented by Save the Children was itself a minor but real challenge. Project documentation has its own flavor and possible biases—informant interviews were essential to providing nuances or correction about the sequence of events on a number of elements. Finding informants with a clear memory of these projects' history proved to be

far more difficult than we thought, given high project staff turnover. More investigation in country and more informants, notably from national institutions, would likely have been helpful with additional resources. We feel however that the study achieved its ambition to maximize learning from available data in a retrospective exercise.

A general limitation is that, in spite of a lot of documentation, we explored a substantial number of lessons that could be inferred from the narratives, but many could not be conclusive for lack of focused evaluation efforts on these domains. This can be attributed to the projects' scope of work – for example, project reports were focused on immediate outputs and outcome indicators related to the reach of emergency health services.

The programs selected for review in this country report used a reporting format guided by the donor, which was heavily focused on the outcomes and outputs of service delivery, as compared with some other donor formats that include more detail on systems strengthening processes of implementation. And even though systems strengthening activities took place in the course of implementation, programs were not designed from a systems strengthening standpoint so systems measures were not incorporated into program monitoring measures and reporting. As such, elements of process that may have strengthened the health system such as the execution of exit strategies and handovers were not detailed in these reports and corresponding measures of success were not available.

Finally, the field of health systems strengthening is itself struggling to advance a clear evaluation model.[46] We used explanatory propositions, expanding on evaluation questions from previous authors[47], but as useful as these propositions are, to construct a multidimensional narrative, they do not have the simplicity and power of reliable quantified measures of change.

Conclusion: Lessons learned from the Pakistan case study

Few of our explanatory propositions could be proved or disproved conclusively by review of project evaluations and reports.[48] Appreciation of systems effects required teasing out narratives in project reports and informant interviews. The overall trajectory of the project phases shows the intent to contribute to systems strengthening, although this is not made explicit in projects' M&E and reporting. The projects' M&E plans were focused on reporting output and service targets. Capacity building and systems strengthening were tacit values of informants, and transpired in the narrative reports, but took second stage to the primary agenda of FP/PAC service expansion. One informant thought that the project could have had a stronger systems strengthening strategy from the onset. Another commented that HSS "was generally not a Save the Children priority," that it perhaps should become more salient in projects, but that this would require internal capacity building.

Once it had built capacity in its own teams (more on this below), Save the Children made contributions to strengthening specific elements of the health systems, from human resources' skills and competency for service delivery, learning-by-doing and mentoring on data tools, processes, and data for decision-making, contribution to technical standards through FP2020, and supervision tools oriented toward quality of care. The Save the Children contribution to community systems strengthening was surprisingly slow to emerge (Phase III) given the agency's established expertise in this

[46] Adam T, Hsu J, de Savigny D, Lavis JN, Røttingen JA, Bennett S. Evaluating health systems strengthening interventions in low-income and middle-income countries: are we asking the right questions? Health Policy Plan. 2012 Oct;27 Suppl 4:iv9-19

[47] *Chee G, Pielemeier N, Lion A, Connor C. Why differentiating between health system support and health system strengthening is needed. Int J Health Plann Manage. 2013 Jan-Mar;28(1):85-94*

[48] This observation is also valid for the companion Sudan report.

area. The central and fixed component of Save the Children's community engagement strategy was to work through the recognized government LHW's program. This was the clearest contribution to the community system component of by the projects over the three phases. In spite of an ambitious initial proposal for broad community involvement, this was not implemented. A redesign of the community approach, with a number of different approaches, came as late as Phase III (2017). For informants, the delay in operationalizing the best intentions of the original proposal is explained by the urgency of the clinical service delivery agenda, and donor-implementer differences in perspectives. Involvement of the government was systematic, primarily due to the project anchoring in the LHW strategy. It is hard to discern how much these efforts will be maintained after end of project given some common structural problems of CHW work (e.g., work overload).

Systems effects and challenges were determined by the initial path taken by the project. Phase I first attempted to work totally through DHO LHVs and physicians.[49] Slow progress led to the orientation of the project toward selected facilities using Save the Children-compensated staff, and creation of conditions for success. This came with a slower path to national ownership, the need to expand energy to manage a large project team, and unfavorable comparison by one informant with "more sustainable" approaches used in other countries, "even if it takes a year for the program to pick up." This resonates with common observations in development and humanitarian work, but we find it hard to judge the pressures that the agency and the project would have faced if this longer path had been chosen. Would the case for expansion of FP/PAC services have been made as strongly to decision makers without demonstration of service uptake? This is at the core of the emergency response dilemma, and the donor of an emergency response might not be so convinced of the value of its investment if program pick up sees substantial delays.

The evolution toward more systems strengthening co-evolved with national health efforts and a development assistance coordination body. Save the Children coordinated with governance structures (DHOs, provinces) close to service delivery but had limited national, even DOH-level interface, until the government itself re-emphasized the role of PWD and the DOH. It is retrospectively easy to suggest that everything should have been aligned, harmonized, and sustainable from the start. However, not taking action until the path ahead is clear is not a feasible option for emergency programs. What is clear is that leadership from the government promoted a constructive evolution of the projects. In the initial phase, harmonization with FP2020 served as an important convergence point, and preceded greater alignment, systems support, and strengthening, encouraged ultimately by the MOH's own policy and programmatic leadership.

At a minimum, this suggests that it may be necessary to better map out and monitor—collectively (project, government, and partners)—the system elements and relationships, which are affected by emergency responses, even under the best of intentions, and do that as early as possible. A project might take a detour for reasons accepted by stakeholders in context, but it would be good to know how far the detour veers from any foreseeable viable direction. This may have to go beyond the self-evident issues such as salary payments, and it calls for better diagnostics, evaluation, and documentation. The best option available in times of confusion may be to have clear theories of change for any innovation, the best engagement possible with government available at the time, explicit and systematic evaluation mechanisms, and the readiness to use data to engage with emerging coordination and governance mechanisms as capacity develops. Partner-government coordination forums, such as FP2020 in this case, may provide proxy accountability mechanisms on the path to full national system leadership.

[49] This early phase of startup is described by informants, but not discussed in project documents.

By Phase III, the situation of the project vis-à-vis the national system closely resembled the situation observed in development projects, with a mix of elements transitioned, in transition, or still strongly dependent on the external implementing agency. Salary differentials between project and MOH staff (five times higher for a clinician, as reported by an informant) are endemic issues in development. Save the Children had established Community Health Volunteers (CHVs) where LHWs were not established. From a human resources system perspective, Phase II had already considered the distribution of roles between these cadres, Save the Children's teams, and facility staff (both Save the Children and MOH). This actually reflected a 'system vision', albeit one where Save the Children was part of the system for the delivery of FP/PAC services. This might be accurate to an on-the-ground reality. Transition to DOH staff and facilities (i.e. progressive integration of health providers in MOH payroll), and to national master-trainers from PWD and training centers shows a 'macro' trend toward reliance on the national system. This, however, also comes with a number of 'micro' costs and dependencies, which accrue to substantial financial sustainability issues.

As in development projects, cost-reducing measures are often considered a way forward for post-project financial viability, but this is far from being without risk. This report documents, for example, how removing an LHW incentive for referral backfired and led to decreased utilization of services. In the case of training, Phase III actively engaged with the MOH to find solutions, but this led to decreased intensity of training efforts.

The opinion of informants was that a new project phase would be required to complete the process of transition to a national system, allowing to accelerate the health systems strengthening measures and transition steps. But the fragmentation between 'emergency' and 'development' financing, even within donor agencies, creates operational disincentives for building on the three previous phases to engage in a determined systems strengthening (i.e. more developmental) effort. Finally, the situation is made even more complex by a new influx of implementing agencies, also using small incentives and payments to mobilize the same human resources (LHWs) toward new goals. These are development assistance, national ownership, harmonization and alignment issues, which are not specific to emergency programs. Projects, again, may face problems, which are not entirely solvable at their level.

This report was not meant to be a summative statement about the achievements of successive projects, which were already evaluated based on their stated objectives. We have identified some major questions notably about the locus of strategic control for decisions that will affect future options for the health system and its partners, when national leadership is not fully operational. We will revisit these questions across the two countries of our embedded case study, and we hope that raising these questions will ultimately help improve how we collectively address health systems strengthening in our emergency efforts.

List of Documents Reviewed

The first set of documents for each phase was reviewed and coded with N.Vivo. A second set of documents was reviewed at a later date.

Phase I

1. Taussig. N. (2011). Strengthening Save the Children's Expertise in, Commitment to, and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Partnership Between The Susan Thompson Buffet Foundation and Save the Children.
2. Taussig. N. (2011). (*Project Grant Agreement*). The Susan Thompson Foundation. Save the Children.
3. Save the Children. (2011). Summary Budget Pakistan.
4. Save the Children. (2013). Pakistan Progress Report. (January – June).
5. Save the Children. (2013). Mid-Year Report – Response to Donor Feedback.
6. Hotel, M. et al. (2012). Pakistan Database for trainings under FP & PAC project.
7. Save the Children. (2012). Pakistan Program.
8. Ashraf, S. (2011). Family Planning and Post-abortion Care for IDPs and conflict-affected women in Haripur & Shikarpur, Pakistan. (*Health Facility Assessment Report*). Save the Children.
9. Save the Children. (2012). Pakistan Progress Report (July – December).
10. Save the Children. (2012). Pakistan Progress Report (June 2011 – July 2012).
11. Spilotros, N. (2012). Measuring Client Satisfaction of Family Planning Services. Save the Children.
12. The Development Strategies Pakistan. (2013). KAP Survey for Family Planning and Post Abortion Care (PAC) Program, Haripur and Shikarpur. Save the Children.

Additional reviews:

13. Save the Children. (2012). Program Summary – Pakistan Family Planning and PAC Proposal. Annex D.
14. Save the Children. (n.d.). Headquarter Training Matrix – Training Plans: (Headquarters, Democratic Republic of Congo and Pakistan). Annex E.
15. Save the Children. (2013). Pakistan Progress Report (January – June).
16. Yasmin, N. (2012). Field Visit Report Shikarpur
17. Taussig, N. (2012). Strengthening Save the Children's Expertise, Commitment to, and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Partnership Between the Susan Thompson Buffett Foundation and Save the Children. (*Semi-annual Progress Report*). Save the Children.

Phase II

18. Save the Children. (n.d.). Guidelines for Community Mobilization FP PAC Project.
19. Save the Children. (2014). Community Coverage and Mobilization Report No. 1.
20. Save the Children. (2012). Pakistan Work Plan.
21. Taussig, N. (2012). Save the Children's Expertise in, Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: A Request to Sustain Our Partnership with the Susan Thompson Buffett Foundation. Save the Children.
22. Save the Children. (n.d.). Roles and Responsibilities of Volunteers.

23. Save the Children. (2013). Pakistan Supportive Supervision Summary Report. (January – June)
24. Columbia University Heilbrunn Department of Population and Family Health. (2014). Columbia University Review Pakistan – Findings and Recommendations. Save the Children.
25. Columbia University Heilbrunn Department of Population and Family Health. (2014). Follow-Up to the Family Planning and Postabortion Care (FP/PAC) Program Review Results Workshop (1). Save the Children.
26. Save the Children. (2014). FP/PAC TOT Training. (*Training Report*).
27. Monitoring, Evaluation, Accountability & Learning (MEAL) Unit. (2014). Quarterly Review Report – MEAL Unit, Save the Children Pakistan Program.
28. Save the Children. (2015). Strengthening Save the Children's Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: Our Partnership with the Susan Thompson Buffett Foundation. (*Progress Report*).

Additional reviews:

29. Columbia University Heilbrunn Department of Population and Family Health. (2014). Follow-Up to the Family Planning and Postabortion Care (FP/PAC) Program Review Results Workshop (2). Save the Children.
30. Columbia University Mailman School of Public Health. (2014). Save the Children-Pakistan Family Planning Register Review Report. Save the Children.
31. Save the Children. (2015). M&E Indicators for FP/PAC Program (2013 – 2015).
32. Save the Children. (2014). Community Coverage and Mobilization Report.
33. Save the Children. (2014). Strengthening Save the Children's Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: Our Partnership with the Susan Thompson Buffett Foundation. (*Progress Report*).
34. Save the Children. (2013). Save the Children Headquarters Progress Report.
35. Save the Children. (2013). Save the Children: Pakistan Progress Report.
36. Taussig, N. (2013). Strengthening Save the Children's Commitment to and Delivery of Family Planning and Post-abortion Care to Women in Crises: Our Partnership with the Susan Thompson Buffett Foundation. (*Progress Report*). Save the Children.
37. Save the Children. (n.d.). Training.
38. Save the Children. (2014). Pakistan Progress Report.
39. Save the Children. (2015). Save the Children Pakistan Progress Report.

Phase III

40. Save the Children. (2017). Client Exit Interviews, Pakistan.
41. Save the Children. (2018). Pakistan Work Plan. (April 2016 – December 2018).
42. Save the Children. (2016). The Susan Thompson Buffett Foundation Budget Report (April – June).
43. Save the Children. (2017). Pakistan Work Plan, Save the Children. (January – June).
44. Save the Children. (2016). Pakistan FP/PAC Program Progress Report (January – June)
45. Save the Children. (2016). Client Validation Report.

46. Flinn, L. (2017). Institutionalizing Family Planning and Comprehensive Abortion Care in Save the Children's Humanitarian Health Responses. (*Summary Progress Report for the Susan Thompson Buffett Foundation*). Save the Children.
47. Save the Children. (2016). Annual Data Audit Report 2016.
48. Save the Children. (2017). Pakistan FP/PAC Program Progress Report (January – June 2017).
49. Save the Children. (2017). Family Planning & Postabortion Care in Emergencies in Pakistan.
50. Save the Children. (2017). Register Review, Pakistan.
51. Save the Children. (n.d.). Research Study on Family Planning and Post Abortion Care Project.

Additional reviews:

52. Save the Children. (2017). Pakistan Program Narrative Report.
53. Save the Children. (2016). Pakistan Work Plan, Save the Children (April – June).
54. Save the Children. (n.d.). Form A Pakistan Narrative Report.

Annexes

Annex 1 - List of Documents Reviewed

Darfur

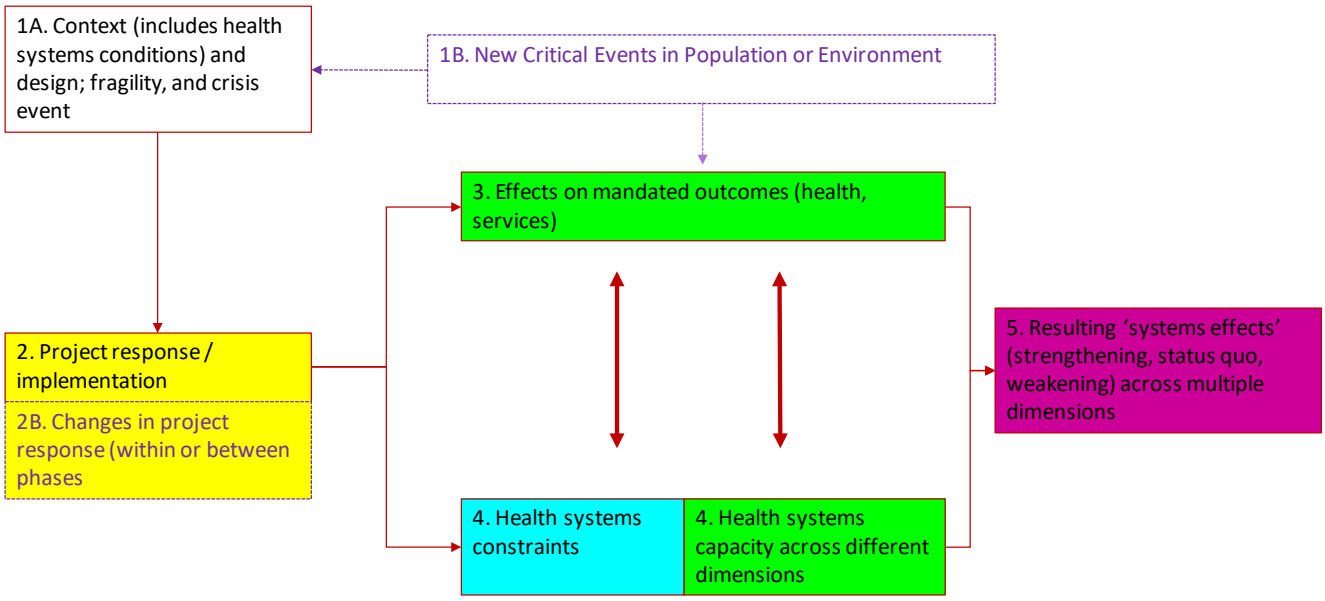
1. Bourns, D. (2015). Promoting Resilience among Communities in Darfur Environment (PRIDE) III. (*Proposal Summary*). Save the Children.
2. Bourns, D. (2015). Promoting Resilience among Communities in Darfur Environment (PRIDE) II. (*Final/Annual Report*). Save the Children.
3. Bourns, D. (2016). Promoting Resilience among Communities in Darfur Environment (PRIDE) III. (*Final/Annual Report*). Save the Children.
4. Bourns, D. (2016). Partnering to Respond to the Critical Needs of the New IDPs and Conflict Affected Populations (PRECAP) I (*Proposal Summary*). Save the Children.
5. Bourns, D. (2017). Partnering to Respond to the Critical Needs of the New IDPs and Conflict Affected Populations (PRECAP) II (*Proposal Summary*). Save the Children.
6. Khush, S. (2014). Promoting Resilience among Communities in Darfur Environment (PRIDE) I (*Final/Annual Report*). Save the Children.
7. Khush, S. (2014). Promoting Resilience among Communities in Darfur Environment (PRIDE) II (*Proposal Summary*). Save the Children.

Kordofan

8. Bourns, D. (2014). Greater Kordofan Lifesaving Intervention Package 3 (GKLIP III) (*Proposal Summary*). Save the Children.
9. Bourns, D. (2015). Greater Kordofan Lifesaving Intervention Package (GKLIP II) (*Final/Annual Report*). Save the Children.
10. Bourns, D. (2016). Greater Kordofan Lifesaving Intervention Package (GKLIP III) (*Final/Annual Report*). Save the Children.
11. Bourns, D. (2016). Partnering for Effective Emergency Response in Greater Kordofan (PEER I) (*Proposal Summary*). Save the Children.
12. Cardinal, L. (2017). Partnering for Effective Emergency Response in Greater Kordofan (PEER II) (*Proposal Summary*). Save the Children.
13. Khush, S. (2014). Greater Kordofan Lifesaving Intervention Package 2 (GKLIP II) (*Proposal Summary*). Save the Children.

Annex 2. Codebook for document review

Theory of Change



Legend

PROCESS

PDP (Project Design & Process): the project implemented by Save the Children and partners was trying to advance such things

OUTCOMES (POPULATION AND SERVICES)

CIS (Changes & Improvements in System): observed changes in the way the stakeholders of the health systems (MOH or partners) behave and perform

HEALTH SYSTEM CONSTRAINTS

HSC (Health System Constraints): health system factors that act as barriers to project implementation or factors that the project must overcome in order to achieve its intended effect

EXPLANATORY PROPOSITIONS

COUNTRY LEVEL (background data)

1) Project Information
   - Budget (total USD)
   - # of Years
   - Geographic reach (province and districts)
   - Beneficiaries reached (# of women and children)
   - Stakeholders and partners involved in the emergency
2) Health Outcomes

3) Cluster mechanisms and operations
4) New critical events in population or environment – events calendar
    - Natural or manmade disasters
    - Population migration

PROJECT LEVEL

1. Overall Achievements

- Health service use
    - Skilled Birth Attendance
    - Antenatal care
    - Postnatal care
    - Family Planning (contraception use)
    - Unmet need for family planning
    - Immunization indicators
- Outbreak and response indicators or information
    - Number of disease outbreaks that Save the Children was involved in responding to
    - Functional disease surveillance system
- ERMS
- Child Protection
- Health
- WASH
- Nutrition

2. Quality of Health Services

- **Improving quality of services to clients of EHN**

  Efforts made to improve service quality to EHN target beneficiaries.

  Changes in service quality.
- **Improved capacity for service delivery among the MOH and other national stakeholders (service readiness), and quality improvement processes**

  Efforts made to develop the capacity of the MOH and other national stakeholders to provide quality services and assess improvement

  Changes in the capacity of the MOH and other national stakeholder to deliver high quality services

- **Health system includes host population** (not just displaced) in improved services
- Services delivered by the health system are **responsive to community needs** and adapted to context
- **Health system innovations** for coverage of health services and preparedness for EHN needs
- Health system has the **capacity to contribute to large EPI campaigns and outbreak responses**.

3. Coordination and Policy Setting

- **Program operated with the MOH or as a parallel system**

  EHN project/program operated in partnership with the MOH or as a parallel system
- **Program was able to follow existing humanitarian policies**

  Documentation of humanitarian policies that were guided the implementation of the project

Documentation of humanitarian policies that hindered the implementation of the project

- **Evolution toward humanitarian and health policies** in support of essential interventions at the national or regional level
- **Signs of ownership and commitment** to the policy, manifested through different levels of the health system

4. Decentralization and Management Capacity

- **Project support to MOH district coordination, and capacity building for planning and management.**

  Capacity building efforts to support district coordination for planning a management.

  Changes in capacity for planning and management at the district level.
- **The project supports the management of human resources for EHN (supervision, performance management, non-financial motivation)**

  Capacity building efforts to increase supportive supervision and performance management in the health system.

  Improvements in the health system in terms of roles and responsibilities in supervision, performance management, and incentives/motivation for health workers (i.e., government health staff conducting supervision visits)

  Obstacles to providing adequate supervision and management.
- Decentralized MOH system uses processes for **program learning and management course correction** based on information
- Decentralized MOH system **limits or corrects displacement** of other essential routine services by emergency response

5. Engagement with Community Organizations & Societal Partnerships

- **Development of local partners – identification, engagement, incremental responsibilities and handover**

  Efforts made by project to establish partnerships with civil society organizations, local non-profits, and other community-based organizations.

  Partnerships for EHN established.
- **The project supports strategic SBC communication efforts**

  Efforts made to implement SBC activities
- **The project seeks to build SBC communication capacity with local actors**

  Efforts made to build capacity for SBCC

  Changes in capacity for SBCC implementation
- **The project seeks to increase the internal organization and capacity of communities to promote their own health, including in engaging with the health care system**

  Efforts made to develop community capacity.

  Changes in community capacity.
- MOH engages in **effective societal partnerships and with community organizations** to improve efficiency, and resilience of community systems and facility-based services
- Health systems stakeholders (MOH, non-health sectors, civil society, private sector) develop **stronger accountability mechanisms**
- The health system has mechanisms in place to **mobilize community volunteers** during emergencies (in addition to paid CHWs).
- There are signs of **increased trust and social capital** between community leaders/ organizations and the health system

6. Costing and Financing

- **Health system financing goes directly to EHN services, rather than through MOH or MOH accredited routine services**

  Internal or external funding applied directly to the implementation of EHN programs and services.
- **Project investments spill over to support other (non-emergency, routine) interventions**

  Internal or external funding intended for EHN services, but is applied to other non-emergency services.
- **Managing financial resources**

  Describes the entities responsible for managing health financing (i.e., Ministry of Finance), and the systemic factors pertaining to the distribution of financial resources for health.

  Project activities are directed at developing and strengthening the infrastructure to manage financial resources for EHN.

  Changes in management strategies for financial resources.

  Weak financial systems at the national or regional level or evidence of lack of engagement with finance.
- The national health system progressively **increases domestic funding for services**, seeks to reduce financial hardship on users, without displacement of resources from other essential public goods.

7. Human Resources

- **EHN interventions are expanding human resources for EHN (hiring, training) at facility level**

  The project builds the health workforce, including recruitment and trainings, and the growth and development of human resources at the health facility level.
- **EHN interventions are expanding human resources for EHN (hiring, training) at community level (CHWs)**

  The project builds the health workforce (e.g., CHWs), including recruitment and trainings, and the growth and development of human resources at the community level.
- **Financial compensations (salary or other) are provided to human resources for EHN interventions**

  The project invests in health worker compensation (salary, stipend, volunteers)

  Tensions between paid and unpaid health workers (or level of compensation among health workers) and any accompanying challenges.
- The health system is **expanding its human resources for health** through domestic resources, including through incorporation of CHWs
- The health system appropriately uses **task shifting** to ensure a more efficient use of staff time and skills

8. Supply Chain Management

- **EHN project implementing commodity supply management (distribution, stock monitoring, etc.)**

  Project addresses gaps in the procurement of commodities to ensure that incoming commodities can adequately supply the entire catchment area

Health system is obtaining essential commodities at the appropriate level (i.e., district health offices) to provide the health workforce with the proper tools for carrying out EHN activities; includes diagnostic equipment, drugs, etc.

Distribution of commodities at the national level (i.e., prioritization, equity, etc.), and availability of resources (or lack thereof).

- **Project is building skills and capacity for managing procurement and supply management**

  Project helps system for supply chain management move from dependency to long-term ownership by MOH and other key stakeholders.

  Improved skills and capacity to manage the distribution of supplies

  Bottlenecks in the health system and extrinsic factors that affect supply chain management activities
- There is **increased capacity and autonomy** of the health system to manage procurement and supply of commodities.

9. Monitoring and Evaluation

- **Collection of EHN related data is carried out through MOH or appropriate national stakeholders**

  Project builds the capacity of the MOH to collect EHN data.

  HMIS is too crowded with indicators and the MOH will not add additional EHN indictors.
- **Aggregation, processing, and analysis of EHN related data is carried out through MOH or appropriate national stakeholders**

  Project builds the capacity of the MOH (or other national stakeholder) to aggregate, process, and analyze EHN data.
- Appropriate **human resources are allocated to HMIS** in the health system to inform decision makers
- **Data systems and information have been strengthened** within the health system

Annex 3: Key Informant Interview Guide

Introduction [checklist of points to cover]

- Thank you for accepting to be interviewed as part of our case study.
- [As appropriate] Thank you for having provided comments on the draft report. The purpose of this interview is to explore some questions that have emerged from the country studies, about options and choices faced by Save the Children and/or donors.
- We intend to finalize the country report after all interviews have been completed, and integrate lessons from these interviews in the report
- Do you have any reservation being cited in the report?

  __ Yes

  _X_ No [in this case, we will acknowledge you as an informant but not cite you by name]
- This interview may be recorded, to allow me to double check my notes, although the recording will not be kept and we do not intend to produce a transcript.

[text in brackets is for the interviewer]

Question #1

Background: Coordination at the national and district levels can be difficult in protracted crisis situations. Governments can, at times, act as barriers to information and access to communities. Therefore, there is a need to work around the health system by working directly with communities and community organizations or working with other humanitarian response organizations to meet the immediate needs of vulnerable populations.

Question: **How did you work with the government? What contributed to your success in working with the government? What made it difficult to work with the government? What decision points did you encounter that caused you to seek alternative approaches to working directly with the DOH/MOH or other government agencies? What were the results?**

[Be ready to probe for relevant details.]

Question #2

Background: Evaluation limitations—Emergency responses must account for rapid delivery of life-saving interventions, in contexts where health systems are often underperforming. This comes with increased emphasis on output reporting, and limited time for more complex systems strengthening assessments. But we are talking more and more about 'transition', so...

Question: **How can EHN projects develop better systems for evaluating health outcomes and health systems strengthening interventions?**

Probe: Beyond projects, what role should there be for coordination or donor structures to build better evaluation platforms?

[Be ready to probe for relevant details.]

Question #3

Background: Parallel health systems are often built when responding to a humanitarian emergency to meet the immediate needs of vulnerable populations. For example, creating a system to ensure supply chain management to meet emergent health needs without building the capacity of the national health system to sustain the supply chain management system.

Question: **[In the case of Pakistan, would you call what SCI set up for supplies/commodities, and information systems a parallel systems?] If so, what do you think could be alternative strategies to parallel systems? Even in a protracted emergency, what could allow us to avoid parallel systems?**

[Be ready to probe for relevant details.]

Question #4

Background: Human resources are difficult to maintain during crisis situations, which can compromise the quality of care that is delivered. For example, if you invest time in building human resource capacity of government personnel or local health professionals, you risk losing this newly developed capacity due to staff turnover. On the other hand, if you build the internal capacity of SC to maintain high quality care, then you would compromise the sustainability of your response.

Question: **What did you decide to do when it came to the decision between building SCI internal capacity or focus on building the capacity of the government and local health professionals? What were the main factors that drove your decisions? What would you have done differently?**

[Be ready to probe for relevant details.]

Question #5

Background: In the midst of an emergency, most funding comes from external donors and it is difficult to ask a stretched national health system to support an emergency response in addition to meeting the existing needs.

Question: **How can you move toward financial sustainability when it comes to your emergency response? In what way did you try (and succeed) to share the burden of the costs of the response with national stakeholders, or at least prepare for financial 'transition'?**

[Be ready to probe for relevant details: like signals that it's possible to transition…]

Question #6

Background: The report seeks to describe major events and changes in the context of the country.

Question: **Where there other significant challenges/unintended consequences faced in the projects that were not mentioned in the reports? On the other hand, were there positive events or surprises**

that were not reported? How did the Save the Children handle those events, positive or negative, in your opinion?

[Be ready to probe for relevant details.]

Question #7

Background: Post-project periods are a time of adaptation by local and national stakeholders. This can be negative (loss of support), but this can also lead to a positive reaction.

Question: **What evidence have you seen after the end of the projects for local/national system actions (positive or negative), based on responding to the gap created by project closures?**

Conclusion

Thank you for your time.

Let me ask you again, now that we have discussed: Do you have any reservation being cited in the report?

Please do not hesitate to contact me (william-story@uiowa.edu) if you have any follow on comments or thoughts.

You can also contact Eric Sarriot at esarriot@savechildren.org.