NORWEGIAN MINISTRY OF FOREIGN AFFAIRS

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Final report for grants from the Norwegian Ministry of Foreign Affairs (MFA)

S81 – Final report form for project/programme support

The report should be sent by email to post@mfa.no with a copy to the responsible unit for the grant.

1. Project information

Name of the grant scheme	Responsible unit for the grant (unit in MFA or Embassy)	
Norway Pakistan Partnership Initiative (NPPI)		
Agreement title		
Norway Pakistan Partnership Initiative (NPPI)		
Agreement number	**Total grant from MFA (NOK)**	**Grant period (mm/yyyy – mm/yyyy)**
		2009-2014

2. About the grant recipient

2.1 Contact information

Name and abbreviation				
UNDP (Admin Agent for UNICEF,WHO & UNFPA)				
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Contact person		**Email**		**Telephone/mobile phone**
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3. About the project

3.1 Cooperating partner – any changes (if several changes in cooperating partners, use attachment)

Name		Contact person	
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3.2 Grant recipient's and cooperating partner's/partners' respective roles in the project

Grant recipient's experience with the cooperating partner(s)

The NPPI projcet objectives and results were directly aligned with the provincial MNCH Programme to improve access, coverage and healthy beahviours in marginalized districts of Sindh province. UNDP Pakistan, acted as an administrative agent for three UN agencies, namely, UNICEF, WHO and UNFPA to successfully implement the NPPI interventions. The UN collaborating agencies in this initiative, under the Delivering as One approach, implemented a range of interventions with their respective implementing partners in close coordination with the provincial and district health departments to improve MNCH services in Sindh. Most of the activities were achieved during the course of the project and are sustainable. The Government of Sindh plans to adapt some interventions through PC1 (District Health Information System) and the

Division of roles and description of what the grant recipient and cooperating partner(s), respectively, contributed to the project

Roles were defined with UNICEF, as convener and implementer, with WHO and UNFPA as the other major implementers while UNDP acted as the administrative agent.

All activities were implemented in accordance with the Sindh MNCH programme, ensuring coherence with the One UN Programme and national and provincial health priorities for achieving MDGs 4 and 5. Each UN agency undertook responsibility for a distinct set of interventions, based on their expertise, which, for the most part, were implemented in distinct geographic areas. UNDP was responsible for timely provision of funds to the cooperating agencies along with quality

3.3. Project implementation – experiences and results

Brief description of the project and main experiences from the implementation

The project intended to reduce maternal, newborn and under-five mortality in 10 underserved rural selected districts of Sindh province during the period 2009-2014. The aim of the project was to boost the efforts of the Government of Pakistan to meet MDGs 4&5. An end of project evaluation (EPE) report dated October 2014 inidcates that substantial progress was made in accordance with the road map and exit strategy during last year and a half of project life. Interventions such as Contracting out, Sick New Born Centers, community mobilization networks, Pre service Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and support to Community Midwives (CMWs) have contributed to improving MNCH in Sindh and have shown real potential for continuity through existing government programs. Innovative health financing interventions i.e contracting out and voucher scheme was highly relevant to the needs of underpreviliged communities of the selected districts however the envisaged budget was not insufficient for implementation in all 10 districts and as a result was carried out in four districts only. Community mobilization and behaviour change communication also played a role in mobilizing key stakeholders to work for betterment of maternal and child health. Establiment of community networks at the community level through volounteer setup empowered community mobilizers to promote key health messages and practices. Setting up center of excellence for newborn care also showed a decrease in infant mortality and morbidity. Pre-service intervention is one of the self sustaining activities whereby Medical Institutions and Public Health Sector Schools adapted national MNCH strategies as a part of teaching and examination system. Target health facilities now have at least one Health Care Provider (HCP) trained in IMNCI, Essential New-born Care (ENC), Pregnancy Child Birth and Postnatal care (PCPNC). Training of CMWs will continue even after the phase out of the project under regular budget of MNCH programme. This is perhaps the only way to provide skilled birth attendant services to poor women living in hard to reach areas, who are most vulnerable to maternal deaths. However, improvements in whole continuum of CMW production - from selection of students up to post-deployment clinical supervision and support are required. MNCH Programme and UNFPA have continued collaboration on this beyond NPPI. Despite all the issues and challenges faced by NPPI, several positive outcomes were achieved. One of the learnings was that demand side financing must have a very strong component of social mobilisation and awareness raising for communities alongside close monitoring and supervision for interventions like voucher programme to succeed. Learning lessons from Voucher Scheme, and to ensure due attention to FP programmme, which was amiss in NPPI, UNFPA with regular funding has intiated a voucher scheme for family planning including newly-wed counseling services in 11 districts across Sindh, Punjab and KP provinces giving due priorities to social mobilisation

Brief analyses of the project's results achievement, with reference to the tables in point 4.1 and 4.2. Describe briefly any deviations between the approved application and the actual implementation of the project, and which consequences these deviations may have had on the project's results.

The overview of the progress made against the interventions under NPPI (2009-2013) can be found as Annexure to this report in addition to Tables in point 4.1 & 4.2. The progress in the first two years was delayed, partly due fund managment issues (apperant procedural complexities which led to delays in transfer of funds from UNDP Headqaurters to respective implementing UN agencies) and floods in 2010-11. Activities and expenditures accelerated in 2012 but the project went through a major corrective restructing after the midterm review in 2013, when Royal Norwegian Embassy (RNE) decided to phase out the project and restrict activities after June 2014. Subsequently interventions not delivering the desired results or not yet initiated were dropped out, clear objectives were set for exit strategy in 2013-14 and road map was developed by UN partners which was endorsed by RNE and the Government of Sindh. A much stronger management structure was put in place by establishing a national coordination unit for NPPI.

Overall the interventions comprised of three broad categories.The first set—Sick Newborn Units, pre-service training, community midwifery training and deployment, establishment of skill labs equipment and health facility equipment provision—are seen as a natural, long term investment for improving Sindh's health sector.The second set of interventions tried to address health care financing for increasing access by the poorest and redressing the shortage of human resources for health in the public sector. These activities were more difficult to implement and evaluate. They also suffered especially from the decision to halt activities by June 2014. The Voucher Scheme, which had a very slow start, had begun to show an impact in changes in the poor's health seeking behaviors through facility use. The intervention may have produced fuller voucher redemption already distributed if the scheme had continued until the end of the project period. The 'Contracting Out' intervention demonstrated that facilities operating all day, seven days a week and providing services at a small markup cost can operate in difficult and remote areas, and can improve service utilization and health outcomes. Even the findings of the mid term review conducted in 2013 indicated that Contracting Out experience accomplished tangible improvement in the quality of services available. Coverage of MNCH services improved in the target districts and data from DHIS shows that utilization of MNCH services increased from January 2012 to December 2013. The focal family scheme is a potential complement to the Lady Health Worker programme by enhancing critical communication and mobilization activities that increase health seeking knowledge and behavior. It also demonstrated, successfully, a community approach to pooling resources for emergencies in birth preparedness. These schemes require additional financial support to go beyond demonstration activities before scale up. The provincical Department of Health is also receptive to these three health financing interventions.The third set of interventions, such as 'Contracting In', faced implementation delays and due to non-availability of specialized staff, it was hard to achieve the desired outcomes and is being phased out. Interventions such as DHIS strengthening, critical for improving health systems, require considerable capacity building for adequate coverage of

4. The project's results achievement

4.1 The project's goal hierarchy with results

Describe the results obtained based on the goal hierarchy in the application. It is required to report on the project's effect on the target group (outcome) and on the products/services delivered. The project's probable impact on society should also be indicated. The goal hierarchy with results may be provided in a separate attachment to the report. The results should be numbered in order to show the link between the levels (i.e. outcome 1, output 1.1, etc.)

DEVELOPMENT GOAL (INTENDED *IMPACT* ON SOCIETY)	Results (indicators if relevant)	Comments
To reduce maternal, newborn and under-five mortality in 10 selected districts in Sindh Province in Pakistan.	Initially MICS Sindh 2004 data was used for planning project baselines but as implementation started in 2009, Pakistan Demographic and Health Survey (PDHS) 2006-07 report became available. For the purpose of measuring impact PDHS is being used as base line and end line. According to PDHS 2012-13, the infant mortality rate for Sindh is 74 per 1,000 live births as compared to 81 in 2006-07 and the under five mortality rate is 93 per 1,000 live births against 97 in 2006-07, while the neonatal mortality rate remains stagnant during this period. Although a modest decline is visible but there is pronounced urban-rural disparity across all child mortality indicators for Sindh. Sindh's maternal mortality ratio, measured directly in 2006-07, was 314 per 100,000 and this indicator has not been measured in PDHS 2012-13. Antenatal care (ANC) coverage by health professional has shown an 8 per cent point increase from 70 to 78 in this period. While Sindh has the highest level of skilled birth attendance, stark urban and rural disparities exist, only 46.5 percent of births take place at a health facility in rural Sindh. Similarly an increase is observed in contraceptive prevalence rate but there is a huge urban-rural difference, 43 per cent and 17 per cent respectively.	Maternal mortality ratio was not measured in PDHS 2012-13. Table: Key indicators for Sindh

	Baseline (PDHS 2006-07)	Endline (PDHS 2012-13)
Impact indicators		
Under five Mortality Rate per 1,000 live births	97	93
Infant Mortality Rate per 1,000 live births	81	74
Neonatal Mortality Rate per 1,000 live births	53	54
Maternal Mortality Rate per 100,000 live births	314	Not measured
Outcome Indicators		
Antenatal care (ANC) coverage by health professional (in per cent)	70.4	78.2
Skilled Birth Attendance (in per cent)	44.4	60.5
Contraceptive prevalence rate (in per cent)	26.7	29.5

No.	PROJECT GOAL, EFFECT ON THE TARGET GROUP (INTENDED *OUTCOME)*	Indicators	Results	Comments
	Outcome 1: Increased coverage of quality MNCH/FP service	28 health facilities (HF) providing 24/7 MNCH services (Basic and Comprehensive EmONC) in 2 selected districts of Sindh (Larkana and Shaheed Benazirabad).	22 HFs providing 24/7 MNCH services (Basic and Comprehensive EmONC) were contracted out in 2 selected districts of Sindh (Larkana and Shaheed Benazirabad). For the remaining six HFs support for capacity building and supplies was provided.	These indicators were set for the phase out period 2013-14, after project mid term review exercise conducetd in 2013, and are different from the NPPI project document. For details of results achieved please see attached Detailed Activity Progress Report (annex 1).
		Three centres of excellence for sick newborn care established in districts Larkana, Shaheed Benazirabad and Jamshoro.	Completed.	The 3 centers have been fully taken up by the three teaching hospitals and marked reduction in new born mortality is being reported in these districts.

		SIX public sector Medical institutions have adapted national MNCH strategies in undergraduate teaching and examination systems.	Notifications have been issued by five medical institutions to adapt national MNCH strategies in undergraduate teaching and examination systems.	
		FIVE public health schools have adapted national MNCH strategies in pre-service interventions and are part of teaching and examinations systems.	Completed.	
		95 % of the target health facilities have at least one Health Care Providers (HCP) trained in IMNCI	Completed.	Cumulative coverage in target – eligible health facilities with at least one health care provider trained in the following: IMNCI: 96% ENC: 100% PCPNC: 100%
		100% of the target health facilities have at least one HCP trained in Essential Newborn Care (ENC)	Completed.	
		100 % of the target health facilities have at least one HCP trained in Pregnancy Child Birth and Postnatal care (PCPNC)	Completed	
		100 % of the three target health facilities (Liaquat University hospital Jamshoro, CMC Hospital, Larkano and PMC Hospital Nawab Shah)have at least one HCP trained in Emergency Triage Assessment and Treatment (ETAT)	Completed	
		Three centres of excellence established as a resource facility /training site for Continuing Medical Education for Health Care Providers at LUMHS, Jamshoro, SMBBMU, Larkano and PUMHSFW, Nawab Shah	Completed	

		Provide equipment (medical / general),medicine, supplies and minor maintenance to EmONC facilities in NPPI districts to target facilities	Completed for all three target districts Jamshoro, Larkana and Nawab Shah.	
		All district and Taluqa headquarter hospitals are fully operational and providing 24/7 Integrated MNCH/FP services in two NPPI districts.	Completed	
		Coverage of Family Planning services increased through strengthened capacities of service provisions, capacity building of service providers and demand creation and review of progress.	Completed	
		Technical assistance provided to MNCH programme for communication, and administration finance	Completed.	
		Supervision of NPPI operations by MNCH program ensured	Carried out in all 10 districts.	
		100 % of Health facilities with DHUIS code report to district DHIS cell on monthly basis	Carried out in all 10 districts.	
		10 management staff from NPPI districts trained in PHC management	Completed	

		Technical support and policy guidance provided to provincial & district level functionaries by placing District MNCH Officers, Provincial MnCAH Officer and their support systems to assist in implementing MNCH interventions	Completed	
		Third party monitoring for contracting out and voucher scheme done	Completed	
		Completion of operational research on low birth weight and maternal anaemia and dissemination of results	Completed	
	Outcome 2: Improved MNCH/FP self care and care-seeking behaviour among families and communities	Provincial capacity developed to carry out Sample Vital Registration with Verbal Autopsy (SAVVY) based on learning in district Jamshoro	Completed	
		Capacity of Community Midwives (CMW), both newly trained and already trained and continuing service in communities enhanced and deployed in communities focussing on underserved and hard to reach areas	Completed	
		Strengthened capacity of MNCH Provincial program provided with technical support for effective follow-up and evidence based programming, and for effectively coordination and programme management	Completed	

		Physical and laboratory capacities of Midwifery schools strengthened with supply of furniture, equipment, instruments and models to improve the quality of CMW training.	Completed	
		Symposiums, inter country visits	Completed	
		Access of poor and impoverished families to reproductive health care including family planning improved through demand side financing (Voucher) scheme and thereby removing financial barrier. Women who had already been distributed with 'Vouchers' by mid-June 2013, are provided with opportunity to redeem the vouchers and access the promised services (antenatal care, delivery care, post natal care, sick newborn care and family planning)	Completed	
		Community networks developed for MNCH and family planning in district Umerkot	Completed	
		Knowledge , attitudes and practices study conducted and report disseminated	Completed	
		Project Management unit at Karachi (NPPI Officer, Programme assistant and Communication specialist)	Completed	
		International Project Manager appointed for the phase out period	Completed	
		Report of final evaluation disseminated	Completed	

No.	PRODUCTS AND SERVICES (PLANNED *OUTPUTS)*	Results (indicators if relevant)	Comments
	Output 1.1 Integrated MNCH/FP care made available through contracting out services (incl. public private partnerships) Output 1.2 Improved governance and results based management Output 1.3 Operational research conducted to produce knowledge and improve future decision making related to increasing MNCH/FP coverage and self care	Detailed assessment of results achieved against each output is available in the End of Project Evaluation Report (annex 2).	
	Output 2.1 Strengthened community based & Outreach MNCH/FP Care services Output 2.2 Voucher/incentive schemes implemented to increase demand and service utilization Output 2.3 Community networks for MNCH/FP advocacy and mobilization established & Behaviour change communication and awareness raising programme implemented		

4.2 The project's implementation plan with status

Based on the approved implementation plan, indicate actual (start- and) end dates. Deviations from the approved plan should be explained in the comments field. (For previous reporting periods covered in progress reports, reporting on output-level is sufficient.) The implementation plan with status may be provided in a separate attachment to the report.

No.	RESULTS (OUTPUTS) ACTIVITIES	Responsible party	Planned start date	Planned end date	Actual start date	Actual end date	Comments
1.1.1	**Contracting Out** 22 Public Sector HFs, contracted to a local NGO, were made functional 24/7 for the the provision of MNCH/FP services including comprehensive and Basict emergency Obstetric services in 2 target districts.	UNICEF	2010	2012	Nov 2011	May 2014	The 22 HFs were made functional through provision of HR, medicines and equipment. In addition capacity building of HR, renovation and repair of infrastructure and establishment og functional referral system was also carried out. To create demand a comprehensive communication strategy was also implemented. Performance based contracts were negotiated i.e. on achieving quarterly based benchmarks, validated by third party monitoring, payments were released.
1.1.1	Capacity Building. About 400 Health care providers in 10 target districts were trained on Infant and Young Child Feeding Practices (IYCF), Emergency Obstetric Care and Infection prevention. In addition in 2 target districts of contracting out IMNCI and Essential New Born Care trainings were also conducted.	UNICEF	2009	2010	2009	2010	- 200 HCPs trained on IYCF in all 10 districts and implementing IYCF practices - 140 Health Care Providers in 3 target districts were trained and are implementing IP practices for the provision of MNCH services - Plan developed for remaining districts for implementation in 2010 & 2011 - 5 masters trainers trained at PIMS, Islamabad - 20 district based trainers trained and are disseminating ENC training to Community Mid Wives (CMWs) in respective districts - ENC module translated in Urdu
1.1.3	3 center of Excellence for Sick new Born Care were established in 3 teaching hospitals to reduce high rate of new born mortality even when they reach hospitals. These centers were upgraded by provision of equipment, short term HR support and capacity building. These centers are also used as resource centers to train HR of peripheral HFs and next districts.	UNICEF	2009	2014	October 2013	June 2014	These centres have been handed over to Government and are running successfully. Early results show significant reduction in new born mortality (from 40% to 21% in CMC Hospital Larkana)
1.1.4	SIX public sector Medical institutions have adapted national MNCH strategies in undergraduate teaching and examination systems.	WHO				March 2014	Pre-service will be an ongoing regular function/activity of all partner institutes and will continue after NPPI
1.1.5	FIVE public health schools have adapted national	WHO				March 2014	

	MNCH strategies in pre-service interventions and are part of teaching and examinations systems.						
1.1.6 1.1.7 1.1.8 1.1.9	**Scale up in service training** 95 % of the target health facilities have at least one Health Care Providers (HCP) trained in Integrated Management of Neonatal and Childhood Illness (IMNCI), 100% of the target health facilities have at least one HCP trained in Essential New-born Care (ENC) 100% of the target health facilities have at least one HCP trained in Pregnancy Child Birth and Postnatal care (PCPNC) 100 % of the three target health facilities (Liaquat University hospital Jamshoro, CMC Hospital, Larkano and PMC Hospital Nawab Shah) have at least one HCP trained in Emergency Triage Assessment and Treatment (ETAT)	WHO				June 2014	Cumulative coverage in target/eligible health facilities with at least one health care provider trained is- IMNCI : 96% ENC: 100% PCPNC: 100%
1.1.10	Three centres of excellence established as a resource facility /training site for Continuing Medical Education for Health Care Providers at LUMHS, Jamshoro, SMBBMU, Larkano and PUMHSFW, Nawab Shah were supported by establishing skills lab and seminar rooms along with provision of teaching aids and equipment.	WHO				March 2014	
1.1.11	Equipment (medical / general), medicine and supplies were provided to EmONC facilities in NPPI districts to target PHC facilities. Minor maintenance was also supported.	WHO				February 2014	
1.1.12	**Contracting In** All district and Taluqa headquarter hospitals are fully operational and providing 24/7 Integrated MNCH/FP services in two NPPI districts	WHO				June 2014	Due to unanticipated delays in finalization of activity and non-availability of specialized staff, implementation of this intervention was delayed.
1.1.13 1.1.14	Coverage of Family Planning services increased through strengthened capacities of service provisions, capacity building of service providers and demand creation.	UNFPA	November 2013	December 2013	May 2014	June 2014	68 Women Medical Officers and Lady Health Visitors from 10 NPPI districts trained on family planning counselling and methods for female care providers. Because of the delay caused in fund-flow to Population Welfare Department due to audit issues, and that USAID/MCHIP came forward to fund the same training to all service providers under PPHI, the target of 200 was reduced.
1.2.1	Technical assistance provided to MNCH programme for communication, and administration finance	UNICEF	-	-	May 2012	Dec 2013	Communication work plan developed and orientation organized for district focal persons. HR support was discontinued in Jan 2014 after technical staff placed in Sindh MNCH programme resigned.
1.2.2	Support provided for monitoring and supervision to MNCH program Sindh. Supervision of NPPI operations by MNCH program ensured	WHO				June 2014	- Support has been provided to implementation of District Health Information Systems (DHIS) in the 10 target districts. - Support has been provided to implementation of District Health Information Systems (DHIS) in the 10 target districts. - District level trainings have been initiated and 270 participants trained in 7 out of 10 districts. - 26 District trainers have been trained from 10 districts. - 7 out of 10 District Officers are in place to support DHMTS and UN partners in implementation, monitoring and supervision.

							- Support has been provided to provincial and district level offices (Laptops, furniture, telephone, fax, vehicle etc.).
1.2.3	**Support to M&E activities through strengthening DHIS** 100 % of Health facilities with DHUIS code report to district DHIS cell on monthly basis	WHO			October 2011	December 2013	Activity will be continued and supported by government counterpart, DHIS cell Sindh
1.2.4	**Strengthening Management** 10 management staff from NPPI districts trained in PHC management	WHO				December 2013	
1.2.5	**Provide technical support to provincial/district level** Technical support and policy guidance provided to provincial & district level functionaries by placing District MNCH Officers, Provincial MnCAH Officer and their support systems to assist in implementing MNCH interventions	WHO				August 2014	- 26 District trainers have been trained from 10 districts.
1.3.1	**Third Party Monitoring** Third party monitoring(TPM) for Contracting out HFs and Vouchers Scheme.. TPM report on quarterly basis against set benchmarks were the basis of release of payments. (Linked to out put 1.3)	UNICEF/UNFPA	2010	2012	Nov 2011	May 2014	Oxford Policy Management acted as Third Party Monitors. The model was presented to the Sindh government as good practice to up-scale.
1.3.2	**Operational Research** Operational Research on Reduction of Low Birth Weight and Maternal Anemia. An evidence based intervention of replacing Iron Folic acid with multiple micro nutrients and giving deworming tablets in pregnancy was piloted through an Operational research in local context.(linked to 1.3 out put)	UNICEF	-	-	May 2013	Dec 2014	Findings of the research and an up- scale strategy has been shared with the provincial government. A policy level decision is required for strategic shift from Iron Folate to multiple micro nutrient.
1.3.5	**SAVVY** Provincial capacity developed to carry out Sample Vital Registration with Verbal Autopsy (SAVVY) based on learning in district Jamshoro	WHO				September 2013	Incomplete/Deferred- This activity has been dropped after official communication with the donor due to challenges in recruitment of an international consultant in the present security situation in Sindh. This technical expertise is not available in Pakistan.
2.1.1	Capacity of Community Midwives (CMW), both newly trained and already trained and continuing service in communities enhanced and deployed in communities focussing on underserved and hard to reach areas	UNFPA	January 2014	March 2014	January 2014	May 2014	42 CMWs trained. In addition to clinical skill enhancement, CMWs were also oriented on prevention and response of gender-based violence. A total of 190 newly graduated CMWs were deployed in 10 NPPI districts with provision of CMW kits/ equipment.Technical support to MNCH was provided though supporting a Procurement Manger post, and a CMW Associate.
2.1.2	Physical and laboratory capacities of Midwifery schools strengthened with the supply of furniture, equipment, instruments and models to improve the quality of CMW training	UNFPA	June 2013	January 2014	November 2013	June 2014	10 CMW schools in project districts were provided with all furniture and equipment items as identified through needs assessment.
2.1	**Advocacy** Symposiums, inter country visits	WHO				October 2014	Inter country visits could not be arranged. Last symposium was held in October 2014.

2.2.1	Thousands of poor and impoverished families especially women accessed reproductive health care services including family planning through demand side financing (Voucher) scheme and thereby removing financial barrier. Women who had already been distributed with 'Vouchers' by mid-June 2013, are provided with opportunity to redeem the vouchers and access the promised services (antenatal care, delivery care, post natal care, sick new-born care and family planning)	UNFPA	June 2013	March 2014	June 2013	April 2014	Total number of vouchers redeemed by type is as follows: ANC1-4: 100,520 women NVD: 17,203 women C/Section: 2,614 women PNC: 15,124 Sick Newborn : 6,402 Family Planning : 10,055
2.3.1	Community based promotion of Primary health care is carried out thorough government run LHWs program but the average coverage is 45 per cent in Sindh . To promote the Primary Health care in LHW uncovered areas a concept of Focal Families was implemented in Umerkot district for deliver the same package as of LHWs(linked to out put 2.3)	UNICEF	-	-	April 2012	March 2014	Focal family data shared with LHW programme. Best practices are being replicated in other UNICEF health projects supported by other donors. This intervention has been well appreciated by government and is under discussion to up-scale in new PC-1.
2.3.2	Knowledge, Attitude and Practices (KAP) study conducted and report disseminated (annex 3)	UNICEF	March 2012	31st March 2013	March 2012	31st March 2013	Completed; Baseline KAP study report disseminated to all relevant stakeholders. The contract was earlier planned for two years and signed between UNICEF, UNFPA and AC Neilsen. However, due to change in the project activities and mechanism, the endline assessment planned in March 2014 was dropped.

5. The project's sustainability and risk factors

5.1 The project's sustainability

Brief description of the expected sustainability of the achieved results (cf. the table in point 4.1)

There is a huge opportunity for scaling up NPPI interventions, as they are so closely aligned with the Government of Sindh's objectives for reducing maternal and infant mortality and raising contraceptive prevalence in a short period of time. Negotiations were held with provincial government countreparts to make financial provisions for the additional proportion of human resource and related expenses for maintaining facilities such as the Sick New Born Units and in-service training and Contracting out HFs. After the project ends, the HR provision will be ensured by Sindh MNCH program with government funding. Pre-Service Training intervention is a self-sustaining and cost effective activity. Manuals and log books will be purchased by students in the future as routine. Human resource, once developed, remain a developed and sustainable resource for the future.Capacity building for human resources for health and health asset support are from public sector, although NPPI has filled essential/critical gaps and provided technical support as catalyst to strengthen the existing system.The equipment provided for EmONC services, will be utilized by health facilities. Renovation and up-gradation of secondary health facilities under Contracting In support, will be the part of health system. NPPI had successfully trained district staff in both the software and hardware approaches of DHIS. Dashboard online system is in place that would help in the storing, management and retrieval of MNCH related data under key performance indicators. Government of Sindh has approved PC-1 of DHIS as part of budget 2013-14 and will take over responsibilities of human resource development, supply of DHIS tools and district MIS cells as part of the regular public sector activities. While, government system has already internalised some components of the intervention, many of the good results produced by the project are being carried forward through various other sources. Some of the examples are hereunder.

5.2 Risk management

Brief description of the risk factors identified before and during project implementation, including financial irregularities, og how these were handled.

The changing political context, governance issues, and reluctance of provincial government to engage private actors and or civil society organisations in service delivery resulted in potential delays in decision making related to major innovations within the project. Strong advocacy was done at policy level and descion makers were engaged to over come the issue.
The project emphasises transparent decision making processes while engaging and developing capacity of the government to take stewardship role. This demands longer term engagement for each of the processes, thus delaying actions on the ground.
The reach of government's health programmes into the community is limited to Lady Health Worker (LHW) covered areas and the LHW programme was reluctant to go beyond these areas to establish community networks. Local NGOs were engaged for interventions such as Contracting out and Vouchers Scheme for areas not covered by LHW programme.
Application of UN procedures for NPPI project implementation, as agreed in the project document, ensured transparency in major procurement and hiring decisions taken for the project but did not significantlyinfluence the prevailing government practices for other health sector related processes. All the supplies under the project were procured by the UN system and were handed over to Government. All the three UN agencies involved in the project have their respective operational modalities, protocols and procurement procedures which caused some delay initially.
Private parties and civil society organizations were able to negotiate and leverage government actors' support and contribution to the projct at district level through a transparent performance-based incentive mechanism.
Third party monitoring allowed financial payments to be made to partners upon satisafctory completion of activities.

5.3 Follow-up of the project

Brief description of the follow-up of the project, if relevant

While most of the activities under NPPI have been successfully handed over to the provincial government, good practices need strong advocacy for scale up where policy level decisions are required. Activities like Operation Reserach on Low Birth Weight and Maternal Anemia and Pilot activitity of Focal Famlies in LHWs uncovered areas need policy level desicions. At the same time, other develoment partners have already picked up few ideas originally initiated under NPPI project for replication. It is necessary to continue advocating with the govenrment for policy and programme decisions to scale up those activities which showed results and without which provision of and access to quality MNCH/FP services is not ascertained such as Contracting Out and Voucher Scheme for poor and vulnerable communities.

5.4 Gender equality, environment and climate change

Brief description of the project's effects on gender equality, the environment and climate change. (If relevant, describe briefly how the intentions of the UN Security Council resolution 1325 on women and peace and security were taken into account.)

Gender aspect was specifically taken into consideration while planning and implementing all NPPI interventions. It has been well known that lack of access to financial resources is a key contributor to low utilization of health services by women.The project helped reduce this constraint by implementing interventions like Voucher scheme/Contracting out. Getting views of beneficiaries was part of the Pay-for-Performance assessment of the parties involved in services delivery under both initiatives. The proposal assessment used gender constitution of management and staffing as one of the proposal rating criterias. The deployment of community midwives, female service providers and support to LHWs has helped in reaching out to women in hard to reach communities and help overcome socio cultural barriers. HR placement in remeote areas and upgradation of HCF in peripheries are one of the positive contribution to working enviroment and empowerment especially for female HCP

6. Financial overview

The detailed financial report must be provided in a separate attachment. The financial report should include project accounts with related explanations, and must be presented according to the same structure and elements as in the approved, detailed budget. The financial report must be confirmed by the person being responsible for financial matters in the grant recipient's organisation.

Tick if amounts are given in 1000s ☐ Currency: USD

	(1)	(2)	(3)	(3) in %	(4)	(5)
	Approved total budget	Total charged as expenses	Variance (2) – (1)	Variance between (1) and (2) in %	Approved budget for the last period	Total charged as expenses for last period
	(2009- 2014)	As of 31/12/14			Jan - Dec 2014	Jan - Dec 2014
Project expenses – grant recipient Costs directly related to the implementation of the project	7,015,336.82	5,604,392.19	-4,888,228.5	-70		1,827,268.96
Project expenses – cooperating partner(s) Costs directly related to the implementation of the project	13,583,157.42	14,715,322.18	-1,358,530.5	-10		2,949,650.13
Overheads The organisation's *indirect* administrative costs related to the implementation of the project	2,175,241.20	1,751,019.36	699,793.46	67		238,167.83
Total expenses	**22,773,734.44**	**22,070,733.73**	**-5,546,965.6**			**5,015,086.92**
- Applicant's own financial contribution and contributions from other sources (mark the amounts with minus signs)	0	0	0	0	0	0
= Grant from MFA	**22,721,510**	**22,070,733/-**	**650,776**			**5,015,086.92**

Disbursed from MFA	22,721,510/-
Disbursement request for final payment (if relevant)	

Comment

Unused funds, reimbursement to MFA	0

Comment

Unspent funds of $ 650,776 will be refund to MFA or will be re-programmed.

Final status of grants from other sources

7. Additional information

Any other information of relevance for the report

Note: This report contains data as of refresh date 19.01.2015 and is provisional. Official expenditures figures are provided by UNICEF HQ in the Donor Financial Statement.

8. Attachments

Tick the boxes below if attached, and give each attachment a number. Any other attachment should also be listed.

Attached	Number	Attachment
☐	UNDP(AA) to provide	**Detailed financial report (mandatory)**
☐		Additional cooperating partners (only when changes)
☐		Protocols for procurements or disposals effectuated during the reporting period (if relevant)
☐		Goal hierarchy with results
☐		Implementation plan with status
☐		
☐		
☐		
☐		

9. Date and confirmation

I am authorised to sign legally binding agreements on behalf of the grant recipient, and confirm that the information contained in this report is correct to the best of my knowledge.

Place and date	Name and signature
31st July 2015	Sara Ansari