PAKISTAN POVERTY ALLEVIATION FUND

IN-DEPTH ASSESSMENT OF EDUCATION, HEALTH & NUTRITION (EHN) COMPONENT

PPR EHN STRATEGIC ASSESSMENT REPORT

March 20, 2019

NEC Consultants Private Limited

CONTENTS

LIST OF ANNEXURES

LIST OF TABLES

ACRONYMS

AICS	Italian Agency for Development Cooperation
AKRSP	Agha Khan Rural Support Program
ANC	Antenatal Care
BHU	Basic Health Unit
BRSP	Baluchistan Rural Support Program
BOQs	Bill of Quantities
CD	Civil Dispensary
CGP	Community Growth Promoter
CHC	Community Health Center
Cos	Community Organizations
CPI	Community Physical Infrastructure
CRM	Complaint Response Mechanism
CRP	Community Resource Person
DEWS	Disease Early Warning System
DGCS	Directorate General for Development Cooperation
DHO	District Health Officer
DoH	Department of Health
DTA	Disease Trend Analysis
EHN	Education Health & Nutrition
EPS	Environmental Protection Society
FATA	Federally Administered Tribal Areas
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GR	General register
GoI	Government of Italy
HMC	Health Management Committee
HTSP	Health Timing and spacing of Pregnancy
IDIs	In-depth Interviews

IEC	Information, Education and Communication
IR	Inception Report
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude and Practice
KII	Key Informant Interview
KPK	Khyber-Pakhtunkhwa
LEP	Livelihood Enhancement & Protection Program
LSOs	Local Support Organizations
MER	Monitoring, Evaluation & Research
M&E	Monitoring & Evaluation
MEAL	Monitoring, Evaluation, Accountability & Learnings
MNCH	Maternal Neonatal Child Health
NGOs	Non-Government Organizations
NRSP	National Rural Support Program
O&M	Operation & Maintenance
PNC	Postnatal Care
PO	Partner Organization
PPAF	Pakistan Poverty Alleviation Fund
PPR	Programme for Poverty Reduction
RH	Reproductive Health
RHC	Rural Health Center
SMCs	School Management Committees
SRSP	Sarhad Rural Support Program
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
ToRs	Terms of References
UC	Union Council
VOs	Village Organizations

EXECUTIVE SUMMARY

Program for Poverty Reduction (PPR) is a three-year program financed by the Government of Italy (GoI) through the Directorate General for Development Cooperation (DGCS) and the Italian Agency for Development Cooperation/AICS. The program focuses on contributing to reducing poverty in selected districts of Balochistan, Khyber Pakhtunkhwa and Federally Administered Tribal Area. The program areas are amongst the most vulnerable and underserved areas of the country, suffering from extreme poverty and facing severe security issues. The total Italian financial contribution is EUR 40 million, through a soft-loan framework agreement.

PPAF hired the consultancy services of NEC Consultants Private Limited (NEC) for undertaking the strategic assessment of PPR. This report pertains to the strategic assessment of PPR EHN Component.

PPR is being implemented in 14 districts of KPK, Balochistan and FATA. Considering the geographical spread of the project area, security constraint, and the scope of assignment, NEC team visited a representative number of interventions in the selected districts: Bajaur, Swat and Chitral (KP) and Gwadar and Pishin (Balochistan). The assessment followed standard criteria of "The Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC)".

The assessment methodology chiefly comprised of literature review, key informant interviews with PPAF, PO and other stakeholders, and focused group discussions with the community. The assessment is a validation of the reported results through qualitative methods thus these may not present a statistically valid picture of findings. Field team did their utmost to extract accurate information however possibility of some bias cannot be ruled out of qualitative information collected.

The POs were found to have good reputation at community level and government line departments. The POs had existing knowledge of the needs and operational context that was leveraged very well to appraise the needs of the target area. The service delivery responded to the most acute needs. The government functionaries praised the interventions as timely and complementing their efforts.

Participants in all H&N FGDs were found well aware of the interventions. However, few HMC members need more clarity about the roles and responsibilities of HMC and its management process. The community members acknowledged service through projects as very gender sensitive and responsive towards the local customs.

One of the areas where CRPs got maximum value added through the trainings was their effective outreach to community females to mobilize them to avail ANC, PNC, RH, FP and awareness services. Some follow-up mechanism could be made part of capacity building component of future interventions to ensure and record the efficacy of trainings.

Regarding developing and enabling health facilities as social enterprises, there were some good examples of basic primary health care services in the form community health centers (CHC) which has a greater utilization in early identification of the medical cases, and increased spatial and temporal coverage within the communities. The sustainability plan of these CHC could have been improved and made uniform across all POs. In future programming such

CHCs can be initiated with seed funds from donors which could then be replicated through public/private partnership.

Community women found ANC, PNC as helpful in terms of accessibility and savings. Mothers termed immunization services as regular and of quality. This corroborates well with project team report that 100% of the children who visited the health facilities were immunized. The Micronutrients and supplements provided during the routine ANC services helped to address the issue of anemia to a large extent. Male counterparts were of the view that there were unaddressed needs in the far off areas where the programme teams could not reach. However, health facility staff opined that community members suspect that mobilization for the ANC and PNC services were aimed to bring community women towards family planning and healthy birth spacing.

PPR's in-built approach of improving community resilience and coping capacity for greater effectiveness and sustainability in the implementation was the key of its successful and effective programming. The capacity building activities helped in sustaining different assistance provided. The Interventions were done in a smaller catchment area of 1-2 Health facilities per PO. Coordination with the communities was capitalized on the existing community structures of the UC and village development committees. This avoided duplication and maximized the impact. The coordination with the District health authorities was also working.

The nutrition component could be made more effective through building partnerships with, and providing information about, other nutrition partners and where to refer or track already referred cases for the IYCF, for treatment of malnourished cases in outpatient care and into the specialized Nutrition stabilization centers for treatment of Nutrition related complications.

A formal Complaint & Feedback mechanism was not part of the implementation methodology for PPR. However, the same could be included for future interventions.

A strong project level M&E system was in place to support projects' implementation, monitoring reports are indicative that monitoring was jointly conducted by the MEAL team, technical health staff and other key stakeholder that included district/agency health department and local health staff.

Health & Nutrition – Conclusions:

The H&N Assessment further concludes that:

- The foremost general conclusion is regarding the fund flows. A number of interviewees pointed out that the fund flows remained rather irregular at times. As per PPAF representatives, this was due to non-issuance of funds in a timely manner from the donor side. PPAF tried to counter this challenge by utilizing its own resources to bridge the gap, however, even this practice was discontinued later. Overall, this resulted in distorted execution of the project activities, with extreme peaks and leans in the workload of PO staff, leading to both qualitative and quantitative challenges.
- Findings indicate that wives and husbands are more frequently discussing RH, FP and STDs now. This indicates that the project has also been able to indirectly improve health and nutrition related behavior, besides its direct benefits.
- The focus on Nutrition counseling, screening, referral, micronutrient supplementation etc. were seen as a lower priority or a lower understanding at the health facility levels. It is understood that nutrition component was taken as a pilot under the programme, and it can be improved in the next phase (if any).

- Most of health staff found training a refresher of their existing skills.
- .
- Health & Nutrition staff lack orientation on management information system ((MIS). PPR program has MIS system, monthly OPD reported on BHU and CHC for ensuring overall access of the local population to these facilities.
- The health facility staff requires training on Healthy Timing and spacing of pregnancy.
- The community mobilization teams are not fully trained on diet diversity and proper caloric intake during pregnancy and importance of breastfeeding and complimentary feeding for children.
- Issues related to personal hygiene and specific health & nutrition needs of adolescent girls are not addressed according to the standards.
- The community outreach health workers do not have sufficient knowledge on topics related to oral rehydration therapy and integrated management of neonatal and childhood illnesses
- The social enterprise development model seems to be more sustainable. Communities in areas such as Swat are contributing to the medicines. Fee is being charged in areas such as Swat, Lasbela etc.
- Due to the unknown lengths of contracts and extensions, it was observed that the sustainability measures could not be planned on time. There were extensive support in kind and in terms of capacity building provided to the health staff and the health committees by the PPR programme but less was known about sustainability, ownership and scale up of these interventions in the post PPR scenario.
- Project health ANC, PNC and Primary Health Care services were strongly appreciated by different community group as addressing their critical needs in the most suitable manner.
- It was generally observed that the staff was clear about their interventions and the sustainability plan was dependent on the length of their contracts and interventions given in the No cost extensions.
- Project document did not capture a detailed analysis of the problem especially the contextual factor those feed into problem.
- Under the programme, IEC material with consultation of DoH for water, foodborne and communicable disease were provided to the CRPs and health facilities as part of communication strategy. However, during field visits, no proper IEC material is available on topics related to communicable diseases i.e. (Pneumonia, Scabies, Tuberculosis, Typhoid etc.) and vector and water borne diseases.
- Communities are not familiar with the any complaint and feedback mechanism in the programme areas.
- Though the programme remained relevant in terms of menu of services offered and area selection, community members especially women in few areas (SWAT and Bajaur) showed reservation over site selection for CHC and mentioned that they are encountering access issues.
- It is not conclusive to say if need was more acute in inaccessible areas. The programme used the approach of first selecting the target geographical area, and then determining health related needs of that area. Arguably, it could be done inversely as well, leading to the needs becoming the driving factor rather than the geographical area.
- The referral mechanism from the village committees to the health facilities seemed to be functional and good binding was observed between the village leaders and the health committee members and the hospital staff.
- There was no mechanism in place to know if trained staff was making use of the training they received and whether trainings improved their work. There was not mechanism at the institutional level to monitor these trainings

Health & Nutrition – Recommendations:

The consultants recommend that:

- Timely availability of funds is essential. Any delays, specially after the field team has been mobilized, compromises the efficiency and effectiveness of the implementation strategy. It is recommended that in future, PPAF legal department should ensure that sufficient provisions are made in the legal instruments (i.e. agreement between donor and PPAF, and agreement between PPAF and PO) to essentially guarantee smooth fund flows. Furthermore, PPAF finance department should also develop modalities, similar to the bridge-financing mentioned above, that could be employed in case of any inadvertent delays in the receipt of funds from the donors.
- PPAF should strictly adhere to its standardized format to report monitoring findings to help ensure activities are monitored and reported in a consistent manner - A consistent format helps in better tracking and reporting System.
- There is need to refer to the knowledge development documents and the KAP surveys conducted by the POs and these findings are to be triangulated with the current strategic assessment and other programme evaluation and PPR strategies.
- Onwards specialized referrals to the secondary and tertiary care hospitals for specialized medical needs and for Nutrition treatment need improvement.
- There could be better planning for the training to ensure these add a substantive value to the existing knowledge and skills to improve the practices. Tracking of training learning can be improved through collaborative action with the government line agencies.
- A consistent approach to project's context analysis is important as it proposes more viable and consistent solutions to draw optimal capacity of organization's function.
- PPAF should have a Complaint and Feedback Mechanism that can be installed quickly made operational in case an emergency. In any emergency response complaint and feedback mechanism are very crucial. Utilization of information pack for the complaint and response mechanism to be embedded in community outreach approaches.
- There should a standardized approach to record beneficiaries data especially data related to different disaggregation markers and vulnerabilities.
- Emphasis is to be made on developing social enterprise in order to implement PPAF's strategy in letter and spirit and ensure sustainability of activities beyond project life.
- Since *"Assistance to resource persons (financial & technical"* is one of the mandatory component of PPR programing; PPAF needs to include indictors (outcome level) under health & nutrition logical framework matrix.
- Though the improvement in understanding of community and increased safe practices is a reflection of improved capacity of trained staff, it will be beneficial to include few parameters in the monitoring system (e.g. increase in the number of PLW to access ANC and PNC services, increase in the number of children fully immunized against vaccine-preventable diseases, decrease in the incidence of diarrhea, pneumonia, and malaria in children under age of five etc.) to capture and quantify this impact.

- The MIS system could be further strengthened if H&N staff could be provided orientation and refreshers
- Strong coordination is to be put in place with district immunization teams to enhance proportion of children fully immunized against vaccine preventable diseases.

Alongside H&N component, the Education component of PPR was also assessed. The assessment finds that the project objective and outputs were achieved through a Community Driven Development approach. Key features of the approach included:

- Social Mobilization
- Linkages and Engagement with Stakeholders
- Development of income generating plan for sustainability of past investments
- Public Private Partnerships
- Formation /Activation of Education groups
- Investment in physical and social infrastructure
- Sustainability of the Community/Enterprise Schools

Primarily, it is the responsibility of the federal as well as provincial governments to provide free primary education to every child in the country. However, failure of these governments in fulfilling their responsibilities, under the programme PPAF has worked with other non-government organizations to enroll out-of-school children and provide them quality education.

The Education component's interventions remained highly relevant to: communities, project objectives, local government education departments, Government of Pakistan's priorities, UN sustainable development goals, etc. Existing government schools were strengthened, government school teachers were provided training, social enterprise schools were established where there were no government schools, incentives were given to the poor students such as, provision of transport, stationery, etc. to the students.

According to the information from field visits, including interaction with government officials, both CRPs and SMCs played important roles in increasing the enrollment and decreasing the drop-out rates. CRPs remained more effective in this regard, being more experienced and trained as compared to SMCs many of whom were capacitated during this project.

Establishment of social enterprise schools is a good innovation and has attracted enrollment. However, most of the respondents lacked in-depth understanding of social enterprise concept. In terms of strict definition, many such schools are not yet social enterprise per se, but most do show potential to graduate into a social enterprise in near term. These schools are likely to continue beyond the project life, if: salary is paid to the teacher; additional teachers are recruited, and school infrastructure expands as the enrollment increases; incentives to the poor students continue; adequate learning materials are available; etc. These schools must be handed over to the relevant education departments.

Establishment of District Education Forums was envisaged in the program design, but has not worked to its potential. Wherever elected representatives were engaged, it has produced good results. EPS Swat invited elected representatives in its meetings and highlighted various issues; appointment of additional teachers, non-functional Maktab Schools, political interference, etc. According to EPS most of issues were resolved.

The approach and implementation methodology applied to the Education component of the project are aligned with the original thinking delineated in the project proposal, e.g., community needs were taken into consideration during site selection for schools - parents are comfortable enrolling their children to the nearby school. Potential enrollment of girls and boys students was another factor in selecting a community for the programme intervention.

The school infrastructure improvements have been carried out with the consultation of the respective District Education Departments. However, these contributions of the project have

not been entered in the District Education Departments records, which might lead to unaccountable spending by the district education department. Some of the respondents (eg KII with PO Swat) have raised the issue of non-availability of funds for provision of furniture in some government schools. Some SMC members have expressed concern over their non-involvement in the utilization of school infrastructure budget.

IT labs and computers have been provided in government and social enterprise schools, IT teachers and IT training was provided but these schools need support in teaching ICT for education such as use of computer in teaching/ learning different subjects. AKRSP uses different strategy such as hiring/ nominating qualified teacher in computer science as lab in charge for six months and it is her/his responsibility to train two other teachers in computer teaching. This approach is more workable as well as sustainable.

Education – Assessment Conclusions:

- CRPs and SMC members, in particular, were very satisfied with the trainings they had received under the project. These trainings enhanced their communication skills that boosted their confidence level and they were able to communicate effectively with the parents, teachers, education department officials, local influential and elected representatives. The ultimate result of these trainings was that the parents were persuaded to send their out-of-school children to schools. *However, SMC members of GPS Gambak, Bamborete in District Chitral were not provided any training at all.* "Only those interventions were carried out which were priorities in SDPs, the training is planned in next phase" as reported by PO Chitral

- 04 to 05 days trainings were imparted to the teachers and CRPs/SMC members. Majority of respondents expressed the need for follow-up trainings.

- The assessment concludes that to check drop-out rate and increase enrollment in government schools, each school must have appropriate and adequate physical infrastructure, well-trained teachers and some form of incentives for the poorest of the poor students.

- It can also be concluded that parents are comfortable enrolling their children to the nearby school. Enrollment is inversely proportional to the distance exists between the school and a house.

- In terms of the enrollment, it can be concluded that the role of both CRPs and SMCs was highly relevant and effective in increasing enrollment and decreasing drop-outs. Further, in the consultants' opinion, the strategy to provide support in physical infrastructure (washrooms, boundary walls etc.), hygiene kits and the ICT support (computer lab) contributed equally, if not more, in encouraging enrolments and decreasing dropouts.

- The strategy to sign an MOU with the district officials and getting approvals from the Education department ensured that there is no duplication of efforts or funds – work done under PPR and that under ADP of the government remained exclusive to each other. However, in few cases, the coordination seemed below par, e.g. in one case in Bajaur, project supported interventions (physical interventions) were later done away with by the government.

- Student enrollment will increase every year, therefore, additional teachers are required

- IT labs and computers have been provided in government and social enterprise schools, IT teachers and IT training was provided but these schools need support in teaching ICT for education such as use of computer in teaching/ learning different subjects. AKRSP uses different strategy such as hiring/ nominating qualified teacher in computer science as lab in charge for six months and it is her/his responsibility to train two other teachers in computer teaching. This approach is more workable as well as sustainable

- Experience has proved time and again that project-based activities are temporary in nature and cease to exist sometime after the project closure, unless specific sustainable measures are taken. It is feared, that the same phenomenon will prevail in this context too. Incentive part could not be sustained as mentioned by PO Chitral & Bajaur, FGD SMC Chitral and additional teachers of Swat. "In my opinion, the government institutions won't be able to sustain the results of grant interventions especially the incentives part will be no longer sustained because we can only provide the text books not the other incentives so it is obvious the incentives based admission will be no longer happen. The PTC funds as well the conditional grants amount is also not that much to sustain the results or to provide salaries to additional teacher.(SDEO Majeedullah Swat)"

- Delay in availability of funds remained an issue in smooth and effective execution of PPR component implementation strategies. Delay in funding from the donor to PPAF led to subsequent delay in provision of financing to the POs. As a stop-gap arrangement, PPAF provided bridge-financing to PPR from its own resources. However, later on, PPAF had to stop this practices which led to prolonged delays of funding to the POs resulting into suspension of activities. A number of KII respondents suggested for timely disbursement of funds from PPAF to partner organization because delays in funds not only affects their rapport with stakeholders especially Education Department and communities, it also affects the quality of work. (KII Gwadar, Bajaur).

Education – Recommendations:

- It is recommended to scale down the integrated development approach adopted by PPAF for the PPR program (i.e. supporting an area / community in the fields of education, CPI, health & nutrition together) to individual component. That is, provision of focused, all-encompassing support to a lesser number of schools might be experimented. Under this approach, each school must have appropriate and adequate physical infrastructure, well-trained teachers and some form of incentives for the poorest students. This could result in better visibility and concentrated impact, and may serve as model for other schools in terms of the desired results, i.e., increased enrollment and reduced drop-outs.

- Teacher training must continue with regular intervals. eacher training becomes due as soon as a new teacher is inducted and the syllabus is revised. Teacher training must focus more on the 'contents of the syllabi', which the teachers have to teach. Trainers were good, but it is better that future trainings are done by the local trainers—a language issue. With local trainers the trainees will be able to interact freely and understand things better.

- Project's contribution in government schools in all cases must be properly recorded in government documents to avoid wastage of government resources.

- PPAF's existing methodology for collecting and analyzing data related to out of school children could be made more scientific by taking family data from the National Database Regulatory Authority [NADRA] and take it along while conducting door-to-door survey for out-of-school children. However, this will be a very time-consuming exercise without making much [or any] difference. The existing strategy is fine, as long as the CRPs/SMCs do it with commitment and do not miss out any household.

- As the project ends, the role of CRPs may decrease or ends altogether. Besides, SMCs are comprised of parents of students who are studying in that particular school. While it was important and useful for PPAF to engage CRPs for enrollment drives during the life of the project, this role must shift to the SMCs for the sake of sustainability.

- Training of SMCs must be provided once every year so that new members get trained. Such training can be provided by the School Head Teacher without any cost.

- Generally, the standard of middle and secondary school teachers is quite good. Efforts must be made to involve these teachers in providing teacher training to the local primary school and social enterprise school teachers.

- Other available avenues of funds generation must be explored. Bajaur Agency's experience is a case in point.

- PPAF as well as other organizations are themselves dependent on external funding. Hence, it is unrealistic to expect from PPAF to develop a sustainable programme that will last for many years. Therefore, PPAF needs to develop long-term partnerships with the national and international for-profit corporations for sustaining its social enterprise initiatives. Also, PPAF should sign MoUs/Agreements with relevant governments that such initiatives will be adopted by the governments after an agreed time period.

- Most importantly, PPAF must work with the local influential and elected representatives for every aspect of education, may it be construction of schools, up gradation of schools, provision of teachers, etc. This is the only approach that has the promise for sustainability. Elected representatives must be made members of the District Education Forums and their active participation in the meetings must be ensured.

- To ensure timely availability of funds and avoid any funding delays in future, PPAF legal department should whet the financing agreements (both of donor and POs) to bring necessary changes ensuring continuity of funding of the programme activities.

- For smoother implementation, and to ensure that most pressing needs are addressed, within the overall budget, transfer of funds from one head to another must be allowed to ensure optimum utilization of all the funds.

1.0 INTRODUCTION

Introduction to PPAF: Pakistan Poverty Alleviation Fund (PPAF) is the lead apex institution for community-driven development in the country. Set up, by the Government of Pakistan, as a fully autonomous not-for-profit private sector organization, PPAF enjoys facilitation and support from the Italian Development Cooperation (IDC), KfW Entwicklungsbank (Development Bank of Germany), The World Bank, International Fund for Agricultural Development (IFAD), Government of Pakistan, and other statutory and corporate donors. PPAF aims to be the catalyst for improving the quality of life, broadening the range of opportunities and socio-economic mainstreaming of the poor and disadvantaged, especially women. The core operating units of the PPAF deliver a range of development interventions at the grassroots/community level through a network of more than 100 Partner Organizations across the country. These include social mobilization, livelihood support, access to credit, infrastructure and energy, health, education and disaster management.

Introduction to PPR: Program for Poverty Reduction through Rural Development in Balochistan, Khyber Pakhtunkhwa, FATA and Neighboring Districts/Program for Poverty Reduction/PPR is a three-year program financed by the Government of Italy (GoI) through the Directorate General for Development Cooperation (DGCS) and the Italian Agency for Development Cooperation/AICS. The program focuses on contributing to reducing poverty in selected districts of Balochistan, Khyber Pakhtunkhwa and Federally Administered Tribal Area. Being situated at the border of Afghanistan the program areas are amongst the most vulnerable and underserved areas of the country which suffer from extreme poverty, as well as face severe security issues. The total Italian financial contribution is EUR 40 million, through a soft-loan framework agreement.

PPAF hired the consultancy services of NEC Consultants Private Limited (NEC) under the contract signed between PPAF and NEC on March 21, 2018. The overall objective of the NEC services is to conduct PPR performance assessment. The assessment activities are inclusive of strategic assessment of both CPI and EHN components of the Project.

The reporting framework of the assignment is as follows:

(i) **Inception Report:** The IR documented the methodology and schedule of activities.

(ii) **Training of Field Staff and Field Testing of Tools:** NEC field teams were comprised of senior professionals. NEC did the field testing of the survey tools in one of the selected districts with the approval of PPAF.

(iii) **Assessment Report for CPI and EHN:** Two separate assessment reports of both CPI and EHN components of the project were required to be submitted. The reports document the overall performance assessment of the implemented projects as mentioned in the ToRs. Following are the final outputs:

- Specific assessment reports,
- Assessment of quality of design of CPIs as per PPAF Infrastructure Manual including the correctness of the bill of quantities (BOQs) of projects,
- Qualitative assessment of construction works and EHN Components, and
- Recommendations and Conclusions

2.0 SCOPE OF WORK

The EHN specific scope of work is as follows:

- Detailed desk review of key documents of the project including: component specific strategies executed by PPAF and POs, agreements with donor, POs work plans, project log-frame, financial documentation, quarterly progress reports, aide memoires, etc.
- KIIs and FGDs with the target beneficiaries and communities, key informant interviews with key stakeholders, interviews with the PPAF team and relevant POs' staff as well as review of project record available with PPAF, POs and community institutions.
- Through appreciative enquiry, analyze the component's strategies, including PPAF and POs staff skill sets of existing staff of PPAF and POs to identify the gaps and contributory factors.
- Recommend corrective measures to address the identified gaps and strengthen contributing factors.
- Focus group discussions with representative community groups.
- In-depth interviews of office bearers of CIs, and partner organization staffs.
- Finalization of component specific assessment reports highlighting key findings related to success, achievements, areas of improvement; and recommending actions for improvements.
- The extent to which the component was able to leverage productive linkages with the government, private sector and other development partners.

3.0 APPROACH AND METHODOLOGY

The approach and methodology of the strategic assessment comprised of review of secondary data collection, field visits, interviews, data collation and analyses. It was be a mix of distant assessment, on-site verification and focused discussion with the stakeholders. The Consultants visited selected sites, and compiled feedback from different stakeholders obtained through meetings, surveys and expert analyses.

3.1 Tecnical Approach

3.2 Overview of Implemented Strategies

The PPR programme focuses on contributing to reducing poverty in selected districts of Balochistan, Khyber Pakhtunkhwa and Federally Administered Tribal Area. Being situated at the border of Afghanistan the programme areas are amongst the most vulnerable and underserved areas of the country which suffer from extreme poverty, as well as demonstrate extremely low education indicators.

3.2.1 Programme Goal

Population poverty reduction through the creation of sustainable conditions of social and economic development, including income and production capacity increase

3.2.2 Programme Purpose

Establishment of a social and productive infrastructure system and the establishment of an effective and sustainable social safety net

3.2.3 Programme Outputs

The expected outputs of the programme include:

- Social structure and community organizations strengthened, with increased empowerment of the local communities and increased capacity of relating with central institutions, other organizations and markets
- Effective social safety net established in favor of the populations' poorest groups, women, children, old people and disabled especially
- Local productive infrastructures (water infrastructures, civil and energetic works, access to markets, wells, roads, pipelines, power grids etc.) built and functioning
- Access of local population to the basic social and health services, including education obtained

The aforesaid objective and outputs were achieved through a Community Driven Development approach by engaging Partner Organizations in the programme target areas.

3.2.4 Assessment Objectives

The specific objectives of EHN component assessment are as follows:

- Assess relevance, effectiveness (in terms of demand and supply dimensions) of health & nutrition as well as education sub-components strategies under PPR in relation to target population needs and proposed programme outcome.

- Identify the interventions and approaches that worked well and that did not work well. Identify areas of improvement and recommend specific workable actions to enhance relevance and effectiveness of health strategy.

3.2.5 Assessment Type

It was formative assessment focusing on review of the existing literature, and qualitative interaction with beneficiaries and other key project stakeholders.

3.2.6 Assessment Scope

The assessment focused on the projects' target community groups and beneficiary groups' projects served and engaged with. The evaluation engaged project team other relevant stakeholder to get their inputs against the pre-defined tools. The evaluation did not involve any surveys with any of the project stakeholders.

3.2.7 Assessment Criteria and Key Questions

The assessment criteria were developed based upon standard criteria of "The Organization for Economic Cooperation and Development" set of evaluation criteria. The table below has assessment criteria and subsequent questions against these;

Table 1: Assessment Criteria and Questions

Criteria	Key Questions
Relevance and Appropriateness	i. To what extent was the project relevant to the Health & Nutrition needs of target communities? ii. Were the approaches used to implement the project and achieve planned outcomes appropriate to the target area context and to the different beneficiary groups (men, women, boys, girls and marginalized groups)? iii. How appropriate were the project targeting strategies? iv. How appropriate were the project strategies towards the inclusion and balancing needs and capacities of different groups especially women, Children, disables and other vulnerable groups? v. How appropriate was project feedback mechanism for different beneficiary groups.
Effectiveness	i. How effective was the project to inclusion and participation of the vulnerable community groups, what worked what did not work and why? ii. How effective was project's information and communication strategies in ensuring outreach to the different beneficiary group regarding their rights and entitlement under the project. iii. How effective was project's M&E System (Framework, approaches and tools) to capture minoring data and report it. iv. How effectively monitoring findings were used to make program and management decision? v. How effective were project approaches in achieving results? vi. What was project's degree of compliance to standard of technical performance for the emergency program in design and implementation – especially globally accepted standards.

Criteria	Key Questions
	vii. How effective was coordination to ensure complementarity and programmatic integration(integration will one be done in consultation with the management)
Transition and Handing Over	i. How robust was project transition plan were right stakeholders factored in. ii. How timely was the handing over to ensure transition allowed line department to effectively assume the charge.
Efficiency	i. How efficiently project implementation approaches (key activities) were resourced. ii. To what extent project' detailed implementation plan was followed?

3.3 Sample Criteria for Strategic Assessment of PPR Project

The Project is being implemented in 14 districts of KPK, Balochistan and FATA. Keeping in view the considerable geographical spread of interventions implemented under the project, security constraint of the assignment especially in Balochistan, and the scope of assignment which requires strategic assessment, the NEC team has visited only a representative number of interventions in the selected districts. The criteria for selecting the interventions for NEC visit was developed through detailed deliberations between PPAF and NEC teams, and comprised of the following:

3.3.1 Geographical and Ethnic/Cultural Coverage

During the meeting with PPAF MER team on March 30, 2018, it was mutually agreed that the basic criteria of sample selection will be the geographical and ethnical/cultural coverage. **Table 2** presents the sample districts selected under the criteria. It should be noted that initially District Zhob was selected to cover the Pushtoon belt of Balochistan. However, due to security reasons, this district was later replaced with Pishin which also represents the target ethnic community with better security situation. It was mutually decided that similar numbers and type of interventions would be selected and assessed as in Zhob district.:

Table 2: Geographical and Ethnic/Cultural Coverage of PPR Interventions

#	District	Geographical Coverage	Ethnic/Cultural Coverage
1	Bajaur Agency (FATA)	The only district covered in FATA by the Project.	
2	Chitral (KPK)	All the geographical regions where the project is implemented have been covered.	Cultural setup is different from other parts of KPK.
3	Swat (KPK)		Represents Pushtoon culture.
4	Gwadar (Balochistan)		Represents Baloch culture.
5	Pishin (Balochistan)		Represents Pushtoon culture typical of Balochistan.

3.3.2 Criteria for Determination of Sample Size

Following are the criteria adopted for the determining the sample size of PPR interventions implemented in aforementioned five districts:

- ***During the meeting it was decided that 10% to 15% sample size based on random sampling will be selected for assessment;***
- ***Sample should represent all intervention areas i.e. health, education;***
- ***Only 100% completed interventions will be selected for areas i.e. health, education;***
- ***Those union councils should be selected where substantial number of multiple interventions have been implemented; and***
- ***Sample should be cost conscious with respect to transaction cost.***

Table 3 presents the summary of sample size by PPR interventions for EHN components implemented in ***aforementioned districts***.

Table 3: Sample Size by PPR Interventions

Components	Completed Projects	10%-15% Sample
Education	298	30 @ 10%
Health & Nutrition	39	10 @ 25%

Table 4 presents the proposed distribution of sample size by districts, union councils, and POs. Sampling has been finalized in coordination with MER team.

Table 4: Sample Size by Districts, Union Councils, and Pos

Districts	Union Councils	POs	Education	Health
Bajaur Agency	Alizai	SRSP	3	0
	Pachagan Section	SRSP	2	1
	Khar	NIDA	2	1
		Sub-total	**7**	**2**
Chitral	Drosh 1	SRSP	2	1
	Drosh 2	SRSP	2	0
	Ayun	AKRSP	2	2
		Sub-total	**6**	**3**
Swat	KozAbakhelKabal	EPS	3	1
	Hazara	EPS	2	0
	Bar AbakhelKabal	Lasoona-SHNRD	2	1
		Sub-total	**7**	**2**
Gwadar	Peshukan	NRSP	3	1
	Sur Bundar	NRSP	4	0
		Sub-total	**7**	**1**
Pishin	Khushab	BRSP	0	1
	Bostan	SEHER	3	1

	Sub-total	**3**	**2**
	Total Sample	**30**	**10**

3.4 Limitations

1. The assessment is a validation of the reported results through qualitative methods thus these may not present a statistically valid picture of findings.
2. Field team did their utmost to extract accurate information however possibility of some bias cannot be ruled out of qualitative information collected.
3. The consultants have considered the PPAF Strategy (2015) as the base document for this strategic assessment. PPR Work Plans were developed later, and there could be minor disconnect between the strategy document and the work plans. The consultants recommend that either update the strategy document, or contextualize the work plan to ensure that the two governing documents are completely aligned.

4.0 HEALTH & NUTRITION COMPONENT

4.1 Methodology for H&N Strategic Review and Assessment

4.1.1 Assessment Methodology

A mixed methods approach of primary data collection and literature was applied to conduct the project's strategic assessment. The details of the methodologies are given below:

4.1.2 Literature Review

Documents review of project relevant documents lay the foundation for understanding procedural, institutional, environmental, social and geographical context of interventions currently being adopted by the Project. Two types of reviews were carried out to accomplish the objectives of the study:

- ***Review of Project Strategy***: Detailed review of these documents helped in understanding the guidelines and assessing the selected projects/interventions against the stipulated guidelines, criteria, and mitigation plan set in the documents.

- ***Review of relevant project documents and reports*:** Following documents were reviewed:

- Project agreement;
- Audit reports
- Profile of selected projects;
- Project/interventions appraisal documents;
- Progress reports;
- Completion reports;
- Internal assessment reports if any;
- Training workshops and events proceedings;
- Output indicators;

4.1.3 Primary Data Collection

A. Focus Group Discussions

Focus group discussions were conducted with the project's primary beneficiaries. For each of the focus group discussions qualitative tools were developed to collect information in a clear and focused manner. These focus group discussions were conducted with 6 – 10 participants a group[1]. A criteria based approach was applied to qualify participants of the focused group discussion. For each of the participant the participation was voluntary and they were allowed to quit FGDs any moment they opted. A team of two members conducted focus group discussion, one performed the role of a moderator and other performed the role of a note taker and observer. Focus group discussions were noted down on the specialized templates in English as well as Urdu language. Each of the focus group discussions were concluded in a time span of 35 – 50 minutes. Prior to the start of the focus group discussion participants were fully briefed on the purpose of the FGD and expectation and utilization of the FGD findings and also participants' privacy. The table below has all the details of the FGDs and tools those were applied for each project.

[1] This was a desired number.

Table 5: Details of FGD

Project	Group	Target	Achievement
PPR	Women who made ANC and PNC visits to health facilities	9	9
	Husband Male Counterparts	9	9
	Health Management Committees	9	9
	Married Women	9	9

B. Key Informant Interviews (KII):

Key informant interviews were conducted with the projects' primary stakeholders to get their inputs against pre-defined questions. Each of the KII was conducted on the explicit approval of the relevant stakeholder on a pre-agreed schedule – for each KII a maximum of 40-60 minutes were required. The KIIs were noted down on a pre-defined template in English language by the interviewer. The participants were allowed to drop any question(s) and also they were allowed to discontinue interview at any point. The table below contains the details of the KII.

Table 6: Details of KII

Project	IDI With	Target	Achievement
PPR	Community resource persons	9	9
	Heath & Nutrition staff in adopted health facilities	9	9
	Partner organization staff	9	9

4.1.4 Team Training in Tools

A full day of training was organized for the data collection team to fully orient them on the tool used during the data collection and also to orient them on the behavioural protocols to evaluate GBV interventions. They were very clearly explained the DOs and DON'Ts as they interacted with community members during data collection in the field. They were provided with ample opportunity to ask questions regarding behavioural protocols to ensure they clearly understood the importance and criticality of these.

Team members discussed tools with each other to further consolidate their understanding of the tools and asked any questioned they had. The note takers were oriented in details on how to take note down the discussion, and also how to observe the proceeding and note important reactions, gestures and expressions. The team was provided English version of the tools.

4.1.5 Data Validation and Quality Control

Each of the FGDs and IDI were supported through signed list of participants or with thumb impression as applicable. As permissible team made photographs of the proceedings to support the activities they had carried out in the field. The evaluation expert did a detailed debrief with the project evaluation team for the FGDs and IDIs they conducted at the start and

provided them feedback on the areas of improvement. For the FGDs a moderation guide was provided to the team to help them build the conversation and guide them in that.

4.1.6 Data Transcription

All the FGDs and KIIs were transcribed into the digital format of Microsoft Word from the handwritten notes. The transcription included participants inputs and observation with the details of the proceeding and different modes and gestures those groups exhibited as a whole.

4.1.7 Data Analysis

A. Thematic Analysis

Thematic analysis approach was used to analyse the data. Based upon tools different theme were identified and a matrix was created. Against each of theme convergence and divergence trends and unique inputs were studied.

B. Triangulation

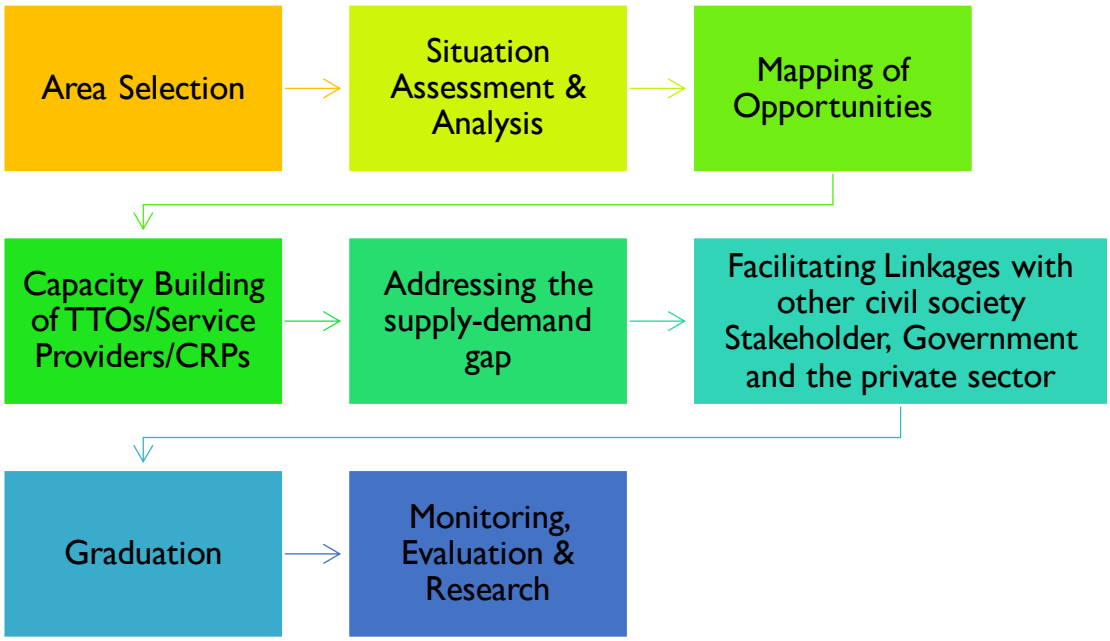
The findings were drawn through the triangulation of project's data sets and reports, findings against the FGDs and findings against the KIIs. The findings were organized against the key questions proposed against the evaluation criteria.

❖ Ethical Consideration

All interaction with the respondents was only made after their consent and they were explained purpose of the data collection, and also use of the collected information. Consultant strictly avoided indulging into any conversation of political or religious nature, and did not use any jargons, words or gestures those could be offensive on religious, ethnic, gender, age or any other ground. Consultant strictly avoided any sexual advances, offers or favours to beneficiaries, neither promised any favours to survey participants. Consultant did not guide/or instigate respondents to provide specific answers, consultants did not misinterpret survey participant inputs or distort these. Safety and security of the survey participants is of the paramount importance consultant did not act in any manner putting security & safety of the survey participant at risk. Interaction with the respondents was guided by PPAF Policy and protocols.

5.0 H&N COMPONENT – OVERVIEW OF IMPLEMENTED STRATEGIES

Figure 1: Strategic Framework of Health & Nutrition Program



In terms of H&N service delivery interventions, the PPAF strategy covers the following:

Addressing the supply-demand gap through:

Assistance to resource persons (financial/technical)

PPAF will provide financial and technical assistance to capacitate CRPs so that they are well equipped to train the community institutions, individual volunteer and community health workers and have the ability to run the advocacy campaigns for more controversial health issues (family planning, Sexually Transmitted Infection (STI) prevention, etc.). PPAF will ensure that health practitioners have appropriate facilities to operate in and means of travel if required.

Development of knowledge Hub "key H&N messages, and youth involvement"

This refers to information sharing resources and digital aids that the community can have access to. Youth can learn the latest preventative and curative techniques and educate members of their communities.

Promotion of Social Enterprise around Health and Nutrition initiatives

PPAF intends to promote the idea of social enterprise around health and nutrition, as it is gaining popularity elsewhere in Asia, and provide relevant skills training. Social enterprises could potentially take over projects in place in the future and run them cost effectively –making them accessible to poor on much less cost than they currently pay for unregulated private sector health services.

Leverage with government Donors, and other programs

Possible linkages with government, donors, private sector and health specialized agencies will be a continued programmatic focus to ensure accessibility of the core beneficiaries to wider range of services and healthy choices.

Facilitating linkages with other civil society stakeholders, government line departments and the private sector through:

Development of income generating plan for sustainability of past investments

Alternative income generating activities, promotion of local enterprise through trained CRPs and business development services through specialized agencies will help develop a culture of entrepreneurship and will open up the possibilities for alternate income generation activities.

Public Private Partnerships

PPAF is already engaged with private sector through its various projects and sector development initiatives which can be leveraged to help forge private –public partnerships to promote demand-driven quality health services.

Formation /Activation of Health groups

These will be formed to ensure that facilities and information centers are accessible to everyone, especially the poorest. CRPs will be integral parts of these groups, providing linkages. The dormant Health Management Committees (HMCs) will also be reactivated as local health groups.

Investment in physical and social infrastructure (CPI, WECC)

This step is to bridge gaps in service and deal with physical issues hindering projects, for example providing facilities for health professionals to operate in. Furthermore, in order to retain the trained health professionals in the remote rural areas, PPAF will support establishing or renovating the residential rooms with toilet facility through CPI program.

Innovative pilot projects –building synergies

This can include telemedicine, voucher programs, accessibility enhancing transport enterprises and life style medication etc.

- *Pre-natal Care including micronutrient Supplements*
  The CRPs will be trained for pre-natal and post-natal care with the provision of micronutrient supplements in collaboration with government and other service providers.

- *Community based Growth Monitoring and Promotion*
  Growth monitoring refers to weighing a child (from birth through the first two, three or five years of life) and recording the weight on a growth chart. Because weighing and charting alone cannot improve growth, Promotional activities are also needed. These include counseling and action to improve child growth. Growth monitoring and promotion will also be part of PPAF nutrition program which requires trained people at the local level with some basic guidelines and sufficient time with families.

The PPAF strategy for Health & Nutrition interventions, also applicable to the PPR project, warrants the following actions to be taken:

1. Tele medicine & Voucher Program
2. Deployment of Mobile Health Clinics
3. Establishment of Health Management Committee and its capacity building and make sure its functionality
4. Awareness regarding Malnutrition, Diet Diversity, Breastfeeding, Anemia etc.
5. Opportunity mapping to ensure sustainability
6. Capacity building of staff & government and community institutions
7. Screening for malnutrition & identification of underlying & basic causes of malnutrition
8. Building Synergies with referral clinics
9. Criteria for area selection to implement Health & Nutrition services
   Union Council development plan (IMR, Reproductive Health, Menstrual Hygiene, ANC & PNC)
   Referred from opening para, section 2, H&N Strategy, PPAF.
10. Transforming community health centers into social enterprises.
11. Activation of dormant health committees by CRP's
12. Improving physical infrastructure on Govt. health facilities such as construction of rooms with toilet to retain trained health professionals.
13. 15. Capacity building of CRPs to provide ANC, PNC etc.
14. Community Growth promoters deployment to conduct Nutrition screening & referral.

The following sections describe in detail the strategic actions implemented during the PPR in terms of their relevance, completeness, and effectiveness etc.

6.0 H&N COMPONENT – STRATEGIC ASSESSMENT

6.1 Qualitative Observations during KIIs

Following is the summary of qualitative observations raised by PPAF and Partners during the assessment.

6.2 Qualitative Observations during FGDs

A majority of FGDs respondents had a fair introduction of PPAF PPR programme and knew it through work it has been doing in the areas from couple of years through partner organizations. Most of the participants knew about the current health interventions. In visited areas of Swat, Bajaur, Chitral, Pishin and Gwadar almost all the FGD participants recognized PPAF partner organizations only as a non-governmental organization. Hence mostly PPAF partner organizations key introduction vary from area to area based on their nature of intervention either with PPAF or through other donor organizations. Through the analysis of the men and women inputs during the focus group discussions it can be established that all the community groups had access to health services. In areas where PPAF partner organizations were providing services through government health facilities greatly helped community to access these services in a rather efficient manner.

PPAF partner organizations implemented different projects in Bajaur, SWAT, Chitral, Gwadar and Pishin etc. with different donor organizations including PPAF and have good reputation at community level and government line departments. It was found during field visits that almost all the people with whom the consulting team interacted were aware of the PPR. The name of PPAF was also known to most people. The educated class, including government functionaries, SMC members and CRPs, etc. were aware of the general mandate of PPAF i.e. poverty alleviation, and the fact that PPR is funded and managed by the PPAF. During FGDs with HMC members; number of participants in all visited areas weren't aware of the process, procedures and mandate of the HMC including mechanism adopted for formation, frequency of meetings, record keeping and roles & responsibilities. Participants in all FGDs were found well aware of the interventions PPAF partner organizations have in their respective areas i.e. primary health, awareness sessions, reproductive health, CRPs and various trainings held under the PPR. More clarity on sustainability of services after project closure is to be provided in the targeted areas to clarify the transition plans been devised in this regards. Community at large and FGDs participants loudly acknowledged services by PPAF partner organizations under PPR program. Following is the summary of qualitative observations raised by community during FGDs.

6.3 Field Findings

6.3.1 Relevance & Ownership

A detailed review of the projects' designs helps to establish all the interventions were designed to respond critical needs of the targeted communities in the programme areas (across Pakistan). PPAF prioritized the target UCs based on how robust their community institutions are, how they perform on the HDI and poverty scales and their levels of food insecurity. The field observations and feedback provided in FGDs and KIIs confirm that the selection of partner organizations was appropriate and the menu of services offered remained relevant to the needs of the target areas and communities. Communities confirmed that POs (EPS, LASOONA, NIDA, SRSP, AKRSP, BKRSP, NRSP & SEHER) are working in our areas since long. In terms of selecting

geographical areas for intervention also, PPR mostly selected appropriate sites from the community perspective. However, in case of Swat and Bajaur, women community members expressed their reservations about the CHC site selection and mentioned that they are encountering access issues.

The selected POs, due to their prior existence in the respective areas, had existing knowledge of the needs and operational context that was leveraged very well to appraise the context. In many cases, roundtables were conducted with relevant line department which helped to ascertain and finalize the needs. In project context analysis PPAF partner organizations had defined other actors and their role during the course of programme implementation as well. Community men and women strongly praised the service provided through PPR programme and mentioned the challenges they would have faced otherwise especially access related issues to government hospital and quality of services provided. They also appreciated the quality of services and availability of the free medicines. Community awareness sessions created awareness regarding Health & Hygiene and communicable & non communicable diseases. The community members were informed about the importance of immunization, Breastfeeding, Antenatal & Post Natal care, methods to prevent the spread of communicable diseases like Diarrhea, Typhoid, & droplet infection and information about the control of Non communicable diseases. The Health centers established by the project provided access to Primary Health Care services at the doorstep of the community. It has helped the community PLWs to get access to the ANC & PNC services. The equity based provision of Health services particularly ANC/PNC services helped address the problems related to the delays in getting Antenatal, Natal & Postnatal services. The Nutrition component of the project built the capacity of the community health committees through provision of trainings on IYCF, Breastfeeding topics. The Health staff were performing Screening of PLWs & Growth monitoring of under five children and provided referral to the patients attending clinics with severity malnutrition. The project identified community needs in each target area through UCDP / VDP exercise. The service delivery to respond to the needs of marginalized communities in the programme areas responded to the most acute needs. The government functionaries praised the interventions as timely and complementing their efforts to respond communities' needs.

Programme community men and women and pregnant women and new mothers were very appreciative of the Primary Health Care Services and ANC and PNC services under the programme. Desk review of the progress reports indicated that a total of 958,438 community people in the program area received medical consultation including Male: 24%, Female: 36%, Children: 17%, Boys: 11% and Girls: 12%. The aspect of quality and access to these services were termed satisfactory The aspect of quality and access to these services were termed satisfactory. The men and women participants of FGDs termed services through PPR adopted health facilities of quality and dignified. However emphasis is to be made on creating awareness about communicable and non-communicable disease. Proper IEC material is to be developed on topics related to communicable diseases i.e. (Pneumonia, Scabies, Tuberculosis, Typhoid etc.) and vector and water borne diseases. They had no complaints or negative feedback regarding these services. They termed staff polite and friendly and appreciated staff for listening and providing them advice in a clear manner. Outreach through field team was acknowledged by community men and women and to generally have informed them of services and raised their awareness on basic issues related to health & hygiene at individual and community levels. The community outreach health workers are to be capacitated on topics related to oral rehydration therapy and integrated management of neonatal and childhood illnesses. The community men and women also acknowledge session on the basic health hygiene as important and helpful.

The community men and women who participated in FGD acknowledged service through projects as very gender sensitive and special arrangements were made to respect women privacy according to local customs. Interviewed participants weren't aware of the complaint

response mechanism neither any CRM banner, complaint box was found in the programme area including health facilities.

It was observed that health centers were established considering ease in access of services for all groups of community. The ANC /PNC needs of the PLW and adolescent girls were balanced in an efficient manner. Appropriateness of the strategic actions was also endorsed by the Government line departments who appreciated the coordination done by the health & nutrition teams and termed the MNCH services as appropriate.

6.3.2 Completeness & Quality

As reported by PPAF key achievements of the projects are given below:

Table 7: PPR Health & Nutrition Progress

S. No	Progress against Programme Activities[2]	Overall Programme Target	Achieved Since Inception	Overall Progress against Programme Target
1	Capacity building program around health and nutrition.	792	732	92%
2	Beneficiaries of household sessions	352,406	254,697	72%
3	Strengthening of government health centres	76	74	97%
4	Establishment of community health centres	57	30	53%
5	Mobility cost for access to health services and provision of latrines at public places	927	1,282	138%
6	Innovative pilot on nutrition	4	3	75%

The programme achievements and other data is recorded in the MIS of PPAF. Data related to OPD is reported on the prescribed format (by the health department) to the line department while POs report the information on MIS to PPAF on quarterly basis. It is good to note that the MIS have the provision of data disaggregation based on age and sex. This will be of immense value for future strategy formulation. Since the consultants did not have the mandate to cross verify claimed achievements (PPAF has a regular monitoring arrangement that covers this aspect fully), no supporting documents from PPAF or partner organizations were reviewed during field visits. However, some areas of improvement were observed during the field visits vis-à-vis completeness and quality. For example, capacity building program around health and nutrition is mentioned in the progress report, however there is no follow up mentioned with the trained CRPs to know if they were using the training and whether training brought any improvements to the work they did. Therefore, some follow-up mechanism could be made part of future interventions to ensure and record the efficacy of trainings to CRPs and others.

PPAF has planned a user beneficiary / community satisfaction survey already. This will provide qualitative data can be done amongst the beneficiaries of these CHCs who have actually demanded for these CHCs to be sustained and not closed. The community members have themselves agreed to a nominal fee which is lesser than their time and cost taken for treatment from a farther health facility.

[2]Source of Information: PPR 15th QPR (October – December 2017)

The basic services within these CHCs were of optimum level for a basic first level medical care and some basic prick and rapid kit tests were also seen which promotes early identification of cases.

Table 8: PPAF PPR Programme – H&N Progress

Goal: Population poverty reduction through the creation of sustainable conditions of social and economic development, including income and production capacity increase	
Expected Output: Access to local population to the basic and health services including education obtained	
Indicator 1: Rehabilitation/support to 76 BHUs.	PPAF PPR progress report indicates that a total of 104 health facilities including 74 government and 30 community health centers were strengthened.
Indicator 2: Essential primary health care services are available to more than 80% of the targeted communities including 60% women.	958,438 medical consultations were provided through these health facilities including 383,882 (40%) women, 297,248 (31%) men and 277,308 (29%) children who received consultation.
Indicator 3: At least 60% of the beneficiaries report satisfaction with the PPAF supported health and education facilities	PPAF PPR need to devise an indicator based tracking system (dashboard etc.) to collect relevant information against these indicators.
Indicator 4: 40% reduction in the number of children under-5 who are stunted	
Indicator 5: 50% reduction of anaemia in women of reproductive age	

PPR programme progress per partner organization

The project has maintained record of treated patients through OPD services. However, record of OPD consultation could be further age disaggregated. Data collection using standardized health reporting format will enable programme team in realigning implementation activities as per the emerging needs and disease outbreak.

6.3.3 Community View on Access and Quality of the Services

> "ANC and PNC services were at our doorstep and very helpful. The staff was also very good and cooperative ".
>
> **A female FGD participant in Zarghon – Pishin.**

Community women found ANC, PNC as helpful components of primary health care service provided through the adopted health facilities. They were of the view these services were at their door steps, and offered them a great ease of access and helped them to save time and money. They termed services of quality as compared to the services provided at the government hospitals. Male counterparts who participated in FGDs termed services of quality and easily accessible. Men and women both appreciated services being free of cost and availability of the free medicines in the adopted health facilities. The Micronutrients and supplements provided during the routine ANC services has helped to address the issue of anemia to a large extent. The staff members were appreciated for their good behavior at the health facilities and also for their interaction in the field. Men and women who participated in the FGD informed that they were provided answer to their questions and queries. The project report shows that only 51,766 (including 36,633 ANC and 15,133 PNC) visits by pregnant and lactating female however health facility staff informed that community members suspected that mobilization for the ANC and PNC services were a way to bring community women towards family planning and healthy birth spacing. Women who availed ANC and PNC services informed that men played a very positive role and supported their women to avail ANC and PNC services. The services provided has helped in timely identification of possible complications during pregnancy and early post-partum period and to provide necessary medical attention to address these issues. However efforts are required to improve breastfeeding and proper maternal diet through community mobilization activities. New mother and pregnant women when asked if PPAF PPR partner organizations did not implement the project in their areas how would it affect them, they were of the view that they would have faced serious challenge to access free of cost services – they feared worst if these services were not there!

These findings also indicated that there has been a close supervision and monitoring of the service through the adopted health facilities. Mothers informed that children were immunized at the health facilities and they termed immunization services as regular and of quality. This corroborates well with project team report that 100% of the children who visited the health facilities were immunized. Although teams reported 100% immunization yet there is a need to issue immunization cards to the children attending clinics and other facilities during community outreach services. This will help to identify and improve the proportion of children fully immunized against vaccine preventable diseases.

In general CRPs found trainings they receive helpful, some of them found trainings as refresher as they already had knowledge and skills. In response to if there was a follow up mechanism on part of their department to monitor use of the learning of the training but there was no mechanism in place as such. One of the areas where CRPs got maximum value added through the trainings was their effective outreach to community females to mobilize them to avail ANC, PNC, RH, FP and awareness services.

> "Our women and children had access to quality health services locally. We were very satisfied as these helped us to save money and avoid hassle of going to hospitals faraway "
>
> **A male FGD participant in DheroKabal**

CRPs informed to have discussed sexually transmitted diseases & infections, FP, RH and

mobilization sessions on basic health hygiene/nutrition with communities to inform them about its benefits and the worst consequences for women, infants and their counterpart wellbeing. It is pertinent to mention that PPAF partner organization staff mentioned that they were not able to stand alone address the issue of STD & STI and FP and they discussed it along other community mobilization discussions. They embedded the message against STD & STI with the messages on importance of education for women and girls and also the importance of good hygiene practices. The community men and women also informed to have received information about RH, FP, STD & STI and acknowledge that more and more people were aware against these critical messages due to PPAF partner organization's efforts in the programme areas. Married women and men informed to have discussed FP, RH & STD more and more now, but exactly what they discussed was not clear. The community men and women informed that family planning was an issue but did not seek assistance as it could bring them shame. They need to be informed about Health Timing and spacing of Pregnancy (HTSP) and different types of family planning methods available to ensure family planning. The health facility staff requires training on availability of minimum stocks to provide FP services and a proper requisition/issuance system is to be ensured at the health facilities.

This is a very good example of program complementarity and leveraging the resources to expand the outreach. Men and women informed to have access to health treatment that they did not have before. The project report shows the number of patients that as of December 2017; 1,103,351[3] received treatment by the programme.

Table 9: PPAF PPR Partner Organization Health Consultations.

Patients Treated Through PPAF Partner Organization adopted health facilities								
Adults		Children > 5 (Boys & Girls)	Children< 5		Immunization		Antenatal/Postnatal Care	
Male	Female		Boys	Girls	Boys	Girls	ANC	PNC
231,351	292,300	163,432	106,776	111,319	66,944	79,463	36,633	15,133
Total: 1,103,351								

Community women informed to have knowledge to take actions against vector borne diseases – key actions mentioned were proper disposal of solid waste, regular cleaning of houses and their premises.

According to the community members the incidence of diarrhea and respiratory tract infections has reduced due to the timely provision of medical assistance and awareness about these issues during community mobilization sessions. Community women and men feared that cases of different disease outbreaks especially malaria, diarrhea, dengue etc. would go up during the summer and they would not have access to service due to project closure.
Through PPAF partner organizations adopted health facilities in programme areas community men and women received quality health services. Community women specially termed services of very highly quality and easily accessible. They informed that prior to the start programme paramedical staff were treating patients at the health facilities and the programme brought them services of qualified doctors. Community men and women especially praised the availability free medicines. Community men were of the view that there were unaddressed needs in the far off areas where the programme teams could not reach. Local health official strongly appreciated services and coordination with them during the course of implementation.

[3] *Source of Information: PPAF PPR Health Database (As of December 2017)*

6.3.4 Sustainability

Health related structures, capacities, knowledge systems and behaviors have been supported during PPR program at the community and partner's level. The main issues of strategic importance for PPAF partner organizations were the way in which it actively seeks to link projects, experiences and capacities to the long-term development phase.

PPAF partner organizations in-built approach of improving community resilience and coping capacity for greater effectiveness and sustainability in the implementation was the key of its successful and effective programming. The capacity building activities conducted with different communities like capacity building of CGP, formation of HMC, financial and technical assistance and promotion sessions on basic health hygiene, Reproductive Health etc. to local people for the community enhancement are the key approaches for sustainability and helped in sustaining different assistance provided.

During focus groups and KIIs interviews with PPAF partner's organization staff and department of health , it was found that the structures build at community level were effective and functional especially responding to pressing MNCH needs. The committees developed under the project shall continue to function towards development in their respective area.

The capacity building and awareness raising activities has built in sustainability.

Regarding Social Enterprise development, there were some good examples of basic primary health care services in the forms of PPR established Community health centers (CHC) which has a greater utilization in early identification of the medical cases, increased special and temporal coverage within the communities and bringing medical and Nutritional services to the doorsteps of the communities. There could have been a better sustainability plan of these CHC at the inception phase and could have been phased out and sustained in a uniform manner across all PPR partners in the region. There are still good practices to be learnt and in future programming such CHCs can be initiated with seed funds from donors and a huge number or CHCs can be established with a public/private partnership lens or an small enterprise development model. These can be done with small budgets but with a larger coverage area to increase the impact.

In principle, the PPR offers links to longer-term development. However, the committees formed during the project require training on formal institutional structures like charter/constitution, record keeping, and overall community organization skills. This is perhaps a result of some external elements and pressure of completing hard components in time. These steps are likely to sustain the good work done under PPR in the post-project scenario. As part of its exit strategy, in order to further strengthen sustainability, PPR could enable POs to make necessary agreements with the department of health of the respective areas for handing over the infrastructure and assets built under the project, as the case may be.

6.4 Effectiveness

6.4.1 Inclusion, Participation and Information Sharing

The Interventions were done in a smaller catchment area of 1-2 Health facilities per Partner. The interventions according to the partners understanding were in line with PPR strategic

documents. The coordination with the communities was capitalized on the already made community structures of the UC and village development committees organized by another NGO in the past. This was a good selection by not duplicating and maximizing the impact by working within the already organized structures. The coordination with the District health authorities was also working and had resulted in round table meetings (LSOs, VOs, COs and community leaders) while the District development forums meetings were also organized by these NGOs which were chaired by the DHO.

The nutrition component could be made more effective through building partnerships with, and providing information about, other nutrition partners and where to refer or track already referred cases for the IYCF, for treatment of malnourished cases in outpatient care and into the specialized Nutrition stabilization centers for treatment of Nutrition related complications. The focus on Nutrition counseling, screening, referral, micronutrient supplementation etc. were seen as a lower priority or a lower understanding at the health facility levels which has a better room for improvement. Investments in nutrition and increased focus on preventive and therapeutic Nutrition shall be improvements which eventually decreased the communicable and non-communicable health burden in the communities and has long term positive impacts.

The health system strengthening approach is focused on provision of need based solution to the target health facilities after consultations and needs identifications along with the health staff. Health facilities are provided with washrooms, Solar systems for energy backup, MNCH equipment's, renovations, some female staff is also provided with a 1.5 years course of health technology. There are community health centers which have basic health care practitioners like LHVs, Dispensers. Provision of furniture, medicine and medical equipment to LHVs proved to be effective in enhancing their outreach and quality of service delivery.

Other strategic actions that enhanced effectiveness of the programme quite significantly include revitalization of HMCs with the aim to include marginalized groups to effectively partake in the health related matters, and assistance to capacitate CRPs to train the community institutions, individual volunteer and community health workers and have the ability to run the advocacy campaigns for more controversial health issues (family planning etc.). This resulted in increased motivation and professionalism in the CRPs, equipping them to better articulate the discourse of change.

Most of the community members were aware about the PPAF PPR programme due to ongoing work of the PPAF partner organizations with the same communities for quite sometimes. All of the FGDs participants acknowledged PPAF partner organizations to have targeted community needs only without any bias or discrimination. It came up very strongly during the FGDs that women were specially facilitated to avail service through respecting local customs towards women's privacy. It is obvious that over a period of time PPAF partner organizations had evolved very effective modus operandi to ensure participation and inclusion of women and other groups. Although health needs of women are addressed to a large extent yet engagement of adolescent girls on issues related to personal hygiene and specific health & nutrition needs of this age groups requires great attention. In response to if male counterparts supported females to avail ANC and PNC services a great majority of them confirmed that males not only encouraged them but also accompanied them to health facilities. In response to the question how they learned about the PPAF partner organizations services in their area, most of the men and women informed that they were already aware about PPAF partner organization's work and services within the communities. Female in response to question on whether they knew about the support mechanism for the ANC, PNC, RH and FP informed that they were made aware about the mechanism through community mobilization team and CRPs. The community mobilization teams are to be trained on diet diversity and proper caloric

intake during pregnancy and importance of breastfeeding and complimentary feeding for (0-59 months) children.

The behavior of the staff was termed as friendly and cooperative. In the visited areas all FGD participants called PPAF partner organizations staff humble and informed to have received response to all their question and queries.

Better forecasting of fund flows could have further improved the effectiveness of the programme. Though the KIIs reveal that PPAF support remained mostly timely, in few cases (EPS, NIDA & LASOONA) the POs reported delay in either settlement of financial claims or allocation of budget for continuity, which subsequently created distress among PO & community.

6.4.2 Complaint and Feedback Mechanism

A formal Complaint & Feedback mechanism was not part of the implementation methodology for PPR. However, the same could be included for future interventions. Once included, the mechanism would also entail information dissemination about the complaint response mechanism and installing complaint boxes inside the health facilities. The POs and communities will be informed about the procedures to lodge the complaints, and the steps involved in addressing the complaints. . It can be advisable for the PPAF to prepare a minimum information package for the compliant and response mechanism to embed in the community outreach and mobilization approaches.

6.4.3 Effectiveness of M&E System

A strong project level M&E system was in place to support projects' implementation, monitoring reports are indicative that monitoring was jointly owned by the MEAL team, technical health staff and other key stakeholder that included district/agency health department and local health staff. The reports suggest that there was tracking of the findings and recommendations that is a critical bit of a MEAL system's strength. PPAF partner organization's MEAL coordinator informed that findings were timely shared with the team to take actions. Observations and agreed actions are shared with monitoring team while PPR tracks the status of agreed actions on quarterly basis.

6.4.4 Coordination

The coordination, in the visited areas, during the project remained very good. Representative of health department in the programme area termed coordination very effective. PPAF partner organization implementation team coordinated well with the stakeholders during the course of implementation. DoH remained actively engaged and monitored the project in the field. Also project maintained good coordination with relevant line agencies as Project Directorate of Health as they participated in monitoring visits as well. The project reports indicate that PPAF partner organization maintained very good coordination with other relevant provincial and federal forum. It is expected that the resultant networking will be beneficial for all future interventions around the theme of health and nutrition, being it executed by PPAF or any other entity.

6.5 Efficiency

One of the key issues highlighted by the POs during the strategic assessment was that the fund flows remained uncertain, ostensibly due to time-lapses in fund releases by the donor to

PPAF. Whenever the funds were made available, the project activities were implemented according to the agreed upon timelines and with allocation & utilization of adequate resources to meet the health needs of the community. A satisfactory level of service delivery was carried out according to the implementation plan of the project. Community perception during the field activity suggests that the H&N component of PPR has resulted in improved health status of target beneficiaries, especially PLW and under-five children.

Though the overall efficiency of the programme remained good, it could have been even higher if the funds flows could have been more regular and planned. PPAF partner organization's head of programs mentioned about allocation of adequate human resource to ensure project's implementation was smooth. PPR project's progress has been steady in all the quarter as the variance section of the reports have shown. Increased focus by PPAF to implement its MIS system will further help in tracking set indicators through field level sound data collection, analysis and tracking system which enable concerned quarters to track and showcase achievements. In a few cases, partner organization's field staff was not clear on targets and reporting requirement.

No formal or informal CbGMP structures have been witnessed in field, though it is understood that PPR has implemented the CMAM pilot program with four POs (BRAC, BRSP, TF and PIDS). CMAM activity needs viable government nutrition cells to implement activities. PPAF might target families with U5 children on nutritional monitoring of their children using MUAC, weighing children & possible signs of malnutrition in CU5 & PLWs.

7.0 H&N COMPONENT – ASSESSMENT CONCLUSIONS

- The foremost general conclusion is regarding the fund flows. A number of interviewees pointed out that the fund flows remained rather irregular at times. As per PPAF representatives, this was due to non-issuance of funds in a timely manner from the donor side. PPAF tried to counter this challenge by utilizing its own resources to bridge the gap, however, even this practice was discontinued later. Overall, this resulted in distorted execution of the project activities, with extreme peaks and leans in the workload of PO staff, leading to both qualitative and quantitative challenges.
- Project health ANC, PNC and Primary Health Care services were strongly appreciated by different community group as addressing their critical needs in the most suitable manner.
- It was generally observed that the staff was clear about their interventions and the sustainability plan was dependent on the length of their contracts and interventions given in the No cost extensions.
- Findings of the FGDs with men and women indicate that wives and husbands are more frequently discussing RH, FP and STDs now.
- The focus on Nutrition counseling, screening, referral, micronutrient supplementation etc. were seen as a lower priority or a lower understanding at the health facility levels which has a better room for improvement. It is understood that nutrition component was taken as a pilot under the programme, and it can be extended in the next phase (if any).
- Project document did not capture a detailed analysis of the problem especially the contextual factor those feed into problem.
- Most of health staff found training a refresher of the training and skills they had acquired earlier.
- The referral mechanism from the village committees to the health facilities seemed to be functional and good binding was observed between the village leaders and the health committee members and the hospital staff.
- There was no mechanism in place to know if trained staff was making use of the training they received and whether trainings improved their work. There was not mechanism at the institutional level to monitor these trainings.
- Health & Nutrition staff lack orientation on management information system (MIS). PPR program has MIS system, monthly OPD reported on BHU and CHC for ensuring overall access of the local population to these facilities.
- The health facility staff requires training on Healthy Timing and spacing of pregnancy and stock out criteria of family planning methods.
- The community mobilization teams are not fully trained on diet diversity and proper caloric intake during pregnancy and importance of breastfeeding and complimentary feeding for (0-59 months) children.
- Issues related to personal hygiene and specific health & nutrition needs of adolescent girls are not addressed according to the standards.
- The community outreach health workers do not have sufficient knowledge on topics related to oral rehydration therapy and integrated management of neonatal and childhood illnesses
- Under the programme, IEC material with consultation of DoH for water, foodborne and communicable disease were provided to the CRPs and health facilities as part of communication strategy. However, during field visits, no proper IEC material is available

on topics related to communicable diseases i.e. (Pneumonia, Scabies, Tuberculosis, Typhoid etc.) and vector and water borne diseases.

- The social enterprise development model seems to be more sustainable. Communities in areas such as Swat are contributing to the medicines. Fee is being charged in areas such as swat, Lasbela etc. If this is given some more attention to ensure self-sustainability of the health projects, it has very good replication potential.
- Communities are not familiar with the any complaint and feedback mechanism in the programme areas.
- Due to the unknown lengths of contracts and extensions, it was observed that the sustainability measures could not be planned on time. There were extensive support in kind and in terms of capacity building provided to the health staff and the health committees by the PPR programme. 76 government health facilities were supported, these are sustained by government line department and PPR facilitated the govt facilities to share the burden. 32 CMWs (2 year training program) will be deputed to ensure the facilities are sustainable.
- Though the programme remained relevant in terms of menu of services offered and area selection, community members especially women in few areas (SWAT and Bajaur) showed reservation over site selection for CHC and mentioned that they are encountering access issues.
- It is not conclusive to say if need was more acute in inaccessible areas. The programme used the approach of first selecting the target geographical area, and then determining health related needs of that area. Arguably, it could be done inversely as well, leading to the needs becoming the driving factor rather than the geographical area.

8.0 H&N COMPONENT – RECOMMENDATIONS

- Timely availability of funds is essential. Any delay, especially after the field team has been mobilized, compromises the efficiency and effectiveness of the implementation strategy. It is recommended that in future, PPAF legal department should ensure that sufficient provisions are made in the legal instruments (i.e. agreement between donor and PPAF, and agreement between PPAF and PO) to essentially guarantee smooth fund flows. Furthermore, PPAF finance department should also develop modalities, similar to the bridge-financing mentioned above, that could be employed in case of any inadvertent delays in the receipt of funds from the donors.
- PPAF should strictly adhere to its standardized format to report monitoring findings to help ensure activities are monitored and reported in a consistent manner - A consistent format helps in better tracking and reporting System.
- There is need to refer to the knowledge development documents and the KAP surveys conducted by the POs and these findings are to be triangulated with the current strategic assessment and other programme evaluation and PPR strategies.
- Onwards specialized referrals to the secondary and tertiary care hospitals for specialized medical needs and for Nutrition treatment need improvement.
- There could be better planning for the training to ensure these add a substantive value to the existing knowledge and skills to improve the practices. Tracking of training learning can be improved through collaborative action with the government line agencies.
- A consistent approach to project's context analysis is important as it proposes more viable and consistent solutions to draw optimal capacity of organization's function.
- PPAF should have a Complaint and Feedback Mechanism that can be installed quickly made operational in case an emergency. In any emergency response complaint and feedback mechanism are very crucial. Utilization of information pack for the complaint and response mechanism to be embedded in community outreach approaches.
- There should a standardized approach to record beneficiaries data especially data related to different disaggregation markers and vulnerabilities.
- Emphasis is to be made on developing social enterprise in order to implement PPAF's strategy in letter and spirit and ensure sustainability of activities beyond project life.
- Since *"Assistance to resource persons (financial & technical"* is one of the mandatory components of PPR programing; PPAF needs to include indictors (outcome level) under health & nutrition logical framework matrix.
- Strong coordination is to be put in place with district immunization teams to enhance proportion of children fully immunized against vaccine preventable diseases
- Though the improvement in understanding of community and increased safe practices is a reflection of improved capacity of trained staff, it will be beneficial to include few parameters in the monitoring system (e.g. increase in the number of PLW to access ANC and PNC services, increase in the number of children fully immunized against vaccine-preventable diseases, decrease in the incidence of diarrhea, pneumonia, and malaria in children under age of five etc.) to capture and quantify this impact.
- The MIS system could be further strengthened if H&N staff could be provided orientation and refreshers

9.0 EDUCATION COMPONENT

9.1 Assessment Objectives for Education Component

The specific objectives of the assessment are as follows:

- Assess relevance, effectiveness as well as strategies under PPR in relation to target population needs and proposed program outcome.
- Identify the interventions and approaches that worked well and that did not work well.
- Identify areas of improvement and recommend specific workable actions to enhance relevance and effectiveness of education strategy.

Following are the key questions addressed during the assessment.

- Assess which interventions worked well in increasing enrollment rate (especially for girls), decreasing drop-out rate; separate analysis and recommendations for community schools and Govt. schools to be made in this regard.
- Assess how POs have collected and analyzed data related to out of school children. Is this accurate? How the data has been utilized in ensuring identified out of school children are enrolled in the schools. Assess relevance and effectiveness of role of SMCs and CRPs in increasing enrollment rate and minimizing drop-out rates.
- Assess relevance and effectiveness of role of SMCs and CRPs in increasing enrollment rate and minimizing drop-out rates.
- Assess what innovation and new approaches have been adopted to improve access and quality of education.
- Assess relevance, usefulness and impact of POs' strategy for social enterprises in education and health as well as viability and sustainability strategies of social enterprises established.

9.2 Assessment Framework

Table 10: Assessment Framework for Education Component

#	Research questions	Proposed tools	Research participants	Descriptions
01	Assess which interventions worked well in increasing enrollment rate (especially for girls), decreasing drop-out rate; (separate analysis and recommendations for community schools and Govt. schools will be made.)	KII and FGDs	KIIs with PPAF project staff, PO staff and Education Department. FGDs with students, SMCs, CRPs and teachers.	Strategies will be the core discussion agenda while having KIIs and FGDs
02	Assess how POs have collected and analyzed data related to out of school children. Is this accurate data? How the data has been utilized in ensuring identified out of school children are enrolled in the schools	KIIs and FGDs	KII with POs and PPAF staff. FGDs with enrolled students	Interview with the sample students, verifying their admission date, General register (GR)
03	Assess relevance and effectiveness of role of SMCs and CRPs in increasing enrollment rate and minimizing drop-out rates.	FGDs and KIIs	FGDs with SMCs and CRPs, and KIIs with Education Department	Interview with the randomized sample of SMCs, CRPs and Education Department

#	Research questions	Proposed tools	Research participants	Descriptions
04	Assess what innovation and new approaches have been adopted to improve access and quality of education.	KIIs	KII with PPAF and Pos	Innovation and new approaches will be the focus of discussions
05	Assess relevance, usefulness and impact of POs' strategy for social enterprises in education and health as well as viability and sustainability strategies of social enterprises established.	KIIs	KII with PPAF and Pos	Social enterprise model as a whole will be studied

Based on above frame work following questionnaires were developed with the consultation of the client.

a) KII questionnaire for PPAF Education Staff
b) KII questionnaire for POs staff
c) KII questionnaire for Government Education Officials
d) FGD questionnaire for enrolled students in Government schools/community schools
e) FGD questionnaire for teachers of Government and Community Schools
f) FDG questionnaire for SMC/ CRP members of Government Schools and Community Schools

Education Component – Assessment Methodology

A mixed methods approach of primary data collection and literature was applied to conduct the project's strategic assessment. The details of the methodologies are given below:

9.2.1 Literature Review

A review of the existing literature was conducted. Key documents those were reviewed included;

- Education Strategy
- Agreements
- Log Frame
- Work Plans
- Quarterly Progress Reports

9.2.2 Primary Data Collection

A. Focus Group Discussions

Focus group discussions were conducted with the project's primary beneficiaries. For each of the focus group discussions qualitative tools were developed to collect information in a clear and focused manner. These focus group discussions were conducted with 6 – 10 participants a group. A criteria based approach was applied to qualify participants of the focused group discussion. For each of the participant the participation was voluntary and they were allowed to quit FGDs any moment they opted. A team of two members conducted focus group discussion, one performed the role of a moderator and other performed the role of a note taker. Focus group discussions were noted down on the specialized templates in English. Each of the focus group discussions were concluded in a time span of 35 – 50 minutes. Prior

to the start of the focus group discussion participants were fully briefed on the purpose of the FGD and expectation and utilization of the FGD findings and also participants' privacy. The table below has all the details of the FGDs.

Table 11: Details of FGD

Project	Group	#
PPR	SMC members	3
	Community Resource Persons	3
	Teachers	4
	Children below 18 years (Community Enterprise Schools)	1
	Children below 18 years (Govt. schools)	4
	Total	15

B. ***Key Informant Interviews (KII)****:*

Key informant interviews were conducted with the projects' primary stakeholders to get their inputs against pre-defined questions. Each of the KII was conducted on the explicit approval of the relevant stakeholder on a pre-agreed schedule – for each KII a maximum of 50-70 minutes were required. The KIIs were noted down on a pre-defined template in English language by the interviewer. The participants were allowed to drop any question(s) and also they were allowed to discontinue interview at any point. The table below contains the details of the KII.

Table 12: Details of KII

Project	KII With	#
PPR	Education Department Officials	3
	Project Office Staff	8
	Total	11

9.2.3 Training of the data collection team

A full day of training was organized for the data collection team to fully orient them on the tool used during the data. They were very clearly explained the DOs and DON'Ts as they interacted with govt. officials during data collection. They were provided with ample opportunity to ask questions regarding behavioural protocols to ensure they clearly understood the importance.

Team members discussed tools with each other to further consolidate their understanding of the tools and asked any question they had. The note takers were oriented in details on how to take note down the discussion, and also how to observe the proceeding and note important reactions, gestures and expressions. The team was provided English version of the tools.

9.2.4 Data Validation and Quality Control

Each of the FGDs and KII were supported through signed list of participants or with thumb impression as applicable. As permissible team made photographs of the proceedings to support the activities they had carried out in the field. The assessment expert did a detailed debrief with the project evaluation team for the FGDs and KIIs they conducted at the start and provided them feedback on the areas of improvement. For the FGDs a moderation guide was provided to the team to help them build the conversation and guide them in that.

9.2.5 Data Transcription

All the FGDs and KIIs were transcribed into the digital format of Microsoft Word from the handwritten notes. The transcription included participants' inputs and observation with the details of the proceeding and different modes and gestures those groups exhibited as a whole.

9.2.6 Data Analysis

A. Thematic Analysis

Thematic analysis approach was used to analyse the data. Based upon tools different theme were identified and a matrix was created. Against each of theme convergence and divergence trends and unique inputs were studied.

B. Triangulation

The findings were drawn through the triangulation of project's data sets and reports, findings against the FGDs and findings against the KIIs. The findings were organized against the key questions proposed against the evaluation criteria.

9.2.7 Ethical Consideration

All interaction with the respondents was only made after their consent and they were explained purpose of the data collection, and also use of the collected information. Consultant strictly avoided indulging into any conversation of political or religious nature, and did not use any jargons, words or gestures those could be offensive on religious, ethnic, gender, age or any other ground. Consultant strictly avoided any sexual advances, offers or favours to beneficiaries, neither promised any favours to survey participants. Consultant did not guide/or instigate respondents to provide specific answers, consultants did not misinterpret survey participant inputs or distort these. Safety and security of the survey participants is of the paramount importance consultant did not act in any manner putting security & safety of the survey participant at risk. Interaction with the respondents was guided by PPAF Policy and protocols.

9.2.8 Limitations

- The assessment is a validation of the reported results through qualitative methods thus these may not present a statistically valid picture of findings.
- Field team did their utmost to extract accurate information however possibility of some bias cannot be ruled out of qualitative information collected.
- The target of KIIs with education dept. could not be completed due to the unavailability of the department's officials due to vacations and general elections training in few districts.

- In few districts, it was vacations so FGDs with govt. school children could not be completed as targeted.
- Strategic assessment took place after a long of project completion and find the relevant project staff was very difficult. Respondents also mentioned that few information had vanished from their minds as it's too late to conduct this assessment.

9.3 Overview of Implemented Strategies

The PPR programme focuses on contributing to reducing poverty in selected districts of Balochistan, Khyber Pakhtunkhwa and Federally Administered Tribal Area. Being situated at the border of Afghanistan the programme areas are amongst the most vulnerable and underserved areas of the country which suffer from extreme poverty, as well as demonstrate extremely low education indicators.

The programme objective and outputs were achieved through a Community Driven Development approach by engaging Partner Organizations in the programme target areas. PPR designed an integrated approach including education; Salient features of which included:

9.3.1 Social Mobilization

Social Mobilization component is the basis on which all components of the programme worked. Social mobilization focused on strengthening and graduation of women and men's community institutions at village and union council level. It built their capacities to prepare multi- sectoral integrated developmental plans and empowered them to actively participate in the implementation of these plans in their villages and union councils. Social mobilization also enhanced their ability to develop linkages with government departments, local government, development partners and private sector which resultantly contributes to sustainable development.

9.3.2 Linkages and Engagement with Stakeholders

Linkages with other NGOs, government agencies and private businesses, and District Development Forums significantly facilitated attainment of the programme outcomes. For the private sector, their CSR policies were studied and appealed to accordingly. Aid, knowledge sharing, technology transfer and problem solving are the advantages which were acquired through these linkages.

9.3.3 Development of income generating plan for sustainability of past investments

Alternative income generating activities were adopted to reduce reliance on donors and ensured long term sustainability. Promotion of local enterprise through trained CRPs and business development services through specialized agencies helped develop a culture of entrepreneurship and opened up the possibilities for alternate income generation activities. Continuous improvement and enhancement of capacity building courses was the essential ingredient.

9.3.4 Public Private Partnerships

Partnerships with government agencies and private businesses was considered is a viable option for the project support. Public sector networking, partnerships and funds along with private sector efficiency, innovation and accountability formed a strong mandate and a mutually beneficial relationship amongst all. Another point to consider in public-private

partnerships is potential linkages in exit strategies. HOPE is a local NGO that utilizes corporate sponsorships to run their schools during the long term. Barclays Bank and HSBC are both corporations that have taken up long term responsibility for funding specific schools.

9.3.5 Formation /Activation of Education groups & School Management Committees

These groups and committees were formed to ensure facilities and information centers are accessible to everyone, especially the poorest. CRPs were the integral parts of these groups, providing linkages. An important aspect of this step was advocacy. Advocacy for basic human rights like the right to education, freedom of expression, religion and thought and equality between men and women, were made part of the mandate to ensure equal access and opportunities.

9.3.6 Investment in physical and social infrastructure

One of the impediments to access to schools and quality education are the lack of facilities and services in schools. To bridge this gap, it was considered quintessential to improve schools' physical infrastructure, facilitate teachers, involvement communities and undertaken capacity building of all.

9.3.7 Sustainability of the Community/Enterprise Schools

The main challenge for community/enterprise schools is financial sustainably for smooth and continued operation. This covers salary for teaching staff, stationery and fulfilling other requirements. For community/enterprise schools mainly LSOs/VOs are responsible for making decisions regarding fee increase and collection, searching for donor opportunities, philanthropists and developing linkages with government line departments for future of the schools. Social enterprises have been successful in India and throughout South Asia. It holds a lot of development potential for Pakistan and PPAF hopes to promote it in its localities. Education based social enterprises are few, but they appear to be poised for growth in the near future.

9.4 Field Findings

9.4.1 Relevance and Ownership of Education strategies

The Education component's interventions have been highly relevant to: communities, project objectives, local government education departments, Government of Pakistan's priorities, UN sustainable development goals, etc. Existing government schools were strengthened, government school teachers were provided training, social enterprise schools were established where there were no government schools, incentives were given to the poor students and many innovative interventions were adopted, such as, provision of transport, stationery, etc. to the students. The consultants perceive that the activities undertaken under the Education component remained substantially relevant for increasing access to schools and improving quality of education.

PPAF has very strong social network at the grassroots level, i.e., Community Organization [at neighborhood level], Village Organization and Union Council Organization. Through this network, PPAF ensures access to each and every member of the community, village and union council. The Community Resource Persons [CRP] are local persons who were entrusted with the task of identifying out-of-school children. They worked through COs and VOs for the identification of out-of-school children. At a later stage, the data of identified out-of-school

children was compared with the education department data, which confirmed enrollment of these children. Therefore, the possibility of missing out on out-of-school children is minuscule.

Education department officials informed that PPR has had a positive contribution in increasing enrolments. For example, Bibi Haleema (DO Chitral) said, “enrolment campaigns by PPR supported us to bring out of school children to the schools. Since last year, 4,000 new children were enrolled as per department record”. Both CRPs and SMCs have played very important roles in increasing the enrollment and decreasing the drop-out rates. Both CRPs and SMCs conducted door-to-door enrollment campaigns in their areas and persuaded parents for enrolling their children in schools. Information gained from FGDs and KIIs strongly suggest that CRPs were more effective in increasing enrollment and decreasing drop-outs, and rightly so. CRPs are relatively experienced and trained professionals when compared with SMCs many of whom were capacitated during this project.

The project provided training to CRPs and SMCs on communication skills, identifying key points to engage government officials, local influential and the prayer leaders etc. They were made aware of the Articles 25 A and 28 of the Constitution of Pakistan, defining education as the basic right of every child. These trainings improved the communication skills and confidence level of CRPs and SMCs. As a result, they were able to hold meetings with school teachers, education department, local influential and elected representatives. However, in some cases, the number of female CRPs remained low, which could be improved in future. Further, the consultants feel there is need for periodic refresher training. Also, many respondents from teachers and community suggested that teachers should also be invited to the CRP / SMC training. This would help create a uniform understanding.

Creation of social enterprise schools and all the inputs are highly relevant, useful and will have positive impact for achieving the objectives of PPR.

9.4.2 Sustainability of interventions / strategies

Many interventions under the Education component were made in the government schools. Such interventions have strong sustainability potential, because of the ownership of the line department. Every intervention that has been tried and tested under this project is highly replicable in any part of the country. However, some activities require continuous financial support, such as, learning materials, maintenance of school facility, incentive to the students and teachers, etc. If such funds are made available, all the activities can become sustainable.

The Education component’s interventions have resulted in increased enrollment of children, including girls, enhanced quality of education, better trained teachers and community satisfaction.

Establishment of social enterprise schools is a good innovation and has attracted enrollment. Mixed responses have been received from the Programme Officers of PPAF and its partner organizations on the sustainability aspect of social enterprise schools. Few of the respondents were of the opinion that these schools could only continue till the time PPR financial support is available. In their view, to sustain social enterprise schools, financial and technical assistance are needed without which they might close down sooner or later. For example, in Bajaur, the PO focal person pointed out that the community, being very poor, will not be able to pay any sizeable fee and hence teachers’ salaries will be difficult to manage after the PPR

support. However, many others were confident that since the schools are the need of the community, it could be sustained. Few community enterprise schools have already started charging a nominal fee from the students – Rs. 100/- in Gwadar to Rs. 700/- in Swat. The fee in generally not uniform and charged according to the financial status of the students. They think that it will inculcate a habit within the community to pay for the education, increase ownership, and the resultant funds will help sustain the school. The responses from most interviewees reflect a lack of understanding about the original concept of social enterprise, i.e. its seld sustaining nature. The consultants perceive that in their current status, many social enterprise schools do not conform to the strict definition – being unable to financially sustain on their own. Nevertheless, they remain an important intervention and are likely to graduate in self-sustaining state with time, given that some financial and technical support is available to them in the short term. The project also made meaningful partnerships with local education departments, and with CSOs and other organizations where they were available. These partnerships might be helpful in devising a mechanism for ensuring sustainability of the social enterprise schools. For example in case of EPS (Swat), an MOU has been signed with the LSO and VOs that they will take care of the equipment and other support provided to these schools in post-PPR scenario. VOs have also committed to run enrolment campaigns from time to time for out-of-school children.

In some cases, POs are trying to leverage technical, in-kind and cash resources from a number of government, private, civil society organizations, etc. for supporting social enterprise schools. Under PPR, AKRSP supported 4 community enterprise schools that existed since 2001 under the financial support of Aga Khan Education Service. These schools, in Bamborait valley are serving Kalasha and other communities. No fee is charged in these schools as the community is very poor. Maintenance and other needs are addressed from the Endowment Fund and some support from other NGOs.

In Bajaur Agency some funds were mobilized through the Bait-ul-Maal and the local zakat committee as reported by SMC members. The funds generated from these sources were used to purchase stationary for schools and also to provide free uniform, bags etc. to the very poor children.In some places, involvement of local influential, elected representatives and District Administration have been helpful, i.e., in improving school infrastructure, school up gradation, provision of additional teachers, etc. This was particularly the case in Pishin as reported by CRPs

Establishment of District Education Forums was envisaged in the program design. However, in terms of regular meetings at fixed intervals, active and full participation from all members, and follow up on the decisions taken, the performance of these forums could be further improved. Wherever elected representatives were engaged/invited it has produced commendable results. EPS Sawat invited elected representatives in its two meetings and highlights issues of appointment of additional teachers in schools, non-functional of Maktab Schools, political interference in Government schools. According to EPS most of issues were resolved.

Majority of the teachers mentioned that the environmental clubs are very useful for us especially for single teacher schools they means a lot. These clubs support the teacher in maintaining discipline and helps in keeping schools clean.

The trainings on DRM also helped the children become aware of how to keep safe in disaster situation because children are extremely vulnerable individuals in case of any disaster. One of the PTC members shared that when he was in a school visit, a parent came to appreciate the head of the school on providing training to the children on disaster preparedness.

9.4.3 Effectiveness of interventions / strategies

Overall, the Education component has been quite effective in meeting the stated 'education related' objectives of the project, i.e., increase enrollment, increase girls enrollment, provide quality education to the poorest of the poor communities, increased participation of communities in their children's education, mobilizing local resources, leveraging support from similar programmes in the areas, etc. Efforts have been made to obtain support from the for-profit private sector, e.g. in the case of BRAC. These efforts should be continued and expanded to all target areas

Predominant majority of interviewees rated school infrastructure improvement, CRP and SMC trainings, and incentives to the students as the most effective interventions. Indeed, enrollment drives and door-to-door awareness campaigns resulted in increased enrollment and decrease in drop-out rates, but these campaigns became effective—as has been reported by CRPs and SMC members—as a result of trainings they received under the project.

Joint enrollment drives by the Education Department and CRPs/SMCs have produced even better results and showed considerable increase in enrollment.

More than 50% teachers who participated in FGDs opined that students learning achievements have enhanced as a result of teacher training. Almost 100% students who participated in 4 FGDs also expressed that now the teachers are employing more group-based methods compared to lecture method – something they refer to as "Joyful Learning". This observation was also validated by parents during FGD with the Parent Teachers Committee (PTC).

Divisional Education Officers in all visited areas were very happy with the teachers training, despite some reservation on the process adopted. For example, they were of the view that the education department should have been engaged more in terms of identifying training needs, back-up plans etc. Many stakeholders indicated that proper Training Needs Assessment should have been carried out before launching any trainings for the teachers (e.g. DO Gwadar and Chitral). They were particularly pleased that the teachers are now able to provide more Activity Based Learning – DO Gwadar and SDEO Swat themselves observed this improvement by visiting various schools on their own.
Almost every interviewee has expressed the need for teacher training on regular basis. They opined that 4-5 days training only once is just not enough as it cannot encompass all aspects of quality education.

Provision of IT laboratory, where relevant teachers training was also provided, proved to be helpful in improving the quality of education. This was the case with AKRSP and EPS for example. In cases where training could not be provided, IT laboratory did not remain very effective. One of the reason is that such schools – especially the Government schools – have senior age teachers (40 years or more) who are not computer-literate.

Apropos increase in girls' enrollment, interviewees with the beneficiary students and their parents, Partner organizations and Education department have attributed this is mainly to the construction of boundary walls and latrines. Parents' foremost concern is always about their girls' protection and inviolability. This finding is aligned with the earlier nationwide surveys conducted by various international organizations.

No intervention was rated as the least effective. All the interviewees considered each intervention useful and helpful in increasing enrollment and decreasing drop-out.

Improvements in the physical infrastructure of the existing government schools attracted increased enrollment. DO in Darosh (Chitral) reported that in an existing school that was badly damaged in the previous earthquake, a couple of rooms were reconstructed and outer boundary wall constructed. In this case, the enrolment increased from 40 students to 245 students as claimed by the department.

In areas where government schools are far away, Community Enterprise Schools played an important role in getting the out-of-school children enrolled. In Surbandar village Gwadar, the community informed that the PPR supported community enterprise school has made it possible for them to send their children to school, as the government school is located far away and no community member can afford transportation costs for their children to attend the school.

Among the poorest of the poor families, incentives in the form of school uniform, stationery, etc. was the major contributory factor for enrolling children in the schools. This finding in common across all the target areas and few quotes from the respondents are presented here. Stories are available of less privileged parents who are sending their children to schools after provision of incentives (CRP FGD Chitral)

“Incentives for students were the most effective part of the interventions as it attracted parents as well as children’s to schools. It was a kind of support for those parents who were not willing to send their children to school due to their poverty, because mostly in our area children are out of school due to the fact that their parents are not being able to provide them uniform, shoes, bags or other stationary needs.(SDEO Majeedullah Swat)”

“The most effective intervention was distribution of bags to students because it contributed a lot in increasing enrollment. Due to incentives, parents willingly sent their children to schools, and department also witnessed more incentive base admission.(Inamullah Khan Bajaur)”

The school infrastructure improvements have been carried out with the consultation of the respective District Education Departments. However, these contributions of the project have not been entered in the District Education Departments records. Some of the respondents (eg KII with PO Sawat) have raised the issue of non-availability of funds for provision of furniture in some government schools.

Some SMC members have expressed concern over their non-involvement in the utilization of school infrastructure budget.

9.4.4 Efficiency of interventions / strategies

The Education component of the project is part of the integrated model of PPAF’s work. As reported by the project and PO staff, needs were identified and prioritized in formal interactions, mostly roundtables, with the line department, and communities’ willingness was ensured before selecting a location and making interventions. Building synergies and leveraging resources wherever possible was done and paid dividends. Partnerships with organizations like, Frontier Education Foundation, Tele-Taleem, Global Fund for Education, Aga Khan Education Service, Pakistan Academy for Rural Development, Elementary Education Foundation, etc. helped in ensuring efficiency. Engagement of local influential and politicians bore good results wherever achieved.

The standard PPAF practice of implementing the project through POs, LSOs and COs was adopted by PPR, which resulted in efficient execution of the project. POs remained the actual project implementers and coordinators through which PPAF implemented each project intervention. Specifically, POs approached the communities, district education departments and other partners, designed intervention plans, conducted social mobilization, etc. The communities attended meetings, enrolled children in schools, provided teachers, etc. This arrangement proved efficient in the project delivery. There were no issues of fund flow from PO to CO. However, the number of COs remained greater than the number of interventions that could be funded, thereby making decisions difficult and sometimes resulting in minor delays.

Additional teachers were very innovative idea which was commended by majority of the respondents where additional teachers were provided. It has not only shared the burden of the teachers but also improved the learning outcomes in the subjects like English, Math and Science etc. The improved results led to some schools funding the additional teachers through PTC funds even after the PPR support expired.

10.0 EDUCATION COMPONENT – ASSESSMENT CONCLUSIONS

- CRPs and SMC members, in particular, were very satisfied with the trainings they had received under the project. These trainings enhanced their communication skills that boosted their confidence level and they were able to communicate effectively with the parents, teachers, education department officials, local influential and elected representatives. These trainings enhanced their understanding about the Constitution of Pakistan's Article 25-A [provision of free primary education is the duty of the government] and Article 28 [it is every child's right to get free primary education, among other things]. The ultimate result of these trainings was that the parents were persuaded to send their out-of-school children to schools. *However, SMC members of GPS Gambak, Bamborete in District Chitral were not provided any training at all.* "Only those interventions were carried out which were priorities in SDPs, the training is planned in next phase" as reported by PO Chitral

- 04 to 05 days trainings were imparted to the teachers and CRPs/SMC members. Majority of respondents expressed the need for follow-up trainings.

- The assessment concludes that to check drop-out rate and increase enrollment in government schools, that each school must have appropriate and adequate physical infrastructure, well-trained teachers and some form of incentives for the poorest of the poor students.

- It can also be concluded that SMCs role is pivotal in increasing enrollment and curbing drop-out.

- It can also be concluded that parents are comfortable enrolling their children to the nearby school. Enrollment is inversely proportional to the distance exists between the school and a house.

- Data for out-of-school children is generally available with the local education department and could also be validated through other sources e.g. Pakistan Education Statistics Report. Methodology adopted by POs for collecting and analyzing data related to out of school children was not based on scientific principles of quantitative data collection.

- In terms of the enrollment, it can be concluded that the role of both CRPs and SMCs was highly very relevant and effective in increasing enrollment and decreasing drop-outs. Further, in the consultants' opinion, the strategy to provide support in physical infrastructure (washrooms, boundary walls etc.), hygiene kits and the ICT support (computer lab) contributed equally, if not more, in encouraging enrolments and decreasing dropouts.

- The strategy to sign an MOU with the district officials and getting approvals from the Education department ensured that there is no duplication of efforts or funds – work done under PPR and that under ADP of the government remained exclusive to each other. However, in few cases, the coordination seemed below par, e.g. in one case in Bajaur, project supported interventions (physical interventions) were later done away with by the government.

- Student enrollment will increase every year, therefore, additional teachers are required

- IT labs and computers have been provided in government and social enterprise schools, IT teachers and IT training were provided but these schools need support in teaching ICT for education such as use of computer in teaching/ learning different subjects. AKRSP uses different strategy such as hiring/ nominating qualified teacher in computer science as lab in charge for six months and it is her/his responsibility to train two other teachers in computer teaching. This approach is more workable as well as sustainable

- Primarily, it is the responsibility of the federal as well as provincial governments to provide free primary education to every child in the country. However, failure of these governments in fulfilling their responsibilities, under the programme PPAF has worked with other non-government organizations to enroll out-of-school children and provide them quality education. Hence, the strategy to build partnerships with all available organizations is fine.

- Experience has proved time and again that project-based activities are temporary in nature and cease to exist sometime after the project closure, unless specific sustainable measures are taken. It is feared, that the same phenomenon will prevail in this context too. Incentive part could not be sustained as mentioned by PO Chitral & Bajaur, FGD SMC Chitral and additional teachers of Swat. "In my opinion, the government institutions won't be able to sustain the results of grant interventions especially the incentives part will be no longer sustained because we can only provide the text books not the other incentives so it is obvious the incentives-based admission will be no longer happen. The PTC funds as well the conditional grants amount is also not that much to sustain the results or to provide salaries to additional teacher.(SDEO Majeedullah Swat)"

- Many KII respondents suggested for timely disbursement of funds from PPAF to partner organization because delays in funds not only affects their rapport with stakeholders especially Education Department and communities, it also affects the quality of work. (KII Gwadar, Bajaur). A number of interviewees pointed out that the fund flows remained rather irregular at times. As per PPAF representatives, this was due to non-issuance of funds in a timely manner from the donor side. PPAF tried to counter this challenge by utilizing its own resources to bridge the gap, however, even this practice was discontinued later. Overall, this resulted in distorted execution of the project activities, with extreme peaks and leans in the workload of PO staff, leading to both qualitative and quantitative challenges.

- PPAF's existing methodology for collecting and analyzing data related to out of school children could be made more scientific by taking family data from the National Database Regulatory Authority [NADRA] and take it along while conducting door-to-door survey for out-of-school children. However, this will be a very time consuming exercise without making much [or any] difference. The existing strategy is fine, as long as the CRPs/SMCs do it with commitment and do not miss out any household.

11.0 EDUCATION COMPONENT – RECOMMENDATIONS

- It is recommended to scale down the integrated development approach adopted by PPAF for the PPR program (i.e. supporting an area / community in the fields of education, CPI, health & nutrition together) to individual component. That is, provision of focused, all-encompassing support to a lesser number of schools might be experimented. Under this approach, each school must have appropriate and adequate physical infrastructure, well-trained teachers and some form of incentives for the poorest students. This could result in better visibility and concentrated impact and may serve as model for other schools in terms of the desired results, i.e., increased enrollment and reduced drop-outs.

- Sustainable interventions must be made. For example, social enterprise schools are likely to continue beyond the project life, if: salary is paid to the teacher; additional teachers are recruited and school infrastructure expands as the enrollment increases; incentives to the poorest of the poor students continue; adequate learning materials are available; etc. These schools must be handed over to the relevant education departments.

- Teacher training must continue with regular intervals. Similarly, follow-up / refresher training should be provided to CRPs / SMC members. Teacher training becomes due as soon as a new teacher is inducted and the syllabus is revised. Teacher training must focus more on the 'contents of the syllabi', which the teachers have to teach. Trainers were good, but it is better that future trainings are done by the local trainers—a language issue. With local trainers the trainees will be able to interact freely and understand things better.

- Project's contribution in government schools in all cases must be properly recorded in government documents to avoid wastage of government resources.

- As the project ends, the role of CRPs may decrease or ends altogether. Besides, SMCs are comprised of parents of students who are studying in that particular school. While it was important and useful for PPAF to engage CRPs for enrollment drives during the life of the project, this role must shift to the SMCs for the sake of sustainability.

- Training of SMCs must be provided once every year so that new members get trained. Such training can be provided by the School Head Teacher without any cost.

- Generally, the standard of middle and secondary school teachers is quite good. Efforts must be made to involve these teachers in providing teacher training to the local primary school and social enterprise school teachers.

- Other available avenues of funds generation must be explored. Bajaur Agency's experience is a case in point.

- PPAF as well as other organizations are themselves dependent on external funding. Hence, it is unrealistic to expect from PPAF to develop a sustainable programme that will last for many years. Therefore, PPAF needs to develop long-term partnerships with the national and international for-profit corporations for sustaining its social enterprise initiatives. Also, PPAF should sign MoUs/Agreements with relevant governments that such initiatives will be adopted by the governments after an agreed time period.

- Most importantly, PPAF must work with the local influential and elected representatives for every aspect of education, may it be construction of schools, up gradation of schools, provision of teachers, etc. This is the only approach that has the promise for sustainability. Elected representatives must be made members of the District Education Forums and their active participation in the meetings must be ensured.
- Timely availability of funds is essential. Delay in provision of financial resources, especially after the field team has been mobilized, compromises the efficiency and effectiveness of the implementation strategy. It is recommended that in future, PPAF legal department should ensure that sufficient provisions are made in the legal instruments (i.e. agreement between donor and PPAF, and agreement between PPAF and PO) to essentially guarantee smooth fund flows.
- For smoother implementation, and to ensure that most pressing needs are addressed, within the overall budget, transfer of funds from one head to another must be allowed to ensure optimum utilization of all the funds.

ANNEXURES

ANNEXURE 1: THE DETAILS OF H&N COMPONENT FGDs AND KIIs

1. DETAILS OF FOCUS GROUP DISCUSSION

Table 1: Focus Groups with Married Women

S/No	Partner Organization	District/Agency	Union Council	# of Participants
1	AKRSP	Chitral	Ayun	10
2	BRSP	Pishin	Khushab	8
3	EPS	SWAT	Koz Aba Khail	18
4	LASOONA	SWAT	Bar Aba Khail	11
5	NIDA	Bajaur	Khar	13
6	NRSP	Gwadar	Peshukan	7
7	SEHER	Pishin	Bostan	9
7	SRSP	Bajaur	Pachagan	16
9		Chitral	Darosh	7

Table 2: Focus Groups with Married Counter parts

S/No	Partner Organization	District/Agency	Union Council	# of Participants
1	AKRSP	Chitral	Ayun	12
2	BRSP	Pishin	Khushab	-
3	EPS	SWAT	Koz Aba Khail	8
4	LASOONA	SWAT	Bar Aba Khail	10
5	NIDA	Bajaur	Khar	7
6	NRSP	Gwadar	Peshukan	-
7	SEHER	Pishin	Bostan	-
7	SRSP	Bajaur	Pachagan	9
9		Chitral	Darosh	11

Table 3: Focus Groups with Health Management Committees

S/No	Partner Organization	District/Agency	Union Council	# of Participants
1	AKRSP	Chitral	Ayun	8
2	BRSP	Pishin	Khushab	7
3	EPS	SWAT	Koz Aba Khail	8
4	LASOONA	SWAT	Bar Aba Khail	8
5	NIDA	Bajaur	Khar	8
6	NRSP	Gwadar	Peshukan	11[4]
7	SEHER	Pishin	Bostan	7
8	SRSP	Bajaur	Pachagan	9
9		Chitral	Darosh	12

[4] In Gwadar; mixed HMC meeting was conducted.

Table 4: Focus Groups with Women who visited for ANC/PNC

S/No	Partner Organization	District/Agency	Union Council	# of Participants
1	AKRSP	Chitral	Ayun	8
2	BRSP	Pishin	Khushab	5
3	EPS	SWAT	Koz Aba Khail	9
4	LASOONA	SWAT	Bar Aba Khail	7
5	NIDA	Bajaur	Khar	10
6	NRSP	Gwadar	Peshukan	9
7	SEHER	Pishin	Bostan	7
7	SRSP	Bajaur	Pachagan	11
9		Chitral	Darosh	14

2. DETAILS OF KEY INFORMANT INTERVIEWS

Table 5: Informant Interviews with Partner Organization Staff

Informant Interviews with Partner Organization Staff			
S/No	**Partner Organization**	**District/Agency**	**Staff Designation**
1	AKRSP	Chitral	Project Manager
2	BRSP	Pishin	Project Coordinator
3	EPS	SWAT	Project Coordinator
4	LASOONA	SWAT	Program Officer
5	NIDA	Bajaur	Project Manager
6	NRSP	Gwadar	Coordinator
7	SEHER	Pishin	Coordinator
8	SRSP	Bajaur	Field Health Officer
9		Chitral	Project Officer

Table 6: Informant Interviews with Health & Nutrition Staff

Informant Interviews with Health & Nutrition Staff			
S/No	**Partner Organization**	**District/Agency**	**Staff Designation**
1	AKRSP	Chitral	Lady Health Visitor
2	BRSP	Pishin	Lady Health Visitor
3	EPS	SWAT	Lady Health Visitor & Female Nurse
4	LASOONA	SWAT	Lady Health Visitor & Female Nurse
5	NIDA	Bajaur	Female Nurse
6	NRSP	Gwadar	Midwife[5]
7	SEHER	Pishin	Lady Health Visitor
8	SRSP	Bajaur	Lady Health Visitor
9		Chitral	Lady Health Visitor

[5] Midwife received training from NRSP under PPR and was providing services in the facility voluntarily.

Table 7: Informant Interviews with Community Resource Person (CRP)

Informant Interviews with Community Resource Person			
S/No	**Partner Organization**	**District/Agency**	**CRP Name**
1	AKRSP	Chitral	Female: Sherini, Naseem Bagium
2	BRSP	Pishin	Male: Gul Datha, Najeebullah, Habib Ullah
3	EPS	SWAT	Male: Tahir Khan
4	LASOONA	SWAT	Male: Ayaz Ud Din Female: Mehnaz Begum, Shamim, Mehnaz
5	NIDA	Bajaur	Male: Aziz, Farman Ullah
6	NRSP	Gwadar	Male: Irshad, Shabbir Ahmed Female: Najma, Najeeba
7	SEHER	Pishin	Female: Zar Gula, Tanzila, Nahida
8	SRSP	Bajaur	Male: Waheed Ullah, Qasim Jan Female: Saima, Saira
9		Chitral	Femal: Sumbal Latif, Bushra, Gul Amna

Table 8: Informant Interviews with Community Growth Promotor (CGP)

Informant Interviews with Community Growth Promotor (CGP)			
S/No	**Partner Organization**	**District/Agency**	**CGP Name**
1	AKRSP	Chitral	
2	BRSP	Pishin	
3	EPS	SWAT	
4	LASOONA	SWAT	
5	NIDA	Bajaur	
6	NRSP	Gwadar	
7	SEHER	Pishin	
8	SRSP	Bajaur	
9		Chitral	

ANNEXURE 2: FIELD QUESTIONNAIRE FOR HEALTH & NUTRITION AND EDUCATION

Women Who Visited Health Facilities for ANC and PNC Services	
Questions	**Responses**
1. Tell us about the PPAF. Its background, what it does whom it serves and what are its basic values.	
2. What do you know about the project PPAF implemented in your area? What services project offered you?	
3. Tell us about the ANC and PNC services under the project, how did you access these services?	
4. How satisfied you were with the quality of these services?	
5. How did staff treat you? Did they answer all your questions and provided you all necessary information?	
6. How the service improved after the PPAF intervention?	
7. What were the main benefits of these services in your area?	
8. If PPAF did not start this project here how would it affect your access to ANC and PNC services and quality of services?	
9. Do you think men are better aware of ANC and PNC related issues now, if yes, how?	
10. If project is closed down how will it affect ANC and PNC services?	

Focus Group Discussion with Community Health Management Committee	
Question	**Responses**
1. Tell us about the PPAF. Its background, what it does whom it serves and what are its basic values.	
2. What do you know about the project PPAF implemented in your area? What services project offered to you?	
3. How crucial was the support women and men received from the PPAF?	
4. In what ways support that women and men received from PPAF was helpful?	
5. How safe and easy was this mechanism for women to access support?	
6. What role family members played to help women access the support?	
7. If the project is closed down how will this support / remain available to the community women & Children?	
8. Do you think now women and men feel more open to discuss issues related to ANC/PNC/ STI prevention/ FP/ Nutrition status and access support?	
9. How community capacity was built on local health issues/preventions etc?	
10. How PPAF Management involved HMC in opportunity mapping?	
11. How local human capital capacitated to articulate health & nutrition demands?	
12. What local solutions were identified to address issue of malnutrition?	
13. How issues related to maternal health, menstrual hygiene, infant & child care etc. made part of the Union Council Development plans?	
14. How youth was engaged for information sharing on Health & Nutrition?	
15. Any self- sustainable social enterprise development model introduced to provide Health & Nutrition services?	
16. How PPAF Health centre reduced the burden of going to Private clinics?	
17. How Mobile Health clinics/Tele Voucher program provided support in provision of Health & Nutrition services?	

Target Group: Adult Men of age 18 & above already into a marital union.	
Key Questions	**Responses.**
1. Tell us about the PPAF. Its background, what it does whom it serves?	
2. What do you know about the project PPAF implemented in your area? What services project offered you?	
3. Tell us about the ANC and PNC services, Family planning, STI prevention services offered under the project?	
4. How the service improved after the PPAF intervention?	
5. What were the main benefits of these services in your area? How has it reduced your expenditure on Health?	
6. Do you think you are better aware of ANC and PNC, FP, STI prevention related issues now, if yes, how?	
7. Do you think Men are better aware of ANC and PNC, FP, STI prevention related issues now, if yes, how?	
8. "How does better awareness of ANC and PNC, FP, STI prevention related issues positively benefit your wife/ child?"	
9. If project has closed down how will it affect ANC and PNC, FP, STI prevention services?	
10. Do you think now women and men feel more open to discuss ANC and PNC, FP, STI prevention related issues and access support?	
11. How has Men knowledge & practice has changed towards ANC and PNC, FP, STI prevention related issues?	

Target Group: Adult women of age 18 & above already into a marital union.	
Key Questions	**Responses.**
1. Tell us about the PPAF. Its background, what it does whom it serves?	
2. What do you know about the project PPAF implemented in your area? What services project offered you?	
3. Tell us about the ANC and PNC services, Family planning, STI prevention services offered under the project?	
4. How the service improved after the PPAF intervention?	
5. What were the main benefits of these services in your area? How has it reduced your expenditure on Health?	
6. Do you think men are better aware of ANC and PNC, FP, STI prevention related issues now, if yes, how?	
7. Do you think women are better aware of ANC and PNC, FP, STI prevention related issues now, if yes, how?	
8. "How does better awareness of ANC and PNC, FP, STI prevention related issues positively benefit yourself?"	
9. If project has closed down how will it affect ANC and PNC, FP, STI prevention services?	
10. Do you think now women and men feel more open to discuss ANC and PNC, FP, STI prevention related issues and access support?	
11. How has family's behaviour especially men knowledge & practice has changed towards ANC and PNC, FP, STI prevention related issues?	

Key informant interview with PPAF management staff	
Questions	**Responses**
1. Can you please tell us about the project background and work? Whom and how it serves?	
2. What was PPAF project in the targeted area? How different needs it aimed to serve and how these were the critical needs of the community?	
3. What was the criteria of selection of the area?	
4. How was the situation analysis carried out? Were communities involved in this process?	
5. How was Multi sectoral approach integrated in this process?	
6. What was the coverage of the project, could everyone in the target area avail the services?	
7. What is your view on the quality of the services? How quality of the services could be better?	
8. How the needs of different community groups were met, especially adolescent girls, PLW, Children under the age of five? How accessible were MNCH and other services to women & Children? (Static/Mobile/Tele medicine/voucher program etc)?	
9. How communities were engaged in awareness campaigns on issues related to health & nutrition?	
10. How PPAF Health centres reduced burden of going to private clinics?	
11. How Management of PPAF carried out opportunity mapping? Were community made part of this activity?	
12. Any innovative Social enterprise development model launched to make services self-sustainable beyond project life?	
13. How did project complement Government Health department efforts in ANC & PNC & other services? i.e. (FP /STI prevention, Awareness campaigns on health & hygiene, provision of nutrition services etc.?	
14. How community institutions capacitated to articulate health nutrition demands	
15. Any youth centre & Knowledge hub developed for information sharing on Health & Nutrition?	
16. Any CPI activity carried out under the project to retain trained health staff in targeted area?	
17. Would you suggest anything that could be done differently to improve the quality of services and why you think it was not done?	

Key Informant interview with Community Growth Promoters (CGPs)	
Questions	**Responses**
1. Tell us about the PPAF. Its background, what it does whom it serves and what are its basic values.	
2. What necessary support (technical support, necessary items to do the work such as stationaries/Growth charts, Bags, T-shirts /transportation), training and capacity building you received from PPAF?	
3. How would you approach women & Children to help them avail Growth monitoring services?	
4. What role men and other member of the family played to facilitate their women & Children to avail Growth monitoring services.	
5. What challenges you had while working with different community groups?	
6. How you negotiated these challenges and who helped you with that.	
7. What challenges community females & Children faced in accessing Growth monitoring service?	
8. How did they negotiate these challenges? What was the role of Health management committees in resolving these challenges?	
9. As project is closing down how would it affect your work with the communities?	

Key Informant Interview with Community Resource person (CRPs)	
Questions	**Responses**
1. Tell us about the PPAF. Its background, what it does whom it serves and what are its basic values.	
2. What do you know about the project PPAF implemented in your area? What services project offered you?	
3. How crucial was the support you received from the PPAF?	
4. In what ways support you received from PPAF was helpful? (Financial & Technical)	
5. How safe and easy was this mechanism for you to access and deliver support?	
6. What role community health management committee (HMC) played to help you deliver the services? How you engaged HMC in provision of these services?	
7. If project has closed down how will this support remain available to the community women? (ANC, PNC, Family Planning, STI prevention etc.)?	
8. Do you think now women feel more open to discuss family planning issues and access support?	
9. How MMN sachets distributions has contributed towards improvement of nutrition status of mothers & Adolescent girls?	

KII Health & Nutrition Facility staff	
Questions	**Responses**
1. Can you please tell us about the PPAF background and work? Whom and how it serves?	
2. What was PPAF project in the targeted area? How different needs it aimed to serve and how these were the critical needs of the community?	
3. What was the key facilitation you provided through this project?	
4. What was the coverage of the project, could everyone in the target area avail the services?	
5. How compliant were the services to international industry standards? Especially OPD services?	
6. How the needs of different community groups were met? How accessible were the services to women especially to access services in a safe and secure manner?	
7. Did the PPAF do any capacity building of the health services? Did the work of PPAF make you look differently at how to work with patients? If yes, in what way?	
8. What challenges you faced in delivery of the MNCH, FP & nutrition services and how were these addressed?	
9. How did project contribute to the government efforts in this regard?	
10. Were you provided any residence?	
11. Would you suggest anything that could be done differently to improve the quality of services and why you think it was not done.	

Key informant Interview with Partners organization Lead person or the focal Person	
Questions	**Response**
1. Can you please tell us about your background and work?	
2. Tell us about your engagement with PPAF in general?	
3. How did PPAF team interact and coordinate with you?	
4. In what areas this coordination and interaction was helpful?	
5. What was your role in project, and how did your perform that?	
6. How could your coordination and interaction with PPAF help improve targeting of the communities?	
7. What is your view on the quality of the services? How quality of the services could be better?	
8. How adequate was response to your request to support in terms of timeliness, and appropriateness of required service?	
9. How could engagement and coordination on part of PPAF be better?	

Programme for Poverty Reduction (PPR) FGD Transcript Template for SMC/ members			
No. of Participants:		**Name of school**	
Grantee Name :		**Grant Name:**	
Source Language :		**No. of participants**	
Date :		**Time Start:**	**Time End:**
Venue :		**City:**	
Moderator		**Note Taker**	

KEY QUESTIONS:	
RELEVANCE:	
1.	**Moderator:** What is this programme about?
2.	**Moderator:** What are the problems/issues that this programme addressing?
3.	**Moderator:** What are the core program activities? Are the project activities relevant to your needs? If yes, please explain how? If not, why do you think they aren't?
EFFECTIVENESS:	
4.	**Moderator:** Did you see any results from the activities you are involved in? If yes, what are the results? If there are no results, why do you think that is so? **PROMPTS:** a. What is the nature and level of community participation in the program? b. What types of linkages are developed under the project and with whom?
5.	**Moderator:** Did you receive any training under the grant? If yes, how effective were these trainings If no, please proceed to Q.6 **PROMPTS:** a. Which were the most beneficial trainings and why? b. How were these trainings relevant to your role/work? c. How effective was the training in improving SMCs/CRP' capacity? (Organizational, administrative, financial management etc. controlling drop out and increasing enrollment in schools)

6.	**Moderator:** How did your engagement with the government change after being involved in this project? a. Has provision of services improved as a result of this project? If yes, how?
7.	**Moderator:** Has the government changed the way it responds to your needs since your involvement in the project? If yes, how? If no, why do you think that is? **PROMPTS:** a. How do you measure the improved responsiveness of the Education Department to the citizens? Please explain your answer by giving examples. b. What changes have you experienced with Education Department in terms of transparency and accountability? c. What changes in education department practices have been experienced?
Impact	
8.	**Moderator:** Whether the activity you are involved in generated any results/benefits, will they continue if grant ends? If yes, please explain how? If no, why not?
9.	**Moderator:** Will education department/communities sustain results/benefits of grant activities if a grant ends? If yes, how? If no, why do you think so?
10.	**Moderator:** Are you able to expand upon the project results/benefits through your own efforts?
11.	**Moderator:** If you were involved in a similar project again, what would you do differently? a. Innovation b. Change in structure of SMC c. Change in community participation methodology d. Change in criteria of SMC/
12.	**Moderator:** Based on your experiences, what activities would you replicate, add or drop in the similar project and why?
13.	**Moderator:** What are the success stories or lessons learned from the program?
MODERATOR OBSERVATIONS:	

Programme for Poverty Reduction (PPR) FGD Transcript Template for teachers			
No. of Participants:		**Name of school**	
Grantee Name :		**Grant Name:**	
Source Language :		**No. of participants**	
Date :		**Time Start:**	**Time End:**
Venue :		**City:**	
Moderator		**Note Taker**	

KEY QUESTIONS:	
RELEVANCE:	
1.	**Moderator:** What is this programme about?
2.	**Moderator:** What are the problems/issues that this programme addressing?
3.	**Moderator:** What are the core programme activities? Are the project activities relevant to needs of the communities? If yes, please explain how? If not, why do you think they aren't?
EFFECTIVENESS:	
4.	**Moderator:** Did you see any results from the activities you are involved in? If yes, what are the results? If there are no results, why do you think that is so? **Prompts** a. Change in teaching practices b. Change in learning practices c. Professional growth of teachers d. Improvement in school environment e. Improvement in classroom environment f. Improvement in attendance of the students g. Improvement in learning outcome of the students

5.	**Moderator:** Did you receive any training under the grant? If yes, how effective were these trainings If no, please proceed to Q.6 **PROMPTS:** d. Which were the most beneficial trainings and why? e. Duration and delivery of training? f. How effective was the training in improving your teaching skills? (Contents, pedagogy etc.) g. Did you make any training request that were not fulfilled by the project h. Do you have any specific suggestions for training component for the future?
6.	**Moderator:** How did your engagement with the parents of students change after being involved in this project? b. Has provision of services improved as a result of this project? If yes, how
7.	**Moderator:** Has the government changed the way it responds to your needs since your involvement in the project? If yes, how? If no, why do you think that is? **PROMPTS:** d. How do you measure the improved responsiveness of the Education Department to the citizens? Please explain your answer by giving examples. e. What changes have you experienced with Education Department in terms of transparency and accountability? f. What changes in education department practices have been experienced?
Impact	
8.	**Moderator:** Whether the activity you are involved in generated any results/benefits, will they continue if grant ends? If yes, please explain how? If no, why not?
9.	**Moderator:** Will education department sustain results/benefits of grant activities if a grant ends? If yes, how? If no, why do you think so?
11.	**Moderator:** If you were involved in a similar project again, what would you do differently?
12.	**Moderator:** Based on your experiences, what activities would you replicate, add or drop in the similar project and why?
13.	**Moderator:** What are the success stories or lessons learned from the programme?
MODERATOR OBSERVATIONS:	

FGD-Questionnaire for young children below 18 years

Respondent No _____
Date of interview _____
Place of interview_____
Village_____
Name:
Your age is (please tick) ❑ <10, ❑11-14, ❑15-18
Sex: _____ Male, _____Female
Education: No education_

		Yes	No
	Education		
1	**Do you go to school?**		
2	**Do you go to school regularly**?		
	If yes, what is the most interesting event for you in the school?		
	b. meet with friends		
	c.like to learn good things		
	d. like enjoying in the brake		
	e. like to participate in the class activities		
	f. any other		
3	**If No, can you share with us the reason behind**?		
	a. domestic responsibilities		
	b. lesson are less interesting		
	c. you can't not pick the lesson properly		
	e. any other		
4	**Do your teacher administers class test**		
5	**If yes, what is your score normally**		
	Good		
	Bad		
	Average		
6	**Do you get appreciation on good performance**		
7	**On bad performance, have you ever been ashamed in the class by the teacher**?		
8	**If yes, that feeling ever restricted you from attending school?**		
9	**Do you parents or family member come to school and met with your teacher?**		
	If yes, what they feel about the meeting?		
	a.Good		
	b. bad		
	c. useless		
10	**What is the most needed thing have been provided to school** 1.stationary to children 2.unifrom 3.latrin facility 4.drinking water facility 5.boundry wall 6.Any other		
11	**How children with disability are treated in the school?**		

		Yes	No
	1.in a good manner 2.students and teacher respect them 3.treated like a normal person 2.face negligence of students and teacher 3.facilitation problems in their movement		
12	**Do you face any problem in mobility towards school**		
	If yes, what's the reason? 1.not easily accessible 2.the location is not convenient for every body 3.family have issue on going to that specific place 4.transporation problems		
13	**Did you enjoyed any co curriculum event in the school?**		
	If yes, can you name please? 1…….. 2…….. 3……		
14	**Have your school ever been visited by any guest or officers?**		
	Do you know their background/where about? Can you elaborate 1…….. 2…….		
15	**Do you want to continue further education?**		
16	**If yes, your family will allow you?**		
17	**If yes, can your family arrange expenses of your further education?**		
18	**If no, then do you have any income source to support your education** 1…….. 2…….. 3……		
19	**In your neighbourhood or family any student have been re admitted to school?**		
	If yes, how they have been convinced? 1.through SMC 2.CRP 3. Attended any campaign on school enrolment?		

Programme for Poverty Reduction (PPR)
In-depth assessment of the programme
KII Instrument for Education Department Interview

Interviewee Name :	**Designation**:		
Grantee Name :	**Grant Name**:		
Department Name:	**Gender (Please check)**	Male	
		Female	
Date :	**Time Start**:	**Time End**:	
Venue :	**City**:		
Interviewer Name:			

Introduction

Thank you very much for meeting us today. My name is _____. We are conducting In-depth assessment of the programme.

We thank you for your time and recognize that your prior involvement is an important contribution to help us in understanding the contribution of the project in Education Development of the area.
The collected information will remain confidential.

As you will hear from our questions, the focus of our conversation will be on your knowledge of the prior grant, grant-funded activities, and future directions.

Do we have your permission to audio record the proceedings? Y / N

If you are ready may we start?

RELEVANCE:	
1.	How were the grant activities relevant to key Education Department priorities at the time? R:
2.	What was the level of government engagement in grant activities? PROMPTS: a. Which departments were involved during the engagement? b. Were any changes made in the partnership during the duration of the engagement? R:

EFFECTIVENESS:	
4	What are the core project interventions? How these interventions were effective? • Teachers training (ECE, Primary, Elementary etc.) • Management training (Principals etc.) • SMC Training • Enrollment campaigns • Addition of IT and Library component in schools • Co- curricular activities in schools • Physical improvement in schools R:
5	Which of above interventions were most and least effective and why? R:
6.	What types of linkages were developed during the engagement and with whom? PROMPTS: a. Public Private Partnership (PPP), media, corporate sector, business associations, other CBOs etc.? R:
7	Which linkage(s) proved most effective in terms of project objectives? R:
8.	What was the result of engaging with the PPAF/PO? (E.g. increase in allocation of funds of schools, development schemes implemented, new teachers appointed, teachers trained, SMC trained, support in Library and IT Lab etc.) a. Were there any lessons learnt for the government as a result of this engagement? R:
9.	Did the grant lead to any policy change during the grant? If yes, what kind? If no, why do you think it didn't? PROMPTS: a. What initiatives were undertaken to influence policy change? R: R:
IMPACT	
10. Please summarize overall impact of the grant at various levels?	
11.	To what extent have targeted government institutions sustained results of grant interventions? PROMPTS: a. What were the key factors that contributed to sustainable results? (Please specify in terms of outputs and outcomes)

	R:
12.	Did you receive any assistance under the project? If yes, what was the nature of the assistance? If no [end of the interview]. PROMPTS: **a.** Did the assistance involve trainings, orientations, study visits, school construction, school supplies ies etc.? R:
13.	Did you see any results from the assistance given under the project? If yes, what kind? If no, why do you think that was so? PROMPTS: a. Did you make any assistance requests that were not fulfilled by the project? b. Do you have any specific suggestions for such assistance component for the future? R:

ANNEXURE 3: FGDS AND KIIs DATABASE FOR EDUCATION

Attached as separate excel File