FINAL REPORT

IFRC PAKISTAN HEALTH REVIEW

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EXECUTIVE SUMMARY

The Pakistan floods crisis 2010 began in July 2010 following heavy monsoon rains in the Khyber Pakhtunkhwa (KP), Gilgit-Baltistan (GB), Sindh, Punjab and Balochistan provinces. UNOCHA estimates indicated that almost 2000 people were killed, over 1.7 million homes were destroyed and almost 18 million people were seriously affected during this flood. Outbreaks of diseases, such as gastroenteritis, diarrhoea, and skin diseases, due to lack of clean drinking water and sanitation soon posed a serious risk to flood victims as did nutritional issues and damage to health facilities and supplies. The elderly, disabled, women and children were especially made vulnerable.

The (International Federation of Red Cross and Red Crescent Societies (IFRC) launched an emergency appeal in August 2010 to support Pakistan Red Crescent Society (PRCS) following the worst floods to hit Pakistan since 1929 targeting to assist 130,000 families (910,000 people) for 24 months. The appeal ultimately grew to the amount of CHF 92.6 million. Health is an important component of the PRCS floods response, covering the emergency to recovery periods and implemented in 24 districts in the five provinces of Sindh, KP, Punjab, GB and Balochistan. The health component, delivered through basic and mobile health units (BHUs and MHUs), volunteer coaches and community volunteers, represented an integrated primary health care package that included not only curative services, but also disease prevention, referral, health promotion and psychosocial support.

The evaluation was carried out by an external Team Leader and national health experts from IFRC and PRCS. The purpose of this review was to examine the progress and impact achieved on the overall health programme within the 2010 Flood Appeal, in the emergency and recovery phases of the operation with regards to the relevance and appropriateness, efficiency, effectiveness, coverage, impact and sustainability of the intervention. The evaluation utilized documents review, staff and external stakeholders' interviews and field work in 12 villages across 8 districts in GB, KP and Sindh provinces.

Overall, the health component has had a clear impact, especially in terms of improving people's health status in both the emergency and recovery phases and in increasing people's resilience through health education work. A number of good practices emerge from this project which can be summarized as follows: i) The integrated approach for the recovery phase; ii) The village committees set up within communities; iii) The health education component which has helped communities enhance their own resilience; iv) The mobile health units in the emergency phase which have provided enormous convenience and cost-savings to communities; v) The recruitment of coaches and volunteers which has exposed young people in remote areas to universal RC values; vi) The location of BHUs (Basic health units) in remote areas in KP. At the same time, several areas of improvement are evident for which the following recommendations are provided:

Program issues

Assessments

- Make sure that targeting at the district, UC (Union Councils) and village levels is based on concrete and objective evidence, as mandated by the RC Code of Conduct, and improve documentation of evidence-based targeting.
- Ensure that assessments reports provide more rationale for areas not selected as well as about community perspectives and requests

Program Design

- Reconsider the current practice of locating BHUs in major towns and consider locating them in isolated, disaster-prone areas
- Enhance linkage between CBHFA (Community-based Heath and First Aid), PSP (psychosocial support program) and BHUs by co-locating them in disaster prone areas
- Base the continuation of MHUs during recovery phase on concrete evidence of continued elevated disease occurrence due to aftermath of disaster
- Ensure replenishment of first aid kits given to volunteers or drop this component completely
- Review the scope for integration and coordination between the hygiene promotion work done by the WatSan (water and sanitation) team and the health promotion work done by the health team by comparing the curricula of these two awareness-raising components to see whether they can be combined and delivered by the same set of volunteers.
- Implement the four health sub-components across the districts based on actual needs.
- Develop a clearer vision of what the role of PRCS should be in the health sector in the recovery phase with a greater focus on capacity-building work which will have both immediate and longer-term utility as true for food and WatSan sector recovery work. Such capacity-building work could be at three levels—community, PRCS and government.
- Implement the health component more closely in integration with the government health structures, e.g., by providing trainings and resources, rehabilitating government BHUs and implementing health services in emergency and recovery phase through government BHUs rather than setting up on BHUs on a short-term basis.
- Ensure that national and PRCS waste disposal guidelines and maintenance of standard medicine guidelines are followed better in BHUs.

Community Mobilization

- Get village committees registered with the social welfare ministry more consistently throughout the country to increase their sustainability.
- Get village committees linked with other agencies working long-term in the area wherever possible to increase their sustainability
- Provide greater training to village committees in CBO (community-based organization) management and on mobilizing the community to apply greater pressure on government institutions to provide better services
- Maintain readily accessible complaint registers and summary reports which would help in analysing the nature of complaints and how they were handled.

- Consider remunerating volunteers or at least provide other incentives which help maintain morale among them and maintain stronger links with them after the recovery phase
- Provide better training to volunteers in CBHFA, PSP and community mobilization and ensure that they are reimbursed adequately for expenses incurred in attending trainings

Management and coordination issues

- Both agencies should review whether staff perceptions about delays occurring due to inadequate coordination agreement between IFRC and PRCS and then within PRCS across NHQ and branches and complicated procedures for approval and cash transfers are valid or not and take remedial action if they are true.
- Both agencies should ensure that assessments provide a clearer rationale for the areas selected and rejected, the reason for the provision of some or all of the four health sub-components across districts and community perspectives about their needs.
- Both agencies should develop a proposal or plan at inception that would qualitatively describe the rationale of the various health components.
- Both agencies should develop a clearer and more comprehensive monitoring plan which specifies the responsibilities of IFRC and all levels of PRCS in monitoring in terms of the frequency, modality and tools each level will use so that all the DAC evaluation criteria are covered in the monitoring plan
- PRCS should review through an independent, credible external evaluation whether staff perceptions about the opaque, top-down, slow and political nature of the decision-making of the top-most PRCS management are valid and take remedial action if they are.
- PRCS should provide much greater capacity-building support to the GB branch which is obviously short of resources and supplies and feels that it is treated in a step-motherly fashion by the NHQ topmost management.
- Both agencies should develop greater capacity at all levels to undertake more well-conceived, implemented and result-oriented PSP activities
- Both agencies should review the appropriateness of placing PSP within the health component rather than the livelihoods or disaster management component given the wide differences in the skills set required for health and PSP work.
- PRCS should provide greater technical and managerial training to BHU staff
- PRCS should ensure that BHUs receive supplies and equipment more on time
- Both agencies should develop a brief 1-2 page written strategy for participating in and influencing the workings of the overall health cluster which could guide the extent and nature of their participation and contribution at the national, provincial and district levels, the division of labour between the two agencies in terms of such participation and the issues that the RCRC movement would like to focus on within the sector.

CHAPTER 1: BACKGROUND

This chapter provides an overview of the emergency context in Pakistan, and the specific program developed and implemented by PRCS with the support of IFRC which is the subject of evaluation in this report. The chapter serves the purpose of placing the whole evaluation in its proper context and in familiarizing readers with project constraints and scope.

1. Disaster Context in Pakistan

The Pakistan floods crisis 2010 began in July 2010 following heavy monsoon rains in the Khyber Pakhtunkhwa, GB, Sindh, Punjab and Balochistan provinces. UN (United Nations) estimates indicated that almost 2000 people were killed, over 1.7 million homes were destroyed and almost 18 million people were seriously affected during this flood, exceeding the combined total of individuals affected by the 2004 Indian Ocean tsunami, the 2005 Kashmir earthquake and the 2010 Haiti earthquake. At the worst point, approximately 20% of Pakistan's total area was underwater, an area bigger than England.

The country suffered extensive damage to health, educational, transportation and communication infrastructure and crops. The total economic impact is estimated to be as much as $10 billion. Floods submerged 17 million acres (69,000 km^2) of Pakistan's most fertile crop land, killed 200,000 heads of livestock and washed away massive amounts of grain. Flood waters soon receded from the north enabling livelihoods & reconstruction to take place, whereas large areas in Sindh province remained submerged under flood waters for several months. Therefore, many farmers were unable to meet the autumn deadline for planting new seeds in 2010, which resulted in massive loss of food production in 2011, food shortages and price increases in staple goods. Sindh province had the highest number of people affected (7.2 million) followed by Punjab with 6 million people and KP with 3.8 million people. Sindh was also the most badly affected area in terms of the percentage of area covered at the sub-district level with 12 of the 17 sub-districts that had more than 50% of their areas affected being in Sindh.

Outbreaks of diseases, such as gastroenteritis, diarrhea, and skin diseases, due to lack of clean drinking water and sanitation soon posed a serious risk to flood victims. Lack of adequate/proper nutrition and damage to health facilities and supply chains increased the risk. The elderly, disabled, women and children were especially made vulnerable due to a lack of aid and the threat of exploitation by traffickers. The UN initially appealed for $460 million to provide immediate help, and later increased it to $2 billion for longer-term work. While camps were ultimately dismantled and the overwhelming percentage of people returned to their villages, huge recovery needs persist in the areas of health in villages. The delivery of primary health services has been disrupted and the capacity of the health systems in flood-affected areas has been reduced resulting to the further deterioration of the health condition of the most vulnerable populations – which was already poor before the floods. Increasing malnutrition and, cases of infectious diseases, epidemics alerts, poor sanitation and loss of homes and livelihood were

some of the health wide-range of issues faced by the most number of flood affected communities whose houses were destroyed by the floods and who needed to be relocated to temporary shelters with limited supply of safe drinking water and sanitation facilities. Relief work was also hampered by the difficult logistical terrain, the destruction of infrastructure and the threat of terrorist attacks against aid agencies. The Pakistani government was blamed for sluggish and disorganized response to the flood, which led to instances of riots by hunger-stricken people and looting of aid convoys. All these factors made this emergency response one of the most difficult ones in recent times.

2. Overview of the Program

The PRCS immediately responded via deployment of MHU by Sindh. Considering the magnitude of the disaster, PRCS requested support from IFRC to scale up and sustain the response, and including recovery components. The IFRC launched an emergency appeal in August 2010 to support Pakistan Red Crescent Society following the worst floods to hit Pakistan since 1929 targeting to assist 130,000 families (910,000 people) for 24 months. As the magnitude of the crisis continued to expand, the emergency appeal was revised in November 2010 to scale up the relief and recovery components of the PRCS response while maintaining the same target of 130,000 families. The latest revision of the appeal was made in August 2012 seeking CHF 92.6 M in cash, in-kind, or service to assist the same number of beneficiaries for the expanded period of 36 months with the completion by end of July 2013. The IFRC's emergency appeal is part of the large scale international humanitarian response to try and address the needs of the affected communities, working through and with the PRCS.

Health is an important component of the PRCS floods response, covering the emergency to recovery periods and implemented in the five provinces of Sindh, KPK, Punjab, GB and Balochistan. The health component, delivered through basic and mobile health units, volunteer coaches and community volunteers, represented an integrated primary health care package that included not only curative services, but also disease prevention, referral, health promotion and psychosocial support. These services were also carried out using community based health and first aid (CBHFA) approach and epidemic control for volunteers (ECV) toolkit. The interventions were implemented in 24 priority districts, including six districts of the integrated recovery programming (IRP) in three provinces of Sindh, KPK and Punjab. The emergency relief and recovery health components of the emergency appeal was pegged at CHF 7,057,925 representing 8% of the total CHF 92.6 M appeal budget (revised budget as of August 2012 with cash, in-kind or services).

The overall outcome of the health component was to reduce the immediate and medium-term health risks of targeted flood-affected communities through the provision of curative and preventive health services. The implementation approach consisted of integrated health programming with health facility-based services in coordination with local health and community-based health interventions with community involvement. This included community-based health and first aid (CBHFA) and psychosocial support program (PSP) with the inclusion

of epidemic control and nutrition activities. The key outputs in the revised Health Log frame were the following:

- Increased capacity of PRCS to plan, respond and cope with health emergencies and challenges in times of recurrent disasters.
- Communities have improved access to primary health services for the treatment of "minor" illnesses and injuries, essential maternal and child care services, referrals as well as psychosocial support.
- Increased awareness on health, MNCH, nutrition promotion, disease/epidemic prevention and control measures and including psychosocial support.

The health component of the emergency appeal was designed and developed using the findings and recommendations from the Field Assessment and Coordination Team (FACT), Transition Planning Assistance Team (TPAT), as well as vulnerability and capacity assessment (VCA), emergency phase evaluation and IRP Baseline assessment. Periodic reviews and the IRP Mid-Term Review reports also informed the implementation of the recovery components of the health response. The deployment of mobile health care units (MHUs) with the start of floods in 2010 and 2011 demonstrated PRCS response capacities and systems in place. The implementation of health interventions during recovery period entailed enhanced efforts in local coordination with stakeholders, community engagement, recruitment and training of health staff and volunteers. The integrated recovery programming components were implemented in three provinces and six districts along with other program interventions of WatSan, livelihood, shelter, and disaster risk reduction. Health interventions were implemented in 24 districts covering 43 Union Councils (UCs) with an approximate population of 727,000 persons (90,000 households) receiving assistance from supported basic health care units (BHUs), mobile health units (MHUs), CBHFA and PSP activities summarized in the table below:

DISTRICTS	NO OF UCS	HEALTH COMPONENTS
SINDH		
Larkana	4	BHU, MHU, CBHFA, PSP
Shikarpur	2	MHU, CBHFA, PSP
KSK	2	MHU, CBHFA, PSP
Jacobabad	2	BHU, CBHFA, PSP, ERU BHC
Thatta	1	BHU, CBHFA, PSP
Dadu	1	ERU BHC
KHYBER-PAKHTUNKHWA		
Swat	4	BHU, CBHFA, PSP
Shangla	2	CBHFA, PSP
Kohistan	2	BHU, CBHFA, PSP
Charsada	4	BHU
BALOCHISTAN		
Jhal Magsi	1	BHU
Sibi	2	BHU, CBHFA, PSP
Dera Murad Jamali	1	BHU

Loralai	3	CBHFA, PSP
Jaferrabad	2	CBHFA, PSP
GLIGIT-BALTISTAN		
Gilgit	2	BHU, CBHFA, PSP
Skardu	1	BHU, CBHFA, PSP
Ghizer	1	CBHFA, PSP
Diamer	1	CBHFA, PSP
PUNJAB		
Muzzafargarh	3	BHU, CBHFA, PSP
Layyah	2	BHU, CBHFA, PSP
Rahim Yar Khan	1	BHU, CBHFA, PSP
Rajan Pur	1	BHU, CBHFA, PSP
DG Khan	1	BHU, CBHFA, PSP
24	**43**	

The Health activities in the five districts of Punjab were suspended in May 2012 due to differences of priorities with the provincial PRCS branch.

CHAPTER 2: Methodology

The evaluation was carried out by an external Team Leader and national health experts from IFRC and PRCS. The purpose of this review was to examine the progress and impact achieved on the overall health programme within the 2010 Flood Appeal, in the emergency and recovery phases of the operation with regards to the relevance and appropriateness, efficiency, effectiveness, coverage, impact and sustainability of the intervention. The review aimed to encompass the identification and consolidation of valuable practices and lessons during the operation, as well as put forward recommendations and opportunities with the aim of strengthening the health components of the PRCS emergency and recovery program, and its connectivity to long-term programming. The results of this review will be used to suggest improvements in design, implementation and management of the emergency health programmes and the delivery of future intervention supported by IFRC and other RCRC Movement Health partners in Pakistan. The review examined the health programmes during the emergency and recovery phases of the 2010 floods operation which was originally planned to be carried out from August 01, 2010 to July 31, 2012 but extended up to July 31, 2013.

1. Evaluation Objectives:

1a. Overall

To examine the progress and impact achieved on the overall health programme within the 2010 Flood Appeal, in the emergency and recovery phases of the operation with regards to the relevance and appropriateness, efficiency, effectiveness, coverage, impact and sustainability of the intervention.

1b. Specific objectives:

- To examine the extent to which the health component and interventions during the emergency and recovery phases of the PRCS-IFRC response to the 2010 flood operation have achieved their intended results (goal, outcomes and outputs) in relation to strategic and operational frameworks and implementation plans jointly developed.

- To review the current PRCS and IFRC Pakistan Health programme set-up (directives, programmes, resources, staffing, field implementation tools, guidelines, reporting and internal procedures, systems, management and coordination) and, its capacity to implement integrated health interventions in a wider scope in response to emergency and recovery programming.

- To identify lessons and opportunities, and recommend good practices for enhanced program management and implementation support of health service delivery of PRCS, IFRC and the wider RCRC Movement as a whole in Pakistan.

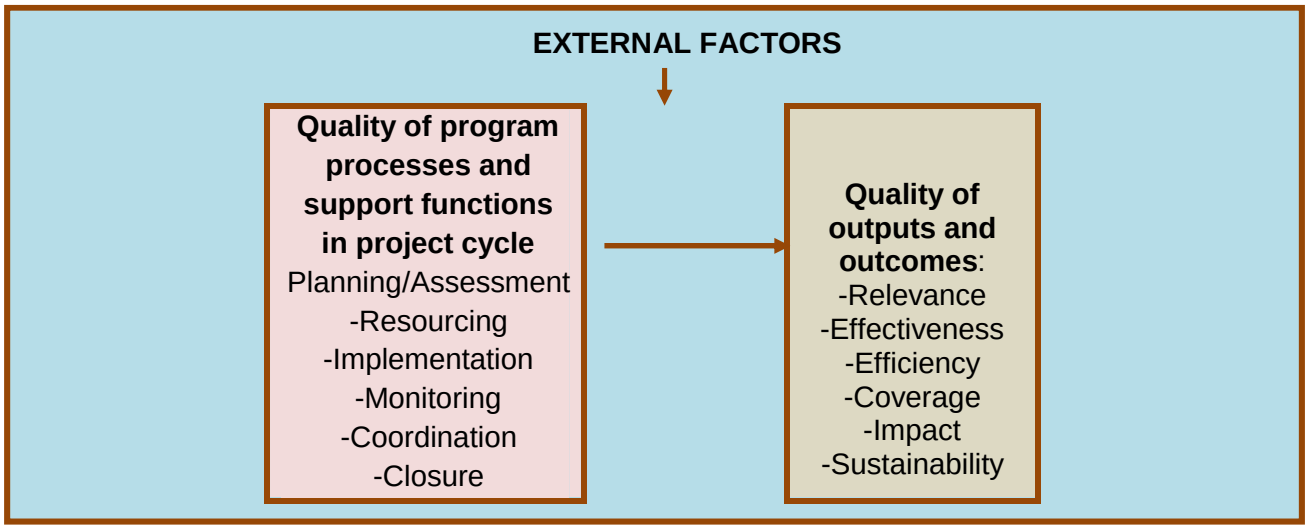
2. Methodology

2a. Overall evaluation criteria

Coverage:	Were the most deserving community and persons targeted?
Appropriateness:	Were project activities relevant, participatory, timely, culturally-sensitive and enhance external linkages for communities
Effectiveness:	Did the project achieve its aims and objectives?
Efficiency:	Were resources used efficiently?
Coherence:	Was the project well-coordinated internally and externally?
Impact:	What was the impact on people's lives?
Sustainability:	Will the impact sustain in the long-term?

2b. Evaluation framework

The evaluation investigation was guided by the framework provided below. According to this framework, the quality of IFRC/PRCS program and program support processes throughout the project life cycle determines the quality and final outcomes of the project. External factors also affect the quality and the success of the project. Thus, the evaluation started by reviewing more deeply the quality of IFRC/PRCS project processes and functions throughout the project cycle, i.e., planning (e.g., assessment quality, resourcing etc.); implementation (e.g., activity scheduling, procurement etc.); monitoring (e.g., quality of monitoring framework, follow-up etc); and closure (e.g., hand-over and follow-up). This chain of analysis is based on the reality that project staff cannot directly improve the performance of the project on the final outcomes. They can only improve the quality of project cycle activities in the future.



Next, the evaluator reviewed the community-level project outputs and outcomes using the criteria mentioned in the TORs. Based on the review of outcomes, external factors and program

processes, the evaluator related specific strengths and weaknesses in program outcomes to specific strengths and weaknesses in program processes as well as external challenges.

2c. Data collection tools

- Interviews with IFRC programme and PRCS staff in Islamabad and field
- Review available materials related to the project
- Interviews with relevant external stakeholders, especially government authorities
- Focus group discussions using participatory techniques in 12 communities
- Household interviews with 5-10 individual beneficiaries in each community (total 102)

2d. Sampling plan

Out of five provinces, Punjab was dropped as the program there had to be suspended due to administrative matters while Balochistan was dropped due to security issues. The districts in Sindh, KP and GB were selected based on logistical considerations such as distance and availability of beneficiaries based on PRCS advice and with a view to get complete coverage of all health sub-components delivered with IRP as well as alone. The UCs and villages were randomly selected by the evaluator from lists provided by PRCS. Finally, the individual beneficiaries were randomly selected by the evaluator from people available within villages at the time of the visits.

2d. Questions addressed in the evaluation using these data collection tools:

a. Relevance and Appropriateness

- Did the health components (BHUs, CBHFA and PSP) and the integrated implementation strategies employed respond to the priorities of the targeted groups and address the identified needs in emergency and recovery situations,? If not, why? What mechanisms were put in place to ensure the health components implemented continued to be relevant and appropriate in the light of the changing situation and needs during the whole period of the operation?
- To what extent were flood-affected communities involved in the implementation and monitoring of the health components? To what extent were the health interventions implemented in a timely manner to meet community health needs and what mechanisms were put in place that enabled beneficiaries to provide feedback to PRCS interventions?

b. Efficiency

- Were the required inputs and resource materials and funds available in a timely manner, and used in the best way possible to achieve the stated objectives? If not, why not?
- Were the appropriate and required human resource support (staff and volunteers) available in terms of skills and experience for the implementation of BHUs/MHUs, CBHFA and PSP at the different levels of implementation? If not, why not?
- To what extent can the PRCS integrated primary health care approach to disaster response in emergency and recovery period be considered efficient? To what extent has the health component in the integrated recovery programming (IRP) contributed to the efficiency of the

programme implementation? What additional steps could be taken to maximize the benefits to targeted communities?

c. Effectiveness

- To what extent did the health components during the emergency and recovery periods of the operation achieve their proposed outcomes and objectives?
- How has the integrated approach – among health interventions, as well as health with other sectors – contributed to more effective (as well as cost-effective) delivery of health services and activities to flood-affected communities?
- What factors have influenced/contributed to the timely implementation of the health services and activities, and what factors have hindered the progress?
- How did the programme management processes, tools and guidelines – in relation to planning, implementing, monitoring, reporting, including financial management – contribute to the effective implementation of health interventions and activities?
- How did the PRCS and IFRC coordination and working mechanisms in health contribute to effective implementation of activities to flood-affected communities? If not, why? How can these be improved in future operations?

d. Coverage

- To what extent were the most vulnerable flood-affected populations reached by PRCS-IFRC health interventions in relation to their needs? To what extent has the health component addressed the specific needs of specific population groups such as women, special needs groups, including hard-to-reach communities?
- Were the interventions delivered proportionate to those most in need?
- What strategies were applied to ensure inclusion priority of and access by the most vulnerable groups (including women, and special needs groups) in targeted areas to ensure access to health services?

e. Impact

- How the different PRCS health interventions contributed to the well-being and, improve health conditions in the assisted communities and community resilience? Provide an indication of attribution.
- To what extent have the health interventions supported the capacity building of target communities towards community resilience? What processes and factors have contributed to these achievements?
- To what extent did the different interventions contribute to the outcomes of the emergency and recovery phases; and in achieving enhanced resilience of the affected population?
- Are all targeted villages with trained CBHFA and PSP volunteers and formed village health committees (VHCs) active? Are the volunteers able to reach their catchment households for service provision? What are the activities undertaken and how often? What facilitates and hinders their service delivery?

- To what extent were the PRCS community coaches and volunteers able to deliver identified community mobilization (for health) tasks and services in targeted communities?

f. Coherence

- Were the health outcomes/objectives in line with the overall goal and outcomes of the PRCS 2010 flood operation, country program support and PRCS health policy and strategic directions? To what extent were the interventions in line with the health policies and strategic directions of the IFRC?
- Were the health interventions implemented and complementary to the local/national health authority's health service delivery and other key humanitarian health partners working in the same areas, and following established national health guidelines and standards? How can these linkages be strengthened?
- To what extent were the engagement of IFRC and PRCS Heath in health and health-related cluster meetings in the country and its relevance to the IFRC/PRCS health response planning and implementation?

g. Sustainability and Connectedness

- What essential necessary support is needed to ensure the sustainability of the health interventions at different levels?
- What plans and directions, as well as mechanisms, are in place for sustaining the health interventions after the completion of the operation? Which of the health interventions ought to be continued by PRCS and incorporated into its regular health programmed plans and budgets and how? Would the experience of integrated health programming approach contribute in future restructuring of PRCS health operations? Why and why not? What are needed to ensure long term sustainability of the PRCS health programmers?
- How have the health components of the floods response contributed to the capacity of PRCS in responding to floods and other disasters in the future? What processes and factors have led to these developments?
- To what extent has the health component trained and mobilized health volunteers who are currently carrying out health activities with the community in the catchment areas?
- Did the health components implemented contribute to the capacity building of the target communities towards enhanced community resilience? If so, in what way?

3. Constraints

A major evaluation constraint was the timing as the evaluation was conducted near the end of the project duration when staff was focused on finishing project activities. The project is focused in logistically challenging and isolated areas throughout Pakistan which resulted in a grueling travel schedule. Additionally, the fasting season had started, which made travel even more difficult. Thus, the team only had about 6 hours of effective working time each day. It was also not possible to generate a randomly selected sample for the individual household interviews since the health component did not target individuals and consequently did not have individual

household lists. Time was also lost due to flight cancellations. Women could not be interviewed in GB and KP as there was no female on the evaluation team for the field work. The PRCS female staff who accompanied the evaluator was solely used for inspecting the PRCS health facilities to ensure independence. Field data collection was largely focused on recovery phase and not emergency phase due to recall issues. IFRC's handling of the evaluation process was also weak at some places, e.g., initial contract payment release delay, lack of prompt and consolidated feedback on the first draft, logistical arrangements for GB travel, lack of timely provision of documents and often weak communication with the evaluator. However, despite all these constraints, the evaluator succeeded in collecting adequate amounts of quality information, mainly because of the strong background of the evaluators in conducing evaluations in Pakistan and the flexibility and cooperation of the IFRC/PRCS teams despite their multiple workloads.

CHAPTER 3: Findings and Discussion

This chapter provides the findings of the evaluation along the Disaster Assistance Committee (DAC) criteria included in the Terms of Reference (TORs). However, the sequence of the questions and their placement under the headings has been changed in some places to enhance the flow of the discussion and to reduce repetitiveness. The findings are based on triangulation of information from various sources of information mentioned in the last chapter. Where provincial variations are not provided, it means that the findings are equally applicable to all provinces. The immediate sections largely focus on the recovery phase. Relief phase performance is briefly covered at the end since the evaluator did not have access to much information for that phase.

1. Coverage

To what extent were the most vulnerable flood-affected populations reached by PRCS-IFRC health interventions in relation to their needs? Were the interventions delivered proportionate to those most in need?

The health component targeted an approximate population of 727,000 persons (90,000 households). The Red Cross's Code of Conduct asserts that agencies will distribute assistance based on objective needs. Thus, the evaluator strongly feels that agencies should have reasonably rigorous information within their files to demonstrate that they are doing so for each project. Careful selection of beneficiaries and the proper documentation of such efforts is important for agencies for two reasons---firstly to ensure that the people in most need are helped in recovering from the effects of the disaster and secondly to be able to demonstrate clearly to external stakeholders (e.g., donors and host governments) that the agency is providing services according to objective needs and not political, ethnic or monetary considerations. The distribution of goods and services are financial transactions just like the procurements of goods and services by the agencies themselves and involve as much risk of misuse as procurement itself**.** Thus, as for procurement, it is important for agencies to be able to provide documentary evidence that their distribution of financial values geographically was transparent and based on objective criteria. This section reviews the extent to which PRCS, with the support of IFRC, are targeting the most vulnerable areas and people and has documentary evidence of this on its files for the district, UC, village and household levels. Given that the health programs were targeting whole communities rather than just some households within them, the analysis focuses more on the districts, UC and villages.

Coverage of Affected Districts

Province	Districts covered	Severely affected	Moderately affected	Neither
Balochistan	5	1	3	1
Gilgit-Baltistan	4	0	4	0

Khyber-Pakhtunkhwa	4	4	0	0
Punjab	5	5	0	0
Sindh	6	6	0	0

The analysis at the district level is done in comparison with the list of the worst flood-affected districts provided by the National Disaster Management Authority (NDMA) in January 2011, which is provided in Appendix 1. The table above shows the number of PRCS-targeted districts that were shown as severely or moderately affected within the NDMA list for each province.

So, out of 24 districts targeted, 15 (62.5%) districts were characterized by the NDMA as severely affected, 7(around 30%) as moderately affected and 1 (Dera Murad Jamali) as neither. Out of the 29 districts classified as severely affected by the NDMA, PRCS is covering 15 (51%) but missing the remaining 14 while covering 7 moderately affected districts for its health component. In Balochistan, three moderately affected districts were targeted while Nasirabad, which was considered as severely affected by the NDMA, was not targeted. All four districts in GB were moderately affected, but then no district there was classified as severely affected by the NDMA. Some other severely affected districts were not targeted, such as Nowshera, Upper and Lower Dirs, D.I. Khan and Tank in KP; Bhakkar and Mianwali in Punjab; Neelum in AJK; and Ghotki, Jamshoro and Kashmore in Sindh. At the UC level, UN provided a list in 2010 which identifies the worst affected UCs in each province. However, since the IFRC has not provided the evaluator with a list of the UCs that it covered, it is not possible to review the accuracy of targeting at the UC level. Finally, at the village level, official lists do not obviously provide details about the most badly affected villages. However, based on the evaluator's own experience of having conducted more than a dozen evaluations in Pakistan since the 2010 floods, it seems that the targeting of villages in Sindh was good. In KP, the targeting in Kohistan and Shangla seemed accurate but not in Swat where people in the visited villages openly asserted that they were not affected by very serious floods. Finally, in GB, the villages seemed moderately affected.

Thus, overall targeting is reasonably good, though there is some room for improvement. More importantly, IFRC did not share any documents that would show that its targeting at various levels was guided by objective needs assessments done by the government, UN or IFRC itself. The assessments conducted by IFRC itself in the emergency and recovery phases such as FACT and VCA do not undertake a comprehensive analysis and largely provide information only about the locations that it selected but no information about why other locations were rejected. The evaluator did not see any reference to the use of secondary information to help guide targeting such as the NDMA and UN lists mentioned above. Thus, there is a need to improve documentation around targeting at various levels.

To what extent has the health component addressed the specific needs of specific population groups such as women, special needs groups, including hard-to-reach communities? What strategies were applied to ensure inclusion priority of and access by

the most vulnerable groups (including women, and special needs groups) in targeted areas to ensure access to health services?

PRCS has done a good job of reaching special needs groups within villages such as women, elderly, disabled etc. This has primarily happened due to the strategy of focusing mostly on community-based services delivered with the assistance of village committees. Thus, three of the four components, i.e., PSP, CBHFA and MHUs as well as health ERUs provided services to people at the community and even house level through their intensive outreach approach. However, the BHUs, with the exception of KP, were largely based in or near large towns and away from isolated communities, thus making it harder for special needs groups to avail their services. Overall, there was a high degree of satisfaction within communities about the extent to which services benefitted special-needs groups, as revealed by the answers to the following question within the individual household interviews:

Coverage of special needs groups

Percentage answering "yes"	
Were the most deserving people in the village provided the health services by PRCS?	90
Did the PRCS programs adequately address the most important health needs of women?	92
Did the PRCS programs adequately address the most important health needs of disabled and elderly people?	85

However, during the FGDs, the level of satisfaction was found to be the highest in Sindh districts and lowest in Skardu where people's perceptions about PRCS work even in the areas of health were affected by delays in the completion of other sectoral work.

2. Relevance and Appropriateness

Did the health components (BHUs, CBHFA and PSP) and the integrated implementation strategies employed respond to the priorities of the targeted groups and address the identified needs in emergency and recovery situations,? If not, why? What mechanisms were put in place to ensure the health components implemented continued to be relevant and appropriate in the light of the changing situation and needs during the whole period of the operation?

The main mechanisms put in place by IFRC to ensure that the health components implemented continued to be relevant and appropriate in the light of the changing situation and needs during the whole period of the operation were repeated assessments. Thus, emergency phase work was guided by FACT assessments while the recovery phase was guided by the TPAT and VCAs. As a result of these assessments, the emergency phase health work included the BHUs and the MHUs, with the latter including Health ERU deployments as well as more informal mobile health camps implemented by the PRCS. PSP work was also undertaken during emergency phase. During the recovery phase, the health component included the BHUs, MHUs, CBHFA and PSP. The MHUs were undertaken where permanent health facilities were absent.Among these four components, the MHUs were highly relevant for the emergency

phase. As mentioned in the introductory chapter, various communicable diseases had become widespread immediately after the floods while health services had been badly disrupted. Thus, people in communities repeatedly mentioned the value that PRCS mobile health camps provided to them. The most commonly mentioned diseases by people in the immediate aftermath of the floods included diarrhoea, cholera, malaria, ARI, skin problems and mental stress. People emphasized the fact that the PRCS health camps were among the first services that they received after the floods whether they were in camps or in their own villages.

Disease Prevalence and PRCS Health Service Utilization

Which of the following health problems did your family suffer after the 2010 floods?		Did you receive any services from PRCS for this health problem
	Yes	Yes
Diarrhoea	83	75
Dysentery	21	14
Cholera	55	47
Malaria	75	68
Skin problems	86	78
ARI	81	74
Malnutrition	45	21
Minor injury	36	23
Mental stress	75	21
Reproductive health problem	34	19

People continued to value MHUs where they were continued during the recovery phase, as in Larkana, Shikarpur and KSK districts in Sindh. In the recovery phase, the MHUs targeted villages where people had returned after the floods. Such services provided people with a lot of convenience as services were available within the villages and also helped them save money which they would have otherwise spent on medicine and transport. The basis for MHU deployment for the recovery period was also to cover health needs of populations where health facilities were damaged and services disrupted. Services were not only curative, but also preventive and promotive. Services were to be ceased as soon as permanent health services have resumed. However, target areas were again flooded in 2011, and some in 2012. From a strategic sense, MHUs would seem more justifiable if there was solid evidence that disease levels continued to be abnormally high until the recovery phase, which in the case of PRCS MHUs only started in December 2011. However, IFRC has provided little evidence to the evaluator which would show that disease levels were still abnormally high in December 2011 due to the 2010 floods. In the absence of such evidence, it is not clear whether the MHUs in the recovery phase were addressing flood-related diseases or more chronic diseases which rural communities in Pakistan face persistently due to poverty, isolation and lack of government services. But even if they were addressing chronic illnesses, they played an important role since permanent health structures in most of these areas were still absent.

There were issues with the relevance of BHUs for both the emergency and recovery phases since most of the PRCS BHUs (except in KP) are located within or near main towns quite far away from the isolated areas where the floods created the most urgent health problems. In KP, BHUs were set up in isolated areas, for example, Goshali in Kohistan, in the recovery phase. However, by that time, as with MHUs in the recovery phase, it is not clear whether the BHUs were addressing diseases caused by the 2010 floods or more chronic diseases.

The CBHFA component in all areas was introduced in the recovery phase and emerged as a highly appropriate and relevant intervention, especially its Health Education component. Communities were generally very positive about such work as they felt that it had increased their knowledge about ways to safeguard their health during both normal and emergency times. Thus, this component can be seen as a significant contribution to increasing people's resilience against health problems while noting the need to consider experience that increased knowledge does not necessarily translate to positive healthy behaviours in the long-run and continued initiatives to support behaviour change are needed. However, the first aid kit component seemed less appropriate as volunteers were given supplies only once which ran out within 2-3 months. Finally, the relevance of the PSP component was less clear for the people as there was little immediate positive mentioning of this component during community visits. The following table reveals the relative value of each component as perceived by the communities:

Relative Utility of Health Components

Which of the following PRCS services did your family find the most useful:	Percentage identifying each component
MHU	43
BHU	3
CBHFA	52
PSP	0
Blank	2

It must be noted that the percentages above have been influenced by the fact that while CBHFA and PSP services were available in all villages during the recovery phase, the BHU and MHUs were only available in some villages as highlighted in the table about recovery phase services across districts provided in the first chapter.

To what extent were flood-affected communities involved in the implementation and monitoring of the health components? What mechanisms were put in place that enabled beneficiaries to provide feedback to PRCS interventions?

PRCS adopted two main mechanisms for involving communities in the implementation and monitoring of the health components and for receiving feedback from communities. The first mechanism was village committees formed within each village. In villages where the health component was part of a broader IRP, the village committees were common for all sectors. In villages where health constituted the only PRCS program, the health teams formed village health committees. These committees served the purpose of providing a communication link

between PRCS and communities, mobilizing communities for project work, supervising the coaches and volunteers and providing feedback to PRCS. The committees were found to be functional in all the villages and the vast majority of individual respondents (92%) felt that they were playing an active and useful role. In KP, all the committees have also been registered with the social welfare ministry. The coaches and volunteers were also from flood-affected communities, and provided feedback to PRCS. The second component included a complaint mechanism which was however instituted only in villages where the IRP was being implemented but not in villages where health was the only component. However, even where instituted, very few people had utilized the complaint system as they felt that they had no complains. Furthermore, PRCS did not share any complaint register or summary reports to the evaluator which would help in analysing the nature of complaints and how they were handled. The following table provides information about the complaint mechanism utilization:

Complaint Mechanism Utilization

	% responding "Yes"
Were you consulted by PRCS about the health program?	67
Were you told the procedure for making a complaint to the agency?	42
Did you make any complains?	5
Did PRCS rectify them?	3

Thus, having complaint mechanisms in all villages and having summary reports from such mechanisms readily available seems essential.

3. Effectiveness

To what extent did the health components during the emergency and recovery periods of the operation achieve their proposed outcomes and objectives?

The status of achievement for the health component as of January 2013 is summarized below:

Status of achievement for health, January 2013

Health-Key Activities	Unit	Original Emergency Appeal Target	Revised Achievable Targets as of March 2013	Achievement reported as of January 2013	%
Running BHUs/MHUs	Unit	24	22	22	100
Distribution, RH Kits	Kits	54	66	66	66
Training LHWs, TBAs and/or Midwives	Persons	144	100	50	50
Training CBHFA, Master Training of Trainers (ToT)	Persons	25	16	16	100
Training CBHFA Coaches	Persons	144	160	150	94
Training, CBHFA Volunteers	Persons	2,880	1,575	1,095	70
Training ECV and Nutrition-Coaches	Persons	312	121	65	53

Training ECV and Nutrition-Volunteers	Persons	Not specified	622	69	11
Formation and Training , Village Committee (VHC)	Committe e	144	76	60 formed, 38 trained	50
Distribution Long Lasting Impregnated Nets (LLINs)	Nets	100,80	50,212	38,614	77
Distribution BP5 biscuits	Bars	166,600	165,792	82,898	50
Community Health and Psychosocial support (PSS) initiative support	villages	144	9	0	0
Training PSS, Master ToT	Persons	25	25	25	100
Training PSS Coaches	Persons	144	157	157	100
Training PSS Volunteers	Persons	Not specified	959	895	93
Training PSS for Staff and Volunteers	Persons	Not specified	100	0	0

More up-to-date information on achievements was not available from IFRC. However, this table from January 2013 shows that while six health components had already achieved 100% or near 100% achievement, three components reflected in table above had not achieved even 50% achievement. However, some of these consisted of training events which could still be achieved before the end of the program with sufficient effort. With respect to the objectives themselves, they were as follows:

- Increased capacity of PRCS to plan, respond and cope with health emergencies and challenges in times of recurrent disasters.
- Communities have improved access to primary health services for the treatment of “minor” illnesses and injuries, essential maternal and child care services, referrals as well as psychosocial support.
- Increased awareness on health, MNCH, nutrition promotion, disease/epidemic prevention and control measures and including psychosocial support.

The evaluator feels that there should also be an explicit objective for working with and building government health capacities.

How has the integrated approach – among health interventions, as well as health with other sectors – contributed to more effective (as well as cost-effective) delivery of health services and activities to flood-affected communities?

There were some inherent factors which restricted the extent to which the health component could develop an integrated approach with other sectors. To begin with, the other sectors were present in only six (25%) out of the 24 districts which the health component covered as there was a conscious decision from the start that other sectors would operate in fewer provinces and districts given more limited PRCS capacities in them. Secondly, while the other three sectors focused on both community-level and individual household levels, the health component mainly focused on the community levels. Thus, while the other three sectors could coordinate on both the community and individual household levels, the health component could only coordinate

with other sectors on project aspects targeting the community levels. Within the confines of these constraints, some integration with other sectors has occurred. So, in common districts, the health component also worked with communities through the single village committees set up for all sectors. This obviously led to increased effectiveness and efficiency as the communities related with only one committee instead of separate committees for each sector which could have led to each committee posing contradictory and overlapping messages for the community. However, each sector mobilized its own set of coaches and volunteers. While this may be seen as lack of coordination, there were at least some good reasons for adopting this approach. While from the point of view of the agency, having a single set of volunteers would have led to better integration across sectors, this approach may not have worked for the volunteers who were not paid anything. Thus, it could have been unrealistic to expect the same volunteers to be willing to carry out the duties of all the sectors for free, especially where the nature of work was very different. So, even within health, there were separate volunteers in many places for the PSP and CBHFA components since the nature of volunteer work was very different for the two sub-components. The separate set of volunteers had the positive impact of increasing the volunteer pool available to PRCS, which is good given the high attrition rates among volunteers. The one area where there may be greater scope for integration and coordination is between the hygiene promotion work done by the WatSan team and the health promotion work done by the health team. It would be useful to compare the curricula of these two awareness-raising components to see whether they can be combined and delivered by the same set of volunteers. Also, overall, by improving the health status of communities, the health component made it easier for other components to engage and mobilize the communities as it is obviously more difficult to engage communities when they are facing widespread health problems. At the same time, there was lack of integration created between the health components by the location of the BHUs in main towns, away from the areas where the PSP and CBHFA work was undertaken. Had the BHUs been located in the same locations, it would have created huge synergies across the three components, especially the BHUs and CBHFA work. The BHU could have served as a place for volunteers to come together and share perspectives and get refresher information and resources from the BHU staff. It would have also enhanced the value of their health education work as they would have been in a position to refer sick people to nearby BHUs. Finally, lack of integration within health was also compounded by the fact that the three(Medical Units, CBHFA and PSP) health sub-components were not all consistently implemented across the districts due to varying needs across them. Thus, some districts had all three components while other districts only had 2 or 3 sub-components (please see table in first chapter). The reason for this lack of consistency is not clear since it is not based the VCA showing different needs in different sectors.

What factors have influenced/contributed to the timely implementation of the health services and activities, and what factors have hindered the progress?

There were some delays in project implementation. So, the VCA was conducted in December 2010. However, the IRP was only envisaged to begin in July 2011, i.e., six months later. Furthermore, many of the health components actually started on ground in 3-4 months later from this planned start date. This led to some problems, as many of the areas where PRCS

wanted to work were taken over by other agencies for some sectors, e.g. Punjab, leading to a situation where an integrated approach could not be adopted in some villages even in the common districts. Furthermore, the nature of community needs also changed significantly over the 10-12 months of delay between assessment and actual inception. According to staff, the main reason for these delays was lack of coordination and agreement between IFRC and PRCS and then within PRCS across NHQ and branches. Delays were also compounded by complicated procedures for approval and cash transfers according to staff. The evaluator did not look at these issues directly and is thus not in a position to confirm whether these staff perceptions are correct or not. However, the complaints are so widespread that it would be advisable for IFRC and PRCS to look into these factors through a separate management review, if not done so already. Many of these factors are beyond the control of PRCS health unit. However, others, such as attempting to ensure greater continuity within its team is something that the unit can influence to a much higher degree since high turnover also created delays.

How did the programme management processes, tools and guidelines – in relation to planning, implementing, monitoring, reporting, including financial management – contribute to the effective implementation of health interventions and activities?

Overall, IFRC and PRCS have strong management tools and guidelines, especially for program support functions like security, administration and finance although in the opinion of many staff they are perhaps overly strong for the emergency phase where they sometimes impede rapid scale-up, e.g., financial approval procedures for emergency phase. This is an issue that IFRC and PRCS would be well-advised to look into separately since this evaluation obviously did not focus on such issues. However, there is clearly a need to improve the quality of the management tools and guidelines for key program processes.

To begin with assessments, while IFRC conducted several assessments in support of PRCS, including FACT, TPAT and VCA, there is still room for improvement so that such assessments provide more concrete and grounded information for program design. So, for example, the VCA report largely focuses on the areas that were selected and provides no evidence or data for other areas that were rejected based on VCA selection criteria. The VCA report does not provide any evidence to justify the inconsistent provision of the three health sub-components across different districts. Finally, the VCA report is short on providing detailed information about any community perspectives that may have been captured during the VCA process.

Secondly, logframes and implementation plan document were provided by IFRC to the evaluator that describe the rationale, targets, approaches and contents of the health components. In other agencies, the project proposal submitted to the donor provides such details. Since the IFRC support for PRCS responses were largely funded by appeals, it is understandable that IFRC will not have donor project proposals for all the funds and the main project documents consist of logframes and implementation schedules. However, even so, it would have been useful for IFRC to develop a project plan which provides greater qualitative justification for each component.

Thirdly, IFRC shared monitoring plans for the health component with the evaluator. There are multiple layers of monitoring involved in the health component, with IFRC monitoring PRCS NHQ, which in turn monitors provincial PRCS branches, which in turn monitor district branches which in turn monitor village-level coaches and volunteers. Thus, a more comprehensive monitoring plan that specifies the roles of each of these levels in terms of the program aspects that they will monitor and the criteria, modalities and frequencies that they will employ in monitoring linked to the final evaluation criteria is helpful. There is an increasing trend among agencies to finally evaluate projects based on the DAC criteria, as done by IFRC for this health review. Thus, instead of waiting for the final evaluation to inform IFRC and PRCS about how the project did along the DAC criteria, it would be helpful for both agencies to develop a comprehensive monitoring plan that helps in collecting information along these criteria through internal monitoring so that gaps can be addressed much before project closure and evaluation.

Finally, throughout his interaction with IFRC and PRCS staff throughout the length and breadth of both agencies, the evaluator heard repeated and extensive complaints about the opaque, top-down, slow and possibly politically motivated nature of the decision-making of the top-most management within PRCS. Clearly, the evaluator did not look into these issues directly and is in no position to say whether these complains are valid or not. However, the evaluator is clearly in a position to say that whether these staff perceptions are right or wrong they are affecting morale and consequently health program quality. Thus, there is a need to review the extent of validity of such complains urgently.

4. Coherence

Were the health outcomes/objectives in line with the overall goal and outcomes of the PRCS 2010 flood operation, country program support and PRCS health policy and strategic directions? To what extent were the interventions in line with the health policies and strategic directions of the IFRC?

The plan seems largely in line with the IFRC and PRCS overall aims and objectives for its Pakistan program. The extent of achievement of 2010 flood objectives has already been covered under “Effectiveness” section. However, there are some issues related to the re coherence of the various health sub-components with each other and the overall coherence of the health component for the recovery phase. The lack of integration of the various health sub-components with each other was addressed under “Relevance” section. This lack of complete integration obviously also affects program coherence. In addition, despite the explanations given by staff, the evaluator feels that IFRC and PRCS must work out a more coherent health component for the recovery phase that shows a clear transition from the health emergency phase work. If one looks at the WatSan sector there is a clear transition from the emergency phase, where PRCS provides water tankering and temporary latrines in camps and villages which only have immediate utility, to the recovery phase where PRCS undertakes permanent construction or rehabilitation of water systems and latrines which have both immediate and longer-term utility. Similarly, in the food/livelihoods sector, PRCS undertakes food aid distribution in the emergency phase and undertakes livelihoods restoration work in the recovery

phase. However, for the health sector, such a clear transition is not present where PRCS is doing BHUs and MHUs in both the emergency and recovery phases. True, CBHFA contains new activities in the recovery phase. However, the combined budget of these new activities probably comprises a small percentage of the total health sector recovery phase budget and the bulk of the recovery phase budget is still spent on BHUs and MHUs which are a continuation of emergency phase work. As such, the recovery phase seems essentially to be an extended emergency phase for the health sector. Thus, there is a clear need to think what the role of IFRC and PRCS should be in the health sector in the recovery phase. Clearly, along with service delivery, there should be a much greater focus on capacity-building work in the recovery phase which will have both immediate and longer-term utility as true for food and WatSan sector recovery work. Such capacity-building work could be at three levels—community, PRCS and government. Unfortunately, as the next section highlights, the two agencies are not working in conjunction with the government in the health sector.

Were the health interventions implemented and complementary to the local/national health authority's health service delivery and other key humanitarian health partners working in the same areas, and following established national health guidelines and standards? How can these linkages be strengthened?

The health work undertaken by PRCS was largely in line with established national health guidelines and standards in the areas of BHUs and MHUs though physical inspections of the BHUs revealed that waste disposal guidelines and maintenance of standard medicine guidelines were not being followed in some locations. However, PRCS did not work in conjunction with the government and government health officials interviewed in Sindh complained extensively about the lack of coordination of PRCS with them. Thus, it established its own BHUs instead of supporting existing government BHUS even where such government BHUs were present within 2-3 kilometres of where PRCS established its own temporary BHUs, though in consultation with health authoritiess. District health officers were consulted and part of the decision making process for this component. PRCS commitment was for it to operate BHU with a specified period, when DHO were still rehabilitating their permanent BHU. However, PRCS could have considered rehabilitating the government BHU instead of setting up its own temporary BHU.

IFRC and PRCS also did not undertake any significant capacity-building activities for the government in the health sector beyond some of training for Lady Health workers, in some cases due to lack of willingness of government staff. This is all the more surprising given that the PRCS has far closer relationships with the government than most other non-profit agencies. With sustainability in mind, PRCS activities should focus on enhancing the resilience and capacity of the public health system to provide life-saving activities on its own in the future. This effort could consists of four dimensions: i) providing training to government health staff, ii) providing essential drugs and equipment, iii) helping the development of various health systems such as epidemic early warning, disease surveillance, health information system, referral system, iv) rehabilitation of health facilities. While PRCS mentioned the difficulty in engaging with the government, other agencies are doing so and the results achieved so far are

encouraging and have laid the foundation for improved public health system services in line with Government of Pakistan Ministry of Health, NDMA and UN health cluster system. PRCS could also enhance resilience further by gradually handing over its emergency services to the government, strengthening community-based primary health care systems; enhancing the capacities of government lady health workers and improving linkages between communities and health service providers.

To what extent were the engagement of IFRC and PRCS Heath in health and health-related cluster meetings in the country and its relevance to the IFRC/PRCS health response planning and implementation?

The evaluator had requested IFRC to arrange a meeting with the Health Sector head or any other agency to get an idea of how other agencies view the role of IFRC and PRCS within the health sector. Unfortunately, this meeting could not be arranged. In the absence of such meetings, the evaluator can only answer this question based on a review of around a dozen minutes of health and nutrition cluster meetings from Sindh and Punjab which were provided by IFRC to the evaluator. From a review of these minutes, it seems that either IFRC or PRCS are usually present in such coordination meetings. However, going at least by the number of times the contributions of these two agencies were considered important enough by note-takers to get noted in the minutes, IFRC and PRCS do not emerge as highly active and influential members of the health sector. Neither IFRC nor PRCS provided the evaluator with a written strategy for participating in and influencing the workings of the overall health cluster which could guide the extent and nature of their participation and contribution at the national, provincial and district levels, the division of labour between the two agencies in terms of such participation and the issues that the RCRC movement would like to focus on within the sector. It would be advisable to develop a brief 1-2 page strategy along these lines for the future to guide all health staff across the two agencies to participate more strategically and coherently in cluster meetings.

5. Efficiency

Were the required inputs and resource materials and funds available in a timely manner, and used in the best way possible to achieve the stated objectives? If not, why not? To what extent can the PRCS integrated primary health care approach to disaster response in emergency and recovery period be considered efficient? To what extent has the health component in the integrated recovery programming (IRP) contributed to the efficiency of the programme implementation? What additional steps could be taken to maximize the benefits to targeted communities? How did the PRCS and IFRC coordination and working mechanisms in health contribute to effective implementation of activities to flood-affected communities? If not, why? How can these be improved in future operations?

Overall, there were delays in the implementation of both the emergency and recovery phases. As the evaluator's Real-Time Evaluation report of the emergency phase had shown, IFRC was able to spend a very small percentage of its overall emergency budget within the first and even the first three months which are the most critical in terms of morbidity and mortality. There were also considerable delays in project implementation during the recovery phase for the health

sector. While the VCA was conducted in December 2010, the IRP only began officially in July 2011, i.e., six months later. Furthermore, many of the health components actually started on ground in 3-4 months later from this planned start date, i.e., around October-December 2011. This led to some problems in some areas, as mentioned earlier, as some areas where PRCS wanted to work were taken over by other agencies for some sectors, leading to a situation where an integrated approach could not be adopted in some villages even in the common districts. Furthermore, the nature of community needs also changed significantly over the 10-12 months of delay between assessment and actual inception. The main reason for these delays at least according to staff was lack of coordination and agreement between IFRC and PRCS and then within PRCS across NHQ and branches. Delays were also compounded by complicated procedures for approval and cash transfers according to staff. BHU inspections also revealed that there were some delays in transfer of supplies and equipment to BHUs from provincial and district PRCS branches, especially to GB.

Were the appropriate and required human resource support (staff and volunteers) available in terms of skills and experience for the implementation of BHUs/MHUs, CBHFA and PSP at the different levels of implementation? If not, why not?

Health is a traditional area of expertise for PRCS which is one of the main reasons why the health component in the IRP was implemented in 24 districts versus six only for the other sectors. Thus, PRCS possesses adequate technical capacity for health work across NHQ and the three provinces visited by the evaluator as he found highly skilled, knowledgeable and motivated health staff everywhere. The same is true for IFRC Pakistan. However, the physical inspections of the BHUs showed that there is a need for greater training for BHU staff in even most permanent locations in technical, medical as well as managerial issues. In addition, IFRC was able to deploy considerable health expertise for Pakistan in the emergency phase including a health ERU. The main area where capacity seemed inadequate was in the area of PSP. IFRC only had a person come in for a few months initially since the Danish RC had a resource person. PRCS also did not have continuous PSP capacity at the NHQ for the recovery phase while capacity for PSP at provincial and district levels was also inadequate. More fundamentally, the evaluator is not convinced that the health sector is the right home for PSP work as the skills set required for regular health work is very different from the community-based approach adopted by PSP for dealing with mental health issues. The former requires technical, medical knowledge while the latter requires social, community-mobilization skills. Thus, technically trained health staff may not be able to provide the relevant supervision and guidance for PSP work. As such, the livelihoods or the DM teams may be better hosts for PSP work. While there are technical aspects to PSP which are related to technical health work, the PRCS approach to PSP does not cover them and only focuses on community mobilization activities. While there is some community mobilization work involved in health work too in the CBHFA component, it revolves around health technical knowledge and despite being involved in such work, health staff still do not have the same expertise in community mobilization as DM/livelihoods staff.

6. Impact

How have the different PRCS health interventions contributed to the well-being and, improve health conditions in the assisted communities and community resilience? Provide an indication of attribution. To what extent have the health interventions supported the capacity building of target communities towards community resilience? What processes and factors have contributed to these achievements? To what extent did the different interventions contribute to the outcomes of the emergency and recovery phases; and in achieving enhanced resilience of the affected population?

The PRCS interventions have clearly created impact at the community level:

Impact of PRCS Health Interventions

	Percentage responding "yes"
Has there been any increase in your knowledge about health issues due to PRCS programs?	82
Has there been any increase in your knowledge about nutrition issues due to PRCS?	87
Has the health status of your family improved significantly due to PRCS programs?	91
Were there any unintended harm resulting from PRCS work for your family?	0
Were the most deserving people in the village provided the PRCS health services?	90
Did the PRCS programs address the most important health needs of women?	92
Did the PRCS programs address the most important health needs of disabled and elderly?	85

In most villages, PRCS was the only agency providing health services though in urban areas where BHU were located, other services also existed in some cases. As such, attribution of impact to PRCS work is relatively robust for villages. In terms of the relative contribution of the different components to this impact, the following table provides important clues:

Relative Utility of Health Components

Which of the following PRCS services did your family find the most useful:	Percentage identifying each component
MHU	43
BHU	3
CBHFA	52
PSP	0

As can be seen clearly, the MHU and CBHFA (in particular health education work) were found to be the most relevant by communities. While BHUs could have played a critical role, their value was reduced by their location within large towns where they were inaccessible for the isolated communities covered during the evaluation. The health education work is the component which has potentially made the most contribution towards increasing long-term community resilience against diseases during normal and emergency times by increasing people's knowledge about preventative strategies for maintaining health. The figures above complement the improvements reported by IFRC's internal end-line surveys.

Key figures	Baseline	Endline
% of household where pregnant members have access to antenatal care	47	62.2
% of households whose members had diarrhoea during last two weeks	54	35.2
% of households that know how you can prevent diarrhoea	27	54.4
% of households that know how you can prevent malaria	34	61.1
% of households that have mosquito nets	41	68

Are all targeted villages with trained CBHFA and PSP volunteers and formed village health committees (VHCs) active? Are the volunteers able to reach their catchment households for service provision? What are the activities undertaken and how often? What facilitates and hinders their service delivery? To what extent were the PRCS community coaches and volunteers (CBHFA and PSP) able to deliver identified community mobilization (for health) tasks and services in targeted communities?

The evaluator met coaches and volunteers only in Sindh and GB as they were usually not present in the meetings in KP. During meetings with them, coaches and volunteers mentioned that the opportunity to serve as volunteers for PRCS was a highly significant one as they had never been exposed to the idea of volunteering. They felt that their knowledge, confidence and exposure had increased significantly by volunteering. They were also positive about the progress that they were making in reaching out within the community and helping change their health habits. At the same time, they did mention the following issues:

- Lack of any incentives to the volunteers in contrast with coaches
- Lack of adequate reimbursement for expenses incurred in attending PRCS trainings
- Inadequate training for CBHFA and PSP
- Lack of supplies to continue first aid work within communities once initial supplies ran out and in the absence of replenishment by PRCS
- Lack of clarity about future support from PRCS
- Low education within the communities and traditional attitudes
- In places where IRP was not present, the volunteers also mentioned that it was difficult to attract people without providing them some tangible services

Village committees were also found to be functional in all villages and their work was being appreciated by the general community. They were generally representative of the larger community and usually included people from all sections of the community. In KP, there was also an attempt to get them registered with government, which is a good practice.

Village Committee Performance

	Percentage responding "yes"
Was a committee formed by PRCS in your village?	82
Was it effective in reducing health problems in the village?	72

7. Sustainability

What plans and directions, as well as mechanisms, are in place for sustaining the health interventions after the completion of the operation? What is needed to ensure long term sustainability of the PRCS health programs? Which of the health interventions ought to be continued by PRCS and incorporated into its regular health programmed plans and budgets and how? How have the health components of the floods response contributed to the capacity of PRCS in responding to floods and other disasters in the future?

Although PRCS programs have delivered clear impact, there are some issues about the sustainability of the impact. This situation has essentially arisen from two aspects of the PRCS programs: the location of BHUs in main towns and the lack of collaboration with the government health structures. Essentially, a sustainable PRCS health program can emerge where instead of running its own BHUs in the main towns, the PRCS largely focuses on supporting government BHUs in isolated areas in regions which are highly vulnerable to disasters as part of its regular country program supported by the IFRC and the PRCS's own resources. This will increase the sustainability of not only the BHUs, but also the CBHFA and PSP components as the BHUs would then also serve as points of support in the long-run for the PRCS volunteers. In addition, PRCS should also make it standard policy to get village committees registered consistently throughout the country with relevant government departments such as the Ministries of Social Welfare, as this will provide them with continued support from these government agencies in the future and hence increase their sustainability. It should also look to link these village committees with other NGOs working in the same areas and also provide capacity-building support to them in CBO management as well as community mobilization and local-level advocacy for government services to peripheral areas. To enhance sustainability of health services, it is also essential for the PRCS and IFRC to support general government capacity in areas like Disease Early Warning system, training of local-level health staff and provision of supplies and equipment to government BHUs.

PRCS's own capacity has increased unevenly. So, the greatest increase in capacity seems to have occurred in Sindh where the provincial branch was subsequently able to maintain health mobile units on its own during the 2011 floods without the need for international deployments. However, there is a need to provide much greater capacity-building support to the GB branch which is obviously short of resources and supplies and feels that it is treated in a step-motherly fashion by the NHQ topmost management.

Relief phase performance

The evaluator's field visits were largely confined to beneficiaries of the recovery phase. Where some relief phase communities were visited, as in Sindh, recall was a major issue since the relief phase had ended almost 30 months ago. Additionally, IFRC did not provide any formal evaluations of the health relief phase. Thus, the evaluation of the relief phase is rudimentary here. A total of 5 provinces, 12 districts and 21 UCs were reached during the first six-month relief phase with the following services:

- 18 mobile health teams deployed in five provinces and 2 ERU BHC deployed in Sindh.

- Existing BHUs catered to the needs of flood-affected people in all provinces
- Distributed basic Emergency Health Kits (EHK) kits and cholera kits of health supplies
- Provision of CBHFA and PSS services through volunteers

A brief analysis of the relief phase for some of the relevant TORs evaluation criteria for which some limited information was available to the evaluator is undertaken here for the relief phase:

Coverage: The relief phase had covered most of the same districts as the recovery phase. Thus, its coverage of the most vulnerable areas was similar to the recovery phase. In addition, PRCS was providing its CBHFA, PSS, MHU and ERU services in camps where a large number of displaced people were to be found. As such targeting was easier and more accurate than the recovery phase. However, the problems raised with the location of BHUs in central towns in GB and Sindh applies to the relief phase too as these major towns, such as Larkana and Skardu, were not badly affected by floods themselves and were too far from the affected villages to be of use for the flood affected people. In fact, during the FGDs, the evaluator had asked whether they utilized the BHUs in Sindh and GB, and the answer in all communities was in the negative.

Relevance and Appropriateness: The services provided by PRCS, especially MHUs, health kits, ERUs and CBHFA, were largely relevant for the relief phase. In a sense, their relevance was higher than in the recovery phase since, as mentioned in previous sections, a major issue with the recovery phase health services is that they are still very service delivery oriented and do not enhance long-term resilience. Obviously, this criticism cannot be made for the same services in the relief phase beyond the location of BHUs in Sindh and GB.

Effectiveness: The health component targeted 105,900 families and actually surpassed this target by 38% during six months. The individual targets for the sub-components in terms of the number of ERUs and MHUs deployed, the number of volunteers trained and the number of kits distributed were also largely met according to staff although specific figures were not available.

Coherence: The relief phase activities were coherent with the policies and strategies of both IFRC and PRCS as well as those of the Pakistani government. Another major coherence of the relief phase was in terms of providing the foundation for the subsequent work in the recovery phase as, except for the ERUs and some MHUs, the other services like the BHUs, remaining MHUs and CBHFA and PSS work continued in the recovery phase, providing PRCS with important skills and resource base to launch the recovery phase.

Impact: The impact analysis is relevant for only Sindh as it was only there in 2-3 communities that the evaluator came across beneficiaries who had availed PRCS relief phase health services. According to the beneficiaries, they had access to PRCS health services then and those services were the first to reach them and helped them immensely in dealing with diseases like malaria, diarrhea, scabies, fever and cold which were common there. The beneficiaries were very positive about the convenience of being able to access mobile services coming to their locations and had found PRCS staff to be very professional, efficient and helpful.

CHAPTER 4: Conclusions

This chapter summarizes the main findings from the last chapter and provided recommendations for some of the areas of improvements identified there. Overall, the health component has had a clear impact, especially in terms of improving people's health status in both the emergency and recovery phases and in increasing people's resilience through health education work. A number of good practices emerge from this project which can be summarized as follows:

1. Good Practices

1. The integrated approach adopted by the two agencies for the recovery phase, despite some of its shortcomings, is a positive step which has helped provide more comprehensive solutions to the multi-dimensional problems that communities were facing in the aftermath of the super floods

2. The village committees set up within communities have the potential, with some further capacity-building, to serve as important mechanisms for mobilizing communities and helping them find collective solutions to their individual and collective problems. Moreover, the practice of having a single committee in IRP villages is a positive step

3. The health education component has helped communities enhance their own resilience and develop proactive strategies for protecting their health status during normal and emergency times

4. The mobile health units have provided enormous convenience to communities and have also helped them save significant expenditures on travelling to distant health facilities

5. The recruitment of coaches and volunteers has exposed young people in remote areas to universal RC values which they may not have otherwise been exposed to. In turn, they have played invaluable role in community awareness-raising

6. The location of BHUs in remote areas in KP is a practice worth emulating on a larger scale throughout the country

At the same time, several areas of improvement are evident. The following section provides some recommendations for these areas of improvement. Some of these may not be immediately implementable given varying PRCS branch capacities. However, such capacities can be developed over time. All of the recommendations are applicable to both IFRC and PRCS unless otherwise stated:

2. Recommendations

Assessments

- Make sure that targeting at the district, UC (Union Councils) and village levels is based on concrete and objective evidence, as mandated by the RC Code of Conduct, and improve documentation of evidence-based targeting.
- Ensure that assessments reports provide more rationale for areas not selected as well as about community perspectives and requests

Program Design

- Reconsider the current practice of locating BHUs in major towns and consider locating them in isolated, disaster-prone areas
- Enhance linkage between CBHFA (Community-based Heath and First Aid), PSP (psychosocial support program) and BHUs by co-locating them in disaster prone areas
- Base the continuation of MHUs during recovery phase on concrete evidence of continued elevated disease occurrence due to aftermath of disaster
- Ensure replenishment of first aid kits given to volunteers or drop this component completely
- Review the scope for integration and coordination between the hygiene promotion work done by the WatSan (water and sanitation) team and the health promotion work done by the health team by comparing the curricula of these two awareness-raising components to see whether they can be combined and delivered by the same set of volunteers.
- Implement the three health sub-components across the districts based on actual needs.
- Develop a clearer vision of what the role of PRCS should be in the health sector in the recovery phase with a greater focus on capacity-building work which will have both immediate and longer-term utility as true for livelihoods and WatSan sector recovery work. Such capacity-building work could be at three levels—community, PRCS and government.
- Implement the health component more closely in integration with the government health structures, e.g., by providing trainings and resources, rehabilitating government BHUs and implementing health services in emergency and recovery phase through government BHUs rather than setting up on BHUs on a short-term basis.
- Ensure that national and PRCS waste disposal guidelines and maintenance of standard medicine guidelines are followed better in BHUs.

Community Mobilization

- Get village committees registered with the social welfare ministry more consistently throughout the country to increase their sustainability.
- Get village committees linked with other agencies working long-term in the area wherever possible to increase their sustainability
- Provide greater training to village committees in CBO (community-based organization) management and on mobilizing the community to apply greater pressure on government institutions to provide better services

- Maintain readily accessible complaint registers and summary reports which would help in analysing the nature of complaints and how they were handled.
- Consider remunerating volunteers or at least provide other incentives which help maintain morale among them and maintain stronger links with them after the recovery phase
- Provide better training to volunteers in CBHFA, PSP and community mobilization and ensure that they are reimbursed adequately for expenses incurred in attending trainings

Management and coordination issues

- Both agencies should review whether staff perceptions about delays occurring due to inadequate coordination agreement between IFRC and PRCS and then within PRCS across NHQ and branches and complicated procedures for approval and cash transfers are valid or not and take remedial action if they are true.
- Both agencies should ensure that assessments provide a clearer rationale for the areas selected and rejected, the reason for the provision of some or all of the four health sub-components across districts and community perspectives about their needs.
- Both agencies should develop a proposal or plan at inception that would qualitatively describe the rationale of the various health components.
- Both agencies should develop a clearer and more comprehensive monitoring plan which specifies the responsibilities of IFRC and all levels of PRCS in monitoring in terms of the frequency, modality and tools each level will use so that all the DAC evaluation criteria are covered in the monitoring plan
- PRCS should review through an independent, credible external evaluation whether staff perceptions about the opaque, top-down, slow and political nature of the decision-making of the top-most PRCS management are valid and take remedial action if they are.
- PRCS should provide much greater capacity-building support to the GB branch which is obviously short of resources and supplies and feels that it is treated in a step-motherly fashion by the NHQ topmost management.
- Both agencies should develop greater capacity at all levels to undertake more well-conceived, implemented and result-oriented PSP activities
- Both agencies should review the appropriateness of placing PSP within the health component rather than the livelihoods or disaster management component given the wide differences in the skills set required for health and PSP work.
- PRCS should provide greater technical and managerial training to BHU staff
- PRCS should ensure that BHUs receive supplies and equipment more on time
- Both agencies should develop a brief 1-2 page written strategy for participating in and influencing the workings of the overall health cluster which could guide the extent and nature of their participation and contribution at the national, provincial and district levels, the division of labour between the two agencies in terms of such participation and the issues that the RCRC movement would like to focus on within the sector.

APPENDIX

1. List of Flood Affected Districts

S. No.	Province	District	Affected Status
1	AJK	Bagh	Moderate
2	AJK	Bhimber	Moderate
3	AJK	Hattian	Moderate
4	AJK	Haveli	Moderate
5	AJK	Muzaffarabad	Moderate
6	AJK	Neelum	Severe
7	AJK	Poonch	Moderate
8	Balochistan	Barkhan	Moderate
9	Balochistan	Harnai	Moderate
10	Balochistan	Jaffarabad	Severe
11	Balochistan	Jhal Magsi	Moderate
12	Balochistan	Kachi	Moderate
13	Balochistan	Killa Saifullah	Moderate
14	Balochistan	Kohlu	Moderate
15	Balochistan	Loralai	Moderate
16	Balochistan	Musakhel	Moderate
17	Balochistan	Nasirabad	Severe
18	Balochistan	Sherani	Moderate
19	Balochistan	Sibi	Moderate
20	Gilgit Baltistan	Astore	Moderate
21	Gilgit Baltistan	Diamir	Moderate
22	Gilgit Baltistan	Ghanche	Moderate
23	Gilgit Baltistan	Ghizer	Moderate
24	Gilgit Baltistan	Gilgit	Moderate
25	Gilgit Baltistan	Hunza Nagar	Moderate
26	Gilgit Baltistan	Skardu	Moderate
27	Kyber Pakhtunkhwa	Abbottabad	Moderate
28	Kyber Pakhtunkhwa	Bannu	Moderate
29	Kyber Pakhtunkhwa	Batagram	Moderate
30	Kyber Pakhtunkhwa	Buner	Moderate
31	Kyber Pakhtunkhwa	Charsadda	Severe
32	Kyber Pakhtunkhwa	Chitral	Moderate
33	Kyber Pakhtunkhwa	D. I. Khan	Severe

34	Kyber Pakhtunkhwa	Hangu	Moderate
35	Kyber Pakhtunkhwa	Haripur	Moderate
36	Kyber Pakhtunkhwa	Karak	Moderate
37	Kyber Pakhtunkhwa	Kohat	Moderate
38	Kyber Pakhtunkhwa	Kohistan	Severe
39	Kyber Pakhtunkhwa	Lakki Marwat	Moderate
40	Kyber Pakhtunkhwa	Lower Dir	Severe
41	Kyber Pakhtunkhwa	Malakand PA	Moderate
42	Kyber Pakhtunkhwa	Mansehra	Moderate
43	Kyber Pakhtunkhwa	Mardan	Moderate
44	Kyber Pakhtunkhwa	Nowshera	Severe
45	Kyber Pakhtunkhwa	Peshawar	Severe
46	Kyber Pakhtunkhwa	Shangla	Severe
47	Kyber Pakhtunkhwa	Swabi	Moderate
48	Kyber Pakhtunkhwa	Swat	Severe
49	Kyber Pakhtunkhwa	Tank	Severe
50	Kyber Pakhtunkhwa	Upper Dir	Severe
51	Punjab	Bhakkar	Severe
52	Punjab	D. G. Khan	Severe
53	Punjab	Jhang	Moderate
54	Punjab	Khushab	Moderate
55	Punjab	Layyah	Severe
56	Punjab	Mianwali	Severe
57	Punjab	Multan	Moderate
58	Punjab	Muzaffargarh	Severe
59	Punjab	Rahim Yar Khan	Severe
60	Punjab	Rajanpur	Severe
61	Punjab	Sargodha	Moderate
62	Sindh	Dadu	Severe
63	Sindh	Ghotki	Severe
64	Sindh	Hyderabad	Moderate
65	Sindh	Jacobabad	Severe
66	Sindh	Jamshoro	Severe
67	Sindh	Kashmore	Severe
68	Sindh	Khairpur	Moderate
69	Sindh	Larkana	Severe
70	Sindh	Matiari	Moderate
71	Sindh	Naushahro Feroze	Moderate
72	Sindh	Qambar Shahdadkot	Severe

73	Sindh	S. Banazirabad	Moderate
74	Sindh	Shikarpur	Severe
75	Sindh	Sukkur	Moderate
76	Sindh	Tando Allah Yar	Moderate
77	Sindh	Tando Muhammad Khan	Moderate
78	Sindh	Thatta	Severe

Source: NDMA - January 2011

2. Acronyms

BHU: Basic Health Unit

CBHFA: Community Based Health First Aide

GB: Gilgit-Baltistan

IFRC: International Federation of Red Cross and Red Crescent Societies

IRP: Integrated Recovery Program

KP: Kyber PakhtunKhwa (Province)

MHU: Mobile Health Unit

MOH : Ministry of Health

NGO : Non-Governmental Organisation

PRCS: Pakistan Red Crescent Society

PSP: Psychosocial Services Program

RCRC: Red Cross Red Crescent Movement

ToR : Terms of Reference

ToT : Training of Trainers

VCA: Vulnerability Capacity Assessment

VC: Village Committee

WatSan: Water and Sanitation

3. Schedule

Program Activities/Destination	Date
Islamabad	4-Jul
Islamabad to Karachi, Khi to larkana	5-Jul
Larkana-BHU , DoH	6-Jul
larkana -Communities(2)	6-Jul
larkana to KSK- Communities (2)	7-Jul

larkana to Shikarpur- Communities (2)	8-Jul
Shikarpur/Sukkur to Khi	8-Jul
Khi to Islamabad	9-Jul
Islamabad	10-11-Jul
Islamabad to Skardu; Visit to BHU	12-Jul
Visit to communities	12-Jul
Skardu to Gilgit- BHU visit	13-Jul
Visit to Communities	13-Jul
Gilgit to Besham	14-Jul
Visit to Kohistan to communities	15-Jul
Visit to Communities in Shangla	16-Jul
Shangla to Swat	16-Jul
Visit to Communities (2) in Swat	17-Jul
Swat to Islamabad	18-Jul
Islamabad -De briefing	19-Jul

Focus Group Discussion Instrument

Guidelines for FGDs

- Introduce yourselves. Inform the community that you are here to get their feedback about their satisfaction with the health services that they received from PRCS after 2010 floods so that the agency can improve its services in the future
- Thank people for giving their time during a busy time of the year
- Encourage people to speak freely and honestly and assure them that any negative feedback that they give will not hurt their chances of getting help from agency in the future and that the evaluators will not share the name of people who make critical remarks with the local staff
- Speak politely and sensitively with people even if they make provocative remarks
- Please do not make any culturally or politically insensitive remarks. Please do not make any promises and make it clear that you are not here to identify people for future aid
- Encourage all sections of the group to speak rather than just the leaders
- Probe appropriately in case people are giving unclear or general or vague answers
- Thank people again in the end and tell them that their views will help the agency improve its services in the future

a. Relevance and Appropriateness

- Did the PRCS take any steps to identify and address the health priorities of the targeted groups in your community? If so how?

- Did the PRCS health programs continue to be relevant and appropriate in the light of your changing situation and needs during the whole period of the operation? Give 2-3 concrete examples of changes made
- What mechanisms were put in place to involve your community in the implementation and monitoring of the health components?
- Were the health interventions implemented in a timely manner in light of your needs? How soon after the 2010 floods did PRCS health services reach you?
- What mechanisms were put in place that enabled beneficiaries to provide feedback to PRCS interventions? Did your feedback make any change to their work?

b. Efficiency

- What additional steps could be taken to maximize the benefits to targeted communities from PRCS health programs?

c. Effectiveness

- Has PRCS adopted an integrated approach – among health interventions, as well as health with other sectors for flood-affected communities?
- How effective were the PRCS programs in solving your health problems in the community?
- Which of the PRCS health services provided were most useful? Which were least useful? MHU, BGU, CBHFSA, PSP
- What other health services should the PRCS have provided?
- How effective was the health committee formed by PRCS? How can it be improved?

d. Coverage

- What concrete and objective criteria did programs use to identify the most vulnerable flood-affected populations at the village level?
- Were the health interventions delivered proportionate to need and services received by most in need at village levels (including women, and special needs groups)?

e. Impact

- How the different PRCS health interventions contributed to the well-being and, improve health conditions in the assisted communities and community resilience?
- Are all targeted villages with trained CBHFA and PSP volunteers and formed village health committees (VHCs) active? Are the volunteers able to reach their catchment households for service provision? What are the activities undertaken and how often? What facilitates and hinders their service delivery?
- To what extent were the PRCS community coaches and volunteers (CBHFA and PSP) able to deliver identified community mobilization (for health) tasks and services in targeted communities?

g. Sustainability and Connectedness

- To what extent were the health interventions linked to local health service delivery?

- Which of the health interventions ought to be continued by PRCS and incorporated into its regular health programmed plans?
- To what extent has the health component trained and mobilized health volunteers who are currently carrying out health activities with the community in the catchment areas?
- Did the health components implemented contributed to the capacity building of the target communities towards enhanced community resilience? In so, in what way?

Individual Household Interview Instrument

1. Village 2. District 3. Province

4. Name 5. Gender: 1)F 2)M 6. Age

RELEVANCE AND APPROPRIATENESS

Which of the following health problems did your family suffer after the 2010 floods?		Did you receive any services from PRCS for this health problem
	Yes =1; No=2	Yes =1; No=2
Diarrhoea		
Dysentery		
Cholera		
Malaria		
Skin problems		
Malnutrition		
Minor injury		
Mental stress		
Reproductive health problem		

EFFECTIVENESS

Which of the following PRCS services did your family use:

Mobile health unit	
Basic health unit	
Community-based First Aid	
Psychosocial services	

Which of the PRCS health services provided was most useful?	
Which was the least useful?	
What other health services should the PRCS have provided?	

RELEVANCE AND APPROPRIATENESS	Yes	No
Did the PRCS health programs continue to be relevant in the light of your changing needs during the whole period of the operation?		

Were you consulted by PRCS about the types of services and their content?		
Were you told the procedure for making a complaint to the agency?		
Did you make any complains?		
Did PRCS rectify them?		
Were the services timely for you in light of your needs?		
Were you or any family member involved in the implementation and monitoring of the PRCS health components?		
EFFECTIVENESS		
Were PRCS health services well integrated with each other?		
Were PRCS health services well integrated with other PRCS services?		
Was a health committee formed by PRCS in your village?		
Was it effective in reducing health problems in the village?		
IMPACT		
Has there been any increase in your knowledge about health and hygiene promotion due to PRCS programs?		
Has there been any increase in your knowledge about nutrition issues due to PRCS programs?		
Has the health status of your family improved significantly due to PRCS programs?		
Were there any unintended harm resulting from this help for your family?		
Did your family receive BP5 biscuits from PRCS?		
Was it very helpful in resolving your health problems?		
Did your family receive mosquito net from PRCS?		
Was it very helpful in resolving your health problems?		
Did your family receive reproductive health kit from PRCS?		
Was it very helpful in resolving your health problems?		
COVERAGE		
Were the most deserving people in the village provided the health services?		
Did the PRCS programs address the most important health needs of women?		
Did the PRCS programs address the most important health needs of disabled and elderly people?		

Terms of References
Attached

List of staff interviewed

Name	Designation
IFRC	
Dr. Jamal Shah	Health Coordinator
Dr. Fawad Iqbal	Senior Technical Officer Health
Jaap Timmer	Program Coordinator
Sacha Bouter	PMER Coordinator
Muhammad Niaz	Incharge Watsan
Michael Higginsson	Program Advisor
Qaswar Abbas	National DM Coordinator
Philip Hayes	Head of Office, KP
PRCS	
Dr Kamran Mushtaq	Acting Director (Health & Training)
Dr. Asma Hasnat	Assistant Director Health
Dr. Shaista Saeed	Deputy Director Health
Dr. Umer Iqbal	Assistant Director CBHFA
Mr. Kanwar Waseem	Provincial Secretary, Sindh
Dr. Ali Warsi	Provincial Health Manager, Sindh
Dr. Muzammil	Health Team, Sindh
Dr. Babar Khan Jadoon	Provincial Health Manager, KP
Dr. Farhad Ali	CBHFA Coordinator, KP
Mr. Mohammed Asif Hussain	Chairman, GB Branch
Mr. Mumtaz Hussain	District Secretary, Skardu

International Federation of Red Cross and Red Crescent Societies

TERMS OF REFERENCE

HEALTH PROGRAMME REVIEW OF THE

2010 PAKISTAN MONSOON FLOOD OPERATION

1. Summary

Purpose	The purpose of this review is to examine the progress and impact achieved on the overall health programme within the 2010 Flood Appeal, in the emergency and recovery phases of the operation with regards to the relevance and appropriateness, efficiency, effectiveness, coverage, impact and sustainability of the intervention. The review will encompass the identification and consolidation of valuable practices and lessons during the operation, as well as put forward recommendations and opportunities with the aim of strengthening the health components of the PRCS national society's emergency and recovery program, and its connectivity to long-term programming. The results of this review will be used to suggest improvements in design, implementation and management of the emergency health programmes and the delivery of future intervention supported by IFRC and other RCRC Movement Health partners in Pakistan.
Audience	Pakistan Red Crescent Society (PRCS), IFRC, PNSs and other Red Cross Red Crescent (RCRC) Movement Partners.
Commissioners	IFRC-Pakistan Delegation
Reports to	IFRC-Pakistan Delegation-Health Coordinator and Program Coordinator
Duration-Timeframe	6 weeks
Location	Islamabad with field work in a number of locations across the five provinces of Balochistan, Gilgit Baltistan (GB), Khyber Pakhtunkhwa (KPK),Punjab and Sindh, subject to security approval.

2. Background

An estimated 20 million people out of Pakistan's population of 170 million were affected by the worst flooding in 2010 sweeping through Balochistan, Punjab, and Khyber Pakhtunkhwa (KPK), Federal Administered Tribal areas (FATA), Pakistan Administered Kashmir (AJK), Gilgit Baltistan (GB) and Sindh. The event caused unprecedented flash floods that damaged and/or submerged homes, roads and bridges, cropland and public infrastructure that left 1,985 deaths, 2,946 people injured and 1,744,471 houses damaged (official figure maintained by NDMA since November 2010). The delivery of primary health services has been disrupted and the capacity of the health systems in flood-affected areas has been reduced resulting to the further deterioration of the health condition of the most

vulnerable populations – which was already poor before the floods. Increasing malnutrition and, cases of infectious diseases, epidemics, poor sanitation and loss of homes and livelihood were some of the health wide-range of issues faced by the most number of flood affected communities whose houses were destroyed by the floods and who needed to be relocated to temporary shelters with limited supply of safe drinking water and sanitation facilities.

The IFRC launched in August 2010 an emergency appeal to support Pakistan Red Crescent Society following the worst floods to hit Pakistan since 1929 targeting to assist 130,000 families (910,000 people) for 24 months. As the magnitude of the crisis continued to expand, the emergency appeal was revised in November 2010 to scale up the relief and recovery components of the PRCS response while maintaining the same target of 130,000 families. The latest revision of the appeal was made in August 2012 seeking CHF 92.6 M in cash, in-kind, or service to assist the same number of beneficiaries for the expanded period of 36 months with the completion by end of July 2013. The IFRC's emergency appeal is part of the large scale international humanitarian response to try and address the needs of the affected communities, working through and with the PRCS.

Health is an important component of the PRCS floods response, covering the emergency to recovery periods and implemented in the five provinces of Sindh, KPK, Punjab, GB and Balochistan. The health component delivered through basic and mobile health units, volunteer coaches and community volunteers with an integrated primary health care package that included curative and rehabilitative services, but also disease prevention, health promotion and psychosocial support. These services were also carried out using community based health and first aid (CBHFA) and epidemic control for volunteers (ECV) toolkit. The interventions was implemented in 25 priority districts, to including six districts of the integrated recovery programming (IRP) in three provinces of Sindh, KPK and Punjab. The emergency relief and recovery health components of the emergency appeal was pegged at CHF 7,057,925 representing 8% of the total CHF 92.6 M appeal budget (revised budget as of August 2012 with cash, in-kind or services).

The overall health outcome of the health component was to reduce the immediate and medium-term health risks of targeted flood-affected communities through the provision of curative and preventive health services. The implementation approach was integrated health programming with health facility-based services in coordination with local health and community-based health interventions with community involvement through community-based health and first aid (CBHFA) and psychosocial support program (PSP) with the inclusion of epidemic control and nutrition activities. The key outputs in the revised Health Log frame were the following:

a. Increased capacity of PRCS to plan, respond and cope with health emergencies and challenges in times of recurrent disasters.

b. Communities have improved access to primary health services for the treatment of "minor" illnesses and injuries, essential maternal and child care services, referrals as well as psychosocial support.
c. Increased awareness on health, MNCH, nutrition promotion, disease/epidemic prevention and control measures and including psychosocial support.

The health component of the emergency appeal was designed and developed using the findings and recommendations from the Field Assessment and Coordination Team (FACT), Transition Planning Assistance Team (TPAT), as well as vulnerability and capacity analysis (VCA), relief phase evaluation and IRP Baseline assessment. Periodic reviews and the IRP Mid-Term Review reports also informed the implementation of the recovery components of the health response.

The widespread coverage of health interventions in the five provinces within the recovery operation, integrated health components provided primary health care facility services, community based health, first aid, and psychosocial support activities linked to government health delivery care for referral and service collaboration. The deployment of mobile health care units with the start of floods in 2010 and 2011 demonstrates utilized PRCS response capacities and systems in place. The implementation of health interventions during recovery period entailed enhanced efforts in local coordination with stakeholders, community engagement, recruitment and training of health staff and volunteers. The integrated recovery programming components was implemented in three provinces, six districts highlighted along with other program interventions of watsan, livelihood, shelter, and disaster risk reduction.

Health interventions were implemented in 25 districts covering 43 Union Councils (UCs) with an approximate population of 727,000 persons (90,000 households) receiving assistance from supported basic health care units (BHUs), mobile health units (MHUs), CBHFA and PSP activities summarized in the table below:

PROVINCE	DISTRICTS	NO OF UC	HEALTH COMPONENTS
Sindh	Larkana	4	BHU, MHU, CBHFA, PSP
	Shikarpur	2	MHU, CBHFA, PSP
	KSK	2	MHU, CBHFA, PSP
	Jacobabad	2	BHU, CBHFA, PSP, Emergency Response Unit Basic Health Care (ERU BHC)
	Thatta	1	BHU, CBHFA, PSP
	Dadu	1	ERU BHC
KPK	Swat	4	BHU, CBHFA, PSP
	Shangla	2	CBHFA, PSP

PROVINCE	DISTRICTS	NO OF UC	HEALTH COMPONENTS
	Kohistan	2	BHU, CBHFA, PSP
	Charsada	4	BHU
Balochistan	Jhal Magsi	1	BHU
	Sibi	2	BHU, CBHFA, PSP
	Dera Murad Jamali	1	BHU
	Loralai	3	CBHFA, PSP
	Jaferrabad	2	CBHFA, PSP
GB	Gilgit	2	BHU, CBHFA, PSP
	Skardu	1	BHU, CBHFA, PSP
	Ghizer	1	CBHFA, PSP
	Diamer	1	CBHFA, PSP
Punjab	Muzaffargarh	3	BHU, CBHFA, PSP
	Layyah	2	BHU, CBHFA, PSP
	Rahim Yar Khan	1	BHU, CBHFA, PSP
	Rajan Pur	1	BHU, CBHFA, PSP
	DG Khan	1	BHU, CBHFA, PSP
Total	25	43	

The target areas for health interventions under the Integrated Recovery Programme (IRP) at the Branch level were finalized in the last quarter of 2011. In June 2012, health interventions support in 6 districts (5 in Punjab and 1 in KPK-Charsada) was phased-out, discontinuing BHUs, CBHFA and PSP activities in those areas. The health targets for IRP plan of action (PoA) and budget were revised in August 2012 with a further reduction of the health targets in the appeal revision in March 2013. Key IRP field activities will be completed by end of March 2013.

As of January 2013, the status of achievement for health is summarized below:

Health-Key Activities	Unit	Original Emergency Appeal Target	Revised Target in August 2012	Revised Achievable Targets as of March 2013	Achievement reported as of January 2013
Running BHUs/MHUs	Unit	24	24	22	22
Distribution, Reproductive Health Kits	Kits	54	54	66	0
Training, Lady Health Workers (LHWs) and/or Traditional Birth Attendants (TBAs) and/or Community Midwives	Persons	144	250	100	50
Training CBHFA, Master Training of Trainers (ToT)	Persons	25	25	16	16
Training CBHFA Coaches	Persons	144	200	160	150
Training, CBHFA Volunteers	Persons	2,880	2,754	1,575	1,095
Training ECV and Nutrition-Coaches	Persons	312	173	121	65
Training ECV and Nutrition-Volunteers	Persons	Not specified	2,498	622	69
Formation and Training , Village Health Committee (VHC)	Committe e	144	137	76	60 formed, 38 trained
Distribution Long Lasting Impreganted Nets (LLINs)	Nets	100,80	67,900	50,212	38,614
Distribution BP5 biscuits	Bars	166,600	166,600	165,792	14,369
Community Health and Psychosocial support (PSS) initiative support	villages	144	24	9	0
Training PSS, Master ToT	Persons	25	25	25	25
Training PSS Coaches	Persons	144	200	157	157
Training , PSS Volunteers	Persons	Not specified	2,754	959	895
Training PSS for Staff and Volunteers	Persons	Not specified	275	100	0

Detailed planning discussions for the exit plan of the 2010 Flood Appeal support took place in the last quarter of 2012, with the field operational activities to be completed by end of March 2013, and the consolidation phase activities (including hand over, final field monitoring, evaluation, report follow and preparation) to be completed by end of June 2013.

3. Purpose and Scope

3.1. Purpose (overall objective)

The purpose of this review is to examine the progress and impact achieved on the overall health programme within the 2010 Flood Appeal, in the emergency and recovery phases of the operation with regards to the relevance and appropriateness, efficiency, effectiveness, coverage, impact and sustainability of the intervention. The review will encompass the identification and consolidation of valuable practices and lessons during the operation, as well as put forward recommendations and opportunities with the aim of strengthening the health components of the PRCS national society's emergency and recovery program, and its connectivity to long-term programming. The results of this review will be used to suggest improvements in design, implementation and management of the emergency health programmes and the delivery of future intervention supported by IFRC and other RCRC Movement Health partners in Pakistan.

3.2. Scope

The review will examine the health programmes during the emergency and recovery phases of the 2010 floods operation which was originally planned to be carried out from August 01, 2010 to July 31, 2012 but extended up to July 31, 2013. The health component was delivered as an integrated primary health care package which included the deployment of basic health care emergency response units, mobile health units/basic health units, and community health volunteers to deliver a combination of curative, preventive and promotive health services.

The interventions were carried out in selected severely-affected districts and communities in the provinces of Sindh, KPK, Punjab, GB and Balochistan – either implemented as IRP (6 districts) or as stand-alone health interventions (18 districts). The key health components of BHUs, CBHFA and PSP were designed with a budget of CBHF 7 million (cash, in-kind or services); and has expended over 83% by the end of January 2013.

4. Evaluation Objectives and Criteria

4.1. Objectives

a. To examine the extent to which the health component and interventions during the emergency and recovery phases of the PRCS-IFRC response to the 2010 flood operation have achieved their intended results (goal, outcomes and outputs) in relation to strategic and operational frameworks and implementation plans jointly developed.
b. To review the current PRCS and IFRC Pakistan Health programme set-up (directives, programmes, resources, staffing, field implementation tools, guidelines, reporting and internal procedures, systems, management and coordination) and, its capacity to implement integrated health interventions in a wider scope in response to emergency and recovery programming.
c. To identify lessons and opportunities, and recommend good practices for enhanced program management and implementation support of health service delivery of PRCS, IFRC and the wider RCRC Movement as a whole in Pakistan.

4.2. Evaluation Criteria

a. Relevance and Appropriateness

- Did the health components (BHUs, CBHFA and PSP) and the integrated implementation strategies employed respond to the priorities of the targeted groups and address the identified needs in emergency and recovery situations,? If not, why? What mechanisms were put in place to ensure the health components implemented continued to be relevant and appropriate in the light of the changing situation and needs during the whole period of the operation?
- To what extent were flood-affected communities involved in the planning, implementation and monitoring of the health components? To what extent were the health interventions implemented in a timely manner to meet community health needs and what mechanisms were put in place that enabled beneficiaries to provide feedback to PRCS interventions?
- Did the health components implemented contributed to the capacity building of the target communities towards enhanced community resilience? In so, in what way?

b. Efficiency

- Were the different health components implemented in a timely manner to meet the community needs? If not, why? What adaptions of services were made to address the changing needs of the operation from emergency to recovery period?
- Were the required inputs and resource materials and funds available in a timely manner, and used in the best way possible to achieve the stated objectives? If not, why not?
- Were the appropriate and required human resource support (staff and volunteers) available in terms of skills and experience for the implementation of BHUs/MHUs, CBHFA and PSP at the different levels of implementation? If not, why not?
- To what extent can the PRCS integrated primary health care approach to disaster response in emergency and recovery period be considered efficient? To what extent has the health component in the integrated recovery programming (IRP) contributed to the efficiency of the programme implementation? What additional steps could be taken to maximize the benefits to targeted communities?

c. Effectiveness

- To what extent did the health components (as well as individual health interventions) during the emergency and recovery periods of the operation achieve their proposed outcomes and objectives?
- How has the integrated approach – among health interventions, as well as health with other sectors – contributed to more effective (as well as cost-effective) delivery of health services and activities to flood-affected communities?
- What factors have influenced/contributed to the timely implementation of the health services and activities, and what factors have hindered the progress?
- How did the programme management processes, tools and guidelines – in relation to planning, implementing, monitoring, reporting, including financial management – contribute to the effective implementation of health interventions and activities?
- How did the PRCS and IFRC coordination and working mechanisms in health contribute to effective implementation of activities to flood-affected communities? If not, why? How can these be improved in future operations?

d. Coverage

- To what extent were the most vulnerable flood-affected populations reached by PRCS-IFRC health interventions in relation to their needs? To what extent has the health component addressed the specific needs of specific population groups such as women, special needs groups, including hard-to-reach communities?

- Were the health interventions delivered proportionate to need and services received by most in need?
- What strategies were applied to ensure inclusion priority of and access by the most vulnerable groups (including women, and special needs groups) in targeted areas to ensure access to health services?
- To what extent has the health component trained and mobilized health volunteers who are currently carrying out health activities with the community in the catchment areas?

e. Impact

- How the different PRCS health interventions contributed to the well-being and, improve health conditions in the assisted communities and community resilience? Provide an indication of attribution.
- To what extent have the health interventions supported the capacity building of target communities towards community resilience? What processes and factors have contributed to these achievements?
- To what extent did the different health interventions contribute to the outcomes of the emergency and recovery phases; and in achieving enhanced resilience of the affected population?
- Are all targeted villages with trained CBHFA and PSP volunteers and formed village health committees (VHCs) active? Are the volunteers able to reach their catchment households for service provision? What are the activities undertaken and how often? What facilitates and hinders their service delivery?
- To what extent were the PRCS community coaches and volunteers (CBHFA and PSP) able to deliver identified community mobilization (for health) tasks and services in targeted communities?

f. Coherence

- Were the health outcomes/objectives in line with the overall goal and outcomes of the PRCS 2010 flood operation, country program support and PRCS health policy and strategic directions? To what extent were the interventions in line with the health policies and strategic directions of the IFRC?
- Were the health interventions implemented and complementary to the local/national health authority's health service delivery and other key humanitarian health partners working in the same areas, and following established national health guidelines and standards?
- To what extent were the engagement of IFRC and PRCS Heath in health and health-related cluster meetings in the country and its relevance to the IFRC/PRCS health response planning and implementation?

g. Sustainability and Connectedness

- To what extent were the health interventions linked to local health service delivery? To what extent were the health components linked to national health mechanism for emergency response? How can these linkages be strengthened?
- What plans and directions, as well as mechanisms, are in place for sustaining the health interventions after the completion of the operation? Which of the health interventions ought to be continued by PRCS and incorporated into its regular health programmed plans and budgets and how? Would the experience of integrated health programming approach contribute in future restructuring of PRCS health operations? Why and why not?
- Have there been any changes in the capacities, skills and knowledge to implement the health program components due to the 2010 flood health supported interventions? If so, what and how can these be strengthened and sustained further?

- What essential necessary support is needed to ensure the sustainability of the health interventions at different levels? What are needed to ensure long term sustainability of the PRCS health programmers?
- How have the health components of the floods response contributed to the capacity of PRCS in responding to floods and other disasters in the future? What processes and factors have led to these developments?

5. Evaluation Methodology

The review will use the following methodologies:

5.1. Desk review of key documents, which will include but not limited to:
- Assessment reports, such as by FACT and TPAT, PRCS emergency and early recovery assessments.
- Flood appeals documents, including operational frameworks, plans of action, budgets, log frame table, and PRCS implementation plans.
- Operational updates, including RCRC Movement operational factsheets, PRCS health intervention progress reports
- Operational review, review of ERU BHC deployments, as well as partner NS-conducted reviews of health response inputs
- PRCS Health Strategic plans, program tools and guidelines
- Field planning and monitoring visits, meeting reports and other relevant secondary health information

5.2. Key informant interview/group interviews, as appropriate
This will include key PRCS Health, PSP, CBHFA technical staff and volunteers at National Headquarter (NHQ) and Provincial Headquarter (PHQ); relevant IFRC and PRCS Senior management; IFRC health and other relevant program staff in NHQ; other RCRC partners supporting PRCS health interventions in emergency and recovery period; external stakeholders and partners such as Government Health Department, UN-WHO, UNICEF/Health and Nutrition Clusters at Islamabad, provincial and district levels.

5.3. Field visits
To cover 4 Provinces and selected villages and districts to gather information directly from the community beneficiaries, village health committees (VHCs) through focus group discussion and key informant interview; and observation of community health supported activities

6. Deliverables (Outputs)

The evaluation team, through the lead evaluator/consultant, will be expected to deliver the following:

6.1. Inception report that will cover the plan of work for the evaluation with the proposed methodologies, data collection, interview guides and questionnaires, reporting plan, travel and logistical arrangement for the evaluation based on the provision of the terms of reference (ToR).
6.2. Preliminary findings which will be produced and presented during a debriefing workshop. Evaluator will arrange preliminary meeting to be attended by senior and health managers of PRCS (NHQ and PHQ), IFRC and in-country Movement partners. The workshop will be an opportunity to note feedback on the preliminary findings and recommendations to enrich the substance of the review.

6.3. Draft Report, following established IFRC evaluation format, the Evaluator will provide the initial draft report to be submitted to the evaluation commission and circulated for comments by PRCS, IFRC and relevant reviewers before the report is finalized.
6.4. Final Report will be submitted to the review commissioner after going through and consolidating feedback and comments. Evaluator will prepare the final report. It shall be no longer than 50 pages and will be expected to include an executive summary, background description of the evaluation methods and limitations, findings, conclusions, lessons learned, recommendations and relevant annexes.
6.5. Additional Deliverables. Field photos related to field evaluation to include in the final report and/or additional attachment.

7. Proposed Timelines (Schedules)

The review will be carried out in 6 weeks over period of May to June 2013 following the proposed timeline schedules:

ACTIVITIES	TIMELINE																LOCATION	DELIVERABLES
	April				May				June				July					
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4		
Identification of lead evaluator		X	X														Islamabad	
Submission of Inception Report/Plan & Agreement				X	X												Islamabad	Inception Report
Desk Review and Data Collection						X	X										Islamabad	
Field Work							X	X	X	X							Sindh, KPK, GB, Balochistan, Punjab	PHQ/District Staff and volunteers to include selected communities completed.
Debriefing											X						Islamabad	Preliminary Findings Presented
Submission of Draft Report & Feedback											X	X						Draft version of Evaluation Report
Final Report Submission													X					Final report delivered.

8. Evaluation Quality and Ethical Standards

The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards and specific, applicable practices outline in the IFRC Evaluation Policy: http://www.ifrc.org/Global/Publications/monitoring/IFRC-Framework-for-Evaluation.pdf. The IFRC Evaluation Standards are:

- Utility: Evaluations must be useful and used.
- Feasibility: Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
- Ethics & Legality: Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
- Impartiality & Independence: Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
- Transparency: Evaluation activities should reflect an attitude of openness and transparency.
- Accuracy: Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
- Participation: Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
- Collaboration: Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at: www.ifrc.org/what/values/principles/index.asp

9. Evaluation Team and qualifications

The composition of review team will consist of qualified representatives from PRCS and IFRC, and an external consultant as team leader. Outlined below are recommended profiles of the review team:

9.1. Team members should have the following skills and experience:

- Technical and background knowledge in emergency health preparedness and response; experience in the management and coordination of health interventions as part of emergency response and recovery programmes is ideal; knowledge and familiarity of the Red Cross & Red Crescent tools, processes and interventions in emergency health response, as well as developmental health programming (such as CBHFA approach) are also desired.
- Strong analytical skills and ability to clearly synthesize and present findings, to draw practical conclusions and to make strategic recommendations.
- Excellent English writing and presentation skills, and able to prepare well-written reports in a timely manner

- Knowledge and experience in working with the Red Cross & Red Crescent as well as understanding on the complexities and constraints associated with NS and IFRC mandates; deep knowledge and understanding of the context in Pakistan; recent professional work experience in Pakistan is an advantage.
- Demonstrated capacity to work both independently and as part of a team.

9.2. Team Leader/Lead Evaluator:

- As above
- Demonstrable experience in the conduct of reviews and evaluations, preferably evaluations of health response to disasters and emergencies; experienced in the use of both qualitative and quantitative methodologies, and preparing evaluation report.
- Pakistani nationality and/or holding double passport- preferred

10. Application Procedures

Interested candidates should submit by 5th April 2013 to include the following:

- An expression of interest which includes the proposed review methodology, proposed work plan and timeframe, in line with the ToR requirements.
- Cover letter summarizing the applicant's experience pertaining to the proposed assignment, financial proposal for the total assignment, proposed start date and three referees.
- Three samples of recent review/evaluation reports written by the applicant.