# Pakistan

# Internal Appraisal 2014

## 1. Brief Description of Process

This Internal Appraisal was conducted for GAVI Secretariat by independent technical expert **Gordon Larsen**, in close cooperation with GAVI CRO for the country **Anne Cronin**, and is based on reports and documentation supplied to GAVI by the national authorities and institutions in the country for the year 2013. The document was shared with the Federal EPI programme and in-country partners WHO/UNICEF and WHO regional office and Headquarters.

## 2. Achievements and Constraints

According to the APR, the country met and exceeded its coverage targets for most of the traditional vaccines in 2013 (although not for TT), but targets were not met for the NVS vaccines Penta and PCV, with the latter being missed by a wide margin.

However, this was partly because targets for the year had been set based on the old administrative data, which is now found to have exaggerated the reported performance.

In accordance with the recent WHO UNICEF Immunization Coverage Estimates 2013, the government has adopted the recent Pakistan Demographic and Household Survey (PDHS) 2012-2013 and adjusted the targets to better reflect reality. This reflects the WUENIC estimate of 75% and administrative estimate of 95% and a Government estimate of 66%, and as a result, there are now considerable discrepancies between the original targets and the actual 2013 performance achieved by the programme. Furthermore the revised targets are used in the recently launched cMYPs with consultation with the stakeholders and in country partners.

Targets for DPT1-DPT3 drop-out were not met in 2013 (8% is reported, compared to a target of 4%), and possibly as a response to these results, it is noted that targets for 2014 and 2015 are revised upwards to 15% and 13% respectively. (Source: cMYP 2014-2018)

There is no discussion in this APR on vaccine wastage rates or of any programme attempts to measure or control. The maximum empirical values permitted by GAVI for each vaccine are used. However, the programme has taken active steps to address this through the US AID vaccine logistics management information systems ( vLMIS ) in place currently for 56 districts, and will be scaled up for the rest of the districts all over the country

Pakistan was approved for CSO type B funding for $ 7,656,073 in October 2008, these funds have been fully disbursed. A CSO named JSCD is working in 12 hard-to-reach Union Councils of Rajanpur district in South Punjab that has one of the poorest indicators of maternal and child health. It suffers from an inadequate and inaccessible healthcare system, poor health indicators and a high level of inequity in access and coverage of immunization leading to weak demand for services.

Under the Gavi business plan, Pakistan is one of ten countries in which UNICEF is leading work to improve equity in vaccine coverage across wealth, geography and gender. In addition, an annual literature review conducted internally in Gavi in July 2014 again resulted in findings in peer-reviewed articles of the existence of sex discrepancies in immunisation coverage in Pakistan, especially in specific ethnic groups or regional communities. In one study, Javed (2014) found that there is an association between the sex of the child and immunisation status, and that boys are 1.3 times more likely to be fully immunised compared to girls in rural areas. Finally, Pakistan also is documented to have high gender inequity on the 2012 UNDP Gender Inequality Index with a ranking of 123 out of 148 countries ranked.

However, the APR states: 'There are no significant discrepancies in reaching boys versus girls with robust evidence to support data. Different surveys have shown varying minor differences for example: [(59 Vs 54) Urban, and (53 Vs 50) Rural] and no evidence of gender related barriers is available'.

UNICEF reports on the work under the business plan for equity in Pakistan: Implementation of equity improvement plans in two pilot districts ongoing with support from national UNICEF staff and consultants at the provincial level, with plans in place for scale up to a further 10 districts under GAVI HSS support and the cMYP 2014 – 2018. Progress with the equity agenda in Pakistan remains patchy, and is being negatively impacted by security issues, high turnover of routine immunization staff and competing priorities, especially around the polio eradication agenda. However, where conditions are positive, progress is being made. Further efforts will be required from the UNICEF side to ensure greater integration of polio and routine immunization activities, and to ensure the strong placement of the routine immunization programme post the polio era.

## 3. Governance

The ICC membership comprises a broad cross-section of government, bilateral, international and CSO organizations. There is support under the business plan for CRS to support the CSO platform in Pakistan. There were no CSOs participating in the ICC in 2012, but in 2013, the APR states 'Representative of CSO consortium is invited to the ICC meeting'. The ICC held 2 meetings in 2012 and 2 in 2013. Meetings are usually chaired by the Federal Minister of Health. Minutes for an ICC meeting held on 30 May 2014 at which this APR was endorsed for submission to GAVI were provided, together with a signature list of 18 members attending. All provinces in the country are represented on the ICC. The ICC and HSCC have merged and all the GAVI related issues will be taken care of by the ICC.. Copies of the only ICC minutes provided show conclusions and actions to be taken.

NITAG is an independent body and as the ICC has membership of the government; the members are not the same as of the NITAG, in fulfilment of the WHO recommendations.

## 4. Programme Management

Annual Plans of Action for EPI are understood to be developed at Federal and Provincial levels, with the support of WHO. However it appears that these action plans are not costed and thus it is unclear how budgetary provision for them is ensured at the Federal or Provincial levels. No examples of such plans were provided as supporting documents for this APR and it is not known whether they are reviewed and commented on by the ICC/HSCC. Different activities in the action plans are included in different PC1's; the cMYP addresses these issues holistically. However there is no comprehensive PC-1 addressing the needs holistically.

Baseline data, performance indicators and future targets are all included in the APR Table 4. The recent Pakistan DHS 2012-13 estimates were used to update baseline data for 2012 in this cMYP and targets were revised accordingly for the years 2014-18. As stated in section 2 above, sharp falls in coverage rates are apparent for 2013 compared to the long-term trends that have been reported on the JRF for all EPI antigens in recent years. It will be noted that falls of up to 30%pt occur with each antigen between 2012 and 2013, with the falls for OPV3, DPT3 and Penta3 being the largest of these. The denominator and coverage targets for different antigens have been changed for upcoming years in comparison to the figures stated in past APRs, and it is anticipated that future reported performance will show substantially lower coverage rates for all antigens compared to previously reports.

It appears that programme activities are generally implemented approximately to schedule, with strengthening of human resources, capacity building for provincial EPI staff on vaccine management, successful introduction of PCV10 in most provinces and areas, successful training of data managers in all provinces and areas, EVM training in approximately 30% of all districts and drafting of the national immunization policy all implemented as planned during 2013. Only limited information is provided in the APR to assess whether these activities have been implemented according to budget or not however, and thus no conclusions can be drawn on this criterion.

## 5. Programme Delivery

The most recent EVM assessment was conducted in March-April 2014, and an Improvement Plan based on recommendations will be developed when the Security situation improves later this year. The previous EVM was conducted in 2009 and it is noted that one of the strongest recommendations from that assessment – i.e., conduct of a systematic temperature monitoring study for the central cold store - has still not been carried out of traditional vaccine. For the forthcoming EVM IP that will be developed per province it is important that there is close supervision and follow up by GAVI Alliance partners to ensure implementation.

The recent EVM found weak management and stock control of vaccines and supplies at all levels which results in frequent stock-outs. Vaccine stock management and vaccine distribution had performance scores of 48% and 38% respectively, which were both seriously below the required EVM performance pass level of 80% each. The EVM found these two aspects of vaccine management to be weakest of all 9 criteria assessed. In the previous EVM conducted in 2009, these same two criteria had performance scores of 47% and 60% respectively, so stock management has improved by just 1%pt. over 5 years, but distribution has worsened by 22%pt. over the same period. Again, both these criteria were seriously below the required performance pass level of 80%. However, the programme is taking active steps to address this through the US AID vaccine logistic Management Information system in place currently for 56 districts, which will be scaled up for the rest of the districts all over the country

According to the APR, the recent introduction of PCV vaccine went according to plan and schedule in some provinces, but could not be achieved in Baluchistan, FATA and Gilgit Baltistan due to security issues and the competing demands of multiple polio SIAs. Even in areas where introduction was achieved however, original coverage targets were not met as noted in section 2, and for PCV 3$^{rd}$ dose, the original target was missed by a wide margin. But at least for this vaccine, there were no reported stock-outs in 2013.

## 6. Data Quality

According to the differences between the 2 sets of results reported, up to 1.6 million children that are claimed to have been immunized with Penta 3 on the APR have actually not been immunized at all, according to data reported on the JRF. The estimates on the lower side were reported in order to address near true estimates. The programme plans to address this through the forthcoming GAVI HSS support to support EPI to build its own information system, and improve programme performance through the HSS support. The programme acknowledges the weakness of the reporting system and is making efforts to improve the system that have been incorporated in the cMYP section 2.2.6

As GAVI is moving forward to use the UN population figures it is important to note that the APRs for 2012 and 2013 show very significant differences between country data and UN Population Division figures for numbers of births, deaths, surviving infants and pregnant women for each of the years 2012 – 2015. For 2013, births indicated are 34% higher than UN projections for the year, and for surviving infants, 32% higher than the corresponding UN figures.

A DHS survey conducted in 2012 showed coverage rates for all EPI antigens that were significantly below the country reported data for that year, below the trend reported by the country over the previous several years, and also below the estimated WHO/UNICEF coverage rates for that year. This suggested that coverage rates have been over-reported for some years and evidence of persistently high incidence rates of the key EPI target diseases (measles, rubella, pertussis, diphtheria, tetanus) supports this suggestion. Subsequently, target coverage rates for all EPI antigens for 2014 and 2015 as shown in APR baseline Table 4 have been reduced compared to the original GAVI-approved targets as a response to this recent DHS data, and based on a desire to align targets more closely with reality. The recently developed cMYP is also based on the figures quoted by the DHS.

## 7. Global Polio Eradication Initiative, if relevant

As one of a handful of countries worldwide that remain polio-endemic, Pakistan has been, and still remains, the focus of intense attention by the Global Polio Initiative team, in their continuing efforts to achieve global polio eradication. One of the most controversial strategies of this effort however, has been the creation of separate, vertical programmes focused on polio eradication that have become independent of a county's routine immunization activities. This separation is now widely recognised to have damaged and weakened routine services in the process. As a consequence, countries are now attempting to 'reintegrate' what was previously a single fully-integrated programme.

In Pakistan, 'reintegration' and collaboration between the routine programme (RI) and the Polio Eradication Initiative (PEI) has so far reportedly been 'variable, unsystematic, reactive and uncoordinated'. As a consequence, a pilot project for integration is ongoing in 16 districts (4 districts in Sindh province, 4 in Punjab, 3 in Baluchistan, 4 in KPK) with integrated micro plans, integrated RI/PEI messaging, training for PEI staff on RI, monitoring, VPD surveillance and communications, a PEI monitoring checklist with key EPI indicators and a joint accountability framework included in the PEI National Emergency Action Plan for 2014. This pilot is to be extended to another 21 districts in 2015 utilizing IMG support. The Prime Minister chairs a dedicated RI/Polio Oversight Committee.

The introduction of IPV vaccine is planned for mid-June 2015 following the measles SIA. Concerns have been voiced over the fact that introduction of IPV will result in a child receiving three injections at one visit and communication efforts will need to be scaled up to alleviate possible reservations on the side of health care workers and caretakers.

## 8. Health System Strengthening

The HSS grant was approved in 2007 for $23,524,500 for 2008 and 2009. However there have been significant delays in implementation and Pakistan submitted a request for reprogramming of the grant which was approved for reprogramming in April 2013. Previous IRCs noted that implementation of the first tranche of $16 million was effective until the end of 2009. Devolution of the health system and limited guidance on institutional arrangements covering HSS operations were attributed to poor grant performance since then.

The grant was approved to go to Government of Pakistan, who had contracted out activities for implementation to UNICEF and WHO. Due to procedural hurdles, there was a change to this arrangement and for the second tranche of the HSS grants funds are now being channelled directly from GAVI to UNICEF and WHO, with two separate MoUs signed in July 2013. Hence there are currently three implementing partners of the HSS grant: Government of Pakistan (PC-1 awaits approval of ministry of Planning), WHO ($3.28 million to be implemented by 31$^{st}$ March 2015), and UNICEF ($3.34 million to be implemented by 30$^{th}$ June 2015). UNICEF is also supporting Pakistan with Equity Analysis through the GAVI Business plan, and plans to scale up a pilot from 2 to 10 districts, using the Reach Every District/ Reach every Union Council approach.

There were large discrepancies in planned and actual implementation in 2013. Pakistan reported $9,492 as expenditure in 2013 of the $10,495,686 available in the year. The reasons for stagnant implementation listed in the APR can be summarised as follows: The HSS PC-1 Ministry of National Health Services Regulations and Coordination, still awaits approval from the Planning and Development Division, which is pending since 2010. The MoU between GAVI and WHO was signed in July 2013, and funds were disbursed in September but due to internal delays, funds were not available before February 2014. UNICEF grant agreement was signed in July 2013, and funds received in September 2013. Planning took more time than anticipated. Governance and management structure in Baluchistan and Sindh provinces caused further delays.

The devolution is continuing to cause delays as activity implementation now require dealing with separate provincial Departments of Health, with varying capacity and priorities. Polio SNID and SIAD occupied the EPI staff, and took priority over HSS implementation.

Pakistan reports the following achievements in 2013: 1) successfully completed processes for enabling funds disbursement of second tranche of HSS funds for utilisation; including consensus on GAVI HSS work plan following a workshop in February 2013. 2) UNICEF equity analysis of main drivers of inequities, shifting the focus from national level planning to reach every district. 3) JSCD (CSO) is working in 12 hard to reach Union Councils in Rajanpur of South Punjab. Through community action plan, the CSO has fostered cooperation among policy makers and local and state level government officials, religious leader's ad local community members to advocate for improved health. 4) the GAVI HSS grant contributed to funding of the EVM assessment (April 2014), the improvement plan will be completed in Q3 2014. 5) Three capacity building workshops on data quality were organised, and provision of hardware and IT support was initiated. 6) NITAG and ICC decided to include HSS into the ICC, to facilitate joint oversight over GAVI support to Pakistan.

The pending approval of the HSS PC1 by the Planning and Development Division since 2011 is considered a major bottleneck for the HSS grant implementation. In addition there is the challenge of the post devolution obligation to engage simultaneously with several provincial / regional DOH, with carrying priorities and capacities and levels

Pakistan has made plans for completing most of the pending activities under the HSS grant work plan in 2014, with plans of facility level trainings of Lady Health Workers and strengthening/establishment of subnational and district warehouses in 2015. The country reports that the cost of establishing these warehouses would have increased since the original plan, but this is not reflected or adjusted in number of warehouses in the plan for 2015.

A country tailored approach for Pakistan is in final stages of development. Pakistan is expected to apply for their next HSS grant in 2015 and the ceiling calculated for the country is $100 million, ($84 million to budget for 5 years). It would be important to include lessons learned from the challenges met in the implementation of the first grant in preparation for the next proposal.

An assessment of immunization financing in 2013 was undertaken with support of WHO consultant. Many of the findings of the assessment is outdated.

The APR reports 'GAVI provided funds for technical support to introduce and support methodologies to identify main drivers of inequities, shifting the focus beyond national level planning for 'Reaching Every District / Reaching Every Union Council' ((RED/REUC). During the reporting period, UNICEF Country Office used different data sources to identify the key determinants in access and coverage of immunization. Based on the desk review and the aforementioned information, the Country Office undertook the situation analysis of the key drivers of immunization inequities in six out of ten selected districts of Pakistan (two from each of the four provinces in addition to the Azad Jammu Kashmir (AJK). Out of ten pilot districts, six are overlapped with Polio high risk districts where PEI-EPI convergence has taken place.'

There was no use of performance-based funding for country during this period.

The CSOs involved in HSS implementation are clearly identified and their tasks and activities are described. A total of USD 60,000 were allocated to UNICEF under the strategic objective of strengthening Civil Society and Community Engagement in Health sector on demand generation and creating awareness for routine EPI activities through CSOs/ and community involvement. A CSO named Jehandad Society For Community Development (JSCD) is working in hard-to reach 12 Union Councils of district Rajanpur, a district of South Punjab with one of the poorest indicators of maternal and child health with inadequate and inaccessible healthcare system and poor health indicators along with high level of inequities in access and coverage of immunization and weak demand for the services. Through a Community Action Plan (CAP), JSCD has fostered co-operation among policy makers, local and state government officials, religious leaders and local community members to advocate on issues related poor health situation of the district. It is also facilitating outreach teams through the listing of mothers and children, refusal cases and missed cases as they are in close contact with the community.

The proposed future HSS activities are described in detail and are considered to be logical and appropriate continuations of the activities already being implemented. They are believed to fit in

well within broader HSS activities and other donors' initiatives according to the description given in the APR.

## 9. Use of non-HSS Cash Grants from GAVI

The ISS funds received by WHO in 2013 of US$9,480,000 are not reflected in the APR table 6.1.

The funds reflected in the APR of US$9,852,972 was carried forward from 2012 reflects funds both in the Secretariat and with the Federal programme. Total expenditure during the year was US$4,672,403, leaving a balance of US$5,180,569 carried forward to 2014, that remains in the Secretariat and will be disbursed once audit requirements are met.

For CSO support Type B, a number of CSOs were to complete the agreements in the first quarter of 2013 and rest during mid-2013. GAVI approved and transferred funds for the extension in July 2013 to UNICEF Country Office to continue support to CSOs. The APR gives details of names, previous involvement in immunization / HSS, GAVI supported activities undertaken in 2013 and outcomes achieved by 11 CSOs. CSO Type B finds received in 2013 were US$1,420,671 and US$1,028,662 was carried forward from 2012 giving a total for the year of US$2,449,333. Total expenditure during the year was US$661,914, leaving a balance of US$1,787,419 carried forward to 2014. No external audit has apparently been conducted on the use of CSO type B funds but a financial statement for the funds used is provided. The completeness and quality of the country's reporting against the use of CSO funds is considered satisfactory by UNICEF.

## 10. Financial Management

An FMA was carried out in 2010 and following completion, an Aide Memoire was issued according to which 4 key requirements and conditions were agreed. The APR confirms that all 4 of these requirements have been implemented and gives the following implementation status:

1. Fund Flow Mechanism: The terms of the Aide Memoire required opening of Assignment Accounts in the provinces for smooth and speedy transfer of funds from federal level to provincial and district levels. After completion of due process the requisite Assignment Accounts have been opened in all provinces. These Assignment Accounts are now fully operational and provincial shares of GAVI funds are being transferred through these accounts.

2. Internal Control Frame Work: The terms of the Aide Memoire required strengthening of internal controls through an internal control framework, and until finalization and placement of such controls, inclusion in the terms of reference of an external audit, a review of existing internal controls. An internal control framework has been devised and an auditor has been appointed to ensure financial control and transparency. It is ensured that all financial transactions and disbursements are as per existing financial rules and procedures, and these fulfil all formalities.

3. Bank Reconciliation and Financial Reporting: The Aide Memoire required that reconciliation of accounts with the bank and accounts office may be carried out on a monthly basis. The reconciliation of accounts of expenditure is being carried out regularly with the bank and Accountant General's Office.

4. External Audit of ISS Funds: The Aide Memoire required that an external audit should be completed for the years 2009 and 2010 and a copy of the audit report submitted to the GAVI Secretariat. The external audit (Director General Federal Audit, Department of the Auditor General of Pakistan) of GAVI ISS accounts for FYs 2012 - 2013 has been completed and a final copy of the audit report has been sent separately to the GAVI Secretariat.

It is noted however, that while all 4 requirements and conditions are claimed to have been implemented, requirement 4 calls for an external audit for the years 2009 and 2010, while the response from country refers to the years 2012 – 2013. It thus appears that requirement 4 has not been fully met to data.

PFO plan to undertake an internal audit in Q4 2014 or Q1 2015.

## 11. NVS Targets

NVS targets for 2014 and 2015 are in accordance with the revised estimates. According to UNICEF SD as of 29 September 2014 the program has 10.9 months stock of Penta and 8.2 months stock of PCV 10 including all planned deliveries.

## 12. EPI Financing and Sustainability

The immunisation expenditure data in Table 5.5 are not accurate and there are major discrepancies hence an analysis is not feasible.

Pakistan has defaulted in 2008, 2012 and 2013 and continues to remain in default for 2013 due to the court case that petitioned against the program availing of UNICEF procurement services. As disbursement of funds for co-financing and co-procurement of pentavalent and PCV in 2013 did not take place prior to closure of the financial year in June 2013, the program lost its funding allocation.

The renewal of vaccine support for 2015 cannot be approved unless the default status of 2013 is resolved. The program avails of the 2014 budget to resolve its 2013 commitments. To date the pentavalent co-financing requirement of $5.9 m is fully outstanding, while PCV co-financing of $3.0 m has been partially paid for already ($2.1 m). It is presently estimates to be out of 2013 default by December 2014, however the current political unrest may delay this result.

## 13. Renewal Recommendations

| Topic | Recommendation |
|---|---|
| NVS Penta | Renewal subject to fulfillment of co-financing requirement for 2013 |
| NVS PCV | Renewal subject to fulfillment of co-financing requirement for 2013 |

## 14. Other Recommended Actions

| Topic | Action Point | Responsible | Timeline |
|---|---|---|---|
| Immunization financing | Revise table 5.5 as there appears to be major discrepancies. | Country | ASAP |
| Programme management | Programme to respond on how the cMYPs at provincial and national levels are developed for 2014-2018. Are to have regular follow-up. | | |
| | The real need is to have strong ownership of cMYPs, their implementation and regular follow up. WHO and partners can have a role in follow up of implementation of cMYP. | Country | |
| Vaccine Management | The EVM improvement plan to incorporate strategies to address the wastage rate. | | |
| | The programme plan to collect gender disaggregated data through adding one column on Gender (M/F) in their data collection forms from the next year (2015-16) | Country | |

| | | | |
|---|---|---|---|
| Financial management | Financial statements to be submitted by WHO has received the following<br>Op-cost measles SIA 20,699,481. | | |