EMPOWERMENT, VOICE AND ACCOUNTABILITY FOR BETTER HEALTH AND NUTRITION (EVA-BHN) – INDEPENDENT ASSESSMENT

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Acknowledgements

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Executive summary

Empowerment Voice and Accountability for Better Health and Nutrition (EVA BHN) – programme description

EVA-BHN is an £18.86 million health voice and accountability programme working at community, district, and province level in Punjab and Khyber Pakhtunkhwa (KP) since February 2014. It is part of the Department for International Development’s (DFID) Provincial Health and Nutrition Programme (PHNP), which supports delivery of an Essential Health Services Package (EHSP) by the governments of Punjab and KP.

EVA-BHN has set up 384 community groups (CGs) in five districts in Punjab and four in KP, by training and empowering community members. The CGs engage directly with primary health facilities and with district government through district advocacy forums (DAFs). Civil society organisations (CSOs), journalists, and other professional groups (such as lawyers) also participate in the DAFs. Some issues are raised to province level for discussion with government and other stakeholders such as development partners and politicians through province advocacy forums (PAFs). By September 2017, 41,162 people had participated in the CGs, DAFs, and PAFs at least once (some have attended more than one meeting, but have only been counted once).

CGs also discuss issues that have been identified in the health facilities through a community-based monitoring system (CBM), which is used by CG core members to collect data on the performance of the health facility. Common issues that are picked up include bad behaviour of staff, inadequate toilets, no drinking water, insufficient medicines, and lack of basic equipment. A total of 2,316 issues have been resolved since the programme began, 75% of which were resolved in Punjab.

EVA-BHN has also worked with journalists by building their capacity and developing networks to improve the quality of health reporting and to raise awareness of health rights. There has been a 201% increase in reproductive, maternal, newborn and child health (RMNCH) and nutrition news in the media since the journalists’ training, though most of this increase happened in the first year after the training and then tailed off somewhat in the second year.

Religious leaders in the nine programme districts are complementing EVA-BHN’s communications efforts. They were given training and a sermon guidance book – and to date have given a total of 453 sermons on health issues and rights.

National communications supported by EVA-BHN include funding a national TV drama with social and health messaging and the introduction of ‘education entertainment’ courses in nine universities.
Independent assessment of the EVA-BHN programme

This assessment provides an external and critical view of the EVA-BHN programme. It provides learning for improving programme effectiveness over the remaining 16 months, for informing the design of future DFID health programme(s) in Pakistan, and for communicating with stakeholders.

The assessment was conducted in October, November, and December 2017 through a desk review of international evidence and programme documentation and data, as well as through a visit to four of the programme districts and the two province capitals, where qualitative data was collected. Eight focus group discussions (FGDs) with community group members and 55 key informant interviews were conducted across the two provinces. Findings in this report come from a desk review of EVA-BHN monitoring data, EVA-BHN research and case studies, and also from the limited primary data collection. It is not possible to generalise many of the findings, but they give useful information and insights.

Assessment findings

Evidence of outcomes

There is some evidence of behaviour change resulting in improved health facility and service quality at the basic health units (BHU) we visited, some policy changes and improved financial flows to the BHUs in Punjab, and some evidence of increased utilisation of health services. Citizen–state relationships are developing and there are clear examples of effective state responsiveness.

There is some evidence of improvements in the quality of health services. Although not all the improvements can be attributed entirely to EVA-BHN, it is likely that EVA-BHN CGs have played a key role in improving health worker availability and behaviour, availability of equipment and supplies, and improvements in the BHU infrastructure, including new boundary walls and separate toilets. These have influenced the acceptability of health services. There has also been an increase in the availability and accessibility of health services due to extended opening hours, as well as more ambulances and mobile health units due to government initiatives in Punjab. It is likely that the EVA-BHN CGs have increased the reach of these initiatives by providing information on the location of communities with the greatest need in hard-to-reach areas.

The district health authorities and BHUs have responded well to issues raised by CGs in Punjab over the last year. This is because newly formed health councils have enabled money to flow more efficiently and transparently to the BHU. It is likely that EVA-BHN played a role in pressuring government to set up the health councils. In KP, the BHUs and district health authorities have less capability to access financial flows and so issue resolution has been slower. However, district core committees (consisting of CG members) have been successful at influencing the KP provincial government, which is now in the process of re-invigorating an initiative similar to the health councils.

The programme has influenced the implementation of the 2012 Breastfeeding and Infant Child Feeding Act in Punjab and also developed a Patients’ Rights Charter in KP. The Charter outlines the service standards for public sector service providers – it has been adopted by KP’s Health Care Commission and will be mainstreamed throughout the province.

Community groups interviewed as part of this assessment report that more people are using the public sector BHUs, partly because CG members are providing information about the services to
the wider community and partly because the services have improved. The CG members appear to be influencing the behaviour of their peers and of diverse community members.

**EVA-BHN structures and support have improved the state–citizen relationship** by establishing multi-stakeholder spaces and engagement and increasing communities’ skills and confidence to engage. The approach is consistent with international good practice evidence. This has been achieved by quality assuring the formation of groups and their management, as well as by ensuring that all of the spaces include information sharing, dialogue, and negotiation. The assessment found examples where relationships and the spaces have become institutionalised, particularly at the district level where district officials are using the CG data and are in regular dialogue with CGs. It is early days, though, and the extension of the programme to all districts in Punjab and KP would support legitimacy and develop relationships with provincial governments further.

**Evidence of effectiveness**

The assessment found examples of improved capability, motivation, and opportunity for community members and government officials to engage in productive dialogue. EVA-BHN has developed both male and female CG members’ and coordinators’ capacity and confidence to identify issues and raise them with government health officials and at the BHU. Participation is based on the internal motivation of CGs, civil society, and government, rather than due to incentives. CGs have built trust and legitimacy with BHUs and district health officials, though not so much with the provincial governments.

**CGs and government health facilities have improved capability to engage with each other and to work together to resolve BHU issues, but systemic issues are less well understood and communicated.** The CG members interviewed spoke about having a better understanding of their rights as citizens and they demonstrated increased knowledge of the channels through which they can express their voice and demands. The CG coordinators interviewed – particularly those that attend the DAF meetings regularly – have learned about political processes through meeting government stakeholders. CG members – both men and women (to a lesser extent) are able to speak and represent the needs of their communities, and are equipped to collect data to understand community perspectives. There is some evidence that CG members are cascading knowledge to the wider group and the community, but the extent of this varies from district to district.

There is less evidence that CGs are engaging with issues of sexual and reproductive health, and this could mean there is limited capacity or social acceptability to discuss these issues and whether services and supplies at the BHU are deficient. Communities’ demands are also influenced by their beliefs and the social expectations around what constitutes a ‘good quality’ health service. CGs sometimes expect expensive equipment such as ultrasound machines at the BHU where there is not sufficient expertise or funding, or expect to receive high levels of medication that might be unnecessary. As seen in international evidence, unrealistic or costly demands can restrict government responsiveness and possibly also hamper the relationship between communities and government.
There is also little capacity in CGs to understand the health system – and the ways in which a community’s health needs relate to it – and the same is seen within DAFs and PAFs. Issues identified within the CGs had not been analysed to understand the root causes, or to relate to health systems issues that provincial governments and PAF participants would be more likely to discuss.

EVA-BHN has provided community members with the **opportunity** to identify and voice concerns within a safe, community-based context and to engage with BHU staff and **government health officials**. The safe space of the CG has been of particular benefit to women in KP, where the CGs are single sex, which has built women’s confidence to engage. In Punjab, there were numerous examples of how CGs have built trust and worked with medical officers (MOs) and BHU staff to resolve issues quickly and effectively. However, to a great extent this is also because MOs have recognised the value of CGs as channels of communication.

There is promising evidence that the CGs have engaged with other actors involved with health service delivery (e.g. non-governmental organisations (NGOs)) and helped them to work in ways that respond to community needs. The programme has also provided opportunities for religious leaders, media professionals, and journalists – who are not normally engaged with health issues – to come together and develop innovative strategies.

**Community members’ motivation** to engage in the CGs stems from a combination of factors, including moral responsibility and a desire to improve their village for this and future generations. CGs benefit from the influence of their members but participation also increases a community member’s status. The sense of momentum that has been created by the resolution of issues (particularly in Punjab) and recognition that the CGs can actually deliver changes and benefit people is another key motivating factor. The project has benefited from increased political will in both provinces within the ruling parties regarding health. In Punjab, there is a strong narrative about hearing from citizens. It is possible that the pressure from the CGs and DAFs may well be having a positive influence on this motivation.

The programme experienced some challenges with legitimacy and trust in the beginning. However there are various promising examples where EVA-BHN has helped to build the legitimacy of the CGs, and the CG has then developed trust with BHUs and district **governments**. The support that the CGs provide to the service providers and district government, in terms of community backing and information on community needs, is also key to enhancing their legitimacy. However, there are mixed views about the legitimacy of the EVA-BHN system at the provincial level, particularly in Punjab. While there is strong commitment to ideas of accountability and service user feedback and voice at the provincial level, stakeholders were critical of the programme’s limited scale and the limitations in the way the issues were presented in a non-policy-relevant way (mostly due to limited health systems strengthening (HSS) analysis). However, having said that it is clear that EVA-BHN has contributed to the development of new structures that have enabled responsiveness to be encouraged in a way that was not being done before.

**Coalitions, partnerships, and institutionalisation**

EVA-BHN has been successful at institutionalising the approach at community level and in beginning to build state–society relationships. However, the programme has not engaged sufficiently yet with civil society and HSS expertise in the country to enable good levels of sustainability. Engagement with politicians, political parties, and the development of the Health
Caucus in Punjab has been an important step for institutionalisation of the state–society relationship. However, there has been less focus on civil society. While a small number of CSOs are DAF members, there are no CSOs involved in the implementation of any EVA-BHN activities and nor is there any work to build coalitions of change within civil society beyond DAF meetings. This means that there is limited potential for the approach to be sustained or expanded beyond the life of the programme. Partnerships with universities, religious leaders, and the media have been successful in terms of institutionalising both health and health rights awareness raising and strengthening the role of the media in the accountability process.

Monitoring, evaluation, and learning (MEL)

Because the originally planned independent evaluation was not implemented, this programme lacks the strategic data collection that would have enabled measurement of outcomes and impact, and progress against the theory of change (ToC). The Management Information System (MIS) data is of excellent quality and is an important monitoring tool and input for the programme management, learning, and effectiveness. It is well integrated into CG and learning processes and is also used for reporting. A few limitations in the system regarding counting participants and issues (which shows that resolved issues are 15% fewer than reported) can easily be corrected; however, it is difficult to use the MIS data as the only evidence for change. Other qualitative research has not yet been fully used to measure change nor adapt the programme.

Conclusions and recommendations

This programme has produced an innovative and high-quality community voice and accountability system that is showing some signs of increasing accountability and government responsiveness. Programme MIS data is reasonably accurate and can be improved with minor adjustments. Programme research and MIS data has been used in this assessment to triangulate with and complement primary qualitative data. However, at a policy level the programme has not adequately analysed and addressed the serious health systems issues, not least health financing, human resource management, and access to medicines and supplies. There is evidence that this could be limiting government engagement. The programme was designed to be separate from the other technical assistance components funded by DFID (i.e. the Technical Resource Facility (TRF) and Health Roadmap) and this has limited the connection between supply-side and demand-side work in terms of HSS, health awareness, and enhancement of health-seeking behaviour.

1. Expectations of health services and quality of care: Social norms and users’ expectations of services and perceptions of the quality of care are defining the type of service that is demanded, and this is not always in the best interests of the health system or people’s health.

Recommendation 1: Ensure that the EVA-BHN approach considers and influences community health-seeking social norms, knowledge of the health system, and quality of care to ensure demands and accountability support a good quality, value-for-money health service. In the short term, pilot work is needed to build capacity within CGs and DAFs to better understand HSS, and to understand and address social expectations about quality of care in the health facilities.
2. **Systemic vs. symptomatic issues:** Many of the local issues resolved are symptoms of wider health system and systemic problems, which are not necessarily addressed. This may be because of lack of HSS knowledge and capacity within the EVA-BHN team and CG/DAF structure.

**Recommendation 2:** Develop the accountability system, and work with partners (including TRF), so that it includes stages to analyse systemic and health system issues beyond the symptoms so that district- and province-level demands are appropriate and so that government has useful information to act on. In the short term, this could include work on a sample of issues to understand their root causes. In the long term, a new programme would need to include responsibility for both supply- and demand-side activities.

3. **Strategic-level support and networks:** There is limited technical input coming from outside the EVA-BHN programme for strategic analysis and planning and this limits the diversity of inputs and the legitimacy of the programme. Although CSOs and other sources of technical expertise attend DAF meetings they do not have a specific role in the programme and nor is there sufficient HSS input.

**Recommendation 3:** Form a strategic Technical Advisory Group (or Steering Committee) of external national and international experts for regular input and feedback, and for building legitimacy.

4. **Working with civil society and other programmes:** EVABHN appears to conduct training of CGs and DAFs directly and has conducted direct advocacy with the provincial governments and assemblies, rather than enabling others, such as CSOs, to do this work. There is also insufficient engagement with and promotion of responsiveness through the DFID-supported TRF and Health Roadmap. This means that EVA-BHN has not yet drawn sufficiently on the significant expertise and experience in Pakistan, nor has it built the sustainable capacity needed to continue the work of EVA-BHN far into the future.

**Recommendation 4:** Work with national organisations and partners (including government) to deliver parts of the programme, such as training of CGs, analysing health systems and root causes, province-level advocacy, and building government capability and commitment for responding.

5. **Gender equality and social inclusion:** This is an important part of the programme and positive steps have been taken to address inequalities and ensure inclusion. However, the approach is not transformational, has had limited impact on power relations to date, and is not systematic or sufficiently embedded.

**Recommendation 5:** Improve the mainstreaming of gender equality, social inclusion, and conflict prevention analysis throughout the programme.

6. **MEL:** Because the planned independent evaluation was not implemented this programme lacks the strategic data collection that would have enabled measurement of outcomes and impact, and progress against the ToC. The MIS data is of excellent quality and is an important monitoring tool and input for programme effectiveness, but some adjustments are needed to account for recurring issues and duplicates of resolved issues in the CG and DAF datasets.

**Recommendations 6:** Design research and data collection so that it can be used more strategically for programme learning and adaption. Improve MIS inputs and processes to ensure data quality – for example, ensure duplication of data between the DAF-resolved issues and the CG-resolved
issues is eliminated so that a more accurate count of resolved issues can be achieved. Adapt the MIS so that it has the capacity to better report recurring issues that might indicate a wider systemic issue. The programme should collect qualitative data to complement the MIS and provide a more nuanced understanding of the issues being raised and how they are resolved for reporting to and discussing with government and other stakeholders.
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
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<td>BHU</td>
<td>Basic Health Unit</td>
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<td>CBM</td>
<td>Community-based monitoring</td>
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<td>CCPP</td>
<td>Centre for Communications Programmes Pakistan (EVA consortium member)</td>
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<td>CG</td>
<td>Community Group</td>
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<td>CSO</td>
<td>Civil society organisation</td>
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<td>DAF</td>
<td>District Advocacy Forum</td>
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<td>DCO</td>
<td>District Coordination Officer</td>
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<td>DCC</td>
<td>District Core Committee</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHO</td>
<td>District Health Officer</td>
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<td>DHQ</td>
<td>District Headquarter Hospital</td>
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<td>EDO</td>
<td>Executive District Officer</td>
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<td>EHSP</td>
<td>Essential Health Services Package</td>
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<td>EVA-BHN</td>
<td>Empowerment, Voice and Accountability for Better Health and Nutrition</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>GRM</td>
<td>Grievance Redressal Mechanism</td>
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<td>HANIF</td>
<td>Health and Nutrition Innovation Fund</td>
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<td>HRH</td>
<td>Human resources for health</td>
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<td>HSRU</td>
<td>Health Sector Reform Unit</td>
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<td>HSS</td>
<td>Health system strengthening</td>
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<td>IMU</td>
<td>Independent Monitoring Unit</td>
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<td>KAP</td>
<td>Knowledge, attitudes and practices</td>
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<tr>
<td>LHW</td>
<td>Lady Health Worker</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MEL</td>
<td>Monitoring, Evaluation, and Learning</td>
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<td>MNCH</td>
<td>Maternal, newborn, and child health</td>
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<td>MIS</td>
<td>Management information system</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>MO</td>
<td>Medical officer</td>
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<td>MPA</td>
<td>Member of Provincial Assembly</td>
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<td>PAF</td>
<td>Provincial Advocacy Forum</td>
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<td>PHNP</td>
<td>Province Health and Nutrition Programme</td>
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<td>PCMC</td>
<td>Primary care management committees</td>
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<td>RCA</td>
<td>Reality Check Approach</td>
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<td>RMNCH</td>
<td>Reproductive, maternal, newborn, and child health</td>
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<td>RME</td>
<td>Research, Monitoring and Evaluation</td>
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<tr>
<td>RTI</td>
<td>Right to information</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<tr>
<td>THQ</td>
<td>Tehsil Headquarter Hospital</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<td>TRF</td>
<td>Technical Resource Facility</td>
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<td>UC</td>
<td>Union Council</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WMO</td>
<td>Woman medical officer</td>
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1 Introduction

1.1 Assessment purpose

The most immediate aim of this assessment is to provide an external and critical view of the Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN) programme, and to articulate learning that the programme team can use to enhance the effectiveness of the programme over the remaining 16 months of implementation and that DFID can use for future programming. One of the recommendations from the Province Health and Nutrition Programme (PHNP) Annual Review in March 2017 was to commission an independent assessment of EVA-BHN’s interventions to measure whether these are plausibly increasing state responsiveness.

The objectives of this assessment are:

- Verification of the quality and validity of the data that is generated by EVA-BHN; and
- Synthesis of any evidence of programme effectiveness and results.

Learning from this assessment will be used for:

- Improving programme effectiveness over the remaining 16 months;
- Informing the design of potential future DFID health programmes in Pakistan; and
- Communicating with stakeholders.

1.2 Assessment questions

During a short inception period and the desk review of programme documentation and international evidence the assessment questions were adapted from the original DFID Pakistan Terms of Reference (see Annex A).

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<thead>
<tr>
<th>Assessment questions</th>
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<tr>
<td>Q1. What evidence is there, if any, of the programme’s contribution toward bringing changes in state responsiveness that are leading to improvements in health service delivery in its intervention districts, including changes in policies and practices of the health department and attitudes of health officials?</td>
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<td>Q2. What is the evidence of increase in citizens’ capacity to voice dissatisfaction and demand change in the way primary healthcare services are delivered?</td>
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<td>Q3. To the extent possible, provide any details of changes in health-seeking behaviour of the population in target districts (including utilisation of health services, increase and application of health knowledge).</td>
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<td>Q4. What is the quality and credibility of the data EVA-BHN collects to measure and record change as a result of its interventions?</td>
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<td>Q5. What evidence is there of additionality achieved through EVA-BHN interventions at district and provincial levels, and what changes have occurred that would not have occurred without EVA-BHN?</td>
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<td>Q6. Is there any evidence of the effectiveness of periodic interactions between citizens and public officials through EVA-BHN supported forums such as district and provincial advocacy forums?</td>
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<td>Q7. What evidence is there of spill-over effects of empowering citizens such as work on education, women’s empowerment and elections (with a focus on gender equality and social inclusion)?</td>
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<td>Q8. How are partnerships with stakeholders (e.g. media, elected representatives, religious leaders, non-traditional civil society, healthcare commissions, right to information (RTI), etc.) used for amplifying citizens’ voice?</td>
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<tr>
<td>Q9. What evidence is there of institutionalisation of EVA-BHN’s work, e.g. journalist training, Entertainment Education curriculum, Patient’s Right Charter, Health Caucus?</td>
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1.3 Methodology

(i) The literature review comprised:

- A review of programme documentation and data, including research studies, the Theory of Change (ToC), Management Information System (MIS), critical reviews, and monitoring and evaluation (M&E) plans; and
- A rapid review of international and Pakistan-specific evidence on good practice in empowerment, voice, and accountability programming. This evidence was used to inform the development of tools and the analysis framework. It also informed the analysis of data and consideration of the ToC.

(ii) Data quality checking of the MIS included a paper- and system-based check as well as a qualitative background check of a sample of data in the field. A sample of issues was selected in the four visited communities as part of the assessment. This was analysed before the visits and discussed with the EVA team, and then with community groups (CGs) and health facility staff. This provided verification of the issues and the stories behind them.

(iii) Interviews were conducted with 55 key informants in Punjab and Khyber Pukhtunkhwa (KP). These included religious leaders, media partners, journalists, WHO and UNFPA representatives, and government officials at the province and district level. Group discussions were also conducted with three District Advocacy Forums (DAFs).

(iv) Field visits were conducted with four communities and the relevant district health authorities. Eight focus group discussions (FGDs) were conducted as part of these – four with women and four with men. The assessment team visited a health facility in each of the communities, interviewed health staff, and conducted observations of some of the changes that were recorded as resolved issues.

(v) An analysis framework based on the programme ToC and the international evidence of good practice was used to organise notes and analyse. Annex B provides a copy of the framework.

1.4 Limitations

(i) One of the main limitations of this assessment is that there is no evaluation planned and so the data does not support a rigorous answer to some of the assessment questions (see Section 4 for full discussion on programme data and research). Given its limited timeframe and budget, this assessment cannot take the place of an evaluation. DFID is aware that most of the qualitative evidence collected during the assessment would be of limited rigour in terms of representativeness but will give some useful anecdotal and circumstantial evidence in combination with EVA-BHN's programme monitoring data and other research.

(ii) Two of the interviewees are ex EVA-BHN employees. Although they have a useful perspective as they know the programme well, this internal knowledge may have influenced their opinion. However, both interviewees made important points related to the health system that should be considered.

(iii) One consultant in the assessment team is a senior government employee, and this may have influenced how people responded.

(iv) There were some restrictions in regard to the choice of communities that were visited. This was influenced by geography and proximity to Lahore in Punjab, security in KP, and the selection of the
EVA team overall. It was not possible to meet to communities in non-programme districts due to time limitations.
2 Programme description and reflection

The EVA-BHN programme is an £18.86 million health voice and accountability programme working at the community, district, and province level in Punjab and KP since February 2014. It is part of DFID’s PHNP which supports delivery of an Essential Health Services Package (EHSP) by the governments of Punjab and KP. The overall budget for the programme is £118.5 million earmarked non-budget support financial aid, with £80 million allocated for Punjab and up to £38.5 million for KP. EVA-BHN and its sister programme – the Technical Cooperation Facility and Health Roadmap (collectively referred to as TRF+) (budget £18.25 million over five years) – are supposed to provide complementary technical assistance for supporting the supply- and demand-side of the health system. TRF+ should be supporting health system strengthening in the provinces, which originally envisaged strengthening the responsiveness of government to EVA-BHN generated citizen demands and the identified gaps in health service delivery. However, because of the programme design and the lack of enforcement, there is no co-implementation and very limited coordination between TRF+ and EVA.

Context: There are various differences in the political and health system governance of Punjab and KP that have implications for the EVA-BHN’s work. Key amongst these is that district governments are elected in KP but appointed in Punjab. Health councils – attached to each Basic Health Unit (BHU) – have been set up in Punjab in the last 12 months, and this has enabled financial flows for basic infrastructure and equipment to reach BHUs. The Punjab government has recently set up a monitoring system for checking the quality of services in BHUs and Tehsil and District Headquarter Hospitals (THQs and DHQs). Data collection is undertaken by a M&E assistant (MEA), who uses a facility checklist, and a set of exit interviews to collect data on health facility performance. Most recently, a mobile phone and SMS based complaints and feedback system has been set up.

In KP, 10% of district budgets must be spent on health. Any shortfall can be funded through the discretionary budget, and so district health officials are expected to lobby local politicians for greater allocation of funds. This effects how much funding reaches the BHU level in communities. Our fieldwork found that district officials in the two KP districts had virtually no budget beyond human resources budget lines for the BHUs. The KP government had set up Primary Care Management Committees (PCMCs) at the BHU level in order to facilitate budget implementation at this level, but these ceased to operate as they were project funded and the project came to an end. Political competition and challenges between the federal ruling party and the KP ruling party also results in disruption of financial flows.

Community engagement and voice: The programme has set up a structure of CGs, DAFs, and Provincial Advocacy Forums (PAFs) for providing platforms and facilitating engagement between communities, civil society, and government. There are 386 CGs: 148 in five districts in Punjab and 240 in four districts in KP. Groups typically have between 20 and 25 core participants who attend regular CG meetings, plus additional casual attenders. According to the recent socioeconomic survey, 1 64% of CG participants are ‘poor and marginalised’. The groups also include more influential (and less poor) community participants who can mobilise resources and networks to get things done. Health facility staff and management can also attend CG meetings and in some communities there is a close coordination and communication between CG and the health facility.

CGs were built on existing participation and community engagement in some communities and built new structures in other communities where there had not been previous suitable participation. CGs are run by volunteer CG coordinators, chosen by the groups – usually two coordinators (a

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1 See Section 4 for an assessment of the quality of this survey
man and a woman) for each group in Punjab, where there are mixed sex groups, or an appropriate gender coordinator in each of the single sex groups in KP. The programme budget provides training, refreshments for meetings, and support for data collection and presentation, but no funds or stipends are given to coordinators or CG members. The CG coordinators have been trained by the EVA-BHN programme team in health rights and accountability, holding effective meetings, and interpersonal skills. The coordinators meet every month at the district level for a ‘check-in meeting’ with the EVA team to log their data, receive refresher training, and to share experiences and learning.

Some CGs have their own Facebook pages and are engaging in direct fundraising through this platform and through personal contacts. They also access further training – for example, one CG requested first aid training from the emergency services and now the coordinators are representatives for first aid.

**District Advocacy Forums:** A selection of five to six CG coordinators are selected to represent community demands at the DAF, where government, civil society, the media, and religious leaders meet to discuss the issues that have been raised by the communities and to input their own suggestions. CG coordinators and members have also used the DAF to conduct direct advocacy to district government or to sub-contracted health service providers. The DAF is provided with training and technical support in the form of an advocacy toolkit, power change analysis, and, in one case (Layyah), district budget analysis. In Peshawar, the CG coordinators have set up District Core Committees (DCCs) among themselves because the CGs felt that once commitments were being made in DAFs there needed to be a mechanism to follow up in districts. The DCC can also be used to have more in-depth discussion, joint learning and analysis, and to establish a more sustainable structure for engaging at district level.

**Provincial Advocacy Forums:** The quarterly DAF meetings feed into bi-annual PAF meetings, which include province-level government participants as well as media, civil society, and multilateral and bilateral donors. CGs can invite people to the DAFs and the PAFs and have invited elected officials on occasion. In Punjab, the provincial government prefers to engage with community members outside of the PAF in their own offices (see Section 3.1.3 for more information about PAF attendance).

**Community based monitoring (CBM) and Grievance Redress Mechanism (GRM):** CGs are trained to collect feedback from the community that they represent and also conduct CBM of the health facility with the approval of the district government. CBM consists of a facility observation checklist and six exit interviews per health facility – conducted by the male CG coordinator and the female CG coordinator respectively. Issues raised at the CGs and from the CBM are shared with the Medical Officer (MO) (who is also the BHU manager) and discussed. The MO can also add issues that s/he needs support in requesting from the health system. Also, CGs are provided with GRM training to promote the channels for reporting.

**Health information promotion:** While the EVA programme has been set up as a voice and accountability programme, and the focus has not been on influencing health knowledge or health-seeking behaviour, DFID has picked up that there is a need for CGs to become engaged in wider behaviour change around health issues, partly because this does not appear to be functioning well within the health system. The role of providing health information and mobilisation rests with the Lady Health Worker (LHW) programme, which has a lot of documented success in improving

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2 LHWs are community-based women who are employed within the health system and provided with around three months of basic training to be able to provide health information and some basic services such as short-term family planning methods. They provide door-to-door services and run community information meetings. There are complaints that LHWs’ time is often taken up by health campaigns (such as the polio eradication campaign) and that donor programmes are often using their time for other vertical programmes rather than for the job they have been trained for.
health access in Pakistan. The LHW programme has only about 50% coverage in KP but high coverage in Punjab. The KP government, however, plans to increase LHW coverage and effectiveness

**Social inclusion:** EVA-BHN is working with the Punjab Chief Minister’s Initiative (on cash transfers) to pilot an approach that will enhance the reach and inclusiveness of health services. This involves referral by peer women (lead mothers) to give information to the most excluded who are receiving cash transfers. The project was set up based on an in-depth analysis of the social and gender issues related to health services utilisation, and the potential for supporting and influencing the most excluded.

**Media and mass communications:** EVA’s focus for mass communications is through TV, print, and electronic media. EVA has trained journalists on health rights and developed a network of 160 journalists, which appears to have resulted in an increase in RMNCH stories in the press. The programme has recently provided training to women and minority journalists and also for activist journalists who are part of DAFs. Included in this training is mentorship and peer-to-peer training. They have also completed a refresher training and created a WhatsApp group as well as establishing the ‘Excellence in Journalism’ award for health reporting.

EVA-BHN has supported the development and production (funding 25% of the production costs) of a very successful drama serial, Sammi, with social and health messaging by running a competition for ideas and concepts and funding two leading quality dramas. Sammi was a huge hit as it was produced by an already successful producer and had top stars in the film. It portrayed issues of ‘vani’ – where girls are given in marriage as compensation for a crime – and how son preference leads many women go through repeated pregnancies. The success has been instrumental in changing the attitudes of the TV stations to education entertainment and its commercial value. However, it is useful to note that Hum TV, a popular entertainment channel that aired it in primetime, was already showing dramas with social messaging.

The EVA programme team discounted radio early in the programme as data shows that there are few users of radio in Pakistan. However, data shows that that around 20% to 30% of people are listening to radio and they are usually those with the lowest income or in remote communities. It would therefore be worth re-visiting this decision about radio.3

**Education entertainment:** EVA has aimed to institutionalise social messaging within entertainment by designing and supporting the introduction of an Education Entertainment Degree course at eight universities.4 The aim is to train tomorrow’s media producers and creatives to include progressive and social messaging in their media products. While the selection of Fatima Jinnah University – with its focus on social and feminist thinking and messaging – is promising, the actual activities, and their effect, do not appear to be particularly related to the rest of the programme.

**Religious leaders’ structures:** The Centre for Communications Programmes Pakistan (CCPP), an EVA consortium member organisation, started work with religious leaders in 2007 with support from the (USAID)-funded Pakistan Initiative for Mothers and Newborns (PAIMAN) programme, which finished in 2011. CCPP have continued this work using the same network of 2,000 religious leaders and working in additional districts. They have engaged with 500 of these ulema on EVA-BHN through the Central Council and through the DAFs and PAFs. EVA-BHN has trained

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3 www.brandsynario.com/radio-industry-in-pakistan-infographics/
4 Fatimah Jinnah Women University, Rawalpindi; Riphah, Rawalpindi; IORA, Islamabad campus; SZABIST, Islamabad campus; SZABIST, Karachi campus; Habib University, Karachi; Kinnaird College for Women, Lahore; Beaconhouse National University, Lahore.
members of the Central Council and they have jointly produced a booklet and toolkit (with posters for display in the mosque) for other religious leaders to conduct sermons on maternal, newborn, and child health (MNCH) messaging. The Central Council include members from all Islamic schools of thought, and it appears that some of them were already on a Peace Council together before EVA-BHN started working with them. For the programme, the Central Council undertook a mapping of the numbers of people in each religious leader’s constituency in order to understand their reach. Each religious leader has conducted two sermons with the EVA developed messaging, on health-seeking behaviour and health rights.

The table below summarises progress for EVA logframe indicators and data quality comments.

### Table 1: EVA Logframe Indicators and Progress

<table>
<thead>
<tr>
<th>Output indicators</th>
<th>Progress 31 Jan 2017 report</th>
<th>Data quality comments</th>
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</table>
| 2.1 Number of citizens reached with messages on health rights/entitlements and healthy behaviours (disaggregated by administrative unit of platforms that include: EVA forums, print media, and electronic media) | Target: 1.1 million Actual: 2.2 million (162,545 EVA forums and 2,046,000 electronic media)                                                                                                                                  | Meeting participants up to Sept 2017  
|                                                                                 | | KP CG participants 21,917  
Punjab CG participants 17,492  
Punjab DAF participants 1,060  
KP DAF participants 693  
Total participants 41,162  
This is the number of CG and DAF participants from EVA’s data. The other EVA forum number is the religious leaders’ forum, which is estimated using the average congregation size established at the mapping stage of the project (151,037 men estimated as at 2017). The Ulemas interviewed in the assessment were not able to say how many people they were reaching. There are issues about the TV ratings and the number that has been reached by Sammi as the ratings system is far from accurate. Both the religious leaders and the media messages were more focused on health awareness and health-seeking behaviour than on accountability, although there were messages about rights and responsibility and women’s rights. |
| 2.2 Number of citizen-led demands raised or submitted to policy makers and health officials each year in DAFs (disaggregated by status, i.e. Dropped, Resolved or in process) | Target: 678 Actual: 1,439 (87 Dropped, 477 Resolved, and 875 in Process)                                                                                                                                                      | A total of 5,298 issues have been raised since the beginning of the programme up to Sep 2017. There is a discrepancy between data provided on resolved issues in the last quarterly report and that received in the EVA spreadsheets (see Section 4 for details). |
| 2.4 % increase in reporting of health and nutrition issues in print and television (disaggregated by language, region, and media) | Target: 30% above baseline Actual: 145% increase over the baseline (235 stories) Urdu 131 stories, English 104 stories, TV 36 stories, newspaper 199 stories, national 92 stories, Punjab 118 stories, KP 25 stories | Methodology for counting is good quality and the figures are reliable, although the assessment was not able to verify these directly.  
2017

![Graph of MNCH and Nutrition News Coverage](chart.png)
3 Findings

This section is structured to demonstrate changes that relate to the EVA-BHN ToC with respect to how the development of capability, opportunity, and motivation contribute to behaviour change. The first section (3.1) reports on behaviour change, the outcome-level change in the EVA-BHN ToC. The next three sections report on the extent to which the programme has been successful in developing capability, opportunity, and motivation (effectiveness). Findings have been analysed in light of the international literature review and good practice examples.

3.1 Evidence of outcomes (Q1, Q3)

There is some evidence of behaviour change resulting in improved health facility and service quality at BHUs, some policy change and improved financial flows to BHUs in Punjab, and some evidence of increased utilisation of health services. Citizen–state relationships are developing and there are clear examples of effective state responsiveness.

3.1.1 Health financing and policy gains

Finance reaching BHUs. The project has benefited from an increase in political will within both province’s ruling parties regarding health. In Punjab this has resulted in the release of funds to the BHU – through Health Councils – which provide for renovations and repairs to the facility. EVA-BHN has most likely played a part in influencing government to establish the health councils. EVA-BHN’s issues log, as well as the interviews with CG members, reflect that many pending or unresolved issues were resolved once funding for the Health Councils became available a year ago.

This funding in Punjab probably accounts for the large difference in the issue resolution rate between Punjab and KP, where such funding does not exist. Government stakeholders identified a critical lack of funding as the main barrier to their ability to respond to CG demands in KP. The DCCs in KP have advocated to the provincial government for the reinvigoration of PCMCs, a BHU-level community participation mechanism initially established by the now-completed AusAid-funded Community Engagement for Social Service Delivery (CESSD) project. The proposal has been accepted by the provincial government, which has notified all District Health Officers (DHOs) that, pending the development of their Terms of Reference, these should be implemented across all the districts. In those districts where EVA is active, the PCMC is envisaged as including the CG coordinator as chair, the MO and one elected member, reporting to the Nazim, and would also have a budget. This is a notable achievement for EVA’s influencing work, and will prove a strong positive outcome if it comes to fruition.

Implementation of legislation. Prompted by issues raised by the CGs, the members of the Provincial Assembly (MPAs) in the Punjab PAF have been active in pushing for the implementation of the 2012 Breastfeeding and Infant Child Feeding Act 2012, which has been dormant since it was passed in 2014, pending notification of its rules. Earlier this year, a meeting of the Punjab Health Caucus facilitated by EVA included the Act as a key item on its agenda, and the Caucus members agreed to bring attention to it in different policy fora and to support steps to implement it in their constituencies. Following the meeting, one of the MPAs raised the issue in the Provincial Assembly and tabled four questions about its implementation that EVA had prepared for her.

Patients’ Rights Charter. Prompted by the large proportion of issues raised by the CGs relating to staff behaviour, and the lack of any policy instrument for addressing these in KP, EVA developed a Patients’ Rights Charter and identified and undertook direct advocacy with the KP Healthcare Commission as the key actor that could exercise the required regulatory oversight. The Charter...
outlines the standards for service public sector service providers and has been adopted by KP’s Health Care Commission, to be mainstreamed throughout the province.

3.1.2 Improved health services

Improving the coverage and utilisation of RMNCH services – which is the outcome of the overall PHNP programme – entails addressing the various dimensions of access to quality health services, i.e. geographic accessibility, availability, affordability, and acceptability. This encompasses barriers that stem from both the supply and demand side. This section looks at the evidence on the extent to which EVA has engaged with these issues, and any changes that have been achieved.

Accessibility

Number of facilities/access points. As the review team was unable to visit the more remote communities that EVA works in, and only met with CG members (and not the wider community), it is unsurprising that none of the respondents indicated they had to travel far – i.e. more than half an hour – to reach a BHU. For them distance was not the key barrier: the main issue was that the facilities that were within reach were often in disrepair, under-staffed, and not providing quality services. As such, the emphasis of CGs’ demands – and the focus of the issues resolved – so far has been to improve the infrastructure of the BHUs, for example by raising boundary walls, creating/refurbishing waiting rooms, building toilets, installing solar panels, etc.

The referral system. It is likely that referrals between the BHU and hospitals are common. Part of a good referral system is certainly the availability of transport, which has been the only focus of referral-related issues raised by the CGs. The lack of access to ambulances has been raised frequently in Punjab – 110 times – but only three times in KP. In Punjab many of the issues were resolved through the roll-out of the Health Department’s Chief Minister’s Ambulance Service, but in a small number of cases ambulances were provided in response to a CG’s demands. In KP, none of the issues were resolved.

There is, however, little evidence of efforts to help communities with the referral system more broadly, i.e. briefing people on how to navigate the hospital, referral forms and systems; ensuring documentation is complete; or developing community responses for a lack of transport, or for people’s inability to pay the costs of higher levels of healthcare. There is evidence that mobility constraints and a lack of community understanding about the organisation of the health system are driving the demand for highly equipped BHUs (the risks of this are discussed more fully in Section 3.2.1). Better referral systems and transport would avoid the need for communities demanding highly equipped BHUs.

Availability

Number of providers. CGs have logged numerous issues around missing or absent providers – around 280 in Punjab, of which 171 were resolved, and 323 in KP, of which only 94 were resolved. This issue arose and was resolved in two of the communities visited – the Punjab CG had specifically requested a female doctor, and one was duly appointed. The CG in KP had also requested a Woman Medical Officer (WMO), but their BHU had been without a doctor for over three months at the time of the our visit. The KP CG had raised the issue on various occasions and the post had been filled, but in each case the various doctors did not stay in post and left for different reasons. This example illustrates the significant challenges to ensuring adequate human resources, particularly in rural areas. It is important to note that the KP government, likely in response to the Health Roadmap, has made a huge investment commitment to fully staff the BHUs in the province, and is currently in the process of recruiting 3,500 new healthcare workers. EVA-
BHN may need to play a role in ensuring the new healthcare workers reach the communities most in need.

**BHU opening hours.** In Punjab, the review team visited BHUs that were a mix of those selected by the provincial government to open 24 hours as part of their ‘BHU Plus’ model, and those that still close at 2pm. The CG representatives we met whose BHUs offer round-the-clock services were obviously more satisfied than those whose clinics close earlier. There have been issues raised about this, particularly from those districts where the ‘BHU Plus’ model has not been extended. EVA’s reporting shows that this was raised in the May 2017 Punjab PAF as a particular issue in Bhakkar, and the Integrated Reproductove, Newborn and Child Health (IRMNCH) programme (provincial government) representative agreed that it would be extended there.

**Waiting times.** None of the CG members interviewed mentioned waiting times as a key issue, and nor were large numbers of clients waiting visible during our visits to the BHUs. No issues relating to waiting times have been raised, but there are numerous issues relating to the doctor or the Lady Health Visitor (LHV) not being punctual, which may be another way of articulating this. However, given that most women are accompanied when they visit the BHU (either by children, other women companions or male family members), a related infrastructure issue that has featured regularly is the need to build or refurbish waiting areas.

**Availability of medicines.** The lack of medicines, likely due to delays in procurement, features prominently in the issue logs and the CBM for both Punjab and KP. In three out of the four communities we visited these issues had not yet been resolved. Two of the CGs had raised this more than 18 times with no resolution, indicating the systemic nature of the issue (see Section 3.2 for more on this). Overall, CGs in Punjab raised the issue of medicines 249 times, of which 49% were resolved. In KP, the issue was raised 180 times but only 27% of those were resolved.

There seemed to be a sense among the CGs that the situation with medicines had improved recently. However, BHU staff indicated that they start to run out of stock nearer the end of the quarter when the next allocation is due. One of the facilities in KP explained that they ration their medicines by only providing them to patients who present before 11.30am. Many CG members confirmed that the lack of medicines at their BHU prompts community members to seek out other service providers.

**Availability of equipment.** There are various examples of issues about the lack of blood pressure and weighing machines being logged and resolved, demonstrating that the CGs have contributed to an improvement in the availability of essential equipment. There have also been a number of demands for ultrasound machines, so that pregnant women do not have to travel far to get scans - an important issue in a context where women lack independent mobility. In two communities in Punjab the CGs have mobilised philanthropic resources to buy and install ultrasounds in the BHUs. In addition, two MPAs – key members of the DAF and PAF – allocated a portion of their development funds to the installation of ultrasound machines in 19 BHUs across their two districts.

However, there are important questions about whether such equipment is appropriate for the primary healthcare level where there is a dearth of trained staff. One expert interviewee pointed out that even trained staff can find it challenging to interpret ultrasound images, and this could lead to misdiagnosis. Ideally ultrasounds should be administered by sonologists who are appropriately trained and can also service and re-calibrate the machines effectively. There is also a risk that easier access to ultrasound machines, without accompanying policies and well-trained health providers, may lead to an increase in sex-selective abortions. This risk has not been considered by the programme and none of the interviewees were aware of or understood this issue. The doctors from the BHUs visited also reported that patients who are not pregnant often demand that they be given an ultrasound as they believe ‘seeing inside of them will help the doctor to treat them better’.
Information about services. There was good evidence that interviewed CG members – who often come from different neighbourhoods in the community – have been raising awareness about the improvements that the CGs are bringing about in the BHUs and encouraging the wider community to use the BHU rather than quacks or private providers. There were examples of CG members from minority groups – for example, Christians and widows – taking these messages to churches, and communal meeting places for poor groups.

An important complement to the awareness work being done by the CGs would be to strengthen the health system’s own outreach work. However, beyond including LHWs in the CGs, there was little evidence that the CGs are engaging with them as a way of directing people to the BHUs and explaining what kinds of services they should expect there.

Utilisation of services. The CGs’ work to raise awareness has likely contributed to some of the BHUs receiving more patients. The doctor at one of the BHUs exceeding its targets for deliveries thinks more women come because the CGs are telling people about improved BHU services (and also because of the ultrasound machine). Influential CG members interviewed have also started using the BHU services instead of private providers. This signals to the wider community that services of a certain quality are available at the BHU. One of the CG members in Punjab said he believed their work had put some of the village quacks out of business. He was careful to say not all.

It is likely, however, that some of the worst health indicators are occurring among the population that has the least access to quality health services. EVA does not have data showing which communities are not able to access and utilise health services due to demand- and supply-side barriers (this was not included in the socioeconomic surveys). Nor is the programme able to monitor yet who they are not reaching with the CGs, and thus the programme’s accountability structure.

Affordability

Direct financial barriers. All the CG members interviewed felt strongly that, since the programme started, they and members of the wider community are using BHU services more and paying much less money than they were paying private providers (although note that no data has been collected on this). The CG members interviewed were highly aware that quality BHUs are particularly important for poorer groups, and many of them spoke about how these groups were having to pay for private services previously, and they can now get quality services for free and ‘save that money for their grandchildren’.

Indirect financial barriers. Many of the male and female CG members interviewed stated that, with the improvement in BHU services since EVA-BHN began, they had opted to have their babies delivered at the BHU, whereas before they used to have to travel to a private provider and incur travel expenses between PKR 12,000 and 14,000 if they travelled to the city. This is obviously easier in those communities in Punjab where the provincial government has designated the BHU as a ‘BHU Plus’ facility providing round-the-clock services. But those women who go into labour after hours in areas where the BHU closes in the afternoon must still incur those expenses. As mentioned earlier, CGs in those EVA-BHN districts where the BHU Plus initiative has not been extended have raised this at the PAF level.

Acceptability

Staff behaviour and patient–provider interactions. The behaviour of service providers has been raised as an issue by numerous CGs. In most cases this has related to the interpersonal skills of providers or of providers referring patients to their private clinics. This issue featured in two of the
communities visited by the review team – one was successfully resolved while the other still has not been. In one BHU, the LHV in question was reprimanded by both the doctor and the DHO. In the KP BHU, the LHV in question has been able to mobilise high-level political contacts to have three transfer orders revoked, and despite complaints from CG members and other staff in the BHU remains in post. Both examples reflect the challenges of this issue.

The CG members interviewed were less able to talk about the quality of the interactions between patients and providers. This includes, for example, the extent to which patients are supported by providers to explain their symptoms accurately, and are provided appropriate and timely treatment and/or referral – issues that are critical to the provision of quality care. While the exit interview includes a question on whether the health provider listened to the patient carefully, it is unlikely that a lay CG member would be able to elicit this kind of more nuanced information. However, there are some examples of where CG monitoring is picking up some aspects. In Punjab, for example, the following issues were logged:

<table>
<thead>
<tr>
<th>Table 2: Issues raised in Punjab relating to quality of care</th>
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<tbody>
<tr>
<td>Issue</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>No proper check-up of children and pregnant women (height and weight)</td>
</tr>
<tr>
<td>No proper check-up</td>
</tr>
<tr>
<td>Doctors do not check properly</td>
</tr>
<tr>
<td>No proper antenatal care</td>
</tr>
<tr>
<td>No proper check-up of children under 2</td>
</tr>
<tr>
<td>WMO did not check male patients</td>
</tr>
<tr>
<td>Clients not satisfied with the answers of MO during routine check-up</td>
</tr>
<tr>
<td>BHU staff did not listen to and care for patients properly</td>
</tr>
</tbody>
</table>

Such issues are best understood through observation monitoring, and as this would be beyond the skill set of a CG member (and unethical) EVA has correctly not included it as part of the CBM process. However, EVA could explore how the CGs can support or monitor the quality assurance or supportive supervision measures that already exist within the health system.

**Respecting community and cultural preferences.** There are various examples of CGs identifying and addressing issues that relate to making BHUs most culturally acceptable. These include raising boundary walls for greater privacy for women, building or renovating separate toilets for male and women accompaniers, refurbishing the labour room, and providing privacy through building breastfeeding corners.

3.1.3 **Productive engagement between citizens and duty-bearers**

**Multi-stakeholder spaces and engagement.** The project has established various spaces through which people with different levels of power can interact with each other, and communities, the media, local government, and the EVA-BHN team themselves can engage in monitoring and advocacy. This is in line with Guillán, Fox & Aceron’s (2016) approach to coordinated civil society action across scale – which is conceived as a partnership between: (a) broad civil society membership organisations monitoring service delivery at local level (the CGs and DAFs); (b) professional CSOs that specialise in policy/ budget monitoring – who pursue advocacy at higher levels – in this case the EVA team; and (c) independent media to disseminate the findings and publicise the citizen action.
It is clear that EVA has made some efforts to understand how power works within an accountability context, and to address some of the challenges inherent in building relationships between unequal partners. One of the key strategies of the programme has been to ensure that all the spaces include information sharing, dialogue, and negotiation. Each of the spaces features the provision of information and data about citizen perspectives, which ensures that all the stakeholders are on the same page. EVA-BHN’s efforts to include excluded groups in the CG meetings, and to include CG coordinators up to the PAF level, means that a relatively wider range of actors can engage in dialogue. Ensuring that the spaces accommodate the perspectives of all the parties involved – including government – helps to ensure that the discussion is constructive and practical. Importantly, there is a focus on collaborative problem-solving, which emphasises the interdependence of the different partners, including the community, and enhances a sense of trust and legitimacy.

**Engagement with government and policy stakeholders, and democratic structures.** As a result of the above, CG members have greater knowledge of the channels through which they can express their voice and demands. Many CG members said that before the EVA project they did not complain because they did not know who to complain to. Now they have this information – ‘now we know who the Executive District Officer (EDO) is’ and ‘now we’re connected to local media’ – as well as greater confidence to interact with these stakeholders.

Most sampled CG members said that while there have been community-level group initiatives before, EVA is the only one that has linked them to district and provincial officials and other key stakeholders such as media and CSOs. The DCCs in KP are engaging intensively outside of EVA’s core processes. With CG coordinators from across individual districts developing linkages with each other, as well as a sense of collective identity, and an understanding of their common problems, the DCCs are a good example of the horizontal civil society integration envisaged by Guillán, Fox & Aceron (2016). The building of connections between local initiatives and actors in this way strengthens their visibility and influence, building ‘civic muscle’, so as to impel government to listen and respond.

There is good engagement observed in the DAF in the assessment districts by DHOs, district government officials in KP, and journalists. On e KP DHO has given his phone number to the CG members and said that they can call him. While most DAF attendees are CG coordinators, more government/policy stakeholders attend the DAFs in KP than Punjab because of the more active involvement of local government with EVA. In one of the KP DAFs, many issues have been solved by a District Assembly member who regularly attends and then advocates to the District Nazim and DHO. Our group discussions with DAF members in Punjab and KP indicated a strong rapport and easy and constructive communication between them, including the women. One of the KP DAFs visited provided a very strong example of cross-party dialogue and collaboration.

PAF meetings take place twice a year and the sampled PAF participants value the opportunity for engagement between CGs and government. For government stakeholders, they are a way of understanding citizen perceptions. In KP, the Health Minister has attended, saying ‘we need to know what people want’. In Punjab, members of the Parliamentary Health Caucus were introduced to CG data, which they then presented in Parliament, and raised a resolution to improve the
behaviour of health staff. The PAF meetings are also a way of eliciting commitments from government officials, which can then be followed by EVA directly, or by the DCCs at the district level. The box below presents some examples of this.

**Box 1: Examples of engagement and collaboration between citizens and local government**

There is good evidence that community, civil society (lawyers, media, etc.) and local government are actively engaging in identifying and pursuing strategic advocacy opportunities at the district level. Each DAF has developed a District Advocacy Plan with EVA’s help. The Peshawar DAF, for example, has various advocacy priorities, including an increase in medicine allocations, construction and staff for labour rooms, and a clustered ambulance service.

In terms of specific initiatives, the Swabi and Mardan DAFs have worked closely with the district governments to develop a Health Vision, which will serve as a guiding document for the district governments in strengthening primary healthcare going forward. One of the priority areas in the two districts’ Health Vision is the roll-out of the Minimum Health Services Delivery Project (MSHDP) to the selected BHUs, as well as its extension to the remaining BHUs. The documents, which have been developed with technical support provided by EVA, were presented to and received endorsement from District Assembly members and Nazim, before being launched through high-profile events.

Following demands raised in the PAF, and direct advocacy by the EVA team, the KP government has agreed to reinvigorate the PCMCs – citizen engagement committees which used to exist as part of AusAID’s CESSD. The Terms of Reference are yet to be developed. The notification letter states that in those districts where EVA is active, the CGs should be engaged in providing capacity building to the PCMCs, and EVA has committed to providing Training of Trainers.

However, attendance has dropped off since the first PAF meetings, with government attending less than at the beginning, especially in Punjab. In KP, attendance in the PAF meetings has dropped from a maximum of 47 participants in 2016 to 12 and 15 participants in the meetings in 2017. Although there is a healthy attendance of between 47 and 77 participants in Punjab, the meetings are often quite full of press (in 2016, one meeting had 18 reporters and cameramen, representing 23% of meeting participants). This may be the reason why government is less interested in attending, and this may lead to a more adversarial rather than collaborative form of engagement.

### 3.2 Effectiveness – capability, opportunity, and motivation (Q2, Q6)

The assessment found examples of improved capability, motivation, and opportunity for community members and government officials to engage in productive dialogue. EVA-BHN has developed both male and female CG members’ and coordinators’ capacity and confidence to identify issues and raise them with government health officials and at the BHU. Participation is based on CG, civil society, and government internal motivation, rather than through incentives. CGs have built trust and legitimacy with BHUs and district health officials, though not so much with the provincial governments.

#### 3.2.1 Capability

Many of the CG members interviewed spoke about better understanding their rights as citizens. This included feeling entitled to receive services at the BHU and having greater confidence to demand those services. There was also evidence of a sense of their power to affect change: ‘the community is a real force – if we complain, people can get dismissed’.

Community and district-level stakeholders have greater knowledge of the health governance system, as well as of the channels through which they can express their voice and demands. Many of the CG members interviewed said that, before the EVA project, they did not complain because they did not know who to complain to. Now they have this information, as well as greater confidence to interact with these stakeholders. The CG coordinators – particularly

*‘We used to think everyone is a doctor: now we know the difference between the doorman and the doctor’*  
*‘Now we know who the EDO is’*  
*‘Now we’re connected to local media’*  
- Community members
those that attend the DAF meetings regularly – have also learned about political processes through meeting government stakeholders and being involved in those discussions.

DAF members and CG coordinators have also been involved in undertaking provincial and district-level political economy analyses (PEAs). EVA-BHN has developed accessible tools intended to be used by DAF stakeholders with the EVA-BHN team facilitating their use. These PEAs have helped EVA-BHN’s stakeholders to understand some of the ways in which broader governance processes and structures affect their work, including, for example, the greater provincial control of the health sector in Punjab and the lack of funding for the district health departments in KP. However, while these exercises have yielded important insights, none of the project’s stakeholders spoke about how the PEA had helped uncover the systemic causes of particular issues or the ways in which their strategies had been informed by the PEA – this is key for the kind of adaptive, problem-solving collective action strategic accountability approach envisaged by Jonathan Fox, an academic whose work on citizen participation and accountability has informed the EVA-BHN team’s thinking.

CG members – both men and (albeit to a lesser extent) women – are able to speak up and represent the needs of their communities. This includes engaging directly with district government officials and speaking in DAF and PAF meetings. The DCCs, meeting 10–15 times a month, engage intensively outside of EVA’s core processes.

Patient confidence and assertiveness. There is strong evidence that CG members have more confidence in dealing with BHU staff and government officials. It was not possible to determine whether this confidence has spread to non-CG members, however, as we did not meet members of the wider community. Many of the CG members we interviewed said that they no longer feel intimidated in engaging with health providers or demanding information and services from BHU staff: ‘One of our CG members went to a clinic and was told that they couldn’t provide him the medicines they needed because they had run out. He demanded to see the medicines register and the doctor said, ‘Who are you to ask to see the register?’ The man took out his ID card, and said, ‘I am a citizen of this country, and this entitles me to see the register’.

While EVA’s approach has resulted in improvements in women’s self-confidence and leadership skills, the programme has not used many targeted measures to enhance the ability of excluded groups to exercise voice and agency. EVA has supported women’s leadership by creating two CG coordinator positions for each CG – one elected position and one reserved for a woman. In one of the Punjab CGs the two female coordinators have developed good confidence and are actively supported by the male CG members. They also very clearly see their role as demonstrating women’s capacity to contribute to community life and exercise responsible leadership.

The female coordinator is usually responsible for identifying and recruiting other female CG members and convening the meetings – as such, most women CG coordinators are community midwives (CMWs), LHWs, or community workers, meaning they are well known in the community and have some level of social status. Interestingly, most of the female CG coordinators interviewed were either divorced or single, indicating that it may be easier for some women than others to practise citizen engagement. DAF participation is majority male, with 70% of DAF participants male in KP and 80% male in Punjab. It seems that those women who participate at the higher levels are ones who are already have either higher status or self-confidence. One of the women CG coordinators interviewed said that attending the DAF is ‘above my level’.

‘The community is surprised that the women are doing something for the village, and taking the men along with them.’
‘We will be remembered by the community -- that these girls did this for us.’
Source: CG coordinators
Almost all the female CG members we interviewed said that the greatest change for them has been that they have started to leave the house and become active in the public space. One of the female coordinators in Punjab said: ‘before I barely left the house but now I walk over to the clinic all the time, sometimes four times a day’. The coordinator of the Panjpeer CG in KP is also acting as a mentor and role model to other women and sees her role as being about transferring knowledge and building their skills.

However, bringing about a more transformative process of women’s empowerment requires integrating more targeted measures that are underpinned by an understanding of how gender inequality affects women’s access to quality and RMNCH-N services, as well as their ability to exercise voice and demand accountability.

There is less evidence that CGs have the capacity to engage on crucial health-related gender issues such as sexual and reproductive health (SRH), which is essential for women’s and children’s health. While the exit interviews include a range of questions on family planning services, few issues have been raised regarding this. In Punjab, only nine issues relating to family planning were raised and none of these were escalated to the DAF. In KP, the three issues that were raised by the CGs were discussed in the DAF. This limited focus may be because of the CGs’ focus on infrastructure and high-technology diagnostic equipment. It is also likely to be because of the stigma associated with talking about SRH, which means it is challenging for women to talk about their needs in an exit interview, within the mixed CGs, and the DAF and PAF spaces. EVA also does not engage with the issue of abortion due to the lack of clarity about the legal framework (all interviewees who were asked were not aware of the legal indications for abortion).

However, the evidence from Pakistan shows that unsafe abortions are a significant cause of maternal mortality and morbidity, and thus an important issue to consider. In KP – where the programme has separate men’s and women’s CGs – CG members also voiced a need for safe abortion services in the assessment focus group, and indicated that they were not able to engage with the men’s CG or the BHU service providers to get more information (see Box 2 below for more about the women’s CGs as safe spaces).

There is limited understanding among CG members about the health system and the public health imperatives that underpin its structure and organisation. This shapes problematic expectations within the community about the level of services that should be available at the primary level. While the CG coordinators are trained on understanding the mandate of the BHU, they are also told that anything beyond that mandate can still be submitted as a ‘demand’ to be taken to the provincial level. EVA considers that it is community members’ right to demand whatever they consider will enhance the acceptability of the services they receive. However, given that CG members are not sensitised as to why certain things fall outside the BHU mandate, it appears that that right is not being exercised in an informed and responsible way. This is evidenced, for example, by the large number of demands for diagnostic equipment, particularly ultrasound machines – the risks of which have been outlined earlier in the report.

There was evidence of some frustration on the part of DHOs interviewed that they are continuously receiving demands that fall outside the BHU mandate that they cannot respond to. There was no evidence that CG coordinators or groups are being engaged in a discussion about the underlying causes of some of these issues and the different ways in which these could be addressed (for example, demands for an ambulance stemming from people not having the money for transport costs or the demand for ultrasound machines stemming from women’s mobility issues).
The risks of strategic accountability initiatives creating citizen expectations that the state is unable or unwilling to respond to, thus increasing distrust of the state and apathy, are well documented (for example in Gaventa and Barrett’s (2010) review of 100 voice and accountability case studies).

While the CGs and DAFs have engaged in some strategic advocacy initiatives, overall there was limited evidence of CG demands being understood and presented in policy-relevant ways. EVA’s programme reports state that while the agenda for the PAF is informed by a policy gap analysis that is underpinned by the issues raised by the CGs, it is not structured around them. This would appear to be good practice, but perhaps this is not happening consistently as the review team received feedback from PAF stakeholders stating, for example, that issues are often presented as a list of individual BHU-specific complaints instead of as part of a more strategic, policy-relevant ask. There was also little evidence from the interviews with CG coordinators and DAF members that they are thinking about the issues in terms of the systemic issues facing the health system. To an extent, this is one of the reasons that most of the issues being raised by the CGs are related to infrastructure and equipment.

The way in which data is communicated is key to whether government view community monitoring information as credible and legitimate. Guillán, Fox, and Aceron (2016) also show through case studies that influence can be fostered if CSOs use aggregated data from communities to expose problems, to reframe public debate, identify ‘smoking guns’, and generate a ‘killer statistic’ that goes viral. This requires an intermediary organisation or set of actors – skilled in relationship-building (including to foster government allies), advocacy, communication, and coordination among civil society groups – who can translate the demands from the community into policy-relevant analysis and support strategic planning processes, as well as allies and champions.

EVA’s advocacy gains demonstrate that the advocacy role is currently provided by EVA staff, rather than national organisations or movements. It is clear that EVA has stepped in to do what was necessary to provide the strategic inputs needed to accelerate change, and to create a sense of movement and excitement around the programme. However, from an effectiveness and sustainability perspective it would be better for this role to be played by a group of district-level policy and advocacy partner organisations, perhaps a local NGO, that participates as a member of the multi-stakeholder spaces and processes, and also provides the training and technical input from a health advocacy perspective. In addition, analysis of systemic root causes of aggregated issues does not appear to be happening at all.

CGs have a strong understanding of the importance of collecting data to understand community perspectives. The CG coordinators all spoke about how the CBM checklist and exit interview underpins the work that they do. Often they use the findings coming out of the data collection to double check with other community members whether they have had similar issues. The CG coordinators use the CBM checklist as the basis for the CG meetings. The opportunity to undertake the data collection at the BHUs and to share the findings with the doctor provides CG members with a legitimacy that is key to their sense of citizenship and confidence to engage.

The capacity of health officials and DAF members can, however, limit their ability to respond. In KP particularly, limited financial flows to the district means that very few of the CG issues are being resolved (around 16%). The capacity of the DHO is one key factor in this respect. In the absence of health budget funding, DHOs are expected to advocate to district Nazims for a share of their discretionary funds. Some DAF members also highlighted their health systems knowledge and management skills as areas that need development. The disconnect between EVA’s approach and the DFID-funded supply-side initiatives (TRF+, Health Roadmap) means that

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5 Cited in Ayliffe (2016).
there is limited opportunity for EVA and communities to feed into technical assistance targeting (e.g. for DHO health system and management capacity building).

3.2.2 Opportunity

**EVA has provided community members a mechanism to identify and voice concerns within a safe, community-based context.** Interestingly, while the overall number of issues raised in KP is similar to Punjab, KP has a lower population, which indicates that either KP has more active CGs or that separate men’s and women’s groups are raising more issues between them. EVA’s model has also provided women with important opportunities to practise citizen engagement. In Punjab, where women have greater mobility, this has involved working together with men, and in the case of one CG – where both coordinators are female – leading them too.

**Box 2: Women’s CGs in KP**

In response to the more conservative gender norms in KP, EVA established separate groups for women there. These groups operate in parallel to the men’s groups, with only the two CG coordinators meeting to discuss issues collectively and align priorities.

Safe spaces for marginalised groups have worked in various projects to promote inclusion. For women, safe spaces can foster solidarity and collective consciousness, which helps to collectivise actions and strengthen their voice. EVA’s women’s groups in KP are operating effectively as much-needed safe spaces for women to develop trust and solidarity, discuss (and become aware of) the health issues most important to them, and build participation and leadership skills. Although the review team visited too few CGs to make any definitive judgements, it did seem that the Punjab women CG members were dominated by one or two members, while in the KP CGs more women were vocal and engaged with the issues. One of the KP CGs was the only one to bring up sensitive issues of family planning and safe abortion. There was a strong sense of solidarity in the other KP women’s CG, where the CG coordinator proactively shares training that she has received from EVA with other members and also teaches CG members sewing so that they can earn an income.

Beyond establishing the women’s CGs in KP, limited consideration has been given to how spaces and groups can be more or less conducive to participation by vulnerable groups. The key issues are the profile of the people engaged in the CGs and their pre-existing relationships. In most of the CGs visited, it appeared that the CG members (many of whom have quite high status in the community) knew each other from before – they were neighbours or in one CG’s case members of an extended family network. Only one of the KP women’s CG was comprised of people who were previously strangers, who the CG coordinator had recruited based on recommendations by the local school teacher and LHW. It can be argued that good social cohesion within a group enables it to be more effective more quickly, as it does not have to spend time building relationships and trust; indeed, this may be one of the reasons the Shamkay Bhattian CG has been so effective. However, it can be difficult for such groups to be open to the needs of others, and also for outsiders to join and participate effectively.

The programme has developed various measures to support the representation of women and excluded groups in the CGs. All four of the CGs said that they conduct roving meetings, i.e. holding them in different neighbourhoods, including in those areas where more marginalised groups live or work, so that the distance and transport barriers to their attendance are minimised. One of the CGs in Punjab said that they are planning to hold a meeting at the nearby brick kiln, which is where some of Pakistan’s poorest caste groups work. To minimise the opportunity cost for the workers, the CG coordinator has negotiated some time off for them with the brick kiln owner.

CGs have also been asked to make efforts to identify and include members of particularly vulnerable groups in the CG groups as more regular participants. In Punjab, this includes members

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6 e.g. PATHs2 safe spaces for adolescent girls, cited in e-Pact (2016).
of the Christian community. One of the CGs in KP includes a representative from the nearby IDP camp. In both provinces widows were considered particularly vulnerable, and in one of the KP CGs the women identified a young single mother participant as highly marginalised.

While there seems to be some understanding among the group as a whole about the importance of these groups being represented in the meetings, however their inclusion does not seem to have gone beyond presence in the meetings to effective participation. Indeed, there is a sense that they are viewed by the wider group tokenistically – the review team were told on more than one occasion 'talk to her, she's Christian!' In one of the Punjab CGs, the Christian representative was also the CG coordinators maid, and likely serves as one during the meetings – as she did after the review team's visit. There is little understanding that her religion intersects with her occupational status and poverty (she also spoke a different dialect) to make it particularly challenging for her to engage. In fact, the CG coordinator accepted that she rarely speaks up in the CG meetings, preferring to talk to the coordinator privately and asking her to raise issues on her behalf.

Much of this is understandable as complex issues of exclusion cannot be addressed overnight. The point here, though, is that it is not enough to bring women and excluded groups into a space and expect them to start participating: targeted measures to raise awareness, support empowerment, and address inequalities are needed. Often, the wider group needs training on how gender inequality and social exclusion affect citizen participation, how to format and chair more inclusive meetings, and how to listen, be attentive to people who look like they want to say something but do not, and create informal safe spaces – one to one if need be. Encouraging community meetings to explore gender, caste, and class inequalities before discussion about health service entitlements in community meetings, as well as a focus on issues that are particularly pertinent to marginalised and poorer groups, such as chronic undernutrition, may be useful approaches (Nisbett, 2017).

In Punjab, there were numerous examples of how CGs have mobilised financial and human resources to resolve issues themselves quickly and effectively without the support of the health system. This has often involved communities supporting and subsidising the BHU – an opportunity they had not had before. One of those CGs wanted toilets at the BHU but the Health Council budget did not cover the construction of new facilities, only repair. The CG had money left over from the purchase of the ultrasound machine, so they donated it to the Health Council to build the toilets. They also donated money to provide a water cooler as it would take too long to wait for government or contractors to provide it.

Box 3: Examples of communities in Punjab subsidising the BHUs

- Providing labour for the renovation of the roof
- Sourcing materials for the renovation of the BHU
- Providing a bed for the maternity room
- Providing a water cooler
- Providing an ultrasound machine purchased through community donations
- Providing an ultrasound machine and training to BHU staff through philanthropic donations
- Providing the gel for the ultrasound machine
- Contributing to the Health Council budget for the construction of new toilets

Providing the community with the opportunity to contribute directly toward the improvement of the BHU has created a strong sense of ownership. This has meant that issues that were outside the BHU’s mandate, or would have required a longer policy process, have been resolved more quickly.
In Shamkay Bhattian, being able to work with the community to provide local labour and source local materials for the renovation of the BHU meant that the WMO did not have to use the government’s Communication and Works Department for procurement, which is known to be excessively expensive and slow, and also takes a significant cut from the budget of any project.

However, there are obvious concerns about sustainability. Apart from Shamkay Bhattian’s ultrasound machine, all the other examples provided in Box 3 involve CG members using their own resources. It is possible that, as CG members are often people who are influential in their community, they feel motivated to be seen to deliver on the community’s demands. In addition, this may have also reinforced a sense of government absence and affected its legitimacy. Many of the CG members when asked what motivates them to improving the BHU replied: ‘No one else is going to do it’.

The CGs we visited have developed a supportive relationship with BHU staff, particularly the (W)MOs (doctors). To a certain extent this seems to be because of longstanding relationships between BHU staff and individual CG members, and many CG members talked about how personable certain doctors are. MOs interviewed did not feel threatened and were all able to describe instances where CG members had given them direct feedback, in some cases even on their own performance. In all the cases this seems to have been done in a collegial and constructive way, a reflection of the CG members’ strong ‘soft skills’ and the emphasis on building trust. MOs and WMOs have recognised the value of CGs as channels of communication. Certainly, the broader literature on successful accountability initiatives in the health sector shows that service providers are more likely to respond and engage when they feel supported and appreciated, and when the process emphasises information sharing and dialogue, avoids open public critique, and provides an opportunity for providers to defend themselves and to address their own concerns as well (Lodenstein et al. 2016).

The CGs have also proven an effective channel through which the BHU and DHO can communicate with the community, for example to explain the constraints they operate under. A WMO in Punjab said that the community now know that she runs short of medicines because of delays in the central procurement system, and so she cannot always provide them. In fact, the same MO gave several examples of the ways in which the CG has managed the community’s expectations.

There is some evidence that the CGs have engaged with other actors involved with health service delivery and helped them to work in relevant ways. In one of the communities in KP visited by the review team, the CG shared their demands with an international NGO working in the area. While the BHU and district government were unable to respond due to lack of funds, many of the issues, such as renovating the waiting room and construction of a washroom, were resolved by the organisation.7

The programme has also provided the opportunity to other religious leaders, media professionals, and journalists not normally engaged with health to come together and develop innovative strategies. EVA’s work with the ulema has involved bringing together scholars from different schools of thought to discuss the realities of health and health service

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7 It is important to note here that as the NGO’s programme has ended, its main area of work which was to turn the BHU into a 24/7 facility, complete with labour room, ultrasound and trained staff, has also ended and the BHU has returned to its earlier timings. Without the trained staff provided by the NGO, the ultrasound machine is no longer used. Women have resumed going to the next nearest (also NGO-run) clinic for their deliveries. The community remains hopeful that the project will return.
delivery and agree on key health-related messages that would be disseminated by their wider network of imams. The opportunity to bridge sometimes deep divisions between different Muslim groups in Pakistan is valued by the scholars themselves: ‘health is important – and to provide health we need an atmosphere of peace and harmony’.

3.2.3 Motivation

Community members’ motivation to engage in the CGs stems from a combination of factors, including moral responsibility and a desire to improve their village for this and future generations. Many CG members voiced a sense of collective responsibility for improving the BHU so that women and children can access better, more accessible, and affordable services. This was connected to a sense of moral/religious responsibility – particularly that their work for the BHU will create long-lasting benefit, and that this will please God. This is in line with the broader literature from South Asia (Nesbitt et al., 2017), which notes that community members on health committees are motivated by social recognition of their work as well as a sense of common identity and clear and reachable goals. Many CG members we interviewed also highlighted that their own families now use the BHUs instead of private providers, and that they have thus personally benefited from the work of the CGs.

Participation in the CGs, while benefiting from the influence of members, has also increased community members’ status. In Punjab, two young women CG coordinators are keen to demonstrate to the wider community what women are capable of. This increased status is manifested in different ways, including having access to the BHU for monitoring, having access to the doctor, and community members expressing gratitude for improving the BHU.

One or two stakeholders mentioned that some CG members harbour political ambitions and are using the CGs to position themselves for this. EVA’s socioeconomic survey found that a significant proportion (43%) of the members of the CGs had close friends/relatives who were elected in the 2015 local elections. Another 40% reported having someone from their biradri elected in the local elections of 2015. On the one hand, this provides important opportunities for informal advocacy, with the CG members able to represent first-hand the impact of low-quality BHU services to office holders. On the other hand, it may have implications for the participation of less-connected members or vulnerable groups, who might fear backlash if they are critical.

The sense of momentum that has been created by the resolution of the issues (particularly in Punjab), and recognition that the CGs can deliver changes and benefit people, is another key motivating factor. Much of the CG members’ willingness to volunteer their time, energy, and resources is related to a sense that their work is achieving results. Members of one of the KP women’s CGs said that initially their families were unsure about the CGs (‘they’re generally suspicious of NGOs’) but after seeing some of the improvements are now more supportive. CG members indicated that they have further ambitions for their BHU – one of the Punjab CGs said they want to bring an x-ray machine to their BHU next, while the other hopes to turn their BHU into a trauma centre.

In KP, the energy and activity within the DAFs is largely due to the high levels of engagement by the local government. However, in the absence of sufficient funds, it is likely that issues will become harder and harder to resolve, and this may erode the high levels of commitment among communities and DAFs. EVA’s 2016 programme report notes as much, stating that the lack of progress in the earlier half of that year had caused CGs to become demotivated.

The project has benefited from an increase in political will within both the provinces’ ruling parties regarding health. However, there is still resistance to integrating citizen-generated
data into government decision making. In Punjab, there is a strong narrative about hearing from citizens and ensuring client satisfaction. The Chief Minister is closely involved with the Roadmap process and personally attends the quarterly stocktake meetings. However, there is a strong sense that the somewhat punitive management culture, as well as the atmosphere of blame and fear that his close engagement has created, has reduced Health Department officials’ appetite to engage with EVA’s data, especially where it might highlight under-performance or contradict their own data. For example, there was some anecdotal evidence that the BHUs had been stockpiling their medicines and not handing them out to patients so that they had full medicine stores for the government inspections. EVA’s CBM data found that patients were being asked to buy medicines themselves even when, according to the government monitoring data, their medical stores were full.

Motivation to engage with communities and to respond is high in KP, where the Director General (DG) Health is very keen to see improvements in the availability of health services. This is reflected in the KP government’s drive to ensure full coverage of health personnel. The government has also committed to increasing LHW coverage from 50% to 80% and to increase the contraceptive prevalence rate from 28.2% to 42% by 2020. EVA has tapped into this motivation by organising for MPAs to visit health facilities and helping them to present the issues in their respective assemblies, including writing questions for them and providing evidence.

3.2.4 Attitude, legitimacy, and trust of the EVA system

The programme experienced some challenges with legitimacy and trust in the beginning, but there are various examples of promising practice in terms of the ways in which EVA and the CGs have built this at the BHU and district level. Initially when the CGs started, several MOs refused to give CG members access to the BHU to complete the CBM checklist, or to sign it. The CG coordinators raised this at the check-in meetings and the District Coordination Officer (DCO) then sent an instruction to all BHUs to cooperate with the CGs – an excellent sign of buy-in at the district level at the outset.

The Nazim of one of the KP communities we visited initially refused to attend the DAF. He felt that the CGs should be holding the provincial government responsible as that is where PHNP money was being channelled. He was also upset about the media coverage of CG issues. DAF members believe he changed his mind once he attended a meeting and saw they were working in good faith.

The role of the CGs, and the CG coordinator in particular, is key to establishing trust within the community and creating effective synergies between very different stakeholders. Guillán, Fox & Aceron (2016) highlight these issues as the key challenges of vertical integration. They have found that collaboration requires agreement on how decisions are made, who speaks for whom, and legitimate representation, feedback, and trust so that all perceive the partnership as balanced and inclusive. CG coordinators play a key role in disseminating the information and training they receive from EVA at orientation and through check-in meetings to the rest of the group. They are also responsible for feeding back on progress on logged issues, and any discussions at DAF and PAF level to the CG members, and through them the wider community. There was a strong sense among the CGs we visited that the members respect and trust the CG coordinators – who were often but not in all cases individuals of higher status with strong community links – to represent their needs to providers and government officials.

The support that the CGs provide to the service providers and district government is also key to enhancing their legitimacy. Service providers and district officials have come to see the CGs as a key source of support for them – in terms of communicating their constraints to the community, managing their expectations, and actively supporting improvements to the BHUs.
However, the role of the media in DAF meetings may complicate this relationship, particularly in Punjab.

There are mixed views about the legitimacy of the EVA-BHN system at the provincial level, particularly in Punjab. While there is strong commitment to ideas of accountability and service user feedback and voice at the provincial level, government stakeholders were critical of the programme’s limited scale. In Punjab, there is a sense that the government’s citizen engagement initiatives – the Health Councils, the automated telephone feedback system, and the integration of exit interviews into the Health Roadmap’s M&E system – are sufficient and preferable as they have been rolled out across all districts. It is difficult to say anything definitively about why EVA-BHN has struggled to build trust with the Punjab government. It is likely this is due to a combination of factors, including EVA’s small number of districts, concerns about the credibility of citizen-generated data, perhaps a lack of perceived legitimacy as a donor-engineered initiative only tolerated in order to maintain PHNP funding (as per Yaseen (2013)), and the accountability culture of the Health Department described above, which has meant that government officials were less able to constructively engage with EVA’s data and the added benefits that EVA’s approach provides.

3.3 Reflections on additionality

Attribution and additionality is challenging to measure in this type of programme, though it can be seen that EVA-BHN has contributed to results to a certain extent. Ideally, change should be driven (and seen to be driven) by national organisations and citizens and this would be important for the legitimacy of such a programme. Consequently, it is not necessarily appropriate to claim attribution – which makes additionality also difficult to measure. In the case of Punjab, it is possible that EVA-BHN activity has provoked the provincial government to set up their own inclusive monitoring system (possibly in competition with the EVA-BHN approach), but it is difficult to say and maybe counterproductive if EVA-BHN were to claim this. However, some evidence picked up in this assessment shows that EVA-BHN is providing some additionality.

The EVA-BHN structure for community to government engagement appears to be new and additional to anything that had been tried before in Pakistan. While there have been health facility committees (e.g. PCMC and through PAIMAN) and community engagement of various types (including the NSRP groups), these have either not been sustainable or have not systematically built effective citizen–state relationships. Some of the CGs have been built upon existing structures and groups and it could be argued that these have been easier to form. However, they may have inherited inbuilt power structures, and capture by a particular extended family, as was the case with one of the communities that was visited. Other CGs are entirely new and were formed by the EVA-BHN programme.

Other parts of the approach have built on work that has already taken place under other government programmes but has been extended and developed further under EVA-BHN. For example, the communications and religious leaders work, led by CCPP, is part of work that has been ongoing and funded under PAIMAN or based on a proposal to the now-completed DFID-funded Maternal and Newborn Health Research and Advocacy Fund programme. This original work was more concerned with influencing health beliefs and health-seeking behaviour and this focus has continued to be dominant in the current EVA-BHN funding period. The religious leaders had already been trained under PAIMAN on the same MNCH topics that were proposed under EVA-BHN, so it is difficult to know what EVA-BHN has added other than extending the work. While some focus on citizen rights is apparent, it is not clear how this part of the programme’s work contributes to overall state–society relationship-building. However, the focus on health-seeking behaviour and citizen rights does support the context for change.
EVA-BHN had a role to play in the development of new structures that have enabled responsiveness to take place (e.g. the Health Councils in Punjab) but it is unclear whether this can be entirely attributed to the work of EVA-BHN. It is clear that the Health Roadmap, TRF+ and the Punjab government were all involved in the decision making and approach. It is likely that the CGs pressure on district governments to respond to their demands has added to the pressure on the provincial government to open up a way of financing improvements in the BHUs. One key informant reported that it was entirely EVA-BHN’s work that had provoked the setting up of Health Councils, while three other key informants were of the opinion that it was impossible to identify responsibility. However, it can be stated that the setting up of the Health Councils has enabled a large number of the CG-identified BHU issues to be resolved, and this can be seen in the timing of the EVA-BHN issue resolution in the data. In addition, DAF members attributed some of the changes in BHU staff behaviour and the higher level of MO attendance to the work of the EVA-BHN CGs.

There was also evidence that the Punjab government had responded to CG requests for ambulances by procuring some of them. EVA-BHN CGs were able to provide information about where they are most needed and some of the ambulances have been sent to the hard-to-reach areas.

In KP, EVA-BHN has been instrumental in encouraging the Independent Monitoring Unit (IMU) to include a brief service user exit interview in the health facility monitoring process, as well as to include an indicator on client satisfaction among their 28 health facility monitoring indicators (monitored using a mobile app). This will ensure a high-quality government approach to quality assurance and accountability.

Several key informants attributed at least two province-level policy changes to EVA. For example, the Punjab Breast Feeding Act was seen to be the work of EVA, which was mostly direct advocacy in partnership with CSOs.

3.4 Coalitions, partnerships, and institutionalisation

EVA has been successful at institutionalising the approach at community level and in building state–society relationships, but it should be noted that this is dependent on the continued enthusiasm and motivation of volunteers. The motivation of volunteers to continue this work (as reported in the previous section) partly depends on the continued responsiveness of the state and an improving relationship between citizens and the state. If this relationship flounders or if issues fail to be resolved, there may eventually be a drop in volunteer engagement. The Punjab and KP governments have taken on some of the principles of service user feedback, which will mean a type of institutionalisation, but possibly will not include direct engagement with communities.

However, EVA has not involved civil society networks or movements in the support to CGs or in the training of community members. Nor have CSOs been involved in policy- and HSS-relevant analysis of the issues raised by the CGs for the DAF and PAF levels. This means that there is limited potential for the approach to be sustained or expanded beyond the life of the programme. While the current CGs may continue to operate at their own expense, there will not be resources to draw on for continued technical input or learning. It could be argued that this may happen at the DAF level and that DAF members would engage with the CGs more. However, while the assessment saw evidence of CSO DAF participation, the approach has not engaged with DAF civil society in a way that draws on their expertise and networks. The only structure that might develop further is the DCC in terms of CG learning and expansion, so this might be an initiative to encourage. It is extremely important for indigenous organisations to lead policy and HSS pressure.
Engagement with politicians, political parties, and the development of the Health Caucus in Punjab has been an important step for institutionalisation of the state–society relationship. The role of politicians in accountability systems and their connection with constituencies is essential for sustainability and for state responsiveness. The cross-party nature of the EVA engagement has been a positive way of building a new culture of engagement with communities. The Health Caucus was grateful for the direct links with CGs and the data and stories made available to them to enable evidence-based and targeted campaigning in the Assembly.

Partnerships with universities, religious leaders, and the media have been successful for institutionalising both health and health rights awareness raising and strengthening the role of media in the accountability process, though religious leaders and universities play limited roles in the accountability process. Influential journalists were seen to be playing a key role in two of the DAFs, both as facilitators and as important witnesses. We heard of several examples where the DAF action and media reporting combined to lead to resolution of issues (e.g. the police using a BHU for their office). However, there were also examples of media contributing to a decline in trust between government and the CG/DAF processes. There are clearly risks with engaging with the media and this has to be planned carefully. The institutionalisation of an entertainment education course in universities is an important upstream action to change the way the entertainment industry influences social norms within the country. However, this activity and the work with religious leaders does not appear to have a clear role within the ToC for voice and accountability; instead, it contributes to wider social norm change around health, knowledge of health rights, and health-seeking behaviour. Additionally, there is currently no data collection that can demonstrate the effect of these two initiatives, nor how these combine with the CG work.
4 Quality and credibility of data to measure and record change (Q4)

The assessment found that MIS data was good quality and can be used to draw conclusions about the level of CG engagement, and about BHU responsiveness. The data can also be used to inform areas for further HSS investigation, as indicated in the previous section and explored further in Annex D. All the sample issues explored in the assessment were verified (see Annex D). A small number of duplications and category errors were identified, and these can be easily rectified. Other data collected by the programme has not yet been sufficiently fed into learning.

This section concentrates on answering Assessment Question 4: ‘What is the quality and credibility of the data EVA collects to measure and record change as a result of its interventions?’ It focuses mostly on the MIS’s approaches to collecting data on CG, DAF, and PAF participants and the issues that are raised in the meetings. It also comments on the research and qualitative data collection that has taken place so far, with the recognition that this has not necessarily been designed to ‘measure and record change as a result of the interventions’, but nevertheless plays a role in the understanding of ‘how’ the programme works and ‘should’ work.

DFID had originally planned an independent evaluation of PHNP, including EVA-BHN. Thus, when EVA began, the programme’s MEL design did not include data collection for measuring outcome and impact-level change in an internal evaluation. Because the independent evaluation has not been implemented, the programme lacks the strategic data collection that would have enabled measurement of outcomes and impact, or progress against the ToC. EVA has, however, used the MIS – its main monitoring tool – both as a key implementation tool, informing communities of progress against the issues they raise, and as a way of monitoring progress. That said, the MIS was not designed to measure outcome results. Other research and data collection (i.e. the Knowledge, Attitudes and Practices (KAP) survey, the socioeconomic survey, and the tracer studies) have been used to feed into the programme approach.

4.1 Review of the MIS

EVA’s MIS uses the following three main data collection systems:

- Record of issues discussed at CG meetings and DAFs;
- Participant tracker data to track participation of individuals in CG meetings and DAF; and
- CBM – issues are reported in the CG ‘record of issues’ and data is further divided into two data collection systems:
  - Observation checklists; and
  - Exit interviews conducted by CG members.

The MIS data collection system is excellent quality and the data produced are an important monitoring tool and input for programme management, learning and effectiveness, as well as for dialogue between communities, BHUs, and government. It is well integrated into CG and learning processes and is also used for reporting to DFID against the logframe. While there are some data discrepancies indicated here, we are of the view that the data is still of good value and can be used usefully in the programme. This report references metrics gleaned from the data sheets provided and has been a useful way of demonstrating specific points (e.g. the lack of issues related to family planning, or that the referral issues only relate to ambulances and not other aspects of referral).

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8 The most recent Annual Review completed by DFID appreciated the robustness of EVA’s data collection system, noting the following: ‘The EVA programme generates a wealth of information, and has established an extremely robust data collection, management and quality assurance system which provides reassurance of the quality of the data’.
This kind of information is essential for feeding back into the programme approach. EVA and DFID will need to assess how much more time and money they want to invest in correcting any system and counting errors.

This assessment attempts to verify the data quality using the following three processes:

(i) **Qualitative verification of a sample of issues in the four assessment visit communities.** A summary table in Annex D shows verification of the issues, the story behind the issues, potential for duplication, and comments on whether the issue is likely to be a symptom of an underlying systemic issue.

- This direct verification processes showed that 25 out of the 34 sample issues (75%) were verified adequately.
- Some issues can be considered to have been marked as resolved more than once because they re-occur, indicating that the issue has not really been resolved. In the sample, shown in Annex D, this can account for between 7% and 80% of resolved issue in the communities assessed.
- There was also a total of three issues that had not been marked correctly as either resolved or in process, although this could have been due to a time lag.
- Four of the sample issues were not discussed with the CG due to lack of time.
- 14 (41%) of the sample issues could be systemic health system issues that require further root cause and province-wide analysis and in many cases coincide with recurring issues.

(ii) **Verification of reported data (reliability) by checking the CG and DAF issue and participant tracker spreadsheets provided to the assessment team by EVA.** This process has enabled a better understanding of how duplication between data sets has been avoided and how the quality assurance of data takes place. Annex E provides our analysis of duplication and estimation of the correct number of resolved issues.

**Duplication:** Analysis of the duplication shows that there are potentially 15% fewer resolved issues than are reported in the September quarterly report (2,741 resolved issues). The **number of resolved issues as at September 2017 is estimated to be 2,316.** The problem of duplication is related to the counting of reported and resolved issues in KP and Punjab. These duplicates were identified by analysing the repeat observations of Ref Code (unique issue ID) and issue narratives across CG and DAF streams. Duplicates in resolved issues have occurred because the CG issues that are discussed in the DAF are often marked as resolved in both the CG and the DAF. In such cases, the EVA team discusses these issues with CG and DAF teams to decide how the duplicates need to removed and in which stream the resolution status needs to be preserved. This exercise is only done to update the final reported figures and does not result in updating of the database.

**Duplication errors:** There were minimal errors found with respect to Ref Code duplication within individual CG and DAF sheets. However, the Ref Code overlap between the DAF and CG streams in KP and Punjab was 27 and 166 respectively. EVA claims to have accounted for 18 duplicates in KP and 50 duplicates in Punjab that were identified after April 2017. However, since this is not reflected in the database, it is not possible to identify which specific duplicates had been dealt with.

One limitation of using Ref Code to identify duplicates is that it is missing for all DAF issues that were entered into the system before December 2016, which is before the introduction of the MIS. This means that DAF issues that do not have a Ref Code (59% in the case of KP) cannot be compared with the CG dataset for automatic duplication check. Therefore, the duplication figures stated above are a very conservative estimate. A further check on the overlap of issues in CG and DAF in Mardan and Peshawar indicated a higher proportion of duplicates.
Note that some of these duplicates have occurred because recurring issues are being reclassified as new issues.

**Data disaggregation and analysis:** The data was found to have sufficient information to be adequately disaggregated across key variables such as gender, location, origin, and resolution status to assess progress against specific components of the ToC.

However, in the issues data, all KP issues are tagged against the ‘all female’ CGs. This is actually by design as they have two groups in the same Union Council (UC) in KP, thus they use the female group and add up the additional issues from the male group within it. However, this means that data on gender and issues raised is being missed.

The data could also be further disaggregated to track the responsiveness of the system across different categories of issues, e.g. how frequently issues get raised before being resolved and how long it takes to resolve various kinds of issue emanating from CGs, CBMs, and DAF.

(iii) Checking of accuracy and reliability of data collection and data entry by assessing how many gaps and duplications there were for the participant tracker and checking data entry forms and hard copies. A table of results can be seen in Annex F. Most gaps and duplications for this data pertain to identity card (CNIC) numbers and phone numbers. Many people do not have IDs or a phone, or do not want to share their number. Moreover, in some cases, duplication of the phone number is because the group facilitator has put his/her number into the data collection sheet as a way of contacting that person. While there are a number of gaps, however, this does not discredit the data. Rather, it indicates that there are some issues with the expectations that the programme has relating to the capability of community members. It might be that a simpler identifier system is required. There are also three cells that have not been filled in at all (see Box 4), which raises questions about the utility of these cells.

CG participant and data entry forms are easy to use and are generally appropriately filled in by coordinators. However, the DAF meetings record issues by taking minutes, which may not be the most systematic way of doing this. Some discrepancies in issues from the CG data sheet and the DAF data sheet have been identified, which require further investigation.

**Quality assurance mechanisms:** The Research, Monitoring & Evaluation (RME) team conducts periodic checks that involve cross-checking a sample of hardcopy forms with the MIS data. In addition, CBM data is monitored by conducting re-visits to randomly selected BHUs and re-doing the checklist questionnaire and exit interviews. EVA monitors and provides feedback on the quality of CG engagement through seven essential criteria and nine additional criteria. The coordinator uses the information to improve group participation and interaction. Poorly performing CGs also are given the opportunity to visit the well-performing CGs to share and learn.

**Learning and data use:** Data and analysis are fed back to the CGs at the monthly district-level check-in meetings. These meetings are also attended by the DAF coordinator. The TRF, the Health Roadmap, and the Punjab provincial government do not yet appear to be using the EVA data at province level. As mentioned earlier in the report, there may be a need to ensure that the data is presented in a more policy-relevant way and that the legitimacy of the data can be enhanced by augmenting it with more qualitative material, stories, and analysis of systemic issues.

**Data security:** EVA does not have a secure system for storing sensitive data about CG and DAF participation. This kind of data should be anonymised for storage and only shared with code

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**Box 4: Data cells not required**

- DAF KP: Response by community member
- DAF KP: Authority level
- DAF KP: Impact level
- DAF Punjab: Response by
references rather than names, phone numbers, and CNIC numbers. **This is an urgent issue related to people's security and should be addressed as a priority.**

### 4.2 Quality and use of other research and data produced by EVA-BHN

The KAP survey has provided some useful baseline data, albeit a little late in the programme development and possibly not targeted enough on measuring results for the EVA-BHN programme (this is partly because DFID requested that the survey be relevant to the whole of PHNP). The methodology was deemed to be good overall. The overall sampling design was appropriate for the study, while our document review of the training agenda, workplan, monitoring checklist, and email exchanges between the monitoring teams showed that appropriate quality control procedures were in place to monitor the quality of data collection across both provinces. However, there were some issues with the methodology. For example, the description of the assumptions behind the sampling size was poor and the questionnaire could be improved by including standardised Demographic and Health (DHS) questions that have already been validated in Pakistan’s context for the computation of income- and wealth-related statistics. These questions would include source of water, toilet, fuel, description of household assets, and ownership of land. The existing KAP survey has significant variations (on key estimates for antenatal care coverage and Skilled Birth Attendant presence) to other studies such as Pakistan Social and Living Standards Measurement (PSLM) and DHS.

**The socioeconomic survey** aimed to:

- Respond to a mid-term review observation that challenged the assumption that poor and marginalised women and children were the main users of PHNP programme; and
- Ascertain the socioeconomic status of BHU clients and CG participants in PHNP intervention locations.

The sample is meant to be representative of CG members and BHU clients. While reasonable assumptions are made in relation to the CG members survey, no information on sample size calculations is provided for the BHU clients survey. As with the KAP surveys, the document review indicates that appropriate quality control measures were put in place during the training, data collection, and data processing to monitor the quality of data. However, there was insufficient field quality assurance implemented during the survey.

The questionnaire uses standardised Poverty Score Card and Vulnerability Index questions and the findings indicate that more than 50% of the respondents are either ‘poor’ or ‘very poor’ and score high on the Vulnerability Index. The main flaw with this survey is that it is not collecting data about communities that are unable to access or communicate with either the BHU or the CGs. It is likely that these are the most vulnerable and hardest-to-reach communities, who most probably account for most of the mortality and morbidity. It is important that BHUs and CGs understand who these people are and monitor how they are reaching them.

EVA-BHN’s qualitative data collection has used the Reality Check Approach (RCA) and a case study methodology for the tracer studies. Both methods have provided valuable qualitative data for the PHNP but have not been complementary to the KAP study and have not been used fully for programme adaption yet. Furthermore, there is important learning from the RCA that has not been used within the PHNP programme even though it has implications for the programme ToC and approach. For example, there are findings about social expectations regarding health service delivery and quality health services, as well as findings about the use of unqualified ‘health’ providers’ services (quacks) that could be harmful. This behaviour in communities and the expectations around high levels of medication and presence of technology as
signifying quality health services is influencing the way communities engage with the CGs and the BHUs, as well as the accountability process. Specifically, it is influencing what communities expect and ask for in the BHU (as mentioned in Section 3 of this report). While the programme has done some analysis of the findings, it is too early for this to be applied. Specifically, programme staff have identified that EVA-BHN CGs could be mobilised to campaign for full coverage by LHWs, and there is already a commitment in KP to increase coverage substantially. They have also recognised that the public sector needs to be more involved in providing health information to communities and in regulating the diverse, and often low-quality, private health services.
5 Conclusions and recommendations

This programme has produced an innovative and high-quality community voice and accountability system that is showing some signs of increasing accountability and government responsiveness. The programme monitoring data (from the MIS) is mostly reliable and could be useful for supporting health system responsiveness, although interpretation and further analysis is not yet happening sufficiently. Serious health systems issues – not least relating to health financing, human resource management, and access to medicines and supplies – are not being adequately analysed and tackled within this programme. While it is not the responsibility of EVA-BHN to tackle the system issues directly, it would be important for the EVA-BHN structure to promote dialogue with government on the systemic and root causes of some of the issues that recur and that cannot be resolved at the district level. There is evidence that a lack of analysis of CG- and DAF-generated issues – aimed at understanding how they are symptoms of underlying health system issues – could be limiting government engagement (see sections 3.1.3 and 3.2.1). Examples of this include district government being unable to address a long list of issues because of financing constraints and level of responsibility and PAF members questioning the policy relevance – due to lack of analysis – of the issues that are presented in the PAF.

There are also social norms around health-seeking behaviour and expectations about health services, such as high levels of medication and use of medical technology, which are unrealistic for the health service and can be harmful. The programme has not done enough analysis of this information or adaption in order to best approach and integrate these issues.

The design of this programme followed the theory and evidence documented by Jonathan Fox (see Guillán, Fox and Aceron, 2016), and the implementation has demonstrated good practice in line with Fox and other international practice and evidence. However, application has been partial and needs to be developed further to respond to broader and up-to-date evidence.

One of the main drawbacks of this programme is that it has been designed as a stand-alone voice and accountability programme with little connection to the other technical assistance components funded by DFID (TRF and Roadmap). This means that the important links between supply side and demand side in terms of health awareness and enhancement of health-seeking behaviour are unable to be coherent in this programme. This also means that a focus on health systems strengthening is not apparent. The ToC does not explore the connection with supply-side components and the health system nor some of the more complex interrelated change that happens in this kind of programme. For example, the role that empowerment, gender equality, and inclusion plays both as an enabler and how it interacts with power and social structure needs further attention.

5.1 Expectations of health services and quality of care (Q1, Q3)

The type of services demanded by the CGs are influenced by problematic social norms and expectations of quality care, and this in turn is affecting government responsiveness and health-seeking behaviour. It is possible that quack doctors, private providers, and health staff are influencing beliefs about what is needed in a health service and what constitutes quality of care. There is evidence that BHU staff invite patients to their private practice and encourage expensive or unnecessary interventions. A lack of registration and quality control of private providers is also driving some of this bad practice. Because these issues have not been analysed within the programme or discussed with TRF, the Health Roadmap, or government, the programme has not been adequately adapted to respond to these kinds of community-level and systemic issues.
EVA-BHN received a recommendation from the mid-term review to produce behaviour change communications (BCC) material and to engage with communities directly through the CGs. The programme does work at linking the CGs with LHWs and with the provincial departments of health. However, as the programme was not originally set up to address the intersection between accountability and health-seeking behaviour, EVA-BHN is not necessarily the right place to do this work. Also, it is the responsibility of the health system to engage through health professionals with communities. Both TRF and the Roadmap have a role to play with this work and with the production of BCC material for use by health workers. Also, mass communications do not necessarily target media that can reach the lowest income or remote communities, who might be more likely to listen to radio (data shows that that around 20%–30% of people listen to radio).

**Recommendation 1:** Ensure that the approach considers and influences community health-seeking social norms, knowledge of the health system, and quality of care to ensure demands and accountability support a good quality, value-for-money health service.

**R1.1 Immediate recommendations for the remaining time of the EVA-BHN programme:**

- Pilot an approach in, for example, two districts to build CGs and citizen capacity for a much more in-depth understanding of good quality health services and the regulations and challenges of the health system. This can be done by engaging with policy makers and BHU staff, study visits, and CSO trainers. Use the learning from this pilot to inform future programming.

- Engage with BHUs and the LHW programme on how CGs can support community social norm change for health-seeking behaviour, responsibility, and self-care (especially around SRH and related rights). Use and influence government BCC tools and methods.

- Engage more with health facility and community-based health staff (e.g. LHWs) in the health rights training (e.g. the CG refresher training and any new CGs that are formed).

- Trial approaches to collective problem-solving (such as in the Health and Nutrition Innovation Fund (HANIF) project on score cards).

- Raise wider population awareness of the Right to Public Services Act 2014 and the Right to Information Act 2013 through existing relationships with journalists and religious leaders.

**R1.2 Recommendations for future programming**

- At the beginning of the programme ensure there is a full and participatory assessment of gender inequality and social exclusion at the community level and of health-seeking behaviour and social expectations around health services. This could include, for example, research to understand which families are experiencing the highest level of newborn, infant, and child deaths. The assessment needs to be owned by government and the communities.

- Support government to establish a reliable registration, accreditation, and quality system for health personnel, BHUs, and private health providers that can also be checked and verified by CGs. This would include assessing the BHUs against defined standards and could help with the expectations issues. It could also ensure that quality of care is supervised within the health system.

- Ensure appropriate media channels are used for reaching low-income and hard-to-reach groups (e.g. radio).
5.2 Systemic vs. symptomatic – nature of demands (Q1, Q2, Q6)

Many of the resolved issues are symptoms of a wider health system and systemic problem, which are not necessarily engaged with or resolved. There was a recognised lack of capacity and knowledge of the health system at the DAF and CG level. This means that there is limited capacity to analyse, interpret, and present the data coming from CGs so that it is policy relevant. Some issues raised by the CGs are symptoms of more systemic root causes and yet there has been no analysis of what these might be nor how to engage with government. This situation is frustrating for public sector officials and might jeopardise ongoing citizen–state engagement and dialogue. The technical assistance part of PHNP is not sufficiently coordinated or linked up to enable and support the kind of analysis and discussion that is required.

Recommendation 2: Develop the accountability system, and work with partners (including the TRF), so that it includes stages to analyse systemic and health system issues beyond the symptoms so that district- and province-level demands are useful and appropriate and so that government has useful information it can act on.

R2.1 Immediate recommendations for the remaining time of the EVA-BHN programme:

- Engage more with CSOs and government at the district and province level to understand the root causes of a small sample of issues (that might be symptoms of wider systemic health system issues – for example, issues picked up in this assessment such as access to family planning, access to medicines, referral systems and communications, human resources for health (HRH) in rural and hard-to-reach areas, etc.). Use government-led research (in partnership with TRF+) if necessary and in KP engage with Health Sector Reform Unit (HSRU).
- Design a scale-up strategy by the end of the programme that includes action to engage with all the districts in each province and with the different levels of the health system.
- Ensure that CGs and DAFs engage with the changes in the LHW programme – e.g. the evaluation in Punjab (can CGs feed in?) and the expansion in KP (can CGs help facilitate and support?). The aim should be to ensure accountability of government’s promises regarding health outreach, and good implementation of the LHW programme.

R2.2 Recommendations for future programming

- Design a programme that explicitly links the supply side, demand side and accountability technical assistance elements so that HSS is part of the whole programme and so that the elements work together as one programme. This should also include the referral and THQ and DHQ parts of the health system.
- Ensure that an HSS and universal health coverage approach (as is explicit in DFID policy) guides the programme and that there is sufficient expertise in teams to cover the demand side, accountability and supply side.
- Consider focusing on some of the health and health system issues picked up in this assessment:
  - Referral systems in relation to gender issues, social norms around health-seeking behaviour, and expectations of the health service (for example, is it better value for money for women to receive all services near their home, or to engage with issues of security and the social norms around mobility so that they are referred to and can reach the THQ and DHQ hospitals for certain services? What other forms of transport can be mobilised beyond ambulances for non-urgent referral?)
  - HRH in hard-to-reach and rural areas – socioeconomic issues around access to health training and women’s access to education to become nurses, midwives, and doctors. This
is particularly pertinent in KP where a government commitment should see deployment of larger numbers of health workers in the next few years.

- Supportive supervision and management of health workers within the health system engaging with community structures (e.g. CGs) and feedback to ensure health workers are well supported and supervised to provide quality of care.
- SRH and related rights – providing appropriate spaces and channels for women to collectively discuss SRH issues, and raise demands for better services.
- Access to medicines and supplies at all levels of the health system. This may need the programme to engage more specifically with the issue of corruption.
- Certification or accreditation for private sector health care providers. This should include a system for quality assurance and widespread communications to service users to ensure non-accredited providers are shut down.

5.3 Strategic level support and networks (Q8, Q9)

There is limited external technical input for strategic analysis and planning, which limits the diversity of input and legitimacy of the programme. There are a range of organisations involved in each of the DAFs, although many of them have only participated once or twice. All DAF and PAF participants are volunteers and so do not have any funds for providing further input from their technical perspective, nor are they strategically invited to do so. There does not appear to be any strong HSS expertise in the DAFs or PAFs, although WHO and UNFPA are members of the PAF and provide an important perspective that needs to be considered. There also did not appear to be any international HSS expertise involved with the programme, which has staff with a predominance of general governance expertise but who do not necessarily understand the health sector. While the national team has good HSS knowledge, the governance-heavy agenda is driven by international team members. The limited engagement with TRF and the Roadmap compounds this situation.

Recommendation 3: Form a strategic Technical Advisory Group (or Steering Committee) of external national and international experts for regular input and feedback, as well as for building a perception of legitimacy.

R3.1 Immediate recommendations for the remaining time of the EVA-BHN programme:

- Hold at least one small national meeting with the two provincial governments, the federal government, and key national and international experts to discuss the programme’s approach and effectiveness. This would be like a critical review with the aim of building national ownership and developing the methodology further, including mutual learning from government initiatives such as the Health Roadmap M&E and IMU monitoring work. Ensure that influential women and feminist groups are part of the meeting. Include at least one governance/accountability and one HSS expert with international experience of good practice.
- Use the meeting to identify who might be interested in engaging with future programmes around accountability and health sector responsiveness.

R3.2 Recommendations for future programming

- Ensure that a strategic Technical Advisory Group is established at the beginning of the programme. This group should include government experts from the federal and province levels, national CSO and/or academic expertise, women’s groups or movements, HSS expertise, and governance and accountability expertise.
Ideally, the members of the Advisory Group would participate in programme research and monitoring visits to gain first-hand experience of the programme and enable informed participation. They could also be part of ongoing technical assistance input teams for specific pieces of the work over the medium to long term. This would be better than having individuals who are inexperienced in the Pakistani context and who fly in and out.

5.4 Working with civil society and other partners – getting things done (Q8, Q9)

EVA-BHN appears to conduct training of CGs and DAFs directly and has conducted direct advocacy with the provincial governments and assemblies, rather than enabling others to do this work. There is limited engagement with partners and civil society to implement activities such as high-level advocacy, training, engaging with government officials and promoting responsiveness (TRF+ and Health Roadmap). This means that EVA-BHN has not drawn sufficiently on the significant expertise and experience in Pakistan, nor has it built sustainable capacity to continue the work of EVA-BHN far into the future.

Recommendation 4: Work with national organisations and partners (including government) to deliver parts of the programme, such as training of CGs, doing analysis of health systems and root causes, province-level advocacy, and building government capability and commitment to respond.

R4.1 Immediate recommendations for the remaining time of the EVA-BHN programme:

- Improve partnerships with other programmes, government, and CSOs. Given the limited remaining life of the programme, this needs to focus in the first place on engaging with TRF+ in a meaningful way and continuing to work closely with the Sub-National Governance (SNG) programme, especially in KP where blockages in financial flows are a serious barrier to progress. TRF+ in particular is well-placed to support EVA-BHN integrate health systems and root cause analysis into its work.
- Community-level partnerships with Health Councils have begun and these need to be encouraged and institutionalised. This will also need to happen if the PCMC is implemented in KP. The DCCs could be encouraged to undertake cross learning between districts so that further districts also consider setting up DCCs.
- Learning from HANIF projects needs to be fed into the programme approach and at the very least reported together for programme learning. Any remaining HANIF funding should be directed toward research for the programme.
- Engage with feminist architecture (e.g. women’s groups and the Commission for the Status of Women, which is an important actor holding government to account on issues around women’s health and rights).

R4.2 Recommendations for future programming

- HANIF or a new type of fund would better serve the whole PHNP programme if it were more strategic and fed learning and evidence back into the programme. For example, it could be used for research on social and gender-related barriers to voice and accountability and to health-seeking behaviour at the beginning of the programme. It could also be used to strategically engage with CSOs and to fund some of the HSS and root case analysis that is required as further input for advocacy.
• Link any health governance work directly into other governance work and ensure there is no duplication and confusion around roles in the districts and UCs (in particular, AAWAZ needs to be better linked in with the health programming).
• Encourage and support partnerships and networks for coalition building and advocacy and ensure higher-level advocacy goes through these organisations rather than directly from the programme.
• Develop a model that government can either invest in or easily engage with, including spaces in which citizens are invited by government and institutionalised. Link up with government’s own systems for monitoring health facilities and existing CGs.

5.5 Gender and social inclusion (Q7)

Gender equality and social inclusion is an important part of the programme and good steps have been taken to address inequalities and ensure inclusion. However, the approach is not transformational, has had limited impact on power relations to date, and is not systematic or embedded enough. The socioeconomic survey, the CBM and CG process, for example, are measuring or getting feedback only from the people who visit the BHU and/or are in the CGs. It is clear, however, that there are people in harder-to-reach areas who are not using the BHU health services, and these may well be the people who experience some of the most severe health problems. There is no way of systematically getting feedback from people who are unable to access the services for a number of reasons. There is now a move to have CG meetings take place in some areas that are more marginalised. However, with no specific work with people in those areas to build their confidence and capacity to participate, there may be some limitations to the feedback that is consequently received by the CGs.

The programme’s key strategy responding to gender and inclusion issues has been to develop various measures to support the representation of women and excluded groups in the CGs. While this aspect is included in the ToC, a full understanding of women’s empowerment, gender equality, and social inclusion is not articulated or described there. Moreover, although there is evidence of improvements in women’s self-confidence and leadership skills, there is limited understanding within the programme of the kinds of targeted measures that are needed to enhance the ability of excluded groups to exercise voice.

Recommendation 5: Improve the gender equality, social inclusion and conflict prevention analysis, and mainstreaming throughout the programme.

R5.1 Immediate recommendations for the remaining time of the EVA-BHN programme:

• Explore targeted measures to develop women’s and excluded groups’ capacity to participate in CGs, DAFs, and PAFs, which could include specific empowerment and communications training and awareness raising within the CGs about social exclusion and gender.
• Consider single sex groups in one or two UCs in Punjab to see if such a change makes a difference to women’s participation and confidence, as well as monitoring whether the issues raised by the separate groups are any different to those raised by the mixed groups. Use learning from the functioning of the women-only groups in KP on how they have built women’s agency and interacted with other conservative, often male-dominated social structures. This learning can also be used for understanding dynamics associated with the inclusion of vulnerable groups.
• Ensure power analysis and PEA continue to incorporate updates on conflict awareness, HSS issues, and advice on the ‘do no harm’ approach. This needs to include assessment of an antagonism that has emerged between communities and district governments as a result of the
CG requests. District-level power analysis is an appropriate place to explore the health systems and systemic problems that are underlying some of the issues.

- EVA-BHN should undertake some qualitative monitoring with CG members to understand and learn more deeply the experiences of different social groups in engaging with the CGs.

R5.2 Recommendations for future programming

- Establish gender equality and women’s empowerment as one of the key enablers of health-seeking behaviour and design the programme accordingly to address key demand-side and social norms issues.

- Build a more transformative process of women’s empowerment, integrating more targeted measures that are underpinned by an understanding of how gender inequality affects women’s access to quality and RMNCH-N services, as well as their ability to exercise voice and demand accountability. This includes building their personal confidence, developing a vision of what leadership looks like, strengthening communication, negotiation, and networking skills, and generating strategies for navigating male-dominated participatory spaces and processes, as well as managing issues such as mobility restrictions, violence against women and girls, and women’s lack of visibility in the public space.

- Develop a better understanding of the multiple issues around gender inequality and social exclusion related to health-seeking behaviour and expectations about health services (e.g. women’s mobility and access to levels of health services). This could involve engaging with the EVA-BHN CGs when doing the necessary research.

- Ensure that all baselines and research for the programme is done on the basis of household surveys and qualitative data collection (mixed methods) that cover both users and non-users of the health services (including marginalised and hard-to-reach people who are not accessing the services).

- Ensure demand-side work is well connected to the health system either through LHWs or in coordination with BHUs. Consider demand-side initiatives that address specific barriers (e.g. community solidarity funds, which can provide loans or grants to poorer households to pay for transport, services, or medicines, and to compensate for opportunity costs). Making it easier for women and excluded groups to access higher-level facilities could reduce their reliance on untrained quack providers, and address the current unrealistic demands for all services at the doorstep.

5.6 Conclusions and recommendations on MEL (Q4)

The MIS data is excellent quality and is an important monitoring tool and input for programme effectiveness. However, the programme lacks other strategic data collection that would have enabled measurement of outcomes and impact, as well as progress against the ToC. The MIS is well integrated into CG and learning processes and is also used for reporting. A few of the limitations can easily be corrected, but it is difficult to use the MIS data as the only evidence for change. Other data collection has been focused only on the positive aspects of the programme (so not exploring the challenges and complexity of the programme) or responding to ad hoc requests from DFID. Thus, the combined data does not necessarily add to the programme learning or provide accountability to DFID (or at least it is not possible to see how this has been done from the documentation).

Recommendations 6: Design research and data collection so that it can be used more strategically for programme learning and adaption. Improve MIS inputs and processes to ensure data quality.
R6.1 Immediate recommendations for the remaining time of the EVA-BHN programme:

- Use the data collected during the second KAP survey to better understand how and why change has happened, to understand empowerment more thoroughly, and to explain some of the complexity, by using a qualitative study and a mixed-methods approach to analysis.

- Improve the quantitative survey by adding more rigour to the sampling methodology by providing a rationale for key assumptions used for sample size calculations and providing details of weighting criteria. Also, improve the questionnaires by using questions and answer options that have been validated in Pakistan’s context in other surveys (e.g. the DHS). Further, document, archive, and publicly share data sets, while also being mindful of data protection, to facilitate access and re-use of data, allow replication of data analysis, enhance transparency, and facilitate assessment of the quality of data.

- EVA-BHN is in the process of adapting the ToC and the RME plan. This should include:
  - A review of the RME plan and indicators which takes into account the feasibility of planned data collection across all indicators. The current version is too ‘ambitious’ in terms of data collection and does not fully explain the data sources required for monitoring.
  - The ToC would benefit from greater elucidation of the connection between the short-term and behaviour change levels, with a more complex and nuanced approach to understanding how the setting up of groups and the opportunities to engage can result in behaviour change by government and communities. There also needs to be some understanding of how TRF+ interacts in this level of change.
  - The ToC would also benefit from inclusion of power, gender equality, and social inclusion issues at all levels. It would also benefit from expanding the capacity, opportunity, and motivation change level to include aspects of trust and legitimacy as essential parts of the change process, and how they feed into and feed off the other aspects of the ToC (these may be at slightly different levels and this complexity needs to be reflected).
  - Better explanation of the role of religious leaders and the education entertainment and TV parts of the programme is needed in the ToC as it is not clear how they are contributing to the empowerment, voice, and accountability agenda. As this is more part of promoting a change in overall social norms and the enabling environment for EVA-BHN, it needs to be articulated as such within the ToC. The press and journalist elements are clearer. There also needs to be a better measure of effectiveness of the media and religious leaders components.
Include the interaction with civil society and social movements in the ToC.

- EVA-BHN continuously updates MIS to respond to strengthen data collection and quality. As part of this ongoing adjustment, we recommend the following to further improve the quality of the data and enable better management.
  - Reduce the number of additional fields that project officers have to fill out in the MIS system without the use of proper data collection forms. For instance, variables such as the impact level of the issue and the mandated level of issue resolution complicate data management without adding much value to the analysis.
  - All new issues that arise in group meetings should be compared against previous resolved issues before being tagged as ‘new’. A new field should be added to the MIS to track issues that recur after being temporarily resolved. If an issue gets raised again after being temporarily resolved, then the status of the issue should be changed to ‘recurring’ from ‘resolved’.
  - Ensure there is an accurate system for checking duplicate resolved issues reported in both the CG and the DAF so they do not get double counted when reporting the total resolved issues.
  - Develop training manuals and protocols for CBM checklists and interviews, MIS data entry, and calculation of indicators from the live data provided by the MIS.
  - Develop structured data entry forms for DAF and PAF to facilitate MIS data entry and data quality cross-checks.
  - Ensure that data protection standards (i.e. national- and province-level laws and protocols and international protocols) are carefully adhered to and that the appropriate secure storage is in place for all personal data.
  - Consider conducting qualitative data collection for a sample of issues every quarter to provide the story and the nuances around issue resolution. This will help with CG and programme learning. This information will also feed into a better understanding of the root causes of some issues that might have a need for more systemic solutions (see also recommendations 1 and 2).

- Review the definition of Outcome Indicator 2.1 to differentiate between outreach, overall participation rate, and specific number of individuals reached. Currently, the RME system reports on total attendance across all meetings rather than individuals. It would also be important to differentiate between those reached in CGs and those reached by other means as the type of interaction is very different and has different objectives. It might be useful to split this into two indicators.

- Apply learnings from the RCA study, previous reviews and the findings from this assessment health-seeking behaviour and social expectations about health services and quality of care to strengthening the programme.

R6.2 Recommendations for future programming

- Design a mixed-method independent evaluation alongside the programme design. A theory-based evaluation would have been appropriate for the current programme and could have been implemented for TRF, Health Roadmap and EVA-BHN together.

- Areas of inquiry could include:
  - EVA-BHN could empirically account not only for its outcomes but also the incentives and motivations needed to mobilise persons with comparatively less agency and capital to participate not only in its programme activities but also to harness voice and accountability mechanisms to make demands and seek change. By relation, in landscaping the settings and forces supportive of demand-making and change seeking, EVA-BHN could identify
additional opportunities for its voice and accountability mechanisms to be refined to better suit the realities of the contexts, populations, and systems with which it works.

- Identification and rigorous exploration of the processes, factors, and variables that EVA-BHN and/or its community participants and health system partners identify as evidence of the programme’s successes. Also, identification and exploration of the observed and perceived short- and long-term sustainability of the same. For example, which of EVA-BHN’s voice and accountability mechanisms is considered most likely to outlast the programme and become integrated into the ways communities, duty-bearers, and health system personnel and officials respond to health system neglects and gaps?
Bibliography

Literature review


Fox, J. (2016) Scaling accountability through vertically integrated civil society policy monitoring and accountability (Working Paper # 133), Brighton: IDS.


Molyneux et al. (2014) Community accountability at peripheral health facilities: a review of the empirical literature, Health Policy Plan 27 (7), pp. 541-54


Programme documentation, data, and research reports

Pending
Annex B  

Assessment methodology

B.1 From the Approach paper

Phase I: Literature review and finalisation of methodology

(i) Review of key documents, existing data, data collection methodology (including tools, questionnaires, and analysis methods) and any ongoing data collection. Key questions for this activity:

- Is there sufficient data from a range of methods (considering a mixed-methods approach) being collected to answer the assessment questions? Has data been collected on changes at individual, collective, institutional and system levels and is it output or outcome level?
- What gaps are there, if any, in terms of data types and methodology?
- How relevant and useful is EVA-BHN’s M&E framework and indicators? Is there a ToC or other framework to which the M&E are relating?
- Was a PEA conducted at baseline?
- To what extent can the quality and credibility of the data be assessed from the documentation and what further interviews will be needed to assess the quality and credibility of the data?
- How independent is the data collection and reporting?
- What is the quality of reports in terms of logic, thorough analysis, clarity of expression, readability and presentation?
- Is gender and social inclusion considered in an integrated way throughout the data collection methods and reporting?
- What evidence is there that the data is being used for reflection and making adaptive changes to implementation?
- What evidence is there for each of the assessment questions (above)? An analysis table in Excel will be developed for collecting evidence against each question for further analysis once the visit has been conducted.

The documents and data sets to be reviewed would include:

- Baseline KAP surveys
- Analyses of socioeconomic status of health facility users as well as project beneficiaries
- RCA
- Tracer studies
- ToC bi-annual reviews
- Case studies
- Critical review paper

(ii) Design of Phase II methodology

It is likely that the main data required for Phase II is qualitative data, which can be organised within the timeframe. The process for designing the Phase II methodology will include:

- Remote interviews with DFID key staff on the perception of need for data collection and what the information will be used for and by who.
- EVA-BHN team leader interview
• EVA-BHN M&E team
• Consolidation of evidence from the literature review
• Team consultation
• Review of international methods and evidence for similar programmes

Phase I will be conducted by the Georgia, Seema and Bilal, with a small input from the senior quality assurance advisers in terms of international evidence and research methods.

**Outputs of Phase I:**

• Initial analysis and recommendations on the MEL programme
• Phase II methodology, tools, visit schedule

**Phase II: Programme visit**

The main purpose of the Phase II data collection is:

• Verification of data already being collecting within the programme
• Primary qualitative data collection to answer the assessment questions

It is likely that qualitative data collection will take place in two districts in rural and peri-urban locations for reaching communities, and in the two province capitals for reaching government departments and other provincial-level stakeholders. Qualitative data is needed to understand the context-specific political realities, levels of citizen agency, and understandings of politics and citizen engagement and state responsiveness in the different areas the project operates in.

The visit will aim to conduct approximately 10 focus groups as well as interviews where appropriate with relevant stakeholders in government, communities, health facilities and in other relevant institutions depending on the project activities (see sample section below). All FGDs will use a participatory methodology that should enable participant led and exploratory discussion. This normally enables a more realistic assessment of attitudes and behaviours that is not interviewer-led. Community focus groups will be split by gender and possibly by age if appropriate.

Indicative schedule for the visit:
The Assessment Team will ensure independence by conducting all FGDs and interviews without participation from the EVA-BHN team. However, the team will ensure sensitivity to the EVA-BHN team members’ relationships with stakeholders and ensure that each interview and FGD is empowering and inclusive in approach.

Assessment questions

The assessment questions required by the Terms of Reference are here broken down into further interest areas to demonstrate how each question will be explored. These will be finalised when Phase I of the Assessment has been completed. (Note that some of the questions have been merged).

(i) The extent to which EVA-BHN interventions are contributing toward bringing changes in state responsiveness that are leading to improvements in health service delivery in its intervention districts including changes in policies and practices of the health department and attitudes of health officials; AND The effectiveness of periodic interactions between citizens and public officials through EVA-BHN supported forums such as district and provincial advocacy forums

- What changes have government made to health service delivery as a result of EVA-BHN activities and initiatives?
- How transparent is government information – do they respond to requests for information from citizens supported by EVA-BHN?
- How relevant is the work? What evidence is there that EVA-BHN’s activities have been based on an effort to understand the interests and incentives of the relevant stakeholders and local powerholders and potential spoilers? Do the targeted stakeholders have the authority and capacity to make the demanded changes happen?
- What mechanisms and processes are in place within government to respond to citizen engagement and social accountability and are these functional?
- What evidence is there of an improvement of health service delivery as a result of EVA-BHN activities and initiatives and how is this assessed by communities?

(ii) Evidence of increases in citizens’ capacity to drive changes in the way primary healthcare services are delivered
• What evidence is there of improvements in communications and engagement capacity among citizens? What methods has EVA-BHN used to contribute to this?
• Who are the citizens who are engaging with the programme and with accountability mechanisms in terms of class, income levels, gender, ethnic and religious differences?
• How have citizens organised themselves to hold government to account and how has the programme empowered and strengthened these movements?
• What mechanisms and strategies are citizen groups using for raising, tracking, escalating and following up issues at local and district levels?
• To what extent have women and marginalised groups been represented and functional within group and collective action? How has EVA-BHN supported them to engage with elites, and what measures have been taken to protect them from backlash?
• How are these groups and processes addressing issues of poverty, limited literacy and mobility, conflict and insecurity and restrictive social and gender norms?
• To what extent has EVA-BHN’s approach either worked with or challenged existing power and political structures?

(iii) To the extent possible, changes in health-seeking behaviour of the population in target districts; AND Additionality achieved through EVA-BHN interventions at district and provincial levels – what changes have occurred that would not have occurred without EVA-BHN.

• In comparison to non-intervention UCs (where data is available), what evidence is there of increases in service utilisation for key services (e.g. vaccination rates, antenatal care, family planning, other child health interventions such as OR, antibiotics)?
• In comparison to non-intervention UCs, what evidence is there of changes in social norms and behaviour around health facility access or community-based service utilisation (this will only be possible if there is enough time for data collection in a non-intervention district or existing good quality data)?

(iv) Primary and secondary effects on final beneficiaries that result from EVA-BHN’s interventions and the direct and indirect causal contribution of these interventions to those effects – including spill-over effects of empowering citizens such as work on education, women’s empowerment and elections, etc.

• Evidence of empowerment – increase in confidence and engagement, especially among youth and women
• Evidence of decrease in women experiencing early and forced marriage and evidence of an increase in school attendance and social norms around school attendance for girls
• Evidence of changes in political participation and economic engagement among women and youth
• Evidence of changes in health expenditure (increases and decreases) by citizens, districts and province

(v) What partnerships has EVA-BHN forged with media, elected representatives, religious leaders, non-traditional civil society, Healthcare Commissions, RTI etc. for amplifying citizens’ voice?

(vi) What evidence is there that EVA-BHN’s work has become institutionalised, e.g. journalists training, Entertainment Education curriculum, Patient’s Right Charter, Health Caucus, etc.?

(vii) Quality and credibility of the data EVA-BHN collects to measure and record change as a result of its interventions –
What evidence is there to verify the key data that EVA-BHN is collecting? and
Is EVA-BHN data and research well respected and considered legitimate by key stakeholders and partners?

Interview and FGD samples

The sample size and type will be finalised during Phase I. The following is an indicative plan of the data collection samples:

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<tr>
<th>Target sample</th>
<th>Number</th>
<th>Method</th>
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<tbody>
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<td>Women in communities</td>
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<td>Men in communities</td>
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<tr>
<td>Other relevant programmes or donors</td>
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<td>interviews</td>
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Design and communications

It is proposed that design and communications will be supported by a professional editor and designer so that info-graphics and useful communications tools can be maximised in the final report. We also propose the use of an illustrator in the final team analysis workshop to record some of the key points in an engaging visual format. An example of his illustrations is shown here (used in the DFID Health Partnership Scheme Evaluation).

Notes on the methodology

The methodology for the visit has been revised and further focused given the information available in the MEL system and the studies that have been done so far by the EVA-BHN team. The country visit and field work will be focused on:
Understanding the programme and all of the interventions fully and how the approach is contributing to change;

Exploring a sample of ‘issues’ that have been raised by CGs in not more than four UCs (in Lahore, Sahiwal, Peshawar and Nowshera); and

Through the sample of issues the functionality of the EVA-BHN system will be explored in line with the assessment questions.

The community groups will be chosen from UCs where the CGs have been in operation the longest since either 2014 or 2015. The UCs should also have one of the following characteristics:

i. a CG that has been built on an existing community engagement or voice and accountability structure or group;

ii. a CG that EVA-BHN developed from the beginning (in a community where there were no suitable community engagement structures already existing);

iii. a well-functioning CG; and

iv. a CG that is either dysfunctional or has discontinued.

Eight focus groups will be conducted in the communities – two in each community, with a possibility of additional focus groups with health providers and/or CSO representatives. All FGDs will use a participatory methodology that should enable participant-led and exploratory discussion. This normally enables a more realistic assessment of attitudes and behaviours that is not interviewer-led. Community focus groups will be split by gender and possibly by age if appropriate.

Interviews will also be conducted with media, elected representatives, religious leaders, non-traditional civil society, CSOs who have not been involved in the programme and healthcare commissions to understand the partnerships and attitudes to the programme approach.

Through the visit and further data quality assurance there will be an analysis of the relevance and usefulness of the data for learning, and some recommendations for evaluation-relevant data collection.
## Framework for analysing the data from the Learning Review

<table>
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<th>District state responsiveness</th>
<th>Health facilities – quality and responsiveness</th>
<th>CGs, DAFs, citizen action</th>
<th>Media</th>
<th>Parliamentarians and political parties</th>
<th>Other actors, e.g. CSOs</th>
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B.2 From the *Phase I report*

What we have learned so far from programme data

There is no collated clear and detailed description of the programme, exploring details of implementation and learning so far. While there are some case studies – one set called tracer studies and one called case studies – they either describe specific aspects of the programme or follow three issue examples and their resolution. They give examples of changes, and some evidence towards the ToC, but are not necessarily rigorous enough. They do not give a critique or overview of the programme. There is also limited information about the methodology, so further exploration of this will be required during the visit.

The KAP survey has only had one data collection round in 2017, so there is no baseline to compare it with. However, the next data collection round should give some interesting results – although not soon enough to consider in this review. There are also limited questions or analysis that explore how poverty, social exclusion and gender inequality interact with the health service utilisation, knowledge and health-seeking behaviour. There would be a need to complement the KAP survey with some coordinated qualitative data collection to understand more fully some of the barriers and the specific contexts that affect women’s service utilisation and also more detail of attitudes and behaviour change. In addition, we need more information about the socioeconomic survey to assess how useful it has been to guide the programme in addressing exclusion and inequality.

While the RCA is an interesting piece of qualitative research, it does not appear to touch on the issue of voice and accountability, nor explore how and who is involved in the CGs and DAFs etc, and whether there is any awareness of the programme.

There is limited data on how EVA-BHN interacts with TRF and the Health Roadmap and how government responsiveness is supported. The visit will explore how this happens and whether EVA-BHN can be held responsible at all for government responsiveness given the design of the overall programme. Also, EVA-BHN appears to only be addressing the supply-side barriers to accessing services, and there does not appear to be any analysis of or acknowledgement of the demand-side barriers to access. There does not appear to be a demand-side element to the overall PNHP programme, unless TRF is working on this. This is also something we need to explore further.

EVA-BHN appear to have a good relationship with the KP RTS and IMU, but we don’t know whether the EVA-BHN activities are additional to what the KP government was doing anyway – and how much EVA-BHN has added to the success of these institutions. Nor do we know yet whether there were any existing voice and accountability approaches in the communities and districts where EVA-BHN is active. There is limited information, in the EVA-BHN documents made available, about the relationship between EVA-BHN and the Punjab government.

Data about community demands and responsiveness of the health services and government appear to come entirely from the issues that have been raised by CGs. We are exploring this data further to understand how success is defined in terms of issues raised, dropped and resolved, and whether we can conclude anything about state responsiveness from this data.

It is clear that all of the data collected by the EVA-BHN programme is not independent and nor was it designed to be (as there was originally going to be an independent evaluation). This means that verification is important, but there is a limit to the amount of data that can be verified with this review.
Issues that we would like to explore further – and framework

Because of the complexity of this programme we have decided to focus more on some key topics, rather than try and cover everything. However, other issues will come into the review as part of these topics. Here we present the issues that we think are relevant the key programme questions we have about these currently. Below there is a draft framework, which we might use for analysis.

Key topics for exploration:

(i) Systemic or symptomatic issues in the health system and service delivery

- How are the issues analysed and prioritised?
- To what extent are issues and complaints understood in terms of the root causes and the health system problems that underlie the issues? Does the programme work with these at all – or are they analysed by TRF?
- How does the accountability system work for contracted out services?
- Has EVA-BHN done any analysis of or addressed any demand-side barriers to health-seeking behaviour and access to health services (beyond the analysis done for the KAP survey)?

(ii) Extent to which the programme is connecting with and between CSOs and wider coalitions

- How were CSOs selected, or how did they become involved with the EVA-BHN process?
- What are their incentives for involvement?
- Do the CSOs and other actors feel ownership of EVA-BHN’s approach?
- How is EVA-BHN facilitating them to connect with one another and to what end?
- Is EVA-BHN building their capacities to build relationships with one another, bring together data and act collectively?

(iii) State responsiveness

- How does the programme interact with and work together with TRF, Roadmap and government?
- How does EVA-BHN interact with legitimate and sustainable structures and mechanisms for vertical accountability, for example parliaments, assemblies, ombudsmen, etc.
- How do governments interact with community representatives? How do they engage with community-generated complaints and evidence? Do they consider this credible?
- What happens to issues after they’ve been discussed at PAF? Does EVA-BHN support follow-up advocacy? What role does EVA-BHN play in high-level advocacy? What is EVA-BHN doing to support the capacity of others to do this?
- How does EVA-BHN support responsiveness? Does EVA-BHN facilitate analysis of the incentives and motivations for government providers to act? Has EVA-BHN analysed the sector and the issues in this way?
- Does EVA-BHN provide training to government officials to support their ability to respond? Who are the government officials who attend the DAF and the PAF? What decision making power do they have?

(iv) Poverty, gender and social inclusion

- Women’s and excluded groups’ participation in CGs and DAF, PAFs and who is not included or listened to, how does voice work within the groups and meetings?
- Does the EVA-BHN approach take into account the incentives and motivations needed to mobilise individuals with comparatively less social agency and capital (e.g. degrees of marginality and social exclusion, such as gender and poverty)?
- How have stakeholders engaged with marginalised groups?
- How is EVA-BHN motivating men to mobilise on women’s health?
- Have stakeholders developed ways of talking about the issues for women and excluded groups to elite government officials?
- How does gender, social status or other affect the choice of ‘issues’ to be addressed and prioritisation?
- How inclusive or participatory are the CG and DAF processes?
- How is capacity built within CGs and communities?
- Is the programme building a culture of questioning?
- How is risk assessed and mitigated in the CG communities?
Annex C  International literature review, to support analysis of EVA-BHN

1. Objective and focus

This note is based on a very brief (two-day) review of international literature (mainly synthesis reports, written in the past 2–3 years) to update the existing knowledge of the team. The aim is to outline potential change processes within social accountability (SAcc) interventions – to help guide the EVA-BHN review fieldwork questions.

Since EVA-BHN has been guided by Johnathon Fox’s work on SAcc, I have provided a summary of his proposition / ToC (Section 2.1). Key points raised in wider literature are then organised by theme. This combines the proposed focus on ‘levels’ (community, facility, provincial) with a focus on relationships and intervention processes (such as the PAF).

Some questions which arise for the EVA-BHN assessment are highlighted in blue text.

A more detailed literature review may be useful. In the short time allocated to this review, I have tried to cover some key recent literature with a view to providing pointers for the research questions.

2. Literature review – potential change pathways (drawing on Jonathon Fox’s proposition for SAcc)

Fox’s work is widely quoted in recent literature, and has been an inspiration for the design of EVA-BHN. Based on an analysis of SAcc projects, Fox (2016) identifies an ‘accountability trap’: SAcc processes are often locally bounded. While many SAcc projects have some effect on relations between service providers and users, and improve some aspects of facility-level service delivery, they focus largely on the symptoms rather than the causes of accountability problems. The causes are often higher up in the chain of decision making and implementation. Fox found that the higher-impact SAcc projects were associated with:

- Coordinated tactics at multiple levels;
- Creating an enabling environment for collective action, to reduce perceived risk of SAcc (e.g. via policy that legitimises SAcc);
- Citizen voice coordinated with government reforms that bolster responsiveness (‘voice plus teeth’);
- Campaigns rather than interventions (iterative, contested uneven processes); and
- Strategies that take into account the possible reactions of both adversaries and allies.

Fox highlights some examples in which SAcc has successfully taken account of scale and used a strategic approach. This involves:

- Going beyond the local, to monitor the chain of decision making, non-decision making and implementation at various levels of the delivery of a public service; and tackling these challenges at each level. In the success stories highlighted, this has often been tightly focused on a particular issue (such as the supply of text books, or monitoring food distribution processes) to identify where the bottle-necks, corruption and policy failures are located. He

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9 Note: I have reviewed his recent work. However, some of his early work also promotes vertically integrated CS SAcc, which may have been the influence on EVA (e.g. Fox, J. (2001) ‘Vertically Integrated Policy Monitoring: A Tool for Civil Society Policy Advocacy’, Nonprofit and Voluntary Sector Quarterly 30.3: 616–627).
elaborates the challenge of ‘squeezing the balloon’ whereby (in reaction to civil society monitoring) government/power holders manoeuvre to relocate corruption to non-monitored locations in the chain. Multi-level monitoring both helps to highlight the systemic causes of accountability failures and to identify how the balloon is being squeezed – thus informing a new CS strategy and focus for monitoring and advocacy. Based on SAcc that was successful in influencing change beyond the local, he thus advocates for adaptive, problem-solving collective action. Fox argues for a distinction between such ‘strategic SAcc approaches’ and ‘tactics’ used at local level (such as citizen report cards).

- **Thoughts re EVA-BHN:** is EVA-BHN promoting monitoring and analysis at different levels, to uncover the systemic causes of particular problems (symptoms) identified at community level? Several EVA-BHN documents refer to issues being taken upwards to DAF and PAF only when they are not addressed at local level with service providers. While EVA-BHN undertakes PEA, is this focused on uncovering the systemic causes of particular problems, such as why medicines are unavailable, where the problems lie, and how to tackle this, including who to get on board? A more generalised PEA would arguably be less useful.

- **Vertical integration of civil society monitoring and advocacy.** Fox’s theory is centred on the need to coordinate civil society action across scale. This is conceived as a partnership between: (a) broad CS membership organisations monitoring service delivery at local level; and (b) professional CSOs who specialise in policy/budget monitoring – who pursue advocacy at higher levels; and (c) independent media to disseminate the findings and publicise the citizen action.

- In regard to local-level monitoring, his vision is for broad coverage monitoring of service delivery points by local organisations in different locations – so as to generate enough evidence and clout to influence public service decision makers. He also elaborates the need for CS horizontal integration (geographical and social inclusion) to generate linkages, collective identity, and an understanding of common problems across geography and social groups. This again supports the need for ‘civic muscle’, so as to impel government to listen and respond. When grassroots initiatives connect, he argues, they become visible and influential.

- **Thoughts re EVA-BHN:** Clearly EVA-BHN would need to be careful in regard to collective mobilisation. However, does EVA-BHN facilitate meetings between CGs from different communities, and does this generate a sense of collective identity around common concerns? What is the process through which different (and possibly divergent) local concerns are prioritised, and how are decisions made in regard to which issues are taken to a higher level? In practice, whose priorities are taken forward (inclusion/exclusion)? Is the EVA-BHN process generating a sense of civic pressure around particular issues, and is this a force in the process of responsiveness? Or how is ‘civic clout’ generated (through media work?) Do government actors and communities perceive EVA-BHN-facilitated CGs and community monitoring perceived as a legitimate voice for communities?

- **At higher levels** (district, provincial), Guilian et al. (2016) show through case studies that influence can be fostered if CSOs use aggregated data from communities as a basis for raising issues and influencing public sector decision makers. The aim of monitoring is to expose problems, to reframe public debate, identify ‘smoking guns’, to generate that ‘killer statistic’ that goes viral – thus to influence officials who are receptive to evidence. This requires that CSOs build skills for relationship-building (including to foster government allies), advocacy, communication, and coordination among CS groups.

- Many SAcc projects show that constructive approaches (such as platforms for dialogue with government) are effective at all levels (i.e. at local level with service providers, and at higher levels). Many successful projects fostered engagement based around mutual trust, and agreement that poor performance would be discussed privately with government, rather than made public through media. Yet successful SAcc also requires pressure from the outside, he
found, or the engaged public officials (allies) are left with the problem of how to promote change in complex systems imbued with power and hierarchy.

- Fox (2016) considers **media and social media** as a realm for amplifying citizen voice. Social media enables citizens to broaden the horizontal projection of voice – to each other. Communicating shared grievances, building collective identity and creating virtual communities helps to facilitate collective action: bringing many voices together, to increase the prospect of being heard. Yet this may not create the kinds of shared meanings required to turn disparate citizen concerns into a cohesive civic pressure; or the deliberative processes required to make the transition ‘from protest to proposal’. Fox thus suggests that social media (and public media) may be more relevant for projecting voice to put problems on public agendas than for the ‘next step’ of building constituencies for specific policy alternatives. This raises the question of what kinds of messages (via what mediums) are heard by key decision makers and those that may influence them.

- **Thoughts re EVA-BHN**: Who are the government officials that participate in PAF – are they decision makers, or low level? The EVA-BHN ‘critical review presentation’ notes that there is low retention in these forums (who are the people that attend only once – is it government actors or CSOs, media?) Is there commitment to the forums, who feels ownership of them, and how are they perceived? What happens after the dialogue at PAF – how are issues taken forwards and upwards, and is there a mechanism for this? Is the PAF linked into a particular policy, budget or decision making process in the sector? Is EVA-BHN or TRF responsible for building government capacity and systems to respond to CS voice? What has been done in this regard?

- Do government actors see the community monitoring evidence as credible and legitimate? Is it presented in a way that is both accessible and influential? Do officials attribute any particular service delivery or policy change to EVA-BHN data, initiatives or forums? Who feels ownership of the data? Has EVA-BHN built CSO capacity to aggregate and analyse the data. Is there a process for CS/community representatives to deliberate over the data and priorities? Is there attention to marginalisation and equity in this process, and what is the mechanism to ensure this?

- Several EVA-BHN documents suggest that EVA-BHN leads the high level advocacy. Why is this? Do CSOs lack capacity, and is EVA-BHN building it? What is the proposed pathway for sustainability?\(^1\)

- Fox notes the **challenges of vertical integration** – in regard to creating effective synergy between very different types of organisations (grassroots and professionalised CSOs). He notes that there may be stigma in defending the rights of excluded groups, trust issues, and CSOs may have more in common with government allies (educated, urban) than grassroots organisations. His case study analysis found that this can be overcome through interlocutors (Tembo, 2013), who foster mutual understanding of where other groups are coming from (a precondition for common ground) and safe spaces to nurture the voice of excluded groups (Fox is weak on how to foster inclusion). He found that collaboration requires agreement on how decisions are made, who speaks for whom, perceived legitimate representation, feedback and trust – so that all perceive the partnership as balanced and inclusive. In EVA-BHN, how do the various stakeholders perceive the collaboration? Is there trust, tension, a common understanding of goals? Do the CG reps that attend the DAF and PAF feed back to the community, and how are they held to account by the CG and wider community? Is this monitored?

\(^1\)In the CEP DFID project in Mozambique (somewhat similar to EVA) the programme is led by CSOs at provincial level, who undertake advocacy – which seems to be a stronger pathway to sustainability (albeit with challenges for CS politics and horizontal integration).
The notes below are from broader literature.

3. Impact and indicators

- Since SAcc processes are embedded in wider processes of change, and supply-side programmes, and it is difficult to determine attribution to SAcc per se (e-Pact, 2016). Impact evaluations principally focus on the more measurable impacts of social accountability on service delivery; and rarely cover outcomes on voice and empowerment, which are harder to capture or to attribute to a particular approach (Ayliffe et al., 2016). Outcomes may sometimes apparently worsen before they improve. Moreover, different contexts present different opportunities, entry points and potential pathways for social accountability.

4. Community level

- Nesbitt et al. (2017) facilitated an online consultation on SAcc with 37 practitioners from Pakistan, Bangladesh and India. Most projects start with awareness raising. They find that, in addition to building awareness of rights and entitlements, it is useful to build local awareness on policy structures and the way the state functions (Has EVA-BHN done this?) This involves/should lead to a ‘culture of questioning’, which is crucial to mobilise communities. Some programmes involve service providers in this process, to fill their own knowledge gap and to reduce the risk of tension from providers. How has EVA-BHN ensured that awareness raising reached women and marginalised social groups, and was accessible to them? Has this changed perceptions of themselves as rights holders, and of service providers as duty-bearers?

- Participation is affected by incentives and motivations. The South Asian practitioners noted that community members on health committees are motivated by social recognition of their work, as well as a sense of common identity and clear and reachable goals. Inhibitors include: fears of reprisal or social costs (particularly for women and marginalised groups) and the opportunity costs of engagement. (Nesbitt et al., 2017).

- e-Pact (2016) reviewed 50 SAcc projects. In regard to local-level service delivery, e-Pact found that a key driver of success is supporting invited engagement through village meetings and facility committees, often supported by skilled facilitators with close community links. Strengthening local networks helps to sustain and increase the impact of the dialogue. Dialogue was more focused and people more motivated when they had access to citizen-generated data that monitored service delivery and user satisfaction. In some cases, informal (uninvited) engagement (i.e. social campaigns or demonstrations) played a supporting role. e-Pact also found that supply-side resource and capacity constraints can limit or undermine the scope and sustainability of local-level SAcc.

- Inclusion: Community engagement processes need to navigate the reality of competing priorities, and the active exclusion of some groups (as EVA-BHN has found: see Kirk, 2017). Inclusion may be tokenistic. Nesbitt et al.’s (2017) analysis of the literature on SAcc in Pakistan, India and Bangladesh finds that, in addition to elite capture, committee selection may be biased towards members of the community already engaged in similar activities (Mahmud, 2007; 2009). Kirk (2017) notes that EVA-BHN has focused on existing community organisations: What is the baggage of these organisations, what norms shape their membership and the possibility of inclusion for new members, especially the marginalised? Do female CG members speak in meetings? Are they heard? What issues have they raised, and were these taken forward? What strategies has EVA-BHN used to promote an inclusive CG space?
• Safe spaces for **marginalised groups** have worked in various projects to promote inclusion.\(^{11}\)
For women, safe spaces can foster solidarity and collective consciousness, which helps to collectivise actions and strengthen their voice. In separate spaces for men, some practitioners from Pakistan/Bangladesh (cited in Nesbitt, 2017) engage men in discussion on gender, caste and class inequalities – before facilitating discussion about health service entitlements. They find that this helps to mediate the dynamics that affect women negatively and constrain their engagement and voice (the analysis did not explain how inter-group dialogue is successfully done). Some analyses point to the need to focus on issues that are particularly pertinent to marginalised and poorer groups, such as chronic undernutrition (Nisbett, 2017, citing others), to promote the inclusion of marginalised groups, and to prioritise their membership and needs over those of more dominant groups.

• Some CSOs in South Asia have used information technology (SMS, interactive voice recording and multimedia photos and videos) to engage community members, which they find promotes participation, especially of women. Such ICT enable anonymous voicing of issues, which side-steps the fear of reprisal. CSOs also argued that the use of ICT can increase the validity of the data in the eyes of government officials (South Asian practitioners, cited in Nisbett, 2017).

• **Risks:** Gaventa and Barrett’s (2010) review\(^{12}\) of 100 SAcc case studies found that, of 830 documented outcomes, 25% were labelled as negative; these included feelings of disempowerment, denial of access to state services, increased community conflict and violent reprisals against citizens. SAcc can create citizen expectations that the state is unable or unwilling to respond to, which can increase distrust of the state and apathy. SAcc can exacerbate existing power asymmetries and perpetuate perceptions of injustice among marginalised groups. This may close the space for citizen engagement instead of opening it. It can also run the risk of fragmenting communities, ultimately weakening their collective power. SAcc can also replace existing, perhaps more legitimate or sustainable, structures and mechanisms for accountability. The state may also respond to citizen voice through reprisals against citizens, thus worsening, rather than improving, their situation. How is EVA-BHN mitigating such risks?

• Much literature refers to the **capacities** required for and built through participation, although the change pathways are not clear. GPSA (2015) refers to effective communication, collaboration skills, understanding of the issues and the wider system, confidence, self-efficacy and belief that change is possible, etc. What forms of capacity is EVA-BHN building in communities, and what is the approach to building it?

5. Health facility (service provider responsiveness)

• Joshi (2013) finds that SAcc initiatives have been quite successful in increasing awareness of entitlements and empowering people to demand accountability and claim rights. However, she concludes that evidence of impact on actual service delivery quality and accessibility has been mixed. In contrast, e-Pact (2016) found that SAcc does often influence some positive outcomes at local level (project area), but (like Fox) they found more limited outcomes at higher level (policy and improved service delivery at scale).

• Lodenstein et al.’s (2016) meta-analysis of 37 SAcc projects in the health sector highlights that many successful initiatives have used a ‘soft’ approach to SAcc at facility level. They found that service providers are more likely to respond and engage when they experience the discussion platform as safe, and feel supported and appreciated. This is most likely to occur when the process emphasises information sharing and dialogue, avoids open public critique, and provides an opportunity for providers to defend themselves and to address their own concerns as well. For example, they found that providers are more likely to listen when their

\(^{11}\) e.g. PATHs2 safe spaces for adolescent girls, cited in e-Pact (2016).

\(^{12}\) Cited in Ayliffe (2016).
own concerns about working conditions are integrated and addressed. They also prefer to be engaged in agenda setting and data collection, and are more likely to engage in SAcc when the approach protects the facility and its staff from public critique. Some initiatives congratulate providers publicly for their good performance and for following up on community demands; Lodenstein et al. found that this kind of social reward is likely to enhance responsiveness, and is central to creating and sustaining collaborative relationships.

- Conversely, Lodenstein (2016) also found that some SAcc initiatives generate responsiveness when they trigger providers’ fears of repercussion for poor performance. He found that citizens are not likely to generate this mechanism on their own; they require the involvement of influential third parties – such as the media and health authorities. SAcc actions may also generate provider responsiveness when they trigger providers’ feelings of moral responsibility or obligation. This may be enabled by framing messages in ways that have resonance for providers. In some cases, a negative framing works: in Bangladesh, a CSO involved a member of parliament in its campaign, who effectively framed health providers’ behaviour as: ‘ungrateful’ (educated on public money but refusing to serve the people), etc. In another case, officials were more willing to promote safe abortion if framed in a professional ‘do no harm’ perspective rather than a perspective of rights [All from Lodenstein (2016)].

- Many social accountability initiatives operate in health systems that are characterised by a strong internal hierarchy, which affects providers’ perceptions of their capacities to achieve change. For example, Cornwall (2007) found that service provider representatives on health committees in Brazil tend to be younger/low level. Even when they are committed, they tend to be reserved in meetings – not due to weak technical capacity but rather a lack of decision making power, or because they are on short-term contracts and fear dismissal. This also affects their ability to report citizen issues upwards.

- Some consider the reliance of citizen groups on soft methods of persuasion as a weakness of social accountability. Without the threat of sanctions by political or bureaucratic authorities, they argue, social accountability is difficult to sustain in the long run and only able to address superficial service delivery challenges.

- Tembo (2013) asserts that both soft approaches and vertical accountability require trust. Without a basic level of trust, he argues, formal enforcement approaches (including sanctions) will be ineffective. Knox’s (2009) study in Bangladesh argues that trust-building is particularly important in settings characterised by political instability or poor trust among citizens.

### 6. Partnerships and interlocutors

- A growing body of literature (like Fox, and often drawing on his work) asserts the importance of civil society vertical integration (e-Pact, 2016; GPSA, 2015) for successful SAcc. In this regard, civil society requires political capabilities to mobilise citizens and build alliances across society: an ability to network, build coalitions, and negotiation in interaction with other actors in the polity.

- There is a growing trend in the literature to promote multi-stakeholder coalitions which overcome the distinction between CS and the state (and the private sector). Booth and Chambers (2015), for example, assert the need to forge partnerships with reformers and potential allies within government, and to draw on the potential of mutual benefits.

- What CS actors are involved? (DAF and PAF etc.) Booth and Chambers’ (2016) analysis of SAVI (Nigeria) highlights that the programme evolved to identify partners and interlocutors in an organic way. Rather than selecting advocacy actors based on perceptions of their

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13 Joshi (2013); Berlan and Shiffman (2012); Acosta et al. (2013); Freedman and Schaaf (2013); all cited in Lodenstein (2016).

14 This argument is also advanced by other scholars comparing constructive and confrontational approaches to SAcc: see Freedman (2003); Joshi and Houtzager (2012); Joshi (2013); Acosta et al. (2013); and Grandvoinnet et al. (2015).
commitment etc., SAVI promoted self-selection. This was facilitated, for example, by round-table discussions from which leaders emerged by offering ideas and being willing to commit time and resources to advocacy. Meanwhile, others dropped out along the way (particularly those looking for funded work and lacking intrinsic motivation). How did the CSOs/CS actors become involved in EVA-BHN – are they the right partners in regard to motivations and influence? What are their capacities and incentives for engagement with government and CGs? What are their weaknesses and how is EVA-BHN building capacity? Is engagement open and fluid? Is there a sense of connection and ownership across civil society, in regard to the processes EVA-BHN is facilitating? What do other CSOs (not involved) think of the EVA-BHN facilitated process?

- **Promoting self-motivated collective action:** SAVI provided limited funding to the advocacy coalitions, so as to strengthen their potential for self-sustaining action on issues which they themselves prioritised. CSOs were not provided with fees or per diems, for example. However, SAVI funded coalition capacity building, and seed funding was provided for activities on the understanding that the groups became resourceful and self-sustaining. This required a process of ‘unlearning’ the more common approach of donor contracting of CSOs for advocacy, which has been shown as ineffective in various contexts. For example, Bano’s (2012) systematic analysis of evidence in Pakistan found that donor money distributed through competitive CSO grant schemes and subcontracts may have suppressed indigenous incentives and capabilities for self-help collective action (cited in Booth and Chambers 2014). Booth and Chambers argue that SAVI’s approach is different, and worked, because it promoted self-reliance, relationship-building and collective achievement. SAVI kept a low profile, providing capacity building and financial support, but not engaging directly in advocacy or branding activities. What is EVA-BHN’s strategy for CS engagement, in regard to incentives and promoting partnership and sustainability?

7. State responsiveness

- The responsiveness of providers and officials is likely to depend on how they perceive users of health services: as patients, recipients, beneficiaries, clients, consumers, citizens or holders of rights. For example, in the context of free healthcare in Bangladesh, Mahmud (2007) explains that providers tend to view users as ‘recipients’, and this view is strengthened by the ‘common belief in society that not everyone has equal rights; and, concomitantly, denial of rights is accepted as the natural order of things’ (Schurmann and Mahmud 2009, cited in Lodenstein 2016).

- Some analyses highlight the importance of legitimacy and credibility in social accountability work, and its effects on responsiveness. The perceived legitimacy of SAcc processes is affected by the way providers and officials perceive and value its formal mandate, citizen capacities, internal consensus, and the genuine concern of citizen groups and their role in service delivery. As such, it is affected by reputation, credibility, trust and perceived ‘representative legitimacy’. In some cases, CSO engagement (at higher level) is accepted because government officials perceive that they fill a capacity or knowledge gap.

- **Example of CS network without sufficient credibility:** The DFID RWSP project in Tanzania fostered a CS coalition (TAWASANET) at national level, which monitored WASH services and fed the analysis into a national bi-annual policy dialogue. This was a component of a wider supply-side programme, which included legislative lobbying, technical support and sector coordination. The Project Completion Report found that TAWASANET had limited influence (longer term) and was ‘an ineffective mechanism for national CS voice’. This was

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15 Lodenstein (2016), and older literature such as Cornwall and Gaventa (2001).
16 GPSA (2016); Lodenstein (2016) (citing various literature).
17 e-Pact (2016), particularly the case studies.
affected by concerns about the quality and credibility of the evidence provided in the TAWASANET monitoring reports, and their adequacy to inform the sector. TAWASANET also lacked the capacity to meaningfully engage in policy processes, and (seen as a donor-engineered network) it lacked perceived legitimacy as a vehicle for citizen voice. The network also appeared to lack a clear purpose and sufficient guidance, as well as a clear and unique role. TAWASANET has subsequently struggled to attract and retain members and donors.

- Where there is a **legal status for citizen mobilisation and monitoring**, as well as procedures for grievance redressal, health workers and officials are more likely to respect citizen groups’ decisions and to respond to their actions. Fayaaz (2013) notes that this enabling environment is lacking in Pakistan, meaning that SAcc initiatives (‘tactics’ such as citizen report cards) enable citizen to express discontent but do not actually hold the service providers/public officials to account.

- Joshi (2010) argues that social accountability mechanisms in themselves have little traction unless they are able to trigger **traditional accountability** (e.g. investigations into corruption) and impose formal sanctions (fines for delays in provision of services).

- Fox (2016) proposes the need to **change incentive structures** so as to promote responsiveness. He asserts the need to explicitly analyse motivations and incentives in each context. [In Punjab, EVA-BHN has tacit agreement that DFID conditional funds will be contingent on government response to 40% of issues raised by CGs].

- Houtzager et al. (2007) also find that the likelihood of SAcc effectiveness is increased when: (a) collective actors representing the poor are involved in policy negotiations at key moments of public sector reform; (b) they are able to engineer some institutionalisation of their role in monitoring service delivery that enables them to access policy makers in the medium to long term; and (c) they are able to draw upon networks of relationships that cross the public–private divide. Others find that SAcc outcomes are strengthened when higher-level political leadership legitimise citizen participation and the process of holding service providers accountable.

- Fox (2015) and others assert the need for SAcc interventions to be embedded in institutions, country systems and the policy cycle (Gaventa, 2008; O’Meally, 2013), rather than being operationalised as a project or discrete intervention. Are EVA-BHN processes integrated into a specific policy or decision making process? What is the status of the PAF? Is EVA-BHN graduating toward CS inclusion on other government platforms?

- Fayaaz’s (2013) analysis of SAcc initiatives in Pakistan notes that they have been introduced by donors, and are entertained by government to maintain donor projects. She notes that government resistance to SAcc is ‘mainly due to the inherent deficiencies – the authorities concerned do not want to be exposed’. She argues that for success in SAcc initiatives, they must be politically astute – located within the context of political action that would include civil society’s role, but not be limited to it. She cites Coventry and Hussein (2010) who argue that it requires ‘good understanding of the political economy of the sector, to align accountability interventions with the other governance developments rather than stand-alone initiatives that are pro-poor and avoid elite capture’.

- **e-Pact’s (2016) review of 50 SAcc initiatives.** In regard to higher level change on service delivery at scale, they found:

  - Some evidence that outcomes are strengthened if SAcc processes are embedded in policy or programme frameworks that leverage entitlements to public services and evidence is then channelled upwards into these.

- **Formal invited citizen engagement is necessary to achieve improved higher-level (at-scale) service delivery. Informal citizen engagement is a contributing factor. However, in contexts**

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18 Lodenstein (2016) (citing various literature).
with a weak social contract e-Pact found that local responsiveness is best achieved by informal citizen action and media oversight.

- Formal citizen engagement with service providers is strengthened by: (a) increasing citizens' knowledge of their entitlements; and (b) working long term through existing organisations and networks, and a strong on-the-ground presence.

- They found some evidence that formal citizen engagement needs to be embedded in a highly institutionalised and integrated approach. They note that this reiterates Fox's (2014) call for a strategic approach to SAcc, which addresses the underlying causes of weak accountability.

- On the demand side, civil society needs to be well coordinated and vertically integrated, often through hierarchies of community-based organisations and CSOs. This can, in some cases, provide the required weight to influence decision making.

- Grandvoinnet et al. (2015) propose a conceptualisation of social accountability (see Figure 1) as supported by three levers on citizen and state action: civic mobilisation, interface, and information. The linkages between these, and directionality, vary; and the nature and legitimacy of interface are important. **They argue that it is increasingly clear that without positive state action, the intended outcomes of social accountability cannot be realised.**

**Figure 1  Grandvoinnet et al. 2015 (World Bank): conceptualisation of SAcc processes**
## Annex D  Issues in assessment visit communities

### Number of issues per community group

<table>
<thead>
<tr>
<th>UC</th>
<th>Total number of issues</th>
<th>Number resolved</th>
<th>Number possibly double or over counted as (i) issues and (ii) resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shamkay Bhattian (Lahore)</td>
<td>40</td>
<td>30 (75%)</td>
<td>(i) 4 (13%) &lt;br&gt; (ii) 2 (7%)</td>
</tr>
<tr>
<td>735 (Sahiwal)</td>
<td>21</td>
<td>17 (81%)</td>
<td>(i) 3 (18%) &lt;br&gt; (ii) 3 (16%)</td>
</tr>
<tr>
<td>Phandu (Peshawar)</td>
<td>34</td>
<td>14 (41%)</td>
<td>(i) 3 (21%) &lt;br&gt; (ii) 2 (14%)</td>
</tr>
<tr>
<td>Pajpeer (Swabi)</td>
<td>38</td>
<td>5 (13%)</td>
<td>(i) 1 (20%) &lt;br&gt; (ii) 4 (80%)</td>
</tr>
</tbody>
</table>

### Verification and comments on potential duplication (recurring issues), system related issues and community involvement

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date raised</th>
<th>Times raised</th>
<th>Date resolved</th>
<th>Status</th>
<th>Verification and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff attitude is not good in Shamkay Bhattian – Lahore</td>
<td>Sep-15</td>
<td>8</td>
<td>Mar-16</td>
<td>Resolved</td>
<td>Verified: Community talked to the MO about the LHV sending people to her private practice. After that there were no further reports of her doing it again.</td>
</tr>
<tr>
<td>LHV attitude is not good in Shamkay Bhattian – Lahore</td>
<td>Jan-17</td>
<td>2</td>
<td>Apr-17</td>
<td>Resolved</td>
<td>Verified: Just over a year later there are issues with the LHV over a period of seven months. This appears to be a recurring issue. During the assessment visit the team heard that the BHU had transformed from a 6x6 to a 24/7 facility, which increased the two LHVs’ workload. One of the two LHVs then went on maternity leave leaving the other to cover the morning and night shift. The CG members said she was understandably overworked and stressed and that was why she was behaving badly. The CG went to the WMO, who warned the LHV, and then the WMO went to the EDO who threatened to transfer her. Since these actions her behaviour has improved. Nevertheless, there may still remain an empty post and the problem may recur, indicating a systemic HRH issue.</td>
</tr>
<tr>
<td>LHV attitude is not good in Shamkay Bhattian – Lahore</td>
<td>May-17</td>
<td>3</td>
<td>Jul-17</td>
<td>Resolved</td>
<td>Verified: Just over a year later there are issues with the LHV over a period of seven months. This appears to be a recurring issue. During the assessment visit the team heard that the BHU had transformed from a 6x6 to a 24/7 facility, which increased the two LHVs’ workload. One of the two LHVs then went on maternity leave leaving the other to cover the morning and night shift. The CG members said she was understandably overworked and stressed and that was why she was behaving badly. The CG went to the WMO, who warned the LHV, and then the WMO went to the EDO who threatened to transfer her. Since these actions her behaviour has improved. Nevertheless, there may still remain an empty post and the problem may recur, indicating a systemic HRH issue.</td>
</tr>
<tr>
<td>Patients facing problems due to LHV’s leaves in Shamkay Bhattian – Lahore</td>
<td>Jul-17</td>
<td>2</td>
<td>Aug-17</td>
<td>Resolved</td>
<td>Verified: Just over a year later there are issues with the LHV over a period of seven months. This appears to be a recurring issue. During the assessment visit the team heard that the BHU had transformed from a 6x6 to a 24/7 facility, which increased the two LHVs’ workload. One of the two LHVs then went on maternity leave leaving the other to cover the morning and night shift. The CG members said she was understandably overworked and stressed and that was why she was behaving badly. The CG went to the WMO, who warned the LHV, and then the WMO went to the EDO who threatened to transfer her. Since these actions her behaviour has improved. Nevertheless, there may still remain an empty post and the problem may recur, indicating a systemic HRH issue.</td>
</tr>
<tr>
<td>Shortage of medicines in Shamkay Bhattian – Lahore</td>
<td>Sep-15</td>
<td>18</td>
<td>In process</td>
<td></td>
<td>Verified: Raised at DAF but not at PAF. This is a systemic issue that hasn’t been resolved over a long period. The assessment team was told by the CG that this is still a problem. This is the issue mentioned in the report where the WMO felt she gets support from the CG – they explain to the community that she can’t give medicines because she has a shortage.</td>
</tr>
</tbody>
</table>
| Ultrasound machine required in Shamkay Bhattian – Lahore              | Sep-15      | 3            | Nov-16        | Resolved| Verified: Community raised funds to buy their own ultrasound machine – which is not part of the essential package at the BHU. Also, while this is marked resolved, it was resolved by the community, so not an indicator of public health service responsiveness. Several of the issues
in this community were resolved by Health Council Funding, with support from the community in the form of labour.

These issues would not be raised if the community had not acquired the ultrasound and it is not necessarily the role of the BHU to be responsible for these aspects of ultrasound management. Is the WMO sufficiently qualified to operate the ultrasound and diagnose accurately?\(^2\)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Start Date</th>
<th>End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>WMO required for ultrasound</td>
<td>Oct-16</td>
<td>2 Nov-16</td>
<td>Resolved</td>
</tr>
<tr>
<td>Availability of ultrasound report</td>
<td>Feb-17</td>
<td>5 Jun-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Need ultrasound gel</td>
<td>Feb-17</td>
<td>2 Mar-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>MO comes 3 days/week</td>
<td>Apr-16</td>
<td>9 Dec-16</td>
<td>Resolved</td>
</tr>
<tr>
<td>MO again comes 3 days/week</td>
<td>Feb-17</td>
<td>3 Apr-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>MO transferred</td>
<td>Oct-16</td>
<td>2 Nov-16</td>
<td>Resolved</td>
</tr>
<tr>
<td>Drinking water is not clean and cold</td>
<td>Apr-16</td>
<td>12 Mar-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Water dispenser demanded</td>
<td>Apr-17</td>
<td>2 May-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Separate toilets should be available for males and females</td>
<td>Jul-16</td>
<td>12 Jun-17</td>
<td>Resolved</td>
</tr>
</tbody>
</table>

WMO not available | Dec-16 | 4 Mar-17 | Resolved |

Boundary wall height | Jan-16 | 8 | In process |

\(^2\) As an example, the UK Royal College of Radiologists require that all those using an ultrasound machine should hold recognised qualifications, including: qualifications approved by the Consortium for the Accreditation of Sonographic Education (CASE), or equivalent from overseas or within the UK; and qualifications awarded as part of medical postgraduate education and training (for example by the Royal College of Radiologists itself or the Royal College of Obstetricians and Gynaecologists).
<table>
<thead>
<tr>
<th>Issue</th>
<th>Date</th>
<th>Rating</th>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of boundary wall needs to be constructed</td>
<td>Aug-16</td>
<td>9</td>
<td>In process</td>
<td>Verified: Both the boundary wall repair and the internal path had begun to be built using funding from the Communication and Works Department at an extremely high cost. The internal path has not been completed, and the boundary wall (while repaired) isn’t high enough to shield the women patients from view (apparently many BHUs have this issue). The DAF is engaging with the DHO on the wall issue but he doesn’t have the money for more work. The boundary wall issue is double counted as it is essentially the same thing.</td>
</tr>
<tr>
<td>Internal pathways inside the BHU are unpaved</td>
<td>Nov-15</td>
<td>5</td>
<td>In process</td>
<td></td>
</tr>
<tr>
<td>BHU sign board is not available</td>
<td>Nov-15</td>
<td>11</td>
<td>Apr-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Signboard providing information regarding services in BHU</td>
<td>Aug-16</td>
<td>14</td>
<td>In process</td>
<td></td>
</tr>
<tr>
<td>Blood pressure and weight checking services are not provided</td>
<td>Jan-16</td>
<td>3</td>
<td>Nov-16</td>
<td>Resolved</td>
</tr>
<tr>
<td>Blood pressure set and weight machine is out of order</td>
<td>Mar-17</td>
<td>3</td>
<td>Jun-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Shortage of medicine</td>
<td>Dec-15</td>
<td>21</td>
<td>In process</td>
<td></td>
</tr>
<tr>
<td>Cleanliness of BHU</td>
<td>Aug-16</td>
<td>3</td>
<td>In process</td>
<td>Not correctly marked as in process: During the visit the women’s CG said that they thought this was resolved. The BHU is an open space and subject to frequent dust storms. They had asked the MO that the BHU should be cleaned every day, which it now is and they are satisfied. This should be marked as resolved.</td>
</tr>
<tr>
<td>Sanitation issue</td>
<td>Jan-17</td>
<td>4</td>
<td>In process</td>
<td>Recurring issues reflecting the frustration that the DHO had at not having any budget for the BHUs even for sanitation.</td>
</tr>
<tr>
<td>Sanitation problem</td>
<td>Mar-16</td>
<td>11</td>
<td>In process</td>
<td></td>
</tr>
<tr>
<td>LHV’s rude behaviour</td>
<td>Aug-16</td>
<td>2</td>
<td>Aug-16</td>
<td>Resolved</td>
</tr>
<tr>
<td>LHV’s behaviour</td>
<td>Aug-16</td>
<td>5</td>
<td>Aug-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Transfer of LHV</td>
<td>Dec-16</td>
<td>5</td>
<td>Jul-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Lack of clean drinking water facility and demand for water cooler</td>
<td>Apr-16</td>
<td>6</td>
<td>Oct-16</td>
<td>Resolved</td>
</tr>
</tbody>
</table>

HEART (High-Quality Technical Assistance for Results)
<table>
<thead>
<tr>
<th>Issue Description</th>
<th>Date</th>
<th>Value</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean drinking water facility</td>
<td>Mar-17</td>
<td>1</td>
<td>Mar-17</td>
<td>Resolved</td>
</tr>
<tr>
<td>Shortage of medicines</td>
<td>Jun-17</td>
<td>4</td>
<td></td>
<td>In process</td>
</tr>
<tr>
<td>Verified:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>This is the BHU that said that they ration – only providing medicines to patients who come before 11.30am (mentioned in the report). Clearly this issue was resolved only very temporarily in May 17 and then recurred in June 17 – one of these was picked up by the CBM, and is still showing as in process. Possibly more a systemic issue – and this was not raised at the PAF (see also Panjpeer). The assessment team were told by the DAF that they have taken the issue to the District Nazim hoping he can use some of his discretionary funds for it.</td>
</tr>
<tr>
<td>Shortage of medicines</td>
<td>Apr-16</td>
<td>14</td>
<td>May-17</td>
<td>Resolved</td>
</tr>
</tbody>
</table>
Annex E  Data duplication in MIS

The following table lists the issues that have an overlap between CG and DAF data sample based on Ref Code in Punjab and KP. We have estimated the total resolved issue number based on the proportion of issues that have been identified as duplicates in the sample that have a Ref Code.

<table>
<thead>
<tr>
<th>1. Province</th>
<th>2. Resolved issues from CG data</th>
<th>3. Resolved issues with Ref Code in DAF data</th>
<th>4. Overlap of issues</th>
<th>5. % of sample DAF issues resolved $t = \frac{4}{3}$.</th>
<th>6. Total resolved issues marked in DAF data</th>
<th>7. Estimated DAF-resolved issues by subtracting projected duplicates $t = 6 - (5 \times 6)$.</th>
<th>8. Estimated total issues resolved $t = 7 + 2.$</th>
<th>9. EVA-BHN reported figures$^{21}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP</td>
<td>364</td>
<td>95</td>
<td>27</td>
<td>28%</td>
<td>386</td>
<td>278</td>
<td>642</td>
<td>732</td>
</tr>
<tr>
<td>Punjab</td>
<td>1,242</td>
<td>354</td>
<td>166</td>
<td>47%</td>
<td>817</td>
<td>433</td>
<td>1,675</td>
<td>2,009</td>
</tr>
<tr>
<td>Total</td>
<td>1,606</td>
<td>449</td>
<td>193</td>
<td>42%</td>
<td>1,203</td>
<td>711</td>
<td>2,316</td>
<td>2,741</td>
</tr>
</tbody>
</table>

Note: $t$ is total

Note: While reporting on issues resolved, in the September 2017 quarterly report EVA-BHN removed 18 duplicates from KP data and 50 duplicates from Punjab data. This removal was only done for issues resolved after April 2017. Out of 166 issues identified as duplicates in Punjab by the assessment team, 78 were marked as resolved before April 2017. Out of 27 issues identified as duplicates in Punjab by the assessment team, eight were marked as resolved before April 2017.

The total estimated resolved issues is 15% lower than the EVA-BHN reported figure.

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$^{21}$ EVA September 2017 quarterly report
Annex F  Quantitative analysis

Response error and completion of source data

The following table highlights the extent of missing values across some of the identifiers:

<table>
<thead>
<tr>
<th></th>
<th>Missing values (N)</th>
<th>% (of total observations)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CGs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KP: CNIC</td>
<td>11,838</td>
<td>54%</td>
</tr>
<tr>
<td>KP: Cell Phone</td>
<td>11,838</td>
<td>46%</td>
</tr>
<tr>
<td>Punjab: CNIC</td>
<td>6,706</td>
<td>38%</td>
</tr>
<tr>
<td>Punjab: Cell phone</td>
<td>3,627</td>
<td>21%</td>
</tr>
<tr>
<td><strong>DAFs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punjab: CNIC</td>
<td>1060</td>
<td>100%</td>
</tr>
<tr>
<td>Punjab: Cell Phone</td>
<td>198</td>
<td>19%</td>
</tr>
<tr>
<td>KP: CNIC</td>
<td>602</td>
<td>87%</td>
</tr>
<tr>
<td>KP: Cell Phone</td>
<td>73</td>
<td>10.5%</td>
</tr>
<tr>
<td><strong>Issues data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KP CG: Source of Issue report (CBM or Other)</td>
<td>76</td>
<td>3%</td>
</tr>
<tr>
<td>Punjab CG: Source of Issue report (CBM or Other)</td>
<td>31</td>
<td>1%</td>
</tr>
<tr>
<td>DAF Punjab: Mandated Level</td>
<td>725</td>
<td>47%</td>
</tr>
<tr>
<td>DAF Punjab: Service Delivery Points</td>
<td>736</td>
<td>48%</td>
</tr>
<tr>
<td>DAF Punjab: Impact Level</td>
<td>1092</td>
<td>72%</td>
</tr>
<tr>
<td>DAF Punjab: Authority level</td>
<td>1,120</td>
<td>74%</td>
</tr>
<tr>
<td>DAF Punjab: Feedback given to CG</td>
<td>209</td>
<td>14%</td>
</tr>
<tr>
<td>DAF Punjab: Response by duty bearer</td>
<td>1,466</td>
<td>96%</td>
</tr>
<tr>
<td>DAF Punjab: Response by community member</td>
<td>1,521</td>
<td>100%</td>
</tr>
<tr>
<td>DAF KP: Mandated Level</td>
<td>715</td>
<td>56%</td>
</tr>
<tr>
<td>DAF KP: Service Delivery Point</td>
<td>715</td>
<td>56%</td>
</tr>
<tr>
<td>DAF KP: Impact Level</td>
<td>1278</td>
<td>99.9%</td>
</tr>
<tr>
<td>DAF KP: Feedback given to CG</td>
<td>359</td>
<td>28%</td>
</tr>
<tr>
<td>DAF KP: Authority level</td>
<td>1278</td>
<td>99.9%</td>
</tr>
<tr>
<td>DAF KP: Response by duty bearer</td>
<td>717</td>
<td>56%</td>
</tr>
<tr>
<td>DAF KP: Response by community member</td>
<td>1279</td>
<td>100%</td>
</tr>
</tbody>
</table>
The following table shows the extent of duplicates that are caused by data entry errors:

<table>
<thead>
<tr>
<th></th>
<th>Duplicates (N)</th>
<th>% (of non-missing values)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CGs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KP: CNIC</td>
<td>1,316</td>
<td>13%</td>
</tr>
<tr>
<td>KP: Cell Phone</td>
<td>900</td>
<td>14.5%</td>
</tr>
<tr>
<td>Punjab: CNIC</td>
<td>1,618</td>
<td>15%</td>
</tr>
<tr>
<td>Punjab: Cell phone</td>
<td>4,621</td>
<td>33%</td>
</tr>
<tr>
<td><strong>DAFs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punjab: Cell Phone</td>
<td>74</td>
<td>8.5%</td>
</tr>
<tr>
<td>KP: CNIC</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>KP: Cell Phone</td>
<td>112</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Checks for inconsistencies**

Additional checks were run to identify any internal inconsistencies across participation data, issues log, and CBM data and no major inconsistencies were found besides the duplicates that have been mentioned above.