Empowerment Voice and Accountability for Better Health and Nutrition (EVA BHN) Assessment

Executive summary

COMMUNITY GROUPS INTERVIEW PEOPLE LEAVING HEALTH CENTRES:

What was the Service like today?

Did the doctor check your blood pressure?

Is the doctor here today?

Can I see him?

...TO ENSURE SERVICE IS ADEQUATE AND IDENTIFY WHERE IT MIGHT BE FAILING.

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

EVA BHN is an £18.86m 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 DFID’s Provincial Health and Nutrition Programme (PHNP) to support 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 community groups engage directly with primary health facilities and with district government and health facilities through District Advocacy Forums (DAFs). Civil society organisations (CSOs), journalists and other professional groups (such as lawyers) also participate in the DAFs. Policy relevant issues are discussed with government and other stakeholders such as development partners and politicians at province level through the 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 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 tailed off in the second year.

Communication about health issues and rights has been complemented in the nine programme districts through 453 sermons by religious leaders who have received training and a sermon guidance book from EVA. National communications supported by EVA includes the funding of a national TV drama with social and health messaging and institutionalisation of education entertainment in university media courses.

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 the programme effectiveness over the remaining 16 months, for informing the design of potential future DFID health programme(s) in Pakistan and for communicating with stakeholders.

The assessment was conducted in October – December 2017 through a desk review of international evidence, and programme documentation and data, and through a visit to four of the programme districts and the two province capitals where qualitative data was collected. Eight focus groups 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 monitoring data, EVA research and case studies and also from the limited primary data collection of the assessment. It is not possible to generalise many of the findings, but they give information that can be used.
Assessment findings

Evidence of Outcomes

There is some evidence from the communities visited in this assessment of behaviour change resulting in improved health facility and service quality at the Basic Health Unit (BHU), some policy change and improved financial flows to the BHUs in Punjab and some evidence of increased utilisation of health service. 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. Though not all the improvements can be attributed entirely to EVA, it is likely that EVA community groups 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, ambulances and mobile health units due to government initiatives in Punjab. It is likely that the EVA CGs have increased the reach of these initiatives by providing information on location of the greatest need in hard to reach areas.

The district health authorities and BHUs have responded well to CG issues raised in Punjab over the last year because of the initiation of the Health Councils that enable money to flow more efficiently and transparently to the BHUs. It is likely that EVA has played a role in pressuring government to set up the Health Councils.

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 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 group formation and management and ensuring that all of the spaces include information sharing, dialogue and negotiation. The assessment found examples of where the relationship 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.

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 standards for public sector service providers and has been adopted by KP’s Health Care Commission, to be mainstreamed throughout the province.
Evidence of effectiveness

Community groups and government health facilities have improved capability to engage with each other and to work together to resolve BHU issues, though systemic issues are less understood and communicated. CG member interviewees spoke about better understanding their rights as citizens and 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 (but to a lesser extent) are able to speak, and represent the needs of their communities, and collect data to understand community perspectives. There is some evidence that CG members are cascading knowledge to the wider group and the community, but this is variable.

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 isn’t sufficient expertise or funding, or expect high levels of unnecessary medication. As seen in international evidence, this can restrict government responsiveness and possibly also the relationship between communities and government.

There is also little capacity to understand the health system – and the ways in which communities’ health needs relate to it – by CGs, but also within DAFs and PAFs. Issues identified within the CGs had not been analysed to understand the root causes or to relate to policy relevant issues. This meant that PAF participants were not receiving feedback from communities in a policy relevant way or in a way that would relate to systemic issues.

EVA 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.

Thanks to the community group we know what the BHU is for--

and we understand what we are entitled to.
There is promising evidence that the CGs have engaged with other actors involved with health service delivery (for example NGOs) and helped them to work in relevant ways. The programme has also provided the opportunity to religious leaders, media professionals and journalists not normally engaged with health 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. Participation in the CGs, whilst benefiting from the influence of its members, has also increased the community members’ status. The sense of momentum that has been created by the resolution of the 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 an increase in political will in both provinces within the ruling parties with regard to health. In Punjab, there is a strong narrative about hearing from citizens. It is possible that the pressure coming from the CGs and DAFs may well have a positive influence on this motivation.

The programme experienced some challenges with legitimacy and trust in the beginning, but there are various examples of promising practice of building legitimacy and trust by EVA and the CGs at the BHU and district level. The support that the CGs provide to the service providers and district government, in terms of community back up and information of community demands, is also key to enhancing their legitimacy. However, there are mixed views about the legitimacy of the EVA 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 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 has been successful at institutionalising the approach at community level and in beginning to build state-society relationships, though 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 civil society organisations (CSOs) are DAF members, there are no CSOs involved in the implementation of any of the EVA activities, 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 media have been successful for institutionalising both health and health rights awareness raising and strengthening the role of media in the accountability process.

**Monitoring, Evaluation and Learning**

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. The MIS data is 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 of 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 been fully used yet 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 almost 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, the programme has not adequately analysed and addressed at policy level 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 as separate from the other technical assistance components funded by DFID (TRF and 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 service and quality of care:
Social norms and expectations of services users and perceptions of 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 approach considers and influences community health seeking social norms, knowledge of 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 to build capacity within CGs and DAFs to better understand HSS and aim to understand and address social expectations about quality of care in the health facilities.

2. Systemic vs symptomatic issues:
Many of the resolved issues are symptoms of a wider health system and systemic problem, which are not necessarily resolved. This may be because of lack of HSS knowledge and capacity within the EVA team and CG/DAF structure.

Recommendation 2: Develop the accountability system 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 that they can act on. In the short term, this could include work on a sample of issues to understand the root causes. In the long term, a programme would need to include both supply side and demand side.
3. **Strategic level support and networks:**  
There is limited technical input coming from outside of the EVA programme for strategic analysis and planning and this limits the diversity of input and legitimacy of the programme. Though CSOs and other sources of technical expertise attend DAF meetings they do not have a specific role in the programme, 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 building of perception of legitimacy.

4. **Working with civil society and other programmes:**  
EVA 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 Technical Resource Facility (TRF) and Roadmap. This means that EVA has not yet drawn sufficiently on the significant expertise and experience in Pakistan, nor have they built a sustainable capacity to continue the work of EVA 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, building government capability and commitment for responding.

5. **Gender equality and social inclusion:**  
This 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.  

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

6. **Monitoring, Evaluation and Learning:**  
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. The MIS data is excellent quality and is an important monitoring tool and input for the programme effectiveness, though some adjustments are needed to account for recurring issues and duplicates of resolved issues in the CG and DAF datasets.  

**Recommendation 6:** Strategically design research and data collection and improve inputs and processes to ensure data quality and use for programme learning and adaption. 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 ability to better report issues that recur and 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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