
# End of Project Report

## *"Community Score Card for the Improvement in the Quality of Primary Healthcare in District Charsadda, Khyber Pakhtunkhwa"*

**FEBRUARY 25, 2018**

**Community Uplift Program (CUP) Pakistan**

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## Acknowledgement

This DFID Funded, Palladium managed & CUP Pakistan Implemented Project in District Charsadda, Khyber Pakhtunkhwa was a "scale up" project that was approved after the successful outcome of a pilot project in 2015-2016 in District Peshawar. We have no words to express our gratitude to all the key stakeholders for their interest, participation and support that led to the achievement of the project goal and objectives. The 879,776 communities of District Charsadda and their 176 chosen "lead activists" were the true flag bearers of this project as they volunteered to understand what "social accountability" was and how citizens could contribute towards the improvement in the quality of primary healthcare services by conducting "Community Score Card" with the Service Providers.

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Our felicitations to the HANIF team as well EVA-BHN and Palladium Pakistan team led by Dr. Fayyaz Ahmad, Team Leader for being a part of the support to the project and its resounding success, which is epitomized by the notification and institutionalization of the CSC throughout the Province of KPK by the Provincial Health Department. It is with special mention that Mr. Muhammad Wasim the Deputy Team Leader was the solid anchor of support whenever we ran into bottlenecks or sought advice, while Mr. Ghulam Farooq, the Innovation Fund Manager, ever so cool & knowledgeable, was at hand 24/7 for coordinating support. He was able assisted by a small but highly able team comprising; Ms. Sumayya Akhter, the Innovation Fund Coordinator, Ms. Farah Naz, the M&E Coordinator, and Mr. Zakaria Rizvi the Innovation Fund Officer and Junaid Abdullah, Grants Officer. Our gratitude to DFID for reposing trust in CUP Pakistan and entrusting it with funds to improve healthcare through this innovation.

Lastly, we would like a special mention of Mr. Mudassir Ahmed, the Project Manager of CUP in Charsadda for very ably and efficiently leading a motivated team to achieve all targets despite several challenges and risks; Fahad (M&E Officer), Umar (Field Coordinator), Shahzad (Finance Officer), Shakira (HR Officer), Ali (Communications/Advocacy Specialist), Sumaira (Stakeholders Liaison Officer), Kamran Raza (Data Management Officer), Husnain (Admin Officer), Social Organizers - Shagufta, Maryam, Nida, Salma, Manal, Gulandam, Ashfaq, Raheel, Shakeel, Bilal, Zaib & the ever resourceful Zahir Shah. The staff at CUP Head Office (Kazim, Waheed and Jabeen) assisted the Team Leader in providing back up support to the project team. Thus, it was a delightful team effort that worked in synchronization at all levels. We leave behind some good memories of this project and are looking forward to being a part of the process of a province wise replication of the CSC method.

Iftikhar Ur Rahman
Chief Executive, CUP Pakistan

**Acronyms**

| | |
|---|---|
| BHU | Basic Health Unit |
| CSC | Community Score Card |
| CUP | Community Uplift Program |
| DAF | District Advocacy Forum |
| DHQ | District Headquarter (Hospital) |
| DFID | Department of International Development |
| EVA-BHN | Empowerment, Voice & Accountability for Better Health & Nutrition |
| HANIF | Health and Nutrition Innovation Fund |
| IMU | Independent Monitoring Unit (of the Health Department of KP) |
| JCMC | Joint Citizen Monitoring Committee |
| KPK | Khyber Pakhtunkhwa |
| LHS | Lady Health Supervisor |
| LHW | Lady Health Worker |
| LGA | Local Government Act |
| LG | Local Government |
| MDGs | Millennium Development Goals |
| M&E | Monitoring & Evaluation |
| MOU | Memorandum of Understanding |
| MUAC | Mid-Upper Arm Circumference |
| NOC | No Objection Certificate |
| PAF | Provincial Advocacy Forum |
| PHC | Primary Healthcare |
| QPR | Quarterly Progress Report |
| QFR | Quarterly Financial Report |
| SDGs | Sustainable Development Goals |
| VfM | Value for Money |

## 1. Executive Summary

This DFID funded, Palladium Pakistan managed and CUP Pakistan implemented project; "CSC for the Improvement in the quality of primary healthcare services in District Charsadda of Khyber Pakhtunkhwa (July 1, 2016 to January 2018) was a result of successful pilot project in District Peshawar (April 2015-February 2016). Initially the scale up project was designed for a 16 months (up to October 31, 2017), however due to the delayed signing of the MOU with the Provincial and District Government (September 30, 2016) as well as issuance of the NOC by the District Administration (November 4, 2016), a two and half months "no cost" extension saw the project extended to January 15, 2018.

Thus, the conceptual framework of this scale up project was to contribute to the larger strategic goal of the government of KP for the achievement of its healthcare goals in the longer term of 3-4 years, as enunciated by the Government of KP Integrated Development Strategy (IDS) 2014-2018 and Health Sector Reforms (2013-2017). We see the achievement of this goal through appropriate resource allocations by government and measures to improve in service delivery, with the CSC as a tool for creating demand for services and evolving joint agreed planning once the issues are identified through the application of the CSC.

This scale up project was also conceived within the overall goals and framework of the DFID Funded Provincial Health and Nutrition Program (PNHP) with the Government of Khyber Pakhtunkhwa, which aims to achieve Reproductive Maternal, Newborn & Child Health (RMNCH) and nutrition results over four years 2013 to 2017 (now extended until 2019). Under PHNP, the project on Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN)" focuses primarily on the 'demand side' of RMNCH and nutrition services. EVA-BHN and HANIF thus aims to complement the 'supply side' activities under the broader PHNP framework through "Enhancing Communities' understanding of their health rights, entitlements and engagement in monitoring the planning and delivery of services

***Project Goal:*** To Improve Quality of Primary Healthcare Services Delivery in District Charsadda using the Community Score Card (CSC) Model for Citizen Feedback, Monitoring & Joint Action Planning.

***2.6: Project Objectives:*** *The specific objectives are:*

- ***Objective-1****: Create Buy-in of the" Key Stakeholders" for Citizen-Led Monitoring, Feedback and Joint Action Planning through the CSC Model.*
- ***Objective-2:*** *Mobilize the communities to identify activists and form Joint Citizen Monitoring Committees (JCMCs) to conduct CSC;*
- ***Objective-3****: Advocacy with key stakeholders" for institutionalization of the CSC as a citizen-inclusive monitoring and planning method.*

During the planning stage community feedback was obtained on the current issue related to primary health care in District Charsadda and then these issues were grouped to form a co-relationship with the "minimum essential standards for primary healthcare

**Project Impact:** *Improved Quality of Primary Healthcare Service Delivery in District Charsadda*.
Indicator: % Improvement in quality of Primary Healthcare Service Standards"

The 1st CSC was taken as baseline. The project impact was measured through the measurement of changes after the 2nd and 3rd CSC as well as assessment through "proxy indicators". The following improvement were recorded after the completion of the 3rd CSC:

- Improvements in BHU Staff Attitude: This was scored as "highly satisfactory" in the 1st CSC and by the end of the 3rd CSC it was "scored as "almost excellent". Thus an improvement by 19%.
- Improvements in LHWs outreach sessions on mother and child health: recorded as "poor" by the first CSC and after the 3rd CSC as "good". This recorded an impressive improvement by 69%.
- Improvement in the quality of the outreach session: was recorded as "poor" and after the 3rd CSC it was scored as "good". Thus an increase by 85%.
- Improvement in the availability of essential medicines; this was scored as "poor" and after the 3rd CSC it was rated as "very good). This is an increase by 86%
- Improvement in referral system by 97%. It was scored as "very poor" after the 1st CSC and after 3rd CSC it was scored as "good".
- Improvement in Services of LHVs by 42%. Baseline it was scored as "poor" and at the end of the project it was scored as "satisfactory".
- Improvement in functionality of equipment by 35%. Baseline was Baseline it was scored as "poor" and at the end of the project it was scored as "satisfactory".
- Improvement in the quality of ANC and PNC services by 49% and 40% respectively. Baseline was "poor", which has graduated to "satisfactory".
- Improvement in provision of safe drinking water at BHUs by 69%. Baseline was "poor" and now the rating is "good".
- Improvement in separate toilets (male and female) by 69%. Baseline was recorded as "poor" and after the 3rd CSC it is touching "good".
- Separate Waiting Areas for Male and Female Patients improved by 44%. Baseline was rated as "poor", while after the 3rd CSC it creeped up to "satisfactory".
- Solid Waste Management improved by 49%. Baseline was "poor" and after the 3rd CSC is recorded as "highly satisfactory".
- Improvement in Infrastructure (boundary walls, EPI rooms, entrance gates, repairs etc.) by 44%. Baseline was "poor" and with funds of elected members it is touching "highly satisfactory" at the end of the project.
- Improvements in grievance/complaints and resolution of complaints by 89%. Baseline was "very poor" but by the establishment of the system it is "satisfactory" by the end of the project.
- Improvement in BHU staffing by 28%
- Improvement in achieving cold chain for vaccines through solar systems for uninterrupted electric supply by 60%. Baseline was "poor" and by the installation of solar panels in 21 BHUs, it has improved and recorded as "highly satisfactory".
- The issue of "institutional deliveries" remains the same as there is no "labor rooms and facilities" in any BHU of District Charsadda. The DOH is considering the "resolution" presented by the communities in the 2nd Advocacy Seminar.

Similarly significant improvements were visible through the assessment of proxy indicators such as number of OPD clients, number of ANC checkups, number of emergency cases referred to DHQ/others, number of pregnant women received obstetric emergency care, number of children

under 5 years immunized, number of pregnant women receiving TT vaccinations. However, the issue of unavailability of screening equipment and medicines or seriously malnourished children and PLWs as the major concern was communicated to the DHO and plans are in the pipeline.

**Project Outcome:** *Community Score Card (CSC) model institutionalized as a citizen-inclusive planning tool*

*Indicators:*

- *CSC method notified as a regular mechanism for citizen-feedback*
- *District Advocacy Forum (DAF) established for institutionalization of the implementation of CSC recommendations at District Level & it linkage with the PAF.*

This outcome was achieved when Community Score Card was notified as a regular mechanism for citizen feedback by the Deputy Commissioner on January 12, 2017 and finally Province Wise by the Department of Health, Khyber Pakhtunkhwa on 28 December 2017. The 7 Joint Citizen Monitoring Committees JCMCs) which were established during the 1st CSC were also notified by the DHO on 13 December 2017 DAF was formed and notified at district level by the Deputy Commissioner on 12 January 2017 and the DAF was formally linked to PAF on 28 December 2017

***Output-1****: Project Buy-in and Agreements with Key Stakeholders*

*Indicators:*

- *Government is committed to improve the quality of health care services through signing of Memorandum of Understanding (MoU) and granting of No Objection Certificate (NOC) to start project intervention in selected district*
- *Strategy for relevant stakeholder's engagement designed.*
- *Inception Workshop for Stakeholders*
- *Agreed set of indicators for PHC Service Delivery for CSC*

Complete "buy in" was achieved: The MOU was signed on September 30, 2016 and NOC issued on November 4, 2016. Strategy for stakeholder's engagement was prepared and applied. The inception workshop was held on September 30, 2016 and the agreed set of indicators for the CSC application was agreed with all stakeholders on November 8, 2016.

***Output-2****: Users aware of PHC Entitlements, Lead Activists and BHU Staff capacitated in the use of CSC by its application quarterly.*

*Indicators:*

- *Increased awareness of User Community and lead activists on PHC entitlements*
- *Capacity of Lead Activists & BHU Staff built on PHC entitlement and CSC*
- *CSCs Conducted & Results shared with Stakeholders*

Awareness Increased through 44 Social Mobilization Sessions were held during August 2016 in order to identify Community Lead Activists where 472 male participants and 269 female participants took part. Among these participants, 176 Lead Activists were selected comprising of 50% male and 50% females. Capacity developed through Training Workshops organized for Lead Activists during September 2016, each workshop comprising of 3 days. Lead Activists were oriented on Citizen Entitlements at BHUs on Primary Healthcare and the usage as well as the application of CSC. Similarly,

training was also provided to BHU staff to build their capacity in 3 batches comprising of 93 participants. Three CSCs were conducted throughout the life cycle of the project. 43 Agreed Action Plans came into existence after the interface meetings followed by the 7 JCMCs where the health department ensured their presence. Follow-up on the issues was made by CUP after each CSC. All the results and information were regularly shared with all the relevant stakeholders

***Output-3**: CSCs advocated with key stakeholders and institutionalized*.
*Indicators:*

- *Advocacy Strategy & Plan*
- *No of Advocacy Events*
- *# of Press releases or media coverage reports highlighting the health Policy, Gaps and Recommendations*
- *Sustainable Close-Out Plan*

Advocacy strategy and plan was developed and shared with HANIF. Three Advocacy Seminars were organized in which representatives of all stakeholders participated and advocated for citizens' rights for Primary Healthcare & Institutionalization of the CSC Method. Numerous press coverage through press releases highlighted the health policy gaps and recommendations. Sustainable Close-out Plan was achieved through Notification of the CSC at Provincial Level, Notification of DAF-Health at the District, and Notification of the 7 JCMCs in District Charsadda & Linkage with the PAF

An overall summary of project achievements are:

- *741 (472 male, 269 female) community members have been sensitized on issues related to Primary Health Care (PHC) in Charsadda.*
- *1,398 community members and 176 lead activists have been sensitized through 86 awareness-raising sessions on BHU entitlement and citizen rights to minimum essential package for primary healthcare.*
- *The capacity of Lead Activists & Staff of 43 BHUs has been built on PHC entitlement and CSC application for an improvement in PHC Services*
- *IEC Materials on the CSC, BHU Entitlements and Citizen Rights to Quality Healthcare are placed at all 43 BHUs.*
- *7 Joint Citizen Monitoring Committees (JCMCs) have been formed, notified and strengthened to continue monitoring the agreed joint action plans.*
- *Boundary walls have been constructed/repaired in 21 BHUs through the funds of local government representatives to facilitate the security of BHUs staff and female patients.*
- *Solar Systems have been installed in 24 BHUs for maintaining the cold chain for vaccines in view of the frequent power outages through the funds of local government representatives.*
- *Evidence Based Improvements in Service Delivery in 43 BHUs as shown under paragraph 2.8 achievements under log-frame.*
- *A letter has been issued from the DHO to the Project Director of Integrated Health KPK to establish 24/7 EMONC services in cluster BHUs of District Charsadda;*
- *Due to follow-up by user communities during CSC cycles, the Government of KP advertised all the position of LHWs. This will be followed by recruitment of 25 LHSs for complete coverage of user communities, which will fill the gaps in the LHWs coverage with regards to sessions coverage;*

- *During CSC cycles, the community users as well as the BHU staff highlighted the need of LHWs' room in the BHUs as one of the major issue, thus making it one of the important components of the agreed action plans. After the follow up by the JCMCs during the 3rd CSC, LHWs' rooms were constructed in 3 BHUs (Tarnab, Sheikho and Daman);*
- *One of the major drivers in the sustainability of this project could be the Complaint Management System which was lacking in almost all the BHUs. CSC project interventions helped in updating Public Information Board, display of Complaint Box and B-2 Register at all the BHUs.*

There were several challenges such as CSC was seen as an intrusive monitoring tool by the service providers. It was for this reason that it took some time for the MOU signing and NOC. Government expectations were for hardware support. As is with projects that have "soft components", there is a lack of interest by government service providers Lack of comprehension- was CSC considered as a duplication of the IMU-Health function. It was also an uphill task to create the Interest of other donors in the replication of the CSC or supporting the supply side, which is a longer timeframe process.

It was also a big effort and a challenging one to engage with policy level stakeholders for institutionalization of the CSC and the JCMCs particularly when the scale up project was only of 18 months. These challenges were overcome by working on multi-pronged strategy by seeking policy support at the highest level in the Department of Health and with the key stakeholders at the Provincial and effort was more painstaking as it involved several awareness meetings with the Deputy Commissioner, DHO and District Nazim. This enabled a greater understanding of the project. We used persuasive and other advocacy techniques that resulted in a complete buy-in. CUP invited potential donors at every stage of the CSC process in all the 3 CSC cycles. The Chief RTI Commission sent an EOI for to CUP Pakistan for "Conducting a Social Audit of Education Services in District Swabi. The challenges were also overcome because of two factors; (a) proving through evidence the improvements brought about through the CSC application and (b) relentless advocacy -3 advocacy seminars, 3 DAF meetings and rapport and liaison with Secretary Health and DG-Health

Some useful Lessons were also learnt such as; Involving Elected Members and MPAs played a key role in implementation of agreed action plans and notifications. Community involvement through presentation of a resolution and charter of demands in Advocacy Seminars was productive. This resulted in allocation of funds for BHU infrastructure such as LHW rooms have been promised in the Annual Development Plan for FY 2018/19. IEC Materials and Advocacy at the Community User Levels increases the awareness on rights and entitlements. Support of Policy Level Stakeholders (Health Department, IMU, and HSRU & Integrated Health Services) was the key to Success and The government buy-in and future participation in CSC projects will have a sustainable effect if the project caters for some of the action plans (a small hard component).

Since general elections are scheduled in 2018, the process of sensitization of the new representatives will have to be carried on CSC. JCMCs have been motivated to monitor this commitment and ensure that the budget is set side. CUP Pakistan will also follow up through its provincial office. IEC and Advocacy is the key to influencing citizens, service providers and policy makers. Thus for such like projects, more allocations would be required. Lastly, a mall supply side items such as provision of MUAC for screening of pregnant and lactating women and children under 5. Some equipment and

Medicines for Outdoor Therapeutic Centers (OTP Centers based in BHUs. This recommendation goes along with the findings that showed almost no nutrition support activities.

The following evidence was successfully used for policy change: notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017 and notification by DG-Health of KPK addressed to all DHOs in the Province for institutionalizing the CSC because of the stated improvements & Notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017. The following evidence was successfully used for changes in practices; the notification by the DHO of December 13, 2017 of 7 JCMCs, all funds were spent by UC members @ PKR 730,000 per BHU during the fiscal year 2016-2017 and now they are utilizing these funds in the fiscal year 2017-2108.

Strong Advocacy played a key and pivotal role in the achievements of the outcome and outputs. This is manifested by the press coverage of all mega and important events by the print English as well as Urdu Media. CUP Pakistan is thus well placed for supporting the Government of Khyber Pakhtunkhwa in replication of the CSC method for improving healthcare in other districts.

## 2. Background Information

This project was a scale up on an earlier pilot project; "Community Score Card for the improvement in family planning services in Peshawar" implemented by CUP Pakistan (15 April 2015-15 February 2016). The resultant CSC model for citizen monitoring, feedback and action planning was acknowledged as a productive and sustainable model by the Secretary Health and Secretary Population Welfare as well as by the Communities in the catchment areas of the selected service facilities. Thus, the stage was set for this scale up project in District Charsadda involving the carpet coverage of all of the 43 BHUs in the District. This replication and scale-up project design took into account several lessons that were learnt during the pilot project, which in brief are:

- Greater orientation of government/other stakeholders on CSC and its benefits.
- Effective coordination /consensus building among stakeholders to own the CSC process.
- Requirement for multi-level stakeholder engagement for primary healthcare standards and institutionalization[1] of the CSC as a regular citizen-health facility service delivery improvement method.
- Community activists and Facility Staff to have the capacity to conduct CSC; understand Primary Healthcare Standards Indicators and escalate CSC recommendations for addressing at policy/provincial level.
- Formation of Advocacy Forums for addressing issues that are raised in the Agreed Implementation Plans that is beyond service facility level resources.
- Procedures to be developed with Key Stakeholders to conduct CSC and present its recommendations at facility, district and provincial levels, as in the pilot phase, only district level recommendations were addressed.

### *2.1 Country Context*

The eight United Nations Millennium Development Goals (MGDs) were time-bound and quantified global targets ranging from halving extreme poverty rates to providing universal primary education by 2015. Pakistan signed off on the MDGs in 2000, however, despite all the rhetoric around policy, budgetary and implementation commitments, and subsequent efforts, the country's track record fell short of the targets, placing it next to those nations ranked the lowest in the Human Development Index. Then, came the Sustainable Development Goals (SDGs), set an ambitious set of 17 goals with 169 indicators set to impact seven billion people, with a single deadline of 2030. However, they are yet another articulation of aspirations reflected in development terminology crafted in the halls of the UN and subscribed to by governments without always comprehending the level of effort and resources required. With Goal 3 – promoting good health and well-being – calling for an integrated approach crucial for progress across multiple goals, including alleviating poverty and hunger, the focus includes a commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable

[1] "Institutionalization" in the context of this project, refers to formal notification of the CSC models by the Provincial health department for improvement of primary healthcare services & the notification of "District Advocacy Forum (DAF)".

diseases by 2030. It also aims to achieve universal health coverage, and provide access to safe and effective medicines and vaccines for all.

Consider the challenges to mother and child health in Pakistan. Especially severe, they can be attributed to poverty, and compounded by social exclusion and discrimination. Behind every statistic, there is a child in distress calling for immediate attention of state and society. According to UNICEF, despite significant improvements over the past two decades, Pakistan ranks towards the bottom among other countries when it comes to infant and neonatal mortality. This is why 44% of all children are stunted and 9.6 million experience chronic nutrition deprivation. Compounding the nation's state of poor health, for example, is the toll taken by pneumonia killing approximately 92,000 children annually. Pakistan's ranking in the Maternal Mortality Ratio Index has slipped from 147 in 2014 to 149 in 2015, recording a staggering 276 deaths per 100,000 births. Excepting Afghanistan, all the other countries in this region have better health indicators than Pakistan.

To add, Pakistan has the third highest rate of infant mortality in the world. The mortality rates among children are often seen as a proxy for the level of social development. And for good reason, because they reflect the level of nutrition, parents' education, and access to health services. Consider the impact of the Benazir Income Support Program – the largest social protection intervention – which targets women living in chronic poverty.

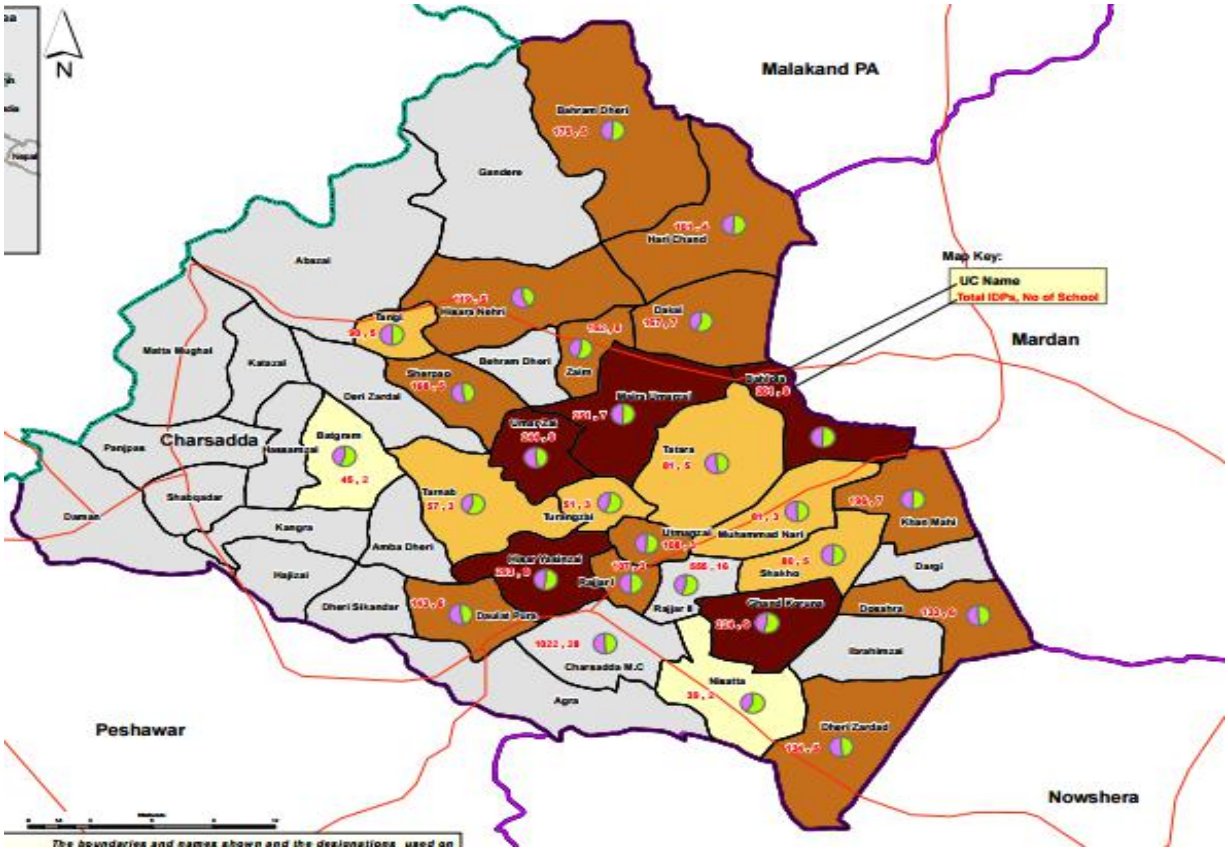
If one examines the recently announced National Health Vision, it may present an alignment of socio-economic commitments, but is also reminds that without national consensus the state-owned health sector will continue to suffer. With no universal medical care, overhauling the health sector not only requires that health be put at the top of the political priority list, but increased funding, efficient cross-sector linkages and medical training are also imperative if the NHV is to be implemented.

With the government's development blueprint premised on an enabling environment essential for socio-economic development, Vision 2025 is to be implemented in sync with the SDGs. For now, all such plans look good on paper. However, sustainable development is achievable through the process of devolution. The reality may be that poverty will not be eradicated by 2030, and the state may not be able to feed around 215m children, nor ensure healthy living for all, but what can be achieved is tailoring programs to the demographics of different geographical regions by looking at the evidence of success and deriving contextual formulas for efficient delivery.

While several INGOs, NGOs and CSOs are working on healthcare awareness and improvement, there has never been a project designed in Pakistan to assess how much improvements can be made by the application of the CSC process. That is why, this project caught the attention of development practitioners who watched with interest the results generated by this intervention.

## *2.2 Project Area Context*

District Charsadda is administratively divided into two Tehsils; Charsadda & Tangi.




BHU Locations in District Charsadda: **There are 43 BHUs spread across the District as per the DHIS as shown at** Annex-2

**Why District Charsadda**? In several meetings with the EVA-BHN Group, the HANIF team & CUP Pakistan it was agreed that the scale up should be in district other than those where EVA-BHN Program are working. This, it was felt would enable us to compare the results of establishment of community groups around each health facility with the CSC method in another district. Two baseline documents are available on the health facility assessment in District Charsadda and KP (conducted by TRF)

- *Health Facility Assessment Provincial MNCH Services Report –Khyber Pakhtunkhwa - February, 2013*
- *Health Facility Assessment – Khyber Pakhtunkhwa, District Charsadda, June 2012*

Since these documents fell short of specific baseline indicators with regard to the approved "***essential minimum standards for primary healthcare in KP"*** we planned, as a part of the project design, to use the results of the 1st CSC for each of the agreed primary healthcare standards/indicators as a baseline in District Charsadda. This enabled CUP to measure changes/improvements after the application of the 2ndCSC and finally the 3rd CSC. The BHU is located at a Union Council Level and serves a catchment population of up to 25,000. Services provided at BHU are promotive, preventive, curative and referral. Outreach/community based services are part of package provided by the BHU. BHU provides all PHC services along with integral services that include basic medical and surgical care, family planning, MCH, CDD, CDC, ARI, malaria and TB control. BHU provides first level referral to patients referred by LHWs. BHU refers patients to higher level facilities as and when necessary. The BHU also provides clinical, logistical and managerial support to the LHWs. It also serves as a focal point, where community and

the public sector health functionaries may come together to resolve issues concerning health. Thus the LHWs are very much a party of the BHU functions with regard to (i) family planning and (ii) primary healthcare.

The primary health care is also within the purview of the local government at the district level. Thus, we had a very supportive role of LG representatives who took active part in all of the CSC activities as well as in providing their funds for healthcare (PKR 730,000 per UC Member) for the Improvements in respective BHUs. The key stakeholders that were engaged in this project were the over 800,000 communities/users in the catchment areas of BHUs, the Health Department of KP, District Health Officer (DHO) District Charsadda, DCO Charsadda, Local Government (District Nazim), the LHW Program Coordinator& the Right to Information Commission.

### *2.3 Rationale for the Project*

This project was based on the lessons learnt in the pilot phase in which the Community Score Card (CSC) was tested on a sample of 9 Service Facilities in District Peshawar as a citizen monitoring & feedback method for triggering improvements in the delivery of family planning/reproductive health Services. Since the CSC model made visible improvements against 16 agreed indicators which were supported by evidence, a scale up project was needed to cover all the primary healthcare service facilities in another district with the goal of affecting improvements in primary healthcare service delivery across "primary healthcare standards and indicators" which are enunciated in the Government of KP approved "minimum essential standards for primary healthcare". This project was also needed to demonstrate the substantive improvements that can be made through the CSC method by a carpet coverage of all BHUs in the District, which would eventually lead to the institutionalization of the CSC as a regular function for citizen-service facility joint action planning for improvements in service delivery.

Thus, the conceptual framework of this scale up project was to contribute to the larger strategic goal of the government of KP for the achievement of its healthcare goals in the longer term of 3-4 years, as enunciated by the Government of KP Integrated Development Strategy (IDS) 2014-2018 and Health Sector Reforms (2013-2017). We see the achievement of this goal through appropriate resource allocations by government and measures to improve in service delivery, with the CSC as a tool for creating demand for services and evolving joint agreed planning once the issues are identified through the application of the CSC.

This scale up project was conceived within the overall goals and framework of the DFID Funded Provincial Health and Nutrition Program (PNHP) with the Government of Khyber Pakhtunkhwa, which aims to achieve Reproductive Maternal, Newborn & Child Health (RMNCH) and nutrition results over four years 2013 to 2017 (now extended until 2019).Under PHNP, the project on Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN)" focuses primarily on the 'demand side' of RMNCH and nutrition services. EVA-BHN and HANIF thus aims to complement the 'supply side' activities under the broader PHNP framework through "Enhancing Communities' understanding of their health rights, entitlements and engagement in monitoring the planning and delivery of services".

## *2.4 Your Innovation its strengths and uniqueness*

This innovation was applied for the first time in KP for integrating citizen led monitoring with the internal monitoring by the IMU-Health, DHO, District Administration and District Council Members. The success of the innovation, which includes a general acceptability of its utility with regard to M&E has led to the institutionalization of the CSC at the District Level (by DHO) and at the Province wise (by DG-Health). Therein lies the concrete evidence of the strengths and uniqueness of the innovation conceived and implemented by CUP Pakistan.

**Strengths of the Innovation**

- **Citizen-Driven**: The Community Score Card is a citizen-driven accountability tool for the monitoring, assessment and planning for improved service delivery. Yet it included the service provider as a part of the CSC process and involved them to carry out self-evaluation against the same essential agreed indicators.
- **User Feedback Facilitated Communication**: The CSC was used to gather feedback from service users and thus it improved user relationship with the service facilities staff through a common understanding of issues and solutions to problems. It thus facilitated accountability, transparency and responsibility by service providers.
- **Complemented Supply Side**: It was designed to complement the conventional supply-side mechanisms of accountability by bringing together service users and service providers to identify the underlying obstacles to effective service delivery, and then develop a shared strategy for their improvement.
- **Sustainable when Integrated with Government M&E:** The acceptability of this project innovation by the government was indicated during the project implementation. It was dovetailed fully with the citizen inclusive initiatives of the government of KP such as the Independent Monitoring Unit of the Health Department of the Government of KP, Integrated Health Services, Right to Information Commission and the "Service Delivery Act of KP". It is for this reason that this innovation was declared sustainable, which was further strengthened by the established and notification of the DAF.
- ***Empowered Women:*** 50% of the Lead Activists were women and 90% of the User Community were women beneficiaries of the improved Primary Healthcare.

**Uniqueness of the Strengths of the Innovation:**

- It is a pioneer innovation involving women-led monitoring through a simple social accountability tool.
- Since the innovation is simple and it generated the evidence based results, government ownership was achieved.
- It promoted dialogue and improved relationship with the 43 service facilities where it was applied.
- It facilitated a common understanding of issues and solutions to problems.
- It empowered service users through community monitoring of services and increased community ownership of services.
- It facilitated accountability, transparency and responsibility by service providers.
- It improved the behaviour of service providers which assisted in improved service delivery.

***2.5: Project Goal:*** To Improve Quality of Primary Healthcare Services Delivery in District Charsadda using the Community Score Card (CSC) Model for Citizen Feedback, Monitoring & Joint Action Planning.

***2.6: Project Objectives:*** *The specific objectives are:*

- ***Objective-1****: Create Buy-in of the" Key Stakeholders" for Citizen-Led Monitoring, Feedback and Joint Action Planning through the CSC Model.*

- ***Objective-2:*** *Mobilize the communities to identify activists and form Joint Citizen Monitoring Committees (JCMCs) to conduct CSC;*

- ***Objective-3****: Advocacy with key stakeholders" for institutionalization of the CSC as a citizen-inclusive monitoring and planning method.*

***2.7 Project Implementation***:

Community Mobilization & Stakeholders Engagement in Catchment Area of 43 BHUs

Selection of 176 Lead Activists (88 Women and 88 Men) – Aug-Sep 2016

Training of 176 Lead Activists (Catchment Area of each Service Facility as Reps of User Community in CSC (Nov 2016)

Community Awareness Sessions on Citizen entitlements for Primary Healthcare Services at (Oct 2016)

Training of 43 Service Facility Staff (BHU) on CSC (Self Evaluation) (Nov-Dec 2016)

**Agreement with Key Stakeholders (DHO, IMU-Health, DOH on Indicators for the CSC (8 Nov 2016)**
During the planning stage community feedback was obtained on the current issue related to primary health care in District Charsadda and then these issues were grouped to form a co-relationship with the "minimum essential standards for primary healthcare". These are shown below:

***Service Provision indicators***

| # | Issues Identified by CUP Social Team with Marginalized User Communities | Indicators for Measurement by CSC & Repeat CSCs | Reference to PHC Standards KP |
|---|---|---|---|
| 1 | Absence of patient friendly attitudes & behavior | 1.1 (%) Improvement in client satisfaction with health facility staff behavior<br>1.2 Reduction in complaints regarding staff attitude and behaviors | 2.2 B |
| 2 | Non-availability of outreach services on Preventive Health Awareness by LHWs | 2.1 No of outreach sessions conducted for user communities on Preventive Healthcare & Hygiene by LHWs.<br>2.2 (%) improvement in client satisfaction with sessions | None |
| 3 | Shortage/non-availability of Essential Medicines | 3.1 (%) improvement in availability of Essential Medicines.<br>3.2 (%) increase in users satisfaction (Score of 3 & above) with medicines dispensation. | 2.15 A |
| 4 | Quality & technical correctness of IMCI, ANC, Delivery, PNC, Polio, and EPI is not according to treatment protocols. | 4.1 (%) improvement in antenatal care services<br>4.2 (%) improvement in postnatal care services<br>4.3 (%) Improvement in referral systems<br>4.4 (%) Improvement in child vaccination system<br>4.5 (%) improvement in institutional deliveries | 2.9 B |
| 5 | LHVs not proving proper LHV services due to their own private clinics. | 5.1 (%) Improvement in client satisfaction with LHV services<br>5.2 (%) clients showing satisfaction on the quality of institutional deliveries | None |

***Service Management Indicators***

| # | Issues Identified by CUP Social Team with Marginalized User Communities | Indicators for Measurement by CSC & Repeat CSCs | Reference to PHC Standards KP |
|---|---|---|---|
| 6 | There is generally non-functional equipment & thus do not meet defined services | 6.1 (%) improvement in availability of functional equipment | 1.4 A |
| 7 | Functionality of BHU facilities need to be ensured (drinking water, separate sign posted toilet for male & female, boundary wall & Waste Management System) | 7.1 Number of BHUs with available clean drinking water<br>7.2 Number of BHUs with separate toilets for male and female<br>7.3 Number of BHU with available waiting areas<br>7.4 Number of BHU with proper waste management system<br>7.5 Number of BHU with improved infrastructure<br>7.6 Number of BHU with functional electricity connections and back up | 1.5 A<br>1.6 B<br>1.7 A<br>1.8 A |
| 8 | The Complaint Management System needs improvement & follow up on issues raised by users | 8.1 Number of BHUs with displayed grievance redress mechanism<br>8.2 (%) reduction in complaints registered<br>8.3 (%) increase in complaints resolved | 1.14 A |

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|---|---|---|---|
| 9 | LHVs capacity building needs to be addressed | 9.1 (%) improvement in LHVs capacities as per their TORs & Annual Reports. | 1.11 A |
| 10 | Absenteeism and staff availability needs to be tackled | 10.1(%) reduction in staff absenteeism<br>10.2(%) improvement in staff adherence to official timings<br>10.3(%) reduction in vacant positions in all categories | 1.10 A |

**Input Tracking at 43 PHC Service Facilities (BHUs)**
**(Nov-Dec 2016)**

***Recording of Existing Facilities, & Services:***
***Building, Medicines, Staffing, Water, Sanitation***
***against***
***Authorized Entitlements at BHUs.***

**Performance Scoring of Services (Each Indicator) by User Community**
**(Dec 2016-Feb 2017)**

**Self Evaluation Scoring of Services (Each Indicator) by Facility (BHU) Staff (Jan-Feb 2017)**

**7 Joint Interface Meetings**
**(Agreement on Key Issues Identified by Performance Evaluation & Self Evaluation)**

**Result:**

- 43 Agreed Action Plans
- Formation of 7 JCMCs

**Implementation of Joint Agreed Action Plans**

**DISTRICT ADVOCACY FORUM**

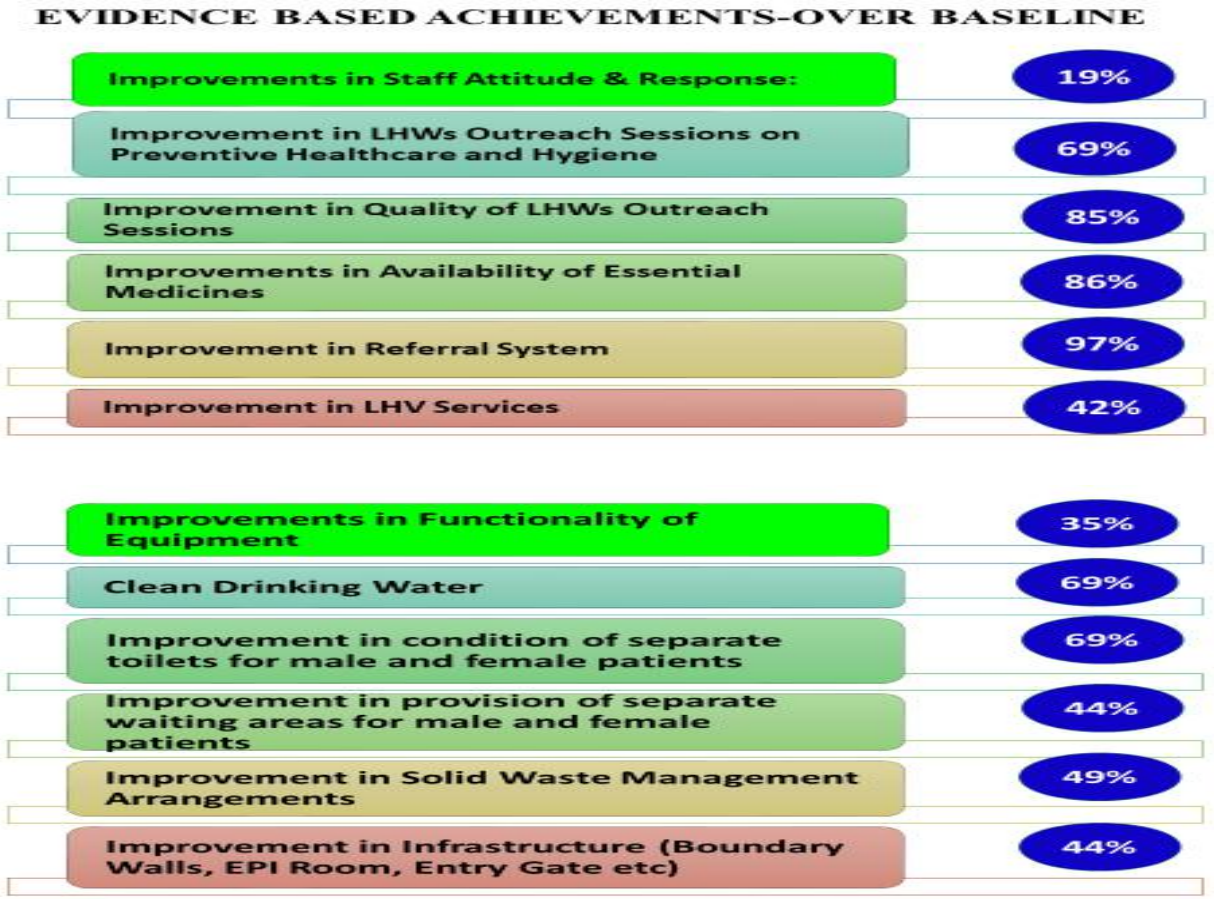


**Repeat CSCs to Validate/Measure Progress of Agreed Action Plan**

1. 2nd CSC (April – May 2017
2. 3rd CSC (September - November 2017

**DAF link up with Provincial Advocacy Forum (28 December 2017)**

### *2.8: Activities & Achievements against the Project Log frame*

| Project Summary | Indicators | Assessments/Achievements |
|---|---|---|
| **Project Impact:** *Improved Quality of Primary Healthcare Service Delivery in District Charsadda*. | % Improvement in quality of Primary Healthcare Service Standards" | The 1st CSC was taken as baseline. The following improvement were recorded after the completion of the 3rd CSC.   |


**Note:** The issue of "institutional deliveries" remains the same as there is no "labor rooms and facilities" in any BHU of District Charsadda. The DOH is considering the "resolution" presented by the communities in the 2nd Advocacy Seminar**.**

**Improvements Measured against "Proxy Indicators"**

For this purpose, proxy indicators were adapted to show the effect of CSC implementation in district Charsadda. Data for proxy indicators is collected for 16 months (from September 2016 (baseline from HMIS)) to December 2017), that is further clubbed into 4 periods quarter (4 months in each period). Data for the 1stperiod (September to December 2016) is taken as the base value for the rest of the three periods in order to gauge any improvement/deterioration during the life cycle of the project. The improvements against the following "proxy indicators" were recorded:

1. ***Number of OPD Clients***

Number of OPD has significantly increased as 11% raise has been observed in January 2017 to April 2017 period, 25% increase in May 2017 to August 2017 while 34% increase in September 2017 to December 2017. This could be attributed to CSC intervention where awareness sessions were conducted within the community. At the early stages of CSC, male participants informed CUP staff that only female patients attend

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| | | the BU facility, they were of the view that BHU provides services to females only in the shape of family planning. During the 1st CSC, service users were not able to attend BHUs because of non-availability of medicines, now that medicines are abundantly available and staff behavior being improved, increase in the OPD influx could be attributed to these factors.<br>***2. Number of ANC Check Ups***<br>As mentioned earlier that non-availability of Labor Rooms coupled with lack of functional equipment in any of the 43 BHUs has exacerbated the provision of Antenatal, Post Natal Care Services, and Institutional deliveries. However, significant improvements are found in the number of patients attending for ANC checkups. This improvement could be ascribed to the hiring of new LHVs and provision of medicines because of implementing CSC.<br>***3. Number of Deliveries in BHU Premises***<br>Absence of Labor Rooms in any of the 43 BHUs is a major issue faced by the residents of district Charsadda, however, the number of deliveries conducted has significantly increase from 182 in Sep-Dec. 2016 to 350 in Sep-Dec. 2017, showing an increase of 92%. Since no labor room exists in all the BHUs, it is very rare to conduct a delivery inside the premises of BHU, however, SBAS conduct deliveries using their own resources inside their houses and later these cases are registered at the BHUs.<br>***4. Number of Emergency Cases Referred to DHQ/Others***<br>The number of referred cases has significantly increased since the inception of this project. Prior to the implementation of CSC, a dubious referral system existed in the BHUs but the implementation of CSC helped in regularizing this system. Although a proper referral system is still not available and this issue was properly communicated to the DHO during the interface and JCMC meetings. In response, he directed all the facility staff to refer patients through OPD slips, as a result, an improvement can be seen by over a peak 149% during the quarter May-Aug 2017.<br>***5. Number of Pregnant Women received Obstetric Emergency Care***<br>Considerable improvement can be found in the number of pregnant women who received obstetric emergency care, from 39 women in Sep-Dec. 2016 to 261 women in the period of Sep-Dec. 2107, showing an increase of 570%. The cause of this improvement could be awareness raised in the community as well as |

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| | | the commencement of LHWs' and LHVs' sessions. LHVs conduct deliveries in the premises of the BHU as well as their own residences since the timing of BHUs is from 8A to 2PM. When they conduct deliveries in the BHU timings, they do not charge for their services otherwise patients are charged whenever they conduct deliveries in own residences apart from the BHU timings.<br><br>***6. Number of Children 0-5 Years Age Immunized***<br>Immunization remain adeptly available in almost all of the BHUs in district Charsadda. The service users also claimed their satisfaction upon the service of immunization and the service providers affirmed this. Although a 15% improvement can still be observed in the number of immunized children. This is mainly the result of new appointments of EPI Technicians for the large catchment population areas.<br><br>***7. Number of Children Screened for Malnutrition with MUAC, Weight and Height***<br>Interface and JCMC meetings of all the rounds of CSC has highlighted the unavailability of equipment as the major concern and it was communicated to the DHO in a proficient manner. Upon the follow-up of CUP, DHO apprised that the procurement process of purchasing equipment has been completed and recently, distribution of medicines has been commenced (BHUs located in settled areas received equipment while the far-flung areas would be equipped shortly).<br><br>***8. Number of Pregnant Women who received TT Vaccinations***<br>During the Performance Assessment Sessions, several women claimed that TT vaccinations have started for the first time in their BHUs and that is mainly because of the implementation of CSC that put pressure on the administration to provide necessary medicines. Additionally, new LHVs and FMTS are also appointed leading to an increase in the number of pregnant women who received TT vaccinations (peak improvements of 24% in the period May-Aug 2017. |
| **Project Outcome:** *Community Score Card (CSC) model institutionalized as a* | 1. CSC method notified as a regular mechanism for citizen-feedback. | This outcome was achieved when Community Score Card was notified as a regular mechanism for citizen feedback by the Deputy Commissioner on January 12, 2017 and finally Province Wise by the Department of Health, Khyber Pakhtunkhwa on 28 December 2017. The7 Joint Citizen Monitoring Committees JCMCs) which were established during the 1st CSC were also notified by the DHO on 13 December 2017. |

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| *citizen-inclusive planning tool* | 2. District Advocacy Forum (DAF) established for institutionalization of the implementation of CSC recommendations at District Level & it linkage with a Provincial Advocacy Forum (PAF) | DAF was formed and notified at district level by the Deputy Commissioner on 12 January 2017 and the DAF was formally linked to PAF on 28 December 2017. |
| ***Output-1**: Project Buy-in and Agreements with Key Stakeholders* | 1.1 Government is committed to improve the quality of health care services through signing of Memorandum of Understanding (MoU) and granting of No Objection Certificate (NOC) to start project intervention in selected district<br>1.2 Strategy for relevant stakeholder's engagement designed.<br>1.3 Agreed set of indicators for PHC Service Delivery for CSC<br>1.4 Inception Workshop for Key Stakeholders Conducted. | *1.1 This output was achieved when a Memorandum of Understanding (MoU) was signed with Health Department in the 1st quarter of the project (30 September 2016). An NOC was also issued in the same quarter on 4 November 2016 paving the way to conduct the activities of the project in a smooth manner.*<br>*1.2 This output was achieved in the 1st quarter of the project.*<br>*1.3 A meeting with the Independent Monitoring Unit (IMU) Khyber Pakhtunkhwa was conducted to finalize the indicators for PHC Service Delivery for CSC, as a result, Agreed set of Indicators were established in the 1st quarter of the project on 8 November 2016.*<br>*1.4 An Inception Workshop for Key Stakeholders was held on September 30, 2016. The underlying theme of this "Inception Workshop" was to bring all key stakeholders of this project under one platform and develop an understanding of how this project will benefit the ultimate beneficiaries through quality primary healthcare services.* |

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| ***Output-2**: Users aware of PHC Entitlements, Lead Activists and BHU Staff capacitated in the use of CSC by its application quarterly.* | 2.1 Increased awareness of User Community and lead activists on PHC entitlements<br><br>2.2 Capacity of Lead Activists & BHU Staff built on PHC entitlement and CSC application for improvement in PHC Services.<br>2.3 CSCs Conducted & Results shared with Stakeholders. | *2.1 Awareness Increased through 44 Social Mobilization Sessions were held during August 2016 in order to identify Community Lead Activists where 472 male participants and 269 female participants took part. Among these participants, 176 Lead Activists were selected comprising of 50% male and 50% female.*<br><br>*2.2 Capacity developed through Training Workshops organized for Lead Activists during September 2016, each workshop comprising of 3 days. Lead Activists were oriented on Citizen Entitlements at BHUs on Primary Healthcare and the usage as well as the application of CSC. Similarly, training was also provided to BHU staff to build their capacity in 3 batches comprising of 93 participants.*<br><br>*2.3 This output was successfully achieved as three CSCs were conducted throughout the life cycle of the project. 43 Agreed Action Plans came into existence after the interface meetings followed by the 7 JCMCs where the health department ensured their presence. Follow-up on the issues was made by CUP after each CSC. All the results and information were regularly shared with all the relevant stakeholders.* |
| ***Output-3**: CSCs advocated with key stakeholders and institutionalized.* | 3.1 Advocacy Strategy & Plan<br>3.2 No of Advocacy Events<br>3.3 # of Press releases or media coverage reports highlighting the health Policy, Gaps and Recommendations<br>3.4 *Sustainable Close-Out Plan* | *3.1 Advocacy strategy and plan was developed and shared with HANIF;*<br>*3.2 Three Advocacy Seminars were organized in which representatives of all stakeholders participated and advocated for citizens' rights for Primary Healthcare & Institutionalization of the CSC Method*<br>*3.3 Numerous press coverage through press releases highlighted the health policy, gaps and recommendations*<br><br>*3.4 CUP Sustainable Close-out Plan was achieved through Notification of the CSC at Provincial Level, Notification of DAF-Health at the District, and Notification of the 7 JCMCs in District Charsadda & Linkage with PAF.* |

## 3. Key Project Achievements

An overall summary of project achievements are:

- *741 (472 male, 269 female) community members have been sensitized on issues related to Primary Health Care (PHC) in Charsadda.*

- *1,398 community members and 176 lead activists have been sensitized through 86 awareness-raising sessions on BHU entitlement and citizen rights to minimum essential package for primary healthcare.*

- *The capacity of Lead Activists & Staff of 43 BHUs has been built on PHC entitlement and CSC application for an improvement in PHC Services*

- *IEC Materials on the CSC, BHU Entitlements and Citizen Rights to Quality Healthcare are placed at all 43 BHUs.*

- *7 Joint Citizen Monitoring Committees (JCMCs) have been formed, notified and strengthened to continue monitoring the agreed joint action plans.*

- *Boundary walls have been constructed/repaired in 16 BHUs through the funds of local government representatives to facilitate the security of BHUs staff and female patients.*

- *Solar Systems have been installed in 24 BHUs for maintaining the cold chain for vaccines in view of the frequent power outages through the funds of local government representatives.*

- *Evidence Based Improvements in Service Delivery in 43 BHUs as shown under paragraph 2.8 achievements under log-frame.*

- *A letter has been issued from the DHO to the Project Director of Integrated Health KPK to establish 24/7 EMONC services in cluster BHUs of District Charsadda;*

- *Due to follow-up by user communities during CSC cycles, the Government of KP advertised all the position of LHWs. This will be followed by recruitment of 25 LHSs for complete coverage of user communities, which will fill the gaps in the LHWs coverage with regards to sessions coverage;*

- *During CSC cycles, the community users as well as the BHU staff highlighted the need of LHWs' room in the BHUs as one of the major issue, thus making it one of the important components of the agreed action plans. After the follow up by the JCMCs during the 3rd CSC, LHWs' rooms were constructed in 3 BHUs (Tarnab, Sheikho and Daman);*

- *One of the major drivers in the sustainability of this project could be the Complaint Management System which was lacking in almost all the BHUs. CSC project interventions helped in updating Public Information Board, display of Complaint Box and B-2 Register at all the BHUs.*

*3.1* ***Project Outcome:*** *Institutionalized Community Score Card (CSC) model as a citizen-inclusive monitoring & planning method.*

**Achievement of the Outcome**

- Notification & Institutionalization of CSC at District Level on 12 January 2017)
- Notification & Institutionalization of DAF Health at District Level on 12 January 2017)
- Notification of 7 JCMCs at the District Level on 13 December 2017
- Notification of CSC Method at the Provincial Level on 28 December 2017

## *3.2 Evidence for Policy and Practice Changes*

This project contributed towards a significant policy change as well as acceptance of citizen-inclusive practices. This was primarily because of evidence based improvements in primary healthcare services measured through the 3 CSCs findings as well as assessment of the "proxy indicators" in each quarter of the project. This evidence was shared through 3 Advocacy Seminars. The evidences are as under:

| # | Policy Changes | Evidence for Policy Changes |
|---|---|---|
| **1** | District Charsadda has adopted the CSC as a regular feature of its primary healthcare | Notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017. |
| **2** | Health Department of KPK has announced it policy for conducting CSC in other districts of the Province because of the contribution of the CSC project in tangible improvements in PHC | Notification by DG-Health of KPK addressed to all DHOs in the Province for adopting the CSC because of the stated improvements. |
| **3** | The DAF-Health at District Charsadda has been institutionalized | Notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017. |
| | **Changes in Practices** | **Evidence for Changes in Practices** |
| **1** | The District Health Office has accepted monitoring by the 7 JCMCs in accordance with approved TORs. It has also agreed in the TORs to assure budgetary support to these JCMCs | The Notification by the DHO of December 13, 2017. |
| **2** | The district and elected UC members are now active in the allocation of their funds for the improvements in BHU services and infrastructure. | All funds were spent by UC members @ PKR 730,000 per BHU during the fiscal year 2016-2017 and now they are utilizing these funds in the fiscal year 2017-2108. The evidence |

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| | | and supporting evidence is the Notification by DG-Health of KPK addressed to all DHOs in the Province for adopting the CSC because of the stated improvements. |
| **3** | User Communities of the catchment areas of 43 BHUs (86,000-women, children and men) are now having a "voice" which they are using whenever they have a complaint with regard to services. | This is manifested by the increase in resolution of complaints (Project see achievements (Paragraph 2.7) |

### *3.3: Financial and programmatic Institutional capacity (How the project has contributed in enhancing the organisational capacity)*

This project helped to enhance the financial and institutional capacity of Community Uplift Program through different approaches. Community Uplift Program as a progressing organization has experience to improve the internal controls, policies and procedures related to budgeting and financial system. There are proven enhancements in financial controls, donor compliance, documentation/record keeping, effective assets and resource management which were reflected in the monthly/quarterly progress reports of the organization. This experience would be useful in the prospective projects/partnerships with Palladium International as well as DFID and other donor agencies. CUP also retained some of the experienced staff in the other ongoing projects.

The strong coordination and collaboration of CUP with the government departments especially the health department helped in the notification of the CSC on district level. Moreover, the Deputy Commissioner of Charsadda also notified DAF and chaired all the DAF meetings on regular basis. While looking at the successes of Community Scorecard process, DG-Health institutionalized the CSC process on provincial level which is a great success of CUP. It is also communicated to the health department that CUP can offer its services in terms of technical assistance to the health department for further strengthen citizen performance monitoring.

Human Resource Management was the heart of an organization, DFID's grant helped CUP to recruit qualified and motivated staff to implement the Community Score Card. In this project CUP also arranged trainings for these staff members, now these trained staff members are the assets of organization for future assignments (if any). CUP also trained the 176 Community Lead Activists and 93 Primary Healthcare Providers/BHUs staff on the application of community score card. These trained community members and healthcare providers can be utilized by the government and other organizations in future to implement social accountability projects. CSC project built the capacity of organization in terms of staff management and project activities. Moreover this value-added organizational capacity would make a significant difference in the lives of individuals and communities we serve.

Monitoring and Evaluation System: This project facilitated in strengthening the monitoring, evaluation and learning process within organization. Citizen based performance monitoring was introduced and implemented at district level. Primary and secondary data on primary healthcare services has been collected and analyzed; this data /knowledge/learning and outcomes would help donors see what we have accomplished and gain external visibility for what we do. After the 1$^{st}$ CSC, 7 Joint Citizen Monitoring Committees were formed which are responsible for the monitoring of Agreed Action Plan

established during the Interface Meetings of the 1st CSC. These JCMCs were also notified by the DHO and CUP is responsible for this innovation which not only strengthen the monitoring and evaluation system of this organization but passed it on to the community as well. Moreover, other stakeholders like health department and BHU staff were also capacitated and this process can be an added advantage to them.

Community Uplift Program emerged as a stronger field focused organization, through field focused approach by working in district Charsadda and strengthening the local primary healthcare services through most of the local staff. It has made a difference by having contributions which in financial terms were minimal but made a big difference in terms of the outputs. This has been achieved by the dedicated and motivated local staff. However with few exceptions, it has resulted in labeling of "CUP" district and spreading out too much with some limited resources. Through the advocacy activities/events and working with media groups in Community Score Card project, Community Uplift Program gained public attention and shared innovation and achievements publically. This would support in fundraising through exposure, and then we continue to improve through more grants and diverse donors.

Programmatic and Financial Capacities of CUP Pakistan: Our core management team for the design and implementation of the project has substantive capacities in project/program management and social accountability involving citizen oversight of government service delivery:

Capacities of the Project Team Enhanced by Palladium Group: Besides the strengths of the senior management team of CUP Pakistan, the Palladium Group set aside a budget allocation from within the pilot project for capacity building of the project team. It would have been more beneficial if these capacity building trainings had been held in the first quarter of the project. These were held as under:

- Capacity building training workshop for Project Finance and Admin/Logistics Staff was held on 15-17 September 2015 (pilot project). The objectives of the training workshop were to train grantee staff in financial management, accounts and book keeping, asset management, inventory and procurement and supporting documentation for HR files.
- Capacity building training workshop for Project Managers and Monitoring Officers on M& E and Report Writing on 18, 19, and 20 Sep 2015 (pilot project). The objectives of the training workshop were to build the capacity of staff project staff in report writing and monitoring, in understanding the process of formation of effective LFA and in comprehending the concept of the "theory of change". During the scale up phase, a training was organized at Karachi in December 2017 on project management in which key managers of CUP participated.

### *3.4: Linkages and Networking*

Building linkages and networking was an important part of the project to facilitate synergies. During the three rounds of Community Score Card process, Community Uplift Program arranged donor organizations visits to brand Community Score Card innovation and for enabling the Community Uplift Program in building synergies and linkages with national & international donors, UN agencies, INGOs, foundations and other sister organizations for future partnerships/funding. The objective of these visits were also to capacitate and link the Community Lead Activists/JCMCs with relevant sister organizations, international agencies and funding bodies to implement the action plans. In different

events representatives from World Health Organization, CDLD, UNDP, Eycon UNICEF, SRSP, ShirkatGah and Malteser International participated.

To establish linkages and networking the Community Uplift Program organized alliance meetings (Interface Meetings, JCMCs Meetings and District Advocacy Forums) with service providers, service users, decision makers and other concerned stakeholders. These meetings served as platforms for discussion of local issues of health service delivery and establishing coordination, linkages and networking among service providers, service users and decision makers.

Community Uplift Program conducted three advocacy seminars at provincial level, in which representatives from national organizations, international organizations, government departments and media groups were participated. In all these advocacy seminars the Community Score Card innovation was highly appreciated at district and provincial level. These advocacy seminars helped Community Uplift Program to gain attention at provincial and national level and also networking with other agencies.


Three meetings of District Advocacy Forum were also held which introduced the members of JCMC and was useful in presenting policy level issues to the decision makers. Towards the end of the project a major event "**Knowledge Sharing and Dissemination Workshop**" on **10 January 2018**was held where provincial and national members along with higher authorities of Health Department participated thus spreading the message of community scorecard method.

During the implementation of Community Score Card process the linkage and collaboration was developed with the Right to Information Commission and Right to Public Services Commission KP as the potential partners in social accountability movement at provincial level. The representatives from RTI and RTPS were invited in events organized by the Community Uplift Program at district and provincial level. In the result of these collaborations the Commissioner RTI applauded the expertise of CUP in the Social Accountability and he invited CUP to submit a proposal for Social Audit of Education Services in District SWABI-KP. This opportunity emerged as a breakthrough for Community Uplift Program in the field of social accountability in Pakistan.

Linkages and networking with Independent Monitoring Unit-Health in KP was the foundation to implement Community Score Card in district Charsadda. Community Uplift Program developed strong coordination and collaboration in the design phase of the project. The indicators for the Community Score Card were developed with the consultation of IMU-Health. During the entire phases of Community Score Card and events the representatives from IMU were involved. As an outcome of this collaboration and networking, in the Knowledge Sharing/Dissemination workshop of Community

Score Card project, the Project Director commended the efforts of CUP to solicit the citizen feedback mechanism and agreed to present the results of Community Score Card process of district Charsadda on the DASHBOARD of IMU-Health.

Community Uplift Program is an active member of COPASAH (Community on Practitioners on Accountability and Social Action in Health), which is a community where practitioners who share an interest and passion for the field of community monitoring for accountability in health interact regularly and engage in exchanging experiences and lessons; sharing resources, capacities and methods; in the production and dissemination of conceptual, methodological and practical outputs towards strengthening the field; and in networking and capacity building among member organizations.

Community Uplift Program established a Facebook page to gain visibility, access to funding of innovative ideas and networking opportunities for projects. This page is regularly updated where we also share community knowledge, best practices and achievements through Community Score Card in district Charsadda.

## 4. Challenges and Lessons Learnt and Solutions:

**a) Challenges**

**(1) Initially the CSC was seen as an intrusive monitoring tool by the service providers. It was for this reason that it took some time for the signing of the MOU with the Health Department and the District Administration of Charsadda, which eventually took place on September 30, 2016. Similarly, the NOC for the project was first issued on 4 November 2016 by the Deputy Commissioner Charsadda after the required clearances from the agencies.**

***Solution (1)**: CUP Pakistan worked on a 2-pronged strategy to overcome this challenge; sought policy support at the highest level in the Department of Health, by inviting Secretary Health to introductory meeting in Peshawar on August 13, 2016 along with the key stakeholders such as the Chief of HSRU, District Nazim Charsadda, DHO Charsadda, Project Director of IMU-Health. In this meeting the video of the successes of the pilot project was shown and this resulted in a policy directive by the Secretary Health to extend full support to the scale up project (reported through QPR-1). The second prong of our effort was more painstaking as it involved several awareness meetings with the Deputy Commissioner, DHO and District Nazim. This enabled a greater understanding of the project.*

**(2) Government Expectations for Hardware Support. As is with projects that have "soft components", there is a lack of interest by government service providers.**

***Solution (2)**: This was the toughest task to sensitize the district health administration for a "buy-in", however the evidence based successes of the pilot project were bandied about through advocacy techniques such as AIDA technique (**A**=Attract by how it will benefit the service providers, **I**=Interest creation of elected members of how the CSC will endear the voters by the improvements made, **D**=Desire Creation in DHO and Elected Members through awareness on the benefits of the CSC and **A**=Action desire in the Health Department and the District Administration).* It was also

mentioned *in our briefings that by creating this evidence based "demand for services", there will be several donors who will come forward to bridge the gap in "supply side".*

**(3) Lack of comprehension-was CSC considered as a duplication of the IMU-Health function**

***Solution (3):*** *In all of our initial meetings to secure a "buy-in" of key stakeholders we successfully explained that CSC was more of citizen engagement &monitoring by users, while the IMU-Health is basically monitoring of staff & services at health facilities. This required perseverance in all contacts with stakeholders. The "buy-in" achieved is evidence of the success of the solution that was applied.*

**(4) Creating the Interest of other donors in the replication of the CSC or supporting the supply side is a longer timeframe process.**

***Solution (4):*** *CUP invited potential donors at every stage of the CSC process in all the 3 CSC cycles. While the sustained advocacy created interest and awareness among donors, which will have an effect in the future, one success was achieved at the end of the project; Chief RTI Commission sent an EOI for to CUP Pakistan for "Conducting a Social Audit of Education Services in District Swabi*.

**(5) It was a big effort and a challenging one to engage with policy level stakeholders for institutionalization of the CSC and the JCMCs particularly when the scale up project was only of 18 months.**

***Solution (5):*** *This challenge was overcome because of two factors; (a) proving through evidence the improvements brought about through the CSC application and (b) relentless advocacy -3 advocacy seminars, 3 DAF meetings and rapport and liaison with Secretary Health and DG-Health.*

**(6) Getting District Elected Members & District Administration on the same page for funding Agreed Action Plans was again a challenge that was daunting.**

***Solution (6):*** *This challenge was tackled through motivating the DHO Charsadda to attend each and every activity of the project. At the same time the 7 JCMCs that were headed by the DHO emphasized the need for notification of JCMCs as well as their funding. This resulted in the Notification of December 13, 2017.*

**b) <u>Lessons Learnt</u>**

**(1) Involving Elected Members and MPAs played a key role in implementation of agreed action plans and notifications**

***Future Recommendation (1).****Since general elections are scheduled in 2018, the process of sensitization of the new representatives will have to be carried on CSC.*

**(2) Community involvement through presentation of a resolution and charter of demands in Advocacy Seminars was productive. This resulted in allocation of funds for BHU**

**infrastructure such as LHW rooms have been promised in the Annual Development Plan for FY 2018/19**

***Future Recommendation (2).****JCMCs have been motivated to monitor this commitment and ensure that the budget is set side. CUP Pakistan will also follow up through its provincial office.*

**(3) IEC Materials and Advocacy at the Community User Levels increases the awareness on rights and entitlements.**

***Future Recommendation (3).****IEC and Advocacy is the key to influencing citizens, service providers and policy makers. Thus for such like projects, more allocations would be required.*

**(4) Support of Policy Level Stakeholders (Health Department, IMU, and HSRU& Integrated Health Services) was the key to Success.**

***Future Recommendation (4).****Continued Interaction with Key Stakeholders must be done. CUP Pakistan will ensure this at least once a quarter.*

**(5) The government buy-in and future participation in CSC projects will have a sustainable effect if the project caters for some of the action plans (a small hard component)**

***Future Recommendation (5).****Small supply side items such as provision of MUAC for screening of pregnant and lactating women and children under 5. Some equipment and Medicines for Outdoor Therapeutic Centers (OTP Centers based in BHUs. This recommendation goes along with the findings that showed almost no nutrition support activities.*

## *4.1 What worked best in the strategy?*

CUP has capitalized on the already existing structures of citizen engagement which enabled stronger citizen participation & government responsiveness. PCMCs are attached with BHUs to provide support to facility administration, monitor & review the facility progress for effective health service delivery. This social constituency comprises community activists, & facility staff providing a platform for joint action. CUP through a screening process selected community activists (male and female) who were also influential in shaping up the joint action plans, JCMCs & continuous feedback to the district officials, resulted in high achievement of implementation of action decisions.

CSC is a feedback mechanism which resorts to closing loop by strenuous follow up by the stakeholders for actualization of joint agreed action plans. JCMC has proved a pronounced forum for citizen actions, & government responsiveness. This has realized the resolution of almost all the issues that were identified in the agreed action plans.

Frequency of the meetings, rigorous follow ups & continuous facility staff-activists interaction has proved its ability to make actionable changes. JCMC composition was a key to its success as this is headed by the district official with sizeable representation from facility staff & community activists. This is such a vibrant forum providing ample opportunities to both facility staff & community activists

to interact with district decision makers. This strategy worked very well &JCMCs have emerged as an effective platform for citizen engagement, feedback & institutional response.

Facility staff & community interaction increased manifold help reducing trust deficit. A strong collaborative approach as a result of improved communication between FWC & BHU staff has now translated into improved services. So, this bred a culture of collaborative approach towards improvement of services.

### *4.2 What didn't work and why? What could be done differently?*

**(1) Though, all the mitigation strategies worked very well to manage all challenges came during implementation of this project. The decision to invite media to all events instead of mega events created problems at times because media at the district level had expectations of TA/DA and because of conflicting group dynamics and their interests during media coverage of project's events.**

**What could be Done Differently**?

*This could be improved by conducting an analysis of media groups and individuals with regards to their conflicting interests especially in area like Charsadda. Representatives of all Groups should be invited at the District Level but only when there is a key event should devise strategy to invite all group representatives.*

**(2) Some of our project activities were affected by the other engagements of the BHU staff and LHWs in the polio campaign which took more time than the anticipated time.**

**What could be Done Differently**?

*More collaborative actions are required to jointly hold the activities in conjunction with the BHU work plans. We could have factored one week per month as written off because of the polio campaign and conducted activities with lead activists and user community during the polio week*

**(3) Some of the Agreed Action Plans required immediate response from the district government and the district health office but due to lack of funds for infrastructure, solar energy and equipment, the actions took time by tapping the resources of the elected members.**

**What could be Done Differently**?

We should in future such like CSC projects, prepare a comprehensive presentation to the "district assembly" on the advantages of the CSC and the need to allocate budgets for the implementation of agreed action plans. This proposal was in the pipeline and agreed to in principle but because of a "vote of no confidence" against the Nazim, put the proposal in the back burner.

**(4) Growing hostile environment within Pakistan & specifically, KP has imposed heavy restrictions on civil society work in development, rehabilitation & reconstruction in different regions within KP. This also impacted CUP Pakistan work in Charsadda.**

**What could be Done Differently**?

We have to live with such like security situations. However there is a substantive improvements in the security environment in Khyber Pakhtunkhwa.

## *4.3 What are the project recommendations for future advocacy?*

- We must develop a short 10 minutes clip/public awareness message aired on TV about citizen rights and citizen engagement in healthcare through social accountability tool of CSC.
- In collaboration with the District LG, address the public assembly on citizen rights to demand quality services and about social accountability.
- Tap selected MPAs as "champions" for social accountability;
- More expansive social mobilization & awareness efforts around the catchment areas of the selected BHUs.
- Develop IEC Materials on Social Accountability & CSC for wider circulation.
- Advocacy for allocation of funds for routine facility repair and maintenance such as improvements to consultation room, waiting room, drinking water supply, functionality of washrooms etc.
- Advocacy for training the staff (LHVs LHWs) on all service delivery including modern methods.
- Advocacy for installing public information board displaying information on the PHC and methods of grievance redressal.
- The current "communication and advocacy" effort was modest as we had a meagre budgetary provision. CUP Pakistan however on its own engaged with the media for coverage of key events and the end of project dissemination workshop.
- Include more multi-pronged advocacy activities over and above the existing activities in project design.
- Nurture, sensitise and focus on majority of lead activists and empower them to lobby and advocate with all stakeholders rather than only a few lead activists, a few were actively engaged in lobbying and advocating for their rights during the complete project cycle.
- Lobbying and sensitisation meetings with Chief Minister and Cabinet on need for Citizen Inclusive Monitoring of Services.
- Key media sensitisation, capacity building workshops for proactive engagement.
- Adequate Budget for project documentary, Radio/TV Messages/Talk shows and Engaging media houses for effective print electronic and social media campaigning/lobbying.
- Inclusion of "advocacy methods" in the orientation workshop for project staff, lead activists and for JCMCs during JCMC progress review meetings.

## *4.4 How can the evidence be used for policy and practice change?*

***The details are given in Paragraph 3.2 of this report. The following evidence was successfully used for policy change***:

- Notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017.
- Notification by DG-Health of KPK addressed to all DHOs in the Province for adopting the CSC because of the stated improvements

- Notification of the CSC in the District by the Deputy Commissioner Charsadda of January 12, 2017.

***The following evidence was successfully used for changes in practices:***

- The Notification by the DHO of December 13, 2017.
- All funds were spent by UC members @ PKR 730,000 per BHU during the fiscal year 2016-2017 and now they are utilizing these funds in the fiscal year 2017-2108. The evidence and supporting evidence is the Notification by DG-Health of KPK addressed to all DHOs in the Province for adopting the CSC because of the stated improvements
- Increase in resolution of complaints after setting up a revamped complaint management system.

## 5. Success Stories/Case Studies

All success stories were reported in Quarterly Progress Report:

1. **Written Expression of Intent to Replicate the CSC Project in KPK**: At a high level meeting in the Provincial Health Department, it was acknowledged that the CSC method was a viable process for the improvement in the quality of primary healthcare services and that it should be replicated in other districts of KPK. To seek assistance of DFID, the DG-Health has written a request letter for the replication of the CSC to other districts.

2. **Facilitating Security of Female Patients**: One of the major issues that forms part of the agreed joint action plans for the improvement in primary healthcare services relate to infrastructure improvement, such as water, sanitation, and waste disposal and boundary walls around BHUs. 16 BHUs had dilapidated or no boundary walls were identified through the CSC. This situation had led to fewer female patients and the BHU female staff also were feeling insecure as the local "Pashtun" culture women are covered with veils. Also, because of the security sensitive regions of the District, it was imperative to have some form of protection against easy ingress to the BHUs. After approval of the Action Plans, the District Health Officer (DHO) approved allocation of funds to address this issue. These 16 BHUs now have proper boundary walls that were erected during the quarter April-June 2017 with barbed wire fence augmenting the protection of valuable equipment, clinical records and expensive medicines from theft as well as creation an enabling environment for both female communities and BHU staff.

3. **LHW Coverage Improvements**: 270 vacant positions of LHWs have been advertised through the agreed action plans and hopefully in the next 2 months the lack of LHW coverage will be augmented with the recruitment of new LHWs.

4. **Space for LHWs/LHSs in BHUs**: District Health Officer (DHO), Charsadda has showed tremendous ownership and commitment in resolving all the identified issues and agreed action plans during two rounds of CSC at BHU level. He has sent a written request to District Nazim, Charsadda for allocation of funds for construction of LHW Rooms in each BHU in the next ADP (Annual Development Program), to which District Nazim has agreed to allocate PKR. 400,000 for construction of LHW room in each facility;

5. **Women Empowerment:** The process of Community Scorecard has empowered the local community especially females to advocate for their health care rights. The advocacy seminar on 25 April 2017 provided a platform to the female lead activist for the first time to be able to come out of their patriarchal society settings and speak for their rights in front of a large audience in the provincial capital. They stressed upon the authorities to resolve the issues agreed upon in the joint agreed action plans and advocated vociferously for their redressal.

6. **Solarization at BHUs to maintain cold chain:** As a follow up of the agreed action plans, the issue of maintaining the cold chain for vaccines at the end point of the chain (BHUs) was resolved with community and BHU management pressure by which 21 Solar Panel Systems for 21 BHUs have been set up. The remaining Solar Panel Systems are in the pipeline.

7. **Institutionalization/Notifications**: Institutionalization of the CSC Province wide was achieved through a Notification by the Department of Health, Khyber Pakhtunkhwa on 28 December 2017. Additionally, the Institutionalization of the 7 JCMCs through Notification of TORs of December 13, 2017 by DHO Charsadda was achieved.

## 6. Value for Money

CUP team followed the strategy to maximize the results of delivering inputs by a thoughtful and productive ground work with teamwork and attained the results with less efforts and resources than the planned one. For instance, during the project management following initiatives were taken to ensure value for money:

a) The project was designed through a budget of UK Pound Sterling 339,720 although our budget ceiling was UK Pound Sterling 350,000. This a saving of around UK Pound Sterling 10,280 was made without compromising of the achievement of the outcome and outputs.
b) During the 2nd CSC process, Performance Assessment Sessions and Self-Evaluation Sessions were conducted on the same day in order to save time, cost and resources due to a reviewed proceeding methodology;
c) Field teams were also collecting and recording the proxy indicators data during the Community Performance and Self –Evaluation process from the respective BHUs, this practice allowed us to save a significant amount of additional time and resources
d) Field teams were also visiting for follow-up of agreed action plans to collect the evidences and updates during self-evaluation process which allowed us to save the amount of time and resources.
e) We conducted 7 Interface Meetings in district Charsadda and at the same time ensuring the participation of district members, which resulted in the efficient use of resources, thus saving cost and resources.
f) The follow-up of agreed action plans of the 2$^{nd}$ CSC was completed in the month of Ramadan where the duration of BHU timings is restricted. Moreover, the JCMC members were not provided with any extra expenses TA, thus saving time, cost, and resources.
g) The number of vehicles were reduced to 2 numbers instead of 3 for the field staff to carry out their activities, resulting in the saving of resources;

h) 2nd DAF meeting was held in Shamalz Hall, Charsadda instead of an expensive air-conditioned venue somewhere else, this resulted in saving money, time and resources;
i) We covered 7 Clusters of BHUs staff training in three Workshops, thus saved time and money;
j) 7 JCMCs were conducted while ensuring the participation of district members and representatives of health department within the limited budget, thus ensured in the judicious use of project resources;
k) During the 7th JCMC meeting, a potential donor visit was also held to brand the Community Scorecard Process resulting in mobilizing resources for CSC process uptake and its sustainability without any financial support.
l) Development of capacities of JCMCs to conduct CSC enabled them to conduct the repeat CSCs on their own and thus the investment in their capacities is a longer term benefit at no additional cost.

## 7. Annexures

***Annex-A: Brief description of the Project team, TORs & Project Organogram***
***Annex-B: Project LFA***
***Annex-C: Approved Work Plan***
***Annex-D: Acknowledgement Letters from DOH/DG-Health, DHO, Deputy Commissioner***
***Annex-E. Citations, Publications, Newspaper Clippings/Articles, etc.***
***Annex-F: List and contact details of field staff***
***Annex-G: Beneficiaries details***
***Annex-H: Training Reports***
***Annex-I: IEC Material***
***Annex-J: Any Other Material***

- *Signed MOU with Department of Health & District Government*
- *NOC for the Project (Initial NOC, 1st NOC Extension and 2nd& Final NOC Extension)*

***Annex-K: Photographs***


**CSC with Female User Communities of Bazmian Kali**

**CSC with Male User Communities of Bazmian Kali**

**Self-Evaluation with BHU Staff facilitated by Lead Activist**

**Interface Meeting between BHU staff and User Community**

**One of the 24 Solar Panels Systems Installed at BHUs**

**Participants at the 1st Advocacy Seminar on 25 April 2017**


**"Community Resolution" being handed over to Dr. Rose Additional DG Health, Government of KPK at the Advocacy Seminar**

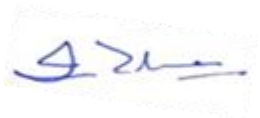

**Mr. Sultan Khan, MPA Charsadda announcing support to "Community Resolution" presented at the 1st Advocacy Seminar**



**Inception Workshop (30 September 2016)-Signing of MOU**


**Knowledge Sharing & Dissemination Workshop (January 10, 2018)**

**Soft Copies of all Pictures have been shared with HANIF as a part of the Close-Out.**



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February 5, 2018