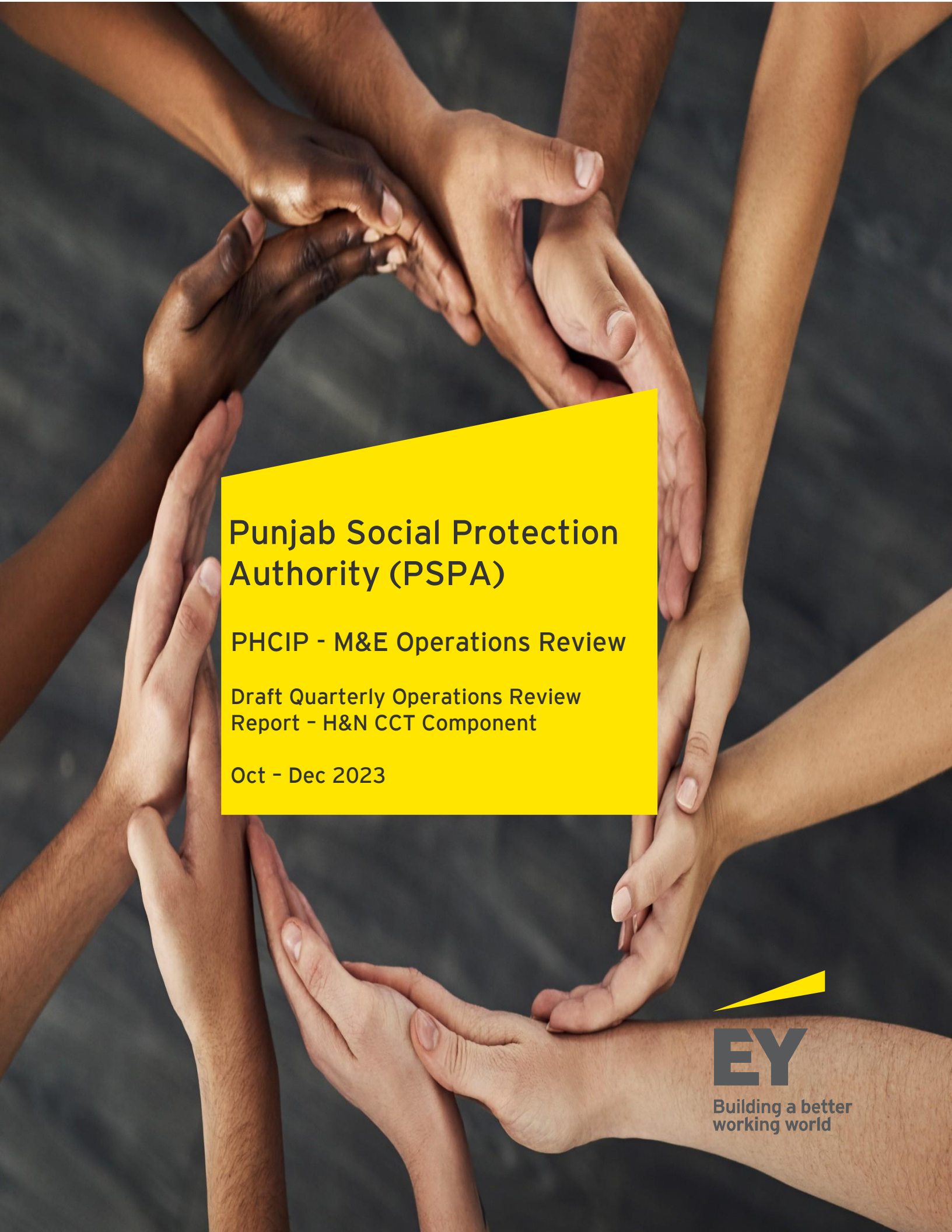

Punjab Social Protection Authority (PSPA)

PHCIP - M&E Operations Review

Draft Quarterly Operations Review Report – H&N CCT Component

Oct – Dec 2023

EY
Building a better working world

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Abbreviations

BBA	Branchless Banking Agents
BCC	Behavioral Change Communication
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
CCT	Conditional Cash Transfer
CNIC	Computerized National Identity Card
COSMOS	Communication, Outreach and Mobilization Strategy
EMR	Electronic Medical Record
GRM	Grievance Redress Mechanism
H&N CCT	Health and Nutrition Conditional Cash Transfer
IEC	Information Education and Communication
KII	Key Informant Interviews
LHV	Lady Health Visitor
LHW	Lady Health Worker
MO	Medical Officer
M&E	Monitoring and Evaluation
NADRA	National Database and Registration Authority
NSER	National Socio-economic Registry
PDO	Project Development Objective
PHCIP	Punjab Human Capital Investment Project
PLW	Pregnant and Lactating Women
POM	Project Operations Manual
P&SHD	Primary and Secondary Healthcare Department
PSPA	Punjab Social Protection Authority
RHC	Rural Health Centre
IP	Implementation Partner

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Executive Summary

1. BACKGROUND AND PURPOSE OF THE OPERATIONS REVIEW

The Punjab Human Capital Investment Project (PHCIP) is a project financed by a World Bank credit to the Government of Pakistan. The project has three components which lead to improvements in the health situation of the eligible beneficiaries, as well as promoting economic and social inclusion helping accomplish the overall project development objective (PDO). This report presents an analysis of the Health and Nutrition Conditional Cash Transfer (CCT) program in Pakistan.

The purpose of this review is to assess the effectiveness of the program operations in improving the health and nutrition status of pregnant and lactating women and/or children under two years of age.

2. OVERVIEW OF H&N CCT COMPONENT

The Health and Nutrition Conditional Cash Transfer (H&N CCT) component aims to enhance the utilization of crucial healthcare services for pregnant and lactating women and children under 2 years in impoverished households across 11 targeted districts in Pakistan. The program, aligned with the revised PC-1, involves the implementation of an Electronic Medical Record (EMR) system for efficient management and a Communications, Outreach, and Social Mobilization Strategy (COSMOS) for informed roll-out. The enrollment process, now universal due to recent floods and inflation, begins with issuing tokens to visiting women, followed by basic examinations and registration using an Android-based tablet. Payment disbursement, facilitated through Biometric Verification System (BVS) based Wallet Accounts, has been revised to PKR 23,000 per beneficiary, with an initial payment of PKR 2,000 at registration. The anticipated impact involves serving 0.7 million Pregnant and Lactating Women (PLWs) over the project's first two years.

3. FINDINGS OF OPERATIONS REVIEW ACTIVITY

For the quarter ended Dec 2023, spot checks of Health Facilities, Branchless Banking Agents, Beneficiary Feedback Surveys and Key Informant Interviews were carried out to assess program success in achieving its desired objectives. The sample size of each activity is as follows.

Table A: Sample Breakdown

Activity	Required Sample Size	Actual Completed
Spot Check	286	286
Beneficiaries (PLWs) Interview	385	410
Key Informant Interviews (KII)	286	288

Several key considerations were taken into account before sampling and data collection:

- Field staff were tasked with visiting selected health facilities, specifically BHUs and RHCs.
- The selection process involved a proportional sample, considering the type of facility, for each district and tehsil. This approach ensured representation across different healthcare settings.
- To prevent redundancy, it was emphasized that the same health facility is not visited more than once, preserving the integrity of the sample.
- In cases where all health facilities within a district have been covered, and additional spot checks are required, the sample may unavoidably be repeated. This ensures that the spot check activity remains comprehensive, even if revisiting a health facility becomes necessary.

- Key informant interviews play a crucial role, involving Medical Officers, Lady Health Visitors (LHVs), and Lady Health Workers (LHWs) at each health facility. The sample for key informant interviews is drawn purposively, emphasizing a targeted selection process to gather relevant and insightful information.
- Beneficiary feedback is actively collected through exit interviews conducted at each health facility.
- The control over this sample is minimal, suggesting that the selection of beneficiaries for exit interviews is not tightly regulated. This approach allows for a more natural and diverse representation of beneficiary perspectives.

A. KEY FINDINGS OF SPOT CHECKS OF HEALTH FACILITIES

General Outlook and Infrastructure Unavailability

- 8% (18 out of 231) of the health facilities lacked a boundary wall. Where it was available, 9 were in poor condition and require reconstruction.
- Waiting areas were available in all health facilities and were in good condition.
- In 7 health facilities (3%), the toilet cleanliness was found to be inadequate and poor.
- 2 out of 231 health facilities, labor room was of poor condition followed by 2 health facilities with unhygienic ward rooms.

Functioning of Electronic Medical Record

- In 80% of the health facilities, dedicated desk was available.
- In 85% of the health facilities, dedicated focal person for data entry was available.
- In 7 out of 231 of the health facilities, (3%) internet connectivity issues were found, and in 11 out of 231 (5%) health facilities, tablets for the EMR utilization were unavailable.
- Brochures detailing the Conditional Cash Transfer (CCT) payment disbursement process were absent in 176 out of 231 (76%) health facilities higher than previous quarter.

Dispensary Operational During Visit and Overall Availability of Supplies

- In 98% of the visited health facilities, the dispensary was open.
- In 88% of the health facilities, micronutrients were available and in 97% of the health facilities contraceptive commodities were available.
- In 125 out of 231 (46%) of the health facilities, the ultrasound facility was not available.
- Refrigerator for vaccine storage was not available in only one health facility of Khushab.

Non-Availability of Key Medical Staff

- In 40% (92 out of 231) of the health facilities, medical officer was unavailable.
- In 10% (20 out of 210) of the visited BHUs, the LHV was not available and in 10% (2 out of 21) of the rural health centers, the nurse was not available. Breakdown of unavailability is given in table B.

Table B: *Health Staff Unavailability*

Medical staff position	*Total facilities*	*Unavailable (vacant)*	*Unavailable (on leave)*
Medical Officers (BHU)	210	32 (15%)	59 (28%)
LHVs (BHUs)	210	2 (1%)	18 (9%)
Medical Officers (RHCs)	21	-	1 (5%)
Nurse (RHCs)	21	-	2 (10%)

Grievance Redressal Mechanism

- In 70% of the visited health facilities, there was a lack of designated individual responsible for registering complaints.
- The dedicated register for complaint registration was not available in 78% of health facilities. As an alternate, a complaint box/complaint form was accessible.

- The helpline number/complaint registration number was not displayed in 38% of health facilities, hindering PLWs from accessing assistance and information.

B. KEY FINDINGS OF SPOT CHECKS OF BRANCHLESS BANKING (BB) AGENTS

- Majority of the spot-checked shops in the sample (42%) were within 1 Km of the closest health facility.
- Awareness about the AAGHOSH program among branchless banking agents is high, with 91% of agents indicating that they received information about the program.
- On average, BB Agents received 2% commission though there is some district variation.
- Technological infrastructure, such as biometric verification machines and internet connectivity was available at all (100%) BBA points.
- Challenges faced by PLWs during verification included failure of thumbprint, wallet account activation, internet connectivity issues, and system errors.
- 13% of the BBAs were observed making payment deductions that ranged from PKR 100 to PKR 500, with the highest deductions of PKR 500 in Rajanpur. Though in beneficiary feedback, an alarming 53% reported deduction. This difference may be attributed to agents being aware of field staff presence and refraining from deducting payments in their presence.
- Recommendations by BBAs to improve the payment procedure are given in table C.

Table C: Recommendations by BBA to Improve Payment

Recommendations	*Proportion*
Create awareness among beneficiaries about compliance requirement	35%
Better commissions by the Bank	53%
Open more cash payment points	7%
Allow access to LHVs to correct mobile numbers	5%

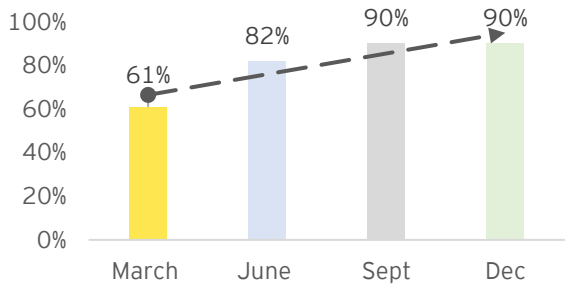
C. DEMAND SIDE PERSPECTIVE – EXIT INTERVIEWS WITH BENEFICIARIES (PLWs)

Beneficiary Enrolled in the Program on the CNIC of their Mother-in-Law.

- Few beneficiaries in the sample were found to be registered on the CNIC of their mother in laws due to unavailability of their own.

Improved Awareness of H&N CCT (AAGHOSH) Program Among Beneficiaries (PLWs)

- The program has seen a substantial improvement in PLWs' awareness, with 90% of beneficiaries reporting knowledge of the program.
- There are district wise variations in awareness levels, with Bhakkar and Khushab and Mianwali districts having relatively low awareness compared to other districts.



Personal Transportation and Affordable Travel Expenditure

- Proximity to healthcare facilities and transportation modes are important factors for beneficiaries. 55% of PLWs reported that a health facility is located within three kilometers of their homes, and the majority have access to personal transportation.
- Financial considerations are also a factor, with 44% of PLWs spending PKR 0 to 150 for travel to health facilities. The average travel cost is PKR 226.
- Overall, access to healthcare facilities may not be a major issue for most PLWs in the program, but some district-specific challenges and financial considerations need to be addressed. Results summarized in table below.

Table D: *Responses on Travel Cost to Health Facilities*

Travel Cost	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
PKR 0-150 (% of beneficiaries)	42%	46%	40%	44%
PKR 151-300 (% of beneficiaries)	35%	31%	31%	31%
More than PKR 300 (% of beneficiaries)	23%	23%	28%	25%
Average Travel Cost	**PKR 260**	**PKR 222**	**PKR 261**	**PKR 226**

Enrolment Process Satisfaction Among PLWs Shows an Increasing Trend

- In the Dec 2023 quarter, 94% of PLWs reported no difficulties during the enrollment process, showing an improvement from the previous quarter's 92%.
- Challenges in enrollment include LHV unavailability due to busy schedules (56%), lack of updated family tree records (8%), and non-availability of CNIC (24%). LHV unavailability has increased since previous quarter.
- 76% of the beneficiaries couldn't read. Out of these, 88% relied on someone else to read messages, and 12% ignored the messages indicating need for alternative ways for beneficiaries to understand messages related to AAGHOSH information and payment.

Beneficiaries' Satisfaction with Healthcare Services (IRI 3)

- In the Dec'23 quarter, 96% of PLWs who utilized healthcare services under the program were satisfied with the services provided, which is greater than the previous quarters.

Table E: *Satisfaction Levels of Beneficiaries with Staff*

Satisfaction Level	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
Overall Behavior of Health staff	93%	98%	96%	97%
Relevant Information Provided	96%	98%	93%	98%
Health Staff Understands Issue of Beneficiary	97%	95%	90%	94%

- 88% of PLWs reported the availability of prescribed medication, which is higher than the previous quarter's 80%. Among those PLWs who reported availability of medication, 100% received the prescribed medicines and nutritional supplies free of cost.

Payment Distribution Process

- 13% of the beneficiaries reported opening their accounts after three months which highlights the need to further improve the efficiency of opening wallet accounts and addressing the increasing delays in account opening for a portion of the beneficiaries.
- 53% of beneficiaries reported deductions made by branchless banking agents, significantly higher than the previous quarters. Rajanpur had the highest reported deductions.
- While 86% of PLWs expressed satisfaction with the payment process, the presence of delays and deductions highlights areas that require improvement.

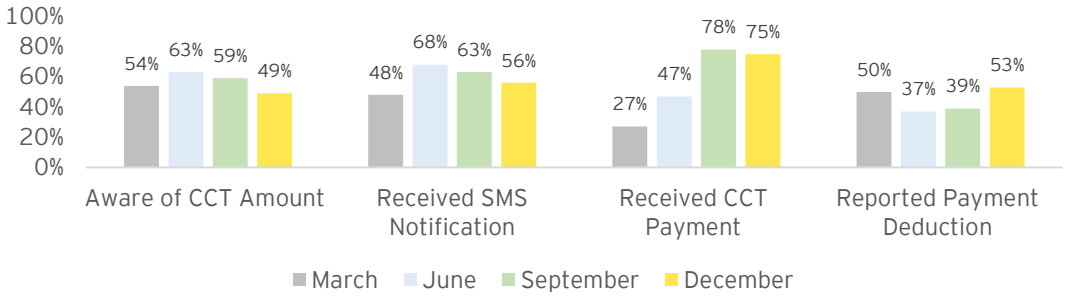


Figure 1: Indicators for Payment Distribution Process

Grievance Redressal Mechanism

- 13% of PLWs surveyed in the Dec '23 quarter were informed about the process of registering complaints, though greater than previous quarters but still indicating a need to increase awareness and communication regarding the complaint registration process.
- Nine PLWs reported registering complaints. None of the PLWs utilized the PSPA helpline for complaint registration, relying solely on the assistance of health staff, primarily LHVs.
- Despite registering complaints, none of the PLWs reported having their grievances resolved, highlighting the need to improve the efficiency and timeliness of the resolution process.

D. SUPPLY SIDE PERSPECTIVE – KEY INFORMANT INTERVIEWS WITH HEALTHCARE STAFF

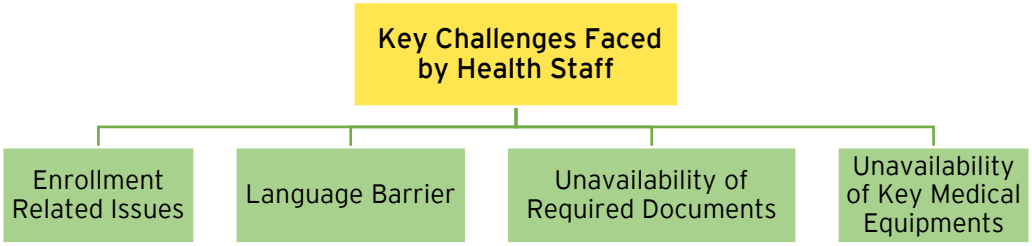
Health Staff Enrolled in the Program as Beneficiaries

- 15 Health staff was found to be enrolled into the program as beneficiaries which raises risk and concerns of fraudulent activity or registration of fake visits undermining the program objectives.

Awareness About AAGHOSH

- 97% of the health staff were aware of the AAGHOSH program and its objectives though in previous quarters, 100% were aware.
- 30% of the LHWs were not aware of the updated enrollment criteria of Aagosh program. (Universal Population)
- 95% of LHWs reported that LHV behavior with beneficiaries is generally good.

Key Challenges Faced by Healthcare Staff (MOs/LHVs/LHWs)



- The most common issue reported by the health staff while operating EMR for the enrollment purposes was internet connectivity, application issue, server issues and inability to edit the EMR in case of any error made while registering.
- Language barrier is a major issue whereby it is difficult to communicate and make the beneficiary understand the treatment and prescription.
- Beneficiaries lack of awareness and unavailability of required documents makes it difficult to register them timely in the program.
- Health staff reported non availability of delivery tables, baby warmers, ultrasound and ambulance etc.

Grievance Redressal Mechanism

- 48% (48 out of 101) LHVs said they received beneficiary complaint for AAGHOSH however, according to them, these complaints were not registered electronically rather, they were verbally considered or either shared within a group of PHCIP members or AAGHOSH team.

E. Conclusion and Recommendations

- A noteworthy observation was made regarding the lack of awareness among both health staff and beneficiaries regarding the updated BISP criteria. According to the revised

criteria, all pregnant and lactating women are eligible for enrollment, irrespective of their BISP beneficiary status. Additionally, it was noted that in 24/7 BHUs, the evening shift staff generally lacks comprehensive awareness of the AAGHOSH program. This calls for a detailed training on the updated program requirements for all Lady Health Visitors (LHVs) and Lady Health Workers (LHWs).

- During a recent spot check of health facilities, review of the Electronic Medical Records (EMR) system uncovered several concerning issues. Notably, the absence of age criteria in the EMR allowed for the registration of individuals, such as mothers-in-law, who are ineligible as they are neither pregnant nor lactating. Furthermore, health staff were identified to be enrolled into the program as beneficiaries and, in some instances, utilized their own CNIC to register under a different name. To mitigate the associated risks, it is imperative to conduct a comprehensive review of the EMR system. This review should focus on implementing robust data authentication controls and mechanisms, along with program-level controls such as age restrictions and the prohibition of health staff enrollment. Additionally, constant monitoring of health staff is essential to prevent unauthorized enrollment of beneficiaries on various CNICs, including those of relatives or the health staff themselves. This proactive approach aims to enhance the integrity of the EMR system and maintain accurate and secure health records.
- To counter slow payment processing and increased payment deductions, targeted efforts are crucial in districts where these issues are most common. A proactive approach involves analyzing payment disbursement data to identify regions with processed but unclaimed disbursements. Establishing payment distribution camps at relevant facilities is recommended to efficiently distribute payments to beneficiaries in those areas, improving the BBA system's functionality and ensuring fair and accurate payments.
- In addition, the challenge of beneficiaries being unable to read messages hinders effective communication. To bridge this gap, it is recommended to introduce recorded audio calls for beneficiaries who face literacy challenges for example, a Robo call that tells the beneficiary the payment amount that is due. This practical solution ensures that essential information is effectively communicated, overcoming barriers, and facilitating better program engagement.
- The overall infrastructure challenges such as building structural integrity and absence of critical medical equipment such as baby warmers, delivery tables, ultrasound machines and ambulances in each health facility etc. poses an impediment to the service delivery in general and effectiveness of the AAGHOSH program in particular. To rectify this issue, it is imperative to prioritize the procurement and installation of key medical equipment.
- One major aspect that impacts the effectiveness of GRM is the absence of designated individuals for complaint registration and Lady Health Visitors (LHVs) who are present only verbally listening to the complaints. To address this challenge, it is recommended to appoint GRM focal persons in each facility, conducting awareness sessions to educate stakeholders on the complaint process and establishing a centralized system for tracking and resolving grievances in a timely manner.

Chapter 1
Introduction

Chapter 1: Introduction

1.1 Overview of PHCIP Program

The Punjab Human Capital Investment Project (PHCIP) is a project financed by a World Bank credit to the Government of Pakistan. The Project goal is to "achieve qualitative and quantitative improvements in Punjab's Human Capital Index (HCI) and related indicators". The project development objective (PDO) is to increase the access to quality health services, and economic and social inclusion programs, among poor and vulnerable households in select districts in Punjab namely Bahawalnagar, Bahawalpur, Bhakkar, Dera Ghazi Khan, Khushab, Layyah, Lodhran, Mianwali, Muzaffargarh, Rahim Yar Khan and Rajanpur. The project has three components which are further divided into sub-components. Each component and sub-components are illustrated in the diagram below.

Project Components	**Component 1:** Quality of and Access to Healthcare Services	**Component 1.1:** Quality of Health Services
		Component 1.2: Utilization of Health Services
	Component 2: Social and Economic Inclusion	**Component 2.1:** Economic Inclusion (EI)
		Component 2.2: Social Inclusion for Education (SIE)
	Component 3: SP Service Delivery Platform	

With regards to healthcare services, the project aims to improve both the demand and the supply side. Through Component 1.1, the supply side will be addressed. In order to do that, 155 Basic Health Units (BHUs) and Rural Health Centers (RHCs) will be upgraded and medical facilities including medicines, family planning and nutrition commodities will be provided. For the demand side, Conditional Cash Transfers (CCTs) will be provided to 731,000 eligible pregnant or lactating women (PLW) and/or parents of children up to 2 years of age if they comply with some pre-determined conditions.

For social and economic inclusion component, program will economically empower around 88,710 eligible young parents by providing Labor Market Readiness (LMR) Training to 80,500 beneficiaries and a productive asset to approximately 75,000 beneficiaries which they can utilize for income generation (Component 2.1). It will also help to improve the Early Childhood Education (ECE) of 3700 classrooms to develop fundamental skills in young children and prevent school dropout (Component 2.2).

Component 3 target improvements to the existing SP Service Delivery Platform, improving coordination and interoperability between the different SP programs currently being implemented. This will be done by ERP through third party for the Punjab Social Protection Authority and providing technical assistance in different functions including beneficiary targeting, procurement, benefit delivery, financial management, grievance redressal and M&E. In combination all three components lead to improvements in the human capital index of the eligible beneficiaries, as well as promoting economic and social inclusion helping accomplish the overall project development objective (PDO).

1.2 Objectives and Scope of Operations Review

The PHCIP includes an operations review component, and the Punjab Social Protection Authority (PSPA) has contracted with EY Ford Rhodes to undertake the operations review of the program interventions. As per the contract, EYFR is required to conduct quarterly operational reviews for two PHCIP sub-components:

- Component 1.2 (CCT – Utilization of Health Services) and
- Component 2.1 (Economic Inclusion),

To assess compliance with PHCIP operations and procedures outlined in the Project Operations Manual (POM), the operations review will help to evaluate the program activities and identify any major bottlenecks in project implementation. It will also help to inform stakeholders of the program on performance and enable lessons to be drawn to improve future practice and policy.

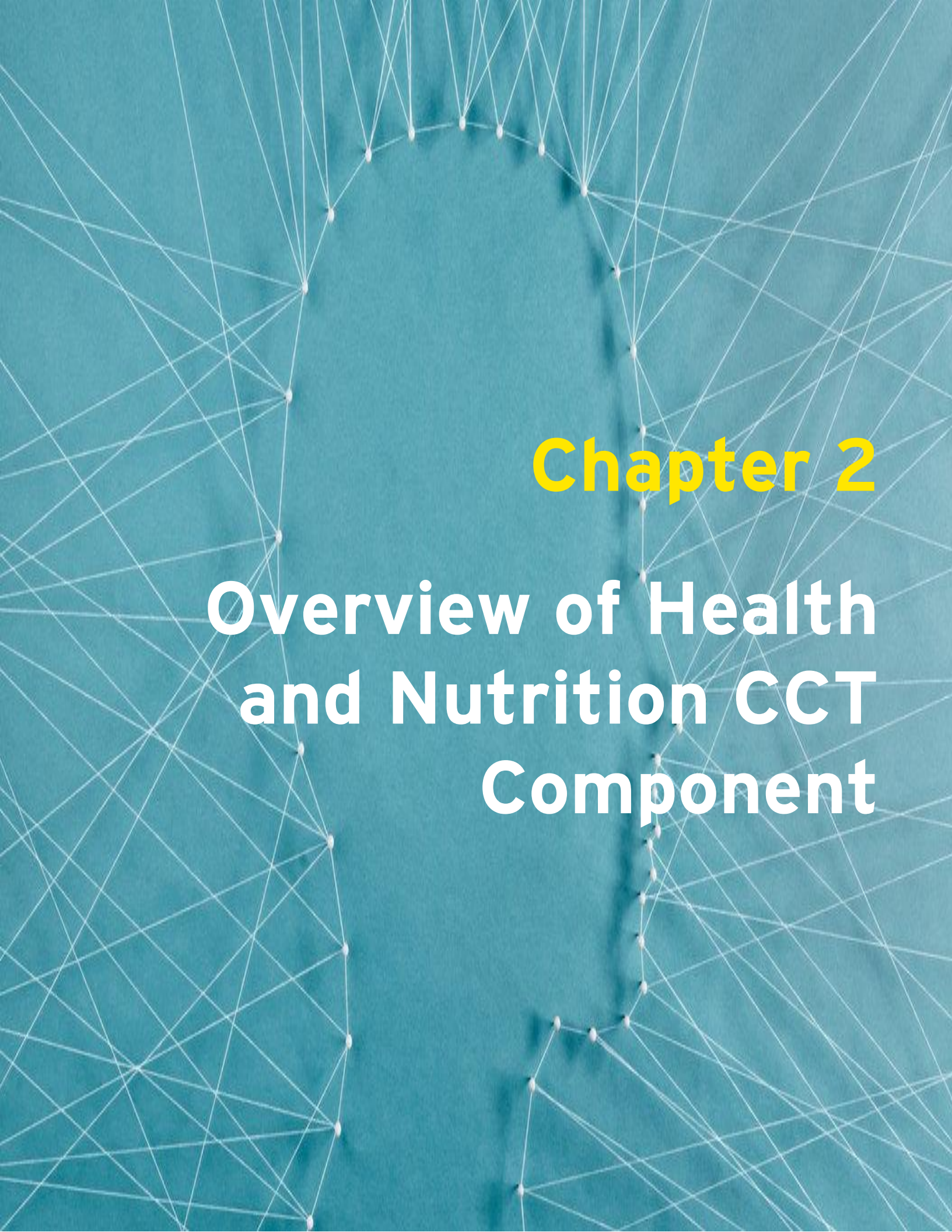
To provide context to the estimates of program operations, process evaluation through spot checks of various activities; beneficiaries' feedback on quality and delivery of services with key informant interviews are planned. For this, the data on the Programme operations including enrollment, behavior of health staff, availability of required medicines and experience with payments mechanism was gathered through spot checks of health facilities (BHUs and RHCs) & Branchless Banking Agent, Key Informant Interviews (KII) and Beneficiary Surveys.

1.3 Organization of this Report

This report provides a brief overview of the Punjab Human Capital Investment Project (PHCIP) and details the role of EY as an Operations' Review Firm. It evaluates the program activities for the quarter ending December 2023 and identifies any bottlenecks in project implementation and improvement opportunities. It also informs stakeholders of the program on performance and enable lessons to be drawn to improve future practice.

In this document, Chapter 1 provides a brief introduction of the Punjab Human Capital Investment Project (PHCIP) and EY's role as an Operations' Review Firm. In Chapter 2, an overview of the H&N CCT component of PHCIP and its implementation process is provided. In Chapter 3, EYFRs field assessment methodology as well as detailed analysis of the field findings are presented. EYFR also evaluates the strengths and weaknesses of the program from beneficiaries' perspective as it is being currently implemented, propose recommendations to improve programmatic weak links and enable effective implementation.

Supplemental details, where required, have been included in the annexures.



Chapter 2

Overview of Health and Nutrition CCT Component

Chapter 2: Overview of Health and Nutrition CCT Component

The Health and Nutrition Conditional Cash Transfer (H&N CCT) component aims to increase the utilization of key healthcare services during the 1000-day period covering pregnancy to the child attaining two years of age among poor and vulnerable households in Pakistan. The component provides Conditional Cash Grants (CCGs) to eligible pregnant or lactating women and/or mothers of children under 2 years of age to compensate for the financial and non-financial costs of visiting healthcare facilities. The component is rolled out in 11 districts with the highest poverty and poor human development indicators, and the primary beneficiaries are Pregnant and Lactating (PLWs) and children under 2 years of age. The component incentivizes eligible PLWs to fulfill conditionalities, such as regular health checkups, skilled birth delivery and birth registration, growth promotion, and immunization of pregnant mothers and children under two years of age, as well as participation in counseling and awareness sessions on population welfare, hygiene and feeding and caring practices, and children's cognitive development.

2.1 H&N CCT Implementation Process

Note: The following implementation process aligns with the revised PC-1 and covers the revisions made in the H&N CCT component.

The need for the current revision of PC-1 arises from

(i) implementation experiences gained over the last two and half years, requiring adjustments in project management and design for enhanced efficiencies and impact.
(ii) The post-flood situation in the target districts.

The initial fund allocation was Rs. 10,250 million (Rs. 9,566.30 million for CCT and Rs. 683.70 million for Social Mobilization). The revised allocation is now Rs. 8,910 million (Rs. 8,543 million for CCT and Rs. 367 million for social mobilization).

Electronic Medical Record (EMR) System

For implementation of H&N component, project deploy an Electronic Medical Record (EMR) system at healthcare facilities in target districts, developed by the Health Information and Service Delivery Unit (HISDU) under the Primary and Secondary Healthcare Department (P&SHD). The EMR is integrated with an application specifically designed and developed for the PSPA H&N CCT to ensure project beneficiaries as well as general patients are served through a single interface. Lady Health Visitors (LHVs) handle the application at Project Health Facilities and register visiting PLWs in the EMR system and verify their eligibility based on NSER data.

Communications, Outreach and Social Mobilization Strategy (COSMOS)

As per the program document, a multi-layered and comprehensive Communications, Outreach and Social Mobilization Strategy (COSMOS) will inform the roll-out and implementation of the H&N CCT. The COSMOS focus on mobilizing and sensitizing the eligible beneficiaries to motivate them for enrolment in the program. The project employs multi-layered communication and delivery channels, including establishing a system to auto-generate SMS alerts and/or Robbo calls to eligible households before commencement of field activities.

Enrolment of Beneficiaries

Originally, the PC-1 focused on targeted intervention for PLWs from BISP beneficiary households. However, due to the recent devastating flood in Pakistan and the current high inflation rate since 2008, relief efforts will be expanded by adopting a universal targeting

approach and making cash transfers more flexible and predictable for all visiting PLWs to health facilities for their checkup.

The H&N CCT component is rolled out in all primary healthcare facilities (Basic Health Units and Rural Health Centers) in the target districts. The process begins when a pregnant or lactating woman visits a health facility. Upon arrival, she is issued a token to ensure she receives the right care at the right time in a comfortable and hassle-free environment.

Before being directed to the Lady Health Visitor (LHV) for enrollment, a designated staff member performs a basic examination on the woman, which involves checking her blood pressure, body weight, and temperature. The LHV or other designated user will then use an Android-based tablet to enroll the beneficiary in the EMR system.

Once the CNIC is entered into the app, the system runs a quick verification by matching it with the available NSER data in the database. Upon successful verification, the system automatically routes the request for creating a beneficiary compliance profile.

For the beneficiaries, an antenatal care and/or immunization schedule is generated at enrollment, and respective compliance is marked. Every day, data related to new registration, visits by beneficiaries, are automatically pushed to PSPA. Bank of Punjab (BOP) then pulls this data and creates inactive profiles of beneficiaries while the data is processed for name screening with the proscribed list of the State Bank of Pakistan. Profiles that fail the name screening are blocked, and those that pass receive payment. Once payment is made, an SMS alert is sent to the beneficiary, who can withdraw cash from any designated pay-point after undergoing biometric verification.

Payment Disbursement

The payment process flow for the component involves the use of the Biometric Verification System (BVS) based Wallet Accounts for making payments. New beneficiaries and existing ones need to undergo the BVS process for registration for which they need to visit designated pay-points for BVS based registration through NADRA, after which wallet accounts are created and funds transferred within an hour of verification. Moreover, the size of the H&N CCT amount has also been revised according to PC-1, from the existing PKR 17000 to 23000 per beneficiary, where PKR 2000 will be given at the time of registration, while the payment schedule in the Operations Manual would specify the payments for subsequent visits. It is anticipated that the project would serve 0.7 million PLWs (combined with the progress of year 1 & 2).

Note: The modifications in PC-1 do not have an impact on the spot checks of health facilities or the Key Informant Interviews (KIIs). However, the Beneficiary Feedback Interviews were conducted with beneficiaries who were registered prior to the old PC-1. it is essential to note that these changes do influence the beneficiary feedback process, particularly when respondents are queried about their anticipated payment amounts. As the sample for the feedback was collected prior to receiving the revised PC-1, the current activity does not reflect these revisions.

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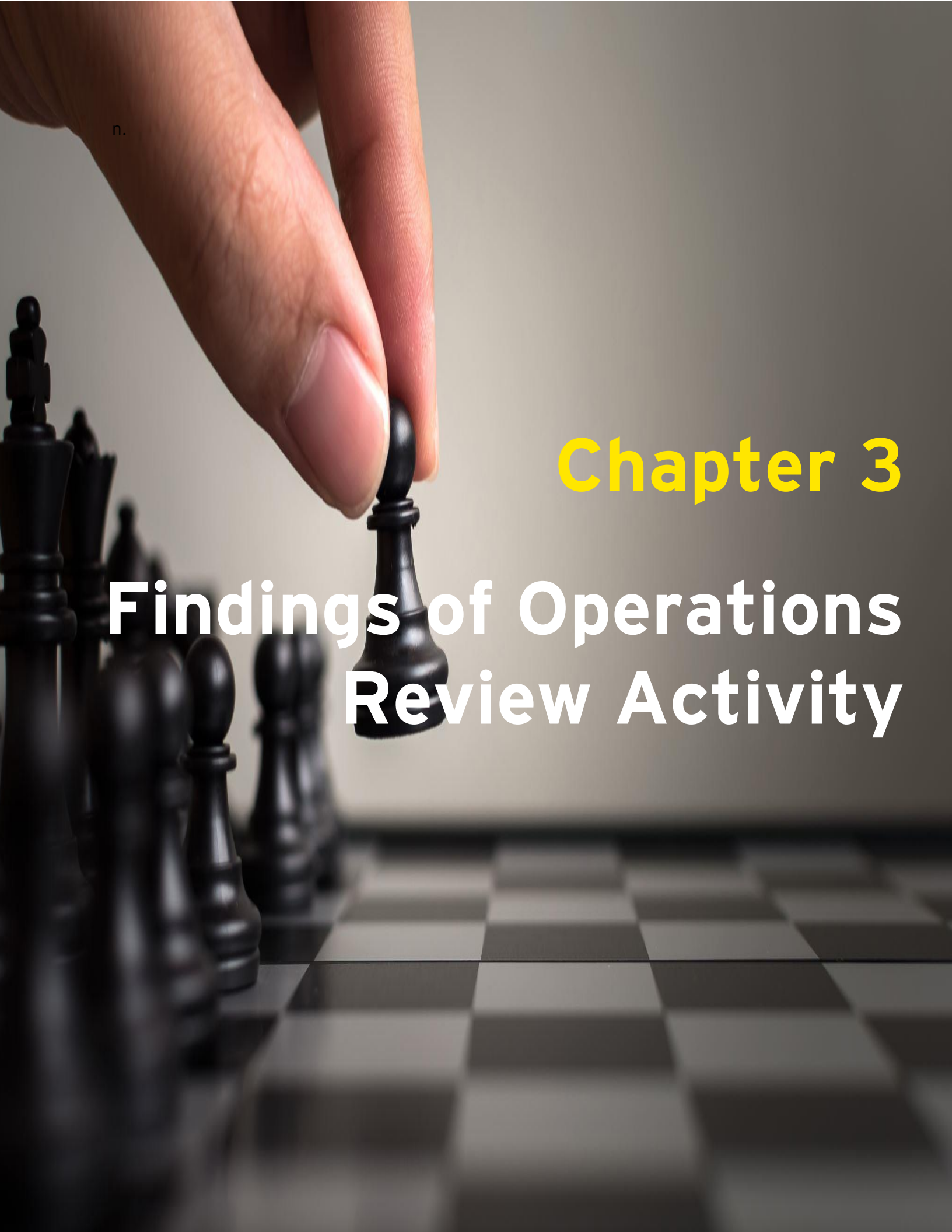

Chapter 3

Findings of Operations Review Activity

Chapter 3: Findings of Operations Review Activity

The operations review employed a quantitative and qualitative research design given the objectives of the assessment. In the preliminary stage, a framework was developed that identified themes corresponding with the program objectives and matched them with the program interventions. This aided in the development of a comprehensive survey tool and ensured compliance with all the objectives of the assessment. As a result, a structured questionnaire was developed for the assessment of program operations.

3.1 METHODOLOGY

The operations assessment was designed to evaluate the effectiveness of various activities involved in the implementation of the H&N CCT program. For this, EYFR executed Spot Checks, gathered Beneficiary (PLWs) Feedback, and conducted Key Informant Interviews (KIIs) to assess the quality and delivery of services of the H&N CCT operations. Throughout each activity, various locations were visited to gather data. Details are illustrated in the table below.

Table 1: Activity Conducted for Dec'23

Activity	Purpose	Relevant Stakeholders
Spot Checks	Assess several key aspects, including the availability of operational infrastructure of health facilities, and observe the beneficiary experience during various stages of the service delivery.	○ Healthcare staff ○ Beneficiaries (PLWs) ○ Branchless banking agents
Beneficiaries (PLWs) Exit Interviews	Beneficiary feedback regarding holistic H&N CCT implementation process from Enrollment to payment disbursement. Includes question on potential beneficiary complaints and their resolution status.	○ Beneficiaries
Key Informant Interviews (KII)	Interview with key supply and demand-side stakeholders to gauge their understanding of the overall program, perspective on issues faced in implementation as well as their own concerns	○ Medical Officers ○ Lady Health Visitors ○ Lady Health Workers

a. Sampling

For the operations review activity, EYFR planned to conduct spot checks on Health Facilities and Branchless Banking Agents (BBA), as well as gather beneficiary feedback and conduct Key Informant Interviews (KII). The following sample sizes have been determined and agreed upon for each activity in the approved inception report.

Table 2: Required Sample Size per Activity

Activity	Required Sample size	Actual Completed
Spot Check	286	286
Beneficiaries (PLWs) Interview	385	410

Table 2: Required Sample Size per Activity

Activity	Required Sample size	Actual Completed
Key Informant Interviews (KII)	286	288

These sample sizes have been carefully selected to ensure a representative and comprehensive assessment of the operations. By conducting spot checks and engaging with beneficiaries and key informants, EYFR aimed to gather valuable insights and data to inform our review process and identify areas for improvement. Following is the rationale behind making the sample representative:

- **Proportional Sample Selection:** The selection process involves a proportional sample, taking into account the type of facility within each district and tehsil. This ensures that the sample represents the distribution of different healthcare settings in the population, providing a more accurate depiction of the program's implementation across different areas.
- **Preservation of Sample Integrity**: To prevent redundancy, the emphasis is placed on not visiting the same health facility more than once. This preserves the integrity of the sample by avoiding duplication and the potential bias that could result from visiting the same facility multiple times.
  In cases where all health facilities within a district have been covered and additional spot checks are required, the sample may unavoidably be repeated. This is done to ensure the spot check activity remains comprehensive, even if revisiting a health facility becomes necessary.
- **Targeted Key Informant Interviews:** Key informant interviews with Medical Officers, Lady Health Visitors (LHVs), and Lady Health Workers (LHWs) at each health facility are conducted purposively. This means that the selection of key informants is based on their expertise, knowledge, and role in the program. The targeted selection process ensures that relevant and insightful information is gathered from key individuals directly involved in program implementation.
- **Beneficiary Feedback through Exit Interviews:** Beneficiary feedback is actively collected through exit interviews conducted at each health facility. The selection of beneficiaries for these interviews is not tightly regulated, allowing for a more natural and diverse representation of beneficiary perspectives. This approach ensures that the experiences and perspectives of a wide range of beneficiaries are captured, providing a more authentic understanding of their experiences with the program.

Overall, the methodology prioritized a comprehensive yet strategic approach to spot checks within health facilities. The proportional sample selection, avoidance of duplication, and targeted key informant interviews contribute to the robustness of data collection. Additionally, the minimal control over the beneficiary feedback sample ensures a more authentic representation of the experiences and perspectives of those receiving health services at the facilities.

b. Allocation of Sample

Please refer to table 3 for a detailed breakdown of the completed sample size for each operational activity, organized by district and tehsil.

Table 3: Breakdown of Allocated Sample for Each Activity (District and Tehsil-wise)

Sr. No	District	Tehsil	Total Health Facilities	Spot Check of Health Facility Visited	Spot Check of BB Agents Visited	Beneficiary Surveyed	KII of LHV	KII of LHW	KII of MO
1	Bahawalnagar	Bahawalnagar	28	11	5	33	5	4	5
		Chishtian	27	3	-	2	2	-	1
		Fortabas	16	3	-	-	-	3	1
		Haroonabad	22	-	-	-	-	-	-
		Minchanabad	20	4	-	-	4	-	-
TOTAL			**113**	**21**	**5**	**35**	**11**	**7**	**7**
2	Bahawalpur	Ahmad pur east	29	5	1	14	1	2	2
		Bahawalpur Saddar	14	3	-	1	1	1	5
		Bahawalpur City	5	2	3	2	2	2	-
		Hasilpur	13	3	-	5	1	2	-
		Khairpur tamewali	8	4	1	8	-	2	1
		Yazman	18	4	-	7	3	-	1
TOTAL			**87**	**21**	**5**	**37**	**8**	**9**	**9**
3	Bhakkar	Bhakkar	17	9	2	21	5	6	4
		Darya Khan	9	6	3	8	3	2	3
		Kalorkot	11	5	-	10	1	-	2
		Mankera	8	1	-	-	-	-	-
TOTAL			**45**	**21**	**5**	**39**	**9**	**8**	**9**
4	DG khan	DG Khan	18	9	3	13	2	2	5
		Kot chuta	17	7	-	22	4	6	1
		Tounsa	18	5	2	1	2	1	3
		Tribal Area	9	-	-	-	-	-	-
TOTAL			**62**	**21**	**5**	**36**	**8**	**9**	**9**
5	Khushab	Khushab	20	17	5	41	8	8	7
		Noorpur thal	12	2	-	1	-	-	-

Table 3: Breakdown of Allocated Sample for Each Activity (District and Tehsil-wise)

Sr. No	District	Tehsil	Total Health Facilities	Spot Check of Health Facility Visited	Spot Check of BB Agents Visited	Beneficiary Surveyed	KII of LHV	KII of LHW	KII of MO
		Noshera	9	1	-	-	1	-	-
		Quaidabad	8	1	-	1	-	-	2
TOTAL			**49**	**21**	**5**	**43**	**9**	**8**	**9**
6	Layyah	Choubra	6	5	-	22	3	3	2
		Karor	17	7	2	3	3	1	2
		Layyah	19	9	3	10	2	5	5
TOTAL			**42**	**21**	**5**	**35**	**8**	**9**	**9**
7	Lodhran	Duniya pur	16	7	2	10	1	4	-
		Kahror pacca	16	6	2	18	5	3	1
		Lodhran	20	8	1	12	2	2	7
TOTAL			**52**	**21**	**5**	**40**	**8**	**9**	**8**
8	Mianwali	Essa khel	13	6	-	2	3	1	1
		Mianwali	27	11	4	23	5	5	6
		Piplan	12	4	1	10	2	2	1
TOTAL			**52**	**21**	**5**	**35**	**10**	**8**	**8**
9	Muzaffargarh	Ali pur	15	3	-	-	3	-	2
		Jatoi	14	-	-	-	-	-	-
		Kot Addu	24	11	-	14	2	4	2
		Muzaffargarh	32	7	5	21	4	5	5
TOTAL			**85**	**21**	**5**	**35**	**9**	**9**	**9**
10	Rahim Yar khan	Khanpur	26	7	2	17	2	2	5
		Laiquat pur	35	7	-	3	3	3	3
		Rahim Yar khan	35	4	3	8	4	1	1
		Sadiqabad	29	3	-	9	2	3	-
TOTAL			**125**	**21**	**5**	**37**	**11**	**9**	**9**
11	Rajanpur	Jam pur	17	5	-	-	3	5	2
		Rojhan	8	2	-	3	-	-	1
		Rajan pur	14	14	5	35	7	2	6
TOTAL			**39**	**21**	**5**	**38**	**10**	**7**	**9**
Consolidated Total			**751**	231	55	410	101	92	95

c. Data collection

The data collection methodology was based on international standards of data collection and had contingencies in place to protect the integrity of the data. After the development of survey tools, it was reviewed by PSPA team for its finalization. After the survey tools were finalized, the questionnaire was codded onto a software platform: KoBo Collect. Pre-testing was conducted using dummy test entries. For all respondent categories, the data was recorded in-real time using tablets. The data collected in the tablets was uploaded onto the cloud at the end of every day. Completeness and accuracy of the data were checked periodically to ensure errors were rectified at the earliest. Data was then cleaned and coded to be entered into the statistical software (SPSS). In addition, a portion of data selected for quality assurance were done by the Component in-charges.

Note: The spread of sample is provided in terms of a heat map.

d. Key Considerations of Survey

Key considerations relevant to survey methodology are given as follows:

- The results of the survey are based on data obtained from a selected sample of beneficiaries, rather than the entire population. While efforts were made to ensure a representative sample, it is important to acknowledge that the findings may not be fully generalizable to the entire beneficiary population.
- The results presented in this section are purely based on the beneficiaries' feedback. The possibility of response bias exists, as respondents may have provided answers, they deemed socially desirable or biased due to factors such as the desire to please or fear of repercussions.
- Beneficiaries' ability to accurately recall specific programmatic details or experiences may have been influenced by memory limitations or other cognitive factors. However, where possible, provided population data was used to validate specific details including the date of visit to health facility etc. In case of any discrepancy, information provided in the population data was utilized.

Heatmaps of Spread of Operations Review Activity

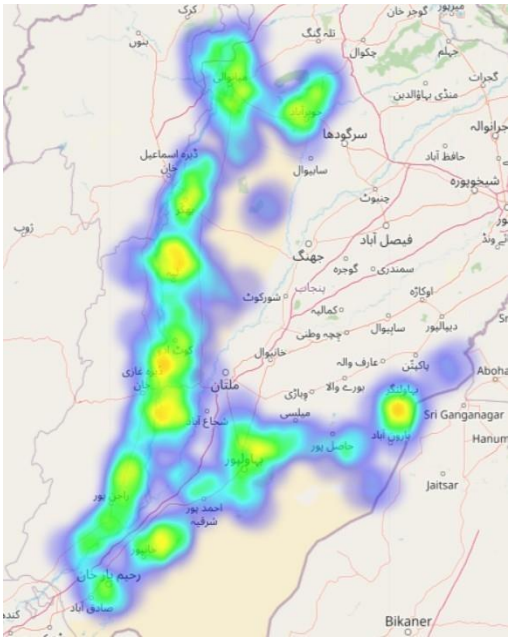

Figure 1: Spot Checks of Health Facilities

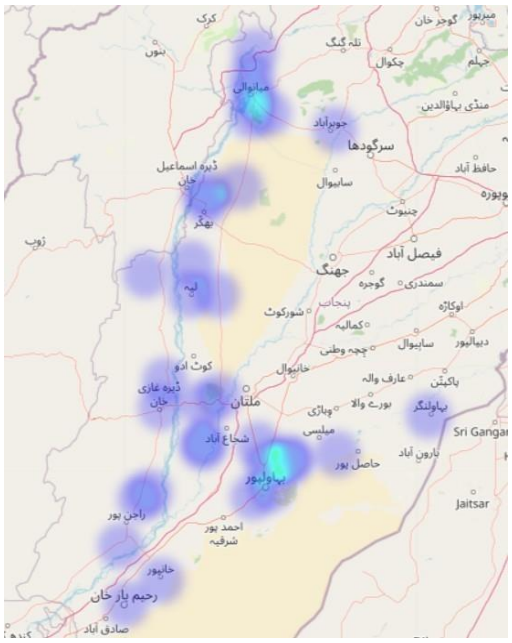

Figure 2: Spot Checks of Branchless Banking Agents

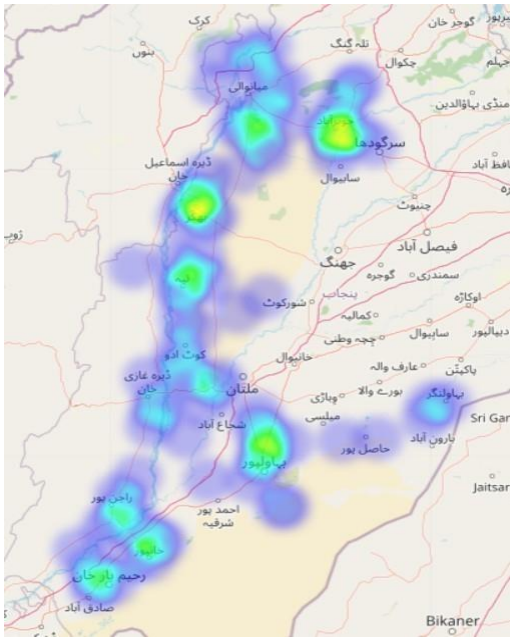

Figure 3: Beneficiary Feedback Interviews

3.2 SPOT CHECKS OF HEALTH FACILITIES AND BB AGENTS

To ensure the quality of the work being performed and identify issues in program implementation, conducting spot checks of the implementation process is important. In Health and Nutrition Conditional Cash Transfer (CCT) component, key processes such as beneficiary enrollment, service delivery are being implemented at health facilities while opening of wallet account including the payment mechanisms are made through branchless banking agents.

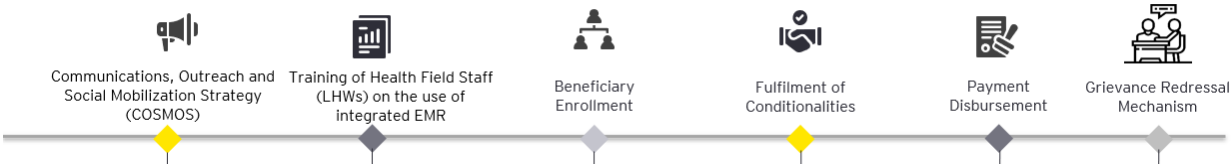

Figure 4: AAGHOSH Implementation Process

As an Operation Review (OR) firm, EYFR conducted the spot checks of health facility and branchless banking agent to assess different stages of the implementation process. In spot check of health facility, it was intended to observe the availability of resources (equipment, medicines, family planning commodities and public services in health facilities etc.) while in spot check of branchless banking agent, the frequency, time taken, and amount disbursed to beneficiaries along with the efficiency of payment system was observed. The stages whose spot checks are currently not being implemented are the training of health staff as these trainings were not conducted since June'23.

Note: This section is based on data collected during spot checks of health facilities conducted for the quarter ending Dec 2023, which has been analyzed and presented.

KEY FINDINGS OF SPOT CHECK OF HEALTH FACILITIES

During the spot check of health facilities, the condition of the health facilities, the availability of paramedic staff, medical equipment and medicines, as well as IEC materials was assessed. Detailed findings are provided in this section.

General Outlook Analysis & Cleanliness Standards at Health Facilities

Note: For the December quarter, different set of health facilities were visited though in some districts where the spot check of all the facilities were conducted for in the previous quarters sample, were inevitably repeated.

During the spot checks, it was found that in 92% (213 out of 231) of the health facilities, boundary wall was available though, it is concerning that 8% of the facilities lack a proper boundary wall which compromises the security of the staff, beneficiaries and health facility in general. Out of these 213 health facilities, 9 (4%) facilities had a boundary wall which was in a state of despair. Boundary walls in "good" condition were painted, a reasonable height, well-built etc. Boundary walls in "average" condition were generally sound, but there might be minor cracks or wear that don't compromise its overall stability. Boundary walls in "poor" condition were classified due to significant structural issues, such as large cracks, sections/bricks that are crumbling. It may not provide adequate security or could be at risk of collapse. Ensuring the proper maintenance and upkeep of boundary walls is crucial to maintain a safe and secure environment for both healthcare staff and PLWs. Details of health facilities and pictorial

evidence of some of such health facilities are attached in **Annexure-A and B.** Table 4 below also provides the results district wise.

Table 4: *Boundary Wall Availability and Condition*

District	Availability	Good	Average	Poor
Bahawalnagar	18 (86%)	13	3	2
Bahawalpur	18 (86%)	14	1	3
Bhakkar	19 (90%)	17	1	1
DG khan	21 (100%)	18	3	-
Khushab	19 (90%)	18	-	1
Layyah	21 (100%)	20	1	-
Lodhran	18 (86%)	15	2	1
Mianwali	20 (95%)	19	1	-
Muzaffargarh	20 (95%)	16	4	-
Rahim Yar khan	18 (86%)	17	1	-
Rajanpur	21 (100%)	20	-	1
Total	**213 (92%)**	**187 (88%)**	**17 (8%)**	**9 (4%)**

The availability of boundary walls according to the table above is relatively high, ranging from 86% to 100%, suggesting a focus on securing the building infrastructure.

- DG Khan, Layyah and Rajanpur stand out as a district with 100% availability of boundary walls, reflecting a strong commitment to building infrastructure.
- Bahawalpur has 86% availability of boundary walls, but some are in poor condition, indicating a potential need for repairs or upgrades.

Moreover, the overall cleanliness of the health facilities was observed. The general state of cleanliness across the majority of the health facilities was found to be adequately upheld. Cleanliness discrepancy was seen in 1 out of 231 health facility in Mianwali. Details of this instance is provided in **Annexure-C**.

Labor/Ward and Toilet cleanliness were also accounted for as given in table 5. Overall, the labor room and wardroom condition/cleanliness were satisfactory except in two labor rooms identified in Muzaffargarh and Rajanpur and 2 wardrooms identified in Bahawalnagar and Muzaffargarh. "Good" condition referred to clean labor/ward/toilet as compared to "Poor" condition where the cleanliness was not maintained/broken tiles etc. Annexure D provides the details and pictorial evidence.

On the contrary, poor toilet conditions were identified in 3% (7 out of 231) of the health facilities of the districts of Bahawalpur, Lodhran, Muzaffargarh and Rajanpur. It was noted that the toilets were not clean, EYFR monitors reported bad smells as well. These findings underscore the significance of addressing these cleanliness issues promptly to ensure that laboring mothers and patients recovering in the ward rooms are provided with an environment conducive to their well-being and recovery.

Table 5: *Overall Condition/State of Cleanliness of Building, Labor/Wardroom, and Toilet*

District	Overall Cleanliness		Labor Room condition		Wardroom Condition		Toilet Condition	
	Yes	No	Good	Poor	Good	Poor	Good	Poor
Bahawalnagar	21	-	21	-	20	1	21	-
Bahawalpur	21	-	21	-	21	-	20	1
Bhakkar	21	-	21	-	21	-	21	-
DG khan	21	-	21	-	21	-	21	-
Khushab	21	-	21	-	21	-	21	-
Layyah	21	-	21	-	21	-	21	-
Lodhran	21	-	21	-	21	-	20	1
Mianwali	20	1	21	-	21	-	21	-
Muzaffargarh	21	-	20	1	20	1	19	2
Rahim Yar khan	21	-	21	-	21	-	21	-
Rajanpur	21	-	20	1	21	-	18	3
Total	**230 (99.5%)**	**1 (0.5%)**	**229 (99%)**	**2 (1%)**	**229 (99%)**	**2 (1%)**	**224 (97%)**	**7 (3%)**

EMR Functionality and Efficiency

The specifics of Electronic Medical Record (EMR) systems were observed, aiming to assess their functionality and efficiency within various districts. This evaluation of the current state of EMR utilization at health facilities, focuses on key elements such as dedicated desks for data entry, the presence of designated focal persons, internet connectivity, and the availability of tablets for streamlined data input.

In December quarter, it was observed that in 184 out of 231 health facilities (80%), a dedicated desk was available. In 197 out of 231 health facilities (85%), a dedicated focal person to enter the beneficiary data was available. Moreover, the internet connectivity was observed in 224 out of 231 health facilities (97%) followed by tablets available at 220 out of 231 health facilities (95%) though there are variations in the average number of tablets available in districts. **Annexure E and F provides details of health facilities where tablets were not available and internet connectivity was an issue.** The table 6 provides a comprehensive overview of the availability of EMR data infrastructure in various districts, detailing the presence of dedicated desks for data entry, assigned focal persons, internet connectivity, and the availability of tablets for data input.

Table 6: EMR Data Infrastructure Availability

District	Dedicated Desk for Data entry		Dedicated Focal person to enter Data		Internet Connectivity		Tablets Available to Enter Data		Average No. of tablets available
	Count	Proportion	Count	Proportion	Count	Proportion	Count	Proportion	Count
Bahawalnagar	4	19%	18	86%	20	95%	11	52%	3
Bahawalpur	4	19%	16	76%	21	100%	21	100%	4
Bhakkar	21	100%	21	100%	21	100%	21	100%	4
DG khan	20	95%	20	95%	21	100%	21	100%	6
Khushab	15	71%	10	48%	21	100%	21	100%	5
Layyah	21	100%	21	100%	21	100%	21	100%	4
Lodhran	20	95%	19	90%	19	90%	21	100%	4
Mianwali	21	100%	21	100%	20	95%	21	100%	4
Muzaffargarh	16	76%	9	43%	21	100%	20	95%	6
Rahim Yar khan	21	100%	21	100%	20	95%	21	100%	4
Rajanpur	21	100%	21	100%	19	90%	21	100%	4
Total	**184**	**80%**	**197**	**85%**	**224**	**97%**	**220**	**95%**	**4**

1 Low availability of dedicated data entry desks in Bahawalnagar and Bahawalpur

In terms of dedicated desks for data entry, it is noteworthy that Bahawalnagar and Bahawalpur exhibit the lowest availability, with 14% and 19%, respectively. This divergence from the (POM) guidelines, which advocates for dedicated desks for data entry, indicates a potential area for improvement in the health facilities of these districts. In particular, the reason for the unavailability was because data entry was done in the rooms of Lady Health Visitors (LHVs).

2 Dedicated focal person required to maintain data consistency and accuracy

The role of a dedicated focal person for data entry is crucial for maintaining accuracy and consistency in the data. However, the data reveals that in some health facilities in districts of Bahawalpur, Khushab and Muzaffargarh where the focal person is not available, the data entry is performed by whoever is available at the time, suggesting a lack of a designated focal person. This highlights a potential gap in the designated roles for data management within certain districts.

3 Internet connectivity generally strong across all districts

On a positive note, the availability of internet connectivity is generally strong, with a high proportion observed in the majority of health facilities. It is noteworthy that internet access is often facilitated through mobile packages, showcasing adaptability to available resources.

4 Tablets are kept at home by the LHVs as EMR is accessed on mobile phones

Regarding the availability of tablets for data entry, the data indicates a high overall proportion. There are on average 4 tablets per district in the health facilities however, there are many variations among the number of tablets available at health facilities ranging between 1-14. Moreover, the unavailability of tablets in facilities of Bahawalnagar, Bahawalpur and Muzaffargarh, are due to the challenges such as tablets being kept at LHVs' homes for charging, utilization of EMR apps on mobile phones therefore the tablets are kept at home. In other instances, the tablets were broken, or the staff member who had hold of the tab was unavailable on the health facility premises. These challenges suggest a need for improved management of tablet resources and maintenance to ensure consistent and effective data entry.

5 EMR controls observed

Several controls have been incorporated and verified within the Electronic Medical Record (EMR) system during spot checks. Upon entering the login information, which includes the CNIC number of registered health staff individual from the health facility, they receive an OTP code. This code serves as a security measure, allowing only them to access the EMR system.

It has been communicated to us by PSPA officers that the beneficiary having the age of 50 or above are unable to register under the Aagosh program. However, during the spot checks of health facility, it has been observed that no control was implemented in the EMR system. Furthermore, in the beneficiary feedback sample, cases were identified where the beneficiaries registered were of ages 50 and above, mostly classified as the mother-in-law registering their daughter in laws on their own CNIC.

Medical Equipment Availability for Enhanced Health Facility Functionality

The spot checks of refrigerators for vaccine storage and ultrasound machines underscores the importance of infrastructure for both preventive care and diagnostic services. In terms of Refrigerators for Vaccine Storage, the majority of health facilities across districts seem adequately equipped, with a total of 230 available. However, it is noteworthy that one facility in Khushab lacked a proper refrigerator. Being situated in a remote area, the staff used a cooler filled with ice, storing the quantity which is required on the current day. Though, it served to be an alternate however, proper storage mechanism is essential for vaccines. Ultrasound machine availability on the other hand was seen in 54% (125 out of 231) of the health facilities. Table 7 provides the district wise breakdown.

Table 7: *Availability of Medical Equipment*

District	*Refrigerator for Vaccine Storage*		*Ultrasound Machine*		
	Available	*Unavailable*	*Available*	*Unavailable*	*Total*
Bahawalnagar	21	-	4 (19%)	17 (81%)	21
Bahawalpur	21	-	12 (57%)	9 (43%)	21
Bhakkar	21	-	5 (24%)	16 (76%)	21
DG khan	21	-	19 (90%)	2 (10%)	21
Khushab	20	1	3 (14%)	18 (86%)	21
Layyah	21	-	16 (76%)	5 (24%)	21
Lodhran	21	-	15 (71%)	6 (29%)	21
Mianwali	21	-	5 (24%)	16 (76%)	21
Muzaffargarh	21	-	16 (76%)	5 (24%)	21
Rahim Yar khan	21	-	9 (43%)	12 (57%)	21
Rajanpur	21	-	21 (100%)	-	21
Total	**230 (99.9%)**	**1 (0.01%)**	**125 (54%)**	**107 (46%)**	**231**

According to the table, ultrasound machines availability varies across districts. Notably, Rajanpur stands out with all 21 health facilities equipped with it. Conversely, in Bahawalnagar, Khushab, Bhakkar and Mianwali, a significant proportion of facilities lack ultrasound machines, indicating a potential gap in diagnostic capabilities in these regions. According to the staff, they have not yet been provided with the machine by the government however, they need it in order to cater to the pregnant beneficiaries that visit them. Therefore, it is crucial to address such discrepancies to ensure comprehensive healthcare services, especially in districts where a large percentage of facilities currently lack ultrasound machines.

Key Medical Staff Unavailability During Visit

The unavailability of key medical staff during the visits to health facilities raises significant concerns about the overall effectiveness of healthcare delivery though, the availability of key staff has improved since previous quarters. In the sample, there were a total of 231 health facilities out of which 210 were Basic health units and 21 were Rural health centers. It was found that in 40% (92 out of 231) health facilities, medical officer was unavailable, in 10% (20 out of 210) BHUs the LHV was not available and in 10% (2 out of 21) rural health centers, the nurse was not available. The breakdown and reason for unavailability are given in table 8 district wise.

Table 8: *Medical Staff Unavailability at BHUs (District-wise)*

District	*Total Facilities Visited*	*Medical Staff Position*	Position Vacant	*Staff On Leave*	*Total Staff Unavailable*
Bahawalnagar	20	Medical Officer	9	6	15 (75%)
		LHV	-	3	3 (15%)
Bahawalpur	21	Medical Officer	1	13	14 (67%)
		LHV	-	4	4 (19%)
Bhakkar	20	Medical Officer	4	4	8 (40%)
		LHV	1	-	1 (5%)
DG khan	17	Medical Officer	-	6	6 (35%)
		LHV	-	2	2 (12%)
Khushab	19	Medical Officer	4	7	11 (58%)
		LHV	-	1	1 (5%)
Layyah	19	Medical Officer	2	5	7 (37%)
		LHV	-	-	-
Lodhran	20	Medical Officer	1	2	3 (15%)
		LHV	1	-	1 (5%)
Mianwali	18	Medical Officer	10	-	10 (56%)
		LHV	-	2	2 (11%)
Muzaffargarh	17	Medical Officer	-	7	7 (41%)
		LHV	-	3	3 (18%)
Rahim Yar khan	21	Medical Officer	-	8	8 (38%)
		LHV	-	1	1 (5%)
Rajanpur	18	Medical Officer	1	1	2 (11%)
		LHV	-	2	2 (11%)
Total	210	**Total MOs**	**32**	**59**	**91 (43%)**
		Total LHVs	**2**	**18**	**20 (10%)**
		Total Unavailable	**34 (31%)**	**77 (69%)**	**111 (48%)**

According to the table above, medical officer absence was seen in 43% (91 out of 210) BHUs and LHV unavailability was seen in 10% (20 out of 210) BHUS. In terms of the reason for absence, majority were found to be absent or on leave on the visit day. Vacant positions were

found the most for medical officers. Moreover, the unavailability of medical officers was found most in the district of Bahawalnagar as in 75% (15 out of 20) of the BHUs, MOs were either vacant or absent. Moreover, LHV `unavailability during the visit was seen the most in the district of Bahawalpur as in 19% (4 out of 21) BHUs, LHVs were absent. It should also be noted that in 7 basic health units, both the medical officer and the LHVs were on leave on the visit day. In such instances, a midwife/medical technician/dispenser was available to cater to the beneficiaries. For the unavailability of staff in RHCs, table 9 provides a similar breakdown.

Table 9: *Medical Staff Unavailability at RHCs (District-wise)*

District	*Total Facilities Visited*	*Medical Staff Position*	*Position Vacant*	*Staff On Leave*	*Total Staff Unavailable*
Bahawalnagar	1	Medical Officer	-	-	-
		Nurse	-	1	1
DG khan	4	Medical Officer	-	-	-
		Nurse	-	1	1
Muzaffargarh	4	Medical Officer	-	1	1
		Nurse	-	-	-
Total RHCs	21	**Total MOs**	-	1	1 (5%)
		Total Nurse	-	2	2 (10%)
		Total Absent	-	3	3 (14%)

In the table above, unavailability of staff was only seen in 3 districts. Among these, the nurses were found to be unavailable in Bahawalnagar and Muzaffargarh. Medical officer absence was only noted in one RHC of DG Khan. Overall, the total availability of medical staff was commendable in RHCs. However, the issue persistent in BHUs require attention as the absence of key medical personnel can hinder the smooth operation of healthcare services, impacting not only the immediate quality of care but also the trust and confidence of the community in the healthcare system. This issue underscores the importance of addressing staffing challenges and implementing measures to ensure the consistent presence of key medical staff during visits, thereby enhancing the reliability and accessibility of healthcare services for the community.

Dispensary Operational During Visit and Availability of Supplies

The overall availability of medicines in the health facilities was good however, in **4 out of 231 (2%) health facilities instances were identified, where the dispensary was not open** during the visit. Moreover, it was noted that in 28 health facilities (12%), vital micro-nutrients were not available. Additionally, in 8 (3%) health facilities, contraceptive commodities were reported to be unavailable. Breakdown of the availability of supplies is given in table 10 and details of the relevant health facilities are provided in **annexure G and H.**

Table 10: *Dispensary Operational During Visit and Availability of Supplies*

District	Dispensary Open at the Time of Visit		Micro-Nutrients Available		Contraceptive Commodities	
	Count	Proportion	Count	Proportion	Count	Proportion
Bahawalnagar	18	86%	19	90%	21	100%
Bahawalpur	21	100%	19	90%	20	95%
Bhakkar	21	100%	18	86%	21	100%
DG khan	21	100%	15	71%	16	76%
Khushab	20	95%	20	95%	21	100%

Layyah	21	100%	20	95%	21	100%
Lodhran	21	100%	20	95%	21	100%
Mianwali	21	100%	17	81%	21	100%
Muzaffargarh	21	100%	19	90%	21	100%
Rahim Yar khan	21	100%	17	81%	19	90%
Rajanpur	21	100%	19	90%	21	100%
Total	**227**	**98%**	**203**	**88%**	**223**	**97%**

Table 11: Availability of Brochures Detailing CCT Payment Process

District	Available		Unavailable	
	Count	Proportion	Count	Proportion
Bahawalnagar	-	0%	21	100%
Bahawalpur	8	38%	13	62%
Bhakkar	15	71%	6	29%
DG khan	1	5%	20	95%
Khushab	2	10%	19	90%
Layyah	5	24%	16	76%
Lodhran	1	5%	20	95%
Mianwali	8	38%	13	62%
Muzaffargarh	4	19%	17	81%
Rahim Yar khan	10	48%	11	52%
Rajanpur	1	5%	20	95%
Total	**55**	**24%**	**176**	**76%**

- As for the four dispensaries, which were also found to be closed, the reasons included the unavailability of the dispenser, ongoing construction work at the respective Basic Health Unit (BHU) and in one case it was not open yet.
- The overall availability of micronutrients and contraceptive commodities in health facilities across all districts was generally satisfactory. It is crucial to highlight that, despite instances where the dispensary was closed, these essential supplies were still accessible. The Lady Health Visitors (LHVs) had stored them in their rooms, ensuring continued availability. Instances where these supplies were not accessible were attributed to LHV unavailability, dispensary closure in the absence of LHVs, or no supply.

Absence of CCT Payment Process Brochures at Health Facilities

As per the POM, the Information, Education, and Communication (IEC) materials e.g., a leaflet, fact sheet or an FAQ detailing introduction of the CCT, objectives, target group, benefits, conditions, payment process and Grievance Redress Mechanism (GRM) etc. shall be made available at primary healthcare facilities and to LHWs. During our spot checks, observations have come to light regarding availability of IEC materials within the health facilities.

Specifically, it has been observed that brochures detailing the Conditional Cash Transfer (CCT) payment disbursement process were absent in 176 out of 231 (76%) health facilities which is higher than our previous quarters spot checks where it was unavailable in (68%) health facilities. Table 11 provides a district wise breakdown.

All surveyed Health facilities in Bahawalnagar, lacked these brochures however, it was available in most health facilities of Bhakkar. The potential reason for the unavailability during the visit was that the brochures had been distributed when they accessed them and now there are out of supply. The absence and limited supply of these brochures could potentially hinder PLWs

understanding of the payment procedures and entitlements, affecting their informed engagement with the program.

Grievance Redressal Mechanism

As per POM, Grievance Redressal Mechanism (GRM) for the H&N CCT program involves notifying GRM Focal Persons at primary healthcare facilities and designating a representative at HISDU to manage helpline calls. Training sessions are to be conducted at both district and facility levels, enabling the registration of grievances and complaints through a standardized format. Registered complaints are to be uploaded to the EMR H&N-CCT application, where they will be categorized and shared with the relevant units for resolution. Healthcare service-related issues will be addressed by PMIU-P&SHD, while payment-related concerns will be handled by the PSPA, ensuring timely and effective resolution of grievances within their respective domains. The PSPA is to also establish an online helpline for payment-related queries. This process aims to streamline and enhance the redressal of complaints for improved program outcomes.

However, EYFR has been informed that the EMR is not being currently utilized to register complaints. Regarding the GRM mechanism following observations were noted as given in table 12.

Table 12: *Availability of GRM Essentials*

District	*Helpline Number*		*Focal Person to Register Complaints*		*Register for Complaints*	
	Available	*Proportion*	*Available*	*Proportion*	*Available*	*Proportion*
Bahawalnagar	13	62%	18	86%	18	86%
Bahawalpur	2	10%	1	5%	-	0%
Bhakkar	16	76%	-	0%	-	0%
DG khan	20	95%	1	5%	1	5%
Khushab	18	86%	1	5%	-	0%
Layyah	17	81%	8	38%	8	38%
Lodhran	12	57%	3	14%	9	43%
Mianwali	15	71%	6	29%	7	33%
Muzaffargarh	5	24%	-	0%	1	5%
Rahim Yar khan	10	48%	10	48%	3	14%
Rajanpur	16	76%	21	100%	3	14%
Total	**144**	**62%**	**69**	**30%**	**50**	**22%**

- In the course of our spot checks, observations regarding the complaint registration processes within the health facilities was noted. It has come to our attention that in **162 out of 231 (70%) health facilities, there was an absence of a designated individual responsible for registering complaints** though in the previous quarter, 77% of the health facilities lacked these.
- Furthermore, in **181 out of 231 (78%) health facilities, the dedicated register for complaint registration was not available**, consistent with previous quarter. On the contrary, health facilities that lack a register have a complaint box in place and complaint forms that can be submitted in them. In other cases, it was observed that the complaints are not registered, rather they are verbally listened to by any medical staff who later share it within their formal group.
- In addition, it was noted that in **87 out of 231 (38%) health facilities the helpline number/complaint registration number was not displayed. Though the availability of the**

helpline number is greater than previous quarters, there is still a need to ensure proper display as the helpline/complaint registration number acts as a crucial communication avenue for PLWs seeking assistance and information, making its accessibility integral to the program's effectiveness.

Overall, the utilization of GRM has somewhat improved since previous quarters though, the issues are still prevalent and significant and require efforts to make the GRM process easier and effective to complete program objectives.

KEY FINDINGS OF SPOT CHECK OF BRANCHLESS BANKING (BB) AGENT

The objective of conducting spot checks on branchless banking agents was to assess several key aspects, including the availability of operational infrastructure, the PLWs experience during cash collection, and the conduct of agents towards PLWs. In pursuit of this objective, EYFR carried out spot checks at various agent points located in close proximity to each health facility. A comprehensive breakdown of the spot check findings is outlined in this section.

Note: This section is based on data collected during spot checks of BB Agent conducted for the quarter ending Dec 2023, which has been analyzed and presented.

Proximity of Shops to Health Facilities and Average Visits of AAGHOSH Beneficiaries

During spot checks of the branchless banking agents, EYFR observed the proximity of the nearest health facility to the shop. This is crucial to ensure that beneficiaries, who frequently visit those health facilities, can easily visit the branchless banking agents for verification and cash disbursement as well. Table 13 provides a district wise breakdown of the distance of shops surveyed in our sample from health facilities.

Table 13: Distance of Shops (surveyed in sample) from Health Facility

District	Less than 1 Km	1-2 Km	2-3 Km	More than 3 Km	Avg. beneficiaries visit per month
Bahawalnagar	0	0	2	3	10
Bahawalpur	1	1	1	2	21
Bhakkar	3	1	0	1	32
DG khan	0	0	2	3	15
Khushab	0	2	3	0	28
Layyah	0	0	0	5	29
Lodhran	4	1	0	0	36
Mianwali	3	2	0	0	34
Muzaffargarh	4	1	0	0	30
Rahim Yar khan	4	1	0	0	36
Rajanpur	4	1	0	0	31
Grand Total	**23 (42%)**	**10 (18%)**	**8 (15%)**	**14 (25%)**	**27**

The analysis of the distances between branchless banking agents (BBAs) and health facilities reveals notable variations across districts. While a significant proportion of these shops (42%) are conveniently located within 1 km of health facilities, attention is warranted in districts where a higher percentage of shops (25%) are situated more than 3 km away. This is particularly evident in the district of Layyah. This discrepancy may lead to potential service gaps, particularly in terms of accessibility for beneficiaries seeking verification and cash disbursement.

Camps Set Up at Health Facilities to Distribute Payment

On average, approximately 27 AAGHOSH beneficiaries visit these shops spot checked in our sample per month. However, the breakdown in Table 13 shows that on average 10 beneficiaries per month visit the BBA shops in Bahawalnagar because in certain tehsils of Bahawalnagar,

camps are established within health facilities to facilitate the coordination between Branchless Banking Agents and beneficiaries for payment collection. The organization of these camps is overseen by AAGHOSH's coordinator, who communicates with LHVs to notify and gather beneficiaries on a particular day.

AAGHOSH Outreach Via Multiple Channels & Program Awareness

During our spot checks, 91% (50 out of 55) of the agents indicated that they had received information about the AAGHOSH program through various channels, such as PHCIP/AAGHOSH team, HBL, OMNI, and others. This underscores the extensive outreach efforts to disseminate information about the program across multiple platforms. Nevertheless, among the 5 Branchless Banking (BB) agents who lacked orientation, upon deeper investigation into their knowledge of the program, 4 out of 5 demonstrated awareness. They acknowledged that the program caters to pregnant and lactating women, offering payments in exchange for availing health services. Only 1 BB agent admitted to having no knowledge about the program. Comparative to previous quarters, the awareness is consistent as showed in table 14.

Table 14: *Source of Information about AAGHOSH over Quarters (multiple choice)*

Source of information	*June'23*	*Sept'23*	*Dec'23*
BOP	5 (10%)	8 (16%)	5 (10%)
Alfalah	17 (33%)	31 (62%)	25 (50%)
Omni	9 (18%)	18 (36%)	10 (20%)
HBL	12 (21%)	19 (38%)	24 (48%)
PHCIP	9 (18%)	17 (34%)	20 (40%)
Total	**52 (95%)**	**50 (91%)**	**50 (91%)**

BB agents were asked about the commission they received. On average, they received 2% commission though there is some district variation as shown in table 15.

Table 15: Commissions Received by BB Agents

District	No Commission	0.5-2%	3-4%	Average Commission
Bahawalnagar	0	4	1	2%
Bahawalpur	3	2	0	1%
Bhakkar	0	5	0	2%
DG khan	1	2	2	2%
Khushab	2	3	0	1%
Layyah	0	1	4	3%
Lodhran	0	2	3	3%
Mianwali	0	5	0	1%
Muzaffargarh	0	5	0	2%
Rahim Yar khan	0	5	0	2%
Rajanpur	0	3	2	2%
Grand Total	**6 (11%)**	**37 (67%)**	**12 (22%)**	**2%**

According to the table above, 11% of the BB agents expressed that they do not receive any commission by the bank, and this is the most evident in the district of Bahawalpur. On the contrary, majority i.e., 67% of the BB agents received a commission between 1-2% and some even suggested to have received 3-4% of commission.

Availability of Utilities at Branchless Banking Agent Points

In terms of the available utilities at these BB agent points, all the visited shops in the sample – 100% - had a functional biometric machine though in previous quarters, it was noted that biometric verification machines were present at 89% (49 out of 55) of the agent locations in Sept'23 and at 95% of the locations in June'23. Functional internet was also available at all agents points though in many cases; BB agents had to use mobile packages to access the internet. However, the availability of AAGHOSH banner was only seen in two shops in DG Khan.

Biometric Verification Failure; A Consistent Issue

BB Agents were inquired about the issues the beneficiaries face when they visit them. Table 16 shows the breakdown of the issues.

Table 16: *Issues Faced by Beneficiaries According to BBA*

District	Failure of thumb print	Internet issue	Mobile number & OTP issue	Over-crowding	Incorrect mobile numbers
Bahawalnagar	2	3	0	0	0
Bahawalpur	4	0	0	0	1
Bhakkar	4	1	0	0	0
DG khan	3	1	0	0	1
Khushab	2	2	0	1	0
Layyah	3	0	0	0	2
Lodhran	4	0	0	0	1
Mianwali	4	1	0	0	0
Muzaffargarh	4	0	0	0	1
Rahim Yar khan	0	2	3	0	0
Rajanpur	3	1	0	0	1
Total	**33 (60%)**	**11 (20%)**	**3 (5%)**	**1 (2%)**	**7 (13%)**

According to the table above, fingerprint biometric verification is the most persistent and evident issue that the beneficiaries have to encounter according to BBAs. This is followed by issues in internet connectivity as the BBAs mostly make use of mobile packages that sometimes cause trouble. Incorrect mobile numbers were also an issue that the beneficiaries have to face due to which their payments are not processed.

Challenges Encountered by Branchless Banking Agents

BB agents were asked what issues they encounter while operating as a cash agent. Table 17 lists down these issues where the most common ones are poor network issues which leads to delay in OTP generation and the fact that beneficiaries do not carry their correct mobile numbers or CNICs with them which hinders the process of verification and hence payment. Almost 44% of the BB Agents surveyed in the sample said that they receive insufficient commissions by the bank which is evident from the previous finding in table 15 where majority receive a commission of 1-2% and some who receive nothing.

Table 17: *Issues Encountered by BBAs (multiple choice)*

District	*Poor Network (OTP/Internet)*	*Unavailable mobiles #/CNIC*	*Unavailability of cash*	*Poor commission*	*Higher influx of BISP beneficiaries*
Bahawalnagar	5	1	0	1	0
Bahawalpur	4	2	0	3	1
Bhakkar	5	0	0	0	0
DG khan	1	4	0	0	0

Table 17: Issues Encountered by BBAs (multiple choice)

District	Poor Network (OTP/Internet)	Unavailable mobiles #/CNIC	Unavailability of cash	Poor commission	Higher influx of BISP beneficiaries
Khushab	4	5	4	5	2
Layyah	5	4	0	3	0
Lodhran	5	0	0	5	0
Mianwali	3	2	0	2	0
Muzaffargarh	4	2	0	2	1
Rahim Yar khan	4	3	0	1	1
Rajanpur	5	0	0	2	2
Total	**45 (82%)**	**23 (42%)**	**4 (7%)**	**24 (44%)**	**7 (13%)**

Recommendations to Improve Payment Issues by BBA

BB Agents provided some recommendations to improve the payment issues listed below.

1

Better Commissions by the Bank:

- Almost half i.e., 53% (29 out of 55) of the BB Agents surveyed suggested that better commissions by the bank should be provided. One way to do this is to incentivize agents by offering competitive commissions, fostering increased engagement and commitment to the program.

2

Create Awareness About Compliance Requirements:

- 35% (19 out of 55) said that targeted awareness campaigns that educate beneficiaries on the program's compliance requirements is crucial. Ensuring that beneficiaries bring the relevant CNIC and mobile number with them.

3

Opening More Cash Payment Points:

- 7% (4 out of 55) of the BBA suggest opening more cash payment points can facilitate payment disbursement as it would allow the influx of the BISP beneficiaries to not become a hindrance for the AAGHOSH beneficiaries, thus reducing any waiting time.

4

Ability to Correct Mobile Numbers:

- 5% (3 out of 55) suggest facilitating LHVs with the ability to correct mobile numbers to ensure successful account opening and biometric verification.

These recommendations aim to address various aspects, including awareness, financial incentives, accessibility, data accuracy, and communication transparency, contributing to an overall improvement in the AAGHOSH program.

Payment Deductions by the BBAs

During the spot check, it was noted that a proportion of agents, totaling 7 (13%) out of 55, applied deductions upon disbursing payments to the PLWs which is greater than the findings in Sept'23 whereby 6 BBAs were observed making deductions. In such instances, our observations indicate that the deducted amounts fell within the range of PKR 100 to PKR 500. It was observed that the BB agents asserts to beneficiaries that deduction is their right, emphasizing that by making payments, they are entitled to receive a corresponding amount as a commission. The number of instances / agents point where the payment deductions are observed are given in table 18.

Table 18: *Number of Payment Deductions Observed at BBA*

District	50 - 100 PKR			101 - 300 PKR			350 - 500 PKR		
	June'23	Sept'23	Dec'23	June'23	Sept'23	Dec'23	June '23	Sept '23	Dec' 23
Lodhran	-	-	-	1	1	2	1	-	-
Rajanpur	-	1	-	-	-	-	-	4	2
Bahawalpur	-	-	1	1	-	1	-	-	-
Layyah	3	-	-	1	-	1	-	-	-
Mianwali	1	-	-	-	-	-	-	-	-

From the table, it is evident that over quarters, payment deductions are most common in the same districts as shown in the table. Maximum amount is deducted in Rajanpur where 2 agents were observed deducting as much as 500PKR. It is important to note that 53% of beneficiaries reported payment deductions during payments from agents. However, during our spot checks, a lower percentage, i.e., 13%, observed such deductions. This difference may be attributed to agents being aware of field staff presence and refraining from deducting payments in their presence. Nevertheless, payment deductions have been triangulated by beneficiaries, EYFR spot checks and KIIs where health staff also acknowledges that BB agents make deductions. Therefore, it is essential to address this issue to maintain program integrity or to provide BBAs with better commissions so that this does not happen.

3.3 DEMAND SIDE PERSPECTIVE – INTERVIEWS WITH BENEFICIARIES

In this section, the beneficiary (PLW) feedback regarding different activities involved in the implementation of H&N CCT program as obtained through field research is analyzed and key findings presented. The satisfaction regarding the overall program is also noted and complaints and concerns have also been highlighted.

Note: This section is based on PLWs feedback conducted for the quarter ending Dec 2023, which has been analyzed and presented.

Beneficiary Profile in the Sample

The program aims to provide support and assistance to women up to age of 49 as conveyed by PSPA. The specific criteria of enrollment into the program are that a women should be pregnant or lactating (PLWs) and/or mother of children under two years of age. Age bracket of selected PLWs are as follows in Table 19.

Table 19: *Age Bracket of Beneficiaries*

Age Bracket	Pregnant	Pregnant & Lactating	Lactating	Total
17- 20	4	0	3	**7 (2%)**
21-25	11	2	33	**46 (11%)**
26-30	33	0	68	**101 (25%)**
31-35	29	1	94	**124 (30%)**
36-40	15	1	58	**74 (18%)**
41 - 49	16	1	41	**58 (14%)**
Total	**108 (26%)**	**5 (1%)**	**297 (73%)**	**410**

From the surveyed PLWs, a majority of 90% visited Basic Health Units (BHUs) for their healthcare needs, 7% visited Rural Health Centers (RHCs) while the remaining 4% visited District Head Quarter (DHQ) and Tehsil Head Quarters (THQ). Table 20 provides a quarter wise comparison of the proportion of beneficiaries utilizing health facilities.

Table 20: *Health Facility Visited (Quarter-wise Comparison)*

Health Facility	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
BHU (proportion)	85%	79%	80%	90%
RHC (proportion)	15%	19%	16%	7%
DHQ (proportion)	-	2%	3%	1%
THQ (proportion)	-	-	1%	3%

- It is evident that throughout the quarters, BHUs are the most frequently accessed health facilities by the PLWs and the proportion of visiting BHUs has increased for the Dec'23 quarter suggesting reliance on this type of health facility.
- RHCs are also utilized by a considerable portion of PLWs, serving as an alternative to BHUs for accessing healthcare services.
- Moreover, District Head Quarters (DHQs) and Tehsil Head Quarters (THQs) utilization is consistent with the previous quarter. Although the proportion is still relatively small, it suggests an increasing awareness among PLWs about the availability of health facilities at higher administrative levels.

Awareness of AAGHOSH Program Quarter on Quarter Comparison

The AAGHOSH H&N CCT program aims to ensure that PLWs are well-informed about the program's objectives, features, and benefits. To achieve these goals, a combination of a well-

targeted public information campaign and beneficiary outreach mechanisms is utilized. In order to mobilize and educate the beneficiaries about the program, various activities are carried out, including the communication of key messages through materials such as leaflets and posters, conducting orientation sessions through targeted meetings and dialogue, mobilizing healthcare staff such as LHVs, LHSs, and LHWs, implementing an SMS campaign, and conducting awareness sessions with local communities through allied government departments, local non-government organizations, and community and village organizations.

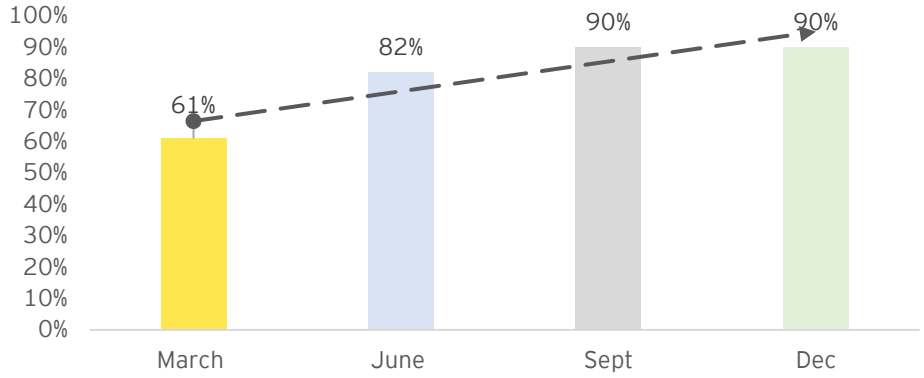

Figure 5: Quarter-wise Improvement in AAGHOSH Awareness

For the quarter ended Dec 2023, the AAGHOSH H&N CCT program saw a consistent level of PLWs' awareness, with **90% reporting knowledge of the program as seen in previous quarter.** This consistency with previous quarter indicates that the program is doing well in terms of the spreading of awareness. Overall, there has been a significant increase since March'23. Moreover, beneficiaries in districts such as Bahawalnagar, Bahawalpur, Bhakkar, Lodhran and Rahim Yar Khan show increased awareness over the period of three quarters. However, awareness of the program in Mianwali has considerably decreased since previous quarter. Targeted efforts are needed to address this and further enhance awareness. District wise breakdown of the beneficiaries aware about AAGHOSH are given in table 21.

***Table 21:** Beneficiaries Aware of AAGHOSH*

District	*March'23*	*June'23*	*Sept'23*	*Dec'23*
Bahawalnagar	22 (31%)	32 (70%)	20 (69%)	30 (86%)
Bahawalpur	41 (58%)	30 (77%)	33 (94%)	37 (100%)
Bhakkar	53 (69%)	9 (24%)	16 (44%)	30 (77%)
DG Khan	43 (57%)	35 (95%)	33 (100%)	35 (97%)
Khushab	22 (28%)	27 (75%)	35 (97%)	33 (77%)
Layyah	77 (99%)	40 (100%)	37 (100%)	35 (100%)
Lodhran	41 (53%)	35 (97%)	38 (97%)	40 (100%)
Mianwali	47 (67%)	29 (83%)	35 (92%)	26 (74%)
Muzaffargarh	54 (75%)	35 (90%)	39 (100%)	28 (80%)
Rahim Yar Khan	42 (55%)	44 (96%)	34 (94%)	37 (100%)
Rajanpur	62 (83%)	41 (95%)	40 (100%)	36 (95%)
Total	**504 (61%)**	**357 (82%)**	**360 (90%)**	**367 (90%)**

Crucially, the Dec 2023 quarter reaffirmed the pivotal role of Lady Health Workers over the quarters, with 89% of those aware of the program crediting LHWs for their knowledge. The role of friends and family spreading awareness has increased from 6% to 9% in this quarter. Other sources (2%) played a lesser role. The overwhelming reliance on LHWs underscores their

significance in disseminating program details. The findings also suggest that the communication strategies, such as letters, and posters/banners, have had limited impact in creating awareness about the AAGHOSH H&N CCT program. Table 22 provides a quarter wise comparison of the source of awareness for AAGHOSH.

Table 22: *Quarter-wise Source of Awareness about AAGHOSH*

Source	Mar'23	June'23	Sept'23	Dec'23
Lady Health Worker	82%	92%	93%	89%
Friends & Family	12%	05%	06%	09%
Posters/Banners/BBA	05%	01%	01%	01%
Letters and Robo calls	01%	02%	01%	01%

Personal Transportation and Affordable Travel Expenditure

For the Dec 2023 quarter, the analysis continued to emphasize the importance of proximity to health facilities and transportation modes. The findings unveiled shifts in PLWs responses, indicating evolving circumstances. Table 23 summarizes the results for distance of health facility from the homes of the beneficiaries and mode of travel used for it.

Table 23: *Responses on Distance to Health Facility & Mode of Travel*

Distance	On Foot	Personal Vehicle	Public Transport	Other's Vehicle	Total
Within a Km	59	35	4	0	**98 (24%)**
1-3 Km	23	92	10	1	**126 (31%)**
3-5 Km	10	50	28	1	**89 (22%)**
More than 5 Km	1	51	44	1	**97 (24%)**
Total	**93 (23%)**	**228 (56%)**	**86 (21%)**	**3 (1%)**	**410**

According to the table above, majority of the beneficiaries have access to health facilities that are within 3 Kms i.e., 55%. A significant proportion of PLWs (56%) own a personal vehicle for their healthcare travels. This underscores the importance of personal transportation in facilitating convenient and efficient access to healthcare services, reflecting the influence of proximity on their choice of travel. Notably, 21% of the beneficiaries have to use public transport for travel and that too when the proximity is more than 5 Kms. Table 24 provides a quarter wise comparison of the responses for travel cost incurred.

Table 24: *Responses on Travel Cost to Health Facilities*

Travel Cost	Mar'23	June'23	Sept'23	Dec'23
PKR 0-150 (% of beneficiaries)	42%	46%	40%	44%
PKR 151-300 (% of beneficiaries)	35%	31%	31%	31%
More than PKR 300 (% of beneficiaries)	23%	23%	28%	25%
Average Travel Cost	**PKR 260**	**PKR 222**	**PKR 261**	**PKR 226**

It can be seen that financial considerations remained a factor, with 44% of PLWs spending PKR 0 to 150, 31% incurring PKR 151 to 300, and 25% allocating more than PKR 300 for their travel to health facilities. The average travel cost was PKR 226, which has decreased since the previous quarter. Nevertheless, considering that PLWs receive monetary incentives for each visit, it may not pose a significant financial burden for the majority of them.

Overall, it can be inferred that the majority of PLWs have relatively good access to healthcare facilities, with 55% reporting that a health facility is located within three kilometers of their

homes. The majority of PLWs also have access to personal transportation, which further eases their travel to these facilities. These factors, combined with the average travel cost, suggest that access to healthcare may not be a major issue for most PLWs in the program though the KIIs reveal a contrasting perspective where the medical staff highlighted beneficiaries to be facing access to transportation as an issue.

Enrolment Process Satisfaction Among PLWs Shows an Increasing Trend

The enrollment process holds immense significance in achieving the targets of the program. It serves as the gateway through which PLWs are identified and connected with the program's benefits and services. According to the survey conducted in quarter ended Dec'23, **94% of the PLWs reported that they did not encounter any difficulties during the enrollment process** which has increased since last quarter whereby 92% reported no difficulties and 87% in March. This finding indicates a positive experience for a significant portion of the PLWs. However, 6% of the beneficiaries who indicated that they encountered difficulties while enrolling is described below.

Issues Faced by PLWs in Enrollment

As we progressed into the Dec 2023 quarter, the challenges remained consistent with the previous quarter, albeit with some changes in statistics. The issue of LHV unavailability due to busy schedules has increased drastically to 56% which requires attention to either increase staff or to train for effective management. The lack of updated family tree records continued to impact the registration process, though it decreased to only 8% of respondents highlighting this issue. However, non-availability of CNIC with the PLWs increased to 24%. Table 25 provides quarter wise results of the issues faced by beneficiaries during enrollment.

Table 25: *Issues Encountered by Beneficiaries During Enrollment*

Time Period	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
Unavailability of LHVs due to being busy	47%	18%	10%	56%
Lack of updated family tree	7%	18%	20%	8%
Non-availability of CNIC/mobile/fingerprint issue	12%	13%	13%	24%

Moreover, it was observed that among the PLWs who encountered challenges, there were variations in their registration timelines. It was found that 04% of the PLWs registered two months ago, 16% registered three to five months ago, 52% registered six to eight months ago, 16% registered nine to eleven months ago, and 12% registered a year or more than one year ago. The table 26 below gives the breakup of respondents.

Table 26: *Beneficiary Registration Timeline who Faced Issues in Enrolment*

Registered in H&N CCT Program	*Percentage of Beneficiaries who Faced any Difficulty in the Enrolment Process*	
	Sept'23	Dec'23
Less than Two Month	7%	4%
Three to Five Month	7%	16%
Six to Eight Month	13%	52%
Nine to Eleven Month	23%	16%
A Year Ago,	20%	8%
More than One Year Ago	30%	4%

Based on the observed variations in registration timelines among PLWs who encountered challenges, it can be inferred that a significant portion of PLWs who faced difficulties registered in the second half of the year. This suggests that there may have been ongoing issues or delays in addressing and resolving these challenges, resulting in a prolonged registration process for

a substantial number of PLWs. Addressing these challenges and ensuring timely registration for all PLWs should be a priority to improve program efficiency.

Moreover, among the surveyed PLWs, it was found that 36% (149 out of 410) of them owned their own mobile phone and numbers. Of those PLWs who owned a mobile phone, 34% provided their own mobile number for registration in the AAGHOSH program which demonstrates their willingness to receive program-related notifications and updates directly. For PLWs who did not own a mobile phone, it was noted that majority provided the mobile numbers of their husbands (87%) followed by fathers/mother/brother-in-law for program registration. In one instance, the beneficiary gave the number of their neighbors as well. Further inquiry into the ease of access to the phone number revealed that 9% (25 out of 271) of these beneficiaries could not easily access the phone number they registered of.

Among the surveyed PLWs, 24% reported being able to read messages by themselves which indicates a low level of literacy among a portion of the PLWs lesser than the previous quarter. For the beneficiaries who were not able to read**, 88% of the PLWs relied on someone else to read the messages whereas 12% ignored the messages.** Quarter wise results are provided in table 27 below.

Table 27: *Proportions of Beneficiaries with Mobile Ownership and Reading Abilities (Quarter-wise Comparison)*

Indicator	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
Proportion of beneficiaries who own a mobile	39%	40%	32%	36%
Provided their own mobile #	60%	67%	27%	34%
Proportion of beneficiaries able to read messages	32%	28%	28%	24%

Satisfaction of PLWs with Healthcare Services (IRI 3)

One of the Intermediate Result Indicator (IRI) of PHCIP program is the percentage of women who are satisfied with the healthcare services under the program. The target of this indicator is 80% women beneficiaries satisfied with the healthcare services. In order to gauge the satisfaction of the H&N beneficiaries, the IRI was broken down into sub-indicators and beneficiaries' feedback was obtained. In Dec'23 quarter, **96% of PLWs who utilized various healthcare services were satisfied with the health services provided. This level of satisfaction has increased since the previous quarters where the satisfaction had remained consistent from March'23 to Sept'23, where 93% of beneficiaries reported being satisfied with the services.**

This notable increase in satisfaction among PLWs utilizing healthcare services under the PHCIP program, reaching 96% in the Dec'23 quarter, reflects the effectiveness of the AAGHOSH program. This positive trend indicates that the healthcare interventions implemented have successfully addressed the needs and expectations of the beneficiaries. Exceeding the target satisfaction rate of 80% signifies the program's success in not only meeting but surpassing the set benchmarks, emphasizing its impact on enhancing the quality and accessibility of healthcare services for PLWs. The satisfaction level of beneficiaries against each sub-indicator can be seen below.

Behavior of Healthcare Staff and their Competency

Based on the survey conducted among program beneficiaries (PLWs), an overwhelming majority of 97% expressed satisfaction with the overall behavior of the staff and expressed that healthcare staff demonstrated a clear understanding of their problems and situations. They reported that the healthcare staff treated them with respect, listened to their concerns, and

communicated effectively during their interactions. Table 28 provides quarter wise satisfaction levels of beneficiaries.

Table 28: Satisfaction Levels of Beneficiaries with Staff

Satisfaction Level	Mar'23	June'23	Sept'23	Dec'23
Overall Behavior of Health staff	93%	98%	96%	97%
Relevant Information Provided	96%	98%	93%	98%
Health Staff Understands Issue of Beneficiary	97%	95%	90%	94%

A majority of PLWs, 98%, also expressed satisfaction with the healthcare staff, stating that they were provided with relevant information which indicates that healthcare staff effectively communicated essential information to PLWs, such as treatment options, procedures, and preventive measures. It is noteworthy that over the quarters, the satisfaction levels have increased and remained positive in the last quarter. **Detailed breakdown of these indicators is provided in the following sub sections.**

Antenatal Healthcare Service Feedback and Satisfaction of Beneficiaries

During feedback interviews conducted at health facilities, beneficiaries were asked about their purpose for visiting that day. 20% (80) of the beneficiaries visited the health facility for their routine antenatal health checkup.

Moreover, a significant portion of pregnant women in the sample were in their second trimester (48%). Out of those who visited for antenatal checkups, 88% received the checkup. The 12% who did not, cited reasons such as increased waiting time due to over crowdedness, the absence of Lady Health Visitors (LHV), or a preference for receiving only an injection. Table 29 summarizes the results for vitals and health services provided during antenatal checkups.

Table 29: Health Services Provided for Antenatal Checkup (multiple option)

Health Service	Count	Proportion
Weight	37	53%
BP	51	73%
Medicine Supply	25	36%
Counseling on Maternal and Child Health	14	20%

97% of beneficiaries expressed satisfaction with the staff's opportunity for them to explain their illness or concerns. While 3% felt rushed, the majority appreciated the staff's empathetic and patient approach during checkups **as 99% of these beneficiaries' expressed satisfaction with how the staff spoke to them and 90% were satisfied that the relevant staff understood their problem.** Moreover, 85% were informed about when to return for a follow-up. This emphasizes the importance of maintaining a compassionate demeanor in healthcare services, ensuring the overall satisfaction and well-being of beneficiaries.

Child Immunization/Illness Visit Experience and Satisfaction for the Beneficiaries

In the subset of 154 beneficiaries who brought their children for vaccination, 95% of these beneficiaries ensured their infants received vaccination. The remaining 5% who did not get their children vaccinated cited reasons such as the incomplete duration of vaccination or having already completed all required vaccinations. This underscores a critical need for enhanced education among beneficiaries regarding the timing and the number of vaccines essential for their children. It is equally imperative for the medical staff to proactively educate beneficiaries

on when to return for the next vaccination. As for those who received vaccination, 92% were told when to come back thus validating the suggestion.

In another scenario, 39 beneficiaries brought their children due to some illness. Notably, all of these beneficiaries expressed satisfaction with the health staff's behavior, the opportunity provided to explain the illness, and overall contentment with how the staff comprehended the child's problem. It is noteworthy that 74% of the beneficiaries reported that the health staff actively engaged with them to ensure their understanding of the illness and prescription. Additionally, 44% were informed about when to follow up for the next visit, reflecting a room for improvement in communication for better healthcare management.

Beneficiaries' (PLWs) Satisfaction with the Available Facilities in Health Centers

Understanding PLWs perspectives on availability of facilities in health center provided valuable insights of the health services and enhancing their overall healthcare experience. **The results indicate that overall, 95% of the respondent were satisfied with the available facilities at the health centers** which is greater than the previous quarters satisfaction levels.

A majority of PLWs, 99%, reported satisfaction with the waiting areas which play a crucial role in the overall healthcare experience, as they contribute to patient comfort, privacy, and convenience. This is also validated by the spot checks which revealed that all the waiting areas were either well maintained or in a satisfactory condition. Among the surveyed PLWs, 97% expressed satisfaction with the pharmacy services provided under the H&N CCT program which increased since last quarter. This indicates the accessibility, availability, and quality of pharmaceutical provisions. For PLWs who had used testing laboratories, 62% reported satisfaction with the services provided which though has decreased somewhat since the previous quarter. In addition, 98% of surveyed PLWs expressed satisfaction with the cleanliness of the washroom facilities offered under the program greater than previous quarter.

Table 30: Beneficiary Satisfaction with Provided Facilities at Health Facilities

Facility	Mar'23	June'23	Sept'23	Dec'23
Comfortable Waiting Areas	98%	99%	97%	99%
Pharmacy	88%	94%	96%	97%
Testing Laboratories	86%	62%	67%	62%
Functional Washroom	96%	98%	94%	98%

Overall, the analysis indicates a high level of satisfaction among PLWs regarding the available facilities in health centers. This indicates successful efforts in ensuring the quality and accessibility of essential services, such as waiting areas, pharmacy services, testing laboratories, and washroom facilities, contributing to the overall positive healthcare experience of PLWs.

Satisfaction with Treatment Provided

94% of the beneficiaries expressed satisfaction with their checkup and believed that medical staff diagnosed their problem correctly, while only a small minority of 6% reported dissatisfaction. The high satisfaction rate indicates that the majority of pregnant women had a positive experience during their checkups.

Availability and Accessibility of Prescribed Medication at Health Facility

According to the survey, 88% of the surveyed PLWs reported the availability of prescribed medication, which is greater than the 80% reported in the Sept quarter. Spot checks also revealed that in 2% of the health facilities, dispensary was closed at the time of the visit as well

thus may contribute to the lack of availability and accessibility to prescribed medication in these health facilities.

However, among those PLWs who reported availability of medication, 100% confirmed that they received the prescribed medicines and nutritional supplies free of cost. This indicates that PLWs are able to fully utilize healthcare services and medicines without significant financial constraints.

Payment Distribution Process

HBL Konnect Wallet Accounts

The opening of HBL Konnect wallet accounts for PLWs involves several steps to ensure their registration and verification. PLWs visit designated health facilities, where they provide their information, and their information is verified from multiple channels. Once verified, inactive wallet accounts are created, and PLWs receive a confirmation SMS. Once the PLW receives the message, they visit any designated pay-point where they undergo biometric verification. Upon successful verification, an OTP message is sent, and the payment is made to the PLW.

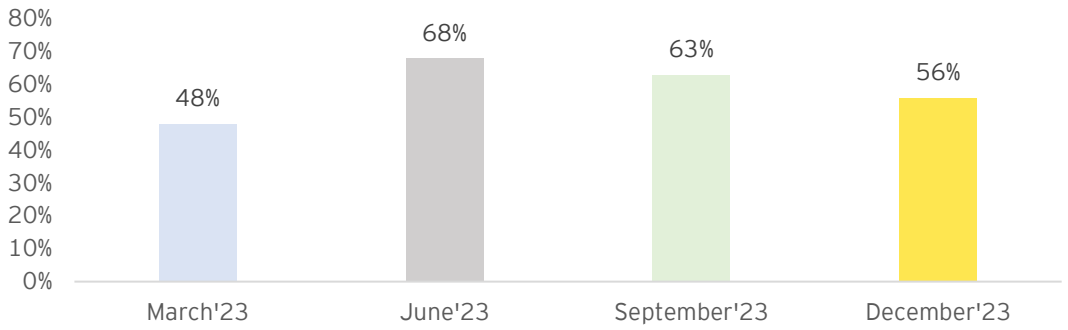

Figure 6: Proportion of beneficiaries who received SMS regarding opening of wallet (quarter wise)

Among the surveyed PLWs, 56% reported receiving SMS notifications regarding the opening of the HBL Konnect wallet account. This represents a slight decrease compared to the June or the Sept 2023 quarter when 68% and 63% of PLWs reported receiving such notifications. As per feedback of the PLWs, the wallet accounts were opened within the following timelines as given in table 31.

***Table 31:** Timeline of the Opening of Wallet Accounts*

Time Period	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
Within One day	-	14%	17%	13%
Less than a Week	-	22%	27%	33%
Within One Month	78%	29%	19%	31%
One to Two Month	9%	22%	1%	6%
Two to Three Month	4%	4%	5%	3%
More than Three Months	10%	09%	14%	13%

According to the timelines above, there is an improvement in the efficiency of opening wallet accounts within a week as 33% of the beneficiaries reported it as compared to previous quarter. However, over the quarters, there is an increase in proportion of beneficiaries who claim to have their accounts opened after three months which highlights the need to further improve the efficiency of opening wallet accounts and addressing the increasing delays in account opening for a portion of the beneficiaries.

CCT Payment Received in AAGHOSH

In the March 2023 quarter, it was highlighted that 54% of surveyed PLWs reported having knowledge of the amount they were supposed to receive under the Conditional Cash Transfer (CCT) program. As we moved into the June 2023 quarter, there was an encouraging increase in PLWs awareness, with 63% of respondents stating that they were aware of the CCT payment amounts. In the September quarter however, this awareness decreased to 59% having knowledge of the CCT amounts to be received and in the **current Dec'23 quarter, this awareness further decreased to 49%.**

Among the PLWs surveyed in Dec 2023 quarter, 75% reported receiving the payment under the H&N CCT program compared to 78% in Sept quarter, 47% in June quarter and 27% in March 2023 hence indicating that the payment disbursement process is consistent with the previous quarter. District wise breakdown of the beneficiaries who received payment is given in table 32 below.

***Table 32:** PLWs who Received Payments District & Quarter-wise*

District	March'23	June'23	Sept'23	Dec'23
Bahawalnagar	11%	33%	65%	59%
Bahawalpur	0%	38%	91%	84%
Bhakkar	40%	19%	74%	21%
DG Khan	62%	68%	82%	94%
Khushab	6%	72%	86%	67%
Layyah	0%	33%	50%	82%
Lodhran	17%	33%	87%	60%
Mianwali	33%	49%	74%	73%
Muzaffargarh	39%	49%	74%	97%
Rahim Yar Khan	42%	41%	74%	92%
Rajanpur	42%	88%	90%	97%

According to the table 32, it is evident that the proportion of PLWs who received payments has increased significantly in several districts. For example, in DG Khan, Layyah, Muzaffargarh, Rajanpur and Rahim Yar Khan since previous quarter. **However, concerningly, only 21% of the beneficiaries in Bhakkar received their payments.**

***Table 33:** Duration of Receiving Payment After Receiving Message*

District	Same Day	Within a week	8-15 Days	16-30 Days	More than 30 days
Bahawalnagar	16	18	0	0	0
Bahawalpur	7	21	0	5	4
Bhakkar	30	4	4	0	0
DG Khan	2	32	1	1	0
Khushab	10	33	0	0	0
Layyah	5	7	18	4	0
Lodhran	16	7	15	2	0
Mianwali	9	24	0	0	0
Muzaffargarh	1	28	4	2	0
Rahim Yar Khan	4	31	1	1	0
Rajanpur	1	25	9	1	0
Total	**101 (25%)**	**230 (57%)**	**52 (13%)**	**16 (4%)**	**4 (1%)**

According to the table above, majority of the beneficiaries retrieved their payments within a week of receiving the message of payment. Those who took more than a week and some who even took a month or more than month after receiving the message could include issues like fingerprint, incorrect mobile numbers, any delays with the biometric verification as verified in our spot check survey. Another potential reason can be the issue of low literacy whereby majority of the beneficiaries rely on others to read messages.

Payment Delays

Based on those who received payments, 81% of the beneficiaries expressed that they received their latest payment without any delay under the program as compared to 80% in the previous quarter. This indicates that majority received the payments without any delay or within a week. The breakup of PLWs who received the payments with delays (19%) are as follows in table 34:

Table 34: *Delays in Receiving Payments*

Time Period	Sept'23	Dec'23
6-15 Days	1 (2%)	2 (4%)
16- 30 Days	4 (7%)	4 (7%)
31- 60 Days	5 (8%)	10 (18%)
61- 90 Days	13 (22%)	15 (26%)
More than 90 Days	37 (62%)	26 (46%)

The table above highlights the increasing severity of delays in receiving payments, with a substantial proportion of beneficiaries experiencing significant delays of more than 90 days. Addressing these delays and ensuring timely and efficient payment disbursement should be a priority to improve the overall effectiveness and impact of the program.

Payment Deductions Made by Branchless Banking Agents

In the Dec quarter, 53% of the beneficiaries reported that deductions were made by the branchless banking agents which has significantly increased since previous quarter whereby 39% reported deductions. The spot checks on the other hand reported 13% deductions. Since, there is an overall increase in proportion of deductions, addressing the issue of deductions made by agents has become important to address and to amend. Breakdown of the deductions reported by PLWs district wise, are given in table 35.

Table 35: *Number of Beneficiaries Who Reported Payment Deduction*

District	*March'23*	*June'23*	*Sept'23*	*Dec'23*
Bahawalnagar	2 (29%)	3 (20%)	2 (12%)	0 (0%)
Bahawalpur	0 (0%)	3 (20%)	13 (43%)	9 (29%)
Bhakkar	5 (16%)	1 (14%)	0 (0%)	0 (0%)
DG Khan	34 (74%)	17 (68%)	21 (78%)	24 (71%)
Khushab	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Layyah	0 (0%)	11 (85%)	13 (76%)	26 (93%)
Lodhran	8 (62%)	0 (0%)	8 (24%)	20 (83%)
Mianwali	2 (9%)	1 (6%)	1 (4%)	4 (17%)
Muzaffargarh	14 (50%)	2 (11%)	6 (21%)	13 (38%)
Rahim Yar Khan	26 (79%)	11 (58%)	16 (64%)	32 (94%)
Rajanpur	21 (66%)	28 (74%)	35 (97%)	31 (89%)
Total	**112 (50%)**	**77 (37%)**	**115 (39%)**	**159 (53%)**

- **The highest deductions have been reported by the beneficiaries in Rahim Yar Khan, Layyah, Rajanpur, Lodhran and DG Khan.** This is also consistent with the previous quarters where beneficiaries in these districts reported the most payment deductions.
- As beneficiaries in **Rajanpur reported the most deductions (97%), our spot checks also validate this finding** as we observed the deductions being made the most in Rajanpur.

Nevertheless, beneficiaries in Bahawalnagar, Bhakkar and Khushab reported no payment deductions over the three quarters. Table 36 shows results of deductions made over the quarters where the proportion of deductions of more than PKR 300 have decreased since last quarter.

Table 36: *Deducted Amount by the BBAs According to PLWs*

Deducted amount	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
PKR 1 to 100 (proportion of beneficiaries)	40%	36%	41%	26%
PKR 101 to 300 (proportion of beneficiaries)	40%	36%	37%	53%
More than PKR 300 (proportion of beneficiaries)	20%	27%	22%	21%

Majority reported payment deductions between 100 to 300 PKR. Another pattern immerged where the deducted amount was 10% of the total payment received by the beneficiary. Majority i.e., 86% PLWs expressed satisfaction with the payment process mechanism in the H&N CCT program which indicates its effectiveness in delivering financial support. However, the presence of delays in payment disbursement and deductions made by agents highlight areas that require attention and improvement.

Grievances Redressal Mechanism

We have been informed that the Grievance Redressal Mechanism (GRM) for PHCIP is developed and PLWs of the program are advised to report any grievance related to the program at the PSPA GRM number 1221 or they may also send written complaints to the PSPA field and head offices. Moreover, complaint box and complaint forms are also available at health facilities. Through this mechanism the program beneficiaries (PLWs) can initiate complaints regarding any aspect of the program. Accordingly, the beneficiary feedback tool incorporated questions regarding beneficiary awareness of the existing GRM and potential complaints escalated by the PLWs using this mechanism.

Table 37: *Quarter-wise Comparison of GRM Feedback*

GRM	*Mar'23*	*June'23*	*Sept'23*	*Dec'23*
Informed about Process of Registering Complaint (proportion)	4%	6%	6%	13%
Registered Complaint (count)	6	7	13	9
Complaints Resolved (count)	0	0	0	0

An analysis of the GRM feedback across different quarters as shown in table 37 reveals important findings.

- In the Dec'23 quarter, beneficiary awareness regarding the process of registering complaint has increased since previous quarters. Majority i.e., 63% of these beneficiaries said they became aware through lady health workers and lady health visitors while the remaining 37% became aware through friends and family and print media etc. Though the awareness has increased since previous quarters, there is still attention needed to spread more awareness regarding this.

- **Nine PLWs reported registering complaints in the Dec '23 quarter, out of which 8 complaints were related to payment issues and one related to incorrect mobile number entry.** Interestingly, **none of the PLWs utilized the PSPA helpline** for complaint registration and relied solely on the assistance of the health staff, primarily LHVs. This suggests that there may be a need to further promote and encourage the use of the helpline as an alternative channel for complaint registration. While PLWs expressed satisfaction with the process of registering complaints, there was dissatisfaction with the resolution process. Despite registering complaints, none of the PLWs reported having their grievances resolved. This underscores the importance of improving the efficiency and timeliness of the resolution process to address the concerns of PLWs promptly.
- Additionally, insights from KIIs revealed that LHVs who receive complaints typically listen to them verbally or share them within their group, but the complaints are not properly registered or resolved. Furthermore, our spot check also highlighted that complaint registration process is not managed effectively yet. This highlights the need for improved oversight and implementation of the GRM system to ensure that complaints are adequately addressed. Efforts should be made to increase awareness and utilization of the PSPA helpline and prioritize timely resolution of complaints to better serve the concerns of PLWs.

Beneficiary Enrolled in the Program on the CNIC of Mother in Laws

During the beneficiary feedback survey, an alarming revelation came to light as it was identified that three individuals, whose ages surpassed the prescribed limit of 49 (as conveyed by PSPA), had been included in the beneficiary pool. Subsequent investigation exposed additional irregularities within the population data sample collected for feedback. Instances were identified where beneficiaries were registered under the identification card of their mothers-in-law, contrary to the population data indicating the daughter-in-law as the designated beneficiary. Furthermore, discrepancies were noted in cases where the husband's name was listed as the beneficiary, despite the beneficiary possessing the corresponding identification card. These anomalies not only pose a threat to the accuracy of the records but also raise concerns regarding the integrity of the beneficiary registration process. There is a critical need to rectify these discrepancies and uphold the transparency and effectiveness of the program.

5.1 SUPPLY SIDE PERSPECTIVE - INTERVIEWS WITH HEALTHCARE STAFF

"Key informants" are individuals who—by virtue of their profession or community role—are experts in some aspect of the systems under consideration and/or well positioned to speak about specific touch points or the experiences of particular groups. These can be relevant system experts, government officials, community leaders, members of civil society, employees of ID or civil registration agencies (e.g., enrollment officers), and employees of service providers that are part of the ecosystem (e.g., mobile operators, banks). Interviews with these individuals are specialized to ask focused questions tapping into the "key" information each can provide by virtue of his or her professional or community position.

EYFR conducted such Key Informant Interviews (KIIs) with key stakeholders involved in the implementation of the AAGHOSH program. These included the Medical Officer, Lady Health Visitor (LHV) and Lady health Worker (LHW). These stakeholders have key roles to play in the various activities that constitute the implementation of the AAGHOSH program including beneficiary enrolment, antenatal checkups, safe delivery and child vaccination. Therefore, their understanding of the overall program, perspective on issues faced in implementation as well as their own concerns were elicited through separately developed survey tools, completed during the KII. The results are analyzed, and key findings presented.

Note: This section is based on interviews conducted with healthcare staff including Medical Officers, LHVs and LHWs for quarter ending Dec'23. The results are presented below.

The working experience of the surveyed Key Informants was diverse, encompassing various roles. This range of experiences provided valuable insights into a wide spectrum of perspectives, contributing to a comprehensive understanding of the subject matter. The breakdown of working experience of the surveyed Key Informants was as follows.

Table 38: *Years of Experience of Health Staff at Health Facilities*

Experience in Years	LHV		LHW		MO	
	Number	*Percentage*	*Number*	*Percentage*	*Number*	*Percentage*
Less than 5	43	43%	5	5%	83	87%
5 - 10	38	38%	0	0%	11	12%
11 - 20	17	17%	47	51%	1	1%
More than 20	3	3%	40	43%	0	0%
Total	**101**	**100%**	**92**	**100%**	**95**	**100%**

All health staff, including MOs, LHVs, and LHWs, displayed a consistent and strong understanding of their job responsibilities. MOs primarily saw themselves as medical experts, conducting thorough examinations and potentially overseeing administrative tasks. LHVs were clear that their duties encompassed providing Antenatal and Prenatal Care, as well as registering PLWs through the EMR system. LHWs described their role as field workers, actively involved in door-to-door awareness campaigns and responsible for PLW registrations and administering vaccinations and medicines.

Health Care Staff Enrollment into the AAGHOSH Program Elevates Concerns

After the Key Informant Interviews, the CNICs obtained of the medical staff were cross checked from the beneficiary population data. As a result, it was found that 15 individuals in our sample for KIIs including Medical Officers, LHVs and LHWs were also enrolled in the AAGHOSH program as beneficiaries. Notably, the majority of registrations occurred in the Oct-Dec'23 quarter.

Upon closer examination, we confirmed that the CNIC and name of the medical staff matched the population data. However, four instances raised concerns as the names of the LHVs and LHWs were different in the population data against their registered CNICs. Subsequent inquiry clarified that they occasionally register beneficiaries who do not have a CNIC on their own CNIC; however, upon further research, only these four instances were found in the population data against their CNICs.

Although, the BISP criteria had been removed in Sept'23 which means that anyone can enroll in the program, however, one LHV in the sample was registered in 2022 and continued to register visits up until June'23.

This raises serious ethical concerns and potential misuse of government resources. The fact that medical health staff, already employed in the government sector, are accessing the program implies a dual benefit scenario where they are not only receiving a salary but also taking advantage of financial assistance meant for a different demographic. This practice raises questions about the ethical standards of the health facility and the potential misuse or misappropriation of government funds.

Risks Associated with Health Staff Enrollment into Program

1. **Manipulation of Service Delivery Records:** Medical staff might manipulate service delivery records to maximize their benefits. This could include exaggerating the frequency or extent of services provided to create the appearance of increased program impact.

2. **Program Vulnerability to Fraud:** Dual-enrolled medical staff may engage in fraudulent activities such as registering fake visits or creating false records to exploit the program for personal gain, further compromising its efficacy.

3. **Undermining Program Objectives:** Dual enrollment undermines the core objectives of the AAGHOSH program by potentially diverting resources away from vulnerable women who require financial assistance during pregnancy or lactation. This is particularly valid in cases where the LHVs register a beneficiary on their own CNIC number and as a result, the beneficiary is not able to withdraw payment due to subsequent biometric verification failure.

Awareness About AAGHOSH Relatively Low Since Previous Quarter

About awareness of the H&N CCT AAGHOSH Program, an overall 97% of the healthcare staff (including MO/LHV/LHWs) were aware of the AAGHOSH Program though in the previous quarters, 100% of the health care staff demonstrated awareness. Table 39 summarizes the finding.

Table 39: Awareness about AAGHOSH Program Among Medical Health Staff

Medical Health Staff	Yes	No
LHV	98 (97%)	3 (3%)
LHW	92 (100%)	0
MO	90 (95%)	5 (5%)
Total	**280 (97%)**	**8 (3%)**

Among the Medical Officers (MOs), 95% affirmed their familiarity with the AAGHOSH Program. 5% of those who were unaware were either new to the system or were not engaged yet with the program. Similarly, the Lady Health Visitors (LHVs) demonstrated in depth knowledge, with 97% responding with a confident "Yes, I know all about the program." 3% who did not know about the program were the evening shift LHVs or an LHV who was recently onboarded for the health facility.

LHWs Lack Clarity on Updated AAGHOSH Criteria for PLW Enrollment

Front-facing staff, represented by Lady Health Workers (LHWs), displayed high level of awareness as well whereby 100% LHWs interviewed displayed understanding of the programs purpose and essentials. However concerningly, **30% of the LHWs among them were acquainted with the previous eligibility criteria whereby BISP beneficiaries were enrolled into the program.** Since this restriction has been removed, it is crucial to inform or give a refresher to the LHWs about the updates in program eligibility criteria so that the program can enhance its reach to fulfil the objectives.

Positive Behavior of LHVs Towards PLWs

In our endeavor to assess the conduct of Lady Health Visitors (LHVs), a distinct approach was undertaken by soliciting feedback from their subordinates, specifically the Lady Health Workers (LHWs), regarding the behavior LHVs exhibit towards PLWs.

The behavior of LHVs towards PLWs is consistently positive over the span of previous quarters. In Dec'23 quarter, 95% (87 out of 92) of the LHWs reported that the behavior is good of LHVs towards beneficiaries which is greater than previous quarter whereby 93% (89 out of 96) affirmed the positive behavior. Table 40 summarizes the results.

Table 40: Behaviour of LHVs with Beneficiaries According to LHW

District	Good Behaviour	Inadequate Behaviour	Total
Bahawalnagar	7	-	7
Bahawalpur	8	1	9
Bhakkar	8	-	8
DG Khan	8	1	9
Khushab	8	-	8
Layyah	9	-	9
Lodhran	8	1	9
Mianwali	8	-	8
Muzaffargarh	7	2	9
Rahim Yar Khan	9	-	9

Table 40: Behaviour of LHVs with Beneficiaries According to LHW

District	Good Behaviour	Inadequate Behaviour	Total
Rajanpur	7	-	7
Total	**87 (95%)**	**5 (5%)**	**92 (100%)**

According to the table above, the remaining 5% (5 out of 92) of LHW respondents shared a contrasting perspective. They indicated that instances of less favorable behavior occur, particularly in circumstances where health facilities become overcrowded or when PLWs interactions may become bothersome. In one instance LHW reported that the behavior is dependent on the mood of the LHV, they are good to some and rude to others. These reports were based on LHWs from Muzaffargarh, Lodhran, DG Khan and Bahawalpur.

Key Challenges Faced by Healthcare Staff (MOs/LHVs/LHWs)

In the previous quarter, some of the key challenges faced by the healthcare staff were communication challenges due to language barriers (accounted for by 23% of LHWs and 30% of LHVs), frustration due to payment delays and challenges in explaining basic concepts to PLWs, such as payment-related queries and program participation eligibility criteria, due to their lack of awareness. In this quarter, LHVs, LHWs and MOs highlighted similar challenges which are consistent with the previous quarter hence indicating that these issues are prevalent and require attention or they will continue to persevere and hinder the program objectives. The challenges and proportion of health staff who highlighted them are given below.

- **Operability Issues of the Electronic Medical Record (EMR):** According to 39% of the LHVs and 84% of the MOs, the most persistent issue with EMR operability was the internet connectivity and application/server issues along with lack of an option to edit registration requests. The beneficiary data is not editable in cases where unintentionally the data entered is incorrect for example the date of birth or any digit of the mobile number etc. Moreover, the application is updated every few days which makes it difficult to operate and navigate.
- **Language Barriers:** One of the primary challenges faced by healthcare staff is the language barrier, reported by 25% of the staff. This issue is particularly prominent for Medical Officers (MOs) with a count of 11, followed by 3 for LHVs and 2 for LHWs. Overcoming this barrier is crucial for effective communication between health staff and beneficiaries. According to the health staff, communication barriers hinder the explanation of crucial medical concepts and prescribed treatments. Beneficiaries often express interest solely in scans and gender-related information, revealing an educational gap as well that necessitates targeted informational campaigns.
- **Unavailability of Documents such as CNIC and Incorrect Mobile Numbers**: The frequent provision of incorrect documents, such as unavailability of CNIC or inaccurate mobile numbers, poses a persistent challenge as reported by 12% of the health staff. Moreover, field and data insights indicated that some beneficiaries resort to registering on the ID cards of their mothers-in-law due to the unavailability of their CNICs, indicating a workaround strategy employed in the absence of required documentation. Notably, beneficiaries often register mobile numbers that are used by multiple family members, and in some cases, even neighbors. This poses a challenge in maintaining accurate and personalized communication with enrolled participants. Streamlining the registration process and enhancing beneficiary education on documentation requirements is imperative to overcome this hurdle.
- **Unavailability of Key Medical Equipment:** In this quarter, 92% of the LHVs and 84% of MOs expressed satisfaction with the upgradation of the health facilities. Others cited concerns over the same matters as previously identified in the Sept quarter including a few others.

According to health staff, there is a need for additional ultrasound machines and baby warmers. Concerns were raised regarding the inconsistent availability of medicines. Non-availability of ambulance services and provision of sufficient delivery tables emerged as a priority for ensuring safe and comfortable birthing environments.

Insufficiency or absence of delivery tables was raised an issue by three MOs/LHVs. The severity of the matter was underscored by a LHV who revealed a distressing scenario: the shortage of delivery tables has reached a point where, in the unfortunate event of two pregnant women arriving simultaneously for delivery, one of them is compelled to lie on the floor. This vivid portrayal of the challenges faced on the ground emphasizes the urgent need for intervention. The lack of adequate delivery tables not only compromises the comfort and dignity of expectant mothers but also raises serious concerns about the overall quality and safety of maternity care in these health facilities.

Suggestions by Health Staff for Improvement in the AAGHOSH Program

1. **Awareness Campaign for CNIC Registration:** Initiate a robust awareness campaign to educate the community about the importance of obtaining individual CNICs. Collaborate with local authorities/community leaders or LHW to conduct door-to-door campaigns. Issues like beneficiaries registering on mother-in-law CNICs or on health staffs CNIC can be resolved as personal identification is important to participate in the AAGHOSH program.

2. **Address Contact Number Issues:** Implement a systematic approach to resolve contact number issues in the EMR system. Advocate for each household member to have a unique contact number to ensure accurate and efficient record-keeping. Collaborate with telecommunication providers to educate the community about the importance of individual contact numbers for health service registration and to avoid discrepancies in the EMR.

3. **Payment Mechanism Enhancement:** Revise the payment mechanism for the AAGHOSH program to address existing challenges. While in some tehsils of Bahawalnagar, camps are organized at the premises of health facilities, this should also be done in other districts to streamline the process. This will also control deductions as currently done by BBAs and will establish a transparent and accountable system for timely payments, reducing delays and fostering trust among program beneficiaries.

4. **Data Entry Support and Incentives for LHVs:** LHVs suggest that since there is no designated focal person sometimes at the health facility, issues in data entry occur due to this. Therefore, there should be a focal person solely responsible for data entry. Adequate refresher trainings and resources should be provided to ensure efficient data entry, reducing the likelihood of errors and enhancing the overall quality of health information.

Grievance Redressal Mechanism (GRM)

The Program Operation Manual (POM) outlines a comprehensive Grievance Redressal Mechanism, designating GRM Focal Persons at primary healthcare facilities. Furthermore, during Key Informant Interviews (KIIs), it was revealed that only 68 out of 101 (67%) LHVs acknowledged it as their responsibility to register PLWs complaints which has improved since

previous quarter whereby 61% of the LHVs acknowledged it. Table 41 provides the responses for who is responsible to register complaints.

Table 41: *Responsible for Registering Complaints According to LHVs*

Responsibility to Register Complaint	*Count*	*Proportion*
LHVs	68	67%
No one is registering complaints	24	24%
Complaint Box	1	1%
Helpline	5	5%
MO/Medical technician/Morning Shift LHV	3	3%
Total	**101**	**100%**

It is evident that there is lack of awareness of who should register complaints of the beneficiaries. Majority indicate that no one does whereas a few LHVs pointed to a complaint box, helpline number or the medical officer. Furthermore, **48% (48 out of 101) LHVs said they received beneficiary complaint for AAGHOSH however, according to them, these complaints were not registered electronically rather, they were verbally considered or either shared within a group of PHCIP members or AAGHOSH team.** When asked if they followed up on these complaints, merely half i.e., 24 out of 48 (50%) LHVs said they did. The rest expressed that either no one follows up on the complaint or they verbally listen to them or share within their group to be followed up by the MOs. Lack of awareness regarding the responsibility to register complaint by the LHVs is one of the reasons why the GRM process is not implemented effectively. It is critical to make them aware of the importance of registering and following up on complaints.

Chapter 4: Recommendations and Conclusions

The operations review activity of the AAGOSH Health and Nutrition Conditional Cash Transfer (CCT) program has offered valuable insights into different facets of the program's implementation and its influence on the target population. The report highlights program accomplishments, such as the majority of beneficiaries expressing satisfaction with healthcare services, while also pinpointing areas necessitating improvements. These findings can serve as a compass for the program team, aiding in the refinement of their strategies and the mitigation of identified challenges. By effectively addressing these challenges and leveraging the program's strengths, its overall effectiveness can be augmented, ensuring it continues to have a positive impact on the health and well-being of the beneficiaries it serves.

Some key considerations in this regard are below.

- A noteworthy observation was made regarding the lack of awareness among both health staff and beneficiaries regarding the updated BISP criteria. According to the revised criteria, all pregnant and lactating women are eligible for enrollment, irrespective of their BISP beneficiary status. Additionally, it was noted that in 24/7 BHUs, the evening shift staff generally lacks comprehensive awareness of the AAGHOSH program. This calls for a detailed training on the updated program requirements for all Lady Health Visitors (LHVs) and Lady Health Workers (LHWs).
- During a recent spot check of health facilities, review of the Electronic Medical Records (EMR) system uncovered several concerning issues. Notably, the absence of age criteria in the EMR allowed for the registration of individuals, such as mothers-in-law, who are ineligible as they are neither pregnant nor lactating. Furthermore, health staff were identified to be enrolled into the program as beneficiaries and, in some instances, utilized their own CNIC to register under a different name. To mitigate the associated risks, it is imperative to conduct a comprehensive review of the EMR system. This review should focus on implementing robust data authentication controls and mechanisms, along with program-level controls such as age restrictions and the prohibition of health staff enrollment. Stricter measures are needed to prevent instances where mothers-in-law register their daughters-in-law under their own CNIC. Additionally, constant monitoring of health staff is essential to prevent unauthorized enrollment of beneficiaries on various CNICs, including those of relatives or the health staff themselves. This proactive approach aims to enhance the integrity of the EMR system and maintain accurate and secure health records.
- To counter slow payment processing and increased payment deductions, targeted efforts are crucial in districts where these issues are most common. A proactive approach involves analyzing payment disbursement data to identify regions with processed but unclaimed disbursements. Establishing payment distribution camps at relevant facilities is recommended to efficiently distribute payments to beneficiaries in those areas, improving the BBA system's functionality and ensuring fair and accurate payments.

  In addition, the challenge of beneficiaries being unable to read messages hinders effective communication. To bridge this gap, it is recommended to introduce recorded audio calls for beneficiaries who face literacy challenges for example, a Robo call that tells the beneficiary the payment amount that is due. This practical solution ensures that essential information

is effectively communicated, overcoming barriers, and facilitating better program engagement.

- The overall infrastructure challenges such as building structural integrity and absence of critical medical equipment such as baby warmers, delivery tables, ultrasound machines and ambulances in each health facility etc. poses an impediment to the service delivery in general and effectiveness of the AAGHOSH program in particular. To rectify this issue, it is imperative to prioritize the procurement and installation of key medical equipment.
- The implementation and effectiveness of the Grievance Redress Mechanism (GRM) within the AAGHOSH program has been identified as a potential issue. One major aspect that impacts the effectiveness is the absence of designated individuals for complaint registration and Lady Health Visitors (LHVs) who are present only verbally listening to the complaints. To address this challenge, it is recommended to appoint GRM focal persons in each facility. Additionally, conducting awareness sessions to educate stakeholders on the complaint process and establishing a centralized system for tracking and resolving grievances in a timely manner will enhance the efficiency of the GRM and ensure that beneficiary complaints are properly addressed.

Annexures

Annexure A - (Lacking a boundary wall in Health Facilities)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Rampura	Bahawalnagar	Bahawalnagar
2	Basic Health Unit, Jand Wala	Bahawalnagar	Bahawalnagar
3	Basic Health Unit, Hasil Saroo	Minchnabad	Bahawalnagar
4	Basic Health Unit, Theri Zebti	Ahmadpur	Bahawalpur
5	Basic Health Unit, Sheikh Wahin	Khairpur Tamewali	Bahawalpur
6	Basic Health Unit, Noonari	Ahmadpur	Bahawalpur
7	Basic Health Unit, Noora	Kalorkot	Bhakkar
8	Basic Health Unit, Sial	Bhakkar	Bhakkar
9	Basic Health Unit, Daduwala	Noorpur thal	Khushab
10	Basic Health Unit, Chak No.56/MB 24/7	Khushab	Khushab
11	Basic Health Unit, Dakhna Gharoo	Kahror paccka	Lodhran
12	Basic Health Unit, Adam Wahan	Lodhran	Lodhran
13	Basic Health Unit, Amir Pur Sadat	Kahror pakka	Lodhran
14	Basic Health Unit, Ghundi	Mianwali	Mianwali
15	Basic Health Unit, Budh	Kotadu	Muzaffargarh
16	Basic Health Unit, Gehna Lar	Khanpur	Rahim Yar khan
17	Basic Health Unit, Saadi Sultan	Sadiqabad	Rahim Yar khan
18	Basic Health Unit, Chak No. 42/A	Liaquat pur	Rahim Yar khan

Note: Following is the picture evidence of Health facility where a boundary wall is lacking.

BHU Sheikh Wahin – Bahawalpur

BHU Noora – Bhakkar

Annexure – B (Boundary wall not well maintained or in a state of disrepair)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Chak No. 134/M	Chistiyan	Bahawalnagar
2	Basic Health Unit, Chak No. 177/M	Chistiyan	Bahawalnagar
3	Basic Health Unit, Chak No. 63/DB	Yazman	Bahawalpur
4	Basic Health Unit, Tibbi Izzat	Ahmadpur	Bahawalpur
5	Basic Health Unit, Haider pur	Ahmadpur	Bahawalpur
6	Basic Health Unit, Punj Girain	Darya Khan	Bhakkar
7	Basic Health Unit, Botala 24/7	Khushab	Khushab
8	Basic Health Unit, Chellay Wahin	Kahror paccka	Lodhran
9	Basic Health Unit, Salam Pur	Jam pur	Rajanpur

Note: Following is the picture evidence of Health facility where the boundary wall is of poor condition or not well maintained.

BHU Chak No. 134/M– Bahawalnagar

BHU Botala 24/7 - Khushab

Annexure – C (Cleanliness Discrepancies of Health Facilities)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Vajnari,	Esa Khel	Mianwali

Note: Following is the picture evidence of Health facility in Bahawalpur with poor cleanliness condition or discrepancy.

BHU Vajnari - Mianwali

Annexure – D (Cleanliness Discrepancies of Labor and Wardroom)

Sr. No	Name of Heath Facility	Tehsil	District	Remarks
1	Rural Health Center, Fazil pur	Rajan pur	Rajanpur	Labor Room in Poor Cleanliness
2	Basic Health Unit, Utra Sandilla	Muzaffargarh	Muzaffargarh	Labor Room in Poor Cleanliness
3	Basic Health Unit, Kot Ganaga Singh	Bahawalnagar	Bahawalnagar	Wardroom in Poor Cleanliness
4	Basic Health Unit, Utra Sandilla	Muzaffargarh	Muzaffargarh	Wardroom in Poor Cleanliness

Note: Following is the picture evidence of some Labor rooms in poor cleanliness condition in health facilities.

RHC – Fazil Pur, Labor Room - Rajanpur

BHU Utra Sandilla, Wardroom - Muzaffargarh

Annexure – E (List of health facilities where EMR tablets was not available)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Punj Kossi	Bahawalnager	Bahawalnagar
2	Basic Health Unit, Kot Ganaga Singh	Bahawalnager	Bahawalnagar
3	Basic Health Unit, Jand Wala	Bahawalnager	Bahawalnagar
4	Basic Health Unit, Chak No. 177/M	Chistiyan	Bahawalnagar
5	Basic Health Unit, Mousa Bhutta	Bahawalnager	Bahawalnagar
6	Basic Health Unit, Peer Skindar	Bahawalnager	Bahawalnagar
7	Basic Health Unit, Hasil Saroo	Minchnabad	Bahawalnagar
8	Basic Health Unit, Khola Mirzeka	Minchnabad	Bahawalnagar
9	Basic Health Unit Noor Muhammad Bhungran	Bahawalnager	Bahawalnagar
10	Basic Health Unit, Chak 260/HR	Fortabbas	Bahawalnagar
11	Basic Health Unit, Sultan Pur	Alipur	Muzaffargarh

Annexure – F (List of health facilities where internet connectivity was an issue)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Jand Wala	Bahawalnager	Bahawalnagar
2	Basic Health Unit, Adam Wahan	Lodhran	Lodhran
3	Basic Health Unit, Chamb Kulyar	Lodhran	Lodhran
4	Basic Health Unit, Kundal	Issa khel	Mianwali
5	Basic Health Unit, Chak No. 150/A	Liaqatpur pur	Rahim Yar khan
6	Basic Health Unit, Kotla Naseer	Rajan pur	Rajanpur
7	Basic Health Unit, Umar Kot	Rojhan	Rajanpur

Annexure – G (List of health facilities where micro-nutrients supplies were not available)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Rampura	Bahawalnager	Bahawalnagar
2	Basic Health Unit, Peer Skindar	Bahawalnager	Bahawalnagar
3	Basic Health Unit, Chak No. 63/DB	Yazman	Bahawalpur
4	Basic Health Unit, Kotla Qaim Khan	Khairpur	Bahawalpur
5	Basic Health Unit, Noora	Kalorkot	Bhakkar
6	Basic Health Unit, Mahne wala	Bhakkar	Bhakkar
7	Basic Health Unit, Mahni	Mankera	Bhakkar
8	Basic Health Unit, Mana Ahmadani	Kot chutta	DG khan
9	Rural Health Centre Vehova	TOUNSA	DG khan
10	Basic Health Unit, Kot Qasrani	TOUNSA	DG khan
11	Basic Health Unit, Sheroo	Kot chutta	DG khan
12	Rural Health Center, Shah Sadar Din	DG Khan	DG khan
13	Rural Health Center, Kala	DG Khan	DG khan
14	Basic Health Unit, Daduwala	Noorpur thal	Khushab
15	Basic Health Unit, Chak No. 366/TDA	Choubra	Layyah
16	Basic Health Unit, Dakhna Gharoo	Kahror paccka	Lodhran
17	Basic Health Unit, Kundal	Issa khel	Mianwali
18	Basic Health Unit, Bani Afghan	Mianwali	Mianwali
19	Basic Health Unit, Ganda	Issa khel	Mianwali
20	Rural Health Center, Musa Khel	Mianwali	Mianwali
21	Rural Health Center, Seet Pur	Alipur	Muzaffargarh
22	Basic Health Unit, Mehmood Kot	Kotadu	Muzaffargarh
23	Basic Health Unit, Chak No. 94/NP	Khanpur	Rahim Yar khan
24	Basic Health Unit, Arif Balouch	Liaquat pur	Rahim Yar khan
25	Basic Health Unit, Havail Gharib Shah	Liaquat pur	Rahim Yar khan
26	Basic Health Unit, Chak No. 107-P	Rahim yar Khan	Rahim Yar khan
27	Basic Health Unit, Saleem Abad	Jam pur	Rajanpur
28	Basic Health Unit, Umar Kot	Rojhan	Rajanpur

Annexure – H (List of health facilities where contraceptive commodities were not available)

Sr. No	Name of Heath Facility	Tehsil	District
1	Basic Health Unit, Kotla Qaim Khan	Khairpur Tamewali	Bahawalpur
2	Basic Health Unit, Kot Qasrani	TOUNSA	DG khan
3	Basic Health Unit, Aali Wala	Kot chutta	DG khan
4	Basic Health Unit, Sheroo	Kot chutta	DG khan
5	Rural Health Center, Shah Sadar Din	DG Khan	DG khan
6	Rural Health Center, Kala	DG Khan	DG khan
7	Basic Health Unit, Chak No. 42/A	Liaquat pur	Rahim Yar khan
8	Basic Health Unit, Chak No. 87/A	Liaquat pur	Rahim Yar khan