

**A REVIEW OF SOCIAL SECTOR INTERVENTIONS BY
RURAL SUPPORT PROGRAMMES**

COMMISSIONED BY RURAL SUPPORT PROGRAMMES NETWORK

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i. *Executive Summary*

Pakistan faces a crisis of social sector service delivery, which is being exacerbated by rapid population growth, rural-urban migration, a high unemployment rate and poor local governance and civil society development. Even with sustained, moderate economic growth over a period of decades, social indicators in Pakistan have not shown signs of commensurate improvement.

The country faces the classic scenario of ‘growth without development’, where despite an average annual growth rate of 2.2 percent per capita over the period 1950-1999, Pakistan has displayed stagnant social development. Other countries in the region have exhibited stronger records in terms of social development with relatively lower levels of per-capita growth.

In more recent times, Pakistan has had to rely on grassroots organizations, especially non-governmental ones that have a strong community-base, for undertaking social development projects. These organizations have provided the state with a tool for genuine and rapid change, a collaboration which has directly affected the developmental paradigm of the nation by gradually eroding the belief in trickle-down growth. Rural Support Programmes (RSPs), representing one such category of grassroots organizations, have pioneered pro-poor and people-first approaches in the country.

This report endeavors to highlight the paths followed by individual RSPs, their output in terms of success of their targets and the replication value of their organizational, implementation and facilitation techniques. The report takes into account the relationship between the State and the NGO sector, locally and internationally as well as historically and contemporaneously. Bringing the focus back to the work of the RSPs, we analyze the relationship of the Pakistani state with these autonomous organizations, the role of the Aga Khan Rural Support Programme (AKRSP) as the vanguard of this approach, and the rapid replication of the RSP approach across the country.

In line with their gradually evolving approach, the RSPs have been involved in direct, grassroots development throughout the country. They function on the premise of social mobilization (SM), playing a direct role in the process at the sub-village level and acting as a facilitator at the village and Union Council (UC) levels. Their agenda has been aided in an irregular fashion by federal and provincial governments, and by local as well as international donors. Evaluating on the basis of incomes and assets, and social indicators, the performance of these interactions has been variable, with success in some sectors and regions, and failure in others.

The RSPs have utilized a conceptual framework in their developmental effort that features an ‘Institutional Model’ and a ‘Production Model’¹. The institutional model incorporates SM and the formation of community organizations (COs) at the local level. Concomitant to this has been the introduction of a range of activities, which aim at building the autonomous capacity of the community and enhancing the community’s earning and productive potential. This has been labeled the production model, whereby the community’s organization is cemented around a productive activity.

This approach has allowed the RSPs unparalleled outreach, with a presence now in 93 out of 127 districts of Pakistan. By 2008, the average CO membership was 20². This can be considered as First Generation of Social Mobilization. However, a large part of RSP and RSPN work and attention is now focused on

¹ Ahmed, Z.U., C. Euler, S. G. Khattak, J. F. Morton, and M. Tariq. *ASSESSING THE IMPACT OF COMMUNITY-DRIVEN DEVELOPMENT: Twenty Six Years of Pakistan’s Rural Support Programmes*. Department for International Development (UK), 2009. 1. Print.

² Ahmed, Z.U., C. Euler, S. G. Khattak, J. F. Morton, and M. Tariq. 34.

what is being described as Second Generation Social Mobilization (2nd GSM) and on a new approach to microfinance, the Community Investment Fund (CIF).

Through 2nd GSM, the RSPs took the concept of SM to a whole new level, incorporating not just members of the most active and influential households of the village, but also bringing into their fold those households which were in the most dire need of direction and leadership. This new ideology was supported in its functioning by Pro-Poor Initiatives (PPIs) taken by the RSPs.

The success and ingenuity with which the RSPs have carried out their tasks has helped them achieve recognition as one of the thirteen 'Ideas that Work' by the World Bank publication, 'Ending Poverty in South Asia'³:

“Pakistan’s Rural Support Program (RSP) movement pioneered bottom-up, community-driven development using a flexible, autonomous, politically neutral approach, which has been replicated successfully...RSPs have also had significant influence on approaches to local governance, and the adoption of microfinance and community-owned infrastructure as mainstream development strategies.”⁴

Using raw data provided by the 9 RSPs, this report analyzes sectoral investments, attempts to elicit trends on area-wise RSP investment and component-wise break up of these investments, and charts out the trend of funding with regards to key donors. A sector-wise breakup of the total investment shows that Rs. 3947 million have been invested into the water sector, Rs. 1698 million in the sanitation sector, Rs. 1965 million into the education sector, and Rs. 2923 million into the health sector, thereby giving the WATSAN sector the largest share of the cumulative funding.

Of this amount, projects initiated before the year 2000 have amounted to: Rs. 632 million (water and sanitation), Rs. 105 million (education), and Rs. 4.5 million (health). This amounts to approximately 7 percent of the total expenditure. Thus, approximately 93 percent of investments have been made during the decade between 2000 and 2010.

A comparative review of region-wise investment in the social sector by the various RSPs shows that of the total investment of approximately Rs. 10530, Rs. 1740 million have been invested in Sindh (16 percent), Rs. 4656 million in Punjab (44 percent), Rs. 1339 million in Baluchistan (13 percent), Rs. 1911 million in KPK (18 percent), and Rs. 877 million in Northern Areas, Chitral and Azad Jammu and Kashmir (9 percent).

In order to assess the replication value of projects in health, education and WATSAN that have been conducted by RSPs both individually as well as jointly, illustrative case studies were formulated by conducting primary research in various areas of Pakistan, from Dadu and Rahim Yar Khan (RYK) in the south to Mansehra in the north-west and Poonch in the north. Care has been taken to make the selected sample of projects reflect geographical and cultural diversity. All in all, four case studies have been provided: work conducted through the Punjab Education Sector Reform Programme I and II in RYK, the Revitalizing, Innovating, Strengthening Education (RISE) Project, the FALAH project for health and family planning (FP) in Dadu, and the Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE) Project in selected districts of KPK and Azad Jammu and Kashmir (AJK).

³ Ending poverty in South Asia: ideas that work / edited by Deepa Narayan, Elena Glinskaya, Washington, DC : World Bank, c2007

⁴ http://www.microfinancegateway.org/gm/document-1.9.25816/24216_file_rural_support.pdf

Name of SSI	Brief Description	Location	What worked	Challenges
Punjab Education Sector Reform Programme in RYK (NRSP)	The formulation of the Punjab Education Sector Reform Programme (PESRP) gave a major impetus to the sector, injecting much needed interventions which enhanced the availability of schooling services to the citizens of the province generally and the rural classes specifically.	Rahim Yar Khan	<ul style="list-style-type: none"> • Inclusive and participatory approach to education service delivery • Formation of SMCs • Employment of the Social Mobilization approach to form CCBs and SCs • Innovative awareness campaigns • Multi-stakeholder engagement • Stable funding sources in the form of JDW Sugar Mill • Preparation of a Teaching Manual and QEFA curriculum • Nutritional campaigns 	<ul style="list-style-type: none"> • Political challenges which were less intense here may be difficult to overcome elsewhere • Funding sources may be limited where local philanthropists do not exist • Many schools have started slipping into patterns involving inefficiency and the lack of motivation • Earning trade-offs for prospective students
Revitalizing, Innovating, Strengthening Education (RISE) Project	RISE has operated in the districts of Mansehra in KPK, Bagh, Muzaffarabad and Poonch in Azad Jammu and Kashmir (AJK). To date, RISE has trained 139 education managers in at least four of six key education management themes in all four districts.	Districts of Mansehra in KPK, Bagh, Muzaffarabad and Poonch in Azad Jammu and Kashmir (AJK)	<ul style="list-style-type: none"> • Comprehensive system of support and training for communities, teachers and educational officials • Fostering relations with key stakeholders 	<ul style="list-style-type: none"> • Frequent transfer of staff • High level of expectation in relief environment • Flagging community morale • Varying geographic locations and cultures • Lack of clarity in set goals
Family Advancement for Life and Health (FALAH)	FALAH, or Family Advancement for Life And Health is a USAID funded 5-year project functioning in the area of reproductive health and family planning. Specifically, FALAH focuses on enhancing the practice of birth spacing as recommended by the World Health Organization (WHO) under the guidelines of 'Healthy Timing and Spacing of Pregnancies (HTSP) so as to improve the health of mothers and children and minimize pregnancy-related complications.	Dadu	<ul style="list-style-type: none"> • Low cost of awareness campaigns • Utilization of existing COs • Selection of CRPs as acting focal persons • Commitment of local staff to service delivery • Use of easy-to-understand posters, banners, brochures, booklets and audio cassettes 	<ul style="list-style-type: none"> • Existing gender relations, socio-religious concerns and a lack of scientific knowledge • Myth-creation regarding family planning and birth-spacing practices • Dearth of medicines and other necessary items relating to RH at BHUs
Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE)	In response to the disaster of 2005, USAID/Pakistan designed the Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE) Project and awarded a \$28.5 million cooperative agreement to the International Rescue Committee (IRC), a US-based NGO, to provide technical support to the public sector	Districts Mansehra and Bagh	<ul style="list-style-type: none"> • standards-based management approach when performing health care services • developing guidelines for a process to improve performance at public health facilities • establishing health management committees and developing 	<ul style="list-style-type: none"> • Taking a step forward from the PHC has been difficult • Delays in planning and implementation of the patient referral system • Lack of capacity in relevant government departments; unavailability of staff

	health system in Mansehra and Bagh districts.		<p>guidelines for them to improve local health care services</p> <ul style="list-style-type: none"> • renovating drug storage facilities and mentoring facility staff 	<ul style="list-style-type: none"> • Other project activities took precedence over revamping the patient referral system
Marginalised Areas Reproductive Health & Family Planning Viable Initiative (MARVI) – District Umerkot (TRDP & HANDS)	In 2007, TRDP collaborated with Health and Nutrition Development Society (HANDS), a non-profit organization, for the implementation of the MARVI project in District Umerkot. MARVI envisages an integration of reproductive health (RH), family planning (FP), microfinance, social marketing and social mobilization services through a well trained and dedicated cadre of women activists (MARVI workers) belonging to the local communities.	Districts Umerkot and Mithi	<ul style="list-style-type: none"> • Integrated approach • Creation of human resource from within communities • Targeted social marketing (women and children) • Combination of efforts by the public and the private sectors • Capacity building and training through the formation of women groups and women assemblies 	<ul style="list-style-type: none"> • The linkage between the community health workers and the government facilities and service providers is unclear • There needs to be a more formal linking of these so as to complement the work of each other and fill the gaps • Implementation delays may occur due to volatile political situations
Public-Private Partnership for the Establishment of Thalassemia Care Center in Badin (RSPN, District Government, Badin, USAID and private sector) – Since 2004	In recent years, the number of Thalassemia patients in Badin and neighboring districts, has increased considerably. However, a large number were deprived of treatment as the only facility existed in Karachi, which most could not access, primarily due to prohibitive costs. It was in response to these conditions that the Thalassemia Care Center was set up in 2005 in Badin.	Badin	<ul style="list-style-type: none"> • The project has generated a very interesting and important example of PPP in a highly sensitive and challenging area • Given the prevailing social norms in the area, awareness-raising about such sensitive issues was tactfully piggybacked on treatment processes. • Social Mobilization approach 	<ul style="list-style-type: none"> • less than expected success in securing commitment for resources from private or institutional philanthropists • Issues of sustainability with regards to funds, involvement of community, dedication of stakeholders and the capacity of teams to run such centers
Community-Based Mother & Child Health Care Initiative (CBMCHCI) – (RSPN, SRSO, NRSP, PRSP, TRDP, SGA, UNICEF and provincial governments) – Since 2009	The CBMCHCI was developed jointly by RSPN and UNICEF in 2009, as part of their goal to build a community based model for introducing integrated health interventions in remote rural areas. The conduit for such interventions is community resource persons (CRPs) trained in various Mother and Child Health (MCH) services.	12 districts	<ul style="list-style-type: none"> • Intricate collaboration between RSPs and the government • The project has trained community members to help in delivering RH and MCH related services. In this way the problem of staff posting and transfer, that has been a perennial problem in the public sector, has been mitigated. 	<ul style="list-style-type: none"> • Missing integrated approach linking this programme to adult literacy, improvements in educational services and micro nutrients' supplementation
Micro-Health Insurance (NRSP and Adamjee Insurance)	In October 2005, RSPN initiated a pilot project in partnership with Adamjee Insurance Company. NRSP was the largest partner in this initiative. Later, NRSP directly partnered with Adamjee Insurance Company and launched the Health Micro Insurance Initiative in order to provide greater access to quality hospital care and to	Member COs of NRSP	<ul style="list-style-type: none"> • Knowledge on micro-credit produced by the programme can be accessed by other RSPs and relevant stakeholders 	<ul style="list-style-type: none"> • As of September 2009, the loss ratio of the insurance scheme has been 53%. The reasons for this need to be looked into

	assist poor households with their medical expenses.			
Chief Minister's Initiative on Primary Health Care in the Punjab - since 2002	To achieve health-related MDG targets, the government has been pushed towards finding alternative ways of delivering health services. ⁵ The innovative CMIPHC is a radical departure from established practice in government, and marks the first time that management of some aspects of basic health services' delivery has been outsourced to a non-governmental agency ⁶ . Though the intervention started with exemplary political support at provincial level, this dwindled over time. However, the Programme carries on due to the momentum of its success, support from District Governments, and has recently been replicated at the national level.	12 Districts in Punjab	<ul style="list-style-type: none"> • Recognition by top political leadership – President and Prime Minister • Redesigning management of PHC services at the District Level • PRSP BHUs produce reports which are in greater detail, high in accuracy and professionally more useful, compared to data from BHUs which is generated on the Government of Punjab's Health Management Information System (HMIS) formats 	<ul style="list-style-type: none"> • Resistance from vested interests hinders project planning and implementation • Lack of capacity of government staff • Compared to curative health services, outreach services have suffered due to a lack of requisite facilities, power and infrastructure • A largely passive role of district health staff • Issues with sustainability once private sector partner has 'exited' the project cycle
Elimination of Child Labour and Provision of Non-Formal Education (NFE) in Household Glass Bangles Industry, Hyderabad (2005-2008) – NRSP, ILO and GoS	This project, to eliminate child labour from the GB industry in Hyderabad, was funded by USDOL through ILO and was implemented by NRSP. The project aims at a gradual shift, whereby, working children are provided an opportunity to distance themselves from the hazardous work and explore other options of livelihood. The project provides: non-formal education to children geared towards placing them into formal education; literacy centers; pre-vocational training; linking families with social safety nets and micro-credit opportunities; child labour monitoring; improvement in working conditions; building linkages with the district government, training institutes, line departments, workers' and employers' organizations and civil society organizations.	Hyderabad	<ul style="list-style-type: none"> • Social mobilization has been applied to broaden the economic choices of vulnerable sections of society • children and their parents are provided an opportunity to slowly distance themselves from the hazardous work and explore other options of livelihood • project demonstrates a complementary relationship among civil society (NRSP), donor agency (ILO) and local government (District Government, Hyderabad) • It is common for development activities not to focus on children directly and the welfare of children seldom gets priority. This project has made a contribution in this crucial area 	<ul style="list-style-type: none"> • It needs to be ensured that the children are sustainably accommodated into the formal education system once they leave non-formal schools • The youths undergoing vocational training need to be linked with affordable microfinance, market and employment opportunities • Delays due to frequent transfers of District Government officials; The Zila Nazim's demanding schedule impeding him from prioritizing the project; dissolution of the Zila Zakat Committee after the new government came into power; and political unrest in the country • Provision of soft loans and easy financing

⁵ Historically, and as recently as 2002, utilisation rates of Basic Health Units (BHUs –primary health care units are the first line of health care) have been as low as servicing 22 patients a day. There are nearly 2500 BHUs in the Punjab.

⁶ PRSP is managing 1049 health facilities in 12 districts out of which 845 are BHUs.

1. Scope, Methodology and Purpose of the Report

Since the establishment of the Aga Khan Rural Support Programme (AKRSP) in 1983, the Rural Support Programmes in Pakistan have attempted to fill gaps in both the supply and demand of basic social sector service delivery. Currently, at least 10 Rural Support Programmes (RSPs) function across the length and breadth of the country, both with and without government assistance, leading the way toward grassroots level development.⁷ The success and ingenuity with which these organizations have carried out their tasks has helped them achieve recognition as one of thirteen ‘Ideas that Work’ by the World Bank publication, ‘Ending Poverty in South Asia’.

The purpose of this report is to undertake a review of wide-ranging social sector interventions (SSIs) initiated by RSPs during the last three decades. The objectives of this research are to:

- (i) Review the SSIs of the RSPs;
- (ii) Analyze the data available on SSIs to assess their coverage and scope;
- (iii) Undertake detailed assessments of selected SSIs in key sectors such as health, education and disaster relief;
- (iv) Identify the features that make SSIs successful;
- (v) Highlight the challenges and potential for scaling up and replicability; and
- (vi) Based on the analysis, highlight policy lessons and make recommendations for the federal and provincial governments in the context of failures, successes and best practices.

The methodology for research consisted of field visits by the research team to Dadu, RYK, Peshawar and Islamabad using multiple-themed structured as well as semi-structured assessments. These assessments were used to evaluate the successes and failures of various community-based projects undertaken by the respective RSPs. In addition to holding focus group discussions with relevant stakeholders, interviews were also conducted with members of the beneficiary communities, selected RSP staff at headquarters, project managers, focal RSPN staff and government stakeholders.

The team also conducted a series of meetings with leading partners of the RSPN such as the United Nations Children’s Fund (UNICEF), Water and Sanitation Program – South Asia (WSP-SA), Ministry of Environment, Population Council (PC), Greenstar Social Marketing and other key development partners and government agencies. In addition to this, relevant reports available at RSP offices were studied.

Constraints: The field visits that were conducted were extremely fruitful. However, the research team was constrained by numerous factors. A field visit to Skardu was not possible due to the looming crisis over the filling up of the Hunza Lake, which made the area dangerous to travel to. Also, visits to Gwadar and Peshawar were not possible due to the floods that hit various parts of Balochistan and the Khyber-Pakhtunkhwa province in July 2010. Furthermore, data collection from the various RSPs took longer than anticipated. There were also issues related to data consistency and the reporting frameworks used by each RSP. Overcoming these data constraints was a challenge encountered during the production of this report.

2. The Challenge of Service Delivery in Pakistan

⁷ Azad Jammu & Kashmir Rural Support Programme (AJKRSP), Aga Khan Rural Support Programme (AKRSP), Baluchistan Rural Support Programme (BRSP), Ghazi Barotha Taraqiati Idara (GBTI), National Rural Support Programme (NRSP), Punjab Rural Support Programme (PRSP), Sindh Graduates’ Association (SGA), Sindh Rural Support Organization (SRSO), Sarhad Rural Support Programme (SRSP) and Thardeep Rural Development Programme (TRDP)

In terms of service delivery, Pakistan's national and sub-national public institutions have not performed well. Although in possession of a significant agricultural resource endowment and a fairly well developed services sector, Pakistan has continued to lag in the delivery of basic social services and in most human development indicators. The country faces the classic scenario of 'growth without development', where despite an average annual growth rate of 2.2 percent per capita over the period 1950-1999, Pakistan has displayed stagnant social development. Other countries in the region have exhibited stronger records in terms of social development with relatively lower levels of per-capita growth. Social indicators such as infant mortality, and female primary and secondary education illustrate the deplorable gap between service demand and supply. In 2000, female literacy rates ranged from 41 percent in urban Sindh to 3 percent in Khyber-Pukhtunkhwa (KPK) and Baluchistan. Compared to the rest of the region, Pakistan had 36 percent lower rate of births attended by trained personnel, 11 percent higher rate of babies born with low birth weight, 42 percent lower health spending per capita, 1.6 percent of GDP less in public health spending, 27 excess infant deaths per thousand, 19 excess child deaths per thousand, and 23 percent less share of population with access to sanitation.⁸

Even with the Social Action Programme (SAP) amounting to US \$10 billion aimed at the enhancement of social indicators, Pakistan kept lagging behind most South Asian countries in social development.⁹ An account of the SAP, its achievements and the challenges faced is provided in Annex 1. Pakistan's case is neither peculiar nor isolated from the general trend of service delivery bottlenecks across developing countries. Before focusing on Pakistan, a few comments on the role of state and the emergence of NGOs as parallel service delivery agents are presented below.

2.1 Government-NGO Cooperation

As noted above, Pakistan has performed poorly on most social indicators due to inadequate social sector delivery, both in terms of quantity and quality. Furthermore, the rural areas of Pakistan have been disproportionately affected, with the systemic failure of service delivery stemming from a significant shortfall in state outreach. The relationship between NGOs and the government of Pakistan has been partially shaped by the evolution and relative success of the Rural Support Programmes (RSPs). The efficacy of these organizations has directed policy-making priority toward eradication of poverty, and has affected government strategies on social sector initiatives. The RSPs can be credited with designing the approach utilized by the country's provincial governments in scaling up community-based programmes in rural areas.

In their paper on the AKRSP, Camps, Khan and Tessororf recommend that, "while Third World governments are reducing the level of state intervention and centralization and attempting to rebuild their administrative capacities, an AKRSP-type 'gap-filler' approach can take up some of the slack in the provision of social welfare services. It is an added bonus that this approach would also have the salubrious effect of strengthening civil society, and thus increase the social capital reservoir, in almost any low- or middle-income country where it was implemented. This can only improve the overall institutional capability of any nation. And that can only be for the good".¹⁰

⁸ Easterly, William. *The Political Economy of Growth Without Development: A Case Study of Pakistan*. Analytical Narratives of Growth Project, Kennedy School of Government, Harvard University. Development Research Group, World Bank, 2001. 2. Print.

⁹ Compared to other countries at this income, Pakistan has 36 percent lower births attended by trained personnel, 11 percentage points higher babies born with low birth-weight, 42 percent lower health spending per capita, 1.6 percent of GDP less in public health spending, 27 excess infant deaths per thousand, 19 excess child deaths per thousand, and 23 percentage points less share of population with access to sanitation

¹⁰ Campos, Nauro F., Feisal U. Khan, and Jennifer E. Tessororf. "From Substitution to Complementarity: Some Econometric Evidence on the Evolving NGO-State Relationship in Pakistan." *Journal of Developing Areas*. 37.2 (2004): 49-72. Print.

RSPs have historically been contracted by government agencies to undertake tasks on the community development components of large projects, and to conduct exercises for shoring up government capacity for basic social sector service delivery and community-based activities. However, direct government funding has usually not been forthcoming, with donor grants being utilized for both independent and government projects.¹¹ Before we turn to the details of RSPs' engagement with the state, it would be useful to highlight the challenges of public service delivery as viewed by Pakistani citizens.

2.2 Social Sector Services Remained Inadequate in Pakistan

Three Social Audit surveys undertaken post-devolution, outlined the impact of devolution on the delivery of social services. The CIET survey of 2010 aimed at bolstering the practical collation of data, with predecessors in the form of the 2002 and the 2004/05 surveys.¹² Data was collected from both rural and urban households, excluding FATA and the Islamabad Capital Territory, where no local government systems existed.¹³ The provision of social sector services has been captured well in the survey, with varying trends observed in different sectors, as shown in Annex 4. The results of the survey show that, overall, there have been improvements in the public response towards the delivery of sewerage and sanitation, water supply, drinking water, and health and education services, as shown by an increase in the percentage of people reporting satisfaction. The only area in which the satisfaction level has decreased has been in the number of households claiming no support from the government in the provision of health services. While this does point to a positive impact of devolution on the delivery of social services, the increase in satisfaction has not been significant enough to have had a major impact on the provision of social services and the consequent improvement in the well-being of society in general.

Thus, even with the existence of local governments, participants in the survey complained of poor sewerage and sanitation services, and the lack of facilities provided for the drainage of rainwater, both of which increased the risk of infection through water-carried diseases. Participants also complained about the lack of consistency in the quality and quantity of water that was being supplied to them in areas where there was government sanctioned provision. With reduced availability of drinkable water, locals had to walk long distances to acquire the resource.

In the sphere of healthcare, government provided health facilities were said to be lacking on two supply-side factors: the availability of doctors and medicines. Participants noted that doctors preferred working at private clinics, with medicines being diverted for sale in the market. Appreciating some aspects of the healthcare system currently in place (if they had access to any), such as the attitude of Lady Health Workers (LHW), participants thought that their demand for health service delivery was not being met.

With regards to education services, participants complained about the lack of qualified teachers, teacher absenteeism, lack of discipline in schools and the overall lack of schools, which went beyond primary education to middle and higher levels. Madrassas were mentioned as a substitute where disciplined, cost-free education was being acquired by the poor.

The next section of this report goes on to expound the original mission of RSPs, the evolution of their mandate, and the role of RSPN in taking forward the Social Sector agenda.

¹¹ Batley, Richard, and Maliha Hussein. *Country Studies - Pakistan: Study of Non-State Providers of Basic Services*. Birmingham: Policy Division, Department for International Development (DFID), UK, 2004. 3. Print.

¹² *Social Audit of Local Governance and Delivery of Public Services*. Pakistan National Report. Islamabad: United Nations Development Programme Pakistan, 2010. Print.

¹³ A sample size of 12,000 was deemed appropriate to produce robust estimates at the provincial level within the 95 percent confidence level. Additionally, the sample distribution allows for comparing current data with previous rounds for 18 of the 21 selected districts. Using a stratified random sample, this survey constructed strata in order to capture inter-district heterogeneity, while simultaneously increasing the spread of randomly selected districts to ensure representativeness at the provincial level.

2.3 Original Mission and Mandate of the RSPs

The original mandate of the Rural Support Programmes (RSPs) is defined as the “reduction of poverty and improvement in the well being of rural people by harnessing people’s potential to plan and implement activities that will improve their quality of life”. The RSP experience in Pakistan has involved the mobilization of communities at the grassroots level, through the creation of COs. Such a mode of social mobilization is understood to entail the provision of a range of services in collaboration and consultation with the community – the purpose of these services being the enhancement of the earning potential of these communities. These activities have included institutionalizing savings and credit mechanisms within the community, capacity-building, training and provision of skills for expanding employment opportunities, and grant funding for community physical infrastructure (CPI). Annex 3 provides a brief on the creation and history of the RSPs.

2.4 The Rural Support Programmes – Strategy and Evolution

With the motto of augmenting social mobilization, the RSPs have utilized a framework containing the ‘Institutional Model’ and the ‘Production Model’. The institutional model incorporates Social Mobilization at the local level and community organization. Concomitant to this has been the introduction of a range of activities which aim at building the autonomous capacity of the community and enhancing the community’s earning and productive potential. This has been labeled as the production model, whereby the community’s organization is cemented around a productive activity.

Social mobilization is built on the belief that communities, if engaged and provided the relevant organizational structure, attempt to work towards their welfare through internal consultation and the establishment of linkages with agents of social sector service delivery as well as through creation of a productive cycle of savings and credit in the form of internal loaning.¹⁴ This approach is now fully recognized in Government policy. A special supplement to Pakistan’s 2005/10 Medium Term Development Framework puts Social Mobilization at the centre of poverty reduction strategies, with \$75 million of World Bank funding having been allocated for Participatory Development through Social Mobilization. A participatory, social mobilization element has also been included in other major programmes, such as the Prime Minister’s Livestock Initiative and the Crop Maximization Project.¹⁵

For 25 years, RSPs have led the social mobilization movement in Pakistan. This has enabled them to build an unparalleled outreach and a presence in 93 out of 127 districts of Pakistan. Until recently, RSPs have predominantly worked with small community organizations at the village or, predominantly, the smaller, *muhalla* level. In 2008, the average CO membership stood at 20 persons per CO. This was part of the first generation of social mobilization. However, a large part of RSP and RSPN work and attention is now focused on what is being described as Second Generation Social Mobilization (2nd GSM) and on a new approach to microfinance, the Community Investment Fund (CIF).¹⁶

In order to provide sustainability to the social mobilization process and to meet its objectives of enabling communities to take developmental efforts into their own hands, AKRSP moved toward creating clusters of COs, with a mandate to establish linkages with external donors, produce future social organizers (SOs) and engineer mechanisms for undertaking large-scale developmental projects. Later, the creation of a 3-tiered structure comprising of the Community Organization (CO) at the *muhallah* level, the Village

¹⁴ Ibid. ii.

¹⁵ Ibid. iii.

¹⁶ Ahmed, Z.U., C. Euler, S. G. Khattak, J. F. Morton, and M. Tariq. 34.

Development Organization (VDO) at the village level and the Local Support Organization (LSO) at the UC level was started.¹⁷

2.4.1 Three-Tiered Structure + Community Resource Persons (CRPs)

The three-tiered approach consists of fostering COs (women's and men's), federating COs into VDOs, and federating VDOs into UC level LSOs. The most important element of this three-tiered structure is its COs, as their strength has a direct impact on the long-term stability and functionality of the VDOs and the LSOs. A CO is made of 15-25 individuals from a neighborhood sharing a common interest. Its functions include planning for a micro-investment plan at household and group levels, facilitating trainings for HR and professional development, promoting savings, providing microcredit, and soliciting membership fees to support VDOs and LSOs (to promote community ownership and avoid 'elite capture' of these organizations).

More recently, Community Resource Persons (CRPs), who are activists from within the community, are involved in Social Mobilization. Identifying CRPs is an effective way of social mobilization in a relatively short period of time and in a cost-effective manner. Since CRPs operate within their own communities, this approach can ensure that coverage is high as well as inclusive of the poorest and the marginalized such as women. The approach also advocates including equitable clauses in the by-laws of both the VDOs and LSOs to encourage equal representation of women in leadership positions, and making planning, budgeting, monitoring and reporting activities gender-sensitive.

Poverty Scorecards (PSCs) are used to ensure that social mobilization is inclusive. The PSC is a questionnaire based on 13 simple and easily-verifiable questions, which are used to allocate poverty scores ranging from 0 to 100. These results are verified by community members as well, in order to eliminate any measuring error. The PSC can be conducted by CRPs, thereby ensuring that the process is community-driven. PSCs thus help CRPs identify and focus on the poorest households which are ordinarily overlooked by development agencies.



Figure 1

2.5 Evolution of the RSP Model – Towards Engagement with Social Sectors

The relative success with which most RSPs have operated over the years has provided them with a fertile ground for expanding their sphere of operations into health, education, water and sanitation, and disaster relief and management (DRM). Given their growing direct involvement in service delivery, with government increasingly contracting RSP expertise, and given their indirect activities undertaken in the role of facilitators, the RSPs have embarked on a new path, dictated by what we may term the

¹⁷ Khan, Shaheen Rafi, and Shahrukh Rafi Khan. *Local Support Organisations: Institutionalizing Participatory Development*. Islamabad: Rural Support Programme Network, 2010. 8. Print.

¹⁸ Azizi, Muhammad Ali, and Nida Khan. *Operation Manual for Social Mobilisation*. Islamabad: Rural Support Programme Network, 2009. 15. Print.

‘Production, Inclusive and Social Approach’. Briefly, the RSP model and its evolution can be illustrated by Figure 2.

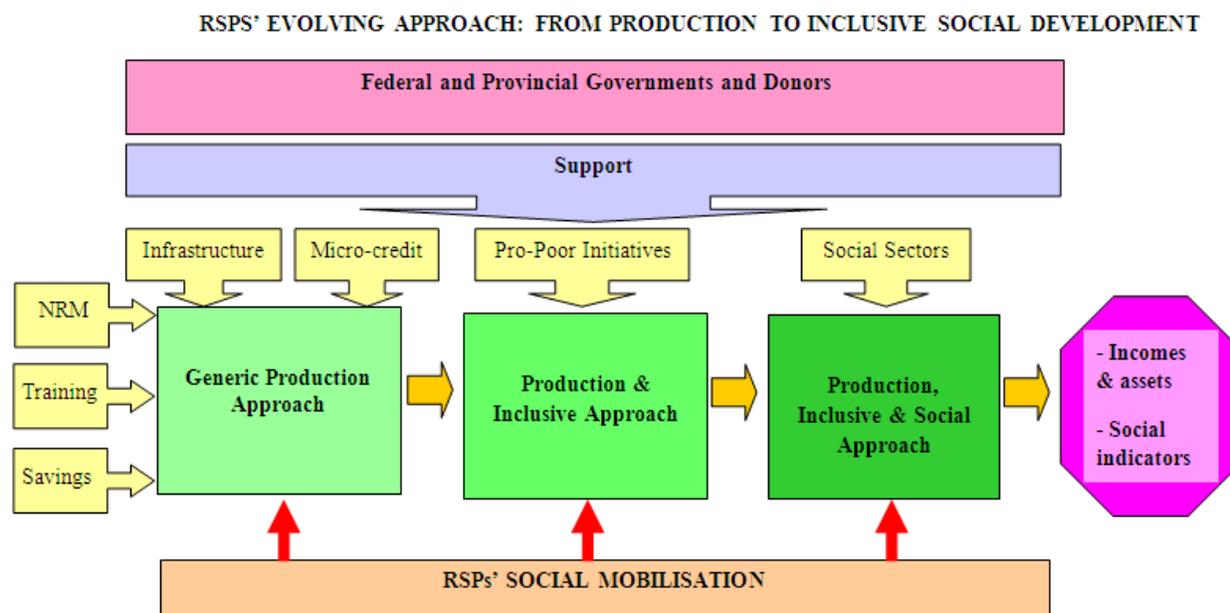


Figure 2

Figure 2 endeavors to represent the complex relationships and evolution trajectory of RSPs’ transformation from following a Production Approach to an Inclusive and Social Approach. In their quest to provide targeted support to communities, reaching out to the poorest and acknowledging the service delivery gaps at the local level RSPs have employed the social mobilization techniques to forge partnerships with and among communities for their local and sustainable development. As noted above, the Inclusive (Production and Social) Approach model predicates itself on an underlying mechanism of social mobilization guiding all actions of RSPs.

Since the creation of the RSPs, all evolving models have made use of this approach. In the case of Pakistan, this has taken place with the support of governments at the federal as well as provincial levels, and international donors – one of the primary reasons for the success of RSPs in the country. Initially, the AKRSP made use of the ‘Generic Production Approach’, whereby, savings creation and micro-credit provision, training and HR development, natural resource management (NRM) and productive physical infrastructure formed the basis for grassroots, rural development. Following this however, RSPs began to take note of, and incorporate more sophisticated pro-poor initiatives into their overall working paradigms, giving way to the ‘Production and Inclusive Approach’. These pro-poor initiatives aimed to target different segments of rural populations, especially the more marginalized. Thus, social mobilization was now being directly aimed at vulnerable groups such as the extremely poor, women and children.

Eventually, lessons learnt from these two approaches allowed the development of the ‘Production, Inclusive and Social Approach’, whereby social mobilization at the grassroots level and demand creation through a bottom-up perspective, together with the integration of pro-poor initiatives created an enabling environment for the multiple stakeholders to establish large-scale programmes in sub-categories of the social sectors. Thus, collaborations between RSPs and the government/donors were scaled up, leading to heavily funded, targeted programmes in the health, education and WATSAN sectors.

3. The Scope and Extent of RSPs Social Sector Interventions

3.1 Overall Investment and Sectoral Distribution

The RSPs can be termed development NGOs working toward the institutionalization of systems, community-based platforms and programmes which allow for a sustainable flow of output even after the individual RSPs have left the areas they intervened in. Sources of funding to RSPs range from endowments, such as is the case with NRSP, SRSO and SRSP, to donations from international donors, who prefer to provide funding based on individual projects and programmes. During the last decade, funding to RSPs has increased enormously, a situation illustrated by the fact investment across sectors rose from 648 million rupees before the year 2000 to 10534.5 million rupees since then (an almost eleven-fold increase).¹⁹

Until now, the cumulative investment by the RSPs in the water, sanitation, health and education sectors has been 10534.5 million rupees²⁰. Projects include drinking water supply schemes, community-based latrine installation programmes, Community Led Total Sanitation schemes (CLTS), irrigation enhancement techniques and infrastructure building for the running of wells and turbines, as well as reproductive health awareness, Mother and Child Healthcare (MCH) projects, and eye, limb and skin camps. In the education sector, the RSPs have conducted exercises which have had a profound effect on developmental efforts in this field. Sustainable, institutionalized methods of mitigating illiteracy in the country have been introduced using community-based platforms. RSP growth has seen a gradual shift of focus from awareness, TBAs, community schools to preventive health and now to reproductive health and the strengthening of government service delivery partnerships e.g. PRSP CMPI; European Commission in Baluchistan for health. RSPN guides its network of RSPs on the SD model, not only according to the mandate of the RSPs but also to fill the gap/vacuum which exists due to weak capacities for national, public service delivery. Since the year 2000, RSPs have benefited from a holistic approach, in contrast to the previously followed ad hoc-ism in selection and implementation of projects.

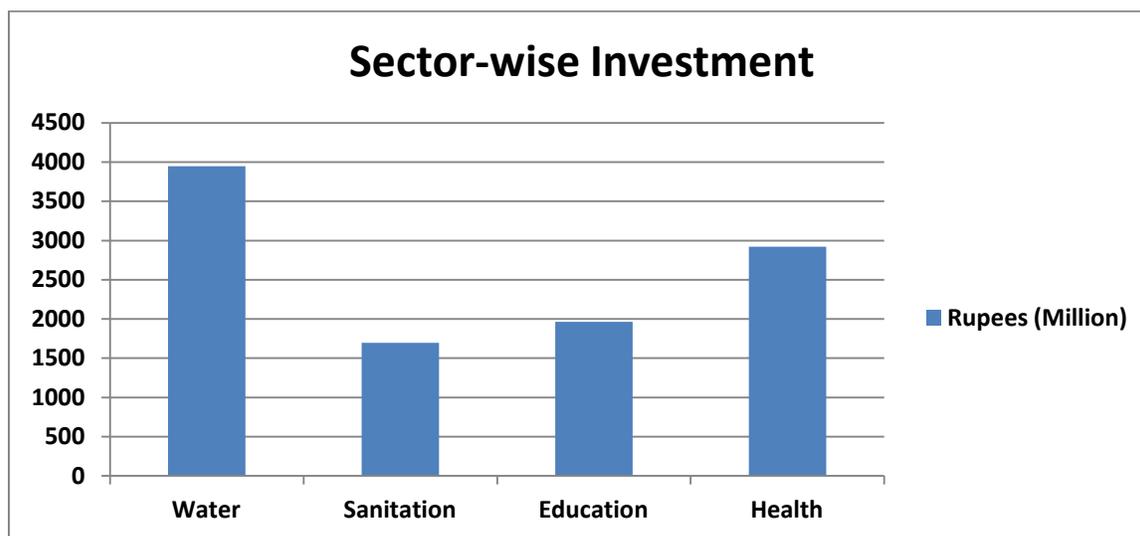


Figure 3

Figure 3 provides a sector-wise breakup of the total investments that have both been made by respective RSPs and by national and international donors (through the RSPs). These figures relate to data obtained from individual RSPs, for projects conducted after their inception. Of the total investment that has been

¹⁹ Rural Support Programme Network, Islamabad (Data collected from all 9 RSP's).

²⁰ These figures are based on all available data which has been systematically collated.

made toward reenergizing and reinforcing social sector service delivery, 3947 million rupees have been invested into the water sector, 1698 million rupees in the sanitation sector, 1966 million rupees into the education sector and 2923 million rupees into the health sector. Projects initiated before year 2000 have amounted to 632 million rupees (water and sanitation combined), 105 million rupees (education) and 4.5 million rupees (health). In other words, 37 percent of funds have been allocated to the water sector, 16 percent to the sanitation sector, 19 percent to the education sector and 28 percent to the health sector (Figure 4), with 7 percent of funds invested before year 2000 and the remaining 93 percent (approximately) of funds invested during the decade 2000-2010.²¹

This trend accentuates the importance of water for communities, a resource that is used for multiple purposes which range from use for drinking purposes and the irrigation of farmlands to use in sanitation mechanisms.

Resources for the education sector have been utilized in broadly five areas: community schools, Adult Literacy Centers (ALCs) and Early Childhood Development (ECD), capacity-building and upgradation, Revitalising, Innovating and Strengthening Education (RISE) project (the project is kept as a separate component due to its wide-ranging operations) and others which include one-off response projects, and the establishment of endowments and educational innovations.

Investments in the health sector have mainly been in the following areas: Awareness, Mother and Child Health (MCH), Reproductive Health (RH), Primary Healthcare (PHC), and Nutrition. Besides these, many other interventions have been made in the health sector by RSPs that do not specifically fall under the above categories.

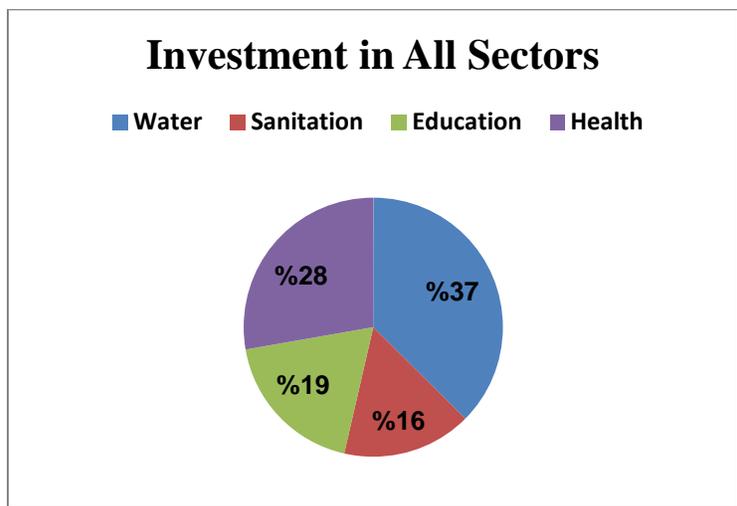


Figure 4

3.2 Total Investments by Region

This section provides a comparative review of region-wise investment, as fractions of total investment in the social sector by the subject RSPs. Of the total investment worth approximately 10550 million rupees, 1743 million rupees have been invested in Sindh (17 percent of total investment), 4656 million rupees

²¹ Ibid.

have been directed towards Punjab (44 percent of total investment), 1334 million rupees have been utilized in Baluchistan (13 percent of total investment), 1911 million rupees have been invested in Khyber-Pukhtunkhwa (18 percent of total investment) and 874 million rupees have been channeled into the development of the area comprising the Northern Areas and Chitral and Azad Jammu and Kashmir (8 percent of total investment).²² Figure 5 represents these items of interest.

From the data acquired from the various RSPs, it is observed that the Punjab province is the largest recipient of funding from Rural Support Programmes and their respective donors, both domestic and foreign, followed by Khyber-Pakhtunkhwa, Sindh, Baluchistan and finally the northern zone (NAC-AJK). Fitting this into the general trend of development in Pakistan, Baluchistan appears to be lagging behind. Apart from this region, the other provinces appear to receive funding which reinforces their development status. Punjab being the most developed, offers greater potential to its pockets of underdeveloped or undeveloped areas, which can exploit the opportunities available in the province to pull themselves out of poverty (through community-based approaches, perhaps). Sindh is in the process of moving towards a more developed outlook, with vast areas of the province suffering from poverty. Organizations such as the TRDP and SRSO are making valuable efforts for improving the state of affairs in Sindh. The northern zone, holding a smaller fraction of the population has attracted a fairly disproportionate fraction of funding, benefitting from the standards of excellence set by the AKRSP and from the unflinching support of the Aga Khan Development Network.

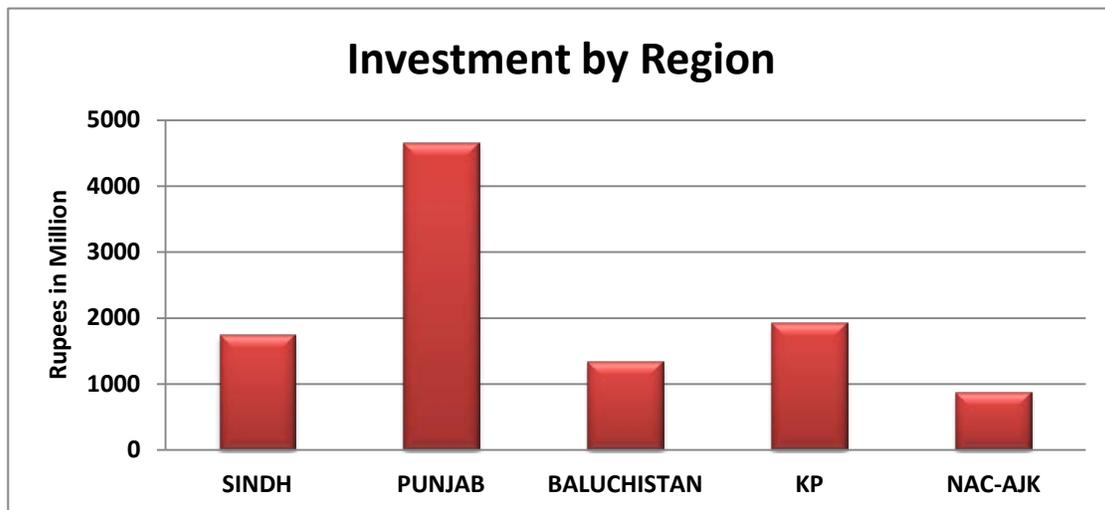


Figure 5

3.3 Sectoral Investments: Area-wise

Taking this analysis a step further, we have attempted to extricate the variations in investments made in the relevant sectors in the above-mentioned regions. The size of each of the four sectors (water, sanitation, education and health) varies among different geographic regions of the country. This section provides a breakup of the size of these sectors in five specific areas, namely Sindh, Punjab, Baluchistan, Khyber-Pukhtunkhwa, and a cluster containing the Northern Areas and Chitral and Azad Jammu and Kashmir (NAC-AJK).

²² These areas have been clumped together for the purpose of our analysis.

3.3.1 Sindh

TRDP, SRSO, SGA and NRSP operate in this area. Figure 6 underscores the investment per sector in Sindh. With an 62 percent investment rate, the water sector emerges as the largest consumer of developmental funding in Sindh. Many areas of the province are labeled as ‘underdeveloped’, where income potential is seen to have fallen over the years. The shortage and fluctuation of water supply in what is a tail end area of the Indus River System causes it to be in dire need of irrigation projects which could link far-flung communities with the irrigation network and allow them to partake in agricultural activities. RSPs are helping provide support with irrigation schemes and projects that are then used as points of penetration for further projects. From an RSP perspective, the coverage of regional organizations has not been tremendously successful, thereby encouraging the RSPs to provide further WATSAN PPIs. Furthermore, the new sanitation thrust in the country has attracted funding for the sector, amounting to 19 percent of the total. This has come more or less over the last one decade. The education and health sectors attract 7 percent and 12 percent of the total investment in the province. Apart from the SGA, which had completed projects in Sindh during the 1990s, all other projects and investments were extended to this area after 2000-01.

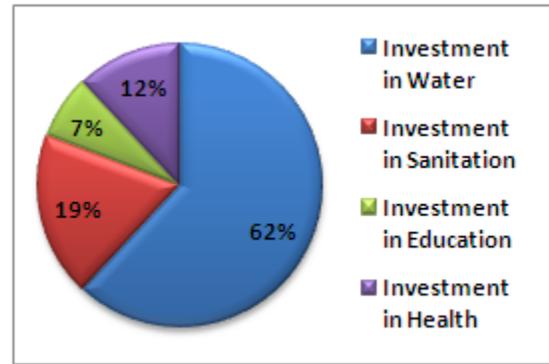


Figure 6

3.3.2 Punjab

In Punjab, two RSPs namely NRSP and PRSP conduct rural support operations, with the Ghazi Barotha Taraqiata Idara (GBTI) undertaking projects in the Attock tehsil. It is interesting to note that the investment pattern in the Punjab province shows a remarkable divergence from that of Sindh. With 51 percent of investment being channeled into the health sector, together with 18 percent for the education sector, we see a greater interest in social capacity related sectors in this province. Investment in the water sector is still considerable, eating up 27 percent of overall funding. Sanitation which is still to take a foothold in the development agenda of the province follows with 4 percent of funding (Figure 7).

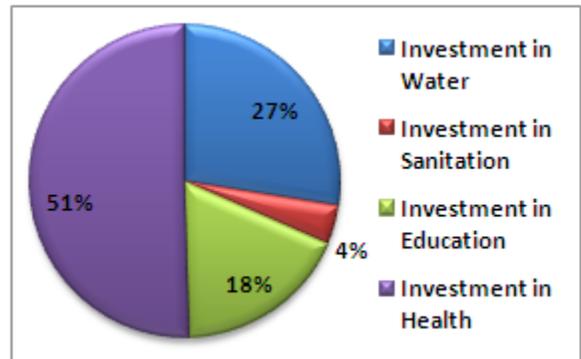


Figure 7

With the Punjab government spending heavily in education while utilizing the services provided by the regional RSPs (NRSP and PRSP), as has been illustrated in the Punjab Education Sector Reform Programme-I (PESRP-I 2005-08) and PESRP-II (2009-12), the demand for investment in education has been creeping up. Apart from PRSP’s efforts in establishing schools since 1999, all other RSP-related projects have been established after 2000-01 in the Punjab province.

3.3.3 Balochistan

BRSP and NRSP handle RSP activities in this region. Investment in the water and education sectors are relatively balanced in the Balochistan province, where 38 percent of RSP funding is funneled into the former while 42 percent is

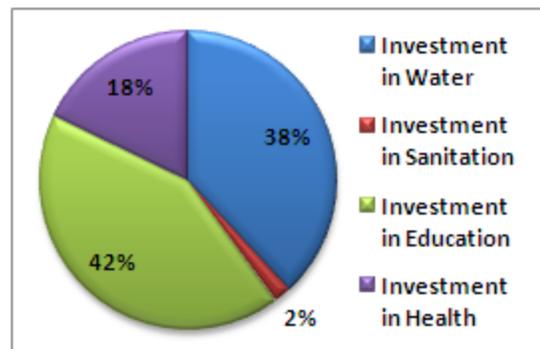


Figure 8

injected into the latter. 18 percent of the investment has been made in the health sector and 2 percent in the sanitation sector (Figure 8). Balochistan has an arid climate and a challenging landscape of poorly fertile soil. This has contributed to its low socio-economic conditions, placing it in a less favorable situation when compared to most other parts of the country. The high percentage of investments committed to the education sector is a manifestation of the ongoing efforts by regional RSPs for pulling up the capacity of local communities.

3.3.4 Khyber-Pukhtunkhwa (KP)

In the KP province, SRSP and NRSP work in tandem, with some supplementation from GBTI, which works in areas within Swabi and Haripur districts. In this province, 46 percent of funding through the RSPs is in the water sector and 44 percent in the sanitation sector, reflecting the high priority assigned to these sectors by donors. Education has received 7 percent of the investment and health a mere 3 percent. Water and sanitation schemes have provided a much needed boost to the denser regions of this infrastructurally underdeveloped province. Investments for rural development in NWFP were robust in the 1990s through the support of SRSP, with one-third of all funding coming in during that time. Recently, again the flow of funds has gained momentum with donors showing increased interest in the area.

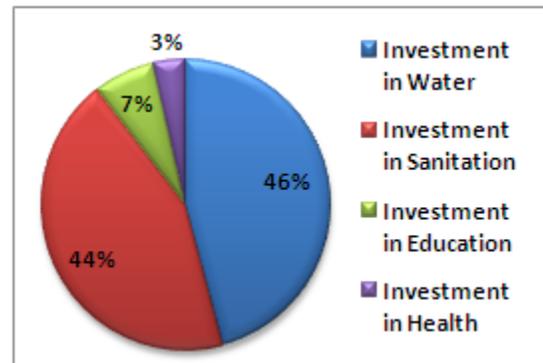


Figure 9

3.3.5 Gilgit - Baltistan and Chitral, Azad Jammu and Kashmir (NAC-AJK)

Given their proximity and specially accorded status, this sub-section treats the Gilgit Baltistan and Chitral (GBC) and Azad Jammu and Kashmir (AJK) as a cluster. AKRSP dominates RSP operations in the areas constituting this cluster. Figure 10 illustrates the investment percentages per sector in this cluster. 37 percent of investment is directed toward the sanitation sector and 23 percent to the water sector, with education and health getting 34 percent and 6 percent respectively. Comparatively low investment in the health sector for all the regions of Pakistan is a trend that needs the attention of policy makers.

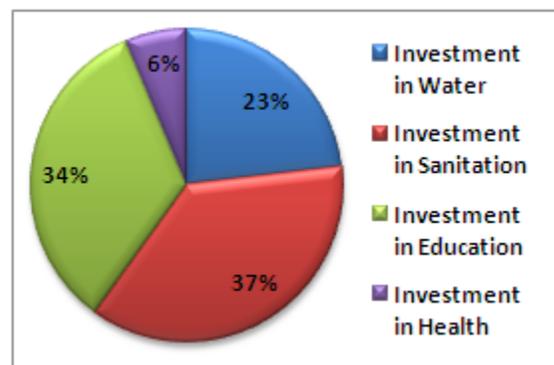


Figure 10

3.4 Donor Funding Per Sector

RSPs fund their operations through local as well as international sources. Over the last 2 decades, the network of RSPs in Pakistan has been successful in building rapport and credibility with foreign donors, which have channeled numerous projects through the RSPs. This section sheds light on the source of funding for RSP operations, and the multiple programmes that are underway in the sectors of water, sanitation, education and health.

3.4.1 Water and Sanitation (WATSAN)

The chief sources of funding for projects belonging to the WATSAN sector have been international organizations (Figure 11). These include the Department for International Development UK (DFID), Canadian International Development Agency (CIDA), International Fund for Agricultural Development (IFAD), German Agro Action, the German Bank, the Asian Development Bank (ADB) and the World Bank (WB). For example, multiple donors for SRSP have contributed 25 percent of the total funding in this sector. German aid organizations contributed 13 percent of the total funding for WATSAN.

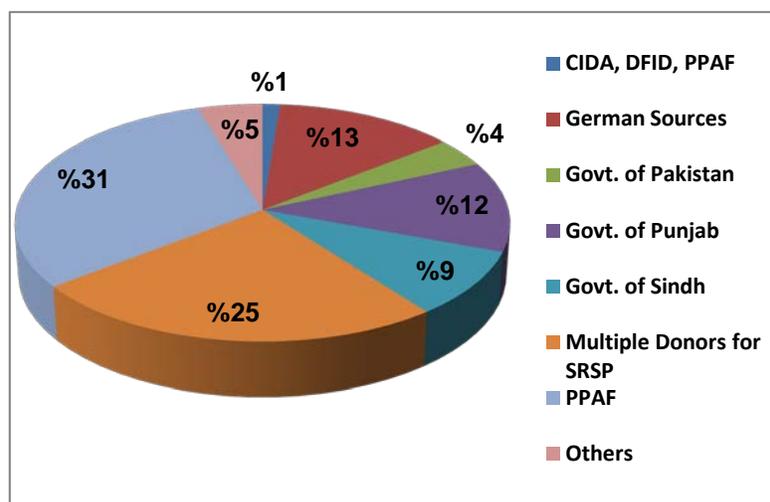


Figure 11

3.4.2 Education

On the basis of its perceived position as a leader in education in the country, Punjab attracted substantial amounts of funding for projects related to education, mainly through government sources. The government of Punjab's funding (acquired locally and through international sources such as the ADB and the World Bank) constitutes 66 percent of total funding through RSP channels in the country (Figure 12).

The United States Agency for International Development (USAID) provides 15 percent of total sectoral funding, mainly for the Revitalizing, Innovating, Strengthening Education (RISE) and the Adult Literacy Center (ALC) projects. In addition to this, the Pakistan Poverty Alleviation Fund (PPAF) – a World Bank backed pro-poor, domestic agency which has RSPs as its largest clients – provides 5 percent of overall funding for RSP initiated or implemented projects. This is followed by DFID (4 percent), together with the federal government, Learning for Life (LFL) and RSP endowments, each of which contribute 2 percent of the total funding. 2 percent of the overall funding comes from other miscellaneous donors.

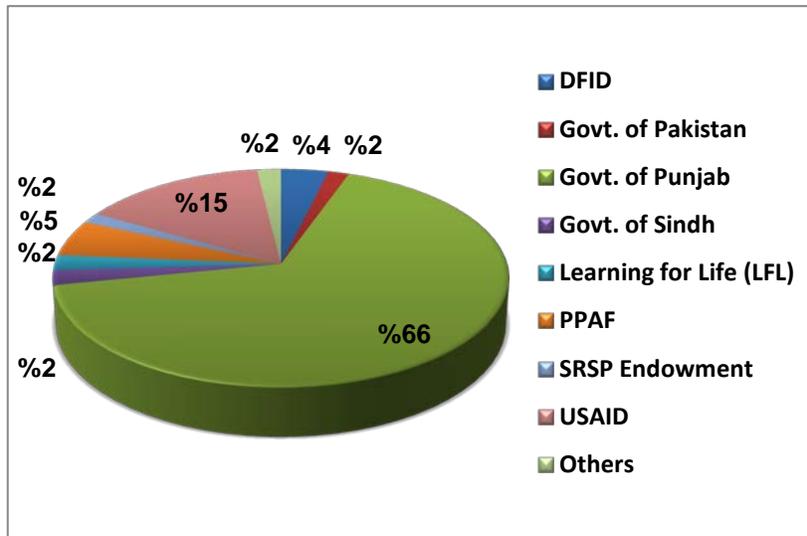


Figure 12

3.4.3 Health

The USAID’s Family Advancement for Life and Health (FALAH) project, which deals with issues of reproductive health, has been a pioneer in the non-formal, public awareness based health sector of Pakistan. The USAID provides an overall 4 percent of total funding in the sector through its flagship project. Adding to this, the EU has been another historical source in the funding of health-related, RSP-managed projects in Pakistan, with 3 percent of total funding in this sector originating from the EU.

Funding through the Punjab provincial government and its donor sources has been exceptionally dominating, according to the data available, with 66 percent of all funding coming through this channel. The PPAF provides 3 percent of total funding for countrywide health projects, making its presence felt in Baluchistan, Punjab and Sindh. The UNICEF contributes an additional 2 percent of funding. Another emerging player for health projects, UNICEF has contributed 2 percent of overall funding in this sector. Other miscellaneous donors have provided 1 percent of overall funding for health sector interventions. Figure 13 is a vivid representation of a skewed trend in funding sources in this sector.

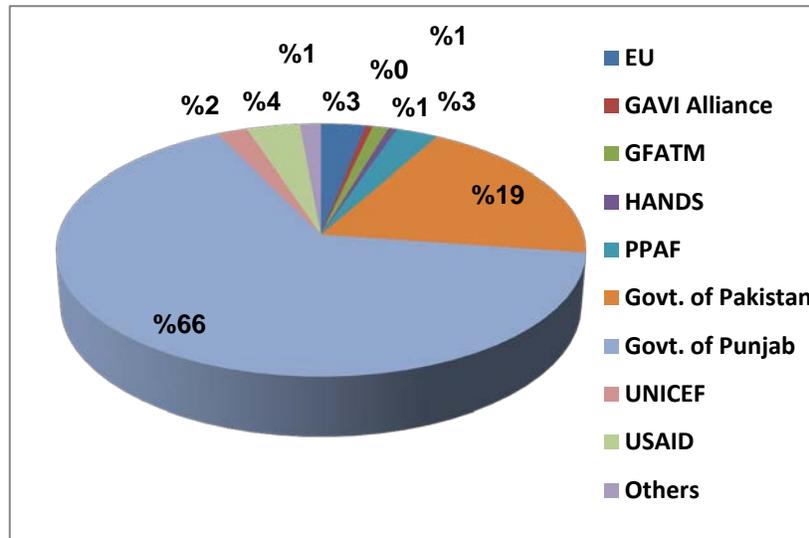


Figure 13

3.5 Component-wise Investment Distribution

This section delves deeper into investments made in the WATSAN, education and health sectors, separating component-wise (sub-sector) funding for each of these sectors and thereby, presenting a compartmentalized and streamlined view of how these sectors have been affected by the RSP's. This avoids generalizing the size of sectors which may couch within them, skewed funding patterns for certain components (such as Adult Literacy Programmes and Early Childhood Development in the education sector, or awareness campaigns in the health sector). Furthermore, understanding the sub-sector funding environment may elucidate the demand of particular services.

3.5.1 Water and Sanitation (WATSAN)

The Water and Sanitation projects being undertaken by, or through RSPs contain various components, which can broadly be divided into sanitation, water supply schemes (WSS), irrigation and multi-purpose schemes (MPS). With an absolute worth of 5558 million rupees, the water and sanitation sector is the largest consumer of national and international funding, as per RSP data. Of this total amount, 1854 million rupees have been spent on sanitation-related schemes (Figure 14). Mega projects have been implemented in Punjab, Khyber-Pukhtunkhwa, AJK and Sindh, supported by the PPAF, German Agro Action, the government of Sindh in collaboration with the Asian Development Bank, as well as various other national and international donors. Nearly matching this is investment for the improvement of water supply and availability of drinking water for the communities, which equals 1614 million rupees.

Projects have been spread out across the four provinces. However, the NAC-AJK, together with the Khyber-Pukhtunkhwa province, has made use of the majority of funding for this component. These are followed by irrigation and multi-purpose schemes (schemes targeting missing facilities in this sector, or reinforcing all or some of the other components), which have availed 881 and 1207 million rupees, respectively. Punjab has utilized the PPAF's extended funding for irrigational development, and cemented this with funds acquired through the provincial government and the ADB. The PPAF has provided massive funding to the WES project in Sindh, targeting Tharparkar, Umerkot, Dadu and Jamshoro districts (over 500 million rupees). Table 1 highlights some projects.

PROJECT	REGION	FUNDS	Yr/ Start	Yr/ End	DONOR
Rehabilitation of Existing Water Supply Scheme and Basic Sanitation)	Bagh (AJK)	Rs. 319 million	2006	2007	German Agro Action
WES Facilities in Flood affected Area	Tharparkar, Umerkot, Dadu, Jamshoro	Rs. 500 million	2007	2010	PPAF
Latrine Construction, Drainage & Drinking Water Supply Schemes	Shikar Pur & Kandh Kot	Rs. 525 million	2009	2010	P&D Dept. Govt. of Sindh
Sustainable Livelihoods in Barani Areas	Rawalpindi, Jhelum, Chakwal, Khushab, Mianwali and Bhakkar	Rs. 164 million	2005	2011	Govt. of Punjab, ADB

Table 1

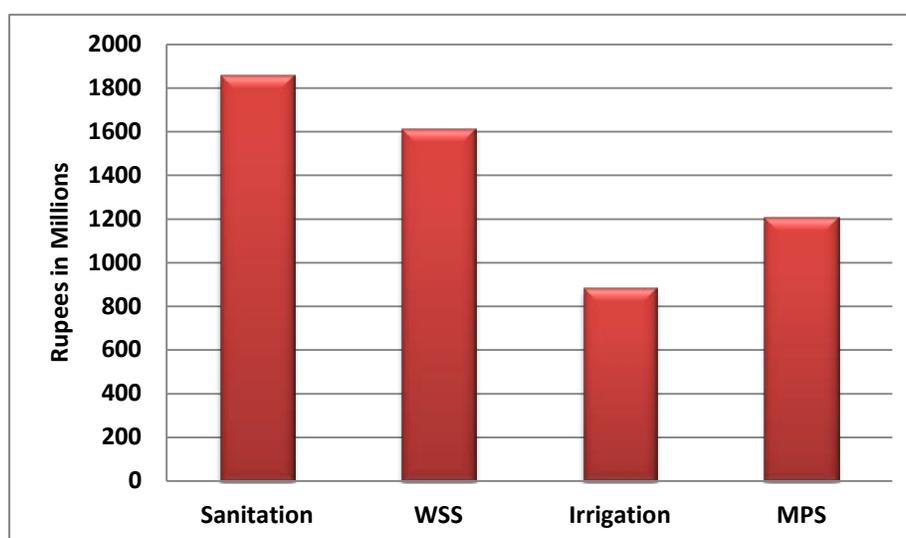


Figure 14

3.5.2 Education

The education sector has been provided with approximately 1955 million rupees of funding by RSPs and their support donors, resources which are utilized in broadly five components: community schools; Adult Literacy Centers (ALC's) and Early Childhood Development (ECD); capacity-building and upgradation; RISE (the project is kept as a separate component due to its wide-ranging operations); and others which include one-off response projects, establishment of endowments and educational innovations. The majority of funding goes towards capacity-building of schools and the upgrading of primary schools into elementary schools, and from this to senior schools, totaling 891 million rupees. NRSP was able to secure valuable funding through the Punjab Education Sector Reform Programme (PESRP), and has utilized those funds for enhancing community school capacity, school status upgradation and revamping of deserted schools. Up till now, 580 million rupees have been allocated to the establishment of community schools, with both Government of Punjab and non-governmental (DFID, UNICEF, LFL) funding. The USAID's RISE project (2006-2010) being implemented in the NAC-AJK and Khyber-Pukhtunkhwa regions has consumed a little less than 300 million rupees and is seen as a success story in educational reform programmes. What is noteworthy, however, is the fact that ALC and ECD programmes have till

this point in time, received low funding worth 14.5 million rupees. This trend can be attributed to the relatively recent emergence of the concept, which has not really matured from its pilot phase.

Other projects include, but are not limited to the Emergency Education Response projects (UNICEF), establishment of endowment funds for schools, PPAF Education Project in Khuzdar and Jhalmagsi (Nov 2009 – June 2010), projects undertaken in Tharparkar and those in the Baltistan (Skardu and Ghanche) region. These take up 192 million rupees of total funding. Figure 15 illustrates varying funding patterns in different components of the education sector, with Table 2 summarizing a few heavyweights.

PROJECT	REGION	FUNDS	Yr/S tart	Yr/ End	DONOR
School Council Capacity Building Programme Phase I	Turbat, Gawadar, Punjgur, Awaran	Rs. 486 million	2005	2008	Punjab Education Sector Reform Programme / World Bank
Revitalizing, Innovating, Strengthening Education (RISE)	Bagh, Muzaffarabad & Rawalakot	Rs. 219 million	2006	2010	USAID
PPAF Education Project	Khuzdar, Jhalmagsi	Rs. 51 million	2010	2010	PPAF

Table 2

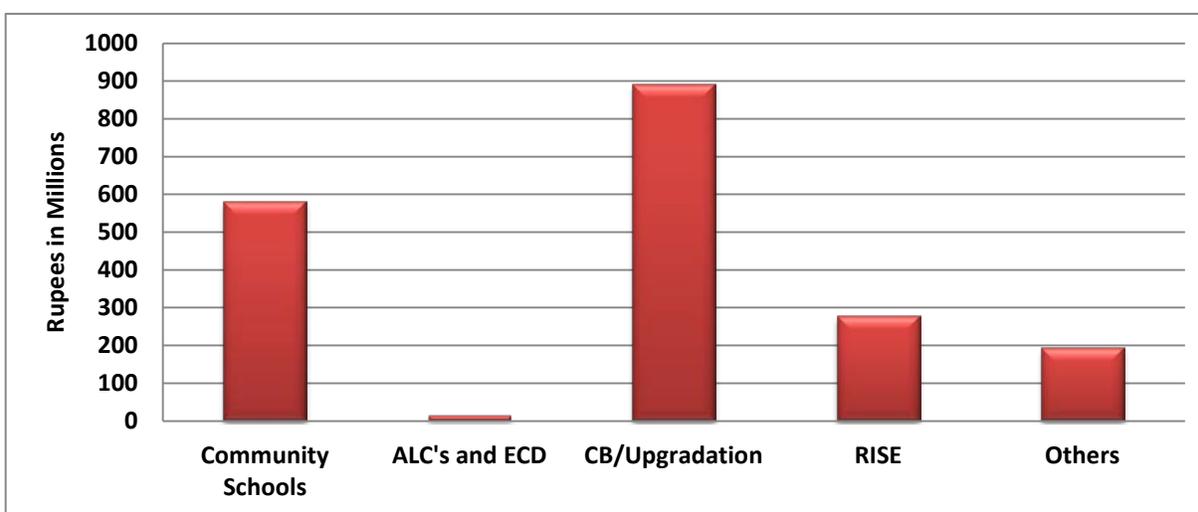


Figure 15

3.5.3 Health

Investments for the augmentation of the health sector flow into six broadly defined groupings, namely: Awareness; Mother and Child Healthcare (MCH); Reproductive Healthcare (RH); Primary Healthcare (PH); Nutrition; and 'Others', which include projects that do not specifically fall under any of the preceding categories (Figure A.4 takes note of these variations). Work done by the RSP's in the health

sector has had the support of funds amounting to 4346 million rupees as of July, 2010. Out of the total funds allocated to this sector, primary healthcare takes the lion's share with a total of 3916 million rupees. Projects in the primary healthcare component of the health sector have attracted projects which have produced positive results, ensuring a perpetuation of its funding sources. These include the President's Primary Healthcare Initiative (PPHI) project (2006-11), the PRIDE (Primary Health Care Revitalization, Integration & Decentralization in Earthquake Affected Areas) project (2007-10) and the Chief Minister's Initiative for Primary Health Care (CMPIHC) project, targeting missing or debilitated health facilities in Baluchistan, Sindh, Khyber-Pukhtunkhwa, Punjab and the NAC-AJK. Other projects have been geared towards mitigating the spread of tuberculosis, malaria, HIV AIDS, together with generating grassroots level awareness for primary healthcare.

Given Pakistan's high fertility rate, and unregulated birth practices, considerable work has been undertaken in the reproductive health component by the RSPs. Absorbing almost 200 million rupees of all funds, the reproductive health component is a driver of grassroots health mobilization strategies, such as those engineered by the USAID FALAH (Family Advancement for Life and Health) project (2007-12) – a movement which targets birth-spacing techniques specifically, and family planning ideals generally. Supplementing the afore-mentioned are projects which receive funding from the EU, the UNFPA and the HANDS PACKARD Foundation. The MARVI (Marginalized Areas Reproductive Health & Family Spacing Viable Initiatives) project (2007-10) is a case in point. Closely related to the RH is the Mother and Child Healthcare (MCH) component, which has individually utilized 124 million rupees in investments. This sector has been driven by multiple donors ranging from the PPAF and the UNICEF, to USAID, GAVI Alliance and TVO. Prominent amongst these have been the Mother and Child Health Care Initiatives (MCHCI) backed by UNICEF, and PAIMAN (Pakistan Initiative of Mothers and Newborns) project (2006-10) funded by the USAID. Table 3 sheds some light on some leading initiatives in this sector.

The three largest consumers of donor funding are followed by the awareness and nutrition components, together with other projects which may be multi-faceted in nature. These components have been provided 12, 18.7 and 75 million rupees respectively, with the PPAF having contributed 60 of the 73 million rupees for its disability-related project in Bagh. Awareness campaigns include medical camps related to skin, eye and limb disorders, together with social marketing of Long Lasting Insecticide Treated Bed Nets (LLINs) and campaigns related to Hepatitis B and C. However, both nutrition and awareness (other than RH which is covered by FALAH) as components have failed to attract substantial funding, and may pose a threat to efforts at entrenching good health practices amongst communities.

PROJECT	REGION	FUNDS	Yr/ Start	Yr/ End	DONOR
MCHCI (Mother and Child Health Care Initiative) Project	Districts Umerkot, Tharparkar and Jamshoro	Rs. 25.3 million	2009	2009	UNICEF
PRIDE (Primary Health Care Revitalization, Integration & Decentralization in Earthquake Affected Areas) Project	District Mansehra	Rs. 66 million	2007	2010	USAID
PPAF-Disability Project	Bagh and Poonch	Rs. 60 million	2007	2010	PPAF
FALAH (Family Advancement for Life and Health) Project	Districts Sanghar, Dadu	Rs. 11.2 million	2008	2012	USAID

Table 3

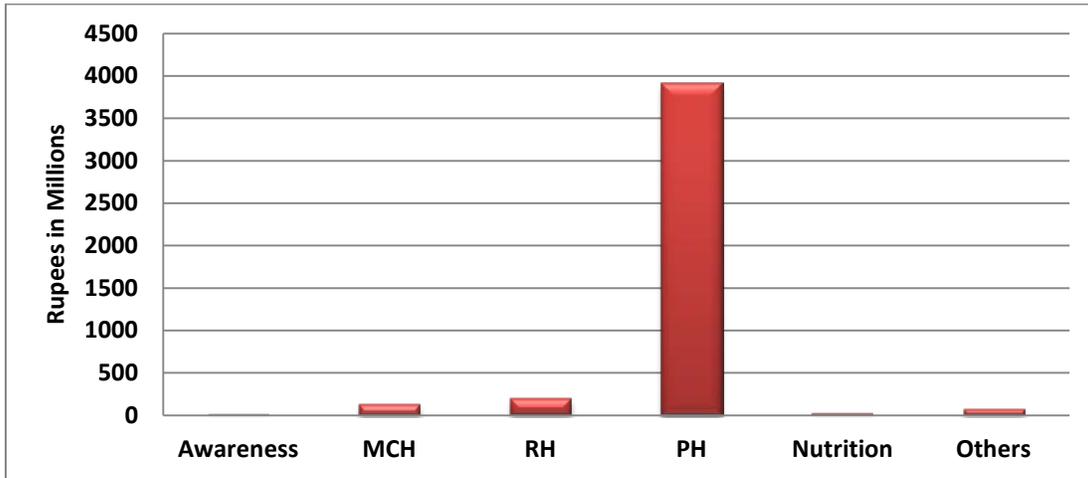


Figure 16

4. Case Studies - Education

4.1 Punjab Education Sector Reform Programme in RYK (NRSP)

4.1.1 Background to the SSI

The NRSP works with multiple partners implementing and initiating large-scale projects in the field of education. The formulation of the Punjab Education Sector Reform Programme (PESRP) gave a major impetus to the sector, injecting much needed interventions which enhanced the availability of schooling services to the citizens of the province generally and the rural classes specifically. PESRP is part of a wider effort at poverty alleviation in Punjab, which is based on 'three pillars' of support:

1. Public finance reforms - to enable the Government to practically spend more on education and pro-poor development.
2. Devolution of power to the district level - to make local councils accountable to local needs.
3. Quality of education - to improve the quality of teaching, schooling and governance of the education system.

Launched in 2003, PESRP-I encouraged the further enrollment of 2.4 million children, increased female enrollment by 2 percent and overall enrollment by 13 percent. The first phase of PESRP concluded in December 2008 with remarkable successes, with the NRSP applying its expertise in 1650 schools across 5 districts in Punjab province and boasting an increase in enrollment rate of up to 11 percent, 8 percent and 3 percent in the first, second and third years of the project respectively. Building upon the success of the first phase, the project was extended for another three years (February 2009 to June 2012), with a revised target of replicating key PESRP-I components across 29 districts and soliciting NRSP assistance in 10 of them. The major components of the project remain the same i.e. social mobilization for effective

School Councils (SCs) and capacity-building of both the SCs and the officials of the District Education Department (DED).²³

4.1.2 Project Design – Data/Facts

In the Rahim Yar Khan (RYK) district, the local arm of NRSP has undertaken the revamping, rejuvenation and rebuilding of 400 schools under PESRP-I. The NRSP and the RYK District Government signed a MoU in 2002 for the provision of Quality Education for All (QEFA). The programme was inspired by the district's pioneering efforts in the education sector, and its inclusive and participatory approach to education service delivery. Under PESRP-I, NRSP was involved in the creation of scores of SCs – community-based bodies undertaking the Operation and Maintenance (O&E) of schools – which have positively affected the running of previously dysfunctional or dilapidated government primary or Masjid Maktab schools.²⁴ This scheme was first implemented in Union Council Rasool Pur, where its success (enrollment rate and number of teachers almost tripled) triggered a flurry of replication across the district in areas such as Union Council Karam Kot and elsewhere under the banners of the National Education Fund (NEF) Project (2004-2010), the Jahangir Khan Tareen/Jamal Din Wali (JKT/JDW) Project (2006-2010) and the JKT/GSM Project (2009-2010). These projects have enhanced the quality of schooling in 19 UCs, directly impacting 129 schools.²⁵

In 2004, seeing the low performance and lack of transparency of other NGOs in the area, the District Government RYK reached out to NRSP to identify sites for Non-Formal Schools (NFS). NRSP marked four abandoned public schools that had failed to convert into formal schools. These schools were subsequently reformed and refurbished as institutions for non-formal education (NFE). Community mobilization and participation are the essence of the non-formal education system. The programmes aim to meet the demands of the local community rather than of central or government planners. As grassroots projects, they are designed not by top policy-makers but by the people themselves.²⁶ The total number of NFSs has now grown to 17, where NRSP has invested in adding a salary component (to control quality) and in improving the school infrastructure with the support of JDW Sugar Mills and PPAF.²⁷

Taking a holistic approach to the education sector, NRSP initiated the Adult Literacy Programme in order to bring into the fold those who were being filtered out of the mainstream channels of education service delivery. Adult Literacy Centers were established after extensive identification of community members who were willing to acquire basic reading, writing and mathematical skills. A lower age limit of 10 years was placed on the participants while no upper limit was sanctioned. This particularly had a positive impact on women who had not been able to receive childhood literacy. In this endeavor, NRSP was provided technical support by the National Commission for Human Development (NCHD) and the Pakistan Education Research and Development (PERD), and financial support by the JDW Sugar Mills.²⁸

²³ National Rural Support Programme. *15th Annual Progress Report 2008-2009 'Including the Vulnerable'*. Islamabad: NRSP, 2009. 36. Print.

²⁴ Monitoring, Evaluation & Research Section, . *Programme Update March 2010*. Islamabad: National Rural Support Programme, 2010. 43. Print.

²⁵ Education – All Projects Report provided by NRSP RYK District

²⁶ http://www.yespakistan.com/education/non-formal_edu.asp

²⁷ Monitoring, Evaluation & Research Section, . *Programme Update March 2010*. Islamabad: National Rural Support Programme, 2010. 43. Print.

²⁸ Monitoring, Evaluation & Research Section. *Programme Update March 2010*. Islamabad: National Rural Support Programme, 2010. 40. Print.

4.1.3 Field Visit Record

The research team conducted extended individual interviews with field staff at NRSP's RYK District Headquarters and with NRSP management at the RYK Regional Office. The field staff included the Education Programme Officer for RYK District, a Male Social Organizer, a Female Social Organizer and a Senior Social Organizer, while the management was represented by the Regional Programme Manager.

The research team conducted field visits in 2 UCs, holding focus group discussions with School Council members, the beneficiary community in Government Masjid-Maktab School (GMMS) Ali Bux Numberdar (UC Rasool Pur), Non-Formal School (NFS) Pacca Munna (UC Rasool Pur), Government Girls Elementary School (GGES) Kotla Hayat (UC Rasool Pur), Government Community Model School (GCMS) Allah Wasaya (UC Akram Abad) and Adult Literacy Centre (ALC) Basti Kumharan (UC Akram Abad). All interviews were conducted by the RSPN research team, with facilitation provided by NRSP officials. The visit was conducted between June 24th and June 27th, 2010.

4.1.4 Views of the Beneficiaries

The SCs for these schools formed the overarching bodies through which the O&M of the respective schools was supervised and upon which the self-sustainability and consequently, the success of NRSP's interventions in the education sector, hinges. In all the facilities visited, the SC was markedly present on time, in line with NRSP's focus on punctuality as a yardstick for measuring qualitative success of these community-based bodies.

NRSP's efforts were widely appreciated by the beneficiary community. Participants frequently pointed toward the physical infrastructure and funding provided by NRSP, and appreciated the awareness campaign that was undertaken. According to Mr. Ahsan Gillani (Head Teacher for GGES Kotla Hayat), "For our community, NRSP has been like a gift from God. This (the intervention) has been a revolution in the field of education." In GMMS Ali Bux Numberdar, since 1990, the community had been attempting to acquire a proper school without success. A makeshift school functioned under an ancient tree close to the now functional facility, where students and teachers alike had to suffer from the heat and dust of the outdoor environment. Based on strong local demand and ownership, in 2005, the NRSP-established CO in the area was handed over a newly constructed school with an SC elected from within the CO in order to make the process participatory.

The SC aided the construction of the building through the provision of 150 trolleys of mud. The SC's organizational structure contains various checks and balances. Transactions on its financial account cannot be made without co-signatures of the chairman and the co-chairman (who is also the head teacher) of the SC. The Council established two teams, one for school maintenance and one for door-to-door campaigning for increasing enrollment, and a third for keeping a check on the working and efficacy of the first two teams. Working with the motto 'Maar Nahi Pyaar' (Love, not Violence), the school provides education up till 5th grade to children from several villages in the region.

SCs established by NRSP follow a similar organizational structure across schools. In NFS Pacca Munna for instance, the Khod Baroj Baradari of the area provided 20 percent of the investment for the revamping of the school in the area. Rafiq Khan (an active member of the community and the president of the local CO) and Shabana (a local teacher) took the lead in the uplift of the school. After being educated in the city, Shabana took the initiative of teaching children of the community in her home, with the aid of her sister. Upon her insistence, together with that of Rafiq Khan, NRSP spent 7-8 lac rupees on establishing the infrastructure for the school which is now comprised of numerous classrooms and a computer center equipped with 6 computer units. Moreover, NRSP currently provides 4 teachers from RYK city. Being a non-formal school, children of 7-14 years of age are educated here, who can then move on to sit their

formal examinations at public and private schools. Recognizing the importance of education in socio-economic mobility, a maid at the school commented: “Had we studied, we too could have been teachers. Now we are getting our girls educated.”

The GGES Kotla Hayat, which is situated 25 kilometers away from Sadiqabad, provides coverage to an area with a radius of 8-10 kilometers, while educating 600 boys and 250 girls. Even though the school formally educates students up till 8th grade, study sessions are also held for up till grade 12th, through which students can receive affordable education and also preparation for formal examinations. Due to a lack of transportation facilities available in the area, it had been difficult for villagers to take their children to public or private schools elsewhere.

Volunteerism has been a key factor in the success of this school, with Muhammad Nazar (an influential community member) having provided 48 canals (worth rupees 60 lac) for the use of this facility. Rasheed Ahmad (teacher at the boys section of the school) is a voluntary member of the SC of the girls’ school, also working for the betterment of female education in the area. This is one of the flagship schools of the NRSP programme, having multiple classrooms, a functioning laboratory and offices for the headmasters and headmistresses. Shazia Firdous (the head teacher for the girls’ school) apprised the research team that the SC collaborates with NRSP in formulating a scheme of study, a work calendar and the syllabus for the school.

The GCMS Allah Wasaya is a Community Model School established by NRSP. The curriculum, level of hygiene, and recreational activities of the school are supposed to exemplify low-cost, quality education for children from backward, rural areas. The school currently has 188 students. Together with the Adult Literacy Center in Basti Kumharan, the two facilities are pioneering models for formal and informal education. These have the potential of transforming the qualitative and quantitative landscape of the education sector in the region.

4.1.5 Voices from the Community: Forging Linkages

In GMMS Ali Bux Numberdar, the SC has been able to establish independent linkages with the government and has requested it to upgrade the status of the masjid-maktab school to a Primary School. This will enable the SC to tap into government resources and receive an additional teacher from the Education Department. NFS Pacca Munna operates under the plan of the government for enrolling children of 7-14 years of age in NFSs. For GGES Kotla Hayat, the Government of Punjab’s cluster, called the Directorate of Staff Development (DSD), conducts training for teachers. The SC in this school has also established linkages with the media, with high profile figures visiting the school to assess its functioning for the purpose of replication.

As per the SM model, the CO is provided with incentives which act as the ‘glue’ for the community, bringing it together for more advanced initiatives. The CO, to which the SC of GMMS Ali Bux Numberdar belongs to, was provided with a turbine, sugar-cane harvest training for increased yields and bio-gas plants, and support from the Prime Minister’s Livestock Initiative. The CO is now making efforts to acquire handicraft schools for women, water channels, metalled roads and filtration plants. It aims to seek support for these efforts from the World Wide Fund for Nature (WWF) and/or UNICEF.

In places where COs may not be present, SCs have been formed through broad-based meetings with the community, as was the case with GGES Kotla Hayat. The Head Master of the school, Syed Ahsan Raza Gillani compares the quality of government schools with the one established with NRSP by calling the former a “normal train” and the latter an “express train”.

At all the sites visited by the research team, tremendous gratitude was expressed toward Mr. Jahangir Tareen (an entrepreneur and politician belonging to the PML-F, and owner of the JDW Sugar Mills). Mr. Tareen has provided funds to multiple education projects in the area and has also been personally visiting these projects and interacting with the local communities.

4.1.6 Managing the Education Interventions: Views of RSP Staff

Basing their work on the principles of the SM approach, NRSP utilizes the support of COs in order to forward their agenda in the education sector. Saadia Samreen, a 27 year old Senior Social Organizer attributes much of the RSP's success to its unique grassroots position in the community. According to her, the CO platform is something that has been found lacking in previous community-based education projects. For PESRP as well as other education-related projects, the CO garners the support of the local community from which members of the SC are drawn. In collaboration with SCs, NRSP has carried out numerous awareness campaigns persuading people to enroll their children in NRSP backed schools. Suhail Shahzad and Saba Zahid (Social Organizers) recall how vehicles, fitted with loudspeakers, moved around neighborhoods publicizing the initiative. Other awareness drives included street-to-street walks, door-to-door visits, puppet shows and advocacy at public forums such as mosques and *deras*.

Saba Zahid explains how the School-Based Action Plan (SCBA) emphasized a participatory approach by enlisting the support of parents and considering this necessary for its success. NRSP management informed that there was not much political resistance to the initiatives, mainly because the feudal system was weaker here as compared to other parts of Pakistan. However, the government was initially apprehensive of the organization's work in the area, perceiving it as a competitor. Initially, there was resistance from the teachers of the target schools, as they felt that their interests had been threatened. To be sure, there were instances of teachers preventing access to NRSP officials by locking the entrance to the schools. Subsequently, confidence-building measures were taken by NRSP, which included introducing the Deputy Education Officers (DEOs) to the project design of these schools. The staff at these schools was provided training from multiple sources, including RSPN and NRSP-IRM (Institute of Rural Management).

Mr. Amjad Iqbal Khan (Regional Programme Manager NRSP) provided valuable insights to the research team regarding the working of NRSP in the education sector, the maturing of COs into LSOs, and the collaboration of NRSP with other NGOs. According to him, "it is holistic decision-making and teamwork that contributes to meeting the targets of the multiple projects in the area. By providing the community with schemes involving lift irrigation, paved streets, drinking water, bio-gas plants and micro-credit, NRSP builds its credibility amongst the host community."

4.1.7 Sustainability and Future Prospects

The education programmes being undertaken by NRSP, in collaboration with multiple stakeholders, have huge replication potential. In the RYK district, the success of the QEFA project precluded a range of other education projects, which included the NEF project, the JKT/JDW Sugar Mills project and the JKT/GSM project. PPAF supported the efforts and PESRP-I and PESRP-II provided the overall development paradigm. This experience of a number of successful community-based education delivery projects is an encouraging sign for their replicability in other parts of Pakistan.

There still exist challenges to education reforms. Political resistance, which has not been strong in RYK district, may be more intense in other regions of Pakistan. The capacity building of government staff is a necessary condition for achieving substantial growth in the education sector. However, what is most important for NGOs is the elimination of overlapping projects of different agencies such as the NCHD, UNICEF and NRSP etc. Furthermore, donor money needs to be spent more efficiently in areas where

funding sources may be limited – an aspect that had been taken care of in RYK through responsible and prioritized use of funding provided by the JDW Sugar Mills.

Even though most PESRP operated schools were functioning initially, many have started slipping into patterns involving inefficiency and the lack of motivation. It is therefore imperative that a consistent mechanism for performance assessment be put in place in order to maintain the achieved basic standard. The preparation of a Teaching Manual and the QEFA curriculum by NRSP RYK in collaboration with 4 other districts is a benchmark for excellence, an effort which needs to be replicated elsewhere.

The awareness campaign that was charted by NRSP is one of the most replicable aspects of the initiative. However, the trade-off between the earning potential of children and education may be too high in poorer regions to allow organizations to affect enrollment rates in schools. In some places, local communities show more vigor and active participation while in others, this kind of participation is hampered by various socio-economic, cultural and political factors. The RSPs need to revisit and tailor their SM approach and its basic assumptions.

NRSP has been innovative. In RYK, NRSP conducted a milk-provision programme in collaboration with PPAF and Tetra Pak in 50 PPAF-supported schools. Such incentives are essential for creating awareness about the importance of education in communities.²⁹ The future of our youth depends on the quality of education that they are provided with. The NRSP motto is equality for all children. As a Social Organizer commented:

“Just as a village boy will not know much about spaceships and submarines, similarly, a city boy will not know most things about agriculture, farming and the tilling of land. What different segments of society and especially the youth lack in this country is exposure.”

4.2 Revitalizing, Innovating, Strengthening Education (RISE) Project

4.2.1 Background to the SSI

The Revitalizing, Innovating, Strengthening Education (RISE) project is grounded in the belief that a comprehensive system of support for communities, teachers and educational officials can substantially improve the quality of classroom instruction and student learning. RISE has operated in the districts of Mansehra in KPK, Bagh, Muzaffarabad and Poonch in Azad Jammu and Kashmir (AJK). To date, RISE has trained 139 education managers in at least four of six key education management themes in all four districts. The six themes are: planning and development, financial and personnel management, school supervision and instructional support, community participation and SMC/Parent-Teacher Council (PTC) mobilization, teacher training, and data-driven decision making.

4.2.2 Project Design – Data/Facts

In total, 10,299 primary, middle and high school teachers received training in the use of active-learning methods linked to the content areas of English, mathematics and science. RISE has helped communities revitalize 2300 SMCs/PTCs, trained over 18500 SMC/PTC members and honorary members, and provided ongoing technical support and peer learning opportunities to the SMCs/PTCs. Out of 1146

²⁹ Monitoring, Evaluation & Research Section, . *Programme Update March 2010*. Islamabad: National Rural Support Programme, 2010. 46-47. Print.

SMCs/PTCs selected for RISE's small grants program, RISE has disbursed the first installment to 1134 of these and the second installment to 1093.³⁰

As part of RISE's initiative to sustain its achievements in teacher training, the staff identified the need to foster key stakeholders, and deepened understanding of RISE's work in teacher professional development and the strategies that they can employ to sustain these initiatives. Between October and December 2009, RISE's Mansehra team, at the request of the Directorate of Curriculum and Teacher Education, trained 56 instructors from 15 out of the 21 Regional Institutes for Teacher Education in KPK in active-learning techniques in math, science and English. The education departments and RISE-trained master trainers continued the work that RISE had started. This is evident through activities like the joint initiatives by district education officials and master trainers to conduct short trainings based on RISE materials for teachers who did not receive training from RISE.

In 2009, the International Book Bank, Baltimore, Maryland donated about 70,000 teachers' guides and other resource books and children's books for distribution in four RISE target districts. Between October and December 2009, RISE delivered the books to 478 schools, 75 learning resource centres and 12 other educational institutions in the districts. In its community development component, RISE focused on the achievement of gender parity in SMCs in AJK through the training of honorary and new SMC members, completion of small grants projects, the progress of SMCs/PTCs into self-sustaining groups, and community awareness raising activities. For monitoring and evaluation the project carried out two longitudinal studies. For the teacher absenteeism study, RISE-trained SMC/PTC members recorded teachers' attendance for a period of one week in October/November 2009. As part of RISE's second longitudinal study on student assessment and teacher classroom behavior, RISE-trained government officials and university students observed teachers in the classroom and tested 4th and 8th grade students in English, math and science.³¹

4.2.3 Feedback – GPS Shoal Najaf Khan (a case in point)

Government Primary School Shoal Najaf Khan is situated in a remote and hilly area of North West Frontier Province in northern Pakistan. After the earthquake of October 2005, the students and teachers were in a state of despair, looking for both short- and long-term help to rebuild what the earthquake had destroyed.

This school's journey to becoming a model school started with its teachers' participation in RISE teacher training workshops, where they learned to use childcentered teaching methodology that actively involved students in learning. The use of these new methods attracted the attention of students and parents alike. Students were excited by what they were learning and parents came to observe what was happening with their own eyes. The school enrollment increased by 40 percent during the academic year, as more parents wanted their children to benefit from this approach and the work of the PTC gained momentum. The effective teaching, student involvement and parental support helped the school in winning first prize in the district-level "Subh-e-Nau," which was a science competition. "I learned to use no-cost/low-cost material to teach the basic concepts of science to students. It is because of the RISE training that we won the Subh-e-Nau competition," stated a teacher at the school.

"My school secured first position in the District Subh-e-Nau, and RISE selected it as a model school," said Abdul Manan, the headmaster. The school has now become the center of RISE teacher training activity. The teachers are so impressed by RISE's contribution that they have opened their building for RISE training to other teachers of the area. The headmaster of the school says, "We made it this far

³⁰ Butt, Dr. Naeem Sohail. *Revitalizing, Innovating, Strengthening Education (RISE)*. QR#14: October to December 2009. Islamabad: USAID, 2010. Print.

³¹ Ibid.

because of the efforts made by RISE staff. We want other teachers of the area to also benefit from this training facility.”³²

4.2.4 An Overview

The United States Agency for International Development (USAID) completed projects worth \$23 million in earthquake-affected areas of AJK and KPK. In earthquake-stricken districts, more than 10,000 primary, middle and high school teachers were trained to use student-centered and active learning methods in English, mathematics and science. In addition, 65 learning resource centers were established and 2300 SMCs were formed to involve the local community for a dynamic role in running the schools. Over 18,900 SMC members received training to help them turn SMCs into self-sustaining entities. Over 1,000 SMCs have presented 180 theatre performances and 34 puppet shows to raise awareness regarding educational issues. Small grants were also provided to 688 SMCs for strengthening and improving the running of the schools. Apart from this, 139 education managers and over 30 education management information system staffers significantly improved their skills in their respective areas under the RISE projects.

5. Case Studies – Health

5.1 Family Advancement for Life And Health (FALAH) Project in Dadu (TRDP)

5.1.1 Background to SSI

In February 2008, the Population Council of Pakistan launched a new family planning project targeting vulnerable districts across Pakistan.³³ FALAH, or Family Advancement for Life and Health is a USAID funded 5-year project functioning in the area of reproductive health and family planning. Specifically, FALAH focuses on enhancing the practice of birth spacing as recommended by the World Health Organization (WHO) under the guidelines of ‘Healthy Timing and Spacing of Pregnancies (HTSP) so as to improve the health of mothers and children and minimize pregnancy-related complications. By tapping into the potential of the lead partner (Population Council Pakistan) and a consortium consisting of a number of national and international implementing and technical partners, the project is being implemented in 26 districts across the four provinces of Pakistan. The major collaborating partners and institutions are the project consortium partners (Population Council, Jhpiego, Greenstar Social Marketing, HANDS, Mercy Corps, RSPN and Save the Children USA), the Ministry of Population Welfare, the Ministry of Health, the four Provincial Departments of Population Welfare and Health, the executive district officers (EDOs) for Health and Population Welfare in the 26 Districts, and the external partners of FALAH including PAIMAN, TACMIL, UNICEF, UNFPA and the donor, USAID.³⁴

The project’s primary target group is Married Women of Reproductive Age (MWRA) and their husbands, with the secondary target group being health and family planning service providers in the public and

³² Adapted from Brush, Dr. Lorelei R. *Revitalizing, Innovating, Strengthening Education (RISE)*. QR#8: April to June 2008. Islamabad: USAID, 2008. Print.

³³ Council, Population. "Pakistan Overview." Population Council, n.d. Web. 8 Jul 2010. <<http://www.popcouncil.org/countries/pakistan.asp>>.

³⁴ USAID, . "Project Overview." *FALAH*. Population Council, n.d. Web. 8 Jul 2010. <<http://falah.org.pk/app/aboutfalah/overview.aspx>>.

private sectors. Its tertiary target group comprises of influential members at the community level, including senior family members, religious leaders, elected officials and media representatives.³⁵

5.1.2 Project Design – Data/Facts

For this project, RSPN provided support in 16 districts. With a population of 1.1 million, Dadu is one of the more underdeveloped areas of Sindh. Situated on the province’s western fringe, bordering Baluchistan, Dadu is connected by road and rail links to more concentrated urban cities such as Hyderabad and Karachi. 79 percent of Dadu district’s population is settled in rural areas. Forming the tail end of the Indus River system, these rural areas have been directly hit by the reduced supply of water in the last few years. There are a total of 349 villages scattered across the 52 Union Councils that constitute Dadu district.³⁶

The Thardeep Rural Development Programme (TRDP) operates in 34 of the 52 UCs of the district. TRDP has achieved relative success in employing the SM methodology for implementing FALAH in the region. This was illustrated by a qualitative Pre & Post Test Analysis conducted by the organization both before the execution of the project and midway through its implementation (between January and March 2010). Using 895 MWRAs, TRDP used test questions, the responses to which were compared before and after project implementation. The following table provides percentage changes in the responses (from Yes to No), showcasing the impact of the campaign.³⁷

S#		Percent Change
1	Family Planning (khandani Mansobabandi & birth spacing (Waqfa) are the same thing	87.70949721
2	A Couple Should continue to use contraceptive at least for 2 years after their last child birth	78.2122905
3	Pregnancy before 18 years for women is safe and should be encouraged	96.64804469
4	Most side effects with the use of pills & injections are temporary and not harmful	91.50837989
5	Husband and wives should avoid discussing sensitive issues such as birth spacing	-33.51955307
6	Birth spacing is permitted in Islam	89.72067039

Table 4

5.1.3 Field visit record

In addition to conducting extensive interviews and group discussions with the management and field staff (including District Programme Officers, the DPO M&E, Social Organizers and the Female Community Mobilizer Officer) at TRDP’s District Headquarters, the research team conducted field visits in three Union Councils.

Focus group discussions and individual interviews were conducted with leaders and members of the beneficiary communities in village Gul Bung, Union Council Gozo Taluka Khairpur Nathanshah, village Dittal Babar Union Council Kanday Chukhi Taluka Khairpur Nathanshah and village Kario Mitho Zangeo Union Council Burira Taluka Khairpur Nathanshah, Dadu District. This assignment was

³⁵ *Social Mobilization Strategy*. Islamabad: USAID FALAH, 2009. 1. Print.

³⁶ "FALAH Districts." USAID FALAH, n.d. Web. 8 Jul 2010. <<http://www.falah.org.pk/app/aboutfalah/pm.aspx>>.

³⁷ Pre & post Awareness Assessment Analysis MWRA, TRDP Dadu

undertaken between the 9th and 12th of July, 2010. TRDP's local assets were used to conduct interviews with female members of the community.

5.1.4 Views of the beneficiaries

In Dadu, TRDP had already been operating through COs providing services such as micro-credit, community physical infrastructure (CPI) and other pro-poor interventions. Community members were enthusiastic about the impact of FALAH and praised the diligence of TRDP staff. Most individuals noted that it was ignorance, more than rejection of ideas of birth spacing that had previously inhibited their communities from family planning in a responsible manner.

Villagers from Dittal Babar and Gozo said that many in their area, particularly religious leaders, opposed the family planning efforts of TRDP on religious grounds. The RSP through dialogue was able to convince them that the programme was not in contravention of religious injunctions. In Dittal Babar, the mosque Imam of Dadu, with the support of the local Imam, endorsed the workings of FALAH and encouraged the community to seek services provided by TRDP. According to Abdur Razzak, a village activist, "people were against government family planning schemes; various myths existed. However, once things were explained to them, people realized the importance of birth spacing and how to manage it."

Governmental efforts in these areas have been found lacking. In Village Gozo, no official work on birth spacing existed before the FALAH project. In Village Kario Mitho Zangeo, the only governmental intervention for health was through the anti-polio campaign. Acknowledging the importance of polio vaccination, the villagers resent the fact that other than that no effort has been made by the government to support health and family planning issues in the area. Basic Health Units (BHUs) are generally located 2-3 kilometers away from these villages. Furthermore, the quality and availability of services at these BHUs has not been reliable. However, there has been a marked improvement in the services provided by BHUs, especially in the quality of female doctors in the context of the President's Primary Healthcare Initiative (PPHI).

Ayaz Ali of village Gul Bung attended FALAH's introductory sessions because of his trust in TRDP, which had earlier provided him with micro-credit for livestock. Similarly, Yar Muhammad appreciated the low mark up being charged on these loans, which he had utilized for enhancing agricultural yields. In Village Kario Mitho Zangeo, Mushtaq Ali was impressed by the credit ventures established through TRDP-given loans. Having gained confidence in the organization's zeal for development in the area after its relief efforts in the wake of the floods in the region, he thought it wise to seek information on FALAH. Participants responded positively to queries about their level of independence from the RSP. Ayaz Ali commented optimistically: "TRDP has shown us the way. Now we can walk."

The research team sought information on the villagers' understanding of social mobilization. It was found that there was a general understanding of the concept, with varying responses such as "collective good", "collection and dissemination of knowledge", "seeking welfare and happiness", and "understanding the problems of the community through consultation and resolving them through dialogue in a participatory and inclusive way."

5.1.5 Views of RSP staff

Working assiduously to meet set targets, the TRDP staff prides itself on making an institutional impact on the communities that it works with under the banner of FALAH. TRDP's office in Dadu is well-equipped for reproductive health (RH) awareness campaigns. Orientation and Training Weeks (OTWs), Training of Trainers (TOTs) and training in Social Mobilization approaches are designed and implemented to upgrade

the skills of the staff located at the TRDP regional office in Dadu. These staffers put in 8-10 hours of field work per day. RSPN has been a key player in this regard, providing direct support for FALAH and the Community Led Total Sanitation project (CLTS), and holding quarterly annual meetings for capacity building.

The recent spate of violence in Dadu district has prevented these teams from performing optimally. However, as District Programme Officer Shabana Buriro and Social Organizer Majid Chandio explained, the motivation and drive in the team to assist in the uplift of the communities they work with has kept the work going in the best possible way under the given circumstances.

SM is the core principle around which staff activities revolve. This platform had already been established by TRDP in the area, and so, it was easier for it to implement the FALAH project, said Female Community Mobilisation Officer Benazir Baloch. Imran Bhand, another staff person, highlighted TRDP's achievements in organizing 800 villages, in 34 out of the 52 UCs in Dadu district.

5.1.6 Challenges

TRDP has faced multiple challenges in implementing FALAH. These have been: existing gender relations, social/religious concerns, and lack of knowledge.

Gender relations entail the lack of social and economic independence of women in rural settings, together with a dearth of communication between the husband and wife – something which is imperative for decision-making regarding issues of collective concern.

Social and religious concerns have traditionally vilified efforts at family planning in these communities. However, these have been tackled well by FALAH's strategy and TRDP's efforts at reaching out to religious leaders within communities. The fact that the moderate Sufi culture is prevalent in the region has helped in dealing with social and religious taboos.

Earlier, efforts at family planning had not provided adequate information especially relevant to dispelling the myths about side-effects associated with services provided by FALAH. Women were scared of their systems responding negatively when using hormonal methods of birth control. It is usual to feel suspicious of new things and the culture of spreading rumors is common in closely-knit rural communities. In order to counter this phenomenon, TRDP has maintained a structured and consistent level of communication with the communities.

5.1.7 Sustainability and Future Prospects

The time constraint on such projects (FALAH was endorsed for 5 years) places pressure on implementing bodies to maintain and sustain the benefits of the project after their completion. The social mobilization spurred by TRDP needs to internalize efforts for RH awareness service delivery.

Other interventions which lend credence to COs become important for their continued functioning. Information about birth spacing requires more awareness-generation methods and less technical tools and skills and therefore, has the potential of being passed down from generation to generation.

Expansion in the coverage of projects like FALAH would directly affect the health sector while greater investment in social mobilization would have an indirect impact on it. At the same time, the government, together with the donors, needs to make medicines and equipment for RH readily available at BHUs so as to build upon the successes of such one-off projects.

5.2 Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE)

5.2.1 Background to SSI

On October 8, 2005, residents of northern Pakistan were shaken by a 7.6 magnitude earthquake that would claim more than 74,000 lives and leave some 3.5 million people homeless. The earthquake took the lives of 16,000 people in the Mansehra District of KPK and 7,500 people in the Bagh District AJK. Thousands of teachers, health care providers and civil servants were among those killed or badly injured. Public systems that supported essential services, including logistics and administration for health care, no longer existed. In response to this disaster, USAID/Pakistan designed the Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE) Project and awarded a \$28.5 million cooperative agreement to the International Rescue Committee (IRC), a US-based NGO, to provide technical support to the public sector health system in Mansehra and Bagh districts.³⁸

PRIDE's mandate was the health component of USAID's reconstruction and revitalization program. It has been implemented by a consortium headed by the IRC with international partners including Management Sciences for Health (MSH) and JHPIEGO, an affiliate of Johns Hopkins University and the Population Council.³⁹ **In the two years after the earthquake, more children between the ages of 0 and 5 years died in Mansehra and Bagh from preventable causes than were killed in the earthquake.** Each year in these two districts, approximately 1500 babies die within 24 hours of birth and 2100 newborns die within the first month. Each year, 6000 children (99 per 1000 live births, according to PRIDE) do not live till their fifth birthday.⁴⁰

5.2.2 Project Design – Data/Facts

The project has three main goals: (1) improving the performance of public health services and management systems, (2) improving access to and quality of PHC services, and (3) promoting healthier behaviors and institutionalizing community participation in health services. The project started on August 15, 2006 for a 4-year period. As of September 30, 2009, the project had received \$18.2 million and had disbursed \$17 million.⁴¹

The project has contributed to improvement in the quality of PHC services. The following project activities contributed to improving the quality of PHC services:

1. Implementing a standards-based management and recognition approach, which sets and implements standards, measures progress and rewards achievement. This activity helped improve the quality of health care in 89 of 126 PHC facilities, covering 14 performance areas.
2. Developing guidelines for a performance improvement process for public health facilities. These guidelines were then used by health facility managers and staff in 121 project health facilities. In applying these guidelines, 11 priority health problems were identified (e.g., pneumonia and tuberculosis), with subsequent corrective actions focusing on these problems at the health care facility level.

³⁸ Murphy, William S. (2010). *Audit of usaid/pakistan's pride project*. Manila: Office of Inspector General, USAID.

³⁹ Rasmussen, Bruce, Pamela Ledbetter, and Tanvir Malik. *PRiDE Project Annual Report 2007*. Islamabad: USAID, 2007. Print.

⁴⁰ Rasmussen, Bruce, Pamela Ledbetter, and Tanvir Malik. *PRiDE Project Annual Report 2007*. Islamabad: USAID, 2007. Print.

⁴¹ Murphy, William S. (2010). *Audit of usaid/pakistan's pride project*. Manila: Office of Inspector General, USAID.

3. Establishing 113 health management committees at BHUs and rural health centers (RHCs) to bring together community representatives, local government representatives, and health care providers in order to develop guidelines for ensuring improved health care services. By the end of September 2009, committees had used project-developed guidelines to approve 35 grant proposals funded at \$268,889. These grants funded local infrastructure improvements such as schemes to supply clean drinking water, roads leading to health facilities, and health facility renovations.
4. Renovating local drug storage facilities and mentoring drug facility staff on managing these facilities. This activity upgraded infrastructure at 58 of the 88 targeted health facilities, mentored facility staff on drug supply management, and developed a list of essential drugs and procurement protocols for managing the drug supply rationally and within existing budgets.
5. Conducting training, mentoring, and workshops on various clinical and operational matters, contributing to an improvement in the quality of PHC.

5.2.3 Feedback

‘Despite relative economic prosperity our country still has frightening levels of maternal and infant mortality... There is a clear need of not only improved health infrastructure but also for improved health systems and for such care to be sustainable... The PRIDE project rightly envisions a revitalized PHC program providing affordable, sustainable, replicable and quality health services...’

(Ali Muhammad Jan Orakzai, Governor, NWFP on the occasion of launching PRIDE in Manshehra district)

5.2.4 Challenges

While the project showed success in improving PHC quality, much work remains to be done regarding improving access to these services—particularly with regard to referral beyond PHC. To promote wider access to such services, the project had planned to strengthen the patient referral system. However, the preliminary planning for improving the referral system was completed a year later than anticipated, and the implementation of an improved referral system is still underway. Implementation was delayed because Government staff scheduled to work with the project implementer were not available when needed. Also, other project activities took precedence over revamping the patient referral system.

5.2.5 Highlights of the Programme’s Success

A. Implementing a standards-based management and recognition approach to use when performing health care services.

After implementing the project’s approach in 89 of 126 PHC facilities— covering 14 performance areas in two phases (30 facilities in the first phase and 59 facilities in the second phase) – performance of management and health care providers has significantly improved. For the first group of 30 facilities, which began measuring performance in June 2007 through March 2009, the quality of PHC services increased from a combined baseline score of 14 percent of standards achieved to 56 percent achieved in performance areas such as physical resources, infection prevention, focused antenatal care, family planning, child immunization, integrated management of newborn and child illness, malaria and tuberculosis. For the second group, which began measuring performance 1 year later in June 2008 through to March 2009, the quality of PHC services increased from a combined baseline score of 7 percent of standards achieved to 30 percent achieved in the same performance areas.

B. Developing guidelines for a process to improve performance at public health facilities.

The project developed guidelines for a process to improve performance at public health facilities. The process would help PHC facility managers assemble information, analyze the current service operations, select priority health problems to address, and choose and plan interventions for improving the performance of health services. In applying these guidelines, 11 priority health problems were identified (e.g., pneumonia and tuberculosis), and subsequent corrective actions focused on these problems at the health care facility level. Also, as part of the improvement process, health facility managers identified six constraints to addressing these problems, which the project then addressed.

C. Establishing health management committees and developing guidelines for them to improve local health care services.

The project established 113 health management committees for BHUs and RHCs to bring together community representatives, local government officials and health care providers. The project also developed guidelines for these committees to improve health care services in their facilities. Most of the committees had obtained legal status, enabling them to open bank accounts to manage small project grants of up to \$10,000 per committee. This grant program helped build the capacity of the committees to manage local health-related improvement projects. For example, at the Khawari RHC in Mansehra, the committee's influence and its ability to manage its own funds helped solve staffing shortages and water and electrical supply problems. The Khawari committee had participated in proposal writing and project management training that enabled the center to receive a grant from the project. In addition, the committee raised funds to make improvements. These improvements, along with added staff, helped increase the number of outpatients using services at the center from 568 per month in 2008 to 835 per month in 2009.

D. Renovating drug storage facilities and mentoring facility staff.

The project renovated drug storage facilities for storing and dispensing drugs and mentored facility staff on drug supply management, storage and dispensing practices. The drug management infrastructure was upgraded in 58 of the 88 targeted health facilities. The remaining facilities are scheduled to be completed during the rest of the agreement period. Furthermore, the government of AJK officially adopted a project-developed essential drug list and procurement protocols to guide them in managing the drug supply more rationally and within the existing budgets. To oversee drug management, the project also established pharmacy and therapeutic committees in AJK.⁴²

5.3 Marginalized Areas Reproductive Health & Family Planning Viable Initiative (MARVI) – District Umerkot (TRDP & HANDS)

5.3.1 Background to the SSI

In 2007, TRDP collaborated with Health and Nutrition Development Society (HANDS), a non-profit organization, for the implementation of the MARVI project in District Umerkot. Funding for this project was provided by the David and Lucile Packard Foundation. MARVI envisages an integration of reproductive health (RH), family planning (FP), microfinance, social marketing and social mobilization services through a well trained and dedicated cadre of women activists (MARVI workers) belonging to the local communities.

⁴² Murphy, William S. (2010). *Audit of usaid/pakistan's pride project*. Manila: Office of Inspector General, USAID.

5.3.2 Project Design

Essentially, the program revolves around the MARVI workers who are trained as community health workers (CHWs). They then mobilize women from the target groups for articulating their collective voice. The CHWs are also responsible for training one local traditional birth attendant (TBA) per village to use the safe delivery kit in each of the 375 villages which are deprived of the services of a lady health worker (LHW). These organized groups are then linked with microfinance products such as micro credit and micro insurance. Simultaneously, health services focusing on RH and FP are provided, and the help of the state as well as that of private sector providers is also sought for this purpose.

Moreover, FP camps and training workshops are organized and social marketing activities, covering health products and RH services, are undertaken. The project also makes provision for primary education services and activities for children.

5.3.3 Key outputs and impact

Local communities have been socially mobilized in 400 villages of the 27 UCs of district Umerkot for the purpose of improving their RH and FP status through an integrated programme of social uplift. CHWs are being trained by the project, which will constitute a crucial human resource base for RH and FP services in this remote, underdeveloped and underserved part of Pakistan. A large number of villages in the district are deprived even of the services of LHWs, and this project aims to fill this gap.

The project is designed to combine the efforts of private sector health providers as well as public sector health practitioners for targeting communities, which are not covered by ordinary service delivery networks. Following the formation of women groups and women assemblies, there is also a strong element of capacity building and training. The project has trained 350 community health workers and an equal number of Traditional Birth Attendants. In Mithi District Headquarter Hospital, a gynecologist has been hired. Health insurance has been set up for those falling in the reproductive age bracket.

5.3.4 Sustainability and Future Prospects

The only challenge appears to be the unclear linkage with government service providers of facilities. If this component is also accounted for in the program design, its effectiveness can be substantially enhanced.

5.4 Public-Private Partnership for the Establishment of Thalassemia Care Center in Badin (RSPN, District Government, Badin, USAID and private sector) – Since 2004

5.4.1 Background to the SSI

Badin district suffers from limited access to health facilities. In recent years, the number of Thalassemia patients in Badin and neighboring districts, has increased considerably.⁴³ However, a large number were deprived of treatment as the only facility existed in Karachi, which most could not access, primarily due to prohibitive costs. It was in response to these conditions that the Thalassemia Care Center was set up in 2005 in Badin.

⁴³ There are more than 65,000 Thalassemia patients in Pakistan; approximately 20,000 are in the province of Sindh including 350 in Badin.

The center aims to provide affordable treatment for Thalassemia (barring the cost of travel, treatment is free) and to spread awareness regarding the causes of Thalassemia, and to, thereby, reduce its occurrence. The establishment and running of this center provides an innovative model of government, civil society and private sector collaboration. Initially, this cause was taken up by a local doctor, who networked with Husaini Blood Bank, the local government, community members, NGOs, and other doctors and philanthropists for this purpose.

5.4.2 Project Design

In 2004, the district government applied for and received funding from the USAID Grant for Rewarding Innovations at the District Level, managed by the RSPN. With the help of this funding, the Thalassemia Care Center was constructed in Badin. The district government partnered with a Citizens Community Board (CCB), seven of whose members were doctors experienced in treating Thalassemia, and with Mirza Sugar Mills Ltd, owned by the *Naib Nazim's* family. Moreover, the district government provided 1200 sq. ft land to the CCB on lease for the construction of the Center. RSPN supported the project by providing Rs. 16 million, facilitating the proposal development phase, and by putting in place a sound monitoring mechanism. The distribution of cost is shown in Text Box 1.

5.4.3 Sustainability and Future Prospects

The activity enabled local governments to employ instruments of social mobilization by providing them with an effective model. It allowed them to achieve critical outcomes which would not have been possible inside existing systems of governance. The only missing area and linkage in this initiative appears to be the less than expected success in securing commitment for resources from private or institutional philanthropies. This could prove to be a major challenge for a local government-RSP joint venture where financial sustainability of an initiative in the long term could become unpredictable.

Text Box 1: Division of costs for the construction of the Thalassemia Care Center, Badin	
Financial Contribution	
District Government	Rs. 1,209,760 (25% of total cost as per contract regulation)
CCB	Rs. 297,440
Private Firm	Rs. 500,000
USAID	Rs. 2,800,000
Total Cost	Rs. 4,807,200

Source: Case Study: Thalassaemia Care Unit – Badin

5.5 Community-Based Mother & Child Health Care Initiative (CBMCHCI) – (RSPN, SRSO, NRSP, PRSP, TRDP, SGA, UNICEF and provincial governments) – Since 2009

5.5.1 Background to the SSI

Pakistan's Infant Mortality Rate (IMR) at 65.14 per 100,000 live births is the highest in South Asia. The Maternal Mortality Rate (MMR) at 276 per 100,000 live births is also very high. The CBMCHCI was developed jointly by RSPN and UNICEF in 2009, as part of their goal to build a community based model for introducing integrated health interventions in remote rural areas. The conduit for such interventions is community resource persons (CRPs) trained in various Mother and Child Health (MCH) services.

5.5.2 Project Design

Following groups are targeted for the various health interventions: married couples for FP; children between the ages 2-5 for de-worming; children between the ages 0-2 for immunization; and pregnant women as well as men and women between ages 15-19 for RH interventions. The project is a result of collaboration between the RSPs and the government, particularly the health department. The government health departments at the provincial and local level including the basic health units (BHUs) and the lady health visitors (LHVs) are involved in the implementation of the project. The health department provides personnel and infrastructure for the provision of services and outreach. The RSPs and UNICEF provide social mobilization, training, equipment and financial assistance.

5.5.3 Key outputs and impact

The project has some remarkable achievements in terms of training of personnel and provision of MCH services. By 2009, 8416 Community Resource Persons (CRPs) had been identified (4208 women & 4208 men) in 129 UCs of 12 districts and 7,867 have been trained. 27 Social Mobilization Teams (SMTs) each for men and women and 1866 Health Groups had been formed. 149,110 children in Sindh and 31,374 in Punjab were immunized; 135,690 children in Sindh and 49,052 in Punjab were de-wormed; and tetanus toxoid injections were administered to 37,129 pregnant women in Sindh and 9,325 in Punjab.

An innovative approach has been used by incorporating various governmental and non-governmental stakeholders for the objective of providing quality RH and MCH services to underprivileged people in remote and under-serviced areas of Pakistan.

Community members have been trained to help in delivering RH and MCH related services. In this way, the problem of staff posting and transfer, that has been a perennial problem in the public sector making it very difficult to retain staff in remote areas, has been taken care of. Similarly, this approach deals with the issue of staff shortage. Moreover, local community members have ownership and a stake in the activities that they undertake, and have better access to, and a better understanding of local issues.

Performance Indicators in Sindh and Punjab - Community-based Mother & Child Health Care Initiative

	Registered		Benefited	
Community Health Sessions with Women	199,988 (Punjab)	(Sindh), 72,653	169, 714 (Punjab)	(Sindh) 69, 938
Community Health Sessions with Men	199,558 (Punjab)	(Sindh), 72,653	163,527 (Punjab)	(Sindh) 66,047
Immunization of Children	174,983 (Punjab)	(Sindh), 35,892	149,110 (Punjab)	(Sindh) 31,374
De-worming of Children	150,011 (Punjab)	(Sindh), 49,222	135,690 (Punjab)	(Sindh) 49,052
TT Vaccination of Pregnant Women	43,498 (Punjab)	(Sindh), 10,064	37,129 (Sindh)	9,325 (Punjab)

Source: RSPN, 2009 (Slides 18-22)

Table 5

5.5.4 Sustainability and Future Prospects

In the future such interventions can be linked with activities such as adult literacy, improvements in educational services and micro nutrients supplementation so that the successes of the project are built upon, and expanded into an inter-linked and integrated program for socio-economic development.

5.6 Health Micro Insurance (NRSP and Adamjee Insurance)

5.6.1 Background to the SSI

Pakistan spends only 0.5% of GDP on health. Approximately, 80% of the health budget is spent on tertiary care services, which are availed by 15% of the population. According to a study carried out at Aga Khan University, cost of medicines (out of pocket expenditure) accounts for 49% of the household expenditure on health, while doctors' fees accounts for 38% and hospitalization for 13%.

5.6.2 Project Design

In October 2005, RSPN initiated a pilot project in partnership with Adamjee Insurance Company. NRSP was the largest partner in this initiative. Later, NRSP directly partnered with Adamjee Insurance Company and launched the Health Micro Insurance Initiative in order to provide greater access to quality hospital care and to assist poor households with their medical expenses.

This product was designed for the members of the COs and micro-credit clients of NRSP. NRSP is responsible for collecting the premium and the insurance claims, and Adamjee handles the processing and payments to the CO members. This initiative aimed to assist the poor with medical expenses and access to quality hospital care.

In order to avail this product, CO members and their families are covered with a premium of Rs. 100/annum covering the client and his/her spouse. The insurance provides coverage up to Rs. 15,000. This includes hospitalization or accidental death or disability. A grant of Rs. 15,000 is available for funeral expenses for death from natural causes. Expenses related to childbirth are covered, with a Rs.7,500 ceiling. Health education workshops were also held.

5.6.3 Key outputs and impact

As of September 2009, 1,011,784 clients had health micro insurance coverage. Of these 463,464 (45.8%) cases pertain to women. The micro insurance scheme is a very useful pro-poor product developed by the NRSP. Health is a crucial area where assistance is required by underprivileged groups especially because this area is neglected by the government. The range of health issues affects the poor disproportionately as compared to the more privileged sections of society, and has graver results for them in terms of depletion of their financial resources, saving and assets, and throwing them in a vicious cycle of poverty, debt and ill health.

Text Box 2: Details of Micro-health Insurance cases

Persons insured: 1,011,784
Insurance cases: 1,670,368
Men: 1,206,904
Women: 463,464
Data of clients sent to Adamjee: 932,696
Premium collected: Rs. 191,870,592
Premium paid to Adamjee: 92,876,778
Claims received at HO: 7,311
Claims pending at NRSP: 5,348
Claims sent to Adamjee: 1,438
Claims approved: 525
Claims in process: 5,348
Claims rejected: 54,693,794
Claims reimbursed to clients: 1,011,784
Amount reimbursed: Rs. 1,670,368
*Note: Adjusted figures are incorporated
Source: NRSP Monthly Programme Update – Micro-insurance Progress as of Sep. 31, 2009

However, as of September 2009, the loss ratio of the insurance scheme has been 53%.⁴⁴ NRSP needs to look at the reasons for this and adapt accordingly.

5.7 Chief Minister's Initiative on Primary Health Care in the Punjab⁴⁵ - since 2002

5.7.1 Background to the SSI

To achieve health-related MDG targets, the government has been pushed towards finding alternative ways of delivering health services.⁴⁶ The innovative CMIPHC is a radical departure from established practice in government, and marks the first time that management of some aspects of basic health services' delivery has been outsourced to a non-governmental agency⁴⁷. Though the intervention started with exemplary political support at provincial level, this dwindled over time. However, the Programme carries on due to the momentum of its success, support from District Governments, and has recently been replicated at the national level.

Reportedly there was bureaucratic resistance to outsource the BHUs to an NGO⁴⁸. However, this was unequivocally overruled by the political leadership. The impressive results of the pilot project in Rahim Yar Khan District such as surge in out-patient numbers and positive feedback from patients and local officials encouraged the up-scaling of this effort to eleven more districts of the Punjab.

The World Bank has studied and documented 8 similar experiences world-wide. This places the PRSP venture in the Punjab in an international context. At the national level, the programme has achieved a scale unparalleled in the history of social sector initiative in the country. The Program has now been adopted at the federal level and is known as the President's Primary Healthcare Initiative (PPHI). It has been launched in fifty districts outside Punjab for which PRSP has been assigned a mentoring role.

5.7.2 Project Design – Data/Facts

PRSP is now managing all BHUs on behalf of twelve district governments. Over time, PRSP has evolved its programme to include community and school health sessions. It has also clustered BHUs for delivering the services of female medical officers, which had been a severe inadequacy in rural areas. Local Support Groups (LSGs) have been established for better monitoring and ownership of the project by the communities.

PRSP adopted a 'management of change' design with the following features:

- Clustering two/ three BHUs under one medical officer (MO)
- Enhancing salary of the MO (from the existing budget since there were many vacancies in every district). Now, after the health reforms have raised the salaries of doctors, one doctor is provided for each BHU.
- Ensuring the presence of doctors in the BHUs through a rigorous process of facilitation.

⁴⁴ Presentation made by CEO, NRSP in RSPs' retreat, Bhurban, December, 2009. Discussions were also held with NRSP staff subsequently.

⁴⁵ This section in addition to the field interviews, data collection has tremendously benefitted from "Effective Technical Cooperation for Capacity Development – Pakistan Case Study" prepared as a Joint Study on Effective TC for CD, Government of Pakistan, 2008.

⁴⁶ Historically, and as recently as 2002, utilisation rates of Basic Health Units (BHUs –primary health care units are the first line of health care) have been as low as servicing 22 patients a day. There are nearly 2500 BHUs in the Punjab.

⁴⁷ PRSP is managing 1049 health facilities in 12 districts out of which 845 are BHUs.

⁴⁸ PRSP was established in 1997 with an endowment of Rs. 500 million by the Government of Punjab. It is also contracted by the provincial government, mainly for community based programs in various sectors.

- Ensuring that all requisite medicines were available all the time
- The District Support Manager's (DSM) role as a facilitator to MOs-this includes provision of necessary supplies, ensuring staff discipline and coordination with line departments, and protecting the MO from unjustified political and social pressures.
- Ensuring adequate hygiene at each BHU
- Identification of the facilities that cannot be covered by the existing arrangements. These are now being added through another government programme.
- The MO made in-charge of paramedical staff
- Capacity of communities and school children was enhanced to become partners in achieving health objectives. The aim is to carry on a continuous planned campaign to inculcate proper health care seeking behavior.
- Capacity building of doctors through sharing and learning opportunities at monthly review meetings (MRMs); relevant district government officials such as the *Nazims*, the DCOs, EDOs and DOs are also invited to participate in the MRMs. In addition to this, training sessions are organized for doctors.

Implementation

PRSP's core organizational competence is community managed programmes. Therefore, this was a learning experience for PRSP as well. It developed a management cadre for the purpose. A voluntary Resource Group comprising of eminent medical professionals provided technical advice. The district health department is responsible for monitoring the performance of the BHUs.

The management model demonstrated greatly improved performance of the BHUs, leading to the President's directive for re-engineering of district health management systems throughout Pakistan. Local Support Groups (LSGs) have been mobilized at each BHU with the help of the local staff at BHUs. Monthly meetings are organized to improve functioning based on community feedback and cooperation. Some of these groups were able to generate funds to buy equipment for BHUs. Patients proved willing to contribute voluntarily to BHU service delivery once the committed efforts of the enterprise became apparent.

Data reveals that before the start of the project there were very few doctors posted in the BHUs of the twelve districts included in the project and some districts like Lodhran, Hafizabad and Pakpattan, had no doctors at all. On taking over the management of the BHUs, PRSP employed doctors on contract and column c of the table shows the surge in the number of doctors available for each district at the BHU level.

There is a jump in the number of outpatients visiting the BHUs in each district since PRSP took over the management of these BHUs. The number of outpatients has been progressively increasing every year. This implies the availability of requisite services in the BHUs and the confidence of the local people in the services provided by these BHUs. Similarly, the number immunizations administered during the month of November 2009 in each district attests to the adequate availability and provision of this service at the BHU level.

5.7.3 Sustainability and Future Prospects

Critical Issues

No serious consideration appears to have been given to how this management model would be sustained once the PRSP hands back the management to the health department. However, since DSMs are from the

public sector, the experience of implementing this model has resulted in building capacity in the area including optimal use of the available budget.

Curative health services have shown marked improvement as a result of this intervention as compared to the outreach services. This is because, though the outreach staff has been placed under the supervision of the MO, requisite facilities, powers and infrastructure have not been put in place to ensure management and monitoring of the outreach staff on professional lines.

Though there are clear terms of agreement between the district government and PRSP, spelling out sharing of responsibilities and division of labor, the districts seem to have taken a more passive role in the arrangement. For example, the district health staff is often resistant to taking administrative action against employees reported on by PRSP MOs. A more comprehensive exercise in facilitating the district government and the PRSP in understanding each other's organizational culture and approach needs to be conducted.

Monitoring and Evaluation

Data from the BHU is generated on the Government of Punjab's Health Management Information System (HMIS) formats, which is transmitted to the District and Provincial Health Departments. PRSP BHUs produce reports which are in greater detail, high in accuracy and professionally more useful.⁴⁹ The monthly meetings of the LSGs at each BHU and the MRMs held at the district level are also two comprehensive mechanisms of assessment and monitoring.

The World Bank undertook an evaluation of the CMIPHC at the request of the provincial government. The evaluation report presents comprehensive data on the impact of the changed management arrangements on utilization of resources and efficiency gains, working conditions, staffing, availability of medicines, quality of care and patients' opinions. It made recommendations for how the agreement between Districts and PRSP could be improved.

Sustainability

The successes of the programme and the lessons learnt need to be applied within government's health service delivery system. This unique experience of the PRSP gives it a vantage point from where to influence the process of evolving an appropriate public sector health services. However, while PRSP can facilitate this process, it is for the government to lead the initiative. The CMIPHC experience shows that the main points for ensuring sustainability include: (i) locating requisite power and authority at the most appropriate levels, combined with rigorous accountability, (ii) ensuring the exercise of authority without formal or informal impediments and (iii) ensuring meaningful community participation.

Lessons and Reflections

- Efficiency gains in public service delivery are possible given the appropriate level of commitment;
- The appointment of DSMs under an incentivised remuneration scheme as facilitators between the health specialists and the government bureaucracy proved to deliver positive results;
- It is easy for politicians to start good governance projects but difficult to remain committed to them, if the reforms clash with political objectives. When politicians opted for the CMIPHC, they

⁴⁹ These are: 1. HMIS Form, 2. Daily expense of medicine, 3. Health Session Report, 4. School Health Report, 5. LHV Progress Report, 6. HSRP Report

had assumed a set of advantages e.g. extra funding, extra jobs etc; they had not anticipated it to mean loss of authority and patronage and loss of control over resources;

- The bureaucracy needs to play a more independent and evidence-based role in decisions regarding policy;
- Financial outlays of the intervention prove that there is adequate financing available in the district budget to provide for an improved service at the primary level, as long as local-level management is efficient and accountable.

Text Box 3: Case Study – Experiencing the change in the efficiency of BHU services

Mr. Noor Ali, who recently retired from military service as Subedar had settled in his ancestral hilly village of Buchal Kalan in District Chakwal. His village is around ten miles away from the main road and those villagers needing medical care used to be taken by expensive public transport to the Tehsil Headquarter Hospital many miles away. Cost of transportation (public transport vehicles are few in this area and unsuitable for patients) and bad condition of road network made the journey, not only tedious but life threatening, in cases of serious illness. There was a BHU around a mile away from his village but villagers would hardly ever visit this BHU as it was notorious for absentee medical staff and rarely had any medicines for patients.

It was, therefore, natural for Noor Ali to get alarmed when an aged uncle of his fell ill and needed immediate medical attendance. While he was contemplating logistics of carrying his uncle to the Tehsil Head quarter Hospital, his wife informed him that the uncle would be taken to the nearby BHU. A little surprised, Noor Ali along with his wife and two cousins reached the BHU through local transport in less than fifteen minutes. And there a further surprise awaited Noor Ali. He had passed the road next to this BHU many times but this time he suddenly saw a great change in the look of the BHU building. The outer walls of the building had been freshly distempered and the lawns around it were well kept. A large number of patients could also be seen at the main entrance of the BHU. But the real surprise was inside. There was a proper registration corner, where his uncle was formally registered for a token fee and was immediately shown to the duty doctor. The doctor conducted a detailed check up of the patient and gave him the prescription. They were directed to a small pharmacy in another tidy room where a dispenser was administering medicines. The patient was given most of the medicines except for a small item that would have to be purchased from a medical store. And by the time Noor Ali, his cousins and the ailing uncle (whose condition had much improved after the check up and administration of the first dose of medicines and injection at the BHU) reached back their village, Noor Ali's opinion about the BHU had undergone a dramatic transformation.

The BHU where Noor Ali's uncle was treated was one of the clusters of three BHUs which had been managed by PRSP for the last three years. The availability of medicines, presence of doctor and paramedics and the overall cleanliness of the building were ample evidence of the effectiveness and success of the PRSP-managed PHC model in the rural areas of district Chakwal.

Source: Field visits and interviews, Chakwal, November 2009

6. Case Studies – Other Pro-Poor Initiatives

6.1 Elimination of Child Labour and Provision of Non-Formal Education (NFE) in Household Glass Bangles Industry, Hyderabad (2005-2008) – NRSP, ILO and GoS.

6.1.1 Background to the SSI

Glass Bangle (GB) making is categorized as one of the worst forms of child labour (WFCL) by the International Labour Organization (ILO) and GoP. This project, to eliminate child labour from the GB industry in Hyderabad, was funded by USDOL through ILO and was implemented by NRSP.

According to a survey conducted by Save the Children Sweden & ILO in 2003-04, this industry supports some 30,000 families and employs 9,584 children below the age of 18. The children are paid meager wages⁵⁰ and work on average for twelve hours a day. They, are at high risk of injury, and lack access to medical care.

6.1.2 Project Design

The project aims at a gradual shift, whereby, working children are provided an opportunity to distance themselves from the hazardous work and explore other options of livelihood. This is done through social mobilization and formation of mother-groups. The project provides: non-formal education to children geared towards placing them into formal education; literacy centers; pre-vocational training; linking families with social safety nets and micro-credit opportunities; child labour monitoring; improvement in working conditions; building linkages with the district government, training institutes, line departments, workers' and employers' organizations and civil society organizations. In line with its commitments under the project, NRSP also provided micro credit to over 1,300 families of working children so that these families opt for alternate income generation thereby breaking the dependency on children's earning.

6.1.3 Key outputs and impact

346 children were provided with scholarships from the Zakat Fund. 1250 families of the children were given access to micro-credit. Further, 2600 children were withdrawn from this work and 650 siblings were prevented from getting employed in the GB industry. 1500 youth were provided with vocational training. The box below gives details regarding the impact of the project on one representative household.

The project demonstrates a strong relationship amongst the civil society (NRSP), the donor agency (ILO) and the local government (District Government, Hyderabad); they have acted together to discourage vulnerable children from working in a hazardous occupation by providing economically viable alternatives.

Text Box 4: Case Study - The impact of the ILO-NRSP-GoS project on Shamim's family

Shamim is a widow, living in a shanty locality in Latifabad, Hyderabad. She lives in a small one-room house. After the death of her husband a few years ago, she has been working hard to earn a livelihood for herself and her three children - Ali Raza (9), Kausar (5) and Dua (3). Shamim brings bangles home for processing. In order to do this, she had to set up a stove to burn fire in her one-room house. Her two older children used to assist her in the work of bangles processing. She could not afford to send her children to school. Frequently, her children would get small burns when they were processing bangles. The earnings were meager (Rs. 2 for "One Tora" of bangles which has 313 bangles in it).

The ILO-NRSP-GoS project provided her with an opportunity to get her children out of this dangerous work and earn livelihood elsewhere. Her son spent three years in an informal project school, and is now studying in class five. His two sisters are also studying in school now. For Shamim hard days are by no means over, however, now she can, at least, expect her children to get basic education.

Source: Data obtained through field visits and interviews, November, Hyderabad, 2009

⁵⁰ Wages of the workers are determined by the number of toras (bunch of 320 glassbangles tied together) as contrasted to the number of hours worked. These vary from Rs. 3.5-Rs.8 for a bundle.

It should be highlighted that NRSP, together with District Education Department Hyderabad, succeeded in developing Hyderabad's first District Education Plan (DEP). DEP clearly demarcated need of the actions to accommodate working children and set aside Rs.1 million in the District's Annual Budget for such needs. So the suggested liaison has already been developed where sensitized District Govt. & Education Department pledged their support for accommodating working children. District Nazim Hyderabad publicly announced provision of additional school rooms in all such government schools that find it difficult to accommodate working children due to lack of space.

6.1.4 Sustainability and Future Prospects

However, there needs to be greater liaison with local education authorities in order to meet the needs of the children who are entering from project-based non-formal schools into the formal government school systems. Moreover, a greater effort should be made to provide financing to the youth, which has been provided vocational skills through the project. This way they can sustainably use the new skills that they have acquired. There needs to be a consistent monitoring and follow up system through which further interventions are designed if the trained youth is in danger of falling back on the GB industry.

It is common for development activities not to focus on children directly. Moreover, welfare of children seldom gets priority. However, this project has made a contribution in this crucial area, i.e. highlighting the importance of youth in the development process.

7. Conclusion

Pakistan faces a classic scenario of 'growth without development', where despite an average annual growth rate of 2.2 percent per capita over the period 1950-1999, Pakistan has displayed stagnant social development. Other countries in the region have exhibited stronger records in terms of social development with relatively lower levels of per-capita growth. Further, even in the presence of the SAP, most social indicators failed to improve between 1993 and 1998.

In order to increase efficiency and to enhance social service provision in the context of a weak, inadequate and inappropriate staffing mechanism at lower levels, the government explored the option of outsourcing the establishment of project proposition and implementation, while acting as a supervisory and monitoring body. The failure of national stakeholders to factor in the lack of attention given to the local citizenry in taking their own initiatives and the shifting of ownership and responsibility of indigenous development projects to the communities was reviewed. Pakistan's Rural Support Programmes (RSPs) have innovated excellent models of locals service delivery that are replicable and have demonstrated results. Table 5 sums up the results and challenges of the SSIs reviewed under this study.

Analysis of Social Sector Interventions Studies (TABLE 6)

Name of SSI	Brief Description	Location	What worked	Challenges
Punjab Education Sector Reform Programme in RYK (NRSP)	<p>The formulation of the Punjab Education Sector Reform Programme (PESRP) gave a major impetus to the sector, injecting much needed interventions which enhanced the availability of schooling services to the citizens of the province generally and the rural classes specifically. PESRP is part of a wider effort at poverty alleviation in Punjab, which is based on 'three pillars' of support:</p> <ol style="list-style-type: none"> 4. Public finance reforms - to enable the Government to practically spend more on education and pro-poor development. 5. Devolution of power to the district level - to make local councils accountable to local needs. 6. Quality of education - to improve the quality of teaching, schooling and governance of the education system. 	Rahim Yar Khan	<ul style="list-style-type: none"> • Inclusive and participatory approach to education service delivery • Formation of SMCs • Employment of the Social Mobilization approach to form CCBs and SCs • Innovative awareness campaigns • Multi-stakeholder engagement • Stable funding sources in the form of JDW Sugar Mill • Preparation of a Teaching Manual and QEFA curriculum • Nutritional campaigns 	<ul style="list-style-type: none"> • Political challenges which were less intense here may be difficult to overcome elsewhere • Capacity-building of government staff • Funding sources may be limited where local philanthropists do not exist • Many schools have started slipping into patterns involving inefficiency and the lack of motivation • Earning trade-offs for prospective students
Revitalizing, Innovating, Strengthening Education (RISE) Project	<p>The Revitalizing, Innovating, Strengthening Education (RISE) project is grounded in the belief that a comprehensive system of support for communities, teachers and educational officials can substantially improve the quality of classroom instruction and student learning. RISE has operated in the districts of Mansehra in KPK, Bagh, Muzaffarabad and Poonch in Azad Jammu and Kashmir (AJK). To date, RISE has trained 139 education managers in at least four of six key education management themes in all four districts. The six themes are: planning and development, financial and personnel management, school supervision and instructional support, community participation and SMC/Parent-Teacher Council (PTC) mobilization, teacher training, and data-driven decision making.</p>	Districts of Mansehra in KPK, Bagh, Muzaffarabad and Poonch in Azad Jammu and Kashmir (AJK)	<ul style="list-style-type: none"> • Comprehensive system of support and training for communities, teachers and educational officials • Fostering relations with key stakeholders 	<ul style="list-style-type: none"> • Frequent transfer of staff • High level of expectation in relief environment • Flagging community morale • Varying geographic locations and associated cultures and norms • Lack of clarity in the established goals and objectives
Family Advancement	In February 2008, the Population Council of	Dadu	<ul style="list-style-type: none"> • Low cost of awareness campaigns 	<ul style="list-style-type: none"> • Existing gender relations, socio-

<p>for Life and Health (FALAH)</p>	<p>Pakistan launched a new family planning project targeting vulnerable districts across Pakistan. FALAH, or Family Advancement for Life And Health is a USAID funded 5-year project functioning in the area of reproductive health and family planning. Specifically, FALAH focuses on enhancing the practice of birth spacing as recommended by the World Health Organization (WHO) under the guidelines of ‘Healthy Timing and Spacing of Pregnancies (HTSP) so as to improve the health of mothers and children and minimize pregnancy-related complications. The project’s primary target group is Married Women of Reproductive Age (MWRA) and their husbands, with the secondary target group being health and family planning service providers in the public and private sectors. Its tertiary target group comprises of influential members at the community level, including senior family members, religious leaders, elected officials and media representatives.</p>		<ul style="list-style-type: none"> • Utilization of existing COs • Selection of CRPs as acting focal persons • Commitment of local staff to service delivery • Use of easy-to-understand posters, banners, brochures, booklets and audio cassettes 	<p>religious concerns and a lack of scientific knowledge</p> <ul style="list-style-type: none"> • Weak communication between spouses • Myth-creation regarding family planning and birth-spacing practices • Dearth of medicines and other necessary items relating to RH at BHUs
<p>Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE)</p>	<p>In response to the disaster of 2005, USAID/Pakistan designed the Primary Healthcare Revitalization, Integration, and Decentralization in Earthquake-Affected Areas (PRIDE) Project and awarded a \$28.5 million cooperative agreement to the International Rescue Committee (IRC), a US-based NGO, to provide technical support to the public sector health system in Mansehra and Bagh districts.</p> <p>PRIDE’s mandate was the health component of USAID’s reconstruction and revitalization program. It has been implemented by a consortium headed by the IRC with international partners including Management Sciences for Health (MSH) and JHPIEGO, an affiliate of Johns Hopkins University and the Population Council.</p>	<p>Districts Mansehra and Bagh</p>	<ul style="list-style-type: none"> • standards-based management approach when performing health care services • developing guidelines for a process to improve performance at public health facilities • establishing health management committees and developing guidelines for them to improve local health care services • renovating drug storage facilities and mentoring facility staff 	<ul style="list-style-type: none"> • Taking a step forward from the PHC has been difficult • Delays in planning and implementation of the patient referral system • Lack of capacity in relevant government departments; unavailability of staff • Other project activities took precedence over revamping the patient referral system

	The project has three main goals: (1) improving the performance of public health services and management systems, (2) improving access to and quality of PHC services, and (3) promoting healthier behaviors and institutionalizing community participation in health services.			
Marginalised Areas Reproductive Health & Family Planning Viable Initiative (MARVI) – District Umerkot (TRDP & HANDS)	In 2007, TRDP collaborated with Health and Nutrition Development Society (HANDS), a non-profit organization, for the implementation of the MARVI project in District Umerkot. Funding for this project was provided by the David and Lucile Packard Foundation. MARVI envisages an integration of reproductive health (RH), family planning (FP), microfinance, social marketing and social mobilization services through a well trained and dedicated cadre of women activists (MARVI workers) belonging to the local communities.	Districts Umerkot and Mithi	<ul style="list-style-type: none"> • Integrated approach • Creation of human resource from within communities • Reports from the project are building a vital knowledge base for future interventions • The initiative provides the trained CHWs with an alternate role which comprises of a social mobilizer and a health service provider • Targeted social marketing (women and children) • Combination of efforts by the public and the private sectors • Capacity building and training through the formation of women groups and women assemblies 	<ul style="list-style-type: none"> • The linkage between the community health workers and the government facilities and service providers is unclear • There needs to be a more formal linking of these so as to complement the work of each other and fill the gaps • Implementation delays may occur due to volatile political situations
Public-Private Partnership for the Establishment of Thalassemia Care Center in Badin (RSPN, District Government, Badin, USAID and private sector) – Since 2004	<p>Badin district suffers from limited access to health facilities. In recent years, the number of Thalassemia patients in Badin and neighboring districts, has increased considerably. However, a large number were deprived of treatment as the only facility existed in Karachi, which most could not access, primarily due to prohibitive costs. It was in response to these conditions that the Thalassemia Care Center was set up in 2005 in Badin.</p> <p>The center aims to provide affordable treatment for Thalassemia (barring the cost of travel, treatment is free) and to spread awareness regarding the causes of Thalassemia, and to,</p>	Badin	<ul style="list-style-type: none"> • The project has generated a very interesting and important example of PPP in a highly sensitive and challenging area • It has made crucial contribution to the knowledge bank of RSPs in terms of innovative, community-based and pro-poor development • Given the prevailing social norms in the area, awareness-raising about such sensitive issues was tactfully piggybacked on treatment processes • Employment of instruments of social mobilization for achieving 	<ul style="list-style-type: none"> • less than expected success in securing commitment for resources from private or institutional philanthropists • Issues of sustainability with regards to funds, involvement of community, dedication of stakeholders and the capacity of teams to run such centers

	<p>thereby, reduce its occurrence.</p> <p>The establishment and running of this center provides an innovative model of government, civil society and private sector collaboration.</p>		critical outcomes which would not have been possible inside existing systems of governance	
<p>Community-Based Mother & Child Health Care Initiative (CBMCHCI) – (RSPN, SRSO, NRSP, PRSP, TRDP, SGA, UNICEF and provincial governments) – Since 2009</p>	<p>The CBMCHCI was developed jointly by RSPN and UNICEF in 2009, as part of their goal to build a community based model for introducing integrated health interventions in remote rural areas. The conduit for such interventions is community resource persons (CRPs) trained in various Mother and Child Health (MCH) services.</p> <p>Following groups are targeted for the various health interventions: married couples for FP; children between the ages 2-5 for de-worming; children between the ages 0-2 for immunization; and pregnant women as well as men and women between ages 15-19 for RH interventions.</p>	12 districts	<ul style="list-style-type: none"> • Intricate collaboration between RSPs and the government • The project has trained community members to help in delivering RH and MCH related services. In this way the problem of staff posting and transfer, that has been a perennial problem in the public sector, has been mitigated • The project has generated valuable data and documentation regarding the design and implementation of the initiative, its analysis and implementation and the coordination and linkages among the various stakeholders 	<ul style="list-style-type: none"> • Missing integrated approach linking this programme to adult literacy, improvements in educational services and micro nutrients' supplementation
<p>Micro-Health Insurance (NRSP and Adamjee Insurance)</p>	<p>In October 2005, RSPN initiated a pilot project in partnership with Adamjee Insurance Company. NRSP was the largest partner in this initiative. Later, NRSP directly partnered with Adamjee Insurance Company and launched the Health Micro Insurance Initiative in order to provide greater access to quality hospital care and to assist poor households with their medical expenses.</p> <p>This product was designed for the members of the COs and micro-credit clients of NRSP. NRSP is responsible for collecting the premium and the insurance claims, and Adamjee handles the processing and payments to the CO members. This initiative aimed to assist the poor with medical expenses and access to quality hospital care.</p>	Member COs of NRSP	<ul style="list-style-type: none"> • Knowledge on micro-credit produced by the programme can be accessed by other RSPs and relevant stakeholders 	<ul style="list-style-type: none"> • As of September 2009, the loss ratio of the insurance scheme has been 53%. The reasons for this need to be looked into

	<p>In order to avail this product, CO members and their families are covered with a premium of Rs. 100/annum covering the client and his/her spouse. The insurance provides coverage up to Rs. 15,000. This includes hospitalization or accidental death or disability. A grant of Rs. 15,000 is available for funeral expenses for death from natural causes. Expenses related to child birth are covered, with a Rs.7, 500 ceiling. Health education workshops were also held.</p>			
<p>Chief Minister's Initiative on Primary Health Care in the Punjab - since 2002</p>	<p>To achieve health-related MDG targets, the government has been pushed towards finding alternative ways of delivering health services.⁵¹ The innovative CMIPHC is a radical departure from established practice in government, and marks the first time that management of some aspects of basic health services' delivery has been outsourced to a non-governmental agency.⁵² Though the intervention started with exemplary political support at provincial level, this dwindled over time. However, the Programme carries on due to the momentum of its success, support from District Governments, and has recently been replicated at the national level.</p> <p>The World Bank has studied and documented 8 similar experiences world-wide. This places the PRSP venture in the Punjab in an international context. At the national level, the programme has achieved a scale unparalleled in the history of social sector initiative in the country. The Program has now been adopted at the federal level and is known as the President's Primary Healthcare Initiative (PPHI). It has been</p>	<p>12 Districts in Punjab</p>	<ul style="list-style-type: none"> • The acknowledged importance of Primary Healthcare to alleviating poverty • Recognition by top political leadership – President and Prime Minister • Redesigning management of PHC services at the District Level • Stakeholder engagement has allowed for enhanced feedback and increased ownership • PRSP BHUs produce reports which are in greater detail, high in accuracy and professionally more useful, compared to data from BHUs which is generated on the Government of Punjab's Health Management Information System (HMIS) formats • The appointment of DSMs under an incentivized remuneration scheme as facilitators between the health specialists and the government bureaucracy proved to deliver 	<ul style="list-style-type: none"> • Resistance from vested interests hinders project planning and implementation • Lack of capacity of government staff • Compared to curative health services, outreach services have suffered due to a lack of requisite facilities, power and infrastructure • A largely passive role of district health staff • Issues with sustainability once private sector partner has 'exited' the project cycle

⁵¹ Historically, and as recently as 2002, utilisation rates of Basic Health Units (BHUs –primary health care units are the first line of health care) have been as low as servicing 22 patients a day. There are nearly 2500 BHUs in the Punjab.

⁵² PRSP is managing 1049 health facilities in 12 districts out of which 845 are BHUs.

	<p>launched in fifty districts outside Punjab for which PRSP has been assigned a mentoring role.</p>		<p>positive results</p> <ul style="list-style-type: none"> • Financial outlays of the intervention prove that there is adequate financing available in the district budget to provide for an improved service at the primary level, as long as local-level management is efficient and accountable 	
<p>Elimination of Child Labour and Provision of Non-Formal Education (NFE) in Household Glass Bangles Industry, Hyderabad (2005-2008) – NRSP, ILO and GoS</p>	<p>This project, to eliminate child labour from the GB industry in Hyderabad, was funded by USDOL through ILO and was implemented by NRSP.</p> <p>The project aims at a gradual shift, whereby, working children are provided an opportunity to distance themselves from the hazardous work and explore other options of livelihood. This is done through social mobilization and formation of mother-groups. The project provides: non-formal education to children geared towards placing them into formal education; literacy centers; pre-vocational training; linking families with social safety nets and micro-credit opportunities; child labour monitoring; improvement in working conditions; building linkages with the district government, training institutes, line departments, workers’ and employers’ organizations and civil society organizations.</p>	<p>Hyderabad</p>	<ul style="list-style-type: none"> • Social mobilization have been applied to broaden the economic choices of vulnerable sections of society • children and their parents are provided an opportunity to slowly distance themselves from the hazardous work and explore other options of livelihood • project demonstrates a complementary relationship among civil society (NRSP), donor agency (ILO) and local government (District Government, Hyderabad) • It is common for development activities not to focus on children directly and the welfare of children seldom gets priority. This project has made a contribution in this crucial area 	<ul style="list-style-type: none"> • It needs to be ensured that the children are sustainably accommodated into the formal education system once they leave non-formal schools • The youths undergoing vocational training also need to be linked with affordable microfinance, market and employment opportunities • Four main reasons for delay included: the frequent transfers of District Government officials; The Zila Nazim;’s demanding schedule impeding him from prioritising the project; dissolution of the Zila Zakat Committee after the new government came into power; and political unrest in the country • A greater role for women councillors could have enhanced the outreach of the project initiatives, especially for families who may not be comfortable in interacting with NGO representatives, but who may feel more comfortable with a state-related entity (lady councillors) • Provision of soft loans and easy financing

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iii. Annexures

ANNEX 1

Intervention through the Social Action Plan (SAP):

The SAP, initiated in 1992, was a multi-sector policy initiative assisted by international donors. The first year of the SAP was a planning and finance exercise whereby social sector budgets were enhanced for better access to education, WATSAN, health and community-wide participation. The first SAP project was from 1993-97 and the second from 1997-2002. However, most social indicators failed to improve between 1993 and 1998. The primary net enrolment rate fell from 46 percent in 1990-91 to 40 percent in 1998-99. Net secondary enrolment rate remained static at 16 percent. Infant mortality rate declined marginally during this period, but this reduction was less than that achieved by other countries in the region. Pakistan performed better in the areas of contraceptive use, percentage of deliveries conducted by qualified personnel and delivery of health services to mothers. However, areas such as sanitation suffered, with the percentage of households connected to a drainage system decreasing from 37 percent in 1990-91 to 33 percent in 1998-99. During this period, the number of 'ghost schools' and the extent of 'ghost employment' increased.

Progress through the SAP was impeded by a multiple factors. The understanding of the rationale for SAP was not shared by the greater part of the state machinery, leading to a lack of ownership of the process and a dearth of political commitment. Till 2001, the SAP failed to induce any significant budgetary shifts from defense and non-social sector expenditures to the improvement of social service delivery. Furthermore, budgeting, and policy-making continued to rest with the Federal government, while the Provincial governments were constitutionally mandated to execute social sector activities, which failed to stimulate ownership of the SAP at the implementation level.

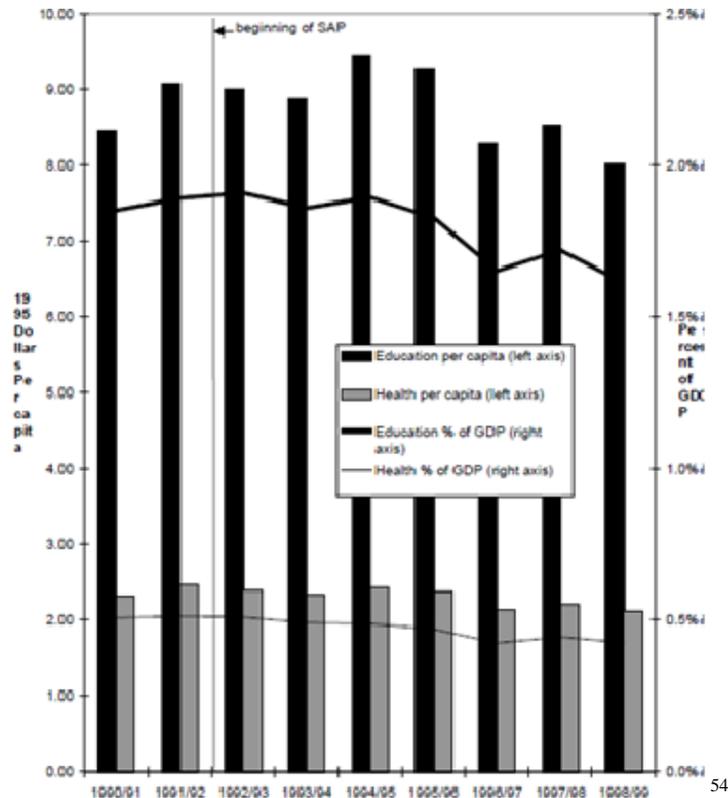
The challenges faced by the SAP were accentuated by a lack of continuity in governmental policies, concomitant with a climate of intense political instability wherein Pakistan saw a change of eight governments over the course of a decade. However, what the Social Action Program did achieve was the prioritization of the social sector, and an acknowledgement of the country's backwardness in the context of social service delivery.⁵³ However, after a slight initial increment, the government reduced the amount spent on SAP, as is shown in the following table:

Table A.1: SAP spending as percent of GDP

Financial Year	SAP Spending as percent of GDP
1992/93	1.70
1993/94	1.72
1994/95	1.88
1995/96	2.05
1996/97	2.35
1997/98	1.69
1998/99	1.60

The following chart illustrates education and health spending before and after the initiation of the Social Action Plan in 1992/93. Against expectation, spending had not increased.

⁵³ Paul, Thornton. 3.



The rapid turnover of democratic governments, together with protracted periods of authoritarian military rule have not allowed for continuity and progress in social sector policy. This has coupled with structural issues such as a lack of decentralization and devolution of authority, poor planning and management, lack of accountability, political interference in day-to-day management, inadequate and mismatched staffing, and inappropriate financing mechanisms. The attempt by donors to take a more direct lead in social sector interventions in order to ensure accountability has led to alienation of other stakeholders, something which is problematic in such participative processes.⁵⁵

ANNEX 2

Education

Nepal

According to the Educational Statistical Report of the Ministry of Education 1997, 30 percent of primary school-going age children have not enrolled in primary school, and 50 percent of those who have, drop out before completing fifth grade. With vast swathes of the population not being able to tap into the formal educational system provided by the government, there is an urgent need for the uplift of the non-formal educational (NFE) sector. However, the government of Nepal spends a mere 2 percent of its

⁵⁴ Easterly, William. 52.

⁵⁵ Ismail, Zafar H. *Impediments to Improvements of Social Sectors in Pakistan*. Conference Paper No. 27. Karachi: Social Policy and Development Centre, 1996. 8. Print.

allocated budget for education on NFE, with the subsequent gap between demand and supply being filled by various NGOs. With the government providing inadequate training and technical skills, a group of about 40 NGOs have set up a “National Resource Center for Non-Formal Education (NRC-NFE)” in Nepal in 1995 which aims at establishing a curriculum for NFE, provide training and formulate plans for the creation of community learning centers. An offshoot of this is the ‘Community Learning and Development System (CLDS)’ and Community Learning Center (CLC).⁵⁶

India

Pratham and Tarang are two important NGOs working in India in the education sector. Established in 1994, Pratham now claims to be the largest NGO dealing with education for underprivileged children in India, both in urban and rural locales. Pratham holds supplementing instead of replacing the government as its essential mantra, having signed memorandums of understanding with 8 state governments, while working closely with various municipal corporations in Mumbai and Delhi.⁵⁷

Latin America

Despite the fact that access to education has increased in Latin America, state institutions have been unable to reach poor communities. To counter this, NGOs have played an important role in supplying quality education. For example, AGES, an NGO in charge of piloting and implementing USAID’s Basic Education Strengthening/Girls Education Programme (BEST/GEP) aims to improve the quality, efficiency, and equity of primary education services in Guatemala. Likewise, Fe y Alegría (FYA) is a not-for-profit institution offering education in Latin America with the principle of equity, quality and lower cost. Similarly, on the basis of a bilingual methodology simultaneously promoting literacy in Quechua and Spanish, a coalition of national NGOs in the Andean region of Peru serves the objective of increasing literacy, schooling, and overall improvement in quality of education.⁵⁸

Health

India

The Voluntary Health Association of India (VHAI) is a non-profit, registered society which was formed in 1970, and exists as a federation of 27 State Voluntary Health Associations, linking together more than 4500 health and development institutions across the country. The VHAI has advocated policies that are people-centered and pursues dynamic health planning and programme management in the country. Sensitizing the public to health issues and awareness, the VHAI strives to build a strong, countrywide health movement in India for a cost-effective, preventive, inclusive and rehabilitative health care system. The VHAI taps both into the public sector – the responsiveness of which it attempts to enhance – and the private sector, the accountability and provision of quality service of which to endeavors to maintain.⁵⁹

Ethiopia

According to Ethiopia’s Ministry of Justice (MoJ), which is responsible for the registration of NGOs, there are over 3,700 local and international NGOs operating in the country. The NGO healthcare system comprises over 300 health institutions in the country constituting 7 percent of the 8,236 health facilities,

⁵⁶ Asia-Pacific Cultural Centre for UNESCO, . "Role of NGO's in Education Development." *Literacy Watch BULLETIN*. 15. (2000): 7. Print.

⁵⁷ "About Us." *Pratham*. Pratham, n.d. Web. 8 Jun 2010. <<http://www.pratham.org/>>.

⁵⁸ Montoya, Mariana. *Good practice and quality education: Three NGOs initiatives in Latin America*. 2004. 9. Print.

⁵⁹ Voluntary Health Association of India, . "Home." N.p., n.d. Web. 10 Jun 2010. <<http://www.vhai.org/>>.

most of which are at the primary level. They provide financing and general (curative, preventive and rehabilitative) healthcare services, HIV/AIDS and reproductive health services in clinics and through health education. According to one source citing a household welfare survey on health utilization, 3.3 percent of respondents reported having used NGO-provided facilities. The second National Health Account reported that in 2000 the Ethiopian health NGO community contributed 10 percent of the national health expenditure⁶⁰

Sri Lanka

In Sri Lanka, the presence of NGO's has been enormous in the field of family planning, pioneered in 1953 by the Family Planning Association of Sri Lanka. At present, Reproductive Health (RH) activities are implemented not only through the four family planning NGOs which have been active for more than two decades now – the Family Planning Association of Sri Lanka (FPASL), Sri Lanka Association for Voluntary Surgical Contraception (SLAVSC), Community Development Services (CDS) and the Population Services Lanka (PSL) – but also through numerous other NGOs which are actively involved in community development and the promotion of women's participation in development such as Sarvodaya, Mahila Samithi, Professional Social Service Workers' Association and CENWOR.⁶¹

Bangladesh

In Bangladesh, improved maternal and child healthcare remains one of the most pressing needs as the infant mortality rate is estimated at 91 per 1,000 live births, while the maternal mortality rate is 380 per 100,000 live births (United Nations Children's Fund-Bangladesh 2004). To respond to the overwhelming health challenges that the Bangladeshi population faces, the government encourages involvement of NGOs and the private sector in health service delivery. More than 4,000 NGOs, including international organizations (such as CARE, Save the Children, and World Vision), large national NGOs (Bangladesh Rural Advancement Committee, Concerned Women for Family Planning, and the Grameen Kalyan health program), and hundreds of small and local NGOs are active in the health sector in Bangladesh. With the financial support of international donors, the government has entered into agreements with NGOs, through which they collaborate to furnish basic health care, for example, Safe Motherhood Programs, the Bangladesh Integrated Nutrition Project, and the Health and Population Sector Program. NGOs have also collaborated with the government in capacity building of health staff. As a result of these initiatives, significant improvements have occurred during the past 15 years in the health status of Bangladesh.⁶²

WATSAN

East Asia

Despite significant coverage gains between 1990 and 2008, access to improved water supply ranges from only 50 percent in the Pacific region to 89 percent in Eastern Asia. Access to improved sanitation facilities is lower still, at 56 percent in Eastern Asia and 69 percent in South-Eastern Asia. Roughly 1 in every 5 rural households in East Asia remains dependent on unimproved water sources. Non-state providers (NSPs) play a significant yet often unrecognized role in WATSAN service delivery. A 2005

⁶⁰ Wamai, Richard G. *Reforming health systems: the role of NGOs in Decentralization – lessons from Kenya and Ethiopia*. 5. Boston, USA: International Society for Third Sector Research, 2008. 6. Print.

⁶¹ "The role of Non-governmental Organizations (NGOs) in Reproductive Health Activities." Regional Office for South-East Asia, n.d. Web. 8 Jun 2010.

<http://www.searo.who.int/LinkFiles/Reproductive_Health_Profile_ngo.pdf>.

⁶² Antuono, Laura, Chris Meeks, Melissa Miller, and Jean Watchou. *Evaluating NGO Service Delivery in South Asia: Lessons for Afghanistan*. Public Affairs 860. University of Wisconsin-Madison, 2006. 11. Print.

World Bank study found evidence of 10,000 small-scale private water providers operating in 49 countries, with the small-scale private water providers accounting for more than 50 percent of water services in Indonesia, more than 30 percent in Vietnam, and more than 10 percent in Cambodia and the Philippines. Public and development partner sanitation programs account for less than 1/3rd of household latrine provision in Cambodia, the Lao People's Democratic Republic, and Timor-Leste, with the vast majority of latrines acquired from private providers or through self-provision.⁶³

South Africa

In order to meet the water and sanitation MDG by 2015, in February 2005, the South African government committed itself to eradicating the bucket system, which was being used by a large segment of the population. The government has been able to take effective steps to meet this particular MDG because of its strong partnership with NGOs working in the WATSAN sector. One such partner is the Mvula Trust, the largest WATSAN NGO in South Africa. The Mvula Trust was established in 1993, as a three-year project whose aim was to alleviate the critical water situation in the early 1990s by setting up a fast and effective mechanism for funding community-driven water and sanitation projects. The Mvula Trust's initial funding was provided by the Independent Development Trust, the Kagiso Trust (EU finance) and loans from the Development Bank of South Africa. During the democratic transition period, the Mvula Trust was able to play a critical advocacy and policy development role in support of the new government. Soon after the new government had established the Community Water Supply Sanitation Programme, an agreement was signed in 1995 between The Mvula Trust and the Department of Water and Forestry (DWAF) formalizing their relationship. 15 years later, this remains a unique agreement in terms of content and scope, especially given that it is between the government and an NGO. .⁶⁴⁶⁵

ANNEX 3

The Creation and History of RSPs

The abject poverty of the northern areas in Pakistan attracted the attention of the Aga Khan Development Network (AKDN) in the 1970s, ushering in an era of intense community-based development in the region. This movement was provided a concrete backbone in 1982, with the establishment of the Aga Khan Rural Support Programme (AKRSP) under the management of Mr. Shoaib Sultan Khan. The AKRSP was established as an Association-Not-For-Profit under Section 42 of the Pakistan Companies Ordinance, at the behest of His Highness Prince Karim Aga Khan. AKRSP's approach to rural development was conceptualized at the Academy for Rural Development, a manifestation of which was the Comilla project in East Pakistan (now Bangladesh) followed by the Daudzai project in Khyber Pukhtunkhwa. The AKRSP proved itself to be one of the most important agents of social sector service delivery in the northern regions, filling the void left by the inefficiencies of the federal and regional state machinery. The success of the AKRSP – the articulation of which has been provided in 4 evaluations by the Operations Evaluation Department (OED) of the World Bank between 1986 and 2002 – catalyzed the initiation of a movement of replication, with various RSPs springing up all across the country within the first two decades of the establishment of the AKRSP.

⁶³ UNICEF-ADB Workshop, . *Non-State WASH Provision in East Asia and the Pacific: Lessons for the Region*. 2010. 2. Print.

⁶⁴ "NGO Profile: The Mvula Trust." *NGO Pulse*. Southern African NGO Network, n.d. Web. 15 Jun 2010. <<http://www.ngopulse.org/article/ngo-profile-mvula-trust>>.

⁶⁵ "About Mvula." *The Mvula Trust*. Southern African NGO Network, n.d. Web. 6 Jun 2010. <<http://mvula.org.za/about/>>.

In Khyber-Pakhtunkhwa, the USAID's requirement for an organizational setup that could tap into resources at the community level and provide them with an impetus for their ongoing work in the region was satisfied by the creation in 1989 of the Sarhad Rural Support Programme (SRSP). This was followed by the establishment in 1991 of the Baluchistan Rural Support Programme (BRSP) and the National Rural Support Programme (NRSP).

The replication of the RSP model incorporated the practical duplication of the original structure and principles of the AKRSP. A manifestation of the success of the RSP model was government recognition of its conceptual and practical significance. This was illustrated by the provision of funds of up to Rs. 0.5 billion to the NRSP by the government. These resources were used to institute an endowment fund for supporting the core activities of the NRSP. Next to come was the Ghazi Barotha Taraqati Idara (GBTI) formed primarily to help in the rehabilitation of people affected by the construction of the Ghazi Barotha Dam. The Government of Pakistan continued to encourage the proliferation of such grassroots organizations, with the governments of Sindh and Punjab aiding the establishment of the Sindh Rural Support Organization (SRSO) and the Punjab Rural Support Programme (PRSP) respectively. Another RSP that came into existence during this period was the Thardeep Rural Development Programme (TRDP) in south-eastern Sindh – with their coverage later extended to parts of western Sindh as well. The Sindh Graduate's Association which was formed in 1972 formalized its relationship with the RSPN in 2001, bringing the total number of RSPs to nine.

Recognizing the importance of the state as the primary source of social sector service delivery and compounding their own role as vanguard facilitators, the RSPs have been able to manage a functional, working relationship with both the federal and the respective provincial governments. This symbiotic relationship manifests itself in the inclusion of senior government officials to the boards of directors while the government has accepted the autonomy of RSP's in all their affairs including their structure, policy matters, funding and pay scales.

In the last 28 years, the AKRSP has been aided financially through both national and international sources. These have included the governments of Canada, UK, USA, Japan, Switzerland, Netherlands, Norway and the European Commission.¹ The replication of the RSP concept in Pakistan created massive demand for financial and human resources, with the new organizations finding it hard to produce tangible results in an environment of low funding. This problem was however, mitigated after the World Bank sponsored Pakistan Poverty Alleviation Fund (PPAF) was founded in 1998. The Bank provided \$90 million to the AKRSP for use in community infrastructure and development, as well as micro-credit projects. This came as a breath of fresh air for the RSPs from the budgetary perspective, which have acquired 60 percent of the total funds coming through this particular channel over the period 1998-2004, reducing their dependence on commercial banks and international NGOs (INGOs).

The RSP machinery has become the largest non-government actor in rural development, having a presence in nearly three quarters of Pakistan's districts, with 1.9 million 'organized households' involved in COs or Women's Organizations as of 2008.

ANNEX 4

Sewerage and Sanitation

In 2010, 25 percent of households reported their satisfaction with the sewerage sanitation services, compared to 20 percent in 2004/05 and 12 percent in 2002. 43 percent households were dissatisfied with these facilities in 2010, 44 percent in 2004/05 and 37 percent in 2002. Figures revealed that 4 percent of

households were indifferent about the nature of these facilities in 2010 and 3 percent in 2004/05, and that 28 percent households reported that they had no access to sewerage and sanitation in 2010, compared to 34 percent and 51 percent in 2004/05 and 2002 respectively.

Water Supply

In the year 2010, 39 percent households were satisfied with the government water supply, a tangible increase from 19 percent in 2004/05 and 18 percent in 2002. The percentage of households dissatisfied with government water supply remained stagnant at 23 percent over the period 2004-2010, which initially stood at 20 percent in 2002. 5 percent households were indifferent towards this facility in 2010 compared to 2 percent in 2004/05. Access had increased over the course of the decade, with 32 percent households reporting no access to government water supply in 2010 as compared to 56 percent and 62 percent in 2004/05 and 2002 respectively.

Drinking Water

Urban dwellers were three times more likely than rural residents to have water supply source inside the house. In 2002, 78.9 percent of households reported a water supply source inside the house, compared to 85 percent in 2004 and 85.7 percent in 2009/10. In 2002, almost 40 percent of households paid for their water supply. The average amount per month paid was Rs 362. In 2004, the average cost of water per month was about Rs 548. In 2009/10, the average monthly cost of water varied by source of water inside the house: it ranged from Rs 164 for tap to Rs 539 for a tanker. Of the households which fetched water from outside the house, almost one half said that they had to walk less than 0.25 kilometers while the distance to a water source was greater in Balochistan. About 2 percent of the households had to cover more than three kilometers to acquire water. Distance to water sources is similar for the vulnerable groups.

Health

The survey of 2010 revealed a 33 percent satisfaction rate at the household level, compared to 27 percent in 2004/05 and 23 percent in 2002. The 45 percent dissatisfaction rate of 2002 had been brought down to 29 percent in 2010. However, it is important to note that the percentage of households that reported no access to health support from the government had risen to 29 percent in 2010 compared to 23 percent in 2004/05 and 32 percent in 2002.

Education

The percentage of households satisfied with government education services remained generally consistent, with a 58 percent, 53 percent and 55 percent satisfaction level in 2010, 2004/05 and 2002, respectively. Dissatisfied households went down from 38 percent in 2002 to 36 percent in 2004/05 and 26 percent in 2010. Households with no access to education stood at 7 percent in 2010, similar to figures in the 2002 CIET survey.

ANNEX 5

Over the last one decade of operations, the Rural Support Programme Network (RSPN) has not only been able to facilitate the RSP movement in this country, but has also created important linkages with the state machinery. Pakistan's Poverty Reduction Strategy Paper and the Medium Term Development Framework 2005-2010 go a long way in highlighting the value of the RSP approach. The RSPN has thus, been able to

prod the government into legislating more potent strategies and policies for the provision of higher income potentials and basic social services to the rural poor. On the supply side, the RSPN has worked towards building government capacity. In its relationship with other RSP's, the RSPN has conducted capacity-building and training exercises, leading to enhanced HRD and an expanded cadre of mid and senior level development professionals in the country.

RSPN has been actively involved in the propagation of the 2nd Generation Social Mobilization Model. The organization has sponsored exposure visits to Andhra Pradesh in India for senior government officials and RSP management, and commissioned research on local level institutions. In collaboration with the Institute of Rural Management, RSPN has developed a Social Mobilization training manual, draft LSO bye-laws, guidelines and checklists. RSPN has trained RSP staff in the 3-tier approach and an SM strategy has been developed for assisting the SRSP and the NRSP. In line with the establishment of 87 LSO's, RSPN has trained communities for LSO formation and leadership. The RSPN has directed funds from its primary financial support – the Department for International Development UK (DFID) – to 45 LSO's, various Community Resource Persons (CRP's) and Community Investment Funds (CIF's). RSPN is supporting the Punjab Rural Support Programme in piloting the 2nd GSM and the CIF in Jamal Chapri Union Council in Layyah District of Punjab, with a Rs. 10 million commitment to the project.

In the area of Policy and Advocacy, RSPN has been able to spearhead efforts at propounding Social Mobilization in the highest levels of governmental policy circles. The success of this advocacy has led to the concept's induction in Pakistan's Poverty Reduction Strategy. RSPN provided invaluable input to the design of the Citizens' Community Boards (CCB) and the Local Government Ordinance (LGO). In partnership with the government, RSPN has worked to promote the involvement of RSP's in the Prime Minister's Special Initiative for Livestock (PMSIL), the President's Primary Health Care Initiative (PPHCI) and the Crop Maximization Project (CMP) II. RSPN has been involved and supported activities in the spheres of the Union Council Poverty Reduction Plan (UCPRP), the Sindh Land Grant Programme, Community Led Total Sanitation (CLTS) and bio-gas generation projects. Moreover, the Network has allied itself with the National Reconstruction Bureau in earthquake relief and rehabilitation efforts. In its pursuit of streamlined assessment methods, the RSPN has worked extensively at tailoring Grameen Foundation's Poverty Score Card (PSC) in the context of Pakistan. With the proliferation of its usage across the country in programmes such as the Benazir Income Support Programme (BISP), the Pakistan Microfinance Network (PMN), the NRSP's projects, RSPN's work on the CIF at Jamal Chapri and the Sindh Land Grant Programme, the PSC has emerged as one of the most significant research tools that has been developed by the RSPN.

The Rural Support Programme Network has helped develop Social Sector Strategies for different RSP's and worked in two specialized areas, namely health micro-insurance and CLTS. Funds from DFID have been channeled towards the Pakistan Microfinance Network, with RSPN directly assisting the expansion of the Sindh Rural Support Organization (SRSO) and the Baluchistan Rural Support Programme (BRSP). The RSPN supports the Adamjee Insurance Initiative, and also works in areas related to birth-spacing, educational entrepreneurship and Child Centered Learning. Through the Enterprise Facilitation Unit, the RSPN supports women's enterprise development. RSP's have been exposed to gender concepts from international sources such as the SANGAT Feminist Course in Nepal. Centralizing gender as a theme in the SM movement, RSPN has supported and facilitated the Women's Leadership Programme conducted by the IRM, as well as numerous Training of Trainers (ToT) courses. The RSPN followed its research on women councilors' roles in decentralization and the impact of micro-credit on women, with the distribution of a training manual for women councilors. The Network envisages an RSP Gender Resource Group (GRG) for deliberating issues of relevance such as Women In Development (WID) and Gender And Development (GAD).¹